Health Board Meeting

Thu 26 September 2024, 09:00 - 13:00

The Hub, Royal Glamorgan Hospital Site, Llantrisant

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Jonathan Morgan, Health Board Chair*

1.2. Apologies for Absence

Information *Jonathan Morgan, Health Board Chair*

1.3. Declarations of Interest

Information *Jonathan Morgan, Health Board Chair*

09:05 - 09:05
0 min

2. CONSENT AGENDA BUSINESS

Information *Jonathan Morgan, Health Board Chair*

The Chair will ask if there are any items from the Consent Agenda (Item 9) that Board Members wish to bring forward to the Main agenda for discussion

09:05 - 09:25
20 min

3. SHARED LISTENING & LEARNING

3.1. Listening & Learning Story - Robotics Surgery

Discussion *Paul Blake, Consultant/Sharon O'Brien Care Group Nurse Director*

3.1 Board and Committee RAS Presentation (final).pdf (7 pages)

09:25 - 09:45
20 min

4. SPOTLIGHT PRESENTATION

4.1. Health Board Performance - Organ Donation and Transplantation Presentation

Discussion *David Jones, Intensive Care Consultant*

4.1 CTM Board Presentation Organ Donation Final v2.pdf (34 pages)

09:45 - 10:15
30 min

5. SETTING THE SCENE

5.1. Chairs Report

Decision *Jonathan Morgan, Health Board Chair*

5.1 Chair's Board Report UHB 26 September 2024.pdf (6 pages)

5.1.1. Action Log from Previous Board Meeting

Discussion *Jonathan Morgan, Health Board Chair*

5.1.1 Action Log Health Board UHB 26 September 2024.pdf (8 pages)

5.2. Chief Executives Report

Discussion *Paul Mears, Chief Executive Officer*

5.2a CEO Board Update Report UHB 26 September 2024.pdf (9 pages)
5.2b Cwm Taf Morgannwg UHB Escalation Framework UHB 26 September 2024.pdf (12 pages)

10:15 - 11:35
80 min

6. GOVERNANCE, RISK AND ASSURANCE

6.1. Board Committee and Advisory Group Highlight Reports

Discussion *Committee Chairs/Executive Leads*

For where there are items requiring escalation to the Board

6.1.1. People Culture Committee Highlight Report - to include a verbal update on Strategic Workforce Planning Discussions

Discussion *Hywel Daniel, Executive Director for People*

6.1.1 PCC Highlight Report to Board 07.08.2024 UHB 26 September 2024.pdf (5 pages)

6.1.2. Quality & Safety Committee Highlight Report 23 July 2024

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

6.1.2 QSC Committee Highlight Report UHB 26 September 2024 Final.pdf (6 pages)

6.1.3. Mental Health Act Monitoring Committee Highlight Report 4 September 2024

Discussion *Geraint Hopkins, Committee Chair/Independent Member*

6.1.3 MHAM Committee Highlight Report to Board 4 September 2024 UHB 26 September 2024.pdf (4 pages)

6.2. Escalation Status Update

Information

For Discussion and Noting - An update in relation to Escalation Status has been included in the Chief Executive Officers Report at agenda item 5.2

6.3. Board Assurance Framework (Principal/Strategic Risks)

Decision *Gareth Watts, Director of Corporate Governance/Board Secretary*

6.3a Board Assurance Framework - Cover Paper.pdf (4 pages)
6.3b Appendix 1 - Board Assurance Framework Report.pdf (72 pages)

6.4. Effective Management of Board Business Review (to include an amendment to the Standing Orders (including revised Terms of Reference)

Decision *Jonathan Morgan, Health Board Chair*

6.4a Effective Mgt of Brd Business - Bd Mtg 26.9.2024.pdf (7 pages)
6.4b Appendix 1 - 01. GC01 Standing Orders (Main Document) - Updated September 2024.pdf (51 pages)
6.4c Appendix 2 - GC01 SO's Schedule 3.0 - Schedule of Board COmmittees.pdf (1 pages)
6.4d Appendix 2 - GC01 SO's Schedule 3.1 - ARAC ToR - Draft Sept 24.pdf (17 pages)
6.4e Appendix 2 - GC01 SO's Schedule 3.2 - CFC ToR Draft Sept 24.pdf (12 pages)
6.4f Appendix 2 - GC01 SO's Schedule 3.3a - MHAMC ToR Draft Sept 24.pdf (12 pages)
6.4g Appendix 2 - GC01 SO's Schedule 3.3b - PoDSC ToR - Draft Sept 24.pdf (9 pages)

- 6.4h Appendix 2 - GC01 SO's Schedule 3.4 - ODC ToR - Draft Sept 24.pdf (11 pages)
- 6.4i Appendix 2 - GC01 SO's Schedule 3.5a - QSEC ToR - Draft Sept 24i.pdf (13 pages)
- 6.4j Appendix 2 - GC01 SO's Schedule 3.5b - HS&FSC ToR - Draft Sept 24.pdf (9 pages)
- 6.4k Appendix 2 - GC01 SO's Schedule 3.5c - ODSC ToR - Draft Sept 24.pdf (8 pages)
- 6.4l Appendix 2 - GC01 SO's Schedule 3.6 - RTSC ToR - Draft Sept 24.pdf (11 pages)
- 6.4m Appendix 2 - GC01 SO's Schedule 3.7 - SDC ToR - Draft Sept 24.pdf (10 pages)
- 6.4n Appendix 3 - BAF Strategic Risks mapped to the new Cmts.pdf (1 pages)

6.5. Integrated Opportunities on Social Care (Section 33) - Presentation

Discussion *Matt Jenkins*

- 6.5 Integrated Opportunities on Social Care.pdf (9 pages)

11:35 - 12:20
45 min

7. DELIVERING OUR PLAN

7.1. Integrated Performance Report (Quality, People & Operational Performance)

Discussion

- 7.1 HB Integrated Performance Dashboard UHB 26 September 2024.pdf (37 pages)

7.2. Financial Performance Update - Month 5

Discussion *Mark Thomas, Deputy Director of Finance*

- 7.2 M5 Finance Report Final UHB 26 September 2024.pdf (22 pages)

12:20 - 12:25
5 min

8. STRATEGIC PLANNING

8.1. Acute Services Clinical Plan Update

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

- 8.1 CTM Board ACSP update UHB 26 September 2024.pdf (5 pages)

8.2. Llantrisant Health Park Update - Presentation

Discussion *Rosie Cavill, LHP Infrastructure Programme Director*

- 8.2 Llantrisant Health Park Update.pdf (19 pages)

12:25 - 12:30
5 min

9. CONSENT AGENDA

9.1. FOR APPROVAL

Information

9.1.1. Unconfirmed Minutes of the meeting held on 25 July 2024

Decision *Jonathan Morgan, Health Board Chair*

- 9.1.1 Unconfirmed Draft Minutes Public Board 25.7.2024 UHB 26 September 2024.pdf (21 pages)

9.1.2. Committee Annual Reports

Decision *Gareth Watts, Director of Corporate Governance/Board Secretary*

- 9.1.2a Board Committee Annual Reports UHB 26 September 2024.pdf (4 pages)
- 9.1.2b Appendix 1 Audit Committee Annual Report 2023 2024 UHB 26 September 2024.pdf (16 pages)

9.1.2c Appendix 2 PCC Annual Report 2023-24 UHB 26 September 2024.pdf (7 pages)

9.1.3. Joint Commissioning Committee Governance Framework

Decision *Paul Mears, Chief Executive*

9.1.3a JCC Governance Framework UHB 26 September 2024.pdf (10 pages)
9.1.3b Appendix 1 Memorandum of Agreement JCC April 2024 UHB 26 September 2024.pdf (25 pages)
9.1.3c Appendix 2 Appendix 2 HOSTING AGREEMENT UHB 26 September 2023.pdf (26 pages)
9.1.3d Appendix 3 Quality Safety and Outcomes Sub committee ToR v8 UHB 26 September 2024.pdf (14 pages)
9.1.3e Appendix 4 Planning Performance Finance Sub committee ToR V6 UHB 26 September 2024.pdf (11 pages)

9.1.4. Putting Things Right Annual Report

Decision *Greg Dix, Executive Director of Nursing/Deputy CEO*

9.1.4a PTR Annual Report 2023-2024 UHB 26 September 2024.pdf (3 pages)
9.1.4b PTR Annual Report 2023-2024 Final UHB 26 September 2024.pdf (11 pages)

9.1.5. Welsh Language Standards Annual Report

Decision *Hywel Daniel, Executive Director for People*

9.1.5a Board Cover Paper WL Standards Annual Report 2023 24 UHB 26 September 2024.pdf (5 pages)
9.1.5b Welsh Language Standards Annual Report 2023 24 FINAL UHB 26 September 2024.pdf (60 pages)
9.1.5c Papur Clawr Bwrdd Adroddiad Safonau'r Gymraeg 2023 24 UHB 26 September 2024.pdf (5 pages)
9.1.5d Adroddiad Perfformiad Safonau'r Gymraeg 2023 24 TERFYNOL UHB 26 September 2024.pdf (62 pages)

9.2. FOR NOTING

Discussion

9.2.1. Board Annual Cycle of Business

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

9.2.1a Cover Report Board Annual Cycle of Business UHB 26 September 2024.pdf (3 pages)
9.2.1b Appendix 1 Board Cycle of Business 2024 UHB 26 September 2024.pdf (4 pages)

9.2.2. Board Forward Work Programme

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

9.2.2 Board Forward Work Programme UHB 26 September 2024.pdf (4 pages)

9.2.3. Board Committee and Advisory Group Highlight Reports

Information *Committee Chairs*

For Noting (e.g where there are no items for escalation to the Board)

9.2.3a Board Committee and Advisory Group Highlight Reports UHB 26 September 2024.pdf (4 pages)
9.2.3b Appendix 1 PHP Highlight Report to Board 01.08.24 UHB 26 September 2024.pdf (5 pages)
9.2.3c Appendix 2 RTSC Committee Highlight Report 14.8.24 11.9.24 UHB 26 September 2024.pdf (4 pages)
9.2.3d Appendix 3 Hosted Bodies ARC Highlight Report 15.08.24 UHB 26 September 2024.pdf (4 pages)
9.2.3e Appendix 4 CTMUHB ARC Highlight Report 15.08.24 UHB 26 September 2024.pdf (6 pages)
9.2.3f Appendix 5 PPFC Highlight Report to Board 27.08.24 UHB 26 September 2024.pdf (6 pages)
9.2.3g Appendix 6 Digital and Data Committee Highlight Report 28 August 2024 (v2) UHB 26 September 2024.pdf (5 pages)

9.2.4. Estates and Energy Performance Annual Report

Information *Sally May, Executive Director of Finance*

9.2.4 Estates Annual Performance Board Report UHB 26 September 2024.pdf (15 pages)

9.2.5. Nurse staffing Levels Annual Three year report 2021-2024

Information *Greg Dix, Executive Director of Nursing/Deputy CEO*

- 9.2.5a Cover paper for 3 year report NSA Final 1.3 UHB 26 September 2024.pdf (6 pages)
- 9.2.5b NSA 3Year 2021-2024 Final version UHB 26 September 2024.pdf (18 pages)
- 9.2.5c 3Year NSA Appendix A UHB 26 September 2024.pdf (15 pages)
- 9.2.5d 3year NSA Appendix B UHB 26 September 2024.pdf (12 pages)
- 9.2.5e 3year NSA Appendix C UHB 26 September 2024.pdf (14 pages)

9.2.6. Annual Unpaid Carer's Report 2023/24

Information *Greg Dix, Executive Director of Nursing/Deputy CEO*

- 9.2.6 Carers End of Year progress report UHB 26 September 2024.pdf (5 pages)

9.2.7. Infection Prevention & Control Annual Report

Information *Greg Dix, Executive Director of Nursing/Deputy CEO*

- 9.2.7a IPC Annual Report Cover Paper UHB 26 September 2024.pdf (6 pages)
- 9.2.7b IPC Annual Report 2023-2024 (1) UHB 26 September 2024.pdf (29 pages)

9.2.8. Annual Letter 2023/2024 Public Services Ombudsman for Wales

Information *Greg Dix, Executive Director of Nursing/Deputy Chief Executive*

- 9.2.8a Board Paper - PSOW - 2024-09-13 UHB 26 September 2024.pdf (6 pages)
- 9.2.8b Board Paper - PSOW - 2024-09-13 Appendix A UHB 26 September 2024.pdf (10 pages)

9.2.9. Decarbonisation Emission Reporting 2023-24

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

- 9.2.9a Decarbonisation emission report UHB 26 September 2024.docx (5 pages)
- 9.2.9b APPENDIX 1 – CTMUHBs Annual Carbon Emission Reporting 202324 UHB 26 September 2024.pdf (27 pages)

12:30 - 12:30
0 min

10. CLOSE OUT BUSINESS

10.1. Any Other Business

Information *Jonathan Morgan, Health Board Chair*

10.2. How Did we do in this Meeting

Discussion *Jonathan Morgan, Health Board Chair*

This provides an opportunity for Board Members to reflect on the meeting and in doing so may find it helpful to consider the following questions:
Is there anything we should do more or less of?
Have we managed our time well and allowed open and balanced discussion?
Have we considered our values and acted in a way that supports embedding our values across CTM?
Have we maintained a strategic focus?
Have we received sufficient assurance from a range of sources?
Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

12:30 - 12:35
5 min

11. PRIVATE/IN COMMITTEE SESSION

In Committee Items to be confirmed

12:35 - 12:35
0 min

12. DATE AND TIME OF NEXT MEETING

The next meeting of the Health Board is scheduled to take place on Thursday 28 November 2024 at 9:00am

(Agenda Item)	(Date of Meeting)	(Name of Meeting)	(Title of Item)

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	
Prepared By:	Rhian Searle, Senior Nurse for Theatres & Recovery, RGH
Presented By:	Sharon O'Brien & Mr Paul Blake
Approving Executive Sponsor:	Greg Dix, Executive Nurse Director
Report Purpose	For Noting
Engagement undertaken to date:	Patients, Staff, Key Stakeholders internal & external.

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	
Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No Supporting a patient story and the lady concerned does not understand or speak Welsh, therefore needs to tell her story in English
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Sustaining Our Future Inspiring People Improving Care

Robotic Assisted Surgery in CTM UHB

Versius- a small, modular, portable surgical robot.

24 January 2024
Theatre ready to undertake the first ever robotic assisted colorectal procedure for CTM patients.

To Date:

- 15 Colorectal Cancer operations have been performed with the robot and 5 cholecystectomies
- No intra- or post-operative complications or problems or need to convert
- Significant reduction in post-operative pain seen in RAS
- Early mobilisation due to good pain control > decreased risk of chest infections, pneumonia, DVTs, PEs, return to normal oral intake, patient well-being
- No admissions to ITU
- Faster recovery time

The Future is bright
The future is robotics!

- Team 2 Colorectal commenced training May 2024
- Team 3 Upper GI Training commenced in July 2024
- Team 4 Gynaecology starting training this week

Recommendation:	**The Board are asked to:** • *NOTE the presentation.*

CTM Board Presentation 2024

CTM Organ Donation Team

Presented by Dave Jones & Charlotte Goodwin
Regional Clinical Lead for Organ Donation

Presentation compiled by:
Corinna McNeil & Victoria Hughes

Let's talk about it

Join the NHS Organ Donor Register
today and share your decision

Yes I donate
ORGAN DONATION

organdonation.nhs.uk

Organ Donation	26th September 2024	CTM Board Meeting	CTM Organ Donation Activity

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Dave Jones, Victoria Hughes and Corinna McNeil (Specialist Nurses)
Presented By:	Dave Jones – Regional CLOD Charlotte Goodwin – Team Leader
Approving Executive Sponsor:	Dr Dom Hurford, Exec MD
Report Purpose	For Noting
Engagement undertaken to date:	Review of publically available KPIs Public engagement at events

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Allowing Organ and Tissue Donation an expected part of end of life care to respect decisions made during life. Reducing waits on transplant waiting list.
Related Health and Care Standard	Governance & Accountability
Has an EQIA been undertaken?	Yes – 28/08/2024
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No – NHSBT funded activity
Link to Strategic Goals	Improving Care Creating Positive End of Life Care Experience for Patients/Families

Specialist Nurses for Organ Donation (SNODs)
Victoria Hughes & Corinna McNeil

- Experienced in acute and critical care
- Advanced communication skills training
- Manage and facilitate process from initial referral to completion of theatre/transfer to mortuary
- 24/7 on-call rota covering South Wales and South West of England
- Expert in the organ donation process and end of life care
- Staff training and raising awareness
- Implement change to incorporate organ donation as an integral part of end-of-life care
- Embedded within Critical Care team
- Engage with community groups to share information and education around organ and tissue donation
- Audit all deaths in Emergency Department and Intensive Care Units.

Clinical Leads for Organ Donation (CLODs)

- Dr Jay Singh & Dr Najia Hasan
- Intensive Care Consultants (0.5PA – NHSBT Funded)
- Deliver teaching across the Health Board, regionally and across UK
- Local experts in Organ Donation and Diagnosis of Death
- Project leads to enhance and develop organ donation process in CTM

- Support SNODs in community engagement

SIGNET

Donor Family Volunteer
Mrs OW

- First in the UK
- Works with the Specialist Nurse in the provision of support and spiritual care to the families who have consented for Organ Donation.
- Offers to remain at patient's bedside if family wish to go home or require a break
- Assists in providing hot and cold drinks for families.
- Offers families the opportunity of a visit from the Chaplaincy
- Provides information to families about the role of the spiritual care department.
- Complies with the Code Of Expectation for Volunteers.
- Family representative on the Organ Donation Committee

Organ Donation Committee

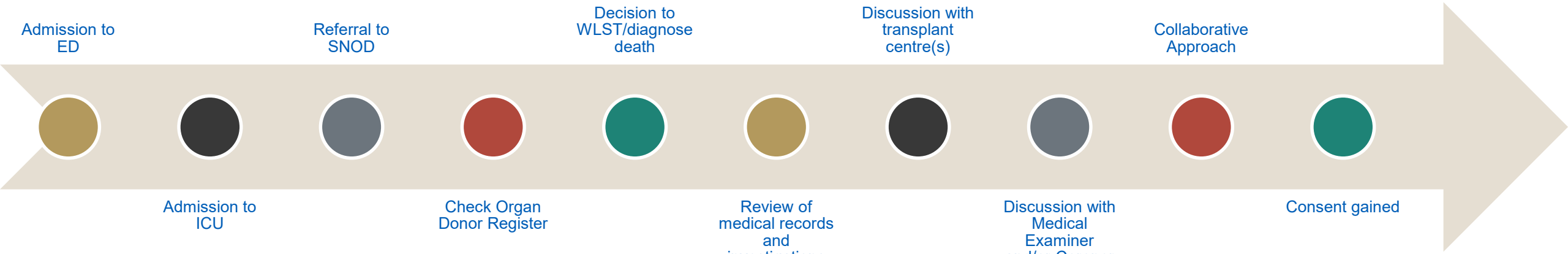
- Chair: Helen Lentle (IM - Legal)
- Meets Quarterly
- Wide stakeholder engagement
- Links NHSBT activity with HB structures
- Local team to provide assurances to ODC
- Development of HB strategy
- Reports to Quality and Safety Committee

Regional Team

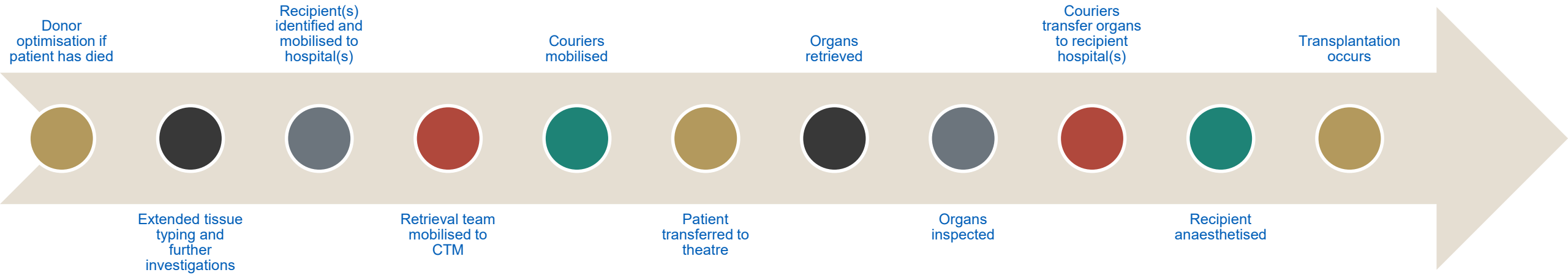
- Regional Head of Nursing – Jo Chalker
- Team Leaders – Charlotte Goodwin & Bethan Moss
- Regional CLOD – David Jones
- 3 Regional TRODs

- 11 SNODs/SRs and 14 CLODs – ICU, ED, Paediatrics, NICU.
- Regional Fund (~£85,000)

Donation Process



Donation Process



Wales
Commenced December 2015

Final Vote

Yes	43
No	8
Abstain	2

England
'Max and Keira's Law'
Commenced May 2020

Private members bill
- No one formally objected!

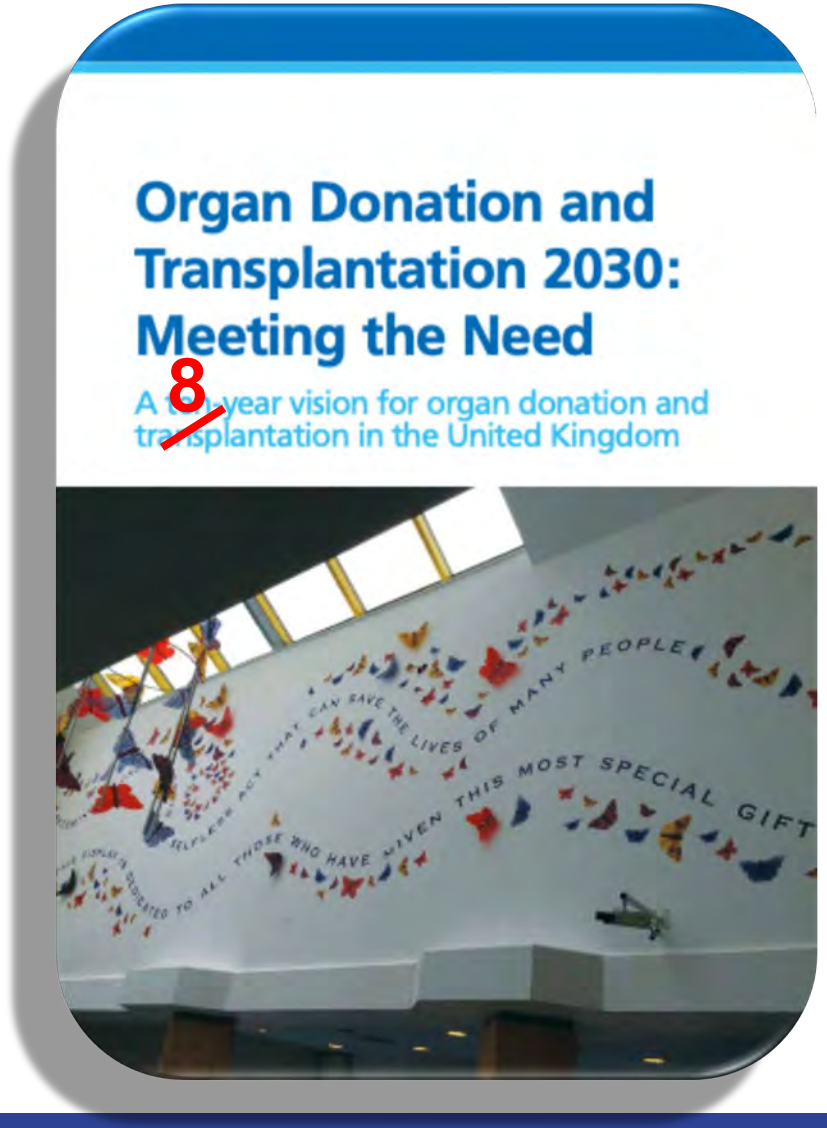
Scotland
Commenced March 2021

Final Vote

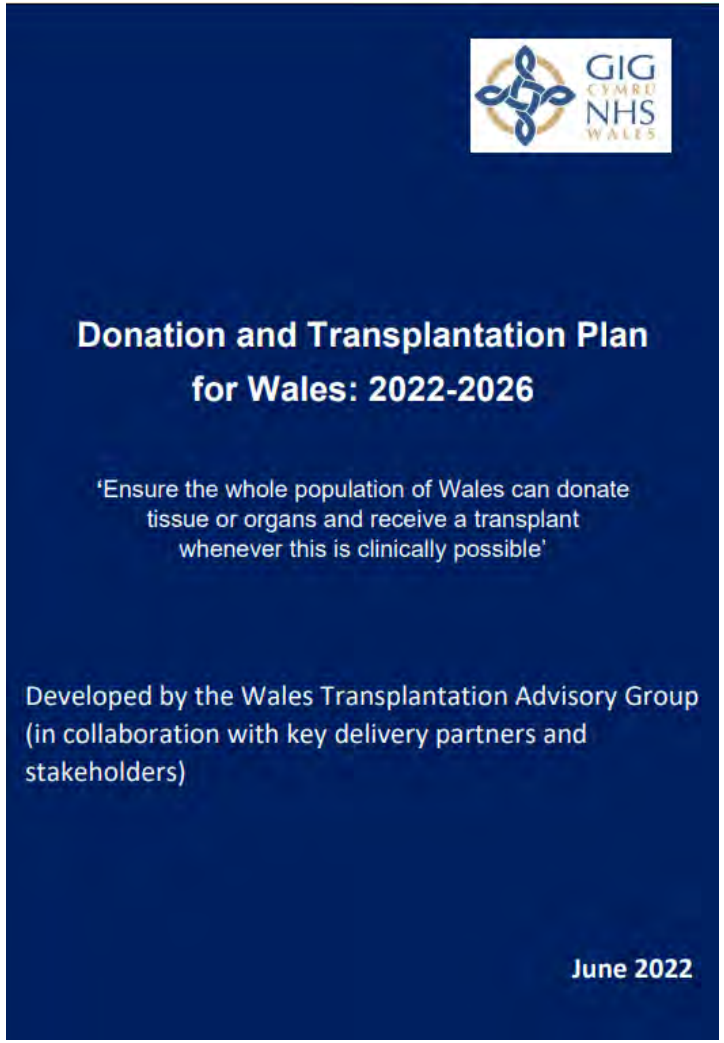
Yes	116
No	3
Abstain	2

Northern Ireland
'Dáithí's Law'
Legislation
February 2022

No verbal dissent.



"Living and deceased donation will become an <u>expected</u> part of care, where clinically appropriate, for all in society"



