

Local Partnership Forum

Thu 08 June 2023, 10:00 - 12:00

MS Teams

Agenda

10:00 - 10:00
0 min

1. Welcome and Introductions
Rachel Gidman

10:00 - 10:00
0 min

2. Apologies for Absence
Rachel Gidman

10:00 - 10:00
0 min

3. Declarations of Interest
Rachel Gidman

10:00 - 10:00
0 min

4. Minutes of the meeting held on 8 February 2023
Rachel Gidman

 4. LPF minutes 13.04.23.pdf (8 pages)

10:00 - 10:10
10 min

5. Action Log
 5. LPF action log 13.04.23.pdf (2 pages)

10:10 - 10:30
20 min

6. Chief Executives Report
Verbal Suzanne Rankin

10:30 - 11:20
50 min

7. Integrated Performance Report
Fiona Kinghorn / Jason Roberts / Rachel Gidman / Paul Bostock / Catherine Phillips

- Population Health
- Quality and Safety
- People
- Operational Performance
- Finance

 7. Integrated Performance Report May 2023.pdf (32 pages)
 7.1 WOD KPI Report Apr-23.pdf (2 pages)

Saunders Naeff
24/05/2023 15:40:16

11:20 - 11:35
15 min

8. Strategic Equality Plan



Mitchell Jones

 8. LPF - SEP Paper - June 2023 (001).pdf (5 pages)

11:35 - 11:45
10 min

9. Generic Terms of Reference for the Clinical Board Local Partnership Forums

Rachel Gidman

 9. CB LPF ToR cover draft.pdf (2 pages)
 9.1 CB LPF Generic ToR v3 final version.pdf (9 pages)

11:45 - 11:45
0 min

10. Review of meeting (items to be brought to the attention of the Board

Rachel Gidman

11:45 - 11:45
0 min

11. Any other business previously agreed with the Co-Chairs

Rachel Gidman

11:45 - 11:45
0 min

12. Future Meeting Arrangements:

- Thursday 10 August 2023 at 10am via Teams, with a staff rep pre-meet at 8.45 am

Saunders, Nathan
24/05/2023 13:40:16

LOCAL PARTNERSHIP FORUM MEETING
Thursday 13th April 2023 at 10am, via Teams

Present

Dawn Ward	Chair of Staff Representatives – BAOT/UNISON (Chair)
Rachel Gidman	Executive Director of People and Culture (Co-chair)
Abigail Harris	Executive Director of Strategic Planning
Bill Salter	UNISON
Ceri Dolan	RCN
Claire Whiles	Assistant Director of Wellbeing, Culture and OD
Fiona Jenkins	Executive Director of Therapies and Health Science
Fiona Kinghorn	Executive Director of Public Health
Janice Aspinall	RCN
Joanne Brandon	Executive Director of Communications and Engagement
Jonathan Pritchard	Assistant Director of People Resourcing
Jonathan Strachan-Taylor	UNISON
Julia Davies	UNISON
Katherine Davies	RCN
Karina MacKay	BDA
Lorna McCourt	UNISON
Mathew Thomas	UNISON
Meriel Jenney	Medical Director
Mike Jones	Independent Member - Trade Union
Paul Bostock	Chief Operating Officer
Pauline Williams	RCN
Peter Hewin	BAOT/UNISON
Robert Mahoney	Deputy Director of Finance
Steve Gauci	UNISON

In Attendance

Mitchell Jones	Head of Equity and Inclusion
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Apologies

Andrew Crook	Head of People Assurance and Experience
Catherine Phillips	Executive Director of Finance
James Quance	Interim Executive Director of Corporate Governance
Jason Roberts	Executive Nurse Director
Joe Monks	UNISON
Katrina Griffiths	Head of People Services
Marie Davies	Deputy Director of Strategic Planning
Lianne Morse	Deputy Director of People and Culture
Peter Welsh	General Manager, UHL and Barry
Rachel Pressley	Deputy Head of People Assurance and Experience
Rhian Wright	RCN
Suzanne Rankin	Chief Executive
Timothy Davies	Head of Corporate Business

Secretariat

Chandra Almeida	People and Culture Coordinator (Minutes)
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LPF 23/015 WELCOME AND APOLOGIES

Dawn Ward (DW) welcomed everybody to the meeting and apologies for absence were noted.

LPF 23/016 DECLARATIONS OF INTEREST

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

LPF 23/017 MINUTES OF THE PREVIOUS MEETINGS

Fiona Kinghorn (FK) requested to make changes to the paragraph on page 1 regarding flu vaccine uptake and primary doses for Covid walk-ins. The minutes were otherwise agreed to be an accurate record of the meeting.

LPF 23/018 ACTION LOG

- Regular updates regarding the COVID-19 inquiry and investigation have been included in the 2023/4 LPF workplan.
- Staff side have submitted their comments to Marie Davies (MD) on both the IMTP and strategy refresh following an extraordinary Workforce Partnership Group (WPG) meeting.
- Staff side will arrange further extraordinary meetings to discuss the impact of the pandemic on staff as required.
- All other actions were signed off as complete.

LPF 23/019 MATTERS ARISING

Matters arising at the pre-meet included:

- Staff side would like sight of the IMTP planning cycle in order to align this with their clinical board (CB) engagement.
- The new People and Culture (P&C) committee was queried and confirmed as commencing on 16th May 2023. Rachel Gidman (RG) and the chair of the committee Sara Mosley are currently reviewing the terms of reference and will share these with the group once finalised.

LPF 23/020 CHIEF EXECUTIVE'S REPORT

The CEO report was delivered by Paul Bostock (PB) in Suzanne Rankin's (SR) absence. Key points included:

- Winter pressures – PB gave thanks and recognition to everybody that has helped the organisation get through winter, noting that though it's been a better winter than expected it has still been very difficult. PB hopes that now we are in spring we can continue with the improvements we have started to make.
- Six Goals programme – PB advised that this agenda is all about transforming urgent care and providing alternatives to prevent patients having to come into hospital. PB encouraged staff to attend the roadshows that are being held to find out more as everyone has a part to play.
- Industrial action – PB thanked staff for behaving professionally during the recent industrial action and said that whatever the outcome of the conversation between Welsh government (WG) and TUs next week we will continue to work together.
- IMTP – The draft plan was submitted to board and signed off at the end of March. We are now awaiting a response from WG.

Abigail Harris (AH) gave an update on the IMTP and strategy refresh as part of the CEO report, reflecting on the challenge of submitting a plan with a financial deficit and the unpalatable things the organisation may need to consider. AH feels that the plan submitted strikes the right balance in terms of keeping our services safe but acknowledged that it does not deliver on all ministerial priorities. The timeframe for getting back into financial balance remains under discussion.

AH noted that the strategy refresh will have a greater influence on next year's IMTP; we are aiming to submit the first draft of the refreshed strategy to board in July and this will be shared with LPF. A comprehensive analysis of the strategy feedback has been carried out which on first impressions is not altogether positive;

staff are telling us that they are exhausted and patients are frustrated at the lack of available appointments. AH noted that the ill health within our local communities will also need to shape the plan.

DW thanked the organisation for supporting trade unions (TUs) to take industrial action in a thoughtful and considered way. DW noted that she had previously asked SR where she projected the organisation to be in terms of enhanced monitoring going forward and PB had given reassurance that we are not intending to cut services. However, we know that we cannot continue delivering services in the same way and TUs would like clarity around the plans relating to this. PH also commented on the unpalatable list, noting that it would be helpful to have early sight of what this might include.

AH advised that these fell into 3 categories. The first relates to variable expenditure, for instance variable pay locums. The second relates to planned care, in the same way that we only carried out level 1 and 2 surgery during the pandemic. If we did this, we would need to reassess the threshold for accessing treatment which would be a very difficult conversation. The third area relates to wider transformation and a more radical look at services, for instance changing our urgent and emergency care model. These things are unpalatable because they would have huge consequences for our population.

PB noted that the plan submitted to WG includes the £32 million cost improvement programme and £88 million deficit which we are aiming to address over a 4-year period. The unpalatable list is if WG were to reject this and say that we need to close the gap within a year. This is unlikely, so we will stick to the plan in terms of delivering the productivity improvements and reducing our spend on high-cost agency.

LPF 23/021 INTEGRATED PERFORMANCE REPORT

DW thanked Rachel Pressley (RP) for bringing this item up the agenda as there is always a lot of discussion around the reports at the pre-meet.

PUBLIC HEALTH

FK thanked all staff that work within health protection, noting that there is a lot of work that goes on that people don't see. For instance, there are still got a lot of outbreaks in care homes which shared regulatory services are involved in managing. FK plans to change the reports going forward to include a greater focus on these wider arenas of work. FK also reiterated that the reports often go out of date by the time LPF takes place.

We have received updated guidance from WG with regards respiratory virus management which includes changes to patient testing, household contacts and management of symptoms. Routine symptomatic testing has been paused for patients, staff and the public. If staff have symptoms, the advice is to stay at home and return to work once well again. FK noted that this is the first time there's been a less interventionist approach to Covid management.

FK also advised that a business case for a sustainable health protection system has been taken to board. We have included everything we think it needs, including hepatitis B&C testing and treatment for vulnerable groups and management of complex TB cases. The spring Covid booster campaign has now begun, focussing on vulnerable groups including children over 5 in at risk groups. FK advised that although we expect that the autumn campaign will include staff this is not yet confirmed.

DW thanked FK for her partnership working and commitment to LPF, as well as the robust response she gave outside of the meeting regarding the Marmot region.

Matthew Thomas (MT) responded to the change in Covid guidance and raised the issue of communicating this to staff. This has been circulated via email since the beginning of the pandemic but is not always cascaded by managers which causes staff without email addresses stress and anxiety. MT felt that we need to resolve this

historical issue and work on getting all staff an e-mail address. RG confirmed that she would pick this up with David Thomas (DT) and feedback at the next meeting. Joanne Brandon (JB) added that all corporate information and staff benefits are posted on the staff app which all staff have access to. DW thanked JB but highlighted that staff who don't have email addresses don't feel of equal value.

Steve Gauci (SG) asked that the graphs and information in all LPF reports be made more accessible for people with neurodiversity, for example dyslexia, using different fonts and colours. DW agreed that the quality and safety reports in particular are graph heavy and can be difficult to interpret. RG agreed to follow this up with Jason Roberts (JR).

DW raised the issue of smoking sensation and queried our stance on vaping as an alternative to smoking. FK confirmed that currently we do suggest that vaping is part of the journey towards giving up smoking for certain groups of smokers. Public Health Wales (PHW) is refreshing its statement on vaping due to evidence that younger people are using vapes as an entry point to smoking. Once this is released, we will review our smoking cessation services and assess if we need to change anything.

DW said advised staff side have taken a strong position in support of smoking cessation but have received pushback from some members who have heard that it is within the health board's gift to provide smoking shelters. DW is unsure of the validity of this but said that it would likely be an ongoing and challenging conversation. DW is working with capital estates around providing an enforcement support mechanism alongside encouraging staff to give up smoking.

QUALITY AND SAFETY

DW noted that this report creates a lot of discussion at the pre-meet since it is how we measure the impact of low staffing levels, however JR was not in attendance to respond to questions. DW will raise this with JR outside of the meeting.

The report references a poster with a QR code and the text 'please tell us about your recent experience'. There was a strong sense around the tokenism of this at the pre-meet and alternative ways to capture information were suggested, for instance printing the QR code on business cards or appointment letters to reach more people. PB said he would feed this back to JR, but noted that historically we haven't received a good response to paper surveys and feel that the QR code will generate a better response.

Ceri Dolan (CD) was disappointed that JR was not in attendance as she had wanted to raise issues relating to staff retention and work life balances. CD feels that although JR is supportive of work life balances, this is not feeding down to managers as there has been an increase in reviews relating to work life balances being taken away. CD clarified that this does not relate to hybrid working but basic things, for example staff with children who have additional caring needs. DW noted that the impact of our children's mental health and wellbeing on working parents has featured in recent staff side meetings.

PB confirmed that the organisation's stance is to offer flexible working and deliver work life balance, however, this also needs to meet the needs of the organisation. RG advised that often the problem is how this is interpreted by managers; it needs to be standardised and should be fair and equitable. RG will follow this up with CD.

DW and CD both felt that the increase in nationally reportable incidences is linked to staff shortages. CD felt that that our focus should be on improving things for our existing staff. PB agreed that we need to make the health board an attractive place to work and gave assurance that we wouldn't turn agency off until we have an alternative.

MT raised the concept of digital equipment and used the example of falls devices used in the community. MT felt that utilising these in hospital settings could help reduce the time patients spend waiting for assistance

following a fall. Fiona Jenkins (FJ) said that whilst digital devices are the way forward, inpatients would not be waiting long for assistance following a fall as the ward teams would manage this. DW noted that we do have bed sensors for particularly high-risk patients.

FJ is the executive lead for falls and advised that there is a balance between creating independence and keeping people safe. We know that familiar environments can help patients work towards being independently mobile, whereas multiple ward moves have been linked to increased falls. FJ advised that Medicine have been working on falls assessments for inpatients and there is also preventative work going on in the community to ensure we keep people active and mobile.

PEOPLE AND CULTURE

RG thanked all staff and noted that during recent patient safety walks to UHL porters and radiology staff had been really proud to show off their departments. RG wanted to highlight that despite evidence of burnout, there are still a lot of motivated and enthusiastic people working for the organisation.

P&C have been working closely with CBs during the recent performance reviews, concentrating on KPIs around sickness, turnover, statutory and mandatory training and VBAs. RG shared updates showing further improvements since submission of the report, as follows:

- Sickness reduced to 5.5% in March 2023 after peaking at 8.37% in December 2022. People Services have a workstream focussing on managing attendance and reiterating basics around managing sickness.
- Turnover has dropped to 12.8%, which is an improvement but still higher than we'd like. P&C are working with CBs where turnover is between 7-9% to highlight and learn from areas of good practice.
- Overall compliance for statutory and mandatory training has increased to 79%, while fire safety has increased from 68% to 72%.
- Although we are aiming for 85% VBA compliance, we gave CBs a realistic target of 60% by the end of March. As an organisation we have reached 59%, while PCIC and CD&T have gone beyond 60%. RG noted that we need to do some work around the quality of these to ensure they are not just a tick box exercise.

Many roles within the Employee Wellbeing Service were funded through the Health Charity during the pandemic and there has been ongoing discussion around making these staff permanent. RG confirmed that we have kept all of these staff and the extended service, which is great news both for the individuals and the organisation. RG thanked SG for his work with Claire Whiles (CW) and colleagues around the disability passport, noting that we now need to cascade this to senior leadership board (SLB) and CBs to get them engaged.

The health minister has written to health boards regarding retention, staff wellbeing and compassionate management. RG is happy to cascade the letter and discuss this in more detail at WPG. P&C are already working on workforce sustainability with regards high-cost agency. From 1st April 2023 the organisation has stopped using agency healthcare support workers (HCSW). We didn't use agency HCSW before the pandemic but have since spent around £5 million on the service. Jonathan Pritchard (JP) advised that 179 agency HCSW have since applied to join our bank and there have been no concerns around filling HCSW shifts.

DW noted staff side were curious about the incentive to join the bank, since agency work generally offers higher pay and flexibility. JP advised that they had written to all agency HCSW in January advising that from 1st April the organisation would no longer be using agency HCSW. The letter included a QR code which when scanned took you straight to a bank application form. JP advised that the organisation felt this was the right thing to do as we can now give staff the proper training and improve on quality and consistency.

RG advised that there are several steering groups in place which will be reaching out to staff side for input, including one which JP and CF are involved in relating to the assistant practitioner band 4 role.

RG noted a change to the People Services structure. The Heads of P&C, who have been focussed on workforce planning and transformation recently, have also been aligned to CBs. RG will circulate this information to the group.

RG also discussed changes to the mass immunisation model and re-deployment of staff working in this area, noting the importance of continuing to develop these individuals. P&C have helped them with their CVs and applications; some have gone on to pursue education and apprenticeships while others have chosen to explore different areas of the health board which is really positive.

DW thanked RG for the update and noted the positive trajectory with regards sickness management. MT queried the new starter survey which has gone out to new nursing colleagues and said that to be equitable he believes this should be circulated to all new starters. RG advised that going forward the P&C team would be holding focus groups to check in with new starters that have attended corporate induction after 3, 6 and 9 months.

MT also raised concerns regarding the application of the managing attendance policy, as some managers are still struggling with the autonomy of decision making. MT has been discussing how we can improve this with Katrina Griffiths (KG) and Peter Hewin (PH). MT also queried whether work-related stress could be monitored as a specific reason for sickness absence. JP said that he thinks we are confined by the options within ESR but agreed to look into this and feedback to the group.

RG informed the group that Audit Wales are looking at strategic workforce planning across Wales to assess how mature everybody is. The Heads of P&C have been working with CBs on workforce focussing on analytics, trajectory and establishment. We've had two meetings and are creating an engine room to enable us to see where we are and make decisions around data. RG will talk more about this at WPG including how staff side can get involved.

OPERATIONAL PERFORMANCE

At the pre-meet TUs had discussed how the organisation does OCP as there are several taking place at the moment which they felt have been poorly planned and inconsistent. There was also a lot of discussion around patient on boarding, as well as praise for the informatic relating to community and integrated working. PB thanked DW and agreed it is positive that we are shining a light on areas of work outside of hospital, for instance the district nurses who are seeing a 25% increase in patients each month.

PB responded to the comments regarding patient on boarding, advising that this is about balancing risk and a mitigation to long waits in the community. Having a patient waiting in an ambulance prevents that ambulance going out and getting another patient who might need it more; the on boarding is about balancing that risk by asking every ward to take one extra patient for a short period of time. PB reiterated that this is about quality and safety and not about hitting targets. PB thanked staff for their cooperation as this has helped the organisation get into a better position.

Katherine Davies (KD) suggested utilising the discharge lounge to allow the most unwell patients access to beds. PB agreed that while this would help us to discharge patients more quickly, unfortunately it is not feasible at present due to the location of the discharge lounge which is on the second floor of Lakeside Wing (LSW).

PB also addressed the comments relating to OCP, advising that this winter the organisation has had time to consider how we can avoid moving staff and patients between specialties going forward. A set of plans is being drawn up which will be brought to LPF to ensure everybody is clear on the purpose. DW said that a separate meeting to discuss this further would be helpful but thanked PB for his honesty and authenticity.

FINANCE

Robert Mahoney (MH) advised that Finance are currently balancing last year's position. They have reported to WG that we will be coming in on target at £26.9 million overspent and will finalise that this week. We also have a £2 billion set of accounts to complete within 3 weeks which Audit Wales will then scrutinise to assess if they believe them to be true and fair. The annual plan has been submitted to WG for the £88 million deficit and £32 million worth of cost improvements. Half the Finance team are working on closing the position and preparing the accounts, whilst the other half set up the budgets and alignment with the £88 million deficit plan.

DW acknowledged that having a balanced IMTP is crucial to the health board's financial reputation. DW also queried the organisation's creditor payments, as the report shows that we are 7% below target. RM advised that in addition to payroll and systems issues, often there are disputes due to the wrong amount being invoiced which can take months to resolve; these then register as late payments which unfortunately we have minimal control over.

DW requested that a Finance representative attend a staff side meeting to explain the reports in layman's terms as they are often difficult to understand and interpret. It is important that staff side understand these in order to engage with CBs around their finances, especially given that capital resource is key to many of the challenges discussed at LPF. RM agreed to connect with DW to arrange this.

LPF 23/022 DRAFT EMPLOYEE WELLBEING FRAMEWORK

CW made an offer to present on this at WPG due to shortage of time. DW advised that staff side have read the papers and will bring their feedback to WPG.

LPF 23/023 CAV ANTI-RACIST ACTION PLAN

Mitchell Jones (MJ) has been developing a local anti-racist action plan with colleagues from the One Voice staff network and staff side. This is a 2-year plan in line with WG's vision for an anti-racist Wales by 2030. A steering group is also being set up to implement the plan and hold the organisation to account. The draft plan has been circulated to the group and MJ welcomed any questions or feedback.

Staff side felt that the plan had all the elements they would expect to see, however one question raised at the pre-meet was around equality health impact assessments (EHIAAs), how these will feature in the plan and be used to hold the organisation to account. TUs are particularly interested in these due to their work around protective characteristics and members citing having been treated less favourably. Staff side also queried whether the plan is ambitious enough, for instance in terms of addressing areas of the workforce that are overqualified. UNISON have done some work around this and have identified that 27% of ethnic minorities feel they haven't been offered equal career progression opportunities. MJ acknowledged these comments and assured the group that they will be taken into consideration.

