RESOURCE AND DELIVERY COMMITTEE
30 January 2018 at 9.00am
Corporate Meeting Room, Headquarters, UHW
AGENDA

Part 1: Items for Action			
1.		Welcome and Introductions	Oral *Chair*
2.		Apologies for Absence	Oral *Chair*
3.		Declarations of Interest	Oral *Chair*
4.	***5 mins***	Minutes of the Resource and Delivery Committee meeting held on 7 November 2017	*Chair*
5.	***5 mins***	Action Log of meeting held on 7 November 2017	*Chair*
6.	***5 mins***	Action taken by Chair on behalf of Committee – Revised Policy on Records Management	*Chair*
Delivery			
7.	***10 mins***	Workforce and Organisational Development Delivery Plan Objective Report – Health and Wellbeing including Sickness Management	*Director of Workforce and OD*
8.	***10 mins***	Annual Equality Statement and Report	*Oral Equality Manager*
Resources			
9.	***10 mins***	Update on Personal Appraisal and Development Review	*Oral Director of Workforce and OD*
10.	***5 mins***	More Than Just Words (Welsh Language)	*Equality Manager*
Governance			
11.	***10 mins***	Policies for Approval: 11.1 - Business Continuity Policy 12.2 - Adoption of Employment Policy and Employment Procedure	 *Director of Planning* *Director of Workforce and OD*

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10.00am			
12.		To discuss and agree the roles and responsibility of the new Committee in order for the Terms of Reference to be prepared	*All*
Part 2: Items to be recorded as received and noted for information by the Committee			
13.		High Level Performance Dashboard	*Chief Operating Officer*
14.		Continuing Healthcare Report	*Chief Operating Officer*
15.			

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 7 NOVEMBER 2017 – 9.00AM CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:	
Charles Janczewski	Chair – UHB Vice Chair
Akmal Hanuk	Independent Member – Local Community
In Attendance:	
Julie Cassley	Assistant Director of Workforce and Organisational Development
Keithley Wilkinson	Equality Manager
Lee Davies	Assistant Chief Operating Officer
Martin Driscoll	Director of Workforce and Organisational Development
Peter Welsh	Director of Corporate Governance
Ruth Walker	Executive Nurse Director
Sharon Hopkins	Director of Public Health
Observer:	
Urvisha Perez	Wales Audit Office
Apologies:	
Fiona Jenkins	Director of Therapies, Health Science and IT
John Union	Independent Member -
Steve Curry	Chief Operating Officer
Stuart Egan	Independent Member – Trade Union
Secretariat:	Glynis Mulford

RD: 17/012 WELCOME AND INTRODUCTIONS

Mr Charles Janczewski, the new Chair, attending his first meeting introduced himself to the Committee. All those present were invited to do the same and welcomed all. Urvisha Perez, from the Wales Audit Office, attended as an observer.

RD: 17/013 MATTERS ARISING

The Chair informed members that the Terms of Reference was still in draft and a meeting to discuss the document further was being arranged in December 2017. It was stated that future meetings would benefit from an indicative timed agenda and described how these meetings would be conducted.

RD: 17/013 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

RD: 17/014 DECLARATIONS OF INTEREST

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

RD: 17/015 MINUTES OF THE RESOURCE AND DELIVERY COMMITTEE MEETING HELD ON 8 AUGUST 2017

The Committee **RECEIVED** and **APPROVED** the minutes of the meeting held on 8 August 2017.

RD: 17/016 ACTION LOG FROM MEETING PEOPLE, PLANNING AND PERFORMANCE MEETING HELD ON 8 AUGUST 2017

The Committee **RECEIVED** the Action Log from the meeting of 8 August 2017 and **NOTED** the following:

RD 17/005: Terms of Reference: To ensure all actions are indicated with a timescale

RD 17/006: Year End Referral to Treatment Time Update: The Executive Nurse Director was not aware that this had been reported to Quality, Safety and Experience Committee.

ACTION: P Welsh to verify that a report had been presented to Quality, Safety and Experience Committee and if not for this to be scheduled for a future meeting. The Committee to be updated on progress at next meeting arranged for January 2018.

PPP 17/018: WAO Review of Operating Theatres & UHB Management Response and Theatre Improvement Project: *As* the report was being presented at the meeting, the status to be changed to *'on agenda for today'*.

Management Executive Meeting - 22.05.17- Employee Relations Case: The Committee was assured that the message had been reinforced to Clinical Boards to release staff for investigation work and for this to be conducted in a timely manner.

The Committee:

- **NOTED** the Action Log

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RD: 17/017 ASSURANCE ON RTT PLANNING CYCLE DEVELOPMENT

Lee Davies, Assistant Chief Operating Officer gave a PowerPoint presentation on Referral to Treatment Time (RTT) Planning Cycle Development. It was highlighted:

- An overview of the key messages in meeting national targets for waiting times was described. The new approach that the UHB had taken to RTT delivery in 2015/16 was also explained working to quarterly performance cycles with the aim of controlling the performance position. This had resulted in reaching and delivering targets for the past 11 quarters. This consistency led to the best 36-week position for seven years. The new strategy had led to significant additional funding from Welsh Government (WG).
- The approach to developing the Planned Care Delivery plans was explained. The demand and capacity analysis had been completed in October and Clinical Boards are in the process of assessing the gaps this leaves and the options to address them.
- During the year the approach must remain flexible, depending on the quarterly demand for each specialty. Each specialty agrees a quarterly target with weekly intensive overviews to pursue delivery of the schemes.
- The purpose of the annual plan was to provide a reasonably robust assessment of deliverability. But emphasised demand could not be predicted precisely and this was not an exact science. The capacity and demand with key specialties was also explained in-depth in relation to new outpatients and inpatients and day cases.
- A summary was presented regarding the change in waiting list sizes stating they still encountered problems with outpatients as the list was still growing but the treatment backlog had reduced in the past year. Two thirds of the growth in the outpatient waiting list had previously been in eight specialties but solutions had been implemented leading to a backlog reduction in these areas over the past 12 months. A residual collection of specialties had continued to go up over the year but recurrent solutions were in place.
- In regard to the 2018-21 Integrated Medium Term Plan (IMTP) – the four scenarios were explained and what type of scenarios would be analysed over the next three years, such as how ambitious we could be in moving towards to 95% compliance.

It was commented and discussed:

- In response to RTT monies from WG and how the Health Board (HB) measures what is expected to be delivered, it was stated that delivery schemes are agreed with Clinical Boards identified where they need to have schemes in place, increase core capacity and look at what the core capacity is. Monies from WG are attained later on in the year but the HB did not rely on this. In terms of value for money from Welsh Government

funding, it was noted that delivery options are limited when funding is provided mid-year.

- The Committee was informed they were asking WG to engage in discussions around receiving full allocation going into next year and what other monies would be available. This was in order to work on value for money and ensure the schemes being put in place were going to add to sustainability and service redesign.
- In regard to what system is used in anticipating the demand triggers, it was explained that it is not possible to forecast demand with precision but projections can be made based upon historical patterns. It was emphasised there was not a whole systems modelling tool in the NHS as there were a number of variables. The team works with the University's school of mathematical modelling and will continue to develop and make use of the tools available.
- It was stated that management of risks was important for the Committee to consider as there were implications on the waiting list and in regard to finance and queried how this would move forward to help mitigate the risk. In response it was explained that this was a part of the Integrated Medium Term Plan aligning to other areas such as workforce and the plans should improve year on year. It was stated there will always be risk but it was about prioritising and scheduling what the risk would be.

ACTION:

The Committee:

- **NOTED** the presentation

RD: 17/018 UPDATE ON THEATRES UTILISATION REPORT

Mr Alun Tomkinson, Clinical Board Director and team updated the Committee on the report and highlighted the following:

- It was reported that back in May 2017 the utilisation of theatres had dropped to between 73-74% with 78% booking compliance and a cancellation rate of19%.
- In order to strengthen areas key strategies were put in place such as:
  - a workforce plan to improve staffing levels
  - to strengthen governance and accountability with the clinical and managerial teams
  - to look at systems reviewing whole pathways around the surgical stream
- Utilisation had increased to 78-79% in September / October with a stretch target of 83%. Bookings had reached 86% compliance; this was an 8% improvement. Improvements in CAVOC had shown 92% of theatre utilisation.

- There was still room for improvement and work had commenced with the Children's Hospital predominantly to do with the use of theatres for elective and emergency surgery. There has also been improved trajectory for day units on both the UHL and UHW sites.
- Learning points from these processes has been around engagement and ownership and ensuring management and clinicians are working with teams. There were different solutions for directorates within the Surgical Service with good practice being shared across the Clinical Board.
- Pre-assessment and preadmission was critical and a working group had been established to review areas and informed it aligned with work for next year in terms of the Integrated Medium Term Plan.
- Work with Public Health had also commenced in regard to DNAs and would be linking this aspect of work to depravation and understanding where particular GP clusters have a commonality with cancellation rates. In addition, they would be working with GPs around communication.

It was commented and discussed:

- In regard to sustainability, it was stated that a performance framework was placed in the directorates and a large part of this was around communication with specialties and services.
- There was a level of assurance this was sustainable and was confident around staffing levels. There were critical elements around engagement and communication with workforce and how this would be managed.
- The Clinical Board were commended in employing those hard to fill vacancies, stating there was a need to keep up morale which was challenging in the environment.
- It was emphasised that a significant component on utilisation was around availability of beds and that theatre inefficiency was not just around theatres.

The Committee:

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

RD: 17/019 WALES AUDIT OFFICE - ORTHOPAEDICS

Mr Alun Tomkinson, Clinical Board Director and team presented the Wales Audit Office report, stating the paper presented a positive aspect in terms of the development of an audit conducted in 2013. A revised model of care was being piloted in CMATS and at this stage indicated a positive impact on outpatient demand.

In regard to outpatient waiting times, there was an extra 2,000 patients referred this year and CMATS was therefore critical in meeting the gap as internal capacity was struggling. There was much work being done to bring the waiting list down

and although challenging, the team were confident this would continue to improve which had been reflected in the RTT position in the last few quarters.

The Committee was informed in regard to prosthesis costs the service, with NWSSP, had negotiated the lowest cost of knee replacement in Wales. It was stated that the Organisation accepts more complicated work from neighbouring Health Boards with significant higher costs, which had raised the average. The service also takes on revision costs and this marker reflects the casemix acquired in Cardiff. On a positive note, the Health Board was now the benchmark in Wales for driving down these costs.

In regard to the revision rates on knee and hips, there had previously been an issue with a manufacturer's metal hip replacements which had a higher failure rate. As a result those cases had been recalled. The WAO report had used data from 2013 but going forward would look at the last five years of data nationally. There had been a change in practice involving more scrutiny and tracking of implants. This was fully in line with the national level with clinical benefits.

PROMS had been rolled out to hip/knee surgery and achieved an 84% response rate for this year. This had allowed only 5-6% of patients to require follow-up and supported the recording of clinical outcomes, noting they were better than the UK average.

It was commented and noted:

- In regard to revision, this was failure of the product and all costs had been recovered from the manufacturer.
- In response to the query on the CMATS pilot running on limited time and how to keep the momentum going, it was stated that the Planned Care Board within Wales said this was the right thing to do and it was critical to make this sustainable. Although this was a pilot a business case was being written which will evidence over time cost neutrality, emphasising this was critical given financial restraints.
- In regard to the timeline, the aim was not to stop the pilot in April but potentially to obtain support from WG with the Invest to Save scheme. This would also run with the IMTP identifying plans for next year. In addition, would be reviewing over a three year period in regard to compliance to what can be worked through financially with the business case where steps and milestones have been considered.
- Questions were raised on what work was being done to ensure we have business models to recoup costs in relation to high cost of implants. Members were informed that arrangements had been set up with the sub group of the IPFR team and with finance that at the point of referral from other Health Boards agreement is received to pay costs over a certain threshold.
- It was raised whether we were confident the risks we carry of infection prevention and control were being addressed. It was recognised there was more vigilance and an emergency meeting had been called at the last

outbreak, ensuring there is good data collection processes in place to monitor trends; ensuring hand hygiene levels are reached and conducting theatre audits and revisiting the issue again.
- Assurances were sought in regard to areas of concern within the action plan and whether these had been addressed.

ACTION: M Bond to update the action plan and circulate to the Committee

The Committee:
- **NOTED** the summary of opportunities highlighted from the Welsh Audit Office
- **NOTED** the areas of focus the Directorate are taking and actions will further assist in delivery of performance

RD: 17/020 WALES AUDIT OFFICE – MEDICINES MANAGEMENT

Dr Graham Shortland, Medical Director, presented the updated report previously audited in 2013-14 in primary care and 2014-15 in an acute hospital setting stating there was a comprehensive process in Medicines Management within the Organisation.

It was commented and noted:
- The Nurse Executive Director was pleased to see there was improvement and progress being made. This was endorsed by the Chair.
- It was agreed for further assurances that recommendations were being acted on, a report would be brought back to the Committee on an annual basis for an update on progress but would be monitored through the Medicines Management Group.

The Committee:
- **NOTED** progress with the actions required by the Auditor General for Wales/ Wales Audit Office

RD: 17/021 WALES AUDIT OFFICE – RADIOLOGY SERVICES

The Resource and Delivery Committee **RECEIVED** and **NOTED** the overall conclusion of the Wales Audit Office (WAO) review of the Radiology service in Cardiff & Value UHB and progress made against the action plan developed to address the WAO recommendations.

Mr Lee Davies, Assistant Chief Operating Officer, stated that the Radiology Strategy is a complex piece of work and advised that in the main the action plan was being progressed as intended.

It was commented and noted:

- It was encouraging to see work had started on the Radiology Strategy but queried when there would be an indication to have sight of the timeframe with milestones finalised and how this would fit in with the IMTP process.
- The Committee was informed that over the next few months this piece of work would continue and acknowledged that it would be helpful to get more specific timelines as this will be a part of the IMTP document. Once this was complete it would be shared with the Committee.
- It was noted that recommendations had not been accepted by the Health Board and asked whether any dialogue had been established with WAO to secure agreement on the way forward.
- Ms Perez reported that she had spoken to the Director of Operations for CD&T and the reasoning behind not accepting the recommendation was because there had been a slight discrepancy. There were not two recommendations but only one not accepted and this was around the workforce which had been incorporated into the strategy.
- The Assistant Director of Workforce and Organisational Development stated that in relation to WOD plan the Clinical Board plan was scrutinised. There were also indicators in place which were part of the overall workforce plan such as PADR. There were components in the IMTP in regard to the workforce and was satisfied they were in place.

ACTION: L Davies to update the Committee in regard to the recommendation that was not accepted.

RD: 17/022 UNIVERSITY HEALTH BOARD WORKFORCE AND ORGANISATIONAL DEVELOPMENT DELIVERY PLAN – 6 MONTH UPDATE

Mrs Julie Cassley, Deputy Director of Workforce and Organisational Development, gave a comprehensive overview on the 17/18 half year Delivery Plan Update.

It was highlighted:

- A plan had been developed over three years ago, however, a more recent detailed delivery plan was revised with five objective areas. The setting for the plan was around Shaping our Future Wellbeing Strategy and the IMTP. The five objectives were explained that support this.
- All Clinical Boards work to the objective areas and may place a different emphasis due to their particular needs and service areas. The objectives are flexible and intended to be a framework as well as a delivery plan.
- The key successes and challenges were described such as the downward trend in sickness absence which has been reduced to 4.89%. The Director of Nurses driving the switchover in agency Healthcare Support Workers

(HCSW) to bank and substantive staff; and the 100% switchover from high premium agencies to on contract framework agencies.

- In regard to maintaining good employee relations, it was noted that there had been an increase in formal cases and this impacted on the time being taken to investigate and conclude cases.
- The Health Board were providing a leading role on the MTI initiative for Wales to achieve assignment of posts put forward for the MTI.
- Seven graduates had been appointed to the Organisation and a number of hard to fill Senior Management posts filled, although more work was needed on talent management for Directorates and Clinical Boards.
- The forecast up to next March 2018 on recruiting Band 5 and 6 nurses was shown informing there would be 114 starters during this period. Work had commenced on retention acknowledging this was a UK wide position.
- Adaption programmes were also being run with return to practice initiatives.
- A considerable amount of work had been planned around the Values and Behaviours Framework for this year to ensure the profile was kept high.

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It was discussed and noted:

- There was a need to look at the organisation as a whole in regard to shaping the integrated plans. The WOD plan was comprehensive and there was a need to view areas which were going to drive the Organisation forward.
- Mr Martin Driscoll said that the Personal Appraisal Development Review (PADR) was a lag measure demonstrating what had happened, but there was a requirement for this to lean more towards Organisational Development, focussing on what activities we are engaged in and how this would be measured going forward.
- There was wider discussion on PADRs such as contracts and the need to align PADRs to behaviours.
- It was suggested that as the Health Board employs a vast amount of staff, to look at the staff groups within the Organisation and to arrange a development session to acquire a base set of information. In addition, a thorough training needs analysis for the Health Board should be further considered.
- There was a need to look at what kind of workforce we envisage for the future. It was acknowledged that as an organisation we had not worked out how these are measured but should look strategically at what would be the key indicators.

The Committee:
NOTED the presentation

RD: 17/023 PERFORMANCE AGAINST STRATEGIC EQUALITY PLAN

Mr Keithley Wilkinson, Equality Manager, outlined and highlighted elements of the report on the Strategic Equality Plan and informed we were in the second year of the four year plan. Members were advised that as a public sector Organisation we had an obligation to have a plan in place under the Equality Act 2010. The plan was based on completed tasks, deliveries and actions which followed the SMART process in what we need to do.

The plan addressed our legal obligations and social and moral obligations and went through a process involving our internal stakeholders, members of staff and external stakeholders in terms of various communities. It was highlighted that the Equality Health and Impact Assessment, although there has been some criticism, was also commended as a piece of work regarding the future horizon scanning approach adopted. The plan was RAG rated with 60 actions completed. Those coded in amber will be completed by March 2018 but pointed that some actions were part of an ongoing process.

In regard to employee information, this was available and would be circulated after the meeting. In terms of Development Day, work has started on how to analyse and monitor some of the information. As an organisation, we are at the equality stage of looking ahead to the future by working in an equitable way. This is a transition stage and giving different support for people to have equal access. The plan for 2018/19 and onwards is to move to a transformation aspect around equity where systematic barriers were being removed.

It was commented and noted:

- In regard to the transgender community awareness training had been developed and delivered to staff. Emphasising this was a societal issue as well as an organisation issue.
- In response to the concern raised around protective characteristics, Members were informed that the Equality Manager and Welsh Language Manager were part of the process for inductions courses, stating that bespoke and tailored training was also conducted. 72% of staff had been involved in equality training where each protective characteristic had been highlighted.

The Committee:
NOTED the contents of the paper

RD: 17/024 MORE THAN JUST WORDS (WELSH LANGUAGE)

The Resource and Delivery Committee **NOTED** the oral update from Mr Keithley Wilkinson, Equality Manager. To date Welsh Government had not responded to the report but envisaged this could be presented at next meeting.

RD: 17/025 POLICIES FOR APPROVAL

1. Records Management Policy

Mr Peter Welsh presented the policy on behalf on the Information Technology and Governance sub-Committee as there was a need to change some of the retention schedules and the policy had been updated to reflect this.

The Committee:

- Did not **APPROVE** the policy on Records Management and did not **APPROVE** the full publication of the Records Management Policy in accordance with the UHB Publication Scheme. The queries raised are highlighted below:

- Concerns were raised in regard to the implementation of the policy protocol across the organisation.
- In regard to the Records Management Procedure - Page 12: The Royal College of Nursing should be changed to *'Nursing Midwifery Council'*.
- The area on staff records did not feel strong enough but it was confirmed this was predominantly about Clinical Records but did cover all records. Compliance with the policy was being tracked through the Records Management Group.
- The cover report stated this was to go to the Strategy and Engagement Committee for 5 September and refers to both versions two and three.
- The link to the Retention Policy did not work.

The Director of Corporate Governance stated that he would report the queries raised to the Information Technology and Governance sub Committee and the policy would be resubmitted at the next Committee in January 2018, but if needed, Chair's Action would be requested to speed up the process.

2. Medical Appraisal Policy

The Committee:

- Formally **ADOPTED** and **APPROVED** the Medical Appraisal Policy with full publication of the Records Management Policy in accordance with the UHB Publication Scheme.

RD: 17/026 UPDATED EXTRACT ON CORPORATE RISK ASSURANCE FRAMEWORK

Mr Peter Welsh, Director of Corporate Governance explained that the risks that previously rested with the People, Planning and Performance Committee had been split between the two new Committees. There had been no change since presented at the last meeting. A major overhaul was being undertaken in looking at the risks and this was being progressed. This was being tracking by the Audit Committee.

Work had commenced in looking at how risks were presented and described. There was a need for this framework to be more aligned to our strategic objectives as we go forward and would be implemented from April next year to tie into the IMTP.

It was commented and noted:

- The Director of Corporate Governance explained that the Clinical Boards managed their own risks but the Committee would receive the higher risks and seek assurances around these.
- Concern was raised that executives had risks allocated to them in two portfolios.
- There was work still to be done on risk framework and the CRAF was still at development stage and a work in progress.

The Committee:

- **NOTED** the report was a work in progress

RD: 17/027 HIGH LEVEL PERFORMANCE DASHBOARD

This paper was presented for information.

RD: 17/028 ANY OTHER BUSINESS

There was no other business to report.

RD: 17/029 DATE OF NEXT MEETING

The next Resource and Delivery Committee meeting is scheduled to take place at 9.00am on **Tuesday, 30 January 2018** in the Corporate Meeting Room, Headquarters, UHW

RESOURCE AND DELIVERY COMMITTEE

ACTION LOG – 7 November 2017

MINUTE	DATE	SUBJECT	AGREED ACTION	ACTIONED TO	STATUS
ITEMS TO BE BROUGHT FORWARD TO FUTURE MEETINGS					
RD 17/005	8.08.17	Terms of Reference	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. To review the relationship of working groups to sub-Committees and Committees to ensure the most appropriate reporting relationships are in place.	P Welsh	To be brought back to Committee once meeting with UHB Chair and Lead Executives have reviewed and strengthened the document. Meeting arranged for **11 January 2018** to discuss Terms of Reference
ACTIONS COMPLETED SINCE LAST MEETING					
RD: 17/019	7.11.17	WAO - Orthopaedics	To update action plan and circulate to Committee	M Bond	**COMPLETE** Circulated 9 January 2018
PPP 17/011	16.05.17	WAO – Medicines Management	A report to be brought to the Committee for sign off	G Shortland	**COMPLETE** Brought to November 2017 meeting
RD: 17/021	7.11.17	WAO – Radiology Report	To update Committee in regard to recommendation 8 – Strengthen Directorate Performance Management - which was not accepted	L Davies	**COMPLETE** There has been subsequent communication with the WAO to provide evidence to support the improvements already made.

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AC: 17/010	24.04.17		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	**COMPLETE** Brought to November 2017 meeting
PPP 17/006	16.05.17 7.11.17	Year End Referral To Treatment Time Update	To consider report at Resource and Delivery Committee on outpatient follow-up improvement plan, with key milestones for delivery To verify that a report had been presented to Quality, Safety and Experience Committee and if not for this to be scheduled for a future meeting. The Committee to be updated on progress at next meeting arranged for January 2018	S Curry P Welsh	**COMPLETE** This was reported to QSE Committee in June 2017 **COMPLETE** The following item was received at QSE in June 2017, Management of Outpatient Follow Ups and Endoscopy Surveillance (QSE 17/105). Further action was to receive an updated report to QSE in February 2018

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APPROVAL OF RECORDS MANAGEMENT POLICY
Name of Meeting Resource and Delivery Committee **Date of Meeting** 30 January 2018

Executive Leads : Medical Director / 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

6.1

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The Policy document and the underpinning procedure and protocol

The Resource and Delivery Committee is asked to:

- **APPROVE** the Policy
- **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 that apply in the Department of Health.

