Health Board Meeting

Thu 24 November 2022, 10:00 - 13:00

Virtually via Microsoft Teams

Agenda

10:00 - 10:05
5 min

1. PRELIMINARY MATTERS

Information

1.1. Welcome & Introductions

Information *Emrys Elias, Chair*

1.2. Apologies for Absence

Information *Emrys Elias, Chair*

1.3. Declarations of Interest

Information *Emrys Elias, Chair*

10:05 - 10:20
15 min

2. SHARED LISTENING & LEARNING

2.1. Patient Story - Frailty Services

Discussion *Chris Waters, Frailty & Chronic Conditions Nurse Primary Care and Melissa Duffy, Frailty Nurse Primary Care*

10:20 - 10:25
5 min

3. Consent Agenda

3.1. For Approval

3.1.1. Unconfirmed Minutes of the meeting held on 29 September 2022

Decision *Emrys Elias, Chair*

3.1.1 Unconfirmed Minutes of the Health Board 29 September 2022 UHB 24 November 2022.pdf (13 pages)

3.1.2. Unconfirmed In Committee Minutes of the meeting held on 29 September 2022

Decision *Emrys Elias, Chair*

3.1.2 Unconfirmed Minutes of the Health Board In Committee Meeting 29.09.2022 UHB 24 November 2022.pdf (2 pages)

3.1.3. Chairs Report and Affixing of the Common Seal

Decision *Emrys Elias, Chair*

3.1.3 Chairs Board Report UHB November 2022.pdf (5 pages)

3.1.4. Committee Annual Reports

Decision *Cally Hamblyn, Assistant Director of Governance & Risk*

3.1.4a Board Committee Annual Reports UHB 24 November 2022.pdf (2 pages)
3.1.4b Appendix 1 Annual Report 2021-22 MHAM Committee UHB 24 November 2022.pdf (15 pages)
3.1.4c Appendix 2 Digital & Data Committee Annual Report 2021-2022 UHB 24 November 2022.pdf (6 pages)

3.1.5. Amendments to the Standing Orders

Decision *Cally Hamblyn, Assistant Director of Governance & Risk*

3.1.5a Amendment to Standing Orders - Schedule 3.1, 3.3, 3.5, and 3.8 - Cover Paper.pdf (3 pages)
3.1.5b App 1 - Amendment to Standing Orders Schedule 3.3 - Digital & Data Committee - Terms of Reference Review - Nov HB.pdf (10 pages)
3.1.5c App 2 - Amendment to Standing Orders Schedule 3.5 - People and Culture Committee Terms of Reference Review - Nov HB.pdf (10 pages)
3.1.5d App 3 - Amendment to Standing Orders Schedule 3.8 - Quality & Safety Committee ToR -Review Nov HB.pdf (11 pages)
3.1.5e App 4 - GC01 Standing Orders - Schedule 3.1 - Audit & Risk Committee ToR UHB 24 November 2022.pdf (10 pages)

3.2. For Noting

3.2.1. Action Log

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.1 Action Log Health Board 24th November 2022.pdf (2 pages)

3.2.2. Board Annual Cycle of Business

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.2 Board Cycle of Business UHB 24 November 2022.pdf (6 pages)

3.2.3. Board Forward Work Programme

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.3 Board Forward Work Programme UHB 24 November 2022.pdf (3 pages)

3.2.4. Committee Highlight Reports

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.4a Board Committee Highlight Reports UHB 24 November 2022.pdf (2 pages)
3.2.4b Appendix 1a Highlight Report QS Committee UHB 24 November 2022.pdf (4 pages)
3.2.4c Appendix 1b Highlight Report Quality Safety Committee 15 November 2022 UHB 24 November 2022.pdf (4 pages)
3.2.4d Appendix 2 DD Committee Highlight Report 28.09.2022 UHB 24 November 2022.pdf (4 pages)
3.2.4e Appendix 3 Highlight Report In Committee QSC UHB 24 November 2022.pdf (2 pages)
3.2.4f Appendix 4 Highlight Rpt MHAMC 29.9.22 UHB 24 November 2022.pdf (3 pages)
3.2.4g Appendix 5 SRG Highlight Report October 2022 UHB 24 November 2022.pdf (3 pages)
3.2.4h Appendix 6 - Highlight Report Hosted Bodies ARC Oct Committee UHB 24 November 2022.pdf (3 pages)
3.2.4i Appendix 7 Highlight Report CTMUHB ARC Oct Committee UHB 24 November 2022.pdf (4 pages)
3.2.4j Appendix 8 Highlight Report PHP 2.11.22 UHB 24 November 2022.pdf (3 pages)
3.2.4k Appendix 9 PCC Highlight Rpt to Board UHB 24 November 2022.pdf (3 pages)
3.2.4l Appendix 10 Highlight Report Charitable Funds Committee UHB 24 November 2022.pdf (3 pages)

3.2.5. Joint Committee Highlight Reports

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.5a Joint Committee Reports UHB 24 November 2022.pdf (2 pages)
3.2.5b Appendix 1 WHSCC Joint Committee Briefing (Public) 8 November 2022 UHB 24 November 2022.pdf (6 pages)
3.2.5c Appendix 2 SSPC Assurance Report 22 September 2022 (003) UHB 24 November 2022.pdf (7 pages)
3.2.5d Appendix 3 Chair's EASC Summary from 8 November 2022 UHB 24 November 2022.pdf (10 pages)

3.2.6. Clinical Education Annual Report

Information *Sallie Davies, Deputy Medical Director*

3.2.6 Clinical Education Annual Report UHB 24 November 2022.pdf (41 pages)

3.2.7. Health & Care Standards Annual Report

Information *Debbie Bennion, Deputy Executive Director of Nursing*

3.2.7a Health & Care Standards Annual Report UHB 24 November 2022.pdf (6 pages)
3.2.7b HCS Audit Report 2022 FINAL UHB 24 November 2022.pdf (72 pages)

10:25 - 10:30
5 min

4. MAIN AGENDA

4.1. Matters Arising not Contained within the Action Log

Discussion *Emrys Elias, Chair*

10:30 - 11:00
30 min

5. INTEGRATED GOVERNANCE & ASSURANCE

5.1. Chief Executive's Report

Discussion *Paul Mears, Chief Executive*

5.1a CEO Update Report UHB 24 November 2022.pdf (5 pages)
5.1b Appendix Bridgend health and social care case for change UHB 24 November 2022.pdf (7 pages)

5.2. Board Assurance Framework

Discussion *Cally Hamblyn, Assistant Director of Governance & Risk*

5.2a Board Assurance Framework - Final - Cover Paper November 2022 (2).pdf (3 pages)
5.2b Appendix 1 - Board Assurance Framework - Final - November 2022 (1).pdf (32 pages)

5.3. Nurse Staffing Act Report

Discussion *Debbie Bennion, Deputy Executive Director of Nursing*

5.3a NSLWA report UHB 24 November 2022.pdf (8 pages)
5.3b Appendix A November Annual Presentation of the Nurse Staffing Levels to . (1).pdf (9 pages)
5.3c Appendix B Summary of Nurse Staffing Levels for §25B wards - Nov 2022 V....docx.pdf (7 pages)
5.3d Appendix C Paeds - Nov 2022 V1.pdf (1 pages)

5.4. Planning Performance & Finance Committee Highlight Report

Discussion *Mel Jehu, Independent Member and Chair of the PPF Committee*

5.4 PPFC 25.10.22 Highlight Report to Board UHB 24 November 2022 v1.pdf (4 pages)

11:00 - 11:45
45 min

6. DELIVERING OUR PURPOSE & STRATEGIC DIRECTION

6.1. Integrated Performance Dashboard

Discussion *Executive Director Leads*

6.1 Integrated Performance Dashboard UHB 24 November 2022.pdf (51 pages)

6.1.1. Introduction

Discussion *Linda Prosser, Executive Director of Strategy & Transformation*

6.1.2. Operational Performance

Discussion *Gethin Hughes, Chief Operating Officer*

6.1.3. Quality Performance

Discussion *Debbie Bennion, Deputy Executive Director of Nursing/ Sallie Davies, Deputy Medical Director/Stephanie Muir, Assistant Director of Concerns and Legal*

6.1.4. Workforce Performance

Discussion *Hywel Daniel, Executive Director for People*

6.1.5. Financial Performance

Discussion *Sally May, Executive Director of Finance*

The Board is requested to approve the application for Strategic Cash Support from WG to cover the cash requirement resulting from the projected Core Plan deficit of £26.5m. This will be applied for via an Accountable Officer letter to be submitted by 08 December 2022. It should be noted that there is a separate process with WG to request cash support to cover movement in working balances, such as release of annual leave accrual and other balance sheet movements. Mitigating actions will continue to be applied where possible to reduce our cash support requirements, including timely recovery of income such as Welsh Risk Pool reimbursements.

6.1.5 M7 Finance Report- Final UHB 24 November 2022.pdf (23 pages)

6.2. Capital Programme - Mid Year Position

Discussion *Sally May, Executive Director of Finance*

6.2 Capital Mid Year Update UHB 24 November 2022.pdf (16 pages)

11:45 - 12:35
50 min

7. DELIVERING OUR RECOVERY/IMPROVEMENT PLANS

7.1. Improving Urgent Care - Progress Report on the 6 Goals Programme

Discussion *Gethin Hughes, Chief Operating Officer*

7.1 6 Goals UEC final UHB 24 November 2022.pdf (8 pages)

7.2. Planned Care Recovery

Discussion *Gethin Hughes, Chief Operating Officer*

7.2 Planned Care Recovery UHB 24 November 2022.pdf (6 pages)

7.3. Regional South East Wales Working - Progress Report

Discussion *Linda Prosser, Executive Director of Strategy & Transformation*

7.3 Regional Programme Update UHB 24 November 2022.pdf (8 pages)

7.4. Integrated Medium Term Plan - Planning for 2023/2024

Discussion *Linda Prosser, Executive Director of Strategy & Transformation*

7.4 IMTP update 2023-26 planning cycle UHB 24 November 2022.pdf (6 pages)

7.5. Integrated Medium Term Plan (Annual Plan) - Quarterly Update

Discussion *Linda Prosser, Executive Director of Strategy & Transformation*

7.5a Annual Plan 2022-23 update UHB 24 Novembr 2022.pdf (5 pages)
7.5b Appendix 1 20220914 CTMUHB Weight Management Programme Report 2022-2023.....pdf (45 pages)
7.5d Appendix 3 - Schools in reach Proforma CTM August 2022 UHB 24 November 2022.pdf (9 pages)
7.5e Appendix 4 NHS Performance Framework - 2022-2023 - Qualitative Reporting....pdf (14 pages)
7.5f Appendix 5 Learning Disabilities Improving Lives Programme 1st April 202....pdf (9 pages)

- 7.5g Appendix 6 - 2022-23 Q2 Qualitative Reporting Decarbonisation Action Pla....pdf (7 pages)
- 7.5h Appendix 7 NHS Performance Framework - 2022-2023 - Qualitative Reporting....pdf (4 pages)
- 7.5i Appendix 8 NHS Performance Framework - Apr-Aug 2022-2023 - Qualitative R.._.pdf (8 pages)

7.6. Winter Plan Update

Gethin Hughes, Chief Operating Officer

- 7.6a Winter Plan report UHB 24 November 2022.pdf (6 pages)
- 7.6c ANNEX A Plan on a Page - 6 Goals for sharing UHB 24 November 2022.pdf (1 pages)
- 7.6d Annex B Discharge to Recovery Flowchart UHB 24 November 2022.pdf (8 pages)
- 7.6d Annex C CTM Surge beds impact scoring UHB 24 November 2022.pdf (2 pages)
- 7.6e Annex D Winter Plan Annexes UHB 24 November 2022.pdf (3 pages)

12:35 - 12:50
15 min

8. Escalation Status: Special Measures & Targeted Intervention

8.1. Maternity & Neonatal Services Improvement Programme

Discussion *Debbie Bennion, Deputy Executive Director of Nursing /Sallie Davies, Deputy Medical Director*

- 8.1 Maternity & Neonatal Improvement Programme Highlight Report September 2022 UHB 24 November 2022.pdf (43 pages)

12:50 - 12:55
5 min

9. Any Other Business

9.1. How Did we do in this Meeting

Discussion *Emrys Elias, Chair*

12:55 - 13:00
5 min

10. Date and Time of Next Meeting - Thursday 26 January 2023 at 10:00am

Emrys Elias, Chair

Agenda Item Number: 3.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University Health Board (CTMUHB) held on Thursday 29 September 2022 as a Virtual Meeting Broadcast Live via Microsoft Teams

Members Present:

Emrys Elias	Chair
Greg Dix	Acting Chief Executive/Director of Nursing
Jayne Sadgrove	Vice Chair/Independent Member
Patsy Roseblade	Independent Member
Ian Wells	Independent Member (In part)
Mel Jehu	Independent Member
Nicola Milligan	Independent Member
James Hehir	Independent Member
Carolyn Donoghue	Independent Member
Lynda Thomas	Independent Member (In part)
Dilys Jouvenat	Independent Member
Linda Prosser	Executive Director of Therapies & Health Sciences
Gethin Hughes	Chief Operating Officer
Kelechi Nnoaham	Executive Director of Public Health
Sally May	Executive Director of Finance
Lauren Edwards	Executive Director of Therapies & Health Sciences
Dom Hurford	Medical Director
Hywel Daniel	Executive Director for People (In part)
Anne Morris	Associate Member

In Attendance:

Georgina Galletly	Director of Corporate Governance
Stuart Morris	Director of Digital
Cally Hamblyn	Assistant Director of Governance & Risk
Tom Barton	Lead Advanced Nurse Practitioner (In part)
Helen Watkins	Deputy Director for People
Suzanne Hardacre	Director of Midwifery
Wendy Penrhyn-Jones	Head of Corporate Governance and Board Business
Richard Morgan- Evans	Chief of Staff
Lee Leyshon	Assistant Director of Engagement and Communications
Emma Samways	Internal Audit
Rhys Jones	Healthcare Inspectorate Wales
Nicola Bresner	Healthcare Inspectorate Wales
Emma Walters	Corporate Governance Manager (Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also **noted** by the Chair.

1.2 Apologies for Absence

Apologies for absence had been received from:

- Paul Mears, Chief Executive
- Lisa Curtis-Jones, Associate Member
- Daniel Price, Cwm Taf Morgannwg Community Health Council
- Geraint Hopkins, Independent Member

1.3 Declarations of Interest

No additional declarations were made.

2 SHARED LISTENING AND LEARNING

2.1 Patient Story

T Barton, Lead Advanced Clinical Practitioner, Acute Clinical Team, presented a story which related to a patients experience of the treatment they received after experiencing a devastating crush injury at work. T Barton also shared a poem he had written reflecting how Advanced Clinical Practitioners support end of life care.

The Chair thanked T Barton for sharing the patient story and poem and extended his thanks to the patient for allowing their experience to be shared.

J Sadgrove reflected how the patient story had provided the Board with real insight into the work undertaken by the Acute Clinical Team and how their efforts make such a difference in supporting patients with their daily lives.

G Hughes commented that the presentation provided such a moving illustration of how services and care can be provided for patients in their own home and took the opportunity to ask T Barton what the Health Board could do to build on the success of the service.

In response, T Barton reflected that one of the biggest challenges is the size and capacity of the team balanced with the enormity of the ask. He commented that the model works well however, the service needs to grow in order to realise the further opportunities and benefits that could be realised including digital innovations and solutions.

L Edwards noted that a key priority for the Health Board is to support staff in working at an advanced practice level, she drew attention to the advanced practice week which is scheduled for early November where an event is being planned to share learning.

3 CONSENT AGENDA

3.1 FOR APPROVAL

3.1.1 Unconfirmed Minutes of the Meeting held on the 28 July 2022

Resolution: The minutes were **APPROVED.**

3.1.2 Chair's Report – Affixing of the Common Seal and Ratification of Chair's Action

Resolution: The report was **APPROVED.**

3.1.3 Committee Annual Reports

Resolution: The reports were **APPROVED.**

3.1.4 Proposal to Return Ferndale/Maerdy Medical Practice back to Independent Status

Resolution: The report was **APPROVED.**

3.1.5 Scheme of Delegation and Procurement Report

Resolution: The Chair made Board Members aware that since the report was published a minor additional amendment had been incorporated following a request from the Director of Therapies and Health Sciences to include the Clinical Director for Allied Health Professionals to the list of Care Group Directors set out within the Scheme of Delegation. It was agreed that this addition was appropriate as this role has the same function as Nurse Directors within the Care Groups. The report was **APPROVED.**

3.1.6 Welsh Language Standards Annual Report

Resolution: The Annual Report was **APPROVED.**

3.1.7 Amendment to the Standing Orders

Resolution: The report was **APPROVED.**

3.1.8 Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement

Resolution: The report was **APPROVED.**

3.2 FOR NOTING

3.2.1 Action Log

Resolution: The Action Log was **NOTED**.

3.2.2 Board Annual Cycle of Business

Resolution: The Report was **NOTED.**

3.2.3 Board Forward Work Programme

Resolution: The Board Forward Work Programme was **NOTED.**

3.2.4 Committee Highlight Reports

Resolution: The reports were **NOTED.**

3.2.5 Joint Committee Highlight Reports

Resolution: The reports were **NOTED.**

3.2.6 Infection, Prevention & Control Committee Annual Report

Resolution: The report was **NOTED.**

3.2.7 Annual Letter 2021-2022 – Public Services Ombudsman for Wales

Resolution: The report was **NOTED.**

3.2.8 Covid-19 Inquiry Preparedness

Resolution: The report was **NOTED.**

3.2.9 Sustainability of General Medical Services

Resolution: The report was **NOTED.**

4. MAIN AGENDA

4.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

5. INTEGRATED GOVERNANCE AND ASSURANCE

5.1 Healthcare Inspectorate Wales (HIW) Annual Report 2021-2022

R Jones presented the HIW Annual Report for the period 2021-2022 noting the key findings from the regulation, inspection and review of healthcare services in Wales and specifically those involving the Health Board.

The Chair extended his thanks to R Jones for sharing the presentation and for recognising the Health Boards commitment to improve and sustain improvements.

Resolution: The presentation was **NOTED.**

5.2 Chief Executive's Report

G Dix presented the report highlighting the key areas of activity of the Chief Executive, drawing particular attention to the section on the 'Institute for Healthcare Improvement / Improvement Cymru'. He noted the informal feedback received and advised that the Health Board is expecting a report in due course, following which the Chief Executive is keen to invite Improvement Cymru to a future Board Development session.

G Dix also reiterated the continuing challenges faced by the Health Board in relation to the sustained pressures across a number of its services and specialities which will be a theme recognised throughout the reports presented to the Board at the meeting.

The Chair extended his thanks to G Dix for presenting the report.

Resolution: The report was **NOTED.**

5.3 Board Assurance Framework

G Galletly presented the Board Assurance Framework drawing the Boards attention to the significant changes to the Strategic Risks this period. She also noted that the Organisational Risk Register has been made available in full on Admincontrol for Board Members.

J Sadgrove drew attention to the following areas within the Board Assurance Framework Report:

- Strategic Risk 2, reference made on Page 10 to the Listening and Learning Framework, commenting that the launch which was held on the 27th September was a success and really well attended. She confirmed that the framework has now been published following its launch at the event.
- Strategic Risk 4 – recognising the Health Boards financial plan to reduce reliance on agency workforce it appears that reference to the Nursing Bank is an omission in this section which currently only refers to Medical Bank. In response, H Watkins agreed that this should be included and the risk will be updated in future reports to reflect this inclusion and the significant

activity being undertaken to modernise and improve the effectiveness of the bank process.

- Strategic Risk 6 – the update under 'Current Performance Highlights' notes that deployment of 'Open Eyes' has been delayed, however there has been progress in terms of glaucoma. In response, S Morris reflected upon the detailed discussion at Digital & Data Committee in relation to the constraints across the digital programme, however, he expressed delight that some areas of the 'Open Eyes' programme are moving forward and this will be reflected in the future risk updates.

The Chair extended his thanks to G Galletly for presenting the report.

Resolution: The Board Assurance Framework was **APPROVED.**

Action: Strategic Risk 4 and Strategic Risk 6 to be updated to reflect the discussion at Board in terms of the Nursing Bank and Open Eyes Programme.

6 DELIVERING OUR PURPOSE/STRATEGIC DIRECTION

6.1 CTM 2030 – Our Health, Our Future

L Prosser shared a presentation with Members noting that Board approval is being sought to progress with the proposal to adopt a phased approach to the delivery of CTM: 2030, Our Health, Our Future. She noted that the small changes will help inform and shape the longer term strategy.

L Prosser noted that the presentation highlights the Health Boards planned approach to delivering the strategy and how the programme would be monitored.

I Wells queried the future arrangements for Maesteg Hospital. In response L Prosser provided assurance that Maesteg Hospital is recognised as a critical part of the Health Boards estate and advised that the Health Board is designing an engagement process which will include stakeholders to support the development of service proposals that best fit the needs of the population. These proposals will be developed early in the new year 2023.

P Roseblade commented that she welcomed sight of how the other programmes of work align with the strategy such as the '6 Goals Urgent and Emergency Care Programme' etc and asked what success would look like in terms of the strategy. In response, L Prosser commented that in order to describe this part of the development journey is to ensure that the Health Board is clear as to its priority metrics and to then use these as outcome indicators.

In support of the question raised by P Roseblade, K Nnoaham reiterated the comprehensive Population Health Programme which was approved by the Board and how these high level indicators, which highlighted what would be delivered, will support the Health Board in monitoring progress in a number of areas.

G Hughes referenced the establishment of the Improving Care Board which will oversee 'Portfolio 2 – Improving Care' and will monitor progress and delivery of this portfolio with close links to the Population Health Programme Indicators.

J Hehir commented that the iterative approach presented will provide the Health Board with greater flexibility to adjust as circumstances change particular in the current challenging financial climate.

The Chair thanked L Prosser for presenting this item and commented that the Board welcomed continued monitoring and evaluation of the progress being made on the development of the strategy.

Resolution: The presentation was **NOTED** and the phased approach to the delivery of CTM 2030, Our Health, Our Future was **APPROVED**

6.2 CTM Operating Model – Progress Report

R Morgan-Evans presented Members with an update on the implementation of the new operating model, guiding Members through the approach taken to support the establishment of the six Care Groups that now form the overarching Care Group Model. It was noted that the next phase is to focus on the most effective structure for the Clinical Service Groups and this will be supported with engagement from Care Group leaders and other key forums within the Health Board.

I Wells queried the challenges that may be posed through differing staffing structures and digital infrastructures. In response R Morgan-Evans and L Prosser provided assurance to Members that as part of the next phase of activity the Health Board will ensure all service areas are mapped and considered in terms of the more technical/infrastructure aspects. S Morris reflected on discussion at the recent Digital & Data Committee where it was recognised that the Care Group Model will further support some of the disaggregation activity and the alignment of differing digital systems.

D Hurford commented that this activity will require a culture change as although close alignment with other Health Boards will be maintained teams in Bridgend are being asked to ensure that along with maintaining close links with Swansea Bay University Health Board they also focus on the Acute Hospital sites on the Health Boards i.e. Prince Charles Hospital and the Royal Glamorgan Hospital.

L Edwards noted that positive feedback has been received from Clinicians in response to the new Operating Model.

J Hehir welcomed the very positive report and noted that any change in services will require an Equality Impact Assessment to be undertaken to ensure that the Health Board is recognising the reach across the entire CTM footprint and demonstrate the commitment to reducing any inequalities.

The Chair thanked R Morgan-Evans for presenting the progress update.

Resolution: The report was **NOTED.**

6.3 Integrated Performance Dashboard

6.3.1 Introduction and Overview

L Prosser introduced the report noting that there had not been any changes to format or presentation of the report on this occasion.

P Roseblade drew attention to the trend information on the quadruple aims and asked if an additional line could be added to the graphs to outline the target position the Health Board aims to achieve as it could be different depending on the activity and its context. In response, L Prosser agreed to take this back to the team.

P Roseblade reflected upon the robust discussion held at the Quality & Safety Committee on Stroke and Ambulance Handovers and commented that as full responses were received in that forum she will not repeat the questions at Board. P Roseblade then drew attention to the Follow Ups Not Booked (FUNBs) performance and reflected that the data as presented may need revisiting to aide understanding. In response, G Hughes agreed that this data will be reviewed. In terms of this activity G Hughes advised that there has been significant focus on FUNBs which is reflected in the Planned Care Recovery update, demonstrating the improvements being made on the backlog which has been reduced by six years with focus now on targeting the 1700 patients who have waited longer than 2020 for their follow up appointment. G Hughes also informed Members that the Outpatient Transformation Project is focussed on implementing improvements in this area.

G Hughes advised that in addition to the detailed presentation received on Stroke Services at Quality & Safety Committee a Board Briefing is planned for December.

G Hughes drew attention to the exceptionally low compliance in CAMHS activity and explained that this is as a result of significant focus currently being aimed at clearing the referral backlog, and although the position is improving this will not be reflected in the performance position for a few months whilst focus on the backlog continues. He noted that the backlog is currently the lowest it has been for over 12 months and recognised the significant efforts of the team in improving performance in this area.

J Sadgrove drew attention to the graphs on page 33 relating to patient discharge and flow and commented that this clearly illustrates that the Health Board has a significant issue compared to the All Wales average in relation to bed occupancy by patients who are ready to leave acute hospital sites. G Hughes advised that this will be addressed in the update later in the agenda under the Six Goals Programme.

J Sadgrove further queried the graph on page 30 which related to adult mental health services performance with regards to residents who are in receipt of secondary mental health services who have a valid care and treatment plan. She commented that performance does not appear to be going in the right direction and the narrative did not provide an update as to what is being done to improve performance in this area. In response, G Hughes suggested that the Deputy COO for Primary Care, Community, Mental Health and Learning Disabilities, prepare a briefing for Members that could be further explored at the Planning, Performance & Finance Committee.

Resolution: The report was **NOTED.**

Actions:

- Additional line to be added to the trend information on the quadruple aims graphs to outline the target position for which the Health Board aims to achieve as it could be different depending on the activity and its context.
- Deputy COO for Primary Care, Community, Mental Health and Learning Disabilities to prepare a briefing for Members that could be further explored at the Planning, Performance & Finance Committee in relation to the performance in relation to residents who are in receipt of secondary mental health services who have a valid care and treatment plan.
- Follow Ups Not Booked (FUNB) performance data to be reviewed to ensure data and narrative accuracy.

6.3.2 Quality Performance

G Dix, G Galletly and D Hurford presented the report highlighting key areas of activity during the period in relation to their respective portfolios.

The Chair reiterated concerns around the critical overcrowding in the Health Boards Accident & Emergency Departments, particularly at the Princess of Wales Hospital, and queried what improvement activity is underway. In response G Dix advised that as well as the significant improvement activity which forms the Six Goals and Urgent Care Programme there is further work needed in relation to admission avoidance and raising awareness of care which can be received in alternative environments.

The Chair also queried the requirement for more resources to support the management of concerns. In response, G Galletly advised that the proposed new Operating Model for Quality Governance has been designed to support a new way of working where concerns are addressed at source. She also advised that the central concerns support team is being realigned and a consultation via the Organisational Change Process is underway. In conclusion, G Galletly recognised that the current concerns response rate is not acceptable however considered that the changes in the operating model will hopefully result in noticeable improvements in response times.

Resolution: The report was **NOTED.**

6.3.3 Workforce Performance

H Watkins presented the reported advising Members that the continued challenges and significant pressures faced by the Health Board and the impact of the economic climate is reflected in increased sickness absence rates. She noted that in response to these concerning rates of absence the Health Board continues to raise awareness of the services available to staff to support their emotional, physical and financial well-being.

In concluding the update H Watkins was pleased to announce to the Board that a Fruit and Vegetable Stall will be trialled at the Royal Glamorgan site from Monday 3rd October 2022 in support of promoting healthy eating.

Resolution: The update was **NOTED.**

6.3.4 Financial Performance

S May presented Members with an update on the challenging financial position and performance for the period to the 31st May 2022.

J Hehir queried whether any re-prioritisation of spending requests is anticipated from Welsh Government. In response, S May advised that this is a fast moving area and currently Welsh Government have asked Health Boards to fix its forecast for month six which may result in alternative areas of focus and potentially lead to more challenging targets. She noted that energy consumption is a focus of attention and will be again after month six.

P Roseblade queried the narrative and expectations around recouping Covid-19 losses and IT home working expenditure. In response, S May advised that the Health Board is not assuming these elements will be funded.

P Roseblade further queried if the Health Board can retain the release of annual leave accrual. In response, S May advised that this is expected however, further guidance is awaited as potentially this could be managed differently and does remain a risk for the Health Boards financial position.

The Chair thanked Health Board Officers for their updates on the Integrated Performance Dashboard.

Resolution: The report was **NOTED.**

7. DELIVERING OUR RECOVERY/IMPROVEMENT PLANS

7.1 Improving Urgent Care

G Hughes provided Members with the following presentations:

- 6 Goals Programme Overview
- Ambulance Handover Performance Summary and EASC Weekly Data Set.

Following the detailed presentations I Wells queried whether there will be an improvement in Ambulance Handover Performance. In response, G Hughes noted that there are ongoing issues at Prince Charles Hospital due to the site improvement works which impacts flow outside the Accident and Emergency Department.

P Roseblade reflected that in previous years the process was to immediately offload patients from ambulances avoiding the delays being experienced currently and whether these processes are being revisited to see if they could demonstrate quality improvements. In response, G Hughes advised that that this is a difficult question to answer due to the need of balancing the risk to safely offloading patients from the ambulance with the patients in the community that are waiting for an ambulance. He confirmed that this cannot be looked at in isolation and requires a risk assessment across the entire pathway.

The Chair requested future updates on bed occupancy activity and how many assessment treatment beds remain occupied by patients who could be discharged from the acute setting.

The Chair extended his thank to G Hughes for the presentation.

Resolution: The presentations were **NOTED**.

Actions: The Chair requested future updates on bed occupancy activity and how many assessment treatment beds remain occupied by patients who could be discharged from the acute setting.

7.2 Planned Care Recovery

G Hughes provided a presentation on the Planned Care Recovery Programme and the targeted activity being taken forward with all specialities within the Health Board.

The presentation captured the following areas:

- Treat in Turn
- Follow Ups Not Booked (FUNBs)
- Activity Volumes – Pre Covid Volumes v. Present New Outpatients
- Outpatient Transformation
- Use of Planned and Unscheduled Care Sustainability Funding
- Next Steps

P Roseblade queried if patients were offered an alternative surgical site but refused would they lose their place on the waiting list. In response, G Hughes advised that this would not be the case.

The Chair drew attention to the wait times for children and queried whether improvements are anticipated soon in this area. In response, G Hughes advised that the Health Board is committed to addressing the wait times, however, highlighted that there are constraints around the number of available

anaesthetic sessions and a limited number of surgeons who operate on children.

The Chair thanked G Hughes for a comprehensive overview of the Planned Care Recovery activity.

Resolution: The report was **NOTED.**

7.3 Maternity & Neonatal Services Improvement Programme

G Dix, S Hardacre and D Hurford presented the report on the progress of the Maternity and Neonatal Improvement Programme.

G Dix highlighted the following additional activity since the report was drafted:

- IMSOP have verified the Boards self-assessment of Maternity Services maturity ratings as follows:
  - Quality of Leadership and Management – 'Early Maturity' Status
  - Safe and Effective Care – 'Maturity' Status
  - Quality of Women's Experience – 'Exemplar' Status
- In terms of the Neonatal Service the maturity rating is 'results' status across all domains.
- IMSOP will be next publishing their progress report on the 24th October 2022.
- 13/14 of the deep dive neonatal recommendations have been closed.
- Maternity and Neonatal Improvement Board have now closed the two remaining service work programmes (Quality of Leadership & Management and Safe and Effective Care). Any residual activity will be incorporated into the "Wash up Plans" led by the new Children and Families Care Group as appropriate.
- The Clinical Review Programme has closed however, the Health Board is committed to action any care reviews received through the self-referral process.
- The new Integrated Dashboard is close to being finalised and will be used for future Board reports to frame the business narrative.

S Hardacre led Members through the metrics report and drew attention to the activity around culture, quality of leadership and management.

J Sadgrove commented on the significant scrutiny afforded to this activity at the Quality & Safety Committee and Maternity and Neonatal Improvement Board. She welcomed the commitment of the staff in driving forward movement and utilising data intelligence to support improvement activity and thanked them all for their continued hard work and dedication.

The Chair also recognised the significant amount of work being undertaken by the Team which is evident in the progress illustrated in the updates. Members also congratulated S Hardacre in obtaining her PHD.

Resolution: The report was **NOTED**

7.4 Ty Llidiard Improvement Plan

L Edwards presented the report which provided Board members with an update on quality, safety and experience issues in Ty Llidiard (TL) Tier 4 CAMHS Inpatient Unit. In concluding the update L Edwards provided assurance that the Health Board is heading in the right direction to support de-escalation from its Enhanced Monitoring Arrangements status with the Welsh Health Specialised Services Committee.

The Chair thanked L Edwards for presenting the report

Resolution: The report was **NOTED**.

7.5 Continuous Improvement Self-Assessment Process in response to Targeted Intervention

R Morgan-Evans presented the report which provided an update on the progress within the Targeted Intervention Improvement Programme.

J Hehir queried whether there was anything concerning R Morgan-Evans in terms of the pending review of sustainability issues. In response, R Morgan-Evans advised that he felt confident that the Health Board now had the right systems in place to effectively and efficiently manage and respond to areas where improvement activity is identified.

The Chair thanked R Morgan-Evans for presenting the report.

Resolution The report was **NOTED.**

8 ANY OTHER BUSINESS

There were no other areas of business identified.

9 How did we do in this meeting?

The Chair advised that he would welcome feedback from Board Members as to how they felt the meeting went today outside the meeting.

10 DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at Thursday 24 November 2022 at 10am.

11 CLOSE OF MEETING

The Chair advised that the Board would now be holding an In Committee session, the outcome of which would be presented to the Board in November 2022

Agenda Item Number: 3.1.1

Minutes of the "In Committee" Meeting of Cwm Taf Morgannwg University Health Board (CTMUHB) held on Thursday 29 September 2022 as a Virtual Meeting Broadcast Live via Microsoft Teams

Members Present:

Emrys Elias	Chair
Jayne Sadgrove	Vice Chair
Ian Wells	Independent Member
Nicola Milligan	Independent Member
James Hehir	Independent Member
Carolyn Donoghue	Independent Member
Dilys Jouvenat	Independent Member
Greg Dix	Executive Director of Nursing / Acting Chief Executive
Linda Prosser	Executive Director of Strategy & Transformation
Gethin Hughes	Chief Operating Officer
Lauren Edwards	Executive Director of Therapies & Health Sciences
Sally May	Executive Director of Finance
Dom Hurford	Interim Medical Director
Anne Morris	Associate Member

In Attendance:

Georgina Galletly	Director of Corporate Governance
Stuart Morris	Director of Digital
Helen Watkins	Deputy Director for People
Richard Morgan- Evans	Chief of Staff
Cally Hamblyn	Assistant Director of Corporate Governance

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the meeting.

1.2 Apologies for Absence

Apologies for absence had been received from:

- Paul Mears, Chief Executive
- Lisa Curtis-Jones, Associate Member
- Daniel Price, Cwm Taf Morgannwg Community Health Council
- Hywel Daniel, Executive Director for People
- Ian Wells, Independent Member
- Lynda Thomas, Independent Member
- Mel Jehu, Independent Member
- Geraint Thomas, Independent Member

1.3 Declarations of Interest

No additional declarations were made.

2. MAIN AGENDA

2.1 Integrated Radiotherapy Solution and Satellite Radiotherapy Centre Full Business Case

The Chair noted that due to related commercial sensitivities contained within the business cases the meeting was being held in private session.

L. Prosser provided a presentation to the Board on the two Full Business Cases for the Integrated Radiotherapy Solution (IRS) and the Satellite Radiotherapy Centre proposed to be sited at Nevill Hall Hospital to serve the North of the South East Wales region.

The Board were advised that due consideration of the Business Cases was undertaken at the Planning, Performance & Finance Committee on the 20th September 2022, where approval by the Board was endorsed.

In considering its position the Board received assurance that the service need had been fully assessed, and whilst noting the challenging financial and economic position, supported that this is a service required by the Health Board and confirmed approval for the Business Cases.

Resolution: The Board **APPROVED** the Full Business Case for the **Radiotherapy Satellite Centre** funded on the basis of activity delivered.

The Board **APPROVED** the Full Business Case for the **Integrated Radiotherapy Solution.**

3. ANY MATTERS

3.1 Any Other Urgent Business

No further business was identified.

4. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at Thursday 24 November 2022 at 10am.

AGENDA ITEM
3.1.3

CTM BOARD

CHAIR'S REPORT

Date of meeting	24 November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Director of Corporate Governance
Presented by	Emrys Elias, Health Board Chair/ Independent Member
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
N/A		NOTED

ACRONYMS	
	None

1. SITUATION/BACKGROUND

This report aims to provide an update to the Board on relevant matters in my capacity as Chair of the Health Board. It also outlines where I have been required to affix the Common Seal of the Health Board for which endorsement is sought.

This overarching report highlights for Board Members the key areas of activity and where appropriate any associated risks, some of which are referred to within the business of the Board meeting and also highlights topical areas of interest to the Board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Health Board Appointments

I am pleased to confirm that the Minister for Health and Social Services has agreed to appoint Sally Bolt as Associate Board Member and Chair of the Clinical Advisory Group for Cwm Taf Morgannwg University Health Board for 2 years. Her appointment commenced with the Health Board on the 1st September 2022. I would like to congratulate Sally on her appointment.

2.2 Board Development Session – 6 October

The Board received the following presentations at the Board Development Session.

- **Children's Right's Charter** - delivered by Emily Payne, CTM Consultant Paediatrician along with Lucy Collins, CTM Interim Senior Nurse, Children's Community Services and Natasha Weeks, CTM Head of Engagement & Involvement.
- **Increasing CTM's Winter Resilience 2022/23 –** delivered by Linda Prosser, CTM Director of Strategy & Transformation and Gethin Hughes, CTM Chief Operating Officer.
- **Welsh Health Specialised Services Strategy -** delivered by Sian Lewis, WHSSC Managing Director and Maxine Evans, WHSSC Project Manager

Board Briefing Session – 20 October

A private Board Briefing session was held on the 20th Ocober 2022 to discuss the IMSOP Progress Report.

The Board received the following presentation at the Board Briefing session.

- **National Imaging Academy** delivered by Phil Wardle, Academy Director / Consultant Radiologist
- **Research and Development in CTM** - delivered by Kelechi Nnoaham, Director of Public Health and presented by Professor John Geen, Assistant Director R & D / Consultant Clinical Biochemist.
- **CTM Digital Update -** Presented by Stuart Morris, Director of Digital
- **Quality & Engagement Act Update** - delivered by Ben Brown & Judith Lewis, Welsh Govt and Ana Llewellyn, Nurse Director, Primary Care, Community & Mental Health and Stephanie Muir, Assistant Director, Concerns & Claims.
- **CTM Quality Improvement and Staff Ideas Scheme** - delivered by Marc Penny, Director of Improvement & Innovation.

2.3 Diary Commitments/Meetings attended since the last Board Meeting.

- Local Authority Leaders/Chair/CEO Meeting
- Independent Members/Chair/CEO Meeting
- Independent Members / Chair Meeting
- 1:1s (Chief Executive, Vice Chair, Director of Governance, Executive Directors, Chairs of other HBs)
- Chair Peer Group Meeting
- Cwm Taf Morgannwg Staff Q&A session
- Cwm Taf Public Service Board
- Board Development Session
- Consultant Interview Panel
- Escalation meeting with Welsh Government
- Visit to LGBT Group meeting Bridgend
- Visit to Bridgend Youth Forum meeting, Bridgend
- Health and Housing Summit
- Board Development Session
- Swansea Bay Crisis Care Concordat Meeting
- Chairs in Wales Meeting
- Meeting with Darren Hughes NHS Confed
- Wallkround – Chair / Independent Member

- Community development of Bridgend Locality with Local Councillors and MPs.
- Meeting with Vanessa Davies – HIW
- CTM2030 Staff Engagement Event
- Reverse Mentorship Launch
- Board Briefing Session
- Development meeting with LA / Archus colleagues
- Chair monthly meeting with IMs
- Mental Health Ministerial Deliver & Oversight Board Meeting
- Welsh NHS Confederation Confererence
- Public Health Event – "Creating Health, Whole System Approach to Healthy Weight".
- IMSOP Meeting – Chair / CEO / CNO / IMSOP Chair
- Bridgend and Cwm Taf (CTM) PSBs - Joint Planning/Merger Session
- Advanced Practitioners' Celebration Event
- Meeting with Internal Audit
- CTM Staff Q&A with CEO and Exec team
- Visit to Sandville Court
- Introductory meeting with Chair WHSSC
- Research and Development Conference
- Ministerial Meeting with Chairs and Chief Executives
- RCT Council Meeting
- CTMUHB Board Meeting

Meetings / discussions with Local Politicians

- MS/MP monthly meetings with Chair/CEO

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 COMMON SEAL

There are no common seals to report.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The number one focus of the Board and its business is to ensure good quality and safe patient care across all areas of its activity.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	Yes (Include further detail below)
	Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5 RECOMMENDATION

Members of the Board are asked to**:**

- **NOTE** the report.

AGENDA ITEM
3.1.4

CTM BOARD

BOARD COMMITTEE ANNUAL REPORTS

Date of meeting	24 November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act Monitoring Committee	12 October 2022	ENDORSED FOR APPROVAL
Digital & Data Committee	28 September 2022	ENDORSED FOR APPROVAL

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In line with Standing Order requirements each Board Committee is required to submit to the Board on an annual basis a report setting out its activities together with a review of its performance and any associated improvements being put into place as a result.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Mental Health Act Monitoring Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2021 – March 2022 and is attached at Appendix 1 for Board approval.

2.2 The Digital & Data Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2021 – March 2022 and is attached at Appendix 2 for Board approval.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/ COMMITTEE

3.1 There are no key risks for escalation to the Board.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) N/A
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **APPROVE** the following Board Committee Annual Reports for the period 2021/2022:

- Mental Health Act Monitoring Committee (Appendix 1);
- Digital & Data Committee (Appendix 2).

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Appendix 1

Mental Health Act (MHA) Monitoring Committee

Annual Report 2021-2022

MENTAL HEALTH ACT (MHA) MONITORING COMMITTEE
ANNUAL REPORT 2021-22

1. FOREWORD

I am pleased to present the Annual Report of the Mental Health Act Monitoring Committee. The purpose of this report is to formally report on the work of the Committee for the year ending 31 March 2022 in accordance with the Committee's Terms of Reference.

I would like to express my thanks to all the officers of the Health Board, Local Authorities and South Wales Police who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines.

2021-22 was another very challenging year with the ongoing Covid-19 pandemic resulting in new ways of working becoming the 'norm'.

The Committee has continued to foster and promote a culture of working in partnership with a view to service improvement for the CTM population. As Chair, I have ensured that the work of the Committee progresses in line with its Terms of Reference and also ensured that crossover work is seamless with the Together for Mental Health Partnership Board which I also chair.

2021-2022 was my first year as the Chair of the Committee and I would like to extend my thanks and appreciation to my predecessor Maria Thomas, former CTM Vice Chair, who had chaired the meetings of this Committee since its outset. Maria was instrumental in steering the Committee to its current level of maturity, for which I am extremely grateful.

My thanks and best wishes are also extended to Superintendent Peter Thomas, Force Advisor for Mental Health, on his retirement from South Wales Police in March 2022. Peter's important contribution to mental health services was of course formally recognised in the award of an MBE in the Queen's Birthday Honours during 2021.

In late 2021 we learnt with great sadness of the news that Councillor Phillip White who was formerly a member of this Committee had passed away. His experience and knowledge was appreciated by all and we will miss the important contribution he made to our proceedings.

Jayne Sadgrove
Chair, Mental Health Act (MHA) Monitoring Committee/ Vice Chair, CTMUHB.

2. INTRODUCTION

The MHA Monitoring Committee is Chaired by the Vice Chair of the Health Board and monitors the Health Board's compliance with the statutory requirements of the MHA. The work of this Committee, including its Terms of Reference, were reviewed and refreshed in July 2022. The Committee has continued to evolve with changes to report format and agenda content during the year.

As part of CTMUHB's commitment to openness and transparency, the meeting papers for this Board Committee are routinely published on the organisation's website.

The Committee meets on a quarterly basis and, following each meeting, produces a highlight report which is then submitted to the next Board meeting to highlight key issues and risks. Broader mental health issues are discussed and taken forward via other established fora such as the Together for Mental Health Partnership Board (which is chaired also by the Vice Chair of the Health Board).

The purpose of the MHA Monitoring Committee is to ensure that all the requirements of the MHA 1983 (as amended) are met by the Health Board.

The Committee considers:

- how the delegated functions under the MHA are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- suitable mechanisms for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the MHA 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice.

The Committee is also responsible for developing an annual report for presentation to the Health Board.

3. MEMBERSHIP

The membership of the MHA Monitoring Committee comprises both Independent and an Executive Director Members, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

Independent membership during 2021-22 was as follows:

- Jayne Sadgrove, Vice Chair of the Health Board (Chair of the Committee - from June 2021)
- Mel Jehu, Independent Member
- James Hehir, Independent Member
- Maria Thomas, Vice Chair of the Health Board (Chair of the Committee – until May 2021)
- Phillip White, Independent Member (until November 2021)
- Geraint Hopkins, Independent Member (from January 2022)

4. MEETINGS

The MHA Monitoring Committee met on four occasions during 2021/22 and as a consequence its forward work programme was reviewed to ensure that issues were appropriately prioritised.

The four dates on which it met during 2021/22 were as follows:

- 5 May 2021
- 4 August 2021
- 3 November 2021
- 3 March 2022

Mental Health Act Monitoring Attendance 2021-2022		**5 May 2021**	**4 Aug 2021**	**3 Nov 2021**	**2 Mar 2022**	**Total**
Maria Thomas (Chair – until May 2021)	Vice Chair, Independent Member	√				**1/1**
Jayne Sadgrove (Chair – from June 2021)	Vice Chair, Independent Member	√	√	√	√	**4/4**
Mel Jehu	Independent Member	√	√	√	X	**3/4**
James Hehir	Independent Member	√	√	√	√	**4/4**
Phillip White (until – Nov 21)	Independent Member	X	X			**0/2**
Geraint Hopkins (from Mar 22)	Independent Member				X	**0/1**

Gareth Robinson (until March 2022)	Chief Operating Officer (Interim)	X	X	X	X	**0/4**
Julie Denley	Director of Primary Care & Mental Health	√	√	√	√	**4/4**
Philip Lewis	Head of Nursing (Mental Health)	√	√	X	X	**2/4**
Robert Goodwin	Service Group Manager, Mental Health	√	√	√	√	**4/4**
Fiona Thomas	Localities Manager, Mental Health	√		√		**2/2**
Peter Thomas	Superintendent, South Wales Police	√	√	√	√	**4/4**
Colin Hatherley	Mental Health Officer, South Wales Police	X	X	X	√	**3/4**
Karen Thomas	Superintendent, South Wales Police	X	√	√		**2/3**
Angela Edavene	Representative, Merthyr Tydfil County Borough Council	√	√	√	√	**4/4**
Frances Hall	Representative, Rhondda Cynon Taff County Borough Council	X	√	√	√	**3/4**
Mark Wilkinson	Representative, Bridgend County Borough Council	√	√	√	X	**3/4**
Katie McPheat-Collins (until Nov 21)	Welsh Ambulance Services Trust	X	X	√		**1/3**
Ben Collins (from Mar 22)	Welsh Ambulance Services Trust				√	**1/1**
Cally Hamblyn	Assistant Director of Governance & Risk	√	√			**2/2**
Wendy Penrhyn-Jones	Head of Corporate Governance & Board Business	√		√	√	**3/3**

All of the above meetings were quorate.

The Committee's Terms of Reference were reviewed and approved by the Committee at its June 2022 meeting with no changes made and were approved by the Health Board in July 2022. For completeness, this Annual Report provides at **Appendix 2,** the current Terms of Reference.

5. MAIN AREAS OF MHAM COMMITTEE ACTIVITY

The agenda for each meeting has followed a standard format in five main parts:

- Part 1 - Preliminary Matters
- Part 2 - Items for Approval/Discussion
- Part 3 - Governance, Performance and Assurance
- Part 4 - For Information / Other Matters.

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB. This includes the action log which captures all areas for attention following the meeting.

Part 2 - Items for Approval / Discussion

This section has included receiving the:

- Committee Annual Report 2020-2021 & 2021-2022 and self-assessment questionnaire
- Results of the Committee Self-Assessment and Self-Assessment Action Plan
- Committee Annual Cycle of Business 2021-2022 & 2022-23

Part 3 - Governance, Performance and Assurance

This section has included reports throughout the year which included:

- Mental Health Act – Quarterly Activity Statistical Report
- Report from Mental Health Operational Group
- Strategic update from South Wales Police (Section 13,15 & 136) - including mental health staff in police control centre
- Strategic update from Local Authority Partners
- Mental Health Act Breaches Relating to the Mental Health Act
- Risks related to the Monitoring of the Mental Health Act
- Crisis Care Concordat
- South Wales Police Mental Health APP
- Update on Alternative Place of Safety, The Sanctuary
- Covid-19 Remote Mental Health Assessments – Change of Practice
- Prison Transfers – Activity & Compliance against the Code of Practice
- Hospital Managers payment for Postponed Hearings
- Individually Commissioned Placements and Mental Health Act use
- Progress on the Recruitment of Section 12 Doctors
- Conclusions from the Section 136 Audit Follow Up and Action Plan

Part 4 - For Information / Other Matters

There were no information items sharing purposes.

The 'Forward Look' plan for the Committee was reviewed at each meeting to ensure its content remained appropriately focused.

The Committee Highlight Report is produced following each meeting and subsequently presented to the next available Board meeting.

Links with Other Committees/Boards
Where appropriate a process is in place for any relevant matters to be referred to other Board Committees for scrutiny and or action.

6. ACTION LOG

In order to monitor progress and any necessary follow-up action, the Committee uses an Action Log that captures all agreed actions and this is reviewed at the beginning of each meeting.

7. GOVERNANCE

The Committee provides an essential element of the overall governance framework for the organisation. The Terms of Reference for the Committee provide a robust commitment to monitor the application of the MHA.

8. ASSURANCE TO THE BOARD

Like many service areas mental health services were impacted by the pandemic and Welsh Government made provision for how the Mental Health Act could be applied and administered should the pandemic have warranted this. The committee was assured that patients' needs were met and full compliance with legislation maintained.

The Committee continued to receive updates regarding ongoing audit work and changes put into place to improve the application of the MHA and work to integrate approaches and policies in relation to the Act have again continued in year.

The MHA Monitoring Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2021-2022, there are effective measures in place to scrutinise and monitor the application of the MHA.

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Appendix 2

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

MENTAL HEALTH ACT MONITORING COMMITTEE

TERMS OF REFERENCE & Operating Arrangements

(Approved by the Health Board – 28 July 2022)

INTRODUCTION

The CTMUHB Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **Mental Health Act Monitoring Committee**- "the Committee**"**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

CONSTITUTION AND PURPOSE

The purpose of the Committee is to advise and assure the Board that the arrangements to monitor and review the way functions under the Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

SCOPE AND DUTIES

The Committee shall consider:

- how the delegated functions under the Mental Health Act are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- a suitable mechanism for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the Mental Health Act 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice
- Develop an annual report for presentation to the Health Board.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Mental Health Act Monitoring Committee has a key role in assisting the Board to fulfil its oversight responsibilities to ensure it is operating effectively and in accordance with legislation.

Hospital Managers may arrange for their functions under the Mental Health Act to be carried out on a day to day basis by particular Officers on their behalf. (COP 11.7) The arrangements for authorising decisions has been set out in a Scheme of Delegation.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:
    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board

- Crisis Concordat Meeting Forum.

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:
A minimum of **(4)** members, comprising

Chair	Vice Chair of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board

The 1983 Act is operated by health and social care practitioners, in collaboration with a range of agencies including police and ambulance services, as well as third sector bodies such as advocacy providers. Membership of the Committee should reflect this, as different agencies and practitioners have differing responsibilities and duties under the Act.

The Vice Chair of the Health Board shall Chair the Committee given their specific responsibility for overseeing the Health Board performance in relation to mental health service.

Attendees

- Chief Operating Officer
- Director of Primary, Community & Mental Health
- Representative from South Wales Police
- Representative from Rhondda Cynon Taf County Borough Council
- Representative from Merthyr Tydfil County Borough Council
- Representative from Bridgend County Borough Council
- Chair of Mental Health Act Monitoring Operational Group
- Head Administrator - Mental Health Act Administration Team
- Carer Representative from the Together for Mental Health Partnership Board
- Representative from Welsh Ambulance Services Trust (minimum twice per annum)
- Clinical Director for Mental Health

- Head of Nursing for Mental Health Merthyr Cynon Locality Group (minimum twice per annum)
- Mental Health Clinical Service Group Manager Bridgend Integrated Locality Group
- Mental Health Clinical Service Group Manager Rhondda & Taff Ely Integrated Locality Group
- Clinical Director, Child & Adolescent Mental Health Service (CAMHS) (minimum twice per annum)
- Head of Nursing CAMHS

By Invitation:

- Other Directors /Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of training, specific support or organisational development for Committee Members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
This will comprise of one Independent Member, the Director of Primary, Community and Mental Health or the Assistant Director; a representative from the partner organisations either from the South Wales Police, Local Authorities or the Welsh Ambulance Services NHS Trust and also at least one clinical representative.

Frequency of Meetings
Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the Health Board's annual plan of Board Business.

Withdrawal of individuals in attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers
The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year

- bring to the Board's specific attention any significant matters under consideration by the Committee

- ensure appropriate escalation arrangements are in place to alert the LHB Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the LHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.
The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in relation to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board

DIGITAL & DATA COMMITTEE

Annual Report
2021-2022

FOREWORD

I am pleased to present the second Annual Report of the CTMUHB Digital & Data Committee which outlines the activity between 1st April 2021 to 31st March 2022.

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information & data with a view to supporting health improvement and enabling high quality healthcare. It is also in being to seek assurance on behalf of the Board around arrangements for appropriate and effective management and protection of information (both patient and personal) as well as to provide advice and assurance to the Board in relation to the direction and delivery of CTMUHB's Digital and Data Strategies.

The Health Board appointed Stuart Morris as Director of Digital in 2022 and his expertise and knowledge will be an asset to the Committee.

I would like to take this opportunity to thank all my fellow Independent Members who sit on the Committee for their invaluable contributions and those who have attended the Committee thus far, for their individual contributions in this regard which are essential to the effectiveness of the Committee. I would like to welcome Lynda Thomas, Independent Member as our newest Committee Member replacing James Hehir and I would like to extend my thanks to James for the extensive contribution that he had made whilst a member of this Committee.

I commend this Annual Report to you.

Ian Wells,
Chair of the Digital & Data Committee/ Independent Member

Digital & Data Committee
Annual Report 2021/2022

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between April 2021 and March 2022 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

1.2 The Committee's Annual 'Business Cycle' was reviewed and approved at its March 2022 meeting and is a key component in ensuring that the Committee effectively carried out its role.

1.3 This report reflects the Committee's responsibilities in terms of the development and monitoring of the Governance and Assurance framework with respect to digital and data issues.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to:

- oversee the development of strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales

- oversee the direction and delivery of the Health Board's Information Communication Technology (ICT), Data and Information Governance Strategies to drive change and transformation in line with the Health Board's Integrated Medium Term Plan (IMTP) that will support modernisation through the use of information, data and digital technology

- consider implications arising from the development of corporate strategies and plans or those of its stakeholders and partners

- consider the implications of internal and external reviews and reports

- oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation)

- seek assurance through monitoring the Cyber Security Action plan

- review organisational risks assigned to the Committee by the Board and advise on the appropriateness of the scoring and mitigating actions in place.

- complete an annual self-assessment exercise in respect of the effectiveness of the Committee. (The output from this work is due to be considered as a separate agenda item).

- seek assurances that strategies and arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of CTMUHB's activities.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Committee Vice-Chair, Executive Lead and Meeting Secretariat develop the agenda content and agree the Committee meeting in advance.

3.2 The secretariat for the meeting is provided through the Director of Corporate Governance.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4. The Terms of Reference and Operating arrangements were approved by the Board in July 2020 and were reviewed again in March 2022 with minor amendments to the membership. The terms of reference are due to be further considered in September 2022 to reflect amendments to areas of responsibility within management portfolios. The terms of reference are attached as a separate agenda item for approval.

4.2 Whilst the Committee Cycle of Business was approved in March 2022 the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues.

5. Membership, Frequency and Attendance

5.1 The terms of reference of the Committee state that the Committee should consist of a minimum of **four** members of the Board.

5.2 During the year the Committee met on three occasions with the fourth meeting in January 2022 meeting being stood-down due to the Covid-19 Pandemic. Independent Member attendance was as follows:

Name	Digital & Data Committee
Ian Wells (Committee Chair)	3 out of 3
Dilys Jouvenat (Committee Vice-Chair)	3 out of 3
Jayne Sadgrove	3 out of 3
James Hehir	3 out of 3

5.3 The Committee has been delighted to have representation from the NHS Wales Informatics Service (now known as DHCW – Digital Health & Care Wales) at its 2021/22 meetings.

5.4 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

5.5 Mirroring other Board Committees, the Digital and Data Committee now operates a Consent Agenda system for routine business consideration.

5.6 The vast majority of meeting papers are available publically via the CTMUHB website. During 2021-22, the Committee met on three occasions for an 'in-Committee' session in respect of a very small number of reports. In-Committee sessions are only held when the subject matter cannot be legitimately considered in the public domain. The subject matter of any one of these Digital and Data Committee 'in-committee' meetings has been routinely reported within the main agenda items of the next meeting of the Committee, the papers for which are published in the public domain.

6. Committee Activity 2020/2021

6.1 As a result of the impact of Covid-19, the Committee had to reprioritise is work plan due to the need to cancel the meeting that had been planned for January 2022. The following topics were considered at its three meetings of 2021/22:

- **Highlight Reports:** Digital Delivery Board and Information Governance Group.
- **Internal Audit Reports:** IT Service Management, Digital Response to Covid-19, Cancer Data Quality, Covid Management, Bridgend/CT Aggregation.
- **Information Commissioners Office Audit Report**
- **Other Reports:** Cyber Security, Cyber Improvement Plan, Cyber Essentials, Coding Improvement Plan, Disaggregation of ICT Services from Swansea Bay, Critical Incident Reports, all-Wales Information Governance Toolkit, Clinical Coding Improvement & Transformation Plan, Digital Infrastructure, IMTP Digital Programme 2022-23, Digital Communication.
- **Policy Approval**: Records Management Policy.

7. Achievements and Plans

7.1 Having reprioritised its work programme (following the need to cancel its January 2022 meeting), the Committee next met in March 2022. The Committee is continuing to mature in terms of the responsibilities it has defined within its Terms of Reference.

8. Committee Effectiveness & Performance

8.1 The Committee is committed to reviewing its effectiveness by completing this report on an annual basis, reviewing its cycle of business setting out the basis on which it will monitor its progress during the year as well as providing clarity for all of those who contribute to the agenda as to the expectations of them. The outcome of the survey that will be undertaken following the September 2022 meeting will be considered at the meeting to be held in December 2022 in order that recommendations and aligned actions can once again be developed and implemented in terms of areas identified for improvement.

9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings using a 'Highlight Report' to the Board. By way of an example, the following link provides the highlight report for the meeting held in July 2022.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 This will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Visit the Health Board's website to access Digital & Data Committee papers.

AGENDA ITEM
3.1.5

CTM BOARD

AMENDMENT TO STANDING ORDERS – SCHEDULE 3.1,3.3, 3.5 AND 3.8

Date of meeting	24.11.2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	CallyHamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Digital & Data Committee	28.9.2022	Endorsed for Board Approval
Audit & Risk Committee	24.10.2022	Endorsed for Board Approval
People & Culture Committee	09.11.2022	Endorsed for Board Approval
Quality & Safety Committee	15.11.2022	Endorsed for Board Approval

ACRONYMS	
SO's	Standing Orders

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be aware of the SOs and, where appropriate, should be familiar with their detailed content.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **Standing Orders – Schedule 3.1 Audit & Risk Committee Terms of Reference**
The Terms of Reference were reviewed with no changes at the Committee meeting held on the 24th October 2022.

2.2 **Standing Orders – Schedule 3.3 Digital & Data Committee Terms of Reference**
The Terms of Reference were reviewed with changes identified in red as outlined in Appendix 1.

2.3 **Standing Orders – Schedule 3.5 People & Culture Committee Terms of Reference**
The Terms of Reference were reviewed with changes identified in red as outlined in Appendix 2.

2.4 **Standing Orders – Schedule 3.8 Quality & Safety Committee Terms of Reference**
The Terms of Reference were received with changes identified in red as outlined in Appendix 3.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 If approved, the Standing Orders will be uploaded to SharePoint and the Health Board's Internet site.

3.2 The Standing Orders will be further strengthened in year as and when required.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Compliance with the SO's support robust quality governance arrangements.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.
Legal implications / impact	No
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **APPROVE**:

- The amendments to the Health Board's Standing Orders as outlined in section 2 of this report.

Schedule 3.3

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

DIGITAL & DATA COMMITTEE

TERMS OF REFERENCE & Operating Arrangements

Approved by Health Board 31 March 2022

Proposed Amendments to Membership Arrangements for consideration at September 2022 meeting.

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with standing orders (and the CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **Digital & Data Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION AND PURPOSE

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information & Data, to support health improvement and the provision of high quality healthcare.

The Committee will seek assurance on behalf of the Board in relation to the Health Board's arrangements for appropriate and effective management and protection of information (including patient and personal information) in with legislative and regulatory responsibilities.

The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the Digital and Data Strategies to drive continuous improvement and support digitally enabled health care to achieve the objectives of the Health Board's Integrated Medium Term Plan (IMTP).

SCOPE AND DUTIES

The Committee will, in respect of its provision of advice and assurance:

- oversees the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales

- oversees the direction and delivery of the Health Board's Information Communication Technology (ICT), Data and Information Governance Strategies to drive change and transformation in line with the Health Board's Integrated Medium Term Plan (IMTP) that will support modernisation through the use of information, data and digital technology

- within the remit of the Committee it considers implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners

- within the remit of the Committee it considers the implications for the Health Board of internal and external reviews and reports

- oversees the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation)

- seek assurance through monitoring the Cyber Security Action plan

- review risks from the Organisational Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

- completes an annual self-assessment exercise in respect of the effectiveness of the Committee.

- The Committee will, in respect of its assurance role, seek assurances that strategies and arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of the Health Board's activities.

To achieve this, the Committee's programme of work will be designed to ensure that:

- there is a clear, consistent strategic direction, strong leadership and transparent lines of accountability

- there is a citizen centred approach, striking an appropriate balance between openness and confidentiality in the management and use of information and technology

- the handling and use of information and information systems across the organisation is consistent, and based upon agreed standards

- there is effective communication, engagement and the workforce is appropriately trained, supported and responsive to requirements in relation to the effective handling and use of information (including IT systems), consistent with the interests of patients and the public

- there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information (WASPI) and Caldicott requirements)

- the integrity of information is protected, ensuring valid, accurate, complete and timely information is available to support decision making across the organisation

- the Health Board is meeting its responsibilities with regard to the General Data Protection Regulation, the Freedom of Information Act, Caldicott Information Security, Records Management, Information Sharing, national Information Governance policies and the Information Commissioner's Office guidance

- the Health Board is safeguarding its information, technology and networks through monitoring compliance with the Security of Network and Information Systems regulations and relevant standards

- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the safety, security and use of information, and in particular that:

  - Sources of internal assurance are reliable, and have the capacity and capability to deliver
  - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
  - Lessons are learned from breaches in the safe, secure and effective use of information, as identified for example through reported incidents, complaints and claims, and
  - Training needs are assessed and met.

- receive assurance on the delivery of the Strategies operational plans including performance against the annual Informatics Capital Programme

- seek assurance on the effectiveness and impact of the Health Board's Digital Transformation Plans

- seek assurance on the performance and delivery of the rollout of the core national IT systems which could have significant impact on the Health Board's operational services and escalate to the Board as appropriate.

  The Committee will receive assurance on compliance with key performance indicators in relation to the quality and effectiveness of information and information systems against which the Health Board's performance will be regularly assessed.

- The Committee will maintain oversight of the effectiveness of the relationships and governance arrangements with partner organisations in relation to activity that falls within the remit of this Committee. This will include NHS Wales Informatics Service (NWIS).

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Digital & Data Committee, the Committee has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's Digital and Data strategy to ensure it is operating effectively.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:

  - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
  - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees
The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:
A minimum of **(4)** members, comprising

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board

Attendees
- Executive Director of Public Health (Caldicott Guardian)
- Director of Digital/Senior Information Risk Owner (SIRO)
- Director of Governance & Board Secretary
- Chief Information Officer / Data Protection Officer (DPO)
- Assistant Director of ICT
- Clinical Leads for ICT (Chief Clinical Information Officer & Chief Nursing Information Officer)
- ~~Information Governance Manager~~ Head of Information Governance
- Representative from Digital Health & Care Wales.

By Invitation:
- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat
The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments
The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members
The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role, and

- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, the Vice Chair or an Independent Member who will be nominated to Chair the Committee.

Frequency of Meetings
Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of individuals in attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers
The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the LHB Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the LHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it

retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the Committee, except in the area relating to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee, for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.

Schedule 3.5

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

PEOPLE & CULTURE COMMITTEE

Terms of Reference & Operating Arrangements

Review October 2022
Last formally approved in 30th July 2020 (Reviewed 11.5.22 with no amendments)

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **People & Culture Committee** The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION & PURPOSE

The role of the People and Culture Committee is to advise the Board on all matters relating to staff and workforce planning of the Health Board, and enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the health service to deliver safer better healthcare.

The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the organisational development and other related strategies to drive continuous improvement and to achieve the objectives of the Health Board's Integrated Medium Term Plan (IMTP).

SCOPE AND DUTITES

The Committee will, in respect of its provision of advice and assurance:

Culture & Values:

- Agree and oversee a credible process for assessing, measuring and reporting on the "culture of the organisation" on a consistent basis over time.

- Oversee the coherence and comprehensiveness of the ways in which the Health Board engages with staff and with staff voices, including

the staff survey, and report on the intelligence gathered, and its implications.

- Oversee the development of a person-centred open and learning culture that is caring and compassionate, which nurtures talent and inspires innovation and excellence;

- Seek assurance that there is positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Health Board.

- Promote staff engagement and partnership working.

- Ensure the organisation adopts a consistent working environment which promotes staff well-being, where people feel safe and are able to raise concerns, and where bullying and harassment are visibly and effectively addressed.

- Supporting the enhancement of collaborative working relationships across the Health Board between professions and other stakeholders including representative bodies and regulators to improve culture.

Organisational Development & Capacity:

- Ensure the systems, processes and plans used by the Health Board have integrity and are fit for purpose in the following areas:
    - strategic approach to growing the capacity of the workforce
    - analysis and use of sound workforce, employment and demographic intelligence
    - the planning of current and future workforce capacity
    - effective recruitment and retention
    - new models of care and roles flexible working
    - identification of urgent capacity problems and their resolution
    - continuous development of personal and professional skills
    - talent management

- Review plans for ensuring the development of leadership and management capacity, including the Health Board's approach to succession planning.

- Receive and consider people & Organisational Development strategies providing assurance to the Board that all strategic developments are informed by the Sustainable Development Principle as defined by the Well-being of Future Generations (Wales) Act 2015.

Performance Reporting

- Seek assurances that governance (including risk management) arrangements are appropriately designed and operating effectively to ensure the provision of high quality, legal and safe workforce practices, processes and procedures.

- Scrutinise risks on the Organisational Risk Register that fall within the remit and control of the Committee.

- Advise the Board on aligning service, workforce and financial performance matters into an integrated approach in keeping with the Health Board's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Ensure there is an effective planning and performance management cycle that meets the needs of the Board in delivering the Health Board's people and organisational development objectives.

- Scrutinise workforce and organisational development performance issues and key performance indicators and the associated plans to deliver against these requirements, achieved by establishing a succinct set of key performance and progress measures (in the form a performance dashboard) relating to the full purpose and function of the Committee, including:

    - The Health Board's strategic priorities on people
    - organisational culture
    - strategies to promote and protect staff Health & Wellbeing
    - workforce utilisation and sustainability
    - recruitment, retention and absence management strategies,
    - strategic communications
    - workforce planning
    - plans regarding staff recruitment, retention and remuneration;
    - succession planning and talent management;
    - staff appraisal and performance management.
    - Training, development and education
    - Management & leadership capacity programmes,

- Ensure the credibility of sources of evidence and data used for reporting to the Committee, in relation to the Committee's purpose and function.

- Ensure there is an effective system in place to consider and respond in a timely manner to workforce and organisational development performance audits received across the organisation and an effective system in place to monitor progress on actions resulting from such audits.

- Monitor and scrutinise relevant internal and external audit reports, management responses to action plans.

- Consider and ratify Welsh Government Workforce & Organisational Development policies, procedures and initiatives prior to implementation across the Health Board.

Statutory Compliance

Ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including:

- Equality & Diversity Legislation
- Welsh Language Standards
- Wellbeing of Future Generations Act
- Consultation on service change
- Mandatory and Statutory Training

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The People & Culture Committee has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's Culture, Organisational Development Strategy, its Values and Behaviours Framework to ensure it is appropriate and operating effectively.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
- Any other committee, or group set up by the Board to assist in the delivery of its functions.

– obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees
The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub-committees/task and finish groups have been established.

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:

A minimum of **(4)** members, comprising

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board (one of which is the Staff side representative)

Attendees
- Executive Director of OD and Workforce (Committee Executive Lead)
- **Executive Director of Nursing**
- **Executive Medical Director**
- **Chief Operating Officer**
- Executive Director of Therapies and Health Sciences
- Representative from the Integrated Locality Group

- Director of Corporate Governance / Board Secretary or their Deputy
- Staff side representatives (nominated by Local Partnership Forum)

By Invitation:

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Corporate Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of three consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role, and

- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, the Vice Chair and the staff side representative Independent Member.

Frequency of Meetings
Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of individuals in attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers

The Director of Governance / Board Secretary will ensure that all papers are distributed at least **7** calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- bring to the Board's specific attention any significant matters under consideration by the Committee

- ensure appropriate escalation arrangements are in place to alert the CTMUHB's Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the organisation.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Corporate Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being

of Future Generations Act.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the Committee, except in the area relating to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.

Schedule 3.8

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

Review October 2022 for receiving at the November 2022 Q&S Committee

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) standing orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Quality and Safety Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

~~*The term locality team, when used within this document, is to describe out of district general hospital services e.g. Community (in and out of hospital) and Independent Contractor services (GPs, Dentists, Pharmacists and Optometrists).*~~

CONSTITUTION & PURPOSE

The purpose of the Quality and Safety Committee "the Committee" is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care. The Committee embraces the values of the Health Board and the objectives outlined within its Integrated Medium Term Plan (IMTP) which are:

- To **improve** quality, safety and patient experience.
- To **protect** and **improve** population health.
- To **ensure** that the services provided are accessible and sustainable into the future.
- To **provide** strong governance and assurance.
- To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.

The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.

- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

SCOPE AND DUTIES

SCOPE:
In order to deliver its stated aims the Committee will, in respect of its provision of advice to the Board:

- Oversee the development of the CTMUHB's strategies and plans for the development and delivery of high quality, staff safety, patient safety and public health, consistent with the Board's overall strategic direction.
- Provide strategic direction and scrutiny for the development of the UHB's corporate strategies and plans for those of its stakeholders and partners.
- To receive high level reports and recommendations from external bodies and ensure robust action is taken, monitored and fully implemented.

The Committee will seek assurances from the sub groups established by the Quality and Safety Committee (Appendix 1) that arrangements are appropriately designed and operating effectively, to ensure the provision of high quality, safe and effective healthcare and workplace health & safety across the whole of the CTMUHB's primary, community and secondary care activities.

DUTIES:
To deliver its aims, the Committee's programme of work will be structured as follows:

Strategy

- Oversee and monitor the development and implementation of the UHB's Strategies for patient quality and safety and staff workplace health & safety:
    - **Patient Quality and Safety**
        - Provide assurance to Board on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for CTMUHB
        - Provide assurance to the Board in relation to the Quality Governance Framework.

        - Contribute to and oversee the development of the Health Board's Annual Quality Statement
        - Monitor quality via the Quality Dashboard
        - Approve the content of the CTMUHB Annual Quality Statement which relates to the committees work programme
    - **Workplace Health & Safety**
        - Provide assurance to Board on the development of related strategies and operating practices to ensure arrangements for staff workplace health & safety are safe and in compliance with associated legislation.
- Monitor and receive reports on the organisation's progress with embedding and implementing the Health & Care Standards
- Scrutinise Quality and Safety arrangements for the Independent Contractor Professions
- Ensure that the organisation, at all levels, has the right systems and processes in place to deliver - from a patient's perspective - efficient, effective, timely and safe services
- Ensure arrangements are in place to undertake, review and act on Clinical Audit activity which responds to National and Local priorities
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- Receive assurance that the organisation protects the health of the population, by promoting delivery and uptake of screening and immunisation programmes
- Receive assurance that the organisation has robust infection, prevention and control measures in place.

Hosted Bodies

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the UHB namely, Emergency Ambulance Services Committee, Welsh Health Specialised Services Committee and the National Imaging Academy, as appropriate. The Committee will consider any quality and safety issues associated with services commissioned for Cwm Taf Morgannwg residents and those services provided by Cwm Taf Morgannwg UHB.

Organisational Risk

- Monitor the arrangements in place to assess, control and minimise risk and
    - Regularly review the high and extreme risks included on the organisational Risk Register and assigned to the Committee by the Board;

Policies and Procedures

- Approve appropriate Policies (once reviewed and endorsed by the appropriate sub group) and where appropriate any related Procedures.
- Oversee the register of policies, ensuring that it is maintained, and that all assigned policies are subject to review at least every three years.

Research & Development

- Receive reports on progress with Research & Development activity within the organisation. These will:
  - Take into account the national objectives published by ~~National Institute for Social Care and Health Research (NISCHR)~~ Health and Care Research Wales.
  - Focus on the outcomes for patients and compliance with Research Risk Governance arrangements.

Quality Improvement activities

The Quality Governance Framework provides the framework for quality improvement projects. The Quality and Safety Committee will:

- Receive regular reports on progress with delivery of its priorities relating to quality improvement.
- Receive at each meeting a Quality Report and Quality and Performance Dashboard – Receive, scrutinise and triangulate quality information to ensure appropriate prioritisation for improvement.

Patient Experience

- Receive and review progress reports relating to the requirements identified in the UHB Patient Experience Plan.
- Receive and review reports on the progress relating to the implementation of the Citizen Engagement Plan.

Concerns

- Receive as presented within the quarterly quality report, reports on Concerns (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learnt, and to inform the Annual Quality Delivery Plan
- Receive assurance of effective and timely management of concerns across the University Health Board
- Receive, review and approve the Annual Concerns Report on behalf of the UHB.

Staff Experience

- Receive assurance that there are appropriate systems in place to support workplace health & safety and to listen to staff views, embracing the principles of the Listening Organisation, in order to promote effective team working and staff satisfaction to provide the best possible outcomes for patients.
- Receive assurance that the workforce is appropriately selected, trained and responsive to the needs of the service, and that professional standards and registration/revalidation requirements are maintained.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:
    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

The Quality & Safety Committee has established the following sub-committee:

- Health, Safety and Fire Sub Committee

This Sub Committee supports the Health Boards statutory obligation by virtue of the Health and Safety at Work etc. Act 1974 (Section two sub-section seven) to establish and maintain a Health and Safety Committee*: "it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed".*

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:

A minimum of **(6)** members, comprising

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Four Independent Members of the Board

Attendees

- Executive Nurse Director
- Medical Director
- Director of Public Health
- Director of Therapies and Health Sciences
- Executive Director of Operations
- Director of Governance / Board Secretary
- Community Health Council Representative
- Executive Director for People
- ~~Integrated Locality~~ Care Group Director representation
- Staff side representative
- Staff side safety chair or vice chair

Notwithstanding the requirement to maintain quorum, Directors may on occasion nominate a suitably senior deputy to attend the Committee on their behalf, but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role, and

- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum

A quorum shall be at least three Independent Members (one of which must be the Committee Chair or Vice Chair).

For effective governance, at least two Executive Directors, one of which must be a Clinical Executive Director should be in attendance at the meeting.

Frequency of Meetings
Meetings shall meet no less than ~~on a 10~~ 6 times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings and align with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of individuals in attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers

The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days ~~5 working days~~ in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes:
  - oral updates on activity
  - submission of written highlight reports throughout the year;
  - to receive annual reports, which will incorporate key information from Research & Development, progress report on the Annual Quality Delivery Plan, Concerns, Safeguarding, Infection Prevention & Control, Clinical Audit & Effectiveness and Medicines Management
- Bring the Board's specific attention to any significant matters under consideration by the Committee

- Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Board Committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically

commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate

consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the Committee, except in the area relating to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Member of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.

Schedule 3.1

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

Reviewed with No Changes Made at the Audit & Risk Committee on the 24th October 2022

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Audit and Risk Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION AND PURPOSE

The Committee will function in accordance with the NHS Audit Committee Handbook as appropriate.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

SCOPE AND DUTIES

Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurance, prior to endorsement by the Board;

- the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation;

- the Health Board's Organisational Risk Register and the adequacy of the scrutiny of strategic risks by assigned Committees;

- the Board Assurance Framework;

- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements.

- the operational effectiveness of policies and procedures

- the effectiveness of risk identification, management, escalation and monitoring

- the policies and procedures for all work related to fraud and corruption as set out in the National Assembly for Wales Directions and as required by NHS Protect and the Counter Fraud and Security Management Service.

- proposed changes to the Standing Orders, Scheme of Delegation, Standing Financial Instructions and Financial Control Procedures.

- the circumstances associated with each occasion where Standing Orders or Standing Financial Instructions are waived.

- matters relating to counter fraud work.

The Committee will also:

- Receive and determine action in response to the declaration of Board member and other officers interests in accordance with advice received from the Director of Governance / Board Secretary;

- Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers;

- Review all losses and special payments;

- Retrospectively assure any purchase / expenditure above the delegated financial limit of the Chief Executive.

Internal Audit

The Committee shall:

- consider the proposals for accessing internal audit services via a shared services arrangement (where appropriate), the audit fee and any questions of resignation and dismissal;

- review the internal audit programme, consider the major findings of internal audit investigations, ensure co-ordination between the Internal and External Auditors and ensure all management responses to recommendations are appropriate and timely;

- ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organization;

- assure itself that IA complies with the requirements of the public sector internal audit standards.

- Monitor the timely implementation by management of agreed audit recommendations.

Clinical Audit

- Ensure where appropriate and in line with the Audit Committee Handbook that the CTMUHB has a Clinical Audit Programme in place and the outcomes of Clinical Audit provide internal assurance to the Board.

External Audit

The Committee shall consider the work carried out by key sources of external assurance, in particular but not limited to the Health Board external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity.

The Committee will:

- from time to time, consider and make any necessary representations to the Auditor General for Wales on his appointment of an engagement partner;

- discuss with the External Auditor, in line with the agreed audit plan, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other External Auditors in the local health economy and with Internal Audit;

- review External Audit reports, including value for money reports and annual audit letters, together with the management response;

- Monitor the timely implementation by management of agreed audit recommendations;

- Receive a report from the Auditor General for Wales / Wales Audit Office on the results of his audit of the annual accounts before recommending adoption of those accounts to the Accountable Officer and the Health Board.

Financial Reporting

The Committee shall review the annual financial statements before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices;

- major judgemental areas;

- significant adjustments resulting from the audit;

- compliance with legal requirements;

- review any material mis-statements identified during the Audit.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Audit & Risk Committee has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's financial reporting, internal control systems, risk management systems and the internal and external audit functions.

AUTHORITY

The Committee is authorised by the Board to:

- investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It may seek relevant information from any:

    - Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

    - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;

- by giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

ACCESS

The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit & Risk Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

The Chair of Audit & Risk Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:

A minimum of **(4)** members, comprising

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board (one of which should be a member of the Quality & Safety Committee).

The Chair of the Health Board shall not be a member of the Audit & Risk Committee.

Attendees:

- Executive Director of Finance & Procurement
- Director of Corporate Governance / Board Secretary (Executive Lead for Risk)
- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General for Wales

- The Chief Executive and Chair shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts. The Director of Finance for WHSSC and Committee Secretary will normally attend the meetings of the Audit Committee. The Director of Specialised and Tertiary Services and the Chair of the Welsh Health Specialised Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.

- The Emergency Ambulance Services Commissioner and the Chair of the Emergency Ambulance Services Committee shall be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement and at the meeting to discuss the Accounts.

- Other Directors may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

By Invitation:

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the CTMUHB Chair – taking account of the balance of

skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

The Independent Member who is the nominated Audit Lead for WHSSC and EASC must be a member of the Audit Committee.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, the Vice Chair or an Independent Member who will be nominated to Chair the Committee.

Frequency of Meetings
Meetings shall be held not less than four times a year, and otherwise as the Chair of the Committee deems necessary. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of Individuals in Attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers

The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the CTMUHB Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Audit & Risk Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.2.1

ACTION LOG HEALTH BOARD MEETING					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
6.3	26 May 2022	**Population Health Report** - Future iterations of the report to include RAG Rating and Trend against the actions identified.	Director of Public Health	November 2022	**In progress**
7.1	28 July 2022	**Integrated Performance Dashboard** – Update on Stroke Services Improvement to be presented to a future Board Development Session	Director of Therapies	To be agreed	**In progress** Topic added to the Board Development Programme
Agenda item 5.3	29th September 2022	**Board Assurance Framework -** Strategic Risk 4 and Strategic Risk 6 to be updated to reflect the discussion at Board in terms of the Nursing Bank and Open Eyes Programme.	Director of Digital Executive Director for People	November 2022	**Complete –** Updates reflected in the Board Assurance Framework report being received at the November 2022 Board Meeting.
Agenda item 6.3.1	29th September 2022	**Integrated Performance Dashboard** • Additional line to be added to the trend information on the quadruple aims graphs to outline the target position for which the Health Board aims to achieve as it could be different depending on the activity and its context. • Deputy COO for Primary Care, Community, Mental Health and	Executive Director of Strategy & Transformation Chief Operating Officer Deputy COO for Primary	November 2022 for Data Reviews. PPF Committee next meeting in December 2022	**In progress**

		Learning Disabilities to prepare a briefing for Members that could be further explored at the Planning, Performance & Finance Committee in relation to the performance in relation to residents who are in receipt of secondary mental health services who have a valid care and treatment plan. • Follow Ups Not Booked (FUNB) performance data to be reviewed to ensure data and narrative accuracy.	Care, Community, Mental Health and Learning Disabilities		
Agenda item 7.1	29th September 2022	**Improving Urgent Care** Future updates on bed occupancy activity and how many assessment treatment beds remain occupied by patients who could be discharged from the acute setting.	Chief Operating Officer	November 2022	**In progress** The automated one list has now gone live and further work continues to be undertaken on Data Quality. Data will be provided at the next Board Meeting and the data will be considered further at the December Planning, Performance & Finance Committee.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item 3.2.2

Health Board

Cycle of Business

(1st January 2022 – 31st December 2022)

The Health Board should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Cycle of Business covers the period 1st January 2022 to 31st December 2022.

The Cycle of Business has been developed to help plan the management of Board matters and facilitate the management of agendas and committee business.

The principal role of the Health Board is set out in the Standing Orders 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Health Board's performance across all areas of activity.

Board Cycle of Business (1st January 2022 – 31st December 2022)

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Action Log	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Chairs Report *(Including affixing of the Common Seal and Chairs Urgent Action Requests)*	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Chief Executive Report	Chief Executive	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Joint Committee Composite Report (NWSSP, EASC and WHSSC)	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Putting Things Right Annual Report	Director of Corporate Governance	Annually							✓					
Safeguarding Annual Report	Executive Director of Nursing	Annually											✓ Deferred to January 2023	
Health & Care Standards Annual Report	Executive Director of Nursing	Annually							✓ Deferred to Sept		✓ Deferred to Nov		✓	
Carers Annual Report	Executive Director of Nursing	Annually					✓							
Clinical Education Annual Report	Executive Medical Director	Annually							✓ Deferred to Nov				✓	
Infection Prevention & Control Annual Report	Executive Director of Nursing	Annually							✓ Deferred to Sept		✓			
Health Emergency Planning Annual Report *	Executive Director of Strategy & Transformation	Annually			✓									
Welsh Language Standards Annual Report	Executive Director for People	Annually			✓ Deferred to Sept Board						✓			
Equality & Monitoring / Strategic Equality Plan Update	Executive Director for People	Annually			✓ Deferred to Sept Board						✓ Deferred to Nov Board		✓ Being captured at People & Culture Committee	
Board Cycle of Business	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Board Forward Work Programme	Director of Corporate Governance	All Regular Meeting	✓		✓		✓		✓		✓		✓	
Shared Listening & Learning														
Patient or Staff Experience Story	Executive Nurse Director	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Governance														
Audit Wales Structured Assessment & Audit Letter	Director of Corporate Governance	Annually	✓											
Organisational Risk Register	Director of Corporate Governance	Annually (from May onwards)	✓		✓		✓							
Board Assurance Framework	Director of Corporate Governance	All Regular meetings (from May onwards)					✓		✓		✓		✓	
Annual Report (including Performance Report, Accountability Report and Remuneration Report)	Director of Corporate Governance	Annually						✓						
Annual Statutory Accounts	Executive Director of Finance	Annually						✓						
Audit & Risk Committee Highlight Report	Director of Corporate Governance & Executive Director of Finance	All regular meetings following a Committee	✓ Dec 21 Highlight Report		✓ Feb 22 Highlight Report		✓ April 22 Highlight Report		✓ June 22 Highlight Report		✓ Aug 22 Highlight Report		✓ Oct 22 Highlight Report	
Audit & Risk Committee Annual Report	Director of Corporate Governance & Executive Director of Finance	Annually									✓ 2021 – 2022 Annual Report			
Charitable Funds Committee Highlight Report	Director of Corporate Governance & Executive Director of Finance	All regular meetings following a Committee					✓ April 22 Highlight Report		✓ July 22 Highlight Report				✓ Nov 22 Highlight Report	
Charitable Funds Committee Annual Report	Director of Corporate Governance & Executive Director of Finance	Annually							✓ 2021 – 2022 Annual Report					
Mental Health Act Monitoring Committee Highlight Report	Interim Chief Operating Officer	All regular meetings following a Committee			✓ Mar 22 Highlight Report				✓ Jun 22 Highlight Report		✓ Sep 22 Highlight Report			

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Mental Health Act Monitoring Committee Annual Report	Interim Chief Operating Officer	Annually							✓ 2021 – 2022 Annual Report					
Remuneration and Terms of Service Committee Highlight Report	Director of Corporate Governance	As required at all Regular Meetings following a Committee	✓		✓		✓		✓		✓		✓	
Remuneration and Terms of Service Committee Annual Report	Director of Corporate Governance	Annually							✓ (2020-2021 Annual Report)					
Targeted Intervention – Programme for Continuous Improvement in response to Targeted Intervention	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Annual Review of the Standing Orders	Director of Corporate Governance	Annually			✓									
Board Effectiveness Self-Assessment	Director of Corporate Governance	Annually			✓									
Risk Management Strategy	Director of Corporate Governance	Annually			✓ Deferred to May Board		✓							
Improving Care														
Quality Dashboard	Executive Director of Nursing	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Integrated Performance Dashboard	Executive Director of Strategy & Transformation	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Quality & Safety Committee Highlight Report	Executive Director of Nursing	All Regular Meetings following a Committee	✓ (Jan 22 Highlight Report)		✓ (Mar 22 Highlight Report)		✓ (May 22 Highlight Report – Verbal Update)		✓ (Jul 22 Highlight Report)		✓ (Sep 22 Highlight Report)		✓ (Nov 22 Highlight Report)	
Quality & Safety Committee Annual Report	Executive Director of Nursing	Annually							✓ (2021-2022 Annual Report)					
Clinical Advisory Group Highlight Report	Executive Director of Strategy & Transformation	All Regular Meetings following a Committee	✓ (Dec 21 Highlight Report)		✓ (Feb 22 Highlight Report)		✓ (Apr 22 Highlight Report)		✓ (Jun 22 Highlight Report)		✓ (Aug 22 Highlight Report)		✓ Deferred to January 2023. Group not yet met	

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Clinical Advisory Group Annual Report	Executive Director of Strategy & Transformation	Annually					✓							
Maternity & Neonatal Services Improvement Programme	Executive Director of Nursing/Executive Medical Director	All regular meetings	✓		✓		✓		✓		✓		✓	
Sustaining our Future														
Digital & Data Committee Highlight Report	Director of Digital & Data	All Regular Meetings following a Committee			✓ (Mar 22 Highlight Report)				✓ (Jun 22 Highlight Report)				✓ (Sep 22 Highlight Report)	
Digital & Data Committee Annual Report	Director of Digital & Data	Annually							✓ (2021-2022 Annual Report)					
Planning, Performance & Finance Committee Highlight Report	Executive Director of Strategy & Transformation/ Interim Chief Operating Officer/Executive Director of Finance	All Regular Meetings following a Committee			✓ (Feb 22 Highlight Report)		✓		✓		✓		✓	
Planning & Performance & Finance Committee Annual Report	Executive Director of Strategy & Transformation/ Interim Chief Operating Officer /Executive Director of Finance	Annually							✓ (2021-2022 Annual Report)		✓ (2021-2022 Annual Report)			
Nurse Staffing Levels (Wales) Act Report – Annual Assurance Report	Executive Director of Nursing	Annually					✓							
Integrated Medium Term Plan – Approval	Executive Director of Strategy & Transformation	Annually			✓		✓							
Integrated Medium Term Plan (Annual Plan) – Quarterly Updates	Executive Director of Strategy & Transformation	Quarterly			✓ Deferred to May		✓		✓				✓	
Monthly Finance Reports	Executive Director of Finance	All regular meetings	✓		✓		✓		✓		✓		✓	
Inspiring People														

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
People & Culture Committee Highlight Report	Executive Director for People	All Regular Meetings following a Committee					✓ (May 22 Highlight Report)				✓ (Aug 22 Highlight Report)		✓ (Nov 22 Highlight Report)	
People & Culture Committee Annual Report	Executive Director for People	Annually									✓ (2021-2022 Annual Report)			
Local Partnership Forum Highlight Report	Executive Director for People	All Regular Meetings following a Committee					✓		✓		✓		✓	
Local Partnership Forum Annual Report	Executive Director for People	Annually					✓							
Creating Health														
Population Health and Partnerships Committee Highlight Report	Interim Chief Operating Officer/Executive Director of Strategy & Transformation	All Regular Meetings following a Committee					✓ (May 22 Highlight Report)				✓ (Jul 22 Highlight Report)		✓ (Nov 22 Highlight Report)	
Population Health and Partnerships Committee Annual Report	Interim Chief Operating Officer/Executive Director of Strategy & Transformation	Annually									✓ (2021-2022 Annual Report)			
Stakeholder Reference Group Highlight Report	Executive Director of Strategy & Transformation	As required at all Regular Meetings following a Committee			✓ (Feb 22 Highlight Report)		✓ (Apr 22 Highlight Report)		✓ (Jun 22 Highlight Report)		✓ (Aug 22 Highlight Report)		✓ (Oct 22 Highlight Report)	
Stakeholder Reference Group Annual Report*	Executive Director of Strategy & Transformation	Annually					✓							
Population Health Report	Executive Director of Public Health	Now Bi-Annually	✓		✓		✓						✓	
Regional Partnerships Board & Public Services Board 6 Monthly Report	Executive Director of Strategy & Transformation	Bi-Annually			✓ Deferred to May		✓ Received at Population Health & Partnerships Committee				✓		✓	

***TBC**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.2.3

HEALTH BOARD – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Email Request from the Executive Director of Public Health	Additional Item	Business Case for the Vaccination Programme	Executive Director of Public Health	26 May 2022 – **Deferred – Revised date to be Agreed**
Agenda Item agreed at the Board Agenda Planning session held in June	Additional Item	Improving Urgent Care	Chief Operating Officer	28 July 2022 – **Completed** 29 September 2022 **– Completed** 24 November 2022 **– On agenda**
Agenda Item agreed at the Board Agenda Planning session held in June	Additional Item	Elective Care Recovery	Chief Operating Officer	28 July 2022 – **Completed** 29 September 2022 **– Completed** 24 November 2022 – **On agenda**
Email Request from the Director of Strategy & Transformation	Additional Item	CTMUHB Winter Plan	Director of Strategy & Transformation	29 September 2022 – **Deferred** 24 November 2022 **– On agenda**
Request made by the Health Board Chair	Additional Item	Capital Programme – Mid Year Position	Director of Finance	24 November 2022 – **On agenda**
Email Request from the Director of Corporate Governance	Additional Item	Spinal Services Operational Delivery Network for South Wales, West Wales and South Powys - SBUHB Governance – Memorandum of Understanding	Director of Strategy & Transformation	24 November 2022 – **Deferred – Now January 2023**
Email Request from the Nurse Staffing Act Senior Nurse	Additional Item	Nurse Staffing Act Report	Director of Nursing	24 November 2022 – **On agenda**
Action Captured at the July Board Meeting	Additional Item	Integrated Health & Social Care System Plan	Director of Strategy & Transformation	24 November 2022 – Deferred to January 2023. To be agreed

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Agenda Item agreed at the Agenda Planning Session	Additional Item	Integrated Medium Term Plan – Planning for 2023/2024	Director of Strategy & Transformation	24 November 2022 – **On agenda**

Completed Requests:				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Agenda Item agreed at agenda planning	Additional Item	CTM Operating Model – Reconfiguration Proposal	Chief Executive	26 May 2022 – **Completed** 28 July 2022 **– Completed** 29 September 2022 **– Completed**
Agenda Item agreed at agenda planning	Additional Item	CTM 2030 Our Health Our Future	Director of Strategy and Transformation	26 May 2022 – **Completed** 28 July 2022 **– Completed** 29 September 2022 **– Completed**
Agenda Item agreed at the Board Agenda Planning session held in June	Additional Item	Ty Llidiard Improvement Plan	Director of Therapies & Health Sciences	28 July 2022 – **Completed** 29 September 2022 **– Completed**
Email Request from the Assistant Director of Governance & Risk	Additional Item	Covid-19 Inquiry Preparedness	Director of Corporate Governance	29 September 2022 – **Completed**
Email Request from HIW	Additional Item	Healthcare Inspectorate Wales (HIW) Annual Report 2021-2022	Director of Nursing	29 September 2022 – **Completed**
Email Request received from the Director of Primary, Community & Mental Health Services	Additional Item	Proposal to Return Ferndale/Maerdy Medical Practice back to Independent Status	Chief Operating Officer	29 September 2022 – **Completed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request received from the Assistant Director of Governance & Risk	Additional Item	Scheme of Delegation and Procurement Report	Director of Finance	29 September 2022 – **Completed**
Email Request received from the Director of Corporate Governance	Additional Item	Annual Letter 2021-2022 – Public Services Ombudsman for Wales	Director of Corporate Governance	29 September 2022 – **Completed**
Email Request received from the Director of Primary, Community & Mental Health Services	Additional Item	Sustainability of General Medical Services	Chief Operating Officer	29 September 2022 – **Completed**
Email Request received from the Director of Strategy & Transformation	Additional Item	Nevill Hall Hospital – Satellite Radiotherapy Unit	Director of Strategy & Transformation	29 September 2022 – **Completed**

AGENDA ITEM
3.2.4

CTM BOARD

BOARD COMMITTEE/ADVISORY GROUP HIGHLIGHT REPORTS

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In line with the Standing Order requirements each Board Committee and Advisory Group is required to submit a Highlight Report setting out its activities at each meeting. This also provides a mechanism for escalating issues to the Board as required.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 A number of Committee/Advisory Groups have been held since the Board last met in September 2022.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Key risks and any matters for escalation to the Board are set out in the appended Highlight Reports.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board are being asked to **NOTE** the following Highlight Reports:

- Quality & Safety Committee (Appendix 1a and 1b);
- Digital & Data Committee (Appendix 2);
- Quality & Safety In Committee (Appendix 3);
- Mental Health Act Monitoring Committee (Appendix 4);
- Stakeholder Reference Group (Appendix 5);
- Audit & Risk Committee Hosted Bodies (Appendix 6);
- Audit & Risk Committee CTMUHB (Appendix 7);
- Planning, Performance & Finance Committee (Included on Main agenda for discussion);
- Population Health & Partnerships Committee (Appendix 8);
- People & Culture Committee (Appendix 9);
- Charitable Funds Committee (Appendix 10).

AGENDA ITEM
3.2.4 Appendix 1a

CTM BOARD	
HIGHLIGHT REPORT FROM THE QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	24 November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Vice Chair and Chair of the Quality & Safety Committee
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on the 20 September 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE QUALITY & SAFETY COMMITTEE

2.1 The purpose of the Quality and Safety Committee is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	No items to escalate on this occasion. There are no items to escalate from the Committee on this occasion.
ADVISE	• The Committee received a **patient story** which related to care that had been provided to a patient who was experiencing pregnancy loss. Members extended their thanks to the patient's husband for sharing the story on behalf of his wife. Health Board Officers were asked to providean update at the next meeting as to the processes that had been put into place for women who were experiencing ectopic pregnancies to ensure they were receiving the required care at the most appropriate time; • The **Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** was received. A number of questions were raised by Members in relation to individual risks and it was noted that responses would be provided outside the meeting. Assurance was provided that work had already commenced in relation to aligning risks to the new Care Group model and Members noted that a projected completion date for this task was January 2023; • A report on the **Covid-19 Inquiry Preparedness** was received. Members noted the risks in relation to resourcing this activity in terms of information management given the departure of the most recent post holder and noted the steps being taken to mitigate this risk; • A report on the **Assurance on the Health Board's plan to improve monitoring and reporting in relation to Continuing Healthcare (CHC) and Funded Nursing Care (FNC) activity** was received**.** Members requested a further report be presented to the next meeting to determine frequency of future reporting and requested that future iterations of the report reflected the voice of patients and their families;

	• The **Annual Letter 2021/2022 – Public Services Ombudsman for Wales** was received and noted; • The **NCCU Quality Assessment and Improvement Service - Annual Quality position statement** was received and discussed in detail; • The **Maternity & Neonates Services Improvement Programme Highlight Report** was received. Following on from the patient story received at the start of the meeting, a discussion was held as to the steps that had been taken to improve communication within the service, with feedback being received that communication had improved. Members agreed it would also be important to reflect the learning from the changes in maternity and neonatal services to other specialties across CTMUHB; • A **Progress Report on Ty Llidiard** was received. Members were encouraged to arrange a visit to the unit to see the good work that had been undertaken to improve service provision; • The **Quality Dashboard** was received. Members noted that issues were being experienced with the Datix system which was currently only permitting certain staff tiers to update incident reports. Members noted that some retrospective work would be required once system permissions were revised; • The report from the **Chief Operating Officer** was received. Members noted that cancer service performance and reducing the backlog in a number of tumour sites remained a key focus. A discussion was held in relation to the 'red release' bed performance, particularly at Princess of Wales Hospital. Members noted that patients at the Princess of Wales Hospital were more likely to experience a delay in discharge compared with patients at the Royal Glamorgan and Prince Charles Hospitals and this was being reviewed so that the issues could be addressed; • **The Infection, Prevention & Control Committee Highlight Report was received** which highlighted one matter for escalation which related to JAG accreditation.
ASSURE	• The Committee received **the Primary Care Quality & Safety Report.** The Committee Chair extended her thanks to the GP Out of Hours Team for the resilience they had shown in addressing the IT issues that had recently been experienced; • **The Stroke Services Progress Report was received.** Members were reassured that thrombolysis was administered across all three district general hospital sites, although Emergency Department staff at the Royal Glamorgan site needed to liaise with colleagues at Prince Charles Hospital in order to provide thrombolysis thrombolysis treatment following a scan. Members noted that discussions were ongoing with Cardiff and Vale colleagues to develop a joint rota to support CTMUHB's two Stroke Consultants.

INFORM	The following reports were received by the Committee for Approval/Noting; For Approval: For approval: • Estates Policy – PAT Testing Policy. • For Noting. For Noting: • Committee Action Log; • Committee Cycle of Business; • Committee Forward Work Programme; • Welsh Health Specialised Services Committee Quality & Patient Safety Committee Chairs Report; • Transition and Handover from Children to Adults Health Services; • Welsh Ambulance Services NHS Trust Patient Experience Report; • Quality Governance – Regulatory Review Recommendations and Progress Updates; • Radiation Safety Committee Highlight Report; • Thematic Review of the feedback received from the Community Health Council – Primary Care; • CTMUHB Nosocomial Covid 19 Incident Management Programme; • Progress Report following Internal Audit on Concerns & Welsh Risk Pool Review on Claims/Redress/Inquests.
APPENDICES	**NOT APPLICABLE**

4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.

AGENDA ITEM
3.2.4 Appendix 1b

CTM BOARD	
HIGHLIGHT REPORT FROM THE QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Chair of the Quality & Safety Committee
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on the 15 November 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE QUALITY & SAFETY COMMITTEE

2.1 The purpose of the Quality and Safety Committee is to provide assurance to the Board on the provision of workplace health & safety and safe and

high quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	There were no items for escalation to Board noted at this Committee.
ADVISE	• The **Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** report was received. Members welcomed the ongoing work to align existing risks to the new Care Group model. A number of queries were raised against specific risks and it was requested that progress reports on Learning From Events Reports and the Welsh Community Care Information System (WCCIS) were presented to future meetings of the Committee; • The Committee received a **Datix Cymru Assurance Report**. A discussion was held in relation to the decrease in the numbers of incidents being reported and Members requested a further update at a future meeting following exploration into the reasons for the reduction and whether coding issues and/or staff training was a factor; • The **Health, Safety & Fire Sub Committee Highlight report** was received. Members noted that the issues in relation to incident reporting on the new Datix Cymru system had been identified as an area of concern in the alert/escalate section of the report. Members also noted that work was being undertaken with the Operational Teams to determine Care Group representation at the Sub Committee moving forwards; • The Committee received the **Highlight Report from the Infection Prevention & Control Committee**. Members noted that JAG accreditation had been identified as an area of concern

	within the alert/escalate section and noted that positive discussions had been held with JAG on the next phase of the plan; • The report from the **Chief Operating Officer** was received. Members noted the ongoing challenges within the Ophthalmology Service and the ongoing improvement activity which is being undertaken, the changes that had been made to assurance processes within the Health Board regarding Cancer Services and the work being undertaken to address Ambulance Handover delays. Members **welcomed** the work that had been undertaken by the Primary Care Team to ensure the service remained resilient during the Cyber Attack on the ADASTRA system and welcomed the reopening of the Minor Injuries Unit at Ysbyty Cwm Cynon; • Members received a report on **Civica – People's Experience Feedback System** and noted the potential benefits of the system moving forward. Members agreed to receive regular progress reports on this matter at future meetings; • The **Peer Review of Urgent Care (Out of Hours and UPCC) In CTMUHB** was received and noted; • The **Ward Based Nursing Assurance Report** was received. Members noted the work being undertaken to standardise processes and templates using the AMaT system;
ASSURE	• Members received a presentation and associated patient story on the work being undertaken by the **Wellness Improvement Service** which is a service that coaches patients on how to self-manage their physical conditions. Members welcomed the work that was being undertaken by the team which they found to be inspirational and uplifting; • The **Maternity Services & Neonates Improvement Programme Report** was received. Members welcomed the news that the service had now been moved out of Special Measures and into Targeted Intervention and that work was being undertaken to address the remaining recommendations by end of March 2023; • Members received a **Progress Report on Ty Llidiard** and acknowledged the significant progress that had been made and the work being undertaken with young people on the Unit to improve services. Members noted that a positive visit to the Unit had recently been undertaken by the National Collaborative Commissioning Unit from which formal feedback was awaited; • The **Quality Dashboard** report was received. Members recognised the progress that had been made against Patient Safety Notices, with only two notices remaining open; • The **Mental Health Care Group Quality & Safety Report** was received. Members welcomed the report which they felt was clear and concise;

	• Members received the **Welsh Health Specialised Services Quality & Patient Safety Committee Chairs report** and noted that assurance was provided to WHSSC that the reports were being shared with the CTM Quality & Safety Committee; • The **Learning from Mortality Reviews report** was received. Members welcomed the report and noted that a robust review system was in place; • The Committee received and **endorsed** the latest version of the **Quality Strategy**.
INFORM	The following items were received via the consent agenda for approval: • Minutes from the meetings held on 20 September and 11 October 2022; • Quality & Safety Committee Terms of Reference. The following items were received via the consent agenda for noting: • Committee Action Log, Cycle of Business and Forward Work Programme; • Quality Governance – Regulatory Review Recommendations and Progress Updates; • Health & Care Standards Annual Report; • National Prescribing Indicator (NPI) Annual Report; • Clinical Education Annual Report; • Clinical Audit Quarterly Report; • Nosocomial Covid-19 Incident Management Programme; • Human Tissue Authority Act Progress Report; • Annual Review 2021-2022 – Welsh Risk Pool and Legal & Risk Services.
APPENDICES	**NOT APPLICABLE**

4. RECOMMENDATION

4.1 The Board is requested to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM 3.2.4

CTM BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE DIGITAL & DATA COMMITTEE

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies Corporate Governance Manager
PRESENTED BY	Ian Wells Digital & Data Committee Chair / Independent Member
EXECUTIVE SPONSOR APPROVED	Stuart Morris Director of Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
IMTP	Integrated Medium Term Plan

1. PURPOSE

1.1 This report provides the Board with details of the key issues considered at the meeting of the Digital & Data Committee which took place on 28 September 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the report.

2. PURPOSE OF THE DIGITAL & DATA COMMITTEE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information & Data, to support health improvement and the provision of high quality healthcare.

2.2 The Committee will seek assurance on behalf of the Board in relation to the Health Board's arrangements for appropriate and effective management and protection of information (including patient and personal information) in with legislative and regulatory responsibilities.

2.3 The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the Digital and Data Strategies to drive continuous improvement and support digitally enabled health care to achieve the objectives of the Health Board's Integrated Medium Term Plan (IMTP).

3. HIGHLIGHT REPORT

ALERT / ESCALATE	No activity to alert and escalate to the Board on this occasion.
ADVISE	• The Committee considered and approved the direction of travel for the **Bridgend / CTM Aggregation Plan.** • An update was received on **IT Major Schemes.** The committee noted the progress of the approved ICT capital projects. • The Committee received an innovative demonstration on advanced clinical coding and an update on the **Coding Strategy and Auto Coder.**

ASSURE	• The **Organisational Risk Register** was reviewed and the importance of ensuring risks are updated in accordance with their review dates was reiterated. The Committee also received a report on all **Digital Risks** and **noted** the actions being taken to mitigate them. • A report was received on the **Information Commissioner's Office (ICO) Audit Feedback and Information Governance Improvement plan.** The Committee **noted** the update on the work progress made in delivering the Information Governance Improvement Plan and the outcomes of the recent ICO re-assessment. • The Committee received the **Digital Assurance Report** which provided the Committee with an update on the progress of the prioritised digital deliverables within the corporate Integrated Medium Term Plan (IMTP) across the 8 strategic solutions and the challenges faced in the last quarter. • The Committee welcomed an update on the **Digital Engagement activity** being undertaken across the Health Board. • An **Update on progress made in taking forward recommendations made by NHS Wales Internal Audit and Audit Wales** was received. The Committee **noted** the outstanding recommendations made by the internal and external auditors relating to the Informatics service and the latest status of delivering the recommendations. • The **"In Committee"** meeting of the Digital and Data Committee received robust updates on the following areas of activity: o Cyber Improvement Programme o Early Reflection on Lessons Learnt from the Adastra Incident o Digital Critical Incidents o Infrastructure Review

INFORM	• The **Committee Annual Report 2021-22** was approved. • Two minor amendments to the Committee **Terms of Reference** to reflect areas of responsibility within management portfolios was approved. • The **Live Streaming & Recording Policy** was approved by the Committee. • The **Freedom of Information Act Policy** was approved by the Committee. • The **Information Governance Group Highlight Report** was noted.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
3.2.4 Appendix 3

CTM BOARD	
HIGHLIGHT REPORT FROM THE QUALITY & SAFETY IN COMMITTEE	
DATE OF MEETING	24 November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Vice Chair and Chair of the Quality & Safety Committee
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on the 11 October 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE QUALITY & SAFETY COMMITTEE

2.1 The purpose of the Quality and Safety Committee is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	No items to escalate on this occasion.
ADVISE	• The Committee received a report on **Patient Falls and Absconsions: Lessons Learnt Report.** The Committee agreed to receive a further update on the position at its next In Committee session.
ASSURE	• The **Stillbirth Thematic Review 2021 report** was received**.** The Committee Chair extended thanks to colleagues for the report providing evidence that stillbirths were continuing to be reported openly and accurately which provided the Committee with the necessary assurances in this regard.
INFORM	Nil.
APPENDICES	**NOT APPLICABLE**

4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 3.2.4

CTM BOARD

HIGHLIGHT REPORT FROM THE MENTAL HEALTH ACT MONITORING COMMITTEE

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Vice Chair & Chair of the Mental Health Act Monitoring Committee
EXECUTIVE SPONSOR APPROVED	Julie Denley, Director of Primary, Community & Mental Health

REPORT PURPOSE	FOR NOTING

ACRONYMS	
MHA	Mental Health Act
SWP	South Wales Police

1. INTRODUCTION

1.1 This paper had been prepared to provide the Board with details of the key issues considered by the Mental Health Act (MHA) Monitoring Committee at its meeting on the 12 October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. PURPOSE OF THE MENTAL HEALTH ACT MONITORING COMMITTEE

2.1 The purpose of the Committee is to advise and assure the Board that the arrangements to monitor and review the way functions under the Mental Health Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• There are no matters to escalate to the Board on this occasion.
ADVISE	• The Committee **received** a **MHA Operational Group update report**. The Committee **noted** the following key matters: • **Hospital Managers Powers of Discharge - Committee -** Proposal submitted for the reintroduction of annual appraisals for Hospital Managers. • **Concerns about the place of safety accommodation in Prince Charles Hospital** – The Committee raised their concerns regarding the facilities for the Section 136 Suite at Prince Charles Hospital and **agreed** that this would be reviewed and an update provided. • **Electronic Communication to Nearest Relatives** - Governance arrangements confirmed with the Information Governance Team. • **Section 117 Aftercare Register**- Validation ongoing. Focus on process for discharging patients where appropriate and an update planned for the next meeting. • **Nominated Adolescent Bed on Adult MH Wards** - Proposals being developed to host this service on Ward 14 at the Princess of Wales Hospital. • **Review of Mental Health Act Policies** - Some lapsed policies require urgent review. Operational Group to prioritise this and future updates would set out the

	target date for completion of reviews. In particular, it was **noted** that progress needed to be in reviewing the Consent to Treatment Policy. • **Quarterly Mental Health Act Activity Report for Adult, Older Persons and Children and Adult Mental Health Services (CAMHS)/Breaches and Errors Report** was received for Quarter 1 – April – June 2022. The Committee noted that CAMHS detentions had remained the same. There has been one occasion in the use of Section 4, which was applied out of hours. • A verbal update was provided and **noted** on the **Use of the MHA for Patients with a Learning Disability.** It was **agreed** that an update on the number of patients subject to this would be provided to the next meeting.
ASSURE	• A report on the **Risks relating to the Mental Health Act (MHA) for Quarter 1** April – June 2022 was **received.**
INFORM	• The Committee **received** and **approved** the **Committee Annual Report for 2021-22.** The Committee **agreed** to undertake the Committee Self Effectiveness Survey and receive the outcome and improvement plan at its meeting to be held in December 2022. • A report was **received** on the **Hospital Managers Fees Review.** The Committee **noted** the recommendations that had been approved by the Executive Leadership Group in July 2022.
APPENDICES	Not Applicable.

AGENDA ITEM
3.2.4 Appendix 5

CTM BOARD	
HIGHLIGHT REPORT FROM THE STAKEHOLDER REFERENCE GROUP	
DATE OF MEETING	Thursday 24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emily Phillips – Planning Assistant and Elizabeth Beadle, Assistant Director of Transformation
PRESENTED BY	Linda Prosser, Executive Director of Strategy and Transformation
EXECUTIVE SPONSOR APPROVED	Linda Prosser, Executive Director of Strategy and Transformation

REPORT PURPOSE	For noting

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
SRG	Stakeholder Reference Group

1. PURPOSE

1.1 This report has been prepared to provide the Board with details of the key issues considered by the Stakeholder Reference Group at its meeting on the 13th October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the report.

2. 2. Role of the Stakeholder Reference Group (SRG)

2.1 The SRG's role is to provide independent advice on any aspect of Health Board business. This may include:

- Early engagement and involvement in the determination of the Health Board's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the Health Boards' operations on the communities it serves.

2.2 The SRG provides a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the Health Board, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the Health Board's decision making.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no issues to escalate.
ADVISE	**EXPRESSIONS OF INTEREST FOR VICE-CHAIR -** Following the resignation of the Vice-Chair of the Stakeholder Reference Group in July 2021, expressions of interest/nominations had been sought but to date none had been received. The chair encouraged members to put forward any expressions of interest or nominations. **TERMS OF REFERENCE –** The terms of reference were circulated to members and some proposals were received and discussed at the October meeting: • The SRG received a proposal to reduce meetings to quarterly, as the newly established Community Leaders group also includes some SRG members. The reference group requested that it be established whether there were any elected members on the Community Leaders group prior to making a decision regarding the meeting frequency. • The Chair updated members that guidance had been sought from the Corporate team on the quoracy of meetings. While SRG is not a decision making body and does not require quoracy, the SRG agreed that if decisions are required an email will be sent to the group in its entirety for input.

	• Members agreed to make provision for deputies to attend when they are unavailable. The theme of the meeting was a focus on older people, to celebrate International Older Persons' Day and the following presentations were received:- **CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD PRESENTATION** – A presentation was received on frailty. The presentation introduced the Electronic Frail index (EFI), its impact on individual patients and the usefulness of the index in being utilised through advancements in technology to further improve quality of life. An opportunity was given to members for discussion and to ask questions which were well received. **CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD PRESENTATION** – The SRG received a presentation on the immunisation team and its work, highlighting attendance at community events to discuss immunisation with the public. Data was presented showing how different vaccinations across the life course can preserve life. An opportunity was given to members to ask questions and discuss the points raised within the presentation. **CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD PRESENTATION -** The SRG received an update on the health board's process and timelines to develop its three year plan in line with statutory requirements.
ASSURE	**NOT APPLICABLE**
INFORM	The SRG received an update from the recent Merthyr Tydfil 50+ Forum meeting.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
3.2.4 Appendix 6

CTM BOARD	
HIGHLIGHT REPORT FROM THE HOSTED BODIES AUDIT AND RISK COMMITTEE	
DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Cally Hamblyn, Assistant Director of Governance & Risk
PRESENTED BY	Patsy Roseblade, Independent Member and Chair of the Audit & Risk Committee
EXECUTIVE SPONSOR APPROVED	Georgina Galletly, Director of Corporate Governance Sally May, Executive Director of Finance

REPORT PURPOSE	NOTING

ACRONYMS	
WHSSC	Welsh Health Specialised Services Committee
EASC	Emergency Ambulance Services Committee

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Hosted Bodies Audit & Risk Committee at its meeting on the 24th October 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE AUDIT & RISK COMMITTEE

2.1 The Committee will function in accordance with the NHS Audit Committee Handbook as appropriate.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS

Wales as appropriate. These are the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	There were no items requiring escalation.
ADVISE	• The Committee received a detailed update from the **Emergency Ambulance Services Committee (EASC)**, highlighting the following key matters: ○ **EASC Risk Register** noting the update on the work being undertaken to address red performance, amber performance and patient safety concerns. ○ **EASC Assurance Framework** ○ **Service Development Proposal** involving the Emergency Medical Retrieval & Transfer Service **(EMRTS Cymru).** ○ **Welsh Ambulance Service performance levels.** ○ **EASC Action Plan** - It was noted that the EASC Team are working with Health Boards to develop local Integrated Commissioning Action Plans which will also be incorporated in the Commissioning Framework activity and would form part of the Health Board's Integrated Medium Term Plan (IMTP). ○ Two further areas of focus were noted in the update from EASC: **Alternative Pathway Admission Avoidance** and **Post Production Lost Hours.** • The **Welsh Health Specialised Services Committee (WHSSC)** presented an update on the WHSSC Corporate Risk Assurance Framework noting that it had been received by the Integrated Governance Committee (IGC) on 11 October 2022. Members noted that as at 31 July 2022 there were 17 risks comprising of 15 commissioning risks and two organisational risks.

ASSURE	• The **WHSSC Audit Recommendations Tracker** report was received and noted. • The Committee received the following assurance on the **WHSSC Internal Audit Reviews**: o WHSSC **Quality Assurance Reporting** which had been allocated a **'Substantial'** assurance rating. o WHSSC **Neurosurgery** which had been allocated a **'Substantial'** assurance rating. • **EASC Assurance Framework** noting that the EASC Integrated Medium Term Plan (IMTP) was confirmed as acceptable by Welsh Government subject to some accountability conditions, many of which have already been completed.
INFORM	• The Committee received for approval a review of **WHSSC Financial Limits and Reporting,** following detailed discussion Members considered that they were unable to approve the review at this time. Whilst the members were supportive of the rationale for initiating the review and seeking the permanency of the current arrangements, it was considered that that due to the significant detail captured in the reports further assurance was required that Joint Committee Members were supportive of the approach and have had an opportunity to review the position and consider their impact in terms of their respective Health Boards. This report will be brought back to the Committee in due course. • **Farewell to George Galletly, Director of Corporate Governance.** On behalf of the Committee the Chair formally noted her thanks to George Galletly for all her hard work, and in particular her ability to clearly articulate and advise on the purpose of this Committee in terms of its hosting responsibilities and the assurance it provides to other Health Boards. George was wished all the very best in her new role as she leaves imminently on Secondment to Welsh Government.
APPENDICES	**NOT APPLICABLE**

4. RECCOMENDATION

4.1 The Board is requested to **NOT**E the report.

AGENDA ITEM
3.2.4 Appendix 7

CTM BOARD	
HIGHLIGHT REPORT FROM THE CTMUHB AUDIT AND RISK COMMITTEE	
DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Cally Hamblyn, Assistant Director of Governance & Risk
PRESENTED BY	Patsy Roseblade, Independent Member and Chair of the Audit & Risk Committee
EXECUTIVE SPONSOR APPROVED	Georgina Galletly, Director of Corporate Governance Sally May, Executive Director of Finance

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Audit & Risk Committee at its meeting on the 24th October 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE AUDIT & RISK COMMITTEE

2.1 The Committee will function in accordance with the NHS Audit Committee Handbook as appropriate.

2.2 The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services

Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

2.3 The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

2.4 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	There are no items to escalate this period.
ADVISE	• The **Local Counter Fraud Report** was received with the following key areas highlighted: o The review undertaken by the NHS Counter Fraud Authority Quality Assurance Inspector. o The plans for the Health Board in terms of its participation in International Fraud Awareness week in November 2022. o Counter Fraud Investigations Update. • The **Procurement and Scheme of Delegation report** was received and approved; attention was also drawn to the Health Boards performance as outlined in the comparative findings report "Preventing Procurement Fraud in the NHS", with an update on the activity being taken forward by the Health Board. • A detailed update was received in relation to the **Post Payment Verification activity** and the position on **PPV visits**. • The **Organisational Risk Register** was received. A number of queries were raised in relation to individual risks which were responded to in the meeting where appropriate and/or directed to the appropriate risk owner outside the meeting. The Committee were informed that activity is underway with Care Groups to align the risks on the Organisational Risk Register to the new operating model structure.
ASSURE	• The **Audit Recommendations Tracker** was received. Members were advised that the workshop to consider the long standing recommendations with Executive Leads was held in October 2022, which led to progress being made with movement on

	recommendations clearly reflected in the latest tracker update received by the Committee. • The **Internal Audit Progress Report** was received recognising the timely responses being received from Health Board Officers in relation to the sign off of management responses. The Committee were made aware that there is significant activity planned for quarter four which will require the Health Board Officers and Internal Audit Colleagues to work closely to ensure the timetable for the fourth quarter is achieved. • The following **Internal Audit Reviews** were received and noted: o **Digital Operating Model –** which had been allocated a limited assurance rating. Internal Audit recognised the positive reflections in the report and the significant restructure activity underway within the Digital and Data Function. o **Medical Records Management -** which had been allocated a reasonable assurance rating. o **Follow Up Review – Prince Charles Hospital Redevelopment: Phase 1b Final Account -** which had been allocated a substantial assurance rating. o **Follow Up Review – Prince Charles Hospital Validation of Management Actions -** which had been allocated a substantial assurance rating. • The **Audit Wales Audit & Risk Committee update** was received and noted;
INFORM	• The **Audit & Risk Committee Terms of Reference** were approved. • A **Committee Referral** to the **Digital and Data Committee** was agreed to provide the scrutiny on the management responses to the Digital Operating Model and Medical Records Management Internal Audit Reviews. • **Farewell to George Galletly** – The Chair expressed thanks to G Galletly personally and on behalf of the Committee in recognition of her invaluable guidance and input into the Committee. She exclaimed that G Galletly should leave feeling proud of the achievements she and her Team have made to date and wished her all the very best in her new role
APPENDICES	**NOT APPLICABLE**

4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.

Agenda Item 3.2.4

CTM BOARD

HIGHLIGHT REPORT - POPULATION HEALTH AND PARTNERSHIPS COMMITTEE

DATE OF MEETING	24/11/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report
PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Chair, Population Health & Partnerships Committee
EXECUTIVE SPONSOR APPROVED	Linda Prosser, Executive Director of Strategy & transformation; Gethin Hughes, Chief Operating Officer.
REPORT PURPOSE	FOR NOTING

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board.
ACD	Accelerated Cluster Development

1. INTRODUCTION

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Population Health & Partnerships Committee which took place on 2 November 2022.

1.2 Key highlights from the meeting are contained in section 2.

1.3 The Board are requested to **NOTE** the contents of the report and actions being taken.

2. PURPOSE OF THE POPULATION HEALTH & PARTNERSHIPS COMMITTEE

2.1 The purpose of Committee is to provide advice and assurance to the Board to assist it in discharging its functions and responsibilities as they relate to **population health across primary and secondary care.** This will have been achieved through various initiatives including partnership arrangements. The Committee will also consider cross-cutting themes and how the organisation is delivering effective service integration and transformation agendas.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• There are no matters to escalate to the Board on this occasion.
ADVISE	• The Committee **received** a report on the **Population Health Organisational Programme.** The Committee **noted** the progress to date and the future plans under discussion for the 36 Population Health Projects as part of the Creating Health pillar of the Unified Transformation Programme. • A report was **received** on the **Inverse Care Law Programme.** The Committee **noted** the Health Board's involvement in the programme and the lessons learned and conclusions of the report. • The Committee **received** the **Whole System Approach to Healthy Weights across CTMUHB** and **noted** the need for engagement of key internal and external stakeholders. • A Strategic update on Primary Care was received. The Committee **noted** progress on delivery against the strategic milestones. • A **Learning Disability Progress Report** was **received** by the Committee. The Committee **noted** the update on the Adult Learning Disability Services provided in CTMUHB by

	Swansea Bay UHB. • The Committee **received** and **noted** the **Strategy Groups** Update. • A report on the **Public Service Board** was **received.** The Committee **noted** the update on the work of the two Public Service Boards in the Cwm Taf and Bridgend localities. Members **noted** work underway to combine the two Service Boards.
ASSURE	• The **Committee Self Effectiveness Survey Outcome and Improvement Plan** was **approved.** • The **Revised Committee Terms of Reference** that were approved by the Board in September 2022 were **noted** by the Committee. • A report and Presentation was **received** and **noted** on the **Resilient Families Service – Evaluation of Stage 2.**
INFORM	• The **Audit Wales Final Report – Transformation Leadership Programme Board Baseline Governance Review** was **received** and **noted.** The Committee **noted** that the relevant recommendations would be added to the Audit Tracker and the report would be submitted to the Audit and Risk Committee. • The **Audit Wales Final Report – Public Sector Readiness for Net Zero Carbon by 2030** was **received** and **noted.** Members **noted** the recommendations were currently under discussion by Strategy and Transformation colleagues and response to the way these would be addressed would be brought back to the Committee at its next meeting. • The Committee **received** and **noted** the **Regional Partnership Board Annual Report for 2021-22.**
APPENDICES	Not Applicable

AGENDA ITEM
3.2.4 Appendix 9

CTM BOARD	
HIGHLIGHT REPORT FROM THE PEOPLE & CULTURE COMMITTEE	
DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Dilys Jouvenat, Independent Member/ Chair of the People and Culture Committee
EXECUTIVE SPONSOR APPROVED	Hywel Daniel, Executive Director for People

REPORT PURPOSE	FOR NOTING

ACRONYMS	
	None Identified.

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the People and Culture Committee at its meeting on the 9 November 2022

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the report.

2. PURPOSE OF THE PEOPLE & CULTURE COMMITTEE

2.1 The role of the People and Culture Committee is to advise the Board on all matters relating to staff and workforce planning of the Health Board, and enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the health service to deliver safer better healthcare.

2.2 The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the organisational development and other related strategies to drive continuous improvement and to achieve the objectives of the Health Board's Integrated Medium Term Plan (IMTP).

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• There are no matters to escalate to the Board on this occasion.
ADVISE	• A report was **received** on **Leadership and Management Development.** The Committee **noted** the progress of the Leadership and Management Programmes, Ignite, Aspire and Inspire adopted across Cwm Taf Morgannwg University Health Board. • The **Nursing Workforce Update Report** was **received** by the Committee along with a Presentation on workforce planning. The Committee **noted** the specific challenges for the nursing workforce across the Health Board and the work undertaken at a national level to model and forecast supply and demand and develop an NHS Wales nursing workforce plan. • A report was received on Medical Workforce and Efficiency Progress Report. The Committee **noted** the current situation in Medical Workforce and the relevant work streams and projects.
ASSURE	• The Committee **received** the **Workforce Metrics Report** which provided key workforce metrics for July – September 2022, with historic trends.

	• The Committee **received** a report on the **Employee Relations Update** for the period July - September 2022. • The Committee received a report on the **Organisational Risk Register** for those matters where risks had a score of **15 or more** assigned the Committee, noting actions taken to manage or mitigate those high-level risks. • A Presentation was received on the **CAMHS Cultural Transformation and Improvement Work.** • The Committee received a Presentation on the **Pathology Cultural Transformation and Improvement Work.**

INFORM	• The Committee **approved** the following Policies:
	  • Alternative Pension Payment Contributions for Medical and Dental Staff Policy
	  • Industrial Injury Cover Policy
	  • Nursing & Midwifery Rostering Policy – The Committee Ratified the Chairs Action of approval of the policy.
	
	• The Committee **approved** the **Revised Terms of Reference.**
	
	• The Committee **Self Effectiveness Outcome and Improvement Plan** was **approved.**

	Not applicable.

AGENDA ITEM
3.2.4 Appendix 10

CTM BOARD	
HIGHLIGHT REPORT FROM THE CHARITABLE FUNDS COMMITTEE	
DATE OF MEETING	24 November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Patsy Roseblade, Independent Member and Chair of the Audit & Risk Committee
EXECUTIVE SPONSOR APPROVED	Sally May, Executive Director of Finance

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Charitable Funds Committee at its meeting on the 10 November 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE CHARITABLE FUNDS COMMITTEE

2.1 The CTMUHB is appointed as corporate trustee of the charitable funds and its Board serves as its agent in the administration of the charitable funds held by the CTMUHB.

2.2 The purpose of the Charitable Funds Committee is to make and monitor arrangements for the control and management of the CTMUHB's Charitable

Funds.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	There were no items escalated at this Committee meeting.
ADVISE	• The Committee received a verbal update in relation to the **Future Management of the CTM Charity** and noted that discussions were ongoing with the Chief Executive as to what portfolio this should sit under; • The **General Charitable Funds Update** was received. Members agreed to **APPROVE** that there was no further distribution of excess reserves at this stage, noting the drop in capital value since the last report; • The **Covid-19 Charitable Funds Update** was received. Following discussion, Members agreed to **APPROVE** the use of NHS Charities Together Stage 2 grant funding for a Staff Wellbeing Counsellor, which was subject to approval from NHS Charities Together; • A report on the **Audit Wales 2022 Audit Plan – CTMUHB Charitable Funds** was received. Members noted that the Audit of Financial Statements was about to commence and noted that an Annual Meeting of the Trustees would be held on Thursday 26 January 2023 to approve the Annual Accounts prior to their submission to the Charities Commission by 31 January 2023; • The Committee received a report on the Request for Reimbursement from the Charitable Fund at its In Committee session. The Committee retrospectively **APPROVED** the reimbursement of expenditure for the individual purchase of a ramp used to expedite discharge.
ASSURE	• The Committee received a presentation from **CCLA** which outlined the current performance of the **Health Board's investments**. Members **noted** that despite the volatility as a result of the current economic climate, the fund was performing as intended.
INFORM	• The Committee received and noted the **Committee Annual Cycle of Business.**
APPENDICES	**NOT APPLICABLE**

4. RECOMMENDATION

4.1 The Board is requested to **NOTE** the report.

AGENDA ITEM
3.2.5

CTM BOARD

JOINT COMMITTEE REPORTS

Date of meeting	24 November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 To present the Board with a number of Joint Committee reports for information only.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 A number of Joint Committee meetings have been held since the Board last met in September 2022.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Key risks and any matters for escalation are set out in the appended Joint Committee Reports.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Creating Health

5. RECOMMENDATION

5.1 The Board are being asked to **NOTE** the following Joint Committee Reports:

- Welsh Health Specialised Services Committee 8 November 2022 (Appendix 1);
- NHS Wales Shared Services Partnerships Committee 22 September 2022 (Appendix 2);
- Emergency Ambulance Services Committee 8 November 2022 (Appendix 3).

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 8 NOVEMBER 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 8 November 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings
The minutes of the meeting held on the 6 September 2022 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Draft Integrated Commissioning Plan (ICP) 2023-2026
Members received an informative presentation on the draft Integrated Commissioning Plan (ICP) 2023-2026.

Members discussed the financial elements of the plan and noted the constrained economic environment, recovery challenges and the volatile inflationary pressures. Members noted that the draft ICP was brought to Joint Committee early on in the planning process in order to support Health Boards (HBs) in developing their own Integrated Medium Term Plans (IMTPs), and that WHSSC will work closely with HBs to develop the ICP in line with HB expectations.

Members **noted** the presentation and that the final plan will be considered at the next meeting 17 January 2023.

4. Recovery Update (incl Progress with Paediatric Surgery)
Members received a presentation providing an update on recovery trajectories since the workshops held with the Joint Committee on the 12 July and 6 September 2022.

Member noted updates on recovery trajectories for paediatric surgery recovery and recovery in key speciality areas including for the six accountability conditions specialities – cardiac, neurosurgery, paediatric surgery, bariatrics, thoracics and plastics.

Members **noted** the presentation and that a further recovery update will be provided at the next meeting 17 January 2023.

5. Chair's Report

Members received the Chair's Report and **noted**:

- The recommendation to appoint two new WHSSC Independent Members (IMs) following a fair and open selection process,
- The recommendation to extend the tenure of the of the Interim Chair of the All Wales Individual Patient Funding Request (IPFR) Panel until 31 March 2023,
- Attendance at the Integrated Governance Committee 11 October 2022; and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Approved** the recommendations to appoint two new WHSSC Independent Members (IMs) from 1 December 2022 for a period of 2 years; and (3) **Approved** the recommendation to extend the tenure of the Interim Chair for the Individual Patient Funding Request (IPFR) panel until 31 March 2023.

6. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates on:

- **Paediatric Radiology Consultant Recruitment** - units in NHS England (NHSE) had agreed to host NHS Wales funded paediatric radiology training posts for trainees on the Wales Radiology Training Programme. HEIW are taking this forward,
- **Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service** – **Engagement Process Update** – Further to the HBs agreeing the approach for engagement at their Board meetings in September 2022, it was planned that the engagement process would commence on 24 October 2022, however this had unfortunately been delayed and the engagement will now commence in November,
- **Evaluation of 4th Thoracic Surgeon activity -** WHSSC supporting the appointment of a 4th consultant surgeon post in CVUHB to provide continued support for the Major Trauma Centre (MTC) and to support the future needs of the service; and
- **Briefing Duty of Candour and Duty of Quality –** WHSSC received a briefing from Welsh Government (WG) on the Health & Social Care (Quality & Engagement) (Wales) Act 2022 with a specific focus on the consultation process for the duty of candour and the soon to be launched consultation process on the duty of quality.

Members **noted** the report.

7. Delivering Thrombectomy Capacity in South Wales

Members received a report outlining WHSSC's position on the commissioning of Mechanical Thrombectomy for the population of Wales.

Members noted the proposed plan for a Mechanical Thrombectomy service at the Neurosciences centre, CVUHB and that WHSSC continued to work with CVUHB to progress the Business Case to develop a Mechanical Thrombectomy centre in south Wales and the financial model had been shared and was being worked through. It was proposed that the service would be implemented in a phased approach over a number of years.

Members (1) **Noted** the report, (2) **Noted** the WHSSC Position Statement on the Commissioning of Mechanical Thrombectomy and **requested** that a revised report be brought back to the Joint Committee to include additional detail on the networked approach, interdependencies around the network approach and to include additional elements concerning the stroke pathway, (3) **Noted** the associated risks with the current delivery model for Welsh stroke patients requiring access to tertiary Thrombectomy centres; and (4) **Noted** the NHS Wales Health Collaborative (NWHC) proposal to strengthen and improve regional clinical stroke pathways in Wales to support the Mechanical Thrombectomy pathway to ensure that patients receive this time-critical procedure in a timely manner.

8. Mental Health Strategy Development

Members received a report advising the Joint Committee of the stakeholder feedback received from the engagement exercise for the Specialised Services Strategy for Mental Health and outline the next steps and proposals to move into implementation of the strategy from April 2023.

Members discussed the need for the demand and capacity work to inform the final version of the strategy and to ensure that it is focussed on delivering sustainable services which offer value for money.

Members (1) **Noted** the stakeholder feedback received from the 12-week engagement exercise on the draft Specialist Mental Health Strategy; and (2) **Agreed** the proposals to:

- Undertake an 8 week consultation process using the draft consultation document,
- Commission demand and capacity modelling with immediate effect; and
- Develop a programme approach to implementation of the Strategy following the consultation exercise; and

(3) **Noted** that the final version of the strategy and the timescales for implementation will need to take into account the demand and capacity modelling.

9. Single Commissioner for Secure Mental Health Services Proposal

Members received a report presenting the options for a single national organisation to commission integrated secure mental health services for Wales for HBs to consider. The report had been prepared following a request received from WG for the WHSSC Joint Committee to provide the mechanism for the recommendation from the "Making Days Count" review to be considered, and for the Joint Committee to make a recommendation to WG on the preferred option.

Members discussed the report and agreed to share the report with HB colleagues and for a response to the options appraisal to be sent to WHSSC by the end of December 2022 in readiness for the Joint Committee meeting 17 January 2023.

Members (1) **Noted** the report, (2) **Considered** the options for a single national organisation to commission integrated Secure Mental Health Services for Wales; and (3) **Agreed** to share the report with HB colleagues and for a response to the options appraisal to be sent to WHSSC by the end of December 2022; and (4) **Noted** that the proposal will return to the Joint Committee for decision on 17 January 2023.

10. Gender Identity Development Service (GIDS)

Members received a report updating members about the Gender Identity Development Service (GIDS) for Children and Young People including what the changes mean for children and young people in Wales and next steps.

Members (1) **Noted** the information presented within the report; and (2) **Noted** the information presented at Appendix 1 regarding the decommissioning of the Tavistock and Portman NHS Foundation Trust (TPNFT) and the NHS England (NHSE) transformation programme.

11. Individual Patient Funding Requests (IPFR) Engagement Update

Members received a report seeking support for the proposed engagement process for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy.

Members noted that the engagement process would commence on the 10 November 2022 for a 6 week period with key stakeholders, including the All Wales Therapeutics and Toxicology Centre (AWTTC), the IPFR Quality Assurance Advisory Group (QAG), the Medical Directors and the Board Secretaries of each of the HBs and Velindre University NHS Trust (VUNT).

Members noted that the process adhered to the specific request from WG for the engagement for the IPFR panel ToR and the specific and limited review of the All Wales IPFR Policy.

Members (1) **Noted** the report; and (2) **Supported** the proposed process for engagement for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy.

12. COVID-19 Period Activity Report for Month 5 2022-2023 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members **noted** the report.

13. Financial Performance Report – Month 6 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 6 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 202-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 6 for WHSSC is a year-end outturn forecast under spend of £13,711k.

Members **noted** the current financial position and forecast year-end position.

14. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

15. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR) Panel

16. Any Other Business

- **Skin Camouflage Pilot Service** – members noted that on 28 October 2022 WHSSC received a formal request from WG following agreement at the NHS Wales Leadership Board (NWLB) for WHSSC to commission the national skin camouflage pilot service. This service will support the national commitment to "Pledge to be Seen". A further formal update will be provide at the next meeting,
- **CMTUHB Audit Lead Independent Member (IM)** – on behalf of the Joint Committee the Chair formally thanked Ian Wells, IM

CTMUHB for all of his support since he was appointed as CTMUHB audit lead for WHSSC eighteen months ago. The Chair advised that he had been an invaluable member of the team and that WHSSC were extremely grateful to him for his commitment of time and effort, which was especially notable given his normal HB responsibilities; and

- **Retirement of CEO BCUHB** – The Chair acknowledged what would have been Joe Whitehead's last meeting with the Joint Committee, and on behalf of the Joint Committee offered thanks for her time and commitment to the Joint Committee's business and wished her well in her retirement.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	22 September 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Recruitment

G Hardacre, Director of People, Organisational Development and Employment Services, gave a verbal update on the position with the pre-employment checks software system.

