



RESOURCE AND DELIVERY COMMITTEE

**Tuesday, 7 November 2017 at 9.00am
Corporate Meeting Room, Headquarters, UHW**

RESOURCE AND DELIVERY COMMITTEE
7 November 2017 at 9.00am
Corporate Meeting Room, Headquarters, UHW
AGENDA

Part 1: Items for Action		
1.	Welcome and Introductions	Oral <i>Chair</i>
2.	Apologies for Absence	Oral <i>Chair</i>
3.	Declarations of Interest	Oral <i>Chair</i>
4.	Minutes of the Resource and Delivery Committee meeting held on 8 August 2017	<i>Chair</i>
5.	Action Log of meeting held on 8 August 2017	<i>Chair</i>
Delivery		
6.	Assurance on RTT Planning Cycle Development	<i>Interim Chief Operating Officer Presentation</i>
7.	Update on Theatres Utilisation Report	<i>Interim Chief Operating Officer</i>
8.	Wales Audit Office – Orthopaedics	<i>Interim Chief Operating Officer</i>
9.	Wales Audit Office – Medicines Management	<i>Medical Director</i>
10.	Wales Audit Office – Radiology Services	<i>Interim Chief Operating Officer</i>
Resources		
11.	UHB Workforce and Organisational Development Delivery Plan – 6 Monthly Update	<i>Director of Workforce and OD Presentation</i>
12.	Performance Against Strategic Equality Plan	<i>Equality Manager</i>
13.	More Than Just Words (Welsh Language)	<i>Equality Manager Oral</i>
Governance		
14.	Policies for Approval: 14.1 Records Management 14.2 Medical Appraisal Policy	<i>Director of Workforce and OD</i>

15.	Updated Extract on Corporate Risk Assurance Framework	<i>Director of Corporate Governance</i>
Part 2: Items to be recorded as received and noted for information by the Committee		
16.	High Level Performance Dashboard	<i>Interim Chief Operating Officer</i>
17.	Review of the Meeting	<i>Oral Chair</i>
18.	To note the date, time and venue of the next meeting of the Committee: Tuesday, 30 January 2018 at 9.00am in the Corporate Meeting Room, Headquarters, University Hospital of Wales	

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

**UNCONFIRMED MINUTES OF A MEETING OF THE RESOURCE AND DELIVERY
COMMITTEE
HELD ON 8 AUGUST 2017 – 9.00AM
CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

Present:

Margaret McLaughlin
Stuart Egan

Independent Member – Third Sector, Chair
Independent Member – Trade Union

In Attendance:

Fiona Jenkins
Julie Cassley

Director of Therapies, Health Science and IT
Interim Director of Workforce and Organisational
Development

Peter Welsh
Sharon Hopkins
Steve Curry

Director of Corporate Governance
Director of Public Health
Chief Operating Officer

Apologies:

Ruth Walker
Akmal Hanuk

Executive Nurse Director
Independent Member – Local Community

Secretariat:

Glynis Mulford

RD: 17/001 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the inaugural meeting of the Resource and Delivery Committee.

RD: 17/002 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

RD: 17/003 DECLARATIONS OF INTEREST

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

RD: 17/004 MINUTES OF THE PEOPLE, PLANNING AND PERFORMANCE COMMITTEE MEETING HELD ON 16 MAY 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 16 May 2017.

RD: 17/005 ACTION LOG FROM MEETING PEOPLE, PLANNING AND PERFORMANCE MEETING HELD ON 16 MAY 2017

The Committee **RECEIVED** the Action Log from the meeting of 16 May 2017 and **NOTED** the following:

PPP 17/006 – Year End Referral To Treatment Time Update: The year-end position will be captured in the performance report. **COMPLETE**

PPP 17/018 – WAO Review of Operating Theatres & UHB Management Response and Theatre Improvement Project: It was explained that the Audit Committee maintains a Tracking Report of all reports received from the Wales Audit Office, these are allocated to relevant Committees for monitoring and receipt of assurance purposes. **COMPLETE**

Management Executive Meeting – Employee Relation Case: This has been dealt with through Management Executive meeting. **COMPLETE**

The Committee:

- **NOTED** the Action Log

RD: 17/006 TERMS OF REFERENCE

The Director of Corporate Governance informed Members that the Terms of Reference were still a work in progress and will be on the agenda for the next few meetings. Comments had been received, which will be reflected in the next draft. It was stated that the new arrangements will be reviewed in six months' time.

The Committee was informed that revisions were being made to the Strategy and Engagement Committee Terms of Reference. These will also be distributed to Resource and Delivery Committee Members since there is a need to have clear mechanisms in place for reporting to and from the Board.

There was wider discussion on needing a clearer definition and understanding on the meaning of 'Resource and Delivery' and further queries were raised and suggestions shared.

The Committee identified a number of matters that need to be addressed as follows:

- There was a need for greater clarity on the purpose of the Committee.
- A number of the current items were operational and therefore considered inappropriate for Committee level. It was acknowledged that the IMTP will feature as part of the Resource and Delivery Committee's work (although it had been identified as key to the work of the Strategy and Engagement Committee in its inaugural meeting).

- In relation to IT, it already sat in the Strategy and Engagement Committee. However, it was relevant to the Resource and Delivery Committee and it was unclear how it would fit in with it.
- It was necessary to strike a balance between monitoring performance and receiving assurance
- It was important that work should not be repeated by Committees.
- A stronger steer was needed to ensure clear alignment with other Committees. There was a need for this Committee to be distinct and lead on issues and when needed, cross-reference to other Committees.

The Chair asked for further comments on each section:

- **1.3:** Paragraph to be reworded as unclear and needing clarity as it references clinical performance and workforce. It was stated that the Committee, in its Delivery capacity, was also about trends and whether the Health Board met Welsh Government targets. In this case they would need to talk about performance.
- **2. Purpose:** The purpose of the Committee will need further discussion.
- **3.1** – For paragraph to be removed.
- **A Performance:** Section to be reworded.
- **C Workforce and Organisational Development:** This section was considered to be too operational.
- **Membership:** It should be made clearer how many Independent Members needed to attend for the meeting to be quorate. It was highlighted that there should be two trade union representatives on the Committee.
- **Equality:** As there would be no Equality, Diversity and Human Rights sub-Committee in future, concerns were raised about where its sub-groups would now feed into, such as the Welsh Language Steering Group. It was suggested that all Sub-Committees Terms of Reference would need to be reviewed to ensure that they were feeding in appropriately to Board Committees. It was confirmed that the equality programme sat within the Workforce and Organisational Development portfolio.

The Director of Corporate Governance agreed to revise the Resource and Delivery Committee's Terms of Reference and circulate them to members. It was suggested that once the Terms of Reference had been redrafted, a meeting would be arranged with the UHB Chair, Chair of Committees and Lead Executives for further discussion.

ACTION: Terms of Reference to be revised with track changes and circulated to Committee Members – P Welsh

ACTION: To arrange meeting with Chair once the Terms of Reference had been redrafted for further discussion – P Welsh

ACTION: To review the relationship of working groups to sub-Committees and Committees and ensure the most appropriate reporting relationships are in place.

The Committee:

- **CONSIDERED** and **NOTED** subject to revisions, the Terms of Reference

RD: 17/007 LEGACY STATEMENT

It was stated that once there was clarity on the Terms of Reference, the Legacy Statement would be revised with more detail on what would be considered at the Committee. A greater sense of the remit, strengths and weaknesses of the Planning, People and Performance Committee in relation to resources and delivery should be provided.

The Committee:

- **NOTED** the Legacy Statement subject to revision

RD: 17/008 BROAD ISSUES FOR WORKPLAN TO BE DEVELOPED

In light of discussion on the Terms of Reference and Legacy Statement, the workplan would need to be reviewed. It was stated that the Committee would require oversight of the IMTP and to make use of its structure and measures to inform the agenda. Members were advised that the Welsh Delivery Framework was changing and should be sighted by the Committee.

The Committee:

- **NOTED** the report

RD: 17/009 KEY ISSUES TO BE RAISED

- To review Terms of Reference and the name of the Committee

RD: 17/010 ANY OTHER BUSINESS

There was no other business to report.

RD: 16/011 DATE OF NEXT MEETING

The next Resource and Delivery Committee meeting is scheduled to take place at 9.00am on **Tuesday, 7 November 2017** in the Corporate Meeting Room, Headquarters, UHW

RESOURCE AND DELIVERY COMMITTEE

ACTION LOG – 8 AUGUST 2017

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
RD 17/005	8.08.17	Terms of Reference	<p>Meeting to be arranged with Chair and Executive Leads for further discussion on ToR. Will be revised with track changes and circulated to Committee members.</p> <p>To review the relationship of working groups to sub-Committees and Committees to ensure the most appropriate reporting relationships are in place.</p>	P Welsh	To be brought back to Committee once meeting with UHB Chair and Lead Executives have reviewed and strengthened the document.
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS					
PPP 17/011	16.05.17	WAO – Medicines Management	A report to be brought to the Committee for sign off	G Shortland	To be brought to November meeting
AC 17/010	24.04.17	WAO – Radiology Report	Audit Committee asked for report to be monitored and reviewed by its successor Committee. Will also be monitored by Audit Committee through Tracking Report	S Curry	Matt Temby to provide report for November meeting.
ACTIONS COMPLETED SINCE LAST MEETING					
PPP 17/006	16.05.17	Year End Referral To Treatment Time	Due to the lack of information in report on Mental Health Services,	L Davies	COMPLETE

		Update	for this to be followed up		
PPP 17/006	16.05.17	Year End Referral To Treatment Time Update	To consider report on outpatient follow-up improvement plan, with key milestones for delivery	Resource & Delivery Committee	COMPLETE. This has been reported at QSE Committee
PPP 17/018	16.05.17	WAO – Review of Operating Theatres & UHB Management Response and Theatre Improvement Project	To present report to new Committee with improvement plan	Resource & Delivery Committee	COMPLETE
Management Executive Meeting	22.05.17	Employee Relations Case	ME agreed that there were no additional resources and SC would support JC with the message that CBs had to release the trained staff in a timely manner to manage these cases.	S Curry / J Cassley	COMPLETE Report brought to ME at the request of PPP as investigations taking too long to investigate and management of disciplinary cases. PPP had hoped additional resources could be made available for investigating the 62 ongoing cases.

RTT and Diagnostics planning 2018-19

6

Resource and Delivery Committee
– October 2017

Key messages

- The UHB is required to meet national targets for waiting times
- Historically performance has been highly variable and not 'in-control'
- Recurrent capacity deficits were long-standing and in some cases have previously been addressed through non-recurrent solutions
- A new annual planning cycle was introduced in 2015 to provide the UHB with an early assessment of the strategic options for performance improvement (**Maintain**, **Improve**, **Eliminate**) and the implications
- This was aligned with the timescales for developing the IMTP
- The strategy for the past three years has been to follow the **Improve** option, i.e. sustainably bring capacity and demand in balance across the key services plus provide modest additional capacity to continue a steady improvement trajectory, within the resources allocated

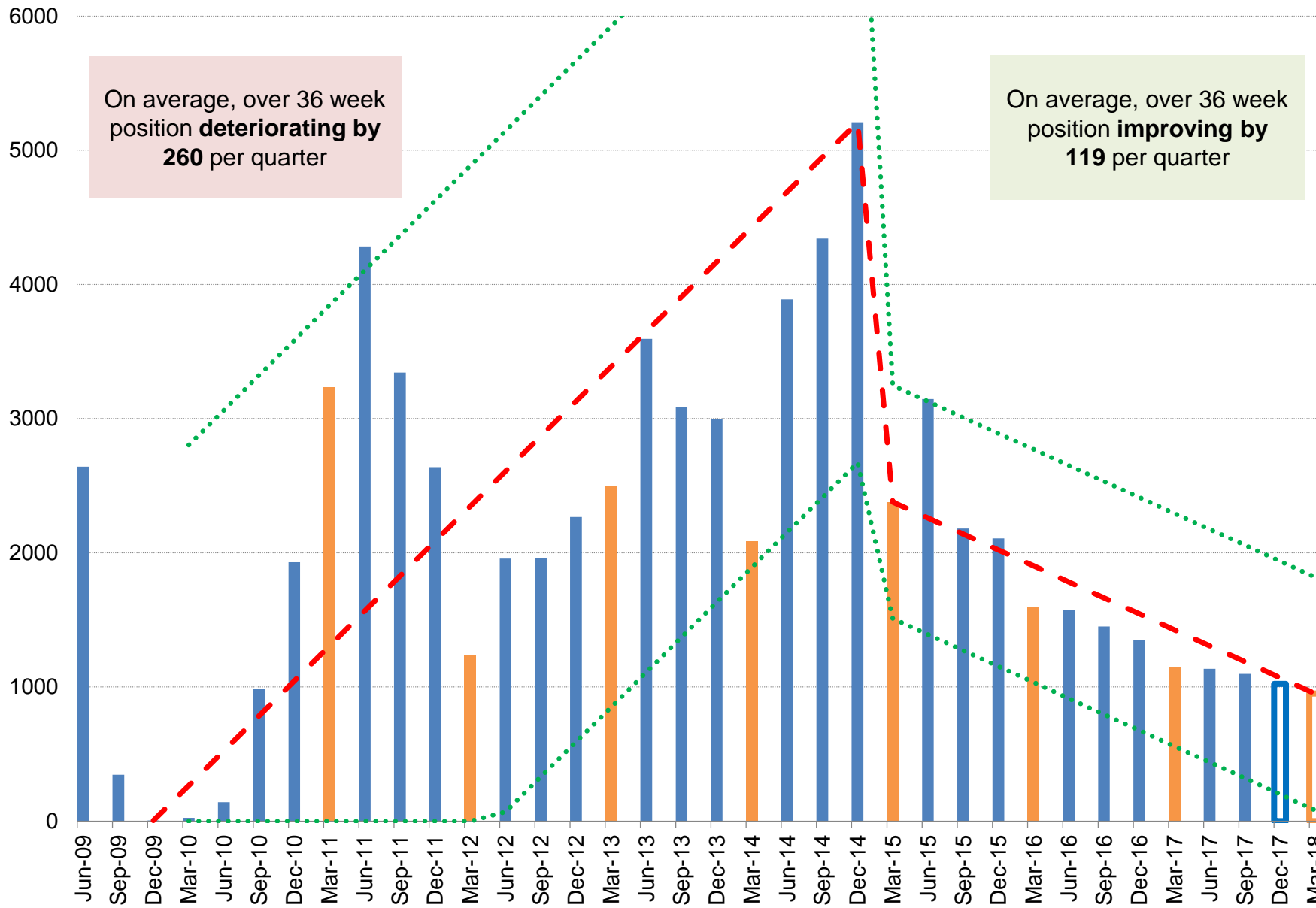
Introduction

- NHS Wales' targets are:
 - 95% patients treated within 26 weeks (referral to treatment, RTT) - however, in practice the main RTT measure is currently the number over 36 weeks, with an absolute target of zero
 - 100% patients receiving their diagnostic within 8 weeks of referral
- Each year the Health Board undertakes an exercise of assessing the delivery requirements of meeting the national waiting times targets for referral-to-treatment (RTT) specialties and diagnostic services
- Assessments undertaken in previous years have identified significant recurrent capacity deficits in many of the key specialties
- Previously these had been addressed through a combination of recurrent and non-recurrent solutions. This approach had contributed to the UHB's highly variable performance typically seeing a significant deterioration in the early part of the financial year before additional activity was commissioned, often at premium rates, and performance improving sharply to an end of March deadline

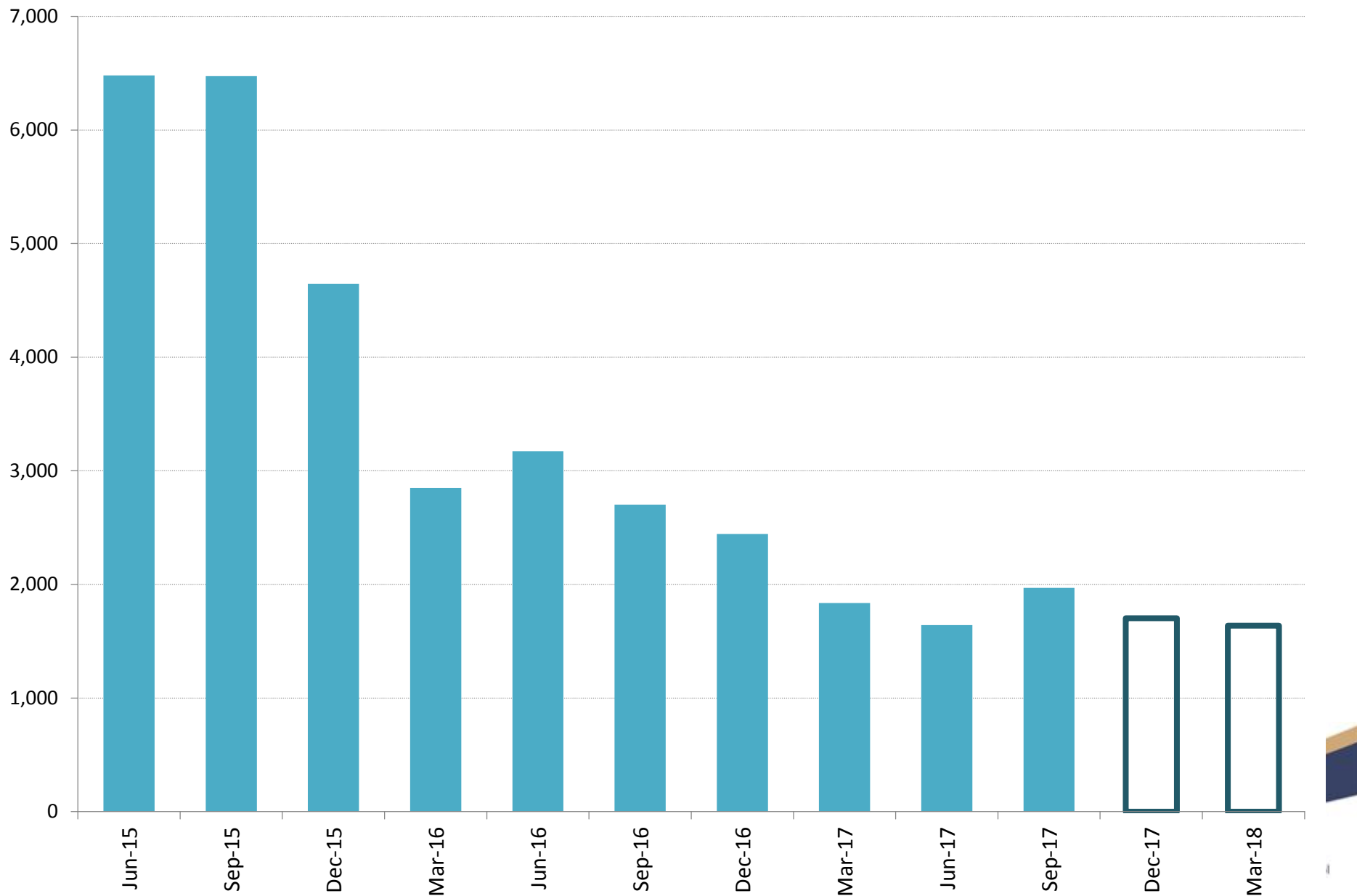
Introduction

- In 2015/16 the UHB took a different approach to RTT delivery, developing and approving plans at an earlier stage and working to quarterly performance cycles
- The aim of this was to maintain control of the performance position and secure quarter-on-quarter improvements in the early part of the financial year
- Delivery of this strategy in 2015/16, 2016/17 and the first half of 2017/18 has achieved credibility with Welsh Government and led directly to significant additional funding
- For the past **eleven** quarters the Health Board has delivered its commitments for RTT, leading to the best 36-week position for **seven** years. The changes in the overall waiting lists are, however, more varied, with the backlogs in some specialties increasing

Cardiff and Vale UHB - RTT performance over 36 weeks

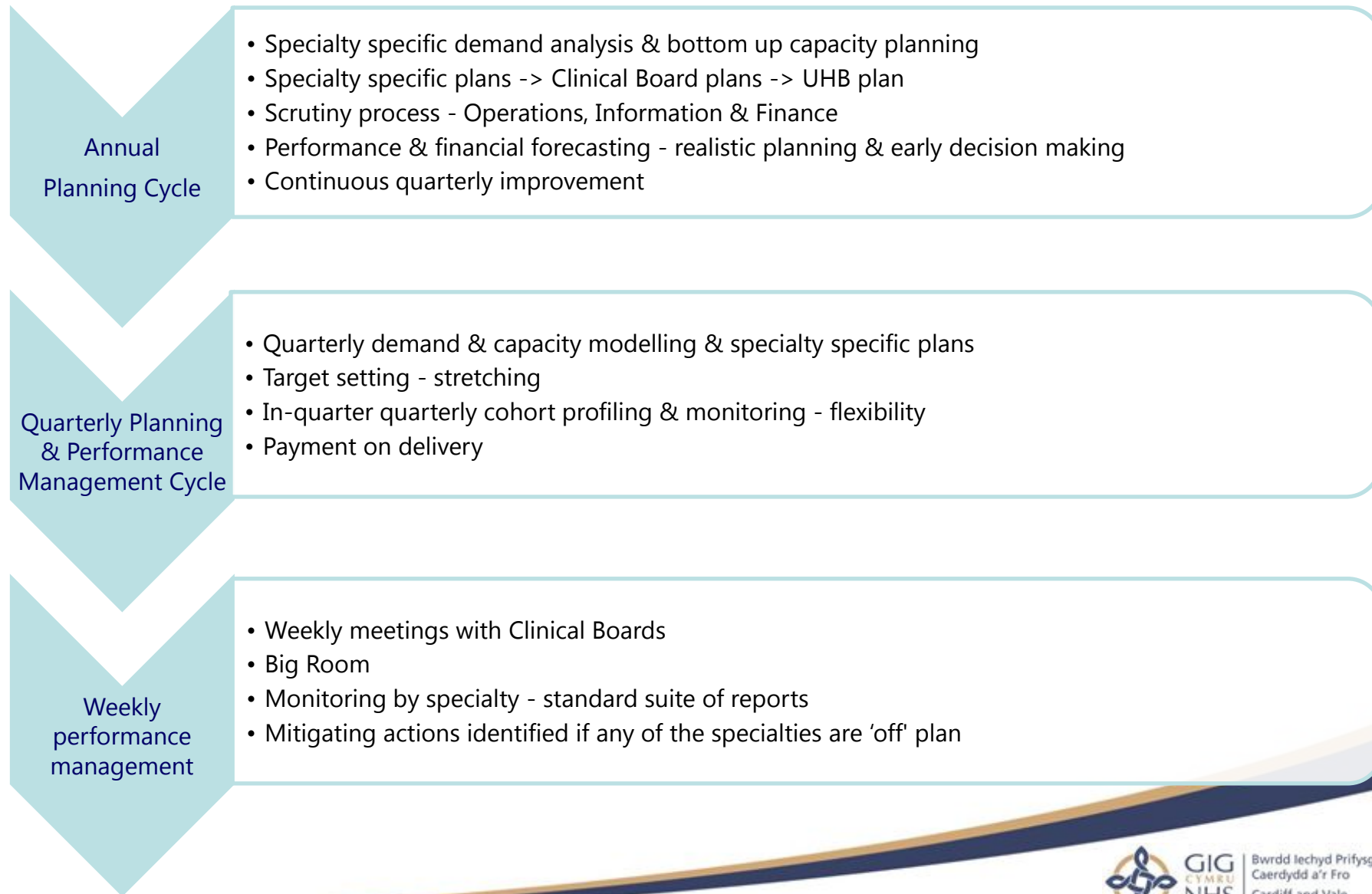


Diagnostic patients > 8 weeks



6

Approach to Planned Care Delivery



Annual Planned Care Cycle

October	Dem-cap analysis completed by information & specialties / CBs
November	First-cut of plans developed and submitted by CBs
December	First round of meetings with CBs Revised plans submitted
January	Submissions developed into three strategic options: maintain, improve, eliminate
February	Second round of meetings with Clinical Boards
March	Formal approval letters issued to Clinical Boards
Quarterly	COO-led activity and performance meetings with all relevant Clinical Boards