BACKGROUND

Cardiff and Vale University Health Board (the UHB) has an approved Records Management Policy, with two separate underpinning documents:
Records Management Procdure and
Records Management Retention and Destruction protocol.

These documents sets out how the UHB will manage all the records that it handles in accordance with required legislation and standards. These will include clinical records, HR Records, finance records and corporate records. 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 had previously adopted the Department of Health retention schedules and the only change required was to amend the schedules to reflect the new schedules in place in the Department of Health. 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.

Reference Number: 142 **Version Number: 2**	**Date of Next Review:** September 2019 **Previous Trust/LHB Reference Number: T197**

Records Management Policy

Policy Statement

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.

6.2

Policy Commitment

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.
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.

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.

Cardiff and Vale University Health Board (the UHB) understands the definition of records to be:

- "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. *Reference BS ISO 15489.1*

- 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." *Reference. Department of Health Records Management: NHS Code of Practice Part 1*

All records held by the UHB fall within the scope of this policy and these are personal (relating to patients, public and employees i.e. clinical/medical records) 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.

Supporting Procedures and Written Control Documents

This Policy and supporting procedures describe the following with regard to all aspects of

- Records creation
- Records keeping
- Record maintenance
- Access and transfer
- Appraisal
- Archiving
- Storage
- Disposal
- Responsibilities for Records Management

Other supporting documents are:

- Records Management Procedure
- Records Management Retention and Destruction Protocol and Schedule
- Information Governance Policy and Framework
- 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

Scope

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.

Equality Impact Assessment	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.

Health Impact Assessment	A Health Impact Assessment (HIA) has not been completed as this document falls under the IG Policy.
Policy Approved by	People Planning and Performance Committee
Group with authority to approve procedures written to explain how	Information Governance Sub Committee

6.2

this policy will be implemented	
Accountable Executive or Clinical Board Director	Medical Director

Disclaimer

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

Summary of reviews/amendments

Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Quality and Safety Committee 16/10/2012	24/4/13	*New UHB document previous Trust document reference.*
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		Only change relates to the retention schedules due to the new retention arrangements in NHS England. Recommended by IGSC 8/8/17 for submission to R&D committee formal approval.

6.2

HEALTH AND WELLBEING UPDATE
Name of Meeting : Resources and Delivery Committee **Date of Meeting: 30th January 2018**

Executive Lead : Executive Director of Workforce and OD
Author : Assistant Director of OD
Caring for People, Keeping People Well: Caring for our staff and keeping them well enables them to provide quality care to patients; a fundamental premise of Shaping our Future Wellbeing
Quality, Safety, Patient Experience impact: As above
Health and Care Standard Number:
CRAF Reference Number
Equality and Health Impact Assessment Completed: No

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided through:

- Ongoing monitoring at the Health and Wellbeing Advisory Group, Maximising Attendance and Health and Safety Committee.
- Ongoing monitoring of WOD Delivery Plan
- Achievement of Gold and Platinum Corporate Health Standards

HSMB is asked to:

- **Note** the update and progress of the health and wellbeing agenda

SITUATION

The health and wellbeing of our staff is fundamental to us having a highly functioning organisation, recognised in the UHB's ambition to be a 'great place to work and learn'. The WOD function plays a central role in enabling this.

BACKGROUND

A focus on health and wellbeing is evident throughout the WOD work plan and is referenced specifically in the Efficient and Engaged Workforce objective, as follows: -

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EFFICIENT WORKFORCE				
OUTCOME	**18/19**	**19/20**	**20/21**	**ACTIONS FOR 18/19**
Improve attendance (sickness absence)	95.4% attendance (4.6% UHB sickness absence) Regularly review performance against measures for Maximising Attendance (to be finished 2017/18) Reduce DNA rates in Occupational Health to 15%	95.6% attendance (4.4% UHB sickness absence Reduce DNA rates in Occupational Health to 10%	95.8% attendance (4.2% UHB sickness absence) Reduce DNA rates in Occupational Health to 5%	• Continue with Maximising Attendance group and delivery of actions • Benchmark against other organisations • Roll out of revised Managers training • Continue to develop managers through coaching • 60% seasonal Flu vaccination uptake • Review CareFirst scheme and PTSD pathway • Prioritise early intervention on LTS cases • Continue with representation on relevant all Wales groups e.g. Sickness Group • Input into All Wales Sickness Policy review

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ENGAGED WORKFORCE				
OUTCOME	**18/19**	**19/20**	**20/21**	**ACTIONS FOR 18/19**
Enhance Staff Health & Wellbeing	60% seasonal Flu vaccination uptake of front-line health care workers Further development of and delivery against Health and Wellbeing Action Plan	Achieve seasonal Flu vaccination target for front-line health care workers Implementation of Health and Wellbeing Action Plan	Achieve seasonal Flu vaccination target for front-line health care workers Implementation of Health and Wellbeing Action Plan	• Include individual responsibility re health and well-being within job descriptions • Review progress against MECC route map for 2018/18 and deliver actions • Implementation of phase 2 of route map for sustainable wellbeing • Include wellbeing question in PADR • Evaluation of Care First (EAP) • Maintain Corporate Health Standards achievements • Update Health and Wellbeing Policy

ASSESSMENT AND ASSURANCE

The health and wellbeing agenda has benefited from a strong focus over the last three years, the impact of which is evident in several ways. The Corporate Health Standard detailed below provides good overall assurance of performance because evidence across all our activity was included as part of that process.

Corporate Health Standard – Gold and Platinum achievement

Every four years the UHB undergoes an independent assessment to determine whether it is meeting standards set by Welsh Government. The Gold assessment focuses on our internal health and wellbeing activity, and the Platinum assessment reviews the way in which we discharge our corporate social responsibilities. These assessments took place in September and October 2017 respectively and we were successful in achieving both standards.

The assessors were extremely complimentary, not only about the evidence that we provided from across the UHB (we submitted over 1000 examples for our Gold assessment) but also in the quality of our submission. They were particularly impressed at the extent of the progress made since the last assessment. For these reasons we are to be held up as an exemplar organisation and have been asked if we will share practice across private as well as other public sector organisations.

We have received a small number of recommendations, which have been integrated with the Health and Wellbeing action plan and are being monitored through the Health and Wellbeing Advisory Group.

Health and Wellbeing Advisory Group

This group was established in 2015, is chaired by the Assistant Director of OD, reports to the Health and Safety Committee, and has representation across all aspects of the health and wellbeing agenda, including: health and safety, occupational health, employee wellbeing service, physiotherapy, dietetics, occupational therapy, Public Health, transport services. It is well-supported by staff side representatives and a specialist communications resource employed through the Public Health team. A clear strategic direction for health and wellbeing was approved by the group in 2015, which informed an initial action plan focused on laying strong foundations across the agenda, through to ‘transformation’ in which health and wellbeing activity is embedded in the culture of the UHB. An operational group – Maximising Attendance – leads on tactical activity to reduce sickness absence and reports progress in to the Health and Wellbeing Advisory Group (see below).

Making Every Contact Count

The Public Health team lead the Making Every Contact Count activity, which is focused primarily on opportunities for clinicians to talk to patients about the four key health-harming behaviours: smoking; unhealthy diet; lack of physical activity; and excess alcohol intake. As an example of activity undertaken because of the multi-disciplinary nature of the Health and Wellbeing Advisory Group, activity is underway to integrate the same principles across workforce processes, such as job descriptions, appraisal conversations, induction and leadership programmes (including ‘managing difficult conversations’). This work plan

follows the same strategic direction as all other health and wellbeing activity, moving from 'laying the foundations' to having the activity embedded fully in the culture of the UHB.

Maximising Attendance
The main focus of this group has been reducing sickness absence from a starting point at the end of March 2015 of 5.71% to 4.89% in November 2017. As a result of significant effort by WOD staff we achieved a 21 month successive reduction in sickness absence between February 2015 and October 2107. This figure has plateaued in 2016-17 as we attempt to put sustainable multidisciplinary solutions in place, working to an action plan that addresses leadership, culture, process, communications and training issues particularly for absence caused by musculoskeletal issues and stress and anxiety. Significant progress still needs to be made if we are to be confident that: all line managers are empowered and are discharging their responsibilities in a timely and effective way; that all aspects of the sickness absence process are efficient and effective, including that the interface with Occupational Health is as good as it can be; data is used to the full potential to inform decision-making; and that we join up wherever appropriate with other delivery groups to ensure alignment of activity (for example, there is an inextricable link between the aims of the Maximising Attendance Group and the Nursing Productivity Group).

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From the outset the group set itself challenging targets for reducing sickness absence over a three-year period from 2015/16. Having taken the decision to ensure sustainable activity we have revised these targets as follows: -

Year	Original	Actual (end of year out-turn)	Revised
2014-15		5.71%	
2015-16	5.0%	5.09%	
2016-17	4.5%	4.86%	
2017-18	4.0%		
2018-19			4.6%
2019-20			4.4%
2020-21			4.2%

Comparisons to other health organisations across Wales are shown below.

	2014-15	2015-16	2016-17
ABMU	5.73%	5.64%	5.79%
Aneurin Bevan	5.52%	5.20%	5.27%
Betsi Cadwaladr	5.18%	4.84%	4.80%
Cardiff & Vale	5.76%	5.09%	4.89%
Cwm Taf	6.22%	5.53%	5.64%
Hywel Dda	5.49%	5.56%	5.07%
Powys	4.53%	4.12%	4.64%
Public Health Wales	3.76%	3.97%	3.62%
Velindre	3.89%	3.95%	3.52%
WAST	8.29%	6.94%	6.79%
NHS Wales	5.59%	5.23%	5.16%

Occupational health and employee wellbeing

The Occupational Health department and the Employee Wellbeing Service (EWS) have made a significant proactive and reactive contribution to the health and wellbeing of our staff over many years. For example, in partnership with Public Health, the Occupational Health team have revised the approach to the Flu Campaign, exceeding the 50% target set by Welsh Government in 2015/16 and they are already exceeding the 60% target to be achieved by March 2018. At the same time, as well as providing counselling support to staff the Employee Wellbeing Service deliver resilience and other wellbeing training across Clinical Boards.

In November 2015 an Employee Assistance Programme (EAP) was introduced for a 12-month pilot. An evaluation at the end of this period concluded that although some staff were choosing the EAP over the EWS, primarily for reasons of anonymity, the majority of staff were continuing to use the EWS because of the value they placed on talking to people who understood the organisation and the context in which they were working. To continue serving both needs a new EAP provider was contracted for a further 12 months at 50% of the cost of the original contract, beginning in May 2017. A review of the performance is underway but early indications are that usage of the EAP is low and demand for the internal EWS continues to grow. A decision will be made by March 2018 regarding ongoing service provision.

RECOMMENDATION

- To note progress and ongoing monitoring arrangements of the health and wellbeing agenda.

MORE THAN JUST WORDS - WELSH LANGUAGE ORGANISATIONAL PLAN
Name of Meeting : Resource and Delivery Committee **Date of Meeting** 30 January 2018

Executive Lead : Executive Director of Workforce and Organisational Development
Author : Welsh Language Officer (ext.42265)
Caring for People, Keeping People Well : This report underpins the Health Board's "For Our Population" and "Our Service Priorities" vision.
Financial impact : N/A
Quality, Safety, Patient Experience impact : There will be an improved quality, safety and patient experience for those who prefer to receive services in Welsh.
Health and Care Standard Number … **3.2/ 4.1/ 4.2 / 7.1**
CRAF Reference Number …… 1.1 / 2.2 / 4.2 / 5.1 / 8.1 / 9.3 /
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Progress and compliance monitored through the Welsh Language Steering Group
- It also shows that the organisation has been preparing for the new Welsh language Standards which are being introduced this year.

The Resource and Delivery Committee) is asked to:

- **NOTE** the course of action undertaken to ensure compliance to the More than Just Words Strategy and the UHB Welsh Language Scheme
- **ENDORSE –** this progress report to Board

SITUATION

This paper provides an update on the organisations' compliance with the Welsh Government's More than Just Words Strategy, which aims to improve the quality of Welsh medium healthcare. It provides an overview of successes and challenges in implementing the strategy.

The Welsh Government Minister for the Welsh Language announced before Christmas that the Welsh Language Standards will be introduced to the Welsh Health sector this year.

Under the UHB's Strategy "*Caring for People, Keeping People Well'*, providing healthcare for patients and service users who prefer to speak Welsh comes under the 'Deliver outcomes that matter to people'.

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BACKGROUND

The organisation has a requirement to enact the Welsh Government's Welsh Language in Healthcare Framework, the 'More than Just Words' Strategy.

The Framework has been in place since 2012 with a broad range of objectives to ensure that the Welsh Language is mainstreamed into the NHS healthcare service. The plan is centred around a concept called *'the active choice*', where patients/service users are asked their preferred language at start of their treatment with the idea that Welsh medium care becomes part of their patient experience. The strategy has three broad objectives:

1. Developing awareness of the staff on the importance of the Welsh Language in healthcare.
2. Improving the ability of the workforce to provide a Welsh language service
3. Health systems that register language choice and front line service which can maximise care through the medium of Welsh.

The framework comes to an end in March 2018. There is a possibility however after reviewing the progress achieved by NHS Wales on this framework, the Welsh Government will wish for the work to continue in a different format. Some aspects of the plan have been challenging to implement,.

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The Welsh Government Minister for the Welsh Language said the public healthcare sector in Wales will come under the new Welsh Language standards this year. These will replace the current Welsh Language Scheme which has been in existence since 1993. We will be required to demonstrate compliance by [date]

The new standards framework has already introduced further powers to the Welsh Language Commissioner. Their new powers include sanctions for public organisations who fail to comply with the Standards. This could ultimately lead to a fine of up to £5000 for each non-compliance.

The aims and objectives of the More than Just Words Strategy and the current Welsh Language Scheme have now been integrated into one single Welsh Language plan (Annex 1) for the organisation. We are the only Health Board to have done this. This approach means Clinical Boards can see more clearly the actions they are required to undertake.

ASSESSMENT AND ASSURANCE

The organisation's work in ensuring progress on the More than Just Words Strategy has had successes and challenges.

Successes include spreading awareness of the Welsh language and the importance of our staff providing Welsh language care. This is done, for

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example, through Corporate Induction, which provides all employees with information about Welsh Language awareness. The mandatory training programmes also include a section on Welsh language awareness, encouraging staff to use their Welsh language skills and explaining why it's important to do so. Further, an e-learning package on Welsh Language awareness has been introduced through the ESR system.

The principal of 'active choice' has progressed. The organisation has been successful in including patient language choice into its patient management systems such PMS and Paris. Therefore, patients can register their language choice and now receive appointment letters in Welsh if that is their preference.

The organisation is also promoting good practice in providing effective Welsh language care. The Welsh Language category of the annual Staff Awards has helped to find excellent examples of services offered by our staff to patients and service users in Welsh.

Lastly, the organisation has had some success in distributing the 'iaith gwaith' badge. The badge is a bright orange badge shaped like a speech bubble, which can be worn as part of the standard uniform or on a lanyard. These have been helpful for patient and service users to identify Welsh speaking staff.

The organisation also had challenges in achieving progress. Having the Welsh language mainstreamed, for example, into the recruitment process has been a slow process. Clinical Boards have expressed concerns that adding the Welsh language into the recruitment process could lead to a reduction in people applying for a position because they lack Welsh language skills. The Welsh Language Officer is in discussions on integrating Welsh language issues with the Clinical Boards to ensure that it doesn't not negatively affect recruitment.

The work in progressing the More than Just Words strategy has helped the organisation to prepare for the Welsh Language standards which are coming later on this year. The detailed requirement is unclear at the moment , but discussions with local authorities who already have their own specific Welsh Language Standards have provided us with some indications which we have already incorporated into the Welsh Language Organisational Plan. It is expected that the Standards and expectations will be much tougher than the current Welsh Language Scheme. The organisation needs to continue with this current plan and be prepared to revise or develop a new plan once the Welsh Language Standards are known.

Further updates will be provided to the R&D Committee when details are known.

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Principle	No.	Recommendation: More than Just Words Strategy	Recommendation: Welsh Language Scheme	How do we know?	What do we do to make it happen	Action delivered by	Target completion date	RAG	Progress
Service Planning and Delivery									
Mainstream the Welsh Language into policies and initiatives Integrating & the Welsh language into the policies of the organisation	1	3.4 NHS Wales departments planning and commissioning system, such as published service plans, to take account of the Welsh language community profile	1.2: ensure that all policies and initiative facilitate and promote the use of Welsh wherever possible and ensure no new policy or initiative undrmines the Welsh language scheme 1.2 assess the linguistic effect of any new and revised policies and initiatives and ensure that they are consistent with the Welsh Language scheme.	1. Annual assessment on percentage of policies which has assessed welsh language impact 2. Clinical Boards will have an explicit reference in their IMTP plans	1. Integrate into the EQIA process 2. Quality assurance mechanism developed to assess quality of WL considerations 3. Annual assessment conducted and reported to xxx	Welsh Language Officer / Policy Governance/Welsh Language Officer / Head of planning	Mar-18	Green	The Welsh Language is an active part of the assessment excercise
1.Integrating the 'active offer' priniciple into all aspects of the services. 2. Develop internal systems to ensure that services ask and respond to patients' language choice	2	1. the need to make an active offer of Welsh language service to people will be communicated to all staff directly emplyed within NHS services 2.NHS should map current provision and capacity to provide an active offer across all services (including primary care). Where capacity is low, an action plan should be formulated to increase capacity. The capacity	4.2.10 All Staff will be provided with Welsh language awareness training 1.3.1: Service Provisions: adopting procedures which facilitate service provision in either Welsh or English such as mechanisms for establishing language choice at the earliest opportunity and workforce planning.	1. All patients on PMS system have ticked their Welsh or English language preference 2. Clinical Board performance monitoring of language preference reporting and ability to meet need developed and reported quarterly to xxx 3. Reduction in WL complaints	1. Clinical Boards to include patients forms which include language choice onto their forms. 2. Clinical Boards to ensure that language choice is asked when welcoming patients 3. CBs to develop monitoring processes 4. WLO to discuss inclusion of monitoring in CB performance reviews	Welsh Language officer /Clinical Boards HOD's.	Mar-18	Green	The e-awareness package is now available on the ESR system. PMS now included language choice of either Welsh or English.
Ensure the primary care contractors offer Welsh language care for service users and patients	3	The Welsh Language needs of people to be met when commissioning or contracting services from the independent or third sector. Welsh Language provision to be included in contract specifications, service level agreements and grant funding.	1.4 Service provided by others: the UHB will ensure that the primary care services such as general practitioners, pharmacies, optometrists and nursing homes will comply with the scheme through our service level agreement.	1. Primary Care systems in place to capture and report on language choice 2. Reduction in number of complaints related to WL in primary care	1. Survey Welsh language skills of pharmacists and Dentists 2. update the Welsh language on the primary care section website 3. 3. Provide Welsh language lanyards to all Clinical Boards	PCIC Clinical Board/ Primary Care providers	Mar-17	Red	PCIC have established a working plan to ensure that the Welsh Language services are improved
1. Develop internal systems to ensure that services ask and respond to patients' language choice	4	NHS should map current provision and capacity to provide an active offer across all services (including primary care). Where capacity is low, an action plan should be formulated to increase capacity. The capacity to deliver an active offer to people with the identified groups with greater need for Welsh language services should be viewed as priority.	1.3.1: Service Provisions: adopting procedures which facilitate service provision in either Welsh or English such as mechanisms for establishing language choice at the earliest opportunity and workforce planning.	1. All CB's have an overall picture of their staff skills across their areas. 2. CB's provide clear evidence of welsh language intergrated into rostering.	1. Staff rostering to include language consideration 2. Patient management systems holding language choice 3. Develop awareness in Wards that they can integrate the Welsh language into rostering.	Clinical Board Head of Operation and Delivery	Mar-17	Amber	1. CBs given the Welsh language skills breakdown of their staff. 2. Staff rostering can include Welsh language skills
Offering a Bilingual Service									
Providing a public service for the patients and the public:	5		2.1 Correspondence: Standard correspondence bilingual / respond in Welsh to Welsh correspondence	1. Bilingual appointment letters to patients/service users.2. Clinical Boards to provide evidence of translated leafelts.	1. Work with RADIS team to develop bilingual letters. 2. Clinical boards to translate 10 leaflets over the financial year	Clinical Boards Head of Operations and Delivery	Mar-17	Green	PMS and PARIS can now provide bilingual appointments - Meeting with RADIS to develop their Welsh or English letters.
Effective communication with the patient.	6		2.2 Communication by telephone: welcome phone calls through the medium of Welsh.	1. Patients being able to use automated phone services in either Welsh or English. 2. Switchboard able to greet bilingually and able to communicate with simple welsh.	1. Bilingual automated telephone systems. 2. Encouraging staff to use their Welsh language skills over the phone	Clinical Boards Head of Operations and Delivery	Mar-17	Green	Official systems can include Welsh language choice i.e appointment confirmation. Working with Patient records to confirm language choice and approve appointment through text messaging.
Ensure that all patient appointment systems ask for the patient language choice at the start and inform staff member along the patient pathway.	7	Data systems in health, social services and social care services enable the service to operate bilingually to fulfill Welsh speakers' needs.	2.4.1: other meetings between the organisation and the patient. 2.4.4: Systems will be developed to establish language choice and refer Welsh speaking patients to Welsh speaking staff. Whenever possible, service teams will be organised so that bilingual staff are available to deal with Welsh speaking clients.	1. Patient appointment letters in Welsh or English. 2. Forms in Welsh and English for patients/service users. 3. Amount of the patients registering welsh language preference.	1. Linking staff with Welsh language skills with Welsh speaking patients 2. Offer language choice via forms 3. Offer bilingual appointment letters	Clinical Boards Head of Operations and Delivery IT Department, NEWIS, Clinical Board Head of Operation and Delivery	Mar-17	Amber	PMS and PARIS provide Welsh and English letters and can now log language preference of the patients. Organisation to shift focus on RADIS
Ensuring that staff with Welsh language skills are recognised and promoted	8	1.the use of the 'working welsh' logo will be promoted amongst health, social services and social care staff to enable people to indentify Welsh speakers. 2.pre-stiched 'working welsh logo on NHS Wales nurses uniforms will be extended to other professions	2.4 other meetings: Staff who are fluent in Welsh will be encouraged to wear badges and/or the Working Welsh logo indicating their ability to deal with enquiries in Welsh.	How many staff who are wearing the iaith gwaith badge on their uniforms?	1. Co-operating with Clinical Boards and procurement to have iaith gwaith on uniforms 2.1. An active campaign to distribute the use and awareness of the 'iaith gwaith' badge amongst staff and patients	Clinical Baords Head of Workforce and Organisational Development / Welsh Language Officers	Mar-17	Green	Clinical Boards given breakdown of their welsh language skills / lanyards and working welsh have been distributed through awareness sessions.
Developing the welsh speaking workforce	9	Heads of services to develop plans to maximise their ability to provide services in Welsh with their current Welsh-speaking staff.	4.2. Welsh Language and Vocational Training	How many job descriptions which has described in detail the Welsh language skills?	1. Clinical Board to provide 3 most popular job specifications	Clinical Baords Head of Workforce and Organisational Development / Welsh Langauge Officers	Mar-17	Green	3 job descriptions received from HOWODS.Co-operating with Specialist Clinical Board to gradually integrate the Welsh language into the
Promoting the message of bilingualism by the organisation	10	The published annual report of health boards, trusts and of Directors of Social Services should include a committment to providing and developing Welsh language services		1. Make statement recognising the Welsh language as an important park of healthcare	1. Working with our communication team to organise a statement as part of the annual report	Welsh Language Officers/Communication Team	Mar-18	Green	Discuss the idea with the Comms team during quarterly meeting

