Cardiff and Vale University Health Board – Local Partnership Forum Meeting

Thursday 8 February 2018 at 10.00 am in Seminar Room 6, Cochrane Building, UHW

LOCAL PARTNERSHIP FORUM – AGENDA
Thursday 8 February 2018 at 10.00 am in Seminar Room 6, Cochrane Building, UHW

PART 1: ITEMS FOR ACTION		
1.	Welcome and Introductions	Verbal *Chair*
2.	Apologies for Absence	Verbal *Chair*
3.	Declarations of Interest	Verbal *Chair*
4.	Minutes of the Local Partnership Forum meeting held on 13 December 2017	*Chair*
5.	Action Log Review	
For Communication:		
6.	Learning from Canterbury – Proposed Next Steps	*Clinical Board Director – Surgical*
7.	Strategic Planning Flash Report	*Executive Director of Planning*
For Consultation or Negotiation:		
8.	Healthy Workplace – Healthy You	*Health & Safety Staff Side*
For Appraisal:		
9.	Finance Report	*Assistant Director of Finance*
10.	Workforce and OD Key Performance Indicators	*Executive Director of Workforce and OD*
11.	IMTP Update	Verbal – *Executive Director of Planning*
PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE FORUM		
1	Patient Safety Quality and Experience report	
2	Performance Report	
3	Any Other Business previously agreed with the co-Chairs	

4	Review of Meeting	Verbal - *Chair*
5	Time and Date of Next meeting: To be confirmed	

Minutes from the Local Partnership Forum Meeting held on Wednesday 13 December 2017 at 10am in Seminar Room 6, Cochrane Building, University Hospital of Wales

Present:

Martin Driscoll	Executive Director of Workforce and OD (Co-Chair)
Joe Monks	UNISON
Ceri Dolan	RCN
Catherine Salter	RCN
Steve Gauci	UNISON
Peter Hewin	BAOT/UNISON
Dorothy Debrah	BDA
Ceri Bowen	UNITE
Sharon Hopkins	Executive Director of Public Health
Abi Harris	Executive Director of Strategic Planning
Joanne Brandon	Head of Communications
Peter Welsh	Director of Corporate Governance
Melissa Rossiter	Consultant Emergency Medicine
Len Richards	Chief Executive
Julie Cassley	Deputy Director of Workforce and OD
Jenny Thomas	Clinical Board Director
Leigh Davies	Deputy Director Major Trauma
Andrew Crook	Head of Workforce Governance

In attendance (observing):

Anne Wei	Strategy Partnership and Planning Manager

Apologies:

Graham Shortland	Medical Director
Ruth Walker	Executive Director of Nursing
Bob Chadwick	Executive Director of Finance
Holly Vyse	CSP
Steve Curry	Chief Operating Officer
Fiona Jenkins	Executive Director of Therapies and Health Sciences
Mike Jones	Chair of Staff Representatives/UNISON (Co-Chair)
Fiona Salter	RCN
Rachel Pressley	Workforce Governance Manager
Karen Burke	UNISON
Dawn Ward	BAOT/UNISON
Pauline Williams	RCN

LPF17/073 WELCOME AND INTRODUCTIONS

Mr Driscoll welcomed everyone to the meeting.

LPF 17/074 APOLOGIES FOR ABSENCE

Apologies for absence were **NOTED**.

LPF 17/075 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 17/076 MINUTES OF PREVIOUS MEETING

The Local Partnership Forum **RECEIVED** and **APPROVED** the minutes from 1 November 2017 as an accurate record of the meeting.

LPF 17/077 ACTION LOG REVIEW

The Local Partnership Forum **RECEIVED** and **NOTED** the Action Log.

LPF 17/078 A MAJOR TRAUMA NETWORK FOR SOUTH AND WEST WALES AND SOUTH POWYS CONSULTATION

After Abi Harris outlined the rationale for the proposal, the Local Partnership Forum **RECEIVED** a presentation from Dr Jenny Thomas, Clinical Board Director, Children & Women Clinical Board. The presentation was on a consultation exercise by Welsh Health Specialist Services Committee and was titled:

The Consultation – A Major Trauma Network for South and West Wales and South Powys

Dr Thomas advised the meeting that South Wales was the only area in the UK without a Major Trauma Network. The main aim of a Major Trauma Network was to enable the patients to have definitive care in the right place. It is envisaged that the establishment of such a network could save up to 30 lives per year.

The presentation focused on the following areas:

- **What is major trauma?**

  Major trauma can include:

  Serious head injuries, multiple injuries cause by road traffic accident, industrial accidents, falls, mass casualty events, and attempted suicide, knife and gunshot wounds.

  Leading cause of death in people under the age of 45

  Significant cause of short and long term illness or poor health
  Increase in number of patients over 60 who suffer severe injuries as a result of falling from a standing height

- **What is a major trauma network?**

  - A major trauma network - group of hospitals, emergency services including ambulance and air ambulances and rehabilitation services, that work together to ensure a patient receives the best possible care
  - 26 major trauma networks across England and Wales.

  - Each network service on average more than 2 million people
  - South Wales has a population of 2.3 million

  North Wales and North Powys are both part of the West Midlands Major Trauma Network and have access to the major trauma centre (MTC) in north Staffordshire.

  South & West Wales and South Powys is the only region of Wales and England that is not part of a major trauma network

- **What does good trauma care look like?**

  - Good trauma care involves:
  - Getting you to the right place at the right time
  - Identifying how serious your injury is as soon as possible, ideally at the scene
  - Detailed investigations as soon as you arrive at hospital.

- **Why are we recommending a major trauma network?**

  Networks are important in managing patients who are further away from the MTC. If you are treated within a major trauma network you likely to have:

  - An increased chance of survival,
  - Better recovery

- Better quality of life

A major trauma network is beneficial to the patients treated in the network and for the hospitals, services and staff who are part of the network

- You are 15-20% more likely to survive if you are admitted to a MTC
- Less likely to have a long term disability
- More able to return to work and other activities
- You will have access to specialist equipment and staff 24/7, consultant led services
- Local emergency department less likely to be disrupted by inappropriate major cases
- Positive impact on recruitment across the network
- Bring clinical services in South Wales in line with rest of England and Wales
- Allow NHS Wales to be more effective as part of nation response to major emergencies

- **What would our major trauma network look like?**

  One major trauma centre – services are highly specialized, available 24/7, normally needed quickly when managing a patient.

  Number of trauma units – support the MTC. They have a higher level of specialist services and care available than an emergency department.

  If you are far from the MTC or need immediate treatment you will be taken to a TU, stabilized and transferred to the MTC.

  Rehabilitation will start shortly after admission to MTC and continue in TU or local community. Specialist rehab will continue to be provided from Rookwood Hospital in Cardiff and Neath Port Talbot Hospital

  You will continue to go to the emergency department if you are seriously ill or have an injury which does not need the highly specialist service only available at the MTC or specialist services only available at TU.

  Pre-hospital care will also support the network. The Welsh Ambulance Services Trust (WAST) or the Emergency Medical Retrieval & Transfer Service (EMRTS) (in partnership with the Wales Air Ambulance Charity) will assess you at the scene and transfer you to the most appropriate place for your treatment.

- **What happens now?**

  Individual circumstances of every patient are considered at scene.

If you have a suspected major trauma the Ambulance service will take you to the nearest A&E unit.

You may then need a secondary transfer by the Ambulance service to specialist services only available in particular parts of Wales- for example Neurological services at UHW, burns and plastic surgery at Morriston Hospital.

This will be determined by Clinicians at the A&E unit to which the patient was taken.

You may require greater support at the scene of the incident or for your secondary transfer. The consultant led Emergency Medical Retrieval & Transfer Service (EMRTS) has supported WAST since 2015 via the Wales Air Ambulance helicopters and response cars.

Services include the delivery of blood product transfusions, emergency anaesthetics and advanced tests and treatments. The service is currently operates 12 hours a day, 7 days a week across Wales with a vision to become 24 hours.

EMRTS offers advanced diagnosis and decision-making about where to take a patient. Patients transported by EMRTS, in partnership with the Wales Air Ambulance Charity, are taken directly to the most appropriate specialist health care facility.

- **What would happen in a network?**

  The ambulance crew will assess you, if your injuries are serious and need the services of a major trauma centre, you will be taken by ambulance or helicopter direct to the centre. This may mean driving past other hospitals

  If you need immediate treatment, the ambulance will take you to the closest trauma unit where you will be treated and stabilised before then being transferred to the major trauma centre for specialist care.

  As soon as you are fit enough you may be moved to a hospital closer to your home

- **What has been done to date?**

  Doctors, nurses, therapists and managers from across all HBs in South & West Wales and South Powys along with ambulance staff, voluntary sector with a particular interest in trauma been involved in developing service model for major trauma network for region. CHCs also been briefed and had observational status in clinical workshops and events.

2014 project board - develop the clinically led service model for the region based on national standards.

2015 clinical workshop recommended a major trauma network in the region, including one Major Trauma Centre and Trauma Units.

Morriston Hospital, Swansea and University Hospital Wales, Cardiff were the only two hospitals in the region potentially able to meet major trauma standards.

2017 - Independent panel of expert clinicians looked at the evidence and also advised on developing a Major Trauma Network for the region.

They looked at:

- Services that need to be located together - Major trauma standards set out the services that need to be available at a MTC.
- Minimum no. of people needed to make a service sustainable – As population of south Wales is small and services such as neurosurgery and plastics are so specialist, they can only be provided from one hospital site for whole of south Wales. Same is true for a major trauma centre
- Travel Times – panel considered geography and made it clear that where there is a network with a MTC you are more likely to survive regardless of the time it takes to travel to the MTC.
- It is not unusual for people to be a considerable distance from the MTC in a network. However, the wider network has a key role to play in managing patients who may be further away.

Sept 2017, HBs considered a report and agreed in principle to recommendations from Independent Panel and proposals for period of consultation.

- **Independent Panel recommendations**

  Why UHW- what was the deciding factor?

  - Panel decided providing specific highly specialist services such as neurosurgery and paediatric neurosurgery on the same site at the MTC was critical to the service model.
  - It is important to have these services available immediately if you suffer a major trauma. Approximately 60% of trauma cases need support for head injuries. Therefore this service on site is a minimum requirement. Plastic surgery is important as part of the network

What does this mean for Morriston?

- The Panel recognised the importance of burns and plastics. However, any choice about a major trauma network or centre does not require the burns and plastic unit to move.
- It does require close working between the major trauma centre and the Welsh centre for burns and plastic surgery at Morriston Hospital.
- As a large Trauma Unit, Morriston is likely to be able to manage some conditions other TUs will not. This means after assessment a patient may not need to be transferred to the MTC.
- Morriston will have a leadership role, which is necessary to make sure the network is coordinated and patients are the main focus

- **How long will it take?**

  Development of the network will take time.

  Most of the key measures required to deliver the service benefits will be in place when the network launches.

  All parts of the network will need to be reviewed regularly and development will continue in the first two years after launch

- **How much will it cost?**

  It is recognised that we will need to invest more money in buildings and staff the meet the standards of a major trauma network.

  Following the consultation we will need to do further work to develop more detailed costs and consider how the network should be funded. We will need to look at how the costs of the network may be met through the existing planning processes in Wales.

- **What happens next?**

  Health Boards have agreed in principle to support a period of formal consultation on the recommendations for the development of the major trauma network.

  The consultation period will be for 12 weeks and last until 5 February 2018.

  Response will be analysed and shared with CHC and health boards and a report considered by health boards in March 2018.

Further work will be required to determine the costs of developing a network for the region

Health Boards will also need to look at how hospitals that have the potential to be a trauma unit are able to meet the criteria in the national standards and guidelines for major trauma. Support will be provided by the Wales Critical Care and Trauma Network

- **How can I get involved?**

  It is really important we make the best decision for the population of South and West Wales and South Powys.

  We want to develop services that will make sure that if you suffer a major trauma, you will have an increased chance of survival, better recovery and better quality of life for the future if you are treated within a major trauma network.

  So how can you give feedback?
  - Attend public meetings
  - Log onto the website www.publichealthwales.org/majortraumaconsultation
  - Complete the response form

  You can also contact your local CHCs or the Health Collaborative for further information.

  The public meetings being held in Cardiff and the Vale of Glamorgan are:

  Tuesday 9 January 6.30 – 8pm in Castleland Community Centre, Belvedere Crescent, Barry, CF63 4JZ

  Wednesday 10 January 6.30 – 8pm in St Andrew's United Reformed Church, Pen-Y-Lan Road, Roath, Cardiff, CF24 3PB

- **Questions**

  Question 1 - Do you agree or disagree that a major trauma network should be established for south and west Wales and South Powys? Please give the reasons for your answer?

  Question 2 - Do you agree or disagree the development of the major trauma network should be based on the recommendations from the independent panel? Please give the reasons for your answer

  Question 3 - If we develop a major trauma network for South and West Wales and South Powys, is there anything else we should consider?

Following the presentation, Mrs Salter asked about the funding for the network. Dr Thomas indicated that WHSCC would be the commissioning body but it was yet to be determined whether monies would be 'top sliced'. Mr Richards indicated that WHSCC would pick this up and there was room for optimism but there was a need to reorganize the resources. The EMRTS service was already in place and patients already come to the University Hospital of Wales.

In response to a question from Mr Gauci regarding the rehabilitation services at Rookwood Hospital, Mrs Harris stated that the business case would be resubmitted to Welsh Government but the services would be re-provided at the University Hospital Llandough.

Following further discussions, it was acknowledged that the Major trauma network could prove to be a fantastic opportunity for recruitment, especially in relation to Joint Ministry of Defence staff. There is a lot of kudos attached to a major trauma centre and the impact of the staffing expertise would diffuse throughout the health system.

LPF 17/079 CHIEF EXECUTIVE'S UPDATE REPORT

The Local Partnership Forum **RECEIVED** a verbal update from the Chief Executive, Mr Len Richards.

Mr Richards fed back on the recent Joint Executive Team (JET) meeting with Welsh Government. Whilst the UHB is still in 'targeted intervention', Mr Richards reported that overall very positive feedback had been received especially in relation to our performance against the key targets. Progress was definitely being made.

Mr Richards updated the Forum on the recent visit to Canterbury in New Zealand. The similarities between the Cardiff and Vale area and Canterbury were highlighted in that both served a similar population size and the health services were similarly set up. Both areas have addressed or are addressing similar challenges.

Within the Canterbury model, the number of falls had reduced; there were fewer attendances in the Emergency Units and a reduction in the fractured neck of femur and; less people were going into older age services.

The proposal was now to build a Cardiff and Vale process/system and to learn from the Canterbury model/experiences. The process would be based on the patients, with them being treated close to home or in the community.

Within the Canterbury model, there was a pervasive vision and everyone shared the 'message'. Professional development and communications were all tied to the vision. There was clinical engagement and empowerment to make decisions, with the system being supported by good, contemporary 'live' data and information.

Mr Richards stated that the UHB would need to look at what we can learn from the Canterbury model and what we can adopt. He stated that the culture in Canterbury seemed liberated and that it seemed easy to get things done. There was a permissive environment but individuals were held to account – this was the Canterbury way of doing things.

Mr Richards advised the Forum that a paper would be discussed with the HSMB before being circulated more widely. It was agreed that this would be on the agenda for the next Local Partnership Forum meeting
ACTION: Mr Crook

In relation to the culture in Canterbury, Ms Debrah commented that this was the most difficult challenge. Mr Richards confirmed that this was the case but Canterbury were already ten years into their process but this was backed up not just in words but in deeds. Cultural change may change the way that the organisation is managed but the principles being 'Caring for People, Keeping them Well' will stay.

It was recognised that the UHB needed to start the journey and to enable lower level decisions. The transition will be built on values and strategy.

LPF 17/080 STAFF BENEFITS UPDATE REPORT

The Local Partnership Forum **RECEIVED** a verbal update from Mr Welsh, Director of Governance on the progress made in relation to Staff Benefits.

The examples Mr Welsh cited included:

- The CAV Spend to Save Vectis Card
- The agreement with Griffin Mill Garages which will allow UHB staff to receive discounts in respect of new cars, vehicle leasing and 2nd Hand Cars
- Enterprise Car Rentals
- A Change Accounts Scheme which will enable staff to open a digital Bank Account
- A 'fast track' Charitable Bids process

LPF 17/081 FINANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** a report from the Chief Executive, Len Richards (in the absence of Bob Chadwick), detailing the financial position of the UHB for the period ended 31 October 2017.

Mr Richards noted that the UHB has a planned deficit of £30.9m for the year and he stated that every month the gap is being eroded. The monthly position is on target and the Finance report reinforces the progress that is being made.

LPF 17/082 WORKFORCE AND OD KEY PERFORMANCE INDICATORS

The Local Partnership Forum **RECEIVED** and **NOTED** the report of Mr Martin Driscoll the Executive Director of Workforce and OD.

Mr Driscoll reported that the sickness absence targets are challenging and while a lot of work is being undertaken on PADRs, the work does not seem to be recognised on the ESR system.

He advised the Forum that the timelines associated with the Disciplinary process were now being closely looked at and were being discussed at the Workforce Partnership Group.

LPF 17/083 IMTP UPDATE

The Local Partnership Forum **RECEIVED** a verbal update from the Executive Director of Planning, Mrs Abi Harris.

Mrs Harris stated that whilst the UHB did not have an approved Intermediate Medium Term Plan (IMTP), we had been encouraged to submit a 3 year plan, which reflects the growing confidence from Welsh Government.

The plan sought the balance of meeting our financial challenge with the need to continue improving services for our patients.

The Clinical Boards' plans had been submitted and were being scrutinized.

She stated that whilst there was a lot to do, we were in a better place.

LPF 17/084 PATIENT SAFETY, QUALITY AND EXPERIENCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Patient Safety, Quality and Experience Report.

LPF 17/085 PERFORMANCE REPORT

The Local Partnership Forum **RECEIVED** and **NOTED** the Performance Report.

LPF 17/086 ANY OTHER BUSINESS

There was no other business raised.

LPF 17/087 REVIEW OF THE MEETING

The Local Partnership Forum reviewed the meeting but no items were highlighted to take to the Board:

LPF 17/088 DATE OF NEXT MEETING

The next meeting of the Local Partnership Forum would be held on Thursday 8 February 2018 at 10.00am in Seminar Room 6, Cochrane Building, University Hospital of Wales. The room would be available from 9.00am for a staff representative pre-meeting.

Local Partnership Forum – Action Log

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
LPF 17/079	13 December 2017	Chief Executives Update	Canterbury paper to be on agenda for the next meeting of the Local Partnership Forum	Mr Crook	Complete

LEARNING FROM CANTERBURY
PROPOSED NEXT STEPS

1 INTRODUCTION

The purpose of this paper is to provide immediate feedback to the Board on the core elements that would describe the way in which the Canterbury Health System is led and is managed. It is also intended that this paper provides the basis of communication to the rest of the organisation and the system in general.

The context for the paper is to suggest that the Canterbury Health System is a system that has a very consistent vision to that set out in Shaping Our Future Wellbeing and that Canterbury can demonstrate significant achievement towards that vision being 10 years on that particular journey. It is however vital to stress that this paper does not suggest a 'lift and shift' type approach as it is extremely important to recognise the context of Cardiff and Vale UHB, and its starting position on the journey set out within Shaping Our Future Wellbeing. I am reminded of a quote from David Meates the Chief Executive of Canterbury Health Board "You can't lift and shift the Canterbury model, but you can learn from what has worked in Canterbury and interpret the high level route map that has been created by the Canterbury Health System."

On the basis of the above I will attempt to focus this paper on the core elements that define the Canterbury Health System. However, before we do that it is worth setting out just some of the outcomes that have been achieved in Canterbury over the last 10 years.

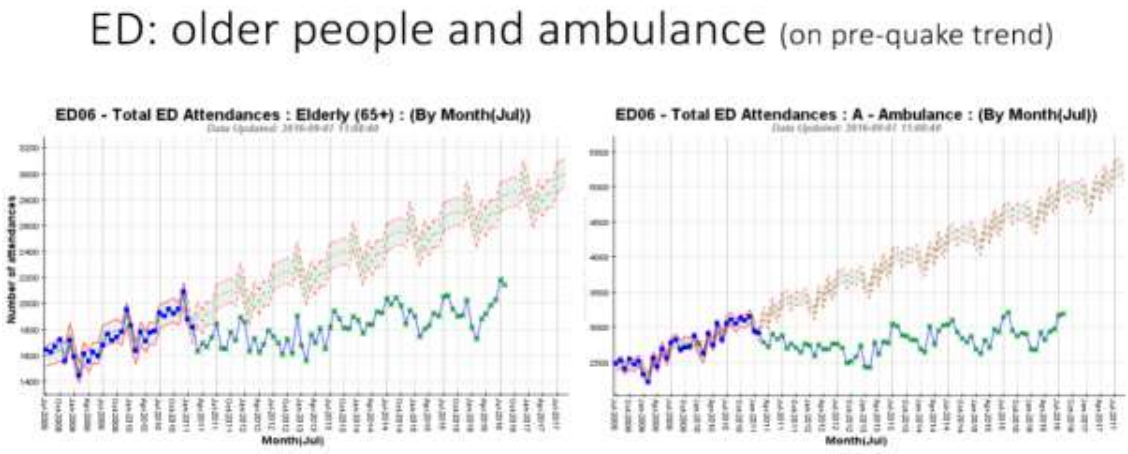
2 SOME KEY RESULTS FROM CANTERBURY

As usual within any Health System, Canterbury have a significant number of key performance indicators. Some are determined within the Health System and many are imposed through government policy. It is not my intention to provide a full analysis of where the Canterbury Health System is against all of these KPI's however I do want to draw out their position against a small number of highly relevant indicators – relevant in terms of their journey and in terms of our Strategy "Shaping our Future Wellbeing."

2.1 Keeping Older People out of ED

The two graphs at Figure 1 show a significant reduction in the number of older people (+65 years) attending the Emergency Department and the number of ambulance attendances. This has been achieved by providing alternative models of care in the community that are available and accessible to General Practitioners. These alternatives would include the Acute Demand Management Service, an active Falls Prevention Service, Community Rehabilitation, Enablement and Support Team, Medication Management Service and a 24/7 GP Practice.

Figure 1



It must also be stated that these achievements should be set against a growing population of older people.

2.2 Falls Prevention Outcomes

Figure 2 shows a number of graphs that demonstrate less demand on hospital services as a result of a fall. The overall impact over the first 4 years (2012 to 2016) shows:

1) 1862 fewer ED attendances
2) 553 fewer neck of femur fractures
3) 32,008 fewer NOF bed days required
4) 211 fewer deaths at 180 days post NOF surgery.

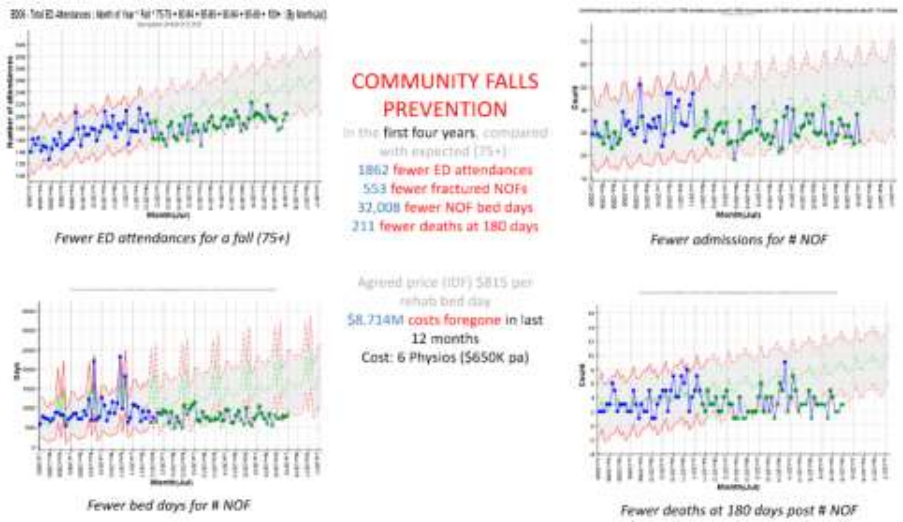


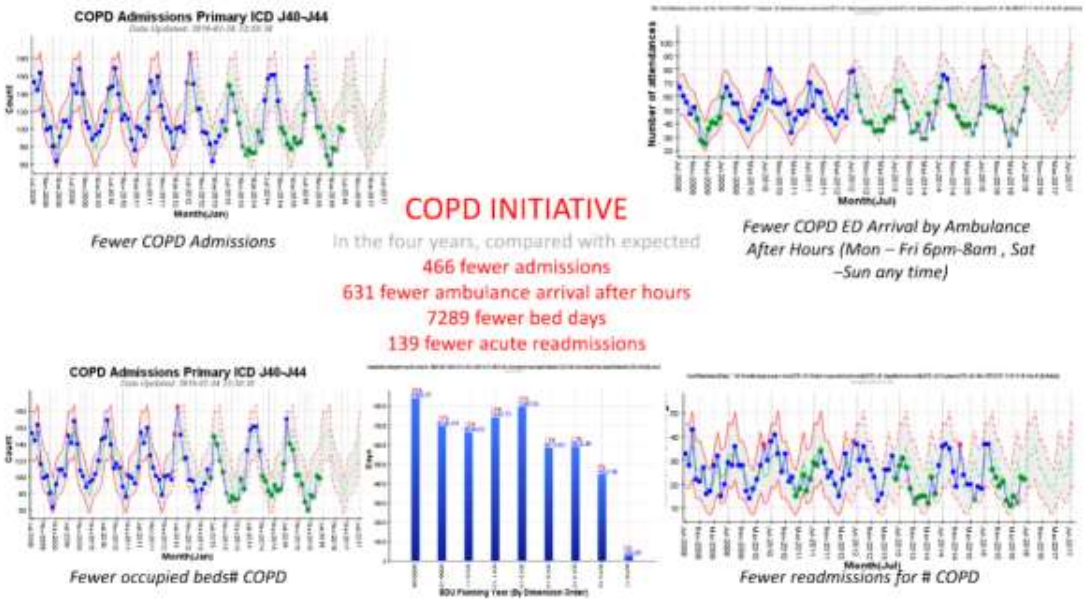
Figure 2

2.3 Chronic Obstructive Pulmonary Disease (COPD)

Figure 3 shows a number of graphs that demonstrate less demand on hospital services for people diagnosed with COPD. The overall results show:

1) 466 fewer admissions
2) 631 fewer ambulance arrival after hours
3) 7289 fewer bed days
4) 139 fewer acute re-admissions.

Figure 3



Attached at Appendix 1 is a paper titled "An Integrated Respiratory Service – COPD Management in Canterbury" which gives a detailed account of how the clinical staff within Canterbury have re-organised clinical services to achieve their vision of care closer to home for COPD patients. The account acts as a blue print for similar service re-designs in the Canterbury Health System.

3 CORE ELEMENTS OF THE CANTERBURY HEALTH SYSTEM

It is immediately apparent when you listen to the senior management team within the Canterbury Health System, that there has not been a Grand Masterplan setting out a step by step approach to the system transformation that has clearly taken place over the last 10 years. It has more been an evolutionary journey built on a platform of stable and values based leadership. The team use metaphors a lot when describing their journey and one which we liked was the sailing metaphor. "We knew where we wanted to get to

but in the changing dynamics of the wind it is necessary to tack from side to side whilst making progress towards the destination."

It is clear that at the outset of their journey in 2007 they could describe what the destination looked like or more practically what good care looked like, but they did not know what the journey was going to be like. It was also very refreshing to listen to various members of the team who describe the things that did not work, as well as the things that did, as they learned to put the right pieces in place.

However, through the uncertainty they were able to maintain a consistency of purpose through a number of core elements which I will describe. Throughout the descriptions of the core elements I will also provide some practical examples of things they did which will resonate with our proposed Next Steps.

3.1 Vision – A Strong Compelling Vision Routed in the Values of the Staff

The vision is represented in Figure 4. It was developed initially by a group of 40 staff drawn from across the organisation and during that development phase the 40 staff became 80. There were a number of events which they called Vision 2020, during which they envisioned a different future. The context at that time was a broken health system, poorly performing on all indicators and very hospital centric. The vision can be characterised as "Care closer to Home" but it is brought to life by Agnes being front and centre of the vision with care delivery building out from her home, her locality and the community with the hospital services being represented on the periphery. Key aspects of the visions are:

1) It is multi-agency in that it describes a complex system with many players.
2) It draws together Health and Social Care under banner of INTEGRATED HEALTH AND SOCIAL SERVICES.

Figure 4

The visual representation as seen in Figure 4 is also underpinned by three Strategic Goals as follows:

1) People take greater responsibility for their own health
2) People stay well in their own homes and communities
3) People receive timely and appropriate complex care.

The Vision as described is not dissimilar to that set out in Shaping Our Future Wellbeing, however what follows is, and sets Canterbury apart from many organisations that find themselves with a well written and constructed Vision document that is partially understood. They brought their Vision to life. When in Canterbury you can't help but be struck by the investment in time, money and initiative in making the Vision real.

In 2009 they held their first "Showcase" session through which each of the 80 original participants in the Vision sessions got an opportunity to invite 10 guests (staff) each, and they would take their own group through the showcase experience.

The "Showcase" experience was a 2½ hour journey through a set of experiences, video diary, monologue and dialogue – almost theatre like - to engage staff with the vision. They had intended to run these sessions over 2 weeks and get 800 staff engaged. They ran it for two months and engaged with over 2500 staff.

It was designed to be an experience. There was a heavy use of metaphor and symbol and it was theatrical in delivery. Agnes was the star of the show and the staff who were engaged became the real life players within the organisation to turn the vision into a reality. Each member of staff that attended was given a "Permissions Card" from the Chief Executive giving them permission to change their service to meet the objectives of the Vision to be more responsive of Agnes.

Interestingly the senior leadership team were not prescriptive about who should be taken into the Showcase it was left to the 80 staff – who were the original contributors to the Vision 2020, to invite their colleagues. Once staff had been through the showcase they could then invite further colleagues. It is described as developing a Social Movement and in doing so recruiting those who will take on the responsibility to turn that vision into a reality.

They repeated the event again in 2013, during which they could demonstrate tangible achievements which further endorsed the Vision and, following the natural disaster in Christchurch, acted as a "call to arms." The concept of the Showcase is a common feature of the Canterbury approach and is viewed as a very pivotal engagement approach.

3.2 Clinical Engagement and Empowerment

Clinical Engagement in its widest context is the engine that drives the organisation forward. This was demonstrated by the clinical staff that we met, but it was also evident when we met with members of staff from the Corporate Departments most notably:

Information, Planning and Funding, Organisational Development. It was clear that the senior leadership team put in place services, processes and built capability to promote clinical engagement and decision making. In this section, I will set out a range of mechanisms that were evident in promoting clinical engagement and empowerment to make decisions.

The headings in bold are those areas that have been identified as being instrumental in promoting the right engagement to facilitate service change.

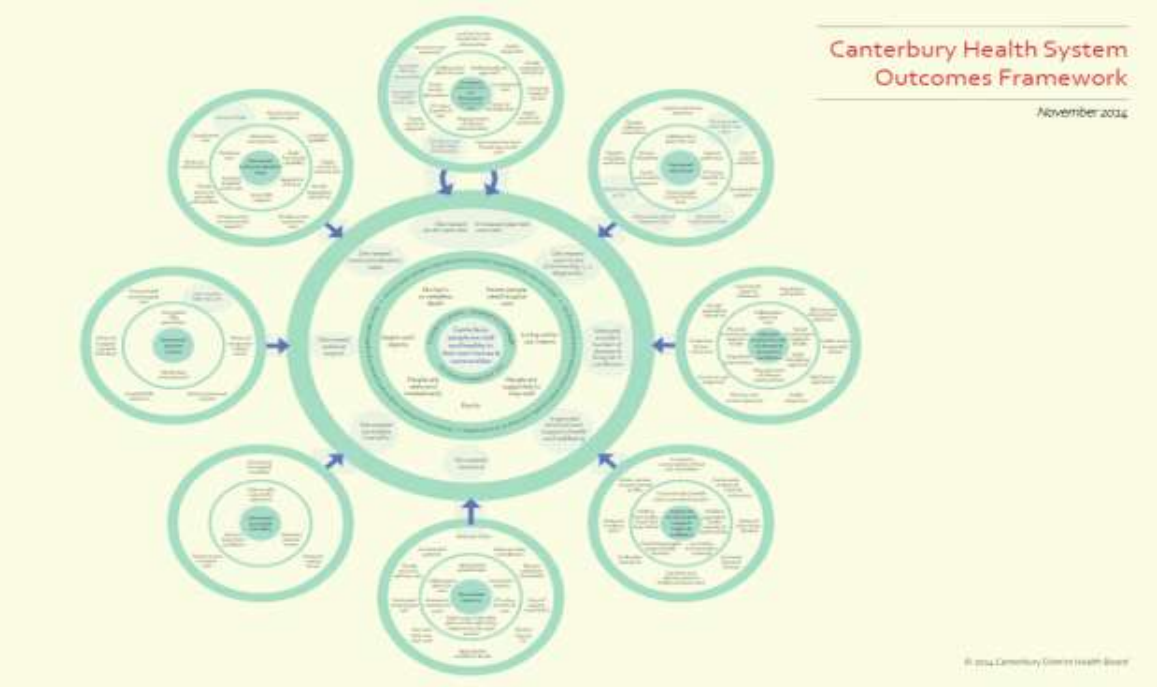
3.2.1 Data into Accessible Information

Canterbury Health System have a system that draws data from the many different IT systems throughout the organisation and that of its Alliance partners to include activity, coded data, Quality and Safety, Human Resources etc. It presents that data (de-identified) at a granular level, in as near to real time as possible and presents it in a format that encourages and enables frontline clinical staff to interrogate and understand what is happening in their service.

The data presentation and the time series nature facilitates clinical staff to define the relevant questions, develop solutions to those questions, define service improvement and then to track the impact of those improvements and any unintended consequences. They call this “Making the invisible visible.” The clinicians we spoke to identified this data driven approach as a key enabler of their input and one senior clinician described it to me as “Data as the means of empowerment, using ‘live’ data we can validate or refute decisions quickly. Because the data is in real time there are short feedback loops meaning good ideas are rapidly adopted and poor ones quickly stopped.”

The data was also aligned to the detailed Clinical Outcomes Framework that has been developed by the Board which provides the ability for a real-time performance report to the Board and cascaded to relevant parts of the organisation so that performance can be pro-actively managed. The Outcomes Framework can be seen in Figure 5.

Figure 5



It is a system-wide set of measures that enable the senior leadership teams of the individual organisations to measure the impact of the services they provide on a system wide basis. It is available to all organisations that make up the Canterbury Health System.

The Outcomes Framework is electronically enabled and so that also forms the basis of internal and external performance reporting.

3.2.2 Clinical Pathways

In response to the divisions that have naturally occurred in medicine between Primary and Secondary Care Clinicians, they started an Improvement approach called The Canterbury Initiative. That initiative was firstly about improvements in Primary Care but it quickly developed into the interface issues between primary and secondary care. The output of the Canterbury Initiative was the development of Care Pathways which is a codified Pathway that is available to GPs in electronic form, which is condition/symptom specific. The Pathway gives guidance to the GP about what should be done in primary care, what services are available within the Community and if a referral is necessary to the hospital what information is required.

These Care Pathways have been developed in collaboration between GPs, secondary care clinicians and other clinicians as appropriate. In the Canterbury System there are over 500 Pathways in use, and they cover all disciplines. In Mental Health, Frailty and a number of other areas, the Pathway includes Social Services provision as well as third sector providers. More recently the Pathways have branched out into the hospital with a number of secondary care Pathways.

Healthcare Pathways are described in Canterbury as one of the foundation blocks for their system. They provide a mechanism to generate discussion and agreement about how patients can be managed in that system, they encourage standardisation, they are a prime information service for junior doctors and new appointees, and they are a good deployment mechanism for changes in practice as a result of new evidence.

3.2.3 The Canterbury Clinical Network – Alliances

The Canterbury Clinical Network is a way of bringing together the varied clinical staff from across disciplines and different organisations to focus on a service or a problem statement in order to transform service delivery. The Canterbury Clinical Network is the mechanism by which clinicians determine the development of services across the Health System.

It does this by bringing relevant frontline staff from a wide range of backgrounds and organisations together to discuss the service in the context of service improvement.

The Network makes a big play of the individuals sat round the table as not being representatives of their organisation or their department but rather they are there to provide a particular clinical perspective. **The binding principle is what is best for Agnes**, not what is best for my organisation or my department. The Network was referenced as the Switzerland of the system – completely neutral and not aligned to any one particular organisation or department.

The organisational interests are bound within an Alliance Framework. The work of the Chief Executives of the different organisations that make up the Canterbury Clinical Network, is focussed on upholding the Alliance principles. The Framework can be seen at Appendix 2.

The work of the clinical staff engaged in the many Service Level Alliances, Work Groups or Work streams is to agree how to organise the particular service to get the best outcome for Agnes.

3.3 Culture

Peter Drucker famously said “Culture eats strategy for breakfast” with intent of demonstrating it is not just about a great strategy but it is also about the capability of the organisation to deliver that strategy.

It is abundantly clear that the leadership of the Canterbury Health System understand this implicitly as there are many examples of where they have worked hard to develop the culture of the organisation in order to meet the challenges of implementing the vision within a complex health system.

The way in which they went about determining the Vision and the Social Movement approach to communications are examples. The focus on Clinical Engagement is another strong example. In this section I want to build upon those, setting out how the senior team have gone about preparing the organisation.

3.3.1 One System, One Budget

This guiding principle manifests itself in a very permissive approach to funding and contracting. The Funding and Planning Team pride themselves in being able to respond appropriately to the new service models that emerge from the improvement activities ie new service models from the Canterbury Clinical Network, or a new care pathway etc. This builds upon the need for data to justify change, it is also built upon the premise that the organisation stops doing the things that are proved as ineffective, and lastly if a change is determined as not meeting the objective then it is switched off quickly.

3.3.2 Empowered Decisions Through Alliance

I talked in the last section of the importance of the Canterbury Clinical Network which is clinically led, multi-disciplinary and multi-agency. The principles of the Alliance are outlined in Appendix 2. However in addition to this, the organisation has an Empowered Decision Making Model which is titled “A new way of working based on Trust” – see Appendix 3.

Clinicians at a service level and at an Alliance level are empowered to make decisions in the best interests of Agnes and in support of the system’s Vision.

3.3.3 Skills and Leadership Development

The organisation has a suite of Training and Leadership Development. There are 3 programmes aimed at different levels in the organisation. They vary in terms of skills acquisition and leadership development but there are a number of common principles that run through them all:

- Skills in improvement and change management
- Re-enforcement of the vision
- Understanding of complex systems, learning from other industries
- Senior Executives demonstrating servant leadership
- Staff being given permission to act on behalf of Agnes.

3.3.4 High Trust – Low Bureaucracy

In a way this is aligned with the permissive approach to improvement – if it is in Agnes’s best interest, it is in the interest of the organisation. However, I have put it in as a specific underlying principle as there are some striking ways in which this has been put in place.

An example of which is:

The Acute Demand Management System is a service that encourages General Practice to do all in their power to put in place services that will avoid the need for admission to hospital. In many instances that requires an enhanced level of support from the GP. In those circumstances the GP is able to claim a fee from the Canterbury District Health Board. Because some of these arrangements are so bespoke to the patients, the GP is able to claim the costs directly without the need for itemised cost schedule. This recognises the urgency with which the GP has to act however it is also a high trust environment ie "tell us how much it costs."

3.3.5 Design Laboratory

There is a dedicated Design Laboratory based in a warehouse in the city of Christchurch. It is a facility that is used for initiatives like Showcase, Organisational Development and various Alliance Meetings. It is set out with various symbols that are important to the Vision of the Health System. As an example it has a model of Agnes's House, it has many cartoon drawings depicting the Vision, the Outcomes Framework, the Leadership model, Empowered Decision Making Tool etc.

It is a resource space to engage staff about anything and everything. In addition to the above we saw some very specific examples of where "prototyping" has been developed as part of the design phase of improvement, refurbishment and new building design. This prototyping gives staff the ability to test new models of care within a mock up Ward or clinic room, etc.

The Design Lab is a symbol in itself. It is a safe place which encourages innovation.

4 PRACTICAL DEVELOPMENTS

The purpose of this section is to set out some of the important service developments that the Canterbury Health System has in place to support the Vision of Care Closer to Home.

I won't go into specific details as I think it will be important to review these against the services that we have available to us already here within Cardiff and Vale. This is an area of joint interest with Canterbury where they think they have further work to do and we could usefully do that together.

In Canterbury they have an Acute Demand Management System that on initial review, correlates well with our Acute Response Team. However, the Canterbury ADMS provides an additional focus on what General Practice can do with specific arrangements for remuneration for additional work by the Practice to manage people at home. ADMS also have a number of observation beds that enable short term observation rather than acute admission.

In Canterbury they have a Community Rehabilitation, Enablement and Support Team (CREST) and we have Community Resource Teams (CRT). It will be interesting to understand the similarities and the differences. One of the differences is that CREST is a joint health and social care team, and has a restorative model of care with very specific measurement of capability.

In that regard it was evident that the restorative model of care was embedded. There was "care coordination" in place to ensure that there was not too many people attending to the patient in their homes, the plan was typically on the fridge so as staff attended they knew what the plan was and could contribute, the patient had a goal orientated plan and a consistent message of "mobilise the patient at every interaction" came through strongly.

The Medical Management Service and our Medicines Optimisation approach have some clear synergies.

Lastly there is a 24 hour/7 day per week General Practice based in Christchurch. The 24/7 Practice provides a home to a number of the above community teams. However, it also operates a walk-in service supported by relevant diagnostics. Again it will be interesting to compare and contrast with our GP Out of Hours Service to see if potential opportunities for further development.

5 NEXT STEPS

Whilst a "lift and shift" of the Canterbury District Health Board would not engender the support that we need from our staff to kick-start our drive to deliver our strategy outlined in Shaping Our Future Wellbeing, there is a great deal to learn from the approach that the Canterbury Team have delivered. It is also very interesting to note that in many aspects the service components are already in place and in some cases we have advanced services in place particularly within some of our Primary and Community Care services. Canterbury have said they are very interested in working with us to learn from our models.

It is clear that within our system, the barriers to change are high, we have a Low Trust-High Bureaucracy culture and we are missing some of the underpinning system requirements eg we do not have an Information Service that supports clinical staff to engage in improvement/service design.

We would therefore propose:

5.1 International Alliance

The development of an International Alliance between Cardiff and Vale UHB, Canterbury District Health Board, South East Sydney Health Board and Grampian Health Board. This would be a non-commercial Alliance opening up opportunities for the four organisations to learn from each other in pursuit of the similar vision that we all hold of Care Closer to Home, Timely Access and Effective Delivery.

It is interesting to note that whilst Canterbury are the most advanced in delivery, they are very keen to develop the Alliance as they believe they have a lot to learn from alliance partners, as well as introducing another dynamic to motivate improvement. They are also keen to develop an international context for their improvement.

The Alliance would utilise the Alliance Framework that is in place in Canterbury and would include:

1) Regular communication forums for leaders throughout our system
2) Data sharing to support service improvement
3) Staff development across the Alliance through secondment, project work, bricklaying system etc
4) Support for the development of Transformation Programmes.

5.2 Re-invigorate our Vision – Shaping Our Future Wellbeing

We have a well formed strategy titled Shaping Our Future Wellbeing. It was borne out of a rapid listening exercise and has overall buy-in from the Executive and our Senior Leadership Teams.

It does not feel like we have leveraged support for the Strategy and unfortunately it is not a common language across the organisation. We have to find a way of bringing the vision to life. Using an initiative like "Showcase" would signal a different approach and would develop the sort of Social Movement required to get a unified vision of our future guiding our decision making.

5.3 Develop an Outcomes Framework

Bring together a reflection of the Strategy through the development of the Cardiff and Vale Outcomes Framework. This will be built on the many indicators that we monitor now, but it will express the indicators in terms of outcomes and drive the various Performance reporting to the Board, sub committees and the Performance Framework at Clinical Service Board, Clinical Directorate and Ward/Department.

The Outcomes Framework presents us with an excellent opportunity to broaden the perspective of health, and similar to Canterbury, to work with partners to develop system measures of performance. This could offer us opportunities to jointly measure the impact of health and social care from a system perspective and maybe of interest to the Public Sector Board and the Regional Partnership Board.