Purpose of the annual plan

To provide a reasonably robust assessment of the deliverability and affordability of maintaining/improving performance of planned care services

6

What it is not:

1. An exact science

- making predictions for 12-18 months in the future
- multiple unknowns and variables

2. A fixed plan

- some flexibility is critical for delivery, n.b. no contingencies included
- plans will alter and develop as the year progresses

1. Recap of 2017/18 plan

6

Components of plan

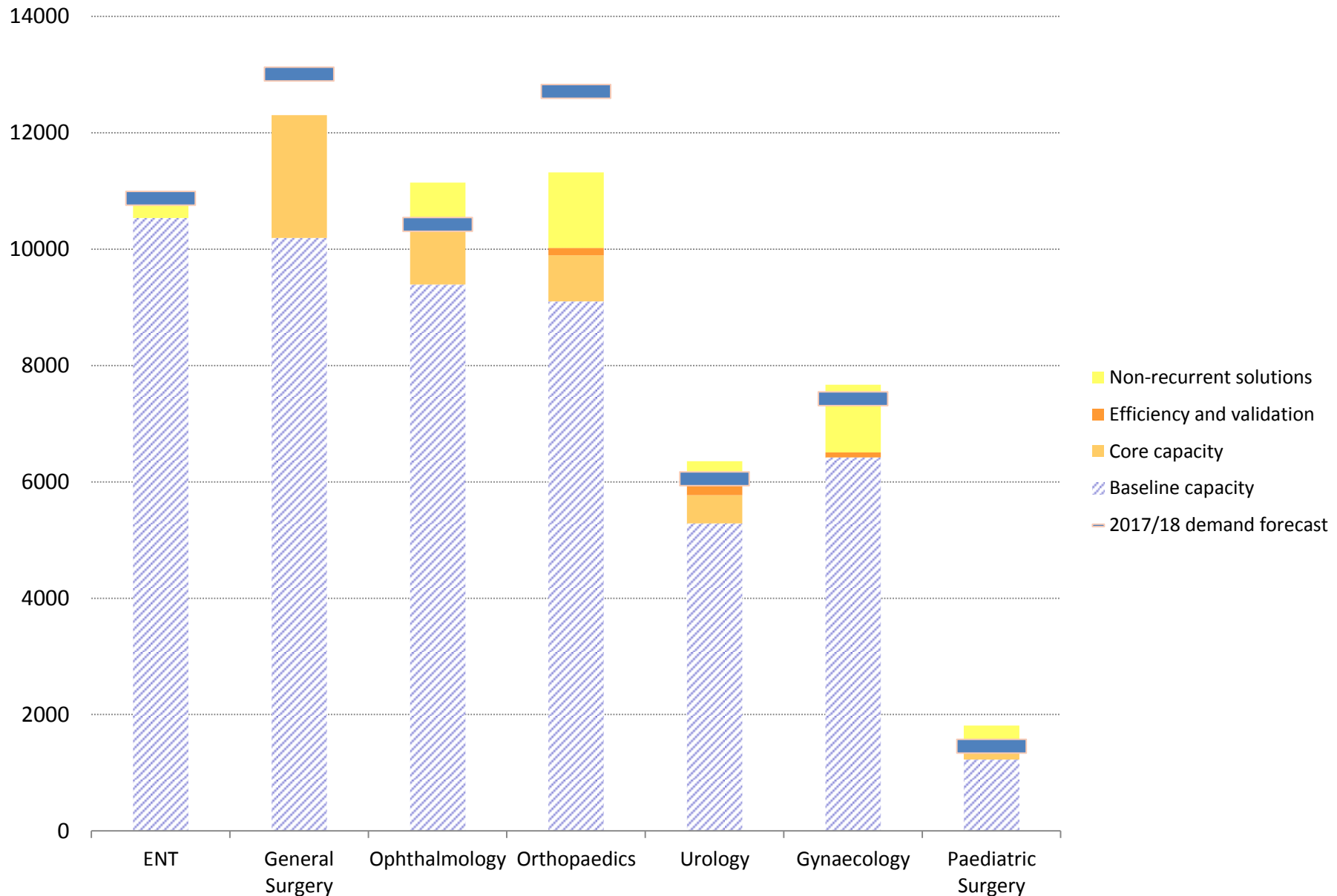
- 1. *RTT delivery plan*** – to maintain / improve performance against 36-week referral-to-treatment targets
- 2. *Diagnostics delivery plan*** – to maintain / improve performance against 8-week target

Demand impacts 17/18

Key points:

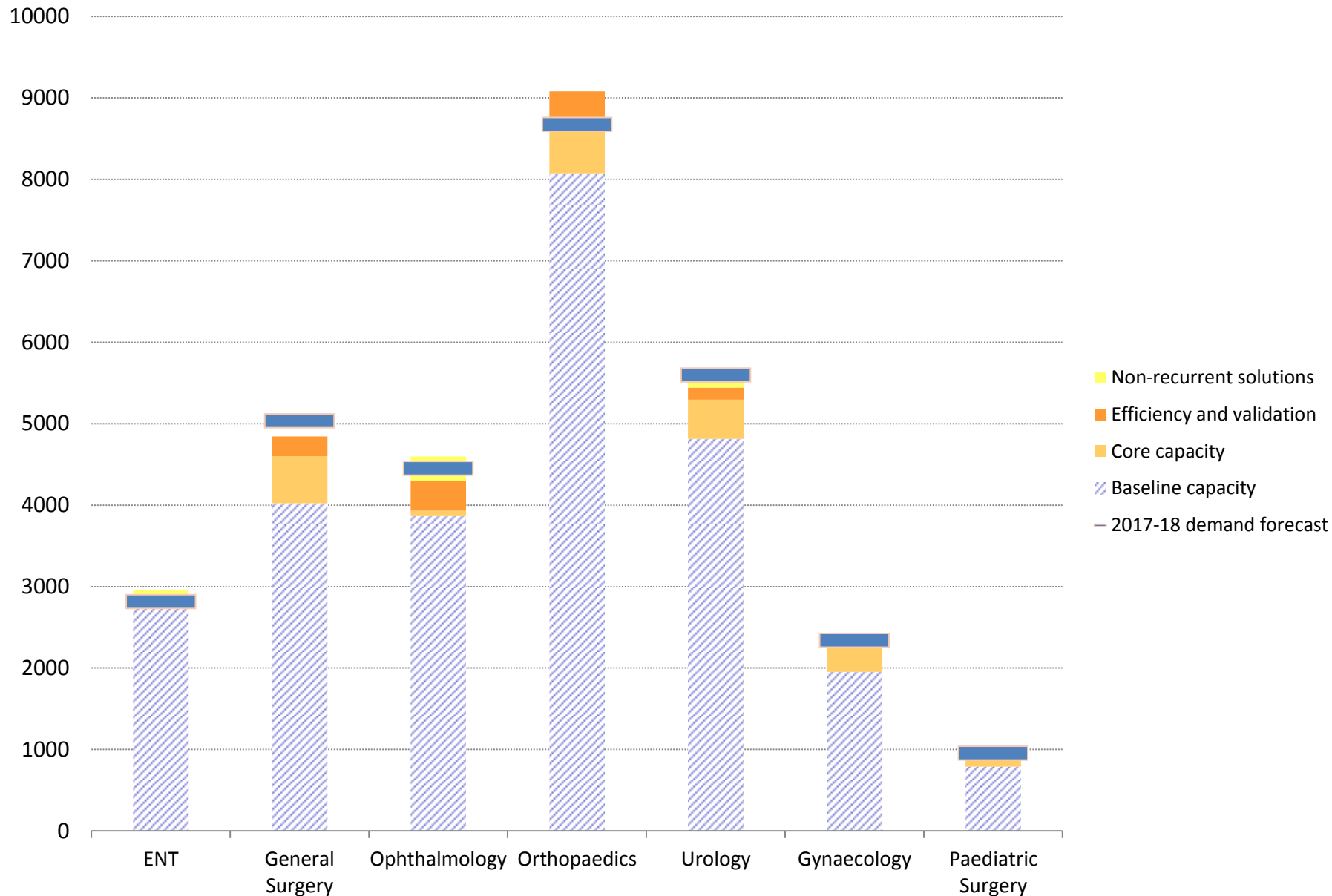
- Overall demand appears to be increasing by c.1% - in line with population increases, however:
 - A 1% increase in treatment demand for top six surgical specialties equates to approx. £750k increase in costs
 - A 1% increase in outpatient demand for the same specialties equates to approx. £75k increase in costs
- Main areas of large demand increases:
 - Orthopaedic outpatients (not treatments at this stage)
 - MRI
 - Non-obstetric ultrasound

New outpatients - capacity and demand, key specialties



6

Inpatients & Daycases - demand & capacity, key specialties



Summary of change in waiting list sizes

	Since Sept'13	Last 12 months (Sept '17 v Sept'16)
New Outpatients	11,193	1655
Inpatient/Daycase	350	-124

6

Key messages:

- Total outpatient waiting list was growing by 3700 per year. It is still growing but rate of growth has reduced by over 50%
- Treatment waiting list is reducing slightly

Change in outpatient waiting list sizes – key specialties

	Growth since Mar'13	Growth last 12 months (Aug '16 – Jul'17)	New Outpatient waiting list size @ end of Jul '17
Orthopaedics	2353	-120	5632
ENT	1547	-50	4500
Ophthalmology	2110	-438	5185
General Surgery	1796	160	4606
Urology	584	188	2132
Gynaecology	1088	-226	3019
Dermatology	2079	253	5236
Oral Surgery	1408	-68	2821
Sub-total	12,965	-301	33,131
All Specialties	18,399	2169	51,093

6

Change in outpatient waiting list sizes – other specialties

	Growth since Mar'13	Growth last 12 months (Aug '16 – Jul'17)	New Outpatient waiting list size @ end of Jul '17
Paediatric Surgery	713	416	906
Paediatrics	354	526	1132
Dental Medicine	345	189	552
Orthodontics	145	129	370
Restorative Dentistry	1059	121	1453
Thoracic Medicine	275	199	655
Rheumatology	481	227	1216
Cardiology	-75	638	1878
Neurology	1135	321	2522
Sub-total	4432	2766	10,684
All Specialties	18,399	2169	51,093

2018 – 2021 IMTP development



Scenarios modelled

Scenario 1 - Deliver zero > 36 weeks; hold outpatient waiting list position; hold middle stage position; hold treatment position 26-35 weeks

Scenario 2 - Deliver zero > 36 weeks; **deliver zero outpatients > 26 weeks**; hold middle stage position; hold treatment position 26-35 weeks

Scenario 3 - Deliver zero > 36 weeks; deliver zero outpatients > 26 weeks; **deliver zero middle stage > 26 weeks**; hold treatment position 26-35 weeks

Scenario 4 - Deliver zero > 36 weeks; deliver zero outpatients > 26 weeks; deliver zero middle stage > 26 weeks; **reduce treatment position < 26 weeks**

6

Indicative additional activity* requirements *per quarter* (over and above *maintain* requirements)

	Across 2 years			Across 3 years		
	New outpatients	Middle stage	Treatments	New outpatients	Middle stage	Treatments
Scenario 1	0	0	119	0	0	79
Scenario 2	716	0	119	477	0	79
Scenario 3	716	464	119	477	309	79
Scenario 4	716	464	232	477	309	154

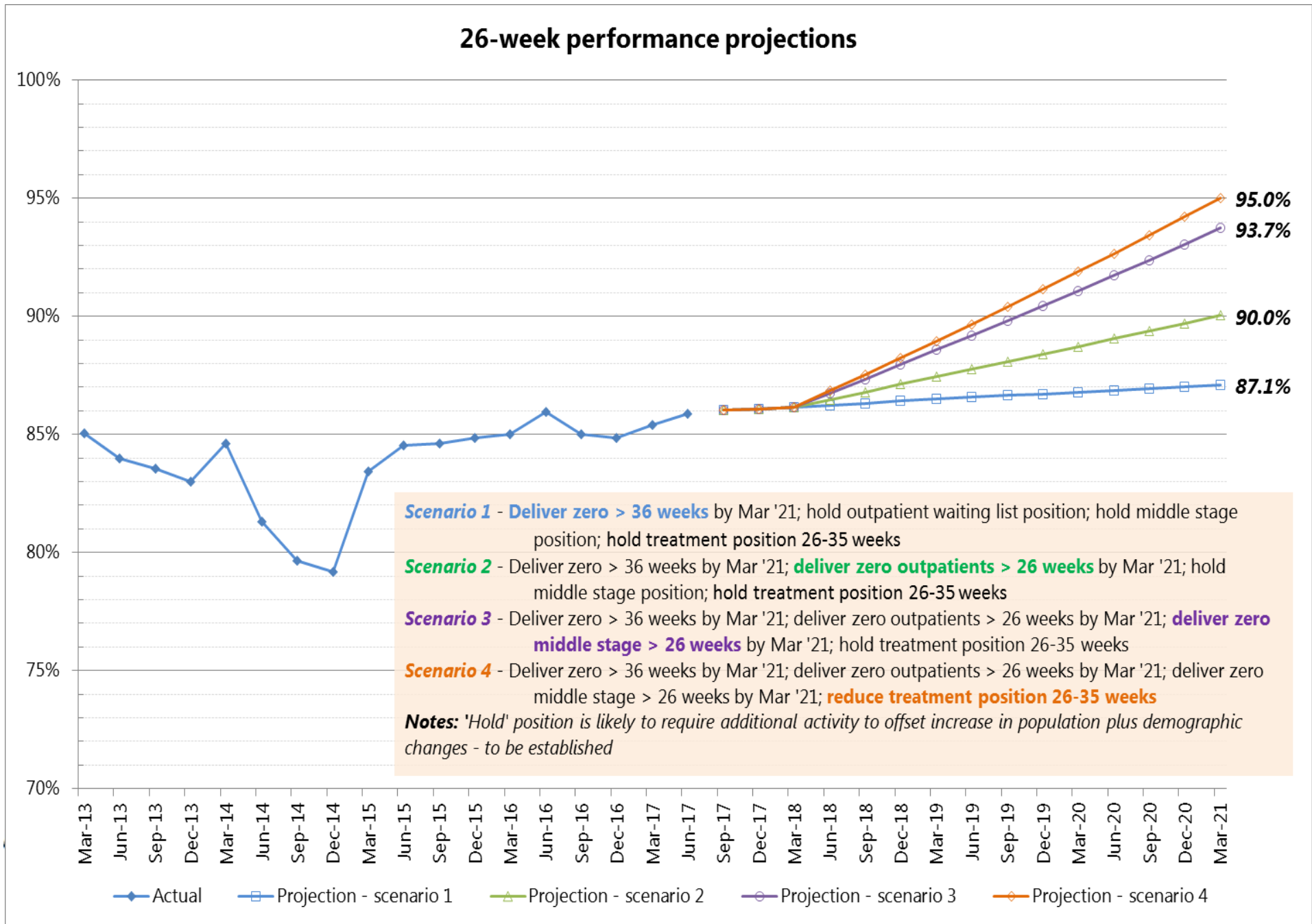
6

**or demand reductions*

Assumptions - conversion rates: OP to FU 20%; OP to IP/DC 30%; FU to IP/DC 10%

GOFALU AM BOBL, CADW POBL YN IACH
CARING FOR PEOPLE, KEEPING PEOPLE WELL





Risks

- Theatre infrastructure and theatre staffing
- Demand increases
- Capacity of external providers
- Repatriation (neurosurgery in particular)
- Impact from regional service changes (plan assumes none)
- Neurosurgery improvement dependent upon WHSSC commissioning

Summary

- Waiting times targets are high profile measures of the performance of NHS Wales
- Over the past two and half years a change in approach has meant the UHB's 36-week RTT and diagnostic performance has been brought more 'in control'
- This has gained the organisation credibility in 'doing what it says it is going to do' and directly led to additional funding from WG
- Robust plans and early decisions are critical to maintaining this, but it is not an exact science and requires in-year flexibility and a great deal of management attention
- Outpatient waiting lists have grown significantly over the past four years - this has slowed (particularly in the key surgical specialties) but will require further action
- Opportunity for further 36-week RTT improvement is narrowing to a smaller number of specialties, with higher average costs
- The assessment for 2018-19 and onwards is underway, which will include implications of 26 weeks compliance

THEATRE UTILISATION REPORT	
Name of meeting: Resource and Delivery Committee	Date: 7 th November 2017
Executive Lead: Chief Operating Officer	
Author: Director of Operations, Surgery Clinical Board	
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" element of the Health Board's Strategy.	
Financial impact: Aligned to sustainability and efficiency and finance plan	
Quality, Safety, Patient Experience impact: Improving Theatre efficiency has a direct correlation with improving access to core services for our citizens and delivering an increase in planned operations within the resources available. On average, a 1% improvement in Theatre utilisation is equivalent to improving productivity by 450 cases per year.	
Health and Care Standard Number 5.1 CRAF Reference Number 5	
Equality Impact Assessment Completed: Not Applicable	

RECOMMENDATIONS

The Resource and Delivery Committee is asked to:

- **NOTE** the contents of this paper and the progress made since the last meeting
- **AGREE** the proposed next steps

SITUATION

At the last People, Planning and Performance Committee in May 2017 Dr. Tony Turley, Clinical Director for Peri-operative care talked through a presentation around theatre utilisation, highlighting the key constraints impacting on the ability of the organisation to deliver improvements within theatre. The main areas of concern included:

- Estates
- Workforce
- Cancellation rates

Plans were drawn up to address the dip in performance and this document highlights the current position on the journey of continuous improvement.

BACKGROUND

The Health Board has forty two operating theatres, running from seven different locations, undertaking in excess of 37,000 surgical operations per year. The importance of ensuring that the Health Board's 'engine room' for delivering surgical activity is running efficiently as possible is critical in supporting the requirements of both the emergency and elective surgical streams, both now and in the future.

In May 2017 it was recognised that there had been a noticeable drop in our key performance measure for the surgical stream. This was cause for concern given the impact on both patient experience, access to services. The table below highlights performance figures presented to the committee.

Indicator (%)	Target	May-17
Booking	90	78
Utilisation	79-81	74

This was also reflected in cancellation rates that for the first five months of this calendar year up to May 2017 ran at 19% leading to the poor utilisation figures.

ASSESSMENT

The Surgery Clinical Board had already developed plans to address the issues highlighted to the committee and had engaged in a number of strategies to support the agenda. These could be split up into four key elements including:

- Workforce planning
- "Systems thinking" Transformation
- Strengthened Governance

The fourth element is the estates strategy, developing a plan to deliver the appropriate environment for staff and patients within peri operative care, however this document will not detail the work undertaken here.

Workforce planning: Through the early part of this financial year and the summer theatres ran with over fifty vacancies. The team has worked tirelessly to address this issue through staff engagement events internally and a recruitment strategy to attract staff from outside of the Cardiff catchment area. The impact of the reduced workforce has been significant on the ability of theatres to operate effectively and efficiently. The clinical service board gave executive colleagues assurance that the robust workforce plan would deliver an improved position by the autumn of 2017. After the strong recruitment run our current position has improved and is in line with

our projections. The current vacancy position is only fifteen whole time equivalents with plans to continue to invest in recruitment and staff engagement events.