PH thanked MJ for joining the Mental Health LPF to talk through the plan and agreed that the focus on winning hearts and minds is really. MJ said that we are trying to create something which can be tailored to everybody and compared the implementation of the plan across the organisation to a choir; we can all implement the plan in different ways as long as we're all singing from the same hymn sheet and working together to deliver this work.

With regards senior buy-in, DW queried whether the alignment with protected characteristics needs to be revisited due to recent executive turnover. DT also noted that some of the CBs have engaged with this agenda more readily than others but that we need to make it everybody's business. MJ has an up-to-date list of inclusion ambassadors and will share this with the group.

WG are developing workforce race equality standards (RES) based on those already in place in England. MJ said that when this launches it will likely have a big impact and the results will be quite shocking. For example, we already know that we have a long way to go around career progression and senior leadership in terms of race. MJ understands from conversations with Professor Antonio Emmanuel (AE), who was involved in developing the RES in England, that Wales will be going further by looking at the entire health and social care system. DW was pleased to hear that MJ has engaged with AE in terms of the learning from the RES in England, as this didn't deliver on everything it promised and there is learning we can take to ensure we don't repeat those mistakes.

DW said that often when a member of staff cites having experienced racism in the workplace, the organisation's response is to disprove that fact and we need to change that narrative. MT said that it's important we are open and honest about the issues we have in our organisation and MJ agreed that this is key to our approach in taking this work forward. CW added that we need to create psychological safety and provide reassurance that we will not respond from a place of defence when staff come forward. We need to we create an environment in which staff feel confident the will be listened to and not dismissed.

DW thanked CW and MJ for their leadership and noted that MJ is on the agenda to come back and give updates to the group on this work.

LPF 23/024 LPF WORKPLAN 2023/4

DW praised the workplan RP has drawn up, noting that some gaps have been left to allow for matters that arise throughout the year.

LPF 23/025 ITEMS FOR NOTING

DW thanked the CB directors and lead TU representatives for their contributions to the annual reports. DW also thanked the Staff Benefits Group for working with the organisation to support staff through the cost-of-living crisis.

LPF 23/026 REVIEW OF MEETING

DW noted that good discussions had taken place, in particular around the integrated performance reports.

LPF 23/027 ANY OTHER BUSINESS

No other business was raised.

LPF 23/028 FUTURE MEETING ARRANGEMENTS

The next meeting will be held remotely on Thursday 8th June at 10am, with a staff representatives pre-meeting at 8.45am.

Saunders, Nathan
24/05/2023 13:40:16

Local Partnership Forum – Action Log

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
LPF 23/008	08.02.23	LEARNING FROM COVID-19	Continue extraordinary meetings with staff side re impact of pandemic on staff	Dawn Ward/Rachel Gidman	To be arranged as and when required
LPF 23/017	13.04.23	MINUTES OF THE PREVIOUS MEETINGS	Amend previous minutes (08.02.23) and return to Chandra Almeida/Rachel Pressley	Fiona Kinghorn	Complete
LPF 23/019	13.04.23	MATTERS ARISING	Circulate terms of reference for P&C committee once signed off	Rachel Gidman	
LPF 23/021	13.04.23	INTEGRATED PERFORMANCE REPORT	Obtain update regarding email addresses for all staff from David Thomas	Rachel Gidman	
LPF 23/021	13.04.23	INTEGRATED PERFORMANCE REPORT	Explore ways to make reports more disability accessible	Rachel Gidman	
LPF 23/021	13.04.23	INTEGRATED PERFORMANCE REPORT	Follow up conversation re work life balances with Ceri Dolan	Rachel Gidman	Complete
LPF 23/021	13.04.23	INTEGRATED PERFORMANCE REPORT	Circulate updated information re Heads of P&C CB alignment to group	Rachel Gidman	Complete

Saunders Nathan
24/05/2023 13:40:16

LPF 23/021	13.04.23	INTEGRATED PERFORMANCE REPORT	Investigate option of monitoring work-related stress in ESR and feedback to group	Jonathan Pritchard	Work-related stress is not included in the drop-down options for sickness absence within ESR, however, there is a box which managers can tick to indicate that sickness is work related.
LPF 23/021	13.04.23	INTEGRATED PERFORMANCE REPORT	Arrange for Finance representative to attend staff side meeting	Dawn Ward/Robert Mahoney	
LPF 23/023	13.04.23	CAV ANTI- RACIST ACTION PLAN	Circulate up-to-date list of Inclusion Ambassadors to group	Mitchell Jones	Complete

Saunders Nathan
24/05/2023 13:40:16

Report Title:	C&V Integrated Performance Report			Agenda Item no.	7
Meeting:	LPF	Public		Meeting Date:	8/6/23
		Private			
Status (please tick one only):	Assurance		Approval		Information X
Lead Executive:	Fiona Kinghorn, Jason Roberts, Rachel Gidman, Paul Bostock, Catherine Phillips				
Report Author (Title):	Information Manager				

Main Report

Background and current situation:

This report provides a summary of performance against a number of key quality and performance indicators. This will include areas where the organisation has made significant improvements or has particular challenges including the impact of COVID-19, together with areas where the Health Board is under formal escalation measures from the Welsh Government and/or where local progress is being monitored.

This Balanced Scorecard comprises indicators that cover Population Health, Quality & Safety, Workforce, Performance and Finance for the Health Board.

Population Health						
	Standard	Trend	2022 / 23 Qtr 3		Standard	Trend
Immunisation				Tobacco		
% of children up to date with scheduled vaccines by 4 years of age	95%	na	81.8% **	% of smokers who become treated smokers	5%	na
% of adults aged 50 years and over who have received a Covid-19 Autumn 2022/23 booster vaccination	na	na	72% *	% of treated smokers who quit at 4 weeks	40%	na
% of people aged 5-49 years in a clinical risk group who have received a Covid-19 Autumn 2022/23 booster vaccination	na	na	39% *			
Quality & Safety						
	Standard	Trend	Apr-23		Standard	Trend
Patient Satisfaction				Mortality		
30 day complaints response compliance %	75%		84%	Myocardial Infarction within 30 days of admission, age 35-74 (Rolling 12 Months)	na	
Patient Experience	na		75%	Stroke within 30 days of admission (Rolling 12 Months)	na	
Falls				Hip Fracture within 30 days of admission, age 65 and over (Rolling 12 Months)	na	
Slips Trips and Falls (30 day moving total)	na		323	Crude Mortality (Last Week of the month)	52.6	
Slips Trips and Falls with harm - moderate to severe (30 day moving total)	na		40	Still births (Rolling 12 Months)	na	
Serious Incidents				Infection Control		
Nationally Reportable Incident (SI) **	na		7	All Reported Infections (Rolling 12 Months)	743	
Number of Never Events	0		0			
Workforce						
	Standard	Trend	Mar-23		Standard	Trend
Sickness Absence Rate (in-Month)	6%		5.4%	Turnover Rate	7% - 9%	
Sickness Absence Rate (12-Month Cumulative)	6%		6.9%	Mandatory Training Compliance	85%	
Values-Based Appraisal Compliance	85%		56.4%	Fire Training Compliance	85%	
Medical Based Appraisal Compliance	85%		79.9%			
Operational Performance						
	Standard	Trend	Apr-23		Standard	Trend
A&E 12 hour waiting times	0		689	Mental Health Part 1a - Assessments within 28 days	80%	
A&E 4 hour waiting %	95%		69.5%	Mental Health Part 1b - Therapy Commencing within 28 Days	80%	
Ambulance Handover Times >1 hour	0		470			
Ambulance Handover Times >4 hour	0		0	Total number of medically fit for discharge patients	na	
Number of 12 hour trolley waits	0		63	Total number of bed days lost	na	
Number of Patients over 24 hours in EU	0		1102	Average number of bed days lost per patient	na	
RTT Waiting less than 26 weeks %	95%		54.2%	Number of Patients Delayed over 100% for follow-up Appt	0	
RTT Waiting Over 36 Weeks	0		37897	Single Cancer Pathway	75%	
RTT Waiting Over 52 Weeks	0		22664	Total number of patients on Single Cancer Pathway	na	
RTT Waiting Over 104 Weeks	0		3740	Total number of patients on Single Cancer Pathway over 62 days	0	
RTT Waiting Over 156 Weeks	0		823	Total number of patients on Single Cancer Pathway over 104 days	0	
Diagnostics >8 weeks Wait	0		4565	Stroke: thrombolysed patients door to needle performance <=45 mins	100%	
GP OOH 'emergency' patients requiring an attendance at a primary care centre within 1 hour	90%		100%	Stroke: CT scan performance 1 hour	100%	
GP OOH 'emergency' patients requiring a home visit within one hour	90%		50%	Stroke: 4 hours to ward	100%	
#NOF: Time to ward performance (4 hours)	na		3.5%			
#NOF: Time to theatre (36 hours)	na		64.6%			
Finance						
	Standard	Trend	Mar-23		Standard	Trend
Deliver 2022/23 Draft Financial Plan	£17.1m planned deficit	na	£26.9m deficit	Delivery of £4m non recurrent target	£4m	
Remain within capital resource limits.	Within planned expenditure £55.410	na	£55.41m	Creditor payments compliance 30 day Non NHS (Cumulative)	95%	
Reduction in Underlying deficit (Forecast)	Under discussion with WG and private finance committee	na	-	Remain within Cash Limit (Forecast cash surplus)	Within Cash Limit	
Delivery of recurrent £15.400m 1.5% devolved target (forecast)	£15.4m	na	£12.721m	Maintain Positive Cash Balance	Positive Cash Bal.	

* Those who have received two Covid-19 doses, with the exception of those who are severely immunosuppressed and are recommended three primary doses

** No new data available

No patients recorded within this measure during this time period

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POPULATION HEALTH

Health protection

- **Immunisations**

- Delivery has commenced for the Covid-19 Spring Booster, with 18,042 doses given in Cardiff and Vale by 26 April 2023, and 37% uptake to date (cf Wales average 26% uptake). Eligible cohorts are: people aged 75 and over; residents in a care home for older adults; and individuals aged 5 and over who are immunosuppressed.
- JCVI have announced on 6 April a new Covid-19 infant vaccination programme (infants aged 6m to 4y in a clinical risk group). This is expected to commence in May 2023, running alongside the Spring Booster Programme
- Planning is also underway for the Winter Respiratory Vaccination Programme which will see the co-administration of Covid-19 and Influenza vaccinations where appropriate. JCVI published its interim recommendations for the Autumn 2023 Booster on 25 January 2023, which indicated that people with a higher risk of severe COVID-19 would be offered a booster.

- **Acute respiratory infections**

- Covid-19 levels remain broadly stable in Cardiff and Vale based on wastewater monitoring. Omicron XBB.1.5 remains the most common variant.

- **Hep B/Hep C elimination plan**

- A detailed C&V UHB Joint Recovery Plan for Hep B/Hep C is being co-ordinated to address the 13 Actions as outlined in WHC/2023/001, following submission of a strategic high-level plan at the end of March. On track to submit by revised deadline of mid-July 2023

- **Health protection integrated system**

- Work continues to take place both regionally and nationally to further strengthen regional health protection arrangements by developing a model for a sustainable and integrated system with an 'all hazards' remit. The Cardiff and Vale of Glamorgan COVID-19 Prevention and Response Plan will be updated in coming months to describe our agreed final partnership model, with the first workshop on 10th May 2023; it is anticipated that this will then become the regional Health Protection Plan.

Health improvement

- **Tobacco**

- The smoking prevalence rate for Cardiff and Vale of Glamorgan is 12% (NSW, 2021-2022), the same as the previous year and is one of the lowest rates in Wales
- 2.1% of smokers made a quit attempt 2021-2022, reflecting a static position from last year (2.2%)
- 64% of 'Treated smokers' quit smoking (self-reported) at 4 weeks, Qtr 3, 2022-2023, a decrease from 80%, Qtr 2, 2022-2023. 74% quit smoking (self-reported) 2021-2022
- The hospital smoking cessation programme achieved an 85% 4 week quit rate (Quarter 3, 2022-2023) and a PGD has been agreed for provision of Nicotine Replacement Therapy (NRT) for patients on admission
- 42% of Community Pharmacies offer a Level 3 Enhanced Smoking Cessation Programme, 38% a Level 2. 68% of Level 3 services are located within areas of high deprivation

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- A MAMSS Programme was implemented in April 2021. 51% of pregnant smokers were referred to MAMSS, (Qtr 3, 2022-2023) – an increase from 25% pre-MAMSS. NRT provision available on first contact with a Midwife with 60% of MAMSS referrals accepting pharmacological support
 - No Smoking Enforcement Officer post implemented March 2022, to reduce incidence of smoking at hospital sites. Launch of 'zero tolerance ' No Smoking Campaign, November 2022.
 - Mental Health Smoking Steering Group established to implement Smoke-free Regulations with progress on-going
- *To note the contents of this section will vary in future reports, focusing on different health improvement and healthcare public health topics.*

QUALITY AND SAFETY

Concerns

During March and April 2023, it is pleasing to note that, despite the current demand on the service and significant rise in the number of concerns managed, we have achieved an extremely high overall performance of 84% of concerns closed within 30 working days including those managed under Early Resolution.

30-day performance

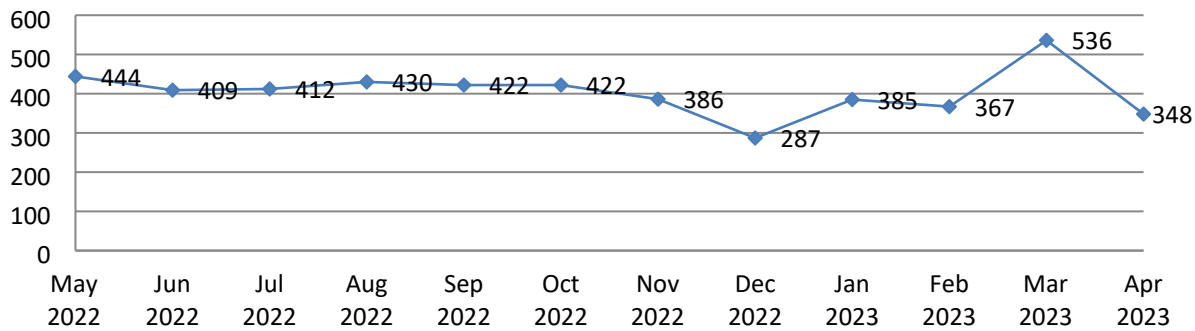
October 85%
 November 77%
 December 80%
 January 77%
 February 81%
 March 85%
 April 84%

In March and April, we continued to focus on timely resolution to concerns in line with Early Resolution (ER) (*this process can be utilised dependent upon the nature of the concern and considering the preferred outcome of the complainant*). We managed 84 % of concerns under ER which is a slight increase of 1% in comparison to February and March.

As you will see from the graph below, we have noted a significant increase in concerns during March, however, as anticipated (due to the Easter Holidays) we did note a reduction during April. Whilst the Health Board continues to feel pressures due to the current demands on the service we continue to be focused upon responding to concerns and improving the response times whenever possible. We continue to feedback to Clinical Boards the themes identified in the concerns (complaints, claims and redress process) aligned with the patient feedback and compliments data.

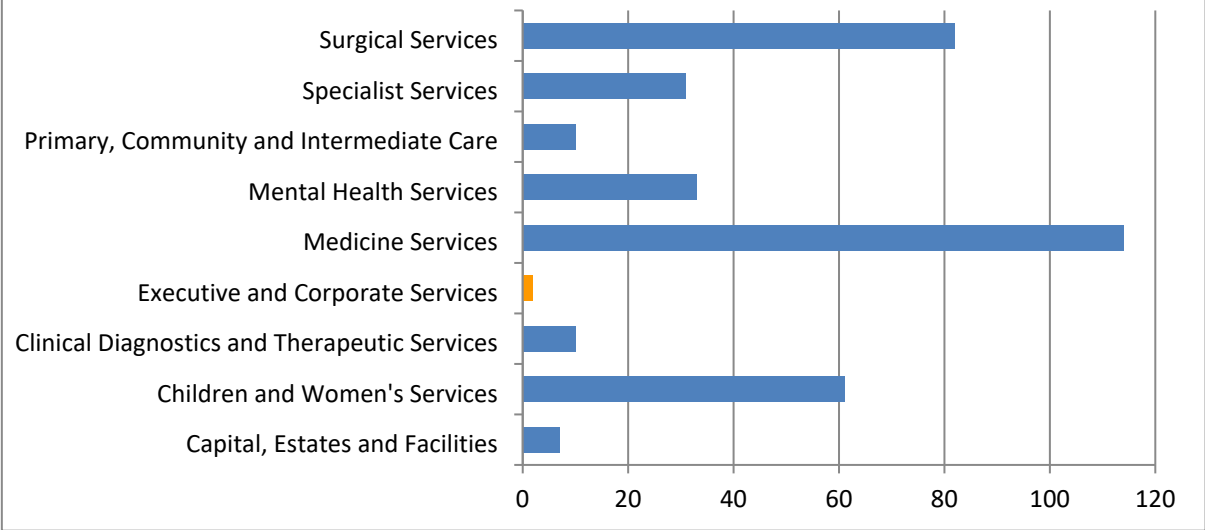
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Concerns received by month - last 12 complete months



We currently have 341 active concerns which is a slight reduction in comparison to the last report (388). Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, this is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of cancellations and delays due and the significant increase and demand on services like EU are reflected in the numbers and nature of concerns received.

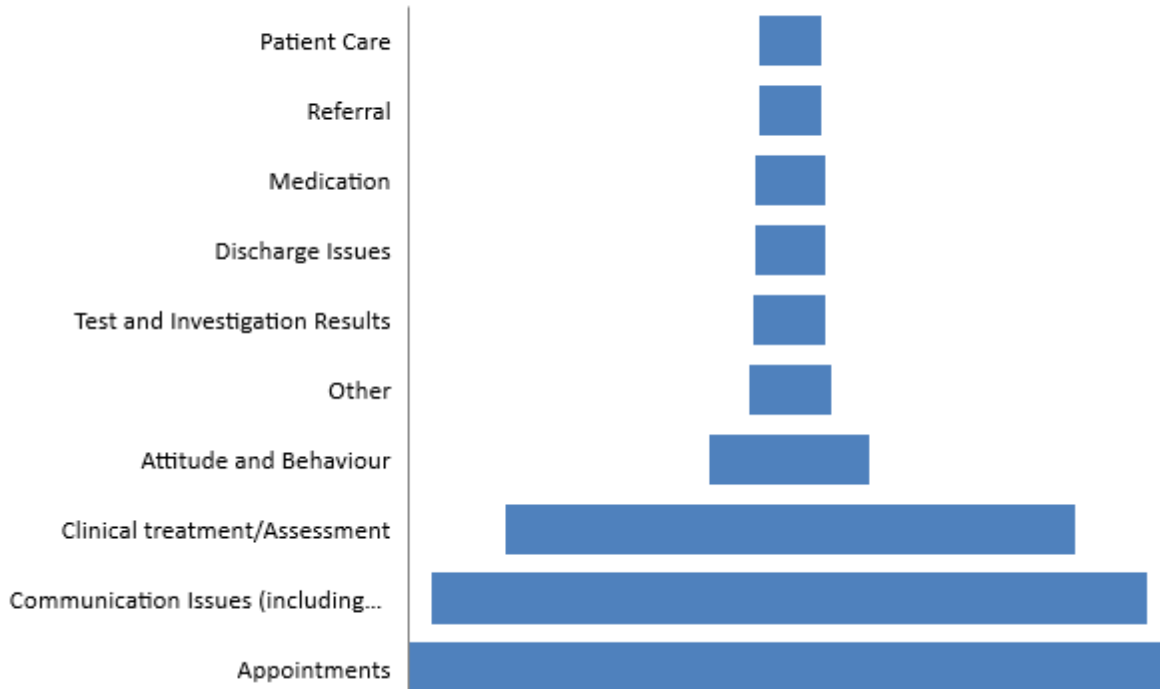
Active Number of Concerns by Clinical Board



The graph below demonstrates the 10 main themes noted in Concerns.

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Concerns Received by Top 10 Primary Subjects



Communication and Clinical treatment have historically been noted as the primary subject in concerns, however, concerns regarding cancellations of appointments have increased. We continue to see an increase in concerns regarding environment, facilities and attitudes and behaviours.

Duty of Candour

The Duty of Candour is a legal requirement. It requires healthcare organizations and care providers to be open and honest with patients and their families when something goes wrong with their care or treatment.

Specifically, the Duty of Candour requires healthcare providers to:

1. Inform patients and their families as soon as possible when an adverse event has occurred.
2. Offer an apology and provide appropriate support to patients and their families.
3. Conduct a review of the adverse event and share the findings with the patient and their family.
4. Provide information on how the patient can make a complaint or raise concerns.