1: Increasing deceased donation

2: Increasing tissue and eye donation

3: Increasing living donation and transplantation

4: Increase access to transplantation

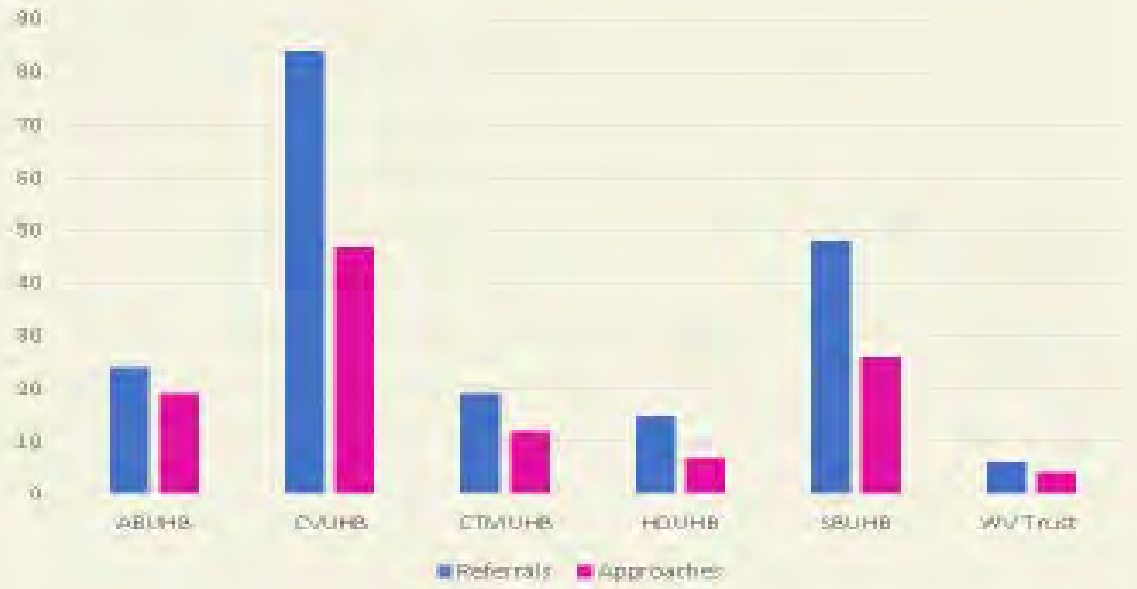
5: Improving transplant outcomes

6: Workforce sustainability, supported and diverse

South Wales Health Boards 2023-2024

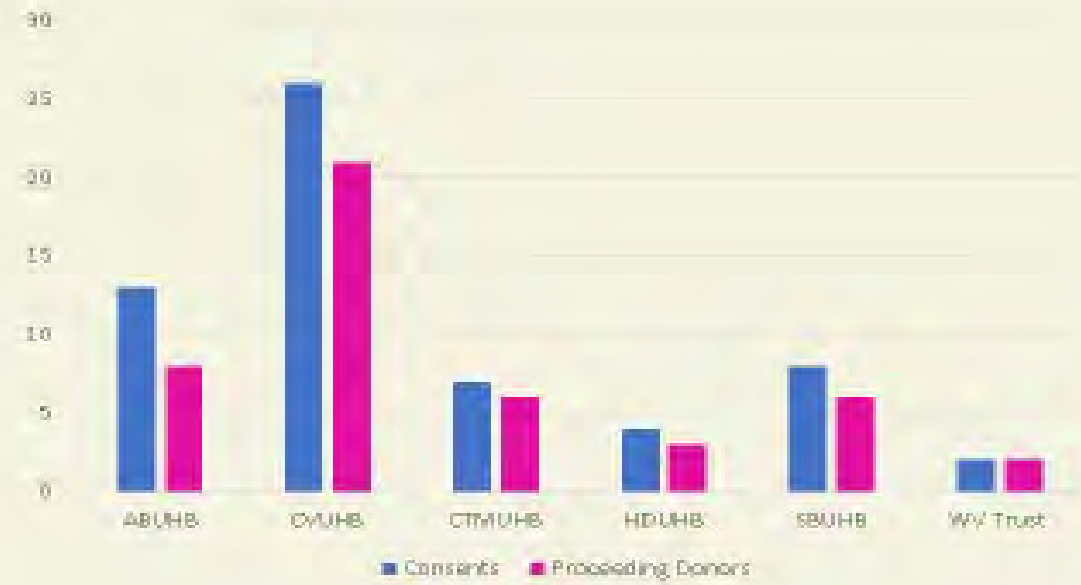
Referrals and Approaches

1 April 2023 – 31 March 2024



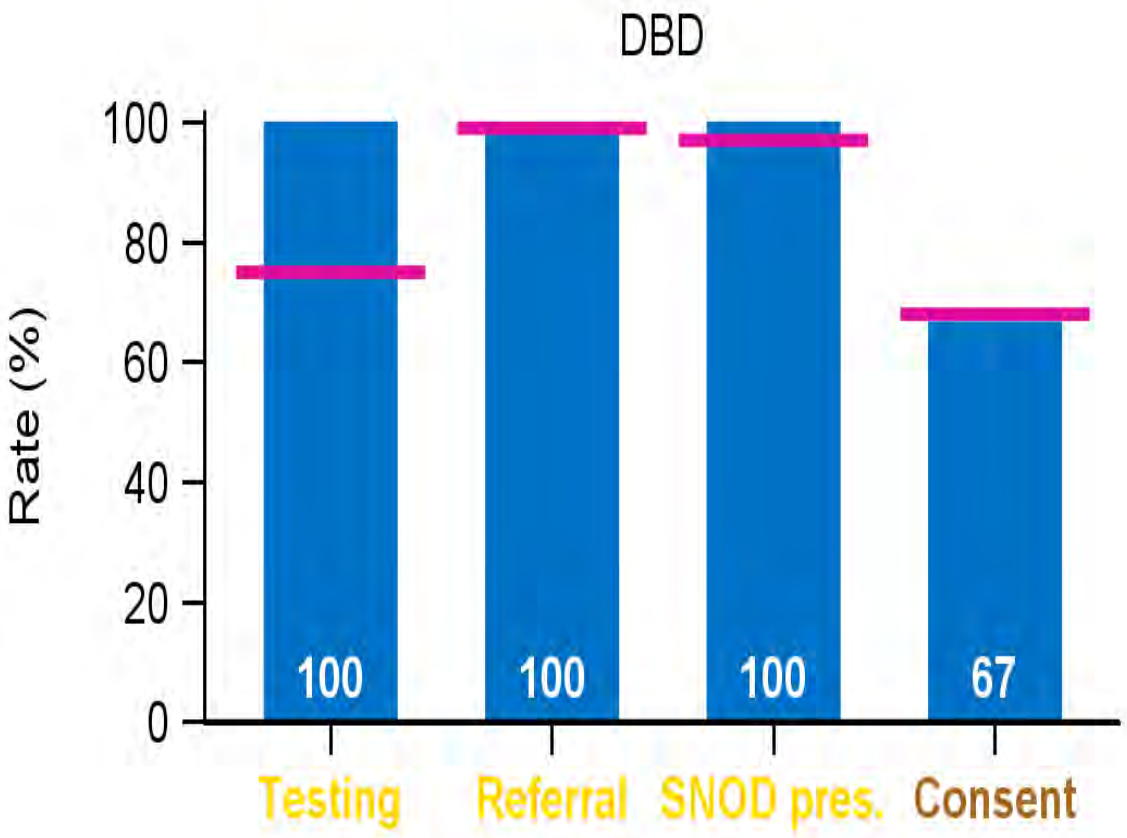
Consent Rate and Proceeding Donors

1 April 2023 – 31 March 2024

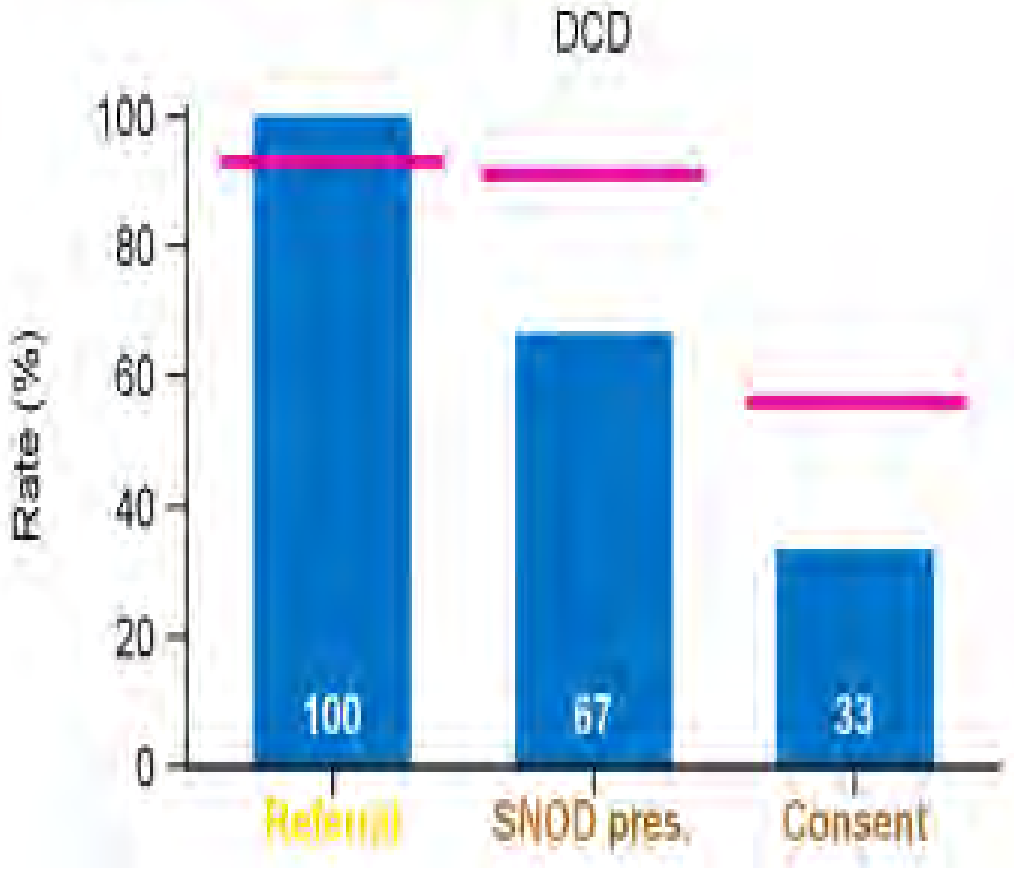


CTM Data 2023-2024

Neurological Death

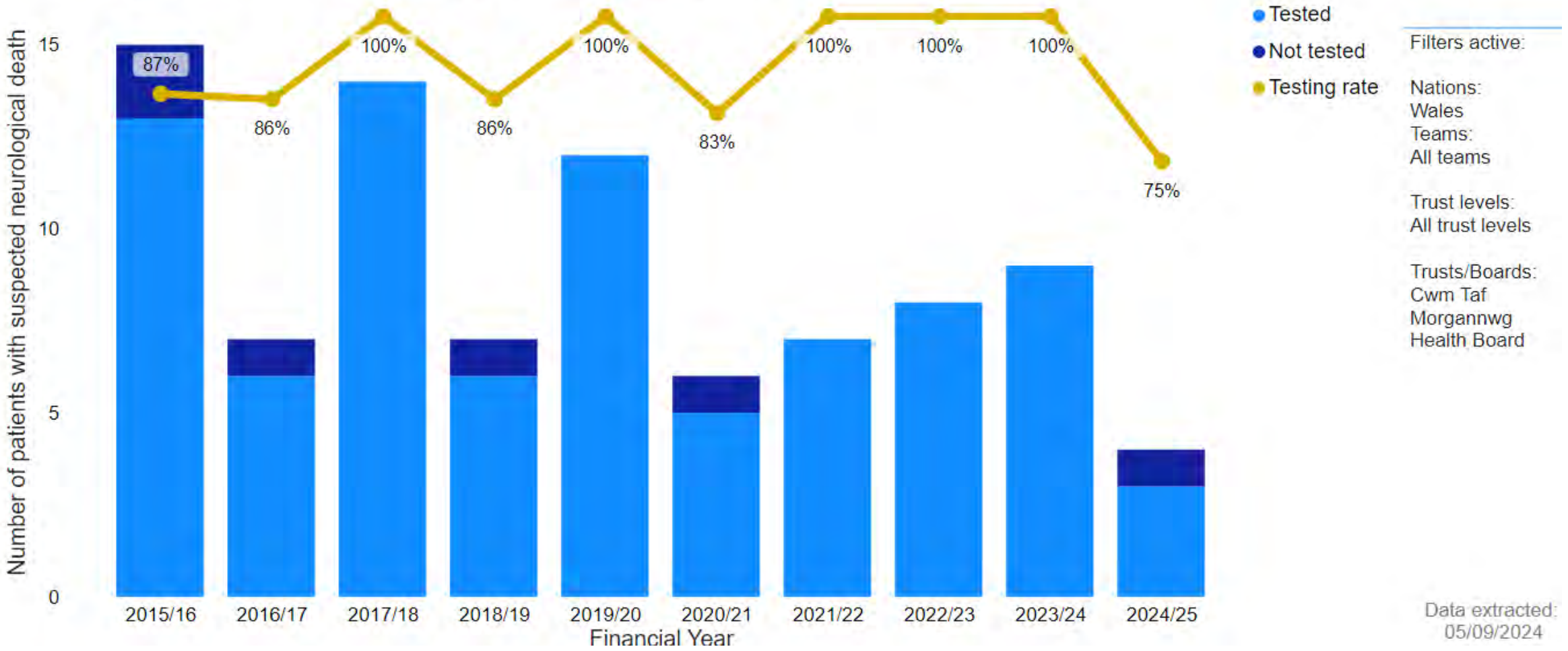


Circulatory Death



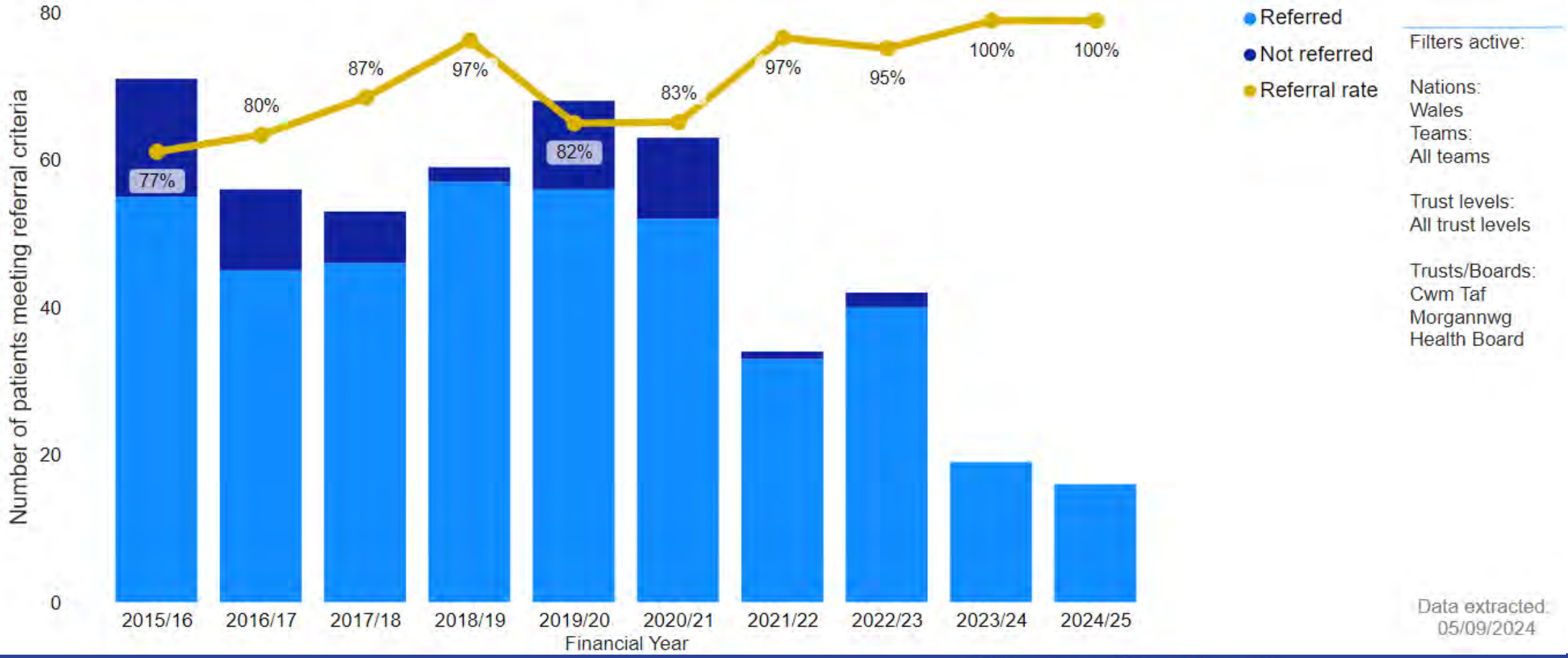
NHS
Blood and Transplant

Neurological death testing rate, April 2015 to August 2024



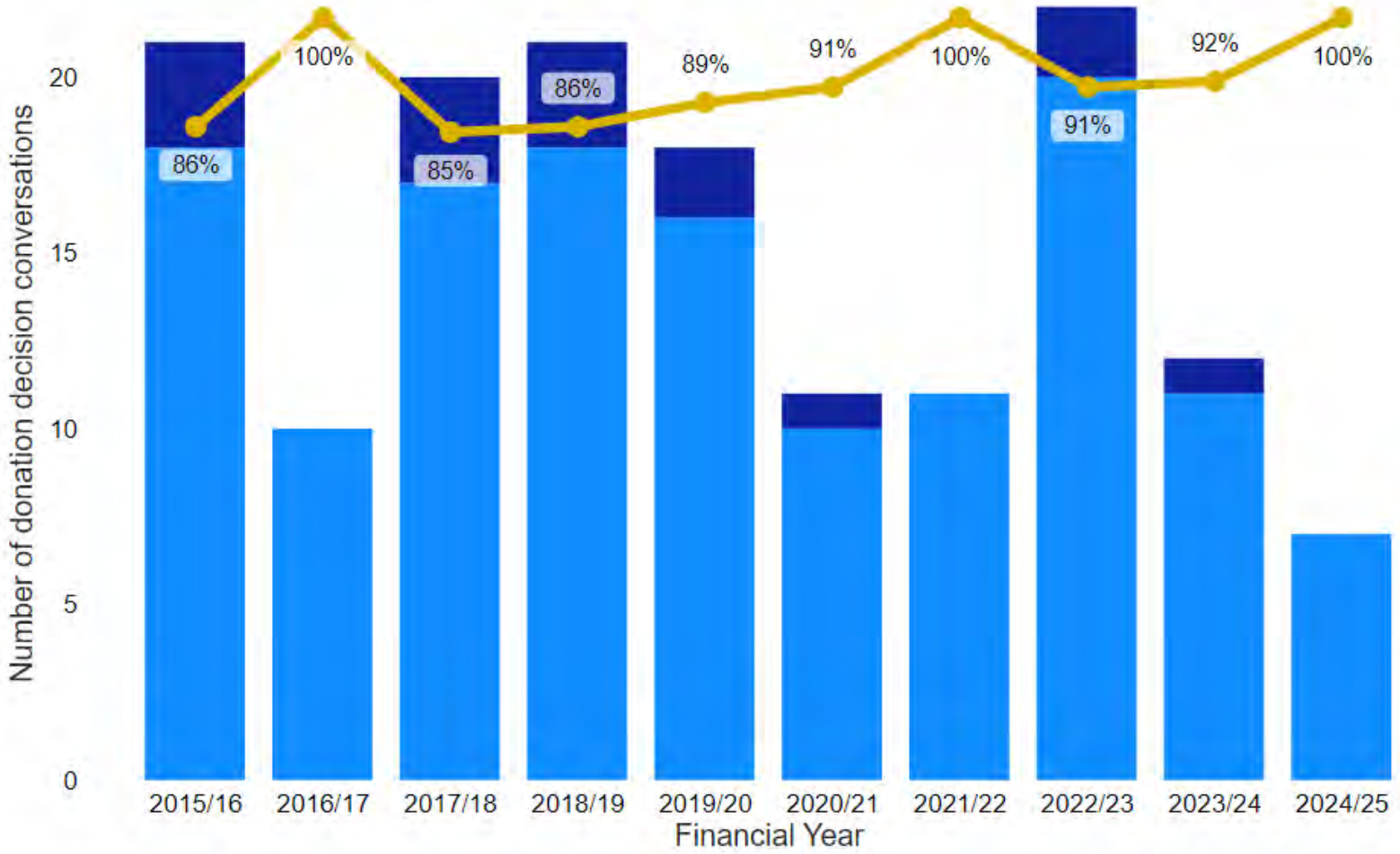
NHS
Blood and Transplant

Overall Referral rate, April 2015 to August 2024



NHS
Blood and Transplant

Overall SNOD* Presence rate, April 2015 to August 2024



SNOD present
SNOD not present
SNOD presence rate

*A SNOD is a Specialist Nurse for Organ Donation, including Specialist Requesters in this report.

Filters active:

Nations:
Wales
Teams:
All teams

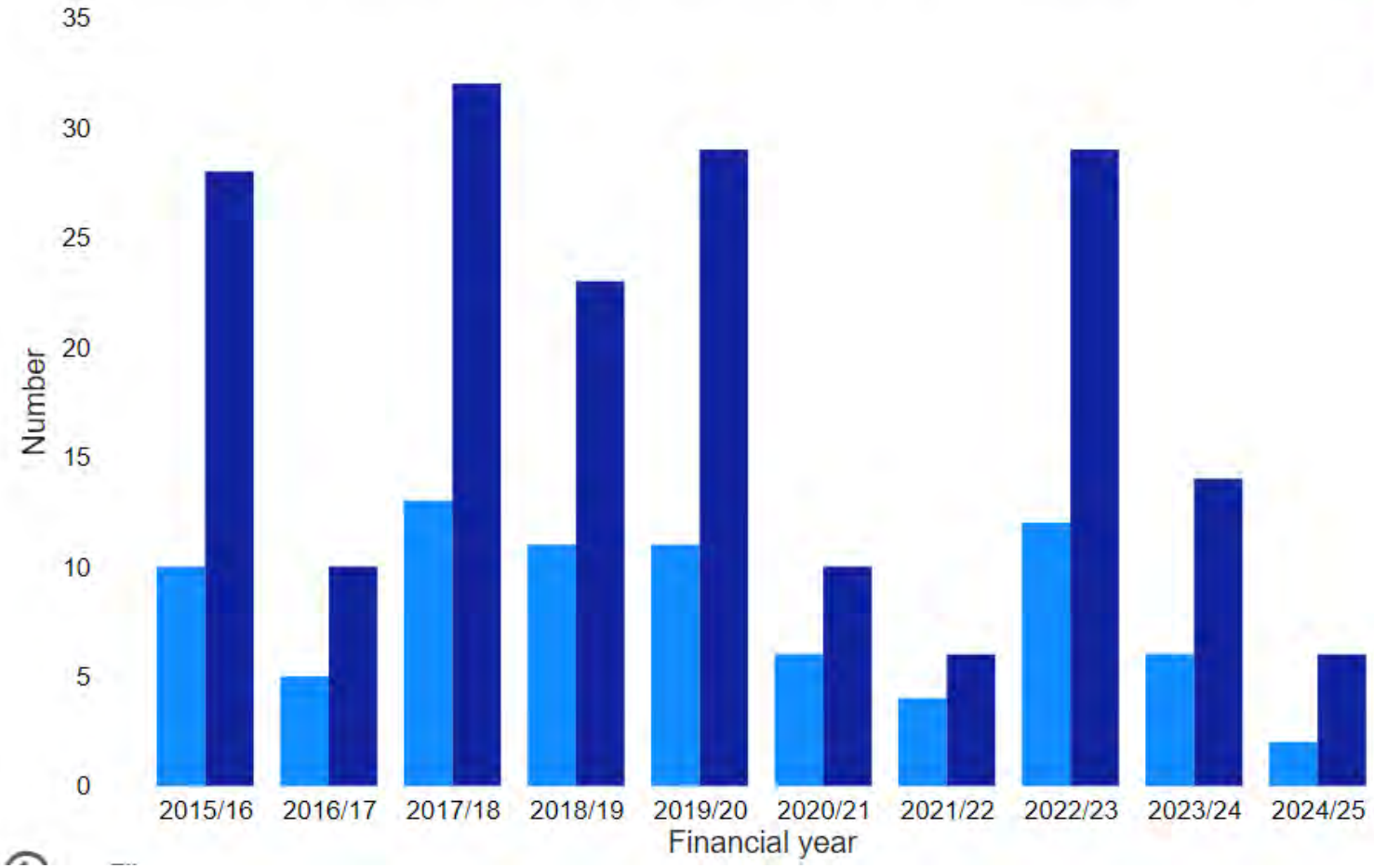
Trust levels:
All trust levels

Trusts/Boards:
Cwm Taf Morgannwg Health Board

Data extracted:
05/09/2024

NHS
Blood and Transplant

Overall number of donors and resulting transplants, April 2015 to August 2024



Number of donors
Number of resulting transplants

Filters active:

Nations:
Wales

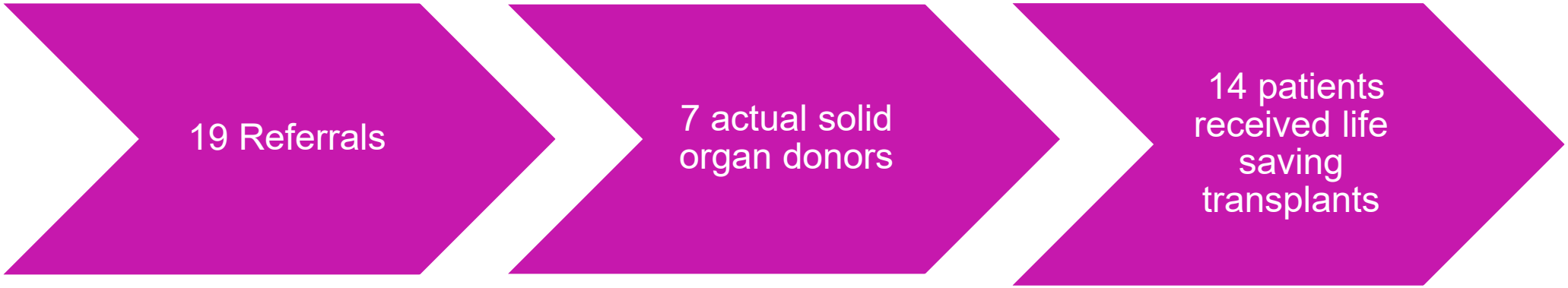
Teams:
All teams

Trust levels:
All trust levels

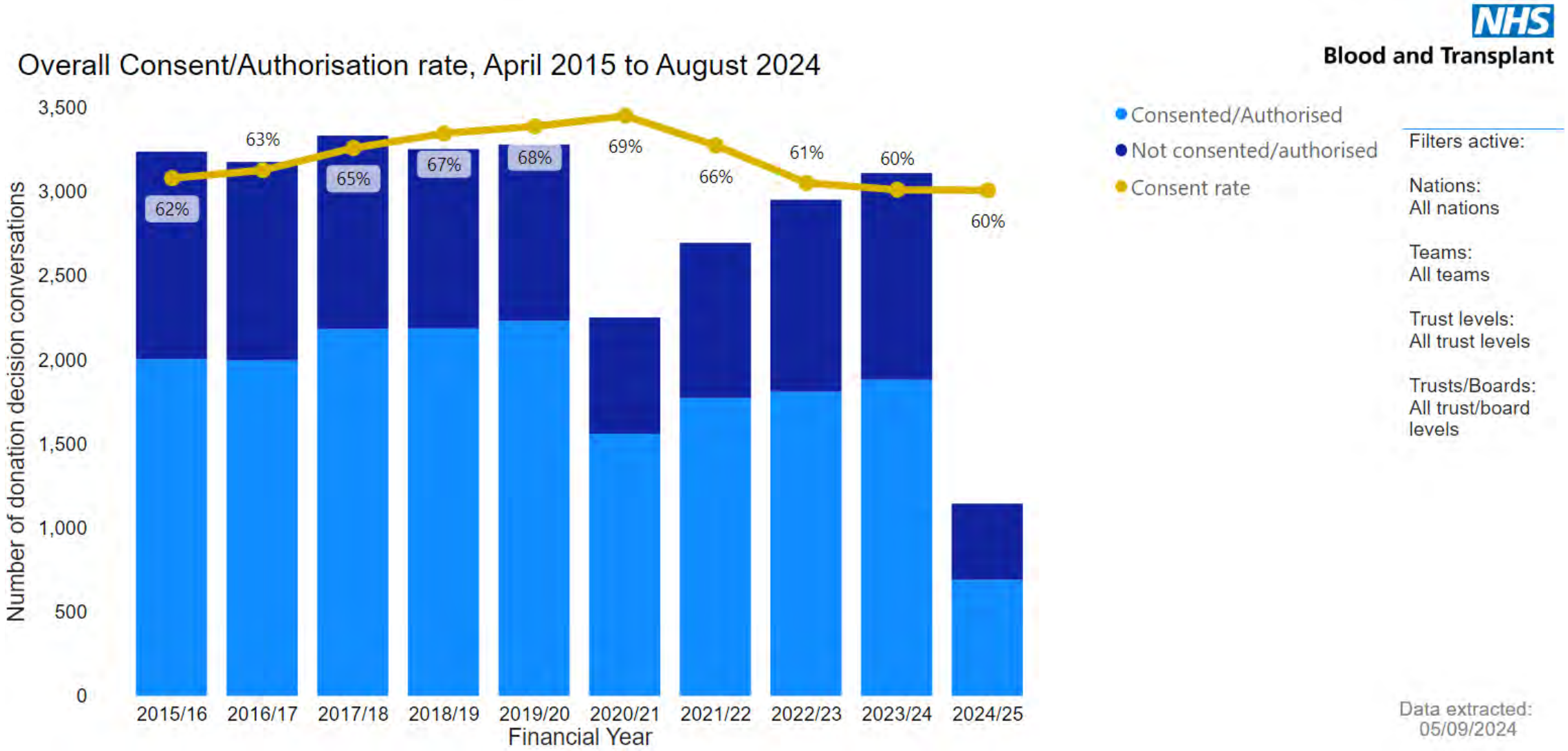
Trusts/Boards:
Cwm Taf Morgannwg Health Board

Data extracted:
05/09/2024

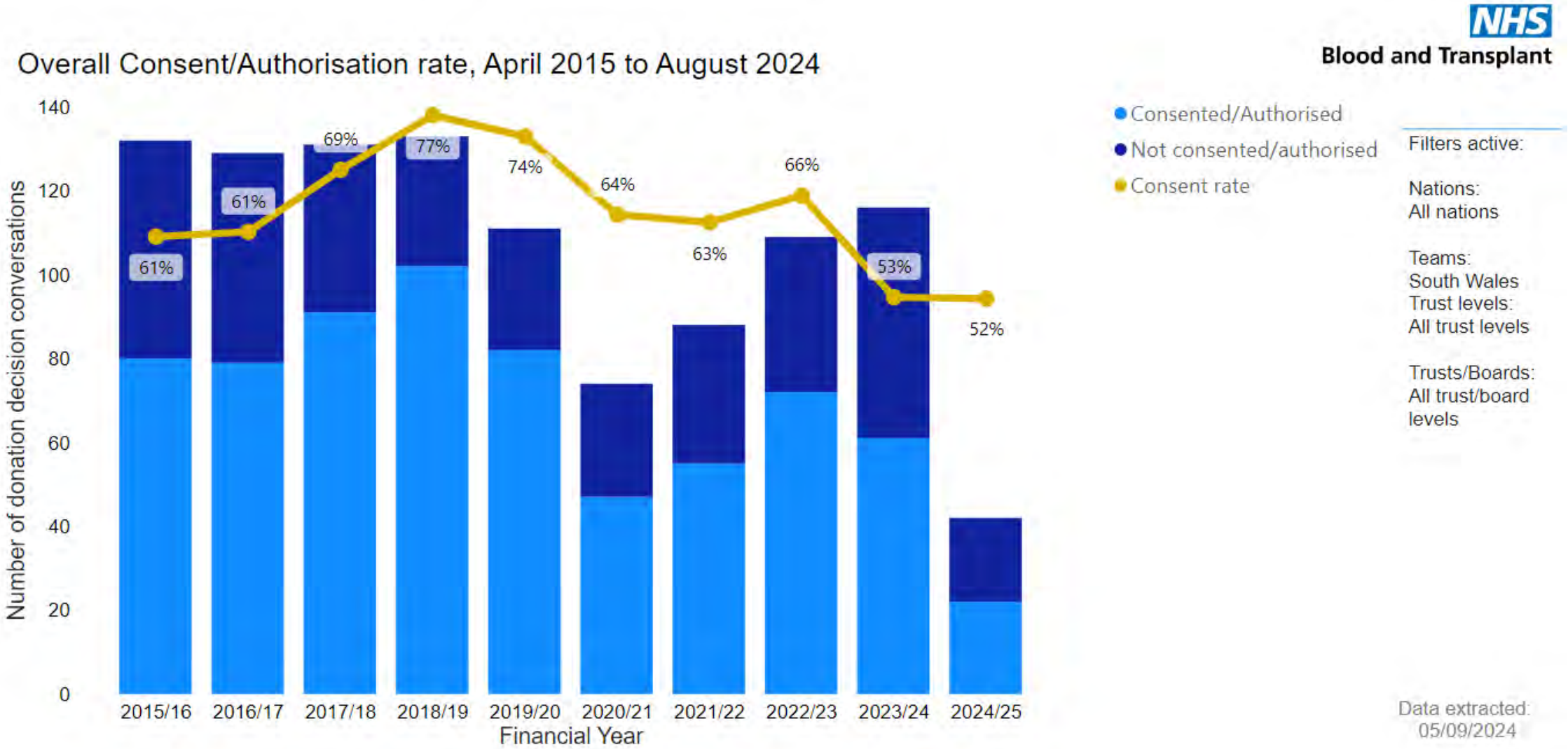
CTM proceeding donors 2023-2024



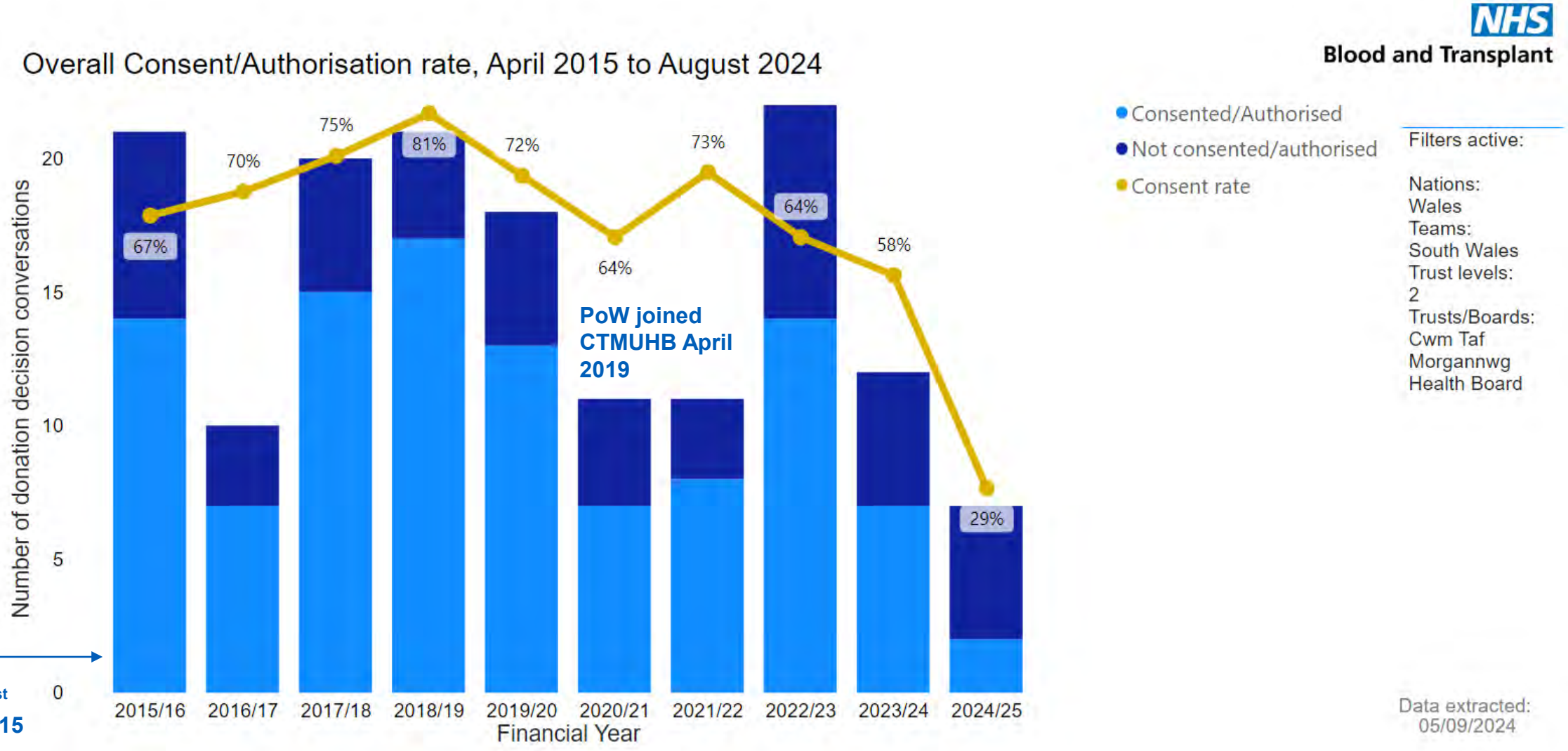
UK: Consent Rates 2015-2024



South Wales: Consent Rates 2015-2024



CTM: Consent Rates 2015-2024



Welsh OD Legislation introduced 1st December 2015

Decline in Consent Rates – Reasons?

Cancer Diagnoses

Post-COVID Donor Pool

Pre-hospital care

Cardiac Arrest and Trauma Centres

ICU has better outcomes

Decline in Consent Rates – Family Reasons

Time - Length of donation process

Suffered enough

Cultural beliefs

Never had the opportunity to discuss with their loved ones

Delay in admission, length of stay

YouGov | UK

Public Data For Business Sign in Sign up

How good or bad are national NHS services

Good Bad Don't know

All adults

Age

Gender

Politics

Region

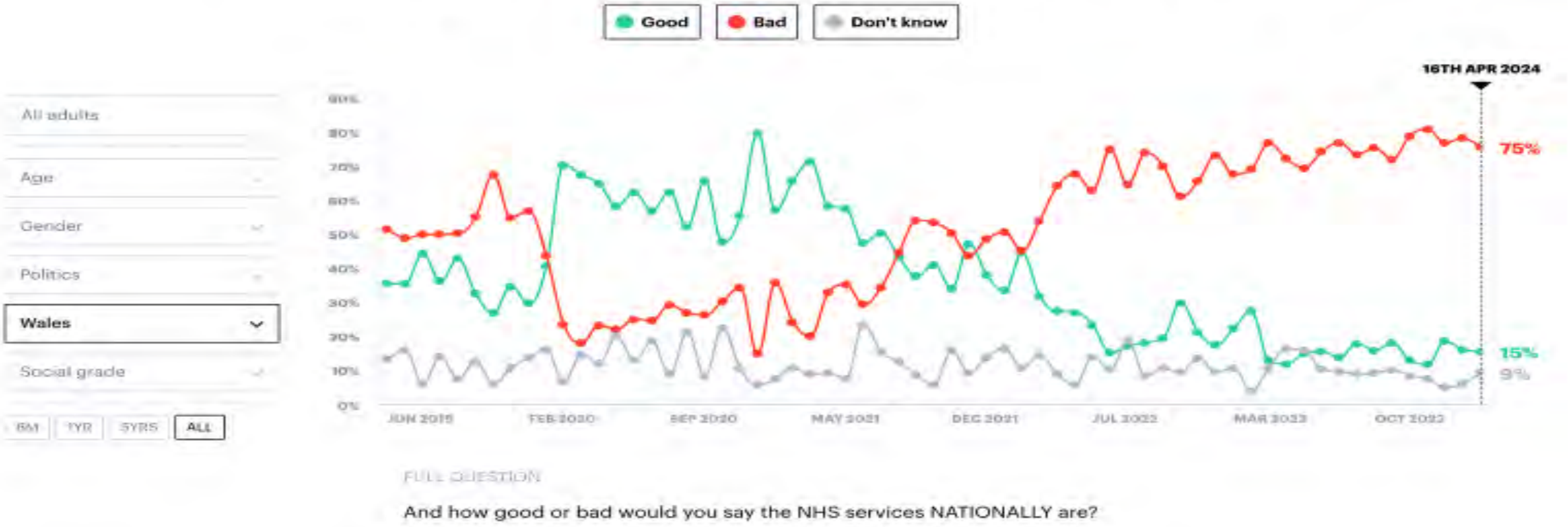
Social grade

6M 1YR 5YRS ALL

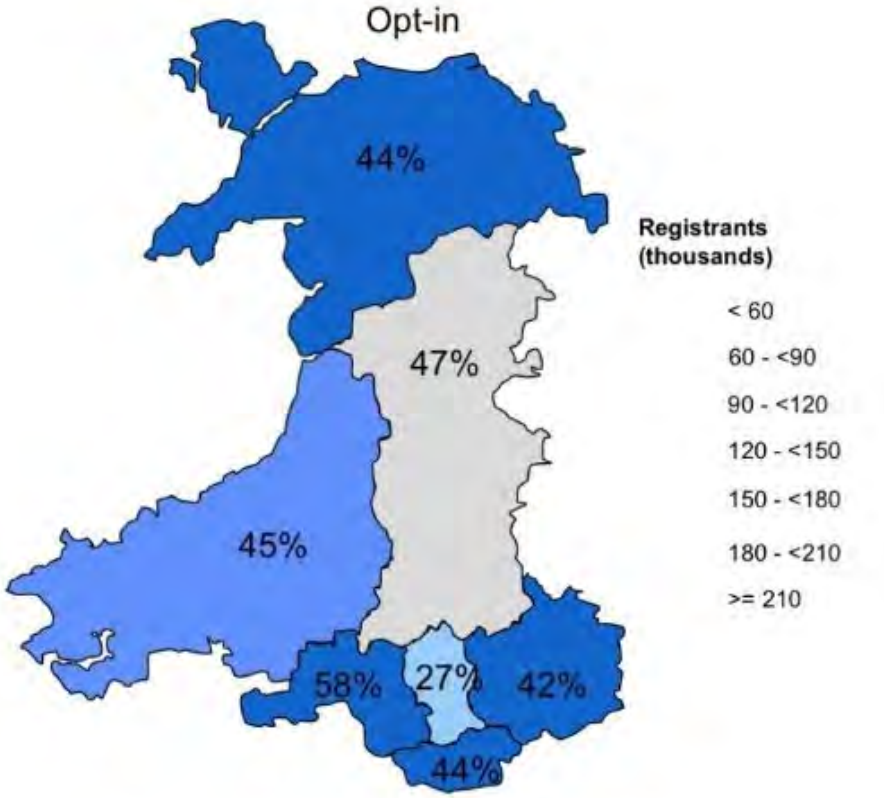
FULL QUESTION

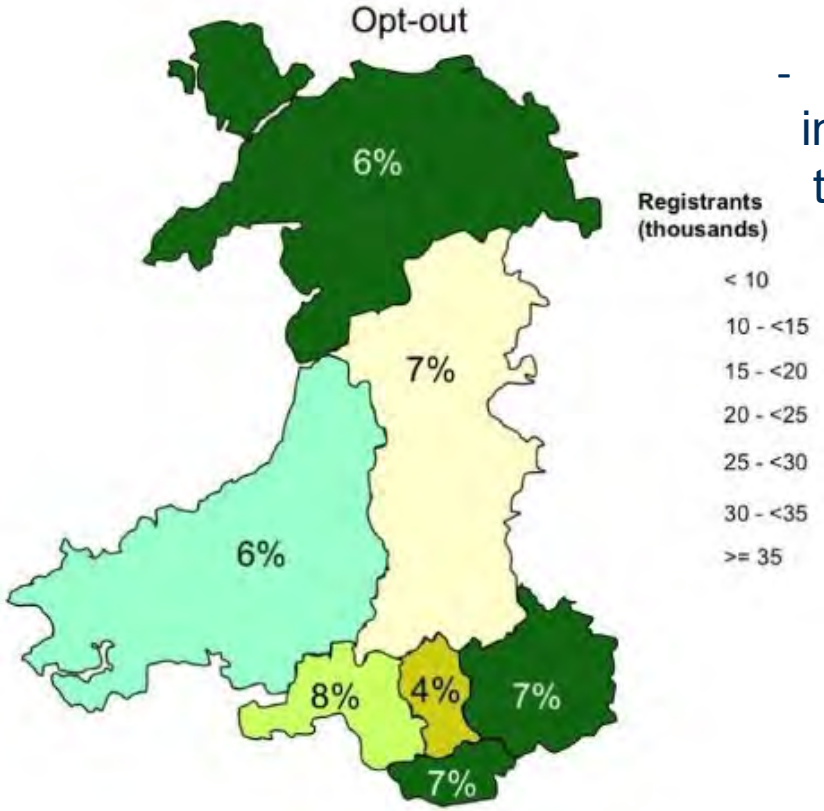
And how good or bad would you say the NHS services NATIONALLY are?

How good or bad are national NHS services



Organ Donation Decisions





- **Urban living**: More likely to live independent of family, more likely to have financial assets/wills and therefore more likely to register formal decisions

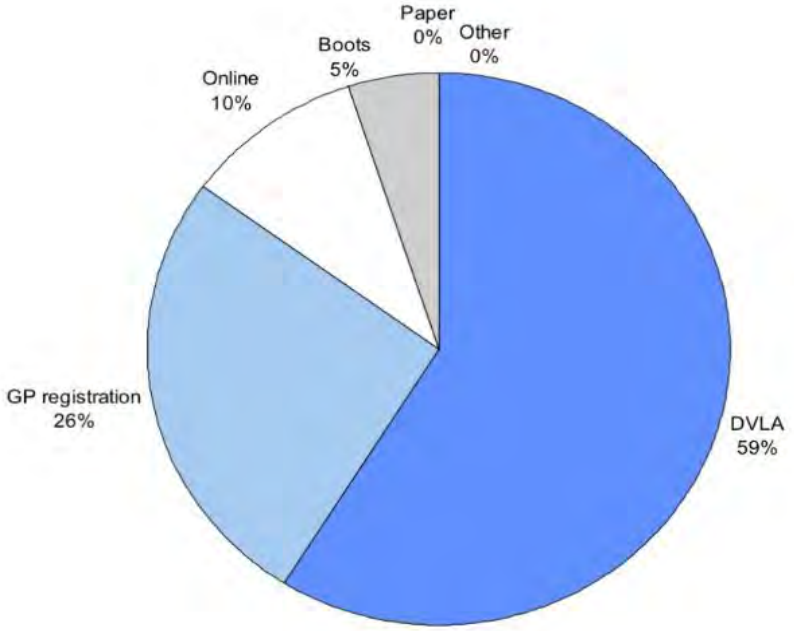
- **CTMUHB**: Close knit communities, living near family/friends, verbal discussion of end-of-life care decisions with no formal registrations, impression that 'everyone is on the register'

Donation and Transplantation Plan for Wales: 2022-2026

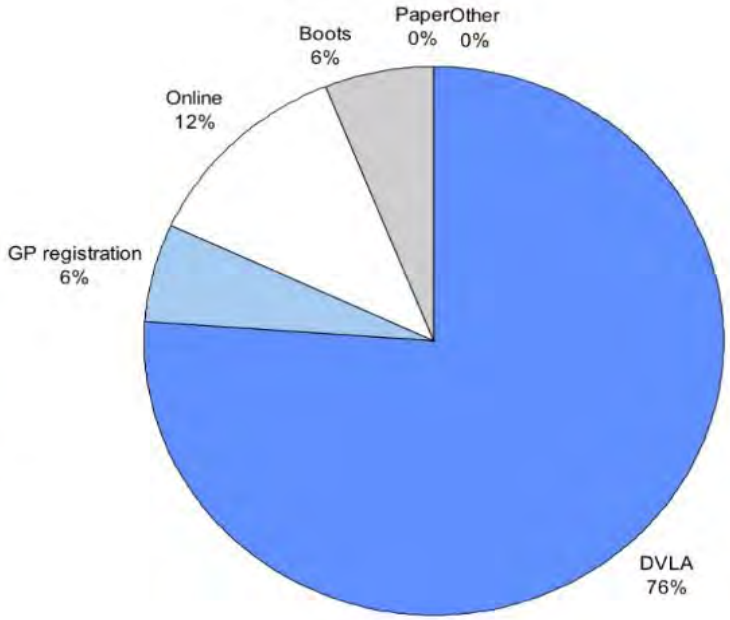
'Ensure the whole population of Wales can donate tissues or organs and receive a transplant whenever this is clinically possible' (WTAG, 2022)

Source of applications to opt-in

2020/2021



2021/2022



2024 – National effort to increase registrations: Passport applicants to be asked to sign up to NHS Organ Donor Register

Organ Donation Committee Priority 2024/2025

Local effort to Improve Registration Rates within CTMUHB

Community Engagement & Public Awareness

Eisteddfod

Organ Donation Week

Turn Pen-y-Fan Pink – 27th September 2024 (Regional News Coverage)

Order of St Johns/Donor Memorial Events

Collaboration with Local Volunteering Groups who focus on community Health and Wellbeing (BRAVO, VAMT)

Presenting at Health & Wellbeing Forums, Churches, Coffee Mornings

OPD Art Work Proposal – Donor Recognition

Collaborate with CTM Comms: Improve awareness of OD for both staff and service users

Share Recipient story/blog: RL of Aberdare received x2 life saving heart transplants

Share SNOD/CLOD/Donor Volunteer Profiles to raise awareness of staff role within CTM

Measuring Success 2024/2025

QR Code for registrations, to be promoted at all Community Events and via HB Comms

- QR Code first rolled out during Eisteddfod (August 2024)
- NHSBT Stats Team can monitor registrations made via QR code
- Request end of financial year registration rates and demographics
- Target: 500 Registrations within CTMUHB

Registration rates in Bridgend, Rhondda, Aberdare & Merthyr as of 31st July 2024

- Opt-in: 95242
- Opt-out: 11660 **~60% of population → NO decision**

Future plans?