Transformation & “Systems Thinking”: The management and improvement of processes are critical in running an efficient and effective surgical flow. Much of this success is related to good governance and management arrangements which are discussed separately in this document. However it is also critical that as an organisation we explore opportunities to transform clinical services, improving both communication and delivery through standardized and clear surgical pathways that have a commonality in both language and form. The aim is to address inconsistencies leading to increased patient and hospital cancellations thereby directly impacting on the efficient running of theatres. Within the Surgery Clinical Board we have picked one to two pathways in each specialty and are mapping out the “ideal” pathway against current practice. This work spans across the whole pathway however theatre plays a big part in terms of both outcome and cost. Benefits included:

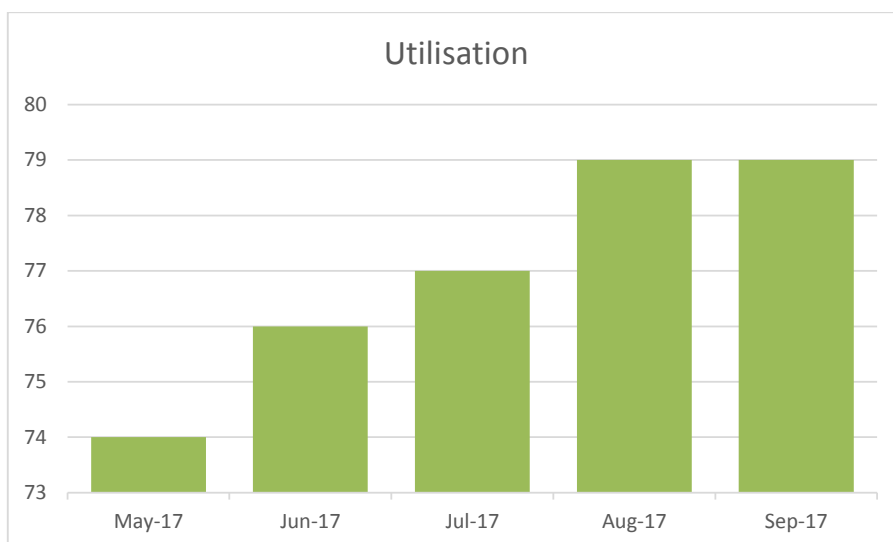
- Reduction in cancellations
- Reduction on number of operations undertaken
- Better communication and information for patients
- Improved understanding through education of workforce
- Reduced costs

Increased clinical engagement is a key component of the plan and the board has set up a small work-group to facilitate change developing a wider framework to support the agenda.

Strengthened Governance: As highlighted above an improvement in performance can be made through strong system processes and robust management. Adopting this approach with timely and relevant information has led to improved utilisation of our resources within theatres. The Clinical Board now meets regularly with all users which lead to clear accountability and ownership of the issues and solutions including the following:

- Regular sharing and analysis of information which supports understanding and learning of constraints within the system leading to evidence based solutions and therefore an improvement in performance.
- Set clear directorate level goals and milestones with agreed targets in each area translated into direct improvement in “value”.

The reinvigoration of a structured approach and performance management has positively impacted on performance over the past six months since we last reported the position. This can be demonstrated below:



The Health Board's target for utilisation is 81%, with a stretch target of 83%. Booking currently sits at 86% which is significantly better than the 74% reported in May '17. The target for booking is 90% and therefore more work is needed to continue improvement this year and beyond.

Cancellation rates have seen a 20% improvement dropping the overall rate down to 14.4% in September 2017. This has been sustained over the last four months and it will be critical to continue this over the winter period. The key area of improvement relates to reduction in staff related cancellations due to the recruitment drive for scrub and ODP staff.

Lessons Learnt

The dip in performance in theatre in the first five months of this calendar year was partially linked to staffing levels in theatres. However upon investigation and review it is clear that there needed to be a refocus on systems and processes to maximise the utilisation of theatre.

- Transparency of information is critical but more importantly ownership of that information by the users. **(Action – regular meeting structure with specialties set up to discuss metrics, actions and milestones for delivery – now to be integrated into the IMTP delivery framework)**
- Further review of pre admission model is needed. “Patient unfit” and “patient cancelled as unwell” accounts for 23% of the overall cancellation rate. **(Action – pre admission workgroup set-up to explore opportunities for further improvement)**

- Late starts in Llandough are 4% and in line with target. UHW currently sit at 6% and this in part can be contributed to a reduction in day of surgery patients. **(Action – Clinical Board of Surgery continue to promote DOSA, however to deliver the optimal position of 90% a day of surgery area is needed. Plans are being drawn up as part of the IMTP to facilitate this)**
- Pockets of good practice at times are overlooked and under-reported. Clinically led service improvement is common in this organisation however the key is to celebrate and learn from this and embed a culture of change. **(Action – Liaise with service improvement team to create repository for success and embed into learning)**
- Patient “did not attends” (DNAs) remain high as part of cancellation. **(Action – Information has been broken down by specialty and this work will be aligned to pathway/specification projects: The urology directorate is leading on this)**

Next Steps

The refocus on the governance and processes has considerably improved performance. However there is more work to do. The time is now right to build on this work and develop a wider focus on the overall surgical pathway/flow and its associated key drivers. Effective engagement with service users at every step will be critical and with positive clinical engagement will ensure we are comparative with national peer groups or potentially lead the way in our safe, efficient and effective use of theatres.

Work over the next six months leading into the new financial year and aligned to the theatre strategy and integrated medium term plan includes the following:

- Continue staff engagement and recruitment to maintain staffing levels
- Set specialty/directorate and clinical board targets aligned to delivery & financial framework.
- Maintain discipline around governance arrangement to continue on improvement trajectory
- Drive clinically led pathway/specification change supported by transformation team.
- Introduce theatre led celebration events for theatre staff and users to promote improved practices and share learning.

The importance of Theatres to the delivery of the Health Board’s agenda can’t be underestimated, and the Surgery Clinical Board are committed to continuous improvement. The theatre strategy has been developed over recent years and this will be used to set the direction and hold the Board to account on the agreed milestones.

Update on Recommendations from Welsh Audit Office report: Comparative review of Orthopaedic Services	
Name of meeting: Resource and Delivery Committee	Date: 7 th November 2017
Executive Lead : Chief Operating Officer	
Author : Deputy Directorate Manager, Trauma & Orthopaedics	
Caring for People, Keeping People Well: Orthopaedic services are a significant element in the Health board's RTT strategy.	
Quality, Safety, Patient Experience impact : Services support the delivery of timely access to planned care	
Health and Care Standard Number CRAF Reference Number	
Equality Impact Assessment Completed: Not Applicable	

RECOMMENDATION

The Committee is asked to:

- Note the summary of opportunities highlighted from the Welsh Audit Office
- Note the areas of focus the Directorate are taking and actions will further assist in delivery of performance

SITUATION

This briefing summarises the [Welsh Audit Office \(WAO\) Comparative Review of Orthopaedic Services](#) in the context of the Local Health Board's position. The WAO report aimed to compare local service provision with the rest of Wales and highlight opportunities for improvement through comparative analysis.

BACKGROUND

The WAO review was undertaken in 2013 with the aim of determining whether the delivery of local Orthopaedic Services are efficient, effective and economical and whether such services are being designed and delivered in a sustainable manner. Since this point the Clinical Board and Directorate have been working hard to introduce a number of schemes and actions that address the recommendations made in the report.

Key Findings, recommendations and associated actions

As clearly identified the findings were positive overall for the UHB however as with all audits there were potential opportunities identified for improvement. The information below concentrates (by exception) on the areas that the Directorate and teams are working on for further improvement:

- **Clinical Musculoskeletal Assessment and Treatment Service (CMATS)**

The provision of a Clinical Musculoskeletal Assessment and Treatment service is seen as an effective community based model of care that aims to treat patients locally with the most appropriate clinician leading to the best possible outcome and experience. The main focus is on developing GPs with specialist interest and physiotherapy services that specialise in musculoskeletal conditions. Successful services have evidenced improved patient experience leading to a reduction in the number of patients referred for on-going care under an Orthopaedic surgeon thereby leading to patients with definitive surgical needs.

The Health Board has provided a mix of services across a number of clinical settings previously. In the last year a multi-disciplinary team has been setup with the support of the service improvement team to develop a cohesive and robust model of care that is fit for purpose. This revised model of care is now being piloted and is in its third month. Additional resources have been secured to extend the pilot as a more comprehensive business case is being developed.

Early information from the pilot evidences the change in pathway for patients leading to a reduction in onward referral into Orthopaedics.

- **Outpatient waiting times**

The Health Board continues to positively address outpatient demand. The number of patients waiting longer than 26 weeks remains high; which is a consequence of a significant increase in outpatient referrals in the 2017/2018 financial year (around 2000 extra 8%). However, the Directorate have continue to meet quarterly and annual targets set to reduce waiting times in each sub-specialty. The continued robust performance management through job planning and improved efficiencies has led to increased activity and the introduction of CMATS is expected to curtail the increase in demands on the orthopaedic service.

- **Prosthesis Costs and Tertiary Status**

The report highlights the high comparative cost per case for prosthesis when compared to other NHS facilities in Wales. The Health Board would contend that this is related to the tertiary referral status of the local service and associated high costs of consumables particularly in spinal surgery and for complex hip and knee revision surgery. The service has actively promoted product rationalisation and improved product purchasing and has reduced the spend on prosthesis, consumables and associated items in 20/17/2018.

Further opportunities are being explored to continue the positive work undertaken, however, it is recognised across Wales that the Health

Board currently have a more favorable pricing structure to other Health Boards in Wales, based on the volume of Orthopaedic work undertaken and therefore further rationalisation and the development of clear standardised pathways and specifications will deliver further improvement in this area.

- **Outcomes - Revision Rates in Hips are high**

Cardiff is identified as a tertiary referral centre for revisions and as such we would expect a higher level of such procedures than the majority of Wales. The report cited concerns with the levels of hip revision surgery at a time when the Health Board was undertaking revisions to address the impact of metal on metal concerns. Further analysis of this has evidenced a drop in the number of hip revisions in line with the reduction of metal on metal revisions.

- **Patient Reported Outcome Measures (PROMS)**

The Health Board continues to lead the way with managing PROMS in Wales with the implementation having a significant impact in reducing follow up attendances for hip and knee surgery. Around 90-95% of those engaged in the process no longer require follow up appointments and are instead followed up using a virtual review system. PROMS is now being rolled out to the spinal team, where similar benefits are to be expected and this is part of the Directorates IMTP for 2018/2019.

Summary

The Health Board is fully committed and engaged with the Welsh Orthopaedic Board and will ensure that the key actions identified as a consequence of the review are successfully delivered within the required timeframe. It must be noted that there have been significant risks associated with extraordinary events including the outbreak of VRE and loss of two theatres in Llandough Hospital. The trauma and orthopaedic team have worked exceptionally in managing these risks and have as a consequence developed more robust systems and governance which have led to further improvements that have directly impacted on patient experience and outcome.

WALES AUDIT OFFICE- MEDICINES MANAGEMENT (UPDATE)
Name of Meeting : Resource and delivery committee Date of Meeting 7 November 2017
Executive Lead : Executive Medical Director
Author : Director of Pharmacy and Medicines management (029 2074 4331)
Caring for People, Keeping People Well : Minimise harm, waste and variation
Financial impact : Delivery of medicines-related savings plans
Quality, Safety, Patient Experience impact : Optimise patient benefits from medicines
Health and Care Standard Number 2.6 Medicines management
CRAF Reference Number
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Initial Health Board response to the Auditor General for Wales report
- Detailed description of progress against each of the recommendations (including update on national and local actions)

The committee is asked to:

- **NOTE** progress with the actions required by the Auditor General for Wales/ Wales Audit Office

SITUATION

Wales Audit Office (WAO) have undertaken a review of medicines management in each Health Board, initially focusing on primary care in 2013-14 and then on acute hospitals in 2014-15. A National report was published in December 2016, outlining the key findings and providing 10 recommendations. This document provides an update on progress with implementation of the recommendations in Cardiff and Vale University Health Board.

BACKGROUND

The overall conclusion presented in the National report was:

- We found many good aspects of medicines management, and health bodies are collaborating well to improve services. Nevertheless, medicines management needs a higher profile within health bodies.
- Whilst NHS Wales is taking positive steps to improve primary care prescribing, there is further scope to make quality and cost improvements.
- In hospital, pharmacy services are rated highly by NHS staff but there are problems with medicines storage, gaps in information about medicines, and the delay in implementing a national electronic prescribing system is frustrating efforts to improve safety and efficiency.

Welsh Government have responded to the recommendations in the report and given evidence to the Public Accounts committee on the 6th March 2017.

The issues raised within the WAO report have been discussed at the UHB corporate Medicines Management Group, actions agreed and monitored.

ASSESSMENT AND ASSURANCE

This paper provides an update on the main actions identified within the WAO Medicines Management review of primary care and acute hospitals. Work by the Chief Pharmacist Peer Group, based on the priorities identified by the Chief Pharmaceutical Officer, should allow specific action to be taken on a collaborative, once for Wales basis.

The financial challenge within NHS Wales will mean a continued focus on efficiency savings from prescribing. Whilst there is an urgency to deliver on the financial agenda, it is important to recognise the need to support patients gain the best outcomes from their medicines, though medicines optimisation services delivered throughout the Health Board.

The Carter review has made is clear that the delivery of hospital pharmacy services and the optimisation of medicines are intrinsically interwoven and, from a value perspective, can't be separated. Therefore the NHS needs to focus the pharmacy workforce to drive optimal value and outcomes from money it spends on medicines. Despite good performance demonstrated in the WAO review and NHS benchmarking metrics, this remains a challenge with our current workforce profile.

Appendix – Update on recommendations contained in the report of the Auditor General for Wales “Managing medicines in primary and secondary care” (2016)

Recommendation	Welsh Government Response	Cardiff and Vale UHB initial response and update October 2017 (<i>italics</i>)
<p>R1. The Welsh Government, NHS Wales Informatics Service (NWIS) and all health bodies should agree a detailed, time-bound plan for implementing electronic prescribing systems in secondary care, along with a clear process for monitoring the delivery of the plan.</p>	<p>Response – Accepted. The NHS Wales Informatics Service (NWIS) has established the Welsh Hospital Electronic Prescribing and Medicines Administration project to develop and implement the national plan for electronic prescribing in secondary care and the inaugural meeting of the project board was held on 23 November 2016. The project team is currently working with stakeholders to define the exact scope of the project and the system requirements. Once this is complete the business case for procurement of a replacement hospital pharmacy system and an electronic prescribing and medicines administration solution will be completed by NWIS and considered by Welsh Government. Subject to the completion of the business case, it is expected that the procurement of these systems will be completed during 2018-19 with implementation beginning in the early part of 2019.</p>	<p>We welcome the emphasis on the requirement for NHS Wales to implement electronic prescribing and the potential this affords to improve safety and efficiency. This is something we agree should have a time bound plan and we are aware that progress with the business case and implementation plans are gathering momentum.</p> <p><i>The HB is engaged in the All Wales project and has included the resources required (as detailed by NWIS) in the UHB IM&T strategy. The HB is ideally placed to pilot the project building on the track record for implementing the Medicines transcribing and electronic discharge (MTeD) and outpatients prescribing (COPPS) systems.</i></p>
<p>R2a. The Chief Pharmaceutical Officer for Wales should lead national reviews to assess each health body’s compliance with the MARRS policy, to assess the effectiveness of the new mandatory training programme on medicines management and to assess the long-term sustainability of actions taken in each health body to address all medicines-related findings from Trusted to Care; and</p> <p>R2b. Each health body should develop a time-bound plan for improving storage and security of medicines on hospital wards, including specific consideration of the benefits of implementing automated vending machines.</p>	<p>Response – Accepted. The Chief Pharmaceutical Officer for Wales will re-convene the Medicine Administration, Recording, Review and Storage (MARRS) working group to undertake a review of each health body’s compliance with the MARRS policy. Due to unforeseen circumstances there has been a delay in implementing the e-learning programme on medicines administration. The working group will therefore give further considerations as to how the e-learning programme can be rolled out most effectively. We envisage the first meeting of the re-convened MARRS working group will be in April 2017 and that it will complete its review by March 2019. Patient Safety Notice PSN 030, issued in April 2016 set out the expected standards for safe and secure storage of medicines on hospital wards. We have identified the</p>	<p>We agree that there should be a review of compliance with the MARRS policy and suggest that this should go a step further to determine how NHS Wales improves the overall approach to medicines management from prescribing through to administration. The MARRS work is still developing (through e-learning based support) and medicines management education for staff involved in medicines administration is now mandatory when joining a HB with a 3 yearly update requirement. This is a huge step forward that has not been recognised in this document, which again seems to concentrate on prescribing, which is only one part of the medicines management process.</p>

	<p>need to review the requirements contained in the notice in light of concerns that the cost of replacing the storage on all hospital wards, regardless of current condition, would be disproportionate to the anticipated benefit; given the low level of risk presented by storage facilities on the majority of wards. The MARRS working group will, as part of its work, review PSN 030 and updated guidance will be issued before the end of 2017.</p> <p>The Chief Pharmaceutical Officer will, with the Chief Pharmacists in local health boards and Velindre Cancer Centre, complete an audit of the current use automated ward vending machines in NHS hospitals in Wales and develop a prioritised list of sites in which automated ward vending should be implemented. This work will be completed by June 2017.</p>	<p><i>The UHB has developed a Medicines Code to cover all aspects of medicines use (from prescribing through to administration and monitoring) and includes storage and security of medicines on hospital wards. An audit tool for medicines storage and administration has been rolled out via senior nurses across all clinical areas.</i></p> <p><i>WG have re-established the MARRS working group and the UHB is represented with the Chief Pharmacist, Nurse Advisor (Medicines management) and a ward senior nurse on the group and fully engaged in developments which includes the e-learning module due to launch shortly..</i></p> <p><i>The UHB has installed automated medicines storage in higher risk areas (critical care, emergency departments and out of hours) and is engaging in discussions about a Wales strategy for further implementation (workshop scheduled 23rd November 2017).</i></p>
<p>R3a . Health bodies should ensure their Chief Pharmacist is, or reports directly to, an executive director; and</p> <p>R3b. Health bodies should have an annual agenda item at the Board to discuss an annual report covering pharmacy services, medicines management, primary care prescribing, homecare medicines services and progress in addressing the issues identified in Trusted to Care.</p>	<p>Response – Accepted in part.</p> <p>We agree fully that the Board of every health body in Wales should regularly scrutinise all aspects of medicines management. To that end and prior to the publication of your report, in 2016-17 we included six national prescribing indicators, covering a range of areas including antimicrobial prescribing, adverse drug reaction reporting, high risk medicines and the efficient use of resources, in the NHS Outcomes Framework.</p> <p>To maintain focus on improving medicines management within NHS Wales, we will continue to develop medicines management indicators as part of the outcomes framework. We will also raise medicines management issues through the Joint Executive Team meetings between Welsh Government and NHS Wales bodies.</p> <p>The UK-wide rebalancing medicines legislation and pharmacy regulation programme, supported by the</p>	<p>We support the recommendation that Prescribing and Medicines Management should have an appropriate profile within the Health Board and our Chief Pharmacist already reports to the Executive Medical Director. With the significant opportunity to improve the patient experience through effective medicines management, the suggestion that our Board should receive a comprehensive annual report is also duly noted.</p> <p><i>The corporate Medicines management group produces an annual report of its workplan, including the cross-cutting enabling medicines management project which support cash-releasing medicines savings. To date, this</i></p>

	<p>Department of Health in England on behalf of the four UK administrations, is considering various changes to medicines legislation which are likely to impact on the role of health body Chief Pharmacists. We do not consider it would be appropriate to make a commitment regarding the reporting arrangements for Chief Pharmacists until the outcome of that programme is known. We anticipate the implications for Chief Pharmacists will be clearer in early 2018. In preparation we will undertake an audit of the reporting arrangements for NHS Chief Pharmacists in Wales, this will be complete by September 2017.</p>	<p><i>report has not been shared at Board level.</i></p>
<p>R4. Chief Pharmacists should seek the support of the NHS Wales Shared Services Partnership's Workforce, Education and Development Services to strengthen current resource mapping approaches to facilitate robust comparisons of pharmacy staffing levels across Wales and to produce a generic service specification. The specification should set out the typical resources required to deliver key pharmacy services, such as clinical pharmacy input and patient education on the wards. The specification should also be flexible enough to recognise that different types of wards will require different levels of resource.</p>	<p>Response – Accepted. During 2017-18 we will work with the NHS Wales Shared Services Partnership's Workforce, Education and Development Service and Chief Pharmacists of NHS Wales bodies to undertake a robust assessment of the current and future needs for the pharmacy workforce. This work will be completed by March 2018.</p>	<p><i>The Chief Pharmacist for C&V UHB is leading the Chief Pharmacist Peer Group Improvement Programme workstream on Workforce Modernisation. This work is in collaboration with WEDS and includes pharmacy staff resource mapping across all sectors in Wales. Additional workstreams involve the Pharmacy Train, Work, Live campaign and development of a supportive career and competency framework to support workforce redesign.</i></p>
<p>R5a. To drive further improvements in prescribing, health bodies should ensure they have a targeted plan of action to achieve cost and quality improvements in prescribing in primary care and in secondary care, in line with prudent healthcare principles. The plan of action should be informed by regular analysis of prescribing data to ensure that attention is focused on the areas where the greatest scope exists to secure cost and quality improvements;</p>	<p>Response – Accepted. The Efficiency, Healthcare Value and Improvement Group have agreed an all-Wales approach to cost and quality improvement in medicines management in primary and secondary care will be a key area for 2017-18. During 2017-18 we will agree with health board Chief Pharmacists and other stakeholders, key priorities in the following six areas: driving efficiency; reducing medicines related harm; improving patient experience and outcomes; workforce modernisation; collaborative working, better use of technology and improved estates;</p>	<p><i>The UHB has an ongoing medicines optimisation and efficiency project (Enabling Medicines Management) now in its fifth year. This provides cross-cutting support for cost and quality improvement across all sectors and Clinical Boards. Prescribing data and savings are analysed and tracked and this is now subject to benchmarking across NHS Wales. Project plans and achievements and C&V performance against National Prescribing Indicators are reported and discussed at</i></p>