The Duty of Candour is intended to promote a culture of transparency, openness, and learning within healthcare organizations. By being open and honest about adverse events, healthcare providers can improve patient safety, learn from mistakes, and prevent similar incidents from happening in the future.

In practice this means - the trigger process for Duty of Candour essentially forms another gateway into existing investigation and PTR processes. It does not require additional investigation work.

Organisations will have existing processes in place whereby incidents are reviewed and it is at this point, that a decision is made as to whether the Duty of Candour procedure is triggered.

Once confirmed that duty has been triggered, this will be the Duty of Candour procedure start date, also known as the day the ‘NHS body first becomes aware’. The organisation will then have 30 working days to undertake their investigation as per PTR timescales.

There must be a gateway to redress if appropriate.

Initial feedback from cases

On review approximately 37% of Incidents are being regraded from the initial grading and in line with the grading framework. There is discussion with the reporter to agree the rationale.

The initial work is focused upon understanding the grading application at the initial recording of the incident and mandatory consideration of the grading on incident closure. Duty of Candour will be managed through the Patient Experience Team, as the process somewhat mirrors the current management of complaints and is part of the Patient Experience Team’s function.

The team are reviewing approximately 70 incidents per day and initial feedback has demonstrated some data validation is required with the understanding of the grading of harm and that crucially the person needs to have been in receipt of healthcare and something unexpected and unintended has happened. Often, triggers for review are collated on the system but no adverse incident has been noted, it is an outcome that is outside of the usual expected parameters and needs further review. These are often categorised where someone reports the outcome as a significant harm level when there is no healthcare acquired harm but it is a patients narrative.

We have noted many cases where pressure damage or a fall has been graded as moderate harm but the incidences have occurred pre-admission when healthcare has not been involved in caring for the person. It is evident that the DOC review work will improve data reliability.

Volunteers

We have undertaken a significant recruitment drive for more volunteers and are pleased to be able to share the collation of volunteer hours for March 2023



Compliments

During the last quarter we received 189 compliments. We continue to encourage areas to share compliments they receive directly, in order for them to be recorded and recognised. Every Friday on Social Media we publish some feedback from our Kiosks on twitter. The feedback from staff and patients to these tweets has been about how they find these tweets very encouraging

This lovely comment was left on our Happy or Not feedback machines at University Hospital Llandough.

I saw my consultant today and the appointment was really good, he explained everything clearly, and all the staff in the department were polite and helpful.

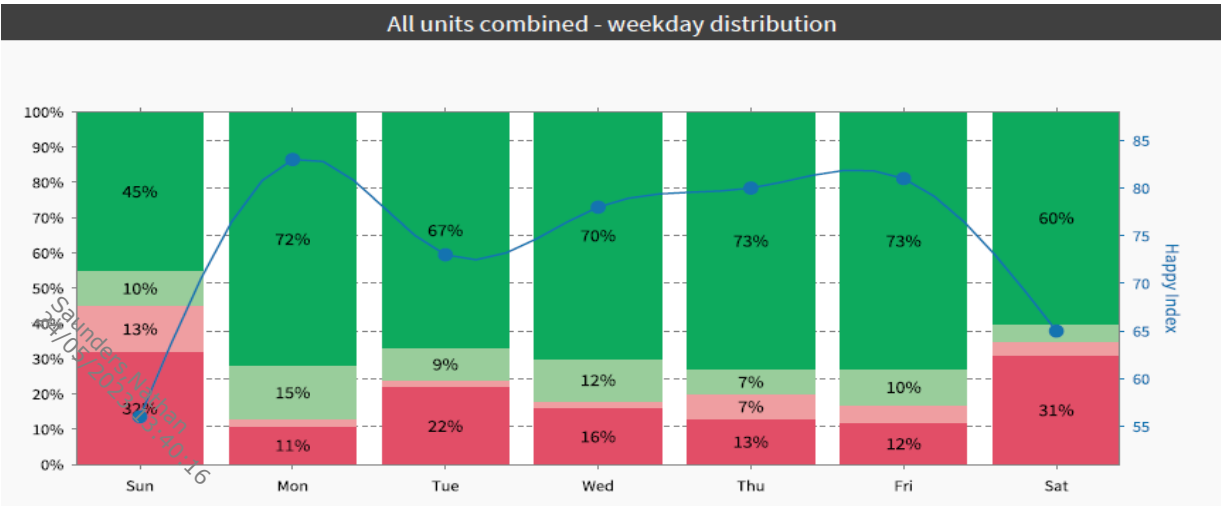
Patient Experience Feedback HappyOrNot feedback (All locations)

In relation to the 'HappyOrNot' feedback, those reported as being satisfied are respondents who when asked: *How would you rate the care you have received?*

A breakdown of the feedback for March and April is:

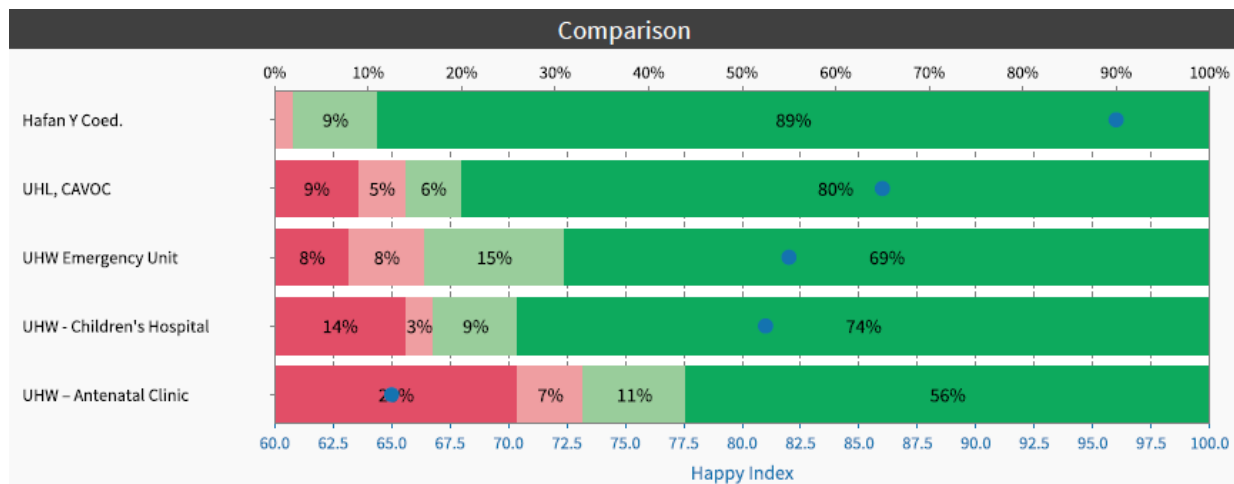
Summary values	March	April
Surveys completed	1338	881
Response: Very happy button (Excellent/Very	62%	66%
Response: Happy button (Good/Positive)	13%	10%
Response: Unhappy button (Fair/Negative)	7%	5%
Response: Very unhappy button (Poor/Very	18%	19%
Respondents satisfied	74%	75%

Chart below. Gives the April feedback, broken down by which day of the week the feedback was received.



There is a theme of satisfaction being lowest on a weekend across the UHB

Chart below. Gives the April feedback, broken down by kiosk location.



HappyOrNot feedback (EU areas only)

The table below is a basic summary of the information received from the HappyOrNot EU feedback:

Summary values	March	April
Surveys completed	154	-
Respondents satisfied	58%	-

* March data is based on feedback from the 01/03/2023 – 17/03/2023.

During April, the 13 kiosk survey completions received need to be disregarded, as the current location of the kiosk is unknown.

Civica 'Once for Wales' platform

Our system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS. At the time of reporting we have contacted some 55.622 people for feedback via text messaging and are seeing a return rate of 19%. It is our understanding this is higher than many organisations but will be a focus for improvement with more targeted experience data collection over the next year, with an aim for a minimum return of 25%.

The table and figures below give some of the summary information received during February and March.

Summary values	March	April
Surveys completed	1915	1543
Respondents satisfied	89%	89%

For March, the 'Respondents satisfied' figure is based on those who answered the rating scale question: *Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?* and gave a score of 7 or more.

As a pilot for April, May and June, we have changed our routine survey to the Friends & Family Test. Consequently, the 'Respondents satisfied' figure for April is based on those who answered the rating question: *Overall, how was your experience of our service?* and is calculated in line with the weighting used nationally.

Table below. Gives a detailed breakdown of April's rating question feedback.

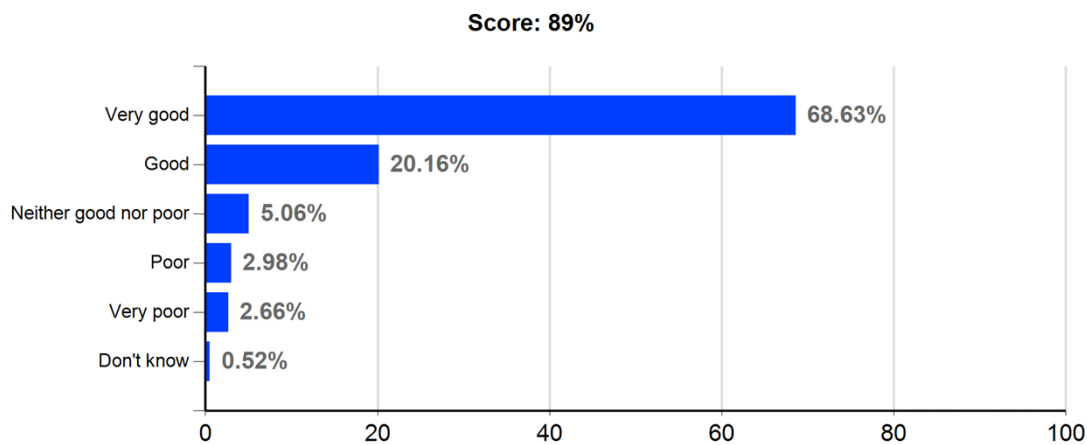
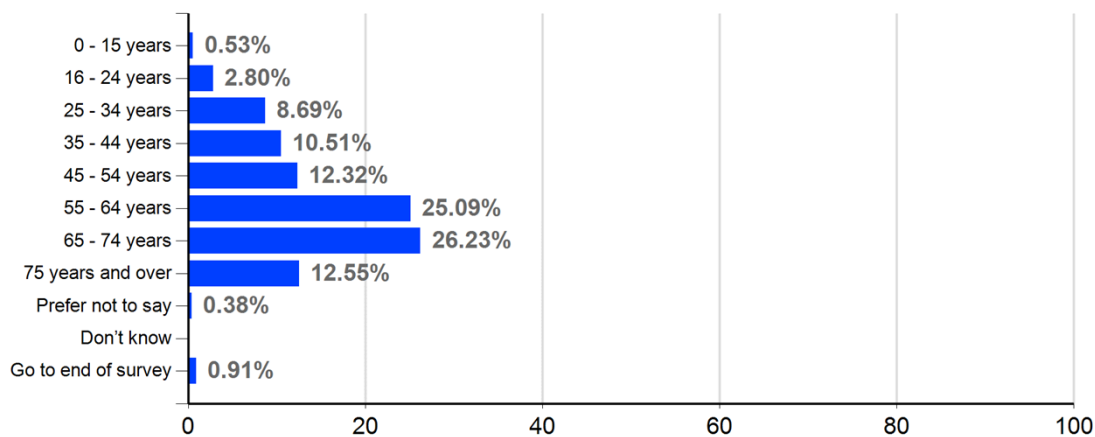



Table below. Gives April's feedback, broken down by age group of respondents.



‘Tell Us in 2’ bedside survey

In addition to our SMS service, we have recently launched a service whereby patients can leave their feedback whilst admitted/attending one of our main hospital sites. An outline of the process is given below.



Tell Us in 2

- The Patient Experience Team have recently launched a new way for patients to leave feedback on their services while in hospital.
- Posters, stickers and signs are placed around hospital sites and at bed sides displaying a QR code, inviting patients to share their recent experiences of using the Health Board's services.
- Once scanned, the QR code gives the individual to access the "Tell Us In 2" survey - a short questionnaire, which takes around two minutes and can be completed in English or Welsh. All responses are anonymous.
- When individuals complete the questionnaire, it is asked that they give an open and honest opinion of their experiences so the Health Board can share compliments, best practice or suggestions, to learn from experiences and help shape services for the future.
- For those requiring special assistance in completing the questionnaire, a dedicated telephone helpline is available from 10am-1pm, Monday – Friday.

The table and figures below give some of the summary information received during April.

Summary values	April
Surveys completed	60
Respondents satisfied	50%

The ‘Respondents satisfied’ figure is based on those who answered the rating scale question: *Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?* and gave a score of 7 or more.

Table below. Gives a detailed breakdown of April’s rating question feedback.

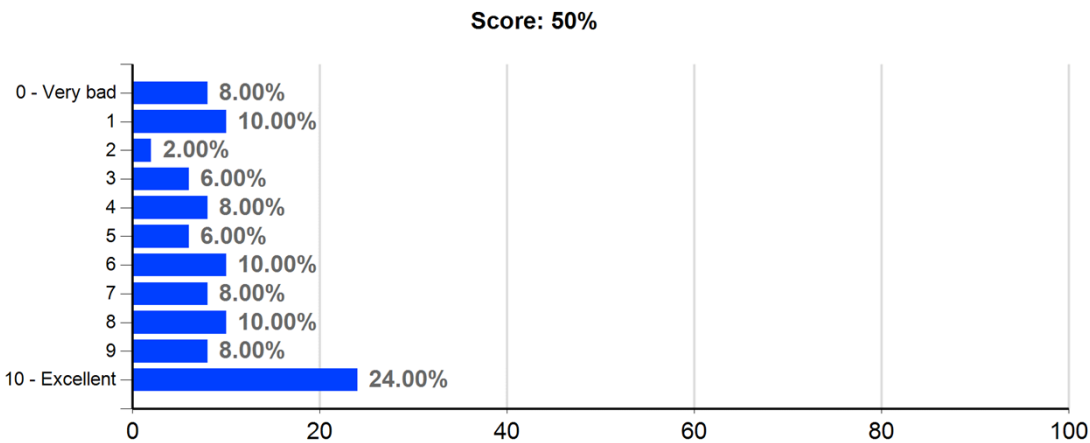
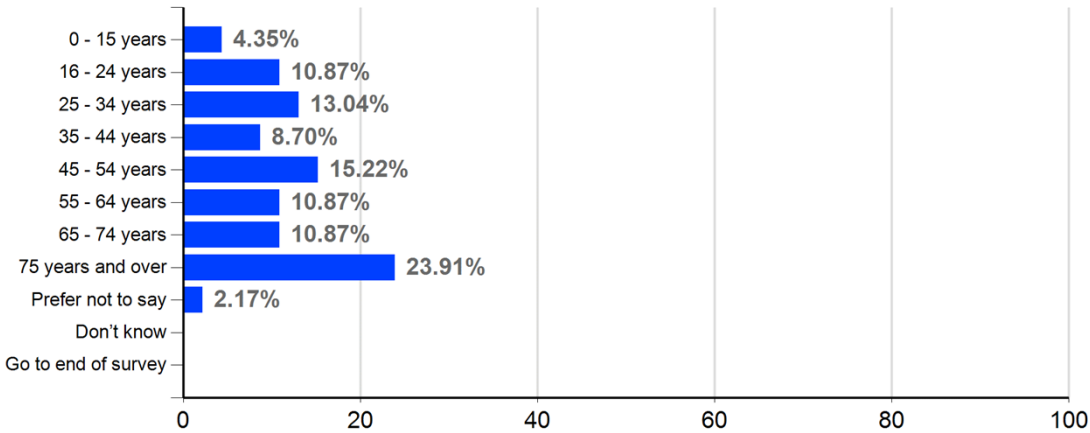


Table below. Gives April’s feedback, broken down by age group of respondents.



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How we receive feedback



The reports available via the Civica platform are quite detailed and include:

Accessibility



- Informative, clear and user friendly survey pages – logical layout, sharp colours and contrast
- Mobile friendly survey pages which adapt to screen size
- BSL for those who are hearing impaired
- Themes for children and young people
- Surveys in languages - English, Welsh and more
- Digital story integration

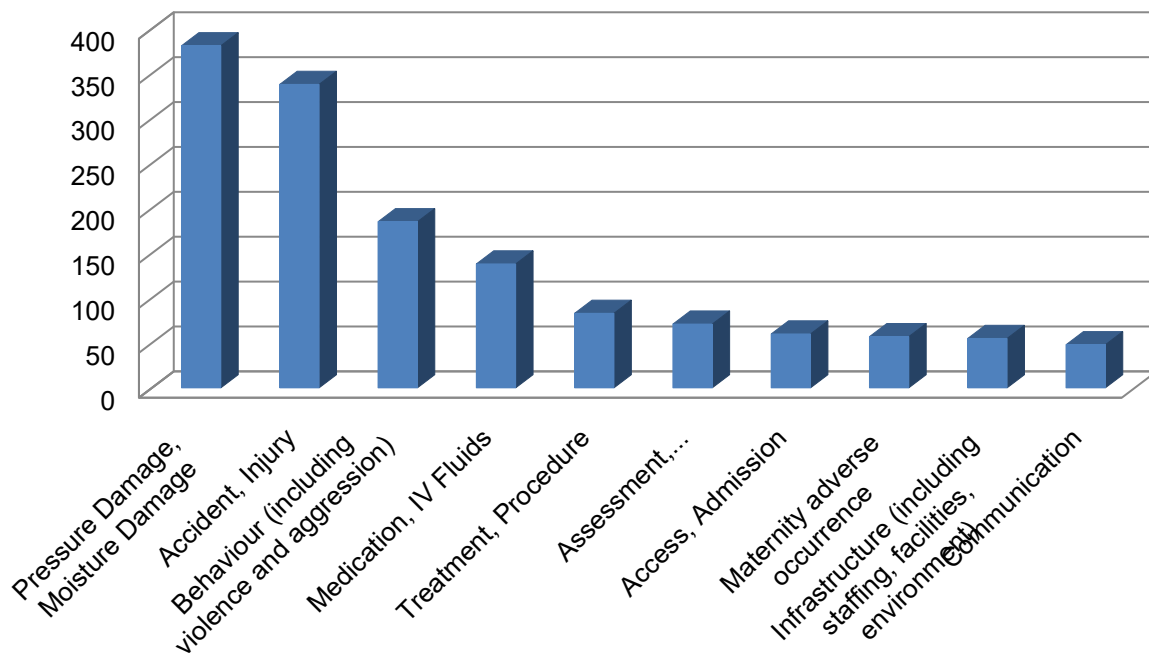
PATIENT SAFETY – Incident reporting

The chart below illustrates patient safety incidents reported during March 2023 by incident type. A total of 1626 patient safety incidents were reported during this period, a reduction from the previous month (March) of 227. The main change is the increase in medication incidents prevalence within the top 10 from the sixth most common to the fourth.

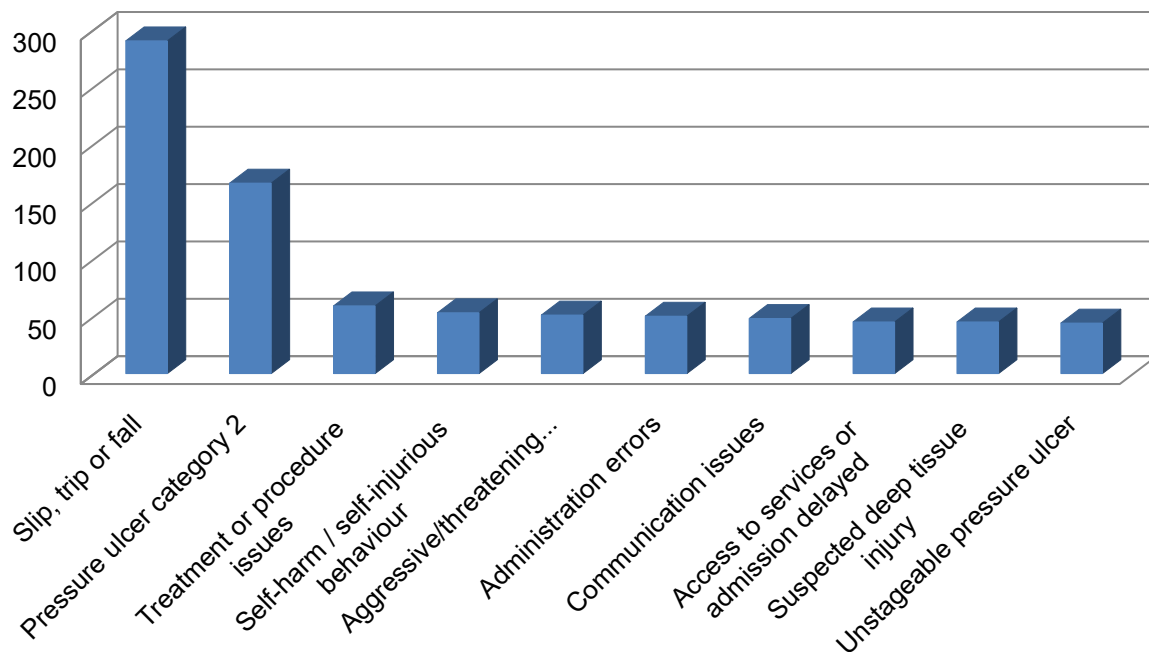
As is usual, pressure damage and accident/injury (falls), are the most commonly reported incidents. The second chart goes further into the detail of the nature of the incident (Incident by subtype).