5.4 Develop the Necessary IT Interface to provide timely data in a format that will encourage clinical engagement

Canterbury have a system called "Signals from Noise" which creates an important interface between the IT systems that are used and the clinical staff enabling them to engage in the data and support improvement work. The system generates timely and

often real time information and it presents that information in a format that encourages the clinical staff to engage.

It is very different from our approach to the use of data, which is often spoken of as a barrier of clinical engagement in our system.

As we all know there is no magic bullet within Healthcare, however this approach is seen as a fundamental platform on which the Canterbury Health System has developed.

It is critical that we develop the capability to pull together the relevant data in a timely way so that we can enable our clinical staff to use the data to inform decision making and improvement. I said earlier in the report the Clinical Engagement is the engine of the Canterbury Health System that being the case the way in which they provide the information is the fuel.

5.5 Clinical Pathways

In the same way that the data is a foundational element in the system in Canterbury so is the implementation of Clinical Pathways. We should look at this from a Primary and Secondary Care perspective and set out a Programme of Work to drive this forward.

5.6 Falls Prevention

The work Canterbury have done around Falls Prevention in the Community has led to some very positive results. We currently invest a significant amount of resources in Falls Prevention however it is not delivered in a consistent way across our Health System.

We should engage our clinical staff through an Alliance type model to review our Falls Prevention service(s) and to design a service for Cardiff and Vale. This will be multi-agency and multi-professional. Learning from Canterbury it will also lead us to engaging with the Community and utilising a range of community resources.

5.7 Alliancing

We should look for other opportunities to develop an Alliancing type model to address a couple of other service type models. These could include COPD and our Stroke services.

5.8 Organisational Development

Engage with Canterbury through the International Alliance to understand the content of their 3 major OD programmes. In doing so develop a more coherent approach to OD, developing reduced but more focussed programmes to give staff the capability that we need to build our system to meet our Vision of the future.

Len Richards
Chief Executive

An Integrated Respiratory Service – COPD Management in Canterbury

Contents

Canterbury Initiative Overview and the Integrated Respiratory Service

The Canterbury Initiative was established in 2007 initially as a referral management project, but subsequently evolved into a process for linking primary and secondary care clinicians into a whole of system approach to management of complex medical and surgical conditions and complex systems. For more details of the Canterbury Initiative please see their website[1].

The Integrated Respiratory Service (IRS) was also established in 2007 to develop and implement a new way of working across the community, primary and secondary respiratory sectors, linking to NGO activities, and with consumer input and support. As part of the service, a community-based team of specialist nurses and physicians was established with the aim of supporting general practice to look after their patients with respiratory disease. Community provision of hospital-standard services such as spirometry, sleep studies and pulmonary rehabilitation were launched in order to provide better access for more people in settings other than the hospital.

[1] www.canterburyinitiative.org.nz

One of the early target projects for the IRS was to improve the management of chronic obstructive pulmonary disease (COPD) across all sectors. This became particularly relevant following the Canterbury earthquakes, with the need to conserve hospital beds for those most in need.

The IRS has undertaken a comprehensive, whole-of-system approach to the management of COPD, both in the stable state and during exacerbations. Details of this approach are set out below.

Prevention

Canterbury and the IRS are supporting the Ministry of Health's mandated approach to smoking cessation. This is clearly the main preventative measure for the reduction of prevalence of COPD, and for its progression. Smoking cessation is encouraged at all stages of severity of COPD, and at every clinical interaction with a patient with COPD. Patients in hospital have received ABC quit advice and their general practitioner is notified via the electronic discharge summary. In addition, smoking cessation is a core component of community activities such as pulmonary rehabilitation and Smokefree are linked to all respiratory health promotion activity across the region.

Case Finding and Early Diagnosis

The diagnosis of COPD requires the demonstration of airflow obstruction that is not fully reversible[2]. Good quality spirometry therefore needs to be readily available in primary care settings, where the majority of COPD diagnoses should be occurring. Without the availability of spirometry, COPD is misdiagnosed in 27% of patients[3]. Unfortunately, spirometry performed in primary care settings is often of variable quality owing to inadequate training, poor quality control and insufficient patient throughput[4]. To address this issue, the IRS developed a laboratory-quality spirometry service in the community. This is delivered by approved general practices, with an agreed quality framework supported by Respiratory Specialist Services and the hospital's physiology laboratory.

The required development steps included provision of web-based clinical information for referring clinicians (on HealthPathways), linkage with an electronic referral management system, standardised testing systems, processes, training and education, web-based reporting of tests and filing of results in an electronic shared care view of the medical record. (For more details of this activity, including outcomes, please see link[5].)

Eleven approved community providers in Canterbury have performed over 5,200 spirometry tests to laboratory standards of quality since 2009.

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[2] Global initiative for chronic obstructive lung disease (GOLD). Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease (updated 2013). Available at http://www.goldcopd.org/uploads/users/files/GOLD_Report_2013_Feb20.pdf.

[3] Jones RC, Dickson-Spillmann M, Mather MJ, Marks D, Shhakell BS. Accuracy of diagnostic registers and management of chronic obstructive pulmonary disease: the Devon primary care audit. Respir Res 2008; 9: 62.

[4] Enright P. The use and abuse of office spirometry. Prim Care Respir J 2008; 17:238–242.

[5] Epton MJ, Stanton JD, McGeoch GR, Shand BI, Swanney MP. The development of a community-based spirometry service in the Canterbury region of New Zealand: observations on new service delivery. NPJ Prim Care Respir Med. 2015 Mar 5;25:15003.

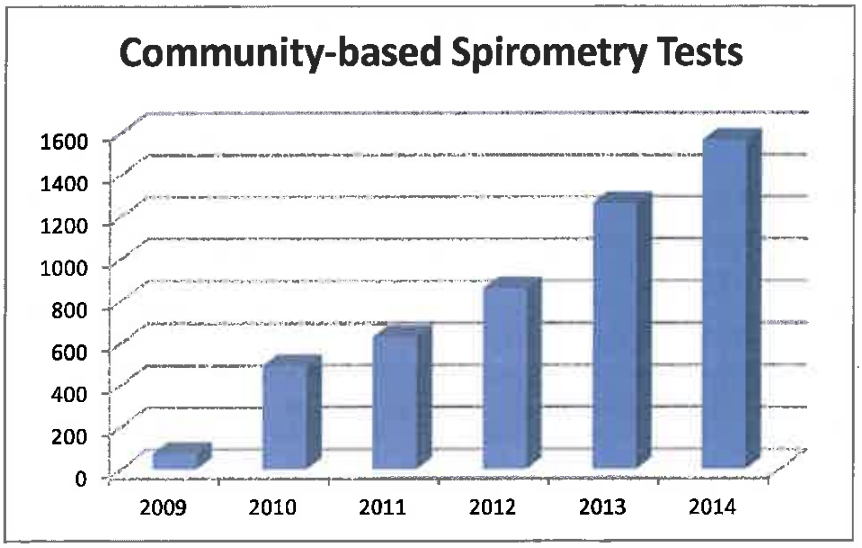


Figure 1. *Spirometry tests carried out by either approved general practices or community respiratory nurses.*

Community COPD Case Finding Project

The utility of case finding for COPD in a primary care setting is clear. International literature demonstrates that identifying symptomatic smokers or ex-smokers over the age of 45 with targeted questions such as the COPD Diagnostic Questionnaire[6], and subsequent quality spirometry, identifies a high proportion of previously unrecognised patients with COPD. Screening of asymptomatic smokers or ex-smokers is not considered to be cost effective.

Previously unrecognised COPD of all levels of severity can be identified using targeted case finding. The IRS has been exploring the uptake of case finding programmes in a pilot project in general practice. This project identified that coding of COPD in primary care is poor, with under-diagnosis of the disease. This project also identified that increasing clinical awareness and education did not automatically translate into increased case finding activities. Barriers to this activity and potential incentives and enablers in primary care are being explored, but it is suggested that targeted case finding for COPD should be undertaken and supported in a similar approach to that undertaken in diabetes.

Hospital Admission 'Sentinel Event' Project

A second case finding project involved identification of previously unrecognised COPD in patients admitted to hospital with other respiratory diagnoses. All patients over the age of 45 who are smokers and ex-smokers and were admitted to Christchurch Hospital in the last three years with diagnoses of, for example, pneumonia, asthma, or lower respiratory tract infection, were included in this project. Patients meeting pre-set clinical criteria were offered community spirometry and a subsidised general practice assessment in order to clarify a diagnosis of COPD, if present, and optimise management according to agreed protocols. This project is still being analysed, but early views of the data suggest that this process identifies a high proportion of previously undiagnosed COPD. The team are exploring whether this also leads to increasing referral to pulmonary

[6] Price DB, Tinkelman DG, Halbert RJ, Nordyke RJ, Isonaka S, Nonikov D et al. Symptom-based questionnaire for identifying COPD in smokers. Respiration 2006; 73: 285–295.

rehabilitation, influenza vaccinations and smoking cessation activities. The cost utility of this project in terms of admission reduction and appropriate use of community resources is also being investigated.

Management of Stable COPD in Primary Care

Canterbury has established a consistent, high quality approach to management of people with COPD and other respiratory disease.

Management of patients with COPD is supported by clinical guidelines. In Canterbury we strive to keep patients well in their own homes as long as possible, supported by an enabled general practice, and drawing on specialist resource only when required.

HealthPathways and HealthInfo

The IRS has developed a number of clinical guidelines on HealthPathways including a comprehensive management overview of COPD (see link[7] for details).

Patient's health literacy and self-management is supported by clinical information for patients, which can be found on HealthInfo (see link[8]). The COPD pages of HealthPathways (Figure 2) are some of the most visited of the respiratory pages. Also of note is the high activity on HealthInfo particularly for pages devoted to respiratory exercise classes and pulmonary rehabilitation.

HealthPathways	Page Views
Respiratory	304
Asthma in Adults	73
Acute Asthma in Adults	162
Non-acute Asthma in Adults	199
Asthma in Children	109
Acute Asthma in Children	257
Acute Asthma in Children Flow Chart	34
Non-acute Asthma in Children	175
Asthma in Pregnancy	21
Bronchiectasis	119
COPD	540
Advanced or End-stage COPD	59
Acute Exacerbation of COPD	144
COPD Care Planning	88
COPD Severity Classification	163
Differentiating Asthma from COPD	52

HealthInfo	Page Views
Lungs	69
Acute bronchitis (new)	0
Asthma	26
Asthma in adults	25
Asthma in children	66
Asthma in pregnancy	11
Asthma in youth and teens	6
Being smokefree	164
Bronchiectasis	1
Bronchiolitis	35
Bronchoscopy	11
Canbreathe	24
Chronic obstructive pulmonary disease (COPD)	240
COPD tests and diagnosis	55
Living with COPD	101
What to do when your COPD symptoms get worse	52

[7] www.healthpathways.org.nz
[8] www.healthinfo.org.nz

Dyspnoea	58
Cystic Fibrosis (CF) Genetics	26
Pulmonary Rehabilitation	182
Respiratory Exercise Classes	42
Respiratory Relief Society	3

COPD treatments	76
More information about COPD	68
Cystic fibrosis	14
Respiratory exercise classes	727
Pulmonary rehabilitation programme	164
Respiratory Relief Society	15

Figure 2. *Page Hits on respiratory topics from HealthPathways and HealthInfo websites, 1 January to 23 March 2015.*

Pulmonary Rehabilitation and Community-Based Exercise

The establishment of a community-based pulmonary rehabilitation service has enhanced COPD care in Canterbury. Pulmonary rehabilitation in Canterbury was established >20 years ago as a hospital-based outpatient service, supported by a hospital physiotherapist and nurse but has since moved to an integrated service between primary and secondary care. Prior to establishment of community physiotherapy programmes, <5% of referrals came from primary care. Community pulmonary rehabilitation programmes have now been established throughout Canterbury to standardised and agreed criteria of assessment and programme delivery based on international standards. The programme is undertaken at nine sites in a mix of urban and rural settings, supported by a team of community respiratory nurses, physiotherapists and a multidisciplinary team of health professionals. Since establishment of community pulmonary rehabilitation, >95% of referrals have come from primary care. Consumers also attend to provide expert patient support. Some feedback from participants includes:

- *This course is very valuable for anyone with breathing problems and I would highly recommend it to anyone in need for it.*
- *The programme will make you feel as if you are reborn.*
- *I was a bit anxious about going but now I am so pleased I took part as I learned I am not on my own.*

571 patients with respiratory disease have been referred to pulmonary rehabilitation between January 2014 and December 2014 (see Figure 3). The service achieves clinically-acceptable participation levels but is reviewing reasons for non-attendance and non-completion and is piloting an alternate means of delivering pulmonary rehabilitation to meet the needs of people, for instance, who work during the day.

Ongoing quality improvement of the programme is a key aim. The service is reviewing barriers to referral (a national survey estimated that approximately 1% of patients who would benefit from pulmonary rehabilitation are actually referred[9]), and exploring novel referral approaches including community pharmacist activities.

[9] Levack WM, Weatherall M, Reeve JC, Mans C, Mauro A. Uptake of pulmonary rehabilitation in New Zealand by people with chronic obstructive pulmonary disease in 2009. N Z Med J. 2012 Jan 20;125(1348):23-33.

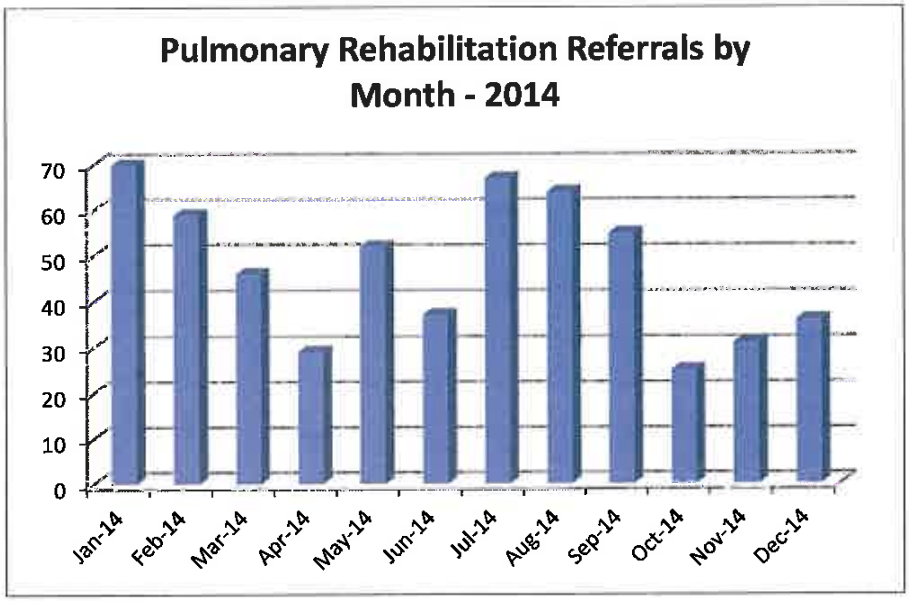


Figure 3. *Pulmonary Rehabilitation Referrals for January to December 2014.*

In addition the IRS has increased community exercise programmes for patients with respiratory disease which are currently running in five locations around the region. These are becoming increasingly popular, as evidenced by the number of page hits on HealthInfo and attendance numbers.

Consumers (Expert Patients)

A consumer group actively supports the pulmonary rehabilitation programme, as well as other respiratory events such as World COPD Day. This consumer group was established 18 months ago and has proven to be an invaluable resource providing insight into respiratory programme design and communications. Members of the consumer group sit on the governing Integrated Respiratory Service Development Group (IRSDG) (see page 12).

Management of Exacerbations and Admission Avoidance

Following the Christchurch earthquakes the IRS worked closely with other clinicians across all healthcare sectors, including ambulance, acute demand, primary care, Emergency Department and Christchurch Hospital inpatient services to reduce hospital admissions and reduce bed occupancy for patients with COPD.

New Zealand has the second highest rate of hospitalisation for COPD per head of population in the OECD[10]. Work in Christchurch has identified that mild exacerbations (DRG Code E65B) predominantly account for the increase in COPD admissions to Christchurch Hospital over the last 10 years. The majority of patients (80%) admitted to Christchurch Hospital with COPD exacerbations are brought by ambulance, which has been accessed via calls to emergency services (111). Since a high proportion of these calls occurred between 9 am and noon on weekdays, rather than after hours

[10] OECD, 2013.

(see Figure 4 and Figure 5) this may have been due to perceived barriers to accessing GP care during exacerbations. Subsequent ambulance service behaviours, partly contributed to by an inability to access the patient record during an exacerbation, as well as proscriptive management protocols, encouraged transfer to the ED, where non-clinical processes including waiting time directives encourage admission and act as barriers to discharge in this patient cohort.

About 85% of patients with COPD in Christchurch who attend the ED with exacerbations will be admitted, as compared with ~50% of asthmatics. This suggests that the increase in admissions is less likely due to prevalence or severity of COPD, but rather illness behaviours, both of the patient, and the health system. As a result COPD is the highest contributor to Adult Ambulatory Sensitive Admissions (ASH) in Canterbury (the leading eight ASH conditions account for 79% of adult ASH admissions).

Between 2010 and 2013, 2,129 patients with COPD were admitted to Christchurch Hospital with a total of 4,359 admissions and 21,001 bed days. With increasing prevalence and incidence, COPD has been shown to have significant epidemiological, clinical, social, and economic impacts. This major and significant burden is not only on the patients who are admitted, but on the healthcare system as a whole.

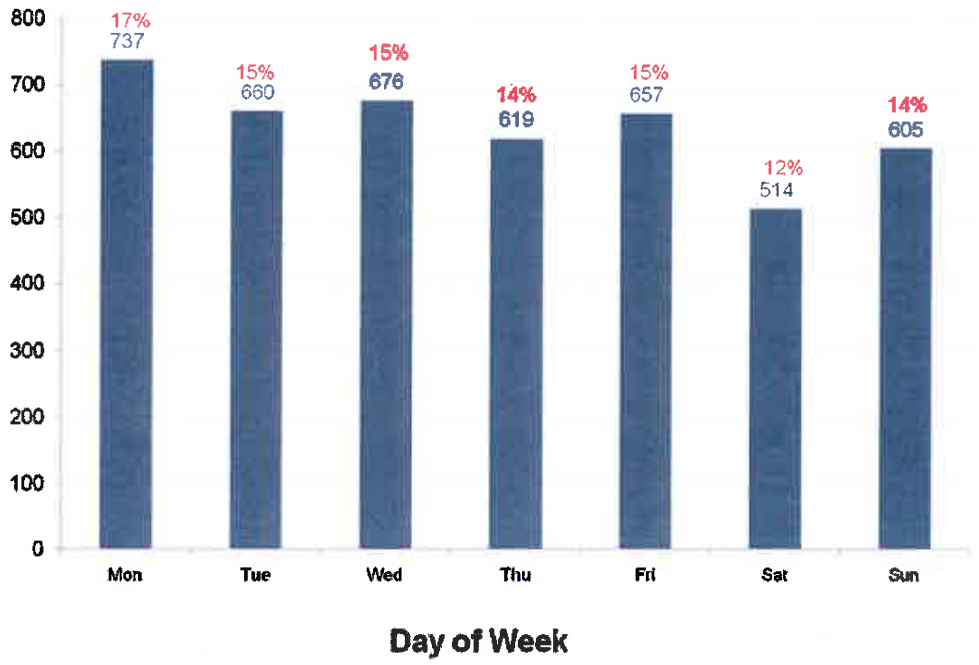


Figure 4. *COPD Admissions by day of the week.*

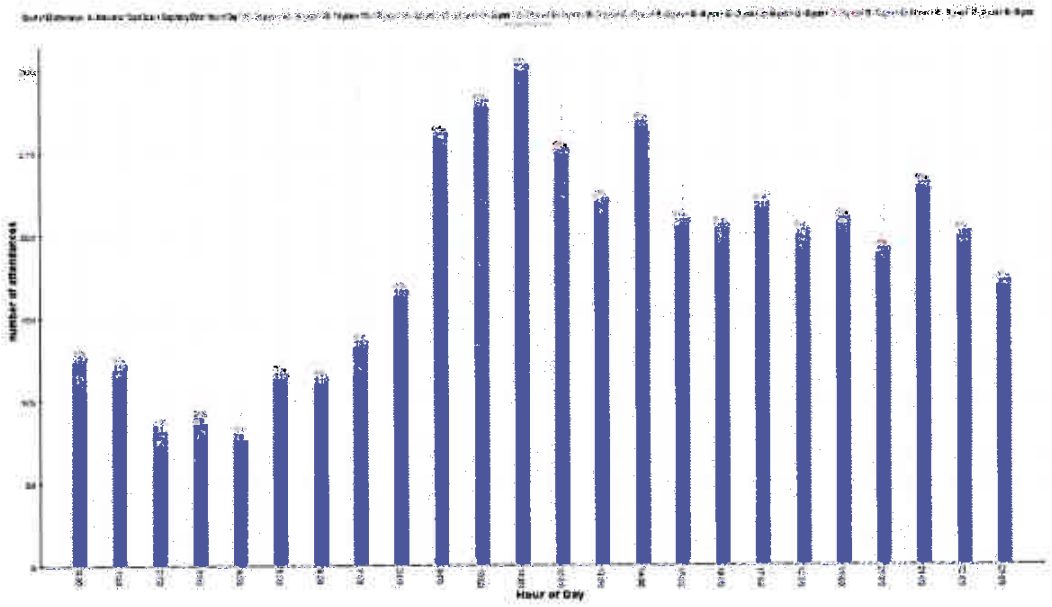


Figure 5. *ED attendance of COPD patients by time of day.*

Canterbury has put in place several programmes to support these patients to stay well in their own homes:

- St John Ambulance triage/diversion to general practice or the 24 Hour Surgery. This enables the ambulance team to triage patients in their home using agreed clinical protocols and offer options other than ED, including linking the patient with their general practice or after hours' facility (Pegasus 24 Hour Surgery), dependent on the patient's need. These activities are supported by acute demand support subsidies for general practice and the acute demand medical and nursing service based out of Pegasus 24 Hour Surgery. Patients at risk of admission were issued with COPD Blue Cards which document patients' clinical status in the stable state and their care wishes, to allow ambulance officers to more accurately assess the severity of the exacerbation. This Blue Card is generated with the patient's general practitioner, and is supported by acute demand funding.
- Acute demand nurses were stationed in the Emergency Department and the Acute Medical Assessment Unit (AMAU). Their role was to facilitate early transfer of patients with COPD to community treatment settings.
- Acute Care Plans, loaded onto web-based Connected Care Management Solution, funded by acute demand funding.
- Following admission a number of programmes were established to enhance facilitated early discharge. These include the CREST service (see link[11]).

These programmes, which began in July 2012, had an immediate and sustained effect on hospital admission numbers (following a severe influenza outbreak in July 2012) and subsequent bed day stay. Total bed days for COPD for the last financial year are 1,500 below the previous average

[11] http://www.cdhb.health.nz/What-We-Do/Projects-Initiatives/Community-Rehabilitation-Enablement-Support-Team/Pages/default.aspx

(approximately 7,000). Of importance, a high proportion of patients were diverted to their general practice, indicating the exacerbation was indeed only mild. There has been strong support for this approach from patients, ambulance officers, and primary care.

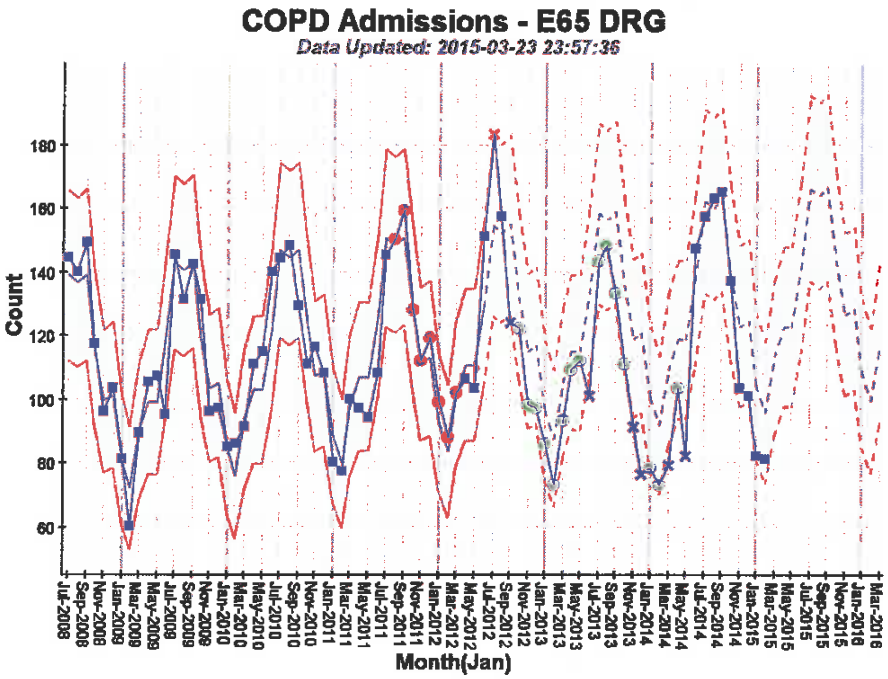


Figure 6. *COPD Admissions, July 2008 – January 2015.*

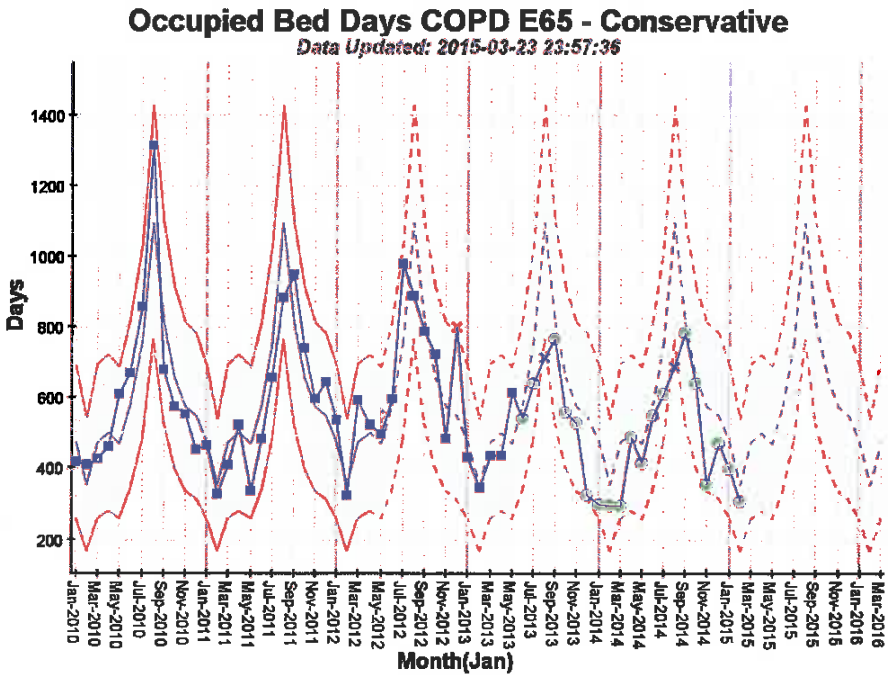


Figure 7. *COPD Bed Days, January 2010 – January 2015.*

Sensing City Project

A project currently in progress is the Sensing City Respiratory Project. The aim of this project is to identify exacerbations at an earlier stage, using Bayesian network algorithms. A recognised feature of COPD is that, in the early stages of an exacerbation, patients often delay seeking help, which means they will end up in hospital, when earlier self-management might have prevented the hospital admission. Using SmartInhaler and smart phone technology, the project is capturing inhaler use to identify whether increased usage signifies the early stages of an exacerbation. This will enable proactive strategies to be put in place, based out of the patient's general practice, triggered by an automated alert.

Frequent Attenders to Hospital

Two separate programmes have been undertaken to address the issue of frequent attenders to hospital with COPD. The first, undertaken in autumn 2011, reduced admissions in this cohort by 40%. This involved a funded case meeting between the patient's practice team and the community respiratory physician to explore patient factors which might lead to frequent admission. Following this meeting an agreed strategy was implemented between the patient and their primary care team.

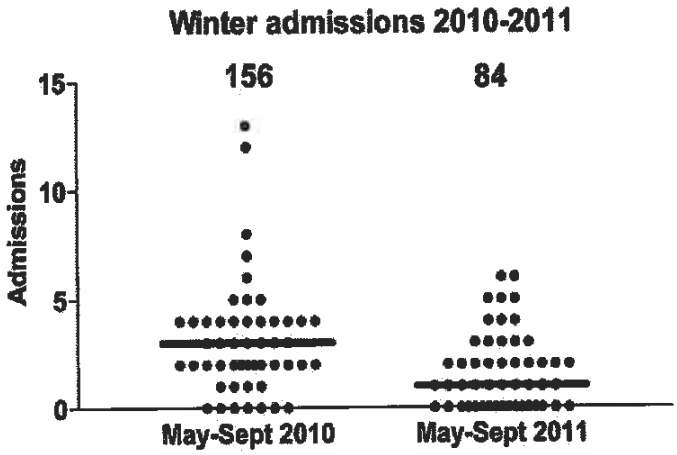


Figure 8. *Winter admissions of a cohort of frequent attenders with COPD, before and after a community intervention.*

International studies suggest social isolation as a major factor leading to frequent admission and readmission. A second programme to explore factors leading to frequent admissions with COPD is currently being undertaken and results will be available on request.

Severe Respiratory Disease, Palliative Care and Advance Care Plans

Clinicians in Canterbury have been working closely around the issue of severe COPD, palliative care, and advance care plans. Frequent attendance to hospital is identified in international literature as a high predictor of mortality. For this reason, patients are being identified with more than two admissions to specialist Respiratory Services at Christchurch Hospital in a one year period, leading to a discussion with the patient around advance care plans. This discussion is being initiated in the hospital, but primarily occurring in primary care, which is felt to be the most appropriate setting,

outside of the acute event. Advance care plans are maintained on a web-based care management system (Connected Care Management Solution-CCMS). This activity is funded by the Canterbury DHB; to date over 150 Advance Care Plans have been created and uploaded.

In addition clinicians in Canterbury are developing strategies for enhanced community management of patients with severe COPD and other respiratory diseases. This includes patients requiring domiciliary oxygen therapy.

Research

In addition to the Sensing City COPD project described above, the IRS has an ongoing commitment to research. We are currently working with the GeoHealth Laboratory at the University of Canterbury to explore access barriers to primary care for patients with COPD such as distance and transport. We have been mapping hospital admissions with COPD by suburb (Figure 9) and are exploring localising interventions to areas where high admissions occur. These include siting of community spirometry and pulmonary rehabilitation activities.

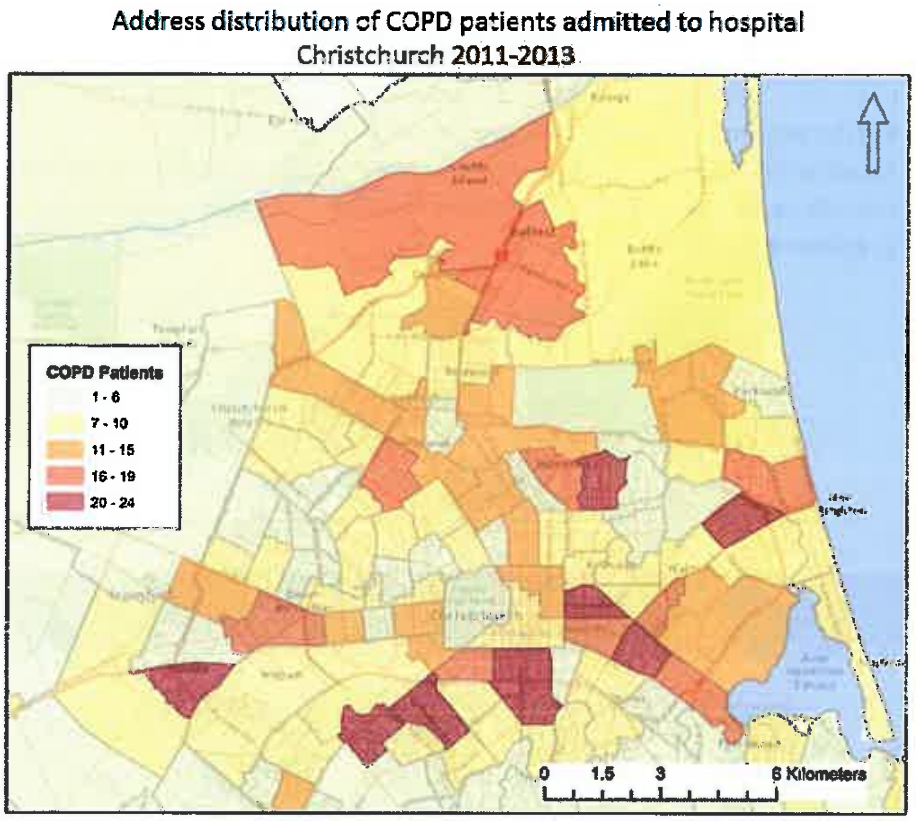


Figure 9. *Distribution of COPD patients admitted to hospital, 2011-2013. Map - thanks to Robert Poynter, GeoHealth Laboratory, University of Canterbury.*

Quality Improvement

Quality improvement activities are automatically incorporated the activities of the Integrated Respiratory Service. Approved providers of spirometry tests and sleep studies are supported to achieve quality standards through web-based feedback, regular training opportunities and newsletters. All activity is regularly reviewed against clinical evidence and best practice.

Clinical Governance

Workstreams, service level alliances, development and working groups under the Canterbury Clinical Network (see link[12]) banner provide governance structure to much of the healthcare activity in Canterbury, including the Integrated Respiratory Service. These groups consist of physicians, nurses and managers from primary and secondary care, NGO providers, consumers and others. The Integrated Respiratory Service Development Group's (IRSDG) purpose is to:

- Provide the governance and operational leadership for the Canterbury Integrated Respiratory Service;
- Develop and monitor a seamless pathway for patients with respiratory disease;
- Facilitate effective ongoing communication with all relevant parties;
- Provide a clearing house for ideas and information on the needs of Canterbury's Integrated Respiratory Services, balancing the demands on the system for patient care and wellbeing and the need for sustainable clinical services and business practices;
- Identify areas requiring redesign and propose transformational service improvement;
- Link with respiratory service working groups and other CCN groups and undertake joint work as appropriate.

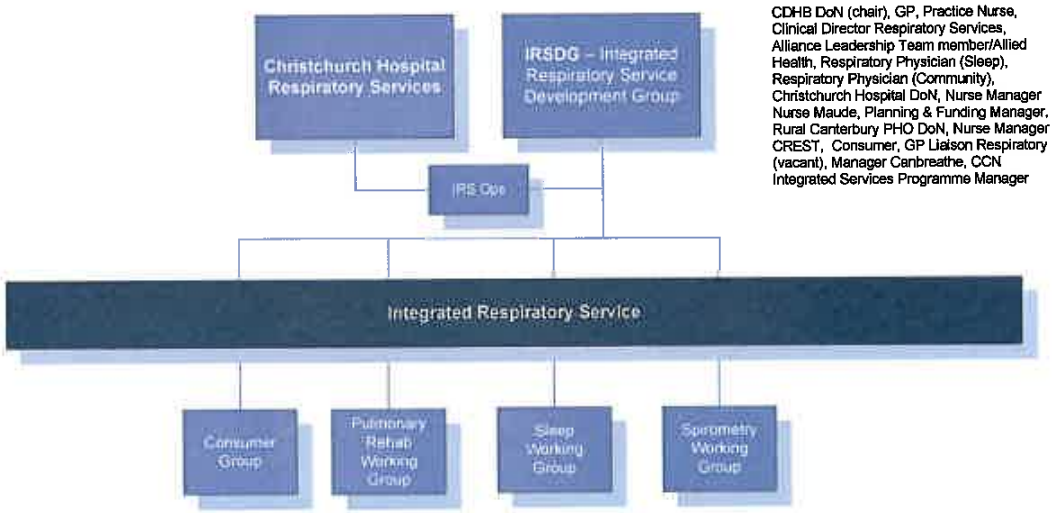


Figure 10. *Diagram of Integrated Respiratory Service and its governance structure.*

[12] www.ccnweb.org.nz

Technology

Communications are supported in Canterbury through use of technology that enables sharing of information. Some examples are:

- The eReferral system, ERMS, provides referral pathways for general practice and other requests across the sector.
- HealthOne is an electronic shared health record available as appropriate to specific clinicians engaged in the care of a patient.
- The Connected Care Management Solution (CCMS) enables multidisciplinary teams to develop and manage care plans with their patients as well as communicate between services such as CREST and Medication Management. Advance Care Plans are also maintained within this programme so they are visible to clinicians engaged in end stage patient care.

Summary

The key enablers for any system change are agreement on the vision, good communication, and permission to innovate. A common understanding of the 'burning platform' enabled culture change across the Canterbury health sector. This has enabled a multi-discipline approach to COPD, a complex medical condition requiring optimum management of the stable state and exacerbations.

The agreed alliance-based principle of 'best for patient, best for system' is a constant focus in innovation and quality improvement activity. The approach is 'employer-agnostic' with agreed outcomes, standards and governance structures.

A fundamental component of this service is the relationship between general practice, hospital clinicians, community, management and funders. This service would not have been created without active enthusiastic participation of all parties, working to agreed values and philosophies within supportive governance structures[13].

For more information:

Dr Michael Epton, Community Respiratory Physician, michael.epton@cdhb.health.nz.

Deborah Callahan, Integrated Services Programme Manager, Deborah.callahan@ccnweb.org.nz, tel: (03) 353-0211.

[13] Timmins N, Ham C. The Quest for Integrated Health and Social Care: a Case Study in Canterbury. The King's Fund: Canterbury, New Zealand, 2013. Available at http://www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care.

Canterbury Clinical Network

TERMS OF REFERENCE
Community Services Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK (CCN)

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.

This SLA/WS will acknowledge and support the principles of the Treaty of Waitangi. We will strive for equitable health outcomes across our population/focus area through accessible, culturally appropriate services.

COMMUNITY SERVICES SERVICE LEVEL ALLIANCE (CSSLA)

1. BACKGROUND

1.1 The CSSLA was formed in November 2011 to enable the development of a new service model which allowed for an individual to receive community services that enable them to live safely within their homes and communities.' To date there has been development of a Community Services restorative home based model of care which incorporates Home Based Support (HBS) and District Nursing (DN).

During this time three CBS providers (Nurse Maude, Health Care of New Zealand and Access) were selected to continue to deliver services. The CBS service was intended to rollout in February 2011. However due to the impact of the earthquakes and transition of clients from the unsuccessful provider this process was delayed until August 2011.

2. PURPOSE

2.1. Monitoring and guiding of Community Services, as described in the Community Services specification. A critical component of this work will be to ensure the service is appropriately integrated with other primary, community services (including CREST) and emergent Integrated Family Health Service developments;
2.2. Provide strategic planning, design, prioritisation and oversee the ongoing development of the ongoing Community Services model across the Canterbury health system;
2.3. Reporting on the implementation's progress and key performance indicators to the ALT and Health of Older People Workstream on a quarterly basis;
2.4. Continuation of development of these services needs to fully account for service, workforce and financial sustainability while maximising service user outcomes;

2.5. Ongoing development of funding model, allocation and available resources from a range of sources;
2.6. Any recommendations for a change of funding allocation will need to go back to Planning and Funding for approval;
2.7. All recommendations for a change of funding approach will need to go back to ALT for approval.

3. SERVICE VISION

3.1. The service includes home and community support services (inclusive of community nursing services) for people who need support whether on a short or long term basis in their homes and community.
3.2. Services will align with the strategic objectives of:
- The New Zealand Health Strategy – 2000
- New Zealand Health Of Older People Strategy 2002
- The New Zealand Disability Strategy - 2001
- Primary Health Care Strategy - 2001
- He Korowai Oranga Maori Health Strategy -2002
- The Pacific Health and Disability Action Plan – 2002

3.3. The vision is a flexible service that:
- Is service user driven focusing on peoples decision making and goal attainment relating to being able to enable people to live at home and participate in community
- Is inclusive of family/whanau and other natural supports;
- Supports an integrated continuum of care by linking to both primary and secondary care.
- The aim is for a person to receive community services that enable them to live safely within their homes and communities and for them to take part in activities that supports and strengthen this objective

3.4. This objective will be achieved through:
- The promotion of recovery and return to independent living (self-care) through outcome focus, support services based on assessed need of the service user and family/whanau and other natural supports;
- Flexible, integrated and responsive services;
- Pro-active interventions to prevent or delay physical, psychological and social deterioration.
- Services are to incorporate and facilitated comfortable and dignified end of life based on informed choices and to consider participation of advanced care planning when needed.

4. SERVICE TARGETS

4.1. Key Performance Indicators will align with the frail elderly pathway initiative.

Previous Service Targets

The Key Performance Indicators will be further developed once information is available from the Frail Elderly Pathway, Health of Older People Workstream outcomes framework and the service development work from the Long Term Conditions Chronic Health Clients and the CDHB wide systems framework including rural

5. MANDATE

5.1. The SLA has the mandate to review current community service activities with the intention of identifying and recommend areas needing increased efficiencies and/or improved service levels;

5.2. Members have the authority to meet with relevant stakeholders and service providers to gain information and ideas for improvements;

5.3. The SLA will work together with service providers to develop an appropriate funding approach for service delivery.

6. SCOPE

6.1. In Scope – The scope of the service being overseen is described in the specifications for Community Services (previously District Nursing, Short and Long Term Home based Support) and CREST and Long Term Support Chronic Health Conditions (LTSCHC);

6.2. Out of Scope – Any contracts of service that falls outside the CCN objectives.

7. MEMBERSHIP

7.1. The membership of the SLA will include professionals and clinicians who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;

7.2. Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the SLA to achieve success;

7.3. The SLA will review membership annually to ensure it remains appropriate;

7.4. Membership will include a member of the ALT;

7.5. Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

7.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;

7.7. When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;

7.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

8. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

8.1. New or replacement members will be identified by the SLA for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the SLA;

8.2. The chair and deputy chair will, in most cases, be nominated by members of the SLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

9. MEMBERS

The composition of the Community Services SLA is:

Name(s)	Perspective/Expertise
Andrea Judd	GP in Kaikoura and on the Kaikoura SLA,
Carole Evans	Consumer
Steve Cate	Regional Manager, HCNZ
Glenda Rich	National Innovations Manager, Access
Sam Powell	General Manager, Clinical Services, Nurse Maude
Donna Hahn	Chair. Collaborative Care and Primary Care Liaison;
Ginny Brailsford	Pharmacist
Anne Roche/Val Fletcher	Physician, Community Geriatrician
Jane Evans	Clinical Nurse Coordinator –Transfer of Care Nurse, CDHB
vacant	Professional Leader, Occupational Therapy
Janice Lavelle	Service Manager - OPH&R
Deb Nind	Care Coordination Centre Manager
Wendy Dallas-Katoa	Maori Perspective
Andrea Davidson	Service Development Manager, Planning and Funding
Jackie Cooper	Primary Care Nurse
Kate Gibb	ALT representative

10. ACCOUNTABILITY

10.1. The SLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

11. WORK PLANS

11.1. The Community Services SLA will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health Targets, the CDHB Annual Plan, legislative and other requirements;

11.2. The SLA will actively link with other CCN work programmes where there is common activity.

12. FREQUENCY OF MEETINGS

12.1. Meetings will be held bi monthly on the 1st Tuesday of the month with subgroup meetings being held when necessary resulting from the SLA meeting;

12.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

13. REPORTING

13.1. The SLA will report to the ALT on an agreed schedule via the CCN Programme Office;

13.2. Reports will be provided by the SLA in a template provided by the CCN Programme Office;

13.3. Where there is a risk, exception or variance to the SLA work plan, or an issue that requires escalation, a paper should be prepared in a template provided by the CCN Programme Office;

13.4. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme office;

13.5. Where applicable, reporting will include progress against or contribution to Ministry of Health Performance and Health Targets.

14. MINUTES AND AGENDAS

14.1. Agendas and minutes will be coordinated between the SLA chair and facilitator;

14.2. Agendas will be circulated no less than seven days prior to the meeting, as will any material relevant to the agenda;

14.3. Minutes will be circulated to all group members within five working days of the meeting and minutes remain confidential whilst 'draft' and until agreed;

14.4. Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

15. QUORUM

15.1. The quorum for meetings is half plus one SLA member from the total number of members of the SLA.

16. CONFLICTS OF INTEREST

16.1. Prior to the start of any new programme of work, conflict of interest will be stated, recorded on an Interest Register;

16.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;

16.3. The Interests Register will be a standing item on SLA agenda's and be available to the Programme Office on request;

17. REVIEW

17.1. These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

18. EVALUATION

18.1. Prior to the commencement of any new programme of work, the SLA will design evaluation criteria to evaluate and monitor on-going effectiveness of activities. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or CDHB as the funder.