<p>R5b. In line with the need to increase the profile of medicines management at Board level, health bodies should ensure that performance against the National Prescribing Indicators is considered regularly by the Board, alongside progress in delivering wider cost and quality improvements in primary care prescribing;</p> <p>R5c. The Welsh Government should ensure the work of the Efficiency, Healthcare Value and Improvement Group takes an all-Wales view on the cost and quality improvements that should be achievable through better prescribing and medicines management, and uses mechanisms such as the twice-yearly Joint Executive Team meeting between government officials and each individual health body to ensure that the necessary progress is being made in securing these improvements.</p> <p>R5d. The Welsh Government should work with NHS bodies to develop and implement a clear national plan of action aimed at reducing medicines wastage, building on the findings from the ongoing evaluation of the Your Medicines, Your Health campaign. Reducing waste leads to cost savings whilst at the same time helping patients to take their medicines as prescribed, thereby helping to secure maximum benefit from the medicine; and</p> <p>R5e. Linked to the above points, the Welsh Government should ensure that there is a clear and time-bound plan in place to roll out improved repeat prescribing systems that are being tested by the Prudent Prescribing Implementation Group.</p>	<p>and benchmarking. These priorities will be taken forward on an all-Wales basis and progress overseen through regular meetings between the Chief Pharmaceutical Officer and health board Chief Pharmacists, and Joint Executive Team meetings.</p> <p>We will work with NHS bodies to develop and implement a clear national plan of action aimed at reducing medicines waste. Primarily this will be achieved by encouraging NHS bodies to adopt the elements of the <i>Your Medicines, Your Health</i> campaign which the ongoing evaluation, once completed, demonstrates are successful. We will also encourage health boards to implement evidence based approaches which reduce medicines waste. These will include implementing improved repeat prescribing systems such as those which have been tested through the Prudent Prescribing Implementation Group or evaluated in other parts of the UK. We envisage this work will begin in 2017-18 with a time-bound plan agreed by March 2018.</p>	<p><i>corporate Medicines Management Group.</i></p> <p><i>The UHB Chief Pharmacist is engaged in the All Wales Chief Pharmacists collaborative work in the six areas described and is leading the workforce modernisation work. C&V host All Wales Medicines Information, Community Healthcare Research, Procurement and Medication Safety lead pharmacists who are all contributing significantly to this improvement programme. This includes reducing medicines waste and development of repeat prescribing systems.</i></p> <p><i>Medicines management developments are included in the regular JET discussions.</i></p> <p><i>A recent review of the NHS Improvement's draft "Top 10 medicines" was presented at the Efficiency and Productivity board in March 17. This demonstrates that the Health Board is performing well and has plans in place for implementation.</i></p>
---	--	--

<p>R6. The Welsh Government should develop a plan, in partnership with All Wales Medicines Strategy Group (AWMSG), health bodies and GPs, to evolve the National Prescribing Indicators so that they begin to consider measures of whether the right patients are receiving the right medicines and whether medicines are making a difference to people's outcomes.</p>	<p>We agree that National Prescribing Indicators are currently too focused on the quantity and cost of medicines prescribed with inadequate consideration given to clinical appropriateness and outcomes. The availability of data to support more sensitive indicators has been a significant constraint. Whilst significant improvements have been made to reduce variation in prescribing, the rate of improvement has slowed in recent years in part as a result of this approach. We will work with the Wales Analytical Prescribing Support Unit (WAPSU) to establish a project in 2017-18 the purpose of which will be to define a new suite of National Prescribing Indicators utilising additional data sources. The indicators will be developed during 2017-18 with the intention they are approved by the All Wales Medicines Strategy Group (AWMSG) prior to their use from April 2018.</p>	<p>No action required from HB</p>
<p>R7. The All Wales Chief Pharmacists' Committee should lead a national audit of compliance with the measures set out in the all-Wales handbook on the safe and effective delivery of homecare services.</p>	<p>Response – Accepted. We note this recommendation is aimed at the All Wales Chief Pharmacist's Committee. We will ensure work to improve the safe and effective delivery of homecare services, including an audit of compliance with the measures set out in the all-Wales handbook, forms part of the key priorities agreed with health board Chief Pharmacists and other stakeholders in 2017-18.</p>	<p>The UHB will engage and undertake an audit of homecare services (delivery of specific medicines directly to patients by external providers). An invest to save case has been included in the IMTP to further develop and ensure compliance with standards for homecare services.</p> <p><i>In 2017, the UHB invested in the development of a medicines homecare team which is now in place and working to the standards set out in the handbook.</i></p>
<p>R8. The Welsh Government, supported by 1000 Lives Improvement, should work with pharmacy teams, clinical coding staff and clinicians across Wales to develop a programme aimed at identifying and preventing medicines related admissions.</p>	<p>Response – Accepted. This work will be scoped with 1000 Lives Improvement during the early part of 2017-18 with a view to establishing a medication safety programme in 2018-19.</p>	<p><i>Whilst there were no specific actions required of the UHB, the Director of Welsh Medicines Information Centre and her staff and the Consultant Pharmacist for Medication Safety are working with AWTTTC (all hosted in C&V) to develop a project and engage with WG/1000 lives improvement.</i></p>
<p>R9a. The Welsh Government and NWIS should continue to work with GP</p>	<p>Response – Accepted. We are continuing to work with NWIS to secure wider</p>	<p>The MTeD system supports ongoing medicines reconciliation and makes the report</p>

<p>representatives to ensure their concerns about information governance are addressed;</p> <p>R9b. Facilitate wider access to the GP Record so that all pharmacists and pharmacy technicians that deliver clinical services on the wards can access the system for patients who are admitted for an elective procedure, as well as those admitted as emergencies; and</p> <p>R9c. Facilitate wider access to, and use of, the GP Record in community pharmacies so that whenever it is clinically appropriate, patients can have their medicines managed in the community without accessing a GP or other NHS services.</p>	<p>access to the Welsh GP Record (WGPR). On 21 November 2016, NWIS announced that access to the WGPR would be extended to hospital pharmacists and pharmacy technicians in planned care settings including outpatients. This builds on the access in emergency care settings which has been available for some time. The Chief Pharmaceutical Officer is working directly with the Medical Director at NWIS to put in place appropriate information governance arrangements which will allow use of the WGPR by community pharmacists in specified circumstances to support patient care. We envisage this work will be completed early in 2017.</p>	<p>back to GP surgeries easy to produce - however, it does require ward based doctors and GPs to be involved in the process as well, and not simply delegate all activity with it to the pharmacy team. This is a significant business and organisational change, the scale of which should not be underestimated.</p> <p><i>UHB pharmacists and technicians now routinely access the GP record for patients on admission.</i></p> <p><i>MTeD is now implemented on all wards except Mental Health and the eDAL is increasingly being sent to community pharmacies as the Choose Pharmacy IT system is rolled out across the HB. The Choose Pharmacy system will be installed in half C&V community pharmacies by the end of March 2018 and all of them by the end of 2018, allowing all community pharmacies to be in a position to access the GP record.</i></p>
<p>R10. Where the Welsh Government makes a decision to make a new medicine available outside the current national appraisal process, it should clearly explain the rationale underpinning its decision and ensure that health bodies are given sufficient time to plan for the financial implications and service changes associated with introducing those new medicines.</p>	<p>Response – Accepted.</p> <p>We are pleased the Auditor General for Wales recognises that from time to time it may be necessary for the Welsh Government to make medicines available outside the current national appraisal process. We recognise that this should happen by exception and only where the rationale for so doing is clear. As has been the case with agreements to date, we expect agreements will continue to be made only where there is strong support for the availability of the medicine(s) both from clinicians and patients across Wales. However we will, with immediate effect and for all future agreements, ensure NHS bodies are more closely involved in the planning arrangements and afforded an appropriate period in which to prepare for the service and financial implications.</p>	<p>The HB Chief Pharmacist works closely with the CPhO and other Chief Pharmacists in Wales to enable improved planning and preparation for access to new medicines.</p>

Response to the WAO report into Radiology Service – Cardiff and Vale University Health Board	
Name of Meeting : Resource and Delivery Committee	Date of Meeting: 7/11/2017
Executive Lead : Chief Operating Officer	
Author : CD&T Clinical Board Director of Operations	
Caring for People, Keeping People Well. This report underpins the Health Board's "Sustainability" and "Deliver Outcomes that Matter to People" elements of the Health Board's Strategy	
Financial impact: No financial impact to respond to the report	
Health and Care Standards: 2.1 Managing Risk and Promoting Health and Safety, 2.9 Medical Devices, Equipment and Diagnostic Systems, 3.1 Safe and Clinically Effective Care, 4.1 Dignified Care	
CRAF Reference Number. 5.3.4 8.1.7	
Equality and Health Impact Assessment Completed: N/A	

ASSURANCE AND RECOMMENDATION:**ASSURANCE** is provided by:

- The Wales Audit Office (WAO) findings and conclusion reached following their review of radiology services
- Development of an action plan to address the recommendations made and progress against the actions

The Resource and Delivery Committee is asked to:

- **NOTE** the overall conclusion of the WAO review of the Radiology service in Cardiff & Value UHB and progress made against the action plan developed to address the WAO recommendations

10

SITUATION

The Wales Audit Office (WAO) undertook a review of radiology services across Wales, including the service provided by Cardiff and Vale University Health Board (CVUHB). The purpose of this paper is to provide a summary of WAO findings for CVUHB and progress made against the action plan developed to address the recommendations made.

BACKGROUND

The Welsh Audit Office undertook a review of the Radiology service in 2016 and issued a final report in February of 2017. The scope of the review included all aspects of the service in radiology including:

1. Performance
2. Workforce
3. Financial management
4. Equipment management

5. Quality and Safety and Risk management

Overall, WAO concluded that the service was well managed but risks to future service delivery remain. This, in the main, is due to the following:

1. A lack of strategic planning
2. Reporting backlogs
3. Ageing equipment
4. Recruitment and retention issues

WAO made eight recommendations for the service to address in order to maintain and improve future service delivery. The Clinical Diagnostics and Therapeutics (CD&T) Clinical Board fully accepts six of the recommendations but believes that two of the recommendations do not reflect the work that has already been undertaken within the service.

ASSESSMENT

In response to the report and the recommendations made, the service and Clinical Board has developed and is implementing an action plan to ensure that improvements are made. The action plan is included as an appendix to this report. The following is a summary of the position against the recommendations:

R1 – Develop an action plan to manage reporting backlogs

As part of the Health Board's Planned Care Planning cycle, the service has been actively working on achieving demand and capacity balance. Appointments to the outstanding vacancies in musculoskeletal and Body radiology were made in the autumn of 2017. Early indications are that the backlogs are decreasing as a result but this will continue to be monitored on an ongoing basis. The use of and training of radiographers to supplement reporting is being actively pursued by the service.

R2 – Increase appraisal levels for the non medical workforce

The department has been actively working on this, with appraisal levels currently at 86.84%. At this current time, the administration workforce is the staff group that presents the biggest challenge in terms of further improvement. This is due to known staff shortages which are being addressed.

R3 – Increase mandatory training levels to 85%

The Directorate actively manages this process and has made good progress. Compliance is currently 83.4%.

R4 – Development of referral guidance with referring clinicians

Clinical referral guidance is published on the portal and the clinical teams are actively working with referrers to develop new pathways to assist in appropriate demand

management. This has started predominantly with primary care colleagues and will become a continuous improvement process within the Directorate.

R5 – Develop a Radiology Strategy

Whilst this is the most complex recommendation for the service to meet, the service fully accepts the need to develop a clear radiology strategy. The agreed process is to develop the strategy on the back of the medical engagement process that is being undertaken in the Directorate. This is due to be complete in the next month and the clinical workforce has demonstrated a desire to be involved in planning and developing the strategy for radiology. Early work has already started with all areas of the Directorate to provide a starting point for the development of a strategy for Radiology.

R6 – Develop a workforce plan

The service and Clinical Board did not accept this recommendation on the basis that there is a clear process already in place for workforce planning. The Directorate has moved through this cycle fully on one occasion and is in the process of reviewing this again. There is an acceptance that this process will need to be reviewed in line with the strategy but plans are already in place to support this.

R7 – Develop an equipment replacement plan

This recommendation was accepted in part due to the fact that the service works closely with Welsh Government on the equipment replacement in radiology. The service has been fortunate to receive capital support in order to ensure that equipment is upgraded. There is recognition that at the time of the audit some equipment was ageing, however the planning process was already in place and has enabled the service to prioritise replacement to key equipment.

R8 – Strengthen Directorate performance management

This recommendation was not accepted as the performance management arrangements in the Directorate had been reviewed and strengthened - resulting in the noted improvements within waiting times performance within the report. The Directorate recognises the need to have a process of continual review of the performance management arrangements and works closely with the Clinical Board on this. The result is an ongoing position of delivery against expectations of performance.

WALES AUDIT OFFICE RADIOLOGY REPORT: CARDIFF AND VALE UHB RESPONSE

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/ no)	Accepted (yes / no)	Management Response	Completion Date	Responsible Officer	Updated Position
R1	Develop an action plan detailing how reporting backlogs will be managed sustainably e.g.:	Reduce reporting backlog, leading to patients receiving imaging results in a timely way. Efficient use of available radiology workforce and skills.						
	<ul style="list-style-type: none"> Making short-term use of outsourcing, whilst workforce and training plans are developed, 		Yes	Yes	A demand and capacity analysis has been completed and further investment agreed into reporting in 17/18 in order to address known demand growth. The recruitment process has begun in May 2017	1 st April 2017	Clinical Director	<p>Ongoing. Capacity shortage in MSK radiology has been recruited too.</p> <p>Capacity gap in neuro-radiology being supported using out-sourced reporting. Further demand and capacity modelling underway to establish resourcing requirement.</p>
	<ul style="list-style-type: none"> Ensuring that radiographers already trained to report are fully utilised, and 		Yes	Yes	Review trained reporting radiographers to ensure fully utilised	1 st April 2017	Professional Heads	Business Case to be developed as part of 2017/18 IMTP submission to implement Radiographer Led Discharge and

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/ no)	Accepted (yes / no)	Management Response	Completion Date	Responsible Officer	Updated Position
								Reporting.
	<ul style="list-style-type: none"> Establishing whether more radiographers need to be trained and how this will be achieved. 		Yes	Yes	Identify further areas for trained radiographers and develop a training plan	1 st April 2017	Professional Heads	<p>Opportunities for extending the scope of practice for radiographer reporting to scoped following implementation of the Imaging Academy.</p> <p>Limited radiologist cover for Chest Radiology impacts on the availability to extend and train an enhanced scoped of practice. Business case for Chest Radiologist to be included in IMTP submission for 2017/18.</p>
R2	Over the next year, increase appraisal rates for non-clinical radiology staff to at least the level of all other radiology staff.	<p>Well supported staff, encouraged to reach their full potential.</p> <p>Better understanding of individual and team training needs.</p>	Yes	Yes	A plan for the achievement of the PADR rate across the directorate has been agreed with the Head of Workforce and OD which includes implementation of Group PADR.	1 st April 2017	Professional Heads & Service Area Leads	<p>Partially Complete.</p> <p><95% completion of PADR for staff at work in radiographic, and RDA roles.</p> <p>Activity begun for group PADR for A&C staff, suspended due to current absence of A&C supervisors and managers. (To</p>

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/ no)	Accepted (yes / no)	Management Response	Completion Date	Responsible Officer	Updated Position
								recommence on their return)
R3	Over the next year, increase mandatory training rates for all radiology staff to at least the Health Board target of 85%.	Better trained staff and improved patient safety.	Yes	Yes	<p>There is an ongoing focus on the completion of the mandatory training requirements to meet the Health Board's target including the use of Mandatory May initiative.</p> <p>The success of the plan is being monitored through the Workforce and OD function and deviation from the plan would be managed via workforce performance panels.</p>	1 st June 2017	Professional Heads & Service Area Leads	Partially Complete – mandatory training rates at 83.4%
R4	Liaise with referring clinicians when developing and reviewing referral guidance. Ensure all referring clinicians know where to access up to date versions of guidance.	Referring clinicians have better access to radiology referral guidelines.	Yes	Yes	<p>As part of the ongoing work associated with the trading framework further guidance and protocols are being developed on an ongoing basis.</p> <p>There is a developed clinical engagement mechanism which is utilised.</p> <p>A review of the availability of guidance will be undertaken throughout the 2017/18 financial</p>	End of 2017/18 financial year, recognising an ongoing management requirement	Clinical Director & Radiologist Clinical Leads	<p>Ongoing / Complete.</p> <p>Clinical referral guidance is published on clinical portal.</p> <p>Membership of LMC now includes radiology representation to support information sharing and development of pathways with Primary Care clinicians. Revised referral pathway for Polycystic</p>

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/ no)	Accepted (yes / no)	Management Response	Completion Date	Responsible Officer	Updated Position
					year.			Ovary Syndrome now in place.
R5	<p>Over the next 12 months develop a radiology strategy which sets out:</p> <ul style="list-style-type: none"> Where the service is now in terms of its demand, capacity and available resources; Where the service needs to be; and How the service will achieve its aims. 	Improved strategic and business planning of the radiology service	Yes	Yes	Development of a cohesive strategy for Radiology	End of 2017/18 financial year	Clinical Director & Directorate Manager	<p>Underway. The development of the Strategy is a significant programme of work which includes engagement and input of all staff groups.</p> <p>A series of Value Based Planning Sessions have been conducted in the Directorate for Agenda for Change Service area Leads.</p> <p>External support has been commissioned to develop a unified approach to medical workforce engagement.</p>
R6	Develop a workforce plan alongside the radiology strategy, which identifies the baseline capacity needed to sustainably meet radiology demand in a timely and safe way.	Better understanding of current and future workforce capacity and needs.	No	No	Whilst there is a recognition that there is a requirement to review the workforce plans on an ongoing basis, radiology has undertaken significant restructuring over the last two years in response to the established workforce	ongoing	Professional Heads, Directorate Manager & Service Area Leads	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/ no)	Accepted (yes / no)	Management Response	Completion Date	Responsible Officer	Updated Position
					planning process.			
R7	<p>By mid-2017, develop an equipment replacement plan. The plan should include:</p> <ul style="list-style-type: none"> equipment priorities, requirements, and associated costs, and Outline the risks to the service/patients of not achieving the plan within the required timescales. 	Documented equipment replacement plan to inform strategic and business planning.	Yes	Yes in part	<p>There is ongoing work with Welsh Government in respect of major capital replacement for radiology and the priorities for the next two financial years are well understood.</p> <p>There is further work that can be developed for a longer term view.</p>	End of 2017/18 financial year for longer term view	Professional Heads, Directorate Manager & Service Area Leads	<p>Complete.</p> <p>A schedule of replacement equipment required has been developed across the Directorate. This has been risk assessed and prioritised to support submission of capital funding bids.</p>
R8	<p>Strengthen directorate performance management by:</p> <ul style="list-style-type: none"> Setting clear business and service objectives; Widening the range of performance measures aligned to the business and service objectives to include: equipment downtime, vacancy levels, the number of unreported images, performance against internal referral and 	Wider pool of performance information from which to identify and strengthen service weakness.	No	No	<p>Equipment downtime already captured.</p> <p>There is an ongoing programme of reviewing the performance data utilised in radiology.</p> <p>This is linked to the directorates performance review and over the last two years the improvement of performance management has been well established.</p>	End of June 2017	Professional Heads, Directorate Manager & Service Area Leads	

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/ no)	Accepted (yes / no)	Management Response	Completion Date	Responsible Officer	Updated Position
	reporting times.							

STRATEGIC EQUALITY OBJECTIVES - DELIVERY PLAN FRAMEWORK 2017-18
Name of Meeting : Resource And Delivery Committee
Date of Meeting 7 November 2017
Executive Lead: Executive Director of Workforce and Organisational Development
Author: Equality Manager (02920742267)
Caring for People, Keeping People Well: This paper underpins the Health Board's 'Priorities', 'Sustainability', 'Culture' and "Values" elements of the Health Board's Ten Year Shaping Our Future Wellbeing Strategy
Financial impact: There are no anticipated costs identified with this paper.
Quality, Safety, Patient Experience impact: The information provided in this paper supports the organisation's goal of providing high quality, safe services to its patients
Health and Care Standard Number 3.2, 4.2 & 6.2 CRAF Reference Number 8.1.6
Equality Impact Assessment Completed: Not applicable. However, the paper puts forward actions that are relevant to meeting the duties under the Equality Act 2010, the Human Rights Act 1998 and other equality related legislation.

RECOMMENDATION

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The actions stated within the delivery plan helps the UHB meet its obligations set out in the Strategic Equality Plan and Objectives Fair Care 2016-17(SEP).

RECOMMENDATION

The Resource and Delivery Committee is asked to:

- **NOTE** the contents of this paper

SITUATION

The four year Strategic Equality Plan Fair Care 2016-20 is now in to its second year. This paper identifies the progress made thus far in the 2017/18 action plan.

BACKGROUND

The Strategic Equality Delivery Plan Framework was approved at the June 2016 meeting of the Equality, Diversity and Human Rights Sub Committee.

The Sub Committee requested regular updates on its progress as a form of monitoring. As the EDHRSC was stood down it has been agreed that the update of progress will now be made to the Resource and Delivery Committee.

ASSESSMENT AND ASSURANCE

This second year of the plan emphasizes wider leadership and increased ownership of EDHR issues. For example, the Chair of the UHB has promoted the completion of the Stonewall Workplace Equality Index survey amongst staff. A paper on successfully gaining the Disability Confident-Employment status went to the Health Systems Management Board. Further, a paper on the achievements and challenges of meeting the All Wales Standards for Accessible Communication and Information for People with Sensory Loss (Sensory Loss Standards) was well received by the Board.

The second year also sees us shifting efforts towards improved engagement work, working more closely with patients through regular UHB activity operations. For example, the Equality Manager, along with others is involved in the work around the Major Trauma Centre. Although this piece of work is not specifically identified in the plan, it is a natural part of our work to meet the first three of our four equality outcomes. Our four outcomes are as follows:

1. **People are and feel respected**
2. **People are communicated with in ways that meet their needs**
3. **More people receive care and access services that meet their needs (including those from disadvantage communities)**
4. **Gender and any other protected characteristic pay gap reduced**

There has been an anecdotal increase in the use of Equality and Health Impact Assessments (EHIA). It has been vital in raising the profile of the UHB desire to reduce health inequalities across the different populations. It has to be acknowledged that there has been a little criticism about the length of the EHIA but its content helps us meet our current legal obligations but with an eye for future requirements. We are looking at ways in which we can monitor the use and assess the quality of EHIAs.

There has been solid progress on the plan over the past six months, mainly around issues of respect (Objective 1), which ties into our values agenda. If the trajectory continues, then there should be a successful completion of the tasks. It does need to be highlighted however, that some progress will remain amber for this year and the next as new legislation around Welsh language and Welsh Government expectations around the Sensory Loss standards are made clearer.