The Home Office have announced that from 1st October 2022 organisations will be able to use a certified Identification Document Verification Technology service provider to carry out digital identity checks on their behalf for those appointees who have an in-date UK or Irish Passport or Share Code. Those who do not meet these criteria will still require a face-to-face pre-employment check from 1st October 2022. Without this system, all appointees would require a face-to-face pre-employment check meeting.

NWSSP Recruitment Services have procured a service provider to enable digital identity checks for NHS Wales as part of the Recruitment Modernisation Programme, which will be implemented on 28th September 2022. This will improve the experience for appointees and also provide process efficiencies for NWSSP Recruitment Service and internal Health Board/Trust recruitment services such as Medical and Bank Recruitment, as most appointees will be able to complete their pre-employment checks via this route. NWSSP have agreed to fund this software for the first year for all organisations due to the benefits this will bring to NHS Wales.

The Committee **NOTED** the update.

Matters Arising – Programme Management Office Highlight Report (Student Awards).

G Hardacre provided members with an update on the replacement of the Student Awards system which had been noted at the May Committee as a red risk within the Programme Management Office Report. He reported that good progress was

now being made with the new system having received confirmation of funding from Welsh Government and the conclusion of the procurement process he now expected the new system to be in place and fully operational by April 2023.

The Committee **NOTED** the update.

Deep Dive – Energy Price Risk Management Group

Eifion Williams (EW), Chair of the Energy Price Risk Management Group (EPRMG), introduced a deep dive into the work of the Group, particularly focusing on recent weeks and months, due to the significant increase in energy prices.

EW has chaired the EPRMG since it was set up in 2005. Prior to that electricity and gas was purchased on behalf of NHS Wales by an individual Procurement Officer who would purchase for the year ahead with little strategic input. The Group was established with representation from all NHS Wales organisations together with a British Gas market specialist who provides an overview of the energy market at each meeting. Based on this, the Group considers its pricing strategy. Currently British Gas provide both electricity and gas to NHS Wales and there is an ability to purchase energy on a monthly or quarterly basis. The Group currently meets on a weekly basis to consider its purchasing strategy but in times of extreme volatility (e.g. when Russia first invaded Ukraine) it has met three times a week. Prices are monitored daily which enables tranches of volumes of energy to be secured when appropriate.

EW demonstrated the current volatility in the market through a comparison of prices in the month of August for the last five years. Between 2018 and 2021 inclusive, the price being paid for gas by NHS Wales in each August was in the range of 39p to 44p a therm. In August 2022, the price per therm was 281p. The same comparison for electricity saw a range of £40 to £47 per megawatt hour between 2018 and 2021 and the price in August 2022 was £218. The price had been falling prior to the Ukraine conflict, and is also affected by the weather, the world economy outlook, and the price of oil. Although the price of energy is totally unpredictable, the forward purchasing strategy adopted by the EPRMG delivered savings of £33.8m for NHS Wales against the actual average daily cost of gas and electricity in 2021/22. It is also important to note that the prices quoted are the global prices on the energy markets which all suppliers use.

The current contracts with British Gas are due to end in March 2025 for electricity and March 2027 for gas. British Gas has given notice that it will not seek new Commercial energy contracts but will fully support existing contracts. Whilst the EPRMG has served NHS Wales well, there was a need to consider whether the current approach remains the best option for NHS Wales given the volatility in the energy market. Liaison is currently taking place with Crown Commercial Services to assess the options that they have available. It was agreed that EW would come back to the Committee later in the year to provide an update on progress.

The Committee **NOTED** the presentation.

Chair's Report

The main update was on the planned IMTP / Committee development sessions, where invites have been issued for Friday 11th November. The Chair stressed the importance of attending and that if members cannot make this date that they nominate another Executive Director to attend in their place.

The NWSSP Senior Leadership Group held a number of internal workshops to provide some initial reflections and ideas for the sessions. The indicative agenda will focus on where NWSSP will be in 2033, assessing where we feel NWSSP is now, identifying opportunities to improve and develop further, and taking a fresh look at our strategic objectives and overarching goals/outcomes. There will also be some discussion on our appetite for risk as a Committee.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The CEO NHS Wales / DG Health and Social Care Group WG wrote in July confirming acceptance of NWSSP IMTP recognising the continued development and maturing of integrated planning across NWSSP and demonstrating the positive position that the organisation is in as we move from the pandemic towards recovery. The letter highlights the continued role of the Committee to scrutinise and monitor progress against the plan throughout the year;
- As part of the decarbonisation work the NWSSP Head of Operations – Procurement Services, is currently working with Health Boards, Trusts, and Special Health Authorities, in reviewing fleet management arrangements with the purpose of defining a common set of data standards and management information to support the decarbonisation agenda. Specialist Estates Service is also supporting Health Boards in establishing a national infrastructure plan for electric vehicle charging. Health Boards have been approached to nominate representatives to sit on the various decarbonisation sub-groups that support the above agendas;
- The Payroll team within Employment Services are currently experiencing an exceptionally busy period responding to the implications of the recent pay rise and processing of pay arrears. This is in addition to implementing the changes to the pension tiers.
- The NWSSP Medical Director, has been asked to work with health organisations to review how the Single Lead Employer rotational and recruitment processes can be further streamlined to improve overall experiences for the trainees; and
- In terms of major projects, the Laundry and TrAMs projects are continuing but in the context of extreme limitations on available capital funding. In particular NWSSP were waiting for formal feedback from WG on the laundry OBC scrutiny panel.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Chair's Appraisal Process

G Hardacre, NWSSP Director of People, Organisational Development and Employment Services introduced a report setting out a proposed revised formal framework process for the appraisal of the Chair.

Following discussion, the Committee **APPROVED** the revised framework which will be implemented during the next few months and **AGREED** to increase the Chair's time commitment given the requirements of the role. Committee members asked to review the various time commitments of the other Chairs at other NHS organisations at the next November meeting.

Procurement SLA

The Chair reminded Committee members that the Service Level Agreements for 2022/23 had already been agreed at the May meeting. However, it was previously agreed that the Procurement element of the SLA would be brought back for approval as it was important to reflect the recent changes which were as a direct result of implementation of the new procurement Operating Model.

The Committee **APPROVED** the Procurement SLA element.

Provision of Digital Patient Pathways and Remote Advice and Guidance

A Butler, Director of Finance & Corporate Services introduced a number of reports which outlined the procurement for two separate contracts for which funding had already been secured and agreed by Welsh Government. Given the nature of the clinical digital elements of the contracts it was felt important to ensure that DHCW were clear on how they linked into the current strategy and processes.

Following discussion the Committee **NOTED** the reports and **ENDORSED** both contracts. Further discussions would be needed with DHCW to ensure the digital elements were aligned to the national strategies.

Welsh Risk Pool – Risk Sharing Agreement

The Committee received a paper setting out the risk sharing details for the current financial year. Committee members were informed that the proposal within the paper had been endorsed at the Welsh Risk Pool Committee on the 21st September 2022.

The Welsh Risk Pool receives an annual funding stream to meet in-year costs associated with settled claims, the Departmental Expenditure Limit (DEL). When expenditure rises above the DEL allocation, the excess is recouped from Health Boards and Trusts via a Risk Sharing Agreement approved by the Shared Services Partnership Committee. The core DEL allocation is currently £109.435M per

annum for Clinical Negligence, Personal Injury and Redress claims. The 2022/23 IMTP DEL forecast is £134.780M and therefore the estimated Risk Share charge for 2022/23 is £25.345M. In 2021/22 this figure was £16.495m.

The current Risk Share methodology was approved by the Welsh Risk Pool Committee and Directors of Finance in March 2017. The overarching principles are set out below:

- a risk-based contribution, based on size and activity levels;
- a contribution based on paid claims experience over five years; and
- a contribution based on known outstanding claims.

These principles have been translated into five specific measures and a weighting applied to each. This results in those organisations that can demonstrate learning and who have implemented strategies to lower risk weightings benefitting as their share of the overall total should be lower.

Applying these measures to the forecast risk share for the current year has meant that although some Health Boards percentage share has reduced compared to last year, the expected 2022/23 monetary charge has increased for all, due to the substantial overall increase in the total charge to be apportioned.

The Committee **NOTED** the report and **APPROVED** the updated Risk Share charges to NHS Wales for 2022/23.

Items for Noting

All-Wales Agency Audit

The Committee received a paper on audit arrangements for agencies supplying nursing staff.

The Temporary Staffing Group is a workstream which reports directly to the National Nursing Workforce Group (NNWG). The Temporary Staffing Group is responsible for the award and monitoring of contracts for agency workers throughout Wales. The contract was awarded in March 2021 for a period of three years with an option to extend for a further year to February 2025. There are 146 agencies on contract and each agency is aware that failure to abide by the contract specification would result in their removal from the framework.

Implementing appropriate audit measures is essential to ensure that all contracted agencies supplying nurses and health care support staff to NHS Wales uphold the conditions of the contract. Agency audits have typically been undertaken internally on an ad-hoc basis when issues arose rather than via a proactive approach linked to a planned audit programme. Following discussions at the Temporary Staffing Group it was agreed that a robust audit programme should be put in place and that various options to achieve this should be explored, including the use of external audit firms and the potential use of NWSSP Audit & Assurance Services.

The Committee **NOTED** the Report and **AGREED** for NWSSP's Audit and Assurance team to carry out the necessary audits providing an audit specification (All-Wales Agency Audit Checklist) was developed and utilised. A risk-based programme of audits will be undertaken focussing initially on the highest spend and highest usage providers. Usage data will be used to agree a priority list of agencies to be audited. It is anticipated that:

- 30 audits will be carried out per year;
- Audit plans will be annually set out based on provider usage and spend; and
- The audit plan will be discussed and created annually by the Temporary Staffing Group led by procurement.

Based on 30 audits in the first year (2022/23), the total auditor time required would be 60 days at a cost of £19,870. This amounts to less than £3k per Health Board.

Finance, Performance, People, Programme and Governance Updates

Finance – A Butler, NWSSP Director of Finance and Corporate Services reported a balance position at Month 5. The year-to-date position includes a number of non-recurrent savings that will not continue at the same level during the remaining months of the financial year. Divisions are currently reviewing budgets with a view to accelerating initiatives to generate further benefits to NHS Wales and a potential increase in the distribution. The forecast outturn remains at break-even with the assumption of £4.985m of exceptional pressures funding being allocated from Welsh Government.

The current Capital Expenditure Limit for 2022/23 is £1.947m. Funding for the Welsh Healthcare Student Hub (Student Bursary and Streamlining) was approved in early September. Capital expenditure to Month 5 is £0.366m and plans are in place to fully utilise all available capital funding. A priority list of capital projects is being finalised in case additional funding becomes available later in the year. Since the transfer of the All-Wales Laundry Service in 2021/22 there is increased pressure on the discretionary capital allocation as this was not increased following the transfer of the new Service.

The Committee **NOTED** the Report.

Performance – The Committee Members reviewed the KPIs and felt that this was positive position with only six KPIs not meeting target. These in the main related to the recruitment position and call handling within the Payroll Helpdesk. Committee members were asked to advise their organisations that prior notice of local recruitment plans is very helpful in that it enables NWSSP to adapt demand and capacity within teams to meet those peaks in demand. There was also a short-term issue with Payroll call handling in August because of increases in activity driven by the new Doctor intake and rotation, and this was not helped by the loss of the phone system for a few hours. Peaks in demand are also anticipated in September because of the payment of pay award arrears and again

in October because of the pension changes. The Quarter Two individual Performance Reports will be issued at the end of October.

The Committee **NOTED** the Report.

Project Management Office Update – The Committee Members noted the report and in particular the ongoing supplier dispute with regard to the Legal & Risk Case Management system replacement which had temporarily halted the implementation. Contingency arrangements have been put in place to ensure that there is no risk to the continuity of services. A question was raised as to whether projects not covered by the PMO (e.g. the Once for Wales Concerns Management System) should be included in the report. This will be included going forward. It was also suggested that a separate and more detailed briefing on the TrAMs programme would be helpful – this will be issued in December.

The Committee **NOTED** the Report.

People & OD Update – The Committee **NOTED** the Report.

Corporate Risk Register – The Committee **NOTED** the Report. In particular members discussed the risk relating to the threat of industrial action had been added to the register.

Papers for Information

The following items were provided for information only:

- Disposal of Surplus Beds to Moldova;
- Audit Committee Assurance Report;
- Welsh Risk Pool Annual Report 2021/22
- Finance Monitoring Returns (Months 4 and 5)

AOB

N/a

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Matters referred to other Committees

N/A

Date of next meeting	19 January 2023

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	8 November 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:
https://easc.nhs.wales/the-committee/meetings-and-papers/november-2022/.
The minutes of the EASC meeting held on 6 September were approved and the notes from the Briefing meeting held on 27 October 2022.

CHAIR'S REPORT

Members noted:

- the Monthly meetings with Minister, CASC and WAST Chair and CEO (20 September, 18 October)
- Ministerial meeting with Chairs (22 September)
- Chairs' Peer Group (27 September)
- EASC Management Group (20 October)
- Emergency Medical Retrieval and Transfer Service Delivery Assurance Group (EMRTS DAG)(1 November)
- The Chair's latest objectives from the Minister for Health and Social Services including a request that the Committee focus more generally on its key role within the Six Goals for Urgent and Emergency Care Programme.

PERFORMANCE REPORT

- **Ambulance Service Indicators -** September data now available on the EASC website https://easc.nhs.wales/asi/
- **Handover delays** including the handover improvement trajectories
- **EASC Action Plan** – most recent version included in the meeting papers and the EASC Team was due to submit the latest version to Welsh Government (WG) and stakeholders following the meeting. Members noted that this was an integrated plan that draws various elements of work together, was developed with health boards and was aligned to actions from the Six Goals for Urgent and Emergency Care Programme.

Members noted the need to use the plan to track progress, to identify and share areas of best practice, to learn from the bad weeks and to ensure mitigating action where required. Two key areas were noted, these were addressing 4 hour waits and generally reducing the variation within the system.

Nick Wood noted the actions being undertaken across NHS Wales, summarised in the consolidated EASC Action Plan and sought assurance from health boards and WAST regarding their organisational commitment regarding their role in the conversations being held and to delivering the actions in the plan.

Jason Killens confirmed the commitment of WAST to its agreed actions and, while noting that further work was required in other areas, reported the progress already made against the roster review programme, working towards stretch targets for 'Consult and Close' and on track in terms of recruitment for the additional 100 full time equivalents by 23 January. The good progress made by WAST was noted.

There was discussion regarding the progress in relation to the shared actions between WAST and health boards with the example of active discussion to expand the provision of advanced paramedic practitioners to direct activity away from Emergency Departments provided.

Members noted that severe pressures exist throughout the system from the 'front door' to community care, and, in addition to the requirement for increased community care capacity, there was a need maximise the opportunities with regard admission avoidance schemes and same day emergency care services.

The focus on the winter plan and the actions within the Six Goals for Urgent and Emergency Care Programme with a particular focus on improving handover delays, 4 hour waits, red release and reducing community risk.

It was recognised that the role of local authorities was critical in addressing delayed transfers, also the impact of ambulance services on other emergency services (primarily police services) and there was therefore a requirement for a joint approach and a wider public service message than was currently being conveyed.

Members noted that there was an increasing trend in terms of units of hours produced and this position would further improve once the additional 100 full time equivalents become operational; while red performance was challenging, more patients were receiving a service. Further work was also required in relation to outcomes for patients that do receive a response and outcomes for those that do not.

Highlighting the citizen's perspective, the Chair welcomed the weekly dashboard being widely circulated to the NHS by the EASC Team. This was felt to be helpful in identifying where performance had improved and deteriorated and broadly indicated where actions at the front door might have made an impact. Members noted the use of the dashboard and requested further work to better understand the wider context, the correlation between different elements and to understand the key drivers behind the data.

It was agreed that further work would now be undertaken with the required teams to ensure access to key data and further development of the dashboard.

Members **RESOLVED** to:

- **NOTE** the content of the report.
- **NOTE** the Ambulance Services Indicators

- **NOTE** additional actions that the committee could take to improve performance delivery of commissioned services
- **NOTE** the handover improvement trajectories
- **NOTE** the EASC Action Plan
- **NOTE** the request to progress the dashboard.

QUALITY AND SAFETY REPORT

In presenting the report, Ross Whitehead reminded Members that an increased focus on quality and safety matters was a priority within the EASC Integrated Medium Term Plan (IMTP).

The following areas were highlighted:

- The work of the **Healthcare Inspectorate Wales (HIW) Task & Finish Group** (convened by the EASC Team) established to lead and coordinate the work in response to the recommendations made as part of the HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover'.

  A formal update was provided to HIW on 30 September, outlining the positions of all health boards and WAST relating to each of the recommendations.

  A formal response from HIW had been received requesting further detail on a number of the recommendations. Health Boards and WAST had also been asked for a response.

  A further 'Fundamentals of Care' workshop was planned to take place at the end of November to further address recommendations relating to patient care whilst waiting for delayed periods of time, on ambulances, outside hospitals.

- Fortnightly meetings had been held in response to the **NHS Wales Delivery Unit Report on Appendix B** submissions.

  As a result of these meetings, a section of the policy had been developed to improve the process for the joint investigation between WAST and other NHS Wales organisations. Members noted this process would be tested over the forthcoming weeks.

  The Deputy Chief Ambulance Service Commissioner had written to each health board asking for written confirmation that they accepted the recommended new process.

  In order to provide support in the testing of the process a new form had been developed to replace the Appendix B form. A draft all Wales agenda template for joint meetings had also been produced to support this new process.

- **Regulation 28 – Prevention of Future Deaths** – Members were asked to note the Regulation 28 – Prevention of future death notice that had been issued to the Welsh Ambulance Service NHS Trust and Betsi Cadwaladr University Local Health Board.

Whilst the report related to a specific case within the health board, Members recognised similar challenges across Wales in the delivery of effective ambulance services both for community response and inter-hospital transfers.

Members **RESOLVED** to:

- **NOTE** the content of the report and the progress made by both Task and Finish Groups
- **NOTE** the impact of deteriorating performance and the resulting challenges in commissioning the provision of safe, effective and timely emergency ambulance services, including the recent issuing of a regulation 28.
- **NOTE** that Quality and Safety Reports relating to commissioned services would be received at all future meetings.

EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) AND WALES AIR AMBULANCE CHARITY SERVICE DEVELOPMENT PROPOSAL

In introducing the report, Ross Whitehead, provided Members with background information and an introduction to the proposal developed by the Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) and the Wales Air Ambulance Charity Trust.

Members noted that the proposal had been received and discussed at the EMRTS Delivery Assurance Group held on 1 November 2022 and further work and scrutiny had been requested, including in relation to weather, modelling and resource requirements.

Members noted that the proposal had been developed following internal service analysis undertaken by the EMRT service (the Charity had carried out a Strategic Review), with key findings indicating under-utilisation of assets and confirming unmet need (geographic, overnight and hours of darkness). The analysis and modelling indicated the opportunity for extended hours of operation and also included changes to base locations.

The proposal suggested that by optimizing the operational configuration the service could:

- potentially attend an additional 583 patients and
- achieve 88% of the total demand compared with the existing model that meets 72% (within the same resource envelope).

Members were aware there had been significant public and political concerns raised around the development of the proposal, particularly in relation to the potential closure of air bases. This has resulted in challenges for both the Charity and EMRTS and there had also been an impact on individual health boards.

Additional challenges were recognised in relation to the Charity including its need to renew aviation contracts and the associated commercial negotiations, both of which could be impacted by the timeliness of the work required to assess the proposal.

The proposal outlined the level of unmet need that exists for the all Wales Service and the Committee would need to understand, and evaluate this, either through the adoption of this proposal or through further work.

Professor David Lockey, EMRTS National Director thanked members for considering the proposal. He noted that it built upon service developments already undertaken by the service since its establishment in 2015, including an increase in the number of air bases, commencement of night operations, the introduction of the Adult Critical Care Service (ACCTS) in both North and South Wales and the work linked to the Major Trauma network.

Prof Lockey also referred to the Strategic Review undertaken by the Charity. Sue Barnes, Chief Executive of the Charity, outlined the process undertaken by the Charity working with EMRTS to understand what further opportunities could be realized. This included alignment with the opportunity afforded by the Charity's required long-term aircraft procurement process with renewal due at the end of 2023.

Members recognised that the EASC Team had not had the opportunity to undertake appropriate due diligence and scrutiny of the proposal ahead of presenting it and making recommendations to Members. However, in view of the public interest it was felt that it was appropriate to receive the proposal at the meeting.

Ross Whitehead explained that there could be an impact on the capacity of the EASC team to support the process of scrutiny and engagement on this proposal, whilst also maintaining business as usual in terms of the commissioning arrangements for all EASC commissioned services. It was agreed that the Committee might need to consider providing temporary additional support once the likely impact has been fully considered.

Stephen Harrhy, the Chief Ambulance Services Commissioner summarised some of the key issues that had been raised and noted by the EASC Team during the activities already undertaken with stakeholders and the comments and questions received to date. These included:

- **clarifying the position regarding resource implications**
- **responding to the significant comments raised and views regarding the importance of response times**
- **understanding how the air and road response model works, recognizing that for urban and rural areas it would be different**
- **further work required regarding the impact of weather**
- **consideration of the data reference period to ensure that this is appropriate and not unintentionally biased**
- **understanding any seasonal variation**
- **improving the understanding of the options available, including to consider whether changing bases is necessary, identifying further options and understanding why options have been discounted**
- **working with health board colleagues to consider the modelling undertaken.**

Members agreed with the proposed approach for additional scrutiny, including the need to develop a streamlined and simplified proposal and to better understand the options identified. Members felt it would benefit health boards to better understand the data and modelling already undertaken and supported utilising the data analysis tool that was being developed to identify the impact on local communities. It was felt that this approach would ensure that the benefits and risks of each option could be fully understood and appraised including the implications relating to key elements such as air and road response, equity of access for the population and resource effectiveness.

Members stressed the need for an open and robust engagement process, in line with the direction provided by the Community Health Councils in Wales and questioned whether the January decision timeline was feasible, considering the need for the development and agreement of suitable engagement material, agreeing the equality impact assessment and the requirements for a mid-process review.

The CASC agreed that there were a number of phases to be undertaken and that there was a need to be transparent and realistic, to ensure the correct process was undertaken and that timelines would need to be revisited. In addition to the initial phase of due diligence and scrutiny already discussed, it was also noted that Community Health Councils had recommended that a meaningful and comprehensive public engagement process should be undertaken for at least 8 weeks, this engagement phase would need to be incorporated in to the timeline. The CASC assured Members that the EASC Team would now work closely with the EMRTS and the Charity to scrutinise the detail in the proposal. Discussions would also need to take place with health board communication, engagement and service change leads to ensure a robust process.

It was recognised that there were many elements to focus on before an update could be provided and next steps agreed at the scheduled EASC session on 6 December.

After discussion Members **RESOLVED** to:

- **NOTE** the content of the EMRTS Cymru and Wales Air Ambulance Charity Service Development Proposal and appendices
- **AGREE** the next steps for additional scrutiny by the EASC Team and the development of a simplified proposal, including suitable engagement materials to meet the requirements of the Community Health Councils in respect of the proposal
- **NOTE** the key risks and any mitigations the Committee need to be put in place.

PROGRESS REPORT ON THE PLAN IN RELATION TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE EMRTS CYMRU AND WALES AIR AMBULANCE CHARITY SERVICE DEVELOPMENT PROPOSAL

The progress report on the plan in relation to the EMRTS Cymru and Wales Air Ambulance Charity Service Development Proposal was received. Ross Whitehead presented an update on the activity that had taken place following the request made by Members at the EASC meeting in September and included the:

- Activities already undertaken with stakeholders
- Comments and questions received to date
- Draft Communications and Engagement Plan
- Draft Project Plan
- Initial Equality Impact Assessment.

Members noted that the CASC was continuing to work with Community Health Councils in Wales and was receiving advice and recommendations for the engagement process required. It was confirmed that discussions with health board and CHC colleagues would continue to take place to agree what would be engaged upon, including the required engagement materials and to further develop the communications and engagement plan.

Following the briefing note issued on 14 October, a second briefing note would be prepared to update stakeholders with regards discussions held at today's meeting and the next steps would be clarified. In addition, the comments and questions received to date would continue to be collated via the online facility on the dedicated page on the EASC website; an important part of the scrutiny process to lead to the engagement phase.

In line with discussions held, the timeline would be reassessed and reconsidered in readiness for an update to be provided at the EASC meeting on 6 December. Members noted the importance of mitigating any impact on the Wales Air Ambulance Charity in the next phase of the work.

In light of the previous agenda item and discussions held relating to the detailed proposal received and the need to undertake appropriate due diligence and scrutiny ahead of a process of engagement, the final recommendation relating to commencement of the formal engagement process was withdrawn.

Members **RESOLVED** to:

- **NOTE** the structured approach adopted since the Committee meeting held 6 September
- **NOTE** the activities already undertaken with stakeholders both face-to-face and online
- **NOTE** the discussions held with CHCs, attendance at CHC meetings as requested by them and completion of the CHC 'Joint Services, Planning & Change Committee Service Change Pro forma'
- **NOTE** the record of activities undertaken to date
- **NOTE** the key themes arising from the questions, comments and letters received by stakeholders
- **NOTE** the Briefing Note sent to stakeholders on 14 October
- **NOTE** the development of a dedicated page on the EASC website
- **NOTE** the draft Communications and Engagement Plan developed to date and a further document would be developed for engagement with the public based on a simplified proposal to be developed
- **NOTE** the draft project plan included for comment
- **NOTE** the Initial Equality Impact Assessment.

WELSH AMBULANCE SERVICES NHS TRUST (WAST) UPDATE

The Welsh Ambulance Services NHS Trust update report was received. In presenting the report, Jason Killens highlighted the following areas:

- challenging red performance in September 2022
- almost 900 patients waiting more than 12 hours
- following temporary cessation of clinical indicator reporting relating to transition to the electronic patient clinical record (ePCR) new data was now available for stroke, fractured neck of femur, hypoglycaemia and ST elevation myocardial infarction (STEMI). Deep dive audits had been completed for these clinical indicators and the return of spontaneous circulation (ROSC) (at hospital door) deep dive audit was ongoing with this clinical indicator scheduled to be published over the coming months
- increase in red demand

- ambulance production was encouraging with unit hour production at 96% in September against the benchmark of 95%
- improvements in sickness aligned to IMTP trend
- highest ever handover lost hours at 28,500 hours, equating to over 30% of WAST conveying capacity

A verbal update was provided regarding NEPTS and the letting of new contracts as a result of the all-Wales business case with the new providers recently notified of the outcome of the tendering process

The Chair summarised including to:

- Note the positive impact in relation to additional capacity and unit hour production, however it was noted that this was not sufficient to counter the losses across the system as noted above
- Welcome the progress made re the electronic patient clinical record and the next steps in terms of data linkages
- Note the update in terms of NEPTS procurement, resulting efficiencies and the focus on service quality.

Members **RESOLVED** to:

- **DISCUSS** and **NOTE** the WAST Provider Report

CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT

The Chief Ambulance Services Commissioner's report was received. Stephen Harrhy presented the report and highlighted the following:

- Progress on the recruitment of the additional 100 front line staff at WAST
- Ongoing work with Heads of Midwifery in health boards and the particular impact of delayed ambulance response on obstetric emergencies. Work was underway to find out what could be achieved and an urgent temporary position was being sought.

Members **RESOLVED** to: **NOTE** the report.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update was received. Matthew Edwards presented the report and Members noted that it provided an overview of the progress being made against the key elements of the collaborative commissioning approach**.**

Members noted the many discussions in relation to the commissioning framework for emergency ambulance services over recent months at EASC Committee, EASC Management Group and other related fora. These discussions have resulted in a collaborative approach to transition and transformation through the development of local integrated commissioning action plans (ICAPs).

The commissioning framework was included as a 'focus on' item at a previous meeting of the EASC Management Group and discussions have more recently taken place with all health boards. Work is being undertaken throughout November to use handover improvement plans to populate ICAPs. Health boards are asked to commit to sending appropriate representation to these meetings.

The update also stated that there would be a focus on aligning actions within the ICAPs to the Six Goals for Urgent and Emergency Care Programme.

In addition to the update on the commissioning framework, the update also included a Quarter 2 update against the EASC integrated Medium Term Plan and the agreed EASC Commissioning Intentions for 2022-23, with detailed updates appended.

Members **RESOLVED** to:

- **NOTE** the collaborative commissioning approach
- **NOTE** the progress made in terms of developing the EMS Commissioning Framework, including the development of the local Integrated Commissioning Action Plans
- **NOTE** the progress made against the EASC IMTP in Quarter 2 as set out in the update provided
- **NOTE** the Quarter 2 update against the commissioning intentions for each of the commissioned services.

FINANCE REPORT MONTH 6

The Month 6 Finance Report was received. The purpose of the report was to set out the estimated financial position for EASC for the 6th month of 2022/23 together with any corrective action required.

A forecasted break-even position was reported.

In light of the significant financial pressure within the system, it was agreed that there is a need for robust financial planning. It was reported that the financial assumptions were in line with the assumptions made by health boards and that there is a need to demonstrate the best use of existing commissioning allocations.

Further discussions would be held to ensure alignment with the IMTP process.

Members **RESOLVED** to: **NOTE** the report.

EASC SUB-GROUPS CONFIRMED MINUTES

The confirmed minutes from the following EASC sub-groups were **APPROVED**:

- Chair's Summary EASC Management Group – 20 October 2022 – Members noted that the meeting was not quorate and agreed to consider how their organisation would be represented at future meetings.
- EASC Management Group – 18 August 2022
- NEPTS Delivery Assurance Group – 4 August 2022
- EMRTS Delivery Assurance Group – 7 June 2022.

EASC GOVERNANCE

The report on EASC Governance was received. Governance documentation is available at https://easc.nhs.wales/the-committee/governance/

- The EASC Risk Register presented to each meeting of the EASC Committee, EASC Management Group and received for assurance at the CTM UHB Audit and Risk Committee (as the host organisation)

- The 3 red risks within the EASC Risk Register
    1. Failure to achieve agreed performance standard for category red calls
    2. Failure to achieve agreed performance standard for amber category calls.
    3. Failure to take appropriate commissioning actions to support the provider in their management of patient safety and to minimise clinical risk during times of escalation
- EASC Assurance Framework report, it was noted that this was in same style as the host body's assurance framework (CTMUHB)
- The EASC Standing Orders would be reviewed prior to the next meeting in line with arrangements by the Welsh Health Specialised Services Committee and would tie into the review of the WHSSC / EASC Standing Financial Instructions
- The list of key organisational contacts was noted.

Members **RESOLVED** to:

- **APPROVE** the risk register
- **APPROVE** the EASC Assurance Framework
- **NOTE** the EASC Standing Orders would be reviewed prior to the next meeting
- **NOTE** the information within the EASC Key Organisational Contacts.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on WAST - **equating to over 30% of WAST conveying capacity**
- Structured approach relating to the engagement process for the Service Development Proposal by EMRTS Cymru and the Wales Air Ambulance Charity

Matters requiring Board level consideration

- To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- From the Performance Report
    - **highest ever handover lost hours at 28,500 hours,** equating to over 30% of WAST conveying capacity
    - challenging red performance in September 2022
    - almost 900 patients waiting more than 12 hours
- Opportunity for health boards to take part in the public engagement process related to the potential changes to EMRTS Cymru working in partnership with the Wales Air Ambulance Charity
- **The latest EASC Management Group meeting was not quorate and health boards are asked to consider who represents their organisation at these meetings**

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**6 December 2022**			

AGENDA ITEM
3.2.6

CTM BOARD

CLINICAL EDUCATION ANNUAL REPORT 2021-22

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Janet Gilbertson- Head of Clinical Education
Presented by	Greg Dix (Executive Director of Nursing, Midwifery & Patient Care) Dom Hurford (Executive Medical Director)
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Leadership Group	24/10/2022	NOTED
Quality & Safety Committee	15/11/2022	NOTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
HEIW	Health Education and Improvement Wales
NEWS	National Early Warning Score
RADAR	Recognition of Acute Deterioration and Resuscitation

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the activities and performance of Clinical Education for the academic year 2021-22 and to share the Strategic Direction for Clinical Education.

1.2 The Clinical Education Annual Report is presented in Appendix 1 for noting

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 That investment in education and training of our workforce underpins the required transformation to the way we work. Underpinning the CTM2030 strategy will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development. Education and support is key and as our workforce is forever changing, this is an ongoing need.

2.2 An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

2.3 To note the progress that has been made in 21-22 towards the delivery of the Strategic Direction for Clinical Education including;

2.3..1 Raising the profile and identity of our service through a branding and refresh of Clinical Education facilities across all sites.

2.3..2 Commencement, with Finance, of a three year plan to align and standardise Service Increment for Teaching (SIFT) funding, enabling the robust resource support structures of the undergraduate medical education activity, and increasing governance and clarity over the utilisation of SIFT funds.

2.3..3 Development of and appointment to the first Multi-professional Practice Education Facilitator role in Wales. A model supported by HEIW.

2.3..4 Governance processes established and developed;

2.3..4.1 Establishment of the Clinical Education Forum and reporting forums as a robust organisational wide education governance infrastructure to assure high quality education and training meeting the requirements and standards.

2.3..4.2 RADAR committee continues to drive forward quality standards and training in Recognition of Acute Deterioration and Resuscitation including an up-to-date consistent approach

across CTMUHB to NEWS, Sepsis, Rapid Response activity, resuscitation audit & training compliance improvements and equipment standardisation.

2.4 Recognition of the organisational contribution of this function through its many education and training activities to safe working practices and patient care.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Permanent accessible training accommodation continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services. It is recommended that the creation of a dedicated multi-professional Education and Learning facility is included as part of the strategic site development plan.

3.2 Continuing support will be needed from executives for the 3 year plan for the re-alignment and re-allocation of SIFT throughout the organisation.

3.3 Continued progress on the delivery of quality standards, training and governance around acute deterioration recognition and Sepsis is at risk as the Acute Deterioration Lead and Clinical Lead for RADAR posts are only funded until 31st March 2023. Recurrent funding of these posts needs to be established.

3.4 The establishment of strong strategic workforce planning activity considering the workforce as a whole is needed to better inform education commissioning, in order to support multi-disciplinary service redesign to deliver our Clinical Strategy.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The quality and investment of education and training of our healthcare workforce is essential for patient safety and improving care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Staff and Resources, Safe Care, Effective Care.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	No policies or services are new or have been withdrawn.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 It is recommended that the Board **NOTES** the Clinical Education Annual Report 2021-22 and the contribution quality education and training makes to our services and improving patient care.

Clinical Education

Cwm Taf Morgannwg

University Health Board

Annual Report
Academic Year
2021-2022

What will this Annual Report tell you?

Our Annual Report provides you with information about the Clinical Education Service within Cwm Taf Morgannwg University Health Board (CTMUHB), what we do and how we work in partnership with external organisations including Universities and Health Education and Improvement Wales (HEIW), and what we plan to do to deliver and continually improve healthcare education, in order to meet changing demands and future challenges.

It provides information about our performance, achievements in 2021/2022 and how we have made progress towards delivery of our strategic ambition to create a CTM Learning Academy, developing and embedding an organisational Learning Culture that enables staff to work flexibly and with agility to respond to the health needs of our population by;

- Encouraging life-long learning
- Generating openness to collaboration and effective co-design
- Developing a greater understanding of human intelligence.
- Promoting multi-professional learning.
- Developing staff to work at the "top of their licence" both registrants and support staff.

It is well recognised that there is a strong causal relationship between targeted and well-designed education and training, service improvement and patient outcomes and that quality healthcare for patients is supported by maintenance and enhancement of clinical, management and personal skills.(1)

Our Annual Report for 2021-22 includes:

- Current health education context in Wales
- Current Education context in CTMUHB
- University Health Board Status
- About us and what we do & activity in 21-22
- Progress with our strategic direction & where we plan to go next.

Contents:

Introduction

Health Education Context in Wales.

Health Services in Wales continue to deliver the vision, ambition and approaches that are needed to deliver '*A Healthier Wales'* (1). The demand for services, increasing health and wellbeing inequalities, higher public expectations, the additional challenges due to the impact of COVID-19 on health and social care services, as well as the possibilities that new and emerging medical and digital technologies offer, are set against a backdrop of changing demography, recruitment and resource challenges as healthcare services reset and recover.

It is now four years since the creation of Health Education and Improvement Wales (HEIW) and they continue to work to deliver *The Workforce Strategy for Health and Social Care* (2) to deliver '*A Healthier Wales'*.

It acknowledges that what we spend on our workforce is not a cost, but an investment. This is critically important when it comes to education and training and establishing a truly learning organisation culture.

The required transformation to the way we work will need to be underpinned by education; expanding existing roles, developing new roles, building skills and capability in areas we have not done so previously and embracing new technology in delivering our services.

The strategy articulates 7 themes

Fig 1 HEIW Strategy Themes

Context in CTMUHB

The Cwm Taf Morgannwg workforce has continued to adapt to new working models and service challenges against the disruption to life in and out of work caused by the pandemic, all the while ensuring that patients and their families receive high-quality care.
Quality is at the heart of the Health Board and the aim is to improve outcomes for our people, whoever they are and wherever they live, by providing access to high quality health and care, delivered through a sustainable culture of learning and improvement.

Underpinning the CTM2030 strategy will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development. Education and support is key and as our workforce is forever changing, this is an ongoing need.

Fig 2 – CTMUHB 2030 Strategy

An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

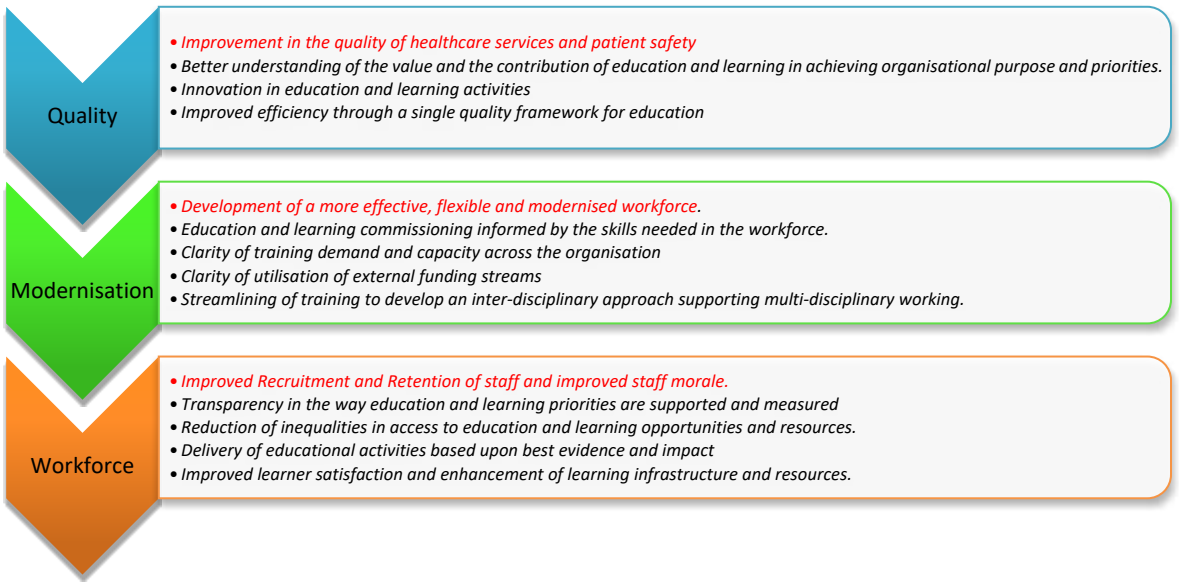


Fig (3) Organisational Benefits of Excellence in Education

University Health Board Status.

Cwm Taf Morgannwg continues to be recognised as a University Health Board, a status first awarded in 2013, due to activity in three pillars; Education & Training, Research & Development, and Innovation.

Welsh Government has recently changed from a Triennial status review to incorporation of the review into the annual Intermediate Medium Term Planning process, requiring consideration and evidence of university health board activity at every level of strategy and delivery. They have also introduced this year, a requirement for a 6 monthly progress update submission.

The potential of University Health Board status, is in the manifestation of the symbiotic and synergistic relationship between three priority activities:

Fig 4

A Learning Culture energises all three elements of university health board activity resulting in Innovation and Improvement

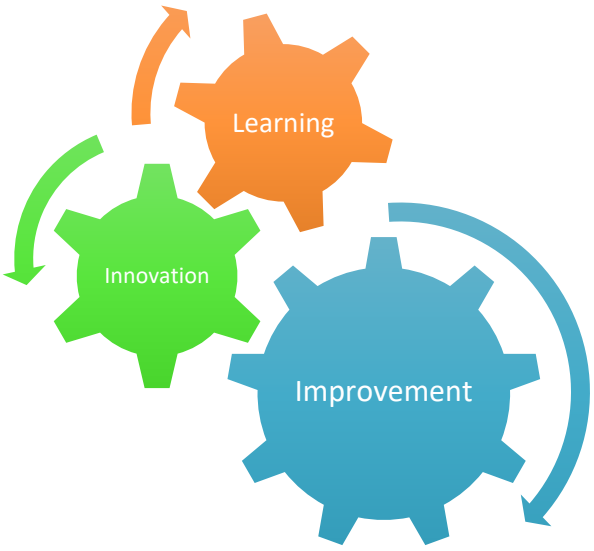


Fig 5

Working in partnership with our Higher Education Institutions (HEI) colleagues in the fields of research, teaching, innovation and evidence based practice, is vital to drive up standards and build momentum for co-creative roles and a collective drive for a better future for our communities.

About Us:

The Clinical Education function sits within the portfolio of the Executive Director of Nursing and Midwifery. There are also strong professional leadership accountability lines with the Medical Director and Director of Therapies & Health Care Sciences.

Over 21-22 focussed development work commenced to bring together what was a group of separate departments to create a cross-functional multi-disciplinary Clinical Education Service. This work will continue over 22-23 and will support and enable the delivery of the Strategic Direction for Clinical Education in CTMUHB.

Fig 6 Clinical Education Team.

The Clinical Education Service encompasses the following functionalities:

Fig 7 Clin ED Services

We are a highly-skilled education workforce of both clinical and specialist administration staff. A central management structure ensures overarching CTMUHB wide consistency of service whilst dedicated education teams manage, deliver and support education activity across all 3 acute hospital sites; Prince Charles, Royal Glamorgan and Princess of Wales and at Keir Hardie Academic Centre. Over 21-22 we have also utilised temporary training accommodation in Ysbyty George Thomas.

Clinical Professional Education.

Undergraduate/ Pre-registration Education and Training

CTMUHB as an organisation contributes significantly to the education and training of healthcare professional students in Wales. Each year our organisation delivers undergraduate clinical placement training weeks including:

- > 6000 medical student training weeks
- > 10,000 student nurse weeks
- > 1600 AHP student weeks

Over 2021/22 we have worked in partnership with 5 universities (HEIs) to deliver clinical placements for healthcare professional students:

- University of South Wales including–
  - Nursing & Midwifery. (*Operating Department Personnel and Part time Occupational Therapy, Physiotherapy courses commencing 2022/23*)
- Cardiff University including
  - Medical, Physiotherapy, Occupational Therapy, Health Care Sciences.
- Swansea University including
  - Nursing, Paramedics and Physicians Associates.
- Cardiff Metropolitan University including
  - Speech and Language Therapy, Dietetics, Podiatry.
- Open University (will be Bangor University from 22-23)
  - Nursing.

Focus on Nursing

The following preregistration routes to nursing are supported:

- Full-time 3 year programmes
- Flexible routes in either Adult or Mental Health (Adult and Child Fields)

The Practice Education Facilitators (PEFs) within the Nurse Education Team actively support the clinical placements within the health board and also deliver clinical teaching within the university. The PEF team also support student issues both clinically and pastorally in collaboration with our clinical and HEI partners.

Student training capacity

CTMUHB	2019/20	2020/21	2021/22	2022/23
Nursing first year student numbers	253	311	323	370

Table 1 Student Nurse allocation numbers

In response to ongoing workforce shortages the number of commissioned undergraduate places for all healthcare professional students is rising. The table above shows the intake number of nursing students allocated to CTMUHB over the last 4 academic years. These nursing students stay with us through the whole of their 3 year programme and represent

our future nursing workforce. Practice Education Facilitator Team work closely with the clinical areas and university partners to ensure areas are supported to provide a positive learning environment. Monthly meetings with our partner HEI's help identify areas for development including those out of compliance with educational audits & struggling with student numbers and also those who go over and above to support our students in practice.

Training capacity is a constant challenge and we are continually working to create innovative placement developments. New for this year were the Community Vaccinations Centres and corporate team placements. Following successful pilot results the Collaborative Learning in Practice (CliP) model is now embedded in a number of areas with further roll out in nursing and across other professions planned. CliP develops peer supervision capability, third year students support the first year students and are overseen by Practice Assessors/ Supervisors, also resulting in increased training capacity. Feedback has been excellent with 3rd year students reporting that they have been able to develop their teaching, leadership and management skills and 1st year students enjoying having a more experienced student to approach and support them.

Fitness to Practice (FtP)/Cause for concerns

The increase in student numbers is also accompanied by an increase in student issues. These can include pastoral and clinical concerns. The PEF team and Senior Nurse work across university and health board processes, including referral of clinical cause for concern issues to universities attending FtP panels and participating in FtP hearings as 'expert witness'. They also ensure students are supported in practice through the development of bespoke action plans to achieve required proficiencies and ensure safe and knowledgeable practitioners upon registration. Through the Covid 19 pandemic there was a rise in students needing additional support. We are working closely with university partners to monitor this situation. In 2021/22 there were ten Official Cause for Concern referrals following clinical issues with three resulting in discontinuation from the programme.

New Nursing Education Standards.

The new Nursing and Midwifery Council's (NMC) Standards of Proficiency and Education for Registered Nurses were launched in May 2018. The new standards made significant changes to proficiencies for registered nurses, standards for preregistration programmes, and student supervision and assessment. They also introduced a new education framework and standards for prescribing programmes. These reforms are designed to enable nurses to meet the changing health needs of patients, provide them with more clinical autonomy where appropriate, and prepare them for leadership roles in service.

All nursing students on clinical placements require Practice Assessors (PA) and Supervisors (PS). The PEFs have planned and delivered a programme of preparation for the supervisors and assessors addressing the need to upskill our current staff to support and assess students with aspects of the requirements. There are currently 2233 PA/PS that have received this training on the database (NMC requirement) for CTMUHB.

As the changes to preregistration nursing training become apparent there is also the need to upskill our current workforce to similar levels if not already achieved. The Practice Development Nurses (PDN's) work closely with the PEF's to ensure existing staff will be upskilled and up-to-date.

Internationally Educated Nurses (IEN's)

After a 10 month gap the International Nurse Recruitment project recommenced with a plan to recruit 97 Internationally Educated Nurses (IEN's) by the end of 2023.

A dedicated education team was appointed to support the recruitment and education of IEN's. Previously, with the first cohort, first time pass rate was 90% however this fell to 25% for the 2nd cohort with 4 candidates needing to sit a third and final attempt. Whilst the first time pass rate across Wales seems to be lower throughout all test centres for this phase, an immediate review was carried out. Potential reasons identified within CTMUHB included a newly established exam centre, a required curriculum increase from 10 to 33 skills and an increase in test stations from 6 to 10, and also changes in the timing of training programme delivery.

To improve future exam results the following mitigating actions have been put in place;

- Focussed OSCE training time increased from 20 to 25 days immediately prior to OSCE exams.
- Re-establishment of a Mock OSCE
- 10 days following exam for other relevant and mandatory training.
- Concerns escalated nationally and with NMC.

We will continue to monitor progress closely with the expectation of improved results with cohort 4. (Training for cohort 3 had been completed by the time results for cohort 2 were received)

As a continuing support to the development in practice of the IENs and in response to feedback from the previous project from the IEN's and Ward Managers, a 'Post OSCE' programme has been developed.

Focus on Medical Undergraduate Training

During Academic Year 21/22 we delivered teaching/placements across the 5 year medical undergraduate (UG) programme–

Year of course	Student weeks	Number of students
1	180	113
2	266	222
3	2312	289
4	1952	262
5	1120	140

Table 2 Medical student numbers across 5 year course in 21-22

Focus this year has been the re-establishment and allocation of SIFT funding. Part of the transitional funding was identified to support the development of a new UG faculty with various appointments to be made to support the comprehensive support, coordination and delivery of UG education. As with all the health care professional students these individuals are our future workforce and it is essential that their education, training develops safe, competent and confident clinicians and their experience with our organisation is of one they want to come back to work for in the future.

Clinical Fellows

There are now 6 Clinical Fellows in Medical Education across CTMUHB, 2 based at each of our acute sites. These appointments are one year tenure and include a level 7 education

qualification. The continuous availability of dedicated teaching clinicians has significantly underpinned the robustness of training delivery and has received fantastic feedback from students.

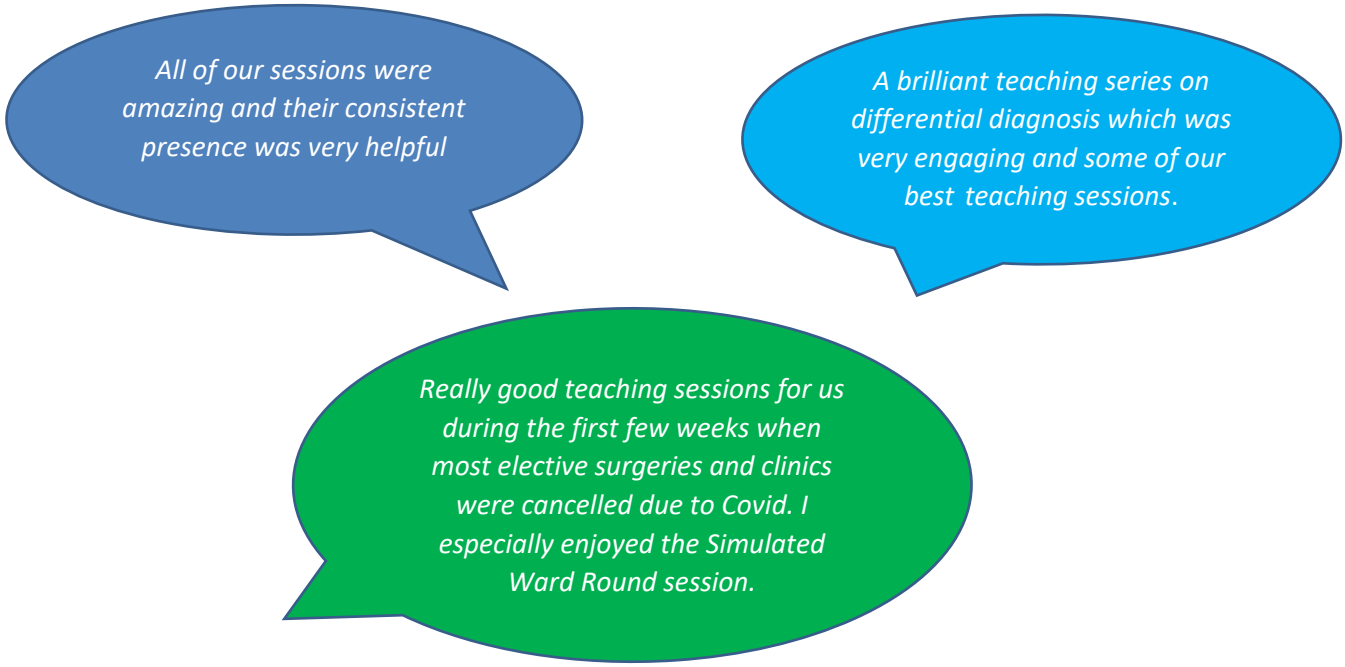


Fig 8 Clinical Fellow student feedback

Underpinning Administration and Co-ordination.

We have also made significant progress in strengthening the underpinning education administrative function. Feedback from students clearly shows the impact of the administration team.

Fig 9 Admin team student feedback

We have additional plans for the use of the development funds in terms of simulation and widening access activity e.g. the creation of simulation scenarios at the USW Simulation suite and various new widening access initiatives.

Undergraduate (UG) Faculty Structure

The following diagram illustrates the progress that we have made so far in strengthening the UG Faculty structure.

We are currently in the process of appointing Module Leads and supporting Honorary Lecturers to the final tier in the organisation chart.

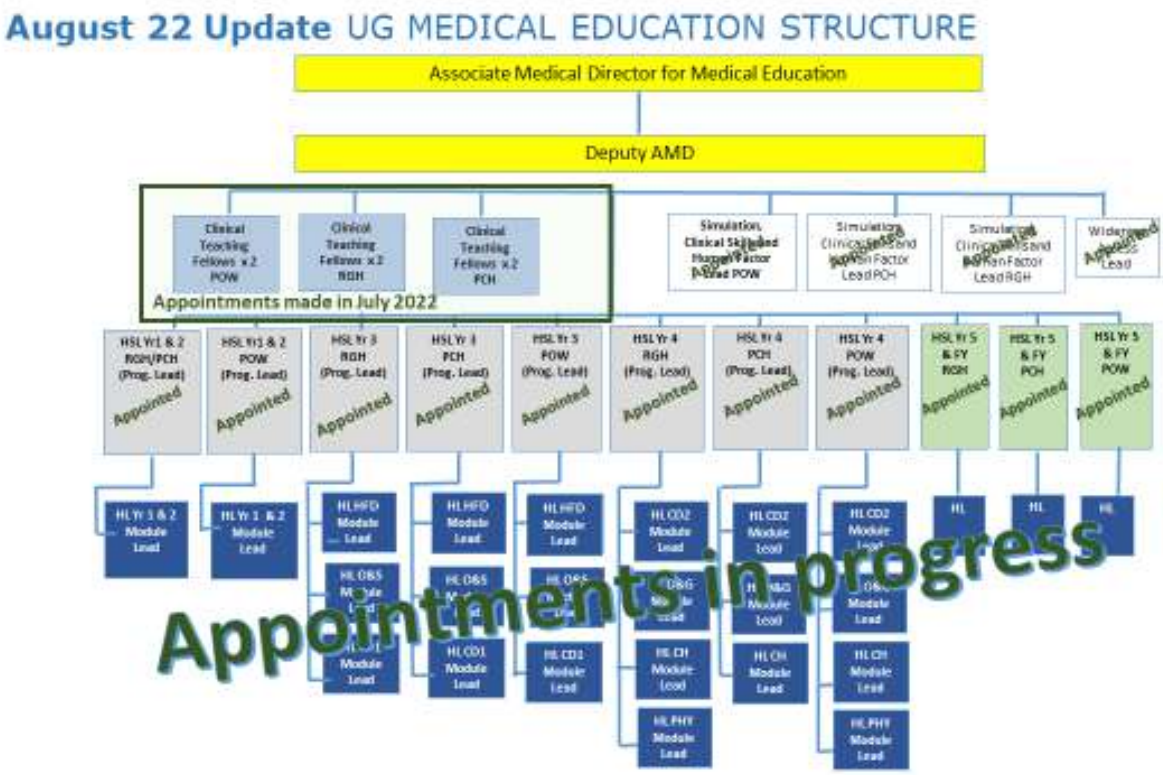


Fig 10 UG Medical Education Faculty Structure

Post Graduate/ Post registration Education and Training.

The Clinical Education Service manages the education, training and development of registered clinical healthcare professionals including:

- Design and delivery of bespoke in-house education programmes to meet training needs e.g. New Nurse Graduate development programme, education packages in response to Clinical Incidents e.g. Nasogastric training, International Nurses training.
- Delivery, Management and co-ordination of Education pathways for Foundation Medical Trainees.
- Management of Health Education Improvement Wales Advanced Practice & Non-Medical Prescribing funding streams.
- Management of HEIW (HEIW) Nursing CPD allocation via University of South Wales.
- Library and Knowledge Management services.
- Recognition of Acute Deterioration & Resuscitation and Clinical Skills including advanced programmes accredited by the Resuscitation Council and Royal College of Surgeons.
- Action Learning Set methodology to support participants to understand organisational context to better apply and embed learning from e.g. MSc in Digital Skills for Health Care Professionals (University of Wales Trinity St David)

Focus on Nursing post registration

The Nurse Education Team have developed and implemented a New Registrant Nurse Induction Programme for all graduate nurses employed within the organisation across all fields of nursing. The structure of the programme is based on research which recommended that, novice nurses are best supported by structuring their experiences in clinical practice while supporting and enabling them to achieve their goals through the learning continuum and their career progression. The aim and structure of the programme was to aid recruitment and retention of newly qualified nurses (or within 6 months of qualifying). The staggered structure of the course allows the graduates to transition into their new role and acquire new skills gradually before they progress to the next level, preventing overwhelm in their new role. The impact of this programme is continually evaluated and amended to ensure clinical need is met. In 2021-22 126 Newly Registered Nurses attended the programme.

The Professional Development and Innovation Programme, targeted for nurses in band 6 roles, focusses on developing their experience of management, leadership and innovation roles to consolidate preparation for the next phase of their careers. The programme is a valuable resource in supporting our Band 6 Nursing workforce, to date 38 Registrants have attended the programme with more dates planned for 2022-23. Leadership and communication themes are at the core of this programme including:

- Demonstrating the role & responsibility of Junior Sister.
- Demonstrating the ability to manage performance.
- Demonstrating their role in relation to managing people.
- Demonstrating their responsibility in relation to managing resources.
- Demonstrating their responsibility in relation to empowering others.

What is clear from the impact of this programme is the agency and self-authorisation shown by the participants to in offering their leadership through their roles and really making a difference, for colleagues, patients and their care.

Focus on Medical post grad

In Academic Year 2021/22 CTM UHB had a total of 72 Foundation Year 1 (FY1) doctors and 59 Foundation Year 2 (FY2) doctors starting their rotations across the three acute hospital sites. In addition, throughout the academic year, we held induction for 281 junior doctors as they started with the UHB. This induction covers corporate/legal requirements and site-specific information.

Foundation training for FY1 and FY2 took place weekly on specific, regular times on each acute site. In addition we held frequent, speciality-related teaching and journal clubs through the year. We also trialled four simulation afternoons for the FYs which proved to be very beneficial for the new curriculum.

For junior doctors we facilitated weekly teaching as well as ad hoc events and "Grand Rounds" for all trainees and consultants.

Performance

Performance is monitored via the HEIW Quality Unit. The HEIW CTM UHB "Risk register", maintained by the Quality Unit, records areas of concern through a number of different data sources, most notably the General Medical Council (GMC) National Trainee Survey.

The sources of concern can range from anecdotal evidence, to formally recorded results on GMC surveys, and the scope of the "risk" from a single point of contact, to covering the whole health board.

HEIW formally review risk position with the health board 3 times a year, operating on a traditional traffic light system. The current version of the risk register (August 22) has 24 risks (23 in September 2021). The Associate Medical Director (Education) and the Clinical Education Manager continue to tackle each individual risk, liaising with trainees and trainers as required, collecting and collating feedback and assisting with the development of action plans. The matrix below shows the risks from September 2021 to August 2022. Medical Education has developed a process for continual monitoring of risks, further detail can be found on p 31 and appendix 1

Acute site Matrix August 22

		Aug 2022	Sept 2021
RED RISK High Risk	RTE	0	0
	MC	3	1
	BRIDGEND	0	0
	ALL	0	1
ORANGE RISK Medium Risk	RTE	5	4
	MC	6	3
	BRIDGEND	4	4
	ALL	2	1
YELLOW RISK Low Risk	RTE	1	4
	MC	1	1
	BRIDGEND	1	4
	ALL	1	0
	TOTAL	24	23

Table 3

Bespoke Education and Training activities

The Teaching skills for Doctors Course is an in-house development which has been so successful that an additional course was commissioned by HEIW. We expect this course to run at least twice a year in the future.

In Prince Charles Hospital we ran the Neonatal Boot camp in August 21, December 21 and April 22, with exceptional feedback and intend to continue this activity.

Likewise we intend to continue development of hybrid study days after a successful Cardiac Study day in Princess of Wales, with a screen of online delegates, and separate cameras and microphones for attending delegates, to ensure interactivity.

The annual Teaching and Educators Development Conference (TED) was held in POW on the 1st of July and was themed "Future Proofing Medical Education." 70 delegates attended and talks and workshops were given with members of CTM UHB clinical staff, as well as contributors from HEIW and Cardiff University.

Continuing Professional Development Education

It is absolutely essential that continuing education for all staff is aligned to and centred on patient care and service developments.

Focus on Nursing

CTMUHB and the University of South Wales (USW) continue to have an excellent partnership and team approach ensuring that the educational requirements of practice are met with the academic infrastructure of the University.
Clinical Education manages utilisation of the contract with USW for continuing post-registration education for nursing and midwifery. The equivalent of approx. 350 module places per annum are available via an internal application and allocation process. Clinical Education continue to work with the USW to develop modules and educational courses which are tailored to support specific service change across the organisation. e.g. Education day on Clinical Supervision.

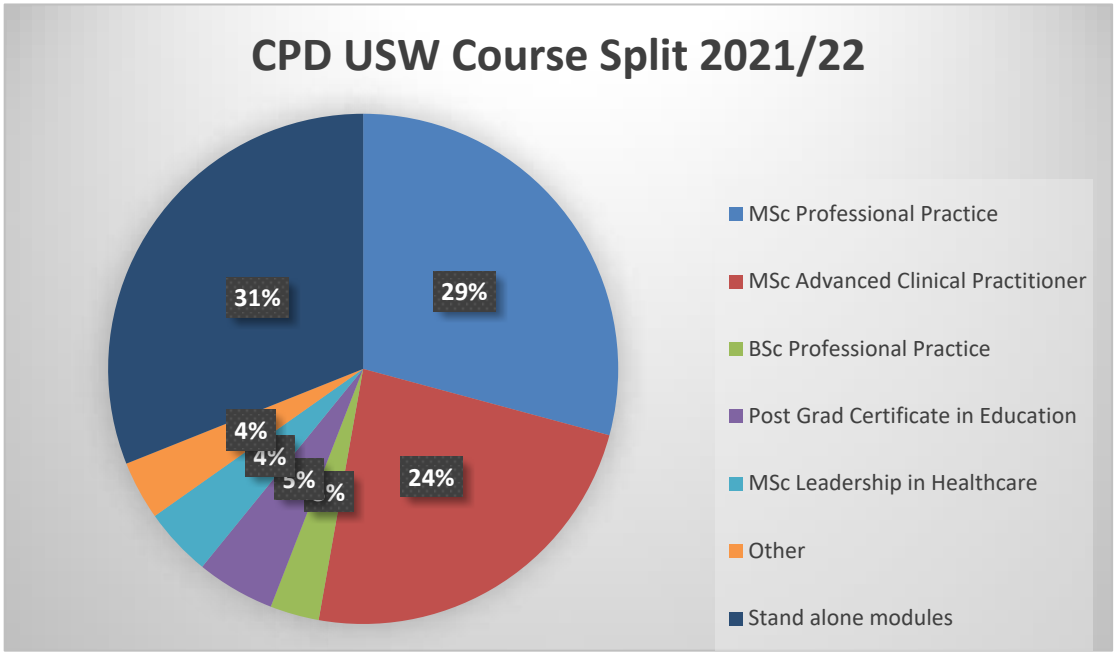


Fig 11 CPD USW Course Split 21-22

Focus on Multi-Professional Advanced Practice

Welsh Government via HEIW continue to invest in health professional education by providing annual funding for *Advanced Practice & Extended Clinical Skills.*

The funding provided by HEIW is to supplement our local investment to ensure that the appropriate staff can access the educational requirements as identified in our Integrated Medium Term Plan (IMTP), in terms of advanced practice/extended skills education requirements and Non-Medical Prescribing programmes. This funding is utilised across our organisation and is inclusive of nursing, therapies & healthcare scientists. There is a separate funding stream for Pharmacy advanced practice and prescribing.

The allocation is informed by an annual CTMUHB Education Commissioning return including undergraduate and advanced practice education requests. HEIW notifies the UHB of its Advanced Practice and Non-Medical Prescribing allocation between April and May each year the allocation is split across primary and priority areas in acute care settings.

Advanced Practice allocation is agreed via a Multi-professional Allocation Group and managed via Clinical Education. All applications must describe the intended service impact to be achieved as a result of the educational request. We meet requests flexibly across both Advanced Practice and Nursing CPD funding streams where appropriate to maximise access to funding for all health care professions and to enable optimal use of resources.

HEIW also funded 40 places for Independent Prescribing Programmes in 21-22 (30UoSW and 10 Swansea). All funded places are available to a range of professions across the organisation.

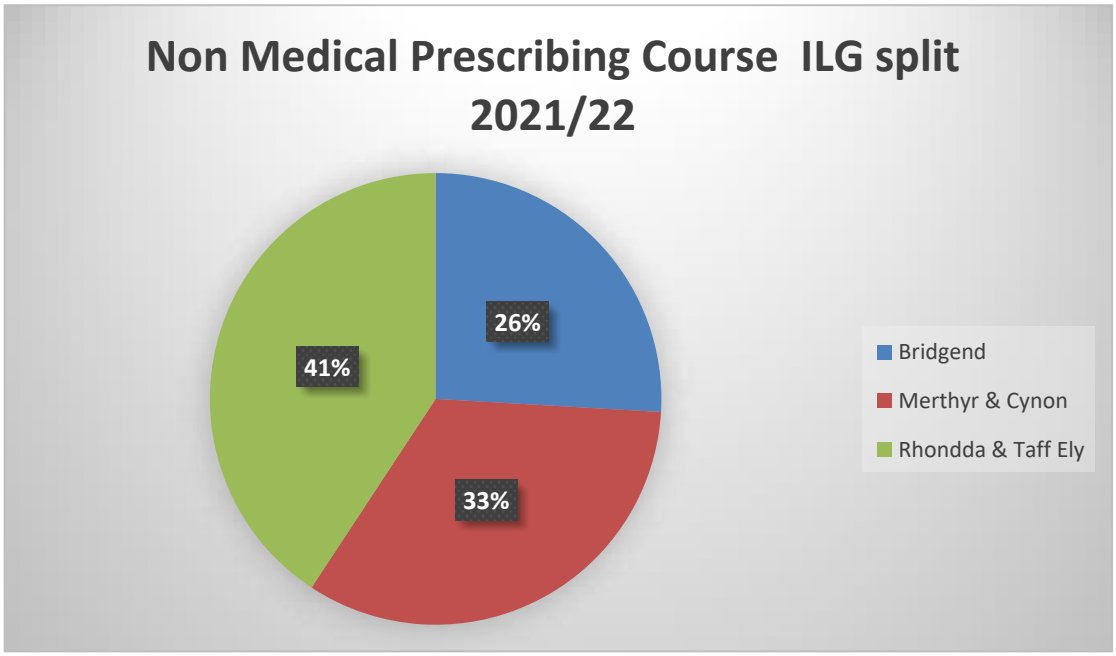


Fig 12 NMP ILG split

New for 2022-23 are Practice Specific Funded training places, these include Child and Adolescent Mental Health, Critical Care, Medical Ultrasound and Reporting Radiology.

Health Care Support Worker (HCSW) Education

Clinical Education supports the skills and career development education pathways for health care support workers across CTMUHB as defined in the HCSW Framework, including clinical and non-clinical roles in primary and secondary care settings.
HEIW continues to allocate funding to CTMUHB for HCSW Education and Development in line with compliance with the All Wales HCSW Framework, with £258,377 being allocated 2021/2022.

21 Clinical HCSW Inductions (5 Day Programme) with 214 staff trained and 16 Consolidation days covering 235 staff were delivered over 21/22. The consolidation days were developed and delivered to the HCSW's that were recruited during the Covid recruitment phase as they had received a shortened, non-accredited Induction, this ensured that any of the HCSW's still in employment worked towards the accreditation in line with other clinical HCSW's.

There were 14 NEWS and Physiological Measurements Agored accredited training days scheduled, due to requests from service and in response to the Acute Deterioration Lead's request. Only 5 days were delivered to 22 HCSW's due to challenges with staff release because of service pressures during the latter part of the year, again due to increase in staff sickness because of another small wave of Covid at the end of 2021. This Covid wave also meant that members of the HCSW Team were redeployed to Community Vaccination Centres for a period of a month to assist with the delivery of immunisations.

The numbers of HCSW's progressing through the framework during this period via Credit and Qualifications Framework Wales (CQF) Level 2&3 Apprenticeships saw a rise as service pressures eased slightly pre-winter and the expansion of the HCSW Team. This has enabled the Clinical Trainers to identify HCSW's that are out of compliance with the framework and aim to enrol them onto heath related apprenticeships, with support from the Apprenticeship's Lead and Coordinator from the Learning & Development team.

There was a healthy interest in the Certificate of Higher Education delivered at USW for September 2022 intake. 29 HCSW's have enrolled on year 1 and 15 enrolled onto year 2 (3 resitting) and 11 graduated and 4 are going directly onto the 2nd year of preregistration nursing via the flexible route at USW. The increased appetite for the Cert HE has been fuelled by the development of Band 4 roles within the community and the need for Level 4 education to underpin these roles.

Reports for compliance with the All Wales HCSW framework are submitted along with an annual detailed bid for ongoing funding to HEIW and this year has seen HEIW request quarterly updates on the progress of the funding spend.

Acute Deterioration, Resuscitation and Clinical Skills

Organisational governance around resuscitation and acute deterioration has been further developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all Recognition of Acute Deterioration and Resuscitation related issues within the Organisation, supporting the provision of appropriate and effective patient care through implementing operational policies governing the prevention of cardiac arrest and those governing cardiopulmonary resuscitation, practice and training. This approach brought together a number of work streams in order to reduce avoidable mortality and morbidity by improving the function of health board systems that enable early recognition and treatment of deteriorating patients, and cardiopulmonary resuscitation.

It chaired by the AMD for Quality and Effectiveness on behalf of the Medical Director with a Consultant appointed as the Clinical Lead. There is a Lead post for Acute Deterioration which commenced in January 2021 (based within Clinical Education) with a plan to have a structured and unified approach across Cwm Taf Morgannwg University Health board (CTUHB) in the identification, escalation and response to the acutely unwell patient.

This group reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee

The work of this governance structure is directly supported by the Head of Clinical Education, the Lead Nurse for Education and the Resuscitation & Clinical Skills team.

Acute Deterioration

National Early Warning Score (NEWS)

To provide a consistent approach across CTMUHB the National Early Warning Score (NEWS) chart has been updated to include NEWS 2 principles and standardised across CTMUHB wards. NEWS is based on a simple aggregate system in which a score is allocated to physiological measurements already recorded at the patient's bedside, the aggregated score then generates a clinical response. NEWS aids the identification of the deteriorating patient. In addition to differentiate the escalation procedure within the community hospital environment a tailored escalation procedure has been developed for the community hospital sites.

In order to provide assurance within the health board that the NEWS charts are completed accurately and appropriately escalated an audit pro forma has been developed based upon NICE CG50. Data is entered monthly onto the Audit Management and Tracking (AMaT) system. Results are disseminated to all ward managers, senior and head of nursing for review. Any compliance issues are also discussed within the ILG Recognition of Acute Deterioration and Resuscitation RADAR meetings. NEWS audits are used to provide evidence of learning in Learning from events reports (LFER).

The plan for 22-23 is to perform a health board wide audit of all NEWS charts within a 24hr period within secondary sites to identify the burden of acute illness and evaluate the response to acute illness.

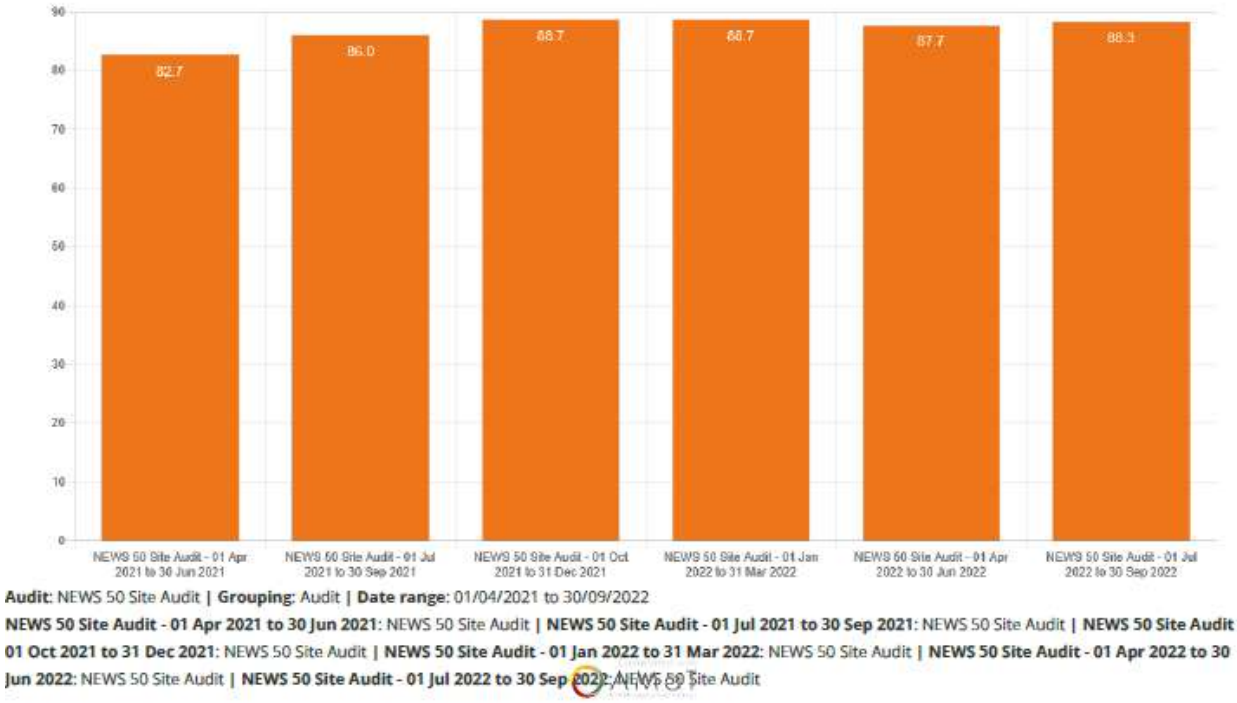


Fig 13. CTMUHB NEWS audits (quarterly view) April 21-Sept 22

The Critical Care Outreach Teams (CCOT) undertake the NEWS training within the secondary sites. NEWS training is also provided by the health care support worker programme and the resuscitation practitioners during Immediate Life Support and Advanced Life Support.

To complement the Immediate Life Support (ILS) course provided by the resuscitation team, the Acute Life Threatening Events-Recognition and Treatment (ALERT) course has been introduced across CTMUHB for all registered nursing staff. This ensures a unified approach to education to manage an acutely unwell patient within a ward environment. The plan for 22-23 is to extend the provision of the course and develop a multi-professional faculty to facilitate, this would provide best learning environment for the candidates on the course.

Rapid Response

To standardise the response to deteriorating patient within CTMUHB a rapid response call has been added to the 2222 emergency call list within Prince Charles and Royal Glamorgan Hospitals. A rapid response call is already established within Princess of Wales Hospital.

The Rapid response call aims to prevent cardiac arrest, initiate treatment decisions, and initiate timely specialist reviews by earlier escalation of the deteriorating patient. To audit the number, timeliness of response and the outcomes of the rapid response calls, a Rapid response and cardiac arrest audit pro-forma has been developed. This together with the emergency call data from switchboard provides information of the effectiveness of the escalation system within CTM.

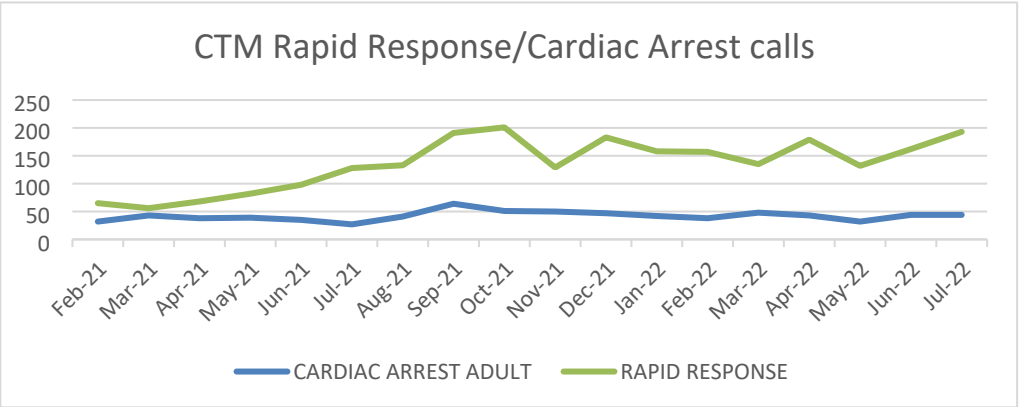


Fig 14. Number of Rapid Response/Cardiac Arrest calls CTM April21-July 22

To further review the escalation system an audit of Cardiac arrests occurring in wards is being developed. This would enable any gaps in escalation to be identified and facilitate training

Fig 4. Rapid Response Outcomes

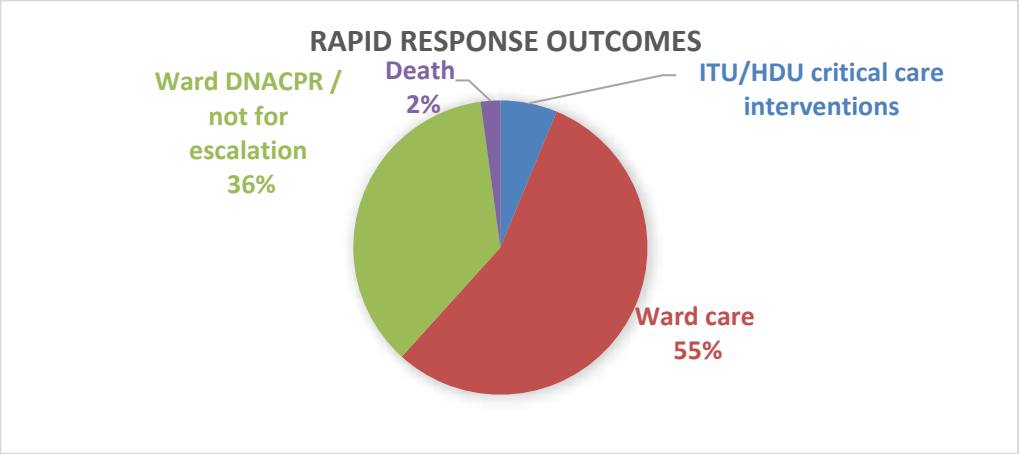


Fig 15 Rapid Response outcomes

Results from data entered into AMaT indicate that over 50% of the rapid response calls result in patients remaining on the ward. This could be due to improving condition following interventions by the Rapid response team. Also 36% of the calls result in timely decision making which can prevent inappropriate admissions to Intensive care and prevent cardiac arrests. It is intended that with the introduction of Treatment Escalation Plans (TEP) that timely decisions around escalation and DNACPR would lead to a reduction in these decisions made at a rapid response call leading to an appropriate outcome for the patient.

Sepsis.

Sepsis can be one of the causes of deterioration within a patient and if not identified and treated timely can lead to multi organ failure and increased admission to Intensive Care and deaths. Within CTMUHB there were several sepsis screening tools in use. Therefore to ensure consistency in the identification of sepsis within the hospital setting a new sepsis tool has been developed using a collaborative approach between pharmacy, medical and

nursing leads. The new sepsis tool focuses on risk stratifying patients into categories to ensure those at most risk receive timely care.

To support the timely administration of antibiotics the first line antibiotics for use within Emergency departments was unified and the addition of a QR code helps to reduce the time to prescription and administration in the patient with probable sepsis.

The sepsis tool was trialled within the three Emergency departments for a period of three months, initial results indicated an increase in the use of screening from 7 screening forms to 90 forms per month and increase in compliance from 34% to 63% with timely treatment.

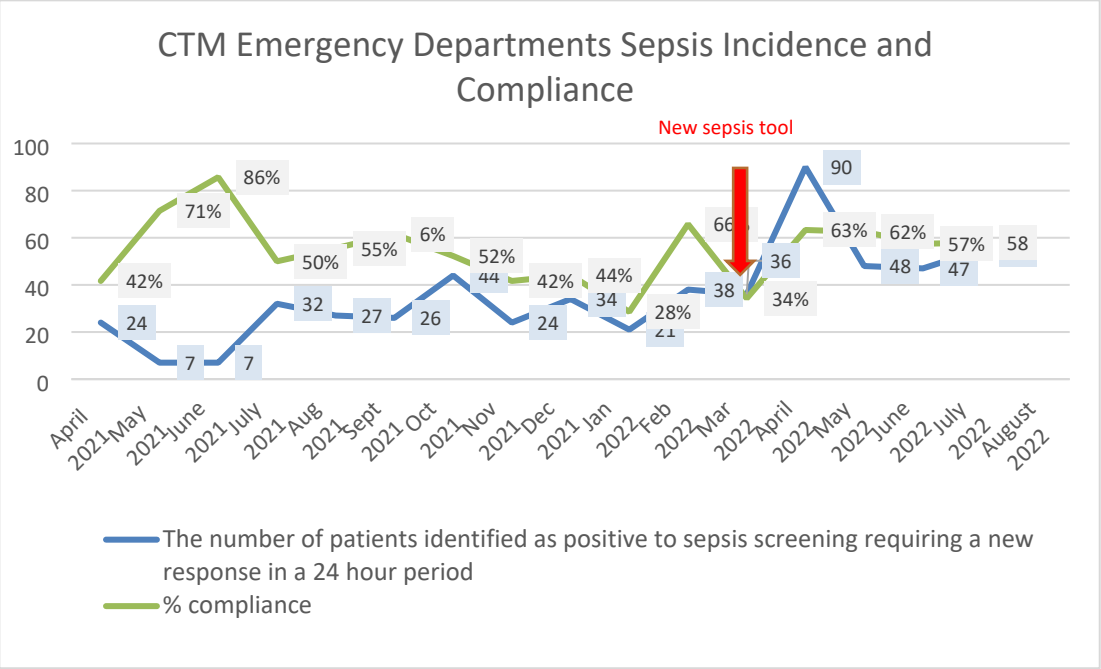


Fig 16 CTM ED Sepsis compliance

Ongoing work continues with the roll out of the sepsis tool to the wards within both secondary and community hospitals and this would formulate the plan moving into 2023. Plans are in place to collaborate with our CTMUHB communities to raise awareness of sepsis and signpost to the relevant areas for support which aligns with **Our Health, Our Future, CTM: 2030**

Resuscitation and Clinical Skills

Throughout 21-22, there was a focus on standardisation of Resuscitation Standards CTMUHB. This included a complete review of the CTMUHB resuscitation policy, and a renewed resuscitation training compliance matrix for the organisation. Additionally, the resuscitation equipment was standardised across the health board, with a major change to equipment taking place in Princess of Wales Hospital with the rollout of new resuscitation trolleys across what was then the Bridgend locality group. The standardisation of equipment, along with the rollout of the Rapid Response Calls, has not only improved patient safety, but has also rationalised equipment with a significant reduction in equipment utilised.

During 21-22 the Royal Glamorgan Hospital and Prince Charles Hospital, received a roll out of 40 new defibrillators along with the relevant training of staff to ensure competence and safe use.

The service also provided support and training for staff to rollout a new standard operating procedure in Ty Llidiard, as part of the response to a Welsh Government investigation into a recent incident. This included working closely with Welsh Health Specialised Services (WHISSC) Committee and Welsh Ambulance Service NHS Trust (WAST) to create a hybrid 2222/999 response to emergency calls.

The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 (graph 1 and 2), for CTMUHB, Powys HB and all local GP's and Dentists. The department is also a leading National provider in the delivery of Level 4 Advanced Resuscitation Courses, for Adults, Paediatrics, Newborns and Trauma. These courses are delivered on an income generation basis, with internal and external faculty engagement required to deliver. The number of staff trained is outlined below.

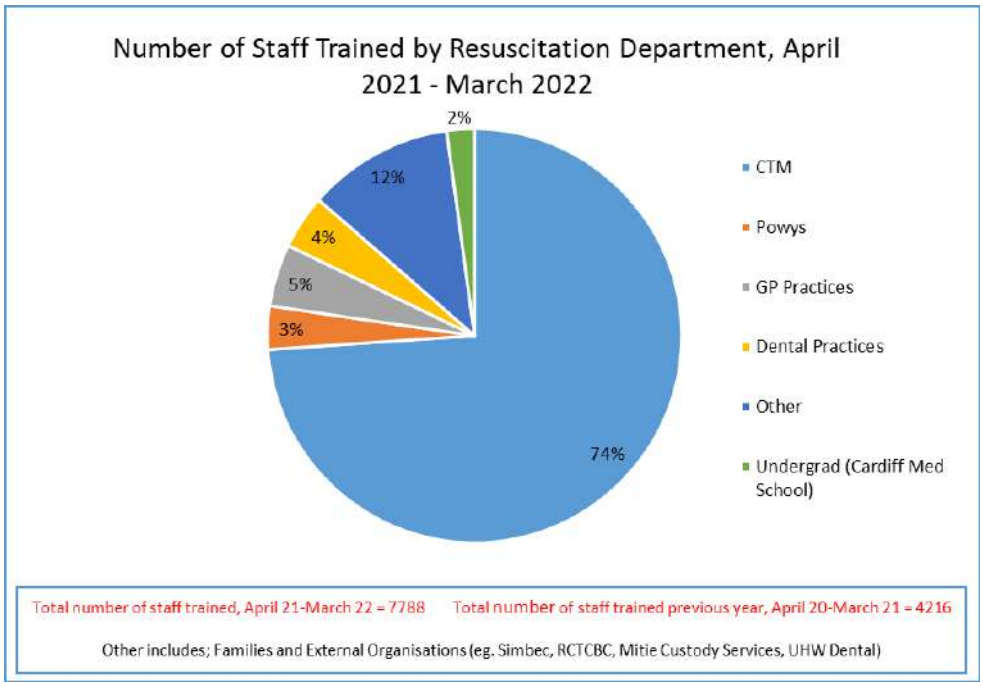


Fig 17 Staff trained, April 2021 to March 2022

Fig 18 Level of training numbers.

Vaccination Teams across the UHB have been supported with training to enable them meet the urgent demand throughout the Covid-19 pandemic. We have also assisted in the upskilling 44 ITU staff and 52 Paediatric staff with level 3 Paediatric Immediate Life Support (PILs) in response to the Respiratory Syncytial Virus (RSV) risk.

Over the past year, the Resuscitation Team worked collaboratively with the Practice Development Nurses and Midwives (PDN & PDM) to deliver 'Train The Trainer' (TTT) 'in house' training programmes for Level 2 Basic Life Support, increasing flexibility and opportunity to offer further training places and therefore increasing compliance. This in turn releases time for the Resuscitation Practitioners and Training Officers to focus on the delivery of Level 3 training, organising and facilitating debriefing sessions following arrest calls, investigating and preparing evidence for Rapid Reviews and scrutiny panels, attending 2222 calls, cardiac arrest audits, and Datix queries. Through this activity areas for improvement are identified and training needs incorporated into future training programmes. E.g. redesign of the cardiac arrest audit form. The revised audit enables identification of areas needing improvement in training and provides a trail of decision making.

Libraries and Knowledge Management.

There are dedicated Libraries on each of the acute sites operating 24/7 access for our staff and students, to our literature collections; journals and books, both electronic and physical, quite study space with IT access & printing. Our specialist librarians are also available for help and support including literature searching, reference sourcing and critical analysis skills. Our libraries are an important part of our health board activity.

Library Usage	**Footfall**	**Loans**	**Literature Searches**	**Current Awareness**	**Articles via Library**
PCH	34917	1054	24	n/a individually	259
POW	21427	3405	163	"	870
RGH	26828	1774	26	"	248
Totals	**83172**	**6233**	**213**	**130**	**1377**

Table 4 Library Usage Stats

Updated Facilities

The Library at PCH has been moved into a new modular building for the next five years as part of Phase 2 redevelopment of PCH.

The library team at PCH worked hard organising the move and ensuring there was as little disruption as possible. The new accommodation is a great improvement on the old facilities and is a bright, welcoming area for users to work and study. Library facilities at RGH and POW have also had a refresh with new furniture and printing facilities.

Fig 19 Updated facilities PCH/ increased study space POW

CLA Submissions

The team at RGH have been working on a new methods of data collection for the Copyright Licensing Agency via the Library Management System which involved working closely with the Systems Librarian at Cardiff University. This is now up and running and is being used across NHS Wales Libraries as the main data collection method for this submission. From 2023 this data is being collected annually rather than 3 yearly and will make the process much quicker and simpler.

NHS Wales Library & Knowledge Services (NHSWLKS) & UpToDate Survey

The NHSWLKS survey was launched on the 10th May until the 4th June 2021. Feedback was excellent with 84% of respondents saying they were very satisfied with the Library & Knowledge Service at CTM.

"The library provide an excellent service and I am truly grateful for all the support they have provided to me. It would not be possible to provide patient care which is in keeping with the latest evidence without their support. They are an essential part of any health board team." [AHP]

Fig 20 Library feedback

UpToDate

To aid the renewal of UpToDate a User Survey was sent to Medical Staff across CTM. The response rate was very good with 96 responses, all recommending that UpToDate is renewed. This information enabled us to repurchase the resource on a 3 year contract (with the option to opt out at the end of each year). Some of the user comments are below:

"I often use up to date to refresh my clinical knowledge of conditions I do not encounter very often. It has also been useful in the wards in reading the latest research on rarer conditions providing better care for those patients."

"Easy point of reference for clinical conditions. Helps to avoid delay in care, unnecessary investigations and offers better patient care. By having one single point of reference it is more efficient to visit one site that searching for multiple."

Staff Development & User Training

A number of online training courses have been made available to Library staff by the NHS Wales Library network. These have ensured that as a service we remain up-to-date with changes and new technologies. Some of the topic covered include:

Advanced literature searching, Artificial Intelligence, Accessing e-Books, Presenting searches to the end user, Using Scopus, Critical appraisal

The Specialist Librarian (POW), received her Chartership from CILIP, the library and information association.

Several online webinars have been provided nationally on how to search databases etc. effectively with support from CTM LKS staff. New short online videos to support library users

have been developed e.g. Accessing e-resources from the NHS Wales network. In person inductions, teaching and training has increased as pandemic restrictions have eased.

Wellbeing

The LKS continues to support the HB wellbeing agenda with a range of books and resources and this year managed the distribution of Chillo pillows to staff.

Bilingual Leaflets

All of the CTM Library guides and leaflets have now been translated into Welsh.

Strategic Direction Progress

This report reflects the progress made over academic year 21/22 to a more integrated Clinical Education Service from departments that have historically functioned separately.

The Strategic Direction for Clinical Education in CTMUHB is to become a Learning Academy meeting the individual education needs of each profession whilst also taking a multi-disciplinary education and inter-professional learning approach, encompassing and enabling benefits from diversity of thought and skill set, contributing to improving patient care and population health and wellbeing.

Creating, sustaining and growing a Learning Culture in Clinical Education

Our Clinical Education Strategy follows a hierarchy of needs model to build and ensure motivation of the individual and therefore supporting and nurturing the development of a Learning Culture in CTMUHB.

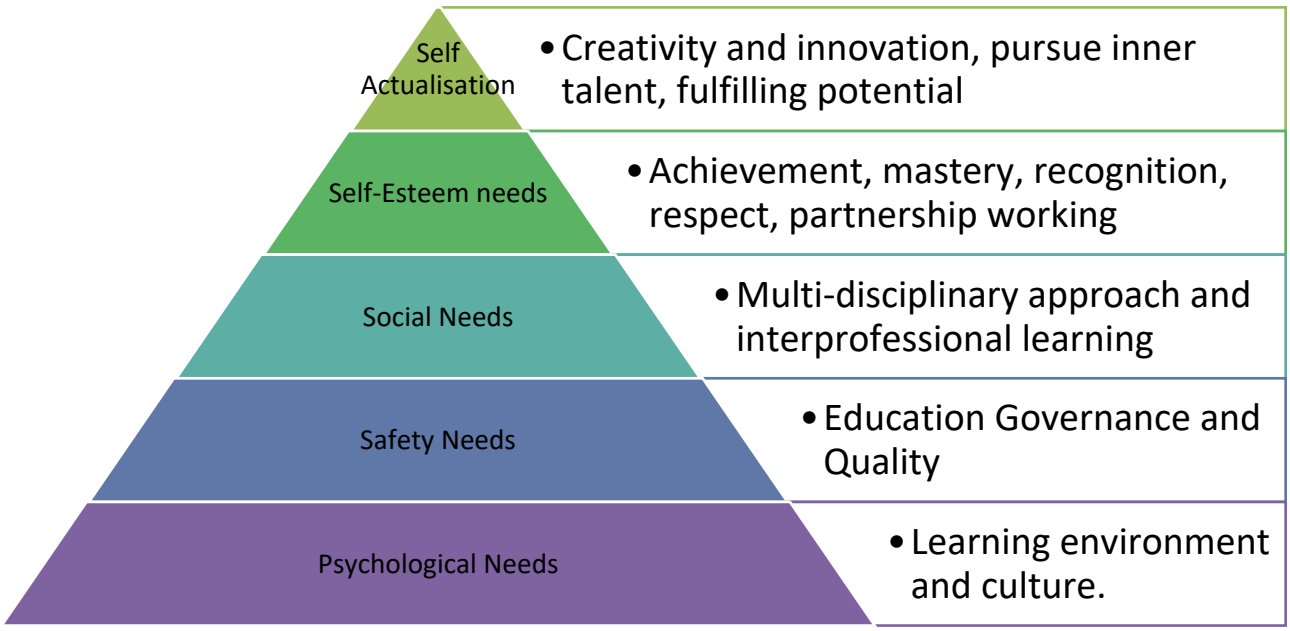


Fig 21 Heirarchy of Needs

Learning Environment and Culture: Resource investment and utilisation

Direction:

- *Quality and excellence in Education and Training is an established and valued part of organisational culture.*
- *CTMUHB is a Centre of Excellence for multi-professional learning.*
- *There are clearly defined, recognisable, flexible, accessible, up-to-date Clinical Education facilities that meet the learning needs of learners from all professional groups.*

Progress over 21-22

Our Facilities

Over 21/22 inspired by work with University of South Wales, we have raised the profile and identity of our service through a branding and refresh of Clinical Education facilities across all sites.

Additional study areas have been added which have been popular with our HCP students and staff using our libraries facilities.

Fig 22 RGH Refresh

During January 2022, the Clinical Education function in PCH moved to its new interim accommodation as part of the PCH rebuild. This has enabled the co-location of some historically separate elements of Clinical Education resulting in beneficial integration of services, efficient sharing of resources, updated facilities and improved layout.

Fig 23 PCH Clinical Education Centre

Learning from this move has also highlighted the need when planning commences for the final location of Clinical Education in PCH, to include libraries and nursing education in the co-located provision.

We are also, with financial investment through IT, coming to the end of a comprehensive Audio Visual (AV) equipment refresh, to ensure that all the rooms available for Clinical Education, have consistent and functional AV capability.

Much work has been done to align and standardise Service Increment for Teaching (SIFT), funding that the organisation receives to deliver medical student education and training as per Cardiff University C21 curriculum requirements.

Significantly, following extensive discussion and evidence gathering, Clinical Education and Finance agreed a two/three year plan with the purpose of better identifying the flow of SIFT funds to services and directorate budgets. This will enable the robust resource support of the undergraduate medical education activity, alongside increasing governance and clarity over the utilisation of SIFT funds.

Permanent training accommodation continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services.
It has been recommended that the creation of a dedicated multi-professional Education and Learning facility should be included as part of the strategic site development plan.

Strong workplace infrastructure - Education Governance and quality infrastructure.

Direction:

CTMUHB has established effective systems of educational governance and leadership

1. *A robust and established Clinical Education Governance infrastructure providing confidence and assurance for individuals and the organisation of excellence in Clinical Education and Learning activity.*
2. *A clear and well developed understanding of Clinical Education, Training and Learning activity and risk management across the organisation.*
3. *Maturing organisational processes around clinical education commissioning, informed and aligned with service delivery priorities and training needs analysis,*

supporting the development of new models of care, innovative service redesign and workforce modernisation.

Progress towards these aims in 21-22

1. Significant progress has been made over 21/22 to develop and establish robust organisational wide education governance infrastructure to assure high quality education and training meeting the requirements and standards determined for the NHS in Wales, with oversight of undergraduate and postgraduate education and continuing professional development for all registered health care professions and clinical healthcare support workers.

   The purpose of the Clinical Education Forum is to provide effective systems of educational governance and leadership that ensure optimal investment and resource utilisation in education activity to support and underpin the capability, capacity and confidence of our clinical workforce.

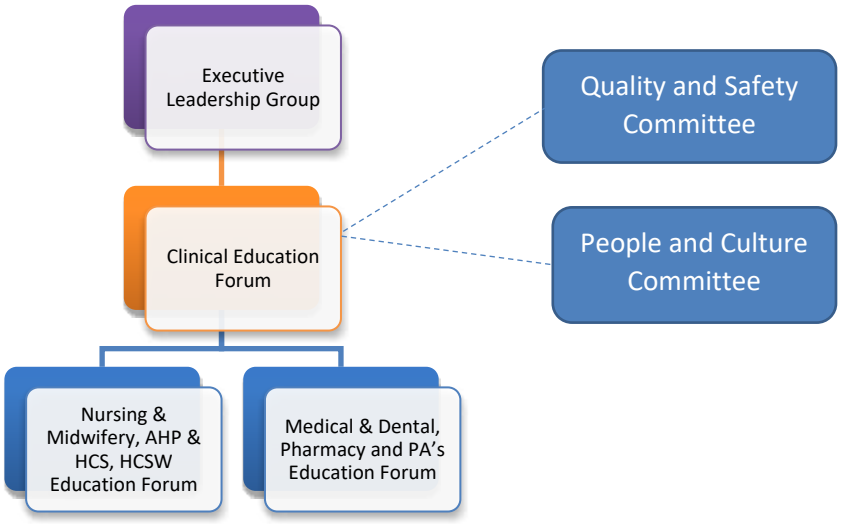


Fig 25 Clinical Education Governance Structure

2. Our risk management processes are maturing and example of this is the approach developed for managing postgraduate medical education risk register as maintained by Quality Unit HEIW.
   a. Medical Education have now developed a process for continual monitoring of the register and formally request updates from Faculty members, seeking continuing consideration of the issues by acute site. The risk register is addressed and updated formally within the internal Medical Education function (AMD Education and Clinical Education Manager). Alongside this process, HEIW undertake a series of targeted visits, meeting with trainees and trainers to assess issues and monitor progress.
   An example of a monthly monitoring report can be seen in Appendix 1

3. Over 21-22 the Head of Clinical Education worked in close partnership with the Deputy Director of Workforce and OD to develop a more robust process for collating annual Education Commissioning numbers return for HEIW. Heads of Workforce and OD worked with locality directors and profession leads to identify requirements at a locality level and these were collated into an overarching CTMUHB wide commission.

Regular sense check meetings were held to review submission status, compare to previous years, identify any outstanding gaps in information and to develop an accompanying service development and workforce position narrative. Further refinement of this process and consideration of the new organisational structure will be reflected in activity for 2022-23.

Multi-disciplinary Learning and Inter-professional Development.

Direction:
*There is a high quality multi-professional education model that delivers equitably for **ALL** healthcare professionals and their support staff. Meaningful inter-professional learning and development is evident throughout the education model.*

As part of a Review of Health Care Professional Education in Wales, HEIW has given a clear direction to education providers that, in addition to meeting professional regulatory standards there must be delivery of meaningful inter-professional learning opportunities through clinical placement activity and beyond into post grad/ post registration career pathways.

Progress in 21-22

We are making good progress in establishing more meaningful interprofessional learning within the health board.

- As a result of learning from a joint project with Swansea University; Working in Partnership to develop a Learning Outcomes approach to Clinical Placements for Paramedics and Nurses' (3) CTMUHB developed and appointed the first Multi-Professional Practice Education Facilitator (MPEF) role in Wales who works across all clinical professions and HEI's with a focus on learning activity opportunities to meet the HEIW requirement of 150hrs of interprofessional learning on clinical placements.
- Informed by the recommendations from the project above, over 22-23 HEIW are looking to provide targeted funding for further MPEF roles across health boards in Wales.
- The staff on the MSc for Digital Skills for Health and Care professions were supported through the first year of their programme with regular multi-disciplinary Action Learning Sets (ALS) to enable their learning through orientation to the landscape of CTMUHB digital context and building of key networks to sustain application of learning directly back into the organisation at pace. Inter-professional learning was enabled by dedicated time and space for reflection, knowledge sharing and sense making. Key digital organisational contacts linked into the group included Director of Digital and Chief Information Officer who were able to share vision, strategy and approaches to governance that enable wider benefits from digital transformation.

  Example feedback from digital ALS.

  "Listening to other peoples experiences can make you reflect on your own journey. Having come from a clinical background with some management experience, it can be difficult to have a wider understanding of other department's roles, expectations and how they manage their journey to ensure policies and guidance is met. Organisational structure is not something I have thought about and how it affects integration for other departments. Therefore this as certainly made me consider my approach and the

realisation of the wider picture for health board's structure and the difficulties and challenges it can pose."

Multi-Agency Training Event (MATE)

At the end of July, we held the first refreshed multi-agency training event (MATE) at Tonypandy Fire station, with the Welsh Ambulance Service and South Wales Fire and Rescue Service. This enabled FYs and Junior Doctors and nurses to be involved in realistic Road Traffic Accident scenarios alongside the agencies with whom they would be working.

We are developing this scenario work further and will also be holding and event for junior doctors in conjunction with USW in the New Year.

Fig 26 MATE Event July 2022

In 22-23 further progress will be made towards establishing an Inter-professional Learning (IPL) Faculty. The early work for this faculty will be focussed on establishing undergraduate IPL opportunities including:

- Consulting with professional leads and Higher Education Institutes regarding common themes, learning outcomes, and barriers to IPL placements and possible solutions.
- Scoping out opportunities across the health board and developing structured IPL opportunities/ placement models/ simulation / student learning sessions in practice for students.

Innovative models for training capacity will continue to be explored including a project to create an education infrastructure to support the newly introduced undergraduate pharmacy clinical placements as part of a central Clinical Education Service which will also enable more interprofessional education and learning opportunities.

Partnership, Achievement, Recognition and Mastery

Direction:

Our workforce are our most significant asset. There will be clear educational frameworks to support career development pathways in CTMUHB.

Learning and development frameworks establishing levels of practice from foundation through to consultant are being taken forward nationally with profession / speciality and

multi-professional scope. Career development pathways must be supported through multi-professional development frameworks defining our educational offer for:

- Early / foundation years
- Extended/ Specialist/Advanced Practice – including Clinical fellowships; practice, education, research, leadership, clinical informatics
- Consultant.

Over 21-22 Clinical Education staff have been directly involved in National work including;

- Phase 1 of the HEIW strategic review of commissioning of Healthcare Professionals education tender process.
- Development of Multi-professional Learning and Development Frameworks, Advanced and Consultant level frameworks.
- Simulation strategy consultations
- Interprofessional Clinical Placements Principles development.

Pathways for medical staff are relatively well developed however the rest of the health care professional workforce needs further work.

Over 2021-22 work commenced to create a CTMUHB Nurse Education Strategy. This work has been delayed due to workplace pressures however will be completed in 2022-23 and will also be carried out with other professions including AHPs and Pharmacy. This will develop education strategies recognising individual professional requirements built around a common Clinical Education quality infrastructure framework.

These frameworks will also enable timely, agile service redesign and responsive workforce modernisation with more robustly informed Education Commissioning.

In 2022/23 another focus of work will be on developing clinical supervision and preceptorship in alignment with the Chief Nursing Officer priorities.

Widening access

To aid recruitment to the Health Board, both Pre and Post Registration nurse teams along with our corporate nursing colleagues have visited a number of schools across Rhondda Cynon Taf and Merthyr to speak to both Primary and Secondary school children about Nursing as a career. The team will develop this work stream further in the next academic year.

As has taken place in previous years, we ran a Medical Work Observation Scheme for pupils of Year 12+ from 4 July to 22 July 2022. The content included a mix of virtual and on-site opportunities, to use work experience as a crucial tool in helping pupils decide whether to pursue a career in Medicine or Dentistry.

One hundred school pupils were enrolled on this scheme in 2022 and the feedback was overwhelmingly positive.

Opportunity, Vision and Innovation.

Direction:
Cwm Taf Morgannwg Learning Academy.

A space where people could feel inspired to think, create and dream, build relationships and collaborate and learn together to improve practice and health.

A living manifestation of University Health Board Status, networked with multiple HEI partners, and HEIW creating a virtuous cycle of learning, innovation and improvement.

- *Innovation ideas supported e.g. Bevan fellowship/ exemplars, Environmental Impact.*
- *Challenge exchange*
- *Systems Design Thinking*
- *Collaborative work e.g. Product Designers 3D personalised healthcare innovation*

Progress and plans.

We have continued to deepen relationships with our partner universities and research and innovation colleagues.

With a focus on advances in simulation Clinical Education was successful in obtaining Levelling Up Funding from WIDI (Wales Institute for Digital Informatics) to release staff time to develop a Digital Simulation Education Strategy (Multi-professional) and a pilot education package. This work commenced in April 2022 and is on track to deliver December 2022 and is being supported by colleagues in Cardiff Metropolitan University and University of South Wales.

In partnership with University of South Wales we will be progressing the development of educational packages utilising their Hydra facility. An area of early focus will be on the Recognition of the Deteriorating Patient.

Over 2022-23 we will be involved in project work with Health and Care Research Wales to embed research into health professional careers.

Refs:

1. *A Healthier Wales: https://gov.wales/sites/default/files/publications/2019-04/in-brief-a-healthier-wales-our-plan-for-health-and-social-care.pdf. Accessed 10.10.2019*
2. *Workforce Strategy for Health and Social Care.* https://heiw.nhs.wales/files/workforce-strategy-for-health-and-social-care1/
3. *Final report of a project delivered by CTMUHB for HEIW, mentioned in the paper, is available upon request. It is for interest and gives a written example of the work Clinical Education are undertaking.*

Appendix 1: **Post graduate Medical Education Specialty Matrix – Movement since September 2021**

	August 2022	September 2021	Score rating movement
HIGH RISK	TP256 Emergency Medicine- PCH	TP256 Emergency Medicine- PCH	↔
		TP361 Psychiatry – All	↓
	TP487 Surgery – PCH		↑
	TP544 General Internal Medicine - PCH		NEW
MEDIUM RISK	TP361 Psychiatry – All		↓
	TP431 Medicine – POWH	TP431 Medicine – POWH	↔
	TP483 Paediatrics - POWH	TP483 Paediatrics - POWH	↔
	TP531 Diabetes & Endocrinology		NEW
	TP078 Ophthalmology –RGH	TP078 Ophthalmology –RGH	↔
	TP488 Anaesthetics - PCH	TP488 Anaesthetics - PCH	↔
	TP160 General Surgery – RGH	TP160 General Surgery – RGH	↔
	TP484 General Internal Medicine – POWH	TP484 General Internal Medicine – POWH	↔
	TP319 Multiple Specialties - All	TP319 Multiple Specialties - All	↔
		TP344 Obs & Gynae - POWH	REMOVED
		TP316 T & O - PCH	↓
		TP430 Medicine –RGH	REMOVED
		TP487 Surgery – PCH	↑
		TP318 T & O – RGH	↓
	TP523 Otolaryngology – RGH		NEW
	TP543 Acute Internal Medicine –PCH		NEW
	TP545 GP – PCH		NEW
	TP546 General Medicine – RGH		NEW
	TP547 Paediatrics – PCH		NEW
	TP548 Acute Medicine – PCH		NEW
	TP549 Cardiology – RGH		NEW
	TP552 General Surgery - PCH		NEW
LOW RISK		TP489 Clinical Radiology	REMOVED
		TP485 GP- Bridgend	REMOVED
		TP519 Diabetes & Endocrinology	REMOVED
		TP448 GP –MC	REMOVED
	TP316 T & O - PCH		↓
		TP459 Anaesthetics - All	REMOVED
		TP486 GP - Bridgend	REMOVED
	TP318 T & O – RGH		↓
	TP245 Obs & Gynae – RGH	TP245 Obs & Gynae – RGH	↔
	TP428 Geriatric Medicine – POWH	TP428 Geriatric Medicine – POWH	↔
		TP432 Paediatrics -RGH	REMOVED

AGENDA ITEM
3.2.7

CTM BOARD

HEALTH & CARE STANDARDS ANNUAL REPORT 2022

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Becky Thomas, Senior Nurse, Quality Improvement Louise Mann, Assistant Director, Quality and Safety.
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee	15/11/2022	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

Since 2009, the NHS in Wales has undertaken a national audit of care and service delivery which has included three elements:

- Patient Experience Survey – where we asked patients about their experiences of care.
- Operational – This included a retrospective examination of patient records to measure compliance against the standards and triangulation of information and observation of clinical practice.
- Staff Survey –where we asked staff about their experience of working within the Organisation.

The Health and Care Standards provide the framework for how services are organised, managed and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework against which standards of care can be measured and highlight focus areas for improvement.

The 22 Health and Care standards have been designed to fit with the seven quality themes identified in the NHS Outcomes and Delivery Framework which were developed through engagement with the public, patients, clinicians and stakeholders.

Each theme includes several standards which have been mapped against the NHS Outcomes and Delivery Framework measures, the measures relating to the fundamental aspects of care and specific areas that comply with legislation and guidance. The benefits of the engaging in the annual audit are:

E*nables patients/carers to:*

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide.
- Have a voice in the quality of the care they receive.

Empowers staff to:

- Make a difference and ensure ownership of their practice.
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern.
- Develop action plans to monitor change.

Enables Organisations to:

- Have a mechanism to monitor/measure the quality of nursing care.
- Develop organisational policies and procedures.
- Identify key themes for improvement.
- Adopt a culture of openness and transparency with the quality standards.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

The findings from the 2022 Annual Health and Care Standards operational audits, patient survey and staff survey are presented in the attached detailed Health & Standards Annual report. The narrative of this report will focus on the areas of good practice identified by the operational audit, our patients and our staff, as well as attempting to recognise and explain any areas of concern that emerge from the findings. It is important to note that this audit report is a partial, specific view of health board performance and should be seen within the context of other health board data and broader system challenges.

When making comparisons to year-on-year results, it must be recognised that there are limitations in making summative comparisons as the number of areas undertaking the audit has increased year on year. In addition, it is important to note that there is no longer a requirement to submit the findings to the Chief Nursing Officer, where data from other Organisations is available. Therefore, the results should not be used to compare Organisations across Wales; it is more helpful to provide assurance information to our Board, our stakeholders, our colleagues and the patients and populations we serve.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Feedback from our population

Between 1st April 2022 and 30th June 2022, a total of **646** patient experience surveys were completed across the participating clinical areas. This is compared with the **1,307** surveys completed in 2019. **444** (69%) were completed by the patient/service user, **62** (10%) by a friend/ family/carer and 54 (8%) completed with the support of a Healthcare Professional.

Feedback from patients confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 90% albeit a slight decrease to the 93% achieved last year. They are also complimentary towards

the attitude and behaviour of staff and nearly all patients (99%) who participated in this year's audit felt that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital.

There are two low scores this year, the first relating to the ability to speak Welsh to staff if needed with an overall patient satisfaction rate of 86% however it's heartening to see an increase on last year's 77%.

The second was related to getting enough sleep and rest, with a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continual challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

3.2 Feedback from our staff

Feedback from staff remains low overall and sees a decrease this year to an overall satisfaction rate of 67% in comparison to last year's 78%. This could be in part attributable to the unprecedented pressures staff have experience over the last two years with the pandemic. However, we must be mindful not to make assumptions and some significant work needs to take place to understand more fully the responses provided by staff

The 3 elements that received the lowest score were:

1. Make you feel a valued member of the organisation and have a sense of belonging (55%) a stark decrease to last year's 78%, some work needs to be undertaken to understand this further

2. Make you feel safe at work (62%) a reduction on last year's 82%

3. Make you feel proud to be a nurse / allied health professional (60%) Whilst this score keeps us in an AMBER position it must be noted that it's a worrying decrease of 22% from last year's 82%.

There is considerable activity in respect of promoting staff wellbeing within the Health Board however it must be acknowledged that those whom replied to this survey report a concerning reduction in feeling valued, safe and feeling less connected to their profession. This apparent loss of morale can potentially have an impact on the quality of care delivered to our patients.

3.3 Operational Audit findings

The operational audit findings have confirmed a top 3 key areas of good practice and areas where improvements could be made.

Top 3 areas of good practice

1. Ongoing successful implementation of the Welsh Nursing Care Record
2. Introduction of a standardised Virtual Visiting service
3. Implementation of Safe to Start across sites

Top 3 areas for improvement

1. **Safe Care** – How will we ensure good patient hydration.
2. **Dignified Care** – How will we improve the environment of care for patients and their families. For example, providing privacy for patients and their relatives during visiting.
3. **Individual Care** – How will we improve the assessment and care of patients experiencing delirium and those patients who have a diagnosed learning disability.

This learning will be shared within the Listening and Learning Forum, added to the Learning Repository and specific improvement requirements subject to further analysis, action planning and outcome monitoring. The planned Ward Assurance Programme will also provide assurance of 100% compliance with the health care standards for future confidence on the quality, safety and effectiveness of our services.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Patient care and staff experiences
Related Health and Care standard(s)	Safe Care
	All Health care standards affected

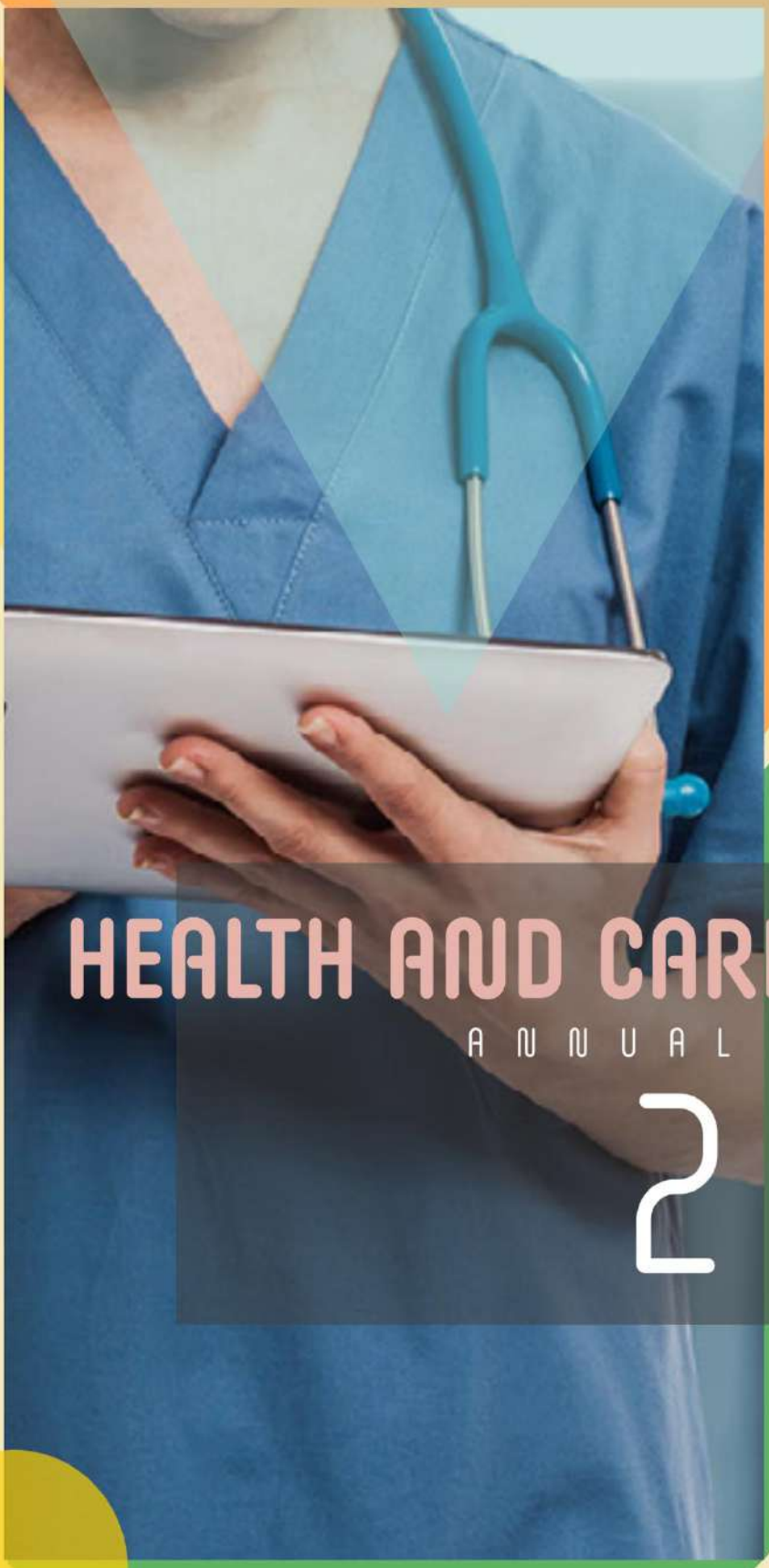
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

The Board is asked to:

- **NOTE** the position of the Health Board with regard to the Health & Care Standards
- **NOTE** the areas of good practice that have been reported within this paper and areas for improvement.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



HEALTH AND CARE STANDARDS

ANNUAL AUDIT REPORT

2022

Contents

Executive Summary

The findings from the 2022 Annual Health and Care Standards operational audits, patient survey and staff survey are presented in this report. The narrative of this report will focus on the areas of good practice identified by the operational audit, our patients, and our staff, as well as attempting to recognise and explain any areas of concerns that emerge from the findings. When making comparisons to year-on-year results, it must be recognised that there are limitations in making summative comparisons as the number of areas undertaking the audit has increased year on year.

Feedback from patients confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 90% albeit a slight decrease to the 93% achieved last year. They are also complimentary towards the attitude and behaviour of staff and nearly all patients (99%) who participated in this year's audit felt that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital.

There are two low scores this year, the first relating to the ability to speak Welsh to staff if needed with an overall patient satisfaction rate of 86% however it's heartening to see an increase on last year's 77%.

The second was related to getting enough sleep and rest, with a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continual challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

Feedback from staff remains low overall and sees a decrease this year to an overall satisfaction rate of 67% in comparison to last year's 78%.

The 3 elements that received the lowest score were:

1. Make you feel a valued member of the organisation and have a sense of belonging (55%) a stark decrease to last year's 78%, some work needs to be undertaken to understand this further

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3. Make you feel proud to be a nurse / allied health professional (60%) Whilst this score keeps us in an AMBER position it must be noted that it's a worrying decrease of 22% from last year's 82%. (See Staff and Resources section p.58)

The operational audit findings have confirmed a few key areas for improvement.

Top 3 areas of good practice

1. Implementation of Safe to Start across sites (p. 17)

2. Introduction of a standardised Virtual Visiting service (p.42)

3. Ongoing successful implementation of the Welsh Nursing Care Record (p. 47)

Top 3 areas for improvement

1. **Safe Care** – How can we ensure good patient hydration?

2. **Dignified Care** – How can we improve the environment of care of care for patients and their families. For example, providing privacy for patients and their relatives during visiting?

3. **Individual Care** – How can we improve the assessment and care of patients experiencing delirium and those patients who have a diagnosed learning disability?

The detailed results of the audit are presented in this report

"I would like to extend my gratitude to all the patients, carers and staff involved with the 2022 Health and Care Standards audit process and for providing assurance of where we are delivering excellent standards of care and for identifying where we need to focus our continuous quality improvement during 2023 and beyond."

Greg Dix

Executive Director of Nursing

Background

The Health and Care Standards provides the framework for how services are organised, managed, and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework against which standards of care can be measured and highlight focus areas for improvement.

The 22 Health and Care standards have been designed to fit with the seven quality themes which were developed through engagement with the public, patients, clinicians, and stakeholders.

The benefits of the engaging in the annual audit are outline below:

E*nables patients/carers to:*

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide.
- Have a voice in the quality of the care they receive.
- Be central to the design of new services to ensure they meet the requirements of our populations.

Empowers our workforce to:

- Make a difference and ensure ownership of their practice.
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern.
- Develop action plans to monitor change.

Enables organisations to:

- Have a mechanism to monitor/measure the quality of nursing care.
- Develop organisational policies and procedures.
- Identify key themes for improvement.
- Adopt a culture of openness and transparency with the quality standards.

Assessment

Compliance Matrix:

The agreed compliance matrix for all elements of the audit

Equal to or greater than 85%
51% to 84%
50% or less

Triangulation of data:

The results from this audit are a part of the wider picture of the services being provided in the organisation. This report will refer to information from other data sources as it helps us to triangulate the information available to us to determine if our organisation is doing the right thing well and providing care which is dignified, safe and effective to meet the needs of individuals.

Source of the data:

Individual question compliance – the source of the data in this report is taken from the Health & Care Monitoring System. The audit includes percentage as well as (Yes/No) type responses for the audit questions. In addition, for the staff and patient surveys a scale of 'Always', 'Usually', 'Sometimes' and 'Never' was introduced.

Interpreting the results

Overall Summary

The HCM audit involves asking patients about their experiences of care and reviewing delivery of care and the assessment of the operational application of the 22 HCSs. This included:

- Examination of patient records to measure compliance against the standards
- Observation of clinical practice
- Environmental assessment

It is important to note that some questions are not included in the operational audit and patient surveys for all areas.

Patient Experience Summary

"I was brought into hospital and was expected to die. Once I recovered my family and I could not be more impressed by the excellent nursing and consultant teams care afforded to me."

(Patient, Ward 5, RGH)

Understanding the experiences of patients, and their relatives/ carers is a key priority for the Health Board, and the HCS audit Patient survey is only **ONE** method by which we can monitor the standard of care provided and better understand the patient experience.

Between 1st April 2022 and 30th June 2022, a total of **646** patient experience surveys were completed across the participating clinical areas. This is compared with the **1,307** surveys completed in 2019. **444** (69%) were completed by the patient/service user, **62** (10%) by a friend/ family/carer and 54 (8%) completed with the support of a Healthcare Professional.

The results of this year's patient survey demonstrate that many patients were satisfied with the standards of care that they received from the Health Board and are complimentary regarding the professional and respectful behaviour of most of the staff. The survey also demonstrates that we do not get it right all the time and this feedback is essential to improve practice. When asked to rate their overall satisfaction with the care provided service users gave the organisation a rating of 90% enabling the Health Board to maintain a RAG rating of green. This is to be commended when considering that the surveys were undertaking during the height of the pandemic

Service User Question	Overall Rag % 2018	Overall Rag % 2019	Overall Rag % 2020/21	Overall Rag % 2022
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	**90%**	**89%**	**93%**	**90%**

Highlights for the Service User Experience

The outcome of this years' patient survey does not vary greatly from the findings of last year's survey. Patients are telling us that they are being treated with dignity and respect. Patients are telling us that staff are kind, helpful and polite. In addition, nearly all patients who responded feel safe.

However, patients are not always able to speak to staff in Welsh if needed. Patients are not having enough sleep and rest. The survey outcome acts as a reminder of what we are doing well most of the time and what we need to improve to make the experience of all service users better.

"Arrived nervous agitated, disoriented completely out of my comfort zone, but from the moment I was met in the car by Bethan who also kindly brought me a wheelchair. My perception began to change and so it went, still a scary time but literally every member of staff was superb, friendly helpful kind and empathetic still not a nice time when you have an operation, but certainty helps 100% by the people on the ward."

"getting sleep was an issue during the night some staff could of shown more consideration by lowering their voices, which of course woke the patients many times through the night and early hours of the morning. however I am very grateful to all the staff"

(Patient, Ward 12, RGH)

"Since my admission I have been treated with nothing more than respect, kindness and dignity off staff and the care received is second to none, should say all staff is A1+. When calling for help with something as rushed and busy as they are they are with you as quickly as possible and always polite and helpful."

(Patient, Ward 6, PCH)

"Everything has been brilliant; I was really nervous after so much scaremongering but honestly I can't fault how the hospital is being run."

(Patient, ACEU, RGH)

Staff Survey Summary

Between 1st October 2020 and 30th April 2021, a total of **249** staff surveys were completed across the participating clinical areas.

Staff Survey Question	Overall Rag % 2018	Overall Rag % 2019	Overall Rag % 2020/21	Overall Rag % 2022
Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with your organisation	**69%**	**70%**	**78%**	**67%**

Highlights for the Staff Survey

The outcome of this years' staff survey varies from the findings of last year's survey.

Staff are telling us that they can access up to date information which supports them in doing their job. Whilst ¾ of staff who responded feel that the organisation supports them in having the knowledge and skills to deliver a consistent standard of compassionate care. Furthermore 89% of staff feel that we put local citizens at the heart of everything we do.

It is however concerning to note that just over half of the staff surveyed do not feel a valued member of the organisation and do not have a sense of belonging. In addition, only 40% of our staff report being proud to be a nurse/allied healthcare professional.

In response to this feedback and other sources of information, we promoted and utilised our Values that were launched in October 2020. Values workshops are being delivered by local managers, heightening people's awareness of the importance of our values and its direct impact on patient outcomes. The Leadership Development program launched in March 2022 seeks to elicit behavioural change in our people managers across CTM, with elements of the program focussing on bestowing value on teams and upholding the tenets of compassionate leadership.

Introduction to our Values Sessions form part of nursing and overseas nursing induction events. Staff recognition through our Values based thank you cards / e-cards has been an effective vehicle for managers to thank staff who have upheld our Values.

Furthermore, a Values and Behaviours Health Check assessment tool has been successfully piloted, enabling the leader to identify specific areas of focus based on the shared experiences of their staff. Feeling valued is synonymous with feeling heard and the ability to provide feedback is essential.

Creating a culture of psychological safety is also a key priority as open and honest feedback cannot exist when people do not feel psychologically safe. The values health check reveals where psychological safety is not present enabling targeted support to be sensitively deployed.

In October 2022, our Senior Executive team embarked on a Reverse Mentoring program in partnership with our BAME Network colleagues. This is a strong signal to our staff that our senior leadership are open to learn more about staff experiences and for this to potentially influence their decision-making in the future.

Development of a CTM Nursing and Midwifery Strategy

The priorities of the Chief Nursing Officer have been developed to set the strategic direction for the Nursing and Midwifery professions. The specific areas of work are supported by and/or led by the Office of the Chief Nursing Officer at Welsh Government to aid delivery of **A Healthier Wales (2018*)***

The 5 overarching priorities which have been agreed are:

1. Leading the Professions
2. Workforce
3. Making the Professions Attractive
4. Improving Health and Social Care Outcomes
5. Professional Equity and Healthcare Equality

Work is underway to revise and develop a refreshed Nursing and Midwifery strategy that is underpinned by the above 5 priorities

Summary Operational Audit

The audit results demonstrate that the UHB achieved a level of compliance for the operational questions of > 85% in all 7 Health and Care Standards themes. The following table provides a breakdown of the operational scores and identifies that improvement has been made across 5 of the standards

Operational Audit Overall Theme Summary	**2017 %**	**2018 %**	**2019 %**	**2020/21 %**	**2022 %**
Staying Healthy	**69.0**	**78.1**	**87**	**86.5**	**88**
Safe Care	**92.1**	**94.0**	**93**	**96.3**	**96**
Effective Care	**85.4**	**88.9**	**91**	**93.1**	**91**
Dignified Care	**84.4**	**88.3**	**88**	**90.5**	**100**
Timely Care	**90.0**	**100**	**98**	**100**	**100**
Individual Care	**87.6**	**91.6**	**93**	**94.4**	**89**
Staff and Resources	**88.5**	**94.9**	**98**	**96.1**	**97**

Operational questions: Overall Standard Summary	**2017 RAG %**	**2018 RAG %**	**2019 RAG %**	**2020/21 RAG %**	**2022 RAG %**
Staying Healthy					
1.1 Health Promotion, Protection, and Improvement	68	78	87	87	88
Safe Care					
2.1 Managing Risk and Promoting Health and Safety	97	95	96	98	97
2.2 Preventing Pressure and Tissue Damage	93	98	95	96	98
2.3 Falls Prevention	91	94	96	97	98
2.4 Infection Prevention and Control (IPC) and Decontamination	97	98	98	98	99
2.5 Nutrition and Hydration	88	88	89	93	91

Operational questions: Overall Standard Summary		2017 RAG %	2018 RAG %	2019 RAG %	2020/21 RAG %	2022 RAG %
2.6	Medicines Management	95	98	95	98	99
2.7	Safeguarding Children and Safeguarding Adults at Risk	92	93	90	94	99
2.8	Blood Management	78	94	90	81	100
2.9	Medical Devices, Equipment and Diagnostic Systems	98	97	98	97	100
Effective Care						
3.1	Safe and Clinically Effective Care	80	89	93	93	87
3.2	Communicating Effectively	88	92	94	95	93
3.3	Quality Improvement, Research, and Innovation	89	75	98	92	100
3.4	Information Governance and Communications Technology	100	100	97	97	93
3.5	Record Keeping	85	89	89	93	92
Dignified Care						
4.1	Dignified Care	84	88	88	90	93
4.2	Patient Information	88	90	93	95	94
Timely Care						
5.1	Timely Access (paediatrics only)	90	100	98	100	100
Individual Care						
6.1	Planning Care to Promote Independence	87	91	92	94	86
6.2	Peoples Rights	100	100	99	98	100
6.3	Listening and Learning from Feedback	95	96	100	97	100
Staff and Resources						
7.1	Workforce	88	95	98	96	96

	Question	2017	2018	2019	2020 /21	2022
All excluding neonates, theatres, District Nursing	For this episode of care, is there evidence that the patient's smoking habits been assessed?	76%	81%	87%	89%	97%
All excluding neonates, theatres, District Nursing	For this episode of care, where the patient is identified as a smoker and wishes to stop smoking, is there evidence that they have been provided with information in relation to smoking cessation?	48%	64%	75%	68%	92%
All excluding neonates, theatres, District Nursing	For this episode of care, is there evidence that the patient's weight has been measured?	86%	89%	92%	91%	82%
All excluding neonates, theatres, District Nursing	For this episode of care is there documented evidence that where the patient's weight is unhealthy that they have been provided with information in relation to a healthy diet?	70%	73%	96%	91%	75%
All excluding neonates, theatres, District Nursing	For this episode of care has the patient's alcohol intake been assessed?	79%	81%	87%	92%	89%
All excluding neonates, theatres, District Nursing	Where the patient has an identified problem with their alcohol intake, is there an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	55%	67%	80%	79%	77%
All excluding neonates, theatres, District Nursing	For this episode of care has the patient's illicit substance use been assessed?	40%	59%	75%	72%	100%

	Question	2017	2018	2019	2020 /21	2022
All excluding neonates, theatres, District Nursing	Where the patient has an identified problem with illicit substance use, is there an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	43%	56%	57%	72%	75%
District Nursing	Is the community nursing service able to demonstrate that systems and processes are in place for patients and their carers to access appropriate health improvement opportunities within the community?	100%	100%	100%	100%	100%
District nursing	Is the community nursing service able to demonstrate that systems and processes are in place to achieve individual service user outcomes?	100%	100%	100%	100%	100%

The principle of staying healthy is to ensure that people are well informed to manage their own health and wellbeing.

People's health related behaviours are influenced by a range of factors including social, economic, and physical environment and mental well-being. By making it easier for people to adopt healthy behaviours we will reduce the burden of disease and help narrow the gap in health inequalities arising from long term conditions such as obesity, cancers, heart conditions, stroke, respiratory disease, and dementia.

This means:

- Rapidly reducing smoking prevalence
- Increasing physical activity and promoting healthy weight
- Preventing harm from a range of behaviours including substance use

The questions for this standard focus on promoting these healthy behaviours.

Smoking Reduction

Of the records reviewed a compliance score of 97% was achieved for the assessment of patients smoking habits, compared to 89% in 2020/21.

Notable Good Practice

- The health board's smoking cessation service offers free and friendly support to staff, inpatients and outpatients who wish to stop smoking and would benefit from one-to-one support. We have Over **200 'No Smoking Champions'** now located on all sites and in most wards, departments, and units.

- The Cardiovascular Risk Reduction Health Check Programme that aims to reduce premature mortality from CVD, targeting more socio-economically deprived areas where prevalence of CVD is highest.

Illicit Substances

This year we have seen a significant increase in the assessment of a patient's illicit substance use from 72% to 100% moving us from an AMBER position to GREEN.

Promoting Healthy Weight

Whilst it's disheartening to see that the records demonstrated a 9% decrease in compliance in the measuring of patients' weight (82% from 91% last year), the comments made by staff in the audit suggest that there were several patients who were too unwell to be weighed, in these instances staff should record an answer of N/A.

Notable Good Practice

The catering team in Cwm Taf Morgannwg UHB have been developing several initiatives to help patients, staff, and the wider population to make the healthier choice. Working with the dietitians, they introduced a range of healthier options. The healthier option meal deal runs Monday to Friday and includes two of your recommended five a day of fruit and vegetables.

In addition, the Bar Barista outlets offering coffees and teas that are only served with semi-skimmed or skimmed milk. As well as providing tasty, healthier, meal deal options. The restaurants at Prince Charles and Royal Glamorgan hospitals now offer a fresh, delicious salad bar.

The catering team have also developed a scheme to encourage patients, relatives, service users and staff to eat more fruit. The Fruit Loyalty Card scheme has been launched across Cwm Taf Morgannwg UHB – buy six pieces of fruit and get one free.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	Do all patients wear an identification band which states their first and last name, date of birth and NHS number?	94%	98%	99%	99%	100%
ALL	Is the patient's identity checked visually and verbally prior to undertaking a procedure?	96%	99%	99%	100%	100%
ALL except Neonates, OPD, Theatres	For this episode of care, is there documented evidence that the patient has an up-to-date manual handling risk assessment?	88%	89%	96%	97%	99%
ALL Except Neonates, OPD, Theatres	For this episode of care, where the patient has an identified manual handling risk, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	83%	87%	93%	97%	98%
ALL except Neonates, OPD	If a patient has been assessed as requiring bed rails, is there an up-to-date risk assessment in place?	87%	92%	95%	96%	96%
ALL	Within the clinical area, are all fire restraint doors free from obstruction or closed if not automatic self-closing?	95%	98%	94%	99%	98%

	Question	2017	2018	2019	2020 /21	2022
Paeds only	Is the Child/Young Person in an age-appropriate bed with cot sides/bed rails in situ?	100%	100%	100%	100%	100%
Endoscopy & theatres only	Is there evidence of the team brief and de brief being undertaken?	100%	100%	100%	100%	100%
Endoscopy & theatres only	Is there evidence that the department is compliant with the WHO checklist?	100%	100%	100%	100%	100%

The overall score for this standard remains consistently high across annual audits, demonstrating that the safety and welfare of our patients is taken seriously.

Patient Perspective: Many patients felt that they were made to feel safe whilst in hospital with 99% of the patients responding positively to this question.

Introducing Safe to Start

A new innovative approach to managing patient flow has been launched. The aim of Safe 2 Start is to bring together all ward managers to discuss staffing, capacity, quality, and safety across the hospital site in order to ensure all wards and departments are safe to start the day.

The daily meetings are a way for nurses and departments to express any concerns and to ensure the hospital can deal with the current pressures by ensuring that all wards are staff and working to full capacity and if not, for staff to be mobilised across the hospital to support each other.

The project has successfully been able to support numerous wards that were not safe to start due to staffing constraints and support the extremely busy emergency department to help cut long ambulance delays and bed waits through the identification of ward capacity and planned patient movement.

Embedding the Safe 2 Start concept was key to the delivery of improvement and change for the teams. We have created a structured approach for the teams to describe the demands on their wards, but also to understand the demands other areas are also seeing. In exposing all

ward areas to this, we have now seen a cultural shift where wards are owning and sharing the response to try and minimise and mitigate the risk that patients are experiencing on site.

The safety of our patients is the key priority across the Health Board and this new approach places the patient truly at the centre of all hospital decisions.

'Safe 2 Start' daily meetings are now in place across all community and acute hospitals in CTM UHB.

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates	For this episode of care, is there documented evidence that the patient's skin condition has been assessed and discussed with the patient or advocate?	90%	97%	95%	98%	99%
ALL except neonates	For this episode of care, where the patient has been identified as requiring assistance with looking after their skin, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	98%	98%	95%	94%	98%

Standard 2.2 Preventing Pressure and Tissue Damage

Of the patients reviewed, 99% of the patients had evidence that their skin condition had been assessed and discussed with them or their advocate an increase of 1% compared to last year.

Of the patients who were identified as requiring assistance with looking after their skin, 98% had evidence that they had an up-to-date care plan, which was being implemented, evaluated and had been reviewed within the agreed timescale. An increase from last year's 94%.

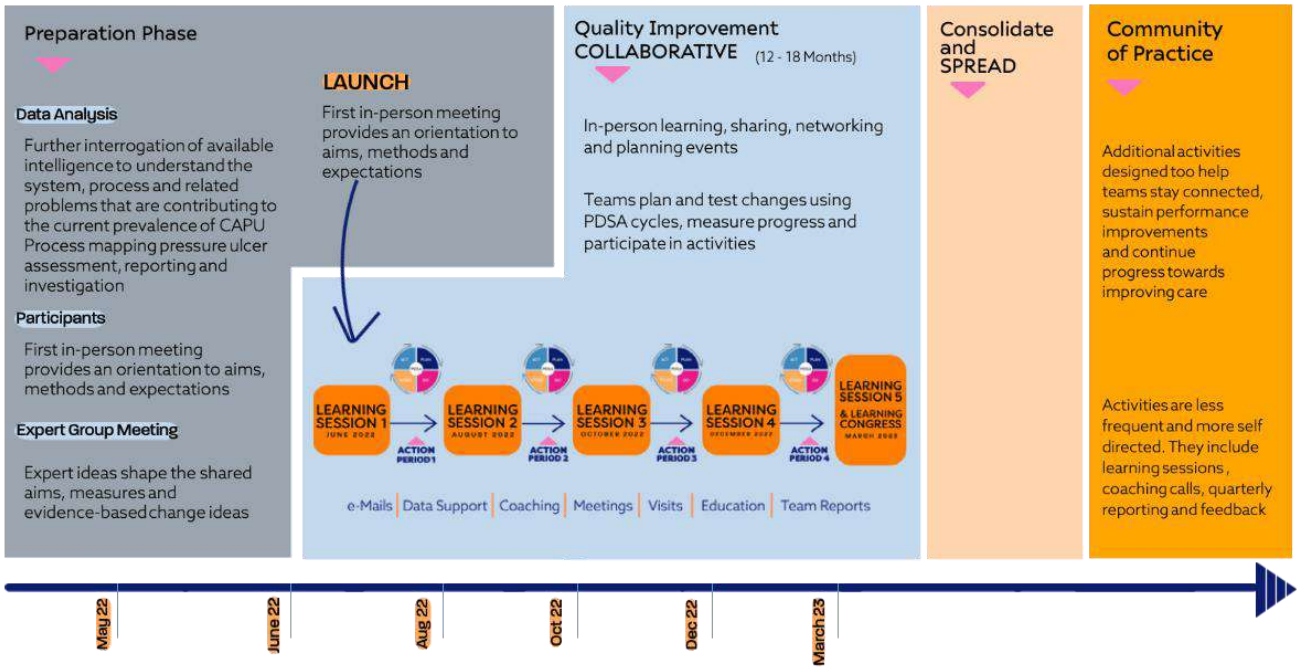
Avoidable Community Acquired Pressure Ulcer Improvement Collaborative Program

For the most part pressure ulcers are avoidable, and their incidence may be related to several system factors such as poor in-hospital flow and over-burden of nurses. When one arises it is painful, debilitating and can have life threatening and devastating impact on patients and their families

The Pressure Ulcer Prevention Collaborative program is a quality improvement initiative designed to support healthcare teams to reduce the incidence of avoidable pressure ulcers in the community.