RESPONSIBLITIES

19. RESPONSIBILITY OF THE SLA

19.1. Apply the delegated funding available to lead the required service/service change;
19.2. Establish new work groups to guide service design;
19.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES & RESPONSIBILITIES

20. CHAIR / CLINICAL LEAD

20.1. Lead the team to identify and recommend opportunities for service improvement and redesign;
20.2. Lead the team in the development of the service vision and annual work plan;
20.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
20.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
20.5. Provide leadership when implementing the group's outputs;
20.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
20.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
20.8. Provide strong clinical leadership across all SLA work activity;
20.9. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

21. SLA MEMBERS

21.1. Bring perspective and/or expertise to the SLA table;
21.2. Understand and utilise best practice and alliance principles;
21.3. Analyse services and participate in service design;
21.4. Analyse proposals using current evidence bases;
21.5. Work as part of the team and share decision making;
21.6. Actively participate in service design and the annual planning process;
21.7. Be well prepared for each meeting.

22. PROJECT MANAGER/FACILITATOR

22.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
22.2. Provide or arrange administrative support;
22.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
22.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
22.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
22.6. Keep key stakeholders well informed;
22.7. Proactively meet reporting and planning dates;
22.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
22.9. Identify report and manage risks associated with the SLA work activity.

23. PLANNING & FUNDING REPRESENTATIVE

23.1. Provide knowledge of the Canterbury Health System;

23.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
23.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

24. ALT MEMBER

24.1. Act as a communication interface between ALT and the SLA;

24.2. Participate in the development and writing of papers that are submitted to ALT;

24.3. Act as Sponsor of papers to ALT so papers are best represented at the ALT table.

TERMINOLOGY

- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- Service level SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Ops Leaders Group – the small operational arm of the ALT who supports the workstreams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District SLA and specify expected outcomes, reporting and funding for the services to be provided.

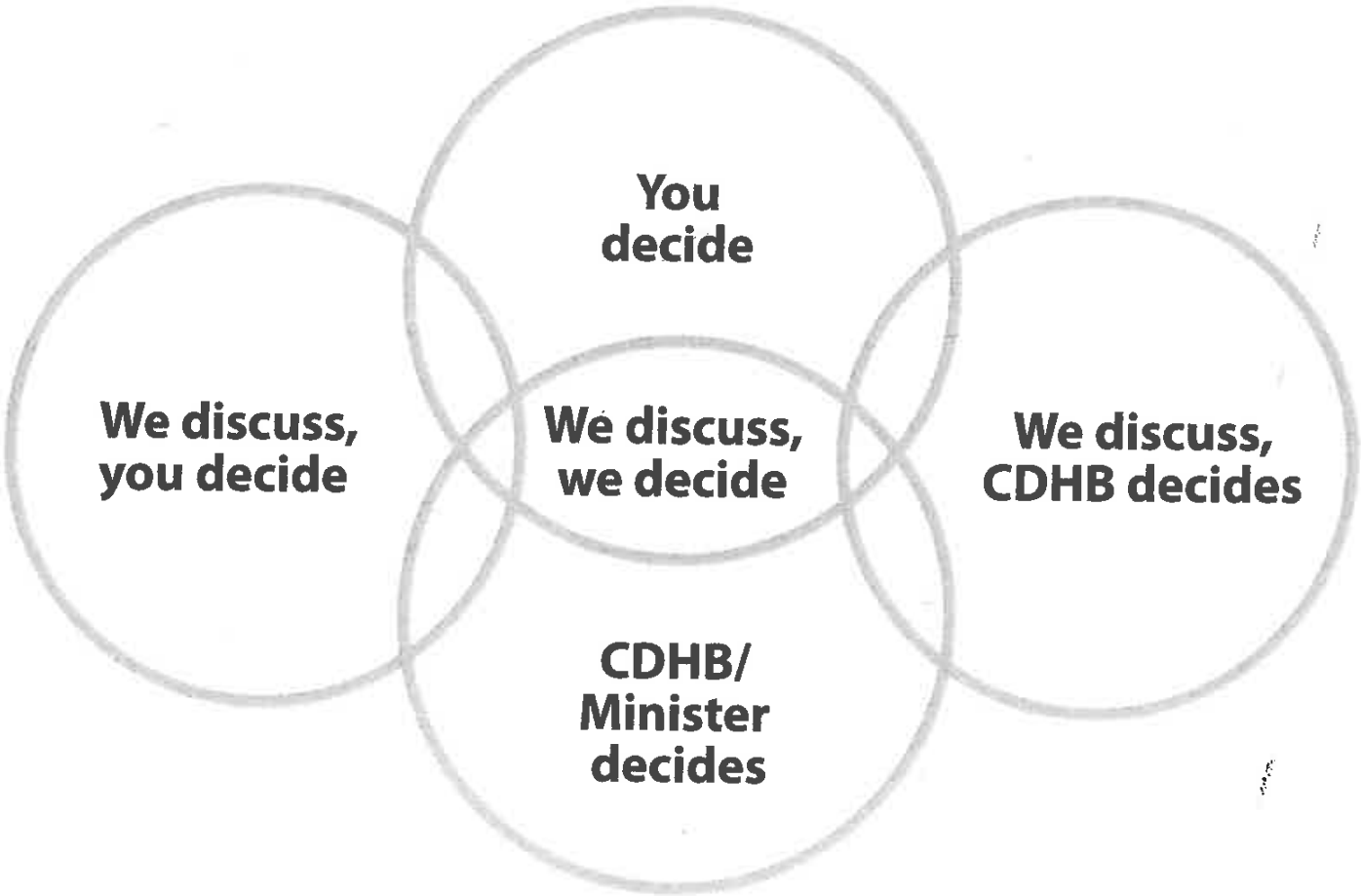
ENDORSEMENT

Date of agreement and finalisation by SLA members: 1 Dec 2015

Date of endorsement from ALT: 16 Feb 2016

Review date for TOR: Dec 2016

A new way of working ...based on trust



Strategic Planning Flash Report

December 2017

Contents

Key

1	Programme not progressing with imminent or actual fundamental service failure; requiring immediate executive or board decision
2	Significant obstacles to programme delivery; requiring executive decision; service compromised
3	Obstacles to delivery with significant risk to service continuity in the medium term. Executive discussion required
4	Significant risks to delivery of either programme or corresponding service . Some level of executive intervention may be required
5	Some risks to delivery of programme or service continuity ; delivery programme may need to be delayed or changed
6	Minor areas of concern regarding elements of the programme or service. Minor delays possible
7	Only minor manageable risks to service delivery or programme exist. These are being mitigated and are unlikely to impact on delivery timescales or service sustainability
8	Progress on track with agreed timescales. No major service risks exist. Regular updates to continue.
✸	Executive Attention Required

Useful Resources:
- Corporate Planning Tracker
- Accommodation Workshop outputs
- Strategic & Service Planning Intranet
- Integration Website www.cvihsc.co.uk
- PMO : PMO Intranet Pages
- Engagement Resources

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

Pg. 1 STRATEGIC SERVICE PLANNING C&V SERVICE DEVELOPMENT AND RECONFIGURATION

THEATRES DEVELOPMENT PROGRAMME

Programme to deliver right size short term and future proof capacity (demand/reconfiguration pressures) and essential plant maintenance. (Marie Davies/Ann Stewart-Davies) **2**

Estimated Capital:£25million+ phased over 5 year programme(£4-6million UHL)

Estimated Revenue: capital only schemes

Status

- **UHL Modular Theatre Paper to Support Funding** Approved by Welsh Government. Theatre completed and commissioning concluded
- **Replacement of Theatres 5 and 6 BJC** commenced. Development of the BJC is progressing with anticipated completion of case by May 2018. Risk workshop held
- **UHW Programme Business Case** progressing. Outstanding information in relation to current facilities, theatre schedules, staffing, model of care, capacity analysis, condition of current estate, benefits, risks, capital costs and revenue costs. Anticipated date for completion of PBC is April 2018. Risk workshop held
- **UHW Theatre 10 and Ventilation Louvres BJC** progressing. Outstanding information as above. Design Team appointed in November. Anticipated date for capital costs based on tendered costs is June 2018. Anticipated date for completion of BJC is July 2018.

Significant Risks or Decisions

- Plant failure risk
- Significant reduced capacity and environmental issue
- Limited available local and WG capital
- Timescales likely to be longer than originally anticipated due to more stringent appointment process for the engagement of Design Team and Contractor & lack of project management support

Decisions, Actions and Next Steps

- Ongoing development of Business Cases
- Design layouts under development
- Further work on medium and longer term demand and service model
- Secure project management support to progress complex service planning and modelling required

TERTIARY SERVICES STRATEGIC PLAN

Development of medium and long term sustainable tertiary services plan which both informs and responds to WHSSC commissioning requirements and aligns with the delivery plans of partner tertiary providers to provide optimum care for the population of South Wales. **6**

Estimated Capital: Not costed at this stage

Estimated Revenue: Not costed at this stage

Status
Commissioning of service-specific planning support underway to develop detailed baseline assessment, gap analysis and service options – interim and longer term (as part of UHW re-provision masterplan)

Significant Risks or Decisions

- Will require significant capital investment in medium term as limited options to reconfigure current capacity and significant infrastructure constraints
- Difficulty meeting existing demand and significant lead time to grow workforce constraint
- WHSSC investment capacity is very constrained

Decisions, Actions and Next Steps

- Reflect in master planning brief UHW redevelopment/re-provision
- Clinical Board to appoint project management lead (supported by corporate planning, capital & estates.)
- Develop medium term plan in line with WHSSC commissioning plans
- Clinical Board to confirm interim and medium term capacity requirements

HAEMATOLOGY

Haematology has been subject to significant risk as a result of potential loss of JACIE accreditation due to care environment concerns (Contact Ann S-D). **4**

Estimated Capital: TBC

Estimated Revenue: TBC to follow additional activity

Status
Long term capital development on hold pending agreement of strategic site plan for UHW. The interim relocation of inpatient Haematology services has now been escalated because of JACIE accreditation and infection concerns. Locations are now being sought.

Significant Risks or Decisions

- Serious risk to service continuity in Haematology. Urgent mitigation and location for this service need to be confirmed

Decisions, Actions and Next Steps

- Identification of emergency options for inpatient/day case haem services
- Finalisation of Schedule of Accommodation for Haem I/P and Day services
- Appointment of Design Team

ACUTE ONCOLOGY

Acute oncology patients housed within various locations in UHW/UHL. (Contact: L Donovan) **4**

Estimated Capital: TBC

Estimated Revenue: TBC to follow additional activity

Status
Dialogue with Velindre re TCS model including AOS.
Dialogue with Macmillan re potential support to develop AOS facility.

Significant Risks or Decisions

- TCS business case not sufficiently aligned with local strategy for AOS
- Multiple UHB cancer strands need central coordination and UHB Cancer Strategy

Decisions, Actions and Next Steps

- UHB Cancer Strategy to be considered under remit of SCRG
- Await outcome of dialogue with Macmillan re scope for support to explore AOS facility

ACUTE MEDICINE UHL

Current acute medicine model operated across the current UHW and UHL sites has a number of sustainability challenges, particularly **medical workforce availability and access to diagnostics/specialist opinion at UHL**. Requirement to test options for acute medicine service delivery at UHL and alignment with Canterbury discussions/next steps. (Contact M Davies) **4**

Estimated Capital:£ Not costed

Estimated Revenue: Significant if any major changes to the model are made

Status
Detailed clinical models have been widely shared and discussed. To be revisited to confirm analysis.

Significant Risks or Decisions

- Current service provision presents a high risk of a clinical incident
- Other strategic pressures on clinical board leads impacting on ability to contribute in a timely fashion
- Any changes to acute medicine service model impacts on viability of other acute services at UHL.

Decisions, Actions and Next Steps

- Develop narrative evaluation of options and confirm strategic direction of travel for UHL. Current gaps are around estimated resource implications and final flows mapping. Identified revenue releasing mechanism required to deliver option
- Focus on delivering an affordable interim solution
- Communicate exercise outcome to wider clinical stakeholders and CHC.

RENAL FACILITIES - SUITE 19

Renal accommodation reconfiguration and replacement **5**

Capital: £1.197m

Estimated Revenue: Revenue Neutral

Status - BJC has now been completed.
Agreed at Business Case Approvals Group 13/11/2017
Agreed at Capital Management Group 20/11/2017

Significant Risks or Decisions
Board Approval awaited

Decisions, Actions and Next Steps: Submission to WG following Board Approval

SOFW: IN OUR COMMUNITY PROGRAMME

Delivery of a network of community facilities to support the implementation of the SOFW strategy.(Contact A Evans) **4**

Estimated Capital:
Estimate in development

Estimated Revenue: TBC Focus on developing service and revenue models for first tranche projects.

Status
Developing Programme Business Case. Planned submission Spring 2018

Significant Risks or Decisions

- UHB strategy for transformation of outpatient clinics to inform high level revenue impact
- Revenue pressure is likely but not fully quantified. Comprehensive picture required
- Agreement with WG that PBC economic appraisal will focus on 1st Tranche of projects
- WH@Maelfa & WH@Eastern Vale not as advanced

Decisions, Actions and Next Steps

- Planned Care Board to develop strategy for transformational delivery of outpatient clinics – January (high level quantification)
- Service and revenue modelling for first tranche projects to be completed. Due date revised to beginning of January 2018.

Health and Wellbeing Centre @ CRI Level of business cases TBC within master plan. Initial projects to be developed: Relocation of SARC; Enabling works Block 10; Safeguarding works; Chapel, Relocation of CMHT	**Status** Draft service scope revised. Space limitations, priority given to client facing services Masterplan reassessed for potential fit – gap remains. Further work required. Indicative capital costs being developed Associated service and revenue modelling work being undertaken BJCs being progressed for initial projects •Masterplan/programme in development	**6**
Wellbeing Hub @ Park View Collaborative project with LA and 3rd Sector. Likely OBC level BC required	**Status** Short list of 4 options identified to be subjected to economic appraisal as part of the business case process Capital costs for each option being developed Associated service and revenue modelling work being undertaken	**6**
Wellbeing Hub @ Maelfa As above to replace Llanedeyrn Health Centre. Level of BC required TBC	**Status** •Population focus for WH to be confirmed •Draft service scope to be reviewed •High level capital costs required to inform level of business case required •Engagement with local community started	**5**
Wellbeing Hub @ Eastern Vale Not currently resourced with Planning team	**Significant Risks or Decisions** •No resource allocated to take the Business case development forward with significant political imperative to proceed	**4**

Pg. 2

STRATEGIC SERVICE PLANNING TEAM UPDATE REGIONAL WORKSTREAMS

MAJOR TRAUMA & REHABILITATION

Bid to become the designated Major Trauma Centre when the Major Trauma Network is developed. (Contact E Wilkins) **5**

Estimated Capital:£23million | **Estimated Revenue:** £7-11m

Priorities and Progress
Board report prepared by Collaborative for Sept '17 outlining recommendations for site of MTC and next steps.
NHS Collaborative leading 3 month consultation 13 Nov – 5 Feb'18. Local approach agreed with CHC.
0.5 wte trauma nurse co-ordinator appointed; 1.5wte in recruitment process incl. role as Major Trauma Practitioner. Recruitment for Administrative support in progress. Programme Implementation Lead post to BCAG for approval.
Meeting held with Collaborative re financial impact of becoming an MTC.

Significant Risks or Decisions
- Next steps dependent on outcome of consultation. Work is being led by the All Wales NHS Health Collaborative.

Executive Action - none at present.

PAEDS, OBS AND NEONATES

Consolidation of inpatient paediatric, obstetric and neonatal services at 5 sites – UHW, Swansea, PoW, PCH and SCCC. (Contact M Davies) **2**

Estimated Capital: £25million | **Estimated Revenue:** £TBC

Status
Detailed implementation plans under development. Revised models and flows provided by Cwm Taf. Tariff still to be confirmed along with Standards based business case approach.
Revised regional planning structures confirmed with PON to remain in scope. Neonatal groups role and governance clarification. ABMU have finalised capital business case for £10m development in Singleton NICU

Significant Risks or Decisions
- Significant delay in local capital programme from April to December 2018- Significant workforce risks in neighbouring UHBs – ***CT plan to centralise at PCH from summer 2018***
- Delay in finalising funding arrangements placing UHB at financial risk
- Risk associated with potential changes to CT/ABM UHB boundaries and resultant impact on flows/ shared workforce arrangements

Decisions, Actions and Next Steps
- Significant resource pressure on local planning leads to support regional activities.
- Interim contingency plans need to be developed in advance of summer 2018 due to fragility of Paeds rotas in AB and CT
- Revised flows paper and regional committee structures/ work programme to Strategic CRG , ME and Strategy and Engagement Committee in October

GENOMICS

WG declared in its Genomics for Precision Medicine Strategy that it would work with the UHB to develop the All Wales Medical Genetics Service. WG is convening key stakeholders to ensure that there is appropriate involvement of partners in the governance and oversight structures. In the interim, urgent local service infrastructure pressures will need to be addressed to maintain service continuity, (Contact M Davies/Clive Morgan) **3**

Estimated Capital: TBC | **Estimated Revenue:** Potentially significant but not quantified at this stage.

Priorities and Progress
Programme governance in the process of being established, with local leads identified.
Programme management post to be advertised to lead the development of the strategic, service and capital programme.

Significant Risks or Decisions
- Current laboratory capacity an immediate constraint – collaborative opportunities being explored with Cardiff uni.
- Late notice of requirement for clinical service support for the Cardiff uni led 100,000 Genomes project - support proposal developed and implemented
- Opportunities for improving existing clinical and laboratory service integration being tested

Executive Action - None at present

REGIONAL ELECTIVE ORTHOPAEDICS & OPHTHALMOLOGY PLANNING

National priority workstream to address perceived issues with growing demand, access and wait in elective orthopaedics & ophthalmology. Development of Regional Plan (Contact M Davies & L Davies) **5**

Estimated Capital: none identified at present | **Estimated Revenue:** none identified at present

Status-Regional Group, PID , reporting and project governance.
Regional demand and capacity data collated.
Opportunities for joint working to improve access – theatres & workforce.

Significant Risks or Decisions
- Challenges with clinical engagement as case for change and regional appetite to adopt new models is variable
- Limited physical capacity to deliver centralised model available at all UHBs
- Project resource required to coordinate

- Finalise current D&C data for SE region and identify gaps and opportunities.
- Identify opportunities for regional pathway improvement
- Liaise closely with Planned Care Board sub groups to ensure alignment and minimised duplications.

SARC

Introduction of a regional hub and spoke model for Sexual Assault Referral Services to ensure a sustainable joined up pathway of care that meets the needs of this highly complex, vulnerable group of adults, adolescents and children. **(Contact M Davies)** **4**

Estimated Capital: BJC – part of CRI programme (above) | **Estimated Revenue:** Under review by NHS Wales Collaborative

Priorities and Progress
Constructive discussion between health, police and NHSWC to address concerns raised. Provisional interim actions agreed to stabilise service in SE region. Capital solution identified but will require BJC (Sept 2018). SE Group met and agreed next steps.

Significant Risks or Decisions
- Local service very fragile due to concerns regarding the current pathways.
- Significant planning/ implementation resource required
- Important to manage political comms regarding SE Interim model

Decisions, Actions & Next Steps
- Secure common SE Wales baseline activity and resource (template issued)
- Identify strategies to address service risk by agreeing interim SE Hub service model
- Agree host arrangements/governance with NHSW Collab. Confirm timescales
- Ensure work stream is properly resourced

VASCULAR SURGERY (HYBRID)

Development of a hub and spoke model for vascular services, building on existing collaboration. UHW to act as the hub. Estimated requirements: additional 13 beds and 7 theatre sessions, 5 sessions in hybrid theatre (Contact L Davies) **4**

Estimated Capital: TBC (Likely) | **Estimated Revenue:** TBC (minimal)

Status- Model Development
SEW group established to finalise the cost implications of the proposal and minimise financial impact as much as possible, Cost differential reduced Agreement in group that AB and CT will need to fund costs of transfer irrespective of releasability.
Options to progress on a phased basis being tested with SEW group

Significant Risks or Decisions
- No dedicated planning resource
- Lead time to implement capital development
- Service interdependencies/ Incremental capacity requirements, e.g. critical care (1 bed), do not justify a BC but equally cannot be absorbed by existing capacity.

Decisions, Actions and Next Steps
- Paper to go to CEOs shortly – definitive summary of current status and issues.
- Develop Business Case for single plane IR for local service only in the first instance. (Part of theatres PBC so 2+ years to deliver).

SEW Regional Planning & Implementation Group

- **Diagnostic Services Modernisation-** CT Diagnostic Hub functional November 2017 with MRI capacity January 2018. Regional collaboration/opportunities on EUS, management of mobile MRIs 2019/20 onwards and endoscopy being explored. WG Strategic Intent & Direction for Diagnostics in development.
- **WHSCC Neonatal Workforce T&F Group-** Proposals were approved at Joint Committee, responsibility for this work now sits with Neonatal task and finish group May 2017 . CEOs view that Regional Planning governance structure does not provide appropriate vehicle, for assuming South Wales-wide responsibilities. PON Board to respond to WHSSC letter(contact M Davies)
- **TCS Programme -** Business Cases circulated for comment; some concerns remain for UHB re model and cost. Hayley Thomas (DoP Powys) co-ordinating collective response premised on concerns but acknowledging requirement for support. Slippage to timescales for final approval outlined by Velindre (was due to be January 2018).
- **ENT-** Meeting arranged for Clinical and Planning Leads to reconfirm model and supporting operational protocols.

Other possible future Developments

- Regional Strategy for **Cardiac MRI-** Demand and capacity assessments ongoing, contingent on UHW additional **MR capacity** and clearly articulated commissioning intentions from UHB partners (Contact M Davies)
- Discussions regarding **Thoracic Surgery** centralisation ongoing with WHSSC and UHBs. 6 week engagement 18 Oct – 29 Nov '17 (Contact M Davies/ L Davies). Significant work to be done to understand the proposed service models and major capacity implications of moving to a single centre for thoracic surgery in South Wales.

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STRATEGIC PLANNING ALIGNED ACTIVITIES

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

Purpose: EPRR team provides an emergency preparedness service for the UHB in accordance with the responsibilities under the Civil Contingencies Act 2004 and other statutory legislation. (Contact: A Stephenson)
Activity to Note: Exercise: EVAC Ark was successfully completed. It focused on the emergency response to an entire hospital evacuation; and the longer term Business Continuity (BC) aspects of recovery. UHB Fire Safety and Directorate Management team looking to develop the specific evacuation plans using lessons identified. Work completed to revise/strengthen Corporate BC Planning Guidance and 'template' BC Plan. Documentation going to relevant committees/boards (Scheduled approval:02/18).

Training and Resources to Note:
- Counter Terrorism (CT) Awareness Training delivered to Perioperative Care on 13/10 & 14/11. 146 trained since April 17, 433 trained to date. One further generic session at St. David's (06/12).
- UHB Staff attending Health Prepared Wales Conference (27/11), SWLRF Water Distribution Workshop (29/11), Exercise TODO – a CT, COMAH/ Port security event (12/12), the PREPARE (CT) Conference (13/02/18)
- Specialist multi-agency training support at Whitchurch ongoing. 8

Priorities and Progress
- Collaboration with PCIC to strengthen business continuity and consequence management arrangements associated with admission avoidance and accelerated discharge in a major incident.
- Partnership work with Cardiff City Council, Natural Resources Wales and PCIC to enhance business continuity arrangements in the event of widespread coastal or fluvial flooding.
- Planning commenced for 2018 Exercise: TURBULANCE (business continuity desktop exercise – denial of access to ED premises post incident on helipad).
- Distribution of the South Wales Local Resilience Forum (SWLRF) Community Risk and Threat Registers for 2017/18 to UHB Executives and Clinical Board triumvirates (OFFICIAL SENSITIVE and RESTRICTED CIRCULATION). This will form basis of EPRR and business continuity work for the next year. 8

Significant Risks or Decisions
- UPDATE to Last Report: The UHB is now in receipt of 2no. replacement PRPS suits. The bulk of the initial stock in Wales is being held by WAST for distribution in the event of an incident.
- The 4 month lead time means that the UHB unlikely to receive more suits to completely replace its stock until February 2018.

PARTNERSHIPS AND ENGAGEMENT

Engagement & Consultation (Contact A Wei)
•Major Trauma Centre – Formal consultation commenced 13 November 2017. Consultation preparation arrangements in progress - Local plan being developed in collaboration with NHS Wales Collaborative, South Wales UHBs & CHCs. WHSSC engagement on Future Shape of Thoracic Surgery Services; Engagement 18 Oct – 29 Nov 2017 on information to be used by Project Board to determine whether 1 or 2 centres. Potential second stage involving Independent Panel to recommend site of single centre. WHSSC requested information to present to Independent Panel. 3

Public Services Boards (Contact A Wei)
•Draft Wellbeing Plans currently out to consultation commencing October 2017. Draft plans circulated internally for comment. Final Plans to be signed off by PSB partner organisations January/February 2018. 7

IMTP 5

UHB Corporate IMTP (Contact M Davies)

•The planning cycle commenced for the 2018-21 plan
•Draft CB IMTPs submitted; initial draft UHB IMTP in development.
•PODs under development for consideration by ME Dec 11th

Internal Detailed Plan Development (Contact M Davies)

•Clinical Board quarterly progress against agreed actions now being monitored through standardised performance review meeting/process (Q2 reviews in October)
•Q3 IMTP report for Board January 2018

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Cross Cutting Steering Group Update (E Wilkins)

•The programme is comprised of procurement, medical productivity, nursing productivity, workforce productivity and medicines management. All project leads are in place
• Workforce productivity support panel meetings underway and taking place on a routine basis.
•Medical productivity has more recently focused upon developing a process for compliance with the locum pay cap rate.
•Programme for 2018-19 is under development following discussion with Executive Lead

Other Developments

Diabetes Service Improvement Group (C Ashman)

•POD's being developed for Community Diabetes Project and hypoglycaemia project as part of transformational work
•Invest to save project has made £42K of the £67K of savings for 17/18. Project expected to exceed target for the year.
•Type 2 Diabetes Whole System Model developed.

Orchard/ WellBEEing Project (S Joslyn)

•***Orchard Project*** *Orchard exhibition completed in art gallery, shared on CAV TV. Securing boundary to be completed. Tree planting this autumn. Issue with horses on site to be resolved.*
•***WellBEEing project****: Aviva bid submitted awaiting outcome.*
•*Meeting arranged with areas regarding housing bee hives.*

HEALTH AND SOCIAL CARE INTEGRATION

Integrated Care Fund (Contact R Jones)

- Implementation of revenue schemes for 2017/18 is underway.
- Capital proposals have now been approved by WG and implementation has commenced – projects include support for the development of the Community Mental Health Service in Barry; Feasibility study for older person accommodation with care; Re-modelling of Grand Avenue Day Centre (Ely) as a specialist dementia day care service; and Out of school facilities for children and Young People with complex needs. 6

Older People Services Model (Contact R Jones)

- The Cardiff and Vale of Glamorgan Market Position Statement and Commissioning Strategy for older people was approved by the Regional Partnership Board on 13th November 2017.
- Work has commenced on an assessment of Older Person Accommodation including with Care and Care Ready. This will involve a review of the physical standards and facilities of current existing designated older person housing stock, a review of existing and future care and support needs of current residents (including owner occupiers) and those on the waiting lists. 8

Area Plan (Contact R Jones)

- The Plan provides the response to the Population Needs Assessment and essentially provides the Care and Support element of the Well-being Plans.
- The Draft Plan is currently out for consultation until 3rd December it can be viewed at: http://www.cvihsc.co.uk/about/what-we-do/cardiff-vale-glamorgan-area-plan/
- The draft Area Plan will be amended to reflect feedback and will be considered by the Regional Partnership Board on 1st February. The Plan will be subject to approval by the UHB Board in March 2018 8

Pooled Budgets (Contact R Jones)

- Part 9 of the SSWB Act requires the establishment of a single pooled budget across Cardiff and Vale of Glamorgan for care accommodation for older people by April 2018.
- In scope services are Continuing Health Care, Funded Nursing Care and local authority responsibilities for long term placements.
- A report setting out the proposed arrangements for the pooled fund will be considered by the UHB Board and two local authority cabinets in January 2018. 5

Pg. 4 STRATEGIC PLANNING FORWARD LOOK (December/January)

Strategic Service Planning Papers Under Development

key: P-papers due, P*-papers late

Papers	Lead	Dec-17																				Jan-18																					
		04/12/2017	05/12/2017	06/12/2017	07/12/2017	08/12/2017	11/12/2017	12/12/2017	13/12/2017	14/12/2017	15/12/2017	18/12/2017	19/12/2017	20/12/2017	21/12/2017	22/12/2017	25/12/2017	26/12/2017	27/12/2017	28/12/2017	29/12/2017	01/01/2018	02/01/2018	03/01/2018	04/01/2018	05/01/2018	08/01/2018	09/01/2018	10/01/2018	11/01/2018	12/01/2018	15/01/2018	16/01/2018	17/01/2018	18/01/2018	19/01/2018	22/01/2018	23/01/2018	24/01/2018	25/01/2018	26/01/2018	29/01/2018	30/01/2018	31/01/2018	01/02/2018	02/02/2018
		Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri	Mon	Tues	Wed	Thu	Fri
Pooled Fund Proposals	RJ																											P																
Cardiff Wellbeing Plan	AW																											P																
Suite 19 - Renal Business Case	ASD																											P																
TCS - UHB Response	?																																												
Thoracic Surgery Update	MD/AW																												P																
Planning Flash Report	LD					P																																						P
Planning Programme Tracker	ASD				P																								P															
CMG Service Planning Report	ASD						P																				P																	
BCAG Agenda	MD																																												
BCAG Decision Report	MD										P																			P															
SDDG Agenda	MD			P																			P																					
Programme Report	MD																									P																			
Draft Corporate IMTP	MD																								P									P											

- Board
- Board Development
- Strategy and Engagement Committee
- Stakeholder Reference Group
- Local Partnership Forum
- Mgt Exec
- HSMB
- OPG / Clinical-Service Boards
- SDDG
- BCAG
- CMG
- Strategic Clinical Reference Group
- SOFW:IOC Programme Board
- SOFW:IOC Project Board
- Directors of Planning
- Strategic Leadership Group

Directors of Planning Key Actions and Upcoming Agenda Items

National Improvement Programme:
Planning updates given at IMTP Winter event

Regional Planning & Delivery
SEW Joint Regional Planning & Delivery Forum (Chairs/CEOs) and SEW Regional Planning & Implementation Group (DoPs/ADoPs/Planning leads) established - governance structure and TOR for supporting regional planning arrangements agreed.

HEALTHY WORKPLACE, HEALTHY YOU
Name of Meeting: LOCAL PARTNERSHIP FORUM **Date of Meeting:** 08/02/2018

Executive Lead : Staff side Health and Safety Group
Author : Lead and Deputy Lead Health and Safety Staff Side Reps
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : Positive impact
Quality, Safety, Patient Experience impact : Implementing this will improve the health and wellbeing of staff which will have a positive impact on patient care
Health and Care Standard Number: Theme 1 & 2
CRAF Reference Number : 1.2, 1.3, 4.1, 5.1, 6.2, 8.1.4
Equality and Health Impact Assessment Completed: No

The Local Partnership Forum is asked to:

- **SUPPORT** the recommendations detailed in this report

RECOMMENDATIONS

1 – The Chief Executive to sign the Pledge for the Healthy Workplace, Healthy You toolkit

2 - For Senior Managers to recognize the importance of this initiative and the positive impact it will have on staff and patient care and share with local managers through meetings and correspondence, such as newsletters

3 – The LPF working with the communications team to agree an action plan to disseminate the toolkit

4 – The LPF requests that the Health and Wellbeing Advisory Group completes the initial health check of the organization to identify areas of improvement and ensures the relevant information is included in the pledge signed by the Chief Executive by the end of the current financial year

5 – That the UHB supports an All Wales Policy on the Menopause and that both management and staff side will progress this through the All Wales Partnership forum

BACKGROUND

The Boorman, Berwick and Francis reviews, to name a few, all mention the importance of treating staff well. At a time of staff shortages it can improve moral and support recruitment and retention of employees.

The average cost of sickness absence to each organization is £3.3 million per year. Retirement due to ill health is estimated to cost the NHS £150 million per year. If the NHS was able to reduce its staff absence levels by a third, it could save 3.4 million days a year. The total cost to the NHS of mental health related staff illnesses stands at £1.3 billion.

Healthy Workplace, Healthy You Toolkit
The Healthy Workplace, Healthy You Toolkit was developed by the RCN to support healthcare employers and workplace representatives to implement healthy working environments with high quality employment practices. The toolkit aims to help organizations achieve the best working conditions for all staff enabling them to deliver the highest standards of patient care. The toolkit acts as an organization health check to work alongside other initiatives.

The toolkit is divided into two categories: Healthy Workplace and Healthy You. The Health Workplace has five domains: Work life balance, Dignity at work, Health and safety, Job design and Learning and development. The Healthy you category includes mind, body, heart, spirit, career, work and balance.

The UHB now has a staff side Health and Safety group of Reps that meet on a monthly basis to discuss concerns. This group would like to use this toolkit as a way of addressing several issues across the UHB in a consistent and fair approach, such as access to affordable healthy eating options for all staff, including shift workers.

The Health and Wellbeing Advisory Group, which led the Corporate Health Standard work, have given their full support to this toolkit, as have the Employee Health and Wellbeing service.

Menopause
The TUC have recently published a document on the Menopause and the need for a policy that actually recognizes the issues and the adjustments that good employers should adopt. The RCN have also produced guidance as part of their Healthy Workplace, Healthy You toolkit to advice employers and employees of what reasonable adjustments should be made (see links below).

The LPF will be well aware that the recent Corporate Health Standard assessment awarded the UHB with a Gold standard, with several recommendations of improvement made, including the need for a policy of the Menopause. There was recognition from the assessors that the UHB is being very forward thinking by addressing the issue.

The UHB supports the need for an All Wales Policy on the Menopause and that both management and staff side will progress this through the All Wales Partnership forum, reporting progress back through the LPF meeting.

ASSESSMENT AND ASSURANCE

Healthy Workplace, Healthy You Toolkit
The toolkit has a check list element where several questions are asked of the organization covering each of the five domains, such as are relevant policies in place. If any requirements of the toolkit are not in place, the pledge from the employer would give assurance that improvements will be made in these areas.

Underlying principles of the toolkit would be the following;

- Recognition of the links between healthy workplaces and patient outcomes
- Recognition that staff also have their part to play 'healthy You'
- Commitment to working in partnership with the trade unions and professional organizations
- Valuing the contribution that staff make
- Commitment to consult and communicate with employees on matters affecting their employment and health
- Commitments to raise managers awareness
- Having policies in place to look after staff, such as the Menopause Policy which would include training/guidance for managers
- Commitment to continuous improvement

Once all requirements of the toolkit have been met, this good standard of practice and improvements will be recognized by staff and their trade unions. This toolkit can then be used to review standards periodically in the future and report back to the LPF on an annual basis.

Further detailed information can be found at;

www.rcn.org.uk/healthyworkplace or https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/february/005467.pdf

www.tuc.org.uk/sites/default/files/TUC_menopause_0.pdf

FINANCE REPORT FOR THE PERIOD ENDED 31st DECEMBER 2017
Name of Meeting : Local Partnership Forum **Date:** 8th February 2018

Executive Lead : Executive Director of Finance
Author : Deputy Director of Finance 02920 743555
Caring for People, Keeping People Well: This report details performance against the annual financial plan supporting the UHB to deliver service priorities, maximise patient outcomes whilst maintaining the sustainability of services.
Financial impact: The UHB financial position at the end of December 2017 is a deficit of £22.177m comprised of the following: • (£0.998m) favourable budget variance; • £23.175m planned deficit (9/12th of £30.900m).
Quality, Safety, Patient Experience impact: This report details financial performance against the one year operational plan which supports improvements in quality, safety and patient / carer experience.
Health and Care Standard Number 1
CRAF Reference Number 6.7
Equality Impact Assessment Completed: Not applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- The work that has been undertaken to develop the 2017/18 operational plan;
- The scrutiny of financial performance undertaken by the Finance Committee;
- The month 9 position which is £0.998m less than the profiled deficit within the financial plan;
- The identification of a full £35m savings programme.

The Local Partnership Forum is asked to:

- **NOTE** that the UHB has an one year operational plan that has a planned deficit of £30.900m for the year;
- **NOTE** the £22.177m deficit at month 9 which includes a planning deficit of £23.175m and budget underspends of (£0.998m);
- **NOTE** that the UHB now has a savings plan that is fully identified;
- **NOTE** the key risks that are outside the current expenditure projection that need to be managed.

SITUATION

The UHB remains on target to meet the £30.9m planned deficit which includes a fully identified £35.0m savings plan. The risk on NCSO drugs has fallen in month and the UHB forecast position now includes provision for the current year costs of £1m for increased NHS Funded Nursing Care (FNC) costs which are expected to arise following the recent Supreme Court judgement.

The residual risks that need to be managed now include:

- The impact of back dated costs arising from increased NHS funded nursing care fees following the Supreme Court judgement currently estimated at £2.7m;
- The continued exceptional cost of £0.6m for NCSO drugs;

The month 9 financial position of the UHB has seen a considerable in month improvement and is now nearly £1m better than planned. The UHB will review its year-end forecast over January and key to this is:

- An assessment of continued improvements and delivery of delegated budgets;
- Clarification of the extent of additional FNC liability that the UHB will be expected to manage;
- Clarification of the likely costs of the Welsh Risk pool for which the UHB currently holds a £1m provision;
- Greater assurances on the further efficiency schemes being pursued by the UHB;
- As assessment of the estimated costs of Winter above the plan.

The review of the financial forecast will be undertaken with a view of reducing the forecast deficit in order to support the All Wales Financial Position as requested by Welsh Government. The reduction could be between £2m - £4m but this is very much dependent upon gaining clarity to the key issues above, some of which are outside the control of the UHB.

BACKGROUND

The UHB submitted a financial plan to Welsh Government on 10th March 2017 which had a deficit of £45.873m. The plan was reconsidered by the UHB at its Board meeting on the 25th May 2017 where it was agreed to work towards a stretch target to deliver a position no worse than the £30.9m forecast position in 2016/17.

The opening underlying deficit position was £54.5m and whilst the UHB has worked towards delivering a £30.9m deficit, many of items needed to achieve this are non recurrent. The UHB's assessed underlying deficit to be carried forward into 2018/19 fell by £0.5m in month and is currently assessed at £54.5m. The UHB is applying further pressure on the underlying deficit with the objective of reducing the figure carried forward to 2018/19 to below £50m.

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

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

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

ASSESSMENT AND ASSURANCE

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

Table 2: Finance Dashboard @ December 2017

Finance Dashboard								
Finance Indicators	Statutory Target	Standard	Performance		In Month	Year to Date	Month 9 Full Year Forecast
			In Month	Year to Date	RAG Rating		
Remain within revenue resource limit - Variance Adv/(Fav)	Yes	£0	£1.733m	£22.177			
Reduction in underlying deficit c/f to 18/19 (£54.5m b/f to 17/18)		£0	(£0.5m)	£54.582m			
Variance against unapproved 2017/18 £30.9m deficit plan		£0	(£0.842m)	(£0.998m)			
Pay expenditure (actual versus Plan)		£0	(£0.066m)	(£1.553m)			
Non-Pay Expenditure (Actual versus Plan)		£0	(£0.592m)	£1.018m			
Income (actual versus Plan)		£0	(£0.184m)	(£0.463m)			
Remain with CAPEX resource limit	Yes	£0	n/a	(£1.211m)			
Creditor payments compliance 30 day Non NHS		95%	95.70%	92.50%			
CRP Green / Amber status - Delegated Targets @ Dec 31st		100% Green		100%			

Month 9 Cumulative Financial Position

The UHB reported a deficit of £22.177m at month 9 as follows:

- (£0.998m) favourable budget management variance;
- £23.175m planned deficit (9/12th of £30.900m).

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

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

Income/Pay/Non Pay	In Month			Year to Date			Full Year		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Forecast £m	Variance (Fav)/Adv £m
Income	(105.345)	(105.529)	(0.184)	(918.678)	(919.142)	(0.463)	(1,275.157)	(1,275.157)	0.000
Pay	49.215	49.149	(0.066)	439.559	438.006	(1.553)	587.336	587.336	0.000
Non Pay	58.705	58.113	(0.592)	502.294	503.312	1.018	718.721	718.721	0.000
Variance to Draft Plan £m	2.575	1.733	(0.842)	23.175	22.177	(0.998)	30.900	30.900	0.000
Planned Deficit	(2.575)	0.000	2.575	(23.175)	0.000	23.175	(30.900)	0.000	30.900
Total £m	(0.000)	1.733	1.733	0.000	22.177	22.177	(0.000)	30.900	30.900

Income

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

Table 4: Income Variance @ December 2017

Income	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Revenue Resource Limit	(72.677)	(72.677)	0.000	(613.568)	(613.568)	0.000
Non Cash Limited Expenditure	(1.628)	(1.628)	0.000	(14.679)	(14.679)	0.000
Accomodation & Catering	(0.230)	(0.181)	0.049	(1.771)	(1.750)	0.021
Education & Training	(3.118)	(3.118)	(0.000)	(28.255)	(28.338)	(0.084)
Injury Cost Recovery Scheme (CRU)	0.011	(0.021)	(0.033)	(1.699)	(1.759)	(0.060)
NHS Patient Related Income	(22.761)	(22.946)	(0.185)	(207.679)	(208.235)	(0.555)
Other Operating Income	(3.877)	(4.004)	(0.127)	(42.737)	(43.088)	(0.351)
Overseas Patient Income	(0.010)	(0.013)	(0.003)	0.124	(0.005)	(0.129)
Private Patient Income	(0.107)	(0.034)	0.073	(1.018)	(0.695)	0.323
Research & Development	(0.949)	(0.907)	0.042	(7.395)	(7.025)	0.370
Total £m	(105.345)	(105.529)	(0.184)	(918.678)	(919.142)	(0.463)

An in month surplus of £0.184m and a cumulative surplus of £0.463m is reported against income budgets.

The reported cumulative deficit against R & D income is primarily due to the reduction in Welsh Government funding.

The Overseas Patient Income is skewed by the application of a resource limit adjustment to extinguish the 2016/17 UHB debtor in respect of overseas reciprocal arrangements.

The over recovery of NHS Patient Related Income in month is due to a revised assessment of income due in month 9 as well as the recovery of further income for additional service delivery in critical care, transplant and haematology services.

The majority of the in month favourable variance reported against other operating Income relates to activity related income collected at a directorate level.

Pay

Pay budgets continue to show sound performance with a year to date underspend of £1.553m. Table 5 highlights that this is favourable performance compared to a month 9 overspend of £1.779m in 2016/17.