- NHS Wales App
- Blanket advertising – TV, newspapers, billboards, buses.
- Targeted advertising – Social Media, streaming services, podcasts
- Opportunistic – UK Census, Electoral Register, probate solicitors, insurance
- GP Contract – QOF Points for registrations

- Change in approach for no registered decision??

Health Board Support

- Support for NHSBT Activity
- Membership of ODC
- ED Input
- Tissue Donation
- Communications/media
- Memorials

#TeamNHSBT

Recommendation:	**The Board or Committee are asked to:**
	The Committee are asked to: • *Note the work by the Organ Donation team in Cwm Taf Morgannwg UHB* • *Continue to support the work of the Organ Donation Committee and NHSBT Activities* • *Identify opportunities for collaborative working between CTMUHB and NHSBT in increasing the number of registrations on the Organ Donor Register*

Agenda Item
5.1

CTM Health Board

CHAIR'S REPORT

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jonathan Morgan, Chair
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Jonathan Morgan, Chair

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CEO	Chief Executive Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
MS	Members of the Senedd

MP	Member of Parliament
Q&A	Question and Answer
EMRTS	Emergency Medical Retrieval Service

1. Background

1.1 This report provides 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.

1.2 This overarching report also 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

2.1 Chair Update

Since our last Board meeting we have a new Welsh Government, with Eluned Morgan MS as our First Minister and Jeremy Miles MS as our Cabinet Secretary for Health and Social Care. I wish them both well in their new roles and I am looking forward to working with them in developing our services and improving what we do for communities across CTM.

A couple of weeks ago the UK Government published the Darzi Report into the English NHS. The report, researched and written by Lord Darzi has shone a spotlight on those key areas of activity that would make a substantial difference to patients, and to the efficient operation of our healthcare system. What he identified is relevant to Wales too and we should consider the findings as key evidence for what needs to be addressed specifically in relation to digital technologies and shifting services towards community based care and prevention.

Over the past few months I am delighted that our Health Board has taken a number of key steps in reimagining our service offer, where we are focusing more on shifting services and support closer to where people live.

The decision to invest in the recruitment of a new army of Healthcare Support Workers to help people out of hospital and back home is a significant move towards to both reducing the number of people who have been stuck in hospital and increasing the capacity of our community based staff to deliver reablement to those needing to get back on their feet. This decision will helps us support more than 100 people to leave hospital more quickly, giving them a better chance of recovery.

We have also started work on our ambition in delivering a more sustainable but exciting offer in primary and community based care. Too many people receive services in hospital for longer term conditions when providing that support locally would be better for them. Once we have concluded our work internally I am looking forward to us engaging partners in local government and the third sector to align what they do with this ambition.

2.2 Independent Member Vacancies/Updates

Lynda Thomas, Independent Member Corporate Business resigned from the Board in August 2024. Lynda has been a valued member of the Board and I would like to place on record my thanks for her contributions and commitment to the work of the Board. I wish Lynda all the very best for the future! A recruitment exercise will now be undertaken to recruit into this vacant role.

I am delighted to advise the Board that Hayley Proctor has been appointed as the Board's new Independent Board Member for Trade Union by the Cabinet Secretary for Health and Social Services. Hayley's role will commence on the 1st October 2024. I would like to congratulate Hayley on her appointment and I am delighted to welcome her to the Board.

2.3 Board Development Session – 11 September 2024

The Board Development session covered the following:

- Board Skills Matrix & Board Diversity Profile – The Board analysed the data captured from the completion of the Board Skills Matrix and Board Diversity Audit to inform the role specification for the current Independent Member vacancy.
- Board Self Assessment Reflections and Learning – Board Members reflected on the improvement activity identified in the Annual Board Self-Assessment and the action that had been taken in response
- Board Development Programme –The Board discussed the Board Development programme for the remaining sessions in 2024 and the plan for 2025. This included defining the role of the Board Development Sessions.
- Effective Management of Board Business Review – The Board were assured on the changes to the new Board Committee Structure and ways of working to support the Effective Management of Board Business and endorsed it for Board approval.

2.4 Diary Commitments

- Local Authority Leaders/Chair/CEO Meeting
- Independent Members/Chair/CEO Meeting
- 1:1 Chief Executive
- 1:1 Director of Governance
- 1:1 Vice Chair

- Chair Peer Group Meeting
- Leadership Group
- CTMUHB Public Board Meeting and In Committee Board Meeting
- CTMUHB Board Development Session
- Staff Q&A
- Regional Partnerships Board
- RCN Shortlisting for Nurse of the Year Awards
- Planning, Partnership & Finance Committee
- Meeting with GMC Wales
- Meet with Huw Irranca-Davies MP
- Welsh Government Partnership Event
- Local Partnership Forum
- NHS Chairs Assurance Meeting
- Social Prescribing Policy & Implementation Group
- Meet with Dave Thomas, Director Wales Audit Office

Meetings / discussions with Local Politicians

- MS/MP monthly meetings with Chair/CEO

3. Key Risks / Matters for Escalation

3.1 COMMON SEAL

The Board is asked to ratify the use of the Common Seal applied since the Board last met;

- Contract between Cwm Taf Morgannwg UHB and Silverstone Green Energy – Units 5&6 Rushacre Enterprise Park, Redstone Road, Narberth SA67 7ET.

This requires endorsement by the Board as set out in the recommendations of this report.

3.2 Chairs Urgent Action –UK Covid-19 Inquiry – Core Participant (CP) Status Application for Module 8 (Children & Young People) and Module 9 (Economic Response)

The Board were asked to approve an urgent Chair's action for the following:

- Approve the decision that CTMUHB will NOT apply for Individual Core Participant Status for Modules 8 and 9.
- Approve that should there be an appetite in NHS Wales for Group Core Participant Status for Modules 8 and 9 then the Health Board would join this collective, subject to robust governance and legal oversight.
- Approve that if a Group application for Core Participant Status is progressed that the Health Board will inform its legal team and agree to this information being shared internally with NHS Wales Shared Services Partnership Legal and Risk Team to facilitate such arrangements to support a joint application.

- NOTE that the default position if no application is put forward or subsequently approved by the Chair of the Inquiry than the Health Board will move forward with no Core Participant Status.
- NOTE that the Health Board will retain its own Legal Advisors which includes Senior and Junior Counsel (from Crown Office Row) and designated Legal Advisors from NWSSP Legal & Risk Services.

3.3 Chairs Urgent Action – Joint Commissioning Committee (EMRTS) Judicial Review (Agreement to commence litigation)

The purpose of this Chairs Urgent Action was to approve that CTM along with the other six Health Boards engages in the litigation process and responds to the claim in relation to a Judicial Review application regarding EMRTS. The reason this action was requested for this approval is that in accordance with the CTMUHB Standing Orders, more specifically its "Reservation and Delegation of Powers" it states under line 37 that any decision/proposal to commence litigation is a decision reserved for the Board.

The Board APPROVED the Health Board responding to the Judicial Review Claim via the Court and therefore commence litigation on this matter.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	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.
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Effective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: 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.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 Members of the Board are asked to NOTE the report, ENDORSE the Affixing of the Common Seal and APPROVE the Chairs Urgent Actions.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 5.1.1

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)
6.4.1	30 November 2023	Regional Partnership Board & Public Services Board 6 Monthly Report Consideration to be given to holding a focussed Board Development session on the Six Goals Programme and Further Faster agenda to provide Board Members with a greater understanding of the work being undertaken.	Director of Strategy & Transformation	23 September 2024	In progress To be considered as an option for a future Board Development session. Focussed discussion taking place at the Executive Leadership Group on the 23 September 2024 regarding the programme of Board Development Sessions for the remaining dates in 2024 and beyond.
7.2	30 November 2023	Llantrisant Health Park Project Further update on progress to be presented to the Board in Summer 2024	Chief Executive	July 2024 Now September 2024	In progress – On agenda This item is on the agenda for discussion at the meeting taking place on 26 September 2024
5.1	25 January 2024	Integrated Performance Dashboard Update to be included in a future report on total demand for Speech and Language Therapy Services and how this compared to other regions	Executive Director of Therapies & Health Sciences	28 March 2024 Now 26 September 2024	Proposed for Closure Attempts have been made to progress by both teams but this has not been possible. The Executive Director of Therapies and Allied Health Professionals has therefore suggested the action is closed. A document containing information on

					increasing referrals within Speech & Language Therapy has been uploaded to the documents folder on Admincontrol for Board Members information.
7.1	28 March 2024	Integrated Medium Term Plan and Budget for 2024/2025 G Watts to include the request to consider years two and three finances within a Board Development Session within the next six months to consider the support required for Primary Care, prevention and early intervention.	Director of Corporate Governance/Board Secretary	30 May 2024 Now 23 September 2024	In progress Topics have been added to the list for further consideration and scheduling. Discussion taking place at the Executive Leadership Group on the 23 September 2024 regarding future topics for discussion at Board Development Sessions
3.1	30 May 2024	Listening & Learning Story Review of the story to be undertaken, alongside other Local Authority Directors, outside the meeting to determine the reasons as to why the placements had broken down and whether there were any steps that could have been taken at different stages to prevent the breakdowns.	Director of Social Services	25 July 2024	Proposed for Closure Discussion held with the Care Group Nurse Director for Mental Health & Learning Disabilities where it has been agreed that the Regional Partnerships Board Care Home Group would review the position, with an aim to establish a system of multi-agency learning from placement breakdowns
3.1	30 May 2024	Listening & Learning Story Report to be presented to a future meeting outlining the key actions	Care Group Nurse Director, Mental Health & Learning Disabilities	28 November 2024	In progress Report to be presented to the November 2024 Board meeting. As a result of capacity

		required that needed to be taken forward		Now 30 January 2025	constraints within the Team, this item will now be presented to the Board meeting taking place on 30 January 2025
4.2	30 May 2024	Chief Executives Report Consideration to be given to inviting some of the Seren Award winners to meet with the Board at a future meeting.	Chief Executive	24 October 2024	In progress It has been suggested that Seren Award winners are invited to meeting with the Board at the October 2024 Board Development Session Discussion taking place at the Executive Leadership Group on the 23 September 2024 regarding the programme for upcoming Board Development dates.
5.3	30 May 2024	Board Assurance Framework (BAF) Consideration to be given outside the meeting regarding the suggestion made to introduce a risk relating to shifting services into the community as it was felt this needed to be more related to the failure to deliver on our strategic goals.	Executive Director of Strategy & Transformation	26 September 2024	Proposed for Closure This risk relates to strategic planning, past, present and future. In terms of the BAF ACSP delivery has been captured within Strategic Risk 9. In terms of the past and present: This is a long term set of operational activities spanning several years. In 23/24 a large proportion of Ophthalmology services were transferred to

					community settings (Glaucoma care). The ECC4 plan will see transfer of £1-2m worth of activity from hospital to the community this year. In terms of the future: A risk log has been created for the ACSP. This includes the risk of failure to deliver which has been assessed at a risk score of 20 and will be escalated to Board Committees as appropriate in accordance with the risk management framework process.
6.1	30 May 2024	Integrated Performance Dashboard Report from the multi-agency event held at the Princess of Wales Hospital on 10 April 2024 to be shared at either the Quality & Safety Committee or Planning, Performance & Finance Committee so that learning could be shared	Chief Operating Officer	26 September 2024 Now 29 October 2024	In progress Report to be shared at the Planning, Performance & Finance Committee meeting taking place on 29 October 2024.
6.3	30 May 2024	Getting it Right First Time Productivity Trajectories to be included in future iterations of the	Chief Operating Officer/Executive Director of Strategy & Transformation	26 September 2024	Proposed for Closure Trajectories have been included in the report within the quadruple aim and any relevant

		Performance Dashboard report to enable progress to be tracked			charts contained within the performance quadrant.
3.1	25 July 2024	Primary Care Update – Taff Vale Practice - Proposed Branch Closures Primary Care and Community Care Group to provide future updates to the Planning, Performance & Finance Committee for assurance and oversight of the implementation of the mitigating actions that will be taken in response to the closure of the two branch sites.	Chief Operating Officer	27 August 2024	Proposed for Closure Verbal update presented to the August 2024 Planning, Performance & Finance Committee and a written report will be presented to the October meeting of the Planning, Performance & Finance Committee.
5.1	25 July 2024	Listening and Learning Story To collectively as a Board take forward the learning from Joanne's shared experience.	Board Members	26 September 2024	In progress – will be ongoing action and commitment by Board Members.
6.2	25 July 2024	Chief Executives Report Add Executive Priorities to Board Cycle of Business.	Corporate Governance Team	1 August 2024	Proposed for Closure This area have been added to the Board Cycle of Business.
7.1.2	25 July 2024	Quality & Safety Committee Highlight Report 16 May 2024 Share the listening and learning story relating to onboarding with all Board members.	Corporate Governance Team	1 August 2024	Proposed for Closure Video shared with Board Members by email on 29 July 2024.
7.3	25 July 2024	Board Assurance Framework Review the risk score of Strategic Risk 5 - Delivery of a digital and	Director of Digital	26 September 2024	In progress An initial review has taken place, however there are a

		information infrastructure to support organisational transformation.			series of national reviews that are due to complete and it will be prudent to review once recommendations have been published.
8.1	25 July 2024	Integrated Performance Dashboard Contact K Palmer outside the meeting to discuss the visibility at Board of the learning disability service.	Chief Operating Officer	28 November 2024	In progress Discussion held with K Palmer where it was agreed that the COO would review learning Disabilities to determine the information that should be shared at Board. An update will be provided at the November 2024 meeting.
8.1	25 July 2024	Integrated Performance Dashboard Bring a report back to a future Board meeting on Neurodevelopment Services activity.	Executive Director of Strategy & Transformation	23 September 2024	In progress It was suggested that this topic may be more suitable to be discussed as a Board Briefing/Board Development topic as discussions are spanning a number of Committee meetings. Discussion taking place at the Executive Leadership Group on the 23 September 2024 regarding future topics for discussion at Board Development Sessions.

8.1	25 July 2024	Integrated Performance Dashboard Identify a session in the Board Development programme for further exploration on the optimal design of health pathways from primary care to secondary care, with invites extended to the Service Director and Medical Director of the Primary Care and Community Care Group as well as Community Pharmacists.	Chief Operating Officer/Director of Corporate Governance	23 September 2024	In progress Discussion taking place at the Executive Leadership Group on the 23 September 2024 regarding future topics for discussion at Board Development Sessions
8.4	25 July 2024	Development of Plan to address Delayed Discharge Issues Extend invite to the August Committee to all Board Members noting that it will be considering the business case for the plan to address delayed discharge.	Corporate Governance Team	27 August 2024	Proposed for Closure Invite was extended to all Board Members to attend the August Planning, Performance & Finance Committee

Completed Actions					
3.1	28 March 2024	Listening & Learning Story Update to be presented to the May Board meeting which identifies the proactive changes that would be undertaken to alleviate some of the issues outlined within the presentation.	Chief Executive	30 May 2024 Now 25 July 2024	Completed Presentation received at the meeting held on 25 July 2024.

Agenda Item
5.2

CTM Health Board

CHIEF EXECUTIVE'S REPORT

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Butt, Chief of Staff
Cyflwynydd yr Adroddiad / Report Presenter	Paul Mears, Chief Executive
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Paul Mears, Chief Executive / Accountable Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ACSP	Acute Clinical Services Plan
CAMHS	Child and Adolescent Mental Health Services
DTOC	Delayed Transfer of Care
EM	Enhanced Monitoring
IMTP	Integrated Medium Term Plan
JCC	Joint Commissioning Committee
KPI	Key Performance Indicator
LTA	Long Term Agreement

SCP	Single Cancer Pathway
SEW	South East Wales
TI	Targeted Intervention

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

2.1 Escalation Status

On 5th August, the executive team joined Welsh Government colleagues for our quarterly escalation meeting to review progress against our Targeted Intervention (TI) and Enhanced Monitoring (EM) objectives. As a reminder, our escalation status is summarised in the table below:

Area	Current Status
Planning and Finance	Enhanced Monitoring
Performance – Associated with long wait times	Targeted Intervention

The sustained improvements in performance over the last 18 months was recognised by Welsh Government colleagues. This particularly applies to key elements of our escalation framework including Planned Care, Cancer and CAMHS. In particular, I am pleased to report that all 156 week waits have been removed by the end of August, as per our plan and commitment, and our CAMHS part 1a and 2 position has remained consistently above trajectory for 12 months, with our part 1b performance also remaining above trajectory since Q1 of this year.

The Single Cancer Pathway (SCP) will remain a key focus for CTM over the next year, with a plan to achieve 70% performance by the end of quarter 4. This also directly links to the revised set of Key Performance Indicators (KPIs) received as part of the accountability conditions, outlined further in section 2.2 of this report.

In addition, performance improvements across Urgent and Emergency Care will also remain a key priority, with a particular focus on 1 hour ambulance handovers and 12 hour waits in our emergency departments. To achieve and sustain the required performance improvements in this area, there is a key dependency on our continued drive and focus to reduce Delayed Transfers of Care (DToC) which will be delivered, in part, through the progression of the CTM 'Hospital at Home' service model, led by Gethin Hughes, Chief Operating Officer.

An updated escalation framework, summarising our key planned interventions and agreed de-escalation criteria has been issued during August. A copy of this framework is shared with Board members at appendix 1. In summary, the Targeted Intervention focus remains on achieving and sustaining the agreed performance trajectories across the following areas:

- Urgent and emergency care – A&E waits and ambulance handovers
- Planned care – Diagnostics, outpatients and referral to treatment
- Cancer – Single Cancer Pathway (SCP) 62 day compliance
- CAMHS – Part 1a and 1b assessment and interventions

For Enhanced Monitoring, as referenced in the updated escalation framework, we have also received a standardised planning maturity matrix, to be completed on a regular (6 monthly) basis. Linda Prosser will be the executive lead for developing the CTM matrix and a self-assessment against the matrix will be brought to the November Board meeting.

Monitoring and assurance of progress against our updated escalation framework continues via monthly oversight meetings between CTM leads and Welsh Government colleagues, as well as quarterly escalation meetings held at executive level.

2.2 2024/2025 Accountability Conditions

CTM have submitted a balanced Integrated Medium Term Plan (IMTP) for the period 2024-27, and this was approved by the Cabinet Secretary for Health and Social Care on 9th August. Our key accountability conditions to be monitored across this financial year are summarised below. These will be monitored and assured via executive reporting to the Board.

Our accountability conditions are:

- Continue to de-risk savings plans and ensure in year delivery;
- Progress regional solutions, working collaboratively with partners, with particular focus on endoscopy services;
- Continue to adopt the Value and Sustainability Board programmes, maximise opportunities for efficiency and productivity;
- Agree Long Term Agreements (LTAs) with other organisations, working collaboratively to avoid arbitration; and
- Review outcomes for hip fractures and plan to achieve improvement in care and pathways.

Whilst progress against the individual elements of the overall plan will continue to be scrutinised at Committee and Board level, an assessment of progress against the accountability conditions set out above will be brought as a quarterly update to the Board, included within the performance report. The first review will be presented at the November Board meeting.

2.3 Acute Clinical Services Plan

As part of our CTM 2030 strategy we are in the process of developing our Acute Clinical Services Plan (ACSP). This plan will consider the future model of services for our hospitals including our community hospitals and acute mental health facilities. It will change and improve the way we provide NHS services in Cwm Taf Morgannwg, making sure we use our resources, expertise and support to our staff to provide safe, effective care so that we can meet the needs of all those in our communities in the future.

It's important to note, that the ACSP is just one of three elements that will deliver CTM 2030, Our Health, Our Future. The other two elements are "Integrating Community Services" and "Building Healthier Communities", both of which are critical to improving the health and wellbeing of the population of CTM.

Since the last update, the main area of focus is providing/producing the information needed for a robust case for change. This includes working with the care groups to ensure the baselining process is correct, understanding our current workforce, finance and activity information, and preparing to procure support to ensure our stakeholder mapping processes are robust. This work is critical, as we need to ensure that our case for change clearly presents our current position, including our service pressures, and details why our current service model will not be sustainable over the long term.

2.4 Capital Works at Princess of Wales Hospital

I am pleased to report that the capital refurbishment works on the maternity and neonatal units at the Princess of Wales hospital have now commenced, and are due to conclude late November. A significant amount of work has been undertaken to decant both units and prepare for the works to commence on these vital improvement works. I would like to thank all affected staff who have been temporarily relocated, for their flexibility, engagement and continuous drive to deliver the safe, effective and high quality care for our families.

All mothers affected by this temporary closure have been contacted directly and alternative plans for each of them have been agreed based on their choices and individual circumstance. I will update the Board during our November meeting to advise of the final timescales for the reopening of the units.

2.5 Joint Commissioning Committee (JCC) Update

The Interim Chief Commissioner at the JCC, Abi Harris, has recently accepted a new position as the Chief Executive of Swansea Bay University Health Board. Abi is due to take up her post in the coming weeks and we wish her well in the new role.

This movement leaves a vacancy within the JCC, and as the host organisation, we will be leading a full recruitment exercise to recruit a permanent Chief Commissioner in the next few months. I will keep the Board apprised of developments in this area.

Included in the pack of Board papers, today is further information on the JCC Governance Framework. The suite of documents, which includes the Hosting Agreement, were endorsed at the JCC meeting on 17 September.

Gareth Watts has been leading on this work for CTM and we are looking for Board approval for these governance framework documents today. A further review of the documents is scheduled for April 2025 which will include input from Gareth, his peer group of Directors of Corporate Governance, ourselves as the Host as well as the other six Health Boards and colleagues from the JCC Team, including the new Chief Commissioner.

2.6 Florence Nightingale Foundation Academy

I am pleased to share that CTM have officially joined the Florence Nightingale Foundation Academy. This is a fantastic opportunity for nurses and midwives at all career stages, from students to senior leaders, to grow and develop their leadership skills in a supportive and innovative environment. As an academy member, CTM nurses and midwives can enjoy exclusive access to webinars, online learning modules, and the opportunity to apply for travel and leadership development scholarships. The academy also offers a unique chance to influence and be part of a global network, through specialist focus network groups and access to mentorship opportunities which will support our staff to grow personally and professionally. This is a reflection of our commitment and investment to the nursing and midwifery profession giving our staff a sense of value and belonging and giving them the courage and confidence to influence policy and health care locally and beyond, positively impacting and supporting our recruitment and retention objectives. Six of our nursing staff begin a fellowship journey over the next 12 months.

2.7 Seren awards

Two more Seren of the Month Awards have been presented to colleagues since my last report.

June's winner was pharmacist Irram Irshad, who was recognised for championing the Welsh Language, despite neither Welsh nor English being her first language.

Irram started learning Welsh in 2010, eventually completing an A level qualification. Since then, despite her busy clinical role, she has supported the health board's stand at the Eisteddfod, recorded instructional videos on the importance of using Welsh in the workplace, has become a columnist

for an online Welsh Learner's magazine, and contributes regular short stories to a Welsh children's magazine. Irram will soon be launching two bilingual books as well as a children's novel.

In July, our Seren of the Month was paediatric staff nurse Kate Helyar.

Kate was nominated by a colleague after receiving glowing praise from the parents of a young, autistic boy who was admitted to one of our wards. The boy's mother said:
"I just wanted to express my heartfelt gratitude for the way you treated my son. Theo is autistic and non-speaking so a hospital ward is not an easy place for him to be, However, your understanding and compassion made it as easy as possible for him.

"Theo is non speaking, not 'non understanding' and you treated him and me with the utmost respect and care. It meant so much that you always asked my opinion when trying to work out the best way to treat him and the way that you explained things, not just to me but also to Theo, is so rare and so appreciated. I never felt out of the loop or confused as to what was happening, even though things moved quickly.
"I have shared my positive experience with many of my fellow SEN mums. I wanted them to know to that, if their child with additional learning needs should ever require your help, they will be in safe hands. The work you do with a smile on your face will always stay with me. Thank you so much."

3. Key Risks / Matters for Escalation

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Not Applicable

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Cwm Taf Morgannwg University Health Board is asked to NOTE this report.

Health, Social Care and Early Years Group
Welsh Government

Cwm Taf Morgannwg University Health Board

Escalation Framework

August 2024

Llywodraeth Cymru
Welsh Government

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Section A: Introduction

The health board is in escalation for two areas: enhanced monitoring for finance, strategy and planning and targeted intervention for performance and outcomes.

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health board will be assessed.

A NHS organisation can be escalated for any, or all, of the domains highlighted below:

In April 2024, maternity and neonatal services and quality and governance were de-escalated from enhanced monitoring (level 3) to routine arrangements (level 1).

Finance, strategy and planning
In November 2022, planning and finance were escalated to enhanced monitoring as the health board had been unable to produce an approvable balanced three-year plan.

In January 2024, finance, strategy and planning remained in enhanced monitoring due to the health board's inability to provide a balanced and approvable plan.

Performance and outcomes
In November 2022, quality related to performance and long waiting times were escalated to targeted intervention following concerns around urgent and emergency care, including ambulance handover, planned care including cancer and

performance against part 1a of the child and adolescent mental health services (CAMHS) measure.

In September 2023, performance and outcomes remained in targeted intervention following concerns around urgent and emergency care, including ambulance handover, planned care including cancer and performance against the child and adolescent mental health services (CAMHS) measures.

In January 2024, performance and outcomes remained in targeted intervention, some improvements were recognised but concerns remained with urgent and emergency care, including ambulance handover, planned care including cancer and performance against the child and adolescent mental health services (CAMHS) measures.

This document sets out the key areas to be addressed as part of the escalation and the expectations for improvement.

A1: Welsh Government approach to oversight and escalation

Information on the escalation and intervention approach can be found in the NHS oversight and escalation framework.

To optimise the capacity, efficiency and effectiveness across health care settings, prudent health care principles and value-based healthcare will be the basis on which services are planned and delivered. Value in health care is realised when the best possible health care outcomes is achieved for our population with the resources that we have.

Interventions will be:

- Collaborative – we will seek to minimise duplication by working collaboratively with other national committees, groups and programmes.
- Collective – we will maximise shared knowledge by sharing common approaches, tools, guidance.
- Impact focussed - we will examine and seek assurance and evidence how organisations are obtaining assurance over delivery and impact of actions.
- Be undertaken with openness; transparency; and mutual trust and respect between the health board, Welsh Government, and the NHS Executive.

Assessment and monitoring

Escalation will result in additional scrutiny being applied to the various performance areas and enhanced monitoring intervention will apply additional scrutiny to the areas of finance, strategy and planning.

Whilst in escalation:

- Normal performance management arrangements will continue through the Integrated Quality, Planning and Delivery Board (IQPD) and Joint Executive Team (JET) meetings.

- There will be quarterly escalation meetings chaired by the Director General of the Health and Social Services Group / Chief Executive NHS Wales.

Escalation Touchpoints

- Frequency of the finance and planning enhanced monitoring touchpoint meetings will be agreed with the NHS Executive - these will examine progress made against the action log, review evidence and agree outputs for inclusion at the Welsh Government led escalation meetings.
- A monthly oversight meeting, chaired by Welsh Government to oversee the targeted interventions and support performance recovery at Cwm Taf Morgannwg University Health Board. This brings together Welsh Government, NHS Executive and Cwm Taf Morgannwg University Health Board leads to co-ordinate and deliver the interventions as required within the targeted intervention improvement framework to support sustained service improvements.
- A quarterly escalation meeting chaired by the Director General of the Health and Social Services Group / Chief Executive NHS Wales

Roles and responsibilities

<u>Welsh Government</u>

1. Support a formal structure for reviewing and reporting progress.
2. Signpost relevant best practice guidance and frameworks.
3. Act as a critical friend and sounding board on existing practices and new developments.
4. Review and provide feedback on developed products.
5. Undertake and share relevant analysis and deep dives of national data.
6. Enable shared approaches to key national issues across Welsh organisations and promote shared learning.
7. Direct the NHS Executive to provide targeted support to areas of concern to help the health board to improve their progress against programme objectives.
8. Work with the health board on critical enablers relating to regional planning, clinical services redesign, infrastructure (digital and buildings).

<u>Cwm Taf Morgannwg University Health Board</u>

1. Appoint an SRO(s) for all areas of escalation.
2. Have Board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
3. To produce an enhanced monitoring/targeted interventions plan in response to the areas of concern and commit sufficient resources to ensure that the plan deliverables are achieved.
4. Provide monthly progress reports and evidence against the escalation plan to Welsh Government.
5. Give assurance that there are formal review mechanisms in place within the health board to monitor and deliver the required improvements.

Section B: Enhanced Monitoring

Enhanced monitoring (Level 3) occurs when Welsh Government has identified serious concerns related to the NHS organisation - this may include ongoing performance challenges, a growing financial deficit, inability to produce an integrated medium-term plan.

Monitoring will be more frequent than that carried out under routine arrangements and may also take a wider variety of forms, including regular interactions and meetings in addition to written progress updates and submission of evidence, including updated action plans and qualitative and quantitative data.

The NHS organisation will need to demonstrate that it is taking a proactive response to the escalation and will need to put in place effective processes to address the issue(s) and drive improvement itself. Welsh Government will co-ordinate activity to closely monitor, challenge and review progress.

The health board is in enhanced monitoring for finance, strategy and planning.

In November 2022, Cwm Taf Morgannwg University Health Board was escalated to enhanced monitoring for finance, strategy and planning as the health board was unable to produce an approvable balanced three-year plan in accordance with the direction given by Welsh Ministers and the NHS Planning Framework, which could be considered for approval under section 175(2A) of the NHS (Wales) Act 2006 (“the 2006 Act”). On 22 January 2024, the Minister for Health and Social Services confirmed the escalation status of Cwm Taf Morgannwg University Health Board would remain in enhanced monitoring for finance, strategy and planning.

B1: Finance, strategy and planning intervention

The finance, strategy and planning domain within the oversight and escalation framework gives consideration to the following:

- Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?
- Is the organisation able to deliver against plan and accountability conditions?
- Is there a significant underlying deficit and/or significant gap to the financial plan?

Finance Intervention

The finance intervention and focus whilst in enhanced monitoring covers the following areas and the health board will be required to action and demonstrate:

Financial governance and control environment

- Financial reports include the analysis and narrative explanation required to enable management and board to discharge their duties, for example through feedback or self-assessment approaches.
- Integrated performance reports clearly identify and monitor metrics against a comprehensive selection of key workforce and activity cost drivers.
- Internal Audit work programme continually encompasses and reports on control environment and financial governance arrangements.

Understanding the existing deficit and key drivers

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- It has reviewed prior year investments to assess whether the planned benefits have been delivered.
- Has a robust process for challenging underlying deficits reported at local divisional levels.
- The cost drivers and investment decisions responsible for the growth in specific areas are well understood; to include particular focus on secondary care drugs.
- As a result of the above there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

Development and realisation of opportunities

- Is translating national opportunities identified through the Value and Sustainability Board into local savings schemes.
- Has a clear process for the development and delivery of strategic opportunities to support the health boards sustainability.

Clear financial plan and strategy

- An integrated and triangulated plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.

Delivery of Plan

- Delivering clear improvement in the planned financial trajectory for 2024/25 (i.e. significant progress towards delivery of the Target Control Total as a minimum), including further progress around identification and delivery of recurring opportunities to support a balanced three-year plan.

Strategy and Planning Intervention

The strategy and planning intervention and focus whilst in enhanced monitoring covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Submission and delivery of an approvable plan

- Deliver a credible annual plan as a stepping stone towards a full and financially balanced IMTP.
- Make good progress in delivering the ministerial targets, accountability criteria and the enhanced monitoring requirements.

2. Clinical strategy

- Demonstrate how the clinical strategy and plan are driving decision making across the organisation.

De-escalation Criteria

Strategy and Planning

1. Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.
2. Evidence of a clear roadmap and implementation of the health board's Clinical Services Plan.
3. Welsh Government's confidence in delivery based on an assessment against an agreed planning maturity matrix.

Finance

1. Sustained improvement in minimising the underlying deficit, controlling identified key cost drivers and realising savings.
2. The development and approval of a deliverable and balanced three-year medium-term plan.
3. Delivery of financial balance.

Section C: Targeted Intervention

Targeted intervention (Level 4) is the second highest level of escalation within the NHS oversight and escalation framework. The Welsh Government will take and co-ordinate action and direct intervention to support Cwm Taf Morgannwg University Health Board to strengthen its capability and capacity in order to drive improvement. The interventions will normally be undertaken by the NHS Wales Executive directed by Welsh Government. If appropriate, external support will be agreed with the organisation.

It is applied when organisations have serious problems and where there are concerns that they cannot make the necessary improvements without external support. It consists of a set of interventions designed to remedy the problems within a reasonable timeframe. Support will always be designed and delivered within the relevant organisational context and specific support needs will be reviewed through regular oversight meetings and additional enhanced oversight arrangements.

C1. Performance and Outcomes

The performance and outcomes domain within the oversight and escalation framework gives consideration to the following:

- Is performance in line with agreed trajectories and national requirements?
- Are issues delivering against plan and accountability conditions identified and addressed appropriately in a timely manner?
- Are outcomes measured and monitored appropriately, with any changes identified, investigated, and actioned promptly?
- Are contracted services managed appropriately?

In line with the above, Cwm Taf Morgannwg University Health Board is in targeted intervention (level 4) for performance and outcomes across a number of areas, including:

- urgent and emergency care - A&E waiting times, and extended ambulance handovers.
- planned care - long waiting pathways, cancer performance, delayed outpatient follow-up, diagnostics (specifically endoscopy) and stroke services.
- CAMHS performance.

Performance and Outcomes Intervention

The performance and outcomes intervention and focus whilst in targeted intervention covers the following areas and the health board will be required to action and demonstrate as highlighted below:

1. <u>Establish baseline and agree improvement plans</u>

- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.

2. Implement improvement plans

- Improve unscheduled care performance to ensure that patients access safe, timely and clinically effective unscheduled care services, reducing waiting times, delays and improving quality.
- Improve access to planned care with reduced waiting times in line with national requirements.
- Improve the timeliness of access to cancer services and demonstrate improved compliance with the suspected cancer pathway, prioritising improvement in the most at risk tumour sites.
- Ensure that cancer backlog reduces to agreed levels and site-specific plans are in place for tumour sites of concern.
- Implement an outpatient's transformation plan that supports a move towards the requirements of the planned care programme.
- Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.
- Improve CAMHS performance consistently meeting the standards set out in the Mental Health Act and Mental Health (Wales) Measure, for adult and children's services.

3. Work with national programmes and respond to external reviews such as GIRFT

- Work with and implement the recommendations from national programmes including but not limited to Strategic Programme of Primary Care, Six Goals for Emergency Care, Planned Care Improvement and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of the GIRFT opportunities as highlighted through the programme reviews.
- Develop and implement an integrated approach to theatre scheduling and management, working with the GIRFT programme to develop and embed the agreed theatre reporting metrics on a bi-weekly basis.
- Develop agreed plans in response to the GIRFT speciality reviews and recommendations.
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

4. Communications and engagement

- Ensure there are plans in place for all long waiters with a clear communication strategy with appropriate support to keep them well.
- Implement the requirements of the three Ps policy.
- Ensure that patients are clear where they can and should access support, signposting away from emergency services.
- Ensure that the benefits of new pathways such as straight to test, primary care management, self-management and see on symptoms pathways are communicated effectively.

De-escalation criteria
De-escalation criteria are set out below and should be maintained for at least 3 months before de-escalation will be considered. De-escalation will be to the next level of the escalation framework. Performance data will be enhanced by a monthly progress report from the health board across a range of measures.

Planned Care and Cancer

- 60% performance maintained for 3 months against the SCP target.
- 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
- 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
- 80% of open pathways to be waiting less than 52 weeks and maintained for 3 months.
- 15% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months and maintained for 3 months
- 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.
- 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.
    - 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
    - 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
- 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.

The below metrics are enabling metrics to support the achievement of the above criteria, within planned care and cancer services only:

- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to planned care.
- Improving ratings from patient experience surveys and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

Urgent and Emergency Care

- A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months.
- Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.
- Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.
- A continuous reduction in delayed pathways of care of 5% for three consecutive months and then maintained for three months (based on November 2023 baseline).

