Bundle Board Meeting 25 July 2019

Agenda attachments

00 - Agenda v6.docx

	PATIENT STORY - Independent Living Service (Sarah McGill, Abigail Harris)
1	Welcome and Introductions
2	Apologies for Absence *Maria Battle*
3	Declarations of Interest *Maria Battle*
4	MINUTES:
4.1	Minutes of the Board meeting held on 30 May 2019 *Maria Battle* 4.1 - Board Minutes 30.05.19.docx
5	Action Log - 30 May 2019 *Maria Battle* 5 - Action log public 30.05.19.docx
6	Chairs Action taken since last meeting *Maria Battle*
7	ITEM FOR REVIEW AND ASSURANCE
7.1	Chairs Report *Maria Battle* 7.1 - Chair's Report July 2019 v3.docx
7.2	Chief Executive Report *Len Richards* 7.2 - Chief Executive Report.docx 7.2.1 - Andrew Goodall - to Len Richards - following JET.PDF
7.3	Patient Safety, Quality and Experience Report *Ruth Walker* 7.3 - Patient Safety Quality and Experience Report for 26.07.18 - FINAL.docx
7.4	Performance Report including Adult Mental Health Compliance Rates *Steve Curry* 7.4 - Performance Report including Adult Mental Health Compliance Rates.docx 7.4.1 - Performance Report July 2019.docx
7.5	Amplify 25 Presentation *Steve Parnell*
7.6	Board Assurance Framework and Corporate Risk Register *Nicola Foreman* 7.6.1 - BOARD ASSURANCE FRAMEWORK (JULY 19).2.docx 7.6 - Board Assurance Framework covering report - July 2019.3.docx
7.7	Integrated Medium Term Plan 2020-2023 *Abigail Harris* 7.7 - IMTP 2020-2023.docx
7.8	Major Trauma Centre Progress Report *Abigail Harris* 7.8 - MTC report for UHB v2 16.07.19.docx
8	ITEMS FOR APPROVAL / RATIFICATION
8.1	Risk Management and Board Assurance Framework Strategy *Nicola Foreman*

8.1 - Covering report Risk Management and BAF.docx

8.1.1 - Risk Management and BAF Strategy.docx

8.2 Welsh Language Policy

Martin Driscoll

8.3 - Welsh language policy approval paper KW JUNE 26 v2.docx

8.3.1 - App5 Welsh Language Policy (incl EHIA).doc

8.3 The Director of Corporate Governance Report

Nicola Foreman

8.3 - Report of the Director of Governance_July19 NF.docx

8.4 Board Development Plan

Nicola Foreman

8.4 - Board Development Programme Covering Report.2.docx

8.4.1 - Board Development Programme.NF.2.docx

8.5 COMMITTEE MINUTES:

8.5.1 Quality, Safety and Experience Committee - April 2019

Susan Elsmore

8.6.1 - QSE Committee Minutes 16.04.19.docx

8.5.2 Finance Committee - May 2019

John Antoniazzi

8.6.2 - Finance Committee Minutes- May 2019.docx

8.5.3 Strategy and Delivery Committee - June 2019

Charles Janczewski

8.6.3 - S&D Minutes April 2019.docx

8.5.4 Health and Safety Committee - May 2019

Michael Imperato

8.6.4 - H&S Minutes 9 April 2019.docx

8.5.5 Charitable Funds Committee - March 2019

Akmal Hanuk

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8.5.6 Mental Health and Capacity Legislation Committee - February 2019

Charles Janzewski

8.6.6 - MHCLC Minutes February 2019.docx

8.5.7 Local Partnership Forum - April 2019

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8.6.7 - LPF Minutes 3.04.19.docx

9 ITEMS FOR NOTING AND INFORMATION

9.1 Reports from Committees and Chairs:

9.1.1 Audit and Assurance Committee - Chair's Report May 2019

9.1.1 - Chair's Report Audit Committee 23.05.19.docx

9.1.2 Quality Safety and Experience Committee - June 2019

Susan Elsmore

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9.1.3 Finance Committee - June 2019

John Antoniazzi

9.1.3 - Finance Commitee Chairs Report.docx

9.1.4 Strategy and Delivery Committee - June 2019

Charles Janczewski

9.1.4 - Chair's Report - Strategy and Delivery - 25.06.19.docx

9.1.5 Health and Safety Committee - July 2019

Michael Imperato

9.1.6 - H&S Chairs Report - July 2019.docx

9.1.6 Charitable Funds Committee - June 2019

Akmal Hanuk

9.1.5 - Charitable Funds Committee Chair's Report_July 2019.docx

9.1.7 Mental Health and Capacity Legislation Committee - February 2019

Charles Janczewski

9.1.7 - MHCLC Chair's Report - June 2019.docx

9.1.8 Local Partnership Forum - April 2019

Martin Driscoll

9.1.8 - LPF Chairs Report (June 2019) for July 2019.docx

10 AGENDA FOR PRIVATE MEETING:

Clinical Claim Approval

11 REVIEW OF THE MEETING

Maria Battle

12 DATE AND TIME OF NEXT MEETING:

Thursday, 26 September 2019

Nant Fawr 1, 2 & 3, Ground Floor, Woodland House

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
BOARD MEETING
To be held on 25 July at 1.30pm

WOODLAND HOUSE, GROUND FLOOR, NANT FAWR 1&2, HEATH

AGENDA

PATIENT STORY - Independent Living Service (Sarah McGill, Abigail Harris)		
1	Welcome & Introductions	Maria Battle
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3	Declarations of Interest	Maria Battle
4	**Minutes**	
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5	Action Log – 30 May 2019	Maria Battle
6	Chairs Action taken since last meeting	Maria Battle
7	**Items for Review and Assurance**	
7.1	Chairs Report	Maria Battle
7.2	Chief Executive Report	Len Richards
7.3	Patient Safety, Quality and Experience Report	Ruth Walker
7.4	Performance Report including Adult Mental Health Compliance Rates	Len Richards
7.5	Amplify 2025 Presentation	Steve Parnell Presentation
7.6	Board Assurance Framework & Corporate Risk Register	Nicola Foreman
7.7	Integrated Medium Term Plan 2020/2023	Abigail Harris
7.8	Major Trauma Centre Progress Report	Abigail Harris
8	**Items for Approval/Ratification**	
8.1	Risk Management and Board Assurance Framework Strategy	Nicola Foreman
8.2	Welsh Language Policy	Martin Driscoll
8.3	The Director of Corporate Governance Report	Nicola Foreman
8.4	Board Development Plan	Nicola Foreman
8.5	**Committee Minutes:** i. Quality, Safety and Experience Committee – April 2019 ii. Finance Committee – May 2019 iii. Strategy and Delivery Committee - April 2019 iv. Health and Safety Committee – May 2019 v. Charitable Funds Committee – March 2019 vi. Mental Health and Capacity Legislation – February 2019	Susan Elsmore John Antoniazzi Charles Janczewski Michael Imperato Akmal Hanuk Charles Janczewski

	Advisory Group Minutes: vii. Local Partnership Forum – April 2019	Martin Driscoll
9	**Items for Noting and Information**	
9.1	**Reports from Committee and Chairs:** i. Audit Committee – May 2019 ii. Quality, Safety and Experience Committee – June 2019 iii. Finance Committee – June 2019 iv. Strategy and Delivery Committee – June 2019 v. Charitable Funds Committee – June 2019 vi. Health and Safety Committee – July 2019 vii. Mental Health and Capacity Legislation – June 2019 **Reports from Advisory Group Chairs:** viii. Local Partnership Forum – June 2019	 John Union Susan Elsmore John Antoniazzi Charles Janczewski Akmal Hanuk Michael Imperato Charles Janczewski Martin Driscoll
10	**Agenda for Private Meeting:**	
	Clinical Claim Approval	Ruth Walker
11	**Review of the Meeting**	Maria Battle
12	**Date and time of next Meeting**	
	Thursday 26th September at 1.00pm Woodlands House, Ground Floor, Nant Fawr 1, 2 and 3	

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

UNCONFIRMED MINUTES OF A MEETING OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD HELD ON 30 MAY 2019
BOARD ROOM, UNIVERSITY HOSPITAL LLANDOUGH

Present:

Maria Battle	MB	Chair
Charles Janczewski	CJ	Vice Chair
Len Richards	LR	Chief Executive Officer
John Antoniazzi	JA	Independent Member - Estates
Professor Gary Baxter	GB	Independent Member - University
Eileen Brandreth	EB	Independent Member - ICT
Robert Chadwick	RC	Executive Director of Finance
Steve Curry	SC	Chief Operating Officer
Martin Driscoll	MD	Executive Director of Workforce and OD
Susan Elsmore	SE	Independent Member – Local Authority
Akmal Hanuk	AH	Independent Member – Community
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Independent Member - Legal
Dr Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member – Third Sector
John Union	JU	Independent Member – Finance
Dawn Ward	DW	Independent Member – Trade Unions

In attendance:

Stephen Allen	SA	Chief Officer, Community Health Council
Nigel Davies	ND	Consultant in Obstetrics and Gynaecology
Daniel Crossland	DC	Head of Occupational Therapy
Indu Deglukar	ID	Chair, Senior Medical Staff Committee
Suzanne Hardacre	SH	Lead Nurse, Women and Children Clinical Board
Nicola Foreman	NF	Director of Corporate Governance
Dr Sharon Hopkins	SH	Director of Transformation and Informatics
Meriel Jenney	MJ	Clinical Board Director, Children and Women Clinical Board
Alun Jones	AJ	Deputy CEO, Health Inspectorate Wales
Mark Jones	MJ	Wales Audit Office
Annie Procter	AP	Clinical Board Director, Mental Health Clinical Board
Jason Roberts	JR	Deputy Executive Nurse Director
Geoffrey Simpson	GS	Vice Chair, Stakeholder Reference Group
Jayne Tottle	JT	Nurse Director, Mental Health Clinical Board

Secretariat:

Glynis Mulford	GM	Corporate Governance Officer

Apologies:

Ruth Walker	RW	Executive Nurse Director

19/05/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting and confirmed that it was quorate. A special welcome was given to Geoffrey Simpson, Vice Chair of the UHB's Stakeholder Reference Group (SRG) and Jason Roberts, Deputy Executive Nurse Director who was attending on behalf of the Executive Nurse Director.	**ACTION**
19/05/002	**Patient Story – Maternity Care: Alexandra's Story** The Chair welcomed Meriel Jenney, Clinical Board Director; Nigel Davies Consultant in Obstetrics and Gynaecology and Susan Hardacre, Lead Nurse from the Children and Women Clinical Board to the meeting. The Chair confirmed that in light of the findings and recommendations arising from the Cwm Taf Maternity Services Review, published on 30 April 2019, the Children and Women Clinical Board had been asked to attend the Board meeting to provide Members with assurance that those using the UHB's maternity services were being listened to, and their stories used to improve Maternity Care. In introducing the Children and Women Clinical Board Team, the Chair emphasised the important role that the Board played in relation to ensuring that the UHBs services remained safe and where issues arise lessons learnt. It was noted that a *Safety Valve* process had been introduced to encourage staff to speak up when they did feel the usual process where working and unsafe practice was identified. The Chair confirmed that the UHB would build on this further with the relaunch of the Speaking *up Safely Programme* another alternative way staff can raise concerns. The importance of the UHB being a listening and learning organisation that encouraged and supported staff to speak up and consistently reinforced its values and behaviours was emphasised The story of Alexandra, a lady who had an emergency caesarean section some four weeks prior to the Board meeting was read out. It was noted that due to a severe form of placenta adherence Alexandra had experienced a catastrophic haemorrhage. The story demonstrated how a strong multi-disciplinary team approach enabled a professional and timely approach. It also highlighted that the following factors were important to Alexandra and gave her confidence and trust: ▪ the team remaining calm. ▪ everyone introducing themselves before going into theatre. ▪ the team being organised and looking professional. ▪ questions asked of the clinical team, being answered and there being a debrief after the incident to explain what had happened and the care provided. ▪ the anaesthetist that cared for Alexandra in theatre going out of his way to see her at her bedside for days after the event. ▪ being supported to have her baby with her throughout her hospital stay.	

Alexandra's story also highlighted:

- the importance of timely communication with relatives, as it had been harder for her husband, who was still struggling with the experience.
- the importance of all doctors introducing themselves and explaining what they were going to do. It was highlighted that ward rounds can be daunting when there are a lot of doctors from different specialties.
- the importance of community midwife support and the need to ensure the needs of the individual are considered when considering the frequency of visits.

Board Members thanked the Clinical Board Director for Children and Women and colleagues for their presentation. As part of the Board discussion that followed and in response to questions raised by Board Members the following points were noted:

- it was confirmed that the Clinical Board had an *Afterbirth Service* that ensured that mothers received appropriate care after a birth and had the opportunity to raise any concerns. It was noted that for most women the *Afterbirth Service* provided an opportunity for them to share their experiences and have a debrief session with a midwife.
- several midwifes were trained in 'rewind therapy' to support women to discuss and overcome issues that had occurred during their pregnancy or the birth. It was confirmed that support groups were in place and partnership arrangements, ensured further support was provided through parenting groups.
- National surveys and a local "two minutes of your time" surveys were undertaken, and the results used to inform the way women were treated. In addition, an annual performance review took place with the Welsh Government, the findings of which were reported in the public domain.

The Board was provided with an overview of the findings and recommendations set out in the report of maternity services at Cwm Taf University Health Board. It was noted that:

- concerns had been raised as early as 2017; highlighting the importance of listening and taking timely action.
- the UHB's maternity service was compliant with only 2 areas of the 70 recommendations set out in the report requiring further work.
- the UHB's maternity services were compliant with staffing levels with good recruitment and retention rates. It was confirmed that an active package of support was in place for newly qualified midwives and two of the UHB's midwives had received the RCN Midwife of the Year award.
- The culture within the Clinical Board and at Directorate level was good with a robust and positive culture of reporting of issues and concerns.
- The Chief Operating Officer considered the midwife recruitment

processes were working well

- In response to questions in relation to the culture of reporting, it was explained that incorporated within the DATIX incident reporting system was a structured trigger list. Any cases triggered through the system would be fully discussed and reviewed. Serious incidents were noted to be escalated to the Clinical Board.
- The Chief Executive Officer referred to the executive team being impressed with the enthusiasm demonstrated by maternity staff on patient walkabouts.
- There were pressures on the service as a result of mothers transferring from Cwm Taf UHB. Fortnightly flow meetings were being held and the matter was to be discussed at the Regional Planning Forum.

On behalf of Board, the Chair thanked the team for all their hard work.

The Board resolved that:

a) the Patient Story be noted.

b) the implementation of the recommendations arising from the Cwm Taf Maternity Services Review would be scrutinised by the Quality, Safety and Experience Committee.

[The Children and Women Clinical Board team left the meeting]

19/05/003 **APOLOGIES FOR ABSENCE**

Apologies for absence were NOTED.

19/05/004 **DECLARATIONS OF INTEREST**

The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. The following declarations of interest were received and noted:

- Charles Janczewski, Vice Chair declared his interest as the Chair of the Quality and Patient Safety Committee of the Welsh Health Specialist Care Committee (WHSSC). The declaration was formally NOTED. It was AGREED that the Vice Chair should participate fully in the Board's discussions and decisions as including the Thoracic Surgery item.

19/05/005 **MINUTES OF THE BOARD MEETING HELD ON 28 MARCH 2019**

The Board reviewed the Minutes of the meeting held on 28 March 2019, and confirmed them to be a true and accurate record.

The Board Resolved that:

a) the minutes of the meeting held on 28 March 2019 be approved as a true and accurate record.

19/05/006	**BOARD ACTION LOG** The Board reviewed the Action Log and noted the following: ▪ ***19/03/05 - Quality Safety and Experience Report-:*** there was a requirement to log all maintenance requests but not all staff were aware of the process. It was confirmed that further guidance would be issued, and improvements made to the mechanisms for providing feedback to staff on maintenance requests. It was also confirmed that prioritisation was a challenge given the age of the UHB's estate and the number of maintenance requests received. The Board agreed that a further update would be received in six months' time. The Chair requested that the Action Log be fully updated in readiness for the Board meeting scheduled for July, and clear timelines inserted. **The Board Resolved that:** (a) the action log and updates received be noted. (b) The action log be fully updated for each board meeting (c) all completed actions be archived. (d) ***19/03/05 - Quality Safety and Experience Report:*** A further update on the approach to the prioritisation and management of maintenance requests be scheduled for six months' time.	AH/NF
19/05/007	**REPORT FROM THE CHAIR** The Chair introduced her report that provided an update on key meetings attended, activities and actions that had taken place since the previous Board meeting. **The Board resolved that:** (a) the Chair's report be noted. (b) the affixing of the Common Seal be endorsed. (c) the reported Chair's Actions and signing of legal documents be endorsed.	
19/05/008	**REPORT FROM THE CHIEF EXECUTIVE** The Chief Executive provided an overview of the content of his report and as part of the discussions that followed: ▪ the Executive Director of Therapies and Health Science confirmed that the further development of the falls pathway and falls framework was progressing under the auspices of the Community Falls Alliance. It was noted that front line staff, third sector organisations, the Welsh Ambulance NHS Trust and Care and Repair were engaged in the first meeting of the Alliance. ▪ the effectiveness of the alliance approach and its use across the Regional Partnership Board footprint would be tested and	

agencies be evaluated.

The Independent Member - ICT, advised that she was pleased that the Chief Executive's report had included details of the use of digital technology and how it was transforming the experience of families using the services of the Neonatal Intensive Care Unit. The view that further examples of how digital technology is being used across the UHB should be reported at Board meetings was noted.

The Board resolved that:

(a) the Chief Executives report be noted.

19/05/009 **THORACIC SURGERY – ASSURANCE OVER THE PROVISION OF THORACIC SURGERY COVER AT THE MAJOR TRAUMA CENTRE**

The Chief Executive introduced the Thoracic Surgery Report confirming that, in November 2018, the UHB gave conditional approval for a single thoracic surgery site to be based at Morriston Hospital, Swansea on the condition that there was safe, on site, thoracic cover for patients in the Major Trauma Centre at UHW. It was noted that:

- The resolutions made by the Board, in November 2018, were based upon the Welsh Health Specialist Services Committee (WHSSC) having given it's commitment to taking forward certain mitigating actions.
- The UHB's Chair had written to the Chair of WHSSC advising of her disappointment that there had been a failure to reach agreement on thoracic surgery at the WHSSC Joint Committee held on 15 May, and concern that the decision on the workforce proposals related thoracic cover to the Major Trauma Centre had been delayed until 28 June 2019.

The Chair of the Senior Medical Staff Committee (SMSC) read out a statement on behalf of the UHB's Senior Medical Staff. This statement:

- reiterated the concerns raised by the SMSC at the November 2018 Board meeting, in relation to the significant clinical risk if safe, on site, thoracic cover for patients in the Major Trauma Centre at UHW was not put in place.
- highlighted the immediate issue of emergency cover of the Major Trauma Centre at Cardiff as of April 2020.
- urged the UHB to withdraw its approval for the Morriston Single Centre, and to not attempt to provide a Major Trauma Service as an important component of the service was inadequately provided for.

The Board considered the letter sent by Stephen Allen, Chief Officer South Glamorgan Community Health Council to the UHB's Chief Executive Officer, dated 19 May 2019. This set out the CHC's concerns and the outcome of assurance work undertaken. It was noted that Members of the CHC's Executive Committee were of the view that assurance given by the WHSSC addressed the issues raised by the CHC, however if safe thoracic cover was not agreed for the Major Trauma Centre this would not have been fully addressed.

- The Chair reiterated the fact that the UHB's approval for a single thoracic surgery site based at Morriston Hospital, Swansea had been on the condition that there was safe, on site, thoracic cover for patients in the Major Trauma Centre at UHW.
- the Independent Member - ICT enquired as to whether it was clear what additional evidence/information WHSSC required. It was noted that the two Medical Directors of Swansea Bay UHB and Cardiff and Vale UHB had agreed a safe model which had clinical consensus including within Cardiff and the Vale. In response, the CEO confirmed that the work undertaken by the Medical Directors was supported and gave a clear position for Cardiff and Vale going forward, but WHSSC wanted to gain an impartial view. It was noted that the UHB's Chair had written to the Chair of WHSSC requesting clarification as to who would be undertaking the work.
- Concerns were raised in relation to the information and evidence gathered by WHSSC not being fully shared with the UHB. There was agreement that the 'closed panel' process was flawed and that WHSSC like all NHS bodies had a duty of candour. It was also agreed that the process adopted by the WHSSC in relation to thoracic surgery needed to be reviewed and lessons learnt in readiness for any future major change proposals.

In drawing the discussion to a close, the UHB's Chair reminded Members that the Board's approval of the WHSSC's recommendations had been was conditional on the following "*if the issues relating to patient safety aligned with the provision of thoracic surgery cover at the major trauma centre were not resolved within 6 months from the date of the meeting, then the Board would withdraw its approval*." It was confirmed that given the current situation the Board had two options:

(i) Withdraw its approval as the issues relating to patient safety aligned with the provision of thoracic surgery cover at the Major Trauma Centre have not been resolved within the stated 6 months.

(ii) Extend the previous resolution by one month pending a decision from WHSSC regarding workforce arrangements on the 28th of June.

The Board resolved that:

(a) a maximum delay of one month be AGREED.

(b) the model agreed by the Medical Directors be SUPPORTED.

(c) A special Board meeting be held as soon as possible after the WHSSC meeting at the end of June to discuss the outcome of the WHSSC meeting — NF

(d) The Chief Executive Officer meet with WHSSC to express the Board's concerns. — LR

19/05/010 **COMMUNITY MENTAL HEALTH SERVICES – IMPLEMENTING A NEW MODEL OF CARE**

The Board was provided with an update on the Vale Locality Mental

Health Team Pilot which commenced on 17 September 2018. The progress and developments made over the previous seven months were outlined. The Clinical Director for the Mental Health Clinical Board presented an overview of the new model of care; highlighting that its implementation required cultural as well as practice changes. The Board was advised that:

- the demand for Mental Health service was outstripping the UHB's capacity to deliver.
- like other Welsh Health Boards, the UHB was struggling to address ongoing estates issues, both in terms of capacity and suitability of environment.
- cultural change was aligned to the need to support staff to ask service users how they can help and what they can do.
- three Community Mental Health Teams (CMHT) from across Cardiff and Vale had merged together to create a Locality Mental Health Team.
- feedback from the *My Say* questionnaire, a service user feedback project, had highlighted that continuity of care was a major issue and service users wanted more say in their care and treatment. This presented a challenge as services were not equipped for this.
- Healthcare Inspectorate Wales found the quality of patient care and engagement with services users to be of a good standard, with staff working well together, although the nursing role sometimes seemed unclear and needed to be recovery focussed.
- the flow of the patient through the system and the CMHT caseload was an issue. Changes in legislation had given rise to additional pressures as unscheduled care patients needed to be seen within four hours.
- the redesigning of crisis pathways had reduced waiting times and partnership working with third sector organisations led to a transfer of 40% of the workload from the NHS.

Board Members acknowledged the importance of cultural change in ensuring that service users were at the centre of care.

- the Independent Member - Third Sector, commented on the fact that often what mattered to service users was not related to NHS care or treatment, and asked how the Clinical Director saw partnerships developing to address the wider needs of individuals. In response, it was confirmed that as a result of partnership work with third sector organisations a holistic view of the needs of service users was taken and social, financial and housing needs addressed.
- the Independent Member - Community, commended the approach of the Clinical Board which demonstrated strong leadership and an approach that put service users at the centre. This view was supported by the Independent Member – Local Government who commented that the approach of the Clinical Board demonstrated the change in culture that the Board wanted to see across the whole system.

	The Board resolved that: (a) the changes to the Part 1 Scheme be SUPPORTED (b) progress would be reviewed again in 6 months and an update provided to the Board (c) innovation and service-development within five Cardiff based CMHTs towards sustainable Locality Mental Health Teams be SUPPORTED.	SC/NF
19/05/011	**HEALTHCARE INSPECTORATE WALES (HIW) 2018-19 ANNUAL REPORT OF THE UHB** The Chair welcomed Mr Alun Jones, Deputy Chief Executive, HIW to the meeting and invited him to start his presentation. Mr Jones provided the Board with a summary of the inspection and review work undertaken across the UHB and its primary care contractors during 2018-19. It was confirmed that HIW would publish their annual report by the end of June. It was noted that: ▪ inspection findings for the UHB were generally positive. ▪ where improvement was required, all services had responded constructively ▪ engagement from the UHB's leadership team had been positive ▪ re-inspections had shown improvement in many areas and it was clear that the UHB sees external and internal scrutiny as a positive means of learning and improving ▪ further work is required in general practices and some hospital settings to ensure that patients are aware of how that can raise a concern about the care they received. ▪ HIW's inspection of the emergency and assessment unit at University Hospital revealed several issues which were impacting on the safety and dignity of patients. The Chair thanked Alun Jones for his presentation and gave her thanks to the HIW team for engaging with the UHB's leadership team in such a positive way. It was confirmed that at the Board Development session held in April 2019, the Board had considered the recommendations made in relation to the Emergency Unit and it was noted that the Quality, Safety and Experience Committee would be keeping the matter under review. It was also confirmed that the findings and recommendations arising from visits to Mental Health wards and teams were being monitored by the Quality, Safety and Experience Committee. The Chief Officer, South Glamorgan CHC confirmed that the CHC's visit workplan was shared with HIW as were the reports of such visits.	

The Board resolved that:

(a) The presentation delivered by the Deputy Chief Executive of HIW be noted.

19/05/012 **PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT**

The Deputy Executive Nurse Director introduced the Quality, Safety and Experience report and confirmed that in accordance with previous reports to the Board it provided an analysis of information drawn from the reporting of patient safety incidents, Serious Incidents (SIs), Never Events, and concerns raised by patients and families and feedback from national and local patient surveys. In discussing the report, it was noted that

- the number of Serious Incidents (SIs) had decreased and the number reported was not out of kilter with the rest of Wales.
- similar assurance arrangements to those outlined in the presentation delivered by the Children and Women Clinical Board (CB) were in place in the six other CBs. All SIs were monitored through weekly management team meetings where there was clear sight of all incidents. The Executive Nurse Director and where appropriate the Medical Director met with the Clinical Board teams.
- Two Never Events had been reported during the time period covered by the report. In each case a Root Cause Analysis had been undertaken. Considering one of the events a review of the Swab Count Procedure was underway.
- The UHB's Vice Chair, noted his disappointment that a 16-year-old had been referred to Hafan y Coed an adult mental health facility. In response, Board Members were advised that the individual had been extremely unwell at the time and a more appropriate facility could not been secured in or outside of Wales. The Board was advised that very strict procedures were in place to ensure that appropriate safeguarding arrangements were put in place when a young person was admitted on to an adult ward.
- Further to questions raised by Board Members in previous meetings of the Board, it was confirmed that steps were being taken to improve the UHB's benchmarking arrangements.
- Board members had requested year on year profiles and trends be included in future reports.

The Board resolved that:

(a) The Quality, Safety and Experience report be NOTED.

(b) The areas of current concern be NOTED and AGREED that the current actions being taken were sufficient.

(c) Year on year profiles and trends be included in future iterations of the report. RW

19/05/013	**PERFORMANCE REPORT** The Deputy Chief Executive/Director of Transformation and Informatics introduced the Performance Report and confirmed that the UHB had shown improvement in performance by achieving compliance with 26 of its 68 performance measures. An overview of the key aspects of the report was provided and the Chief Operating Officer confirmed that planned trajectories continued to be complied with. Board Members requests for benchmarking data and long-term trends to be reported were acknowledged, and it was confirmed that work was ongoing. As part of Board discussions, it was noted that: ▪ there were significant fluctuations in demand for Child and Adolescent Mental Health Services (CAMHS) and work was ongoing to enable a better understanding of the reasons for such fluctuations and how they could be better managed. ▪ the repatriation of CAMHS provided an opportunity to fundamentally review the service model. ▪ although the four- and 12-hour unscheduled care targets set by Welsh Government had not been met, the UHB's performance was positive when compared to other health boards in Wales. ▪ partnership working was going from strength to strength and having a positive impact on quality of care and performance. ▪ the development of an outcomes framework was progressing. ▪ the UHB's MMR uptake rates were positive in the context of increased outbreaks across Europe. ▪ The roll out of a Mental Health and Musculoskeletal (MSK) Multi-disciplinary team had commenced with the aim of reducing the call on GP appointments. It was noted that the Executive Director of Therapies and Health Science was leading on the development of this model on an all-Wales basis. ▪ Finance: Month 1 figures were not encouraging with an overspend of £650,000 with a further £383,000 overspend expected. The UHB's CIP target was also adrift by £3.3m. It was confirmed that focused action had been taken to drive improvement. **The Board resolved that:** (a) The Board considered the UHBs performance and actions been taken to improve performance.	
19/05/014	**TRANSFORMATION REPORT - DEVELOPING CLEAR BENEFITS & MEASURES** The Deputy Chief Executive/Director of Transformation and Informatics introduced the report, confirming that transformation work was aligned to key operational issues. It was noted that the report provided a summary of progress with each of the five programmes and supporting projects. As part of discussions it was confirmed that:	

- To date the focus had been on scoping the enablers setting the programmes of work, building the content of each and starting active work.
- Benefits and outcomes had been identified for each programme and supporting projects. Work continued to refine these to ensure measurable benefits and outcomes.
- The five key programmes would be visualised in the information room at Woodland house to highlight progress and benefit realisation.
- Independent Members had attended a workshop on the Health Pathways which they had found helpful.

The Board resolved that:

(a) the contents of the Transformation Programme report be noted.

[Independent Member – Local Authority left the meeting at 15.50]

19/05/015 **BOARD ASSURANCE FRAMEWORK**

The Director of Corporate Governance introduced the report on the Board Assurance Framework (BAF) and confirmed that:

- the key risks arising from Corporate and Clinical Board Risk Registers would be presented to the Board alongside the BAF at the July 2019 meeting.

The Board Resolved that:

- the BAF be APPROVED and the progress made in relation to the actions, management and mitigation of the key risks to the achievement of objectives NOTED.

THE WINTER PLAN

The Chief Operating Officer provided an overview of the Winter Plan, confirming that it provided a review of last winter and set out the plans for the coming winter. It was noted that during the winter of 2018-19 performance had improved and the Welsh Government recognised that the UHB appreciated the importance of early planning for Winter.

The Chair confirmed that she would write to staff on behalf of the Board to thank them for their efforts in preparing for and coping with winter pressures.

19/05/016 **The Board resolved that:**

- the report be noted together with the learning points from the winter of 2018-19.
- the recommendations for the development of next year's plan be endorsed

19/05/017	**THE WALES AUDIT OFFICE ISA 260 REPORT FOR 2018/19** Mark Jones, Wales Audit Office provided an overview of the Wales Audit Office ISA 260 Report for 2018-19, and confirmed that the Auditor General: ▪ intended to issue an unqualified audit opinion on the 2018-19 financial statements, regarding them being true, fair and properly prepared. ▪ intended to issue a qualified opinion on regularity because the UHB has breached its revenue resource-limit for the three-year period 2016-17 to 201819. ▪ was due to sign the Audit Certificate and Report on 11 June 2019. ▪ intended to issue a substantive report (as opposed to a 'nil' report) that explained the statutory financial duties applicable for 2018-19 and the duties that the UHB had breached. The Board's attention was also drawn to: ▪ the two breaches for 2018-19. The £65.968 million revenue overspend and the lack of an integrated medium-term plan (IMTP) for 2018-19 to 2020-21 that the Welsh Government had approved. ▪ the summary of corrections made to the draft financial statements provided at Appendix 3 to the report. It was confirmed that following the audit certification by the Auditor General a separate report would be issued in readiness for submission to the Audit and Assurance Committee meeting scheduled for September 2019. **The Board resolved that:** (a) The Wales Audit Office ISA 260 Report for 2018-19 be noted.	
19/05/018	**YEAR END STATEMENTS: ANNUAL ACCOUNTABILITY REPORT, ANNUAL ACCOUNTS AND HEAD OF INTERNAL AUDIT OPINION** The Chair of the Audit and Assurance Committee advised the Board that the Accountability Report and supporting accounting and governance documents had been reviewed by the Audit Committee at its special meeting held earlier that day and advised the Board that the Committee was satisfied that: ▪ the financial statements had been prepared with legislative requirements and the Treasury Financial Reporting Manual. ▪ the accounts directions issued by Welsh Ministers had been observed. ▪ judgements and estimates made were responsible and prudent and applicable accounting standards have been followed and disclosed and any material departures explained. ▪ the Annual Accountability report for 2018/19 met legislative	

requirements as set out in the Treasury Financial Reporting Manual and the 2018/19 Manual of Accounts for NHS Wales issued by Welsh Government.

On behalf of the Audit and Assurance Committee, the Committee Chair recommend that the Board formally adopt the Annual Accounts for 2018/19 and the Annual Accountability report.

The Board resolved that:

a) the reported financial performance contained within the Annual Accounts be NOTED

b) it be NOTED that the UHB has breached its statutory financial duties in respect of revenue expenditure

c) the Wales Audit Office ISA 260 Report for 2018/19 which includes the letter of representation be AGREED and ENDORSED

d) the Head of Internal Audit Opinion and Annual Report for 2018/19 be AGREED and ENDORSED

e) the UHB's response to the audit enquiries of those charged with governance and management be AGREEDED and ENDORSED

f) the Annual Accountability Report for 2018/19 including the Annual Accounts and financial statements be APPROVED.

19/05/019 **NURSE STAFFING ACT**

The Deputy Executive Director of Nursing presented the report and highlighted that:

- nurse staffing levels were being reviewed for a third time under section 25(A).
- The Clinical Boards and Executive Nurse Director had agreed establishments that they considered would meet all reasonable requirements with the exception of Mental Health Clinical Board.
- The UHB was looking at the infrastructure to identify how it could ensure compliance with Section 25, in the care we commission both inside and outside of Wales.
- The obstetrics service was coping with issues relating to the growing workload at the time of reporting to Board. Work to change the service model was ongoing and should help alleviate pressures.

The Board resolved that

a) the nurse staffing levels in line with the Nurse Staffing (Wales) Act (2016) be approved.

19/05/020 **CAPITAL PLAN FOR 2019/20**

The Executive Director of Planning provided the Board with a summary of the key elements of the Capital Plan for 2019/20. The report included

updates on the current status of each of the key projects within the programme, a detailed schedule of projects, and highlighted key risks to the programme and matters that may require escalation. It was noted that:

- there had been some slippage in relation to the move of services from Rookwood, as some of the services had taken longer to relocate but steps to speed the move had been taken.
- the park and ride service would be introduced at Llandough Hospital in July 2019. It was noted that a few issues were being finalised with Cardiff Council.
- The Strategic Outline Programme had been endorsed for Shaping our Future Wellbeing and was the first such programme in Wales.

The Executive Director of Planning took the Board through the:

- Outline Business Case (OBC) for the Maelfa Wellbeing Hub, advising that Board approval was needed prior to its submission to Welsh Government for approval of capital funding from the Primary Care Pipeline Fund.
- Business Justification Case for the Cystic Fibrosis, advising that Board approval was needed before its submission to Welsh Government for approval of All Wales Capital funding.
- Strategic Outline Case for the Academic Avenue advising that Board approval was needed before its submission to Welsh Government for All Wales Capital funding to allow the development of the OBC. It was confirmed that UHW Infrastructure Programme Board had been established to oversee the project.

As part of discussions Board Members asked:

- Whether the Academic Avenue project had been factored into the plans for UHW site. In response, it was confirmed that an early piece of work would be undertaken to develop a plan for the UHW site, and that advice would be sought on whether to undertake a new hospital build, a phased build or complete build.
- questions regarding the relationship between the Academic Avenue Project and the Major Trauma Centre (MTC) being built on the site. It was confirmed that further business cases would be brought to the Board over time.
- whether the timelines for completion of the projects was feasible give the time it took to develop business cases and commission the work. It was confirmed that the fact that modular buildings, for example theatres could be built off site helped with the timelines.

The Board resolved that:

a) the Capital Plan be NOTED

b) the Wellbeing Hub OBC be APPROVED for submission to Welsh Government for approval of capital funding from the Primary Care Pipeline Fund.

c) the Cystic Fibrosis BJC be APPROVED for submission to Welsh Government for approval of All Wales Capital funding.

d) the Academic Avenue SOC be APPROVED for submission to Welsh Government for All Wales capital funding to allow the development of the OBC.

19/05/021 **BOARD PLAN OF BUSINESS 2019/20**

The Director of Corporate Governance presented the Board's Plan of Business for 2019/20.

The Board resolved that:

a) the Board's Plan of Business for 2019/20 be APPROVED

b) to NOTE that that the Plan would continue to be populated with timescales for the delivery of Strategies, Annual Reports and Board Champion Reports

19/05/022 **MEMBERSHIP OF COMMITTEE AND BOARD CHAMPION**

The Director of Corporate Governance presented the review of the Committee Membership and Board Champion roles.

The Board resolved that:

a) The Membership of the Committees of the Board and specifically approved the changes detailed within the last column of appendix 1.
b) Approved the proposed Board Leads and Champions set out in appendix 2.

19/05/023 **TERMS OF REFERENCE AND WORKPLAN FOR THE HEALTH AND SAFETY COMMITTEE**

The Board reviewed the Terms of Reference for the Health and Safety Committee and associated work plan for 2019/20 that were attached to the report. It was noted that the Terms of Reference and Work Plan for the successor to the IG and T Committee would be presented at the July Board.

The Board resolved that:

a) the revised Terms of Reference and associated work plan for 2019/20 of the Health and Safety Committee be approved.

19/05/024 **THE DIRECTOR OF CORPORATE GOVERNANCE REPORT**

The Director of Corporate Governance presented the report, providing an overview of the key points set out therein.

The Board resolved that:

	(a) the update provided by the Director of Corporate Governance be NOTED. (b) the consultations and the need for the UHB to formally respond would be considered further by the Management Executive in future and then a recommendation made to the Board.	NF
19/05/025	**AUDIT AND ASSURANCE COMMITTEE** **The Board resolved that:** a) the minutes of the Audit and Assurance Committee held in February 2019 be RATIFIED.	
19/05/026	**QUALITY, SAFETY AND EXPERIENCE COMMITTEE** **The Board resolved that:** a) the minutes of the Quality, Safety and Experience Committee held in February 2019 be RATIFIED.	
19/05/027	**FINANCE COMMITTEE** **The Board resolved that:** **a)** the minutes of the Finance Committee held in March 2019 RATIFIED.	
19/05/028	**STRATEGY AND DELIVERY COMMITTEE** **The Board resolved that:** a) the minutes of the Strategy and Delivery Committee held in March 2019 be RATIFIED.	
19/05/029	**HEALTH AND SAFETY COMMITTEE** **The Board resolved that:** a) the minutes of the Health and Safety Committee held in January 2019 be RATIFIED.	
19/05/030	**STAKEHOLDER REFERENCE GROUP** **The Board resolved that:** a) the minutes of the Stakeholder Reference Group held in January 2019 be RATIFIED.	
19/05/031	**LOCAL PARTNERSHIP FORUM**	

	The Board resolved that: a) the minutes of the Local Partnership Forum held in February 2019 be RATIFIED.	
19/05/032	**AUDIT COMMITTEE REPORT TO BOARD** **The Board resolved that:** a) the report of the Chair of the Audit and Assurance Committee be NOTED.	
19/05/033	**QUALITY, SAFETY AND EXPERIENCE COMMITTEE REPORT TO BOARD** **The Board resolved that:** a) the report of the Chair of the Quality, Safety and Experience Committee be NOTED.	
19/05/034	**FINANCE COMMITTEE REPORT TO BOARD** **The Board resolved that:** a) the report of the Chair of the Finance Committee be NOTED.	
19/05/035	**STRATEGY AND DELIVERY COMMITTEE REPORT TO BOARD** **The Board resolved that:** a) The report from of the Chair of the Strategy and Delivery Committee be NOTED.	
19/05/036	**HEALTH AND SAFETY COMMITTEE REPORT TO THE BOARD** **The Board resolved that:** a) The report of the Chair of the Health and Safety Committee be NOTED.	
19/05/037	**STAKEHOLDER REFERENCE GROUP REPORT TO BOARD** **The Board resolved that:** a) The report of the Chair of the Stakeholder Reference Group be NOTED.	
19/05/038	**LOCAL PARTNERSHIP FORUM REPORT TO BOARD** **The Board resolved that:** a) the report of the Chair of the Local Partnership Board be	

	NOTED.	
19/05/039	**AGENDA OF THE PRIVATE BOARD MEETING** In terms of openness, the items to be discussed at the Private meeting were confirmed as being: ▪ The Healthcare Inspectorate Wales Report ▪ The Vascular Surgery Review ▪ The Wales Audit Office's Letter of Representation	
19/05/040	**ANY OTHER URGENT BUSINESS** No other business items were raised.	
19/05/041	**DATE OF THE NEXT MEETING OF THE BOARD:** Thursday 25 July 2019, 1.00pm Woodlands House, Heath, Cardiff CF14 4TT.	

ACTION LOG
FOLLOWING BOARD MEETING
30 MAY 2019

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
19/03/068	UHB Research & Development: Strategy Implementation Plan	Consideration to be given to how the R&D agenda can be made more visible at public Board meetings	TBA	N Foreman	**COMPLETE** - R&D Annual Report now on the Board work plan 2019/20 presentation date to Board to be agreed with Executive Lead
19/03/079	Public Accounts Committee Closure Report	Board to Receive an Assurance Report from the Director of Corporate Governance on an annual basis to ensure ongoing compliance and sustainability of actions in the future	March 2020	N Foreman	**COMPLETE** - Added to the Board cycle of business for March 2020.
19/05/006	Board Action Log 28.03.2019	The Chair asked that the Board Action Log be updated with clear time lines for the next meeting	25.07.2019	N Foreman	**COMPLETE** – Action log updated with time frames for each action.
19/05/009	Thoracic Surgery – Assurance over the provision of cover at the MTC	(a) A Special Board Meeting to be held at the end of June to discuss Thoracic Surgery and safety issues around the MTC (b) The CEO to Meet with WHSSC to raise the concerns of the Board	04.07.2019 13.06.19	N Foreman L Richards	***COMPLETED – Meeting held on 4th July 2019*** ***COMPLETED – Meeting with CEO and WHSSC took place on 13 June 2019***
19/03/058	Quality Safety And Experience Report	The Executive Nurse Director would explore approaches and options to	26.07.19	R Walker	**COMPLETED.** Information in July Board Report.

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
		benchmarking			The Patient safety Team and Patient Experience Team have met with Lightfoot colleagues and Canterbury colleagues and have been informed that we are a little further forward in this area. The benchmarking information will therefore be revisited.
19/05/013	Patient Safety, Quality and Experience Report	Year on year profiles and trends to be included in future iterations of the Patient Safety and Experience report		R Walker	**COMPLETED.** To be included in future reports.
Actions In Progress					
19/01/005	18/119- Relocation of the Links Centre	The Capital Estates and Facilities team is working with PCIC and Mental Health Clinical Boards	26.03.2019	A Harris	There is agreement with the Mental Health Clinical Board and Capital Estates and Facilities to move the team based in the Links to Global link until the longer term plan is finalised.
18/154	RCS Review of Paediatric Surgery	Review how situation was handled from 2013 to learn lessons.	26.09.2019	L Richards	All relevant staff interviews have been completed and a report is awaited and will be presented to the Board Meeting held on 26th September 2019.
19/03/05	Quality and Safety Experience Report	A further update on the approach to prioritisation and management of maintenance requests be scheduled for six months' time	28.11.2019	A Harris	To be presented to the Board Meeting to be held on 28th November 2019.
19/03/051	Presentation of the Canterbury Study Tour	The Canterbury Team be invited to present to the Board again in six months' time to provide an update on progress	26.09.19	N Foreman	To be presented to the Board Meeting to be held on 26th September 2019.
19/03/059	Performance Report – Part 1b of the Mental Health Measure	A Baseline Assessment of compliance with Part 1b of the measure to be brought back to the Board in 6 months' time	25.09.19	S Curry	To be added to the September Board Meeting to be held on 26th September 2019.
19/03/059	Performance Report – Part 1a of the Mental Health Measure	Adult Mental Health compliance rates to be investigated and then reported back to Board	25.07.2019	S Curry	***On agenda item no: 7.4***

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
19/03/060	Board Assurance Framework 2018/19	A paper on Risk Management to be brought to the July Board meeting	25.07.19	N Foreman	***On agenda item no: 8.1***
19/05/010	Community Mental Health Services	A progress report would be provided to the Board in six months' time	28.11.2019	S Curry	A report will be presented to the Board Meeting to be held on 28th November 2019
19/05/024	Director of Corporate Governance Report	Consultations would be discussed at Management Executives in future and then a recommendation made to the Board as to which consultations would be responded to	25.07.2019	N Foreman	Management Executive discussed the consultations that were live as 6 June, when it met on 24 June. The outcome of these discussions is included in the Director of Corporate Governance's report – see agenda item 8.3.
Actions referred to Committees of the Board/Board Development					
UHB 18/053	R&D Implementation	Bring clinical innovation work to a Board Development Day	29.08.19	A Harris	The Clinical Innovation Work will be discussed at the Board Development Day on 29th August 2019.
19/03/009	Performance Report	Deep dive into the appraisal rates	03.09.19	M Driscoll	A report on the 'deep dive' to be presented to September Strategy and Delivery Committee Meeting to be held on 3rd September 2019.
19/03/012	Winter Resilience Programme	Steve Curry, Chief Operating Officer would take the programme back to PCIC	27.03.19	S Curry	To be discussed with PCIC Clinical Board *A verbal update will be provided at the July meeting of the Board.*
19/03/055	Board Action Log 19/01/006 – Patient Walkarounds	An outline of the revised approach to be taken to the Quality, Safety and Experience Committee	29.08.2019	R Walker	Patient Safety Walk arounds are to be discussed at the Board Development Day to be held on 29th August 2019.
19/03/059	Performance Report	CAHMS Performance 'deep dive' to be undertaken due to a fall in performance.	03/09/2019	S Curry	To be added to the September Strategy and Delivery Committee Meeting to be held on 3 September 2019.

Report Title:	**CHAIR'S REPORT**								
Meeting:	CARDIFF AND VALE UHB BOARD MEETING						**Meeting Date:**	25.07.19	
Status:	**For Discussion**		**For Assurance**	✓	**For Approval**	✓	**For Information**		
Lead Executive:	**N/A**								
Report Author (Title):	**INTERIM HEAD OF CORPORATE GOVERNANCE**								

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 meetings and events, outlines where the Chair has been required to affix the Common Seal of the UHB and, where appropriate, Chair's Action has been taken in line with Standing Orders which requires ratification of the Board.

BACKGROUND

This is my last Chair's Report to the Board. I have been honoured to serve Cardiff and the Vale for almost eight years and privileged and humbled to have worked with such dedicated caring and resilient colleagues across the UHB. I will be sad to leave but also happy to stay in the NHS and go home to Tenby where I have lived for the past 30 years. I will miss my colleagues in Cardiff and the public and patients, many of whom I have got to know personally and would like to thank everyone for their support and their dedication .Cardiff and the Vale UHB is in a much stronger place in terms of performance, culture and values than when I joined and that is a credit to everyone. I wish the Board well in its continuing improvement and transformation journey.

1. Annual Appraisal 2018/19

As this is my last Chair's Report it is fitting that I start with my Annual Appraisal with the Minister that took place mid July. I was pleased to report that 2018/19 had been a good year for the UHB; it was a year when we worked our way out of Targeted Intervention, our IMTP for the next 3 years was approved and we reached levels of performance in RTT, diagnostic waiting times, therapy waiting times, unscheduled care, and a number of other areas that as an organisation we have not seen before. Above all, I think that our work to engage with clinical staff across the organisation, to put them in the driving seat, and to put "Wyn" at the centre of what we do has provided us with a platform to really capitalise on the above and create a sustainable and high performing organisation going forward.

2. South Central & East Regional Planning and Delivery Forum

I attended my last South Central & East Wales Planning and Delivery Forum as Chair on 29 May. At the meeting progress in relation to ENT Services, Paediatrics/Obstetrics/Neonatal Services and Vascular Surgery was discussed. Composite reports outlining progress in relation to the two regional programmes i.e. Diagnostics (Cwm Taf UHB) and Ophthalmology (Aneurin

Bevan UHB) were also received.

Board Members will wish to note that at the meeting Professor Marcus Longley was appointed as the new Chair of the Forum.

3. Sexual Assault Services Project Board

At the June Sexual Assault Project Board meeting all Health Boards and Police Forces and Police Commissioners from across South and West Wales agreed the model for the Sexual Assault Referral Services. An additional Project Board on 1 August will consider the financial model with the aim of reporting to all relevant health and police boards in September for approval. The Childrens Commissioner for Wales has taken a keen interest in this work and will be visiting the Cardiff SARC Ynys Saff this month.

4. Urdd Eisteddfod

I joined Julie Morgan AM, Deputy Minister for Health and Social Services, at this year's Urdd Eisteddfod and talked to the young people who were visiting the UHB's stall. Young people had great fun dressing up in uniforms from a range of health professions such as nursing, housekeeping, radiology and health visiting, and taking photos using selfie frames with a view to interesting them in careers in the NHS. We were also recruiting for our apprenticeship programme.

We partnered with the Makers Guild Wales on an arts project, *Get Well Soon*. Julie and I joined children and young people creating unique get well messages on giant plasters and nurses` hats and needlework. These symbols of caring were given to older patients in St David`s and Barry Hospitals as Get Well Soon messages from young people

5. Teenage Cancer Trust Unit's 10th Anniversary Celebrations

The Teenage Cancer Trust Unit celebrated its 10th year anniversary with a special visit from the charities patron, the Duchess of York. I was honoured to join the celebrations and meet with young people and their families who shared their experience of living with cancer and the wonderful care they are receiving.

The Unit is the only specialist unit for young people with cancer in Wales and over the past ten years nearly 500 young people with cancer from across Wales have been treated there. The young people were truly inspiring; showing enormous courage and honesty about their experiences and their hopes for the future.

6. Children and Women's Clinical Board Celebration Event

The Children and Women's Clinical Board recently held their annual celebration event and staff recognition awards and I was delighted to attend. The event focused on the theme of "Living Our Values" and gave an insight into the inspirational work that is taking place.

The Celebration Event was uplifting and thought provoking, demonstrating the importance of taking time out to celebrate our staff`s achievements. Members of the Children and Youth Partnership Board presented prizes.

7. Capital, Estates and Facilities Staff Recognition Awards

The Capital, Estates and Facilities Staff Recognition Awards event provided a wonderful opportunity to celebrate the outstanding work and contribution that the team makes to the objectives and vision of the UHB. I was delighted to be invited to speak at such an inspiring event

8. Opening of the Neonatal Intensive Care Unit

We opened the new Neonatal Intensive Care Unit. Our partners and staff and some patients attended to celebrate the new unit which provides additional beds and is beautifully decorated. A bell has been introduced and is rung to celebrate the completion of a baby's treatment. In addition, new IT equipment allows families to keep in contact with their little ones when they are away from the unit.

9. Partnership Council For Wales

I represented NHS Wales at the Partnership Council for Wales meeting that took place on 12 June. Brexit and the Review of Strategic Partnerships were the key topics discussed. The review is being undertaken jointly by the Welsh Government and WLGA and will report to the Partnership Council for Wales, with a final report scheduled to be considered in October. It is important that this focuses on the people we collectively serve rather than organisations and learns from the experiences to date.

10. Engagement Event with Young Carers in Cardiff

As part of an ongoing programme of engagement conversations with different stakeholder and community groups I met with the Barry and Cardiff Young Carers YMCA Group to give them the opportunity to share their views and discuss any issues that they wanted to talk about. The Group highlighted the importance of the 'Carer Passport' as it identifies a carer and would assist them care for their family member improving access to clinicians and advice and overcoming confidentiality issues.

11. Joint Commissioning Strategy for Adults with a Learning Disability 2019-2024

Individuals with a learning disability, their families, carers and the third and independent sector, Cardiff Council, the Vale of Glamorgan Council and the UHB launched the first Joint Commissioning Strategy for Adults with a Learning Disability on 18 June 2019.

The Strategy has taken two years to finalise and is rooted in co-production and partnership. It outlines a commitment to working with people with a learning disability to provide them with the support they want to live the lives they choose and reflects with the UHB's commitment to ensuring that a person's chance of leading a healthy life is the same wherever they live and whoever they are. The event was led by people with a learning disability and their carers and their messages were incredibly powerful about what works well, what needs to improve and most importantly need to now get on and deliver the strategy.

12. 'Through The Trees' Arts for Wellbeing Project

This spring a group of artists, volunteers, patients and NHS staff members took part in the

'Through The Trees' arts for wellbeing project, and were given the opportunity to work in the atmospheric Rookwood Boardroom.

I was delighted to join those involved in the project patients and staff, June Osbourne, Bishop of Llandaff, Rachel Lewis, Rookwood Hospital Chaplain and members of the public to view the art and poetry work produced by the group and take part in a tree trail. The session was truly inspiring and demonstrated the positive impact of both nature, wildlife and the creative arts upon physical and mental wellbeing particularly for patients in Rookwood.

13. British Deaf Association's British Sign Language (BSL) Charter

On 26 June, the UHB became the first NHS health board in Wales to sign the British Deaf Association's BSL Charter; by doing so the UHB has pledged to:

- Consult with our local deaf community on a regular basis
- Ensure access for deaf people to information and services
- Support deaf children and their families
- Ensure staff working with deaf people can communicate effectively using British Sign Language
- Promote learning and high quality teaching of British Sign Language.

The signing of the Charter is testimony to the hard work and innovation of the Patient Experience Team who worked collaboratively with members of the deaf community in Cardiff and the Vale of Glamorgan, for over 18-months, to ensure that the UHB's services are more accessible and suitable for those that need them now and those who will come to need them in the future.

14. Child Health Seminar 2019

On 2 July 2019, I attended the Children's Commissioner for Wales's annual Child Health Seminar. A number of topics key to the delivery of responsive and seamless care were discussed and explored, including transitions to adult services and advocacy in health settings. The Seminar provided the opportunity for the UHB to share the progress that has been made in relation to the Youth Board and Children's Rights Charter. We have delivered on our pledges made last year to form a Children and Young Persons Board, to launch a Childrens Rights charter and to work with young people in adult A&E to ensure their rights are upheld. The Childrens Commissioner praised us for our progress and I would like to pay tribute to Lisa Cordery and the Children and Womens Clinical Board. Over the coming months I hope that the link between the UHB Board and the Youth Board will further develop and strengthen.

15. Four staff at Cardiff and Vale University Health Board received an MBE in this year's Queen's Birthday Honours

I would like to congratulate:

- Professor Anthony James Bayer, Professor of Geriatric Medicine and Director of Memory Assessment Service;
- Kathryn Ellaway, lately Designated Nurse Safeguarding, National Safeguarding Team;
- Suzanne Louise Poley, Consultant Nurse for Substance Misuse; and
- Ruth Walker, Executive Nurse Director.

who have been awarded an MBE in the Queen's Birthday Honours for their services to health and care. Each of our colleagues thoroughly deserve this national recognition, they are all outstanding in their individual fields and have made such a difference to some of the most vulnerable people we serve.

16. Single Cancer Pathway Workshop

On 3 July I attended the Single Cancer Pathway Workshop at Cardiff City Stadium called "What does Good look Like." Clinicians and voluntary organisations from across Wales shared good practice and challenges in cancer care and implementing the single cancer pathway. I chaired a question and answer panel of leading clinicians and the need for widespread prehabilitation to increase patients` chances and an increase in diagnostic capacity were key messages.

17. Cardiff County Council Scrutiny Committee

Together with the leader of Cardiff Council, Huw Thomas, and the Chief Executive, Paul Orders and Dr Sian Griffiths I attended the Cardiff County Council Scrutiny Committee as Vice Chair of the Public Services Board to be scrutinised on our draft wellbeing plan. The committee were pleased with the progress made by all partners. We highlighted the impact of the transport plan with Next Bikes across the city, the increase in Park and Ride to UHW and UHL, the Staff Healthy Travel charter and the impact of "Me My Home and Community" which has helped patients get home from hospital and improve flow. We also discussed the Clean Air proposals and Move More, Eat Well and the impact on health and wellbeing.

Both organisations agreed that relationships at leadership and executive levels had positively influenced how we collectively deliver better for our citizens. We confirmed Brexit planning with all agencies was continuing as well as asset management and discussed plans for considering a new build of UHW. Many of the aims within the plan are the wider determinants of health such as education, employment, housing, the environment and poverty and can be more effectively delivered in partnership.

18. 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 4 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.

Seal No.	Description of documents sealed	Background Information
885	Call Off Contract for Regional Project Manager. Major Trauma & Vascular Hybrid Theatres at University Hospital Wales, Cardiff The delivery agreement is between Cardiff and Vale University Health Board	Gleeds is one of three project management companies listed under the Designed for Life. All NHS major construction projects with a construction value over 10 million are required to be let through this framework.

	and Gleeds Management Services Limited.	
886	Lease relating to Land at Whitchurch Hospital, Whitchurch, Cardiff between Cardiff and Vale University Health Board and Wales & West Utilities	The lease is to enable Wales and West Utilities Ltd to gain access to use a compound at the Whitchurch Hospital Site.
887	Call off Contract for Regional Cost Advisor Major Trauma & Vascular Hybrid Theatres at University Hospital of Wales, Cardiff The delivery agreement is between Cardiff and Vale University Health Board and Gleeds Management Services Limited.	Gleeds is one of three project management companies listed under the Designed for Life. All NHS major construction projects with a construction value over 10 million are required to be let through this framework.
888	Call Off Contract for Regional Supply Chain Partner Major Trauma Centre & Vascular Hybrid Theatres at UHW	The Call Off Contract is between the UHB and Wilmott Dixon Construction Limited.

b. Signed Legal Documents

The following legal documents have been signed:

Date Signed	Description of Document	Background Information
21/03/19	Food for Life Get Togethers: Programme Partner Agreement	The Agreement is between the Soil Association Ltd and the Cardiff and vale University Local health Board General Purpose Charity. It relates to the provision of monies to deliver activities under the Food for Life Get Togethers programme. The activities will be delivered by Food Sense Wales.
07/06/19	Heads of Terms and Conditions for Parking Licence	The Heads of Terms and Conditions relates to the Car Park at the former Toys R Us Unit, International Sports Village, Olympian Drive, Cardiff. The arrangement is between Cardiff County Council and Cardiff and Vale University Health Board.

05/07/19	NEC 3 Engineering and Construction. Short Contract, Refurbishment of Ward B4, UHW	The contract is for the conversion of existing Scope Room in main theatres UHW into a new Endoscopy Decontamination Suite comprising of dirty room and clean room and all associated ME works.

c. Chair's Action

Chair's Action was taken on two occasions in relation to:

04/06/2019	Agreement to seek the Welsh Governments approval to start negotiations to settle a claim brought against the Health Board out of court.
04/06/2019	Agreement to seek the Welsh Governments approval to start negotiations to settle a claim brought against the Health Board out of court.

ASSURANCE AND RECOMMENDATION:

ASSURANCE is provided by:

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

The Board is recommended to:

- **NOTE** the report
- **ENDORSE** the affixing of the Common Seal
- **APPROVE** the Chairs Actions and signing of legal documents

Shaping our Future Wellbeing Strategic Objectives
This 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	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	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						
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	X	Involvement	X
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**CHIEF EXECUTIVE'S REPORT**						
Meeting:	CARDIFF AND VALE UHB BOARD MEETING				**Meeting Date:**	25.07.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**CHIEF EXECUTIVE**						
Report Author (Title):	**INTERIM HEAD OF CORPORATE GOVERNANCE**						

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.

REPORT

BACKGROUND

This is the ninth written report being presented and, where appropriate, has been informed by updates provided by members of the Executive Team.

As Board Members will be aware I recently had ankle surgery at the Orthopaedic Clinic at the University Hospital Llandough (UHL) and my experience was first class. I would like to thank all of the team involved in not only the prehab, surgery and recovery but all of those who organise and run the clinic providing a great service for our patients. I would also like to thank Dr Sharon Hopkins who stepped into the CEO on an interim basis while I was away and wish her well in the interim CEO role at our neighbouring Health Board, Cwm Taf Morgannwg University Health Board. I can't think of anyone more capable of providing cover during what must be a difficult time for the Health Board.

Thank You and a Fond Farewell

I would like to congratulate our Chair, Maria Battle who has been appointed to the role of Chair of the Board at Hywel Dda University Health Board. It is Maria's last Board meeting with us at Cardiff and Vale UHB and while we are sad to see her go, we are delighted that she is remaining within the NHS family. Maria has made a significant contribution as a leader in the NHS and has contributed and led on so many projects and initiatives; all of which have impacted upon patients.

I would personally like to thank Maria for all of her support and encouragement that she has given me over my two years as CEO and for her role in improving the UHB's position on performance, enabling us to be one of the highest performing health boards in Wales, including getting our Integrated Medium Term Plan approved by Welsh Government and lifting us out of

targeted intervention.

During her tenure as Chair Maria has made a significant contribution to Cardiff and Vale University Health Board, consistently striving to place the patient at the heart of everything she does. She has been one of the key advocates of organ donation and transplant within Wales, supporting the campaign for presumed consent which is now being adopted elsewhere and has striven to raise awareness of this. She also led the charge for a number of major projects such as a new Children's Hospital for Wales in 2015 and more recently a new spinal and neuro unit to replace the much loved Rookwood Hospital

Internally, Maria has led on some of the UHB's key initiatives to ensure openness and transparency with our public such as the Freedom to Speak up campaign and Safety Valve, encouraging staff to come forward on any issue, particularly those around patient safety. Maria has also been a leading light in introducing and promoting art to support the physical and mental wellbeing of both staff and patients and has been instrumental in the establishment of an Orchard at Llandough and countless art, theatre and musical productions – all positively impacting on our patient care and wellbeing.

Maria will be missed by all of her colleagues and friends at Cardiff and Vale UHB but I am sure I join many of you in wishing her well in the next stage of her NHS career.

ASSESSMENT

GOVERNANCE AND ASSURANCE

1. Welsh Health Specialised Services Committee (WHSSC)

The Committee's last scheduled meeting took place on 28 June 2019. Board members will wish to note that the meeting focused on Thoracic Surgery and in particular the Thoracic Surgery Workforce Plan.

The agenda and papers, including the minutes of the meeting held on 28 June 2019 can be accessed via the following link: http://www.whssc.wales.nhs.uk/2018-19-whssc-joint-committee

2. Emergency Ambulance Service Committee (EASC)

Board members will wish to note that the EASC is scheduled to meet on 23 July 2019 (*papers were yet to be published at time of reporting*). For ease of reference the link to the agenda and papers for the July meeting is provided below: http://www.wales.nhs.uk/easc/committee-meetings

3. NHS Wales Shared Services Partnership Committee (NWSSP)

Board Members will wish to note that the Committee last met on 18 July 2019. Board members can access the agenda and papers for the May meeting via the following link: http://www.nwssp.wales.nhs.uk/sspc-papers-2019

4. HIW report

Healthcare Inspectorate Wales has published a report on an unannounced inspection in March of our Emergency Unit and Assessment Unit (AU). The report raised concerns about patient experience within the lounge area of the AU.