Table 5: Analysis of fixed and variable pay costs

	2016/17 Total Spend £m	2016/17 Month 1 to Month 8 £m	2017/18 Month 1 to Month 8 £m	2016/17 Month 9 £m	2017/18 Month 9 £m	2016/17 Cum. to Month 9 £m	2017/18 Cum. to Month 9 £m
Basic	502.093	330.977	339.498	42.358	43.324	373.335	382.821
Enhancements	23.635	15.520	16.159	1.844	1.843	17.364	18.002
Maternity	4.136	2.812	2.756	0.359	0.358	3.170	3.114
Protection	0.743	0.498	0.453	0.061	0.055	0.560	0.509
Total Fixed Pay	**530.607**	**349.807**	**358.866**	**44.622**	**45.580**	**394.429**	**404.447**
Agency (mainly registered Nursing)	9.017	5.581	5.267	0.497	0.643	6.077	5.910
Nursing Bank (mainly Nursing)	14.249	8.837	9.435	0.917	1.031	9.754	10.466
Internal locum (Medical & Dental)	2.105	1.459	2.811	0.118	0.348	1.577	3.160
External locum (Medical & Dental)	9.547	6.471	4.632	0.645	0.593	7.116	5.225
On Call	2.154	1.399	1.431	0.159	0.165	1.558	1.596
Overtime	6.072	4.067	3.601	0.433	0.439	4.501	4.041
WLI's & extra sessions (Medical)	3.549	2.343	2.814	0.245	0.348	2.588	3.161
Total Variable Pay	**46.693**	**30.157**	**29.991**	**3.015**	**3.568**	**33.172**	**33.559**
Total Pay	**577.301**	**379.964**	**388.858**	**47.637**	**49.149**	**427.600**	**438.006**
Pay Budget	**576.692**	**378.023**	**390.345**	**47.798**	**49.214**	**425.821**	**439.559**
Budget Variance (Fav)/Adv £m	**0.609**	**1.940**	**(1.487)**	**(0.161)**	**(0.066)**	**1.779**	**(1.553)**

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

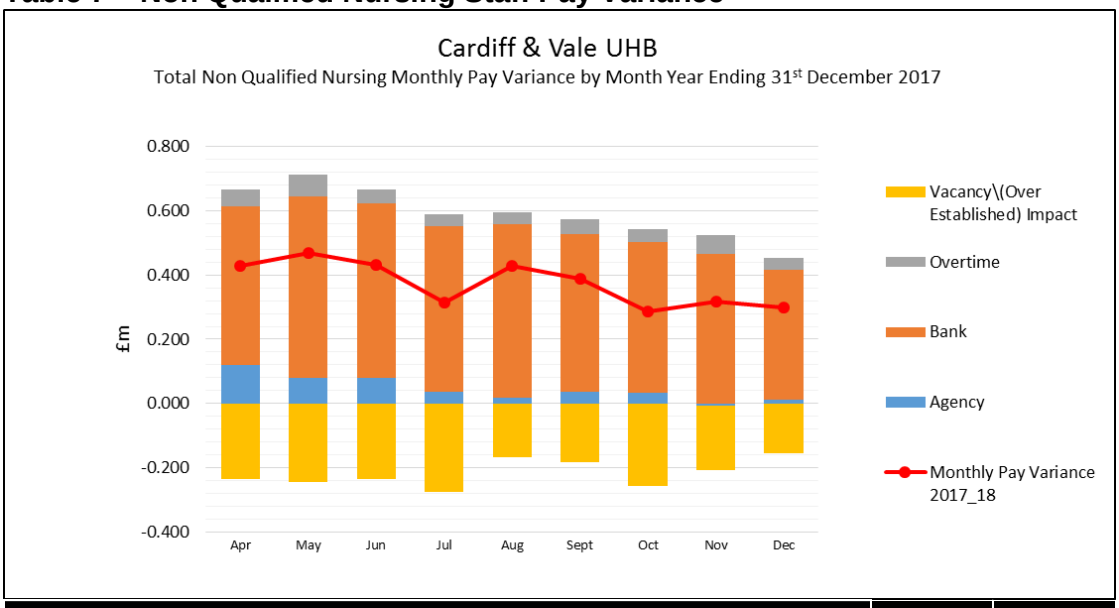
An analysis of pay expenditure by staff group is shown in Table 6.

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

Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Additional clinical services	1.929	1.856	(0.074)	17.017	16.519	(0.498)
Management, admin & clerical	5.883	5.808	(0.076)	51.853	50.983	(0.870)
Medical and Dental	12.716	12.716	(0.000)	113.343	112.685	(0.658)
Nursing (registered)	14.656	14.579	(0.077)	131.691	130.283	(1.408)
Nursing (unregistered)	3.821	4.119	0.298	34.828	38.189	3.361
Other staff groups	7.380	7.360	(0.020)	65.716	65.433	(0.284)
Scientific, prof & technical	2.829	2.712	(0.117)	25.112	23.914	(1.197)
Total £m	49.214	49.148	(0.066)	439.559	438.006	(1.553)

The in month underspend of £0.066m against pay budgets is broadly consistent with the trend established in the first eight months of the year.

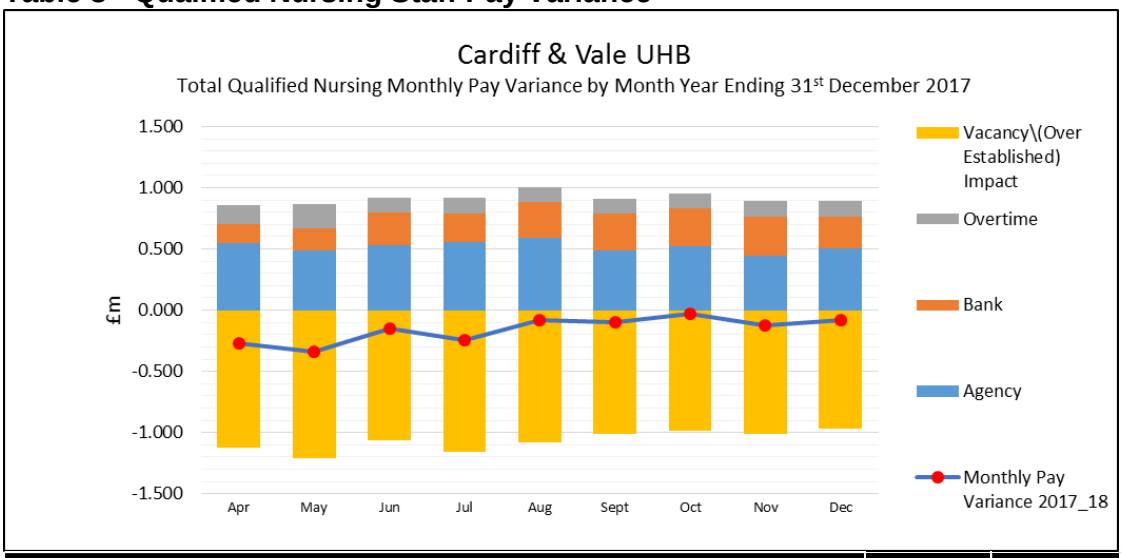
Table 7 – Non Qualified Nursing Staff Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.012	0.406
Bank	0.403	4.486
Overtime	0.039	0.420
Adverse Impact	0.454	5.311
Vacancy\(Over Established) Impact	(0.156)	(1.950)
Total Pay Variance - Unqualified Nursing (Fav)/Adv £m	0.298	3.361

Table 7 demonstrates that the majority of adverse variance against non-qualified nursing assistants is due to an overspend of £4.486m on bank staff which is partly offset by an underspend against established posts. The in month overspend of £0.298m compares favourably against the average monthly overspend for the year to date of £0.373m.

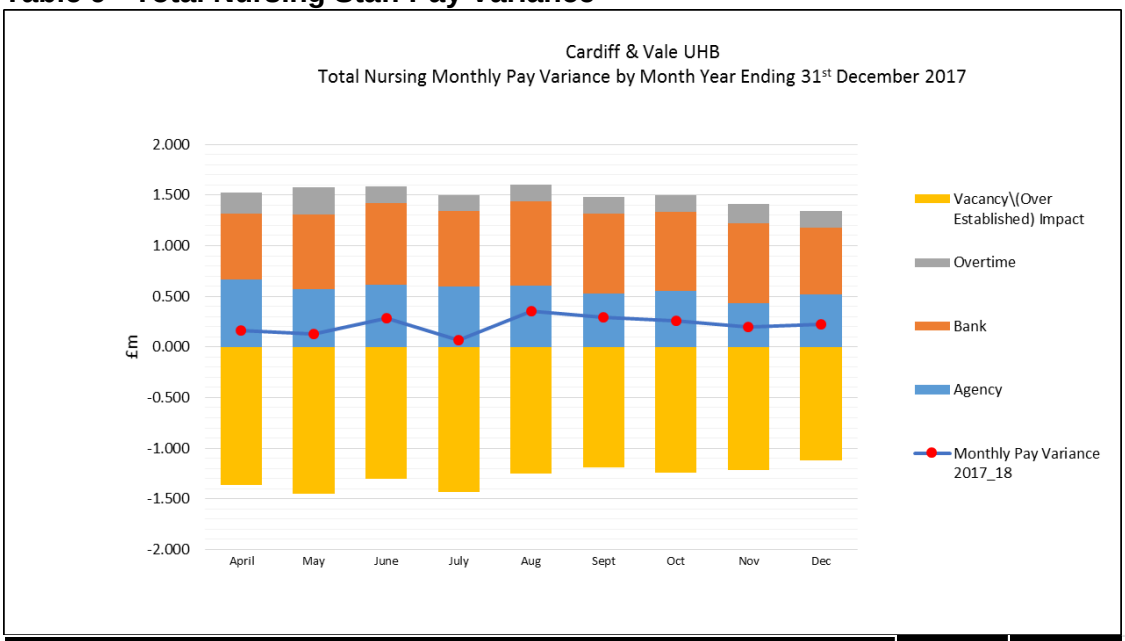
Table 8 - Qualified Nursing Staff Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.507	4.681
Bank	0.254	2.314
Overtime	0.129	1.205
Adverse Impact	0.890	8.200
Vacancy\(Over Established) Impact	(0.968)	(9.608)
Total Pay Variance - Qualified Nursing (Fav)/Adv £m	(0.077)	(1.408)

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

Table 9 - Total Nursing Staff Pay Variance

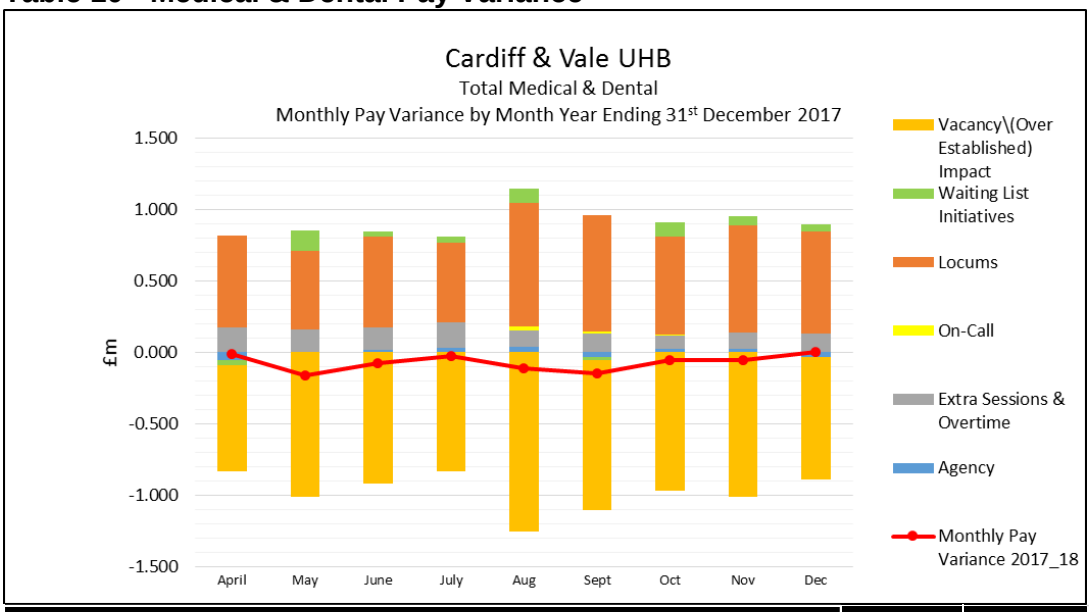


Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	0.519	5.087
Bank	0.657	6.800
Overtime	0.168	1.625
Adverse Impact	1.344	13.511
Vacancy\(Over Established) Impact	(1.123)	(11.558)
Total Pay Variance - (Fav)/Adv £m	0.221	1.953

Table 9 shows that the expenditure against substantive nursing posts for the year to date is less than budget as reported by a £11.558m surplus against established posts. However the combined £13.511m overspend on agency, bank and overtime is greater than the underspend against vacant posts leading to an overall overspend against nursing budgets.

Table 10 shows financial performance against medical and dental pay budgets. This identifies that the favourable variance against established posts is partially offset by expenditure on locums, waiting list initiatives and extra sessions leaving a favourable variance of £0.658m at month 9.

Table 10 - Medical & Dental Pay Variance



Reason	In Month £m (Fav)/Adv	Year To Date £m (Fav)/Adv
Agency	(0.035)	(0.003)
Extra Sessions & Overtime	0.131	1.253
On-Call	(0.000)	0.052
Locums	0.712	6.209
Waiting List Initiatives	0.049	0.473
Adverse Impact	0.856	7.984
Vacancy\(Over Established) Impact	(0.856)	(8.642)
Total Pay Variance - Medical & Dental (Fav)/Adv £m	(0.000)	(0.658)

Non Pay

Table 11 highlights an in month underspend of £0.592m and a £1.018m cumulative overspend against non pay budgets.

Table 11: Non Pay Variance @ December 2017

Non Pay	In Month			Year to Date		
	Budget £m	Actual £m	Variance (Fav)/Adv £m	Budget £m	Actual £m	Variance (Fav)/Adv £m
Clinical services & supplies	8.021	8.041	0.020	70.292	70.619	0.327
Commissioned Services	13.202	13.250	0.048	120.815	120.940	0.125
Continuing healthcare	4.278	4.269	(0.009)	43.840	44.202	0.361
Drugs / Prescribing	12.021	11.610	(0.411)	110.437	109.971	(0.466)
Establishment expenses	1.049	1.005	(0.043)	8.057	7.963	(0.094)
General supplies & services	0.606	0.705	0.098	3.826	4.273	0.448
Other non pay	4.462	4.410	(0.052)	16.510	17.725	1.215
Premises & fixed plant	3.560	3.320	(0.240)	26.723	26.119	(0.604)
Primary Care Contractors	11.506	11.503	(0.003)	101.794	101.501	(0.293)
Total £m	58.705	58.113	(0.592)	502.294	503.312	1.018

The NHS funded nursing fees pressure arising from the recent court judgement is now assessed to be up to £0.941m in respect of 2017/18 and £2.705m for prior years. The in year costs are now included in the UHB's forecast however costs associated with previous years remain outside the forecast and therefore remain a risk.

The variance reported against commissioned services has arisen due to an increase in WHSCC commitments primarily to cover specialist services provided by the UHB through the WHSCC contract.

The surplus against premises and fixed plant in December and for the year to date is due to an underspend against the energy budget.

The December list of NCSO price concessions issued by the Department of Health confirmed that the price concession granted against a number of drugs had fallen in month. As a consequence the risk of continuing NCSO status for a number of high volume drugs has been re-assessed and quantified at £0.6m in the UHB's assessment of risk.

Other non-pay includes the additional costs resulting from the outsourcing of the neuro-interventional radiology service which are now estimated to be £0.516m for the year to date. The UHB has prepared a paper for WHSCC to consider sharing the risk of the outsourced service. Whilst some constructive dialogue has taken place a decision has still not been made regarding funding.

Also included in other non pay is a £1.119m contribution to the stretch target due to planned underspends in delegated budgets

Financial Performance of Clinical Boards

Budgets are set to ensure that there is sufficient resource available to deliver the UHB's plan. Financial performance for 9 months to 31st December 2017 by Clinical Board is shown in Table 12.

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

Clinical Board	M8 Budget Variance £m	M9 Budget Variance £m	In Month Variance £m	Cumulative % Variance
Clinical Diagnostics & Therapies	0.250	0.299	0.048	0.38%
Chidren & Women	0.666	0.657	(0.009)	0.89%
Capital Estates & Facilities	(0.191)	(0.312)	(0.121)	(0.65%)
Dental	(0.028)	(0.028)	0.000	(0.10%)
Executives	(0.193)	(0.235)	(0.042)	(0.82%)
Medicine	0.444	0.370	(0.074)	0.44%
Mental Health	(0.123)	(0.246)	(0.123)	(0.45%)
PCIC	(1.517)	(1.890)	(0.373)	(0.83%)
Specialist	(0.463)	(0.560)	(0.097)	(0.49%)
Surgery	0.397	0.283	(0.113)	0.29%
Central Budgets	0.601	0.663	0.062	0.67%
SubTotal	**(0.156)**	**(0.998)**	**(0.842)**	**(0.11%)**
Planned Deficit	20.600	23.175	2.575	2.52%
Total	**20.444**	**22.177**	**1.733**	**2.41%**

In total delegated budget holders are now reporting an underspend approaching £1m. The Medicine, Children and Women, Surgery and the CD&T Clinical Boards are reporting cumulative overspends.

The overspend against the Medicine Clinical Board is primarily due to its nursing budget performance. In month performance by the Medicine Board improved, however, pressures on nursing budgets remained. Underperformance in PICU and NICU alongside premium costs of medical cover and drug overspends are pressures in the Children and Women Clinical Board. The deficit reported by the Surgery Clinical Board fell by £0.113m in month and is primarily due to the early recognition of underperformance in orthopaedics, renal and sarcoma alongside overspends on wet AMD. The overspend reported by the CD&T Clinical Board is due to the additional costs arising from the outsourcing of the neuro-interventional radiology service.

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

Savings Programme

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

At month 9 the UHB now has a fully identified savings plan to deliver the £35.001m savings target as summarised in Table 13 and is detailed in **Appendix 1**.

Table 13: Progress against the 2017/18 Savings Programme at Month 9

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

For the year to date £24.1m (68.9%) of savings are profiled into the position and these have been delivered. It should be noted that a number of identified corporate schemes are profiled into the last 3 months of the year.

Underlying Financial Position

A key risk to the UHB is its c/f deficit from 2017/18 into 2018/19. The underlying deficit in 2016/17 b/f into 2017/18 was £54.5m. The assessed deficit c/f into 2018/19 is currently £54.5m as shown in Table 14.

Table 14: Summary of Underlying Financial Position

	2017/18 Plan £m	Forecast Position @ Month 9	
		Non Recurrent £m	Recurrent Position £m
Opening Underlying Deficit	54.533	0.000	54.533
Income	(23.414)	0.000	(23.414)
Cost pressures less mitigating actions	34.782	5.861	40.643
Less CIPs	(35.001)	17.821	(17.180)
Deficit	30.900	23.682	54.582

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

Balance Sheet

The Balance sheet is shown in **Appendix 3.**

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

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

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

Cash Flow Forecast

The cash flow forecast is contained in **Appendix 4**.

Welsh Government wrote to the UHB on December 14 2017 to confirm that it will provide up to a maximum of £29.389m strategic cash only support to Cardiff & Vale UHB in 2017/18.

The total working balances cash assistance that the UHB is seeking fell by £3.701m to £3.333m following a revision to forecast provisions and working capital balance estimates in month 8. This requirement was reconfirmed in the UHB's month 9 financial report to Welsh Government. Welsh Government confirmed in the letter of December 14 that the request for working balance cash allocations for capital and revenue were noted, and would be confirmed and allocated in the normal manner, subsequent to HMT approval of the Welsh Government 2017-18 estimates in January 2018.

The UHB has requested total cash assistance of £32.722m (£29.389m strategic cash only support & £3.333m working balances cash assistance).

Public Sector Payment Compliance

The UHB's cumulative performance to the end of December improved by 0.5% in month to 92.5%. As previously reported the poor performance to date is linked to the transition to the All Wales Nursing Agency Contract. The UHB expects performance in this area to gradually improve following the 1st August 2017 roll out of an automated ordering & receipting process that currently works well in respect of one supplier. In addition, the UHB is piloting a "No Purchase Order, No Pay" policy within corporate departments with the long term intention of rolling the policy out across the UHB and improving the efficiency of invoice payments. Furthermore all Clinical Boards have formally been reminded that the UHB expects all invoices received to either be authorised or receipted on Oracle within 3 days of receipt. It is expected

that the combination of remedial actions will produce a steady improvement across the remaining months of the year.

Capital Resource Limit (CRL)

Progress against the CRL for the period to the end of December 2017 is detailed in **Appendix 5** and summarised in Table 15.

Table 15: Progress against Capital Resource Limit @ December 2017

	£m
Planned Capital Expenditure at month 9	18.545
Actual net expenditure against CRL at month 9	17.334
Variance against planned Capital Expenditure at month	(1.211)

Capital progress to date has been slow but this has been skewed by three significant asset sales where the net book value will provide a source of capital funds for the full year and not just the first nine months.

Financial Risks

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

- The prior year risk in NHS Funded Nursing Care fees following the Supreme Court judgement in respect of weekly fees which is assessed as circa being £2.705m for previous years. This risk is not included in the UHB's forecast outturn.
- Whilst the UHB had accounted for NCSO drugs pressures of £3.5m as part of its forecast position, the high costs continue which was not anticipated. If NCSO costs continue at the rate experienced in month 9 for the rest of the year the UHB has a £0.6m risk that is not covered in its plan.

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

Key Concerns & Recovery Actions

At month 9, the key concerns and challenges are set out below:

1. Concern- Budget overspends at month 9;

   Action – All Clinical Boards have confirmed expected year end outturn through a detailed forecasting exercise. Clinical Boards with forecast year end

overspends are required to implement recovery actions as part of the Clinical Board Performance Escalation process.

2. Concern – Key financial risks;

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

3. Concern – Underlying Deficit.

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

CONCLUSION

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

The UHB's draft 2017/18 financial plan requires the delivery of £35m financial savings to achieve a £30.9m deficit. There are however a number of significant financial risks that need to be managed in order to achieve the forecast out turn position. The UHB financial position is currently better than planned. This financial improvement and clarity on financial risks and internal efficiencies being pursued will be reviewed in month with the intention, if possible, of reducing the UHB forecast position to support the NHS Wales overall financial position as requested by Welsh Government. In addition, the UHB aims to identify further recurrent savings in order to reduce the underlying deficit carried forward into 2018/19.

The UHB will continue to share progress being made with Welsh Government at its Targeted Intervention meetings. The UHB will also ensure good financial management processes remain in place to explore further options to support longer term financial sustainability.

The reported financial position for the nine months to the end of December is a deficit of £22.177m. This is made up of a budget plan deficit of £23.175m and a favourable variance against plan of £0.988m

Appendix 1

2017/18 Part Year Effect Month Ending 31st December 2017-18

Identified Savings	17-18 CRP Target	Granular Identified Green	Amber	Red Pipeline	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000
Corporate Execs	681	941	106	72	1,046	-365
Specialist Services	2,400	2,636	311	324	2,947	-547
Capital Estates and Facilities	1,244	1,355	0	0	1,355	-111
PCIC	3,323	3,327	226	450	3,553	-230
Surgery	2,357	2,407	118	35	2,526	-169
Dental	400	408	0	10	408	-8
Children & Women	1,775	1,665	147	420	1,812	-37
CD&T	1,880	1,890	0	163	1,890	-10
Mental Health	1,395	1,433	0	0	1,433	-38
Medicine	1,878	1,879	0	157	1,879	-1
Clinical Board Forecasts			3,065		3,065	-3,065
Corporate schemes	17,668	10,143	2,945	234	13,088	4,580
Total Savings	**35,001**	**28,084**	**6,918**	**1,864**	**35,001**	**0**

2017-18 Full Year Effect Month Ending 31st December 2017-18

Identified Savings	Recurrent 17-18 CRP Target	Granular Identified Green	Amber	Red Pipeline	Total Green & Amber	Shortfall on Total Target vs Green & Amber
	£'000	£'000	£'000	£'000	£'000	£'000
PCIC	2,493	3,239	275	160	3,514	-1,021
Mental Health	1,047	1,047	0	0	1,047	0
CD&T	1,382	1,340	0	163	1,340	42
Dental	300	88	0	20	88	212
Surgery	1,768	1,794	170	86	1,964	-196
Capital Estates and Facilities	933	873	60	420	933	0
Children & Women	1,331	926	425	723	1,351	-20
Medicine	1,408	1,702	0	368	1,702	-294
Specialist Services	1,800	1,365	450	324	1,815	-15
Corporate Execs	501	609	74	16	683	-182
Corporate schemes	17,668	4,197	0	0	4,197	13,471
Total Savings	**30,631**	**17,180**	**1,454**	**2,279**	**18,634**	11,997

Appendix 2

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

	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Forecast Year end Position £'000
Gross costs	**103,244**	**101,554**	**110,313**	**109,081**	**110,590**	**109,803**	**96,177**	**113,911**	**110,823**	**118,150**	**117,264**	**144,276**	**1,345,186**
Identified savings	-618	-1,481	-2,972	-1,757	-2,739	-2,898	-4,741	-3,568	-3,403	-3,381	-3,369	-4,073	-35,001
Unidentified savings required for stretch target													
Total savings required	**-618**	**-1,481**	**-2,972**	**-1,757**	**-2,739**	**-2,898**	**-4,741**	**-3,568**	**-3,403**	**-3,381**	**-3,369**	**-4,073**	**-35,001**
Net costs	**102,626**	**100,073**	**107,341**	**107,324**	**107,851**	**106,905**	**91,436**	**110,343**	**107,420**	**114,769**	**113,894**	**140,203**	**1,310,186**
Income (phased as per budget plan)	98,952	98,579	104,814	104,728	105,337	104,301	88,882	107,862	105,687	111,862	110,987	137,295	1,279,286
Net surplus/ (deficit)	**-3,674**	**-1,494**	**-2,527**	**-2,596**	**-2,514**	**-2,604**	**-2,554**	**-2,481**	**-1,733**	**-2,908**	**-2,908**	**-2,908**	**-30,900**

Notes

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

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

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

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

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

Appendix 3

BALANCE SHEET AS AT 31ST DECEMBER 2017

	Opening Balance 1st April 2017	Closing Balance 31st December 2017
Non-Current Assets	**£'000**	**£'000**
Property, plant and equipment	628,042	640,304
Intangible assets	1,601	1,572
Trade and other receivables	42,437	46,621
Other financial assets		
Non-Current Assets sub total	**672,080**	**688,497**
Current Assets		
Inventories	15,129	16,252
Trade and other receivables	137,493	192,460
Other financial assets	0	0
Cash and cash equivalents	881	2,156
Non-current assets classified as held for sale	1,815	0
Current Assets sub total	**155,318**	**210,868**
TOTAL ASSETS	**827,398**	**899,365**
Current Liabilities		
Trade and other payables	157,516	130,354
Other financial liabilities	0	0
Provisions	102,277	151,981
Current Liabilities sub total	**259,793**	**282,335**
NET ASSETS LESS CURRENT LIABILITIES	**567,605**	**617,030**
Non-Current Liabilities		
Trade and other payables	10,207	9,808
Other financial liabilities	0	0
Provisions	44,615	43,365
Non-Current Liabilities sub total	**54,822**	**53,173**
TOTAL ASSETS EMPLOYED	**512,783**	**563,857**
FINANCED BY: **Taxpayers' Equity**		
General Fund	399,057	449,816
Revaluation Reserve	113,726	114,041
Total Taxpayers' Equity	**512,783**	**563,857**

Appendix 4

CASH FLOW FORECAST AS AT 31st DECEMBER 2017

	April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
RECEIPTS													
WG Revenue Funding - Cash Limit (excluding NCL)	77,340	60,358	90,378	66,386	67,086	79,642	71,292	73,102	82,767	65,128	78,705	38,076	850,260
WG Revenue Funding - Non Cash Limited (NCL)	1,830	1,830	1,150	1,410	1,610	1,815	1,375	1,720	1,605	1,620	1,620	1,982	19,567
WG Revenue Funding - Other (e.g. invoices)	2,360	2,360	2,506	2,361	2,361	2,331	2,356	2,356	2,878	2,386	2,386	7,220	33,861
WG Capital Funding - Cash Limit	9,000	2,000	1,000	2,100	3,900	2,950	0	4,200	375	3,325	5,200	6,915	40,965
Sale of Assets	0	9,152	0	0	0	0	212	550	0	0	0	0	9,914
Income from other Welsh NHS Organisations	47,076	17,644	41,554	29,101	31,459	41,273	25,977	32,259	39,530	26,413	30,943	36,188	399,417
Other - (Specify in narrative)	11,438	3,599	7,579	5,630	8,324	6,620	9,018	6,738	5,850	6,573	5,125	8,489	84,983
TOTAL RECEIPTS	**149,044**	**96,943**	**144,167**	**106,988**	**114,740**	**134,631**	**110,230**	**120,925**	**133,005**	**105,445**	**123,979**	**98,870**	**1,438,967**
PAYMENTS													
Primary Care Services : General Medical Services	5,249	4,042	8,318	3,992	3,986	6,294	4,142	4,059	6,769	4,134	4,064	6,734	61,783
Primary Care Services : Pharmacy Services	153	124	144	112	125	135	121	101	215	484	250	250	2,214
Primary Care Services : Prescribed Drugs & Appliances	15,528	2	15,095	4	7,945	16,115	3	7,429	16,189	0	7,830	7,830	93,970
Primary Care Services : General Dental Services	1,734	1,877	1,908	1,936	1,720	1,806	1,845	1,793	1,768	1,839	1,820	1,820	21,866
Non Cash Limited Payments	1,986	2,196	1,910	2,173	2,105	2,125	2,135	2,174	2,201	2,220	2,140	2,140	25,505
Salaries and Wages	45,715	47,104	47,578	46,857	46,825	46,822	46,626	47,425	47,459	47,178	47,603	47,554	564,746
Non Pay Expenditure	41,188	43,621	48,892	44,051	45,352	44,772	49,641	44,931	40,770	42,345	45,674	49,011	540,248
Capital Payment	9,738	1,925	1,323	1,802	3,587	2,322	2,277	3,052	2,773	3,449	3,951	8,752	44,951
Other items (Specify in narrative)	15,801	2,891	17,084	2,836	9,095	16,775	2,913	8,717	17,075	3,186	9,200	10,833	116,406
TOTAL PAYMENTS	**137,092**	**103,782**	**142,252**	**103,763**	**120,740**	**137,166**	**109,703**	**119,681**	**135,219**	**104,835**	**122,532**	**134,924**	**1,471,689**
Net cash inflow/outflow	11,952	(6,839)	1,915	3,225	(6,000)	(2,535)	527	1,244	(2,214)	610	1,447	(36,054)	
Balance b/f	881	12,833	5,994	7,909	11,134	5,134	2,599	3,126	4,370	2,156	2,766	4,213	
Balance c/f	12,833	5,994	7,909	11,134	5,134	2,599	3,126	4,370	2,156	2,766	4,213	(31,841)	

Appendix 5

PROGRESS AGAINST CRL AS AT 31st DECEMBER 2017

Approved CRL issued November 30 2017 £'000s	40,965

Performance against CRL	Year To Date			Forecast		
	Plan £'000	Actual £'000	Var. £'000	Plan £'000	F'cast £'000	Var. £'000
All Wales Capital Programme:						
Replacement Cardiac Catheter Labs UHW	3	2	(1)	3	3	0
Rookwood Emergency Works	379	286	(93)	1,445	1,383	(62)
Relocation of Central Processing Unit	0	0	0	0	0	0
Neonatal Phase 2	10,992	10,273	(719)	15,935	15,935	0
Primary Care Fees	0	0	0	125	125	0
Gamma Cameras	135	12	(123)	672	672	0
Anti Ligature Works	20	0	(20)	500	500	0
CRI Wards 14 and 14(a)	388	53	(335)	2,148	1,601	(547)
Genomics	0	67	67	960	960	0
Implementation of WIFI	0	0	0	600	600	0
National Clinical Information Systems	0	0	0	448	448	0
Modular Theatre Llandough	1,697	1,659	(38)	1,697	1,697	0
Interventional Radiology Suite UHW	0	0	0	1,500	1,500	0
Sub Total	**13,614**	**12,352**	**(1,262)**	**26,033**	**25,424**	**(609)**
Discretionary:						
I.T.	339	308	(31)	1,162	1,162	0
Equipment	374	356	(18)	2,078	2,078	0
Statutory Compliance	1,508	1,464	(44)	2,524	2,524	0
Estates	10,610	10,754	144	17,468	18,077	609
Sub Total	**12,831**	**12,882**	**51**	**23,232**	**23,841**	**609**
Donations:						
Ronald McDonald House, Oakgrove Foundation & Endowments	5,648	5,648	0	6,048	6,048	0
Sub Total	**5,648**	**5,648**	**0**	**6,048**	**6,048**	**0**
Asset Disposals:						0
West Wing	1,750	1,750	0	1,750	1,750	0
The Former Filling Station at Llandough	10	10	0	10	10	0
CRC Credits Surrendered	212	212	0	212	212	0
Longcross House	280	280	0	280	280	0
Sub Total	**2,252**	**2,252**	**0**	**2,252**	**2,252**	**0**
CHARGE AGAINST CRL	**18,545**	**17,334**	**(1,211)**	**40,965**	**40,965**	**0**
PERFORMANCE AGAINST CRL (Under)/Over £'000s		**(23,631)**			**0**	

Workforce Key Performance Indicators December 2017

Indicators 1, 2, 4 - 7 and 9 all moved in a positive direction; indicators 3 and 8a moved in a negative direction.

Key Performance Indicator	2016-17 Outturn	YTD	Monthly Actual	Comparison with Previous Month	2017-18 target	Notes
1. Vacancy Rate (WTE)	4.61%	5.50%	5.08%	⇩ 0.39%	5.00%	YTD is 12-month average
2. Turnover Rate (WTE)	9.24%	9.19%	9.19%	⇩ 0.03%	7.0% - 9.0%	Excludes junior medical staff in training
3. Sickness Absence Rate	4.87%	4.94%	5.69%	⇧ 0.08%	4.20%	YTD is 12-month cumulative rate
4. PADR Rate	57.65%	60.32%	60.32%	⇧ 0.29%	85.00%	
5. Statutory and Mandatory Training Rate	66.18%	69.14%	69.14%	⇧ 1.14%	85.00%	
6. Pay Bill Over/Underspend	0.24%	-0.35%	-0.13%	⇩ 0.01%	Underspend	YTD is April-17 to current month, value shown is the amount of over/underspend as a % of budget
7. Variable Pay Rate	8.08%	7.66%	7.26%	⇩ 0.06%	No target	YTD is April-17 to current month, value shown is variable pay as a % of pay bill
8a. Recruitment Time to Hire	56 (Days)	53	53	⇧ 7 days	Less than 44 days	From vacancy created to sending of conditional offer
9. Job Plan Compliance	21.99%	40.90%	40.90%	⇧ 1.68%	85.00%	Compliance is having a job plan recorded in ESR with a review having taken place within the last 12 months.

Key Messages:

Enablers (WOD)	Operational Implementation (Clinical Boards)
• **Nurse Recruitment:** The December 2017 nurse vacancy rate at Band 5 was 10.87% (209 vacancies), up by 2.37% from December 2016. Turnover has risen by 0.10% over the same period to 11.78%. There has been a net decrease of 39 wte fewer in post, and 46 wte more vacancies than a year ago. Nurse Workforce Sustainability Plan being implemented to further progress this improved position. • Representatives from Cardiff & Vale UHB attended a national recruitment event in Southampton organised by the RCN. At the event several attendees (34) expressed interest in working in Cardiff. A significant portion of those in attendance were student (paediatric branch) nurses who were informed of our paediatric recruitment event planned for February 2018. Throughout December clinical boards were supported with the organisation of forthcoming local recruitment events. Funding was agreed to support national recruitment events in the new year; the first to be held in Bristol (March) and the second will be held in Cardiff (May). • **Medical Recruitment:** As at end of December 2017 there are 29.00 WTE hard-to-fill vacancies, 3 WTE of which are consultant posts. This represents 2.41% of the M&D workforce. Specific workforce plans are being developed to address	• **Children & Women:** Improvement to PADR compliance during December due to i. Increase in Nursing and Midwifery staffing numbers in rosters facilitating increased capacity to complete statutory and mandatory training and PADRs ii. Back log of Information being in put on ESR • **Children & Women:** Work has commenced with the Speech and Language Therapists to look at how the "Early Language Pathway" can be implemented in to the current service. • **Children & Women:** Work will commence in January to commence the proposed relocation of the Palliative Care Team currently based at UHW to designated offices at Ty Hafan, Sully. • **Children & Women:** A review is to be undertaken to look at the Paediatric Occupational Therapy Service. This review will be undertaken by external parties. Once finalised, the Continuous Service Improvement (CSI) team will provide support in progressing the implementation of any recommendations. • **PCIC:** HoWOD supported the first project group for the development and implementation of the physician associate role.
• **PADR:** All managers/ reviewers now have the responsibility to record their	• **PCIC:** Local Workforce Recognition Scheme winners were awarded.

- **PADR:** All managers/ reviewers now have the responsibility to record their staffs PADRs electronically via ESR. Enhanced reviewer training evaluated well in November, which aims to provide reviewers/ line managers with the core softer skills they require for the review meeting. Work is continuing to ensure the revised values and behaviours framework is incorporated into the appraisal process i.e. updating documentation, incorporating into the training etc. A video will be launched in the new year which will promote the benefits of an effective PADR.
- **Statutory and Mandatory Training:** 'Mandatory November' has taken place, with 308 staff attending the classroom fire session (over 9 dates); the other modules were also well attended. Since migration to ESR and undertaking the data cleanse, compliance figures are slowly increasing. As ESR self-service is fully deployed, managers and staff now have access to view their compliance records and complete the relevant modules as required; training is being provided.
- **Staff Engagement:** Local engagement plans are being monitored within the Clinical Boards, which incorporate the results from the Medical Engagement Survey (MES) and All Wales Staff Survey; the next All Wales Staff Survey will be provided in Spring 2018. All branding and communication aids for the 'Living Our Values' project have been agreed and information/ promotional packs will be distributed widely throughout the UHB shortly. Values based recruitment is progressing; a draft interview guide has been developed incorporating staff group specific questions; this will be distributed for wider consultation shortly. Also, an interview skills train the trainer workshop has been scheduled for March 2018.
- **Employee Assistance Programme:** The new EAP service, provided by Care First, continues to offer assistance to staff. Since May 2017, 63 staff have accessed the counselling service while there have been 183 instances of staff accessing the online resources. Information on the service has been cascaded throughout the Clinical Boards and there is information available on the WOD internet sit. Further information on the Zest and Lifestyles services has been shared across the UHB via the Communication team in order to promote use of these services.
- **Employee Wellbeing Scheme:** Employee Wellbeing had 16 referrals in December 2017. 32 people attended a 1st appointment (resource appointment) and 85 sessions were attended in total. 2 workshops were delivered, one on Stress in UHW and the other on Resilience in UHL.
- **IMTP:** The 2018/19 IMTP refresh is in draft. This will incorporate CB submissions and the agreed revised WOD Delivery Plan identifying key actions for the 3 years. It is essential that CB's submit their WTE forecasts on the WG templates so that the UHB aggregated picture is as accurate as possible and integrated with the service and financial plan.

- **PCIC:** Local Workforce Recognition Scheme winners were awarded.
- **PCIC:** Community Director Lead for IM&T appointed.
- **Specialist Services:** Three Mandatory Training sessions have been set up to provide all staff in the Clinical Board with the opportunity to attend classroom based sessions.
- **Specialist Services:** The sickness rate for November 2017 was at its lowest ever level at 4.28% against a target of 4.13%.
- **Specialist Services:** At the end of November 2017, the Clinical Board was £499,000 underspent on pay.
- **Surgery:** The Clinical Board are currently reviewing its Nursing establishments to ensure that they are compliant with the requirements of the Nurse Staffing Act.
- **Surgery:** Focused work continues to ensure that managers and staff understand the importance of having a meaningful PADR.
- **Surgery:** Managers are continuing to release staff wherever possible to undertake Statutory & Mandatory training.
- **Mental Health:** Winter sickness reporting has commenced
- **Mental Health:** A bespoke leadership development programme has launched in MHSOP
- **Mental Health:** The Adult Directorate Manager post has been successfully filled
- **Mental Health:** PADR trajectories have been developed for each department, alongside the monthly activity trackers.
- **CD&T:** The Clinical Board is in the process of meeting with all Directorates to provide feedback on their individual IMTP submissions. This meeting will also include discussions around possible reduction in management costs, as well as the more prudent use of the unregistered workforce.
- **PCIC:** A sickness audit was carried out in CHAP on 5 December 2017
- **PCIC:** Local Workforce Recognition Scheme winners were presented with their certificates. A senior manager and lead union representative presented the certificates in the workplace.

Clinical Board Nursing Recruitment Activity

Clinical Board Nursing Recruitment Activity

- **Children & Women:** Vacancy factor now on target in line with trajectory which reflects flexible staffing aligned to winter activity
- **Children & Women:** New starters working as part of rosters in Midwifery, Paediatrics & Health Visiting . Overall nursing position much better however maternity leave , turnover to Health Visiting remains on going challenge
- **Children & Women:** Currently out to advert for ACH and CCNS Nursing staff (small number of suitable applicants)
- **Children & Women:** ACH preparing for recruitment event scheduled to take place on 10th February 2018.
- **Children & Women:** Increasing challenges with filling Band 5 Therapy Vacancies , ST7 & Obstetrics and Gynaecology
- **Medicine:** Representatives of the Medicine Clinical Board are due to attend external recruitment events on 24th March in Bristol and 12t h May in Cardiff, following the approval of funding
- **Medicine:** A small scale recruitment event is being arranged to take place in early February
- **Medicine:** Following the most recent round of interviews, a further four band 5 nurses were appointed. Three of which are due to qualify in the summer, one is already qualified so it is anticipated that she will commence in February. These appointments are in addition to the following expect ed starters: January 1.40 WTE, March 3.00 WTE, September 12.00 WTE

1. Vacancy Rate (Monthly WTE)

	WTE	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Dental	401.16	2.96%	2.69%	2.84%	3.12%	2.48%	1.39%	2.32%	3.31%	1.90%	2.27%	2.99%	3.29%	0.88%
Specialist Services	1659.22	2.88%	3.06%	2.72%	2.42%	2.00%	2.38%	1.75%	1.97%	2.35%	1.57%	1.31%	1.93%	1.83%
Children & Women	1694.93	1.95%	2.02%	2.17%	2.89%	3.50%	5.32%	4.63%	5.21%	7.94%	6.33%	3.33%	2.06%	2.16%
CDT	2045.26	0.34%	-0.05%	-0.10%	0.30%	1.48%	1.68%	4.76%	3.77%	5.22%	4.93%	4.98%	4.55%	3.91%
Mental Health	1213.13	6.63%	7.16%	7.41%	7.64%	8.02%	7.71%	7.77%	11.81%	7.32%	7.24%	6.93%	6.46%	5.70%
PCIC	668.82	9.26%	9.07%	8.32%	8.65%	10.33%	9.04%	8.77%	7.51%	7.65%	7.54%	8.05%	6.34%	5.97%
Medicine	1616.73	7.43%	6.95%	7.23%	6.89%	7.80%	7.75%	9.04%	9.83%	10.70%	9.16%	10.23%	7.99%	6.86%
Surgical Services	1761.95	5.07%	4.54%	5.62%	5.57%	6.46%	6.77%	7.74%	8.31%	7.75%	7.06%	7.56%	7.19%	7.22%
Capital, Estates & Facilities	1066.73	4.60%	6.38%	6.66%	6.39%	7.08%	7.06%	7.25%	6.86%	8.25%	7.30%	8.20%	7.82%	7.80%
Corporate	702.16	7.83%	7.34%	6.58%	6.26%	8.11%	8.11%	8.92%	7.68%	8.52%	8.68%	9.51%	8.75%	9.04%
uHB	**12830.08**	**4.41%**	**4.41%**	**4.54%**	**4.61%**	**5.33%**	**5.54%**	**6.12%**	**6.62%**	**6.96%**	**6.23%**	**6.17%**	**5.47%**	**5.08%**

Over 5.0%
Under 5.0%

Note:
This data is sourced from ESR and whilst the WTE staffing numbers are accurate (Payroll-managed), department managers and Finance staff are required to maintain the accuracy of the recorded establishment data.
The WTE staffing numbers and % rates for PCIC and CD&T are adjusted to reflect posts that are hosted within CD&T for professional accountability purposes where the service delivery is within PCIC.