The primary aim of this initiative is to reduce the number of **avoidable** pressure ulcers across the collaborative areas. A secondary aim is to increase the capacity and capability of frontline clinical teams to improve the care they deliver using quality improvement methods.

This proven methodology enables teams to become part of an active learning community learning from other teams and recognised experts around a chosen topic or focused set of objectives. The collaborative model provides a framework for improvement and sets a momentum and pace for executing sustainable change. The collaborative will run for 12-18 months following the methodology promoted by the IHI (Fig.1).

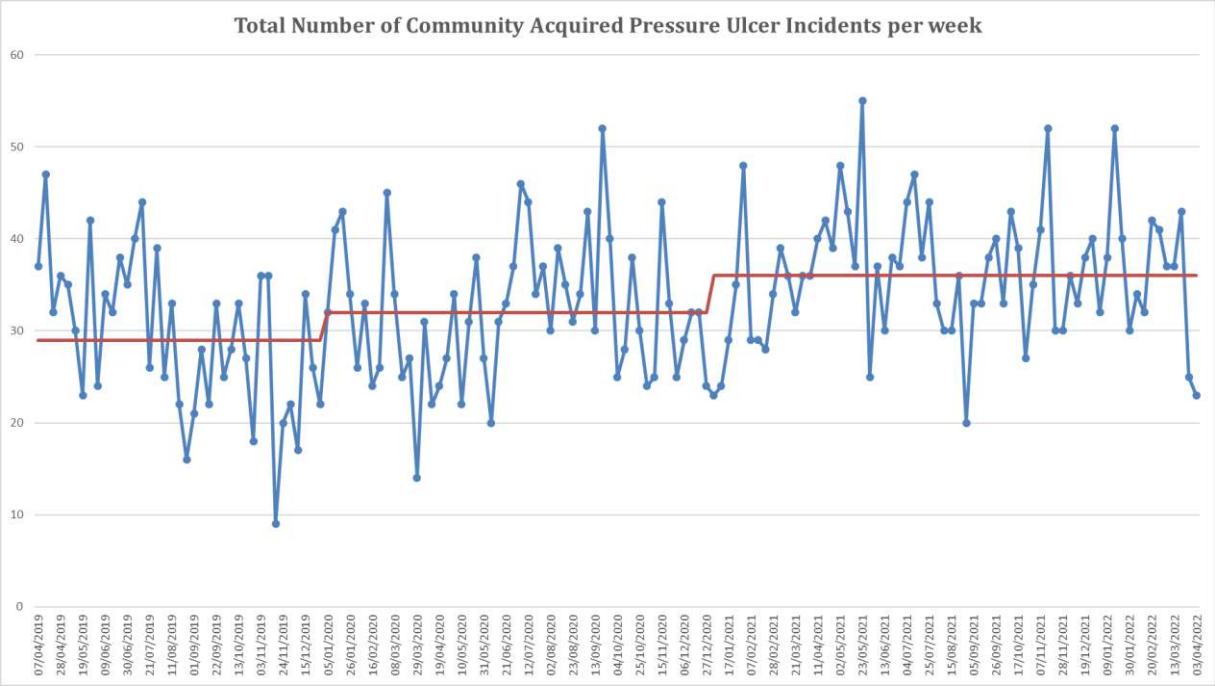


(Fig.1).

Discovery Phase: Understanding the problem

Further interrogation of available intelligence has helped us to start to understand the system, process and related problems that are contributing to the current prevalence of CAPU

The run chart below shows a steady increase in the total community acquired pressure ulcers over the last 3 years



The major themes for action cycles will be identified through a series of learning sessions with periods of action and facilitation between them to promote and produce sustainable change. Teams will be supported to take local ownership for improvement and to build processes of care that are reliable enough to achieve the goal. (*See below*)

Key Milestone dates agreed to date

1. **May 19th** – Inaugural meeting of Expert Faculty
2. **29th June** – Collaborative Launch Event
3. **16th September** - First Learning Session

Pressure Ulcer Investigation Panels

To support a culture of learning and improvement we have introduced a fortnightly programme of investigation panels where we scrutinise all pressure ulcers incidents. The panels consist of a head of nursing, tissue viability nurse and a safety improvement manager.

The senior nurse, ward manager and ward staff attend the panels and present their cases using the patients' nursing records which are reviewed to help identify any areas for improvement and learning.

Where an outcome of avoidable harm has been made which would indicate that there have been missed opportunities, a referral to safeguarding is made. An improvement plan which aims to address all missed opportunities with a view to improve care, patient experience and outcomes along with a proposed percentage reduction of pressure ulcer incidents at clinical level is developed and monitored for progress.

The benefits recently identified through this process include:

- the importance of using the correct equipment immediately
- escalation of any difficulties in obtaining equipment
- actual repositioning of patients (and not moving the patient back to the original position),
- use of knee brakes,
- use of cushions when a patient sits out

Patient Perspective:

"During your stay, were you given help and advice on how to prevent damage to your skin?"

93% of the patients answered positively to this. This is an increase on last year's 86%

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates & OPD	For this episode of care, is there documented evidence the patient's mobility has been assessed and discussed with the patient or advocate?	96%	97%	96%	99%	99%
ALL except neonates & OPD	For this episode of care, where the patient has been identified as requiring support and/or assistance with mobility, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	91%	91%	96%	97%	98%
ALL except maternity neonates, paediatrics, OPD, theatres	For this episode of care, is there documented evidence the patient's risk of falls has been assessed and discussed?	91%	95%	96%	98%	99%
ALL except maternity neonates, paediatrics, OPD, theatres	For this episode of care, where the patient has been identified as being at risk of falls, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	84%	94%	96%	93%	97%

Patient safety is a priority for us and reducing the incidence of in-patient falls remains a challenge. Whilst we continue to test and develop initiatives to help us tackle this problem. Being in hospital does not mean we can completely prevent falls, but we are committed as a University Health Board to reducing the number of avoidable falls and any injuries that may occur as a result.

Of the patient records reviewed, 99% of the patients had documented evidence that the patient's mobility had been assessed and discussed. Of those patients identified as requiring support and/or assistance with mobility, 98% had evidence of an up-to-date plan of care, which was being implemented and evaluated and had been reviewed within the agreed timescale, a slightly improved position from last year

This year we have seen an increased compliance with our falls risk assessment and care planning. Of the patient records reviewed, 99% of the patients had documented evidence that the patient's risk of falls had been assessed and discussed. Of those patients identified as being at risk of falls, 97% had evidence of an up-to-date plan of care, which was being implemented and evaluated and had been reviewed within the agreed timescale (up 4% on last year's position).

The Quality Improvement team, central patient safety team and the corporate nursing team continue to support the Integrated Locality teams in a targeted approach to reducing inpatient falls. However, it has been recognised there is a need for a CTMUHB wide Falls Prevention and Management Group to be established (please see section 2.3 for further details).

Falls Scrutiny Panels

Hospital sites and community nursing have regular, robust multidisciplinary team falls panels, which include representation from a medic, physiotherapist, occupational therapist, pharmacist and nurse.

All Wales Falls Investigation Tool

The Delivery Unit and Once for Wales Datix team have confirmed plans for an All Wales Falls Investigation Tool to be launched, which will align with a similar tool which in in place for pressure damage investigation. The introduction of a robust investigation tool which will be used across all ILG's will aid consistency and support a clear outcome from panel, with agreed level of harm and whether the fall was avoidable or unavoidable.

CTMUHB wide Falls Prevention and Management Group

This group will support the Quality & Safety Committee's role and function in its responsibility for ensuring the quality and safety of healthcare in relation to the prevention, assessment and management of falls in line with Health Care Standard 2.2.

The terms of reference for this multidisciplinary group have been drafted and an initial meeting took place in June 2022.

The group will:

- Provide a means for the multidisciplinary representation of the Clinical Service Groups, patient safety team (s), corporate nursing team, safeguarding and quality improvement team to work to develop a robust quality improvement programme**,** which will be a vehicle for reducing the incidence of avoidable harm from falls.

- Monitor progress via an annual plan of work, which will include the creation and launch of CTMUHB Falls Strategy, the monitoring of compliance with NICE guidance and any national audits (e.g. fracture neck of femur audits), and the review of the CTMUHB Inpatient falls policy**.**

- Monitor all aspects of the "Putting Things Right policy" and any Safeguarding concerns as applicable to a patient who has sustained a slip, trip or fall within our health care setting; this will allow the patient experience and any financial penalties in terms of redress and claims to feature at the forefront of any improvement work

Whilst there is a need to focus on inpatient falls, it is recognised that there is an urgent need to work with our partner agencies for example Welsh Ambulance Service, Fire service and third sector teams to reduce the number of slips, trips, falls that occur in our community settings which often result in admission to hospital. This will feature heavily in the proposed CTMUHB Falls Strategy and form part of the Falls Prevention and Management Group agenda.

This Falls Prevention and Management Group will assist the Quality and Safety Committee in measuring the success of quality improvement goals by sharing learning and best practice and identifying trends which should be taken into account in improving and escalating risks.

The progress of the "Falls Prevention and Management Group" will be evaluated at their monthly meetings and report on a quarterly basis to the Quality & Safety Committee.

	Question	2017	2018	2019	2020 /21	2022
ALL	Are staff able to give examples of the correct procedure for infection control?	100%	98%	100%	100%	98%
ALL except maternity, peads, LD, OPD,	Are staff able to give examples of the correct procedure for isolating patients?	98%	99%	99%	100%	100%
ALL Except maternity, neonates, OPD,	Are all patients given the opportunity to wash or cleanse their hands with hand wipes prior to eating food?	92%	97%	94%	95%	100%

We achieved a green RAG rating in all three of the infection prevention & control (IPC) and decontamination questions.

The IPC work programme remains a priority for the health board and the IPC committee aims to ensure that the Board receive assurance that safe and effective policies for Infection Prevention and Control are in place. This has been under pressure in the last 2/3 years with the frequently changing guidance for managing the COVID 19 pandemic

Hand Hygiene:

100 % of the areas confirmed that *all patients are given the opportunity to wash or cleanse their hands with hand wipes prior to eating food (up 5%)*.

The annual audit does not include a general question on hand hygiene, but compliance is monitored on an ongoing basis using the Care Indicator module of the Health & Care Monitoring System. The expectation is that the audit is undertaken for a minimum period of 20 minutes (or until at least 10 opportunities are observed) across all clinical areas at least once a month and the auditor would observe if all staff disciplines working in patient areas have adequately decontaminated their hands, in accordance with the requirements of the WHO 5 moments.

The target compliance for this indicator is 95%. Several wards consistently achieve 100%, however, the result can be influenced by the time of day the audit is undertaken, the staff on the ward at the time and the number of opportunities for decontamination.

Spot audits by the IP&C team to triangulate the results obtained by the teams themselves demonstrated that there was still work to do to ensure consistency in both the audit process and the hand hygiene required.

The IPC Nurses perform an IPC investigation for other preventable bacteraemia infections, for example urinary catheters. This is shared with the Ward/ District Nursing Team/ Bowel and Bladder team to investigate further and for sharing of lessons learned. This process is currently undertaken on paper, and the aim is to introduce an "IPC huddle" for these also.

	Question	2017	2018	2019	2020 /21	2022
ALL except Maternity, neonates, LD, theatres	Prior to eating, are patients that require help, assisted into a suitable position?	98%	100%	100%	100%	100%
ALL except Maternity, neonates, LD, theatres	Prior to meal service, are bed tables and communal areas cleared and tidied prior to eating?	93%	97%	100%	98%	100%
ALL except Maternity, neonates, LD, theatres	Are patients' meals placed within easy reach?	100%	100%	100%	100%	100%
Inpatient, paeds, MH & LD only	Is there evidence that the systems in place to enable staff to identify patients with special eating and drinking requirements are being implemented and their effectiveness evaluated?	96%	96%	97%	100%	100%
Inpatient, maternity MH, Day Units only	Are water jugs changed 3 times daily?	39%	35%	45%	85%	56%
ALL except Maternity, neonates, MH, theatres	Is fresh drinking water available for patients?	100%	100%	100%	100%	100%
ALL except neonates, MH, OPD, endoscopy, theatres	Are drinking water jugs and glasses within the patient's reach?	97%	100%	97%	99%	100%
Inpatient, ED, Maternity, MH & LD only	During a 24-hour period, are a minimum of 7 beverage rounds are carried out within your clinical area?	48%	56%	48%	70%	59%

	Question	2017	2018	2019	2020 /21	2022
Inpatient, ED, paeds, MH & LD only	Does a Registered Nurse co-ordinate every mealtime?	83%	76%	88%	85%	83%
Inpatient, ED, MH & LD only	Is there evidence that all members of the nursing team are engaged in the mealtime service?	98%	85%	97%	96%	97%
ALL except neonates, OPD, theatres	Is a range of snacks available for patients who have missed a meal or who are hungry between meals?	92%	87%	87%	92%	100%
Inpatient, ED, paeds, MH & LD, endoscopy only	Family/friends can assist at mealtimes?	100%	100%	100%	84%	97%

The Health Board is committed to providing and promoting good nutritional care, as nutrition and hydration are vital aspects of patient care. Early detection and management of nutritional risk across community and secondary care promotes well-being and supports better patient outcomes and improved recovery rates.

The 'All Wales Nutrition and Catering Standards for Food and Fluid for Hospital Inpatients' provides a framework for the nutrition and hydration needs of our patients which includes:

- The provision of nutritious meals that meet all patient's nutritional, therapeutic and cultural needs, and preferences.
- Easy availability of snacks at ward level.
- 'Protecting mealtimes' and promoting mealtimes as a crucial part of the treatment process.
- Supporting all patients to meet their nutritional needs; and
- Early enhanced nutrition for patients who are unable to meet their requirements.

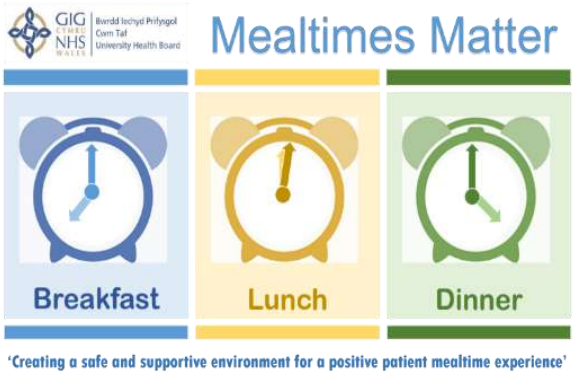
The audit includes several questions around mealtimes and the provision of beverages. We have a consistent low score relating to the changing of water jugs 3 times a day. When looking at the staff comments in the audit they refer to jugs being changed twice a day and then as required.

Conversely, we are scoring 100% for the question relating to the availability of fresh drinking water for patients. In addition, we continue to score low

with the question relating to beverage rounds. Some work needs to be done to understand why this is the case

We need to do some work to understand staff's perception of the three questions to ensure we are getting an accurate reflection of what is happening in clinical practice.

Registered Nurses have a professional accountability for ensuring patients receive appropriate food and assistance to eat where required, monitoring their food & fluid intake in accordance with the All-Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients. Whilst there is an improvement in members of the nursing team engaging in mealtimes there is still some work to be done in improving the co-ordination of mealtimes by a registered nurse.



As a part of identifying priorities for 2020/21 we pledged to redesign our current protected mealtime's policy so that it is more conducive to a supported positive mealtime experience for patients.

A meal does not start with the appearance of food on a table, and it does not end with the last bite. It encompasses various aspects including the preparation of food, the anticipation of a meal, the environment in which it's eaten, the conversation during the meal, eating with dignity, the end of the meal and cleaning up. It is important to realize that an individual's experience around mealtimes extends far beyond the food.

Activities occurring before and after meals, menu choices and how they are offered, how the meal is introduced and the social interactions during mealtimes all need to be actively considered. Each one of these parts affects the individual's overall mealtime experience and consequently their nutritional status. The Patient Mealtime Procedure aims to improve the mealtime experience by:

- Allowing patients to eat meals without unnecessary interruption by limiting non-essential clinical ward-based activities and non-essential patient transfers.

- Ensuring that all patients receive a meal that meets their personal preferences and any specialist dietary requirements, such as modified textured food.

- Supporting clinical staff to prioritise mealtimes.

- Recognising and supporting the social aspects of eating.

- Providing an environment conducive to eating.

- Offering assistance with eating and drinking to those requiring it.

When this procedure is implemented fully it will help in the recovery of our patients empowering nursing and catering staff to provide effective nutritional care. Positive and encouraging behaviour when handling and serving food is essential in '*Creating a safe and supportive environment for a positive patient mealtime experience'*

Using a 'Speaking Mug' to encourage vulnerable patients to drink more

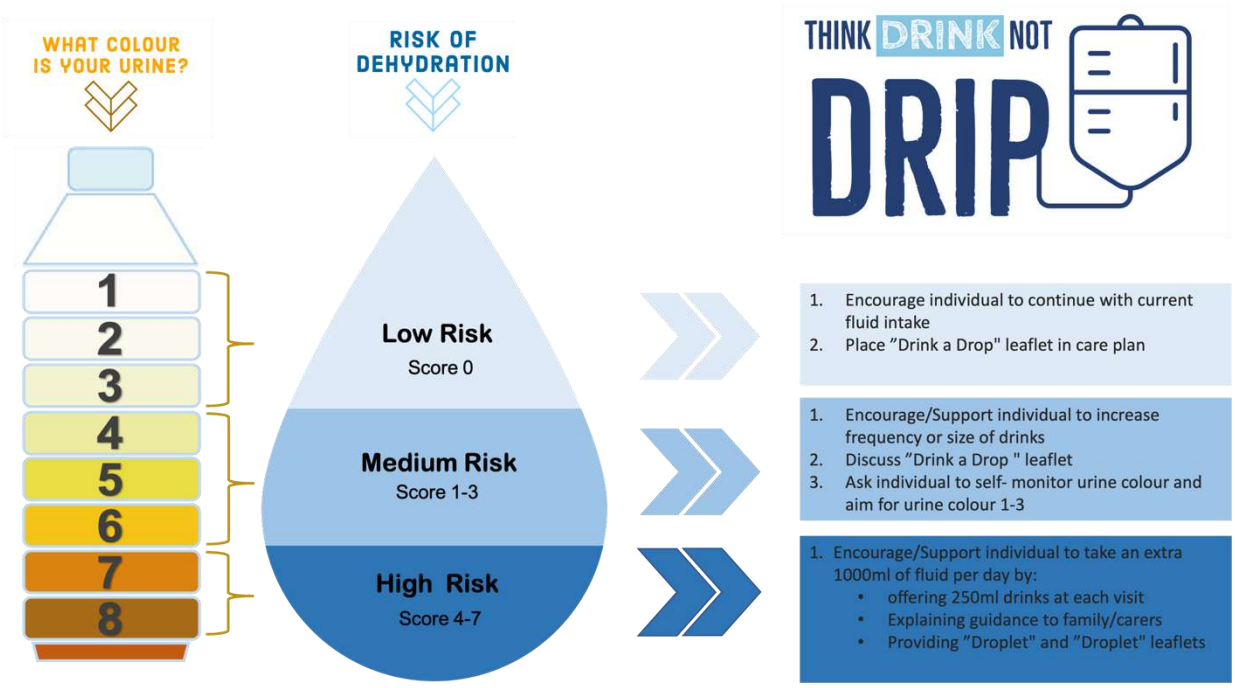
We have tested the use of Droplet® in a bid to see if it helped increase the amount of fluid drunk by our vulnerable patients in hospital. Droplet® is the first hydration aid to tackle dehydration by simultaneously supporting both individuals and carers. Droplet® helps those who need additional support or encouragement to stay hydrated.

We have been testing this across several wards within the Health Board and have seen an average increase of **43%** in the average amount of fluid drunk - that's equivalent to just over 4 8oz glasses of fluid per patient. We need to undertake further tests of change before committing to purchasing further units for the health board

Furthermore Droplet® is one intervention being used in a research study referred to as PARCHED (Prompting And encouRaging Community Hydration through Education). The study aims to test the possibility that education and/or Droplet® can help reduce ill-health in a catheterised community-dwelling population through empowering district nurses to

improve hydration. The study was due to take place over a two-year period but has stalled due to the impact and restrictions imposed by COVID

Building on this work we have been looking at understanding some of the behaviours that might be affecting patient and staffs understanding of the importance of oral hydration. We have developed a poster to raise awareness and need to test this in practice and measure the impact of any behaviour change



Further work is needed to understand the challenges around oral hydration in hospitals

Patient Perspective: The survey scores indicate that most patients are happy with the provision of food and drink and that they are provided with support when required. Overall satisfaction has remained above 97% for all questions.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	Are all medication charts completed with the following information: patient demographics and allergies and it is clear whether there is more than one medication chart?	87%	95%	90%	100%	98%
ALL	Is the patient's identity checked visually and verbally prior to giving medication?	96%	99%	99%	99%	100%
ALL	Are all drug cupboards/trolleys locked and secure as per local policy?	93%	100%	100%	98%	98%
All except neonates & OPD	Has the nurse witnessed the patient taking the medication given to them?	100%	99%	97%	97%	100%
All except neonates & OPD	Is there evidence that medication is taken in a timely manner and is not left on lockers/around patient beds?	100%	100%	91%	98%	100%
Neonates & Paeds	Are all medications checked by two qualified nurses?	100%	100%	100%	100%	100%
District Nursing	Is the community nursing service able to demonstrate clearly defined processes including policies and procedures for obtaining and storing medication and for medicines management?	100%	100%	100%	100%	100%

Of the medication charts reviewed, 98% of the charts had the patient demographics and allergies documented on them and it was clear whether there was more than one medication chart completed, however this was a slightly worsened position than last year.

Of those patients observed having medication, 100% of the patients had their identity checked visually and verbally prior to giving medication an improved position from last year

98% of the areas participating in the audit confirmed that all drug cupboards/trolleys locked and secure as per local policy. Where areas were not compliant this was addressed immediately to ensure compliance. Many high-risk areas such as Emergency departments and Theatres are using Mediwell electronic medication dispensary systems. This ensure restricted access and is only accessible with personal identification log in details or fingerprints so no need for keys. Further work is being undertaken with pharmacy to ensure the policy and audit questions relate back to clinical practice in line with local policies.

Additional data can be found in the visual below from the Controlled Drugs Audit. This is conducted monthly as part of the wider point review audits.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Insight detail

Generated on 25th July 2022

Controlled drug medicines and storage audit

Insight detail	Compliance over last 6 periods						Current	Improvement	Overdue actions
Audit	98.1%	97.8%	97.8%	98.2%	99.2%	95.2%	98.3%	▼	4

Low scoring Qs	Compliance over last 6 periods						Current	Improvement	Overdue actions
Q4. Is the nurse in charge clearly identifie? (Eg on duty, on patient at a glance board etc.)	100.0%	100.0%	100.0%	87.5%	100.0%	95.1%	100.0%	▼	
Q6.1. Does the nurse in charge know who has the keys?	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	▼	
Q6.2. Was the person holding the keys a registrant/ ODP?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	➤	
Q10. Are the controlled drug keys separate from the main bunch of keys?	88.9%	100.0%	100.0%	100.0%	100.0%	88.1%	96.2%	➤	
Q18. The receiving person is NOT the same as the person who ordered the CDs?	88.9%	100.0%	85.7%	100.0%	100.0%	80.0%	95.8%	▼	0
Q20. Is there a record that ward CD stocks checked at least once in 24 hours and daily balances checked by two Registrants?	88.9%	75.0%	87.5%	87.5%	87.5%	69.4%	86.4%	▼	2
Q26. Are transfers of CD's to a new page recorded appropriately?	100.0%	100.0%	100.0%	100.0%	88.9%	96.7%	100.0%	▼	
Q27. • Date…	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	▲	

AMaT

Insight detail

	Question	2017	2018	2019	2020 /21	2022
ALL	Can staff demonstrate they know the procedure if a safeguarding concern is identified?	93%	95%	97%	98%	99%
ALL	Can staff demonstrate they know the safeguarding lead nurse for their area and how to contact them?	100%	100%	100%	100%	100%

Safeguarding and Public Protection training is vital in protecting our service users, their families, and our communities from harm. Safeguarding Children and Safeguarding Adult training is identified as two of the Mandatory training requirements in the NHS UK Core Skills Training Framework. All staff must have achieved the competency level required to their role in relation to children, young people or adults who are at risk.

The corporate team ensures that appropriate training is available for all staff to ensure that they are confident in safeguarding people. Staff will achieve the competency they require through safeguarding training and dissemination of learning as well as research from Practice Reviews and Multi Agency Practitioner Forums.

There are four key dimensions of Safeguarding Training:

- Adults at Risk
- Child at Risk
- Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
- DoLS/MCA

The safeguarding team participate in training development and delivery and host several training sessions on Health Board sites to facilitate accessibility for staff. Bespoke training has also been provided by the corporate team to individual staff groups on request where a specific need has been identified.

The Safeguarding Team has undertaken several events and exercises in 2021/22 to embed safeguarding culture and awareness across the health

board including a greater presence on social media and activities during Regional Safeguarding Week. Changes have and will be made to the delivery of safeguarding training for the Health Board for greater accessibility.

Safeguarding training for Adults and Children will be available both virtually and face to face from January 2023. Bespoke level 3 training for adults and children will also be offered to areas of low compliance, where there is an importance to ensure that staff have an appropriate level of knowledge and skills.

The Cwm Taf Multi Agency Safeguarding Hub (MASH) sits within the structure of the Safeguarding Board and acts as the single point of contact for all professionals to report safeguarding concerns across Merthyr Tydfil, Rhondda Cynon Taf and Bridgend. MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a more timely and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved.

Cwm Taf Morgannwg currently has two MASHs, one based at Pontypridd Police Station and the other in Bridgend. The success of these Hubs has been developed through a phased co-location of key statutory partners, including the police, health, probation, education, and local authorities. Cwm Taf MASH is the 'front door' for all adult and child safeguarding referrals, including high risk domestic abuse.

The MASH team are available 24 hours day 7 days per week inclusive of the Emergency Duty Team team for out of core hours 9-5pm. Within Health, there are four Public Protection Nurses based in MASH to provide support and guidance to all health colleagues, each allocated to a specific ILG and identified clinical areas for continuity and robust information sharing, they role is pivotal in the facilitate the delivery of the safeguarding agenda across CTM. Our Safeguarding and Public Protection intranet site provides all details for contact numbers for both MASH and the corporate team, relevant email address and information for safeguarding topics. This information is further shared in training and via all communication channels within our governance structures.

The team share learning from adult and child practice reviews and other relevant reviews or investigations. Whilst this is predominantly achieved through the Safeguarding Operational Groups and Quality, Safety and Patient Experience Groups. Further work is required to ensure learning is repeatedly shared effectively throughout the Health Board. Collaborative working with both primary and secondary care will identify further opportunities to provide early help and support with regards to community wellbeing. All Safeguarding policies will be reviewed and updated to reflect the risks and vulnerabilities identified within our communities.

Improved use of SharePoint, social media and comms will improve the ability to repeatedly share learning and key safeguarding messages across the Health Board and communities. Planned audits throughout several services will measure outcomes and evidence if shared learning and changes are effective.

A total of 3,027 safeguarding referrals were submitted by Health and recorded by Cwm Taf Morgannwg MASH for 2021-22. This is inclusive of 2,481 child at risk concerns, 438 adult at risk referrals and 108 related professional concerns relating to staff employed by CTM UHB. This is a reflection on staff awareness in identifying safeguarding concerns and reporting appropriately as guided by the Wales Safeguarding Procedures. The aim of the Safeguarding team is to continue raising awareness and supporting staff to be confident and competent to embed safeguarding within their daily roles and engage within the Safeguarding and Public Protection processes.

Deprivation of Liberty Safeguards and Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS)

Since April 2009 the Mental Capacity Act has been supplemented by the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people who lack the capacity to consent to treatment or care in a hospital or a care home, where the care might involve depriving the person of their liberty. There is a supplementary Code of Practice for the Deprivation of Liberty Safeguards which explains how to identify when a person might be being deprived of their liberty, how deprivations might be avoided and, where necessary and in a person's best interests, how a deprivation of liberty can be authorised.

A DoLS authorisation application will need to be made for any patient where:

- You believe the patient lacks capacity to validly consent to being in hospital for care and treatment.
- The patient is under continuous supervision and control.
- The patient is not free to leave; and
- These circumstances apply for a not insignificant period of time.

(For more Information see Page 39)

	Question	2017	2018	2019	2020 /21	2022
Neonates only	All staff involved in direct nursing care should have been trained in Blood Transfusion Administration	78%	100%	100%	95%	100%

Overall results for this question show an improved position in compliance of the staff involved in direct nursing care have been trained in blood transfusion administration of 100% a 5% increase on last year.

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates	Are any Manual Handling aids and slings regularly checked for wear and tear?	98%	98%	97%	95%	97%
ALL	Is all equipment used up to date with maintenance and calibration?	99%	96%	99%	99%	97%

The high rating for Standard 2.9 Medical Devices, Equipment and Diagnostics Services shows consistent green RAG rating, this demonstrates that ward staff are proactive in ensuring that equipment is checked and maintained regularly.

	Question	2017	2018	2019	2020 /21	2022
Inpatient areas, emergency departments, mental health and learning disabilities	For this episode of care, where there is doubt about the patients' capacity to make decisions, is there documented evidence that an assessment of capacity has been undertaken?	87%	86%	96%	94%	90%
Inpatient areas, emergency departments, mental health and learning disabilities	Where it has been identified that the patient lacks capacity, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	60%	84%	90%	90%	84%
Inpatient areas, emergency departments, mental health and learning disabilities	For this episode of care, is there documented evidence that where a patient's liberty has been restricted, that a Deprivation of Liberty Safeguard application has been made?	92%	96%	93%	97%	87%
Inpatient areas, emergency departments, mental health and learning disabilities	Where it has been identified that the patient's liberty is being restricted/deprived, is there evidence of an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	80%	97%	84%	90%	76%
Paeds	Are staff able to demonstrate they are aware of the Paediatric Best Practice" guidelines and how to access this document?	100%	90%	100%	100%	100%

Mental Capacity: The Mental Capacity Act (MCA) 2005 has been in force since October 2007 and places the person, who may lack capacity, at the centre of care. In the healthcare context, every adult with mental capacity has the right to decide whether to accept treatment, even if a refusal may risk permanent injury to health or even lead to premature death. If

somebody lacks mental capacity, they should not be deprived of treatment that they need just because they cannot make the decision.

Deprivation of Liberty Safeguards (DoLS): Since April 2009 the Mental Capacity Act has been supplemented by the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people who lack the capacity to consent to treatment or care in a hospital or a care home, where the care might involve depriving the person of their liberty. There is a supplementary Code of Practice for the Deprivation of Liberty Safeguards which explains how to identify when a person might be being deprived of their liberty, how deprivations might be avoided and, where necessary and in a person's best interests, how a deprivation of liberty can be authorised.

A DoLS authorisation application will need to be made for any patient where:

- It is believed that the patient lacks capacity to validly consent to being in hospital for care and treatment.
- The patient is under continuous supervision and control.
- The patient is not free to leave; and
- These circumstances apply for a not insignificant period of time.

The UHB has received investment from Welsh Government to improve the provision of the MCA and DoLS Service in preparation for the Liberty Protection Safeguards (LPS) implementation.

The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.

Due to Covid 19 the implementation of the LPS has been delayed by a year with an unofficial implementation date of Spring 2024.

The figures from the survey correlate with the DoLS Teams Welsh Government Data where the Health Board received the most referrals on record 1220 (+18% on last year, and +7% pre-Covid) which demonstrates that wards are correctly identifying patients that lack capacity to consent to their hospital admission for care and treatment require DoLS authorisations.

The DoLS Team has been heavily involved in training and education groups throughout the Health Board completing work with:

- YCC Improvement Group
- MCA Consent Group
- Ombudsman reports and actions at YCR
- D2RA
- Safeguarding Operational Groups
- LPS All Wales Task and Finish Groups
- Advocacy Support
- Bespoke MCA training with regards to consent, MCA, and legal implications in critical care treatment.
- Bespoke MCA/MHA interface training on the older person mental health wards.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	For this episode of care, is there documented evidence that the patient's ability to achieve effective communication has been assessed and discussed with the patient or advocate?	93%	96%	98%	97%	97%
ALL except OPD	Patients have an up-to-date care plan in respect of communication needs?	80%	90%	85%	92%	94%
ALL except theatres	Is a nurse present to support the patient during formal senior contact between healthcare professionals' doctors/consultants/GP Questions and patients?	99%	98%	97%	99%	98%
ALL except neonates, day units, theatres	For this episode of care, is there documented evidence that an assessment of the carer's needs has been considered?	70%	78%	94%	86%	94%

Of the patient records reviewed, 97% had documented evidence that the patient's ability to achieve effective communication had been assessed and discussed with the patient or advocate (unchanged from last year); and of those patients identified as requiring assistance with effective communication, 94% had evidence of an up-to-date plan of care, which had been implemented, evaluated, and reviewed within the agreed timescale (a 2% increase on last year).

It was pleasing to note an increase in the compliance of evidence that a carer's assessment had been undertaken, following the significant decrease of 10% last year.

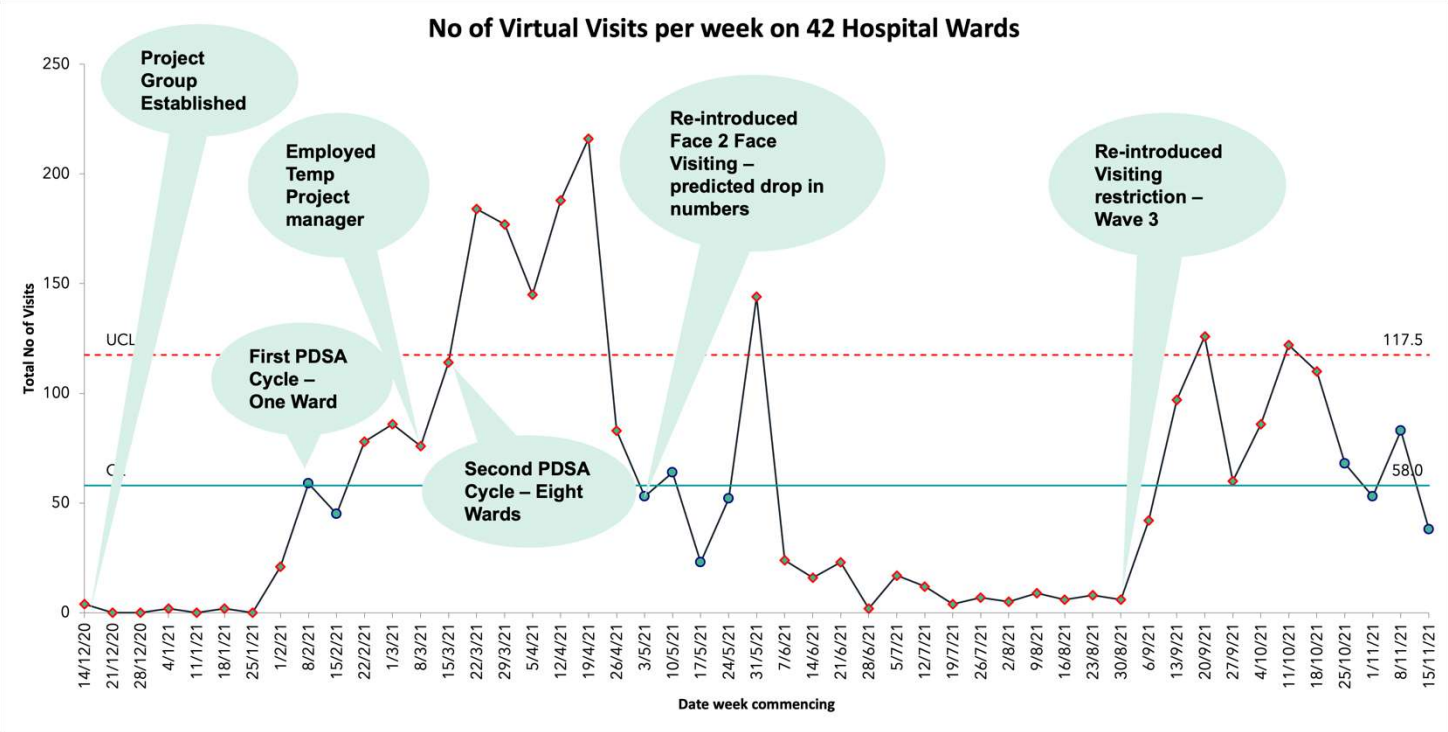
Introducing a Virtual Visiting Service

With its transformative and rapid impact on society, COVID-19 is driving significant changes in our healthcare system. And whilst this has been a catalyst for the need to introduce a virtual visiting service, we must not develop the service for this reason only. Beyond the COVID-19 pandemic and indeed before we know that there are many reasons why relatives/carers may not be able to visit their loved one in hospital. Some examples include simple geography (living away), those who may be housebound and those who are unable to get to the hospital due to transportation issues, to name a few. We know that digital technology has enabled people to stay connected during the crisis and we believe that this can benefit our population beyond the crisis too. With more interactions moving to virtual healthcare models, such as telehealth, we are reimagining how patient care is delivered now and in the future. Our aim was to introduce a Person Centred Virtual Visiting service, to support patient mainlining contact with their relatives while they are in hospital and for whatever reason this cannot be face to face.

What we did

1. Identified key administrators for attend anywhere access
2. Secured and prepared the hardware and software for use
3. Provided Training & technical support for patients & staff
4. Developed Guidelines & resources to support & ensure privacy & security.
5. In partnership with our communications team, developed a communications strategy and resources to support this
6. Undertook an equality impact assessment to ensure we are inclusive of all our citizens needs

The impact of the project can be seen in the run chart below.



We were able to achieve a significant impact for patients and relatives by enabling them to experience / participate in key milestones despite being confined to a hospital bed

	Question	2017	2018	2019	2020 /21	2022
District Nursing	Is the community nursing service able to demonstrate compliance with systems/ procedures/ policies in place to respond to service user and carer feedback?	100%	55%	100%	89%	100%
District Nursing	Is the community nursing service able to demonstrate a process to evidence achievement of outcomes which will include patient reported outcomes, a regular process to audit care plans and discharge records?	75%	75%	100%	89%	100%
District Nursing	Is the community nursing service able to demonstrate engagement with the Health Boards Quality Improvement strategy, using initiatives and projects to effect real, significant, and sustainable change?	75%	73%	100%	89%	100%
All	Are staff supported and engage in regular audits?	70%	80%	80%	100%	100%

District Nursing: The compliance rating for the question regarding compliance with systems/ procedures/ policies in place to respond to service user and carer feedback has improved this year from 89% to 100%.

	Question	2017	2018	2019	2020 /21	2022
ALL	Can staff demonstrate they know how to ensure that confidential patient information is stored safely and securely?	100%	100%	100%	100%	100%
ALL	Can staff demonstrate they know how to report an incident, accident or near miss via the DATIX reporting system and where applicable conduct an investigation?	100%	100%	100%	100%	100%

All staff when questioned about how to ensure patient information is stored safely and securely were able to demonstrate the appropriate knowledge.

All staff were also able to describe the incident reporting process and mechanism for conduction an investigation, if applicable.

	Question	2017	2018	2019	2020 /21	2022
ALL	For this episode of care, are the patient's demographic details clearly recorded (and where required, has a photograph) on all the patient's documentation?	96%	95%	95%	99%	97%
ALL except Neonates , OPD, Theatres	For this episode of care, is there documented evidence that each plan of care has been assessed and discussed with the patient or advocate?	83%	89%	93%	93%	90%

	Question	2017	2018	2019	2020 /21	2022
ALL except theatres	For this episode of care, are the contact details of the first point of contact recorded in the patient's documentation?	99%	95%	98%	98%	98%
ALL	Is the patient's preferred language clearly indicated in the nursing documents?	80%	82%	85%	88%	94%
ALL except neonates	Does the patient's documentation capture their preferred name and/or title?	83%	87%	85%	89%	86%
Inpatients, ED, paeds, LD, endoscopy, only	For this episode of care, where the patient has an identified swallowing problem, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	82%	90%	100%	91%	94%
Inpatients, MH, LD, OPD only	For patients who require a food chart, is it signed by a registered nurse for each 24-hour period?	65%	79%	68%	80%	83%
ALL except OPD, theatres	For patients who require a fluid chart, is there evidence that they are kept up to date and evaluated?	94%	92%	99%	98%	75%

Keeping clear and accurate records is a requirement for Healthcare Professionals under their relevant Codes and guidance

The overall RAG rating for Record Keeping is green but the amber ratings achieved for individual questions indicate that improvement is required, in particular around the signing of food and fluid charts by registered nurses.

This is recurring theme from previous audits undertaken, and despite seeing small improvements year on year we need to continue to ensure our registered nursing staff are aware of their responsibility to sign food and fluid charts. In addition, we need to understand any barriers to them achieving this consistently.

Electronic Nurse Documentation

Cwm Taf Morgannwg continues to implement the Welsh Nursing care Record (a digital system to record adult inpatient care) and has successfully implemented this in 3 of our hospitals (Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda, and the Royal Glamorgan Hospital). Prince Charles Hospital will be using the system by mid-September 2022 with the Princess of Wales Hospital planned for Q3/4 2022.

In total 4751 patients have had their care recorded digitally between August 2021-August 2022 with 386,509 digital entries completed. This is the equivalent of 246,458 Pages of A4 paper saved with associated printing cost savings.

A recent audit comparing paper completion to digital completion has demonstrated significant improvement in the completion of key documentation metrics, for example, patients' Spiritual and cultural needs were assessed in 25% of the paper record compared with 92% digitally.
The Implementation of the system has been well received with 69% of staff surveyed agreeing that it has improved the quality of documentation (Survey of 75 staff).

Interviews with 11 ward managers have explored the benefits seen by users with sample comments below.

The evaluation of the implementation and benefits realised will continue until fully implemented across the Health Board. Further releases and content are planned throughout 2022-2024 as part of the national programme to standardise and digitise nursing documentation.

	Question	2017	2018	2019	2020 /21	2022
ALL	If a patient's language of need is Welsh, do staff know how to access a Welsh speaking member of staff?	98%	98%	94%	97%	97%
ALL	For this episode of care, is there documented evidence that the patient's cultural needs have been assessed and discussed with the patient or advocate?	73%	77%	78%	80%	92%
ALL	For this episode of care, is there documented evidence that the patient's spiritual needs have been assessed and discussed with the patient or advocate?	73%	70%	74%	78%	88%
ALL except from theatres	Is there a facility for patients to talk in private to staff (e.g., a quiet room or office)?	97%	100%	97%	95%	95%
ALL except maternity, neonates. OPD, theatres	Is there a quiet room for patients to spend time with their visitors away from their bedside?	55%	61%	60%	69%	50%
Maternity & Neonates only	Are there facilities to preserve a mother's dignity if she wishes to express or feed at the cot-side i.e., patient screens?	100%	100%	100%	100%	
Inpatients, paeds, MH, Endoscopy, Day units	Within the clinical area, are all the bays single sex bays?	83%	85%	94%	73%	72%
Inpatients, paeds, LD, OPD, Endoscopy, Day units	Do all patients have access to single sex toilet and washing facilities?	81%	89%	91%	79%	82%

	Question	2017	2018	2019	2020 /21	2022
All except maternity & neonates	Is there a facility to preserve patient's dignity by communicating to others that care is in progress?	100%	100%	100%	98%	100%
ALL except neonates & theatres	Within the clinical area, are washing and bathing facilities suitable for all Patients?	90%	86%	91%	90%	97%
ALL except neonates & theatres	Within the clinical area, are toilet facilities suitable for all service users?	93%	96%	100%	98%	100%
Inpatients, paeds, MH & LD	Does the clinical area allow patients to bring in personal items to assist with patient orientation/familiarity?	100%	98%	97%	97%	100%
Inpatients, paeds neonates MH, LD only	For this episode of care, is there documented evidence that the patient's normal sleep pattern and needs have been assessed and discussed with the patient or advocate?	79%	86%	80%	84%	95%
Inpatients, paeds, MH, LD only	For this episode of care, where the patient has an identified sleep issue or sleep has been recorded as poor/disrupted is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	64%	83%	67%	86%	93%
Neonates only	Does the clinical area allow for a period of 'quiet time' during the day to ensure that babies have a period of rest/sleep period?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area allow for the noise levels to be controlled at the cot-side especially during periods of rest and sleep?	100%	100%	100%	100%	100%

	Question	2017	2018	2019	2020 /21	2022
Neonates only	Does the clinical area allow for the lighting particularly during periods of rest and sleep to be individually controlled at the cot-side?	100%	100%	100%	100%	100%
Inpatients, ED, neonates, paeds, MH, LD only	Except for areas where care is taking place / close observation is required, are lights within the bed space switched off or dimmed at night?	98%	100%	100%	99%	100%
ALL except OPD	For this episode of care, is there documented evidence that the patient's pain has been discussed and assessed using an appropriate pain assessment tool?	87%	93%	83%	94%	99%
All except OPD	For this episode of care, where the patient has an identified problem with pain is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	78%	85%	74%	87%	100%
Neonates only	For this episode of care, is their documented evidence that the baby's comfort has been discussed and assessed using a developmental care tool?	50%	100%	100%	96%	
Neonates only	For this episode of care, where the baby has an identified disrupted sleep/rest issue i.e., Neonatal Abstinence Syndrome, there is evidence that there is an up-to-date plan of care that incorporates rest and sleep times, which is being implemented and evaluated and has been reviewed within 24 hours?	100%	100%	100%	100%	
ALL except ED, neonates, OPD, theatres	For this episode of care, is there documented evidence that the patient's concerns/anxieties or fears has been assessed and discussed with the patient or advocate?	76%	79%	82%	86%	91%

	Question	2017	2018	2019	2020 /21	2022
ALL except ED, neonates, OPD, theatres	For this episode of care, where the patient has expressed concerns, anxieties, or fears, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**66%**	**68%**	**78%**	**80%**	**90%**
ALL except OPD, endoscopy, theatres	For this episode of care, is there documented evidence that the patient's hygiene needs have been assessed and discussed with the patient or advocate?	**88%**	**98%**	**99%**	**95%**	**99%**
ALL except OPD, endoscopy, theatres	For this episode of care, where the patient's hygiene needs have been identified is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**93%**	**90%**	**97%**	**99%**	**96%**
District Nursing	Is there evidence that patient's self-care ability to meet their own hygiene needs have been met	**58%**	**82%**	**93%**	**80%**	**100%**
Inpatients, paeds, MH, LD, day units only	Are patients given the opportunity to go to the toilet before eating?	**96%**	**98%**	**100%**	**98%**	**100%**
Inpatients paeds, MH, LD only	For this episode of care, is there documented evidence that the patient's foot and nail condition has been assessed, and discussed with the patient or advocate?	**60%**	**68%**	**75%**	**86%**	**83%**
Inpatients paeds, MH, LD only	For this episode of care, where the patient has an identified risk or requires assistance with foot or nail care, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**51%**	**68%**	**70%**	**86%**	**94%**

	Question	2017	2018	2019	2020 /21	2022
ALL except maternity, OPD, day units	For this episode of care, is there documented evidence that the patient has been assessed using an evidence based oral health tool with respect to their oral health needs?	**93%**	**88%**	**98%**	**93%**	**99%**
ALL except maternity, OPD, day units	For this episode of care, where the patient has an identified risk or requires assistance with oral health, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**84%**	**92%**	**85%**	**95%**	**97%**
ALL except neonates	For this episode of care, is there documented evidence that the patient's toilet needs/continence has been assessed and discussed with the patient or advocate?	**90%**	**95%**	**98%**	**95%**	**99%**
ALL except neonates	For this episode of care, where the patient has been identified as requiring assistance with their toilet/continence needs, is there evidence that an appropriate assessment has taken place with an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**84%**	**92%**	**85%**	**96%**	**99%**

1. Cultural and Spiritual Care:

Spiritual Care is an integral part of healthcare and endorses the need to respect the physical, psychological, and social life values and beliefs of individuals.

Of the records reviewed, 92% of the patients had documented evidence that the patient's cultural needs had been assessed and discussed with the patient or advocate and 88% had documented evidence that the patient's spiritual needs had been assessed and discussed with the patient or advocate, a much-improved position on last year moving us to have a green RAG rating.

2. Environment of care:

Whilst we achieve a GREEN rating for all areas having facilities for patients to talk in private to staff, we achieved an RED rating (50%) for being able to support patients to spend time with their visitors away from the bedside, a noted 19% decrease on last year. Whilst a day room facility is unavailable on many of the wards, we need to consider alternative ways in which we can support private time away from the bedside.

It's very important to note that there has been a slight increase in our compliance scoring related to single sex bays and single sex toilet and washing facilities. Under ordinary circumstances this can be challenging but it is likely that our response to COVID, particularly at its highest peaks has impact on this

3. Rest and Sleep:

Sleep plays a vital role in good health and well-being throughout a person's life. Getting enough quality sleep at the right times can help protect a person's mental health, physical health, quality of life, and safety.

We have seen a significant increase in our assessment and care planning compliance rating moving us to a green RAG score. However, when asking patients about getting enough sleep and rest, we received a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continues challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

4. Ensuring comfort, alleviating pain:

<u>Pain management:</u>

We are pleased to share an improved position in relation to the assessment and management of pain, achieving a GREEN RAG rating with a score of 99%. This can be attributed, in large, to the implementation and increased compliance of the All-Wales pain assessment tool

Patient Perspective: most of our patients continue to feel that they were, as far as possible, always / usually kept free from pain

Patient's concerns/anxieties

We continue to see an improving position with the assessment of patients concerns/anxieties and fears as we also do with the care planning and evaluation of the same. A further increase this year, sees us achieve a GREEN rating.

Patient Perspective: Most of our patients felt that they were always/usually made to feel comfortable.

Personal Hygiene Needs**:**

All areas continue to see a compliance rating of GREEN for the assessment, care planning and evaluation of patient's hygiene needs.

Patient Perspective: 99% of the patients felt that their personal hygiene needs were always/usually met.

Foot Care:

Previous audits have identified concerns around foot care and a significant amount of work has been undertaken to improve both assessment and care planning over the last four years. This year we have seen a 3% decrease in compliance to assessment, moving us back to an AMBER rating. However, it is re-assuring to see an increase in our compliance to care planning and evaluation of patients' foot and nail care. Enabling us to achieve a GREEN RAG rating

Oral Health & Hygiene:

Mouth care is an integral part of nursing practice. Maintaining good mouth care for patients in hospital is imperative in reducing the risk of Health Care Associated Infection and improving patient comfort, nutrition, and experience.

There has again been significant work undertaken in relation to oral health and hygiene, and this year's results show that there is continued compliance for this aspect of care.

Patient Perspective: 93% of the patients responded positively when asked if they were given help with their oral hygiene an unchanged position from last year

Toileting/continence needs:

Promoting continence is a very important nursing role. "Whether or not a patient can be helped to regain continence can have a huge impact on an individual's quality (of life) and wider health and social care" (Learning from Trusted to Care report 2015).

We have continued to see an improvement in compliance with patient records evidencing that the patient's toilet needs/continence had been assessed and discussed with the patient or advocate

And of those patients who had an identified need, 99% had evidence that an appropriate assessment had taken place with an up-to-date plan of care, which had been implemented and evaluated and had been reviewed within the agreed timescale (up 4% on last year).

Patient Perspective: 96% of the patients felt that we always/usually responded quickly and discreetly if they needed help to use the toilet. The comments made by patients give examples of when patients felt that staff did not achieve this, with one patient stating:

"Sometimes I had to wait as staff were busy, but they would always acknowledge my call and tell me they would come as quick as they could" whilst another patient noted that "getting to toilet at night not always timely".

	Question	2017	2018	2019	2020 /21	2022
ALL	Is there evidence to demonstrate that patient identifiable information is treated in a confidential and secure manner?	95%	99%	97%	99%	100%
ALL except neonates, theatres	For this episode of care, is there written evidence in the patient's clinical notes that the patient's consent to the sharing of information with others has been obtained?	76%	76%	88%	88%	85%
Neonates only	Does your unit inform parents that information regarding their baby may be shared with other professionals to ensure appropriate care?	100%	100%	100%	100%	100%
Maternity & neonates only	Is there evidence of information available for women and their families on infant feeding?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area offer translation services and/or professional interpreters to parents?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area have written information available in a language and format appropriate to their local community?	100%	100%	100%	100%	100%
Neonates only	In the clinical area, is there information available regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home?	100%	100%	100%	100%	100%

We have achieved an overall GREEN rating for this standard. However, there is some improvement work to be done in relation to ensuring that there is written evidence in the notes that the patient's consent has been obtained in relation to sharing of information with others.

Examples of good practice include:

- Lockable trolleys are used to store patient records.
- Confidential waste bins are provided on wards.
- Electronic system used where only staff have access.

Patient Perspective: Most patients are satisfied with the information they were given about their care with 96% of the patients responding positively when asked "how often did you feel that you and those that care for you, were given full information about your care in a way that you could understand"

	Question	2017	2018	2019	2020 /21	2022
Paeds only	Is there evidence that the Children and Young People have been correctly triaged on admission?	90%	100%	100%	100%	100%

The above question only applies to paediatric and health visiting areas and relates to the requirement to the recording of core information on the child and young person's admission to hospital. However, there are two questions included in the patient experience survey that relate to this standard.

Most of our patients felt that when they asked for assistance, they got it when they needed it. Patients continue to report that they felt that they were always/usually kept informed of any delays, for example appointment times, tests, treatment, discharge.

	Question	2017	2018	2019	2020 /21	2022
Inpatients, ED, paeds, MH, Endoscopy, theatre, day units only	For patients with no known diagnosis of dementia, delirium or other cognitive impairment at admission, there is documented evidence that within 72 hours of admission, the following screening question has been asked, Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life?	**76%**	**82%**	**81%**	**86%**	**82%**
Inpatients, ED, MH, day units only	For this episode of care, where the patient has an identified care need in respect of cognitive impairment, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**75%**	**85%**	**78%**	**90%**	**90%**
ALL except neonates, OPD	For this episode care, is there documented evidence that the patient's level of independence has been assessed and discussed with the patient or advocate?	**93%**	**95%**	**98%**	**97%**	**99%**
ALL except neonates, OPD	For this episode of care, where the patient has been identified as requiring support and/or assistance to maximise independence, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**90%**	**94%**	**97%**	**91%**	**95%**
ALL except OPD, Theatres	Where appropriate, do all patients have written evidence of a discharge assessment and plan?	**91%**	**93%**	**94%**	**96%**	**77%**

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD, Theatres	Where appropriate, is there written evidence that the patient's family/carer has been involved in discharge planning?	**91%**	**89%**	**89%**	**95%**	**88%**
ALL except maternity, neonates, OPD, Theatres	Does the clinical area have access to mirrors for patients to use?	**95%**	**93%**	**94%**	**98%**	**94%**
Inpatients, ED, paeds, MH, LD only	Does the clinical area have supplies of toiletries for patients who have been admitted without them?	**96%**	**100%**	**100%**	**100%**	**100%**

Patients with dementia/delirium/Cognitive Impairment:

We have achieved an AMBER compliance rating in the compliance with the documentation that the following screening question has been asked for patients with a known diagnosis of dementia and so further improvement work is needed, a worsened position from last year.

We have achieved a GREEN compliance rating with care planning for a patient identified with a care need in respect of cognitive impairment where we have seen an increase in compliance this year

CAM-ICU Assessment for Delirium in Prince Charles Hospital

Background

Delirium is underdiagnosed in ITU and leads to longer admissions, increased complications, and poorer QOL post discharge. If it is not identified, control measures cannot be introduced to mitigate the impact. A multidisciplinary project is underway looking to improve the assessment of delirium on ITU units in Cwm Taf Morgannwg UHB

Challenges

Challenges were initially team awareness and appreciation of the importance of identifying delirium. Additional barriers around agency workforce, and challenges in terms of how it is recorded were mitigated as best possible

Objectives

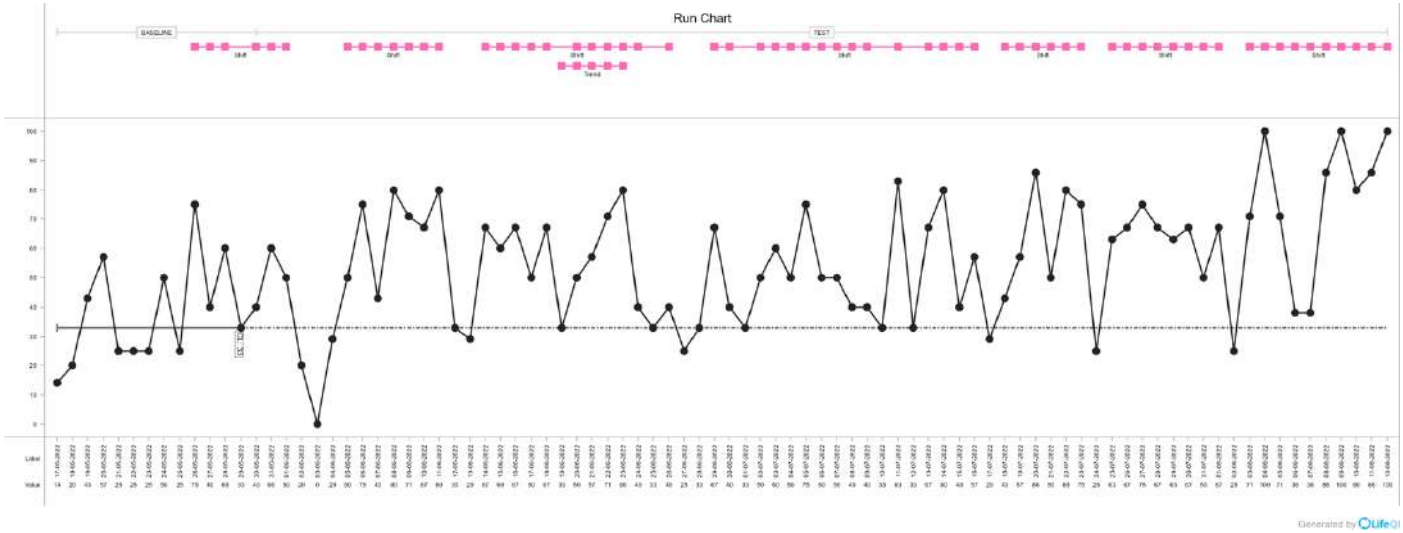
- Increase delirium screening to 75% compliance by the end of the year
- Measure daily compliance and administration errors
- Anticipate improved delirium identification

Solutions

A working party comprised of nursing, psychology, consultants, junior doctors, and member of QI faculty was set up to continuously review the data and plan new cycles of change. This was in liaison with the M&C faculty and advice from the core QI team.

Impacts

The work is ongoing however there has been a significant shift in favor of identification of delirium. Further cycles of change are needed to optimize screening and introduce control measures when delirium identified. The run chart below demonstrates the percentage compliance to delirium screening in ITU



Learning

Further work is ongoing however there is expected to be learning around environmental/human factors that contribute to challenges in delivering care that meets standards outlined in national guidance.

	Question	2017	2018	2019	2020 /21	2022
Inpatients and paeds only	Does the clinical area allow CYP/family/carers to bring in personal items to assist with CYP's orientation/familiarity/anxiety?	**100%**	**100%**	**100%**	**100%**	**100%**
Maternity & neonates only	For this episode of care, is there documented evidence that mothers who require breastfeeding support and/or assistance has been assessed and discussed?	**100%**	**100%**	**100%**	**100%**	**100%**
Maternity & neonates only	For this episode of care, where the mother has been identified as requiring support and/or assistance to establish breastfeeding on the unit, prior to going home, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	**100%**	**100%**	**100%**	**89%**	**100%**
Paeds only	Are there age appropriate playrooms for children/young people?	**100%**	**100%**	**100%**	**100%**	**100%**

We continue to achieve a GREEN compliance rating in all the areas highlighted for this standard.

	Question	2017	2018	2019	2020 /21	2022
ALL except theatres	In the clinical area, is there accessible information regarding how patients/relatives/advocates can raise a formal or informal concern?	**95%**	**96%**	**100%**	**96%**	**100%**
Neonates only	Does the clinical area allow parents to regularly feedback their experience of the service?	**100%**	**100%**	**100%**	**100%**	**100%**
Neonates only	Does the clinical area allow parents to be involved in the planning and development of service improvements?	**100%**	**100%**	**100%**	**100%**	**100%**

As with the findings of previous audits, it is pleasing that most wards and departments provide information on how to raise formal or informal concerns. Within CTUHB all patients are given the opportunities to give feedback and where a concern is raised the Patient/Carer should receive a timely response and action where required. Patient/Carer feedback is used to continuously improve services.

A joined-up approach between the patient experience team and the clinical education, quality improvement and audit leads sharing information and working together to make continuous improvements in care.

With **accessible patient experience data** which is shared ward to board and the emphasis on **investigation for learning not blaming,** CTMUHB is making continuous improvements to listen and learn from patient experience.

Cwm Taf Morgannwg University Health Board is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety, and experience.

A framework of ensuring effective listening, learning, and improving is urgently required and has been a significant criticism of the Health Board in external reviews and audits such as the Health Inspectorate Wales/Audit Wales and NHS Delivery Unit review of quality, governance, and incident management processes. Effective learning and improvement processes has also been a cross cutting theme of concern within the Independent Maternity Services Oversight Panel reviews of our maternity and neonatal services.

This Listening & Learning Framework demonstrates how learning will be identified, triangulated, disseminated, and implemented in practice, to facilitate and embed a culture of appreciative enquiry and continually improving health care services.

The Listening & Learning Framework recognises that the Care Groups and Clinical Service Groups have internal governance and learning structures. This Framework, therefore, seeks to complement and build on these arrangements by adding a strategic approach to support the organisation to learn lessons from a range of internal and external sources, to store and use this learning to share knowledge, shape change and create opportunities to develop excellence in practice.

	Question	2017	2018	2019	2020 /21	2022
ALL	All clinical staff wear identification badges	**84%**	**92%**	**96%**	**93%**	**93%**
ALL	All clinical staff comply with All Wales Dress Code	**91%**	**98%**	**100%**	**99%**	**100%**

The All-Wales Dress Code (2010) was developed to encompass the principles of inspiring confidence, preventing infection and for the safety of the workforce.

The principles set out in the code include:

- All staff will be expected to dress in smart (that is, neat and tidy) clean attire in their workplace.
- All staff will present a professional image in the workplace.
- Staff should not socialize outside the workplace or undertake social activities while wearing an identifiable NHS uniform.
- All clinical staff must wear short sleeves or elbow-length sleeves in the workplace to enable effective hand washing techniques.
- All staff must always wear clear identification.
- Staff who wear their own clothing for work should not wear any clothing that is likely to cause a safety hazard.

Staff are to be commended for their efforts to ensure that staff are complying with the All-Wales Dress Code (100%). It is a little concerning to see a decrease in staff's compliance with the wearing of identification badges, down 3%, scoring 93% this could be attributed to the heightened IPC restrictions because of the pandemic

Staff Survey

	Question	2017	2018	2019	2020 /21	2022
ALL	Our organisation aims to make sure you can access up to date information in order to be able to do your job. For example, access to policies, clinical guidelines etc. Do we achieve this?	91%	91%	92%	92%	91%
ALL	Our organisation aims to ensure that as an employee you are treated with dignity and respect. Do we achieve this?	75%	74%	75%	81%	68%
ALL	Our organisation aims to make you feel safe at work. Do we achieve this?	76%	76%	71%	81%	62%
ALL	Our organisation aims to make you feel you have a positive contribution to patient care. Do we achieve this?	79%	77%	79%	85%	68%
ALL	Our organisation aims to provide you with sufficient equipment to do your job. Do we achieve this?	74%	73%	75%	80%	75%
ALL	Our organisation aims to provide you with opportunities to enhance your skills and professional development. Do we achieve this?	72%	72%	70%	78%	74%
ALL	Our organisation aims to provide you with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area? Do we achieve this?	57%	59%	68%	77%	65%
ALL	Our organisation aims to provide you with opportunity to identify and learn from good practice to bring about improvements in care. Do we achieve this?	74%	75%	79%	85%	73%
ALL	Our organisation aims to provide opportunities for you to raise any concerns that you have. Do we achieve this?	75%	75%	73%	83%	74%
ALL	Our organisation aims to provide you with the opportunity to establish a work life balance. Do we achieve this?	63%	66%	70%	81%	67%

	Question	2017	2018	2019	2020 /21	2021/ 22
ALL	Our organisation aims to make you feel a valued member of the organisation and have a sense of belonging. Do we achieve this?	**60%**	**61%**	**64%**	**78%**	**55%**
ALL	Our organisation aims to make you feel proud to be a nurse / allied health professional. Do we achieve this?	**64%**	**64%**	**68%**	**79%**	**60%**
ALL	Our organisation aims to put local citizens at the heart of everything we do'. Do we achieve this?	**77%**	**71%**	**90%**	**63%**	**88%**
ALL	Our organisation aims to ensure that you have the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care. Do we achieve this?	**84%**	**82%**	**86%**	**90%**	**77%**
ALL	Our organisation aims to work together to be the best that we can be. Do we achieve this?	**76%**	**71%**	**74%**	**84%**	**64%**
ALL	Our organisation aims to strive to deliver and develop excellent services. Do we achieve this?	**74%**	**75%**	**72%**	**84%**	**67%**
ALL	Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with the care that you provide for your patients and their families?	**83%**	**81%**	**83%**	**86%**	**78%**
ALL	Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with your organisation?	**70%**	**69%**	**70%**	**78%**	**64%**

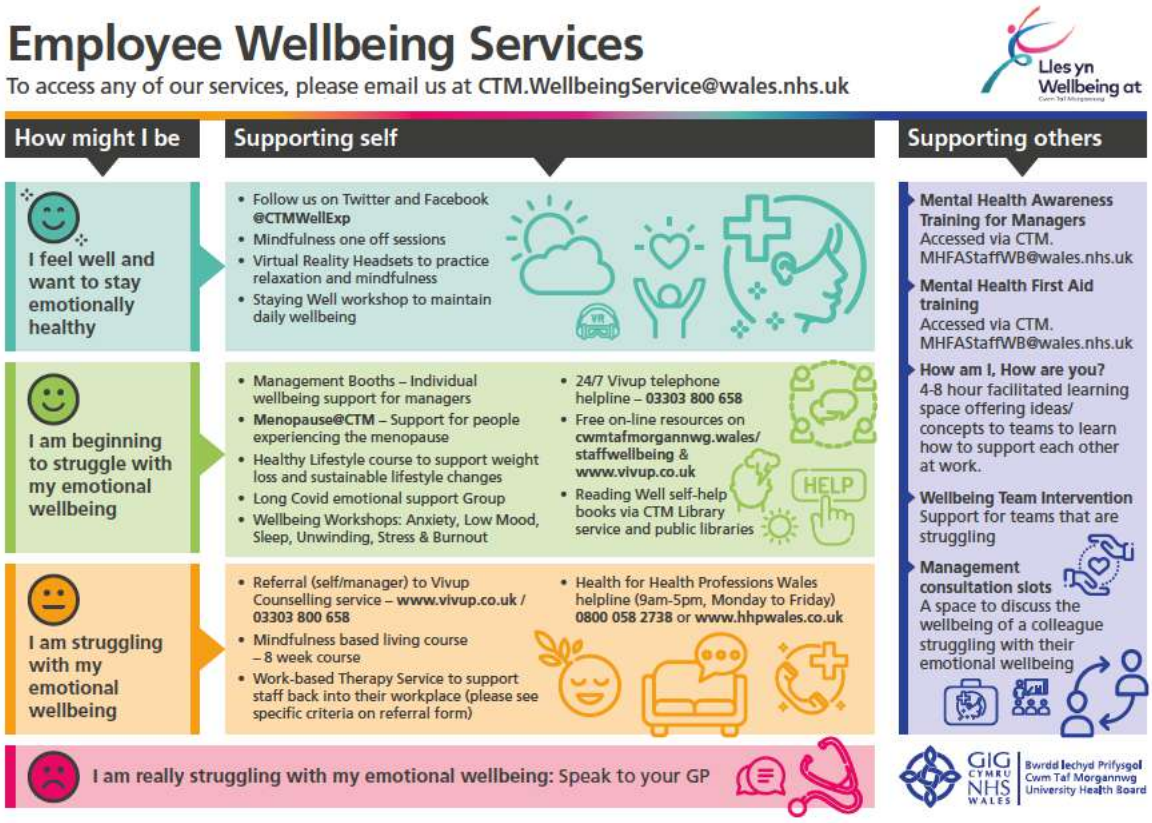
Overall, there is a downward trend in the responses received in this year's Staff Survey. This could be in part attributable to the unprecedented pressures staff have experience over the last two years with the pandemic. However, we must be mindful not to make assumptions and some significant work needs to take place to understand more fully the responses provided by staff

Some of the key themes identified include:

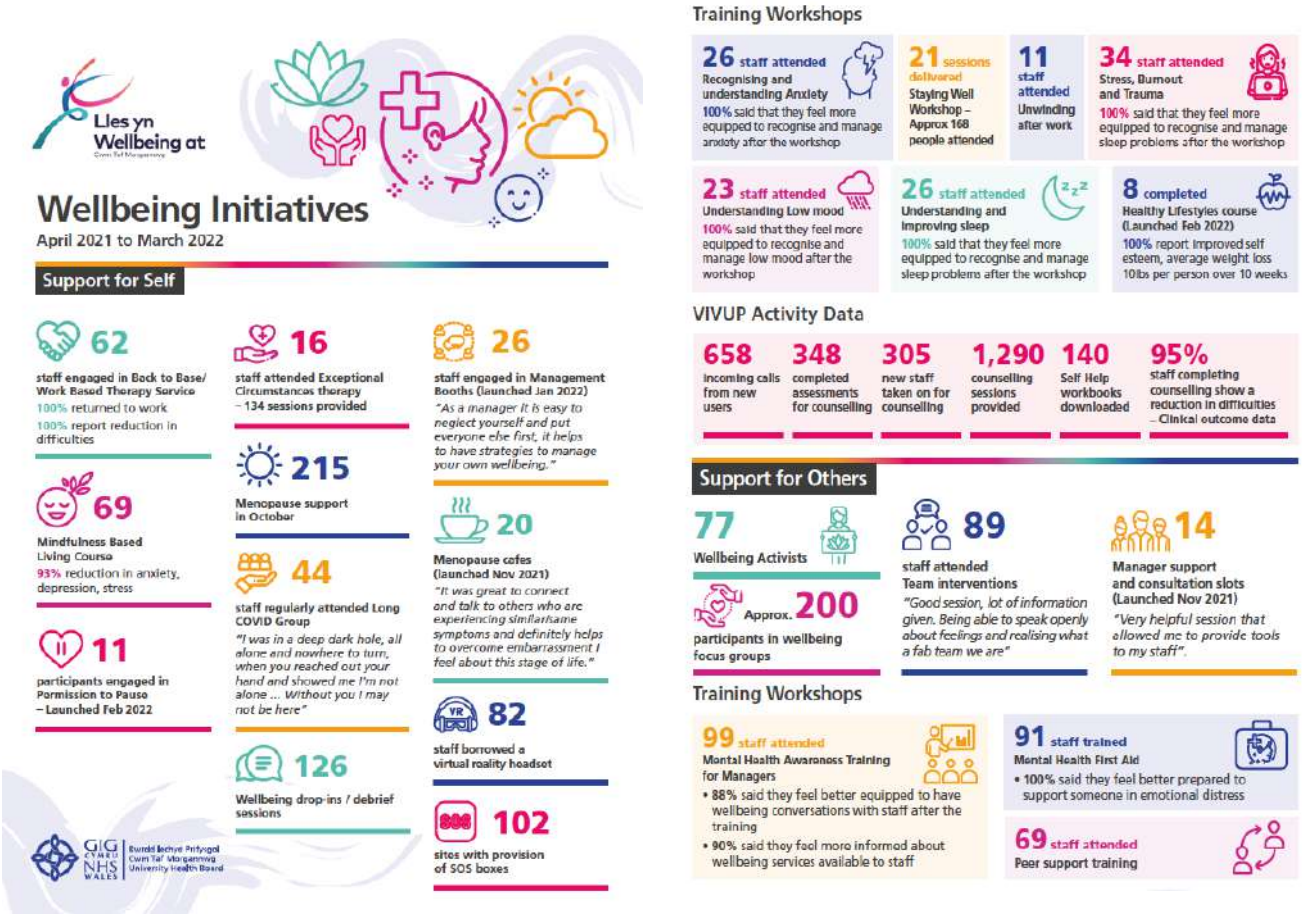
1. Training – often cancelled due to staffing
2. Lack of communication/feedback following an incident
3. Lack of staff
4. Poor skill mix
5. Don't feel valued – perception that organisation focuses on blaming staff when things 'go wrong'

The Wellbeing Service offers a stepped care approach matching the needs of staff to the intensity level of the intervention provided. We continue to contract an Employee Assistance Programme to provide 24/7 telephone support and counselling alongside CBT guided self-help workbooks. We also continue to provide a wide range of Mindfulness based groups and courses.

Over the past 12 months the Wellbeing Service has introduced several new initiatives based on the results of the 2021 Wellbeing Survey (Sleeping Well Course, unwinding after work course), on feedback from our Wellbeing Activists, managers, and other key stakeholders (Manager's Booths, Management consultation slots, how am I, How are you? Course). All the services provided are listed on our Emotional Wellbeing Care Pathway (below)



A summary of our outcome data, activity data and feedback from staff, are listed on our Dashboard (below).



We will be launching the 2022 Wellbeing Survey on 12th September 2022, and we will use those results to review our current service provision.

In the past 12 months we have launched a variety of services for staff impacted by the menopause – either directly or because they live or work with someone going through it. These include Menopause café's, Mindfulness for Menopause, Chill Max pillows and the Permission to Pause cause which looks at key lifestyle areas of reducing stress, improving sleep, nutrition, and exercise levels.

At the request of our male staff, we have launched Men's' Wellbeing @CTM in which we have collated wellbeing interventions specifically designed to appeal to our staff who identify as men.

Earlier this year the Wellbeing Service also launched a Healthy Lifestyles 10-week group which provides a psychologically informed course encouraging staff to adopt healthy approaches to nutrition, hydration, exercise, sleep and to understand their relationships with food. The outcome data so far has been very encouraging. Data from the first 4 cohorts demonstrated that 89% of staff who attended reported a loss in

weight, with an average loss of 8.7lbs per person. This is considered a sustainable and healthy loss in weight over a 10-week period. 92% reported an increase in self-esteem, whilst 100% reported an increase in psychological health and quality of life.

In recognition of the current financial pressures that staff may be experiencing and the negative impact that may be having on their emotional wellbeing, we have also put together a financial wellbeing care pathway which sign posts staff to sources of advice, support and financial assistance if required (see below).

Learning from the 2022 Audit

The service specific results of this audit should be reviewed within the operational team's current governance structures to ensure that any areas of good practice and areas for improvement are identified and shared.

Local action plans must be developed for individual wards, departments and services. The ward mangers and senior nurses are expected to progress the improvements identified and feedback through their governance and monitoring arrangements, overseen by the Listening and Learning Forum that reports to Quality and Safety Committee on a quarterly basis.

The health board is asked to accept the Health & Care Standards (2022) audit findings which are presented in this report as an assurance that the care delivered within the health board continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.

Simply Do – *using an ideation platform to improve on top 3 areas identified in the 2022 HCs Audit*

The results of the 2022 audit have highlighted 3 key areas for us to improve across the health board these are

1. Patient hydration
2. Providing a dignified environment of care
3. And improving our assessment and care management of patients suffering with delirium and those patients with a diagnosed learning disability

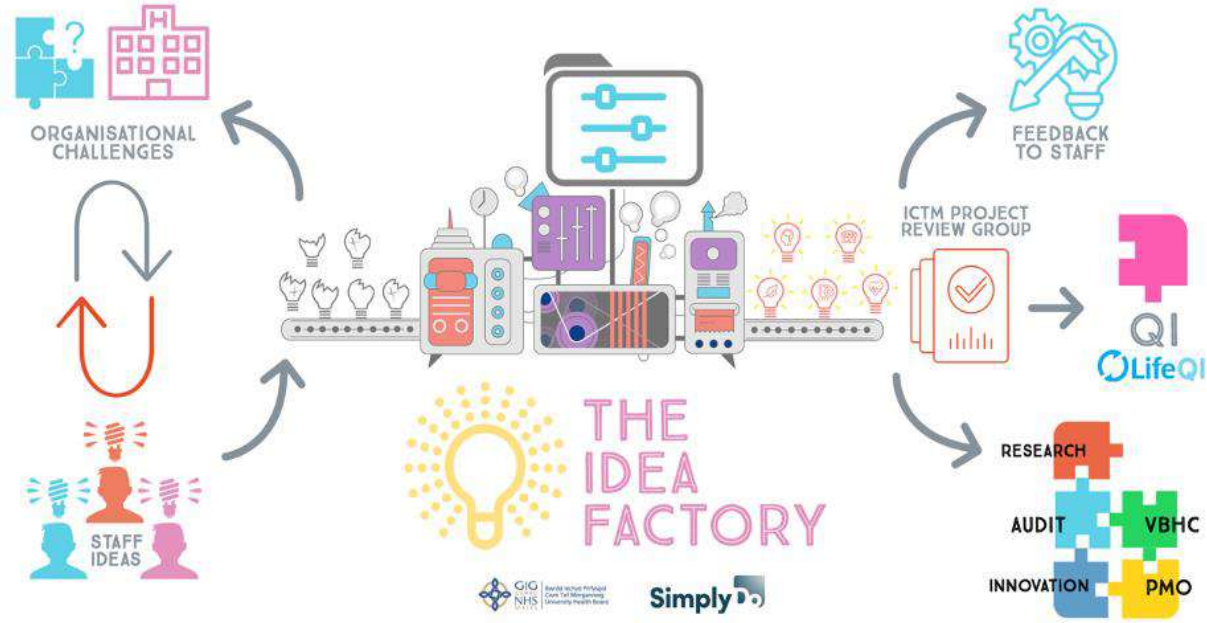
We have launched a challenge on the simply do platform. This challenge has been launched to provide an opportunity for staff to:

- Submit ideas you have that could address one of the 3 key issues raised
- Share those ideas with colleagues via the portal

As part of this collaborative, transparent process, we will:

- Listen to and recognise innovative ideas and approaches
- Share the progress we make together in real-time
- Support you with Improvement training

To find out more about how you can submit an idea go to https://sdi.click/ictmaudit2



AGENDA ITEM
5.1

CTM BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	24th November 2022

[1]

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Rebecca Goode, Executive Business Manager
Presented by	Paul Mears, Chief Executive Officer
Approving Executive Sponsor	Chief Executive

Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to keep the Board up to date with key issues affecting the Organisation. A number of issues raised within this report feature more prominently within key reports on the main Board agenda.

1.2 This overarching report highlights for Board Members the key areas of activity of the Chief Executive, some of which is further referenced in the detailed reports, and also highlights topical areas of interest to the Board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Special Measures - Maternity & Neonatal Services

On the 7th November 2022, the Independent Maternity Services Oversight Panel (IMSOP) published the September 2022 Progress Report which summarises its assessment of the progress made by the Health Board in Maternity and Neonatal services.

I am pleased to report that the panel's assessment of each of the conditions have been met and the Health Board's maternity and neonatal improvement journey can now be considered sustainable. The Minister for Health and Social Services announced the decision to de-escalate the Health Board's maternity and neonatal services from special measures to targeted intervention. The Health Board remains committed to delivering on the remainder of the neonatal improvement plan and service development activities.

On behalf of the Health Board, I would like to take this opportunity to thank staff and families for their clear commitment to ensuring maternity and neonatal services meet the expectations of local communities.

2.2 Targeted Intervention

Welsh Government (WG) officials met with Audit Wales and Healthcare Inspectorate Wales in October 2022 to discuss the overall assessment of Cwm Taf Morgannwg University Health Board's escalation and intervention arrangements. WG have confirmed the escalation status of Cwm Taf Morgannwg University Health Board as follows:

- **Targeted Intervention for:**
    - **Maternity and Neonatal** -The group acknowledged the progress made and acknowledged the implementation of many of the recommendations of the Independent Maternity Services Oversight Panel (IMSOP). However, there is still further work to do, especially in neonatal services.
    - **Quality Governance** - the group noted the considerable progress made in this area but was aware that the Health Board is in the process of implementing its new operating model and would like to see how that is embedded across the Health Board and the impact.
    - **Quality related to performance and long waiting times** - Performance areas in both planned care and urgent and emergency care remains challenging with lengthy waiting lists.
- **Enhanced Monitoring for Planning and finance** – The Health Board has been unable to produce an approvable and balanced three-year financial plan.

The Health Board is working hard to address the above areas and will continue to keep the Board appraised on the work plans and progress through the appropriate forums. The focus continues to be around 'conditions for sustainability' and the Health Board remains committed to improvement and service development in all areas.

Our Team will work with WG officials to agree an appropriate work plan and targeted intervention framework that will seek to put in place the necessary conditions for de-escalation.

2.3 Executive Leadership Team Update

- **Kelechi Nnoaham, Executive Director of Public health** - Kelechi will leave CTMUHB at the end of November to join lead international health programmes for Shell based in London. In his new role Kelechi will be tasked with setting up the Health Programmes Development work.

- **Georgina Galletly, Director of Corporate Governance –** Georgina will be joining Welsh Government's NHS Executive Implementation Programme Team on 14 November 2022 to support the transition arrangements for the establishment of the NHS Executive as a unified body.

Both Kelechi and Georgina have provided exceptional leadership and built robust structures for their professions within CTMUHB and the wider NHS. I am sure that the Board will join me in thanking Kelechi and Georgina for their leadership and commitment to the Organisation during their time with us.

2.4 Winter planning with Local Authority partners

Our Health Board's winter plan is working to a number of assumptions around demand. Our teams are working on implementing the local plans as part of the Welsh Government's national 6 goals programme for unscheduled care.

The Health Board will continue to work closely with our external partners including the Chief Executives of the three Local Authorities to ensure a joined approach and to do all that we can to avoid severe pressures this winter.

2.5 Bridgend Health & Social Case for Change

There is a strong history of the Health Board and Bridgend County Borough Council working together to deliver integrated services for the local population. We already have an integrated team of health and social care professionals working in the locality and there has been good progress on developing these relationships over the past year.

Recently the Chairman and I met with the Leader and Chief Executive of the council as well as the Director of Social Services and Cabinet Member

for social care to discuss how we could further advance our approach to integrated health and social care in Bridgend. We have agreed that there is an opportunity to move to a single operational head of service to lead the adult health and social care services within Bridgend working to the Deputy Chief Operating Officer in the Health Board and the Director of Social Services in the Council.

This development is an exciting step forward for the two organisations and could provide a model for us to explore with the other two Councils with whom we work. We will be keeping the Board updated as these plans progress and will be planning a series of engagement events with staff working in health and social care in Bridgend as well as local residents and other stakeholders.

2.6 Development of Maesteg Community Hospital

I am pleased to say that we have recently begun a series of discussions with local councillors and stakeholders in Maesteg on the potential development of Maesteg Community Hospital.

The Health Board is keen to engage with the local community in Maesteg how we can deliver an improved range of services on the hospital site in partnership with other agencies including the Council. We wish to discuss with residents the services which are important to them as well as recognising the significant health inequalities in the area which we would want to respond to in any future site development.

Having briefed local elected representatives and the League of Friends we are now planning a series of engagement events in Maesteg and the surrounding area to further these discussions and shape the service provision we would want to provide on the hospital site. We will be undertaking these events in December and January and will continue to update the board on these discussions.

2.7 Healthcare Inspectorate Wales (HIW) Inspection at Princess of Wales - Feedback

We had excellent and positive feedback on the quality of patient experiences from an unannounced HIW Inspection of the Emergency Department at Princess of Wales in October.

Patients praised the compassion and care of the staff and HIW noted that there was accurate and timely record keeping from both doctors and nurses. The inspectors recognised that there were good clinical pathways in place, evidence of learning from events and incidents and they recognised the leadership of the frontline team.

There was a recognition of the considerable challenges of patient flow and the impact of the high number of delayed transfers of care. HIW recognised the excellent care that our staff gave to patients despite the significant challenges they were under and I am sure that the Board will join me in thanking staff for their continued commitment and hard work.

2.8 CTM Operating Model Update

As a reminder to the Board, the Care Groups model was launched in August 2022 with the majority of appointments now made to the Care Group Leadership Teams. The next phase will focus on the best structure for the Clinical Service Group layer of the Health Board and we are undertaking a mapping exercise to help inform discussion and engagement about the way we want to establish and manage our services in the future.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The Board should note the changing context and environment for commissioning and delivering healthcare and wellbeing services, in the context of balancing the need to continue to respond to the COVID-19 pandemic, as well minimising harm from non-COVID-19 activity, winter pressures and providing essential and routine services to our communities. This balance will bring a new set of issues to manage and risks to consider.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	It is anticipated that all elements of quality, safety and patient safety will be impacted positively by the implementation of the "Continuous Improvement in response to TI Programme".
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required in terms of this update.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5 RECOMMENDATION

The Cwm Taf Morgannwg University Health Board is asked to **NOTE** the report**.**

Potential Health & Social Care Integration between Cwm Taf Morgannwg Health Board and Bridgend CBC

A case for change

Introduction and background

Health and social care services are facing significant and unprecedented challenges as Wales comes out of the Covid pandemic. The demands on health and social care services have never been greater and the economic and social impact of local, national and international events risk creating more pressure on an already struggling system.

The significant health inequalities experienced by the population in the Cwm Taf Morgannwg (CTM) health board area are well known and the Covid pandemic brought these into even greater focus. Whilst progress has been made on improving the health and wellbeing of our citizens, there is still much more work to do to manage some of the real health challenges facing local people and supporting them to live healthier lives in their own homes for as long as possible.

The health and social care workforce is under immense pressure with high levels of vacancies in key roles such as nurses, doctors, residential care and domiciliary care workers. Despite significant recruitment efforts across health and social care, challenges remain significant and vacancies continue to outstrip supply of workers meaning continual impact on service sustainability and impact on care for our communities.

Despite these challenges which are common across Wales and the UK, there is a strong track record within Bridgend of the Health Board and BCBC working in integrated teams at an operational level. Strategic relationships between the Health Board and Council are strong and there is a shared commitment to work together to improve the health outcomes for the local population of Bridgend. Throughout the Covid pandemic, the relationships between the council and the health board were strengthened and the joint work on Test, Trace and Protect (TTP), Covid vaccination programme and wider public health measures evidence how working together across our statutory organisations can deliver significant agendas within a rapid timescale.

In Bridgend there is already a well-developed model of integrated health and social care in the community with shared management arrangements and innovative models such as the Acute Care Team designed to keep people at home with acute healthcare needs supported by specialist nurses and care support. The Health Board and the Council are working together to develop innovative models of domiciliary care support to tackle some of the current challenge in the homecare sector and both organisations are working on developing new models of intermediate care/step-down beds with a local social care provider.

All of these examples are aimed at improving the experience for our local community and helping people to be independent at home for as long as possible. However these initiatives

have all been developed as responses to particular system challenges or funding allocations from Welsh Government which means that they are often at risk of funding being withdrawn, duplication of effort with mainstream services or inconsistent provision for residents. To date there has not been any integrated governance or shared leadership between the Health Board and Bridgend CBC within which local service integration can be framed.

National Drivers

Integration of health and social care has been a long-held ambition of Welsh Government. The drive to integrate care was clearly articulated in 'A Healthier Wales' and in the current Programme for Government (2021) sets out that government will legislate further to integrate health and social care. In addition the Cooperation Agreement states that Welsh Labour and Plaid Cymru "*will continue to better integrate health and care and work towards parity of recognition and reward for health and care workers*".

There have been a number of discussions more recently around the need for health and social care to work more closely in a number of areas including mental health, older people's services, hospital discharge and learning disability services. Much of the national direction on this integration agenda has been focussed on the Regional Partnership Boards (RPB) as the vehicle of integration, however whilst the RPBs are helpful in bringing together health and local authorities with voluntary sector, housing and independent sector representatives, they do not have oversight of the operational delivery of statutory health and social care services which sit with the health board and local authorities respectively.

Local Drivers

The challenges faced in our health and social care services are well known and understood. However it is important to acknowledge that the service provided to many local residents is not to the standard we would want nor are the staff within our services content that they are enabled to provide the best service to our citizens.

Despite the positive and collaborative leadership shown by both our organisations there are a number of factors that are either preventing or slowing down further integration of services including:

- Lack of a clear shared vision and purpose across the Health Board and Council of how we see integrated health and social care being delivered locally
- Lack of alignment of strategies and planning/commissioning between the health board and the Council in respect of health and social care services
- Separate funding streams leading to discussions about whether services should be health or social care funded
- Community health and social care teams being managed by separate line managers in separate locations
- Limited senior capacity and project resource to develop the integrated health and social care agenda

As well as the service challenges articulated in the introduction, there are significant pressures facing the health and social services departments including the recovery of the backlog of patients waiting for elective tests and diagnostics, the number of people seeking support in the community leading to pressure on assessments for social care, managing the financial impact of constrained budgets across health and social care and the need to develop and modernise the social care provision locally. In all these areas there are potential unintended consequences should one of the partner organisations act independently of the other. If we are to have the best chance to collectively respond to the challenges set out above then we need to consider how the health board and Council social services functions can deepen the integration of service delivery and share our collective resources to the greatest effect for our communities.

The potential scale of our ambition

If we are really intent on delivering a truly integrated health and social care system in the Bridgend area we need to be bold in our ambition and define what success would look like for our organisations, our staff and our communities. A proposed approach for phase 1 is set out below:

Phase 1 – Discovery phase

1. The first step in this journey would be **agreeing a shared vision for integration** across the health board and the Council which would have endorsement from elected members and the board members of the Health Board. This vision needs to be centred on how things would be different for local people using the services as this must be the primary reason for integration of health and social care.
2. **Agree the scope of the programme** i.e. which services/functions of the Health Board and councils will be included in the programme. There are some key questions to answer including:
    - **a.** Are we planning to integrate services just for adults
    - **b.** What services in the partner organisations would be included in the programme
    - **c.** Are we including mental health and learning disabilities in scope
    - **d.** What are the common principles that will underpin this programme
3. **Appointing a joint Senior Operational leader** to be charged with bringing the health and social care team in Bridgend together. This individual would report to the Director of Social Services in BCBC and the Deputy Chief Operating Officer (Community & Mental Health) in the Health Board.
4. **Establishing an Integration Programme Team** to lead the programme of work across the local authorities and health board. This programme team will need to have dedicated project resource to ensure the programme moves at pace and remains on track.
5. **Review existing integrated team arrangements** to understand what has worked well, what needs to be improved and lessons for future integration plans

6. **Engagement with local service users and communities** to share the vision for integrated health and social care as well as gathering insights and feedback on what is important to communities and their experience of services in Bridgend.
7. **Engagement with frontline staff** including social workers, social care teams, providers, community health teams, GPs and others to understand how the system is working today and what opportunities they see for improving the service to citizens through closer integration. This will also provide the opportunity for staff from health and social care to better understand each other's roles and develop a 'shared purpose' for how they will work together in the future.

Phase 2 – Design phase

Using the shared vision and the feedback from local service users/patients and staff phase 2 will focus on designing how a truly integrated health and social care model will be deployed across Bridgend. This care model will need to consider:

- How will people access their local health and social care services through a single point of contact
- What will an integrated community health and social care team include e.g social workers/community nurses/occupational therapists/physiotherapists/mental health workers
- How will other partners (e.g. housing, voluntary sector) be included in the integrated community health and social care teams to ensure people are signposted
- How to align this work with the development of Accelerated GP Clusters
- How to ensure children's services are also considered alongside the work on adult services

What could 'good' look like with respect to health and social care integration?

A desired future integrated service would have a shared vision which was understood and owned by both council and NHS staff. Integrated teams would be co-located together and would share integrated management arrangements for all care teams working within Bridgend. These integrated teams could be aligned to GP clusters with a single point of access into the team underpinned by a shared digital care record between health and social care.

Fully pooling budgets together would allow the most effective use of resources and reduce duplication of spend. Utilising the population segmentation analysis we can focus on reducing inequalities and take a proactive, targeted approach to support the most vulnerable in our communities.

Commissioning arrangements could also be integrated including all aspects such as care home, domiciliary care and continuing care commissioning to ensure a consistent and joined up strategy for working with the local social care market between the Council and the Health Board.

The performance management for the integrated service would be monitored by a joint committee of BCBC elected members and Health Board independent members ensuring that the outcomes of integrated service delivery were evidenced. This committee would then enable the Health Board and the Council to assure themselves that their statutory responsibilities are being met consistently.

What benefits would closer integration bring?

There could be a range of measurable benefits for our citizens and our staff/organisations, as outlined below:

1. **Benefits to our citizens**

- Improved coordination of care and simplified access to health and social care
- Patients and their families only have to 'tell their story' once
- More rapid and responsive care when it is needed most
- Being cared for in the right place at the right time
- Supported to be independent for as long as possible in their own homes
- Improved signposting and access to community activities/voluntary groups
- Only going to hospital when it is absolutely necessary
- Improved support offering for families and carers

2. **Benefits for our staff and organisations**

- Reduced duplication of work and effort
- Less frustration and more rewarding jobs
- Ability to get right professional input when needed
- Satisfaction of providing right support to people
- Reduced bureaucracy and hand-offs
- Integrated information available when needed
- Improved support for families and carers
- Access to right long term support for people when needed
- Professional development and career development opportunities

Forward timeline / next steps

This to fully integrate health and social care in Bridgend will take time and resource. Being able to gain support and agreement for this agenda is a critical first step to ensure both organisations are fully committed to the agenda and to bringing their services together for the benefit of local people.

Next steps:

1. **Agree case for change document** –Agree this case for change document amongst senior leadership within the Council and Health Board. Follow up informal meetings with formal agreement from Council and Health Board.

2. **Build a shared vision for the future** – Using an outline vision statement, work with staff groups and local people to develop an agreed vision and scope.

3. **National support and potential funding** - Inform Welsh Government of the innovative integration programme and discuss opportunity for support as part of a pilot within Wales. Seek to achieve funding to resource this programme.

4. **Agree job description and specification for Senior Integrated leadership role** and recruit to this post

5. **Initiate programme** – On-board and build a programme team and structure, setting out a clear plan and milestones to deliver the joint vision.

Ensuring this is a priority for both organisations is critical and to do this a robust governance structure would need to be established to be able to deliver this ambition. This structure would require regular oversight taking the form of a joint programme board including senior representatives from both organisations.

Risks

As this initiative progresses there will be a number of risks which could impact the pace or successful deliverability of the programme.

Risk	Mitigation
Perceived overlap with the RPB causing friction or a delay in approvals to proceed	Requirement to either set out how this initiative is about a statutory obligation to deliver sustainable services early and / or understand what role the RPB could play in this.
Potential reluctance for staff at all levels to engage with this transformation	The scale of change to ways of working would be far reaching. Being able to resource the change management side of the transformation would be essential to

	build a level of internal engagement of staff who could then act as change agents themselves throughout the programme.
Lack of enthusiasm by involved organisations given the host of wider priorities	On receipt of funding there should be a nationally agreed MoU between organisations to ensure continued engagement and prominence on internal agendas. Stipulated Board / Cabinet items on the topic would keep updates on the agenda.
Development of model for Bridgend being very different from ambitions of RCT and Merthyr Tydfil councils causing complexity of service models for the Health Board	Engagement and informing RCT/MT of progress of work in Bridgend to ensure alignment with developing work on integration in these Council areas.
Lack of Political/Independent Member/Welsh Government backing for the ambition	Ensuring buy in early on in engagement sessions and workshops will encourage engagement and ownership of the plans. Regular updates and championing by organisational Executives / Officers update on progress
Capacity to deliver programme of significant service change	Agree between Health Board and BCBC the necessary capacity to support this programme and seek potential funding from other sources (e.g. RPB/Welsh Govt)

Paul Mears Chief Executive, Cwm Taf Morgannwg Health Board

Mark Shepherd Chief Executive, Bridgend County Borough Council

October 2022

AGENDA ITEM
5.2

CTM BOARD

BOARD ASSURANCE FRAMEWORK REPORT

Date of meeting	24th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Strategic Risk Owner updates	Oct/Nov 22	Reviewed and signed Off
Executive Leadership Group	7.11.2022	Endorsed for Board Approval

ACRONYMS	
BAF	Board Assurance Framework

1. SITUATION/BACKGROUND

1.1 It is good practice for the Health Board to have a Board Assurance Framework (BAF) that clearly sets out the risks, actions and relevant sources of internal and external assurances to provide a clear picture of

the 'health' of the organisation and the high level risks threatening delivery of the Board's strategic goals. The concept for the revised BAF was approved at the Board on the 31st March 2022.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The BAF has been developed to ensure it appropriately reflects;

- the four new strategic goals of the Health Board;
- assurance reporting that supports a streamlined and effective committee and reporting structure;
- a robust mechanism that reaches into each of the localities and central functions to provide assurance on performance, quality and resources across the breadth of the integrated Health Board;
- international best practice; and
- the management of board meetings and agendas to be focussed equally on Oversight, Insight and Foresight i.e. balancing the governance of immediate operational priorities with the need to focus on long-term strategic planning.

2.2 As agreed at the Health Board meeting in July 2022, the Organisational Risk Register will no longer be received formally by the Board. The Organisational Risk Register will continue to be received in its entirety by the Audit & Risk Committee and the assigned risks to the other Board Committees as appropriate.

2.3 The latest Organisational Risk Register will be uploaded to the meeting date "document folder" in Admincontrol so although not published it is fully accessible to Board Members should they wish to view the detail behind the linked risks noted in the BAF.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 During October / November 2022 the Strategic Risk Owners have reviewed and updated the BAF to ensure it robustly reflects the latest position.

3.2 Please refer to Appendix 1 which outlines the key risks for discussion and review. Amendments have been highlighted in red.

3.3 The Board are asked to endorse the following significant changes:

Risk Score:

- **Strategic Risk 3 – Finance Revenue Resource** – risk score remains unchanged however, the order of the Consequence and Likelihood scoring has been changed around as it is considered a 4 for consequence and a 5 for likelihood is a more appropriate assessment of this risk score. The reference to Estates and Premises have been removed from this risk narrative as not appropriate to be

considered within this risk assessment. As indicated in 3.4 below a strategic risk in relation to Capital is being developed. The risk was reframed to clearly articulate that it relates to revenue resources.

- **Strategic Risk 5 – Community & Partner Engagement** risk score reduced from a 16 to a 12 this period. The rationale for a reduction in the likelihood risk score is based on the completion of the Population Needs Assessments and Wellbeing Assessments that have been shared and embraced in the community with resulting activity now underway by Health Board and key partners. The Target Score has also been revaluated during this period with a new likelihood score of 2 assessed.

3.4 Emerging Strategic Risks:

- The Executive Director of Finance is currently developing a Strategic Risk in terms of Capital Resources.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The BAF will provide a robust mechanism that reaches into each of the localities and central functions to provide assurance on performance, quality and resources across the breadth of the integrated Health Board; international best practice; and
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Health Board is asked to **APPROVE** the BAF as follows:

- The updates to the Board Assurance Framework Report for November 2022.
- The changes in risk score highlighted in section 3.3.

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory *(since the last report received by the Board)*
1.	**Sufficient capacity to meet emergency and elective demand** Click Here for Risk 1	**Improving Care** 	Chief Operating Officer, and Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance	**20** (C4xL5)	↔
2.	**Ability to deliver improvements which transform care and enhance outcomes** Click Here for Risk 2	**Improving Care** 	Exec. Dir. Of Nursing, Midwifery Exec. Medical Director	Quality and Safety	**16** (C4xL4)	↔
3.	**Finance Revenue Resources** Click Here for Risk 3	**Sustaining our Future** 	Exec. Director of Finance; ~~Exec. Director for People~~	Planning, Performance and Finance; People and Culture	**20** (~~C5xL4~~) (C4xL5)	↔
4.	**Sufficient workforce to deliver the activity and quality ambitions of the organisation** Click Here for Risk 4	**Sustaining our Future** 	Executive Director of People	People & Culture Committee	**20** (C5xL4)	↔
5.	**Community and Partner Engagement** Click Here for Risk 5	**Creating Health** 	Exec. Director of Public Health	Population Health & Partnerships	**12** (C4xL3)	↓ Reduced from a 16 in November 2022
6.	**Delivery of a digital and information infrastructure to support organisational transformation** Click Here for Risk 6	**Improving Care** 	Director of Digital	Digital & Data	**16** (C4xL4)	↔

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)	Current score	*Trajectory (since the last report received by the Board)*
7.	**Leadership and Management** Click Here for Risk 7	**Inspiring People** 	Exec. Director for People	People and Culture	**16** (C4xL4)	↔
8.	**Culture, Values and Behaviours** Click Here for Risk 8	**Inspiring People** 	Exec. Director for People	People and Culture	**12** (C4xL3)	↔
9.	**Fulfilling our Environmental and Social Duties and ambitions** Click Here for Risk 9	**Sustaining our Future** 	Exec. Director of Strategy and Transformation	Population Health and Partnerships	**16** (C4xL4)	↔

Click here to view CTMUHB's Risk Appetite Statement

Click here to view CTMUHB's Risk Domain and Scoring Matrix

Section 2 Strategic Risk Heat Map

Current risk scores in **black**
Target risk scores in ***grey italic***

Consequence						
	5				**4**	
	4		***5,7,8***	***1,*5***2,3,4,6,*** **8,**	**,6, 7,9,2**	**1,3**
	3			***9***		
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

Section 3 –Strategic Risks

Strategic Goal: **Improving Care**		Risk score **20**
Strategic Risk: **Sufficient capacity to meet emergency and elective demand - (Risk No.1)**		
If the Health Board is unable to meet demands for services at all points in the patient journey, exacerbated by the impact of the Covid-19 pandemic	***Then*** its ability to provide high quality care and to meet access targets will be reduced	***Resulting in*** avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community

	Consequence	Likelihood	Score	**Risk Trend**
Initial	4	5	20	↔ Risk remains unchanged this review
Current	**4**	**5**	**20**	
Target	4	3	12	
Risk Appetite	**Cautious** *(quality and safety; trust and confidence; legal and regulatory)*			

Risk Lead	• Chief Operating Officer • Executive Director of Strategy & Transformation	Assurance committee	• Quality & Safety Committee *(potential harm)* • Planning, Performance and Finance *(performance targets)*

Controls	Assurances reported to Board and committees
Strategies and Plans • Annual Planning Process • Winter Pressures Plan • Elective Recovery Portfolio • Annual Capacity Plan established April 2022. • A Residential and Nursing Care for Older People Report has been completed and approved by the Regional Partnership Board and actions being implemented. • Alternative bed options being worked-up by Rhondda Cynon Taf County Borough Council to aid patient flow and 'Discharge to Recover then Assess' (D2RA) out of hospital stabilisation and onward decision-making.	• Integrated Performance Report • Nurse Staffing Act twice-yearly compliance reports • Harm Reviews • Assessment Dashboard • Update reports on specific services experiencing pressure, e.g. Ophthalmology • Follow-up reports on outpatients not booked • Urgent Care six goals progress reports (monthly) • Planned Care Recovery Update report (monthly) • Escalation processes leading to Chief Operating Officer Report to Quality &

Improvement Programmes • Targeted Intervention / Special Measures programme work • Improvement CTM • Urgent and Elective Care Improvement Programme • Enhanced support for specific services e.g. CAMHS • Enhanced monitoring process for Cancer Services • Elective Care Recovery Programme (includes external provider commissioning) • Integrated Health & Social Care Programme Board. • Regional Integrated Fund (RIF) • Urgent Care Six Goals • Planned Care Board • Stroke Strategy Group • Ty Llidiard Improvement Board • Pathology Improvement Group • Ophthalmology Improvement Board • Dermatology Improvement Board • **Regional Pathology Steering Group** **Governance Structures** • Operational Management Board (Health Board wide) • Improving Care Board (Health Board wide) • Six Goals Board • Cancer Board • Weekly Cancer Meetings • Planned Care Recovery Board • Innovation Board • Prince Charles Hospital Improvement Board **Operational Processes** • Clear criteria to prioritise based on clinical need • Centralised decision-making around use of spare capacity across the organisation	Safety Committee including ILG performance review meetings. • Corporate Risk Register via ILG risk Registers. • Integrated Health & Social Care Plan to be received in November 2022 by Board. • Board Members received an update on Winter Plan in October 2022.
Gaps in Controls and Assurances	**Mitigating Actions**
• Annual Operational Plans • Central digitally-based Capacity Management System • Robustness of cancer tracking and specialty-specific elective data – Improvements being made in elective care trajectories albeit not fully embedded.	• Speciality Specific and Cancer Improvement Trajectories • As part of the Six Goals Framework a Task and Finish Group has been established to scope options for a digital alternative e.g. e-whiteboards. Timeline projector available upon request within the six goals information pack.

	• Additional Winter Bed Capacity being mobilised from November 2022. • Reconfiguration of elective surgery from October 2022. • Initiated business continuity plan in October 2022 due to increased capacity pressures. • Development and from November 2022 implementation of Winter Plan. Pressures upon capacity continually being monitored to feed into Winter Plans.
Linked National Priority Measures	**Current Performance - Highlights**
Ministerial Measures: *Six Goals of Urgent and Emergency Care:* • Percentage total conveyances taken to a service other than a Type One Emergency Department; • Number of people admitted as an emergency who remain in an acute or community hospital over 21 days since admission; and • Percentage of total emergency bed days accrued by people with a length of stay over 21 days. *Access to Timely Planned Care* • Number of patients waiting more than 104 weeks for treatment; • Number of patients waiting more than 36 weeks for treatment; • Percentage of patients waiting less than 26 weeks for treatment; • Number of patients waiting over 104 weeks for a new outpatient appointment; • Number of patients waiting over 52 weeks for a new outpatient appointment; • Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%; • Number of patients waiting over 8 weeks for a diagnostic endoscopy; and • Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route). • Patient and delayed ambulance handovers (15min handover) •	The following key performance indicators should be considered from the Integrated Performance Dashboard: • Urgent care • planned care, • cancer • and diagnostic indicators
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
3826	Emergency Department overcrowding	**20**
4071	Failure to sustain services as currently configured to meet cancer targets	**20**
4103	Sustainability of a safe and effective Ophthalmology service	**20**
4491	Failure to meet the demand for patient care at all points of the patient journey	**20**
4632	Demand and capacity across the stroke pathway	**20**
4743	Failure of appropriate security measures / safety fencing	**20**
4721	Shift of the boundary for attendances at the Emergency Department	**20**
5036	Pathology services unable to meet current workload demands.	**20**
4458	Failure to deliver Emergency Department Metrics (including 15 minute handover and 4 and 12 hour breaches	**16**
4149	Failure to sustain Child and Adult Mental Health Services	**16**
1133	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital	**16**
4152	Back log for Imaging in all modalities / areas and reduced capacity	**16**
2808	Waiting Times/Performance: ND Team	**15**
5207	Care Home Capacity	**15**

Click here to go back to the summary Section

Strategic Goal: **Improving Care**	Risk score **16**
Strategic Risk: **Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)**	

If the Health Board fails to achieve fundamental quality standards or implement improvements in practice and innovations	***Then*** we may not be able to deliver safe, timely, compassionate and effective care in accordance with the Duty of Quality	***Resulting in*** avoidable harm to patients, poor patient experience, diminished staff morale, potential for greater regulatory intervention and loss of trust and confidence

	Consequence	Likelihood	Score	Risk Trend
Initial	5	4	20	↔ Risk remains unchanged this review
Current	**4**	**4**	**16**	
Target	4	3	12	
Risk Appetite	**Cautious** *(quality and safety; trust and confidence; legal and regulatory)*			

Risk Leads	• Executive Nurse Director • Executive Medical Director	Assurance committee	Quality and Safety

Controls	Assurances reported to Board and committees
Quality Frameworks and Policies • Quality Governance Framework (will be updated to reflect new National Quality and Patient Safety Framework) • Clinical Guidelines • Suite of Standard Operating Procedures • Clinical Education Framework • Incident Management Framework launched June 2022 to reflect national changes in national incident reporting. • Incident Investigation training established and being rolled-out across the Health Board on a monthly basis. • Improvement and Innovation Board • Clinical Education Forum (providing overarching Governance) established, with its inaugural meeting in July 2022. • Listening & Learning Framework launched and implemented at the Listening and Learning Event in September 2022. **Learning from Experience** • Mortality Review programme • Shared Listening and Learning Forum	**Annual Reports** • Clinical Audit Annual Report • Clinical Education Annual Report • Safeguarding Annual Report • Putting Things Right Annual Report • Infection Prevention and Control Annual Report • Medicines Management Expenditure Committee Annual Report • Health and Care Standards Annual Report (incorporating patient survey) • GMC Survey **Quarterly Reports** • Quality Dashboard • Integrated Performance Dashboard • Quality Governance – Regulatory review progress updates • IPC Highlight reports • Integrated Locality Group reports • High level update on mortality indicators • Research and Development Update • National Clinical Audit and NCEPOD studies

- Community Acquired Pressure Ulcer Collaborative. Forum for shared learning on prevention and improvement with internal and external stakeholders e.g. (Welsh Wound Innovation Centre (WWIC) and Local Authorities).
- Weekly executive-led patient safety meetings
- Service Level Patient Safety meetings incorporate learning from events.
- Joint Executive and Independent Member Walkarounds
- Patient and Staff Stories received at Board Meetings and Quality & Safety Committee
- Active Forums such as "My Maternity My Way" which includes past and present service users.
- Real-time patient feedback (Civica System) being rolled out across the Health Board (PREMS).
- Following discussions in relation to the operating model that will support the new Care Groups it is considered that Quality Assurance will be will be incorporated within these new structures which plan to be introduced in September 2022.
- Patient Safety Clinics, targeting service areas with high or low incident reporting.
- Learning from events coordinator role in place, with lesson of the week via social media and a monthly newsletter is shared across the Health Board sharing learning around incidents and concerns.
- Patient Reported Outcomes Measures system procured and piloted in Heart Failure / Cardiology services and plans in place to roll out across HB (PROMS).
- Staff ideas scheme launched across CTM for staff to provide ideas for improvement and collaborate on solutions.
- RADAR (Recognition of Acute Deterioration & Resuscitation) Committee. – Training standards and compliance.
- It is anticipated that the New Operating Model will support the triangulation and learning across the Health Board as one CTM.
- Advanced Clinical Practice Board established to provide governance oversight with regards to advanced practice professionals.
- Targeted intervention process – continuous improvement self-assessment reports to board
- Maternity and Neonatal Improvement Programme Highlight Report
- Community Health Council briefing papers
- RADAR Reports
- Improvement portfolio report
- Multiple engagement events underway

Ad hoc Assurances

- PCH spot visits to services – improvement programme
- Covid-19 updates to Quality and Safety Committee
- Executive and Independent Member Patient Safety Walkabouts (when circumstances permit)
- Peer reviews of specific services e.g. critical care
- Community Health Council visits.
- Health Inspectorate Wales unannounced visits.
- Medication Prescription and Administration incident update
- Bridgend Safeguarding Hub
- Community Acquired Pressure Damage
- Patient Safety Solutions – safety alerts and notices
- Mental Capacity Act (LPS)

Qualitative Intelligence

- Patient and Staff Stories
- Executive & Independent Member Walkarounds
- Executive Nurse Director weekly clinical focussed site visits.
- Improvement case studies
- Social Media feedback and intelligence
- Listening and Learning forum
- Weekly executive-led patient safety meetings
- Delivery Unit (DU) Dashboard reports inform the Health Board in terms of compliance across the Patient, Care and Safety portfolio.
- The Health Board is represented at the Candour and Safety Learning Network meeting. Inaugural meeting due to take place in September 2022.

Innovation & Improvement Programmes

- iCTM (Improvement & Innovation) department in place and 2022-2025 iCTM business plan developed aligned to CTM 2030 focusing on Experience, Efficiency and Effectiveness all underpinned by Improved outcomes and Patient Safety.
- Leading for Patient Safety with Improvement Cymru and Institute for Healthcare Improvement (IHI) launched. Draft work programme to be discussed with Executive Leads during November 2022.
- Improvement and Innovation CTM are actively supporting a number of services
  - CAMHS
  - Maternity
  - Urology
  - General Medicine (RGH) e.g. CAMHS
  - Prince Charles Hospital improvement
  - Pressure Ulcer Improvement with WWIC
  - Engaging with external partners to ensure collaboration in relation to multiple stakeholder working to realise benefits for the communities we serve.
- Targeted Intervention / Special Measures programme work
- ~~PCH/Merthyr ILG Improvement Programme~~. Removed as now integrated as business as usual. Immediate make safes complete.
- Enhanced monitoring and support for specific services e.g. CAMHS
- Monthly Quality Improvement (QI) training commenced from June 2022
- Patient Safety Clinics commenced June 2022 and will run bi-monthly or as required by services.
- Investigation and Putting Things Right (PTR) Training commences during July 2022
- Value Based Healthcare programme in place aligned to national Value in Health priorities
- Enhanced resources in place for business analysis / data analysis to identify areas of improvement and change through data
- Innovation programme aligned to Value Based Healthcare principles
- Building leading and empowering Improvement and Innovation into the new
- Partnership Working with Cardiff & Vale re South Central Regional Stroke Network.
- Board Briefing regarding Regional Stroke Developments taking place December 2022.

External Assurance

- Ombudsman's Annual Letter
- Internal Audit Review – CSG & ILG Quality Assurance. August 2022 – outcome of Reasonable Assurance.
- Healthcare Inspectorate Wales reports e.g. Prince Charles Hospital (PCH) Improvement Programme
- Audit Wales review of Quality Governance arrangements and follow up
- Delivery Unit governance and incident management
- Delivery Unit Maternity and Neonatal SI closures
- Annual Undergraduate Review
- General Medical Council National Survey Feedback
- External Independent Maternity Services Oversight Panel - Maternity and Neonates.
- Positive IHI and Improvement Cymru visit feedback as part of Leading for Patient Safety received and feedback to Board scheduled for later in 2022.

Ignite, Aspire and Inspire leadership programmes • Implementation of ILG Improvement Faculties **Research** • Research & Development Programme	
Gaps in Controls and Assurances	**Mitigating Actions**
1. Data : • Real-time performance and quality data accessible via electronic systems across the organisation 2. Fundamentals of Care Audit (under development – piloted in Maternity Services & Paediatrics) 3. Raising awareness of staff responsibilities under the Duty of Quality and the Duty of Candour linking in with the actions arising out of the All Wales forum for which the Health Board is represented, which will include the development and roll out of training packages. 4. Plans now in place to address any legacy issues to resolve any duplications identified on implementation. 5. Quality Strategy in development as of June 2022 -Phase 1 – outlining our approach. Next phase will set SMART objectives, phase 3 – delivery. Received at July Q&S Committee. Stakeholder engagement underway. Quality Strategy planned for submission to Q&S Committee in November 2022. 6. Feedback from staff and our communities on the ability to raise ideas, freedom and support to make change and empowerment. Holding engagement sessions for staff. Clinical staff sessions also ~~7. Listening and Learning Framework is in development and will be available during July 2022. Will be launched with the listening and learning event in September 2022.~~	1. Central Patient Safety Team are manually reviewing and validating data currently in relation to locally reportable incidents. In progress, pace impacted by the implementation of the new Operating Model. 2. Medical Productivity Group now operational with initial meetings underway. 3. Nursing Productivity Groups operational. 4. Medical Day Surgery expansion expanded to address the backlog in the light of capacity challenges. Plans in place for four specialties with a view to increasing day case surgery throughput. 5. Nursing Ward Assurance Audit ~~Fundamentals of Care~~ Pilot (Baseline ward assurance audit completed June 2022) and in the process of being adapted to support a Ward to Board Nursing and Midwifery Assurance Framework. Timescale – September 2022. Complete and will be received at the Q&S Committee in November 2022. 6. CTMUHB is represented on the work being undertaken with the Delivery Unit to explore how benchmarking in quality performance can be shared across NHS Wales. The Delivery Unit are also rolling out a National Quality Safety Framework to support a consistent approach to quality reporting. Timescales dependent on external sources. 7. The Health Board is represented on the programmes of work supporting the roll out of the Duty if Candour and Duty of Quality. Focus in terms of quality will be on the Code of Practice and the implementation of any training. Timescales: by April 2023. ~~8. The Datix Team are undertaking manual exercises on a daily basis to mitigate any~~

	~~duplication with the implementation of the OFW incident module to avoid duplicate reporting as far as possible. Timescales are dependent on the National Team support, however the Health Board has committed to transfer all legacy incidents to the new system by the end of August 2022.~~ Completed so can now be removed. 9. Speciality Teams across CTM are now regularly meeting to enhance shared learning amongst doctors. This will be enhanced further by the care group model currently being rolled-out. 10. Ambition to develop live clinical quality dashboard 11. Quality Strategy in draft for approval with plan for presentation to November 2022 Quality & Safety Committee and the Board thereafter. 12. Implementation Board for the Duty of Quality and Candour being established – inaugural meeting planned for November / December 2022. Board Briefing held October 2022.
Linked National Priority Measures	**Current Performance - Highlights**
Care Closer to Home • 6. Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes • 7. Percentage of patients (aged 12 years and over) with diabetes achieving all three treatment targets in the preceding 15 months **Patient Safety Solutions** **Infection Prevention and Control** • Six Tier One IP&C Targets • National IP&C Guidance – to include implementation of respiratory and non-respiratory pathways. • NHS Wales National Framework – Management of patient safety incidents following nosocomial transmission of Covid-19	Please refer to the following sections of the Integrated Performance Dashboard to triangulate risk, assurance and performance: • Cancer Standards • Unscheduled Care • Six Goals Programme (Emergency & Urgent Care) • Waiting List Delays • Mortality Indicators • Tier 1 IP&C Indicators • Nurse Sensitive Outcome Measures – Falls, Pressure Ulcers, medication administration. • Sepsis • Mental Health Measures. • Putting Things Right Compliance • Patient Safety Solutions compliance

Children's Charter To reinforce children's rights and endorse CTM's commitment to upholding these rights within its services. **Safeguarding** • National Improvement Plan • Preparation for Liberty Protection Safeguards (LPS). **Chief Nursing Officer's Launch of the Nursing and Midwifery Priorities – 2022-2024** **New national nurse education standards** **Dementia Standards -** which include standards for inpatient hospital admissions. **NHS Wales Quality and Safety Framework: Learning & Improving**. Published by WG September 2021. **The Health & Social Care** (Quality & Engagement) (Wales) **Act 2020** Improving quality and public engagement in health and social care. **National Value Based Healthcare Strategy –** alignment of CTMs programme of work to meet national priorities	
Were there any significant incidents affecting this strategic Risk this period:	
Significant incidents (NRI or LRI) are managed in according with the Incident Framework and reported to the Quality & Safety Committee.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4479	No centralised decontamination facility in Princess of Wales Hospital	**20**
4907	Failure to manage Redress cases efficiently and effectively	**20**
5254	Failure to manage redress cases efficiently and effectively in respect of the Duty of Candour. New risk escalated November 2022.	**20**
5214	Critical Care Medical Cover	**20**
4922	Covid-19 Inquiry Preparedness – Information Management	~~**16**~~ **20**
3133	Non-attendance at medical gas safety training and courses being rescheduled	**16**
3585	Princess of Wales Emergency Department hygiene facilities	**16**

4148	Non-compliance with Deprivation of Liberty Safeguards legislation and resulting authorisation breaches	**16**
4906	Failure to provide evidence of learning from events (Incidents and Complaints)	**16**
4940	Delay to full automated implementation of Civica	**16**
4679	Absence of a TB vaccination programme for staff.	**16**
4908	Failure to manage legal cases efficiently and effectively	**16**
2787	Absence of a robust Health Surveillance Programme for employees	**16**
4417	Management of Security Doors in All Hospital Settings	**16**
5014	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	**16**
5267	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses – New risk escalated October 2022.	**16**
3993	Fire enforcement notice – POW Theatres	**15**
4512	Care of patients with mental health needs on the acute wards	**15**
4590	Critical care pharmacist resource	**15**
4732	Replacement of press software on the 13 & 10 stage CBW presses	**15**
4920	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	**15**
4253	Ligature points – inpatient services	**15**
2987	Fire enforcement order First Floor PCH	**15**
4691	New Mental Health Unit	**15**
5207	Care Home Capacity	**15**
4217	No infection prevention and control resource for primary care	**15**
~~4106~~	~~Increasing dependency on agency staff which impacts on continuity of care and patient safety~~	~~**16**~~
~~4157~~	~~Risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives~~	~~**16**~~
	The Deputy Director of Nursing has created a new risk to amalgamate risks 4106 and 4157. The new risk is Datix Reference 5267.	

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Strategic Goals: **Sustaining our Future**	Risk score **20**
Strategic Risk: **Finance Revenue Resource - (Risk No.3)**	

If the Health Board fails to manage its revenue resources that are appropriate and sufficient for now and the future	***Then*** we may fail to fulfil our financial and other statutory duties in 2022-2023.	***Resulting in*** inability to fund planned improvements and new services, and increased regulatory scrutiny and enforcement

	Consequence	Likelihood	Score	Risk Trend
Initial	5	5	25	↔ Overall Risk Score remains unchanged, however, consequence score has changed to a 4 and likelihood changed to a 5.
Current	~~**5**~~ **4**	**45**	**20**	
Target	4	3	12	
Risk Appetite	**Minimal** *(financial stability)* **Cautious** *(legal and regulatory)* ~~**Open** *(estates)*~~			

Risk Lead	• Executive Director of Finance • ~~Executive Director for People~~	Assurance committee	• Planning, Performance and Finance *(finance and estates issues)* • ~~People and Culture *(workforce planning)*~~

Controls	Assurances reported to Board and committees
Financial Management • Budget setting process • Budgetary control and management accounting • Standing Financial Instructions • Scheme of Reservation & Delegation • Local Counter-Fraud Service • Monthly financial performance reviews for Care Groups and corporate directorates • Recovery plans for financially challenged services accompanied by enhanced monitoring and support ~~**Premises**~~ • ~~Capital Programme~~ • ~~Estates and Capital Planning Group~~	**Financial Management** • Annual Report and Accounts • Monthly Finance Reports • Monitoring Returns to Welsh Government • Internal Audit Programme • External Audit Programme • Losses and Special Payments Report to Audit Committee ~~**Premises**~~ • ~~Estates and Facilities EFPMS dashboard~~
Gaps in Controls and Assurances	**Mitigating Actions**
Finance • Understanding of budgetary control and procurement processes in some services • A recognised risk of in year inflationary pressures. ~~**Premises**~~	**Finance** • Deliver training to budget holders within localities – *ongoing, for completion by end 2022.* • Deliver procurement training to departments where compliance with

~~• Estates Strategy~~ • Reporting of performance information to Board and committees regarding estates and premises	procurement processes is low - ongoing, for completion by end 2022. • Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. • Developing a more a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. • Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. • Further discussions needed with Welsh Government to understand the likely funding position for 22/23 in relation to the Core plan deficit, Exceptional items and ongoing Covid-19 response costs. **~~Premises~~** • ~~Introduce regular reporting to PPF Committee based on Estates key performance indicators – *June 2022*~~ • ~~Develop Estates Strategy aligned to priorities within the 'Our Health Our Future' 2030 corporate strategy – *end 2023*~~
Linked National Priority Measures	**Current Performance - Highlights**
Workforce • 23. Agency spend as a percentage of the total pay bill **Public Sector Prompt Payment (PSPP) Performance**	• The Month 6 Year to Date position is a £14.6m deficit. This represents a £1.4m adverse variance compared to 6/12ths of the planned £26.5m Core plan deficit (£13.2m). • The Month 6 savings position is forecasting £17.5m of savings in 22/23 but only £10.4m on a recurrent basis. The savings target for 22/23 is £17.3m. The Recurrent savings gap is therefore £6.9m. • The Month 6 Year to Date agency spend was £28.5m which represents 8.9% of the total pay costs of £322.4m. • PSPP performance at M6 was 94.6% which exceeds the 95% target.
Were there any significant incidents affecting this strategic Risk this period:	
Volatile economic and UK Political instability is a significant impact upon this strategic risk.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
5153	Failure to achieve financial balance in 2022/23.	**20**
5154	Failure to reduce the planned recurrent deficit of £28.0m at the end of 2022/23.	**20**

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Strategic Goals: **Sustaining our Future**	Risk score **20**
Strategic Risk: **- Sufficient workforce to deliver the activity and quality ambitions of the organisation (Risk No. 4)**	

If the Health Board fails to identify and plan for its future workforce requirements, and to promote CTMUHB as an attractive place to work	***Then*** we may fail to recruit and retain staff with the right skills and experience	***Resulting in*** Loss of skills and talent, staffing shortages which adversely affect the quality of care and employee experience and prevent us from delivering services fit for today and tomorrow

	Consequence	Likelihood	Score	Risk Trend
Initial	5	5	25	↔ Risk remains unchanged this review
Current	**5**	**4**	**20**	
Target	4	3	12	
Risk Appetite	**Minimal** *(financial stability)* **Cautious** *(quality and safety, (legal and regulatory)*			

Risk Lead	• Executive Director for People	Assurance committee	• People and Culture

Controls	Assurances reported to Board and committees
Recruitment • Online recruitment through TRAC • Overseas recruitment of clinical professionals • Pathways to Employment programmes (Kick Start, Project Search, apprenticeships) • NHS Wales and Academi Wales public sector graduate trainee programmes • Living Wage employer status • Local Recruitment & Retention Premium Payment Protocol **Retention** • Career development opportunities, e.g. Pathways into Management programme • Exit questionnaires to understand reasons for leaving • Employee Experience Work stream • Talent Management • Leadership Development Programme **Temporary staffing solutions** • New Medical Bank • Modernised processes for Nurse Bank	• Workforce and Organisational Development Metrics report (includes key performance indicators such as staff in post, turnover, unfilled hours, sickness) which is regularly reported to the CTM to People & Culture Committee. Data also included in Integrated Performance Report to the Board. • Bi-annual Medical Workforce and Medical Efficiency Reports • Twice yearly nurse staffing assurance reports to the Board • Benchmarking analysis • Annual Education Commissioning Submission

• Locum Managed Service Agreements **Day-to-day management of staffing levels** • Electronic rostering • Medical job planning • Sickness absence management process **Workforce Planning** • Assistant Director role established to lead strategic workforce planning • Health Education Improvement Wales (HEIW) Workforce Planning Tool and Skills for Health modelling tool • Establishment Control • Procured 'expert' workforce planning to support CTM to identify immediate tactical priorities that inform our existing plans. This will also identify longer term opportunities for workforce redesign. • As part of an all-Wales piece of work, Nurse Workforce Modelling will provide high level indication of vacancies and routes to fill. • Workforce Strategy development for Health Care Sciences and AHPs is a key priority. • Attendance at National Careers Fairs with learning to inform future attendance. • **Engagement with national programme to review Advanced and Consultant level framework.**	
Gaps in Controls and Assurances	**Mitigating Actions**
Workforce Planning • Workforce Planning process not yet in place – currently at very early stage • Establishment control not in place **Recruitment** • Work experience programmes to be considered in conjunction with ongoing work in relation to pathways to employment. ~~suspended due to Covid-19~~	As noted in the controls, the Workforce & Organisational Development department have ~~are~~ procured external support to take forward the following activities which will commence end of October / early November 2022. ~~and this will initially be reviewed at the beginning of October 2022.~~ • Development of local, operational workforce resourcing plans that minimise vacancies and optimise the skills of the existing workforce to ensure opportunities to grow our own are maximised. • Design a workforce planning approach that will encompass all elements from establishment control and improved workforce analytics to ensure we understand who CTM has and who it needs, to improved attraction and recruitment approaches to employ the

	best people from the widest possible pool. • The strategic lens approach will drive consideration of the shape of the workforce, seamless workforce models that are multi professional and multi-agency and consider the roles that are needed in a technology driven workplace where robotics and AI are commonplace. • Plans will be developed that take account of workforce trends and horizon scanning to inform consideration of future models of care and an understanding of the skills and capabilities needed and education required to deliver the future health needs of the CTM population.
Linked National Priority Measures	Current Performance - Highlights
Workforce • 23. Agency spend as a percentage of the total pay bill • 27. Percentage sickness rate of staff	The following key metrics are set out within the Workforce and Organisational Development Metrics section of the Integrated Performance Report: • The number of job plans for consultants and other senior doctors needs to be improved. • Sickness absence currently remains above target • Staff in post stands at 12,548 with staff turnover at 13.22% The Health Board's integrated dashboard sets out further details in respect of workforce related performance metrics.
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4080	Failure to recruit sufficient medical and dental staff	**20**
4827	Lack of lead for Face Fit Training along with Face Fit Trainers	**20**
5214	Critical Care Medical Cover	**20**
4780	Patient Handling Training. Risk rated as a 16.	~~**16**~~ **20**
4722	Senior Medical Workforce Shortfall. Risk scored at a 16.	**16**
4106	Increasing dependency on agency staff cover impacting on continuity of care and patient safety	**16**
4157	Difficulty recruiting sufficient numbers of registered nurses and midwives	**16**
4798	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital	**16**
4997	Consultant Physician in Ysbyty Cwm Cynon (YCC).	**16**
4356	Overdue/Out of date fire risk assessment due to resource issues and the amount required to be undertaken	**16** ~~**20**~~

4500	Difficulty recruiting sufficient numbers of registered therapists and healthcare scientists	**15**
4971	Adult Special Care Dentistry	**15**
4315	Non Compliance of Fire Training – Provision	**15**
4809	Non Compliance with Mandatory Violence and Aggression Training	**15**

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Strategic Goal: **Creating Health**	Risk score **12**
Strategic Risk: **Community & Partner Engagement - (Risk No.5)**	

If the Health Board ***does*** not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	***Then*** we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	***Resulting in*** continuing health inequalities and poor population health outcomes, including in relation to Covid-19

	Consequence	Likelihood	Score
Initial	4	5	20
Current	**4**	**4 3**	**12**
Target	4	~~3~~ 2	8
Risk Appetite	**Cautious** *(quality and safety; trust and confidence)*		

Risk Trend

↓

Reduced from a 16 in November 2022

The rationale for a reduction in the likelihood risk score based on the completion of Population Needs Assessments and Wellbeing Assessments that have been shared and embraced in the community with resulting activity now underway by CTMUHB and key partners. Target score also revaluated during this period - new likelihood score of 2 assessed.

Lead Director	Executive Director of Public Health	Assurance committee	Population Health & Partnerships

Controls	Assurances reported to Board and committees
Strategies & Plans • 2030 Strategy – 'Our Health Our Future' (in development) • Public Engagement Plan for 'Our Health Our Future' • Becoming an Engaging Organisation • Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021 • Public Service Board – Well Being Plans (CT and Bridgend). • Integrated Level 2 and Level 3 Weight Management Services – established in September 2022. **Engagement Forums** • Regional Partnership Board • Public Service Board • Stakeholder Reference Group	**Reports to Board** • Director of Public Health Annual Report (estimated January / February 2023) • Population Health Board Report CTM Public Health Team have established baselines for high level indicators in the Population Health Plan to enable system performance accountability and measure the impact of our work which will be reported to Board through update reports. However there are further baseline measures that require engagement with Public Health Wales to develop. **Reports to Population Health & Partnerships Committee** • Covid-19 and Vaccination Programme Reports

- Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well
- Engagement with community groups by Lead Independent Members
- Links with Community Health Council including representation on Board
- Regular joint executive meetings with the three local authorities
- Accelerated Cluster Development Programme Board – engagement across Primary Care
- Health and Social Care Integration Board
- Forum with local authority Chief Executives to address health inequalities

Needs Assessment & Consultation Processes

- Population Segmentation & Risk Stratification
- Pharmaceutical Needs Assessment
- Health Needs Assessments, e.g. Homeless People, Prison Health
- Wellbeing Assessment
- Population Needs Assessment (Regional Partnership Board)
- Formal consultation processes for service reconfiguration, e.g. vascular

Organisational Structures

- Public Health Consultants allocated to support Risk Leads for each priority in the Population Health Organisation plan
- Public Health & Primary Care Oversight Group which is an integrated Group established to bring together Public Health and Primary Care to ensure improved coherence across Population Health Programmes / Projects.
- Locality Structures enabling more engagement with local communities
- Membership of the key partnership forums.

Population Health Assessments

- Completion of the Population Needs Assessments and Wellbeing Assessments undertaken. The community have embraced the themes and CTMUHB along with key partners are taking forward activity as appropriate.

- Regional Partnership Board Annual Report
- Transformation Fund and Leadership Board Updates
- Population Health Management Updates
- Mental Health Strategic Update

Reports to other committees

- Community Health Council briefing papers to Quality and Safety Committee

Gaps in Controls and Assurances	Mitigating Actions
• Work to establish statistical baselines delayed / interrupted by Covid pandemic • Limited analytical and health intelligence capacity, particularly in specialist areas such as epidemiology • Long-term sustainability of resources to undertake Population Health work	• Implementation of key actions in the Population Health Plan approved by Board in May 2021. *Framing and incorporating these actions as part of the Unified Transformation Programme – Creating Health.* • Further baseline work with Public Health Wales in relation to population health outcome measures. *Timeframe April 2023.* • Refocus preventative early years funding from Welsh Government to tackle gaps in resource – *Completed for 2022-2023. Requires annual review.* • Activity underway to evaluate current deployment of community resources with the aim of rationalising resource to deploy the intelligence from population health management. In Progress – target timeframe 28.2.2023.

Linked National Priority Measures	Current Performance - Highlights
Population Health – Ministers Measures Phase One 1. Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All Wales Weight Management Pathway 2. Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway 3. Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally. 4. Percentage of adult smokers who make a quit attempt via smoking cessation services 5. Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates	Integrated Performance Dashboard: Quadruple aim 1: the percentage of adult smokers who make a quit attempt via smoking cessation services. Target 5%

Were there any significant incidents affecting this strategic Risk this period:
None identified for inclusion in the BAF Report.

Associated Risks on the Organisational Risk Register		

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Strategic Goal: **Improving Care**	Risk score **16**
Strategic Risk: **Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.6)**	

If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	***Then*** We will be unable to design and execute a Health Board wide strategy to transform services that are tailored to meet the needs of our people and our communities.	***Resulting in*** Continuing health inequalities and poor population health outcomes, an inability to transform our cost base and our service design, which will result in slow progress towards improving our population's and patients experiences, and continue to constrain our ability to work seamlessly across our region.

	Consequence	Likelihood	Score	Risk Trend
Initial	4	5	20	
Current	**4**	**4**	**16**	↔
Target	4	3	12	Risk remains unchanged this review
Risk Appetite	**Cautious** *(data and information; legal and regulatory)*			

Risk Lead	Director of Digital	Assurance committee	Digital & Data

Controls	Assurances reported to Board and committees
• Digital & Data Strategy • Population Health Strategy • Digital & Data Delivery Programme • IT Infrastructure Review • Digital Delivery Board • Digital Investment Fund • Information Security, Records Management and Information Governance Policies and Improvement Programmes	**Reports to Digital and Data Committee** • All-Wales Information Governance Toolkit and ICO Audit Review. • NIS-D Cyber Assessment Framework and Improvement Plan (CRU). • Digital Programme Assurance Report • Internal Audit Reports • Coding Improvement Plan • Bridgend Aggregation Programme **Reports to other committees** • Progress updates against Population Health Strategy • Planning, Performance & Finance
Gaps in Controls and Assurances	**Mitigating Actions**
• Closing the gap in Digital Helplessness • Training and Awareness Programme • Tested and integrated cyber incident management plan • Incomplete asset register	• Work with WG to mandate digital and cyber security training for all staff • Pursue funding from Government to enable further integration of Bridgend IT

• Poor adherence to policies • Insufficient capital and revenue resource allocation and the capacity of the skilled workforce • Integration of information systems for services in the Bridgend area transferred from Swansea Bay University Health Board • Lack of an open architecture • Widespread non-adherence to data standards • Critical supplier(s) unable to respond to the UHB's requirements and ministerial priorities within defined timescales • Capacity within current team to deliver digital transformation agenda • Delayed delivery of the digital patient notes programme • Resourcing of Information Governance function within the Health Board • No function within the UHB focussing on benefits realisation • Limited progress to reduce/remove paper processes and move to a fully integrated digital patient record	systems and support delivery of the digital programme- *ongoing* • Establish agile change management practices across the organisation • Review of existing resources and structure for Digital Directorate and recommendation of new operating model – *June 2022 for review; to be implemented during 2022/23* • Make progress in delivering the cyber, IG and digital and data programmes • Work with other NHS Wales partners, industry, academia and third sector organisations to improve our current digital competencies across the Health Board and our communities
Linked National Priority Measures	**Current Performance - Highlights**
Digital and Technology National Clinical Framework (WHC 2021/03) Welsh Government, March 2021), Quality and Safety Framework: Learning and Improving (WHC 2021/022 September 2021) Value Based Health and Care Coding standards	• Majority of agreed digital programmes have delivered (coding, nursing record) or are delivering to timescales however the Emergency Department system implementation is delayed due to funding and capacity constraints. • In terms of 'Open Eyes' CTMUHB is ready to deploy for Glaucoma however, further roll-out is paused due to funding and capacity constraints. • Access to digital funding streams is under review due to proposed decreases in the national digital prioritisation funds • IG and Cyber programmes are structured but constrained by resources • Much progress on infrastructure enhancements across CTM sites • Analytics capacity falling short of demands, delaying service improvement initiatives • Programme to share data across primary and secondary care on hold due to adverse resource allocation choices.