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Principle	No.	Recommendation: More than Just Words Strategy	Recommendation: Welsh Language Scheme	How do we know?	What do we do to make it happen	Action delivered by	Target completion date	RAG	Progress
Recgonising and awarding excellent practice	11	Best Practice in providing Welsh language services to be shared to all staff involved in delivering health services.		How many nominations did we recieve for the category of Welsh language category of staff awards? How many nominations we put into the annual welsh language in healthcare awards?	1. To sought out good working practice acroos the organisation 2. Co-operating with nursing staff to discuss potential good work	Clinical Boards Head of Operations and Delivery, Welsh Language Officer	Mar-18	Green	5 good practice nominations were submitted to the More than Just Words celebration event.
Developing a bilingual workplace	12	Welsh Language interfaces and software to be available for health, social services and social care services to enable and help them to work bilingually.	2.6.2 The UHB will ensure that both languages are treated on the basis of equality within its information technology systems.	1. How many staff members have integrated the Welsh language onto their computer 2. How is IT making Welsh language options available.	1. Raise awareness of availability of Windows and Microsoft Office in Welsh	Welsh Language Officer/ Head of IT/Internal communication	Mar-17	Red	New microsoft system demands payment for Welsh language package.
Patient Feedback and the Welsh language: Looking for patient experience.	13	All service audits should include questions relating to people's perception of the availability of Welsh language service provision from the service provider, alongside the Welsh speakers' experiences of those services.	3.4 The UHB will ensure that all forms, questionnaires and explanatory materials provided for the public in Wales will be totally bilingual.	How many response through patient experience " A minute of your time" and HIPPO surveys which points out the Welsh language serices?	1. Developing bilingual patient feedback forms. 2. Work with patient experience teams in patient response surveys	Welsh Language Officer/ Patient Feedback Group/ Heads of Delivery and organisational development	Mar-17	Amber	Patient experience asks question on the standard of Welsh language services received.
Recruitment & Training									
Putting the Welsh language as part of the long term plans of the organisation.	14	The IMTPs of health boards and trusts should consider the current and future requirements for Welsh language service provision to inform NHS organisations' workforce strategy and education commissioning		To what extent is the Welsh Language is focused in the IMTP? Does it provide details on objectives on how to improve Welsh language care?	1. Develop a section on how the IMTP will consider the Welsh language	Welsh Language Officer / Head of planning	Mar-17	Green	Welsh Language part of the IMTP, including setting out requirements of the More than Just Words strategy
Working with education providers to develop Welsh speaking healthcare staff	16	Staff training to deliver services in Welsh, focusing in particular on encouraging Welsh speakers to use their language skills in the workplace, will be supported. Language training opportunities and resources to increase the confidence of staff to deliver services in Welsh will also be promoted.	4.2.1: the UHB is committed to support Welsh Language training for its staff, to facilitate the implementation of the scheme and will promote a culture where we encourage our staff to speak Welsh.	How many staff members have attended Welsh language awareness sessions? How many members of staff have attended Welsh language lessons? Has there been a committee/management board which has started with a Welsh language patient story?	1. Develop staff/patient stories about the importance of Welsh langauge care. 2. Promote the free Welsh language lessons to all staff 3. Ensure that Staff can attend Welsh Language Awareness sessions through mandatory and induction.	Welsh Language Officer/ Heads of Workforce and Organisational Development/ Nursing Directorate/LED	Mar-18	Amber	26 members of staff currently doing the online course with a total of 60 people interested in particpating. 3 people registered to do the 5 residental course. Welsh Language awareness part of mandatory training/Awareness course part of the ESR training system/ Promoting Shwmae Day.
Working with education providers to develop Welsh speaking healthcare staff	17	HEIs, FEIs, social services and NHS organisations to work in partnership to ensure that the value and benefits to service providers and to Welsh-speaking people of having bilingual staff are reflected in their recruitment, commissioning and staff development processes. Careers Wales can help by assisting the organisations to accurately target their promotional work to Welsh speakers.	5.3 Recruitment section	Is the organisation co-operating with higher and further education to help recruitment of Welsh speaking nursing and medical staff? Have the organisation met with Career Wales and developed a working relationship.	1. Co-operate with local colleges and universities on encouraging Welsh speaking students.	Welsh Language Officer/	Mar-18	Amber	Representation going to the careers fair at the Fitzalan High School and the Coleg y Cymoedd FE college.
Working with education providers to develop Welsh speaking healthcare staff	18	1. Welsh Language Officers (within the NHS Wales) and Welsh Language Champions (within social services) to become Business Ambassadors with Careers Wales. 2.In partnership with the Welsh Government, health boards and social services departments to explore how both practising professionals and those undertaking education and training programme in Wales might engage in the widening access agenda. to promote the need for Welsh-speaking staff in the health, social services and social care sectors within schools and FEIs in Wales.	Recruitment 4.1.9	How many schools/colleges we have engaged with us? How many schools and college careers fair has the organisation attended?	Work with local schools and attend open days	Welsh Language Officer	Mar-18	Amber	Welsh language officer contact local schools to be involved in their open days.
Developing Staff awareness of Welsh language in healthcare	19	An awareness of the link between linguistically-sensitive services and individuals' dignity, as well as awareness of the Active Offer to be delivered to all NHS Wales, social services and social care staff as part of routine induction sessions. NHS Wales staff should also complete the Welsh Language Awareness e-learning module as a priority.	4.2.10 - All staff will be provided with language awareness training	How many staff have attended our Welsh language awareness sessions? How many staff have used our Welsh language awarness package?	1. Develop the e-learning package on Welsh language awareness 2. Integrate Welsh language awareness into other areas of staff training i.e Children.	Welsh Language Officer/ LED/ Heads of Workforce and Organisational Development	Mar-17	Green	Awareness training taking place at mandatory training and corporate induction. E-learning package now available on the ESR system. LED regularly provides data on those who've completed their awareness sessions.
Welsh language as part of the staff development within the organisation	20	NHS organisations should ensure that Welsh language skills are mainstreamed into the KSF (Knowledge and Skills Framework) as core competencies.	4.2.5 The UHB will ensure funding is made available to support Welsh language training via the NHS personal development plan process	Is the Welsh language part of our KSF/PADR assessment as a category?	1. Discuss the requirements with head of workforce and organsiational development about integration.	Welsh Language Officer/ LED/ Heads of Workforce and Organisational Development	Mar-18	Red	Lack of progress. No other health Boards have been able to progress.

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APPROVAL OF BUSINESS CONTINUITY POLICY & GUIDANCE
Name of Meeting: Resources and Delivery Committee **Date of Meeting:** 30th January 2018

Executive Lead: Executive Director of Planning and Strategy.
Author: Emergency Preparedness Manager.
Caring for People, Keeping People Well: The Business Continuity (BC) Policy underpins the 'Sustainability' and 'Values' elements of the Health Board's Strategy by establishing a process that will:- • Incorporate a set of agreed plans and procedures to respond to a business disruption that could adversely affect the productivity/normal operating of CVUHB; • Mitigate the impact of a disruptive challenge; • Provide guidance on the recommended methods to rapidly recover the situation.
Financial impact: Not applicable
Quality, Safety, Patient Experience impact: Not applicable
Health and Care Standard Number: Safe Care: Standard 2.1 - Managing Risk and Promoting Health and Safety.
CRAF Reference Number: Objective 06, Resources - 'All the UHB's resources: money, staff, estates and equipment are maximized to deliver the best possible care.' • Workforce: 6.2, Insufficient numbers of well trained, skilled and competent staff in some areas (see also 7.1) • Workforce: 6.2, Effective Leadership & Management
Equality and Health Impact Assessment Completed: Not applicable.

11.1

ASSURANCE AND RECOMMENDATION:

ASSURANCE that the Emergency Preparedness, Resilience and Response (EPRR) team has reviewed and updated the BC policy and BC Planning Guidance to reflect internal audit recommendations as well as organisational, and legislative changes.

The Resources and Delivery Committee is asked to:

- **APPROVE** the BC Policy and BC Planning Guidance.

and

- **APPROVE** the full publication of the BC policy and BC Planning Guidance in accordance with the UHB Publication Scheme.

SITUATION

Since October 2010, Cardiff & Vale University Health Board (UHB) has had a BC policy and BC Planning Guidance, promoting a culture of business continuity management, to instill confidence in its stakeholders (staff, patients and customers) in its ability to effectively deal with and recover from disruptive challenges.

BACKGROUND

In November 2014, an internal BC audit was undertaken, and the report finalised in February 2015. This highlighted three issues which resulted in an overall rating of 'Limited Assurance'. All three were addressed and recognised in the follow up visit. A subsequent report was produced in 2016, with a more detailed list of recommendations.

ASSESSMENT AND ASSURANCE

The BC Policy and Planning Guidance have been reviewed (August 2017) and updated to reflect the audit recommendations, organisational, and legislative changes. This has led to the following revisions to include:

- A revised scope specifying the inclusion of UHB services, information technology systems, business processes, personnel and utilities such as power and gas; and examples of incidents which may cause a business disruption. (Guidance Section 1.4)
- The identification of key clinical and support services. (Guidance Section 1.5)
- Further clarification the accountability and responsibility of the:
  - Chief Executive;
  - Executive Director of Strategy and Planning;
  - Chief Operating Officer;
  - Medical Director and Executive Director of Nursing;
  - Strategic Communications Director;
  - Emergency Preparedness, Resilience and Response team;
  - Clinical Board triumvirate teams;
  - Directorate Managers / Service Leads;
  - All staff;
  - Corporate departments;
  - Capital Planning, Estates and Operational services.
    (Guidance Sections 1.6 & 1.7)
- The introduction of a command and control element, firmly linking this policy to the arrangements set out within the UHB 2017 Major Incident Plan. (Guidance Section 5.4).

11.1

Further to this BC Policy and Planning Guidance update; work to revise and strengthen the 'template' BC Plan, and the training and monitoring arrangements has taken place.

The EPRR team will collaborate with the Chief Operating Officer to ensure that a quarterly forum is in place to agree, monitor, and review consistent BC practice throughout the UHB.

The Clinical Boards, Corporate Service Board (and critical corporate departments such as IM&T) must have an identified lead individual to attend the forum. The forum will produce a quarterly BC report for Management Executive and an annual BC report to the Board for assurance.

Consultation has taken place to ensure that the BC policy and BC Planning Guidance meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The documentation was added to the Policy Consultation pages on the intranet between 4th October and 1st November 2017;
- Comments were invited via individual e-mails from Executive Directors, the Clinical Board Triumvirates, Directorate Managers and other key Service Managers.

The primary source for dissemination of the BC policy and Planning Guidance within the UHB will be via the intranet. The external publication of the full document will be restricted as it contains information that could result in a threat to the security of the UHB or a risk to the health and safety of employees, patients or visitors.

The title of the document only and the Equality Impact Assessment will be published on the UHB Internet with a statement advising that anyone seeking further information should make a request in accordance with the requirements of the Freedom of Information Act.

Reference Number: UHB50 **Version Number:** 06	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** N/A

BUSINESS CONTINUITY POLICY

Policy Statement

The UHB will promote a culture of business continuity management (BCM). It will instil confidence in its stakeholders (staff, patients and customers) in its ability to effectively deal with, and recover from disruptive challenges.

The UHB will:

- Ensure statutory obligations and policy objectives are met;
- Seek to improve overall business resilience;
- Ensure that adequate business recovery arrangements and plans are in place;
- Safeguard its employees, clients or service users, and all stakeholders to whom the UHB has a duty of care;
- Preserve and promote the reputation of the UHB.

Policy Commitment

The Chief Executive, Executive Directors, the Chief Operating Officer, Assistant Directors, and Clinical Board Management Teams are committed to ensuring that business continuity (BC) processes are implemented, plans are written and brought to the attention of relevant staff in their Directorates.

Supporting Procedures and Written Control Documents

The supporting BC Planning Guidance describes the UHB BC process that will:

- Assist with the development and maintenance of agreed plans and procedures to respond to a business disruption that could adversely affect the productivity/normal operating of the UHB;
- Mitigate the impact of a disruptive challenge;
- Provide guidance on the recommended methods to rapidly recover the situation back to normal operation.

Other supporting documents include:

- Risk Management Policy (UHB 023)
- Major Incident Plan (UHB 053)
- Adverse weather Procedure (UHB 095)
- Bomb Alert and Suspect Package Procedure (UHB 234)

Scope

This policy applies to all staff including those with honorary contracts. Where the disruption of those activities impact on the wider community the UHB will engage with the community representatives and/or relevant partner agencies. This includes:

- All UHB services
- Information Technology systems (voice and data communications systems) – inclusive of disaster recovery.
- Business processes
- Personnel
- Liaison with utility providers i.e., power, gas

11.1

Document Title: **Business Continuity Policy**	2 of 2	Approval Date: dd mmm yyyy
Reference Number: **UHB50**		Next Review Date: dd mmm yyyy
Version Number: **6**		Date of Publication: dd mmm yyyy
Approved By:		

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact
Policy Approved by	*Resources and Delivery Committee*
Group with authority to approve procedures written to explain how this policy will be implemented	*Resources and Delivery Committee*
Accountable Executive or Clinical Board Director	Executive Director for Strategy & Planning

Disclaimer

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

Summary of reviews/amendments

Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Unknown		• Information not available
2	October 2010		• Approved by Planning Committee
3	May 2012		• Information not available
4	April 2014		• Approved by HSMB
5	March 2015		• Approved by HSMB
6	DD MMM YYYY		• A revised scope specifying the inclusion of UHB services, information technology systems, business processes, personnel and utilities such as power and gas; and examples of incidents which may cause a business disruption. • The identification of key clinical and support services. • Further clarification the accountability and responsibility • The introduction of a command and control element, firmly linking this policy to the arrangements set out within the UHB 2017 Major Incident Plan.

11.1

Equality & Health Impact Assessment for

BUSINESS CONTINUITY POLICY (UHB50)

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	**Title:** Business Continuity Policy (UHB50)
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	**Executive Lead:** Executive Director of Planning and Strategy. **Author:** Head Emergency Preparedness, Resilience and Response, 029 21 847737.
3.	Objectives of strategy/ policy/ plan/ procedure/ service	This policy provides a clear commitment to BC which enables the UHB to: • Develop organisational resilience to mitigate the likelihood of disruption of critical infrastructure; • Facilitate enhanced use of personnel and resources at times when both may be limited; • Reduce the period of disruption to the organisation; • Lessen the operational and financial impact of any disruption; • Continue to provide core services at pre-determined levels.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research	In 2015 there were estimated to be 357,160 people living in Cardiff, and 127,592 living in the Vale of Glamorgan. The population of the Vale is projected to increase by around 1% over the next 10 years; however this masks significant growth in the number of people aged 65 or over. The population of Cardiff is projected to increase by around 10% over the next 10 years, or around 35,000 additional people. While much of this growth is among people aged 65 or over, there is also projected to be

11.1

	• good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	considerable growth in the number of children and young people aged under 16. Ref: http://www.cvihsc.co.uk/about/what-we-do/population-needs-assessment In emergencies people are more likely to respond reliably if they:- • Have clearly agreed, recorded and rehearsed plans, actions and responsibilities. • Are well trained and competent. • Take part in regular and realistic practice. Consultation has taken place to ensure that the BC policy and Planning Guidance meets the needs of our stakeholders and the Health Board. The consultation undertaken specific to this document was as follows:- • The documentation was added to the Policy Consultation pages on the intranet between 4th October and 1st November 2017; • Comments were invited via individual e-mails from Executive Directors, the Clinical Board Triumvirates, Directorate Managers and other key Service Managers.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	This policy applies to all of our staff in all locations including those with honorary contracts.

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

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No specific impact at this stage other than noting the average age of in-house patients being in the 80's which could have a negative impact.	No action required at this stage. However, in the event of a trans individual requiring temporary accommodation Clinical Boards, Directorate Managers and Service Leads should seek to provide a plan for such circumstances.	No action required at this stage.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health	No specific impact.	In the event of a staff member noting that this might be an issue, Clinical Boards, Directorate Managers and Service Leads should seek to	No action required at this stage.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
conditions, long-term medical conditions such as diabetes		provide interpretation/translation services.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	No specific impact at this stage, however confidentiality issues would need to be addressed in terms of any temporary accommodation	No action required at this stage. However, in the event of a trans individual requiring temporary accommodation Clinical Boards, Directorate Managers and Service Leads should seek to provide a plan for such circumstances.	No action required at this stage.
6.4 People who are married or who have a civil partner.	No specific impact. This protected characteristic only applies to employment /	No action required.	No action required.

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How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	staffing issues. It does not apply to service provision.		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No specific impact at this stage. See Recommendations	In terms of pregnant women and this becoming an issue, Clinical Boards, Directorate Managers and Service Leads should seek to provide specific action plans.	No action required at this stage.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	No specific impact with the exception of those who may not use English as their first language.	In the event of a staff member noting that this might be an issue, Clinical Boards, Directorate Managers and Service Leads should seek to provide interpretation/translation services. .	No action required at this stage.

11.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No specific impact identified at this stage though this may be dependent on the time of the emergency	In the event of a religious issue arising, Clinical Boards, Directorate Managers and Service Leads should seek to provide contact with the Chaplaincy department.	No action required at this stage.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No specific impact identified at this stage.	No action required at this stage.	No action required at this stage.
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	No specific impact with the exception of those who may not use English as their first language.	In the event of a staff member noting that this might be an issue, Clinical Boards, Directorate Managers and Service	No action required at this stage

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11.1

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of vibrant culture and thriving Welsh language		Leads should seek to provide interpretation/translation services.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No specific impact identified at this stage.	No action required.	No action required.
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No specific impact identified at this stage.	No action required.	No action required.
6.12 Consider any other groups and risk factors relevant to this strategy,	No specific impact	No action required.	No action required.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
policy, plan, procedure and/or service			

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

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

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No specific impact.	No action required.	No action required.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	No specific impact.	No action required.	No action required.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No specific impact.	No action required.	No action required.
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods,	No specific impact.	No action required.	No action required.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No specific impact.	No action required.	No action required.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No specific impact.	No action required.	No action required.

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	No Impact.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Clinical Boards, Directorate Managers and Service Leads should seek to make provision in planning for age, equality, gender and religious issues which may arise as a result of a business disruption.	Clinical Boards		No action required at this stage.

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	The policy provides further clarification the accountability and responsibility of Clinical Boards, Directorate Managers and Service Leads regarding business continuity.			No action required.

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

8.4 What are the next steps?
 	
Some suggestions:-
• Decide whether the strategy, policy, plan, procedure and/or service proposal:
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	Revised policy to be approved and implemented.
	
	This EHIA will be monitored through/by the EPRR Team as part of the overall review process.
	
	It will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.
	
	The UHB standard is that all policies are reviewed within 3 years (1 year if a statutory requirement) Intranet for consultation, Executive Board.
				No action required.

Business Continuity Planning Guidance

Prepared by the Head of Emergency Preparedness, Resilience and Response

Version	Issue Date	Purpose / Changes	Author	Circulation
Version 01	**19/12/13**	Guidance for staff	**Head of Emergency Preparedness, Resilience & Response**	See distribution list
Version 02	**16/10/17**	Updated to reflect internal audit recommendations, organisational, and legislative changes.	**Head of Emergency Preparedness, Resilience & Response**	See distribution list

Purpose & Summary of Document

This guidance document supports the UHB Business Continuity Policy (Ref: UHB50).

It describes Cardiff and Vale University Health Board's (CVUHB) approach to Business Continuity Management, and provides practical advice and guidance to staff tasked with implementation.

It also incorporates the Business Continuity Management Planning Assessment Tool for capturing information gathered when analysing services, and the corporate template for Business Continuity Plans.

11.1

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Reference Number: **UHB??**		Next Review Date: **dd mmm yyyy**
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Approved By: **??**		

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Approved By: **??**		

Distribution List

The Business Continuity (BC) Planning Guidance (BC Guidance) document for Cardiff and Vale University Health Board (UHB) is formally distributed to, and held on file by:-

- Chief Executive
- Executive Director of Strategy and Planning
- Chief Operating Officer
- Medical Director and Executive Director of Nursing
- Strategic Communications Director
- Emergency Preparedness, Resilience and Response Team
- Clinical Board Triumvirate Teams
- Directorate Managers / Service Leads
- Corporate Departments
- Capital Planning, Estates and Operational Services

The Emergency Preparedness, Resilience and Response (EPRR) Team will retain responsibility for the annual review and maintenance of the BC Guidance, BC Policy and BC Plan on behalf of the UHB.

11.1

Further Information

Should additional information be required, please do not hesitate to contact the EPRR Team.

Tel: 029 21 847737 or 029 21 847734

Email: angela.stephenson@wales.nhs.uk or huw.williams15@wales.nhs.uk

1.0 Introduction

1.1 What is Business Continuity Management?

Business Continuity Management (BCM) is a planned process aimed at managing the many and varied operational risks inherent in the day-to-day activities involved in delivering services.

The main purpose of the process is to ensure continuity of service delivery following a business disruption. Examples of such incidents which may fall broadly into four categories:

- **Damage or denial of access to workspace**

  Evacuation of a department due to fire, structural damage (including flooding), contamination etc.

- **Loss or damage to equipment, or a system failure**

  Internal power failure, failure of significant medical devices, loss of specialist IT systems, failure of medical gas delivery system etc.

- **Non availability of critical staff**

  Industrial action, infectious disease outbreaks, environmental conditions (severe weather conditions) etc.

- **Non availability / disruption of other key resources including primary suppliers & utilities**

  External electrical power supply, gas supply, water supply, fuel shortage, communications system failure (telephones and pagers), collapse of procurement chain supplier etc.

The key considerations in developing a BCM response for the UHB include the:

- Identification of key clinical and support services and information in advance of an event, so that an informed decision can be taken on the extent to which such systems should be protected.
- Definition of the accountability and roles of individual officers – both in terms of responding to and recovering from a disruption;
- Determination of the resources required to maintain a minimum acceptable service;

It is the BC plan that provides the primary defence in ensuring an organised and effective ‘return to normality’.

This document aims to provide guidance in developing a BC plan, as well as demonstrating the importance and some of the benefits of the process.

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1.2 Aim

In support of the UHB BC Policy (Ref: UHB50):

This document aims to describe the UHB approach to BCM, and provide practical advice and guidance to staff tasked with implementation.

1.3 Objectives

- To explain in detail, the lifecycle of the BCM process.
- To outline the steps required in developing robust and resilient BC arrangements.
- To provide guidance for Clinical Boards, Directorate Managers and Service Leads in developing BC plans.
- To ensure the UHB meets the requirements of the Civil Contingency Act (CCA) 2004.

1.4 Scope

BCM (and the BC Guide) is relevant for all UHB activities and its employees. This includes:

- All CVUHB services.
- Information technology systems (voice and data communications systems) - inclusive of disaster recovery.
- Business processes.
- Personnel.
- Liaison with utility providers i.e. power, gas etc.

Where the disruption of these activities has an impact on the wider community, the UHB will engage with community representatives and/or relevant partner agencies.

Examples of UHB incidents which may cause disruption include:

Evacuation of a department:

- Fire
- Structural damage (including flooding)
- Contamination
- Exclusion by emergency services

Equipment or system failure:

- Internal power failure

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- Failure of significant medical devices
- Loss of specialist IT systems
- Failure of medical gas delivery system

Loss of primary suppliers and utilities:

- External electrical power supply
- Gas supply
- Water supply
- Fuel shortage
- Communications system failure (telephones and pagers)
- Collapse of procurement chain supplier

Planned or predicted service disruption:

- Industrial action
- Planned maintenance

Unavailability of critical staff:

- Infectious disease outbreaks
- Environmental conditions (severe weather conditions)

1.5 Key Services (Critical Activities)

BCM affects all parts of the UHB. Therefore each corporate function, support service and Clinical board will have BC plans utilising the template established for this purpose (refer to Appendix B).

The preparation of BC plans for critical activities will provide a series of targeted action plans to be implemented in the event of an incident.

Key Services have been split into two distinct areas:

1.5.1 Key Clinical Services

- Emergency unscheduled care
- Critical care
- Trauma and emergency surgical services
- Maternity, paediatrics and neo-natal care
- Emergency and clinically urgent diagnostics
- Acute mental health crisis service

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1.5.2 Key Support Services

- Information Technology and Telecommunications
- Estates inclusive of utility services and medical gases
- Laboratory services
- Facilities and Operational Services
- Payroll
- Human Resources
- Procurement chain

1.6 Accountability and Responsibility

The Chief Executive has overall accountability for compliance with legislation, although for BCM this is delegated to the Executive Director of Strategy and Planning as the "Executive Strategic Lead" for Emergency Preparedness, Resilience and Response (EPRR); and the Chief Operating Officer for implementation of the BCM process in line with existing Clinical Board authorisation processes.