We are working with the leadership teams in the Clinical Boards of Medicine and Surgery to put in place a robust improvement plan to address the recommendations. That has included immediately putting in place a number of measures and committing to delivering the actions required to ensure patients have timely access to care and improved overall experience by the staff on the unit.

I was pleased that despite the issues that we need to address, HIW highlighted staff in the unit as being kind and compassionate to patients, and treating patients with respect, courtesy and politeness at all times, as well as there being a good emphasis on teamwork and support for each other amongst clinical teams. I am sure that this strong sense of care for our patients and commitment to working together will drive the success of our improvement plan.

The HIW report was raised as part of the Cardiff and Vale Scrutiny Hearing at the Senedd. It was a challenging session as these formal scrutiny sessions tend to be. Unfortunately, the session was followed by some negative media coverage as I had to admit that in my effort to ensure that we reached a sustainable improvement in the waiting times for patients in the Lounge area, I have not moved quickly enough on this issue. I would like to apologise to the staff and the patients in the area and commit to working alongside staff to reach a solution.

5. Joint Executive Team Meeting with Welsh Government

The Joint Executive Team (JET) Meeting between Directors from Welsh Government and the UHB's Executive Team took place on 21 June 2019. The focus of the meeting was on the year-end position and performance during 2018/2019. Overall it was a good review meeting and the UHBs' continued improvement in terms of finance and performance and the fact that we now have an approved three year plan was acknowledged.

The UHB was noted to be operating at a broader system level demonstrating a maturing organisation. Welsh Government colleagues requested a further discussion around the UHW site issues and planning processes and confirmed that the UHB's target for the coming year was to maintain the progress made and to continue delivering against the milestones set.

A copy of the letter received from Andrew Goodall, Director General Health and Social Services/ NHS Wales Chief Executive following the JET meeting is appended to this report.

6. Chief Medical Officers Annual Report

The link takes you to the Chief Medical Officer for Wales Annual Report 2018/19 and describes the health news of the nation. The good news within the report is that health indicators are continuing to improve but the recent levelling off of life expectancy has attracted a lot interest. Obesity levels within the population are at a worrying level with childhood obesity being a particular concern and the Chief Medical Officer is developing a healthy weight plan for Wales and is seeking views on actions to be taken.

Please follow this link to read the full report:

https://gov.wales/sites/default/files/publications/2019-05/valuing-our-health.pdf

TRANSFORMATION AND ENGAGEMENT

Improving the Pathways of Care for Frail Older People

Members of the Board will be aware that Medicine Clinical Board are looking at ways to redesign and strengthen services which support improved pathways for frail older people. The focus is on reducing lengths of stay in hospital by supporting earlier intervention and rehabilitation. This work aligns closely with our plans to develop a Health and Wellbeing Centre in each Locality, which will play a key role in supporting care closer to home. We now want to test proposals for transforming the pathway with the public. The model places a reduced reliance on our bed base and has implications for services at Barry Hospital which we want to explore in the context of it becoming a Health and Wellbeing Centre for the Vale Locality. We have been working with the South Glamorgan Community Health Council (CHC) to agree a process for engagement and potential consultation on proposals for service change to commence shortly. The outcome of this engagement will be shared with the Board in the early autumn.

Day Surgery at University Hospital Llandough (UHL)

In line with the UHB's emerging Clinical Services Plan, we propose to start to provide an increased range of non-complex surgical treatments for the population of Cardiff and the Vale of Glamorgan at UHL. The proposed initial focus is on moving some day case and 23 hour stays for patients who need ENT procedures from the University Hospital for Wales (UHW) to UHL. We have been working with the CHC to agree a process for engagement on these proposals, to commence shortly. The outcome of this engagement will be shared with the Board in the early autumn.

Referral to Treatment (RTT)

I am pleased to confirm that RTT figures have continued to improve, which follows a continuous trend since my arrival. Improvements have been seen across the board, most notably a 95% reduction in patients waiting longer than 8 weeks for diagnostics to just 40, while nobody waited longer than 14 weeks for therapies; our best reported position for nine years.

There will always be areas where we must strive to continue improving. We know from the concerns raised by patients that waiting times and delays for treatment is high on their agenda, so I would like to thank and congratulate staff on these achievements, which for some of our patients can be lifesaving.

Amplify 2025

Over the next few weeks a number of staff will have been invited to the first of many leadership and innovation learning experiences, led by Martin Driscoll our Executive lead for Workforce and Organisational Development. This is another exciting strand to our Transformation agenda and is part of the Alliancing work we have committed to with Canterbury District Health Board. This is

a two day programme which will really test out our preconceived ideas and encourage us to look at how we can deliver services that matter to people in the future. This is the starting point of what promises to be a thought provoking development programme.

Well-being of Future Generations (Wales) Act in the UHB

During May and July this year the Wales Audit Office has been undertaking an audit of how the Health Board is implementing the Well-being of Future Generations (Wales) Act (WFG), with a focus on a specific area of work. This was agreed as Shaping Our Future Well-being in the Community, the capital programme to support our ten year strategy and design principles. A workshop with the Audit Office and key stakeholders took place on 12 June, with separate additional interviews with key individuals. There is a follow on workshop with the Audit Office scheduled for 23 July, and we expect a formal report one to two months after this workshop.

On 27 June, a Board development session focusing on the Act, how it is being implemented, and how we ensure the sustainable development principle (embodied in the five ways of working) is being routinely followed was held.

A Health Board WFG Steering Group, chaired by the Executive Director of Public Health, meets quarterly and reports progress against our action plan via the Strategy and Delivery Committee. The UHB is routinely putting the five ways of working into practice by implementing our organisational strategy, Shaping Our Future Well-being, and embedding the design principles in our work. Alongside this are a number of projects which are highlighted on our website which epitomise our approach to the Act, following the spirit as well as the letter of the legislation. These include the Creative Arts in Healthcare Strategy, the apprenticeship academy, and the recent extensions to the Park and Ride services to our sites.

Improving Sustainable Travel

I am delighted that we have recently been able to start a Park and Ride service at UHL and extend the service at UHW to cater for the phenomenal demand for it, thanks to funding from the Cardiff & Vale Health Charity.

Not only is sustainable travel like our park and ride service helpful in reducing the amount of traffic and car parking issues on our sites, but it's also great for the environment and air quality here too, which makes a huge difference to some of our patients.

Another growing alternative for travel are the fantastic nextbikes, which have been extremely popular since we introduced the station at UHW in November. They are a great option for commuting into work for those of us who live in and around Cardiff, and have become a useful mode of transport between UHW and Woodland House, where there is also a station. The number of bikes will soon be increasing so you can expect to see greater availability at both sites.

In May, we launched a pilot offering nextbikes on prescription at two of our GP practices, which is a UK first. As a health board, we know that prevention and health promotion is one of our most important roles and we're keen to promote activities which keep people healthy. To be the first UK city to introduce nextbike on prescription is fantastic testament to the Healthy Travel Charter, which we recently signed along with 13 public sector partners.

New developments in the Women's Unit at UHW

We've recently unveiled some new facilities that will help women and families in our care at the Women's Unit at UHW.

The delivery suite at the University Hospital of Wales has recently had sky tiles installed to help transform their birthing environments into calm and relaxing spaces. The sky tiles are LED illuminated panels that are set into the ceiling, which display high definition images.
They have been installed to help transform their birthing environments into calm and relaxing spaces, and feedback has been great so far. The first woman to give birth in the room following the installation and her husband commented on how nice it was to focus on the images and be able to dim the light themselves to create a calming environment.

A new bereavement suite and memory-making room have also been opened at UHW. The much-needed facilities have been established to support parents and families during a very sad and traumatic time, giving them precious time to spend together with their baby and make memories with them before saying goodbye.

I would like to thank our own Cardiff & Vale Health Charity for supporting these facilities, and helping to improve the services we offer to women and their families.

Pontypridd High School Live Bowel Cancer Event

The Chair and I had the pleasure of attending an event at Pontypridd High School hosted by year 8 pupils where they showcased what they have learnt about bowel cancer, the symptoms and the importance of taking part in the screening programme**.** This was part of a project led by Jared Torkington to improve Bowel Cancer outcomes.

Over eight week project, pupils learnt about bowel cancer, how to reduce the risk of the disease and were also given a unique opportunity to visit the training and education centre at the University Hospital of Wales to learn through the latest augmented reality technology. They also had the chance to speak to a bowel cancer patient about their diagnosis and treatment, and learn about the equipment used in surgery.

The Primary Choice Campaign

The new Primary Choice Campaign is being run to raise awareness about the skills and expertise that can be accessed throughout Primary Care. It focuses on Community Pharmacists, Optometrists, Dentists, General Practice Nurses, GP Receptionists and GPs to highlight their expertise and specialist skills, so that members of public know who to approach to receive the most appropriate advice, care and treatment for their needs, first time.

The campaign has had a fantastic reaction so far. By making the right Primary Choice, patients can access the healthcare they need and more quickly, but it also means that our GPs can spend time with the most vulnerable, complex and very ill patients.

I would urge everybody to get involved with the campaign by sharing the range of resources that have been made available on our website, including posters, flyers, videos and web and social media content.

International Nurses Day and Summer Switch Event

International Nurses Day was recently celebrated on our social media accounts to thank all of the nurses who care for people and keep them well here at Cardiff and Vale. Nurses make up a huge amount of our workforce, and we have regular recruitment drives to attract and retain newly qualified and registered nurses to join our team.

I was delighted with the turn out and the commitment of our nursing staff and other colleagues in supporting the Summer Switch recruitment festival; the third recruitment event of its kind that we have held. 105 people turned up on the day to meet our nursing teams and find out more about the opportunities we have available across the UHB, and some candidates were also interviewed on the day. It is encouraging to see these events grow and to see the dedication of our staff who gave up their sunny Saturday to welcome potential new recruits to the UHB.

We offered jobs to 45 people on the day with more who couldn't make the event to be interviewed. We also trailed the recruitment drive for the new Major Trauma Centre and had ten candidates interested in joining the team.

Once again I would like to thank the staff behind the event and those that worked on the day, who showed Cardiff and Vale as a great place to train, work and live.

Building Our Future Workforce

Board Members will wish to note that we have now launched new values-based appraisals and recruitment across the health board. This fresh approach to appraisals will replace the existing PADR process, and will focus upon engaging existing staff members in honest, open and supportive conversations that will help them to explore their career potential. Alongside this, our move towards a values-based recruitment framework will help us to appoint the right people, with the right skills and the right values to make sure that our workforce is fit for the future.

Celebrating diversity and our international staff

On Friday, I was delighted to see the Rainbow Flag flying at UHW for International Day against Homophobia, Biphobia and Transphobia (IDAHOBIT). I'm proud that we are a diverse organisation; homophobia, biphobia, transphobia or any other kind of prejudice has no place in our Health Board.

The UHB will once again be showing it's colours at the Pride Cymru parade in support of LGBT+ colleagues and the wider community.

Armed Forces Day

On Saturday, the 29 June, Armed Forces Day was celebrated and people from all over the United Kingdom came together to show their support for both current and past military personnel. Since last year's Armed Forces Day, Cardiff and Vale UHB has achieved Veteran Aware Accreditation, making it one of 24 NHS bodies across the UK that have received accreditation from the Veterans Covenant Hospital Alliance.

This year we're focussing our efforts on encouraging veterans across Cardiff and the Vale to disclose their status as a veteran to their GP so that the UHB is able to best support their

healthcare needs. We believe in putting our patients at the centre of everything we do and our fast track service for those who have served in the Armed Forces will ensure that patients are treated quickly and effectively by staff who understand the needs that veterans have.

ASSURANCE is provided by:

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

RECOMMENDATION:

The Board is asked to **NOTE** the report

Shaping our Future Wellbeing Strategic Objectives *This 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	✓

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

Equality and Health Impact Assessment Completed:	Not Applicable

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Len Richards
Chief Executive
Cardiff and Vale University Health Board
UHB Headquarters
Woodland House
Maes-y-Coed Road
Heath
Cardiff
CF14 4TT

Our Ref: AG/MR/SB

2 July 2019

Dear Len

Cardiff and Vale University Health Board JET

Thank you for hosting the JET meeting on 21 June with your Executive Team colleagues to discuss the end of year position across a number of key areas and for providing the papers beforehand to aid the discussion, as these form an important part of the official record of the meeting. We have had less contact over recent months following the health board being de-escalated to 'enhanced monitoring' and progress against milestones has continued and you are now an organisation with an approved plan. I would like to put my thanks on record to Dr Sharon Hopkins for agreeing to go to Cwm Taf Morgannwg as interim Chief Executive.

You began the meeting with a brief summary of the previous year; you are proud of the achievements of the health board and wanted to express your thanks to your Executive team for their support. You have delivered what you said you would, though there are some areas where improvements are still required, particularly in terms of urgent suspected cancer performance and outpatient follow-ups. You delivered your financial commitment and RTT and unscheduled care profiles. You continue to build on your relationships with the RPB and PSBs, as well as with other partners. You are capitalising on the relationship with Canterbury (New Zealand) and are there is a commitment to shape the future well-being of the population and you are aligning your strategy to '*A Healthier Wales*', and are looking at the whole health and care system. You continue to work closely with Canterbury and there is a shared learning agreement in place between your two organisations. You are looking

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to build on the progress made in terms of your clinical services strategy and how to deliver services differently, initially at a hospital level, but then wider. You will continue to engage with the University. You will look to build on the progress made over recent months with the aim to move to the lowest escalation level. Despite the recent changes in your Executive team, you feel you continue to work well together and your new Medical Director takes up post on 17 July.

On population health, your work is linked to Well-being for Future Generations objectives and is highlighted in your Board papers. Your vice Chair is a Champion within the health board. You are engaging with colleagues and partners and the hubs are co-joined with local authority hubs. You are looking at all health and well-being, and there is a health and arts strategy, which is being led by yourself. You have an apprenticeship academy in place, recognising the importance of work to a person's well-being. You are developing the healthy environments at work, and you are part of the Cardiff and Vale healthy travel charter, where 14 public sector organisations have signed up to the scheme. You have placed a consultant in public health in Cardiff Council one day a week.

On smoking prevalence, you reported the rate at 16% meaning you are meeting the all-Wales target and there has been an increase in the number of pharmacies offering a level 3 service. Your staff flu uptake is above 60%, which is above the national target. It was suggested that you may wish to discuss with colleagues in Powys around using midwives to deliver the flu vaccine to pregnant women, though you reported this is already happening. On childhood immunisations, you reported delivering against the target remains a challenge, particularly in certain deprived areas of Cardiff and you are working closely with local communities and primary care to address this. You have reported the lowest level of childhood obesity in Wales.

You have established a youth health board and there have been some good developments in terms of partnership working. You reported prevention is part of core business and there has been a cultural change within the health board and the wider community. In response to how you are measuring outcomes, you stated this is part of the wider health outcomes work and are looking at how you can move this upstream. You are working to link the evidence to outcomes and work from the clusters is being embedded and tracked through. It is important for you to make sure your work is aligned to the national plans.

On population growth, you reported you are working closely with local authorities to understand the plans that are in place. You are supporting the clusters to understand the models they should have and there is good clinical leadership. There is a primary care estates plan in place and the PSB has discussed transport requirements at a recent meeting. On inequalities, you reported there is an annual report produced for the PSBs. There is a homelessness team in place and you are diverting money to help strengthen vulnerable group support. This had been a rounded view of the work you are doing on population health and you need to continue along this way. With regard to transformation bids, it is important that you include milestones in your bids.

On quality, you reported the Annual Quality Statement is available on-line and a quality and safety report is regularly presented to the Board. On patient experience, you regularly score around 95% satisfaction. Over 1,000 surveys a month are carried out and you use "Happy or Not" machines to record patient satisfaction. You have a 'you said, we did' approach to staff and patient recommendations. You have launched a learning disability strategy with the local authority and there has been a lot of social media activity. You have signed a charter with the British Deaf Association (BDA) after some concerns were raised around

how the deaf community were being treated and there is now a good relationship with the deaf community. On concerns, 87% received a response within 30 days, which shows continued improvement. Although there had been a few public reviews, you had received a positive report from the Ombudsman and he had removed the specific case worker linked to the health board.

On serious incidents (SI), you continue to report these in the public domain; there are currently 89 still open, the majority relating to pressure damage. You have carried out a lot of work around falls and ways to prevent admission to hospital and there has been a 50% reduction in the number of patients coming to harm in hospital following a fall. There have been a number of recalls following SI reviews; you have revisited diabetic retinopathy and after reviewing all cases, you found that just four patients had come to harm. You have also reviewed cases following the issue you had with ophthalmology outsourcing and have been in contact with all patients involved. There was also a recent issue with sterilisation which resulted in one pregnancy. You continue to align redress arrangements and are working closely with GPs around indemnity.

There is a challenge around infection prevention control (IPC) and reported you are not meeting the e-coli target, though there is good work taking place. There is a challenge with staph aureus, with particular hot spots being seen in patients with chronic conditions. You have had good feedback from HIW colleagues with regard to the Assessment Unit environment, and you are taking action, but it is recognised this is not a short term response. With regards to the maternity services review in Cwm Taf Morgannwg, you have provided a response and there were a couple of areas of concern for you to address. You feel there are sufficient numbers of staff in place to cover the increase in the number of women wanting to have their babies in Cardiff instead of Cwm Taf Morgannwg, together with the increase seen due to the rise in the local population. You have offered to run additional ante natal clinics in Cwm Taf Morgannwg. This has been a significant issue for the Board and you invited members of the Women's and Children's team to attend a recent Board meeting. You have increased the visibility of Executives in the unit and have attended a recent quality and safety meeting in the division.

On transgender services, you reported this has been a difficult planning and implementation period for the health board. The specialist consultant is now confirmed to start in July and there has been a telephone discussion with WHSSC around when the service will be able to start. It is important to set a visible date for the start of the service and when you will be able to see the first patient as there has been a lot of external profile. You are currently training staff in line with the service specification. You recognise you are not a perfect organisation, but there has been good feedback received from the regulators. I noted the additional information included in the background supporting papers.

We then moved on to discuss performance; on planned care, this had been a transitional year for you moving from quarterly forecasting to monthly and you had successfully delivered against your profile. There had been a smaller bounce back at the beginning of this year compared to previous years. The challenge going forward is at a speciality level, particularly orthopaedics and ophthalmology. On diagnostics, you had 40 patients waiting over eight weeks and you now expect this to clear over the coming month. On follow-up outpatients, the number of people on the list has reduced, as has the number with no date and those who are passed their scheduled appointment date. There is clinical engagement, with good work being done, and there is a recognition that the model needs to change and you are working alongside the Planned Care Programme to do this. You recognise there is

a need to improve urgent cancer performance, with 62 day performance currently around 85%. There have been significant increases in demand, particularly around GI and urology.

On unscheduled care, performance has generally been better over the last year compared to the previous year and has represented best performance in Wales. There is good clinical leadership in place and a number of processes have been rolled out across the department which has led to a 47 bed improvement, 40 of these in respiratory medicine. On mental health, you have repatriated specialist CAMHS from Cwm Taf and there had been an improvement seen in performance between March and April and have launched a single point of access. You have redesigned the CMHT service on a locality basis. On psychological therapies, there are currently around 3,000 people waiting, with 80% waiting less than 26 weeks. It was suggested that you have a conversation with colleagues in Swansea Bay as they have already met this target. You have increased access to those patients with first onset psychosis. You reported that demand is increasing and you are looking at actions to address this, with teams going out and visiting patients in care homes. You are looking at the entirety of the service and whether you are able to provide some services on-line. On primary care mental health, an area for focus for you is CTP for those under the age of 18. It was agreed to have a separate conversation outside of the meeting.

On primary care, you have previously shared information on the innovative work you are doing. You stated there were two particular schemes that you have decided to scale up, one on MSK services (first contact physiotherapist) and the other around mental health. On MSK, the service has seen over 1,400 patients, with only 1% proceeding to requiring an appointment with a T&O consultant. On mental health clinics, these will be run from a general practice facility. You are now looking at rolling these out across the whole health board area. You reported there are no managed GP practices and you are working to develop a sustainability fund.

On finance, you delivered against your control total of £9.9 million and have a savings target of £33 million. You stated that the coming year will be challenging in terms financial delivery, but your aim is to break even and we need to see a recovery in performance after the first two months of this year. You wanted to highlight a couple of areas of progress over the last 12 months; work around palliative care has progressed and is enabling more patients who want to die at home to do so; and work around dementia care, with over 22,000 dementia friends created. You continue to work closely with Cardiff University and the PSBs on this.

We then moved on to a forward look; you are making progress in developing your long term plan and are putting all the pieces together to enable successful delivery. You are focussing on developing your priorities for 2019-22 and primary care is engaged in the process. You are engaging with the workforce and other partners and are looking to learn from others. You recognise the importance of improving digital services and are supporting the national digital strategy and are looking to develop a digitally enabled workforce. You are looking at how this can now be rolled out to patients and be used in the community setting. You have recently appointed a director who will have responsibility for digital. It is important that when you are implementing new systems that they are compatible with national systems. You are following the lead of Swansea Bay and will be using Patient Knows Best and the aim is to enable clinicians to have easier conversations.

On developing service priorities, one service constraint is critical care and you are looking at the number of delayed transfers from critical care. You are looking at implementation of a major trauma network. We then moved on to discuss workforce; you reported you had

improved the engagement score compared to the previous year and there was a lot of work on-going around engagement and empowering front-line staff to deliver the improvements necessary, as set out in the Amplify 2025 programme. Sickness absence levels are slightly higher than you had hoped and PADR performance was below where you wanted it to be. On your clinical services plan, you stated clusters were looking at how primary care will be delivered, with more services being delivered in an out of hospital setting. You have business cases in place for the infrastructure hub and you are looking at what UHW could look like and this is set out in your three year plan. You will need to maintain a regular conversation with colleagues in Welsh Government as this progresses. It was noted that the milestones included in your 10 year plan have been strengthened, which has enabled you to have an approved IMTP.

You continue to build on your partnership working with other organisations and have a good relationship with Swansea Bay and you are looking at the whole patient pathway and population. On research and development, you have a joint working group with Cardiff University and are looking at working closer with Welsh Government. On the Nurse Staffing Act, you confirmed you are compliant with the requirements.

In summary, this has been a good review meeting. I acknowledge the additional information that was contained in the background papers which highlighted a number of initiatives being undertaken across the health board. I am pleased with the continued improvement in terms of finance and performance and the fact you now have an approved three year plan. The papers have conveyed the structure of the health board operating at a broader system level which shows a maturing organisation. I would appreciate it if we could have a further discussion around the UHW site issues and planning processes. It is clear from the discussion that you are an outward looking organisation that is keen to learn from others and are confident in the actions being taken. Your target for the coming year is to maintain the progress made and to continue delivering against the milestones set.

I would appreciate a response to my letter by **16 July 2019**.

Yours sincerely

Dr Andrew Goodall

REPORT TITLE:	**PATIENT SAFETY QUALITY AND EXPERIENCE REPORT**						
MEETING:	Board Meeting				**MEETING DATE:**	25.07.19	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
LEAD EXECUTIVE:	Executive Nurse Director						
REPORT AUTHOR (TITLE):	Assistant Director, Patient Safety and Quality – 029 2184 6117 Assistant Director, Patient Experience – 029 2184 6108						

PURPOSE OF REPORT:

SITUATION:

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from May to June 2019.

REPORT:

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

Serious incidents – the number of serious incidents open with Welsh Government has reduced by 39% since January 2019 (from 132 to 80). This is predominantly because of the revised arrangements for the reporting of avoidable pressure damage as well as the overall number of monthly closures exceeding the agreed targets during the six month period.

Complaints – The Board should be advised that Concerns data for May and June shows a significant increase in the number of concerns received in comparison to last year. During this period last year, (2018) the Health Board received 385 concerns whilst, during the same period this year, we have received 497. This represents a substantial increase but there are currently no identified themes or trends and the increase has been seen across all Clinical Boards. This will continue to be closely monitored, but should be recognised as a positive way of gaining the views of patients.

Serious incidents related to patients known to Mental Health Services – the UHB has seen an increase in the number of patients known to Mental Health Services reported as missing. The UHB believes that this is as a result of the increased use of social media by the Police and by family in the immediate aftermath of a missing person. Previously the UHB may only have known about a missing person when the person was reported to have died. Reasons for incidents include people reported missing, suicides, deaths in patients with long history of addiction as well as deaths where the circumstances are unclear e.g. patient found to have died unexpectedly at home. Sometimes this may be due to natural causes.

RECOMMENDATION:

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.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This 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	
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If “yes” please provide copy of the assessment. This will be linked to the report when published.									

[Appendix 1]

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
May – June 2019

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

The majority of reported incidents cause no harm or minor harm to patients and this is within the context of well over a million contacts by patients with healthcare services each year. However, during May and June 2019, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	**Number**	**Description**
Children & Women	1	A baby on the Neonatal Unit was administered with the incorrect dose of Oromorph due to a calculation error.
	1	A therapist has accessed a child's records without appropriate authorisation.
	1	An external and internal review has concluded that the care of a pregnant woman in June 2018 was suboptimal.
	1	Concerns were raised in 2016 with the follow-up arrangements for patients who had received ESSURE implants. This has been retrospectively reported to WG and has been reported in full to the QSE Committee.
Clinical Diagnostics & Therapeutics	1	A child prescribed with medication to treat heart failure, had the wrong concentration of medication dispensed by Pharmacy at UHW. The child subsequently suffered an overdose and was admitted to hospital in Swansea as a result. The child was discharged the following day. An investigation is underway.
Executive & Corporate Services	1	A mother found her baby blue in bed; it appears to be a case of co-sleeping and sadly the baby died.
Medicine	4	Grade 3, 4 or unstageable healthcare acquired pressure damage.
	3	Falls where the patient sustained significant injury.
Mental Health	1	An adolescent patient required admission to Hafan Y Coed as no suitable beds were

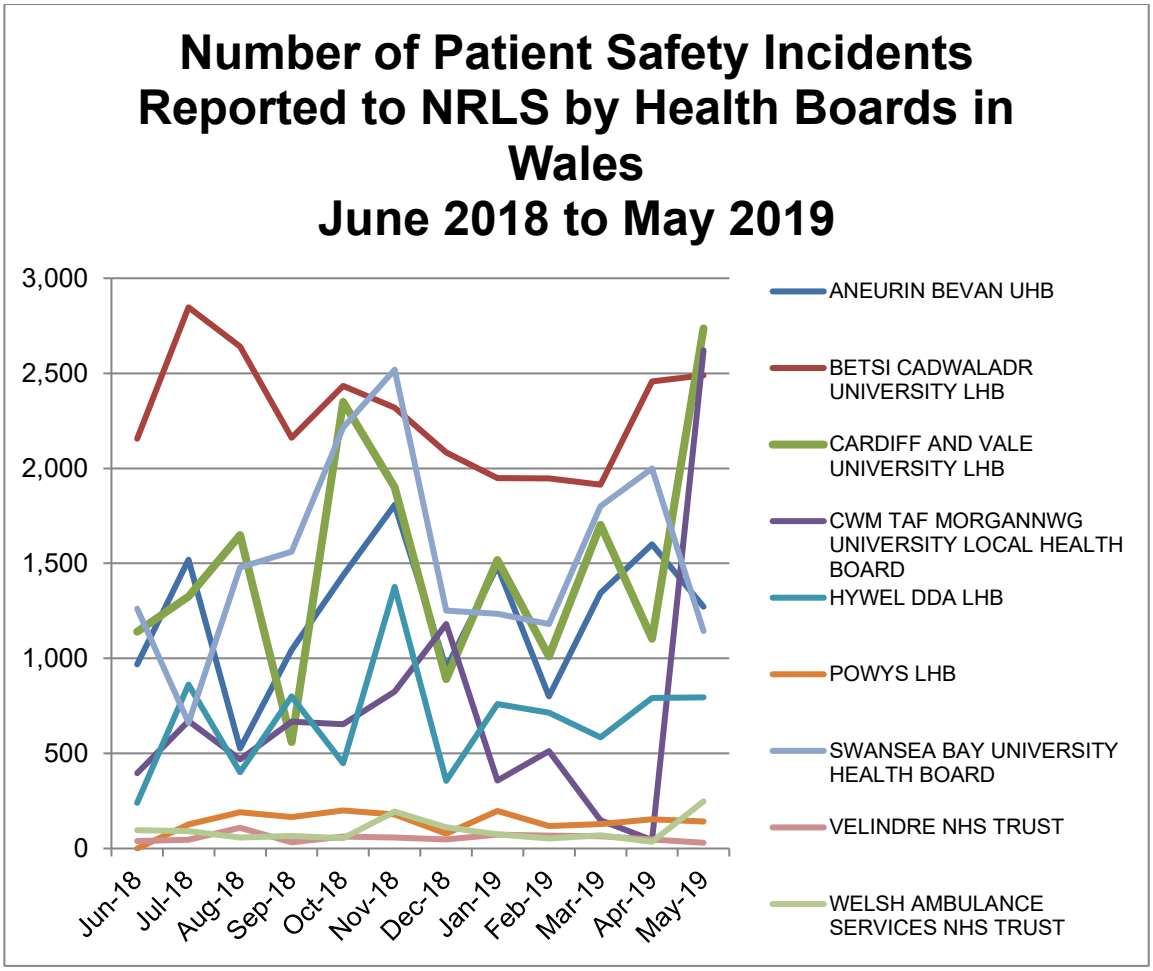
		otherwise available.
	1	A patient was found to have swallowed cutlery and other objects acquired from the ward over a period of time. The patient subsequently required transfer to UHW to treat a perforated bowel.
	1	A patient physically assaulted staff and members of the public whilst in supported accommodation.
	8	Unexpected deaths of patients known to Mental Health services, including substance misuse services. It is thought that the Coroner is likely to conclude suicide in three of the patient's deaths. For the remaining five patients, the circumstances of their deaths are not yet confirmed.
Primary Care & Intermediate Care	1	It has been reported that a Practice Nurse from a GP surgery in Cardiff has administered incorrect vaccinations to six children. A number of documentation errors were also identified. The nurse had been referred to the NMC and has reportedly handed in her notice with the practice. No harm has been caused to any of the children.
	1	A prisoner who became unwell required transfer to hospital where he died several days later. As with normal process, this is subject to review by the Prison and Probation Ombudsman and Coroner and was therefore reported to Welsh Government.
Specialist	0	None reported.
Surgery	9	Grade 3, 4 or unstageable healthcare acquired pressure damage.
	1	A lady was transferred to UHW from Morriston Hospital with a subarachnoid haemorrhage. An aneurysm was identified following an angiogram for which coiling was required. Despite interventions the lady sadly died. An investigation is underway to determine if any delays in treatment contributed to her death.
Total	36	

No Surprises		
Clinical Board	**Number**	**Description**

Medicine	1	HIW carried out an unannounced inspection to the Emergency Unit and Assessment Unit at University Hospital of Wales on 25th, 26th and 27th March 2019. No Surprises report was submitted to WG as the report was due for publication on 28.06.2019.
Mental Health	2 1 1	Patients known to Mental Health Services were reported missing. A 22-year-old male who has previously been known to Mental Health Services has been arrested in connection with an alleged murder of his partner. A patient known to Mental Health Services has been arrested by police on suspicion of attempted sexual assault.
Specialist	1 1	Fire on a cardiothoracic ward. A patient who had previously had smoking paraphernalia removed from his possession was in the room at the time an explosion was heard. The patient was admitted to ITU with smoke inhalation. Four members of nursing staff with smoke inhalation were assessed in the Emergency Unit and have since returned to the ward. A Haematology patient was admitted to the Haematology ward in August 2018. A bronchoscopy was carried out in December 2018 and TB was detected. Due to the nature of compromised immunity in Haematology patients, it was agreed that information letters should be sent to the patient contacts, their GPs and their consultants to inform them of the situation.
Multiple	1	An outbreak of Norovirus temporarily affected ward areas across the UHB.
Total	8	

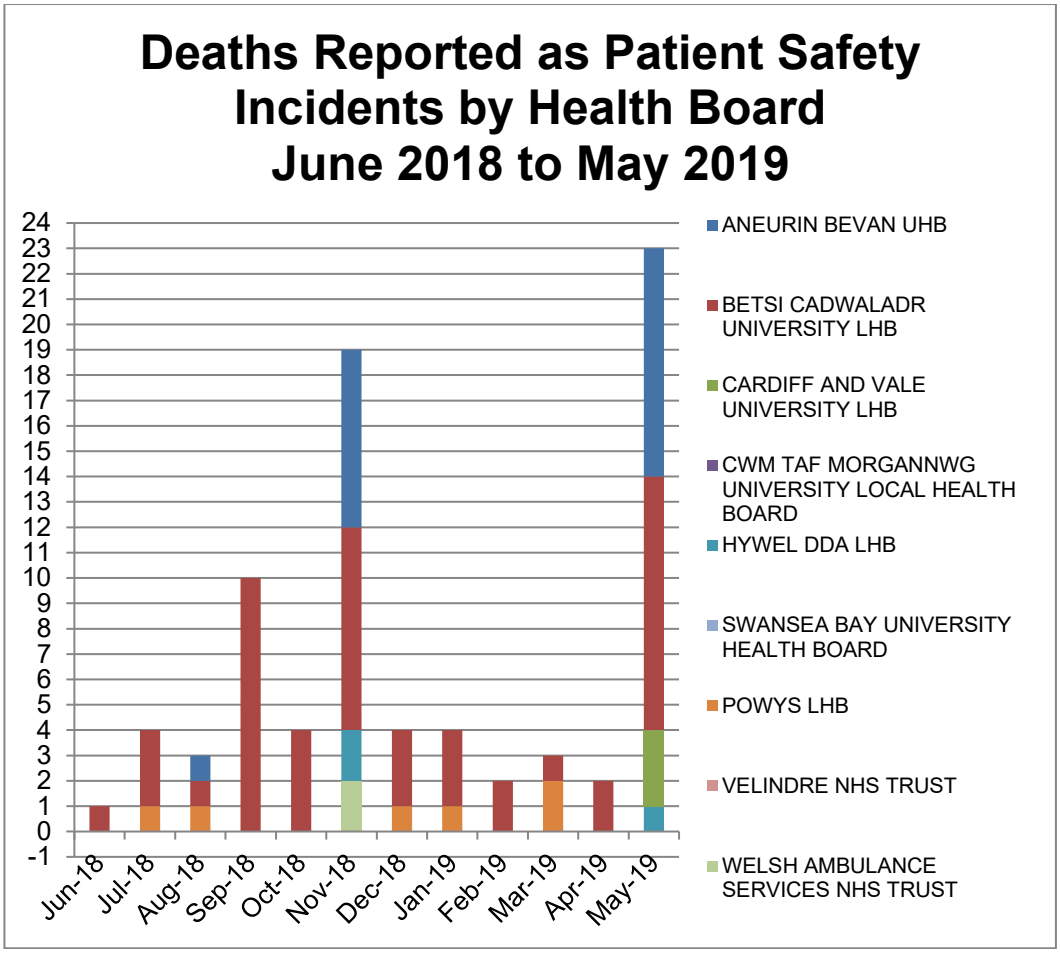
How do we compare to our Peers?

The National Reporting and Learning System (NRLS) currently collects and provides data on patient safety incidents in England and in Wales.



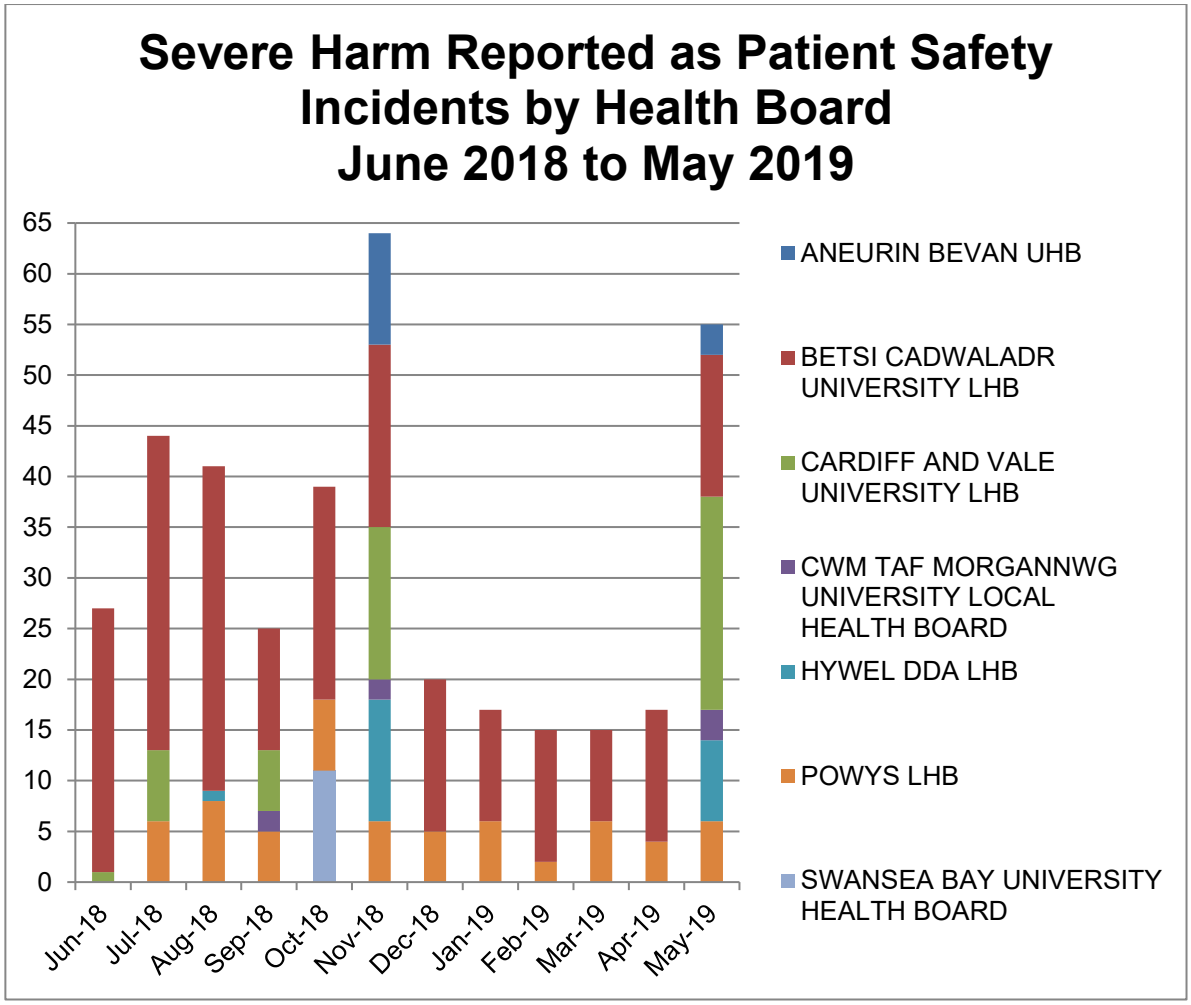
The Board will note that in terms of trends in reporting, the UHB reports more patient safety incidents to the NRLS than smaller organisations in Wales, is in approximately the same reporting range as Aneurin Bevan and Swansea Bay UHBs but reports significantly less than Betsi Cadwalader UHB (BCUHB). Further work will be undertaken to try and understand the profile of incident reporting In BCUHB so that the UHB can determine whether there are areas of under – reporting that may need to be addressed.

The number of deaths reported as patient safety incidents across Wales is represented in the following diagram:



Within the UHB, there is a quality assurance process that takes place before each NRLS upload. This is to determine that any incident that is recorded as having caused the death of a patient is factually accurate. It is clear from the graph that the UHB reports less deaths as a result of a patient safety incident than other organisations of comparable size. The UHB will continue to monitor this and also take action to try and determine the types of incidents reported as causing deaths in other UHBs across Wales.

The number of patient safety incidents recorded as causing severe harm across Wales are demonstrated in the following diagram:

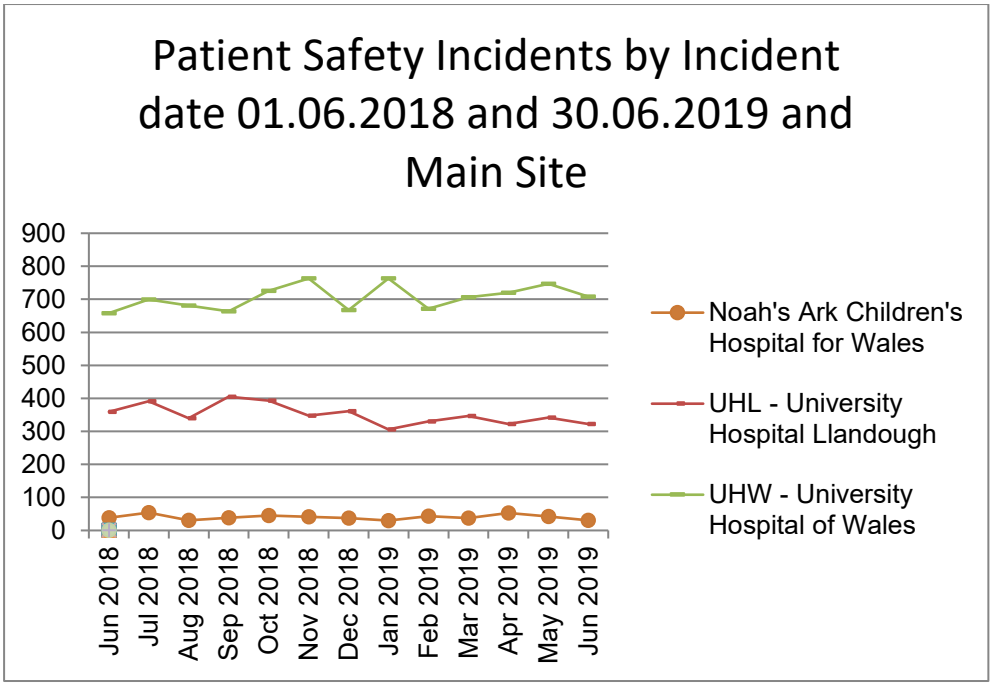


Again, it would appear that the UHB reports considerably less than BCUHB for this category of incident, but more overall than Aneurin Bevan UHB or Swansea Bay UHB.

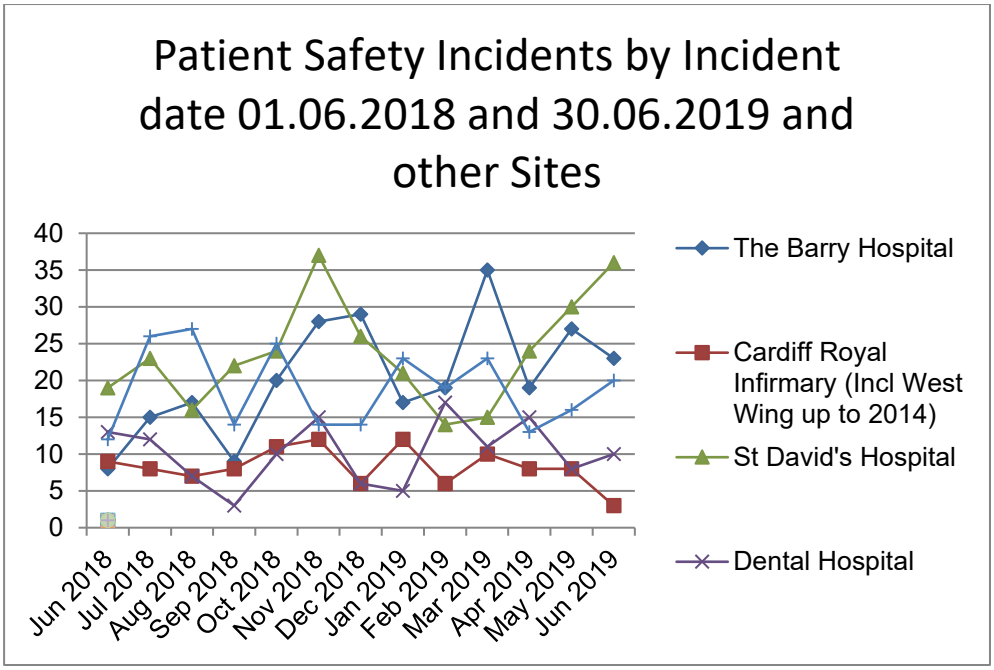
The Board should be advised that in late 2019 the NRLS will be replaced by a different system called the Patient Safety Information Management System. We have been advised that this improved incident management system will make it easier to record incidents and simpler for people and organisations to analyse and learn from the information we hold, better supporting us to learn and improve patient safety.

UHB trends in patient safety incident reporting

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 June 2018 and June 2019. 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. The majority of reported incidents cause no harm or minor harm to patients and this is within the context of well over a million contacts by patients with healthcare services each year.



The graph below demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites between June 2018 and June 2019. The lower volume of incidents reported reflects the size and activity levels at the sites.



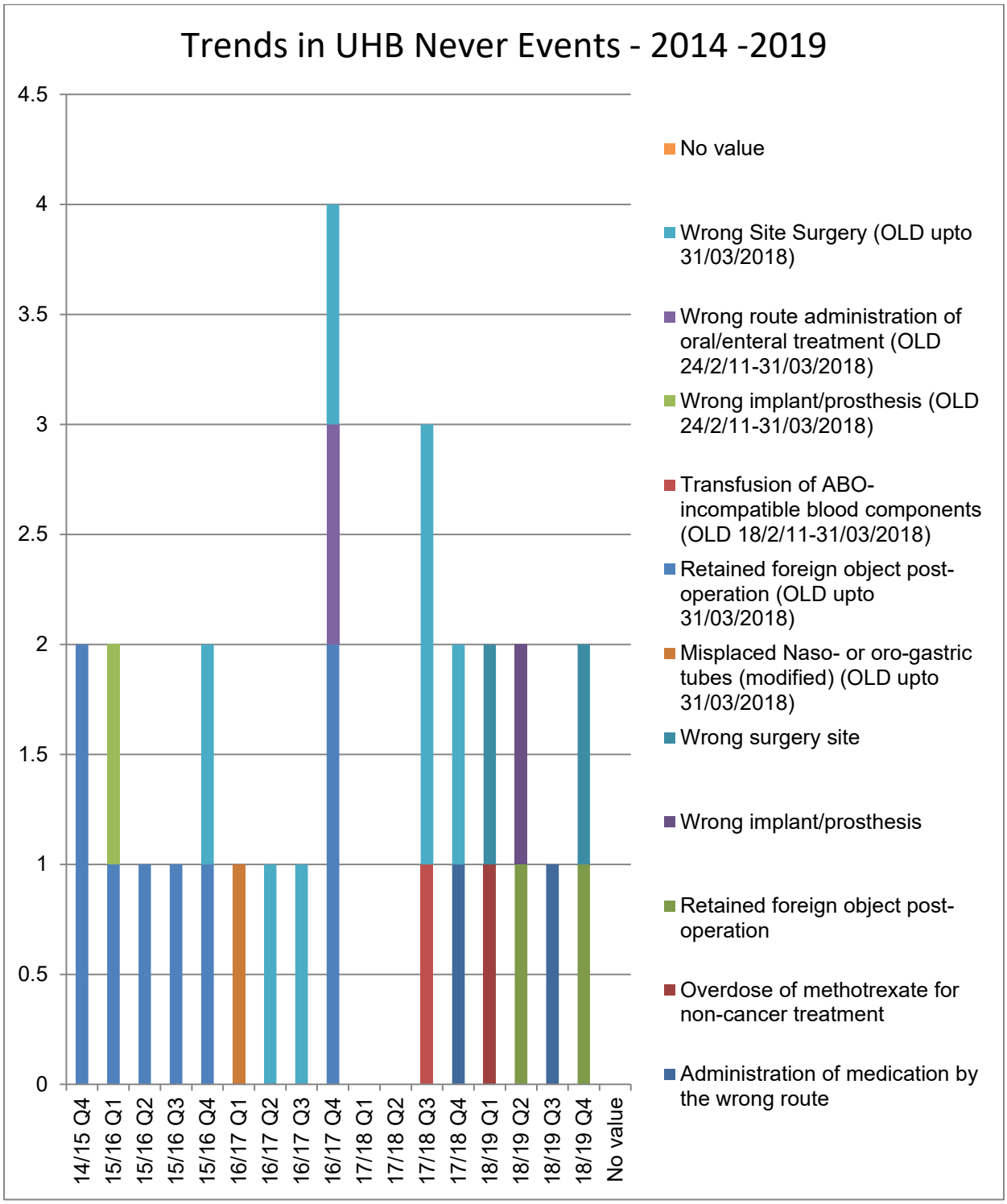
Never Events

How do we compare to our peers?

The UHB is currently concluding investigations to four Never Events. These have previously been reported to Board and comprise of:

- Wrong route medication error
- Wrong lens implant in the Ophthalmology setting
- Retained swab following major surgery
- Botox injection in to wrong leg

The diagram below shows UHB trends in Never Events over the last 5 years:



*Please note that definitions for Never Events were revised in February 2018

There have been no Never Events reported in the UHB during May and June 2019.

Data published by NHS Improvement indicates that in England a total of 496 Never Events were reported between April 2018 and March 2019.

In summary these were categorised as:

Type of Never Event	Number
Wrong site surgery	207
Retained foreign object post procedure	104
Wrong implant/prosthesis	63
Unintentional connection of a patient requiring oxygen to an air flowmeter	50
Misplaced naso or oro-gastric tube	29
Overdose of insulin due to abbreviation or incorrect device	14
Wrong route administration of medication	10
Failure to install collapsible rails	7
Transfusion of ABO incompatible blood or organs	4
Mis-selection of high strength Midazolam	3
Overdose of Methotrexate for non–cancer treatment	3
Falls from poorly restricted windows	2
Total	**496**

More detailed information can be found at the following link:

What are we doing about it?

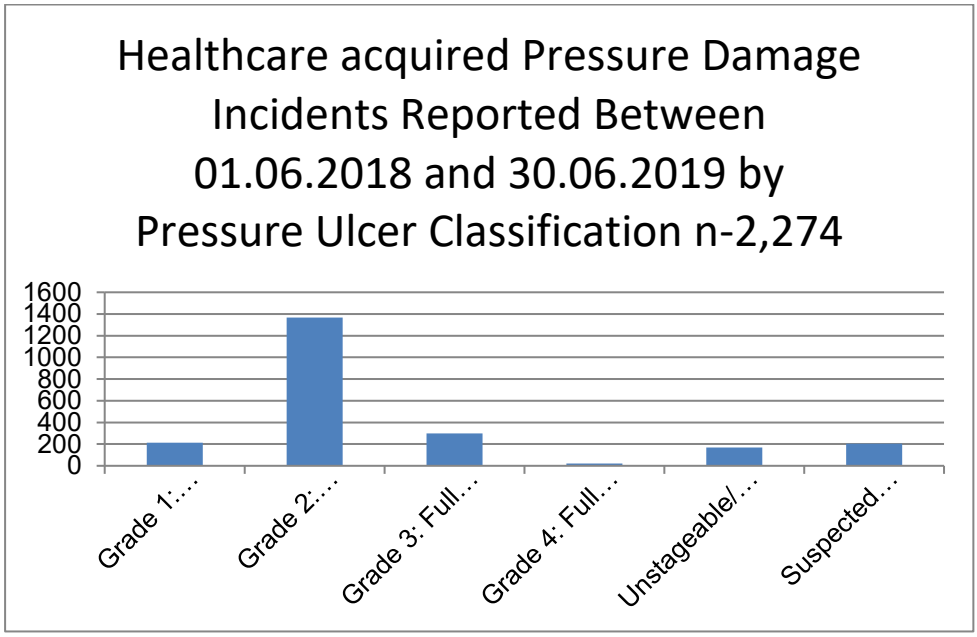
There is a NatSSIPs Group established that is taking forward work to embed the Standards to prevent Never Events (related to invasive procedures) across the UHB.

In relation to a learning outcome following two previous Never Events of retained guidewires following central line insertion, a meeting of the NatSSIPs Group took place in May 2019 where a new way of reviewing procedures for vascular access, using a multidisciplinary and pan-Clinical Board process was discussed. The meeting identified that a separate Task and Finish Group was required to review the current Vascular Access arrangements and with a view to developing a UHB-wide Vascular Access Service. A visioning workshop to progress this work has been arranged for 9th July. There has been great multidisciplinary interest and engagement and a plan is in place to progress this work over the coming months.

Pressure Ulcers

Pressure ulcers are frequently reported on the UHB's risk management database as a patient safety incident. Analysing pressure ulcer incident forms continues to be complex. It is not always immediately obvious as to where the patient was located when the pressure damage developed; whether it is healthcare acquired and whether there has been duplicate reporting of the same incident due to patient movement between departments.

Between 01.06.2018 and 30.06.2019, 3,181 incidents of pressure ulcers were reported as patient safety incidents. Of these, staff indicated that 2,274 (71%) were healthcare acquired, which means that the patient was in receipt of NHS funded healthcare at the time the pressure ulcer developed. It is evident that the majority of the reported incidents are grade 2 pressure ulcers. 874 of the incidents were recorded as having occurred in the home setting which indicates the complexity and frailty of patients in the community.



How do we compare with our Peers?

Welsh Government has recently revised SI reporting procedures for pressure ulcers. From January 2019, they now require Health Boards to retrospectively report to them healthcare acquired grade 3, 4 and unstageable pressure damage that has been determined to be avoidable.

Additionally, Welsh Government has asked all Health Boards to report all healthcare acquired pressure ulcer incident reporting data to them on a monthly basis. This will allow them to see the extent of the issue across Wales.

What are we doing about it?

The UHB's Pressure Damage Task and Finish Group continues to be an active forum taking forwards improvement work required.

A recent pressure damage prevalence audit has been undertaken, led by the Tissue Viability Nurses, in conjunction with Medstrom. The outcome of their findings were presented to the Task and Finish Group on 18th June 2019. Two of the issues identified from the audit were that pressure relieving seat cushions and heel offloading devices were not always being used.

The Patient Safety and Datix Teams continue to take forwards system developments required. This work is supporting the Task and Finish Group with implementing the revised pressure damage reporting arrangements brought in by Welsh Government in January 2019.

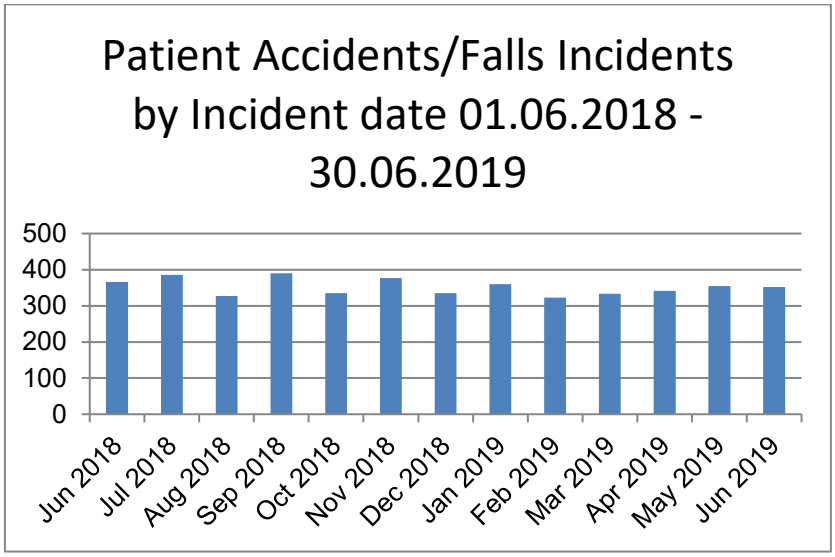
Patient Falls

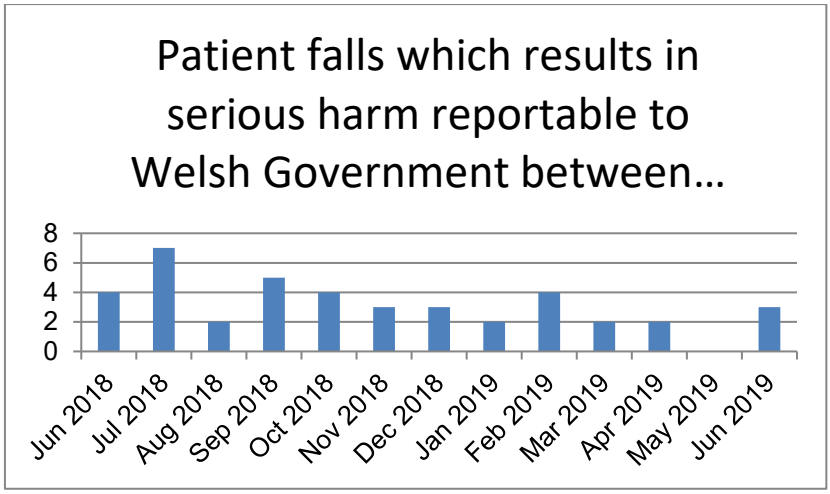
How are we doing?

Patient falls continue to be a frequently reported patient safety incident. Reliable benchmarking information is not currently available.

How do we compare with our peers?

The following table indicates the number of patient accidents/falls reported between June 2018 and June 2019. The majority of falls continue to result in no significant injury to patients. The trend in a lower volume of falls incidents requiring SI reporting has essentially continued.





What are we doing about it?

Simulation training is available to all inpatient ward staff, providing an immersive learning environment in which to improve knowledge and skills around inpatient falls. It focuses on the areas of completing a falls risk assessment, managing a non-injurious fall and managing an injurious fall with a head injury.

Intergenerational falls awareness sessions are being held in primary schools across Cardiff and the Vale. The Staying Steady Schools scheme, was highly commended at the recent HSJ Patient Safety Awards, and is now in its second year and is a Bevan Exemplar for 2019. Oliver Williams, Falls Lead, has been invited to speak at an international conference in Sweden later in the year.

A Community Falls Prevention Alliance, funded by the International Health Foundation, has been set up in Cardiff and the Vale of Glamorgan, with representatives from various services within the Health Board, Social Services, partner organisations and 3rd sector organisations. It aims to improve links between services, identify gaps and duplications and make falls pathways easier to follow and access for patients by taking a 'best for patient, best for system' approach.

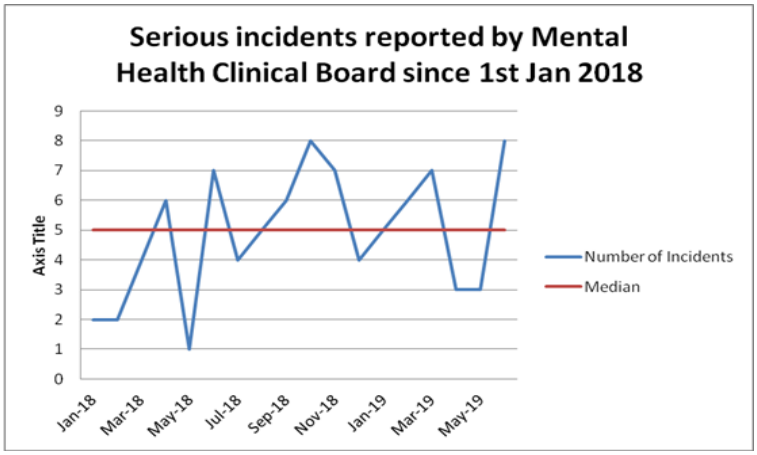
'Stay Steady' Clinics and a falls single point of contact have been set up in Cardiff as part of a Pacesetter Funding scheme, with collaborative working between the UHB and Cardiff Council's Independent Living Services. Two clinics currently run in North and Southeast Cardiff, offering multifactorial falls risk assessments to those at the lower end of the risk scale, taking a preventative approach to reducing the risk of falls by offering interventions sooner.

Falls Brief Intervention (FBI) training, developed by the Wales National Taskforce for Falls Prevention, is available to UHB staff and other local services in Cardiff and the Vale of Glamorgan. The two-hour training session covers the major risk factors for falls, how to spot them, and what to do about them.

Serious incidents involving patients known to mental health services

In line with WG Guidance for Serious Incident reporting, the UHB is required to report the unexpected deaths of patients who are known to mental health services. All deaths are reviewed. A full Root Cause Analysis is carried out for the deaths of a patient when there are concerns about the level of care given.

The following graph shows the number of serious incidents reported in patients known to mental health services, on a monthly basis:



Incidents reported in May and June 2019 include people reported missing, suicides, deaths in patients with long history of addiction as well as deaths where the circumstances are unclear e.g. patient found to have died at home. Sometimes this may be due to natural causes.

All incidents are currently under investigation. The UHB also works closely with the Coroner as required, to assist in the provision of all relevant evidence for ensuing Inquests.

The UHB is currently participating in All Wales work to re-define the criteria for serious incident reporting in a mental health setting and also for the proportionate investigation of reported patient safety incidents.

Regulation 28 reports

One Regulation 28 report has been issued to the UHB in the current reporting timeframe. The Regulation report 28 was also sent to four other Health Boards.

The regulation 28 relates to referral pathways for specialist advice in Cardiff and the Vale UHB specifically in relation to neurosurgery and spinal surgery.

The Coroner raises concerns that there are a high number of referrals to the single rota on call neurosurgical specialist registrar every day and that the system for making and receiving referrals requires improvement.

The Coroner has requested a collaborative single response from the five Health Boards, including the UHB, setting out a proposal for a new system of referrals. Unusually, the Coroner has allowed 112 days (rather than the normal 56 days) to respond. A meeting with relevant stakeholders, including WHSSC is currently being arranged.

Outcomes of internal and external inspection processes

Internal observations of care inspections

Following receipt of iPads, purchased by the Health Charity, a new electronic inspection tool has been piloted. Following feedback from senior colleagues, it is

now being used to undertake all inspections. The benefits of the inspection app has found to:

- Reduce variation in the quality of report writing;
- Prevent delays in writing reports (wards now receive their report within a day);
- Questions can be added into the app, based on changes that wards report to be making, so that these changes can be assessed during the next visit.

A new approach to internal inspections is being piloted within Medicine Clinical Board. Currently, all wards in Medicine Clinical Board are visited throughout a year. Each visit to a ward generates an action plan. In total, hundreds of actions may be generated from inspections. The extent to which changes occur is difficult to assess until the next visit (twelve months later).

We are inspecting every ward in Medicine Clinical Board over the next ten weeks. The findings from these inspections will be integrated with a year's worth of patient feedback, clinical incidents and health and care standards audit. The Clinical Board will be presented with the most recurring themes from these data sources. The decision as to what actions to prioritise will be made by the Clinical Board. Further visits to clinical areas will be undertaken over the coming year to provide assurance that actions are being completed, or to provide additional support to teams.

Twenty unannounced internal inspections were undertaken during May and June 2019. These were undertaken across Medicine (6), Specialist (2), Children and Women (1), and Surgery (11) Clinical Boards; all twenty inspections were undertaken as part of the planned programme of unannounced inspections.