Were there any significant incidents affecting this strategic Risk this period:
None identified for inclusion in the BAF Report.

Strategic risk assessment	Holding information securely and confidentially	Effective governance, leadership and accountability	Obtaining information fairly and efficiently	Recording information accurately and reliably	Using information effectively and ethically	Sharing information appropriately and lawfully
Impact	5	4	4	3	3	3
Likelihood	4	2	2	4	4	5
Risk	**20**	**8**	**8**	**12**	**12**	**15**

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
5276	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025. Risk rated as a 20. New Risk October 2022.	**20**
4664	Ransomware attack resulting in loss of critical services and possible extortion	**20**
4887	Retrieval and filing of case notes in the POW Medical Records Library	**20**
4337	Lack of Integrated IT systems	**16**
3337	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**15**
4671	NHS Computer Network Infrastructure unable to meet demand	**15**
4672	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards	**15**
4772	Replacement of press software on the 13 & 10 stage CBW presses	**15**
5040	Digital Healthcare Wales (DHCW interdependencies	**15**
4699	Failure to deliver a robust and sustainable Information Governance Function	**15**

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Strategic Goal: **Inspiring People**	Risk score **16**
Strategic Risk: **Leadership and Management – (Risk No.7)**	

If we fail to provide compassionate and effective leadership at all levels of the organisation and all professions to empower and enable our workforce	***Then*** there will be lack of confidence to enable informed decision-making at the appropriate level and to implement organisational change	***Resulting in*** lack of commitment and engagement, poor communication, deterioration of staff wellbeing, and difficulty in recruiting and retaining the staff we need

	Consequence	Likelihood	Score	Risk Trend
Initial	4	4	16	↔ Risk remains unchanged this review, although the target score has been revised.
Current	**4**	**4**	**16**	
Target	~~3~~ 4	~~3~~ 2	~~9~~ 8	
Risk Appetite	**Cautious** *(assets; trust and confidence)*			

Risk Lead	Executive Director for People	Assurance committee	People and Culture

Controls	Assurances reported to Board and committees
Leadership Development • Board Development Programme • Comprehensive leadership development programmes. • In-house Leadership Development Programme (Senior Leaders / Developing Leaders / Management Essentials) • Learning partnerships with HEIW, The Kings Fund and Academy Wales • HEIW Compassionate Leadership Programme • Establishment of Leadership Coaching & Mentoring Network • Re-launch of Leadership 360 Degree Feedback • Leadership and Culture Workshops for executives and senior leadership teams • Additional leadership development work targeted to specific services, e.g. Maternity **Leadership Engagement with the workforce** • Leadership Forum • Local Partnership Forum	**Internal Assurances** • Workforce and Organisational Development metrics report • Employee Relations Update • Medical Workforce and Efficiency Report • Statutory and Mandatory Training Compliance Report • Targeted intervention process – continuous improvement self-assessment reports (incorporates leadership and culture) • PULSE surveys themed around particular topics (ad hoc) • Post-implementation evaluation report completed and Leadership Programmes relaunched in October 2022 • Performance Development Review (PDR) processes evaluated quarterly. Bilingual. training package launched October 2022 **External Assurances** • Teaching Hospital status renewal • Corporate Health Standard Gold accreditation

• Clinical Advisory Group • Q&A with the Chief Executive via MS Teams **Employee Wellbeing** • Employee Experience Programme • Occupational Health Services • Employee Assistance Programme • Wellbeing Conversations • Money and Pensions Service	• National Staff Survey
Gaps in Controls and Assurances	**Mitigating Actions**
• Full implementation of leadership development programmes and embedding in practice to achieve Level 4 (maturity) and eventually Level 5 (exemplar) • Measuring impact of Organisational Development interventions on improving the leadership and culture of the organisation	• Working with our academic partners at the University of South Wales, participants will be able to accredit their learning with the Institute of Leadership and Management (ILM) from January 2023. • An initial programme evaluation report was published in September 2022, further evaluation reports will be available every quarter. The report provides quantitative and qualitative data, from registrations and completions to participant's feedback. • Whilst compassionate leadership is interwoven throughout the programme, a dedicated compassionate leadership module and associated resources will be developed which will complement the programme from January 2023.
Linked National Priority Measures	**Current Performance - Highlights**
Culture, Values and Behaviours • 25. Percentage of staff who report that their manager takes a positive interest in their health and wellbeing • 26. Percentage compliance with all Level 1 competencies of the Core Skills and Training Framework by organisation • 27. Percentage of sickness absence rate by staff	In April 2022 CTM has self-assessed itself as **Level** 4(maturity early results) for leadership capacity and capability development; and also for employee experience in the targeted intervention framework, having started at Level 1 (principle accepted and commitment to action) in March 2020. An update was provided to People and Culture Committee in May 2022, further update scheduled for November 2022.
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
3008	Unavailability of opportunities to train and maintain compliance with Manual handling training	**16**
3638	Pharmacy & Medicines Management - Training & Development Infrastructure	**15**

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Strategic Goal: **Inspiring People**	Risk score **12**
Strategic Risk: **Culture, Values and Behaviours – (Risk No.8)**	

If the Health Board fails to put the values of the organisation into practice	***Then*** we will not have a culture that embraces inclusion, openness, innovation and teamwork	***Resulting in*** poor experience for staff and patients alike, diminishing the trust and confidence of our population

	Consequence	Likelihood	Score	Risk Trend
Initial	4	4	16	↔ Risk remains unchanged this review although the target score has been revised.
Current	**4**	**3**	**12**	
Target	~~3~~ 4	~~3~~ 2	~~9~~ 8	
Risk Appetite	**Cautious** *(assets; trust and confidence)*			

Risk Lead	Executive Director for People	Assurance committee	People and Culture

Controls	Assurances reported to Board and committees
Policies and Frameworks • Workforce Policies, e.g. Respect and Resolution, Standards of Behaviour • Values and Behaviours Framework – co-produced with staff • Raising Concerns Procedure • All-Wales work to promote speaking up, led by Executive Director for People **Communication and Engagement re: values & culture** • Values Cafes and Values Workshops • Leadership and Culture Workshops for executives and senior leadership teams • Publicity campaign around values following launch in October 2020 • Back to Behaviour Basics Training Programme • Values based induction run with nurses, healthcare support workers, graduates and junior doctors **Putting Values into Practice** • Listening, Learning and Improvement (Just and Learning) Culture programme – 28 Senior Leaders within CTMUHB received training by Merseycare and Steering Group established to embed approach.	• National Staff Survey • PULSE surveys themed around particular topics (ad hoc) • Values and Behaviours Update • Equality Annual Report • Welsh Language Standards Annual Report • Living Wage Accreditation

• Performance and Development Reviews • Values Based Recruitment • Suite of values-based resources and activities for managers and staff on SharePoint. • Celebrated World Values day on 20th October 2022 supporting the Values in our Community.	
Gaps in Controls and Assurances	**Mitigating Actions**
• Embedding values in practice after successful launch and communications campaign • Empowering staff to feed back on, or challenge behaviour which is inconsistent with the organisation's values • Measuring impact of Organisational Development interventions on improving the leadership and culture of the organisation	• Re-launched values-based recruitment pages in October 2022 to provide advice and guidance including values-based questions to support the process. • In response to feedback regarding our leaders embodying our values a reverse mentoring program was launched in October 2022 with senior colleagues and employees from our minority groups. Through our Aspire and Inspire Leadership programmes our approach to leading behaviour change through leadership is paramount and a key feature of the programmes.
Linked National Priority Measures	**Current Performance - Highlights**
Culture, Values and Behaviours • 24. Overall staff engagement score • 28. Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	In April 2022, CTM has self-assessed itself as **Level 3** (initial achievements realised) for values and behaviours; and also for inspiring shared purpose in the targeted intervention framework, having started at Level 1 (principle accepted and commitment to action) in March 2020. An update was provided to People and Culture Committee in May 2022, a further update scheduled for November 2022.
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
N/A	No directly linked risks on organisational risk register	**N/A**

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Strategic Goal: **Sustaining our Future**	Risk score **16**
Strategic Risk: **Fulfilling our Environmental and Social Duties and ambitions (Risk No.9)**	

If the Health Board's decisions fail to reflect our values or consider the long-term environmental or social impact	***Then*** we will not fulfil our Socio-economic duty, our Wellbeing of Future Generations objectives and our value-based healthcare principles	***Resulting in*** negative environmental and social impacts, and loss of trust and confidence among stakeholders

	Consequence	Likelihood	Score	Risk Trend
Initial	4	5	20	↔ Risk remains unchanged this review
Current	**4**	**4**	**16**	
Target	4	2	8	
Risk Appetite	**Cautious** *(assets; trust and confidence)* **Open** *(estates)*			

Risk Lead	Executive Director of Strategy and Transformation	Assurance committee	Population Health and Partnerships

Controls	Assurances reported to Board and committees
Wellbeing and Socio-economic duties • Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. **Environmental Sustainability – Net Zero** • Decarbonisation Strategy • Established a CTM Decarbonisation Group which will have oversight and delivery of CTM's decarbonisation agenda • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles	**Wellbeing and socio-economic duties** • Wellbeing Statement accompanying Annual Plan • Progress reports against the Annual Plan • Case studies of projects contributing to wellbeing and equality, e.g. Connected Communities, Healthy Schools, Social Prescribing, Sustainable Procurement **Environmental Sustainability – Net Zero** • Environmental Sustainability Annual Report • ISO 14001 (Certified Environmental Management System) accreditation Commenced reporting to Board / committees regarding Net Zero – Timeframe: June 2022. Complete - moved to assurance.

• Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases	
Gaps in Controls and Assurances	**Mitigating Actions**
• Dedicated resource to manage and deliver Net Zero programme across the whole Health Board. • Enhancing board reports about sustainability issues to address Net Zero 2030 goals. • Procurement framework to reduce carbon footprint of goods and services purchased from outside the organisation. • Mapping against 'More Equal Wales' guidance for Socio-economic Duty which came into effect in April 2021. • Nationally the formula to establish carbon footprint of our organisation has changed CTMUHB's baseline assessment which has placed the organisation significantly further away from its 2025 goal. • Global energy crisis will impact on service delivery for our communities and staff, this is being closely monitored as it will impact upon health and wellbeing.	• Ensure resourcing to manage Net Zero work programme across the Health Board, taking into account potential savings in energy costs. The delivery of the Health Board's decarbonisation plan 2030 is dependent on capital. Timeframe: Ongoing subject to capital availability. • CTMUHB Financial Care Wellbeing Pathway launched to support the workforce recognising the impact of the cost of living increase impacting our workforce and population.
Linked National Priority Measures	**Current Performance - Highlights**
Economy and Environment • 32. Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach • 33. Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan • 34. Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme **Wellbeing of Future Generations Act**	The Health Board is developing its approach for an annual report on performance which is anticipated for the latter part of 2022.
Were there any significant incidents affecting this strategic Risk this period:	
Nil	

Associated Risks from the Organisational Risk Register		
Risk no.	Description	Current score
N/A	No directly linked risks on organisational risk register	**N/A**

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iAGENDA ITEM
5.3

CTM BOARD

Annual Presentation of Nurse Staffing Levels to the Board

Date of meeting	24th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Tanya Tye, Senior Nurse, Nurse Staffing Act Professional Lead
Presented by	Debbie Bennion, Deputy Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**

ACRONYMS	
NSLWA	Nurse Staffing Levels Wales Act
LG	Locality Group
CG	Care Group
RN	Registered Nurse
HCSW	Healthcare Support Worker
WLoC	Welsh Levels of Care

wte	Whole Time Equivalent

1. SITUATION/BACKGROUND

This paper is a reflective account to demonstrate how CTM maintains compliance with the Nurse Staffing Act (NSA) and explains the changes and amendments to the wards and specialities between the periods of October 2021-Sept 2022. There is a repository of data available for reference to reflect all changes, however there has been a number of changes to wards locations and speciality over this period which adds to the complexity to articulate.

The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 became law in March 2016 with the final sections of the Act coming into effect in April 2018 with an extension of the 2nd Act for inpatient paediatric wards became law on 1st October 2021.

The Nurse Staffing Levels (Wales) Act 2016 Statutory Guidance requires the designated person (Executive Nurse Director) to formally present to the Board the nurse staffing requirements for adult inpatient medical, surgical and paediatric inpatient wards. The aim of this report is to provide the Board with a detailed summary of the agreed nurse staffing levels and the changes that have taken place over the reporting period for each ward where Section 25B applies.

The Act requires health service bodies to make provision for appropriate nurse staffing levels and ensure that they are providing sufficient nurses to allow the nurses' time to care for patients sensitively. Section 25A requires Health Boards to ensure there is robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their Organisations.

Section 25B identifies in patient wards where there is a duty to calculate nurse staffing levels to maintain safe nurse staffing levels using a prescribed methodology. This methodology to determining the staffing levels across the Health Board is well established. Wards that are included in 25B are required to undertake a bi-annual acuity audit by ward managers and senior nurses. This information is then triangulated with professional judgment, patient population, staff in post and a number of pre-determined patient outcomes that are regarded as being nurse sensitive indicators such as patient falls or hospital acquired skin damage.

As the Health Board continues to adjust, resetting back to business as usual, work has been undertaken to ensure wards are realigned and returned to their pre pandemic status. Medical wards have now reset in location and their original service/ speciality of the ward, whereas surgical wards are working through their recovery programme and resetting services accordingly. As a consequence of Covid-19 the ward establishments varied from those set pre Covid-19 (January 2020) ,with

some wards requiring a temporary increase in their establishment in order to meet the needs of the patients with increased acuity and complexities.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Health Boards are required to calculate and submit their nurse staffing levels for all their section 25B inpatient wards every 6 months and formal presentation of the nursing staff level of each individual Section 25B ward to the Board annually.

Following the bi-annual acuity audit undertaken in January 2022 and June 2022, any proposed changes in staffing levels required on some of these wards, have been reviewed via the process stipulated within the statutory guidance. Each ward has been subjected to the triangulated approach which involves reviewing patient acuity, key quality indicators and professional judgement by the Ward manager and Senior Nurses.

The establishments have been approved and signed off by the Integrated Locality Nurse Directors (now known as Care Group Nurse Director). Each ward has been subjected to review using a triangulated approach, with the workforce planning tool used to produce a ward template. On evaluation this has resulted in Prince Charles Hospital wards 8 & 9, Royal Glamorgan Hospital ward 19 & 20 using a temporarily workforce uplift since June 2021 to date resulting in a cost pressure.

The Board is asked to formally receive and note the information contained within the Annual Presentation of Nurse Staffing Levels to the Board (Appendix A) which has been produced using the prescribed NHS Wales reporting template.

Adult and Paediatric in patient wards where Section 25B applies

The table below shows the number of wards at the beginning and end of the reporting period October 2021- September 2022. There was a total of 36 Section 25B wards within the Health Board at the time of the June 2022 (illustrated as September 2022 in the table below) bi-annual acuity audit.

	Oct 2021	Sept 2022
Number of Acute Medical inpatient Wards	18	16
Number of Acute Surgical inpatient Wards	16	17
Number of Paediatric inpatient wards	3	3

To note during this reporting period, 12 wards have either moved geographical location, repurposed or reset back to their original purpose.

(The establishments for these wards is provided in more detail in Appendix B & C.)

Changes to note

- During the pandemic some Section 25B wards, required their staffing establishments to be temporarily revised as wards were repurposed to provide high care and Covid-19 specific ward areas. These wards have now been returned to their original specialty and location.

- Results of the June 2022 bi-annual acuity audit and changes to ward establishments are explained below:

Prince Charles Hospital

Ward 7

Ward 7 initially located on ward 3 was repurposed into a Covid-19 ward therefore temporarily removed from Section 25B, the ward reverted back to being an elective surgical/ trauma orthopedic and assessment area in June 2022 and is now reportable under Section 25B of the Act.

Ward 8

Ward 8 is a Trauma & Orthopaedic ward and is identified as a Trauma Unit as part of the South Wales Trauma Network (SWTN). The temporary uplift of 5.76wte Band 2 Health Care Support Workers (HCSW), which has been in place since June 2021 continues as a result of June 2022 acuity audit . The audits continues to indicate a rise in acuity levels, with evidence of improvement in the quality indicators, e.g. a decrease in the number of falls. This has led to a temporary decision to maintain the temporary increase in establishment at a cost pressure until the new Care Groups are embedded when further review will take place.

Ward 9

Ward 9 is a medical Endocrinology ward. The temporary uplift of 5.76wte Band 2 Health Care Support Workers (HCSW), has been in place since June 2021 and continues following the June 2022 acuity audit. The audits continue to indicate a rise in acuity levels, with evidence of improvement in the quality indicators, e.g. a decrease in the number of hospital acquired pressure areas. This has led to a temporary decision to maintain the temporary increase in establishments at a cost pressure until the new Care Groups are embedded when further review will take place.

Royal Glamorgan Hospital

Ward 19

As previously reported in the Board paper (May 2022), Nurse Staffing Levels on Ward 19 continue to be temporarily uplifted at a cost pressure of an additional 2.76wte Band 5 RNs to provide a 5 bedded high acuity Non Invasive Ventilation (NIV) bay. This is a result of the recommendation of The British Thoracic Society (BTS) minimum nurse/patient ratio of 1:2 when caring for acute NIV patients. This establishment and funding will be reviewed as the new Care Groups are embedded.

Ward 20

Up until June 2020, Ward 20 was sitting outside of Section 25B of the Act as it was a rehabilitation ward. Since June 2021, it has been repurposed into an acute medical ward under Section 25B of the Act. A recalculation assessment resulted in a required temporary uplift at cost pressure of 2.76wte Band 5 RNs and 5.76wte Band 2 HCSW to meet the acuity and dependency levels. This establishment and funding will be reviewed as the new Care Groups are embedded.

Princess of Wales Hospital

Ward 19

Ward 19 which had previously been located on ward 8 (moved to current location in June 2022) has been repurposed to a medical rehabilitation ward, therefore now sits outside of S25B and will be subjected to the audit going forward.

Ward 11

Ward 11 is a Gynecological ward and was previously located on ward 19 prior to its move in May 2022 to its current location. Due to a reduction in the number of beds (22 down to 19) in the new location, this has resulted in a reduction in staffing by 5.57wte RN's.

Ward 21

Ward 21 is a now a community rehabilitation ward which was previously located in Maesteg Hospital and sits outside of S25B. The previous ward based on ward 21 moved to ward 18 in May 30th 2022.

With many of the wards recovering and resetting post pandemic and following the June 2022 bi-annual acuity audit, the Head of Nursing for the Princess of Wales Hospital has requested an uplift in the WTE of HCSW for eight of the eleven wards under S25B of the Act (Wards 5, 6, 7, 8, 9, 10, 18 and 20) . The acuity data for

these areas (see detail in appendix C) indicates that there is a marginal increase in patients scoring level 4/5 (WLoC) presented through the data.

Across many of the 25B acute inpatient wards, there are a number of patients who are waiting transfer into ongoing long-term care or a more suitable rehabilitation area who are medically fit and do not require acute care. Some of these have underlying cognitive impairments such as Dementia and are high risk of falls requiring enhanced supervision. This has resulted in the increased use of a temporary workforce of HCSW at a cost pressure. Using her professional judgement the Head of Nursing has requested a permanent funded uplift to the workforce. Further detailed scrutiny and analysis by the Care Group Nurse Directors is required using the triangulated methodology before this is can be approved as a permanent funded uplift due to the financial impact.

It should be noted that six out of the eight wards (6,7,8,9,10,18) requesting a HCSW uplift do not have a permanent ward hostess service resulting in this role being undertaken by nursing staff. The ward hostess supports patient care providing meals three times a day, clearing away dishes and providing hot drinks. Further work is required as part of the wider workforce analysis to aid in decision making where the workforce is best placed. In addition while this is being undertaken a more detailed strategic nurse staffing review will be undertaken which will include monitoring compliance with the enhanced supervision guidance.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Each of the Locality Group Nurse Directors (now known as Care Group Nurse Directors) have been involved in discussions regarding the establishment staffing level templates and any proposed workforce changes highlighted following June's acuity. The acuity audits are only one aspect of the triangulated methodology that must be used to calculate and agree the workforce requirements. The Care Group Nurse Directors will be responsible for the scrutiny of the nurse sensitive 'quality indicators' (falls, pressure ulcers, medication errors) along with their professional judgement to approve and request any changes to the funded establishment for these wards to the Executive Director of Nursing.

As part of CTM UHB resetting post pandemic, some of the wards within Section 25B of the Act continue to be repurposed or realigned to meet the clinical service needs required. Due to the ongoing surgical recovery programme, the nursing establishments for some of these Section 25B wards may change again before the next bi-annual acuity in January 2023. As part of the requirement of the Act, any changes to ward clinical models, reconfiguration and staffing requirements will be updated on the designated staffing level templates approved by the Care Group Nurse Directors and following approval be authorised by the Executive Nurse Director.

Paediatrics (Health Board Wide)

In October 2021 Section 25B was extended to include Paediatric inpatient wards. It has been recognised during the initial phase of the pandemic that there was reduced numbers of acutely ill or injured children and admitted to the paediatric inpatient wards. Therefore the validity of the calculations for in- paediatrics NSA results remain untested. Close scrutiny is required to identify if clinical presentation and workload show signs of returning to pre pandemic numbers and dependency or if there are differing clinical presentation resulting in an increase in workload on other services such as mental health for example.

3.1 Other All Wales Nurse Staffing Programme Work Streams in Development

The other All Wales Nurse Staffing Programme work streams, namely, Mental Health, District Nursing & Health Visiting are currently on pause at the request of the Chief Nursing Officer (CNO).

3.2 Nurse Roster Policy

The ratification and current implementation of the Nurse Roster Policy, in conjunction with the roll of Safe Care Module (linked to the roster system) with their defined key performance indicators (KPI's) will enable greater scrutiny of nurse rostering across the organisation and will be used to support any changes to any of the nursing establishments.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Staff and Resources
	Safe Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.

	Not required
Legal implications / impact	Yes (Include further detail below)
	Those contained within the Nurse Staffing Act
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Any temporary increase to current agreed ward establishments will have financial implications. These will be defined, reported and discussed within the Operational Management Board of which the Executive Nurse Director, Deputy Director of Workforce and Deputy Director of Finance respectively are members.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

The Board is asked to **NOTE:**-

- The report as assurance that the statutory requirements relating to Section 25B wards have been completed.

- There are changes to patient acuity and service needs pre Covid, during Covid and now during the resetting phases post Covid adding a level of complexity of evaluation and compliance

- Further work is ongoing at the Princess of Wales to scrutinise wider workforce and workload demands

- Wards continue to reset and as business returns to pre Covid activity the January 2023 acuity audit will enable the Care Group Nurse Directors to have a clearer oversite of the changing population needs and services required to meet these needs.

- The recommendation for any permanent funded uplift in establishment will not be authorized until the output of the January 2023 audit in conjunction with the Enhanced supervision work and a review of the potential benefits of a dedicated ward hostess service

<table>
<tr><th>Appendix A</th><th>Annual Presentation of Nurse Staffing Levels to the Board</th></tr>
<tr><td>Health Board</td><td>Cwm Taf Morgannwg UHB (CTMUHB)</td></tr>
<tr><td>Date of annual presentation of Nurse Staffing Levels to Board</td><td>24th November 2022</td></tr>
<tr><td>Period covered</td><td>1st October 2021 to 30th September 2022.</td></tr>
<tr><td>Number and identity of section 25B wards during the reporting period.
• Adult acute <u>medical</u> inpatient wards
• Adult acute <u>surgical</u> inpatient wards
• Paediatric inpatient wards</td><td>Appendix B of this report lists the nurse staffing levels for all wards that have been included under Section 25B of the Nursing Staffing Level (Wales) 2016 Act (hereafter referred to in this document as the 2016 Act), during the period 1st October 2021 to 30th September 2022.

As the Health Board continues to adjust to resetting after Covid-19, work has been undertaken to ensure wards are realigned and patient care is delivered as needed. Medical wards have now reset, whereas surgical wards are working through their recovery programme and resetting services accordingly.

The table below identifies the number of wards that are included under Section 25B of the 2016 Act during the time period above.

<table>
<tr><th></th><th>Oct 2021</th><th>Sept 2022</th></tr>
<tr><td>Number of Acute Medical inpatient Wards</td><td>18</td><td>16</td></tr>
<tr><td>Number of Acute Surgical inpatient Wards</td><td>16</td><td>17</td></tr>
<tr><td>Number of Paediatric inpatient wards</td><td>3</td><td>3</td></tr>
</table>
To note during this reporting period, 12 wards have either moved, been repurposed or reset back to their original purpose to ensure provision of care is provided to all patients following the Covid-19

Wards that have been added to S25B following Covid-19 recovery.

Within CTMUHB the following areas have been repurposed from high care (non-invasive ventilation (NIV) wards, which were excluded from S25B as discussed by CNO letter in October 2020 and reinstated to Section 25B during this reporting period:
• Ward 7 (formally 3), Prince Charles Hospital</td></tr>
</table>

- Ward 9, Princess of Wales Hospital
- Ward 3, Royal Glamorgan Hospital

Nursing establishments for Section 25B wards. (Reporting period October 2021 – September 2022).

The tables below provide a summary of the ward establishments for each 25B ward by each Integrated Locality Group (ILG). A more detailed overview is provided in Appendix B. Please note that the wards have been tracked by their last ward location in Sept 2022 and have then been tracked backwards across the reporting period (i.e. PCH ward 3 was on ward 7).

Merthyr and Cynon Integrated Locality Group

Prince Charles Hospital has 11 wards (previously 9) that are included within Section 25B the 2016 Act

Section 25B inpatient Acute Medical wards

Medical Wards at Prince Charles Hospital						
Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
2	20.9	14.21	20.9	14.21	20.9	14.21
3 (F7)	20.9	14.21	20.9	14.21	20.9	14.21
9	20.9	19.90	20.9	19.90	20.9	19.90
10	20.9	17.06	20.9	17.06	20.9	17.06
11	20.9	14.21	20.9	14.21	20.9	14.21
12	23.74	17.06	23.74	17.06	23.74	17.06

- In May 2021, using the triangulated methodology prescribed within the 2016 Act, ward 9 increased the HCSW establishment by 5.69wte, this continues on a temporary funded basis.

Section 25B inpatient Acute Surgical Wards

Surgical Wards at Prince Charles Hospital						
Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
5	20.9	14.21	20.9	14.21	20.9	14.21
6	20.9	14.21	20.9	14.21	20.9	14.21
7					20.9	14.21
8	20.9	19.9	20.9	19.9	20.9	19.9
PESU	12.37	8.53	12.37	8.53	11.37	8.53

- Using the same triangulated approach, ward 8 increased its HCSW establishment by 5.69wte, this continues on a temporary funded basis.
- PESU Band 7 shared with Day surgery, therefore there is a decrease in the RN wte.
- Ward 7 has been repurposed back to a surgical trauma & orthopaedic ward in May 2022 and moved to its current location in July 2022.

Rhondda and Taf Ely Integrated Locality Group

The Royal Glamorgan Hospital has 11 wards (Previously 11) that are included within Section 25B of the 2016 Act.

Section 25B inpatient Acute Medical Wards

Medical Wards at Royal Glamorgan Hospital						
Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
5	20.9	19.9	20.9	19.9	20.9	19.9
12	20.9	19.9	20.9	19.9	20.9	19.9
14	20.9	19.9	20.9	19.9	20.9	19.9
19	26.58	19.9	26.58	19.90	26.58	19.9
20	20.9	19.9	20.9	19.9	20.9	19.9

Section 25B inpatient Acute Surgical Wards

Surgical Wards at Royal Glamorgan Hospital						
Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
2	18.08	17.08	17.08	14.21	17.08	14.21
3	20.9	17.06	20.9	17.06	20.9	17.06
8	20.9	19.09	20.9	19.9	20.9	19.09
9	20.9	14.21	18.06	14.21	18.06	14.21
10 & 11	21.12	16.24	16.43	12.59	16.43	12.59
15	14.21	10.56	12.37	8.53	14.21	10.56

- Ward 2 has reduced its HCSW requirement at night by 2.87wte in January 2022 following the bi-annual acuity audit.
- Wards 10 &11 are a surgical elective 'Green wards' that have a combined staffing level for both areas. Ward 10 is a S25B ward whilst Ward 11 is predominately a day case surgical area. Their staffing levels are combined and flexed accordingly. This has been reflected in the workforce requirements agreed, funded establishments.
- Ward 15 was established as an elective orthopaedic ward in January 2022, this ward currently consists of 15 beds, however there are proposed plans to increase bed numbers and staffing accordingly as part of the CTM surgical recovery programme.

Bridgend Integrated Locality Group

The Princess of Wales Hospital has 11 wards (Previously 11) that are included within the Section of the 2016 Act.

Section 25B inpatient Acute Medical Wards

Medical wards at Princess of Wales Hospital						
Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
4	28.24	13.62	28.24	16.34	28.24	16.34
5	20.07	13.62	20.07	13.62	20.07	13.62
6	20.07	13.62	20.07	13.62	20.07	13.62
10	24.06	13.62	23.79	13.62	23.79	13.62
18	11.90	10.90	11.90	10.90	20.07	13.62
20	20.07	13.62	20.07	13.62	20.07	13.62

- Ward 18 remains within the Act but changed its speciality from surgery to acute medicine in July 2022. The ward also increased its bed capacity in May 2022 and staffing levels were changed to reflect this increase.

Section 25B inpatient Acute Surgical Wards

Surgical wards at Princess of Wales Hospital						
Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
7	20.07	13.62	20.07	13.62	20.07	13.62
8	20.07	13.62	20.07	13.62		
9	20.07	13.62	20.07	13.62	20.07	13.62

11	20.07	13.62	20.07	13.62	14.62	13.62
Ward 21	11.9	10.9				
Bridgend Clinic	11.89	10.89	11.89	10.89	11.89	10.89

- Ward 8 has been repurposed to a medical rehabilitation ward, therefore now sits outside of S25B.
- Ward 11 was previously located on ward 19. There has been a reduction in staffing due to reduction in bed numbers.
- Ward 21 moved to ward 18 in May 22 to accommodate a community rehabilitation ward therefore now sits outside of S25B.

With many of the wards recovering and resetting after the Covid-19 pandemic and following the June 2022 bi-annual acuity audit, the Head of Nursing for the Princess of Wales Hospital has proposed changes in the HCSW workforce for 8 of the 11 wards under S25B of the Act.

The acuity data suggests that there is a slight increase in patients scoring level 4/5 (WLoC) on these wards. Additional HCSW have been utilised to provide care which the Head of Nursing has contributed to a significant number of patients awaiting onward care, which is increasing the demand for enhanced supervision on many of the section 25B wards. Whilst professional judgement is recommending the uplift, the triangulated methodology needs to be explored further, and as such the Deputy Director of Nursing will undertake a more detailed strategic nurse staffing review which will include updating enhanced supervision policies and guidance.

Paediatric inpatient wards

The extension of the 2nd duty of the 2016 Act came into force on 1st October 2021. There are 3 Paediatric inpatient wards included within Section 25B of the 2016 Act

Ward	Oct-21		Apr-22		Sep-22	
	RN	HCSW	RN	HCSW	RN	HCSW
RGH Ward 17	29.43	5.69	29.43	5.69	29.43	5.69
PCH Ward 31	35.11	7.72	35.11	7.72	35.11	7.72
PoWH – Children ward	29.43	5.59	29.43	5.59	29.43	5.59

	As operational pressures are yet to return to the pre pandemic levels, the review of the paediatric inpatient activity includes the 2019/20 period. There have been ongoing challenges in relation to filling registered nurse vacancies following the previous calculation which has resulted in many posts identified are yet to be filled meaning that the validity of the calculation remains untested due to the exceptional circumstances created during the pandemic. All three inpatient wards within Health Board have experienced an increase in Children and Adolescent Mental Health Service (CAMHS) admissions that will require addressing as part of Health Boards recruitment strategy and service alignment. Due to preventative measures taken during Covid-19 pandemic which resulted in almost complete elimination of common respiratory virus in children, there remains a potential in the surge of Respiratory Syncytial Virus (RSV) this year. The Health Board has developed contingency plans for the potential surge in the number of children contracting RSV requiring admission to hospital. In preparation, surge capacity plans have been discussed, calculated (25% and 50% additional capacity) and agreed by the Children and Young Peoples Care Group. Longer term, due to the South Wales plan no longer progressing there is a need to review current in-patient models and bed plans within CTMUHB.
Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated methodology prescribed in the section 25C of the 2016 Act sets out the principles to calculating the nurse staffing levels. There is also a requirement to undertake at least 6-monthly calculations for each ward within Section 25B of the Act. For each inpatient ward identified under Section 25B for the June 2022 bi-annual acuity audit, data capture from various systems was collated and analysed to assess compliance with the nurse staffing recommendations. The following areas were considered and explored with the Ward Sister, Senior Nurse and Lead Nurse responsible for the ward and the Heads of Nursing from the each acute hospital to aid the report. • Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager and ward administrators (in PoW only). • Patient acuity data for the month of June 2022. • Care quality indicators data from the previous 12 months (falls, medication errors, pressure damage and serious incidents and concerns).

	• Workforce related metric data, mandatory training compliance, vacancy, recruitment and sickness. • Clinical dashboard via the Datix system are produced measuring care quality metrics as well as Power BI apps that provide access to patient acuity and flow are available to ward managers, Heads of Nursing and ILG Nurse Directors for review. • Assurance of compliance that all workforce models included in the Nurse Staffing Levels Act have an uplift of 26.9% and supernumerary Band 7 Ward Sister/Charge nurse calculated within the overall workforce plan for that ward. • The planning templates have been discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and by the ILG Directors of Nursing. The final templates are endorsed by the Executive Nurse Director.
Finance and workforce implications	There has been a number of changes to ward functions, nursing staffing Act status and ward capacity during the last year which has been outlined in Appendix B. Any changes to ward establishments that have financial implications are discussed and presented by the ILG Nurse Directors via their individual ILG Management Board meetings. Subsequently, the Executive Nurse Director, will then provide updates via Executive Senior Leadership Team meetings and reports to the Executive Board.
Conclusion & Recommendations	
	The Nurse Staffing Level Wales (2016) Act bi-annual acuity audit conducted in June 2022 identified challenges as Section 25B wards continue to recover and reset following the Covid-19 pandemic. There continues to be ongoing temporary staffing uplifts within PCH and RGH until March 2023. Following the bi-annual audit in June 2022 any changes to nursing establishments have been implemented and authorised by the ILG Nurse Directors and by the Executive Nurse Director. The Board is asked to • Receive the report as assurance that the statutory requirements relating to Section 25B wards have been completed. • Approve and note the changes to the funded establishments to ensure the Health Board remains fully compliant with the Nurse Staffing Levels (Wales) Act. • Note the detailed strategic nurse staffing review being undertaken in PoW.

	The work programme for CTMUHB inpatient wards under section 25B of the 2016 Act for 2022/23 will be: • To continue to roll out of the Safe Care Module across S25B wards in the Health board.

Appendix B:

Summary of Nurse Staffing Levels for wards where Section 25B applies

Health Board/Trust:	Name: Cwm Taf Morgannwg UHB	
Period being reported on :	Start date: Oct 1st 2021	End Date: Sept 30th 2022
Number of wards where section 25B has applied during the period:	**Medical:18**	**Surgical: 18**
	PCH wards – 2, 3, 9, 10, 11, 12 **RGH wards – 5, 12, 14, 19, 20** **PoWH wards – 4, 5, 6, 8, 10, 20, 15**	**PCH wards –5, 6, 7, 8, PESU** **RGH wards – 2, 3, 8, 9, 10&11, 15** **PoWH wards – 7, 8, 9, 11, 18, 21 BC**

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment**

Medical Wards at Prince Charles Hospital

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PCH Ward 2	E	4	3	20.9	14.21	Yes	E	4	3	20.9	14.21	Yes	Yes	No		NA	No	
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PCH Ward 3	E	4	3	20.9	14.21	Yes	E	4	3	20.9	14.21	Yes	Yes	No		Yes	No	Moved from Ward 7 July 2022
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PCH Ward 9	E	4	4	20.9	18.90	Yes	E	4	4	20.9	19.9	Yes	Yes	No	HCSW WTE calculated incorrectly in Sept 2021	Yes	No	
	L	4	4				L	4	4									
	N	3	3				N	3	3									
PCH Ward 10	E	4	4	20.9	17.06 Excludes *2.84 Band 3	Yes	E	4	4	20.9	17.06 excludes *2.84 Band 3	Yes	Yes	No		NA	NA	
	L	4	4				L	4	4									
	N	3	3				N	3	3									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PCH Ward 11	E	4	3	20.9	14.21	Yes	E	4	3	20.9	14.21	Yes	Yes	No		NA	Choose an item.	
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PCH Ward 12	E	5	3	23.74	17.06	Yes	E	5	3	23.74	17.06	Yes	Yes	No		NA	NA	
	L	5	3				L	5	3									
	N	3	3				N	3	3									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Medical Wards at Royal Glamorgan Hospital

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
RGH Ward 5	E	4	4	20.9	19.9	Yes	E	4	4	20.9	19.9	Yes	Yes	No		no	Choose an item.	
	L	4	4				L	4	4									
	N	3	3				N	3	3									
RGH Ward 12	E	4	4	20.9	19.9	Yes	E	4	4	20.9	19.9	Yes	Yes	No		no	Choose an item.	
	L	4	4				L	4	4									
	N	3	3				N	3	3									
RGH Ward 14	E	4	4	20.9	19.9	Yes	E	4	4	20.9	19.9	Yes	Yes	No		no	Choose an item.	
	L	4	4				L	4	4									
	N	3	3				N	3	3									
RGH Ward 19	E	4	4	20.9	19.9	N	E	4	4	20.9	19.9	Yes	Yes	No		no	Choose an item.	Creation of a NIV Bay - funding via winter pressure budget to start date to be agreed
	L	4	4				L	4	4									
	N	3	3				N	3	4									
RGH Ward 20	E	4	4	20.9	19.9	Yes	E	4	4	20.9	19.9	Yes	Yes	No		no	Choose an item.	
	L	4	4				L	4	4									
	N	3	3				N	3	3									

Medical wards at Princess of Wales Hospital

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PoWH Ward 4	E	6	4	28.24	16.34	Yes	E	6	4	28.24	16.34	Yes	Yes	No		NA	Choose an item.	
	L	6	4				L	6	4									
	N	4	2				N	4	2									
PoWH Ward 5	E	4	3	20.07	13.62	Yes	E	4	4	20.07	13.62	Yes	Yes	No		NA	Choose an item.	Ward has moved from ward 7
	L	4	3				L	4	4									
	N	3	2				N	3	2									
PoWH Ward 6	E	4	3	22.28	13.62	Yes	E	4	3	20.07	13.62	Yes	Yes	Yes	1 x RN moved to cover day unit	NA	Choose an item.	Moved from ward 8
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PoWH Ward 10	E	5	4	23.79	19.07	Yes	E	5	4	23.79	19.07	Yes						Plus Co-ordinator M-F 7-4
	L	4	4				L	4	4									
	N	4	3				N	4	3									
PoWH Ward 15	E	3	4	14.62	19.07	Yes	E	3	4	14.62	19.07	Yes	Yes	No		No	No	S25A ward
	L	3	4				L	3	4									
	N	2	3				N	2	3									
PoWH Ward 8	E	4	3	20.09	13.62	Yes	E									Yes	Yes	Ward repurpose to medical fit and rehab ward – Sits outside S25B definition- 24/2/22
	L	4	3				L											
	N	4	3				N											
PoWH Ward 20	E	4	3	20.07	16.34	Yes	E	4	3	20.07	16.34	Yes	Yes	No		No	No	Ward moved from Ward 7 to ward 20
	L	4	3				L	4	3									
	N	3	3				N	3	3									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Surgical Wards at Prince Charles Hospital

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PCH Ward 7	E	7	16	40.80	90.96	Yes	E	4	3	20.90	14.21	Yes	Yes	No		Yes	Yes	Was on ward 3 - Change of speciality from High care Covid ward to Surgical T&O ward. Ward then moved to ward 7 July 2022
	L	7	16				L	4	3									
	N	7	16				N	3	2									
PCH Ward 5	E	4	3	20.9	14.21	Yes	E	4	3	20.9	14.21	Yes	Yes	No		No	Choose an item.	
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PCH Ward 6	E	4	3	20.9	14.21	Yes	E	4	3	20.9	14.21	Yes	Yes	No		No	Choose an item.	
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PCH Ward 8	E	4	3	20.9	14.21	Yes	E	4	4	20.9	19.9	Yes	Yes	No		Yes	Yes	Review of Acuity and dependency of patient
	L	4	3				L	4	4									
	N	3	2				N	3	3									
PESU	E	2	2	11.37	8.53	Yes	E	2	2	11.37	8.53	Yes	Yes	No		No	Choose an item.	Oct 2021 RN WTE incorrectly down as 12.37 B7 covered by another area corrected to 11.37
	L	2	2				L	2	2									
	N	2	1				N	2	1									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Surgical Wards at Royal Glamorgan Hospital

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
RGH Ward 2	E	3	3	18.08	17.06	Yes	E	3	3	18.08	14.21	Yes	Yes	No		NA	Choose an item.	
	L	3	3				L	3	3									
	N	3	3				N	3	2									
RGH Ward 3	E	4	4	20.9	17.06	Yes	E	4	4	20.9	17.06	Yes	No	No	Ward 3 is defined as AMU	NA	Choose an item.	
	L	4	4				L	4	4									
	N	3	2				N	3	2									
RGH Ward 8	E	4	4	20.9	19.9	Yes	E	4	4	20.9	19.9	Yes	Yes	No		No	No	
	L	4	4				L	4	4									
	N	3	3				N	3	3									
RGH Ward 9	E	4	3	20.9	14.21	Yes	E	3	3	18.06	14.21	Yes	Yes	No	Change to RN numbers to reflect acuity	Yes	No	
	L	4	3				L	3	3									
	N	3	2				N	3	2									
RGH Ward 10 & 11	E	4	4	21.12	16.24	Yes	E	4	4	21.12	16.24	Yes	Yes	No		No	N/A	
	L	4	4				L	4	4									
	N	4	2				N	4	2									
RGH Ward 15	E	3	3	14.21	10.56	Yes	E	3	3	14.21	10.56	Yes	Yes	No		NA	NA	
	L	3	3				L	3	3									
	N	2	1				N	2	1									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Surgical wards at Princess of Wales Hospital

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
PoWH Ward 7	E	4	3	20.07	13.62	Yes	E	5	3	21.07	13.62	Yes	Yes	No	Coordinator M-F 7-4 not on October 2021 data	No	No	Previously on ward 20
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PoWH Ward 8	E	4	3	20.07	13.62	Yes	E	4	3	20.07	13.62	Yes	Yes	No		No	No	Ward moved from 11 to 8 on 24/2/22
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PoWH Ward 9	E	4	3	20.07	13.62	Yes	E	4	3	20.07	13.62	Yes	Yes	No		No	No	Previously on ward 18
	L	4	3				L	4	3									
	N	3	2				N	3	2									
PoWH Ward 11	E	4	3	20.07	13.62	Yes	E	3	3	14.62	13.62	Yes	Yes	No	Previously located on ward 19- reduction in staffing due to reduction in bed numbers	No	No	
	L	4	3				L	3	3									
	N	3	2				N	2	2									
PoWH Ward 18	E	3	2	11.9	10.9	Yes	E	4	3	20.07	13.62	Yes	Yes	No		Yes	Yes	Ward speciality changed from surgical to medical ward.
	L	3	2				L	4	3									
	N	2	2				N	3	2									
Bridgend Clinic	E	2	2	10.9	10.90	Yes	E	2	2	10.9	10.90	Yes/Shared between Ward 18	Yes	No		NA		
	L	2	2				L	2	2									
	N	2	2				N	2	2									
Ward 21	E	3	2	11.9	10.9	No – shared band 7 with BC	E											Ward moved to ward 18 in May 22 to accommodate community rehab ward.
	L	3	2				L											
	N	2	2				N											

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Appendix C

Summary of Nurse Staffing Levels for Paediatric inpatient wards

Health board/trust:	Cwm Taf Morgannwg University Health Board		
Period reviewed:	June 2022 – September 2022		
Number of paediatric inpatient wards where section 25B applies:	Site: PoWH	Site: RGH	Site: PCH
	1 ward - 16 beds	1 ward – 19 beds	1 ward – 22 beds

Nurse staffing level per ward where section 25B applies (*)	RN (wte)	HCSW (wte)	TOTAL (wte)
Children's ward PoWH	29.43wte	5.69wte	35.11wte
Ward 17 RGH	29.43wte	5.69wte	35.11wte
Ward 31 PCH	35.11wte	7.72wte	42.83wte

Board/ Executive level Authorisation	Designated person	Name & signature	Director of Operations	Name & signature	Director of Finance	Name & signature

Date presented to the Board by designated person	Date, name, title and signature of designated person

(*) Points to consider:

Uplift of 26% has be included applied to RN and HCSW wte, to cover staff absences

1wte ward sisters/charge nurse and managers are supernumerary and has been added

CTM BOARD
HIGHLIGHT REPORT – PLANNING, PERFORMANCE & FINANCE COMMITTEE

DATE OF MEETING	24/11//2022

/

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Mel Jehu, Independent Member (Committee Chair
EXECUTIVE SPONSOR APPROVED	Director of Strategy and Transformation, Chief Operating Officer, Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
IMTP	Integrated Medium Term Plan
ILG	Integrated Locality Groups
PPF	Planning, Performance & Finance

1. INTRODUCTION

1.1 This paper had been prepared to provide the Board with details of the key issues considered by the Planning, Performance & Finance Committee which took place on 26 October 2022.

1.2 Key highlights from the meeting are contained in section 2.

1.3 The Board are requested to **NOTE** the contents of the report and actions being taken.

2. PURPOSE OF THE PLANNING, PERFORMANCE & FINANCE COMMITTEE

The Committee will allow appropriate scrutiny and review to a level of depth and detail not possible in Board meetings in respect of planning, performance and finance. The Committee will ensure that evidence based and timely interventions are implemented to drive forward improved performance thereby allowing the Health Board to achieve the requirements and standards determined for the NHS in Wales, and as outlined within the Board's 3 Year Integrated Medium Term Plan.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• A report was **received** at the "private" In Committee session on **Ophthalmology Follow Up Not Booked (FUNB).** Members **noted** the current number of FUNB within Ophthalmology, the challenges currently facing the service and the actions being taken to reduce these.
ADVISE	• The Committee **received** the **Organisational Risk Register** and reviewed the Planning, Performance & Finance risks, **noting** the updates in terms of the mitigating action identified within the report. • The **Month 6 Finance report** was **received**. Members **noted** that at M6 the Health Board were reporting a forecast Core plan deficit of £26.5m noting that performance year to date was £1.4m worse than plan and assumes £6m in exceptional costs to £17.8m. The decrease was due to a significant reduction in energy costs and the recently announced reduction in NI contributions. The Health Board were forecasting a slight increase in Covid-19 costs programme and response to £30.9m. The underlying position had deteriorated by £6.9m from £28.0m and this was due to a forecast shortfall in current savings delivery in 2022-23 and that further work would be undertaken to address this gap.

	• The Committee **received** and **noted** the Month 6 financial performance of the individual Care Groups and Directorates. • A Presentation was **received** by the Committee on the **Delivery of the Six Goals for Emergency Care.** The Committee **noted** the four key work streams and task and finish groups that were aligned to the Six Goals and requested an update on progress in relation to timescales and expected outcomes for a future meeting. • The Committee **received** and **noted** a progress report on the **Annual Plan for 2022-23.** • A report was **received** on the **Integrated Medium Term Plan (IMTP) for 2023-26.** The Committee **noted** the Welsh Government requirements for the development of the IMTP and that they would receive regular updates on the draft plan for consideration at future meetings. • The Committee **received** and **noted** the **Bridgend Transition Progress Report.**
ASSURE	• A detailed review of the **Integrated Performance Dashboard** was undertaken with particular focus and scrutiny in the following areas: - Ambulance Red Releases - Stoke Performance - Infant Feeding Programme performance figures – the Committee **agreed** to receive a report at the next meeting. - Staff Survey percentage figures. - Urgent Suspected Cancer 62 day wait – the Committee **agreed** to receive a Deep Dive Report at the next meeting. - Adult/CAMHS Mental Health – the Committee **agreed** to receive a Deep Dive Report at a future meeting. - Staff Sickness and Agency Rate percentages. • The Committee **received** a report on the **Delivery of the Planned Care Recovery Programme.** The

	Committee **noted** the overall progress, challenges, risks and operational schemes in relation to the Elective Recovery Portfolio of work. • A report was **received** on the progress of the **Stroke Action Plan.** The Committee **noted** the progress made against the Action Plan and the successful bid to enhance preventative developments, **noted** the planned immediate actions to the acute and rehabilitations aspects of the stroke pathway, **noted** the plan to establish a focused task and finish group and the ongoing challenges in performance against the four Quality Improvement Measures in the Performance Framework.
INFORM	• The Committee received for **information the Monthly Monitoring Returns to Welsh Government** for Months 5 and 6. • The Committee received and **approved** the **Business Continuity & Emergency Preparedness Response & Recovery Policy.** • The Committee **approved** the **Outcome of the Committee Self Effectiveness Survey and Improvement Plan.**
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
6.1

CTM BOARD

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jose Roper, Senior Performance Monitoring Officer
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Linda Prosser, Executive Director of Strategy and Transformation
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Strategic Leadership Group	19/10/22	Choose an item.

ACRONYMS	
AMU	Acute Medical Unit
C.difficle	Clostridium difficle
CAMHS	Child and Adolescent Mental Health Services
CTM	Cwm Taf Morgannwg
CTP	Care and Treatment Plan
CYP	Children and Young People

D2RA	Discharge to Recover then Assess model
DHCW	Digital Health and Care Wales
DNA	Did Not Attend
DToC	Delayed Transfers of Care
E.coli	Escherichia coli bacteraemia
ED	Emergency Department
ESD	Early Supported Discharge
FUNB	Follow-up Outpatients Not Booked
HIW	Health Inspectorate Wales
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
Klebsiella sp.	Klebsiella sp. Bacteraemia
LD	Learning Disabilities
LRI's	Locally Reportable Incidents
LPMHSS	Local Primary Mental Health Support Service
MDT	Multidisciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NOUS	Non Obstetric Ultra-Sound
NPT	Neath Port Talbot
ONS	Office for National Statistics
OoH	Out of Hours
P.aeruginosa	Pseudomonas aeruginosa bacteraemia
PADR/PDR	Personal Appraisal and Development Review
p-CAMHS	Primary Child and Adolescent Mental Health Services
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
PMO	Programme Management Office
POW	Princess of Wales
PSPP	Public Sector Payment Performance
PTR	Putting Things Right
PUs	Pressure Ulcers
QIA	Quality Impact Assessment
QIM	Quality Improvement Measures
RCS	Royal College of Surgeons
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment
S.aureus	Staphylococcus aureus bacteraemia
SALT	Speech and Language Therapy
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SCP	Single Cancer Pathway
SIOF	Single Integrated Outcomes Framework
SIs	Serious Incidents
SOS	See on Symptom
SSNAP	Sentinel Stroke National Audit Programme
WAST	Welsh Ambulance Service NHS Trust
WCP	Welsh Clinical Portal
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Committee
WPAS	Welsh Patient Administration System
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. SITUATION/BACKGROUND

1.1 This report sets out the UHB's performance against the Welsh Government's (WG) Performance Framework and other priority areas for the UHB.

1.2 This report aims to highlight the key areas that the UHB is concentrating on. The summary assessment therefore highlights critical areas of performance which are below target for attention, and the actions being taken to drive improvement.

Executive Management and Strategic Scorecards are provided in sections 2.1 and 2.2 of this paper. The Executive Management scorecard indicates that the UHB is presently compliant with one (previously) two of its twenty nine performance measures and is making progress towards delivering a further two. There remains twenty six measures where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

The Quadruple Aim metrics have been endorsed by Welsh Government (Strategic Scorecard), continuing into 2022/23 and incorporating the Ministerial Priorities: https://gov.wales/nhs-wales-performance-framework-2022-2023

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Executive Management Scorecard is shown below. The measures selected are operational and outputs based; they allow for earlier detection of change in metrics that affect our impact and outcomes.

FINANCE

Month 6	Variance from Plan			
	Current Month	Year to Date	Forecast Full Year	Forecast Recurrent
	£m	£m	£m	£m
Pay	-1.4	-0.8		
Non-Pay	1.8	0.0		TBC
Income	0.6	3.2		
Efficiency Savings	-1.9	-1.1		6.9
Allocations	0.0	0.0		
Planned Deficit	2.2	13.3		
Total	1.3	14.6	26.5	34.9

	Current Month	Year to Date	Forecast Full Year	
PSPP	86.2%	94.6%	95.0%	Target 95%
Capital Expenditure	£4.1m	£26.3m	£63.7m	
Agency as % of total pay costs	7.6%	8.9%	8.7%	12 Month Reduction Trend

PERFORMANCE

Indicators	Oct-22	Sep-22	Target	RAG
A&E 12 hour Waiting Times	2,085	1,881	Zero	
Ambulance Handover Times within 15 mins	20.2%	19.0%	Annual Improvement	
RTT 52 Weeks	38,423	38,222	Zero	
Diagnostics >8 Weeks Waits	15,566	15,570	Zero	
FUNB - Patients Delayed over 100% for Follow-up Appointment	30,663	30,854	19,606 by 2023	
	Sep-22	Aug-22	Target	RAG
Mental Health Part 1a - CAMHS	22.3%	14.9%	80%	
Mental Health Part 1b - CAMHS	42.6%	32.3%	80%	
Admission to Stroke Unit within 4 hrs	21.9%	9.5%	SSNAP Average 38.3%	
% of Out of Hours (OoH) / 111 patients prioritised as P1CHC that	Jun-22	May-22	Target	RAG
started their definitive clinical assessment within 1 hour	89.8%	90.4%	90%	
Delayed Discharges waiting for packages of care rate	Oct-22	Sep-22	All Wales Average	RAG
(D2RA/bypassing D2RA) per 100,000 population (at census date)	19.1	19.8	13.4	

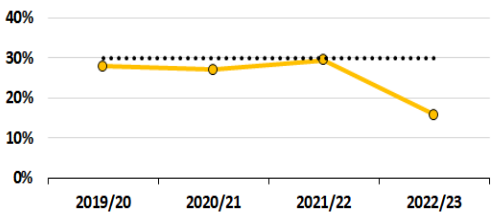
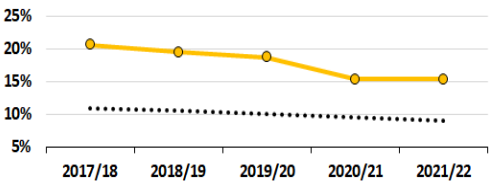
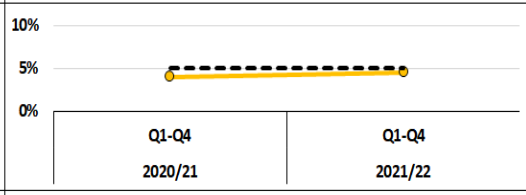
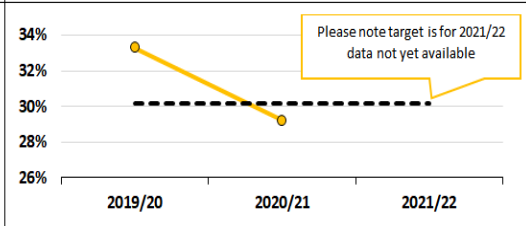
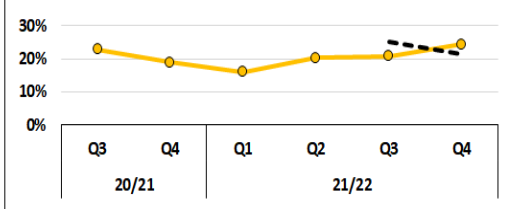
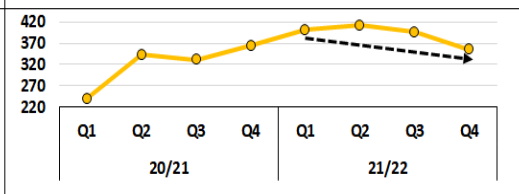
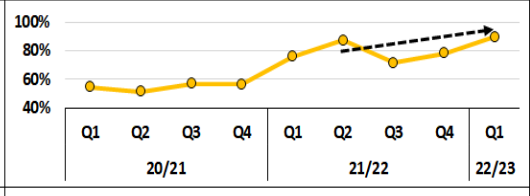
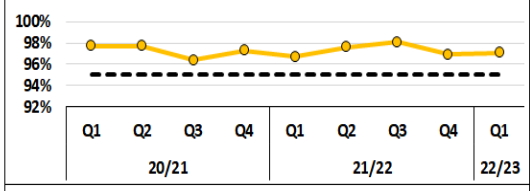
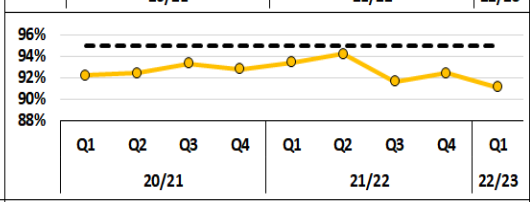
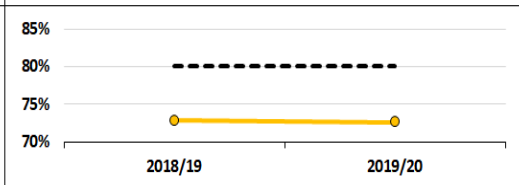
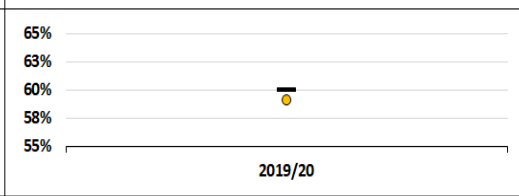
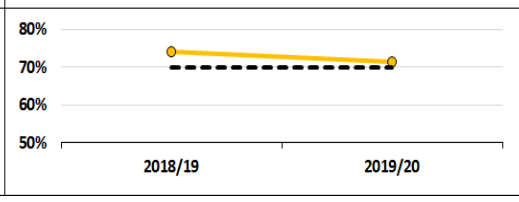
QUALITY

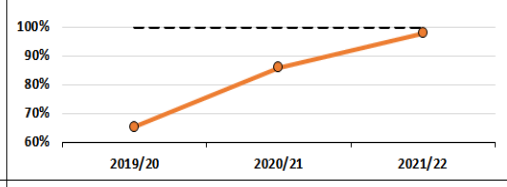
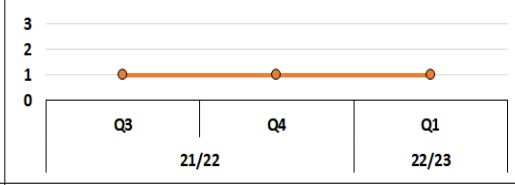
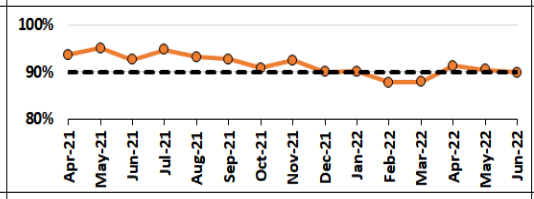
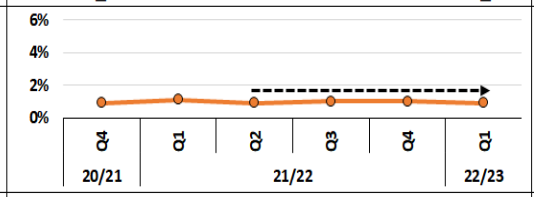
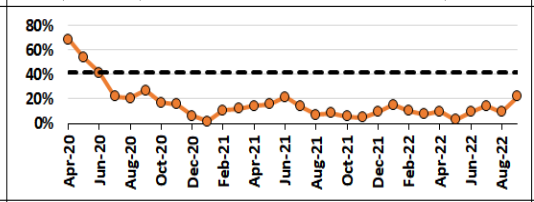
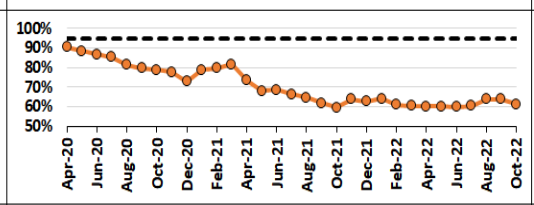
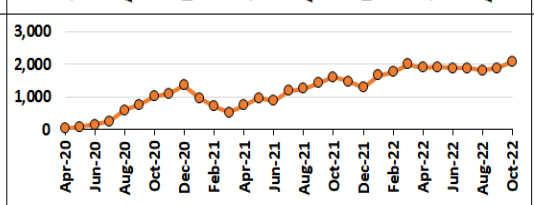
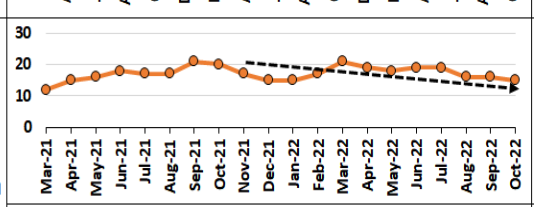
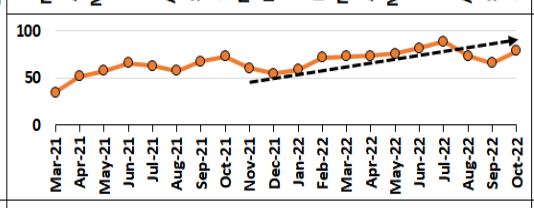
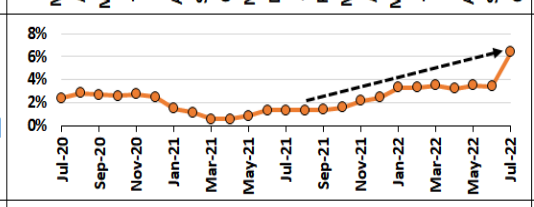
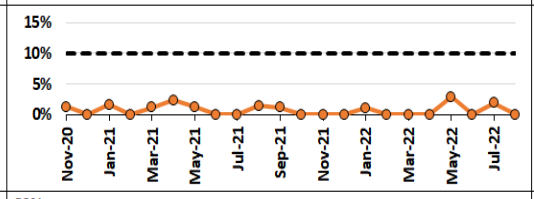
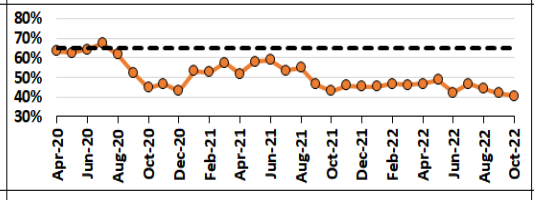
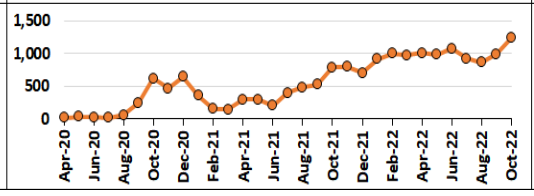
Indicators	Oct-22	Sep-22	Target	RAG
% complaints final/interim reply within 30 working days	62.7%	63.8%	75%	
	Sep-22	Aug-22	Target	RAG
Single Cancer Pathway	46.2%	46.0%	75%	
Thrombolysis for Eligible Stroke Patients within 45 Minutes	45.5%	14.3%	100%	
	Apr - Oct 22	Apr - Sep 22	Target	RAG
Cumulative rate of bacteraemia cases per 100,000 population - E.coli	88.34	85.57	67 per 100,000 pop.	
Cumulative rate of bacteraemia cases per 100,000 population - S.aureus	34.88	37.24	20 per 100,000 pop.	
Cumulative rate of bacteraemia cases per 100,000 population - C.difficle	26.92	27.49	25 per 100,000 pop.	
	Oct-22	Sep-22	Target	RAG
Total number of Nationally Reportable Incidents	7	2	TBC	
Number of Formal Complaints Received	75	88		
Number of Compliments Received	80	80		
Falls Causing Harm (Moderate/Severe/Death)	22	17		
Hospital Acquired Pressure Ulcers (Grade 3/4)	6	5		
Total number of instances of hospital acquired pressure ulcers	133	120		
Number of Community Healthcare Acquired Pressure Ulcers (Grade 3/4)	12	9		
Total number of instances of Community Healthcare acquired pressure ulcers	118	105		
Number of Never Events in Month	0	0	0	

PEOPLE

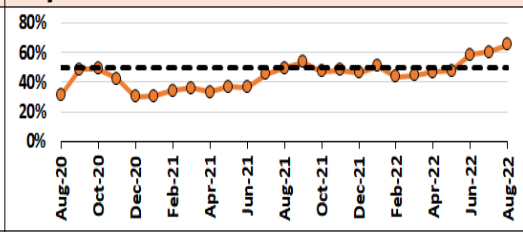
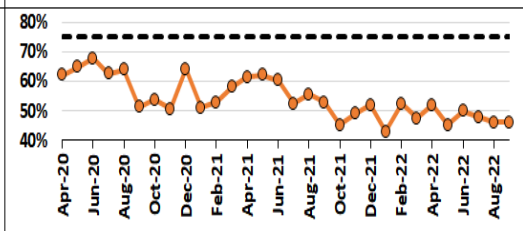
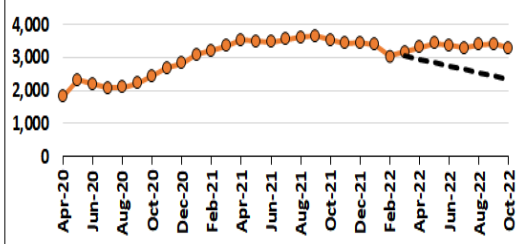
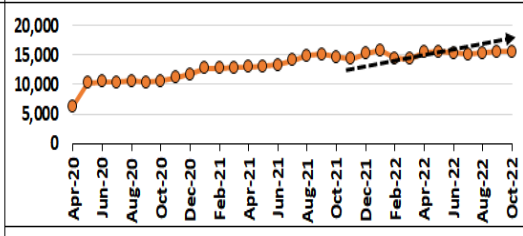
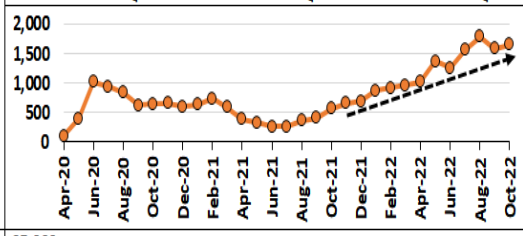
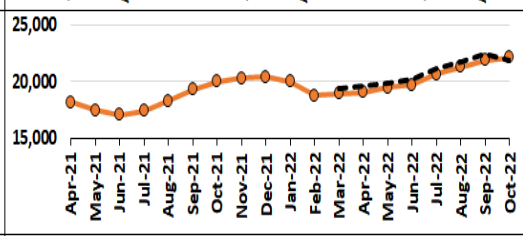
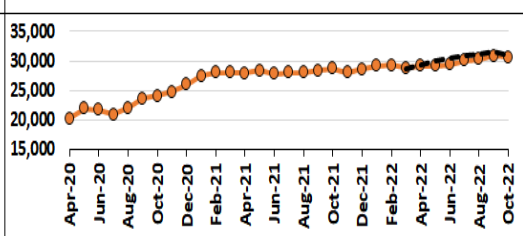
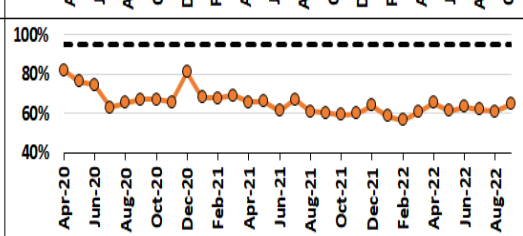
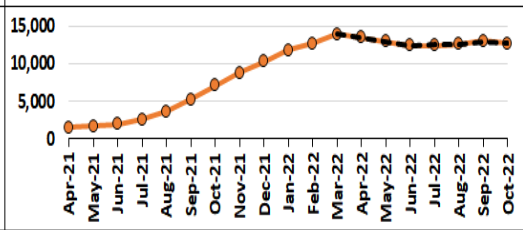
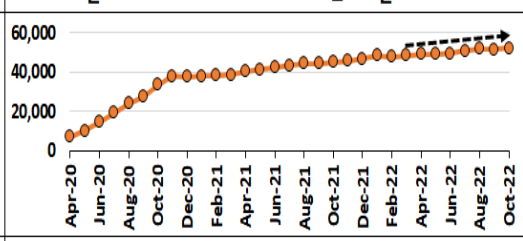
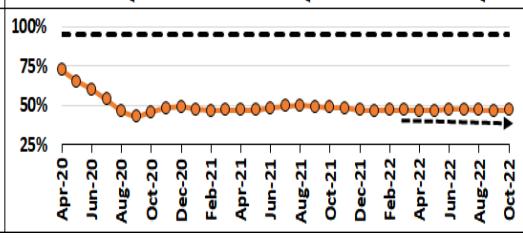
Indicators	Oct-22	Sep-22	Target	RAG
Turnover	13.33%	13.22%	11%	
Exit Interview by Leaver	0.00%	0.00%	60%	
	Sep-22	Aug-22	Target	RAG
Sickness Absence Rate (in month)	6.7%	7.1%	4.5%	
Sickness Absence Rate (rolling 12 month)	7.7%	7.8%		
Return to Work Compliance	44.1%	44.0%	85%	
	Oct-22	Sep-22	Target	RAG
Fill Rate Bank	35.4%	36.7%	90%	
Fill Rate On-contract Agency (RNs)	36.1%	35.1%		
PDR	57.0%	57.5%	85%	
Statutory and Mandatory Training - All Levels	60.5%	60.7%		
Statutory and Mandatory Training - Level 1	68.2%	68.1%		
Job Planning Compliance (Consultant)	36.0%	38.0%	90%	
Job Planning Compliance (SAS)	31.0%	35.0%		
Direct Engagement Compliance (M&D)	72%	67%	100%	
Direct Engagement Compliance (AHPs)	90%	95%	100%	
RN Shift Fill by Off-contract	764.0	692.5	0 Hours	

2.2 The UHB's strategic assessment of progress towards delivery of the NHS Wales Quadruple Aim are shown below.

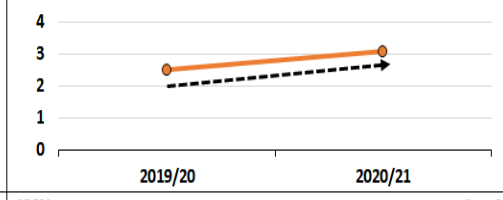
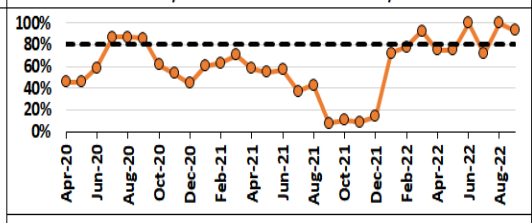
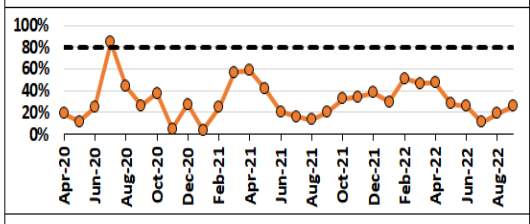
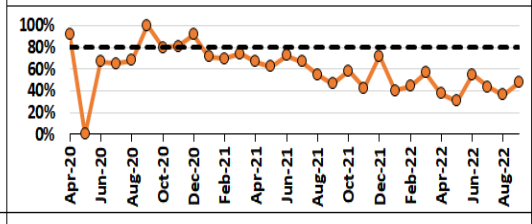
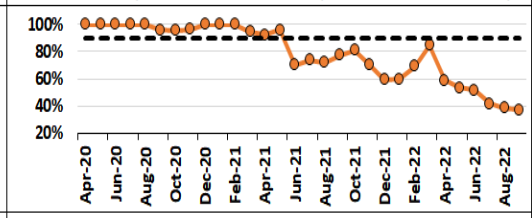
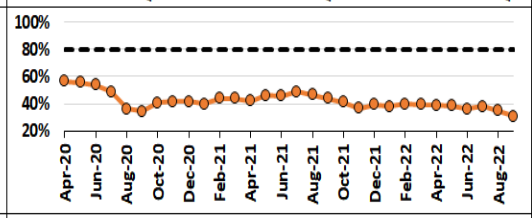
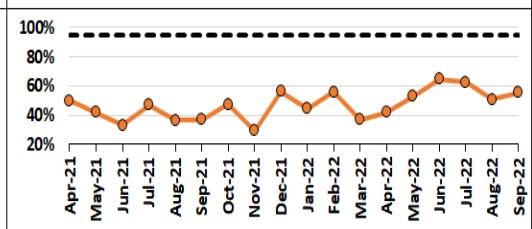
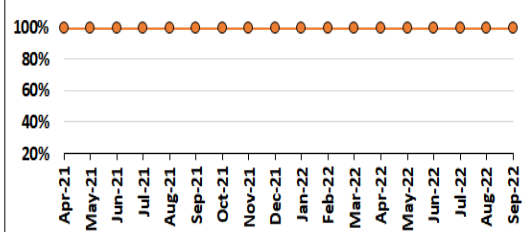
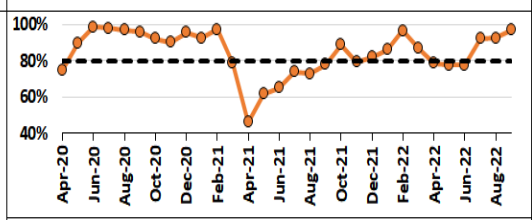
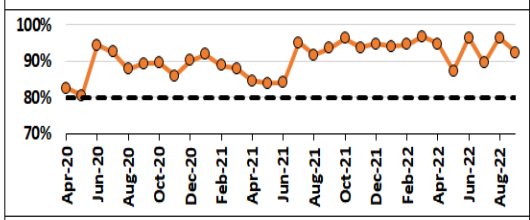
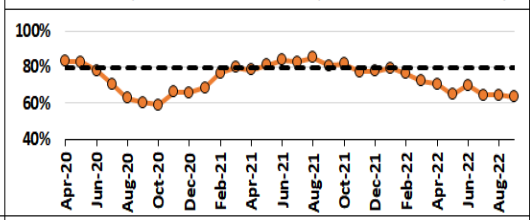
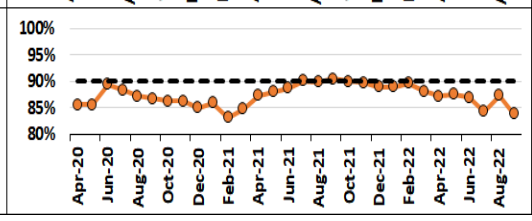
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management					
	Performance Measure	**Target**	**Key: Trend, Target, Desired Position**	**Latest Position**	
Weight Management	**Percentage of babies who are exclusively breastfed at 10 days old** *(please note that the data for 2022/23 is provisional & locally sourced and will be subject to change with formal publication)*	**Annual Improvement**		**15.8%**	**Apr-Oct 2022**
Smoking	**Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally**	**An annual reduction towards a 5% prevalence rate by 2030**		**15.4%**	**2021/22**
	Percentage of adult smokers who make a quit attempt via smoking cessation services	**5% Annual Target**		**4.5%**	**2021/22**
Diabetes	**Percentage of patients (aged 12 years and over) with diabetes achieving all 3 treatment targets in the preceding 15 months:** ❖ **Blood pressure reading is 140/80 mmHg or less** ❖ **Cholesterol values is less than 5 mmol/l (<5)** ❖ **HbA1c equal or less than 58 mmol/mol or less**	**1% annual increase from baseline data of 2020-21**		**29.2%**	**2020/21**
	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	**A quarterly improvement of 2.5% against a baseline of 2020-21 (21.5%)**		**24.4%**	**Q4 2021/22**
Substance Misuse	**European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales (episode based)**	**4 Qtr Reduction Trend**		**Reduction achieved against Qtr 1 21/22 354.5**	**Q4 2021/22**
	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	**4 Qtr Improvement Trend**		**Improvement achieved against Qtr 2 21/22 89.7%**	**Q1 2022/23**
Vaccinations	**Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1**	**95%**		**97.1%**	**Q1 2022/23**
	Percentage of children who received 2 doses of the MMR vaccine by age 5			**91.1%**	
Screening	**Percentage of eligible people aged 25-49 who have participated in the cervical screening programme within the last 3.5 years and eligible people aged 50-64 within the last 5.5 years**	**80%**		**72.60%**	**2019/20**
	Percentage of eligible people who have participated in the bowel screening programme within the last 2.5 years	**60%**		**59.1%**	**2019/20**
	Percentage of women resident and eligible for breast screening at a particular point in time who have been screened within the previous 3 years	**70%**		**71.40%**	**2019/20**

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement					
	Performance Measure	Target	Key: Trend --- Target ····· Desired Position	Latest Position	
Primary & Community Care	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%		98%	2021/22
	Number of Urgent Primary Care Centres (UPCC) established in each Health Board footprint (i.e. both UPPC models)	As outlined in the Health Board's Six Goals Programme Plan		1	Q1 2022/23
Urgent & Emergency Care	% of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being completed	90%		89.8%	Jun-22
	Percentage of total conveyances taken to a service other than a Type One Emergency Department	4 Quarter Improvement Trend		Improvement not achieved against Qtr 2 21/22 0.9%	Q1 2022/23
	% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time	38.3% (SSNAP Quarterly Average)		21.9%	Sep-22
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%		61.1%	Oct-22
	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero		2,085	
	Median time from arrival at an emergency department to triage by a clinician	12 month reduction trend		12 month reduction achieved 15	
	Median time from arrival at an emergency department to assessment by a senior clinical decision maker			12 month reduction not achieved 79	
	% of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	12 month improvement trend		12 month improvement achieved 6.4%	Jul-22
	% of stroke patients who receive mechanical thrombectomy	10%		0.0%	Aug-22
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		40.5%	Oct-22
	Number of ambulance patient handovers over 1 hour	Zero		1,245	

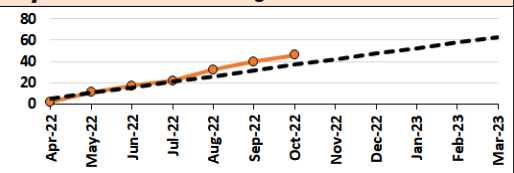
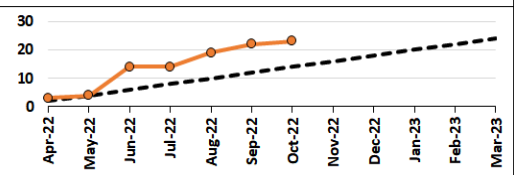
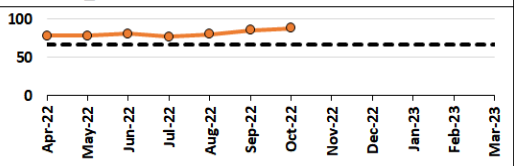
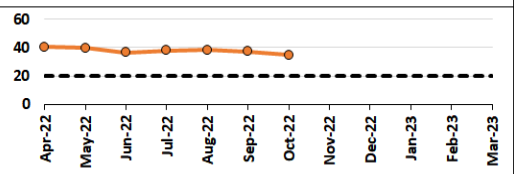
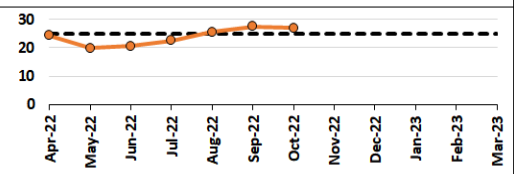
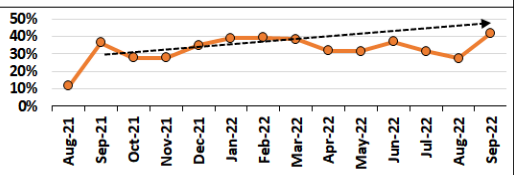
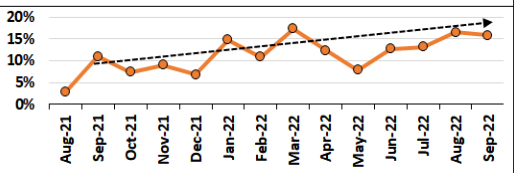
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Performance Measure	Target	Key: Trend / Target / Desired Position	Latest Position	
Elective Planned Care	% of stroke patients that receive at least 45 minutes of speech and language therapy input in 5 out of 7 days	50%		65.3%	Aug-22
	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	75%		46.2%	Sep-22
	Number of patients waiting over 8 weeks for a diagnostic endoscopy	Improvement trajectory towards a national target of zero by Spring 2024		3,283	Oct-22
	Number of patients waiting more than 8 weeks for a specified diagnostic	12 month reduction trend towards zero by spring 2024		12 month reduction not achieved 15,566	
	Number of patients waiting more than 14 weeks for a specified therapy			12 month reduction not achieved 1,652	
	Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by 31 December 2022		21,896	
	Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	<=19,606 by 2023		30,663	
	% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	95%		64.8%	Sep-22
	Number of patients waiting more than 104 weeks for referral to treatment	Improvement trajectory towards a national target of zero by 2023		12,811	Oct-22
	Number of patients waiting more than 36 weeks for treatment	Improvement trajectory towards a national target of zero by 2026		Improvement trajectory not achieved 52,223	
	% of patients waiting less than 26 weeks for treatment	Improvement trajectory towards a national target of 95% by 2026		Improvement trajectory not achieved 47.2%	

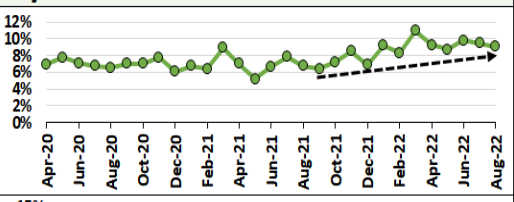
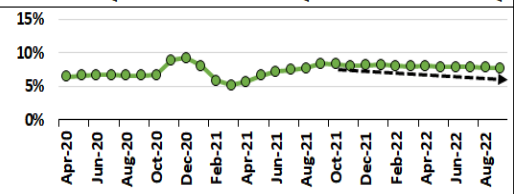
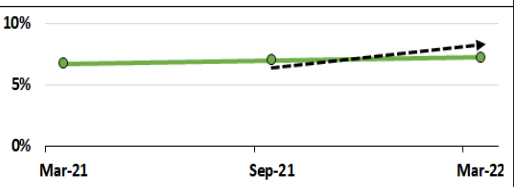
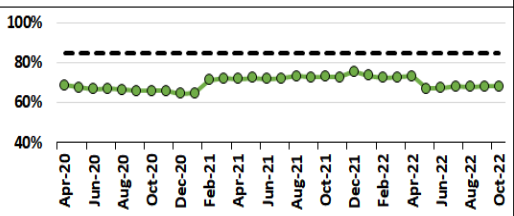
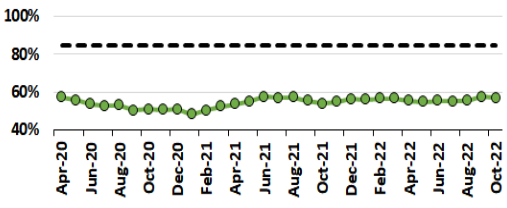
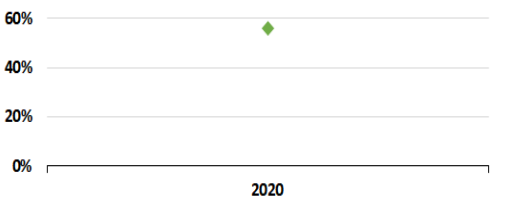
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

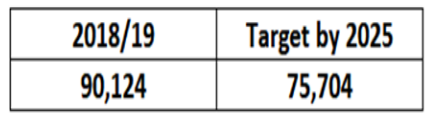
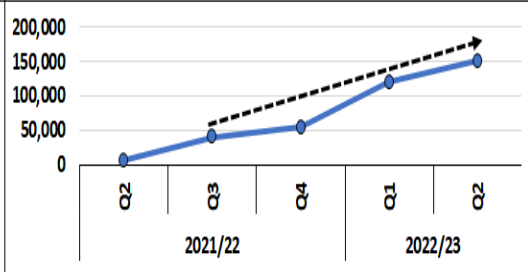
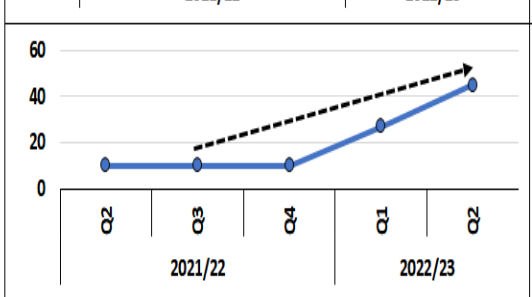
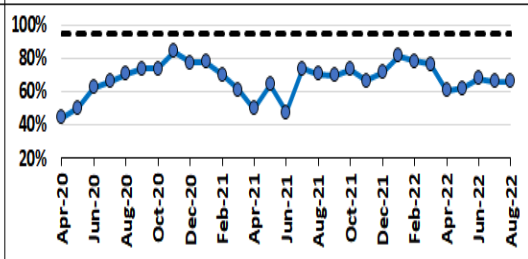
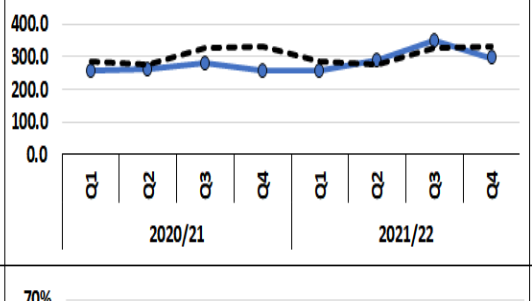
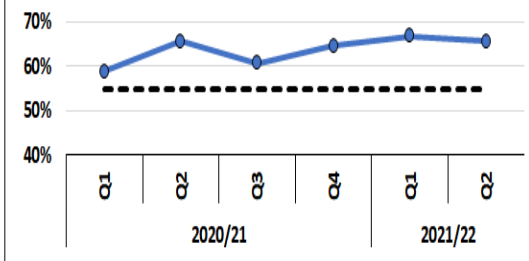
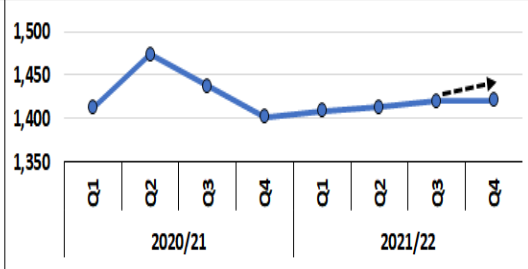
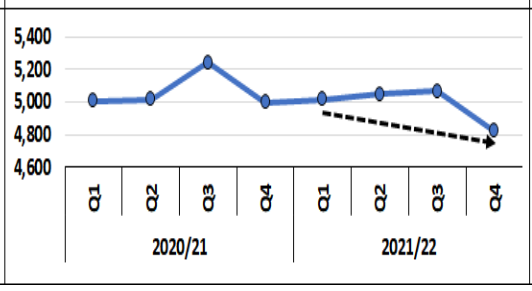
	Performance Measure	Target	Key: Trend Target Desired Position	Latest Position	
Mental Health	Rate of hospital admissions with any mention of intentional self-harm for children and young people (age 10-24 years) per 1,000 population	Annual Reduction		Annual reduction not achieved 3.08	2020/21
	% of patients waiting less than 28 days for a first outpatient appointment for Specialist Child and Adolescent Mental Health Services (sCAMHS)	80%		92.9%	Sep-22
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age under 18 years)			26.1%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)			47.5%	
	% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for those age under 18 years	90%		37.1%	
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD a neurodevelopment assessment	80%		30.7%	
	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital between 09:00 and 21:00 hours that have received a gate-keeping assessment by the CRHT service prior to admission	95%		55.7%	
	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital who have not received a gate keeping assessment by the CRHTS that have received a follow up assessment by the CRHTS within 24 hours of admission	100%		100.0%	
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)	80%		96.9%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)			92.4%	
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			63.7%	
	% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for those age 18 years and over	90%		83.8%	

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Measure	Target	Key: Trend / Target / Desired Position	Latest Position	
Hospital Infection Control	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	63		46	Cumulative Numbers Apr to Oct 2022
	Cumulative number of laboratory confirmed bacteraemia cases: p. aeruginosa	24		23	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli	67.00 per 100,000 population		88.34	Cumulative Rate Apr to Oct 2022
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus bacteraemia	20.00 per 100,000 population		34.88	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: C.difficile	25.00 per 100,000 population		26.92	
	% of confirmed COVID cases within hospital which had a definite hospital onset of COVID	Reduction against the same month in 2021-22		Reduction not met 41.8%	Sep-22
	% of confirmed COVID cases within hospital which had a probable hospital onset of COVID	Reduction against the same month in 2021-22		Reduction not met 15.8%	

Quadruple Aim 3: The health and social care workforce in Wales in motivated and sustainable

	Performance Measure	Target	Key: Trend / Target / Desired Position	Latest Position	
Staff Resources	Agency spend as a percentage of the total pay bill	12 Month Reduction Trend		Reduction trend not achieved 9.1%	Aug-22
	% of sickness absence rate of staff	12 Month Reduction Trend		Reduction trend achieved 7.7%	Sep-22
	% of staff who have recorded their Welsh language skills on ESR who have Welsh language listening/speaking skills level 2 (foundational level) and above	Bi-annual Improvement		Improvement achieved 7.2%	Mar-22
Training & Development	% compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	85%		68.2%	Oct-22
	% of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	85%		57.0%	
Staff Engagement	% of staff who report that their line manager takes a positive interest in their health and well-being	Annual Improvement		56.1%	2020

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes					
	Performance Measure	Target	Key: Trend Target Desired Position	Latest Position	
De-carbonisation	Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach	16% reduction in carbon emissions by 2025 against the 2018/19 NHS Wales baseline position		90,124	2018/19
New Ways of Working	Number of risk assessments completed on the Welsh Nursing Clinical Record by Health Board/Trust	4 Quarter Improvement Trend		Improvement achieved against Qtr 3 21/22 150,352	Q1 2022/23
	Number of wards using the Welsh Nursing Clinical Record by Health Board/Trust			Improvement achieved against Qtr 3 21/22 45	
	% of episodes clinically coded within one reporting month post episode discharge end date	12 month improvement trend towards achieving the 95% target		66.0%	Aug-22
Clinically Effective Prescribing	Total antibacterial items per 1,000 STAR-PUs (specific therapeutic age related prescribing unit)	A quarterly reduction of 5% against a baseline of 2019-20		295.1	Q4 2021/22
	% of secondary care antibiotic usage within the WHO Access category	55%		65.7%	Q2 2021/22
	Number of patients age 65 years or over prescribed an antipsychotic	Qtr on Qtr Reduction		Reduction not achieved against Qtr 3 21/22 1,421	Q4 2021/22
	Opioid average daily quantities per 1,000 patients	4 Qtr Reduction Trend		Reduction achieved against Qtr 1 21/22 4,823	

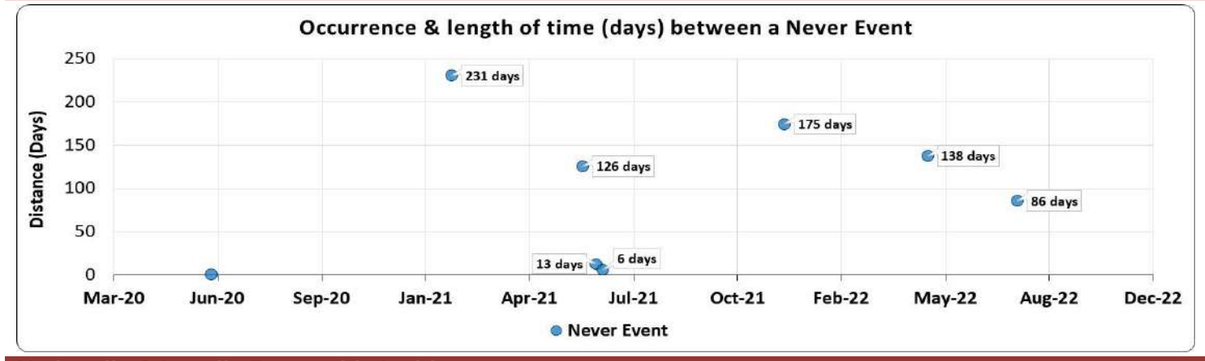
2.3 Quality

Never Events & Serious Incidents

Never Events

Number of Never Events – October 2022

0



Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

There were no Never Events reported in October with the last occurrence being 27th July 2022 (formal reporting September 2022) relating to a wrong side implant and an investigation is ongoing.

In total, 3 reportable events have been observed during the past twelve months, as detailed in the chart to the left.

Nationally & Locally Reportable Incidents

Number of Nationally Reportable Incidents – October 2022

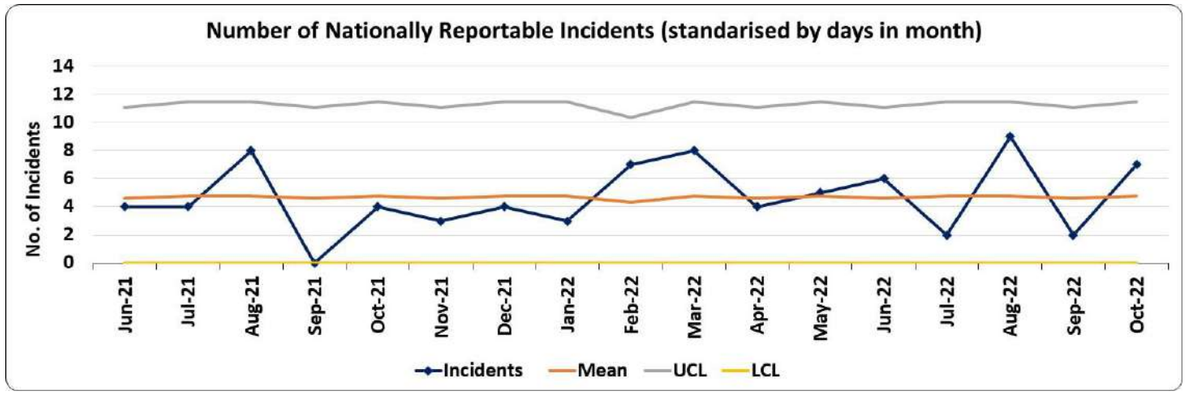
7

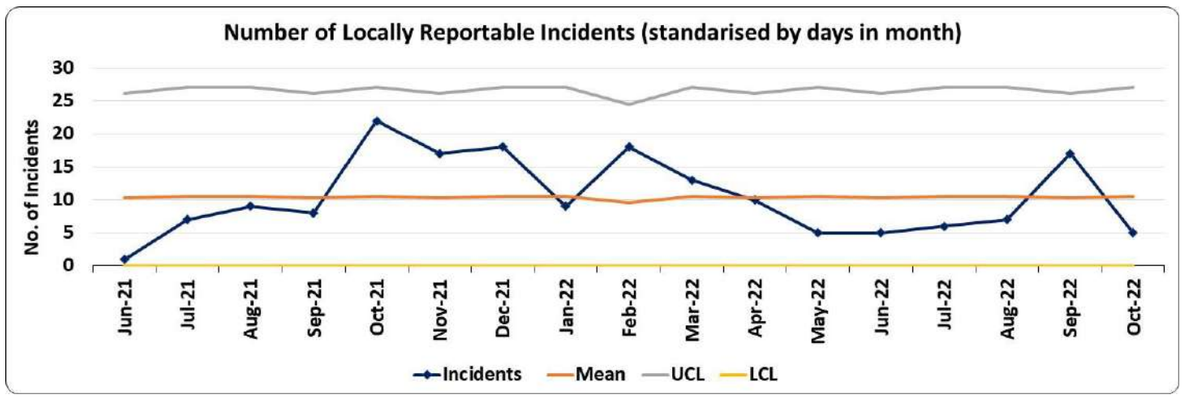
Number of Locally Reportable Incidents – October 2022

5

Number of Patient Safety Incidents – October 2022

2,291





Throughout October 2022, there were 2,291 patient safety incidents reported on Datix across the Health Board. Of these, 7 were Nationally Reportable Incidents (NRIs are detailed in the table below) and a further 5 were graded as Locally Reportable Incidents (LRIs).

LRIs are reported centrally to ensure timeliness of investigation and organisational oversight of patient safety incidents previously identified as Serious Incidents but are no longer nationally escalated.

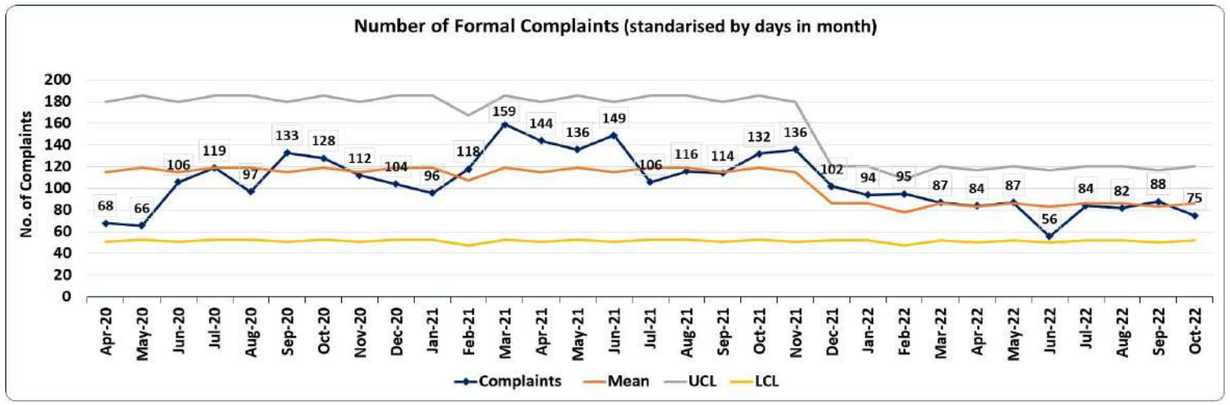
Type of Nationally Reportable Incidents	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Total
Absconding			1										1
Admission / Transfer / Discharge			1									2	3
Behaviour (including violence and aggression)								1		2			3
Clinical Assessment, clinical diagnosis							1					1	2
Delays	1	2		4	2					2			11
Diagnostic Testing - Radiology										1			1
Maternal Event				1									1
Maternity adverse occurrence						2						1	3
Medication					1		1						2
Monitoring/Observations								1			1		2
Neo-Natal Event					2								2
Organisational - Failure to follow Policy/Procedure				1									1
Personal Incident - Personal injury attributed to clinically related challenging behaviour of patient		1											1
Pressure Damage	2		1				1	3		1			8
Records, Information										1			1
Safeguarding												1	1
Slip, Trip or Fall				1	1		1		1				4
Staffing									1				1
Transport							1						1
Treatment Error		1											1
Treatment, Procedure						2		1			1	2	6
Unexpected Complications			1		1								2
Unexpected or Trauma Related Death	1				1					2			4
Grand Total	4	4	4	7	8	4	5	6	2	9	2	7	62

Complaints & Compliments

Complaints

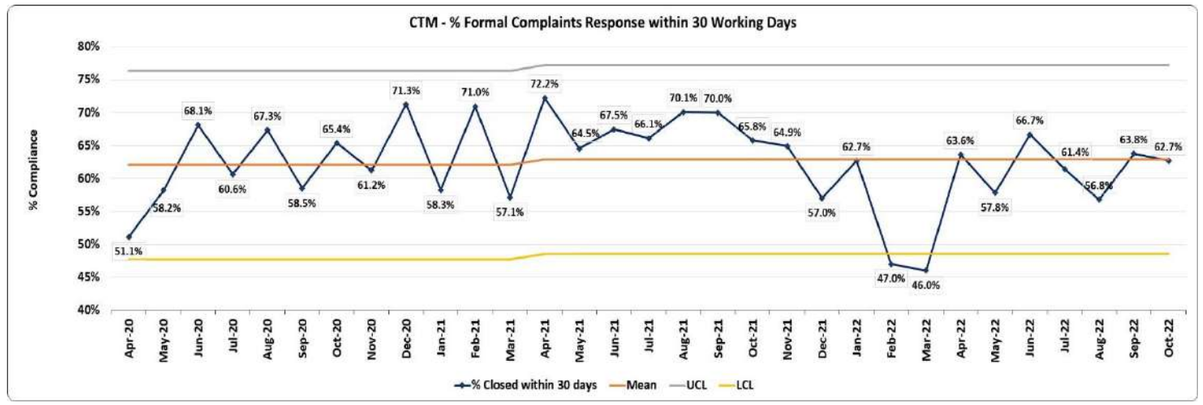
Number of formal complaints managed through PTR – October 2022

75



% formal complaints response within 30 working days – October 2022

62.7%



During October 2022, 75 formal complaints were received within the organisation and managed in line with the 'Putting Things Right' regulations. As can be seen, the chart above indicates a sustained change from December 2021. For those complaints received during October 2022, the top five themes relate to clinical treatment/assessment (40), medication issues (8), patient care (7), attitude & behaviour (4) and communication issues (3).

The proportion of complaints responded to within 30 working days was 62.7%, with no sustained change observed since December 2021 and remaining under the target threshold of 75%.

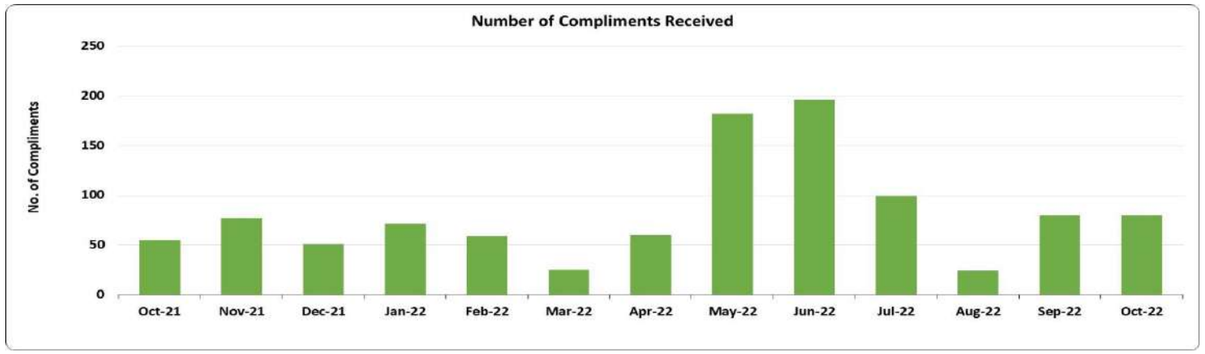
The review of the operating model gives the opportunity to establish a concerns triage process to ensure all concerns are managed in the most effective way for the patient/family and the Health Board. It is envisaged that changes will be in place during the early part of 2023. It is hoped that there will be a reduction in formal complaints and a rise in early resolutions, giving a better outcome for our patients and their families. Systems and processes in respect of the management of complaints are being reviewed taking into account changes to the operating model. Improvements have already been made in respect of the MS/MP complaints. Quality assurance and audit programmes in respect of complaint responses are due to recommence. Templates for complaint responses are being reviewed and improved.

Top Ten - Main Themes from Complaints	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Total
Clincial treatment/Assessment	64	37	51	54	45	47	51	36	54	44	55	40	578
Communication Issues (including Language)	16	17	10	15	14	8	9	5	4	1	5	3	107
Appointments	19	13	6	7	5	7	5	5	4	4	4	3	82
Attitude and Behaviour	11	5	7	4	8	4	4	2	7	9	5	4	70
Discharge Issues	7	15	8	6	6	6	5	3	1	5	3	1	66
Medication	2	3	5	5	0	2	6	3	1	3	3	8	41
Admissions	4	6	2	1	3	0	2	0	4	2	2	1	27
Test & Investigation Results	1	2	2	1	2	1	1	0	0	0	0	2	12
Patient Care	1	0	0	0	0	3	0	0	0	4	4	7	19
Referral	2	0	1	0	0	1	0	0	3	5	1	0	13

Compliments

Number of compliments – October 2022

80



During October 2022, there was an equal amount in the number of compliments recorded on the Datix system as the previous period, totalling 80, which is around the 12 month average.

Compliments are captured via a number of feedback mechanisms, but are mainly captured on Datix Cymru and CIVICA.

There is an All Wales Compliments Workstream focusing on how compliments are captured and coded.

There are a number of social media platforms which capture compliments. The Health Board are in the process of scoping the various platforms which capture compliments to determine how they can be captured and recorded in a unified way.

Medication Incidents & Mortality Rates

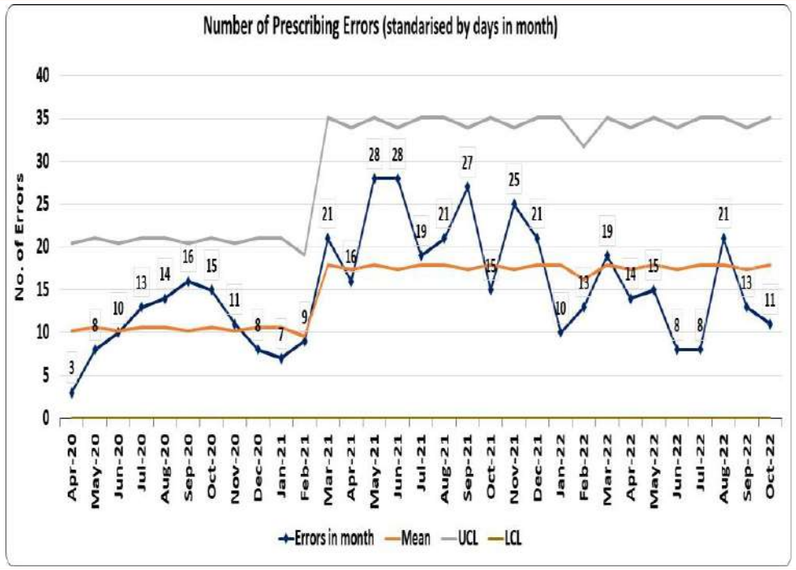
Medication Incidents

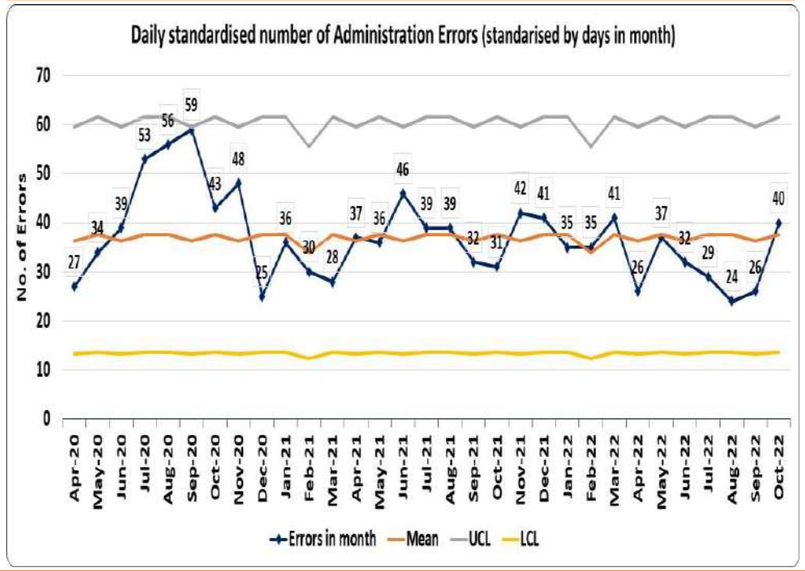
Total Medication Incidents – October 2022	Total number of Prescribing Errors	Total Administration Errors
98	**11**	**40**

The total number of medicine related incidents is 98 with the charts to the right focusing on patient safety prescribing and administration errors. Of the 98 medication incidents reported for October, 61% caused no harm with around 29% of incidents recorded as moderate/low. One medication supply error resulted in severe harm, this related to the discovery of a bacterial contaminant in an IV preparation and a safety alert was issued with all batches affected being removed. One person in the community known to have received the drug was admitted for sepsis management and has made a good recovery.

Medication prescribing errors fell to 11 this period and remains within natural variation (control chart first right). Medicines safety was the focus of World Patient Safety Day where pharmacists and patient safety teams visited hospital sites in September to raise awareness and optimise safe medicines use. The CTMHB public health campaign *Your Medicines, Your Health* was also reintroduced to advise on the benefits of safe and effective use, storage and disposal of medicines in the community.

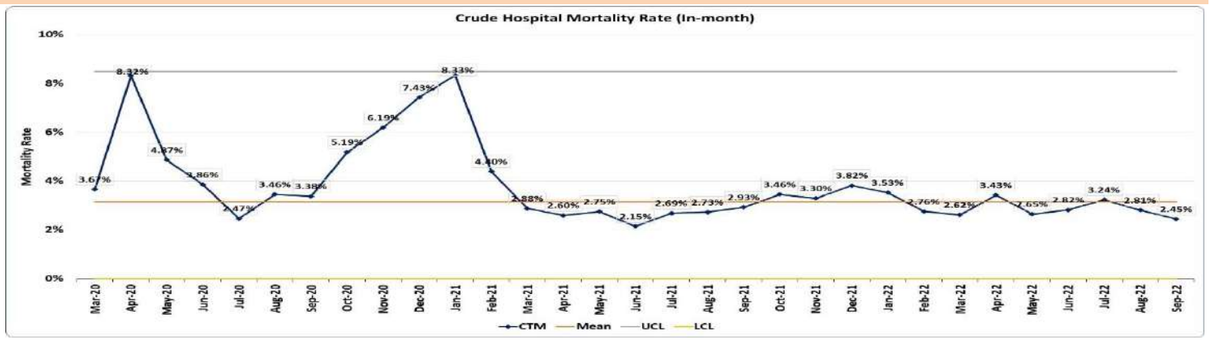
The number of administrative errors, shown in the control chart (second right), increased to 40 incidents this month, but remains within natural variation.

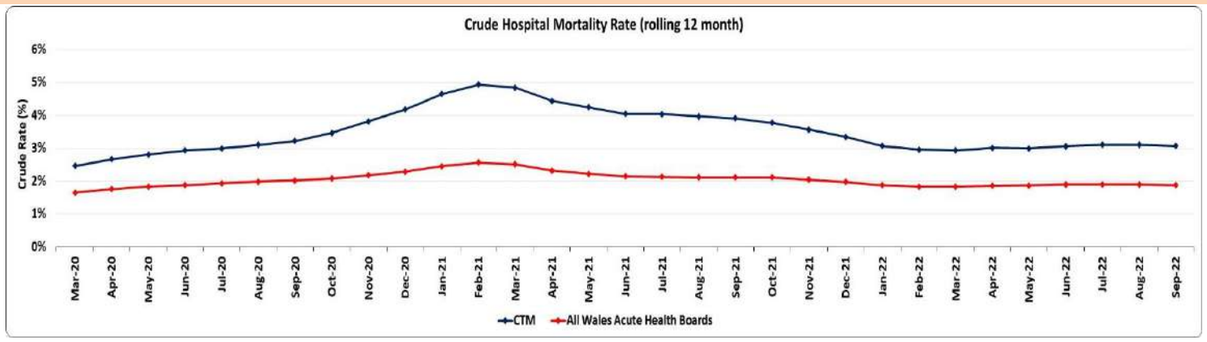


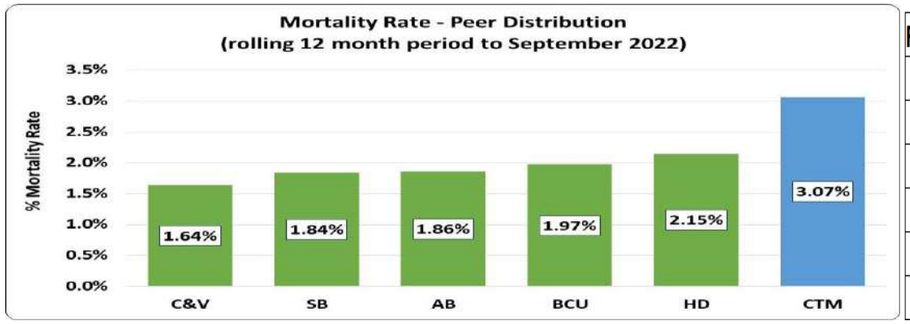


Crude Hospital Mortality Rates

In Month Crude Hospital Mortality Rate – September 2022	Rolling 12 Month Crude Hospital Mortality Rate to September 2022
2.45%	**3.07%**







Rolling 12 month Mortality Rates	
(period October to September)	
2017/18	2.42%
2018/19	2.28%
2019/20	3.22%
2020/21	3.91%
2021/22	3.07%

Crude hospital mortality rates remain positively correlated to Covid prevalence and the volume of hospital admissions. Predicted monthly mortality rates increased during July, but now appear to be falling, albeit not at the levels seen prior to Covid 19, as demonstrated in the table to the left. The rolling 12 month rate currently stands at 3.07%, a similar rate that that observed during January of 2022.

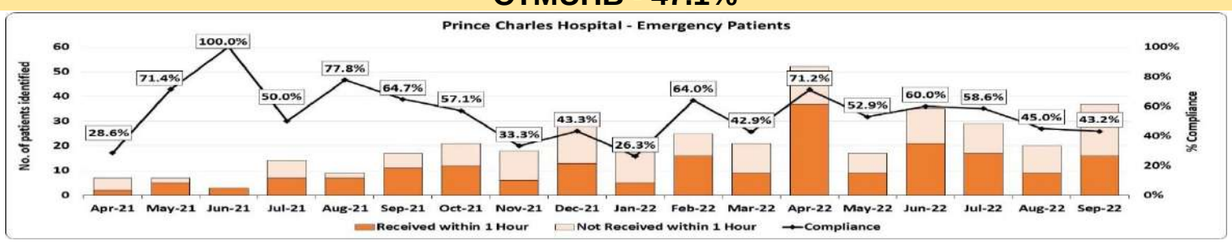
As can be seen in the peer distribution chart to the left, CTMUHB does have a higher crude mortality rate as a provider of services than Welsh peers, which can be interpreted as the UHB having a higher number of deaths in hospital than other health boards. A factor in this outlying position is the UHB's provision of palliative care and hospice services.

Sepsis Six Bundle

Emergency A&E Patients

% of Patients with a Positive Screening for Sepsis who have received all 6 Elements of the "Sepsis Six" Bundle within 1 Hour – Emergency A&E

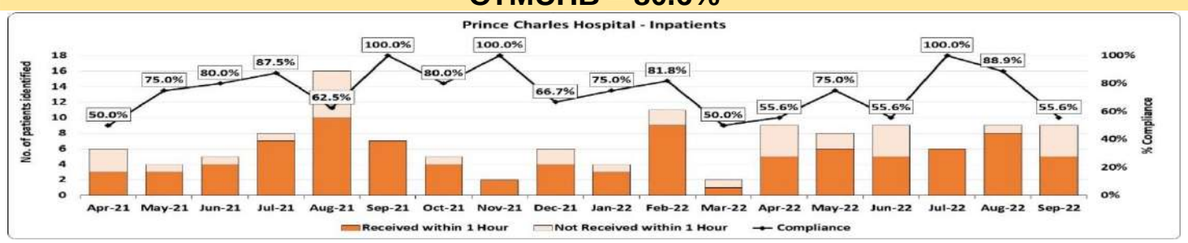
CTMUHB - 47.1%

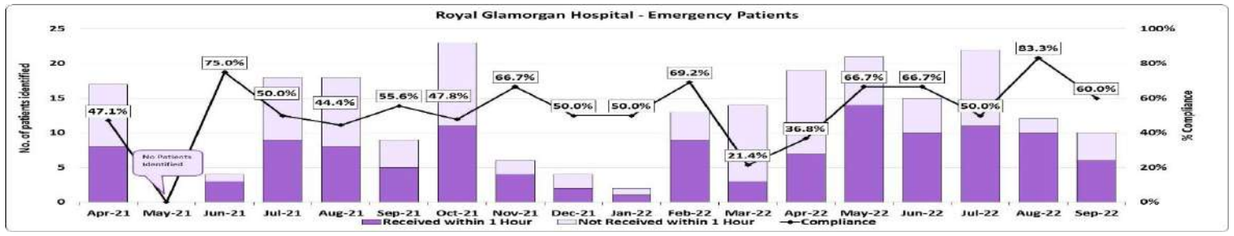


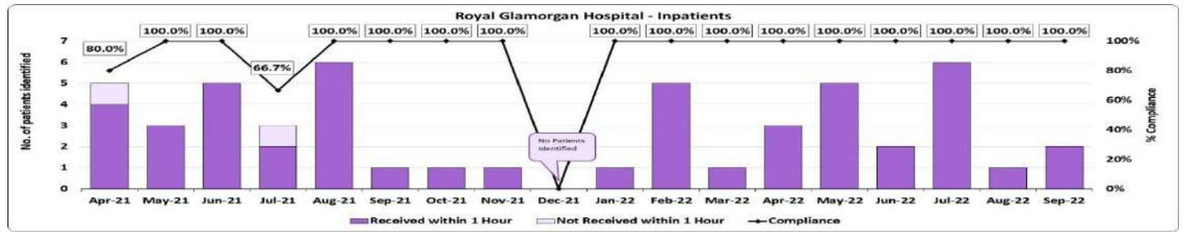
Inpatients

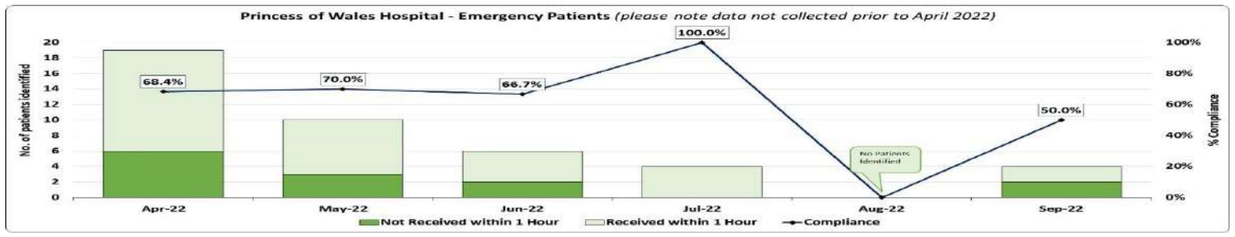
% of Patients with a Positive Screening for Sepsis who have received all 6 Elements of the "Sepsis Six" Bundle within 1 Hour – Inpatients

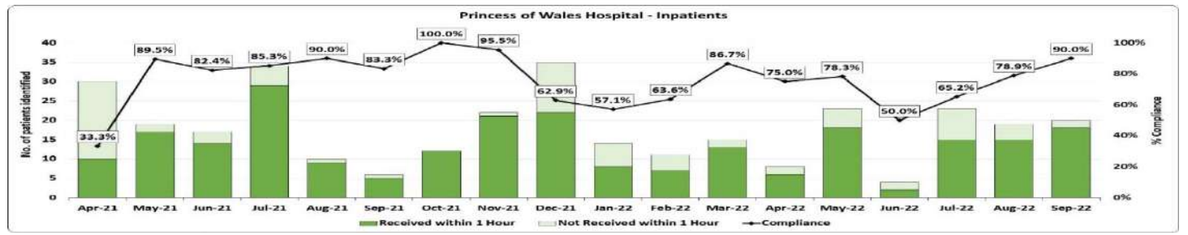
CTMUHB – 80.6%

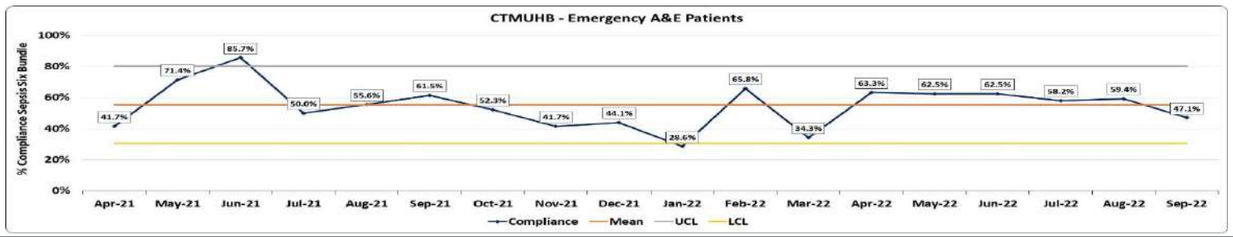


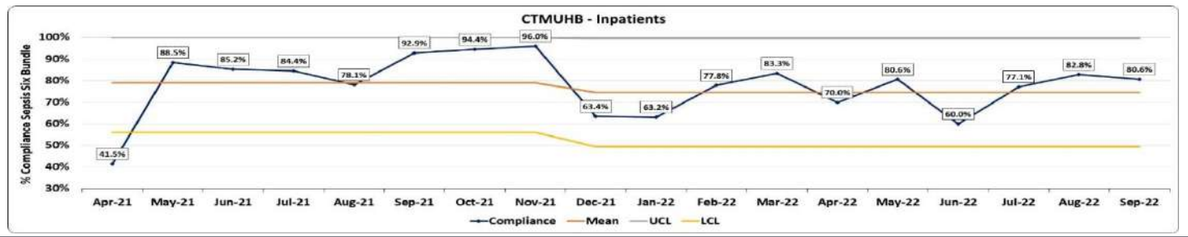












How are we doing & what actions are we taking?

When is improvement anticipated & what are the risks?

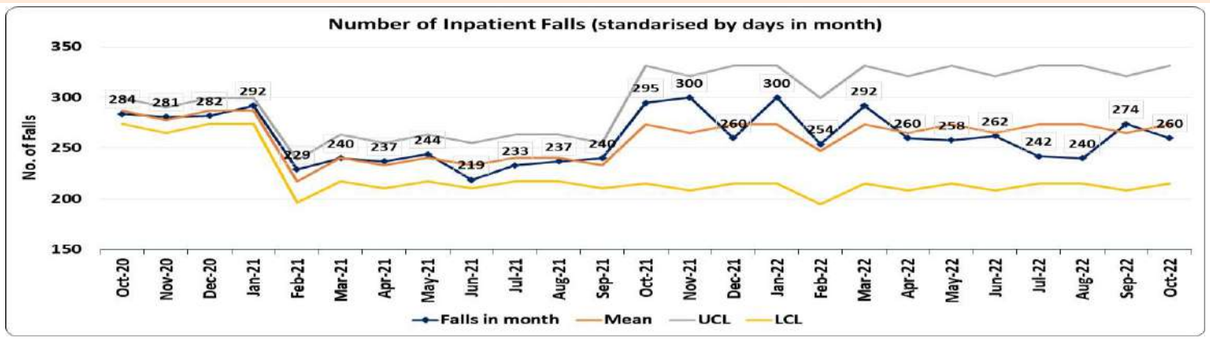
To standardise care within CTM the sepsis screening tool has been revised. This revision risk stratified patients into 'probable sepsis', 'possible sepsis' and 'sepsis unlikely'. The aim of risk stratification is to ensure that patients with 'probable sepsis' receive timely treatment of the sepsis 6 interventions within 1 hour. Patients with 'possible sepsis' require time for further investigation with an antibiotic decision being made within 3 hours and patients with 'unlikely sepsis' requiring a search for other diagnosis and re-assessment if their condition changes. In March 2022 a trial of the revised tool was conducted within our three Emergency Departments (EDs). Audit results for April 2022 for the EDs indicate that the use of the screening tool had increased in all three sites with sepsis compliance also improving (note: only 'sepsis probable' patient data is displayed). Previous data, pre-April 2022, included all patients with a 'suspicion of sepsis' using a different screening process. Every month, incidence of sepsis and compliance with treatment data is collected and circulated to the sepsis leads within each ED. Themes and trends are noted, and a plan for improvement made. As illustrated, compliance within PCH/RGH for the sepsis6 intervention bundle dipped in September 22. This was put down to clinical pressures with the departments. A plan for more education and formation of a sepsis nursing group within PCH has been established. Sepsis is also on the agenda for the PCH ED monthly Governance meetings. Plans are in place to replicate this approach within RGH/POW. Following the trial within EDs the sepsis tool was rolled out to the wards at RGH/PCH/POW in September 2022. As illustrated Sepsis6 compliance for the inpatient wards is increased (80.6% compared to 47.6% for ED). This is attributed to a lower number of inpatients with 'probable sepsis' and timely delivery of the sepsis 6 interventions by the Critical Care Outreach teams on each site evidenced by completed sepsis forms.	The introduction of the new tool and the associated education showed instant improvement in gathering data on cases of sepsis. This improvement has been maintained. Compliance with the treatment bundle has also improved but, depending on a number of factors, has fluctuated over the last few months. These factors are mostly related to the clinical acuity pressures in the EDs and also the presence or absence of Outreach staff. The new sepsis tool is in use on all PCH, RGH and POW adult ward areas (excluding Mental Health for now). There is ongoing sepsis education for medical and nursing staff. There is monthly reporting of sepsis probable incidence and compliance. The Acute deterioration team are working with Welsh government and Peers in other HBs to standardise our approach across Wales. The Risks to this improvement are: • Inability to know the true number of patients presenting to ED with Sepsis (to provide a number to which to aspire to treat.) • Need to emphasise that clinical tools are just part of wider clinical judgement which should be made in a timely fashion by suitably senior clinical decision makers. • Education and clinical response are often provided by the Outreach teams which, in times of clinical pressures, are pulled back into critical care, thus reducing their inability to respond to cases of sepsis. • The Acute Deterioration clinical leads who developed and maintain the tool are funded non-recurrently and there is no plan from the care groups to ensure continued funding of Sepsis and other work streams from next April.

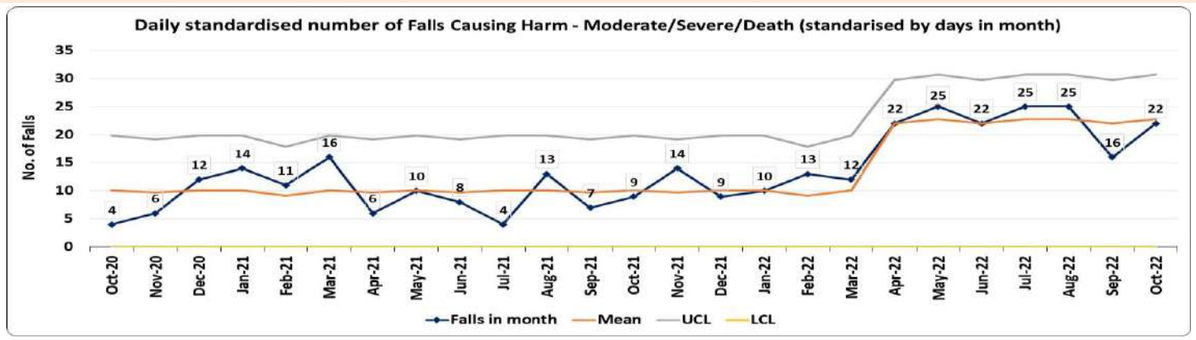
Inpatient Falls & Pressure Damage Incidents

Inpatient Falls

Total number of Inpatient Falls – October 2022

260



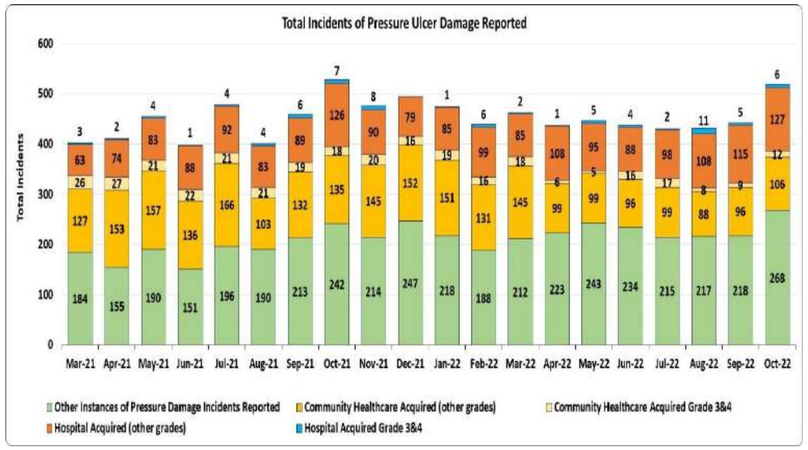


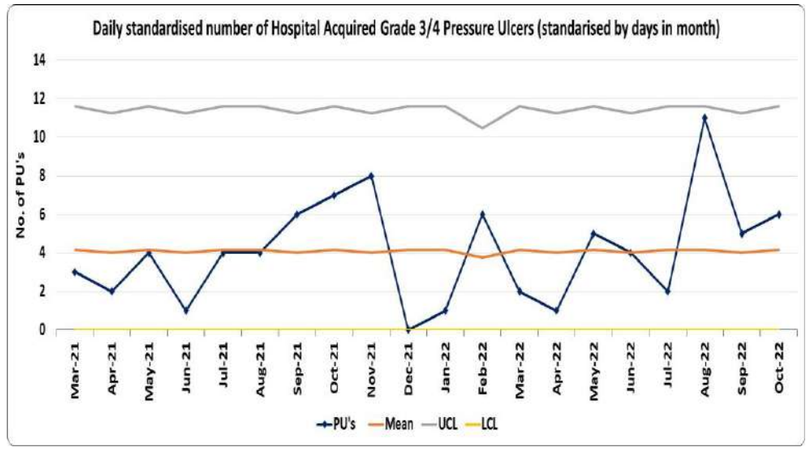
The number of patients falling whilst in the care of the UHB totalled 260 during October and lies just below the mean of 274. Four of the falls resulted in severe harm and a further 18 causing moderate harm and as per the right hand control chart, lies just below the current mean. Whilst there appears to be an increase in falls causing higher grades of harm, it is important to recognise that since the introduction of the new incident module in April 2022, these reports are initial Datix entries and that all falls moderate and above are subject to a falls panel which may result in downgrading of harm categorisation. The new module did not permit clinical teams to downgrade initial categorisation on Datix, hence the apparent increase in harm since April 2022. There is an expectation that when the first line approval issues have been resolved that reporting of initial categorisation of harm will have greater accuracy, however it is important that vigilance remains to ensure that we explore any increase in numbers for assurance and action. We have introduced for Quality & Safety Committee pressure damage and falls per 1,000 occupied bed days as an improved measure of benchmarking fall rates, with the next step to set reduction goals for numbers and severity of harm. This metric also facilitates flexibility in identifying areas of greatest risk and setting reduction targets accordingly.

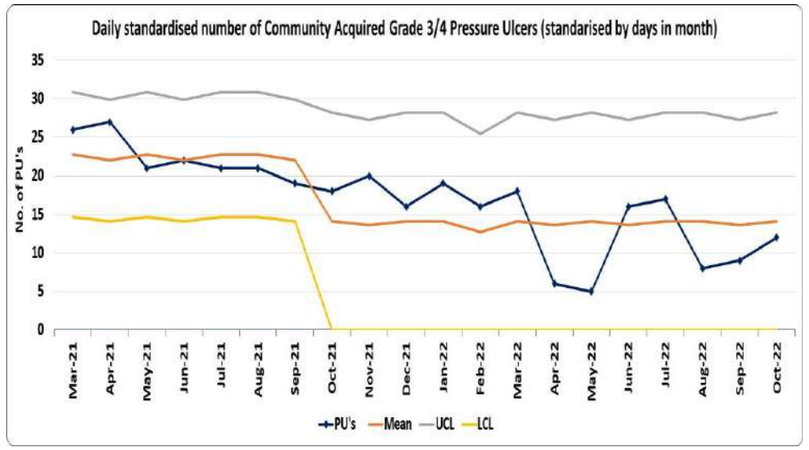
Pressure Damage Incidents

Total number of reported Pressure Damage – October 2022

519







During October 2022, a total of 519 pressure damage incidents were reported which is around 13% higher than the 12 month average of 458 incidents. Just under 26% of the total incidents reported were identified as those being hospital acquired and almost 23% recorded as developing outside of a hospital setting (within district nursing settings). Of the total number of pressure damage incidents reported, 52 (10.0%) were reported as grade three or four (6 hospital acquired and 12 community acquired).

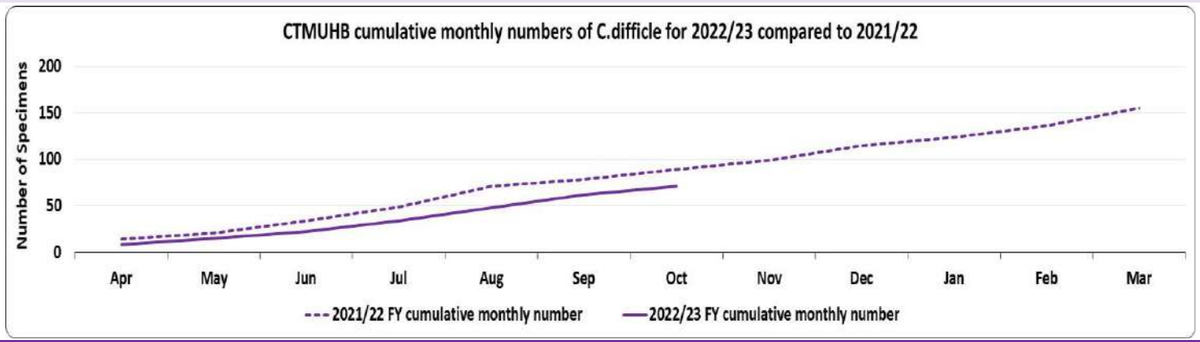
The highest numbers of hospital acquired pressure damage were recorded for Emergency Care & AMU, Princess of Wales Hospital (16). There is an increase seen in hospital acquired pressure damage in August and this may be related to excessive delays in ambulance handovers where pressure relief is more difficult to administer, and generalised increase in acuity which will require continued monitoring. There is a sustained reduction in higher grades of community acquired pressure damage. The Health Board launched its Community Acquired Pressure Ulcer prevention strategy in July, which is a sustainable health improvement collaborative to prevent and reduce incidence of pressure damage where the highest numbers of incidents are reported. The collaborative have now moved into its second learning phase with lead professionals working on agreed actions using QI methodology for evidencing impact.

Throughout the past 12 months, a total of 2,796 Healthcare Acquired Pressure Damage Incidents were reported, of which an investigation has been completed for 1,594 (57.0%) of these, with 221 (13.9%) recording an outcome of avoidable.