The UHB Executive Board is responsible for reviewing the effectiveness of Internal Controls - financial, organisational and clinical. The Board is required to produce statements of assurance which demonstrate that it is doing its 'reasonable best' to ensure that the UHB meets its objectives and protects patient, staff, the public and stakeholders against risks to its business in line with the requirements of the CCA.

11.1

1.7 Individual Roles

1.7.1 Chief Executive

Ultimately responsible for ensuring the organisation meets its statutory obligations under the CCA and complies will all relevant EPRR guidance for the NHS, including non-statutory guidance that accompanies the CCA.

The Chief Executive has overall responsibility for:

- The management structures and systems necessary to implement corporate governance, controls assurance standards including BCM.
- Meeting all statutory requirements to manage risks to normal business operations.
- Adhering to guidance issued by the Welsh Government in respect of resilience and BCM.

- Ensuring that the UHB receives an annual report on the effectiveness of organisational systems.
- The BC policy and this guidance are subject to regular reviews in line with the UHB's policy document, and that measures for implementing the policy are established, maintained and monitored.
- Funding for action required as a result of the business impact analysis is provided.
- There are competent people who have the knowledge and training to carry out appropriate business impact assessments.

In practice the actions necessary to ensure compliance will be delegated to the nominated Strategic leads - namely the Executive Director of Strategy and Planning, and the Chief Operating Officer - who will discharge the duty on behalf of the Chief Executive.

1.7.2 Executive Director of Strategy and Planning

As the Executive Strategic Lead the post holder has responsibility for leading on BCM, and will ensure that there is a suitable overarching system and process in place to enable success.

S/he will oversee the EPRR agenda within the UHB by means of receipt of annual reports to Executive Board.

1.7.3 Chief Operating Officer

The COO will ensure implementation of, and compliance with the BC policy and BCM process within Clinical Boards.

In alignment with the Clinical Board authorisation process, the COO will ensure that BC planning becomes a routine agenda item for both Governance and Audit meetings. Collectively these actions will promote:

- Delivery of a structure which can be used to strengthen resilience during times of disruption.
- Identification and risk assessment of potential threats to, and weaknesses of the organisation.
- Aid preparation, prevention and recovery from the identified risks and potential disruption.
- Support the continuance and recovery of core critical services.
- Promote return to business as usual.
- Defend and protect stakeholder interests.
- Ensure reputational integrity of the UHB.

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1.7.4 Medical Director and Executive Director of Nursing

The Medical Director and Executive Director of Nursing have particular responsibilities for Governance, patient safety and investigating serious adverse incidents.

If the incident directly impacts patients, staff or visitors they must be notified by the Clinical Board management structure (or the Senior Manager on Call (SMOC) out of hours).

Any serious incident which necessitates activation of a BC plan must be reported through e-Datix for escalation, investigation and debrief.

1.7.5 Strategic Communication Director

CVUHB has a statutory duty in relation to "Warning and Informing" pre, during and post any incident.

The post-holder will be part of any major incident response or serious BC event. It is paramount that they are actively involved in the activation of all EPRR and BC response plans.

Forward planning is essential to achieving effective communication with all stakeholders. The success of any incident response will be beholden in part to the UHBs ability to communicate key messages quickly and efficiently. The Communications Team will have a communication strategy with a plan and pre-prepared statements ready for release in the event of a significant BC incident.

1.7.6 Emergency Preparedness, Resilience and Response team

At a Strategic level, support for UHB wide plans will be via the Head of EPRR who will provide expert advice and guidance on the development and delivery of the BCM process.

The EPRR programme manager will provide guidance to Clinical Board Directors / Heads of Service to enable development and maintenance of BC plans for their areas of responsibility.

Further, the EPRR team will ensure that a quarterly forum is in place to agree, monitor, and review consistent practice throughout the UHB. The Clinical Boards, Corporate Service Board (and critical corporate departments such as IM&T) must have an identified lead individual to attend the forum.

This forum will collaboratively produce a quarterly BC report for Management Executive and an annual BC report to the Board.

The EPRR team will retain responsibility for annual review of the BC Policy, corporate guidance and plan template; and for providing both internal and external assurance, as required by the Executive Strategic Lead.

1.7.7 Clinical Board Triumvirate team

Clinical Board leadership teams are instrumental in achieving the requirements of this policy, and are accountable to the COO for ensuring implementation of the BC policy within their area of responsibility. Specific responsibilities include:

- Identification of managers/clinicians who will co-ordinate business impact assessments and the resulting BC / contingency plans.
- Align BC planning against any known risks within the Clinical Boards Risk Register;
- Make sure any business impact assessments that have a potential Corporate impact are communicated to the COO;
- Ensuring representation at the EPRR / BC; Major events planning and other associated committees, as required.
- Identify staff to attend BC awareness sessions (to be arranged through the EPRR team);
- Work with corporate teams e.g. Information Technology / Estates /operational Services to develop their plans and ensure collaborative working.
- Identify the need for additional funding or other resources within the directorate as a result of undertaking business impact assessments is identified;
- Produce reports to the UHB in order to confirm that all business risks identified have suitable and sufficient plans that have been fully and effectively tested and are reviewed regularly.
- Ensure post incident debriefs are undertaken as/when required and plans are revised as required.

1.7.8 Directorate Managers / Service Leads

Directorate managers and service leads will be responsible for the actual business impact analysis and subsequent development of their plans.

This will necessitate the documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable the organisation to continue to deliver its critical activities at an acceptable pre-defined level.

All local/operational BC plans will require approval and sign off by Clinical Boards who must retain an overarching view of all plans.

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1.7.9 All Staff

All staff must have a basic awareness of EPRR and BC, other responsibilities include;

- Attend training appropriate to their roles.
- To act in line with the BC process, EPRR policies and plans, where applicable.
- To report any adverse incidents, or potential BC risks to their line manager for assessment.

To ensure that their line managers are advised of any changes to their personal contact details, particularly their home address and telephone number(s) as these will be used to contact staff during an emergency.

1.7.10 Corporate Departments

It is essential that corporate departments are fully engaged within the BC process. All plans must routinely be cross referenced against the work of the EPRR team, and other Corporate Groups such as Health and Safety; Governance and Risk Management.

Individual corporate functions which provide key services e.g. Finance; Information Technology; Workforce and Procurement must have in place robust BC plans in the same manner as clinical services.

NB. Process should mirror actions listed in points 1.7.7 through to 1.7.9.

1.7.11 Capital Planning, Estates and Operational services

It is possible that specialist support will be needed in some circumstances e.g. widespread utility failure; Fire; Chemical spillage or building instability. Subject matter experts can be accessed by the relevant Directorate/service manager, via the Capital Planning department.

1.8 Equality Statement

The UHB is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment or gender identity and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the policy. It takes into account the requirements of the Equality Act 2010 and progresses equal opportunities for all.

In carrying out its functions, the UHB must have due regard to the different needs of different protected characteristic groups in our area. This applies to all the activities for which the UHB is responsible, including policy development,

review and implementation. The UHB's commitment to equality means that this guidance (supporting the UHB BC Policy (Ref: UHB50)) has been assessed in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

By committing to a policy encouraging equality of opportunity and diversity, the UHB values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The UHB is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence for the benefit of staff, patients and their families/carers.

The UHB will therefore take every possible step to ensure that this policy is applied fairly to all employees regardless of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment or gender identity and pregnancy/maternity or any other basis not justified by law, length of service, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor.

Where there are barriers to understanding; e.g., sensory loss issues or an employee has difficulty in reading or writing or where English is not their first language or where there are barriers to access in regard to someone's disability additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee or patient/family member/carer is not disadvantaged at any stage in the process.

The purpose of this UHB BC Policy is to maintain essential services and thereby maintain appropriate access to our services regardless of the protected characteristics of patients and their families/carers our service users and our staff. We know that there may well be an impact in regard to age and disability protected characteristics in terms of communication and mobility issues.

Specific planning for the needs of individual patients and their families/carers and staff and their protected characteristics in the event of an emergency is managed at a Clinical Board level

The Protected Characteristics of those members of staff who have specific responsibilities in the event of a Business Continuity response i.e. Clinical Board Directors and On Call Managers have all been considered at the point of appointment to the role.

Business Continuity Plans and planning are necessary to assist in minimising the impact of a business disruption on any patient, family members/carers of members of staff in the event of any plan being invoked.

Care will be taken by those writing BC plans that no one's protected characteristics are impacted on in a negative way. Every attempt will be made to mitigate where possible these circumstances

2.0 Business Continuity Management

2.1 Why have BCM?

BCM has evolved primarily as a result of private sector risk management requirements and experience, and requires some modification before it can be effectively applied within NHS Wales.

In the private sector, risk is assessed in terms of how a disruption might adversely affect the value of the business as perceived by shareholders and financial markets. Whilst in the public sector, risk is more about failure to deliver quality services to the communities it serves

The UHB has key organisational objectives, some of which will be based on statutory requirements. All will be aimed at providing and improving services to the health and social care community.

Any failure, actual or perceived, to deliver a full range of services will have a negative impact on both the UHB and wider community.

Every business activity is at risk of disruption from a variety of hazards and threats, which vary in magnitude.

For example, a minor electrical fire or a burst water pipe may cause limited damage to assets; but if those assets are vital to service delivery, then the result can seriously impair the UHB's ability to deliver that service.

As such, all reasonable measures should be adopted to minimise the likelihood of business or service interruption.

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2.2 Risk and BCM

BCM is an important constituent of risk management. It identifies the services which the UHB must deliver, and can identify what is required for the organisation to continue to meet its obligations.

Through BCM, the UHB can recognise what needs to be done before an incident occurs to protect its people, premises, key clinical and support services, and reputation.

With that recognition, the UHB can then take a realistic view on the responses that are likely to be needed as and when a disruption occurs, so that it can be confident that it will manage any consequences without unacceptable delay in delivering its services.

2.3 The BCM Lifecycle

BCM has a lifecycle which splits into four stages:

Stage	Activities	Section
1	**Understanding the Organisation**	**3.0**
	Identify the specific services your area delivers	
	Identify red, amber, green and black services	
2	**Determining the BCM Requirements** *(Using BC Planning Assessment Tool)*	**4.0** *Appendix A*
	Business impact analysis	
	Risk assessment	
	Risk reduction & continuity options	
3	**Developing the BCM Response**	**5.0**
	Implement risk reduction measures	
	Develop BC plans (Incl. initial training, testing & sign off)	*Appendix B*
	Links to wider UHB arrangements	
4	**Train, Exercise, Maintain & Review**	**6.0**
	Train Staff	
	Exercise Plans	
	Maintain & Review	
	Assurance	

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3.0 Understanding the Organisation

BCM is NOT a one-off project. It is a continuous process which must maintained to ensure that plans are current, relevant and executable.

- Clinical Boards, Directorate Managers and Service Leads are required to identify the specific services it delivers.
- The specific services must then be categorised as considering the criteria in the table below:

Priority	Definition
Red	Critical service needing to be restored within 0-1 hour.
Yellow	Essential service needing to be restored within 1-12 hours.
Amber	Significant service needing to be restored within 12-24 hours.
Green	Routine service needing to be restored within 3 - 5 working days.
Black	A service which can be restored progressively after 5 working days.

This exercise is just an initial guide to prioritise the services to be taken through the BCM process according to their time criticality.

Clinical Boards, Directorate Managers and Service Leads must consider the impact of loss in respect of:

- Loss of or threat to life
- Human welfare
- Environment
- Legal obligations
- Finance
- Reputation
- Ability to respond to emergencies

4.0 Determining the BCM Requirements

At this stage, Clinical Boards, Directorate Managers and Service Leads will begin to determine how services will be maintained in the event of a business disruption.

INFORMATION MUST BE COLLECTED IN A BCM PLANNING ASSESSMENT TOOL WHICH WILL ENABLE DECISIONS TO BE MADE ON:

- The reduction of risk to service delivery prior to any disruption.
- The requirements for facilitating effective recovery in the event of a disruption.

NB. A template BCM Planning Assessment Tool with supporting notes has been developed to assist Clinical Boards, Directorate Managers and Service Leads.

This information will form the back bone of the BC Plans that will be completed.

Information collected in the BCM Planning Assessment Tool will come through the completion of three related tasks:

4.1 Business Impact Analysis (BIA)

The BIA provides the narrative which:

- **Outlines the details of the service, and its method of delivery.**

  At this point, Clinical Boards, Directorate Managers and Service Leads need to determine what is provided, to whom, how, when, where and why.

  This provides clear scope and a statement outlining the specific service(s) actually delivered. In addition, a full inventory of resources normally employed should be compiled.

- **Identifies the range and determines the severity of different impacts (on ALL stakeholders) of NOT providing the service.**

  Any failure, actual or perceived, to deliver a full range of services will have a negative impact on both the UHB and wider community

  Clinical Boards, Directorate Managers and Service Leads need to identify these impacts – consideration may include:

  - Risk to patient safety
  - Risk to workforce or public safety.
  - Loss of operational capability.
  - Breach of the law.
  - Political or corporate embarrassment.

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- Financial loss / reduced income.
- Loss of goodwill.
- Loss of credibility.
- Increased cost of working.
- Financial penalties.

- **Determines how quickly the service needs to be re-instated.**

  If serious impacts have been identified, then swift reinstatement action may be needed. This will be reflected in the special time considerations (section of the BCM Planning Assessment Tool), which is an indication of the time period within which to achieve a minimum acceptable resumption of that service.

  NB. A planning assumption has been made that the UHB will achieve a 'normal service' within a maximum of one month. However, this does NOT mean everything will be reinstated to a level equal to that prior to the disruption.

  For example, a damaged building may take longer to repair than one month, and this could mean that staff may have to continue to work from temporary locations.

- **Quantifies the resources that will be required to enable the service to be re-instated within the timescales specified.**

  Clinical Boards, Directorate Managers and Service Leads need to determine the minimum resources required to meet the special time considerations. It would be desirable to use the resources normally employed, but this is not likely to be feasible, and would not reflect reality.

  NB. A planning assumption has been made key clinical and support services should be delivered without reliance on corporate ICT/ Property services/ HR support for up to 3 days following a disruption.

4.2 Risk Assessment

Risk assessment for the purposes of BCM is a careful examination of a service to identify the areas which are most likely to be disrupted.

Clinical Boards, Directorate Managers and Service Leads should utilise the current UHB Corporate Risk Assessment Framework (CRAF) to support this activity.

UHB Health and Safety Policy must be applied, ensuring that risk within buildings relating to issues such as fire and building security are managed effectively.

Specific, foreseeable threats to service should be identified. To support this process it is helpful to review any business disruption which has occurred within the last 5 years.

The assessment will identify the severity of the impacts on which could result in one or more of the following:

- Damage or denial of access to workspace.
- Loss or damage to equipment, or a system failure.
- Non availability of critical staff.
- Non availability / disruption of other key resources including primary suppliers & utilities.

The outcome of the assessment will determine measures to manage the impacts of business disruption.

4.3 Risk Reduction & Continuity Options

Clinical Boards, Directorate Managers and Service Leads should consider the impacts on the service, whether any cost effective risk reduction measures can be implemented to address the risk, or reduce it to an acceptable level.

- **Risk reduction options**

Risk Reduction options are measures taken to reduce the likelihood of a disruption occurring.

Where the risk cannot be reduced to an acceptable level, Clinical Boards, Directorate Managers and Service Leads should consider all recovery options.

- **Continuity options**

Continuity options are measures that need to be taken following a disruption in order to resume service provision, and assist the UHB in its return to normality.

Continuity options may include the identification of alternative work areas, temporary staffing options and/or manual workarounds if an IT failure occurs etc.

11.1

5.0 Developing A BCM Response

At this stage Clinical Boards, Directorate Managers and Service Leads should establish a work programme for BC within their area of responsibility.

This will include the implementation of risk reduction measures and the development/testing of recovery plans and procedures.

5.1 Implement risk reduction measures

Subject to value-for-money considerations and approval from the Clinical Board, these measures should be implemented speedily.

Delays in introducing risk reduction measures could mean the service carries a higher than necessary risk of disruption or interruption.

NB. Some risk reduction measures will themselves be procedures, and managers should ensure that all staff with a role to play clearly understand what is expected from them. This may involve the provision of training.

5.2 Development of BC Plans

Clinical Boards, Directorate Managers and Service Leads should include the agreed continuity measures in a BC plan.

Again, managers should ensure that all staff with a role to play clearly understand what is expected from them. This may involve the provision of training.

The plan must be tested and signed off by the Clinical Board.

NB. A template BC Plan has been developed to assist Clinical Boards, Directorate Managers and Service Leads.

5.3 Link to wider UHB Plans

So far, this guidance document has focused on developing BCM arrangements for a single service. Any disruption large or small will, however, have some implications for the wider organisation.

If a large disruption occurs affecting more than a single service it may be appropriate to trigger other activities to help the UHB recover or protect itself from further effects of the disruption.

This includes:

- An emergency response.
- Incident management.
- Damage assessment.
- Salvage and recovery of assets;
- Communication with staff, customers, partners and suppliers.

These are outside the scope of the single service BC plan (although they rely on information from Clinical Boards, Directorate Managers and Service Leads), but are nevertheless vital to ensure the eventual return to normality.

5.4 Command & Control

Each BC plan must clarify the reporting procedure to be followed (both in and out of normal office hours) to ensure the response is activated in a timely fashion.

For many incidents this will be sufficient, and the issue can be resolved at an operational management level. However, dependent upon the nature, scale, severity, and predicted length of the disruption it may be necessary to implement the formal Command, Control and Co-ordination process normally associated with a major incident declaration.

Command, Control and Co-ordination are important concepts in the multi-agency response to emergencies. A nationally recognised three tiered structure known as Strategic (Gold), Tactical (Silver) and Operational (Bronze) has been adopted by the emergency services and most responding agencies.

The UHB Command and Control arrangements are based upon this system. These arrangements help to ensure interoperability between responders and are set out within the UHB 2017 Major Incident Plan, Section 5.

6.0 Train, Exercise, Maintain & Review

The final stage of the lifecycle ensures that the arrangements continue to be exercised, maintained and reviewed on an on-going basis.

6.1 Train

Staff awareness of the BC Policy and plans is essential to the on-going success of the initiative, and awareness programmes are an integral part of this stage helping to embed BCM at the UHB.

An ongoing programme of education and awareness should ensure that:

- Staff understand the risks, remain vigilant and know how to respond.
- Changes or issues that could affect the UHB's BC Plans are identified and acted upon.
- Team members remain fully aware of their responsibilities and the actions expected from them.

NB. Some staff may require specific training on particular elements of BC Plan.

6.2 Exercise

Clinical Boards, Directorate Managers and Service Leads can achieve this through a combination of discussions, table-top and live exercises.

Exercising is an excellent way to raise awareness for those with continuity responsibilities. Experience shows that the more rigorously that a plan is exercised the greater the benefit to those involved and to the organisation when faced with a real disruption. Ideally, exercises should be carried out at least every 12 months.

6.3 Maintain & Review

BCM is an ongoing process and needs to be constantly updated and improved. Reviewing the BCM process and building BCM solutions must also be an ongoing process. Integration of BCM in to the culture of the UHB via its policies and procedures is essential to build resilience and safeguard our services.
The EPRR team will retain responsibility for annual review of the BC Policy, corporate guidance, assessment tool and plan template; and for providing both internal and external assurance, as required by the Executive Strategic Lead.

6.4 Assurance

The final process in the BCM lifecycle for the UHB involves obtaining assurance that the quality of the BCM deliverables is acceptable to senior management and the operational processes work satisfactorily.

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Clinical Boards are responsible for providing assurance to the Chief Operating Officer (& EPRR team) that the risk reduction measures introduced and the BC Plans developed are fit for purpose.

The EPRR team will also provide internal and external assurance, as required by the Executive Strategic Lead.

NB. Improvements in this process, the development of this guide and BCM solutions for the UHB are an ongoing task which requires a continuous commitment of time and resource.

6.5 Retention & Archiving

In cases of Police investigations/public enquiries and other legal processes it is often necessary to demonstrate that the policy in place at the time of the incident. The Director of Governance must therefore ensure that copies of policies and procedures are archived and stored in line with the UHB Records Management Policy and are made available for reference purposes should the situation arise

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7.0 The Next Steps

Clinical Boards, Directorate Managers and Service Leads are now required to undertake the process described in the BC Guidance.

Use the information from this document and the supporting notes in the BCM Planning Assessment Tool (Template) to assist in the collection of information needed to develop robust BC arrangements.

Once the BCM Planning Assessment Tool has been used to undertake a full review; Clinical Boards, Directorate Managers and Service Leads can utilise the information gathered to create BC Plans.

NB. Copies of the Directorate and Service BC plans must be is lodged with the responsible Clinical Board, forming part of an overarching set BC arrangements for the organisation.

11.1

(Appendix A)

Business Continuity Management

Planning Assessment Tool

(Insert Service Name)

Prepared by the (insert name)

Version	Issue Date	Purpose / Changes	Author	Circulation
Information…	**Information…**	Information…	**Information…**	Information…

Purpose & Summary of Document
(Insert Service Name) has collected information in the Business Continuity Management Planning Assessment Tool which will enable decisions to be made on: • The reduction of risk to service delivery prior to any disruption. • The requirements for facilitating effective recovery in the event of a disruption. This information will form the back bone of the BC Plans that will be completed, and has come from the completion of three related tasks: • Business Impact Analysis (BIA) • Risk Assessment • Risk Reduction & Continuity Options

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1.0 Introduction

1.1 Purpose

The Business Continuity Management (BCM) Planning Assessment Tool outlines the requirements determined necessary to mitigate the effects of a disruption to (Insert Service Name).

It details the information gathered from the completion of three related tasks:

- The Business Impact Analysis (BIA)
- The Risk Assessment

and the identification and evaluation of;

- Risk Reduction & Continuity Options

(Insert Service Name) will retain this report as a source document for future BCM audit purposes.

It should be amended to reflect any changes, either in the provision of the service, and/or in business continuity arrangements for the service.

(Insert Service Name) will further utilise the information gathered to create BC Plans.

- Notes in **RED** should be replaced with corresponding content
- Information or sections in **BLUE** should be deleted when the BC Planning Assessment Tool has been completed.

(Please also delete this information box)

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2.1 Service Description

Briefly describe what is provided to whom, how, when, where and why?

Service Description
Information…

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2.2 Service Activities

Briefly describe the activity, including its time sensitivity - i.e. how quickly after a disruption the activity would need to be re-instated.

(Refer to section 2.3.1 BCM Planning Guidance: Red, Yellow, Amber Green & Black. Add/delete rows as necessary.)

Activity	Description	Service Priority
Information…	Information…	**Info…**
Outpatients at UHW Women's Unit	General and specialist outpatient services are provided in a devolved setting within the Women's unit. Clinics operate over 10 sessions per week.	**Amber**
Specialist gynae-oncology New outpatients	Time sensitive, clinically urgent. Need to comply with Cancer standards. This is a significant clinical service and would attract an Amber priority – an alternative provision to facilitate rescheduling of the session would need to be identified within 24 hours	**Amber**
Nurse led cytology clinic	Not highly time sensitive, unlikely to be clinically significant. Service would ideally need to be reinstated within 3-5 working days- so would attract a Green priority	**Green**

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2.3 Service Resource Requirement (FULL)

Document the **FULL** range of resources upon which the service depends in order to be able to deliver **ALL** the activities detailed in Section 2.2.

2.3.1 Staff

List all staff, Job title and numbers employed.

(Do not use individual staff names. Add/delete rows as necessary.)

Job Title/Role	Number of Staff
Information…	**Information…**
Consultant surgeon	**01**
Specialist Registrar	**01**
Junior doctor	**02**
Nurse / HCSW	**03**
Clinic Coordinator	**01**

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2.3.2 Suppliers

List the key suppliers for the service provided,

(Include names, and contact details. Add/delete rows as necessary.)