The below metrics are enabling metrics to support the achievement of the above criteria, within urgent and emergency care services only:

- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback.
- Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.
- Improving ratings from patient experience surveys and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

CAMHS/Mental Health

- 80% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral.
- 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS.
- 80% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan.

The above metrics, and monthly reports will form the basis of an assessment by the Welsh Government and NHS Executive as to the confidence levels of the health board's ability to maintain and sustain improvements.

Section D: Document Rendition

Date Created	Updated	Review date
23 May 2024	Document created	
30 May 2024	Document finalised, with roles and responsibilities aligned to other health board frameworks	
21 August 2024	Framework revised to make clear which services quality metrics are measured against and separated enabling metrics from de-escalation criteria	

Agenda Item
6.1.1

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE PEOPLE & CULTURE COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dilys Jouvenat, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
EDI	Equality, Diversity and Inclusion
SUS	Speaking Up Safely
WG	Welsh Government

1. Situation /Background

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the People & Culture Committee which took place on the 7th August 2024.

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

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

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 to engage the talent, 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	• The Committee received the Workforce Metrics Report for the period May – June 2024, which included historic trends. • The Committee received the Culture Update Report, noting progress on the activities and achievements of each of the services involved in the combined approach to provide qualitative and quantitative information on the activity completed including feedback from staff and the planned activity for 2024-25. • A report was received on Restorative, Just and Learning and Speaking Up Safely Working Group Action Plan Updates, noting the work being undertaken by the task and finish groups and the SUS working group.

	• The Committee received a report on the Employee Relations (ER) Update, noting the ongoing ER cases and trends within the Health Board. • The Committee received a report on the Organisational Risk Register for those matters where risks had a score of 15 or more assigned to the Committee, noting actions taken to manage or mitigate those high-level risks.
ASSURE	• A detailed presentation and video was received by the Committee on the Lateral Moves – Member of Staff Story. The Committee congratulated the team on the excellent work and progress made to date with 25 members of staff having successfully moved to other posts within the Health Board. • A report was received on Strategic Workforce Planning, noting the significant amount of work to support the infrastructure of workforce planning and integration with key stakeholders.
INFORM	• The Minutes from the meeting held on 15th April 2024 were APPROVED. • The Committee's Annual Report for 2023-24 was APPROVED. • The Revised All Wales Respect & Resolution at Work Policy was APPROVED. • The Welsh Language Standards Annual Performance Report 2023-24 was ENDORSED FOR BOARD APPROVAL. • The Committee Annual Cycle of Business 2024-25 was noted. • The Action Log was noted. • The Committee's Forward Work Plan was noted.
APPENDICES	Not applicable.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Not Applicable
	If more than one applies please list below:

Link to CTMUHB Strategic Goal(s)	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required

	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 Members of the Board are asked to NOTE the report.

Agenda Item
6.1.2

CTM Health Board

Highlight Report from the Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Committee Chair/Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

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 23 July 2024.

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

2. Purpose of this Meeting

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

Alert / Escalate	• Committee Members received a Listening & Learning Story in relation to Boarding of Patients which they found to be powerful. Members noted the need to be cogniscent in the way in which issues had been raised in regard to whole system issues and advised that they were encouraged to hear that lessons had been learnt from this particular patient's experience in relation to the risk assessment process. The Committee advised that whilst they would support the work being undertaken on the whole system approach, they felt that this needed to include an exit strategy to stop boarding at the earliest possible time. • The Stroke Progress Report was received and discussed. Members noted the fragility of stroke services and were made aware that the Unscheduled Care Group were reviewing their budgetary position to establish if it would be possible to fund additional posts this year from within their existing budget. Members noted that in relation to regional working, the

	Health Board were working closely with Cardiff and Vale UHB on a Central South Wales solution for Stroke. Items of Positive Escalation • Positive escalation was made in relation to the Mental Health & Learning Disability Improvement Priorities and Healthcare Inspectorate Wales acceptance of the Ty Llidiard Action plan
Advise	• A Spotlight Presentation – Mental Health & Learning Disabilities Quality Improvement Priorities was received and noted. Committee Members welcomed the presentation and the work being undertaken by the team which was being recognised through the NHS Wales Awards for 2024. Members noted the significant backlog of estates issues, which was a strategic and operational issue; • The Report from the Clinical Executives was received. Members discussed the report in detail and noted that that significant focus had been placed on the estates backlog and noted that a review of the list was being undertaken to risk stratify the legal requirements in addition to the issues that were affecting Infection, Prevention and Control and Nosocomial transmission. Members noted that plans were in place to address areas where there was poor hand washing compliance, with some further focussed attention being placed in regard to expectations about bare below the elbow; • • The Children and Families Care Group Highlight Report was received. In relation to Special School Nursing provision, Members noted that whilst inequity was being seen in regard to the way in which nursing staff were being deployed within the schools, no concerns had been raised by parents; • The Unscheduled Care Group Highlight Report was received and discussed; • The Primary & Community Care Group Highlight Report was received. Members noted the challenges being faced by staff within prison services in regards to setting up of new services and the introduction of new ways of working and noted that staff were being supported by the Wellbeing Team and a Health Board Psychologist, with increased management support based on site; • The Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report was received. Members were provided with assurance that a significant amount of work

	was underway by the Primary Care and Communities Care Group to support prisoners, including steps to increase education and provide public health support in relation to raising awareness regarding drug potency; • The Organisational Risk Register – Risks assigned to the Quality & Safety Committee was received and discussed; • The Quality & Safety Committee Annual Self-Assessment was received and discussed; • The Duty of Quality Annual Report was received and endorsed for Board Approval; • The CTM Quality Strategy Work Plan Update was received. Members requested that some further thought was given as to how the significant challenges that were still being faced could be better reflected; • The Health, Safety & Fire Sub Committee Highlight Report was received and the matters contained within the alert/escalate section were discussed. Members approved the Sub Committee Annual Report; • The Quality Impact Assessment process was received and supported; • The Mental Health In-Patient Improvement Progress Report was received. Members recognised the issues regarding the single electronic patient record and noted that discussions were being progressed nationally in regard to different options.
Assure	• The Planned Care Highlight Report was received. Members welcomed the efforts that had been made within the Urology Service with a recognition that significant improvements had been made in relation to Urological Cancer performance, alongside the improvements in the quality of service that was being provided; • The Mortality Reviews and Mortality Indicators report was received. Members welcomed the progress that had been made in this area; • The Body Store Recommendations from Welsh Government report was received. Members welcomed the report and were pleased to note that appropriate actions were being taken;

	• The Evaluation of the Success of the Falls and Pressure Damage Programme report was received. Members felt assured that changes were being implemented in relation to this matter; • The Patient Safety, Quality and Experience Dashboard was received. Members commended the achievement the 75% target for responding to complaints within 30 working days.
Inform	The following items were approved via the Consent agenda: • Unconfirmed Minutes of the meeting held on 16 May 2024; • Unconfirmed In Committee Minutes of the meeting held on 16 May 2024. The following items were noted via the consent agenda: • Action Log; • Committee Annual Cycle of Business 2024; • Forward Work Programme; • Healthcare Inspectorate Wales Action Plan Tracker; • Recognition of Acute Deterioration and Resuscitation Committee (RADAR) Committee - Annual Report; • Clinical Audit Quarterly Update report; • Annual Unpaid Carer's Report 2023/24.
Appendices	No items identified.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality	Learning, Improvement & Research
	If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to NOTE the highlights outlined in section 3 of this report.

Agenda Item
6.1.3

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE MENTAL HEALTH ACT MONITORING COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Geraint Hopkins, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Julie Denley, Deputy Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
MHA	Mental Health Act
CTM	Cwm Taf Morgannwg
RGH	Royal Glamorgan Hospital
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 4 September 2024

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

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	• Members received a report on Mental Health Act Quarterly Activity Report / Breaches Analysis of Unlawful Detentions report and raised concerns about the lack of electronic recording system, however, noted a business case for a system will soon be presented to the Board.
ADVISE	• The Committee reviewed the MHA operational group report and found no immediate concerns for escalation. They will monitor future trends and take action if needed. • An update on the successful establishment of a safe space tribunal room at Prince Charles Hospital and securing a further two rooms was presented to the committee through the Risks relating to monitoring of the MHA. Members requested a review of the rooms at Prince Charles Hospital and Royal Glamorgan Hospital due to location and risk concerns in the Emergency Department. • The Committee received and noted the progress report on power of discharge subcommittee. • Members received the Strategic Update from South Wales Police (SWP). • The Committee received a verbal strategic update from local authority partners.

ASSURE	• Members received the Organisational Risk Register, it was highlighted there were no new risks, no risks were closed during the period and the scores for existing risks remained unchanged.
INFORM	Unconfirmed Minutes of the Meeting held on the 5 June 2024 The minutes were APPROVED as a true and accurate record Procedure for allocation of responsible clinicians and nominated deputy, Mental Health Act 1983 The Committee APPROVED the policy. Annual Cycle of Business 2024-2025 The Committee NOTED the Annual Cycle of Business Action Log The Action Log was NOTED.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality	Not Applicable If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 Members of the Board are asked to NOTE the report.

Agenda Item
6.3

CTM Health Board

BOARD ASSURANCE FRAMEWORK REPORT

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / 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	August / September	Reviewed and signed Off
Executive Leadership Group	9th September 2024	Risks reviewed and management sign off received.

Acronyms / Glossary of Terms	
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.

2. Specific Matters for Consideration

2.1 The BAF has been developed to ensure it appropriately reflects;

- the four 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 Care Groups 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 The Organisational Risk Register is 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

3.1 During August 2024, 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 In addition to updates significant changes have been made as follows:

- Strategic Risk 3 – Sufficient workforce to deliver the activity and quality ambitions of the organisation – this strategic risk has been reduced from a risk score of 20 to a 16. The rationale for this reduction is outlined on page 33 of the BAF Report at Appendix 1.

3.5 The People Team are undertaking a thorough review of the following risks to ensure they remain reflective of the current risks. This has been delayed and will be addressed by the Deputy Director of People in December 2024.

- *Strategic Risk 6 - Leadership and Management*
- *Strategic Risk 7 – Culture, Values and Behaviours*

3.6 The Executive Director of Finance is continuing to consider the development of a new Strategic Risk for the BAF in relation to *Capital and Estates* which is being developed and risk assessed by the Assistant Director of Planning (Capital and Estates).

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Dying Well, Growing Well, Living Well, Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Culture and Valuing People, Data to knowledge, Learning, Improving and Research, Whole- system Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Equitable, Person Centred, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail captured for each risk	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	See detail captured for each risk	

5. Recommendation

5.1 The Health Board is asked to:

APPROVE

- The updates to the BAF Report for September 2024 as captured in Appendix 1.
- The changes outlined in Section 3 of this report.

6. Next Steps

6.1 Routinely review the risks captured in the BAF to it 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.

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee	Current score	Scoring Trajectory *(since the last report received by the Board)*
1a	Sufficient capacity to meet elective demand Click Here for Risk1a	Improving Care	Chief Operating Officer	Quality and Safety; Planning, Performance and Finance	16 (C4xL4)	⟷
1b	Sufficient capacity to meet emergency demand Click Here for Risk1b	Improving Care	Chief Operating Officer	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	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality and Safety	16 (C4xL4)	⟷
3.	Sufficient workforce to deliver the activity and quality ambitions of the organisation Click Here for Risk 3	Sustaining our Future	Executive Director of People	People & Culture Committee	16 (C4xL4)	Risk score reduced from a 20 this period. ↓
4.	Community and Partner Engagement Click Here for Risk 4	Creating Health	Director of Communications, Engagement & Fundraising	Population Health & Partnerships	12 (C4xL3)	⟷
5.	Delivery of a digital and information infrastructure to support organisational transformation Click Here for Risk 5	Improving Care	Director of Digital	Digital & Data	16 (C4xL4)	⟷

6	Leadership and Management Click Here for Risk 6	Inspiring People	Executive Director for People	People and Culture	12 (C4xL3)	⟷
7	Culture, Values and Behaviours Click Here for Risk 7	Inspiring People	Executive Director for People	People and Culture	12 (C4xL3)	⟷
8	Fulfilling our Environmental and Social Duties and ambitions Click Here for Risk 8	Sustaining our Future	Executive Director of Strategy and Transformation	Population Health and Partnerships	16 (C4xL4)	⟷
9	Healthy Life Expectancy Click Here for Risk 9	Creating Health	Executive Director of Public Health	Population Health and Partnerships	20 (C5xL4)	⟷
10	Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government Click Here for Risk 10	Sustaining our Future	Executive Director of Finance	Planning, Performance & Finance Committee	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		3,4,8,7,8	4,6,7, *1a,2,5,9,10*	1a,2,3, 5,8,9,10 *1b*	1b
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

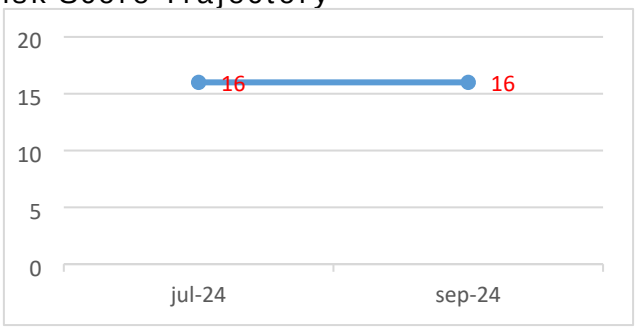
Strategic Goal: Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care			Risk score 16
Strategic Risk: Sufficient capacity to meet elective demand - (Risk No.1a)			
If the Health Board is unable to meet demands for services at all points in the patient journey.	*Then* its ability to provide high quality and affordable 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, ongoing overspends.	

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change in risk score September 2024.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities. The risk score has been reviewed and remains unchanged on this occasion, due to the following potential impacts. The financial and economic challenges faced by the third sector and local authority partners has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected.

	The large-scale capital programme at Prince Charles Hospital will temporarily reduce the number of operating theatres by 2. An ongoing work programme continues to review options to mitigate this. The current Fire enforcement notice at Princess of Wales hospital will reduce the number of operating theatres. Plans are ongoing for the temporary location of the theatres. Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however, ongoing risk treatment activity outlined in the mitigating actions section.

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
Productivity, improvement and transformation programme (PIT) • Increase Planned Care Capacity • Transform the way Planned Care is delivered • Prioritise both diagnosis and treatment	• Integrated Performance Report • Harm Reviews • Assessment Dashboard • Update reports on specific services experiencing pressure, e.g. Ophthalmology, Urology • Performance RTT, Cancer trajectories

• Provide better information and support to patients Progress has been made against these four commitments; however, patients are still waiting too long for both diagnosis and treatment, and there is now a national requirement to outline how the waiting times for elective treatment in Wales will further improve. In addition to setting up the National Six Goals programme for Urgent & Emergency Care, Welsh Government have now outlined the national direction for Planned Care, with health boards expected to deliver against key objectives aligned to national policy. This is an opportunity to radically transform the way services are both designed and delivered, ensuring the best possible outcomes can be achieved, maximising sustainable throughput, with an emphasis on improving productivity and efficiency within the envelope of existing resource. The key areas for improvement each Health board are expected to incorporate into their improvement programme are: 1. Effective Waiting List Management Systems: clear national pathways; focused treat in turn; effective booking processes; robust demand management 2. Outpatient & Preoperative Modernisation: utilisation of SOS and PIFU; additional advice & guidance services; virtual preoperative clinics 3. Theatre Capacity: reduction of fallow lists; efficient scheduling; increased utilisation; improved productivity 4. GiRFT & Clinical Implementation Networks: identifying opportunities for full implementation of high volume, low complexity; adopting procedure time best practice; maximising day case surgery	• Follow-up reports on outpatients not booked • PIT Programme reports • Planned Care Recovery Update report • Escalation processes leading to Chief Operating Officer Report to Quality & Safety Committee including Care Group performance review meetings. • Organisational Risk Register via Care Group Risk Registers. • Planning, Performance & Finance monthly report. • TI meetings • Audit Wales commencing a Planned Care Audit in August 2024. • Audit Wales commencing a Health Protection Audit in August 2024.

5. Diagnostics: regional and community diagnostic centres; straight to test pathways; diagnostic pathway best practice

All areas of the programme will focus on the following crosscutting themes:

1. Increased efficiency: streamlining processes to reduce waiting times, eliminate unnecessary delays, and ensure all services are delivered in a cost-effective manner.
2. Enhanced Quality of Care: ensuring our patients receive the right care at the right time, by sharing best practices, standardising procedures, and improving coordination between services.
3. Optimised resource utilisation: making better use of the available resource, including staff, equipment, and facilities, to ensure maximum productivity and minimal waste.
4. Improved Patient Outcomes: focusing on patient-centred care to improve outcomes, satisfaction, and overall experience, whilst ensuring our care is well-co-ordinated and effectively managed.
5. Reduction of Variability: minimising variations in clinical practices and outcomes by implementing evidence-based guidelines and protocols, delivering consistent and high-quality care.
6. Data utilisation: using our data and intelligence to pinpoint areas for improvement, regularly monitor key performance matrix and empowering data-driven decision-making to drive continuous improvement
7. Support Workforce Development: training our staff to develop the right skills and knowledge to help implement and sustain necessary changes and create the environment for effective cross-sector working.

All elective care services will hold a monthly Service Improvement Group.

Planned Care Recovery Programme

- Enhanced monitoring process for Cancer Services –weekly focussed meetings
- Llantrisant Health Park site plans under development
- Clinical Services Plan Group being established
- Speciality Specific and Cancer Improvement Trajectories Completed.

IMTP – investment agreed by Board.

Additional 'South Theatre' at the Royal Glamorgan Hospital
An old obstetric theatre has been recommissioned to support the SBUHB disaggregation and increase capacity and efficiency. This alongside the 'Snowdrop Centre' has transformed the delivery of Breast services across CTMUHB.

Specific Improvement Groups/Boards

- PIT programme
- Planned Care recovery
- ~~Pathology Improvement Group -~~ no longer exists. CTM are linked in with regional pathology work now.
- Service Improvement Groups
- Cross Cutting Improvement Groups – Theatre, Pre assessment, Diagnostics, Outpatients and therapies.

All updates feed into the Improving Care Board.

Annual Planning Process

Lessons learnt from Winter Planning process currently being analysed from a lessons learnt perspective.

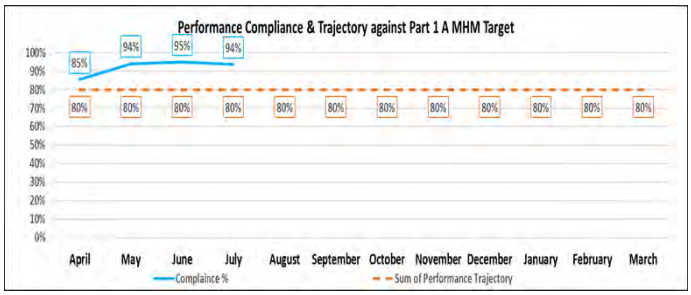
Partnership Leadership Team established with LA and NHS representation to look at planning across the region.

Commissioning Group established to oversee the delivery of the optimised integrated care model Annual Demand and Capacity Plan established to manage demand and making best use of capacity. Escalation Status programme work Regional Working • 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 all CTM local authorities to aid patient flow and 'Discharge to Recover then Assess' (D2RA) out of hospital stabilisation and onward decision-making. • Welsh Government supporting intervention with Bridgend County Borough Council regarding backlog of patients Medically Fit for Discharge. • Regional Pathology Steering Group • South East Regional Programmes of work – Collaborative approach to restoration with a number of targeted work streams. Governance Structures • Operational Services Management Board (Health Board wide) • Improving Care Board (Health Board wide) • Six Goals/Unscheduled Care Board • Cancer Board • Weekly Cancer Meetings • Planned Care Recovery Board/ Planned Care Recovery Operations Board. • Innovation Board Operational Processes • Clear criteria to prioritise based on clinical need	

• Centralised decision-making around use of spare capacity across the organisation. • Robust Interventions Not Normally Undertaken (INNU) application. • Weekly performance tracking. • Robust Demand and Capacity with mitigating actions. • Service improvement and transformation	
Gaps in Controls and Assurances	**Mitigating Actions**
• CTMUHB digitally-based enabling systems	• Manual processes in areas of no system. • Scope of digital Pre-assessment system • Digital dictation consolidation and standardisation • Theatre system update • Need for digital outpatient system • Consultant connect implementation • Attend anywhere use for virtual activity • WPRS full roll out
• Robustness of cancer tracking and specialty-specific elective data	• Weekly performance meeting • Implementation of online escalation process for all patients outside of agreed component waiting times. • Canisc replacement ongoing. Implementation of Breast, Urology & lower GI datasets • Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance
• – Improvements being made in elective care trajectories albeit not fully embedded.	• Contract awarded for endoscopy insourcing to increase endoscopy capacity. Commenced in November 2023 to September 2024 • Regional Ophthalmology service with increased activity across the region for CTMUHB patients. • Reconfiguration of elective surgery has seen an increase in activity. This will continue to be monitored and developed Completed, will move to control at the next iteration. • Reconfiguration of Trauma ongoing assessment • In sourced additional staff to open up additional theatre activity until theatre plan fully recruited to.

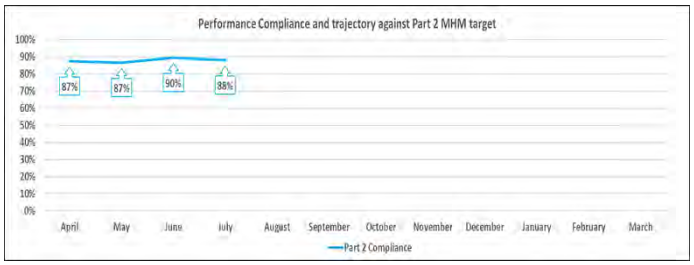
	• Effective initiation of business continuity plans to respond to increased capacity pressures and challenges in the service (ongoing). • In Development – Clinical Services Plan
Linked National Priority Measures	**Current Performance - Highlights**
Ministerial Measures: *Access to Timely Planned Care* • 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).	The following key performance indicators should be considered from the Integrated Performance Dashboard: • Theatre • Outpatient • cancer • and diagnostic indicators PIT Programme PID including trajectories included in Admincontrol for reference. Mental Health and Learning Disabilities

- Both CAMHS (94%) and Adult Services (93%) remain above the Welsh Government target of 80%
- Demand for both services currently remain stable for this financial year with an average of 137 referrals per month (CAMHS) and 813 referrals per month (Adult Services)



*All services (CAMHS & Adult)

- CAMHS on target at 90% (caseload 261)
- Adult below target at 86% (caseload 1459)
- Older Adult above target 92% (caseload 435)
- LD below target 86% (caseload 90)



*All services (CAMHS, Adult & LD)

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
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
5462	Adult weight management service - Insufficient capacity to meet demand. New escalation to the Organisational Risk Register in July 2023.	20
5417	Paediatric dentistry – General Anaesthetic theatre list. New risk escalated to the Organisational Risk Register in March 2024.	16
4152	Back log for Imaging in all modalities / areas and reduced capacity	16
5730	No Health Board MRI Pacemaker Service	20

	New risk added to the organisational risk register in July 2024.	
5821	Provision of secondary care immunology services by external provider (this is a service that is not provided by CTMUHB). New risk added to the organisational risk register in July 2024.	20

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Section 3 –Strategic Risks

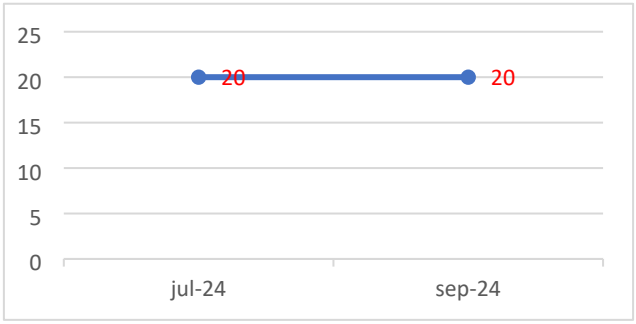
Strategic Goal: Improving Care • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care			Risk score 20
Strategic Risk: Sufficient capacity to meet emergency demand - (Risk No.1b)			
If the Health Board is unable to meet demands for services at all points in the patient journey.	*Then* its ability to provide high quality and affordable 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, ongoing overspends.	

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	5	20
Target	4	4	16
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

Risk score remains unchanged in September 2024.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	There has been some improvement against trajectories for emergency demand. Specifically in total reduction of lost ambulance hours. The risk score has been reviewed and remains unchanged, due to the following potential impacts. There remains a high number of clinically optimised patients in core capacity that is impacting on patient flow. The financial and economic challenges faced by the third sector and local authority partners

	has an impact on the Health Boards ability to mitigate this risk, as capacity cannot be protected. Workforce recruitment continues across the care group to enable a sustainable capacity model. There continues to be a reduction of ADH and WLI activity attributed to standardisation of pay. The conversion from locum to substantive and establishing COVID uncommissioned capacity remains a priority. Regional working continues and the positive and negative impact of this will be continuously reviewed. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however, ongoing risk treatment activity outlined in the mitigating actions section.

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
Six Goals for Urgent and Emergency Care Programme (signed off by ELG on 5 June 2023): • Admission Avoidance • Integrated Front Door • Acute Hospital Flow and Discharge • Integrated Discharge In addition to setting up the National Six Goals programme for Urgent & Emergency Care, Welsh Government have now outlined the national direction for urgent care with health boards expected to deliver against key objectives aligned to national policy. This is	• Integrated Performance Report • Assessment Dashboard • Update reports on specific services experiencing pressure, e.g., Neurology, Stroke • Performance RTT, Cancer trajectories • Follow-up reports on outpatients not booked • Stroke Programme Board • SDEC Programme • Optimise • Ambulance Handover and ED Improvement Plan • Escalation processes leading to Chief Operating Officer Report to Quality & •

an opportunity to radically transform the way services are both designed and delivered, ensuring the best possible outcomes can be achieved, maximising sustainable throughput, with an emphasis on improving productivity and efficiency within the envelope of existing resource. The key areas for improvement each Health board are expected to incorporate into their improvement programme are: 6. Effective waiting List Management Systems: clear national pathways; focused treat in turn; effective booking processes; robust demand management 7. Outpatients and Planned Services within USC: utilisation of SOS and PIFU; additional advice & guidance services 8. Diagnostics: regional and community diagnostic centres; straight to test pathways; diagnostic pathway best practice 9. GiRFT/SEDIT: Clinical Implementation Networks: Emergency Medicine All areas of the programme will focus on the following crosscutting themes: 8. Increased efficiency: streamlining processes to reduce waiting times, eliminate unnecessary delays. Ensuring patients receive the care in the lowest acuity setting for their needs. 9. Enhanced Quality of Care: ensuring our patients receive the right care at the right time, by sharing best practices, standardising procedures, and improving coordination between services. Reducing overcrowding within the UEC system to reduce harm and improve patients and staff experience. 10. Optimised resource utilisation: making better use of the available resource, including staff, equipment, and facilities, to ensure	• Safety Committee including Care Group performance review meetings. • Organisational Risk Register via Care Group Risk Registers. • Planning, Performance & Finance monthly report. • TI meetings • Audit Wales commencing an Urgent and Emergent Care Audit. • Reset fortnight commenced week commencing 19th August 2024 – sets out Care Group plans with an aim to resetting and de-escalating sites ahead of winter.

maximum productivity and minimal waste. Lowering the number of avoidable attended to ED by directing patients to more appropriate urgent and community settings.

11. Improved Patient Outcomes: focusing on patient-centred care to improve outcomes, satisfaction, and overall experience, whilst ensuring our care is well-co-ordinated and effectively managed.
12. Reduction of Variability: minimising variations in clinical practices and outcomes by implementing evidence-based guidelines and protocols, delivering consistent high-quality care and minimising harm.
13. Data utilisation: using our data and intelligence to pinpoint areas for improvement, regularly monitor key performance matrix and empowering data-driven decision-making to drive continuous improvement.
14. Support Workforce Development: training our staff to develop the right skills and knowledge to help implement and sustain necessary changes and create the environment for effective cross-sector working.

Programme

- 6 Goals Programme Board
- Stroke Programme Board
- MTC Programme Board
- Improving Care Board
- Speciality Specific and Cancer Improvement Trajectories Completed.

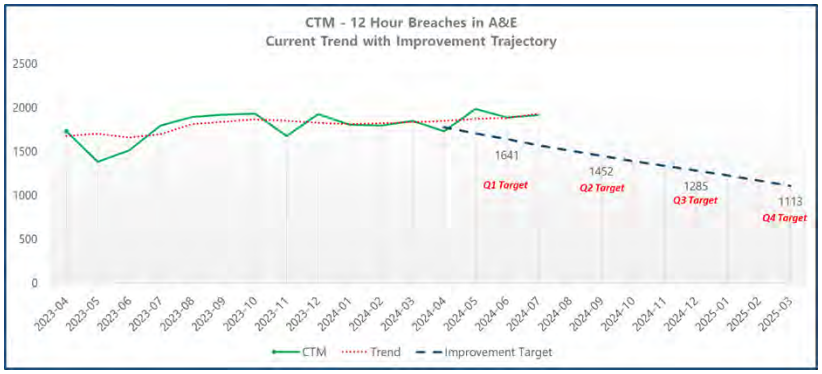
IMTP – investment agreed by Board.

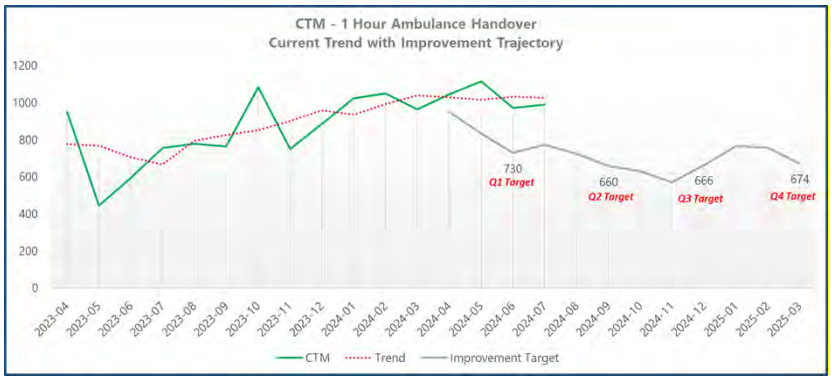
Specific Improvement Groups/Boards

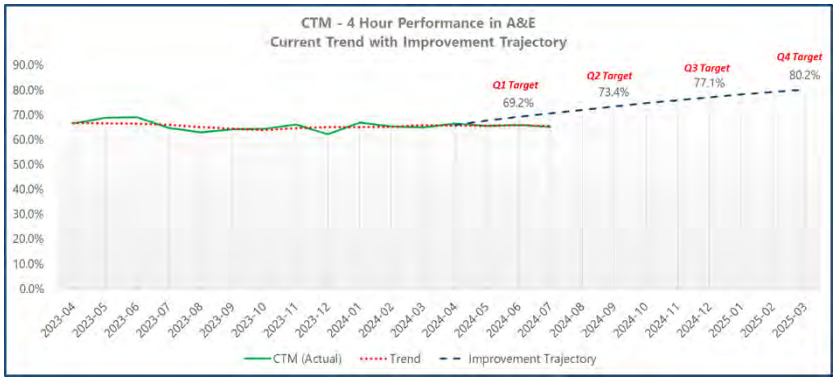
- Optimise Project Board
- SDEC Project Board
- UTC Project Board
- FLS Project Board
- Frailty Project Board
- Diabetes Project Board

All updates feed into the Improving Care Board. Annual Planning Process Lessons learnt from Winter Planning process currently being analysed from a lessons learnt perspective. Partnership Leadership Team established with LA and NHS representation to look at planning across the region. Commissioning Group established to oversee the delivery of the optimised integrated care model Annual Demand and Capacity Plan established to manage demand and making best use of capacity. Escalation Status programme work Regional Working • 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 all CTM local authorities to aid patient flow and 'Discharge to Recover then Assess' (D2RA) out of hospital stabilisation and onward decision-making. • Welsh Government supporting intervention with Bridgend County Borough Council regarding backlog of patients Medically Fit for Discharge. • South Central Regional Programmes of work – Collaborative approach to restoration with a number of targeted work streams e.g., Stroke Governance Structures • Operational Services Management Board (Health Board wide) • Improving Care Board (Health Board wide) • Six Goals/Unscheduled Care Board • Cancer Board	

• Weekly Cancer Meetings • Planned Care Recovery Board Operational Processes • Clear criteria to prioritise based on clinical need • Centralised decision-making around use of spare capacity across the organisation. • Robust Interventions Not Normally Undertaken (INNU) application. • Weekly performance tracking. • Robust Demand and Capacity with mitigating actions. • Service improvement and transformation.	
Gaps in Controls and Assurances	**Mitigating Actions**
• Improvements being made in urgent care trajectories albeit not fully embedded.	• Update escalation plan for 1 Hour handover for Ambulance • Update escalation plan for 12 Hour reduction • Reconfiguration of ED footprint • Re-alignment of ward capacity • Establish uncommissioned capacity with substantive workforce • Effective initiation of business continuity plans to respond to increased capacity pressures and challenges in the service (ongoing). • In Development – Clinical Services Plan. • Task Group established with Chief Executive Officer leadership to address clinically optimised patients in Pathway 1 – with a view to creating a model of care delivery for patients closer to home.
Linked National Priority Measures	**Current Performance - Highlights**
Ministerial Measures: Access to Timely USC Services • 12 Hour ED Performance requires a reduction of 20% by September 2024 and an additional 20% by March 2025 • 1 Hour Ambulance Handovers require a 30% reduction on March 2024 baseline • Improvement in 4-hour performance with a current baseline of 65%. To achieve an 80% target by March 2025, *Access to Timely Planned Care Services in USC* • As per Planned Care BAF	







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
4632	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	20
3826	Emergency Department (ED) Overcrowding	20
~~1133~~	~~Sustainability of the Emergency Department at the Royal Glamorgan Hospital~~ Risk score reduced so risk de-escalated from the Organisational Risk Register.	~~15~~

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IMPROVING CARE	**Strategic Goal: Improving Care** • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care	Risk score 16

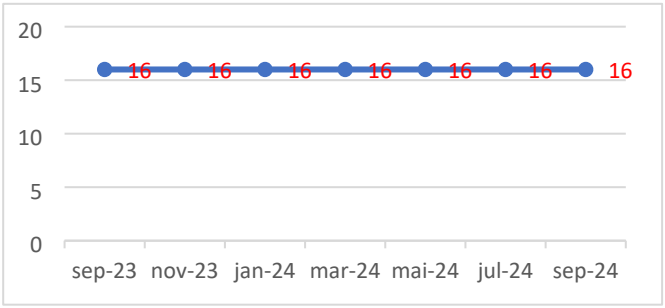
Strategic Risk: Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)

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
Initial	5	4	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

Whilst improvement against trajectories continue to improve the risk score has been reviewed and remains unchanged on this occasion.

Detailed discussion was held in August 2023 to consider reducing the likelihood score to a 3, in response to the positive progress being made e.g. HIW AW Joint Review into Quality Governance arrangements review outcome. However, in triangulating the risk description with incidents and complaints data, and in considering the mitigation activity still underway a decision was made to retain the likelihood score at a 4. Phase 2 of the Organisational Change Process is complete however, as that structure matures and develops the risk score will remain unchanged with a review in coming months.

	It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service. It is also recognised that cultural change can only be achieved over time.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however, ongoing risk treatment activity outlined in the mitigating actions section.

Risk Leads	• Executive Nurse Director • Executive Medical Director	Assurance committee	Quality and Safety

Controls	Assurances reported to Board and committees
Quality Frameworks and Policies • Strategic review of Infection, Prevention & Control (IP&C) is underway which will result in an IP&C Strategy 2024-2026. Review outcome received at the Quality & Safety Committee in May 2024. IPC Strategy received at the May 2024 Quality and Safety Committee (QSC) and approved by Board in May 2024. • Development of the CTM Safeguarding Strategy 2024-2027. This was paused due to national review underway which will inform CTM's approach, however, has now been restarted and will now be presented to the November QSC and Board. • Quality & Safety Framework approved by the Board in January 2023, which is aligned to the Care Group Model, is fully embedded across CTM. Internal Audit review on "Embedding the Quality Framework" completed and final report awaited. Any recommendations will be acted upon and managed via the audit tracker. • Quality Strategy action plan updated and an update received at the Quality & Safety Committee in July 2024 • Clinical Guidelines; • Suite of Standard Operating Procedures; • Clinical Education Framework; • The Incident Management Framework, was launched in June 2022 to reflect national changes in national incident reporting; following consultation across	External Reports HIW / AW – Quality Governance Arrangements Joint Review Follow-Up – August 2023: The follow-up review found the Health Board has made significant progress in addressing the concerns and recommendations of the 2019 report. It has a stronger strategic focus on quality and patient safety, and there is greater clarity on roles and responsibilities in relation to quality and patient safety compared to 2019. The organisation's scrutiny of quality and patient safety has also improved considerably, with greater openness and transparency. There is also greater awareness of risk management across the organisation, and clearer processes in place for identifying, managing, and escalating risks. The Health Board's concerns and complaints processes are much clearer, and new corporate roles have been created to support implementation and ensure consistency. There is also an improved culture of learning, with a series of arrangements now in place to support the sharing of learning and improvement across the organisation. Outcome letter for the above follow up review submitted to Audit & Risk Committee in August 2024, which concluded that given their overall view that the Health Board has made good progress in addressing the outstanding recommendations and areas of

CTM, the Incident Management Framework has been updated and was approved in January 2024 at the Quality & Safety Committee. • Incident Investigation training established and being rolled-out across the Health Board on a monthly basis; • Clinical Education Forum (providing overarching Governance) established and continuing through 2024. The Board received the annual report in November 2023. • Listening & Learning Framework launched and implemented at the Listening and Learning Event in September 2022. A further Listening and Learning Event was held in May 2023 and event took place on the 26th June 2024. Awareness of the new Quality Act was shared at this session, along with other learning for the organisation. We are looking to plan the next event for November 2024, and thereafter, every six months. • Quality Strategy. A Quality Strategy, Annual Action Plan supports the achievement of the deliverables within the Quality Strategy. Update received at the Quality & Safety Committee in January 2024. Annual Quality Work Plan received in January 2024. The Action Plan was updated and presented to the Quality & Safety Committee in July 2024. • Ward Accreditation Programme Framework established and is in the process of being rolled out • Nursing and Midwifery delivery plan was received at the May 2024 Quality & Safety Committee and formally launched in July 2024. • Implementation Board for the Duty of Quality and Candour being established – inaugural meeting undertaken. Board Briefing held October 2022. Change Team supporting implementation of Duty of Candour arrangements as of April 2023 including the roadshow events mentioned above. The duties within the act are integral to the Quality Strategy and have been built into Board and Committee report templates from November 2023.	further work identified, they do not propose to undertake any further formal joint follow up work in these areas. Instead, they will continue to monitor the Health Board's progress in addressing these matters through their routine audit and inspection work 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; • Organ Donation Annual Report. • Health and Care Standards Annual Report; (incorporating patient survey) • GMC Survey • Improvement to be reported through Improving Care Board / Change to be reported through Strategic Transformation Board; • ICTM (Improvement and Innovation) Annual Report • Annual Duty of Quality Report Quarterly Reports • Quality Dashboard; • Integrated Performance Dashboard; • Quality Governance – Regulatory review progress updates; • IPC Highlight reports; • Care Group reports; • High level update on mortality indicators; • Research and Development Update; • National Clinical Audit and NCEPOD studies; • Maternity and Neonatal Improvement Programme Highlight Report; • Llais briefing papers; • RADAR Reports; • Improvement portfolio report; • Multiple engagement events underway. Internal Assurances • Executive and Independent Member Patient Safety Walkabouts framework. The revised framework now implemented

- CTM Allied Health Professionals and Health Care Science Delivery Plan.