Infection Prevention and Control

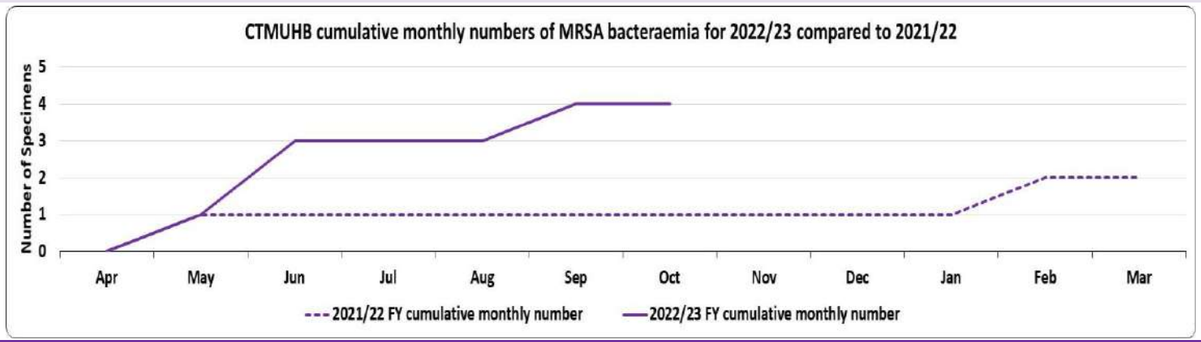
C.difficle

71 C.difficle have been reported by CTM between Apr-Oct 2022. This is approximately 20% fewer than the equivalent period in 2021/22. The provisional rate per 100,000 population for 2022/23 is 29.92



MRSA

4 MRSA bacteraemia have been reported by CTM between Apr-Oct 2022. This is twice as many as that reported for the whole of 2021/22. The provisional rate per 100,000 population for 2022/23 is 1.52

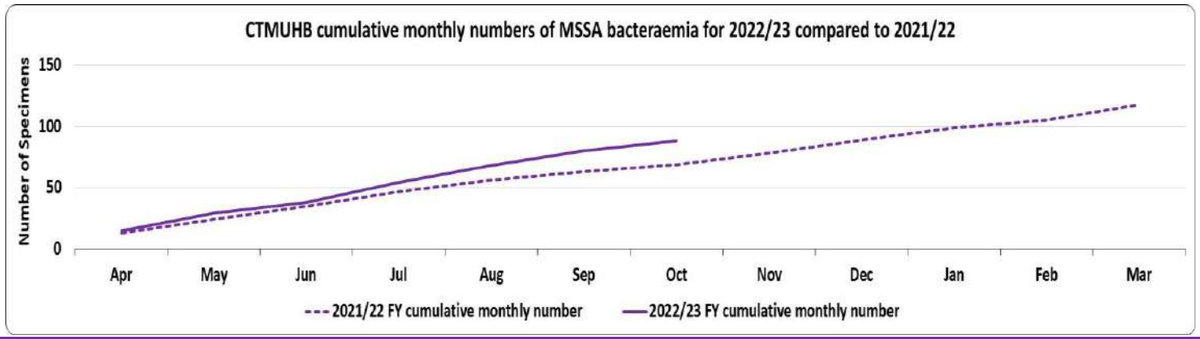


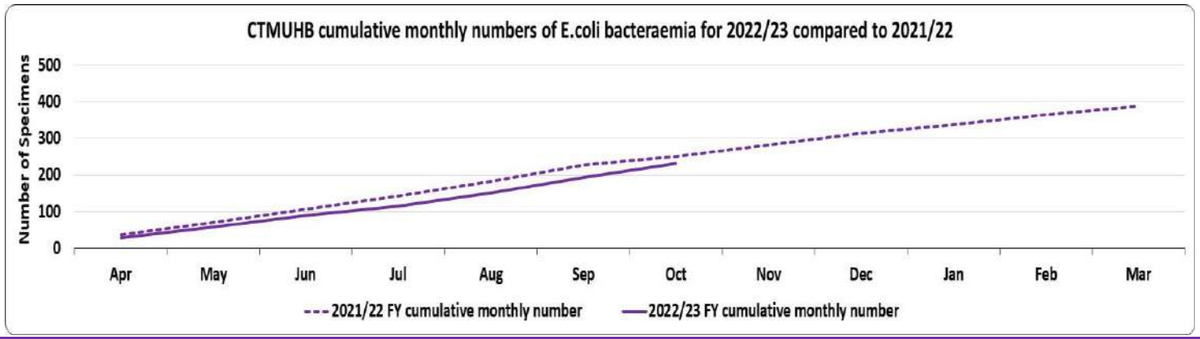
MSSA

88 MSSA bacteraemia have been reported by CTM between Apr-Oct 2022. This is approximately 28% more than the equivalent period in 2021/22. The provisional rate per 100,000 population for 2022/23 is 33.37

E.coli

233 E.coli bacteraemia have been reported by CTM between Apr-Oct 2022. This is approximately 8% fewer than equivalent period in 2021/22. The provisional rate per 100,000 population for 2022/23 is 88.34



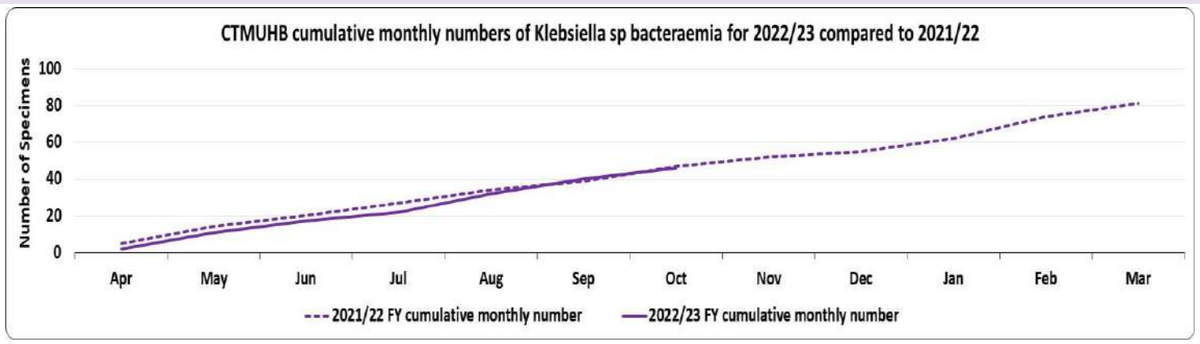


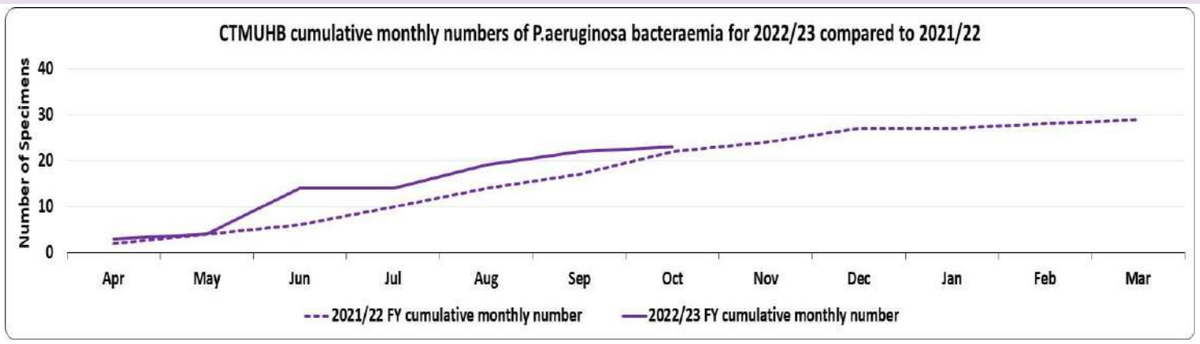
Klebsiella sp

46 Klebsiella sp bacteraemia have been reported by CTM between Apr-Oct 2022. This is approximately 2% more than the equivalent period in 2021/22. The provisional rate per 100,000 population for 2022/23 is 17.44

P.aeruginosa

23 P.aeruginosa bacteraemia have been reported by CTM between Apr-Oct 2022. This is approximately 5% more than in the equivalent period in 2021/22. The provisional rate per 100,000 population for 2022/23 is 8.72





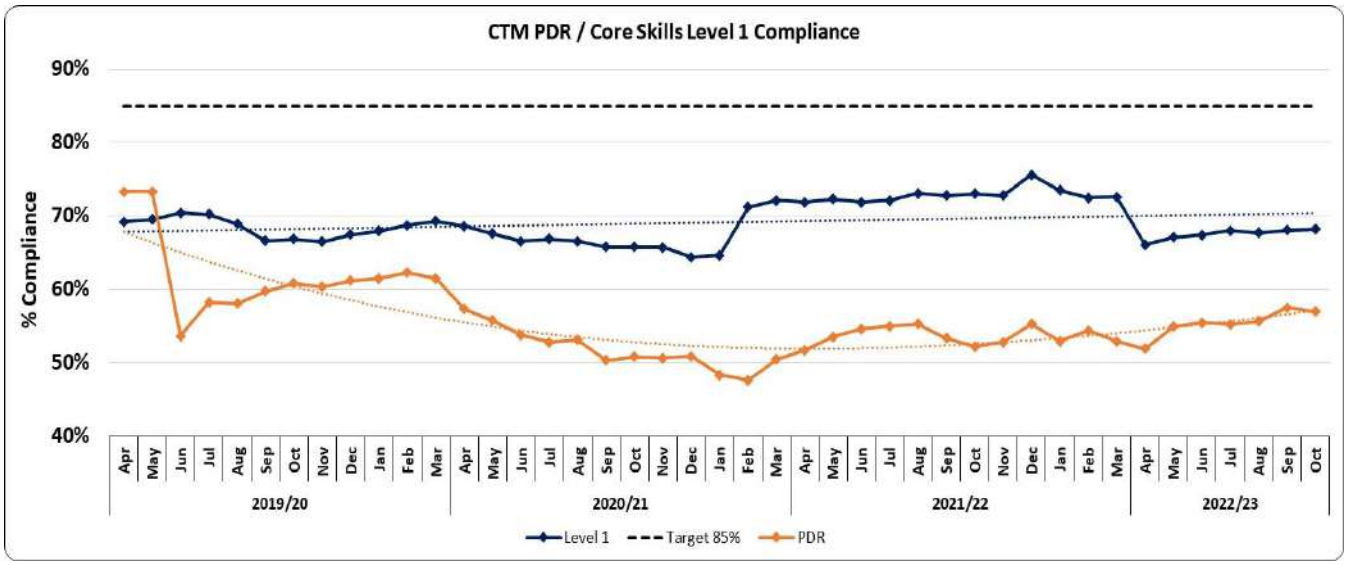
Mandatory surveillance continues nationally for five key organisms including C. difficile, Staphylococcus aureus bacteraemia and E.coli, Pseudomonas and Klebsiella bacteraemia. The Health Board has reported fewer cases of C.Difficile infection and gram-negative bacteraemia compared to the same period in 2021. Local reduction expectations have been agreed with Senior Clinicians, which has improved understanding and ownership of data. More than half of the bacteraemia reported are community acquired infections and work is underway to secure an infection prevention and control resource for primary care.

2.4 People

In summary, the main themes of the People Scorecard are:

2.4.1 Personal Development Reviews (PDRs) & Core Mandatory Training (Level 1):

Overall PDR compliance (non-medical staff) during October 2022 remained almost static at 57% (57.5% September). It is acknowledged that this continues to remain below the target threshold of 85%.

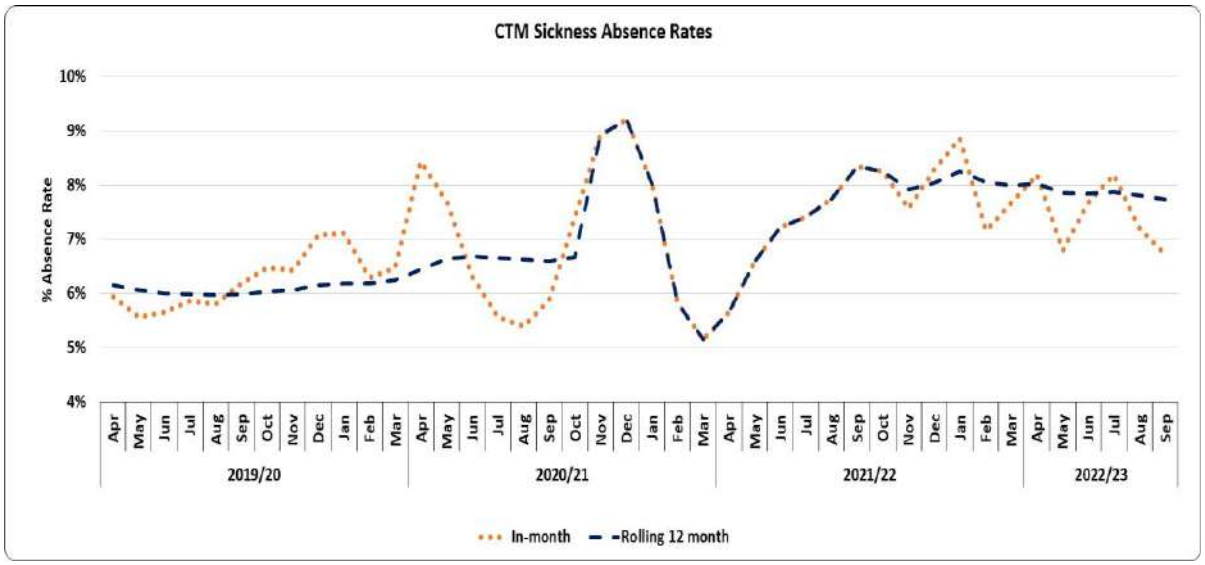


Combined core mandatory training compliance for October 2022 remains fairly static at 60.5%, with overall CTM compliance for 'Level 1' disciplines just over 68% and likewise, remains below the required standard of 85%.

CTM Level 1 Core Manditory Training Compliance October 2022	
Equality, Diversity & Human Rights	79.5%
Health, Safety and Welfare	76.2%
Moving & Handling	75.7%
Safeguarding Adults	74.9%
Information Governance	72.2%
Safeguarding Children	71.9%
Infection Prevention and Control	69.3%
Violence & Aggression	63.8%
Fire Training	57.6%
Resuscitation	44.8%
HB Overall Compliance	**68.2%**

2.4.2 Sickness Absence:

The overall CTM rolling twelve-month sickness rate to September 2022 is 7.7% (6.7% in-month), continuing on a downwards trajectory. In comparison to the previous month, provisionally occurrences of short term absences have increased by 7.2% (91 occurrences), bringing the total to 1353, whilst long term absences have reduced by just over 16% (148) occurrences, bringing the total to 756.



Top 10 Absence Reasons by FTE Days Lost - September 2022				
Absence Reason	**Headcount**	**Absence Occurrences**	**FTE Days Lost**	**% of all absence reasons**
Anxiety/stress/depression/other psychiatric illnesses	427	437	6,940	31.61%
Infectious diseases	189	189	1,933	8.81%
Other musculoskeletal problems	124	126	1,814	8.26%
Chest & respiratory problems	140	141	1,560	7.11%
Gastrointestinal problems	300	305	1,411	6.43%
Other known causes - not elsewhere classified	127	128	1,242	5.66%
Back Problems	88	89	1,111	5.06%
Injury, fracture	74	75	1,096	4.99%
Benign and malignant tumours, cancers	37	38	856	3.90%
Cold, Cough, Flu - Influenza	206	209	782	3.56%

2.4.3 Premium rate agency nurse

The CTMUHB's use of premium rate nurse agency staff saw a small increase of 7.5% during October to 4.76 whole time equivalents (WTE), with efforts continuing to maximise the use of bank over agency staff.

2.5 Access

Detailed analysis is provided in the following section of this report, but in summary, the main themes of the Access Scorecard are:

2.5.1 Urgent Care:

During October, just over 61% of patients were treated within 4 hours in our Emergency and Minor Injury Departments, with around a fifth of ambulances ready to respond to the next '999' call within 15 minutes of arrival at an ED.

There were 15,846 attendances over the course of the month, 3.2% higher than the equivalent period last year.

The CTM 15 minute ambulance handover compliance rose marginally this month, albeit to just 20.2%, whilst the 60-minute compliance fell to its lowest level of just over 48%.

2.5.2 Stroke Care:

Performance against the desired standards in stroke care continues to remain low. Whilst absolute performance varies month on month, statistical analysis would suggest that any variances is natural rather than special cause in nature.

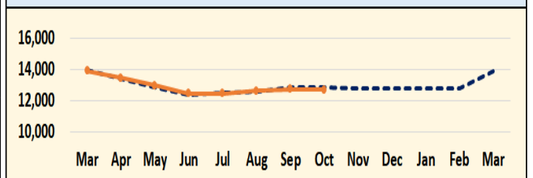
The only observable change this month, though performance being low, was the 4 hour compliance to ASU within 4 hours at POW; after recording zero compliance for the past ten months, 2 of the 15 stroke patients (13.3%) were admitted within the specified timescale.

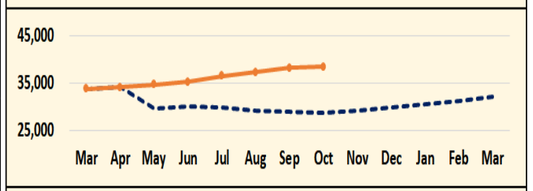
2.5.3 Planned Care & Cancer Care:

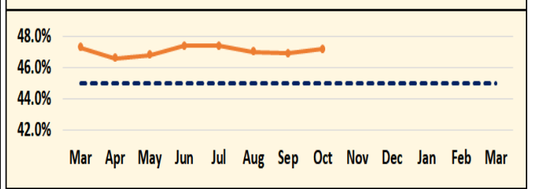
The CTM performance against the health board's trajectories for access to planned care and cancer care (shown on the following page), indicates that we remain behind where we should be in regards to treatments and new outpatient productivity and waiting times, but are improving ahead of trajectory for follow up outpatient management.

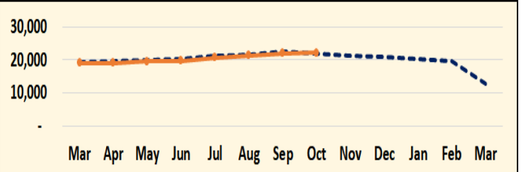
ACCESS TO TIMELY PLANNED CARE	Measure	Target / Delivered	Progress against our plans (IMTP) 2022/23								Key: Better than Forecast / Same as Forecast / Worse than Forecast				
			Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by 2023	13,925	13,387	12,848	12,375	12,483	12,595	12,818	12,811	12,805	12,798	12,792	12,785	13,846
		Actual	13,885	13,439	12,968	12,441	12,449	12,605	12,715	12,701					
	Number of patients waiting more than 52 weeks for treatment	Improvement trajectory towards a national target of zero by 2026	33,849	34,089	29,724	30,230	29,877	29,305	28,908	28,748	29,193	29,811	30,488	31,264	32,104
		Actual	33,849	34,089	34,694	35,320	36,504	37,286	38,222	38,423					
	Percentage of patients waiting less than 26 weeks for treatment	Improvement trajectory towards a national target of 95% by 2026	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%	45.0%
		Actual	47.3%	46.6%	46.8%	47.4%	47.4%	47.0%	46.9%	47.2%					
	Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by December 2022	19,330	19,606	19,892	20,198	21,198	21,719	22,433	21,896	21,359	20,822	20,284	19,747	12,884
		Actual	18,965	19,040	19,454	19,684	20,637	21,291	21,916	22,108					
	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	A reduction of 30% by March 2023 against a baseline of March 2021	28,736	29,311	29,897	30,495	30,899	31,128	31,703	30,910	30,138	29,384	28,650	27,933	27,235
		Actual	28,845	29,123	29,147	29,412	30,024	30,246	30,854	30,663					
	Number of patients waiting over 8 weeks for a diagnostic endoscopy	Improvement trajectory towards a national target of zero by March 2026	3,046	3,354	3,488	3,424	3,345	3,437	3,477	3,377	3,277	3,177	3,077	2,977	2,877
		Actual	3,169	3,306	3,435	3,366	3,281	3,382	3,395	3,283					
	Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of 75%	50.0%	52.8%	45.4%	51.9%	48.5%	46.0%	53.7%	66.0%	68.0%	69.0%	71.0%	73.0%	74.0%
		Actual	47.4%	52.0%	45.2%	50.0%	47.9%	46.0%	46.2%						

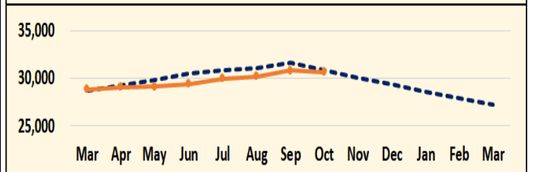
Key: Actual --- IMTP

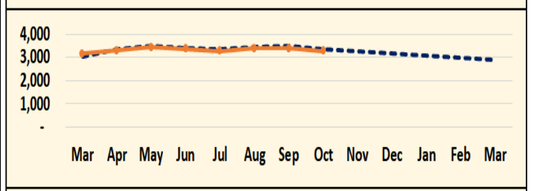


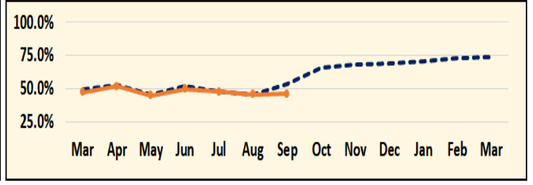






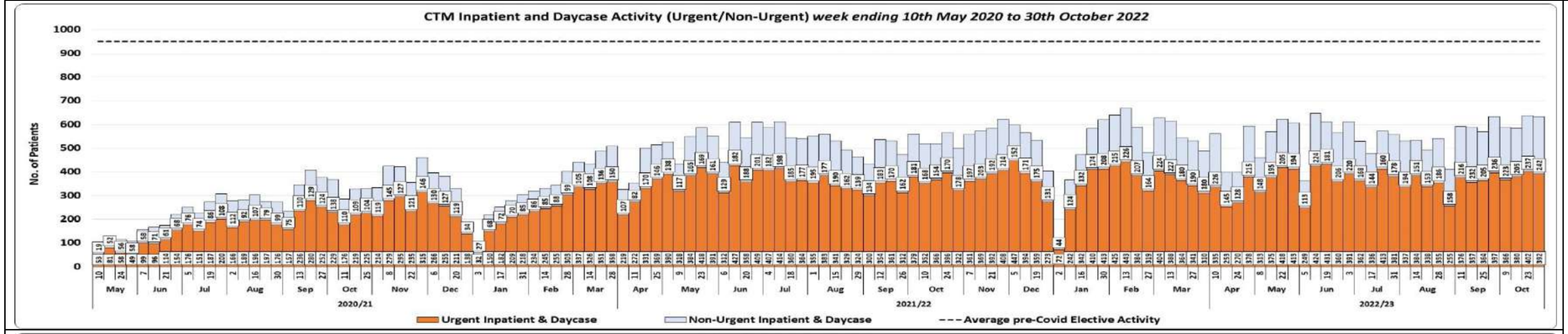


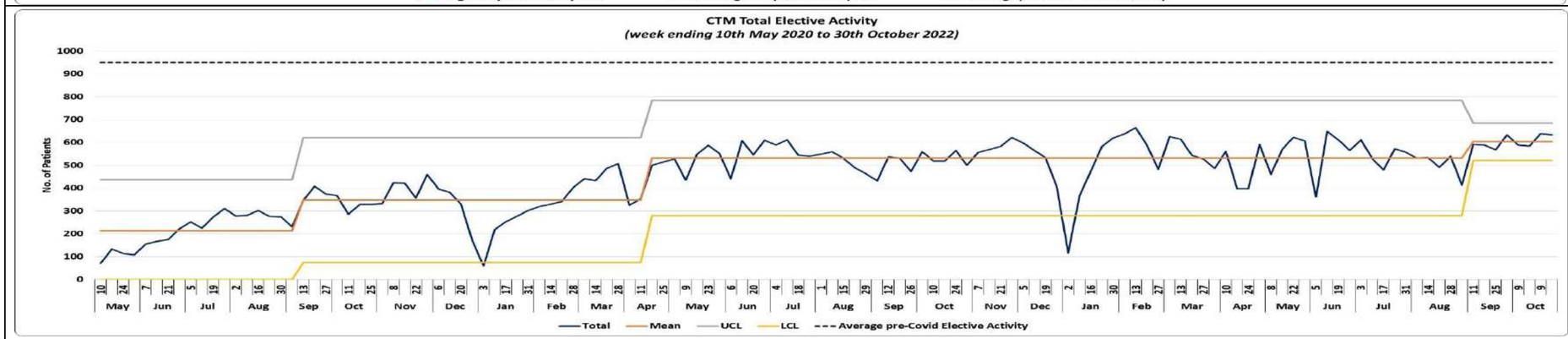




Resetting Cwm Taf Morgannwg – Inpatient / Day Case Activity – to 2nd October 2022

Activity Undertaken within Internal Hospital Capacity – Inpatient and Day Case





"Top-10" Specialties with highest volumes of treatments carried out within Internal Capacity

Elective Activity - Top 10 October 2022	Average Weekly Elective Activity	Pre-covid Weekly	Variance	% Variance
General Surgery	129	211	-82	**-38.9%**
General Medicine	98	150	-53	**-35.0%**
Urology	67	108	-42	**-38.4%**
Trauma & Orthopaedic	64	120	-56	**-46.9%**
Ophthalmology	57	100	-43	**-43.0%**
Gastroenterology	56	53	3	**5.7%**
Gynaecology	38	66	-28	**-42.4%**
ENT Surgery	32	55	-24	**-42.7%**
Cardiology	31	24	7	**29.2%**
Oral Surgery	15	22	-8	**-34.1%**

The table above details the average weekly "Top Ten" specialties that have carried out the highest volumes of elective activity during October compared to the average pre-Covid levels (six week average calculated from 27th January to 8th Mar 2020).

As can be seen, Cardiology & Gastro are the only specialties treating more patients within internal capacity than pre-Covid. A number of specialties do not have access to the same number of theatre lists as they did pre-Covid (Gynaecology and Ophthalmology) and others such as Surgery in POW have limited beds.

How are we doing?

As per the charts above, the average number of weekly elective treatments delivered in October currently stands at 612; an increase in activity of 3% on the average for the previous month (596). In regards to the WG indicator, elective treatments continue to be less (around 36%) than the pre-Covid weekly average (951).

Since the start of the last financial year (2021/22) to date, CTM have sent 2,122 patients to be treated at Spire and Nuffield Hospitals. Of these patients, 1,385 (on average 73 patients per month) have been treated, as detailed below:

Outsourced Activity as at end of October 2022

Specialty	Sent to Date	Returned	Treated to Date	Dated	Outpatient Booked	Outstanding
SPIRE - Orthopaedics	863	98	599	87	56	23
SPIRE - Shoulders	25	10	15	0	0	0
SPIRE - Gynaecology	78	29	49	0	0	0
SPIRE - General Surgery	114	19	54	18	23	0
NUFFIELD - Orthopaedics	415	104	246	12	3	50
NUFFIELD - General Surgery	83	24	59	0	0	0
NUFFIELD - Gynaecology	201	52	123	6	15	5
NUFFIELD - Ophthalmology	343	67	240	9	7	20

Source: Spire / Nuffield Healthcare

What actions are we taking & when is improvement anticipated?

The focus by the end of October has been on the reducing the number of patients waiting over 156 weeks for treatment and reducing the number of patients waiting over 104 weeks by the end of December. During October, all the Medical specialties which have small numbers of IPDC were on track to meet both these targets but this was not the case for any of the surgical specialties.

Ophthalmology: Funding has been provided to Ophthalmology to undertake Super Saturday outpatient, pre-assessment and operating lists for cataracts between now and Christmas. This will clear the number of patients currently waiting >156 weeks on the IPDC waiting list, but must note that there is a high level of conversions for surgery from outpatients, for which >1800 patients are waiting over 104 weeks for a first appointment.

Orthopaedics and Day Surgery: Additional theatre staff have been procured from an insourcing company which will allow for centralisation of Orthopaedic Inpatients in the Royal Glamorgan and increase capacity by approx. 17 Orthopaedic elective cases per week from the beginning of December. The insourced staff will allow for an additional two all day surgery theatre lists a week to be undertaken in Prince Charles across a number of specialties inc. Gynaecology, General Surgery and Oral Maxillo Facial Surgery. It is estimated that this will generate an additional 12 patients a week.

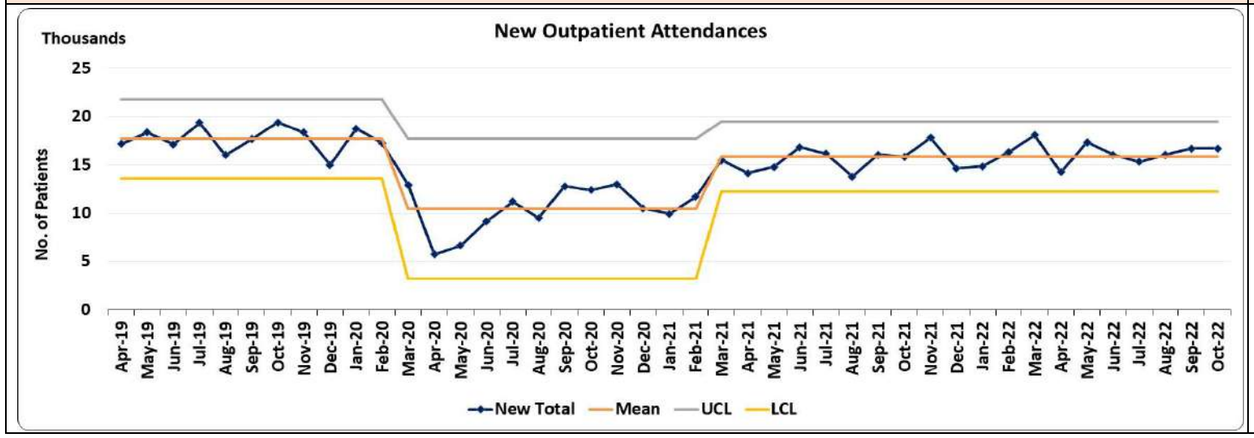
Stage 4-104+ Week Validation: The external validation company commissioned by the National Planned Care recovery programme to provide administrative and telephone validation to all patients waiting over 104 weeks started work in October to ensure that those on the waiting list still require the operation and whether they are willing travel to different sites to receive it.

What are the main areas of risk?

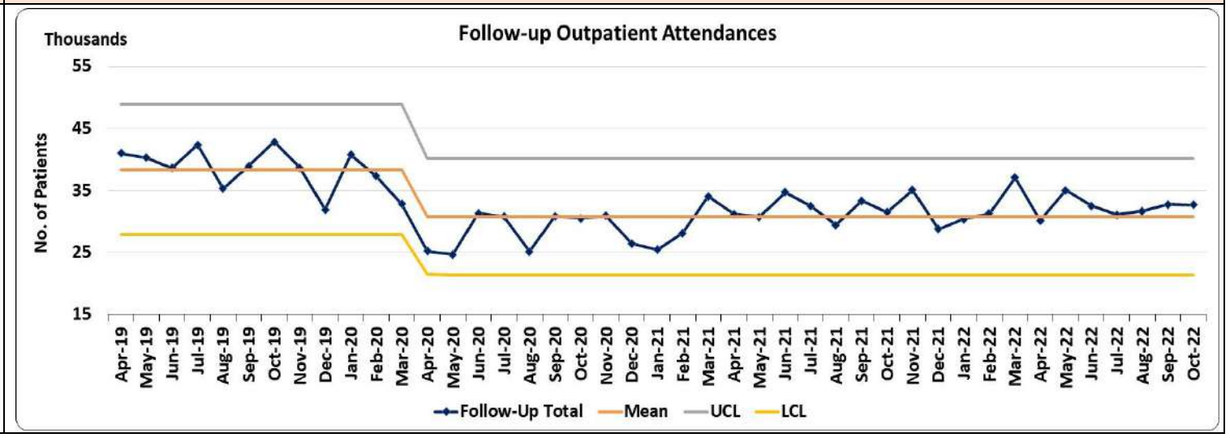
- There are still a number of specialties without clear plans to make improvements to their IP/DC elective position as their capacity is predominantly being used for cancer cases. These include ENT, Gynaecology and Urology. Gynaecology have also seen their theatre capacity reduced by approx. 6 lists a week compared to pre-Covid.
- Ophthalmology and Orthopaedics are areas of risk from a pure volume perspective with >5,000 patients awaiting a cataract.
- Availability of 'elective bed capacity'. Currently POW only has 9 beds identified for elective care although plans to reinstate the Day Unit are being implemented. This risk is heightened by the Winter forecast that has identified that the organisation has a 100 bed shortage going in to the Winter, and that this excludes the potential for covid and influenza to increase the bed requirement by a further 200 at the peak

Resetting Cwm Taf Morgannwg – Outpatient Attendances – October 2022

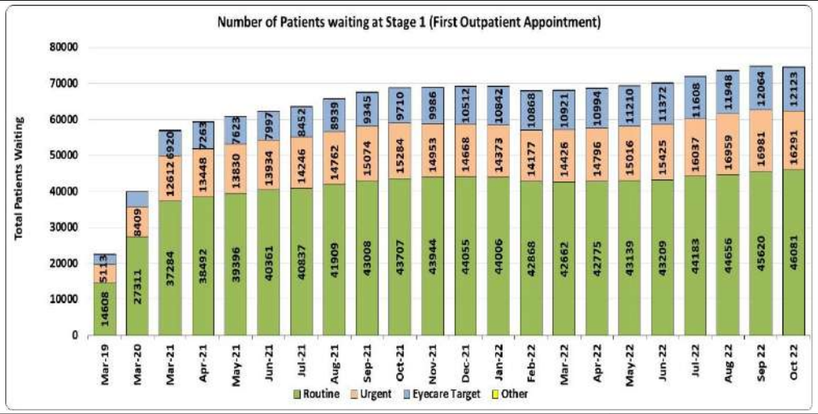
New Outpatient Attendances October 2022 – provisionally 16,731



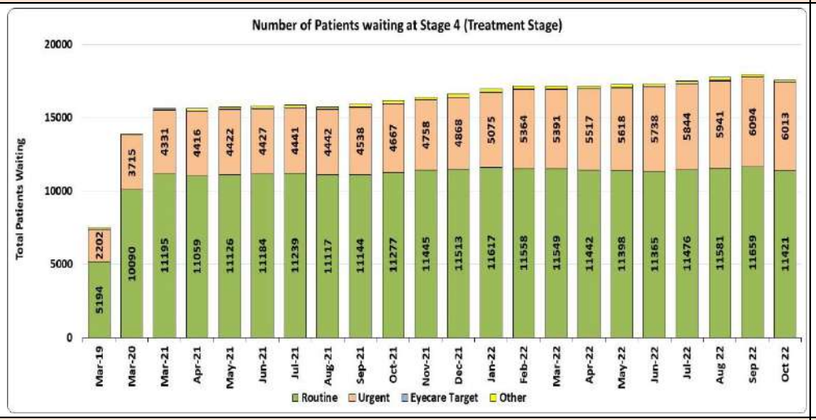
Follow-up Outpatient Attendances October 2022 – provisionally 32,691



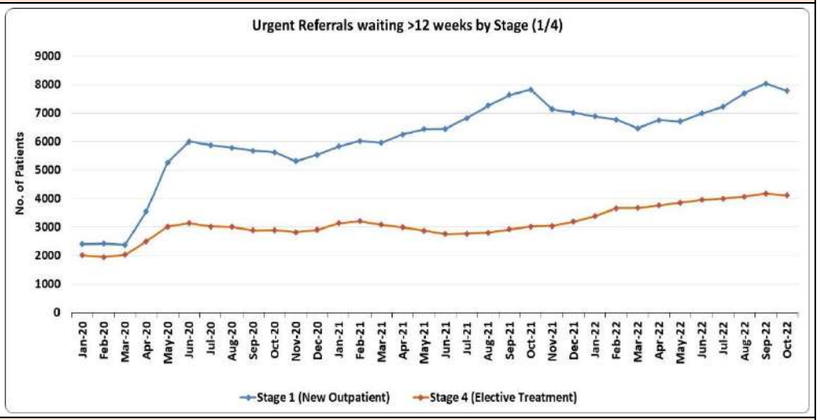
Waiting times Stage 1 (New Outpatients) - 74,528 patients



Waiting times Stage 4 (Treatment Stage) – 17,551 patients



Urgent referrals waiting >12 wks (Stage 1 – 7,782)(Stage 4 – 4,121)



How are we doing?

As at the end of October 2022, there were 74,528 patients awaiting a new outpatient appointment, of which, 16,291 (21.9%) patients were categorised as urgent and 11,916 (16.3%) were ophthalmic patients who are prioritised to alternative clinical triage criteria. The total waiting list volume represents an increase of just over 8% (5,802) on the 68,726 patients waiting at the end of the equivalent period last year.

Additionally, there were 17,551 patients who were awaiting treatment and of these, 6,013 (34.3%) were categorised as clinically urgent, a small reduction (1.3%) on the September position of 6,094.

What actions are we taking & when is improvement anticipated?

The following actions are being taken to eliminate waits of >104 weeks by the end of December

Use of WISE for Pain Management patients: The Health Board's Wellness Improvement Service (WISE) is the initial intervention for Pain Management Stage 1 referrals.

Super Saturday clinics: Are being undertaken in Oral Maxillo Facial Surgery and Cardiology

Implementation of Breast Pain pathway: The Breast Clinic Fellow is undertaking specific clinics to see the Breast Pain referrals.

Health Board wide waiting lists: We are working to HB wide waiting list management in order to bring equity to waiting times i.e. General Surgery patients are only breaching in RTE currently so are requesting to be seen by Clinicians in the other two localities.

Stage 1-52+ Week Validation: The external validation company commissioned by the National Planned Care recovery programme to provide administrative and telephone validation to all patients waiting over 52 weeks started work in October.

Dermatology: we are out to advert for a Locum Consultant and are looking for opportunities with the wider MDT including nursing and pharmacy support. This will reduce rather than eliminate >104 weeks.

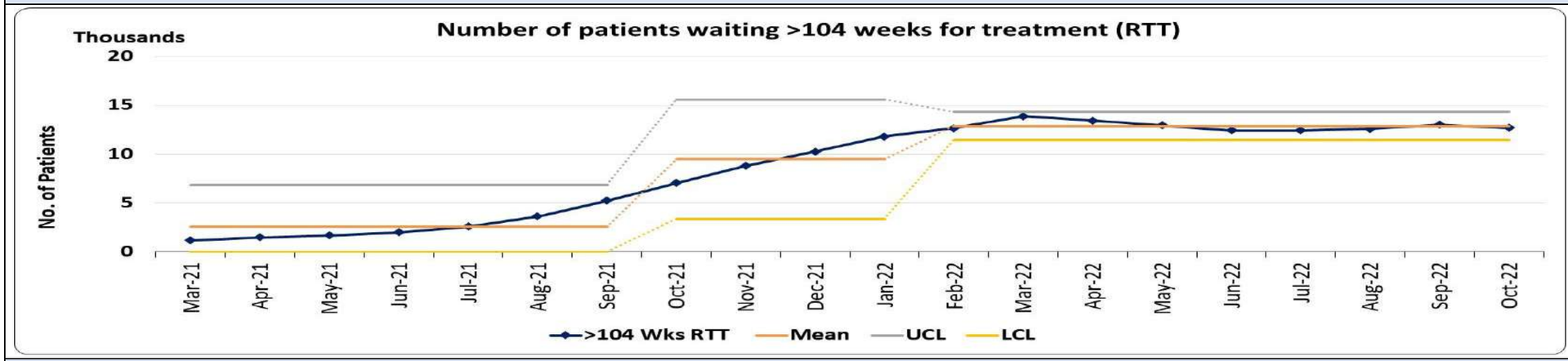
What are the main areas of risk?

The main areas of risk in terms of meeting the WG revised priority of no patients waiting over 104 weeks by the end of December are in Dermatology, Ophthalmology, ENT, Urology and Cardiology. These specialties are all currently forecasting patients waiting over 104 weeks for a first appointment.

Those specialties with a high Urgent Suspected Cancer referral rate have highlighted that should the rates increase then the capacity for referrals prioritised as routine will continue to experience long waits.

Referral to Treatment Times (RTT) – October 2022 (Provisional Position) – Total Open Pathways 120,545

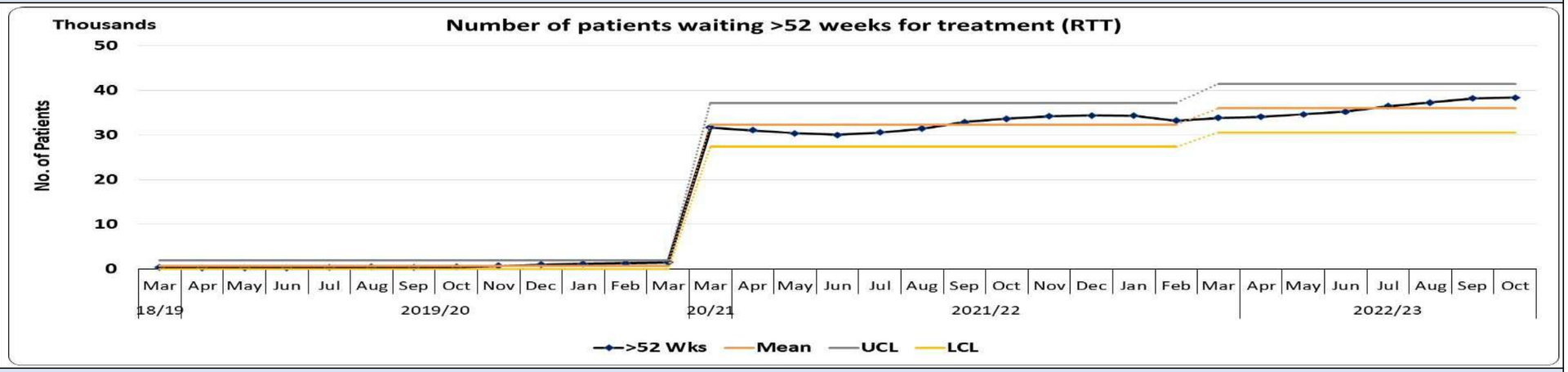
Number of patients waiting **>104 weeks (12,701)** Target - Improvement Trajectory towards a national target of Zero by 2023



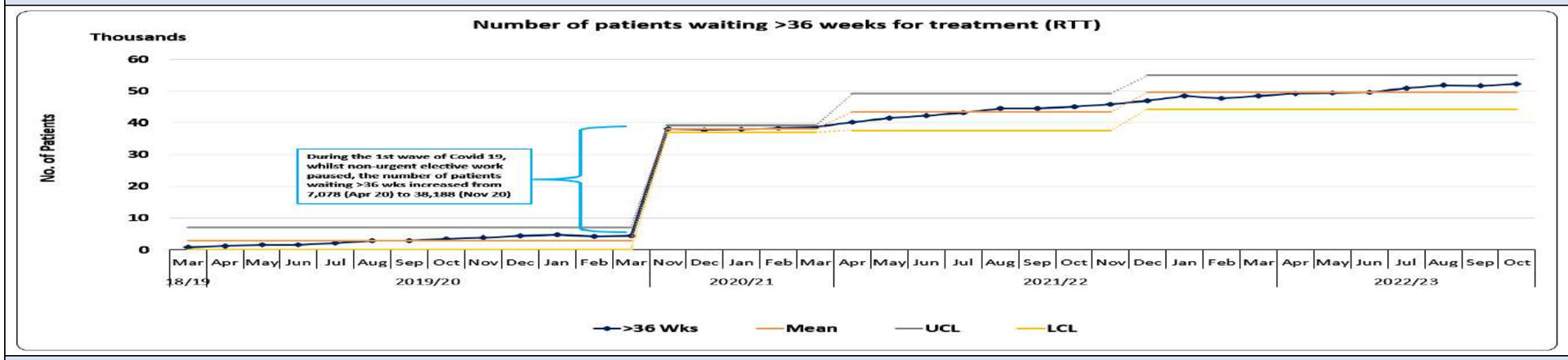
The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for treatment at the end of October is 12,701, which as it currently stands is a reduction of 2.4% (316) from the reported September position.

Number of patients waiting **>52 weeks** (**38,423)**

The provisional position across the Health Board for patients waiting over 52 weeks for treatment at the end of October is 38,423, which as it currently stands is a small rise of around 0.5% (201) from the September reported position.



Number of patients waiting **>36 weeks (52,223)** Target – Improvement Trajectory towards a national target of Zero by 2026

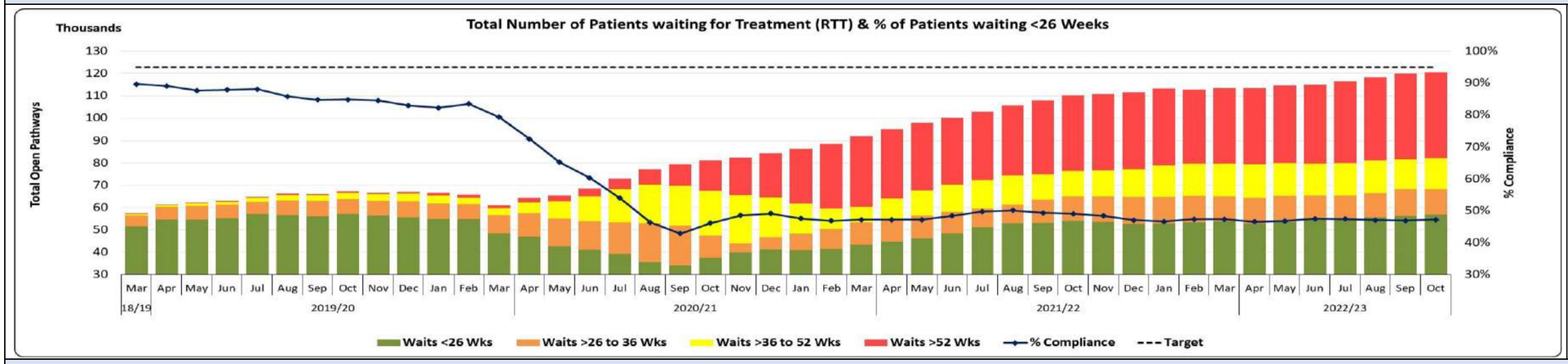


The number of patients waiting over 36 weeks at the end of October, across Cwm Taf Morgannwg, is a provisional position of 52,223 patients, which is an increase of around 1% (507) from September (N.B. includes the 38,423 patients waiting over 52 weeks).

RTT continued on the next page…

Cont'd…Referral to Treatment Times (RTT) – October 2022 (Provisional Position) – Total Open Pathways 120,545

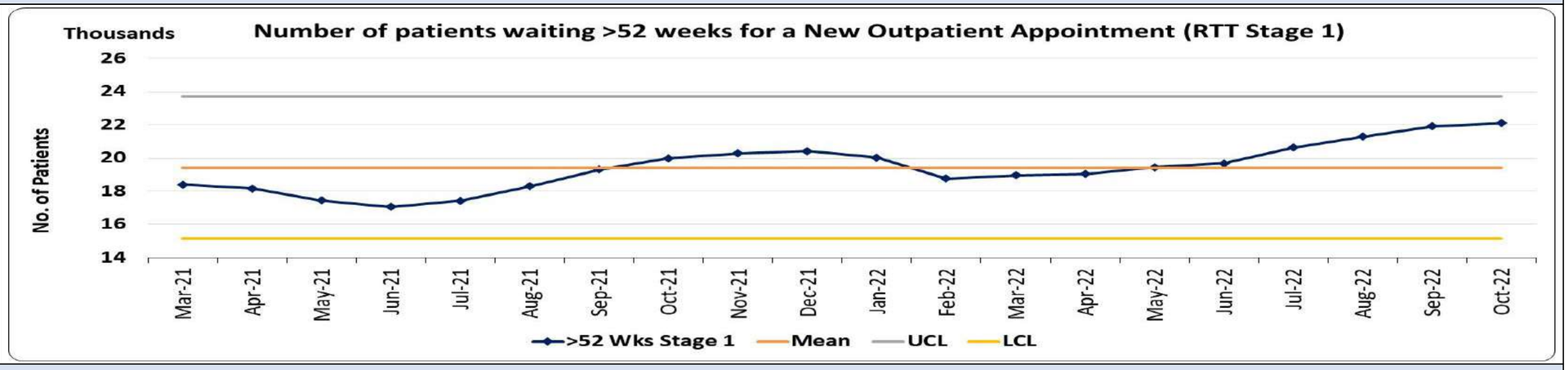
% of patients waiting less than **26 weeks (47.2%)** Target – Improvement Trajectory towards a national target of 95% by 2026



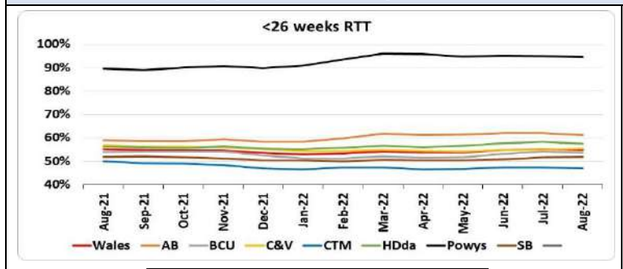
In terms of the 26 week position (including the provisional direct access Diagnostic & Therapy figures), performance for October across Cwm Taf Morgannwg is a provisional 47.2%.

Number of patients waiting **over 52** weeks for a **new outpatient appointment (22,108)** Target - Improvement Trajectory towards eliminating over 52 week waits by December 2022

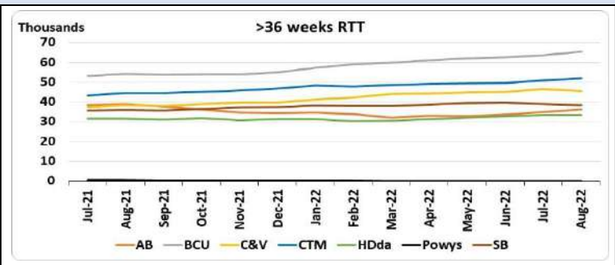
The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of October is 22,108, which as it currently stands is a rise of 0.9% (192) from the September reported position.



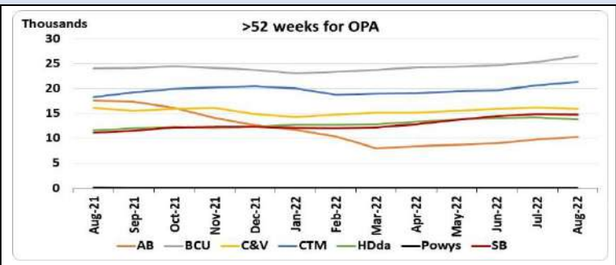
How do we compare with our peers?



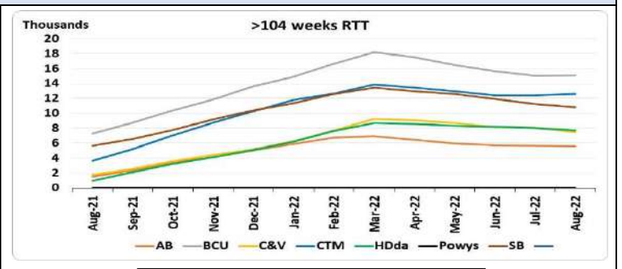
Status as at August 2022		
Health Board	**Compliance**	**Rank**
Powys	94.6%	1st
AB	61.3%	2nd
HDda	57.4%	3rd
C&V	55.4%	4th
BCU	53.6%	5th
SB	52.0%	6th
CTM	**47.0%**	**7th**



Status as at August 2022		
Health Board	**Compliance**	**Rank**
Powys	94	1st
HDda	33,475	2nd
AB	36,051	3rd
SB	38,576	4th
C&V	45,600	5th
CTM	**51,964**	**6th**
BCU	65,405	7th



Status as at August 2022		
Health Board	**Compliance**	**Rank**
Powys	0	1st
AB	10,242	2nd
HDda	13,822	3rd
SB	14,830	4th
C&V	15,962	5th
CTM	**21,291**	**6th**
BCU	26,515	7th



Status as at August 2022		
Health Board	**Compliance**	**Rank**
Powys	0	1st
AB	5,620	2nd
C&V	7,517	3rd
HDda	7,708	4th
SB	10,825	5th
CTM	**12,605**	**6th**
BCU	15,075	7th

RTT continued on the next page…

Cont'd…Referral to Treatment Times (RTT) – October 2022 (Provisional Position)

Specialty Breakdown – October 2022 (Provisional Position)

Total number of open pathways per specialty - October 2022 (provisional)

Specialty	<26 Weeks	26 Weeks Compliance	>26 to 36 Weeks	>36 to 52 Weeks	> 52 Weeks to 104 Weeks	>104 Weeks	Total Open Pathways
Anaesthetics	435	18.1%	125	216	579	1047	2402
Cardiology	3242	61.7%	610	637	457	309	5255
Care of the Elderly	15	93.8%	0	0	1	0	16
Dermatology	4216	46.8%	913	842	1533	1495	8999
Endocrinology	203	87.5%	12	17	0	0	232
Gastroenterology	1968	52.4%	347	501	730	208	3754
General Medicine	1938	70.4%	272	266	196	80	2752
Nephrology	141	78.3%	24	15	0	0	180
Respiratory Medicine	1390	69.0%	204	220	195	6	2015
Rheumatology	758	51.3%	118	138	283	180	1477
Sport and Exercise Medicine	8	88.9%	1	0	0	0	9
Thoracic Medicine	454	85.2%	60	18	1	0	533
Diagnostics	5793	52.7%	989	1210	2865	129	10986
Therapies	2223	76.2%	170	150	324	52	2919
ENT	4601	37.2%	1078	1594	3118	1963	12354
Ophthalmology	5743	37.9%	1428	1981	4224	1767	15143
Oral Surgery	1876	53.0%	336	404	587	335	3538
Orthodontics	201	59.8%	29	50	53	3	336
Restorative Dentistry	51	26.0%	17	27	68	33	196
Gynaecology	4245	55.2%	780	869	988	814	7696
Paediatric Neurology	5	100.0%	0	0	0	0	5
Paediatrics	2164	86.0%	239	62	50	0	2515
Haematology (Clinical)	124	98.4%	2	0	0	0	126
General Surgery	3869	38.9%	1058	1332	2532	1161	9952
Trauma & Orthopaedic	5601	38.2%	1541	1853	3931	1739	14665
Urology	3024	41.3%	669	862	1749	1019	7323
Colorectal	1946	50.5%	342	395	867	305	3855
Breast Surgery	634	48.3%	90	141	391	56	1312
Total	**56868**	**47.2%**	**11454**	**13800**	**25722**	**12701**	**120545**

How are we doing?

At the end of October 2022, the provisional position for the over 52 week waiting list saw volumes increase marginally by 0.53% on the previous month, bringing the total to 38,423. Compared to the position at the end of October 2021; the current position represents an increase of just over 14% in the number of patients waiting over 52 weeks.

The number of patients waiting over 52 weeks has been increasing incrementally with a significant urgent waiting list in many specialties. Weekly performance meetings are in place with specialties.

What actions are we taking & when is improvement anticipated?

- As described previously it is anticipated that the length of time that patients are waiting will reduce across all specialties by the end of December, with patients being seen for first outpatients within two years within all specialties other than ENT, Urology, Ophthalmology and Dermatology where plans are being put in place to increase capacity.
- Additional IPDC capacity will be in place between December 2022 – March 2023 through the insourcing of theatre staff enabling the centralisation of Orthopaedic inpatient activity and more concentrated DC capacity in PCH.
- A request for a regional approach to managing cataracts has been submitted to WG which between January and March would allow the Health Board to treat a minimum of 400 additional cases in the additional theatres in Cardiff.

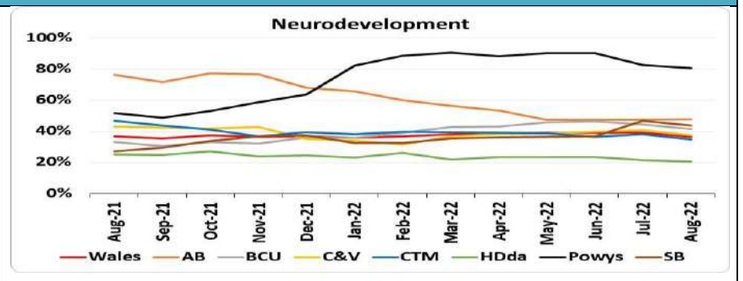
What are the main areas of risk?

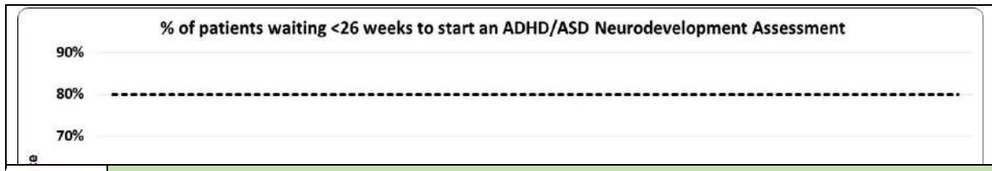
- Insufficient theatre staff to enable our theatres to run at full capacity. This is looking to be mitigated from November through insourcing with independent providers, but at increased costs if provided in house.
- Recruitment; delays in approval to recruit to existing posts within the structure that have become vacant and new posts. The Scrutiny Panel is adding further delays to an already protracted process.
- Staff fatigue / willingness to support additional capacity; additional activity reliant on staff support and less attractive to a number of staff groups following the previously enhanced rates ceasing.
- WPAS issue does not facilitate pooled waiting lists across the UHB increasing the administrative cost and the risk of duplicate entries and 'lost patients', which results in losses in productivity, over- reporting and potentially adverse outcome for our patients.

% of patients waiting less than 26 weeks to start an ADHD/ASD Neurodevelopment Assessment (30.7%) - Target 80%

The chart to the left highlights that there has been a significant deterioration in the compliance against the 26 week target for Neurodevelopment services with compliance remaining falling to 30.7% for September, well below the target threshold of 80%.

The total waiting list volume continues to grow and now stands at 1,631 patients, which as it currently stands is 62% higher than the equivalent period last year.





The additional Consultant post and uplift to the Pharmacy post that was supported through Planned Care funding for a fixed term has been made permanent but it is recognised that this does not increase capacity but sustains the current through-put. Additional funding has been made available to RPBs for Neuro-Development and a workshop is taking place with partners in education and social services as to how

Status as at August 2022		
Health Board	Compliance	Rank
Powys	80.8%	1st
AB	47.7%	2nd
SB	43.5%	3rd
BCU	41.2%	4th
C&V	37.3%	5th
CTM	**34.7%**	**6th**
HDda	20.3%	7th

Diagnostics & Therapies – October 2022 (Provisional Position)

Number of patients waiting >8 weeks for Diagnostics – Target Zero

Total >8 weeks 15,566

CTMUHB - Number of Patients waiting more than 8 Weeks for a Diagnostic Test		
Service		
Cardiology	Echo Cardiogram	424
Cardiology Services	Cardiac CT	98
	Cardiac MRI	9
	Diagnostic Angiography	87
	Stress Test	60
	DSE	55
	TOE	18
	Heart Rhythm Recording	187
	B.P. Monitoring	0
Bronchoscopy		5
Colonoscopy		755
Gastroscopy		830
Cystoscopy		485
Flexi Sig		1208
Radiology	Non-Cardiac CT	366
	Non Cardiac MRI	775
	NOUS	9728
	Non-Cardiac Nuclear Medicine	1
Imaging	Fluoroscopy	38
Physiological Measurement	Urodynamics	160
Neurophysiology	EMG	141
	NCS	136
Total		15566

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	6,338	10,282	10,508	10,429	10,561	10,338	10,631	11,052	11,747	12,776	12,759	12,890
2021/22	13,019	13,113	13,313	14,111	14,855	15,134	14,705	14,308	15,200	15,841	14,500	14,284
2022/23	15,437	15,579	15,363	15,080	15,315	15,570	15,566					

Number of patients waiting >14 weeks for Therapies – Target Zero

Total >14 weeks 1,652

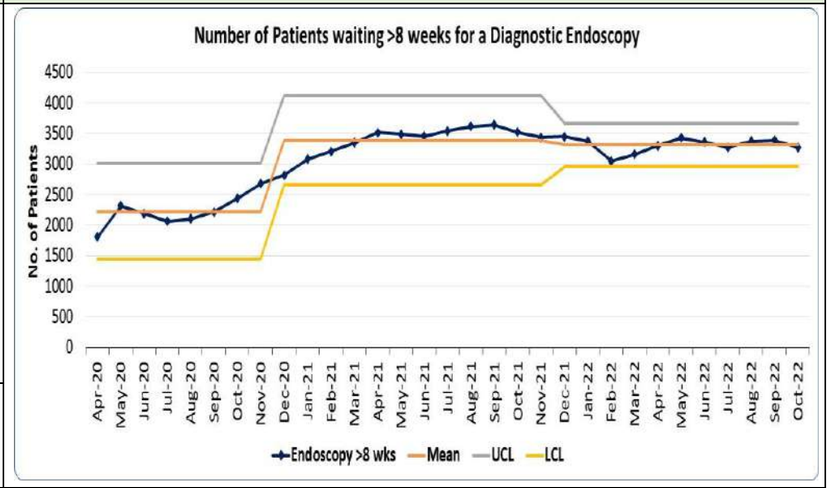
CTMUHB - Number of Patients waiting more than 14 Weeks for a Therapy	
Service	
Arts Therapy	1
Audiology	187
Dietetics	1384
Occupational Therapy	43
Physiotherapy	3
Podiatry	4
Speech & Language	30
Total	**1652**

Therapies	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	109	396	1,020	945	842	632	647	674	603	639	740	595
2021/22	388	336	267	268	363	416	570	663	691	873	918	969
2022/23	1,019	1,370	1,265	1,570	1,795	1,589	1,652					

Number of patients waiting >8 weeks for a Diagnostic Endoscopy

Target - Improvement Trajectory towards national target of Zero by March 2026

Total >8 weeks 3,283



How are we doing?

Diagnostics: Provisionally, at the end of October, 15,566 patients had been waiting in excess of 8 weeks for a diagnostic procedure, an almost static position compared to the previous month (15,570). Improvements are observed in Endoscopy with a 3% reduction in the number patients waiting in excess of eight weeks, however the number of patients currently breaching the target now stands at 3,283. The NOUS service continues to have the highest volume of breaching patients with 9,728 currently waiting over 8 weeks for a scan, an increase of 2.3% (215) from September.

Therapies: There are provisionally 1,652 patients breaching the 14 week target for therapies in October, an increase of 63 (4%) on the reported position for September. This increase can be attributed, in part, to the rise in the number of breaching patients for Audiology and Dietetics, which currently stands at 187 and 1,384 respectively.

The Dietetic service accounts for almost 84% of the total patients waiting beyond the 14 week target for therapies.

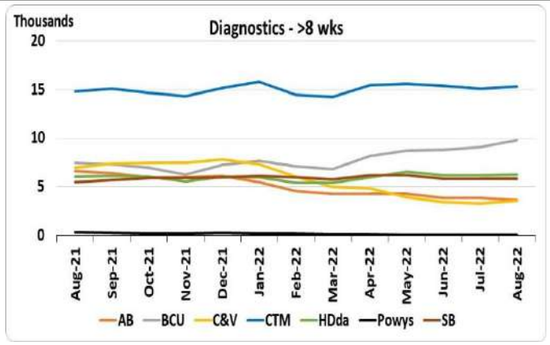
What actions are we taking & when is improvement anticipated?

- Established structured performance meetings with CT, MR & US Modality Teams in order to monitor performance and productivity and to agree remedial actions. Weekly tracker implemented to monitor performance.
- Validation of US, MR, CT waiting lists ongoing.
- Realigning patient bookings around clinical priority.
- Modality Action Plans and Business Cases being developed to support existing services and to create additional capacity.
- Work around staffing rosters to enable operation of the 2nd MR scanner at RGH.
- Additional staff funded for the additional Mammography machine in the new Breast Unit.
- Work ongoing in streamlining the Single Cancer Pathway.
- Additional patient lists are running to reduce waiting times.
- Demand and Capacity monitoring and forecasting of services commenced.
- Discussions held around potential additional capacity through insourcing/outsourcing.
- Funding agreed through Planned Care Recovery Board for in house NOUS solutions, insourcing/outsourcing request to be considered by Board once cases for MRI and CT are also complete.

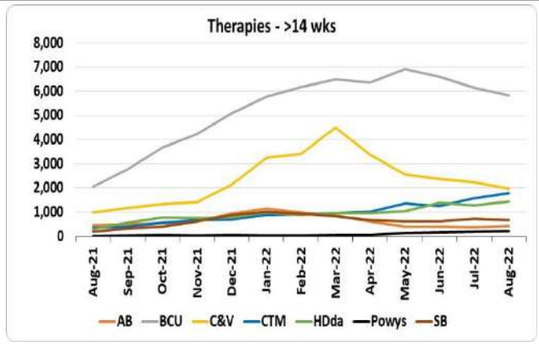
What are the main areas of risk?

- Current vacancies being held at scrutiny panel.
- Limited staff numbers coming through via the staff bank.
- Demand and Capacity imbalance.
- Securing funding for additional activity.
- Cardiopulmonary diagnostic services need additional staff to address the backlog.
- Current sickness and vacancies within the administration teams.
- Lack of Band 2 and Band 3, HCA support staff.
- Consultant vacancies and inability to recruit.
- Radiographer vacancies and inability to recruit.

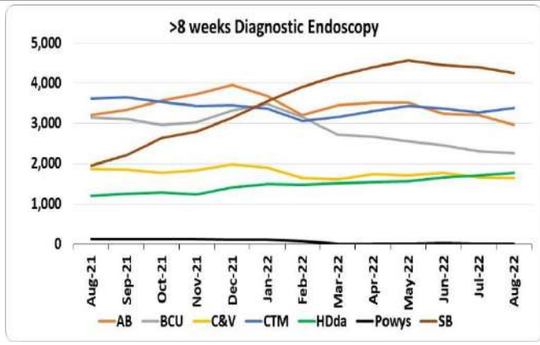
How do we compare with our peers?



Status as at August 2022		
Health Board	Compliance	Rank
Powys	71	1st
C&V	3,564	2nd
AB	3,641	3rd
SB	5,861	4th
HDda	6,261	5th
BCU	9,776	6th
CTM	**15,315**	**7th**



Status as at August 2022		
Health Board	Compliance	Rank
Powys	212	1st
AB	419	2nd
SB	682	3rd
HDda	1,449	4th
CTM	**1,795**	**5th**
C&V	1,962	6th
BCU	5,837	7th

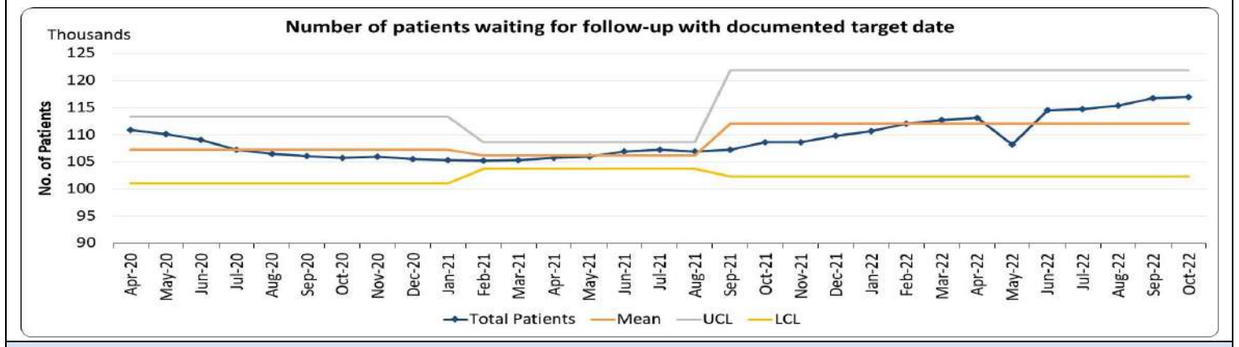


Status as at August 2022		
Health Board	Compliance	Rank
Powys	5	1st
C&V	1,645	2nd
HDda	1,768	3rd
BCU	2,260	4th
AB	2,967	5th
CTM	**3,382**	**6th**
SB	4,257	7th

Follow-up Outpatients Not Booked (FUNB) – October 2022 (Provisional Position)

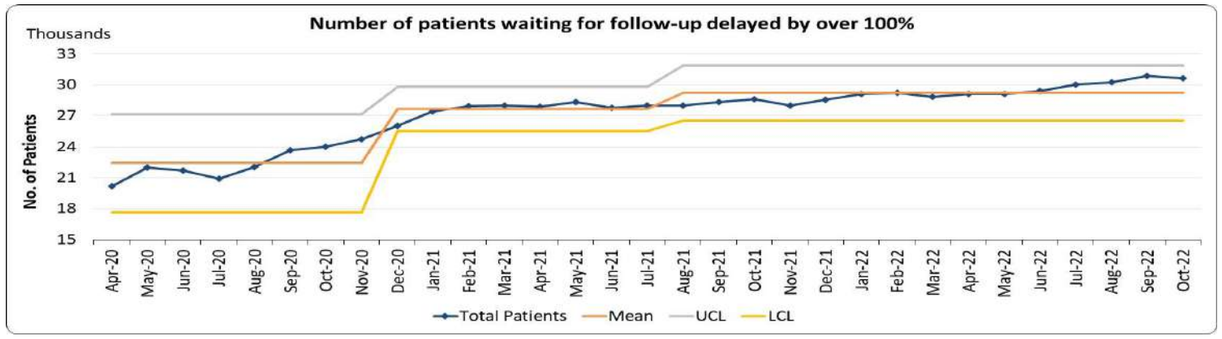
Number of patients waiting for a Follow-up with documented target date

No. of patients waiting for follow-up appointment			
No documented target date	Not Booked	Booked	Total
14	76,911	40,072	116,997

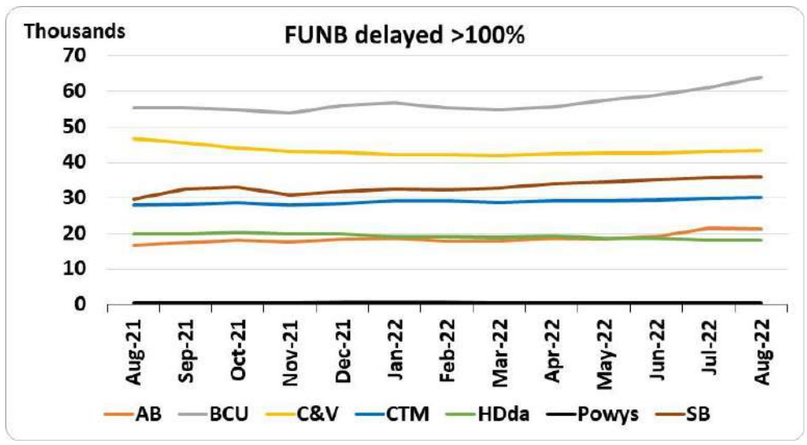


Number of patients waiting for a Follow-up delayed over 100% - Target – A reduction of 30% by March 2023 against a baseline of March 2021 (<=19606 by 2023)

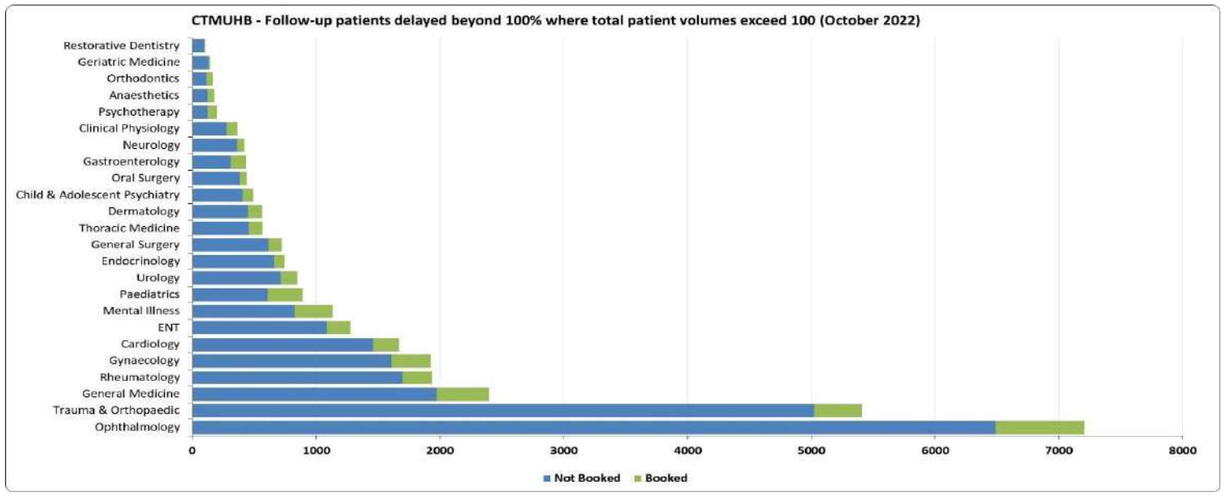
No. of patients delayed over 100% past their target date			
Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
26,315	4,348	30,663	26.2%



How do we compare with our peers?



Status as at August 2022		
Health Board	Compliance	Rank
Powys	541	1st
HDda	18,259	2nd
AB	21,306	3rd
CTM	**30,246**	**4th**
SB	36,037	5th
C&V	43,454	6th
BCU	64,002	7th



How are we doing?

The total number of patients waiting for a follow-up appointment in CTM as at the end of October provisionally stands at 116,997 and of those patients waiting, 30,663 have seen delays of over a 100% past their target date, representing an increase of 7% on the equivalent period last year.

The number of patients without a documented target date stands at 14.

What actions are we taking & when is improvement anticipated?

Clinical validation of follow ups not booked (FUNB) by CTM Consultants in Ophthalmology continues to be undertaken which demonstrates that a high number of patients do not require follow up and should have been recorded as discharged. These outcomes are still in the process of being updated on wPAS but should be completed by the end of October.

Targeted work on reducing the number of follow ups not booked across specialties has reduced the number of years that FUNBs are reported as waiting by five years. This work is continuing.

What are the main areas of risk?

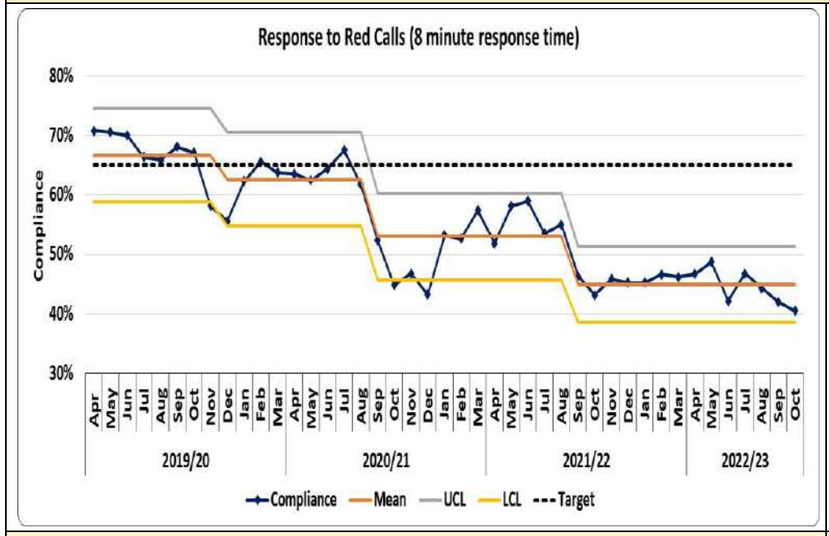
As at October 2022, there has been very little significant movement in terms of the overall number of patients waiting for a follow up, currently equating to 116,997 patients (76,911 not booked & 40,072 booked). Our most concerning area remains the 100% delayed patients; this is more evident in the Ophthalmology and T&O specialties across the health board with figures currently at 29,713 for those two specialties, of which around 42.5% (12,617) are delayed beyond 100% of their target date.

Outpatient activity levels continue to be below pre-Covid levels with the provisional October figures below for new and follow-up patients compared to prior the pandemic:

- Total New Patients seen: 16,731; which as it currently stands is around an 8% reduction on the Pre-Covid average (19/20) of 18,186, but is 5.5% higher than attendances during the same period last year.
- Total Follow-up Patients seen: 32,691; just over a 19% reduction on the Pre-Covid average (19/20) of 40,500, but is a rise of 3.7% on the equivalent period last year.

Emergency Ambulance Services – Response to Red Calls & Red Release Requests - October 2022

Response to Red Calls - % of emergency responses to Red Calls arriving within 8 minutes (Target 65%) October 2022 – 40.5%



WAST Operational Area Response to Red Calls within 8 minutes - Target 65% *(Please note that the data respresents WAST Operational area)*

	Merthyr			RCT			Bridgend			CTM		
Period	Total Responses	Responses within 8 mins	% within 8 mins	Total Responses	Responses within 8 mins	% within 8 mins	Total Responses	Responses within 8 mins	% within 8 mins	Total Responses	Responses within 8 mins	% within 8 mins
Oct-21	95	48	50.5%	355	145	40.8%	173	76	43.9%	623	269	43.2%
Nov-21	91	43	47.3%	342	157	45.9%	160	72	45.0%	593	272	45.9%
Dec-21	94	48	51.1%	327	149	45.6%	186	78	41.9%	607	275	45.3%
Jan-22	69	39	56.5%	277	124	44.8%	160	66	41.3%	506	229	45.3%
Feb-22	74	41	55.4%	242	110	45.5%	147	65	44.2%	463	216	46.7%
Mar-22	78	43	55.1%	319	139	43.6%	155	73	47.1%	552	255	46.2%
Apr-22	82	49	59.8%	267	118	44.2%	145	64	44.1%	494	231	46.8%
May-22	95	53	55.8%	287	140	48.8%	139	61	43.9%	521	254	48.8%
Jun-22	80	35	43.8%	299	124	41.5%	169	72	42.6%	548	231	42.2%
Jul-22	106	43	40.6%	314	152	48.4%	172	82	47.7%	592	277	46.8%
Aug-22	83	41	49.4%	248	108	43.5%	136	58	42.6%	467	207	44.3%
Sep-22	97	52	53.6%	281	109	38.8%	150	61	40.7%	528	222	42.0%
Oct-22	121	59	48.8%	345	128	37.1%	191	79	41.4%	657	266	40.5%

Immediate Vehicle Release Requests

	PCH			RGH			POW		
Period	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance
Jan-22	12	10	83.3%	11	9	81.8%	12	1	8.3%
Feb-22	17	13	76.5%	8	3	37.5%	18	2	11.1%
Mar-22	12	5	41.7%	13	10	76.9%	11	2	18.2%
Apr-22	12	7	58.3%	11	4	36.4%	10	3	30.0%
May-22	15	13	86.7%	11	5	45.5%	12	5	41.7%
Jun-22	14	11	78.6%	15	10	66.7%	25	8	32.0%
Jul-22	20	13	65.0%	10	9	90.0%	31	7	22.6%
Aug-22	23	7	30.4%	24	15	62.5%	47	4	8.5%
Sep-22	24	13	54.2%	33	14	42.4%	47	2	4.3%
Oct-22	19	7	36.8%	8	4	50.0%	24	1	4.2%

How are we doing?

Response to Red Calls: Response times during October to life-threatening calls, fell further to its lowest level of 40.5% and remaining well below the compliance threshold of 65%. As can be seen in the chart above, there has been no significant change since September of last year with the performance trend demonstrating natural variation with average response times for CTMUHB for the past 12 months equating to 45.0%.

The Welsh average for October saw under half (48.0%) of emergency responses arriving at the scene within 8 minutes. Likewise this is the lowest compliance observed and has remained below target since August 2020.

There was a 24% increase in the volume of Red Calls during October (657) compared to the previous month, as shown in the top right table. Volumes remain higher than pre-Covid levels (currently 89% higher) which averaged 347 per month, with the average pre-Covid response times just under the compliance threshold at 64.7%.

Immediate Release Requests (shown above) received when a WAST crew, which is currently with a patient at hospital, needs to be released to respond to an urgent call, provisionally totaled 51 during October. The ED services were able to support affirmatively only 12 (23.5%) of those requests.

What actions are we taking & when is improvement anticipated?

Red Calls – Red Release Standard Operating Procedure approved 10th October 2022 via Emergency Department Task & Finish Group with review period set up at 6 weeks.

The operational procedure approved by stakeholders will ensure that there is a consistent approach for the response to an immediate release request in all Emergency Departments across CTM. This includes ring fencing arrangements (1 x Resuscitation space and 1 x Majors space) to be in place at all times.

What are the main areas of risk?

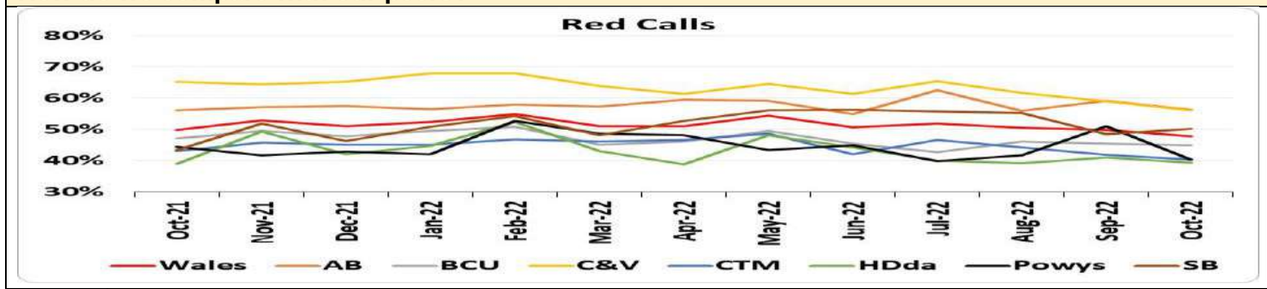
System flow and lack of in-patient capacity across sites remains as the major risk in responding to red release requests. Furthermore, the acuity of ambulatory patients presenting in ED often requires a provision of trolley in the ED waiting areas.

Ring fencing offload capacity to ensure immediate release is a challenge as due to the acuity of patients self presenting in an ambulent way (as a marker, 50% of the total admissions to ITU from ED originally walk in to the departments, whilst 48% of ambulance arrivals end up being discharged from ED).

The ring fencing arrangements (1x Resuscitation space and 1 x Majors space) are subject to a review of improved flow on each acute site against the rapid improvement actions detailed below, and should this be achieved with the intended impact we would seek to remove one of the ring-fenced areas:

1. Implementation of discharge lounges on all 3 acute sites by 4th November
2. Implementation of clear and consistent pre-emptive transfer and boarding processes and SOP across all 3 sites by 4th November
3. Visit to EDs by all adult inpatient band 7s and band 6 deputies to visualise and understand current ED pressures and risks, and facilitate the sharing of risk across the hospital.

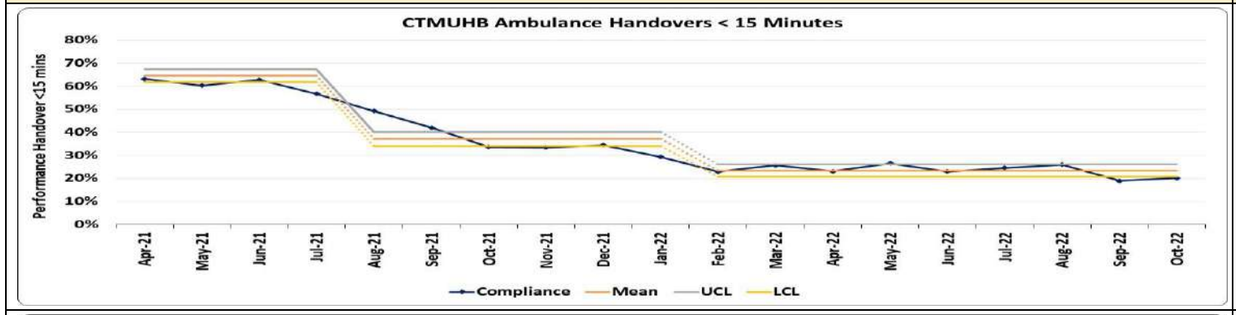
How do we compare with our peers?

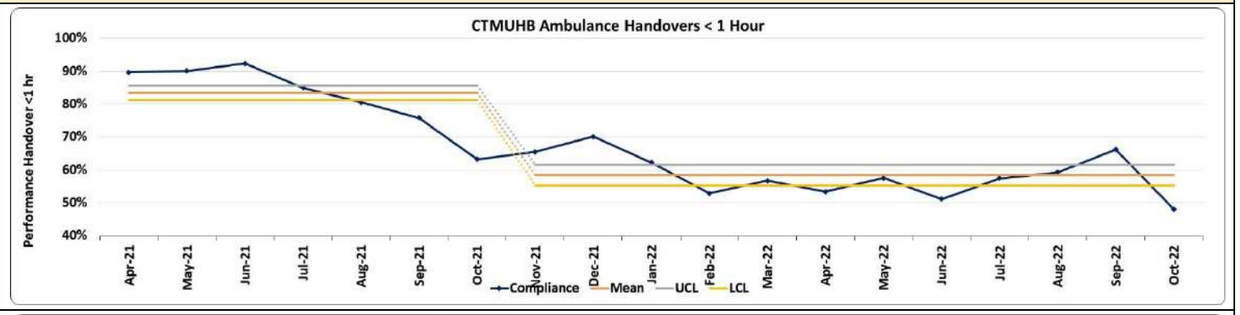


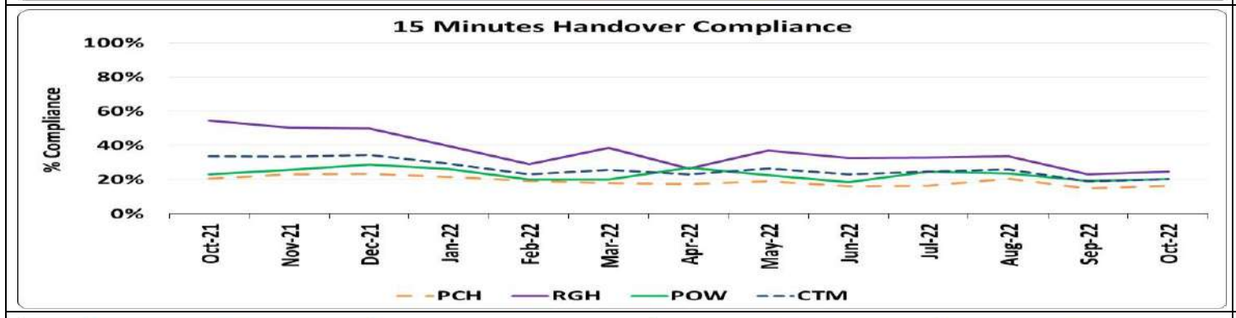
Status as at October 2022		
Health Board	**Compliance**	**Rank**
AB	56.4%	1st
C&V	56.2%	2nd
SB	50.3%	3rd
BCU	45.0%	4th
CTM	**40.5%**	**5th**
Powys	40.5%	5th
HDda	39.4%	7th

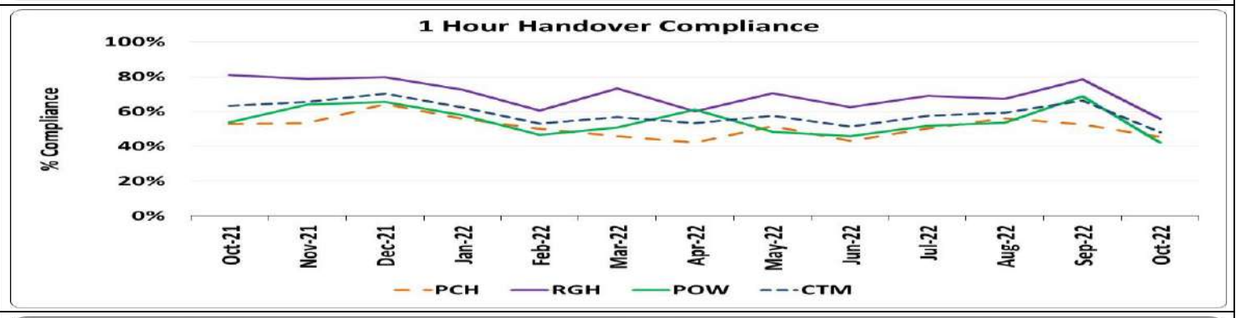
Emergency Ambulance Services - Handover Compliance – October 2022

Number of ambulance handovers within 15 minutes – Target Improvement	Number of ambulance handovers over 1 hour – Target Zero
Total handovers 2,398 of which 484 handovers were within 15 minutes (20.2%)	**1,245 handovers were over 1 hour (48.1% of handovers were within 1 hour)**

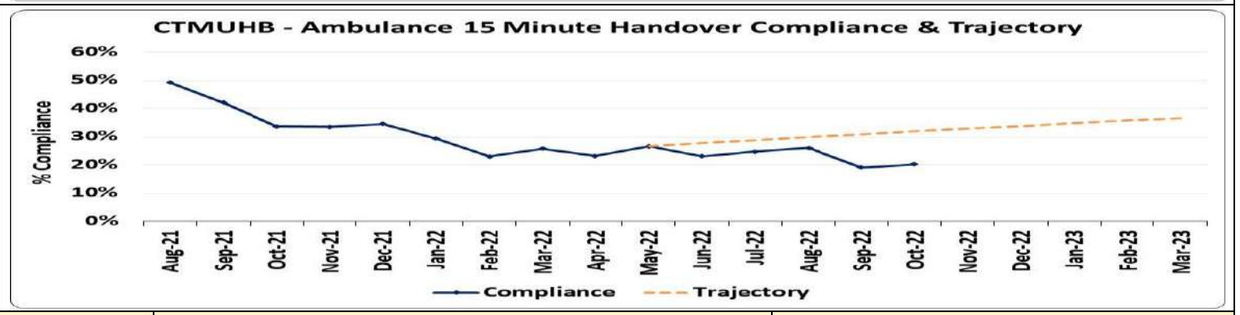


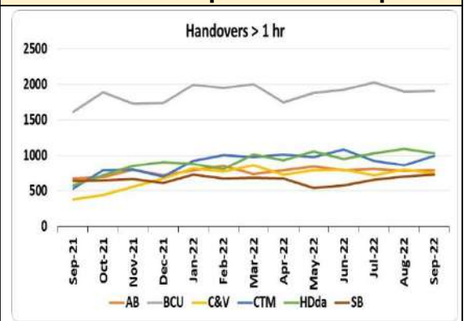






Period	PCH Handovers	PCH 15 Mins %	PCH 1 Hour %	RGH Handovers	RGH 15 Mins %	RGH 1 Hour %	POW Handovers	POW 15 Mins %	POW 1 Hour %	CTM Handovers	CTM 15 Mins %	CTM 1 Hour %
Oct-21	794	20.5%	52.8%	781	54.7%	80.9%	571	23.1%	53.8%	2146	33.6%	63.3%
Nov-21	806	23.1%	53.3%	810	50.5%	78.8%	697	25.7%	64.0%	2313	33.5%	65.5%
Dec-21	841	23.3%	64.2%	853	49.9%	79.6%	663	28.7%	65.5%	2357	34.5%	70.1%
Jan-22	855	21.5%	55.8%	875	39.5%	72.3%	714	26.2%	57.7%	2444	29.3%	62.3%
Feb-22	780	19.2%	50.1%	776	29.0%	60.6%	590	20.0%	46.6%	2146	23.0%	52.9%
Mar-22	840	18.0%	45.8%	787	38.5%	73.2%	635	20.0%	50.7%	2262	25.7%	56.7%
Apr-22	836	17.3%	42.1%	770	26.5%	60.0%	571	27.0%	60.9%	2177	23.1%	53.4%
May-22	841	19.0%	51.5%	840	37.1%	70.5%	639	22.5%	48.4%	2320	26.6%	57.5%
Jun-22	777	16.2%	43.1%	845	32.5%	62.4%	593	18.4%	45.7%	2215	23.0%	51.2%
Jul-22	796	16.3%	50.4%	790	32.9%	68.9%	596	24.7%	51.7%	2182	24.6%	57.4%
Aug-22	808	20.5%	56.1%	748	33.7%	67.1%	568	23.6%	53.5%	2124	26.0%	59.3%
Sep-22	761	14.8%	52.4%	756	23.1%	78.3%	590	19.2%	68.6%	2107	19.0%	66.3%
Oct-22	988	16.3%	45.3%	821	24.7%	55.7%	589	20.4%	42.1%	2398	20.2%	48.1%

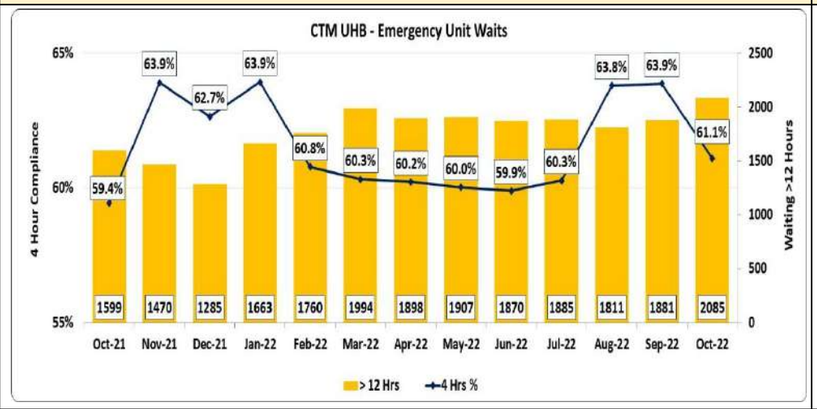


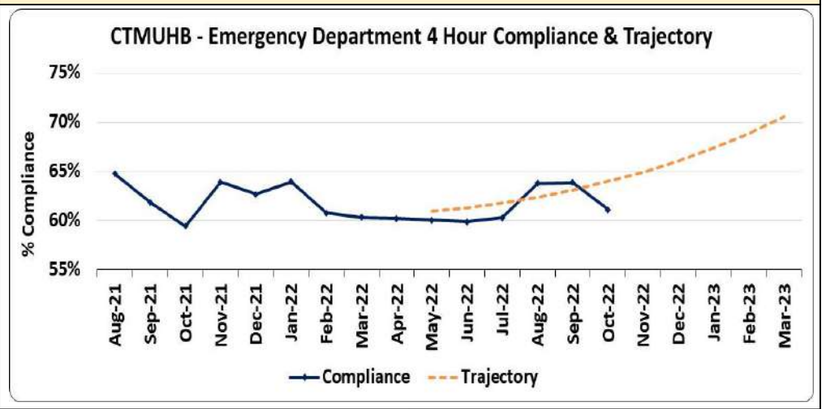
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?	How do we compare with our peers
During October the 15 minute handover compliance rose by just 1.2 points on the previous month to 20.2%, whilst the compliance of handovers within 1 hour fell to its lowest level of 48.1% from 66.3% in September. The number of Ambulance conveyances increased by c. 14% on the previous month, bringing the total to 2,398. The volume is around 12% higher than the volume seen in the comparable period of 2021.	We have launched the flow recording system One List App, which identifies all the patients in a hospital bed who are medically fit for discharge. This will be enhanced by the implementation of eWhiteboards to enable efficient flow management and support appropriate discharge process across CTM. The implementation is expected on 5th December across all 3 sites in CTM. Pre-emptive boarding SOP to be reviewed at ELG on 7th November. Preliminary ring-fencing of beds for patients presenting with stroke and respiratory difficulties (NIV) was implemented at the end of October and the capacity for ring-fenced beds is being monitored daily during site calls. Implementation of CTM cross site-call SOP – with associated site meeting scripts have been drafted and awaiting official launch on 5th December with the aim of improving standard principals across CTM wth renewed focus on quality and safety of care for our patients. Escalation plan policy and associated action cards have been formulated and awaiting official launch on 5th Dec., this will enable unscheduled care group to have an oversight and appropriately monitor pressures across the system.	The levels of acuity of patients walking into ED departments remains high. Recent data shows, of the total patients admitted to ICU, 50% were not conveyed by ambulance. The data analysis also shows that 48% of patients conveyed by WAST were discharged from ED the same day. System flow remains highly impacted by capacity within social care. Implementation of Navgation Hub (admission avoidance element) is in progress, but the launch of service has been delayed, which has a direct impact on redirection of WAST conveyances to other services in community.	 **Status as at September 2022** Health Board / Compliance / Rank SB 732 1st C&V 745 2nd AB 789 3rd **CTM 995 4th** HDda 1,028 5th BCU 1,905 7th

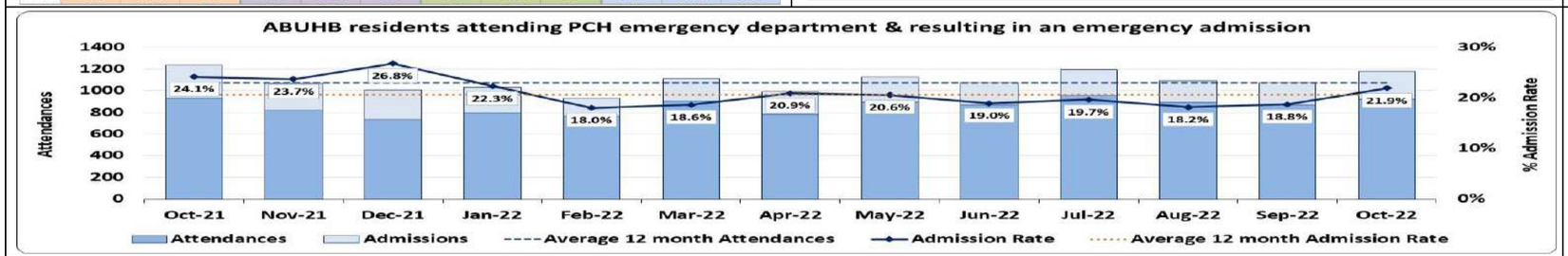
Emergency Unit Waits – October 2022 (Provisional Position)

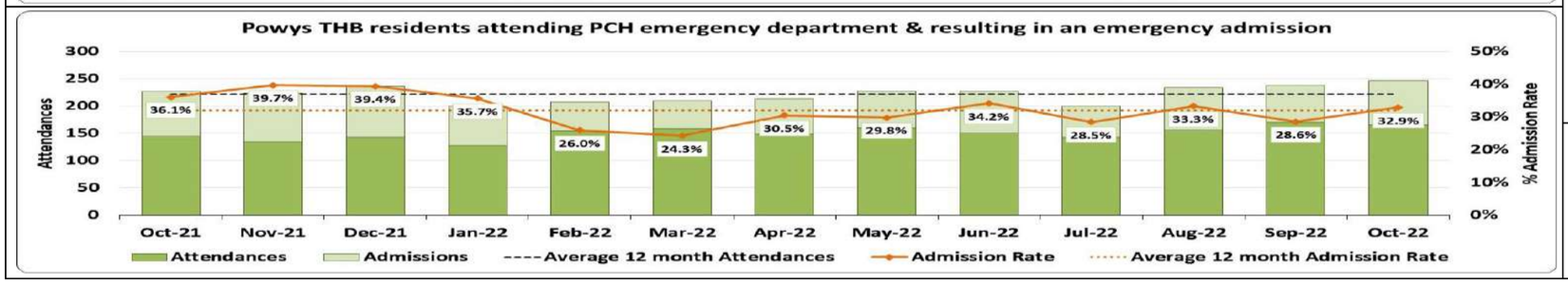
Number of Attendances	% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge - Target 95%	Number of patients who spend 12 hours or more in emergency care facilities from arrival to admission, transfer or discharge - Target Zero
15,846	**61.1% were seen within 4 hours (Waiting >4 hrs 6,164)**	**13.2% of patients were waiting over 12 hours (2,085)**

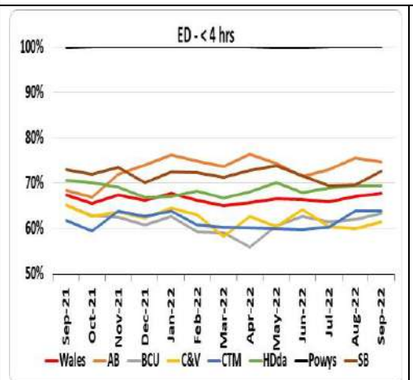
Period	PCH Attends	PCH 4 Hrs %	PCH > 12 Hrs	RGH Attends	RGH 4 Hrs %	RGH > 12 Hrs	POW Attends	POW 4 Hrs %	POW > 12 Hrs	CTM Attends	CTM 4 Hrs %	CTM > 12 Hrs
Oct-21	5129	52.0%	640	5075	69.6%	325	4900	54.7%	634	15353	59.4%	1599
Nov-21	4739	53.2%	603	4703	74.7%	325	4485	61.2%	542	14258	63.9%	1470
Dec-21	4485	55.3%	541	4564	72.1%	310	4211	58.5%	434	13464	62.7%	1285
Jan-22	4503	55.7%	753	4608	73.9%	403	4242	58.1%	507	13788	63.9%	1663
Feb-22	4351	55.3%	753	4362	69.1%	429	3997	53.5%	578	13135	60.8%	1760
Mar-22	5259	50.4%	964	5104	69.3%	417	4798	57.4%	613	15672	60.3%	1994
Apr-22	4750	57.1%	824	4681	68.0%	534	4452	51.7%	540	14298	60.2%	1898
May-22	5119	57.5%	767	4972	68.1%	491	4947	51.2%	649	15455	60.0%	1907
Jun-22	4942	57.6%	722	5013	66.9%	564	4752	51.1%	584	15162	59.9%	1870
Jul-22	5285	53.7%	872	4991	68.9%	429	4915	55.5%	584	15580	60.3%	1885
Aug-22	5016	59.0%	817	4881	69.2%	422	4660	60.7%	572	14891	63.8%	1811
Sep-22	4801	59.2%	767	4798	70.1%	546	4683	59.4%	568	14649	63.9%	1881
Oct-22	5340	53.4%	839	5166	65.8%	607	4911	61.2%	639	15846	61.1%	2085

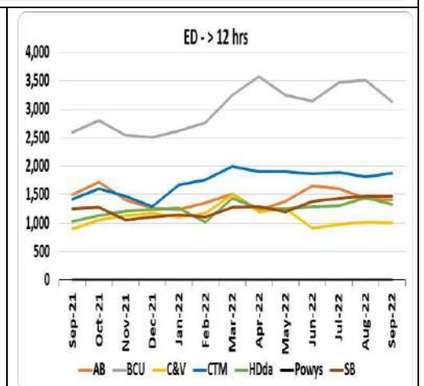










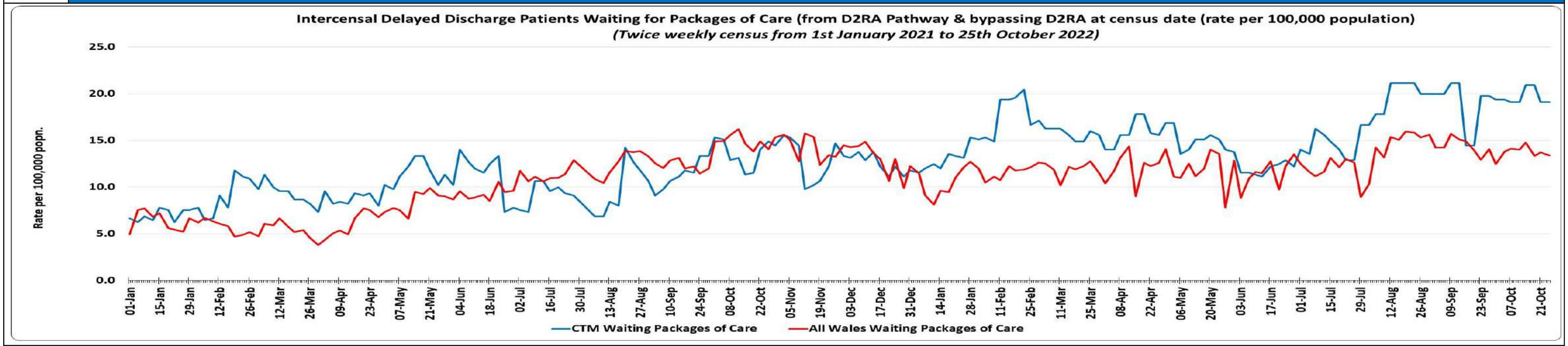


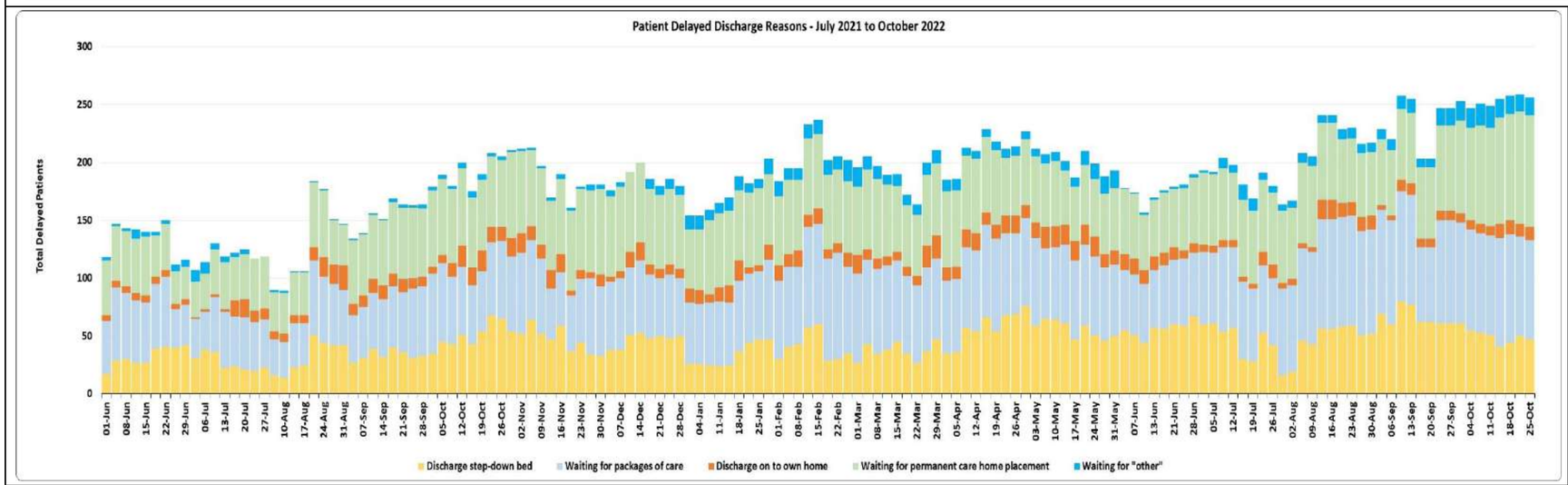
Status as at September 2022		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
AB	74.8%	2nd
SB	72.7%	3rd
HDda	69.5%	4th
CTM	**63.9%**	**5th**
BCU	63.3%	6th
C&V	61.5%	7th

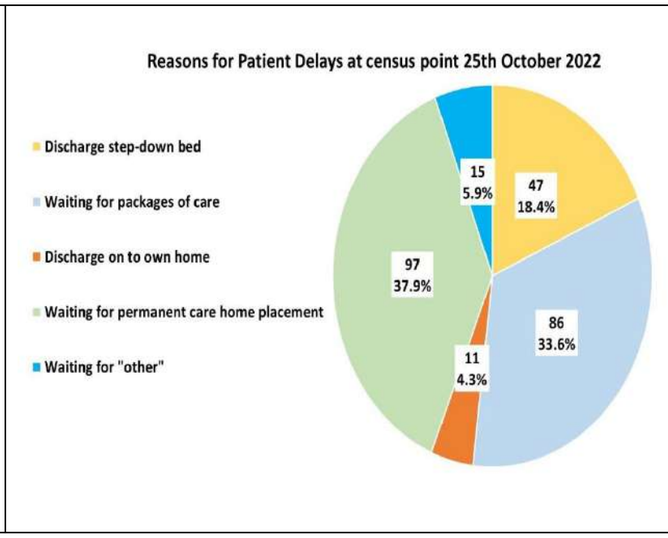
Status as at September 2022		
Health Board	**Compliance**	**Rank**
Powys	0	1st
C&V	1,004	2nd
HDda	1,331	3rd
AB	1,413	4th
SB	1,475	5th
CTM	**1,881**	**6th**
BCU	3,126	7th

How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival, fell slightly from the previous month to 61.1%. As per the table above, the UHB continues to experience challenges at PCH, with compliance at around 53.4% for the four hour waiting times measure. Improvement was observed this month at POW at 61.2%, whilst RGH fell to 65.8% All three acute sites saw a rise in the number of patients waiting in excess of twelve hours within the UHB's Emergency Departments, with a combined 11% increase from September, bringing the total for CTM to 2,085 patient breaches compared to the WG minimum standard of zero.	CTM Escalation Plans including Full Capacity Protocol, Escalation Cards and Pre-emptive Boarding under review to formulate a standardised approach across CTM UHB – planned launch on 5th December Data Sharing Agreement with Local Authorities is in progress to enable effective data input and information transfer across patient pathways (One List/eWhiteboards and e-Transfer of Care) D2RA pathways and delivery model has been redesigned at the national level and all associated policies, pathways and data collection processes within CTM have been amended to address the change and prevent delays with implementation. Implementation of MIU in YCC from 7th November with operational provision from Monday to Friday 8.30 am to 6.30 pm. Implementation of discharge lounges across 3 DGHs in progress to enable more effective discharge processes and improve flow across each site. Anticipated launch in November.	• Significant risk in social care capacity and funding • D2RA Pathway 1 (new) will have resource gaps to meet demand – need to identify funding resources • Insufficient therapy resources within CTM to drive effective D2RA pathway 2 (new) in community beds (mitigation is resource allocation) • Supported Discharge Team resource insufficient – (mitigation is resource allocation) • Seasonal demand plus exceptional Covid-19 and influenza demand, exacerbated by the challenges in social care may result in significant inefficiencies to care delivery, flow and consequently detriment to patient care, safe staffing levels and staff morale. • Discharge lounge in PCH – lack of physical space, ongoing work with Estates to mitigate the issue

Monitoring Patient Discharge & Flow to 25th October 2022





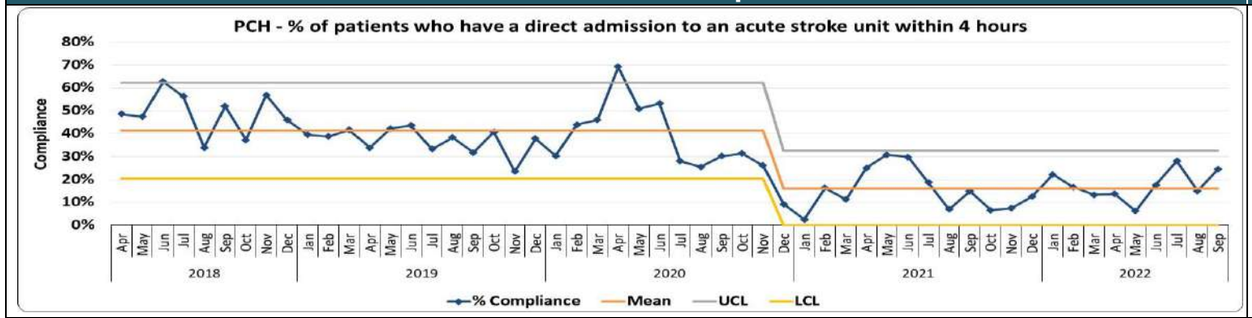


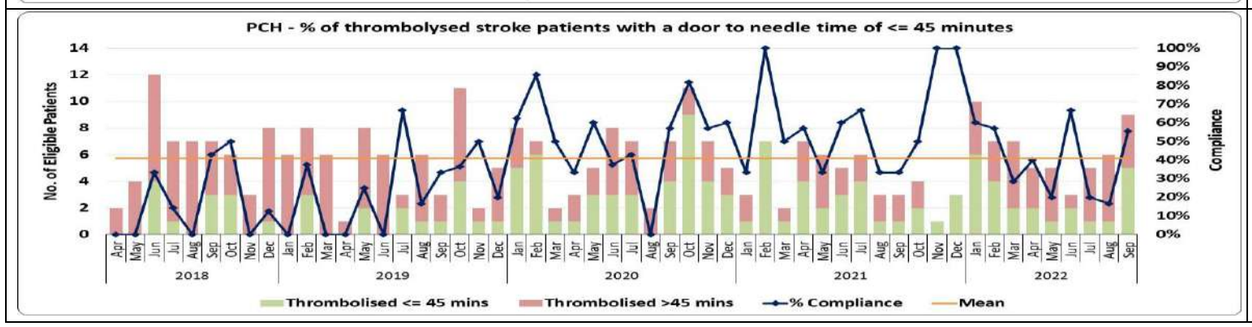
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk
The top chart indicates that the current volume of patients whose transfer of care is delayed due to waiting for packages of care (on both the D2RA and bypassing pathways) is at a similar high level to that seen during February this year {86 individuals}. This equates to approximately 19.1 delays per 100,000 population, and as it currently stands is just over 42% higher than the national rate which is 13.4 per 100,000 population (please note that the all Wales data may be subject to change due to late data submissions by other health boards). The bottom charts show the total number of patients currently awaiting their next stage of care, presently there are 256 individuals in this predicament. The reasons for patients experiencing a delay in the transfer of their care are detailed in the chart bottom right. As shown the greatest proportion are awaiting care home placement, followed by the wait for a package of care.	We continue progressing implementation of D2RA pathways working closely with Local Authority colleagues. Data metrics and reporting across sites has been agreed and signed off by health and social care, which is currently tested via One List App (almost fully operationalised across all 3 sites). Furthermore, digital enablers such as installation of eWhiteboards across unscheduled care inpatients areas in POW and further implementation of phase 2 eWhiteboards system specification (all-CTM) will enable ward staff to have an oversight and ability to plan daily activities, monitor delays concerning patient journey (Red 2 Green implementation) and support ongoing referral based on patients' needs (electronic Transfer of Care). Both digital solutions will be implemented and operationalised on 5th December. The set-up of Navigation Hub service (backdoor element) on 5th December, will function as central point of discharge, referrals coordinated and managed by CTM staff in partnership with social care colleagues to ensure ongoing provision of appropriate care and support in community. 1000 Beds and Partnership plans to provide additional capacity in community (D2RA bridging beds)	Provision for individuals who are elderly and have mental illnesses remains limited in the independent sector and is impacting on our discharges. Our Care Home placements continue to be problematic due to Covid-19 restrictions across the patch. High-level risk remain and are associated with resource capacity and recruitment – lack of or limited funding and difficulties to recruit specific health professionals groups: pharmacy, therapy, and medical staff. To mitigate, teams are reviewing alternative ways of workforce modelling, this is being supported by Workforce colleagues and addressed in Integrated Workforce Sub-group. Staffing risk – Navigation Hub (backdoor element) difficulty in acquiring provision of administrational staff provision (utilising existing resources) to support referral management process. Mitigation - reviewing re-deployment register, but current options are limited, funding request submitted via Winter Schemes – awaiting update. Location risk – Navigation Hub (backdoor element) – reviewing various options across CTM to secure an office space for up to 8 staff allowing to provide space for newly establish team to coordinate and manage e-ToC referrals.

Stroke Quality Improvement Measures (QIMs) – September 2022

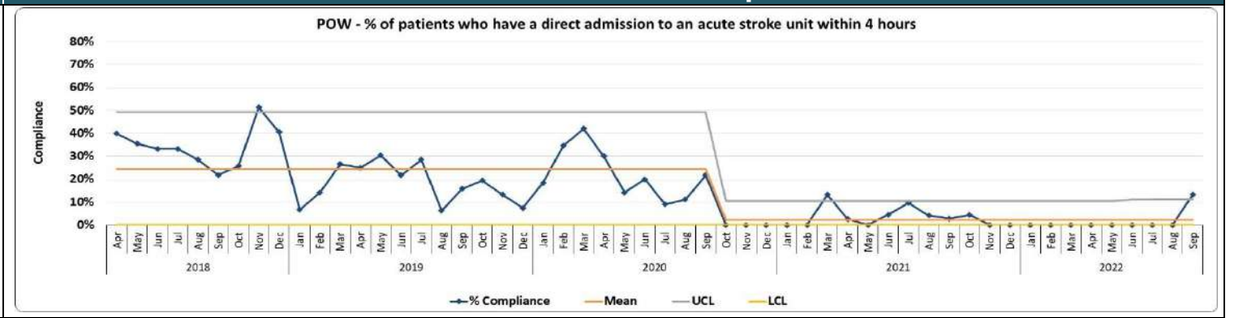
% compliance with direct admission to an acute stroke unit within 4 hours			% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes			% compliance of patients diagnosed with stroke received a CT scan within 1 hour			% compliance assessed by a stroke consultant within 24 hours		
PCH	**POW**	**CTM**	**PCH**	**POW**	**CTM**	**PCH**	**POW**	**CTM**	**PCH**	**POW**	**CTM**
24.5%	**13.3%**	**21.9%**	**55.6%**	**0%**	**45.5%**	**54.9%**	**66.7%**	**57.6%**	**64.7%**	**33.3%**	**57.6%**

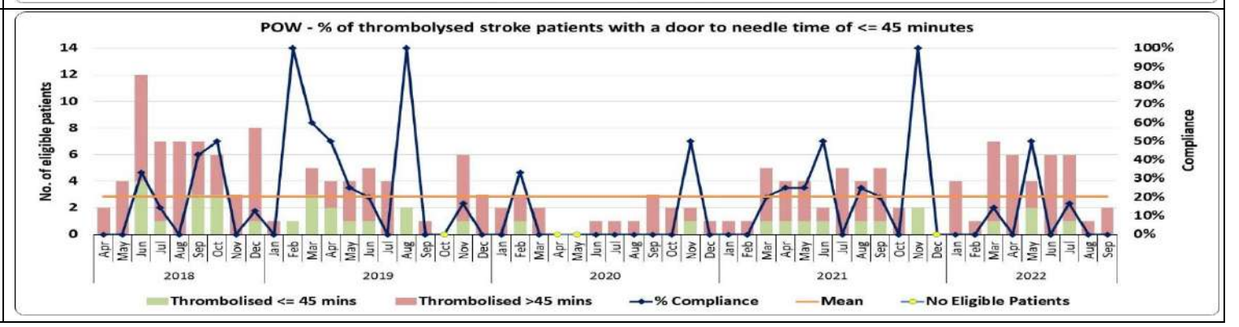
Prince Charles Hospital

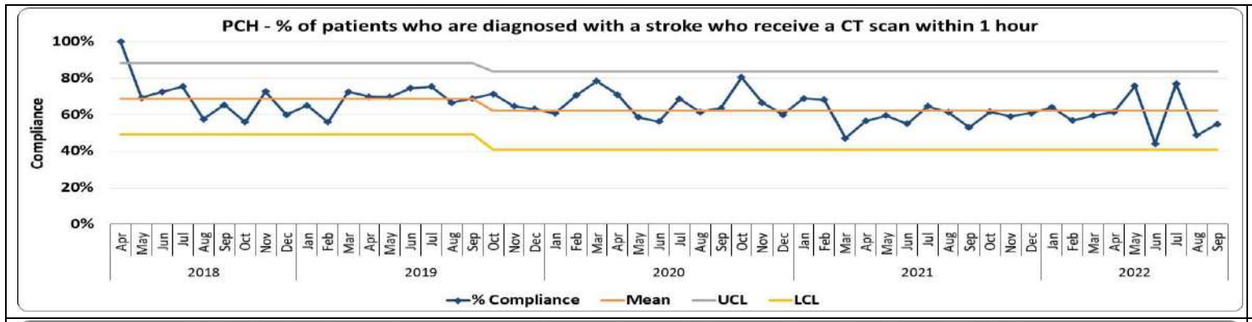


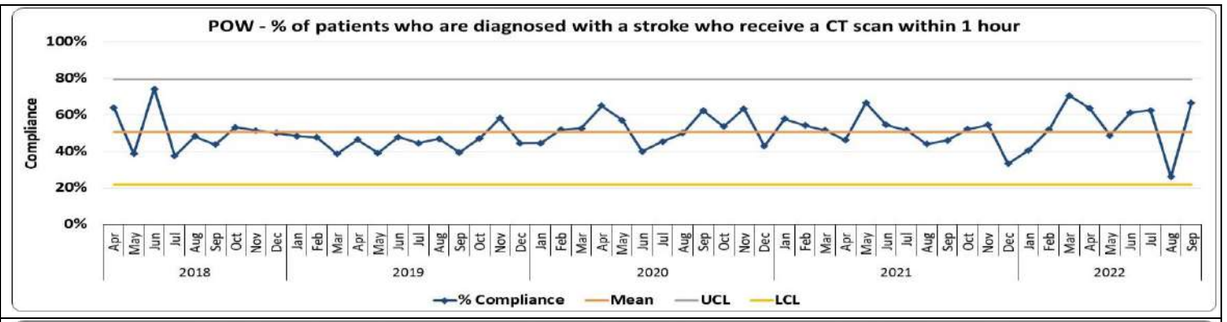


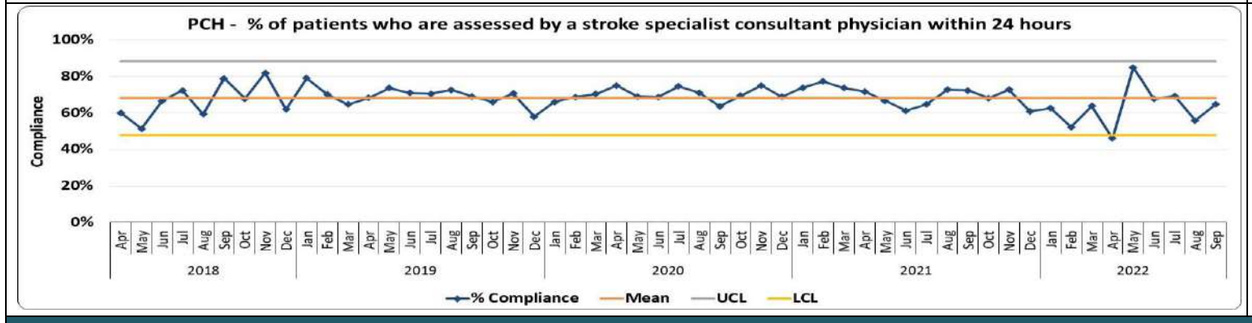
Princess of Wales Hospital

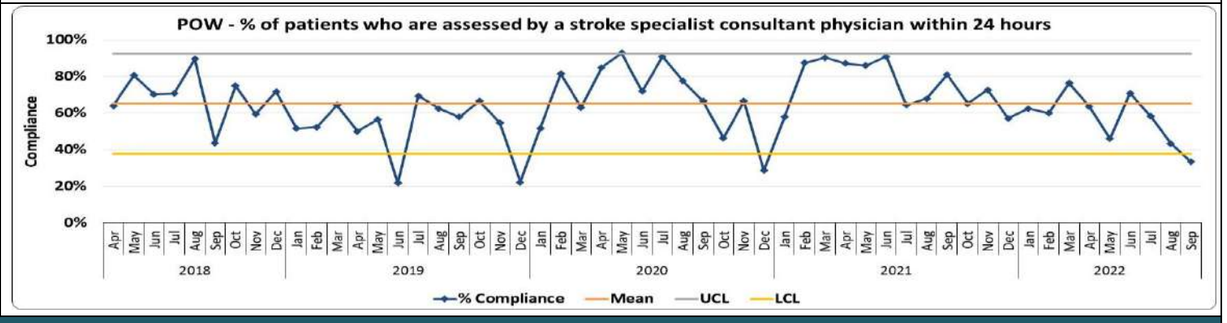












Stroke QIMS continued on the next page…

Cont'd…Stroke Quality Improvement Measures (QIMs) – September 2022

How are we doing?

Across all four metrics, stroke performance continues to remain at low levels of compliance. During September 21.9% (14 out of 64 admissions) of stroke patients were admitted directly to an acute stroke unit within 4 hours. Only 5 of the 11 eligible patients were thrombolysed within 45 minutes (45.5%) and 57.6% of patients (38 out of 66 diagnosed patients) had a CT scan within an hour. There were also 38 out of the 66 stroke patients (57.6%) seen by a specialist stroke physician within 24 hours of arrival at the hospital.

Key factors contributing to poor performance against stroke care standards include:

- 5-day/week service model for medical and therapy provision.
- Lack of access to an Early Supported Discharge team and adequate bedded rehabilitation beds impact on length of stay and flow of stroke patients through the Princess of Wales hospital
- Demand for acute beds and the absence of ring-fenced stroke beds impact on the ability to admit to the stroke wards within 4 hours across the whole hospital site.

September 2022 stats:

Stroke QIMs - September 2022		PCH	POW	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	49	15	64
	No. of patients within 4 hours	12	2	14
	% Compliance	**24.5%**	**13.3%**	**21.9%**
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	9	2	11
	No of patients within 45 mins	5	0	5
	% Compliance	**55.6%**	**0.0%**	**45.5%**
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	51	15	66
	No. of patients within 1 hour	28	10	38
	% Compliance	**54.9%**	**66.7%**	**57.6%**
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	51	15	66
	No. of patients within 24	33	5	38
	% Compliance	**64.7%**	**33.3%**	**57.6%**

What actions are we taking & when is improvement anticipated?

The CTM Stroke Strategy Group has agreed an integrated action plan with a number of short, medium and long term actions, some of which have resource implications. Progress is being made in a number of areas:

- Recruitment process underway as part of CTM Consultant Recruitment Drive. The CSG are working with medical staffing agencies to aid the recruitment of a Locum Consultant following the resignation of Consultant Stroke Physician at Prince Charles Hospital. Development of a CTM stroke consultant rota, with joint working between PCH and POW consultants to enable a more stable rota. Continued dialogue with Cardiff and Vale UHB to look at long term solutions, feeding into the South Wales Central Regional Programme Board.
- Regional developments with Cardiff and Vale UHB continue to progress, with second meeting of the South Central Regional Programme Board taken place on 25th October and joint CTM/C&V UHB Stakeholder Event on 26th October. Continued engagement with NHS Collaborative over timelines for national programme.
- Stroke Pathway Task and Finish Group meetings continue to take place at fortnightly intervals. Review of priorities and risks undertaken within the Task & Finish meetings, nominated leads identified and priority actions are being progressed at pace. Work underway to review demand/capacity and therapies workforce gaps, exploring potential improvements to data streams and review of pathways for TIA across CTM.
- Action taken forward from Stroke and Bed Management Task and Finish Groups to re-start ring fencing stroke capacity on a daily basis. Daily plan to create a ring fenced bed for stroke in PCH and POW to be confirmed through daily flow calls. Confirmation of stroke demand on all three sites (PCH, RGH and POW) also to be communicated through daily flow calls. Stroke patients needing transfer from RGH to PCH to be prioritised, however if there is significant pressure in PCH then POW can be explored as an option. Communications poster will be circulated soon.
- Continued implementation of VBHC stroke prevention programme: optimal management and targeted case finding of atrial fibrillation and hypertension in primary care. GP with Special Interest recruited and other key posts underway.
- FAST programme being rolled out nationally and analysis underway to understand delayed seeking of help within Merthyr locality. Plan to be developed once reasons better understood.

What are the main areas of risk?

The intended impact of the short-term actions, along with the long-term aims, is to improve the quality, safety and experience of care for patients, their families and our workforce. CTM will develop a strategy for progressing towards a SSNAP rating of 'A'.

The main risks to this are the wider patient flow problems experienced in ED and throughout the hospital, which make it difficult to ring fence stroke beds, particularly affecting the 4 hour target. This is part of the wider unscheduled care improvement programme and the wider performance management of the system (see actions alongside) .

In POW, the ongoing staffing challenges within the therapy services are effecting the ability to update the information on SSNAP in a timely manner which will affect the accuracy of the therapy performance measures.

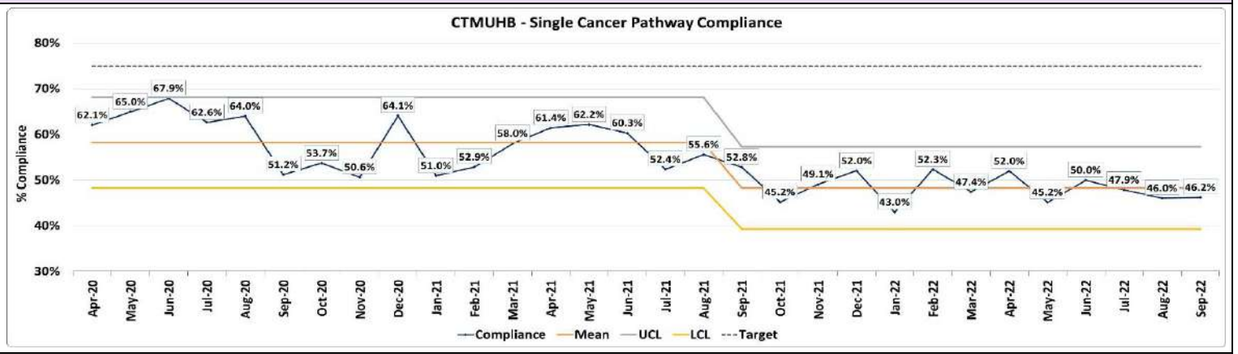
The inability to access ESD and a specialist bedded rehab unit for POW patients impact on outcomes, length of stay, and flow. Expanding these services to support all localities across CTM requires additional or re-allocation of resource.

Single Cancer Pathway (SCP) – September 2022

% of patients starting first definitive cancer treatment within 62 days from point of suspicion Target 75%
Compliance 46.2%

CTMUHB - SCP % Treated Without Suspensions - September 2022				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated in Target Without Suspensions
Head and neck	3	9	12	25.0%
Upper GI	15	11	26	57.7%
Lower GI	13	18	31	41.9%
Lung	18	12	30	60.0%
Skin (exc BCC)	32	8	40	80.0%
Breast	24	21	45	53.3%
Gynaecological	4	11	15	26.7%
Urological	12	48	60	20.0%
Haematological	5	8	13	38.5%
Other	3	4	7	42.9%
Total	**129**	**150**	**279**	**46.2%**

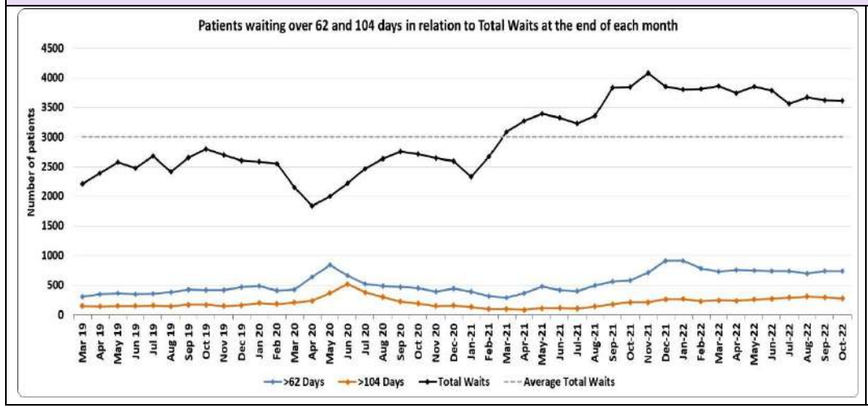
Single Cancer Pathway compliance trend



Performance for September remained almost static at 46.2% attainment, with predicted compliance for October currently at 46.3%. With the exception of Skin, no other tumour sites have achieved the current SCP target. Delays at first outpatient (39.5%) and diagnostic stage (41%) continue to be the biggest concern and significant factor for not achieving target.

Total volumes have reduced by 9% over the last month as have backlog volumes (7.5%). Backlog clearance is the primary focus.

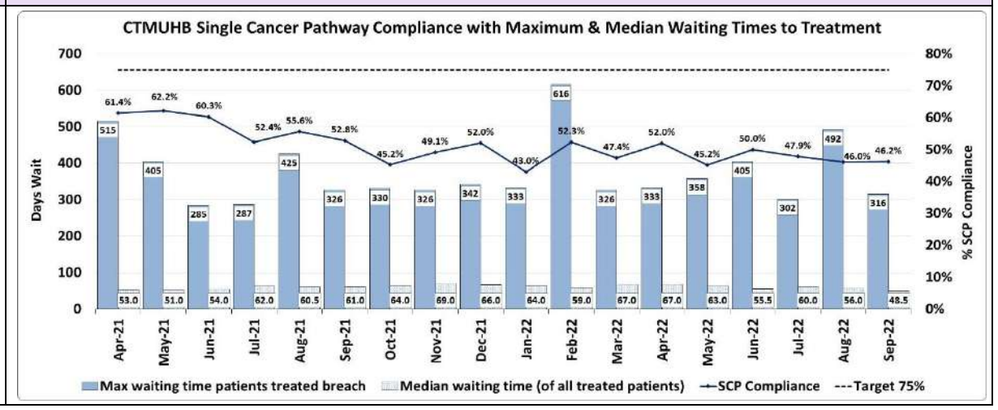
Patients currently waiting on a Cancer Pathway and of those patients the number waiting more than 62 days as at 1st November 2022



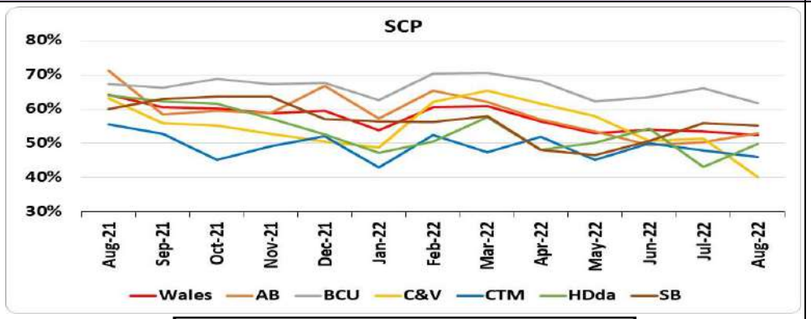
CTMUHB	SCP Cases 62-90 days	SCP Cases 91-104 days	SCP Cases >104 days
Head and neck	17	5	11
Upper GI	49	13	30
Lower GI	115	37	79
Lung	17	0	3
Sarcoma	0	0	2
Skin (exc BCC)	32	8	11
Brain/CNS	0	1	1
Breast	23	6	1
Gynaecological	50	16	24
Urological	78	25	98
Haematological	7	2	6
Other	2	0	1
Grand Total	390	113	267

As at the 1st November 2022, the number of patients waiting over 62 days stands at 770 and around a third of those patients (267) are waiting over 104 days.

SCP Compliance detailing Maximum & Median Waiting Times to Treatment



How are we doing & how do we compare with our peers?



Status as at August 2022		
Health Board	**Compliance**	**Rank**
BCU	61.7%	1st
SB	55.1%	2nd
AB	53.0%	3rd
HDda	49.8%	4th
CTM	**46.0%**	**5th**
C&V	40.1%	6th

What actions are we taking & when is improvement anticipated?

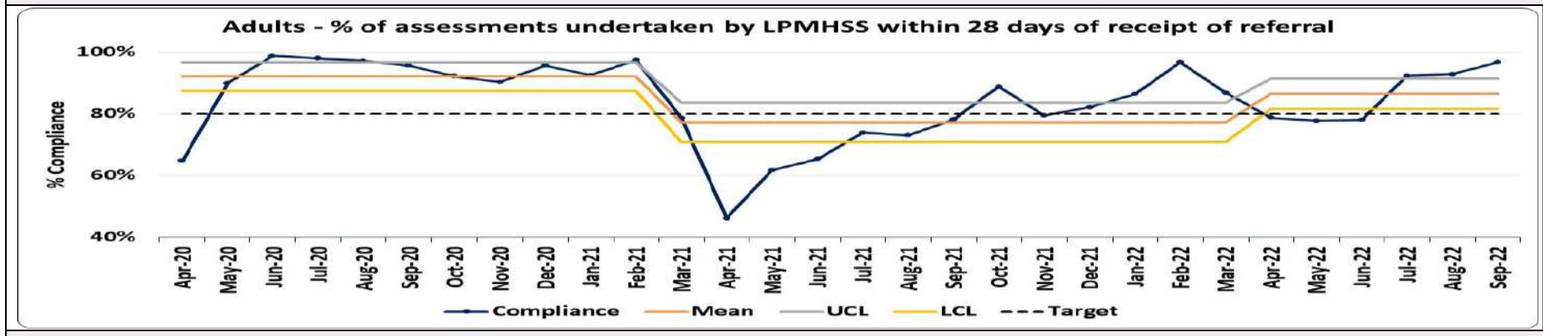
- Breast recovery plans continue, with noted improvements in relation to total volumes.
- Breast unit launch is now planned for January 2023.
- Development and agreed implementation of Lower GI pathway
- Super Saturday clinics undertaken to clear backlog at 1st Outpatient stage
- Focus specifically on reducing backlog.
- Outsourcing of LAPB procedures (Local Anaesthetic Perineal Biopsy) agreed with start from October to Dec 2022
- Merging of Urology MDT's and streamlining of processes / pathways
- Additional OP and surgical lists in skin continue with anticipated full backlog clearance by Dec 2022.

What are the main areas of risk?

- Performance challenges for Lower and Upper GI, Gynaecology, Head & Neck and Urology. These tumour sites account for a significant proportion of our cancer activity and as such, non-compliance significantly affects our overall position.
- 80.5% of all patients on the active SCP are at 1st outpatient or diagnostic stage
- Resources required to effectively plan and implement the Wrapper / Canisc replacement programme.
- Downgrading practices.
- Delays in pathology, endoscopy and radiology continue.
- Delays in tertiary investigations & treatments at SB, Velindre Cancer Centre and C&V.
- Delays in Pathology turnaround times for routine specimens. Incidental findings of malignancies in samples sent that have taken almost 1 year to process.
- Increased demand via BSW due to age range being lowered for screening.

CTM Adult Mental Health Services – September 2022

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (96.8%) - Target 80%



Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target of 80% of referrals to be assessed within 28 days. The adult mental health services compliance for September further improved to 96.8% and is the highest compliance attained since February this year. The number of referrals increased by 72% on the previous month bringing the total referrals received during September to 962. Pre-Covid levels were in the region of 1,000 to 1,100 with the average referrals thus far for 2022/23, averaging 830 per month.

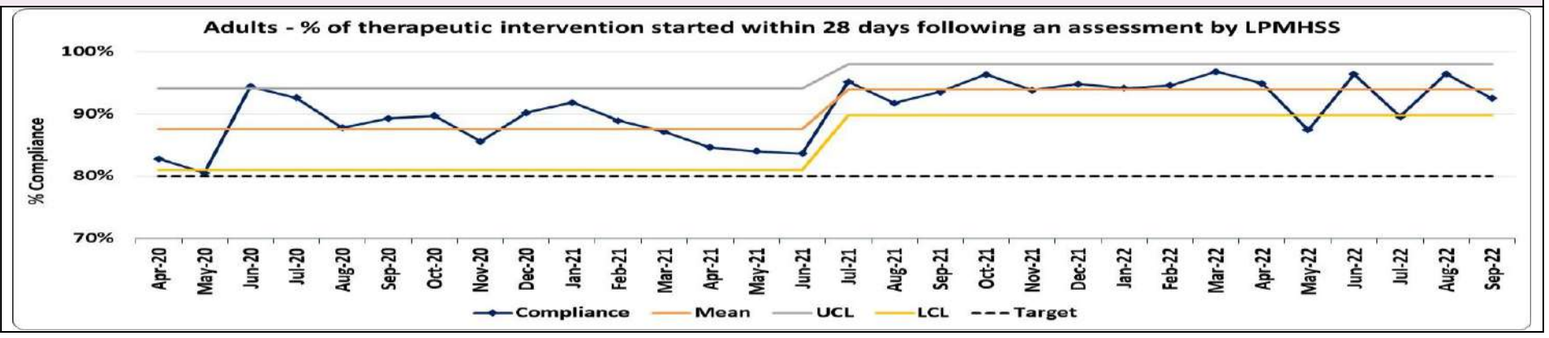
As a result of a Quality Improvement project, changes have been made to the delivery of our local primary mental health support services (LPMHSS). These changes will be rolled out gradually throughout the university health board and as a consequence our data collection parameters may be shifting for this period.

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (92.5%) - Target 80%

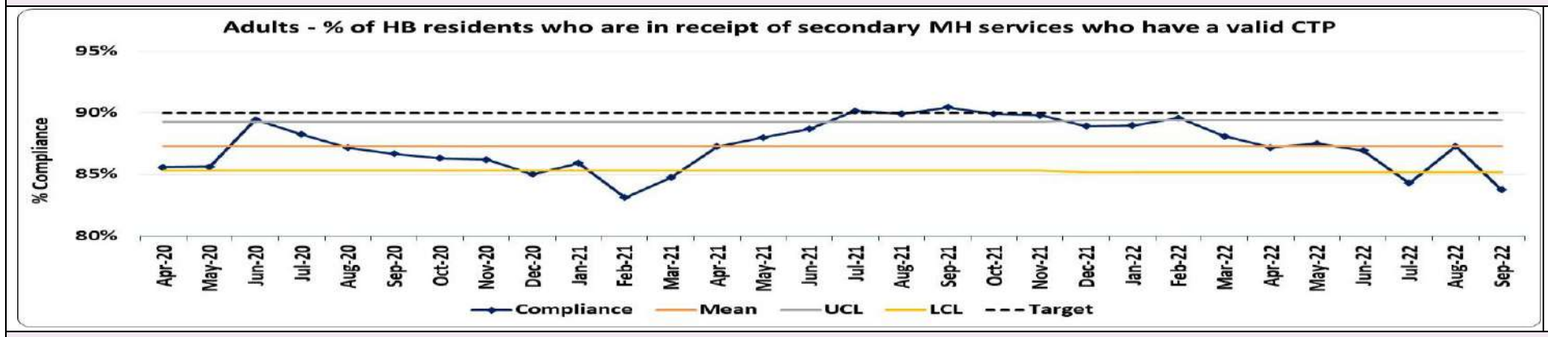
Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS dipped slightly to 92.5% from 96.4% in the previous month, with the target being achieved consistently for over two years.