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Top 10 Patient Safety Incidents by Incident Type reported in April 2023

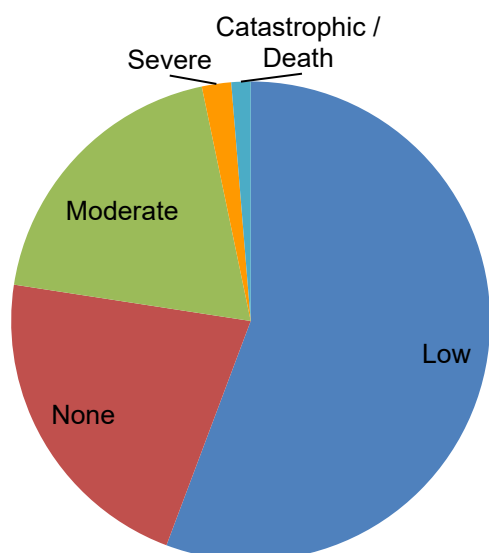


Top 10 Incidents reported in April 2023 by Sub Type



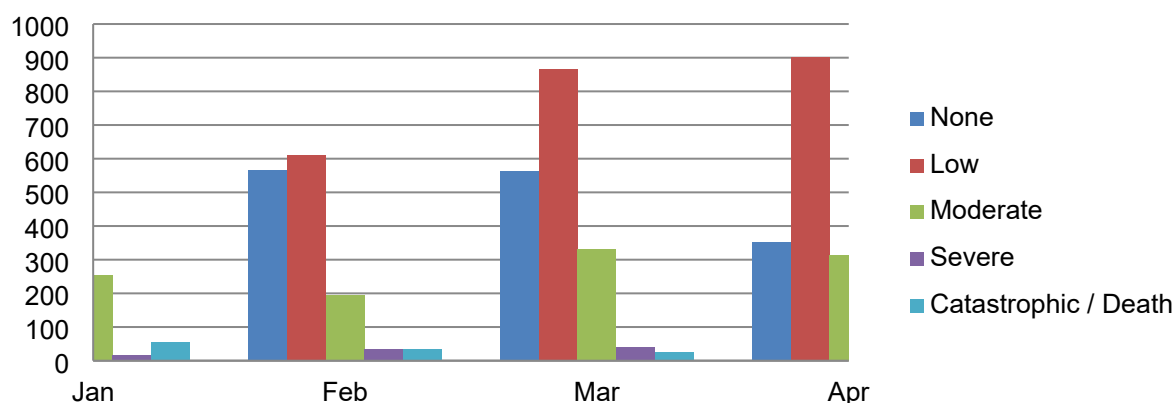
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Incidents by Reporters view on level of harm



As can be seen in the chart above most of the incidents reported are assessed as being of 'Low' harm. This assessment is being monitored now that the Duty of Candour has gone live, to ensure that incidents are not under or over graded. This is being carried out by the Corporate Team. After the initial management review process, if there is deemed to be an incorrect recording of harm, an email is sent to the incident reporter with the aim of improving learning and accuracy of future harm assessments.

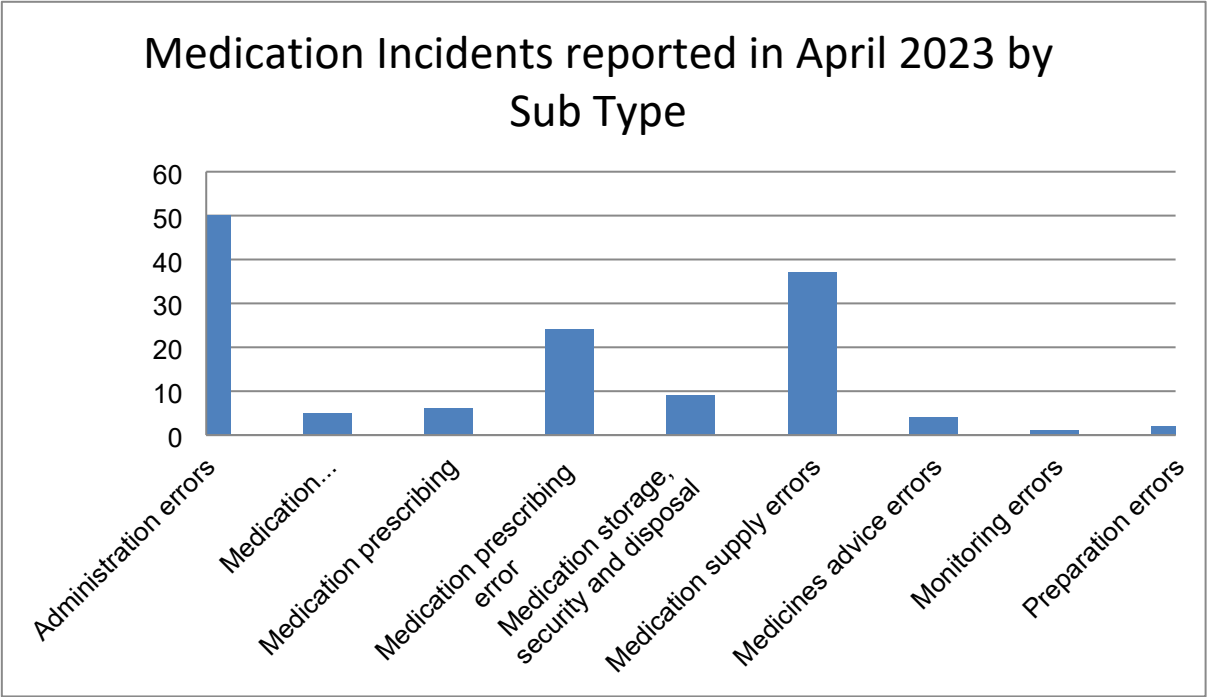
Incidents by Date Reported (January to April 2023) and Reporters view on level of harm



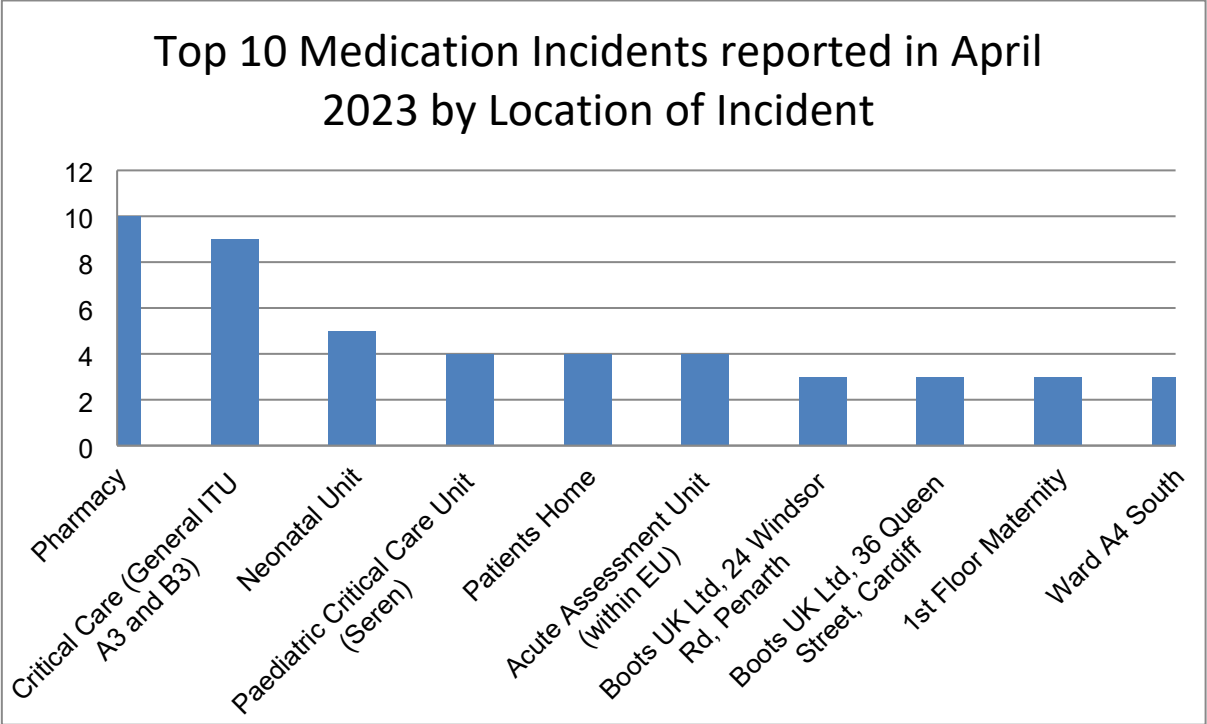
The chart above shows the breakdown of reporter's assessment on level of harm by month. This will be interesting to continue to monitor how harm assessments change with the education/feedback being provided by the Corporate Team. A very early review shows that incidents with 'no harm' assigned has reduced however, it is too early to draw comparisons yet.

Falls and pressure damage were reviewed in detail last month, this will be picked up again in May's report. For April, there is a focus on medication incidents, a category which has increased in prevalence since the March paper.

Medication errors



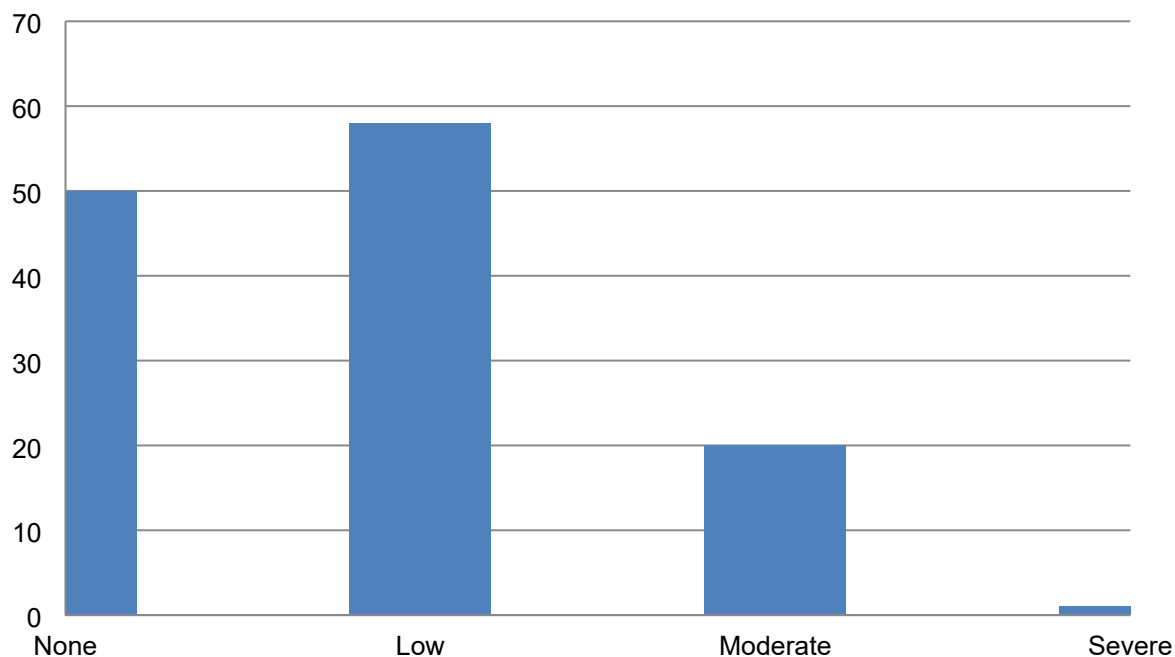
The above chart shows that administration, prescribing and supply errors are the most commonly reported medication incidents.



The above shows the top 10 locations for medication incident reporting and the majority are reported as 'no' or 'low' harm (see below).

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April 2023 Medication Incidents by Reporters view on level of harm



Nationally Reportable Incidents (NRIs)

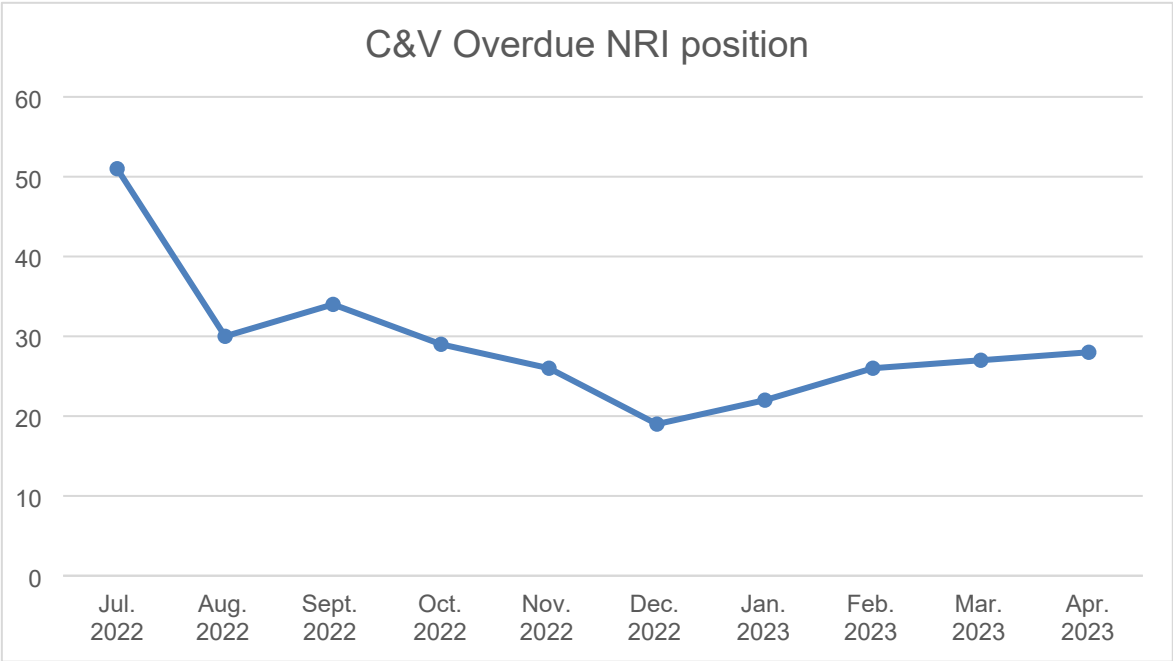
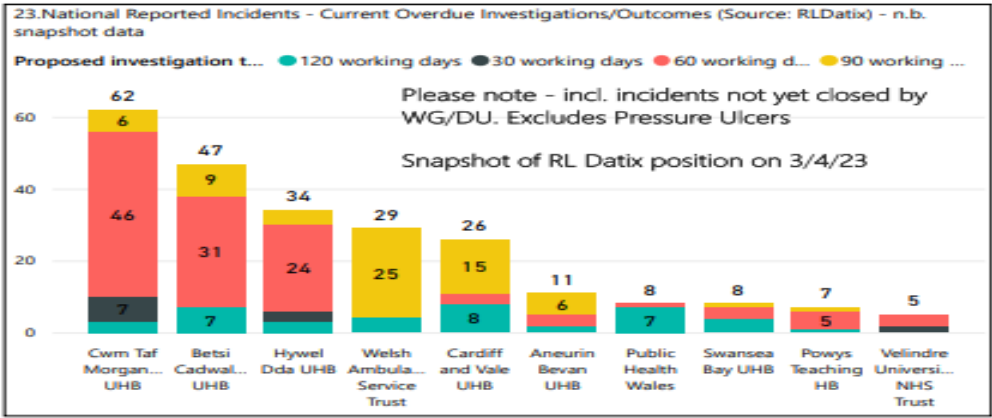
The table illustrates performance of Nationally Reportable Incidents until 30th April 2023. It is an improving position and reflects the focus and hard work of the Clinical Boards and Patient Safety Team, however, the increase in new NRIs is challenging the closure targets, as focus goes on ensuring a robust review of the new incidents.

	Open	Overdue
September 2022	53	34
October 2022	48	29
November 2022	51	26
December 2022	43	19
January 2023	46	20
February 2023	57	26
March 2023	65	27
April 2023	62	28

Clinical Board	Open NRIs as of 02.05.23	Overdue NRIs as of 02.05.23
Children and Women	13 ↔	5 ↔
CD&T	3 ↓	0 ↔
Executive	3 ↔	2 ↓
Medicine	7 ↓	2 ↓
Mental Health	11 ↔	6 ↔
Surgery	8 ↑	4 ↑
PCIC	4 ↑	2 ↑
Specialist	11 ↓	6 ↔
Total	62 ↓	28 ↑

The main factors to note from the figures is that Surgery and Primary Care Clinical Boards have both seen a small increase in their open NRIs with a corresponding increase in the number of overdue for closure. Medicine Clinical Board have reduced their open NRIs from 10 to 7 and their overdue from 4 to 2 since last month.

The report below shows how our overdue NRI position compares with other HBs across Wales. This has been a significantly improving position, over the last year.



The above chart shows how the overdue position is starting to deteriorate which is reflective of the increasing open NRIs. Despite this however, our position is improving nationally in comparison with other Health Boards.

Mortality

The November 2022 Quality Safety and experience committee agreed a three-tier model for reporting and monitoring mortality data across the Health Board.

Tier 1 - Health Board wide mortality measures which will be reported including All-Cause Mortality and Crude inpatient mortality.

Tier 2 - Clinical Board level mortality indicators which includes some condition specific mortality indicators.

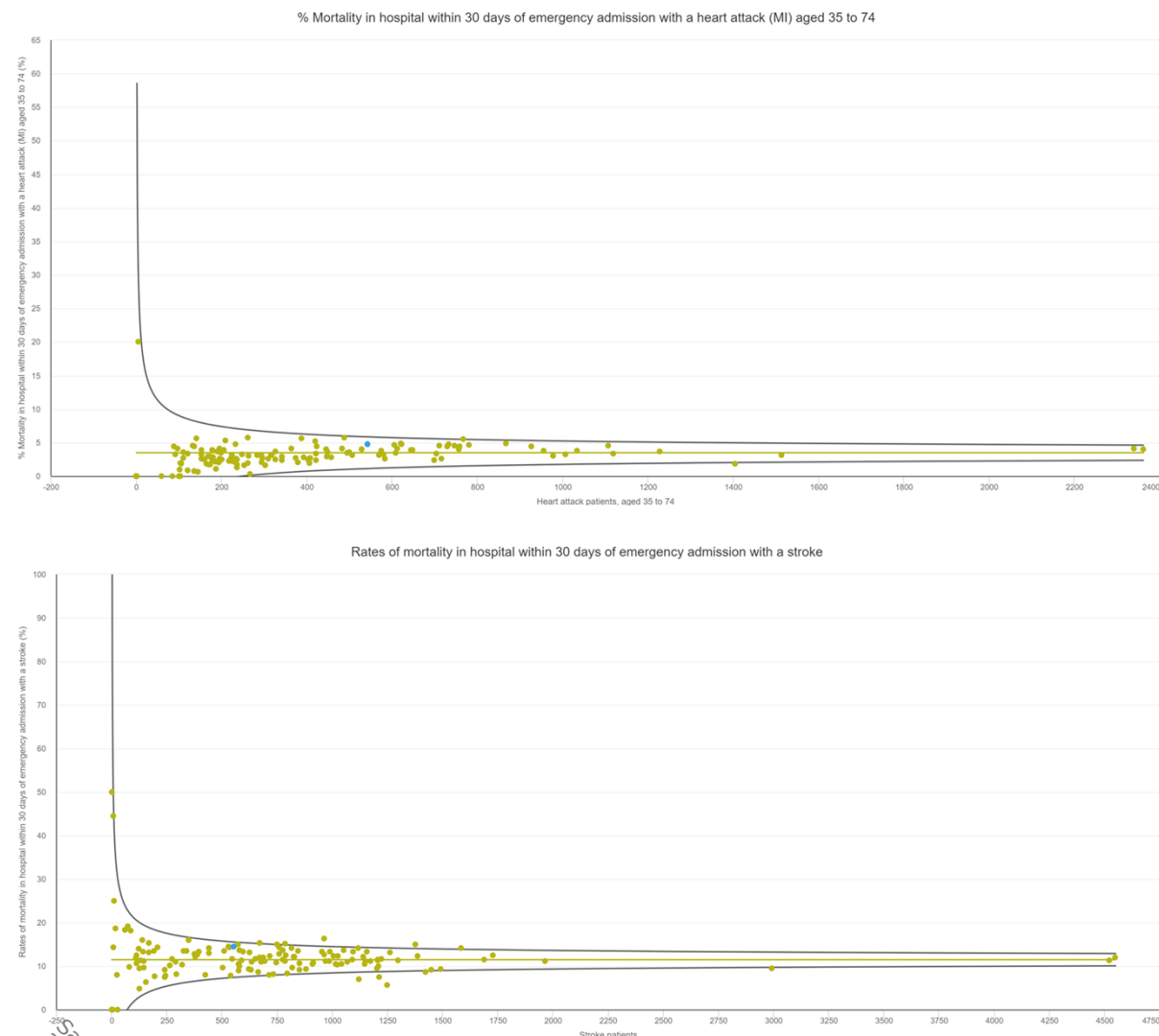
Tier 3 - Speciality level mortality indicators to include condition and intervention specific mortality data.