Learning from Experience

- New Patient Experience Forum established, with the inaugural meeting held in April 2024, with regular meetings to be held moving forwards.
- Executive and Independent Member Patient Safety Walkabouts framework complete and implemented. Evidence based review underway which will inform the ongoing format and approach to IM walkarounds.
- Citizen's Voice bodies (Llais) launched in place of CHCs. unannounced visits by Llais has recommenced and monthly meetings have been set up with Llais and the corporate team for early escalation and assurance of issues.
- Mortality Review programme secondary care established and continues to embed. Medical Examiner reviews fully incorporated. Focus level 2 / 3 reviews across CTM;
  From September 2024, community deaths will need to be included in the Mortality Review Programme with new processes and systems developed to accommodate this requirement.
- Shared Listening and Learning Forum will meet four times per annum: 2 listening and learning events and 2 information sharing meetings, commencing in November 2024. ~~currently paused to consider amalgamating with other forums to avoid duplication. Led by the Deputy Executive Director of Nursing.~~
- Community Acquired Pressure Ulcer Collaborative. A new collaborative has been created for falls reduction / harm reduction. Forum for shared learning on prevention and improvement with internal and external stakeholders ~~e.g. (Welsh Wound Innovation Centre (WWIC)~~ and Local Authorities. Steering Groups established and inaugural meetings have taken place with continued reporting to Quality & Safety Committee.

which includes 'Purpose, Form and Function' of IM Walkaround Visits.

- The Health Board has strengthened the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up. HIW Tracker is now in place;
- Launched Nursing & Midwifery Delivery Plan and agreed a set of nursing care related audit standards monitored via the Senior Lead Nurse Forum with onward reporting on annual basis to the Quality & Safety Committee.
- ~~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.~~ No longer applicable.
- Medicines Safety Group, Access to Medicines Group established. Replacing the Medicines Formulary Committee with a broader remit.
- ~~Peer reviews of specific services e.g. critical care;~~
- Health Inspectorate Wales unannounced visits;
- Medication Prescription and Administration incident update, which reports into the Medication Steering Forum.
- All Safeguarding Hubs working collaborative across CTM population;
- Planned Level 3 Safeguarding training for all Senior Clinical leaders (Execs – Care Group directors); Completed. Plan in place to roll out to all Care Group Clinical Directors and equivalents within this financial year.
- Multi-agency training days established and being rolled out in terms of Safeguarding training, with the aim of maintaining robust and strong engagement and relationships with agency partners.
- Recruited a Safeguarding Practice Development Nurse to support Safeguarding Education across CTM. ~~pending recruitment processes;~~

- Hydration and Nutrition Steering Group established and will also report to Quality & Safety Committee.
- Weekly executive-led patient safety meetings;
- Service Level Patient Safety meetings incorporate learning from events;
- 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 (current system Civica) being rolled out across the Health Board (PREMS), now rolled out across Emergency Departments. New software procured to replace Civica and to collect PREMS and PROMS - 2024 roll out plan in development with new supplier and CTM teams. System set up and ready for phased roll-out.
- Following discussions in relation to the operating model that will support the new Care Groups it is considered that Quality Assurance has been embedded within the quality reporting structures.
- 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); PROMS provider selected for CTM wide – procurement complete and roll out plan for 2024 in development. (Linked to PREMS and Civica replacement update above). PREMS now live in Emergency Departments. System set up and roll out planned.
- Staff ideas scheme launched across CTM for staff to provide ideas for improvement and collaborate on solutions; Over 1000 individuals registered and using the system.
- RADAR (Recognition of Acute Deterioration & Resuscitation) Committee.
- Contacted (letter, key message and verbal reminders) all medical teams to emphasise, and expect, need to complete level 2 Safeguarding training and certain areas level 3;
- Community Acquired Pressure Damage / Falls Reduction Collaborative;
- Patient Safety Solutions – safety alerts and notices;
- Mental Capacity Act (LPS);
- Ad-hoc visits to Ty Llidiard (CAMHS) facility and ad-hoc review of clinical records;
- Executive Director of Nursing and Executive Director of Therapies and Health Science have undertaken the relevant training on Duty of Quality & Duty of Candour to ensure that there is sufficient knowledge and influence in relation to the legislation at Board level.
- HIW undertake adhoc reviews of medical training within the Health Board.
- Review of Interventions Not Normally Undertaken (INNU) processes to ensure there are robust levels of compliance within clinical practice and appropriate assurances provided.

Qualitative Intelligence

- Ongoing weekly safety huddles taking place with Executive Directors and Care Group Directors, and Quality and Safety Team to review concerns and complaints compliance across the Health Board;
- Development of high level dashboards accessible to Ward Managers and to Nurse Directors to support high level overview and decision making using Workforce and Quality Indicators;
- Ongoing monthly meetings with Executive Director of Nursing, Directors of Nursing and Ward Managers;
- Service User and Staff Stories;
- Executive & Independent Member Walkarounds;
- Executive Nurse Director and Deputy Executive Nurse Director undertake weekly clinical focussed site visits;
- Improvement case studies;
- Social Media feedback and intelligence;
- Listening and Learning forum;

– Training standards and compliance. This is now a work stream within the Unscheduled Care Group;
- 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 concerning advanced practice professionals.

Innovation & Improvement Programmes
- Quality Improvement showcase event held in July 2023 to highlight and share best practice improvement initiatives across CTM. 2024 event took place in July 2024.
- Improvement Community of Practice implemented with over 30 QI champions currently in place.
- Healthcare Pathways Initiative completed – writing and establishing guidelines from primary to secondary care referrals.
- Theatre Utilisation Group established to pilot the WG initiative to drive efficiency and standardise theatre processes across the Health Board.
- 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; Team working 2026-2028 business plan.
- Leading for Patient Safety with Improvement Cymru and Institute for Healthcare Improvement (IHI) launched. Work plan established and programme continuing for 2023/2024; Shared learning event held in November 2023. Working with Improvement Cymru to develop the continuation of the collaborative, following its completion in May 2024. Awaiting guidance from the NHS Exec Quality, Safety and Improvement Team on next steps;
- Improvement and Innovation CTM are actively supporting a number of services, a full list is available from iCTM;
- Weekly executive/deputy executive led patient safety meetings;
- Performance and Assurance Directorate of the NHS Executive—Dashboard reports inform the Health Board in terms of compliance across the Patient, Care and Safety portfolio;
- CTM now have access to the All Wales Beacon Dashboard which allows us to benchmark quality metrics.
- iCTM joint working with academic partners to explore cutting edge quality and safety activity to support the Health Board's continuing improvement journey;
- The Health Board is represented at the Duty of Quality & Duty of Candour all Wales meetings which concluded in March 2024, however, additional meetings will be held in the future as required to benchmark and share learning;
- Partnership Working with Cardiff & Vale re South Central Regional Stroke Network;
- Board Briefing regarding Regional Stroke Developments held in December 2022 and followed up in January 2023;
- Discussions are urgently being undertaken with C&VUHB to mitigate CTMUHB's stroke service fragility.
- Regular Director of Therapies & Health Sciences Team quality assurance visits to clinical services.

External Assurance
- National Neonatal Audit Programme provided report identified Prince Charles Hospital as 'Outstanding' for the NNAP 2023 audit measure two year follow-up. PCH neonatal service has been identified as scoring 100% (National average result was 77%).
- Letter from Public Health Wales complimenting CTMUHB on the excellent Bowel Screening service provided for patients requiring a bowel colonoscopy for suspected cancer.
- External audit in June 2024 in collaboration with Arjo Huntleigh regarding pressure ulcer prevalence and results are awaited.
- Ombudsman's Annual Letter;

• ICTM developed and delivering a QI Capacity and capability programme; • Related escalation Status activity; • Monthly Quality Improvement (QI) training commenced from June 2022 and ongoing on a monthly basis; • ~~Patient Safety Clinics commenced June 2022 and will run bi-monthly or as required by services;~~ • Investigation and Putting Things Right (PTR) Training commenced 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; • Leading and empowering Improvement and Innovation built into the new Ignite, Aspire and Inspire leadership programmes; • Implementation of Care Group Improvement Faculties; • Medical Workforce & Nursing Workforce Productivity Programme established. Medical Workforce Productivity Group has been recently repurposed to allow scrutiny at senior level across Care Groups; • Appointment of the Bereavement Clinical Lead to support the implementation of the All Wales Care of the Bereaved Framework and Pathways. • The Improvement Team have aligned resource to care groups and are meeting care group management on a monthly basis to discuss quality improvement activity. • The Deputy Executive Director of Nursing is a steering group member led by WG on the national safeguarding review for health, commissioned by the CNO. This will be due for completion in June 2024. Completed and awaiting final approved report. • The Deputy Executive Director of Nursing is a steering group member, working with WG on a program of work following a recent national report on Sexual Safety	• Internal Audit Review – CSG & Care Group Quality Assurance. August 2022 – outcome of Reasonable Assurance; • HIW reports ~~e.g. PCH Improvement Programme;~~ • The Health Board is in the process of strengthening the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up. Local governance of HIW actions will take place through our new Care Group quality and safety committees. The system will allow for the Care Group leads to have a dashboard of all their HIW Inspection activity and continuous monitoring of the improvement plans; The AmAT Inspection Module is being implemented for HIW Audit Recommendations with the first report received in May 2024 at the Quality & Safety Committee, which will be a hybrid approach as CTM fully transitions to the new automated system. • Performance and Assurance Directorate of the NHS Executive governance and incident management; • Performance and Assurance Directorate of the NHS Executive Maternity and Neonatal SI closures; • Annual Undergraduate Review; • General Medical Council National Survey Feedback; • MSOP stood-down as of December 2022, oversight and scrutiny now conducted through internal Board mechanisms and to Welsh Government via IQPD and escalation meetings; • Positive IHI and Improvement Cymru visit feedback (autumn 22) as part of Leading for Patient Safety received and feedback to Board received; • National Safe Care Collaborative Programme Audit. Presented findings to the Board in December 22; • Following the completion of all tasks and actions set out during the escalation process, it was recommended that Ty Llidiard be de-escalated to Level 0 and out

and associated safeguarding concerns. There are currently delays in terms of scheduling from an All Wales perspective and will update accordingly. First all-wales NHS Executive Led meeting on Sexual Safety held to define the structure of this programme of work. • Duty of Quality and Duty of Candour Training will be ongoing as required as the Act is embedded within the Health Board. Data on Duty of Candour now routinely reported through weekly Executive Director Led Patient Safety Weekly meetings. Duty of Quality will continue to embed into services. • A Clinical Effectiveness Committee has been introduced to be an effective and efficient forum for high-level clinicians, leaders and managers to support continuous quality improvement in clinical care in CTMUHB. It will monitor the implementation of the clinical audit program and implementation of NICE/national guidelines/standards to ensure best practice across the Health Board. It will provide support and strategic direction for the Health Board's national and local clinical audit programme, receiving assurance reports from the sub groups and following analysis escalate issues or provide assurance to the Q&S committee and Board. Research • Research & Development Programme. Healthcare Research Wales have validated the Health Board's self-assessment of its Research and Development strategy and the feedback will be used to shape ongoing strategic direction. Flow Efficiencies and Productivity • ~~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. Clinical Directors have now been appointed to support this process.~~ • Nursing Productivity Groups operational • Reset Fortnight / Optimise	of escalation entirely. This was agreed at a meeting of the WHSSC Corporate Directors held on Monday August 14th 2023. Routine performance monitoring meetings will be set up from September 2023 in line with the Joint Commissioning Committee Performance Framework.

Gaps in Controls and Assurances	Mitigating Actions
• Roll out of the Clinical Ward/Department Assurance Programme.	Rolling programme commenced and 10 wards have been completed.
• Strategy & Framework Reviews and Development o Safeguarding Strategy o ~~IPC Strategy –~~ Completed will remove on next iteration.	Timeframes: • Development of a strategy, timeframe end of quarter 3 2024. National review undertaken and final report awaited.
• Data and Audit - Real-time performance and quality data accessible via electronic systems across the organisation;	• Mortality Data Improving – should be in place by end of September 2023. Baseline position established by the end of September with dashboard development to follow in the coming months. Implementation delayed due to Digital and Data Team capacity constraints. Progress meetings scheduled with a new timeframe to be agreed. To further support the pace of this activity, the Medical Directorate have engaged the Chief Information Officer to support data intelligence. Data should be available for the purpose of analysis by April 2024. Progress being made, remains on track for April 2024. Proforma agreed – data validation in progress. Availability of the proforma for use is planned for July 2024. The data once the proforma has been implemented will be reviewed initially circa September 2024. • CTMUHB is represented on the work being undertaken with the Performance and Assurance Directorate of the NHS Executive to explore how benchmarking in quality performance can be shared across NHS Wales. The Performance and Assurance Directorate of the NHS Executive are also rolling out a National Quality Safety Framework to support a consistent approach to quality reporting. Timescales dependent on external sources; • Ambition to develop live clinical quality dashboard – live for maternity and neonatal services– to be rolled out for other areas by the end of the financial year; Work in progress for other areas. • Improving Care Board has developed a portfolio of improvement programme and projects. Monthly governance meetings established. Move to control next period.

	• National Safe Care Collaborative Programme Audit recommendations and action plans led by IHI and Improvement Cymru – by the end of 2024; next steps currently being explored to ensure sustainability.
• 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;	• Staff ideas scheme implemented (May 22) for raising ideas for improvement – to increase participation in 23/24 – Implemented. Ongoing and numbers increasing through the year. Onsite events planned for Quarter 1/ Quarter 2 2024-2025 – completed. Ongoing programme. • Improvement into practice training taking place every other month. • Permanent funding secured for PREMs and full deployment across the Health Board is planned. Further activity is also scheduled to increase awareness around the mechanism for sharing feedback using the "Have Your Say" process. Recruited and appointed to posts. ~~although post holders have not yet commenced.~~
• Improving flow and efficiencies and productivity	• Medical & Nursing Workforce Productivity Programmes operating within the transformational programme governance structure and delivering to plan.
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. Children's Charter	Please refer to the following sections of the Integrated Performance Dashboard to triangulate risk, assurance and performance: • Quality Dashboard • Maternity & Neonatal Dashboard • Cancer Standards; • Unscheduled Care; • Six Goals Programme (Emergency & Urgent Care, D2RA); • 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

To reinforce children's rights and endorse CTM's commitment to upholding these rights within its services. Safeguarding • National Improvement Plan; • Further Mental Capacity Act (MCA) awareness being funded by Welsh Government along with measures to strengthen current Deprivation of Liberty Safeguards until MCA becomes the dominant legislation. • Independent Review (by HIW/CIW) being undertaken of CTM Region Safeguarding Boards in relation to Child Protection Practices including the sharing of information. 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
4907	Failure to manage Redress cases efficiently and effectively	16
~~5254~~	~~Failure to manage redress cases efficiently and effectively in respect of the Duty of Candour.~~	~~16~~

	It was agreed to close this risk and amalgamate it with risk 4907 and the Duty of Candour element has been added as a new risk with a rating of 12 (ID 5895).	
~~3133~~	~~Non-attendance at medical gas safety training and courses being rescheduled~~ Risk score reduced so risk de-escalated from the Organisational Risk Register.	~~16~~
4417	Management of Security Doors in All Hospital Settings	16
4908	Failure to manage Legal cases efficiently and effectively.	16
5646	Impact of Right Care Right Person approached. New risk escalated to the organisational risk register in January 2024.	16
3993	Fire enforcement notice – POWH Theatres	15
4691	New Mental Health Unit	15

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Strategic Goals: Sustaining our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value based healthcare • Ensuring our estate is fit for the future	Risk score 20
Strategic Risk: - Sufficient workforce to deliver the activity and quality ambitions of the organisation (Risk No. 3)	

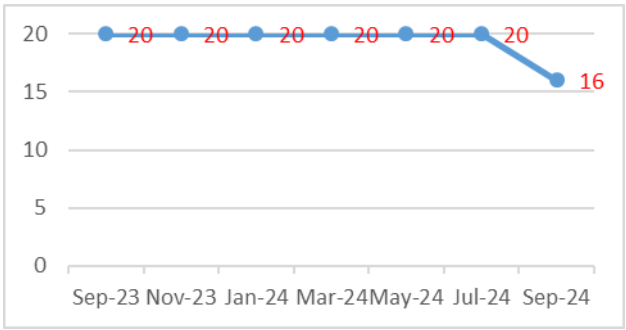
If the Health Board fails to identify and plan for its current and future workforce requirements, and to promote CTMUHB as an attractive place to work	*Then* we may fail to ensure we have the right people with the right skills and experience, in the right place at the right time and cost to meet service demand.	*Resulting in* increased gaps in our workforce which adversely affect the quality of care, increased burden on other workforce and the employee experience, with a potential increase in variable pay impacting our ability to deliver high quality and affordable services fit for today and tomorrow.

	Consequence	Likelihood	Score
Initial	5	5	25
Current	~~5~~ 4	 4	~~20~~ 16
Target	~~5~~ 4	 2	~~10~~ 8
Risk Appetite	Minimal *(financial stability)* Cautious *(quality and safety, (legal and regulatory)*		

Risk Score Trend this Period:

The risk score has decreased this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	This risk is complex and reflects increasing recruitment & retention challenges with skills shortages across health and social care on a local, national and international scale. Therefore, although we are "treating" this risk it is recognised that significant progress on this will not be achieved in the short term. Workforce gaps due to lack of available skilled workers either in local or national labour market and we are having to look at

	alternative options to meet demands and reduce variable pay. International recruitment is being explored but is expensive and not sustainable. This is a short-medium term solution while we develop alternative plans to build skills with the intent of ceasing international recruitment or using in exceptional circumstances. Alongside this, innovative solutions such as developing new roles/additional/extended skills take time to grow. The increased burden on existing staff leading to high sickness levels reported reduced to 6.31% in May 2024 and to 6.26% in June 2024. Turnover reduced to 11.18% in June 2024 and 10.95% in July 2024. The risk score has been reviewed in accordance with the Risk Domain/ Scoring Matrix. The following consequences have not been seen, as outlined at L5, which suggests the original risk score may have been overstated: • Non-delivery of key objective/service due to loss of several key staff. • Ongoing unsafe staffing levels or competence/skill mix. • No staff attending mandatory/professional training. The workforce risk remains significant but this reduction places the risk score more appropriately within the risk domains at L4. • Late delivery of key objective/service due to lack of staff. • Unsafe staffing level (>1 day)/competence. • Low staff morale. • Poor staff attendance for mandatory/key professional training. We continue to treat and mitigate the risk as follows in the report.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through the expansion of programmes of work focused on improved data analytics and strategic workforce planning: workforce transformation, attraction recruitment/ development, retaining our workforce, building skills and flexible workforce options which are aligned to current and future workforce requirements, which are more affordable and sustainable.

Risk Lead	• Executive Director for People	Assurance committee	• People and Culture

Controls	Assurances reported to Board and committees
Recruitment • Vacancy Scrutiny Panel. • Bank modernisation action plan • Online recruitment through TRAC. • Review of the CTM 'reducing the time to hire, ownership of the journey' aligned to the NWSSP Recruitment Modernisation Group. • International recruitment of clinical professionals. Development of an International Educated Nursing paper with a recruitment proposal for a four year programme (2024-2028) which was submitted to Welsh Government via NWSSP for funding. Unfortunately, insufficient funding meant this year's programme was not supported but we continue to plan for 25/26. • Pathways to Employment programmes (Project Search/Supported Internships, apprenticeships, Network 75, Jobs Growth Wales +, Graduate Activity) alongside NHS graduate training schemes • Living Wage employer status • Medical Recruitment plan in development and working with NWSSP on possible international recruitment. Initial focus is on job description standardisation which will be discussed the MWPP Framework Group for an agreed organisational approach. • Attraction and Resourcing Key priorities: increased social media presence, employer branding, student streamlining and attendance at careers fairs to promote CTM as an employer of choice learning to inform future events. • Actively involved in senior key critical appointments within the People Directorate and across the Health Board. • Reviewing the CTM approach to the selection process and to standardise the approach to the use of psychometrics and assessment centres to improve appointment decision making. • Work experience pathway established.	• Workforce and Organisational Development Metrics report (includes key performance indicators such as staff in post, turnover, sickness) which is regularly reported to the CTM to People & Culture Committee. Data also included in Integrated Performance Report to the Board. Reporting also via Nursing Productivity and Medical Productivity into Values & Effectiveness Board. • Bank modernisation improvement plan and International Educated Nurse (IEN) recruitment are standing agenda items at Nurse Productivity. • Medical Productivity Performance and Escalation (PEG) meeting includes data on bank usage, agency spend, job planning compliance and trajectories, sickness absence. The Framework meeting which reports to the PEG focuses on recruitment, retention and consistent policies and practices with the aim of a 'Once for CTM' approach. • Annual Education Commissioning Submission and IMTP Chapter and MDS. This year's IMTP Education and Commissioning submission was approved at ELG on 8 April 2024. • Quarterly data return submitted to Welsh Government for NHS vacancy statistics • A suite of BI People dashboards launched, and dashboards are in development with the nursing dashboard launched through a phased approach with phase 1 delivered during April 24 These have been well received, giving easy access to timely, relevant and accurate People data to inform decision-making. Further reporting automation and dashboards are progressing.

- Bank recruitment plan in progress focussed on proactive recruitment across 12 months.
- A 'Loop' app launched in July 2024 to improve access for bank workers to book shifts.
- Updating controls and escalations for medical bank and agency shifts.
- Non-Consultant rate card was launched 19 October 2023.
- Consultant rate card launched on 24 June 2024 to provide consistent rates.
- Reviewing M&D fixed term contracts and agreeing a more robust approach and controls with the Medical Director.
- Review of support for nurses recruited via IEN Programme to improve experience, cpd, career pathways, wellbeing and retention.

Retention

- Engagement in All Wales Nursing Retention group, alongside launch of local group
- Retaining and Valuing Nurses within the NHS in Wales: A Nurse Retention Plan & HEIW Retention Resources launched 25th September 2023 with local plan developed including key areas of focus: lateral moves, flexible working and moving on questionnaire.
- A CTM Retention Steering Group in place since 2023 but re-focussed during June 2024 to ensure appropriate stakeholders, priorities and alignment with other Groups/Committees to avoid duplication and encourage collaborative working to deliver the plan.
- Career development opportunities, e.g. Apprenticeships, Qualifications & in-house learning and development offer e.g. Leadership & management programmes
- Moving on questionnaires under review with aim of increasing completion rates and providing us with a valuable data source on turnover. This is being reviewed to establish links to other workforce data and to ensure the process around it is robust.

- In partnership with Digital and Finance, development of one source of workforce data to help inform the vacancy position.
- In partnership with Digital, developing a CTM strategic approach to the use of Robotics.
- In partnership with the National Data Resources (NDR), piloting ONS's data Masterclass within the people directorate to enhance data and analytical capability for leaders to improve data driven decisions. This is due to complete early July 2024 to review the possible usage more widely within CTM.
- Strategic Workforce Planning approach discussed at Inspiring People Board on 10 April 2024 with follow up with Heads of People to align to Care Group Service Plans.
- Positive Review of Workforce Planning Arrangements undertaken by Audit Wales with six recommendations which have been developed into an action plan with agreed deadlines. The audit report and actions were shared at the CTM Audit and Risk Committee on 18 April 2024.
- Retention and Workforce Planning Lead is a key part of the Health Education Improvement Wales (HEIW) retention community of practice, which will encourage sharing best practice and utilizing networks across Wales.
- CTM are connected to stakeholder events such as the Physician Associates (14 May 2024) and key stakeholders at the Physician Associate Recruitment Group and Medical Associate Profession (MAPs) groups.
- International Nurse Recruitment (IEN) Paper shared with NWSSP for WG Funding. Outcome resulted in £751k funding but created a cost pressure which is being worked through to consider all options to increase staff in post. This year's programme could not continue due to insufficient funding.

- Internal Lateral Moves Scheme for Band 5 Nurse and Midwifes was launched in February 2024. The Scheme has agreed 11 moves, 2 in process and 13 pending matches. Work is underway to consider roll out of the scheme to other staff groups.
- All Wales Flexible Working Policy launched with accompanying promotion and implementation of oversight mechanism in place which align to retention as a key initiative.
- Wagestream as a mechanism for regular pay
- Organisational Induction launched
- PDR "Your Conversation" promoting safe and productive environments for managers to interact with and listen to their staff

Temporary staffing solutions

- Medical Bank
- Review of Retinue M&D Bank to ensure better controls and improved active management by Retinue.
- Review of controls, monitoring and assurances for M&D Agency with Retinue.
- Modernised processes for Bank workers with service improvement project underway
- ~~Locum Managed Service Agreements~~

Day-to-day management of staffing levels

- Electronic rostering
- Complete review of e-job planning cleansing the system, updating and confirming the sign off managers
- Job Planning Guide to be updated to reduce sign off period from 10 weeks to 4 weeks.
- Medical job planning compliance.
- Junior doctor rota monitoring. A rota monitoring scheduler is in development to prioritise activity.
- Sickness absence management process

Workforce Planning

- CTM is aligned to the all Wales International Medical Recruitment Group and considering opportunities for the autumn 2024 depending on funding arrangements and agreed speciality being recruited from Kerala, India.
- Attraction questionnaire developed to seek information on the elements which influenced staff joining CTM. ~~To be trialled in the People Directorate in July 2024 before rolling out more widely to identify themes to inform our attraction strategy~~. The questionnaire was initially sent to all AFC staff who joined CTM in last 12 months and to date 125 responses to formulate a report on themes and next steps to inform our CTM attraction strategy. Next step is to send out to M&D new starters to support M&D attraction.
- Establishment of a multi-disciplinary workforce shape and supply steering group to discuss workforce supply pipelines. First meeting was held on 4 July 2024 and a workshop developed on 15 August 2024 with stakeholders to develop content.
- Work to review the data modelling is underway with the ambition to provide information for ACSP.
- Horizon scan work underway in accordance with the Audit Wales audit recommendations.
- Update on Workforce Planning was discussed at People and Culture in August 2024.
- Workforce Planning and People response to the HEIW Nursing Strategic Workforce Plan was provided on 21 June 2024. Update awaited.
- Assessment of the CTM progress against HEIW Strategic Workforce plans was undertaken and discussed at People and Culture in August 2024.
- Two PAs vacancies identified and two possible PA posts available subject to funding. The remaining nine yet to be found to meet the 13 PAs CTM requested

• Health Education Improvement Wales (HEIW) Workforce Planning Tool and Skills for Health modelling tool. • CTM approach to workforce planning developed and shared at Inspiring People. • Development of tool for workforce modelling/forecasting, including projecting the impact of interventions. Internal action plan and next steps underway with updates via the Inspiring People Board. • HEIW all Wales Strategic Workforce Plans across: Dental, Mental Health, Perinatal, Pharmacy and Primary Care with AHPs and Genomics out for consultation. Nursing is in development. Guidance for Radiology is also available. • The Head of Workforce Planning is aligned to the HEIW Workforce Planning Network. • 13 Physicians Associates allocated for 2024 intake- building on our commitment to expand into alternative roles. • SWP Audit by Audit Wales completed and reported in March 2024. • Medical establishments in development to align ESR and ledger data to be agreed with CGs. Initial focus is C&F as a pilot CG by Nov 24.	in IMTP education commissioning in 2022 submission. • HEIW PA student streamlining postponed from early June 2024 across Wales due to low vacancy numbers and to be re-established September 2024.
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 and ongoing challenges in vacancy reporting	Designed and developed an all-encompassing workforce planning approach. This will include establishment control and improved workforce analytics - to ensure we understand whom CTM has and who it needs, to improved attraction and recruitment approaches to employ the best people from the widest possible pool. Enhancement of our people data (quality & provision), analytics and intelligence. This will support the development of our workforce both for now and the future. The following Workforce Planning activity is also now underway: • Neonatal SWP workshop held on 26 February 2024 with a further workshop to build the plan scheduled for May 2024. This has been postponed due to moves in

	Children and Families with the next session proposed for October 2024. • Facilitating the development of workforce plans in Regional Ophthalmology and Orthopaedics, the latter aligned to Llantrisant Health Park. This has been postponed and awaiting further updates from the Regional Ophthalmology Group. • The Health Board is building a framework for local, operational workforce plans that minimise vacancies and optimise the skills of the existing workforce to ensure opportunities to grow our own are maximised. • This 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. • The plans under development will consider all the above, alongside 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. Alongside development of our approach to workforce planning we are also developing a framework regarding new roles • Establishment of PA Working Group July 2024. • The Head of Workforce Planning is representing CTM on the All Wales Registered Nurse Assistant Band 4 post to support the development of a CTM action plan. • Workforce planning alignment to the ACSP to promote opportunities to maximise workforce productivity, integrated working, redesign and new role developments. • Establishment control paper in development. This should be finalised for consideration in the ~~first~~ second quarter of 2024.

	• SWP Audit Wales Recommendations Action Plan in place and progress will be updated at People & Culture Committee in August 2024.
Recruitment & Retention • The Health Board does not currently have a signed off Recruitment & Retention Plan.	• A draft retention action plan is in place, aligned to the 10 HEIW nurse retention themes. The plan is being monitored and updated by the Retention lead and discussed within the CTM Retention Steering Group. • Retention updates being provided on an ongoing basis via the People and Culture Committee.
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: • Turnover remains high within the Health Board (10.95%in July 2024). This is an agreed area of focus for the Retention Group now the Retention and Workforce Planning Lead is in post to develop initiatives to reduce turnover and to encourage staff to stay. • Job Planning compliance is now a key agenda item on the V&E; MWPP Performance Escalation Group to improve job planning compliance. • A Framework Group is also in development to address key medical and dental productivity and performance feeding into the V&E MWPP Performance and Escalation Group. This will focus on standardised policies and practice alongside review of implementation plans. • Sickness absence currently high reporting as 6.26% in March 2024; Rolling 12 months' rate for the same period was 6.82%

	Absence FTE %	Rolling 12 Months Absence FTE %
Add Prof Scientific and Technic	3.72%	**3.87%**
Additional Clinical Services	8.15%	**9.24%**
Administrative and Clerical	5.38%	**5.79%**
Allied Health Professionals	4.37%	**4.26%**

Estates and Ancillary	10.03%	**10.73%**
Healthcare Scientists	4.44%	**4.32%**
Medical and Dental	2.04%	**2.41%**
Nursing and Midwifery Registered	6.31%	**6.83%**
Students	7.21%	**5.75%**
Grand Total	**6.26%**	**6.82%**

- Staff in post stands at 12,907 headcount and 11,254.60 FTE as at 29th August 2024.

The Health Board's People Dashboard and metrics report sets out further details in respect of workforce related performance metrics, trends and actions that are underway. A workforce metrics report is a standing agenda item at our People & Culture committee and Local Partnership Forum.

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
5658	Lack of Dietetic service provision to Princess of Wales Critical Care.	16
4809	Non Compliance with Mandatory Violence and Aggression Training	15
4080	Failure to recruit sufficient medical and dental staff	15

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Strategic Goal: Creating Health	Risk score 12
• Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation	

Strategic Risk: Community & Partner Engagement - (Risk No.4)

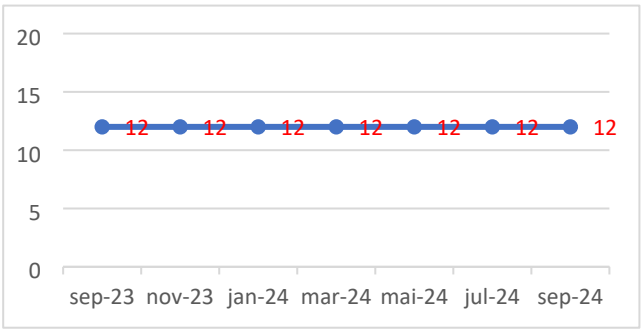
If the Health Board *does* not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	*Then* we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	*Resulting in* • Lack of trust between the community and the Health Board. • Loss of opportunity to build relationships and create an inclusive environment where people connect, collaborate, and share ideas. • Challenge to public decisions relating to future service developments due to limited engagement • The inability to affect positive change in terms of improving health inequalities and health outcomes.

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	3	12
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence)*		

Risk Score Trend this Period:

No Change to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	This risk remains unchanged, as engagement with communities and partners is ongoing. It is hoped that CTMUHB will be in a place to update on the community engagement work for the Acute Clinical Service Plan in the next iteration of the BAF.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being actively managed via the communications team and wider

	engagement. As above, we will need to tolerate the fact that management of the risk will need to be ongoing.

Lead Director	Director of Communications, Engagement & Fundraising.	Assurance committee	Population Health & Partnerships Quality & Safety Committee (Experience element) People & Culture Committee (Values Behaviours)

Controls	Assurances reported to Board and committees
Strategies & Plans • 2030 Strategy – 'Our Health Our Future' • 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. Completed* • 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 Engagement Forums • Regional Partnership Board • Public Service Board • Area Partnership Board • CTM2030 Leaders Groups • Acute Clinical Services Plan – Senior Leaders Group • Hybrid Staff Q&A • Stakeholder Reference Group • Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well • Engagement with community groups by Lead Independent Members • Links with Llais including representation on Board • Regular joint executive meetings with the three local authorities • Accelerated Cluster Development Programme Board – engagement across Primary Care	Board Development Session – held on the 14th December 2023 in relation to community engagement and the maturity journey for the Health Board in further developing its approach to being an engaging organisation. Routine discussions with Board undertaken in relation to the engagement strategy for the Acute Clinical Services Plan. Reports to other committees • Community Health Council briefing papers to Quality and Safety Committee • People & Culture Committee consider reports in relation to culture and behaviours.

• Health and Social Care Integration Board • Forum with local authority Chief Executives to address health inequalities • Community Voluntary Councils (Interlink RCT, BAVO, VAMT) • OPAG (Older Person's Advisory Committee) • CTM 50+ Forums • Maesteg Stakeholder Reference Group • Partnership with CTM WISE (Wellness Improvement Service) • Regional Mental Health Forum • Partnerships with colleges and education providers Needs Assessment & Consultation Processes • Population Needs Assessment (Regional Partnership Board) • Formal consultation processes for service reconfiguration, e.g. vascular Organisational Structures • Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars	
Gaps in Controls and Assurances	**Mitigating Actions**
• Review the Becoming and Engaging Organisation Strategy	• Revisit to ensure the principles support the direction of travel, particularly there consistency and alignment with the ACSP engagement strategy, • Board Development Session reviewed the strategy on the 14th December 2023, outputs of which will now be taken forward. • Engaging with the Consultation Institute to develop and embed robust systems and processes within the Health Board for managing consultation. Work has begun with the consultation institute to improve our understanding of our stakeholders and the risks associated with service change. Timeframes: 1st July 2024. • Development of specification for procurement of consultation partner to support creation of hyperlocal stakeholder mapping to enable improved targeting of engagement activities and resources. • Collaboration with Regional Partnership Board on use of stakeholder management

	system to provide increased rigor and improved data capture.
Linked National Priority Measures	Current Performance - Highlights
	Staff Survey Headline Report now received Indicates a maintained performance for staff engagement vs a national decrease. New Terms of Reference under development with CTM Leaders Forum to embed shared purpose. Stakeholder mapping workshop jointly facilitated by CTM with the Consultation Institute taking place on 17 April to improve understanding and identification of stakeholders.

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		
Nil.		