2. Turnover Rate (12-Month WTE, excluding junior medical staff)

	Average WTE	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Children & Women	1586.49	8.30%	8.75%	8.64%	9.23%	9.02%	9.39%	9.32%	9.18%	8.95%	8.80%	8.39%	8.68%	8.29%
Dental	363.69	6.58%	6.82%	6.86%	6.68%	6.55%	5.99%	5.67%	6.66%	9.38%	9.59%	9.02%	9.18%	8.45%
Capital, Estates & Facilities	1077.37	6.25%	6.42%	6.72%	6.93%	7.18%	7.73%	7.70%	7.76%	8.56%	8.34%	8.72%	8.13%	8.55%
CDT	2012.48	8.84%	8.66%	8.68%	8.93%	8.61%	8.50%	8.03%	8.24%	8.70%	8.56%	8.47%	8.10%	8.66%
Specialist Services	1524.77	8.52%	9.18%	9.22%	8.85%	8.62%	8.56%	8.44%	8.67%	8.66%	8.64%	8.65%	9.31%	8.90%
Surgical Services	1581.78	8.91%	8.85%	9.12%	9.08%	9.18%	8.87%	8.85%	8.72%	8.75%	8.64%	9.06%	9.37%	8.97%
Medicine	1475.02	8.24%	8.73%	9.19%	9.50%	9.65%	9.60%	10.18%	9.45%	9.84%	9.06%	9.58%	9.37%	9.29%
Mental Health	1171.65	10.11%	10.46%	10.67%	9.89%	10.12%	10.32%	10.49%	10.66%	10.61%	10.62%	9.67%	9.77%	9.56%
Corporate	703.87	9.16%	9.08%	9.71%	9.91%	10.08%	10.36%	9.58%	9.40%	10.29%	10.31%	10.32%	9.94%	10.48%
PCIC	645.51	12.99%	13.85%	13.79%	14.43%	14.85%	13.75%	13.10%	12.92%	12.91%	13.48%	13.80%	13.07%	13.39%
uHB	**12142.63**	8.73%	8.99%	9.16%	9.24%	9.24%	9.22%	9.11%	9.09%	9.38%	9.24%	9.24%	9.22%	9.19%

Under 7%, Over 9%
7.0% - 9.0%

Note:
Turnover data in respect of junior medical staff in training has been excluded from these calculations, so the average WTE numbers also exclude this staff group. There are other areas (notably Dental) that are training centres where student turnover may skew the turnover rates.

uHB Staffing Position

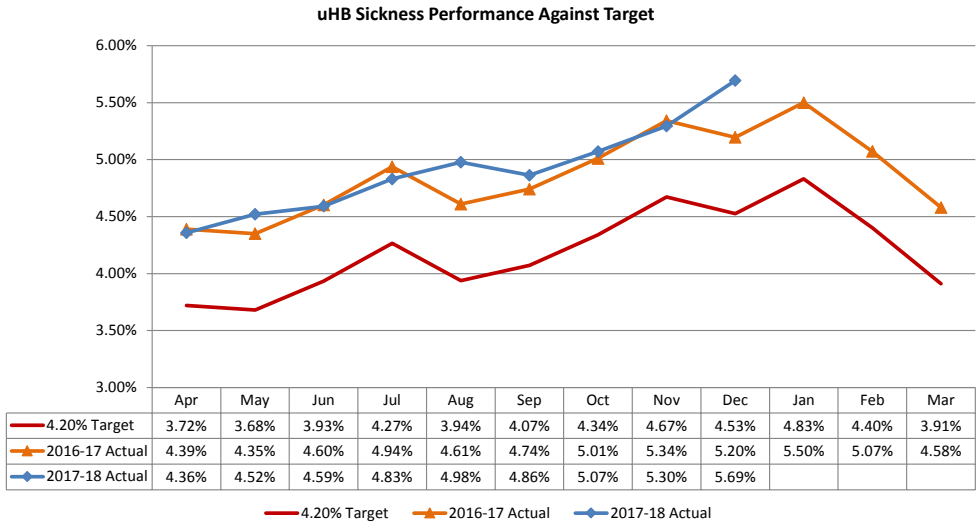
	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Change since March 17
Worked WTE	12992.83	12844.54	12848.86	12896.82	12947.34	12916.46	12980.06	12867.64	12893.14	12937.81	12896.59	12897.38	13038.92	12977.01	29.67
Contracted WTE	12687.61	12647.33	12674.90	12674.54	12667.96	12585.67	12551.70	12557.24	12591.86	12579.02	12710.07	12684.55	12771.19	12830.08	162.12

Note:
Currently an improvement would be a reduction in the worked WTE, as this is a calculated value and includes staff overtime and bank use; and an increase in contracted WTE, as this would demonstrate that vacancies are being filled. As can be seen above both the contracted and worked WTE are higher than those for March 2017

3. Sickness Rate (12- Month Cumulative)

	WTE	Target	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Corporate	702.16	2.68%	2.87%	2.70%	2.64%	2.57%	2.57%	2.52%	2.54%	2.51%	2.46%	2.48%	2.40%	2.42%	2.41%
Dental	401.16	3.46%	3.86%	3.98%	3.92%	3.88%	3.91%	3.92%	3.84%	3.88%	3.82%	3.86%	3.81%	3.70%	3.64%
CDT	2045.26	3.25%	3.65%	3.70%	3.71%	3.70%	3.72%	3.74%	3.73%	3.75%	3.77%	3.77%	3.80%	3.75%	3.81%
Specialist Services	1659.22	4.13%	4.79%	4.79%	4.76%	4.69%	4.66%	4.62%	4.57%	4.48%	4.43%	4.45%	4.34%	4.28%	4.35%
Children & Women	1694.93	3.77%	4.43%	4.49%	4.48%	4.43%	4.46%	4.47%	4.50%	4.40%	4.40%	4.47%	4.52%	4.49%	4.59%
Surgical Services	1761.95	3.96%	4.62%	4.64%	4.69%	4.74%	4.75%	4.81%	4.81%	4.72%	4.78%	4.83%	4.85%	4.78%	4.89%
PCIC	668.82	4.37%	5.23%	5.24%	5.22%	5.23%	5.24%	5.24%	5.10%	5.05%	5.05%	4.98%	4.94%	4.96%	5.15%
Medicine	1616.73	4.67%	5.53%	5.58%	5.58%	5.51%	5.51%	5.50%	5.47%	5.49%	5.57%	5.62%	5.63%	5.49%	5.49%
Mental Health	1213.13	5.56%	6.42%	6.36%	6.40%	6.41%	6.43%	6.45%	6.39%	6.35%	6.33%	6.34%	6.40%	6.56%	6.70%
Capital, Estates & Facilities	1066.73	6.08%	6.94%	7.00%	7.07%	7.09%	7.14%	7.25%	7.18%	7.36%	7.56%	7.56%	7.61%	7.60%	7.83%
uHB	**12830.08**	**4.20%**	**4.86%**	**4.88%**	**4.89%**	**4.87%**	**4.88%**	**4.89%**	**4.86%**	**4.84%**	**4.86%**	**4.89%**	**4.89%**	**4.86%**	**4.94%**

> 0.5% Off Target
< 0.5% Off Target
Below / On Target

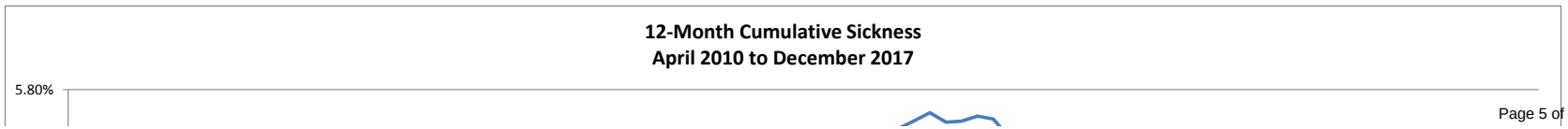


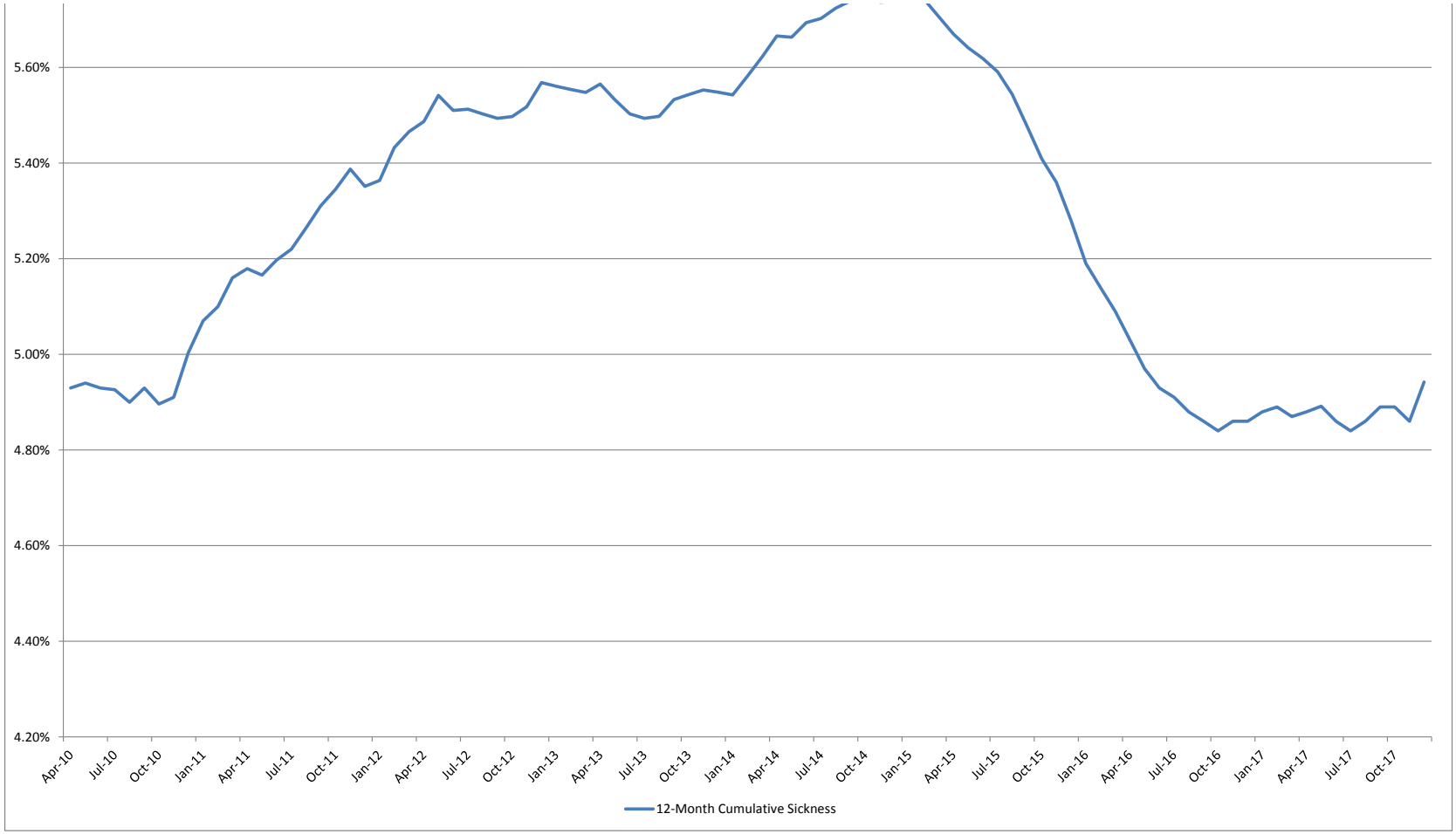
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.20% Target	3.72%	3.68%	3.93%	4.27%	3.94%	4.07%	4.34%	4.67%	4.53%	4.83%	4.40%	3.91%
2016-17 Actual	4.39%	4.35%	4.60%	4.94%	4.61%	4.74%	5.01%	5.34%	5.20%	5.50%	5.07%	4.58%
2017-18 Actual	4.36%	4.52%	4.59%	4.83%	4.98%	4.86%	5.07%	5.30%	5.69%			

Position	Rate	Av. WTE Lost per Calendar Day	Av. Calendar Days Lost per WTE	Actual Direct Cost
Start – Mar-17	4.87%	613	18	£18.1m
Current – Dec-17	4.94%	627	18	£18.7m
Progress achieved to date	0.07%	+14	0	+£0.6m
Target – Mar-18	4.20%	528	15	£15.6m (projected)

Note:
The target lines are based on the 2016-17 sickness trend, reduced by the necessary reduction to deliver 4.2% sickness.

The Direct costs of sickness shown are the actual and target of the amount of salary paid to staff who are absent from work due to sickness. This takes no account of the replacement costs (Bank, overtime etc.)




5.60%
5.40%
5.20%
5.00%
4.80%
4.60%
4.40%
4.20%
Apr-10
Jul-10
Oct-10
Jan-11
Apr-11
Jul-11
Oct-11
Jan-12
Apr-12
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Jan-13
Apr-13
Jul-13
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Apr-14
Jul-14
Oct-14
Jan-15
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
Oct-16
Jan-17
Apr-17
Jul-17
Oct-17
12-Month Cumulative Sickness

3a. Sickness Hotspot Monitoring

		Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Capital, Estates & Facilities	Ward Based Teams UHL	10.13%	11.38%	7.82%	10.86%	9.27%	9.79%	5.90%	2.18%	1.73%	3.87%	7.41%	8.10%	8.39%
	Ward Based Teams UHW	7.51%	8.74%	8.13%	8.30%	7.36%	7.62%	8.34%	9.62%	9.58%	8.86%	8.77%	9.03%	11.11%
Children & Women's	C1	4.52%	8.95%	6.24%	6.00%	4.96%	1.08%	8.02%	13.62%	7.26%	7.63%	11.71%	9.14%	8.33%
	CCNS (Childrens Community Nursing Service)	8.91%	6.70%	11.73%	14.19%	9.63%	9.52%	9.50%	9.65%	10.04%	12.10%	10.67%	8.39%	11.61%
	Child Health Occupational Therapy	11.03%	8.82%	11.11%	8.19%	6.12%	3.03%	4.34%	4.08%	4.45%	6.60%	0.00%	0.83%	2.77%
	Health Visiting	6.13%	6.14%	4.92%	6.09%	7.72%	7.01%	4.97%	5.12%	3.90%	2.49%	3.37%	6.83%	8.24%
	Paediatric ICU/HDU	6.31%	7.10%	7.19%	10.13%	6.62%	7.63%	6.69%	3.57%	8.23%	6.18%	6.75%	9.30%	9.38%
CD&T	Patient Administration UHL	7.21%	7.22%	4.97%	3.82%	6.56%	8.17%	7.22%	7.30%	10.77%	9.76%	12.49%	10.42%	7.42%
	Phlebotomy Service	13.74%	10.01%	5.84%	5.24%	3.54%	1.95%	3.46%	5.35%	8.35%	10.00%	12.12%	8.27%	7.87%
Medicine	A1 Short Stay	5.70%	5.57%	5.45%	7.89%	7.41%	8.89%	9.47%	12.34%	9.98%	6.20%	4.86%	3.63%	4.90%
	A6 Stroke Unit	8.78%	10.95%	7.91%	10.40%	10.08%	13.22%	11.04%	8.75%	5.22%	7.07%	10.32%	8.86%	7.43%
	C7 Medical	5.71%	7.52%	6.45%	8.19%	6.54%	4.63%	3.28%	7.94%	7.41%	3.90%	5.63%	4.03%	6.71%
	East 4	2.55%	1.99%	2.86%	1.33%	3.06%	3.56%	4.06%	8.94%	9.74%	10.69%	8.80%	9.38%	6.71%
	East 6	2.14%	6.02%	6.40%	9.66%	10.95%	9.48%	12.32%	8.86%	8.21%	6.26%	12.05%	11.56%	8.53%
	East 7	14.15%	8.72%	6.07%	5.38%	6.80%	3.59%	7.67%	10.70%	10.39%	5.65%	6.42%	7.72%	6.56%
	East 8	8.54%	13.39%	12.63%	12.48%	8.65%	5.26%	1.92%	7.51%	7.89%	13.44%	6.12%	5.86%	9.47%
	Respiratory Unit UHW (B7)	9.96%	12.36%	11.10%	5.67%	4.96%	6.05%	7.28%	7.21%	9.29%	6.81%	3.47%	6.81%	6.14%
	Stroke Rehabilitation Centre	15.29%	18.42%	8.88%	2.50%	7.82%	8.91%	7.77%	8.29%	11.78%	10.16%	11.83%	17.03%	19.31%
	Ward A4 - Medicine	2.80%	6.06%	9.19%	6.17%	8.80%	9.33%	12.45%	11.65%	9.29%	6.56%	6.57%	4.01%	3.80%
	West 2	8.66%	11.21%	11.60%	6.94%	5.93%	7.96%	8.48%	10.46%	11.15%	10.31%	6.86%	7.55%	8.17%
Mental Health	Alder Ward	17.77%	17.63%	9.11%	7.58%	16.86%	15.44%	22.12%	21.26%	18.84%	12.69%	20.01%	21.47%	20.26%
	Cedar Ward	8.21%	10.26%	9.94%	7.41%	10.85%	10.28%	9.81%	11.42%	9.38%	11.17%	10.39%	8.53%	4.20%
	Daffodil Ward	7.21%	8.62%	9.08%	8.59%	12.59%	16.02%	20.44%	12.22%	11.20%	11.49%	9.42%	8.89%	12.02%
	Hazel Ward	14.32%	5.97%	6.61%	6.52%	5.86%	1.61%	7.26%	9.87%	4.39%	1.27%	7.20%	9.35%	9.53%
	East 12 (formerly Whit W1)	16.90%	17.98%	10.21%	5.89%	5.90%	2.54%	4.35%	7.81%	14.08%	11.90%	11.18%	13.84%	7.65%
	East 14	13.72%	16.84%	9.66%	9.52%	10.62%	17.40%	17.41%	17.01%	18.29%	20.51%	20.08%	17.16%	18.23%
	East 16	4.94%	7.08%	7.70%	11.45%	6.50%	8.68%	10.52%	15.34%	8.02%	8.96%	8.15%	8.81%	10.33%
	East 18 (formerlyHamadryad Ward)	15.30%	11.96%	11.65%	14.34%	12.56%	10.93%	9.51%	7.42%	1.27%	3.85%	7.94%	17.02%	20.91%
	Meadow Ward	13.88%	12.26%	15.80%	13.99%	13.52%	11.51%	5.14%	8.14%	7.33%	11.36%	7.55%	9.68%	8.57%
	Pine Ward	3.53%	5.79%	16.14%	11.95%	11.80%	12.14%	9.29%	3.24%	3.99%	8.69%	3.25%	6.16%	9.28%
PCIC	Continence	0.00%	8.12%	23.32%	23.32%	23.32%	11.47%	9.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Llanrumney District Nursing Team	16.85%	16.07%	21.51%	18.57%	10.00%	8.09%	6.70%	10.24%	2.52%	5.52%	1.13%	0.64%	0.11%
	Nurse Assessor Team						0.00%	6.83%	33.00%	15.95%	9.87%	14.11%	18.77%	29.34%
	Palliative Care Nurses	9.24%	9.37%	8.47%	15.04%	16.95%	14.37%	16.08%	15.63%	24.27%	9.14%	6.16%	5.96%	0.54%
	Penarth District Nursing Team	12.24%	17.76%	8.13%	6.15%	0.00%	4.16%	1.20%	2.45%	10.66%	6.90%	9.42%	16.00%	13.73%
	Riverside District Nursing Team	15.41%	13.02%	5.76%	8.36%	14.02%	14.85%	11.63%	14.99%	17.52%	10.74%	9.64%	12.57%	11.42%
Specialist Services	Adult Cardiac ITU	4.56%	5.30%	6.12%	5.86%	5.41%	4.27%	3.85%	6.24%	5.73%	5.99%	5.50%	5.84%	6.07%
	B5 Nephrology and Tx	5.95%	6.70%	5.54%	3.94%	4.48%	5.88%	5.80%	6.22%	3.79%	3.01%	2.63%	3.56%	5.68%
	Critical Care Adult UHW	7.50%	7.68%	5.59%	5.30%	5.22%	6.46%	5.83%	4.51%	4.20%	5.33%	5.82%	6.15%	6.35%
	Neurosurgery	14.35%	11.32%	8.29%	7.94%	13.22%	9.00%	8.17%	7.84%	8.69%	8.93%	4.57%	5.29%	10.65%
	T4, Neurosciences UHW	4.31%	4.88%	5.91%	5.15%	4.80%	4.79%	3.71%	4.55%	6.18%	7.14%	8.25%	11.31%	9.03%
Surgical Services	SSSU Recovery & Anaesthetics	0.65%	3.88%	9.75%	7.66%	11.90%	13.92%	5.77%	6.95%	10.36%	13.04%	7.98%	5.92%	2.91%
	SSSU Theatres	7.23%	6.10%	5.49%	8.62%	8.05%	8.38%	9.91%	8.22%	6.68%	8.53%	8.65%	10.90%	9.77%

Source: ESR Self-Service

< last month & < last year
< last month or < last year
> last month & > last year

4. Combined PADR and Medical Appraisal Rate (12- Month Cumulative)

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
PCIC	842	62.41%	61.04%	60.61%	62.90%	73.27%	71.07%	73.98%	73.97%		73.85%	78.16%	80.95%	77.91%
Dental	454	64.53%	65.85%	70.26%	67.68%	81.01%	69.69%	66.60%	70.11%		50.00%	55.11%	66.96%	68.94%
Specialist Services	1696	62.40%	60.95%	63.55%	62.47%	68.16%	64.23%	64.54%	66.49%		61.01%	61.45%	68.43%	66.21%
Children & Women	1917	53.18%	54.30%	54.76%	59.17%	63.97%	60.92%	60.30%	59.31%		51.44%	54.90%	64.43%	64.32%
CDT	2278	65.45%	65.45%	67.39%	66.92%	71.71%	69.15%	69.04%	68.65%		65.77%	64.97%	65.64%	63.96%
Medicine	1712	49.26%	50.51%	51.29%	49.90%	54.60%	52.87%	53.83%	54.78%		49.37%	47.76%	58.39%	58.94%
Corporate	796	61.01%	59.12%	60.20%	57.09%	64.15%	60.35%	59.78%	58.00%		55.31%	56.48%	57.29%	57.41%
Surgical Services	1823	45.27%	45.46%	44.25%	45.30%	49.24%	47.08%	46.51%	49.63%		49.70%	49.15%	57.83%	55.68%
Mental Health	1329	51.49%	51.20%	54.13%	52.35%	56.40%	52.10%	50.47%	51.81%		48.07%	50.15%	52.27%	49.21%
Capital, Estates & Facilities	1232	63.29%	62.97%	63.06%	58.69%	59.68%	42.68%	29.98%	22.94%		22.82%	24.63%	30.36%	46.75%
uHB	**14079**	**56.95%**	**56.90%**	**58.00%**	**57.65%**	**62.81%**	**58.34%**	**57.12%**	**57.18%**		**53.15%**	**54.12%**	**60.03%**	**60.32%**

Under 75%
75% - 85%
Over 85%

Note:

There is no combined PADR and medical appraisal rate for August, due to complications with an upgrade to the Medical Appraisal Recording System (MARS).

4a. Medical Appraisal Rate

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Corporate	1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%
PCIC	10	70.00%	63.64%	60.00%	63.64%	63.64%	72.73%	90.91%	100.00%		100.00%	100.00%	100.00%	100.00%
CDT	72	91.30%	92.86%	94.29%	87.32%	88.73%	92.75%	94.03%	92.65%		87.14%	88.73%	88.89%	88.89%
Children & Women	120	61.84%	63.95%	64.86%	59.46%	61.07%	62.42%	83.33%	89.47%		79.31%	79.66%	83.48%	82.50%
Surgical Services	223	80.62%	79.30%	79.04%	75.44%	81.50%	81.82%	81.90%	83.19%		80.44%	79.65%	81.61%	81.17%
Mental Health	61	77.78%	77.78%	80.95%	79.69%	81.25%	80.30%	81.82%	78.13%		73.77%	73.02%	73.77%	73.77%
Specialist Services	161	70.59%	71.52%	73.83%	71.81%	72.19%	74.83%	73.86%	75.66%		70.51%	70.70%	73.46%	73.29%
Dental	49	60.42%	64.58%	68.75%	64.58%	73.91%	76.09%	67.35%	72.92%		72.92%	72.92%	72.92%	71.43%
Medicine	151	73.43%	68.49%	68.00%	61.29%	63.87%	66.88%	70.13%	73.03%		67.74%	66.46%	69.43%	70.20%
Capital, Estates & Facilities														
uHB	**848**	**73.85%**	**73.53%**	**74.39%**	**70.17%**	**73.26%**	**75.06%**	**78.75%**	**80.86%**		**76.01%**	**75.70%**	**77.86%**	**77.71%**

Under 75%
75% - 85%
Over 85%

4a i. Consultant Medical Appraisal Rate

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Corporate	1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%
PCIC	6	85.71%	85.71%	83.33%	71.43%	71.43%	71.43%	85.71%	100.00%		100.00%	100.00%	100.00%	100.00%
CDT	72	91.30%	92.75%	94.29%	87.32%	88.73%	92.75%	94.03%	92.65%		87.14%	88.73%	88.89%	88.89%
Surgical Services	190	86.67%	85.20%	85.49%	82.20%	88.89%	90.53%	90.05%	89.06%		87.56%	86.53%	88.48%	87.89%
Children & Women	85	76.04%	76.04%	78.13%	74.19%	78.26%	80.22%	85.88%	90.59%		82.35%	83.53%	86.75%	87.88%
Mental Health	33	83.78%	83.33%	86.11%	86.11%	88.89%	91.67%	91.67%	86.84%		85.71%	88.57%	87.88%	87.88%
Medicine	97	84.78%	80.65%	80.85%	75.53%	77.08%	78.35%	80.61%	83.51%		82.47%	82.47%	87.63%	86.60%
Specialist Services	114	79.46%	78.38%	80.91%	80.73%	81.65%	82.73%	82.73%	82.73%		81.43%	82.30%	84.35%	84.21%
Dental	39	65.00%	68.29%	73.17%	68.29%	78.95%	81.58%	75.00%	80.00%		80.00%	80.00%	80.00%	82.05%
Capital, Estates & Facilities														
uHB	**637**	**82.59%**	**81.69%**	**83.13%**	**79.63%**	**83.57%**	**85.45%**	**86.30%**	**87.13%**		**84.53%**	**84.87%**	**86.99%**	**86.81%**

Under 75%
75% - 85%
Over 85%

4a ii. SAS Medical Appraisal Rate

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
PCIC	3	50.00%	33.33%	33.33%	76.67%	66.67%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%
Surgical Services	5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%
Children & Women	17	72.82%	72.82%	77.78%	70.59%	70.59%	72.22%	88.24%	94.12%		88.24%	88.24%	88.24%	88.24%
Medicine	17	80.00%	75.00%	75.00%	68.42%	76.47%	82.35%	82.35%	82.35%		82.35%	82.35%	82.35%	82.35%
Mental Health	20	73.91%	78.26%	82.61%	82.61%	82.61%	75.00%	79.17%	71.43%		70.00%	70.00%	75.00%	70.00%
Specialist Services	12	63.64%	81.82%	81.82%	72.73%	72.73%	72.73%	63.64%	72.73%		63.64%	63.64%	66.67%	66.67%
Dental	10	37.50%	42.86%	42.86%	42.86%	50.00%	50.00%	33.33%	37.50%		37.50%	37.50%	37.50%	30.00%
CDT		100.00%	100.00%											
Capital, Estates & Facilities														
Corporate														
uHB	**84**	**71.59%**	**73.86%**	**75.86%**	**72.94%**	**75.00%**	**75.58%**	**76.74%**	**78.05%**		**75.31%**	**75.31%**	**76.83%**	**73.81%**

Under 75%
75% - 85%
Over 85%

4a iii. Clinical Fellow Medical Appraisal Rate

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Children & Women	12	18.18%	15.79%	15.79%	15.00%	20.00%	19.23%	50.00%	62.50%		55.56%	66.67%	77.78%	66.67%
Specialist Services	32	42.31%	44.00%	45.83%	40.00%	40.74%	46.15%	46.43%	51.85%		36.67%	36.67%	40.63%	40.63%
Medicine	24	47.62%	45.00%	45.45%	50.00%	50.00%	52.38%	54.55%	52.38%		30.43%	28.00%	24.00%	25.00%
Surgical Services	24	33.33%	30.43%	32.14%	28.57%	33.33%	32.26%	35.48%	46.67%		20.83%	24.00%	25.00%	25.00%
Capital, Estates & Facilities														
CDT														
Corporate														
Dental														
Mental Health														
PCIC														
uHB	**92**	**36.08%**	**35.23%**	**35.48%**	**33.68%**	**35.58%**	**36.54%**	**44.94%**	**51.16%**		**32.56%**	**33.71%**	**35.56%**	**35.87%**

Under 75%
75% - 85%
Over 85%

4a iv. Other Medical Appraisal Rate

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
PCIC	1	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%
Surgical Services	4		33.33%	66.67%	50.00%	66.67%	40.00%	40.00%	60.00%		66.67%	66.67%	66.67%	75.00%
Specialist Services	3	25.00%	25.00%	25.00%	25.00%	25.00%	50.00%	50.00%	50.00%		0.00%	0.00%	33.33%	33.37%
Children & Women	6	25.00%	35.71%	26.67%	22.22%	13.33%	14.29%	75.00%	100.00%		40.00%	28.57%	33.33%	33.33%
Mental Health	8	33.33%	25.00%	25.00%	20.00%	20.00%	33.33%	33.33%	40.00%		16.67%	12.50%	12.50%	25.00%
Medicine	13	10.00%	7.69%	7.14%	0.00%	5.00%	10.53%	17.65%	29.41%		22.22%	21.05%	22.22%	15.38%
Capital, Estates & Facilities														
CDT														
Corporate														
Dental														
uHB	**35**	**20.59%**	**23.08%**	**21.95%**	**15.38%**	**14.58%**	**20.41%**	**35.14%**	**47.22%**		**28.57%**	**24.39%**	**28.21%**	**31.43%**

Under 75%
75% - 85%
Over 85%

4b. Non-Medical PADR Rate

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17		
PCIC	832	69.67%	69.30%	67.97%	70.59%	73.70%	71.00%	73.22%	72.89%	72.92%	73.54%	77.90%	80.72%	77.64%	Under 75%	671.5648949
Dental	405	77.57%	76.87%	77.41%	78.60%	82.63%	68.24%	66.43%	69.45%	68.10%	47.80%	53.40%	66.25%	68.64%	75% - 85%	268.3125
Specialist Services	1535	65.06%	64.61%	63.98%	65.35%	67.87%	63.47%	63.87%	65.83%	66.71%	60.14%	60.60%	67.88%	65.47%	Over 85%	1042.014875
CDT	2206	68.10%	67.65%	67.73%	69.40%	71.23%	68.49%	68.35%	68.01%	67.74%	65.09%	64.21%	64.86%	63.15%		1430.918919
Children & Women	1797	58.10%	57.01%	56.62%	62.87%	64.14%	60.83%	58.94%	57.55%	57.13%	49.77%	53.38%	63.15%	63.11%		1134.781924
Medicine	1561	55.09%	52.77%	52.03%	52.95%	53.99%	51.91%	52.72%	53.52%	53.25%	47.67%	46.01%	57.24%	57.85%		893.4876584
Corporate	795	65.57%	64.41%	63.32%	63.09%	64.06%	60.25%	59.68%	57.97%	59.50%	55.26%	56.43%	57.24%	57.36%		455.0193798
Surgical Services	1600	44.81%	42.50%	41.22%	44.44%	45.38%	42.95%	42.26%	45.59%	49.44%	45.87%	45.39%	54.43%	52.13%		870.860077
Mental Health	1268	54.30%	55.15%	55.59%	55.33%	55.22%	50.75%	49.02%	50.63%	49.22%	46.88%	49.04%	51.19%	48.03%		649.1325103
Capital, Estates & Facilities	1232	65.20%	64.22%	62.90%	60.13%	59.68%	42.68%	29.98%	22.94%	21.20%	22.82%	24.63%	30.36%	46.75%		373.9818031
uHB	**13231**	**60.68%**	**59.71%**	**59.16%**	**63.09%**	**62.19%**	**57.37%**	**55.86%**	**55.82%**	**56.04%**	**51.77%**	**52.80%**	**58.85%**	**59.21%**		7786.284364

5. Statutory and Mandatory Training Rate (12- Month Cumulative)

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Dental	543	82.94%		85.04%				71.61%	73.16%	74.67%	80.81%	85.34%	87.59%	87.92%
CDT	2340	80.71%		79.34%				73.42%	75.65%	77.57%	78.91%	79.80%	80.33%	80.10%
Corporate	804	70.11%		71.12%				67.11%	68.72%	71.04%	72.00%	75.06%	78.00%	78.51%
PCIC	884	67.41%		66.40%				61.23%	61.48%	63.37%	65.89%	69.20%	71.52%	72.24%
Children & Women	2078	66.84%		67.12%				60.56%	61.95%	64.55%	64.92%	66.32%	70.53%	71.65%
Specialist Services	1819	67.11%		66.50%				59.22%	60.07%	61.54%	60.99%	62.72%	64.96%	65.56%
Mental Health	1371	65.09%		58.62%				56.95%	58.24%	59.53%	61.02%	61.32%	63.14%	64.06%
Capital, Estates & Facilities	1233	59.31%		58.51%				52.24%	54.64%	55.72%	57.17%	58.31%	60.15%	63.58%
Medicine	1834	59.70%		56.66%				49.74%	49.43%	50.98%	52.76%	55.85%	60.93%	62.65%
Surgical Services	1979	59.04%		60.53%				49.25%	50.52%	52.27%	53.02%	55.04%	57.32%	59.49%
uHB	**14885**	67.23%		66.18%				59.30%	60.56%	62.36%	63.55%	65.43%	68.00%	69.14%

Under 75%
75% - 85%
Over 85%

Statutory and Mandatory Training Rate (12- Month Cumulative) by Topic

	Headcount	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Equality	14885	75.99%		77.07%				68.63%	69.33%	70.46%	70.93%	72.01%	74.01%	75.26%
Fire	14885	56.94%		52.60%				48.85%	50.87%	52.99%	54.16%	57.47%	60.63%	61.57%
Health & Safety	14885	78.94%		78.86%				69.52%	70.53%	72.31%	73.35%	74.64%	76.75%	78.01%
Information Governance	14885	63.78%		63.87%				57.59%	59.77%	62.94%	64.60%	67.08%	69.77%	70.54%
IPC	14885	79.48%		79.39%				71.11%	71.64%	73.39%	74.14%	75.17%	76.97%	78.17%
Manual Handling	14885	64.93%		61.71%				61.82%	62.36%	62.95%	63.55%	64.77%	66.76%	67.63%
Resuscitation	14885	49.05%		51.52%				28.54%	30.13%	32.47%	35.58%	40.28%	44.46%	45.46%
Safeguarding Adults	14885	63.05%		52.02%				61.68%	63.37%	65.20%	66.23%	67.20%	69.61%	71.11%
Safeguarding Children	14885	64.76%		65.95%				62.66%	63.84%	65.37%	66.34%	67.57%	70.48%	71.70%
Violence & Aggression	14885	75.34%		78.83%				62.64%	63.75%	65.49%	66.62%	68.11%	70.56%	71.97%

Under 75%
75% - 85%
Over 85%

Between March and June 2017 learning compliance data has been migrated from the Learning@NHS Wales system into ESR, as a part of the transition to the use of ESR as the recording database for learning compliance. Staff compliance is now directly recorded in ESR as soon as statutory or mandatory e-learning is undertaken. Whilst the migration of data has been completed there remains a need for managers and staff to validate the records for accuracy.

All staff (i.e. inclusive of junior medical staff in training) are expected to achieve and maintain compliance. Staff are being measured individually against 13 subjects (Dementia Awareness, Mental Capacity Act and Violence Against Women, Domestic Abuse and Sexual Violence have been added to the list of topics) but the Health Board compliance won't be extended to incorporate the longer list until April 2018.

6. Pay Bill Over/Underspend (Year-to-Date from April)

	Budget	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	April-17 to Date (£)
PCIC	£30,170,291	-2.83%	-3.75%	-3.59%	-2.76%	-4.34%	-3.56%	-3.24%	-2.75%	-3.07%	-3.13%	-2.99%	-2.85%	-2.57%	-£597,546
Surgical Services	£91,912,583	0.71%	0.35%	0.20%	0.02%	-0.98%	-1.14%	-1.56%	-1.64%	-1.38%	-1.47%	-1.42%	-1.36%	-1.56%	-£1,096,915
Specialist Services	£82,278,050	-0.63%	-0.62%	-0.77%	-1.09%	-0.84%	-1.40%	-1.49%	-1.25%	-0.90%	-0.83%	-0.93%	-0.85%	-0.97%	-£598,138
Corporate	£31,726,141	-0.67%	-1.67%	-1.99%	-3.22%	-1.25%	-1.28%	-0.63%	-3.36%	-0.42%	-1.07%	-0.97%	-0.90%	-0.95%	-£228,200
Mental Health	£51,526,846	-0.80%	-0.88%	-0.92%	-1.41%	-0.74%	-0.93%	-0.58%	-0.77%	-0.64%	-0.60%	-0.51%	-0.69%	-0.81%	-£308,687
CDT	£81,085,751	-0.25%	-0.34%	-0.24%	-0.34%	-0.01%	-0.12%	-0.16%	-0.13%	-0.40%	-0.66%	-0.73%	-0.71%	-0.44%	-£272,448
Capital, Estates & Facilities	£28,952,918	-1.14%	-0.93%	-0.93%	-1.23%	-4.66%	-3.26%	-1.39%	-0.29%	0.28%	0.27%	-0.08%	-0.22%	-0.26%	-£56,105
Dental	£17,038,173	0.36%	0.49%	0.67%	0.77%	-0.37%	-0.23%	0.21%	0.32%	0.12%	-0.15%	0.09%	0.04%	0.08%	£10,213
Children & Women	£75,693,632	2.58%	2.50%	2.41%	2.39%	-0.65%	-0.36%	-0.29%	-0.31%	-0.13%	-0.06%	0.15%	0.40%	0.55%	£322,738
Medicine	£77,386,399	2.57%	2.59%	2.45%	2.72%	2.69%	2.19%	2.14%	2.18%	2.12%	2.15%	2.04%	2.14%	1.97%	£1,190,415
uHB	**£577,519,906**	**0.42%**	**0.25%**	**0.16%**	**0.24%**	**-0.50%**	**-0.60%**	**-0.51%**	**-0.55%**	**-0.30%**	**-0.41%**	**-0.40%**	**-0.34%**	**-0.35%**	-£1,553,329

Over Budget
Under Budget

Note:
The pay budget for December 2017 was £49,214,487 and the pay bill was £49,148,085. This represents an underspend of £66,403. For the financial year 2017-18 the 12-month pay budget is £577,519,906.

7. Variable Pay Rate (Year-to-Date from April)

	Budget	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Dental	£17,038,173	1.19%	1.15%	1.27%	1.30%	1.98%	1.82%	2.00%	2.17%	2.51%	2.46%	2.45%	2.51%	2.47%
Corporate	£31,726,141	2.47%	2.46%	2.45%	2.61%	1.95%	2.37%	2.39%	2.15%	2.38%	2.74%	2.69%	2.67%	2.60%
PCIC	£30,170,291	5.64%	5.46%	5.48%	6.78%	2.85%	3.74%	4.28%	4.34%	4.65%	4.40%	4.21%	3.65%	3.75%
CDT	£81,085,751	5.01%	5.01%	5.08%	5.25%	4.21%	4.66%	4.84%	4.79%	4.72%	4.65%	4.55%	4.54%	4.51%
Children & Women	£75,693,632	5.71%	5.57%	5.47%	5.50%	4.13%	4.49%	4.60%	4.44%	4.39%	4.59%	4.63%	4.73%	4.69%
Capital, Estates & Facilities	£28,952,918	5.94%	5.89%	5.89%	6.11%	6.85%	5.48%	5.88%	5.54%	5.75%	5.57%	5.40%	5.27%	5.10%
Specialist Services	£82,278,050	7.39%	7.38%	7.42%	7.53%	5.87%	7.28%	7.30%	7.40%	7.52%	7.58%	7.47%	7.53%	7.46%
Surgical Services	£91,912,583	8.65%	8.57%	8.59%	8.72%	8.91%	8.89%	8.79%	8.87%	8.96%	9.01%	8.99%	8.99%	8.87%
Mental Health	£51,526,846	8.28%	8.34%	8.33%	8.43%	10.11%	9.86%	9.64%	9.50%	9.57%	9.78%	10.10%	10.16%	10.16%
Medicine	£77,386,399	15.48%	15.75%	15.96%	16.41%	17.45%	16.83%	15.51%	15.85%	16.01%	15.93%	15.85%	16.13%	16.05%
uHB	**£577,519,906**	**7.76%**	**7.76%**	**7.80%**	**8.08%**	**7.61%**	**7.79%**	**7.65%**	**7.67%**	**7.76%**	**7.78%**	**7.75%**	**7.72%**	**7.66%**

No Target

Note:
The matrix above shows variable pay represented as a percentage of total pay bill. The percentage of spend on variable pay has fallen slightly since December 2016. The proportion of the paybill attributable to bank and agency for December 2017 (4.74%) is 0.17% higher than for December 2016.

Medicine: A review of the Agency accrual was undertaken prior to month 8 reporting and this created cumulative adjustments for all Clinical Boards. Medicine, due to the use of agency, reported a significant element of the impact.
The drivers within nursing for the use of temporary spend continue to be vacancies, sickness and specialling. Qualified vacancies remain in the region of 60wte, in month 9 sickness across the ward areas increased by 1%; 8% average across wards and there was also increased cover for maternity leave with just short of 30wte nursing staff on maternity leave.
Extra sessions increased in month which are directly related to funded elements of the winter plan to support AU and medical outliers. Locum and staff flow costs reduced in month reflecting a number of realities which included the ability to book cover for shifts but also within IM a reduced need to cover variable pressures such as sickness and maternity.
Waiting list initiative usage continues to be directly related to the RTT plan.

Mental Health: The cumulative variable pay expenditure is mainly driven by nursing bank and agency expenditure. The ongoing usage reasons are due to the need to cover nursing vacancies, sickness and continued high acuity levels which has resulted in a greater requirement of specialing and close observations. The variable expenditure on HCSWs is higher than the other staff groups as they cover the majority of the requirements of the specialing and close observations of patients with Mental Health needs. The HCSW Agency switch off at the end of October has had a positive financial impact within November & December reporting. Within December the qualified nursing agency is higher than average of previous months, the reason for this is probably due to high sickness levels and vacancies. The medical variable pay is made up of both locums and Staff flow and is due to the requirement to fill/backfill vacancies, largely within the Community Mental Health Teams. The medical variable pay has reduced considerably within November & December due to the Clinical Board putting internal cover arrangements in place.

Surgical Services: As reported in earlier months of 2017-18, the variable pay in M9 continues to be driven primarily by Agency, Bank and overtime usage. The mix of which is fluctuating between months, however this is variable due to both demand and supply of the sources of cover to support vacancies, sickness, specialing of patients etc and the need to support additional capacity and supernumerary nurses. At month 9, these three types of pay are attributable for 51% of the total cumulative variable pay expenditure.
In addition expenditure on Locums, staff flow, WLI and extra sessions is being driven by the ongoing need to cover vacant junior medical posts, sickness and the usage of WLI's to support RTT. At Month 9, these four types of pay are attributable for 46% of the total cumulative variable pay expenditure – with on-call accounting for the remaining 3%.

8. Time to Hire (Time to hire from vacancy authorisation to actual or booked start date - Trac T15)

	Vacancy Rate	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Capital, Estates & Facilities	7.80%	85	84	66	72	91	81	65	122	98	74	93	0
Children & Women	2.16%	95	93	78	76	88	87	115	112	116	94	81	0
Dental	0.88%	82	86	67	66	80	51	77	61	125	64	64	0
Medicine	6.86%	89	82	104	91	95	100	90	90	122	89	89	0
Mental Health	5.70%	87	85	100	88	110	89	100	88	92	87	85	0
Surgical Services	7.22%	88	96	74	96	73	93	135	108	81	90	73	0
CDT	3.91%	83	80	77	82	81	89	95	124	90	78	73	51
PCIC	5.97%	84	78	48	80	72	69	90	80	83	72	75	51
Corporate	9.04%	71	62	87	58	69	56	68	87	93	94	113	52
Specialist Services	1.83%	91	94	92	100	75	82	87	98	117	112	71	73
uHB	**5.08%**	**86**	**83**	**82**	**84**	**84**	**85**	**95**	**100**	**103**	**88**	**85**	**56**

Poorer performance than previous month
Better performance than previous month

8a. Time to Hire (From vacancy created to sending of conditional offer - Trac T16)

	Vacancy Rate	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Capital, Estates & Facilities	7.80%	44	46	51	42	23	40	129	43	47	50	54	0
Dental	0.88%	34	36	52	26	68	71	57	42	47	50	31	0
Mental Health	5.70%	55	54	72	75	53	51	61	49	41	61	75	0
Specialist Services	1.83%	50	50	58	46	58	59	59	63	54	61	49	0
Surgical Services	7.22%	57	52	54	48	60	66	45	54	57	51	53	0
PCIC	5.97%	36	50	43	55	50	59	43	44	54	52	48	20
Corporate	9.04%	71	44	45	38	37	32	51	38	57	74	24	41
CDT	3.91%	64	56	63	51	56	60	66	64	69	57	53	54
Medicine	6.86%	55	46	52	40	42	76	49	49	55	66	51	84
Children & Women	2.16%	56	45	63	59	68	71	72	68	66	66	55	91
uHB	**5.08%**	**57**	**49**	**56**	**49**	**52**	**55**	**57**	**55**	**56**	**62**	**46**	**53**

Over 44 Working Days
44 Days or Under (NWSSP Target)

8b. Approval to Advertise (From authorisation start to final approval - Trac T1b)

	Vacancy Rate	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Capital, Estates & Facilities	7.80%	17	23	12	18		19	15	17	14	13	19	0
Children & Women	2.16%	22	13	14	30	24	31	39	29	25	26	23	0
Dental	0.88%	9	10	11	3	11	20	15	25	12	26	10	0
Medicine	6.86%	17	11	8	42	24	24	18	19	12	6	20	0
Mental Health	5.70%	23	27	20	16	29	26	26	24	16	23	17	0
PCIC	5.97%	16	10	8	39	9	10	11	10	14	12	9	0
Specialist Services	1.83%	20	16	13	15	19	26	19	15	21	17	21	0
Surgical Services	7.22%	17	14	11	46	30	13	28	15	16	15	10	0
Corporate	9.04%	23	22	9	16	13	18	15	21	18	19	13	2
CDT	3.91%	21	13	10	21	30	15	33	25	28	21	14	21
uHB	**5.08%**	**19**	**14**	**11**	**26**	**23**	**20**	**24**	**20**	**19**	**19**	**16**	**12**

Over 10 Working Days
10 Days or Under (NWSSP Target)

Source: Trac

Please note that for December the Clinical Boards shown with zero compliance rates represent not posts recorded for this period.