The plan (**Appendix 1**) continues to use the RAG rating system as follows:

Red = Not started/Off track

Amber = Started/On track

Green = Completed

Of the 21 key actions, there are no Reds. Fifteen of the key actions are at the Amber stage and have begun or are on track. Six key actions have been completed. More individual tasks have been completed since the last update which indicates that the coming months should see the completion of the individual key actions.

While progress should be celebrated, the real challenge will come in 2018/19 as we look to move from transition to transformation. For example, integrating a new Information Standard into the UHB will test our internal mechanisms, such as the way we use technology to communicate with those who use our services.

The third year of our action plan will look to take this and other issues into account. Any new proposals or actions will help Cardiff and Vale UHB to focus on continuing to provide equitable services.

Members are asked to note the progress of the equality agenda within the UHB.

Fair Care - Cardiff and Vale Health Board SEP Delivery Plan 2017-2018: Living our Values

Outcome 1 People are and feel respected

Objective 1.1		To support and promote the Health Board as a great place to work for all			
Performance Measures	Data Source	Frequency of data			
Ranking in Stonewall Employers' Index	Stonewall	Annual			
Number of staff who identify as coming from fr	Staff records	Annual			
Number of staff who identify as disabled	Staff records	Annual			
number of staff who identify as LGBT	Staff records	Annual			

Action	Action owner	Action delivery by	Target date	Tasks	Deliverables
	Equality Manager	Equality Manager; Rainbow LGBT FFlag Network	Oct-17	1.Complete WEI submission 2.Purchase PRIDE Stall space 3. Establish a disabled staff network	1.Submission achieved. 2. Staff attended stall
Continued participation in Stonewall's WEI- whilst linking the Index to other protected characteristics	Equality Manager;	Equality Manager; Rainbow LGBT FFlag Network	Sep-17	1. Implement support plan. 2. Make bid to charitable funds 3. Meet with new Executive Director of WOD	1. Support plan implemented 2. Successful bid to Charitable Funds 3. Meeting with Executive Director of WOD takes place.
Continued support for the Rainbow LGBT FFlag Network	Network		Nov-17	1. Map existing accreditations and identify any gaps 2. Nominate lead for each accreditation 3. Map requirements for each and develop timetable for completion of application.	Accreditation achieved for Disability Confident Scheme. Lead nominated and timetable established
Successful continuation of current accreditation/charters such as Disability Confident Scheme and Mindful Employer Identify and shape opportunities to engage with staff to understand their experience and respond to feedback to ensure all staff feel valued and involved, and ensure equality of opportunity is UHB wide.	Assistant Director of OD Assistant Director of OD	Senior HR officers & Equality M LED Manager; Workforce Information Manager; Head of Communications; Equality Manager; Technical Development Manager	Apr-18	1.HoWOD lead role for staff engagement - meeting with Keithley to determine expectations and requirements of local engagement plans 2. Support development of engagement toolkit to ensure equality considerations	1. Comprehensive coverage of equality issues in staff engagement toolkit and values work. 2. Equality Champions influencing and supporting engagement activity in CBs 3. Meeting with Director of Communications and Engagement to take place.
Recommendations of EDHRSC legacy document accepted by Board	Board Secretary	Board Secretary; Equality Manager	Jun-17	1. Board Secretary and Equality Manager to produce a legacy document	1. Full integration of equality and Welsh Language considerations in Board decision-making

Objective 1.2		To undertake engagement activities to communicate with stakeholders and obtain views on service delivery for all			
Performance Measures	Data Source	Frequency of data			
Number of equality issues raised and resolved	Concerns Team	Annually			
Number of stakeholders attending events or activity					

Action	Action owner	Action delivery by	Target date	Tasks	Deliverables
Gain feedback from stakeholders (and disseminate) through involvement in and attendance at partnership equality or related events and activities, including: Annual Minority Ethnic Communities (MEC) Health Fair; Annual Carers' Events; Annual Pride; Stakeholders Reference Group; Annual third sector engagement; and a number of equality engagement events per year to assess progress against the SEP	Assistant Director of Patient Experience/Assistant Director of OD/Assistant Director of Planning/Equality Manager	Equality Manager	Mar-18	1. Arrange at least 2 stakeholder events during 17/18 2. Responding to issues raised 3. Equality Champion allocated in each Clinical Board to support contributions to the stakeholder events	1.Refreshed SEP Delivery Plan, taking account of feedback 2. Issues raised are responded to. 3. Equality Champions identified and contribute to stakeholder events

Objective 1.3 To ensure that people are respected and free from abuse, harassment, bullying and violence

Performance Measures	Data Source	Frequency of data
Number of hate crime issues reported and resolved	Head of Health and Safety	Annually
Number of staff attending Violence and Aggression training	Head of Health and Safety	Annually

Action	Action owner	Action delivery by	Target date	Tasks	Deliverables
Disseminate hate crime, abuse and harassment materials whilst making sure that reporting links are clear and well communicated	Head of Health and Safety	Head of Health and Safety/Equality Manager/Equality Champions	Mar-18	1.Establish an intranet page that defines hate crime and which includes reporting links 2. Establish a circulation list for each Clinical Board 3. Review the current Violence and Aggression (V&A) training package 4. Achievement of 85% staff receiving V&A training 5. Establish mechanism for receiving relevant up to date information	1. An intranet page 2. Up to date circulation list for all clinical board which is used 3. V& A training which includes information on hate crime, abuse and harassment 4. Achievement of 85% across the UHB 5. Relevant, up to date information is communicated across the UHB

Objective 1.4 To review all equality related training, support and development with a view to creating a more inclusive workplace and more inclusive services

Performance Measures	Data Source	Frequency of data
% of staff who receive training publicised in Annual Equality Report	LED Manager	Annually
Number of Equality Champions in the organisation	Equality Manager	

Action	Action owner	Action delivery by	Target date	Tasks	Deliverables
Redesign, develop and roll out a programme of equality training for all staff	HoWOD lead for HR Ops team / Equality Manager	Equality Manager & HoWOD le:	Mar-18	1. Use feedback from equality training to monitor requirements 2. Write up a rationale and a plan for the organisation which addresses all staff groups	1.Refreshed equality and dignity training programme taking account of feedback/evaluation is delivered

Provide additional materials and reference guides for all managers and supervisors	Equality Manager	Equality Manager	Mar-18	1. Gather and produce guides on LGBT, Religion, race and disability	Comprehensive coverage of equality issues in guides
Continue to support and develop the role of Equality Champions within the organisation	Equality Manager	Equality Manager	Mar-18	1. To continue work with the champions about a work plan	Work plan actions achieved

Objective 1.5 To explore the use of positive action employment initiatives with regards to protected characteristics

Performance Measures Data Source Frequency of data

Number of placements	Mar-18
Completion of review	Mar-18

Action Action owner Action delivery by Target date Tasks

Explore possibility of developing learning disabilities work with Elite Supported Employment Agency.	Equality Manager	HR Ops team in partnership with CBs and corporate depts	Mar-18	1. Meet with ELITE and placement leads 2. Meet with CB/Corporate leads 3. Develop new placements withing CB's & Corporate	Rise in number of placements achieved
Review to be undertaken of the Breaking Barriers Programme/work for BAME consultants by September 2016	Equality Manager	Equality Manager	Oct-17	1. Plan 'unconscious bias' training	1. Training has been implemented

Objective 1.6 To promote person-centred services that respect people's human rights and communication, spiritual and cultural needs


Performance Measures Data Source Frequency of data

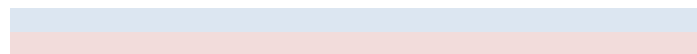
Number assessed by Red, Amber and Green rating (Health and Care Standards)
--


Action Action owner Action delivery by Target date Tasks Deliverables

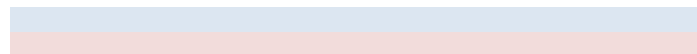
Support Clinical Boards to understand and implement Health and Care Standard 6.2 People's Rights	Equality Manager	Equality Manager	Jun-17	1. Refine the self-assessment process to capture impact not just compliance 2. Clinical Boards to know what happens with the process (communication & feedback)	1. Self-assessment process refined
Identify targeted interventions to ensure patients' communication, cultural and spiritual needs are assessed	Assistant Director of Patient Experience	Lead Nurse Patient Experience/Chaplaincy Manager	Mar-18	1. Data is collected 2. Review of patients' communication, cultural and spiritual needs	1. Data is used to full potential 2. Accessible guidance is produced to ensure needs of patients with communication, cultural and spritual needs are met 3. Availability of special dietary requirements for cultural needs are met
Provide screening and educational sessions to meet the needs of patients with cultural, religious dietary requirements	Nutrition & Dietetics Manager	Nutrition & Dietetics Manager/ Equality Manager	Feb-17	1. Review of assessment process for patients' communication, cultural and religious dietary needs 2. Importance of assessing needs is included in induction 3. Review of patients' communication, cultural and spiritual needs is part of redesigned equality process/training	1. Accessible guidance is produced to ensure needs of patients with cultural and religious dietary needs are met 2. Availability of special dietary requirements for cultural needs are met


Progress	RAG rating
Submission has been completed and we await result in January 2018. Staff attended stall in partnership with other Health Board/Trusts. The establishment of a disabled staff network requires further work as to its likelihood.	Amber
Support plan has been implemented. Bid to Charitable Funds (partially) successful. Meeting with new Executive Director of WOD established.	Amber
Successful Disability Confident- Employer status achieved ahead of time	Green
Staff survey undertaken and disseminated. Delivery Plan shared with Equality Champions. Meeting with Director of Communications and Engagement has taken place with a plan being developed to a toolkit. Equality Manager has met with a number of disabled staff to discuss the possibility of establishing a disabled staff network	Amber
Legacy document recommendations acted upon	Green

Progress	Rag Rating
<p>Work with Engagement Lead for Perfect Locality continues in regard to events and support provided through development of an EHIA . Stakeholder planning revised as part of the SEP delivery. Equality Manager works closely with Concerns Team. Review of whether each Clinical Board has a Equality Champion has taken place. Plan agendad for January Champions meeting.</p>	



Progress	RAG rating
<p>Intranet page established. Circulation list updated. V&A awareness includes information on hate crime, abuse and harassment. Target of 85% not yet achieved. Awareness raising is communicated via newsletters/intranet.</p>	

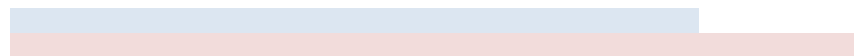


Progress	RAG rating
<p>Equality Manager has facilitated Skills to Change and Leadership & Management sessions. Future sessions are planned</p>	

Work on guides on religion and LGBT issues has completed. Work on other protected characteristics continues.



Actions such as newsletter articles and equality diary dates/calendar have been completed

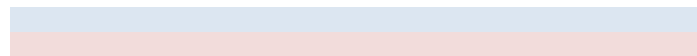


Progress **RAG rating**

Meeting with Elite has taken place. Date for discussions with Clinical Boards agreed as to placements.



Work on developing 'unconscious bias' training has been refined. Discussions around external trainer being explored.



Progress

This work has been completed.



A good practice guide is to be produced.



Department of Nutrition & Dietetics and Diabetes Specialist Nurse win Five Star Award for their work on meeting patient educational and accessibility need. Work undertaken to meet the need of Jewish patients



Fair Care - Cardiff and Vale Health Board SEP Delivery Plan 2017-2018: Living our Values

Outcome 2: People are communicated with in ways that meet their needs

Objective 2.1	To meet the All Wales Standard for Accessible Communication	
Performance Measures	Data Source	Frequency of data
Improvement reported in Community Health Council environmental audit and by Third sector	Sensory Loss Task & Finish Group	Annually

Action	Action owner	Action delivery by
Implement a Health Board wide action plan to meet the All Wales Standards for Accessible Information and Communication for People with Sensory Loss	Sensory Loss Standards Group chaired by Chief Operating Officer	Sensory Loss Standards Group

Objective 2.2	To comply with the Welsh Language Standards Framework	
Performance Measures	Data Source	Frequency of data
% of frequently used information both leaflets and letters which are available in Welsh	Clinical Board Directors of Operations	Annually
% of identified staff who receive training	LED Manager	Annually

Action	Action owner	Action delivery by
Implement the Welsh Language Standards Framework including through the continued work of the Welsh Language Steering Group	Assistant Director of OD	Welsh Language Officer/ Welsh Language Steering Group

Objective 2.3	To create environments accessible to people with sensory loss	
Performance Measures	Data Source	Frequency of data

Action	Action owner	Action delivery by
Through engagement and in partnership with the RNIB, Action on Hearing Loss and other third sector organisations CB's create a more accessible environment	Clinical Boards Heads of Delivery/Assistant Director of Planning/Equality Manager	Clinical Boards Heads of Delivery/Assistant Director of Planning/Equality Manager

es

on and Information for people with sensory loss

Target date	Tasks	Deliverables
Mar-18	1.Continue to implement action plan 2. Good practice is shared across the UHB 3. Organisation's delivery of standard goes beyond the Sensory Loss Standards Group	1. Action plan has begun to be implemented 2. All Wales Standard is achieved 3. CB's through their action plans and Sensory Loss Leads/Champions are aware of baseline situation in their areas.

on and Information for people with sensory loss

Target date	Tasks	Deliverables
Mar-18	1. Respond to the Standards. 2. Good practice is shared across the UHB 3.Organisation's delivery of standard goes beyond the Welsh Language Steering Group 4. Action plan is developed	1. Action plan has begun to implemented 2.Welsh Language Standards have begun to be achieved CB's through their action plans and Welsh Language Steering Group members are aware of progress

ss, stroke and dementia and which consider lighting, colour, contraqst, signage, back

Target date	Tasks	Deliverables
Mar-18	1. CB's to identify pilot area 2. CB Sensory Loss Champions to develop best practice guidance for accessible environments 3. CB Sensory Loss Champions to develop and collate all patient feedback/concerns 4. CB's attend and hold engagement events which include issues of accessibility.	1. Pilot area identified 2. Best practice guidance produced 3. Feedback mechanism and baseline analysis with action plan produced 4. Engagement events undertaken

	Progress
--	-----------------

Progress	RAG rating
Work on action action plan has been begun. Clinical Boards report back to the Sensory Loss Standards Group and are working towards achieving the Standards.	

	Progress
--	-----------------

Progress	RAG rating
Awaiting the Welsh Language Standards and the outcome of the new Welsh Language Bill. The Board have been actively involved in the consultaion. Anticipatory work has begun	

ground noise etc	Progress
-------------------------	-----------------

Progress	RAG rating
<p>Clinical Boards have identified their Sensory Loss Champions and began work to meet the tasks/standards. The UHB became the first Hospital in the UK to be awarded the RNIB's Visibility Better Accreditaion in the Radiology department. Estates and planning provided with appropriate guidance. Wayfing and Accomodation Group has invited a RNIB representative to become a member of the group. Some Clinical Boards have established links with Action on Hearing Loss. Equality Manager represents the UHB at the All Wales Standards for Accessible Communication and Information for People with Sensory Loss Senior Officers Group.</p>	

Fair Care - Cardiff and Vale Health Board SEP Delivery Plan 2017-2018: Living our Values

Outcome 3 More people receive care and access services that meet their needs (including those from disadvantaged backgrounds)

Objective 3.1 To support the implementation of Addressing Health Inequalities and Access IMTP 2016/17-2018/19

Performance Measures	Data Source	Frequency of data
Number and quality of Equality and Health Impact Assessments (EHIA)		

Action	Action owner	Action delivery by	Target date	Tasks
Engage with service users to ensure they are involved in service redesign, for example, adults with learning disabilities and asylum seekers and refugees	Clinical Boards	CB Directors of Operations	Mar-18	<ol style="list-style-type: none"> 1. To develop engagement plan for service redesign that includes a diversity of methods 2. To implement plan in conjunction with communities identified 3. To develop a communication plan - internally and externally- for diverse communities including roadshows and community letters. 4. To implement the communication plan

Objective 3.2	To ensure that we have the necessary mechanisms in place to capture and monitor the protected	
Performance Measures	Data Source	Frequency of data

Action	Action owner	Action delivery by	Target date	Tasks
Regularly review and monitor the data collected in order to ensure that it is collected and processed in a manner which enables us to make more informed decisions on how to improve the services we provide.	Chief Operating Officer/ Director of WOD	Director of WOD	Mar-18	1. To review and monitor any equality data collected in order to ensure that it is collected and processed in a manner which enables us to make more informed decisions on how to improve the services we provide

Objective 3.3	To create combined Equality and Health Impact Assessment (EHIA) process	
Performance Measures	Data Source	Frequency of data

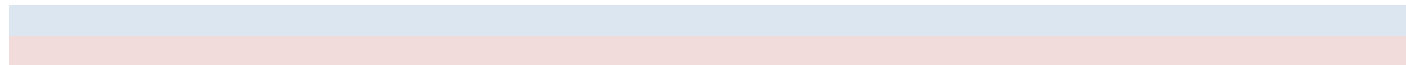
Number of EHIAs completed and published

Action	Action owner	Action delivery by	Target date	Tasks
--------	--------------	--------------------	-------------	-------

Monitor the quality of Equality & Health Impact Assessments.	Equality Manager/ Governance Manager/Principal Health Promotion Specialist	Principal Health Promotion Specialist/Equality Manager	Dec-17	1. Develop a monitoring plan to assess the quality of EHIA's and linking in to the IMTP. 2. Review the EHIA training package 3. Explore the possibility of establishing a virtual EHIA group for quality assurance purposes.
--	---	---	--------	--

Objective 3.4	To explore the Health literacy needs of patients so as to reduce health inequalities			
Performance Measures	Data Source	Frequency of data		
Number of participants with protected characteristics				

Action	Action owner	Action delivery by	Target date	Tasks
Explore how to build upon the work of the pilot Ophelia Approach that supports the identification of community health literacy needs	Clinical, Diagnostic and Therapies Clinical Board/ Equality Manager	Associate Lecturer & Physio/ Equality Manager	Nov-17	1. Review Evaluation Report of the pilot






ged communities)

) including support for people with learning disabilities and for asylum seekers and refugees

Progress

Deliverables	Progress	RAG rating
1. Engagement Plan developed. 2. Engagement Plan implemented with community support 3. Communication Plan developed. 4. Communication Plan implemented	The deliverables are evident throughout the 2015/16-2017/18 IMTP. (See in particular pages 207-212)	

characteristics data **Progress**

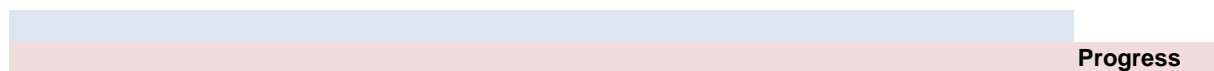
Deliverables	Progress	RAG rating
1.To produce regular updates to the appropriate Board Committee.	This work has begun. The deliverables are evident throughout the 2015/16-2017/18 IMTP. It is also tied in with what we already know from events such as Pride where data is collected.	

Progress

Deliverables **Progress** **RAG rating**

1. Monitoring plan for EHIA is developed, communicated and available for use across the UHB.

Work on monitoring and review has begun, including exploring the possibility of establishing a virtual EHIA group for quality assurance.

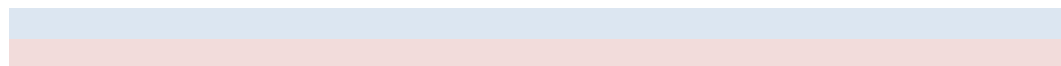


Progress

Deliverables	Progress	RAG rating
---------------------	-----------------	-------------------

1. Decide whether work can be taken forward

Meeting has been arranged to begin discussions as to how the work can be taken forward.





Fair Care - Cardiff and Vale Health Board SEP Delivery Plan 2017-2018: Living our

Outcome 4 Gender and any other protected characteristic pay gap reduced

Objective 4.1	To reduce any other protected characteristic pay gap to promote
Performance Measures	Data Source

Meet the legislative requirements of the gender pay gap information regulations

Action	Action owner
Identify any trends and to formulate an action plan to address any unfair differentials that may emerge	Deputy Workforce & OD Director

Values

equality and good practice
 Frequency of data

Action delivery by	Target date	Tasks	Deliverables	Progress
Workforce Governance Manager/Equality Manager	Mar-18	1. Data set established to identify and organise fields of search 2. Action Plan formulated to address an gaps or issues that arise	1. Established data set 2. Implemented action plan	Currently scoping out data sets. Meeting around action plan established.



APPROVAL OF RECORDS MANAGEMENT POLICY
Name of Meeting Strategy and Engagement Committee Date of Meeting 5 September 2017
Executive Lead : Director of Corporate Governance (SIRO)
Author : Corporate Governance Senior Information and Communication Manager
Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : There are significant potential financial implications in relation to this work. The Information Commissioner has powers to fine organisations that are in breach of the law and through their acts or omissions materially harm or damage individual. The levels of fine can reach half a million or more and the ICO now has the right to undertake mandatory audits on NHS organisations. This does not exclude the ability for individuals to take legal action against the organisation in respect or harm or damage both as a result of physical or psychological harm or reputational harm.
Quality, Safety, Patient Experience impact : The content of the Policy directly impacts significantly on the quality, safety and experience of our patients, service users and their families.
Health and Care Standard Number 3.4 & 3.5
CRAF Reference Number 8
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Policy document and the underpinning procedure and protocol

The Strategy and Engagement Committee is asked to:

- **APPROVE** the Policy **and**
- **APPROVE** the full publication of the Records Management Policy in accordance with the UHB Publication Scheme

SITUATION

The Records Management Policy has been reviewed and the retention schedules amended to reflect the revised retention schedules of the Department of Health.

14.1

BACKGROUND

Cardiff and Vale University Health Board (the UHB) has an approved Records Management Policy, with an underpinning procedure and protocol, which sets out how the UHB will manage all the records that it handles in accordance with required legislation and standards. The documentation needed to be reviewed and amended following changes made to the Department of Health retention schedules which the UHB had previously adopted.

ASSESSMENT

Wider consultation was not required as the UHB as adopted retention schedules that had been renewed and therefore the amendment was required to reflect the new schedules. No other amendments were identified as being required at this time.