Tier 1 mortality data will be included as part of the quality indicators report on a regular basis and Tier 2 indicators will be reported to board on a six-monthly basis.

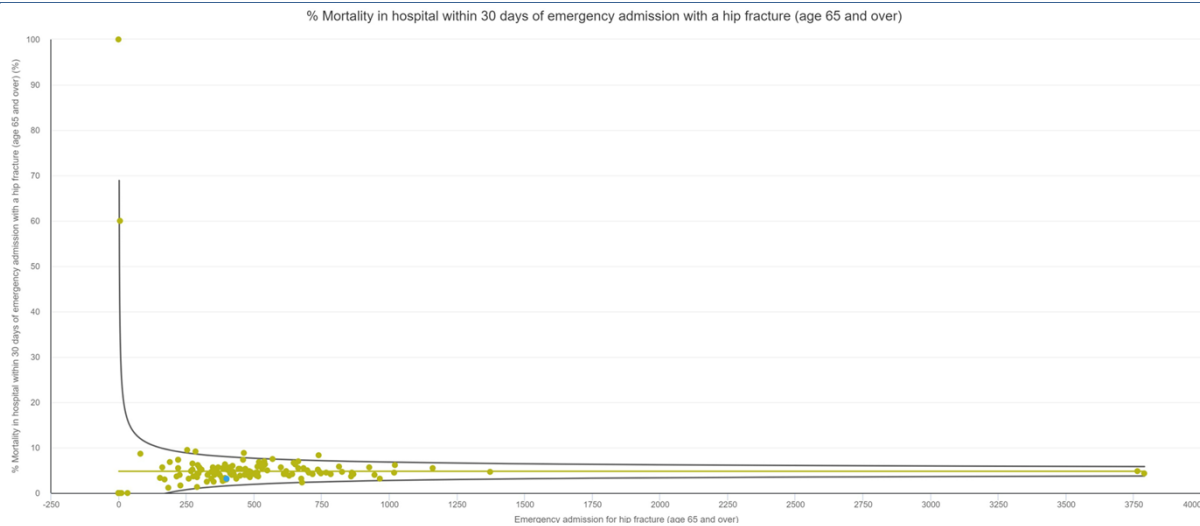
Tier 1 Mortality

Measuring the actual number of deaths over time (crude mortality) supports the monitoring of trends in mortality rates. The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates a mortality rate that is comparable to the 5-year average for the same reporting week, with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19 where inpatient deaths rose above the 5-year average.

Crude all-cause mortality, demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan, regardless of where they occurred. COVID – 19 deaths the pink line, illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had Covid on their death certificate during the first two waves of the pandemic (Spring 2020 and Winter 2020/21).



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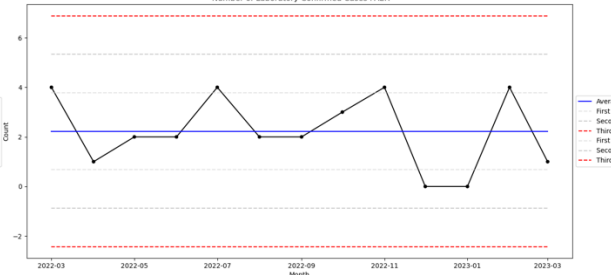
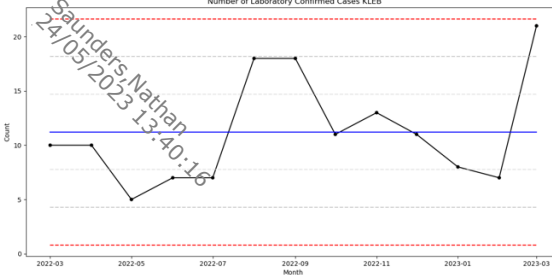
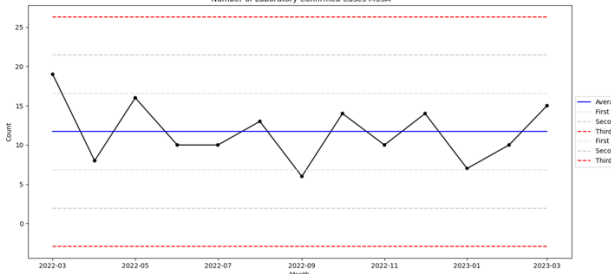
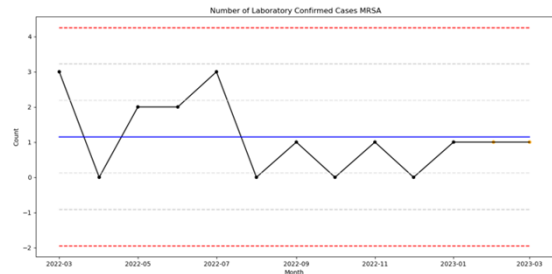
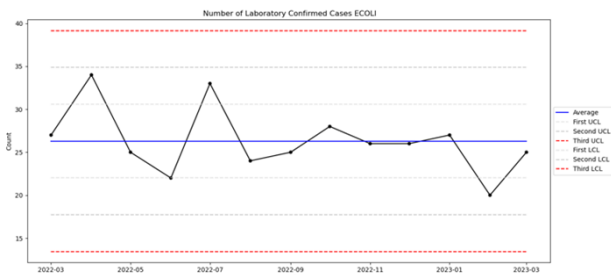
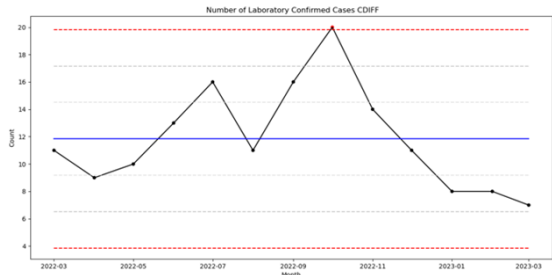


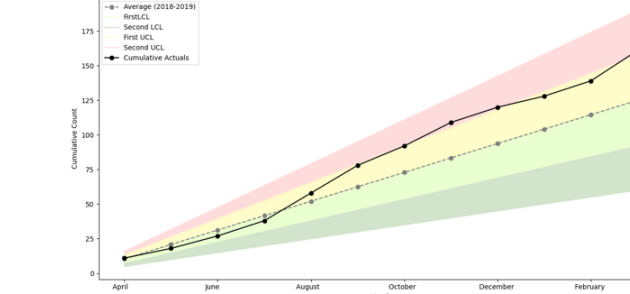
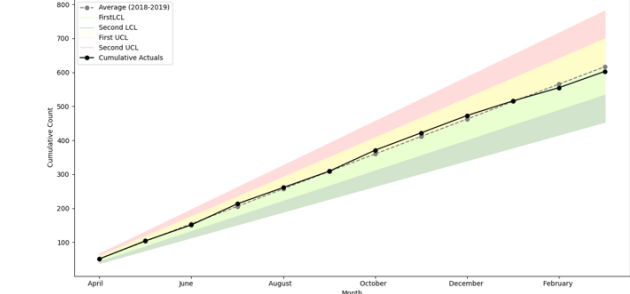
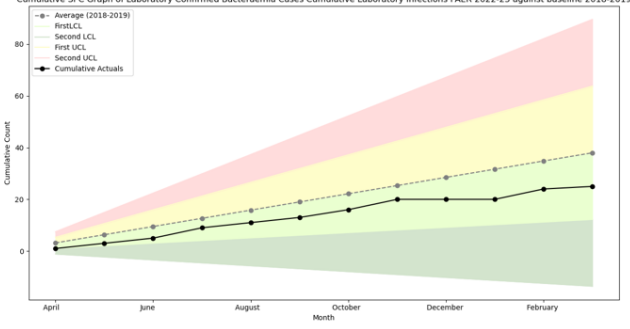
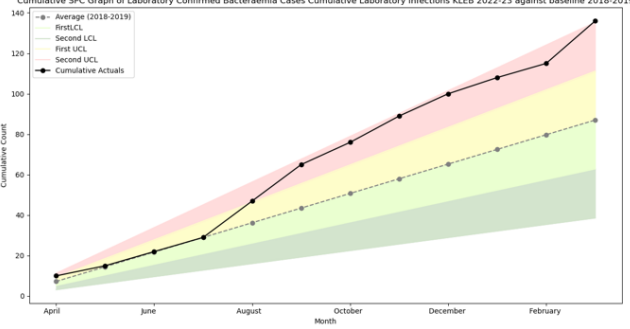
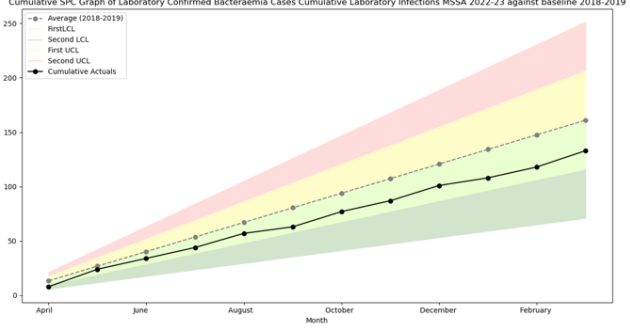
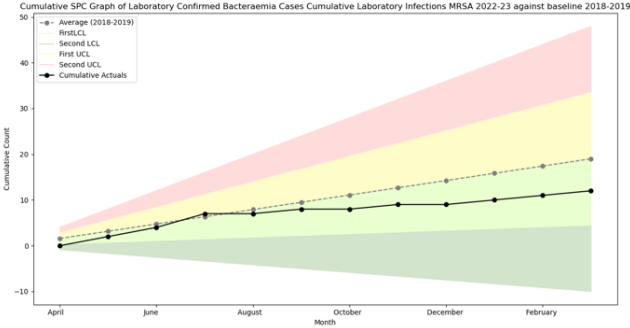
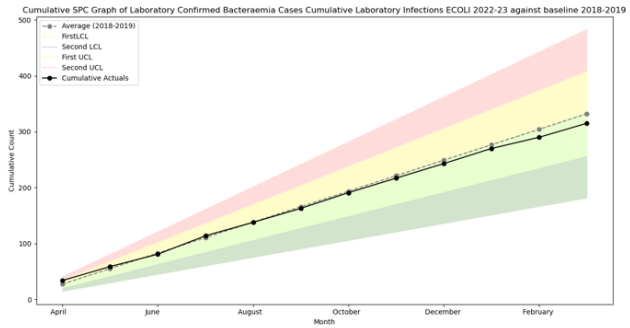
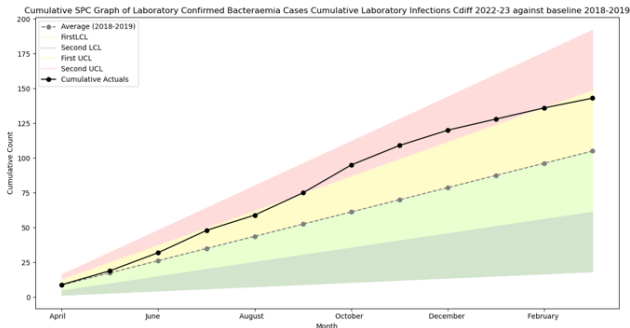
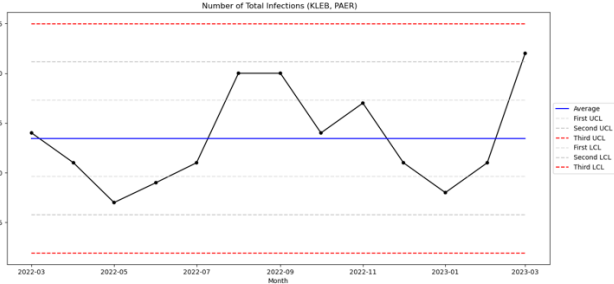
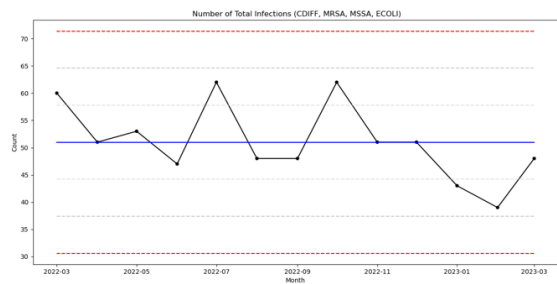
The age standardised cancer mortality, reported as mortality per 100,000 population, demonstrates significant variation in relation to deprivation. Mortality rates in those living in the most deprived fifths in Wales are around 50% higher than those living in the least deprived areas. The pandemic has impacted on this for some diagnoses, particularly marked in colorectal cancer mortality, where inequalities in cancer mortality increased rapidly from a 30% relative difference between the most and least deprived areas of Wales in 2019 to 80% by 2021.

Infection control

Hospital Infections – the total infection rates are falling. MRSA and E coli have slightly reduced.

There has been significant investment in the IP&C team in the past 2 years, which has enabled increased audit and review of infections and supports a bespoke approach to supporting wards and primary care reviews.

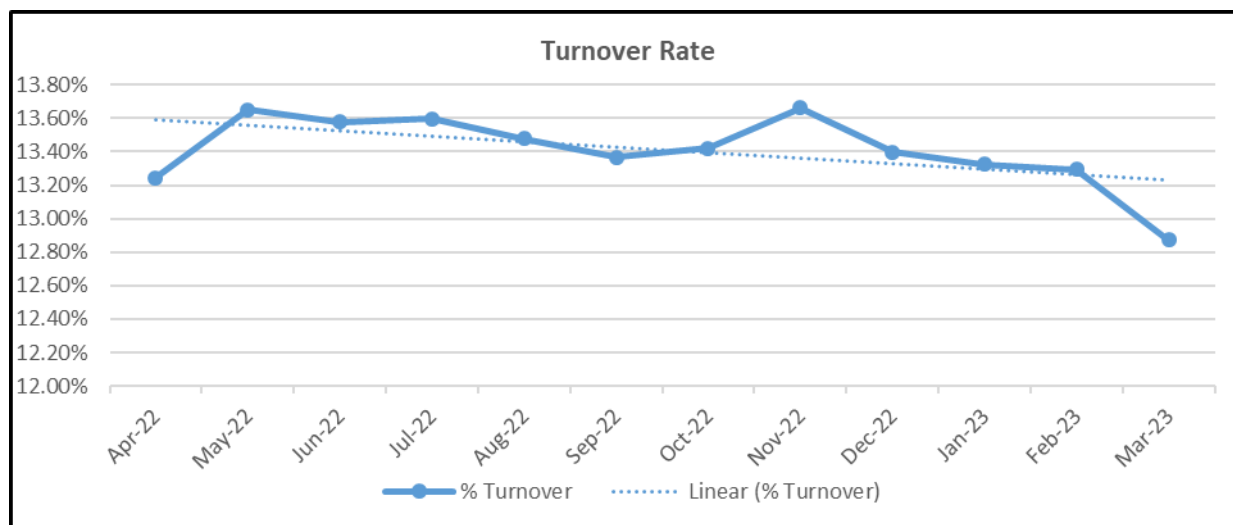




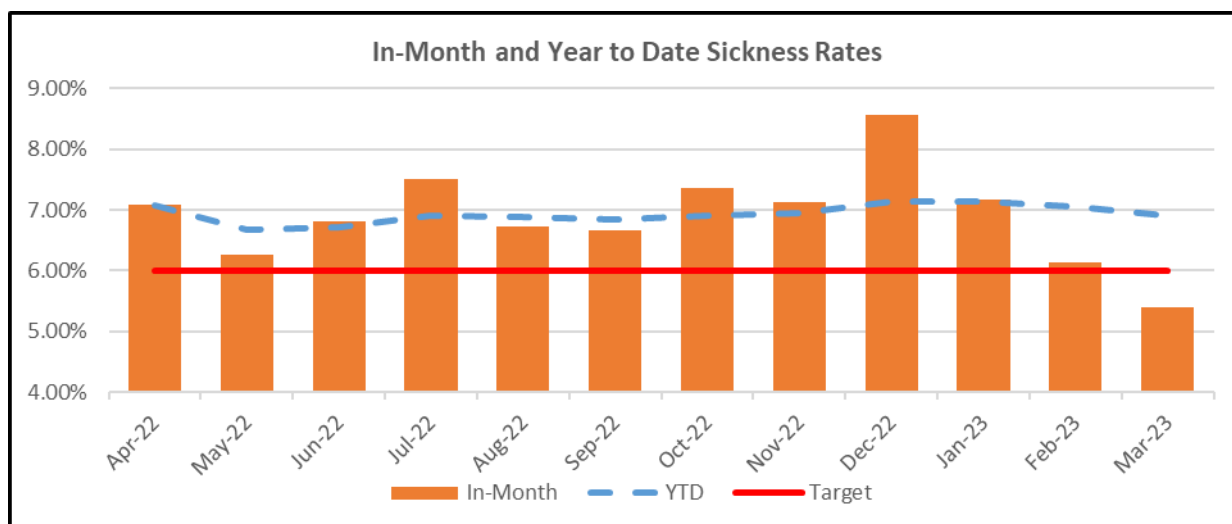
PEOPLE/WORKFORCE

The Executive Director of People and Culture provides regular workforce metrics updates to the Board and an overview report demonstrating progress with the People & Culture Plan.

- **Turnover** rate trend is downwards since Apr-22; the rates have fallen from 13.66% in Nov-22 (the highest rate of turnover in the past 12 months) to 12.87% in Mar-23 UHB wide. This is a net 0.79% decrease, which equates roughly to 109 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation - Promotion' and 'Voluntary Resignation – Work Life Balance'



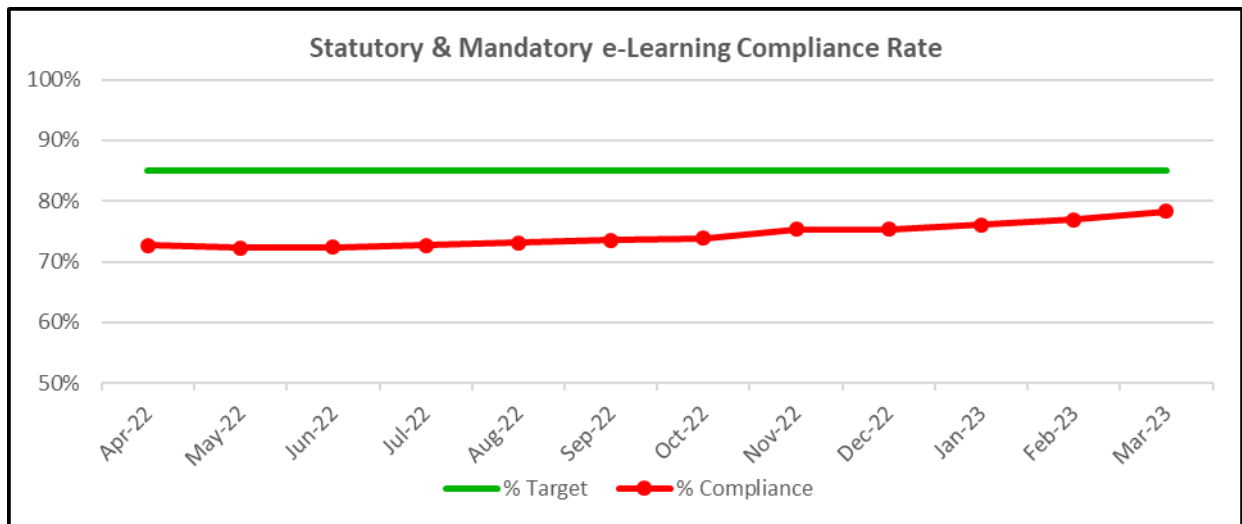
- **Sickness Absence** rates remain high; although the rates appear to be the falling to more 'normal' levels. The monthly sickness rate for March 2023 was 5.40% and February 2023 was 6.13%, after an all-time high of 8.56% for December 2023. The cumulative rate has fallen over the past 3 months to 6.90% (marginally lower than for March 2022, which was 6.92%). This figure is derived from absence since April.