The inspection findings continue to provide a positive picture of staff delivering care in a professional and dignified manner within calm, well organised environments; evidence of the UHB values and behaviours being displayed by staff are seen across all areas, with this being confirmed by patient feedback and comments provided during the inspection process.

Key findings for May and June have highlighted:

- Continued improvement with medicines management, but attention required to ensure that all medicines fridges and cupboards are locked when not in use and that fridge temperature recordings are made consistently across all areas.
- A good standard of documentation across the majority of areas visited, particularly in relation to comprehensive risk assessment completion and review, although individualisation of care plans is not observed in all areas.
- Excellent leadership and team working continues to be observed, evidenced by calm, organised ward areas, good communication between the MDT and positive comments from both staff and patients. Conversations with staff show a committed, passionate workforce.
- Examples of patient identifiable data (PID) being left unattended have been seen, e.g. patient records left in an unlocked, accessible room, computer screens displaying PID left unattended.

- As highlighted in previous reports, outstanding maintenance issues are of concern. Ward Sister/Charge Nurse and Senior Nurses continue to chase up these outstanding requests
- Lack of available storage within areas continues to be an 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 and health and safety risk e.g. when equipment is stored in corridors, that may cause fire exits to be blocked
- Excellent interaction between staff and patients observed throughout all areas, with patients complimentary about the care they received

All areas are provided with a report and improvement plans are put in place to address the findings.

Health Care Inspectorate Wales (HIW)

The Board has previously been fully briefed in relation to an unannounced visit to the Emergency Unit/Assessment Unit at UHW in March 2019. On 28th June, HIW published their report of this unannounced visit. There were some immediate assurance issues identified. The report and improvement plan can be viewed here and will be reported in full to the September 2019 Quality, Safety and Experience (QSE) Committee along with the detailed improvement plan.

On 8th July, HIW also published the report which followed an unannounced visit to three wards in Hafan Y Coed in April 2018. This was a very positive report and can be viewed here. Again, this will be reported in full at the September 2019 QSE Committee.

HIW have also confirmed a positive inspection to Park Place Dental Practice in May 2019. They have also confirmed that Tynewydd Dental Care Practice have responded appropriately to immediate assurance issues related to the Hepatitis B status of one member of staff and well as fire safety practice, following an announced visit in May 2019.

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.

Real Time

Each month the Patient Experience Team receives in excess of 1,000 paper surveys. This supports the data collected through our Tablet and Kiosk mechanism as well as the seven 'Happy or Not' machines situated across the Health Board.

The patient satisfaction scores from the all surveys administered across the Health Board are illustrated in the following table.

	May	June
UHL	91%	94%
UHW	92%	92%

How are we doing?

During May and June the 'new' inpatient and outpatient surveys were administered. These surveys have been designed to ascertain feedback supporting the Health Board strategy, providing information that we could learn from and importantly act upon.

This report provides equality information which includes:

- **29%** of patients considered themselves to be disabled.
- English was the preferred language for **96%** of our patients.
- **57%** of the patients were aged 65+.

This is what they told us:

> I am overwhelmed by how outstanding the service I have received so far. It has been professional, rapid, robust and compassionate. Furthermore the patient, understanding approachability of the service providers has been excellent. The result is that I feel like I am now being fully supported which has significantly reduced my stress and anxiety, resulting in decreased alcohol and valium consumption.

> Staff are welcoming and helpful. They are attentive and listen carefully when I talk to them. They explain everything very clearly and are very supportive.

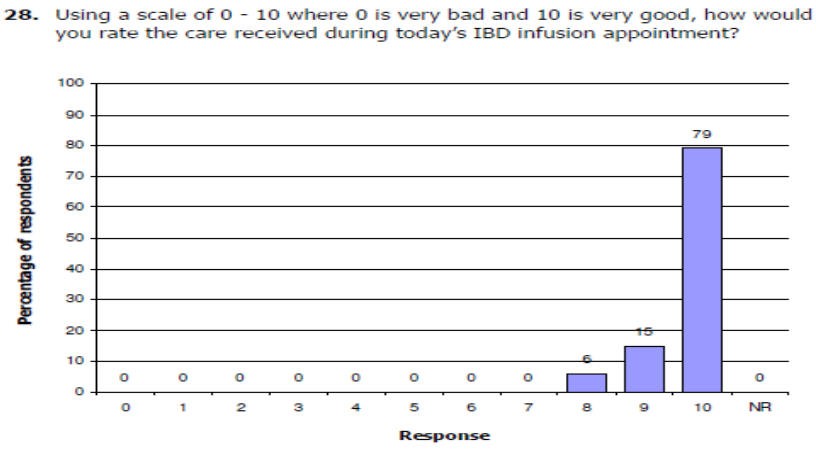
Retrospective

Retrospective data can be very informative to ascertain experience, once a person has left our care. There are numerous bespoke surveys being undertaken to inform colleagues, examples include:

Inflammatory Bowel Disease (IBD) Infusion Room Survey

A report was provided to the team in relation prior survey undertaken to ascertain patient's experience of:

- The appointment
- Car parking
- Wayfinding
- Clinic environment
- Communication



100% of the patients noted their experience as 8 or above and in the qualitative comments, commended the staff very highly.

Areas noted for improvement included:

- Environment being too small and car parking

This information has been used to inform the development of the 'new' IBD Infusion room; with building works underway, funded by Cardiff and Vale Health Charity.

Proactive and Reactive

Feedback Kiosks

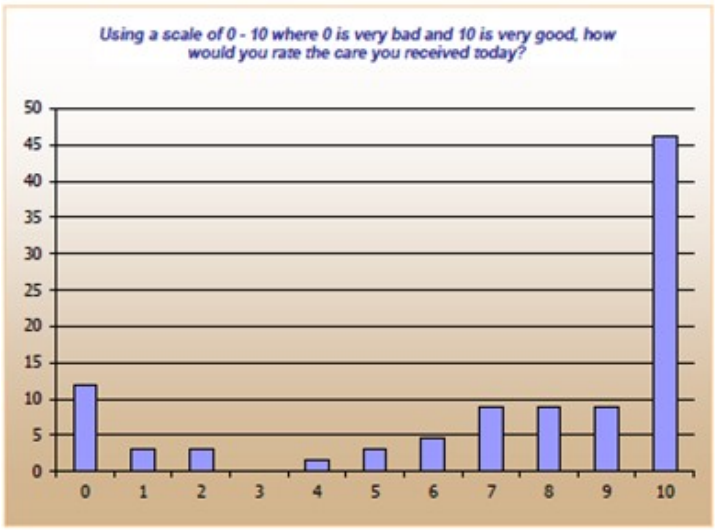
During May and June the mobile kiosks have been at Four Elms Surgery at CRI along with Ward A4.

A4 had **49** respondents during a three week period – with more than 70% of the respondents being staff.

Staff work incredibly hard and are lucky to have the addition of activity support helping patients maintain cognitive, physical and emotional needs.

In Four Elms Surgery 97 surveys were completed:

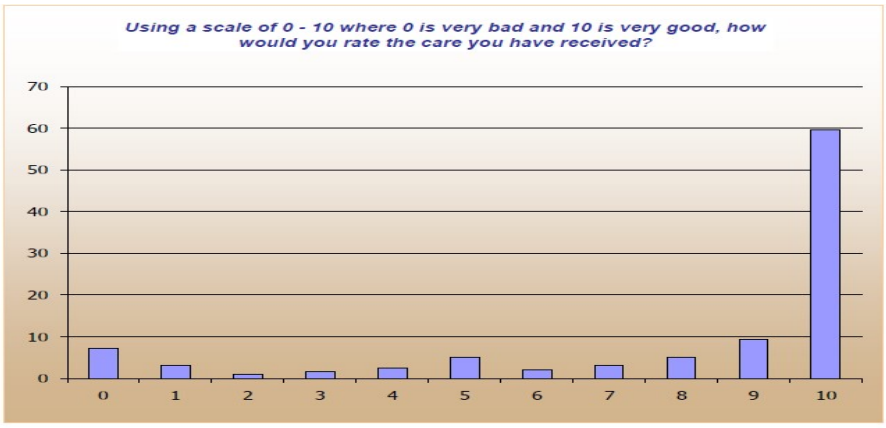
- Generally positive re staff.
- Two comments only regarding difficulty in obtaining appointments.



73% scored their experience as 7 or over.

Data has been shared with the Practice Manager who fed back and the data will be using in staff training.

During the last two month period the Kiosk at the Concourse also provided opportunity for experience to be shared. Nearly 500 surveys were completed, of those **47%** were completed by patients and **53%** by relatives, friends or carers.



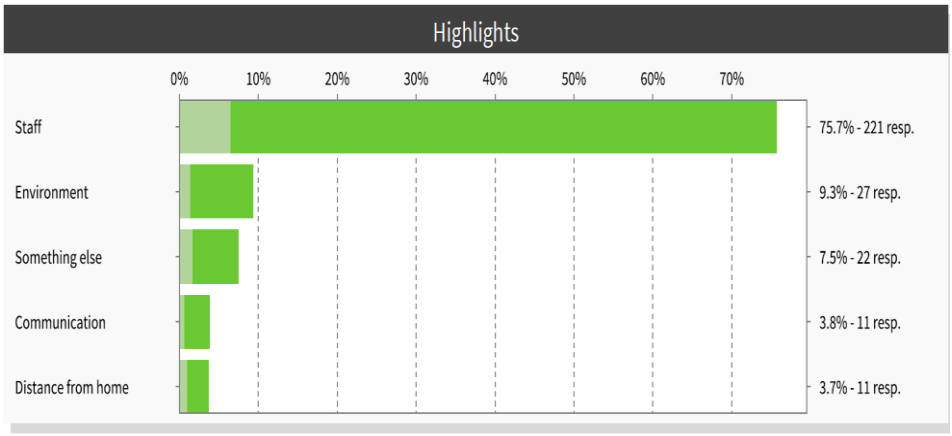
Of the patients who completed the Concourse surveys **75%** scored their care as 8 or above.

At the beginning of July three new ‘Happy or Not’ machines have been placed in the main entrance at UHL, the Concourse at UHW and the foyer at the Children’s Hospital for Wales.

This will provide an opportunity for people to share experience feedback and to identify themes.

Recently we have collated 628 responses.

When asked to theme the responses staff are overwhelmingly the most positive aspect of people's experience.



Balancing

What are we doing?

You Said	We Did
I would like to have more quilt covers on the ward as sometimes I run out.	Quilt covers have been ordered
Alternative choice of Halal meals	Halal options are now available
Blind on the window	A maintenance request has been completed to fix it
The Midwife was a bit brusque and patronising and didn't listen very well – caused me to get upset, which was a shame as the other staff had been very caring	The Midwife was identified and was spoken with and was genuinely sorry she had upset the lady
More activities on ward would be appreciated	Discussion with CWTCH; who have agreed that ward clients can now attend

Balancing

The three Information and Support Centres, along with wards B4 and B6 at the University Hospital of Wales have received '*Carer Friendly Accreditation'.*

The Carer Friendly Accreditation scheme aims to improve, share and recognise support for carers in health and social care service areas. The accreditation criteria are broken down into five standards:

- Understand
- Inform
- Identify
- Listen
- Support

In order to gain accreditation, service areas complete a self-assessment tool, provide a portfolio of evidence to prove that they meet the criteria and that portfolio is then put forward to the Carers Review Panel who then review the portfolios and either approve the accreditation or provide constructive feedback on areas for improvement.

Cardiff and Vale UHB has become the first Welsh Health Board to sign the British Deaf Association's BSL Charter

Since early 2018, staff have been working incredibly hard to improve the experience of patients who are deaf or have hearing loss, accessing our services. For many people, coming into hospital can be a daunting experience anyway and this is especially true for people for whom there is a language barrier between themselves and the staff providing their care.

UHB staff and members of the deaf community met numerous times over several months as they highlighted areas in which accessibility could be improved and the steps the organisation could take to achieve this.

The hard work and innovation of the Patient Experience Team is beginning to show as the UHB has become the first NHS Health Board in Wales to sign the British Deaf Association's British Sign Language Charter.

By doing so the UHB has pledged to:

- Consult with our local deaf community on a regular basis.
- Ensure access for deaf people to information and services.
- Support deaf children and their families.
- Ensure staff working with deaf people can communicate effectively using British Sign Language.
- Promote learning and high quality teaching of British Sign Language.

This is ongoing work and we are delighted to be working so closely with our deaf community to improve their access to health and experience of using our services.

Concerns - Complaints

As part of the All Wales work the definitions of 'formal' and 'informal' complaints has been discontinued. The categorisation to be used is:

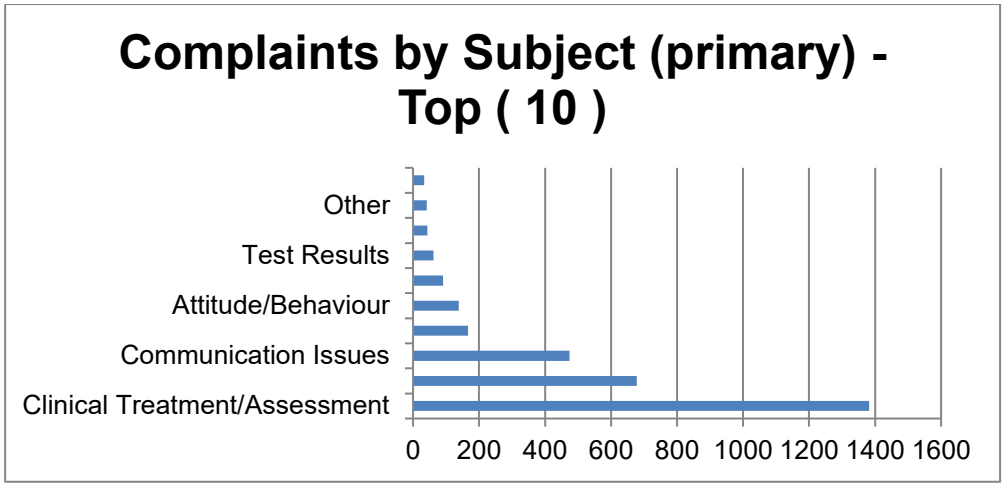
a) Complaints managed through the Putting Things Right Regulations.
b) Complaints managed through 'early resolution'.

Early Resolution cases are considered to be complaints which are resolved no later than two working days (which includes the day of receipt of the complaint to the satisfaction of the person raising the complaint and where the complaint was notified verbally (in person or over the phone).

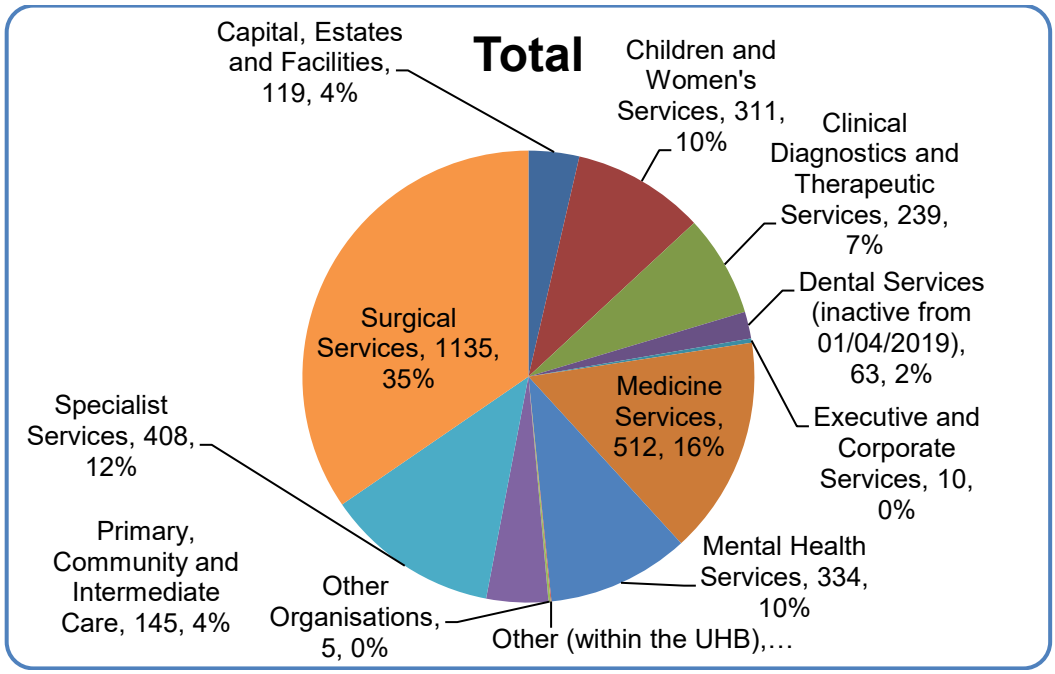
Early resolution will include cases where the person raising the complaint has requested for it not to be processed through the PTR regulations.

The definitions need to be applied retrospectively and the interpretation of 'Complaints managed through the Putting Things Right regulations' has been established. This means that the data submitted by organisations will be accurate and consistent across Wales. However, the change in definition and retrospective data capture means that data presented to Board meetings during the year 2018/19 will be different.

As you will note from the breakdown below, the highest number of concerns, 1,382, in total, related to concerns about clinical diagnosis, treatment and assessment, followed by 678 relating to appointments



Complaints by Clinical Board



You will see from the chart above that Surgery continue to receive the highest number of concerns; (35% of all concerns); in total they received 1,135 concerns. The highest number of concerns registered for Surgical Clinical Board relate to the ENT, Ophthalmology and Urology Directorate.

Medicine received the second highest number of concerns, 512 in total.

Concerns data for May and June shows a significant increase in the number of concerns received in comparison to last year. During this period last year, (2018) the Health Board received 385 concerns whilst, during the same period this year, we have received 497. This represents a substantial increase but there are no identified themes or trends and the increase is across all Clinical Boards.

During May and June, the Concerns Team continued to receive a high volume of concerns that relate to the waiting times and cancellation of follow up

Ophthalmology appointments. More recently, the Concerns Team have received a small number of concerns regarding the ordering and delay in patients receiving specialist Contact Lenses. A number of actions have been taken to rectify this problem, i.e. proactively ordering lenses so that replacements are available to patients when required.

We also continue to receive a high number of calls and emails regarding parking, particularly at UHW. These include issues around Parking Charge Notices, the appeals process, including, the lack of option to appeal in the Welsh Language.

There have also been a number of concerns regarding the signage and the lack of information provided in appointment letters about parking.

It is hoped that the increased number of initiatives that will support patients, visitors and staff access our sites more easily will reduce parking concerns. These initiatives include at UHW the Park and Ride service now runs until 11pm and between 7am and 7pm, the bus now runs every ten minutes rather than every twenty. The numbers of people using the service continues to increase steadily.

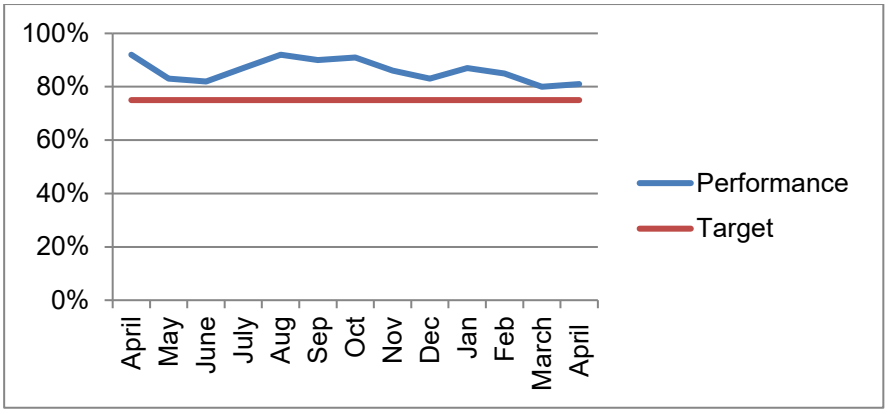
A new Park and Ride service will be introduced for UHL, hopefully in July subject to final contractual arrangements. The service will run on a 20-minute loop from the old Toys-R-Us car park to UHL. The location was agreed as being most convenient to serve people travelling to UHL from Cardiff, the Vale of Glamorgan and from the M4. Anecdotal feedback received by patients and visitors is that they were not aware that we provide a Park and Ride service (or that it is free). The UHB is therefore trying to increase the publicity and awareness raising regarding the Park and Ride services, and is looking at how we make the information more prominent on our website, providing the information on our appointment letters to patients and through improved signage on our site.

Performance

As mentioned in the previous Board Report, Welsh Government has now circulated a directive that has changed the way we record our concerns. Based on the new directive, all concerns that are not resolved by close of play on the day following receipt will have to be recorded under the Formal Concerns process. Therefore, it is anticipated that in future reports, there will be a marked decrease in the percentage of concerns recorded as being managed under informal resolution and a higher number of formal concerns.

Based on the data available, of the 497 concerns received during May and June, 276 have already received a 30-day response, with a further 149 ongoing within the 30 day target.

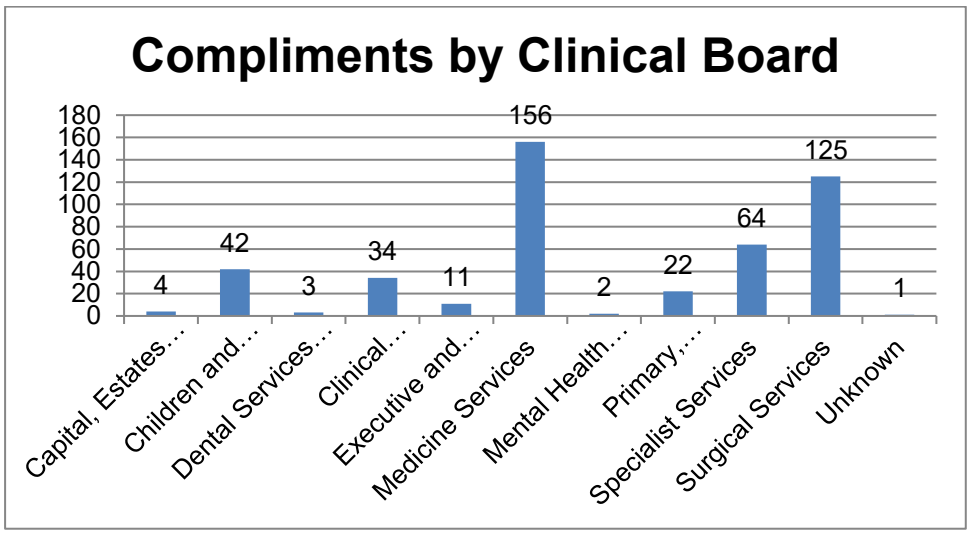
It is pleasing to note that the Health Board is consistently exceeding Welsh Governments Target for 30-day responses; the average is 87%.



Balancing

Compliments

During the period 1st March 2018 to 30th April 2019, the Health Board received 464 compliments.



As you will see from the chart above, Medicine Clinical Board continues to receive the highest number of compliments (156), in particular for the Emergency Unit. This is followed by Surgery receiving 125 compliments for the same period.

There has been a significant decrease in the number of compliments received during May and June 2019 (16 in total) in comparison to the same period last year, where 137 compliments were recorded.

Previously the Concerns Team have received large bundles of compliments from various areas and have logged them retrospectively. However, there has not been the normal influx expected this year. The UHB will continue to monitor this.

What are we doing?

You said	We did
Child was nil by mouth for a total of 13 hours as there was a delay in surgery.	Staff have been reminded that when the waiting time is unclear any child should have intravenous fluids.
Orders made for specialist shower equipment for a child with special needs was not received.	All orders will now be placed through an online ordering system that can be tracked at each stage of the process and provide robust data to audit compliance with the standard time of delivery.
An internal referral form with the patient's own details was sent by post to the patient.	Further measures have been introduced within the post room whereby 2 members of staff now check all mail to ensure that it does not contain private patient details.
Delay in a child receiving a 6-monthly appointment.	An electronic recall list has been implemented to give clear instructions on when a child should be seen.
Confusion regarding a referral process.	Escalated to the Clinical Director for Gynaecology for urgent review. Discussed at MDT to raise awareness and email sent to all staff to remind them of the referral process.

Report Title:	**Performance Report including Adult Mental Health Compliance Rates**						
Meeting:	Board Meeting				**Meeting Date:**	25.07.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Deputy Chief Executive						
Report Author (Title):	Members of the Performance and Information Department (tel 029 20745602)						

SITUATION

The Performance Report sets out the UHB's performance against Welsh Government (WG) Delivery Framework and other priority targets for the first quarter of 2019/20 where the data is available and provides more detail on actions being taken to improve performance in areas of concern.

BACKGROUND

The UHB is presently compliant with 22 of the 70 performance measures, for which historic comparative data exists. This compliance is based on new standards having been introduced (March 19 = 26/68) and is making satisfactory progress towards delivering a further 21 (March = 22).

Since the last report 6 measures have been introduced:

- % people (aged 16+) who found it difficult to make a convenient GP appointment
- % HB population regularly accessing (within 2 years) NHS primary dental care
- % of children waiting less than 26 weeks to start ADHD / ASD neurodevelopment assessment
- % patients waiting less than 26 weeks to start a psychological therapy
- % of high risk (R1) ophthalmology patients waiting 25% beyond their target date for an OP appointment
- Number of patients waiting for a follow up & no. delayed by >100%

Improvements have been observed for

#7 – The % C&V residents who are CO validated as successfully quitting at 4 weeks improved to 60%. The WG target is 40%

#25 – The % GP Practices offering appointments between 17:00 and 18:30 on 5 days a week increased to 94.5% from 88%

#37 – The number of Staphylococcus Aureus Bacteraemia (MRSA, MSSA) recorded has reduced from 39 in quarter 1 of 2018/19 to 27 in quarter 1 2019/20. The rates of c-difficile and e-coli remained similar levels.

#56 – The UHB is compliant with 7 of the new standards for out of hours primary care services, and within 10% of complying with a further 4. There are now only 3 standards which the UHB was not within 10% of complying with.

There were eight measures were a deterioration in performance was observed.

#20 The number of emergency hospital admissions for basket of 8 chronic conditions per 100k population increased in the 12 months to March-19 to 1065 from 1020 in the previous year

#32 – The proportion of patients with a positive screening for sepsis who received all 6 elements of the 'sepsis six' bundle within 1 hour reduced to 69%. The standard is to demonstrate continuous improvement on the previous year, which was 79%.

#34 – The proportion of patients for whom a nutrition assessment was completed within 24 hours of admission reduced to 94%

#39 – The UHB has a £1.808m financial deficit at month 3 against our plan.

#44 – The business case for transformation monies to support acceleration of the Enhanced Recovery After Surgery Programme was unsuccessful. Alternative routes are now being pursued.

#46 – The rolling 12 month total number of procedures cancelled either on the day or the day before the procedure was due, increased to 2106, relative to the standard requiring a 5 #% reduction.

#48 & # 49 – Data quality issues have been observed in the reporting of parts 2 and 3 of the mental health measure. Best endeavours have indicated performance to be in the region of 56% for part 2 against the WG standards of 90%. No datat is presently available for part 3.

The UHB's performance in meeting the expected standards is summarised in the table below:

Policy Objective	Green	Amber	Red	Score
Delivering for our population	10	7	5	13.5/22
Delivering our service priorities	2	2	2	3/6
Delivering sustainably	9	9	16	13.5/34
Improving culture	1	3	4	2.5/8
Total	22	21	27	32.5/70

ASSESSMENT

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

- Mental Health Measures
- Unscheduled care report incorporating Emergency Department and ambulance response and handover times and delayed transfers of care
- GP Out of Hours services

- Stroke
- Cancer
- Elective access
- Eye Care Measures
- Outpatient Follow Ups
- Finance

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

The corporate scorecard is embedded here, or displayed on the page overleaf: Performance report_July_19_bd.xl

REASONABLE ASSURANCE is provided by:

- the UHB's level of compliance with the national delivery and outcomes framework and ability to deliver our Integrated Medium Term Plan for 2019-22, noting there are a number of new measures and standards introduced.

RECOMMENDATION

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

Shaping our Future Wellbeing Strategic Objectives *This 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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Cardiff and Vale University Health Board - Performance Dashboard - June 2019

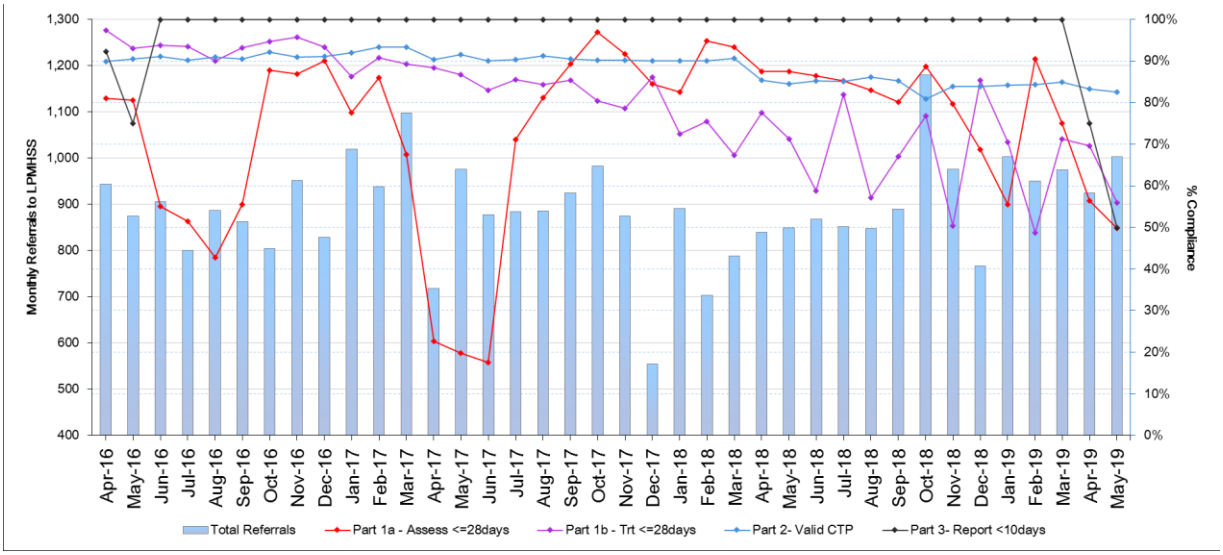
Purpose	Strategic Objectives		Measure	n	Status report: Mar-14	Mar-15	Mar-16	Mar-17	Mar-18	RAG rating	Jan-19	RAG rating	Mar-19	RAG rating	Jun-19	RAG rating	Latest Trend	Target	Time period	Exception Report
For Our Population	Our Service Priorities	All take responsibility for improving our health and wellbeing	Uptake of influenza vaccination among high risk groups	1	>65: 69%, @risk: 52%, pregnant women: 44%	>65: 70%, @risk: 53%, pregnant women: 49%	>65: 68.5%, @risk: 47.7%, pregnant women: n/k	>65: 68.5%, @risk: 48.1%, staff:52.9%	>65: 70.8%, @risk: 49%, staff:64.7%	A	>65: 67%, @risk: 40%, pregnant:1677 women, staff:57%	A	>65: 70%, @risk: 44%, pregnant women 77.2%, staff:60.7%	A	>65: 70%, @risk: 44%, pregnant women 77.2%, staff:60.7%	A	↔	Green: Community: 75%, staff 60%; Amber (improvement on 16/17) - profile FYO >65: 70%, @risk: 52%, staff:50%	at 31 March 2019	
			Percentage of children who have received 3 doses of the 6 in 1 vaccine by age 1 & who received 2 doses of the MMR vaccine by age 5	2	84.6%	84.0%	83.7%	81.2%	5 in1 : 94.7%, MMR2: 87.5%	A	6 in1 : 94.4%, MMR2: 86.3%	R	6 in1 : 94.1%, MMR2: 91.2%	A	6 in1 : 94.4%, MMR2: 90.9%	A	↑	Target: 95%, amber = IMTP trajectory of 95% and 88.5%	Q4 18/19	
			Proportion of adults obese or overweight	3	55% (12/13)	54% (13/14)	54%	54%	52%, Age std 54%	G	56%	R	56%	R	56%	R	↔	reduction on previous year (54% 2012/13, 2013/14)	NSW 2016-18	
			% of adults consuming > 14 units of alcohol p. Wk (New measure)	4	44% (12/13)	44% (13/14)	44%	42%	23% Age std 23%		21%	G	21%	G	21%	G	↔	New measure - previous results relates to consumption above recommended units	NSW 2016-18	
			Proportion of adults meeting physical activity guidelines	5	26% (12/13)	27% (13/14)	27%	60%	60% Age std 59%	A	57%	A	58%	A	58%	A	↔	Target continuous reduction in % of adults who reported being physically active for more than 150 mins in the previous week	NSW 2016-18	
			% of C&V resident smokers who make a quit attempt via smoking cessation services - target 5%	6	not available	0.6%	1.1%	0.7% to Q2	0.85% to Q2 17/18	R	0.8Q2%	R	1.2%	R	1.7%	R	↔	WG target 5% over course of full year	Q4 18/19	
			% C&V residents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	7	not available	36.9%	46.0%	67.0%	55.3% Q2 17/18	G	57.0%	A	50.4%	A	60.0%	G	↑	Tier 1 target 40%,	Q4 18/19	
			Rate of conceptions among females under 18	8	Cardiff 35 per 1000, Vale 28.4 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	Cardiff 30.4 per 1000, Vale 19.4 per 1000	Cardiff 27.5 per 1000, Vale 15.8 per 1000	Cardiff 27.5 per 1000, Vale 19 per 1000	A	Cardiff 22.3 per 1000, Vale 15.9 per 1000	G	Cardiff 21.2 per 1000, Vale 13.6 per 1000	G	Cardiff 21.2 per 1000, Vale 13.6 per 1000	G	↔	reduction on previous year	2017 (Annual)	
		Deliver outcomes that matter to people	Crude Hospital Mortality Rate for people aged less than 75	9	94	103	0.60%	0.60%	0.62%	G	0.60%	G	0.59%	G	0.59%	G	↔	12 Month Improvement Target (18/19 was 0.59, 12M to Jun-18 :0.6%%)	12 months to Jun-19	
			Emergency crude mortality rate (12 mth)	10	3.15%	3.27%	2.94%	3.05%	3.05%	G	2.97%	A	2.81%	G	2.78%	G	↔	Reduction in CMR (12M to June-18 = 3.08%)	12 months toJun-19	
			Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event, 12 mth)	11	stroke 14.5%, heart attack 3.7%, #NOF 8.9%	stroke 12.8%, heart attack 3.2%, #NOF 6.9% (Feb)	stroke 10.1%, heart attack 3.7%, #NOF 5.9%	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	stroke 12.5%, heart attack 3.8%, #NOF 8.1%	A	stroke 13.3%, heart attack 4.4%, #NOF 5.7%	A	stroke 12.2%, heart attack 4.8%, #NOF 4.7%	A	stroke 12.6%, heart attack 5.0%, #NOF 3.5%	A	↔	Demonstrable reduction in rolling 12 month rate (2017: 12.8%,4.2%, 7.2%)	12Mths to Mar-19	
			% Universal mortality reviews undertaken within 28 days of a death	12	25%				71%		73%	R	78%	R	67%	R	↓	NEW MEASURE from April-17 - Target is 95%, IMTP trajectory= 83%	May-19	
			National Patient experience survey	13	Operational score 84% (4/12 >85%), User Experience score 89% (2/15 >85%)	Operational score (8/12 >85%), User Experience score 89% (23/26 >85%)	Operational score (15/18 >85%), User Experience score 89.7% (23/26 >85%)	87%	87%	A	87%	A	97%	G	97%	G	↑	% of pts responding who rated overall experience of care as 8/10 or above (Green 90%)	National patient experience report Mar-19	
			"Two minutes of your Time patient feedback scores"	14	8/11 >90%	7/11 >90%	6/11 >90%, 7/11 >85%	6/11 >90%, 7/11 >85%	6/11 >90%, 8/11 >85%	R	7/11 >90%, 8/11 >85%	R	7/11 >90%, 8/11 >85%	R	7/11 >90%, 8/11 >85%	R	↔	Green: 90% for each of the 11 questions, Amber: >85%	Monthly snapshot for May-19	In Nursing director's report
			Proportion of formal complaints responded to within 30 working days	15	45%	43%	55%	43%	74%	A	84%	G	74% (78% for 2018/19)	A	74% (78% for 2018/19)	A	↓	Green: 80%, Amber sustainable improvement from 40-50% range	Monthly in performance up to 31/3/19	In Nursing director's report
		Reduce health inequalities	Life expectancy at birth	16	80.5 2009/11	80.8 2011/13	80.8	80.8	Cdf- F: 82.6, M:78.4, V- F: 83.5, M: 78.8	G	Cdf- F: 82.6, M:78.3, V- F: 83.2, M: 79.1	G	Cdf- F: 82.7, M:78.5, V- F: 83.4, M: 78.9	G	Cdf- F: 82.7, M:78.5, V- F: 83.4, M: 78.9	G	↔	Continuous Improvement (June-18 figures updated)	2015-17	
			Reduce infant mortality for population	17	4.1 per 1,000 live births (2012)	4.3 per 1,000 live births (2013)	4.3 per 1,000 live births	3.9 per 1,000 live births	2.8 per 1,000 live births	G	2.8 per 1,000 live births	G	3.8 per 1,000 live births	G	3.8 per 1,000 live births	G	↓	reduction on 2015 rate (3.9)	ONS (2017)	
			% live births with a birth weight of less than 2500g	18	7.3% (provider)	6.7% (provider)	5.8% (provider)	5.90%	5.98%	G	6.50%	A	6.10%	A	6.3%	A	↔	12 mth cumulative reduction on previous year (5.9%)	May-19	
			Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 popn (New measure)	19			433	387	3.5	G	3.4	G	3.4	G	3.4	G	↑	Annual reduction from 3.6 in 16/17, 3.87 in 15/16 & 4.33 in 14/15	Year 17/18	
			Reduction in the number of emergency hospital admissions for basket of 8 chronic conditions per 100k popn	20	1157	1048	1020	1089	1020	A	997	G	1036	A	1065	R	↓	reduction against same 12 month period of previous year (1014)	12M to Mar-19	
			Reduction in the number of emergency hospital readmissions within a year for basket of 8 chronic conditions	21	223	196	192	196	202	A	190	A	176	G	181	G	↑	reduction against Apr-Mar 2018 =201	12M to Mar-19	
			Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) (Revised Populations applied)	22	727.5 (Mar-Feb14)	633.9 (Mar- Feb 15)	499	554.8	583.7	A	549	A	547	A	542	A	↔	reduction on previous year (562 per 100,000 conf limit+/-52)	12 months to Feb-19	
		Offer services that deliver the population health our citizens are entitled to expect	Delivery of the 31 day (Non- USC) and 62 day (USC) cancer access standards	23	96% NUSC, 83% USC	96.4% NUSC, 82% USC	100% NUSC, 74.2% USC	97% NUSC, 83% USC	98.3% NUSC, 86.8% USC	R	98% NUSC, 82% USC	R	96% NUSC, 84% USC	R	99% NUSC, 81% USC	R	↔	Green Tier 1: 98 % NUSC, 95% USC, Amber IMTP trajectory Q3 = 98% & 92%	May-19	✓
			Primary care contractor professionals assurance status	24	Satisfactory	Satisfactory	Satisfactory	Satisfactory	Managerial Intervention Required	A	1 contract termination, 0 new sustainability application 0 closed list. 0 new applications to close a list.	A	2 contract terminations (1 that has been reissued so is resolved, 1 that was subsequently retracted) 0 new sustainability applications 4 temporary list closures (2 of the 4 applications made in 2017-18 but the closure continued in to 2018-19).	G	0 contract terminations 0 new sustainability applications 0 temporary list closures	G	↑	Present internal assessment of C&V GP sustainability position - text relates to Q1 2019/20 events	as at 31/6/19	
			% GP Practices offering appointments between 17:00 and 18:30 on 5 days a week	25	76% (2013)	83% (2014)	83% (2015)	88%	88%	G	88%	G	88%	A	94%	G	↔	Improvement target (2017 - 88%)	2018	
			% people (aged 16+) who found it difficult to make a convenient GP appointment	26											42%			New measure: Aunnual reduction on 41.6% in 2017/18	2017/18	
			% HB population regularly accessing (within 2 years) NHS primary dental care	27											56%			New measure - quarterly improvement trend - baseline 56.1% in Dec-18	Dec-18	
			Dementia Bundle: Diagnosis rates, Access & training	28	97%	Diagnosis: 54% Access: 84%, Training: 42%	Diagnosis: 55% Access: 71%, Training: 33%	Diagnosis: 58% Access: 98%, Training: 30%	Diagnosis: 63% Access: 99%, Training: 32%	G	Diagnosis: 63% Access: 99%, Training: 32%	G	Diagnosis: 63% Access: 99%, Training: 23%	R	Diagnosis: 63% Access: 99%, Training: 23%	R	↓	Target: Diagnosis improvement in proportion >65years diagnosed with dementia, Access attain 95% memory patients seen within 14 weeks, Trainingimprovement in %GP practices that completed MH DES in dementia care	Diagnosis Yr 17/18, Access: June-19, Training Year 17/18	
			% of people over 65 who are discharged from hospital and referred to a care home and not their usual place of residence	29	2.77%	2.77%	2.60%	3.00%	3.30%	A	3.33%	A	3.37%	A	3.19%	A	↔	Demonstrable reduction in rolling 12 month rate (2017: 3.29) - Amber remain in SPC limits (p_mean = 3.09, UCL 4.2%)	12 months to Jun-19	
			Sustained compliance against four acute stroke bundles	30	1: 96%, 2: 46%, 3: 77%, 4: 91%	1: 98%, 2: 86%, 3: 94%, 4: 96%	1: 35%, 2: 100%, 3: 57%, 4: 67%	1: 40%, 2: 96%, 3: 64%, 4: 79%	1: 23%, 2: 90%, 3: 60%, 4: 92%	R	1: 53%, 2: 98%, 3: 77%, 4: 91%	A	1: 42%, 2: 96%, 3: 64%, 4: 90%	A	1: 38%, 2: 97%, 3: 73%, 4: 98%	A	↔	Amber: Continuous improvement Green: UHB IMTP trajectory	Monthly performance in May-19	✓
Caring for people and keeping them well		Reduce harm, waste and variation sustainably making best use of the resources available to us.	Number of new serious incidents & % assured within agreed timescale	31	102	97 serious incidents, 47 no surprises	219 serious incidents, 21 no surprises	206 serious incidents, 39 no surprises	240 Sis, 31 no surprises - 52% assured in timescale	A	362 Sis, 26 no surprises -71% assured in timescale	A	336 Sis, 27 no surprises -27% assured in timescale	R	315 Sis, 33 no surprises -27% assured in timescale	R	↔	No. of SIs: reduction in year (231 Sis in17/18, 336 Sis in 18/19) ; Timeliness for assurance : 90%	No. of SIs: 12M to Jun-19, Timeliness Mar-19	In Nursing director's report
			% patients with a positive screening for sepsis in both inpatients and emergency A&E who have received all 6 elements of the 'sepsis six' bundle within 1 hour.	32	Bundle 6 84% compliant	Bundle 6 86.7% compliant	Bundle 6 90.6% compliant	64.9%	Jan-18: 55%, YTD 66%	A	Yr to Nov: 81%	G	18/19: 79%	G	69%	A	↓	Continuous improvement target (last 12 months 67%, 18/19: 79%)	Mth of April-19	
			Reduction in number of patients who had a potentially preventable Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	33					10 potentially preventable, 0 to be reviewed		2 potentially preventable, 0 to be reviewed		5 potentially preventable	G	5 potentially preventable	G	↑	rolling 12 mth reduction in preventable HATs post level 2 Root Cause Analysis	Apr-Dec '18	
			% of nutrition score completed and appropriate action taken within 24 hours of admission	34	92%	94%	95%	94%	95%	G	97%	G	95%	G	94%	A	↔	Green: 95%, Amber 90%	May-19	
			Patient environment: Credits 4 cleaning scores for high risk areas	35	Very high risk: 93%, High risk: 92%, Significant risk: 89%	Very high risk: 93%, High risk: 93%, Significant risk: 92%	Very high risk: 94.7% High risk: 94.4% Significant risk: 91.3%	Very high risk: 98.1% High risk: 97.0% Significant risk: 96.7%	Very high risk: 98.2% High risk; 96.7% Significant risk: 96.8%	G	Very high risk: 99% High risk: 97% Significant risk: 94%	G	Very high risk: 98% High risk: 97% Significant risk: 95%	G	Very high risk: 98% High risk: 97% Significant risk: 95%	G	↔	Very high risk: 98% High risk: 95% Significant risk: 85%	Monthly snapshot for June 19	ü
			% compliance with Hand Hygiene (WHO 5 moments)	36	91%	91%	94%	94%	94%	R	95%	A	96%	A	95%	A	↔	Green: 100%, Amber:>95%	Monthly snapshot for May 19	
			Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA), working towards a zero tolerance	37	263 C difficile cases; 31 MRSA cases	172 C difficile cases; 44 MRSA cases	11 C difficile cases; 11 S. aurea cases	13.7 C difficile cases; 10.6 S. aurea cases	115 C difficile cases; 140 S. aurea cases; 316 E. coli cases	R	85 C difficile cases; 122 S. aurea cases; 265 E. coli cases	R	107 C difficile cases; 171 S. aurea cases; 335 E. coli cases	R	24 C difficile cases; 27 S. aurea cases; 95 E. coli cases	A	↔	WG target: tbc (M3 18/19: c-diff:25, s-aureas: 39, e-coli:90)	Apr 19 to June-19	
			Reduction in the number of healthcare acquired pressure ulcers	38	Mthly average = 38	Monthly average = 31 (372 14/15)	M12 = 413, avg = 34.4	M10 = 577 MA(12) = 55	M10 = 1119 MA(12) =107	R	Data quality issue identified		Data quality issue identified		Data quality issue identified			10% reduction on previous year (2015/16 avg = 34.4, target = mthly average of 31) (source:FOC)		
			Financial balance: remain within revenue resource limits	39	£19.177m deficit at M12	£21.364m Deficit at M12	£0.068m surplus at M12, (£13.3m favourable variance from plan)	£29.717m deficit at M11	£25.502m deficit at M11	R	£7.428m deficit at month 9. £0.003m adverse variance against plan	R	£9.873m deficit at month 12. £0.027m favourable variance against plan	R	£1.808m deficit at month 3.	R	↓	2019/20 Break-Even	M3 2019-20	
			Reduction in Underlying deficit	39a							£36.3m assessed underlying deficit position at month 9	R	£36.3m assessed underlying deficit position at month 12	R	£36.3m assessed underlying deficit position at month 1. FYE of identified savings meet recurrent target at month 3.	R	↑	If 2019/20 plan achieved reduce underlying deficit to £4.0m	M3 2019-20	
			Delivery of recurrent £16.345m 2% devolved target	39b							Fully Identified Savings Plan	G	Fully Identified Savings Plan	G	£16.345m identified at Month 2	R	☻	£16.345m	M3 2019-20	✓
			Delivery of £12.8m recurrent/non recurrent corporate target	39c								G		G	£12.800m identified at month 2.	R	☻	£12.800m	M3 2019-20	
			Remain within capital resource limits.	40							Expenditure at the end of December was £22.788m against a plan of £24.967m.	G	Expenditure at the end of the Year was £48.413m against a plan of £48.486m.	G	Expenditure at the end of the June was £5.075m against a plan of £6.196m.	G	☻	Approved planned expenditure £40.030m	M3 2019-20	
			Creditor payments compliance 30 day Non NHS	40a							Cumulative 95.4% in December	G	Cumulative 95.0% in March	G	Cumulative 96.2 % in June	G	↑	95% of invoices paid within 30 days	M3 2019-20	
			Remain within Cash Limit	40b							Forecast cash deficit of £2.418m	R	Cash surplus of £1.219m	G	Forecast cash surplus of £ 0.677 m	G	☻	To remain within Cash Limit	M3 2019-20	
			Maintain Positive Cash Balance	40c							Cash balance = £3.809m	G	Cash balance = £1.219m	G	Cash balance = £3.724m	G	☻	To Maintain Positive Cash Balance	End of June 2019	
		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	41			5315	5528	5197	A	6786	A	6861	A	6859	A	↔	NEW INNU list adopted from August 2018: 12 month rolling reduction (June16-Jun17 : 6597)	12mth to 31/5/19	
			Reducing outpatient did not attend rates for New and Follow Up appointments	42		N 10.8%, FU 12.1%	N 10.5%, FU 11.7%	N 10.2%, 11.8%	N:10.1%, FU 12.2%	R	N:10.1%, FU 11.3%	R	N:9.6%, FU 10.7%	A	N:9.6%, FU 10.6%	A	↑	12 month rolling reduction- 16/17 New DNA 10.2%, FU 11.9%	12mths to Jun-19	
			Increasing in-session theatre utilisation (adopting Newton measure)	43	Tier 2	78%	79%	72%	75%	A	75%	A	75%	A	76%	A	↔	Newton consulting set standards: green >= 85%, amber 67%-85%, red <=67%	May-19	
			Uptake of ERAS across whole HB.	44			Programme has stalled	Programme has stalled	Refresh being planned as part of TTC	R	Prehab to rehab programme progressing to plan	A	Case for acceleration submitted for transformation funding	A	Alternative approach to secure resources being pursued	R	↑	Self assessment based on roll out plan agreed with WG	Jun-19	
			Ensure that the data completeness standards are adhered to within 1 month of the episode end date	45	92% in month, 97% past 12 months	95% in month, 96% past 12 months to Feb-15	95.2% in month, 96.5% past 12 month	95.8% within 30 days	94.9%	A	96.0%	G	97.3%	G	96.6%	G	↓	95% within 30 days	Jun-19	
		Have an unplanned (emergency) care system that provides the right care, in the right place, first time	Number of procedures postponed either on the day or day before for specified non clinical reasons	46	52%	38%	56%	28%	37%	R	23%	R	2070	A	2106	R	↓	WG target: 5% reduction on 2018/19 figure = 1967 . amber continual improvement	12 Mths to 30/4/19	
			Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	47	5.5% (28 days), 73% (56 days)	98.7% (28 days), 96% (56 days)	82.2% (28 days), 92.8% (28 days)	78% (assessment), 86% (therapy)	83% (assessment), 79% (therapy)	A	80% (assessment), 68% (therapy)	R	75% (assessment), 71% (therapy)	R	50% (assessment), 56% (therapy)	R	↓	80% within 28 days for assessment, 80% within following 28 days for therapy	Monthly snapshot for Mar-19	
			Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	48	88.3%	91.9%	90.4%	91.0%	90.1%	G	86.0%	A	85.0%	A	56.0%	R	↓	90% - NB data quality issues	Monthly snapshot for May-19	✓
			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	49	100%	100%	89%	100%	100%	G	100%	G	100%	G	Data quality issue identified	R	↓	Green: 100%, Amber: Continuous improvement as new standard	Monthly snapshot for May-19	
			Part4 Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	50	100%	100%	100%	100%	100%	G	100%	G	100%	G	100%	G	↔	100%	Monthly snapshot for May-19	
			% of children waiting less than 26 weeks to start ADHD / ASD neurodevelopment assessment	51									76%	R	76%	R	↓	New target- target 80%	Apr-19	
			% patients waiting less than 26 weeks to start a psychological therapy	52					29%	R	26%	R	21%	R	15%	R	↔	New target- target 80%	Monthly snapshot for May-19	
			% of high risk (R1) ophthalmology patients waiting 25% beond their target date for an OP appointment	53									51%	R	58%	R	↑	New target- target 95%	Monthly snapshot for June-19	ü
			Number of patients waiting for a follow up & no. delayed by >100%	54									#: 235,000 delayed >100%: 78,000	R	#: 234,000 delayed >100%: 78,000	R	↔	Targets: 15% redn in total no.= 196,640. 15% redn on nop. Delayed >100%. Target: 66,739	Snapshot at 5/7/19	✓
			95% of patients will be waiting less than 26 weeks for treatment with a maximum wat of 36 weeks	55	86.4% <26 weeks, 2088pts > 36 wks	84% <26 weeks, 2386pts > 36 wks	84% <26 weeks, 2522pts > 36 wks	83% <26 weeks, 2720pts > 36 wks	84% <26 weeks, 2921pts > 36 wks	A	84% <26 weeks, 948pts > 36 wks	R	86% <26 weeks, 327pts > 36 wks	A	87% <26 weeks, 604pts > 36 wks	A	↑	95% <26 wks, 0 > 36 wks: Amber: Achieve quarterly IMTP milestone	Snapshot at 30/6/19	✓
		Have an unplanned (emergency) care system that provides the right care, in the right place, first time	Attainment of the primary care out of hours service standards	56	7 Green, 1 Amber, 7 Red	7 Green, 8 Red	5 Green, 3 Amber, 9 Red	6 Green, 6 Amber, 5 Red	8 Green, 1 Amber, 8 Red	R	6 Green, 3 Amber, 8 Red	R	6 Green, 4 Amber, 7 Red	R	7 Green, 4 Amber, 3 Red	A	↔	Number of standards where the UHB is compliantn.b. Standards changed in March 19	Monthly performance in June-19	✓
			Deliver the 70% Cat A 8 minute response times all Wales target on a rolling 12 month basis and sustain the 65% Health Board target on a monthly basis	57	59%	48%	80%	82%	82%, 83% for 12 mths	G	80%, 81% for 12 mths	G	78%, 81% for 12 mths	G	79%, 80% for 12 mths	G	↓	70%	Upto Jun-19	
			95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	58	86%	82%	85%	84%	75%	R	84%	R	84%	R	83%	R	↓	WG target: 95%, IMTP for Q4: 87%	Monthly performance in Mar 19	✓
			Eradication of over 12 hour waits within all hospital emergency care facilities	59	175	101	55	59	290	R	39 in month (188 in Q3)	R	34 in month, 301 in Q4	R	84 in month, 200 in Q1	R	↔	WG target: 0, IMTP trajectory: 175 for Q4	to Mar-19	
			% critical care bed days lost due to delayed transfers of care	60									6.30%	R	6.30%	R	↔	Quarter on quarter improvement & <=5%	Q4 18/19	
	Culture	Be a great place to work and learn	Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	61	51%	56%	56%	58%	59%	R	56%	R	55%	R	54%	R	↓	Green: >85%, Amber 68-84%, Red <68%	Jun-19	
			Medical Staff – percentage of staff undertaking Performance Appraisal	62	66%	77%	75.2%	74.4%	77.0%	A	80%	A	74%	R	74%	R	↓	Green: 85%, Amber: increase from Mar-18 position of 77%	as at Mar-18	
			% staff who would be happy with care by their organisation oif friend / relative needed treatment	63									79%		79%			Improvement on the 2018 79% baseline	2018 Survey	
			Overall measure for organisational climate / engagement	64	Not available	51%	60%	3.64/5	3.64/5	A	3.85/5%	A	3.85/5	A	3.85/5	A	↑	Bi-Annual	2018 Survey	
			Achieve annual local sickness and absence workforce target	65	5.60%	5.54%	5.14%	4.86%	5.12%	R	5.15%	R	5.11%	R	5.18%	R	↔	12 month rolling reduction from 5.12% Mar-18,	Jun-19	
			Retain platinum corporate health standard	66	In progress	Achieved	Achieved	Achieved	Achieved	G	Achieved	G	Achieved	G	Achieved	G	↔	Re-assessed as meeting standard	2017/18	
		Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	Ambulance handover times: % within 15 and 60 minutes	67	15 mins: 41%, 60 mins: 90%	15 mins: 60%, 60 mins: 92%	15 mins: 56%, 60 mins: 93%	15 mins: 49%, 60 mins: 90%	15 mins: 31%, 60 mins: 71%	R	15 mins: 53%, 60 mins: 91%	R	15 mins: 50%, 60 mins: 92%	R	15 mins: 43%, 60 mins: 84%	R	↓	15 mins: 60%, 60 mins: 100% (Amber: IMTP trajectory for 60 mins requires c. 94%)	Monthly performance in May-19	✓
			No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	68	55 NMH, 15 MH	109 NMH, 24 MH	73 NMH, 21 MH	29 NMH, 17 MH	32 NMH, 14 MH	A	43 NMH, 8 MH	R	32 NMH, 5 MH	A	40 NMH, 6 MH	A	↓	IMTP trajectory is 7 MH, 28 NMH	Monthly snapshot for Jun-19	
			Progress in Delivering Strategic Programme	69	Progress on developing high level strategies & relationships with CU	Progress on developing high level strategies & relationships with CU	Blueprint for HEART prepared for board	Slippage on aspects due to changing financial posn	Transformation programme accelerating	A	Me, my home, my community, accessible information & health pathways implenting at pace	A	2nd transformation bid to accelerate progress submitted	A	Furter transformation resource sevured	A	↔	Sustained improvement	Assessment at Jun-19	

1) MENTAL HEALTH

How are we doing?

1,927 referrals were received by primary mental health services in the period April to May 2019, an increase of 14% on the same period in 2017/18.

Part 1 of the measure requires service users of primary mental health services to receive an assessment within 28 days and to receive therapeutic intervention following assessment within a further 28 days. Since the beginning of 2019/20 the proportion of service users receiving an assessment within 28 days has significantly decreased to 50% in May 2019 compared to the Welsh Government's expected standard of 80%.



In May 2019, only 56% of service users received a therapeutic intervention subsequent to their assessment within 28 days, below the minimum standard expected by the Welsh Government of 80%. All three services saw a deterioration in their performance against part 1A of the measure: Adult Services (59%), CAMHS (11%) and Services for Older people (36%).

The deterioration in performance is predominantly attributable to the continually increasing level of referrals being received, although the CAMHS performance was also adversely affected by a reduction in capacity reduced due to establishment vacancies.

Part 2 of the measures sets out an expectation that mental health service users should have a valid Community Treatment Plan completed at the end of each month. The UHB performance for May 2019 fell to 56% against the Welsh Government's minimum standard of 90%. At a service level, the deterioration in performance was driven by the challenging circumstances in CAMHS, which resulted in only 21% of users having a plan completed at month end.

Data quality issues have come to light relating to Part 3 compliance in MHSOP and adult services. These issues are currently being worked through and there is a delay, therefore, in this information being available to report to the Board

Part 4 provision of an advocacy service for patients continues to be met.

How do we compare with our peers?

In April 2019 the UHB's performance deteriorated, with performance being below average against all measures.

Indicator	Target	Month	SB	AB	BCU	C&V	CTaf	Hdda	Powys	CV Rank
Part 1a. % of assessments within 28 days	80%	Apr-19	86.1%	86.9%	74.6%	56.4%	61.0%	93.4%	78.6%	7/7
Part 1b. % of Therapeutic Interventions started within 28 days of assessment	80%	Apr-19	97.6%	78.3%	70.3%	69.6%	94.4%	89.9%	71.8%	7/7
Part 2 % of residents with a valid CTP	90%	Apr-19	88.9%	90.5%	89.9%	83.2%	88.5%	90.9%	95.1%	7/7
Part 3 % of residents sent their outcome assessment report within 10 days of their assessment.	100%	Apr-19	100.0%	100.0%	100.0%	75.0%	66.7%	100.0%	100.0%	6/7

What are the main areas of risk?

The main risk to providing an accessible responsive service is the lack of resilience within the services' capacity at periods of relatively higher demand.

What actions are we taking?

In respect of Part 1 the UHB is seeking to accelerate the increased use and ability of Primary Care services as the first point of contact Mental Health provision, by right sizing the capacity of the service in order to balance assessment and intervention and manage the variation and rising levels of demand.

Particular emphasis has been placed on the CAMHS service, with an independent review taking place which will report in early August. The CAHMS recovery plan includes:

- Increase in short term capacity, through overtime, additional hours, bank and agency workers.
- The process to recruit band 6 workers to fill the current vacancies is anticipated to fill all vacancies from September.
- Procurement of a Digital solution is underway. It is anticipated that this more transformative development will take a further 3 months from the time the contract is awarded to it being operationalised and the appropriate governance requirements put in place.

Further to the identification of the data quality issues, the processes and practices that Adult and MHSOP services have in place for delivering the measure are being swiftly reviewed and all parties including local authority teams are working on iteratively and agilely developing and delivering a plan going forward to address the issues.

Plans are already being implemented to support HM Prison service in the delivery and recording of the measure as they have never been included previously. It is envisaged that this may impact on parts 1-3 of the measure, although the materiality is not yet known.

For parts 2 & 3: the focus in on establishing multi-agency consensus to enable standardisation of processes across Learning Disability services, Local Authorities, the UHB and HM Prison in order to assure practice and definitions. Actions being pursued in parallel include

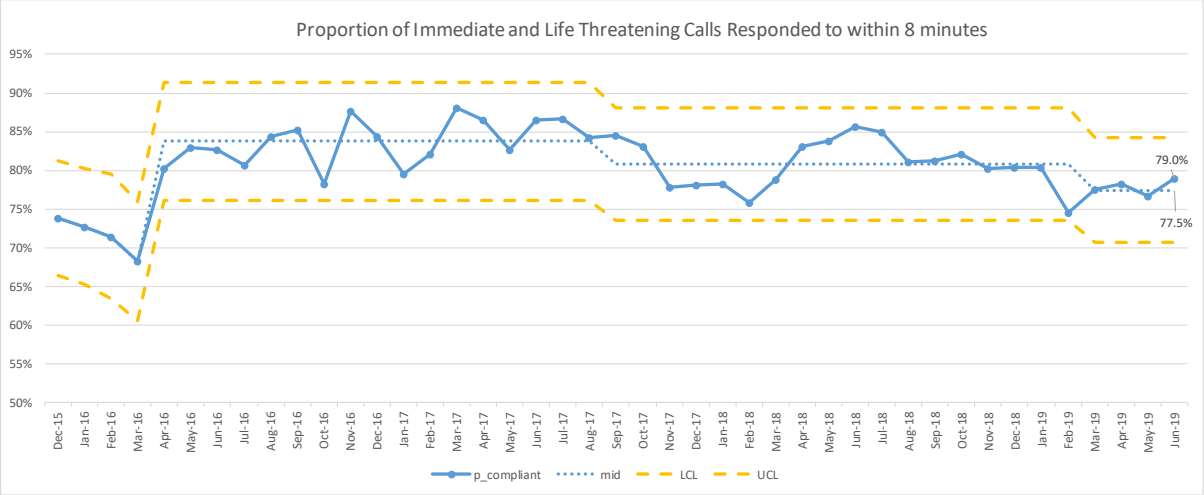
- Creating a waiting list approach to the management of patients who fall within part 3 of the Mental Health Measure, which includes the development and circulation of frequent patient management reports and training for staff
- For adult services, upgrades to the functionality of the PARIS EPR system are underway, with additional fields and revised reports and business intelligence reports to support the Community Mental Health Teams and mandating time stamp fields to improve accuracy in particular in regards to the 4 hour measure presently being developed.
- Efforts to automate data extraction from the numerous systems to provide earlier awareness of issues and reduce the time spent administrating the process
- Multi-agency working and sharing to provide similar tools to those identified as being required by the clinical teams employed by the UHB to be available for MHSOP services, which are provided by the local authority.

It is envisaged that the vast majority of the data quality issues will be resolved by September.