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

14.1

Reference Number: 142	Date of Next Review: September 2019
Version Number: 2	Previous Trust/LHB Reference Number: T197
Records Management Policy	
Policy Statement	
<p>To ensure that Cardiff and Vale University Health Board (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently in respect of the records it holds. To ensure that the UHB handles and processes all records in accordance with the legal requirements, codes of practice and guidance issued by relevant authorities including, but not restricted, to the Welsh Government and the Information Commissioner's Office.</p>	
Policy Commitment	
<p>This policy and supporting procedure sets out the overall commitment of the UHB to comply with relevant legislation for handling all the records it creates.</p> <p>The UHB will follow the Lord Chancellor's Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000. It will ensure that all staff are informed of the importance attached to the way in which records are managed and the relationship of records management to assist in achieving the overall business strategy of the organisation. This policy and supporting procedure will ensure that the UHB have effective systems of record management as recommended within the code to fully comply with all legal requirements placed upon it in respect of records management.</p> <p>To provide clear direction for the management of all UHB records, including both clinical and corporate records. To address business and performance standards such as the requirement to meet Caldicott standards, Welsh Health and Care Standards Framework, and the Information Governance Toolkit Standards as far as possible in the Welsh context.</p> <p>Cardiff and Vale University Health Board (the UHB) understands the definition of records to be:</p> <ul style="list-style-type: none"> • “Information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations, or in the transaction of business. <i>Reference BS ISO 15489.1</i> • An NHS record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees including consultants, agency or casual staff.” <i>Reference. Department of Health Records Management: NHS Code of Practice Part 1</i> <p>All records held by the UHB fall within the scope of this policy and these are personal (relating to patients, public and employees) and corporate (for example financial records, letters, reports) and in electronic, virtual or physical format. It applies to all areas and services within the remit of the UHB.</p>	

14.1

Document Title: <i>Insert document title</i>	2 of 3	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

<p>Supporting Procedures and Written Control Documents</p> <p>This Policy and supporting procedures describe the following with regard to all aspects of</p> <ul style="list-style-type: none"> • Records creation • Records keeping • Record maintenance • Access and transfer • Appraisal • Archiving • Storage • Disposal • Responsibilities for Records Management <p>Other supporting documents are:</p> <ul style="list-style-type: none"> • Information Governance Policy and Framework • Records Management Procedure • Records Retention and Destruction Protocol • Data Protection Act Policy and Procedures • Freedom of Information Act Policy • IT Security Policy • Risk Management Policy • Information Risk Management Procedure • Guide to Incident Reporting Incident Management Investigation and Reporting. [Serious incidents] • Electronic and Paper Clinical Results Review and Retention Protocol • Records Management Code of Practice for Health and Social Care 2016 	
<p>Scope</p> <p>This policy applies to all UHB staff whether permanent, temporary, or contracted including students, contractors or volunteers in all locations including those with Honorary contracts.</p>	
<p>Equality Impact Assessment</p>	<p>An Equality Impact Assessment has been completed for the overarching IG Policy. The assessment found that there was some impact on the equality groups mentioned in relation to communication. An action plan has been developed to address those areas.</p>
<p>Health Impact Assessment</p>	<p>A Health Impact Assessment (HIA) has not been completed as this document falls under the IG Policy.</p>
<p>Policy Approved by</p>	<p>People Planning and Performance Committee</p>
<p>Group with authority to approve procedures written to explain how</p>	<p>Information Governance Sub Committee</p>

Document Title: <i>Insert document title</i>	3 of 3	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

this policy will be implemented	
Accountable Executive or Clinical Board Director	Medical Director
<p><u>Disclaimer</u></p> <p>If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.</p>	

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Quality and Safety Committee 16/10/2012	24/4/13	<i>New UHB document previous Trust document reference.</i>
2	Date Approved by People, Planning and Performance Committee 6/9/16		Reviewed and structured into new UHB format
3	Submitted to IGSC 8/8/17		Amended to reflect the new retention arrangements in NHS England. Recommended by IGSC 8/8/17 for submission to SEC for formal approval.

APPROVAL AND ADOPTION OF EMPLOYMENT POLICIES
Name of Meeting : Resources and Delivery Committee Date of Meeting 7 November 2017
Executive Lead : Executive Director of Workforce and OD
Author : Workforce Governance Manager, 47559
Caring for People, Keeping People Well : This report underpins the Values elements of the Health Board's Strategy.
Financial impact : not applicable
Quality, Safety, Patient Experience impact : The implementation of this policy will impact positively on the delivery of clinical services through the raising of standards
Health and Care Standard Number 7
CRAF Reference Number not applicable
Equality and Health Impact Assessment Completed: Yes

ASSURANCE AND RECOMMENDATION
ASSURANCE is provided by: <ul style="list-style-type: none"> • Agreed national processes have been followed to approve this policy • Agreed local processes are now being followed to implement this policy • Dissemination of information across the UHB <p>The Resources and Delivery Committee is asked to:</p> <ul style="list-style-type: none"> • Formally ADOPT the revised All Wales Medical Appraisal Policy and • APPROVE the full publication of it in accordance with the UHB Publication Scheme

SITUATION

This paper summarises for the Resources and Delivery Committee details of an All-Wales Policy which has been reviewed and should now be adopted by the UHB.

BACKGROUND

The Medical Appraisal Policy was originally developed by Wales Revalidation, Appraisal Implementation Group (RAIG) and adopted by the UHB in 2012. It is applicable to all doctors employed by the Designated Body, as well as to all medical independent contractors on the performers list, doctors in training and locums.

14.2

Appraisal is a professional, formative and developmental process. It is about identifying development needs, not performance management. It is a positive process to give doctors feedback on their past performance, to chart continuing progress and identify development needs.

RAIG agreed an updated version of this policy and it was ratified by the Wales Revalidation Delivery Board (WRDB) on 17th March 2016. It was then issued via the Revalidation Wales website. Unfortunately, the UHB was not officially notified of this through the usual channels and therefore it was not formally adopted by the UHB or entered onto the UHB Policy Database. However it is noted that the procedures followed within the UHB were such that no changes were required as a consequence of the new updated Policy

ASSESSMENT

Key changes to the revised policies are as follows:

- 3.3.1 The objectives of medical appraisal in Wales have been extended to include 'document person, team or service level issues which have constrained their service delivery or development'
- 4.5 It is made explicit that while appraisal and job planning are separate processes, each process should inform the other and some information will need to flow between them. Generally the doctor is responsible for this information flow.
- 4.10 Each designated body will have to follow this policy and demonstrate how it will be delivered to appropriate standards
- 6.2 A new section on GMC expectations around 'whole practice appraisal' and the provision of evidence has been added
- 7.1 Reference is made to the All Wales Exceptions Management Protocol
- 7.2 An All Wales appeal process similar to the agreed job planning appeal model will be developed to manage conflict of interest situations/disputes which have exhausted local procedures
- 9.4 The requirement for appraisers to 'discontinue the appraisal discussion' if there are concerns about fitness to practice has been removed
- 15 A section of 'Designated Body' approval has been added – this section is to be completed by the Designated Body. In the case of the UHB it is suggested that this should read: 'Responsibility for formally adopting this policy sits with the UHB Resources and Delivery Committee.'

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

14.2

Document Title: <i>Medical Appraisal Policy</i>	1 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

Cardiff and Vale University Health Board

All Wales Medical Appraisal Policy v10 March 2016

Approved by: Revalidation and Appraisal Implementation Group (RAIG)
/ Wales Revalidation Delivery Board (WRDB).

Issue Date: March 2016

Review Date: March 2018

14.2

Document Title: <i>Medical Appraisal Policy</i>	2 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

CONTENTS

1. Policy statement
2. Scope of policy
3. Objectives of appraisal
4. Key principles
5. Appraisal in the context of revalidation
6. Accountability, roles and responsibilities
7. Managing exceptions
8. Integration between appraisal and other quality and safety systems
9. Confidentiality
10. Data Protection Act 1998
11. Freedom of Information Act 2000
12. Equality and Diversity
13. Review
14. Monitoring
15. Approval

Note: Development of the policy

This policy has been developed by a sub group representing the Revalidation and Appraisal Implementation Group (RAIG) at the request of the Wales Revalidation Delivery Board (WRDB).

The sub group was chaired by NHS Employers and included representatives from BMA Wales Cymru, the Health Boards and the Deanery. Drafts of the policy were shared with the WRDB, the Welsh Government Workforce and Organisational Development Section and the BMA Employment Advisers.

14.2

Document Title: <i>Medical Appraisal Policy</i>	3 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

V06 of the policy was agreed by the Chair of RAIG on 13th April 2012, and ratified at WRDB on 25th April 2012.

In line with the Review requirements (section 13) Version 10 of the policy was agreed by a sub group of RAIG and ratified by WRDB on 17th March 2016.

14.2

Document Title: <i>Medical Appraisal Policy</i>	4 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

1. **Policy Statement**

- 1.1** It is the policy of Cardiff and Vale University Health Board (the UHB) to promote the value and worth of appraisals for all medical employees and contractors.
- 1.2** It is the policy of the UHB to ensure effective arrangements exist to facilitate appraisal for all such employees in a fair and consistent manner.

2. **Scope of Policy**

- 2.1** This policy is applicable to all doctors, employed by the UHB, as well as to all medical independent contractors on a performers list, doctors in training, and locums.
- 2.2** Where an employee is either jointly employed, or is not employed by the UHB but provides a service to the UHB, the issue of who is responsible for providing the appraisal will be addressed in line with the GMC's flowchart available at http://www.gmc-uk.org/doctors/revalidation/designated_body_tool_landing_page.asp .
- 2.3** Any organisation in which a doctor is working, but which is not responsible for the doctor's appraisal, may still wish to have an interest in the outcome of the appraisal to ensure that its duties as a Health Board are discharged.

3. **Objectives of appraisal**

- 3.1** Appraisal is a professional, formative and developmental process. It is about identifying development needs, not performance management. It is a positive process to give doctors feedback on their past performance, to chart continuing progress and identify development needs¹.
- 3.2** During their annual appraisals, doctors will use supporting information to demonstrate that they are continuing to meet the principles and values set out in *Good Medical Practice*².
- 3.3** The objectives of medical appraisal in Wales are to:

¹ DH 2002

² GMC *Supporting information for appraisal and revalidation 2011*

Document Title: <i>Medical Appraisal Policy</i>	5 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

3.3.1 Provide individuals with an opportunity to:

- Reflect on their practice and their approach to medicine
- Reflect on the supporting information they have gathered and what that information demonstrates about their practice
- Identify areas of practice where they could make improvements or undertake further development
- Document personal, team or service level issues which have constrained their service delivery or development
- Demonstrate that they are up to date³.

3.3.2 Provide assurances to their organisation/s and to the public that doctors are remaining up to date across their whole practice.

3.3.3 Provide a route to revalidation which builds on and strengthens existing systems with minimum bureaucracy.

3.4 Appraisal is NOT:

- The mechanism by which serious concerns regarding health, capability, behaviour or attitude are identified or addressed. Such concerns should be managed in an appropriate and timely manner outside appraisal.
- A mechanism by which employers review or judge performance against a contract of employment, job plan or service objectives⁴.

4. Key Principles

4.1 Appraisal is an annual requirement (in most cases contractual) for all doctors. It should be a positive process which adds value for the doctor and the organisation without being unnecessarily burdensome.

4.2 Annual appraisal for every doctor will be based on a system which reflects the GMC's *Good Medical Practice* framework for appraisal and assessment⁵ and incorporates the GMC's core set of supporting information for appraisal and revalidation. This core set of supporting

³ GMC *Framework for Appraisal and Assessment 2011*

⁴ RST *Medical Appraisal Guide for Piloting 2011 v2*

⁵ http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp

Document Title: <i>Medical Appraisal Policy</i>	6 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

information required for appraisal for the purposes of revalidation is defined by the GMC in their 2011 document *Supporting Information for Appraisal and Revalidation*⁶. Any additional guidance provided, for example by the Royal Colleges, is advisory only for the purpose of revalidation, although in the wider context of professional appraisal doctors may choose to include additional information relevant to their role/s.

- 4.3** Every appraisal will result in an agreed summary and Personal Development Plan which will be accessible to the UHB to inform their revalidation recommendation. There is a shared responsibility between the doctor and the UHB to support and progress the outcomes of the appraisal, including the Personal Development Plan.
- 4.4** Appraisal is a professional process. All appraisers must have received appropriate appraisal training and must keep these skills up to date through regular refresher training.
- 4.5** Appraisal and job planning are separate processes, although each process should inform the other and some information will need to flow between them. Generally the doctor is responsible for this information flow.
- 4.6** To ensure the requirements of revalidation are met, the annual appraisal will consider the whole of the doctor's practice.
- 4.7** The doctor and the Responsible Officer (RO) must be satisfied with the match between doctor and appraiser. Ideally, doctors will be able to choose their appraiser from a list of trained appraisers.
- 4.8** To ensure all doctors have an opportunity to experience different appraisals and to provide robust evidence for revalidation, wherever possible any doctor will only be appraised by the same appraiser twice within any rolling five year period.
- 4.9** Appraisal will be subject to whole system quality management which will include minimum levels of quality assurance.

⁶ http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp

Document Title: <i>Medical Appraisal Policy</i>	7 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

4.10 Each Designated Body will have to follow this policy and demonstrate how it will be delivered to appropriate standards.

5. Appraisal in the context of revalidation

5.1 The Revalidation Support Team (England) described appraisal in the context of revalidation⁷:

Revalidation is the process by which a doctor will have the opportunity to demonstrate that he or she remains up to date and fit to practise. Revalidation will be based on local clinical governance and appraisal processes. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice (GMP) and support the doctor's professional development.

As part of annual appraisal, the portfolio of supporting information based on the GMP framework for appraisal and revalidation will be reviewed and discussed, and an evaluation made of the doctor's professional practice according to Good Medical Practice. This process is to be supervised by a responsible officer. Every five years the responsible officer will make a recommendation to the GMC that the doctor is suitable for revalidation by the GMC.

Where indicated, the responsible officer will inform the GMC of any concerns about a doctor's fitness to practise, or a doctor's refusal to engage in the processes that inform the revalidation process.

These issues should be addressed as they arise and not solely when revalidation is due

5.2 The GMC has produced a number of documents which describe revalidation and the requirements of appraisal in this context:

- *Good Medical Practice* – defines the principles and values on which doctors should base their practice
- *Statement of Intent* – sets out the basis for revalidation
- *Framework for Appraisal and Revalidation* – translates *Good Medical Practice* into a format suitable for demonstration at appraisal
- *Supporting Information for Appraisal and Revalidation* – describes the information required of doctors for the purposes of appraisal and revalidation

⁷ *Medical Appraisal Guide v2, RST 2011*

Document Title: <i>Medical Appraisal Policy</i>	8 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

All of these documents are available via the GMC's website, www.gmc-uk.org

6. **Accountability, roles and responsibilities**

6.1 For all doctors, annual appraisal is a professional responsibility. It is a requirement of revalidation. For most doctors it is a contractual requirement, or a requirement of continued employment or inclusion on the Medical Performers List (MPL).

6.1.1 The requirement to undertake annual appraisal applies equally to locum doctors. Locum General Practitioners are required to participate in appraisal as a requirement of their continued inclusion on the MPL. Locum doctors employed in secondary care will be given an opportunity to undertake appraisal within the UHB with which they have a prescribed connection. Locum doctors with a prescribed connection with an agency will be provided an opportunity to undertake appraisal by the agency.

6.1.2 Supplementary guidance has been developed by the Independent Healthcare Advisory Service for doctors working full time or substantially in the independent sector (<http://www.independenthealthcare.org.uk/>).

6.1.3 The Responsible Officer for all doctors in training in Wales is the Postgraduate Dean. Appraisal for doctors in training is provided through their training programme. Revalidation recommendations are based on engagement with the Annual Review of Competency Progression (ARCP) process. It is essential that there are clear communication links between the UHB and the Wales Postgraduate Deanery regarding clinical governance issues so that the revalidation recommendation can be made. Guidance on revalidation for trainees will be available separately from the Deanery.

6.2 The GMC expects doctors to provide evidence of whole practice appraisal, ie to bring to annual appraisal supporting information relating

14.2

Document Title: <i>Medical Appraisal Policy</i>	9 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

to all roles for which their professional qualification is required⁸. Employers and contracting bodies have a responsibility to make such data and evidence available to the doctor where possible. The Responsible Officer will make a recommendation to the GMC about a doctor's fitness to practise across the whole of their professional practice, normally every five years. In order to do this the Responsible Officer will need to be satisfied that appraisal has covered all of the doctor's professional roles. The appraisal system needs to be able to demonstrate that a doctor is qualified to undertake the additional roles, carries out appropriate development within these roles and is practising safely. This will usually be captured by bringing evidence relevant to all roles to a single annual appraisal, or by a doctor bringing evidence of appraisal or performance review from the additional roles to their main appraisal.

An All Wales policy relating to whole practice appraisal has been agreed and is available at <http://revalidation.walesdeanery.org/>

6.2.1 Where a separate appraisal or performance review is included in the main medical appraisal, the main Appraiser cannot be held liable for errors within that documentation. Performance concerns that may be raised within that documentation MUST be dealt with by the organisation providing that appraisal/performance review. The Appraiser has the responsibility to report that the appraisal/performance review has occurred but should not (normally) be expected to read or comment on areas of practice outside their remit as an Appraiser in the role that they are undertaking, if these have been covered by others.

6.2.2 For University Employed doctors, the Follet review concluded that 'universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants to meet the needs of both partners'⁹ The Responsible Officer (RO) for these

⁸ Supporting Information for Appraisal and Revalidation, GMC 2012, <http://www.gmc-uk.org/doctors/revalidation/9622.asp>

⁹ Follet and Ellis, *A review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties*, Department for Education and Skills, London 2001

Document Title: <i>Medical Appraisal Policy</i>	10 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

doctors should be identified using the GMC¹⁰ and DH (England) guidance, although it is anticipated that in most cases this will be the NHS RO. There is a model form for and guidance on the appraisal process for medical academics produced jointly by the BMA and the Universities and Colleges Employers Association (UCEA) and published by UCEA¹¹.

The UHB will take steps to facilitate this process in partnership with the relevant University. However it remains the doctor's responsibility to ensure they are matched with suitable appraisers; that they provide evidence relevant to both role; that they agree a suitable meeting date and agree a single appraisal summary via MARS. The employers and contractors remain responsible for making relevant data and information available to the doctor where possible. It should be noted that, in accordance with the objectives described at section 3 above, the medical appraisal remains a formative process which does not constitute performance management, and is separate from job planning.

6.2.3 Doctors employed full time or substantially in management will still be required to undertake appraisal for the purposes of revalidation. Advisory standards for supporting information for medical managers are currently being developed by the Faculty for Medical Leadership and Management (www.fmlm.ac.uk). Performance reviews already in place in relation to this role will feed into the appraisal for the purposes of revalidation.

6.3 In line with the Medical Profession (Responsible Officer) Regulations 2010¹², ROs have a duty to ensure that appropriate, quality assured systems of appraisal are in place within their organisations and equally available to all doctors working for those organizations¹³. In relation to revalidation ROs also have a role in ensuring systems are available to enable doctors to collect the supporting information required for revalidation.

¹⁰FAQs: http://www.gmc-uk.org/doctors/revalidation/faq_revalidation_p5.asp#x4

¹¹ <http://www.bma.org.uk/support-at-work/appraisals/model-appraisal-form>

¹² <http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

¹³ This includes all doctors regardless of location or branch of practice

Document Title: <i>Medical Appraisal Policy</i>	11 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

- 6.4** To avoid conflicts of interest, ROs will not usually undertake appraisals of doctors about whom they will be required to make a revalidation recommendation.
- 6.5** Appraisers are responsible for maintaining their own skills in this role (eg through taking up approved training), preparing for and facilitating appraisal discussions and producing the appraisal summary and PDP in line with agreed quality criteria.
- 6.6** Appropriate leadership, support and ongoing development will be provided for appraisers, usually by the organisation which employs them in this role.

7. Managing exceptions

- 7.1** There will be agreed processes in place for supporting and managing doctors and Designated Bodies who fail to complete the appraisal within the required timeframes. The principles underpinning these processes for all doctors are set out in the All Wales Exceptions Management Protocol which can be accessed at <https://gp.marswales.org/default/library>
- 7.2** All Wales appeal processes similar to the agreed job planning appeal model, will be developed to manage conflict of interest situations / disputes which have exhausted local processes, for example conflicts between appraiser and appraisee or failure to agree the appraisal summary.

8. Integration between appraisal and other quality and safety systems

- 8.1** Clinical governance information plays a key role in the supporting information for appraisal and revalidation. Doctors are required to include quality improvement activity including audit, significant event analysis, a review of complaints, and clinical performance data where this is available. It is the doctor's role to ensure this information is included in their supporting information, but the UHB also has a role to play in ensuring this information is as accessible as possible.
- 8.2** Appraisal, performance management and rehabilitation / remediation are separate systems which fulfil separate purposes, while all contributing to overall clinical governance and the wider quality and safety agenda.

14.2

Document Title: <i>Medical Appraisal Policy</i>	12 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

However, for doctors to be properly supported and for revalidation as a whole to operate effectively and fairly it is essential that there are clear, consistent and transparent links and information flows between these systems.

- 8.3** Doctors should have an opportunity to discuss at their appraisal any factors constraining their ability to deliver their roles or progress their PDP. It is best practice for the UHB to collate these constraints and issues of workplace governance reported in appraisal summaries, and feed these into their workplace governance processes.
- 8.4** Appraisal and Continuing Professional Development (CPD) are closely linked. Doctors are required to bring evidence of CPD relating to their practice to their appraisal, and one of the key outputs of appraisal is the Personal Development Plan. It is best practice for the UHB to collate the agreed development needs reported in appraisal summaries, and to describe in their local training strategies the links between these identified development needs, organisational development activity and study leave.
- 8.5** Peer and patient feedback systems will comply with the GMC's *Guidance on Colleague and Patient Questionnaires*¹⁴.

9. Confidentiality

- 9.1** The appraisal discussion, as a professional discussion between colleagues regarding the appraisee's development, remains in principle confidential.
- 9.2** A sample of appraisal inputs (appraisal documentation and supporting information) will be reviewed anonymously each year for quality assurance purposes.
- 9.3** All appraisal outputs (appraisal summary and PDP) will be subject to appropriate quality assurance, and will be utilised by the Responsible Officer and his / her delegated officers to inform the revalidation recommendation. It may also be necessary to review other elements of the appraisal documentation to inform this recommendation.