Time to hire from vacancy authorisation to booked (or actual) start date
This figure relates to the period from the date when the vacancy is authorised by NWSSP Recruitment or the UHB Medical Workforce Department to the booked or actual start date.
It should be noted that the recruitment of Student Nurses/Midwives skews the figures as the applicants are frequently recruited months before they actually qualify and are able to commence employment. This figure includes the notice given by any applicant who is currently employed.
Local targets have not been set, so the RAG-rating simply identifies improvements or deteriorations in performance.

From vacancy requested by manager to sending of conditional offer
This figure relates to the period from the date when the vacancy is created on the Trac system by the Recruiting Manager through to the date when NWSSP Recruitment or the UHB Medical Workforce Department are advised of the outcome of the recruitment process and issue a conditional job offer. This then initiates the pre-employment check process.
It should be noted that this includes both the vacancy authorisation, short listing and interview stages. In August 2017, on average the internal vacancy authorisation stage took 19.6 working days and the UHB managers took an average of 9.6 working days to short list candidates for interview.
The targets used are as set by NWSSP Recruitment.

9. Job Plans Compliance - % Consultants and SAS Doctors with Reviewed Job Plans

	Headcount	% With No Recorded Plan	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Dental	56	7.14%	1.75%	1.72%	1.72%	1.28%	1.72%	1.72%	30.51%	39.66%	38.60%	42.11%	73.68%	73.68%	76.79%
PCIC	10	0.00%	2.94%	2.94%	5.88%	66.67%	66.67%	90.91%	100.00%	100.00%	90.91%	70.00%	70.00%	70.00%	70.00%
Children & Women	107	2.80%	24.30%	23.36%	24.07%	37.07%	39.05%	42.45%	61.32%	67.92%	60.75%	62.96%	66.67%	66.04%	61.68%
Medicine	107	5.61%	15.84%	16.67%	13.86%	13.51%	14.71%	15.24%	15.24%	15.24%	28.85%	31.43%	43.40%	43.40%	41.12%
Mental Health	47	4.26%	14.55%	12.96%	12.96%	45.90%	58.18%	61.11%	63.64%	58.49%	58.82%	55.10%	52.08%	43.75%	40.43%
Specialist Services	112	1.79%	20.18%	18.69%	21.50%	22.95%	24.53%	26.17%	28.30%	42.06%	42.06%	38.53%	40.54%	38.39%	33.04%
CDT	63	0.00%	45.16%	41.94%	43.55%	38.57%	67.74%	66.13%	66.10%	36.21%	35.09%	33.33%	33.33%	31.75%	31.75%
Surgical Services	190	1.58%	8.33%	8.29%	10.42%	9.00%	9.47%	10.53%	11.05%	10.47%	9.42%	8.95%	10.05%	11.64%	24.74%
Capital, Estates & Facilities															
Corporate															
uHB	**692**	**2.89%**	**16.41%**	**15.72%**	**16.74%**	**21.99%**	**26.70%**	**27.99%**	**33.91%**	**34.54%**	**35.04%**	**34.59%**	**40.03%**	**39.22%**	**40.90%**

Under 75%
75% - 85%
Over 85%

Source - ESR

Note:

'Headcount' above shows the number of consultant and SAS doctors (both uHB contracted and honorary) by Clinical Board for the current reporting month. These are contractually required to have a job plan, which should be reviewed every 12 months. The '% with No Recorded Plan' shows the percentage (at the current month) of the Consultant and SAS doctors for whom no job plan has been recorded in ESR. The 12-month trend shows the percentage of consultant and SAS doctors for whom a record of the job plan having been signed off in the past 12 months has been recorded in ESR.

The mechanism for recording the review of job plans in ESR commenced during December 2016.

Job Plans Compliance - % Consultants with Reviewed Job Plans

	Headcount	% With No Recorded Plan	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
PCIC	6	0.00%	11.11%	11.11%	22.22%	77.78%	77.78%	100.00%	100.00%	100.00%	85.71%	100.00%	100.00%	100.00%	100.00%
Dental	21	0.00%	5.00%	5.00%	5.00%	2.44%	5.00%	5.00%	52.38%	76.19%	76.19%	80.95%	90.48%	90.48%	95.24%
Children & Women	88	3.41%	28.74%	27.59%	28.41%	43.75%	46.51%	50.57%	73.56%	76.74%	67.05%	69.66%	70.79%	70.11%	64.77%
Medicine	89	5.62%	18.52%	19.51%	16.05%	15.22%	16.67%	17.24%	17.05%	17.05%	33.33%	36.36%	50.56%	50.00%	47.19%
Mental Health	29	6.90%	16.13%	16.67%	16.67%	45.95%	61.29%	63.33%	63.33%	61.29%	58.06%	53.33%	53.33%	46.67%	41.38%
Specialist Services	100	1.00%	21.88%	20.21%	23.40%	24.32%	26.32%	28.13%	30.53%	45.83%	45.83%	41.84%	44.00%	43.00%	37.00%
CDT	63	0.00%	45.90%	42.62%	43.55%	38.57%	67.74%	66.13%	66.10%	36.21%	35.09%	33.33%	33.33%	31.75%	31.75%
Surgical Services	183	1.09%	8.65%	8.60%	10.81%	9.33%	9.84%	10.93%	11.48%	10.87%	9.78%	9.29%	10.44%	12.09%	25.14%
Capital, Estates & Facilities															
Corporate															
uHB	**579**	**2.25%**	**19.58%**	**18.91%**	**20.18%**	**23.57%**	**29.12%**	**30.42%**	**35.85%**	**36.32%**	**36.78%**	**36.68%**	**40.17%**	**39.69%**	**41.45%**

Job Plans Compliance - % SAS Doctors with Reviewed Job Plans

	Headcount	% With No Recorded Plan	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Dental	35	11.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.42%	18.92%	16.67%	19.44%	63.89%	63.89%	65.71%
Children & Women	19	0.00%	5.00%	5.00%	5.00%	5.00%	5.26%	5.26%	5.26%	30.00%	31.58%	31.58%	47.37%	47.37%	47.37%
Mental Health	18	0.00%	12.50%	8.33%	8.33%	45.83%	54.17%	58.33%	64.00%	54.55%	60.00%	57.89%	50.00%	38.89%	38.89%
PCIC	4	0.00%	0.00%	0.00%	0.00%	50.00%	50.00%	75.00%	100.00%	100.00%	100.00%	25.00%	25.00%	25.00%	25.00%
Surgical Services	7	14.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.29%	0.00%	14.29%
Medicine	18	5.56%	5.00%	5.00%	5.00%	5.26%	5.56%	5.56%	5.88%	5.88%	5.88%	5.88%	5.88%	11.11%	11.11%
Specialist Services	12	8.33%	7.69%	9.09%	7.69%	9.09%	9.09%	9.09%	9.09%	9.09%	9.09%	9.09%	9.09%	0.00%	8.33%
Capital, Estates & Facilities															
CDT															
Corporate															
uHB	**113**	**6.19%**	**4.08%**	**3.68%**	**3.40%**	**13.71%**	**15.45%**	**16.53%**	**24.79%**	**26.27%**	**26.32%**	**23.89%**	**39.29%**	**36.84%**	**38.05%**

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
Name of Meeting : Local Partnership Forum **Date of Meeting :** 8 February 2018

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

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

The Local Partnership Forum is asked to:

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

SITUATION

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from November to end December 2017.

BACKGROUND

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

The UHB has a wide range of data which provides a level of assurance on the safety, and quality of services as well as on the experience of patients and families. This report provides an analysis of information drawn from the reporting of patient safety incidents, Serious Incidents (SIs) and Never Events, as well as concerns raised by patients and families, and feedback from national and local patient surveys. Themes emerging from internal and external inspections of clinical areas also provide a very valuable level of assurance in relation to the quality and safety of clinical services.

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

ASSESSMENT

- There were 45 serious incidents reported during this period. This contrasts with 37 in the previous reporting period and is due to an increase in the reporting of Grade 3 and Grade 4 pressure damage, following an indication from Welsh Government that the UHB was a low reporter when compared with peers. All are currently under investigation.
- At the time of writing the UHB has 86 SIs open with WG in contrast to January 2017, when there were 169 incidents open. This represents a 49% reduction in a year which has been achieved through the introduction of monthly targets for Clinical Boards. These have helped in reducing their backlogs in closing historical SIs as well as ensuring that there is more timely investigation and closure of current incidents.
- The open number of SIs has increased from the last report to Board and this again is due to the increased reporting of Grade 3 and Grade 4 pressure damage. The Board should be advised of the likely increase in the average number of SIs being reported monthly as the UHB continues to address this reporting requirement during 2018.
- In the last report to Board there had been an upward trend in the reporting of patient safety incidents on both the University Hospital of Wales (UHW) and the University Hospital of Llandough sites over the last three months.

There were no particular emerging themes or trends. During this period the rate of reporting at UHW has reduced to below normal reporting rates and there has also been a reduction at University Hospital Llandough. There has been a 42% reduction in the number of reported patient safety incidents in the community hospitals and again this is a trend that we will continue to monitor.

- In the last report we commented on a noticeable increase in patient safety incident reporting at both Iorwerth Jones Centre and St David's Hospital over the previous three months. Services previously provided at the Iorwerth Jones Centre have now transferred to UHL. The average rate of reported incidents per month at Iorwerth Jones between January and October 2017 was 33 incidents per month. The rate is slightly lower following the transfer to UHL with 28 incidents reported per month on average. Incident reporting has reduced at St David's and more detail is provided below.
- There have been 2 Never Events reported during this period which is described in more detail below. The Board was advised in the previous report that there had been a Dental Never Event involving a wrong tooth extraction in early November. This was followed by another incident in which invasive treatment was carried out on the wrong tooth.
- In the last report to Board we it was evident that there was an increase in patient falls in October 2017. There was a similar increasing trend in falls seen over the winter months in 2016. The Board should be advised that there has since been a reduction in the level of falls during November and December 2017 although 7 falls were reportable to WG due to significant injuries being sustained by patients. It is also noted that the patients were all greater than 65 years of age. A whole range of measures is being put in place to prevent and manage patient falls and these are described in more detail below.
- Feedback from a range of patient experience is very positive with 83% of people (n =94,262) using the Happy or Not machines placed throughout the UHB, indicating a positive experience. The patient satisfaction scores from the National Surveys distributed across the UHB during November and December were 88% and 92% consecutively a slight decrease from scores of 94% in the previous reporting period.
- The latest overall Health Board performance in response to 30-day concerns is 53 % which compares with the previous report to Board, but remains a reduction in performance from previous reports during the year. The proportionate investigation of concerns in a timely manner remains a focus and there are robust performance targets in place for Clinical Boards which are subject to Executive scrutiny on a monthly basis. 62% of concerns however are now responded to informally and the overall informal response time is 70%.

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
November – December 2017

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

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

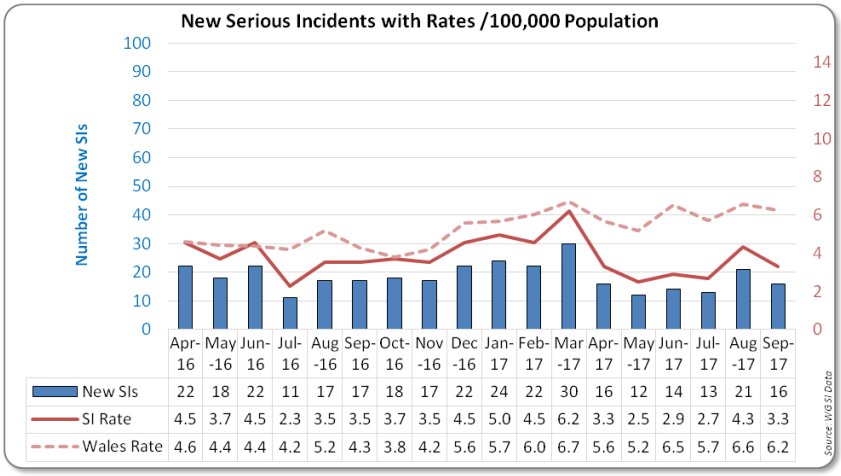
Serious Incidents		
Clinical Board	**Number**	**Description**
Children and Women	1 1	• Grade 3 or 4 healthcare acquired pressure damage. • Incident reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) process has been instigated. The child was well known to paediatric health services.
Dental	1 1	• A wrong tooth extraction incident has occurred which is being managed as a Never Event. • An incorrect tooth was prepared for root canal treatment. The error was realised and the tooth was repaired. This is being managed as a Never Event.
Executive Nurse	3	• Incidents reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) process has been instigated.
Medicine	8 5	• Grade 3 or 4 healthcare acquired pressure damage. • Falls where the patient sustained significant injury.
Mental Health	1 1 9 1	• Falls where the patient sustained significant injury. • Grade 3 or 4 healthcare acquired pressure damage. • Unexpected deaths of patients known to Mental Health services, including Addictions services. It is likely that HM Coroner will conclude that at least 4 of the deaths were suicides. Circumstances are not fully clear in all of the cases as yet.

		• Significant self-harm incident where the patient has survived.
Primary Care and Intermediate Care	1	• Grade 3 or 4 healthcare acquired pressure damage.
Specialist	4 1	• Grade 3 or 4 healthcare acquired pressure damage. • Falls where the patient sustained significant injury.
Surgery	4 1 1 1	• Grade 3 or 4 healthcare acquired pressure damage. • Apparent delay in following up a patient for further investigation where a possible colon cancer was identified on CT scan. • A patient with Rapid Advanced Macular Degeneration was not offered an appointment within anticipated timeframes due to clinic capacity issues and apparent patient unavailability. The patient's vision has significantly deteriorated. • A long-standing orthopaedic patient's care is under review as his death from multi-organ failure had not been anticipated.
Total	**45**	

No Surprises		
Clinical Board	**Number**	**Description**
Clinical Diagnostics and Therapeutics	1	• The UHB alerted Welsh Government ahead of the publication of a report by the Human Tissue Authority following an inspection of the mortuary.
Executive/ Miscellaneous	1	• The UHB was alerted to potential media interest relating to a family who have previously raised concerns regarding the care of their son.
Medicine	2	• An outbreak of diarrhoea and vomiting temporarily affected two wards.

How do we compare to our Peers?

As reported to the previous Board meeting, the graph below demonstrates the reporting rate of Serious Incidents to Welsh Government per 100,000 population. The information is provided to the UHB from WG on a 6-monthly basis so updated information is not available. The UHB continues to strive to achieve timely reporting of SIs; identification and reporting of healthcare acquired grade 3 and 4 pressure damage and timely submission of robust closure forms based on the feedback from WG.

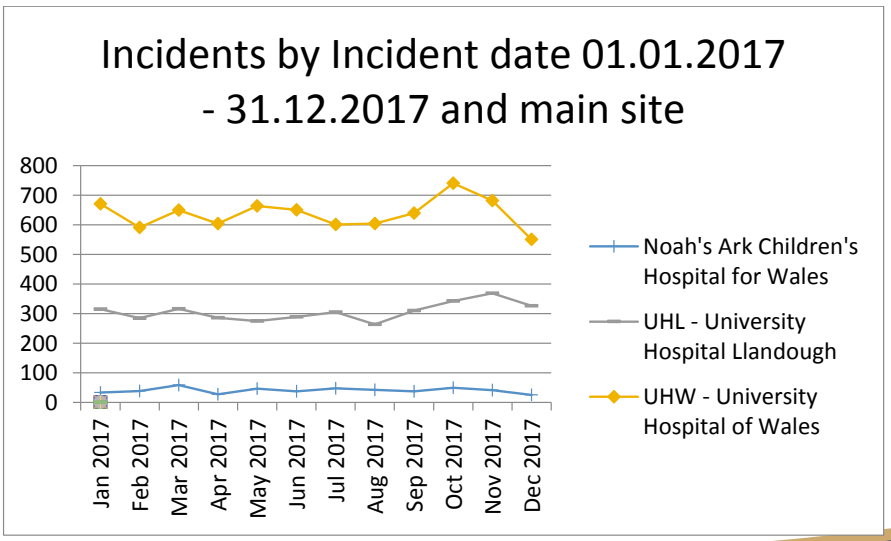


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
New SIs	22	18	22	11	17	17	18	17	22	24	22	30	16	12	14	13	21	16
SI Rate	4.5	3.7	4.5	2.3	3.5	3.5	3.7	3.5	4.5	5.0	4.5	6.2	3.3	2.5	2.9	2.7	4.3	3.3
Wales Rate	4.6	4.4	4.4	4.2	5.2	4.3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

In terms of general incident reporting, the following graph demonstrates the patient safety incidents reporting on to the UHB's Datix risk management system by main sites over the last 12 month period. As anticipated, the majority of incidents are recorded at the University Hospital of Wales (UHW) site followed by University Hospital Llandough (UHL) which reflects the size and activity at those sites.

There is a downward trend in this reporting period at UHW and UHL following a previous upward reporting rate. The trend will continue to be monitored.

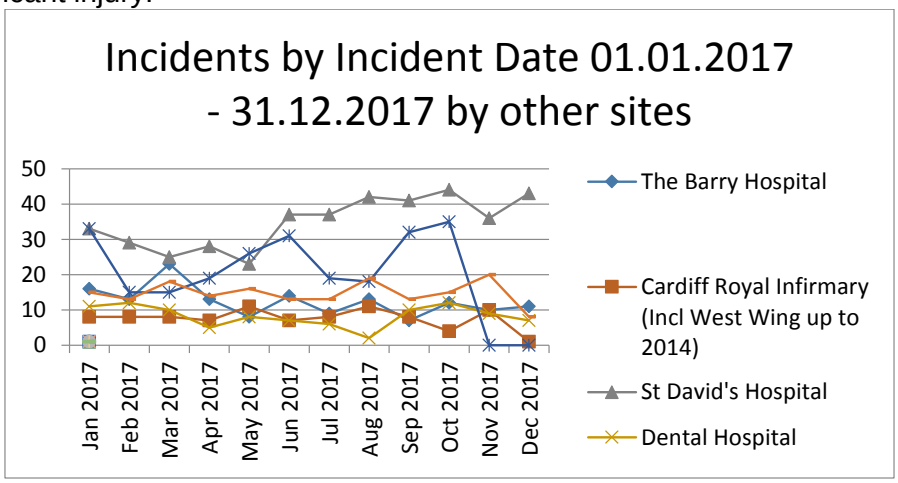
It should be noted however, that the UHB achieved a seven year high in incident reporting rates in 2017. This is encouraging, demonstrating that staff know how to report incidents and it is embedded within the culture to do so. However, it is recognised that reporting rates differ across healthcare professions and the Patient Safety and Quality Department intends to work with the Medical Education Department in 2018 to promote the value of incident reporting to medical staff.



The graph below demonstrates the patient safety incidents reported onto the UHB's Datix risk management system by other sites over the last twelve months. The lower volume of incidents reported reflects the size and activity levels at the sites.

Increasing numbers of incidents at St David's Hospital have been monitored. The largest volume of incidents reported at St David's continue to relate to patient falls. In November 2017, 16 falls were recorded. There were several patients who fell more than once with a maximum of 4 falls in one patient. The falls did not result in harm to the patients. In December 2017, 32 falls were recorded. There were several patients who fell more than once with a maximum of 3 falls in one patient. There was one incident which resulted in a patient sustaining a fractured neck of femur; this patient had fallen twice on the ward in December 2017 and once in November 2017. The other falls did not result in harm to the patients.

Services previously provided at the Iorwerth Jones Centre have transferred to UHL. The average rate of reported incidents per month at Iorwerth Jones between January and October 2017 was 33 incidents per month. The rate is slightly lower following the transfer to UHL with 28 incidents reported per month on average. In November and December 2017, 13 incidents were reported in the Behaviour categories and these were restricted to repeated incidents in a small number of patients such as refusal of treatment, medication or interventions. In the same timeframe, there were 11 patient falls. One patient sustained 3 of these falls; no patient sustained any significant injury.



Never Events

All Wales position:

The 6 monthly feedback report from WG reported at the previous Board meeting, indicates that there were 6 Never Events reported in Wales between April and September 2017. They were mainly surgical in nature.

	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sept 17
Overdose of methotrexate for non-cancer treatment	0	1	0	0	0	0
Retained foreign object post-procedure	0	0	0	0	1	1
Wrong implant/prosthesis	1	0	0	0	0	1
Wrong site surgery	0	0	0	1	0	0
Total	**1**	**1**	**0**	**1**	**1**	**2**

Unfortunately, a further two Never Events have been reported by the UHB to WG in the current reporting timeframe. They relate to an incorrect tooth removal and a procedure commenced on an incorrect tooth in Dental Clinical Board. These incidents are under investigation.

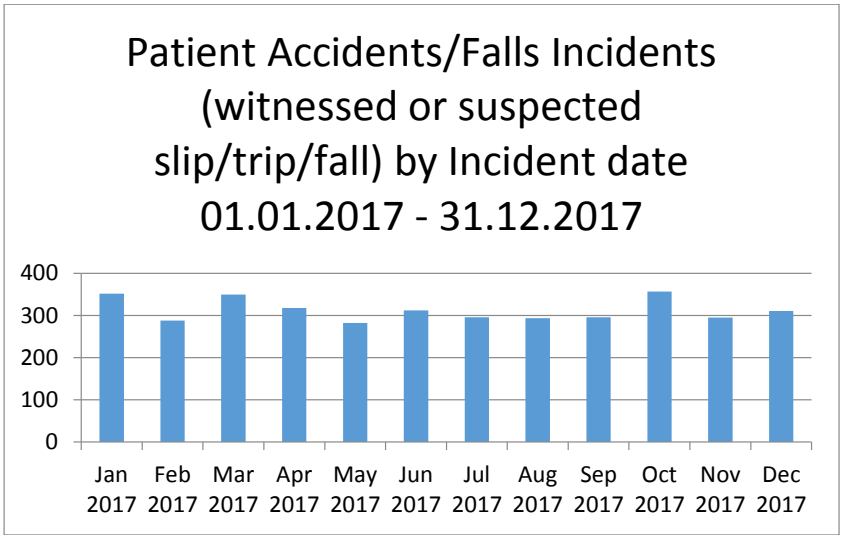
What are we doing about it?

Detailed work to embed National Safety Standards for Invasive Procedures (NatSSIPs) continues. The UHB is exploring human factors with a greater emphasis in the Dental Never Events currently under investigation.
The UHB anticipates the imminent publication of a revised list of Never Events and following this will be undertaking a piece of work with Clinical Boards to risk assess the controls that are in place to reduce the likelihood of Never Events within their areas.

Patient Falls

How are we doing?

Patient falls continues to be a frequently reported patient safety incident. The following table indicates the number of patient accidents/falls and the level of harm sustained as reported between January and December 2017.



The majority of falls continue to result in no significant injury to patients. The UHB will continue to monitor the trend of falls over the Winter period. It is noted that 7 falls were reportable to WG in November and December 2017 due to significant injuries being sustained by patients. It is also noted that the patients were all greater than 65 years of age.

How do we compare with our Peers?

There is currently no reliable All Wales benchmarking data available.

What are we doing about it?

The excellent work of the Falls Delivery Group continues, and there are a range of measures and activities taking place to prevent and manage Falls, as described in the previous report to Board.

Of note in this reporting timeframe is the #SlippersForChristmas campaign that was launched over the Christmas period providing advice on the importance of appropriate footwear in falls prevention. This followed a successful campaign in 2016.

A Physiotherapy Team Leader from the Vale Community Resource Team organised a falls prevention campaign in December 2017 entitled The 12 Days of Christmas Falls Prevention. Further information can be found on the UHB's website.
http://www.cardiffandvaleuhb.wales.nhs.uk/12-days-of-christmas-falls-prevention

The newly appointed Falls Strategy Implementation lead commences in post on January 15th 2018.

Regulation 28 reports

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

Outcomes of internal and external inspection processes

How are we doing?

Internal observations of care

Seventeen unannounced internal inspections were undertaken in November and December 2017. These were undertaken across five Clinical Boards. Of these, 16 inspections were undertaken as part of the planned programme of unannounced inspections, and one at the request of the Executive Nurse Director.

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

Key findings for November and December have shown:

- Very good examples of medicines management, in contrast to the last reported findings;
- Evidence of good leadership and team working;
- Calm, homely environments;
- Comprehensive risk assessments completed;
- Good examples of evaluation.

However, whilst findings did indicate good medicines management in most areas, it was noted that in some areas, medications were not being stopped in accordance with the All Wales Prescription Writing Standards 2014.

Issues relating to confidentiality were also highlighted, where computers displaying patient identifiable data were left unattended, and PSAG boards displayed in public facing areas in some wards were seen to display sensitive data.

What are we doing about it?

The Corporate Nursing Team have met with the Nurse Advisor for Medicines Management to discuss the medicines management issues observed during the inspections so that these can be fed back into training and education; a monthly report detailing all findings relating to medicines management is provided to the Nurse Advisor for Medicines Management.

Discussion has taken place with the nurse in charge at the time of the inspection with regards to the patient confidentiality issues identified.

The Corporate nursing team will continue to undertake a schedule of internal inspections to wards and departments.

The new Medicines Code has been approved by the Quality, Safety and Experience Committee and was launched in the UHB during this reporting period.

Patient Experience

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

How are we doing?

We are able to demonstrate activity in all four quadrants.

Real Time

The number of routine 'real time' surveys completed each month across our Clinical Boards is consistently in excess of eight hundred and fifty; with over ten thousand eight hundred received and analysed during 2017. The patient satisfaction scores from the National Surveys distributed across the UHB during November and December were 88% and 92% consecutively.

The majority of qualitative comments received were in relation to a positive experience and included:

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

Importantly it is about acting upon what we are being told, ensuring a 'listening organisation'. An example of this includes;

Better help with people who are hard of hearing.

Ward sister signposted to guidance available and Audiology contacted and they agreed to provide a staff awareness session if required.

One of our patients at Hafan Y Coed provided a few requests on his feedback form and one was in relation to benefits. Citizens Advice information was shared with the ward and this was followed up. Due to the complexity of the patient's circumstances, the colleague from Citizens Advice arranged an appointment outside his regular weekly slot; ensuring he had additional time to assist and support our patient as required.

Patients do feedback that they can on occasion feel bored in hospital, this is aligned to the CHC report into 'Older People in Community Hospitals: Avoiding Boredom and Loneliness (2016). To assist in counteracting this, during 2017 there were additional volunteer roles introduced that included:

- Musicians
- Art and Craft Volunteers

The Health Board ward befriender role has also been further developed now encompassing students from Cardiff University, University of South Wales and Cardiff and Vale College.

A Knit and Natter Group was also set up with both patients and people living in the community attending University Hospital Llandough on a Monday afternoon. Due to its success there are plans to commence volunteer led Knit and Natter sessions on additional wards at the University Hospital of Wales.

During December festive 'twiddle muffs' and knitted teddies were distributed to Gerontology and Mental Health Services for Older People at Barry Hospital. Chocolate selection boxes were also shared with patients in Hafan Y Coed.

Happy or Not Feedback - A total of 94,262 people have now given feedback via Happy or Not machines placed throughout the UHB and 83% have indicated a positive experience. We note that the day which receives consistently the most negative feedback is a Saturday

Proactive and Reactive

Outpatients Kiosk

Outpatients Kiosk - Introduced to the department in May, the outpatient's kiosk provides a means of gathering feedback from patients, relatives, friends and carers. The survey tool, currently loaded on the kiosk, is of a bespoke design based around car parking, signage, waiting times and information. 949 surveys have been completed to date, both full and partial - 750 (79%) are by patients, 144 (15%) by relatives/friends/loved ones and 55 (6%) by carers/helpers.
The feedback continues to inform us that many patients find it difficult to find a parking space and that this makes them late for their appointment. In addition a small percentage of patients continue to experience difficulties in finding their clinic and that this has also made them late for their appointment. Many patients' appointments were running late and they had not received an apology or been told the reason why.

Ward Feedback Kiosks were introduced to the wards in June this year and are a means of gathering real time feedback from patients, relatives, friends, carers and staff. The survey tools, currently loaded on the kiosks, are based on the 'Feedback in 5' survey and are available in both English and Welsh. During each survey period, the kiosk remains on its designated ward for one week. A detailed report is then sent to the area the following week.

To date, 24 areas have been surveyed at UHW and 24 areas at UHL.

Based on data from 6th November – 31st December 2017 inclusive, 420 surveys (both full and partial) have been completed, 257 (61%) by staff, 116 (28%) by relatives/friends/carers and 47 (11%) by patients. It is very encouraging that of the patients who responded:

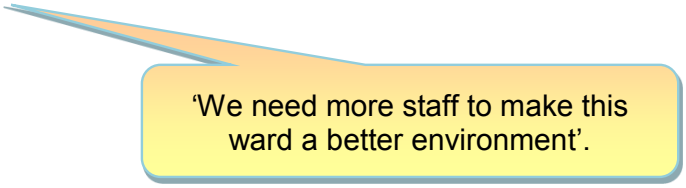
- 79% reported feeling safe whilst in our care.
- 62% thought staff were always kind and caring towards them.
- 67% of patients felt they were involved when decisions were made about their care/treatment.
- 52% of patients rated their care as excellent.

- On the whole comments left by patients and relatives/friends/carers were positive however, there were negative around the ward environment/decor, facilities and understaffing.

'Nurses were very friendly'.

'Not enough staff ever, inadequate care'.

- Comments left by staff centered mainly around understaffing issues, pay. However, there were some positive comments made around team work.



Balancing

The UHB receives approximately 2,600 concerns per year; this is set in the context of approximately 1.8 million patient contacts. To date the Health Board has received over 2,000 concerns and January and February are two of the busiest months in concerns. The latest overall Health Board performance in response to 30-day concerns is 55%; there is however much variability across the UHB. The focus upon the proportionate investigation of concerns in a timely manner remains a focus and 62% of concerns are now responded to informally and the overall informal response time is 72%.

For the reported period 34% (97) of formal concerns related to concerns about medical treatment.

59 (21%) formal concerns were raised regarding communication between staff and patients.

32 (11%) formal concerns were raised regarding cancellation of out-patient appointments and 29 (10%) regarding the length of out-patient waiting lists.

In December, 34 (40%) of the informal concerns received related to concerns about medical treatment.

10(12%) informal concerns were received regarding cancellation of out-patient appointments and 10 (12%) regarding the length of out-patient waiting lists.

Compliments

During the period 1st December 2016 – 31st December 2017, the Health Board logged 787 compliments. Medicine Clinical Board have logged the highest volume of compliments, particularly within the Emergency, Medicine Directorate.

How do we compare to our Peers?

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

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

How do we compare to our Peers?

There is currently no reliable benchmarking data related to Patient Experience. The Once for Wales project, in which the UHB is participating, is aiming to develop a common data set for 'concerns' across Wales to aid benchmarking with peers.

What are we doing?

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

- Following a query raised regarding the possibility of using of Entonox for endometrial biopsies, all staff in the Gynaecology Outpatient Department have received training in the use of Entonox and been made aware of its availability for patients.
- After receiving a concern that a latex allergy was missed causing a reaction for the patient, the All Wales Maternity record will be reviewed at its next planned update in January 2018 so that allergies can be recorded more prominently.
- A patient raised concerns about some nurses / doctors sterility when using central lines. UHB wide work currently being implemented, is to be rolled out in the area raising the importance of aseptic, non-touch technique.
- A patient suggested a 'snack trolley' might be helpful at one of the Outpatient Clinics. A new Trolley service initiative is now underway whereby the trolley will visit on a Monday and Friday.
- Cleanliness raised –the management team visited the ward and undertook a cleaning audit.
- Patient flush in Endoscopy Out Patient Department not working – this was noted on a feedback form and fixed.
- Although there was no adverse event identified from the investigation, following the sad death of a child with longstanding complex health needs, scoping has been undertaken with advice from Clinical Engineering on equipment suitable for community use. A portable kit which enables recording of blood pressure, heart rate, oxygen saturation and temperature has been identified. Twenty five of these kits are being procured for used by Community Child Health staff. In addition, twenty encrypted netbooks have been released to Community Child Health staff. Forty access tokens have been procured which allow the netbooks to be used by more than one staff member. A new netbook is currently under development and will be considered for a phased roll out if additional devices are needed.

PERFORMANCE REPORT
Name of Meeting : Local Partnership Forum Date of Meeting : 8 February 2018
Executive Lead : Director of Public Health
Authors : Members of the Performance and Information Department (tel 029 20745602)
Caring for People, Keeping People Well: This report underpins the integrity value of the Health Board's Strategy, providing transparency on our progress in delivering our duties to our resident population and patients and clients who rely on us to provide clinically and cost effective care.
Financial impact: The achievement of the efficiency and productivity targets will deliver savings to support the financial position
Quality, Safety, Patient Experience impact : The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement
Health and Care Standard 1 – Governance Leadership and Accountability **CRAF Reference No 6** - Resources

Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

REASONABLE ASSURANCE is provided by:

- the fact that the UHB is making progress in delivering our Operational Delivery Plan for 2017/8 by achieving compliance with 21 of its 60 performance measures.

The Local Partnership Forum is asked to:

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

SITUATION

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

BACKGROUND

The UHB is presently compliant with 21 of its 60 performance measures (November = 19, March = 23/58) and is making satisfactory progress towards delivering a further 24 (November = 24, March =13).

The Welsh Government's Delivery Framework continues to be revised for 2017/18 and 18/19, with new measures or revisions to existing measures having been

adopted or proposed. A review of the performance reporting considering these changes has commenced and will be the subject of a future board development session.

Since the last report two measures have improved to green:

#1 – The proportion of patients who have had a nutrition score completed and appropriate action taken within 24 hours of admission has increased to 95%

#62 = The number of patients whose transfer of care has been delayed has reduced to 38 in total.

There are now 16 measures where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

This is summarised in the table below:

Policy Objective	Green	Amber	Red	Score
Delivering for our population	9	9	3	13.5/21
Delivering our service priorities	2	3	1	3.5/6
Delivering sustainably	8	7	10	11.5/25
Improving culture	2	5	2	4.5/9
Total	21	24	16	33/61