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IMPROVING CARE	**Strategic Goal: Improving Care** • Delivering safe and compassionate care. • Developing new models of care. • Digital transformation for patients and staff • Ensuring timely access to care	Risk score 16

Strategic Risk: Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.5)

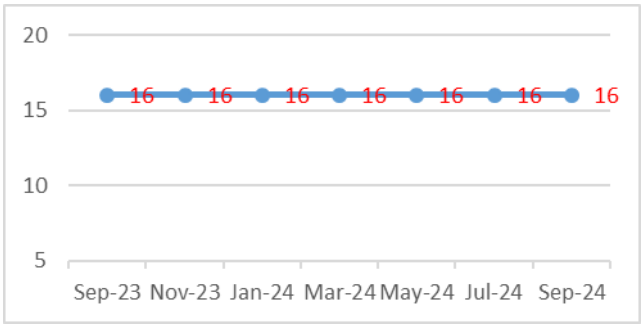
If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	*Then* We will be unable to design and execute 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
Initial	4	5	20
Current	4	4	16
Target	4	3	12
Risk Appetite	Cautious *(data and information; legal and regulatory)*		

Risk Score Trend this Period:

No Change to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

Progress continues to be made in improving the:

- Digitisation of the medical record
- security and protection of our data and digital assets.
- digital infrastructure across some sites
- standardisation of digital tools
- Contract and Project mobilisation for e-prescribing
- the advancement and availability of our clinical information.
- the advancement our clinical information

	• Consolidation of the clinical systems in the Bridgend disaggregation • Development of a programme of work for patient centred contact • The Health Board continues to manage its information and digital debt on a risk-based basis. The Health Board still has vulnerabilities that need to be managed. Since January 2024 3 significant partners of the UHB have been subject to cyber-attacks, and it is widely acknowledged that cyber attempts are now widespread. Increasingly the NHS is being targeted and as a result an attack on NHS Wales is now considered highly likely. Having reviewed the risk around cyber it remains at 20. This risk score has been reviewed and the assessment is that it remains unchanged from a score of 16 on this review.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is considered that the Health Board is continuing to 'Treat' this risk as it has a number of actions it is taking forward to mitigate this risk.

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 • Project Portfolio Board		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 • Medical Records Assurance Report 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		• Investment required in training resources to embrace and use existing technology, digital tools and basic troubleshooting. Publicise and expand the use of digital material already available. Included within	

	the IMTP Proposal – funding to be determined. Timeframe: 2-3 year programme of work.
• Training and Awareness Programme	• Resources required to prioritise the development of a training and awareness programme. Included within the IMTP and identified as a requirement within the functional proposal for Digital & Data Timeframe: 2-3 year programme of work.
• Maintaining a healthy cyber posture	• Delivery of the cyber improvement plan (business sensitive) Timeframe: This action will not have a specific timeframe as will be a continuing activity without an endpoint.
• Tested and integrated cyber incident management plan	• Continued testing of our cyber incident plan with periodic table-top exercises. The Digital SMT and Health Board emergency planning lead undertook a table-top exercise on 26th July using the facilities in the University of South Wales. We are working in conjunction with the Health Board emergency planning lead to ensure greater understanding of risk to service delivery (from a service perspective) and with external service providers most notably Swansea Bay University Health Board and Digital Healthcare Wales and the private sector Timeframe: This action will not have a specific timeframe as this activity will be subject to undergoing periodic testing and iteration of the management plan.
• Develop a baseline Asset Register and product catalogue	• Development and maintenance of our asset register and product catalogue as part of NIS-D and data protection improvement plans. Cyber Resilience Unit's Assessment of our organisation's maturity has taken place, and we are awaiting the final report.
• Poor adherence to policies	• Recognised requirement for policies to balance enablement with protection. National discussions ongoing as to whether national policies should be 80:20 based, so that local circumstance can be incorporated within policies, improving adherence. This needs to be undertaken alongside increased training and awareness of policies as part of the OCP process. Timeframe: It is anticipated that this activity will take 24 months to complete

	recognising the need to ensure it is managed through the new Care Group Structure.
• Insufficient capital and revenue resource allocation and the capacity of the skilled workforce – exacerbated by the short-term nature of funding and seldom meets post implementation requirements.	• Prioritise existing resources and available funding to meet the highest risk areas. We have allocated additional revenue resources this year and a recruitment plan is forming Timeframe: No timeframe set as this action is dependent on external parties. There remains a gap in the required Capital and Revenue to meet several core system deliveries and wider improvement opportunities, which is a continuing National challenge that organisations are facing.
• Integration of information systems for services in the Bridgend area transferred from Swansea Bay University Health Board	• Programme agreed with WG, DHCW and Swansea Bay University Health Board and year 1 delivery exceeded milestones. Year 2 ongoing however constraints exist most notably with regards to availability of capital funding. May 16th 2025 has been identified as the agreed merger weekend for WPAS. • Timeframe: 2-3 year programme of work.
• Lack of an open architecture	• As part of the review of our EPR strategy, we are working with WG, Health Board partners and national services to develop existing commitments for delivery of an open architecture for NHS Wales and exploring alternatives for addressing gaps in functionality. • Consideration of CTMUHB's requirements for clinical and administration management to be undertaken and incorporated into the architectural design and EPR strategy. • Ongoing development of CTMUHB's own clinical data repository to nationally agreed technical and data standards. • Increasing representation for National Data Resource programme to accelerate benefits realisation. Timeframe: It is not possible to set a specific timeframe as this is dependent upon National Strategic Direction.

• Widespread non-adherence to data standards	• New clinical applications are now required to meet data and technical standards. • A clinical safety assurance process has been described and tested, to support an options appraisal. • Education and Training required for staff to develop their data literacy. • Seeking further assurances from DHCW for roadmap that will see their products come into compliance with standards. • Improvement and greater multi-disciplinary management of the changes to service models, counting practices and consequent impact on measures which carry significant effect on both the efficiency and reputation of the Health Board (e.g. mortality rates and quality measures, income, bed capacity planning) is required. Timeframe: It is not possible to set a specific timeframe as this is dependent upon National Strategic Direction.
• Critical supplier(s) unable to respond to the UHB's requirements and ministerial priorities within defined timescales	• Need to develop a more robust SLA and contract monitoring and management process for critical suppliers. Timeframes – 1 Year. The Health Board is in a planned programme of work with the relevant critical suppliers to ensure delivery against key objectives in year 1)
• Capacity within current team to deliver digital transformation agenda	• 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. • Adoption of self service for basic Business Intelligence • Recruitment to vacant posts. • Resources required for CTMUHB to have the skills and expertise to use data and digital tools effectively- capacity and capability gaps exists when compared to other HBs and DHCW Timeframe: Q2 24/25 - Following ePMA business case approval from Welsh Government we are now actively recruiting Digital Transformation resources as part of the wider ePMA programme. As part of ePMA recruitment of clinical informatics leads we now have representatives from a range of clinical

	areas, we will upskilling their digital knowledge over the coming months.
• Delayed delivery of the digital patient notes programme	• Resourcing required to increase activity and accelerate completion of the programme • Timeframe: 2-3 year programme of work.
• No function within CTMUHB focussing on benefits realisation	• ~~This function is identified within the Digital Transformation function which will be developed during 2023/2024. Now needs to be resourced as the Health Board moves into 2024-2025.~~ • There are no dedicated benefits realisation resource however the function will form part of the wider Digital Transformation team as part of business analysis and business change roles.
• Limited progress to reduce/remove paper processes and move to a fully integrated digital patient record	• Scoping of a business case to implement an integrated health record complemented by a digitally enabled patient centred contact programme is now the focus for the Digital and Data team. ~~The March 2024 Board Development session was provided a clear action to develop a strategic outline for the July 2024 Board.~~ The July 2024 Board approved the recommendation to proceed with the preparation of relevant documentation to procure a strategic partner to support and deliver a modular electronic patient record. • National data resource programme has delivered University Health Board's clinical data resource, which supports capture and transfer of clinical information in line with common language, terminologies and standards. • Proposal being made to the Digital Services for Patients & the Public which will enable the use of the NHS Wales patient portal and secure, authenticated digital communications between patients and clinicians in line with technical, information and clinical safety standards. Timeframe: 2-3 year programme of work.
• Recruitment challenges due to short term funding allocations leading to an increased use of contracting arrangements.	• Work completed to understand substantive baseline. Need to prioritise recruitment of new roles aligned to Health Board Integrated Medium Term Plan (IMTP). Timeframe: Additional resources are being added to the team this year however

	recurrent funding is still a challenge for some of the National Programmes.
• Information Commissioner Office (ICO) Audit planned to be completed March 2023.	• Mitigated - ICO have signed off their audit engagement with CTMUHB as completed and satisfied sufficient plans are in motion.
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	• Risk relating to the removal of the current video consultation solution has been identified – current arrangements have been extended to March 2025 • The contract for ePrescribing in Secondary Care has now been signed. The delivery programme will be formally launched in September 2024. • Digital and Data team are supporting the procurement of Regional Diagnostic Hub at the LHP site. • The rollout of new desktop PCs, replacing older thin client devices is continuing. • The rollout of new Wireless Access Points is almost complete in Princess of Wales (POW). Further rollout is planned for the wider Bridgend locality providing the more advanced Wi-Fi network across the Health Board. • The patient contact and medical records transformation business case has been finalised and ongoing discussion with WG regarding next steps. • The team are supporting Critical Care services in determining way forward for a single digital system across CTMUHB, we are awaiting a decision from the Board regarding expansion of the current system. • Progress continues to be made with Bridgend disaggregation programme with a further consolidation of clinical systems. WPAS merger is on track to deliver in May 2025. • Good process is being made disaggregating the telephone infrastructure in Bridgend from Swansea Bay, giving us having control over the whole service in that locality. • LIMS2 and RISP national projects are progressing to plan and are expected to deliver to the current project timelines.
Were there any significant incidents affecting this strategic Risk this period:	
Critical incidents under NIS-D:	

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, LIMS Programme, by summer 2025.	20
4664	Ransomware attack resulting in loss of critical services and possible extortion	20
5669	Increased cost of Citrix Subscription.	16
4337	Integrated Patient Records across the Health Board	16
4671	NHS Computer Network Infrastructure unable to meet demand	16
3337	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	15
4672	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards	15
5040	Digital Healthcare Wales (DHCW interdependencies	15
5761	• Cross Health Board Data Sharing - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 16.	

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INSPIRING PEOPLE	**Strategic Goal: Inspiring People** • Viable and inspiring leadership • Promoting diversity and inclusion • Embedding our values and behaviours • Encouraging local employment	Risk score 12

Strategic Risk: Leadership and Management – (Risk No.6)

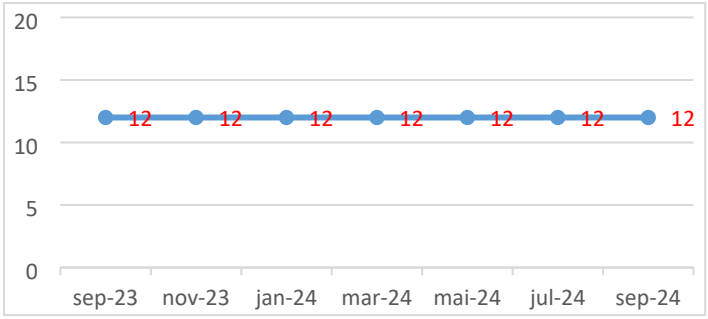
If we fail to provide compassionate and effective leadership at all levels of the organisation and all professions to empower and enable our workforce	*Then* there will be lack of confidence to enable informed decision-making at the appropriate level and to implement organisational change	*Resulting 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
Initial	4	4	16
Current	4	3	12
Target	4	2	8
Risk Appetite	Cautious *(assets; trust and confidence)*		

Risk Score Trend this Period:

No change to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score:
Including where risk score remains unchanged and for any changes

The Health Board is emerging from the Phase 1, 2 and 3 Organisational Change Programmes (OCP) that have seen CTMUHB move from a locality-based model, to one that operates services on a pan-CTM basis. We recognise through the OCP lessons learned, and through workforce metrics and surveys that we still need to work on developing our leadership capability. We need to make clear what good leadership looks like and ensure there is support to enable implementation in order to deliver on our IMTP objectives.

In recognition of the controls set out under this risk, and with new programmes and tools launching into the system imminently, it is likely that the risk score of 12 will be reviewed in the next submission. This will be with a view to

	lower the score, in light of the launch of key control measures and further programmes of work.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	The risk will continue to be treated, as the Health Board strives to set the underpinning principles, initiatives and frameworks that shape and inform leadership at CTM.

Risk Lead	Executive Director for People	Assurance committee	People and Culture

Controls	Assurances reported to Board and committees
Leadership Development • CTM Leadership Hub developed on HEIW's Gwella portal, providing an inclusive and centralised space for staff to access in-house and HEIW's leadership development offer. • Ignite: Leading Self programme available to all staff via Gwella, developing the essential skills that underpin management. • Inspire: Leading Systems Cohort 1 launching September 2024, with approx. 40 Care Group Leads. • 360 Feedback Module procured via HEIW for use throughout leadership development offer, starting with Inspire Cohort 1. • Work ongoing to scope and design a wider leadership development offer, building micro-credentials to align to 'leading self, others and systems' alongside the 8 leadership competency areas. • HEIW Compassionate Leadership train the trainer event attended with Michael West, with L&D now planning to embed programme into leadership development offer. • Board Development Session 24th August 2023 – Compassionate Leadership. • Learning partnerships with University of South Wales, the Institute of Leadership and Management, HEIW, The Kings Fund and Academi Wales • Establishment of Leadership Coaching & Mentoring Network • Specific & targeted leadership development work within specific services, e.g. Maternity, Nursing, Medics	Internal Assurances • Inspiring People Board established and scheduled for each quarter • Workforce and Organisational Development metrics report • Employee Relations Update • Medical Workforce and Efficiency Report • Statutory and Mandatory Training Compliance Report • Targeted intervention process incorporated as business as usual. • Annual Wellbeing surveys undertaken, last one launched in May 2023. • Internal Audit took place in January 2024, with action plan created to meet requirements • PDR – *Your Conversation* training package launched October 2022 and being expanded into 2024 • Living Wage Employer Status – achieved in February 2023. • Disability Competent Leader awarded in February 2023 for a further three years. External Assurances • Teaching Hospital status renewal • Corporate Health Standard Gold accreditation received in February 2023. Platinum assessment achieved in March 2023, awards will be retained for the next three years following which the awards will cease to exist. • National Staff Survey closed December 2023, awaiting results from HEIW • Improved levels of leadership accreditation in staff gaining external qualifications (ILM/CMI).

• Training development between DoTHS and University of South Wales to deliver identified leadership priorities for AHP & HCS leads. Training now underway for 2024. • Leadership Competency Model has now been developed and aligned to Values & Behaviours, the evidence review and wider Culture work; with input from Subject Matter Experts for each categories. This will then form the basis of the revised leadership development programmes which includes psychometric testing. Leadership Engagement with the workforce • Leaders Headlines Briefing issued by the Director of Communication, Engagement & Fundraising. • Local Partnership Forum • Local Negotiation Committee (medical and dental) • Clinical Advisory Group • Staff Q&A with the Chief Executive via MS Teams • CEO and Senior People Team meetings with Trade Union partners held on a monthly basis. Employee Wellbeing • Employee Experience Programme • Emotional Wellbeing Care Pathway • Occupational Health Services • Employee Assistance Programme • Staying Well Plans as part of the PDR Your Conversation meetings • Financial Wellbeing Care Pathway • Wellbeing surveys (Annual)	
Gaps in Controls and Assurances	**Mitigating Actions**
• Full implementation of leadership development programmes and embedding in practice	• Working with Executive and Care Group teams to drive accountability and uptake of programmes across the Care Groups, integrating with local development plans in-line with Phase 2 organisational restructure. • Working with HEIW ongoing to improve engagement data in order to drive accountability.

• Measuring impact of Organisational Development interventions	• Quantitative data around engagement and completion of the programmes is shared with Care Group/ Directorate Leads via the Heads of People on a monthly basis. • Evaluation of the leadership development offer is continuous, with an evaluation framework embedded into the programmes. This data supports the internal audit being out by Shared Services.
• Improved accessibility to leadership and management toolkits via an online repository, in partnership with HEIW.	• ~~L&D have designed and launched the new CTM Leadership Portal, in collaboration with HEIW and hosted on HEIW's Gwella site. This acts as a virtual central space for all leadership development activity within the Health Board.~~ Leadership Hub on Gwella provides access to all staff. • This includes facilitating all programmes via the Gwella Learning Management System, bringing an annual cost saving of £40k and further aligning the Health Board's offer to HEIW's resources. • The aim of this is to increase visibility and accessibility of CTM's leadership offer, whilst also providing a space to collaborate with other services to establish a wider range of leadership development pathways (e.g. managing wellbeing at work). • The Health Board also continues to inform the Compassionate Leadership resources being developed by HEIW.
Linked National Priority Measures	**Current Performance - Highlights**
Culture, Values and Behaviours • 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	This question is not specifically asked in the Wellbeing Survey. We know that, on average, 64% of referrals to Vivup are from Managers. Please refer to latest performance dashboard information under the people services section.
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

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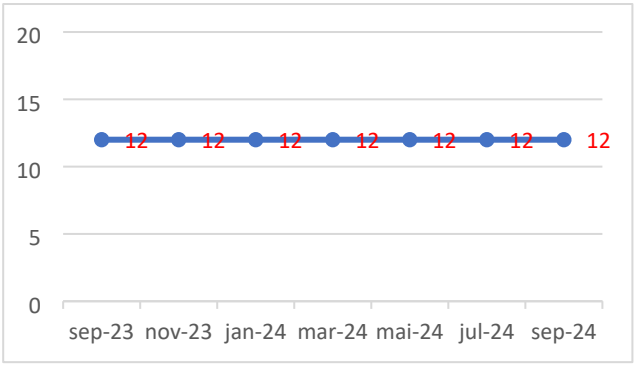
Strategic Goal: Inspiring People • Viable and inspiring leadership. • Promoting diversity and inclusion. • Embedding our values and behaviours. • Encouraging local employment		Risk score 12
Strategic Risk: Culture, Values and Behaviours – (Risk No.7)		
If the Health Board fails to put the values of the 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
Initial	4	4	16
Current	4	3	12
Target	4	2	8
Risk Appetite	Cautious *(assets; trust and confidence)*		

Risk Score Trend this Period:

No change to risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The score remains unchanged although progress continues to be made as the Health Board's work on Culture, including values and behaviours becomes more defined with a focus on how we are working to address inequalities within CTMUHB.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through the expansion of programmes of work that supports culture change – this is following a Culture Current State Analysis which was undertaken during the Summer 23 and a framework for a draft Culture Plan developed. Strategic Equality Plan (SEP) consultation now closed and action plan has been signed off by the Board in March 2024 and subsequently published. The SEP underpins the health board's strategic goals and aims to create an inclusive environment that welcomes diversity

	and helps to build a workforce that better represents our communities.

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. • Emerging Culture Plan. • Equality, Diversity and Inclusion Working Group chaired by Linda Prosser (Exec Director for Strategy and Transformation) • Restorative Just and Learning Working Group, Chaired by Lauren Edwards (Exec Director of Therapies). • Strategic Equality Plan including alignment to Welsh Language Plan • Raising Concerns Procedure. • All-Wales work to promote speaking up safely, led by the Director of Corporate Governance / Board Secretary. Speaking up Safely program aligned with Restorative, Just and Learning WG – June 2024. ~~Currently with WG – expectation is to launch in autumn 2023.~~ Communication and Engagement re: values & culture • Stakeholder Analysis was undertaken in Autumn 23 to support emerging culture work~~the emerging work around the Culture Plan~~. • Soft launch of Restorative, Just and Learning principles with Speak Up Safely Launch in October 2023 undertaken. • ~~Speaking Up Safely Programme to be more closely embedded with the Restorative Just and Learning work.~~ • Developed Inclusion Communication Plan with monthly topic focus, which is currently being rolled out. Putting Values into Practice	• National Staff Survey was conducted in autumn 2023 with results published in spring 2024. Due to be repeated on October 2024 • Annual Wellbeing Survey (Follow Up survey timing to be confirmed). • Values and Behaviours Update. • Equality Annual Report. • Gender Pay Gap Report. • Workforce Race Equality Standards. • Strategic Equality Plan. • Welsh Language Standards Annual Report • Living Wage Accreditation awarded in February 2023.

• Values Based Recruitment has been picked up by the Attraction and Resourcing Lead. • Suite of values-based resources and activities for managers and staff on SharePoint – further review of behaviours to ensure alignment to emerging culture work ~~new draft culture plan~~ • ~~Desk based review of behaviours have been undertaken to ensure alignment to new draft culture plan; this will link to the leadership competency model~~. • Review of behaviours undertaken to ensure alignment to emerging culture work; this will link to the leadership competency model. Newly adapted behaviour statements to be socialised with wider stakeholders for feedback. • Delivered x7 Cultural competency workshops over 5 areas: Executive Team, Strategy & Transformation, People Directorate, Mental Health & Learning Disability, ICTM • Deliver Cultural Competency Workshops to 3 further areas identified – (Legal & Complaints; Patient Safety; Patient Experience) and an additional 3 areas (yet to be confirmed in discussion with Heads of People and Care Groups) –completed by March '24 • Dedicated support allocated for the completion of the Cultural Competency workbooks for all 11 areas by Dec '24. Seeking Silver accreditation from Diverse Cymru in 2025. • Developing internal Cultural Competency programme by Q1 24/25and deliver internal programme from Q2 24/25. • Delivery commenced on the Educational offer to support ~~Culture Plan~~ emerging culture work responding to WG NHS Anti-Racist Wales Action Plan; LGBTQ+ Action Plan, Gender Equality & Disability Action Plans. • Developed framework to support Staff Networks and attended key events to support under-represented groups to raise awareness and deliver education. Developed Joint Chair Network; and supporting infrastructure of network	

• Developed workshop on Inclusive Thinking and Practice as a Leader to be delivered-as well as an Introduction to Restorative, Just & Learning Principles. • Developed and delivered pre-employment workshops for our minority ethnic community; engaging with community partners to support with recruitment and entry into the Health Board in collaboration with L&D. • Completion of the Affina OD training programme providing team effectiveness, diagnostics through newly qualified cohort of 8 practitioners. Separate Affina qualification for 12 further practitioners due to be completed by Sept 2024 Deployment of diagnostic tool underway.	
Gaps in Controls and Assurances	**Mitigating Actions**
• Themes from culture current analysis shows further work in role-modelling and embedding values and behaviours is required	• Developed a Values & Behaviours work plan that looks at: review of current behaviours framework; update current resources and tools; update current education and support offer; looking at impact and sharing good practice; linking and aligning to emerging Culture Plan
• Empowering staff to feed back on, or challenge behaviour which is inconsistent with the organisation's values	• Further work ongoing in collaboration with Staff Network Groups. • Speak up Safely Campaign launched in Oct 2023 and further alignment to the Restorative Just and Learning Approach. • Restorative; Just & learning approach launch (soft) in Oct 2023. • Targeted work on Staff survey for 2023 to support developing a baseline for Culture Plan. High level priorities identified with associated action plans in development. • Dedicated education and leadership offering around managing behaviours and conflict; restorative conversations and providing feedback through the emerging Culture programme.
• Cultural Health Check diagnostic tool now been superseded by the Affina OD diagnostic model	• National Staff Survey complete and results made available from May 2024 with action planning now taking place.
• Current Strategic Equality Plan (SEP) has been updated to align with the changing national context.	• The Strategic Equality Plan (SEP) has been approved at the Board and now published. Action complete and will be removed.
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)	NHS Staff Survey 2023 results demonstrated a 71% engagement score based on an 18.1% return rate. CTMUHB was the only Health Board in Wales to not see a reduction in engagement score. 61.65% of the organisation have had a PDR/Appraisal within the last 12 months.

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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SUSTAINING OUR FUTURE	**Strategic Goals: Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value based healthcare • Ensuring our estate is fit for the future	Risk score 16

Strategic Risk: Fulfilling our Environmental and Social Duties and ambitions (Risk No.8)

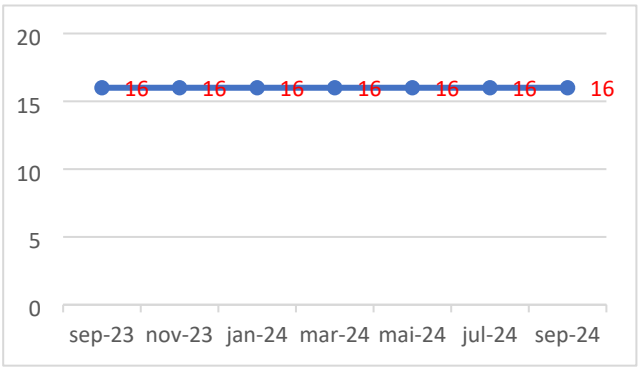
If the Health Board's decisions fail to reflect our values or consider the long-term environmental or social impact	*Then* we will not fulfil our Socio-economic duty, our Wellbeing of Future Generations objectives and our value-based healthcare principles	*Resulting in* negative environmental and social impacts, and loss of trust and confidence among stakeholders

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(assets; trust and confidence)* Open *(estates)*		

Risk Score Trend this Period:

No change to risk score.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce and financial capacity constraints, which limits the available investment into the environmental infrastructure.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however, ongoing risk treatment activity outlined in the mitigating actions section particularly around the Climate Adaption Plan.

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 Environmental Sustainability Group as part of transformation 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 • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases • Sustainable Health Care delivered a workshop to Board Members in March 2023. • Decarbonisation Action Plan in place. • Appointed a full time permanent Sustainability Manager	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. Independent Assurance NWSSP Internal Audit Services review of Decarbonisation Action Plan delivery and compliance is underway. All Health Boards are subject to this review. Outcomes will be reported to the appropriate committee and associated actions added to the strategic risk as appropriate.
Gaps in Controls and Assurances	**Mitigating Actions**
• Climate Adaption Plan (moving away from mitigation)	• Climate/Environmental Adaption Plan proposal went to Executive Leadership Group in July 2023 who accepted recommendations that the Health Board develop a Climate/Environmental Adaption Plan. Environmental Sustainability Group established a sub group to undertake this work and this has now commenced. This work aligns with PSB Climate Change Risk Assessment in the region
• Dedicated resource to manage and deliver Net Zero programme across the whole Health Board.	• 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. The Health Board recognises that that there is a risk that the pace of change may slow in light of the current financial environment and challenges faced. Team restructure.
• Procurement framework to reduce carbon footprint of goods and services purchased from outside the organisation.	• Procurement team part of Environmental Sustainability Group and wider decarbonisation networks. Ongoing. Pace of progress likely to be slowed as financial considerations become more dominant.
• Mapping against 'More Equal Wales' guidance for Socio-economic Duty which came into effect in April 2021.	• To include as discussion point as part of Building Healthier Communities work moving forward, including public health involvement. Ongoing.
• 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.	• CTMUHB Financial Care Wellbeing Pathway launched to support the workforce recognising the impact of the cost of living increase impacting our workforce and population. Ongoing.
Linked National Priority Measures	**Current Performance - Highlights**
Economy and Environment • Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach • Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan • 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	Quarter 4 reporting against the Decarbonisation Action Plan completed and submitted by the 30th April 2024. Next return due April 2025. Annual Carbon Plan report September 2023. Completed – submitted to Welsh Government. Next one due September 2024.

Were there any significant incidents affecting this strategic Risk this period:

Nil

Associated Risks from the Organisational Risk Register

Risk no.	Description	Current score
5374	Fulfilling our environmental and social duties. New risk escalated March 2023.	16

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Strategic Goal: Creating Health • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation	Risk score 20

Strategic Risk: There will be a decrease in Healthy Life Expectancy (HLE) and an increase in the gap between the most and least deprived and an unsustainable health service. (Risk No.9)

If the Health Board does not effectively shift its services to prevention and early intervention and engage the population to improve their health	*Then* we will fail to improve healthy life expectancy and reduce inequalities in healthy life expectancy	*Resulting in* poorer health outcomes, greater inequalities and an unsustainable health service.

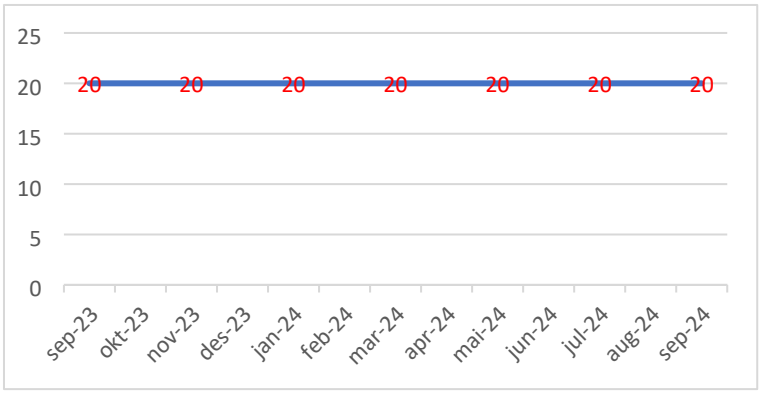
	Consequence	Likelihood	Score
Initial	5	4	20
Current	5	4	20
Target	4*	3	12
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change to risk score September 2024.

*The consequence score has reduced for the target score assessment, as there will be an element of both mitigation and adaptation. The Health Board aims to reduce the behaviour and health risks (primary, secondary, tertiary prevention), however, the organisation will still need to adapt as appropriate.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	Whilst not inevitable, the current trajectory indicates increasing health risks reduced healthy life expectancy and widening inequalities.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through programmes of primary, secondary and tertiary prevention across the health board, as well as in partnership with system partners to influence the wider determinants of health.

Risk Lead	Executive Director of Public Health	Assurance committee	Population Health and Partnerships

Controls	Assurances reported to Board and committees
Strategies & Plans • Welsh Government strategies/ plans: "Healthier Wales", "Healthy Weight Healthy Wales", "Smoke Free Wales". • CTM 2030 Strategy – 'Our Health Our Future' • Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021, updated November 2022. • Public Service Board – Well Being Plans. • Creating Health delivery plan under development. • CTM Health Protection Strategy under development • Development of Acute Clinical Service Plan (ACSP). Engagement Forums • CTM Creating Health Portfolio Board • Regional Partnership Board • Public Service Board • Area Partnership Board • CTM2030 Leaders Groups • Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well • Engagement with community groups by Lead Independent Members • 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. • CTM Health Protection Board • Welsh Government Health protection Operational and Resilience Group Needs Assessment & Consultation Processes • Population Segmentation & Risk Stratification • Pharmaceutical Needs Assessment	Wellbeing and socio-economic duties • Wellbeing Statement accompanying Annual Plan • Progress reports against the Annual Plan Reports to Board • Annual Director of Public Health Annual Report • Creating Health Portfolio Board reports to the transformation board Reports to Population Health & Partnerships Committee • Population Health Management Programme • Health Protection Programme • Vaccination Programme Reports • Regional Partnership Board Annual Report • Transformation Fund and Leadership Board Updates • Mental Health Strategic Update • ACSP updates provided to the Committee.

• Health Needs Assessments, e.g. Homeless People, Prison Health, staff wellbeing • Wellbeing Assessment (PSB) • Population Needs Assessment (Regional Partnership Board) • Formal consultation processes for service reconfiguration, e.g. vascular Organisational Structures • CTM Leaders Network • Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars • Primary Care clusters Services: • Integrated Level 2 and Level 3 Weight Management Services – established in September 2022. • Smoking Cessation Service • All hazards Health protection Service	
Gaps in Controls and Assurances	**Mitigating Actions**
Recurrent funding to support the development and implementation of the Acute Clinical Service Plan	Review of resource options underway.
Delay in developing health protection / immunisation capacity	Recurrent funding for 24/25 onwards now secured. All Hazards Health Protection plan in draft form. Development of a HP strategy and associated priorities.
Strategic Focus on prevention/ inequalities	CTM2030 strategy; Creating Health Portfolio board Creating Health Delivery Plan drafted in Q4 2023/24. Draft Health Protection Strategy.
Capacity for population health management	Population health management programme maturing alongside primary care clusters; implementation within health board Review of resource options underway, consideration for external short term capacity

	Work underway to consolidate a shared clinical record.
Impactful action to address health inequalities	• Whole system approach to Healthy weight • Help me quit/ hospital programme • WISE • Cancer inequalities group • Implementation of Stroke equity Audit recommendations. • HP intervention plan for vulnerable groups to be developed once HP posts recruited e.g. Prison health, vulnerable communities events • Vaccination equity strategic plan in place
Coherent prevention (1,2,3) for high burden diseases	Partnership work underway with PHW to address diabetes, with links to CVD, MSK etc.
Ability to influence wider system partners/ determinants of health	Engagement in partnership fora (RPB, PSB, Leaders groups)
Linked National Priority Measures	**Current Performance - Highlights**
Population Health – Ministers Measures Phase One • Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All Wales Weight Management Pathway • Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway • Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally. • Percentage of adult smokers who make a quit attempt via smoking cessation services Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates NHS Performance Framework Quadruple aim one: • Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	Please refer to Integrated Performance Dashboard - Quadruple Aim 1.

• Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 • Percentage uptake of the influenza vaccination amongst adults aged 65 years and over Percentage uptake of the COVID-19 vaccination for those eligible	

Were there any significant incidents affecting this strategic Risk this period:
No

Associated Risks from the Organisational Risk Register		
Risk no.	Description	Current score
5462	Adult weight management service - Insufficient capacity to meet demand	20
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	16
5726	Public Health Funding for Microbiology Testing New risk escalated to the Organisational Risk Register in May 2024.	15
5820	~~Reduced Health Protection Funding allocation 2024-2025~~ Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	12

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Strategic Goals: Sustaining our Future • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value based healthcare • Ensuring our estate is fit for the future	Risk score 16

Strategic Risk: Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG) – (Risk 10)

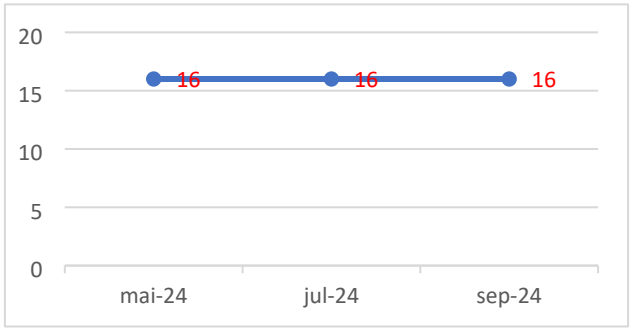
If the Health Board fails to plan and manage its revenue resources within the Revenue Resource limits set by WG.	*Then* we may fail to fulfil our two statutory financial duties (i.e. Approved IMTP and break even over 3 year period) and also the planned break-even position for 2024-25.	*Resulting in* inability to fund planned improvements and new services, and increased regulatory scrutiny and enforcement.

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	4	3	12
Risk Appetite	Minimal *(financial stability)* Cautious *(legal and regulatory)*		

Risk Score Trend this Period:

No change to the risk score this period.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The Health Board has submitted a balanced financial plan for 24/25 but this plan includes significant risks, including the delivery of £26.3m of efficiency savings.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	The financial plan highlights a number of significant risks for 24/25. This risk will therefore be *treated* until there is confidence that the Health Board can achieve the planned break even position.

Risk Lead	Executive Director of Finance	Assurance committee	Planning, Performance and Finance

Controls	Assurances reported to Board and committees
Financial Management • Financial Accountability letters issued by CEO. • Budget setting process and Budgetary control • Standing Financial Instructions • Scheme of Reservation & Delegation • Local Counter-Fraud Service • Monthly financial performance reviews for Care Groups and corporate directorates	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 & Risk Committee
Gaps in Controls and Assurances	**Mitigating Actions**
1. Understanding of budgetary control and procurement processes in some services	• Deliver budget holder training within Care Groups/Directorates – *Ongoing throughout 2024-2025.* • Deliver procurement training to departments where compliance with procurement processes is low - *Ongoing throughout 2024-2025.*
2. A recognised risk of shortfalls in savings delivery	• Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.
Linked National Priority Measures	**Current Performance - Highlights**
1. YTD position 2. Savings plan position	• The M4 position was a £1.5m deficit in month and the M4 YTD position is now a £4.1m deficit. • The main driver for the £4.1m YTD deficit is a £6.2m shortfall in savings delivery compared to the straight-line YTD savings target of £8.8m (£2.2m per month). This has been offset by £2.1m of other improvements. • As at M4 we are continuing to forecast a break even position for 24/25. However, the level of risks that the Health Board is

	now trying to manage has increased significantly in M4. A detailed review of these risks and associated recovery plan actions will be undertaken for the M5 Monitoring Return submission to WG. It is important to highlight that, at this stage, there is a significant risk that the 'In year' and 'Recurrent' forecasts could deteriorate in M5. • The net risks to the forecast break even position at M4 are estimated at £16.1m (M3: £9.2m).

Were there any significant incidents affecting this strategic Risk this period:
None

Associated Risks on the Organisational Risk Register		
Risk No.		
5764	Failure to achieve the planned break even position in 24/25 (New risk escalated to the Organisational Risk Register in May 2024)	16
5765	Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25. (New risk escalated to the Organisational Risk Register in May 2024)	16

Agenda Item
6.4

CTM Health Board

Effective Management of Board Business

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Directors and Independent Members	January to March 2024	No objections received
Audit Partners (Audit Wales and NWSSP Internal Audit)	January to March 2024	No weaknesses identified, areas to consider identified.
Welsh Government	January to March 2024	No weaknesses identified, areas to consider identified.
CTM Public Board Meeting	28th March 2024	Approved the development of the new structure

Committee / Group / Individuals	Date	Outcome
Drafting and informal consultation with Executive Team and Independent Member colleagues including the Chair meeting 1:2:1 with Independent Members if required.	1st April 2024-30th June 2024	Comments and feedback captured
Executive Team Away Day	22nd July 2024	Draft documentation supported and commitment to finalise drafts.
IM Catch Up Chair / CEO Meeting	29th August 2024	Progress update noted and draft documentation shared for comment
Email circulation of final drafts shared with all Board Members	5th September 2024	Any comments received were incorporated into the final documentation.
Board Development Session	11th September 2024	Final documentation shared and remaining comments captured. Endorsed for Board approval.

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Chair commissioned a review of the effectiveness of Board Business, which commenced in January 2024.

1.2 The aim of the review was to ensure Board and Committee business is managed in the most effective and efficient manner within the Health Board whilst ensuring clear alignment to the Health Boards Strategic Goals, Values and Behaviours framework and Board Assurance Framework.