Product/Service Provided	Supplier Name	Address	Key Contact	Contact Details
Information…	Information…	Information…	Information…	Information…
Laser	A N Other Ltd	44 Thames Road, London, NW3 4DZ.	Mr J Bloggs, (Manager)	Tel: 0207 302123 Mob: 07770 976875 Fax: 0207 302456 Email: J.Bloggs@anotherltd.co.uk

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2.3.3 Premises

Record the location(s) details where the service is delivered, and list the number of staff based there.

Indicate if staff can work remotely (from home etc.) and confirm whether arrangements for them to do so are already in place.

Also note if additional staff work space is available which is not currently utilised. Measure this in the number of staff that could be accommodated at that specific location if the usual place of work is unavailable.

(Add/delete rows as necessary.)

Premises Location – Full Address Including Post Code	Number Of Staff Based In Working Location	Number Of Staff That Could Work Remotely	Number Of Staff Set Up To Work Remotely	Additional Staff Work Space Available
Information…	Information…	Information…	Information…	Information…
Suite 3 UGF Women's Unit, UHW, CF14 4XW	8	1	1	0

11.1

2.3.4 Technology: Hardware

The term hardware refers to items such as PCs, laptops, mobile phones. Detail the technology required to operate service.

(Include serial number / UHB asset number if known. Add/delete rows as necessary.)

Hardware Item (Technology)	Quantity
Information…	Information…
Samsung DP500A2D-A01UK 21.5 inch Full HD Touchscreen All in One Desktop PC. **Serial number xxxxxx**	**01**
Epson WorkForce Pro WP-4535DWF A4 Multifunction Inkjet Printer. **Serial number xxxxxx**	**01**

11.1

2.3.5 Technology: Software

The term software refers to specialist software packages which are required for service delivery. Also include any service specific databases.

Please consider reliance on systems listed in Appendix C:

(Do **NOT** include Microsoft applications, Email and the internet, these are included as standard. Add/delete rows as necessary.)

Software Package (Technology)	Quantity
Information…	Information…
Cansic database	**01**

?

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2.3.6 Other Equipment

Detail any other equipment required in order to deliver service.

Paper records or documents that are important to the operation of your service should also be identified here.

(Add/delete rows as necessary.)

Equipment	Quantity
Information…	Information…
Short Wave Diathermy, serial number xxxxxx	**01**

11.1

2.3.7 Special Time Considerations

Some of the activities may be subject to some special time considerations. These could be based on specific times, dates and months through the year.

Record all such considerations for each of your activities i.e. Monthly outreach clinics; UHB payroll cycle etc.

(Add/delete rows as necessary.)

Activity	Special Time Consideration
Information…	Information…
Joint Gynaecology / Lymphoma	Held monthly. But would need to be rescheduled within 3-5 working days. Unacceptable clinical risk if patients allowed to wait 4 weeks until next scheduled clinic.

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2.3.8 Service Level Agreements

List any service level agreements and the potential impacts if an activity is disrupted.

(Add/delete rows as necessary.)

Activity	Service Level Agreement	Potential Liabilities
Information…	Information…	Information…
Tertiary OP service for AN OTHER health board	Provision of xx New OPA, xx DC procedures	Financial penalty

11.1

2.3.9 Regulatory Compliance

List any regulatory compliance that the UHB is required to comply with e.g. Human Tissue Act / COSHH.

(Add/delete rows as necessary.)

Activity	Regulation	Compliance Details
Information…	Information…	Information…
Surgical biopsy	Human Tissue Act 2004	The Act makes it unlawful to remove, store or use human tissue from the living or deceased without consent to do so for specified health-related purposes or public display

11.1

2.3.10 Internal Dependencies

Considering the information collated, list the internal service dependencies.

NB. Check the contingency arrangements of your internal service dependencies to ensure they can continue to meet your needs in the event of them experiencing a business disruption.

(Add/delete rows as necessary.)

Activity	**Relationship to service**		**Name of the Internal Dependency /Dependant.** (Include brief details of the relationship and time scale needed within)
	Dependency (Required for delivery of an activity)	**Dependent** (Depends on delivery of an activity)	
Information…	Information…	Information…	Information…
Operating theatres	TSSD	Urgent oncology lists	Surgical Clinical Board. Clinically urgent – 31 day cancer pathway. Clinically urgent and may be time critical. May be priority Red/Yellow / Amber dependent upon precise clinical presentation.

11.1

3.1 Assessment

(Insert Service Name) has undertaken an assessment to quantify the impact on service in the event of the following:

Impact	Risk/Cause
Damage or denial of access to Workspace.	Fire, arson, vandalism, flood or weather damage, aircraft or vehicle impact, public order or terrorist attack
Loss or damage to equipment, or a system failure.	As above + power failure, technical failure, virus, human error, failure of external provider.
Non availability of critical staff.	Industrial Action, sickness/injury, transport difficulties.
Non availability / disruption of other key resources including primary suppliers & utilities.	Commercial or utility failure, service provider failure, damage to distribution network.

(Insert Service Name) has utilised the current UHB Corporate Risk Assessment Framework (CRAF) to support this activity,

(Link the output to this report.)

UHB Health and Safety Policy has been applied, ensuring that risk within buildings relating to issues such as fire and building security are managed effectively.

Risk reduction measures and BC plans will be developed to mitigate the impacts on the delivery of the service and its varied activities.

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3.2 Service Resource Requirement (MINIMUM)

Document the **MINIMUM** resources required in order to be able to deliver key activities **following a disruption**.

(Add/delete rows as necessary.)

Resource	MINIMUM Requirement
Staff	Extracted from section 2.3.1
Information…	Information…
Premises	Extracted from section 2.3.3
Information…	Information…
Technology: Hardware	Extracted from section 2.3.4
Information…	Information…
Technology: Software	Extracted from section 2.3.5
Information…	Information…
Other equipment	Extracted from section 2.3.6
Information…	Information…

4.1 Continuity Options

Document **ALL** practical options for:

- Reducing the likelihood of a disruption occurring
- Continued delivery of key activities **following a disruption**.

(Add/delete rows as necessary.)

Impact	Continuity Options
Damage or denial of access to Workspace.	Information…
Loss or damage to equipment, or a system failure.	Information…
Non availability of critical staff.	Information…
Non availability / disruption of other key resources including primary suppliers & utilities.	Information…

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4.2 Continuity Choices

Document the **AGREED** continuity choices for:

- Reducing the likelihood of a disruption occurring
- Continued delivery of key activities **following a disruption**.

(Add/delete rows as necessary.)

Impact	Continuity Choice	Action Required	Action Owner	Target Completion Date
Damage or denial of access to Workspace.	Information…	Information…	Information…	Information…
Loss or damage to equipment, or a system failure.	Information…	Information…	Information…	Information…
Non availability of critical staff.	Information…	Information…	Information…	Information…
Non availability / disruption of other key resources including primary suppliers & utilities.	Information…	Information…	Information…	Information…

11.1

(Appendix B)

Business Continuity Plan

(Insert Service Name)

Prepared by the (insert name)

Version	Issue Date	Purpose / Changes	Author	Circulation
Information…	**Information…**	Information…	**Information…**	Information…

Purpose & Summary of Document

This Business Continuity (BC) Plan has been developed by (Insert Service Name) to assist recovery in the event of a disruption. It sets out the roles responsibilities and actions to be taken by (Insert Service Name) in order to continue services and reduce disruption for patients and staff to an acceptable level.

- Notes in **RED** should be replaced with corresponding content
- Information or sections in **BLUE** should be deleted when the BC Plan has been completed.

(Please also delete this information box)

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Distribution List

The (Insert Service Name) BC Plan is formally distributed to, and held on file by:-

(Add/delete rows as necessary.)

Copy Number	Name	Job Title	Email
Info…	Information…	Information…	Information…
001	Steve Curry	Chief Operating Officer	Steve.Curry@wales.nhs.uk

(Insert Service Name) will retain responsibility for the annual review and maintenance of the BC Plan. It will be exercised annually or following any significant change to the organisation, and improvements will be fed in.

If changes to service delivery or personnel occur, (Insert Service Name) will update and re-issue the document.

NB. A copy of this BC plan must be is stored with the responsible Clinical Board, forming part of an overarching set BC arrangements for the organisation.

Further Information

Should additional information be required, please do not hesitate to contact (Insert Service Name).

Tel: (Information…)

Email: (Information…)

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Appendix 01: Staff Contact Details

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Appendix 03: Service Resource Requirement **(MINIMUM)**

11.1

1.0 Introduction

1.1 Aim

The plan aims to:

- Assist (Insert Service Name) to continue services, and assist recovery in the event of a disruption.

1.2 Objectives

It objectives are to:

- Set out the roles, responsibilities and actions to be taken by (Insert Service Name) in order to continue and/or recover services.
- Reduce disruption for patients and staff to an acceptable level.

1.3 Planning Assumptions

Corporate planning assumptions which have been made:

- Key clinical and support services should be delivered without reliance on corporate ICT/ Property services/ HR support for up to 3 days following a disruption.
- The UHB will achieve a 'normal service' within a maximum of one month. However, this does NOT mean everything will be reinstated to a level equal to that prior to the disruption.

  e.g. A damaged building may take longer to repair than one month, and this could mean that staff may have to continue to work from temporary locations.

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2.0 Recovery Objectives

2.1 Overview

(Insert Service Name) have been identified the service/activity restoration priorities against the following categories:

Priority		Definition
Red	Information…	Critical service needing to be restored within 0-1 hour.
Yellow	Information…	Essential service needing to be restored within 1-12 hours.
Amber	Information…	Significant service needing to be restored within 12-24 hours.
Green	Information…	Routine service needing to be restored within 3 - 5 working days.
Black	Information…	A service which can be restored progressively after 5 working days.

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NB: A summary of the resource requirements to recover the Red, Yellow & Amber priority service / activities are detailed in appendix C.

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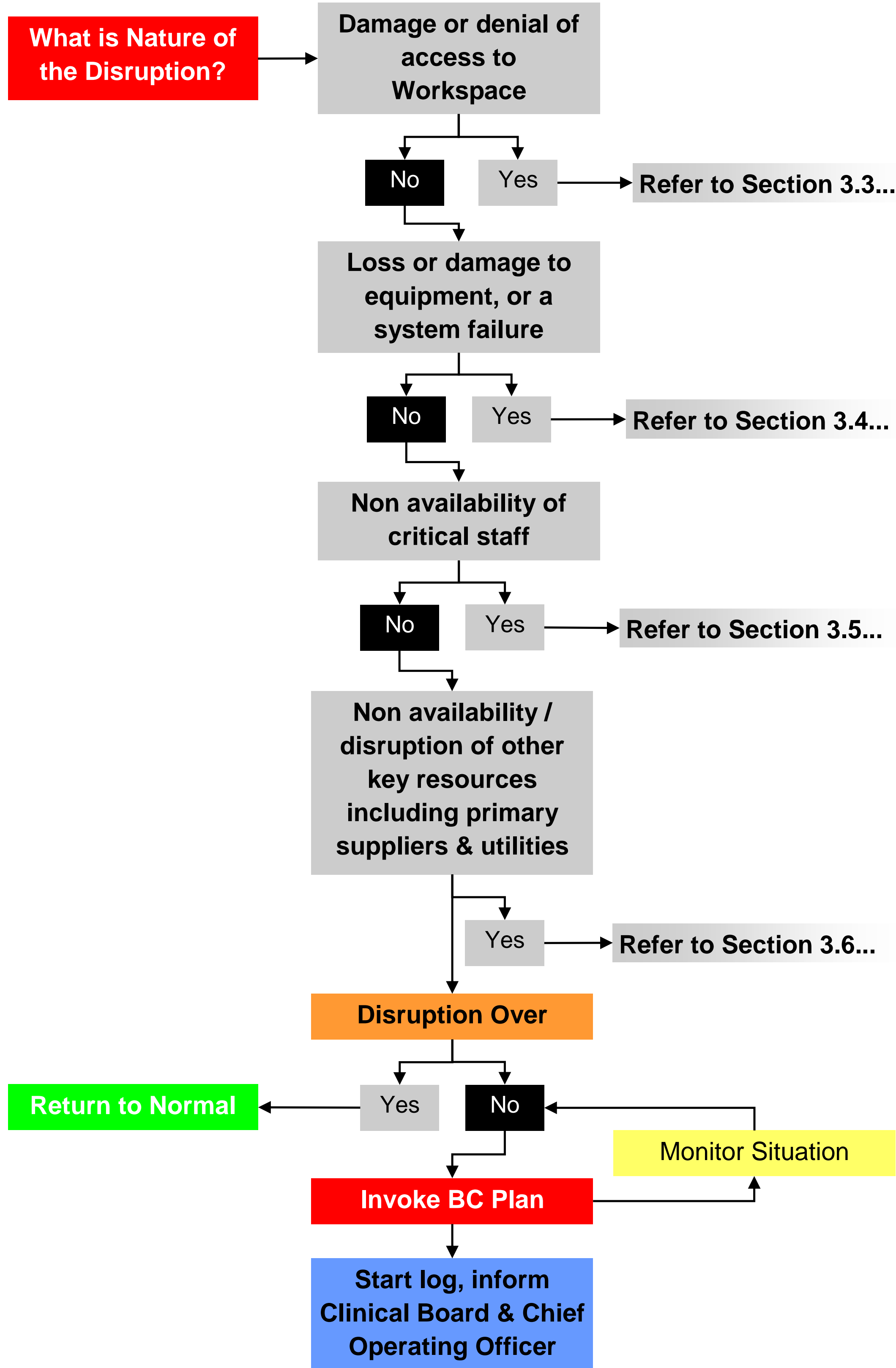
3.0 Plan Activation

3.1 Process



11.1

3.2 Activation

The Directorate Manager/Service Lead will be responsible for the activation of the Business Continuity Management Plan.

At the point the plan is activated the Clinical Board must be informed. All staff members will be contacted and advised of the current situation and what their role will be in the recovery phase.

Key staff contact details are listed at Appendix A

Notification of a business disruption may originate from any source. It is envisaged however that it will come from site staff during occupation of premises, or from security/site manager or the emergency services during unoccupied periods.

The following activation sequences (Sections 3.3 to 3.6) will normally be used when informing UHB personnel of the activation of this plan.

Most disruptions should be manageable via existing Clinical Board structures. However, if the disruption escalates or it impacts a number of key clinical and/or support services, then it may be appropriate to trigger other activities to help the UHB recover or protect itself from further effects of the disruption.

This includes:

- An emergency response;
- Incident Management;
- Damage Assessment;
- Salvage and Recovery of Assets;
- Communication with staff, customers, partners and suppliers.

These are outside the scope of the single service business continuity strategy (although they rely on information from Directorate Managers/Service Leads), but are nevertheless vital to ensure the eventual return to normality.

Command, Control and Co-ordination are important concepts in the multi-agency response to emergencies. A nationally recognised three tiered structure known as Strategic (Gold), Tactical (Silver) and Operational (Bronze) has been adopted by the emergency services and most responding agencies.

The CVUHB Command and Control arrangements are based upon this system. These arrangements help to ensure interoperability between responders and are set out within the CVUHB 2017 Major Incident Plan, Section 5.

3.3 Damage Or Denial Of Access To Workspace

(Add/delete rows as necessary.)

Objective	Actions/Considerations
Establish the current situation at the affected site / workspace.	• What has happened? • When did it occur? • Are the Emergency Services informed / on-site? • Is there access to the site? • Are the IT systems and services still running? • Who else has been informed (media officer, comms, stakeholders)? • How potentially serious is it? • Are there any casualties? • If so, details?
Decide whether the BC Plan should be invoked?	• How quickly the business will be able to re-enter the affected workspace? • What are the prevailing weather conditions? • Is the service currently responding to an external incident • **IF THE DECISION IS TO RELOCATE KEY STAFF TO THE AGREED ALTERNATIVE ACCOMMODATION:** Alert the site - contact details in table below. • Inform staff that the BC Plan is being invoked - contact details are listed in Appendix 01. • Contact key suppliers if appropriate - contact details are listed in Appendix 02. • **IF THE DECISION IS MADE NOT TO INVOKE THE PLAN:** Continue to monitor the situation until such time as normal service is resumed.
Communicate with staff	• **IF EVACUATION IS NEEDED**: Follow site evacuation plan taking into account staff, patient and visitor safety.

11.1

Objective	Actions/Considerations
	• Keep staff informed at Assembly Points until a decision has been made about whether the building is likely to become available again soon. If the building will not be available, relocate identified key staff to the agreed alternative workspace and send other staff home and tell them to await instructions. Remind them to check the website for updates or their manager will contact them at an agreed time. **Out of Hours**: If the disruption occurs outside office hours, staff communication will be co-ordinated by the senior manager on call.

Alternative Site Contact Details

(Add/delete rows as necessary.)

	Service/Activity	Staff To Be Relocated
Alternative Accommodation Location:	Information…	Information…
Contact Name at Location:	Information…	Information…
Contact Number:	Information…	Information…

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3.4 Loss Or Damage To Equipment, Or A System Failure

(Add/delete rows as necessary.)

Objective	Actions/Considerations
Confirm the nature of the disruption	• What has happened? • When did it occur? • Which systems and/or services are affected? • How potentially serious is it?
Decide whether the BC Plan should be invoked?	• Are the systems affected required to support the Time Critical / Important Business Activities? • How long systems will be unavailable? • Is the service currently responding to external incident? • **OPTIONS:** Put staff on standby **or** invoke agreed manual systems to ensure that the service can continue to operate. • **IF BCM IS TO BE INVOKED**: • Inform staff that the BC Plan is being invoked - contact details are listed in Appendix 01. • Contact key suppliers if appropriate - contact details are listed in Appendix 02. • **IF THE DECISION IS MADE NOT TO INVOKE THE PLAN:** Continue to monitor the situation until such time as normal service is resumed.
Enter specific continuity choices, actions / considerations	Information…

11.1

3.5 Non Availability Of Critical Staff

(Add/delete rows as necessary.)

Objective	Actions/Considerations
Confirm the nature of the disruption	• What has happened? • When did it occur? • Which systems and/or services are affected? • How potentially serious is it?
Decide whether the BC Plan should be invoked?	• Are the critical staff affected required to support the Time Critical / Important Business Activities? • How long are critical staff likely to be unavailable? • Is the service currently responding to external incident? • **OPTIONS:** Put staff on standby **or** invoke agreed manual systems to ensure that the service can continue to operate. • **IF BCM IS TO BE INVOKED**: • Inform staff that the BC Plan is being invoked - contact details are listed in Appendix 01. • Contact key suppliers if appropriate - contact details are listed in Appendix 02. • **IF THE DECISION IS MADE NOT TO INVOKE THE PLAN:** Continue to monitor the situation until such time as normal service is resumed.
Enter specific continuity choices, actions / considerations	Information…

11.1

3.6 Non Availability / Disruption Of Other Key Resources Including Primary Suppliers & Utilities

Objective	Actions/Considerations
Confirm the nature of the disruption	• What has happened? • When did it occur? • Which systems and/or services are affected? • How potentially serious is it?
Decide whether the BCM Plan should be invoked?	• Are the resources etc. affected required to support the Time Critical / Important Business Activities? • How long will the resources etc. be affected? • Is the service currently responding to external incident? • **OPTIONS:** Put staff on standby **or** invoke agreed manual systems to ensure that the service can continue to operate. • **IF BCM IS TO BE INVOKED**: • Inform staff that the BC Plan is being invoked - contact details are listed in Appendix 01. • Contact key suppliers if appropriate - contact details are listed in Appendix 02. **IF THE DECISION IS MADE NOT TO INVOKE THE PLAN:** Continue to monitor the situation until such time as normal service is resumed.
Enter specific continuity choices, actions / considerations	Information…

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4.0 Supporting Information

4.1 Staff Welfare

(Insert Service Name) recognise that a business disruption may also cause additional pressures for staff. It will ensure that they are:

- Fully aware of their responsibilities and the actions expected from them.
- Given clear direction regarding the priorities of the service, and the UHB.
- Monitored more closely to ensure that their welfare is maintained (e.g. regular breaks due to increased intensity or pressure of work).

NB: If staff have suffered undue stress or even trauma as a result of the business disruption; support can be accessed via the Employee Wellbeing Service.

4.2 Communicating with Staff

(Insert Service Name) recognise that clear and concise communication with staff is pivotal to having an organised response.

- **During Office Hours**

  If the disruption occurs during office hours, (Insert Service Name) will inform staff by (Information…)

  In addition, (Insert Service Name) will also utilise corporate communication channels such as team briefings, email and the intranet.

- **Out of Office Hours**

  The Senior Manager on Call, and Site manager will keep staff up to date until such time as a Clinical Board representative is available.

  (Insert Service Name) will inform staff by (Information…)

4.3 Media / Public Information

In the event of a major disruption the UHBs Communications and Engagement Officer must be contacted to inform them of what has happened and the estimated length of the disruption and possible impacts of the disruption.

NB: Out of hours, the principal contact for media/public information is the Executive on call.

All staff should be made aware that any enquiries from the media must be directed to the UHBs Communications and Engagement Officer.

In line with the statutory duty under the Civil contingencies Act 2004, it is vital to keep the public, key stakeholders and media informed of a major disruption to service.

11.1

5.0 Train, Exercise, Maintain & Review

5.2 Train

(Insert Service Name) recognises that staff awareness of the BC Plan is essential to it success. In order to help to embed BCM, (Insert Service Name) will ensure that an ongoing programme of education and awareness is established to ensure that:

- Staff understand the risks, remain vigilant and know how to respond.
- Team members remain fully aware of their responsibilities and the actions expected from them.

5.3 Exercise

Experience shows that the more rigorously that a plan is exercised the greater the benefit to those involved and to the organisation when faced with a real disruption.

(Insert Service Name) will hold an exercise to validate this plan every 12 months.

5.4 Maintain & Review

BCM is an ongoing process and needs to be constantly updated and improved.

(Insert Service Name) retain responsibility for annual review of the BC Plan; and for providing assurance to the responsible Clinical Board.

5.5 Assurance

Clinical Boards are responsible for providing assurance to the Chief Operating Officer (& EPRR team) that the risk reduction measures introduced and the BC Plans developed are fit for purpose.

The EPRR team will also provide internal and external assurance, as required by the Executive Strategic Lead.

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Appendix 01: Staff Contact Details

(Add/delete rows as necessary.)

Name	Grade/Position	Office Telephone Number	Home Telephone Number	Mobile Telephone Number
Information…	Information…	Information…	Information…	Information…
Mr J. Bloggs	Senior Officer	029 20 888767	01443 665653	07891 710543

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Appendix 02: Supplier Contact Details

(Add/delete rows as necessary.)

Organisation	Name	Position	Office Telephone Number	Mobile Telephone Number
Information…	Information…	Information…	Information…	Information…
Blogs & Bloggs Ltd	Mr J. Bloggs	Senior Officer	029 20 888767	07891 710543

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Appendix 03: Service Resource Requirement **(MINIMUM)**

Below are the **MINIMUM** resources required by (Insert Service Name) in order to be able to deliver key activities **following a disruption**.

This information can be directly extracted from section 3.2 of the BCM Planning Assessment Tool

(Add/delete rows as necessary.)