ASSESSMENT

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

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

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

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

Purpose	Strategic Objectives		Measure	n	Status report: Mar-16	RAG rating	Mar-17	RAG rating	Nov-17	RAG rating	Jan-18	RAG rating	Latest Trend	Target	Time period	Exception Report
Caring for people and keeping them well	For Our Population	All take responsibility for improving our health and wellbeing	Uptake of influenza vaccination among high risk groups	1	>65: 68.5%, @risk: 47.7%, pregnant women: n/k	R	>65: 68.5%, @risk: 48.1%, staff:52.9%	A	>65: 55.9%, @risk: 33.7%, staff:40.8%	G	>65: 68%, @risk: 45.3%, staff:60.2%	G	↑	Green: Community: 75%, staff 60%; Amber (improvement on 16/17) - profile FYO >65: 70%, @risk: 52%, staff:50%	upto 2/1/18	
			Percentage of children who have received 3 doses of the 5 in 1 vaccine by age 1 & who received 2 doses of the MMR vaccine by age 5	2	83.7%	A	81.2%	R	5 in1 : 95%, MMR2: 87.4%	A	5 in1 : 94.7%, MMR2: 87.5%	A	↓	Target: 95%, amber = EOY IMTP trajectory of 95% & 90%	Jul-Sep 17	
			Proportion of adults obese or overweight	3	54%	G	54%	G	52%, Age std 54%	G	52%, Age std 54%	G	○	reduction on previous year (54% 2012/13, 2013/14)	NSW 2016/17	
			% of adults consuming > 14 units of alcohol p. Wk (New measure)	4	44%	A	42%	G	23% Age std 23%		23% Age std 23%			New measure - previous results relates to consumption above recommended units	NSW 2016/17	
			Proportion of adults meeting physical activity guidelines	5	27%	G	60%		60% Age std 59%	A	60% Age std 59%	A	○	Target continuous reduction in % of adults who reported being physically active for more than 150 mins in the previous week	NSW 2016/17	
			% of C&V resident smokers who make a quit attempt via smoking cessation services - target 5%	6	1.1%	R	0.7% to Q2	R	0.4% Q1 17/18	R	0.85% to Q2 17/18	R	○	WG target 5% by 2017/18, IMTP trajectory = 1% for Q1&2	Q2 17/18	
			% C&V residents who are CO validated as successfully quitting at 4 weeks - measured annually - target 40%	7	46.0%	G	67.0%	G	52.4% Q1 17/18	G	55.3% Q2 17/18	G	↑	Tier 1 target 40%, IMTP trajectory = 58%	Q2 17/18	
			Rate of conceptions among females under 18	8	Cardiff 30.4 per 1000, Vale 19.4 per 1000	G	Cardiff 27.5 per 1000, Vale 15.8 per 1000	G	Cardiff 27.5 per 1000, Vale 19 per 1000	A	Cardiff 27.5 per 1000, Vale 19 per 1000	A	○	reduction on previous year	2015 (Annual)	
		Deliver outcomes that matter to people	Crude Hospital Mortality Rate for people aged less than 75	9	0.60%	G	0.60%	G	0.62%	G	0.62%	G	○	12 Month Reduction Target	12 months to Dec-17	
			Emergency crude mortality rate (12 mth)	10	2.94%	G	3.05%	G	3.01%	G	3.05%	G	○	Reduction in CMR (Aug 2015 to Jul 2016 = 2.9%)	12 months to Dec-17	
			Demonstrable reduction in the mortality rate for stroke, heart attack and fractured neck of femur patients (30 day post event, 12 mth)	11	stroke 10.1%, heart attack 3.7%, #NOF 5.9%	G	stroke 11.2%, heart attack 3.7%, #NOF 6.1%	A	stroke 13.1%, heart attack 3.8%, #NOF 6.2%	A	stroke 13.7%, heart attack 4.2%, #NOF 7.5%	A	○	Demonstrable reduction in rolling 12 month rate (Oct 15 to Sep 16: 10.1%, 3.7%, 6.9%)	12 months to Sep 17	
			% Universal mortality reviews undertaken within 28 days of a death (New measure)	12		G			81%		71%	A	↓	NEW MEASURE from April-17 - Target is 95%, Amber is improvement from 70% baseline	Oct-17	
			Patient experience monitored through "Fundamentals of Care" audit and national surveys	13	Operational score (15/18 >85%), User Experience score 89.7% (23/26 >85%)	A	87%	A	87%	A	87%	A	○	% of pts responding who rated overall experience of care as 8/10 or above (Green 90%)	National report Sept-16	
			"Two minutes of your Time patient feedback scores"	14	6/11 >90%, 7/11 >85%	R	6/11 >90%, 7/11 >85%	R	7/11 >90%, 7/11 >85%	R	5/11 >90%, 7/11 >85%	R	↓	Green: 90% for each of the 11 questions, Amber: >85%	Monthly snapshot for Dec-17	In Nursing director's report
			Proportion of formal complaints responded to within 30 working days	15	55%	R	43%	R	54%	R	55%	R	○	80%	Complaints received to 22/11/17	In Nursing director's report
		Reduce health inequalities	Life expectancy at birth	16	80.8	G	80.8	G	Cdff F: 82.6, M:78.3, V- F: 83.2, M: 79.1	G	Cdff F: 82.6, M:78.3, V- F: 83.2, M: 79.1	G	○	Continuous Improvement	2013/15	
			Reduce infant mortality for population	17	4.3 per 1,000 live births	A	3.9 per 1,000 live births	G	3.9 per 1,000 live births	G	3.9 per 1,000 live births	G	○	reduction on 2012 rate (4.1)	ONS (2015)	
			% live births with a birth weight of less than 2500g	18	5.8% (provider)	G	5.90%	G	6.30%	G	6.00%	G	○	12 mth cumulative reduction on previous year (5.9%)	Upto Nov-17	
			Rate of hospital admissions with any mention of intentional self harm for children and young people per 1000 popn (New measure)	19	433		387		3.5	G	3.5	G	↑	Annual reduction from 3.87 in 15/16 & 4.33 in 14/15	Year 16/17	
			Reduction in the number of emergency hospital admissions for basket of 8 chronic conditions per 100k popn	20	1020	G	1089	A	1032	A	1034	A	○	reduction against same 12 month period of previous year (1078)	Upto Sep-17	
			Reduction in the number of emergency hospital readmissions within a year for basket of 8 chronic conditions	21	192	G	196	A	201	A	202	A	○	reduction against same 12 month period of previous year (198)	Upto Sep-17	
			Emergency admission for hip fractures (age-standardised, 65+ per 100,000 people) (Revised Populations applied)	22	499	G	554.8	G	552.8	A	555.2	A	○	reduction on previous year (575 per 100,000 conf limit+/-48)	Sep-Aug 2017	
	Our Service Priorities	Offer services that deliver the population health our citizens are entitled to expect	Delivery of the 31 day (Non- USC) and 62 day (USC) cancer access standards	23	100% NUSC, 74.2% USC	R	97% NUSC, 83% USC	R	94.2% NUSC, 83.5% USC	R	98.8% NUSC, 89.7% USC	R	↑	98 % NUSC, 95% USC	Monthly snapshot for Nov-17	✓
			Primary care contractor professionals assurance status	24	Satisfactory	G	Satisfactory	G	Managerial Intervention Required	A	Managerial Intervention Required	A	○	2 formal sustainability applications reviewed by panel. Further 7 receiving support to ensure viability	as at 1/1/18	
			% GP Practices open during daily core hours or within 1 hour of daily core hours	25	83% (2015)	G	88%	G	88%	G	88%	G	○	Improvement target (2015 - 86%)	Dec-17	
			Dementia Bundle: Diagnosis rates, Access & training	26	Diagnosis: 55% Access: 71%, Training: 33%	R	Diagnosis: 58% Access: 98%, Training: 30%	G	Diagnosis: 58% Access: 98%, Training: 30%	G	Diagnosis: 63% Access: 98%, Training: 32%	G	↑	Target: Diagnosis improvement in proportion >65years diagnosed with dementia, Access attain 95% memory patients seen within 14 weeks, Trainingimprovement in %GP practices that completed MH DES in dementia care	Diagnosis Yr 16/17, Access: Oct17, Training Year 16/17	✓
			% of people over 65 who are discharged from hospital and referred to a care home and not their usual place of residence	27	2.60%	G	3.00%	A	3.20%	A	3.20%	A	○	Demonstrable reduction in rolling 12 month rate (Jan-Dec 16: 2.8%) - Amber remain in SPC limits (o mean = 3.09, UCL 4.2%)	12 months to Dec-17	
			Sustained compliance against four acute stroke bundles	28	1: 35%, 2: 100%, 3: 57%, 4: 67%	R	1: 40%, 2: 96%, 3: 64%, 4: 79%	R	1: 57%, 2: 100%, 3: 75%, 4: 77%	A	1: 43%, 2: 95%, 3: 72%, 4: 98%	A	○	Continuous improvement against all 4 NHS Wales Quality Improvement Metrics (NEW)	Monthly performance in Nov 17	✓
	Sustainability	Reduce harm, waste and variation sustainably making best use of the resources available to us.	Number of new serious incidents & % assured within agreed timescale (NEW MEASURE)	29	219 serious incidents, 21 no surprises	R	206 serious incidents, 39 no surprises	A	120 Sis, 16 no surprises - 54% assured in timescale	A	159 Sis, 20 no surprises - 53% assured in timescale	A	○	No. of SIs: reduction in year (219 Sis in15/16, 236 16/17) , Timeliness for assurance : 95%	No. of SIs: Dec-17, Timeliness: Nov-17	In Nursing director's report
			% patients with a positive screening for sepsis in both inpatients and emergency A&E who have received all 6 elements of the 'sepsis six' bundle within 1 hour.	30	Bundle 6 90.6% compliant	A	64.9%	A	Oct-17: 75%, YTD 67%	A	Nov-17: 75%, YTD 68%	A	○	Continuous improvement target (Q1 16/17 = 48.1%, Q2 = 62%, Q3=64.9%, Q4 = 57%)	M7-17/18	
			Reduction in number of patients who had a potentially preventable Hospital Acquired Thrombosis (VTE) up to 90 days post discharge	31	156		161	A	5 potentially preventable, 22 still to be reviewed		11 potentially preventable, 0 to be reviewed			NEW Definition FOR 2016/17: rolling 12 mth reduction in preventable HATs post level 2 Root Cause Analysis	12 mths to June-17	
			% of nutrition score completed and appropriate action taken within 24 hours of admission	32	95%	G	94%	A	94%	A	95%	G	○	Green: 95%, Amber 90%	Monthly snapshot for Nov-17	
			Patient environment: Credits 4 cleaning scores for high risk areas	33	Very high risk: 94.7% High risk: 94.4% Significant risk: 91.3%	R	Very high risk: 98.1% High risk: 97.0% Significant risk: 96.7%	G	Very high risk: 98.4% High risk: 97.4% Significant risk: 97.3%	G	Very high risk: 98.4% High risk: 96.9% Significant risk: 95.3%	G	○	Very high risk: 98% High risk: 95% Significant risk: 85%	Monthly snapshot for Nov-17	
			% compliance with Hand Hygiene (WHO 5 moments)	34	94%	R	94%	R	93%	R	93%	R	○	Green: 100%, Amber:>95%	Monthly snapshot for Nov-17	
			Reduction in C. Difficile and Staphylococcus Aureus Bacteraemia (MRSA), working towards a zero tolerance	35	11 C difficile cases; 11 S. aurea cases	A	13.7 C difficile cases; 10.6 S. aurea cases	R	88 C difficile cases; 99 S. aurea cases; 215 E. coli cases	R	98 C difficile cases; 117 S. aurea cases; 262 E. coli cases	R	○	Target is average monthly rate of no more than 10 C difficile, 8 S. aurea and 24 E. coli cases for Apr 17 to Mar 18 period	9 mths: Apr 17 to Dec-17	✓
			Reduction in the number of healthcare acquired pressure ulcers	35	M12 = 413, avg = 34.4	G	M10 = 577 MA(12) = 55	R	M6 = 519 MA(12) = 88	R	M8 = 776 MA(12) = 95	R	↓	10% reduction on previous year (2015/16 avg = 34.4, target = mthly average of 31) (source:FOC)	M8 - to Nov 2017	
			Financial balance: remain within revenue resource limits	36	£0.068m surplus at M12, (£13.3m favourable variance from plan)	G	£29.717m deficit at M11	R	£17.963m deficit at M7	R	£22.177m deficit at M9	R	○	2017/18 Draft Planned Deficit £30.9m	M9 - 2017/18	In Finance Report
			Remain within capital resource limits.	37	Actual spend at M12= £41.0m	G	Actual spend at M11= £20.216m	G	Actual spend at M7= £13.496m	G	Actual spend at M9= £17.334m	G	○	Approved planned year end spend as at November 6 2017 = £40.965m	M9 - 2017/18	
			Show reductions in annual total pay spend.	38	£545.781 to m 12	R	£524.4m to m 11 2016/17	R	£339.807m to m 7 2017/18	R	£438.006m to m 9 2017/18	R	○	£427.600m to m 7 2016/17	M9 - 2017/18	
			Number of procedures undertaken that are on the UHB's "Interventions not normally undertaken" list for procedures of limited clinical effectiveness	39	5315		5528	A	5202	A	5180	A	↑	12 month rolling reduction (Dec-Nov16 : 5671)	Dec-Nov17	
			Reducing outpatient did not attend rates for New and Follow Up appointments	40	N 10.5%, FU 11.7%		N 10.2%, 11.8%	A	N:10.2%, FU 11.9%	R	N:9.9%, FU 11.9%	R	○	12 month rolling reduction- 16/17 New DNA 9.8%, FU 12.2%	M7/9- 2017/18	
			Increasing in-session theatre utilisation (adopting Newton measure)	41	79%	A	72%	A	75%	A	77%	A	○	Newton consulting set standards: green >= 85%, amber 67%-85%, red <=67%	Nov-17	
			Uptake of ERAS across whole HB.	42	Programme has stalled	R	Programme has stalled	R	Refresh being planned as part of TTC	R	Refresh being planned as part of TTC	R	○	Self assessment based on roll out plan agreed with WG	Dec-17	
			Ensure that the data completeness standards are adhered to within 1 month of the episode end date	43	95.2% in month, 96.5% past 12 month	A	95.8% within 30 days	G	95.6% within 30 days	G	95.5% within 30 days	G	↑	NEW MEASURE FOR 2016/17: 95% within 30 days	Sep-17	
		Have a planned care system where demand and capacity are in balance	% hospital cancellations rebooked with 14 days	45	56%	R	28%	R	30%	R	43%	R	↑	WG target: 100%, IMTP trajectory 44%	Monthly snapshot for Oct-17	✓
			Part 1 Local Primary care Mental Health Support Services (% assessed within 28 days & therapy started within 28days)	46	82.2% (28 days), 92.8% (28 days)	G	78% (assessment), 86% (therapy)	R	97% (assessment), 80% (therapy)	A	92% (assessment), 79% (therapy)	A	↓	80% within 28 days for assessment, 90% within following 28 days for therapy	Monthly snapshot for Nov-17	
			Part 2 Coordination of care and treatment Planning for secondary Mental Health Users (% of users with a care and treatment plan)	47	90.4%	G	91.0%	G	90.4%	G	90.1%	G	○	90%	Monthly snapshot for Nov-17	✓
			Part 3 % of former users of secondary mental health services who are assessed under part 3 of the measure, who received their outcome assessment report within 10 days	48	89%	A	100%	G	100%	G	100%	G	○	100%, Amber: Continuous improvement as new standard	Monthly snapshot for Nov-17	
			Part4 Mental Health Advocacy (Provision of an advocate to all eligible requesting users)	49	100%	G	100%	G	100%	G	100%	G	○	100%	Monthly snapshot for Nov-17	
			95% of patients will be waiting less than 26 weeks for treatment with a maximum wait of 36 weeks	50	84% <26 weeks, 2522pts > 36 wks	A	83% <26 weeks, 2720pts > 36 wks	A	82% <26 weeks, 3339pts > 36 wks	A	82% <26 weeks, 1012pts > 36 wks	A	○	95% <26 wks, 0 > 36 wks: Amber: Achieve quarterly IMTP milestone (1023)	Posn at 31-Dec-17	✓
		Have an unplanned (emergency) care system that provides the right care, in the right place, first time	Attainment of the primary care out of hours service standards	51	5 Green, 3 Amber, 9 Red	R	6 Green, 6 Amber, 5 Red	R	7 Green, 2 Amber, 8 Red	R	5 Green, 2 Amber, 10 Red	R	↓	Number of standards where the UHB is compliant (Green 13/17, Amber 10/17)	Monthly performance in Dec-17	✓
			Deliver the 70% Cat A 8 minute response times all Wales target on a rolling 12 month basis and sustain the 65% Health Board target on a monthly basis	52	80%	G	82%	G	83%, 85% for 12 mths	G	78%t, 83% for 12 mths	G	↓	70% n.b	Monthly performance in Dec-17	
			95% of patients spend less than 4 hours in all hospital emergency care facilities from arrival until admission, transfer or discharge	53	85%	R	84%	R	83%	R	82%	R	↓	WG target: 95%, IMTP for Q3 90%	Monthly performance in December-17	✓
			Eradication of over 12 hour waits within all hospital emergency care facilities	54	55	R	59	R	80	A	91	A	↓	WG target: 0, IMTP trajectory: 100	Monthly performance in December-17	
	Culture	Be a great place to work and learn	Percentage of staff (excluding medical) undertaking PADR (Performance Appraisal Development Review)	55	56%	R	58%	R	57%	R	60%	R	○	Green: >85%, Amber 68-84%, Red <68%	12 months to Nov-17	
			Medical Staff – percentage of staff undertaking Performance Appraisal	56	75.2%	R	74.4%	R	76.0%	A	77.8%	A	○	Green: 85%, Amber: increase from Mar-15 position of 77%	as at Dec-17	
			% of staff completing staff survey in the organisation.	57	22%	R	36% 0f 7000 staff surveyed	R	36% 0f 7000 staff surveyed	R	36% 0f 7000 staff surveyed	R		Bi-Annual	2016 staff survey	
			Overall measure for organisational climate / engagement	58	60%	A	3.64/5	A	3.64/5	A	3.64/5	A	○	Bi-Annual	2016 staff survey	
			Achieve annual local sickness and absence workforce target	59	5.14%	A	4.86%	G	4.86%	A	4.86%	A	○	12 month rolling reduction was 4.9% by end of Mar-17, target reduce to 4.2% Mar-18	to 30-Nov-17	
			Retain platinum corporate health standard	60	Achieved	G	Achieved	G	Achieved	G	Achieved	G	○	Re-assessed as meeting standard	2017/18	
		Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	Ambulance handover times: % within 15 and 60 minutes	61	15 mins: 56%, 60 mins: 93%	A	15 mins: 49%, 60 mins: 90%	R	15 mins: 47%, 60 mins: 87%	A	15 mins: 49%, 60 mins: 85%	A	○	15 mins: 60%, 60 mins: 100% (Amber: IMTP trajectory for 60 mins = 63%)	Monthly performance in Dec-17	✓
			No. of Delayed transfers of care – mental health (all ages) and non mental health (75 years and over)	62	73 NMH, 21 MH	R	29 NMH, 17 MH	G	47 NMH, 7 MH	A	30 NMH, 8 MH	G	↑	Continuous improvement : March 2017: 29 Non MH, 17 MH - IMTP trajectory is 10% redn on March posn	Monthly snapshot for Dec -17	
			Progress in Delivering Strategic Programme	63	Blueprint for HEART prepared for board	A	Slippage on aspects due to changing financial posn	A	TTC programme accelerating	A	TTC programme accelerating	A	○	Sustained improvement (metrics to be developed)	Assessment at Jan-18	
											Current Performance = 33/61					

ASSESSMENT

1) IMMUNISATION

How are we doing?

Childhood vaccinations

In the most recent COVER report (Jul-Sep 2017) uptake of the 5 in 1 at age 1 dropped slightly below 95% for the first time in 2 years, to 94.7%. Uptake of MMR2 at age 5 remained relatively unchanged, at 87.5%.

Seasonal flu

The seasonal flu campaign is ongoing, so figures will change before the end of the season. Current uptake (to 2 Jan 2018) is:

- Community over 65s: 68.0% (target: 75%)
- Community under 65s at risk: 45.3% (target: 55%)
- Staff with patient contact: 60.2% (to end of Nov 2017) (target: 60%)

An accurate figure for pregnant women is not known until towards the end of the season (point of delivery audit).

How do we compare with our peers?

Childhood vaccinations

Wales average figures are:

Uptake of 5 in 1 at age 1: 95.9%
Uptake of MMR2 at age 5: 90.5%

Seasonal flu

Wales average figures are:

- Community over 65s: 66.6% (target: 75%)
- Community under 65s at risk: 45.3% (target: 55%)
- Staff with patient contact: 50.7% (to end of Nov 2017) (target: 60%)

What are the main areas of risk?

Childhood vaccinations

The fall to below 95% for 5 in 1 is a concern, as uptake has exceeded the 95% target for the last 2 years following a set of interventions to improve data recording timeliness and engage practices and parents. The 5 in 1 vaccine has recently been replaced by the 6 in 1 vaccine (which adds hepatitis B to the vaccine) and it is thought that initial problems with the Child Health 2000 (CH2K) system in recording and reporting the new vaccine alongside the 5 in 1 may have contributed to the drop

in uptake. CH2K was also unable to run routine reports of uptake for 5 in 1 / 6 in 1 which are essential components of the data cleansing cycle in place locally in Cardiff and Vale. This was escalated via NWIS and seems to now be resolved but it means that data cleansing was not possible for the most recent quarter (Oct-Dec 2017), so recorded uptake may well fall short of the target for the next quarter too. Data cleansing is planned to restart for the Jan-Mar 2018 report.

Roll out of the Cypris Child Health system which is due to replace CH2K and eventually remove the need for manual data cleansing by harmonising GP practice and Child Health data automatically, has been delayed again by NWIS with no confirmed implementation date for Cardiff and Vale UHB. Previously Cypris was due to be implemented before the end of 2017/18 but this may now be another year later. The delays to Cypris roll out have been escalated with WG as a risk to maintaining and improving uptake in Cardiff and Vale.

Seasonal flu

Frontline staff uptake in Cardiff and Vale has been the first among LHBs to exceed the new WG 60% target, and we hope to further increase uptake in the rest of the season and in subsequent years.

Community flu vaccine uptake, in common with the rest of Wales and the UK, has remained little changed this season compared with last season so far despite additional efforts to raise awareness and prompt vaccination. With recent increases in circulating flu virus in the community we continue to encourage vaccination to reduce the risk of localised institutional outbreaks of flu in the community, and reduce the impact of flu consultations and cases on primary and secondary care.

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

Childhood vaccinations

We have recently fully implemented a quarterly data cleansing and performance cycle in primary care, consisting of quarterly practice and cluster profiles of key immunisation uptake; a transparent system for identifying and engaging with practices with outlying uptake each quarter, working with those practices to implement evidence-based interventions; and targeted data cleansing in advance of COVER reporting. This should start to impact on uptake from the next quarter.

Seasonal flu

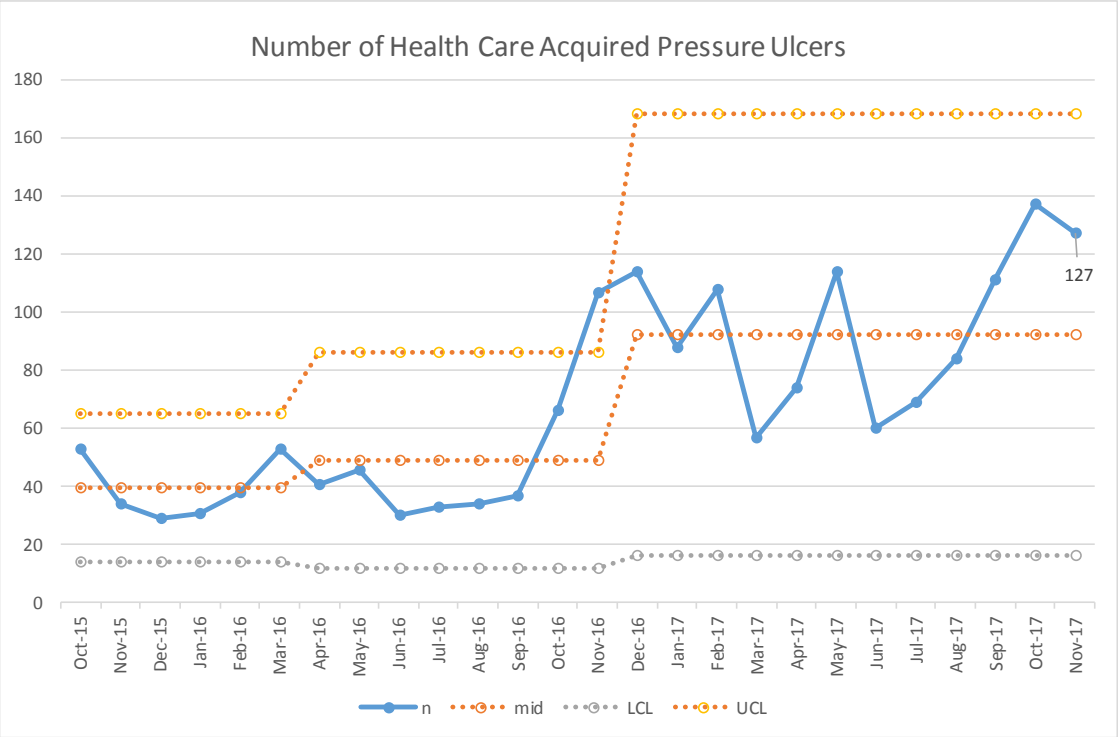
We are continuing to raise awareness of seasonal flu vaccination with eligible groups in the community. We will be undertaking end of season reviews of staff and community campaigns in order to understand areas for improvement in the 18/19 season.

2 HEALTH CARE ACQUIRED PRESSURE ULCERS

How are we doing?

The number of health care acquired pressure ulcers in quarter 3 has been higher than that observed in previous quarters, averaging 125 per month.

As per the statistical process control chart below, this level is within the current process limits, with the monthly average over the past 12 months being 92.



How do we compare with our peers?

All Wales data is no longer made available.

What are the main areas of risk?

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

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

A Pressure Ulcer Task and Finish group has been convened to drive improvements in pressure ulcer prevention. This is led by the Director of Nursing Surgery Clinical Board and will report to the Nursing and Midwifery Board. The main focus of the group has been on the following:

- Influencing the all Wales pressure ulcer reporting and investigating guide which has now been agreed and is waiting sign off for adoption by the Health Board at the Nursing Midwifery Board.
- Involvement with the Bed Management contract
- Health Board policy and procedure for pressure ulcers has been revised and due to be presented at the Quality Safety and Experience Committee.
- Launch of new guidance for the selection of mattresses.

Compliance with completion of Waterlow risk assessment is checked during unannounced inspections conducted by corporate nursing.
Influencing work is also progressing to improve and apply consistency to the reporting from an All Wales electronic incident reporting system. All pressure ulcers have an RCA undertaken to review care and ensure action is taken to prevent reoccurrence. All pressure damage is reported as a POVA.

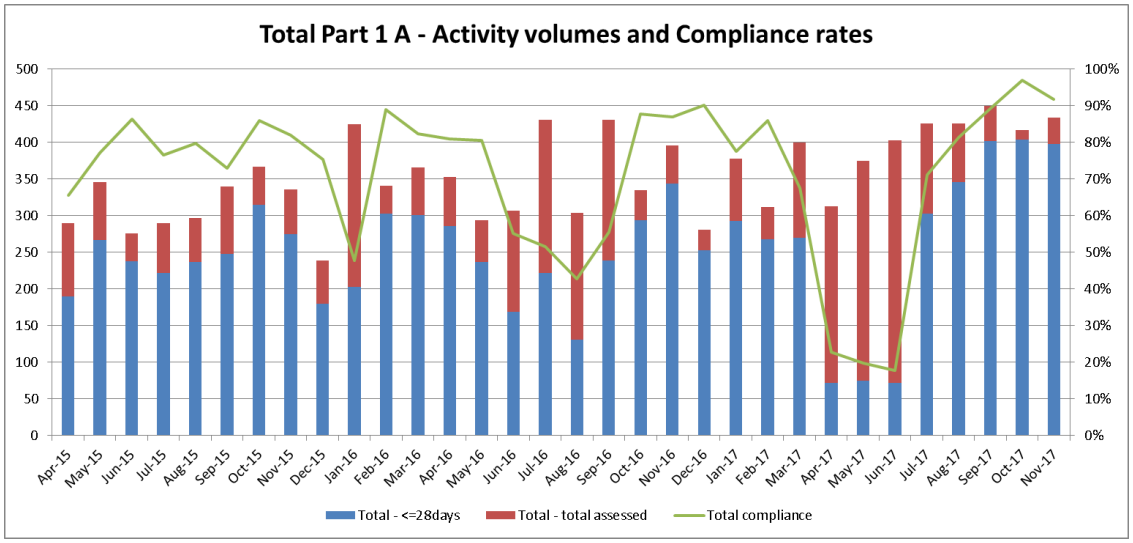
3 MENTAL HEALTH

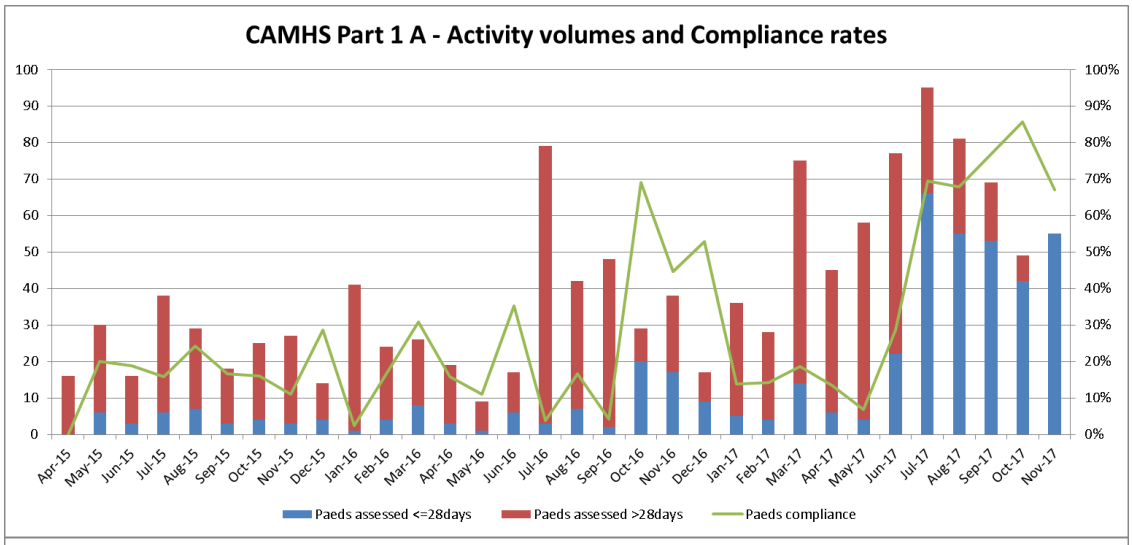
How are we doing?

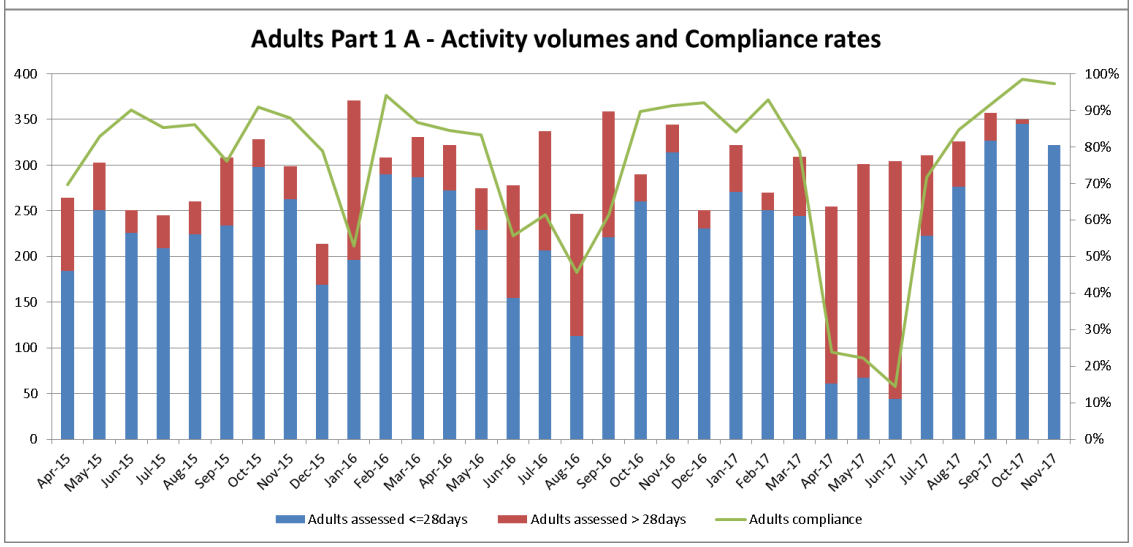
Part 1a: Service users to receive an assessment within 28 days

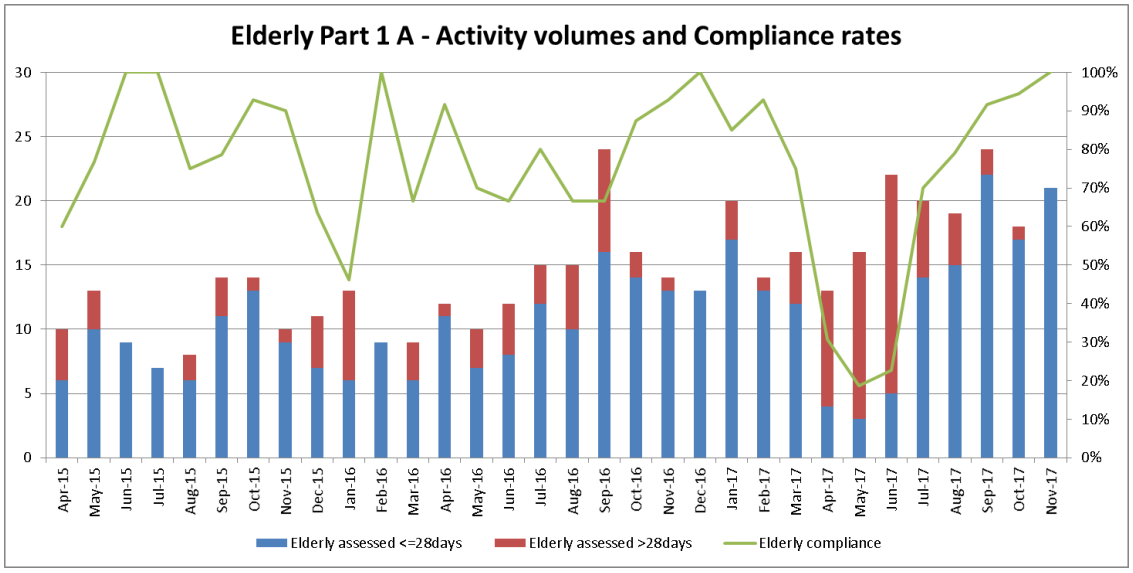
Overall 92% of service users seen in November were assessed by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of referral, against the Welsh Government's minimum standard of 80%.

Both the adult and older people's services achieved the standard of 80%, delivering 97% and 100% respectively. This is predominantly due to staff returning from sickness and improvements in the service's administration of patients who do not attend or who cancelled their appointments. Referral volumes received by the adult and older people's services over the 2017 calendar year averaged almost 900 per month, a slight increase on the previous year.


Total Part 1 A - Activity volumes and Compliance rates
Total - <=28days
Total - total assessed
Total compliance


CAMHS Part 1 A - Activity volumes and Compliance rates
Paeds assessed <=28days
Paeds assessed >28days
Paeds compliance


Adults Part 1 A - Activity volumes and Compliance rates
Adults assessed <=28days
Adults assessed > 28days
Adults compliance



Part 1b: Overall 79% of service users started a therapeutic intervention following assessment by the Local Primary Mental Health Support Service (LPMHSS) within 28 days of their assessment against a standard of 90%**.**

Therapy Commenced within 28 days	CAMHS	Adult	Elderly	Total
<= 28 days	2	98	3	103
Total Commencing therapy	2	125	4	131
% Compliance	100%	78%	75%	79%

Part 2: Overall 90.1% of LHB residents had a valid Community Treatment Plan completed at the end of November. Performance remains above the standard of 90%.

Part 3. 100% of former users assessed under part 3 of the measure were sent their outcome of assessment report within 10 days.

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

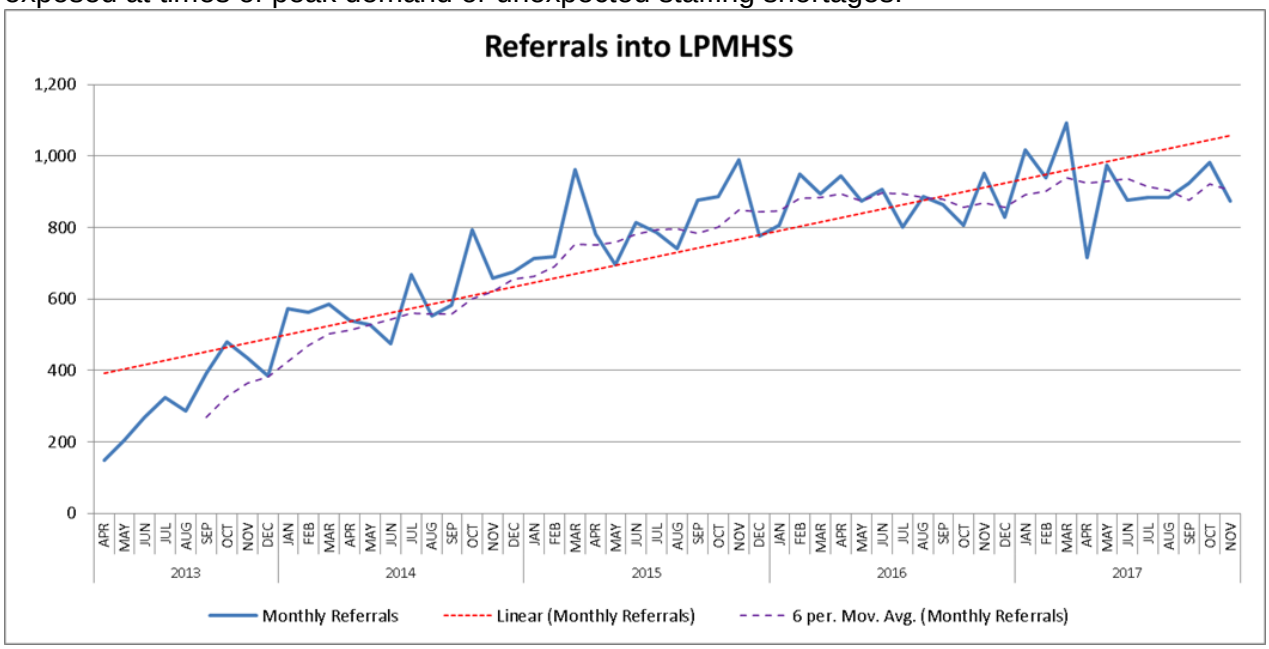
How do we compare with our peers?

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

October 2017	Part 1a	Part 1b	Part 2	Part 3
	Part 1a. % of assessments by the LPMHSS undertaken within 28 days from the receipt of the referral	Part 1b. % of Therapeutic Interventions started within 28 days following an assessment by the LPMHSS	% of residents with a valid CTP	% of residents sent their outcome assessment report within 10 days of their assessment.
Wales	81.5%	82.7%	90.7%	100.0%
ABM	65.2%	96.6%	89.7%	100.0%
AB	81.1%	75.4%	91.4%	100.0%
BCU	82.0%	89.8%	90.1%	100.0%
C&V	96.6%	80.4%	90.1%	100.0%
CTaf	84.1%	77.7%	91.5%	100.0%
HDda	76.2%	83.2%	93.2%	100.0%
Powys	90.1%	78.1%	89.1%	100.0%
Rank	1/7	4/7	4.5/7	-/7

What are the main areas of risk?

The key risk has been the steadily increasing demand on primary mental health services and the inherent variation within the monthly demand. As per the chart below, the 12 month average now appears to be stabilizing around demand of 900 per month. This risk exacerbates a further risk relating to the low level of resilience planned for with regard to the service's capacity to meet the demand, which is often exposed at times of peak demand or unexpected staffing shortages.



What actions are we taking?

Primary Mental Health

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

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

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

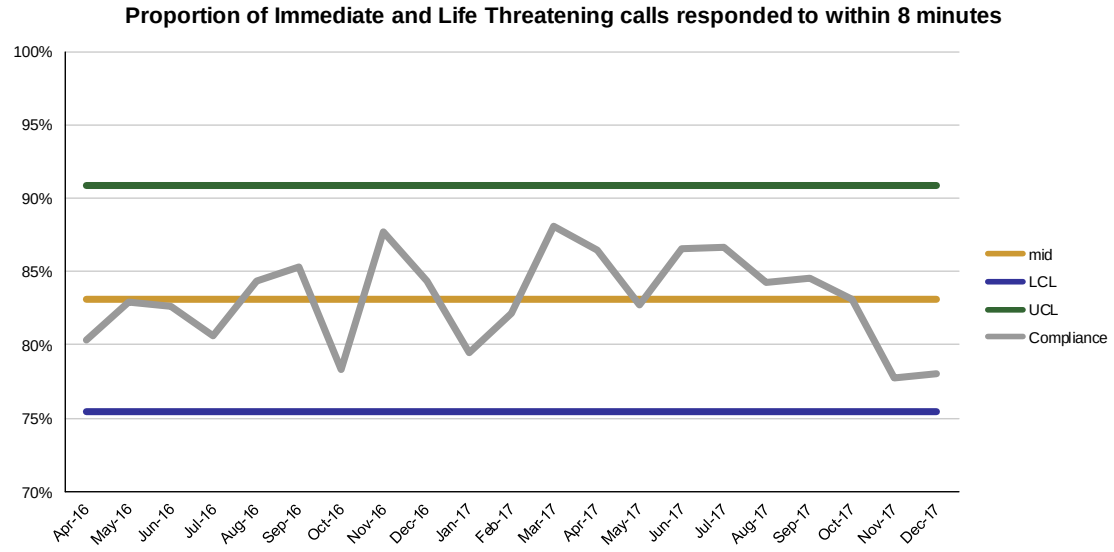
Adult and Older People Services

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

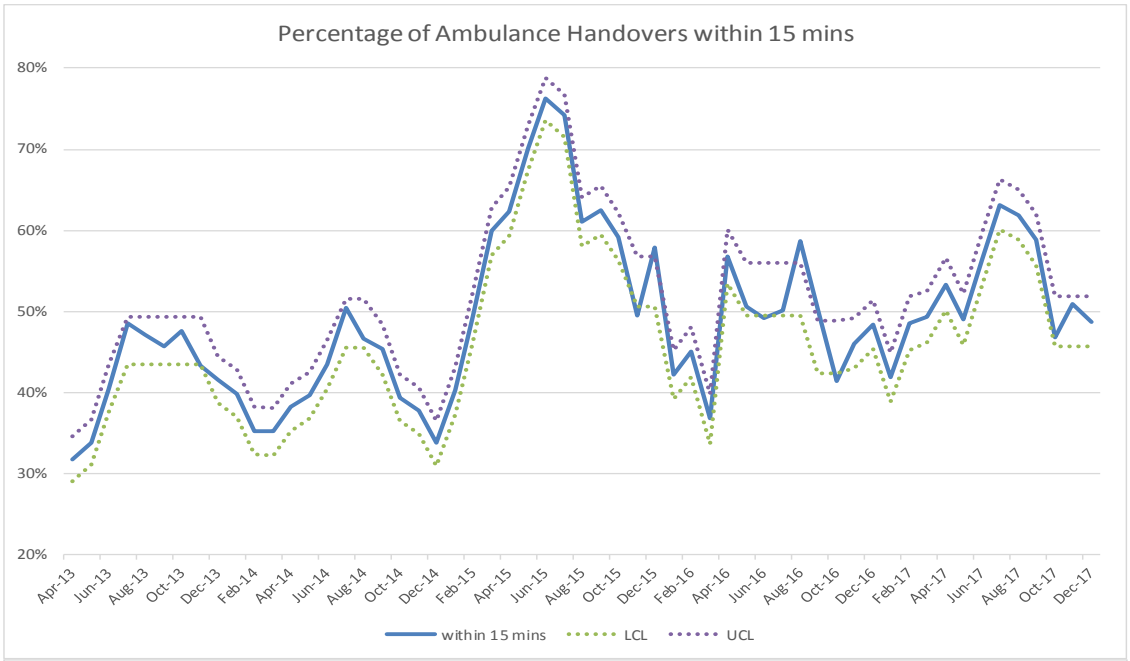
The service has improved administrative procedures ensuring that they are consistently applying the guidance set by the Welsh Government for the management of patients who fail to attend or cancel their appointments.

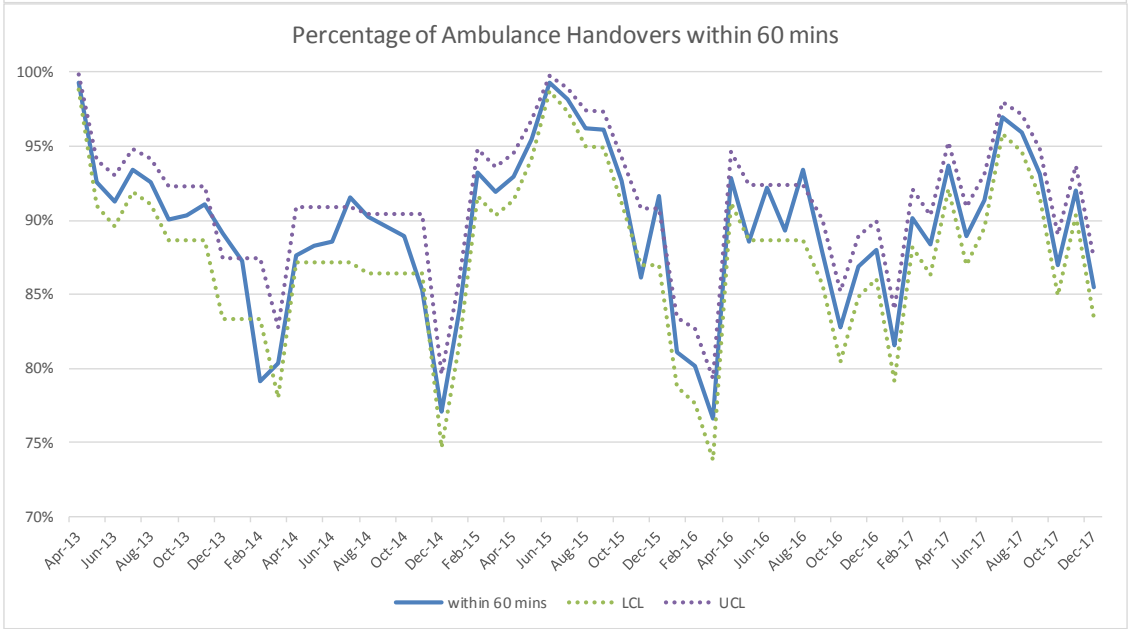
4) Unscheduled Care

The proportion of immediate and life threatening calls responded to within 8 minutes remains stationary around a mean of 83%, above the Welsh Government target of 70%.

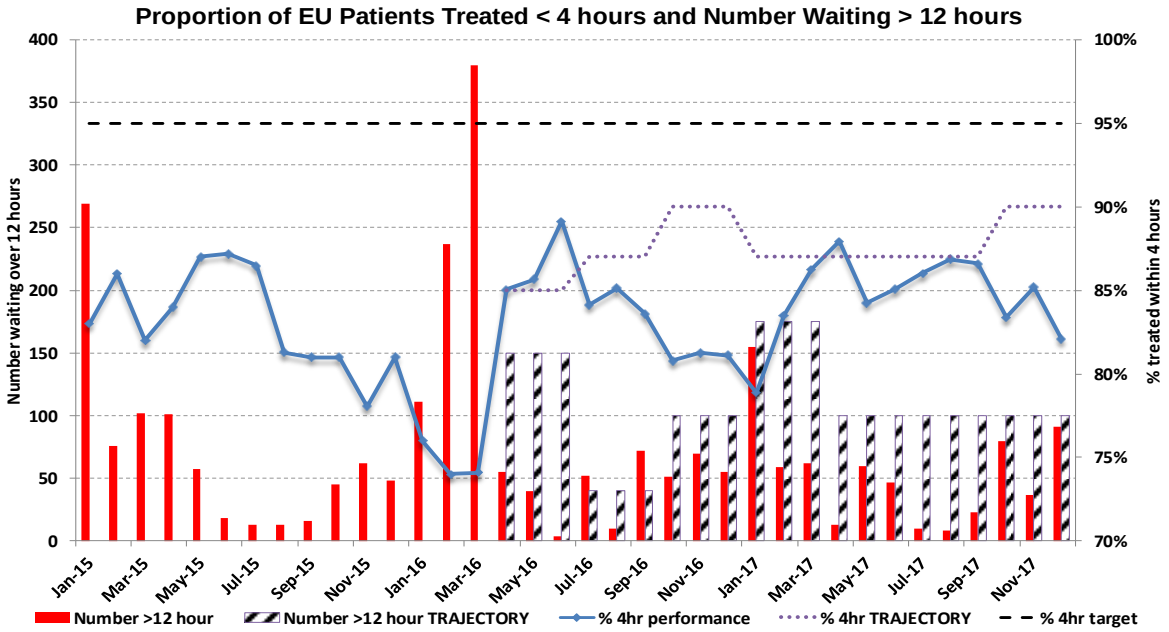


In respect of ambulance handover delays, performance in December had fallen to 49% for patients handed over within 15 minutes and 85% of patients handed over within an hour. Performance in this area is highly volatile, suggesting the service lacks resilience.

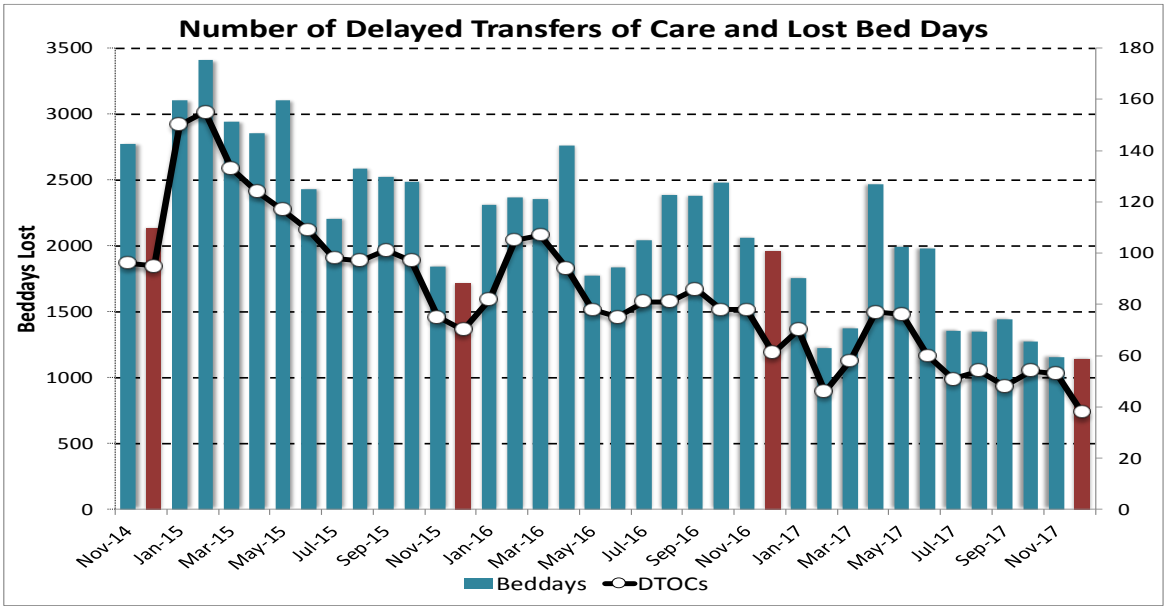




The proportion of patients admitted, discharged or transferred within 4 hours fell in December to 82.1%, against the WG expected level of performance of 95% and the UHB's IMTP trajectory of 90%. The number of patients waiting in excess of 12 hours increased to 91, below the IMTP trajectory of 100, but in excess of WG's standard of zero. These figures exclude patients where there has been clinical justification for the patient requiring extended periods of care and observation within the Emergency Department footprint.



At the December 2017 census point, the UHB recorded that 38 patients had their care pathway delayed as per formal WG rules. The number of bed days attributed to patients whose care was delayed was 1140 in the month, equating to 37 beds per day. This is the lowest level for over 3 years and meets the Welsh Government's expectation to deliver continuous reduction.



How do we compare with our peers?

The latest performance data available indicates that C&V performs within or better than the Welsh average.