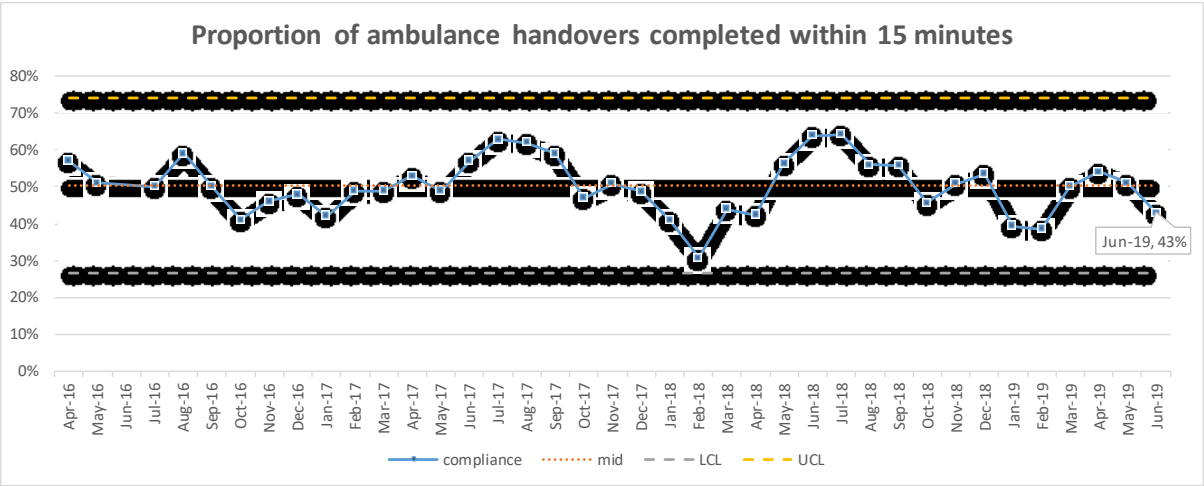
2) UNSCHEDULED CARE

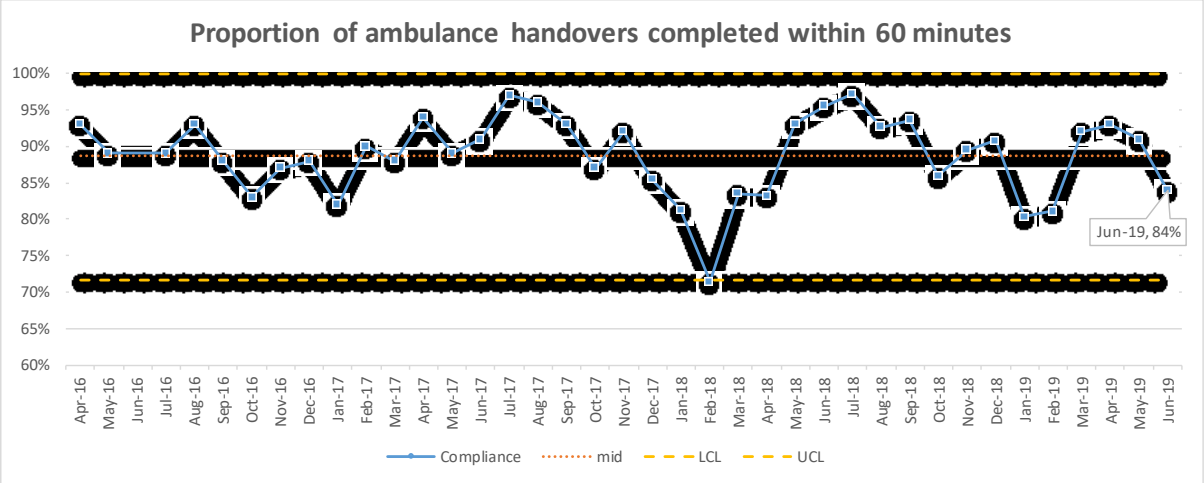
WAST 8 Minutes Response

The Health Board commissions the Welsh Ambulance Service Trust to provide responsive, high quality services to patients. Whilst the proportion of patients with a potentially immediate or life threatening condition within Cardiff and the Vale to whom the Ambulance Service responded within 8 minutes has fallen in the past 6 months by c.4%, performance remains above the Welsh Government target of 65%. June's performance being 79%.



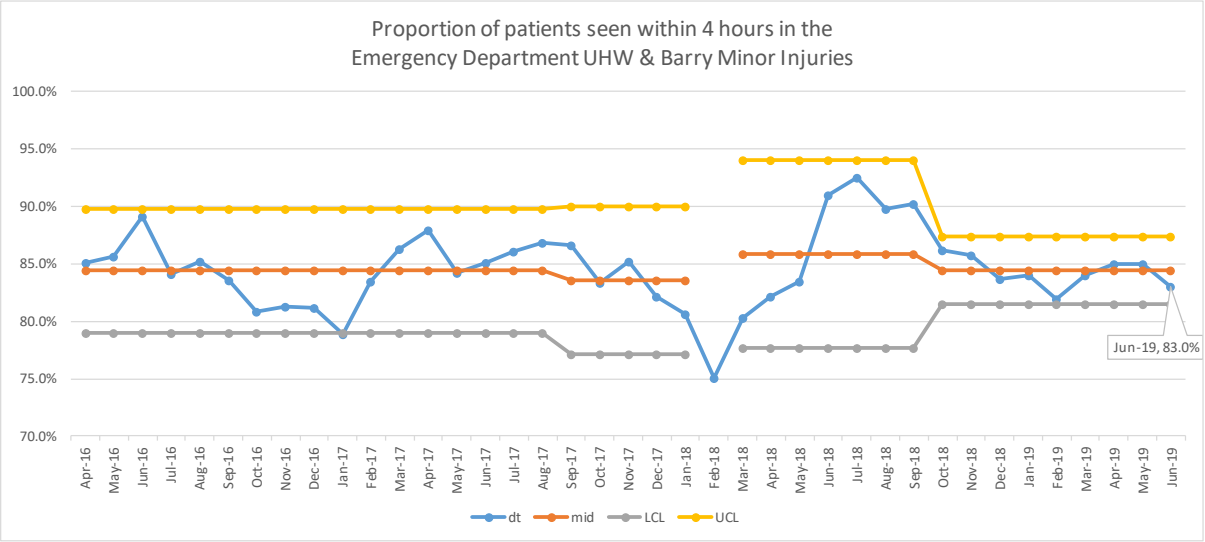
In respect of ambulance handovers, performance has not changed significantly for 3 years, fluctuating around a mean of 50% of patients being handed over within 15 minutes, and a mean of 88% within 60 minutes. The WG minimum standard is 60% within 15 minutes, and 100% within 60 minutes.

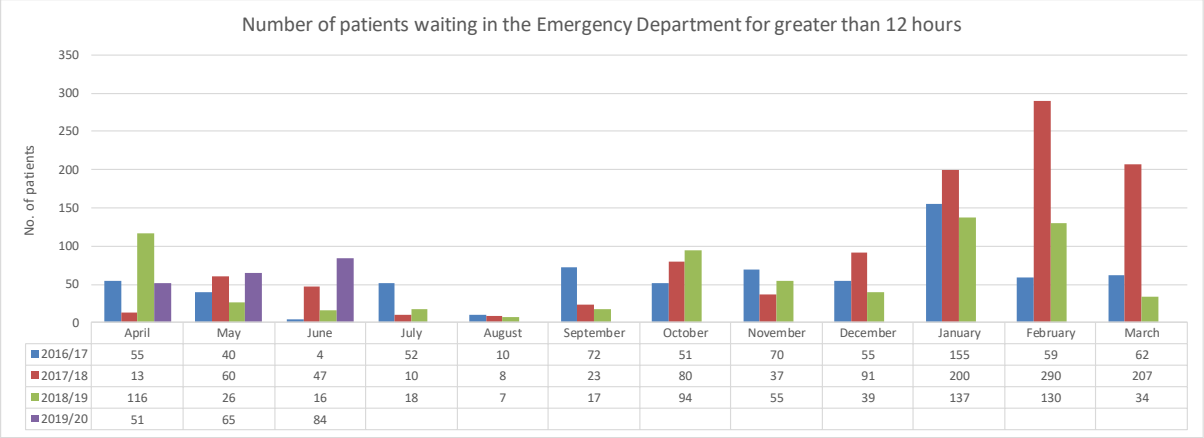




The proportion of patients admitted, discharged or transferred within 4 hours was 83% in June, fluctuating around a mean of 84%. This level of performance has also been fairly stationary for the past 3 years, recognising the impact of seasonality on demand observed in 2018. The WG standard is 95%.

The number of patients waiting in excess of 12 hours was 84 in the month of June, and 200 for the quarter. The WG's expected standard is that no patient should wait in excess of 12 hours. These figures continue to exclude patients where there has been clinical justification for the patient requiring extended periods of care and observation within the Emergency Department footprint.



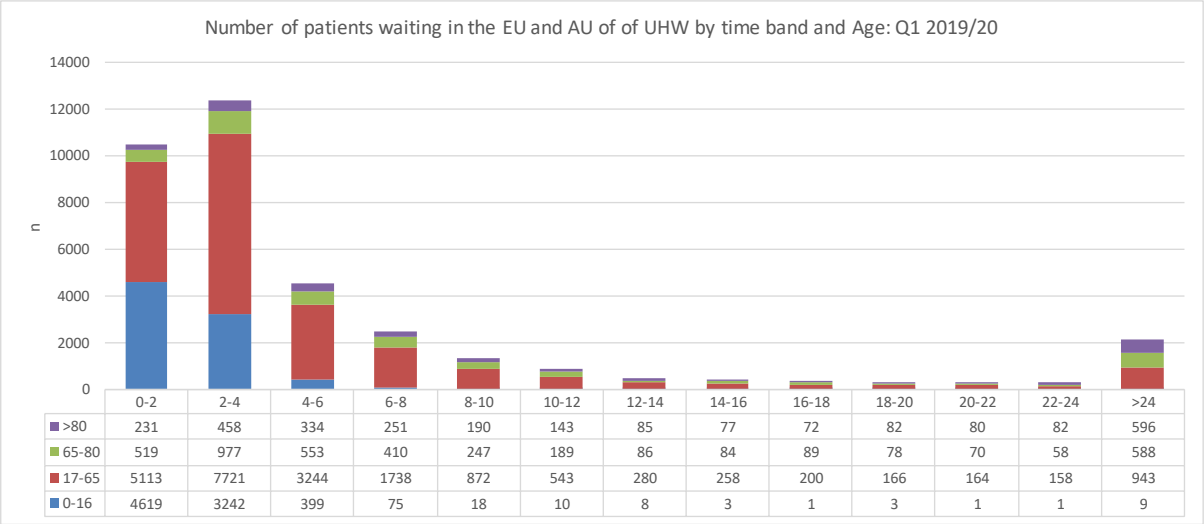


	April	May	June	July	August	September	October	November	December	January	February	March
2016/17	55	40	4	52	10	72	51	70	55	155	59	62
2017/18	13	60	47	10	8	23	80	37	91	200	290	207
2018/19	116	26	16	18	7	17	94	55	39	137	130	34
2019/20	51	65	84									

Emergency Assessment Waiting Times

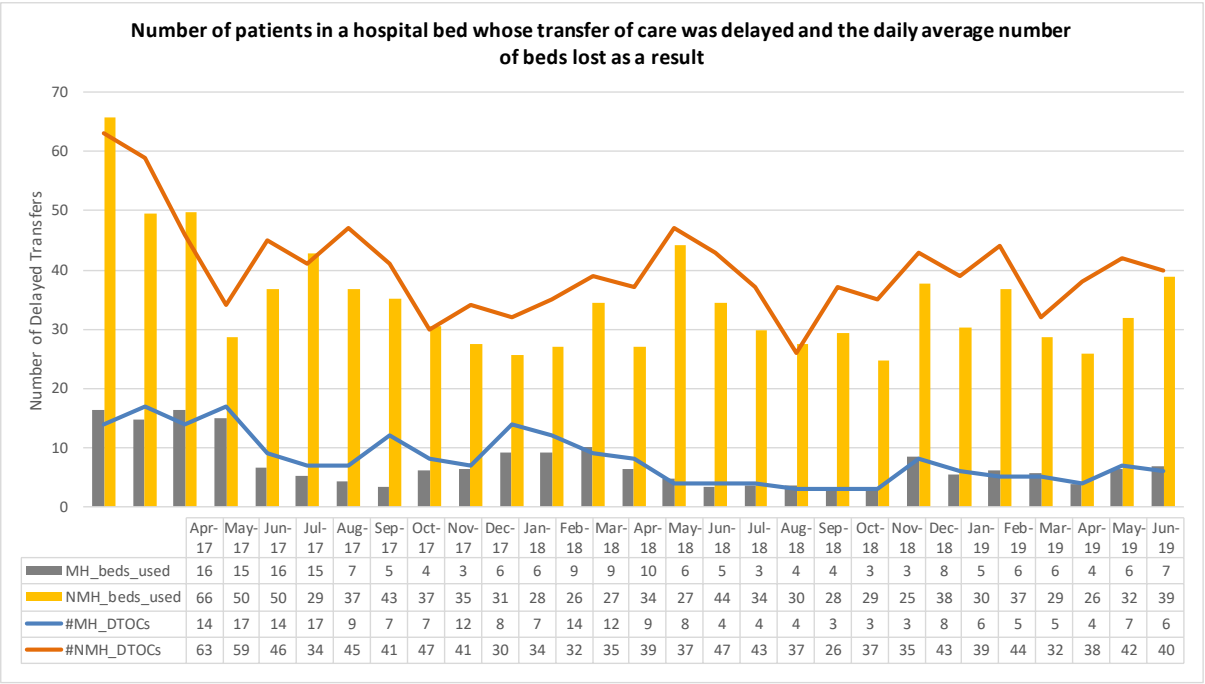
The UHB saw an average of 400 patients per day through the UHW emergency and assessment units in quarter 1. Our patients present from various different locations, arrive via different routes and have very different personal and clinical requirements. As a result there is wide variation in the time and the demands they have on our front line hospital unscheduled care services, the most significant factor of which is whether they require admission.

Over the quarter, 2136 patients waited in the combined EU AU area for more than 24 hours, an average of 24 patients per day and 6% of the total. As it is the more elderly patients who are more likely to require admission and wait in the unit for a bed, the proportion of patients aged 80 and above who wait greater than 24 hours was disproportionate at 22% of the total aged >80.



	0-2	2-4	4-6	6-8	8-10	10-12	12-14	14-16	16-18	18-20	20-22	22-24	>24
>80	231	458	334	251	190	143	85	77	72	82	80	82	596
65-80	519	977	553	410	247	189	86	84	89	78	70	58	588
17-65	5113	7721	3244	1738	872	543	280	258	200	166	164	158	943
0-16	4619	3242	399	75	18	10	8	3	1	3	1	1	9

Delayed Transfers Of Care: The total number of patients whose care was delayed was 46 in June 2019, in line with mean, since July 2017 of 45.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
MH_beds_used	16	15	16	15	7	5	4	3	6	6	9	9	10	6	5	3	4	4	3	3	8	5	6	6	4	6	7
NMH_beds_used	66	50	50	29	37	43	37	35	31	28	26	27	34	27	44	34	30	28	29	25	38	30	37	29	26	32	39
#MH_DTOCs	14	17	14	17	9	7	7	12	8	7	14	12	9	8	4	4	4	3	3	3	8	6	5	5	4	7	6
#NMH_DTOCs	63	59	46	34	45	41	47	41	30	34	32	35	39	37	47	43	37	26	37	35	43	39	44	32	38	42	40

How do we compare with our peers?

The latest performance data available indicates that UHB ranked first in comparison to its peers for the recorded unscheduled care access measures in April and March 2019.

	Target	AB	BC	C&V	CTM	HD	SB	C&V Rank	Month
% Red calls WAST respond to within 8 mins	65%	71%	70%	77%	71%	60%	74%	1/6	May-19
Patients waiting > 1hr for a handover	0	629	614	200	312	204	646	1/6	May-19
% new patients waiting longer than 4 hrs in EU	95%	77%	70%	85%	72%	81%	75%	1/6	Apr-19
No. patients waiting >12 hrs in EU	0	752	1741	51	988	924	653	1/6	Apr-19

What are the main areas of risk?

Demand continues to rise with the volume of patients attending our Emergency Departments up 3% and emergency admissions by 5% year-to-date compared to the same period last year. This is placing sustained pressure on frontline services and the unscheduled care system.

The need to balance the risk and pressure across the whole unscheduled care system.

What actions are we taking?

As reported previously, we continue to work with our partners across health, social care and the voluntary sector focusing on:

1. *Right place, right time* - Improved access to Urgent and Emergency care
2. *Every Day Counts* – Timely decision making and access to diagnostics and therapies
3. *Get Me Home* - Alternative services in the community to reduce long hospital stays

Programmes of work are ongoing with schemes in place to support these, including the rollout of 'Red to Green' on wards; continuing to maximise our core Community Resource Team capacity; and 'Get me home plus'. A number of pathway improvement initiatives are being taken forward as part of the Length of Stay improvement programme of work, most recently in respiratory and trauma and orthopaedics. This work is being informed and supported by an increased use of data and business intelligence.

Actions agreed as part of the improvement plan, developed by the Medicine and Surgery Clinical Boards, to address the recommendations from the Health Inspectorate Wales report on the Emergency Department and Assessment Unit, University Hospital of Wales are being progressed.

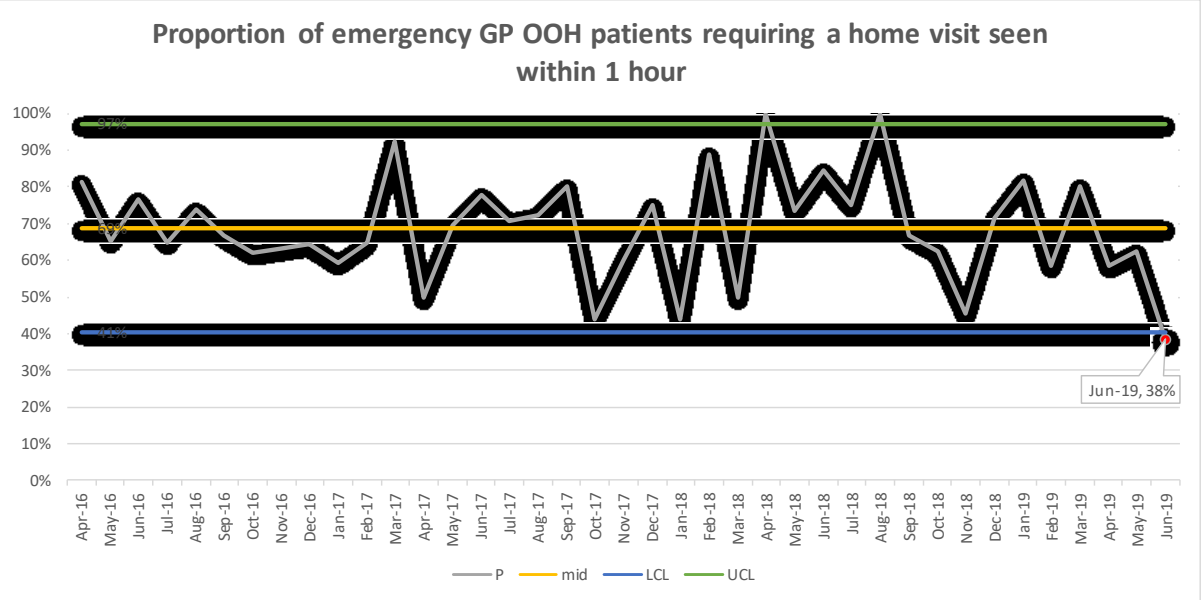
3) GP OUT OF HOURS SERVICES (OOH)

How are we doing?

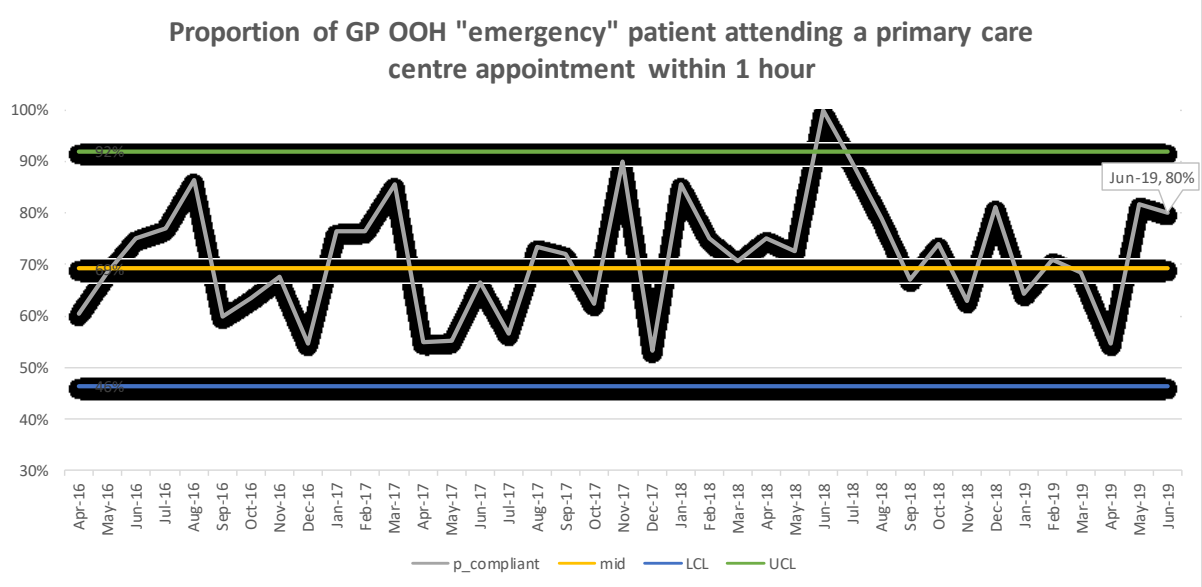
The Welsh Government have introduced a new suite of indicators for 2019/20 and extended the scope of the measures to include patients accessing primary care through the 111 service. In June the UHB was compliant with 7 of the 14 measures, and within 10% of the compliance standard (marked as amber) for a further 4.

	Demonstrates that a standard has been achieved		Total Contacts= 10132				Total Contacts= 9401			
	Demonstrates that a standard is within 10% of being achieved		Total Clinical Contacts Recorded on Adastra = 8803				Total Clinical Contacts Recorded on Adastra = 8058			
	Demonstrates that a standard has **not** been achieved									
	Demonstrates volumes only		**May-19**				**Jun-19**			
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	**8921**	**7853**	**88%**		**8091**	**7612**	**94%**	
Abandoned Calls	Number of callers who abandon their attempt after 60 secs.	No more than 5%	**8921**	**166**	**2%**		**8091**	**91**	**1%**	
Handling	Number of patients wishing to conduct the call in welsh	No standard	Data not available				Data not available			
Telephone Triage Services										
Urgent Triage	Number of urgent calls, logged & returned within set timeframes	90% triaged within 1 hour	**2484**	**2319**	**93%**		**2242**	**2161**	**96%**	
	Median Time Waiting		**9**				**7**			
Routine Triage 1	Number of routine calls, logged & returned within set timeframes	90% triaged within 2 hours	**4333**	**3854**	**89%**		**4059**	**3844**	**95%**	
	Median Time Waiting		**22**				**11**			
Routine Triage 2	Number of routine calls, logged & returned within set timeframes	90% triaged within 4 hours	Data not available				Data not available			
	Median Time Waiting		Data not available				Data not available			
Home Visiting										
Home Visits	The number and percentage of home visits	No target	**8803**	**595**	**7%**		**8058**	**549**	**7%**	
HV P1 (Emergency)	The number of face to face contacts within one hour	90% within one hour	**8**	**5**	**63%**		**13**	**5**	**38%**	
HV P2 (Urgent)	The number of face to face contacts within two hours	90% seen within two hours	**169**	**140**	**83%**		**152**	**134**	**88%**	
HV P6 (Less Urgent)	The number of face to face contacts within six hours	90% seen within six hours	**418**	**310**	**74%**		**384**	**334**	**87%**	
All calls	Total number of face to face contacts within eight hours	99% seen within eight hours	**595**	**518**	**87%**		**549**	**531**	**97%**	
	Median for all priorities		**122**				**101**			
Primary Care Centre Appointments										
PCC	The number and percentage of PCC attendances	No target	**8803**	**2734**	**31%**		**8058**	**2685**	**33%**	
PCC P1 (Emergency)	The number of face to face contacts within one hour	90% seen within one hour	**11**	**9**	**82%**		**10**	**8**	**80%**	
PCC P2 (Urgent)	The number of face to face contacts within two hours	90% seen within two hours	**225**	**187**	**83%**		**213**	**195**	**92%**	
PCC P6 (Less Urgent)	The number of face to face contacts within six hours	90% seen within six hours	**2498**	**2448**	**98%**		**2462**	**2437**	**99%**	
All calls	Total number of face to face contacts within eight hours	99% seen within eight hours	**2734**	**2701**	**99%**		**2685**	**2673**	**100%**	
	Median for all priorities		**107**				**101**			
Transmissions										
Transmissions	The number of reports sent to GP Practice by OOH	100% by 9am	**9223**	**9223**	**100%**		**8668**	**8668**	**100%**	
Other Data										
Outcomes	The number of calls ending in telephone advice	No target	**8803**	**2382**	**27%**		**8058**	**2181**	**27%**	
	The number of calls advised to contact their GP within 24hrs.	No target	**8803**	**1066**	**12%**		**8058**	**1034**	**13%**	
Referrals OUT	The number of referrals to the Emergency Department	No target	**8803**	**599**	**7%**		**8058**	**604**	**7%**	
	The number of referrals to WAST	No target	**8803**	**224**	**3%**		**8058**	**209**	**3%**	
	The number of referrals for direct admission	No target	**8803**	**342**	**4%**		**8058**	**319**	**4%**	
Referrals IN	The number of referrals from the Emergency Department	No target	**8803**	**71**	**0.8%**		**8058**	**57**	**0.7%**	
	The number of referrals from WAST	No target	**8803**	**176**	**2%**		**8058**	**164**	**2%**	
Rota	Shift fill rate (reported in hours)	100% of shifts filled	**4961**	**3601**	**73%**		**4828**	**3925**	**81%**	
Complaints/Incidents										
Complaints	Total number of complaints received & number upheld	No target		**6**				**3**		
Compliments	Total number of compliments received	Volume only		**2**				**1**		
Significant Events	Total number of significant events recorded	Volume only		**0**				**0**		
Serious Incidents	Total number of serious incidents recognised	Volume only		**0**				**0**		

As per the chart below the proportion of home visits for patients prioritised as “emergency” which were provided within 1 hour continued to fluctuate wildly over the course of the year between limits of 41% and 97%, reflecting the large variation in demand on this service, both in terms of very small volumes and location. The median performance is 69% compared with the Welsh Government’s delivery standard of 75%. At 38% performance in June was below the control limits.



The proportion of primary care centre appointments provided within 1 hour for those prioritised as “emergency” also remains stationary at a median of 69%, with discrete performance for June at 80%.



How do we compare with our peers?

The latest performance data available indicates that UHB’s performance is in line with that of Betsi Cadwaladr UHB but below that of AB and Cwm Taf Morgannwg areas.

		Target	AB	BC	C&V	CTM	HD	SB	C&V Rank	Month
Proportion of GP OOH patients triaged as emergency receiving:	a home visit with 1 hour	90%	94%	95%	88%	81%	no data	no data	3/6	Apr-19
	a primary care centre consult within 1 hour	90%	82%	50%	55%	84%	no data	no data	3/6	Apr-19

What are the main areas of risk?

The two areas of concern are:

- An ability to provide home visits within 60 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 peak periods and 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?

- Workforce planning – Capacity and Demand exercises have been completed alongside best practice reviews. Following this a three year workforce plan is being implemented and an evaluation of the MDT taking place.
- Emphasis continues to be placed on increasing shift fill rates, with the June level having increased to 81% of the targeted establishment from 73% previously.

4) PRIMARY CARE

How are we doing?

The UHB is presently engaged with Welsh Government and other Health Boards in Wales to develop a standard approach to reporting risk in relation to General Medical Services (GMS). The UHB's present status in respect of three of the key metrics that are expected to be adopted, are reported on below:

a) Sustainability applications: The UHB currently has zero active applications from GPs to support with the sustainability of their services and there are no lists presently closed to new registrations.

b) Contract terminations: There have been no contract terminations

c) Directly managed GP services: The UHB presently has no directly managed primary medical care services

d) Other contract variations: There are presently no closed lists.

How do we compare with our peers?

Data to inform the all Wales position in respect of GMS is presently under development.

What are the main areas of risk?

Primary care is essential to delivery of the organisation's strategy and strategic objectives, affecting all dimensions of health and care. Owing to a number of factors, the UHB is facing challenges in recruiting and retaining sufficient numbers of General Medical Practitioners to meet the demands of a growing, aging population, who have increasingly complex clinical needs from some fairly antiquated estate.

The key indicators presently used across Wales to assess the risk of GP sustainability at a practice level are:

- Age distribution of the Practice population age spread
- Number of sites/branch surgeries within the practice group
- Condition of premises
- Capacity of premises
- Whether it is a Partnership or singlehanded partnership
- Patients per GP & per senior clinician (GP, Advanced Practitioner, Pharmacists)
- Age profile of the GPs in the partnership
- Current vacancies & Length of vacancies within the practice
- Number of unfilled clinical sessions per week
- Income loss arising after 'Minimum Practice Income Guarantee' redistribution
- Recent changes to opening hours (per site)
- Merger discretionary payment scheme development to support practice mergers and the costs associated with this.

What actions are we taking?

In July, as part of the a National Initiative, we welcomed a delegation from the Basque region including the Minister for Health where we shared good practice and lessons being learnt in the development of primary and integrated care services.

Further to initiatives previously described, developments over the past 2 months, include:

- Procurement of IM&T solutions including template building for all GP practices in C&V. Reducing duplication of task and variation in quality of templates to support patient management, improved positive outcomes and workforce re-design
- Nurse trainee scheme – supporting recruitment and retention of primary care nurses, providing a positive training experience and ongoing mentorship for nurses moving in to primary care.
- Peer to peer visits – GP associates from primary care visiting GP practices to offer advice and practical solutions.

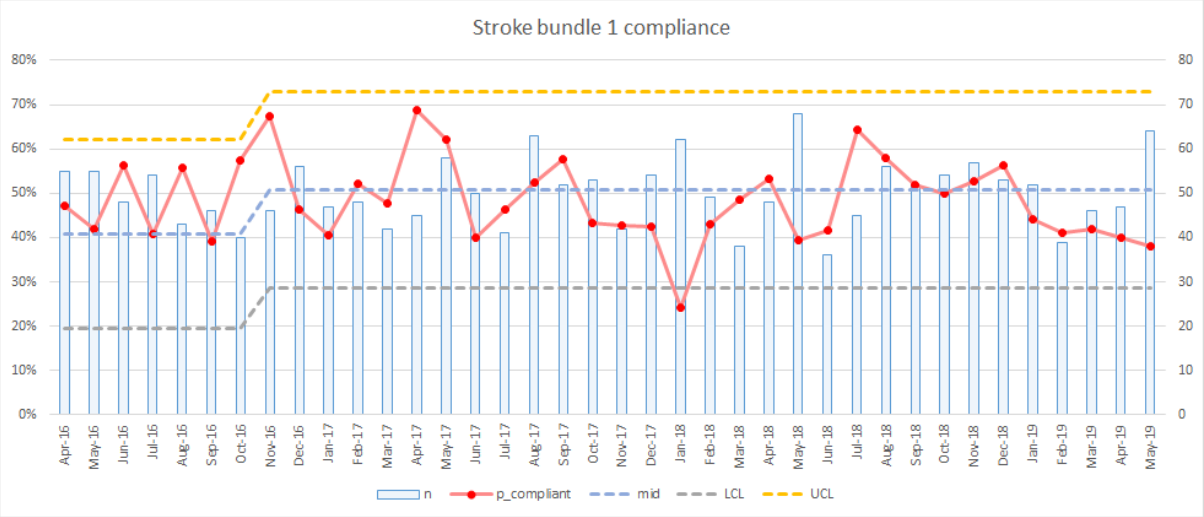
5) STROKE

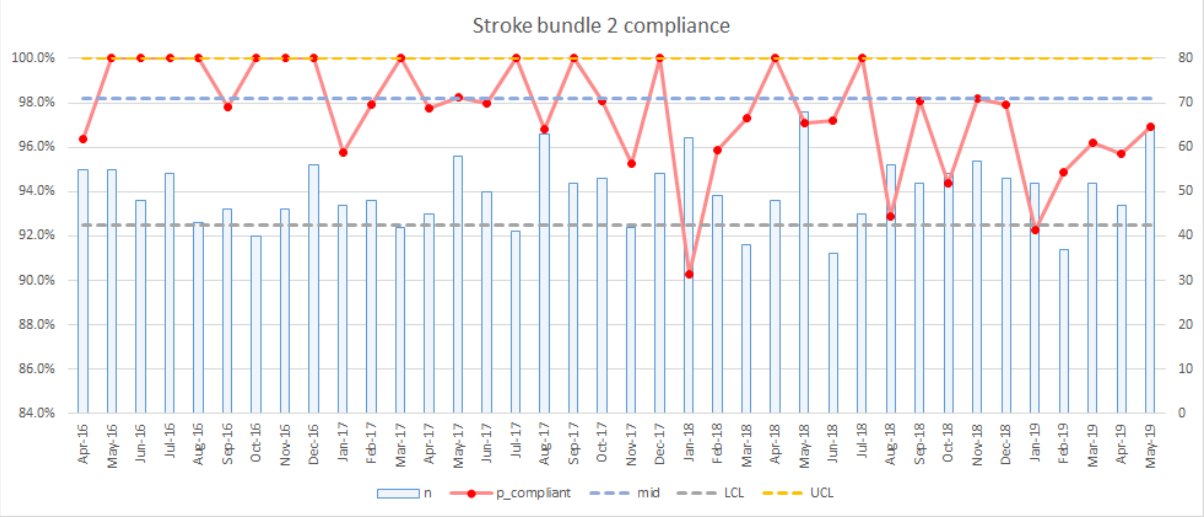
How are we doing?

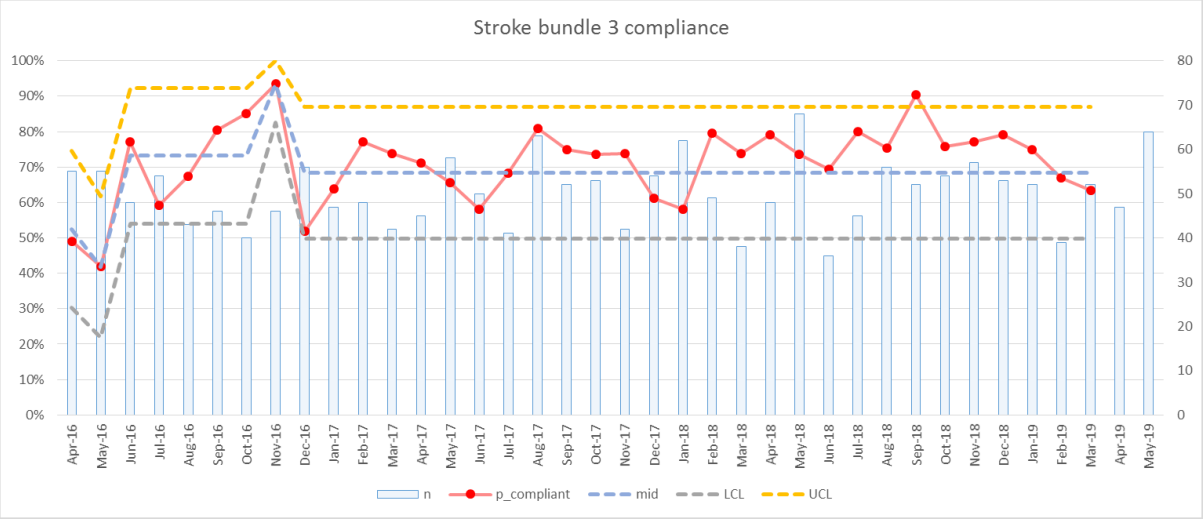
Welsh Government have changed two of four headline measures that will be monitored in 2019/20. The CT scan and thrombolysed door to needle measures are replaced by compliance with patients receiving the required minutes for occupational therapy, physiotherapy' psychology and speech and language therapy; and six month follow-up assessment.

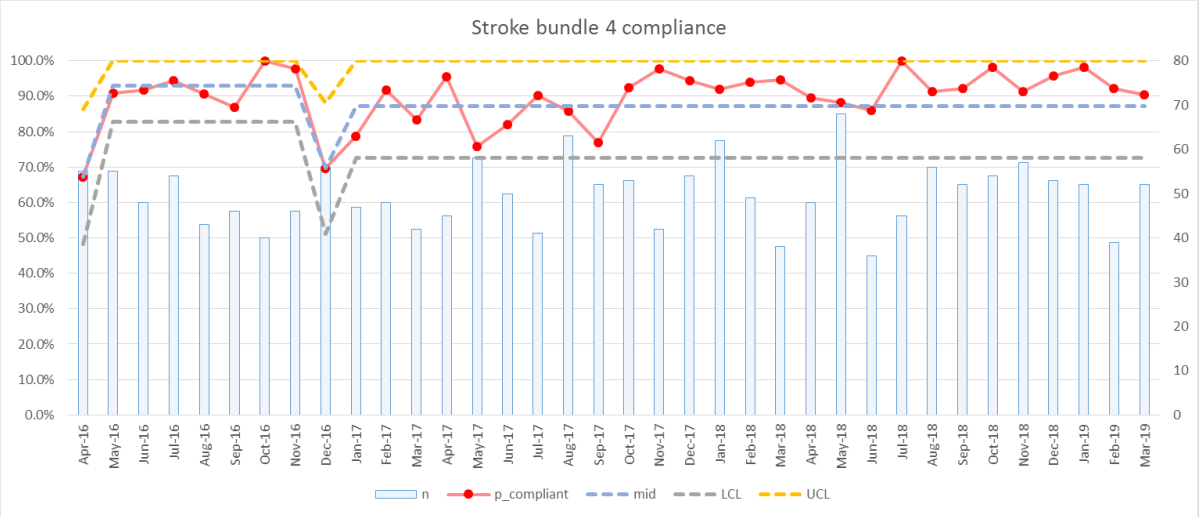
WG benchmarking standard		IMTP trajectory	UHB in May-19
4 Hour QIM	65%	38%	54%
12 Hour QIM	99%	96.9%	97%
24 Hour QIM	80%	73.4%	76%
45 Minute QIM	35%	51.6%	19%

Trends in performance in delivering the full bundles are shown below.









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 on a sustainable basis.

Indicator	Target	Month	Wales	SB	AB	BCU	C&V	CT	HDda	C&V Rank
Direct admisson to Acute Stroke Ward within 4 hours	59%	May-19	50.4%	62.0%	54.7%	54.1%	40.9%	29.5%	67.8%	5/6
Assessed by Stroke Consultant within 24 hours	84%	May-19	84.3%	96.0%	100.0%	80.2%	74.5%	62.9%	100.0%	5/6

What are the main areas of risk?

The challenge for the Health Board remains to achieve consistency in delivery.

What actions are we taking?

The Health Board, through the re-established Stroke Programme and the Stroke Operational Group, continues with its programme of improvement work. The RCP Guidelines (2016) identifies a number of key priorities including both detecting stroke quickly and delivering fast, effective care, Improvement actions include:

- Ongoing work to raise awareness of the Code Stroke process
- Ongoing training and education for junior doctors in ED, general medicine, stroke and neurology
- To support admission within 4 hours a Stroke escalation procedure has been developed and implemented.
- A test of change for stroke bed capacity is being trialled in August for a four week period.
- Review of the medical model for stroke with the aim of increasing cover from senior decision makers on wards

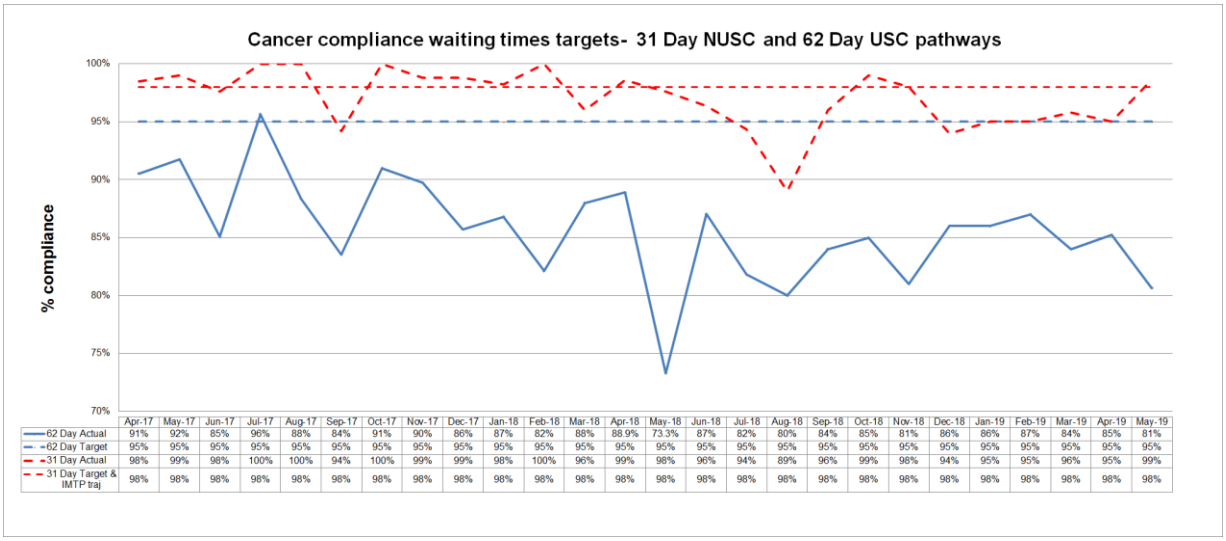
6) CANCER

How are we doing?

During May 2019 80.7% of cancer patients who were referred by their GP as urgent with suspected cancer commenced treatment within 62 days of their referral, against a minimum expected standard of 95%. This is a decrease on the 85.2% observed in April 2019.

98.6% of patients who were not on an “urgent suspected cancer” pathway commenced treatment within 31 days of the requirement for treatment being agreed with them. The UHB met the minimum expected standard of 98%.

Monthly performance against the 31 and 62 day standards is shown below:



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
62 Day Actual	91%	92%	85%	96%	88%	84%	91%	90%	86%	87%	82%	88%	88.9%	73.3%	87%	82%	80%	84%	85%	81%	86%	86%	87%	84%	85%	81%
62 Day Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
31 Day Actual	98%	99%	98%	100%	100%	94%	100%	99%	99%	98%	100%	96%	99%	98%	96%	94%	89%	96%	99%	98%	94%	95%	95%	96%	95%	99%
31 Day Target & IMTP traj	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

What are the main areas of risk?

Demand increases have compounded a number of pre-existing process and capacity constraints. Urology and GI remain the two tumour sites of biggest challenge.

The UHB is focusing on reducing the volume of patients waiting > 62 days on the urgent suspected cancer pathway. Whilst it remains the right thing to do for our patients, this will adversely affect compliance against the Welsh Government target.

What actions are we taking?

Improvement plans have focused on balancing demand and capacity and strengthening tracking and expedite of patients through their pathway.

In urology, an increase in short term capacity for robotic procedures has been secured, an area identified as a specific constraint. The recruitment process has commenced for an additional consultant – to increase capacity for patients on the cancer pathway. An additional TRUS session is planned from September 2019. Bi-weekly tracking and expedite meetings are now in place.

The Health Board continues to insource endoscopy activity – thereby allowing core capacity to be protected for patients on a cancer or surveillance pathway. The UHB has increased its dedicated tracking resource for GI, with an additional tracker commencing in June 2019.

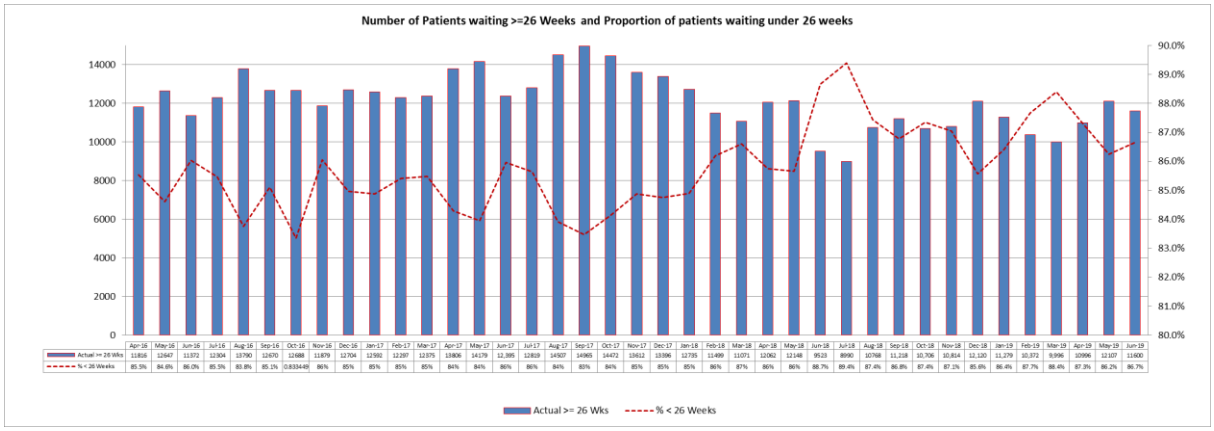
The UHB continues to work with Velindre NHS Trust representatives regarding timely access to chemotherapy. Whilst this work progresses to its conclusion, the UHB has commissioned a short term increase in chemotherapy treatment capacity from an external provider.

The Health Board continues to progress with its Implementation Plan for the Single Cancer Pathway. Shadow reporting for May showed compliance as 72% treated in target (with suspensions applied).

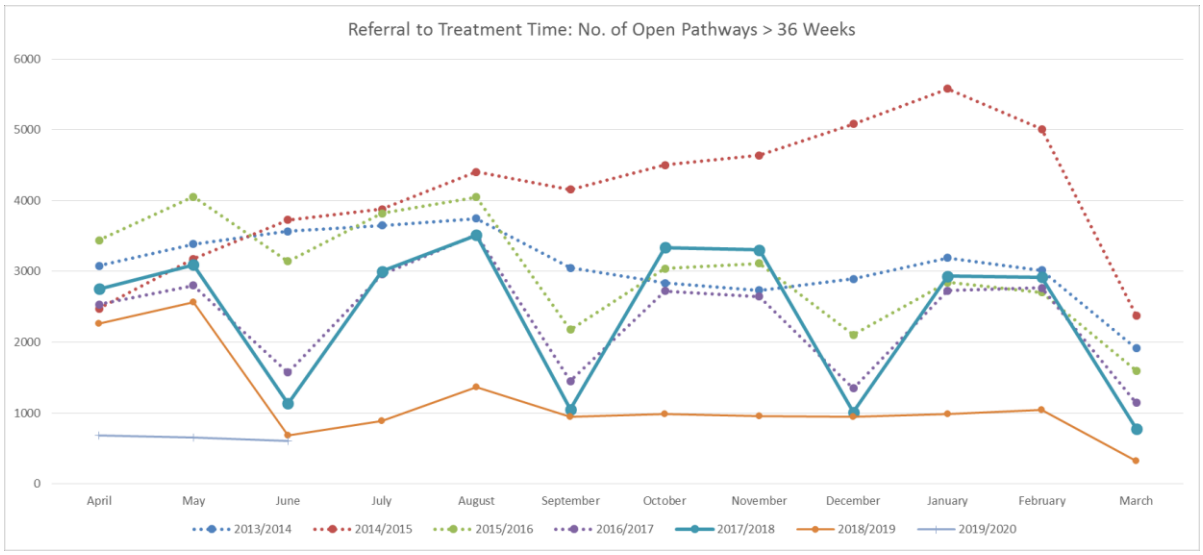
7) ELECTIVE ACCESS

How are we doing?

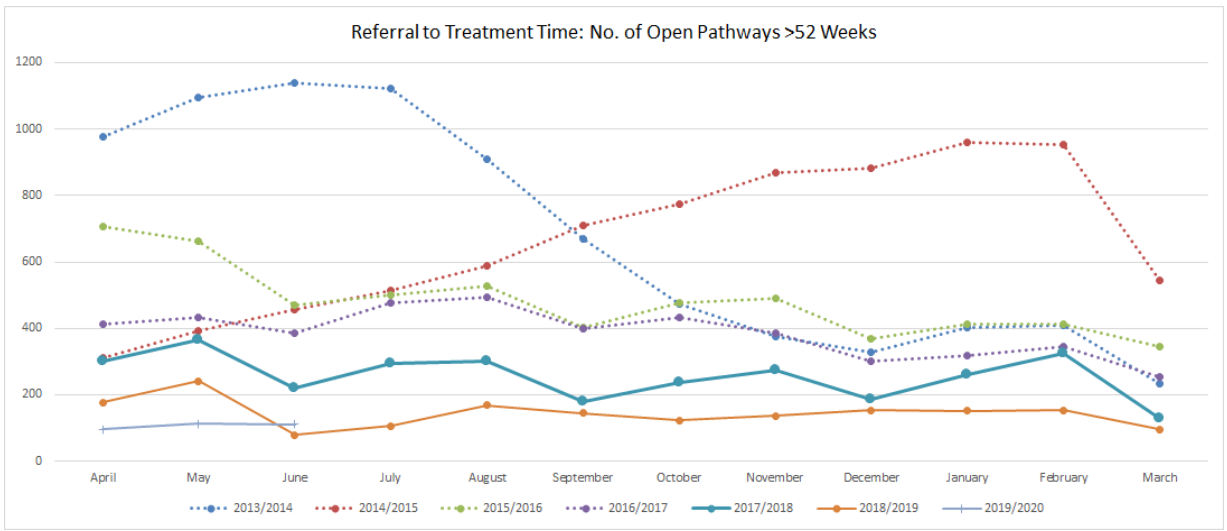
The Welsh Government has set a target that 95% of most patients referred for consultant-led elective care should be treated within 26 weeks from date of receipt of referral, with the remaining 5% seen within 36 weeks. At the end of May 2019, there were 11,600 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway, equating to 87% of patients waiting under 26 weeks.



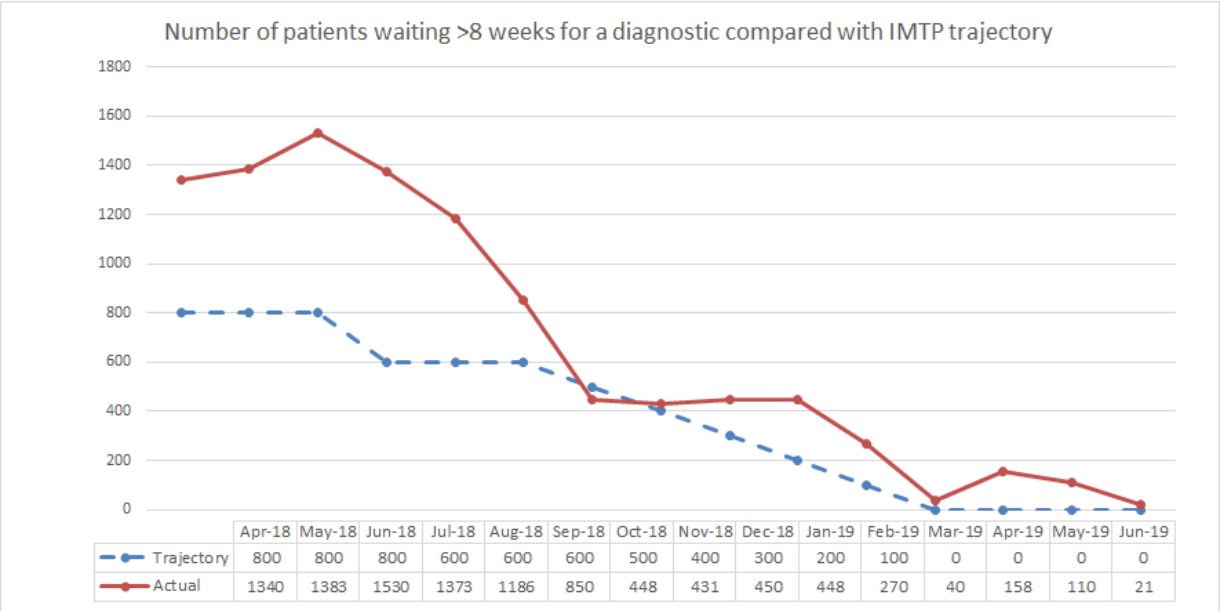
The number of patients waiting in excess of 36 weeks for elective care was 604 for June 2019, an increase of 277 patients from the end of March 2019 position of 327.



At the end of June 2019 the UHB had 111 patients still who had been waiting greater than 52 weeks. This is a 15% increase on the position at the end of 2018/19, the Welsh Government's expectation is that no patient will wait in excess of 52 weeks.



The Health Board had a reduction in the number of patients waiting greater than 8 weeks for a diagnostic test from 40 in March 2019 to 21 in June 2019, against a revised target of 0. This position represented a 98% reduction on June last year (1530).



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Trajectory	800	800	800	600	600	600	500	400	300	200	100	0	0	0	0
Actual	1340	1383	1530	1373	1186	850	448	431	450	448	270	40	158	110	21

How do we compare with our peers?

The All-Wales waiting time position at the end of April is shown below. The table suggests that the UHB's performance is in the middle of that of our peers.

Indicator	Target	Month	Wales	SB	AB	BC	C&V	CTaf	Hdda	Powys	C&V Rank
% of patients waiting less than 26 weeks (RTT)	95%	Apr-19	88.0%	88.8%	91.2%	93.2%	87.2%	89.1%	89.4%	100.0%	7/7
Number of patients waiting > 36 weeks (RTT)	0	Apr-19	11043	1973	271	6768	690	1128	213	0	4/7
Number of patients waiting > 14 weeks for therapies	0	Apr-19	45	0	1	0	1	0	41	2	4/7
Number of patients > 8 weeks for diagnostic	0	Apr-19	3271	401	31	2548	158	61	56	16	5/7

What are the main areas of risk?

There are two types of risk – the first relates to the impact on patients whose treatment is delayed and the second relates to specific issues presenting a risk to delivery of the agreed RTT trajectory as agreed with Welsh Government.

Specifically in regard to the latter, the Health Board (as are many other UK wide NHS organisations) is being impacted by staff not willing to undertake additional sessions due to NHS pension taxation charges related to exceeding the 'annual allowance' for pension growth.

What actions are we taking?

Implementation of speciality specific delivery plans remains the key action in delivery of RTT and diagnostics. An assessment is underway of the impact of the pension taxation issue.

There are two key programmes of work under the umbrella of UHB's Transformation Programme related to sustainable planned care services - productivity and efficiency and model outpatients.

8) Eye Care Measures

Poor eye health is a common and growing issue. Currently nearly 100,000 people in Wales are living with sight loss. By 2020, this is predicted to increase by 22 per cent and double by 2050. Over 50% of sight loss can be prevented through early identification and intervention. Concerns were raised by clinicians and the third sector, in 2017, with the Cabinet Secretary about patients who are placed on waiting lists, especially those listed as follow-up, which are not subject to any national performance measure or outcome measures.

Therefore, the Cabinet Secretary commissioned the establishment of an outcome focussed measures task and finish group chaired by Dr. Graham Shortland (previous Medical Director, Cardiff and Vale University Health Board). The outcome of the group is to introduce a measure devised to account for both new and existing patients, based on clinical need and risk of harm. It is compliant with relevant guidance, including NICE, Royal College of Ophthalmologists guidance, College of Optometrists guidance and the standards defined by ICHOM.

There are three categories of risk called Health Risk Factors which are:

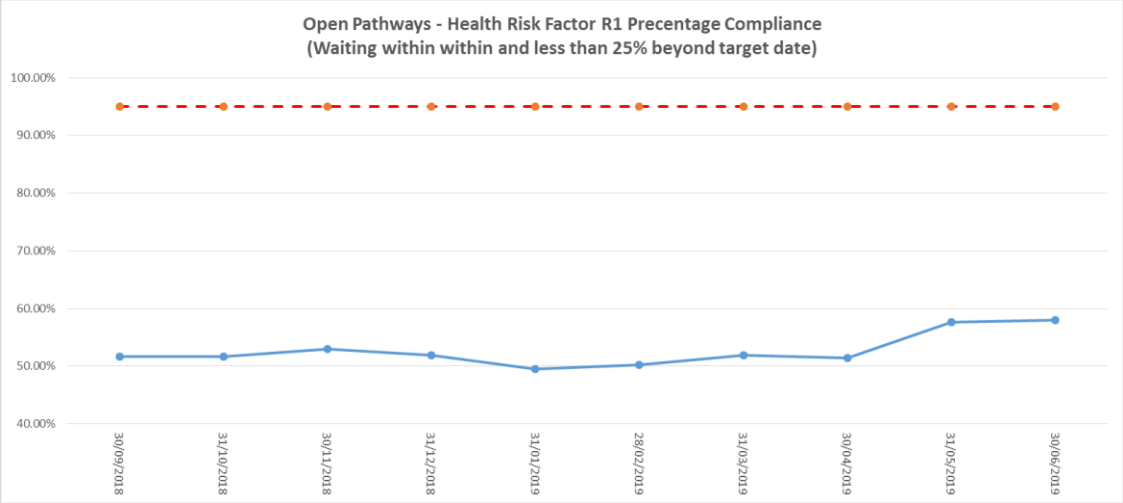
R1: Risk of irreversible harm or significant patient adverse outcome if patient target date is missed
R2: Risk of reversible harm or adverse outcome if patient target date is missed
R3: No risk of significant harm

The new performance measure is based on R1 Health Risk Factor:

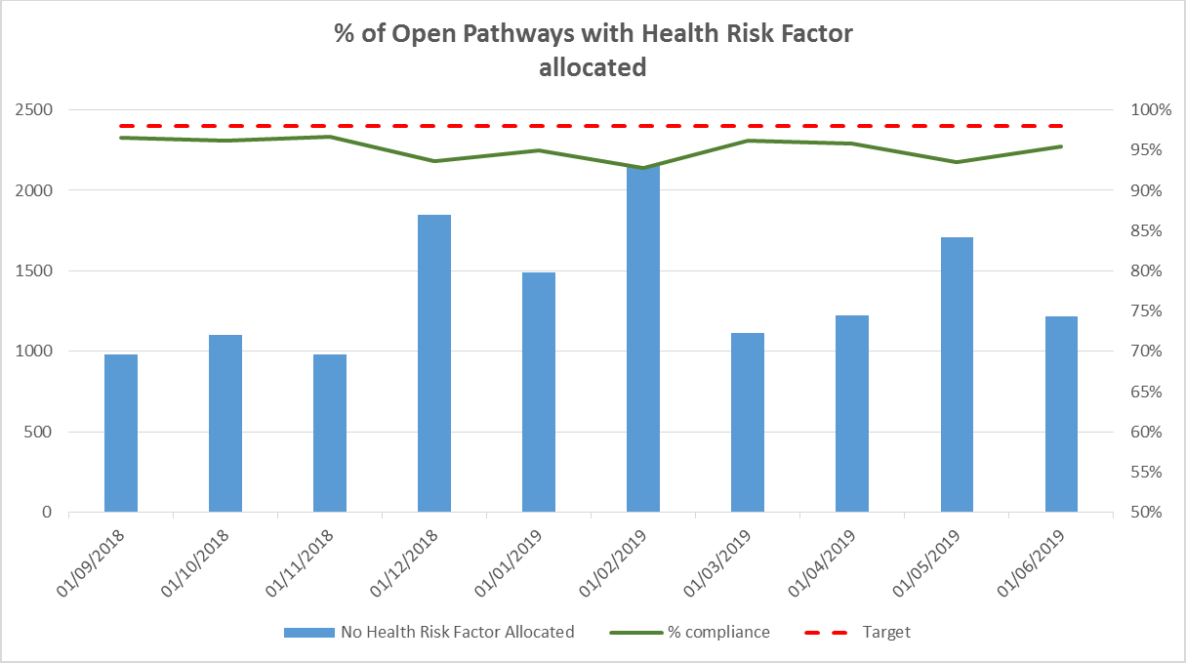
- 95% of priority 1 patients are to be seen by their target date or within 25% in excess of their target date for care/treatment

How are we doing?

At the end of June 2019 the UHB performance against the measure was 58%, a 7% improvement on the 51% observed in April 2019 when the measure moved from shadow reporting to official publication.



In addition to the main measure all health boards to have allocated a clinical risk factor to 98% of patients on the eye care outpatient waiting list by December 2019. The Health Board is well placed to do so with current compliance at 93.57%.



The graph above demonstrates the percentage health risk factor allocated and the number of pathways where a Health Risk Factor has yet to be allocated which currently stands at 1214. On average the UHB receives 250 referrals per week which add to the non-vetted / prioritised backlog and currently there is no mechanism to allocate a HRF for patients who attend the Eye Emergency Clinic who require a follow-up appointment.

What are the main areas of risk?

- The main reasons for not meeting the measure relate to a demand and capacity gap.
- There are data quality issues affecting reported compliance of the R1 measure.
- Delay in rolling out of the COMII into all clinical areas within Ophthalmology.

- The backlog of non-vetted and prioritised pathways

What actions are we taking?

- Increase of capacity in line with the funding provided by Welsh Government for the Eye Care measures. The Health Board is currently in the process of evaluating tenders and awarding a contact. It is anticipated that this will go-live in August-September 2019.
- Agreed process by which the backlog of patients within the follow cycle is continuously reviewed and reduced, with full support from the Clinical Director.
- New vetting slip will be implemented with effect from week commencing 8th July which will ensure HRFs are allocated in an improved timely manner.
- Roll out of COMII into call clinical areas by end of September 2019.
- Review of the data quality issues identified, document them and take the necessary action to prevent them happening in the future. Focus on the longest waiting R1 pathways and take the necessary actions.
- Review the target date allocation focusing on the booking processes and management of the target date.

9) OUTPATIENT FOLLOW UPS

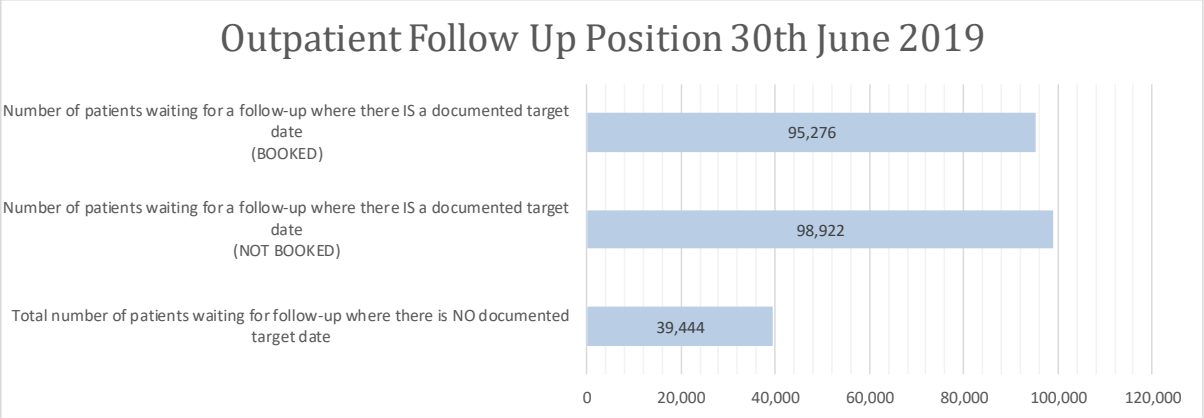
How are we doing?