¹⁴ http://www.gmc-uk.org/Colleague_and_patient_questionnaires.pdf_44702599.pdf

Document Title: <i>Medical Appraisal Policy</i>	13 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

9.4 It remains the case that should information come to light in the appraisal discussion which raises concerns about fitness to practise or patient safety, the appraiser has a professional responsibility to “discontinue the appraisal discussion” escalate the issue in accordance with specified procedures.

9.5 In Wales all doctors with a prescribed connection to an NHS Responsible Officer, other than those in training or employed by locum agencies, are required to use the online Medical Appraisal Revalidation System (MARS) which is governed by specific terms and conditions of use, including confidentiality, to which all users agree at registration

10. Data Protection Act 1998

The UHB’s Data Protection Policy will cover appraisal and revalidation.

11. Freedom of Information Act 2000

All UHB records and documents, apart from certain limited exemptions, can be subject to disclosure under the Freedom of Information Act 2000. Records and documents exempt from disclosure would, under most circumstances, include those relating to identifiable individuals arising in a personnel or staff development context. Details of the application of the Freedom of Information Act within the UHB may be found on the UHB website.

12. Equality and Diversity

12.1 The UHB’s Equality and Diversity Policy will apply to appraisal and revalidation.

12.2 This policy has been impact assessed to ensure that it promotes equality and human rights. The assessment was undertaken using the toolkit of the NHS Centre for Equality and Human Rights and completed on The equality impact assessment outcome report is available to download at:
<https://revalidation.walesdeanery.org/images/2012%20App%20Policy%20EIA%20full.pdf>

13. Review

This policy will be reviewed every two years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

14.2

Document Title: <i>Medical Appraisal Policy</i>	14 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

14. **Monitoring**

It is the responsibility of the UHB to monitor local compliance with this policy, and to report on this to the Welsh Government and the Wales Revalidation Delivery Board as required.

15. **UHB Approval**

Responsibility for formally adopting this policy sits with the UHB Resources and Delivery Committee.

Signatures / Dates

14.2

Document Title: <i>Medical Appraisal Policy</i>	15 of 15	Approval Date: 16.Mar.2016
Reference Number: 129		Next Review Date: 16.Mar.2018
Version Number: 2		Date of Publication: dd mmm yyyy
Approved By: RAIG/WRDB		Adopted within the UHB: Resources and Delivery Committee dd mmm yyyy

CORPORATE RISK AND ASSURANCE FRAMEWORK – UPDATE REPORT
Name of Meeting: Resource and Delivery Committee
Date of Meeting: 7 November 2017
Executive Lead: Director of Corporate Governance
Author: Head of Corporate Governance sian.rowlands@wales.nhs.uk
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact: Where a risk is financial this should be clear from the Corporate Risk and Assurance Framework (CRAF) and known by the Executive Lead and/or Risk Owner.
Quality, Safety, Patient Experience impact: The CRAF includes a number of risks that impact on quality, safety or patient experience.
Health and Care Standard Number: 2.1
CRAF Reference Number: Not applicable
Equality and Health Impact Assessment Completed: Not Applicable

<p>ASSURANCE AND RECOMMENDATION</p> <p>ASSURANCE is provided by:</p> <ul style="list-style-type: none"> Mitigation of our risks being monitored by Board and the appropriate Committees of the Board albeit the information provided via the CRAF requires strengthening. <p>The Committee is asked to:</p> <ul style="list-style-type: none"> CONSIDER the CRAF Update Report; AGREE the assignment of risks to the Committee; CONSIDER whether further assurance is required for its risks.
--

SITUATION

Each risk contained within the CRAF is assigned to Board or a Lead Committee for oversight. 41 risks within the CRAF were assigned to the People, Planning and Performance Committee (PPP), oversight for 8 of these were shared with other Committees of the Board.

Following the split of the PPP Committee into two new separate Committees, the risks assigned to it now need to be properly assigned to the new Committees for Resource and Delivery and for Strategy and Engagement for oversight going forward.

BACKGROUND

The May Board, following the Board Development Day on Risk Management, agreed a review and renewal of the Risk Management Process. This work is progressing and includes engagement with Clinical Boards and Corporate areas to support analysis / amendment of registers to strengthen the system and provide more assurance.

The Board has agreed the production of more visual, less text based standardized reports and this report is prepared with that aim in mind albeit the detail is extracted from the CRAF in its current format (updated 11 September 2017).

As work progresses, the Board, its Committees and our stakeholders should more easily be able to gain assurance from the CRAF.

ASSESSMENT AND ASSURANCE

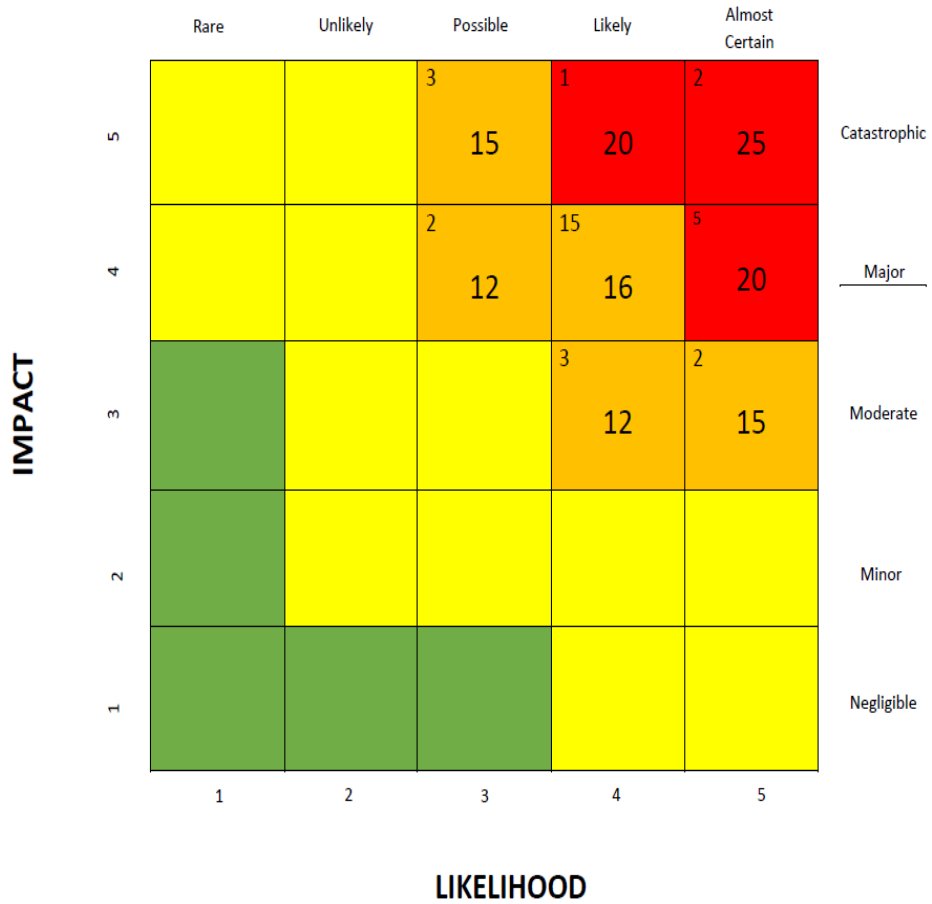
The latest version of the full CRAF can be found at:

<http://www.cardiffandvaleuhb.wales.nhs.uk/opensdoc/248865>

This shows the detail of all 41 risks assigned to the previous PPP Committee. On reviewing the current Terms of Reference for the replacement Committees; the risks captured in the table at Appendix 1 have been identified as appropriate for assignment to this Committee. 12 of these risks also have oversight by another Committee and it is considered that 5 span both the Resource and Delivery and Strategy and Engagement Committees (risk numbers 3, 6, 18, 32 and 33).

It is proposed that risks 1.3, 2.1, 2.3, 3.1, 7.2, 7.3, 8.1.6, 10.1 (which can be viewed on the CRAF) sit solely with the Strategy and Engagement Committee.

The below Heat Map provides the profile of all the risks proposed for this Committee.



Appendix 1							
Proposed Risks to be assigned to the Resource and Delivery Committee							
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 1 - 2014-15 Health Improvement - Population health is improved with action targeted at the main areas of population health need							
1.	1.2	Meet Public Health Targets	<p>LPHT Priority Areas 2015/16 - actions to be taken forward in Clinical Board plans.</p> <p>Clinical Boards set targets for smoking cessation uptake.</p> <p>Working with GPs to increase referrals for smoking cessation.</p> <p>Work is underway nationally to agree data collection of smoking cessation from GPs</p> <p>A Level 3 Enhanced Service for Community Pharmacies has been funded for one year targeting pharmacies in Communities First Areas - 15 are participating.</p> <p>A mobile unit targeted at high deprivation areas (where smoking prevalence is the highest) has been provided by Stop Smoking Wales)</p> <p>A 'Tobacco 20' Challenge is to be launched in March 2016 to coincide with No Smoking Day to encourage staff to promote the Smoke Free UHB Policy. Work as part of this challenge will plan targeted activities for 4 years to Welsh Government's 2020 smoking prevalence target of 16%</p>	16		↔	R&D

			<p>Detailed immunisation action plan being implemented, including restructure of Child Health (complete), postcard reminder pilot, release of practice level data. Operational group led by Children & Women's Clinical Board meeting regularly to plan changes to Fluenz programme</p> <p>Community development work in South Cardiff progressing (commenced Feb 15) to improve uptake in BME communities.</p> <p>PCIC and Public Health to carry out targeted work with GP practices using practice-level immunisation data.</p> <p>Regular reports to Chief Operating Officer and Clinical Boards</p> <p>Flu discussed monthly at Big Room as figures published</p> <p>Staff Influenza Vaccination Policy approved September 2015</p> <p>MH - Pilot to reduce service user smoking to commence July 2017 and stakeholder working group established.</p>				
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 2 - 2014/15 - Commissioning - Services are commissioned to ensure access to services is equitable and based on needs							
2.	2.5	Have robust governance / SLA arrangements in	SLAs to be in place and monitored with all externally commissioned services. SLAs and Service Specifications in place for all	12		↔	R&D

		place (including quality standards) with all external service providers	Third Sector Organisation with UHB service leads monitoring delivery. Governance arrangements for Nursing Homes/Independent Care Sector being developed. PCIC - Nurse Assessment (NA) Teams in place working with Local Authorities to monitor & review individual placements within current resources. Monitoring & Review Protocol developed.				
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 3 - 2014/15 - Service Integration - All services will have a clear specification setting out how joined up care will be provided							
3.	3.1.2	Provide effective and appropriate resourced primary and community care services to meet increasing demands	Continued work using care bundle approach to reduce admissions. Pathways for Atrial Fibrillation, Chronic Obstructive Disorder and Chronic Heart Failure Dementia Plan agreed July 2014 BMA GP Committee has launched guidance - Quality First: Managing Workload to Deliver Safe Patient Care Regular performance monitoring and early intervention where required. Early interaction with practices who apply for "List Closure" with support from Primary Care Team to try to maintain an "Open List" Issues and concerns raised regarding impact of Local Delivery Plans (see 5.1 above)	16		↔	R&D S&E

			<p>Strategic Planning</p> <ul style="list-style-type: none"> - Outline Service Plan developed in response to proposed large housing developments in the North West of Cardiff, which forms the basis for UHB response to relevant planning applications. <p>Potential for a shared community facility with Local Authority. Wider exercise to be undertaken to map our future community facilities as part of SOFW: In Our Community Programme. Potential offered by the proposed healthcare facility within the Plas Dwr development is being factored into the exercise.</p> <p>IMTP and Primary Care Plan</p> <p>Clinical Board IMTPs</p> <p>IHSC programme prioritising exercise for pooled budgets (prioritisation in process with anticipated start date of Jan 2016).</p> <p>PCIC</p> <p>CHAP - Improvement plan complete and tender process concluded.</p> <p>Primary mental health provision in HMP Cardiff - robust processes for initial and secondary health screening.</p> <p>Medicine</p> <ul style="list-style-type: none"> - CB involved in BIG1 priority - Patient Flow Rota implemented. - Patient flow review as part of Leaner and Fitter and supported by GE in progress (6 month programme) - Daily deep dives undertaken for all inpts to identify discharges. 				
--	--	--	--	--	--	--	--

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
4.	3.2	Failure to implement/deliver recommendations of the McClelland Review resulting in adverse impact on patient and non patient transport experience and UHB reputation with Welsh Government (risk redefined to ensure reflects actual risk to UHB - Jan 2015)	All Wales Non Emergency Patient Transport (NEPT) implementation team has been charged with taking forward the implementation at a national level reporting to All Wales CE Officers Group. Transition arrangements agreed - Health Courier Service transferring to NHS Wales Shared Services April 2015 on a cost neutral and no service impact basis. An All Wales PCS modernisation group has been established to explore future options for the management of PCS and ensure Health Board requirements are taken into account.	16		↔	R&D
Objective 4 - 2014/15 - Co-production and partnerships - Services are co-produced with staff, the public and partners to shape the best possible experience of care							
5.	4.1	Failure to communicate and engage meaningfully with staff	LPF and LNC partnership working policies and protocols Operational Health and Safety Group and Health and Safety Committee Organisational Change Policy Audience with Adam Clinical Board Communication Plans Weekly eBulletin Health and Wellbeing Advisory Group focusing on	15		↔	R&D

			<p>staff engagement Staff Representatives members and/or attendees at a range of Clinical Board and Directorate meetings Dental Clinical Board Employee of the Month award Staff Recognition Awards Big Room open to all those who wish to attend Staff representatives aligned to Clinical Boards.</p>				
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
<p>Objective 5 - 2014-15 - Operational and Clinical Excellence - High quality services will be delivered sustainably through a committed and engaged workforce which meets targets within available resources</p>							
6.	5.1.2	<p>Deliver a responsive and efficient unscheduled care system</p>	<p>Unscheduled Care plan in place across Medicine, Surgery and PCIC Clinical Boards - but not yet fully implemented Choose Well Campaign to try to ensure the public access the most appropriate part of the system. Continue to work with social care partner to provide/commission adequate rehabilitation and reablement capacity in the Community to ensure DTOC is improve (Home First Principle) Medicine Urgent and acute medicine service models / capacity plans Escalation measures in place. Plans in the Emergency Unit to improve flow and communicate with the Welsh Ambulance Trust</p>	20		↔	R&D S&E

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			(WAST) Weekly performance meetings between the COO and WAST Further EU Controllers in place for Winter period 2015/16 AEC unit opened within the acute medicine directorate assessment unit to improve patient flow Winter pressure beds opened in UHW & UHL C&W Acute Child Health: Directorate management team currently working with A&E re: assessment & treatment of children overnight due to the overnight closure of CAU.				
7.	5.1.4	Provide expedient access to emergency theatres	Provision of some dedicated theatre space Open additional CEPOD theatre after 5pm Theatres = Work stream under Leaner and Fitter Programme External support procured to ensure programme succeeds. C&W - Emergency Paediatric Surgery continues to be undertaken in Main Theatres UHW due to delayed transfer of CEPOD to CHFV: ongoing discussions and confirmation of transfer date awaited Specialist Services - Insufficient access to CEPOD and the related	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			increase in cold ischaemic time for solid organ transplantation, no dedicated CEPOD for transplants: risk of loss of organs. Transplant team always available but solution is based on recruitment in theatres. Discuss with Surgery CB whether NORS team can run a CEPOD theatre for transplant in the evenings.				
8.	5.1.10	Ability to deliver appropriate Neurosurgery / neuroradiology / Neurovascular services	Regular dialogue between the Clinical Boards Specialist Services - Neurovascular CNS appointed. Consultant led ward rounds every morning. Two new Consultant Neuroradiologists now in post - WHSSC fully informed.	15		↔	R&D
9.	5.1.11	Insufficient critical care capacity and workforce to meet need	Surge capacity identified to 100% via CITU and recovery. Ideally this should only be utilised at times of MI or pandemic due to requirement to keep RTT in line. PACU now opened. Adverts for medical staff are out, Consultants requested to work locum shifts to cover the gaps, reliant on support from H@N team to maintain cover OOH. CCANP aligned to PACU. Escalation plan in place which forms part of UHB escalation. Planning for Critical Care Expansion. Seasonal influenza - Plans in place for management of patients, escalation of services, surge capacity. Staff have been trained in use of	20		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			PPE. Plan for vaccination of staff implemented and achieved over 50% for last 3 winters. All long term patients vaccinated.				
10.	5.1.13	Patients being treated in inappropriate settings, outlying or requiring specialling due to lack of appropriate service provision	<p>Unscheduled Care Plan and patient flow work. Detailed protocols agreed between Clinical Boards including escalation arrangements out of hours. Patient flow review as part of Leaner and Fitter and supported by GE in progress (6 month programme) Winter Plan for 15/16 Benchmarking occurring re specialling of patients with Salford NHS Trust.</p> <p>Medicine</p> <ul style="list-style-type: none"> - Patient Flow Rota implemented. Redesigned Unified Assessment to incorporate a domain for Cognitive Impairment. Improve communication and information between care homes and secondary care regarding individual patients. <p>C&W</p> <ul style="list-style-type: none"> - system of escalation implemented to inform Directorate and Clinical board, UHB and WG via patient access. - Reduced paediatric critical care beds results in admission refusals: escalated to WHSSC <p>Specialist Services</p> <ul style="list-style-type: none"> - number of outliers monitored daily & reported to CB. 	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
11.	5.1.14	Inability to sustain thoracic surgery service	Full time thoracic surgeon has been appointed and 3rd post agreed with WHSSC. Sustainable workforce plan agreed. Potential impact on cancer waiting times. Assessment of size of service to meet elective and emergency demand has been completed. Work ongoing on a regional basis to provide sustainable service.	15		↔	R&D
12.	5.3	Achieve Referral to Treatment (Waiting) Times (RTT) and other Tier 1 targets	Clinical Board and Corporate Department Integrated Medium Term Plans. Waiting List validation and management Theatres Modernisation Programme under Leaner and Fitter Prudent Healthcare - outsourcing alternative treatments in the community Identified as 1 of 5 priority areas for 15/16 as agreed by Board. Discussions in the "Big Room" Funding for a number of actions to manage RTT. Medicine - 4th Endoscopy Suite established. Weekend initiative lists and outsourcing being completed. Clinical validation of referrals undertaken. Designated Band 5 coordinator managing surveillance list. Risk stratification for patients in place C&W - gynae & surgery - Ongoing negotiations with Surgery Clinical Board as to availability of	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			<p>surgeons. Specialist services - Weekly meetings held with every Directorate to ensure proactive management of WL. Weekly meetings between SpS and Surgery to jointly develop sustainable plans. Weekly operational meetings commenced between cardiac and theatres to review and plan lists. WG have agreed RRP for theatre cardiac staff. Reduction in 36 week breaches. Number of cases undertaken and number of cases on waiting list increasing. Therefore, increasing risk to patients waiting longer for surgery. PCIC Continence Service - Job requests processed for vacancies and clinics diverted.</p>				
13.	5.3.2	Insufficient Provision of Out of Hours Services to meet demand	<p>PCIC</p> <ul style="list-style-type: none"> - Undertaking demand and modelling exercise relating to GP Out of Hours provision - New Clinical Director for Out of Hours Service commenced July 2015. Action Plan developed re GP Out of Hours provision - Pilot between Oct 15-Jan 16 an initiative to incentivise GP shift cover for hard to fill shifts using a Bundle approach - In hours GPs covering HMP Cardiff CD&T - Structured workforce planning has commenced. 	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			<ul style="list-style-type: none"> - Locum staff recruited to cover blood bank and Haematology. - Capacity plans being developed - Staff compliance to professional codes and statutory framework requirements - Continuous Service Improvement projects - Increased service improvement capacity and capability - Speciality on-call in Radiology implemented July 2016. <p>Improvements in staffing and 7 day working in some clinical areas e.g. Medical Decision Unit (although this has not reduced demand), Assessment Unit, Gastroenterology.</p>				
14.	5.3.3	Risk that patients who have had a stroke are experiencing sub-optimal outcomes as a consequence of the failure to meet the standards of care set out by the Royal College of	<p>Workplan has been devised which will facilitate the implementation of the UHB Action Plan.</p> <p>Key changes to process have been introduced and some aspects of the business case have been funded including additional nursing, medical and speech and language therapy staff.</p> <p>The UHB continues to work with the Delivery Unit particularly in relation to the <4 hour bundle.</p> <p>High Care area on Ward A6S has been commissioned.</p>	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
		Physicians and represented in SSNAP guidelines	Appointment of SSNAP Co-ordinator role. Appointment of Discharge Support Officer which has improved discharge from SRC. Stroke Operational Group reviews performance on a weekly basis Assistant Director of Therapies and Health Science seconded in as Senior Lead to provide an interface across the CBs and support the Clinical Gerontology Directorate in making sustainable and embedded change.				
15.	5.3.4	Bone Marrow Transplantation - unacceptable waiting times leading to the potential relapse or death	Specialist Services - Policies, protocols, guidelines, procedures. MDT discussion prior to being placed on waiting list. Internal meetings and discussions to monitor waiting list. Issue escalated to Clinical Board and Quality and Safety meetings. CNS input. Regular contact with finance dept and WHSSC re funding for services- business case has been submitted Regular forecasts submitted. Regular meetings set up with WHSSC and some extra posts agreed to support day Unit, extra bed on TCT and ward - Phase 2. Jacie report received. Apherisis Nurse Specialist post in place. Utilising Tenovus mobile unit twice a week to reduce pressure on Day Unit and allow them to treat bounce backs avoiding ward admissions. 3rd BMT consultant appointed Oct 16 .CB has received	25		↔	R&D

			notification and formal letter from WHSSC agreeing £1.8m for Phase 3 Strategic Planning -Capital Planning seeking alternative locations for Haematology facility, pending agreement of strategic site plan for UHW and long term solution. Funding agreed for Programme Manager to develop Programme Business Case for scope and design of service and analysis of demand/capacity. C&W Failure of the adult Haematology Bone Marrow Transplant Programme to renew its JACIE accreditation of the clinical transplant programme or fails to meet the HTA regulatory requirements for the stem cell collection facility will lead to the cessation of any autologous stem cell transplant activity for solid tumours at the Paediatric Oncology/Haematology Department. Numerous control measures in place but additional control measures are required - all detailed in C&W Jan 2017 risk register.				
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
16.	5.4	Failure to sufficiently prepare for a major incident including event resulting in mass casualties, communicable	Appropriate Policies and Plans in place: Major Incident Plan (Annual review underway 2017), Civil Contingency Strategic Framework (reviewed Oct 2015), Business Continuity Policy (Oct 2014); Business Continuity Plan template has been developed and successfully piloted. Revisions	12		↔	R&D

		disease outbreak (inc. pandemic flu/Viral Haemorrhagic Fever[Ebola]) or environmental public health emergency whilst ensuring business continuity	underway prior to refocused effort to support BCP across clinical boards Infectious Diseases: SWLRF Strategic Framework (Strategic Gold), Cardiff & Vale Area Tactical Framework (Tactical Silver) and C&V UHB Operational Framework (operational Bronze) in place. Presently being reviewed in light of new national guidance. Internal Audit Review positive for EP but gave only limited assurance for Business Continuity. Training & Exercises - engagement in multiple multi agency training exercises - live and tabletop. Live activation of Major Incident plan during 2015/16. WECTU accredited training in counter terrorism awareness and Stay Safe rolled out across the UHB. All Wales mass casualty management has demonstrated a deficit of surgeons trained in the treatment of ballistic injuries. UHB did not support internal financing of training - issue now referred to WG for further review as to possible funding mechanisms.				
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 6 - 2014/15 - Resources - All the UHB's resources: money, staff, estates and equipment are maximized to deliver the best possible care.							
17.	6.1	Shared Services Partnership	Approval of SSP Operational Plan by lead Execs Membership of SSP Committee	12		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
18.	6.2	Insufficient numbers of well trained, skilled and competent staff in some areas (see also 7.1)	<p>Regular meetings between CEOs All amendments requested to SSP IMTP for 2014/15 were actioned See also 6.2 Recruitment.</p> <p>Staff establishment standards, Integrated Workforce plans. Recruitment, sickness and other workforce policies, procedures & support mechanisms. Pooling, bank and agency arrangements Health and Care Standard 7.1 - Workforce Staff appraisal and personal development plans Nursing acuity tools and patient risk assessment used to inform staffing requirements. Time to Hire Project Group established - responsibilities of managers for aspects of recruitment and manageable KPIs defined for Clinical Boards Project Group has completed work plan Time to Hire league tables on 3 key stages of recruitment process Significant improvements in recruitment arrangements with NWSSP Protective Administration of Medicine Clinical Board Biannual Nursing Conference, Health Professionals Annual Conference</p>	16		↔	R&D S&E