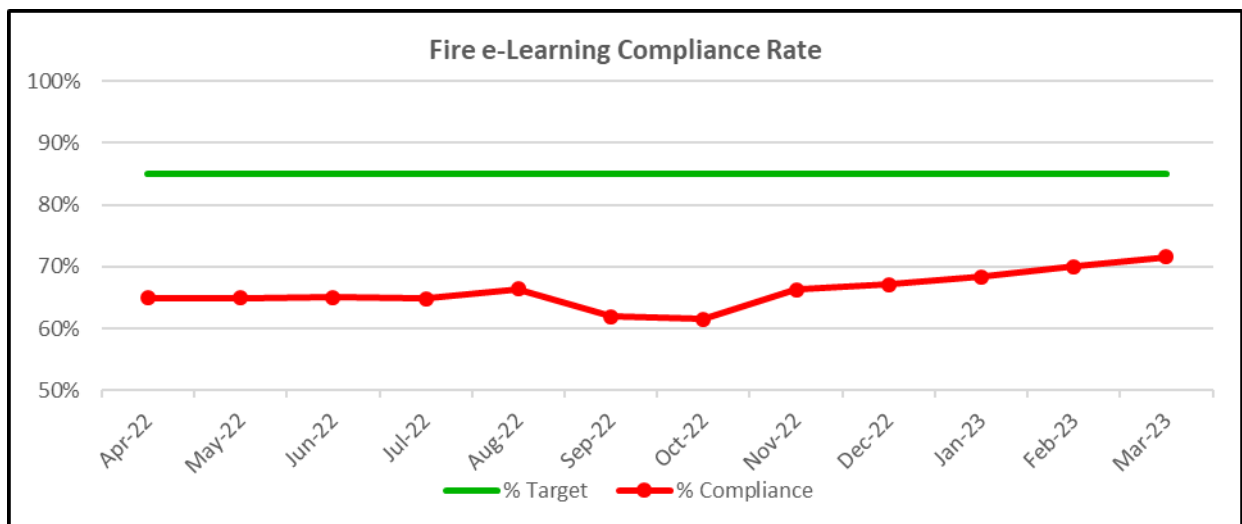
The top 5 reasons for absence for the past 12 months are; 'Anxiety/stress/depression/other psychiatric illnesses', 'Cold, Cough, Flu – Influenza', 'Chest & respiratory problems', 'Other musculoskeletal problems' and 'Gastrointestinal Problems'

The number of staff on long term sick leave suffering where the absence reason has been identified as 'Anxiety/stress/depression/other psychiatric illnesses' has risen slightly. On 31/03/22 there was 284 and as at 31/03/23 there were 295 (an increase of 11 – 3.87%). There are 89 staff on long term absence where Covid-19 has been identified as a Related Reason.

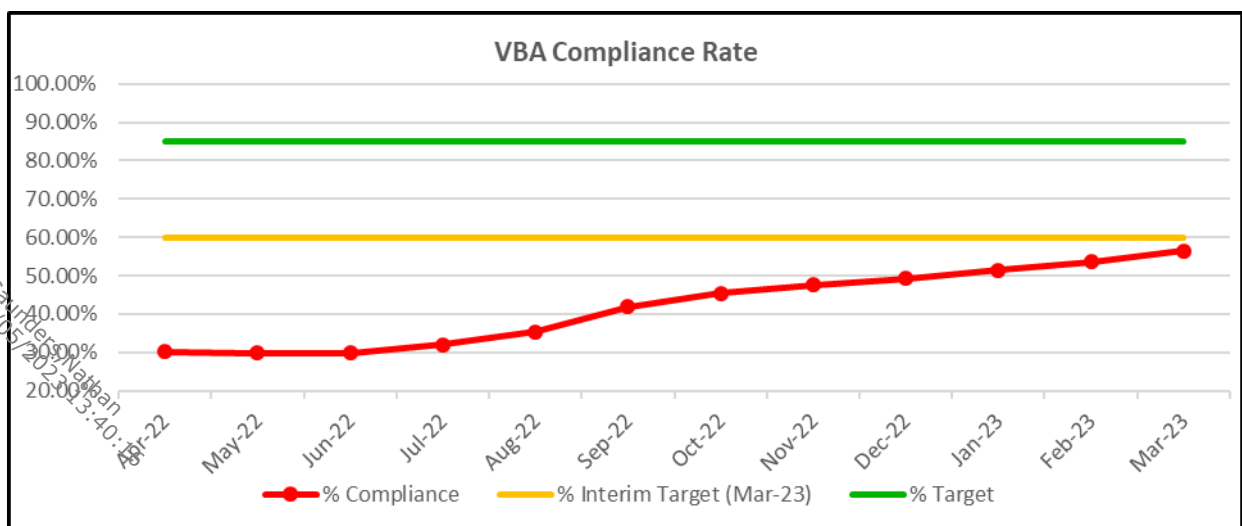
- The **Statutory and Mandatory** training compliance rate has risen, to 78.26% for March, 6.72% below the overall target.



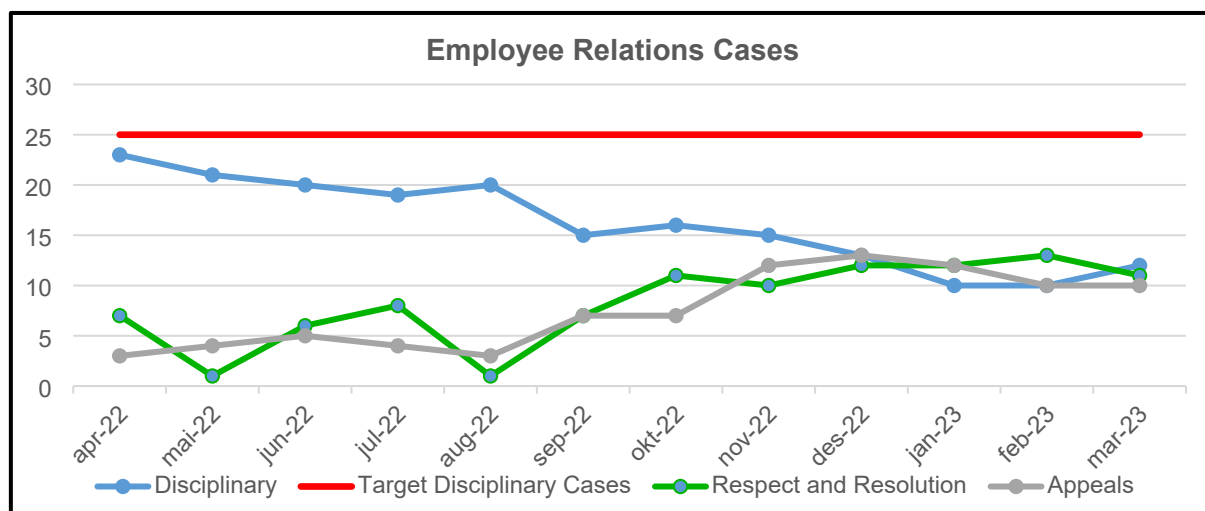
- Compliance with **Fire** training has also risen during March, to 71.53%.



- The trend of the rate of compliance with **Values Based Appraisal** has risen over the last 9 months; the compliance at March 2023 was 56.40%. Clinical Boards had been set an improvement target of 60% by the end of March 23, then 85% by the end of June 2023. Capital, Estates & Facilities (79.88%) Clinical Diagnostics & Therapeutics (67.76%) and PCIC (63.31%) exceeded the 60% transitory target, and Children & Women's reached 59.81%.



- **Employee Relations** - Disciplinary Cases have decreased from 23 in April 2022 to 11 in March 2023. There are currently 12 requests for Formal Resolution under the Respect and Resolution Policy. There are an additional 9 cases being resolved informally with support from the People Services Team.



- **Future Workforce** – a new unregistered Assistant Practitioner role has been developed which provides us with an opportunity to modernise the skill mix, fully implement care around the patient, aligns with prudent health care and ensure the Registered Nurses do what only they can do. The first cohort of 14 Assistant Practitioners commenced their training on 24 April and the next cohort commencing in July are in the process of being recruited to.
- **Workforce Sustainability** – the use of Agency Health Care Support Workers (HCSWs) was introduced during the Covid pandemic. This ceased on 1 April 2023 as part of the Workforce Sustainability Plan and substantive and Bank HCSWs rates have been increased.

Corporate Health Standards - the UHB was successfully re-assessed for the Gold and Platinum Corporate Health Standards in March 2023 and maintained the standards to be recognised as an exemplar organisation. The Wellbeing Strategy Group continues to oversee the delivery of the priorities and actions resulting from the Corporate Health Standard, and much progress has been made over the past year, including staff room and nursery facility refurbishments, provision of financial wellbeing education, signposting and roadshows, and the continued development of peer support. Work has also commenced on developing managers and leaders to effectively support the wellbeing of their teams through effective conversations and a compassionate leadership approach.

OPERATIONAL PERFORMANCE

Emergency & Urgent Care

Performance against the 4-hour standard, 24-hour EU waits, 12-hour trolley waits and ambulance handover times are shown in the balanced scorecard.

There continues to be a challenging position across the urgent & emergency care system, largely driven by high levels of adult bed occupancy, as a result of the high number of patients who are

delayed transfers of care (DTOC) and the continued challenge in our ability to achieve timely discharge and create flow for the Emergency Unit.

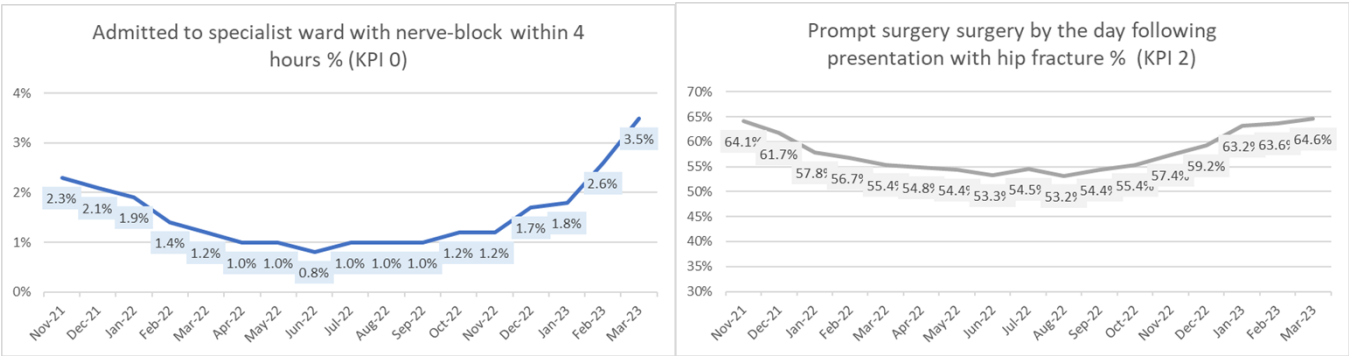
There has been significant improvement in ambulance handover times which has led to an improvement in total number of lost hours and the volume of crews waiting greater than 4 hours to handover.

The number of ambulance handovers >4 hours has reduced from 230 in September 2022 to 0 in February, 2 in March and 0 in April 2023. We are now giving the same focus to patients waiting 2-hours for an ambulance handover.

Fractured Neck of Femur

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. In March 2023, 3.5% of patients were admitted to a specialist ward with a nerve block within 4 hours, with a significant reduction in the median time patients are waiting to move to the ward.

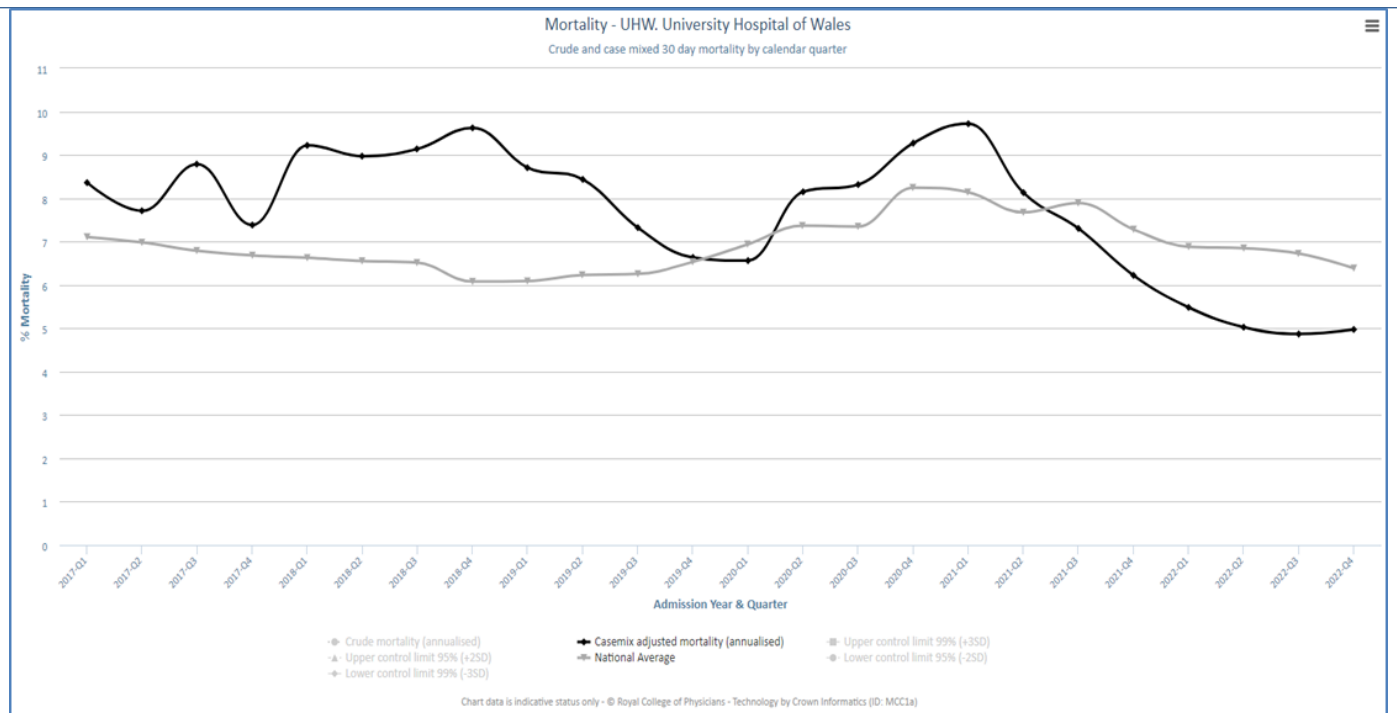
In March, 64.6% of patients received surgery within 36 hours, this is reflective of the general trend during 2022 but a small reduction when compared to October 2021 performance (64.6%). Our performance is above the national average of 56% over the last 12 months.



Summits with key stakeholders were held in March and April with the ambition for significant increases in our performance moving forwards to make Cardiff and Vale an upper quartile performer when compared to UK peers.

In addition to pathway improvements, we are committed to improving outcomes for patients. Data below from the National Hip Fracture Database shows that annualised Casemix Adjusted Mortality rates have falls from early 2021 and is now below the national average.

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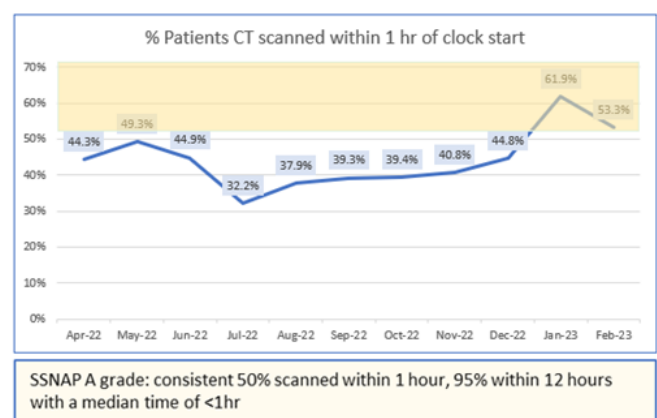
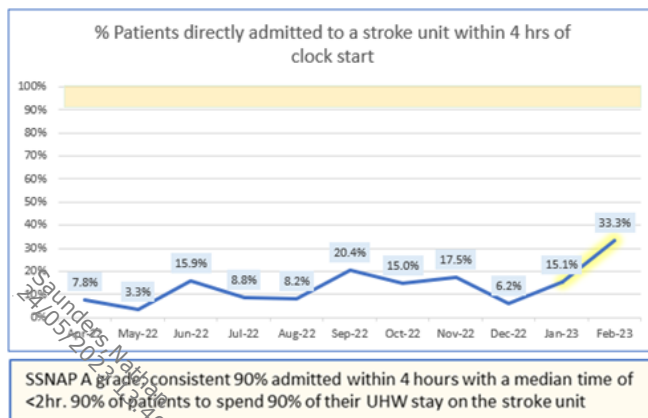


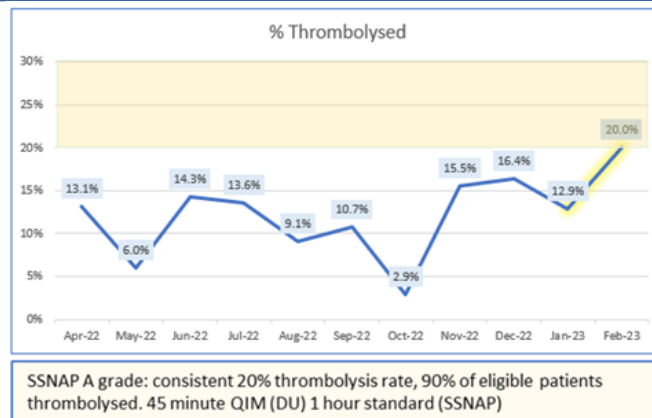
Stroke

Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP), but February saw an improvement in the thrombolysis rate and door to ward performance. In February:

- 8.3% of patients were thrombolysed within 45 minutes of arrival, the All-Wales average was 14.3%. The percentage of patients given thrombolysis improved to 20%, above the All-Wales Average of 15.9%
- The percentage of CT scans that were started within 1 hour in February was 53.3%, the All-Wales average was 59.7%
- The percentage of patients who were admitted directly to a stroke unit within 4 hours saw improvement to 33.3% in February, the All-Wales average was 22.8%

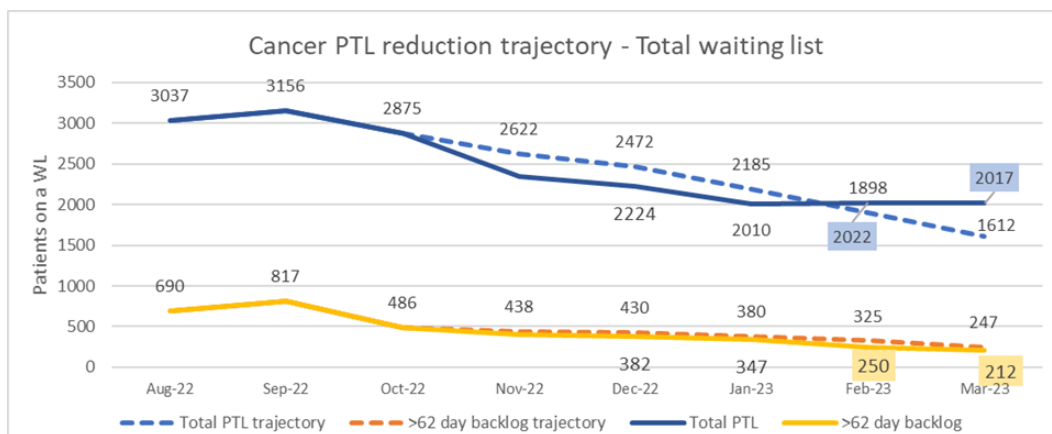
The UHB has held three internal Stroke summits and a number of improvements to the stroke pathway are now being implemented including increased Clinical Nurse Specialists during out of hours, additional middle grade medical cover for the Emergency Unit and ringfencing of additional stroke beds to deploy the pull model from EU effectively. The UHB aspires to achieve a rating of grade 'A' for SSNAP and the gaps for some of the indicators are shown below:





Cancer

There continues to be an improvement against the Single Cancer Pathway and the backlog trajectories agreed with the Delivery Unit. February saw another improvement of 6% compared with January with 61.5% of patients receiving treatments within 62 days.