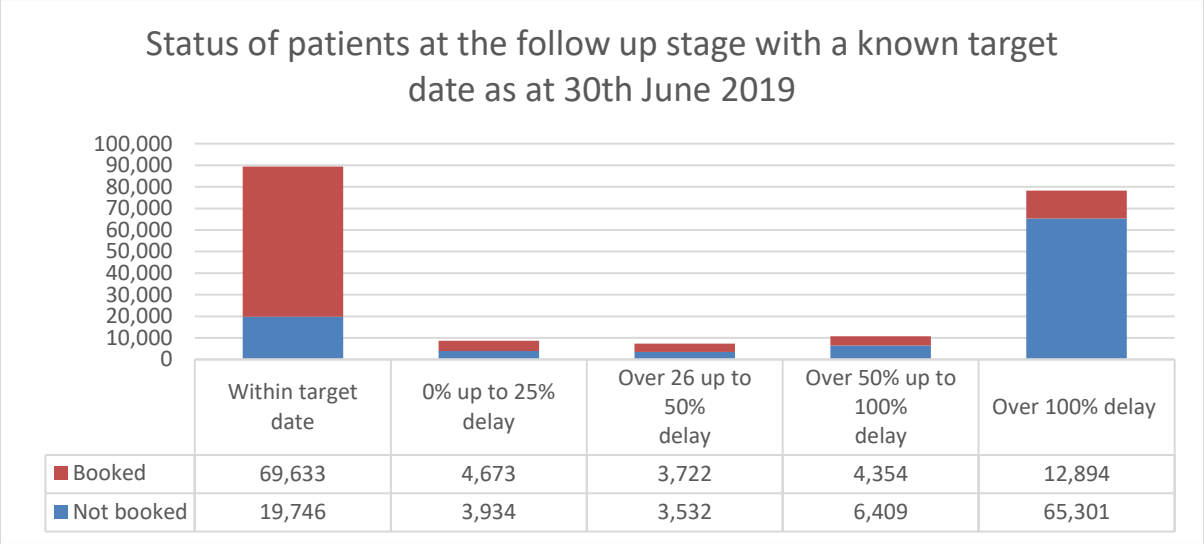
Welsh Government announced in June 2019 a number of targets for follow-up outpatients for 2019/20, described below.The baseline for improvement is March 2019.

1) Health boards to have allocated a clinical review date to 98% of patients on a follow up waiting list by December 2019. As at March 2019, there were 39,469 patients recorded on the system without a target date.
2) Health Boards to achieve a 15% reduction in the number of patients waiting for a follow-up outpatient appointment by March 2020. At the end of March there were 236,106 open pathways, making the target 200,690.
3) Health Boards to achieve a 15% reduction in the number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% by March 2020. At the end of March there were 78,516 pathways reported as being delayed by >100%, making the target 66,739.

As at the 30th June 2019, there were:

- 39,444 had no target date identified – similar levels to March 2019
- 233,642 open pathways where the patient may be requiring a follow up appointment, a 1% reduction on March 2019
- 78,195 patients recorded as delayed over 100% - similar volumes to March 2019





	Within target date	0% up to 25% delay	Over 26 up to 50% delay	Over 50% up to 100% delay	Over 100% delay
Booked	69,633	4,673	3,722	4,354	12,894
Not booked	19,746	3,934	3,532	6,409	65,301

How do we compare with peers?

Data reported on a national basis only relates to a limited number of specialties being monitored as part of the Planned Care programme. These are not representative of total volumes but are shown below as it is the only comparator available.

	Target	AB	BC	C&V	CTM	HD	SB	C&V Rank	Month
No. of follow up appointments waiting beyond target date	tbd	10503	49465	42455	No data	18199	no data	3/6	Apr-19

From the work undertaken by the Wales Audit Office, Cardiff and Vale is an outlier in terms of its overall volumes.

What actions are we taking?

The UHB still has a number of data quality issues to address and is using a number of analytical approaches alongside improved functionality within digital applications in an effort to overcome these.

Whilst our annual activity demonstrates there is significant capacity for follow-up care within our current system, growing demand and poor patient experience means that we need to move away from the traditional hospital-based outpatient model of care. Locally, transformation is being driven through the Health Board's transformation Programme and nationally through a number of priorities from the National Planned Care Programme Board. Our work is focused on improving patient access, experience and outcomes through transforming the way outpatient consultations are delivered, establishing a pathways approach, rethinking the location (closer to home) and enhancing the role of patients. This work is underpinned by creating a digitally enabled organising and workforce and changing and modernising professional roles.

Examples include:
- using mobile devices and Patient Reported Outcome forms to provide 'virtual' support and more evidenced based decisions for requiring physical consultations.
- greater use of see on symptom type approaches, empowering patients to instigate the requirement for an appointment
- extending the scope and use of primary and community care professionals to take on the ongoing review of patients who may previously have been asked to return to a hospital appointment such as optometrists.
- Rollout of Healthpathways, an internet based repository of clinical pathways and guidance developed collaboratively by primary and secondary care. There are 45 pathways live with more in development.

10) FINANCE

How are we doing?

The UHB's 2019/20 operational plan includes a balanced financial plan.

This is dependent upon managing the following key challenges:

- identifying and delivering a £29.145m savings target;
- the management of operational cost pressures and financial risks within delegated budgets.

The UHB has a full savings programme in place and the delivery of this is key to the success of the plan. The UHB is reporting an overspend of £1.808m against this plan for the 3 months to the end of June 2019.

Background

The Health Board agreed and submitted its 2019/20 – 2021/22 IMTP to Welsh Government by the end of January 2019 for its consideration. Approval of this plan was received by Welsh Government in March 2019. The financial plan aims to deliver a break even position for each year during the period of this plan.

Reported month 3 position

At month 3, the UHB is reporting an overspend of £1.808m against the plan.

The UHB plans to recover this year to date deficit and deliver a break even position by the year end. This will take concerted effort and will require the delivery of remedial actions that are being worked through. The position is expected to show sustained improvements in the second half of the year towards a break even position.

Income and Expenditure Analysis

Summary Financial Position for the period ended 30th June 2019

Income/Pay/Non Pay	In Month			Cumulative Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Income	(120.568)	(120.542)	0.026	(355.228)	(355.222)	0.006
Pay	52.948	52.785	(0.163)	160.652	160.138	(0.514)
Non Pay	67.620	67.849	0.230	194.576	196.892	2.316
Variance to Plan £m	0.000	0.093	0.093	0.000	1.808	1.808

Progress against savings targets

The UHBs £31.245m savings target has been reduced by £2.1m to £29.145m to reflect the release of the UHBs remaining investment reserve. At month 3 the UHB had fully identified schemes to deliver against the £29.145m savings target.

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total £m	29.145	29.145	0.000

Underlying deficit position

The underlying deficit position brought forward into 2018/19 was £36.3m. Successful delivery of the 2019/20 plan will reduce this to £4m by the year end.

Creditor payment compliance

Non-NHS Creditor payment compliance was 96.2% for the 3 months to the end of June, achieving the 95% 30 day target.

Remain within Capital expenditure resource limit

The UHB had an approved annual capital resource limit of £40.030m at the end of June. Capital expenditure for the first 3 months of the year was £5.075m against a plan of £6.196m.

Cash

The UHB has a forecast year end cash surplus of £0.677m. The UHB cash balance at the end of June was £3.724m.

What are our key areas of risk?

The key challenge for the UHB is now managing operational service pressures within current budgets.

What actions are we taking to improve?

Managing operational pressures – Clinical Boards have been tasked with the delivery of balanced budget plans including the identification of recovery measures. In addition the UHB will need to carefully manage its corporate risks and opportunities. This work is ongoing and will continue until the UHB has assurances on the delivery of the financial plan.

RECOMMENDATION:

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

BOARD ASSURANCE FRAMEWORK 2019/20 – JULY 2019

It is essential that Cardiff and Vale University Health Board is aware of the major risks which could impact upon the delivery of Strategic Objectives as set out in Shaping Our Future Wellbeing.

Strategic Objectives

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

Principle Risks

Risk	Gross Risk	Net Risk	Target Risk	Context	Executive Lead	Committee
1. Workforce	**25**	**15**	**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Financial Sustainability	**25**	**20**	**5**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.	Executive Director of Finance	Finance Committee

3. Sustainable Primary and Community Care	**20**	**15**	**10**	The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.	Chief Operating Officer	Strategy and Delivery Committee
4. Safety and Regulatory Compliance	**16**	**12**	**4**	Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.	Executive Nurse Director	Quality, Safety and Experience
5. Sustainable Culture Change	**16**	**8**	**4**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of Workforce and OD	Strategy and Delivery Committee
6. Capital Assets (Estates, IT Infrastructure, Medical Devices)	**25**	**20**	**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Deputy Chief Executive, Executive Director of Therapies and Health Science	Strategy and Delivery Committee, IG & T Committee, Quality, Safety and Experience Committee

1. Workforce

Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff.

Risk **Date added:** 12.11.2018	There is a risk that the organisation will not be able to recruit and retain a clinical workforce to deliver high quality care for the population of Cardiff and the Vale		
Cause	Increased vacancies in substantive clinical workforce Requirements of the Nurse Staffing Act and BAPM Standards Ageing workforce Insufficient supply of Nurses at UK national level High nurse turnover in Medicine and Surgery Clinical Boards Insufficient supply of Doctors in certain specialties at UK national level (e.g., Adult Psychiatry, Anaesthetics, General Medicine, Histopathology, Neurosurgery) Changes to Junior Doctor Training Rotations (Deanery) Brexit		
Impact	Increase in agency and locum usage Increase in costs of using agency and locum Impact on quality of care provided to the population Rates above Welsh Government Cap (Medical staff) Low Staff moral and sickness Poor attendance at statutory and mandatory Training Potentially inadequate levels of staffing		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Project 95% Nurse Recruitment and Retention Programme Medical international recruitment strategies (including MTI) Recruitment campaign through social media with strong branding Job of the week Staff engagement with recruitment drive Programme of talent management and succession planning Values based recruitment Medical Training Initiative (MTI) 2 year placement scheme Comprehensive Retention Plan introduced from October 2018 Nurse Adaptation Programme commenced October 2018 Plan in place for recruitment of overseas nurses Social Media Campaign and Open Days		
Current Assurances	Workforce metrics reported to Strategy and Delivery Committee High conversion rates from media campaign and Open Day Highest percentage of students in Wales applied to Cardiff and Vale UHB (23.2%) Nurse monitoring at Nurse Productivity Group (NPG) Medical monitoring at Medical Workforce Advisory Group (MWAG) Trajectory showing next vacancies in nursing Paediatric Surgery now fully established A & E fully established by February 2019 Extra capacity put in place to deal with winter pressure – winter ward Student streamlining produced the biggest intake in Wales due to the way C&V recruit students and engagement.		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls			
Gap in Assurances			

Actions	Lead	By when	Update since 30.05.2019
1. Nurse adaptation programme started in October 2018 which is a 6mth education programme with four cohorts (two a year) which run consecutively.	RW	Commenced October 2018	**Action commenced** with the first two cohorts for 2018
2. Continuation of social media campaign Campaign commenced Open day	MD/JB	 22/04/2019 22/06/2019	 **Complete** **Complete -** with another Open Day planned for September 2019
3. Nurse retention plan in place including internal nurse transfer scheme	RW	31/05/2019	**Action commenced**
4. New social media campaign being developed for working on the bank	MD/JB	31/07/2019	**New action**
5. Nurse recovery plan for Medicine and Surgery as part of financial recovery plan and business case for international recruitment	SC	30/06/2019	**New action –** recovery plan in place and signed off by the Executive Director of Finance as part of financial recovery plan and part of nurse recruitment.
6. To consider how resources are used going forward in nursing	SC	31/03/2020	**New action**
Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (High)**

2. Financial Sustainability

Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent Healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future.

Risk **Date added:** 20.05.2019	There is a risk that the organisation will not be able to deliver its ambition within the approved plan with Welsh Government		
Cause	Budgets overspent at month 2 within Medicine and Surgery and insufficient progress being made with Corporate Savings (shortfall of £2.3m) (one Clinical Boards currently in escalation) Cost Improvement Programme not yet identified in all areas Significant nursing overspend Reduction in income received		
Impact	Unable to deliver approved plan with Welsh Government Reputational Loss		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Full savings programme and financial improvement plan in place Finance Committee meets monthly and formally reports into the Board Performance Meetings held monthly with Clinical Boards Financial performance is a standing agenda item monthly on Management Executives Meeting Standing Financial Instructions in place with clear delegations of authority		
Current Assurances	Performance Meeting outcomes reported monthly to Management Executives Clinical Boards placed in escalation where not meeting budget or agreed financial forecast Finance report presented to every Finance Committee Meeting demonstrating progress and reporting variances		
Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	Not all Clinical Boards or Corporate have a CIP in place recurrently		

Actions	Lead	By when	Update since 30.05.2019
1. Clinical Boards in escalation to recover the position and CIP	RC	30/06/2019	Clinical Boards have produced recovery plans which have been Performance Reviewed and reported to Finance Committtee
2. Investments on hold, pending identification of future savings schemes, to meet corporate affordability gap	RC	30/06/2019	Action still stands

Impact Score: 5	Likelihood Score: 1	Target Risk Score:	**5 (moderate)**

3. Sustainable Primary and Community Care

The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.

Risk **Date added:** 12.11.2018	The risk of losing resilience in the existing service and not building the capacity or the capability of service provision in the Primary or Community care setting to provide the necessary preventative and responsive services.		
Cause	Not enough GP capacity to respond to and provide support to complex patients with multiple co-morbidities and typically in the over 75 years age bracket. GP's being drawn into seeing patients that could otherwise be seen by other members of the Multi-disciplinary Team. Co-ordination of Health and Social Care across the communities so that a joined up response is provided and that the patient gets the right care. Poor consistency in referral pathways, and in care in the community leading to significant variation in practice. Practice closures and satellite practice closures reducing access for patients. Lack of development of a multidisciplinary response to Primary Care need. Significant increase in housing provision		
Impact	Long waiting times for patients to access a GP Referrals to hospital because there are no other options Patients turning up in ED because they cannot get the care they need in Primary or Community care. Poor morale of Primary and Community staff leading to poor uptake of innovative solutions Stand offs between Clinical Board and Primary care about what can be safely done in the community Impact reinforces cause by effecting ability to recruit		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (red)**
Current Controls	Me, My Home , My Community Signals from Noise to create a joined up system across Primary, Community, Secondary and Social Care. Development of Primary Care Support Team Contractual negotiations allowing GP Practices to close to new patients Care Pathways		
Current Assurances	Improved access and response to GP out of hours service Sustainability and assurance summary developed to RAG rate practices and inform action Three workshops held to develop way forward with engagement of wider GP body in developing future models		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (red)**
Gap in Controls	Actively scale up multidisciplinary teams to ensure capacity Achieving scale in developing joint Primary/Secondary Care patient pathways Recruitment strategies to sustain and improve GP availability and develop multidisciplinary solutions		
Gap in Assurances	No gaps currently identified.		

Actions	Lead	By when	Update since 30.05.2019
1. Health Pathways – to create a protocol driven of what should and can be done in Primary care/Community care.	SC	31/03/2020	Health pathways launched on 14/02/2019. As at 07/05/2019 32 pathways were live. Pathways will continue to be developed until the end of the financial yera
2. Roll out of Mental Health and MSK MDT's to reduce the primary care burden on GP's	SC	31/01/2019 31/03/2020	Roll out commenced and plan continue to be monitored through GMS Sustainability Implementation Board Continue roll out until the end of the financial year
3. Roll out digital solutions for smart working (join up system – Vision 360 degree)	DT	31/03/2020	Vision 360 platform procured- phased roll out plan to be implemented with completion due by end of the financial year
4. Development of recruitment strategies for GP and non GP service solutions	MD	Ongoing	GP Support Unit helps with recruitment and finding GP alternatives action also lined to No 2 above.
5. Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs	SC	30/09/2019	**Not due**

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

4. Safety and Regulatory Compliance

Patient safety and compliance with regulatory standards should be above all else for the Cardiff and Vale University Health Board.
Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and feedback. Undertaking a high quality level of investigation to identify the root causes. Implementing solutions to minimise/mitigate the risk of them recurring.

Risk **Date added:** 12.11.2018	There is a risk that systems of safety and regulatory compliance are potentially not as robust as they could be and this has been demonstrated by the HTA Review, poor decontamination systems and the commissioning of services outside the Health Board which were not of a high quality.		
Cause	Non-compliance with regulatory or statutory requirements Non-compliance with effective decontamination processes to support the delivery of high quality patient care Appointment of contractor without required quality checks being in place to ensure service delivered was of a high standard		
Impact	Harm and distress caused to patients and their families Reputational damage to the Health Board Increase in clinical claims Financial consequences		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	Human Tissue Act HTA Licencing Standards Statutory Designated Individual in post Clinical Board QSE arrangements; CD&T – regulatory compliance group Quality, Safety and Experience Committee in place supported by robust governance and reporting structure Office of Professional Leadership shares responsibility for Quality Agenda (Medical Director, Executive Nurse Director, Executive Director of Therapies and Health Science) Quality and Safety Team Patient Experience Team Health and Care Standards Decontamination and reusable devices procedure in place Decontamination Group Weekly Executive led concerns/claims and serious incidents meeting Monitoring of ongoing investigations Quality control system that triangulates areas of concern		
Current Assurances	Annual Report to Quality, Safety and Effectiveness Committee on key quality and safety areas External accreditation processes Monitoring of incident trends, noise in the system or any concerns arising from inspections Heath and Care Standard Self-Assessment undertaken on key areas and reported into the Quality , Safety and Experience Committee Internal Audit reviews on quality and safety Health and Safety Committee		
Impact Score: 4	Likelihood Score:3	Net Risk Score:	**12 (High)**

Gap in Controls	Lack of central decontamination Unit Lack of robust QSE criteria/monitoring in procurement and commissioning processes Capacity of the Patient Safety and Patient Experience team to enable more proactive approach to quality improvement and data analysis Limited Assurance Internal Audit Report on Legislative/ Regulatory Compliance Lack of robust patient identification processes			
Gap in Assurances	Robust ongoing monitoring and assurance reporting on historical areas of concern Internal audit programme needs to be more closely aligned to areas of greatest risk			
Actions		**Lead**	**By when**	**Update since 30.05.2019**
1. Discuss and agree a way forward in relation to central decontamination unit		RW / FJ	~~30/06/2019~~ 31/12/2019	Investigation of endoscopy decontamination incident will highlight issues which need addressing. A central decontamination unit is likely to be a recommendation from the investigation. The Lead for Decontamination is currently developing a plan which was reported to the Infection, Prevention and Control Committee.
2. Review of procurement and commissioning processes to be undertaken to ensure that robust quality, safety and experience criteria and included		RW/ RC	~~30/06/2019~~ TBC	Process of investigation been undertaken on ophthalmology insourcing incident – Terms of Reference for investigation include procurement processes in relation to clinical services. The RCA is near completion and the Clinical Expert Reviews are awaited. Timeframe for completion to be confirmed.
3. Actions within Limited Assurance Internal Audit report on Legislative and Regulatory Compliance to be completed		NF	~~28/02/2019~~ ~~30/04/2019~~ 30/06/2019	**Complete** - Internal audit review taking place on 19th July 2019 and outcome will be reported to Management Executives and Audit Committee.
4. Review of IRMER breaches to be undertaken to identify trends and themes		RW	~~31.05.2019~~ 27/08/2019	New action added March 2019 No new IRMER breaches have occurred. IRMER breaches will form part of the Board Development session on Serious Incidents.
Impact Score: 4	Likelihood Score:1	Target Risk Score:		**4 (Moderate)**

5. Leading Sustainable Culture Change

In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which is building upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust. Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition. Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.		
Impact	Staff morale may decrease Increase in absenteeism Difficulty in retaining staff Potential decrease in staff engagement Transformation of services may not happen due to staff reluctance to drive the change through improvement work. Patient experience ultimately affected.		
Impact Score: 4	Likelihood Score: 4	Gross Risk Score:	**16 (Extreme)**
Current Controls	Values and behaviours Framework in place Task and Finish Group weekly meeting Cardiff and Vale Transformation story and narrative Leadership and Management Development Programme Programme of talent management and succession planning Values based recruitment Staff survey results and actions taken – led by an Executive (WOD) Patient experience score cards CEO sponsorship for the Values and behaviours (culture) enabler. Executive Director of WOD highly engaged with this enabler Raising concerns relaunched in October 2018 Financial resources in place but need to be careful how used		
Current Assurances	Transformation activity reported to monthly to Management Executives, HSMB and Strategy and Delivery and Board. Engagement of staff side through the Local partnership Forum (LPF) Matrix of measurement now in place which will be presented in the form of a highlight report		
Impact Score: 4	Likelihood Score: 2	Net Risk Score:	**8 (High)**
Gap in Controls			
Gap in Assurances			

Actions	Lead	By when	Update since 30.05.2019
1. An experiential leadership suite of programmes to be launched in 2019	MD / RG	~~31/05/2019~~ 31/03/2020	**Commenced** - Compassionate Leadership sessions facilitated by Professor West undertaken in November for senior leaders and other staff Programme continues.
2. A staff survey task and finish group established (led by Executive Director of WOD) with representation of staff and staff side to action a delivery plan in response to the survey.	MD	~~30/11/2018~~ 31/07/2019	**Complete and ongoing** – group established and action plan being finalised. Four main themes have been identified by the group and work will be complete by July 2019
3. Learning from Canterbury Model with a Model Experiential Leadership Programme	MD	~~June 2019~~ 31/10/2019	**Commenced** – planning and design of programme has started. Work on this programme and work with Canterbury continues.
4. Leadership Styles and Climate Programme Top 80 Leaders in the organisation	MD	30/06/2019	Individual feedback to staff taking place during April which will be followed by with workshops in June. There are 2 cohorts and this is the first cohort. Initial cohort of leaders complete workshop taking place in June for top 40 leaders- **Action complete**
5. Wellbeing Service for staff which triangulates: - Mental - Physical - Financial wellbeing	MD	30/06/2019	This is being increased for 2 years with a bid going to the Charitable Funds Committee in June 2019. **Action complete** bid approved at Charity Trustee on 27th June 2019
6. Toyota Visit by Executive Directors	SH	~~31/05/2019~~ 31/08/2019	Outputs from visit and way forward being discussed at Management Executives Follow up and action and outputs to be discussed at Management Executives date to be confirmed
7. Amplify 2025 and 8. Showcase	MD MD	16/07/2019 31/10/2019	New Action – session booked for 16th and 17th July for invited staff of 80+ Showcase timeframe to be confirmed but will involve 80 staff inviting 10 staff which will total 800 staff going through the programme.
Impact Score: 4	Likelihood Score: 1	Target Risk Score:	**4 (Moderate)**

6. Capital Assets (Estates, IT Infrastructure, Medical Devices)

The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.

Risk **Date added:** 12.11.2018	The condition and suitability of the estate, IT and Medical Equipment impacts on the delivery of safe, effective and prudent health care.		
Cause	Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B. Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. Lack of investment in IT also means that opportunities to provide services in new ways are not always possible and core infrastructure upgrading is behind schedule. Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement		
Impact	The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. Service provision is regularly interrupted by estates issues and failures. Patient safety and experience is sometimes adversely impacted. IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk Medical equipment replaced in a risk priority where possible, insufficient resource for new equipment or timely replacement		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. IT SOP sets out priorities for next 5 years, to be reviewed in early 2019 Medical equipment WAO audit action plan to ensure clinical boards manage medical equipment risks The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP, with regular oversight of the programme of discretionary and major capital programmes. Medical Equipment prioritisation is managed through the Medical Equipment Group Additional discretionary capital £1.7m for IT and £1.6m for equipment which enabled purchasing of equipment urgently needing replacement.		
Current Assurances	The estates and capital team has a number of business cases in development to secure the necessary capital to address the major short/medium term service estates issues. Work is starting on the business case to secure funding to enable a UHW replacement to be build.		

	The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised. The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks. Regular reporting on capital programme and risks to Capital Management, Management Executive and Strategy and Delivery Committee IT risk register regularly updated and shared with NWIS. Health Care Standard completed annually Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group, health care standard completed annually.

Impact Score: 5	Likelihood Score: 4	Net Risk Score:	**20 (Extreme)**

Gap in Controls	The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the 3 services. In year requirements further impact and require the annual capital programme to be funded by capital to be re-prioritised regularly. Traceability of Medical Equipment
Gap in Assurances	The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year

Actions	**Lead**	**By when**	**Update since 30.05.2019**
1. Progress implementation on the estates strategic plan	AH	30/11/2019	Forms part of IMTP. Annual report against Estates Plan to be presented to the Board in November 2019
2. Review of IT SOP to be undertaken	DT	~~31/03/2019~~ 31/08/2019	**Commenced –** new Director in post who will be taking this forward This will be reported to the newly established Digital Intelligence Committee
3. Strengthen Clinical Board engagement with Medical Equipment Group	FJ	31/03/2019	**Complete** - agreed that this group will in future report into HSMB on a regular basis
4. Traceability of Medical Equipment sits with Medical Equipment Group	FJ	31/08/2019	Clinical lead working with Welsh Government National Group to get advice on plan to be developed.

Impact Score: 5	Likelihood Score: 2	Target Risk Score:	**10 (high)**

Key:

1 -3	**Low Risk**
4-6	**Moderate Risk**
8-12	**High Risk**
15 – 25	**Extreme Risk**

Report Title:	Board Assurance Framework July 2019							
Meeting:	UHB Board					**Meeting Date:**	25.07.19	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**	✓	**For Information**	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Director of Corporate Governance							

SITUATION

The Board Assurance Framework (BAF) was first presented to the Board in November 2018 for approval. It highlighted the principle risks to the achievement of strategic objectives at Cardiff and Vale University Health Board.

The BAF provides a structure and process that enables the organisation to focus on those risks that might compromise the organistion achieving its most important objectives. It maps out the key controls to managing or mitigating those risks and confirms the assurances on the effectiveness of those controls.

The benefits of a working BAF are:

- A simple and comprehensive method for managing risks to achievement of objectives
- It provides evidence to support the Annual Governance Statement
- It helps to simplify Board reporting and prioritisation which allows more effective performance management
- It provides assurances about where risks are being managed effectively and objectives delivered
- It allows the Board to determine where to make efficient use of resources
- It allows the identification of priorities for Board to provide confidence that the organisation is able to understand capacity to deliver.

REPORT

BACKGROUND

The BAF was developed by the Director of Corporate Governance to replace the CRAF which had previously received negative feedback from Wales Audit Office (WAO) regarding its complexity and the regularity in which it was updated and presented to the Board.

ASSESSMENT

At the Board Meeting in November 2018 the six risks detailed below were agreed as the main risks to the achievement of Cardiff and Vale UHB's Objectives.

These risks were also confirmed to still be the main risk facing the organisation during 2019/20 at the Board Meeting in March 2019.

1. Workforce
2. Financial Sustainability

3. Sustainable Primary and Community Care
4. Safety and Regulatory Compliance
5. Sustainable Culture Change
6. Capital Assets (including Estates, IT and Medical Equipment)

The risk of a 'no deal Brexit' could also have an impact on the delivery of Cardiff and Vale UHB's Objectives and a detailed Business Continuity Plan remains to be in place for this issue.

The above risks have been reviewed and updated by the Director of Corporate Governance and the Executive Lead for each individual risk.

Changes have been highlighted in red so the Board Members can see what has happened since the BAF was last presented to the Board in May 2019.

In November 2018 there were also a number of further actions identified by the Director of Corporate Governance which needed to be progressed to ensure that the organisation continued to develop robust risk management arrangements. Progress against these actions can be seen below:

Action	Update
Report the new BAF process to the Audit Committee so the Committee can provide assurance to the Board	**Complete** - The new BAF was presented to the Audit Committee at the beginning of December 2018 and has been referenced in the WAO Structured Assessment 18/19.
Continue to develop and then update the BAF with Executive Directors to ensure it remains a dynamic and live document	**Complete** and continuing
Report individual risks on the BAF to the relevant Committees of the Board to allow the Committees to undertake a more detailed review and then provide assurance to the Board	**Complete** - This is now happening and Committees of the Board are reviewing risks which are relevant to their Committee to provide further assurance to the Board.
Assess the organisation's 'Risk Appetite'	**Complete** - A Board development day was held in April to assess the organisation's 'Risk Appetite'. This has now been included within the Risk Management and Board Assurance Framework Strategy presented to Board on 25th July 2019.
Develop Risk Management and Board Assurance Framework Strategy	**Complete** – presented to Board on 25th July 2019
Ensure that the work on the Corporate and Clinical Board Risk Registers is completed within a timely manner and then reported to the Board alongside the Board Assurance Framework	**Continuing** - There will be a phased approach to the development of the Corporate Risk Register which will include risks rated 20 and above from Corporate Directorates and Clinical Boards. This phased approach will be supported by a Risk Improvement Programme to ensure the way risk is approached across the UHB is consistent. This plan will be in line with the Risk Management and Board Assurance Framework Strategy presented to Board on 25th July 2019.

ASSURANCE is provided by:

- Discussion with Executive Directors on progress being made against the management and mitigation of risks which they lead upon on the BAF.

RECOMMENDATION

The Board is asked to:

- **APPROVE** the BAF and progress which has been made in relation to the actions, management and mitigation of the key risks to the achievement of objectives.

Shaping our Future Wellbeing Strategic Objectives			
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	✓

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	✓	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**Integrated Medium Term Plan 2020-23**							
Meeting:	**Board**					**Meeting Date:**	25/07/19	
Status:	**For Discussion**	**X**	**For Assurance**		**For Approval**		**For Information**	
Lead Executive:	**Executive Director of Planning**							
Report Author (Title):	**Corporate Strategic Planning Lead**							

SITUATION

The NHS Wales Finance Act requires the submission of a three year Integrated Medium Term Plan (IMTP) to Welsh Government. As the Board will be aware the Welsh Government approved the organisations plan for 2019-22. The plan is required to be refreshed, bringing forward a greater level of detail into the first year of the plan and considering actions for the next three year cycle.

This paper sets out the process for the refresh of the approved IMTP and provides a set of initial priorities for 2020-21.

REPORT

BACKGROUND

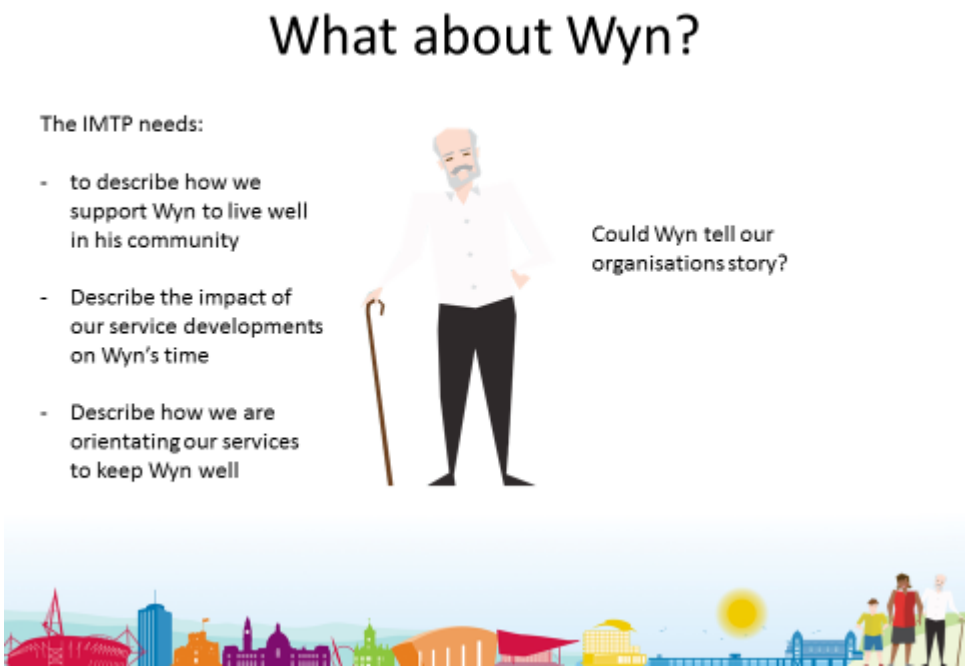
The process of developing an Integrated Medium term plan is not one that sits outside of our approach to change and delivery in the organisation, it is integral to the way we do things round here. The IMTP process has been maturing in the organisation and the way we presented and conveyed our 2019/22 plan to Welsh Government provides a strong foundation for delivery. The maturing of the transformation programme, alongside work on commissioning, operational delivery and clinical strategy all combine as part of our approach to medium term planning.

Planning is not about a document but about creating opportunities for new conversations, helping teams make connections and providing a coherent narrative for our organisation. It is about clarity of expectation on priorities for our staff and with our partners, providing a basis for accountability.

Shaping our Future Wellbeing remains the focus and our IMTP sets out the process by which we will deliver our strategy. Our organisational objective are out wellbeing objectives and, as discussed at the Board away day in June, the Wellbeing of Future Generations Act provide an underling driver for our organisation.

We have an approved plan for the next three years. Therefore the emphasis needs to shift to refreshing the approved plan for year two, as opposed to drafting a new plan from scratch. This will allow us to roll forward and refresh many of the priorities in the plan and should not mean lots of new initiatives emerging.

We also need to continue to set the plan in the context of the Area plan and partnership working with other Health Boards. There are a range of national priorities driven through a range of programmes and whilst we must acknowledge the role we plan in delivering these programmes we must have a relentless focus on deriving better value for our patients and communities.



We are required to submit a refreshed IMTP to Welsh Government in December, therefore we are working to the following high level timeline:

- July/ August- Development of refreshed plans, workshops with corporate teams
- August- Discuss draft plans with CHC OSPGs
- 20 September- Draft Clinical and Service Board plans completed
- October HSMB- First draft of Corporate IMTP
- November Board- Sign off draft IMTP for submission to Welsh Government

ASSESSMENT

In order to provide clarity to out teams it is important we are clear on our organisational priorities. We recognise that a large and complex system will need to be delivering multiple actions, but we also need to be clear about what are the core actions on which we will focus in order to deliver Shaping Our Future Wellbeing.

The Planning process needs to provide a space for our clinical teams to articulate what is important to them. Not to present wish list but to support informed conversation about how we allocate our resources as a system. In discussion with our clinical boards and management executive we have developed an initial set of proposed priorities to inform the planning process:

Organisational Priorities 2020-23

Home First

- Primary Care Model for Wales- GMS Sustainability (MSK and MH roll out, Out of Hours and Urgent Care Model development)
- Enhanced Social Care development
- Preventing Decline- promoting wellbeing and social prescribing, preventing deconditioning

Avoiding Waste, Harm and Variation

- Optimising Clinical Governance
- Efficiency Programme- Outpatients/ Length of Stay
- Maintaining Regulatory Compliance
- Diagnostic Sustainability- Endoscopy, MRI, CT, EUS
- Surgical Efficiency and Centralisation

Outcomes that matter to people

- Major Trauma Centre/ Hub Implementation
- Single Cancer Pathway
- Stroke Pathway
- Prehabilitation/ Rehabilitation
- Advanced Therapies and Genetics- Putting the systems in place, quality, governance, labs etc
- Regional Service Delivery- Vascular Centralisation, Paediatric Service, Spinal Service, SARC

Empower the Person

- Additional Learning Needs Services
- Transformation of CAMHs
- Transforming services for vulnerable groups- Prisoner Health and wellbeing, homeless services

- Our Priorities
- Welsh Gov/ NHS Wales Priorities

Priority areas have been mapped against our strategic priorities.

The Board is asked to note these priorities and discuss the proposed actions. A full set of priorities will then come back to the Board in October and then IMTP sign off in November.

ASSURANCE is provided by:

Assurance is provided through our clear process for the production of the IMTP. A detailed timeline is available and robust scrutiny through Clinical Boards, Management Executives, and HSMB ahead of Board submission is in place.

RECOMMENDATION

The Board is asked to:

- Note the process for the refresh of the IMTP
- Discuss the initial set of organisational priorities for 2020-21

Shaping our Future Wellbeing Strategic Objectives

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Major Trauma Centre**								
Meeting:	**UHB Board**						**Meeting Date:**	**July 2019**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Abigail Harris								
Report Author (Title):	**Victoria Le Grys, Programme Director** **Melissa Rossiter, Clinical Lead**								

SITUATION

The Board is asked to take note of the progress with the Major Trauma Centre Programme.

REPORT

BACKGROUND

The MTC Programme aims to deliver an effective Major Trauma Centre for both adult and paediatric patients for the south, mid and west Wales network in April 2020. The MTC Programme forms part of the Major Trauma Network Programme for south, mid and west Wales.

The MTC programme is split into four core workstreams:

1. Capital Infrastructure
2. Workforce
3. Capacity
4. Governance and Quality

The output of the above four workstreams will be captured in two key documents:

1. An MTC Business Case based upon the requirements of meeting National Quality indicators (some may be phased) and meeting the predicted activity uplift. A financial plan including both capital and revenue investment for launch and year 1 and 2 will be described.
2. An Operational Plan describing how the MTC will operate from day 1 covering the entire patient pathway including rehabilitation and repatriation. This document will also detail management and governance structures and arrangements.

MTC business case process

The case has been developed with involvement from all core specialties. Service Planning Templates have been completed by each of the specialties at CAV UHB along with face to face meetings with the MTC project team. This has supported the Directorates to review their current

service and supported planning against:

1. The expected increase in activity following Network ‘go live’
2. The relevant National MTC Quality Indicators.

Activity modelling

Current Major Trauma activity is modelled at 385 Major Trauma patients and 164 moderate trauma. The first year predicts an overall uplift of 294 candidate major trauma patients. This can be broken down into 193 Major Trauma patients with an additional 101 patients classified as moderate trauma in the first year after go live. This equates to a 50% uplift in Major Trauma patients.

National quality indicators

There are 52 adult MTC standards and 46 Children’s MTC standards in total. Whilst there are a number of these standards that are being met or partially met with current activity levels, there are 20 key indicators that are not currently met. CAV UHB meets all but 4 of the Trauma Unit standards.

Internal assurance and approval

In order to provide assurance to the Network Board, WHSSC and Welsh Government that the MTC components of the Network Programme Business case have been internally scrutinised the following have taken place:

1. Clinical Board sign off of specialty planning templates

Boards provided assurance that due diligence has been undertaken in completion of the template, and that the revenue implications of the pathways are understood and relate solely to the national MTC Quality Indicators for the totality of Major Trauma patients and/or uplift in major trauma activity.

2. CAV UHB Executive Assurance Panel

A panel was convened to ensure overarching assurance and scrutiny of Clinical Board elements of the business case.

3. MTC Business Case Approval

Final internal sign off of the business case at combined Major Trauma Project Board/ Business Case Approval Group meeting.

External feedback

Network Board

The Network Board is providing oversight of the development of the Programme Business Case, and the MTC business case will form part of the Programme Business case. At the moment the Programme Business Case in its entirety is deemed unaffordable and work is ongoing to refine the plans. It was suggested that the case includes unmet need for existing services in Cardiff and Vale Health Board. It was suggested that a further review of MTC business case took place at a WHSSC meeting.

Welsh Government policies meeting

Case presented alongside Network cases, advised case whilst large cost needs to go through the WHSSC process. Acknowledged huge amount of work that has been put into planning and development of the case.

WHSSC additional Business Case review meeting

Professional input into the review meeting was provided by Professor Chris Moran, National Clinical Director for Major Trauma, which was extremely helpful. The feedback was discussed with clinical boards and teams and informed the revisions to the business case which are currently ongoing. The rehabilitation section of the case has been sent to the Stoke rehabilitation lead for professional review and feedback.

Gateway review

A Gateway review of the Programme Business Case has been completed. There are a total 11 recommendations in the report from which an action plan will be developed by the Network. The key points to note from the review are as follows:

1. Development of Health Board cases to reflect a more phased approach to go live (particularly Trauma Units).
2. Undertake further scrutiny of all current Health Board and WAST cases and that the Network design a process for this. It is likely to involve a peer review process.
3. Ensure PBC sets out all capital requirements including all proposed MTC investment
4. Confirm HB commitments to funding programme and set out approval process for PBC including roles of WG, WHSSC, EASC and HBs as part of an assurance plan for programme
5. Programme should:
    - secure additional leadership for network team
    - develop a coordinated and collaborative approach to developing a skilled workforce
    - develop integrated implementation plan for network & review programme board structure
    - develop an Operational Delivery Network governance structure
6. Programme Board and team to assess whether current go live date and phasing is affordable and achievable

The gateway review has also recommended a gateway review of the MTC (no timeline set at present) given our role and scale of project.

ASSESSMENT

MTC Case

On the basis of the feedback from the above meetings, all elements of the case with the exception of the Emergency Unit and Rehabilitation, have been revised with Clinical Boards. These have been resubmitted to WHSSC for consideration at July meetings in order to achieve approval to begin recruitment processes in August.

There remain service pressures that will require further discussion with Medicine Clinical Board

and the Executive team regarding the risk management approach to the Emergency Unit. The Clinical Board is therefore currently reviewing the proposals for the Emergency Unit. Recognising that recruitment timelines for consultant posts are lengthy, and in order to maintain an April 'go live' date, it has been proposed that a nominal number of EU consultants (3.5 wte) are considered as a part of this case for 'in year' funding. There are identified individuals for these posts.

As similar approach will be taken for rehabilitation once feedback has been received.

It is recognised that WHSSC may need to set up an exceptional meeting in August if the 'in year' funding/approval to recruit is not signed off at the July meeting. It is also likely the MTC case will undergo further scrutiny in the form of a 'peer review' type panel.

Development of local Trauma Unit service
There is a requirement to consider the services to support Major patients who are local to the Health Board. Currently the standards not met as per Trauma Unit national standard focus on rehabilitation and geriatrician support. This needs to be developed as a part of CAV UHB IMTP process.

Current risks

- Affordability - failure to secure in year funding and approval to recruit will impact on the April 2020 go live.
- Deliverability – risk to delivery of recruitment to a large workforce. Risk also of limited workforce being funded and inability to effectively deliver the service and/or meet the uplift in activity. Failure to address gaps in existing services could impact on delivery of MTC service.
- Clinical engagement - risk of loss of engagement if funding not approved or process for approval of the case does not remain transparent.
- Cross organisational working – challenges in planning and delivering Major Trauma services between Swansea and Cardiff, in relation to complex orthoplastic, spinal and thoracic surgery.

Assurance is provided by:

The Wales Trauma Network Board for the Network programme. During the implementation phase, the Network is being managed by the NHS Wales Health Collaborative, through the Wales Critical Care and Trauma Network, and this will transfer to a health board once the network becomes operational.

The Major Trauma Centre Project Board for the delivery of the MTC Programme. The MTC Directorate sits within the Specialist Services clinical board.

RECOMMENDATION

The Board is asked to note the contents of the paper. Reports will be submitted as the work progresses.

Shaping our Future Wellbeing Strategic Objectives *This 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	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
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	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	N/A

Report Title:	**Risk Management and Board Assurance Framework Strategy 2019-22**								
Meeting:	Board						**Meeting Date:**	25.07.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

SITUATION

The purpose of the report is to enable the Board to review and approve the attached Risk Mangement and Board Assurance Framework.

REPORT

BACKGROUND

A key objective for the Director of Corporate Governance on coming into post was the development and implementation of an appropriate Board Assurance Framework and Risk Management arrangements.

This was a priority due to the Health Board being criticised by the WAO in it's Structured Assessment Report for 2017 and 2018 that arrangements were not adequate for the management of risk and hence internal controls.

Since appointment the Director of Corporate Governance has, in relation to Risk Management and the Board Assurance Framework:

1. Developed a Board Assurance Framework which was first reported to the Board in November 2018.
2. Reported individual risks from the BAF to the relevant Committee to review and assess the controls and assurances to in turn provide further assurance to the Board
3. Held a workshop on 25th April with Board Members to assess the Board's current 'risk appetite' and where it wished it's 'risk appetite' to be in the future.

ASSESSMENT

The Risk Management and Board Assurance Framework Strategy provides a framework and reporting structure to ensure that risks are identified, managed and/or mitigated at appropriate levels within the organisation and ensures that there is clarity on respective individual duties in relation to risk management. It also provides detail on the Trust's risk appetite to achieve its objectives which will be assessed by the Board on an annual basis.

A plan will be developed by the Director of Corporate Governance to ensure that a consistent approach is applied across the Clinical Boards and Corporate Directorates in the management

and mitigation of risks and the Strategy delivered.

RECOMMENDATION

The Board is asked to:

- Approve the attached Risk Management and Board Assurance Framework Strategy 2019-2022.

Shaping our Future Wellbeing Strategic Objectives *This 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	x	7. Be a great place to work and learn	x
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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Cardiff and Vale University Health Board
Risk Management and Board Assurance Framework Strategy

Document Reference No:	C&VUHB/CGP **	Version No:	1	Previous C&VUHB Ref No:	N/A

Document Type:	Corporate Strategy	Non-clinical
Issue Date:	August 2019	
Implementation Date:	August 2019	
Review Date:	* July 2022 (3 years post issue date)	

Documents to be read alongside this policy:	• Standing Orders • Scheme of Reservation and Delegation • Standing Financial Instructions. • UHB 024 - Risk Assessment and Risk Register • UHB 435 - SOP Managing Concerns • UHB 043 – Raising Concerns (Whistleblowing Policy)

Executive Summary:

This strategy sets out the UHB's approach to the Board Assurance Framework and Risk Management

For more information on the Board Assurance Framework or Risk Management please contact the
Director of Corporate Governance email: nicola.foreman@wales. nhs.uk. You may also send an email to the Governance Directorates Advice inbox Advice.Cav@wales.nhs.uk

Disclaimer

The latest version of this document is located on the UHB's intranet. Please check the review date and if there are any doubts contact the author.

Author / Reviewer:	Director Corporate Governance
Document Owner:	Director of Corporate Governance
Accountable Executive:	Director of Corporate Governance
Consultation method & time period:	Distributed via email. Dd/mm/yy to dd/mm/yy
Consultees: (Groups &/or Individuals)	Management Executive, Health Systems Management Board
Approved by:	**
Date Approved:	**
Scope:	UHB Wide

Engagement has taken place with:

Name	Title	Date Consulted
Management Executive		
Health Systems Management Board		

Version Control Table

Version No	Issue Date:	Summary of Amendments
1		
2		
3		

Important Note:
The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as 'uncontrolled' and, as such, may not necessarily contain the latest updates and amendments.

Risk Management and Board Assurance Framework Strategy

TABLE OF CONTENTS

1. Introduction and aims

Cardiff and Vale University Health Board is committed to developing and implementing a Risk Management and Board Assurance Framework Strategy that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives. The Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon Strategic Objectives. It will be considered alongside other key management tools, such as performance and quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

It aims to:

- set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation; and
- describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives.

The objectives of Cardiff and Vale University Health Board's Risk Management and Board Assurance Framework are to:

- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
- maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;
- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- ensure that risk management is an integral part of Cardiff and Vale University Health Board's culture;
- minimise avoidable financial loss, or the cost of risk transfer through a robust financial strategy;
- ensure that Cardiff and Vale University Health Board meets its obligations in respect of Health and Safety.

2. Scope

The Risk Management and Board Assurance Framework Strategy covers the management of strategic and operational risks and the process for the escalation of risks for inclusion on the Board Assurance Framework. Strategic risks are significant risks that have the potential to impact upon the delivery of Strategic Objectives and

are raised and monitored by the Executive Team and the Board. Operational risks are key risks that affect individual Clinical Boards and Corporate Directorates and are managed within the Clinical Boards and Corporate Directorates and if necessary, escalated through the risk reporting structure (See Appendix 2).

The Board Assurance Framework (BAF) is an integral part of the system of internal control and defines the extreme potential risks (15 & above) which impact upon the delivery of Strategic Objectives. It also summarises the controls and assurances that are in place or plans to mitigate them. The BAF aligns principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the development of an action plan for closing the gaps and mitigating the risks which is subsequently monitored by the Board for implementation.

Levels of assurance are applied to each of the controls and the assurance on controls as follows:

(1) Management Reviewed Assurance
(2) Board or Committee Reviewed Assurance
(3) External Reviewed Assurance

This provides an overall assurance level on each of the strategic risks.

This Strategy applies to those members of staff that are directly employed by Cardiff and Vale University Health Board and for whom Cardiff and Vale University Health Board has legal responsibility.

The Risk Management and Board Assurance Framework Strategy is intended to cover all the potential risks that the organisation could be exposed to.

3. Risk Management Organisational Structure

3.1 The Board

Executive Directors and Independent Members share responsibility for the success of Cardiff and Vale University Health Board, including the effective management of risk and compliance with relevant legislation. In relation to risk management, the Board is responsible for:

- articulating the Strategic Objectives for the organisation;
- protecting the reputation of Cardiff and Vale University Health Board;
- providing leadership on the management of risk;
- approving the risk appetite for Cardiff and Vale University Health Board;

- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- reviewing the Board Assurance Framework (strategic risks) and the corporate risk register risks (operational risks 15 and above) at each meeting
- endorsing risk related disclosure documents
- Approving the Risk Management and Board Assurance Framework Strategy on an annual basis**.**

3.2 Audit and Assurance Committee

The Audit and Assurance Committee has a specific role in relation to reviewing the effectiveness of the Risk Management and Board Assurance Framework Strategy.

In relation to risk management, the Audit and Assurance Committee is responsible for reviewing the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), prior to endorsement by the Board; and
- the underlying assurance processes that indicate the degree of achievement of strategic objectives, the effectiveness of the systems and processes for the management of risks, the Board Assurance Framework and the appropriateness of disclosure documents.

3.3 Other Committees of the Board

The Committees of the Board all have a role to play in ensuring effective risk management in particular they will:

- Receive and scrutinise assurances and provide onwards assurance to the Board in relation to their areas on the Board Assurance Framework.

3.4 Management Executive and Health Systems Management Board

The Management Executive and Health Systems Management Board undertake the following duties:

- Promote a culture within the Health Board which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Health Board
- Ensure appropriate actions are applied to both clinical and non-clinical risks Health Board wide.

- Enable risks which cannot be dealt locally to be escalated, discussed and prioritised.
- Ensure Clinical Board and Corporate Directorate Risk Registers are appropriately rated and agreeing action plans to control them.
- Review the risks on the Corporate Risk Register (risks 15-25 from Clinical Boards and Corporate Directorates) to determine whether any of them will impact on the Health Boards Strategic Objectives, and if so, the risk will be added to the Board Assurance Framework (BAF).
- Review the Board Assurance Framework prior to its presentation to the Board.
- Advise the Board of exceptional risks to the Trust and any financial implications of these risks.
- Review and monitor the implementation of the Risk Management and Board Assurance Framework Strategy
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Annual Governance Statement
- Approve documentation relevant to the implementation of the Risk Management and Board Assurance Framework Strategy

Provide assurance to the Board that there is an effective system of risk management across the organisation.

3.5 Clinical Boards and Corporate Directorates

The Clinical Boards and Corporate Directorates are responsible for risks within their areas of operation and providing assurance to the Management Executive and HSMB on the operational management and any support required in relation to the management of risk.

The Clinical Boards and Corporate Directorates will review and update existing risks, consider new risks for inclusion and escalate any extreme risks. These are presented to the HSMB by the Clinical Boards of Corporate Directorates.

Cardiff and Vale University Health Board's risk reporting structure is attached at Appendix 2.

4 Duties

The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

4.1 All staff

All members of staff are accountable for maintaining risk awareness, identifying and reporting risks as appropriate to their line manager.

In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for Cardiff and Vale University Health Board and attend/complete risk management training as appropriate.

They will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the health board's business;
- report all incidents/accidents and near misses;
- comply with the health board's incident and near miss reporting procedures;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed; and
- be aware of the health board's Risk Management and Board Assurance Framework and processes and the local strategy and procedures and comply with them.

4.2 Line Managers

The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework.

Managers at all levels of the organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/ward operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff are provided with the education and training to enable them to do so.

Managers must be fully conversant with the UHB's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

4.3 Clinical Board Directors

Clinical Board Directors are responsible for implementation of the Risk Management and Board Assurance Framework Strategy and relevant policies which support the health board's risk management approach.

Specifically they will:

- ensure a forum for discussing risk and risk management is maintained within their Clinical Board which will encourage integration of risk management;
- co-ordinate the risk management processes which includes: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- provide reports to the appropriate committee of the Board that will contribute to the UHB-wide monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting; and

4.4 The Director of Corporate Governance

The Director of Corporate Governance will:

- work closely with the Chair, Chief Executive, Chair of the Audit and Assurance Committee and Executive Directors to implement and maintain the Risk Management and Board Assurance Strategy and related processes, ensuring that effective governance systems are in place;
- work with the Board to develop a shared understanding of the risks to the UHB's strategic objectives;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- lead and participate in risk management oversight at the highest level, covering all risks across the organisation, on a UHB basis;
- work closely with the Chief Executive and Directors to support the development and maintenance of Corporate and Directorate level risk registers;
- develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein,
- monitoring the action plans and reporting to the Board and relevant Committees; and
- develop and implement the health board's Risk Management and Board Assurance Framework Strategy.

4.5 Executive Directors

Executive Directors are accountable and responsible for ensuring that their directorates are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the health board's strategic objectives.

Specifically they will:

- communicate to their directorate the Board's strategic objectives and ensure that directorate, service and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area which will encourage integration of risk management;
- co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

Executive Directors are also responsible for ensuring that the BAF and the risk management reporting timetable are delivered to the Board.

4.6 Chief Executive

The Chief Executive is the Accountable Officer of the UHB and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, financial and organisational controls and governance.

The Chief Executive has overall accountability and responsibility for:

- ensuring the health board maintains an up- to-date Risk Management and Board Assurance Framework
- endorsed by the Board;
- promoting a risk management culture throughout the health board;
- ensuring that there is a framework in place which provides assurance to the Board in relation to the management of risk and internal control;
- ensuring that risk issues are considered at each level of business planning from the corporate process to the setting of staff objectives;
- having in place an effective system of risk management and internal control;
- setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974.

The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

4.7 Internal Auditors

Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the health board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards and good practice contained within the NHS Internal Audit Manual. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Assurance Committee as appropriate.

4.8 Local Counter Fraud Services

The UHB's Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The UHB's Annual Counter Fraud Work Plan, as agreed by the Audit and Assurance Committee, identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS and then reported to the Audit and Assurance Committee as appropriate.

The LCFS works with the Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned and are then escalated through the UHB's escalation process.

5 Risk Management Process

Cardiff and Vale University Health Board is committed to developing a pro-active and systematic approach to risk management.

A separate document attached at Appendix 4 sets out in detail the approach to identifying, assessing and managing risks.

5.1 Risk Assessment

Each Clinical Board or Corporate Directorate needs to identify operational and strategic risks through the completion of risk assessments and for ensuring that risk assessments are completed on an ongoing basis.

5.2 Risk Register

The Risk Register is a record of all the risks identified through the Risk Management process, their controls, score and risk treatment/mitigation.

The risk register covers all risks and will inform the decision making of the risk committees and managers by providing them with a central reference of all risks.

5.3 Management of Local Risks

Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and six, can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each ward / department.

All local risks should be reviewed and updated monthly at a minimum. This may need to be more frequently if circumstances require.

If it is felt that the risk can no longer be managed locally and requires more senior input and support then it will be escalated up through the Clinical Board and beyond all the way to the Board if required.

5.4 Types of Risk

There are two categories of risk, **strategic** and **operational**. These include clinical and non-clinical risks.

Strategic risks are risks that could significantly interfere with the Health Board achieving its strategic objectives as outlined in its IMTP. These are most likely to affect the performance and delivery of strategic objectives. Operational risks are

risks that, if they occur, will affect the quality, safety or delivery of services or continuity of business. They are not mutually exclusive and a risk may escalate from an operational risk to a strategic risk or be both.

5.5 Board Assurance Framework (BAF)

The BAF details the highest risks faced by the Health Board in meeting its strategic objectives and provides the Health Board with a comprehensive method of describing the Health Board's objectives, identifying key risks to their achievement and the gaps in assurances on which the Board relies.

The BAF is developed through the following key steps:

a. The Board annually agree the Strategic objectives as part of the business planning cycle.

b. The Management Executive with the support of the Director of Corporate Governance will draft the principle risks that may threaten the achievement of the strategic objectives; these risks will then be discussed and approved by the Board of Directors.

c. For each principle risk the Executive Lead will:
   - Give an initial (inherent) risk score, by determining the consequence and likelihood of the risk being realised,
   - Link the risk to the strategic objectives

d. Risks from the previous year's BAF will be reviewed and a decision made whether to:
   - Transfer the risk on to the BAF for the current year
   - Move the risk to the corporate risk register and nominate a risk owner Management Group
   - Close the risk

e. The Executive Lead will then:
   - Identify the key controls in place to manage the risks and achieve delivery of the strategic objective
   - Identify the arrangements for obtaining assurance on the effectiveness of key controls across all the areas of principal risk
   - Evaluating the assurance across all areas of principal risk, i.e. identifying sources of assurance the Health Board is managing the risks to an acceptable level of tolerance
   - Identify how / where / when those assurances will be reported

- Identify areas where there are gaps in controls (where the Health Board is failing to implement controls or failing to make them effective)
- Identify areas where there are gaps in assurances (where the Health Board does not have the evidence to assure that the controls are effective)
- Develop an action plan to mitigate the risk
- Agree a current (residual) risk rating for the first quarter of the financial year which is determined by the consequence and likelihood of the risks

f. The BAF will be presented to the first meeting, in the financial year, of the HSMB. It will moderate the risk scores and ensure there are appropriate controls and assurances, gaps in control and assurances with associated action plans in place for each risk.

g. By monthly the Executive lead will with the support of the Director for Corporate Governance, for each of the risks for which they are responsible, review and monitor the controls and reported assurances and update the risk score and action plans.

h. The Executive will review and monitor all of the risks on the BAF each month prior to presentation to the Board. In particular the Management Executive will ensure that progress is being made to reduce or eliminate the impact of the risk.

i. Once agreed by Management Executive the completed BAF will be presented to the Board for scrutiny and approval on a monthly basis. At the first meeting, in the financial year, it will be reviewed in its entirety.

The Audit and Assurance Committee, as a sub-committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

5.6 Risk Quantification and Escalation

The approach to quantifying risk is described in Appendix 4. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target (after completion of actions) circumstances. A risk scoring matrix to describe the quantification of risk is also included in the Procedure.

The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and where it should be reported to. The Board defines as

"Extreme" any risk that has the potential to damage the organisation's objectives. General guidelines are:

Extreme Risk	Score 15 - 25	Report immediately to relevant Executive Director who will inform the Chief Executive. In the event this causes delay the Clinical Board Director can report directly to the Chief Executive.
High Risk	Score 8 - 12	Report to Clinical Board or for Corporate Directorates to the Executive Director
Moderate Risk	Score 4 – 6	Report to Heads of Service with proposed treatment/action plans, for particular monitoring.
Low Risk	Score 1 – 3	Report to local manager for local action to reduce risk

5.7 Risk Appetite

At its simplest, risk appetite can be defined as the amount of risk that an organisation is willing to take on in pursuit of value, or that it is prepared to accept in the pursuit of its strategic objectives.

Decisions on accepting risks may be influenced by the following:

- the likely consequences are insignificant
- a higher risk consequence is outweighed by the chance of a much larger benefit
- occurrence is rare
- the potential financial costs of minimising the risk outweighs the cost consequences of the risk itself
- reducing the risk may lead to further unacceptable risks in other ways

Therefore a risk with a high numerical value may be acceptable to the organisation, but that decision would be taken at an appropriate level.

The Board assessed its risk appetite using the Good Governance Institute Matrix for NHS Organisations at a Board Development Workshop on 25th April 2019 (see appendix 3 for results of workshop) and agreed that it currently had an overall 'risk

appetite' which is 'cautious'. However, overtime and with a clear plan of development in place it agreed that it wished to have an appetite which was 'seek'. The Board will review its risk appetite on an annual basis to ensure that progress is being made to the 'risk appetite' the LHB wishes to achieve. The matrix has six risk levels as follows:

Avoid	Avoidance of risk and uncertainty is a Key Organisational objective
Minimal	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

6 Accountability, responsibilities and training

Overall accountability for procedural documents across the Health Board lies with the Chief Executive who has overall responsibility for establishing and maintaining an effective document management system, for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

Overall responsibility for the Risk Management and Board Assurance Framework Strategy lies with the Director of Corporate Governance who has delegated responsibility for managing the development and implementation of the Risk Management and Board Assurance Framework Strategy.

7 Monitoring and review

7.1 Monitoring

This policy will be reviewed on an annual basis and as and when required in accordance with the following:

- legislative changes;

- good practice guidance;
- case law;
- significant incidents reported;
- new vulnerabilities; and
- changes to organisational infrastructure.

7.2 Equality impact assessment

Cardiff and Vale University Health Board aims to design and implement services and policies that are fair and equitable. As part of its development, this Strategy and its impact on staff, patients and the public have been reviewed in line with the Cardiff and Vale's Equality Impact Assessment. The purpose of the assessment is to improve service delivery by minimising and if possible removing any disproportionate adverse impact on employees, patients and the public on the grounds of race, socially excluded groups, gender, disability, age, sexual orientation or religion/belief.

The equality impact assessment has been completed and has identified impact or potential impact as "no impact".