The total number of adult interventions during the month were 333, a similar amount to the pre-Covid average. The total adult interventions commencing within 28 days during September amounted to 308 patients.

As assessments have increased in month, to mitigate the risk of the demand for interventions rising a pre-emptive waiting list initiative has been commenced to increase capacity.



% of HB residents who are in receipt of secondary MH services who have a valid CTP (83.7%) - Target 90%



Part Two of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month fell to 83.7% during September and is at the lowest level observed since February 2021.

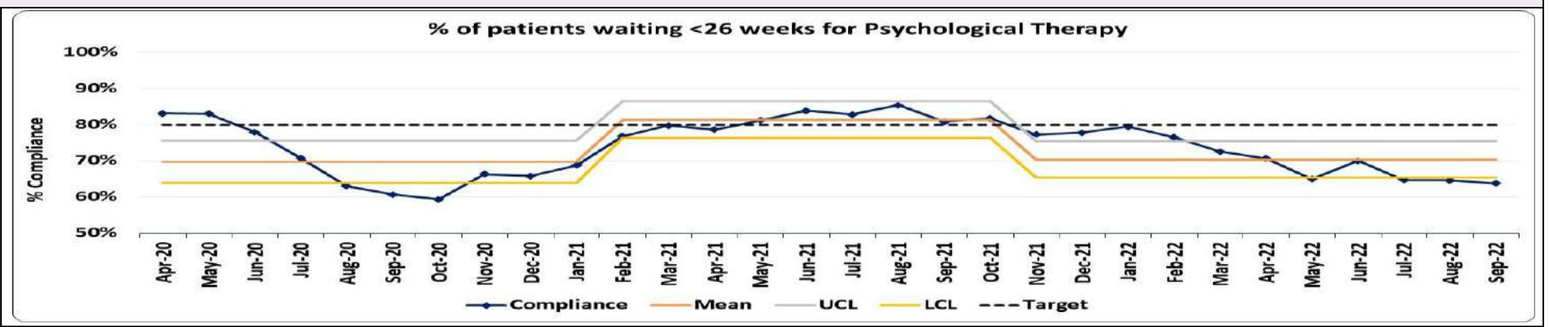
As seen in the chart to the left, compliance has remained just under the target threshold since April 2020, with the exception July and September 2021.

Part 3: There were no outcome of assessment reports sent during September.

% of patients waiting less than 26 weeks to start a Psychological Therapy (63.7%) - Target 80%

During September Psychological Therapies compliance fell to 63.7% of patients waiting less than 26 weeks to start a therapy and continuing to remain below the 80% compliance threshold.

The total number of patients waiting to start a psychological therapy, as at the end of September, equates to 852, which represents an increase of around 39% on the number of patients that were waiting at the end of September 2021 (611). Two waiting list initiatives have been approved (1) to outsource intervention for 80 service users and (2) to recruit two Assistant Psychologists to implement and evaluate a number of tests of change designed to improve waiting list data, ensure 'waiting well' and improve the utilisation of existing capacity.

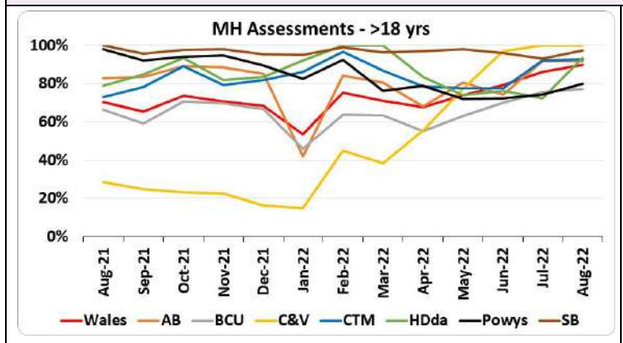


Adult Mental Health Services continued on the next page…

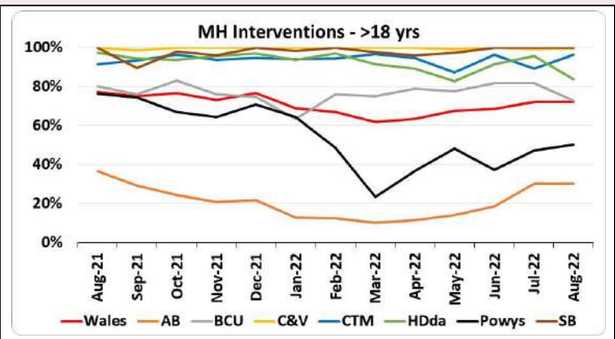
Cont'd…Adult Mental Health Services

How are we doing and what actions are we taking?	When is improvement anticipated and what are the main areas of risk?
Part 1a: compliance has slightly improved on the previous month from 92.8% to 96.8%. All areas of the Health Board are above target. **Part 1b:** compliance continues to stay above target at 92.5%. All areas are above target. **Part 2:** Compliance for both Adult and Older Adult Services combined has reduced to 83.9% from 85.9% and is below the target threshold of 90% • Adult Services reduced from 85.5% to 82.3% • Older Adult Services improved from 87.3% to 89%. Analysis is on-going on Non-Compliant CTPs to identify and prioritise work to reducing risk and providing assurances. **Psychological Therapies:** The waiting time standard is; at least 80% of the people who are waiting for an intervention should be waiting for less than 26 weeks. In September, only 63.73% are waiting for less than 26 weeks. Particular areas of challenge include the CMHT in the Rhondda Taff Ely area where 20.15% of those waiting have waited for less than 26 weeks, the CMHT in the Merthyr and Cynon area where 44% of those waiting have waited for less than 26 weeks. Challenges also remain in the LPMHSS in the Rhondda Taff Ely area, where 46.74% of those waiting have waited for less than 26 weeks.	**Part 1a:** compliance continues to be above the target of 80%. Increased demand during the winter months and the possibility of reduced capacity due to staff absence poses a risk to fluctuations in performance. Systems are in place to regularly monitor performance. **Part 1b:** compliance continues to remain above target. **Part 2:** In response to the targeted work being carried out on non-compliant CTPs an anticipated increase to above target compliance (90%) is expected in Quarter 4 2022/23. There is also on-going work with Local Authority partners to ensure non-compliant social worker lead CTPs are also prioritised based on reducing risk. The main risk to these improvements will be a reduction in staffing capacity caused by increased sickness and turnover. **Psychological Therapies:** CMHT Mental Health Service Improvement funding has been approved for a waiting list initiative to procure an external provider to deliver care for 80 of the 129 service users on a waiting list. This will enable core services to prioritise the remaining 49 service users on that waiting list. The improvement involves an initial cohort of patients commencing therapy in February 2023 and for all 80 service users to have commenced therapy by April 2023. Progress against plan reports into the fortnightly MH&LD Planned Care Recovery Board. Discussions with other Health Boards and procurement indicate that external providers with the capacity exist, however this remains a risk until a suitable provider has been identified and the contract has been awarded. An action plan is being developed to address the shortfall in staff due to retirement / staff having found other positions. LPMHSS: A waiting list initiative has been approved to fund 2 x Band 5 Assistant Psychologists to deliver tests of change it will (1) Introduce a 'first contact' and 6 month contact calls to ensuring 'waiting well' and improve waiting list data and (2) trial single session pre-therapy workshops to clarify goals of therapy, along with arrangements for those who do not wish to attend workshops and evaluate impact on length of treatment and improved outcomes. This scheme reports into the fortnightly MH&LD Planned Care Recovery Board and recruitment is on track to have staff in post by April 2023. The impact of increased demand and the current number of vacancies on potential increases in waiting times on a waiting list has been assessed and a plan has been agreed to deliver additional groups to mitigate against this risk.

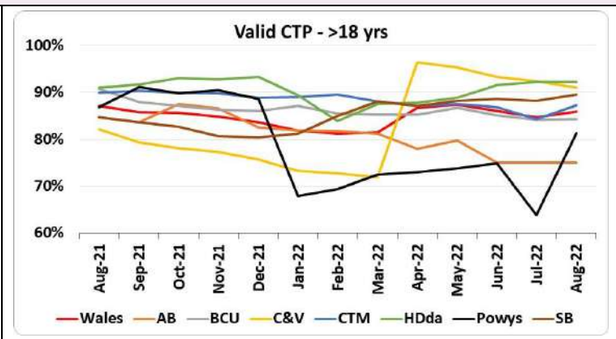
How do we compare with our peers?



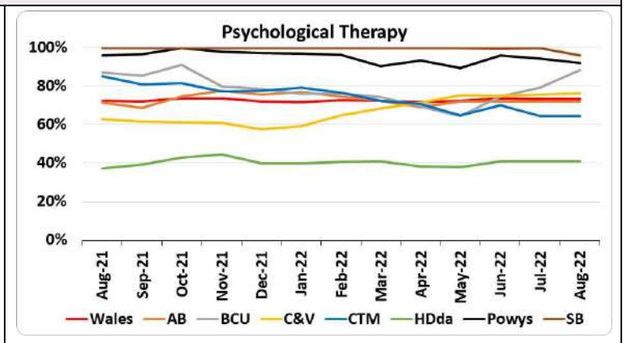
Status as at August 2022		
Health Board	**Compliance**	**Rank**
C&V	100.0%	1st
SB	97.4%	2nd
HDda	93.6%	3rd
CTM	**92.7%**	**4th**
AB	91.9%	5th
Powys	80.2%	6th
BCU	77.3%	7th



Status as at August 2022		
Health Board	**Compliance**	**Rank**
SB	100.0%	1st
C&V	99.5%	2nd
CTM	**96.4%**	**3rd**
HDda	84.0%	4th
BCU	72.9%	5th
Powys	50.3%	6th
AB	30.2%	7th



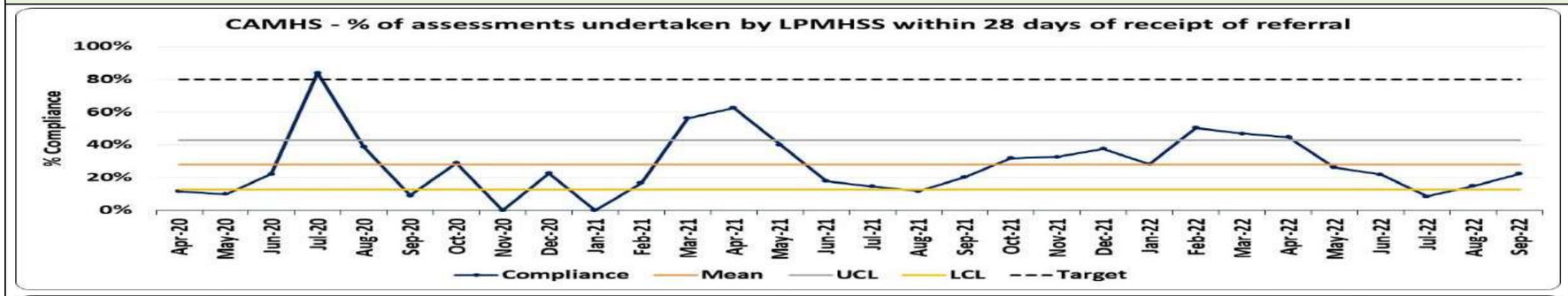
Status as at August 2022		
Health Board	**Compliance**	**Rank**
HDda	92.3%	1st
C&V	91.1%	2nd
SB	89.6%	3rd
CTM	**87.3%**	**4th**
BCU	84.3%	5th
Powys	81.4%	6th
AB	75.0%	7th

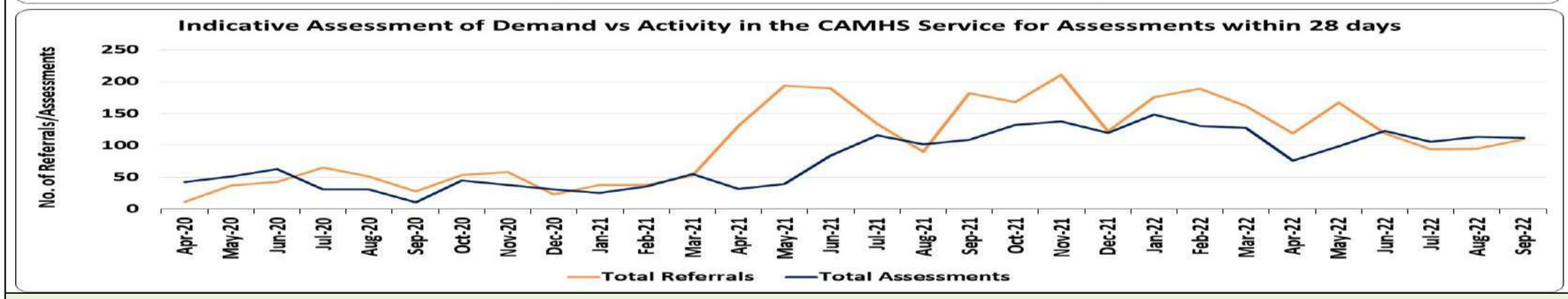


Status as at August 2022		
Health Board	**Compliance**	**Rank**
SB	96.0%	1st
Powys	92.0%	2nd
BCU	88.5%	3rd
C&V	76.4%	4th
AB	72.0%	5th
CTM	**64.6%**	**6th**
HDda	41.0%	7th

CTM Child & Adolescent Mental Health Services (CAMHS) – September 2022

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (22.3%) - Target 80%





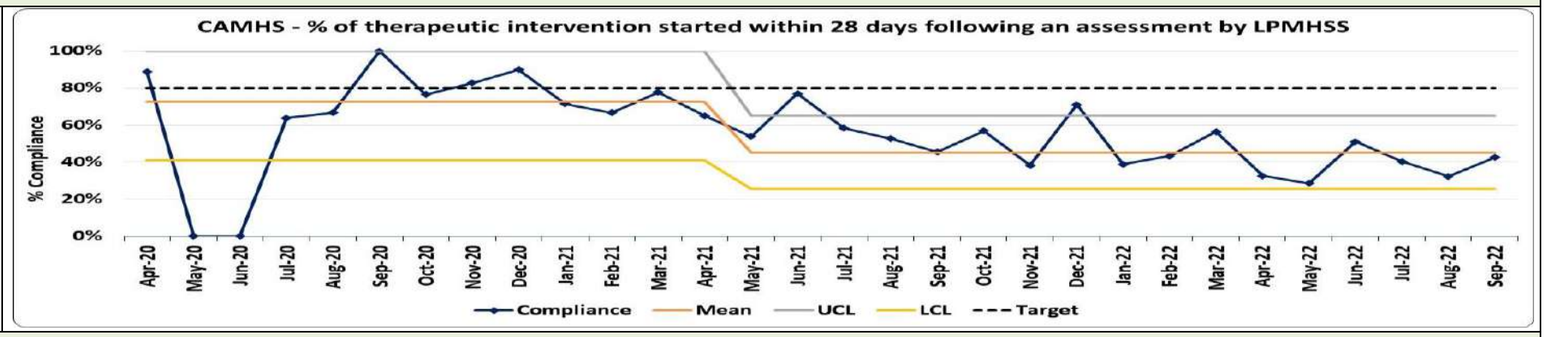
Compliance during September saw a small improvement on the previous month but remaining low with just 22.3% of assessments undertaken within 28 days of referral and continuing to remain well below WG's minimum expected standard of 80%, (the last time the target being met was in July 2020).

Achievement of the 28 day standard requires a significant waiting list reduction as detailed in the chart 2nd left, but further progress needs to be made in order to achieve the desired compliance.

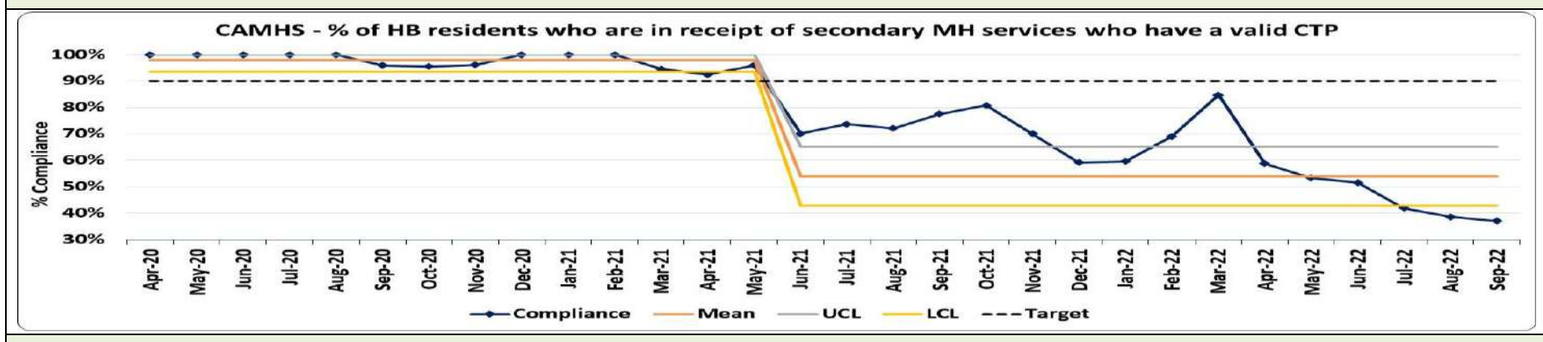
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (42.6%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS improved compared to the previous month to 42.6% with 23 of the 54 interventions for September commencing within 28 days.

Compliance continues to remain well below the 80% threshold and the last time the target was met was in December of 2020 (90%).



% of HB residents who are in receipt of secondary MH services who have a valid CTP (37.1%) - Target 90%



Part Two of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month continues to fall with just 37.1% compliance observed during September and continuing to remain below the set target (90%). The last time compliance was achieved was May 2021.

Part 3: There were no requests for a CAMHS assessment under Part 3 of the Mental Health Measure during September.

CAMHS continued on the next page…

Cont'd…CAMHS

How are we doing and what actions are we taking?

Demand has increased slightly during September 2022 in line with seasonal demand. The acuity of the presentations of the CYP still remains high and evidenced by the increasing number of CYP requiring Part 2 in the service. There has been an expected slight decrease in the demand for crisis over the summer school holidays. The crisis service has extended to providing 24 hours cover on a Friday; Saturday; Sunday; Monday and a Tuesday as staffing levels increase with positive feedback from EDs on the impact on increasing discharges overnight and young people requiring less admissions.

The Rapid Intervention Service for Eating Disorders continues to experience similar level of referrals, although we are consistently seeing increasing level of clinically urgent patients. The demand has been on a sustained trajectory since October 2021. The Team are working on pathways with Paediatric colleagues and ensuring that all referrals are screened within 48 hours. The service aims to meet the NICE guidance whereby young people should be seen within 2 weeks of referral for assessment. More recently we have had funding approved to support additional medical time in the service alongside some additional nursing time, and recruitment to these posts is underway.

The Community CAMHS team are continuing to work on pathways to ensure timely interventions are undertaken within 28 days. There was a backlog of patients waiting to be seen over 28 days across all areas which corresponds with the lower performance in July and August as the service also saw a decrease in the number of referrals and patients who were deemed urgent alongside focusing on seeing the longest waiters first. However, September has shown a decrease in patients waiting over 28 days, improved treat in turn rates and equity across the locality teams in terms of length of wait. We are progressing plans to consider alternative ways to run the groups in each locality with input from third sector organisations, such as Mind Cymru and Mental Health Matters. Additional funding has also been approved to support the Community CAMHS team in terms of Health Care Support Workers for each locality and also CAMHS RMN's, and part of their roles will be to facilitate groups. This is a new and exciting initiative in the service, and it's anticipated to support the development of staff and also enable the service to offer alternative methods of delivering treatment to CYP. Recruitment to these posts is progressing.

Patients presenting with higher levels of need and risks are being identified and are in receipt of a Care Treatment Plan (CTP). The number of CYP who require a Part 2 Care and Treatment plan continues to increase within the service (increasing to over 400 CYP) and further work is taking place to ensure these patients are allocated a care co-ordinator and have a valid CTP. Some detailed project work is being undertaken to put in place improvements and also identify the capacity gap in the service.

The Single Point of Access Team currently provides triage, information and advice to CYP and their families as well as professionals. The team continues to promote Consultant Connect and the team has met with GPs to discuss the service and referrals. With confirmation of funding from the Mental Health Service Improvement Funds the service is recruiting into a further 2 posts to support the development of liaison with primary care.

The In-Reach Service/Whole Schools Approach was implemented from beginning of September and there is staff working within their cluster schools as planned. This service will underpin early intervention and prevention, building up resilience in CYP to prevent onward referrals into specialist CAMHS.

When is improvement anticipated and what are the main areas of risk?

Improvements: An improvement action plan and revised trajectories have been developed in order to improve compliance for all Mental Health Measures targets. This is being reviewed with the service team leads and senior staff on a fortnightly basis. Actions from this work include; movement of resources to areas of longest waits and supporting clinicians with identifying discharge plans as well as identifying ways to increase capacity by reducing non-clinical work as well as working with third sector partners.

Staffing has continued to be moved in some localities to support demand and waiting times and to increase capacity for assessments as well as interventions. This is reflected in the last few months with increasing number of assessments and reduction in the waiting list. Additional WLI have commenced to support additional capacity to target both the waiting times for assessment and the waiting times for intervention.

There has been a slight increase in the performance against the mental health measure for September. The overall number of patients on the waiting list for CAMHS has reduced further to around 185. This is the lowest the waiting list has been in over a year. However, it's anticipated that following the return to school, the numbers will increase in line with seasonal demand. There are now less patients waiting longer than 28 days for assessment, and the predicted compliance for October stands at 49%, which is a significant improvement and the highest it's been since the beginning of the year. Average waiting time is now around 3 weeks.

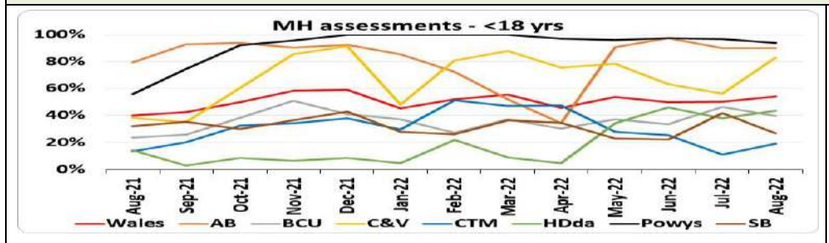
Plans have been implemented to improve Part 2 compliance. All CYP will be initially regarded as an eligible patient in receipt of secondary care and requiring a CTP. There has been a significant increase in number of identified CYP on Part 2 of the measure but recognition that there needs to be an increase in the number of patients with a valid CTP. Actions have been identified to support this area, including reducing non-clinical time and undertaking an analysis of numbers in each areas to determine the capacity gap.

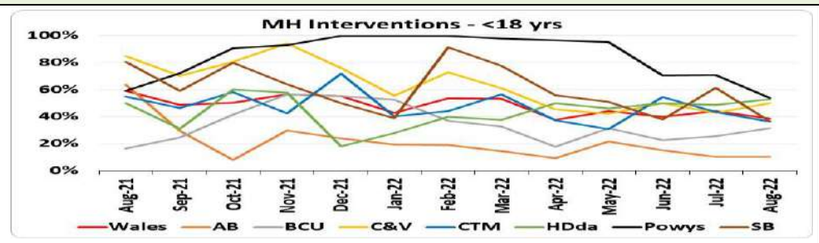
The implementation of the groups across all sector areas will provide additional capacity and a different way of working which will support performance improvement in Part 1a. and Part 1b. The first groups have commenced, with some good evaluation and other groups in each locality are being developed. We are working with 3rd sector organisation Mental Health Matters and have started discussions with Mind Cymru to consider roll out of some further groups to support those waiting as well as support patients deemed suitable for discharge. The service has had confirmation of funding from the Mental Health Service Improvement Funding in September and has progressed recruitment into these posts with interviews scheduled in October to support additional capacity into the Winter when demand increases.

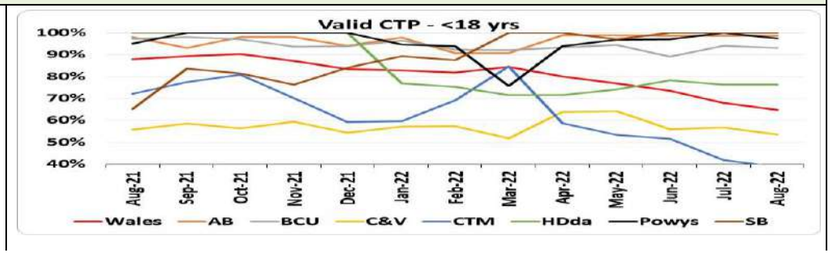
Main areas of risk

- Demand and capacity imbalance increasing the backlog of patients waiting to be seen
- Increased acuity of presentation in CYP has resulted in CYP being unwell and needing more intensive longer-term work or possible admission.

How do we compare with our peers?







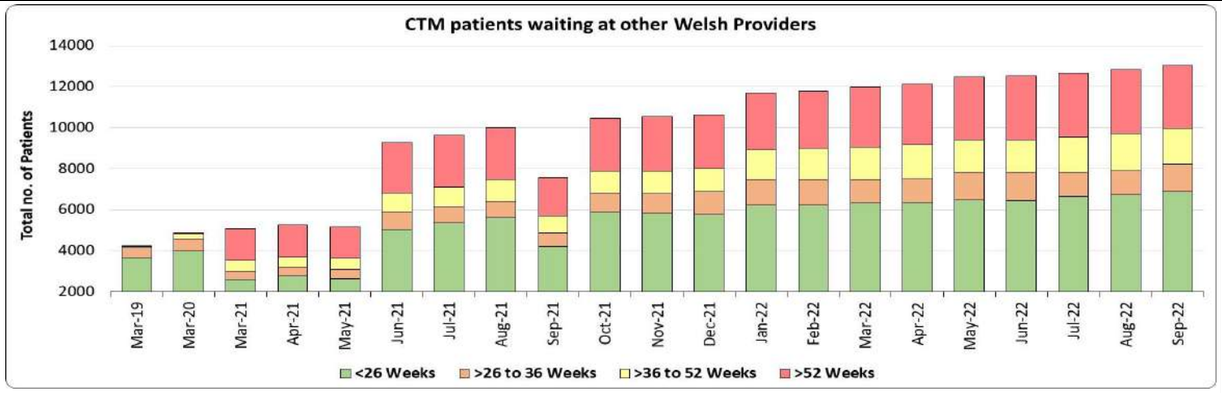
Status as at August 2022		
Health Board	Compliance	Rank
Powys	93.9%	1st
AB	90.1%	2nd
C&V	82.9%	3rd
HDda	43.6%	4th
BCU	39.6%	5th
SB	26.9%	6th
CTM	**19.2%**	**7th**

Status as at August 2022		
Health Board	Compliance	Rank
Powys	53.8%	1st
HDda	53.0%	2nd
C&V	50.0%	3rd
SB	36.8%	4th
CTM	**36.2%**	**5th**
BCU	31.6%	6th
AB	10.3%	7th

Status as at August 2022		
Health Board	Compliance	Rank
SB	100.0%	1st
AB	98.6%	2nd
Powys	97.6%	3rd
BCU	93.0%	4th
HDda	76.4%	5th
C&V	53.7%	6th
CTM	**38.7%**	**7th**

WHSSC – Welsh Health Specialised Services Committee

CTM Residents Waiting for Treatment at other Welsh Providers – ***Please note that w.e.f. from June 2021, Swansea Bay UHB have applied a LHB residents code to their waiting list submission that has had the impact of revealing an increase in the number of CTM residents waiting for treatment at SB that were previously regarded as being their own residents. This does not affect the management of the patients as they have been reported on SB waiting lists and will continue to do so until the patients are treated. Please note that 50% of the CTM patients on the SB waiting list were submitted with an incorrect LHB code, resulting in a temporary reduction in the number of patients displayed for September 2021.***



Using data collected and reported by Digital Health and Care Wales (DHCW), the chart above shows waiting times for CTM residents at other Welsh providers, though the actual Commissioner is not WHSSC in all instances.

Over 99% of the waiting lists for CTM residents awaiting services commissioned by WHSSC in other parts of Wales are in three Health Boards. The tables to the right provide the RTT, Diagnostic and Therapy waits for CTM patients waiting for treatment at three specific Welsh providers together with a specialty breakdown of the number of patients waiting.

The number of CTM patients waiting over 36 weeks (RTT) at these three Health Boards in September is 4,791 of which 3,040 are waiting more than 52 weeks. The number of patients waiting over 8 weeks for a diagnostic at these Health Boards is 281 and there are just 2 patients waiting over 14 weeks for a therapy.

CTMUHB Patients waiting at Cardiff & Vale UHB		
Referral to Treatment Times (RTT)		
Specialty	>36 to 52 Weeks	>52 Weeks
Trauma & Orthopaedics	207	725
Ophthalmology	88	228
Clinical Immunology & Allergy	43	167
General Surgery	37	74
Gynaecology	19	46
Urology	19	38
ENT	19	36
Oral Surgery	14	30
Paediatric Surgery	21	27
General Medicine	15	25
Dental Medicine Specialties	9	21
Dermatology	13	7
Gastroenterology	12	7
Neurology	618	7
Cardiology	11	6
Paediatric Dentistry	6	4
Neurosurgery	5	4
Paediatrics	21	3
Restorative Dentistry	1	3
Pain Management	1	
Anaesthetics	1	
Clinical Pharmacology	1	
Orthodontics	6	
Paediatric Neurology	2	
Cardiothoracic Surgery	1	
Grand Total	1190	1458

Diagnostics		
Service	Total Waits	>8 wks
Endoscopy	77	43
Cardiology	116	30
Radiology	191	17
Physiological Measurement	17	14
Neurophysiology	2	
Imaging	1	
Total	404	104

Therapies		
Service	Total Waits	>14 wks
SALT	5	2
Dietetics	11	0
Podiatry	2	0
Occupational Therapy	4	0
Physiotherapy	27	0
Total	49	2

CTMUHB Patients waiting at Aneurin Bevan UHB		
Referral to Treatment Times (RTT)		
Specialty	>36 to 52 Weeks	>52 Weeks
Urology	20	58
Trauma & Orthopaedics	10	57
ENT	12	27
Ophthalmology	15	14
Oral Surgery	2	6
General Surgery	10	4
Orthodontics	5	1
Gastroenterology	1	
Cardiology	2	
Gynaecology	2	
Grand Total	79	167

Diagnostics		
Service	Total Waits	>8 wks
Endoscopy	27	14
Radiology	19	1
Cardiology	6	
Physiological Measurement	2	
Total	54	15

Therapies		
Service	Total Waits	>14 wks
Audiology	3	0
Dietetics	1	0
Physiotherapy	15	0
Total	19	0

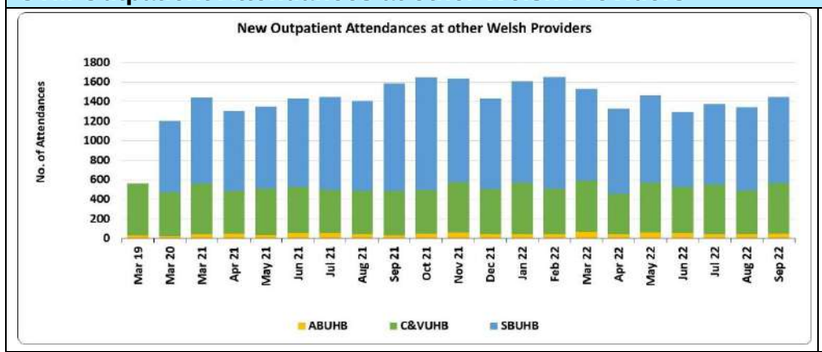
CTMUHB Patients waiting at Swansea Bay UHB		
Referral to Treatment Times (RTT)		
Specialty	>36 to 52 Weeks	>52 Weeks
Oral Surgery	170	541
Plastic Surgery	77	216
Trauma & Orthopaedics	50	214
Gynaecology	54	128
General Surgery	50	126
Orthodontics	30	101
ENT	6	21
Ophthalmology	4	19
Gastroenterology	4	17
Urology	3	16
Dental Medicine Specialties	2	9
Paediatrics	4	4
Neurology	23	3
Cardiothoracic Surgery	1	
Diagnostic	1	
Clinical Haematology	1	
Cardiology	2	
Grand Total	482	1415

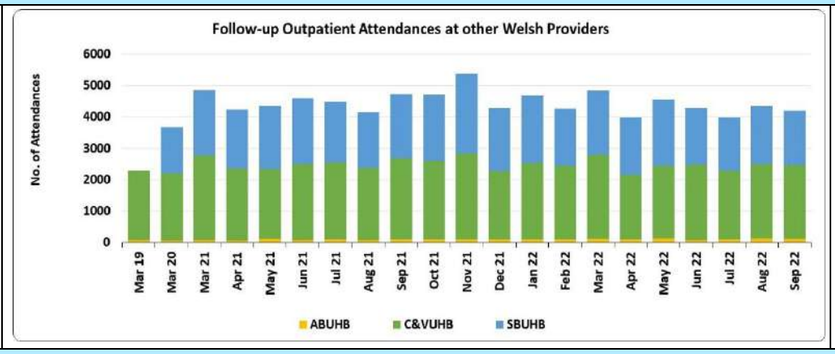
Diagnostics		
Service	Total Waits	>8 wks
Neurophysiology	195	103
Endoscopy	43	32
Cardiology	81	27
Total	319	162

Therapies
No patients waiting for a therapy

CTM patients waiting at specific health boards (RTT)						
September 2022	Cardiff & Vale UHB		Aneurin Bevan UHB		Swansea Bay UHB	
Weeks Wait	Patients	% waiting	Patients	% waiting	Patients	% waiting
<26 Weeks	3547	51.2%	284	46.5%	3046	55.8%
>26 to 36 Weeks	738	10.6%	81	13.3%	517	9.5%
>36 to 52 Weeks	1190	17.2%	79	12.9%	482	8.8%
>52 Weeks	1458	21.0%	167	27.3%	1415	25.9%
Total Waiting	6933		611		5460	
% of Total Waiting	53.1%		4.7%		41.8%	

CTM Outpatient Attendances at other Welsh Providers

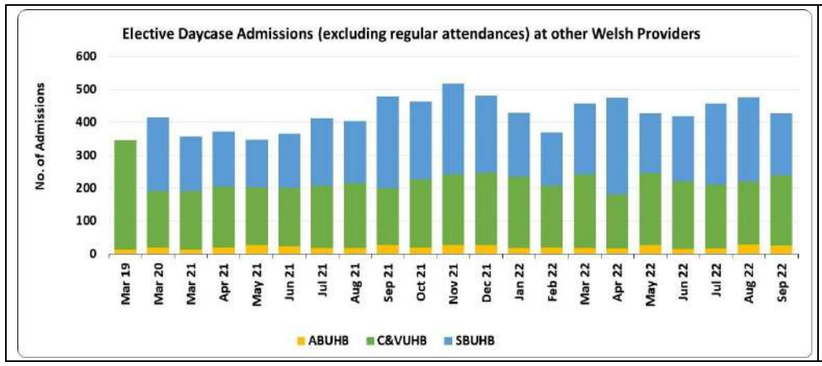


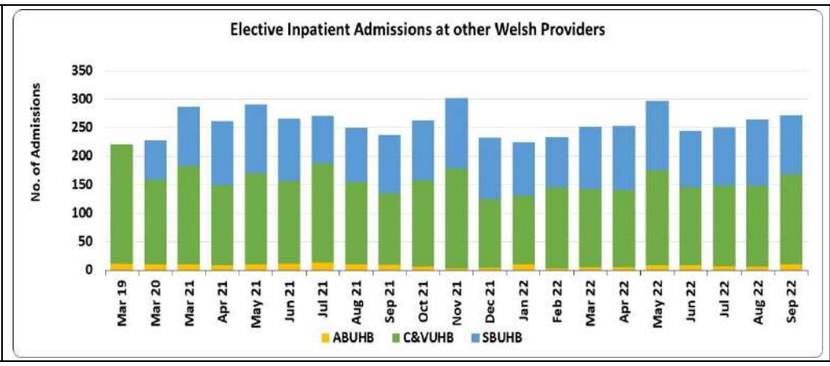


The September 2022 position (reported at October WHSSC meeting) continues to show marginal change from the previous reported positions overall with some marked improvement in Cardiac Surgery.

There is currently one CTMUHB resident waiting up to 52 weeks at Cardiff and Vale UHB for and one further patient in the 36-52 week category at Swansea Bay UHB for Cardiac Surgery. This month's report is the first with no patients waiting over 52 weeks. Swansea Bay reports that it is on track for the new outpatient targets in Cardiac Surgery.

The volume of CTMUHB residents with long waits for Neurosurgery remains relatively stable. Overall patient numbers reduced by one by waits over 52 weeks increased by one.





Cardiff and Vale reports an anticipated increase in Paediatric Surgery elective activity for quarter four. However, during September the total number of long waiting patients (Greater than 36 weeks) increased by one.

Plastic Surgery new outpatient activity is at contracted volumes, however elective and emergency activity remains significantly below contracted levels. The UHB reports a gap of 23 new appointments per month to address the >52 week waits by December 2022. There is an ongoing challenge of elective cancellations due to lack of beds and theatre capacity remains below pre-COVID-19 levels. (31 sessions pre COVID - currently 15.5 sessions). The number of CTMUHB residents with over long waits reduced slightly in September 2022.

2.6 Finance update – Month 7

Updates on the financial position become available on the 9th working day of the month. Consequently there is no further update available to that provided in the last financial report. **£3.0m of the accrual which is 6/12ths of £6.0m.**

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The key risks for the **Performance** quadrant are covered in the summary and main body of the report.

3.2 The following issues/risks have been identified in relation to the **Quality** quadrant:

- Learning From Events Reports (LFERs) remain a challenge, however work continues to address the backlog. In addition, new systems and process in respect of learning and capturing learning have been implemented, which will support the timely management of LFERs for the newly triggering cases.
- Post pandemic recovery and increased demand and pressures of unscheduled care, patient flow and discharge difficulties for patients requiring ongoing support, continues to have considerable and ongoing consequences on the experience of patients and the ability of the HB to provide continuity around its core business. The six goals programme board is being launched within urgent and emergency care.
- The health board is working with the Welsh Ambulance Service Trust (WAST) to review how incidences such as patients being unable to receive an ambulance in the community can be reduced, and to mitigate the risk of harm to those waiting extended periods to be off loaded from ambulance in the meantime. The Unscheduled Care Nurse Director and acute sites Heads of Nursing are working through a set of care principles during delays in offloading to Emergency Departments. This will be co-produced with consultants and WAST.
- Prince Charles Hospital is committed to being an active participant in the development and sustainability of stroke services across CTM. If current increase in number and complexity of stroke patients across these sites continues, then the ability of Occupational Therapy, Speech and Language Therapy, Physiotherapy and Dietetics, to respond and provide a quality service to these patients will reduce and not be sustainable without additional resource. A CTM wide, stroke plan is currently in progress to the previously escalated concerns regarding the staffing and the on call rota; furthermore

under the six goals framework the 'hyper acute sites' will be moving to a model of ring-fenced 'hyper acute stroke beds' next month.

- The proposals in relation to a changed operating model presents challenges in ensuring the quality, patient safety and people's experience agenda remains well led and managed throughout.
- Ensuring robust implementation of the RLDatix system, which is aligned to the new operating model and progressing the ambition to develop an IT infrastructure to ensure up-to-date high quality data that is readily accessible enable triangulation and is meaningful.
- Gaining health board wide assurance across the breadth of UHB services, especially during a period of significant change in its operations.
- Actions to address these issues and risks are in place in the improvement action plans relating to the targeted intervention areas. Beyond this, the Health Board require ambitious pursuit of quality and safety in all it does to provide excellence in service delivery to the population of CTM.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.
Related Health and Care standard(s)	Choose an item.
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes. The work reported in this summary and related annexes take into account many of the related quality themes.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not yet assessed

Legal implications / impact	Yes (Include further detail below)
	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **NOTE** the Integrated Performance Dashboard.

2022-23 Finance Report

Month 7

Summary

Situation	Background
Our revised draft financial plan was submitted to Welsh Government (WG) on 29 April 2022 and was analysed into three elements; core, exceptional cost pressures and ongoing COVID response costs. Our core plan submission was a deficit of £26.5m. The failure to submit a financially balanced plan is a breach of our statutory duty under the Finance (Wales) Act 2014. Our deficit core plan includes savings of £17.3m to be delivered in year. In addition, recovery actions are required to address bought forward cost pressures of circa £11m. Meeting these requirements will represent a step change in savings delivery. In accordance with WG plan guidance, additional allocations have been assumed in respect of our assessed exceptional cost pressures (£19.0m) and ongoing COVID response costs (£32.3m). However, this funding has not yet been confirmed and is therefore shown as at risk. There remain a number of residual risks and uncertainties spanning all elements of our plan and our cost estimates and risk assessments will continue to be refined and updated during 2022/23. This report outlines our financial performance against our draft plan for the period to 31st October 2022	Our financial performance for 2021-22 was a small surplus of £0.037m and thus we achieved our break even financial duty against its Revenue Resource Limit over the 3 year period 2019-20 to 2021-22. However, our underlying position deteriorated during 2021-22 to a recurrent deficit of £44.5m, compared with a planned recurrent deficit of £31.4m. This deterioration was primarily due to a recurrent shortfall in savings delivery. We planned to achieve savings of £14.5m by the end of March 2022 and £16.1m was planned to be delivered recurrently. We achieved in year savings of £14.5m, of which £5.0m was delivered recurrently. Our recurrent savings shortfall in 2021-22 was therefore £11.1m. During 2021-22, we received COVID funding of £93.6m plus Planned Care Recovery funding of £20.8m.

Summary

Assessment

As at Month 7, we are:

- Maintaining a forecast **Core plan** deficit of £26.5m, noting that performance YTD is £1.7m worse than plan and assumes £6m is realised from our 2021/22 annual leave provision.
- Forecasting that **Exceptional** costs will remain at £17.8m (M6: £17.8m)..
- Forecasting a slight decrease in **COVID** costs, programme and response, to £30.5m (M6: £30.9m).

Key financial issues to note include:

- Our plan assumed that all **Exceptional** costs and **COVID** response costs would be fully funded by Welsh Government. WG have now confirmed that the Health Board's M6 forecasts for **Exceptional** costs and **Covid** costs will be funded to a maximum level of the M6 forecasts. Any underspend below the M6 forecast will be returned to WG but any overspending will need to be managed by the Health Board. This represents a potential risk to the Core plan forecast.

- The forecast recurrent deficit at 31 March 2023 has deteriorated to £47.5m (M6: £34.9m) this represents a £19.5m deterioration from the planned deficit of £28.0m. This forecast underlying deficit excludes any recurrent impact of **COVID** response costs and **Exceptional** items continuing into 2023/24.

- The forecast cash shortfall of £38.7m will require careful management and ongoing dialogue with WG during the latter months of the financial year (See page 5). We will shortly be submitting an Accountable Officer letter to WG to seek cash support for the planned Core plan deficit of £26.5m.

- Compliance with the Public Sector Payment Policy target has been significantly below the 95% target in both M6 (86%) and M7(88%) due to delays in paying nurse agency invoices. The M7 YTD performance is now 93.9%. A new Agency self-billing process commenced in October and this is expected to have a significant improvement from November, enabling the Health Board to achieve the 95% target for 2002-23.

Recommendation

The Board is asked to **DISCUSS** and **NOTE** financial performance for the period to 31st October 2022.

Contents

Executive Summary

Year to Date Revenue	• The M7 in month **Core position** reported a £2.6m deficit (M6: £1.2m deficit). The M7 YTD **Core position** is a £17.2m deficit , which is £1.7m worse than plan (M6 £1.4m). • M7 YTD **COVID** Programme expenditure of £9.6m (M6: £8.5m) and YTD Response expenditure of £10.0m (M6: £8.6m). • M7 YTD **Exceptional** cost pressure expenditure of £9.6m (M6: £7.5m).
Key Financial Issues - Forecast	• Forecast **Core** plan deficit maintained as per plan at £26.5m (M6:£26.5m) which assumes a £6.0m release from the 2021/22 annual leave accrual. • Forecast **Exceptional** costs **have been maintained at** £17.8m (M6: £17.8m), We are currently reviewing recent figures issued by NWSSP/BG which showed a significant increase in Energy volumes for CTM which we believe include a number of errors. • Forecast **COVID** costs at £30.5m (M6: £30.9m). • WG have confirmed that funding for **Exceptional** and **COVID** costs in 22/23 will be capped to the M6 forecasts. Main risk is energy volumes and price changes.

Recurrent Position	• Forecast **core** recurrent deficit at 31 March 2023 has deteriorated to £47.5m (M6: £34.9m) this represents a £19.5m deterioration from the planned deficit of £28.0m. This is fundamentally due to:
	  • Shortfall in recurrent savings £6.6m
	  • Shortfall in recurrent pay award funding of £1.9m
	  • Forecast recurrent overspends from Care groups and directorates of £11.0m.

Cash	• The M7 cash flow forecast is showing a cash shortfall of £38.7m which includes a forecast Core plan deficit of £26.5m plus a forecast movement in Working Balances of £12.2m , This forecast assumes that all Covid and Exceptional cost pressures will be fully cash funded in 2022/23. • In previous years WG have funded movements in Working balances and we will shortly be submitting an accountable officer letter to WG to seek cash support for the planned Core plan deficit of £26.5m.
Capital	• The Capital Resource Limit (CRL) is currently £61.6m. As at M7, £32.1m has been incurred against the CRL. • The forecast capital position remains breakeven to the CRL. There are a number risks to the programme that are subject to ongoing review and management.

Year to Date Performance and Forecast

	Current Month Variance	Year to Date Variance	M7 Forecast Variance	M6 Forecast Variance	Financial Plan
	£m	£m	£m		£m
Core plan deficit	**2.6**	**17.2**	**26.5**	**26.5**	**26.5**
Exceptional items:					
National insurance changes	0.4	3.1	3.1	3.1	5.0
Energy inflation	1.2	5.1	12.3	12.3	11.6
Real Living Wage for Social Care Workers	0.2	1.4	2.4	2.4	2.4
Anticipated funding	(1.8)	(9.6)	(17.8)	(17.8)	(19.0)
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Covid response costs:					
Programme	1.1	9.6	14.1	14.4	15.6
Other	1.4	10.0	16.4	16.5	16.7
Anticipated funding	(2.5)	(19.6)	(30.5)	(30.9)	(32.3)
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Grand total	**2.6**	**17.2**	**26.5**	**26.5**	**26.5**

Key Points for In month & Year to Date Performance:

- The M7 in month position reported a £2.6m deficit (M6: £1.2m deficit). This includes a £1.1m deficit due to a shortfall in assumed funding for pay awards of £1.1m (7/12ths of £1.9m annual shortfall), together with other operating variances.
- The M7 YTD position is reporting a £17.2m deficit against the Revenue Resource Limit, which is £1.7m worse than plan (i.e. 7/12ths £26.5m). Circa £1.8m of this variance is due to a Welsh Government instruction to remove COVID income losses and ICT/Homeworking costs from COVID response costs and to treat them as a Core plan cost.
- Our planning assumption is that the £1.9m recurrent shortfall in pay award funding will be managed non recurrently in 22/23 through retention of the forecast non-recurring underspend on the dental contract of £1.7m. This has been included on our risk table (page 19) pending confirmation from WG.

Key Points for Current Year Forecast:

- The Core plan forecast remains on track to deliver a planned deficit of £26.5m. This forecast assumes a £6m full year release from the 21/22 annual leave accrual. We believe that this is a prudent estimate and a further £4m has been included as a potential opportunity in our risk table at Page 19.The potential full year release of £10m is based on the key assumption that the carry forward of annual leave at the end of 22/23 will revert to the normal preCovid level of 5 days, compared to a maximum of 30 days at the end of 21/22
- There is no change in the forecast cost of Exceptional items from M6. WG have confirmed that the Health Board's M6 forecasts for RLW and NIC will be funded in full but the M6 forecast for Energy is a maximum. Any underspend below the M6 forecast will be returned to WG but any overspending will need to be managed by the Health Board
- The M7 Covid forecast has improved by £0.4m over M6. WG have confirmed that the Health Board's M6 forecasts for Covid costs will be funded to a maximum level of the M6 forecasts. Any underspend below the M6 forecast will be returned to WG but any overspending will need to be managed by the Health Board
- The risks to the forecast overspend of £26.5m have reduced significantly in M7 following WG confirming the funding cap for Exceptional costs and COVID costs. The total risks of £25.8m at M6 has now reduced to a small net opportunity of £1.1m. Please see page 19 for further details.

Year to Date Performance

	Annual Budget (£m)	Cur Month Variance (£m)	YTD Variance (£m)	Page reference
Pay	636.6	0.4	(0.4)	8
Non Pay	759.6	(0.5)	(0.4)	12
CRES	(2.2)	0.0	(1.0)	15
Income	(153.7)	0.5	3.6	16
Allocations	(1,213.8)	0.0	0.0	
Planned Deficit (£26.5m)	(26.5)	2.2	15.5	
Grand Total	**0.0**	**2.6**	**17.2**	

Pay Expenditure

Staff Group	Plan £'m	YTD Actual £'m	YTD Variance £'m
Administrative & Clerical	51.7	49.9	(1.8)
Medical And Dental	91.6	95.6	4.0
Nursing And Midwifery Registered	124.3	119.4	(4.9)
Add Prof Scientific And Technical	11.3	10.2	(1.1)
Additional Clinical Services	46.2	49.3	3.1
Allied Health Professionals	23.2	22.7	(0.6)
Healthcare Scientists	7.6	7.5	(0.1)
Estates And Ancillary	21.9	21.7	(0.2)
Students	0.0	0.7	0.6
Pay Budget Adjustments	(0.4)	0.0	0.4
Grand Total	**377.3**	**376.8**	**(0.4)**

Key Points:

- The M7 YTD pay expenditure is £376.8m . This represents a £0.4m favourable variance compared to the M7 plan of £377.3m.
- The M7 YTD pay expenditure includes a £3.5m benefit from the release of annual leave accruals from 21/22.
- The £4.0m adverse variance in Medical & Dental is mainly due to increased ADH payments and agency costs.
- The £3.1m adverse variance in Additional Clinical Services includes additional cover provided to manage registered nursing vacancies.
- We have now received confirmation that the pay award funding is £1.9m less than our assumed funding. Our planning assumption is that this recurrent shortfall will be managed non recurrently in 22/23

Pay Expenditure Trends

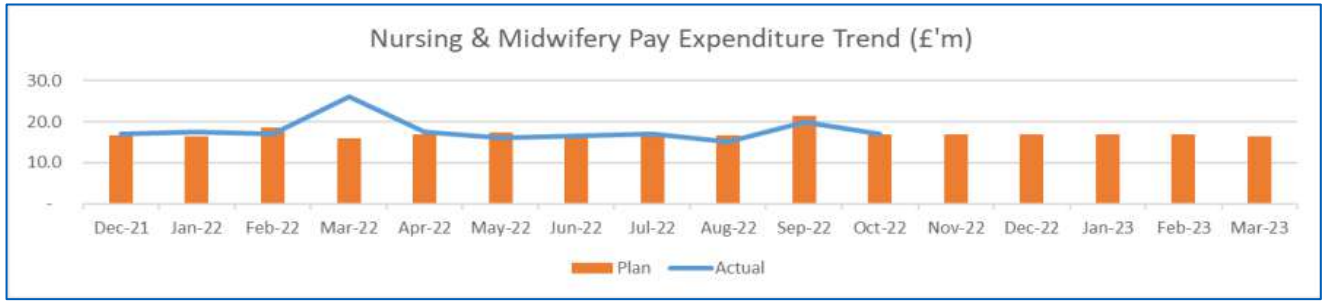
Staff Group	May-22 £'m	Jun-22 £'m	Jul-22 £'m	Aug-22 £'m	Sep-22 £'m	Oct-22 £'m
Administrative & Clerical	6.9	6.8	6.9	6.4	8.5	7.2
Medical And Dental	13.4	13.6	13.4	12.6	16.7	13.5
Nursing And Midwifery Registered	16.0	16.7	17.1	15.2	19.9	17.1
Add Prof Scientific And Technical	1.4	1.4	1.4	1.3	1.7	1.5
Additional Clinical Services	6.6	6.6	7.0	6.2	9.0	7.1
Allied Health Professionals	3.1	3.1	3.2	3.0	4.0	3.1
Healthcare Scientists	1.0	1.0	1.1	1.0	1.3	1.1
Estates And Ancillary	2.9	2.9	3.0	2.8	4.0	3.1
Students	0.0	0.1	0.1	0.1	0.2	0.2
Pay Budget Adjustments	0.0	0.0	0.0	0.0	0.0	0.0
Grand Total	**51.3**	**52.2**	**53.2**	**48.7**	**65.2**	**53.8**

Staff Group	May-22 £'m	Jun-22 £'m	Jul-22 £'m	Aug-22 £'m	Sep-22 £'m	Oct-22 £'m
Core	43.5	43.6	43.8	40.6	54.9	45.4
Agency	4.4	5.1	4.9	4.6	5.5	4.2
Overtime	0.9	1.2	2.1	1.2	1.9	1.6
ADH	1.3	1.2	1.4	1.2	1.1	1.1
Bank	1.0	0.9	0.9	1.0	1.6	1.2
WLI	0.2	0.2	0.2	0.1	0.2	0.2
Grand Total	**51.3**	**52.2**	**53.2**	**48.7**	**65.2**	**53.8**

Key Points for Pay Expenditure Trends:

- M7 expenditure was £53.8m which was £11.4m less than M6. This is mainly due to the M6 expenditure including the pay award arrears for M1-M5 which were estimated at circa £11.2m.
- M7 core staffing costs decreased by £9.5m over M6, due primarily to the pay award arrears in M6.
- M7 agency costs decreased by £1.3m compared to M6. This is primarily due to a £0.6m error reported in M6 and corrected in M7. The average of the last 4 months remains consistent at £4.8m.
- M7 overtime costs decreased by £0.3m in M7, mainly due to pay award arrears being processed in M6.
- Bank costs decreased by £0.4m in M7, again mainly due to pay award arrears being processed in M6.

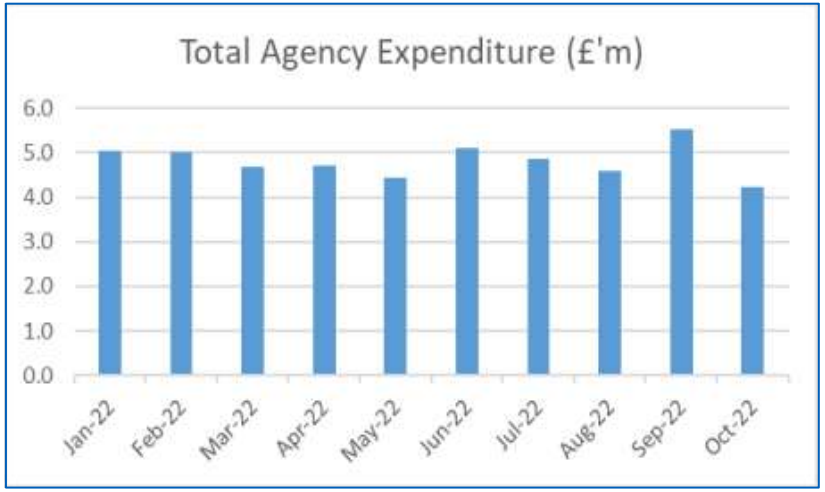
Pay Expenditure Trends

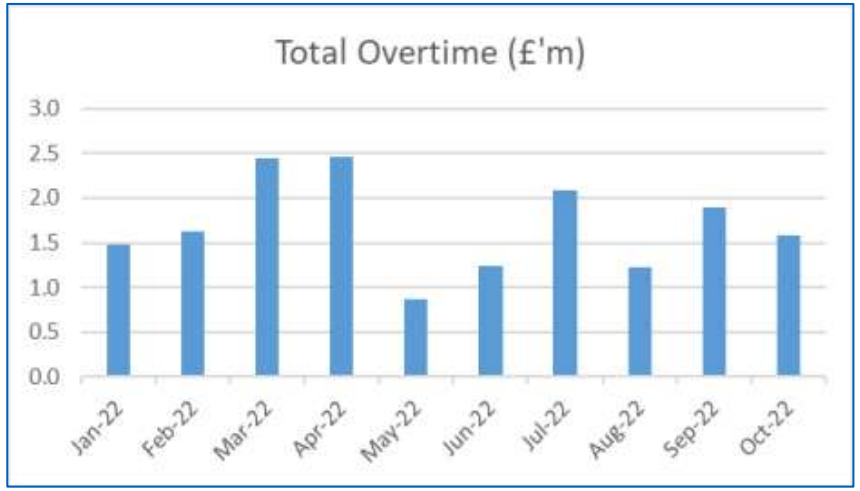


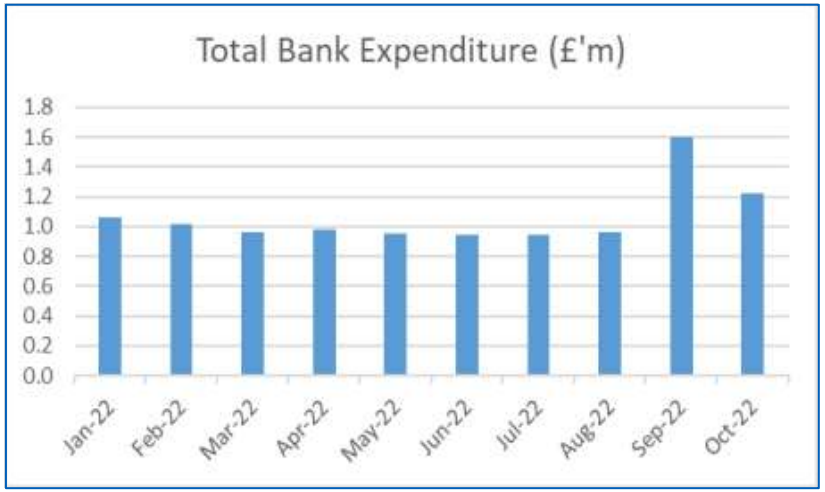
Key Points for Pay Expenditure Trends:

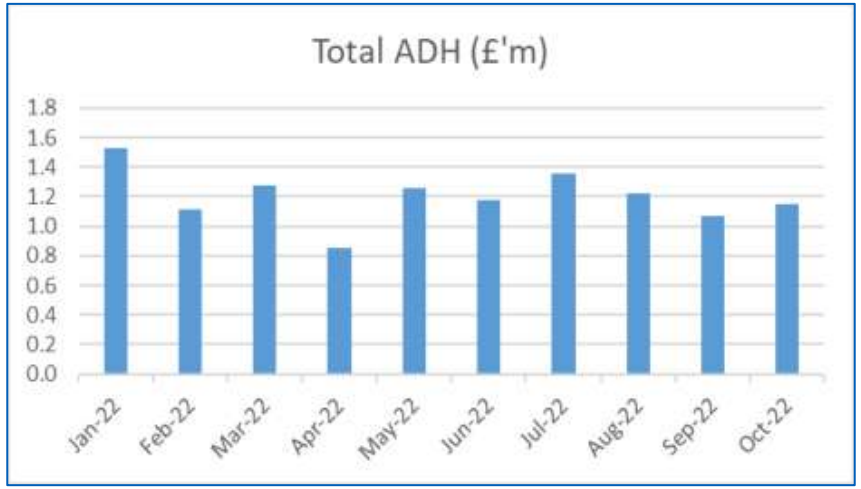
- Medical pay expenditure was £13.5m in M7 compared to £16.7m in M6 . Circa £1.7m of this decrease was due to the pay award arrears in M06 with a £1.3m decrease in agency costs.
- Nursing pay expenditure decreased by £2.8m in M7, £17.1m in M7 compared to £19.9m in M6. The reduction is primarily due to the arrears paid in M6

Variable Pay Expenditure Trends









Key Points for Variable Pay Expenditure:

- Total agency expenditure decreased by £1.3m in M7 to £4.2m. As noted above, the M6 agency costs included an error of £0.6m, which has now been corrected in M7.
- Overtime costs decreased by £0.3m in M7 due to the pay award arrears in M6.
- Bank Expenditure decreased by £0.4m, again partly due to the pay award in M6.
- ADH expenditure remained consistent with M6

Non Pay Expenditure

Staff Group	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m
Primary Care Contractors	76.5	76.2	(0.4)
Primary Care Drugs	54.2	56.3	2.0
Provider Non Pay	99.9	100.8	0.9
Commissioned Activity	194.1	194.1	(0.0)
Capital Charges	19.1	19.1	0.0
Other Non Pay	(5.6)	(8.6)	(2.9)
Total Expenditure	**438.3**	**437.9**	**(0.4)**

Key Points for Non Pay Expenditure:

- The M7 YTD non pay position is reporting a £0.4m surplus.
- The main overspending area is Primary care drugs. The most recent M5 Prescribing data is showing that YTD growth is higher than planned plus NCSO & Cat M pricing movements is creating the YTD variance of £2m. (NCSO - This is where contractors are unable to source products at the agreed tariffs, a temporary concession is offered to increase the price to match current market conditions).
- The breakeven Commissioned Activity position includes an underperformance on LTA and commissioning budgets of £2.4m (See income) offset by a £2.4m overspend on CHC.
- The underspend of £2.9m in Other Non pay includes a release of non delegated reserves of £2.9m.

COVID Expenditure

	M7 Actual	M7 YTD	M7 Forecast	M6 Forecast	Financial Plan	Change
Programme costs	**£m**	**£m**	**£m**		**£m**	**£m**
TTP	0.4	4.1	5.7	5.8	6.5	(0.1)
Mass Vaccination	0.6	4.4	6.5	6.7	7.4	(0.2)
PPE	0.1	1.1	1.8	1.9	1.6	(0.1)
Sub total	**1.1**	**9.6**	**14.1**	**14.4**	**15.6**	**(0.3)**
COVID Response Costs:						
Cleaning Standards	0.1	0.0	1.8	1.9	2.3	(0.1)
Capacity & Facilities costs	0.6	2.5	3.7	3.0	3.0	0.7
Prescribing costs	(0.8)	0.2	0.4	2.1	2.1	(1.7)
Dental income losses	0.1	1.3	2.0	2.0	2.5	0.0
Increased workforce costs	0.3	3.2	4.7	4.7	2.6	0.0
Long Covid	0.1	0.3	0.8	0.8	0.8	0.0
Flu extension	0.4	0.5	1.1	1.1	0.6	0.0
Discharge support	0.0	0.3	0.3	0.3	0.6	0.0
Other Covid Response	0.6	0.8	1.5	0.6	2.3	0.9
Sub total	**1.4**	**10.0**	**16.4**	**16.5**	**16.7**	**(0.1)**
Total Covid costs	**2.5**	**19.6**	**30.5**	**30.9**	**32.3**	**(0.4)**
Anticipated funding	**(2.5)**	**(19.6)**	**(30.5)**	**(30.9)**	**(32.3)**	**0.4**
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Key Points for the M6 COVID Expenditure:

- Programme Costs – the M7 spend of £1.1m was marginally lower than the M6 costs of £1.2m. Whilst a number of costs have been reclassified in M7, the total forecast is £0.4m below the M6 forecast of £30.9m.
- Other COVID Costs – the M7 spend of £1.4m was higher than the M6 costs of £1.3m. Prescribing costs have been reduced by £1.0m, Capacity costs have increased by £0.5m and Other costs have increased by £0.5m.
- WG have confirmed that COVID Costs will be funded to a capped maximum of the M6 forecast.

Key Points for forecast COVID Expenditure:

- Programme Costs – the M7 forecast has decreased by £0.3m from M6, this includes a reduction of £0.1m for anticipated Local Authority TTP redundancy costs.
- Other Covid costs – the M7 forecast has decreased by £0.1m from M6.
- The forecast costs for COVID remain within the WG capped funding (i.e M6 forecast).

Exceptional Cost Pressures Expenditure

	M7 Actual	M7 YTD	M7 Forecast	M6 Forecast	Financial Plan	Change
	£m	£m	£m	£m	£m	£m
National insurance changes	0.4	3.1	3.1	3.1	5.0	0.0
Energy inflation	1.2	5.1	12.3	12.3	11.6	0.0
Real Living Wage for Social Care Workers	0.2	1.4	2.4	2.4	2.4	0.0
Total Exceptional Costs	**1.8**	**9.6**	**17.8**	**17.8**	**19.0**	**0.0**
Anticipated funding	**(1.8)**	**(9.6)**	**(17.8)**	**(17.8)**	**(19.0)**	**0.0**
Grand total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Key Points:

- The M7 spend of £1.8m was £0.1m higher than the M6 spend of £1.7m, due to increased energy costs.
- There is no change in the forecast from M6. WG have confirmed that the Health Board's M6 forecasts for RLW and NIC will be funded in full but the M6 forecast for Energy is a maximum. Any underspend below the M6 forecast will be returned to WG but any overspending will need to be managed by the Health Board.
- Recent figures issued by NWSSP/BG for the M7 energy forecast showed a significant increase in energy volumes for CTM. We believe that these figures include several errors and we are following this up with NWSSP/BG. In the meantime, our M7 forecast has been maintained at the same level as M6.

Savings (including Accountancy Gains)

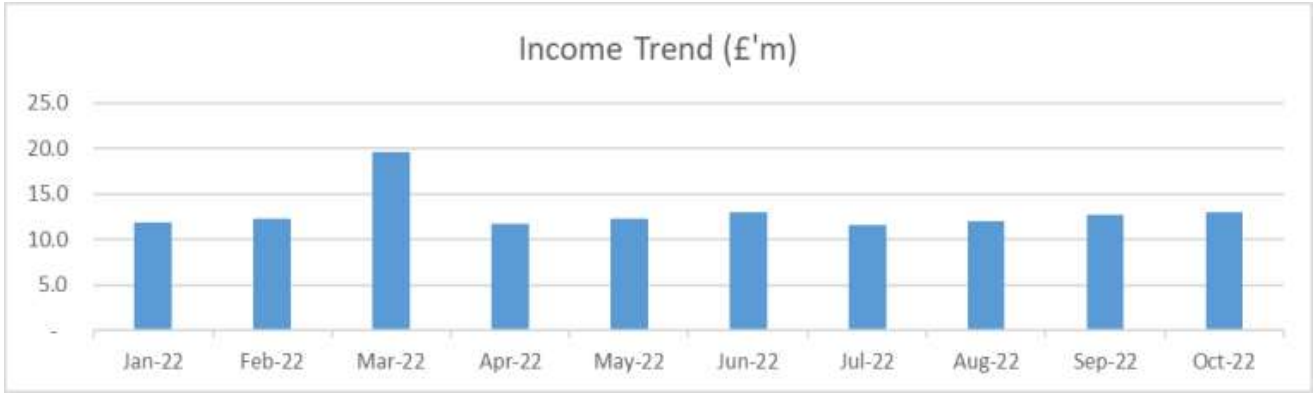
	Month 7		
	M7 YTD	22/23	Rec
	£m	£m	£m
Planned savings		14.1	
Planned income generation		0.2	
Plans to be finalised		3.0	
Savings target as at M7	**10.1**	**17.3**	**17.3**
Actual and Forecast Savings	**(11.1)**	**(17.7)**	**(10.7)**
Total	**(1.0)**	**(0.4)**	**6.6**

Key Points for Savings achievement:

- The actual savings in M7 was £1.4m compared to £3.3m in M6. The main reason for the decrease was additional WHSSC savings of £1.5m in M6.
- Forecast In year savings has increased by £0.2m to £17.7m.
- Forecast Recurrent savings have increased by £0.3m in M7 to £10.7m.
- Urgent work is still needed to develop a robust savings plan to deliver £17.3m of savings on a recurrent basis. The M7 gap has reduced to £6.6m.
- In addition to the £17.3m savings target the financial plan incudes a target of £4.5m for accountancy gains. Delivery of this target is classified as Green and is considered to be low risk.

Income

Income Group	Plan £'m	YTD Actual £'m	YTD Variance £'m
Health Organisations Income	60.2	57.8	2.4
Local Authorities Income	6.7	6.8	(0.1)
Catering Income	1.7	1.3	0.5
Private Patients	0.1	0.2	(0.1)
Other Income	20.9	19.9	1.0
Total Expenditure	**89.6**	**86.0**	**3.6**



Key Points for Non Pay Expenditure:

- The M7 year to date income position is reporting a £3.6m overspend .
- Healthcare organisations are reporting a £2.4m overspend, which is mainly due to underperformance on LTA Inpatient & Day case activity. This variance needs to be seen alongside a Non Pay favourable variance of £2.4m for contracting & commissioning LTAs.
- Catering Income is reporting an adverse variance of £0.5m, following reduced footfall at sites.
- The other income adverse variance of £1.0m includes:
  - £0.5m of reduced injury cost recovery scheme income
  - £0.2m of reduced dental patient charges income

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,026.4	28.5	24.2	80.8	1,160.0
Anticipated Allocations:					
Pay Award 22/23	25.8				25.8
COVID Programmes	5.6				5.6
Other COVID Response	12.7				12.7
Exceptional Costs	17.8				17.8
Substance Misuse	3.9				3.9
Unscheduled Care 6 Goals	3.0				3.0
Value in Health Care Hosting	2.2				2.2
Holiday Pay on Overtime	2.4				2.4
Queens Funeral Bank Holiday	1.2				1.2
Medical Trainees	0.9				0.9
Bands 1&2 NLW uplift	0.2				0.2
Obesity Pathway	0.4				0.4
Other Allocations	1.3				1.2
Total Allocations	**1,104**	**28.5**	**24.2**	**80.8**	**1,237.3**

Key Points for Allocations:

- As at M7 the confirmed revenue resource allocation was £1,160.0m.
- The forecast position assumes a further £77.3m of Anticipated allocations to give a Total allocation of £1,237.3m.
- Recent correspondence from WG has confirmed the assumed allocations for Pay awards, Covid costs and Exceptional items .
- The anticipated allocation for substance misuse of £3.9m, has recently been approved by the Area Planning Board and the Chair has written to WG to confirm the approval and agree the release of the allocation.

Income Assumptions- NHS

	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	30.5	1.7	32.2
Aneurin Bevan University	20.7	1.3	22.0
Betsi Cadwaladr University	0.0	0.2	0.2
Cardiff & Vale University	17.1	1.6	18.6
Cwm Taf Morgannwg University	0.0	0.0	0.0
Hywel Dda University	0.5	0.3	0.8
Powys	2.6	0.8	3.4
Public Health Wales	3.0	0.8	3.7
Velindre	0.0	8.7	8.7
NWSSP	0.0	0.0	0.0
DHCW	1.2	0.0	1.2
Wales Ambulance Services	0.0	0.1	0.1
WHSSC	11.1	0.6	11.7
EASC	0.0	0.0	0.0
HEIW	0.0	12.5	12.5
NHS Wales Executive	0.0	0.0	0.0
Total	**86.6**	**28.6**	**115.1**

Key Points :

- The M7 plan assumes £115.1m of income from Welsh NHS organisations.
- A further £38.5m of non NHS income is also included in the financial plan of which £11.4m relates to Local Authority income and £4.4m for patient dental charges.
- Over the last 2 years there has been an All Wales agreement to support 'stability of LTA income' by retaining a block arrangement based on 19/20 income levels uplifted for inflation. The All Wales agreement has changed for 2022/23 and will transition towards a hybrid Cost & Volume agreement where performance is measured against 19/20 activity levels and variances will impact LTA income & expenditure.
- With current LTA activity levels below 19/20 activity this represents a risk to our income assumptions.
- All LTAs for 22/23 have been fully signed off.

Risk Management
Risks and Opportunities

	Month 7 £m	Month 6 £m	Financial Plan – 30 April £m
Risks:			
Energy expenditure above agreed M6 forecast	tbc	0.0	0.0
COVID expenditure above agreed M6 forecast	tbc	0.0	0.0
New Pay advisory notices leading to increased pay rates and costs	tbc	tbc	0.0
Dental Allocation - risk will be recovered by WG	1.7	0.0	0.0
Additional Bank Holiday – Queen's Funeral	1.2	tbc	0.0
Total risks	**2.9**	**29.8**	**16.1**
Opportunities:			
Potential reduction in Energy & COVID costs below M6 forecast	tbc	0.0	0.0
Annual Leave accrual	(4.0)	(4.0)	(2.0)
Microsoft Contract - Potential VAT recovery	tbc	0.0	0.0
Potential reduction in costs due to RCN industrial action	tbc	0.0	0.0
Total Opportunities	**(4.0)**	**(4.0)**	**(2.0)**
Total	**(1.1)**	**25.8**	**14.1**

Key Points :

- WG have confirmed that Covid costs and Energy costs will be funded up to a maximum of the Health Board's M6 forecasts. Any underspend below the M6 forecast will be returned to WG but any overspending will need to be managed by the Health Board.
- As at M7, the forecast assumes the retention of £1.7m of dental underspends. Initial discussions with WG policy leads indicate this is acceptable, risk that this position changes will deteriorate our forecast by £1.7m.
- The forecast position assumes £1.2m will be funded to cover the additional cost of the bank holiday for the Queen's funeral. This remains a risk until WG confirm the allocation.
- The forecast position has released £6.0m of the annual leave accrual. There is a further opportunity of £4.0m
- There are further opportunities in regards to VAT recovery on the Microsoft contract and potential RCN industrial action reducing pay costs.

Statement of Financial Position

Balance Sheet	Opening Balance (01/04/2022)	Closing Balance as at M06	Closing Balance as at M07	Forecast Closing Balance M12
	£'000	£'000	£'000	£'000
Non Current Assets				
Property, Plant & Equipment	603,871	613,652	616,645	603,871
Intangible Assets	3,596	3,586	3,586	3,596
Trade and Other Receivables	43,216	43,216	43,216	43,216
Total Non-Current Assets	**650,683**	**660,454**	**663,447**	**650,683**
Current Assets				
Inventories	6,856	6,985	7,125	6,856
Trade and Other Receivables	91,571	76,668	66,626	87,571
Cash and Cash Equivalents	438	4,036	4,056	(38,727)
Total Current Assets	**98,865**	**87,689**	**77,807**	**55,700**
Current Liabilities				
Trade and Other Payables	182,269	144,856	161,138	166,503
Provisions	27,052	25,916	16,137	26,152
Total Current Liabilities	**209,321**	**170,772**	**177,275**	**192,655**
Non-Current Liabilities				
Trade and Other Payables	976	976	976	976
Provisions	49,555	49,555	49,555	49,555
Total Non-Current Liabilities	**50,531**	**50,531**	**50,531**	**50,531**
TOTAL ASSETS EMPLOYED	**489,696**	**526,840**	**513,448**	**463,197**
Financed By:				
General Fund	427,163	464,307	450,915	400,664
Revaluation Reserve	62,533	62,533	62,533	62,533
TOTAL	**489,696**	**526,840**	**513,448**	**463,197**

Key Points on the Statement of Financial Position:

- The closing cash balance at 31st October was £4.06m.
- Trade and Other Receivables decreased by £10.0m from M6. This was mainly as a result of the withdrawal of one Clinical Negligence case relating to maternity, with a corresponding reduction in WRP Provisions.
- Trade and Other Payables increased by £16m - RCT LA Systems creditors increased by £5m, Capital creditors by £0.9m and £11m relates to the timing of the processing and payment of the Pharmacy Contractor Services Payments
- The Balance Sheet M12 forecast has been updated to reflect the forecast changes in cash including movements in working balances. The forecast cash shortfall of £38m is discussed on the next page.

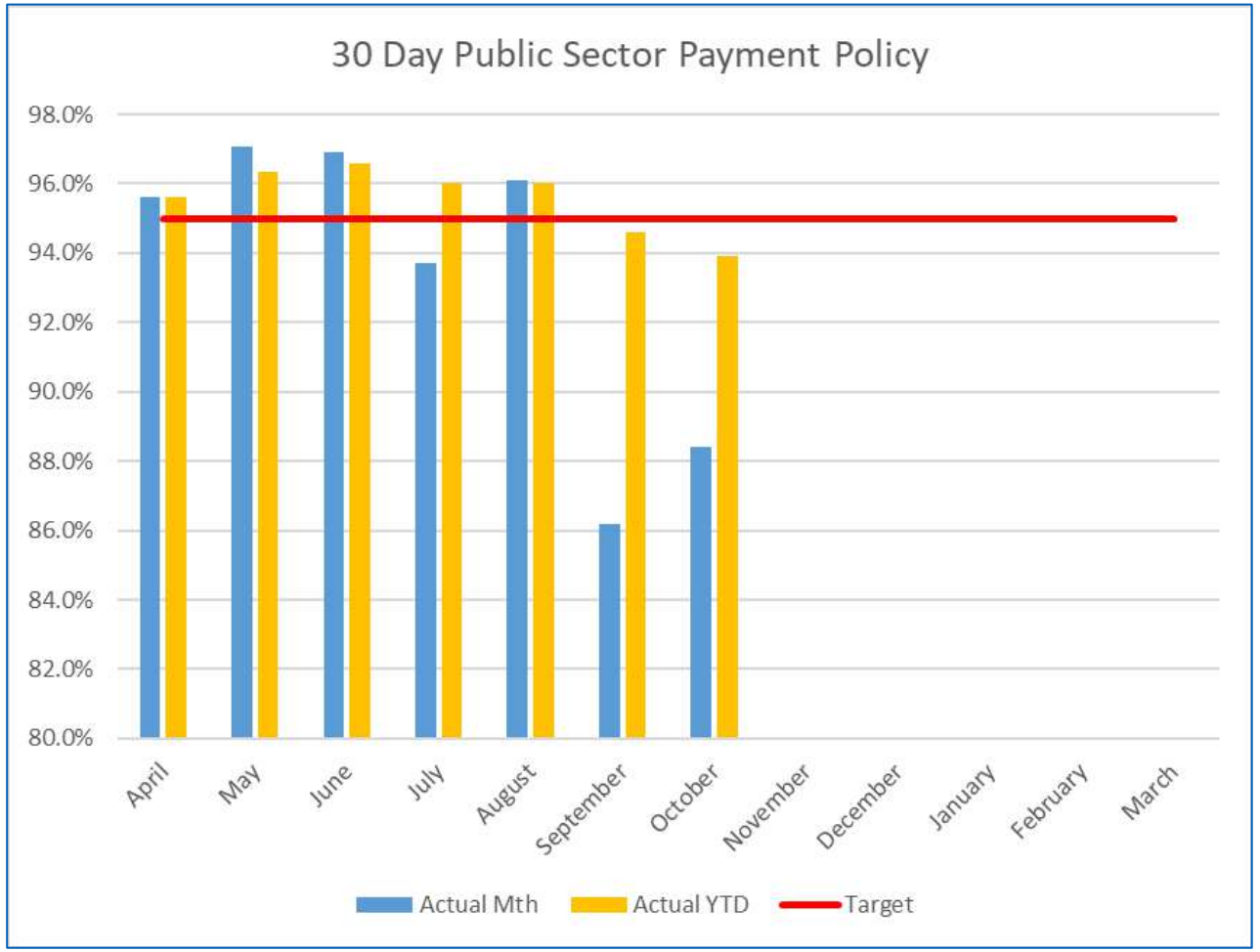
Cash Flow Forecast

Cashflow	Actual/Forecast												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Receipts													
WG Revenue Funding	108,788	99,263	95,000	98,090	102,644	114,275	89,811	107,300	115,300	98,040	104,800	82,732	1,216,043
WG Capital Funding	9,000	4,000	5,000	5,000	6,500	5,000	4,500	3,000	5,000	5,500	5,500	3,602	61,602
Sale of Assets	5	(7)	233	0	0	35	8	0	0	0	0	0	274
Welsh NHS Org'ns	12,037	12,061	16,108	9,633	16,269	9,933	14,186	10,300	10,300	10,300	10,300	10,300	141,727
Other	4,256	6,004	3,238	4,476	3,121	2,669	2,948	2,500	2,500	2,500	2,500	2,500	39,212
Total Receipts	**134,086**	**121,321**	**119,579**	**117,199**	**128,534**	**131,912**	**111,453**	**123,100**	**133,100**	**116,340**	**123,100**	**99,134**	**1,458,858**
Payments													
Primary Care Services	26,653	7,211	19,962	16,489	16,595	28,126	7,118	17,071	28,945	8,750	17,245	17,770	211,935
Salaries and Wages	47,067	50,967	50,466	49,819	49,246	54,113	57,327	50,440	49,750	51,440	51,440	51,440	613,515
Non Pay Expenditure	52,316	51,147	47,978	45,541	55,418	48,347	42,279	51,400	50,000	50,000	50,000	60,464	604,890
Capital Payments	6,433	7,201	4,973	4,275	5,154	3,536	4,709	4,700	5,750	5,250	5,150	10,552	67,683
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**132,469**	**116,526**	**123,379**	**116,124**	**126,413**	**134,122**	**111,433**	**123,611**	**134,445**	**115,440**	**123,835**	**140,226**	**1,498,023**
Net Cash In/Out	1,617	4,795	(3,800)	1,075	2,121	(2,210)	20	(511)	(1,345)	900	(735)	(41,092)	
Balance B/F	438	2,055	6,850	3,050	4,125	6,246	4,036	4,056	3,545	2,200	3,100	2,365	
Balance C/F	2,055	6,850	3,050	4,125	6,246	4,036	4,056	3,545	2,200	3,100	2,365	(38,727)	

Key Points within the Cash Flow Forecast :

- The closing Cash Balance at the 31st October 2022 is £4.056m and the above forecast shows a cash shortfall of £38.7m at the end of the financial year.
- This forecast shortfall includes a forecast Core plan deficit of £26.5m plus a forecast movement in Working Balances of £12.2m and assumes that all Covid and Exceptional cost pressures will be fully cash funded in 2022/23.
- In previous years WG have funded movements in Working balances and we will shortly be submitting an accountable officer letter to WG to seek cash support for the planned Core plan deficit of £26.5m.

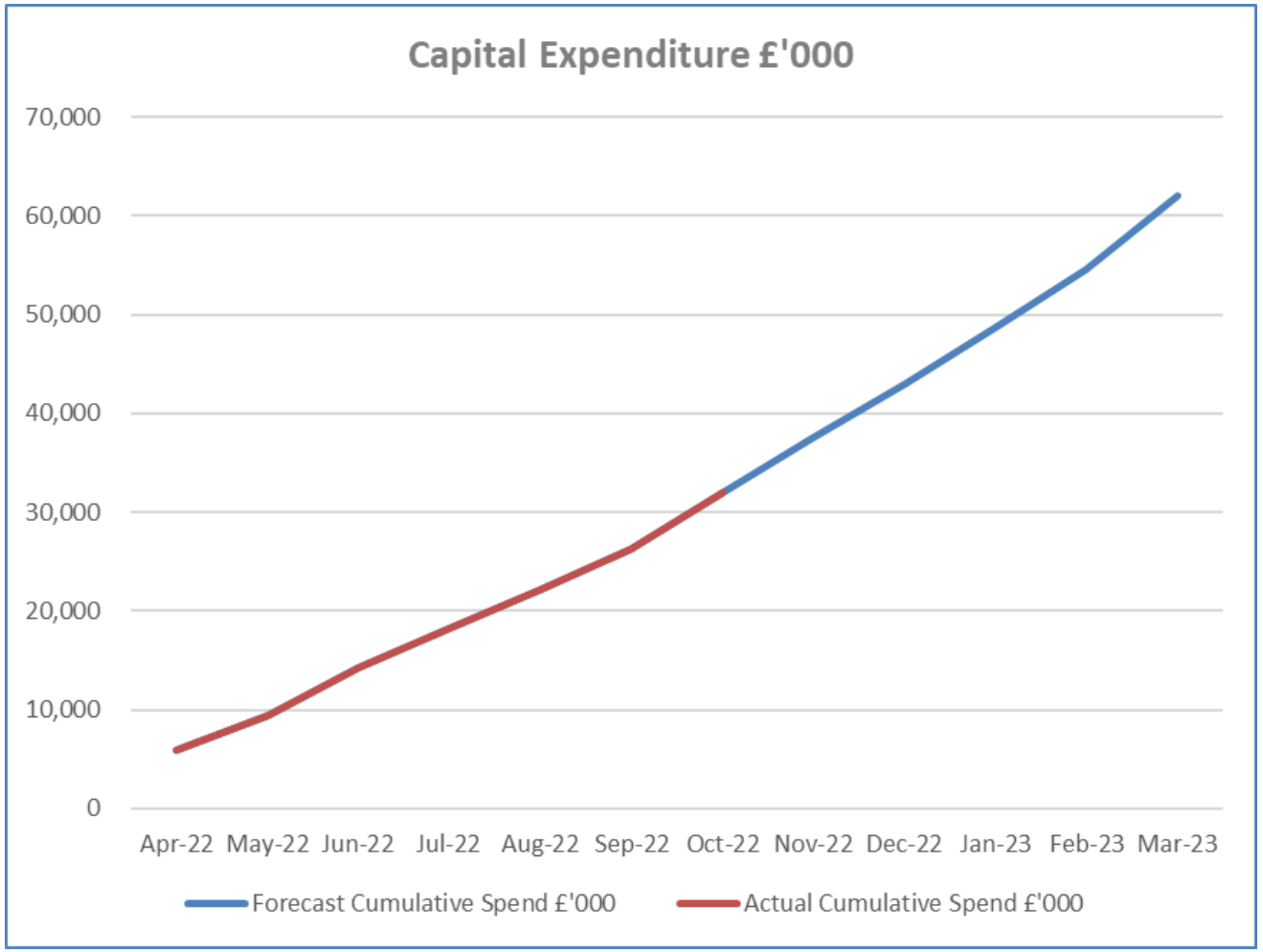
Public Sector Payment Policy



Key Points in the Public Sector Payment Policy :

- Welsh Government have set a target of 95% for non NHS invoices to be paid within 30 days (by number of invoices).
- The percentage for the number of non NHS invoices paid within the 30 day target in October 2022 was 88.4%.
- The cumulative percentage year to date at the 31st October 2022 was 93.9%.
- The target was not achieved in October mainly due to the failure of 1,189 Nurse Agency invoices which accounted for 7%.
- The Agency self-billing process commenced in October and this is expected to have a significant improvement from November, enabling the Health Board to achieve the 95% target for 2002-23.

Capital Expenditure



Key Points in Capital Expenditure:

- The Capital Resource Limit (CRL) of £61.6m was issued on the 31st October 2022
- This is supplemented by £0.1m of donated funds giving an overall programme of £61.7m. Assets with a NBV of £0.2m have been disposed of in this financial year which will also be added to the programme.
- The expenditure to the 31st October 2022 amounted to £32.1m.
- The forecast capital position remains breakeven to the CRL.

AGENDA ITEM
6.2

CTM BOARD

CAPITAL PROGRAMME, 2022/23, MONTH 6 POSITION

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Rosie Cavill, Head of Capital
Presented by	Sally May, Director of Finance, Procurement, Capital and Estates
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Matters discussed at ECMG	(26/10/2022)	SUPPORTED

ACRONYMS	
CRL	Capital Resource Limit
AWCP	All Wales Capital Programme
ECMG	Executive Capital Management Group

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide a month 6 update to the Health Board on the capital resource limit and capital expenditure and an

update on all current major capital projects.

1.2 As a result of the reductions to the 2022/23 capital programme across Wales, all Health Boards' discretionary capital allocations were reduced, this represented a 29% reduction for CTMUHB from the 21/22 position noted in table 1:

Table 1 Discretionary Funding Position

	Recurrent Discretionary pre21/22 £000	21/22 Funding £000	22/23 Recurrent Forecast Discretionary funding £000	22/23 Actual Discretionary Funding
Funding Sources				
Discretionary Capital Funding	10,230	10,945	7,782	6,182
10% Over commitment	1,023	1,095	778	1,051
Total Anticipated Funding	**11,253**	**12,040**	**8,560**	**7,233**
% Reduction from Recurrent			**24%**	**36%**
% Reduction from 21/22 Actual			**29%**	**40%**

1.3 Table 1 shows an opening discretionary capital allocation of £6.18M for 2022/23, after accounting for closing 21/22 adjustments, in addition the Executive Capital Management Group agreed to over commit the programme by 17% to manage inevitable year end slippage in capital schemes and the likely year end capital allocations from Welsh Government, consequently the 2022/23 discretionary funding amounts to **£7.2M.**

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **Discretionary Capital Update**

The month 6 position of the discretionary programme is set out in table 2 and notes all approvals and commitments up to the end of October. It shows that the majority of the programme is committed with £881K contingency held to address both urgent equipment replacements and transformation funding is to be committed on the Ward 16 Princess of Wales Hospital (POWH) surge capacity and other urgent winter schemes.

Table 2 Committed Discretionary Capital Programme

	Month 6 Position £000
Funding Sources	
Discretionary Capital Funding	6,182
Property Disposals	525
17% Over commitment	1,051
Total Anticipated Funding	**7,758**
Expenditure	**-**
Capital Scheme Commitments B/F	
Total Schemes	1,445
Total Funding (Including 10% over-commitment)	**6,313**
Department Allocations	
IT Funding	1,269
ICT Expenditure Allocations	1,269
ICT Contingency Allocation	- 0
Uncommitted Balance of ICT Allocation	**0**
Statutory Compliance Funding	1,171
Statutory Expenditure Allocations	1,120
Statutory Contingency Allocation	50
Balance of Statutory Contingency/Provision	**1**
Backlog Maintenance Funding	1,814
Backlog Expenditure Allocations	1,794
Backlog contingency allowance	21
Balance of Backlog Contingency/Provision	**- 1**
Equipment Funding	944
Replacement Equipment Expenditure Allocations	491
Replacement equipment contingency allowance	453
Balance of Equipment Contingency/Provision	**-**
Service Design and New Equipment Funding	1,115
Service Redesign and New Equipment Expenditure Allocations	758
Service redesign contingency allowance	357
Balance of Service Redesign Contingency/Provision	**-**
Sub Total Committed Expenditure	5,432
SUB TOTAL CONTINGENCY/PROVISION	**881**
TOTAL OVER COMMITMENT AGAINST FUNDED CRL	**1,050**
% Overcommitment Against Funded CRL	**17%**

The spend to date on the discretionary programme is £3.0 which represents 40% of the approved programme.

3. 2022/23 Major Capital Programme

Table 3 shows that the current allocation for major capital projects is £55.4M, the current status and detail of the key projects is provided in the appendix A.

Table 3

	22/23 £000
Discretionary Capital Funding	**6,182**
All Wales Capital Funding	**55,420**
Prince Charles Hospital Refurbishment - Phase 2	48,708
Prince Charles Hospital Refurbishment - Phase 1b	32
Primary Care - Sunnyside	822
National ImagingProgramme	3,080
Fire Enforcement Works - Princess of Wales - fees	397
Anti-ligature works	851
Electrical Infrastructure Modernisation at RGH	86
COVID 19 Recovery Plans	588
National Programmes – Infrastructure	51
National Programmes – Decarbonisation	319
National Programmes – Mental Health	174
DPIF - Digital Medicines Transformation Pre-implementation	17
DPIF - Welsh Patient Administration System (WPAS)	136
Fees Funding – Centralising Decontamination at POWH	59
Fit out and equipping of Innovation and Improvement "Space"	100
Total Approved Funding	**61,602**

3.1 In addition to the above, WG ring-fenced £2M across Wales to improve Emergency Care environments. Following a bidding process they have recently approved £545k to make improvements to Princess of Wales and Royal Glamorgan emergency departments.

3.2 The spend to date on the major capital programme is £28.9M which represents 48%

3.3 The total spend on both discretionary and major capital is £32.0M which represents 47%

4. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 The risk of slippage in approved schemes remains under review with options for expenditure being developed.

4.2 Additional Welsh Government funding as the year continues remains both a risk and an opportunity for the Health Board and the capital team are putting in plans to be able to capitalise on any additional funding that arrives later in the financial year.

4.3 Welsh Government continue to report that the future years capital programme remains under pressure. The Health Board continue to work closely with Welsh Government to deliver and submit business cases to access funding. However availability of funding within the Health Board's required timescales remains a significant risk to the future programme.

5 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	Yes (Include further detail below)
	Legal implication of the capital programme are assessed for each project and advice sought accordingly.

Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The paper describes how capital resources are being directed to support the organisations objectives.
Link to Strategic Goals	Improving Care

6 RECOMMENDATION

The Board are asked to **DISCUSS** and **NOTE** the contents of the report and attached appendix.

Appendix A – Detailed Major Capital Programme Update

PCH Ground and First Floor Programme Phase 2

Phase 2 of the Ground and First Floor Refurbishment Programme, addressing the lifting of the Fire Enforcement Notice on Prince Charles Hospital, is currently in month 24 of a 68 month, £220M programme. Construction began in November 2020 and is anticipated to complete in June 2026.

The works are due to complete in June 2026 and are being delivered in 6 Sections of activity.

- Section 1 – Completed 8th April 2022
- Section 2 – Ongoing. Due to complete December 2022
- Section 3 – Ongoing. Due to complete April 2024
- Section 4 – Due to commence November 2023 and complete October 2024
- Section 5 – Due to commence November 2024 and complete June 2026
- Section 6 – Ongoing. Due to complete March 2023

Section 1 created decant space through refurbishing existing accommodation or providing modular buildings to house services so as to vacate space for the refurbishment of the original hospital.

Section 2 is a refurbishment within the original hospital to relocate Pathology on the 1st floor and is nearing completion.

Section 3 is ongoing refurbishment of the Out-patient, Therapies and Radiology Department on Ground Floor and Maxillofacial, Endoscopy, Oncology and Theatres areas on the 1st Floor.

Asbestos remediation has been undertaken in phases and is nearing completion. Construction of the Roof top plant rooms is ongoing with the independent structure erected for Plant-room A and foundations being constructed for Plant-rooms B and C.

Section 6 car parking enhancement has been completed. The site now provides 1313 spaces with 80 being disabled spaces. Replacement of hospital services infrastructure is ongoing.

To date the scheme has £48.708M funding for 22/23 which is kept under constant review. The sum was uplifted by £4M from the opening funding position. This was due to the pressures on the opening AWCP at WG level, the contractors programme indicated that

an additional £9M over the opening funding position would be required in April. By October this requirement had dropped to £7M and spend including inflation was tracking below the profiled funding level. As a result an increase of £4M funding to the £48M has been agreed and will be reviewed with WG in January with the final in year funding position agreed at that point. The cash flow profile is being managed on a risk share arrangement with WG due to its size and impact on the total capital programme.

Bridgend Heath and Wellbeing Centre (Sunnyside)

Total WG Approved Allocation £000	Previous Years Spend £000	22/23 Opening CRL Allocation £000	Current Year forecast Spend £000	Completion Date
10,707	785	6,332	822	Autumn 2024

Funding of £10.7M was approved by WG in October 2020 for this scheme being delivered in partnership with Linc Cymru. At this point a contractor was appointed by Linc to develop the full site which is a joint housing and health wellness village. In early July 2021 however the contractor (WRW) went into administration. Linc formally terminated WRW's contract and a full tender for a replacement contractor was undertaken. The closing date of 16th February 2022 saw only 2 tenders returned with one party subsequently withdrawing citing capacity issues (and has subsequently gone into administration). The final tender report from Linc's consultants confirmed that the remaining tender had significant quality and qualification issues and did not represent value for money and thus the project has been left without a valid tender from this process.

Recently however Linc have had an approach from two further contractors who didn't submit during the last tender exercise so it would not be possible to engage with them under the current tender process. Concerns remain over how to ensure value for money and procurement requirements as neither contractor wishes to enter a formal bidding process. These issues have been raised with Linc and the Health Board is currently awaiting a formal response from Linc addressing these issues.

Whilst these delays are of concern the greater concern now revolves around the infrastructure of the clinics that are part of the land swap once the building has completed. There are concerns about the safety

of both Bryntirion and Bryncethin Clinics with the latter having been closed and services temporarily transferred to Princess of Wales hospital whilst more suitable accommodation is identified.

National Programme Imaging Funding

Project	Funding Total £000	Actual Expenditure £000 21/22	Forecast Expenditure £000 22/23	Over/(under) Spend £000
POW Gamma Camera	1,080	-	1,145	65
POW Room 4	750	545	345	140
RGH Room 1	650	264	319	-67
RGH Cas Room 1 XR17	650	264	314	-72
RGH Cas Room 2 XR 13	650	264	299	-87
YCR room 2	650	264	467	81
RGH MRI Upgrade	970	794	156	-20
Sub Total Schemes	**5,400**	**2,394**	**3,046**	**40**
c arm	120	182	-	62
Ultrasound Replacement	160	19	-	-141
Total	**5,680**	**2,595**	**3,046**	**-39**

In 21/22 WG confirmed that there would be funding for a 22/23 Imaging equipment replacement programme with a request for organisations to bring forward as much spend as possible. As a result the HB received the funding as outlined in the table above with much of the equipment funding provided in 21/22. As Room 4 at POWH failed in January 2022 and as there was an underspend on the 21/22 MRI and Fluoroscopy funding, it was agreed that via SQT and extension to the existing prime cost contract, the contractor would proceed to undertake room 4 works. However due to the speed at which this commenced the area was not fully designed. In 21/22 there was an £84K overspend on the total imaging allocations which was covered by discretionary and an allocation of £100K discretionary was set aside for this in the February meeting.

Room 4 proved to be a challenging project in terms of infrastructure and ventilation which led to cost increases as reported in the May ECMG meeting. However these works are now complete with commissioning having been undertaken in the week commencing 6th June.

The gamma camera has now been ordered with a 26 week lead time, which is expected to give time to undertake the required detailed design and tender work with the scheme able to complete in 22/23. A recent shared service audit of the ventilation in this area has been undertaken and has identified some additional works required and some issues around compliance. This delayed the issue of the tender, which was published in the week commencing 10th October however works are still due to complete

by March 2023. The install of the camera is currently scheduled for mid February 2023.

The Capital Team have worked with service colleagues to identify the works required to upgrade the DR (general X Ray) rooms in Royal Glamorgan Hospital (RGH) & Ysbyty Cwm Rhondda (YCR). Following a tender process, consultants were appointed to produce detailed specifications and drawings, which have been used to produce a works tender pack published on the 11th October with a tender return date of 31st October. The anticipated start on site is 14th November. Currently the projects are forecast to break even within their total allocations however this will remain a risk until the total amount of works are confirmed and tenders returned.

Works for the install of the MRI at RGH are minimal as the MRI is housed in an area which was subject to the £7M diagnostic hub investment back in 2017/18. However, the installation of the MRI upgrade itself was due to commence on 19th October but was halted due to operational concerns over reduced capacity. A plan is currently being developed by the service to address this issue and the installation (which takes 5 weeks) is now due to commence on 12th January. There is also a need to introduce a separate chiller for the room under updated guidance however this will not add significant cost to the scheme and it is expected that the works will complete in late February. Final costs are being determined and the table will be updated thereafter to show total forecast performance against the Imaging fund to date.

Fire Enforcement Notice at Princess of Wales Hospital Main Theatres

Approved Allocation £000	Previous Years Spend £000	22/23 AWCP allocation £000	Forecast 22/23 spend £000
720	343	397	Tbc

The fire enforcement notice was applied to the main theatre at POWH in December 2018, however the former ABMU Health Board was unable to discharge the full requirements prior to the boundary change. Since that time CTM has proactively worked to discharge the "below ceiling" elements of the notice covering storage and training however the above ceiling elements around the theatre infrastructure have proven more complex.

An initial WG approval in April 2021 released fees to develop a case to create a 6 theatre modular decant on the POWH site to enable theatres to move totally into another unit whilst the above ceiling works are

undertaken to remediate the area. This is due to the fact that the works cannot safely be undertaken with any theatres in situ, even with phased closures due to safety and Infection, Prevention & Control (IPC) concerns around segregation of clean and dirty areas, noise disruption and general Safety concerns.

Work proceeded to develop a design and cost plan, however the changes in the construction market and required procurement framework led to an increase in cost from the estimated £36M to £50M which was reported to WG in January 2022. At this point capital programme constraints led to a WG requirement to revisit alternative decant arrangements and carry out an option appraisal of the same.

Two stakeholder workshops were held over the spring and early summer which concluded that phased theatre closures with out of hours working would still not be an option due to the close adjacencies of wards which could NOT be closed as there could be no reduced bed capacity. As a result the general view was that it may be more effective to close theatres for the works duration but attempt to get works undertaken on extended days and shorten the programme as much as possible. Therefore the project scope became focused on alternative and lower cost decant options for theatres.

To address the closure of theatres plans were considered around the use of "spare" ophthalmology theatre sessions for day surgery to enable the day surgery to be used as trauma and CEPOD (2 theatres) – this will require installation of laminar flow into at least one of the theatres. However it is understood that this occurred during COVID with the emergency theatre so could be managed.

This would not provide additional capacity across CTM to continue to meet ongoing elective theatres requirements in locality so a number of potential options are being investigated from a technical infrastructure and patient safety and flow and overall theatre capacity perspective:

1. 2 mobile theatres and a modular supporting unit out the back of the hospital site on a temporary hire basis. The 2 day theatres would be used for emergency and trauma so this option would mean reduced day surgery capacity and loss of one main theatre capacity (currently running at 5) however suggestions that for a shortened programme could theatres run over extended session days to mitigate some loss of capacity, could sessions otherwise in CTMUHB be used? This is under further development

2. 4 mobile theatres and supporting infrastructure hired for shortened

period – this would be a very high short term cost with no long term benefits to the investment at this level. There will potentially need to be some managing of certain cases across CTMUHB as mobile theatres may not be suitable for all procedures.

5 Instead of mobile theatres an option of permanently increasing theatre capacity in POWH Eye Unit and creating an additional theatre alongside the disused maternity theatre at Royal Glamorgan Hospital is under consideration. Whilst this would require considerable movement of patients across CTM it would result on a long term improved and increased Theatre infrastructure within CTM.

A list of formal options was generated and scored at a second internal workshop on 30th June. Whilst there was no clear preferred option for the formal WG meeting on the 12th July there was an acknowledgement that Do Nothing and Do Minimum (FEN only) works with theatres in situ were not feasible.

In order to progress further a formal option appraisal considering all aspects of the design is required. Over the summer the construction supply chain partner has been checking the technical feasibility and likely costs of all options and alongside this the service, clinical and patient impacts are being evaluated. A fortnightly task group has been set up to develop this into a formal option appraisal to be discussed with WG over the winter. This should identify a preferred option to enable further fees to be funded for a business case which includes a fully tendered preferred option.

A formal update on the progress to date on the discharge of the POWH Fire Enforcement Notice (FEN) was presented to the Health Safety and Fire committee October Meeting, in addition to this a formal update on HB progress was presented to South Wales Fire & Rescue Service (SWFRS) in early October. Concerns remain within SWFRS about the need to identify a deliverable plan. Furthermore a formal review date will need to be arranged with WG to discuss the outcome of the option appraisal.

The Fire Enforcement notice has been extended twice since the Boundary change and is now due to expire on 31st December 2023. It is possible that this requires further extension so regular meetings and discussions are being held with SWFRS to discuss this.

Bridgend Locality Anti Ligature

Approved Allocation £000	Previous Years Spend £000	22/23 AWCP allocation £000	Forecast 22/23 spend £000	Completion date
4,200	3,149	851	851	Oct 22

WG approved the requested sum of £4.2M over the period 20/21-22/23. Works commenced late in 20/21 and significant progress was made during 21/22 with completion of phase 1 comprising Ward 14, Angelton Clinic and POW PICU.

Phase 2 was initially a 35 week programme commencing on 2nd August and included Caswell Clinic, Taith Newydd and Cefn yr Avon. Whilst there have been some delays to the programme caused by Covid restrictions all works have completed apart from minor snagging and a final account is awaited.

In addition the mental health team based in Caswell have requested further works to rooms in Newton ward to support service changes. These works have now been costed, instructed and completed, and will be funded from the scheme contingency.

The core scheme is currently forecast to deliver an outturn underspend which is largely due to VAT savings, as well as scheme savings and efficiencies in delivery, which have meant no need to use contract or overall scheme contingency. At the last CRM there was agreement in principle to use part of the underspend to appoint an architect to undertake design works to address the QAIT concerns at Ty Llidiard. In principle WG are in agreement to the total underspend being used to carry out the design and works however it remains unclear whether this funding will be adequate.

There have been a number of changes to the scope of the Ty Llidiard scheme as a result of further walk-rounds and commissioner and user input. This has led to pressures on the pre tender estimate cost for this scheme. This has gone out to tender and returns and the total cost are awaited for further discussion with WG.

Royal Glamorgan Infrastructure Works – Electrical Infrastructure Phase 2

Approved Allocation £000	Previous Years Spend £000	AWCP Allocation Remaining £000	Forecast 22/23 spend £000	Expected completion date
3,471	3,385	86.291	166.291	Dec 22

Following WG approval of the business case in January 2021, works commenced on site on the 15th March 2021 and were programmed to run for 11 months, completing in early February 2022. Unfortunately works initially experienced a combined 13 week delay associated with changes to layouts of plant areas as a result of supplier specification changes associated with newer technology and the Welsh Government's decarbonisation agenda. In addition, the identification of poor workmanship by a sub-contractor to the plinths and flooring in the switchrooms caused a further 10 week delay (whilst remedial works were undertaken), which pushed the completion date back to late August 2022.

There have also been ongoing issues around the late procurement (and other organisational and coordination issues) by Western Power Distribution, the statutory undertaker, of essential electrical meters meaning substantial further delays. Completion is therefore now expected in late December. As a result the Health Board will incur additional contract costs however the contractor and our external consultants are doing all they can to try to mitigate these and finish in the soonest possible timeframe, and these additional costs can still currently be met from within the uplifted allocation.

Finally, there have also been discussions at Capital review meetings around the need to develop a Business justification case for cooling and ventilation systems. Tenders will be sought for fees to develop this business case.

Centralised Decontamination Unit at POWH

Approved Allocation £000	Previous Years Spend £000	22/23 AWCP allocation £000	Forecast 22/23 spend £000
195	136	59	120

The driver for this scheme was to lift the limited JAG accreditation that was given to the POWH endoscopy unit in 2018 as well as address the infrastructure, capacity and sustainability issues within the current "land locked" HSDU department on the first floor of the main building.

As a result, at a scoping meeting with WG, agreement was made for a Strategic outline case (SOC) followed by a single business justification case (BJC) to be developed looking at 2 options only – single or double storey build to create a separate centralised decontamination unit on the POWH site. A suitable location was identified but involved the demolition of some aged portacabins currently used as offices. Ideally a two storey solution would enable these offices to be located above the new unit otherwise they will need to be found accommodation on the POWH site.

The SOC was approved by ECMG in February 2020 and endorsed by WG in September 20 who released fees to develop the design and business case for WG submission in 22/23.

Since this date, detailed designed development has taken place with the consultants and service lead teams. This has enabled the tender package to be developed to be issued in November.

The pre-planning application (PAC) was submitted on 26th September and as at 17th October no responses have been received. The full planning application will be submitted around 28th October and will take between 8 and 12 weeks to be processed (depending on whether the BCBC decide to take it to Planning Committee).

Planning still remains on course for the business case to be completed in December and January and to go to ECMG at the end of January and to the next Board available post this date, however this remains subject to both the tender and planning outcomes.

Maesteg Hospital

The original plan for this site was to apply for Intermediate Care Funding to develop a scheme to create a Health Park at Maesteg similar to that at Keir Hardie Health Park (KHHP). However a number of early stakeholder meetings took place pre the COVID pandemic but were on hold with the pandemic response. During the COVID pandemic the Maesteg beds were temporarily relocated to Ysybty Seren. Whilst these beds were relocated the Health Board was able to address the roofing issues and strip out the asbestos in the Llynfi ward area. In order to create a compliant ward area an investment of over £1m will be required to create a smaller more compliant unit.

To take the case forward a scoping meeting with WG was held on the 1st November just prior to the commencement of the programme of

stakeholder engagement. This consultation is being undertaken to shape the strategic direction of the site. At the WG scoping meeting it was agreed to reconvene in January after the consultation and engagement process has been undertaken to discuss the outcomes and shape the next steps in terms of business case preparation and timings.

AGENDA ITEM
7.1

CTM BOARD

6 GOALS FOR URGENT AND EMERGENCY CARE PROGRAMME

Date of meeting	24 November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Anna Pepper, Programme Manager
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
	D2RA - Discharge to Recover than Assess BCBC - Bridgend County Borough Council MTCBC - Merthyr Tydfil County Borough Council RCTCBC - Rhondda Cynon Taf County Borough Council RPB - Regional Partnership Board SDEC – Same Day Emergency Care UEC – Urgent and Emergency Care ELG – Executive Leadership Group

1. SITUATION/BACKGROUND

In July 2022 Welsh Government launched the '6 Goals for Urgent and Emergency Care' national programme which sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health.

The Six Goals Programme plan and its delivery must be produced in partnership between health and social care organisations across Cwm Taf Morgannwg University Health Board (CTM UHB). The programme's scope includes areas of work that transcends across boundaries of current health and social care provision. The delivery of the six goals UEC objectives requires extensive redesign of existing pathways, discharge processes and their supporting functions. The principal objective of the programme is to conduct a transition of patient care with the emphasis on integration and delivering care closer to home or within the cluster-based community services.

The six goals UEC Programme consists of four main workstreams:

1.1 **Workstream 1: Admission Avoidance**, the purpose of this workstream is to rapidly develop and implement a robust, equitable and responsive integrated primary/community care solution for the CTM local population, aligning to national best practice and guidance around hospital attendance avoidance. This workstream links directly to Goals 1, 2 and 3 – to ensure that patients get the right care at the right time in the right place irrespective of hospital and system pressures, and are able to stay well at home wherever possible.

1.2 **Workstream 2: Integrated Front Door**, the purpose of this workstream is to rapidly develop and implement a robust, equitable and responsive integrated emergency care front door solution at each of the 3 acute hospitals for the CTM local population, aligning to national best practice and guidance around urgent and emergency care. The workstream aligns to Goals 2, 3, 4, and 6 – to ensure that patients get the right care at the right time in the right place irrespective of hospital and system pressures, and ensure that the EDs are not 'single point of access = single point of failure'.

1.3 **Workstream 3: Acute Hospital Flow & Discharge,** the purpose of this workstream is to rapidly develop and implement a robust, equitable and responsive range of acute hospital patient flow and discharge solutions at each of the three acute hospitals for the CTM local population, aligning to national best practice and guidance around urgent and emergency care. The workstream aligns to Goal 5 – to ensure that patients get the right care at the right time in the right place irrespective of hospital and system pressures, and ensure

that any flow and discharge delays are minimised.

1.4 **Workstream 4: Integrated Discharge**, the purpose of this workstream is to rapidly develop and implement a robust, equitable and responsive integrated discharge solution for the CTM local population, aligning to national best practice and guidance around Discharge to Recover then Assess (D2RA). The workstream aligns to Goal 6 – to ensure that patients get the right care at the right time in the right place irrespective of hospital and system pressures.

The approach of the 'CTM Six Goals Programme for UEC' sets out a long-term future vision of a 'whole system approach to health and social care', where the outlined vision asserts the shift over time from the reliance on traditional hospital services to a seamless approach of integrated care including health, local authority and third sector services, facilitated by collaboration and consultation that empowers local communities.

The Programme structure is being delivered through 24 task & finish groups with defined scope and objectives and reports / escalates issues using agreed programme governance structures.

Current status of programme delivery is Amber.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **Navigation Hub (Backdoor) –** It was agreed in October this year to manage the development and mobilisation of the "Front Door" and "Back Door" elements of the Navigation Hub as separate pieces of work for a period of several months, to best enable the launch of Navigation Hub component supporting discharge pathways to be planned and expected on 5th December 2022.

- Navigation Hub ("Front Door") – triaging UEC 'referrals' from primary care / WAST to signpost patients to out-of-hospital services (supporting attendance avoidance), but where acute conveyance required to signpost to the right element of an integrated front door (supporting admission avoidance).
- Navigation Hub ("Back Door" – Discharge) – referral management centre for supported discharge referrals (including D2RA pathways), streaming patients into the appropriate pathways, and monitoring community capacity, and flow into, through and out of the D2RA pathways.

2.2 Some IT infrastructure envisaged to optimally automate the hub will not be in place by the 5 December 2022, and therefore there has been significant and urgent contingency planning and developing interim manual referral triage processes in order to preserve the launch date and other inter-dependencies. The analysis of data relating to expected demand has informed workforce modelling for the service and need for appropriate staffing provision, including social care workers, discharge liaison nurses and referral management administrative support.

The delivery of the service is anticipated to be cost-neutral, but short-term funding has been secured through Winter Plans submission to finance three band 4 administrative coordinators until the end of March 2023 with the view to confirm sustainable source of funding past this date. This may include service re design, and Local Authority colleagues have been working in collaboration to deliver on a solution. The implementation of the service plays a pivotal role in delivery of D2RA pathways and supporting 'Home First' approach.

2.3 **D2RA –** the preparatory work for implementation of D2RA pathways has been completed and aligned with recent national changes to the delivery of D2RA model. The systems specification of digital enablers (described below) has been appropriately amended to reflect the simplified pathways.

The effective delivery of D2RA pathways is highly dependent on successful implementation of the Navigation Hub (Back Door) and the electronic Transfer of Care (e-Toc).

For noting, we currently assess to discharge within CTM, so this is a priority stream of work that needs to be embedded over the coming months to meet Welsh Government objectives.

2.4 **SDEC** – rapid mobilisation plans have been enacted to ensure delivery of medical and frailty SDEC across three District General Hospitals in CTM by 5 December 2022 supported by approval of a paper on Therapies, outlining multidisciplinary supported discharge team at the front door, with a focus on admission avoidance and returning people to the community when acute inpatient admission is not required.

2.5 **Optimal Flow and Discharge** – standardisation of policies and procedures is underway and nearing completion to include CTM-wide escalation plan, pre-emptive boarding policy, Safe to Start and service operational policies (including Discharge Lounges and Hot Clinics provision on all three hospital sites, and Minor Injury Units in community hospitals). Concurrently to this, the HB has influenced the National SAFER and Red2Green guidance (the national launch is on 6 December 2022). The UHB is also awaiting confirmation of the new All Wales Discharge Policy, which aims to provide a recognised framework that has been legally verified to support discharges of clinically optimised patients**.**

2.6 **Winter Surge Beds** – the plan for Winter surge beds was approved at Executive Leadership Group (ELG) on 14 November as below:

- Ward 16 (15 beds) and 1 ward at YGT (19 beds) – both for clinically optimised patients awaiting home care, and if necessary for those awaiting care homes

- Potential for six D2RA Pathway 3 beds (general nursing) at Brocastle Care Home. This is to be confirmed with the Hafod Group who own the home (D2RA Pathway 3 aims to avoid permanent care home placement direct from acute hospitals)

- Beds at YGT are expected to come on line in mid-December. As a consequence of capital works, ward 16 at POWH will come on line early in January. To mitigate this delay other decant and contingency options are being explored in a bid to bring some of the beds online sooner.

Staffing plans for the CTM beds are still being mobilised at pace.

2.7 **Digital Enablers and Innovation:**

There are a number, including:

a) One List Application /eWhiteboards – full roll out of the application in progress, data specification aligned with national D2RA requirements, Red 2 Green guidance and Pathway of Care Delays KPIs (formerly known as Delayed Transfer of Care), the current solution will be soon superseded by implementation of eWhiteboards across inpatient acute and community wards in CTM UHB to include acute assessment unit. The project is progressing at pace and formal launch of phase 2 system development is planned for 5 December 2022. There is currently a test system within Qlick Sense to view the metrics being collected through One List.
b) Automated referral management system – electronic Transfer of Care (eToC). The development of eTOC is nearing completion. The content of the eToC has been developed in partnership with Local Authority colleagues, allied health professionals and 3rd sector organisations commissioned by the Health Board. The successful application and utilisation of eToC and its functionality is highly dependent on implementation of Navigation Hub (Back Door) service.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

They include:

3.1 Current provision of Government funding (including SDEC, Winter Funding) is limited in scope and funding is not recurrent.

Mitigation: Six Goals UEC programme plans to effectively utilise available funding (SDEC, UPCC) and identify other resource requirements and access other available funds (RIF).

3.2 High demand at the front door and systematic issues with patient flow inhibit effective ring-fencing of specialist beds i.e. for NIV and Stroke patients.

Mitigation: agreement reached to ring-fence interim agreement – monitoring through daily calls on all three sites enacted on 24 October. There is a contingency plan in progress to include prioritisation of set up of "Back Door" Navigation Hub to enable centralised management of e-ToC referrals and discharge support to

enable launch of D2RA pathways and support for flow and discharge processes.

3.3 Workforce (recruitment) – there are difficulties in recruiting into specialist roles, specifically consultant roles in community settings, therapy and pharmacy practitioners (this is a national issue).

Mitigation: need to re-engage with Retinue around efficiency of recruitment process and speed of output, especially regarding the need to adopt a 'head-hunting' approach for difficult to recruit to groups. This is being addressed within Integrated Workforce Sub-group and appropriate assessment will be carried out to provide alternative methods for recruitment.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Effective Care
	Timely Care, Staff and Resources, Individual care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	In progress
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Not yet assessed in detail but included in Care Group planning with Finance colleagues.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

The Board is asked to **NOTE** the progress within the 6 goals programme.

AGENDA ITEM
7.2

CTM BOARD

PLANNED CARE RECOVERY UPDATE

Date of meeting	(24/11/2022)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire Nelson, Planned Care Recovery Lead
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS

1. SITUATION/BACKGROUND

1.1 This report provides an update on Planned Care recovery in terms of how the Health Board is performing against the Welsh Government ministerial measures pertinent to 2022/23 and the steps being taken to improve performance against them.

1.2 The key ministerial measures for 2022/23 are:

- Eliminating waits of over 52 weeks for new outpatient appointments by the end of December 2022

- Eliminating waits of over 104 weeks across all stages of waiting list by March 2023

1.3 Chief Executives were also requested by Welsh Government on 20th September to focus on four specific areas which support the ministerial measures:

- Return to at least 100% of pre-Covid activity levels, prioritising specialties with the largest cohorts on long waiting patients
- Ensure that all patients at outpatient stage 1 waiting over 156 weeks have an appointment by the end of October 2022
- All patients waiting over 104 weeks to be booked into the next available slots
- Allocate at least 60% of activity to cohort patients at Outpatient and Treatment stages (excluding high areas of Urgent Suspected Cancer).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Eliminating waits of over 104 weeks for first outpatient appointments

Due to the volumes of patients waiting over 52 weeks for a first outpatient appointment (stage 1 waiting list), the Delivery Unit requested that Health Boards look to eliminate waits of over 104 weeks by the end of December 2022. We are currently forecasting 3793 waits over 104 weeks in the following specialties:

- Dermatology (1479)
- Ophthalmology (850)
- Ear, Nose & Throat (ENT) (1000)
- Urology (464)

To reach the above figures, weekend clinics and theatres are being undertaken in Ophthalmology between now and Christmas and Super Saturday clinics in ENT. We are in the process of appointing a Locum Consultant Dermatologist and are looking at continued weekend working across the specialties up until the end of March 2022 with additional finance support, to enable all stage 1 waits over 104 weeks to be cleared by this time.

2.2 Returning to pre-Covid activity levels

Monthly monitoring of activity levels at a specialty basis against pre-Covid activity levels for both new outpatients and inpatients/day-cases show that new outpatient activity has increased by 3473 slots or 23% between September and October 2022 with a number of specialties including ENT, Urology and Gynaecology exceeding pre-Covid levels.

The inpatient/day-case position is currently static but is expected to improve from the beginning of December when insourced theatre teams begin work in the Health Board allowing for two additional all day day-case theatres a week and the centralisation of inpatient Orthopaedic activity in the Royal Glamorgan Hospital which increases throughput.

2.3 Total Reported Waiting List

The total reported waiting list in the Health Board has increased between Mar-October 2022:

28/03/2022	31/10/2022	Variance	% increase/ decrease
101,298	106,773	5745	5.4%

The reported new outpatient waiting list has also increased during this time period which can be attributed to increased referrals in Cardiology, Rheumatology and Oral Surgery and an increase in urgent referrals specifically in ENT and Breast.

28/03/2022	31/10/2022	Variance	% increase/ decrease
68,098	74,557	6549	9.5%

2.4 Efficiencies

Treat in turn reports are being produced weekly for Clinical Service Groups (although the information is always available and updated daily on the QLIK Information system) to highlight which patients prioritised as routine as showing have a date in turn (in green) and outside of the >104 week cohort of patients (in red). The intention is to improve efficiencies within existing capacity, allocating all the routine capacity available to cohort patients, alongside increasing capacity with additional schemes where required. Patients in a number of specialties are being managed across the Health Board rather than on a locality basis in order to 'treat in turn' and reduce current inequities in waiting times.

An Outpatients Efficiencies Group has been established to introduce the 6:4:2 to the cancelling and offering out of clinic capacity amongst specialties and look at reducing the number of hospital cancellations of clinics and DNAs and CNAs. An audit of outpatient capacity across the Health Board acute and community sites is being undertaken so that the outpatient footprint can be maximised. The relocation of the Breast Service from RGH outpatients to the new Snowdrop Breast Centre will release

capacity from early 2023 and a number of specialties are looking to utilise this.

2.5 External validation of waiting lists

The company HBSUK who were commissioned by the Delivery Unit on behalf of a number of Health Boards to undertake administration validation of waiting lists over 52 weeks has been working in the Health Board since October. The clerical validation of the waiting list system to check if patient pathways are being effectively managed in terms of duplications, DNAs and CNAs being actioned have had minimal impact in terms of identifying patients that should not be on the waiting list (0% in Dermatology and 2% in Ophthalmology) but provides assurance that waiting lists are being appropriately managed locally.

2.6 Updating of Patient Access Policy

The Patient Access Policy for Planned Care has been updated as although a Cwm Taf Morgannwg Health Board wide policy was produced in June 2020, it provided a strategic overview to managing patient access to Planned Care rather than the operational rules for managing referral to treatment waiting times as set out by Welsh Government. It was evident from reviewing the waiting lists that the rules were not being applied consistently across the Health Board.

The revised Policy along with a quick guide to managing waiting lists in terms of what constitutes a reasonable offer, what to do following a patient that 'Could not Attend' or 'Did not Attend' is shortly to go out for consultation.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Urgent demand for Cancer and Clinical expedites

As highlighted previously, the Health Board is still seeing high levels of urgent suspected cancer and urgent referrals which is the reason why the four specialties set to breach the 104 week target have limited capacity to see patients prioritised as routine within existing capacity. A high proportion of the additional clinics that are being undertaken are firstly managing the urgent referrals, a number of which are waiting a significant amount of time.

3.2 Workforce availability

The ability to undertake additional clinics and theatres is reliant on the relevant workforce being available. Workforce constraints are evident across the system from Medical Records through to Consultant and nursing staff.

3.3 **Winter Pressures**

The severity of the winter pressures experienced by the Health Board could affect the planned care activity which is already constrained by a reduction in beds compared to pre-Covid levels, most notably in Princess of Wales Hospital, although this is currently expanded with the use of Bridgend clinic beds for NHS planned care.

3.4 **Recovery monies**

Whilst it is positive that additional funding has been identified by the Delivery Unit to support the reduction of waits over 104 weeks by the end of March 2022, there is a question over the recovery funding that was allocated by Welsh Government recurrently to Health Boards from the beginning of the financial year and whether this should be managed centrally to enable delivery of specific improvement objectives. As the recovery fund is fully committed within the Health Board, this would have implications for the wide range of schemes that it is supporting. The benefit of the schemes is currently being reviewed by Care Groups.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There are potential unknown harms to patients whilst they remain on a waiting list for a long period of time. There could be potential further harm to patients if capacity remains static. Waiting times will continue to increase in some areas where demand outweighs capacity and additional activity and growth in skillset for a sustainable workforce will be required.
Related Health and Care standard(s)	Timely Care
	Also, Effective Care, Safe Care, Staff and Resources, Governance, Leadership and Accountability.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	This is not a policy or relating to withdrawing of a service.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The CTMUHB Board is asked to **NOTE** the Planned Care Recovery update.

AGENDA ITEM
7.3

CTM BOARD

REGIONAL COLLABORATIVE PROGAMME UPDATE

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elizabeth Beadle, Assistant Director of Transformation
Presented by	Linda Prosser, Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Following a renewed commitment of the chief executives across Aneurin Bevan University Health Board (ABUHB), Cardiff & Vale University Health Board (CAVUHB), and Cwm Taf Morgannwg University Health Board (CTMUHB) to work regionally where clinically appropriate, a portfolio of programmes across Orthopaedics,

Ophthalmology and Diagnostics has been agreed along with the creation of Regional Programme Director role to facilitate delivery.

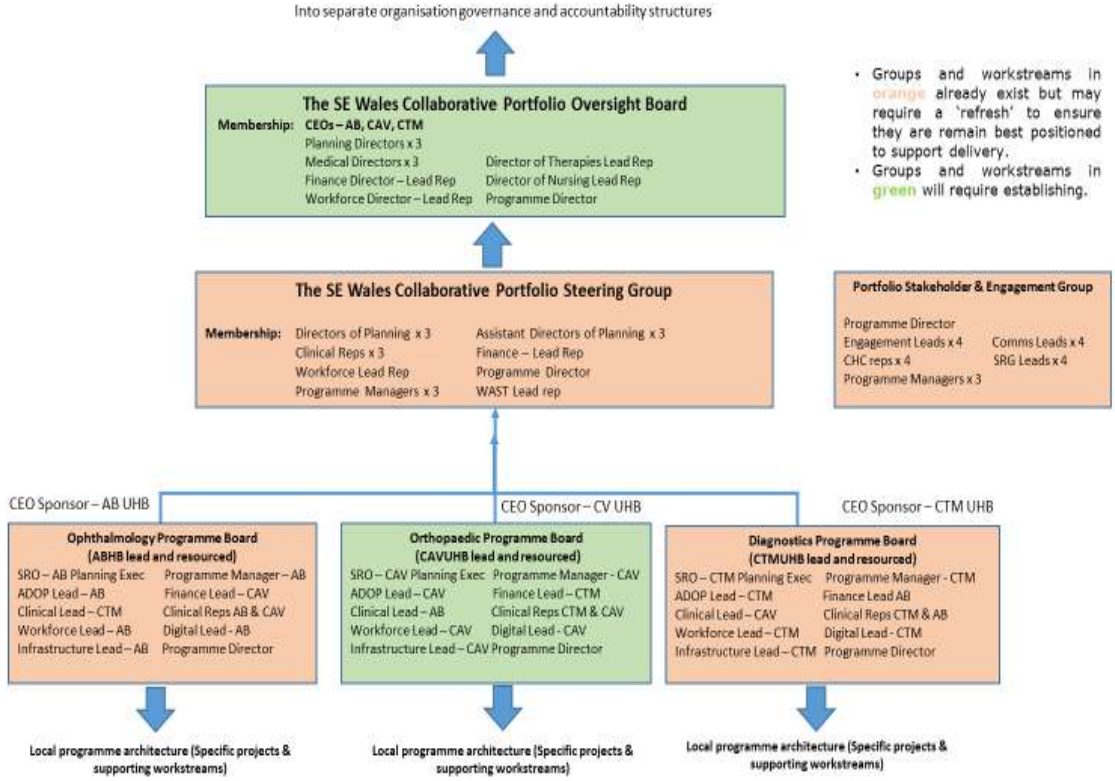
1.2 The objective of the regional programme is to work collaboratively across South East Wales to bring together collective resources, talent and expertise in order to achieve the best outcomes for the populations we collectively serve by giving colleagues the mandate to co-create solutions and plans to meet the collective challenge. Initially, the focus is on the three identified specialities.

1.3 A number of guiding principles have been agreed by the three chief executives.

- Reduce unwarranted variation and inequality in health outcomes and access to services and experience.
- Improve resilience.
- Make effective use of capacity and capability in whichever organisation it sits.
- Create critical mass for effective high-quality care
- Accepting service delivery occurs when and where it makes sense to do so and accepting that may not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources.
- Enable clinical leaders, and others, to work together, lead together and learn together.
- Approach all aspects of the collaboration with benign intent, honesty, transparency, and integrity in order to build trusting and effective relationships.
- Agree approaches to engagement and communications together.
- Avoid leaving anyone behind.
- Establish an effective but not overly bureaucratic governance structure
- Learn from past regional initiatives in an open, honest and humble way.

1.4 A governance structure and approach has been developed to build on existing fora that are operating in the regional planning sphere across the three health boards.

1.5 The image below represents a schematic of the proposed structure to progress this work, and further details are supplied in Appendix one.



1.6 Chief Executives have committed to this regional programme of work and the development of the associated programme infrastructure.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

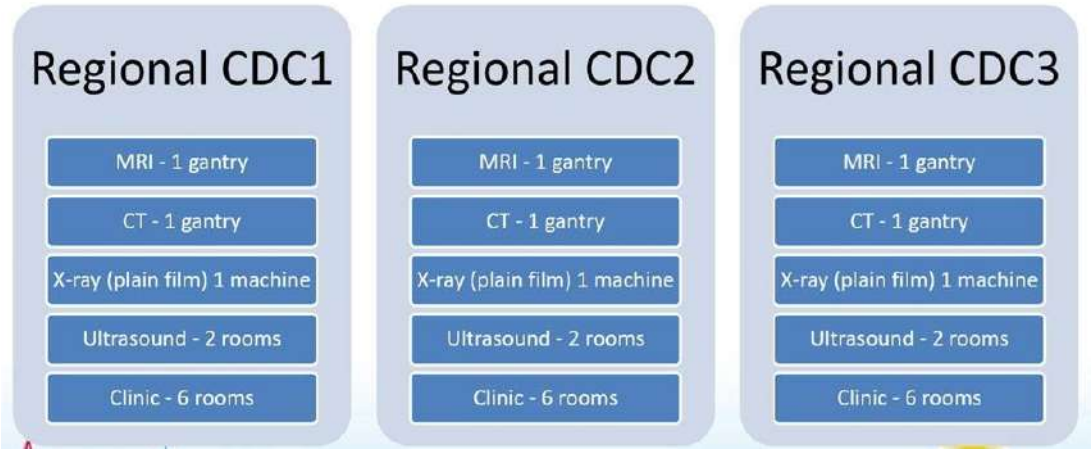
2.1 The Ophthalmology programme is the longest-standing of the regional programmes and is shortly due to deliver a business case for regional cataract service recovery. The business case proposes to utilise hubs in the south and north of the region in a joint outsourcing arrangement to run from April 2023 onwards, subject to funding. The business case is due to be submitted to Welsh Government by December 2022.

2.2 The Orthopaedics programme has appointed a programme manager who is due to commence in post by the end of the calendar year.

2.3 The Diagnostics programme, hosted by Cwm Taf Morgannwg University Health Board now has a programme infrastructure in place, with the exception of the programme board which is expected to hold its inaugural meeting in December 2022.

2.4 Within the diagnostics programme there are three constituent projects. The first is the community diagnostics centre project. Work to develop a specification to procure a regional diagnostics solution comprising between three and nine regional diagnostics centres is nearing completion. This will be presented to the programme board in December.

2.5 The community diagnostic centres are intended to provide a number of modalities, as set out in the image below, with the aim of improving access times to diagnostics across the region. Subject to approval of a business case to Welsh Government, it is anticipated that it would be possible to establish a first unit during 2023-24.



2.6 The regional pathology project board has met twice, with excellent engagement from colleagues across the region. The group has identified initial aims for the collaboration and the supporting project group is being established.

2.7 The endoscopy project has been supported by demand and capacity assessment undertaken by the NHS Wales Delivery Unit and a South East Wales regional plan has been developed to deliver longer-term solutions to endoscopy capacity challenges, with a number of potential options under consideration. This plan will be presented to the National Endoscopy Board during week commencing 7th November 2022.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Key challenges to delivery of the regional development programmes are:

3.1.1 Securing the programme/ project team resources to progress at pace. Programme managers are in place or being recruited to for each programme and additional resource has been sought from regional and national partner organisations, where appropriate.

3.1.2 Capital and revenue to deliver the schemes, however the programmes will all develop robust business cases setting out the value of each proposed case.

3.1.3 Close links are maintained with Welsh Government, in support of business cases under development.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
	Regional planning and service development is intended to provide improvements to
Related Health and Care standard(s)	Safe Care
	Timely care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) Not required at this stage. All service developments associated with regional work will have all appropriate impact assessments undertaken.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **note** the contents of the report and to receive regular updates on progress with regional developments to deliver improved access to care to patients across the regional partnership.

Appendix One – SE Wales Collaborative Programme Governance and Roles

The roles of the Portfolio Oversight Board, Steering Group and supporting Programmes are outlined below:

SE Wales Collaborative Portfolio Oversight Board:

Scope:

The Portfolio Oversight Board (POB) will provide strategic direction to and seek assurance for the delivery of the agreed programmes within the regional portfolio to enable these services to provide safe, sustainable and equitable care across the region by optimising the collaborative opportunity.

Role:

The POB will provide the strategic direction as well as regional and local leadership for the regional programmes and to agree the programmes that should be included within the Portfolio. The POB will also seek assurance for delivery of the programmes within the portfolio against the agreed objective and milestones. The POB will provide assurance to Welsh Government of the partner UHBs' commitment to the development and delivery of effective regional service redesign and delivery.

SE Wales Collaborative Portfolio Steering Group:

Scope:

The Portfolio Steering Group (PSG) will ensure effective planning and coordination of the programmes within the regional portfolio and ensure the Programme Director, Health Boards lead reps and the programme managers are enabled to progress, at pace, the agreed programmes and supporting projects.

Role:

The PSG will ensure the programmes:

- Develop clear objectives and measurable outcomes/benefits for each programme
- Develop consistent and joint approaches to communication, engagement and planning – at programme and implementation level
- Share workforce, infrastructure and other appropriate resources and, in doing so, get the best possible outcomes for all patients within the regional partners' catchment populations.

Specifically, the PSG will:

- Ensure that the appropriate governance and resources are appropriately identified for each of the programmes and secured from the appropriate sources within partner UHBs and expert national resources e.g. NHS Finance & Delivery Unit, Welsh Modelling Collaborative and Digital Health Improvement Wales lead reps to ensure that effective data extraction, demand and capacity analysis and operational modelling methodology is led and supported by these national expert teams across the programmes within the regional portfolio.

- Receive formal Programme Assurance Updates from each of the Programme Board leads to report to POB.
- Ensure the critical risks and interdependencies between the programme plans are clearly identified and either:
    - Explicitly managed within the relevant programmes' plans
    - Escalated to POB with a recommendation for action
- Ensure alignment in the planning and delivery of the Regional Portfolio with the partner UHBs' strategies and statutory corporate plans e.g. Strategic & Operational Programmes, IMTP/Annual Plans, Major and/or Discretionary Capital Business cases.

Programme Boards:

Ophthalmology Programme -

Scope: Regional Eye Service Model, Low Risk Cataract Centre

Role:

To develop the programme governance, programme plan and implementation plan to deliver agreed objectives and measurable outcomes agreed with the POB.

Specifically, the Programme will:

- Develop a clear programme plan with key milestones to meet the agreed objectives for the programme.

- Confirm the key products and timescales required within the programme plan e.g. stakeholder mapping, communications and engagement plan, development of service specification, options appraisal, business case(s), implementation plan

- Ensure that the appropriate governance and resources are deployed to enable the programme and supporting projects and/or workstreams (e.g. clinical modelling, digital, workforce, finance, estates) to operate effectively.

- Ensure that the critical activities to deliver the programme plan milestones are explicitly defined within project/workstream plans and allocated to appropriate leads with delivery timescale and outputs agreed (what/who/when).

- Ensure that risks and dependencies within the programme are clearly identified and reported with proposed mitigation or management plans or escalated to PSG if executive support is required.

Orthopaedics Programme –

Scope: TBC

Role: As Ophthalmology above.

Diagnostics Programme –

Scope: Projects include – Endoscopy, Pathology (Phase 1), Community Diagnostics Centres

Role: As Ophthalmology above

AGENDA ITEM
7.4

CTM BOARD

INTEGRATED MEDIUM TERM PLAN 2023-2026

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elizabeth Beadle, Assistant Director of Transformation
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
IMTP	Intermediate medium term plan
MDS	Minimum data set

1. SITUATION/BACKGROUND

1.1 Developing an intermediate medium term (three-year) plan (IMTP) is a statutory duty for all Welsh health boards alongside the associated duty to achieve a financial break-even position during the three-year period, in accordance with section 175(2) of the National Health

Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014)

1.2 The IMTP is required to align performance, service, workforce and financial planning along with the wider corporate teams' plans.

1.3 During the planning cycle for 2022-2025, undertaken during the last financial year, the health board established that due to the significant current and forecast cost pressures it would not be possible to achieve a financial break-even during the three-year period. Consequently, the planning cycle for 2022 focused on an annual plan.

1.4 Welsh Government publishes a planning framework in support of the IMTP process annually. Indications from Welsh Government representatives are that the planning framework for the 2023-2026 will be provided during October 2022.

1.5 Health organisations will be required to complete a minimum data set (MDS) comprising service, financial and workforce information. This is used to provide assurance on the robustness of plans.

1.6 A further anticipated requirement for this planning cycle is the inclusion of a template for the provision of detailed milestones for the plans for the first year of the next three-year cycle. Such a template has not been a specific requirement of previous cycles although organisations have been expected to provide detailed time-bound plans with milestones.

1.7 The MDS and planning template are expected to be issued in late November with the planning framework.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 The proposed approach for the 2023-2026 IMTP is to be set in the context of CTM 2030 built from service plans for each care group and the corporate portfolios and with relation to partnership planning mechanisms.

2.2 The IMTP will be founded on the principle of seeking to balance service performance and improvement, quality and safety and financial improvement. It is essential that health board teams take as their starting point the ambition to transform services to meet the required expectations within budget.

2.3 The Health Board is forecasting a Core plan deficit for 22/23 of £26.5m, which excludes ongoing COVID costs and Exceptional costs such as energy.

2.4 At this stage it is unclear what the level of WG funding will be for 23/24 for the core plan uplift and also for COVID programme costs, COVID response costs and Exceptional energy costs. Our planning assumption is that this will be a very tight settlement and we have done a very high level estimate of the potential financial challenge for 23/24. This estimate is based on the assumption that WG funding is only provided for the 23/24 pay award, COVID programme costs (but not response costs) plus exceptional costs for energy and the real living wage impact on care homes:

	Best case	Most Likely	Worse case
	£m	£m	£m
Planned Recurrent deficit from 22/23	**28.0**	**28.0**	**28.0**
Forecast financial challenges from 22/23 – Care Groups and directorates (Note 1)	37.1	37.1	37.1
Forecast recurrent overspends – Non Delegated	(3.6)	(3.6)	(3.6)
Forecast recurrent overspends	**36.9**	**36.9**	**36.9**
Covid response costs – estimated impact on Recurrent position if costs not stopped by March 23	**10.6**	**10.6**	**10.6**
Estimated new cost pressures	**21.9**	**32.1**	**42.4**
Total financial challenge	**94.0**	**104.2**	**114.5**

2.5 The intention is to develop a full three-year plan, with the expectation that the plan for the first of the three years will provide more detailed milestones with broader objectives and high-level milestones set for the remaining two years of the plan.