1.3 At the CTM Board meeting on the 28th March the Board approved the following proposal:

- The implementation of new Board Committee and Sub Committee Structure which was outlined in the proposal paper received.
- The responsibilities of all Board Members in terms of the approach to Board Development Sessions, Board Briefings and Agenda Planning.
- The next steps as outlined in section 23 of the proposal paper which was received.

1.4 Since the March Board meeting significant work has been undertaken to complete the 'next steps' activity and the purpose of this report is to present the new Board Committee Structure and 'Ways of Working' to the Board for formal approval.

1.5 It has been agreed that the implementation of the new structure and ways of working will be with effect from the 1st January 2025.

2. Specific Matters for Consideration

2.1 There has been significant engagement and consultation with all Board Members and this is illustrated on pages 1 and 2 of this report. Any comments and suggestions for amendment received during all consultation stages has been incorporated and feedback has been shared with respondents confirming the action that had been taken.

2.2 At the Board Development Session on the 11th September Board Members were provided with a detailed presentation summarising the activity to date and the finalised documents that are being presented to the Board for approval. Confirmation was sought that Board Members were sufficiently assured of the process undertaken to achieve the new Board Committee structure and endorse the new ways of working.

2.3 The Board are directed to the following appendices to this report which require formal approval to support the new structure:

- Minor amendments to the Standing Orders (Main Document) (Appendix 1)
- Terms of Reference (Schedules to the Standing Orders) for the following meetings: (Appendix 2 items d-m)

1. Audit Risk & Assurance Committee
2. Charitable Funds Committee
3. Mental Health Act Monitoring Committee (Sub Committee: Provision of Discharge (Hospital Managers) Sub Committee)
4. Operational Delivery Committee
5. Quality, Safety & Experience Committee (Sub Committees: Health, Safety & Fire Sub Committee & Organ Donation Sub Committee)
6. Strategic Development Committee
7. Remuneration & Terms of Service Committee

- A copy of the Board Assurance Framework report with Strategic risks assigned to the new Committee Structure. (Appendix 3).
- All Meetings will be published with the exception of those held in closed session and Remuneration & Terms of Service Committee, Organ Donation Sub Committee, Provision of Discharge Sub Committee, Clinical Advisory Group and Local Partnership Forum.

2.4 Whilst formal approval by the Board is not required on the following areas of activity, it is important for assurance purposes that the Board notes that the following documentation and actions have also been completed and shared at a number of intervals during the consultation process, lastly being at the Board Development Session on the 11th September 2024.

- That the table of Board and Committee Membership has been reviewed and updated to ensure key membership and quorum arrangements are known to all Board Members.
- Board and Committee Cycles of Business have been updated.
- Board and Committee report templates will be updated for use from the 1st January 2025.
- A revised approach has been agreed in relation to Board Development and Board Briefings with a refresh of defining the scope for those sessions and agree a programme of activity that is closely aligned to the strategic direction of CTM.
- Electronic Board System has been updated to reflect new Committee Structure for use from the 1st January 2025.
- CTMUHB's public facing website will be updated to reflect the new structures and membership changes.
- Template Agendas are available to support Committee Agenda Planning with clear scopes set and agreed for the format of agenda planning meetings.
- Annual meeting schedule updated with new dates and removal of legacy meetings.
- Legacy reports from any Committees no longer in the structure will be completed and received at the first meetings of the new Committee structure as appropriate capturing any actions that have not yet been completed.

- The risks on the Organisational Risk Register will be mapped to the new Committee Structure in readiness for the November iteration of the register.

3. Key Risks / Matters for Escalation

3.1 The consultation and engagement to date has recognised the concerns from some Board Members that a Committee restructure could de-stabilise the Board, create lengthy meetings and agendas, and lose visibility of key areas of business. Assurance has been provided on the steps taken to mitigate that risk and confirmation given that the revised Committee Structure will be reviewed formally in 12 months.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: This will be considered in the review of the suite of governance documents which will require review if the proposal is approved.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* Equality *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This will be considered in the review of the suite of governance documents which will require review if the proposal is approved.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	The Board needs to adopt a structure that delivers trust and confidence in Health Board leadership.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	As outlined in the report there are capacity and resource impacts as a result of this proposal.	

5. Recommendation

5.1 The Board are asked to CONSIDER if this proposal has been managed in a manner that demonstrates good governance and provides assurance that the implementation will be managed effectively and efficiently with appropriate review points.

5.2 The Board are also asked to APPROVE:

- Minor amendments to the Standing Orders (Main Document) identified in red (Appendix 1).
- Terms of Reference (Schedules to the Standing Orders) for the following meetings: (Appendix 2 items d-m)
  - Audit Risk & Assurance Committee
  - Charitable Funds Committee
  - Mental Health Act Monitoring Committee (Sub Committee: Provision of Discharge (Hospital Managers) Sub Committee)
  - Operational Delivery Committee
  - Quality, Safety & Experience Committee (Sub Committees: Health, Safety & Fire Sub Committee & Organ Donation Sub Committee)
  - Strategic Development Committee
  - Remuneration & Terms of Service Committees

- A copy of the Board Assurance Framework report with Strategic risks assigned to the new Committee Structure. (Appendix 3).
- A variation to the Standing Orders in terms of the publication of Board Committee, Sub Committee and Advisory Group papers due to the exclusion of some papers being published. The approach agreed is that all meetings will be published on the Health Boards public facing website with the exception of those held in closed session and the Remuneration & Terms of Service Committee, Organ Donation Sub Committee, Provision of Discharge Sub Committee, Clinical Advisory Group and Local Partnership Forum due to the sensitive (business and otherwise) and potentially identifiable documentation discussed.

5.2 The Board are asked to NOTE the following activity:

- That the table of Board and Committee Membership has been reviewed and updated to ensure key membership and quorum arrangements are known to all Board Members.
- Board and Committee Cycles of Business have been updated.
- Board and Committee report templates will be updated for use from the 1st January 2025.
- A revised approach has been agreed in relation to Board Development and Board Briefings with a refresh of defining the scope for those sessions and agree a programme of activity that is closely aligned to the strategic direction of CTM.
- Electronic Board System has been updated to reflect new Committee Structure for use from the 1st January 2025.
- CTMUHB's public facing website will be updated to reflect the new structures and membership changes.
- Template Agendas are available to support Committee Agenda Planning with clear scopes set and agreed for the format of agenda planning meetings.
- Annual meeting schedule updated with new dates and removal of legacy meetings.
- Legacy reports from any Committees no longer in the structure will be completed and received at the first meetings of the new Committee structure as appropriate capturing any actions that have not yet been completed.
- The risks on the Organisational Risk Register will be mapped to the new Committee Structure in readiness for the November iteration of the register.

6. Next Steps

6.1 The Corporate Governance Team will work with Board Members to implement the new arrangements from the 1st January 2025.

Standing Orders

Reservation and Delegation of Powers

For Cwm Taf Morgannwg University Health Board

Adopted from the Model Standing Orders and Standing Financial Instructions issued by Welsh Government in April 2021

Date approved:	*Pending 26th September 2024*
Approved by:	Health Board
Review date:	Annual
Version:	6
Responsible Director:	Director of Corporate Governance/Board Secretary
Distribution:	Board Members All staff
FOI Status:	Open

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Local Health Boards (LHBs) in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs LHBs must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

These SOs are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of decisions reserved to the Board; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the LHB.

These documents form the basis upon which the LHB's governance and accountability framework is developed and, together with the adoption of the LHB's Values and Standards of Behaviour framework known as the Standards of Behaviour Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the LHB.

Further information on governance in the NHS in Wales may be accessed at: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

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The following Schedules which support the Standing Orders are held separately to this main Standing Orders Document. These are:

- **Schedule 1 Scheme of Reservation and Delegation of Powers**
- **Schedule 2 Key Guidance Instructions and Other Related Documents**
- **Schedule 2.1 Model Standing Financial Instructions for LHB's**
- **Schedule 3 Board Committee**
- **Schedule 4 Joint Committee Arrangements**
- **Schedule 5 Advisory Group Terms of Reference**

Section A – Introduction

Statutory framework

i) On 1 April 2019 following the transfer of the principal local government area of Bridgend from Abertawe Bro Morgannwg University Local Health Board to Cwm Taf University Local Health Board as a result of the **Local Health Boards (Area Change) (Wales) Miscellaneous Amendments) Order 2019** Abertawe Bro Morgannwg University Health Board was renamed Swansea Bay Local Health Board/Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Local Health Board.

ii) The principal place of business of the LHB is – Ynysmeurig House, Navigation Park, Abercynon, CF45 4SN

iii) All business shall be conducted in the name of Cwm Taf Morgannwg University LHB, and all funds received in trust shall be held in the name of the LHB as a Corporate Trustee.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how LHBs are governed and their functions.

v) Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made **the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779)** ("The Constitution Regulations") which set out the constitution and membership arrangements of LHBs, which includes a requirement for LHBs to make SOs for the regulation of its proceedings and business including provision for the Boards suspension.

vi) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHB's statutory functions are set out in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009 (S.I. 2009/1511).**

vii) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven LHBs in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:

(a) Specialised services for –
(i) Cancer and blood disorders,
(ii) Cardiac conditions,
(iii) Mental health and vulnerable groups,
(iv) Neurosciences, and
(v) Women and children,
(b) Services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
(c) Emergency medical services,
(d) Non-emergency patient transport services,
(e) Emergency medical retrieval and transfer services,
(f) NHS 111 services,
(g) Sexual assault referral centres, and
(h) Other services as directed by the Welsh Ministers.

Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **National Health Service Wales Joint Commissioning Committee (Wales) Regulations 2024 (2024 No. 135 (W29))**, which make provision for the constitution and membership of the Joint Commissioning Committee, including its procedures and administrative arrangements.

viii) In addition to directions the Welsh Ministers may from time to time issue guidance which LHBs must take into account when exercising any function. However in some cases the relevant function may be contained in other legislation. In exercising their powers LHBs must be clear about the statutory basis for exercising such powers.

ix) As a statutory body, the LHB has specified powers to contract in its own name and to act as a corporate trustee. The LHB also has statutory powers under sections 194 and 195 of the NHS (Wales) Act 2006 to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

x) The **National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-**

being (Wales) Act 2014 (2014).

xi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xiii) Further duties and powers placed on health boards in relation to co-operation and partnership with local authorities and other partners in Wales are set out in the **Social Services and Well-being (Wales) Act 2014**. This Act establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs in order to effectively plan and provide a sufficient range and level of care and support services. The **Partnership Arrangements (Wales) Regulations 2015 (2015/1989),** made under Part 9 of the **Social Services and Well-being (Wales) Act 2014** set out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services**.**

Guidance on the provisions of Part 9 can be found at https://gov.wales/sites/default/files/publications/2020-02/part-9-statutory-guidance-partnership-arrangements.pdf

xiv) The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (the 2020 Act) makes provision for:

Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);

- Ensuring NHS bodies and primary care services are open and honest with patents, when something may have gone wrong in their care (the Duty of Candour);
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of

the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) The Welsh Language (Wales) Measure 2011 makes provision with regards to the development of standards of conduct relating to the Welsh language. These standards replace the requirement for a Welsh Language Scheme previously provided for by Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xvii) LHBs are also bound by any other statutes and legal provisions which govern the way they do business. The powers of LHBs established under statute shall be exercised by LHBs meeting in public session, except as otherwise provided by these SOs.

NHS framework

xviii) In addition to the statutory requirements set out above, LHBs must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xix) Adoption of the principles will better equip LHBs to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xx) The overarching NHS governance and accountability framework incorporates these SOs; the Schedules of Reservation and Delegation of

Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxi) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015,** have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xxii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/ Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Local Health Board Framework

xxiii) Schedule 2 provides details of the key documents that, together with these SOs, make up the LHB's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxiv) LHBs will from time to time agree and approve policy statements which apply to the LHB's Board members and/or all or specific groups of staff employed by Cwm Taf Morgannwg University LHB and others. The decisions to approve these policies will be recorded in an appropriate Board minute and, where appropriate, will also be considered to be an integral part of the LHB's SOs and SFIs. Details of the LHB's key policy statements are also included in Schedule 2.

xxv) LHBs shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxiii below).

xxvi) For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members shall be referred to as Executive Directors and

Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SOs 1.1.2 refers.

Applying Standing Orders

xxvii) The SOs of the LHB (together with SFIs and the Values and Standards of Behaviour Framework – the Standards of Behaviour Policy will, as far as they are applicable also apply to meetings of any formal Committees established by the LHB, including any Advisory Groups, sub-Committees, joint-Committees and joint sub-Committees. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs and further details on joint-Committees may be found in Schedule* 4.

xxviii) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit and Risk Assurance Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and LHB officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

xxix) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxx) Although these SOs are subject to regular, annual review by the LHB, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 15 of the Constitution Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit and Risk Assurance Committee and is the subject of a formal report to the Board; and
- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxi) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the LHB shall have the final say,

provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

xxxiii) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within LHBs, and is a key source of advice and support to the LHB Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within the LHB. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of LHB business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the LHB's compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers;

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

xxxiv) Further details on the role of the Board Secretary within Cwm Taf Morgannwg University LHB, including details on how to contact them, are available on the Cwm Taf Morgannwg website (Board Members - Cwm Taf Morgannwg University Health Board (nhs.wales)

Section B – Standing Orders

1. THE LOCAL HEALTH BOARD

1.0.1 The LHB's principal role is to ensure the effective planning and delivery of the local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

1.0.2 The LHB was established by the **Local Health Boards (Establishment and Dissolution) (Wales) Order 2009** (S.I. 2009/778) and most of its functions are contained in the **Local Health Boards (Directed Functions) (Wales) Regulations 2009** (S.I. 2009/1511). The Establishment Order was amended in 2019 to reflect the Local Health Boards (Area Change) (Wales) (Miscellaneous Amendments) Order 2019 which changed the areas of Cwm Taf University Local Health Board and Abertawe Bro Morgannwg University Local Health Board and also changed their names. The principal local government area of Bridgend transferred from Abertawe Bro Morgannwg University Local Health Board and forms part of the area of Cwm Taf University Local Health Board from 1 April 2019 onwards. Abertawe Bro Morgannwg University Local Health Board was renamed Swansea Bay University Local Health Board and Cwm Taf University Local Health Board was renamed Cwm Taf Morgannwg University Health Board. The Amendments giving effect to these changes were made to the Local Health Boards (Establishment and Dissolution) (Wales) Order 2009 and the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. The LHB must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.

1.0.3 To fulfil this role, the LHB will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Local Health Board

1.1.1 The membership of the LHB shall be no more than 24 members comprising the Chair, Vice Chair, non-officer members (appointed by the Minister for Health and Social Services), Associate Members, the Chief Executive (appointed by the Board with the involvement of the Chief Executive, NHS Wales) and officer members (appointed by the Board).

1.1.2 For the purposes of these SOs, the members of the LHB shall collectively to be known as "the Board" or "Board members"; the officer and non-officer members (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. Officer and non-officer

members shall have full voting rights. Associate Members do not have voting rights.

Officer Members [to be known as Executive Directors]

1.1.3 A total of 9 (including the Chief Executive), appointed by the Board, whose responsibilities include the following areas: Medical; Finance; Nursing; Primary Care and Community and Mental Health Services; Strategic and Operational Planning; Workforce and Organisational Development; Public Health; Therapies and Health Science. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.

Non Officer Members [to be known as Independent Members]

1.1.4 A total of 9, appointed by the Minister for Health and Social Services, including: an elected member of a local authority whose area falls within the LHB area; a current member or employee of a Third Sector organisation within the LHB area; a trade union official; a person who holds a post in a University that is related to health; and five other Independent Members who together have experience and expertise in legal; finance; estates; Information Technology; and community knowledge and understanding.

1.1.5 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Associate Members

1.1.6 A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights.

1.1.7 No more than three Associate Members may be appointed by the Minister for Health and Social Services. This may include:

- Director of Social Services (nominated by local authorities in the LHB area)
- Chair of the Stakeholder Reference Group
- Chair of the Healthcare Professionals' Forum

1.1.8 The Board may appoint an additional Associate Member to assist in carrying out its functions, subject to the agreement of the Minister for Health and Social Services.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice Chair
- Non Officer Members

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the LHB is shared between more than one person because of their being appointed jointly to a post:

i) Either or both persons may attend and take part in Board meetings;
ii) If both are present at a meeting they shall cast one vote if they agree;
iii) In the case of disagreement no vote shall be cast; and
iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

1.3.3 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.4 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are

applicable, as specified in Schedule 2 of the Constitution Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.5 The LHB will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the LHB Board and responsibilities of individual members

Role

1.4.1 The principal role of the LHB is set out in SO 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 LHB's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 Associate Members, whilst not sharing corporate responsibility for the decisions of the Board, are nevertheless required to act in a corporate manner at all times, as are their fellow Board members who have voting

rights.

1.4.6 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the LHB within the communities it serves.

1.4.7 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.8 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.9 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.10 In addition to their corporate role across the breadth of the Board's responsibilities, the Vice-Chair has a specific brief to oversee the LHB's performance in the planning, delivery and evaluation of primary care, community health and mental health services ensuring a balanced care model to meet the needs of the population within the LHB's area.

1.4.11 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the LHB. They are the appointed Accountable Officer for the LHB and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.12 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the LHB, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF LHB FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i) Schedule of matters reserved to the Board;
ii) Scheme of delegation to committees and others; and
iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2.(i)) to Committees and others, setting any conditions and restrictions it considers necessary and following any directions or regulations given by the Welsh Ministers. These functions may be carried out:

i) By a Committee, sub-Committee or officer of the LHB (or of another LHB or Trust); or

ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
iii) Jointly with one or more bodies including local authorities through a joint-Committee, sub-Committee or joint sub-Committee.

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees, sub-Committees, joint-Committees or joint sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 LHB Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the LHB 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. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term 'Committee'

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- joint-Committee
- sub-Committee

- joint sub-Committee

unless otherwise stated. The Board's Advisory Groups are referred to separately.

3.2 Joint Committees

3.2.1 The Board may, and where directed by the Welsh Ministers must, together with one or more LHBs or NHS Trusts or the local authorities operating within the LHB's area, appoint joint-Committees or joint sub-Committees. These may consist wholly or partly of the LHB's Board members or Board members of other health service bodies or of persons who are not LHB Board members or Board members of other health service bodies. Any such appointments must be made in accordance with the Board's defined requirements on membership (including definition of member roles, powers and terms and conditions of appointment) and any directions given by the Welsh Ministers.

3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.

3.2.3 The Board shall establish, as a minimum, the following joint-Committee(s):

- The National Health Service Wales Joint Commissioning Committee (JCC)

Joint Committee Standing Orders, terms of reference and operating arrangements

3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);
- Any budget, financial and accounting responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.

3.3 Sub-Committees

3.3.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.4 Committees established by the LHB

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

3.4.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity; and
- Maximise cohesion and integration across all aspects of governance and assurance.

3.4.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board its Committees and Advisory Groups)
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.4.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.4.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the LHB Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the LHB Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the LHB.

3.4.6 Executive Directors or other LHB officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated LHB officers shall, however, be in attendance at such Committees, as appropriate. The only exception to this position is the Charitable Funds Committee where all Board Members form the Corporate Trustee.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.5 Other Committees

3.5.1 The Board may also establish other Committees to help the LHB in the conduct of its business.

3.6 Confidentiality

3.6.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.7 Reporting activity to the Board

3.7.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre University NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261) ("the Shared Services Regulations") require the Velindre NHS Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs and Trusts setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre University NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The LHB has a statutory duty to take account of representations made by persons and organisations who represent the interests of the communities it serves, its officers and healthcare professionals. To help discharge this duty, the Board may and where directed by the Welsh Ministers must, appoint Advisory Groups to the LHB to provide advice to the Board in the exercise of its functions.

5.0.2 The LHB's Advisory Groups include a Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum. *The membership and terms of reference for these groups are set out in Schedule 5.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise

it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Terms of reference and operating arrangements

5.1.1 The Board must formally approve terms of reference and operating arrangements for the Advisory Groups. These must establish the governance arrangements and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the LHB Board, its Committees and Advisory Groups) as well as other relevant local and national groups);
- Any budget and financial responsibility;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.1.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements are set out in Schedule 5.

5.1.3 The Board may determine that the Advisory Group shall be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.2 Support to the Advisory Groups

5.2.1 The LHB's Board Secretary, on behalf of the Chair, will ensure that the Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the LHB and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see Schedule 5.3, paragraph 1.7.1);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;

- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.3 Confidentiality

5.3.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.4 Advice and feedback

5.4.1 The LHB may specifically request advice and feedback from the Advisory Groups on any aspect of its business, and they may also offer advice and feedback even if not specifically requested by the LHB. The Groups may provide advice to the Board:

- At Board meetings, through the SRG and CAG Chair's participation as Associate Members;
- In written advice;
- In any other form specified by the Board.

5.5 Reporting activity

5.5.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.5.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.5.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.6 THE STAKEHOLDER REFERENCE GROUP (SRG)

Role

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

- Early engagement and involvement in the determination of the LHB's overall strategic direction;

- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the LHB's operations on the communities it serves.

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

5.6.3 The SRG's role is distinctive from that of Llais, who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the LHB. Membership may include community partners, provider organisations, special interest and other groups operating within the LHBs area.

5.6.4 It does not cover those stakeholders whose interests are represented within the remit of other Advisory Groups established by the LHB, e.g., the Healthcare Professionals' Forum and Local Partnership Forum.

5.6.5 In addition to the provisions above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

5.7 Relationship with the Board

5.7.1 The SRG's main link with the Board is through the SRG Chair's membership of the Board as an Associate Member.

5.7.2 The Board may determine that designated Board members or LHB officers shall be in attendance at Advisory Group meetings.

The SRG's Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the LHB Chair.

5.7.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the SRG.

5.7.4 The Board's Chair shall put in place arrangements to meet with the SRG Chair on a regular basis to discuss the SRG's activities and operation.

5.8 Relationship between the SRG and others

5.8.1 The Board must ensure that the SRG's advice represents a balanced, co-ordinated stakeholder perspective from across the local communities served by the LHB. The SRG shall:

- Ensure effective links and relationships with other advisory groups,

local and community partnerships and other key stakeholders who do not form part of the SRG membership;

- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

5.9 Working with Llais

5.9.1 The SRG shall make arrangements to ensure designated Llais members receive the SRG's papers and are invited to attend SRG meetings.

5.9.2 The SRG shall work together with Llais within the area covered by the LHB to engage and involve those within the local communities served whose views may not otherwise be heard.

Refer to Schedule 5.1 for detailed Terms of Reference and Operating Arrangements

5.10 THE CLINICAL ADVISORY GROUP (CAG)

Role & Scope

5.10.1 The CAG will:

- Act as the clinical voice within CTMUHB.
- Work with and alongside Management Board and Executives and will be the representative voice of all clinical groups across the Health Board advising on clinical services and care.
- Provide a balanced, multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery.
- Facilitate engagement and debate amongst the wide range of clinical interests within CTMUHB's area of activity, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the CTMUHB's decision making.

5.10.2 The role of CAG does not include consideration healthcare professional terms and conditions of employment.

5.11 Terms of reference and operating arrangements

5.11.1 In addition to the provisions in 5.2.1 above the Board must set out, the relationships and accountabilities with others, as well as the National Professional Advisory Group.

5.12 Relationship with the Board

5.12.1 The CAG's main link with the Board is through the CAG Chair's membership of the Board as an Associate Member.

5.12.2 The Board may determine that designated Board members or CTMUB officers shall be in attendance at Advisory Group meetings. The CAG's Chair may also request the attendance of Board members or CTMUHB officers, subject to the agreement of the CAG Chair.

5.12.3 The Board shall determine the arrangements for any joint meetings between the CTMUHB Board and the CAG.

5.12.4 The Board's Chair shall put in place arrangements to meet with the CAG Chair on a regular basis to discuss the CAG's activities and operation.

5.13 Rights of Access to the LHB Board for Professional Groups

5.13.1 CTMUHB Chair, on the advice of the Chief Executive and/or Director of Corporate Governance (Board Secretary), may recommend that the Board afford direct right of access to any professional group, in the following, exceptional circumstances:

i) Where the CAG recommends that a matter should be presented to the Board by a particular healthcare professional grouping, e.g., due to the specialist nature of the issues concerned; or

ii) Where a healthcare professional group has demonstrated that the CAG has not afforded it due consideration in the determination of its advice to the Board on a particular issue.

5.13.2 The Board may itself determine that it wishes to seek the views of a particular healthcare professional grouping on a specific matter, in accordance with Standing Order 7.5.7.

5.14 Relationship with the National Professional Advisory Group

5.14.1 The CAG Chair (or CAG Vice-Chair) will not necessarily be a member of the National Professional Advisory Group and this is a position approved by the Board as variation to the model Standing Orders. CTMUHB will however, ensure at least one member of the CAG is a member of the National Professional Advisory Group who will act as the formal link between the two Groups.

Refer to Schedule 5.2 for detailed Terms of Reference and Operating Arrangements

5.15 THE LOCAL PARTNERSHIP FORUM (LPF)

Role

5.15.1 The LPF's role is to provide a formal mechanism where the LHB, as employer, and trade unions/professional bodies representing LHB employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the LHB - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the LHB's workforce.

5.15.2 It is the forum where the LHB and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.16 Relationship with the Board and others

5.16.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.16.2 The Board may determine that designated Board members or LHB staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or LHB staff, subject to the agreement of the LHB Chair.

5.16.3 The Board shall determine the arrangements for any joint meetings between the LHB Board and the LPF's staff representative members.

5.16.4 The Board's Chair shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.16.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 5.3 for detailed Terms of Reference and Operating Arrangements

6. WORKING IN PARTNERSHIP

6.0.1 The LHB shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers, e.g., the development of population assessments and area plans.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the LHB through:

- The LHB's own structures and operating arrangements, e.g.,

Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Regional Partnership and Public Service Boards – of Board members and LHB officers with delegated authority to represent the LHB and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (to be known as Llais)

6.1.1 Part 4 of the Health **and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs in relation to the engagement and involvement of Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the LHB to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

6.1.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.4 The 2020 Act also places a statutory duty on the LHB to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The LHB must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

6.1.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.6 In discharging these duties, the Board shall work constructively with Llais to ensure both organisations are able to discharge their duties. They will ensure their involvement in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and

- Engaging, formally consulting and working jointly within the LHB's area on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023.

  The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.7 The Board shall ensure that Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.8 The Board may determine that a designated Llais representative(s) shall be invited to attend Board meetings.

The Board shall ensure arrangements are in place for regular meetings between LHB officers and regional representatives of Llais.

6.1.9 The Board's Chair shall put in place arrangements to meet with the Regional Director and relevant representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The LHB's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The LHB, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested or required) and in electronic formats;
- Requesting that attendees notify the LHB of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011 .

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the communities served by the LHB, including any views expressed formally to the LHB, e.g., through the SRG or Llais.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the LHB to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

7.2.5 The LHB must hold an AGM in public no later than the 31 July each year [Note: no later than 30 September 2023 for year 2022/2023]. At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the LHB's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the LHB are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the LHB. The

Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 7.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the LHB's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The LHB shall encourage attendance at its formal Board meetings by the public and members of the press as well as LHB officers or representatives from organisations who have an interest in LHB business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67)."

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the

Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the LHB, (whether directly or through the activities of bodies such as The LHB must hold an AGM in public no later than the 31 July each year Llais and the LHB's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the LHB will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least six Board members, at least three of whom are Executive Directors and three are Independent Members, must be present to allow any formal business to take place at a Board meeting.

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the

nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion

becomes the basis on which the further amendments are considered, i.e., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Board.

7.5.24 In determining every question at a meeting the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the

community and healthcare professionals within the LHB's area. Such views will usually be presented to the Board through the Chairs of the LHB's Advisory Groups and the Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulation 2018, and the LHB's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members (including Associate Members), together with members of any Committee or Advisory Group established by or on behalf of the Board and LHB officials must respect the confidentiality of all matters considered by the LHB in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework - Standards of Behaviour Policy or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will

apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board is the Standards of Behaviour Policy which will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework - Standards of Behaviour Policy and their statutory duties under the Constitution Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Board Secretary must take reasonable steps to ensure that the citizens served by the LHB are made aware of, and have access to view the LHB's Register of Interests. This may include publication on the LHB's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or

possibly seeking to do business with the NHS shall be published in the LHB's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the LHB and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;
ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;
iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;
iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests*** **–** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Constitution Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests*** **-** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a LHB Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of LHB officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit and Risk Assurance Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework - Standards of

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.
[2] The term gift refers also to any reward or benefit.

Behaviour Policy approved by the Board prohibits Board members and LHB officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or LHB officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Board member or LHB officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:.

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the LHB;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the LHB; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items

offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to LHB officers working within their Directorates.

8.7.2 Every Board member and LHB officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.
- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.7.4 Board members and LHB officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the LHB ;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the LHB to be submitted to the Audit and Risk Assurance Committee (or equivalent) at least annually. The Audit and Risk Assurance Committee will then review and report to the Board upon the adequacy of the LHB's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the LHB is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

9.0.2 Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1. Register of Sealing

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealing's shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the LHB, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the LHB any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has

delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the LHB shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF LHB BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of LHB business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit and Risk Assurance Committee (or equivalent).

10.0.3 Assurances in respect of the services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the LHB.

10.0.4 Assurances in respect of the functions discharged by the National Health Services Wales Joint Commissioning Committee (the JCC) shall be achieved by the reports of the JCC Chair, and reported back by the Chief Executive. Reference should be made to paragraph 3.2 above regarding the governance arrangements which should be agreed for each of the Joint Committees.

10.0.5 Arrangements for seeking and providing assurance in respect of any other services provided on behalf of or in association with the LHB shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit and Risk Assurance Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.2 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.3 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.4 The Board shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Board Development Programme, as part of an overall Organisation Development framework; and
- The Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the LHB implements any recommendations relevant to its business made by the Welsh Government's Audit, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

10.3.4 The LHB shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the communities it serves and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their community and other partners.

11.0.3 The Board shall also facilitate effective scrutiny of the LHB's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the LHB, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 An equality impact assessment has been undertaken and found that as an administrative document, there is no *direct* impact on the health of the population, the addressing of inequalities in health or the delivery of services. However, it does clearly impact on how Cwm Taf Morgannwg UHB makes its decisions.

12.0.2 These SOs shall be reviewed annually by the Audit and Risk Committee, which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

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

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid 'put downs' of views or points made by colleagues
- Respect a colleague's point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No 'side-meetings' to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCM)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

3.1 Audit, Risk & Assurance Committee
3.2 Charitable Funds Committee
3.3a Mental Health Act Monitoring Committee
3.3b Provision of Discharge (Hospital Managers) Sub Committee
3.4 Operational Delivery Committee
3.5a Quality, Safety & Experience Committee
3.5b Health, Safety & Fire Sub Committee
3.5c Organ Donation Sub Committee
3.6 Remuneration & Terms of Service Committee
3.7 Strategic Development Committee

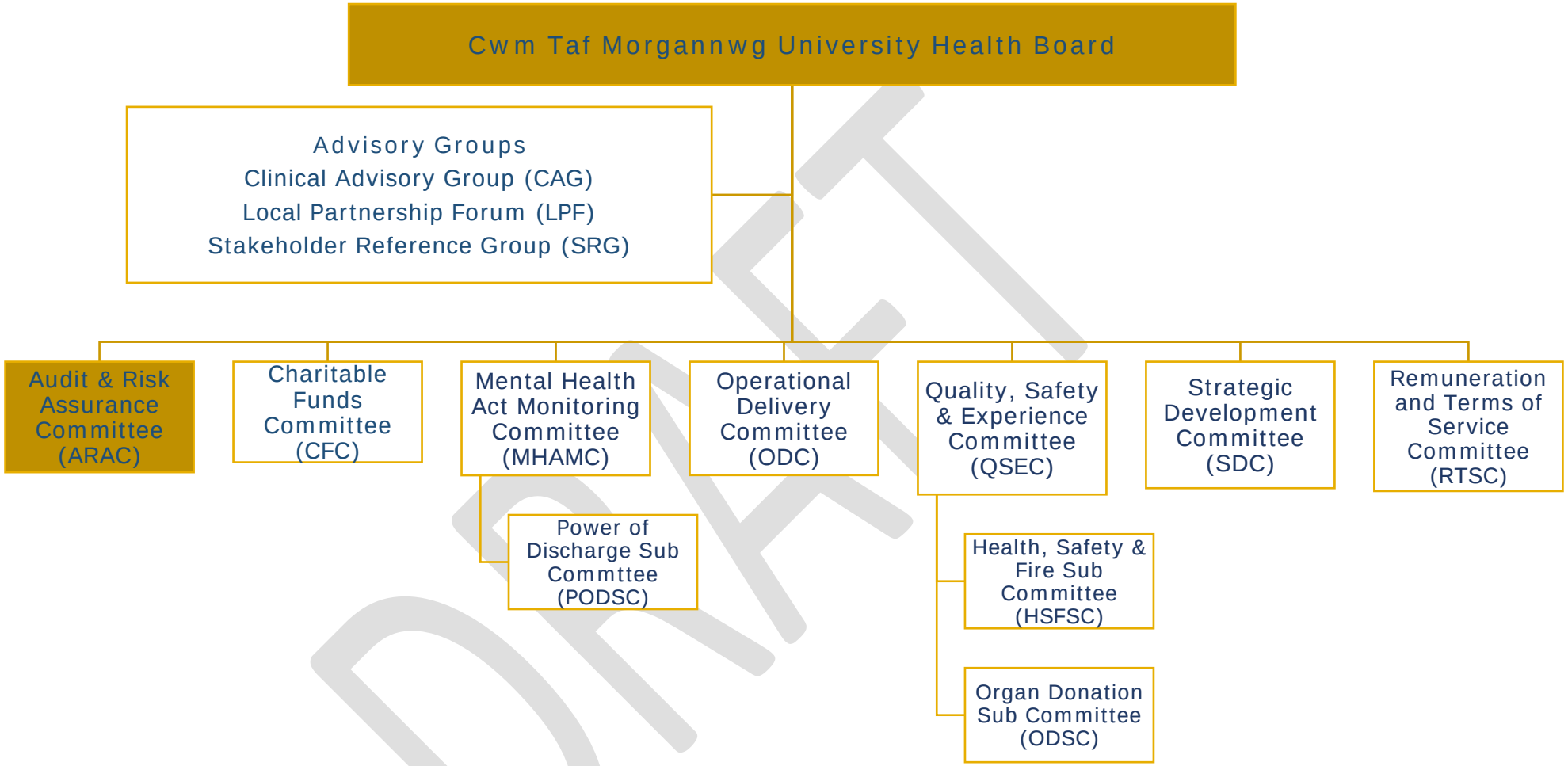
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

AUDIT & RISK ASSURANCE COMMITTEE (ARAC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

DRAFT

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Power of Discharge Sub Commttee (PODSC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)

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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

DRAFT

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 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".

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

1.3 The Committee will also consider items within the remit of the ARAC in respect of the roles and responsibilities of Committees/Programmes hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Joint Commissioning Committee (JCC) and the National Imaging Academy for Wales (NIAW). The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and JCC and NIAW discussed and recorded separately. Please refer to Appendix 1 which articulates the specific remit and responsibilities for the hosted ARAC Committee.

2. Purpose

2.1 The Audit and Risk Assurance Committee should support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements. The scope of the Audit and Risk Assurance Committee's work should be defined in its Terms of Reference and should encompass all the assurance needs of the Board and Accounting Officer. Within this the Audit and Risk Assurance Committee should have particular engagement with the work of Internal Audit, the work of the External Auditor and Financial Reporting issues.

2.2 The ARAC will advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of CTMUHB's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Health Boards objectives, in accordance with the standards of good governance determined for the NHS in Wales.

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2.3 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes.

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.

2.5 The Committee's principal duties encompass the following:

- the strategic processes for risk, control and governance and the Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of both internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- (where appropriate) proposals for tendering for either Internal or External Audit services or for purchase of non-audit services from contractors who provide audit services
- anti-fraud policies, raising concerns (Speaking up Safely) processes, and arrangements for special investigations;
- receiving assurance from the Senior Information Risk Owner and Data Protection Officer that the data and cyber security and information risk is being effectively managed and that there are appropriate and sustainable frameworks in place. It is important to understand the organisation's tolerance for risk and evaluate the risk decisions made by Health Board officers.
- periodically review its own effectiveness and report the results of that review to the Board.

3. Scope and Duties

Governance, Risk Management and Internal Control

3.1 The Committee shall review the adequacy of CTMUHB's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

3.2 In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Accountability Report and the Performance Report), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- the underlying assurance processes that indicate the degree of the achievement of strategic and planning objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service.

3.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, however, will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.5 The Committee will seek assurance that effective systems are in place to manage risk, that the organisation has an effective framework of internal controls to address principal risks (those likely to directly impact on achieving strategic objectives), and that the effectiveness of that framework is regularly reviewed.

3.6 Monitor the assurance environment and challenge the build-up of assurance on the management of key risks across the year, and ensure that the Internal Audit plan is based on providing assurance that controls are in place and can be relied upon (particularly where there is a significant shift between the inherent and residual risk profile), and review the internal audit plan in year as the risk profile changes.

3.7 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the frameworks, charts/charters and action plans that are developed, supporting and endorsing these as appropriate.

3.8 Consider and recommend to the Board approval of any changes to the Risk Management Framework and oversee development of the Board Assurance Framework.

3.9 Provide assurance with regard to the systems and processes in place for clinical audit, and consider recommendations from appropriate clinical forums on suggested areas of activity for review by internal audit.

3.10 The Committee will be responsible for reviewing CTMUHB's Standing Orders and Standing Financial Instructions and Scheme of Delegation annually, (including associated framework documents as appropriate), monitoring compliance, and reporting any proposed changes to the Board for consideration and approval.