Appendix 1

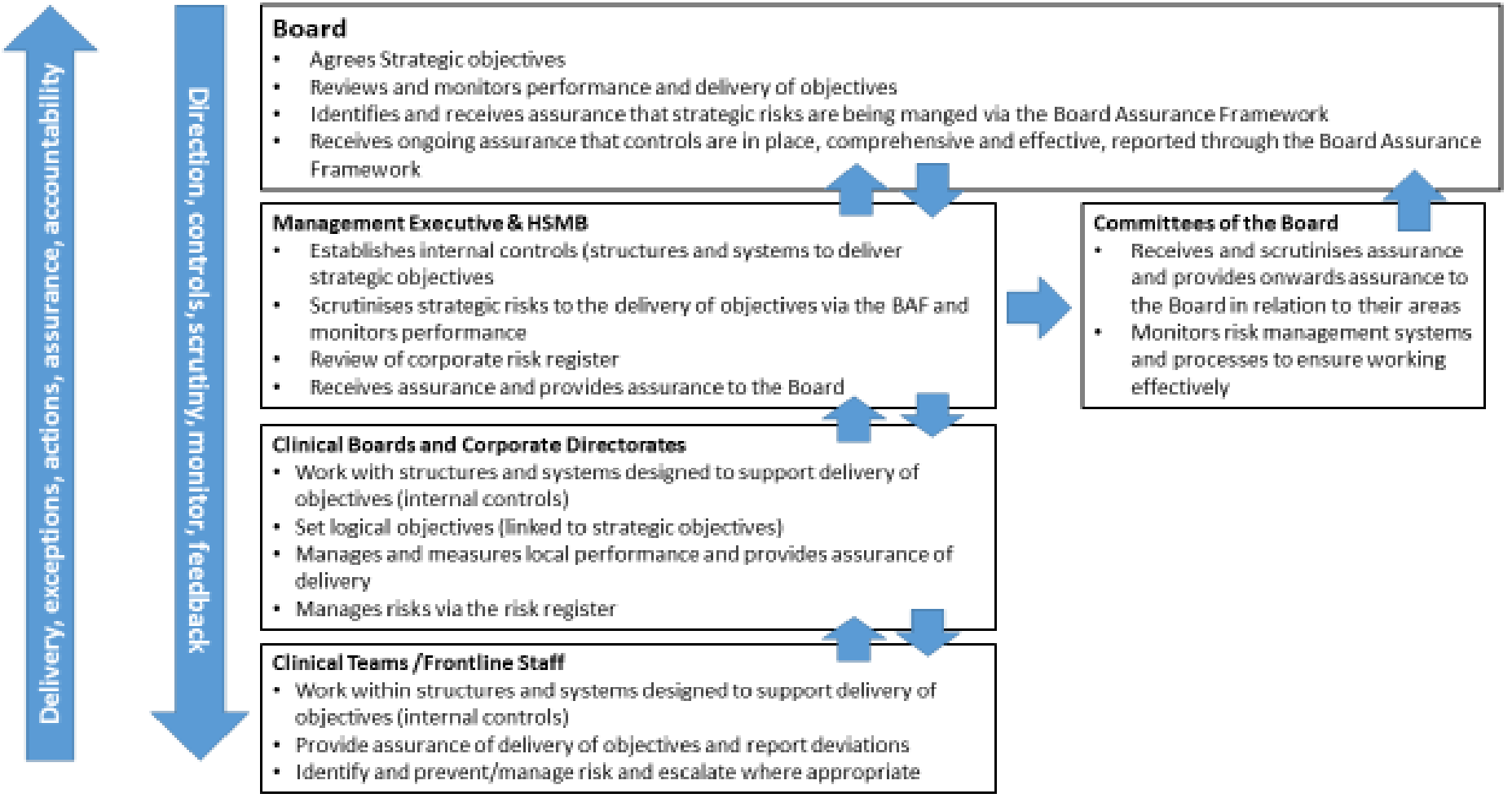
Definitions

Ref.	Column Heading	Information Required
1.	Date Opened	Date the risk was added to the Risk Register.
2.	Risk Description	A structured statement describing the risk usually containing the following elements: sources, events, causes and consequences / impact. A well-written risk statement contains three main parts; 1. **Explain risk-** Summarise the relevant background facts. These may include prior decisions, assumptions, dependencies and relevant objectives, i.e. introduce the area / topic. *Start by writing "There is a risk that……."* 2. **Source(s) of uncertainty / Cause / Event -** The conditions that currently exist that create the risk i.e. the factors that may cause the risk to occur and/or influence the extent of its effect. *Start by writing "Due to……."* 3. **Consequence / Impact -** The impact to the Programme / Organisation in the event of the risk occurring. Consequence could also result in opportunities that may surface in correcting the problems. *Start by writing "Resulting in …."*
3.	Risk Rating	This is calculated by multiplying consequence x likelihood (impact x probability).
4.	Impact / Consequence (see separate risk scoring matrix document)	This is the outcome of an event that has an effect on objectives. A single event can generate a range of consequences which can have both positive and negative effects on objectives. Initial consequences can also escalate through knock-on effects.
5.	Probability / Likelihood (see separate risk scoring matrix document)	This is the chance that something might happen. Likelihood can be defined, determined, or measured objectively or subjectively and can be expressed either qualitatively or quantitatively.

6.	Initial Risk Rating	The risk rating before any controls have been put in place.
7.	Current Risk Rating	The risk rating whilst risk responses are in the process of being implemented. Some controls are probably in place but others required are still being actioned & will be shown as gaps in control & actions until implemented.
8.	Target risk rating / Residual Risk	When action is taken to treat risks, it may eradicate the possibility of the risk occurring. However, actions are often more likely to reduce the probability of the risk occurring, leaving the residual risk. The remaining level of risk after all treatment plans have been implemented is the residual risk. Generally the target level is the level at which the organisation is saying it's happy to live with. All agreed controls are in place & assurance is being provided that controls are working as planned. At this point the risk should be closed unless further actions are deemed required.
9.	Controls	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.
10.	Gaps in Controls	A gap in control implies a measure or action that would help modify or control the risk is missing / yet to be implemented. Gaps result from failure to put in place sufficiently effective policies, procedures, practices or organisational structures to manage risks and achieve objectives
11.	Assurance	Confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved. Sources of assurance include; reviews, audits, inspections both internal & external.
12.	Gaps in assurance	Gaps in assurance imply that insufficient evidence is available that controls are in place & operating effectively & that the risk is being actively managed & controlled. Work is required to fill gaps & enable assurance to be obtained.

13.	Actions	Actions required to mitigate the risk. Actions should be SMART & have clear owners assigned. This will allow action progress to be tracked & monitored & issues with action completion to be visible & dealt with.
14.	Risk Owner	Senior person best placed to keep an eye on the risk with decision making authority. This person is accountable for the Risk & should be aware of its current status.
15.	Action Owner	Person responsible for implementing the risk response / actions, providing updates on action progress & flagging issues relating to action completion.
16.	Risk treatment / Risk response	This is a risk modification process. It involves selecting & implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls. Treatment options include; • Avoidance / Remove the source of the risk • Reduction • Transference • Retain / Accept the risk • Also known as the four T's – Treat, Transfer, Tolerate & Terminate
17.	Assurance rating	This is the rating which has been given regarding the level of assurance: • (1) = Management Reviewed Assurance • (2)= Board Reviewed Assurance • (3)= External Reviewed Assurance

Risk Management Reporting Structure



Risk Appetite for NHS Organisations

A matrix to support better risk sensitivity in decision taking

Appendix 3

Risk levels Key elements	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focused on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mold' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mold' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Appendix 4

Approach to assessing Risk

Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key

			attendance for mandatory/key training	morale No staff attending mandatory/ key training	training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence × likelihood (C × L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk

Instructions for use

Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

Determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

Determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score the risk multiplying the consequence by the likelihood:

C (consequence) × L (likelihood) = R (risk score)

Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Report Title:	**Welsh Language Policy**								
Meeting:	**Board Meeting**						**Meeting Date:**		
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	Executive Director for Workforce and Organisational Development								
Report Author (Title):	**Welsh Language Officer**								

SITUATION

Evidence on patient language choice has shown the positive outcomes for the patients when they can use their preferred language, including improved communication between patient and staff and a decrease in anxieties and concerns. The UHB supports our patients and services users who prefer to use Welsh when discussing their healthcare and also recognises the importance of enabling staff to speak Welsh and develop their Welsh Language skills.

A new Welsh Language Policy has been developed to encourage and enable the use of the Welsh Language by our patients when receiving our services. The Policy encourages staff to use and develop their own Welsh language skills.

The Policy complies with our Welsh Language Standards and endorses the Welsh Governments' Welsh Language in Healthcare Strategic Framework (the More than Just Words Strategy), both of which are regularly reported to the Strategy and Delivery Committee.

BACKGROUND

On May 31st, the Cardiff and Vale University Health Board came under the new Welsh Language (Wales) Measure (2011). The Welsh Language Scheme, in place since 2010, has now been replaced by the Welsh Language Standards. The organisation will be monitored for compliance by the Welsh Language Commissioner.

Under the previous Welsh Language Scheme system, the organisation focused on ensuring that patients and service users could use their preferred language of Welsh. In the new Standards system, staff will also enjoy specific, though limited freedoms, to use Welsh within the workplace.

As part of complying with the Welsh Language Standards, it is expected that the organisation will have a Policy to ensure that those who prefer to speak Welsh can access healthcare in their chosen language whenever possible, as well as promoting and facilitating the use of the language internally by staff.

ASSESSMENT

This Welsh Language Policy complies with the new Welsh Language Standards and supports the continuing work of the Welsh Government's More than Just Words Strategic Framework through the following requirements in the policy:

- that the organisation will, when possible, record the language choice of the patient throughout their treatment pathway
- incorporating the working welsh badge on staff uniforms
- continuing with the provision of bilingual information for patients and the public
- encouraging staff to use their range of Welsh language skills when answering the phone and talking to patients face to face
- rolling out the availability of Welsh language lessons and encouraging staff to enrol on online and classroom based Welsh courses.

A consultation took place across the organisation to ensure that the policy/procedure meets the needs of our stakeholders and the Health Board, this included engaging with the WLSG and the staff representatives through the Employment Policy Sub Group.

The Policy was also discussed at the Strategy and Delivery Committee on 25th June 2019 and the committee recommended that it was approved.

The Policy has been subject to EHIA which found there to be a positive impact.

ASSURANCE is provided by:

- UHB wide consultation.
- Equality & Health Impact Assessment
- The policy has been considered and recommended for approval by the Strategy & Delivery Committee
- Full publication of this policy will be in accordance with the UHB publication scheme.

RECOMMENDATION

The Board is asked to:

- APPROVE the Welsh Language Policy

Shaping our Future Wellbeing Strategic Objectives *This 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	x	7. Be a great place to work and learn	x
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	x	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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	x	Integration		Collaboration		Involvement	x
Equality and Health Impact Assessment Completed:	Yes / - included in the policy document. It was found that there was….								

Reference Number: Version Number:	Date of Next Review: Previous Trust/LHB Reference Number:

Welsh Language Policy

Policy Statement

Cardiff and Vale University Health Board supports our patients and services users who prefer to use Welsh when discussing their healthcare with our staff and service users.

The Board will endeavour to provide the best patient experience in their preferred language. Evidence from research on patient language choice has shown the positive outcomes for the patients when they are able to use their preferred language, including improved communication between patient and staff and decrease in anxieties and concerns.

We recognise the importance for staff to use their preferred language of Welsh when applicable and developing their Welsh skills We also recognise the duty the UHB in ensuring that it complies with the Welsh Language Measure (2011) and progress and support on the Welsh Governments' Welsh Language in Healthcare Strategic Framework (the More than Just Words Strategy).

Policy Commitment

- We welcome and encourage patients to use their preferred Welsh with staff in our everyday business. We positively encourage our staff with all ranges of Welsh language skills

- We will record the language choice of our patients and service users on our main patient management systems.

- We cannot guarantee a Welsh language service, but we welcome the use of Welsh by staff who can do so. We will mainstream the Welsh language into our recruitment processes, ensuring that Welsh language skills are considered in job descriptions when necessary. We will ensure that the language becomes an overall part of the overall staffs' skills mix, including as part of the staff level and service provision processes when appropriate.

- While staff are encouraged to use their Welsh Language skills, they should not feel under any pressure to communicate in Welsh beyond a level they are comfortable with, particularly in Clinical or other complex discussions.

- We incorporate the Work Welsh logo on Welsh speaking staff's uniforms, badges and lanyards. We'll encourage Welsh speaking staff to wear them and place posters in areas (reception and ward areas) where staff can provide a level of Welsh language service.

- We will continue to provide critical patient/service users and visitor information on the Cardiff and Vale University Health Board website in a bilingual format. The organisation will also use Welsh as much as possible on its social media channels.

- The organisation will provide fully bilingual signage across the organisations to help patients/service users/public to find their way around our sites in their preferred language of either Welsh or English. Promotional and information posters will also be bilingual across the organisation.

- The organisation will welcome all communication in the patient/service user preferred language of Welsh or English. The Board will treat both languages equally in terms of response. The organisation will offer the language choice of Welsh/English/bilingual in patient appointment letters and information leaflets.

- The organisation encourage staff to answer all telephone calls with a bilingual greeting and use their level of Welsh language skills when dealing with callers who prefer to speak Welsh**.**

- We will encourage all staff to register their language skills onto their ESR records.

- We will include Welsh language skills as the overall part of staff development in our PADR system.

- Managers are encouraged to discuss the Welsh Language skills and any interest in learning/improving with their staff as part of their PADR discussion.

- We will promote and arrange relevant training for staff who want to improve their Welsh language skills.

- The organisations' procurements processes will ensure that all relevant third party contractors consider our Welsh language policies when offering services on the organisations' behalf, including bilingual posters, leaflets and signs and face to face services.

Supporting Procedures and Written Control Documents

This Policy describe the following with regards to ensuring care through the preferred language of Welsh.

Other supporting documents are:

- Welsh Language Standards Compliance Notice for Cardiff and Vale University Health Board
- More than Just Words Strategic Framework

Scope

This policy applies to all of our staff in all locations including those with honorary contracts	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive. Key actions have been identified and these can be found in incorporated within this policy/supporting procedure. ***Note: Policies will not be considered for approval without an EHIA***

Policy Approved by	Strategy and Delivery Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Strategy and Delivery Committee Quality, Safety and Experience Committee Employment Policy Sub Group
Accountable Executive or Clinical Board Director	Executive Director for Workforce and Organisational Development

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1			New policy
2			

Equality & Health Impact Assessment for

Welsh Language Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	
2	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

3	Objectives of strategy/ policy/ plan/ procedure/ service	To improve the Welsh language care of patients who prefer to speak Welsh.
4	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available	• The are approximately 50,000 Welsh speakers living in Cardiff and Vale area. Cardiff is 4th in the highest amount of Welsh speaking residents according to Wales statistics : https://statswales.gov.wales/Catalogue/Welsh-Language/welshspeakers-by-localauthority-gender-detailedagegroups-2011census • Research into patient experience shows how language choice can provide an important choice when it comes receiving effective language which can leads to improved outcomes: 1. My language, my healthcare (Welsh Language Commissioner investigation of language choice in primary care): http://www.comisiynyddygymraeg.cymru/English/Publications%20List/Health%20inquiry%20full%20report.pdf 2. Welsh language speakers of health and social care : https://www.iaith.cymru/uploads/general-uploads/welsh_speakers_experiences_of_health_and_social_care.pdf 3. More than Just Words Strategy – Welsh Language in Healthcare Strategic framework

	from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	
5	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Patients and service users who prefer to speak Welsh In particular: older patients, children & young people and those with mental health issues.

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

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

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	• For those under 18, being able to use the language of their family, home or schooling environment. • Over 18 – being able to continue to use the language they prefer as the easiest way to communicate while receiving in healthcare.	Ensuring that language choice is being asked during patient intake and registered on patient management systems. Ensuring that front line areas are aware of the language choice made by the patient, and ensuring they provide best care as possible in that language.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Welsh speaking patients who suffer from dementia and may struggle in English and find it much easier to discuss matters in Welsh. Welsh speaking service users with long term illnesses and disabilities who are used to speaking welsh with families, communities and friends will find it easier to discuss their ailments in Welsh.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is	Welsh speakers come from diverse range of backgrounds including those who are undergoing reassignment. Many of them will find it	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	easier to discuss their treatment/process with our healthcare staff in their preferred language.	face areas as much as possible. 3. Provide bilingual patient information.	than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.4 People who are married or who have a civil partner.	Patients who are married or have a civil partnership might use Welsh with their partners throughout their partnership/marriage. Their partners/spouse might prefer to use Welsh regardless of the patient choice.	1. Ensure that they are given a language choice during intake and/or discussion about their healthcare. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		3. Provide bilingual patient information.	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Expectant and new mothers who's preferred language is Welsh will find it easier to discuss their care and maternity period through the medium of Welsh.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Offering a Welsh language choice as default will ensure that all patients will be given the choice, regardless of race, nationality and background.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		possible. 3. Provide bilingual patient information.	encouraging staff to use Welsh language skills and use them with patients.
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	Welsh speakers might hold their religious faith through the medium of Welsh. Therefore, they might prefer to discuss any faith aspects of their care through the medium of Welsh.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Welsh speakers come from a diverse range of communities, including from the LBTG community. Many of them prefer to receive healthcare in the preferred	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	language of Welsh	possible. 3. Provide bilingual patient information.	encouraging staff to use Welsh language skills and use them with patients.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	By providing a choice for patients to receive healthcare in Welsh means that it helps people to have a widening access of public, social and health care services in their own language.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Welsh speakers come from a diverse range of communities. Many of them prefer to receive healthcare in the preferred language of Welsh	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		possible. 3. Provide bilingual patient information.	encouraging staff to use Welsh language skills and use them with patients.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Our Welsh speaking patients and service users range across the South Wales area, especially for our specialist services. They will be able to continue to use their preferred language of Welsh with this organisation.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	None		

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

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	**Equity in access : I**mproved access and communications for patients/service users who preferred language is Welsh.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on	Improved quality of information for those who prefer to speak Welsh – would lead to more people	1. Ensure that they are given a language choice during intake. 2. Front line areas will	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	receive messages on healthier lifestyles.	ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information. These will include how to maintain healthy lifestyles.	and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility	It would help with staff with welsh speaking skills be able to communicate and bond better with their patients, leading to improve outcomes	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	for both parties.	to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information. These will include how to maintain healthy lifestyles.	2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to	Clear bilingual information on signs and public information will help patients navigate easier around the hospitals.	1. Bilingual signs and signpostings	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	Patients and service users will be able to use their will promote a feeling of belonging and minimise social isolation.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information. These will include how to maintain healthy lifestyles.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	Being able to use Welsh will help with the Welsh Governments aim of a million Welsh speakers by 2050.	1. Ensure that they are given a language choice during intake. 2. Front line areas will ensure that they are able to use Welsh in face-to-face areas as much as possible. 3. Provide bilingual patient information – including messages through social media and online information.	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Adopting the policy will help patients and services user to have an improve care in their preferred language of Welsh.

Action Plan for Mitigation / Improvement and Implementation

	Action	**Lead**	**Timescale**	**Action taken by Clinical Board / Corporate Directorate**
8.2 What are the key actions identified as a result of completing the EHIA?	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.	Welsh Language Officer/ Equality Adviser/ Assistant Director for Organisational Development	30/11/2019	1. Achieve compliance to the Welsh language standards around patient choice on language choice, information and face to face services. 2. Progress on the More than Just Words strategy of encouraging staff to use Welsh language skills and use them with patients.

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or servi proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review				

Report Title:	**Report of the Director of Corproate Governance/Board Secretary**									
Meeting:	Board Meeting							**Meeting Date:**	25.07.19	
Status:	**For Discussion**	x	**For Assurance**	x	**For Approval**		**For Information**			
Lead Executive:	Director of Corporate Governance									
Report Author (Title):	Interim Head of Corprorate Governance									

SITUATION

This report provides the Board with a briefing on a range of governance related issues that have arisen since the Board met in May 2019.

REPORT

ASSESSMENT

1. Board Development Programme

As Board Members will be aware I circulated a draft Board Development Programme for their feedback at the end of April. This has now been finalised and is on the meeting agenda for approval – see agenda item 8.5.

2. Standards of Behaviour

Board Members will wish to note that the Standards of Behaviour Policy has been reviewed and a new strengthened Policy developed. It will was due to come to the Board for formal approval in July 2019, following a period of consultation. However, as a number of changes have been made to the Policy it is important that the Local Partnership Forum have the opportunity to review and comment on it; the Forum meets next on the 7 August 2019; the Policy will therefore be brought to the September meeting of the Board for approval. As previously advised, a communication plan is being developed to support the launch of the revised policy.

As Board Members will be aware, in tandem with the work on the policy, we have initiated a programme of work to ensure interests, gifts, hospitality and sponsorship are properly declared. To date over 400 declarations have been received from departments across the UHB.

3. Policy on Policies

The UHB's *Policy on Policies* is being reviewed but is not on the July Board agenda for approval as planned, due to the need to reflect the requirements of the Welsh Language Standards in the revised version. An improvement programme is in place and is currently being reviewed by Internal Audit colleagues as part of an advisory piece of work.

4. Welsh Health Circulars (WHCs)

Board Members will wish to note that there have be no WHC's issued since the last Board meeting in held in May.

The Directorate of Corporate Governance has developed a register of all WHC's issued since 2015. Arrangements are in place to monitor compliance and a report will be brought to each Board meeting.

5. Consultations

As agreed at the May Board meeting Management Executive reviewed the consultations that were 'open', as at 6 June 2019, and agreed that:

- the Nursing and Midwifery Board would respond to the NMC's consultation in relation to its new organisational strategy - *Shaping the Future.* It was confirmed that this was the route for consideration of all nurse related consultations.
- a formal UHB response would be submitted in respect of the *GMC's consultation* related to revalidation.
- a response to the Welsh Government's consultation on *Children and Young Peoples Continuing Care* would be prepared by the Women and Children Clinical Board.
- the PCIC Clinical Board would prepare a response to the Welsh Government consultation on *Measuring Social Services.*

The review of 'open' consultations to inform whether a formal UHB response should be submitted is now a regular item on the Management Executive agenda, and the Board will be advised of the decisions made through the Director of Corporate Governance report.

RECOMMENDATION

The Board is asked to:

NOTE the updates provided in this report.
DISCUSS and AGREE whether the Board should be formally responding to any of the consultations detailed at Section 6 of this report.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
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	

Five Ways of Working (Sustainable Development Principles) considered

Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable									

Report Title:	**Board Development Programme 2019/20**								
Meeting:	**Board**							**Meeting Date:**	
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

SITUATION

The purpose of the report is to enable Board Members to discuss and approve the attached Board Development Programme for 2019/20.

REPORT

BACKGROUND

The attached Board Development Programme has been developed for the financial year 2019/20. The Board Development Programme is a requirement of the UHBs Standing Orders. It should be noted that going forward the Programme will be presented to the Board for approval at the end of the financial year however, the plan was circulated to the Board in April 2019 for comments and agreement with the draft Programme and it is this draft that the Board has been working to thus far.

ASSESSMENT

The attached Board Development Plan has been developed by the Director of Corporate Governance and has included a number of inputs primarily from Board Member requests, the outputs from Board Members appraisals, requests from outside organisations and other important areas/ priorities.

It should be noted that this is fluid document and items will be added and or deferred dependent upon other commitments and priorities.

ASSURANCE is provided by:

Review of other Board Development Programmes produced by NHS organisations and by discussion with other Board Secretaries/ Directors of Corporate Governance.

Going forward feedback forms will be introduced. The purpose of the forms will be to understand the effectiveness of the Board Development session.

RECOMMENDATION

The Board is asked to:

- Review and approve the attached Board Development Programme for 2019/20.

Shaping our Future Wellbeing Strategic Objectives *This 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	X	7. Be a great place to work and learn	X
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	X
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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

BOARD DEVELOPMENT PROGRAMME 2019-20

1. INTRODUCTION

It is important for Boards to develop a framework of knowledge, skills and competencies that fit the requirements and context of the organisation and can serve as the basis for whole Board and individual Board member appraisal. Alongside whole Board performance evaluation, Board members should undergo an annual appraisal of their individual contribution and performance. This appraisal should focus on the member's contribution as a member of the Corporate Board; in the case of Executive Directors this is distinct from their functional leadership role. The appraisal of the Chief Executive by the Chair is particularly important because the effective performance management of the Chief Executive is critical to the success of the organisation and sets the benchmark for other Executive Directors and Senior Managers.

The pre-requisites of effective and continuous Board development are:

- Chair and Chief Executive commitment
- Board appetite for development
- Good appraisal and personal development planning processes

2. CARDIFF AND VALE UHB CONTEXT

The UHB's Integrated Medium Term Plan for 2019-22, sets a challenging and exciting agenda for the next three years. It is important that the Board is supported to deliver this agenda and provided with opportunities to develop as a team and as individuals, therefore in developing this Board Development Programme the following were considered:

- Shaping our Future Wellbeing;
- The Cardiff and Vale University Health Boards Standing Orders;
- Board Assurance Framework;
- Key National developments;
- Areas requested by Board Members; and
- Requests from outside bodies.

(a) Shaping our Future Wellbeing

Cardiff and Vale University health Board's (UHB's) ten-year strategy, *Shaping our Future Wellbeing* states that **Caring for People; Keeping People Well** is why we exist as a UHB, with a vision that **a person's chance of leading a healthy life is the same wherever they live and whoever they are**.

The Strategy is based upon a number of design principles, all of which are aligned with the Principles of Prudent Healthcare introduced by the Welsh Government. It focuses on:

- Empowering the person.
- Home First.

- Delivering outcomes that matter to people.
- Avoiding unwarranted variation and reduce harm and waste.

The UHB's collective ambition for the people of Cardiff and Vale is high and we will continue to push hard to innovate and develop, and to be leaders in Wales.

(b) The Cardiff and Vale University Health Boards Standing Orders, Standing Financial Instructions, Schedule of Powers and Scheme of Delegated Authorities

LHBs are required by law to develop Standing Orders, which regulate the way in which the proceedings and business of the LHB will be conducted.

Standing Orders, including the Standing Financial Instructions, Schedule of Reservations of Powers and Scheme of Delegated Authorities identify who in the LHB is authorised to do what.

- The documents provides a source of the key rules under which the LHB is managed and governed.
- The regulations which determine the way that the Board operates and is governed are spelt out in the Standing Orders.
- Financial responsibilities and authorities are described in the Standing Financial Instructions and Scheme of Delegated Authorities
- All employees of the LHB need to be aware of their responsibilities and authorities described in these documents.

(c) Board Assurance Framework

The Board Assurance Framework (BAF) was presented and approved by the Board in November 2018. It has been updated and presented to each Board meeting since November 2018 and highlights to the Board the key risks to the achievement of Strategic Objectives. These risks are:

- Workforce
- Financial Sustainability
- Sustainable Primary and Community Care
- Safety and Regulatory Compliance
- Sustainable Culture Change
- Capital Assets (including Estates, IT Infrastructure and Medical Devices)

These risks if not properly managed or mitigated could impact upon the delivery of our strategy.

(d) Key National Developments

Key National Developments from Welsh Government and NHS Wales will be presented to Board Development sessions by the relevant Executive Director who will inform the Board of areas of importance and the impact of any national developments on the LHB. These developments may also require formal reporting to the Board and will be timetabled to be presented to the Board when most appropriate.

(e) Areas requested by Board Members

Throughout 2018-19 and through the recent round of Independent Member appraisals, Board Members identified areas and issues that they considered worthy of further exploration at a Board Development Session, these included:

- The NHS Financial system with a focus on Cardiff and Vale and its financial position.
- Standing Orders and the UHB's Scheme of Reservation and Delegation.
- Charitable Funds and legal duties of Charity Trustee.
- Serious Incidents and Root Cause Analysis (RCA) and how we learn from incidents.

(f) Requests from outside bodies

A number of requests are received each year from outside bodies and joint committees, who wish to present to the Board at an informal session, these include:

- The Bevan Commission
- The Emergency Ambulance Services Committee
- NHS Wales Shared Services Partnership
- Welsh Health Specialised Services Committee
- Community Health Council

(g) Other Leadership Development Programmes

Independent Members will also get the opportunity to be involved in wider Leadership and Management Programmes taking place at Cardiff and Vale such as 'Amplify 2025' and 'Showcase' and the work which is ongoing to change the culture and make things happen by consistently putting the patient 'Wyn' at the centre of everything we do.

3. BOARD MEMBER INDUCTION PROGRAMME

A Board Member Induction Programme will be developed by the end of September 2019 for approval by the Board and in readiness for the new Board Members. The new Induction Programme will ensure that, going forward, new Board Members particularly Independent Members are appropriately inducted into Cardiff and Vale University Health

Board.

In addition to the Induction Programme for new Board Members induction will also be provided when Independent Members change the Committees they serve upon. This will be done on an individual basis and will be undertaken by the Director of Corporate Governance in conjunction with the Chair of the relevant Committee.

4. DEVELOPMENT OF BOARD MEMBERS AND SUCCESSION PLANNING

(a) Need for flexibility

The Board Development Plan is a fluid document and additional training/ development sessions will be added into the plan throughout the year and as priorities emerge.

During 2019-20 a holistic development programme for Board members will be put in place; this programme will include opportunities for:

(b) Personal Development

All Board members (Executive Directors and Independent Members) participate in an appraisal process on an annual basis. A summary of the key outputs from this process for Executive Directors will be shared at the Remuneration and Terms of Service Committee meeting. In addition to this any collective development needs that have been identified have been included within the development programme for 2019/20.

The identification of individual development needs, including continuing professional development, and implementation of any follow up action is undertaken as part of the appraisal process. Appraisals for Independent Members were all completed during June and July. Individual Development needs which were identified through the appraisal process will be organised through the Director of Corporate Governance

(c) Coaching

All Board members will be encouraged to take up coaching and/or mentoring support this year, in addition to utilising informal networks, and professional support groups.

(d) Academi Wales Programme

The Board Secretary Peer group worked with Academi Wales to develop a Governance and Board Leadership Programme. The first session 'essential skills for Board Members' took place in September 2018. Regular updates on the

programme, including podcasts and webinars can be found at https://academiwales.gov.wales/events and learning resources at https://academiwales.gov.wales/Repository.

(e) Shadowing and external learning opportunities

The Board will work with other NHS organisations, inside and outside of Wales, to identify opportunities for shadowing and learning. A programme of visits and events will be developed for 2019-20.

(f) Statutory and Mandatory Training

The following statutory and mandatory training sessions should be undertaken by all Board Members. The Director of Corporate Governance will ensure that Board Members are made aware of when training sessions are taking place and will organise the booking of Board Members onto sessions as requested.

- Equality and Diversity
- Infection control
- Safeguarding
- Information Governance
- Health and Safety
- Finance

5. SUCESSION PLANNING

Over the next twelve months a succession plan will be developed by the Executive Director of Workforce and Organisational Development and the Director of Corporate Governance. The plan will be developed and agreed for both Independent Members whose terms of office are coming to an end and for Executive Directors. This will identify high risk areas and will be aligned to Leadership and Management Development Programme currently in place.

(a) Skills Analysis

In support of the succession plan a skills analysis will also be undertaken to identify the full range of skills/qualifications and experiences on the current Board but also to identify where there are any gaps or future gaps which are likely to occur.

Appendix 1

Board Development Programme for 2019-20

Before the commencement of the calendar year dates for a series of Board development sessions to be held on a bi-monthly basis are agreed. The development sessions are structured around the areas identified in paragraph 2 of the plan.

Board Development Session Date	Areas to be covered	Purpose	Executive Lead	Status
25th April 2019	Board Development Programme for 2019-20	To engage the Board in the finalisation of the Board Development Programme for 2019-20	Director of Corporate Governance	Circulated to the Board by Director of Corporate Governance in April for comments and presented to the Board for approval on 25th July 2019
	Clinical Services Plan	To inform Board Members of the development of the Clinical Services Plan	Executive Director of Strategic Planning	**Session completed** on 25th April 2019
	Development of Risk Appetite Statement	To engage the Board in the development of the Board's Risk Appetite Statement	Director of Corporate Governance	**Session completed** 25th April. Risk Appetite Statement included within Risk Management and Board Assurance Framework Strategy presented to the Board for approval on 25th July 2019.

	Well Being Hubs	To discuss the OBCs prior to presentation to Board for approval	Executive Director of Strategic Planning	**Session completed** on 25th April 2019 prior to presentation to Board on 30th May 2019
	Nurse Staffing Act	To discuss progress against the Act and a draft paper prior to presentation to Board	Executive Nurse Director	**Session completed** on 25th April 2019 prior to presentation to Board on 30th May 2019
27th June 2019	The Emergency Ambulance Services Committee (EASC)	To ensure the Board has an understanding of the role, remit and 2019-20 priorities of EASC and its relationship with the UHB.	Director of Corporate Governance	**Session deferred** to future date - TBC
	Welsh Health Specialised Services Committee (WHSSC)	To ensure the Board has an understanding of the role, remit and 2019-20 priorities of WHSSC and its relationship with the UHB.	Director of Corporate Governance	**Session deferred** to August Board Development Session
	Standing Orders and Scheme of Reservation and Delegation	To ensure that Board Members are aware of the requirements set out in Standing Orders	Director of Corporate Governance	**Session deferred** to future date - TBC
	Wellbeing of Future Generations Act	To update Board Members on progress being made against the Act	Executive Director of Public Health	**Session completed** on 27th June 2019

	LGBT Inclusion Session	To ensure the Board are briefed and understand LGBT	Executive Director of Workforce and Organisational Development	**Session completed** on 27th June 2019
30th August 2019	Patient Safety Visits, RCAs and SIs Discussion	To discuss and how Board Members can get the most out of patient safety visits and agree a way forward for feedback To understand the process for conducting an RCA on an SI and how as an organisation we are learning from the outputs.	Executive Nurse Director	
	NHS Wales Shared Services Partnership (SSP)	To ensure the Board has an understanding of the role, remit and 2019-20 priorities of SSP and its relationship with the UHB.	Director of Corporate Governance	
	The Bevan Commission	To ensure that the Board has an understanding of the role and 2019-20 priorities of the Bevan Commission.	Director of Corporate Governance	
	Charitable Funds	To ensure that the Charity Trustee understands their legal responsibilities and have clarity regarding on what purpose Charitable Funds can be used	Executive Nurse Director / Director of Corporate Governance	

31st October 2019	Canterbury Visit Team – Update on Progress	To ensure the Board remain update to date on progress being made with the Transformation Project and the impact it is having.	Chief Executive	
	CHC Board to Board (TBC)	The Boards are required to meet on a six month basis	Director of Corporate Governance	
13th December 2019	Integrated Medium Term Plan for 2020-23	To gain the Board's input to the IMTP.	Executive Director of Strategic Planning	
	NHS Financial System with a focus on Cardiff and Vale's Financial Plan	To enable Board Members to understand how the finances work within and NHS context	Executive Director of Finance	
28th February 2020	Board Annual Self-assessment	To undertake an assessment of the effectiveness of the Board and the efficiency of its processes. This will inform the Directorate of Corporate Governance's Work Programme and the Board Development Programme for 2021-22	Director of Corporate Governance	

	Board Assurance Framework	To identify and discuss as a Board emerging risks which will impact upon delivery of Strategic Objectives and which will be managed or mitigated through the Board Assurance Framework	Director of Corporate Governance	

MINUTES OF QUALITY, SAFETY AND EXPERIENCE COMMITTEE
HELD ON TUESDAY, 23 APRIL 2019
CORPORATE MEETING ROOM, HEADQUARTERS,
UNIVERSITY HOSPITAL WALES

Present:		
Susan Elsmore	SE	Committee Chair
Maria Battle	MB	UHB Chair
Michael Imperato	MI	Independent Member - Legal
Dawn Ward	DW	Independent Member – Trade Union
In attendance:		
Steve Curry	SC	Chief Operating Officer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Christopher Lewis	CL	Deputy Director of Finance
Graham Shortland	GS	Executive Medical Director
Ruth Walker	RW	Executive Nurse Director
Alun Tomkinson	AT	Clinical Board Director - Surgery
Ann Jones	AJ	Patient Safety & Quality Assurance Manager
Clare Wade	CW	Acting Nurse Director – Surgery Clinical Board
Ian Wile	IW	Director of Operations – Mental Health Clinical Board
Jayne Tottle	JT	Director of Nursing – Mental Health Clinical Board
Mike Bond	MB	Director of Operations – Surgery Clinical Board
Val Wilmot	VW	Clinical Nurse Specialist
Glynis Mulford	GM	Secretariat
Apologies:		
Akmal Hanuk	AH	Independent Member – Community
Gary Baxter	GB	Independent Member - University
Robert Chadwick	RC	Executive Director of Finance
Observer:		
Urvisha Perez		Wales Audit Office

QSE:	WELCOME AND INTRODUCTIONS	ACTION
19/04/001	The Chair welcomed everyone to the meeting and noted that it was quorate. A special welcome was given to Urvisha Perez from the Wales Audit Office.	

19/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
19/04/003	**DECLARATIONS OF INTEREST** The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. The following declaration of interest were received and noted: ▪ Michael Imperato, Independent Member (Legal) declared a conflict of interest in respect of the Blood Inquiry. The declaration was formally noted and it was agreed that Michael Imperato would leave the meeting for any discussions related to the Blood Inquiry.	
19/04/004	**MINUTES OF THE QUALITY, SAFETY AND EXPERIENCE COMMITTEE HELD ON 19 FEBRUARY 2019** The Committee reviewed the Minutes of the meeting held on 19 February 2019. **Matters Arising:** **19/02/008 - PCIC Clinical Board Assurance Report:** In relation to the environment issue with flooding at Riverside, the Executive Director of Nursing reported that there had been communication with the teams and patient safety visits undertaken. In respect of the mobile units in the Ely Hub and Splott Clinic, it was confirmed that there would be further communication with the team as to date no feedback had been received on the work undertaken. It was confirmed that the Executive Nurse Director would discuss the action needed outside of meeting. **The Committee Resolved - that:** a) the minutes of the meeting held on 19 February 2019 be approved as an accurate record. b) the action needed in relation to the Ely Hub and Splott Clinic would be left to the Executive Nurse Director to discuss outside of meeting.	RW
19/04/005	**COMMITTEE ACTION LOG** The Committee reviewed the Action Log and noted that: ***19/02/010 – Gosport Independent Panel Report:*** There had been a delay in filling the role of the UHB's Medical Examiner. It was confirmed that NHS Shared Services would be responsible for the Medical Examiner recruitment exercise and that a further update would be brought to a future Committee meeting by the Executive Medical Director. ***19/02/007 – Patient Story:*** The Committee was content that this action had been completed.	GS

	18/196 – Emerging Themes from UK Maternity Service Reviews: The Executive Nurse Director confirmed that the report on maternity services at Cwm Taf Morgannwg University Health Board would be published on 30 April 2019 and following publication a report would be brought to the Committee for consideration. ***19/02/012 – Assessment Unit, UHW – Response to the CHCs Concerns:*** The Executive Nurse Director confirmed that a report would be presented at the private session of the Board scheduled for May 2019. **The Committee Resolved – that**: a) the action log be received and noted. b) all completed actions be archived.	
19/04/006	**CHAIR'S ACTION TAKEN SINCE LAST MEETING** It was confirmed that there had been no Chair's Action taken since the last meeting of the Committee. The Chair also confirmed that at the private session of the Committee held on 19 February 2019: ▪ Steps being taken to improve radiological reporting times were discussed ▪ A paper on gastroscopy and colonscopy decontamination was presented. ▪ The Blood Review was discussed. It was noted that Michael Imperato, Independent Member – Legal, left the meeting due to his declared conflict of interest. ▪ An overview of Safeguarding matters was provided.	
19/04/007	**PATIENT STORY** The Director of Operations for the Surgical Clinical Board introduced the patient story that was titled '*Patient Knows Best'*. The Clinical Board's Director and Clinical Nurse Specialist delivered a presentation and as part of this it was confirmed that: ▪ there was a need to individualise and improve the patients' journey through the care system as patients were having to repeat their information at various points in the care process and at each appointment. Patient's needed to be placed at the centre of the care process and a single shared record would assist this. ▪ *Patient Knows Best* (PKB) PKB works on any computer, anywhere, anytime as long as you have internet access. It has the ability to hold a patient's medical data, connect to wearable activity devices, communicate with the patients' healthcare team and track signs and symptoms. It was noted that PKB is safe, secure and approved for use by the NHS. ▪ PKB enabled timely feedback from patients and therefore supported the quality and safety assurance agenda. The system strengthened engagement as it enabled the team to communicate	

regularly with patients. It was confirmed that funding had been provided to enable a project to test the use of PKB.

- the use of PKB as part of the paediatric tracheostomy care pathway, enabled close links to be developed with patients and their families as both staff and parents were trained how to look after a tracheostomy. It also enabled families to ask questions and get advice quickly.
- the use of PKB as part of the establishment of virtual clinics had commenced and was an area where development continued. It was confirmed that the approach had been used in audiology with good results in the area of cochlear implants as implants could be tuned away from the hospital site. It was noted that the approach empowered patients to make decisions about their own care and had led to a reduction in the number of patient needing to be seen in clinic; overtime this could lead to decrease follow up appointments.
- the use of PKB to issue questionnaires to assess the need for a follow-up appointment for young people with a hearing impairment had reduced follow-up appointments. It was noted that previously individuals had been seen routinely every three months.
- providing patients and their families with access to appointment slots helped reduce cancellations and DNA rates as they were able to move appointments to suit their availability.
- the PKB project was a transformational piece of work on the digital and as part of this the use of Patient Reportable Outcome Measures (PROMs) would need to be considered.
- the Clinical Nurse Specialist role was evolving as part of the PKB development work.

The Committee Resolved - that:

a) the Patient Story be noted

19/04/008 **SURGERY CLINICAL BOARD ASSURANCE REPORT**

The Director of Operations for the Surgery Clinical Board introduced the Surgery Clinical Board's Assurance Report and outlined the arrangements, progress and outcomes in relation to the Quality, Safety and Patient Experience agenda over the previous 12-months. In providing an overview of the detailed Assurance Report it was confirmed that:

- a well-established formal Quality, Safety and Patient Experience (QSPE) that meets bi-monthly, was in place and that this structure is formally replicated by each of the Clinical Directorates.
- The Clinical Board's Risk Register was monitored at Directorate and Clinical Board level. The top three risks on the Clinical Board's risk register as at March 2019 were discussed, these were confirmed as being:

  - The fabric and plant of the main theatre suite at UHW. The

Committee was advised that remedial works had been carried out on the theatres that posed the most significant concern.

- Escalating pressures from medical outliers. It was noted that an escalation process was in place to attempt to accommodate all Surgical patients within the Clinical Board's bed base. It was also confirmed that work being taken forward with Lightfoot enabled the consideration of real time data.
- Increasing Bank/Agency use. The Committee was advised that there were challenges in relation to the recruitment and retention of registered nurse and Allied Health Professionals, although a viable work plan was in place for the future.

- a formal clinical audit plan was in place, which includes both local and national audits. The need to invest in resources to enable regular and consistent data input to national databases was highlighted.
- between 1 April 2018 and 31 March 2019, 52 *Serious Incidents* and three *No Surprise* events had been reported to Welsh Government. It was noted that the learning from Serious Incidents had been taken forward as a team ensuring ownership and understanding at all levels.
- the Clinical Board's Director of Nursing facilitated a UHW wide group to consider and address pressure damage issues. A summary of the work streams delivered over the last 12-months was discussed. As part of discussions the Independent Member - Trade Union, asked if comparisons between the number of reported grade 3 and 4 pressure damage incidents had been made. In response, it was confirmed that there had been a change to reporting arrangements that required only avoidable Grade 3 and 4 damage to be reported.
- Root Cause Analysis (RCA) reviews of the 12 falls reported between 1 April 2018 and 31 March 2019 that had resulted in an injury had not identified any trends or themes.
- four Never Events had been reported during the previous 12-months, all of which had (or were in the process of having) RCA reviews undertaken. It was confirmed that following the completion of a RCA relating to a medication incident changes had been made to pharmacy systems.
- PADR rates were low and the need for these to be improved was acknowledged.

The Committee congratulated the Surgical Clinical Board for its work over the last 12-months and for the improvements made. The leadership of the Clinical Board Director was acknowledged.

The Committee Resolved - that:

a. The progress made by the Surgical Clinical Board be noted.

b. the assurance provided by the Surgery Clinical Board be acknowledged.

19/04/009	**MENTAL HEALTH SERVICES FOR OLDER PEOPLE – IN-PATIENT CARE IMPROVEMENT PROJECT THROUGH ALOS REDUCTION** The Director of Operations and the Director of Nursing for the Mental Health Clinical Board presented the Committee with an overview of the steps being taken to reduce the average length of stay (ALOS), bed numbers and the resources associated with elderly inpatient care. As part of the overview it was confirmed that: ▪ The Mental Health Service for Older People's (MHSOP) Directorate had a total of 115 beds, of which a little over half (66) were acute assessment beds. ▪ Mental Health services has seen 40% of its beds close over the last 11 years with two MHSOP wards closing in the last five years. ▪ The service on average sees a split of 22% / 78% functional / dementia patients within in the inpatient service, which often results in placing functional patients on a dementia ward. ▪ the MHSOP service, remains an obvious national outlier, for high ALOS and bed numbers in the UK, specifically for its elderly population in hospital beds. It was noted that the MHSOP was initially working towards reducing the number of beds by 9/10 within the 2019-20 calendar year, with a further 4/5 beds released in quarter four. This would require an average length of stay of 89-91 days, which would be in line with upper quartile ALOS in benchmarking peer organisations. The Committee was advised that the intention was to either reduce a small number of beds on each of the assessment wards or close an entire ward. It was confirmed that the latter would require Community Health Council involvement at an early stage for engagement/consultation purposes The Committee was advised that a number of work-streams had been implemented to improve efficiency and effectiveness, including: ▪ discharge planning from admission ▪ effective reporting and monitoring of ALOS and inpatient pathway performance ▪ staff training and awareness of long lengths of stay ▪ closer working with social work, Complex Care Commissioning Team and community teams ▪ Multi-Disciplinary Team (MDT) working and ward rounds ▪ Clarity of MDT roles and responsibilities ▪ Optimisation of support services such as crisis and day services. The dementia service has all the ingredients of a community service that is capable of keeping people out of hospital, with a crisis team, nursing home liaison service and a typically resourced integrated community service. ▪ appointment of a pilot Band 7 clinical post in MHSOP to look at improving inpatient pathways and ALOS in MHSOP ▪ the provision of support by Judith Hill, Head of Integrated Care to	

look at LOS and patient flow; focussing on care at the right time and in the right place.

The Executive Nurse Director advised the Committee that there was Regional Partnership Board funding set aside for dementia and confirmed that that community developments were progressing at a good pace.

The committee Resolved – that:

a) the work being conducted by the Mental Health Clinical Board be noted

b) a phased bed reduction programme of up to 14/15 beds in 2019/20 be supported.

19/04/010 **MENTAL HEALTH CLINICAL BOARD: REPORT ON MEDICAL COVER FOR MENTAL HEALTH PATIENTS WITH PHYSICAL HEALTH NEEDS ON THE LLANDOUGH HOSPITAL SITE**

The Executive Medical Director and Executive Nurse Director provided the Committee with a verbal update in respect of the situation in relation to medical cover for mental health patients with physical health needs on the Llandough Hospital site. As part of this update it was confirmed that:

- concerns had been highlighted with regards to the availability of medical support in the event of a cardiac arrest. The Committee was advised that in the case of an emergency it had been agreed that the cardiac arrest team would attend Llanfair Unit on a 2222 call. It was noted that further work was needed to firm up arrangements for the transportation of patients to the most appropriate care facility.
- there would also be occasions when the most suitable course of action would be to make a 999 call (e.g. following a fall and/or fracture) and Clinical Boards had been asked to communicate this information to their frontline staff.
- if a clinician contacted WAST and was clear that the patient was acutely unwell, WAST had given assurance that they would respond in a clinically based way and transport the patient as an appropriate priority. If any problems arose in relation to ambulance transport, it was confirmed that the team had been advised to go through the Executive Medical Director and/or Executive Nurse Director.
- The Hospital at Night arrangements at Llandough Hospital was an area in need of strengthening. It was noted that support had been offered and the medicine team had been asked to undertake risk based assessments
- The Executive Medical Director confirmed that he was content with resuscitation arrangements at Hafan y Coed, and confirmed that all psychiatrists had been reminded of their responsibilities in respect of the physical health needs of their patients. It was noted that a senior nurse had ben delegated responsibility for providing support in relation to physical health needs, and that the team had

access to the GP service for the management of chronic conditions.

- It was acknowledged that as additional specialities were introduced on the Llandough Hospital site the risks and complexities aligned to the Hospital at Night would need to be closely monitored.

The Committee Resolved – that:

a) the verbal update provided by the Executive medical Director and Executive Nurse Director be noted.

19/04/011 **COMMUNITY HEALTH COUNCILS REPORT: ONE SIMPLE THING – COMMUNICATION IN THE NHS AND THE UHBs RESPONSE**

The Assistant Director of Patient Experience provided the Committee with an overview of the findings of the Community Health Councils report *One Simple Thing – Communication in the NHS* and the UHBs response. The Committee was advised that:

- the report was an all-Wales report and so the findings were generic rather than UHB specific.
- The report was structured around nine themes, namely:
  - Attitude, understanding and listening.
  - Empathy when delivering bad views
  - Keeping people informed and involved
  - Appointments
  - Using technology
  - Coordination of care and communication across services
  - Using Welsh
  - Meeting individual needs
  - Raising concerns
- communication was one of the biggest themes arising from concerns raised by patients of the UHB.

An overview of the steps being taken by the UHB to improve communication was provided.

The Committee Resolved – that:

a) the findings and recommendations set out in the Community Health Councils report *One Simple Thing* and the UHBs response be noted.

19/04/012 **ANNUAL QUALITY STATEMENT FOR 2018-19 (FIRST DRAFT)**

The Executive Nurse Director presented the Committee with the draft Annual Quality Statement (AQS) for 2018-2019 for approval. The Committee was advised that for the 2018-19 financial year the requirements for submitting the report had been brought forward by three months. The Committee noted that the draft AQS had been reviewed by the Management Executive and comments made addressed.

	A high level overview of the draft AQS was provided by the Patient Safety & Quality Assurance Manager. As part of the overview it was confirmed that: ▪ The draft report had been developed in collaboration with colleagues across the health board and in partnership with the Community Health Council, as well as through engagement with the Stakeholder Reference Group. ▪ Each chapter of the AQS was aligned to a Health and Care Standards theme, and contained three components including the Quality, Safety and Improvement framework, patient and staff story and examples of improvements and areas to focus on during 2019-2020. ▪ The patient and staff stories included in the AQS had been developed with clinical teams and patients across the UHB to reflect the approach being taken to ensure that care is being provided in the most appropriate settings. ▪ Due to the timeframes for publication final year figures around performance and delivery would be inserted following the approval of the draft and before publication. ▪ The AQS was subject to audit by Internal Audit prior to publication. ▪ The approach to developing the AQS was changing and guidance from Welsh Government was awaited. It was noted that it was likely that the UHB would develop a website with up to date Quality, Safety and Experience information. ▪ Feedback on the draft was required by 30 April. Due to the timing of the May Board meeting it was necessary to agree arrangements for the sign-off of the draft AQS by the Committee. **The Committee Resolved – that:** a) the draft Annual Quality Statement be approved, subject to any comments received by 30 April 2019. b) final sign-off of the Annual Quality Statement, on behalf of the Committee, would be delegated to the Committee Chair.	All
19/04/013	**POLICIES FOR APPROVAL** The Executive Nurse Director presented the following Policies and related Procedures for Approval: ▪ **Labelling of Specimens Submitted to Medical Laboratories Policy and related Procedure:** This policy and supporting procedure describes the requirements for accurate positive identification of the patient from whom the specimen was taken, the clinical details surrounding the patient and the person and location where the result should be sent. ▪ **Venepuncture for Non Clinically Qualified Research Staff Policy and Related Procedure: T**his policy and supporting	

	procedure identifies the key standards required to ensure the safe practice of venepuncture by research staff without clinical qualifications working within Cardiff and Vale University Health Board **The Committee Resolved - that:** a) the Labelling of Specimen's Submitted to Medicine Laboratories Policy and related Procedure be approved b) the Venepuncture for Non-Clinically Qualified Research Staff Policy and related Procedure be approved	
19/04/014	**HEALTH AND CARE STANDARDS ANNUAL AUDIT REPORT** The Health and Care Standards Annual Report was presented by the Executive Nurse Director; a video accompanied it. The Committee was advised that feedback received from patients as part of the annual audit had confirmed the high standards of care provided across the UHB, with an overall satisfaction rate of 92% (91% in 2017 & 89% in 2016). It was also noted that nearly all patients (98.4%) who participated in this year's audit reported that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital. The Committee discussed the areas that had received low feedback scores i.e. sleep and rest with an overall patient satisfaction rate of 77.82%; provision of help and advice to prevent damage to skin - 79%; 63% in relation to question: *Were you able to speak Welsh to staff if you needed to?* and 73% in relation to: *parents were encouraged to attend ward rounds (paediatric & neonatal areas).* The Executive Nurse Director advised the Committee that a comparison of compliance with operational standards over the last three years demonstrated that clinical areas had achieved greater and more frequent improvement, specifically in relation to: ▪ Nutrition and Hydration: staff knowledge of dietary requirements, frequency of beverage rounds, frequency of water jug changes and availability of snacks ▪ Care planning & evaluation of care for people who lack capacity ▪ Evaluating the care of people with substance misuse problems ▪ Provision of smoking cessation information ▪ Medication charts completed fully and correctly Reduction in compliance, totalling more than 5% over three years, were confined to the following standards: ▪ Fire restraint doors are free from obstruction or closed ▪ Assessment of cultural & spiritual needs ▪ Reviewing patient hygiene and continence needs within agreed timescales ▪ Patient documentation captures their preferred name	

The Independent Member, Legal asked whether timescales for implementation were attached to the Standards, and whether the impact of non-compliance had been clearly set out. In response, it was confirmed that the Health and Care Standards established a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for improvement. It was also confirmed that many of the Standards are overlapping and interrelated, and that where concerns had been highlighted a further audit would be undertaken.

The Executive Nurse Director confirmed that a number of the areas for improvement highlighted by the Annual Audit had already been identified by the UHB and as a result improvement work was already progressing. Such areas included, length of stay, pressure damage, discharge and patient flow.

The Chair of the UHB advised that in relation to the Standard relating to the spiritual and pastoral care needs of people and their carers it had been recognised that staff needed further guidance and support to ensure that they asked the right questions in the right way. The Independent Member, Trade Union offered her support and assistance in this task.

The Committee discussed the feedback received in relation to cleanliness and it was recognised that often the age of the UHB estate impacted on a patient's perception of cleanliness. It was agreed that such perceptions needed to be appropriately addressed.

The Committee Resolved – that:

a) The continued improvements made across most standards, especially in relation to; nutrition & hydration, evaluation of care for people with substance misuse problems, availability of smoking cessation information, full completion of medication charts and care planning for people lacking capacity be noted.

b) The high parent satisfaction (95%), based on over 300 responses, achieved within Children's Community Directorate be noted. The Committee also noted that this high rating had the effect of increasing the UHB's overall patient satisfaction to its highest recorded level (92%)

c) The reduced compliance with Standards, that had occurred for three consecutive audits be noted.

19/04/015 **PATIENT SAFETY SOLUTIONS (STANDARD 2)**

The Assistant Director of Quality and Safety presented a high level update on the UHB's position in relation to Patient Safety Solutions, which include alerts and notices from Welsh Government. The Committee was advised that:

- overall compliance with Patient Safety Solutions where the deadline had passed was 93% (compliant with 51 out of 55).
- Two Safety Solutions had been recently issued by Welsh Government, and work was underway to ensure compliance by the

required deadline:

- PSA009 – Wrong selection of orthopaedic fracture fixation plates
- PSN047 – Management of life threatening bleeds from arteriovenous fistulae and grafts

- The UHB had been unable to confirm compliance with the following Safety Solutions:
  - PSA008 – Nasogastric tube misplacement: continuing risk of death and severe harm. It was noted that the particular issue to address with the Alert related to uptake of competency- based training for all staff who undertake the procedure, regardless of seniority.
  - PSN030 – The safe storage of medicines: This Notice is subject to further consideration by Welsh Government.
  - PSN040 – Confirming removal or flushing of lines and cannulae after procedures. It was confirmed that the outstanding issue to address relates to amending the 'sign out' section of WHO surgical safety checklists in operation. The UHB is currently undertaking a review of all Directorate WHO checklists for this to be considered.
  - PSN043 – Supporting the introduction of the Tracheostomy Guidelines for Wales. It was noted that an audit of all patients in the community who have a tracheostomy is currently being undertaken.

The Committee acknowledged the improvements made by the Patient Safety Team.

The Committee Resolved – that:

a) the Patient Safety Solutions update be noted.

19/04/016 **PATIENT FALLS (STANDARD 2.3)**

The Executive Director of Therapies and Health Science provided the Committee with an overview of the work undertaken in respect of falls prevention and described the UHB's proposed approach to falls prevention going forward. An update on the launch of the Falls Prevention Framework and the outcome of the first Community Falls Prevention Alliance workshop held in March 2019, was also provided.

The Executive Director of Therapies and Health Science advised the Committee that data analysis by Lightfoot has identified that there were:

- 500-600 attendances (including Paediatrics) to the Emergency Department (ED) at UHW as a result of falls each week.
- 40-50 of those patients aged 75+ discharged from ED following a fall, will re-attend ED.
- 7 patients aged 75+ were admitted per week with fractured neck of femur, with an average length of stay of 20-45 days, occupying 30-50 beds at any one time.

	It was also noted that the key focus of the '*Falls Framework: Reducing Risk and Harm*' was primary prevention and the community falls pathway. It was confirmed that the UHB had: ▪ recently entered into a partnership with Canterbury District Health Board. As part of the Health Pathways and Alliancing approach a Community Falls Prevention Alliance had been set up to address the primary prevention, healthy ageing and community services prevention and management aspects of the framework. ▪ already made significant progress in implementing a number of schemes such as Model Ward, Get me Home and End PJ Paralysis which all contribute to promoting independence and preventing decline. ▪ facilitated the first meeting of the Community Falls Prevention Alliance on 25 March 2019, bringing together representatives from multiple services and organisations An update on Stay Steady Clinics; Simulation Training for inpatient staff and Staying Steady Schools was also provided. It was also confirmed that team members from Canterbury would return in May to continue the work on systems development. **The Committee Resolved – that:** a) the progress made by the Falls Delivery Group in the development of the Framework and Community Falls Alliance be noted. b) the new Falls Framework: Reducing risk and harm across the UHB be shared, spread and embedded. c) the development of the Community Falls Prevention Alliance Scope development of an Inpatient Falls Prevention Alliance to address inpatient falls prevention and management be developed. d) uptake and embedding of Simulation Training for inpatient staff be encouraged. e) the second running of Staying Steady Schools scheme for 2019 be implemented. f) Stay Steady Clinics and improved WAST referral pathways to CRT across UHB (Transformation Bid funding dependent) be rolled out. g) links and availability of strength and balance exercise groups in the community to improve long-term outcomes be improved.	
19/04/017	**PRIMARY OUTCOME: PEOPLE ARE SUPPORT TO MEET THEIR NUTRITIONAL AND HYDRATION NEEDS, TO MAXIMISE RECOVERY FROM ILLNESS OR INJURY (STANDARD 2.5)** The Executive Director of Therapies and Health Science presented the Committee with an overview of the UHB's approach to the assessment of compliance against the Health and Care Standard 2.5. As part of this overview the criteria and evidence used to undertake the assessment was discussed. It was also noted that good progress had been made in many areas notably staff catering and public health with reference to the	

delivery of the corporate health standard framework.

The Committee was advised that the implementation of a Model Ward across four wards within the UHB had enabled a standardisation of nutrition and hydration practices across the inpatient setting. It was also noted that the Model Ward had been accepted as a Bevan Exemplar and for a research grant.

Progress in implementing the improvement actions identified as key deliverables for 2018-19 was discussed. The following next steps were brought to the Committee's attention:

- The Nutrition and Hydration Bed plan to be embedded in ward routine and processes as the tool that is used to record patients dietary needs and for the Nursing and Midwifery Board to mandate its use for all wards across the UHB requires further work
- Ward managers take up the role of supporting the implementation of the bed plan on the ward through raising awareness of the benefits of using the tool and auditing its use on the ward
- Review the role of the qualified nurse in overseeing the meal service and develop a role profile
- Ensure new descriptor for dysphagia (IDDSI) knowledge is embedded across the Health board
- Development of a suite of models of delivery for nutrition training offer in the light of reduction in nurse induction time
- Address concerns highlighted in the CHC visit and HIW report around nutrition and hydration at front door following. No funded dietetic service in the Emergency Unit
- Subject to business case approval the Implementation of All Wales catering IT system
- Roll out of model ward for Nutrition and Hydration to other wards in the UHB subject to a funding stream

The Committee acknowledged the work of Rebeca Aylward, Director of Nursing, Medicine Clinical Board and Judith Jenkins, Head of Dietetics in respect of the Model Ward. Committee Members also offered their congratulations to the Multi-Disciplinary Team who had been successful in securing a UK award for efficiency improvements in respect of nutrition and hydration at a the Hospital and Caters Association (HCA) national conference. It was noted that this was the first time the Wales branch of the HCA had won an award in 12-years.

The Committee Resolved – that:

a) progress against the actions identified as key deliverables for 2018-19 be noted.

b) The new challenges set out in the report be noted.

c) A copy of the power-point presentation that accompanied the paper be circulated to Committee Members.

19/04/018	**OVERVIEW OF REGULATION 28 REPORT 2018/19** The Assistant Director of Patient Safety and Quality provided the Committee with an update on the Regulation 28 reports issued by the Coroner to the UHB during 2018-2019. It was noted that during 2018-2019 the Coroner had issued five Regulation 28 reports and had written to the UHB on two further occasions to raise issues following the conclusion of an inquest. The Committee was provided with a brief overview of each of the five cases: The Committee was advised that in two of the cases the UHB had not been informed of the inquest, as a result UHB staff had not been given the opportunity to provide assurance to the Coroner on the processes in place. The UHB's involvement could have potentially avoided the issue of a Regulation 28 report. The Committee was informed that a request for the Coroner's Office to liaise with the corporate departments prior to Inquests had been made. **The Committee Resolved – that:** a) the overview of the recommendations made by Her Majesty's Coroner be received. b) the actions undertaken in response to the internal investigations and Coroner's recommendations be noted.	
19/04/019	**ENDOSCOPY DECONTAMINATION – PATIENT NOTIFICATION EXERCISE** The Executive Nurse Director provided the Committee with an overview of the Endoscopy Decontamination Patient Notification Exercise (PNE), reminding the Committee that during a decontamination process undertaken in August 2018, the UHB had identified that a gastroscope and a video colonoscope had not been adequately decontaminated in line with the manufacturer's decontamination re-processing instructions. The Committee was advised that this had happened because each endoscope contained a sixth internal channel that staff were unaware of. The Committee was advised that: ▪ A multi-disciplinary Serious Incident Management Team (SIMT) had been established and the UHB was worked closely with colleagues from Public Health Wales to investigate the matter. ▪ A total of 111 patients underwent procedures involving the endoscopes. ▪ Patients who received procedures with the two endoscopes may have been placed at a very low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV). Based on this clinical advice, Public Health Wales did not recommend screening for all patients as the risk is very low. However, a telephone line was set up and if a patient wishes necessary arrangements for a simple blood test screening for BBV, can be made.	