Month	Oct-17	Oct-17	Nov-17 (Prov)	Nov-17
HB	4 Hour	Patients >12Hrs	Red Call<8 Minutes	Ambulance Waits>1 Hr
ABM	79.1%	706	73.4%	698
AB	87.3%	246	71.5%	305
BCU	78.7%	1262	77.6%	892
C&V	83.4%	80	77.5%	188
CT	88.7%	183	73.7%	3
HD	85.4%	580	65.4%	111
Wales	83.5%	3057	73.0%	2254
C&V Rank	4/6	1/6	2/6	3/6

The UHB has the 4th highest rate of delayed transfers of care of patients aged over 75 years overall in Wales for non-Mental Health, whilst the Mental Health rate is the 5th highest. Recognising that for the past 5+ years, the UHB has been the worst performer in this area, this position would indicate that the levels of improvement made by the UHB in improving the discharge process and our approach to integrated care are relatively speaking far better than those seen in other Health Boards

November-17		Wales	ABM	AB	BCU	C&V	CT	HDda	Powys	C&V Rank
No. of DTOCs per 10,000	Non Mental Health	140.6	123.6	164.5	163.2	153.8	138.5	68.6	174.3	4/7
	Mental Health	3.2	5.9	2.0	2.3	3.1	2.8	3.4	2.7	5/7

What are the main areas of risk?

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

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

What actions are we taking?

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

- Winter Plan – developed with our partners, the plan takes a whole system approach to winter. It builds on and maximises what is already in place, in addition to building in some additional resilience. This includes:
  - Tactical deployment of additional bed capacity
  - Maximising our integrated models of care – CRT; Integrated discharge team; Increased capacity for Residential Discharge to Assess services (2 beds)
  - '7 days no delays' - 4 patient flow escalation weeks (1 in each of Dec, Jan, Feb & March) as a 'firebreak' approach to produce a step-change in performance, safety

and patient experience - focusing on patient flow, increasing discharge, reducing length of stay and maximising admission avoidance
    - Increased GP OOH resilience in line with demand
    - Additional Senior Decision Makers at the front end
    - Additional ward cover
    - Dedicated clinical team to focus on the management of outliers
- Development of alternative pathways / models including:
- Emergency General Surgery model (commenced October) – second dedicated general surgery consultant during day time hours to support the EU and Surgical Assessment Unit. CEPOD (emergency surgical theatre) capacity has also increased
- Continued joint working with WAST to develop and implement new EU attendance avoidance pathways e.g. gynaecology, mental health
- Extending & maximising Ambulatory Emergency Care model at UHW – better streaming of patients with ambulatory sensitive conditions away from ED. Looking at what we can do further over winter e.g. extending opening hours. In addition, co-location of GP OOHs commenced Nov 2017
- Moving 'unplanned' to 'planned' – e.g. urology 'hot slots' as part of new urology on-call cover and Medicine Clinical Board / Patient Access test of change of planned slots for GP referrals (initiated as part of the escalation week)

5) GP OUT OF HOURS SERVICES (OOH)

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

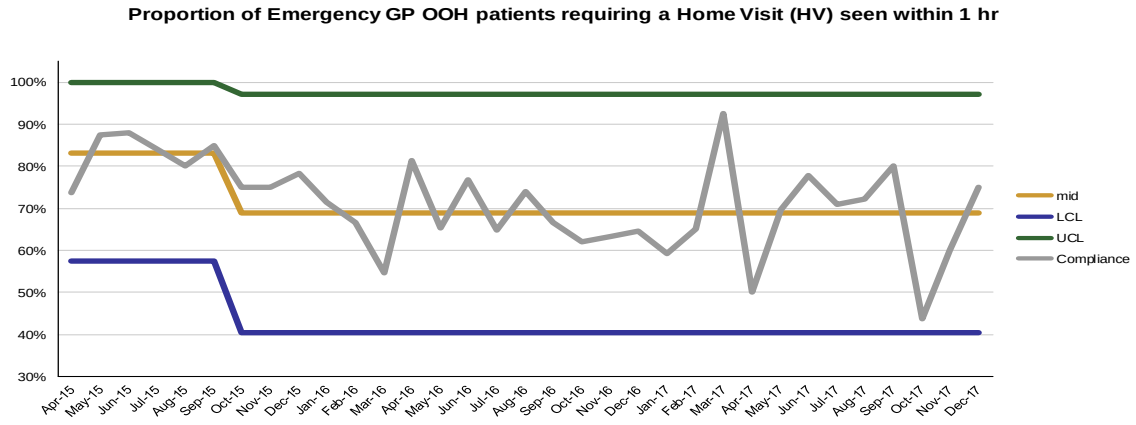
In summary for December, the UHB achieved the following:

- 5 areas were reported as Green (7 reported for October)
- 2 areas were reported as Amber (2 reported for October)
- 10 areas were reported as Red (8 reported for October)

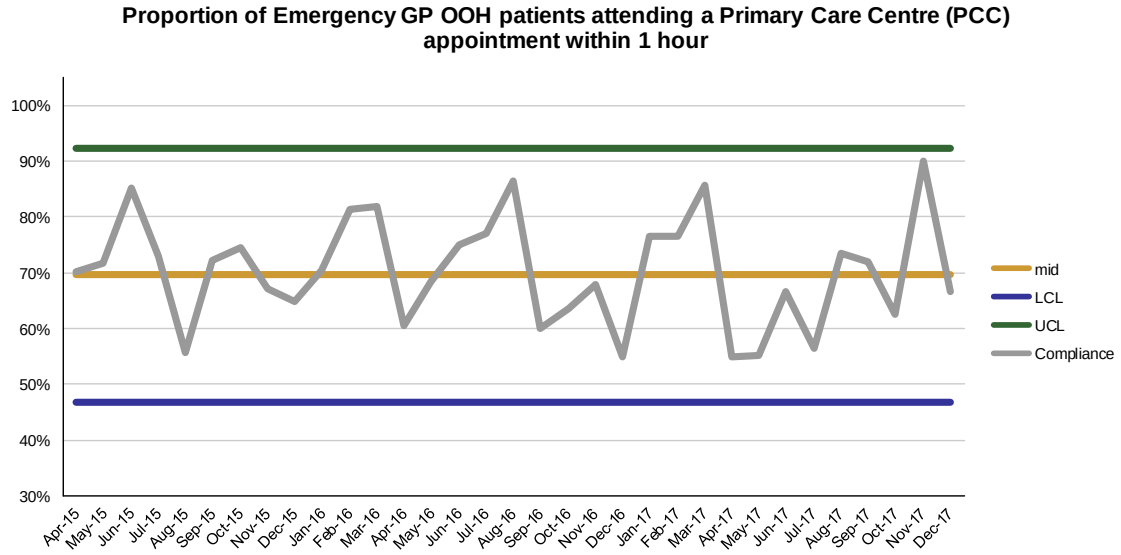
	Demonstrates volumes only		Dec-17			
Standard	**Description**	**Target**	Total	Result	Score	
Telephone Services						
Telephone Calls	Number of calls answered within target	95% ans. in 60 seconds	**11761**	**8960**	**76%**	
		100% ans. in 120 seconds	**11761**	**9910**	**84%**	
Abandoned Calls	No. of callers who abandon after 60 secs.	No more than 5%	**11761**	**677**	**6%**	
Handling	% of calls recording the correct demographics	100% Correct	**11761**	**11761**	**100%**	
Telephone Triage Services						
Urgent Triage	No. of urgent calls, logged & returned	98% triaged within 20 mins	**3510**	**2132**	**61%**	
Routine Triage	No. of routine calls, logged & returned	98% triaged within 60 mins	**4790**	**2753**	**57%**	
Immediate Life Threatening (ILT) Conditions						
Referral	Number of life threatening conditions identified	100% within 3 mins	**289**	**289**	**100%**	
Home Visiting						
Home Visits	The number and percentage of home visits	No target	**10507**	**721**	**7%**	
HV P1 (Emerg)	No. of face to face contacts within one hour	75% seen within one hour	**12**	**9**	**75%**	
	No. of face to face contacts within two hours	100% seen within two hours	**12**	**11**	**92%**	
HV P2 (Urgent)	No. of face to face contacts within two hours	98% seen within two hours	**246**	**154**	**63%**	
HV P6 (	No. of face to face contacts within six hours	98% seen within six hours	**463**	**245**	**53%**	
Primary Care Centre Appointments						
PCC	No. and percentage of PCC attendances	No target	**10507**	**3108**	**30%**	
PCC P1 (Emerg)	No. of face to face contacts within one hour	75% seen within one hour	**15**	**8**	**53%**	
	No. of face to face contacts within two hours	100% seen within two hours	**15**	**15**	**100%**	
PCC P2 (Urgent)	No. of face to face contacts within two hours	98% seen within two hours	**342**	**227**	**66%**	
PCC P6	No. of face to face contacts within six hours	98% seen within six hours	**2751**	**2631**	**96%**	
Transmissions						
Transmissions	No. of reports sent to GP Practice by OOH	100% by 9am	**11757**	**11757**	**100%**	
Other Data						
Rota	Shift fill rate (reported in hours)	100% of shifts filled	**5368**	**3878**	**72%**	

Whilst the seasonal nature of demand was expected to result in an increase in call volumes in December, the increase from 8243 in October to 11761 in December, represented a 13% increase in demand above the volumes observed in December 2016. This significant increase along with a reduction in the proportion (not volume) of shifts filled to 72% in December (3878 hours of care provided) from 87% in October (3627 hours of care provided) were the key factors in performance deteriorating.

The proportion of home visits for patients prioritised as “emergency” which were provided within 1 hour rose to 75% in December, meeting the 75% standard.



The proportion of primary care centre appointments provided within 1 hour for those prioritised as “emergency” fell from 63% to 53%. Performance has remained within the same process control limits for the past 30 months.



How do we compare with our peers?

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

What are the main areas of risk?

The key area of concern continues to be meeting the targets set by WG in particular for P1 Home visits due to the geographical area and triage targets. In December there was a reduction in the 2nd overnight GP shift fill rate which decreased from 90% in November to 72% in December.

What action are we taking?

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

- The latest bundle payment, whereby GPs have to book 6 hot spot shifts over a 3 month period, has been approved from January – March 2018. Easter payment rates have yet to be agreed.
- The post of Deputy Clinical Shift lead is to be advertised externally following the Governance Review of the Service.
- A plan to address the IT issues affecting the delivery of the service has been developed.
- Clinical Practitioners – a study day is taking place on 12th January 2017 with all Clinical Practitioners in terms of the future role, the needs of the service and keeping up their Advanced practice portfolio. Practitioners from the 111 service are attending to look at taking the framework forward within their service.
- A Paediatric Advanced Nurse Practitioner and a triage nurse with a background in Paediatrics will be commencing work in the service over the next few weeks.
- A Workforce plan is being created to get the service on a more sustainable and performant footing.
- The UHB is exploring with the University opportunities to deploy Advanced Paramedic in the out of hours service in the future.

6) STROKE

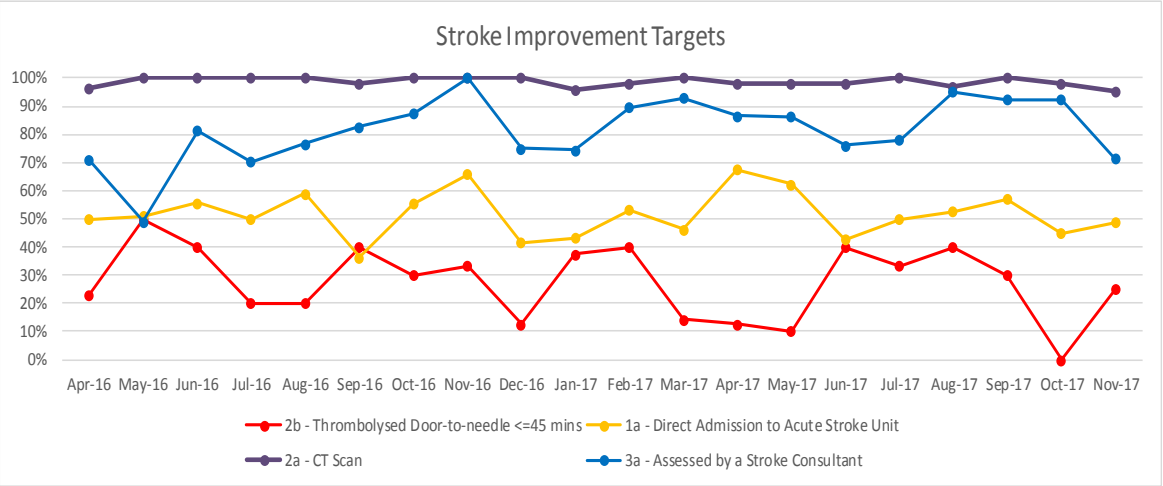
How are we doing?

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

The Welsh Government has chosen four areas within the Quality Improvement Measures (QIMs) to focus on for All-Wales benchmarking. There is a target for three of them, whilst an improvement trend is required for the other. Compliance for both the 4 and 24 hour QIM has deteriorated since May.

WG benchmarking standard		IMTP trajectory	UHB in Nov-17
4 Hour QIM	Direct Admission to Acute Stroke Unit within 4hours	60%	49%
12 Hour QIM	CT Scan within 12 hours	96.0%	95%
24 Hour QIM	Assessed by a Stroke Consultant within 24 hours	89%	71%
45 Minute QIM	Thrombolysis Door to Needle within 45 minutes	Improve	25%

Trends in performance are shown below:



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

Stroke Care Performance Indicators	*Nov-16*	*Dec-16*	*Jan-17*	*Feb-17*	*Mar-17*	*Apr-17*	*May-17*	*Jun-17*	*Jul-17*	*Aug-17*	*Sep-17*	*Oct-17*	*Nov-17*
1. Access													
1a - Percentage of All Stroke Patients Thrombo	13.0%	28.6%	17.0%	20.8%	16.7%	17.8%	17.2%	10.0%	7.3%	15.9%	19.2%	11.3%	9.5%
1b - Percentage of Eligible Stroke Patients Thr	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2. Time													
2a - Thrombolysed Patients with Door-to-needl	33.3%	0.0%	12.5%	10.0%	0.0%	0.0%	10.0%	40.0%	0.0%	20.0%	20.0%	0.0%	25.0%
2b - Thrombolysed Door-to-needle <=45 mins	33.3%	12.5%	37.5%	40.0%	14.3%	12.5%	10.0%	40.0%	33.3%	40.0%	30.0%	0.0%	25.0%
2c - Thrombolsyed Patients with Onset-to-Nee	33.3%	6.3%	12.5%	0.0%	0.0%	0.0%	10.0%	20.0%	0.0%	10.0%	10.0%	0.0%	0.0%
2d - Thrombolysed Patients with Pre and Post	66.7%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	66.7%	90.0%	100.0%	100.0%	100.0%
72 Hour Pathway Care KPIs													
1. Within 4 Hours Care KPI	67.4%	46.4%	40.4%	52.1%	47.6%	68.9%	62.1%	40.0%	46.3%	52.4%	57.7%	43.4%	42.9%
1a - Direct Admission to Acute Stroke Unit	65.9%	41.7%	43.2%	53.3%	46.2%	67.5%	62.3%	42.6%	50.0%	52.5%	57.1%	44.9%	48.7%
1a - TRAJECTORY for above	55.0%	55.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
1b - Swallow Screening	80.5%	74.5%	76.7%	74.5%	75.0%	82.9%	81.5%	63.8%	71.8%	71.7%	76.0%	66.0%	70.0%
2. Within 12 Hours Care KPI	100.0%	100.0%	95.7%	97.9%	100.0%	97.8%	98.3%	98.0%	100.0%	96.8%	100.0%	98.1%	95.2%
2a - CT Scan	100.0%	100.0%	95.7%	97.9%	100.0%	97.8%	98.3%	98.0%	100.0%	96.8%	100.0%	98.1%	95.2%
2a - TRAJECTORY for above	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
3. Within 24 Hours Care KPI	93.5%	51.8%	63.8%	77.1%	73.8%	71.1%	65.5%	58.0%	68.3%	81.0%	75.0%	73.6%	71.4%
3a - Assessed by a Stroke Consultant	100.0%	75.0%	74.5%	89.6%	92.9%	86.7%	86.2%	76.0%	78.0%	95.2%	92.3%	92.5%	71.4%
3b - Assessed by a Stroke Nurse	95.7%	92.9%	97.9%	89.6%	95.2%	95.6%	93.1%	90.0%	97.6%	96.8%	92.3%	88.7%	92.9%
3b - TRAJECTORY for above	70.0%	70.0%	88.0%	88.0%	88.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
3c - Assessed by One of OT, PT, SALT	95.7%	60.7%	72.3%	87.5%	81.0%	84.4%	75.9%	72.0%	85.4%	85.7%	82.7%	81.1%	100.0%
4. Within 72 Hours Care KPI	97.8%	69.6%	78.7%	91.7%	83.3%	95.6%	75.9%	82.0%	90.2%	85.7%	76.9%	92.5%	97.6%
4a - Formal Swallow Assessment	100.0%	68.0%	41.7%	82.4%	76.9%	85.7%	73.7%	65.0%	82.4%	82.6%	75.0%	89.5%	100.0%
1a - TRAJECTORY for above	84.0%	84.0%	84.0%	84.0%	84.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
4b - OT Assessment	97.6%	84.0%	100.0%	93.3%	90.0%	100.0%	86.3%	94.0%	93.9%	92.9%	93.8%	91.3%	97.4%
4c - Physiotherapy Assessment	100.0%	90.4%	100.0%	97.9%	95.2%	100.0%	94.3%	98.0%	97.3%	95.0%	93.9%	100.0%	100.0%
4d - SALT Communications Assessment	97.1%	71.1%	88.9%	96.7%	90.9%	95.7%	75.0%	76.9%	90.9%	84.2%	78.8%	93.9%	100.0%
Patients Treated per Month	46	56	47	48	42	45	58	50	41	63	52	53	42

How do we compare with our peers?

The latest available benchmarking data across Wales is for November 2017, indicating that the UHB's relative performance has deteriorated against 3 of the 4 bundles.

HB	4 Hours	12 Hours	24 Hours	Door to Needle <= 45 Minutes
ABM	35.2%	94.5%	73.6%	22.2%
AB	43.4%	96.2%	83.0%	20.0%
BCU	45.1%	95.6%	82.4%	14.3%
C&V	42.9%	95.2%	71.4%	25.0%
CT	61.1%	100%	66.7%	0%
HD	83.6%	100%	85.1%	75.0%
Wales	50.5%	96.6%	78.2%	27.1%
C&V Rank	5/6	5/6	5/6	2/6

What are the main areas of risk?

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

The greater operational challenges to delivery are:

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

What actions are we taking?

4hr target:

- Review the Code Stroke 2 pathway with the aim to reduce the number of inappropriate calls to the stroke team
- Re-circulate inpatient pathway for query/ confirmed strokes on inpatient wards
- Review rehab pathway for patients on Stroke Rehabilitation Centre who do not require stroke specific rehabilitation / do not have rehab potential

Thrombolysis:

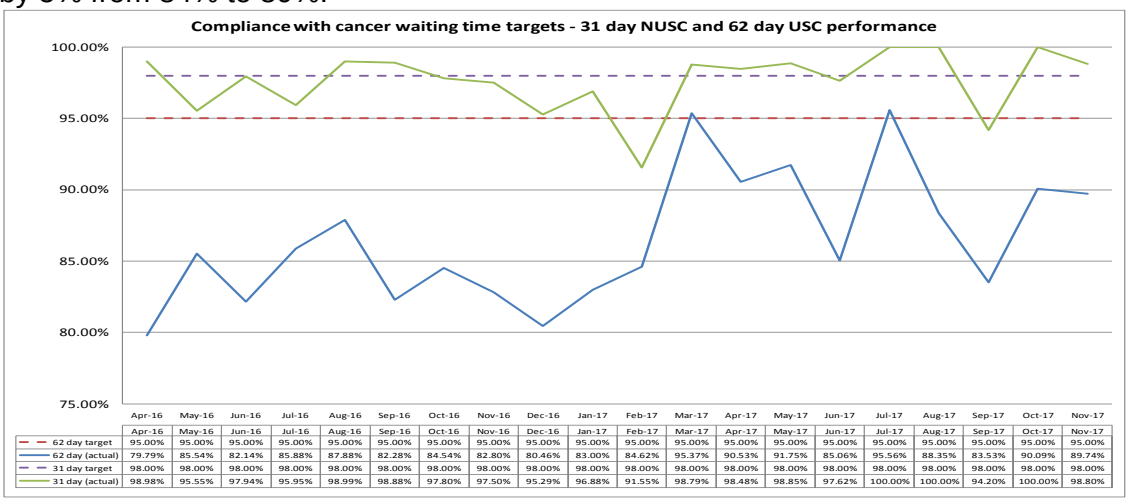
- Process map the thrombolysis pathway to look for areas of improvement. The Continuous Service Improvement team to facilitate.
- Routine Cause Analysis forms are being completed at weekly breach meetings for patients who have breached the 45 min target. Breach reasons taken to SOG.

7) CANCER

How are we doing?

The Health Board continues to perform close to or above target (98%) for patients on the Non-urgent suspected cancer 31 day pathway. Discrete performance for November 2017 is 98.80%.

November's performance for patients on the urgent suspected cancer 62 day pathway is 89.74%, against the target of 95%. Performance quarter to date is 89.91% against an IMTP trajectory of 91%. Year to date performance has improved by 5% from 84% to 89%.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
62 day target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
62 day (actual)	79.79%	85.54%	82.14%	85.88%	87.88%	82.28%	84.54%	82.80%	80.46%	83.00%	84.62%	95.37%	90.53%	91.75%	85.06%	95.56%	88.35%	83.53%	90.09%	89.74%
31 day target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
31 day (actual)	98.98%	95.55%	97.94%	95.95%	98.99%	98.88%	97.80%	97.50%	95.29%	96.88%	91.55%	98.79%	98.48%	98.85%	97.62%	100.00%	100.00%	94.20%	100.00%	98.80%

The Cabinet Secretary announced in November 2017 intentions to implement a Single Cancer Pathway (SCP) from April 2019, in place of the existing two cancer waiting time targets. Whilst formal guidance has not yet been issued confirming the target and rules, the current assumption is that the target will be 95% of patients must be seen, diagnosed and treated within 62 days of the point of suspicion. Health Boards will be expected to formally shadow report from 1 January 2018, with the first return due to Welsh Government in March 2018. Since April 2017, Health Boards have been informally reporting on the SCP, although data definitions have changed since its start – with April's data now being excluded as a result. Discrete monthly performance based on internal shadow reporting is as follows:

SCP	May 17	Jun 17	Jul 17	Aug 17	Sept 17	Oct 17
% Performance (no suspensions)	66.10%	74.25%	68.21%	70.48%	60.96%	84.44%

How do we compare with our peers?

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

Oct 17	ABM	AB	BCU	C&V	CT	HD	Wales	C&V rank
Non USC	95.0%	93.5%	98.1%	100 %	98.4%	97.4%	96.6%	1/6
USC	85.1%	86.7%	88.4%	91%	84.7%	87.3%	87.4%	1/6

What are the main areas of risk?

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

- Whilst we continue to treat patients in turn or according to their clinical priority, our backlog of untreated patients waiting > 62 days fluctuates and remains too high. 83% of the total backlog is GI. Whilst upper and lower GI have a lower conversion rate than other tumour sites, the UHB needs to further reduce the backlog in GI and other tumour sites to be assured of continuous improvement and achieving the levels of performance set out in our IMTP.
- The need to balance waiting time target demands against clinical urgency across all diagnostic areas – specifically radiology, pathology and endoscopy
- Full implementation of the Single Cancer Pathway. Whilst the Single Cancer Pathway is conceptually simple (and strongly supported by the UHB), it is operationally complex. The main issues for the Health Board are: (i) Lack of written guidance from Welsh Government / Cancer Network on the target and rules (ii) Aligning the UHB's Project Structure to national structure and ensuring project resources are in place to mange and deliver the project (iii) Ensuring capacity and systems for tracking are fit for purpose (iv) Ensuring demand and capacity balance for the forecast increase in demand and the speed / timeliness within which diagnostic tests will need to be undertaken and reported (v) Ensuring IT systems are fit for purpose and there is an agreed data set for Wales (vi) Identifying the point of suspicion - Wide programme of Clinical engagement required and processes / system will need to be changed.

What actions are we taking?

The UHB remains committed to achieving and sustaining improvement. The approach remains largely similar to that previously reported:

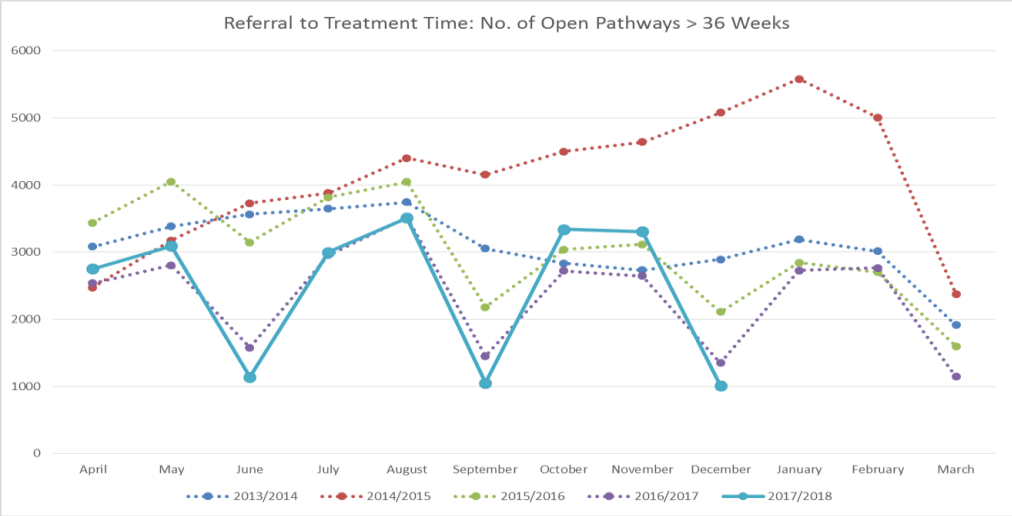
- UHB continues to do the right thing and treat patients in turn, according to their clinical priority.
- Patients continue to be tracked at both Directorate and UHB level, with actions escalated as appropriate.

- A specific project focusing on lower and upper GI pathway redesign and improvement is ongoing with executive and improvement support.
- The UHB continues with implementation of its endoscopy plan to reduce the backlog and balance demand and capacity, thereby improving patient experience and access to endoscopy services.
- The UHB is continuing to work with the All Wales Cancer Network and other Health Boards to prepare for the implementation of the Single Cancer Pathway. The delivery of the project and resources to address capacity gaps specifically (tracking and diagnostics) will require additional investment. This will be taken forward via the Health Board's IMTP / BCAG process. Cancer Services are planning to bring all tumour sites onto the UHB's tracking system (Tentacle) and are working with IT to develop our systems. Local modelling and regional approach to demand and capacity is in development through the regional diagnostics group - current estimated of uplift in capacity are between 20 and 30%. Initial Clinical engagement through UHB's Cancer Leads group.

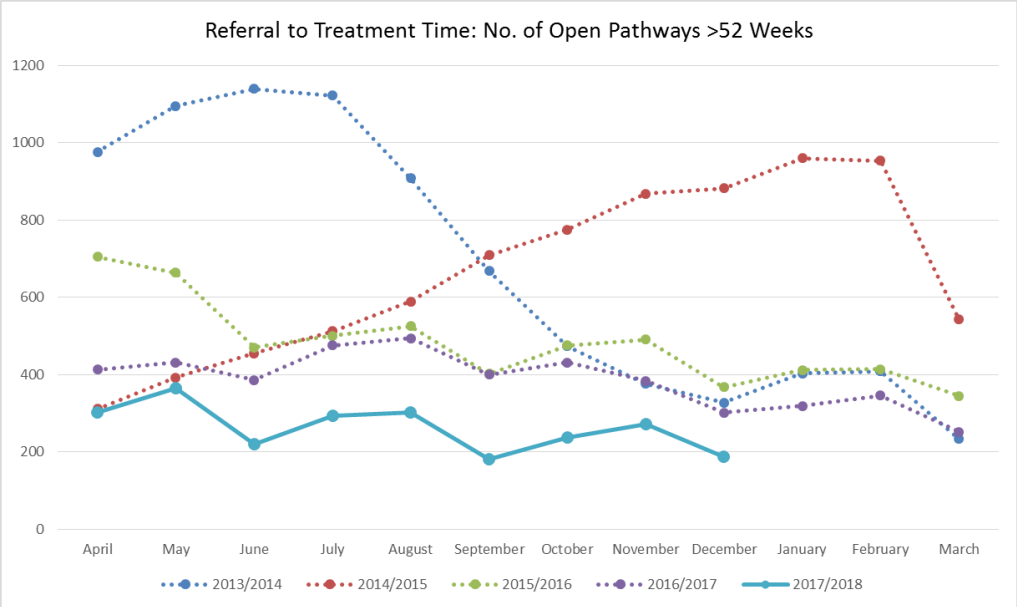
8) ELECTIVE ACCESS

How are we doing?

The UHB achieved its elective referral to treatment time improvement trajectory in December reducing the number of patients waiting in excess of 36 weeks to 1012 against the milestone of 1023 patients.

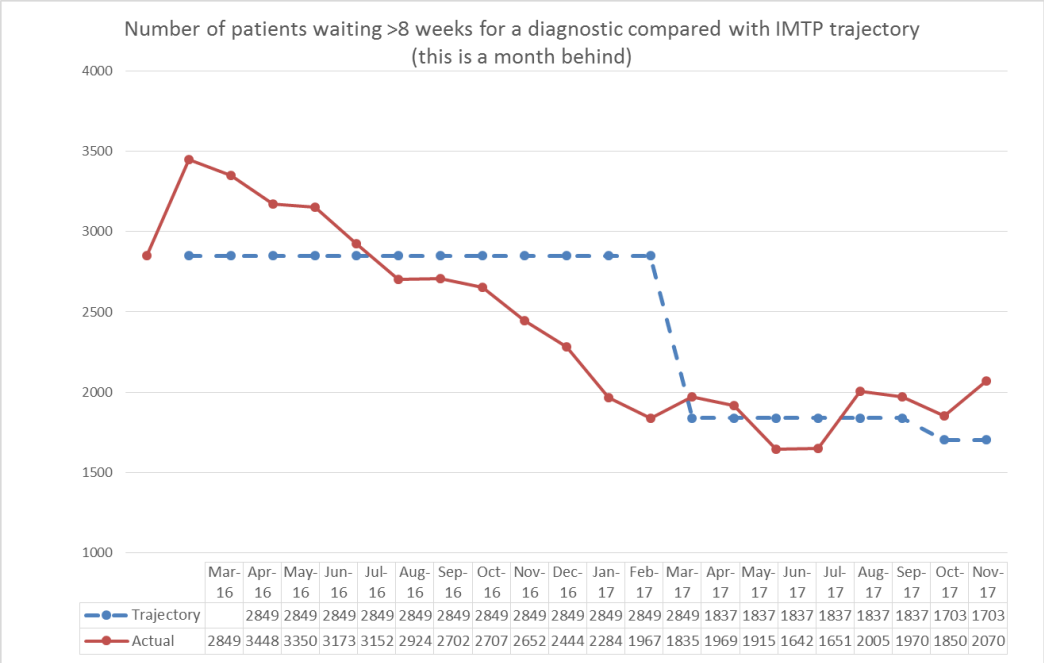


There has been a decrease in the numbers of our longest waiting patients; there were 187 patients waiting greater than 52 weeks (276 in November).



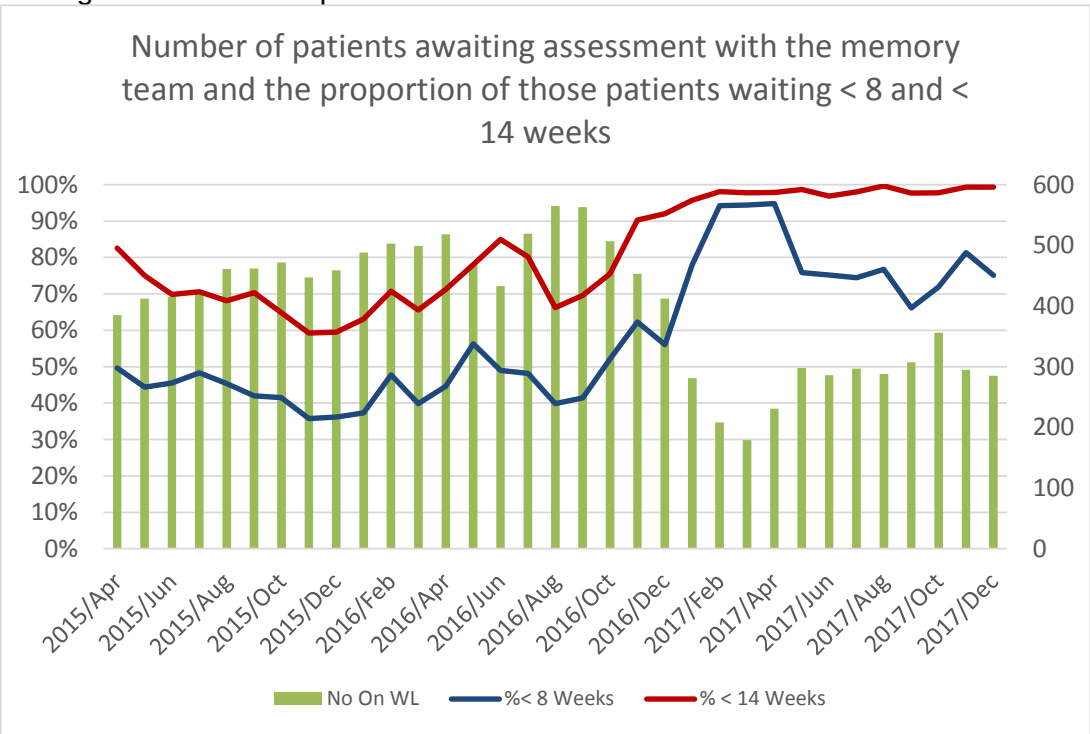
There were 13,396 patients waiting in excess of 26 weeks on an elective referral to treatment time pathway at the end of December, equating to 83% of patients waiting under 26 weeks. This performance is below the 86% improvement trajectory submitted in the annual plan.

The December position for the number of patients waiting more than 8 weeks for a diagnostic test is 1869. Whilst representing a 5% reduction on the quarter two ends position, the UHB did not achieve the quarter 3 IMTP target of 1703. Whilst the UHB had implemented a number of recovery actions in December, the timing and volume of additional capacity secured was insufficient. The main areas off plan were cardiology (echocardiograms) and endoscopy.



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Trajectory		2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	2849	1837	1837	1837	1837	1837	1837	1703	1703
Actual	2849	3448	3350	3173	3152	2924	2702	2707	2652	2444	2284	1967	1835	1969	1915	1642	1651	2005	1970	1850	2070

At the end of December 2017, 99% of patients requiring a memory assessment were waiting less than 14 weeks, against a standard of 95%. The number of patients waiting less than 8 weeks, deteriorated from 81% in November to 75% in December 2017. Since October 2017 GP-led clinics have been reinstated to stabilise the waiting list and reduce the worsening trajectory. This has reduced the waiting times down to a present maximum of 10-12 weeks.



How do we compare with our peers?

The All-Wales waiting time position at the end of October 2017, shown below, indicates that Cardiff & Vale ranked 4th for the % of patients waiting less than 26 weeks, 4th for the lowest number of patients waiting in excess of 36 weeks and 6th for the number of patients waiting in excess of 8 weeks for a diagnostic.

October 2017	Wales	ABM	AB	BC	C&V	CT	HD	C&V Rank
% < 26 weeks -RTT	85.1%	86.9%	89.5%	80.5%	84.1%	86.7%	83.6%	4/6
No. > 36 weeks - RTT	22931	4463	1517	9608	3340	738	3265	4/6
No. > 8 weeks diagnostic	5980	349	1780	497	1850	1504	0	6/6

What are the main areas of risk?

The RTT target for year end is 800 with the expectation that there will be no more than 4 areas with breaches; Orthopaedics, Ophthalmology and Neurosurgery are three of those areas. There is an ongoing reliance on the private sector to provide additional capacity.

What actions are we taking?

- The UHB, with the Welsh Government waiting time improvement monies, continues to secure additional capacity – both internally and externally – to achieve the revised target of no more than 800 greater than 36 week breaches by the end of March
- The UHB has procured additional endoscopy activity through an insourcing arrangement with an external company – anticipated start date 27th January 2018
- The Specialist and Surgery Clinical Boards are developing a plan and options to be considered to address theatre capacity constraints for neurosurgery
- The Orthopaedics Directorate continues to maximise opportunities resulting from re-provision of one theatre through a 'modular build' laminar flow unit – operational at the end of November 2017

9) HEALTHCARE ACQUIRED INFECTIONS

How are we doing?

Welsh Government Reduction Expectations 2017/18

The requirements for Cardiff and Vale UHB are as follows:
- *C.difficile*: To reduce to 26 cases per 100,000 population by end March 2018.
- *Staph. aureus* bacteraemia: To reduce to 20 cases per 100,000 population by end March 2018.
- *E.coli* bacteraemia: To reduce to 60 cases per 100,000 population by end March 2018.

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

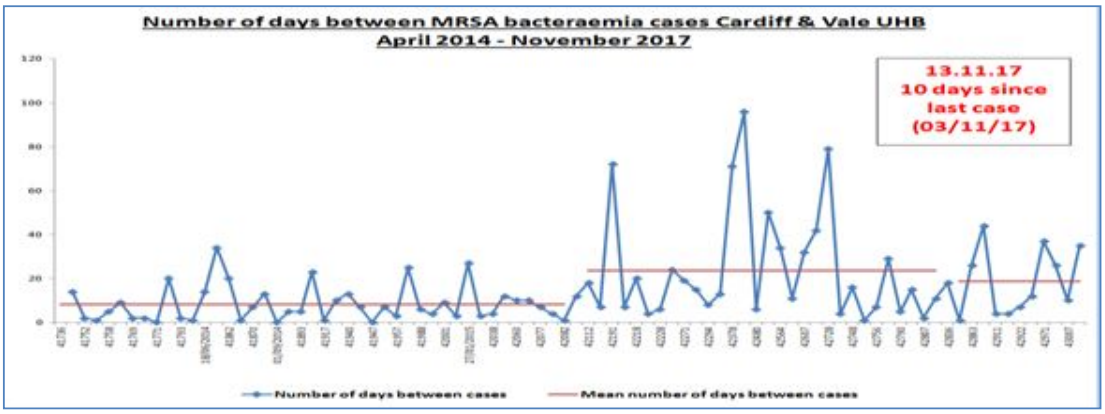
Target Organism	Total Allowable for 2017/18	Month 9 target	Apr-Dec 2017
C. difficile	126	94	98
***S. aureus* (Total)**	96	72	117
E. coli	290	218	262

Included within the *S. aureus* total were 12 MRSA cases against a target of zero.

Position as at Quarter 3:

C. difficile: The position has improved considerably with regard to *C. difficile* cases during November and December. 4 cases only were recorded during November and 6 cases in December, these are the lowest number of cases in two consecutive months that we have seen in the last 3 years. We need to continue to see these improved numbers of cases to meet the reduction expectation by end March 2018. It is still possible.

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



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

***E.coli* blood stream infections:** There has been a modest improvement in *E.coli* cases in November and December 2017, which means that we can still achieve the required reduction expectation by end financial year, but we will need to see fewer than 10 cases of *E.coli* per month over the next three months to achieve this.

How do we compare with our peers?

C. difficile, S. aureus bacteraemia and *E. coli* bacteraemia monthly commentary, up to Dec 17

Reduction expectation summary (Apr - Dec 17)

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

Not on trajectory to achieve expected reduction by Mar 18
On trajectory to achieve expected reduction by Mar 18

	C. difficile		*S. aureus* bacteraemia		*E. coli* bacteraemia	
	Number (*)	Rate**	Number (*)	Rate**	Number (*)	Rate**
ABM UHB	211 (+109)	52.91	149 (+71)	37.36	417 (+153)	104.57
AB UHB	169 (+60)	38.40	117 (+35)	26.58	361 (+95)	82.03
BC UHB	203 (+68)	38.72	145 (+41)	27.66	407 (+59)	77.63
C&V UHB	98 (+4)	26.55	117 (+45)	31.70	262 (+44)	70.98
CT UHB	43 (-1)	19.14	75 (+31)	33.39	220 (+71)	97.95
HD UHB	125 (+51)	43.24	99 (+42)	34.24	350 (+158)	121.07
All Wales	**875 (+271)**	**37.31**	**706 (+242)**	**30.10**	**2028 (+471)**	**86.46**

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

As can be seen from the above summary Cwm Taf are on target to achieve the reduction expectation for *C. difficile* and C&V UHB are only 4 cases above the trajectory to achieve the reduction expectation. No other Health Board is on target to deliver on any of the HCAI reduction expectations for 2017/18.

2017/18 FY summary (Apr - Dec 17)

Number and rate of *C. difficile,* MRSA bacteraemia, MSSA bacteraemia and *E. coli* bacteraemia per 100,000 population by health board, Apr - Dec 17

More cases than Apr – Dec 16
Same cases as Apr – Dec 16
Fewer cases than Apr – Dec 16

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		*E. coli* bacteraemia	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
ABM UHB	211	52.91	15	3.76	134	33.60	417	104.57
AB UHB	169	38.40	12	2.73	105	23.86	361	82.03
BC UHB	203	38.72	32	6.10	113	21.55	407	77.63
C&V UHB	98	26.55	12	3.25	105	28.45	262	70.98
CT UHB	43	19.14	10	4.45	65	28.94	220	97.95
HD UHB	125	43.24	7	2.42	92	31.82	350	121.07
P THB	18	18.08	0	0.00	1	1.00	3	3.01
V NHST	8	N/A	0	N/A	3	N/A	8	N/A
All Wales	**875**	**37.31**	**88**	**3.75**	**618**	**26.35**	**2028**	**86.46**

* Rate per 100,000 population

When the number of cases seen in April to December 2017 is compared with the same period in 2016 it can be seen that Cardiff and Vale has seen a reduced number of cases of *C. difficile* in Apr-Dec 17 vs 2016 and also fewer cases of *E.coli* BSI, *Staph. aureus* BSI (MRSA & MSSA) cases have increased compared with 2016 figures. BCU and Powys Health Boards have also reduced their cases of *C. difficile* compared with April – December 2016; Hywel Dda HB is the only health board to reduce *Staph. aureus* BSI; Velindre NHS Trust is the only other NHS organisation to reduce their cases of *E.coli* BSI.

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

C. difficile*:*
Work to reduce *C. difficile* through focussing on hotspots, improving early isolation of patients with diarrhoea, improving treatment and adhering to antimicrobial prescribing guidance appears to be making a difference to our numbers of cases month on month. We need to understand what is making the difference and ensure that the good work is spread across the whole organisation and sustained, so that our numbers of *C. difficile* cases continue to decrease.

Staphylococcus aureus:
Our figures for *Staphylococcus aureus* blood stream infections are heading in the wrong direction and we are no longer able to achieve the required reductions for 2017-18. It is extremely disappointing that our MRSA blood stream infection position has also slipped back. We need to refresh our approach to reducing this burden of infection focussing on medical device management and implementation of ANTT across the Health Board and more focussed work in the community related to wound management and prevention of infection in substance misusers. With regard to the increases in MRSA bacteraemia, we need to reverse the upward trend in cases urgently and may need to challenge clinical boards again to discuss cases of MRSA bacteraemia (and other healthcare associated infections) with the Nurse Director / DIPC to bring back a focus on not tolerating cases of MRSA and preventable infections.

E.coli:
Our figures for *E.coli* blood stream infections are lower in April to December 2017 vs the same period in 2016. It was a challenging new target introduced this year and we will probably not achieve the required reduction by end March 2018. However, tracking our cases month on month has shown the significant burden of infection that is related to *E.coli* blood stream infections and we have seen some improvement. As this target is linked to the UK Antimicrobial Resistance Strategy commitment to reduce Gram negative blood stream infections by 50% by 2020/21 there will be further pressure to make improvements over the coming years. A significant burden of *E.coli* blood stream infection presents from the community, but even so, it is estimated that a significant proportion of these cases are healthcare associated and therefore potentially preventable. We have started a UTI improvement group through the PCIC clinical board to take forward work in the community to improve the management of UTI and urinary catheters in the community with a view to that feeding into reductions in *E.coli* BSI. This work needs to continue and to move from pilot work to spreading good practice and improvements in UTI prevention and management across the broader healthcare services of the Health Board as soon as possible.

1000 Lives HCAI Collaborative:
The Health Board contributed a team to attend the launch event of the 1000 Lives HCAI collaborative in October 2017. The next collaborative learning event will be in April 2018. The Health Board needs to use the Quality Improvement approach and

engagement with the 1000 Lives collaborative to implement and embed interventions to reduce the burden of HCAI and Antimicrobial resistance across our organisation.

RECOMMENDATION:

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