			<p>Attendance at Mandatory/Statutory Training, Bulk recruitment events held for Band 5 Nurses. Overseas recruitment underway PCIC - GMS sustainability framework to be used from 2016/17 to address GMS workforce issues. WG Primary Care Investment will be directed at supporting improving workforce resilience within PCIC. Workforce Planning expertise to be recruited. C&W - Unable to achieve 168hr Consultant presence on delivery suite - proposals through SWA - Restricted nursing establishment in ACH: Bed capacity temporarily reduced, use of bank, SBAR to CB - lack of A&C support for paediatrics therapies: rationalised individual service support where possible - insufficient LAC staff to ensure statutory duties can be met: service restricted, process in place to notify of OOC placements - Funding by Families First for Perinatal Mental Health Services due to cease at end of March 2017: WG funding for 0.3WTE PNMH midwife - insufficient radiology cover for outpt clinics: BC fir additional cover for clinics - insufficient cover for Nurse Pracs: cross cover of clinics, only 1 nurse off at a time - no 24hr cover for delivery suite & MLU: staff redeployed where feasible</p>				
--	--	--	---	--	--	--	--

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			<ul style="list-style-type: none"> - BC submitted for role to support diabetes management in education settings. Funding due to cease March 17 - Shortage of HV's across Wales creating significant vacancies: skill mix being considered, use of bank. - Delay in provision of CCNS due to staff shortages: recruitment & retention plans in place. - Awaiting outcome of business case to support full School based immunisation team. 				
19.	6.2.1	Sickness levels not in line WG Target and locally set target to ensure sufficient staff to meet patients' needs	<p>All Wales Sickness Absence Policy (revised November 2015)</p> <p>Project Group established</p> <p>Occupational Health and Stress and Wellbeing Service to support the return of staff to work and maintain others in the workplace.</p> <p>Development of Health and Wellbeing Internet pages, creation of Advisory Team which is focussing on strategic direction supported by Communication Group</p> <p>Mental Health piloting new approach</p> <p>Hot spot areas identified and targeted</p> <p>Sickness Advisory Team in place</p> <p>Clinical Board WODs developing local plans</p> <p>Undertaking a gap analysis and options appraisal re optimising</p>	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			Flu Vaccination Action Plan Employee Assistance Programme launched Nov 2015.				
20.	6.2.2	Departments unable to release staff for training due to operational pressures leading to a failure to meet Statutory and Mandatory Training requirements	Monitoring of Mandatory training Programmes A range of suitable courses available to meet needs A range of face to face and e-learning courses provided to help ensure training is provided in the most appropriate format Compliance monitored through performance management arrangements Mandatory May and November are the two months where face to face workshops are provided as an alternative to the e-learning packages Introduction of Nursing and Midwifery Validation process will require completion of mandatory training Introduction of Pay Progression Policy will require staff to complete training Introduction of WIRED to provide more timely information re shortfalls in attendance Statutory/mandatory training action plan developed Mandatory Training Steering Group established.	12		↔	R&D
21.	6.3	Effective leadership and management	Executive Leadership programme Clinical Board Leadership Programme Organisational Development Arrangements	12		↔	R&D

No	Risk Ref	Risk Descriptor	Leading Improvement in Patient Safety (LIPS) Programme. Controls	Score	Previous Score (if applicable)	Change	Lead Committee
22.	6.4.1	Meet statutory compliance in respect of estates maintenance	Estates and statutory compliance audit process Prioritisation of maintenance requests Establishment of dedicated compliance team External audit of statutory compliance C,P& E - The emergency lighting requires specification and tendering to take place. Asset collation being progressed. Contract in place to service main plant. Currently progress OJEU tender for all medical gas compliance. New contract to start a phased approach to emergency lighting has commenced.	25		↔	R&D H&S
23.	6.4.2	Failure of lifts - potential to cause injury and disruption to services. Reports of statutory breaches of lift inspection to the Health & Safety Executive	Lift failures reported to Estates maintenance. Contract for lift maintenance has been awarded to an alternative contractor.	20		↔	R&D H&S
24.	6.4.3	Maintain Whitchurch & Rookwood Hospitals to safe	Additional management controls including storage, smoking, fire and training. Regular site surveys	16		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
		and reasonable standards in lead up to closure	Some remedial works in Rookwood but still experiencing frequent loss of heating, lighting and water supplies Specialist services - OBC approved by WG. £2m agreed by WG to support purchase of new boilers and new roof on old house.				
25.	6.4.13	Vehicle congestion and traffic management on the UHW site leading to:- a) patients missing appointments/staff arriving late leading to service disruption b) Emergency service vehicles unable to flow freely on the site c) Potential contact with pedestrians and/or cyclists d) Contact/collision with other vehicles e) Increased	Temporary traffic flow management and traffic lights to assist with vehicle flows at the busiest times Indigo police and manage the traffic on site and security staff are also occasionally utilised to manage traffic flows The UHB has a Sustainable Travel Policy and Procedures to encourage site users to utilise alternative transport arrangements The site has various cross-hatched road markings and yellow lines to keep traffic moving and to resist blocking key areas Independent traffic survey completed.	20		↔	R&D

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
		environmental impact (new risk added March 2016)					
26.	6.6	Plan, fund and deliver safe, appropriate and up to date equipment requirements.	<p>Capital prioritisation process / Discretionary capital programme</p> <p>Additional capital investment secured for high risk areas such as Endoscopy suite.</p> <p>Cardiff and Vale UHB Strategic Planning Programme 2014/15-2018/19 developed and considered by Board in Sept 2014.</p> <p>Director of Therapies and Health Sciences = Exec Lead</p> <p>Governance structure agreed for Medical Equipment</p> <p>Management Group formed to replace existing groups and to holistically manage medical equipment life cycle risks.</p> <p>Capital equipment catalogued and stratified by risk</p> <p>Non capital medical equipment to be catalogued during 2015 / 2016.</p> <p>Decontamination group implemented corrective action plan to findings on National audit in 2014.</p> <p>Bed contract</p> <p>Bariatric equipment contract</p> <p>Health and Care Standard 2.9: medical devices,</p>	16		↔	R&D

			<p>equipment and diagnostic systems Health and Care Standard 2.4: Infection Prevention and Control and Decontamination Surgery - issue of ageing fleet of P5000 IVAC PCA devices (65 out of 82 devices over 15 years old) - equipment library manages devices and collects, cleans and checks for faults and /or damage. Repairs are carried out an as required basis but many are becoming beyond economical repair. Storz C-MAC (video laryngoscope) - one in UHW, one ordered for UHL - 3 further required. Business case submitted - placed on MEG spreadsheet as Surgery priority 1 - on discretionary capital list for Feb 16 Electrical safety testing of new equipment not being conducted by Medical Physics due to lack of staff, many items need annual safety checks. Specialist Services - unable to decontaminate TOE probes to national standards - Tristel 3-stage wipe used between cases. Sterile TOE sheath used for each procedure. ALAS - powered wheelchair fleet aging and 53% of fleet no longer manufactured - parts will not be available from 2019 - planned preventative maintenance programme in place but not adhered to due to staff shortages PCIC - Beds/mattresses - additional stock within the system and internal audit report on Stores giving reasonable assurance. CD&T - UHB wide Ultrasound image storage strategy to include gynaecology clinicians.</p>				
--	--	--	--	--	--	--	--

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			Development and role out of audit programme. Development of robust competence framework. Development of a comprehensive and robust in-house quality and assurance maintenance service. Extended suite of UHB protocols for the use of ultrasound to include respiratory medicine and in particular the placement of chest drains.				
27.	6.8	Plan, fund and maintain effective & resilient IM&T systems to support service delivery	IM&T implementation programme IM&T sub Committee established to oversee progress Health and Care Standard 3.4 - Information Governance and Communications Technology C,D&T - The inability to procure an integrated PACS restricts opportunities to improve efficiency and patient safety - assessment of systems undertaken. C,D&T - Hardware issues with Telepath servers leading to loss of service in Blood Transfusion and Cellular Pathology. Hardware is 9 years old (beyond the recommended life-cycle), primary and back-up server failed in December 2016 and back-up failed in September 2016. Actions - Internally developed risk management strategies. Disaster recovery plan in place Each laboratory has contingency procedures C&W - Images of ultrasound scans printed and	20		↔	R&D IM&T Inf Gov

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
			<p>maintained in hospital records. Full written report of scan documented. No funding available for ultrasound scans to be stored on Radis/Pacs system for EPAU</p> <p>C&W - finding bid for upgrade links between Cardio base and hospital-run IT systems, specifically PMS</p> <p>Specialist Services - inadequate support for genetics data - SHIRE upgrade required: IT exploring packages used by medical genetics centers across the UK. Neurosurgical referrals on a paper based system & added to in-house database.</p>				
28.	6.8.1	Failure of NWIS to deliver strategic IM&T needs of Wales and the UHB	Improved partnership working.	15		↔	R&D IM&T
29.	6.8.2	Management of the Health Record as a result of poor compliance with tracking the records leading to the records not always being available at point of care or for	<p>Health records policies, procedures and protocols</p> <p>Clinical Portal arrangements</p> <p>Health records modernisation programme including digitisation of the paper record has focused primarily on EU and paediatric services to date.</p> <p>Professional Lead for Health Records in post</p> <p>Health and Care Standard 3.5 - Record Keeping</p> <p>Action plan designed to provide additional storage areas to enhance safety and more effective</p>	16		↔	R&D Inf Gov

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
		coding. As a result, on occasion clinicians are not able to deliver the required level of patient care and coding is not completed in accordance with WG performance requirements. (Descriptor updated March 2016 as storage issues largely resolved)	retrieval in place. Ongoing plan of expansion with first stage having started with a positive effect on UHL Central Storage. Devolved issues and management plan for records at Whitchurch Hospital will be completed by Nov 2015. Establishment of Health Records Group under leadership of Clinical Board Director for CD&T reporting to Information Governance Sub Committee Health Records staff trained in tracking Partially restricted access to libraries Medicine - An audit to be undertaken in MCB in January regarding the utilisation of temporary folders. Emergency and Acute Medicine patients notes are available and saved digitally.				
30.	6.9.1	Laboratory Information Management System (LIMS) - Risk of clinical governance and information governance concerns as LIMS goes live into	Internally developed risk management strategies. Collaboration with NWIS to develop solutions to national system issues NWIS Project Management Arrangements. Staff training arrangements Disaster recovery plan in place Each laboratory has contingency procedures to ensure urgent or emergency results are communicated by telephone.	20		↔	R&D Inf Gov

		additional laboratory areas due to the level of robustness of the system. [Risk previously deleted as it was captured in another risk. This has since been removed so a decision has been made to include again as the LIMS risk remains)					
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 8 - 2014-15 - Governance - To have effective governance arrangements ensuring the UHB is compliant with relevant legal and regulatory frameworks and its processes for decision making are robust.							
31.	8.1.5	Failure to comply with Information Governance legislation in respect full compliance with : Information Governance Framework, Controlled Documents Framework,	Information Governance Framework, policies and procedures Developed a "live" Controlled Documents Framework in line with the Caldicott Assessment and IG Toolkit to ensure all key documents in place by December 2015. Information Governance sub-Committee UHB Programme of Modernising Health Records Information Governance team to advise on Information Governance, Data Protection and Freedom of Information compliance.	16		↔	R&D Inf Gov

		operational implementation, training monitoring and risk management	<p>WASPE Information Sharing Agreements in place for a number of areas</p> <p>Review of incidents reported</p> <p>Monitoring information systems</p> <p>IG Training Policy in place and launched programme of foundation training using the NHS e-learning Mandatory IG Module</p> <p>Specialist Services - Cwm Taf Neurology Service. Notes are currently transferred back and forth between Cardiff and Cwm Taf by secure courier, also in Consultants cars as couriers aren't always able to get notes up there reliably in time for clinic.</p> <p>Risk to loss of PII: Meeting with Cwm Taff to agree the model required to provide a more safe and sustainable service.</p>				
No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
Objective 10 - 2014-15 - Benefits Realisation - To realise benefit in everything that is done through a culture that drives delivery and improvement at the required pace.							
32.	10.1.1	Failure to operationalise significant changes to models of care as part of major re-developments	<p>Business cases to be underpinned by agreed service delivery models which flow from the shared Whole Systems Service Model.</p> <p>Re-designed clinical pathways, along with Locality/Cluster Plans, to shape the Programme for SOFW: In Our Community and the BIG programme for: 1. redesigning the inpatient platform for medicine based on stratifying patients and resources based on clinical need and risk. 2.</p>	15		↔	R&D S&E

No	Risk Ref	Risk Descriptor	Controls	Score	Previous Score (if applicable)	Change	Lead Committee
33.	10.1.2	Failure to have sufficient capacity and focus to deliver change and improvement programmes at the required pace	<p>Key element of O4E and Good to Great programme.</p> <p>Additional programme support to drive priority work Service Delivery template being finalised</p> <p>Some capacity gaps filled for Clinical Services Strategy, Leaner and Fitter and SW Programme but significant gaps in other change programmes - issues identified</p> <p>LIPS programme</p> <p>IHI Programmes for Board and Senior Leaders</p> <p>GE Finnermore involvement to support sustainable model of improvement</p> <p>Clinical Boards and Corporate Directorates to recognise and utilise corporate advisors and expertise already within UHB</p> <p>Strategic Planning - Significant challenges to resourcing the complex change programmes developed, namely around HEART, BIG priorities and Leaner and Fitter. Additional temporary resource agreed for transformation (1 programme manager post) but project management still represents a significant capacity challenge.</p> <p>UHB response to escalation level rising to 'targeted intervention' includes a request to Welsh</p>	16		↔	R&D S&E

			Government for additional change, organisational development and project management support. Funding agreed to support BIG Programme but some difficulty in freeing up individuals to take on BIG 2. Alternative staffing options are being explored. CAV Academy proposal is being developed to provide a more cohesive approach to change management within the UHB.				
		Total		33		0	

HIGH LEVEL PERFORMANCE DASHBOARD	
Name of Meeting : R&D Committee	Date of Meeting 7 th November 2017
Executive Lead : Chief Operating Officer	
Author : Assistant Chief Operating Officer – 02920 744120	
Caring for People, Keeping People Well: This report is a summary of performance against key Tier 1 performance measures, which underpin the Sustainability and Service Priorities elements of the Health Board's strategy.	
Financial impact : Not applicable	
Quality, Safety, Patient Experience impact : Timely and effective access to unplanned and planned services is integral to the delivery of safe clinical care and good patient experience	
Health and Care Standard Number 1 and 5.1	
CRAF Reference Number 5.3	
Equality and Health Impact Assessment Completed: Not Applicable	

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The development of an IMTP delivery dashboard outlining performance against a range of key Tier 1 targets and other priority measures.

The Resource and Delivery Committee is asked to:

- **NOTE** Year to date performance for 2017-18 against key Tier 1 targets and other priority measures

SITUATION

Timely and effective access to unplanned and planned care is integral to the delivery of the Health Board's strategy "Caring for people, keeping people well". The purpose of this paper is to provide a summary of year to date performance against key Tier 1 targets and other priority measures.

BACKGROUND

A full Performance Report is presented to the Board on the Health Board's performance against the Welsh Government's Outcome Framework and other priority measures, including actions being taken to improve performance. This report for the Resource and Delivery Committee provides a high level summary of year to date performance against key Tier 1 targets and other priority measures.

ASSESSMENT AND ASSURANCE

The tables in Appendix 1a and 1b provide a high level summary of the Health Board's year-to-date performance for 2017-18 against key Tier 1 measures and other priority targets. Actual performance is shown against both Welsh Government targets and the delivery profiles set out in the Health Board's Integrated Medium Term Plan for 2017-18.

A verbal assessment will be provided to the Committee on year to date performance against Welsh Government targets and the delivery profiles set out in the Health Board's Integrated Medium Term Plan.

Appendix 1a

16

Performance against key Tier 1 measures and other priority targets

		March	April	May	June	July	Aug	Sept
Unscheduled Care								
	IMTP 17/18 profile	-	87.0%			87.0%		
	17/18 Actual - Monthly	86%	87.9%	84.3%	85.0%	86.0%	86.9%	86.6%
EU waits - 4 hours (95% target)	17/18 Actual - Qtly	83%	85.7%			86.5%		
	IMTP 17/18 profile	-	100			100		
	17/18 Actual - Monthly	62	13	60	47	10	8	23
EU waits - > 12 hours (0 target)	17/18 Actual - Qtly	276	120			41		
	IMTP 17/18 profile	-	370			370		
	17/18 Actual	295	163	281	207	77	91	168
Ambulance handover > 1 hour (number)								
	IMTP 17/18 profile	-	70.0%			70.0%		
	17/18 Actual	88.1%	86.5%	82.9%	86.6%	86.6%	84.3%	84.5%
Ambulance - 8 mins red call (65% target)								
Delayed Transfers of Care	17/18 Actual	58	77	76	60	51	54	51
Stroke								
	IMTP 17/18 profile		60.0%			60.0%		
1a - % of patients who have a direct admission to an acute stroke unit within 4 hours (Target = 54.8%)	17/18 Actual	44.7%	67.5%	62.3%	42.6%	48.6%	53.3%	57.1%
	IMTP 17/18 profile		96.0%			96.0%		
2 - % of patients who receive a CT scan within 12 hours (Target = 94%)	17/18 Actual	100.0%	97.8%	98.3%	98.0%	100.0%	96.8%	100.0%
3a - % of patients who have been assessed by a stroke consultant within 24 hours (Target = 81.1%)	17/18 Actual	92.7%	86.7%	86.2%	76.0%	77.5%	95.2%	92.2%
Time 2b - Thrombolysed patients door to needle <=45 mins (Target = reduction - 12 month trend)	17/18 Actual	14.3%	12.5%	10.0%	40.0%	33.3%	40.0%	30.0%

Appendix 1b

16

Performance against key Tier 1 measures and other priority targets

		March	April	May	June	July	Aug	Sept
Planned Care								
31 day NUSC cancer (Target = 98%)	IMTP 17/18 profile		98.0%			98.0%		
	17/18 Actual	98.79%	98.48%	98.85%	97.62%	100.00%	100.00%	
62 day USC cancer (Target = 95%)	IMTP 17/18 profile		90.0%			90.0%		
	17/18 Actual	95.37%	90.53%	91.75%	85.06%	95.56%	88.35%	
62 day USC cancer (Target) - Monthly	17/18 Actual	-	89.25%					
62 day USC cancer (Target) - Quarterly cumulative	IMTP 17/18 profile (revised)		1,837			1,770		
	17/18 Actual	1,837	1,969	1,915	1,642	1,651	2,005	1,970
Mental Health measures								
Part 1a: % of mental health assessments undertaken within (up to and including) 28 days	IMTP 17/18 profile		80%	80%	80%	80%	80%	80%
	17/18 Actual	68%	23%	20%	18%	71%	81%	89%
Part 2: % of UHB residents in receipt of secondary mental health services (all ages) who have a valid CTP (Target = 90%)	IMTP 17/18 profile		90%	90%	90%	90%	90%	90%
	17/18 Actual	93%	91%	89%	88%	90%		
Part 3: All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working	IMTP 17/18 profile		90%	90%	90%	90%	90%	90%
	17/18 Actual	91%	100%	100%	100%	100%		
Part 4 - % of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients (Target = 100%) - 6 monthly assessment	IMTP 17/18 profile		100%					
	17/18 Actual	100%						