	▪ No other six channelled endoscopes were in use in the UHB and all endoscopes in use, were being decontaminated in line with manufacturer's instructions. ▪ The UHB, with the support of Public Health Wales and the Community Health Council, carried out a PNE in the weeks commencing 25th March 2019 and 1st April 2019. ▪ A helpline was provided by Public Health Wales and this was made available from 26th March 2019 – 29th March 2019 and from April 1st to April 5th form the hours of 09.00 to 17.00hrs. ▪ Fourteen patients had contacted the UHB via the telephone helpline and eight of those wished to undergo tests. The Committee Chair thanked Clare Wade for preparing the paper and acknowledged the amount of work that had gone into ensuring the PNE was effective. It was confirmed that the information and learning would be shared with other Directors of Nursing and Clinical Boards. The Executive Director of Therapies and Health Science also commended the work of the team and highlighted the need for a central decontamination department and strengthened centralised decontamination facilities and standard UHB wide procedures. It was agreed that the Executive Director of Therapies and Health Science would bring a progress update to a future Committee meeting. **The Committee Resolved – that:** a) the actions taken in response to the decontamination incident be noted. b) the outcomes arising from the Patient Notification Exercise be noted. c) all the necessary steps had been taken to avoid a re-occurrence of this incident and that all reasonable steps had been taken in respect of the affected patients d) the learning from the incident and Patient Notification Exercise should be shared Directors of Nursing and Clinical Boards e) a progress updated should be scheduled for a future meeting of the Committee.	FJ
19/04/020	**CANCER PEER REVIEW: THYROID (STANDARD 3.1)** The Executive Medical Director outlined the findings of the initial review of the UHB's Thyroid Cancer Services which took place on 3 December 2018. As part of his summary the Executive Medical Director noted that while no immediate risks had been highlighted, the following serious concern had been noted: ▪ *Rare, advanced and complex cancer cases*: As the number of cases are small the panel suggest the MDT should agree the criteria for rare and complex cancer cases to be referred to a nominated specialist centre/s for treatment and management.	

	The Executive Medical Director outlined the six areas for improvement highlighted as part of the review. It was confirmed that the improvements needed required collaborative working at a regional level and through the Cancer National Network. The fact that members of the Peer Review team also had a role as part of the Cancer National Network was noted. The Executive Medical Director confirmed that he would continue conversations outside the meeting with the Cancer National Network to ensure their full engagement. **The Committee Resolved – that:** a) the report on the Thyroid Cancer Peer Review be noted. b) appropriate assurance had been provided in relation to the trends, themes and resulting actions, including the plans to address areas of concern.	
19/04/021	**NATIONAL HIP FRACTURE DATABASE (NHFD): IMPLICATIONS OF THE 2018 NHFD ANNUAL REPORT FOR PATIENT CARE IN CARDIFF AND THE VALE** The Executive Medical Director provided the Committee with an update on the NHFD, confirming that the 2018 Annual Report focused on case mix adjusted 30 day mortality and six new Key Performance Indicators (KPIs). It was noted that Welsh Government require UHBs to report quarterly on their progress against the six KPIs. The eight key findings set out in the NHFD Annual Report, and the UHB's response to these were discussed by the Committee. It was confirmed that: ▪ Findings highlighted a need to re-design the admission and treatment pathways; ▪ Work was in hand to unify the approaches to pre-op. and post-op. care bundles for hip fracture and general trauma patients. ▪ The Clinical board had invested in two trauma nurse practitioners to support patient flow from the Emergency Unit to the perioperative phase ▪ value ward based social worker (± AHP) will be explored through the Lightfoot work streams. ▪ Two different teams would be created and be responsible for flow at the front and back door and design the metrics. A separate team would be formed for the theatre environment who would redesign the way the list was run inside the theatre. Work needed to be undertaken with the ambulance service and for patients to be prepared for theatre. Less theatre time and beds would be used and instead of discharging back to residential home patients could be discharged to their home. ▪ The Challenge was the need for clinicians both in and out of hospital to adhere to the pathways and deliver on making change	

	occur. ▪ The Clinical Board would be happy to update the Committee on the progress of the Lightfoot work later this year. **The Committee Resolved – that:** a) the Surgical Board action plan be agreed. b) an update on the Lightfoot work be added to the Committee Work Plan.	GM
19/04/022	**HEALTHCARE INSPECTORATE WALES (HIW) ACTIVITY UPDATE** The Assistant Director of Quality and Safety provided the Committee with an update on the inspections and reviews undertaken by Healthcare Inspectorate Wales and the findings arising. It was confirmed that: *Thematic reviews* ▪ The final report of a review of *Patient discharge from Hospital to General Practice* was issued in August 2018. It was noted that an action plan was under development and would reported to the Committee in June 2019. ▪ The report of the All Wales Joint Thematic review of Community Health teams was published in February 2019. It was noted that the UHB had developed an improvement plan to address the findings. ▪ The UHB had participated in phase 1 of a review that set out to answer the question *How are Healthcare services meeting the needs of young people?* It was noted that although a phase 2 was anticipated it was not undertaken. HIW published their final report on 22 March 2019 and this will be reported in full at the Committee meeting scheduled for June 2019. *Special reviews* ▪ In March 2018, HIW commissioned an Independent Review of how Abertawe Bro Morgannwg University Health Board (ABMUHB) handled abuse allegations made against (KW). One of the patients who made an allegation against KW was a patient of Cardiff and Vale UHB and, as the UHB remains a commissioner of learning disability services from ABMUHB, it was recognised as a stakeholder in this process. It was noted that a stakeholder meeting was held on 19 April which was attended by the UHB who have fully engaged in the process as required. *Announced visits* ▪ Vale Locality Mental Health Team: Feedback was largely positive. There were no immediate assurance issues. It was confirmed that the UHB had submitted an improvement plan and was currently awaiting confirmation that HIW was satisfied with the steps being taken to address the findings. It was confirmed that the findings would be reported to the Committee in more detail in the next	

report to Committee in June 2019.

Unannounced inspections

Two unannounced visits had been undertaken, namely:

- a visit to Mental Health Services at Hafan Y Coed during the week commencing 18 March 2019. It was noted that feedback was very positive with no immediate assurance issues and that the findings would be reported in more detail at the June 2019 Committee meeting
- The Emergency and Assessment Units (EU/AU) at University Hospital of Wales during week commencing 25 March 2019. It was noted that while the reviewers could not speak highly enough of the staff that they met over the three day visit, immediate assurance issues in relation to the suitability of the Lounge area in the AU as an area for unwell patients who want to sleep and/or lie down, staffing levels in the Medical Assessment care Unit (MACU), checks in relation to the resuscitation trolley, fridge temperatures had been identified.

The Committee was provided with an overview of the immediate actions taken to address the concerns raised and it was noted that in lieu of the fact that the HIW report was yet to be received a more detailed discussion would take place in the private session that followed.

Primary Care Contractors

It was noted that an announced visit to a Dental Practice in Cardiff and the Vale had resulted in an immediate assurance issue in relation to the recording and monitoring of fridge temperatures. It was noted that this had been addressed by the practice and that HIW had confirmed that they were satisfied with the action taken. It was confirmed that a full update on primary care inspections would be presented to the June 2019 meeting of the Committee

The Committee Resolved – that:

a) the level of HIW activity across a broad range of services be noted.

b) the appropriate processes were in place to address and monitor the recommendations.

c) a further report be considered when the Committee met in June.

d) HIW be reminded of the need to send copies of all reports to the Chief Executive so that robust corporate governance arrangements could be implemented.

19/04/023 **COMMITTEE SELF-ASSESSMENT OF EFFECTIVENESS**

A verbal update was provided by the Director of Corporate Governance on the Committee's Self-Assessment of its effectiveness. It was

	confirmed that the Communications Team were coordinating feedback from Committee Members using Survey Monkey, and that survey questions would be circulated by the end of the week. **The Committee Resolved – that:** a) the verbal update on the Committee Self-assessment process be noted and an update be provided at the meeting of the Committee scheduled for June 2019.	NF
19/04/024	**ITEMS RECEIVED FOR NOTING AND INFORMATION** The Assistant Director of Patient Safety and Quality provided a summary and update in relation to the key patient experience, quality and safety issues escalated by Clinical Boards. As part of this summary the following points were highlighted: *Clinical Diagnostics and Therapeutics Clinical Board* ▪ Issues had been raised by Podiatry in relation to heel pressure ulcers, and escalated to the Chair of UHB Pressure Ulcers Group so that themes and trends could be reviewed. It was noted that the Clinical Board would continue to ensure that such issues were escalated. ▪ Phlebotomy at Barry was reporting a marked increase in demand on its services and there has been an increase in complaints from patients. It was noted that information had been sent out to GP Practice Managers regarding the service, and an extra phlebotomist has also been sent to Barry Hospital to provide additional resource. *Specialist Services Clinical Board* ▪ The issues related to Urology Services for spinal injury patients in Rookwood remained unresolved. It was noted that Urology had raised concerns about the suitability of the area provided in Rookwood for the service but the nature of these concerns remained unclear. ▪ The Joint Accreditation Committee ISCT and EBMT (JACIE) inspections of the South Wales BMT Programme had been positive especially regarding Quality management/data management/processes/protocols, but the state of the physical facilities at UHW site (adults) had been highlighted as a weakness. **The Committee Resolved – that:** a) the key patient experience, quality and safety issues highlighted in the report be noted and further updates brought to future meetings of the Committee.	RW
19/04/025	**ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD / COMMITTEE**	

	The Committee Chair confirmed that the following items should be brought to the attention of the Board: ▪ The Committee's feedback on the Annual Quality Statement and the action agreed. ▪ The key findings and recommendations arising from the Annual Health and Care Standards audit. **The Committee Resolved – that:** a) the Committee's feedback on the Annual Quality Statement and the action agreed, together with the key findings and recommendations arising from the Annual Health and Care Standards Audit be brought to the attention of the Board.	SE
19/04/026	**REVIEW OF THE MEETING** The Committee Chair facilitated a review of the meeting. Members confirmed that: ▪ Discussions and the level of scrutiny was improving in terms of depth and maturity, with open recognition of the key challenges. ▪ the meeting had been managed well in terms of timing and ensuring a focus on the key issues. **The Committee Resolved – that:** a) the review of the meeting be noted.	
19/04/027	**ANY OTHER URGENT BUSINESS** No other business was raised	
19/04/028	**DATE OF THE NEXT MEETING OF THE QUALITY AND PATIENT SAFETY COMMITTEE:** Tuesday, 16 June 2019, Woodlands House, Heath, Cardiff	

MINUTES OF FINANCE COMMITTEE
HELD ON 29th MAY 2019
LARGE MEETING ROOM, HQ, UHW

Present:

John Antoniazzi	JA	Chair, Independent Member – Estates
Charles Janczewski	CJ	Vice Chair (Board)
John Union	JU	Independent Member – Finance
Maria Battle	MB	UHB Chair
Abigail Harris	AH	Executive Director of Planning
Andrew Gough	AG	Assistant Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Robert Chadwick	RC	Executive Director of Finance
Ruth Walker	RW	Executive Nurse Director
Sharon Hopkins	SH	Deputy Chief Executive
Steve Curry	SC	Chief Operating Officer

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Len Richards	LR	Chief Executive
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director

FC 19/053	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 19/054	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 19/055	**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 WHSSC sub-committee and declared an interest in discussions in respect of WHSSC.	

FC 19/056	**MINUTES OF THE BOARD MEETING HELD ON 24th APRIL** The minutes of the meeting held on 24th April 2019 were reviewed for accuracy. **Resolved – that:** The minutes of the meeting held on 24th April 2019 were approved by the Committee as an accurate record.	
FC 19/057	**FINANCE REPORT AS AT MONTH 1** The Deputy Director of Finance presented the UHB's financial performance to month 1 and highlighted that the UHB had reported a deficit of £0.658m which was made up of £0.383m operational overspend and £0.275m RTT costs incurred at risk. In response to a query from the UHB's Vice Chair (CJ) it was confirmed that the UHB and Welsh Government were continuing discussions over the level of additional funding that would be made available to the UHB to cover the additional costs of improving UHB performance. The UHB's approach to delivering improvement against performance targets had previously been discussed by the Committee and the identification of costs incurred at risk at month 1 was consistent with the reporting requirement previously agreed. In this context the Independent Member - Finance (JU) asked for clarification over the point in time when the UHB would need to reconsider operational plans in order to recover the excess costs of RTT by year end. The Director of Finance indicated that this was under continual review and added that discussions with Welsh Government indicated that an additional allocation for performance would be provided in 2019/20 and that the risk to be manged by the UHB lay around the actual level of funding that would be provided and whether this would provide adequate coverage for the excess costs incurred. The UHB Chair concurred and indicated that this was a common assumption held by Health Boards. The UHB Vice Chair (CJ) asked whether it was the UHBs intention that the excess costs of RTT would continue to be included in the UHB position and highlighted on a monthly basis. In response the Deputy Director of Finance confirmed that this principle had been adopted by the UHB and that the excess costs were also included and highlighted in the monthly financial monitoring return provided by the UHB to Welsh Government. Moving onto the Finance Dashboard the Committee was informed that 4 measures had been RAG rated Red namely: remaining within revenue resource limits; the reduction in the underlying deficit to £4m; the delivery of the recurrent £16.345m 2% devolved target; the delivery of the £14.9m recurrent/non recurrent corporate target. It was also confirmed that delivery of the 2019/20 plan would not enable the UHB to meet its statutory duty to ensure that its expenditure did not exceed the aggregate of the funding allotted to it	

	over a period of 3 financial year; the rolling deficit reported by the UHB over the 3 year period from 2017/18 to 2019/20 would be £36.7m if the UHB delivered a balanced plan in 2019/20. A surplus of £0.020m was reported against income budgets and it was noted that were no discernible trends at month 1. The Committee was informed that total pay budgets were broadly balanced at the end of month. The Deputy Director of Finance warned that the £0.320m overspend against nursing budgets at month 1 was a significant concern and added that If the adverse run rate on nursing budgets continued at the same rate an overspend of £3.840m could occur by the end of the year. It was noted that the projection excluded costs in relation to nurse overseas recruitment plans which were estimated at c13k per overseas nurse recruited. The Finance Committee Chair (JA) observed that the month 1 nursing overspend was a continuation of the trend recorded in 2018/19 and asked how the UHB planned to manage this position moving forwards. The Deputy Director of Finance confirmed that the nursing position had been escalated via the performance reviews; the UHB had not yet secured plans to remedy and recover the nursing position by year end, however it was noted that the overspend against nursing pay was broadly balanced at month 1 by pay underspends against other staff groups. The Chief Operating Officer confirmed that the nursing position was prioritised at performance review meetings and indicated that specific plans had been developed by the Medicine and Surgery Clinical Boards to manage the pressures. It was also expected that the closure of winter beds and the reconfiguration of services would reduce the pressure on the UHB's nursing capacity. In response to a query from the UHB Chair (MB) around immediate actions, the Chief Operating Officer confirmed that best practice in respect of specialling and sickness management was shared with Clinical Boards for incorporation within action plans where required. Turning to non pay, an overspend of £0.649m was reported at month 1. A large part of the overspend was due to the £0.275m of RTT costs incurred at risk; in addition the overspend due to pressures in Primary Care and Medicine drugs budgets were highlighted. In respect of Clinical Board performance, the largest in month overspends had been incurred in the Medicine and Surgery where the overspends were primarily driven by nursing pressures. At month 1 the UHB needed to identify a further £3.347m of cost reduction schemes to meet is £31.245m savings target. The Director of Finance stressed that the impact of any remaining CRP shortfall would be reflected in the month 3 position and that unidentified savings had not affected the month 1 position. The committee was noted that the Public Sector Payment Compliance score had exceeded the 95% target in April. The Finance Committee Chair (JA) observed that the month 1	

	position was concerning and indicated that the UHB would need to see how the position unfolded over the coming months before an assessment of any additional action required could be considered. The Director of Finance agreed and added that the flexibility available to the UHB to address pressures though investment slippage and the balance sheet was limited. On this theme the UHB vice chair (CJ) asked whether the UHB had undertaken any sensitivity analysis around the financial pressures facing the UHB and the Deputy Director of Finance confirmed that the UHB maintained a list of risk and opportunities that was re-assessed on a continuing basis to inform the year end forecast position. **ASSURANCE** was provided by: • The scrutiny of financial performance undertaken by the Finance Committee and the UHBs intention to recover the year to date deficit and deliver a break even position by the year end as planned. **Resolved – that:** The Finance Committee **noted** that the UHB has an approved IMTP which includes a balanced Financial Plan for 2019/20; The Finance Committee **noted** the £0.658m deficit at month 1 which includes a £0.383m overspend on operational budgets and £0.275m costs for improvements in RTT performance; The Finance Committee **noted** the key concerns and actions being taken to manage risks	
FC19/058	**COST REDUCTION PROGRAMME AND CROSS CUTTING THEME** The Assistant of Finance asked the Finance Committee to note the 2019/20 Cost Reduction Report which included the following key points: • At 30th April 2019 £15.298m of schemes had been identified as Green or Amber against the devolved 2% savings target of £16.345m, leaving a gap of £1.047m. £13.528m of the identified schemes were recurrent. • Schemes totalling £12.600m had been identified as Green or Amber against the £14.900m corporate and high value opportunities target as at 30th April 2019 leaving a shortfall of £2.300m to be identified. The recurrent effect of the identified schemes was £12.900m. The Committee was informed that the shortfall against the cost reduction target for the Surgery Clinical Board was a concern which had been escalated through the performance review process. The Director of Finance added that the gap against the recurrent savings target would have an impact on the reduction to the	

	Underlying Deficit and would require review as the year progressed. The UHB Chair (MB) asked how the UHB was addressing the shortfall against the Corporate Target and the Director of Finance confirmed that the UHB was considering further efficiency, workforce and service changes and that this tied in with the themes explored with Canterbury Healthcare and Welsh Government Finance Delivery Unit. The Chief Operating Officer added that it was important that the UHB ensured that Clinical Boards remained on side in the delivery of corporate savings themes which cut across the organization and where the target is currently held centrally. **Resolved – that:** The Finance Committee **noted** the progress against the £31.245m UHB savings requirement for 2019/20.	
FC19/059	**RISK REGISTER** The Director of Finance presented the 2019/20 Risk Registers and highlighted to the Committee that 5 of the risks identified on the 2019/20 Risk Register were now categorized as extreme risks (Red) namely: • Reduction in the £36.3m underlying deficit b/f to201 19/20 to the IMTP planned £4m c/f underlying deficit in 2020/21; • Development and delivery of the 2% delegated recurrent CIP (£16.4m); • Development and delivery of corporately led financial opportunities of £14.9m to achieve year end break even position; • Management of Budget pressures; • Management of Nursing overspend - £0.320m month 1. Turning to other risks, the Director of Finance indicated that new concerns around the containment of IT developments had emerged since the distribution of the Committee papers. The concerns centred around the availability of additional Welsh Government funding to cover the cost of extending software licences and developing clinical systems. The risk rating would be reviewed in light of the new concerns. It was noted that the UHB expected the risk around increased employer's superannuation payments to be managed by Welsh Government. The UHB Vice Chair (CJ) asked whether the Committee thought that	

	there current scoring of the delivery of RTT within resources available was adequate in light of discussions and the Committee agreed that the scoring at 12 was a fair reflection of the current risk. **Resolved – that:** The Finance Committee **noted** the risks highlighted within the 2019/20 risk registers.	
FC 19/060	**MONTH 1 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 19/061	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD/OTHER COMMITTEES** The Director of Finance asked for the month 1 financial position and the additional red rated items on the Risk Register to be brought to the attention of the main Board. **Resolved – that:** The month 1 financial position and the additional red rated items added to the Risk Register were to be brought to the attention of the main Board.	
FC 19/062	**DATE OF THE NEXT MEETING OF THE BOARD** **Wednesday** 26th June**; 2.00pm;** Coed Y Nant Meeting Room, Ground Floor, HQ, Woodland House	

CONFIRMED MINUTES OF THE STRATEGY AND DELIVERY COMMITTEE
HELD ON TUESDAY, 30 APRIL 2019
EXECUTIVE MEETING ROOM, WOODLANDS HOUSE

Present:		
Charles Janczewski	CJ	Vice Chair
Dawn Ward	DW	Independent Member – Trade Unions
Eileen Brandreth	EB	Independent Member – ICT
In Attendance:		
Abigail Harris	AH	Executive Director of Planning
Chris Lewis	CL	Deputy Finance Director
Fiona Kinghorn	FK	Executive Director of Public Health
Martin Driscoll	MD	Executive Director of Workforce and OD
Nicole Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Dr Sharon Hopkins	SH	Deputy Chief Executive / Director of Transformation and Informatics
Steve Curry	SC	Chief Operating Officer
Secretariat:	GM	Glynis Mulford
Observer:		
Urvisha Perez	UP	Wales Audit Office
Apologies:		
Gary Baxter	GB	Independent Member - University
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
John Antoniazzi	JA	Independent Member - Estates
Robert Chadwick	RC	Executive Director of Finance
Sara Moseley	SM	Independent Member – Third Sector

SD: 19/04/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the Strategy & Delivery meeting.	**ACTION**
SD: 19/04/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
SD: 19/04/003	**DECLARATIONS OF INTEREST** Charles Janczewski declared his interest as Chair of the Quality and Patient Safety Committee at WHSCC.	
SD: 19/04/004	**MINUTES OF THE BOARD MEETING HELD ON 5 MARCH 2019** Subject to a few minor amendments the minutes of the meeting were agreed as a true and accurate record. **Resolved – that:**	

	(a) The Committee approved the minutes of the meeting held on 5 March 2019.	
SD: 19/04/005	**ACTION LOG FOLLOWING THE LAST MEETING** **Resolved – that:** The Committee **REVIEWED** the Action Log from the March meeting.	
SD: 19/04/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** There had been no Chairs actions taken since the last meeting.	
SD: 19/04/007	**SHAPING OUR FUTURE WELLBEING IN OUR COMMUNITY PROGRAMME** The Executive Director of Planning presented the report. Members had previously received an in depth paper at the Board Development meeting. The following comments were made: • The report ensured services and infrastructure were in place and gave an update on the latest tranches from the programme and the All Wales Capital Programme. • Two projects were at a critical stage and the Board would receive a detailed business case on the £20m funding to complete Cogan and the Maelfa Wellbeing Hubs which were linked to the local authority. • This was a positive step forward in terms of the wider population being co-located. The Maelfa was part of a redevelopment scheme including upgrading community facilities and housing. • Progress confirmed we were in the latest tranches of work but needed to accelerate and move faster on the Barry Health and Wellbeing Hub. Clinical Boards were discussing ideas on the needs of the service. Further discussion would take place shortly regarding these plans with the Vale Local Authority. • In relation to North Cardiff, the GP lead was pushing for support in planning for a Health and Wellbeing Centre. In particular regarding the population growth and the added pressure with resourcing planning. • The Quality and Health Impact Assessment did not raise any issues and gave assurance that the Board received quality of work and was focussed. • Members stated the report presented a good example of how we were implementing the wellbeing hubs into the strategy. • In response to the Cardiff Royal Infirmary (CRI) being fit for purpose, it was explained that the programme business case was delayed as Welsh Government had changed their approach. The business case had also been updated. The programme business case would be circulated to Members. • Cardiff Royal Infirmary required significant investment as it was a listed building. There was expectation that the Health and Social Minister who was supportive of the plan, would endorse the work	AH

	programme and enable the business case to go through quickly. There would be a discussion on the constituency and advice would be taken on who we need to keep engaged locally. There would be a series of business cases to ensure the work was completed over time. • The CRI Chapel would be the heart of the Health and Wellbeing Centre for the community. Other spaces would be utilised to bring areas of the building into life. **Resolved – that:** (a) The Committee noted progress made in relation to the development and implementation of the SOFW: In Our Community Programme	
SD: 19/04/008	**SCRUTINY OF THE CAPITAL PLAN** The Executive Director of Planning presented the report informing that the Finance Committee had confirmed we were on track with the latest schemes. The following comments were made: • The report highlighted where we were in terms of investment required. It acknowledged that the capital programme was large and some of the red displayed within it had a knock on effect in terms of slippage. • The Committee was informed that there would not be a dedicated trauma centre in place by April 2020 as the build was being undertaken in a court yard and there was no access. This added to the complexities as well as keeping services running. • Management Executive agreed for a process being put in place to receive early warning signs from the team by alerting them to potential slippage so that intervention could occur before this happened and was working through a process. **Resolved – that:** (a) The Committee recognised the difficulty in managing a large and complex programme of works within a limited resource be noted (b) The Committee 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	
SD: 19/04/009	**UPDATE ON THE CLINICAL SERVICES PLAN** The Executive Director of Planning presented the report. The following comments were made: • There had been wider discussion at Board Development where it was agreed to focus engagement on the principles and the shape. For example, UHL would grow into a complex surgery. An EHIA would need to be undertaken so as not to effect a particular group of patients. A meeting would be arranged with the Community Health Council to agree the principles to the approach.	

	Involvement of advice and the quality of service would be beneficial in driving the UHL redevelopment. This would accelerate our services. • New access measures would emerge once the GMS negotiations concluded. • As not all planned services would be in place this would need to reviewed continually over the next 10 years and nuancing the scale in what was needed. • Regarding unscheduled care there was a need to ensure wider engagement filtered down to all staff as they would be involved in the carrying out services. • Engagement with communities would involve a series of events. Sessions based on the Canterbury working and Amplified 25 would also be considered. **Resolved – that:** (a) The Committee noted progress to date on the development of the UHBs strategic clinical services plan and the emerging clinical models for UHW and UHL.	
SD: 19/04/010	**A HEALTHIER WALES – IMPLEMENTATION UPDATE** The Executive Director of Planning presented the report, stating our strategic intent was in line with Welsh Government. The following comments were made: • To take stock and keep on top of all of the actions in A Healthier Wales and to ensure that as an organisation we were working through delivering the design principles, how we achieve our strategic objectives and if there was a close alignment. • To consider how we have a conversation with the public in how things would change. It was acknowledged that the model of care needed to look different but as yet the mechanisms were not in place to drive this forward, although we were on track with the things we could influence on a national agenda. • Some of the projects were encouraging and a good piece of work to be undertaken was to make comparisons in its application. Staff were more interested in what the purpose was. • The Clinical Board Directors would put items on their agendas to take to meetings. • Work was needed to be undertaken with the Regional Partnership Board. A workshop had been arranged to take stock of the action and consider accelerating the Health and Social Care agenda. We had set ourselves the year 2025 for our Strategy to be completed and to start the build for a new hospital. • Collectively with the Vale of Glamorgan we spend nearly £2b in using money on resource and prevention. Our Regional Partnership Board (RPB) was in a good place in terms of understanding how we make preparations for the next change. • Alastair Roeves from Welsh Government would be working with Canterbury to weave into the WG approach and align this with the	

	Health Boards direction of travel. Invitations would be sent out to people from various stakeholder groups and through the Amplify 25 programme would endeavour to understand the vision through natural process by being more flexible through our approach. • Also discussed was the modifications in Health Care globally and how this was delivered in a different way. There was an important shift in the way we think and work. • There was a need to develop the clinical plan and respond to the new ways of working. • Welsh Government was taking an increasing shift to measure what matters in outcomes and increasing interest in how we measure outcomes. **Resolved – that:** (a) The Committee discussed the contents of the report and confirmed it was assured that the Health Board was taking appropriate action to implement A Healthier Wales, which was aligned to Shaping Our Future Wellbeing	
SD: 19/04/011	**SHAPING OUR FUTURE WELLBEING: STRATEGY REVIEW** The Executive Director of Planning presented the report. The following comments were made: • The Health Board was coming to the midway point of the strategy and was taking stock whether the strategy was fit for purpose and how we were progressing against it. • The paper focused on pieces of work in the Strategy and was a subjective view of pulling the IMTP together and to see where we were by drawing out exemplars and using some indicators that would not normally be reviewed. • This was a helpful way in looking at specific areas that had made good progress. It also presented an opportunity to look forward at what was left to do and put some milestones in place. • The data activity articulated the actions that delivered the transformation programme. It also articulated some of the IMTP to ensure it did not sit outside. In addition, it reviewed the key milestones and tried to put these under headings. • The ability to enable the organisation to come up with the next step and health pathways was moving in the direction of travel and within the aims of the strategy. • Work regarding the Outcomes Framework and Lightfoot helped to develop this piece of work and there would be a workshop next week. • The UHBs role as tertiary and specialist provider did not come through clearly in the strategy. Ian Langfield from Welsh Health Specialised Services would be seconded for two years working solely with the Health Board on what was our role to meet the agenda. An update had been provided at the Health Systems Management Board (HSMB) where it was explained how our clinical services plan regarding genomics was developing and the cell and gene service was excelling.	

	Resolved – that: (a) The Committee agreed the direction of the strategy and its strategic objectives continued to provide a clear and effective direction for the organisation and it was not recommended that the objectives be amended. (b) Identified our strategy as a specialist services provider on a regional and national basis within the context of Shaping Our Future Wellbeing (c) The Committee agreed to ensure partnership working was the norm for all areas of activity in the next phase of strategy deployment in line with A Healthier Wales. The Strategy would only be delivered in a partnership, whilst progress had been made through our Regional Partnership Board arrangements	
SD: 19/04/012	**ENSURING THAT SERVICE, QUALITY, FINANCE AND WORKFORCE ARE ALIGNED AND INTEGRATED** The Executive Director of Workforce and Organisational Development presented the report where an example of filling band 5 nurses was chosen to see how we were demonstrating looking at issues across the whole structure. The report was in line with most of the UK where there had been challenges in the nursing workforce. There was success in attracting nurses to Wales but even with the programmes in place there was still a gap. The following comments were made: • Our position had improved with 231 nurses being employed but recognised there was still a number of posts which needed to be filled. This had been discussed at the Local Partnership Forum. • A number of conversation had been undertaken through MDTs. The recommendation from the group was to go back to the international service as the retention rate for overseas staff was high at 88%, although this would be at a cost to the Health Board, there was a financial benefit. • The programme was being worked on collectively to share the approach in the cost envelope. The second step which needed to be undertaken in order to build some workforce plans. • To recognise the complexities of the Health Board with the amount of numbers coming in and out and how not to repeat where we had been before. This issue was around the retention of the nurses. • The Group listed the lessons learnt from the last time and was working on embedding them into the society and culture of the organisation. • There was a need to provide pastoral support for overseas staff and The UHB was using Filipino nurses to support new staff coming over. • The Health Board had good success with being a good place to work and learn, especially with the student cohort. • This was a blended approach with regards to the financial aspects and offered value for money. There needed to be a deliberate strategy to be carefully managed with pace and timing. This was	

	about investment and it did carry a risk which was understood and shared at Management Executive and Clinical Board level. • The paper demonstrated how these were being aligned and this showed an example. • There was a design principle about balancing on quality, activity performance and finance. • The report provided the ability to see practically how the alignment was working and as a Committee, needed to be assured that colleagues across the Health Board were working in an integrated way and not in silos. **Resolved – that:** (a) The Committee noted the Report on Integrated Working	
SD: 19/04/013	**DIGITAL HEALTHCARE UPATE** The Director of Transformation provided a verbal update on Digital Healthcare. The following comments were made: • Part of the restrictions encountered was the way we do business. It was explained that systems come in and were delivered to the organisation but there was no understanding of what the staff required. • The way in which this was organised had changed significantly with digital managers placed in each Clinical Board. This looked at what was needed in a more helpful way. • Two pieces of work had been undertaken on accessible information and base work on the electronic patient record. This would enable our own local and national records to be able to talk to each other. This was a national piece of work and fast tracking of what we needed to do locally with detailed work behind the scenes to make this happen. Lots of things were being linked together and needed storage to draw everything together. Also explained was how the records were drawn together from different systems. • Work had been undertaken on Dashboarding which was demonstrated by design and a ward dashboard with aggregated data which drilled down to patients. • The outcome of this work was that three awards had been shortlisted for the MJ Awards with significant work around PROMS. • The work with Lightfoot (who were one of the companies that partnered with Canterbury) enabled clinicians and staff to make much more rapid decisions in terms of flow. • Workshops had been scheduled and a bid for a five year partnership with Lightfoot had been submitted to Welsh Government. • Another system called Patient Knows Best was a portal for both staff and patients. This provided patients with access to their records and the system was waiting to be implemented	

	into the organisation. The implementation was being prepared in the speciality areas that were running the project first. • All these systems do slightly different things but needed to work together. If we get all this right it will be easier for people to put things together for them to move forward. • A further document would be presented at a future meeting. • The strategic outline case has been refreshed and will come to next meeting. **Resolved – that:** a) The Committee noted the update and b) The Strategic outline case would come to the June meeting and c) A further report at a future meeting.	 SH SH
SD: 19/04/014	**DEVELOPING A PERFORMANCE FRAMEWORK** The Chair introduced the report stating it was a piece of work the Director of Transformation was engaged with to look at what needed to be dealt with at each Committee to ensure we were not duplicating work. The Director of Transformation made the following comments: • There were a number of targets and indicators associated with the Wales Delivery Framework and what was adding value by reviewing material used to make daily, weekly or yearly decisions and in turn how this could be value added for the Committee. • The measures were reviewed and what was routinely used for business. • 32 of the 42 measures were actively used on a weekly or monthly basis and was used to inform whether they were progressing. For our organisation improvement trajectories were set and not just RAG rated. It was found that 10 indicators were not used routinely. • These indicators should be looked at to see whether the Committee could add value and how they may be better used in the organisation. • One of the measures not useful was ERAS and suggested this measure should not be considered at this stage. • Eight measures were not routinely used but one of them may be helpful and was doing work with relevant leads around this. For example the reduction in number 20 and know this was a good indicator in how we are managing chronic conditions. These do get reported to the Board on an annual basis and would see all of these being reported in the Board report. These are not routinely informed for business. • For the 32 measures routinely reviewed it was suggested they would only be brought by exception. • To consider looking at indicators not being used with the advice of how they could be applied and scrutinise an area that	

	was not subject to routine measures. • Informing those indicators we were not currently using to see how they can be helpful or valuable indicators. • The development of the Outcomes Framework was being worked through and were using the outline of Canterbury. • There was a need to have a balance of scrutiny and challenge through the next phase to see what the work looked like. • Dashboards ranged from validated to unvalidated and a currency needed to be agreed. • Some public health indicators were only seen on an annual basis and there was a need to know how they were used in the organisation to inform our business. • The direction of travel was encouraging and recognised reviewing 42 measures would not be manageable. There was a need to have a balance and identify areas necessary to scrutinise, it was agreed to meet outside the committee and look at the indications at the next Committee. • To ask Wales Audit Office if there was anything to be shared form other Health Boards. **Resolved – that:** (a) The Committee agreed to only scrutinise routinely reported measures by exception as advised by the lead Executive (b) The Committee considered scrutinising those indicators which were currently not used to actively inform practice, following completion of work outlined (c) The Committee be appraised of areas achieving or exceeding agreed trajectories and / or targets (d) That a report detailing the above be presented in the September committee.	
SD: 19/04/015	**IMPLEMENTATION OF WELLBEING OF FUTURE GENERATIONS (WALES) ACT IN CARIDFF AND VALE UHB - UPDATE** The Executive Director of Public Health presented the report and advised the Health Board was currently being examined by Wales Audit Office on how we are embedding the Act into Health Board strategy and delivery.. There was a Flash report that summarised progress made by the Steering Group against the action plan for 2019/20. The following comments were made: • The Wellbeing of Future Generations (WFG) Act was world leading legislation and internationally there was interest in how this was being implemented. The Health Board was required to take on board implementation of the sustainability principle and five ways of working throughout its business The UHB's wellbeing objectives are the SOFW objectives. • A WFG Steering Group had been set up to oversee and embed the culture change required by the WFG Act and would like to see this as part of our Amplify 2025. The Wales Audit Office had a statutory requirement to ensure the organisation is delivering on	

	the WFG Act. There is a developmental approach about what the organisation will choose to demonstrate how the act is being implemented. Our chosen arena for a detailed review is our SOFW in our community work. • Two workshops would be undertaken and there would be interviews with people who couldn't participate. • Work needed to be done around communication which related to people and staff on the ground and what they can do to contribute to implementing the Act and the five ways to wellbeing. The Committee Chair, Charles Janczewski is the Board Champion for FGW Act and sat on the Steering Group. **Resolved – that:** (a) The actions the UHB are planning for 2019/20 to further embed the WFG Act in the organisation be noted. (b) The Committee noted the attached Flash Report which would provide regular assurance in the future of progress against the Steering Group's action plan to undertake actions required for the UHB to meet its statutory duties under the Act.	
SD: 19/04/016	**KEY ORGANISATIONAL PERFORMANCE INDICATORS** The Chief Operating Officer presented the report. The report covered end of year period relating to tier 1 on the overall plan. The following comments were made: • **Planned care**: It had been a good year and largely delivered on commitments to Welsh Government. The remaining patients related back to tertiary services and a bespoke plan for spinal patients was in progress. • **Diagnostics:** The Health Board was 40 patients short in delivering its target but reflected a year on year improved position. There were additional changes in the rules for cardiology tests and although there was a marked improvement The UHB had not reached its goal. • **Cancer:** Improvements had been made but were below the national target. The position ended at 82% of a 62 day target being met and was 5 short on the IMTP. There was a need to do more work to increase from 80 – 87% this year. In the spring there was a significant increase in referrals with a 20% increase over the year and neurology was a third more. There was a 24% increase in the Upper GI. Cardiff & Vale were the best performing in Wales at just over 90%. • There had been improvement (from a challenging position in follow-up delays) in the trajectory and had the highest volume in Wales. The Wales Audit Office provided an extensive update on Follow-Up Outpatients Report. Our data and systems were defaulting to a conservative position and there was a significant piece of work being undertaken around this. There was a need to be cautious as taking someone of the list could be detrimental. This was a clinical led service guided by our clinicians. Cardiff &	

	Vale were the only Health Board in Wales that had risk stratified against the patients. • This work was continuing and this year there would be actual targets set to achieve and ensure we were working through systems to ensure we were compliant. • **MH Measure:** This was 8.9% higher than last year. There were challenges with CAMHS and work was ongoing to improve the primary care service through reform and capacity changes. In addition, the CAMH service had recently been repatriated back to the Health Board. There was a piece of work to be undertaken to redesign the service. CAMHS performance would be monitored by the Strategy and Delivery Committee. It was suggested for the Committee to review the baseline information for June. • **Unscheduled Care:** This did not meet national requirements although relative performance was good. The four hour position improved and the picture over winter showed year on year improvement. The trend continued to improve throughout Wales and the UK overall. There was a need to build on this going forward. • Figures published by Welsh Government showed The UHB were the best in Wales for four and 12 hour waits. • **DTOCs:** Targets focused on improving 14 day Length of Stay. Thanks were conveyed to Judith Hill who had undertaken work on this area over the past year. The outcome of the Internal Audit Assurance showed a substantial rating. The minister for Health and Social Care during his intended visits to the Regional Planning Board would be looking at DTOC processes. • **Stroke:** The centennial assigns rating levels of A being the best and D not so good. The Organisation retained level B and was rated in one of five in Wales. In regard to the stroke measures, there would be greater emphasis on stroke input and changes going forward. A gap analysis would be undertaken to see how this could improve. Some trajectories had been set to see consistent delivery with Clinical Boards and was looking to attain level A. Overall this was a positive picture for performance. Areas to focus on would be cancer, stroke and unscheduled care. • Improvements from here would become much more difficult. Moving from this point was an issue of volume. The new issue was specialist and would have to go back to the 'X matrix'. There were pathways with transformation improving over time through redesigning and decreasing trajectory, through efficient productivity tactics and moving from one type of working to the other. • It was acknowledged we could not live in the transformation space and must not forget it was the staff taking these projects and services forward and the people who benefited was the patients. • Looking at comparisons within the UK regarding four hour waits, the Organisation were able to help colleagues in other HBs and to share learning with them. It was explained that we did not have a sustainable position and was moving all the time. • The Chair asked Members to reflect on how we could enforce the message to recognise the work staff had accomplished and to thank them for their achievements.	SC

	Resolved – that: (a) Year to date performance for 2018/19 was considered.	
SD: 19/04/017	**WORKFORCE KEY PERFORMANCE INDICATORS / DASHBOARD** The Executive Director of Workforce and Organisational Development presented the report. The following comments were made: • **Sickness Absence Rate:** In looking at absence it was acknowledged that performance in organisations that were doing very well was because they had good leadership and engagement. • The absence rates was the same as last year. Therefore there was a need to have a different conversation on the contributors. • **Job Planning:** There had been a number of conversations with letters disseminated across the Health Board and undertaken training and the outcome was that job planning compliance was very poor. A workshop was being set up with Clinical Boards to explore this. • **Turnover rate**: There needed to be an understanding why people were leaving the Organisation. Work was being undertaken on retaining numbers and staying at the same level. Exit interviews had improved and were looking at people who were leaving the NHS altogether. • **Pay Bill:** There had been an under spend on the pay bill. • Good news on head count showed that 1400 people had been recruited to the Health Board. • **Training**: Although a move in the right direction, fire training needed to achieve 85% compliance. • **PADR rate:** These were not taking place in a timely way and needed to improve. • The People dashboard was a work in progress and the aim was for the dashboard to replace the boxes from the previous format. The new style was more progressive and enabler driven. • Some of challenges were beyond what the Executive Team could achieve and the Clinical Boards were being held to account. The workforce planning was significantly better and would sit with the Director of Operations to work through. **Resolved – that:** (a) The Committee Noted the People's Dashboard.	
SD: 19/04/018	**STAFF SURVEY RESPONSE GROUP REPORT** The Executive Director of Workforce and Organisational Development presented the report. The following comments were made: • Established from the survey was four key themes. A Steering Group had been set up which the Director of Workforce and Organisational Development would continue to chair.	

	• Volunteers would continue to determine how we would make this happen in the next stage and had written to people who had been previously engaged. • This item will be kept live at the Committee. • The Director was thanked for his personal involvement and leadership **Resolved – that:** (a) The contents of the report, the attached action plan and the role of the Staff Survey Steering Group be considered	
SD: 19/04/019	**DEEP DIVE REPORT ON ABSENCE RATES AND HOTSPOTS** The Executive Director of Workforce and Organisational Development provided a presentation. The following comments were made: • The capability of line managers was being built on with 140 being trained. People were being furnished with the skills to have the right conversations for sickness absence. • Work behind the scenes was ongoing with the right level of activity and results was being achieved although not reaching the considered targets. • Regarding health and wellbeing, the highest reason for absence reporting was stress. The key stressors for 2 out of 3 of the workforce was money worries. • There were people employed in the Health Board on low pay and there was a need to look at the whole individual. A programme was envisaged to be set up by Autumn. • An action plan had been put in place which the HR operations team were working on. • It was considered that themes had been inherited that were policing absence and disempowering managers. The team had worked hard over the past 10 months to change the way of thinking. Under the new ethos focus would be on the bigger picture and the root causes of absence. This would be driven through the Maximising Attendance Group. • It was suggested to make links to each of the local councils who could provide assistance through their hubs by offering solutions to financial issues and housing advice. • Public Health were also looking at strengthening prevention across the Health Board in relation to keeping people well and considered to join these two elements together. • Staff were encouraged to approach the Trade Union where they could obtain Welfare Grants. • The principle was how to help our workforce to be more resilient and in a rounded view make people aware of this. • The Chair stated this was a very constructive deep dive in trying to understand as an Organisation how we move forward. **Resolved – that:**	

	(a) The Committee noted the presentation.	
SD: 19/04/020	**STRATEGIC EQUALITY OBJECTIVES – DELIVERY PLAN FRAMEWORK 2018-19** The Equality Manager presented the report. The following comments were made: • There was a legal obligation to have a Strategic Equality Plan in place. • Steady progress had been made during year three of the four year plan and all actions should be completed by year four. • The Annual Equality Plan would be brought to the next meeting. • A Task and Finish Group had been established to explore how to improve our scoring on the Employers Index. The Group was looking at weaknesses and there were no guarantees to return as there were unforeseen elements out of our control. • One of the advantages was The UHB had been consistent but there was work ongoing with the Task and Finish Group. • There were difficulties with staff disclosing their orientation. A communications brief had been written and the purpose was to build on recording nationality. This was down to a trust issue in order for the employer to help them. • The briefing paper that had been shared with people was to take a more directive approach and endeavoured to explain the benefits of the information. **Resolved – that:** (a) The Committee noted the contents of the paper (b) The Committee noted the fourth year SEP delivery plan	KW
SD: 19/04/021	**BOARD ASSURANCE FRAMEWORK: SUSTAINABLE PRIMARY AND COMMUNITY CARE** The Director of Corporate Governance presented the report. The following comments were made: • There were six key risks on the Board Assurance Framework and four were monitored by the Strategy and Delivery Committee. • It was agreed the Committee would look at one risk at a time. • The risk on Sustainable Primary Care would go forward to the May Board meeting. • The purpose of the Committee was to do some check and challenge and ensure the controls in place were working. • It was acknowledged that the Director of Corporate Governance had brought some rigour around risks but thought it would be helpful but difficult to provide a summary on how this could be achieved. It was acknowledged that the work contributed that mitigate the risks were much more extensive and were looking for alternative roles and flexible working.	

	• A lot of work had been undertaken with high level markers that indicated in comparison we were doing well but there was a need to make it resilient and stable. There were a number of milestones and themes going forward such as integration. • Access was another theme and sparked a discussion on how we take these forward that was linked contractually. The non-traditional methods of providing care would be dominant going forward and this needed to be considered carefully. • Governance was another theme and the Multi-Disciplinary Team element of primary care. To prudently provide care that they were working at the top of their licence and people were accessing care at the right level. • A paper was being developed on how this would be going forward. **Resolved – that:** (a) The Committee reviewed the attached risk in relation to Sustainable and Primary Community Care to enable the Committee to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
SD: 19/04/022	**MEMORANDUM OF UNDERSTANDING BETWEEN CARDIFF AND VALE UHB AND THE THIRD SECTOR IN CARDIFF AND VALE OF GLAMORGAN** The Director of Public Health provided an overview of the report. The following comments were made: • The Third Sector play a key role not least in that they can reach people we are unable to. The Health Board commissions around £7m of services from the Third Sector. • The Strategic Framework had been in place for five years since 2012. Services had changed over this time and it was important to review how we continued a bilateral relationship with the CEO of the Third Sector. • The development of the Memorandum of Understanding (MOU) was due to many changes over the past few years including the creation of Public Service Boards and the Regional Partnership Board. The Framework had moved on significantly where stronger relationships had developed. • Health & Social Care Facilitator action plans have also been reframedas part of the approach. • The Steering Group had been stood down. • Subject to confirmation of this paper at a Management Executives' meeting, the Committee would approve the document. **Resolved – that:** (a) The Committee approved the MOU.	FK

SD: 19/04/023	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD / COMMITTEE** • A Healthier Wales Report • CAMHS report	
SD: 19/04/024	**REVIEW OF THE MEETING** • Conversations were focussed and constructive. • It was interesting to see conversations being strategic and not operational. • To talk about what was noted in meeting with the Wales Audit Office. • Felt quality of papers were very good and addressed the demanding responsibilities in the Terms of Reference. This would provide assurance to the Board that we are addressing the issues.	NF / CJ
SD: 19/04/025	**ANY OTHER URGENT BUSINESS** There was no other business to raise	
SD: 19/04/026	**DATE OF THE NEXT MEETING OF THE COMMITTEE** Tuesday, 25 June 2019, 9.00am – 12.00pm Corporate Meeting Room, Headquarters, UHW	

CONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD AT 9.30am on 9 APRIL 2019 IN THE CORPORATE MEETING ROOM, HEADQUARTERS, UNIVERSITY HOSPITAL OF WALES (UHW)

Present:	
Michael Imperato	**Independent Member – Legal (Chair)**
Charles Janczewski	Vice Chair
Akmal Hanuk	Independent Member - Local Community
In attendance:	
Janice Aspinall	Staff Safety Representative
Charles Dalton	Head of Health and Safety
Martin Driscoll	Director of Workforce and OD
Carol Evans	Assistant Director of Patient Safety and Quality
Nicola Foreman	Director of Corporate Governance
Stuart Egan	Staff Lead for Health and Safety
Fiona Jenkins	Director of Therapies and Health Sciences
Fiona Kinghorn	Director of Public Health
Geoff Walsh	Director of Capital, Estates and Facilities
Mark Pinder	Arjo UK Representative (for agenda item HCS: 19/035)
Samantha Skelton	Manual Handling Adviser (for agenda item HCS: 19/035)
Apologies:	
Secretariat:	
Rachael Daniel	Health and Safety Adviser

PART 1

HSC: 19/029 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

HSC: 19/030 DECLARATIONS OF INTEREST

The Chair invited Committee Members to declare any interest in the proceedings included in the agenda. None were declared.

HSC: 19/031 MINUTES OF PREVIOUS MEETING

The minutes of the Health and Safety Committee held on the 22nd January 2019 were **APPROVED** and **ACCEPTED** as a true record with the exception of the following minor amendment:

(i) Charles Janczewski - Vice Chair's apologies to be recorded.

HSC: 19/032 UPDATED ACTION LOG

The Committee **RECEIVED** the Updated Action Log from the previous meeting. The following updates were provided:

- HSC: 19/006 – the Director of Corporate Governance advised the Terms of Reference will need to be presented to the May Board meeting for sign off along with the Committee's Workplan.

  ACTION – Mrs N Foreman

- HSC: 19/015 – the Head of Health and Safety informed the Committee a Managers Safety Course with an accompanying handbook had been developed to support Managers in their role in relation to health and safety and also references their responsibilities for implementing policies and procedures.

  A pilot course was delivered for safety representatives the previous week and was very well received, the course will now be offered to Managers with the first course running in June 2019.

HSC: 19/033 PRESENTATION ON THE ARJO PROACT AUDIT SURVEY FINDINGS

Mr Imperato welcomed Mr Mark Pinder, National ProACT Manager for Arjo UK to the meeting.

Mr Pinder provided the Committee with details of the audit undertaken in November 2018. He added the data was being compared to the two previous audits undertaken in 2016 and 2017 with the trend graphs looking very similar.

The Vice Chair queried whether the community was part of the audit, it was confirmed it was not.

The Independent Member – Local Community queried whether there were any costings associated to the audit, he was advised these were currently being worked up. Mr Hanuk then queried whether this was considered as core or non-core business, this was confirmed as being core business.

The Chair requested assurances at the next meeting on how the results of the audit were to be taken forward. The Director of Therapies and Health Sciences added that a paper will also need to be presented to Management Executive.

ACTION – Mr C Dalton

The Committee **NOTED** the findings of the Arjo Proact Survey and **REQUESTED** assurances on the findings at the next meeting.

HSC: 19/034 BOARD ASSURANCE FRAMEWORK (BAF) – HEALTH AND SAFETY RISKS UPDATE

The Director of Corporate Governance informed the Committee the Corporate Risk Assurance Framework (CRAF) no longer exists and has been replaced by the Board Assurance Framework (BAF) which highlights the big risks for the Health Board.

Each Corporate Department and Clinical/Service Board will have their own risk register and high level health and safety risks should be reported through this Committee. Mrs Foreman added Mandy Collins, Interim Head Corporate Governance would be supporting departments with this process.

The Head of Health and Safety stressed the risk assessment process must underpin the BAF. Mrs Foreman advised the Risk Management Policy was currently being reviewed.

The verbal update in respect of the BAF was **RECEIVED** and **NOTED** by the Committee.

HSC: 19/035 PEDESTRAIN ACCESS SAFETY STRATEGY AND INDEPENDENT SURVEY REPORT

The Director of Capital, Estates and Facilities informed the Committee the key risks had been extracted from the Independent Report which identified three high risk areas:

- Allensbank Road entrance to the roundabout adjacent to the multi-storey car park. Mr Walsh advised this entrance was not under health board control and requires discussion with the Local Authority.

- Residential Road/Heath Park Way delivery/logistics areas. Mr Walsh advised delivery vehicles were queuing on the zig zag lines and to resolve this consideration was being given to removing some of the zebra crossings in the area. He added Shared Services had changed some of their deliveries to avoid a build-up of delivery vehicles. It had also been agreed that Shared Services would arrange for banksmen to be present however there had been no evidence of this and he would continue to work closely with Shared Services.

- Access from footbridge over A48/Dental car park 6 to Gateway Road, there is currently no footpath through the car park to the Dental Hospital.

The Staff Lead for Health and Safety welcomed the report and highlighted a few recent concerns in respect of contractor control and pedestrian safety at University Hospital Llandough. Mr Walsh stated he would discuss these outside of the meeting as they were operational issues that he is not aware of and therefore cannot respond to at this time.

The Head of Health and Safety stated pedestrian safety must be routinely considered as part of the work programme for any contract.

The Director of Workforce and OD noted the three high risk areas and queried whether any timescales had been identified. Mr Walsh advised the report would be considered as part of the Sustainable Travel Plan but there was no programme plan at this time.

The Independent Member – Local Community acknowledged this would not be immediately resolved but queried whether there was any interim strategy. Mr Walsh stated the highest risk related to the stores area and further conversations were required with Shared Services in relation to having banksmen. Mr Dalton added they must take responsibility for banksmen and for ensuring vehicles were not delivering until it was safe for them to do so.

The Vice Chair requested the Committee was kept up to date with progress against the programme of works.

ACTION – Mr G Walsh

Mr Driscoll informed the Committee he was now the Executive Lead for Health and Safety and he would raise at Executive Team.

ACTION – Mr M Driscoll

The contents of the Independent Report was **NOTED** by the Committee.

HSC: 19/036 ENFORCEMENT AGENCIES CORRESPONDENCE REPORT

The Head of Health and Safety informed the Committee the final submission in relation to the contractor fall was being submitted the following day with the preliminary hearing being held on the 2nd May. The outcome would be brought to the July Committee Meeting.

ACTION: Mr C Dalton

Mr Dalton also informed the Committee that the Health and Safety Executive (HSE) was currently undertaking a programme of Well Working Audits of Healthcare. Two Health Boards in Wales had already been audited and it has

been intimated that Cardiff and Vale would be audited in the 3rd quarter although this had not yet been confirmed by the HSE. The audits were focusing on violence and aggression and musculoskeletal disorders and preparations will need to be put in place.

The Chair requested an update be provided to the July meeting.

ACTION – Mr C Dalton

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: 19/037 CONTROL OF CONTRACTORS IN NON-ESTATE ACTIVITIES

The Head of Health and Safety advised this was a progress report following previous submissions to the Committee.

The Chair advised the culture of the organisation would be looked at in any legal proceedings and this was an important paper in respect of the continued progress made by the Health Board in contractor control management in both estates and non-estate activities.

The Independent Member – Local Community requested clarification in respect of the red and amber cards issued to contractors. The Director of Capital, Estates and Facilities advised a red card resulted in the contractor immediately leaving site and the amber card related to a procedural breach, also two amber cards equated to a red card. Mr Walsh added all contractors have to attend the Health Board induction and are then registered on the system. All contractors also have to submit health and safety information to the health board.

The Committee **NOTED** the progress made in relation to both estates and non-estates contractor control activities.

ASSURANCE was provided by:

- The actions and details identified within the report.

HSC: 19/038 FIRE SAFETY MANAGEMENT AND COMPLIANCE REPORT

The Director of Capital, Estates and Facilities informed the Committee there were currently no enforcement notices in place and no significant audits had taken place.

Mr Walsh advised the Fire Service had changed their policy when responding to fires and would now not be sending two appliances and would be driving at normal road speed until an actual fire had been confirmed. Concerns have been raised with the fire service in relation to the high rise buildings on site.

The Staff Lead for Health and Safety informed the Committee as part of workplace inspections he repeatedly sees the tunnels full of items that should not be stored there which impacts on fire safety. Mr Walsh stated the Fire Safety Officers constantly raise the same issue and the estates/waste teams clear on a regular basis but it is a constant challenge to keep the tunnels clear.

The report was **CONSIDERED** and **NOTED** 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: 19/039 HEALTH AND SAFETY IMPROVEMENT PLAN – EXCEPTION REPORT

The Head of Health and Safety updated the Committee on the current status of the improvement plan.

The Vice Chair requested for abbreviations not to be used and noted 52 milestones must be a challenge to manage. The Head of Health and Safety stated this was a live document and the milestones would be updated accordingly.

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: 19/040 HEALTH AND SAFETY RELATED POLICIES SCHEDULE

The Health and Safety Adviser informed the Committee an extra column had now been added to the schedule following a request at the last meeting. This column provided details of the status of those policies which were currently out of date.

The schedule was **NOTED** by the Committee.

HSC: 19/041 SECURITY SERVICES POLICY

The Director of Capital, Estates and Facilities informed the Committee informed the Committee amendments made to the Policy were in relation to managerial changes and policy format.

The policy was **APPROVED** by the Committee.

PART 2

HSC: 19/042 COMMITTEE WORK PROGRAMME FOR 2019/20

The Work Programme for 2019/20 was **RECEIVED** and **NOTED** for information by the Committee.

The Director of Corporate Governance advised the work programme required some amendments which she would take forward.

ACTION – Mrs N Foreman

HSC: 19/043 REGULATORY REVIEW AND TRACKING REPORT 1ST APRIL 2018 – 31ST MARCH 2019

The Regulatory Review and Tracking Report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/044 HEALTH AND SAFETY IMPROVEMENT PLAN (IN DETAIL)

The improvement plan was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/045 LONE WORKER DEVICES REPORT

The report was **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/046 ENVIRONMENTAL HEALTH INSPECTION REPORT OF BARRY HOSPITAL ON 13TH MARCH 2019

The report was **RECEIVED** and **NOTED** for information by the Committee. It was noted that a hygiene rating score of 4 had been achieved.

HSC: 19/047 OPERATIONAL HEALTH AND SAFETY GROUP MEETING OF DECEMBER 2018

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/048 FIRE SAFETY GROUP MINUTES OF DECEMBER 2018

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/049 **WATER SAFETY GROUP MINUTES OF DECEMBER 2018**

The minutes were **RECEIVED** and **NOTED** for information by the Committee.

HSC: 19/050 **REVIEW OF THE MEETING AND ITEMS TO BRING TO THE ATTENTION OF THE BOARD OR OTHER COMMITTEES**

The Director of Workforce and OD stated operational issues should be taken to the Operational Health and Safety Group with the appropriate individuals present and not discussed at the Committee meeting.

HSC: 19/051 **DATE AND TIME OF NEXT MEETING**

The next meeting will be held at 9.30am on Tuesday 9th July 2019 in the Corporate Meeting Room, HQ, University Hospital of Wales.

Signed ……

Date ……

CONFIRMED MINUTES OF CHARITABLE FUNDS COMMITTEE
HELD AT CORPORATE MEETING RM, HQ, UHW
19th MARCH 2019

Present:		
Akmal Hanuk	AH	Chair
In Attendance:		
Joanne Brandon	JB	Director of Communications and Engagement
Mandy Collins	MC	Interim Head of Governance
Nicola Foreman	NF	Executive Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Director of Therapies and Health Sciences
Barbara John	BJ	Business and Operational Manager
Mike Jones	MJ	Trade Union Staff Side
Simone Joslyn	SJ	Head of Arts and Health Charity
Chris Lewis	CL	Deputy Finance Director
Dawn Ward	DW	Independent Member – Trade Unions
John Union	JU	Independent Member – Finance
Peter Welsh	PW	Llandough Hospital General Manager
Alun Williams	AW	Acting Financial Services Manager
Secretariat:		Sheila Elliot
Apologies:		
Maria Battle	MB	Chair

CFC19/03/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting. Mandy Collins, Interim Head of Governance introduced herself and was welcomed by Akmal Hanuk, Chair and the Committee	**ACTION**
CFC19/03/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
CFC19/03/003	**DECLARATIONS OF INTEREST** No interests were declared.	
CFC19/03/004	**MINUTES OF CFC MEETING HELD 11 DECEMBER 2018** **Resolved - that**	

	(a) The Committee received and approved the minutes of the last meeting	
CFC19/03/005 **CFC 18/075**	**ACTION LOG FOLLOWING THE LAST MEETING** • British Sign Language Training and Awareness was an ongoing activity and training sessions were spread over the year. A report will be received at the next meeting **Resolved - that** (a) The Committee received the Action Log from the December meeting and noted the update.	AH
CFC19/03/006	**BENEFITS OF COLOUR ENHANCING THE PATIENTS MEALTIME** An update was presented by Peter Welsh and discussed. • Crockery had been delivered to all sites and was in use. It had proved extremely popular with patients, staff and relatives. The crockery was easy to use with the high lip, eye-catching and homely. One or two items had broken or gone missing and some items damaged as they were not microwave-safe, but apart from that they had a life-time guarantee • This initiative supports our nutrition and good eating habits • Fiona Jenkins, Director of Therapies and Health Science would check whether there has been less food waste since the crockery had been introduced • A note on the menus, would be made stating that the crockery had been provided by the Charitable Funds Committee • There was discussion on whether patients, staff and relative could buy items. The proceeds could be used to replace stock. • It was noted that some people would not be able to afford to buy items, alternatively, we could ask for a charitable donation. • If there was a Charitable Funds shop in the Concourse items could be sold or donations made. • The Director of Corporate Governance would check whether the Charitable Funds Committee would be able to sell items, from a governance perspective **Resolved – that:** (a) The Committee noted the update on the enhancing crockery scheme.	FJ FJ NF
CFC19/03/007	**FOOD SENSE WALES** The Head of Arts and Health Charity introduced the report which was for noting and there was some discussion. • It was noted that this was good for those who did not always have the chance to eat healthily	

	• The Director of Therapies and Health Science would check on the success of this project at the next Nutrition and Catering Meeting and would report back to the Committee • It was noted that it would have been helpful to have a cover sheet included with the report as there was no one present to explain it further. • It was noted that the assurance risk was the responsibility of Nutrition and Catering and not the Charitable Committee **Resolved – that:** (a) The Committee noted the report	FJ
CFC19/03/008	**BIDS PANEL REPORT** Mike Jones, Trade Union Staff Side introduced the report. • It was noted that the Panel was working well and most bids were now accepted as the correct criteria was being followed • Recent bids had primarily been for wards and departments. • Communications was improving and the profile of the Charitable Funds Committee was more visible. Recent initiatives had helped. • A representative from the Clinical Board should be present when a bid is requested – otherwise the bid won't be reviewed • The staff recognition awards was a great event and was a good staff incentive. • Discussion followed regarding requests for new awards, of which there were quite a few. This should be limited so that the evening event would not take too long • A celebration meeting was suggested as an alternative to an award and this could showcase the good things which have occurred as a result of the funds provided by the Charitable Funds Committee and the impact the monies can make • To be discussed further at the next meeting **Resolved – that:** (a) The Committee noted the report	SJ
CFC19/03/009	**FINANCIAL POSITION REPORT** Chris Lewis, Deputy Director of Finance introduced the report • The investment portfolio was looking good, despite the fact that £750k was taken out of the account earlier in the financial year • Internal Audit of the Committee funds noted there were a large amount of dormant funds. • It could be that some dormant funds could be moved into the active funds after a period of time, maybe six months • Dormant funds with the value of £10k were being targeted with a view to spending the money appropriately **Resolved – that:**	

	(a) The Committee noted the report	
CFC19/03/010	**FUNDRAISING REPORT** The Head of Arts and Health Charity introduced the report. • It was agreed that the website was unwieldly and the support company were slow to respond to change requests. • The contract was up for renewal in May 2019. There were ongoing discussions on whether the website would be brought in house • £100k was raised following the Cardiff half-marathon which was a good result • The team acknowledge that not all events should be based on physical activity and were trying to be creative in organising different types of events • The format of this report is helpful. However it would be good to include how much an event costs to host, to ensure complete transparency • It was noted that events would provide 'hidden benefits' such as raising the profile of the Committee • Costs setting up an event should be charged against the appeal, not against Charitable funds • It was noted that one member of the general public had raised just over £100k single-handedly which was a huge achievement **Resolved – that:** (a) The Committee noted the report	
CFC19/03/011	**FINANCIAL OUTLOOK 2019/2020** The Deputy Director of Finance introduced the report. • There are some large commitments over the next year and therefore monies available from the General Purpose Fund would decrease • It should be noted that the General Purpose Fund was affected by the stock market, be it good or bad • There was a strong cash balance and liquidity • It was suggested that we look at the delegated funds at a workshop or the next Board Development day **Resolved – that:** (a) The Committee noted the update	NF/CL
CFC19/03/012	**HORATIO'S GARDEN** The Head of Arts and Health Charity introduced the report. • Care was needed that the project demonstrated transparency and governance, particularly as the project had a large ceiling of £500k (inc VAT). The expected costs at the moment were circa £425,000. • After discussion the Committee requested assurance that the money would be well-spent and that good value for money would be achieved	

	• It was suggested that the Rookwood Fund might be a more appropriate place for the monies to be granted rather than Charitable Funds. However, it had already been agreed previously that the monies would come from Charitable Funds. • The original agreement needed to be looked at more closely as members of the Committee were not aware of the detail of the project. The neuro garden was incorporated in the development of Horatio's garden, although the upkeep of the neuro garden going forward would be provided by another source • The proposal needs greater scrutiny and clarity. A more detailed paper needs to be brought to the next meeting which brought all the elements of the garden together including costs. **Resolved – that:** (a) The Committee requests further clarity on the project	SJ
CFC19/03/013	**ANNUAL REPORT OF THE CHARITABLE FUNDS COMMITTEE** The Director of Corporate Governance introduced the item for approval • The Annual Report of the Committee was brought to ensure that the Committee was fulfilling its' purpose. • There should be three Independent Members and three Executive Directors. The current number of Executive Directors need to be addressed. **Resolved – that:** (a) The Committee approved the report	NF
CFC19/03/014	**TERMS OF REFERENCE CHARITABLE FUNDS COMMITTEE** The Director of Corporate Governance introduced the item for approval • It is important to ensure correctness and that the right people with the right experience are on the right committees across the Board. **Resolved – that:** (a) The Committee approved the report	
CFC19/03/015	**TERMS OF REFERENCE BIDS PANEL** The Director of Corporate Governance introduced the item for approval • Any comments need to be forwarded to Nicola Foreman before Thursday 21st March in time for inclusion in the Trustee's meeting on 28th March 2019 **Resolved – that:** (a) The Committee recommended the report be approved by the Board.	