At the time of writing there are a total of 1914 suspected cancer patients on a single cancer pathway. 258 have waited over 62 days, of which 65 have waited over 104 days.

Of these, there are 1848 Cardiff and Vale patients (excluding tertiary patients) of which 201 have waited over 62 days.

There have been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. Three cancer summits have taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions are required to reduce the delays experienced by our patients.

In addition to internal Cancer summits and the ongoing demand and capacity exercise, there is senior weekly oversight and a current focus on eliminating the number of patients waiting over 62 and 104 days to start their definitive treatment.

Planned Care

The total number of patients waiting for planned care and treatment, the Referral to Treatment (RTT) waiting list was 122,708 as at March 2023. The tail of this waiting list breaks down as follows:

- Patients over 156 weeks – March – 823
- Patients over 104 weeks – March – 3,740

- Patients over 52 weeks – March – 22,644

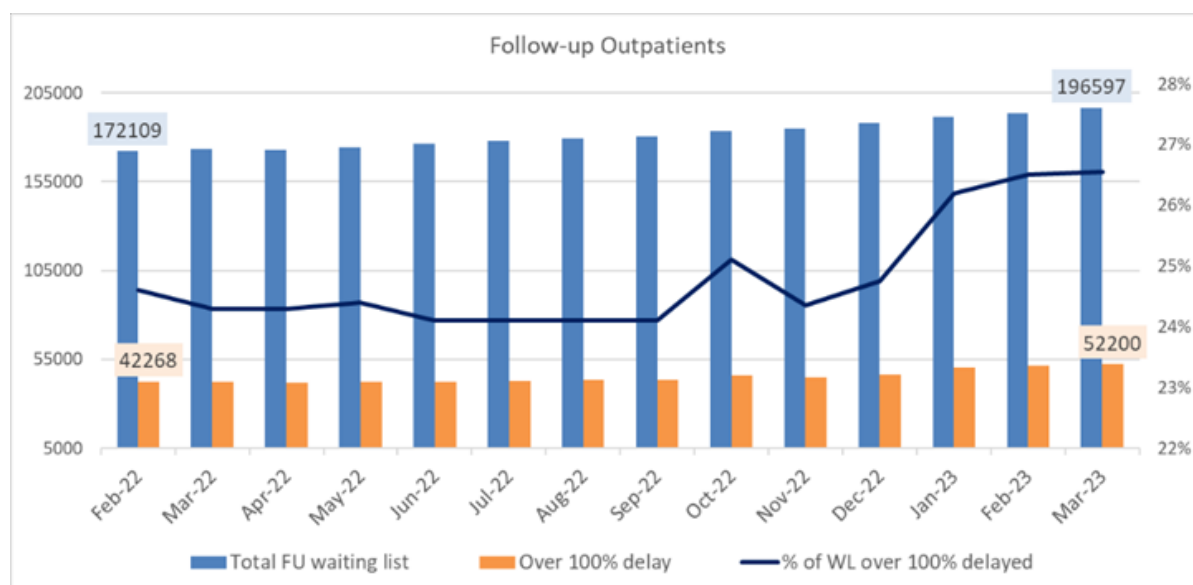
Work continues to reduce the number of these long waiting patients.

The number of patients waiting for planned care and treatment over 36 weeks has decreased to 37,897 at the end of March 2023. 50% of these are at New Outpatient stage.

The overall volume of patients waiting for a follow-up outpatient appointment at the end of March 2023 increased to 196,597. 98.3% of patients on a follow up waiting list have a target date, above the national target of 95%. The number of follow-up patients waiting 100% over their target date has increased to 52,200. This is of concern and will be an area of additional focus and support to improve the position over the next few months. This work will be driven through the Outpatients Delivery Group with action plans being developed by Clinical Boards focusing on:

- Use of COMII system to record and book follow-ups
- Review of automated processes used to maintain waiting lists
- Administrative and clinical validation
- Risk stratification of waiting lists

This is in addition to ongoing pathway work looking at alternatives to traditional follow-up appointments such as the use of see-on-symptoms pathways.



Ministerial Measures

Weekly tracking of delivery against the following ministerial priorities is established. The health board remains on track to deliver against trajectories shared with the NHS Wales Delivery Unit.

Measure	WG Ambition	IMTP commitment	Trajectory shared with DU	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of patients waiting over 52 weeks for a new outpatient appointment	0 (end of December 2022)	20,235 (end of December 2022)	15,723 (end of December 2022)	15,588	15,810	16,272	16,584	16,179	15,291	14,697	13,311	11,775	10,951	10,707	10,102
Number of patients waiting over 104 weeks for treatment (all stages)	0 (end of March 2023)	750 (end of March 2023)	6415 (end of March 2023)	9,066	8,820	8,300	8,308	7,687	7,038	6,309	5,553	5,099	4,587	4,333	3,740

Where we are not able to deliver against the 104-week ambition, we are working to eliminating 3 year waits in these specialties. We have some further work to do to give full assurance on this for all specialties, there are patients in this cohort requiring a plan across ENT, Ophthalmology, Spines, General Surgery and Urology. The reduction in this 3 year wait cohort is tracked on a weekly basis and reported monthly:

Cohort	Oct	Nov	Dec	Jan	Feb	March
Number of patients who will have waited more than 156 weeks for treatment (all stages) by end of March 2023	3,491	2,704	2,152	1,611	1,216	823

Diagnostics and Therapies

The volume of greater than eight-week Diagnostic waits has increased to 4,782 at the end of March 2023 from 4,421 in February, largely driven by increased waits in Radiology. Greater than eight-week waits for a diagnostic endoscopy increased and remain high as detailed below:

Radiology modality	Jan-23	Feb-23	Mar-23	Trend
MRI	1084	915	874	
Non-Obstetric Ultrasound	1311	946	1279	
CT	8	18	15	

Diagnostic endoscopy	Jan-23	Feb-23	Mar-23	Trend
Cystoscopy	241	228	224	
Colonoscopy	239	240	272	
Flexible Sigmoidoscopy	348	337	311	
Gastroscopy	767	679	741	
Bronchoscopy	11	13	15	

The number patients waiting over 14 weeks for Therapy has reduced to 952 in March from 1,113 in February, driven largely by a reduction in waits for Dietetics.

Mental Health

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, with referrals for the Local Primary Mental Health Support Service (LPMHSS) at 1523 referrals in March 2023. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioural needs.

Significant work has been undertaken to improve access times to adult primary mental health and CAMHS services:

- Part 1a: The percentage of Mental Health assessments undertaken within 28 days was 96.8%, decreased from 99.6% in February 2023. For CAMHS services, compliance decreased from 97.9% in February to 92.7% in March 2023.
- Part 1b: 99.5% of therapeutic treatments started within 28 days following assessment at the end of March 2023, an increase from the reported compliance in February 2023 (91.1%)
- Part 2: 80% of Health Board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP) at the end of February 2023
- Part 3: 69% of Health Board residents were sent their outcome assessment report within 10 days of their assessment in February 2023

Primary Care

The Health Board was 50% compliant in March 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 1 of 2 patients receiving their visit with one hour. For patients that required an 'Emergency' appointment at a primary care centre in March the Health Board was 100% compliant, with 7 of 7 patients receiving an appointment within 1 hour.

Pressure has continued within GMS. There were 9 practices reporting either level 3 or 4 escalation at the time of writing the report. The 2 GMS contract resignations have been effectively managed by the primary care team. General Dental services were operating at around 68% of pre-Covid activity in December, with the uptake of the new Dental Contract this measure

has been discontinued and will be replaced for 23/24 reporting. Optometry is operating at pre-Covid levels. Community pharmacy has remained open with no issues reported.

Integrated and System Working

The number of medically fit for discharge patients remains high and continues to present significant operational and financial pressures. For the four years prior to the pandemic the numbers of MFFD patients were between 120 – 150 patients.

Since January of 2023 the number has remained at c330 – 350, The latest position and reasons for delay are shown below:

January 2023

Constraint	Cardiff	Vale	Other
Social Worker Assessment	74	33	0
Social Worker Allocation	41	8	0
Package of Care	40	23	0
Residential home	21	4	0
Rehabilitation	11	5	3
Get me Home +	11	0	0
Nursing Home	8	7	1
CRT/VCRS	6	2	0
Housing	6	0	0
Legal	6	0	0
Therapy Support	4	2	1
Repatriation	1	1	6
Total by Local Authority	229	85	11
Grand Total	325		

Bed days Lost	8110	2625	572
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In order to mitigate this increase and to be able continue with planned care and reduce the pressure in EU, the UHB has opened an additional c150 beds since the pandemic.

Although working relationships with local authority partners is good, at the current time there are no obvious solutions to significantly reduce these numbers of delays.

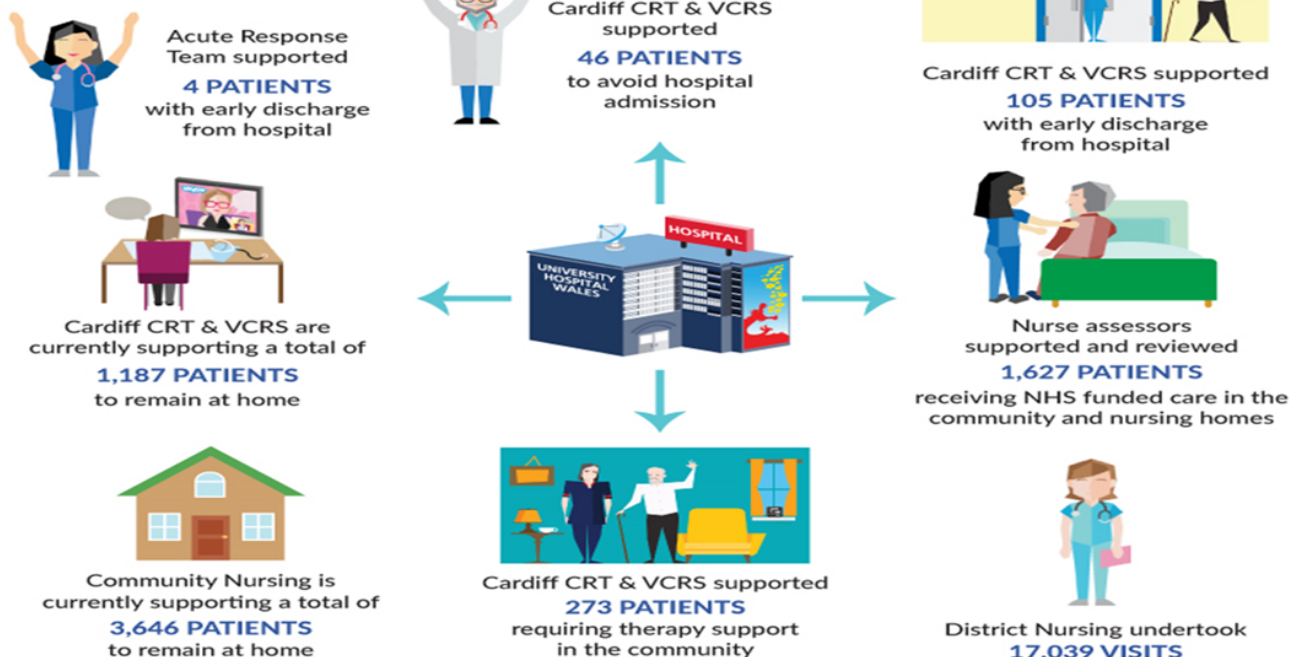
'Further Faster' and the @home programme will certainly help in the medium to long term but the UHB will need to continue to manage this significant safety, quality, operational and financial risk for the foreseeable future.

Community Care

Our community teams continue to provide valuable services to the residents of Cardiff and the Vale. Our teams work to care for patients in the community and also provide timely and supportive discharges from secondary care. In March 2023 the community nursing team supported over 3,600 patients to remain at home and the District Nursing team undertook 17,039 visits – seeing 25% more patients than attend the EU each month. A breakdown of our teams' activity across primary, secondary and social care can be seen below:

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DURING MARCH 2023...



Thank you to the wards & teams who continue to make the most of community services



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

FINANCE

How are we doing?

The Health Board agreed and submitted a final financial plan to Welsh Government at the end of June 2022. The final plan is structured in three parts in line with Welsh Government guidance as follows:

- Core Financial Plan including recovery
- National inflationary pressures which are out of the direct control of individual Health Boards.
- Ongoing COVID response costs.

The UHB's core plan incorporated: -

- Brought forward underlying deficit of £29.7m
- Allocations and inflationary uplifts of £29.8m
- Capped cost pressures and investments of £36.9
- A £16.0m (2%) Initial Savings programme
- £3.7m Further Financial Recovery Actions (£3.4m Savings & £0.3m reduction in Investments)

This resulted in a 2022-23 planning deficit of £17.1m.

Following discussions with Welsh Government, the Finance Committee and Board, the forecast deficit increased to £26.900m at month 8 in recognition of the cumulative year to date position and additional unforeseen cost pressures that had emerged in 2022-23.

Reported month 12 position

The Welsh Government monthly financial monitoring returns capture and monitor costs due to COVID 19 and exceptional cost pressures that are over and above LHB core plans. At month 12 the UHB reported to Welsh Government that it will meet its control target of a £26.9m deficit for the end of 2022-23 and this is summarised in Table 1.

Table 1 : Month 12 Financial Position

	Forecast Year-End Position £m
Planned deficit	17.100
Operational position (Surplus) / Deficit	9.800
Financial Position £m (Surplus) / Deficit £m	26.900

The UHB expects to deliver a £26.9m deficit in its draft accounts. The UHB is reporting that it stayed within its Capital Resource Limit. Creditor payment compliance met the 95% target.

The Board is asked to note that the reported performance is provisional at this stage as the draft accounts have not yet been finalised and will be subject to Audit Wales scrutiny. The year-end reported position is, however, not expected to materially change.

The actual and provisional performance against the 3 year break even duty on revenue is shown in Table 2 below.

Table 2: Performance against the 3 year financial break even duty

	Actual / Forecast year end position surplus/(deficit) £m	Rolling 3 year break even duty surplus/(deficit) £m	Pass or fail financial duty
2014/15	(21.364)	n/a	n/a
2015/16	0.068	n/a	n/a
2016/17	(29.243)	(50.539)	Fail
2017/18	(26.853)	(56.028)	Fail
2018/19	(9.872)	(65.968)	Fail
2019/20	0.058	(36.667)	Fail
2020/21	0.090	(9.724)	Fail
2021/22	0.232	0.380	Pass
2022/23	(26.900)	(26.578)	Fail

The three year break even duty came into effect in 2014/15 and the first measurement of it was in 2016/17. The table above shows the UHB did not meet its financial duty in 2022/23. The tables also outline that the UHB breached its statutory financial duty from 2016/17 to 2020/21 and met the duty in 2021/22.

Savings Programme

The UHB savings delivery was broadly in line with the revised £19.400m savings target

Creditor payment compliance

The UHB achieved the public sector payment compliance with performance for the year of 95.2% at the end of March.

Remain within capital resource limit

The UHB's remained within its approved annual Capital Resource Limit (CRL) which was £55.410m at the 31st March 2023. Expenditure was broadly in line with the CRL.

Recommendation:

The LPF is requested to:

NOTE the contents of this report

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	x	Long term		Integration	x	Collaboration		Involvement	
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/No

N.A

Safety: Yes/No

N.A

Financial: Yes/No

N.A

Workforce: Yes/No

N.A

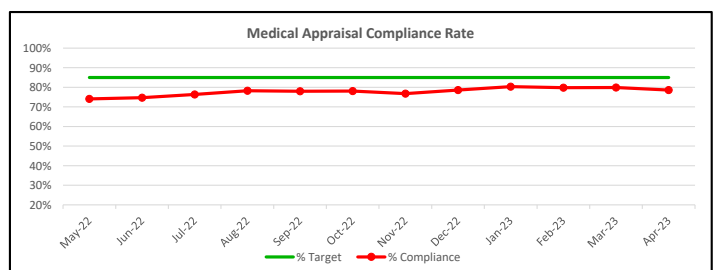
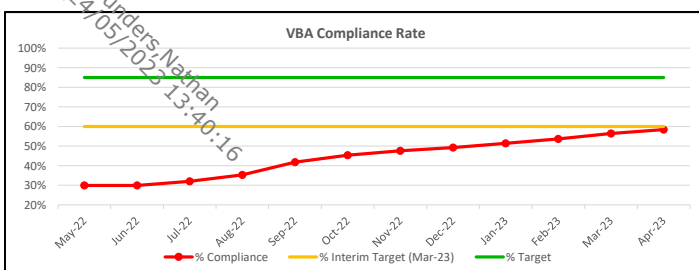
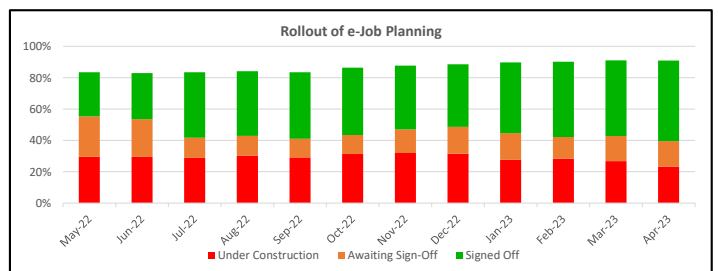
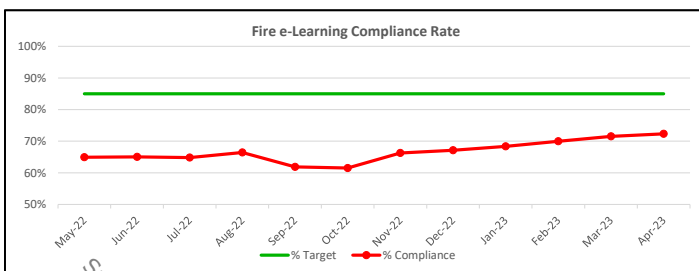
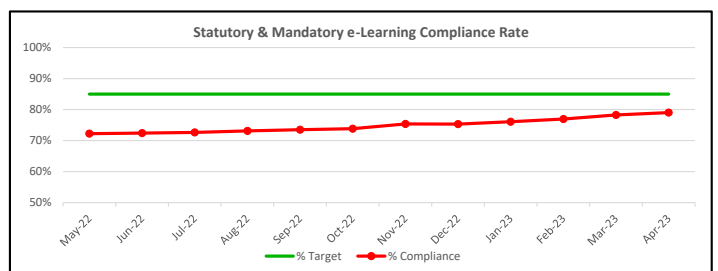
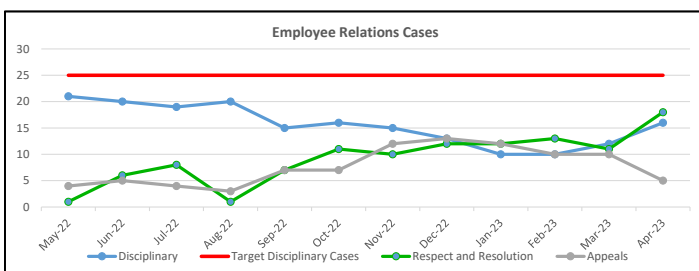
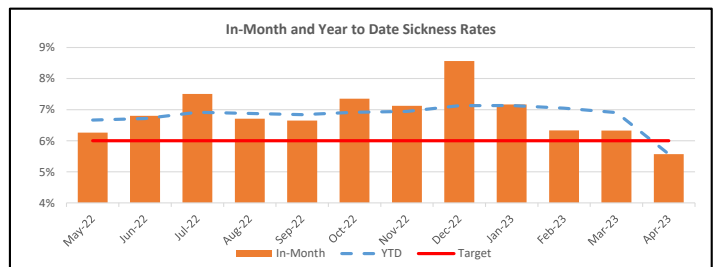
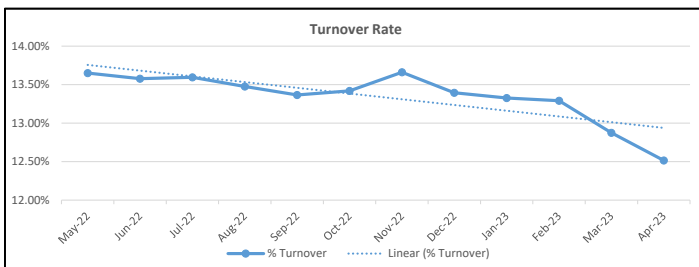
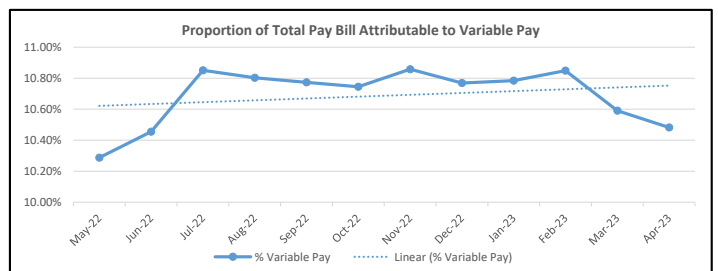
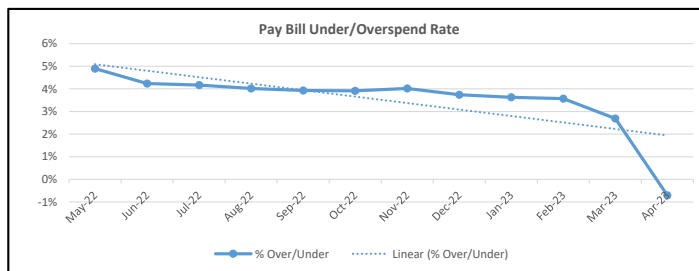
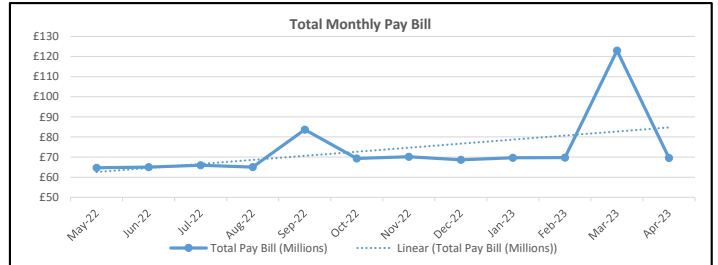
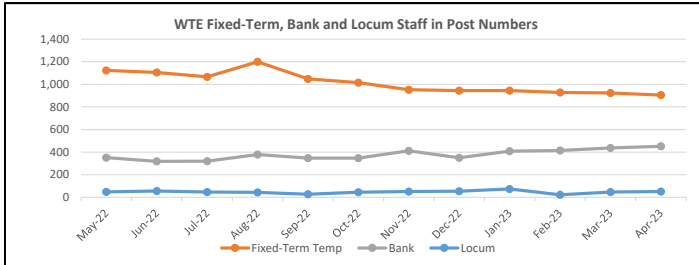
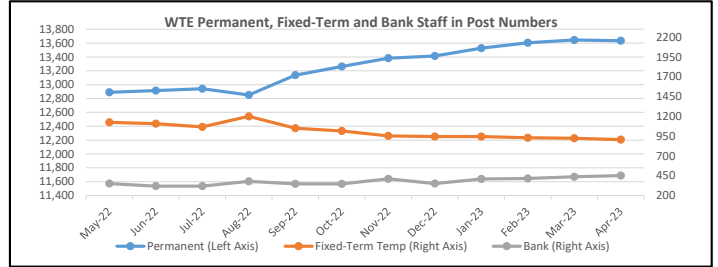
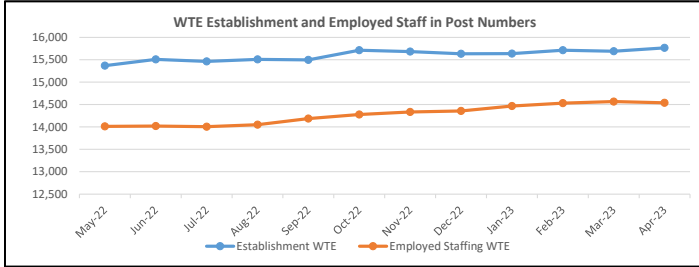
Legal: Yes/No