2.6 It is the Health Board's ambition to seek to achieve a financially sustainable position over the period of the IMTP. However, the financial position moving into 2023/2024 presents significant challenges, as noted above, and will require transformational change to deliver savings while maintaining and improving patient care.

2.7 Ministerial expectations for the IMTP will include a requirement for the health board to deliver on the following:

2.7.1 Ministerial priorities and measures

2.7.2 NHS Performance Framework

2.7.3 Outcomes Framework

2.7.4 The four national programmes: mental health, primary care, urgent and emergency care (Six Goals for Urgent and Emergency Care) and planned care (Planned Care Recovery)

2.8 The requirements against which NHS organisations are measured comprise quantitative and qualitative measurement in the NHS Performance Framework and include measures aligned to the quadruple aim and the Health and Care Standards. This incorporates:

2.8.1 Measures for improved health and wellbeing incorporating a number of areas including weight management, diabetes, substance misuse and vaccination.

2.8.2 Planned care deliverables, including the requirement to ensure no patients to wait longer than 52 weeks for new outpatient assessment (delivery date December 2022) and patients to be treated in under 104 weeks.

2.8.3 Urgent and emergency care key measures including number of conveyances by ambulance to a setting other than a type 1 emergency department, time from arrival to triage and definitive treatment.

2.8.4 Cancer screening and cancer pathway delivery measures

2.8.5 Mental health measures for both child and adolescent mental health services (CAMHS) and adult services, which assess access for diagnosis and treatment.

2.9 The graphic below represents the component parts of the planning process at a high level.

2.10 Internal guidance will be provided to care groups for the development of internal service plans along with a supporting template to assist them with setting out these plans. Care groups will have allocated planners from the corporate planning team to support them to develop their service plans and meetings/ workshops will be undertaken with each care group, as required. Planning, Finance and

Workforce and Organisational Development business partners will work closely with care groups to ensure alignment of the plans.

2.11 The timescale for the development of the plan is set out below.

Month	Key activities/ deliverables
October 2022	• Welsh Government Planning Framework is expected – internal guidance will be updated, as required • WHSSC draft plan will become available • EASC planning – lists to support commissioning expected Internal service plans to be commenced
November 2022	Internal service plans to be completed Draft IMTP to be drafted
December 2022	Executive team and committee approvals
January 2023	Board discussion and approval **Submission to Welsh Government 31/01/2023**

2.9 A further key enabler for completion of the Health Board's three-year plan is confirmation from Welsh Government of the financial allocation for 2023-24. This will be fundamental to the assurance of deliverable plans within the Health Board's financial allocation. Welsh Government officials have not yet confirmed a date for notification of the Health Board's 2023-24 financial allocation.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 This report is presented to provide the Committee with the process for developing the Health Board's IMTP for the period from 2023-24 to 2025-26.

3.2 Given the tight timescales for delivery of the plan to Welsh Government by the stipulated deadline of 31st January 2023, planning must commence in advance of receipt of the key planning documents and templates for the submission and in advance of confirmation of financial allocation for the forthcoming financial year.

3.3 This will require service plans and the draft IMTP document to go through several iterations to ensure that it they are aligned with the requirements and expectations of Welsh Government.

3.4 To minimise the risk of requiring major changes, regular meetings are held between the Health Board's Planning Team and Welsh Government's officers.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	The IMTP presents the health board's key priorities and plans to address these during a three-year period. Consequently, the IMTP relates to all Health and Care Standards
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Any service changes described within the IMTP would be subject to EIA at the relevant point in the service development and change process.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
	Provision of a board-approved, financially balanced three-year plan is a requirement under section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014).
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is requested to **note** the requirement for the development of the IMTP and the approach for this year's plan development.

5.2 The Board will be provided with updates on progress, as required and will receive the draft plan for consideration.

AGENDA ITEM
7.5

CTM BOARD

ANNUAL PLAN 2022-23 UPDATE ON DELIVERABLES

Date of meeting	24/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elizabeth Beadle, Assistant Director of Transformation
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Planning Performance and Finance Committee	25/10/2022	NOTED

ACRONYMS	
CTM	Cwm Taf Morgannwg University Health Board
IMTP	Integrated Medium Term Plan
PPF	Planning, Performance and Finance
WG	Welsh Government

1. SITUATION/BACKGROUND

1.1 For 2022-2023 Cwm Taf Morgannwg University Health Board (CTM) identified that it would not be possible to submit a financially-balanced three year Integrated Medium Term Plan (IMTP) and consequently developed an annual plan.

1.2 The Annual Plan was submitted to Welsh Government (WG) and the Health Board received formal notification from Welsh Government on 13th July 2022 that the Annual Plan would be subject to ongoing monitoring via the Performance Framework and Integrated Quality Planning and Delivery (IQPD) meetings between WG and Health Board officials.

1.3 This report provides an update on progress in relation to the development of the level 2/3 weight management service, a brief summary of key quantitative performance highlights in the Performance Framework 2022-23 and details of the recent qualitative reporting submission process.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Annual Plan 2022-23 Progress Update – Weight Management Pathway

2.1.1 A priority action in the 2022-23 Annual Plan was the implementation of the UHB's level 2/3 weight management service for adults with an enhanced level 1 offer (Food Wise).

2.1.2 This work programme is progressing well. The level two service has commenced and recruitment is largely completed across the multi-disciplinary team.

2.1.3 Key metrics have been identified to measure progress with implementation and service process and outcome measures. Further details are available in the formal submission for Welsh Government (please refer to section 2.3 below).

2.2 Welsh Government Performance Framework

2.2.1 The Welsh Government Performance Framework sets out the expectations for organisations to report on delivery against both quantitative and qualitative measures.

2.2.2 The Integrated Performance Report provides the Health Board's Performance against the Welsh Government Performance Framework and other key deliverables for the organisation on a monthly basis.

2.2.3 Key points to note from the September report included confirmation that the UHB is presently compliant with two of the twenty nine performance measures and is making progress towards delivering a further two. There remain twenty five measures where performance is either below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

2.2.4 The report further highlighted that there had been good progress during July in the Adult Mental Health Services measures. Part 1a of the Mental Health Measure has seen an upswing in compliance to 92.3% having been relatively static during the first quarter of 2022/23 at around 78%.

2.3 Welsh Government Qualitative Reporting:

2.3.1 The Health Board is required to report to Welsh Government bi-annually providing qualitative submissions on a suite of nine areas.

- Progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway (Appendix 1)
- Implementing Help Me Quit in Hospital smoking cessation services and to reduce smoking during pregnancy (Appendix 2)
- Progress against the Health Boards' plans to deliver a Same Day Emergency Day Care Service (12 hours a day, 7 days a week) across all acute sites (Reported via Six Goals)
- Progress to develop a whole school approach to CAMHS in reach services (Appendix 3)
- Progress to improve dementia care (providing evidence of learning and development in line with the Good Work – Dementia Learning and Development Framework) and increasing access to timely diagnosis (Appendix 4)
- Progress against the priority areas to improve the lives of people with learning disabilities (Appendix 5)
- Progress of NHS Wales' contribution to de-carbonisation as outlined in the organisation's plan (Appendix 6)
- Evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme (Appendix 7)

- Evidence of NHS Wales embedding Value Based Health and Care within organisational strategic plans and decision making processes (Appendix 8)

2.3.2 The first submission was provided by the Health Board in September 2023, covering the reporting period for quarters one and two of 2022-23. All nine reports are appended to this report.

2.3.3 The Health Board will be required to provide a further submission covering the second reporting period from September 2022 to March 2023 in April 2023. Monitoring and review for this period will inform the development of the three-year IMTP.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD

3.1 Work programmes continue to deliver improvement in service delivery measures.

3.2 The qualitative reporting requirements have been met and progress is being made in the areas supported by the qualitative reporting templates. The full submissions are provided for information.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	The annual plan covers the requirements of all Healthcare Standards.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The IMTP is a strategic document and does not specifically make changes to any policies and services. Any requisite changes will be supported by a full EIA, where required.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Board is asked to **note** the Annual Plan 2022-23 update.

Monitoring & Evaluation Form - All Wales Weight Management Pathway Report

Organisation	CTMUHB	**Allocation**	£439,000	**Date of Report**	14th September 2022	**Report Prepared By**	Gary Howell, Head of Nutrition and Dietetics, Dan Clayton, Principle Public Health Practitioner and Hannah Crocker, Project Lead, Life Sciences Hub Wales

The Deputy Minister for Mental Health, Wellbeing and Welsh Language agreed funding of £6.5m to support the delivery of Healthy Weight: Healthy Wales, which included £2.9m to deliver Pathway Transformation Plans. The Children and Families Pathway is one in a series of documents laying out the components, standards and guidance to support the development and delivery of weight management services across Wales. The pathway sets out the key elements and principles underpinning the planning, commissioning and delivery of weight management services for the population of Wales.

Reporting Schedule: The Adult and Children's Weight Management Pathways timetable for funding and reporting is detailed below:

- Submission of Draft Plan – 30 April 2022
- Peer Review of Plan – 18 May 2022
- Final Sign Off of Plans – 30 June 2022
- Interim Report – 14 September 2022
- Final Report – 14 April 2023

Progress against the organisation's plan is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales

To be completed by Welsh Government on receipt of Monitoring Form

Total allocation	£
Total spend	£
Total agreed	£
Total reimbursement	£

Update on the actions implemented during the current operational year to advance the development of the AWWMP in the health board's day to day activities

	Key actions planned	**Risks to delivery corrective actions & by when** including a timeline	**What was achieved**	**Spend actual and planned** including a breakdown of resource time	**Spend of HB core budget against HWHW**	**Prevention fund investment into pathway L 1&2**
Planning						
1. Ethos of Healthy Weight: Healthy Wales is embedded into service change/transformational programmes and service delivery plans	1.1: Ensure that Healthy Weight: Healthy Wales is a core priority in the HB's CTM2030 strategy for creating health in our population.	RISK 1.1: There is a risk that without strong governance arrangements the ethos and implementation of the strategy will not be met. ACTION 1.1: Establish governance arrangements for WMS linking into CTM Healthy Weights group and Public Health and Primary Care Oversight Group. TIMELINE 1.1: September 2022	1.1: Weight management services are a core priority in the CTM2030 strategy in creating health and improving care (Please see Appendix 1). Strengthening of the WMS governance structure was undertaken to support service implementation, following funding allocation. (Please see Appendix 2). WMS is part of wider "CTM Health Weights" (wider determinants) strategy group. WMS reporting is via the Public Health and Primary Care Oversight Board chaired by the Exec Director of Public Health.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

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	1.2: Align CTMUHB weight management service (WMS) pathways with other HWHW initiatives throughout the health board.	R1.2: There is a risk that patients on other pathways who would benefit from the WMS may be overlooked without alignment of services. A1.2: Aim to have single access point for WMS and members of the implementation board who are involved in other work within health board to ensure alignment.	Healthy people, healthy settings, developing leadership, enabling change and healthy environment are all keen themes within the CTM 2030 strategy and the HB values and behaviours. 1.2: Members of the Implementation Board are engaged in work to align the WMS to other work within the HB, such as All Wales Pre-diabetes programme, local pre-diabetes programme, Fatty Liver pathway development, R&D group, diabetes education and WISE (Wellness Improvement Service) for example. The weight management			

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		T1.2: December 2022	service also reports to CTMUHB's Value Based Health Care board to ensure alignment and realisation of benefits.			
	1.3: Ensure systems in place for continual development of the service.	R1.3: There is a risk that we could miss key opportunities to include novel innovations/transformational programmes into the service that would benefit patients. A1.3: Meet regularly with key R&D, academic and industry partners to discuss the service and research opportunities. T1.3: October 2022.	1.3: Included key stakeholders in the continual development of the weight management service via multi-professional steering group and established WMS R&D group.			
	1.4 Ensure that Make Every Contact Count (MECC) is adopted throughout the health board	R1.4: There is a risk that we won't be treating patients holistically to maximise	1.4: Working closely with the LPHT MECC lead to develop a weight specific programme delivered to priority health			

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Planning						
		patient outcomes at every contact. A1.4: Working closely with local public health team MECC lead to develop training programme for staff. T1.4: On-going.	board staff (primary care, outpatients) as well as wider delivery to local authority staff. This will ensure that non-stigmatising, empathetic behaviour change conversations can take place with all patient groups and residents in CTM.			
	1.5: Ensure sufficient psychological support is embedded into the WMS.	R1.5: There is a risk that some patients will require psychological support to support their weight management as obesity is linked to a range of psychological triggers. A1.5: Recruitment of highly specialist psychologist to inform service development. T1.5: September 2022.	1.5: A highly specialist psychologist has been recruited to ensure all parts of our pathway are psychologically informed and dignified for service users and patients. In many cases there is a need for specialist psychologically informed support through a skilled team of professionals to support positive lifestyle change.			

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Planning						
2. Progress against Level 2 services 2.1 Children and Young People	2.1.1: Establish Children's weight management implementation group in line with weight management governance structure. 2.1.2: Establish business case for children's WMS.	R2.1.1: There is a risk that the Children's WMS implementation group will not be supported by stakeholders. A2.1.1: Establishing good governance arrangements around Children's WMS in line with strategic direction. Work with and influence stakeholders to develop a collaborative approach to business case development. T2.1.1: September 2022 R2.1.2: There is a risk that the Children's WMS business case will not be supported. A2.1.2: Work with stakeholders and executive lead to develop business case based on local needs and identified gaps in service provision.	2.1.1: Children's Weight Management Service Governance Structure reviewed and agreed. 2.1.2: Secured additional senior PHW practitioner resource to support the development of Children's WMS business case.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

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Planning						
		T2.1.2: December 2022.				
2. Progress against Level 2 services 2.2 Adults	2.2.1: Undertake process of discovery with health boards across Wales to support the implementation of the CTM WMS. Explore service set up, pathways, group interventions, workforce core competencies and resource required.	R2.2.1: There is a risk that inefficiencies observed by the other health boards during set up could be repeated by CTMUHB. A2.2.1: Collaborative and preventative conversations between health boards to discuss services and lessons learned. T2.2.1: September 2022	2.2.1: Meetings with other health boards service managers to understand their requirements and lessons learned. Collaborative working and learning from each other. Engagement with CAVUHB, ABUHB, HDUHB and BCUHB to date. Following each meeting the information gathered is shared with our WMS team and discussed at the implementation group. This information is now being used to influence the WMS delivery plan for CTMUHB. Strong working relationships with other WMS have been developed.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

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Planning						
	2.2.2: Establish workforce for CTMUHB L2/3 weight management service.	R2.2.2: There is a risk that the start of the service would be delayed due to issues with staff recruitment. A2.2.2: Improve attractiveness of job descriptions and options for hybrid working offered to incentivise staff. T2.2.2: Please see timelines for recruitment in following box and Appendix 3.	2.2.2: Across the Level 2/3 service we have successfully recruited to: - project support officer - 3x dietitians - 2x dietetic assistants We are actively recruiting to: - Service manager (second time of advertisement, interviews planned for w/c 26th September 2022). - Physiotherapist (interview planned for end of September 2022) - 2x administrators (interview planned for end of September 2022). - 2x dietitians (interviews w/c 26th September 2022).			

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	2.2.3: Validate Adult WMS waiting list.	R2.2.3i: There is a risk that the number of patients on the waiting list will outweigh the capacity of the new WMS service, as there are currently 894 patients on the WMS waiting list. A2.2.3i: New waiting list validation process established and implemented. T2.2.3i: September 2022. R2.2.3ii: There is a risk that the admin processes could cause delays as there is currently limited admin capacity to undertake the validation process. A2.2.3ii: We have advertised additional admin posts and offered additional admin time to therapies admin staff.	2.2.3: New waiting list validation process agreed and commenced. Letters sent to patients to establish if they still require WMS and to identify preferences of service delivery (face to face or virtual). To support patients with the virtual groups we have linked with NHS virtual volunteers who support patients to get online. Also established weekly highlight reports/dashboard on validation process to track numbers of validation letters sent and patient responses.			

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	2.2.4 Standardise outcomes within CTM WMS multi-disciplinary team. 2.2.5: Develop single point of access, referral criteria, pathways and design interventions to meet the needs of our population.	T2.2.3ii: September 2022. R2.2.4: There is a risk that poor reporting of minimum data set will lead to an uncoordinated approach to outcomes and benefits. A2.2.4: Development of a WMS outcomes framework including process around reporting and alignment into current HB digital systems. T2.2.4: October 2022. R2.2.5: There is a risk that the start of the service will be delayed due to this being a new service and all pathways, referral criteria and patient information needs to be developed and refined through quality	2.2.4: WMS outcome framework being developed to support the reporting of the WG minimum data set and the collection of PROMS and PREMS. This will ensure a coordinated approach across the service and by each professional group. This work is being supported by the HB's VBHC team. Further work is required to establish digital integration of outcomes framework once this is established. 2.2.5: Networking with other WMS, leading to sharing of information. Understanding of their mistakes in implementation and lessons learned has			

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		improvement process, which will take time. A2.2.5: We have met with other HBs to understand their service configurations, pathways, referral criteria and group interventions. Reviewing this information and establishing the local procedures are the priorities of the newly appointed clinical lead dietitian and psychologist. T2.2.5: November 2022	helped refine our own implementation. Digital options for single point of access are being developed via MS forms. Clinical psychologist post commenced 6th September 2022 and we have negotiated early start for clinical lead dietitian (started 1 day week 26th Aug 2022) who will review the other HB information and develop local procedures. They will also review the emotional regulation offer for L1/L2 services and the CAVUHB "Eating for Life" programme. Met with CTM stakeholders such as primary care directorate, WISE (Wellness Improvement			

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	2.2.6 Commence level 2 WMS groups (virtual and face to face).	R2.2.6i: As per risk 2.2.3 and R2.2.6ii: There is a risk that there will be a delay to the L2 service delivery as we will need to develop group content, patient information, pathways etc. prior to the implementation of the service both virtually and face to face. This programme will also need to be tested and validated to meet the L2 offer. A2.2.6ii: Agreement with CAVUHB to utilise their 'Eating for life' programme to ensure short timeframe	Service), Liver MDT and Staff Wellness Service (WM service) to ensure alignment of services, collaboration and development of integrated pathways. 2.2.6: Collaborative working with CAVUHB WMS to ensure quicker implementation of service, through the use of 'Eating for Life' programme. Tailoring of service planned upon recruitment of professional service manager, WM specialists and feedback from patients. Through waiting list validation, patient can choose mode of delivery (face to face or virtual) to meet			

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		from recruitment to service delivery. T2.2.6ii: August 2022.	their needs, including support to help digital inclusion.			
	2.2.7: Secure project management support for L2/3 WMS implementation.	R2.2.7: There is a risk that without coordinated project management support and in the absence of the service manager (due to recruitment difficulties) the implementation of the L2/3 WMS would be piecemeal and will not deliver at the pace that is required for our population. A2.2.7: Project management support secured from Life Sciences Hub Wales for the implementation of the L2/3 adult WMS. T2.2.7: July 2022	2.2.7: Due to recruitment issues with the service manager post we identified the need for senior project management support. With the support of the UHB's Project Management Office we have secured project management support from Life Sciences Hub Wales to develop an implementation plan and support its implementation.			

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Planning						
	2.2.8: Develop communications plan for L2/3 WMS.	R2.2.8: There is a risk that poor communication of service to health professionals and service users will result in the service not reaching desired target population, or poor referrals with lack or limited information. A2.2.8: Develop communication plan to cover launch of service, how to refer and single point to access. Engage with CTM communications team. T2.2.8: October 2022	2.2.8: Working with stakeholders to engage with service design and ensure pathway alignment. Communication plan to be developed in October 2022 and meet with CTM comms team to discuss plans, social media presence and how best to communicate new service information.			
2. Progress against Level 2 services 2.3 Maternity	2.3.1: Continue to deliver Bump Start service for those with BMI > 40.	R2.3.1: There is a risk that there will be no dietetic workforce to support the delivery of Bump Start. A2.3.1: Develop business case for dietetic support for Bump Start and to ensure on-going quality assurance of nutritional component of service.	2.3.1: This service has been running for 7 years, and is provided by public health midwives. BMI > 40 accounts for 8.2% of the population in CTMUHB and 93% were referred (reasons for non-referral include late	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

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Planning						
		T2.3.1: December 2022.	miscarriage, late booking. Transfer in late, moving out of area). 83% of referrals engaged with the service, which has risen since last year. The average weight gain during pregnancy was 4.4 kg (gradually decreasing year on year), the low birth rate was 7% (only 1.1% of these were term babies, compared to 1.5% last year). 0.4% still birth rate within this BMI group (however all still births did not engage with the service). Learning shared with All Wales Weight Management Pathway Group.			
	2.3.2: Expand upon current service to include those with BMI 35-39.9.	R2.3.2: There is a risk that the service will not align with HWHW due to the	2.3.2: First full year of service complete. BMI 35-39.9 accounts for			

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Planning						
		limitations of the BMI inclusion criteria. A2.3.2: Review BMI inclusion criteria and impact on service demand and capacity. T2.3.2: December 2022.	11% of pregnant population and is provided by community midwives. 89% were referred to the service. Average weight gain during pregnancy was 7 kg, low birth rate was 7.3% (2.6% were full term babies). Further outcomes and acceptability of the service is about to be audited. Quality improvement within maternity supporting development of service. Breastfeeding rates have increased from 46% (20-21) to 50% (21-22). Continue to align maternal weight management support with adult weight management offer and Children and families pilot in Merthyr (PIPYN).			

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Planning						
3. Progress around Level 3 services 3.1 Children and Young People	3.1.1: Establish Children's weight management implementation group in line with weight management governance structure. 3.1.2: Establish business case for children's WMS. 3.1.3: Ensure the most vulnerable children with high complexity are offered weight management advice.	As per section 2.1.1 As per section 2.1.2 R3.1.3: There is a risk that the number of patients requiring unfunded dietetic services may out-weigh the service capacity. The current dietetic offer to children with highly complex needs is not part of a formal pathway or MDT but is based on individual clinical need. A3.1.3: On-going monitoring of referral numbers into dietetic 1:1 clinics. T3.1.3: On-going.	As per section 2.1.1 As per section 2.1.2 3.1.3: In the absence of a formal Level 2/3 Children's weight management service, 1:1 dietetic led services are offered to a small subset of children referred with the most urgent need. Assessment of need is based on individual referrals. Between June and Aug 2022, 50 referrals have been received and either seen by dietetics or signposted to first line advice or HENRY.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

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Planning						
3. Progress around Level 3 services 3.2 Adults	In addition to the progress outlined in level 2 adult service (section 2.2) the following describes specific activity targeted at level 3. 3.2.1: Establish workforce for Level 3 weight management service.	R3.2.1: There is a risk that the start of the service will be delayed due to issues with staff recruitment. A3.2.1: Improve attractiveness of job descriptions and options for hybrid working offered to incentivise staff. Work with medical directorate regarding job planning of consultant lead post and nurse post. Work with primary care directorate for GPwER post. T3.2.1: Please see timelines for recruitment in following box and Appendix 3.	3.2.1: In addition to the staff described in 2.2.2 Level 2 adult service, we have successfully recruited to the psychology lead (6th Sept 22). We are actively recruiting to: - 0.2 WTE Secondary care consultant lead – Adding 0.2 wte to existing job plans is proving difficult therefore in decision with medical directorate they are advertising a 0.6 wte diabetes role which will allow job planning of Diabetes and	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

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			Endocrine consultant to support WMS lead post. Currently out to advert (closing on 29th Sept 22). - GPwER – Working with primary care directorate to develop the expression of interest and GPwER scope and job roles prior to advertising. - 0.2 wte Band 7 nurse, discussions are ongoing with medical directorate around this role and how best to utilise. We are exploring the option of combining this within an existing diabetes nurse post. - Physiotherapist role. Currently exploring internal expressions of interest to scope physiotherapy service			

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	3.2.2: Develop appropriate pathways for the use of weight loss medication	R3.2.2: There is a risk that the pathway and number of referrals for Saxenda will be inappropriate as the number of patients eligible to receive weight loss medication Saxenda is unknown in CTM and there is currently no local pathway for its use. A3.2.2: Recruit to secondary care consultant to provide oversight of pathway development. T3.2.2: November 2022	needs. Interviews planned for end of September 2022. 3.2.2: Engaged with medical directorate, executive director of public health to expedite job planning and recruitment to secondary care consultant. Engaged with other health boards, pharmacy and Novonordisk around Saxenda pathway. Currently exploring option of GPwER prescribing (learning from ABUHB experience) if unable to recruit to secondary care consultant.			

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	3.2.3: Undertake L3 service location appraisal.	R3.2.3: There is a risk that the location of the service may not be the most appropriate for this patient group. A3.2.3: Early discussions and involvement of Health & Safety team to ensure appropriateness and maintain patient dignity and safety. T3.2.3: July 2022.	3.2.3: Location confirmed for Level 3 MDT service. Newly refurbished bariatric space in Dewi Sant Hospital & designated time in new outpatients clinic space in St Marks building on RGH site. Met with Health and Safety team regarding clinic space. All equipment purchases are supported by health and safety team to ensure patient dignity and safety.			

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Planning						
4. Comments/updates on Level 1 and Level 4 4.1 Children & Young People Level 1 Weight Management Service Update	4.1.1: Continue planning and development of Children and Families Pilot Merthyr (PIPYN) and its referral pathway and criteria. 4.1.2: Delivery of a range of evidence based services through Public Health Dietetics / Nutrition Skills for Life: - 2x Community Food and Nutrition Skills for the Early Years - 2x Community Food and Nutrition Skills for schools - Healthy Snack Award	R4.1.1: There is a risk that the service will outweigh the capacity of the dietetic and school staff. A4.1.1: Additional funding approved by WLGA to pilot dietetic coordination in Merthyr. T4.1.1: from September 2022. R4.1.2: There is a risk that there will be insufficient staff as recruitment to key roles has been problematic. A4.1.2: Local public health team resource has been utilised to support programme implementation. T4.1.2: from September 2022.	4.1.1: Steering group met and TOR developed. Recruitment of family support workers and administrative staff. Family engagement questionnaires produced. 4.1.2: Delivery of a range of evidence based services through Public Health Dietetics / Nutrition Skills for Life and Community Food and Nutrition Skills for Schools. Continued to try to recruit and to be flexible within the roles. Utilise underspend to recruit ex-head teacher to support planning of the programme.	Please see Welsh Government quarterly return for Children's and Families.		

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	4.1.3: Increase knowledge, referrals and uptake of HENRY.	R4.1.3: There is a risk of low level engagement with the programme from both referrers and families. A4.1.3: In-house awareness sessions developed to be delivered to health and wider key stakeholders. Additional sessions added to the service offering (virtual, face to face, 1:1 and evening sessions) to increase uptake for working families. T4.1.3: On-going.	4.1.3: Between September 2021 and June 2022, 5 cohorts of 'HENRY – Raise, Engage, Refer' have been delivered to 51 partners from health and social care professions. Each consists of two online sessions. LPHT HENRY Awareness programme created – 36 professionals currently on waiting list for this. This training will now be delivered on-going to health and social care staff. New Standard Operating Procedures developed for HENRY Waiting Lists to manage referrals and parent contact. Webpage and SharePoint page being created for HENRY.			

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			Social media post on Healthy Start Healthy Future reaching over 10,000 views/interactions. KPI agreed for all referred families to be contacted to discuss HENRY programme. Please see Appendix 4 for parent survey overview.			

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4. Comments/updates on Level 1 and Level 4 4.2 Adults Level 1 Weight Management Service Update	4.2.1: Delivery of a range of evidence based services through Public Health Dietetics / Nutrition Skills for Life	R4.2.1: There is a risk that the cost of venues in communities may be too high for the budget and recruitment and retention of dietetic staff. A4.2.1: Key relationship building with stakeholders in leisure facilities to enhance partnership engagement. Wider advertisement of dietetic workforce in light of national workforce shortages. T4.2.1: December 2022	R4.2.1: Launch of level 1 website content and electronic self-referral system for self-booking. Dietetic triage of patients implemented Delivery of a range of evidenced based services through Public Health Dietetics /Nutrition Skills for Life: - 2x Level 2 Community Food and Nutrition Skills - 10x Foodwise (72 patients) - 10x Get cooking (starting Sept 22) Marketing & Comms plan developed to enhance community and partnership engagement.			

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	4.2.2: Roll out of All Wales Diabetes Prevention programme and local CTMUHB pre-diabetes brief interventions. Ensure pathways into WMS. 4.2.3: Re-establish the Joint Care Programme (JCP) to pre-pandemic levels of referral and uptake.	R4.2.2: There is a risk of delays to the programme due to short term funding, general recruitment delays as well as recruitment and retention of registered dietetic staff. A4.2.2: Restructure of public health dietetics team and wider advertisement of dietetic workforce in light of national workforce shortages. T4.2.2: Sept 22 R4.2.3: There is a risk of low patient engagement due to lack of referrals from other HCP's into Level 1 services. A4.2.3: Wider communications plan being developed alongside self-referral option. T4.2.3: September 2022.	4.2.2: Restructuring and recruitment of dietetic staff on a permanent basis. Engaged local clusters, implementation groups established. Learning from AWDPP and local CTM pre-DM work. Monthly CPD and supervision provided by dietetic staff with direct referral into Foodwise. 4.2.3: Launch of level 1 website content and electronic self-referral system for self-booking. JCP also accepts referrals from primary and secondary care. Dietetic triage of patients implemented Equipment purchased to support roll out			

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			and community engagement work Roll out of JCP pan CTMUHB. BMI referral criteria reduced to ≥25kg/m2 - September 22 to align AWWMP.			
	4.2.4: Develop level 1 local content to feed into NHS Healthy Weight website	R4.2.4: CTM local content will not be available on an All Wales NHS platform. A4.2.4: Develop local level 1 content. T4.2.4: Sept 22.	4.2.4: Local content fed into central public health team.			
	4.2.5 Align the new CTMUHB staff "Healthy Lifestyle" course to the HB weight management service.	R4.2.5: There is a risk the new staff healthy lifestyle course will not be aligned to the HB WMS offer, the HWHW pathway and therefore not benefit from the expertise and pathways of the service.	4.2.5: 10 week Healthy Lifestyle course developed by CTMUHB wellbeing service with support from public health dietetics. 4 courses completed since Jan 2022. Staff Wellbeing			

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Planning						
		A4.2.5: Engage staff wellbeing services and align pathways and service criteria with HWHW. Establish if offer is L1 or L2. T4.2.5: October 2022	lead is stakeholder on WMS implementation group. Further work required to align pathways for each service, but good collaboration between services has been demonstrated. Please see Appendix 5 for overview.			
	4.2.6: Align adult WMS pathways with Wellness Improvement Service (WISE).	R4.2.6: There is a risk that WM pathways will not align between WISE and the new WMS. A4.2.6: Ensure WISE are represented within the implementation group. Collaborate with WISE and Primary Care services to align pathways and service criteria with HWHW. Establish if offer is L1 or L2 and need for triage. Explore option for WMS waiting list. T4.2.6: Oct 2022	4.2.6: The Wellness Improvement Service (WISE), developed by the Primary Care team of CTMUHB, will be offering patients from the pre-diabetes and cardiovascular risk programmes opportunities to utilise Second Nature as an additional weight management programme for patients. Primary Care are represented on the Implementation			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Planning						
			Group to ensure dovetailing of services and appropriate referral for patients. Initial meeting between WMS and WISE has taken place and pathway is being developed.			
4. Comments/updates on Level 1 and Level 4 4.3 Level 4	4.3.1 No Level 4 service available as this is a WHSCC commissioned service provided by Swansea Bay UHB.	N/A	N/A	N/A	N/A	N/A

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
5. Each Health Board publishes a strategic weight management pathway development plan, agreed with Welsh Government. The plan should set out: an assessment of need to inform priorities for action; a phased development plan; a description of services at each level of the All Wales Weight Management Pathway for adults, children and those with specific needs e.g. pregnant women.	5.1: Submit the strategic weight management pathway development plan to WG.	R5.1: Funding is the main risk to the expansion of the weight management service to include children and young people. Currently the fixed term WG funding and recurrent HB funding has been prioritised towards the development of an adult integrated service. Prior to 2022 there was no historic investment for WMS in CTMUHB. A5.1: Business case development for Children and Young People's WMS. Additional resource from LPHT secured to support the development of the business case. T5.1:Dec 2022	5.1: Many aspects of the pathway development plan have progressed in the recent months including: - Establishing recurrent HB funding - Agreeing hosting of service within dietetics - Establishing the governance structure and internal reporting for the service - Securing external project management support from Life Sciences Hub Wales for development of L2/3 adult WMS implementation plan. - Several key roles have been recruited into as described above and on-going recruitment continues at pace. - Received recognition from steering group to deliver on the implementation plan.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
			- Validation process of WMS waiting list established and ongoing. - Support provided for digital inclusion to support hybrid offer - Commenced Level 2 adult groups. - Base for service agreed as Keir Hardie Health Park and staff moved into office space. - Working with stakeholders and networks to learn from others, to establish lessons learned and implement at pace.			
6. Health Boards can demonstrate how services in the strategic weight management pathway development plan will meet the needs of the population and reduce inequalities in outcomes. Health Boards should be able to demonstrate that services are: accessible; targeted to specific needs where appropriate and;	6.1: Develop business case for Children and young people weight management service to be considered by the health board.	R6.1: There is a risk that the business case development will be delayed due to limited resource and availability of staff. A6.1: Secure LPHT resource, recruit to	6.1: Established new governance structure including a Children and young person's implementation group, which will provide focus on this aspect of the service.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
that monitoring of service uptake considers equity of access for vulnerable groups. Health Boards should report annually on service capacity at each level of the pathway.	6.2: Develop multi-stakeholder steering group to support delivery of the development plan	service manager post, galvanise support for Children's WMS with clinicians and stakeholders. T6.1: December 2022 R6.2: There is a risk that there is disconnect between the strategic direction of the organisation (CTM2030), HWHW, the delivery of the WMS and other services. A6.2: Engagement from wider stakeholders and development of WMS steering group. T6.2: Sept 22	6.2: Steering group established with deputy director of public health as chair. Wide ranging multi stakeholder representation. Further work required on engagement of external stakeholders and patient feedback and co-production events.			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
	6.3: Hybrid adult service offer to support efficiencies in service delivery and patient choice. 6.4: Service to be delivered as close to the persons home as possible	R6.3: There is a risk that the lack of patients' digital skills may prevent them taking up the option of virtual appointments / programmes. A6.3: Engaged with NHS digital volunteers to support digital inclusion prior to appointments. T6.3: Sept 2022 and ongoing. R6.4: There is a risk that there will be a lack of suitable accommodation in community venues. A6.4: Scope local venues. Currently central location within HB with good public transport links, with aims to identify	6.3: Digital inclusion questions added to validation letters. Offer of additional support to get online provided. Engaged with NHS digital volunteers to support patients prior to appointments / groups. 6.4: Scoping of suitable community venues for L2 adult service is currently underway. In addition a list of commonly used venues and contact details has been developed. Working with therapies services to establish wider accommodation need for community			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
		additional locations throughout HB to accommodate those living further afield T6.4: October 2022	venues, work with leisure partners on availability of venues. Level 3 service will be based in Dewi Sant hospital where the lymphedema service is co-located, environment is bariatric friendly and has been reviewed by health and safety.			
	6.5: Planned activity around seldom heard groups to increase service engagement	R6.5: There is a risk that seldom heard groups will not have equitable access to service provision. A6.5: Data collection on demographics essential to describing population. T6.5: Ongoing	6.5: Referral population data reports need to be developed and evaluated. Monitoring of service uptake and will consider equity of access for vulnerable groups. Collaborative working with HBs VBHC team to identify any under-represented groups. We have developed a piece of qualitative research with Promo-Cymru to understand			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
			the enablers and barriers to attendance for patients who are overweight / obese and are also pre-diabetic. A series of interviews and workshops will take place to inform service delivery across pre-diabetes and weight management community deliver.			
7. People with higher body weights are treated with dignity and respect and do not feel stigmatised due to a lack of appropriate equipment or facilities. This includes patient transport and emergency services.	7.1: Review outpatient locations and equipment available to ensure dignity and respect is maintained.	R7.1: There is a risk that patients will not be treated with dignity and respect due to the setup of outpatient clinics. A7.1: Review outpatient locations and equipment with regards to dignity and respect and ensure HB values and behaviours are maintained. T7.1: Sept 22	7.1: Planned location of Level 3 service (Dewi Sant) has bariatric friendly equipment and facilities. Worked with Health & Safety department early in planning process. H&S training planned for staff regarding adverse events with bariatric patients. Bariatric weighing scales being purchased for clinic areas. L3 service in Dewi sant will be for those who have a degree of	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
			independency when it comes to transport, however online/home visits are being discussed for those unable to get to the service in person. The HB values and behaviours of treating everyone with respect will be embedded within the team as well as opportunities for training and education including MECC.			
8. Planning, commissioning, evaluation and delivery of services actively engages with and involves people living with overweight and obesity.	8.1: Develop robust evaluation process for the L2/3 adult WMS.	R8.1: There is a risk that there will be a lack of patient engagement in PROMs and PREMS. A8.1: Develop and implement an outcomes framework including PROMS and PREMS to support ongoing service improvements through patient outcomes and feedback. Good patient understanding	8.1: Engagement with VBHC service to support PROMS/PREMS. Following recruitment to key posts the outcomes framework is a key priority for development. Further work will be required in this area once outcomes framework has been agreed by the service.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
	8.2: Develop a process for patient experience and patient stories including the co-production of services.	of the need for PROMS/ PREMS and patient feedback. Simple easy process that's not too onerous should be developed. T8.1: Outcomes framework to be developed by Oct 22. R8.2: There is a risk that a lack of patient co-design, co-production and feedback will result in the adult L2/3 services not meeting the needs of the population and the desired health outcomes. A8.2: Develop a process of co-production, patient stories and patient feedback. T8.2: Dec 22	8.2: Further work in this area is required. Need to engage with CTM's Head of public engagement and involvement to ensure the adult WMS used patient experience data and patient stories to improve quality of service delivery. Current work underway as described in 6.5 with Promo Cymru.			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
9. The Weight Management Pathway in the local area is managed and co-ordinated. Services delivering elements of the pathway have a clear understanding of roles and responsibilities and mechanisms to facilitate movement of individuals within the pathway in a seamless manner as needs change.	9.1: Establish a single point of access for adult weight management services.	R9.1: There is a risk of duplication or omission of service offerings due to multi-disciplinary team approach to weight management service. A9.1: Single point of access to weight management service being developed. Professional service manager is being recruited to oversee the service and assist with collaboration between departments. T9.1: November 2022.	9.1: Active recruitment for professional service manager on-going (with difficulties previously described in sections 2.2.2 and 3.2.1). Established multi-stakeholder implementation group that meet on a monthly basis. Through the steering and implementation groups, clear roles and responsibilities have been developed, agreed and documented in the Terms of Reference. Collaboration with improvement team to develop single point of access into pathway.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
10. Protocols informed by the All Wales Child Protection Procedures (2008) are followed when childhood obesity is a cause for professional concern, regarding wellbeing and risk of harm	10.1: Embed the All Wales Child Protection Procedures (2008) across the service.	R10.1: There is a risk that children within the services will be at a risk of harm. A10.1: Ensure safeguarding processes are in place and work in partnership with safeguarding leads when developing new service. Safeguarding is part of all staffs mandatory training. T10.1 Ongoing	10.1: Establish Children and young person's implementation group. All staff undertake mandatory child protection training once recruited. Supervision and training opportunities will be available for all staff members.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.
11. Staff working within the Health Board receive training to enable them to offer compassionate, psychologically informed care that avoids stigma and discrimination. All staff are able to engage in supportive conversations with patients regarding weight management in line with Level 1 of the pathway.	11.1: Develop training and education to ensure compassionate, psychologically informed care is core to service delivery.	R11.1: There is a risk that a lack of training opportunities for staff could result in sub-optimal care, resulting in poorer outcomes for our population. A11.1: Embed Health Board values across the service. Review training needs of staff with	11.1: This area requires further work as the workforce is currently coming into post. Work is ongoing to establish suitable training around healthy weight and core competencies for the workforce.	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
		psychologist (started 6/9/22). Review capacity of training provision. Ensure staff undertake MECC training as part of induction. Develop core psychologically informed competencies into service. Ongoing supervision and training updates will be required. T11.1: Dec 2022				
12. The Health Board adopts a continuous improvement approach to service quality and outcomes using the minimum dataset and other mechanisms including patient stories. The Health Board submits returns to Welsh Government in line with the minimum services standards and actively encourages participation in national audit and review.	12.1: Establish and embed the outcomes framework (includes minimum dataset, PROMS & PREMS) and develop a performance dashboard to enable continuous service improvement, service feedback and reporting to WG.	R12.1i: There is a risk that there will not be enough capacity of the CTM digital team to support the development of the performance dashboard. A12.1i: Early engagement with CTM digital team. T12.1.1i: Oct 2022	12.1: Outcomes framework in development by clinical lead dietitian and psychologist. Engaged with local VBHC team. Following recruitment of the wider team we will work on incorporating minimum data set into outcomes framework (PROMS & PREMS).	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
	12.2: Develop a culture of R&D across the weight management service.	R12.1ii: There is a risk that staff will not be able to identify areas for improvement and have the skills and knowledge to implement change. A12.1ii: Engage with iCTM (HB QI department) on training and support for service. T12.1ii: Sept 2022 R12.2: There is a risk that without an ethos of R&D, patients will not have access to the most evidence based treatments resulting in poorer outcomes. A12.2: Engage with R&D colleagues and academic partners to establish WMS research group.	Further work is required to engage with digital leads regarding integration of outcomes. Met with iCTM who have agreed training for WMS workforce once recruited. Staff will be supported to undertake service evaluations and QI projects. 12.2: Met with R&D department and academic partners to establish WMS Research group. Terms of Reference are being established and first formal meeting due in Oct 2022. Also recruited staff with research experience to help embed this culture across the			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
		T12.2: Oct 2022	service. Training and education opportunities will be mapped for the service once workforce is recruited to.			
13: Weight management services share their learning with colleagues within and beyond weight management services.	13.1: Participate in national weight management meeting and contribute to the wider WM agenda both within CTM and nationally.	R13.1.1: There is a risk that by not participating in the national network or sharing learning internally, the CTM WMS will not; be up to date on strategic direction, be able to influence policy and guidance and will not benefit from the wider experts in the WM field. This will result in poorer outcomes for our population. A13.1.1: Engage in national WM network. Engage with local networks and groups to demonstrate the impact of the WMS.	13.1: Actively engaged in national peer review and all Wales meetings. Outside of these meetings we have undertaken shared learning opportunities with HB across Wales (see section 2.2.1). Governance and reporting agreed, which has a wide range of stakeholders. Aligned reporting of WMS to the HB's Public Health and Primary Care Oversight Board. This allows oversight by the Exec director of PH and Primary Care Director and alignment to other initiatives across the HB such as	Please see Appendix 3.	Please see Appendix 3.	Please see Appendix 3.

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
		T13.1.1: Ongoing	diabetes prevention (both the local diabetes prevention programme and the AWDPP), WISE and staff wellbeing programme. Invited to participate in the L3 specialist interest group supported by Novonordisk. PH Dietetic lead is the chair of the All Wales Public Health Dietitians Group. Staff and operational managers engaged in national developments around DM prevention and obesity. The CTM WM services plans to share our learning and actively engage in the network across Wales. Engaged with stakeholders around the development of an integrated WM pathway and establish			

	Key actions planned	Risks to delivery corrective actions & by when including a timeline	What was achieved	Spend actual and planned including a breakdown of resource time	Spend of HB core budget against HWHW	Prevention fund investment into pathway L 1&2
Standards						
			CPD sessions on weight management. On-going collaboration between health boards WMS service leads and Life Sciences Hub Wales.			

Relevant Strategies and Guidance

AWWMP Guidance https://gov.wales/adult-weight-management-pathway-2021
https://gov.wales/weight-management-pathway-2021-children-young-people-and-families
Weight Management Standards https://gov.wales/weight-management-services-standards
Welsh Government Healthy Weight: Healthy Wales Strategy https://gov.wales/healthy-weight-strategy-healthy-weight-healthy-wales
Delivery Plans https://gov.wales/healthy-weight-healthy-wales-delivery-plan-2020-2022
Welsh Government 'A Healthier Wales' https://gov.wales/healthier-wales-long-term-plan-health-and-social-care

Appendices – available on request

Appendix 1: CTMUHB Unified Transformation Portfolio

Appendix 2: CTMUHB WMS Governance Structure

Appendix 3: CTMUHB WMS Finance Information September 2022

Appendix 4: HENRY Parent Survey Overview

Appendix 5: Staff Wellbeing Healthy Lifestyle Overview

Whole School Approach to CAMHS In Reach Services

Organisation	CAMHS	Date of Report	30/08/2022	Report Prepared By	Christina Morgan

Following the allocation of funding to progress the development of the Whole School Approach, there is a requirement to evaluate the delivery of the scheme in your area. Please utilise your initial request submissions to determine whether delivery and spend to date is comparable to your anticipated position.

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales. Please provide a copy of necessary plans & documents with the report.

	Annual Submission	Delivery to Date
Total spend to date		£206,677 (staff costs and travel)
Period of claim		April 2022 to August 2022
Staff (please list each member of staff in post, by band and per local authority to and their whole time equivalent i.e. 0.4 Band 5)	Provided in formal submission to Welsh Government.	All in post
Other costs incurred to date (please list i.e. staff training)	Laptops and phones for each individual. Awaiting costs for non-pay	
Please explain how your service has progressed in each area, building on what was anticipated at the beginning of the financial year		
	Update 1 April 2022 – 31 August 2022	**Update 1 September 2022 – 31 March 2023**
1. How have you engaged schools/school leaders and wider partners in service development and rollout across LA areas?	We continue to be part of the Whole School Approach (WSA) pilot rolled out within CTM, working closely with regional commissioners and Nest/Nyth. Planning has focussed on co production of the service in collaboration with Local Authority and Education colleagues. All	

	pilot schools have attended ‘meet and greets’ with their specified locality teams with information and wellbeing days arranged and well attended for school clusters. The teams have also received expressions of interest from non-pilot schools to be involved in the next cohort and have agreed with the healthy schools lead on Nest. Team leads and Operational Manager continue to attend many strategic meetings with statutory and third sector services, in order to map, plan, implement and review the current services into schools and the wider community, with a mapping exercise underway lead by education and supported by CAMHS in reach . Regular co-production meetings with partners have been organised and well attended with the view to foster collaborative service development and working relations. Multi agency, collaborative and strategic Emotional Wellbeing meetings are planned throughout the year for ongoing development and monitoring of services in relation to children and young people’s emotional mental health needs. These panels are across the RCT/ Bridgend localities with sub groups addressing local need.	

	Update **1 April 2022 – 31 August 2022**	**Update** **1 September 2022 – 31 March 2023**

2. How have you ensured service development as part of an integrated, whole-system, regional approach? Developing and delivering services that support the emotional health and well-being of children and young people, ensuring schools/children and young people have timely access to appropriate support when needed?	The triumvirate Nest/ WSA /In reach leads have been working closely together with relevant regional stakeholders to ensure a collaborative approach. In-reach has been part of the WSA pilot from the initial implementation in line with the NEST framework. The process takes into consideration the “No wrong door” approach and enables “access to specialist advice and trusted adults. WSA have carried out mapping exercise within schools to identify needs/ gaps. This has included meeting with several other service providers across England and Wales to secure our understanding of what is currently being provided and what is required. Following scrutiny and evaluation of this information, the In reach team have been able to design the service that best meets the needs of our Children and Young people within education, which involves tailoring the bespoke interventions. In addition, co-production meetings have taken place with stakeholders in SCAMHS, to develop pathways for stepping up and stepping down CYP. The In reach team will ensure there is regular evaluation via the pilot work to monitor and ensure they are delivering appropriate services and able to offer	

	timely access to children and young people. As from the 5th September each locality will have a team of In reach staff placed within the pilot schools providing f2f input with children, young people and their families along with the school staff. This direct access will ensure timely and appropriate response within the educational environment. All schools as yet to be included in the pilots will also have access to advice, psychoeducation, consultation, training and bespoke pieces of work as and when requested, through their allocated Team lead or Emotional wellbeing Practitioner. Planned input will be in line with the current need highlighted within the WSA mapping and regional agencies.	
3. What supervision process does your service provide to school staff? Please outline what and how.	Our service aims to provide consultation to all school staff in relation to the emotional wellbeing and mental health of its children, young people and their families. Future plans in discussion with stakeholders is to set up multidisciplinary forums within schools for all key agencies to be able to have input and overall decision making regarding the children they are concerned about. The school in reach team have co-produced with local authority, guidance for school staff around seeking support for their own emotional health needs.	

	Multidisciplinary forums will continue to be discussed within each school following the 5th September.	
4. How have you ensured that the role of a CAMHS In-reach practitioner will not be diluted (by, for example, supplementing core sCAMHS or by stretching their time too thinly across too many staff and/or schools or through pressure to work directly with children and young people)?	There are approximately 5 staff for each locality with an allocated team lead. The team leads predominantly offer consultation, training and liaison for each secondary school enabling the dissemination of support and information to a wider audience, with the rest of the Emotional wellbeing practitioners offering input into the primary schools. The service has “piggy backed” the whole school approach pilot and will be rolled out initially to 40 schools addressing the gaps/needs of the schools in a timely manner. However, all schools will have access to the In reach service. There is a multitude of disciplines within the In reach team, predominantly with different qualifications and backgrounds than those required to work within SCAMHS therefore limiting the opportunity to supplement.	
5. How do you continue to ensure the Welsh language offer is strengthened through for example, Welsh speaking practitioners and ensuring the translation of written material?	Careful recruitment of staff into the In reach service has enabled us to employ Welsh speakers, whilst all communication and written material has been disseminated in English and Welsh medium.	

	Correspondence continues to be disseminated in English and Welsh with added members of school in reach currently learning welsh through the health board.	
6. Recruitment of highly skilled and experienced staff to provide training and advice is important. However, this is demonstrated as challenging. How are you ensuring appropriate provision? Have you utilised alternative methods where recruitment/ retention of appropriate staff has produced difficulties?	Significant thought went into the person specification of the role whilst recruiting, enabling opportunities for those that had positions relevant to the in-reach role. We have recruited a diverse group of staff with extensive and broad range of skills and experience; this enhances the creativity and vigour of planning and implementation of the service. The individual's induction has been robust with training provided by external and internal sources, including local authority, education, CAMHS, Psychological services and external training providers. Staff have shadowed staff in all teams, had training in Mental Health first aid, DBT, CBT, ALNET, NEST and continue to attend in-house training delivered by CAMHS staff. Team leads utilise and disseminate relevant webinars. Training and development are ongoing. All staff are in post. Staff Co- production and engagement has been key to the planning and delivery of the service. Staff continue to show motivation, creativity and hold a responsibility for the success of the service.	
Monitoring and Evaluation		

Public Health Wales, should already provide a national coordination role, including a National Forum for the sharing of good practice, etc. for the service across Wales. They will work with you to develop a nationally agreed data collection set. Please explain how you have met the following questions and intend to continue doing so.		
	Update **1 April 2022 – 31 August 2022**	**Update** **1 September 2022 – 31 March 2023**
7. You will work with partners to ensure that there is robust monitoring and evaluation of the effectiveness of action to support pupil and staff mental health and well-being and the initial targets you propose to measure progress (together with timescales).	Linked with the WSA and Nest rollout being part of the initial rollout and collaborative implementation. Small task and finish group formed (within team) to look at evaluation and performance measurement. Data collation has been developed within the confines of specific roles. Monthly stats has been agreed with daily data being recorded. Staff, pupil and family evaluation documentation is the current task and finish group topic. Data monitoring has been formalised and embedded into the Quality Safety and Patient Experience group. Database is on sharepoint in order to reduce contemporaneous note taking and ease of access for resources for schools. Staff attend Regional partners MDT meetings for monitoring and evaluation on a regular basis.	
8. The In-reach Service is closely linked to and has potential to strengthen how Health Boards fulfil their statutory duties under the ALNET Act in terms of provision of help and support for learners. Does your In-reach plan continue to align with your planning in relation to the ALNET Act? What processes do you use to work closely with the	The team continue to attend all ALNET training and monthly meetings with the DECLO, all relevant parties are aware of our statutory duties. We are currently involved in discussions relating to the act, and approach to any patients requiring input and will include the In reach team liaising with Schools to understand their needs. Currently the CAMHS triage teams	

DECLO for the LHB in continuing the development and delivery of plans and services to allow those statutory duties to be met?	are dealing with the Local authority requests. Help and support for learners will be paramount to the in-reach input within schools therefore the act will be part and parcel of daily continuity. Continue to meet with DECLO monthly with the overall s65/s20 and PCP meetings being the responsibility of our SPOA service. However, staff will continue to attend ALNET training in light of providing emotional health input within schools.	
9. Use this line to add any further information you may feel useful and which has not been included above e.g. risks/ corrective actions	In order to open up opportunities for evaluation and service development the team are planning set up/ links with a CAMHS Youth Board. This will enable co - participation of young people and enable further evaluation and service co-production. Team are currently liaising with Youth board participation members to engage their thoughts, advice and support on the roll out of the service. This would enable the service to be co-produced and informed by our service users. Youth Boards have engaged and progress is being made towards a dedicated CAMHS Youth Board. The Inreach service are also planning to establish a formal link with HB safeguarding in order to safeguard and	

	protect those vulnerable CYP within education that have experienced a sudden death of someone close.	

Dementia Care (Learning and Development in Line with the Good Work) and Access to Timely Diagnosis

Organisation	CTMUHB	Date of Report	September 2022	Report Prepared By	

As outlined in the 'Good Work – Dementia Learning and Development Framework' all staff who work for NHS Wales need to have a good awareness of dementia and the issues that surround it so that they can support people with dementia to live well. NHS organisations are required to evidence the actions that have been implemented to deliver and record training at an informed, skilled and influencer level.

Individuals are diagnosed early so that the individual and their families can plan for the future, access support services and start treatment at an appropriate point.

Responses should consider the relevant Dementia Care Standards. Specifically **standard 17** for learning and development and supporting diagnosis **- standards 3-6**.

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales.

Dementia Care (Learning and Development in Line with the Good Work)

	Achievements for 2022-2023	Issues Impacting Delivery	Corrective Actions
Informed Level			
Training delivered at an informed level. *Focusing on Dementia Friends training programme and essential communication skills.*	**Update at 31 August 2022**		
	Dementia Care Training - Level 1 - Goodwork Framework - Informed Level - 48 Dementia Care Training - Level 2 - Goodwork Framework - Informed Level - 93	Staff availability to undertake training	Noncompliance with mandatory training is flagged to managers in order to support direct action where appropriate

	Update at 31 March 2023		

	Achievements for 2022-2023	**Issues Impacting Delivery**	**Corrective Actions**
Skilled Level			
Actions to identify staff groups that require training at a skilled level.	**Update at 31 August 2022**		
	We have developed a specific work stream to lead on the implementation of the learning and development All Wales Dementia Care standard. Alongside the creation of a specific learning and workforce development work stream we have established links with other areas to explore training needs for staff. This has included working with the hospital charter work stream to identify where there are opportunities for cultural change. There are dementia modules of training that are mandatory for staff to complete and this is monitored through our ESR system.		The work stream will be requesting quarterly updates on progress against good work to enable hot spots and pinch points to be identified and discussions around support required to be held at a senior level with issues escalated to the Dementia Steering group and integrated adult board.
	Update at 31 March 2023		

Training delivered at a skilled level. *Covering the well-being themes of: rights & entitlement; physical & mental health; physical environment; social & economic well-being; safeguarding; meaningful living; meaningful relationships; community inclusion & contribution.*	**Update at 31 August 2022**		
	Dementia Care Training - Level 3 - Goodwork Framework - Skilled Level – 39 Further detail on compliance figures can be found in appendix B below.	Covid has had a tremendous impact on our ability to release staff to attend training.	We have arranged a learning and development hackathon for front line skilled staff (further details below) to help inform the development of a workforce plan for CTM.
	Update at 31 March 2023		
Mechanisms to record the completion of training at a skilled level. *Including details of how the organisation will measure the impact the learning is having on practice and people living with dementia and carers*.	**Update at 31 August 2022**		
	Training for all staff is recorded through our electronic systems and compliance reports against mandatory training is scrutinised and flagged to managers. Feedback and evaluation in incorporating into our training mechanisms in order to support analysis of the efficacy of what is delivered.		We are exploring dementia care mapping as a means to evidence the impact of training on the culture and care provided
	Update at 31 March 2023		

	Achievements for 2022-2023	**Issues Impacting Delivery**	**Corrective Actions**

Influencer Level			
Actions to identify staff groups that require training at an influencer level.	**Update at 31 August 2022**		
	As part of the VIPS pilot we identified a series of wards / ward managers/influencers to implement this pilot. Influencers are involved in the work of the dementia steering group and link directly to the work stream surrounding this area. Regular highlight reports are provided to the dementia board to ensure they continue to be informed on developments.		As a continuation of the work of the hospital charter we are identifying opportunities to develop dementia care mapping in CTM and to utilise the care fit for VIPS platform to make systematic change to our sites and the provision of dementia care within these inpatient settings. We are also exploring opportunities to feed in the work for a series of hackathons with people with a lived experience, carers, staff and managers to senior leaders within CTM in support of the development of our workforce plan.
	Update at 31 March 2023		
Training delivered at an influencer	**Update at 31 August 2022**		

level. *Focusing on: drivers, policy & research; effective service mapping & co-ordinated delivery; collaborative & integrated working; shared values; creating & owning a clear & shared vision; culture & language; delivering excellence; creative approaches; safeguarding and; quality assurance & improvement.*	As part of the workforce and learning work stream we will be seeking to identify steps that need to be undertaken to ensure that we are compliant with the requirements under good work for training for influencers Awareness raising of our existing services and techniques employed in other health settings are to be shared with influencers at the learning and development hackathon and through our knowledge exchange programme with Imperial College London. Further detail on compliance figures can be found in appendix B below.		We have arranged a learning and development hackathon for managers/influencers (further details below) to help inform the development of a workforce plan for CTM.
	Update at 31 March 2023		
Mechanisms to record the completion of training at an influencer level. *Including details of how the organisation will measure the impact the learning is having on practice and people living with dementia and their carers.*	**Update at 31 August 2022**		
	We are currently exploring dementia care mapping as a means to demonstrate cultural change within our settings.	Demonstrating the impact of training outside of quantitative records can prove challenging and has been flagged as an area of development for the learning and workforce work stream.	The work on evaluating the success of training is ongoing and will be further developed along with the action plan of the workforce and learning work stream.

	Update at 31 March 2023		
Provide detail on any delivery of integrated learning and development, particularly with social care.	Within CTM we are hosting a range of engagement, coproduction and training opportunities for staff. We have arranged a learning and development hackathon and partnered with people with a lived experience (Lleisiau dementia) and Imperial College London to deliver a session to staff (skilled level) and managers (influencer level) gathering their experiences together to inform the work of the work stream 5a from the All Wales Dementia Care standards. This session is a collaborative approach between health and social care and includes representatives from both areas. The intention is that we will use this creative approach to Our regional social care work force development teams are active members of our 5a work stream and they are working with social care providers to raise awareness of the good work framework and to support providers and commissioners in its implementation. A series of training sessions are currently being provided by SCDWP and SCW on this area. The Dementia Steering group has agreed to support further resource into the in house dementia training team (who utilise the Teepa Snow model of person centred support) and have agreed to fund dementia care mapping training for staff to ensure that we are able to appropriately map whether the training undertaken has positively impacted service delivery. Care fit for VIPS is being rolled out across the health board and we are exploring site specific roll out in the first instance supported by additional training resource (referenced above) and monitored by an improvement group which is tasked with implementing positive change across the site as a whole. Work around the new D2RA models will support this approach.		
If you have a regional, integrated learning and development plan for dementia. Please provide a hyperlink.	This is something we are considering developing in response to the requirement from the All Wales Dementia Care Pathway of standards and we are currently working on priority setting in support of this piece of work.		

Access to Timely Diagnosis of Dementia

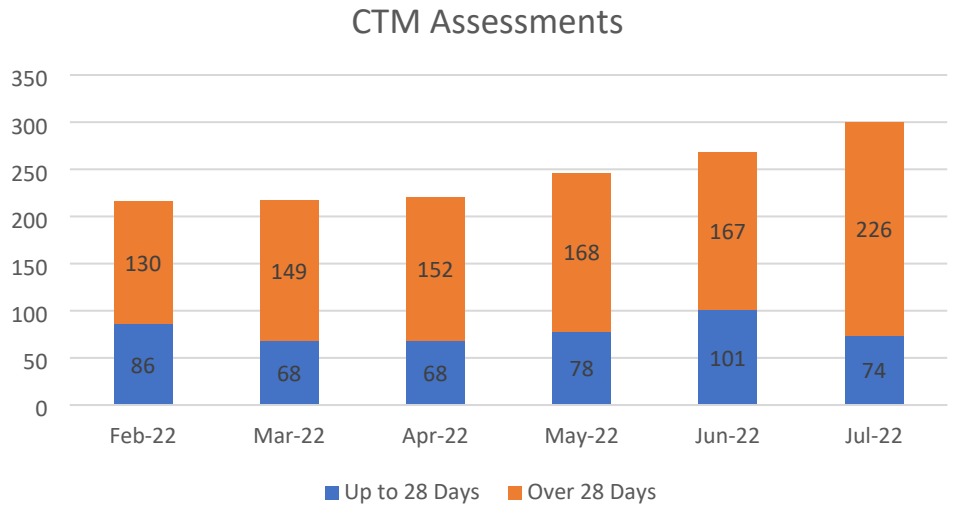
	Achievements for 2022-2023	Issues Impacting Delivery	Corrective Actions
What actions are you taking to support timely diagnosis of dementia? Please consider how this work aligns with the relevant Dementia Care Standards when responding.	**Update at 31 August 2022**		
	CTM has fully developed its MAS work stream in response to the All Wales Dementia Care Standards. Within the MAS work stream 3 subgroups have been created to address specific standards under the following headings: ❑ Emotional Support and skills ❑ Accessibility and Data ❑ Assessments and Intervention Each sub group has created its own priorities for development and implementation and a number of small projects have been identified in support of this including work around standardising paperwork and cross referencing MAS and GP registers linked to READ codes. Consideration of the different styles of communication needed has also been flagged alongside the need to work closely with Swansea Bay health board as the provider of our LD support. Work stream 5b (measurements) is working to support the MAS services across CTM to standardise and streamline their data collection processes in support of the revised data set released by Improvement Cymru. This continues to be a work in progress but positive steps have	Inconsistency in approach across the MAS services in Merthyr Tydfil and RCT. No MAS service in Bridgend	There is a focus on improving data consistency across CTM ensuring that what is recorded is the same across all MAS and other memory services. There is exploratory work ongoing in relation to the need for a MAS service to be developed within Bridgend. Current distribution of resources is being explored and a number of additional services have been funded to support improvement in MAS services as a whole. Psychology is currently exploring opportunities to support in this area. A number of psychologist have undertaken enhanced training which would enable them to support with diagnosis.

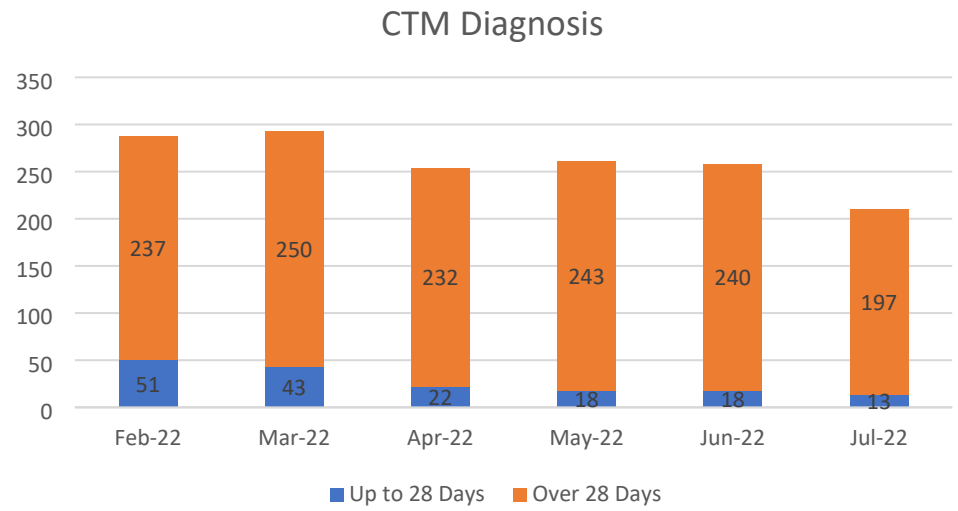
	been taken to ensure that the data provided is comparable across the regional footprint. The Dementia Steering group has agreed to fund some additional allied health professional resource into the MAS service to support individuals through their dementia journey and has also agreed to pilot an ANP in MAS to assess whether this approach will aid diagnostic levels. Internally reconfiguration approaches to support individuals with a mild cognitive impairment are being explored alongside improvements in data collection to ensure when/if these individuals begin to develop dementia diagnosis is expedited and early interventions and lifestyle changes implemented to help delay the severity of the condition as much as possible. Hub models are being pursued across the region with varying levels of speciality ranging from a dementia hwb model in Bridgend to more generic hubs in community settings such as Cynon Linc in Aberdare closely aligned to memory services to support individuals in settings closer to home. All areas of development are directly linked to the All Wales Dementia Care Pathway of Standards.		A trial of MCI groups in each locality is being arranged to ensure that people are offered support post diagnosis. It is anticipated that this pilot will also highlight ways to improve standardisation of READ codes, recall rates and a systematic approach to track conversion rates. We are currently exploring capacity to roll out the EPP Cymru Dementia Syllabus across CTM linked to the WISE programme and the living well dementia group.

	Data on wait times within MAS can be found in Appendix A below. As of September 2022, 311 individuals were awaiting diagnosis across Cwm Taf Morgannwg (around 0.35% of the over 65 population of the region). This includes data from Bridgend.		
	Update at 31 March 2022		

Appendix A: MAS Wait times across CTM

CTM					
Assessment					
Waiting Times	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**
Up to 28 Days	68	68	78	101	74
Over 28 Days	149	152	168	167	226
Total patients waiting	217	220	246	268	300
Diagnosis					
Waiting Times	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**
Up to 28 Days	43	22	18	18	13
Over 28 Days	250	232	243	240	197
Total patients waiting	293	254	261	258	210

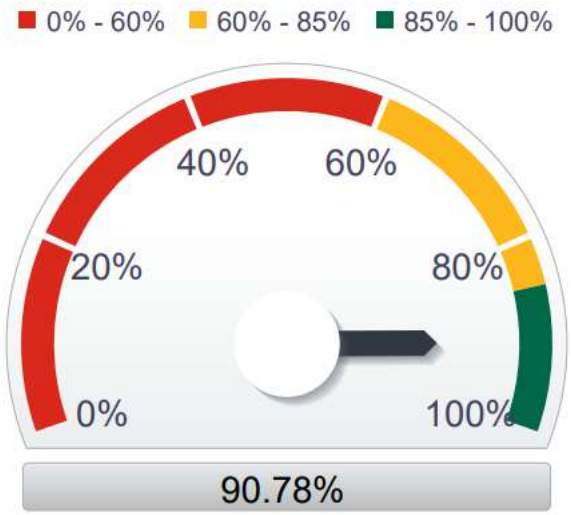




Appendix B: Pan CTM mandatory dementia awareness training compliance figures

Compliance Overview

The gauge below provides a compliance % for the single level of Dementia training.



The table below provides a compliance percentage for the single level of Dementia training.

Competence Full Name				Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
NHS|MAND|Dementia Awareness - No Renewal|				12313	12313	11178	90.78%	0	90.78%

The Table below provides an overall combined compliance % for each Staff Group

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	391	391	370	94.63%	0	94.63%
Additional Clinical Services	2368	2368	2281	96.33%	0	96.33%
Administrative and Clerical	2517	2517	2393	95.07%	0	95.07%
Allied Health Professionals	779	779	745	95.64%	0	95.64%
Estates and Ancillary	1390	1390	910	65.47%	0	65.47%
Healthcare Scientists	211	211	203	96.21%	0	96.21%
Medical and Dental	787	787	568	72.17%	0	72.17%
Nursing and Midwifery Registered	3793	3793	3685	97.15%	0	97.15%
Students	77	77	23	29.87%	0	29.87%

Compliance by ILG

The Table below provides an overall combined compliance % for each ILG

ILG	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Balance Sheet Care Group	3	3	3	100.00%	0	100.00%
110 Bank Care Group	1	1	1	100.00%	0	100.00%
110 Chief Operating Officer Care Group	1278	1278	797	62.36%	0	62.36%
110 Children & Families Care Group	1332	1332	1254	94.14%	0	94.14%
110 Corporates Care Group	1206	1206	1140	94.53%	0	94.53%
110 Diagnostics, Therapies & Specialities Care Group	1527	1527	1460	95.61%	0	95.61%
110 Hosted Organisations Care Group	106	106	96	90.57%	0	90.57%
110 Mental Health & Learning Disabilities Care Group	1235	1235	1201	97.25%	0	97.25%
110 Planned Care Care Group	1990	1990	1811	91.01%	0	91.01%
110 Primary & Community Care Group	1528	1528	1481	96.92%	0	96.92%
110 Unscheduled Care Care Group	2107	2107	1934	91.79%	0	91.79%

The Table below provides an overall combined compliance % for each Service Group

ILG	Service Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Balance Sheet Care Group	110 Balance Sheet Service Group	3	3	3	100.00%	0	100.00%
110 Bank Care Group	110 Bank Service Group	1	1	1	100.00%	0	100.00%
110 Chief Operating Officer Care Group	110 COO COVID-19 Response Service Group	10	10	10	100.00%	0	100.00%
	110 COO Facilities Hub Service Group	162	162	116	71.60%	0	71.60%
	110 COO Facilities Service Group	1073	1073	642	59.83%	0	59.83%
	110 COO Management Team Service Group	31	31	27	87.10%	0	87.10%
	110 COO PCRP Service Group	2	2	2	100.00%	0	100.00%
110 Children & Families Care Group	110 Children & Families Management Service Group	29	29	27	93.10%	0	93.10%
	110 Obstetrics,Gynaecology & Sexual Health Service Group	585	585	549	93.85%	0	93.85%
	110 Paediatrics, Acute & Community Service Group	718	718	678	94.43%	0	94.43%
110 Corporates Care Group	110 Chief Executive Service Group	37	37	31	83.78%	0	83.78%
	110 Corporate Development Service Group	57	57	55	96.49%	0	96.49%
	110 Estates Service Group	164	164	159	96.95%	0	96.95%
	110 Finance Service Group	73	73	70	95.89%	0	95.89%
	110 ICT, Performance & Information& Medical Records Service Group	360	360	339	94.17%	0	94.17%
	110 Medical Director Service Group	24	24	23	95.83%	0	95.83%
	110 National Imaging Academy Service Group	11	11	11	100.00%	0	100.00%
	110 Patient Care & Safety Service Group	180	180	169	93.89%	0	93.89%
	110 Planning & Partnership Service Group	29	29	28	96.55%	0	96.55%
	110 Public Health Service Group	85	85	82	96.47%	0	96.47%
	110 Research & Development Service Group	24	24	24	100.00%	0	100.00%
	110 Therapies & Healthcare Sciences Service Group	2	2	2	100.00%	0	100.00%
	110 Value Based Healthcare Service Group	10	10	9	90.00%	0	90.00%
	110 Workforce & Organisational Development Service Group	150	150	138	92.00%	0	92.00%
110 Diagnostics, Therapies & Specialities Care Group	110 Clinical Support Services Pathology Service Group	248	248	237	95.56%	0	95.56%
	110 Clinical Support Services Radiology Service Group	301	301	281	93.36%	0	93.36%
	110 Medicine Management Service Group	318	318	300	94.34%	0	94.34%
	110 Therapies Service Group	660	660	642	97.27%	0	97.27%
110 Hosted Organisations Care Group	110 Emergency Ambulance Services Committee Service Group	32	32	30	93.75%	0	93.75%
	110 Welsh Health Specialist Services Committee Service Group	74	74	66	89.19%	0	89.19%
110 Mental Health & Learning Disabilities Care Group	110 CAMHS Service Group	268	268	258	96.27%	0	96.27%
	110 Mental Health & Learning Disabilities Service Group	967	967	943	97.52%	0	97.52%
110 Planned Care Care Group	110 Cancer Services Service Group	34	34	28	82.35%	0	82.35%
	110 Planned Care Outpatients Service Group	41	41	41	100.00%	0	100.00%
	110 Surgery & ACT Service Group	1915	1915	1742	90.97%	0	90.97%
110 Primary & Community Care Group	110 Localities Service Group	929	929	910	97.95%	0	97.95%
	110 Primary Care Service Group	599	599	571	95.33%	0	95.33%
110 Unscheduled Care Care Group	110 Acute Medicine and A&E Service Group	2107	2107	1934	91.79%	0	91.79%

Rows 1 - 38 (All Rows)

Learning Disabilities Improving Lives Programme

Organisation	CTM UHB	Date of Report	28/09/22	Report Prepared By	M Abraham & W James

The Welsh Government's new strategy Learning Disability Strategic Action Plan 2022 to 2026 | GOV.WALES outlines the priority areas that will strengthen services and subsequently improve the lives of people with learning disabilities. The delivery of these priority areas involves collaborative working across NHS Wales, Regional Partnership Boards, Public Service Boards, Local Authorities and the third and private sectors. NHS organisations are required to evidence how they are contributing towards the priority areas of the strategy and in particular, the areas and key actions outlined in this reporting template.

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales

Update on the actions implemented during the current operational year to deliver the Learning Disabilities Improving Lives Programme.

Implementing the recommendations of the comprehensive review of adult in-patient learning disability services.

Key Actions:

1. **Reducing reliance on medication to manage challenging behaviour.**
2. **Improving access to community based early intervention and crisis prevention.**
3. **Increasing community based provision enabling individuals to move on from in-patient units as soon as it is safe for them to do so.**
4. **Ensure all in-patients are regularly assessed for discharge to "step down" care and discharge plans are actioned within 7 days.**

Achievements	Risk to Delivery	Corrective Actions
The specialist learning disability service has reviewed and updated the current processes for managing the transfer, transition and discharge of inpatients across the NHS and independent sector. This reflects the requirements of the national specialist LD	Workforce challenges - recognised deficits across professions, new roles and opportunities for staff present risks to existing services due to recruitment/retention challenges.	Engagement with staff working in learning disability services and communication opportunities to keep the workforce engaged and alert to change.

action plan and Goal 6 of the Six Goals for urgent and emergency care.		
The reflection of the multi-disciplinary model in a redeveloped inpatient area to ensure timely assessment and intervention planning, shared goals and transitional supports.	Capital and estate challenges related to funding constraints and limited resource respectively delay the development of key environmental improvements required to holistically meet all care needs, particularly for those who are identified for assessment and have potential to step down from high cost private placements.	6 monthly learning disability inpatient audit, alongside the health boards own transition and transfer meetings to maintain shared oversight of individual's pathways. Capital bids submitted within SBUHB to request funding for key environmental developments. Heightened focus on Estates performance with monthly meetings and review of demand vs delivery.
A multiagency group has already met to look at the priority areas of early intervention & crisis, timely transition and quality specialist learning disability services. This is linked to the work of the National Implementation Advisory Group.	Potential impact of the pandemic/pandemic response – challenges have already been experienced in some areas for delivery.	Learning disability intensive support team development is phased to recognise the potential impact of staff changes/destabilising effect. Involvement in the national task and finish group which will develop a framework to support the use of non-pharmaceutical interventions in Wales for people with a learning disability.

Implementation of the Welsh Governments' "Reducing Restrictive Practise Framework". **Key Action:** **1. Promote the use of evidence based interventions, e.g. Positive Behavioural Support (PBS) in all settings. Ensure restrictive practise used is proportionate, compliant with the framework and is recorded and monitored.**		
Achievements	**Risk to Delivery**	**Corrective Actions**
Processes and monitoring in place to ensure that Health Board staff access physical interventions training that is compliant with the requirements of the RRN training standards (BILD ACT certificated) – PBM SBUHB Theory and Practical training. This training is underpinned by pro-active, least restrictive approaches. The Specialist Behaviour Team (SBT) serve inpatient, community, independent sector and peoples own homes to undertake thorough understanding of behaviour described as challenging and to support professionals and carers in developing personalised Positive Behaviour Support plans and interventions to reduce the impacts of challenging behaviour and improve quality of life.	Non-health board staff in the flexible workforce may not be trained in PBM SBUHB Theory and Practical training.	PBM SBUHB strategic lead and team work with agencies and bank to offer relevant training. Use of substantive staff for bank means that they do have the appropriate training. The RRP group to implement a clear process for reporting, monitoring, auditing and evaluating restrictive practice across the Service Group. The implementation of the reducing restrictive practices checklist and action planning with areas. Capturing people's experiences, learning from incidents and working together with people with learning disabilities and their families on the impact of PBS and RP's.

The learning disability division reducing restrictive practices group is in place reporting to the MH&LD reducing restrictive practices group. Multi-disciplinary approaches to reducing restrictive practice are utilised within the service.	Information systems that do not allow the effective and accurate recording and collation of RRP performance measures.	

Develop integrated housing, health, social care models and guidance, learning from previous examples that provide accessible services for vulnerable people especially those with a learning disability. Utilise the new Regional Integrated Fund.

Key Action:

1. **As a member of the Regional Partnership Board drive integrated services across health, housing, social services and the third sector. People with a learning disability are one of the key priority groups for funding under the Regional Integrated Fund.**

Achievements	Risk to Delivery	Corrective Actions
The Regional Partnership Board LD Sub Group has been relaunched post Pandemic and appointed its first paid chair person with an LD. This Group has reviewed the local and national priorities identifying HOME as one of the three priorities.	Lack of dedicated staffing resource to drive the transformation program.	LD Program Manager Job Description developed for application of RPB funding for 2 years.
Regional Programs have been established to explore demand and capacity in for specialist models of care and support for people with complex needs better known as 'Closer to Home' (C2H).	Identifying suitable land and or accommodation to develop more capacity in C2H.	Engagement events with RSL's to encourage joint working and stimulate interest in the programs.

There are 3 live C2H Schemes in Bridgend area and 1 in RCT, which goes live in Sept 2022. All schemes previously benefited from ICF and will provide the foundation for further applications to RIF applications this year.	Capacity and skills within the CLDT's and social care sectors.	Modernisation of CLDT's and introduction of Learning Disability Intensive Support Teams. Define a sustainable model of C2H which includes Health Housing and Social Care.

Primary Health Care: Improve the take up and quality of annual health checks to identify and address health needs (target: 75% of all individuals registered with their GP practise who have a diagnosed learning disability are to have an annual health check).

Key Actions:

1. **Strengthen the role of community learning disability teams to support delivery of the annual health checks (primary care cluster level).**
2. **Establish a community learning disability link nurse for every primary care cluster.**

Achievements	Risk to Delivery	Corrective Actions
Senior Nurses from the 3 CLDT'S have been identified as Cluster Leads for each of the Clusters across Primary Care. This is being enhanced by other Nurses being allocated to a Cluster to offer additional support CLDT's advise individuals about the importance of AHC during Psychiatry reviews, assessments etc and will offer support by contacting the practices where necessary and also offer support via any identified desensitisation programmes Data has been compiled on the number of individuals registered with GP across the CTMUHB footprint and liaised with Data Analyst in Improvement Cymru to	One Senior Nurse due to retire which will leave a vacancy in one of the CLDT's and therefore could impact on support to Clusters until recruited. Vacancy of the existing part time Learning Disability Liaison post have resulted in the lack of dedicated primary care focus from the CLDT to date. Due to the pressures on Primary Care, Cluster Meetings/training reduced and therefore it's been difficult for People First to meet with Clusters and deliver their presentations	SBUHB in the process of recruiting into the vacancy Clinical Skill set of Nurses within the CLDT's to be enhanced to enable joint working with Primary Care to meet the requirements of the AHC's but also metabolic screening Lead Nurses from each of the CLDT's to meet to explore ideas and examples of good practice on how the Teams are ad can continue to support Primary Care colleagues

compare the data with the data held with Improvement Cymru. Number of AHC's undertaken across each GP practice and Cluster over the last three years have now been identified and compared with the number of individuals registered with a GP. A baseline has therefore been established to enable the Health Board to measure improvement over time. This is considerable progress and will be monitored in the newly formed Health Sub Group of the Regional Learning Disability Partnership Group. Currently exploring proposals to submit to WG to access additional funding that WG has been made available to increase the uptake and quality of AHC's across CTM UHB. Looking at a proposal where there will be an increase in the dedicated resource to support Primary Care to undertake AHC's consistently and monitor actions following the AHC, focussing on one Cluster area and then looking at rolling out the model across other Clusters. Proposal will be discussed in the Health Sub Group to ensure those individuals and their families using services across the footprint are consulted with. Existing dedicated resource of a Part time Primary Care Liaison Nurse has been vacant for a considerable amount of time but has been recruited into by SBUHB, awaiting start date. CLDT's are in the process, once they are up to full compliment to deliver the Primary Care Education Pack, developed by Improvement Cymru. Individuals with a learning disability trained as Health Champions via Cwm Taf People First and developed a presentation to deliver to GP Clusters on the importance of AHC's. Two films developed, one relating to Health Champions and one relating to a Right to Life, shared across the HB. Nurses in the CLDT's trained to deliver the Covid Vaccine and the most recent report shows the	Uptake of flu vaccine in individuals with a learning disability across the CTM footprint is lower compared to the uptake of the Covid Vaccine. Vacancies within the CLDT have impacted on their ability to deliver the Primary Care Education Pack	Post has now been recruited into, awaiting start date. Cluster meetings/training sessions are in the process of being re-established across Primary Care. However, Health Champion role and a Right to Life translated into film to enable staff to view them digitally if face to face sessions is still challenging. Discussions taking place with Public Health Colleagues on how this can be improved with the support of the CLDT's. This will also be an agenda item on the newly formed Regional Health Sub Group to raise the profile of the importance of accessing flu vaccination. SBUHB are in the process of recruiting into vacancies to bring the CLDT's up to full compliment

uptake of the Covid Vaccine to be very good for individuals with a learning disability across CTM. However, the report also shows that the uptake of the Flu Vaccine in people with a learning disability is not as good. Discussions ongoing with representatives from Public Health Wales and the CLDT to look at this.		

To ensure reasonable adjustments are made for people with a learning disability accessing mainstream NHS services.

Key Actions:

1. Establish sustainable models of learning disability champions and learning disability liaison nurses.

2. Ensure system flagging to identify patients with a learning disability and increase the use of the health passports.

3. All staff in a public facing role to undertake the mandatory Paul Ridd Foundation Level Training.

Achievements	Risk to Delivery	Corrective Actions
Three full time Acute Learning Disability Liaison Nurses are in place across CTMUHB, one based in each of the three large hospital sites.	One Acute Learning disability Liaison Nurse has been on long term sick leave for a considerable amount of time impacting on one of the hospital sites	Some backfill arrangements were in place but awaiting confirmation of further arrangement to manage shortfall from SBUHB
A rolling programme of monthly learning Disability Champion training is in place alternating between the three large hospital sites. Learning Disability Champions within each departments is increasing	Releasing staff to attend the Learning Disability Champion training can be challenging	The two Acute Learning disability Liaison Nurses provide cover along with the support of the CLDT where necessary
The Acute Learning Disability Liaison Nurses maintains a register and shares relevant information with the Champions on a regular basis.		The three Heads of Nursing in each large hospital site is committed to increasing the number of Champions and raise the profile
CTMUHB purchased a number of Learning Disability Champion Training Packs from the Paul Ridd Foundation to support the training.	Whilst individuals with a learning disability are flagged on the WPAS system it is not easy to see the flag when the person comes in to hospital	Discussions in the process of taking place with the lead for WPAS in the Health Board to look at how the problem can be rectified
Learning Disability Information Boards are in place across the sites and are monitored and updated by the Champions. Discussions with Arts within the	Changes in staff personnel and long-term sickness has resulted in a delay in the CLDTs flagging individuals who are on their caseload on to CTMUHB WPAS system.	Lead for WPAS has agreed to give access and train newly appointed SBUHB staff on how to flag individuals and provide refresher training

To ensure reasonable adjustments are made for people with a learning disability accessing mainstream NHS services.

Key Actions:

1. Establish sustainable models of learning disability champions and learning disability liaison nurses.

2. Ensure system flagging to identify patients with a learning disability and increase the use of the health passports.

3. All staff in a public facing role to undertake the mandatory Paul Ridd Foundation Level Training.

Achievements	Risk to Delivery	Corrective Actions
Health Board to look at how we can utilise the skills of arts/graphic design students to provide support on how the Boards can be improved Staff are encouraged to ask an individual with a learning disability and their family/carer for a copy of their Health Profile when they come into hospital as per the Policy. The staff intranet continues to develop for staff to access information relating to learning disabilities. The Paul Ridd Foundation recently commented on the good work done to develop the site. The intranet page also continues to develop CTMUHB has purchased ward packs from the Paul Ridd Foundation to support the Wards when an individual with a learning disability comes on to their Ward. A number of issues have been identified with the flagging system that is in place in CTM UHB, whilst individuals with a learning disability are flagged, ot's not always easy to see the flag, therefore discussions taking place with WPAS leads to look at how this can be overcome.		Continue to monitor compliance figures for the Paul Ridd Ridd Foundation level training on a weekly basis. Continue to deliver targeted communication pitches at regular intervals to staff. Target areas/departments where compliance is low.

To ensure reasonable adjustments are made for people with a learning disability accessing mainstream NHS services.

Key Actions:

1. Establish sustainable models of learning disability champions and learning disability liaison nurses.

2. Ensure system flagging to identify patients with a learning disability and increase the use of the health passports.

3. All staff in a public facing role to undertake the mandatory Paul Ridd Foundation Level Training.

Achievements	Risk to Delivery	Corrective Actions
Joint nomination submitted to the RCN Nurse of the Year Awards for the two Acute Learning Disability Liaison Nurses by the Lead Nurse for Learning Disabilities and following a presentation and interview, they are finalists in the Mental Health and Learning Disability Category. The Health Board mandated the Paul Ridd Foundation level training and made the necessary changes to the ESR system. The training formally launched within the Health Board during Learning Disability Week with targeted communications to all Managers and every staff member. Compliance figures collated on a weekly basis and is currently at 44.88%, which means that 5,672 have now completed the training. The Health Board is planning another targeted communication pitch to all staff when the compliance figure reaches 50%		

Health & Social Care Climate Emergency National Programme – NHS Wales Decarbonisation Action Plans

Organisation	Cwm Taf Morgannwg UHB	**Date of Report**	2/9/2022	**Report Prepared By**	Elle McNeil, Head of Planning and Commissioning
DAP Senior Sponsor	Linda Prosser, Executive Director for Strategy and Transformation	**Finance Allocated to Support Delivery (£s)**	NA	**FTE Resource allocated to support delivery**	NA

Aims and objectives: Wales has legally binding targets to deliver the goal of Net Zero emissions by 2050 this target is underpinned by an ambition for the Public Sector to be collectively Net Zero by 2030. There is a significant opportunity for Wales' health and social care system to lead the way on reducing carbon emissions. Action is needed not only because NHS Wales is the biggest public sector emitter (with a carbon footprint of around 1.00 MtCO2e which represents approximately 2.6% of Wales's total greenhouse gas emissions) but also because the health and social care system are at the forefront of responding to the impact of the climate and nature emergency on health outcomes. In response the Health and Social Care Climate Emergency National Programme has been established to support both National and Local action across the sector including the delivery of the *NHS Decarbonisation Strategic Delivery Plan 2021-2030.* A key enabling action within the Delivery Plan is the requirement for NHS Organisations to produce Decarbonisation Action Plans (DAP) which form the basis of how organisations are implementing Delivery Plan initiatives and more generally demonstrate the organisation's contribution to the collective ambition and target. This qualitative monitoring return supports the implementation of DAPs and the aims of the National Programme by providing a mechanism for reporting on progress and improvements.

NHS Wales Organisations are asked to report detailing the progress of their contribution to the Climate and Nature Emergency and associated targets as outlined in the organisation's plan (Priority Measure 31).

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales

Please attach a copy of your organisation's Decarbonisation Action Plan which should form the basis of how your organisation is implementing initiatives within the NHS Wales Decarbonisation Strategic Delivery Plan and more generally demonstrate the organisation's contribution to the ambition for the Public Sector in Wales to be collectively Net Zero by 2030 (for NHS Wales this means collectively reducing emissions by at least 34% by 2030) and achieving Net Zero by 2050.

Alongside this qualitative reporting organisations should also report quantitative, organisation level emissions in line with the Welsh Public Sector Net Zero Carbon Reporting Approach and timeline (Priority Measure 30*).*

Please provide an update on the actions implemented during the current operational year. Reporting should focus on providing evidence of progress and improvement along with key risks to delivery. Reporting can also be provided using the organisation's own reporting dashboard or equivalent if agreed with the Programme Team in advance.

Executive summary of progress to date:
Staff capacity to engage or deliver initiatives beyond core duties and services is currently very limited. This is impacting on implementation of our decarbonisation action plan and workforce mobilisation to achieve the culture change required to move towards being a more sustainable healthcare provider. Progress is being made within estates and facilities despite staffing and capital allocation issues. It is highlighted in the return that our ability to deliver the needed estate/facilities driven decarbonisation will not be achievable without additional revenue and capital funding due to the tight fiscal position of CTMUHB. Wider progress to achieve system change to reduce our carbon emissions is more limited, in particular driving down the high carbon emission factors associated with procurement of medical goods, services and technology where procurement is driven centrally for many of our contracts with focus on financial cost, rather than wider consideration of the true whole cost pathway, recyclability of products or our role as an anchor institution.

	Current RAG Status	**Previous RAG Status**
Progress RAG: Provide the RAG status of delivery against DAP	**Amber**	**Not applicable**
Delivery confidence RAG: Provide the RAG status of the organisations overall confidence of delivering a minimum of 16% reduction in emissions by 2025	**Amber**	**Not applicable**

Route to green including asks of WG
The following high-level issues are impacting on our ability to deliver the required structural, cultural and physical changes required to achieve our route to green carbon reduction in-line with the WG guidance: • Staff capacity to engage or deliver initiatives beyond core duties and services is very limited. This is impacting on implementation of our decarbonisation action plan and workforce mobilisation to achieve the culture change required to move towards being a more sustainable healthcare provider. This is as a consequence of high vacancy levels, staff exiting the NHS post-COVID pandemic and a challenging financial position resulting in CTMUHB all non-medical related posts being frozen and subject to additional scrutiny in order to reduce the wage bill. • The escalating cost of energy is impacting on our financial position, with end of year forecast estimated at £28m for 2022/23, where 2021/22 spend was ~£8m. While this is focusing attention on reducing our energy consumption the massive gap which is anticipated to remain in place over the coming years will impact on service delivery. We are exploring our role as an anchor institution to use our size, financial footprint and capacity to achieve wider sustainability goals, e.g. delivering care closer to home to reduce carbon emissions and/ or using active travel pathways; or, procuring goods and services locally to reduce carbon footprint and

support local businesses. Working with our local partners to use our collective size, spend and influence will help achieve the public sector net zero targets overtime, however the scale and breadth of changes required may take longer than the given timeframe.

Asks of Welsh Government:

- To provide support for a central consistent data reporting function to ensure NHS and cross-sectoral public sector reporting is carried out in the same manner in order to effectively monitor decarbonisation activities. The current reporting carbon emission template changes as a consequence of improving data collection have led to CTMUHB reporting an increase our carbon emissions despite activities to decrease them. This will be further exasperated in 2022/23 as a consequence of steep inflationary rises impacting on how the carbon emissions are calculated as well as any further amendments to the template if made.
- To provide greater leadership and coordination across NHS Wales and the public sector to enable greater sharing of information, ideas, learning, examples of good practice and innovations and to enable cross-sectoral large scale partnership working on services and projects that will reduce our collective public sector carbon footprint. As part of this, providing greater central guidance and support to develop the anchor institution role of public sector bodies would enable us to fully lever our capacity to deliver sustainability.
- To acknowledge and respond to the issues arising from the directive to increase electric vehicle (EV) usage within our fleet when the infrastructure plans for Wales do not support a wholescale change to EV due to grid capacity. Nor is there sufficient revenue or capital to meet the increased costs associated with implementation of this emerging technology.
- To provide additional revenue and capital investment to make the required improvements across our buildings, estates and facilities as well as service delivery to achieve our target carbon footprint reductions.
- To consider how best to support innovative approaches and emerging technologies to be adopted more quickly across health through devolving responsibility to those within health boards to overcome risk aversion practices which preventing uptake of new delivery, e.g. use of microbes to breakdown polymers rather than requiring high incineration or burial of clinical waste; or enabling installation of batteries to store electricity for SPV panels despite the lack of guidance on the use and safe installation of these new products.
- For Welsh Government and the new NHS Executive function to proactively engage and support changing the mind-set from seeing health care delivery bi-products as waste, as opposed to a resource that can be used or reinvested.
- To enable suppliers to work with health care providers to make products that can be reused or recycled – providing a focus of procurement value rather than financial cost, with greater consideration of the true whole cost pathway.
- Further consideration is required with central support of the role of joint appointments between universities and health boards in order to promote greater levels of collaborative working and to make the NHS an attractive employer, therefore helping to ensure sustainability of the NHS workforce.

	Achievements	Risks to delivery
Procurement initiatives	• iCTM working with NWSSP central team on a number of recycling projects, e.g. reducing IV fluid packaging to improve compliance, MediBoot project (see below). • CTMUHB are progressing their approach to being an anchor institution and developing a foundational economy model. • Some contracts are now being awarded to local suppliers, such as Bridge Roasters to supply our coffee shops. • Adoption of standard contract monitoring is ongoing, and will be developed to include greater scrutiny of carbon footprint of our purchased goods and services.	• Staff capacity to engage/ undertake the work and share the learning across Wales. • Cost of buying locally often exceeds larger/ international companies, putting delivery of the foundational economy and carbon savings at risk through procurement guidance focused on bottom-line cost. There are associated cost pressures of buying locally.
Buildings, estates planning and land use initiatives	• Solar panels now live at: Dewi Sant, Keir Hardie Health Park, Ysbty Cwm Cynon and Ysbty Cwm Rhondda. • Installation of ~2,000 LED lights across Princess of Wales Hospital. • Replacement of windows across whole ward block at Prince Charles Hospital to improve energy efficiency. • Discussion ongoing with all 3 local authority partners regarding private wire connections for solar energy. • Feasibility study complete for large scale solar panel installations at Glanryhd and Ysbty Cwm Cynon. • Recommenced discussion with Bridgend CBC regarding heat source network for the Bridgend Health and Wellbeing development. • Nearing contractual agreement with a Re:fit partner. • Discretionary capital approved for voltage optimisation scheme.	• Staff capacity and resourcing is a large pressure on delivery. Additional revenue investment is needed to develop a decarbonisation estates/ capital and facilities teams to achieve the decarbonisation targets. • Additional capital investment is needed to make the required improvements across our buildings and estates. Funding is required for improvement, retrofitting work, LED replacement, CHP removal planning, etc. to move towards carbon neutrality. All capital spend is subject to greater scrutiny as a consequence of CTMUHBs financial position putting delivery at risk. • Establishing the correct baseline position for 2019/20 to enable accurate forecasting and working towards 16% reduction by 2025. Ongoing changes to the annual carbon emission reporting template and inflationary price rises are resulting in increased carbon emission reporting, despite progress being made to reduce emissions. Ensuring that the most up-to-date carbon emission reporting template is used to re-establish the baseline and WG confirmation that these changes will be taken into account when assessing progress towards the 16% reduction target.

Transport initiatives	• Performance, Planning and Finance Committee approved the updated Travel, Transport and Car Parking policy. • Submission of NHS All Wales Fleet & Transport Decarbonisation Questionnaire on behalf of CTMUHB to NWSSP and Welsh Government. • Comprehensive review of all UHB transport provision completed and submitted to the Planning, Performance and Finance Committee to consider changing the fleet to include electric or hybrid vehicles in our vehicle mix. Current fleet vehicle contract is due for renewal; tender exercise to be completed 2022/23, which could reduce the CTM fleet carbon emissions. • The Facilities Technical Services team are in consultation with the workforce and staff teams to approve the use of tracking in Health Board vehicles. This would improve the monitoring and recording of the fleet mileage, maintenance, safety and compliance with speed and fuel consumption and emissions. A bid for funding a vehicle tracking system has been submitted in the Facilities 2022/23 IMTP submission. • A review of the current operating transport fleets, their routes and schedules has commenced. The scope of the review involves an assessment of quality, compliance with health care standards and legislation. In addition we are exploring ways to consolidate transport services.	• Staff capacity to engage/ undertake the work and share the learning across the health board/ wider Wales. • Additional capital investment is needed to make the required travel related infrastructure improvements (e.g. EV charging points) across our estates. Funding is required for improvement to move towards carbon neutrality. • Availability of space, capacity and access on sites to implement initiatives. E.g., estates advise that the electric power load capacity at some of our sites may not be sufficient to support a fleet charging infrastructure and require support from Western Power Distribution and funding to upgrade and increase capacity. • Increases in CTM electric charging energy costs, up from £8m in 2021/22 to estimated £28m for 2022/23. • Organisational changes (e.g. changes in services, staff numbers, CTMUHB estate and allocation of resources and access to them). • Keeping up to date with increasing advances in equipment and technology and ensuring implementation in initiatives. • Improvements required involve a lot of work in a relatively short period of time to achieve decarbonisation targets. • Risks identified on consideration of implementing the vehicle tracking device system (e.g. Legislative and NHS Requirements, Increased User and Management Responsibilities, Additional requirements of Accident Reporting, Training Implications).

Approach to health care (service design/models of care, medicines, waste)	Waste and Recycling • SBRI bid submitted in partnership with CAVUHB, ABUHB, USW, NWSSP and Wale's value in health team regarding physio and orthotics use of plastic devices. • Health Hack funding secured for 'Team MediBoot' to explore recycling single use MediBoots and reduce clinical waste. • Your Medicines, Your Health with primary care and iCTM/ USW have reviewed inhaler's polymer types to identify how to improve their recyclability. • CEIC project exploring potential of cardboard packaging recycling into a product for resale (*potential for income generation*). Healthcare service design • Green endoscopy is being adopted across CTM following a Quality Improvement project which has altered waste segregation, improving recycling rates and reducing clinical waste through working with the suppliers, clinicians and facilities staff. CTM2030 includes *'Sustaining our Future'* as a key strategic goal which will underpin all services changes moving forwards. Work has commenced to mainstream decarbonisation into our Project Management Office approach to service transformation and change in order to capture carbon reduction activities across all work streams. This is supported by the developing 'CTMUHB Unified Transformation Portfolio' approach chaired by our CEO Paul Mears to provide strategic oversight and guidance across the 4 CTM2030 goals. Portfolio programme boards are being established to oversee 2 sustainability work streams, portfolio 4: Value & Effectiveness, and portfolio 5: Environmental Sustainability.	Waste and Recycling • Staff capacity to engage/ undertake the work and share the learning across the health board/ wider Wales. • Innovative approaches work quicker than governmental oversight, leading to risk aversion preventing uptake. • Lack of expertise in climate change, carbon reporting and sustainable improvement throughout the workforce. • CTMUHB failed to secure Cardiff City Regional funding for a series of plastic waste focused initiatives despite altering submissions in line with previous feedback. The decision has been taken to cease any further applications to this funding source. Healthcare service design • There are no dedicated corporate roles to deliver our decarbonisation agenda.

Further initiatives	Informing the Workforce/ Enabling Cultural Change
	• Welsh Government funding has been secured for:
	  ○ 'Innovation Sustainable Scholar' programme accessing training and support from the Centre for Sustainable Healthcare over a 6 month period.
	  ○ Developing an introductory e-learning package for CTMUHB staff, with potential to spread and scale to all NHS employees via ESR (mandatory) training.
	• Embedding information about our decarbonisation strategy and the links between climate change and healthcare within our mandatory corporate induction training (go-live Q3).
	• Developing a 'Green CTM' newsletter as part of a wider communication and engagement plan to highlight green initiatives, practices and changes that individuals can make.
		Informing the Workforce/ Enabling Cultural Change
		• Staff capacity to engage/ undertake the work and share the learning across the health board/ wider Wales.
		• Completion of the sustainable quality improvement projects by March 31st 2023 (funding window).

Relevant Strategies and Guidance

- Net Zero Wales sets out the actions needed to meet Wales's second carbon budget (2021-2025).
- Prosperity for All; A Climate Conscious Wales is the climate change Adaptation Plan for Wales. This plan provides the overarching framework for Adaptation Planning within Health and Social Care.
- NHS Wales Decarbonisation Strategic Delivery Plan provides an ambitious mandate for National and Local action across NHS Wales including the requirement for NHS organisations to produce Decarbonisation Actions Plans.
- The requirement for NHS Wales to develop plans in response to the Climate Emergency is referenced in the NHS Wales Planning Framework 2022-2025. NHS Wales Chairs have also been briefed on the need for plans to reflect the milestones that need to be achieved to respond to climate change and achieve the goal of the Public Sector being collectively carbon neutral by 2030.
- Best practice and case studies from NHS Organisations can be found:
  - Home | Green Health Wales | Iechyd Gwyrdd Cymru | Sustainable Healthcare Network
  - How NHS Wales is responding to the climate emergency | NHS Confederation
- The Public sector net zero reporting guide provides a guide and reporting requirements for the public sector in Wales to estimate their net carbon footprint, including direct and indirect emissions.

Embedding Foundational Economy Principles

Organisation	Cwm Taf Morgannwg University Health Board (CTM)	Date of Report	30/09/22	Report Prepared By	Linda Prosser, Executive Director of Strategic Transformation

The Welsh Government is committed to build on its approach to the foundational economy of Wales. Each organisation within NHS Wales is an 'anchor institution' and has significant spending power that can be used to achieve broader policy goals.

Recognising the value of focussed spending in Wales that supports local economic growth, regeneration and community resilience will help address inequalities and socio-economic determinants of health.

Organisations must embed foundational economy principles in strategic plans, spending policies and decisions.

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales

Update on the actions implemented during the current operational year to support the embedding of Foundational Economy Principles.

	Area of Focus	Key Actions Taken During the Reporting Period	Risks to Delivery, Corrective Actions & By When	Outcome/What Was Achieved
1.	**Detail of any projects where solution redesign** is benefitting Welsh organisations, i.e. redesigning services to enable	Food is one key area of focus for the health board: through the Healthy Options programme, CTMUHB continues to ensure sustainable and healthy catering for staff.		CTMUHB continues to focus on providing healthy options for staff and looking to future opportunities for expanding this.

	Area of Focus	Key Actions Taken During the Reporting Period	Risks to Delivery, Corrective Actions & By When	Outcome/What Was Achieved
	Wales-based solutions to existing problems.	We are continuing to explore the option of purchasing culled meat locally, with a view to reducing costs as well as supporting local business.	There may be a financial risk in using local suppliers as they are not producing to the same economies of scale as existing providers.	
2.	**Detail of any employment initiatives** that increases training and employment opportunities for individuals from the geographic area served by your organisation. This should have particular focus on initiatives that target those individuals who are furthest from the labour market e.g. long term unemployed, disabled workers, etc.	The UK Government Apprenticeship Scheme is active in CTMUHB involving the health board contributing towards a levy to help new and existing employees develop skills to meet current and future skills requirements. We continue to promote and look for opportunities to employ apprentices. Project Search - offering internships to those with a learning disability and/or Autistic Spectrum Disorder. Kickstart - work placement opportunities for younger workers to gain valuable experience		The Apprenticeship and Qualifications Manager continues to work with line managers and training partners to recruit to a variety of apprenticeship pathways and work with HEIW on accreditation processes for apprenticeships including the Health Care Science (Level 4) scheme. We seek to introduce **12** apprenticeship roles during the 2022-23 financial year. From September 2022, the programme will expand into Merthyr and Cynon creating a further **8** intern placements. We employed 10/25 of those who had been part of Kickstart.

	Area of Focus	Key Actions Taken During the Reporting Period	Risks to Delivery, Corrective Actions & By When	Outcome/What Was Achieved
		We are currently working with the Department of Work and Pensions to explore a scheme for employing unemployed over 50s. CTM are exploring the concept of an in house care service. There will be a focus on recruitment of individuals from our local communities as part of the recruitment to this service.		To reduce the number of unemployed over 50s within our region. We want to employ local people as part of this service as we feel that they really understand the needs of the communities we serve and want to promote health and care as a future employment/career option.
3.	**Detail of any projects where the location and co-location** of services and their impact upon other organisations has led to service change.	There have been no additional changes to the previous submission. However, as part of our capital planning process we continue to focus on the importance of where services are located and which other services would ideally be co-located/located nearby to have the greatest impact.		

Area of Focus		Key Actions Taken During the Reporting Period	Risks to Delivery, Corrective Actions & By When	Outcome/What Was Achieved
4.	**Detail of changes to strategic decision-making processes** to ensure items 1-3 above are considered as standard.	The Anchor group continues to meet is developing a strategy to support the work. This is a key element to CTM2030. Sustainability in CTM has been supported by a CTMGreen Group (see https://www.greenhealthwales.co.uk/ctmuhb) with representation across clinical and non-clinical staff. A new Decarbonisation Board has been established with the first meeting planned for October 2022. The Healthy Housing Partnership continues to meet and has a planned summit for the region taking place on the 5th October 2022 to further the work of the partnership.		The Anchor steering group is meeting regulalrly and is in the process of finalising an Anchor strategy for CTM. The CTMGreen group has secured several achievements including improvements in use of disposable clinical materials, food waste collection at all hospital sites and senior engagement to support the NHS Wales Decarbonisation Strategy.

Embedding Value Based Health and Care

Organisation	CTMUHB	Date of Report	28/9/22	Report Prepared By	Head of Value Based Healthcare

Value based health and care (VBHC) is the equitable and sustainable use of available resources to achieve better outcomes and experiences for every person.

The NHS Wales Planning Framework 2022/25 recognises our overarching system focus must be on safety, equality of access and improving outcomes, with VBHC as the basis on which services should be planned and delivered.

Four areas of focus are listed below, against which organisations should be able to demonstrate progress in adopting a VBHC approach in their strategic decision-making, planning and allocation of resources. Organisations are welcome to submit their Value Based Health and Care Plan as additional supporting material.

Reporting Schedule: Progress is to be reported bi-annually. This form is to be submitted on:

- 14 September 2022 (covering the period 1 April 2022 to 31 August 2022)
- 14 April 2023 (covering the period 1 September 2022 to 31 March 2023)

Completed form to be returned to: hss.performance@gov.wales

Update on the actions implemented during the current operational year to support the embedding of Value Based Health and Care

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
1.	Demonstrate improvements in the **reduction of adverse clinical outcomes** (as captured in clinical audit) in chronic conditions.	**Optimising Heart Failure Diagnosis – NT Pro BNP** In support of the work to produce a standardised pathway across CTM for the diagnosis of heart failure via Primary Care, the current reality pathways across the three former ILG areas have been mapped in partnership with clinicians and costed.	The initial TDABC costs have been prepared for each step in the current pathways using the agreed Welsh approach and toolkit. There is strong clinical engagement supporting the process. Data is currently being collated from a range of sources to review effective and appropriate	This project is part of a whole systems pathway approach in Heart Failure, including projects in optimising medication, rehabilitation and palliative care. This will enable the service to understand the impact at each stage within the pathway and the cumulative effect for patients.

<table>
<tr><th></th><th>Area Of Focus</th><th>Key Actions Taken During the Reporting Period</th><th>Outcome/What Was Achieved?</th><th>Comments/Context</th></tr>
<tr><td></td><td></td><td>Further work to review the current utilisation levels of NT ProBNP and potential impact on inappropriate use of ECG is being undertaken. A costing review will also be undertaken.

Evaluation of Remote Monitoring of Heart Failure Patients App, (HUMA)
To support the evaluation of a proof of concept patient digital remote monitoring system in the heart failure medication titration process. Patients are reviewed and if appropriate registered to use the digital app, supported by the Heart Failure nurse. The cost of new and historic treatment routes was identified and reviewed, as well as any change in intervention method and patient outcomes.</td><td>diagnostic opportunities and to reduce inequity across CTM.

This data will further be used to test a VBHC procurement contracting system which can utilise patient clinical outcomes aligned with contract agreements.

Given the typical nature of condition-specific specialist nursing, bottom-up costing was not viable and as such a fully-apportioned approach was used.
Core costs per cohort were identified and an analysis of available activity data was undertaken.

It was identified that although there was not a significant difference in the Heart Failure nurse costs for intervention, 6/8 appointments were undertaken virtually rather than face to face, and took place following changes identified in symptoms and clinical measurements related to medication titration – enabling a shorter time to optimise. Usual practice of face to face titration usually takes 8 months, titration supported by the digital app is demonstrated in Table 1.
Table 1
<table><tr><th>Days to Optimise</th><th>Frequency</th><th>%</th></tr></table></td><td>The next step is to finalise the indicative current pathways and associated costs, a workshop with clinical teams has been planned for Nov 22.

The pathways are to be compared to standing activity data from PAS in support of the Value Based Procurement aspect of this exercise.

A trial run of data through the Digipharm platform is being planned following required training from McKesson to access and use the data.

VBHC allocated funds were used to extend the original project to enable evaluation work to take place. CTM are currently undertaking wider work to review a strategic approach to the use of digital applications as an organisation.

Further details of the pilot are available on request</td></tr>
</table>

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
			8-66 | 37 | 56% 66-125 | 19 | 29% 125-183 | 6 | 11% 183-242 | 1 | 0.02% 242-300 | 1 | 0.02% >300 (407, 418) | 2 | 0.03%	
		24/7 Alcohol Liaison Service To facilitate the opportunity and benefits of a 24/7 alcohol liaison service across CTM, based on the VBHC best practice approach of ABUHB, current service pathway mapping, resource (staffing, partners and costing) mapping and identification of activity have been undertaken. This is being led by service and planning colleagues with support from the VBHC team to progress this work.	Indicative pathway schematics have been developed with strong support from clinicians from all three teams. Planning has commenced to identify common currency & language to describe the activities the three teams undertake. This is important for numerous reasons including the ability to ensure any changes made improve the efficiency of the service and outcomes for patients. The resource mapping and activity identification are underway.	This project sits within the VBHC portfolio and was recently successful in mid-year VBHC funding allocation received from WG/FDU for additional VBHC projects. The Task & Finish Group is evolving into a Steering Group and VBHC programme plans and recruitment will shortly take place.
		Interventions Not Normally Undertaken (INNU) Action came from the workstream from the Chief Executive to review INNU activity and potential related savings.	Given the current INNU activity levels, the review was shifted to analysis of INNUs entered onto the waiting list to ensure that elective capacity is maintained for high value activity with ongoing engagement with the services. The waiting list data has been extracted and is undergoing validation checks. An updated list of INNUs to cover the entire health board is being prepared to reflect latest guidance on INNUs and the amalgamation of	Next steps: Publish updated INNU guidance within HB whilst awaiting full INNU review by WG and Public Health colleagues. Include INNU information in external validation of waiting lists i.e. asking patients if they have experienced tonsillitis in last 12 months if on a waiting list for a tonsillectomy.

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
			Princess of Wales with Royal Glamorgan and Prince Charles Hospitals.	
2.	**Delivery programme of PROM collection and sharing PROM data nationally** to inform value-based decision making and direct clinical care.	• 257 Heart failure PROMs completed • 215 Lymphoedema PROMs completed • 106 RIW PROMs completed • Palliative Care PROM- set up on DrDoctor but not live- awaiting agreement/ authorisation from the project team. • Training has been provided to the relevant clinical staff to enable them to access and review the patient PROM data that has been completed by patients on the digital PROM platform. Staff can review the data and action where needed within the relevant clinical care teams • Discussion took place with DHCW on reporting of the heart failure PROM data to share nationally.	• CTMUHB have worked with SBUHB regarding repatriation and access to former patient records of Bridgend • CTMUHB has successfully transferred all HF PROM data from DrDoctor and is now being held in CTMUHB warehouse • CTMUHB have now made the HF PROM data available to DHCW for reporting who have confirmed that the raw data being transferred to them is good and covers a lot in the DCCQ-12 DSCN. Therefore the testing of the reporting raw data is now complete • CTMUHB currently in talks with DrDoctor to automate the heart failure PROM data from their system to CTMUHB and then automate out from CTMUHB to DHCW. This is currently a manual process which will need to be rectified in the near future • Digital Lymphoedema PROMs within CTMUHB went live June 2022. This data is currently not being reported to the national lymphoedema network team however discussions are being undertaken to make this happen in the near future. • Spirometry Mobile Respiratory Unit PROM data is a 6 month pilot project, in partnership with Hywel Dda UHB & RIW, which will finish at the end of Oct 2022. A clinical respiratory PROM was developed and agreed with RHIG, PROM data is currently not being reported on	CTMUHB are supporting the National VIH Team and Shared Services in the development of a National PROMs provider procurement framework, and are keen to then utilise this to undertake a local procurement exercise to procure a PROMs provider which meets the newly published PSOM National standards and guidelines. This will ensure that key data interoperability, sharing, analysis etc within CTMUHB and Nationally will be achievable. Other founding aspects of this work include the requirement for ease of visualisation of the data by clinical teams, which is not possible with our current limited provision. A number of delays have been experienced in the development of the National PROMs procurement framework, which have directly impacted on our ability to progress this area. However, CTMUHB have used the opportunity to introduce the concept and processes of PROMs collection, analysis, and integration to service delivery, however, we have restricted the roll-out across the VBHC portfolio, awaiting the framework, to reduce the impact of implementing and then withdrawing. We have developed hybrid clerical support roles, which provide clinical

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
			nationally, however a report will be published on the data in the future once the project is complete.	booking support, and patient and clinical team support with awareness and understanding of PROMs, to support integration and improved uptake completion rates. These roles commence in Oct 22. Aligned to PROMs, we have taken the strategic decision to implement PREMs (Patient Reported Experience Measures) and WREMs (Workforce Reported Experience Measures) concurrently, to provide a wider breadth of information to support the whole of the patient outcome and experience in health intervention, and to identify if interventions and approaches do enhance relationships and improve shared decision making.
3.	Progress with **allocating resources to secondary prevention activities** in high volume clinical areas that have a significant influence on patient outcomes and utilisation of resources.	CTMUHB VBHC funding allocated across our VBHC portfolio and to key CTMUHB and National priority areas and programmes including: **National:** • **Lymphoedema Phase 1 & 2** • **Cellulitis** – funded band 7 AHP in National Team **CTMUHB**: • **Heart Failure Pathway** NT Pro BNP – Optimising HF Diagnosis HF Optimising Medications – Recruitment of 4 x HF Nurses and hybrid VBHC clerical support HUMA Digital Remote App HF Optimising HF Rehabilitation	A systematic performance and assurance framework has been developed and implemented across the VBHC portfolio, ensuring consistency. A VBHC programme management suite has been developed and utilised with support to the established programme groups. Highlight reporting templates are completed by each programme, shared at specialist Steering Group level and then form regular composite reporting to the VBHC Steering Group. Task and Finish Groups were established in new areas including AF & Hypertension, 24/7 ALS and Spirometry MRU. Baseline reality resource and activity mapping has been undertaken and is being aligned with costing profiles, to support identification of optimising interventions. Recruitment for projects has been on-going, with a number of posts being filled in this timeframe.	Business cases, programme plans and highlight reports on the commenced projects are available on request. Further projects have been allocated funding as agreed at beginning of September 2022, including: Diabetes Podiatry UroGynae Physiotherapy Medicines Management Digital App Programme Support for ILD Lung Project Review Programme Support for Frailty Project Review In addition, CTMUHB bid and were successfully allocated funding from the National VBHC pot for a 24/7 Alcohol

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
		HF Improving HF Palliative Care • **Diabetes** Pre-Diabetes Project Diabetes ante-natal project & pilot GD-M App Weight Management Diabetic Retinopathy • **24/7 Alcohol Liaison Service (ALS) – Task & Finish Group - mapping** • **AF & Hypertension – Task & Finish Group - mapping** • **UroGynae Physiotherapy** • **Mobile Respiratory Unit – Spirometry with HDUHB & RIW** • **MyMobility T&O Digital App**	The CTMUHB VBHC portfolio is supporting a number of digital apps to enable proof of concept trial and review.	Liaison Service and as a partner in a Regional AF & Hypertension Project with SBUHB and & HDUHB.
4.	**Reduction in unwarranted variation and activity of limited value**, and standardisation of best practice pathways which support delivering improved outcomes.	Building on the Heart Failure work carried out in Swansea Bay and CTM Bridgend ILG, the VBHC Team initiated a project to investigate the unwarranted variation in the diagnostic phase of the Heart Failure pathway. A JWA (Joint Working Agreement) has been put in place between CTM, Roche Diagnostics and Digipharm with the intention of: a) Improving outcomes for patients in the diagnostics phase, increasing the use of NT-proBNP within CTMUHB primary care Utilising a Value Based Procurement approach to contracting on outcome improvements and payments on	Several Joint workshops have been held involving CTM Clinical Staff, Procurement, Finance, Programme Management, Industry Partners, Welsh Value in Health Team, Life Sciences Hub In consultation with clinical staff, 3 Heart Failure pathways (per CTM ILG) have been mapped and costed. An MDT Workshop is being planned for mid-Nov 22 with the intention of reviewing the pathways and identifying unwarranted (and warranted) variation, and standardising wherever possible for CTM	Lack of organisational access to data sources has delayed the transfer of data to Digipharm, and subsequent monitoring of agreed Outcome Measures.

	Area Of Focus	Key Actions Taken During the Reporting Period	Outcome/What Was Achieved?	Comments/Context
		results, outcomes being monitored by the Digipharm platform		

Supporting Information

A VBHC approach requires consideration of the whole pathway of care, so that we make informed decisions regarding optimal utilisation of resources to achieve the best outcomes.

In order to do this, a data-driven health and care system is needed, where decision makers at every level have readily accessible information on patient outcomes, to support decisions on planning the allocation of resources and service design that meets true need across the whole pathway of care.

We achieve value for our population through the sum of all interventions across the pathway:

There are many ways to improve outcomes and sustainability of our healthcare system. In this planning cycle, we are focussing on **interventions that are likely to improve outcomes and optimise resource utilisation in the short to medium term, whilst organisations build their systems for longer-term value.** These are:

- reducing **unwarranted variation** in care pathway delivery, to release capacity; and

- investment in **secondary prevention** approaches to improve outcomes, minimise harm and reduce acute health care utilisation. Secondary prevention refers to activities which reduce the impact of conditions already diagnosed, with shorter-term favourable impact on outcomes.

We are also asking organisations to invest in their **collection and use of data on both clinical and patent-reported outcomes** to inform value-based decision making and direct clinical care. Measuring cost and outcome data will provide an evidence-base from which to demonstrate improvements in **the reduction of adverse clinical outcomes in priority condition areas**.

These vital foundation steps in embedding a VBHC approach are set out as **four areas of focus in the template above**. Providing information on progress against these four areas will allow for a consistent picture nationally of VBHC delivery, within an approach that recognises local priorities and population need.

The Welsh Value in Health Centre can provide support to organisations as they look to embed a VBHC approach, including advice on data collection and analysis, access to information tools, and examples of high-value interventions across a range of condition areas.

AGENDA ITEM
7.6

CTM BOARD

WINTER PLANNING 2022-23

Date of meeting	24 November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	David Allison, Interim Director of Operations USC Care Group/UEC 6 Goals Advisor and Elizabeth Beadle, Assistant Director of Planning
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
UEC 6 Goals Programme Board	18/10/2022	NOTED
Executive Leadership Group	7/11/2022	APPROVED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The NHS Wales Delivery Unit informally issued advance notice of expected structure for the assurance on seasonal planning for winter 2022-23.

1.2 This was followed by the provision of formal guidance on 23rd September 2022.

1.3 The guidance set out a number of key requirements for the winter plan which were to be founded on the framework of the Six Goals for Urgent and Emergency Care plans. The requirements were:

1.3.1 NHS Wales Ambulance Delivery (EASC) Action Plan
1.3.2 Fit to Sit implementation across all acute hospital sites
1.3.3 Critical care services
1.3.4 Children and young people's services
1.3.5 Planned Care
1.3.6 Cancer services

1.4 The full guidance is included as appendix 1 (available on request).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The health board planning and operational teams have worked to develop specific winter plans that are <u>in addition</u> to the changes/improvements resulting from the UEC 6 Goals CTMUHB improvement programme (Annex A).

2.2 The plans include:

2.2.1 Winter vaccinations for seasonal influenza and COVID-19
2.2.2 Surge requirements to sustain urgent and emergency care and planned care resilience.
2.2.3 Communication for staff and the public.
2.2.4 Ambulance plan

2.3 Potential options to increase capacity have been assessed by a group comprising representatives of the breadth of the health board's services. Schemes were assessed for their impact on sustaining service resilience and quality and safety of care to our patients, affordability and the likelihood of being able to put the plans in place in a timely manner to positively impact on winter pressures.

2.4 Additionally, the winter planning group highlighted the need to seek organisational approval to fund therapies services (within the national UEC 6 Goals SDEC funding) which would further augment the integrated front door discharge teams at the health board's three acute hospital sites and also enable an acute frailty assessment offer at all three acute sites. The cost of this development is £601,000 per annum. £94,000 has already been committed and the remainder of the funding - £507,000 was requested for approval by Executive Leadership Group as a key contributor to the improvement of the urgent and emergency care offer.

2.5 The Winter surge capacity proposal (closely aligned to the WG 1000 beds submission) is for a range of prioritised additional capacity

across a range of settings. This proposal has been through several iterations to ensure rigorous assessment of the viability of the surge options and ability to deliver within requisite timescales to support winter resilience.

2.6 The final proposal is for three surge schemes: discharge to recover then assess (D2RA) beds at Brocastle Care home, and bridging pathway capacity at Princess of Wales Hospital (Ward 16) and Ysbyty George Thomas).

Beds	Number	Est Date	Capital £k	Revenue £k	Bed type
YGT (Seren)	16	Mid Dec 22	60 TBC	447	Bridging (Pathway 2.3)
POW W16	15	1 Feb 23	164	226	Bridging (Pathway 2.3)
Brocastle (50% cost)	6	1 Dec 22	0	78	D2RA Pathway 3 (non-Dementia)
TOTAL	37		**224**	**752**	

2.7 The total capital cost of these schemes is £225,000 and recurrent costs (until 31/03/2022) are £752,000.

2.8 CTMUHB will continue to have significant discharge delays through winter whilst we embed the D2RA model and whilst Local Authorities attempt to further build domiciliary care capacity.
Current delay data shows significant waits for homecare within both acute and community hospitals.

2.9 There are significant therapy workforce challenges so it is essential that the surge beds both meet delay demand and also mitigate against the need for any significant therapy input – hence most beds will be for D2RA pathway 2.3 (D2RA pathway 1/package of care waits bridging). The model is attached as Appendices B-D for information.

2.11 The winter plan also includes a number of prioritised (green) schemes that will best contribute to optimising patient admission avoidance, and flow and discharge in both acute and community hospitals. There was a large number of schemes submitted initially; however this list was significantly reduced based upon the criteria and also the financial affordability challenges. These schemes are set out below.

Focus	Scheme Description	Start date	£k
Reducing LOS	RGH - Additional acute care physicians	mid Nov	142
Reducing LOS	RGH – Discharge lounge	01/12/2022	51
Front door	POW - Paediatric Nurse Practitioner in ED	01/12/2022	20
Clearing back door	POW (CTM-wide) - Discharge Liaison Practitioner Service	01/12/2022	101
Admission avoidance	PCH (CTM-wide) - nMAB service (nursing OOH)	01/12/2022	60
Front door	PCH treatment rooms - additional HCA by night	01/11/2022	332
Front door	Weekend Trauma List	01/12/2022	85
Reducing LOS	PCH - Patient, Family and Flow Liaison Officers	mid Nov	30
Community hospitals	2 x band 5 Pharm Techs to support self medication	01/12/2022	50
Clearing back door	Discharge Hub – discharge referral management assistants	01/12/2022	36
Winter resilience	Adverse weather - 4x4 vehicles	20 weeks	26
Winter resilience	Adverse weather - gritting & snow clearance	01/11/2022	55
Total			**987**

The final winter plan was presented to the Executive Leadership Group on Monday 7th November 2022, and was approved for implementation.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Not mobilising the priority schemes within the plan will:

3.1.1 Result in unacceptably high numbers of medically/MDT optimised patients occupying both acute and community hospital beds through winter.

3.1.2 As a consequence, this will impact on the ability for acutely unwell patients to be able to access inpatient beds when they need them, with associated clinical risks.

3.1.3 Exacerbate emergency department crowding/exit block, and prevent timely offloading of ambulances, with associated mortality risks and adverse reputational risks to the health board.

3.1.4 Significantly impact and work against the mobilisation of Discharge to recover then Assess (D2RA) pathways – patients will be assessed 'at their worst' in hospital with associated avoidable delays and subsequent over-prescribing of care/unnecessary use of available community capacity

3.1.5 Detract from the effectiveness of the improvements implemented as part of the CTMUHB UEC 6 Goals programme.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The elements of the proposed winter plan will directly contribute to: • Reducing discharge delays and clinical deconditioning (avoidable harm) • Enable people to get the right care in the right place at the right time • Improve peoples' levels of independence and enhance their recovery and longer term outcomes • Contribute to reducing ED crowding/exit block, and thus improving associated patient safety
Related Health and Care standard(s)	Timely Care
	If more than one Healthcare Standard applies please list below: Staff and resources Safe care Individual care Dignified care Effective care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	The winter plan seeks to improve access to services and improve ability to discharge patients safely to an appropriate destination and improve system flow.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Please note the financial implications in the body of the report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is requested to **ratify** the approval of the executive team to mobilise the prioritised surge bed schemes to enable them to be successfully brought on line before winter.

5.2 The Board is further requested to **approve** mobilisation of the prioritised associated green schemes and to enable them to be successfully delivered in time to support winter resilience.

5.3 The Board is requested to **ratify** the approval of the executive team to implement the proposed therapies services to support further augmenting the integrated front door discharge teams and also enable an acute frailty assessment offer at the health board's three acute hospital sites.

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

Six Goals Programme – Plan on the Page

CYNNAL EIN DYFODOL – SUSTAINING OUR FUTURE
YSBRYDOLI POBL – INSPIRING PEOPLE
GWELLA GOFAL – IMPROVING CARE
CREU IECHYD – CREATING HEALTH

Six Goals Programme Board (Urgent & Emergency Care)

- Goal 1: Coordination, planning and support for people at greater risk of needing UEC
- Goal 2: Signposting, information and assistance
- Goal 3: Clinically safe alternatives to admission
- Goal 4: Rapid response in crisis
- Goal 5: Optimal hospital care and discharge practice from the point of admissions
- Goal 6: Home first approach and reduce risk of readmission

Integrated Data & Performance Dashboard Sub-group

Workstream 1: Attendance Avoidance (UEC Goals 1,2 & 3)

111/111#2
Navigation Hub (Second Point of Access)
High Intensity Frequent Attenders
Urgent Primary Care
Community Frailty (falls,integrated crisis response/virtual ward)
Enhanced care home support
MIU resilience

- Navigation Hub T&F Group
- Community Frailty T&F
- High Intensity Frequent Attenders T&F Group
- Urgent Primary Care T&F Group
- MIU T&F Group

Workstream 2: Integrated Front Door (UEC Goals 2,3,4 & 6)

SDEC (surgical and medical)
Acute Frailty – SDEC/Assessment unit
Ambulance handover/offload
ED /acute assessment (med/surg)
Direct referral pathways
MH Crisis Response
Hot / rapid access clinics
D2RA Pathway 1

- ED T&F
- SDEC T&F Group
- Acute medicine T&F Group
- Hot clinics T&F Group
- Acute frailty T&F Group
- D2RA Pathway 1 (Front Door) Group

Workstream 3: Acute Hospital Flow & Discharge (UEC Goal 5)

SAFER relaunch/Red2Green implementation
One List App
Consistent board rounds/Electronic whiteboards
Optimise discharge lounges
"Doing tomorrow's work today"
Robust escalation action cards/procedures
Accurate EDDs
Improved clarity re: medically optimised
Site/bed management processes
LLOS review process
Vascular/Stroke/NIV pathway

- One List App Project Group
- NIV Pathway Resilience T&F Group
- Bed Management /flow T&F
- Stroke Pathway Resilience T&F Group
- Ward flow and discharge T&F Group
- Vascular Pathway T&F Group

Workstream 4: Integrated Discharge (UEC Goal 6)

D2RA implementation – right sizing community services
Development of e-TOC referral form
CLD community hosps
SAFER/Red2Green in community hosps
Community hosp D2RA electronic whiteboard solution
Supported discharge management
Review of referral management (SPOA)

- D2RA Pathway 1 T&F Group
- D2RA Pathway 2 T&F Group
- D2RA Pathway 3 T&F Group
- Supported integrated discharge T&F Group
- D2RA referral mgt T&F Group

Integrated Resource (Workforce) Sub-group

Integrated Commissioning Sub-group

Discharge to Recover then Assess (D2RA) Pathway 2 flowchart

It is recognised that many of the people we may be supporting have multiple or long-standing conditions and will never be fully 'medically fit' or 'medically optimised'. D2RA Pathway 2 should be initiated as soon as treatment, which can only be delivered in an acute hospital environment, is completed and only if Pathway 1 has first been ruled out as inappropriate for the individual's level of need. 'Home First' will always be the first consideration.

D2RA Pathway 2 is designed to support people to recover in a bedded intermediate care facility before being assessed for any ongoing need, in order to:

- Avoid deconditioning and loss of confidence in hospital;
- Minimise exposure to in-patient infection risk;
- Maximise recovery and independence;
- Provide a seamless transfer to longer-term support in the community, if required.

Within CTM, the D2RA Pathway 2 model has been developed to encompass the following specific pathways:

Focus	Pathway	Definition
	Discharge to Recover then Assessment (D2RA) Pathway 2.1	**bedded rehabilitation** where care needs cannot **currently** be supported at home (and where alternative capacity not available)
	Discharge to Recover then Assessment (D2RA) Pathway 2.2	**bedded reablement** where care needs cannot **currently** be supported at home (and where alternative interim residential home/extra care housing capacity not available)
	Discharge to Recover then Assessment (D2RA) Pathway 2.3	Transitional care (**short term 'bridging'**) for those awaiting D2RA Pathway 1 (home with support) where alternative home care capacity not currently available and supported with 'light touch' reablement during inpatient stay (**as per pathway 2.2**). D2RA P2.3 will provide bridging ideally for up to 5 days. **Red delay code EXT ER6** (D2RA (discharge to recover then assess) Pathway 1 (Home with support) will be applied for this period until discharge into D2RA P1 (effective from date of transfer into D2RA P2.3)

Definition of Rehabilitation

Rehabilitation is the provision of personalised support to enable people to **recover from periods of physical and mental ill-health**. Rehabilitation ranges from supporting people to manage long-term health conditions and disabilities through primary care services to acute hospital settings preparing people to return home and back to their local community. Rehabilitation is about enabling and supporting individuals to recover or adjust, to achieve their full potential and to live as full and active lives as possible, and reflecting what matters to them as individuals.

Restorative rehabilitation focusses on interventions that improve impairments such as muscle strength or respiratory function and cognitive impairment to get **maximal recovery of function**. This is a common form of rehabilitation after surgery, illness or acute events such as a major trauma or a stroke.
Supportive rehabilitation increases a person's self-care ability and mobility using methods such as providing **self-help devices** and teaching people **compensatory strategies or alternative ways of doing things**. This may include the provision of assistive equipment or environmental modifications. This is sometimes referred to as adaptive rehabilitation.

Definition of Reablement

Reablement services aim to encourage and support people to **learn or re-learn skills necessary for daily living**, following a period of illness or after a stay in hospital. Reablement support is about helping people to discover what they are **capable of doing for themselves** reflecting their personal wishes, and to give them **confidence** when moving around their home and with tasks such as washing, dressing, managing medications and preparing meals. Reablement services must have the aim, through therapy or treatment, to support someone to **recover** or **maintain their ability to live independently at home**.

Review every patient against the 5 prompts (COVID-19 National Hospital Discharge Service Requirements [Wales] April 2020, Section 8.3):

- Has this person recovered to the point that their care now be provided in another setting? Think 'Home First'
- What is value added for this person remaining on a community hospital ward, balanced against the risks?
- Why not home? Why not today? (use CTM D2RA Pathway 1 criteria poster to confirm earliest point for home)
- If not today, when? (Expected date of discharge)
- What needs to happen next? (Actions for today)

D2RA Pathway 2 - Explore if patients still require rehabilitation/reablement in a community hospital setting

D2RA Pathway 2 - Ensure that all nursing care delivery maximises independence 7/7 and aligns with the patient's rehab/reablement plan and goals ('preventing PJ paralysis')

Discharge to Recover then Assess (D2RA) Pathway 2.1 – Bedded rehab

Colour coding key

Colour of box	Definition
Blue	Acute Hospital ward based actions/process steps
Cream	Timeline within which to undertake/complete in order to prevent unnecessary delay(s) for the patient
Grey	Provides additional information related to the process step for addition guidance/context
Brown	Navigation Hub based actions/process steps
Green	Community Hospital ward based actions/process steps

Patient is inpatient in acute hospital and requires a supported discharge

Within 24 hrs of admission

Ward staff must conduct a "What matters to me" conversation with patients – the outcome of this along with patient condition and response to treatment in hospital indicates they will require formal care support at point of hospital discharge (once medically optimised/no criteria to reside). **Issue national discharge leaflet A**

Patient has mental capacity re: discharge and may have worries about returning home

Within 24 hrs of admission

The "What matters to me" conversation with patients will be key in terms of confirming patient wishes but also giving staff an early opportunity to work with patients/families around **managing expectations** on discharge – even where there are concerns about coping, we may collectively decide to discharge home 'at risk'

Patient is **currently *NOT*** deemed to be safe between care visits/overnight

Within 24 hrs of admission

Ward staff to refer to **D2RA pathway 1 safe between visits criteria poster** for guidance/confirmation that not safe, along with "What matter to me" discussion, and advice from Supported Discharge team (SDT) where required – **"Home First" – why not home? Why not today?** D2RA pathway reviewed daily at **board round** – does the plan need to change? **Issue national discharge leaflet B2**

Board round daily review - Patient has the ability/potential to meaningfully engage in rehab

Patient will be able to **meaningfully engage in rehab** if:

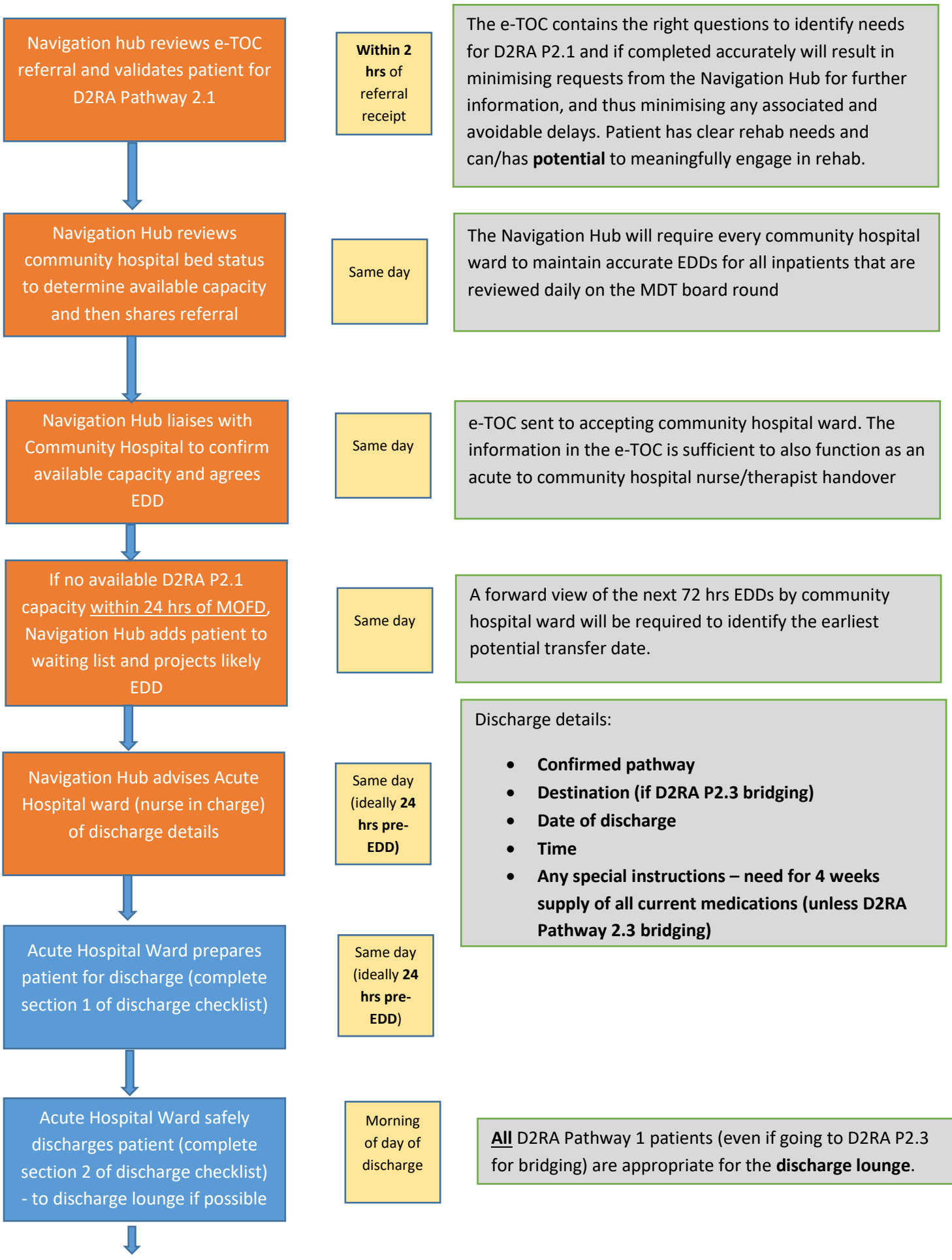
- They can understand instructions from therapists to carry out exercises/instructions
- They can remember what they were told and carry out exercises/instructions safely and correctly even when the therapist is not here
- They have manageable levels of pain that enable them to carry out the required level of rehab
- They don't have a physical problem that makes it difficult/impossible to carry out the required level of rehab (eg: large wounds, fractured limb)

Ward to submit D2RA Pathway 2 e-TOC referral to Navigation Hub **24-48 hrs pre-EDD**

24-48 hrs pre-EDD / MOFD date

Continue to think 'Home First'; only use Pathway 2.1 if Pathway 1 has been ruled out. The motivation for implementing this pathway is to achieve the best outcomes for the individual, and it should only be used where their needs rule out support for recovery and assessment in their own home. These needs are likely to be medium to high level and include overnight assistance greater than could be provided by short-term night-sitting or periodic calls. Individuals on this Pathway should be regularly reviewed and, where appropriate, transferred onto Pathway 1 as soon as their recovery permits

Electronic Transfer of care (e-TOC) referrals must accurately detail patient's care needs and abilities at that point and on that basis suggest the most appropriate discharge pathway from ward MDT perspective.