CFC19/03/016	**WORKPLAN** The Director of Corporate Governance introduced the item for approval • The Work-plan was based upon the Terms of Reference. • A three-year strategy needed to be put in place to ensure direction of travel. • A draft paper is to be brought to the June meeting • Investment Fund Managers present to us twice a year. This contract is up for renewal in 2019/2020. • The Trustees signed this off following recommendation from the committee **Resolved – that:** (a) The Committee recommended that the work-plan be approved by the Board.	JB/SJ
CFC19/03/017	**ANNUAL EFFECTIVENESS REVIEW** The Director of Corporate Governance introduced the item for approval • Self-assessment was important and would be carried out via Survey Monkey • An action plan will be brought to the June meeting **Resolved – that:** (a) The Committee approved the format of the Effectiveness review	NF
CFC19/03/018	**MEMORANDUM OF UNDERSTANDING** The Director of Corporate Governance introduced the item for approval **Resolved – that:** (a) The Committee recommended approval the MOU which would be approved by the Trustee.	
CFC19/03/019	**CORE / NON-CORE FUNDING GUIDANCE** The Director of Corporate Governance introduced the item for approval **Resolved – that:** (a) The Committee noted this had received legal-signoff and recommended approval by the Trustee.	
CFC19/03/020	**CHARITABLE FUNDS EXPENDITURE APPROVAL (WASTE BINS)** • Discussion was carried out on the report and it was decided that this item did not fall under the Charitable Funds remit. • The Director of Corporate Governance will notify the appropriate parties of the decision	NF

	Resolved – that: (a) The Committee will not approve this item	
CFC19/03/021	**UHB TRANSPORT SOLUTION PAPER** The Director of Communications and Engagement introduced this report. • There was full and detailed discussion regarding this solution. • The parking situation was a huge, emotive issue both at UHW and UHL and staff and patients were suffering. • A large car park at UHL had been removed. • Cardiff Bus are reducing the current bus services to Llandough. • On both sites clinics and operations had been affected, staff were frustrated and unhappy, and the situation in part contributing to sickness absence. • Patients were very distressed when they missed their appointments due to inability to park. • The current situation was intolerable, causes excessive and unnecessary stress and needed addressing. • The Committee were in complete agreement with the proposals which were improving the health and wellbeing of staff and patients alike. • The proposal was in line with the Health and Lifestyle Travel policy of the Board which encouraged a more active lifestyle, encouraged people to use public transport and not their cars. It aligned with the development of the Cardiff and Vale sites and also the Sustainable Travel policy of the Welsh Government. • The cost of the total solution from Cardiff Bus for one year was estimated at £381,854. • The Committee were worried that once the pilot project was in place (if successful) it could not be taken away. Therefore there would be recurrent annual charges of circa £382k. • The Committee were worried that if they financed the pilot project they would be expected to continue financing this project every year, which is an unsustainable option for the Committee, and also not the purpose of the Committee Funds. • There was discussion on whether some dormant funds could be utilised but it was then agreed that this was not appropriate. Therefore there was discussion on the right way forward. • It was thought that the Welsh Government would not provide funds for this • It was thought that if the pilot were successful then annual charges would thereafter be incorporated within the operational costs. However, the Committee would like this to be confirmed. • Various discussions then took place on how the cost of £382k could be reduced. • Trusts and Estates had been liaising with Cardiff bus with regards to the proposal and Cardiff Bus had said that the shortest pilot period they would consider was one year. The Committee would refer to Trusts and Estates to request a shorter pilot period reducing the costs. • There should be some measurements on the success of the pilot	

	project. If the project was shortened to either three or six months this would still give indications on whether the project would be a success. • There were discussions on whether all items included in the proposal were equally important and which the biggest priorities were. • As part of the Welsh Government Transport Policy all local parties had been involved, including the Local Authority, Cardiff Bus, Cardiff Council, Enterprise cars and data from these consultations was available. • Priorities of the use of Charitable funds were discussed • Chris Lewis, Deputy Director of Finance was concerned that £382k expenditure for this project from the General Purpose Funds could impact on other already agreed commitments which might have to be deferred due to lack of funds. **Resolved – that:** (a) The Committee were in complete agreement with the proposals which would improve the health and wellbeing of staff and patients alike. The benefits were seen but the costs unsustainable to the Charitable Funds Committee. (b) It was agreed that a discussion would be held at the Trustee Meeting in March	NF
CFC19/03/022	**REMINISCENCE INTERACTIVE THERAPY AND ACTIVITIES (RITA)** No lead executive to introduce this. • This would be reviewed at next meeting when there will be confirmation on whether four or five items are to be purchased • The Director of Corporate Governance will notify the appropriate parties of the decision **Resolved – that:** (a) The Committee noted the report	NF
CFC19/03/023	**TEAM SUSTAINABILITY** • There was the ability to sign up for events on website **Resolved – that:** (a) The Committee noted the report	
CFC19/03/024	**PLATFORM EVENTS** • A nursing conference was held bi-annually at the City Hall with good attendance costing £20k to host. Chris Lewis, Director of Finance would arrange for funds to be available for the next conference. **Resolved – that:**	CL

	(a) The Committee noted the update.	
CFC19/03/025	**ANNUAL FUNDRAISING REPORT BREAST CENTRE APPEAL** The General Manager of UHL introduced the paper and gave an update on the appeal **Resolved – that:** (a) The Committee noted the paper	
CFC19/03/026	**REVIEW OF MEETING** There were some difficult business cases to discuss and it was felt that the meeting went well overall.	
CFC19/03/027	**DATE AND TIME OF NEXT MEETING** The next meeting will be held on the 11th June 2019 9.00am – 12.00pm Corporate Meeting Room, Headquarters	
CFC19/03/028	**ANY OTHER URGENT BUSINESS** There was no other business to raise.	

CONFIRMED MINUTES OF MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE ON 12th FEBRUARY 2019
CORPORATE MEETING ROOM, HQ

Present:		
Charles Janczewski	CJ	Vice Chair
Eileen Brandreth	EB	Independent Member – ICT
Sara Moseley	SM	Independent Member – Third Sector
In Attendance:		
Julia Barrell	JB	Mental Capacity Act Manager
Steve Curry	SC	Chief Operating Officer
Nicole Foreman	NF	Director of Corporate Governance
Jane Hancock	JH	Service User Representative
Jenny Hunt	JH	Clinical Psychologist
Kay Jeynes	KJ	Director of Nursing, PCIC
Robert Kidd	RK	Consultant Psychiatrist
Dr Graham Shortland	GS	Medical Director
Katie Simpson	KS	Project Manager for CAMHS Repatriation
J C Smith	JS	Mental Health Act Hospital Manager
Sunni Webb	SW	Mental Health Act Manager
Ian Wile	IW	Director of Operations, Mental Health
Secretariat:	HB	Helen Bricknell
Apologies:		
Amanda Morgan	AM	Service User Representative
Lucy Phelps	LP	Service User Representative
Annie Proctor	AP	Clinical Board Director – Mental Health
Jane Tottle	JT	Mental Health Clinical Board Nurse

MH19/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
MH19/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
MH19/02/003	**DECLARATIONS OF INTEREST** The Chair invited Members to declare any interests in the proceedings. Mr Charles Janczewski stated that he is Chair of the WHSSC Quality and Patient Safety Committee and Sarah Moseley informed the Committee that she was the Director of MIND Cymru.	
MH19/02/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 23rd OCTOBER 2018** **Resolved – that:**	

(a) The Committee agreed the minutes of the meeting held on 23 October 2018

MH19/02/005 **ACTION LOG FOLLOWING THE LAST MEETING**

The Committee received the Action Log from the October meeting.

Resolved that:

The Committee Members reviewed the action log for the meeting held in October 2018.

MH19/02/006 **ANY OTHER URGENT BUSINESS**

There was no other business to raise

MH19/02/007 **DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) MENTAL CAPACITY ACT 2005**

Dr Graham Shortland, Medical Director introduced the report. The following comments were made:

- The key issues remain the same as previously.
- There were significant waiting times and urgent referrals were being given priority
- Blake Morgan, Solicitors, would be delivering training to staff who would be undertaking the DoLS signatory role on the 6th and 7th March 2019.
- 15 reviews were not undertaken for Learning Disability clients who would be jointly funded within the community. The results were not shown with the reviews which had not taken place since 2016 due to constraints within the team. Regarding the Court of Protection applications – Independent Mental Capacity Assessments and Best Interest Assessments, these needed to be submitted as soon as they were completed and this had been raised with the Local Authority. The high demand on requests for COP and DoLs was having an impact on the timeliness of assessments. The Local Authority had put an action plan in place and every effort was being made to expedite the process.

Resolved – that:

(a) The Committee noted the report.

MH19/02/008 **MENTAL CAPACITY ACT (MCA) UPDATE REPORT**

The above report was presented to the Committee and the following comments were made:

- The Learning, Education and Development (LED) Department had not provided the MCA training figures.
- The LED Department had stated that they would be able to produce the training statistics for the next meeting.
- It was agreed that MCA information should be explicitly included in the Healthcare Standards assessments that Clinical Boards

JB/MD

undertake. The Medical Director would liaise with the Assistant Director of Nursing, Patient Safety, about this.

- Monitoring and triangulation includes the monitoring of incident reports and training around the Mental Capacity Act. If a more detailed audit were undertaken on patients' notes would the correct recording of the Mental Capacity Act be documented in how it was considered, mentioned or used.
- Jane Hancock, Service User Representative mentioned that conversations could be recorded with patients in order to demonstrate that MCA was being followed. However, t was agreed that this would be a large piece of work to undertake.
- Kay Jeynes, Director of Nursing PCIC mentioned that the audit cycle was important as it flags up opportunities for training.
- The uptake by Drs of MCA training needs to increase. The potential consequences of non- compliance were raised and it was agreed that this needed to be discussed outside of the meeting.

Resolved – that:

(a) The Committee noted and approved the continuing arrangements for the DoLS service.

MH19/02/009 **MENTAL CAPACITY ACT REPORT**

Resolved – that:

(b) The Committee noted the MCA report.

MH19/02/010 **MENTAL HEALTH ACT MONITORING REPORT**

The Director of Operations, Ian Wile introduced the report and presented an overview of the exception report, highlighting the following:

- Section 135 Legislation. There was no further direction from Richard Jones on the start time of Section 136.
- Section 136 Legislation – Patients were distressed when admitted on section 136 and not being signposted to other pathways within Mental Health services when the section starts. The Health Board had been advised to adhere to the Code of Practice which was the Statutory Guidance but was still awaiting a response from Welsh Government on what their position was.
- The Chair of the Crisis Care Concordat and Ministerial Assurance Group and the Board was unable to provide assurance in South Wales and the matter had been escalated.
- Trends on activity would be reported on in the next Mental Health Act Report for the Committee.

Resolved – that:

(a) The Committee noted the report

MH19/02/011 **MENTAL HEALTH BENCHMARKING REPORT (RCP)**

The Director of Operations, Ian Wile introduced the above report and the following was noted:

- For each quarter the information gets reported to Ian Wile, Director of Operations Mental Health for the purpose of performance reporting
- It was noted that Part 2 was currently compliant.

Resolved – that:

a) The Committee noted the national benchmarking information

MH19/02/012 **NATIONAL REVIEW OF MENTAL HEALTH ACT 1983**

The Director of Operations, Ian Wile introduced the report and informed members that 154 recommendations had been made.

Resolved – that:

(a) The Committee noted the report

MH19/02/013 **HOSPITAL MANAGER'S HEARINGS AND OBSERVATIONS**

A verbal update was provided by the Mental Health Act Manager, Sunni Webb and highlighted the following:

- Seven Mental Health Act Hospital Manager's hearings were observed and it was noted that effective communication was delivered at all times during the course of the hearings.

Resolved – that:

(a) The Committee noted the update

MH19/02/014 **MENTAL HEALTH MEASURE MONITORING REPORT**

The Director of Operations, Ian Wile provided a report on the above. The following comments were made:

- The Delivery Unit audit of care and treatment plans the last year part 2 was poor across Wales, and Cardiff was no exception. An action plan has been developed with the DU which will be monitored through the 90 day review cycle with them.
- Part 1b was out of compliance for a number of months due to a fault with reporting. This had now been corrected to show C&V had never been out of compliance with this Tier 1 target.

Resolved – that:

(a) The MHCLC Committee were asked to note the report

MH19/02/015 **PART 2 MENTAL HEALTH MEASURE CARE AND TREATMENT PLANS**

The Director of Operations, Ian Wile presented the above report. The following comments were made:

- An action plan was in place due to the need for the issues to be addressed.
- Care Aims model - The standards needed to be re-audited.
- Care and Treatment Plan training was carried out in January and it was queried if the timetable should be rolled out further.

Resolved – that:

(a) The Committee noted the report

MH19/02/016 **TIER 2 CAMHS UPDATE**

Project Manager for CAMHS Repatriation, Katie Simpson provided an update:

- The Committee asked to see CAMHS benchmarking information
- For adult services a senior Band 7 post has been appointed to lead a program of work to reduce Average Length of stay and the problems to patients associated with that. IW
- There was low compliance on Care and Treatment Plans of 53% in CAMHS
- It was 6 weeks to transfer day and a single Point of Access had been mapped out
- There had been no risks identified at the time of transfer and all steps had been taken to ensure a safe transition for patients.
- The Health Board recognised that there were risks currently around non-compliance of waiting time targets and more understanding around the KAPPA model was required.
- After 1st April a large amount of vacancies would become available and it was important that this was recognised and how the recruitment to these roles would be managed within the Organisation.
- Mental Health Measure Part 1 of the scheme is being updated around the single point of access.
- Part 2 Compliance lies within the specialist CAMHS service and the service are doing work around achieving the targets.
- Current performance target for referrals is 28 days and it was reported that we are currently treating approximately 65% of these.
- Target Date for the services to be open was the 1st April 2019.
- Eileen Brandreth, mentioned that we should ensure that the caseloads/referral figures are correct so that the team are aware of the level expected.
- The age of Children to transfer into Adult services is 17½ years of age.

Resolved – that:

(a) The Committee noted the update

MH19/02/017	**MENTAL HEALTH OPEATIONAL GROUP** Dr Robert Kidd provided a verbal update: • If the Chair meets with the Minister a mention of Section 136 status would be helpful as would input from Welsh Government. • A new poster had been approved relating to Section 136 and it could be placed in the A& E Department. • Section 135 warrant that allows entry into a persons' home and the process of obtaining a warrant. • Section 136 forms would be going electronic in the near future. • It was mentioned that other Forums can cascade information down to the Mental Health Operational Group for further discussion. • AMHP forum has been invited to share any operational issues with them so items can be dealt with together. **Resolved – that:** **(a)** The Committee noted the update	
MH19/02/018	**CONTROLLED DOCUMENTS TO BE APPROVED** The Director of Operations, Ian Wile introduced: • Patient Rights Information to Detained/Community Patients under Mental Health Act, 1983 Policy • Patient Rights Information to Detained/Community Patients Mental Health Act, 1983 Procedure • Admission to Hospital under Part II of the Mental Health Act, 1983 Policy • Application for admission to hospital under Part II of the Mental Health Act, 1983 Procedure • Review of Detention and Community Treatment Order, Mental Health Act 1983 Policy • Review of Detention and Community Treatment Order, Mental Health Act 1983 Procedure **Resolved – that:** **(a)** The Committee approved the documents	
MH19/02/019	**Self-Assessment** • Self-assessments needed to be rolled out to every member of the Committee for them to complete. • Results would then be reported back to a future meeting of the Committee. **Resolved – that:**	NF

(a) The Committee approved the process for self-assessment.

MH19/02/020 **Annual Report 2018/19**

The Annual Report was introduced by the Director of Corporate Governance. The report provided detail of the work of the Committee for the past 12 months**.**

Resolved – that:

- The Committee recommended approval of the Annual Report to the Board.

MH19/02/021 **Terms of Reference Review**

The Director of Corporate Governance introduced the report stating it was good governance and in line with Standing Orders that Terms of Reference should be revised annually.**Resolved – that:**

(a) The Committee recommended approval of the Terms of Reference by the Board.

MH19/02/022 **Work Plan 2019/20**

The Director of Corporate Governance introduced the report which provided a plan for 2019/20 for the Committee.

Resolved – that:

(a) The Committee recommended approval of the work plan from the Board.

MH19/02/023 **ITEMS TO BRING TO THE ATTENTION OF OTHER BOARD/COMMITTEE:**

INSPECTION/REGULATION COMPLIANCE HIW REPORT

The Director of Operations, Ian Wile gave a verbal update:

- This item to be brought to the next meeting.

Resolved – that:

(a) The Committee agreed the updates

MH19/02/024 **HOSPITAL MANAGERS POWER OF DISCHARGE**

The Chair of the Power of Discharge Group, Jeff Champney-Smith introduced:

- Sub-Committee Minutes

	• Terms of Reference **Resolved – that:** **(a)** The MHCLC Committee agreed the Sub-Committee minutes and Terms of Reference
MH19/02/025	**REVIEW OF THE MEETING** There was nothing to report
MH19/02/026	**DATE OF THE NEXT MEETING:** Tuesday June 4th 2019 at 10am, Corporate Meeting Room, Headquarters

Minutes from the Local Partnership Forum Meeting held on 6 February 2018 at 10am in the Meeting Room, Executive Headquarters, University Hospital of Wales

Present:	
Martin Driscoll	Exec Director of Workforce and OD
Mike Jones	Chair of Staff Representatives / UNISON
Joe Monks	UNISON
Dawn Ward	Independent Member – Trade Union
Ffion Matthews	CSP
Steve Gaucci	UNISON
Nicola Foreman	Director of Corporate Governance
Len Richards	Chief Executive (part of meeting)
Rachel Gidman	Assistant Director of OD
Fiona Salter	RCN
Ceri Dolan	RCN
Stuart Egan	UNISON
Rhian Wright	RCN
Caroline Bird	Deputy COO
In Attendance	
Rachael Barlow	Clinical Lead Prehabilitation and Enhanced Recovery Programme
Keithley Wilkinson	Equality Manager
Donna Davies	Head of Workforce and OD (observing)
Rose Lewis	Equalities Officer
Apologies:	
Peter Hewin	BAOT/UNISON
Pauline Williams	RCN
Peter Welsh	Senior Manager UHL and Barry
Julie Cassley	Deputy Director of WOD
Andrew Crook	Head of Workforce Governance
Julia Davies	UNISON
Mat Thomas	UNISON
Rebecca Christy	BDA
Secretariat:	
Rachel Pressley	Workforce Governance Manager

LPF 19/015 WELCOME AND INTRODUCTIONS

Mr Driscoll welcomed everyone to the meeting.

LPF 19/016 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

LPF 19/017 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 19/018 MINUTES OF THE PREVIOUS MEETING

The minutes from the meeting held on 6 February 2019 were agreed to be an accurate record of the meeting.

Mr Egan raised a matter arising relating to sustainable travel and car parking. He described a situation at St David's hospital, where staff are having to take photographs of their parked cars in order to prove they had parked appropriately. Mr Richards said that he knew there had been issues on this site, but had not heard of that particular situation and agreed that the burden of proof should be on Parking Eye not the individual. Mr Driscoll agreed to pick this matter up with Mr Walsh (Assistant Director of Capital, Planning and Facilities) outside of the meeting.
Action: Mr Driscoll
It was agreed that sustainable travel would be a standing item on future LPF agendas.
Action: Dr Pressley

LPF 19/019 ACTION LOG

The Local Partnership Forum noted the action log.

LPF 19/020 'PREHAB TO REHAB': OPTIMISING CANCER OUTCOMES

The forum received a presentation from Dr Rachael Barlow Clinical Lead for Prehabilitation and the Enhanced Recovery Programme on using 'prehabilitation' to optimise cancer outcomes.

Dr Barlow advised that while many cancer treatments of becoming increasingly sophisticated, there is evidence to show that they can be affected if the general health of the individual is compromised. 15 years of research and work has gone into developing this programme and a transformation bid has been submitted to put into place a system of prehabilitation between diagnosis and treatment for patients who require major surgery for cancer. Engagement work was taking place within primary care and GPs were being asked to signpost for these interventions rather than just refer to treatment.

Powerful patient feedback and stories had been received and everyone who had been through the pilot programme rated it as excellent. All parts of the programme had now been piloted and were being joined up into a phase 1 pathway, but this was subject to investment including the recruitment of 75 new members of staff. There had been interest from other services, including haematology and blood cancers, but they would not be part of Phase 1.

Mr Richards reiterated that this programme had been a long time in the making. Recruitment and investment would determine the timescales for

rollout, and while this focused particularly on cancer it could be applicable to everyone having a difficult intervention.

Miss Ward stated that she supported the work and that she believed the right principles were being translated into practice, with clear links to the UHB strategy. She asked if the proposal was to de-invest in secondary care to enable investment in primary care instead. Dr Barlow confirmed that this was the plan, but advised that estates were a major concern. The intention was to provide treatment as close to home as possible with pharmacists playing a key role. Miss Salter stated that she was pleased to see a more holistic approach being taken.

Mr Driscoll thanked Dr Barlow for the presentation. The Local Partnership Forum supported the work and wished them every success.

LPF 19/021 CHIEF EXECUTIVE'S UPDATE

Mr Richards informed the LPF that the UHB was no longer in targeted intervention, but had been de-escalated to enhanced monitoring status. He said that this showed that Welsh Government had increased confidence in the organisation and emphasised that it was the result of the good work of frontline staff on a day-to-day basis. He thanked everyone involved.

Mr Richards also advised that the IMTP had been approved by Welsh Government. This was another vote of confidence and showed that the UHB had a sustainable plan for the next three years. Mr Richards noted that an approved IMTP would be helpful in the consideration of transformation bids like that submitted for the prehabilitation work.

In terms of finance, it looked likely that the UHB would achieve the £10 million overspend it had been aiming for, which was is a significant improvement from previous years. The trajectory for 2019/20 was breakeven. Mr Richards indicated that spending on nursing was still an area of concern and that we needed to find ways of keeping to budget. RCN representatives challenged this, stating that they believed there were areas which were underspent and were deliberately not using bank and agency staff in order to maintain this, with the consequence of not meeting the new Staffing Act requirements. It was agreed that it would be appropriate to have a discussion outside of the Forum with the Executive Nurse Director. The outcome of that meeting would be reported back to the LPF.
ACTION: Mr Richards/RCN

Miss Salter pointed out that the Executive Director of Nursing's report was currently included in Part 2 of the agenda for noting only, and was therefore not discussed. She requested that this was moved into the main body of the agenda and Mr Driscoll agreed to this.
Action: Dr Pressley

(Mr Richards left the meeting)

Mr Monks asked about the headcount in the context of the IMTP. Mr Driscoll stated that in his opinion the workforce plans still do not stand up to full scrutiny and he was working on this with the Clinical Boards.

LPF 19/022 INCLUSIVITY

The Local Partnership Forum received a verbal report from the Equality Manager. Mr Wilkinson explained that this was a potential change to the equalities agenda, with more emphasis being placed on including everyone and striving to create an environment where everyone feels respected. He reminded the Forum that we are now in year 4 of our Strategic Equality Plan, and a new plan will be developed from 2020. The intention was to use this final year to look at the inclusivity of our practices, with a specific project being established around employing disabled staff. Discussions were taking place with Velindre and Public Health to enable us to do joint planning and work with them.

The Forum supported this work but noted that there are lots of existing staff with undiagnosed learning difficulties who require additional support as well. Mr Driscoll noted that the Local Partnership Forum had a big part to play in the success of this work, both formally by supporting it and informally through our everyday actions.

(Mr Wilkinson left the meeting)

LPF 19/023 STAFF SURVEY RESPONSE GROUP

Mr Driscoll reminded the forum of the continuing work taking place around the staff survey results. Three meetings had taken place to discuss the results, with staff from all areas and levels involved. Key themes had been identified and suggested actions noted. He noted that it had strong links with the Canterbury and transformation model. The next step would be for the action plan to be formalised and volunteers sought to carry out the tasks.

Mr Jones advised that he had heard very positive comments from and about the group. His only concern was that previously such actions have not been followed through. Mr Driscoll told the Forum that he had placed himself centre of this piece of work as a way of demonstrating how seriously he took it.

Miss Ward thanked Mr Driscoll for including her in the workshops and for playing an Executive lead role in this. She said he had demonstrated strong leadership and had a good support team, and that she was happy to be involved.

Mrs Wright asked whether exit questionnaires were issued to people who moved around the organisation or just to leavers. It was noted that people moving within the organisation could complete the questionnaires as they are available online, but that this tended to be fairly ad hoc. Dr Pressley agreed to issue the link to the online exit questionnaire to staff representative

members of the forum for their information and so that could encourage members to complete it.
Action: Dr Pressley

Mr Egan stated that the action plan was realistic and improved from previous years but asked for timescales to be included. Mr Driscoll advised that this was an unedited output from the last workshop and was not a complete action plan. It would be brought back to the Local Partnership Forum regularly and would also be reported to the Strategy and Delivery Committee.

LPF 19/023 FIRST MINISTER'S SPEECH

Mr Driscoll advised the Forum that Mr Richards had wanted to talk to them about a speech delivered by the First Minister to the NHS Confederation in February. Unfortunately Mr Richards have been called out of the meeting but Mr Driscoll knew that he wanted to draw their attention to the resonance between this speech and the UHB strategy. A copy of the speech would be issued to Forum members.
Action: Dr Pressley

LPF 19/024 WORKFORCE KPI REPORT

Mr Driscoll advised that the Strategy and Delivery Committee would be receiving a 'deep dive' on absence at the end of the month. There were pockets of concern but overall absence levels were very similar to the previous year. He advised that February figures had now been released and sickness was at 5.37% and the year-to-date was 5.08%.

It had been agreed nationally that unsocial hours payments could be retained during sickness periods if the target of 4.4% was achieved. Mr Driscoll noted that this was a big jump but stated that he did not want to drive the organisation into hard end absence management as he believed engagement, leadership etc. would get better absence outcomes through cultural change.

Mrs Dolan asked what was happening around the rapid access program which had been discussed nationally. Mr Driscoll advised that they were trying to achieve this through the Employee Health and Wellbeing team. In general there was a mixed picture across Wales but he believed Cardiff and Vale was further down the line than most organisations. Miss Ward advised that she had discussed this with the Head of Employee Health and Wellbeing recently and understood it to be a more complex issue then she had initially realised.

Mr Egan expressed concerns around delays and complications in the recruitment process and stated that he thought the UHB would be better to bring recruitment back in house. Mr Driscoll did not agree, however, stating that we need to recognise that we also put hurdles into the process. He stated that there was work taking place within WOD to improve this and that we were engaging with Shared Services.

Mr Monks noted that sickness remained a massive challenge, but within

Capital Estates and Facilities Service Board they were starting to look at a different approach involving understanding the reasons for absence. He noted said that the Staff Survey provided some information into issues such as bullying and stated that a cultural shift was needed. He believed that housekeeping staff were treated disproportionately harshly at times but that he was working with senior management to make inroads in this area and he understood that it would not happen overnight.

Mr Driscoll stated that he was not saying the sickness target was unachievable, however he did question how realistic it was to achieve it within 6 to 9 months. Miss Ward agreed stating that some areas have made a huge impact already but in others there are deep rooted issues because of the local culture.

LPF 19/025 Part 2 - ITEMS FOR INFORMATION

The Local Partnership Forum received and noted the following reports:

- Patient Safety, Quality and Experience Report
- Performance Report

LPF 19/026 ANY OTHER BUSINESS

Miss Salter expressed disappointment and concern about her recent experiences of the disciplinary process. She explained that on two occasions following the submission of a statement of case the hearings had been cancelled. She did not believe that this had been an appropriate response. It was agreed that Mr Driscoll and Miss Salter would discuss the details outside of the meeting but Mr Driscoll did say that he was disappointed to hear that this was still happening and that he was happy to challenge the process. Mr Jones noted that while the submission of a statement of case is not a Policy requirement, historically this has been done because it was helpful, however this type of behaviour would deter the Staff Representatives and their members from submitting their statements in advance of the hearings. Mr Jones did note that the situation had largely improved, however.

LPF 19/027 FUTURE MEETING ARRANGEMENTS

The next meeting would be held on Wednesday, 5th of June 2019 at 10 am with a staff representatives pre-meeting at 9 am (venue to be confirmed

Report Title:	**Audit & Assurance Committee Report**								
Meeting:	UHB Board					**Meeting Date:**	23.05.19 and 30.05.19		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	**n/a**								
Report Author (Title):	**John Union, Chair Audit & Assurance Committee**								

SITUATION

The Audit & Assurance Committee (AC) held a public meeting on 23.05.19 and 30.05.19 and the following note provides Board with a summary of the key issues discussed at those meetings.

AUDIT AND ASSURANCE COMMITTEE HELD ON 23 MAY 2019

BACKGROUND

This written report is provided to Board by the Chair of the AC. Reports from the Chair will highlight to Board the key issues discussed pending the Board being provided with the full confirmed minutes of the meeting held by the AC.

ASSESSMENT

N/A

ASSURANCE is provided by: N/A

RECOMMENDATION

The Board is asked to: note the following update covering the key issues discussed on 23.05.19.

Items for Review and Assurance

1) Internal Audit (IA) Progress Report. Cyber Security. Limited Assurance rating. Eight (8) recommendations made by IA (4H, 4M,0L). Sharon Hopkins provided the AC with an update of actions being taken to deal with the recommendations made.

Items for Approval / Ratification

2) Report of the losses and Special Payments Panel. This report covered period 1/10/18 – 31/3/19. The AC were provided with the minutes of the Panel held on 13/5/19 and an update by Bob Chadwick. The AC as requested approved the write offs as detailed in the report.

Items for Information

3) Internal Audit provided 7 reports for information. Of these reports 1 was rated as Substantial (Strategic Planning and IMTP) and 6 rated as reasonable (Core Financial Systems, Estates Statutory Compliance – Water, E-Advice, UHB Transformation Process, MHRA Compliance and Health and Care Standards). All recommendations made by IA will be monitored for completion within the timescales agreed.

SPECIAL AUDIT AND ASSURANCE COMMITTEE HELD ON 30 MAY 2019

BACKGROUND
This written report is provided to Board by the Chair of the AC. Reports from the Chair will highlight to Board the key issues discussed pending the Board being provided with the full confirmed minutes of the meeting held by the Audit Committee.

ASSESSMENT
N/A

ASSURANCE is provided by: N/A

RECOMMENDATION

The Board is asked to: note the following update covering the key issues discussed on 30.05.19 pending receipt of the confirmed minutes of the Special Audit and Assurance Committee Meeting.

Items for Approval / Ratification

1) Craig Greenstock presented the Counter Fraud Annual Report for 2018/19. This included the Annual Report on Counter Fraud and Corruption, the Counter Fraud Workplan for 2019-20, the Counter Fraud Self Review Tool which Graig explained the overall score for C&V UHB was rated as Green. The Declaration included within the report had been signed by Bob Chadwick, Director of Finance.
2) Chris Lewis presented the Annual Accounts of the UHB 2018/19. The AC noted the reported financial performance and that the UHB has breached its statutory financial duties in respect of revenue expenditure, noted the changes made to the draft Annual Accounts, Agreed and Endorsed the ISA 260 Report, the Head of Internal Audit Report, the Letter of Representation, the response to the Audit enquiries to those charged with governance and management and the Annual Accountability Report which includes the Annual Accounts and financial statements.
3) The Wales Audit Office (WAO) presented the ISA 260 Report to the AC. This included at Appendix 1 the Final Letter of Representation, Appendix 2 The proposed certificate and independent auditor's report of the Auditor General for Wales to the National Assembly for Wales, and Appendix 3 a Summary of corrections made to the draft financial statements which should be drawn to the attention of the Board.
4) Ian Virgil, The Head of Internal Audit presented the Head of Internal Audit Opinion & Annual Report 2018/19. The AC noted that the Head of Internal Audit Opinion was that the Board can "take Reasonable Assurance that arrangements to secure governance,

risk management and internal control, within those areas under review, are suitably designed and applied and applied effectively. Several significant matters require management attention with low to moderate impact on residual risk exposure until resolved".

5) The AC received and considered the following for 2018/19: a) The Letter of Representation included within the ISA 260 Report (see above item 3 above), b) The response to the audit enquires to those charged with governance and management (see item 2 above) and c) The Annual Accountability Report including the Financial Statements (see item 2 above).
6) The AC agreed to recommend to the Board approval of the Annual Accountability Report for 2018-19 including the Annual Accounts and financial statements.

Shaping our Future Wellbeing Strategic Objectives *This 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	x	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	x
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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Quality, Safety and Experience – Chair's Report**							
Meeting:	Board					**Meeting Date:**	25/07/2019	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	
Lead Executive:	**Ruth Walker, Director of Nursing**							
Report Author (Title):	**Susan Elsmore, Chair of Quality, Safety and Experience Committee**							

SITUATION

This report provides the Board with and overview of the matters discussed at the Quality, Safety and Experiecne Committee that took place on 18 June 2019.

Board Members will wish to note that due to the June meeting not being quorate there are a number of decisions set out in this report that the Board is being asked to ratfiy.

REPORT

PATIENT STORY

The Specialist Services Clinical Board delivered a presentation that took the Committee through the story of conjoined twins who had moved to Cardiff from Senegal. The presentation demonstrated how through the work of ALAS the twins were given greater mobility and their quality of life improved.

Committee Members agreed that the Patient Story was an excellent example of where UHB services had gone the extra mile. The Posture Mobility Service is unique as it is the only service in the UK to include clinicians, nurses and health scientists, and operates a factory, workshop and a research facility. .

SPECIALIST SERVICES CLINICAL BOARD ASSURANCE REPORT

Board Members will wish to note that the Committee was advised of the top five risks on the Clinical Board's, namely:

- Insufficient Critical Care capacity to meet demand.
- Haematology - Lack of isolation cubicles and appropriate filtration on Ward B4H.
- Neurosciences – Sustainability of services at Rookwood Hospital due to infrastructure issues.
- Neurosciences – Continuity of neurovascular service.
- Cardiac Surgery waiting list - ability to meet 36-week RTT, ability to treat urgent patients.

Discussions focused on the capacity of the Critical Care Service and the findings of a recent review undertaken by the Royal College of Anaesthetists. Cardiac waiting times were also

discussed as they were an area of concern and the Committee was assured that this matter was being monitored and addressed though the UHB's performance frameworks escalation process.

The Board is asked to ratify the Committees resolution to:

b) APPROVE the content of the Assurance Report, subject to the Royal College of Anaesthetists Report on Critical Care being brought to the September 2019 meeting of the Committee, together with the improvement plan developed in response to the recommendations made.

c) AGREE that if progress in relation to Cardiac Surgery waiting times was not evident by the end of the calendar year a paper should be brought back to the Committee for consideration.

QUALITY AND SAFETY IMPROVEMENT FRAMEWORK

The Committee reviewed the report, which provided a high-level overview of the progress made in relation to the implementation of the Quality, Safety and Improvement Framework 2017 - 2020. It was noted that the UHB's Annual Quality Statement, due to be published on 25 July 2019, provided a summary of the progress made in 2018-19.

Board Members will wish to note the Quality and Safety Improvement Framework report demonstrated that a lot of work had been undertaken across the UHB in support of the quality and safety agenda. The importance of ensuring that the work was closely aligned to the UHB's Strategy was acknowledged.

PATIENT EXPERIENCE FRAMEWORK AND IMPROVEMENT INDICATORS

The report provided a high-level overview of progress in relation to the implementation of the refreshed Patient Experience Framework 2017 -2020. As part of discussions it was confirmed that steps were being taken to ensure that patient experience was central to the delivery of the UHB's Strategy.

The Board will wish to noted that patients have been found to be less happy with the care and treatment provided over the weekend. It was confirmed that action is in place to investigate the reasons for this.

The Putting Things Right Annual Report will be considered at the meeting of the Committee scheduled for September. A report on the new powers granted to the Public Services Ombudsman for Wales will also be prepared for the September meeting of the Committee.

ESSURE (ISSUES WITH THE FAILIURE OF THE PROCESS)

The Committee was provided with an overview of the patient notification exercise that was undertaken when it became apparent that the outcomes of some patients who had undergone the ESSURE procedure (hysteroscopic sterilisation), were unclear.

The paper provided assurance that the ESSURE issue had been identified, fully investigated and necessary action taken.

Board Members will wish to note that the UHB no longer performs the procedure and that all Clinical Board's have been reminded of the process to be followed when they wish to introduce new procedures.

INFECTED BLODD INQUIRY UPDATE

The Committee received an update on the activity undertaken by the UHB to support and engage with the Infected Blood Inquiry. *In line with the agreed Board agreed approach to the management of Michael Imperato, Independent Member – Legal's declared conflict of interest he left the meeting.*

It was confirmed that a cohort of 150 patients predominately individuals under the care of the Haemophilia Centre had made enquiries of the UHB and these individuals were being supported to review their medical records

Board Members will be aware that four days of hearings were held in Cardiff during July 2019. The majority of the infected or affected Welsh individuals called to give oral evidence did so during this week.

The Committee was asked to agree the UHB's stance which it to not disagree or challenge the views and opinions of the patients and families involved. As the Committee Chair, I was content with this, but request that the Board ratify this.

OPHTHALMOLOGY REPORT

The Committee received a presentation on the priorities set out in the Ophthalmology Plan, the key factors considered when developing the Plan and progress against the key priorities. The importance of the work undertaken by the Clinical Board and of strong clinical leadership was clearly demonstrated. There was also clear evidence of improvement, although it was acknowledged that there is more still to do.

The importance of moving services out to the community and developing regionalised approaches to pathways was highlighted. It was agreed that a short update report, that includes benchmarking data, would be brought to the December 2019 meeting of the Committee.

CAR PARKING UPDATE REPORT

The improvements made to the Park and Ride facilities as a result of the Health Charity Board of Trustees agreeing to fund the first-year costs of a number of initiatives were outlined. The information provided demonstrated that issues and concerns raised by patients and staff had been considered and acted upon.

The Committee agreed that further steps to publicise the Park and Ride service were needed along with communication of the steps taken to address issues raised by patients and staff.

HTA CAPA PLAN CLOSURE LETTER

Board Members will wish to note that the HTA inspection findings have been closed. The action plans intended monitoring mechanism through the CD&T Clinical Board's governance structures

and the proposed Quality Led Governance approach were discussed and noted by the Committee.

POLICIES AND PROCEDURES FOR APPROVAL

The following policies and procedures were brought to the Committee for approval:

- Ionising Radiation Risk Management Policy
- Exposure of Patients to Ionising Radiation Procedure
- Exposure of Staff and Members of the Public to Ionising Radiation Procedure
- Radioactive Substances Risk Management Policy
- Radioactive Substances Risk Management Procedure

It was confirmed that all documents had been subject to review by the relevant professional groups. Due to the meeting not being quorate it was agreed that the approval of the policies and procedures would be referred to the Board for ratification. I request that the Board ratifies the approval of these policies.

STROKE REHABILITATION MODEL AND WORKFORCE

It was confirmed that the Medicine Clinical Board was undertaking a reconfiguration of its stroke services towards a Hyperacute Stroke Unit on the UHW site and acute rehabilitation at SRC, UHL. This work involves the redesign of the inpatient bed structure, enhancing community support to stroke patients and remodeling the multidisciplinary workforce.

It was agreed that an update will be brought back to the September meeting of the Committee to confirm the deadlines and the timeframes for delivery of the key pieces of work.

COMMITTEE EFFECTIVENESS REVIEW FEEDBACK

The self-assessment process and the action plan that had been developed in response to the findings of the self-assessment were discussed. It was noted that the findings arising from the self-assessment process were fairly consistent and that a common theme arising from the self-assessment process was the need to improve the committee administrative processes

The Board is asked to ratify the approval of the action plan for improvement, which is to be completed by March 2020 in preparation for the next Effectiveness Review.

HEALTH AND CARE STANDARDS SELF-ASSESSMENT

It was confirmed that as the process was now working smoothly a self-assessment would be undertaken at the start of the year and an improvement plan developed, with an update brought to the Committee in December. This revised approach will replace the routine reporting to the Committee.

Board Members will wish to note that the UHB's Health and Care Standards process was subject to review by Internal Audit and a rating of 'Reasonable' assurance achieved.

The Committee was asked to approve the Corporate Priorities for 2019/20, these now needs to be ratified by the Board.

CWM TAF UHB MATERNITY – CARDIFF AND VALE LESSONS LEARNT

Following on from the presentation given to the Board in May 2019, the Committee discussed the outcomes of the self-assessment undertaken against the finding of the review and the progress made in relation to the areas of identified improvement.

It was noted that there continued to be a lack of clarity from Cwmtaf UHB in relation to the number of births that were expected to come to Cardiff. The importance of the UHB's maternity service having a full understanding of the demands on it was emphasised. It was clear that executive colleagues have a good understanding of the situation and related risks, The Committee was satisfied that the issue had been appropriately escalated though the South East Wales Regional Planning Board.

Point of Care Testing (POCT)

An overview concerns around POCT and the steps taken to resolve them was provided.

The Board is asked to ratify the Committees resolution to:

a) make POCT a part of the Quality and Safety review for each clinical board.

b) ensure POCT data is clearly visible on a Business Intelligence dashboard to each clinical board and for the UHB.

c) agree to the POCT group establishing a task and finish group, which reports into the POCT group (which meets quarterly), to establish solutions for the IT/governance issues

d) ensure that no new POCT devices are introduced into the UHB until these problems had been solved

e) receive a further report at the December meeting of the Committee.

CLINICAL AUDIT PLAN 2019-20

The UHB's Clinical Audit Plan for 2019-20 was considered and it was noted that the UHB would take part in 36 National Audits that formed part of the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) developed annually by Welsh Government.

Clinical Boards should have governance arrangements in place to ensure that clinical audits are planned, prioritised, undertaken and reported in a way that maximises the benefit of the audit to the organisation.

The Committee was asked to approve the Clinical Audit Plan for 2019-20, I request that this is ratified by the Board.

RECOMMENDATION

The Board is asked to:

- **NOTE** the report of the Chair of the Quality, Safety and Experience Committee

This 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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**FINANCE COMMITTEE KEY ISSUES REPORT**						
Meeting:	Board Meeting				**Meeting Date:**	25th July 2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Robert Chadwick, Executive Director of Finance**						
Report Author (Title):	**John Antoniazzi, Chair of Finance Committee**						

SITUATION

To provide the Board with a summary of key issues discussed at the Finance Committee held on 26th June.

Finance Report as at Month 2
The report updated the Committee on the UHB's financial performance to month 2.

The UHB's approved 2019/20-2021/22 Integrated Medium Term Plan (IMTP) includes a balanced financial plan for 2019/20.

The Committee was informed that at month 2, the UHB had reported an overspend of £1.715m against the plan due to a £1.134m operational overspend and £0.581m of costs for improvements in RTT performance which was being incurred at risk pending the conclusion of ongoing discussions with Welsh Government around additional funding.

It was emphasized that the operational overspend at month 2 was cause for concern, however the UHB was committed to recover the year to date deficit and had asked Clinical Boards for recovery actions to deliver a break even position by the year end as planned.

Cost Reduction Programme and Cross Cutting Theme
The report updated the Committee about the UHB's progress against the £31.245m UHB savings requirement for 2019/20. Recurrent and non recurrent schemes totaling £28.444m had been identified as Green or Amber as at 31st May 2019 leaving a shortfall of £2.801m to be identified. The recurrent impact of schemes was forecast to be £24.427m.

Risk Register
The 2019/20 Finance Risk register was presented to the Committee. It was highlighted that 4 of the risks identified on the 2019/20 Risk Register were categorized as extreme risks (Red) namely:

- Reduction in the £36.3m underlying deficit b/f to 2019/20 to the IMTP planned £4m c/f underlying deficit in 2020/21.

- Management of budget pressures including month 2 overspends of £0.749m reported in Medicine Clinical Board
- Development and delivery of corporately led financial opportunities of £14.9m to achieve year end break even position. Shortfall against target of £2.3m at month 2.
- Management of nursing position which was £0.574m over budget at month 2.

RECOMMENDATION

The Board is asked to:

- **NOTE** this report.

Shaping our Future Wellbeing Strategic Objectives *This 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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**CHAIR'S REPORT – STRATEGY AND DELIVERY TUESDAY, 25 JUNE 2019**						
Meeting:	**BOARD MEETING**				**Meeting Date:**	25.07.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:							
Report Author (Title):	Chair, Strategy and Delivery Committee						

SITUATION

To provide the Board with a summary of key issues discussed at the Strategy and Delivery Committee held on 25 June 2019.

Performance against Strategic Objectives

In line with its annual work plan requirements, the Committee received performance updates covering:

1) Annual Childhood Immunisation. Work is being undertaken to address the uptake of vaccinations as data provided by Public Health Wales identified a mixed picture with the uptake of some vaccinations declining. A number of positive actions have been identified to further improve performance.

2) Maximising Prevention. Committee Members were informed that the aim was to further strengthen the UHB's approach and maximise prevention by coordinating efforts in a stronger way. Good progress is being made.

3) A Planned Care System where Demand and Capacity are in Balance (presentation). The Committee was provided with a very good overview of the programme of work in place to achieve a planned care system that achieved a balance between capacity and demand. The Chief Operating Officer confirmed that in general the waiting list volume had stabilised and was moving in a positive direction. The presentation outlined the progress made during the initial years of SOFW. This presentation would be worth presenting to the Board at a development session.

Mental Health Measures – CAMHS Baseline Assessment

Following the repatriation of secondary specialist CAMHS from Cwm Taf UHB on April 1st, the Committee received an assessment of the very challenging inherited position together, with an outline of the intention to review and redesign the service model and to recruit to existing vacancies in the context of scarce skills.

Commercial Developments

An update was provided on the performance of the commercial outlets operating across the UHB e.g. Aroma outlets, Y Gegin. A positive contribution of £134,600 was made to the UHB for the financial year 2018/19. A Healthy Eating Audit has identified a compliance rate of 77% to 83% against a 75% target.

Key Organisational Performance Indicators
The Committee discussed the most recent performance delivered and achieved across the main areas of service activity that are closely monitored by Welsh Government (WG). The Committee was encouraged to note the continued positive performance and year on year improvement in most areas.

Workforce Metrics – People Dashboard
The Committee was introduced to the new reporting format outlining the key workforce performance indicators. In acknowledging that there is more work to be done in refining the data, the format was warmly received.

Annual Equality Statement and Report 2018 - 19

The Committee was presented with a copy of the very well developed annual report and advised that progress this year had been good in the delivery the UHB's the equality agenda. It is intended that the UHB would continue to embed its equality and human rights approach and increasingly align it to the organisation's priorities and values. A more inclusive approach would be taken with the development of the next Strategic Equality Plan.

Board Assurance Framework (BAF)
Of the six key risks set out in the BAF, four are linked to the S&D Committee i.e. workforce, sustainable primary care and community services, sustainable cultural change and capital assets.
At this June 2019 meeting the committee reviewed the risk relating to Sustainable Culture Change (the committee will review one of the key risks at each of its meetings). The risk areas identified and agreed by the Board were reviewed.
A full discussion took place around the causes, impact, current controls in place and current assurances provided.

Committee Effectiveness Review
The Committee was presented with the outcomes of the recent self-assessment review. The Director of Corporate Governance presented the data together with an action plan designed to further improve the way the Committee functions.

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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Health & Safety Committee – Chair's Report**						
Meeting:	Board Meeting				**Meeting Date:**	25 July 2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**n/a**						
Report Author (Title):	**Michael Imperato, Independent Member – Legal**						

SITUATION

To provide Board with key issues from the Health and Safety Committee held on 9 April 2019.

The Health and Safety Committee of the UHB held its last meeting on 9 July 2019 and the following report provides Board with a summary of the key issues discussed at that meeting.

REPORT

This is a written report provided to Board by the Chair of the UHB Health and Safety Committee.

Reports from each Committee Chair will highlight to the Board the key issues discussed at the last meeting of their Committee, and provide assurance regarding the business assigned to that Committee by the Board.

ASSESSMENT

The Health and Safety Committee considered the following:

- Head of H&S Charles Dalton presented the H&S Annual report. It was encouraging in that there has been a noticeable reduction in RIDDOR injuries and Manual Handling that mandatory training figures were increasing. Refresher training still has low compliance.

- There was a substantial discussion about the forthcoming HSE audit and the head of H&S at Swansea Bay UHB attended to give the benefit of his recent experience of the audit. The Committee was advised that the HSE would expect the Risk Management policy to be up to date (this rests with the Audit Committee).

- In respect of fire compliance there were no issues, relations have greatly improved with the fire service. There were two recent fire incidents and these were discussed.

RECOMMENDATION

The Board is asked to:

- **NOTE** this report.

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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Charitable Funds – Chair's Report**								
Meeting:	Board						**Meeting Date:**	25/07/2019	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		
Lead Executive:	**Ruth Walker, Director of Nursing**								
Report Author (Title):	**Akmal Hanuk, Chair of Charitable Funds Committee**								

SITUATION

This report provides the Board with and overview of the matters discussed at Charitable Funds Committee that took place on.11 June 2019

REPORT

FINANCIAL POSITION REPORT FOR THE PERIOD ENDING 31 MARCH 2019

The Committee considered the Financial Position Report. Board Members will wish to note that during the period income and expenditure had broadly matched; there had been market value gains of £0.337m on investment which was a good performance; there had been a net increase in fund balances of almost £400,000 for the year and during the year the Charity sold £700,000 of investment assets which had provided a very strong cash balance.

FUNDRAISING ACTIVITY REPORT

The report which covered the progress and activities of the Health Charity for the period 1 March to 31 May 2019 was discussed and it was confirmed that good progress was being made.

Board Members will wish to note that a Health Charity Strategy for the next 4-5 years is being drafted and will be brought to the Committee for consideration before being taken to the Trustees for approval.

BSL TRAINING AND AWARENESS UPDATE REPORT

The Committee was advised that UHB plans to train up to 500 staff over the next year through BSL Equality Training and Taster sessions; feedback from staff has been positive.

The Committee was pleased to note that on 19 June 2019 the UHB would become the first health board in Wales to sign the BSL Charter

INVESTMENT REPORT

The Portfolio Director provided the Committee with a presentation on the Investment Report and confirmed that the value of the portfolio had increased by 3.2% and was performing well.

STAFF BENEFITS GROUP UPDATE

Committee Members were provided with information in relation to staff benefits discussed and agreed by the Group during the six month period November 2018 - April 2019

It was confirmed that the Health Charity was looking to update the Staff Benefits Page and take steps to raise awareness once capacity issues in the Charity team had been addressed

Staff Benefits Group Terms of Reference

The Committee agreed that the Staff Benefits Group Terms of Reference should be referred to the Trustee for approval

Self-Assessment of Committee Effectiveness

The Committee discussed the results of the Committee Effectiveness Review for 2019 and approved the action plan for improvement and completed by March 2020 in preparation for the next Effectiveness Review.

Charitable Funds Scheme of Delegation

The committee agreed that the Charitable Funds Scheme of Delegation should be referred to the Charity Trustee for approval.

UHB Transport Timeframes

Board Members will wish to note that at the meeting it was confirmed that the frequency of the Park and Ride from Pentwyn to UHW had been increased; the mini bus service was due to live over the coming weeks; there were difficulties getting the Park and Ride operating from other sites up to UHW, as Cardiff Council had requested additional funding to enable the use of some of their premises

Staff Lottery Bids Panel Report

The bids supported by the Staff Lottery Bids Panel when it met on 8 May 2019 were discussed and noted

Charitable Funds Application: Employee Wellbeing

The Committee agreed to refer the application to fund the Employee Wellbeing Service to the Charity Trustee.

Charitable Funds Application: Reminiscence Interactive Therapy and Activities (RITA)

The Committee agreed to fund the purchase of four RITA units: three for the five Older People's Mental Health Assessment wards in UHL; one for the Functional Mental Health ward in Llanfair Unit; and one for the Young Onset Dementia ward in Barry Hospital.

Charitable Funds Application: Patient Information Screens for the University Dental Hospital

The Committee supported the bid, for four patient information screens.

Cardiff and Vale Health Charity Website Proposal

The proposal for the engagement of a new website provider for Health Charity and the appointment of Celf Creative as the new website provider.

Arts Programme Report

The Arts Programme Report presented to the Committee provided an overview of the activities and progress made by the Arts Programme during the six month period from December 2018.

Barry Hospital Update

The Committee received an update on how the charitable funds approved for the Barry Hospital First Impressions Programme were being spent

RECOMMENDATION

The Board is asked to:

- **NOTE** the report of the Chair of the Charitable Funds Committee

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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE (MHCLC) - CHAIR'S REPORT**						
Meeting:	Board Meeting				**Meeting Date:**	25.07.19	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	N/A						
Report Author (Title):	**Chair, Mental Health and Capacaity Legislation Committee**						

SITUATION

To provide the Board with a summary of key issues discussed at the Mental Health and Capacity Legislation Committee held on 4 June 2019.

PATIENT STORY

The Committee received its first patient story which was delivered by Dr Jane Hancock who shared her experiences of using the UHB's Mental Health services and provided an overview of her struggles with depression that started when she was 15 years of age.
The patient story highlighted the way forward was to deliver services from the user's perspective.

MENTAL CAPACITY ACT (MCA)

(Explanatory note: The MCA covers people aged 16 years and over with three main issues:

1) *The process to be followed where there is doubt about a person's decision making abilities and decisions may need to be made for them*
2) *How people can make future plans and/or to appoint people to make decisions for them at a time in the future when they can't take their own decisions*
3) *The legal framework for authorising deprivation of liberty in hospitals or care homes)*

Improved engagement with Mental Capacity Act training continues to be needed across the health board. Compliance varies within clinical boards with the required improvement being overseen by the Interim Medical Director. The Committee is keen to see an improvement in this area and will monitor progress closely.

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

(Explanatory Note: Dols provides a means by which a mentally disordered, incapacitated, adult can lawfully be deprived of their liberty in hospitals or care homes, if it is in the best interest of the person and there is no less restrictive way of caring for them)

The number of applications for DoLS authorization increased substantially following a landmark Supreme Court Ruling in 2014. Whilst the level of demand has now stabilised, it has not reduced. There is an on-going risk of DoLS authorizations not being processed in a timely manner and hence leading to unauthorized deprivations of liberty. This is being manged jointly through the UHB and the local authorities in Cardiff and the Vale of Glamorgan. The Mental Capacity Amendment Bill had been enacted and DoLS would be replaced by a new system, to

be known as Liberty Protection Safeguards (LPS).
The Committee will continue to monitor the situation.

MENTAL HEALTH ACT MONITORING

(Explanatory Note: The Committee also scrutinises the wider implications of the Mental Health Act with particular focus on matters relating to the functions of hospital mangers and the care and treatment of patients detained by Cardiff and Vale UHB and those subject to a community treatment order to ensure compliance with the requirements of the Act.)

It is pleasing to report that, once again, there were no breaches seen in the review period. The Committee recognised this positive achievement. The data provided in the monitoring report in relation to people being admitted to crisis care, was sparse and the Committee has requested more detailed information at the next meeting.

SECTION 136 PARTNERSHIP ARRANGEMENTS

A report was presented to the Committee which provided a detailed overview of the Mental Health Crisis Care Concordat, its origins and the way in which it was working in the Cardiff and Vale area. The Welsh Assembly Health and Social Care Committee had recently explored a number of issues with the UHBs in South Wales related to the crisis care agenda and the questions asked had been used as the framework for the paper. As well as supporting people in crisis, the focus of the Cardiff and Vale approach had been on the preventative agenda, with significant investment used from WG funding as well as local UHB funding support to provide mental health and wellbeing support to primary care practice.

FEEDBACK ON MENTAL HEALTH LEGISLATION GROUP (MHLG)

During a routine update from this multi-disciplinary operational group that supports the MHCLC, a concern was raised regarding a section 136 patient who had been suicidal and not seen by the service for two months. It was confirmed that this matter had been reported to the senior nurse for the Crisis and Liaison Service but no feedback had been received. The Committee was advised that this case had been reported to the police and it was confirmed that an update would be brought back to next committee meeting.

MENTAL HEALTH MEASURES

(Explanatory Note: The Mental Health (Wales) Measure 2010 introduced a legal requirement for health boards to deliver mental health service provision which are measured in four specific parts. Performance is reported to Welsh Government against these measures on a monthly basis)

Compliance with parts 1, 3 and 4 of the Measures were achieved for the period under review. Due to staff shortages for the following quarter, part 1a would be breached for around 50%. The Committee was assured that this was a temporary situation and would not be complied with for a couple of months only. The service would be back to full capacity and in compliance by July. A small breach of circa 5% was evident in part 2 of the measure which relates to Care & Treatment Plans for patients and this is being addressed through a comprehensive action planning process which has been reviewed by the committee.

COMMITTEE'S SELF ASSESSMENT OF EFFECTIVENESS

The results of the recent self-assessment were shared with the Committee together with an action plan that was discussed and approved. It is aimed at driving continuous improvement in the way the Committee works.

INHERITANCE REPORT FOR CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

An inheritance report was provided to the Committee that had been prepared following a 12 month project to repatriate CAMHS back to the UHB and highlighted the key issues that had been inherited from Cwm Taf UHB. The Directorate Management Team had identified a wide range of concerns about the service in relation not only to performance against required targets, but to the management of capacity and demand, clinical practice and HR and workforce. An independent review of the service has been commissioned that will provide an overview of how it compares to similar services across UK. It was confirmed that this report would be brought to the September meeting of the Committee. The Committee noted that the Strategy and Delivery Committee had been asked to take on the responsibility of monitoring CAMHS performance and in particular intervention rates.

RECOMMENDATION

The Board is asked to:

- NOTE the report

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Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**Local Partnership Forum Chair's Report**							
Meeting:	UHB Board					**Meeting Date:**	25 July 2019	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**
Lead Executive:	Executive Director of Workforce and OD							
Report Author (Title):	Workforce Governance Manager							

SITUATION

The Local Partnership Forum of the UHB held its last meeting on 5 June 2019. This report provides Board with a summary of the key issues discussed at that meeting.

REPORT

BACKGROUND

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of Workforce and OD. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

This report highlights for the Board the key issues discussed at the last meeting, and provide assurance regarding the business assigned to the Forum by the Board.

ASSESSMENT

For Consideration:

- The Forum received a copy of the mid point review of the UHB Stategy *Shaping Our Future Wellbeing* and the implementation of A Healthier Wales in Cardiff and Vale UHB.

For Communication:

- The Deputy Chief Executive updated the Forum on the following:
  - The end of year financial position
  - The recent visit from Canterbury
  - Support being offered to Cwm Taf Maternity Services
  - Operational pressures being faced now that additional winter capacity has been released

- The Deputy Director of Nursing gave a presentation on nurse staffing levels and compliance with the Nurse Staffing Act. It was recognised that maintaining the required levels can be challenging, but through initiatives like Project 95 and new ways of working we are in a better position that many other organisations, and we received Substantial Assurance following an Internal Audit Report. Mr Roberts also acknowledged the efforts made by staff and the flexibility they show by moving around in order to achieve compliance.
- The Forum received a demonstration of the 'Patient Knows Best' tool. This is an interactive online tool which allows patients and clinicians to share information and communicate much more easily. The Forum welcomed this new development, particularly noting the flexibilities different specialities could utilise and the importance of communicating differently with young people.
- Work has been taking place to streamline the number Employment Policies we have and from the end of June we will have 6 local overarching policies which will have a number of supporting procedures describing the operational detail. In addition, we will continue to have the suite of All Wales policies for issues such as attendance, disciplinary, concerns etc. There is a robust process for developing and reviewing both Policies and Procedures in partnership in place.
- The Executive Director of Strategic Planning provided the Forum with an update on sustainable travel, including the extended Park and Ride Service

For Appraisal:

- LPF received the Finance Report, Workforce KPI Report and Patient Safety, Quality and Experience Report for March 2019.

ASSURANCE is provided by:

- Ensuring alignment of Local Partnership Forum agendas with the purpose of the Forum as set out in the Terms of Reference

RECOMMENDATION

The Board is asked to:

- **NOTE** the contents of this report

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Prevention		Long term		Integration		Collaboration	x	Involvement	x
Equality and Health Impact Assessment Completed:	Not Applicable .