N.A

Reputational: Yes/No	
N.A	
Socio Economic: Yes/No	
N.A	
Equality and Health: Yes/No	
N.A	
Decarbonisation: Yes/No	
N.A	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

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Workforce Key Performance Indicators Trends April 2023



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Report Title:	Strategic Equality Plan – Annual Review			Agenda Item no.	8
Meeting:	Local Partnership Forum	Public	X	Meeting Date:	8 June 2023
Status (please tick one only):	Assurance	X	Approval	Information	
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Equity & Inclusion Senior Manager				

Main Report

Background and current situation:

The Strategic Equality Plan: Caring about Inclusion is our third, four-year Strategic Equality Plan (SEP) and is closely aligned to our ten-year strategy 'Shaping Our Future Well-being' and our IMTP, as well as to the organisation's values. Our ambition is that a person's chance of leading a healthy life is the same wherever they live and whoever they are. The current SEP sets out the most important outcomes we want to achieve and some of the ways in which we will deliver improvements between April 2020 and March 2024.

Progress on the report is monitored via the Equality Strategy and Welsh Language Standards Group (ESWLSG). The Plan outlines four key outcomes:

1. People are and feel respected this includes patients, carers and family members as well as staff and volunteers
2. We communicate and engage with people in ways that meet their needs (whether this is through written communication, face to face, signage, Welsh or other community languages including British Sign Language)
3. More people receive care and access services that meet their individual requirements, including those from socio-economic communities
4. Gender and any other protected characteristic pay Gaps are eliminated Under each of these headings are a set of objectives outlining the steps needed to achieve the outcomes.

Over the past year, the Equity and Inclusion Team have worked to establish a number of workstreams to support delivery of the SEP.

Please see highlights below:

- **Disability Confident Level 3**

A key objective of the SEP was met last autumn when the UHB achieved Disability Confident Leader (Level 3) status, meaning the UHB can promote itself as a leader in disability inclusion. The Disability Confident Leader logo is now included on our job adverts to promote the UHB as an inclusive employer.

- **LGBTQ+ - Pride & Stonewall**

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Last summer, the UHB joined other NHS Wales organisations at Pride Cymru, which was the first time the event had been held in person since the start of the pandemic. The UHB enjoyed an excellent turnout and had the privilege of leading the parade as part of NHS Wales, with some CAVUHB colleagues holding the Pride Cymru banner at the front.

On 17th June 2023, colleagues from CAVUHB will once again join the NHS Wales parade as part of Pride Cymru, demonstrating organisational commitment to LGBTQ+ inclusion.

Our activity around LGBTQ+ inclusion resulted in the UHB maintaining its Gold Award as part of Stonewall's Workplace Equality Index (WEI) and CAVUHB being ranked as the 80th most LGBTQ+ inclusive employer in the UK by the charity.

- **Staff Networks**

The organisation has continued to support our three staff networks, with some of the networks' highlights recorded below.

Access Ability Staff Network

As the organisation's newest staff network, Access Ability hosted events to promote the network and have provided advice and support in developing the 'Wellbeing Passport', which will be launched this year. The passport will help disabled employees to have discussions with their manager about creating a work environment where they can thrive.

LGBTQ+ Staff Network

The network has appointed a new committee and have hosted a couple of social events over recent months. The network supported the UHB with attendance at Pride Cymru and with its submission to Stonewall's WEI.

One Voice Staff Network

The One Voice Staff Network has been very active over recent months, which has included hosting awareness days on numerous UHB sites during Black History Month. The network has also worked with the UHB to develop the draft CAVUHB Anti-racist Action Plan and invited Prof. Anton Emmanuel, who was key to establishing the Workforce Race Equality Standards (WRES) in NHS England and has supported Welsh Government with the scoping of the Welsh version, to one of their staff network meetings to discuss the importance of collecting data. Race Equality First have recently delivered a training session to network members.

Rhwyd-iaith

Rhwyd-iaith is a new Welsh language staff network in its infancy and yet to meet for the first time. When requesting expressions of interest in establishing the staff network, over 50 people contacted to advise they would like to join Rhwyd-iaith with ten of those keen to join the committee.

- **SharePoint**

The Equity and Inclusion Team have developed a SharePoint site to support colleagues throughout the organisation in better understanding how they can build inclusive environments for patients, service users, and staff. The site includes a library of resources, information and on our staff

networks, and advice in completing an Equality Health Impact Assessment (EHIA), amongst other items.

- **Inclusion Calendar 2023**

The 2023 version of the UHB's Inclusion Calendar has been published, which raises awareness of different celebratory and commemorative events and dates throughout the year which relate to equity and inclusion. The calendar is available to staff via the Equity and Inclusion SharePoint.

- **Inclusion Ambassadors**

The UHB has Inclusion Ambassadors for each of the protected characteristics and Welsh language at Executive and Board level, as well as at senior leadership level in a number of the clinical boards. An 'Inclusion Ambassador Starter Pack' has been published, which aims to support Inclusion Ambassadors in undertaking their role. Accompanying resource lists have also been finalised, which will aid Inclusion Ambassadors in better understanding the lived experiences of those who have the protected characteristic which they represent.

- **Welsh Language**

Progress has been made in organisational compliance with the Welsh Language Standards and the UHB now reports compliance with 81 out of the 121 standards.

The recruitment of two Senior Welsh Language Translators has proved successful with the team translating over a million words in each of the past two years. The use of translation memory software led to an 11% increase in the number of words translated in 2022 in comparison with 2021, with the team translating 1,158,688 words last year. The team have supported with the translation of UHB communications, organisational strategy, and patient facing resources.

- **EHIA Training**

The development of an EHIA training package, co-designed with colleagues in Public Health, has supported departments in understanding the importance of EHIA's and how they are most effectively undertaken. Training can be booked through the Equity and Inclusion SharePoint.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The UHB has made good progress in meeting its objectives as set out in our SEP.

Over the coming months, the Equity and Inclusion Team will maintain a focus on key areas outlined below to support with the delivery of the SEP during 2023 and to make a difference to the experiences of our communities and colleagues.

- **Data**

The Equity and Inclusion Team will work with colleagues in People Analytics and the wider People & Culture function to improve the collection of equality monitoring and Welsh language skills data of staff, including that collected through ESR, through a proactive data campaign. The campaign will make it easier for staff to record their information through the creation of additional reporting channels.

- **Race Equality**

The UHB's Anti-racist Action Plan will be published in June 2023, following Board approval. In the meantime, work is underway on a number of actions, including undertaking listening exercises to better understand the experiences of our colleagues from ethnic minority communities.

- **Welsh Language**

Work will continue to improve our compliance with the Welsh Language Standards. Our Clinical Consultation Plan scheduled to be published at the end of May 2023.

- **Health Equality, Equity, Safety and Experience Framework**

A small task and finish group, with senior representation from Public Health, Quality and Safety, Patient Experience, and People and Culture, has been established to develop a framework which will support the UHB in tackling any inequalities and inequities experienced by our communities and colleagues.

Recommendation:

The Local Partnership Forum is requested to:

- **Note** and **discuss** the contents of the report
- Support the work underway and continue to actively contribute to workstreams, such as the equality data campaign and the Anti-racist CAVUHB Action Plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
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Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Safety: Yes

Risk to the safety of patients and staff who do not trust the organisation will treat them fairly.	
Financial: Yes	
Potentially through claims for discrimination.	
Workforce: Yes	
Attracting and retaining a diverse workforce	
Legal: Yes	
There is a legal requirement as part of the Public Sector Equality Duty under the Equality Act 2010 to publish equality objectives.	
Reputational: Yes	
CAVUHB viewed as an organisation that is not inclusive of its communities	
Socio Economic: Yes	
Linked to demographics served / represented.	
Equality and Health: Yes	
Health inequalities and inequities within our communities are exacerbated.	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Local Partnership Forum	

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Report Title:	Clinical Board Local Partnership Forum – generic Terms of Reference			Agenda Item no.	9
Meeting:	LPF	Public		Meeting Date:	08.06.23
		Private			
Status (please tick one only):	Assurance		Approval	x	Information
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Head of People Assurance and Experience				
Main Report					
Background and current situation:					
<p>Members will be aware that the University Health Board (UHB) has statutory duty to ‘take account of representations made by persons who represent the interests of the community it serves’. This is achieved in part by three advisory groups to the Board and the Local Partnership Forum (LPF) is one of these as the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. This in turn has three sub-groups; the Workforce Partnership Group (WPG), the Employment Policies Sub Group and the Staff Benefits Group.</p> <p>At a more local level, each Clinical Board also has monthly or bi-monthly Local Partnership Forums which enable the Clinical Board leadership team to engage with trade union representatives and establish ongoing dialogue, communication and consultation on service and operational management issues specific to CB areas on local matters. The LPF received the Annual Report from the Clinical Board LPFs in April 2023.</p> <p>The Terms of Reference (ToR) have been reviewed and consulted upon to create a standard set for all Clinical Boards. These were considered at Workforce Partnership Group on 9 May 2023 and are now presented to the UHB LPF for approval.</p>					
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:					
Recommendation: <p>The Local Partnership Forum is requested to:</p> <ul style="list-style-type: none"> Approve the generic Terms of Reference for the Clinical Board Local Partnership Forums 					
Link to Strategic Objectives of Shaping our Future Wellbeing:					
Please tick as relevant					
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance			
2. Deliver outcomes that matter to people		7. Be a great place to work and learn		x	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology		x	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us		x	

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	
Five Ways of Working (Sustainable Development Principles) considered <i>Please tick as relevant</i>			
Prevention		Long term	
		Integration	
		Collaboration	
		Involvement	
Impact Assessment: <i>Please state yes or no for each category. If yes please provide further details.</i>			
Risk: Yes/No			
Safety: Yes/No			
Financial: Yes/No			
Workforce: Yes/No			
Legal: Yes/No			
Reputational: Yes/No			
Socio Economic: Yes/No			
Equality and Health: Yes/No			
Decarbonisation: Yes/No			
Approval/Scrutiny Route:			
Committee/Group/Exec	Date:		

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NHS
WALES

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

Clinical Board Local Partnership Forum

Terms of Reference

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

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1. INTRODUCTION

1.1 The UHB Local Partnership Forum (LPF) is the formal mechanism where the Management and Trade Unions* work together to improve health services for the people of Cardiff and the Vale of Glamorgan and for others accessing services provided by the Health Board. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues. At a more local level, each Clinical Board also has Local Partnership Forums which enable the Clinical Board leadership team to engage with trade union representatives on local matters.

*all references to Trade Unions include Trade Unions, Professional Staff Organisations and Staff Associations

General Principles

1.2 The Clinical Board LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

The principles of true partnership working between Management and Trade Unions are as follows:

- Management and Trade Unions show joint commitment to the success of the organisation with a positive and constructive approach.
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect.
- They demonstrate commitment to security for workers and flexible ways of working.
- They share success – rewards must be felt to be fair.
- They practice open and transparent communication – sharing information widely with openness, honesty and transparency.
- They must bring effective representation of the views and interests of the workforce.
- They must demonstrate a commitment to work with and learn from each other.

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All members must:

- Behave in line with and be role models for the UHB Values: kind and caring; respectful; trust and integrity; and personal responsibility.
- Be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes.
- Promote the work of the LPF within the professional discipline they represent.

A Code of Conduct is attached as **Annex 1**.

2. PURPOSE

2.1 The purpose of the Clinical Board LPF is to:

- Establish a regular and formal dialogue between the Management and Trade Unions on matters relating to workforce and health service issues within the Clinical Board .
- Enable Employers and Trade Unions to put forward issues affecting the workforce within the Clinical Board .
- Provide opportunities for Managers and Trade Unions to input into Clinical Board service development plans at an early stage.
- Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- Consider the implications for staff of NHS reorganisation at a national or local level and to work in partnership to achieve the mutually successful implementation where it impacts on the Clinical Board.
- Appraise and discuss in partnership the financial performance of the Clinical Board on a regular basis.

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- Appraise and discuss in partnership the Clinical Board service and activity and its implications.
- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.
- Communicate to the partners the key decisions taken by the Health Board and senior management.
- Negotiate on matters subject to local determination.
- Ensure Trade Union representatives are afforded reasonable paid time off to undertake Trade Union duties.
- Develop in partnership appropriate facilities arrangements using Agenda for Change Facilities Agreement as a minimum standard.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 The Clinical Board LPF may establish sub committees or task and finish groups to carry out on its behalf specific aspects of LPF. This must be done in Partnership.

4. MEMBERSHIP

Members

- 4.1 All members of the Clinical Board LPF are full and equal members and share responsibility for the decisions of the LPF. The Clinical Board shall agree the overall size and composition of the LPF in consultation with the lead Staff Representative for that Clinical Board . The Health Board's Trade Union Independent Member will be invited to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Chairs

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The Clinical Board Director of Operations and Lead Staff Representatives will co-chair the Clinical Board LPF. The Chairs shall work in partnership with each other. Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

Management Representatives

This will differ for each Clinical Board LPF but it is recommended that management representatives include:

- Director of Operations
- Director of Nursing
- Directorate Managers
- Finance (as required)
- People Services (as required)

Staff Representatives

The Clinical Board Lead Staff representative for that Clinical Board or a deputy.

Staff representatives from each of the Trade Unions or Professional Organisations recognised by the Health Board (listed in the UHB Partnership and Recognition Agreement) specific to the staffing group membership working within the specific clinical board.

The Chair of Staff Representatives and the Lead Staff Representative for that Clinical Board will engage and decide on the formula to achieve proportionate maximum number of staff representatives from each of the Trade Unions or Professional Organisations to attend in partnership with the Clinical Board. This will be reviewed locally and periodically as required.

The Chair of Staff Representatives has a standing invitation to attend all Clinical Board Local Partnership Forum meetings or to send the Vice Chair as a Deputy

Standing Invitation

Chair of Staff Representatives (or Deputy)

Independent Member (Trades Unions)

4.2 Staff representatives must be employed by the organisation and accredited by their respective organisations. If a representative

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ceases to be employed by the Health Board or ceases to be a member of a nominating organisation then they will automatically cease to be a member of the LPF.

- 4.3 Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend within a year (except for reasons of sickness, pre-planned annual leave, maternity leave, etc.), the Joint Chairs will write to the member and bring the response to the next meeting for further consideration and possible removal from the LPF.

In attendance

4.4 By invitation

The Clinical Board LPF Joint Chairs may invite any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

5. FORUM MEETINGS

Quorum

- 5.1 There must be 3 management representatives and 3 staff representatives for the meeting to be quorate.
- 5.2 If the meeting is not quorate no decisions can be made but information may be exchanged and recommendations can be endorsed at the next meeting (when quorate).

Frequency of Meetings

- 5.3 Meetings will be held bi monthly but this may be changed to reflect the need of either staff or management representatives.
- 5.4 Where Joint Chairs agree, extraordinary meetings may be scheduled with 7 calendar days notice.

Management of Meetings

- 5.6 The business of the meeting shall be restricted to matters pertaining to Clinical Board operational issues. e.g. finance, policies, workforce and

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service issues and strategic/commissioning plans that form part of the Clinical Board IMTP

The agenda and papers shall be sent out no later than 7 days prior to the following meeting.

The Clinical Board should ensure the administration of meetings (including agendas, papers etc) by nominating a LPF secretary.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Clinical Board LPF shall:

- Report formally at least annually to the UHB LPF on the Clinical Board LPF's activities.
- Raise with the UHB LPF or Workforce Partnership Group any significant matter under consideration by the Clinical Board LPF.
- Enable the Clinical Board Lead Representative to raise any matters from the Workforce Partnership Group and the UHB LPF to the Clinical Board LPF.
- Provide a record of the meeting to share with the workforce on matters discussed and outcomes agreed.
- Report the outcome of the meeting to the Clinical Board escalating any risk, issues, areas of good practice and to celebrate success.

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Appendix 1

Code of Conduct

A code of conduct for meetings sets ground rules for all participants.

- Respect the meeting start time and arrive punctually.
- Attend the meeting well-prepared, willing to contribute and with a positive attitude.
- Commitment to complete actions from meetings.
- Listen actively - allow others to explain or clarify when necessary.
- Observe the requirement that only 1 person speaks at a time.
- If a participant has an opinion that they wish to contribute, this should be noted to the Chair (raise hand in person/virtually) so they can manage the meeting effectively and avoid people speaking over each other.
- Avoid ‘put downs’ of views or points made by colleagues.
- Respect a colleague’s point of view.
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation.
- Try not to react negatively to criticism or take as a personal slight.
- Put forward criticism in a positive way.
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views.
- No ‘side-meetings’ to take place.
- A focus on the quality of health and wellbeing of working life.
- Respect the Chair.

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- All participants must respect the values and behaviours of the Health Board at all times and foster a can-do approach.
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the member.
- Be mindful of other agenda items when delivering to ensure that the meeting runs on time.
- Actions from each meeting to be agreed, confirming the date of completion and by whom.

Appendix 2

Six TUC Principles of Partnership Working

- A shared commitment to the success of the organisation.
- A focus on the quality of working life.
- Recognition of the legitimate roles of the employer and the Trade Union.
- A commitment by the employer to employment security.
- Openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation.
- Adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the Trade Union and employees.

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