Navigation hub reviews e-TOC referral and validates patient for D2RA Pathway 2.1
Within 2 hrs of referral receipt
The e-TOC contains the right questions to identify needs for D2RA P2.1 and if completed accurately will result in minimising requests from the Navigation Hub for further information, and thus minimising any associated and avoidable delays. Patient has clear rehab needs and can/has potential to meaningfully engage in rehab.
Navigation Hub reviews community hospital bed status to determine available capacity and then shares referral
Same day
The Navigation Hub will require every community hospital ward to maintain accurate EDDs for all inpatients that are reviewed daily on the MDT board round
Navigation Hub liaises with Community Hospital to confirm available capacity and agrees EDD
Same day
e-TOC sent to accepting community hospital ward. The information in the e-TOC is sufficient to also function as an acute to community hospital nurse/therapist handover
If no available D2RA P2.1 capacity within 24 hrs of MOFD, Navigation Hub adds patient to waiting list and projects likely EDD
Same day
A forward view of the next 72 hrs EDDs by community hospital ward will be required to identify the earliest potential transfer date.
Navigation Hub advises Acute Hospital ward (nurse in charge) of discharge details
Same day (ideally 24 hrs pre-EDD)
Discharge details:
Confirmed pathway
Destination (if D2RA P2.3 bridging)
Date of discharge
Time
Any special instructions – need for 4 weeks supply of all current medications (unless D2RA Pathway 2.3 bridging)
Acute Hospital Ward prepares patient for discharge (complete section 1 of discharge checklist)
Same day (ideally 24 hrs pre-EDD)
Acute Hospital Ward safely discharges patient (complete section 2 of discharge checklist) - to discharge lounge if possible
Morning of day of discharge
All D2RA Pathway 1 patients (even if going to D2RA P2.3 for bridging) are appropriate for the discharge lounge.

Community Hospital - Baseline assessment – nursing, therapy and medical (if latter required) – including medication reconciliation	Day of admission to CH	**e-TOC referral** will function as nursing and therapy **handover document**, along with CTM inpatient notes from Acute. E-TOC mobility and transfer info to be **transposed onto whiteboard** to reflect baseline patient needs/capabilities – nursing staff to use as initial mobility plan until first therapy review. **Post-joint replacement precautions** to be followed as necessary.
Patient reviewed on daily board round (as per SAFER) – any red delay codes apportioned and then addressed	Every 24 hrs	Ward MDT to follow: • SAFER board round scripts (**7/7 rehab review**) • Discharge policy action cards (**daily** rehab review) • Escalation card actions (Level 1 = good practice/business as usual) Regular reviews throughout the recovery and assessment period will ensure that a clear exit strategy is in place, to avoid the person becoming 'stuck' in the intermediate care facility
If required, social care allocation within 2 working days of admission/receipt of referral and completion of assessment within 5 working days (SDT to support)	Within 2 and 5 working days of admission / receipt referral	e-TOC referral **should** indicate those patients who may need social care input – eg: pre-existing POC/care home LA-funded, known to social care, or e-TOC indicates may have social care needs despite rehab/reablement.
Doctor/ANP/Pharmacy undertake holistic medicines review for each inpatient	1-2 times each week	The medication review will include ensuring the correct dose/monitoring/interactions/ administration support needed
Nurses/ANPs to risk assess patients for ability to self medicate	Every day	Denote self medication level on the whiteboard and review daily.
Nurses/ANPs to effectively educate patients regarding their medication	Every day	For all self medication levels, counselling must be provided to ensure patient adequately understands their medication
Formal 2 week (day 14) MDT review – care adjusted and ongoing care plan agreed. **All** discharge assessments completed and clear discharge plan agreed (SDT to co-ordinate).	After 2 weeks in pathway	It is recommended that all individuals on D2RA Pathway 2.1 should be reviewed by the MDT after 2 weeks, so that the input can be modified in response to changing need/recovery. 'Home First' transfer to Pathway 1 (recovery and assessment in the person's own home) must be a consideration wherever possible. It should be clear at this stage which patients may need a longer term package of care and arrangements can then start to be made for this. This decision has been based on assessment and recovery out of hospital (key D2RA principle).
Patient discharged from D2RA pathway 2.1	Max LOS 21 days	At the end of the period of supported recovery and assessment, the next steps for the individual will be co-produced with them, their families and any ongoing support services.

Discharge to Recover then Assess (D2RA) Pathway 2.2 – Bedded reablement

Colour coding key

Colour of box	Definition
Blue	Acute Hospital ward based actions/process steps
Cream	Timeline within which to undertake/complete in order to prevent unnecessary delay(s) for the patient
Grey	Provides additional information related to the process step for addition guidance/context
Brown	Navigation Hub based actions/process steps
Green	Community Hospital ward based actions/process steps

Acute ward - follow D2RA Pathway 2.1 identification and referral process

Pre-referral

The reablement approach supports people to do things for themselves. It is a 'doing with' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness.

Navigation Hub reviews e-TOC referral and validates patient for D2RA Pathway 2.2

Within 2 hrs of referral receipt

The e-TOC contains the right questions to identify needs for D2RA P2.2 and if completed accurately will result in minimising requests from the Navigation Hub for further information, and thus minimising any associated and avoidable delays. Patient has clear reablement needs (does not fulfil rehab definition) and can/has potential to meaningfully engage in reablement.

Navigation Hub reviews e-TOC referral and liaises with community hospital around immediate plans to support **reablement** needs and expedite a safe transfer

Same day

The reablement environment must be conducive to enabling patients to address their reablement needs – this may include availability of side rooms with ensuite/assisted bathroom, dedicated area for therapy support in relation to mobility/transfer, and a safe area to prepare basic food/drinks under supervision.

Community Hospital - Baseline assessment – nursing, therapy and medical (if latter required)

Day of admission to CH

Baseline assessment must identify what reablement support the patient needs in terms of daily activities of living and reflects “What matters to me”

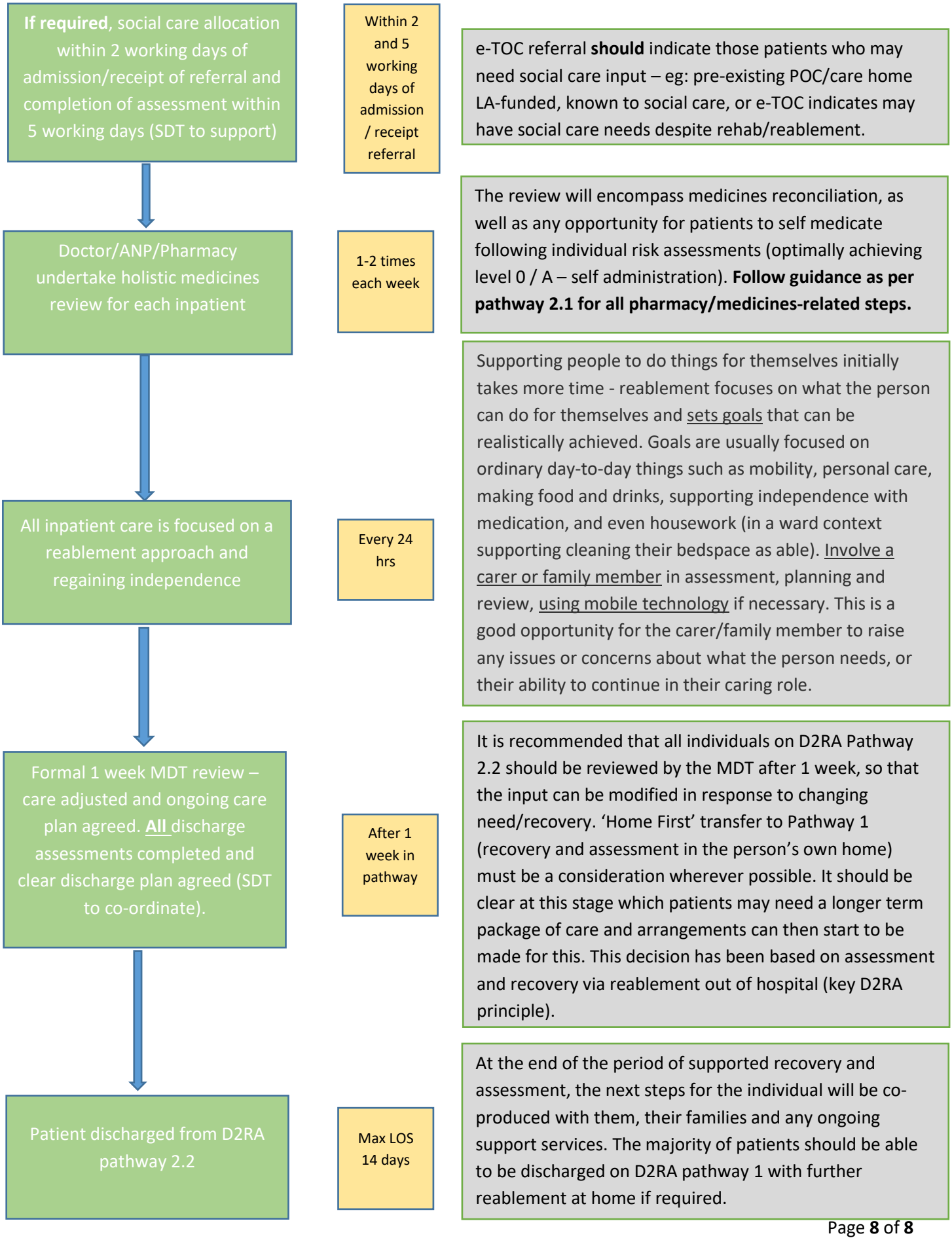
A plan to support and enable reablement needs agreed and implemented, and reviewed daily

Every 24 hrs

The reablement approach supports people to do things for themselves. It is a 'doing with' model. Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness - to enable the individual to do ordinary activities like cooking meals, washing, dressing, moving about. Support workers are taught to stand back and allow the person the time to complete a task on their own. This may involve the person being shown a different way to carry out the task to achieve independence, such as putting the weaker arm with the least amount of movement into the sleeve of a top first. Support reablement by managing pain effectively and using mobility aids as required.

Patient reviewed on daily board round (as per SAFER) – any red delay codes apportioned and then addressed

Every 24 hrs


If required, social care allocation within 2 working days of admission/receipt of referral and completion of assessment within 5 working days (SDT to support)
Within 2 and 5 working days of admission / receipt referral
e-TOC referral **should** indicate those patients who may need social care input – eg: pre-existing POC/care home LA-funded, known to social care, or e-TOC indicates may have social care needs despite rehab/reablement.
Doctor/ANP/Pharmacy undertake holistic medicines review for each inpatient
1-2 times each week
The review will encompass medicines reconciliation, as well as any opportunity for patients to self medicate following individual risk assessments (optimally achieving level 0 / A – self administration). **Follow guidance as per pathway 2.1 for all pharmacy/medicines-related steps.**
All inpatient care is focused on a reablement approach and regaining independence
Every 24 hrs
Supporting people to do things for themselves initially takes more time - reablement focuses on what the person can do for themselves and sets goals that can be realistically achieved. Goals are usually focused on ordinary day-to-day things such as mobility, personal care, making food and drinks, supporting independence with medication, and even housework (in a ward context supporting cleaning their bedspace as able). Involve a carer or family member in assessment, planning and review, using mobile technology if necessary. This is a good opportunity for the carer/family member to raise any issues or concerns about what the person needs, or their ability to continue in their caring role.
Formal 1 week MDT review – care adjusted and ongoing care plan agreed. **All** discharge assessments completed and clear discharge plan agreed (SDT to co-ordinate).
After 1 week in pathway
It is recommended that all individuals on D2RA Pathway 2.2 should be reviewed by the MDT after 1 week, so that the input can be modified in response to changing need/recovery. 'Home First' transfer to Pathway 1 (recovery and assessment in the person's own home) must be a consideration wherever possible. It should be clear at this stage which patients may need a longer term package of care and arrangements can then start to be made for this. This decision has been based on assessment and recovery via reablement out of hospital (key D2RA principle).
Patient discharged from D2RA pathway 2.2
Max LOS 14 days
At the end of the period of supported recovery and assessment, the next steps for the individual will be co-produced with them, their families and any ongoing support services. The majority of patients should be able to be discharged on D2RA pathway 1 with further reablement at home if required.

CTM Surge beds impact scoring

Scoring:

Level 1 = high impact

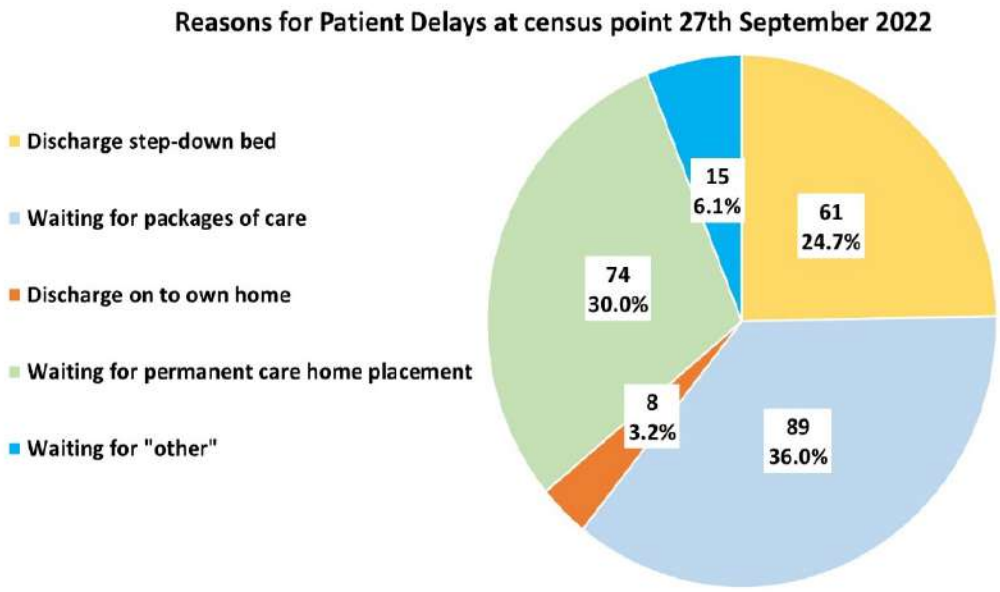
Level 2 = medium impact

Level 3 = low impact

Criteria:

Impact level	Score	Criterion
High	3	Scheme has no/minimal estates/capital requirements
High	3	Estates work can be completed quickly (low complexity) within required timelines
High	3	Estates work is relatively inexpensive and VFM based on other criteria
High	3	The type of bed provided meets what the discharge delay data states is required
High	3	Actively supports embedding of D2RA model
High	3	Maximises reduction of lost bed days/discharge delays
High	3	The number of beds meets the demand requirement
High	3	Requires little or no therapy input
High	3	Medical model can be resourced/supported and/or not Consultant led (affordable)
High	3	The environment is conducive for maximising independence/socialisation
Medium	2	Scheme has some estates/capital requirements
Medium	2	Estates work may not be completed quickly (medium complexity) within required timelines
Medium	2	Estates work is relatively expensive and may not be VFM based on other criteria
Medium	2	The type of bed provided only partially meets what the discharge delay data states is required
Medium	2	Partially supports embedding of D2RA model but risks of deviation
Medium	2	Partial contribution to reduction of lost bed days/discharge delays
Medium	2	The number of beds only partially meets the demand requirement
Medium	2	Requires some therapy input which may be a challenge
Medium	2	Medical model will be a challenge to resource/support and might need to be Consultant led (affordability issues)
Medium	2	The environment is not really conducive for maximising independence/socialisation
Low	1	Scheme has significant estates/capital requirements
Low	1	Estates work cannot be completed quickly (high complexity) within required timelines
Low	1	Estates work is expensive and not VFM based on other criteria
Low	1	The type of bed provided doesn't actively meet what the discharge delay data states is required
Low	1	Doesn't actively support/may contradict embedding of D2RA model
Low	1	Doesn't maximises reduction of lost bed days/discharge delays
Low	1	The number of beds does not meet the demand requirement
Low	1	Requires formal therapy input
Low	1	Medical model very difficult to be resourced/supported and/or Consultant led (not affordable)
Low	1	The environment is not conducive for maximising independence/socialisation

Data used



*POW = c30% of POC waits (based upon local unvalidated data)

Criteria	POW ward 16	Brocastle	RGH ward 1	YGT	Parc Newwydd	Ward 3
Estates work?	2	3	3	3	2	1
Speed of work	3	3	3	3	2	2
Cost of work	3	3	3	3	2	1
Right type of bed?	3	3	2	2	2	2
Supports D2RA?	3	3	3	2	2	2
Reduces LOS	3	1	2	2	2	2
Meets demand	3	1	2	2	2	1
Therapy input	3	3	2	2	3	3
Ease of medical model	3	3	2	2	2	2
Environment	2	3	2	2	3	2

Surge bed scheme	Score
POW ward 16	28
Brocastle (Hafod)	26
RGH ward 1	24
Ysbyty George Thomas	23
Parc Newwydd	22
Ward 3 Angleton	18

Summary conclusion

Green schemes are a priority for mobilisation by end of November, with ward 3 Angleton and 2nd ward at YGT by mid-Jan 2023 latest.

Scheme	Lead	Beds	Monthly Revenue Costs	Capital Costs
Brocastle (Hafod)	D2RA Consultant	6	42,900	0
Ward 3 Angleton	Head of Nursing	10	64,676.00	137,200.00
Ward 16 POW	Acute Services G	16	116,833.00	164,000.00
Ysbyty George Thomas	AD of Nursing	19	103,853.00	
Parc Newwydd	CSG Manager	10		52,000
Total		**61**	**328,262**	**353,200.00**

	Staff requirement		
Cost for 6 months	**Medical**	**RGN**	**HCSW**
257,400.00			
525,256.00	3 GP Sessions	5.69	8.53
864,998.00	3 GP Sessions	13.6	17.4
623,118.00	3 GP Sessions	12.6	17.4
52,000.00			
2,322,772.00	**9**	**31.89**	**43.33**

	Nurses on duty	shift length	days per week	WTE	Headroom	Total
RGN days	1	12	7	2.24	0.6	2.84
RGN nights	1	12	7	2.24	0.6	2.84
RGN Sub-total				**4.48**	**1.21**	**5.69**
HCSW days	1	12	7	2.24	0.6	2.84
HCSW - Nigh	1	12	7	2.24	0.6	2.84
HCSW Sub-total				**6.72**	**1.21**	**5.69**

Agenda Item	8.1

CTM Board	
Maternity and Neonatal Improvement Programme Highlight Report September 2022	
Date of Meeting	24 November 2022
FOI Status	Open / Public
Prepared by	Shelina Jetha, Programme Manager MNIP
Presented by	Greg Dix, Executive Nurse Director Sallie Davies, Deputy Medical Director
Approving Executive Sponsor	Greg Dix, Executive Nurse Director Sallie Davies, Deputy Medical Director
Report Purpose	Update the Board on the progress of the Maternity and Neonatal Programme.

ACRONYMS

ATAIN	Avoiding Term Admissions into Neonatal Units
CNO	Chief Nursing Officer
EPAU	Early Pregnancy Assessment Unit
GAU	Gynaecology Assessment Unit
IMSOP	Independent Maternity Services Oversight Panel
IPAAF	Integrated Performance Assessment and Assurance Framework
MDT	Multi Disciplinary Team
MNIB	Maternity and Neonatal Improvement Board
NNU	Neonatal Unit
QLM	Quality Leadership and Management (Maternity Workstream)
QWE	Quality Women's Experience (Maternity Workstream)
PCH	Prince Charles Hospital
PREM	Patient Reported Experience Measure
PTR	Putting Things Right
SEC	Safe and Effective Care (Maternity Workstream)
SOP	Standard Operating Procedure

SITUATION/BACKGROUND

The purpose of this report is to provide an update on the progress of the Maternity and Neonatal Improvement Programme in the form of a highlight report.

SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

This section outlines an overview narrative describing some of the key matters within the Maternity and Neonatal Improvement Programme:

- Conditions for sustainability SRO challenge – 4th session held and approved
- Neonatal immediate recommendations progress
- IMSOP report to Welsh Government to be submitted Oct 22
- Change to Governance structure (CSG) – programme reporting
- Progress on MIP wash-up plan
- Neonatal metrics
- Neonatal engagement – progress (June-sept 2022)
- QI - progress

RECOMMENDATIONS

The Board are asked to **NOTE** the report.

KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Please note the **"Programme Risks/Issues"** are captured on slide 3 of the highlight report.

Work to understand the extent of a new risk added in March 2022 is still underway. This relates to a number of recommendations in the Neonatal Deep Dive report specifically seeking additional investment in workforce. Costs have already been predicted to exceed £1m, so this will be significant.

IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below) Please refer to the highlight report for detail.
Related Health and Care standard(s)	Governance, Leadership and Accountability All Health and Care Standards apply.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) Not required for a progress report.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below) Please refer to the highlight report for detail.
Link to Strategic Goals	Improving Care

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

September 2022

TOP PROGRAMME RISKS AND ISSUES:

Risks/Issues	Details	Mitigating actions	Rating
The new Health Board Operating model could create uncertainty and impact progress	The programme will need to monitor progress closely and to mitigate uncertainty will need to respond quickly to circumstances as they evolve. The new model should help with some of the current risks within the programme. Discussions are planned to begin exploring how transition of the programme into operating structure, which the operating model could disrupt. Mitigating this we'll focus on areas where accountability and governance structures can be transitioned with minimal disruption. The arrival of the Health Board wide Director of Midwifery role will aid this transition.	The Clinical Care Group was formed on 1st Sept 2022; Triumvirate appointments in new structure of Director of Midwifery, Medical Director and Director of Operations. Maternity and neonatal risk escalation framework developed and approved at MNIB Board on the 28th September and Q&S on the 20th September.	low
Neonatal Deep Dive recommendations lead to increased operating costs	Work is underway to understand the operational cost consequences of a number of recommendations in the Neonatal Deep Dive report (3.3, 3.4, 3.5, 3.6, 3.7 & 3.8). The additional costs are greater than £1M but there are other posts that need scoped and costed.	Key improvement posts appointed; Workforce plan being developed; Risk Manager appointed 30.8.22; benchmarking of UK models of care and identify 3 potential models of care i.e. ANNP; PA, medical etc. to be discussed at a planned away day Sept.22; Supernumerary shift coordinators allocated – issues to be recorded on Datix; also recruiting to post for Maternity and Neonatal Safety champions	Moderate
Sustainability of improvements	The improvements achieved through the MNIP needs to be embed in BAU practices and must be sustainable	Regular audit in place through AMAT maintained by HoMs, DoM, Consultant Midwives and Clinical Directors. Newly appointed Maternity and Neonatal Safety Champions due to commence in post during November as part of the diagnostic and discovery phase of the Mat/Neo Safety Support Programme. QSE committee (formally SWAG) at service group level to provide scrutiny, assurance and oversight. WEESEE practices embedded and monitored through this group.	Moderate

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

September 2022

FOUR THINGS YOU NEED TO KNOW:

- Neonatal DD immediate recommendations – IMSOP verified 15, 4 had been submitted by 30.9.22 but all 4 returned unverified; HB request to 'push-back' on Esc 5 (cooling); esc 7 (Sis) and Esc 5.1 (data) and Esc 2 (IUT) further review of evidence; meeting with IMSOP colleagues 18.10.22 to better understand reasons for not verifying
- Conditions for Sustainability last session no. 4 held 21.9.22 (see below): Approved by SROs and independent board member
- IMSOP final report to Welsh Government submitted Oct 22

CONDITIONS FOR SUSTAINABILITY ACTIVITY PROGRESS

Maternity and Neonatal challenge sessions with SROs/independent HB member: **'APPROVED'**

- **Session 1 (5.8.22):**
  - IPAAF
  - RCOG recommendations
  - Programme Management
- **Session 2 (16.8.22):**
  - Engagement
  - Serious Incidents (SI)
- **Session 3 (22.8.22):**
  - Corporate Governance
  - Clinical Review
  - QI and data

CONDITIONS FOR SUSTAINABILITY ACTIVITY PROGRESS

Maternity and Neonatal challenge sessions with SROs/independent HB member: **'APPROVED'**

- Session 4 - final (21.9.22):
  - Strategic vision (i.e. Long-term strategy)
  - Medical Leadership
  - Culture and Leadership
  - Neonatal – immediate actions
  - Neonatal – Long-term actions
  - IMSOP onsite visit (5th and 7th September 2022)

Neonatal – Summary of Immediate actions/Escalations as at 5.10.22

- **Total 19,**
- **15 verified**
- **4 uploaded to IMSOP 30.9.22**
- **All 4 unverified 5.10.22; meeting arranged with IMSOP Neonatal clinical panel 18.10.22**

Submitted to IMSOP 30.9.22 and returned unverified 5.10.22

No.	Immediate Action/Esc. unverified	Workstream (WS)	Leads	Comments
1	Esc. 5 (cooling)	**Clinical Case Assessment**- *The Health Board must review its cooling practice in line with national frameworks and ensure local practice meets this standard.*	Consultant Paediatrician/ Neonatal Governance Nurse	Processes and training in place. No case of HIE for 8 months. Sign off contingent on reviewing a case to ensure processes followed
2	Esc.5.1 (data)	**Wales and National Reporting** - *The clinical team must ensure completeness and accuracy of Neonatal Unit data.*	Consultant Neonatologist / Consultant Paediatrician	On going development of dashboard. Better understanding of what is required following meeting with IMSOP clinicians
3	Esc. 2 (work with Maternity)	**Neonatal Unit functionality** - *The Health Board must continue to show an improvement in the working relationship with maternity services in numerous areas.*	Lead Neonatal Nurse	Under review by HB
4	Esc. 7 (SI/PMRT/Mortality/MDT/NICU)	**Clinical Case Assessment** - *The Health Board must ensure clinical incident reviews, SI reviews and PMRT/Mortality reviews are carried out as an MDT with external support from colleagues within the local NICU to provide clinical expertise and questioning.*	Consultant Paediatrician/ Neonatal Governance Nurse	HB completed SI reviews in conjunction with Maternity Improvement programme, HB working to submit recent reviews to comply with IMSOP requirements.

Maternity and Neonatal Improvement Programme - Workstreams

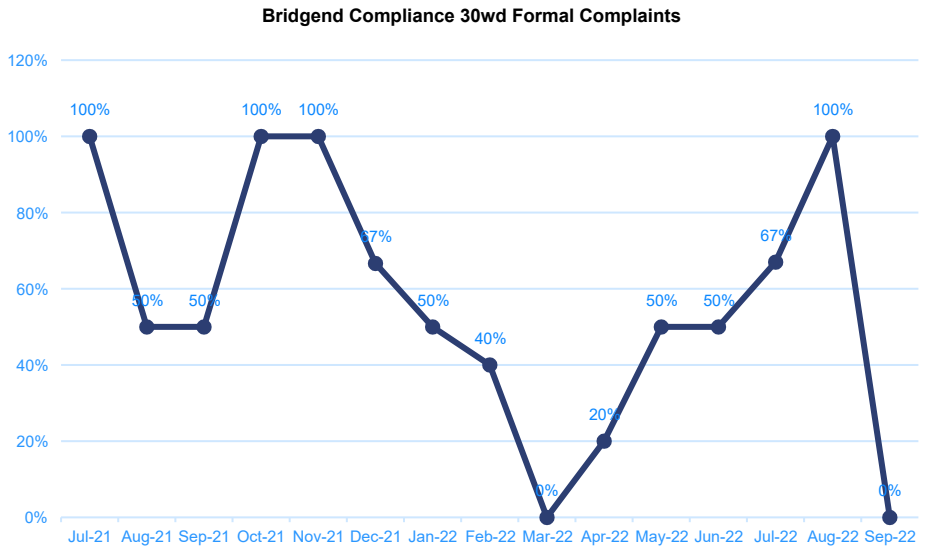
SROs : Greg Dix and Sallie Davies

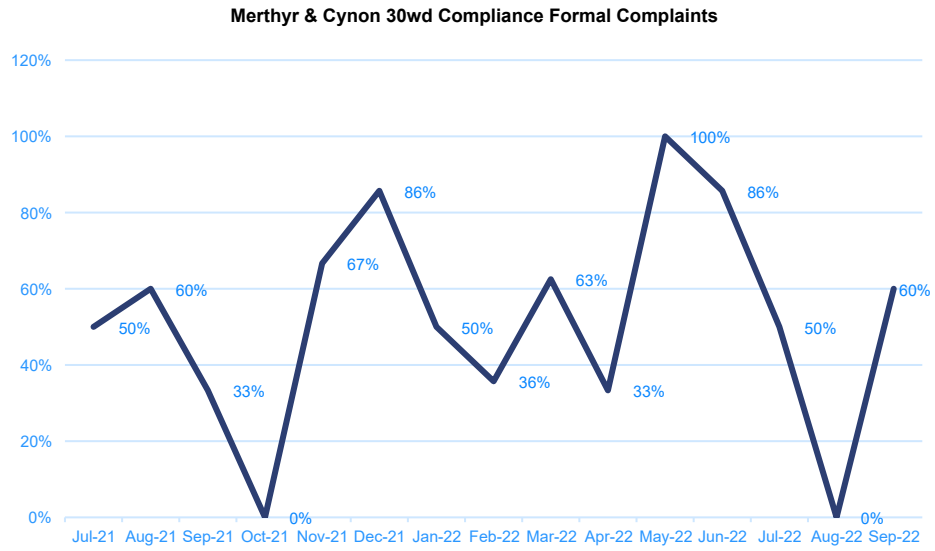
September2022

Things to know: Focus during September has predominantly been on closure of Maternity Improvement programme SEC and QLM; IMSOP visit on 5th and 7th Sept and delivery of the remaining immediate actions (as per previous slides); Leadership courses with protected time; data dashboard development and presentation in various forums such as Q&S; MNIB board etc Coaching from local NICU; SIMS training; Training programme 28.9.22; Extreme pre-term SIMS 12.10.22 at PCH; engagement progress report June-Sept 2022; Some delays in Engagement workstream due to clinical demands on lead but solution now found to provide further support; Culture and Leadership plan completed and uploaded to IMSOP; joint Maternity and Neonatal in engagement with staff and show

Milestone	Due	Progress
Establish mechanisms/processes (CSG assurance)	Aug 22	Quarterly report June to Sept 2022 compiled; shared at NNIP project meeting 10.10.22 and Oct MNIB huddle
Well-being champions as part of the workforce, working together to provide accessible support for staff and families.	Sept 22	Staff on both sites have accessed the mental health first aider course. Psycho social meetings embedded in both wards also.
FIC (care team; plan; working group; passports etc.)	July 22	Leads from POW/PCH identified and aim to have a CTM approach but also dependent on All Wales network solution; further QI training to be provided; Workstream lead provided with further resources due to clinical demands.
Audit: gov. process/outputs and action plan/review by NICU	May 22	Audit system governance process map was shared at NNIT 4th July and further discussion held with clinical leads. Audit process examples provided as part of immediate actions/escalations
Supernumerary Shift Co-Ordinator role	Dec 21	Initiated during Aug 22 and instruction to datix if issues arise
Ensure Clinician NLS training is up to date	Nov 21	19 staff members received NLS since 2018 with expiry dates ranging from 2023 to 2027; HB has 5 instructors; CD to ensure all NLS is completed
IMSOP suggested proformas	Jun 22	Proforma's completed; signed off/some being used by staff but require review of implementation and imrorvement
Infant feeding lead for Neonates JD	July 22	JD completed; protected time and will be included in workforce paper regarding improvement roles and sustainability
Radiology – procedure /reporting/review of image by specialist consultant radiologist	Dec 21	Paediatric Radiologist appointed by HB; stickers on patients notes being used; scbu audit completed; Longumbilical lines audit completed. Verified by IMSOP 21/9/22
PREMS - questionnaire	Aug 22	Developed and shared with Engagement forum; various mediums to be utilised for capturing feedback; trial survey set-up access via QR code and also paper; next - discussion with CIVICA and need to launch on electronic platform
Plan to handover improvement hub to operational team	June 22	This had been showing as delayed in previous reports but has now been set-up and active
Safety Culture Survey	Sept 22	Now on CIVICA and live 2.9.22; next stage to ensure MDT included

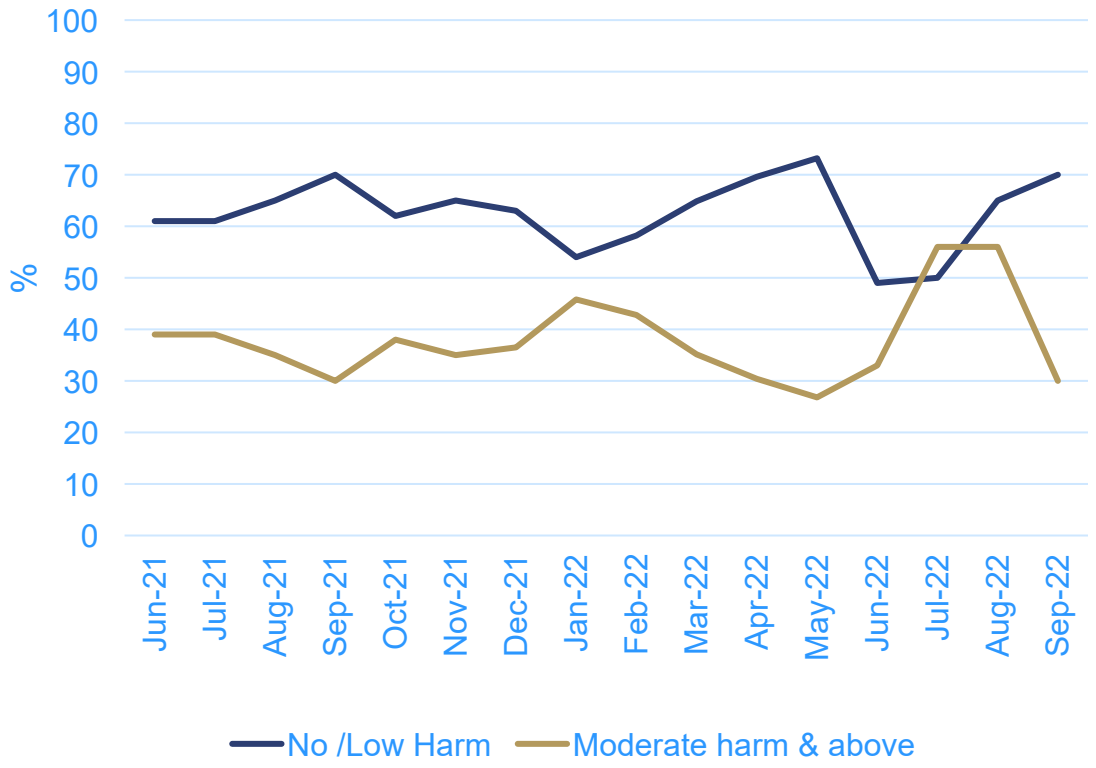
Compliance against 30 working day target concerns (O&G)
Sept 22





Note: All concerns are Quality Assured by the CD and HOM together note: the process is lengthy. Overall, in Sept 6 complaints were closed with an outcome of 'not upheld'. As of 4.10.22 14 complaints are open. One RCA is open and being completed.

Maternity only Clinical Incidents by level of harm
Sept 22



Incidents now reporting on new Once for Wales system which allows a post-review grading of the incident which should provide a more accurate reflection of the severity of the incidents.

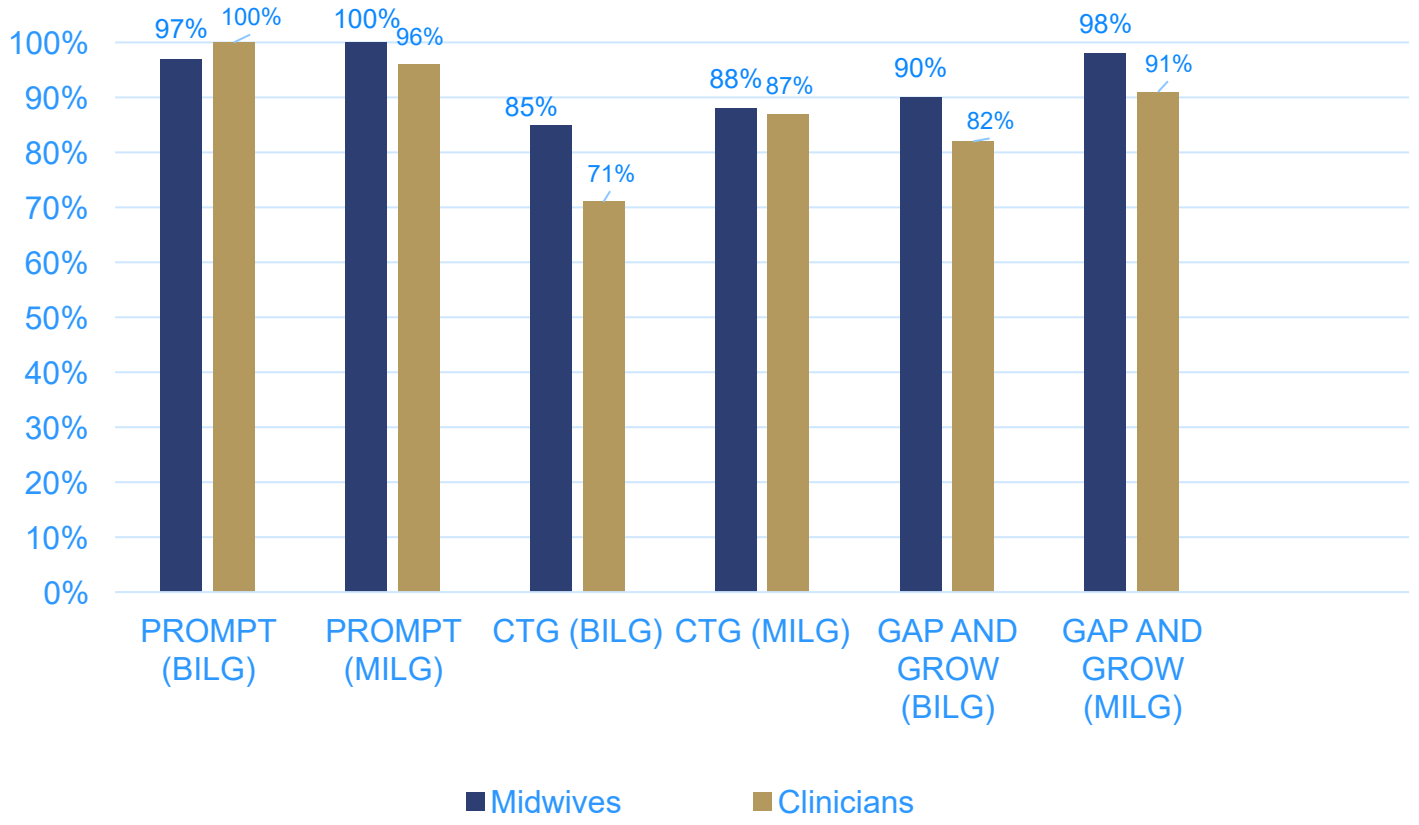
Graph indicates low harm showing an increase but moderate harm showing a significant decrease in September.

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

Sep 2022

Training Compliance for Sept 2022 (as at 5.10.22)
(Expected compliance 95%)
(no training in Aug)



MILG: *PROMPT Obs 1 out of compliance and 1 new Registrar booked for Oct 22; non-compliance escalated to matron/CD*

BILG: *PROMPT* – 4 midwives outstanding due to short term sickness; last course in July cancelled due to facilitator sickness but poor staff engagement by Obstetricians to meet their compliance; non-compliance escalated to matron/CD

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

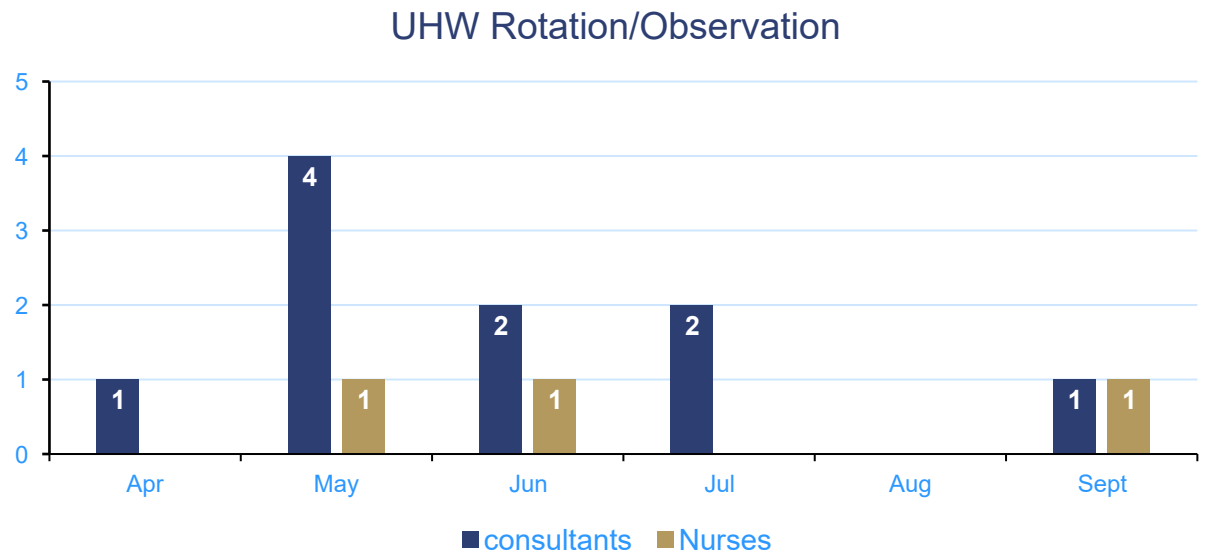
September 2022

KEY PROGRAMME METRICS

Neonatal – Nurses and Consultants rotating in UHW tertiary centre each month by role

- Consultants – 2 day visits in non-patient care role
- Nurses' rotate for a week and are involved in full patient care
- ISSUES: Nurse rotation delays due to DBS and identity checks

Consultant visit timetable: arranged from April 2022 to December 2022 (except August due to A/L and cover)



- Consultants continue to visit as per agreed plan: 10 on visit plan; 8 visited UHW and 3 have visited twice.
- 39 nurses in the dept. But only 3 rotated and 5 are on Maternity leave.
- Nurse rotations in September poor due to delays in DBS and occupational health checks.
- We are in the very early stages of discussions for rotation to other tertiary centres.
- The shared learning from the nurse's experience is presented on neonatal study days, through reflections and by sharing with their colleagues.

Neonatal – Nurses and Consultants rotating in UHW tertiary centre each month – Example of some LEARNINGS

Some Consultant Learnings

1. Plan introducing Non-invasive ventilation using SLE 6000 ventilators. Arrange Local trial of the new F&P 950 humidification system with a view to replacement of current humidifiers
2. TPN light protective giving sets. Cardiff NICU uses different pumps and syringe drivers.
3. Pharmacist and nurses introducing set times of the day for administering common medications such as Caffeine, Iron and multivitamins (minimise drug errors, be cost effective)
4. Noticeboard - Medications errors on Datix on a noticeboard.
5. Noticed a poster about electronic reporting of Learning from Excellence https://learningfromexcellence.com
6. Safety huddle (included signposting to teaching/training events) - our senior nurse has refreshed the framework for safety huddle includes 'key learning messages for the week' emerging from Incident reviews
7. 'neonatal knowledge cards' that go on the lanyard for juniors
8. Re-enforcement of IPC messaging- 'bare below elbow posters'
9. Psychosocial meeting at lunch time - family needs/emotional wellbeing and our working on the same
10. Handwashing/Infection control - reinforce positively the practices of handwashing.

Some Nurse Learnings

Trollies

- Trollies for resuscitation were very organised just the essential things/checked daily
- The neobars were boxed up singularly and just one per colour
- Sealed intubation box; checked once a week for dates or once a month to make sure everything on there was in date, but this held everything you needed to prepare drugs for an intubation
- All stock is placed into cupboards on the unit (minimises the need for trollies)
- Silver trollies for procedures e.g. blood gases or bloods etc and a sterile pack is opened out onto the trolley

Drugs

- Online library of drug monographs with backup of file
- Nurses when drawing up drugs refer to the guidelines online (our Pharmacist working on this)
- Premade antibiotic - new antibiotic stewardship to administer within an hour of being charted.

Neonatal nugget: 'neonatal nugget'/A4 piece of paper/different topic every month/2 mins to read e.g hydrops and different topics written by different staff

IPADS: For long term babies – keep them stimulated used youtube e.g. watch and listen to music and things like colourful fish etc.

MILK : laminated label 'CAUTION! SAME/SIMILAR NAME! PLEASE CHECK CAREFULLY USING M NUMBER, NAME, D.O.B'

Charts: 2 sided use e.g. HDU chart had on the back a blood gas record and an apnoea/bradycardia record

Nurse in charge: Oversee everything. (we now have supernumerary shift coordinators – datix if issues)

Care Plans: in one place e.g. Respiratory, thermoregulation, nutrition, developmental care and safe environment, are all within the admission booklet

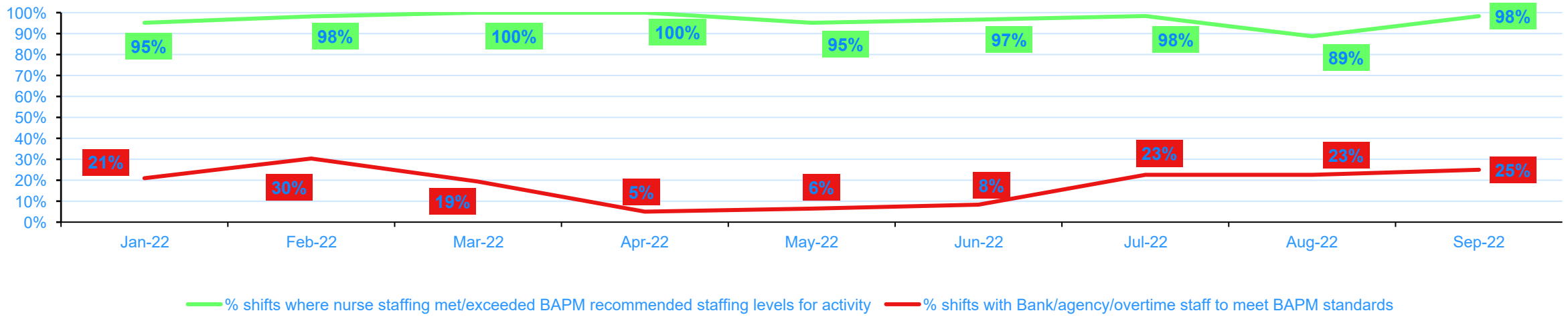
Diaries: All babies have diaries updated on a daily basis,/ parents there really appreciate these little things

Newly qualified nurses: go into ITU, with support; Drs and ANNP's are most of the time – good insight into HDU and ITU before you do your course

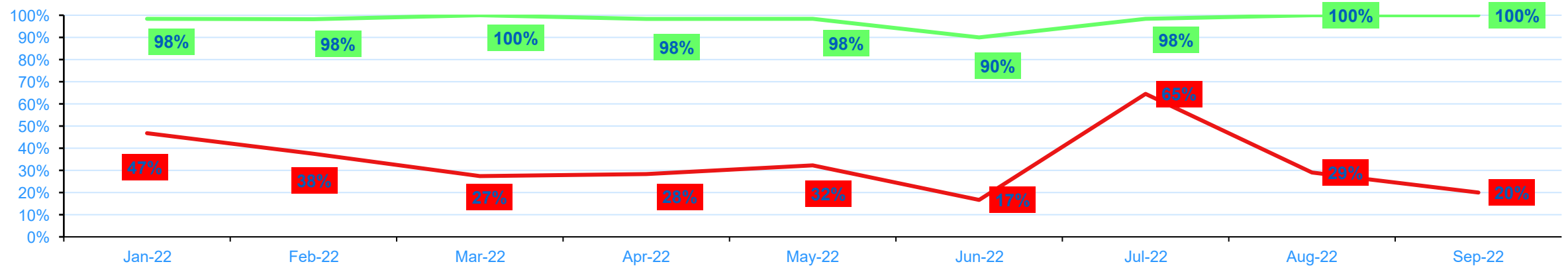
Neonatal Improvement Programme – Metrics
September 2022
David Deekollu/Rebecca Pockett

PCH & POW Nurse Staffing
(Based on shifts per month)

PCH Nurse Staffing



POW Nurse Staffing

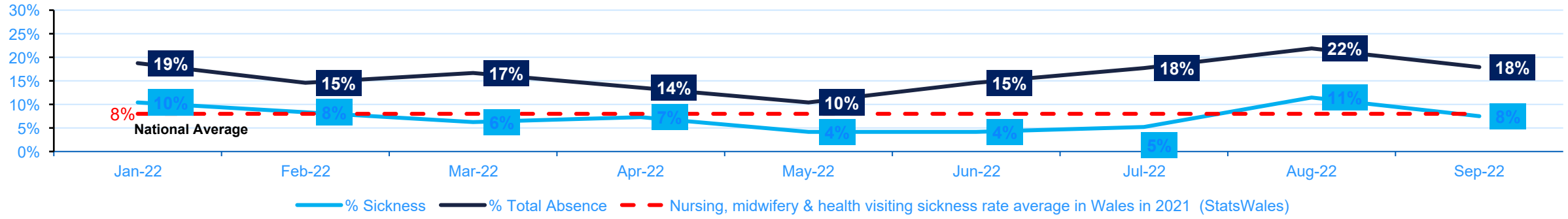


Both Units remained open to admissions. Red line indicates use of bank/agency/overtime staff to maintain BAPM staffing levels, with up to 25% in September.

SICKNESS & ABSENCE 2022

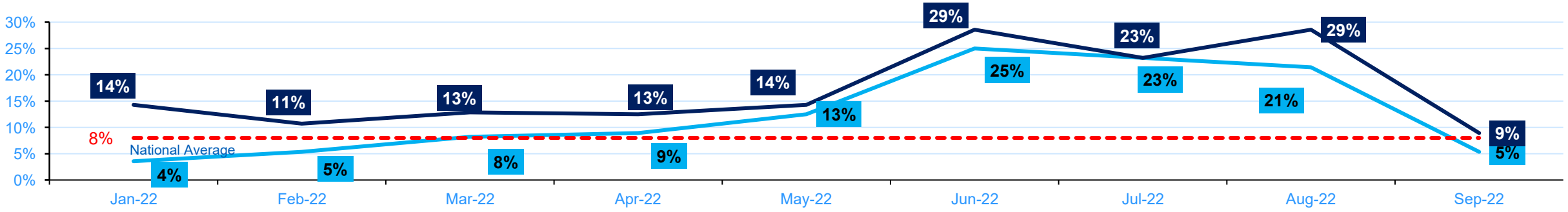
Total absence (unavailable) includes: Sickness, Maternity Leave, Special Leave, Other (e.g. Covid Related). Annual Leave not included as staff potentially available to work.

PCH - Sickness/Absence %



Compared to the national average PCH sickness rate remains at an acceptable level. The increased absence is due to a number of nursing staff being on maternity leave.

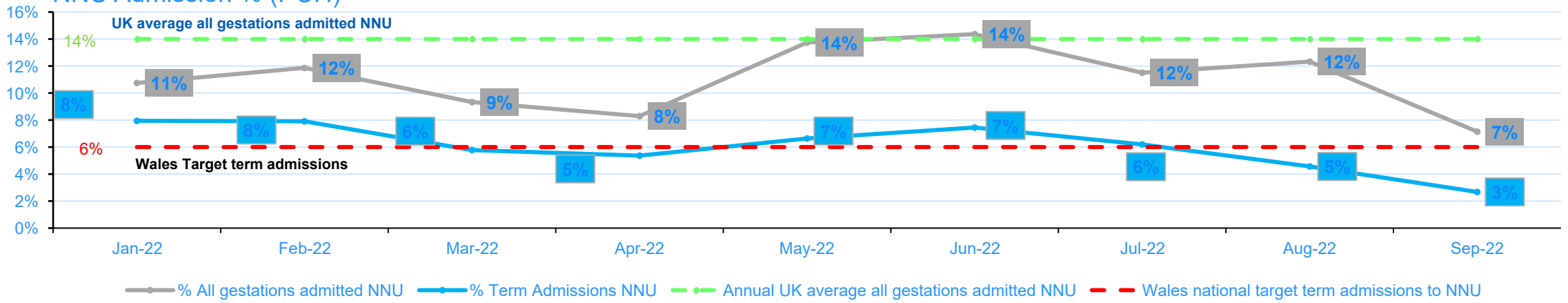
POW-Sickness/Absence %



Although for a period of 3 months sickness in POW was above the national average, it has now reduced to be in line with the national average due staff returning after extended periods of sickness.

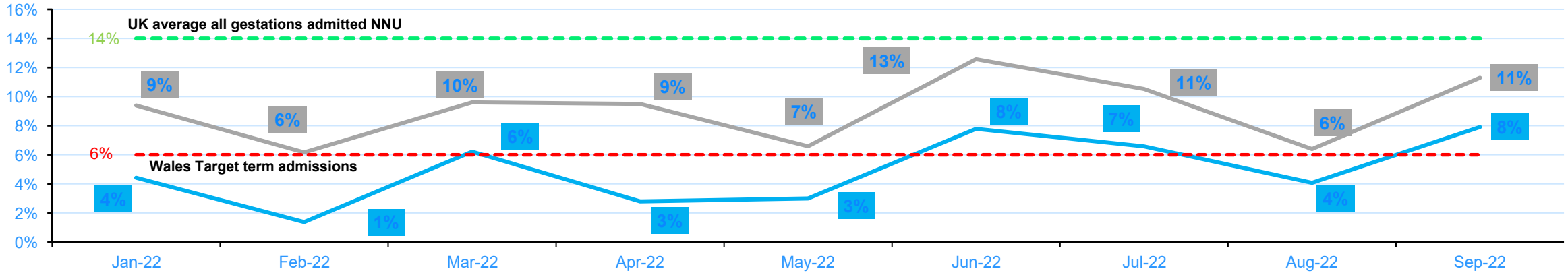
PRINCESS OF WALES - SCBU

NNU Admission % (PCH)



PCH term admission rate has fallen for the third month in succession to be below the national target. There was a significant decrease in all admissions this month even though the birth rate remained similar to the previous month.

NNU Admissions % (POW)



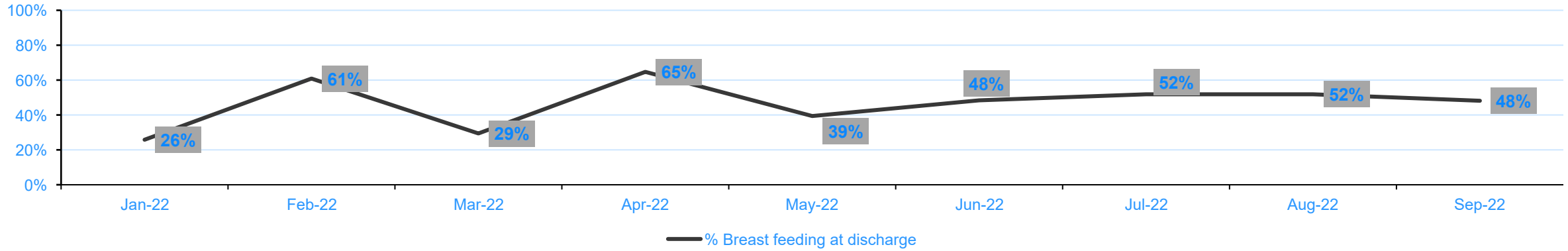
All admissions have doubled from previous month but still below the UK average i.e. all admissions per total births. The term admission rate has doubled and slightly above the national target. Total births has remained similar to previous month.

CTM – Receiving Breastmilk on Discharge

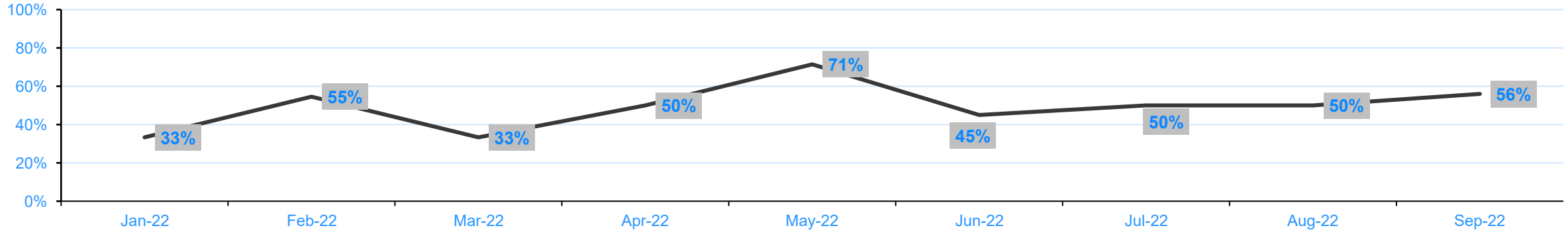
Percentage of all babies discharged to either Post natal ward or Home who were breast feeding or receiving EBM.

(*Wales range 54.2% - 80% of new mums breastfeed at birth and between 29.4% - 54.1% of new mums who still breastfeed at 10 days*)

PCH - % Breast feeding (receiving EBM)at discharge (all gestations)



POW - % Breast feeding (receiving EBM) at discharge (All Gestations)



Although, further improvements are required to improve breastfeeding rates during some months for both units continue to be relatively successful with breast feeding in the first 10 days.

Maternity Improvement Programme – Metrics September 2022

Elinore Macgillivray

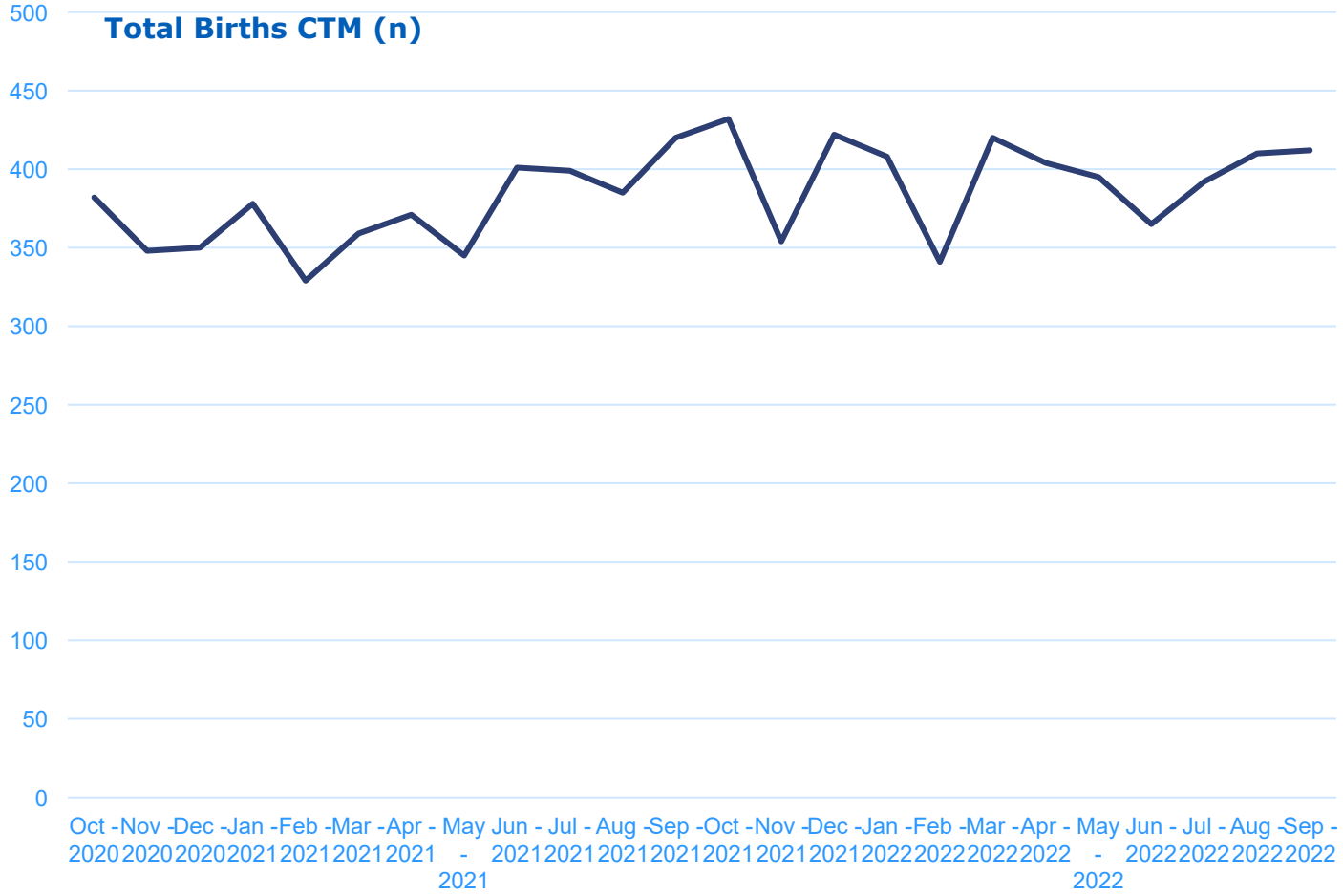
October 2022 – Maternity Metrics for CTMUHB Board Assurance

Quality and Safety Committee – Narrative by Exception

Maternity data are presented as time series data from October 2020- September 2022, extracted from Qlik Sense. Data are auto-populated from the Maternity Information Systems (MITS at PCH &RGH, WPAS at POW). Data will continue to be presented on a rolling 2 year basis unless otherwise indicated. Patient Reported Experience Measures (PREM) will form an integral part of the maternity data set. Measures shown are for October 2021 (launch) to September 2022.

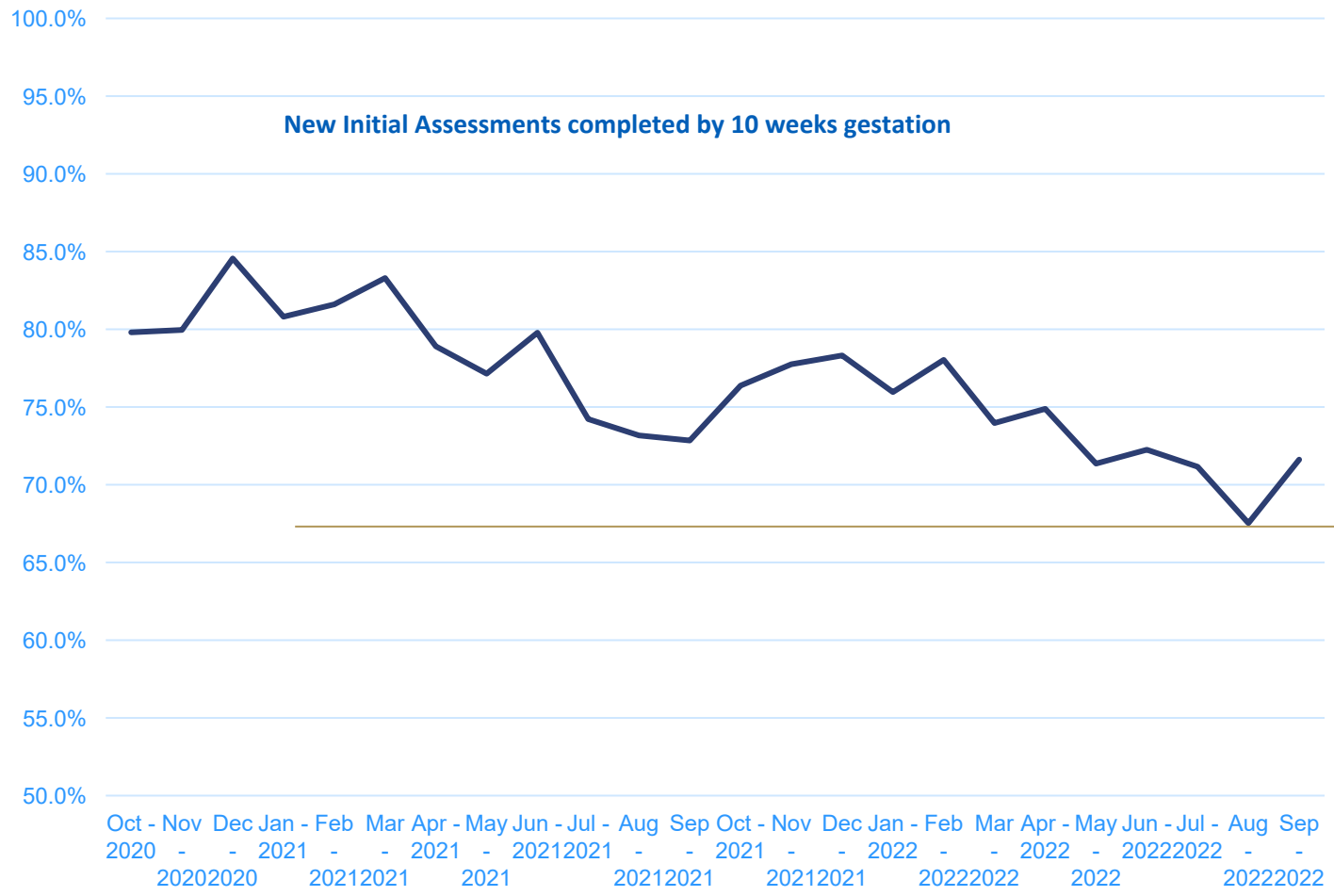
Patient Reported Experience measure (PREMS) was launched in September 2021, with increasing uptake since. The experience data is now a core part of maternity metrics reporting and will be reported as such (as per measures below). All QI projects will include the relevant PREMs data as a key measure (for example the IOL improvement work will include the IOL experience data reported through PREMs).

Neonatal data are manually collected from BadgerNet and input into Excel to create time series data.



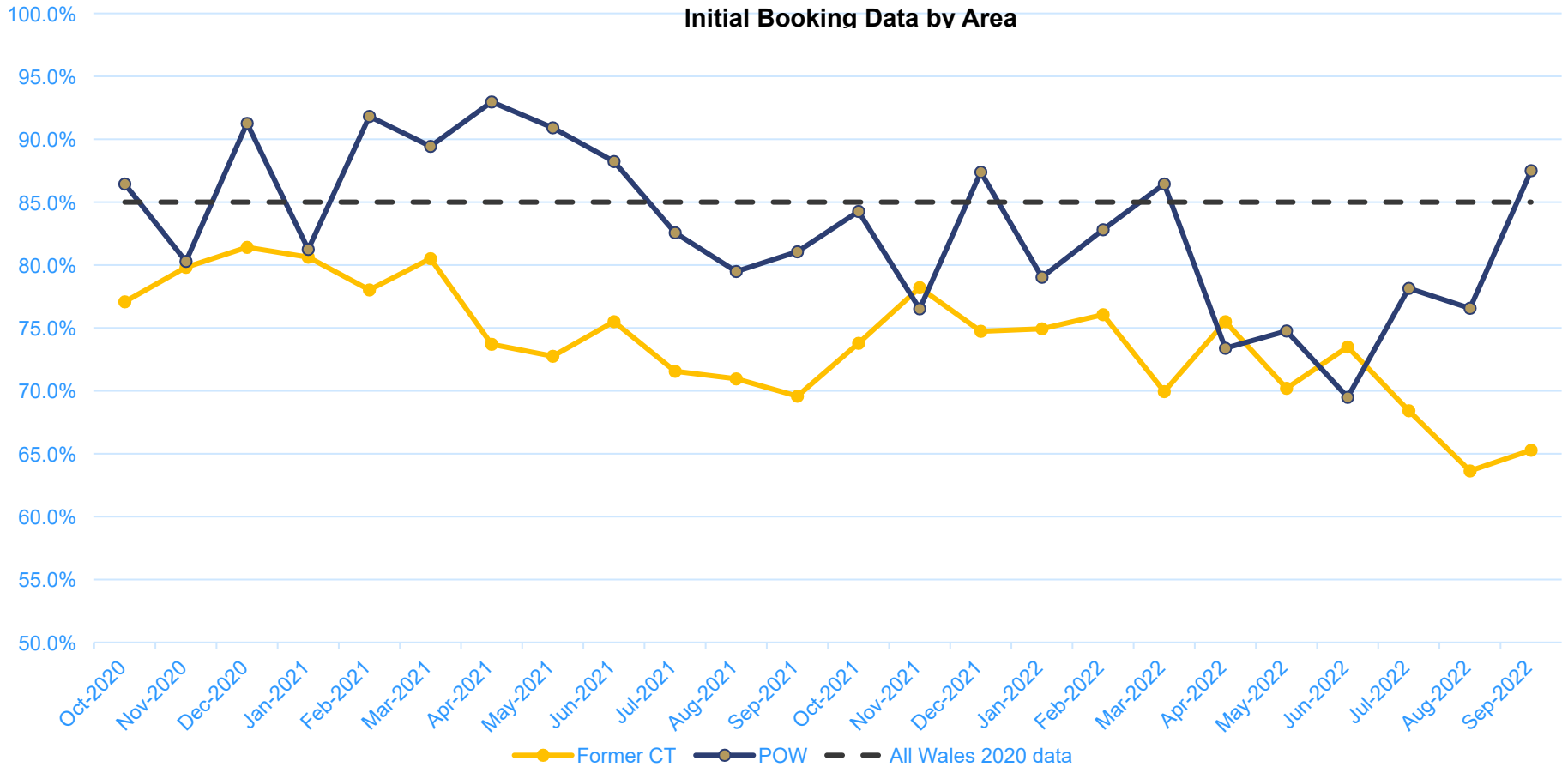
Notes: Total Births

Normal variation over time, data stable overall.
Number of births on each site show no concerning shifts or trends in the data.
Some signs that birth numbers are increasing. This may be a part of normal variation. Next few months' data will be important for understanding the birth numbers.
These data are reported per site at bi-monthly maternity governance meetings.



Notes

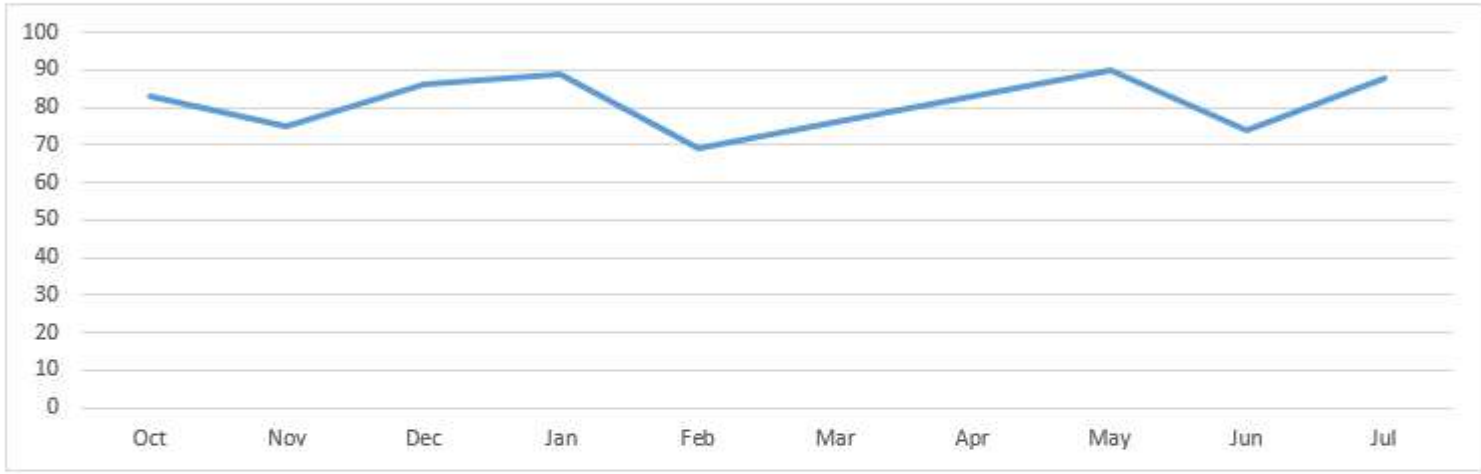
WG target is 85% of new initial assessments to be completed by 10 weeks of pregnancy (shown as amber line).
Decrease over time in achieving target of completing booking by 10 weeks of pregnancy.
Deeper dive into data undertaken. Significant variation in practice identified, as well as waste. Pathway being simplified to release time for midwives to provide care.
SMART improvement plans have been developed, including digitising booking system for easier access by Service Users and prioritisation of appointments for women at later gestations.
Aiming to test the new system in October. These data will provide real time signals of the impact of planned improvements.



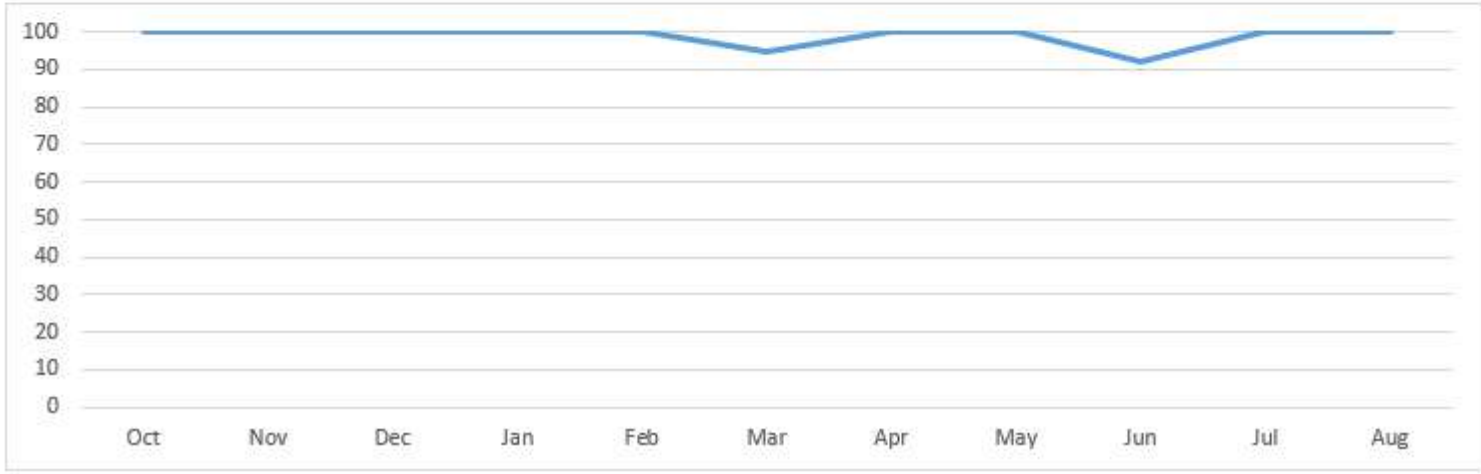
POW are showing significant signs of improvement, although this is not being seen at former CTM. Scoping work suggests this may be down to multiple factors including variation in the initial booking process across sites, and variation in what is considered as the initial booking date.

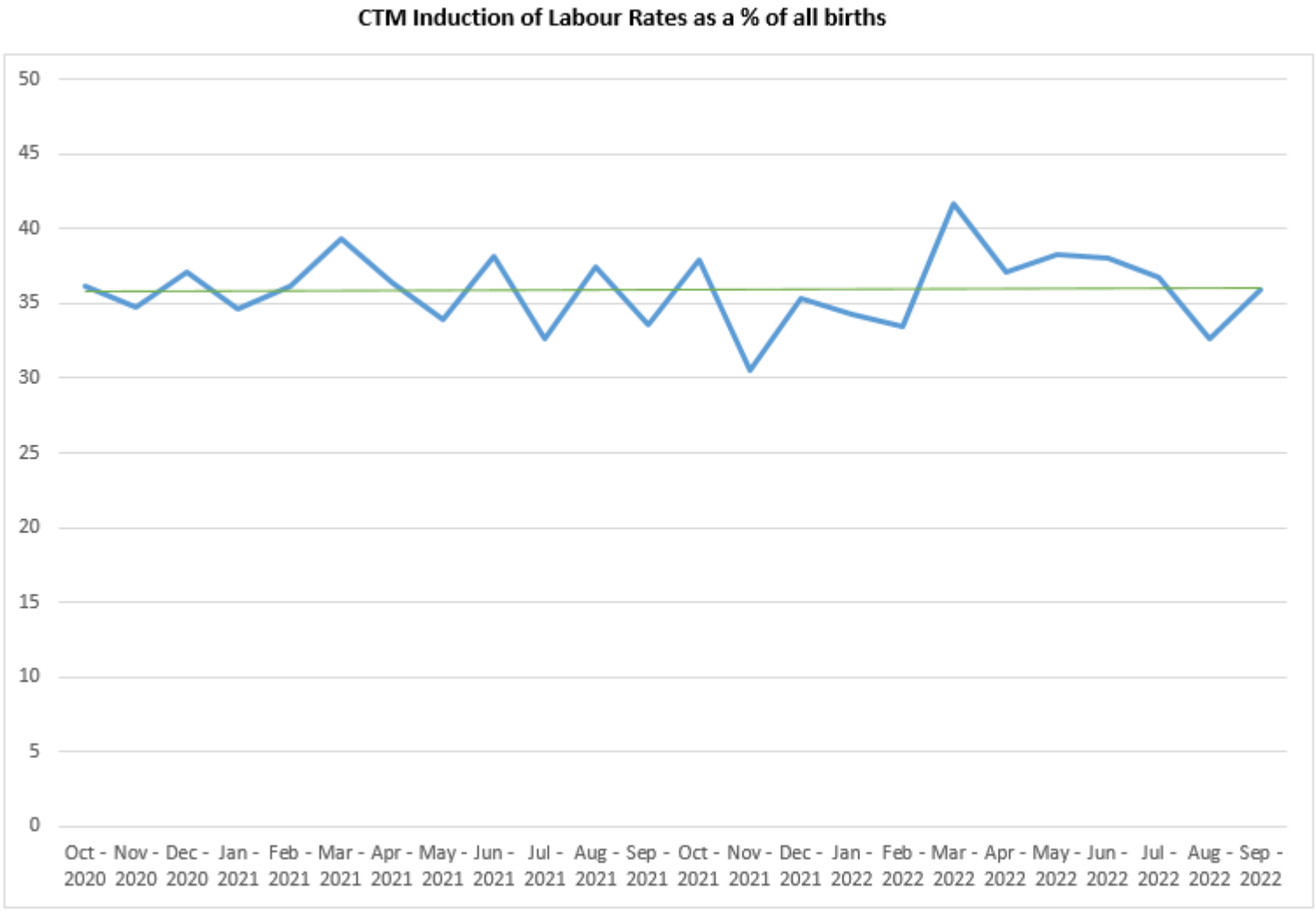
PREM: What women are telling us about early antenatal care

During your early antenatal appointments, were you given enough time to ask questions or discuss your pregnancy?



During your early antenatal appointments, did your midwife ask you about smoking?





Notes

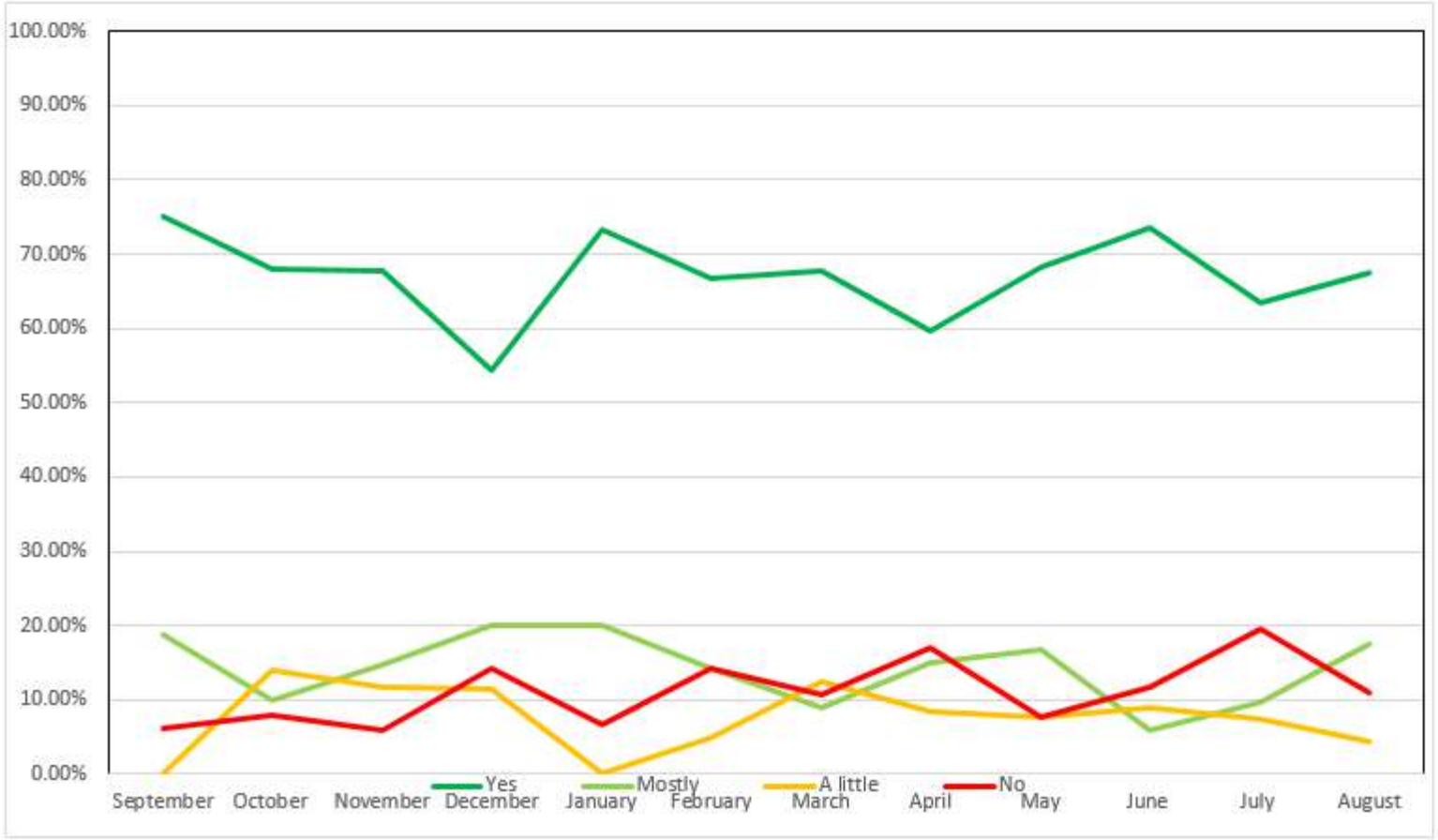
Rates stable- normal variation but no trend or shift seen over 2 year period. Trend line is stable (shown in green).

Induction of Labour rates are increasing across the UK. No target set by WG, as rates impacted by many factors, including local population demographics.

IOL improvement group is undergoing a refresh with a QI methodology approach. Aim is to improve the quality, safety and experience of care. This includes adherence to guidance and supporting women and families with decision making.

What women are telling us about their experiences of making choices about, planning and undergoing induction of labour. These data are extracted from the Patient Reported Experience Measure (PREM) questionnaires sent to women throughout their pregnancy journeys, as previously described.

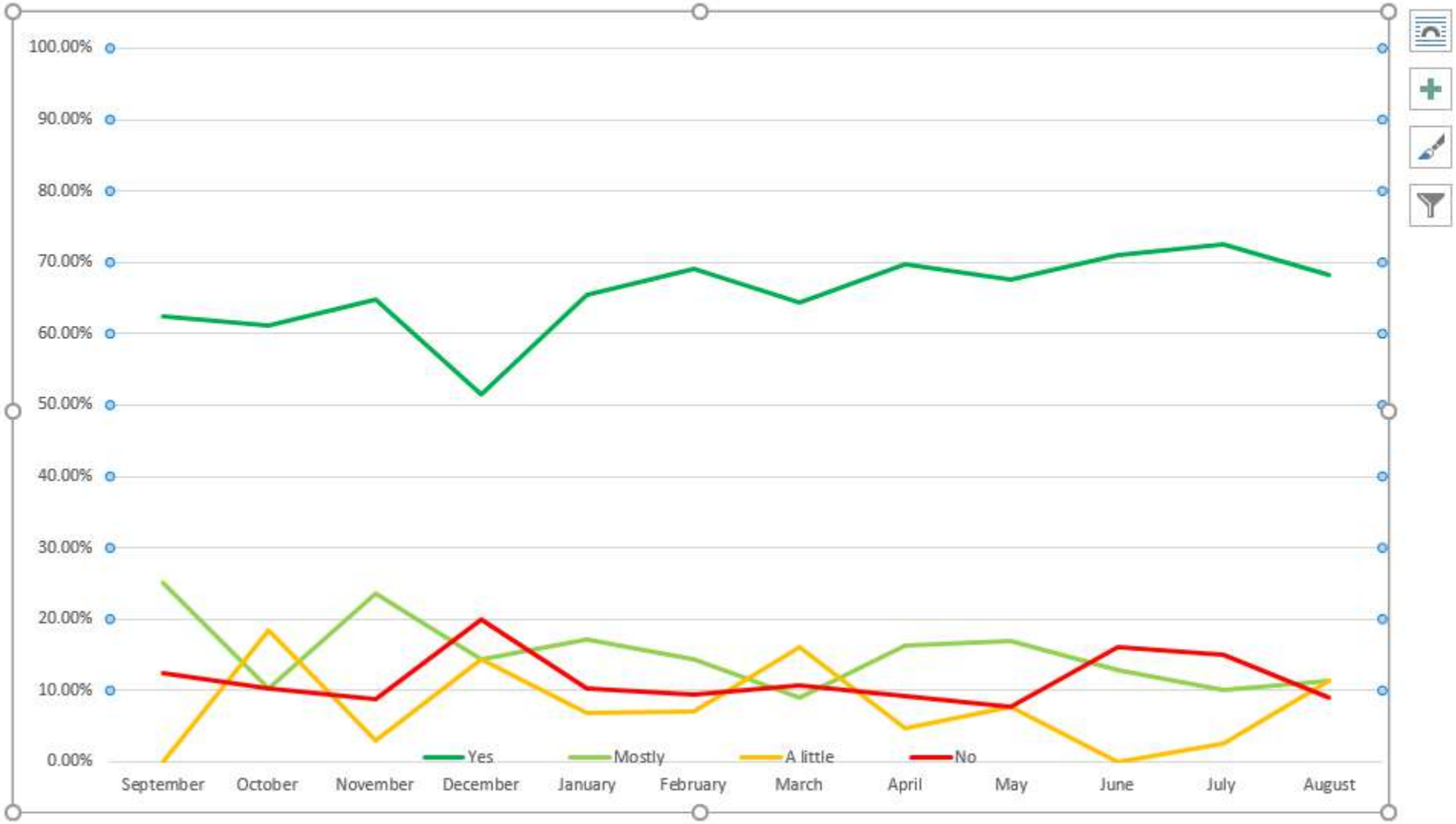
If you were offered an Induction of labour, did you feel fully involved in the decision for this to go ahead?



Notes

PREMs data relating to IOL will be a key metric of the IOL improvement group.

If you were offered an induction of labour, did you feel you were supported with enough information or discussion from your midwife or doctor?



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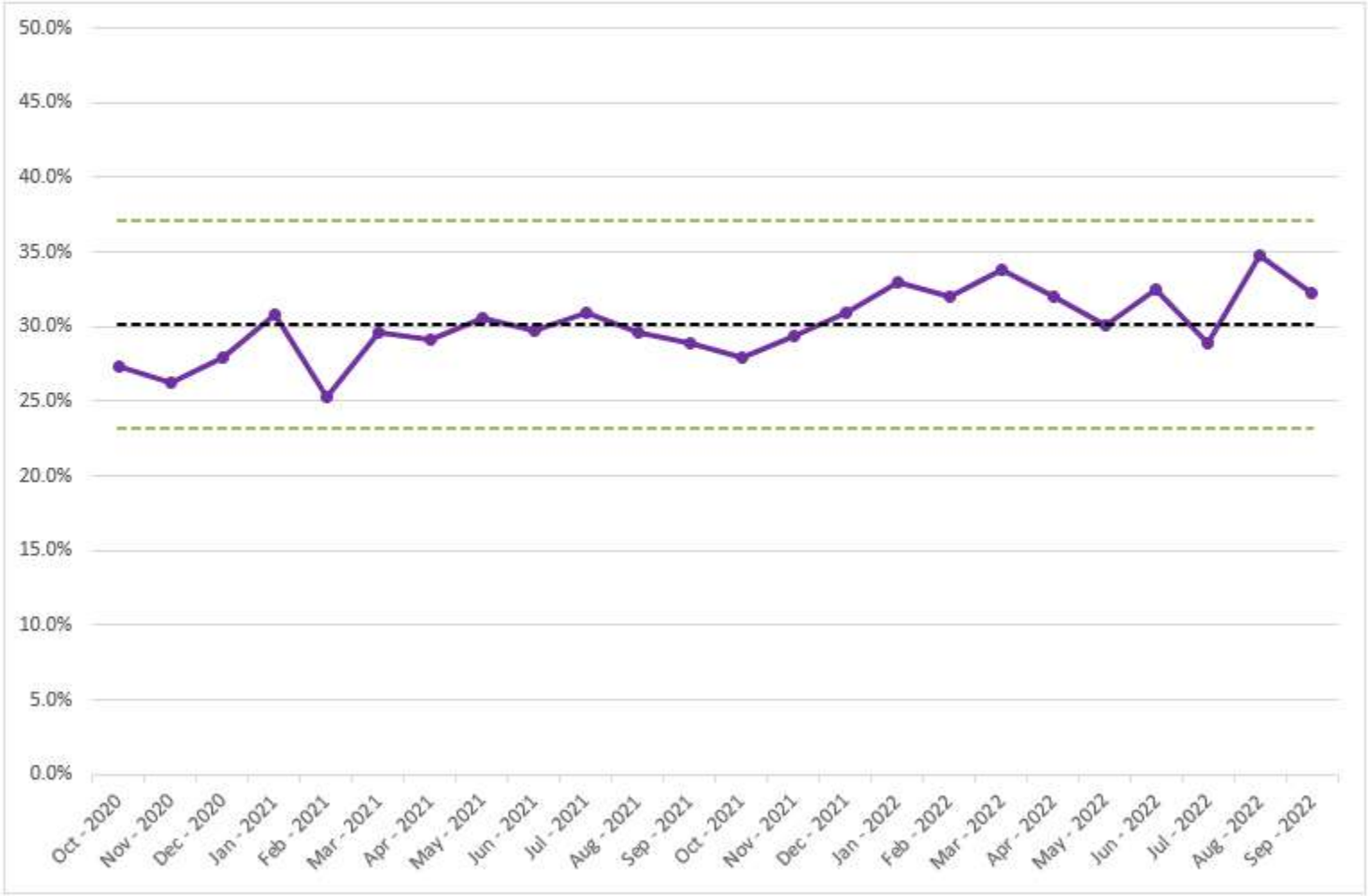
Total Caesarean Sections as a % of all births all CTM



Notes

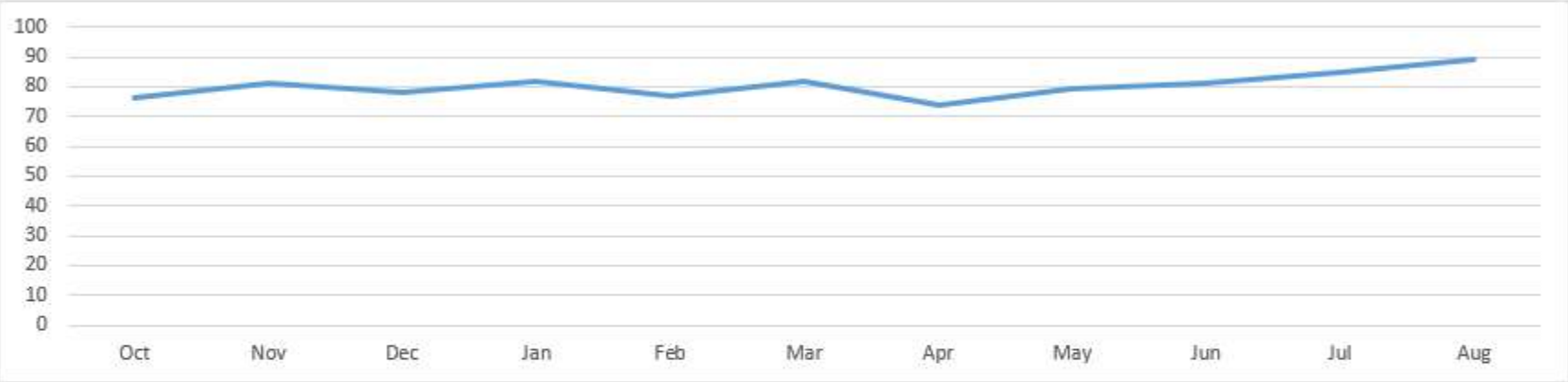
In future, this will be cross referenced against CHKS data, to support data verification.

As part of the maternity dashboard update, all grades of CS will be displayed separately (1,2,3 & 4) allowing for better understanding of CS data.

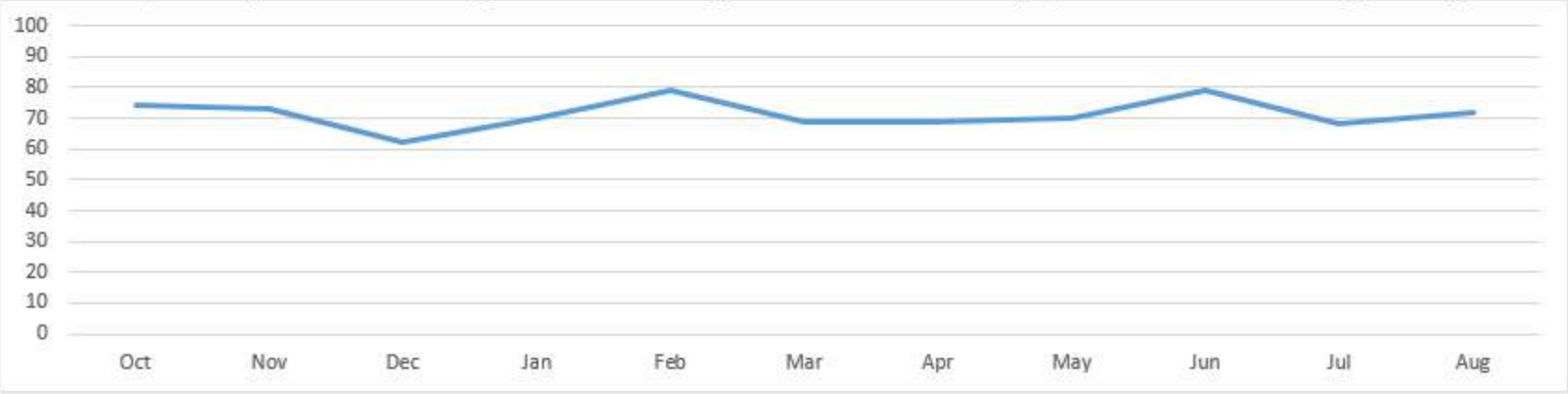
Some signs that total CS rate may be increasing.

No target rate. Focus on supporting information and choice for women, birthing people and families.

PREM question relating to birth planning: During your labour and birth, did your midwife and/or doctor listen to and respect your birth plan/s and preferences?

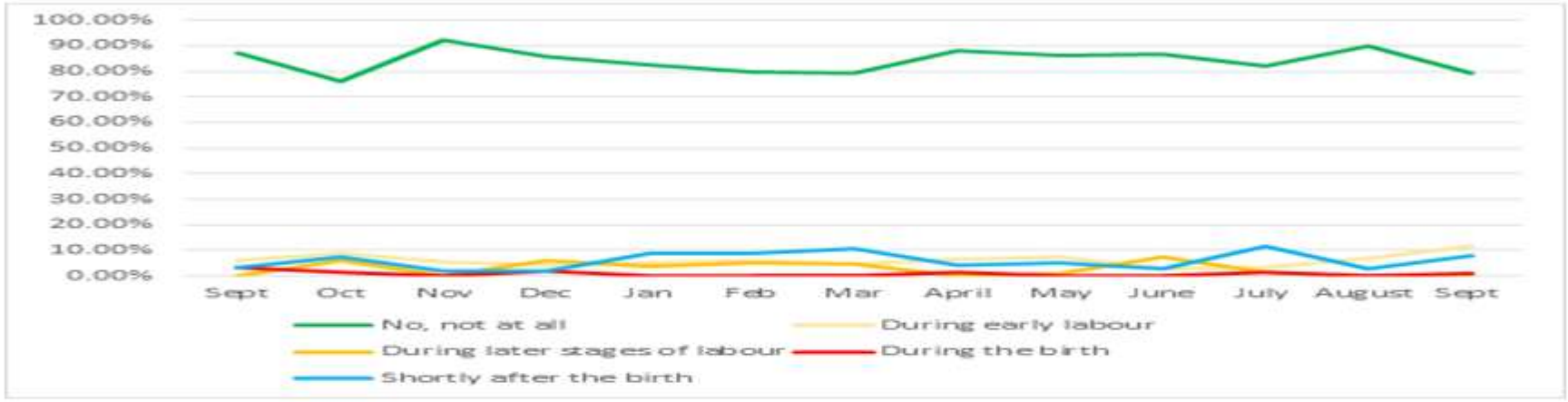


PREM: Do you feel you have had enough information from your midwife/doctor to help you decide where to have your baby?

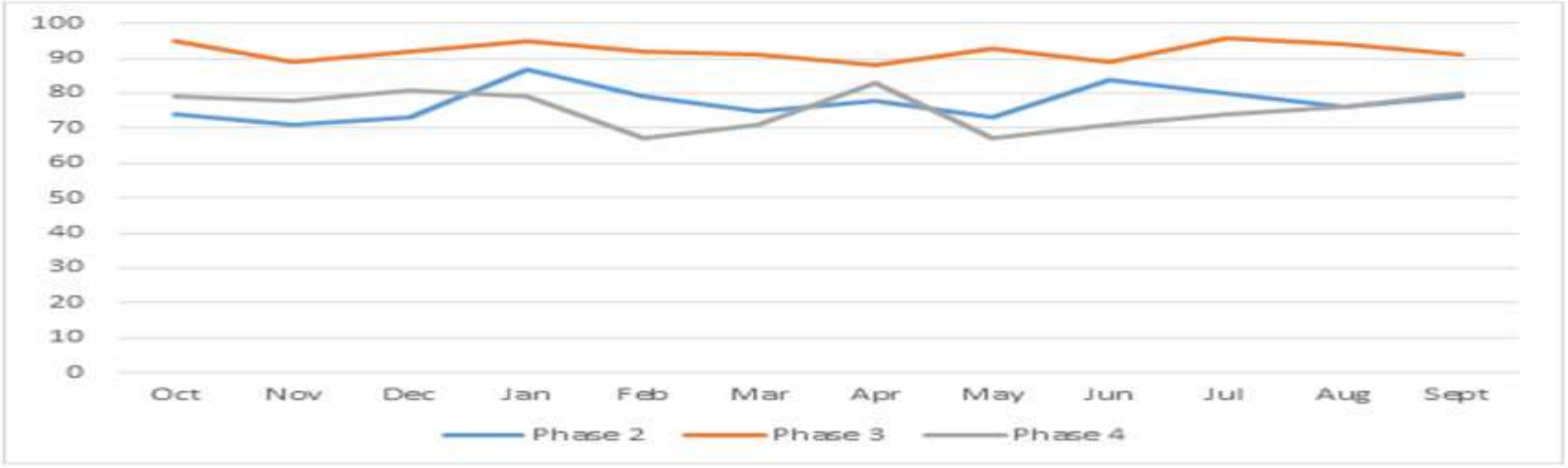


Themes and Trends in PREMs

Were you left alone at a time when it worried you?

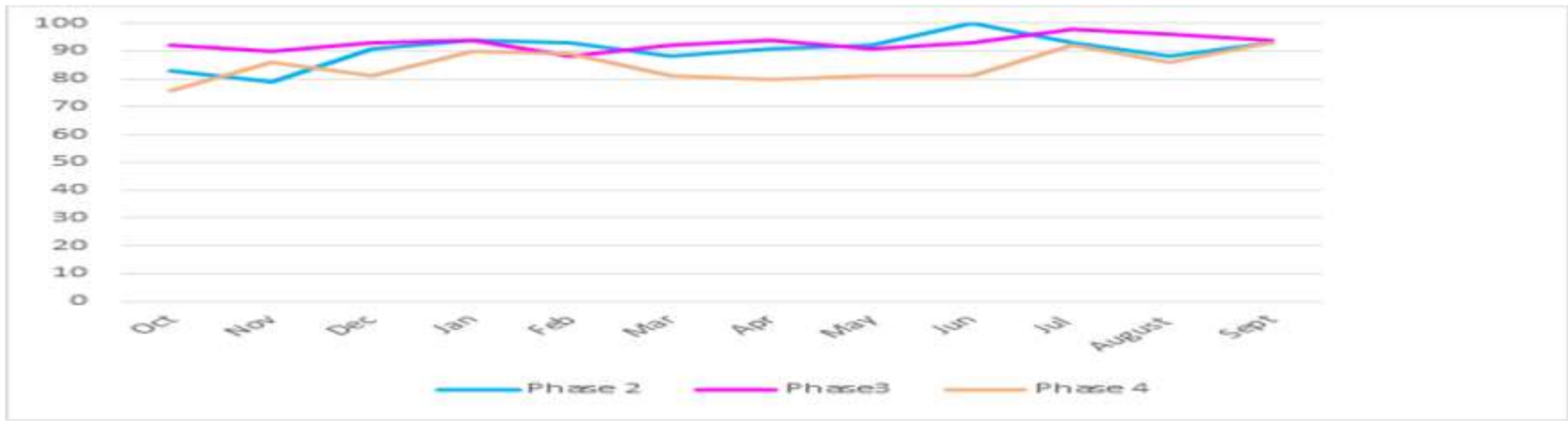


Did you have confidence and trust in the staff caring for you?



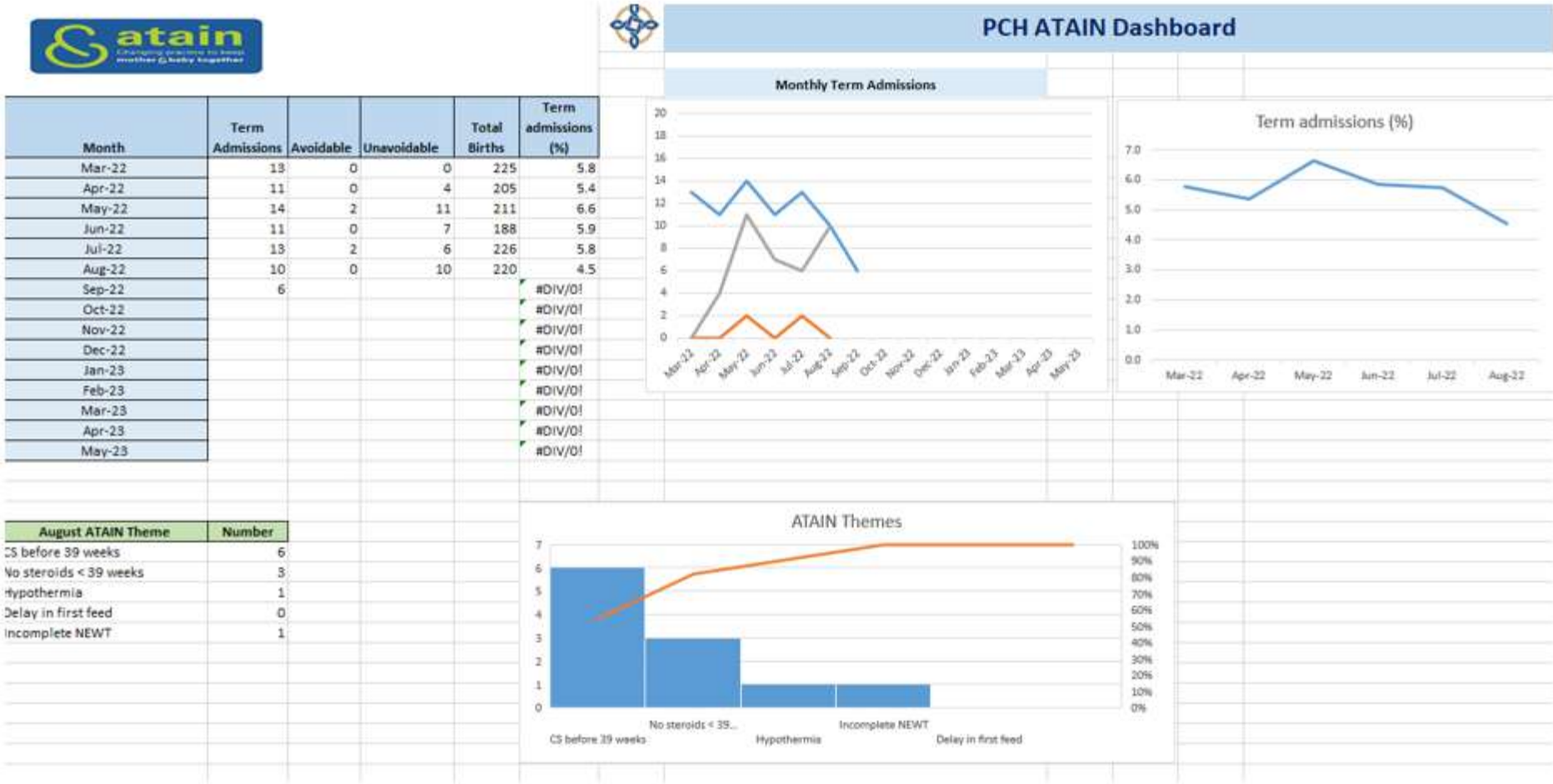
During your care were you given enough time to ask questions or discuss your pregnancy in a meaningful way?

Thinking about your care, were you treated with respect and dignity?



Avoiding Term Admissions to the Neonatal Unit (ATAIN)

The ongoing ATAIN programme is undergoing a refresh with a structured quality improvement methodology approach. The newly appointed Neonatal Governance Lead will be leading this across sites with support from the Maternity and Neonatal QI Lead. An ATAIN dashboard has been developed to capture themes arising from ATAIN multi-professional reviews (screen shot below). These themes will then be used to develop SMART action plans.



Month	Term Admissions	Avoidable	Unavoidable	Total Births	Term admissions (%)
Mar-22	13	0	0	225	5.8
Apr-22	11	0	4	205	5.4
May-22	14	2	11	211	6.6
Jun-22	11	0	7	188	5.9
Jul-22	13	2	6	226	5.8
Aug-22	10	0	10	220	4.5
Sep-22	6				#DIV/0!
Oct-22					#DIV/0!
Nov-22					#DIV/0!
Dec-22					#DIV/0!
Jan-23					#DIV/0!
Feb-23					#DIV/0!
Mar-23					#DIV/0!
Apr-23					#DIV/0!
May-23					#DIV/0!

August ATAIN Theme	Number
CS before 39 weeks	6
No steroids < 39 weeks	3
Hypothermia	1
Delay in first feed	0
Incomplete NEWT	1

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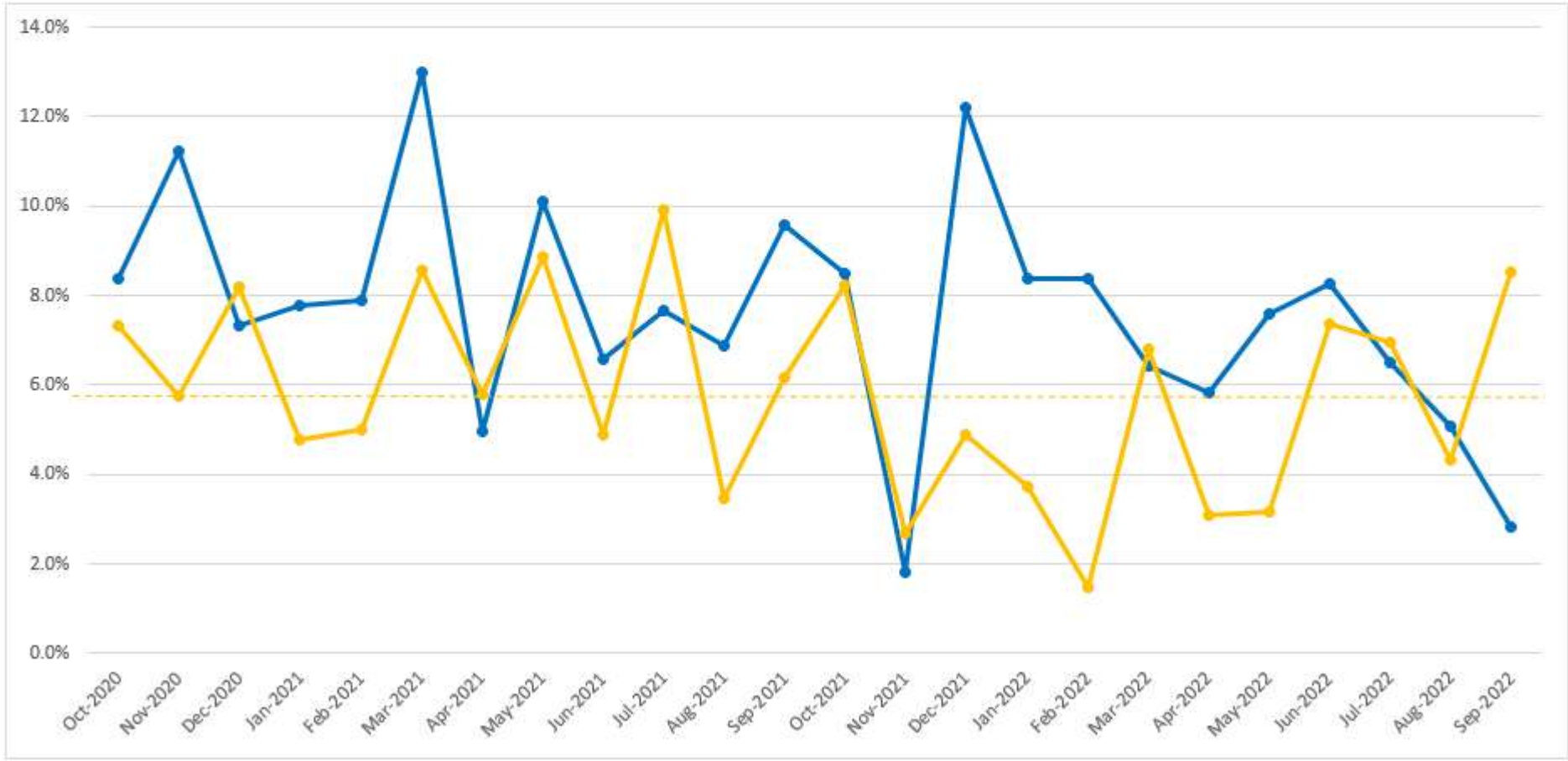
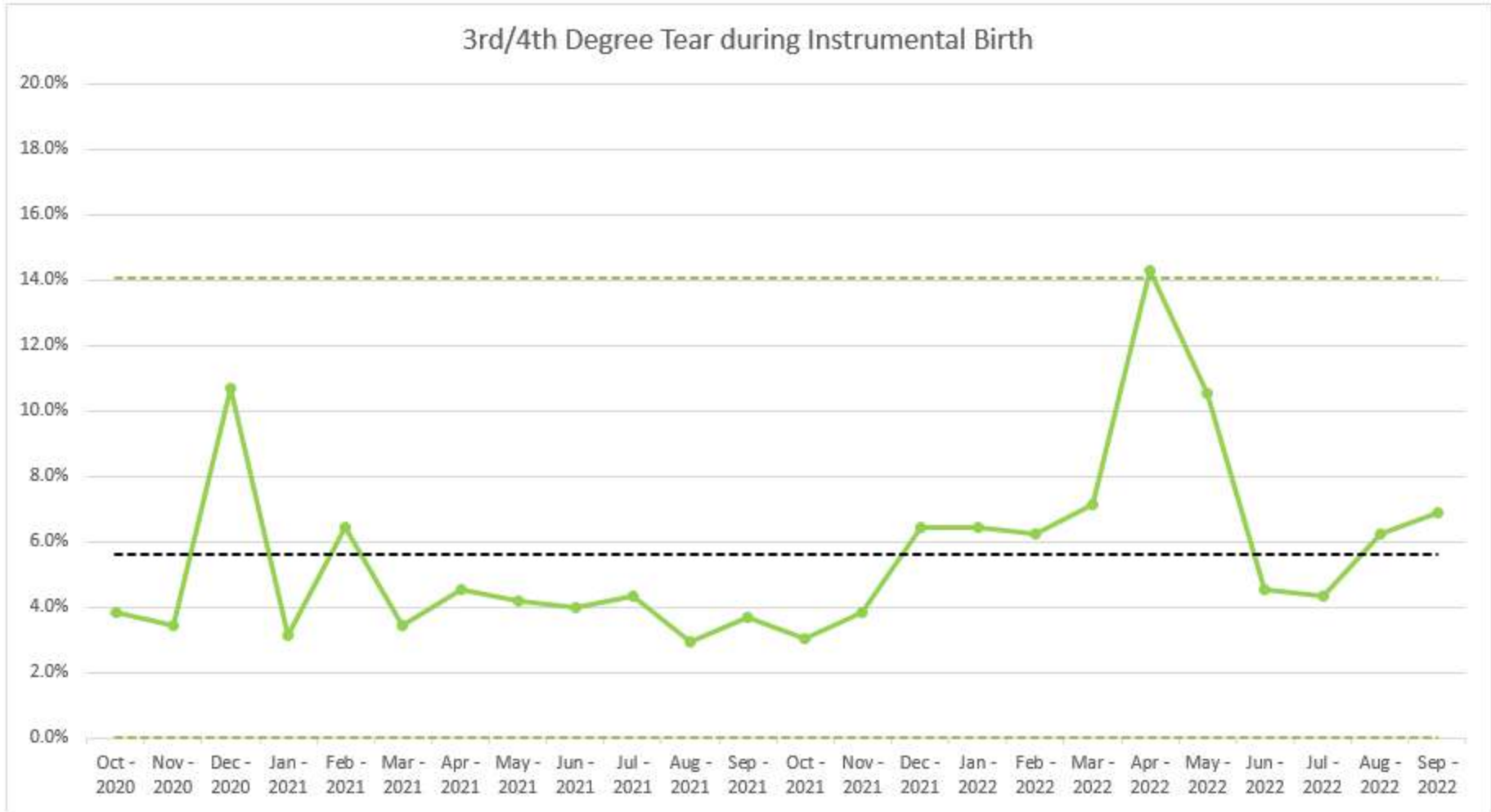
Term Admissions to the Neonatal Unit

Term admission rate at PCH is shown in blue. POW is shown in yellow. There are positive signs of improvement at PCH. The data will continue to be monitored.



Previously raised as a concern as 3rd & 4th degree tear rates were increasing following instrumental birth. OASI implementation in progress. Rates now significantly decreased.



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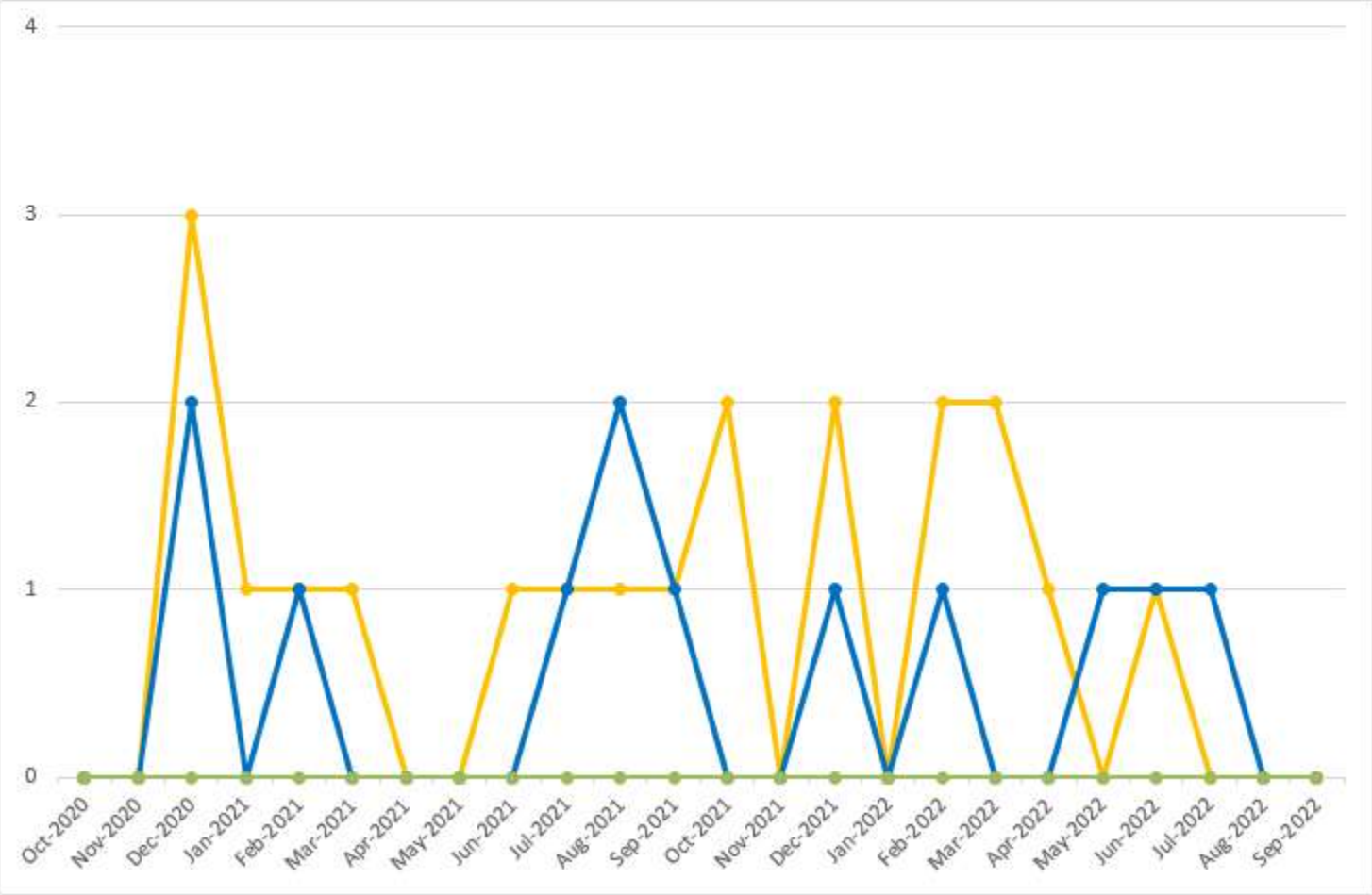
Stillbirth rates



Notes

CTM is not an outlier for stillbirth rates (MBRRACE 2021).

These data appear very variable due to low numbers, but the rates are stable, with no signals of change, or data outside normal variation.

All cases are reported to Datix and rapidly reviewed (within 72 hours).

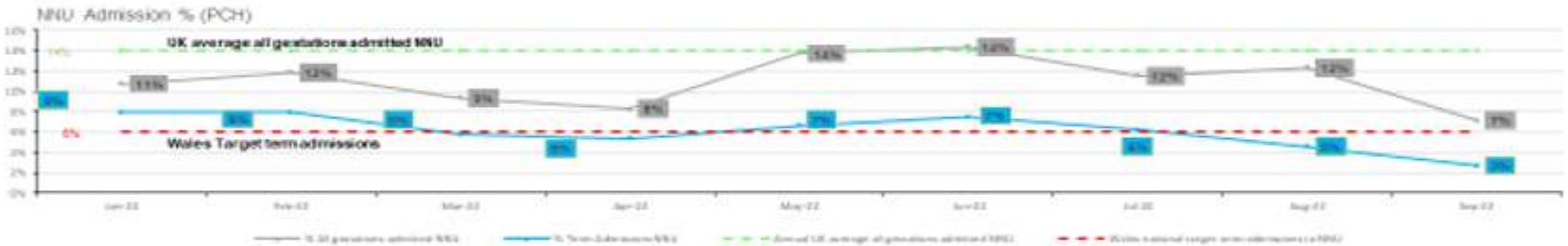
CTM's 'Rainbow Baby Clinic' is in development, to provide enhanced continuity of carer for families experiencing pregnancy after loss.

Neonatal Data

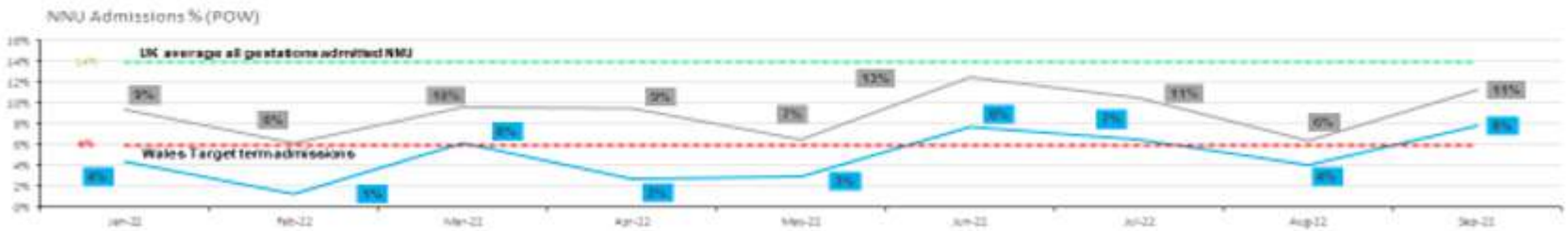
The neonatal dashboard is in early development phase. All data are currently manually extracted from the clinical input system BadgerNet. Options are currently being explored for auto-population of the neonatal monthly dashboard. Some data overlaps with maternity data and therefore could be digitally extracted. Early plans are underway to align the Maternity and Neonatal Dashboard. Currently, there are no examples of this available nationally. Work will align with DHCW's ongoing digital improvement work.

September 2022

PCH & POW



Total live births has remained at a consistent level for the last 3 months. There was a significant decrease in all admissions this month. PCH term admission rate has fallen for the third month (by 2%) and is currently below the national target.



All admissions have doubled from previous month but remains below the UK average for all admissions per total births. The term admission rate has doubled to take the percentage slightly over the national target. Total births have remained similar to previous month.

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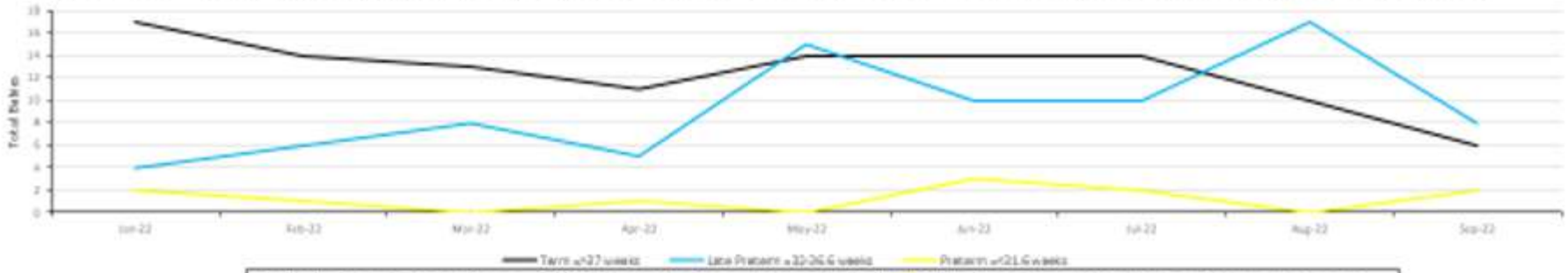
PCH & POW

September 2022

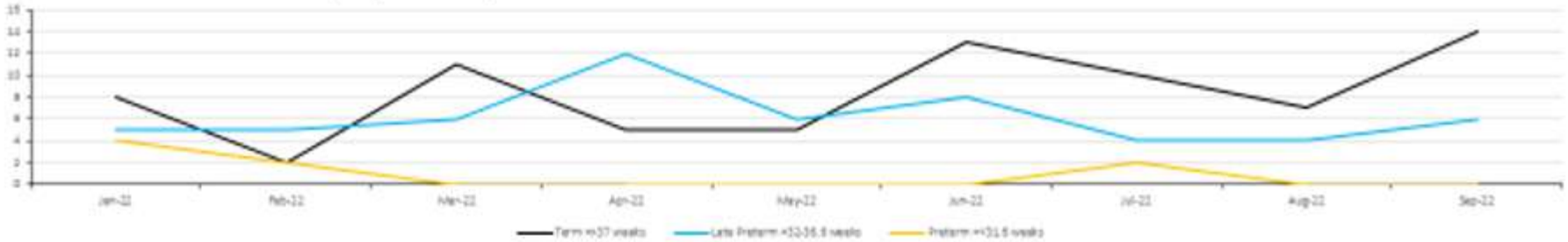
PCH - Total admissions 16 (all gestations). 6 admissions were >37 weeks. 2 admission exceptions outside of unit admission criteria.



Admission Exceptions - 29+6 week twins, transferred to Welsh tertiary centre for intensive care

No Neonatal Deaths

POW - Total admissions 20 (all gestations). 14 admissions were >37 weeks.



No Admission Exceptions

No Neonatal Deaths

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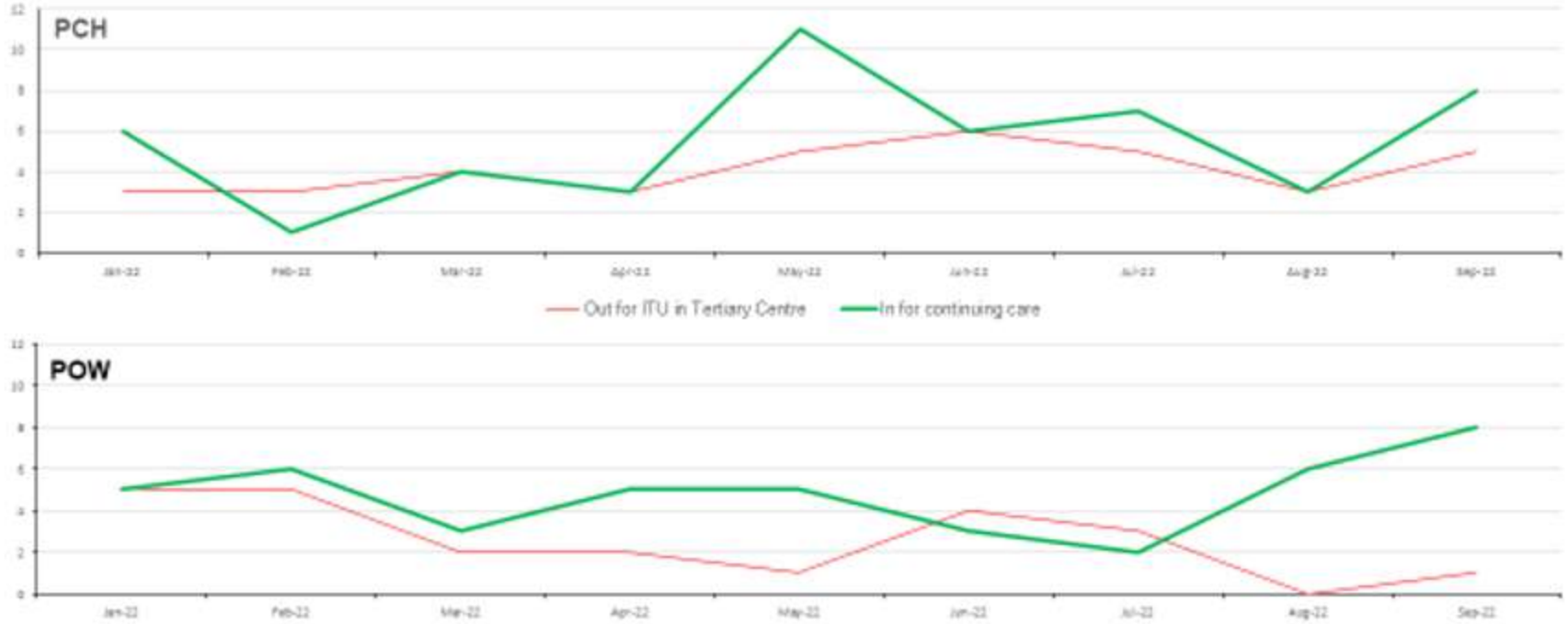
September 2022

CTM UHB – Neonatal Transfers

Transfers out – All babies requiring an increased level of care. Transferred to tertiary centres for intensive care.
Transfers in – Repatriation to be at booking unit having delivered or received care at another hospital. Supporting local tertiary centres, babies who no longer require that higher level of care are transferred to LNU's helping to relieve occupancy pressure



Both units have supported the tertiary centres with repatriations and accepting babies to relieve occupancy pressure during September.

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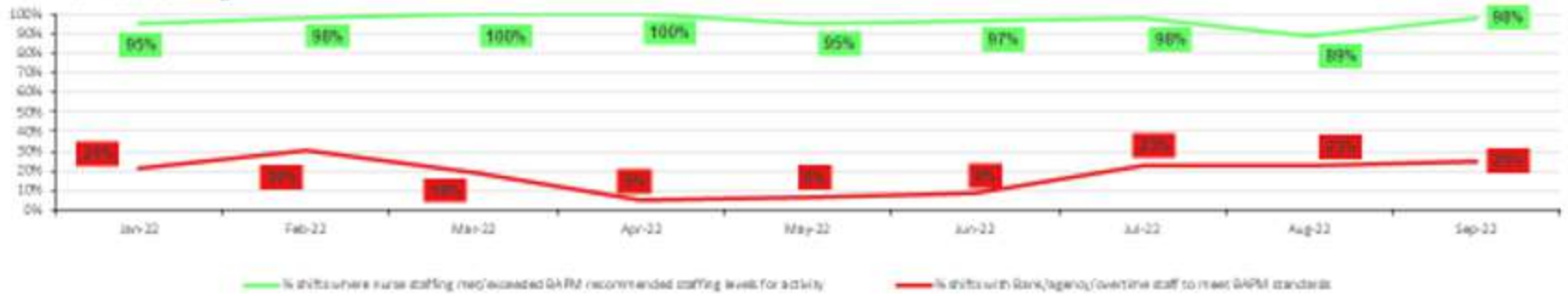
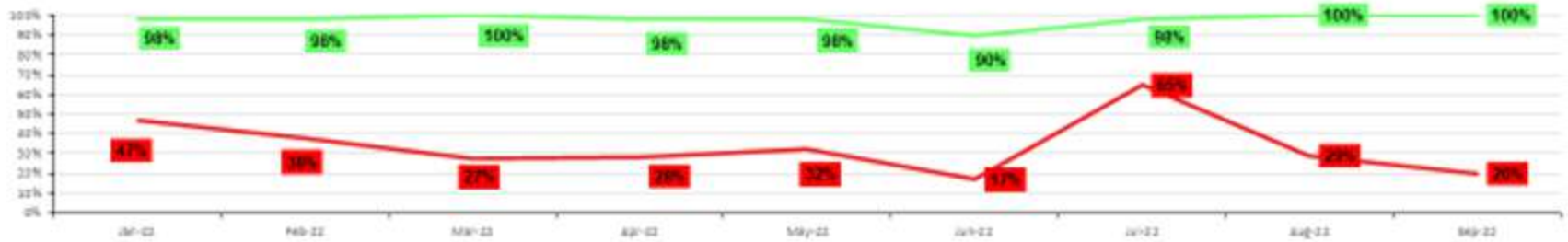
September 2022

PCH & POW Nurse Staffing
(Based on shifts per month)

PCH Nurse Staffing



POW Nurse Staffing



Both Units remained open. The percentages in red are the total number of shifts for the month that required one or more bank/agency/overtime staff to ensure that the units met the BAPM standards.

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SICKNESS & ABSENCE 2022

September 2022

Total absence (unavailable) includes: Sickness, Maternity Leave, Special Leave, Other (e.g. Covid Related).
Annual Leave not included as staff potentially available to work.

PCH - Sickness/Absence %

PCH sickness rate remains at an acceptable level when compared to the national average. The increased absence is due to a number of nursing staff being on maternity leave.

POW-Sickness/Absence %

June to August POW had a sickness rate 3 times the national average. September has seen a significant reduction. This is due to a number of staff returning after extended periods of sickness.

Maternity Incidents September 2022

Maternity Incidents by Level of Harm

	None	Low	Moderate	Total
Other Sites	1	2	0	3
Prince Charles Hospital	32	19	17	68
Princess of Wales Hospital	15	27	28	70
Royal Glamorgan Hospital	2	7	0	9
Total	**50**	**55**	**45**	**150**

Maternity Incidents by Approval Status (and Unit)

	New incident	Under Investigation	Awaiting closure	Closed	Total
Other Sites	1	1	0	1	3
Prince Charles Hospital	7	41	8	12	68
Princess of Wales Hospital	2	38	5	25	70
Royal Glamorgan Hospital	0	6	0	3	9
Total	**10**	**86**	**13**	**41**	**150**

Maternity Incidents by Incident Type

	Other Sites	Prince Charles Hospital	Princess of Wales Hospital	Royal Glamorgan Hospital	Total
Access, Admission	0	1	8	1	10
Accident, Injury	0	2	1	0	3

Assessment, Investigation, Diagnosis	0	2	4	0	6
Communication	1	2	1	1	5
Equipment, Devices	0	3	0	0	3
Information Governance, Confidentiality	0	0	0	1	1
Infrastructure (including staffing, facilities, environment)	0	14	9	0	23
Maternity adverse occurrence	2	35	40	2	79
Medication, IV Fluids	0	0	1	0	1
Monitoring, Observations	0	1	0	0	1
Safeguarding	0	2	0	0	2
Transfer, Discharge	0	4	1	4	9
Treatment, Procedure	0	2	5	0	7
Total	**3**	**68**	**70**	**9**	**150**

Total absence – sickness, maternity, study

Site	Roster area (cost code)	Sick leave				Maternity Leave				Study Leave				Total Leave (wte)	
		Qual		Unqual		Qual		Unqual		Qual		Unqual		Qual	Unqual
		%	wte	%	Wte	%	wte	%	wte	%	wte	%	wte	wte	wte
POW	H432 core	5.1	2.6	7.0	1.5	5.9	3.1	0	0	2.5	1.3	0.1	0.02	16.0	5.7
	H404 ANC	12.6	0.8	32	0.7	0	0	0	0	0.9	0.1	0	0	2.7	1.1
	Midwives	6.1	0.1			0	0			0	0			0.4	
	Nurses														
PCH	1303 core	12%	9.36	18.3%	4.97	3.9%	3.08	1.9%	0.60	2.6%	2.02	0.8%	0.26	26.70	11.35

	1304 ANC	17.9%	0.42	16.0%	0.56	0	0	0	0	3.8%	0.14	2.7%	0.09	0.56	0.65
Community	H438 Bridgend														
	H438 Bridgend mca														
	MC RTE Community 1306 Cynon 1306 Llan 1306 Merthyr 1306 Ponty 1306 Rhondda	RN 33.3% RM 7.7%	0.32 2.54	0	0	RM 7.6%	2.47	0	0	RN 4.2% RM 3.6%		0.3%	0.01	RN 54.2% RM 36.1%	15.3%
Tirion	4121	0	0	6.7%	1.64wte	0	0	0	0	4.5%	0.30wte	2.6%	0.15wte	1.38	1.95
RGH	4114 YCR	7.8%	0.33	3.3%	0.14	0	0	0	0	1.1%	0.05	1.1%	0.05	0.38	0.19
ISH															
Gynae MCILG RTE			0		3.2		0		0		1		0		3.2
GYNAE BILG	EPAU ANC –qualified nurses														

NB. In future, workforce data will be reported into the dashboard, allowing for monthly review of trends.

Next Steps

The Maternity Dashboard will 'Go Live' in mid-October. Communication will be sent out across the service to ensure all staff members can access the dashboard. Information and training sessions have been planned to demonstrate how to access, understand and utilise the data.

Manual input will need to be timely to ensure the dashboard remains contemporaneous for data which is not currently routinely collected electronically, such as workforce data.

The Neonatal Dashboard is being developed with a view to aligning maternity and neonatal data sets. Neonatal data cannot currently be extracted from BadgetNet the way maternity data can be extracted from QlikSense. Auto-extraction is being explored.

Procuring data analysis software to support improved data presentation and understanding, particularly for metrics with low monthly numbers (ie stillbirth, 3rd & 4th degree tears).

Align dashboard with evolving All Wales Maternity Dashboard, and wider programme of Digital Maternity Cymru work (ongoing as All Wales work progresses).

'Staff Voices' launched in September 2022 to capture real time staff feedback. This will form an integral part of the monthly dashboard and reporting, so the service can triangulate clinical data and workforce data with PREMS and what staff are telling us.

Continue with ongoing priority QI projects: BSOTS Triage Project, Booking by 10 weeks, ATAIN. Also, continue to monitor the dashboard, including PREMs data for early signals of change. To support with QI where data are telling us improvement is required.