Resource	**MINIMUM Requirement**
Technology: Hardware	
Information…	Information…
Technology: Software	
Information…	Information…
Other equipment	
Information…	Information…

11.1

(Appendix C)

IM&T Systems

Supporting Clinical Boards

11.1

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Version Number: **02 Information supplied by IM&T (16.10.17)**		Date of Publication: **dd mmm yyyy**
Approved By: **??**		

IT SUPPORTING CLINICAL BOARDS

MENTAL HEALTH	PRIMARY, COMMUNITY, INTERMEDIATE CARE PICU	CHILDREN AND WOMEN	DENTAL	SURGERY	MEDICINE	SPECIALIST SERVICES	CLINICAL DIAGNOSTICS & THEATRES
SERVICES: Adult Services Older Persons	**SERVICES:** Locality Directorate Cardiff and the Vale OPAIC Primary Care Contractors	**SERVICES:** Children Services Obstetrics & Gynaecology	**SERVICES:** Hospital Dental Community Dental	**SERVICES:** General Surgery, Urology & Vascular Head & Neck, Maxillio Facial & Ophthalmology Theatres & Anaesthetics SSU Day Surgery Endoscopy & Sterilisation Services	**SERVICES:** Integrated Medicine Dermatology & Rheumatology Unscheduled Care: Emergency Unit Barry MIU & MEAU	**SERVICES:** ALAS Cardiac Services Critical Care Haematology & Clinical Immunology Nephrology & Transplant Neurosciences Medical Genetics	SERVICES: Medicine & Toxicology Laboratory Radiology Pharmacy Medical Physics & Clinical Engineering Therapeutics Poisons & Toxicology Outpatients – Patient Admin Svcs and Media Resources
SYSTEM PORTFOLIO INTERNAL: MHCS – PARIS HBA 86 – Poppy Prescribing App Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network Access	SYSTEM PORTFOLIO INTERNAL: MHCS – PARIS Adstra – Comms Hub HBA 11 – Cardiobase Digital Records Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network Access	SYSTEM PORTFOLIO INTERNAL: CH 2000 MHCS PARIS PMS Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network access HBA 1- Acubase HBA 35- Fetal Medicine HBA 36- Fetal Monitoring HBA 44- GUM HBA 48 IVF Services HBA 50 – Maternity Sys	SYSTEM PORTFOLIO INTERNAL: PMS Cardiff Clinical Portal Results Reporting Email Telecomms System Wifi Network access HBA 22- Salud Sys HBA 23- Dental Lab HBA 24- Dental Server HBA 25- Dental Storage HBA 51 Max Factor Sys HBA 49- Louden Square HBA 19 Community Dental System	SYSTEM PORTFOLIO INTERNAL: PMS WCW Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network access HBA 3 – Anaesthetics Patient Monitoring HBA 31 – Endoscopy HBA 97 – Theatre System HBA 70 – Open Eyes HBA 42 – Glaucoma HBA 5 - Audiology Bluespear Digital Records	SYSTEM PORTFOLIO INTERNAL: PMS Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network access WCW EU Workstation OOH PARIS Digital Records	SYSTEM PORTFOLIO INTERNAL: PMS WCW Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network access Digital Records HBA 2 – ALAS System HBA 10- CCW – GE system HBA 12 – ISCV – Philips System HBA 13 - NAS Storage HBA 14 – Directorate sys HBA 93/94 – Renal HBA 62 – Neurology HBA 63/64 – Neurophysiology HBA 52/53/5455 – Med Gen Sevcs HBA 37 – FH Service HBA46 – Haemophilia	SYSTEM PORTFOLIO INTERNAL: PMS WCW Cardiff Clinical Portal Results Reporting Email Telecomms system Wifi Network access Digital Records PACS RADIS 1 Telepath HBA – 83 Poisons
SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS	SYSTEM PORTFOLIO NATIONAL: Integration to : WCCG / MPI / MHOL WCP (MTeD, TRRR, WPRS, WGPR, WCRS, WRRS) WLIMS WRIS GP Links Choose Pharmacy NIIAS

11.1

ADOPTION OF EMPLOYMENT POLICY AND EMPLOYMENT PROCEDURE
Name of Meeting : Resource and Delivery Committee **Date of Meeting:** 30 January 2018

Executive Lead : Executive Director of Workforce and OD
Author : Head of Workforce Governance, 42925
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 the policy and procedure 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:

- The All Wales Policy and All Wales Procedure have both been developed and agreed through defined national processes
- Information is contained within the policy and procedure about the roles, responsibilities and obligations of managers and staff, and the processes to be followed
- Dissemination of information across the UHB

The Resource and Delivery Committee is asked to:

- **ADOPT** the revised All Wales Special Leave Policy
- **ADOPT** the revised All Wales Procedure for NHS Staff to Raise Concerns
- **APPROVE** the full publication of the Policy and Procedure in accordance with the UHB Publication Scheme

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SITUATION

This paper summarises for the Resource and Delivery (R & D) Committee details of an NHS Wales Employment Policy and NHS Wales Employment Procedure which have both been reviewed and should now be adopted by the UHB.

BACKGROUND

Attached are the following revised policies:

- NHS Wales Special Leave Policy (Appendix 1) and original EQIA (Appendix 2)
- NHS Wales Procedure for NHS Staff to Raise Concerns (Appendix 3) – there is no EQIA for this procedure

The NHS Wales Special Leave Policy and the NHS Wales Procedure for NHS Staff to Raise Concerns were both approved by the Welsh Partnership Forum and issued to all NHS Wales Organisations by NHS Employers on 2 January 2018. The covering letter (attached as Appendix 4) distributed at this time made it clear that the policy and procedure should be adopted and implemented at the earliest opportunity.

The Employment Policy Sub Group will discuss the revised policy and revised procedure at its meeting and will consider any implementation issues which need to be addressed.

ASSESSMENT

Key changes to the revised policy and procedure are as follows:

Special Leave Policy

- Additional reference to Core Principles of NHS Wales;
- Amended section on the types of leave that can be taken;
- Reference to discourage individuals who have been allowed paid time off to undertake public duties from claiming further remuneration from the other organisation.

Procedure for NHS Staff to Raise Concerns

- Additional reference to Core Principles of NHS Wales;
- Addition of examples demonstrating where raising a concern with a line manager may not be appropriate;
- Inclusion of a diagram at appendix 1 demonstrating different mechanisms for raising issues.

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.

Cardiff and Vale University Health Board

Special Leave Policy

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Approved by: **Welsh Partnership Forum**

Issue Date: **January 2018**

Review Date: **January 2020**

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Appendix A – Application for Special Leave

Appendix B – Legal Framework

1. Policy Statement

The Core Principles of NHS Wales are:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of staff.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support staff working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial

challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

2. Introduction

This policy sets out the approach of the Cardiff and Vale University Health Board (the UHB) to special leave and the procedure for dealing with applications for leave.

This policy is intended to ensure that the UHB complies with section 57A of the Employment Rights Act 1996, as amended by the Employment Relations Act 1999, which came into effect on 15th December 1999. These regulations provide a right for employees to request a reasonable amount of time off work to deal with unexpected or sudden emergencies and to make any necessary long-term arrangements; together with section 50 of the Employment Rights Act 1996, these regulations ensure that employees are allowed reasonable time off work to perform certain public duties.

In line with the Equality Act 2010, the UHB is committed to implementing the policy in a way which promotes the fair and equal treatment of all employees and eliminates discrimination on the grounds of race, disability, gender, gender reassignment, age, sexual orientation, religion and belief, language and human rights. It is the responsibility of managers and employees to ensure that they implement this policy/procedure in a manner that recognises and respects the diversity of the workforce and the different needs of all employees.

The UHB recognises the right of all employees subject to this policy to be treated fairly and with dignity and respect.

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The UHB also recognises it has a legal duty to make any reasonable adjustments to the workplace, or to the way work is done, to ensure that a disabled employee is not substantially disadvantaged.

The UHB attaches considerable importance to assisting employees in balancing the responsibilities of their work with their domestic and family responsibilities. It is recognised that in the majority of instances these commitments can be planned and are therefore outside of the remit of this policy.

The UHB supports its employees, at times of urgent and unforeseen need, by consideration of the provision of additional leave according to circumstance.

The situations that this policy is intended to deal with are:

- Emergency carers and dependant leave
- Unexpected crisis leave
- Bereavement leave

Leave granted under this policy is not intended for long term or foreseeable domestic and family situations, which may be provided for in other ways, e.g. annual leave, unpaid leave, reduced working hours etc.

The policy will also consider the awarding of reasonable time off to staff to enable them to undertake civil and public duties requiring them to be away from the workplace in the following circumstances:

- Time off for public duties
- Jury service
- Reserve and cadet forces
- Attending job interviews

(This list is not exhaustive)

Special Leave is not an entitlement; however, requests for special leave will be considered sympathetically in the light of individual circumstances and may be granted at the discretion of the UHB. It is important for employees to consider the needs of the UHB and to make every effort to make alternative arrangements wherever possible.

3. Scope

This policy applies equally to all employees and aims to give clear guidelines to employees and managers when dealing with requests for paid and/or unpaid special leave.

There is no minimum service requirement to make a request for special leave.

This policy recognises that there are 2 types of special leave; unforeseen/unplanned need for personal reasons; and time off to perform public duties. Section 7 of the policy looks at the differential between the two distinct types of leave in detail.

4. Principles

Managers should interpret the policy in a flexible and caring way. Managers will wherever possible and appropriate seek to grant requests for special leave, within the scope of the policy, bearing in mind workplace demands.

Treating all employees in a trusting and respectful manner, at such times, is good management practice, which can bring positive long-term benefits to the employment relationship, between the manager and the employee.

Employees will need to openly discuss with their manager the reasons and circumstances that have led to their special leave request. There should be an acknowledgment by the employee that special leave may only be granted by the agreement of their manager, in consultation with their Workforce & OD department, if appropriate.

This policy includes the provision for staff to be granted a period of paid or unpaid leave, dependent upon the circumstances. It is also important to stress that it is not necessary for employees to use up their annual leave entitlement before they can apply for special leave.

All special leave must be applied for and granted consistently throughout the UHB.

5. Responsibilities under the policy

5.1 Line Managers

Line managers are responsible for

- ensuring that employees are aware of the policy;
- all requests for paid and unpaid special leave are made on the relevant application form (appendix A);
- decisions about special leave requests are made on the basis of the employee’s individual circumstances and are consistent with the policy;
- monitor the usage of special leave and where refused identify what alternatives have been offered;
- retaining relevant documentation within the employee’s personal file;
- ensuring notification of any period of paid or unpaid special leave to payroll, including completion of the Electronic Staff Record (ESR) on Self Service where available;
- maintaining regular contact where appropriate with individual staff members;
- offering/signposting counselling as appropriate.

5.2 Employees

Employees are responsible for:

- ensuring they are familiar with this policy;
- ensuring they have relevant and appropriate arrangements, including contingency arrangements to allow them to fulfil their contractual obligations;
- ensuring that they tell their employer as soon as possible the reason for their absence and how long they expect to be absent;
- ensuring all requests for paid and unpaid special leave are made using the relevant special leave application form (appendix A), having been discussed with their line manager.

6. Types of Leave

6.1 Definition of paid leave

The pay that an individual would normally have expected to receive for the shift(s) had they been in work.

6.2 Unpaid leave

Leave taken when an employee's time off from work is not covered by existing benefits such as sick leave, annual leave and is not remunerated.

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6.3 Time off in lieu

Time that an employee who has worked additional hours (unpaid not overtime) over and above their contacted hours may take off from work with the agreement of their employer.

6.4 Annual leave

Annual leave is paid time off from work granted by employers to employees to be used for whatever reason the employee wishes (see NHS Terms and Conditions of Service – Section 13)

6.5 Flexitime leave

Leave to be taken from time built up as part of a formal or informal flexitime arrangement.

6.6 Parental leave

Leave for eligible employees to look after their child's welfare, e.g. look at new schools (NHS Terms and Conditions of Service Section 35)

7. Different types of Special Leave

7.1 Unplanned/Times of unforeseen need

7.1.1 Emergency carers and dependant leave

A dependent is someone who is married to, is a civil partner, or a partner (whether opposite or same sex) "a near relative" or someone who lives at the same address as the employee. A relative for this purpose includes: children, parents, parents-in-law, adult children, adopted adult children, siblings (including those who are in-laws), uncles, aunts, grandparents and step relatives or is someone who relies on the employee in a particular emergency (NHS Terms and Conditions of Service Section 35.4).

This enables employees to take action, which is necessary to deal with an unexpected or sudden problem concerning a dependant and to make necessary long-term arrangements e.g.:

- if a dependant falls ill, or has been injured, or assaulted;
- to make longer term care arrangements for a dependant who is ill or injured;
- to deal with an unexpected disruption or breakdown of care arrangements for a dependant;
- to deal with an unexpected incident involving a child during school hours.

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It should be noted that this does not include any situations, which are pre-planned or where the employee has prior knowledge of the arrangements. In these instances, special leave will not apply, and the expectations will be for the employee to make alternative arrangements such as requesting annual leave.

Usually no more than 3 days may be granted per episode, or no more than 6 days paid leave pro rata in any rolling 12-month period, as other types of leave may be taken to extend the period of absence. As an alternative or in addition to the above, "home working" may be an option in some circumstances.

7.1.2 Unexpected crisis leave

There may be times when employees may need to deal with situations not mentioned in the policy but are nevertheless considered important enough to affect the ability of the employee to attend work and which may be resolved by

limited time off. An example of such a situation may be the need to deal with urgent unexpected house repairs, or following a burglary or flood. Usually no more than 1 day will be granted to deal with the initial crisis. This type of leave is not meant for example to await delivery of a household item, or awaiting a pre-arranged engineer to call as these would not be regarded as emergencies.

7.1.3 Bereavement

An employee will be allowed to take a reasonable amount of time off, for bereavement, in the following circumstances:

- Death of an immediate family member or partner. Normally from the day of death up to and including the day of the funeral. (In some circumstances this may be a significant period of time and in these circumstances discussions will need to be held between the employee and manager in a sensitive manner about the amount of leave required).
- Death of extended family member. Normally the day of the funeral but, dependent upon the circumstances of each individual case.
- Death of close friends; normally unpaid leave or alternatively annual leave or flexi-leave should be taken wherever possible.

7.1.4 Medical Appointment

Reasonable time off for medical and dental appointments is covered in the All Wales Sickness Absence Policy.

7.2 Planned Time Off

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7.2.1 Time off for public duties

Individuals have the right to reasonable paid time off work to carry out certain public duties and services. These rights will vary depending on the type of work, and what the duty or service is. When contemplating undertaking such roles, staff should discuss this with their line manager and together they should consider the likely impact this will have on their work attendance and the needs of the service.

Individuals are allowed reasonable time off work for public duties (up to 18 days pro rata) if they are one of the following:

- a magistrate, sometimes known as a justice of the peace
- an elected local councillor
- a member of a police authority
- a member of any statutory tribunal (e.g. an Employment Tribunal, Fitness to practice hearings)

- a member of the managing or governing body of an educational establishment
- a member of the General Teaching Council for Wales
- a member of the Natural Resources Wales
- a member of the prison independent monitoring boards

Individuals requesting time off for public duties need to discuss these arrangements with their line manager in a timely manner, confirming the nature of the duties and the amount of time to be taken.

Without imposing any obligation on an individual who has been allowed paid time off for public duties, such individual is encouraged to refrain from then claiming or accepting any fee or allowance for undertaking that public duty. For the avoidance of doubt, in this context, 'fee or allowance' is not intended to cover any subsistence payment or re-imbursement of expenses incurred in the performance of the public duties.

7.2.2 Job Interviews

Requests for leave to attend job interviews within the NHS or Welsh Government's Health and Social Care Department will not be unreasonably refused. However, the UHB may insist that annual leave is taken to attend interviews outside of the NHS rather than special leave granted.

7.2.3 Jury Service/Court Witnesses

Individuals will continue to be paid by the UHB for any period of jury service or court attendance as a witness that they are required to undertake. The individual should discuss with their line manager whether or not they will continue to be paid as normal during the period of jury service, and consequently, whether they will need to make a loss of earnings claim to the Court.

Individuals should provide documentary evidence of the request for jury service/court attendance as a witness and discuss with their line manager in a timely manner.

Employees must be aware that if the court advises that they are not required for court service on any given day or if the court finishes early the employee must contact work and agree working arrangements for the period.

Alternative arrangements to cover this e.g. home working / annual leave may be agreed through discussion with their line manager.

7.2.4 Reserve and Cadet Forces

Staff must discuss any proposal to join the Territorial Army (TA) or Reserve Forces with their manager in order to establish the likely time commitment required and seek their agreement before doing so.

Leave for annual camp and arrangements for “call up” are covered in the All Reserve Forces – Training and Mobilisation Policy (2016).

7.2.5 Fertility Treatments

It is recognised that infertility can cause considerable distress and UHB is supportive of employees who may decide to undertake fertility treatment.

The UHB will provide limited paid leave for this purpose, where the request is supported by documentary evidence, from the employee’s GP or consultant/specialist.

As fertility treatment can be a lengthy process, managers should discuss with the employee concerned, the likely duration of their treatment, together with the number of occasions and where possible dates, when they are likely to need time off work, to attend hospital for their fertility treatment appointments.

It should be noted that following implantation, in law the employee will be considered to be pregnant and as such should be treated as pregnant and the normal pregnancy provisions applied.

The UHB will provide an employee who is to receive fertility treatment, with normally up to three days paid leave and a period of agreed unpaid special leave, in any rolling 12-month period. Each case should be treated on its own merits and alternative arrangements may also be considered, e.g. annual leave.

Where an employee experiences side effects or ill health as a result of their fertility treatment, which renders them unfit for work, such absences must be reported, certified and recorded in accordance with the sickness absence policy.

7.2.6 Wales for Africa

Requests for leave to attend initiatives as part of the “Wales for Africa” programme will be given fair consideration where not covered in local policies. **For more information, visit**
wales.gov.uk/topics/sustainabledevelopment/**walesforafrica**

8. Appeals

An individual who considers the UHB has failed to comply with the provisions described previously in this policy should refer to the appeal process within the UHB's Grievance Policy and Procedure.

9. Training and awareness

All staff will be made aware of this policy upon commencement with the UHB. Copies can also be viewed on the UHB's Intranet or obtained via the Workforce and OD department and/or line manager.

10. Equality

The UHB recognises and values the diversity of its workforce. Our aim is to provide a safe environment where all employees are treated fairly and equally and with dignity and respect. The UHB recognises that the promotion of equality and human rights is central to its work both as a provider of healthcare and as an employer. This policy has been impact assessed to ensure that it promotes equality and human rights.

11. Data Protection Act 1998

All documents generated under this policy that relate to identifiable individuals are to be treated as confidential documents, in accordance with the UHB's Data Protection Policy.

12. Freedom of Information Act 2000

All UHBs' 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 in the UHB's publications scheme.

13. Records management

All documents generated under this policy are official records of the UHB and will be managed and stored and utilised in accordance with the UHB's Records Management Policy.

14. Monitoring

An accurate record of all special leave requests should be maintained on the Electronic Staff Record (ESR), to enable the organisation to consider whether there any issues that may be contributing to unintended discrimination. This information must be capable of

being disaggregated by each of the protected characteristics and routinely collected, analysed and reported on to ensure that the process is fair and equitable for all individuals and groups, and to demonstrate that the UHB is meeting its employment equality monitoring duties.

15. Review

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

Signed on behalf of the Staff Side

Signed:	
Name:	
Title:	
Date:	

Signed on behalf of the Management Side:

Signed:	
Name:	
Title:	
Date:	

Appendix A – Application for special leave

Please note that if your organisation is using ESR self-service then special leave should be recorded through this mechanism

Cardiff and Vale University Health Board	
Application for special leave	
Personal Details	
Full name:	
Employee number:	
Position:	
Organisation (Department):	
Work base:	
Contact telephone number:	
Circumstances of leave	
Emergency carers & dependant leave – Section 7.1.1 of policy (please give details)	
Unexpected crisis leave – Section 7.1.2 of policy (please give details)	
Bereavement – Section 7.1.3 of policy (please give details)	
Time off for public duties – Section 7.2.1 of policy (please give details)	
Interviews – Section 7.2.2 of policy (please give details)	
Jury service/Attendance at court as a witness – Section 7.2.3 of policy (please give details)	
Fertility Treatments – Section 7.2.5 of policy (please give details)	

Wales for Africa – Section 7.2.6 of policy (please give details)	
Other reason (please specify)	
Number of days requested	
Total number of days requested:	
From (date):	
To (date):	
Signed:	**Date:**
<u>To be completed by Line Manager</u>	
Special leave granted (this episode):	Yes / No
Is the special leave paid or unpaid?:	Paid / Unpaid
Number of days granted:	
Number of days granted (in last 12-month period)	
From (date):	
To (date):	
If not granted, please give reason:	
Signed:	**Date:**
Name:	
Position:	

<u>Copy to be placed on employee's personal file. This form can be completed retrospectively as long as permission for the special leave has been granted verbally.</u>

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Appendix B

Legislation

The right to request Special Leave is covered by a raft of legislation including:

- Trade Union and Labour Relations (Consolidation) Act 1992
- Criminal Justice and Public Order Act 1994
- Employment Rights Act 1996
- Human Rights Act 1998
- Public Interest Disclosure Act 1998
- Public Interest Disclosure Act 2013
- Employment Relations Act 1999
- The Gender Recognition Act 2004
- Crime and Disorder Act 1998
- Employment Act (Dispute Resolution) Regulations 2004
- The Equality Act 2010

The Equality Act 2010 provides a cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all; to update, simplify and strengthen the previous legislation; and to deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

Form 1: Preparation

To complete this form, refer to Guidance set out on Page 20 of the Toolkit

1.	**What are you equality impact assessing?**	All Wales Special Leave Policy
2.	**Policy Aims and Brief Description**	The situations that this policy is intended to deal with are: • Emergency carers and dependant leave • Unexpected crisis leave • Bereavement leave **Leave granted under this policy is not intended for long term domestic and family situations, which may be provided for in other ways, e.g. annual leave, unpaid leave, reduced working hours etc.** The policy will also consider the awarding of reasonable time off to staff to enable them to undertake civil and public duties requiring them to be away from the workplace in the following circumstances: • Time off for public duties • Jury service • Reserve and cadet forces • Attending interviews This policy sets out the approach of the *NHS Organisations* to special leave and the procedure for dealing with applications for leave.

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		This policy is intended to ensure that the *NHS Organisation* complies with section 57A of the Employment Rights Act 1996, as amended by the Employment Relations Act 1999, which came into effect on 15th December 1999. These regulations provide a right for employees to request a reasonable amount of time off work to deal with unexpected or sudden emergencies and to make any necessary long-term arrangements; and section 50 of the Employment Rights Act 1996, these regulations ensure that employees are allowed reasonable time off work to perform certain public duties. The policy attaches considerable importance to assisting employees in balancing the responsibilities of their work with their domestic and family responsibilities. This policy is not intended to deal with commitments which can be planned.
3.	**Who is responsible for the Policy/work?**	NHS organisations and sub committee of the Welsh Partnership Forum Business Committee
4.	**Who is Involved in undertaking this EqIA?**	Welsh Partnership Forum Business Committee (Sub Group)
5.	**Is the Policy related to other Policies/areas of work?**	Equality, Sickness, Disciplinary, Grievance and Dignity at Work Policies. Codes of Conduct of Professional/Regulatory Bodies, Staff Charters. All Wales Workforce Strategy. Individual organisation's workforce and OD plans.
6.	**Stakeholders**	All employees, trade unions, carers

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7.	What might help/hinder the success of the Policy?	**Factors that may hinder**: Lack of leadership and commitment at Board level. Difficult financial climate and reductions to budgets. The process not being followed inside organisations, lack of follow through by managers. **Factors that may help:** Introduction of stronger public sector General Duty. The organisational change that service is currently going through. An all Wales implementation plan to support consistent delivery of policy objectives. Clarity of obligations, expectations, accountability and performance objectives of all parties.

Form 2 : Information Gathering✓

To complete this form, refer to guidance set out on Page 22 of the Toolkit

	Race	Disability	Gender	Gender Reassign	Sexual Orientation	Age	Maternity and pregnancy	Religion Belief	Marriage and Civil Partnership	Welsh Language
Is the policy relevant to the public specific duties relating to each equality strand? Tick as appropriate (for a definition of Relevance, refer to Page 22)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
In other words, should the Policy: • **eliminate discrimination and eliminate harassment in relation to:**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• **promote equality of opportunity in relation to:**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• **promote good relationships and positive attitudes in relation to:**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• **encourage participation in public life in relation to:**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
In relation to disability only, should the Policy take account of difference, even if it involves treating some individuals more favourably?		✓								

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to **Appendix A: The Legislative Framework**.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

	Yes	No
Consider, is the Policy relevant to:		
Article 2 : The right to life **Examples**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control		N/A
Article 3 : The right not be tortured or treated in an inhuman or degrading way **Examples**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control		N/A
Article 5 : The right to liberty **Examples**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		N/A

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Article 6 : The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	Appeal process is fair.	
Article 8 : The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Examples**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	Policy supports the rights of an employee to enjoy their private life.	
Article 11 : The right to freedom of thought, conscience and religion **Examples**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers		N/A

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Equality Strand	Information Gathered
Race	Various case studies relating to the need for flexible arrangements for staff who may not live in the same country as their relatives.
Disability	Work Foundation report on Work, Health and Absence in the Public Sector
Gender	The Work Foundation has also produced a number of reports on changing demographics. Chwarae Teg reports on flexible working.
Gender Reassignment	The Workplace and Gender Reassignment – A Guide for Staff and Managers. WWW.gov.uk
Sexual Orientation	
Age	EHRC report "Working Better 2008" The Work Foundation has also produced a number of reports on changing demographics, changing work patters for young workers, retention of older workers, e.g. 0-5 How small children can make a big difference, The Ageing Workforce, Work, Health and Absence in the Public Sector
Maternity and pregnancy	Equal Opportunities Commission "Gender Equality and the Future of Work" Legal and General's "Value of a Mum"
Marriage and Civil Partnership	
Religion or Belief	Various case studies relating to the need for flexible arrangements for staff who may not live in the same country as their relatives. CIPD surveys on flexible working

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Welsh Language	Some Work Foundation reports relating to employers and the Welsh Language.
Human Rights	**General** There are gaps in workforce equality monitoring data across all of the protected characteristics. Disaggregated workforce monitoring data is required to inform future policy review and assessment. It is also noted that the Welsh Assembly Government is proposing that public sector employers in Wales will have a specific duty to make arrangements to collect employee data in respect of disciplinary procedures (Welsh Assembly Government Equality Act 2010: Performance of the Public Sector Equality Duties in Wales).

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Form 3 : Assessment of Relevance and Priority

Equality Strand	Evidence: Existing Information to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Race	2	+2	4
Disability	2	+3	6
Gender	3	+3	9
Gender reassignment	1	+2	2
Sexual Orientation	1	1	1
Age	3	+3	9
Religion or Belief	2	+2	4
Maternity and Pregnancy	3	+3	9
Marriage and Civil Partnership	1	2	2
Welsh Language	2	1	2
Human Rights	2	+2	4 52/10 = 5.2

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Scoring Chart A: Evidence Available Decision

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

11.2

Form 7 : Outcome Report

To complete this form, refer to guidance at Page 41 of the Toolkit

Organisation:	Welsh Assembly Government/NHS Wales/Trade Unions

Proposal Sponsored by:	**Name:**	Janet Wilkinson/Peter Finch
	Title:	Joint Chairs
	Department:	Wales Partnership Forum

Policy Title:	Special Leave Policy

Brief Aims and Objectives of Policy:	The situations that this policy is intended to deal with are: • Emergency carers and dependant leave • Unexpected crisis leave • Bereavement leave **Leave granted under this policy is not intended for long term domestic and family situations, which may be provided for in other ways, e.g. annual leave, unpaid leave, reduced working hours etc.** The policy will also consider the awarding of reasonable time off to staff to enable them to undertake civil and public duties requiring them to be away from the workplace in the following circumstances: • Time off for public duties • Jury service • Reserve and cadet forces

11.2

	• Attending interviews This policy sets out the approach of the *NHS Organisations* to special leave and the procedure for dealing with applications for leave. This policy is intended to ensure that the *NHS Organisation* complies with section 57A of the Employment Rights Act 1996, as amended by the Employment Relations Act 1999, which came into effect on 15th December 1999. These regulations provide a right for employees to request a reasonable amount of time off work to deal with unexpected or sudden emergencies and to make any necessary long-term arrangements; and section 50 of the Employment Rights Act 1996, these regulations ensure that employees are allowed reasonable time off work to perform certain public duties. The *NHS Organisation* attaches considerable importance to assisting employees in balancing the responsibilities of their work with their domestic and family responsibilities. This policy is not intended to deal with commitments which can be planned.

Was the decision reached to proceed to full Equality Impact Assessment?:	**Yes ☐**	**No ✓**
	Record Reasons for Decision: The principles and values of the policy are grounded in the promotion of fair and equal treatment. The policy makes explicit reference to the legal duty to consider reasonable adjustments for disabled employees and the requirement to collect and report on the equality monitoring of the process to ensure that there is no unintended discrimination arising from the implementation of the policy.	
	Yes ✓	**No ☐**

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If no, are there any issues to be addressed?	Record Details: Lack of robust workforce monitoring data to be addressed through all Wales action plan and local implementation. Action will be taken to ensure data gaps are addressed through Workforce Information Systems Programme and Electronic Staff Record (ESR). Also, training for managers to ensure that the provisions of the policy are applied fairly and equally should be addressed through all Wales OD leadership programme.	

Is the Policy Lawful?	**Yes ✓**	**No ☐**

Will the Policy be adopted?	**Yes ✓**	**No ☐**
	If no, please record the reason and any further action required:	

Are monitoring arrangements in place?	**Yes ✓**	**No☐**
	Refer to Action Plan (Form 8) Monitoring arrangements will be addressed through local application of all Wales action plan. Scrutiny and review of monitoring reports will be undertaken at regular intervals by NHS organisation's executive teams and boards.	

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Who is the Lead Officer?	Name:	Julie Rogers
	Title:	
	Department:	Welsh Assembly Government
Review Date of Policy:	March 2016	

Signature of all parties:	Name	Title	Signature
	Andrew Davies		

Please Note: An Action Plan should be attached to this Outcome Report prior to signature

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Form 8: Action Plan for Special Leave Policy

	ACTION	WHO	HOW/ WHEN
Monitoring Arrangements			
How will the Policy be monitored?	Monitoring arrangements will be determined locally. Monitoring outcomes will be reported to Health Boards	Workforce and OD Directors	 Every 6 months
What monitoring data will be collected?	Local application of special leave policy and procedure disaggregated against each protected equality characteristic, workplace/directorate and staff group.	Workforce and OD Directors	Ongoing
Other Actions			
Describe any other actions highlighted through the policy screening	Policy training for managers to include scope and application of duty to consider reasonable adjustments for disabled employees	OD Group	To be confirmed

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Cardiff and Vale University Health Board

Procedure for NHS Staff to Raise Concerns

11.2

Introduction

The Core Principles of NHS Wales are:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of staff.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support staff working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

The safety and wellbeing of patients and service users are seen as the responsibility of everyone involved in the provision of health and social care services. The Cardiff and Vale University Health Board's Board and senior management are committed to providing an environment which facilitates open dialogue and communication so as to ensure that any concerns which staff may have are raised as soon as possible.

This procedure refers in the main to 'raising concerns' rather than 'whistleblowing' because the latter has come to denote a sudden, drastic or last resort act which can hold negative connotations.

The Cardiff and Vale University Health Board (the UHB) is working towards a culture that encourages the raising of any concerns by staff to be embedded into routine discussions on service delivery and patient care, (e.g. problem solving, service review, performance improvement, quality assessment, training and development) as these are the most effective mechanism for early warning of concerns, wrongdoing, malpractice or risks and line managers are accordingly best placed to act on, deal with and resolve such concerns at an early stage

It is, however, acknowledged that such processes take time to develop and embed into the organisation and until such time as such a culture exists comprehensively across the UHB that a clear process needs to be in place to guide individuals who wish to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. This procedure

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sets out the UHB's commitment to support individuals who raise concerns as well as setting out the processes for individuals to raise such concerns and to provide assurance on how such concerns will be listened to, investigated and acted upon as necessary.

'Whistleblowing' is the popular term applied to a situation where an employee, former employee or member of an organisation raises concerns to people who have the power and presumed willingness to take corrective action. The types of situation where this will be appropriate are outlined in Appendix 1. "Protected disclosure" is the legal term for whistleblowing and is referenced in the context of describing the protection is afforded to the person raising the concern in the interest of the public (see appendix 2).

The development of this procedure is an ongoing process and is a part of the wider work across NHS Wales to ensure that an open culture exists to provide the highest standards of care and experience across all services. This procedure does not form part of an employee's contract of employment and may need to be amended from time to time.

1. A Commitment to Support Those Who Raise Concerns

1.1 The UHB actively encourages feedback and has a transparent and open approach to listening to and responding to all concerns.

1.2 The UHB aims to ensure that individuals:

- Are fully supported to report concerns and safety issues;
- are treated fairly, with empathy and consideration when raising concerns; and
- have their concerns listened to and addressed, when they have been involved in an incident or have raised a concern.

1.3 The UHB aims to develop and maintain a culture across all parts of the organisation that provides an environment where people feel able to raise concerns and are treated with respect and dignity when raising concerns.

1.4 Safety is at the heart of all care and must be underpinned by a culture which is open and transparent. This leads to increased reporting, learning and sharing of incidents and development of best practice. The *UHB* recognises that this is the responsibility of everyone involved in the provision of health and social care services. The *UHB* is committed to working towards ensuring that all individuals are treated in a service which is open to feedback and encourages as well as supports its staff to raise concerns.

1.5 The UHB will ensure that individuals always feel free to raise concerns through local processes and are supported to do so directly with the *UHB,* their professional regulatory body, professional association, regulator or union.

1.6 The UHB is committed to:-

- Working in partnership with other organisations to develop a positive culture by promoting openness, transparency and fairness;
- Fostering a culture of openness which supports and encourages staff to raise concerns;
- Sharing expertise to create effective ways of breaking down barriers to reporting incidents and concerns early on;
- Exchanging information, where it is appropriate and lawful to do so, in the interests of patient and public safety; and

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- Signposting individuals to support and guidance to ensure that they are fully aware of and understand their protected rights under the Public Interest Disclosure Act 1998.

1.7 The UHB will monitor the use of this procedure and report to the Board or a sub committee, as appropriate.

2. About this Procedure

2.1 The aims of this procedure are:

a) To encourage staff to discuss concerns and safety issues as soon as possible, in the knowledge that their concerns will be taken seriously and acted upon as appropriate,
b) To encourage staff to report more serious concerns and suspected wrongdoing as soon as possible, in the knowledge that their concerns will be taken seriously and investigated as appropriate, and where requested that their confidentiality will be respected.
c) To provide staff with guidance as to how to raise those concerns.
d) To assure staff that they should be able to raise genuine concerns without fear of reprisals, even if they turn out to be mistaken.

2.2 This procedure applies to all employees, officers, consultants, contractors, students, volunteers, interns, casual workers and agency workers.

3. Raising a Concern

3.1 All healthcare settings and workplaces should encourage ongoing open dialogue and feedback on matters relating to provision of care/service delivery through supervision, team or departmental meetings, staff forums. These ongoing mechanisms are the place where the UHB will actively seek suggestions for improvement and regularly review the safe and effective delivery of services and ways of working.

3.2 All managers will ensure that there is a shared responsibility to focus positively on the quality of service/care, continuous improvement and/or problem solving.

3.3 If concerns are held by an individual or individuals, the UHB will ensure that such concerns are addressed and responded to with the outcome being verbally communicated, as a minimum, to the individual or individuals raising the concern.

3.4 More Serious Concerns

Confidentiality

As noted in section 1.3 of this procedure, the UHB aims to develop and maintain a culture across all parts of the organisation that provides for an environment where people feel able to raise concerns". It is therefore hoped that all staff will feel able to voice concerns openly under this procedure. However, if an individual wants to raise a concern confidentially this will be respected. It is sometimes difficult however, to investigate a concern without knowing the individual's identity. In such circumstances if it is considered absolutely necessary to share the identity of the person raising the concern this will be discussed with them prior to any disclosure being made, and their permission sought.

Stage 1 – Internal (Informal)

If an individual has a concern about any issue involving malpractice/wrongdoing they are encouraged to raise it first either verbally or in writing with their line manager or the manager responsible for that area of work, unless it relates to fraud or corruption (see paragraph overleaf relating to this issue). They may also wish to involve their Trade Union/Staff Representative. Medical staff should report the issue to their Lead clinician.

It is important to remember that raising a concern is different from raising a personal complaint or grievance and in such circumstances the Grievance or Dignity at Work Policies may be appropriate (see appendix 1). If the concern is around the abuse of children or adults with vulnerabilities then the All Wales Child Protection Procedures 2008 and Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse 2013 should be followed and initiated immediately.

and/or

To ensure effective operation of the Procedure for Raising Concerns, NHS organisations must provide an alternative route for issues to be raised where going through the line manager is not appropriate e.g.

- *the member of staff feels there is an immediate issue of significant risk to safety which would not be addressed by line management*
- *the concern raised relates to the conduct or practice of one or more individuals in the line management accountability structures who would normally consider the concern*
- *the member of staff has strong experiential evidence that the line manager(s) would not address the concern*
- *the member of staff feels that similar concerns raised in the past had been ignored*
- *the member of staff feels that the raising of concern would place him/her at risk of harassment or victimisation from colleagues or managers*

Accordingly, NHS organisations should set up their own arrangements, e.g.

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- *Workforce & OD (HR) staff*
- *Governance staff*
- *Professional heads*
- *“Raising concerns” champion (this should be a nominated member of the Board)*
- *Telephone hotline*
- *Safe Haven*

(Individual NHS organisations need to specify and publicise their own arrangements which should be agreed in partnership. These must be incorporated in the space highlighted below in the adopted procedure for local application).

Any concerns regarding potential fraud or corruption should be raised initially with the Local Counter Fraud Specialist (LCFS) on (*NHS Organisation to insert contact details).* Alternatively, reports can be made via the Fraud and Corruption Reporting Line or Website. Full contact details are available via the Counter Fraud pages of the Health Board / Trust intranet site.

These concerns will then be managed in line with the UHB’s Counter Fraud Policy and Response Plan.

(Individual NHS organisations need to specify and publicise their own arrangements).

The individual will be entitled to a verbal response, as a minimum, and where appropriate detail needs to be conveyed a written response to their concern may be appropriate, provided that they have not wished to remain anonymous. The responsibility for providing this response will be either the manager to whom the concern was addressed, or the individual identified to provide such responses in any local processes in place to ensure that concerns can be raised as described in the previous paragraph.

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Stage 2 – Internal (Formal)

If, having followed the approach outlined in stage 1, the individual's concerns remain, or they feel that the matter is so serious that they cannot discuss it with any of the above then they can move on to use the more formal steps as follows.

The individual should make their concerns known to an appropriate senior manager in writing. They may also wish to involve their Trade Union/Staff Representative.

When a concern is raised it is helpful to know how the individual considers the matter might be best resolved.

The senior manager will meet with the individual raising the concern within seven working days. The outcome of the meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Once an individual has told someone of their concern, whether verbally or in writing, the UHB will consider the information to assess what action should be taken. This may involve an informal review or a more formal investigation.

The individual will be told who is handling the matter, how they can contact them and what further assistance may be needed. If there is to be a formal investigation the manager to whom they have reported their concern will appoint an Investigating Officer. If an internal investigation takes place this will be undertaken thoroughly and as quickly as possible (usually within 28 days) in light of the matters to be investigated. At their request, the individual will be written to summarising their concern, and setting out how it will be handled along with a timeframe.

The UHB will aim to keep the individual informed of the progress of the investigation and its likely timescale. However, sometimes the need for confidentiality may prevent specific details of the investigation or any disciplinary action from being disclosed. All information about the investigation should be treated as confidential.

If the matter falls more appropriately within the remit of other W&OD policies, the employees should be advised that they should pursue the matter through the relevant policy and that the Procedure for NHS Staff to Raise Concerns will not be followed (see appendix 1).

The UHB does not expect any individual reporting a matter under this procedure to have absolute proof of any misconduct or malpractice that they report, but they will need to be able to show reasons for their concerns, so any evidence that they have such as letters, memos, diary entries etc. will be useful. These will need to be redacted if they contain any patient identifiable

information.

If the alleged disclosure is deemed to be serious enough, then the UHB may follow the process laid down in the Disciplinary policy and procedure, where the issues raised could relate to individual misconduct, when considering the most appropriate line of action.

The aim of this procedure is to provide an effective process for serious concerns to be raised. If it is concluded that an individual has deliberately made false allegations maliciously or for personal gain, then the UHB will instigate an investigation into the matter in accordance with the Disciplinary policy and procedure.

Subject to any legal constraints, the UHB will inform the individual(s) who raised the concern, of an outline of any actions taken. However, it may not always be possible to divulge the precise action, e.g. where this would infringe a duty of confidentiality of the UHB towards another party.

Stage 3 – Senior Manager

If an individual is either dissatisfied with a decision to only undertake an informal review, or is dissatisfied with the outcome of stage 2 through the mechanisms outlined previously, they should raise their concerns in writing with the Chief Executive, and/or an appropriate Executive Director. If the concern relates to the Chief Executive or Executive Director, concerns should be raised with the Chair. Exceptionally, an individual should proceed directly to this stage as a "Last Resort Escalation" in the unlikely event that having made every attempt to raise a concern through the mechanisms outlined previously there has been little or no attempt to address the matter.

The Chief Executive or Chair (or a nominated representative not previously involved) will meet the individual within 28 working days. Again, the outcome of this meeting will be recorded in writing and a copy given to the individual within seven working days of the meeting.

Stage 4 - Serious or Continued Concerns and Regulatory/Wider Disclosure

The aim of this procedure is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing/inappropriate practices in the workplace. In most cases individuals should not find it necessary to alert external parties.

However, the law recognises that in some circumstances it may be appropriate to report concerns to an external body. It will very rarely if ever be appropriate to alert the media. It is strongly encouraged that an individual seeks advice before reporting a concern to external parties. The independent charity, Public Concern at Work, operates a confidential helpline to support individuals in determining the appropriate course of action. They also have a list of prescribed regulators for reporting certain types of concern. Public Concern at Work's details are included later in this procedure.

All staff have an individual responsibility to safeguard people from harm or suspected harm, by making known their concerns about abuse. Children and adults with vulnerabilities can be subjected to abuse by those who work with them in any setting; all allegations of abuse must therefore be taken seriously and treated in accordance with the All Wales Child Protection Procedures 2008 and Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse 2013. These procedures may dictate that any investigation should be handled by a partner organisation such as Social Services or the Policy which would take precedence over internal procedures, therefore advice from a safeguarding professional should be sought at the earliest opportunity.

If an individual has followed the above procedure to deal with the matter and still has concerns or if they feel that the matter is so serious that they cannot discuss it in any of the ways outlined previously, then in exceptional circumstances they may wish to contact:-

- The National Fraud and Corruption reporting Line on 0800 028 40 60, or alternatively via the on line reporting facility at www.reportnhsfraud.nhs.uk. (if your concern is about financial malpractice)

- Welsh Government

The UHB hopes that this procedure will provide individuals with the reassurances required to raise any matters of concern internally or exceptionally with the organisations referred to above. However, there may be circumstances where individuals are required under their professional regulations to report matters to external bodies such as the appropriate regulatory bodies, including:-

- ❖ General Medical Council (www.gmc-uk.org)

- ❖ Nursing and Midwifery Council (www.nmc-uk.org)
- ❖ Health and Care Professions Council (www.hpc-uk.org)
- ❖ General Pharmaceutical Council (www.pharmacyregulation.org)

The UHB would rather the matter is raised with the appropriate regulatory body than not at all. Other regulatory bodies may include;

- Health and Safety Executive
- Health Inspectorate Wales
- Wales Audit Office
- Police

(This list is not exhaustive).

If an individual needs further advice they can contact the charity Public Concern at Work on 020 7404 6609 or by email at helpline@pcaw.co.uk. Public Concern at Work can advise individuals how to go about raising a matter of concern in the appropriate way (www.pcaw.co.uk/law/lawregulators.html). Alternatively, the Department of Health also provide a service for NHS and Social Care employees in England and Wales on 08000 724 725 or by email at enquiries@wbhelpline.org.uk.

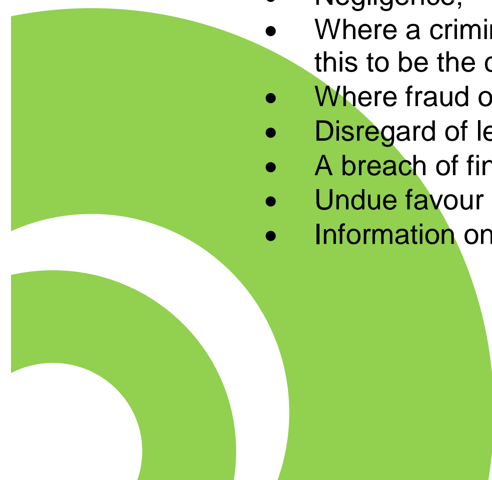
Appendix 1

What is whistleblowing?

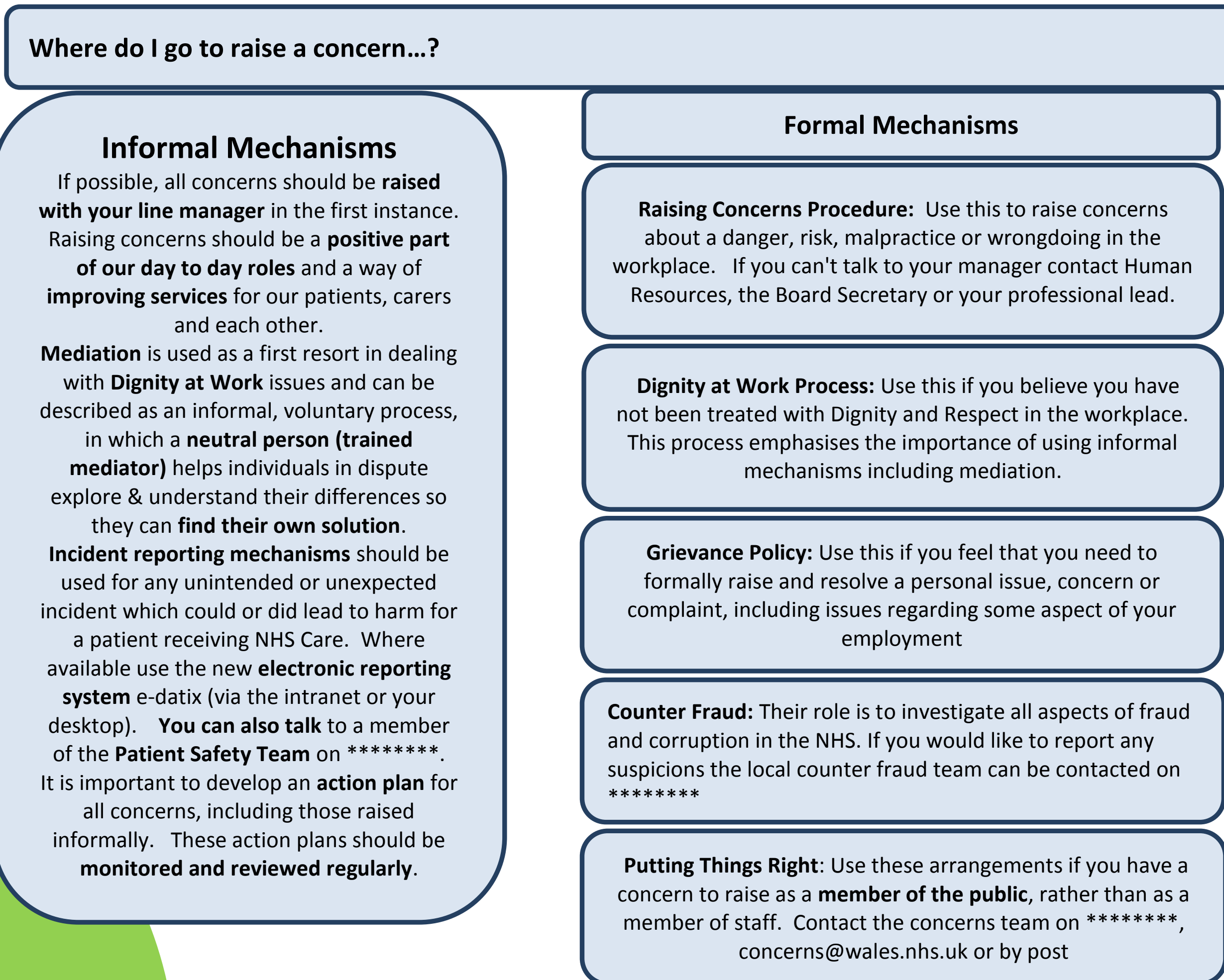
Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrongdoing or malpractice that has a public interest aspect to it, usually because it threatens or poses a risk to others (e.g. patients, colleagues or the public).

This may include:

- Systematic failings that result in patient safety being endangered, e.g. poorly organised emergency response systems, or inadequate/broken equipment, inappropriately trained staff;
- Poor quality care;
- Acts of violence, discrimination or bullying towards patients or staff;
- Malpractice in the treatment of, or ill treatment or neglect of, a patient or client;
- Disregard of agreed care plans or treatment regimes;
- Inappropriate care of, or behaviour towards, a child /vulnerable adult;
- Welfare of subjects in clinical trials;
- Staff being mistreated by patients;
- Inappropriate relationships between patients and staff;
- Illness that may affect a member of the workforce’s ability to practise in a safe manner;
- Substance and alcohol misuse affecting ability to work;
- Negligence;
- Where a criminal offence has been committed / is being committed / or is likely to be committed (or you suspect this to be the case);
- Where fraud or theft is suspected;
- Disregard of legislation, particularly in relation to Health and Safety at Work;
- A breach of financial procedures;
- Undue favour over a contractual matter or to a job applicant has been shown;
- Information on any of the above has been / is being / or is likely to be concealed



This procedure should not be used for complaints relating to your own personal circumstances, such as the way you have been treated at work. In these cases, the Grievance policy or the Dignity at Work policy should be used as appropriate. Please see illustration below:-



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Appendix 2

Protection of those making disclosures

It is understandable that individuals raising concerns are sometimes worried about possible repercussions. The UHB aims to encourage openness and will support staff who raise genuine concerns under this procedure, even if they turn out to be mistaken. In addition, there are statutory provisions for individuals who make what are termed “protected disclosures”.

In law individuals must not suffer any detrimental treatment as a result of raising a concern. Detrimental treatment includes dismissal, disciplinary action, threats or other unfavourable treatment connected with raising a concern. If an individual believes that they have suffered any such treatment, they should inform a member of the Workforce and Organisational Development department, immediately. If the matter is not remedied they should raise it formally using the Grievance Procedure.

Those who raise concerns must not be threatened or retaliated against in any way. If an individual is involved in such conduct they may be subject to disciplinary action. [In some cases, the individual raising a concern could have a right to sue for compensation in an employment tribunal.]

The UHB aims to protect and support staff to raise legitimate concerns internally within the organisation where they honestly and reasonably believe that malpractice/wrongdoing has occurred or will be likely to occur. Staff who make what is referred to as a “protected disclosure”, i.e. a disclosure concerning an alleged criminal offence or other wrongdoing, have the legal right not to be dismissed, selected for redundancy or subjected to any other detriment (demotion, forfeiture of opportunities for promotion or training, etc.) for having done so and the protections are set out in law in the Public Interest Disclosure Act 1998.

If an individual is raising a matter of serious or continued concern the same protection applies as for internal disclosure. This is intended to promote accountability in public life and there is no requirement that such concerns should first be raised with the UHB although it is preferred that the UHB should be given an opportunity to resolve the matter first.

If an individual is raising a matter with a regulatory body defined within the Public Interest Disclosure Act 1998 they will be protected where they honestly and reasonably believe that the malpractice/wrongdoing has occurred or is likely to occur and in addition they honestly and reasonably believe that the information and any allegation contained in it are substantially true. The Public Interest Disclosure (Prescribed Persons) Order 2014 amends the list of prescribed persons

and came into force on 1 October 2014 and applies to disclosures made on or after this date. The new list of prescribed persons in respect of matters relating to healthcare services is set out below:-

Relevant matters	Prescribed person
Matters relating to the registration and fitness to practice of a member of a profession regulated by the relevant council and any other activities in relation to which the relevant council has functions.	The Nursing and Midwifery Council, Health and Care Professions Council, General Medical Council, General Chiropractic Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council.

For healthcare services in Wales (specifically):

Relevant matters	Prescribed person
Matters relating to the registration of social care workers under the Care Standards Act 2000.	Care Council for Wales
Matters relating to: • The provision of Part II services as defined in section 8 of the Care Standards Act 2000 and the Children Act 1989. • The inspection and performance assessment of Welsh local authority social services as defined in section 148 of the Health and Social Care (Community Health and Standards) Act 2003. • The review of, and investigation into, the provision of health care by and for Welsh NHS bodies as defined under the Health and Social Care (Community Health and Standards) Act 2003. • The regulation of registered social landlords in accordance with Part 1 of the Housing Act 1996 (as amended by the Housing (Wales) Measure 2011.	Welsh ministers

If an individual is making a wider disclosure (for example to the police, or an Assembly Member (AM) (other than the Minister for Health and Social Care or a Member of Parliament (MP)) they will be protected only if:

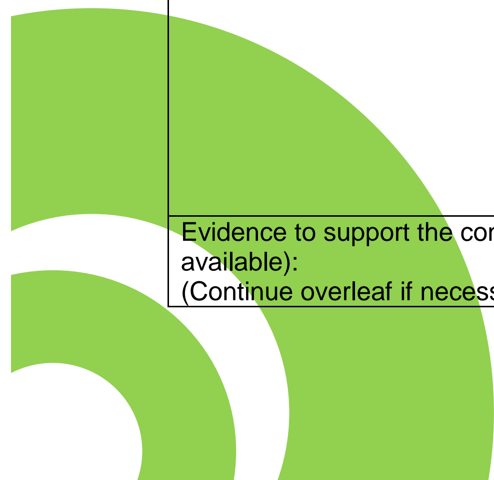
- they meet the above tests for internal and regulatory disclosures;
- they have not made the disclosure for personal gain;
- they have first raised the matter internally or with a prescribed regulatory body unless the matter was exceptionally serious and they reasonably believed they would be victimised if they did so; or
- there is no prescribed regulatory body and it is reasonably believed that there would be a cover up

Public Concern at Work or a Trade Union will be able to advise on the circumstances in which an individual should use this procedure and where they may be able to contact an outside body without losing the protection afforded under the Public Interest Disclosure Act 1998.

Appendix 3 – Cardiff and Vale University Health Board

Form WB1 – Recording a concern raised under the procedure

Concern raised by (name):				
Designation				
Ward / Department				
Confidentiality requested:	yes		No	
Nature of concern raised:	Delivery of care/services to patients			
	Vale for money			
	Health and safety			
	Unlawful conduct			
	Fraud, theft or corruption			
	The cover-up of any of the above			
Details of concern raised: (Continue overleaf is necessary)				
Evidence to support the concern (if available): (Continue overleaf if necessary)				



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Any suggestions from employees as to a resolution?		
How will the matter be handled?	Informal review	
	Internal investigation	
Concern reported to:		
Contact name:		
Designation:		
Telephone no:		
Signed:		
Date:		
N.B. Once completed, this form should be retained on a case file		

11.2

Appendix 4 – Cardiff and Vale University Health Board

Form WB2 Concerns Raised Under the Procedure: Summary of findings and outcome of investigation

Concern raised by (name):	
Designation:	
Informal review undertaken by:	
Investigation undertaken by:	
Summary of findings of review / investigation: (continue overleaf if necessary)	
Outcome: Action taken: (continue overleaf if necessary)	
No action taken for the following reasons:	

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Further action (if appropriate): (e.g. report the matter to Welsh Government / Regulator)	
Name:	
Signed:	
Designation:	
Date:	
N.B. Once completed, this form should be retained on a case file.	

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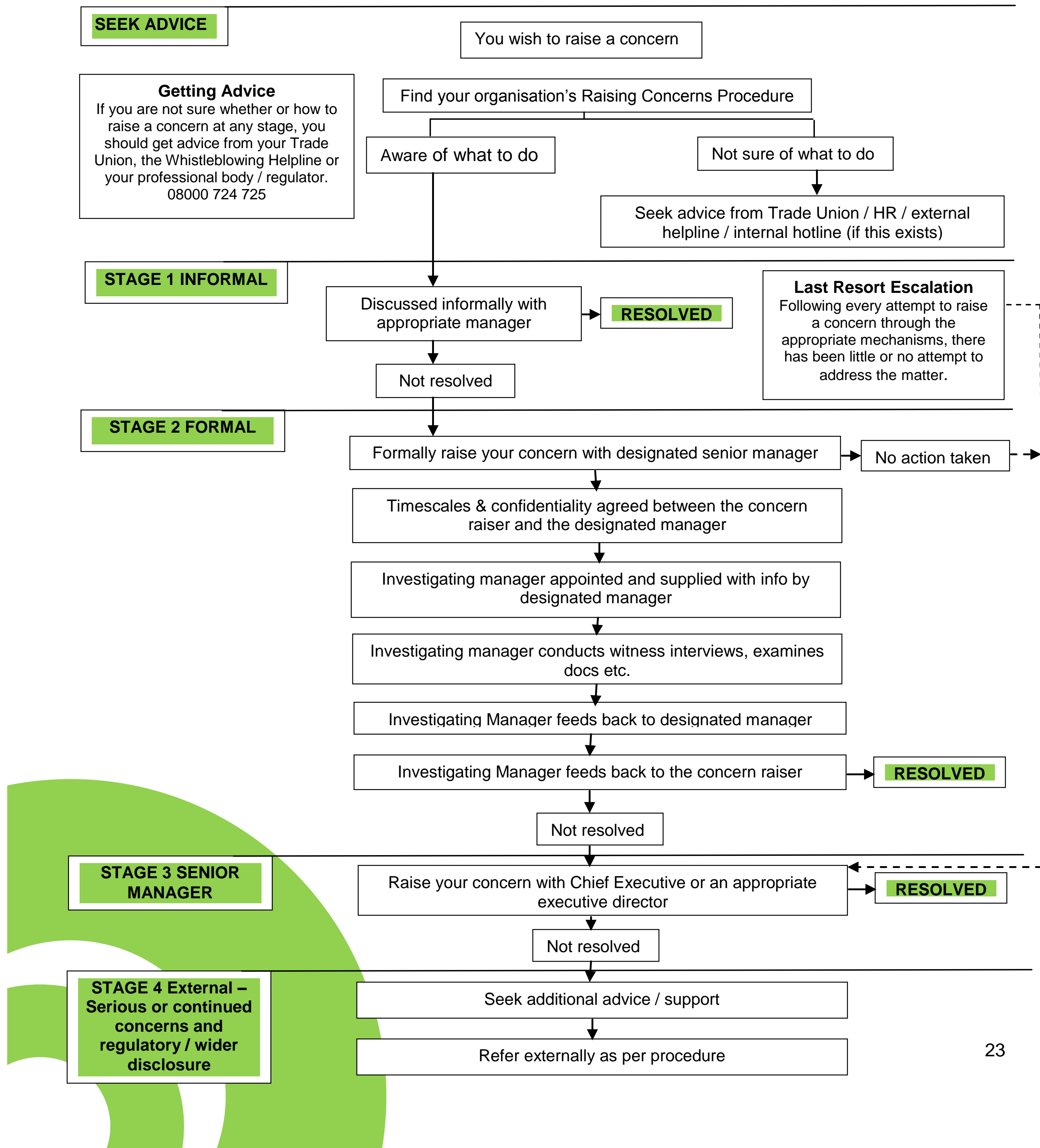
Appendix 5 – Flowchart of Raising Concerns Process

This flowchart sets out the stages in raising a concern and shows the management levels for internal disclosure. In a small organisation, there may not be more than one or two levels of management to whom you can escalate your concerns. In these cases, you should consider escalating your concern to the regulator or other prescribed person at an earlier stage than is shown on the flowchart.



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NHS Wales Employers is hosted by and operates as a part of the Welsh NHS Confederation

LHB/Trust Chief Executives
LHB/Trust Chairs
LHB/Trust Directors of Workforce & Organisational Development
WPF Members

2 January 2018

Dear colleague,

Please find attached the following revised policy and procedure for NHS Wales: -

- Special Leave Policy;
- Procedure for NHS Staff to Raise Concerns.

The main changes from the previous policy and procedure are outlined below: -

<u>Special Leave Policy</u>

- Additional reference to Core Principles of NHS Wales;
- Amended section on the types of leave that can be taken;
- Reference to discourage individuals who have been allowed paid time off to undertake public duties from claiming further remuneration from the other organisation.

<u>Procedure for NHS Staff to Raise Concerns</u>

- Additional reference to Core Principles of NHS Wales;
- Addition of examples demonstrating where raising a concern with a line manager may not be appropriate;
- Inclusion of a diagram at appendix 1 demonstrating different mechanisms for raising issues.

11.2

Ty Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ
Tel: 029 2034 9850

The current policy and procedure should now be replaced with these versions which were approved for implementation by the Welsh Partnership Forum on 7 December 2017.

I would be grateful if the revised policy and procedure could be adopted by your Board (or sub committee) and implemented at the earliest opportunity. Please note that individual organisations will need to ensure that references to “NHS Organisation” are changed to your organisation’s name.

Yours sincerely

Richard Tompkins
Director
NHS Wales Employers
On behalf of the Joint Chairs of the Welsh Partnership Forum

11.2

Ty Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ
Tel: 029 2034 9850

REVIEW OF STRATEGY AND ENGAGEMENT AND RESOURCE AND DELIVERY COMMITTEES
Name of Meeting: Joint Committee meeting of the above **Date of Meeting:** 30 January 2018

Executive Lead : Chair
Author : Director of Corporate Governance
Caring for People, Keeping People Well
Financial impact : N/A
Quality, Safety, Patient Experience impact : N/A
Health and Care Standard Number: Governance Leadership and Accountability
CRAF Reference Number: N/A
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Discussion with Chief Executive, Chairs of Committees, Executive Leads of Committees
- Discussion at Management Executive Team Meeting
- Discussion at Chair's Governance Coordinating Group

The Committee is asked to:

- **AGREE** to stand down the Strategy and Engagement and Resource and Delivery Committees and replace these with a new Strategy and Delivery Committee
- **SUPPORT** Chair's Action to agree the terms of reference of this new Committee and for this to be endorsed at the Board's meeting on 29 March 2018

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SITUATION

Each year the Wales Audit Office (WAO) reviews the Health Board arrangements, which supports good governance with a Structured Assessment report. In the 2016 Structured Assessment, comments were received on The People, Planning and Performance (PPP) Committee. The WAO felt the scope of the Committee was too large and should be reviewed. This was reported to the Board's development session in February 2016 where they undertook a review of the effectiveness of the Board and Committees.

BACKGROUND
In examining the Board and Committee structure at the development session, a number of changes were identified and two new Committees were established with the Terms of Reference approved by the Board to replace the PPP Committee. The first meetings were held in July and August 2017. (Click here for ToRs for Strategy and Engagement and Resource and Delivery).

ASSURANCE
When the two Committees were established, it was agreed that there would be a formal review before the end of the financial year. In addition, the Organisation has now received a draft Structured Assessment for 2017 where comments on observations were made on both Committees. In the first draft of the Structured Assessment the comments made revolved around the need for further scrutiny at meetings.

The Committees have met twice since its inauguration and at each Committee the Terms of Reference have been discussed and reviewed to establish whether they were fit for purpose.

On the 16 January 2018, a meeting was set up with the Chair, Chief Executive, Chairs of the Committees and Lead Executives to consider the recommendations in the draft Structured Assessment. It was proposed:

- To merge the two Committees and establish a new Committee to be called ‘Strategy and Delivery’. This Committee will be focused and avoid duplication with other Committees. This will overcome the concern in the draft Wales Audit Office 2017 report.

- It would concentrate on the UHB ‘Shaping our Future Strategy’. The Committee would also monitor the Strategy in the context of the Wellbeing of Future Generations and the recent links with Canterbury District Health Board, New Zealand.

- The delivery of the strategy will be monitored and assurances received through the Integrated Medium Term Plan (IMTP).

- The aim of the Committee is to provide assurance and where appropriate a ‘deep dive’ into issues.

- The Committee will also receive assurances on the principle risks on achieving our objectives for the year within the IMTP.

Following discussion, a draft Terms of Reference will be developed in February and presented to members for comment. If agreed, Chair’s action will be presented to the Board on 29 March 2018. This will be presented to the Chair for the first meeting of the Strategy and Development Committee to be held on 13 March 2018.

HIGH LEVEL PERFORMANCE DASHBOARD	
Name of Meeting : R&D Committee	**Date of Meeting** 30th January 2018

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 operational performance targets, 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 operational performance targets.

The Resource and Delivery Committee is asked to:

- **NOTE** Year to date performance for 2017-18 against key operational performance targets.

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 operational performance targets.

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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 operational performance targets.

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 operational performance 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

Performance against key operational performance targets

		March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Unscheduled Care											
EU waits - 4 hours (95% target)	IMTP 17/18 profile	-	87.0%			87.0%			90.0%		
	17/18 Actual - Monthly	86%	87.9%	84.3%	85.0%	86.0%	86.9%	86.6%	83.4%	85.2%	82.1%
	17/18 Actual - Qtly	83%	85.7%			86.5%			83.6%		
EU waits - > 12 hours (0 target)	IMTP 17/18 profile	-	100			100			100		
	17/18 Actual - Monthly	62	13	60	47	10	8	23	80	37	91
	17/18 Actual - Qtly	276	120			41			208		
Ambulance handover > 1 hour (number)	IMTP 17/18 profile	-	370			370			739		
	17/18 Actual	295	163	281	207	77	91	168	302	188	319
Ambulance - 8 mins red call (65% target)	IMTP 17/18 profile	-	70.0%			70.0%			70.0%		
	17/18 Actual	88.1%	86.5%	82.9%	86.6%	86.6%	84.3%	84.5%	83.1%	77.5%	78.0%
Delayed Transfers of Care	17/18 Actual	58	77	76	60	51	54	48	54	53	38
Stroke											
1a - % of patients who have a direct admission to an acute stroke unit within 4 hours (Target = 60.2%)	IMTP 17/18 profile		60.0%			60.0%			60.0%		
	17/18 Actual	44.7%	67.5%	62.3%	42.6%	48.6%	53.3%	57.1%	44.9%	48.7%	45.1%
2 - % of patients who receive a CT scan within 12 hours (Target = 94%)	IMTP 17/18 profile		96.0%			96.0%			96.0%		
	17/18 Actual	100.0%	97.8%	98.3%	98.0%	100.0%	96.8%	100.0%	98.1%	95.2%	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%	92.5%	73.8%	77.8%
Time 2b - Thrombolsyed 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%	0.0%	25.0%	12.5%

Appendix 1b

Performance against key operational performance targets

		March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Planned Care											
31 day NUSC cancer (Target = 98%)	IMTP 17/18 profile		98.0%			98.0%			98.0%		
	17/18 Actual	98.79%	98.48%	98.85%	97.62%	100.00%	100.00%	94.20%	100.00%	98.80%	
62 day USC cancer (Target = 95%)	IMTP 17/18 profile		90.0%			90.0%			91.0%		
62 day USC cancer (Target) - Monthly	17/18 Actual	95.37%	90.53%	91.75%	85.06%	95.56%	88.35%	83.53%	90.99%	89.74%	
62 day USC cancer (Target) - Quarterly cumulative	17/18 Actual	-	89.25%			88.72%			89.91% (Oct - Nov)		
Diagnostics > 8 weeks (Target = 0)	IMTP 17/18 profile (revised)				1,837			1,770			1,703
	17/18 Actual	1,837	1,969	1,915	1,642	1,651	2,005	1,970	1,850	2,070	1,869
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%	80%	80%	80%
	17/18 Actual	68%	23%	20%	18%	71%	81%	89%	97%	92%	
Part 1b: % of therapeutic interventions started within (up to and including) 28 days following	IMTP 17/18 profile		90%	90%	90%	90%	90%	90%	90%	90%	90%
	17/18 Actual	89%	88%	87%	83%	85%	84%	85%	80%	79%	
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%	90%	90%	90%
	17/18 Actual	93%	91%	89%	88%	90%	91%	91%	90%	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%	90%	90%	90%
	17/18 Actual	91%	100%	100%	100%	100%	100%	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%						100%		
	17/18 Actual	100%	100%						100%		

CONTINUING HEALTH CARE (CHC) REPORT

Executive Lead : Director – Chief Operating officer
Author : PCIC Director of Nursing
Caring for People, Keeping People Well: This update underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy and meet the Welsh Government requirements for Implementing, monitoring and managing the Continuing Health Care policy responsibilities Locally within the Cardiff and Vale area.
Financial impact : £ 4.8 million growth (approximate)
Quality, Safety, Patient Experience impact :
Health and Care Standard Number 2.7, 3.1,4.1,6.1 CRAF Reference Number
Equality Impact Assessment Completed: Yes / No / Not Applicable

RECOMMENDATION

The Committee is asked to:

- **NOTE** this update on Continuing Health Care (CHC). This is in accordance with the recommendation of the Public Accounts Committee, that a Continuing Health Care Board report or update is provided incorporating relevant finance and activity monitored against statutory requirements for Executive approval on a quarterly basis. The PCIC Clinical Board will monitor and review this information on behalf of the Executive Board on a monthly basis at the PCIC Service Delivery Group, providing high level information on a regular basis within this template and will raise specific issues outside of the quarterly reporting at PCIC Clinical Board Executive Performance Review.

SITUATION

The National Complex Care Board (Welsh Government) have identified the need for Health Boards across Wales to provide Welsh Government with evidence that Boards have considered Continuing Health Care related matters in line with the Performance Framework.

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BACKGROUND

The Public Accounts Committee has advised that all Health Boards across Wales have a requirement within the agreed NHS Performance Framework from April 2015 that Continuing Health Care reports should be considered by a Board level Committee to allow for greater scrutiny.

The PCIC Clinical Board review all CHC and FNC related performance at the monthly performance meeting chaired by the Director of Operations (Service Delivery Group). This, in turn, informs the update to the Board level committee, which highlights risks with actions and progress that have been recorded within the PCIC Service Delivery Group. Any specific risks will be noted on the Clinical Board risk register and also raised and discussed at the Clinical Boards monthly Executive Performance Review meetings.

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ASSESSMENT

The following has been identified as key issues:

- Increase in demand for CHC assessments including fast track applications is continuing to impact on performance in relation to timely responses to initial assessments and reviews across the three Locality CHC teams (North & West, South & East and Vale)

- Protracted delays in allocation of social workers continue to reflect negatively on the ability to meet timescales for CHC assessments within the Cardiff Localities and to undertake the required MDT meetings for retrospective cases.

- Ability to organise Independent Review Panels (IRP's) in a timely manner because of availability of panel members as well as cancellations of arranged panels at request of solicitors and family is causing increased administrative workload and stress within the Retrospective team.

- The Executive Director of Finance will be leading a fee setting process with Nursing home providers for 2018/19. This is crucial in order to establish agreed rates and ensure patients are able to be placed in a timely manner not impacting of DTOC or resulting in unnecessary admissions.

- There have been sustainability issues noted in a small number of complex Community CHC Packages resulting in gaps in staffing which has resulted in a long term admission for one patient. A complex legal challenge is currently being managed within the clinical board to attempt to facilitate a discharge plan. A framework contract is also being scoped for development to support alternate options for sustainability of packages.

- CHC savings plan is being progressed through the sustainability CHC framework.

- The Funded Nursing Care (FNC) weekly rate has increased by 1.1% for 17/18 in line with NHS pay increases (approx. £0.085m impact), however there is also the potential for a further substantial backdated

increase depending on the consequences of the Judicial Review judgment from the Court of Appeal (April 2017).

- CHC Training sessions have been developed through LED by PCIC staff for staff to access across the UHB and other stakeholder groups. Many of the sessions have been cancelled due to poor attendance. An alternate training strategy is being considered.

- The UHB Executive Board is asked note the key issues affecting CHC as at the end of Q3 2017/18