3.11 Review the adequacy of the circumstances associated with each occasion where Standing Orders or Standing Financial Instructions are waived/breached.

3.12 To receive annually a full report of all offers of gifts, hospitality, sponsorship and honoraria recorded by CTMUHB and report to the Board the adequacy of these arrangements.

3.13 To review and report to the Board annually the arrangements for declaring, registering, and handling interests.

3.14 Approve the writing-off of losses or the making of special payments within delegated limits.

3.15 Review the adequacy of arrangements related to counter fraud activity.

3.16 Receive an assurance on Post Payment Verification Audits through bi-annual reporting to the Committee.

3.17 Receive a report on all Single Tender Actions and extensions of contracts.

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

Internal Audit and Capital / Private Finance Initiative

3.19 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;

3.20 The Committee shall ensure that there is an effective internal audit and capital/PFI function established by management that meets mandatory Internal Audit Standards for NHS Wales and provides appropriate independent assurance to the Committee, Chief Executive and Board.

3.21 This will be achieved by:

- review and approval of the Internal Audit Strategy, Charter, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation;
- review of the adequacy of executive and management responses to issues identified by audit, inspection and other assurance activity, in accordance with the Charter;
- regular consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- annual review of the effectiveness of internal audit.

External Audit

3.22 The Committee from time to time, will consider and make any necessary representations to the Auditor General for Wales on his appointment of an engagement partner.

3.23 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.

3.24 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.

3.25 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. This will be achieved by:

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors and inspection bodies in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Local Health Boards/NHS Trusts and associated impact on the audit fee;
- review all External Audit reports, including agreement of the Annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses; and
- review progress against the recommendations of the annual Structured Assessment.

Other Assurance Functions

3.26 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications on the governance of the organisation.

3.27 The Committee's programme of work will be designed to provide assurance that the work carried out by the whole range of external review bodies be brought to the attention of the Board. This will ensure that the Health Board is aware of the need to comply with related standards and recommendations of these review bodies and the risks of failing to comply. These will include, but will not be limited to, any reviews by Inspectors and other bodies (e.g. Healthcare Inspectorate Wales, Welsh Risk Pool, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

3.28 The ARAC and the Quality, Safety and Experience Committee both have a role in seeking and providing assurance on Clinical Audit in the organisation. The Audit and Risk Assurance Committee will seek assurance on the overall plan, its fitness for purpose and its delivery. The Quality, Safety and Experience Committee will seek more detail on the clinical outcomes and improvements made as a result of clinical audit. The internal audit function will also have a role in providing assurance on the Annual Clinical Audit Plan.

3.29 The ARAC will also seek assurances where a significant activity is shared with another organisation and collaborative partnerships, in particular the NHS Wales Shared Services Partnership, Joint Committees and other regional committees. The ARAC will expect to receive assurances from internal audit performed at these organisations that risks in the services provided to them are adequately managed and mitigated with appropriate controls.

Management

3.30 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.31 The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

3.32 The Committee may also request or commission special investigations to be undertaken by Internal Audit, directors or managers to provide specific assurance on any areas of concern that come to its attention.

Financial Reporting

3.33 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board, focusing particularly on:

- the ISA 260 report to those charged with governance;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- significant adjustments resulting from the audit;
- other financial considerations include review of the Schedule of Losses and Compensation.

3.34 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

4. Membership

Members

4.1 The Membership of ARAC is as follows:

Chair	Independent Member The Chair of the ARAC should also be a member of the Quality, Safety & Experience Committee.
Vice Chair	Independent Member
Members	2 further Independent Members

Support to Committee Members

4.2 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 for People.

4.3 The Chair of CTMUHB should not be a member of the Audit and Risk Assurance Committee and will not normally attend but may be invited by the Committee Chair to attend all or part of a meeting to assist with its discussions on any particular matter.

4.4 The membership of ARAC will be reviewed annually.

4.5 In Attendance

Executive Director of Finance (Joint Executive Lead)
Director of Corporate Governance / Board Secretary (Joint Executive Lead)
Representative of the Auditor General
Head of Internal Audit
Local Counter Fraud Specialist
Head of Corporate Finance

4.6 The Chief Executive, as the Accountable Officer, should be invited to attend, as a minimum when the Committee considers the draft internal audit plan, to present the draft Accountability Report and the annual accounts, and on request by the Committee.

4.7 As and when required the Senior Information Risk Owner and Data Protection Officer will be asked to attend the Committee to provide assurance on mitigating actions taken in terms of Data Breaches / cyber incidents and also on the sustainability of relevant frameworks to support the digital and data infrastructure.

By Invitation:

4.8 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.

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

5 Quorum & Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee, together with a third of the "In Attendance" members.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

5.3 Any senior officer of CTMUHB or partner organisation may where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any 'in attendance' officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet at least four times per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

7.4 The External Auditor and Head of Internal Audit may request a meeting if they consider one is necessary.

8 Withdrawal of Individuals in Attendance

8.1 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.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

10.1 The Head of Internal Audit and the representative of the Auditor General shall have unrestricted and confidential access to the Chair of ARAC at any time, and vice versa.

10.2 The Committee members will meet separately with Internal Auditors, External Auditors, the Local Counter Fraud Specialist and the Accountable Officer without the presence of other officers on at least one occasion each year.

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

11 Accountability, Responsibility & Authority

11.1 The ARAC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The ARAC 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.

11.5 The Committee shall embed CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.6 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

11.7 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.

11.8 At this stage, no sub Committees/task and finish groups have been established.

12 Reporting

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

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

12.2 In doing so, the Committee shall contribute 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.

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 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 Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

12.7 The CTMUHB ARAC will undertake an annual assessment of effectiveness, with reference to this assurance framework. The self-assessment will inform continuous improvement of the arrangements and will be included in the Committee's annual report to the CTMUHB Board

13 Applicability of Standing Orders to Committee Business

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

- Quorum

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15 In Committee (Private Meeting)

15.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1 – Hosted Audit and Risk Assurance Committee

1 Purpose

1.1 As per the approved Assurance Map of the Joint Commissioning Committee (JCC), issues relating to the functions of the JCC delegated from the seven LHBs will be fed into a separate Hosted Bodies Audit Risk Assurance Committee, operating within its own work cycle as required. The assurance for this will be to the seven LHBs.

1.2 Additionally, the Hosted Bodies Audit Risk Assurance Committee will also consider issues relating to the National Imaging Academy Wales (NIAW).

1.3 The assurance for the governance and issues relating to the hosting of the JCC and NIAW will be to the Cwm Taf Morgannwg Board.

2 Reporting Requirements in relation to Hosted Organisations

2.1 CTMUHB will convene an ARAC at a frequency determined by the CTMUHB Board, but not less than four times a year, to consider matters relating to the organisations hosted by CTMUHB.

2.2 The following provides and outline of the requirements (not exhaustive) to satisfy the CTMUHB Board in relation to seeking assurance on the governance arrangements in hosted bodies. This list can be reviewed at any time, as determined by the CTMUHB's ARAC.

- Internal and External Audit Plans (It is for CTMUHB ARAC to ensure there is an audit plan in place, but not to determine what is agreed to be within the plan, this is for the host body to agree with Joint Committee Members or SRO. This does not preclude any audit areas that CTMUHB may wish to instruct Internal Audit to review in relation to gaining assurance from hosted body activities in regarding the hosting relationship).
- Internal and External Audit Reports with completed management action plans
- Progress reports against audit recommendations (Audit Tracker) NB - to be highlighted to Joint Committee and/or Lead Sponsor if progress is deemed unsatisfactory
- Assurance Framework Report and Risk Register
- Compliance and activity governed by CTMUHB Standards of Behaviour Policy (i.e. Declarations of Interest, Gifts & Hospitality)
- Single Tender Actions

- Breach or waivers to Standing Orders and/or Standing Financial Instructions

2.3 Other routine information will be monitored by the Joint Commissioning Committee/SRO Performance meetings and where necessary, may be appropriate/necessary to report to and be scrutinised by any relevant CTMUHB Committee.

2.4 Taking advice from CTMUHB's Director of Corporate Governance, hosted bodies will also be expected to report on novel or contentious issues relating to any activity governed by CTMUHB Policy.

3 Membership and Attendance

3.1 The Membership of the Hosted Bodies ARAC and support offered to the members will be in line with the details outlined in paragraphs 4.1 to 4.4 inclusive in the main ARAC Terms of Reference.

3.2 The Director of Finance and Committee Secretary for the Joint Commissioning Committee will normally attend the Hosted Bodies meetings of the Hosted Bodies Audit, Risk & Assurance Committee. The Chief Commissioner 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 in particular in respect of their role as an Accountable Officer for the purposes of regularity and propriety. Additionally a nominated Lay Member of the JCC will also attend the Hosted Bodies ARAC.

3.3 The National Imaging Academy Director will normally attend the Hosted Bodies meetings of the ARAC on at least a six monthly basis.

3.4 The CTMUHB Executive Director of Finance and Head of Corporate Finance will also attend the Hosted Bodies meetings of the ARAC, as will the Director of Corporate Governance/Board Secretary.

4 Other Meeting Arrangements

4.1 Meeting arrangements including secretariat support and quoracy for the Hosted Bodies ARAC will mirror those set out in the terms of reference of the main CTMUHB ARAC.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CHARITABLE FUNDS COMMITTEE (CFC)

Terms of Reference & Operating Arrangements
(Schedule 3.2 of the Standing Orders)

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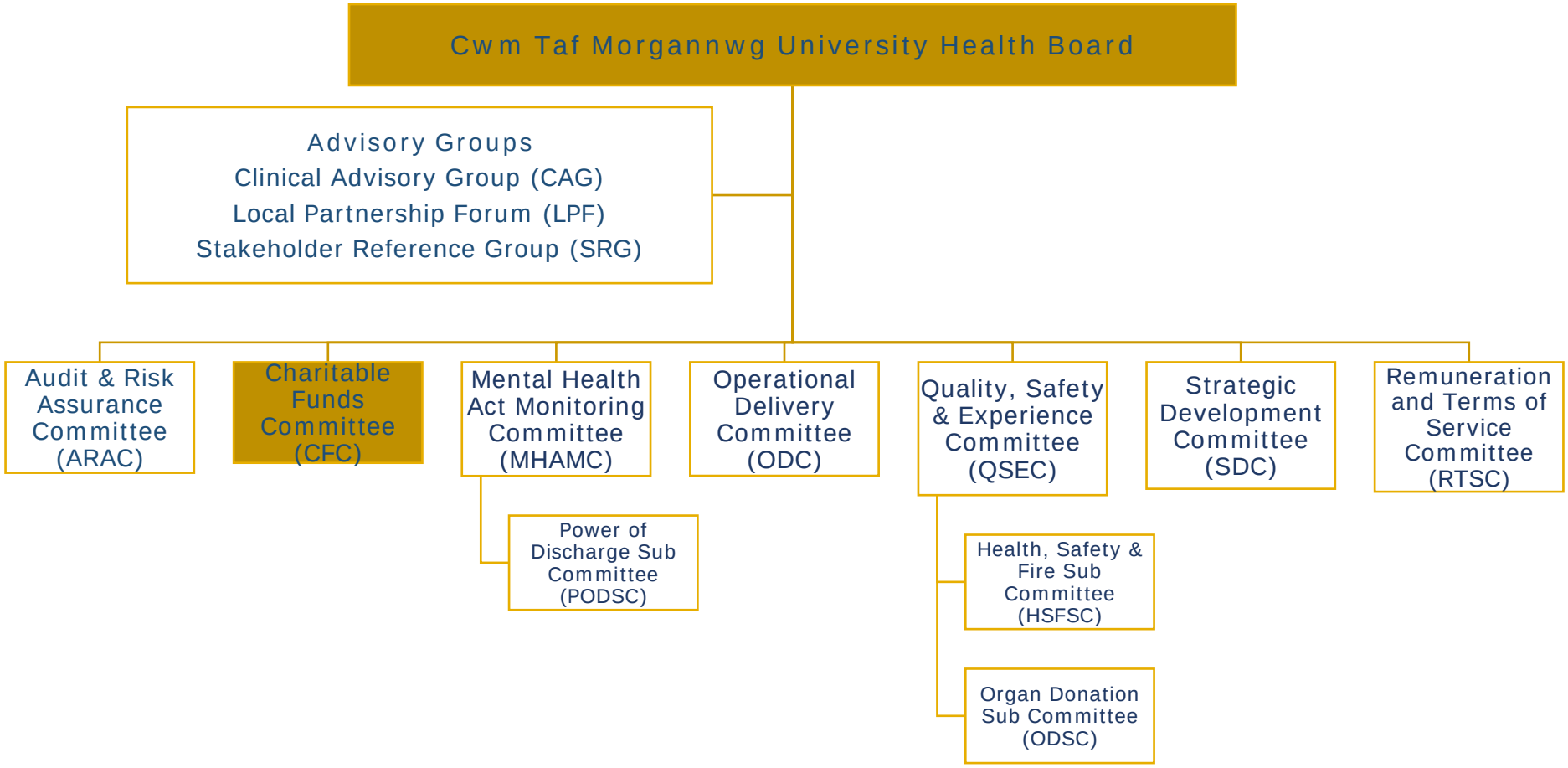
Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Power of Discharge Sub Committee (PODSC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)

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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Board's Standing Orders

1. Introduction & Constitution

1.1 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".

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

1.3 The CTMUHB are 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. The Corporate Trustee is a person having the general control and management of the administration of a charity regardless of what they are called.

1.4 Board Members (those who are voting members i.e. Executive Directors and Independent Members (excluding Associate Board Members) have a dual role in that as members of the Board they are also therefore CTMUHB Charitable Fund Trustees. The Trustees are responsible for controlling the management and administration of the Charity and have collective responsibility for these monies. The duties of a Trustee are to ensure compliance, duty of prudence and duty of care.

1.5 The Charity Number for the "Cwm Taf Morgannwg NHS General Charitable Fund" is 1049765. Details of the Governing document are available here: Governing document, CWM TAF MORGANNWG NHS GENERAL CHARITABLE FUND - 1049765, Register of Charities - The Charity Commission

1.6 All Trustees are welcome to attend all Committee meetings, however, they are formally invited to attend at least one meeting of the Charitable Funds Committee per annum to approve the Annual Accounts and Trustees report.

2. Purpose

2.1 To make and monitor arrangements for the control and management of CTMUHB's Charitable Funds, within the budget, priorities and spending criteria determined by the Board and consistent with legislative framework.

2.2 To provide assurance to the Board in its role as Corporate Trustee of the charitable funds held and administered by the Health Board.

2.3 To oversee the strategic direction and development of the CTMUHB Charity.

3. Scope and Duties

3.1 Within the budget, priorities and spending criteria consistent with the Charitable Objectives, the Charities Act 2011 and Charities Act 2022 (or any modifications of these acts) and spending criteria as delegated to the Corporate Trustee. The Charitable funds will also be managed in accordance with the respective governing documents.

3.2 Provide advice to the Corporate Trustee in the discharge of its duties and responsibilities for charitable funds.

3.3 Discharge delegated responsibilities from the Corporate Trustee for the control and management of Charitable Funds.

3.4 To ensure that the Health Board's policies and procedures for charitable funds and investments are followed.

3.5 To make decisions involving the sound investment of the charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with the:

- Trustee Act 2000
- The Charities Act 2011
- The Charities Act 2022
- The terms outlined in the CTMUHB Charity's governing documents.

3.6 Provide advice to the Corporate Trustee on its charitable funds strategy, including fundraising, budgets, priorities and spending criteria.

3.7 To receive at least annually, reports for ratification from the Executive Director of Finance and investment decisions and action taken through delegated powers upon the advice of the Investment Adviser.

3.8 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial instructions as well as the Charity's annual programme of activity.

3.9 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered material.

3.10 To monitor and review CTMUHB's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.11 To ensure that funds are being utilised in a reasonable, clinically and ethically appropriate manner, in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

3.12 To ensure funds are used for the enhancement of services and for the benefit of the communities served by CTMUHB in accordance with the Health Board and Charity's strategic direction. There should also be consideration and alignment with the requirements of the Socio Economic Duty, the Wellbeing of Future Generations Act, sustainable development principles and other relevant legislation and principles as appropriate.

4. Membership

Members

4.1 The Membership of CFC is:

Chair	Independent Member
Vice Chair	Independent Member
Members	2 further Independent Members Executive Director of Finance (who may be represented by a Nominated Representative in their absence)

4.2 At least half of the overall membership must be Independent Members.

4.3 All Members of the Board (as Corporate Trustee) are welcome to attend the Committee.

Support to Committee Members

4.4 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 for People.

4.5 The membership of CFC will be reviewed annually.

In Attendance

Director of Communications, Engagement and Fundraising
Director of Corporate Governance / Board Secretary or Assistant Director of Governance & Risk
Head of Corporate Finance
Head of Charity and Income Generation

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By Invitation:

4.6 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.

5. Quorum & Attendance

5.1 At least 3 members must be present to ensure the quorum of the Committee. Of these three, two must be Independent Members (one of whom is the Chair or Vice Chair) and one must be the Executive Director of Finance (or the Deputy Director of Finance).

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

5.3 Any senior officer of CTMUHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the CFC.

5.8 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

6. Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7. Frequency of Meetings

7.1 The Committee will meet at least twice per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8. Withdrawal of Individuals in Attendance

8.1 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.

9. Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10.Access

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

11.Accountability, Responsibility & Authority

11.1 The CFC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The Executive Director of Finance has prime responsibility for CTMUHB's Charitable Funds as defined in the Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Director of Finance are:

- administration of all existing charitable funds
- to identify any new charity that may be created (of which the Health Board is a trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity
- provide guidelines with regard to donations, legacies and bequests, fundraising and trading income

- responsibility for the management of investment of funds held on trust
- ensure appropriate banking services are available
- Consider and recommend for approval the audited Annual Report and Accounts.

11.5 Oversight of the management of the investments of the charitable fund in accordance with the investment strategy set down from time to time by the Trustee and the requirements of the Health Board's Standing Financial Instructions.

11.6 The appointment of an Investment Manager to advise on investment matters. Delegating, where applicable the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power, the Committee must ensure that:

- The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
- There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
- The performance of the person or persons exercising the delegated power is regularly reviewed.
- Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2021.
- Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Director of Finance. Materiality can be either material in value or nature (type of investment). The value of investments that can be made/disposed of is set out in the investment strategy. The nature of investments is set out clearly to the Investment Manager and monitored on a regular basis. Any changes to the type of investments made will require authority from the Committee or the Chair of the Committee in conjunction with the Director of Finance.
- If any decisions are taken by the Chair and Director of Finance outside of a Committee meeting they should be reported back to the next meeting of the Committee for formal endorsement. Please also see section on Chair's Urgent Action.

11.7 Ensure that the banking arrangements for the charitable funds are kept entirely distinct from the Health Board's NHS funds.

11.8 Ensure that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

11.9 Ensure the amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

11.10 Ensure the operation of an investment pool when this is considered appropriate to the Charity in accordance with charity law and the directions

and guidance of the Charity Commission. The Committee shall propose the basis to the Health Board for applying accrued income to individual funds in line with charity law and Charity Commissioner guidance.

11.11 Obtain appropriate professional advice to support its investment activities.

11.12 Regularly review investments to see if other opportunities or investment services offer a better return or alignment to the objectives to the Charity.

11.13 Regularly review risks included on the organisational Risk Register as assigned to the Committee by the Board.

11.14 The Committee shall embed the CTMUHB vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.15 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

11.16 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.

11.17 At this stage, there are no sub Committees established.

12.Reporting

12.1 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including joint/sub Committees and groups, to provide advice and assurance to the Board through the:

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

- sharing of information.

12.2 In doing so, the Committee shall contribute 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.

12.3 The Committee may establish sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 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 Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

13.Applicability of Standing Orders to Committee Business

13.1 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 following areas:

- Quorum

14.Chair's Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub 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 Committee, after first consulting with one other Independent Member and at least two other 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.

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

15.In Committee (Private Meeting)

15.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16.Review

16.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

MENTAL HEALTH ACT MONITORING COMMITTEE (MHAMC)

Terms of Reference & Operating Arrangements
(Schedule 3.3a of the Standing Orders)

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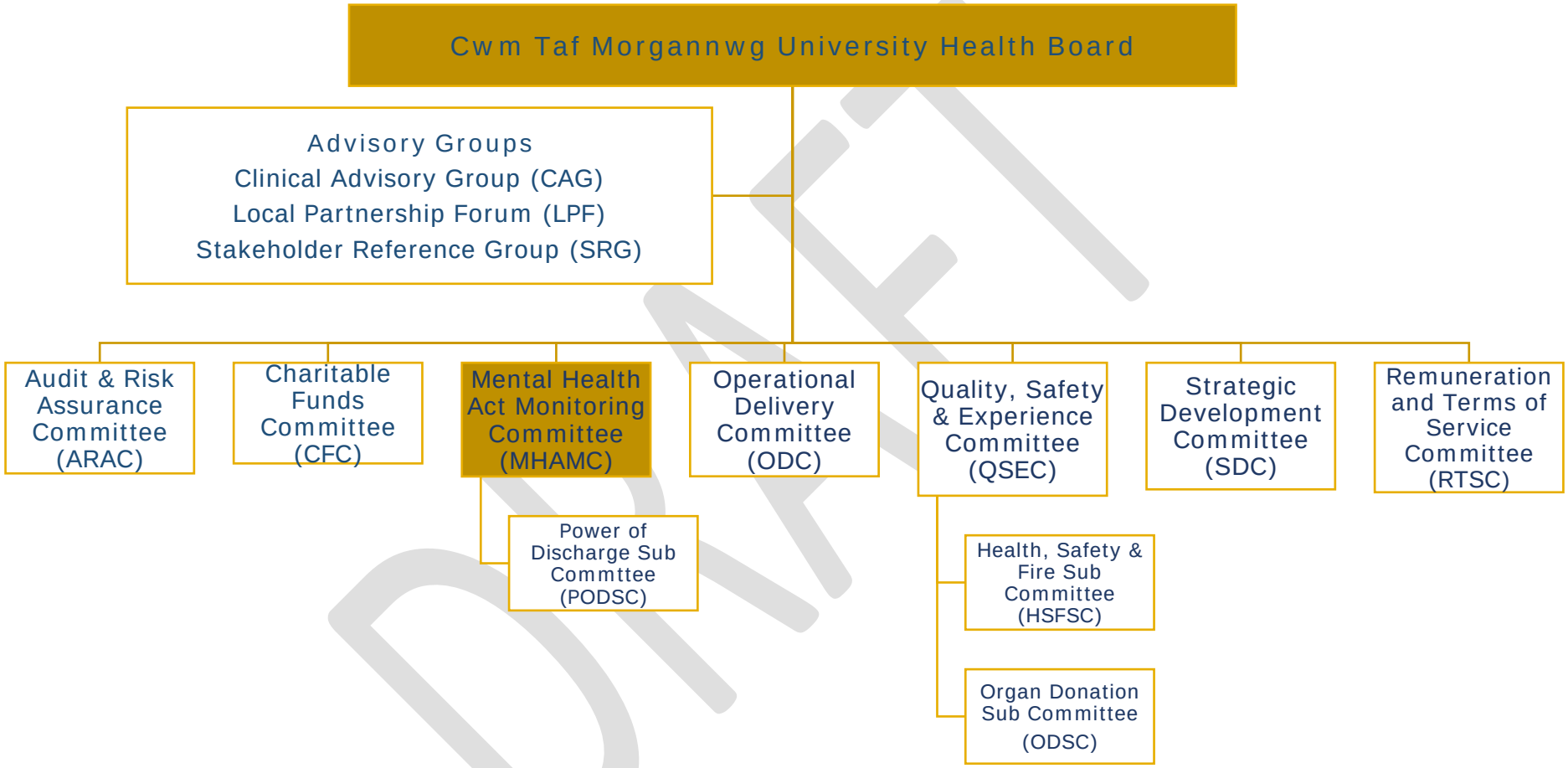
Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
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Mental Health Act Monitoring Committee (MHAMC)
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Remuneration and Terms of Service Committee (RTSC)
Power of Discharge Sub Commttee (PODSC)
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Organ Donation Sub Committee (ODSC)

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Version 1				

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 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 Mental Health Act Monitoring Committee (MHAMC), the detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

2. Purpose

2.1 To seek assurance that those functions of the Mental Health Act 1983, as amended, which have been delegated to officers and staff are being carried out correctly; and that the wider operation of the 1983 Act in relation to the CTMUB's area is operating properly;

2.2 The provisions of the Mental Health (Wales) Measure 2010 are implemented and exercised reasonably, fairly and lawfully;

2.3 CTMUHB's responsibilities as Hospital Managers are being discharged effectively and lawfully;

2.4 CTMUHB is compliant with Mental Health Act, 1983 Code of Practice for Wales;

2.5 CTMUHB works in partnership for example adhering to the South Wales Police Initiative: Right Care, Right Person.

2.6 The Committee will also advise the Board of any areas of concern in relation to compliance with mental health legislation and agree issues to be escalated to the Board with recommendations for action.

3. Scope and Duties

In respect of its provision of advice to the Board, the MHAMC shall:

3.1 Review reports which have Mental Health Act related content from Healthcare Inspectorate Wales visits, the Delivery Unit and other external scrutiny bodies and approve the action plans for monitoring through its sub-

committee structure;

3.2 Review the Mental Health & Learning Disabilities Risk Register bi-annually to ensure that the Mental Health Act Operating Group is appropriately managing risks relating to compliance with mental health legislation.

3.3 Receive Mental Health Act Monitoring Operating Group Update Report from previous meeting;

3.4 Consider issues arising from its Sub-Committee and Group structure;

3.5 Receive Hospital Manager's Power of Discharge Committee Update Report. This report should ensure compliance with the Code of Practice.

In respect of its provision of assurance to the Board, the MHAMC will seek assurances that:

3.6 The operation of mental health legislation is exercised fairly and lawfully and that specific issues related to compliance are managed through its Sub-Committee and Group structure;

3.7 The wider operation of the 1983 Act (the Board's delegated functions as Hospital Managers) are being exercised reasonably, fairly and lawfully and that specific issues related to compliance are managed through its Sub-Committee and Group structure;

3.8 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated;

3.9 Arrangements for the delegated authority of approval for Approved Clinicians and Section 12 Doctors in Wales are compliant with the Directions and Guidance from Welsh Government, and are monitored through the Mental Health Act Operations Group;

3.10 Policies and procedures are developed and approved in line with the organisation's Written Control Document Policy, through the Mental Health Act Monitoring Operational Group;

3.11 The training requirements of those staff who exercise the functions of mental health legislation have the requisite skills and competencies to discharge the Board's responsibilities, through the Mental Health Act Monitoring Operational Group;

3.12 Ensure that relevant legislation, in particular, the Human Rights Act 1998, the Equality Act 2010, and the Data Protection Act 2018, are adhered to.

3.13 Cross-agency audit themes and sponsor appropriate cross-agency audits

3.14 Lessons learnt from difficulties in practice and the development of areas of good practice.

3.15 There is a suitable mechanism for reviewing multi agency protocols / policies relating to the 1983 Act.

3.16 Consider trends and patterns of use of the Mental Health Act 1983.

3.17 Consider issues arising from the operation of the hospital managers' power of discharge.

4. Membership

Members

4.1 The Membership of MHAMC is:

Chair	Independent Member (Vice Chair of CTMUHB) 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.
Vice Chair	Independent Member
Members	Two further Independent Members

4.2 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.

4.3 The Independent Member Chair of the (Hospital Managers) Power of Discharge Committee should be a member of the MHAMC.

Support to Committee Members

4.2 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 for People.

4.3 The membership of MHAMC will be reviewed annually.

In Attendance

Chief Operating Officer
Deputy Chief Operating Officer - Primary Care, 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 the 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 of twice per annum)
Mental Health & Learning Disabilities Care Group Director representative (Service Director, Medical Director or Nurse Director)

By Invitation:

4.4 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.

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

5 Quorum & Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee and one other Independent Member, together with a third of the In Attendance Members.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

5.3 Any senior officer of CTMUHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

5.8 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

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet at least four times per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

8.1 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.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

10.1 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the MHAMC.

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

11 Accountability, Responsibility & Authority

11.1 The MHAMC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The Committee shall embed the CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 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.

11.6 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

11.7 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.

11.8 At this stage, the Committee has established the following Sub Committee:

- (Hospital Managers) Powers of Discharge (POD) Sub Committee

Related Sub Groups

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

12 Reporting

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

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

12.2 In doing so, the Committee shall contribute 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.

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically

comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.

- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 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 Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

13 Applicability of Standing Orders to Committee Business

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

- Quorum

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15 In Committee (Private Meeting)

15.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

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GIG CYMRU NHS WALES

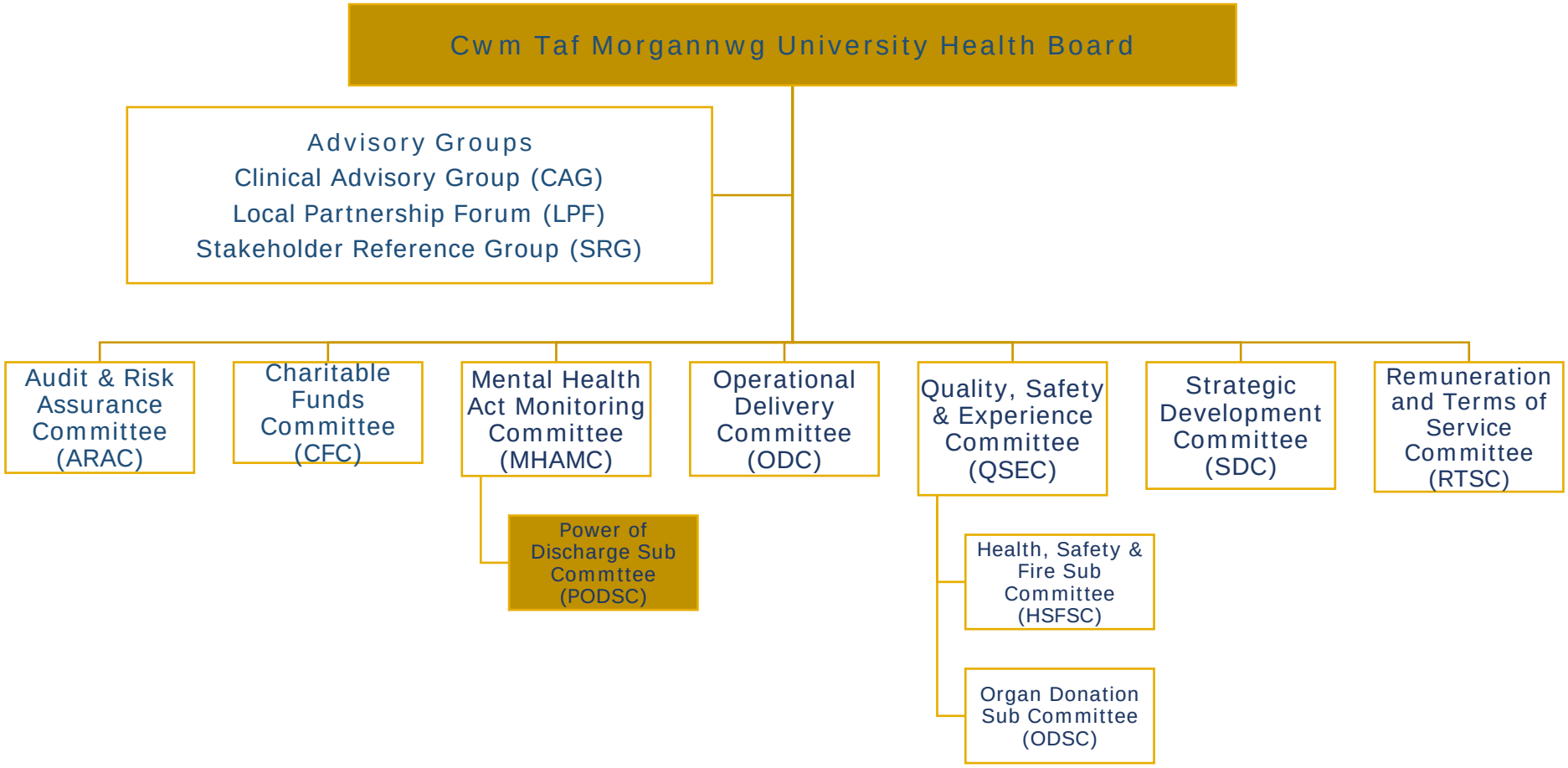
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE

Terms of Reference & Operating Arrangements
(Schedule 3.3b of the Standing Orders)

Last Approved: Health Board Meeting ( )

CTM_Corporate_Governance@wales.nhs.uk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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 The Mental Health Act Monitoring Committee, established as a Committee of CTMUHB, has established a Hospital Managers Power of Discharge Sub Committee to carry out specific aspects of the Mental Health Act Monitoring Committee's business on its behalf.

1.2 The Chair of the Hospital Managers Power of Discharge Sub Committee must be a member of the Mental Health Act Monitoring Committee and will for assurance purposes make regular reports to the Mental Health Act Monitoring Committee on the activity of the subcommittee.

2. Requirements of the Mental Health Act

2.1 The primary purpose of the 1983 Act is to ensure that compulsory measures can be taken, where necessary and justified, to ensure that people who experience a mental disorder get the care and treatment they need. Because these provisions place people under compulsion (for example to receive treatment) the 1983 Act also contains a number of safeguards. These include, for example, a right to apply for discharge to the Hospital Managers. Hospital Managers have a central role in operating the provisions of the Act and as detailed in these terms of reference CTMUHB has made the decision to delegate this responsibility to the Hospital Managers Power of Discharge Sub Committee, and assurance will be provided to the Board through monitoring by the Mental Health Act Monitoring Committee.

3. Purpose

3.1 The purpose of the Hospital Managers Power of Discharge Sub-Committee is to review and monitor how the operation of the delegated functions under Section 23 of the Mental Health Act 1983 (the 1983 Act) and the Code of Practice are being exercised; and to provide assurance to the Mental Health Act Monitoring Committee (and ultimately to the Board) that the processes employed by the Sub-Committee, tasked with considering whether the power of discharge should be used, are fair, reasonable and exercised lawfully.

2.2 A panel of three or more Members drawn from the Hospital Managers Power of Discharge Sub-Committee will hear individual cases where patients or their nearest relative have applied for discharge. The Members also sit on Renewal Hearings – they are collectively known as Hospital Managers Reviews.

4. Scope and Duties

4.1 The purpose of the Hospital Managers Power of Discharge Sub Committee is to:

- Monitor the exercise of Power under Section 23 of the Mental Health Act 1983 by Hospital Managers at Hearings involving 3 or more members of the Hospital Managers Power of Discharge Committee. These powers are formally delegated by the Health Board in its "Policy for Hospital Managers' Scheme of Delegation". This policy sets out the statutory functions of Hospital Managers
- Consider all relevant issues for Mental Health Act Hospital Managers to undertake their role in accordance with CTMUHB and legislative requirements.
- Ensure that discharge panels are acting in a fair and reasonable manner and exercised lawfully, this would include ensuring that during manager's hearings reasonable adjustments are made or support provided to ensure the patient's voice is heard. This could include responding to a request for a face to face hearing, provision of advocacy or translation services.
- Consider updates regarding recommendations made during panel hearings.
- Receive professional advice to support the discharge of the Mental Health Act Manager Role.
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act.
- Receive development/discussion sessions to improve overall knowledge of services.
- Develop a rolling programme of training activities to ensure that its members are fully able to exercise their responsibilities. This will include a formal induction programme and regular training on the Mental Health Act 1983.
- Consider issues which are identified by Hospital Managers at Hospital Managers Hearings and which required action. This will be a standing agenda item for discussion by the group. The Chair will determine if the issue needs to be escalated and will liaise with the Director of Corporate Governance should legal advice need to be sought.

5. Membership

5.1 The Membership of the Hospital Managers Power of Discharge Sub Committee is as follows:

Chair	Independent Member (who must be a member of the Mental Health Act Monitoring Committee)
Vice Chair	Hospital Manager Designated
Members	All of the Mental Health Act Hospital Managers appointed by CTMUHB
In Attendance	Executive Director of Allied Health Professions and Health Science
	Head of Nursing – Mental Health & Learning Disabilities Care Group
	Directorate Manager for CAMHS and Specialist Services.

5.2 By invitation, the Sub Committee Chair may invite any other officers from CTMUHB or those outside the organisation where appropriate. The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

5.3 Member Appointments - The membership of the Sub Committee shall be determined by the Mental Health Act Monitoring Committee, based on the recommendation of the Sub Committee Chair. The membership of the Hospital Managers Power of Discharge Sub Committee will be reviewed annually.

6. Quorum

6.1 A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the Sub-Committee.

7. Meeting Secretariat

7.1 The secretariat will be appointed via the Mental Health Act Managers.

8. Frequency of Meetings

8.1 The Hospital Managers Power of Discharge Sub Committee shall meet at least four times per annum and as otherwise directed by the Chair.

9. Withdrawal of Individuals in Attendance

9.1 The Sub 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.

10. Circulation of Papers

10.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

11. Delegated Powers, Authority & Access

11.1 The Hospital Managers Power of Discharge Sub Committee will comprise Mental Health Act (MHA) managers who have been independently appointed. The MHA managers sit as panels of three or more in order to exercise their power of discharge as detailed in chapter 27 of the MHA Code of Practice. The decisions made by the panels are binding and therefore are not required to be ratified by the Mental Health Act Monitoring Committee or by the Health Board. However, the procedures and behaviours adopted by the panel are subject to scrutiny and as such the MHA Managers are accountable to the Board via the Mental Health Act Monitoring Committee.

11.2 The Hospital Managers Power of Discharge Sub Committee will, in respect of its provision to the Mental Health Act Monitoring Committee, comment specifically upon:

- Processes in place to support discharge panels.
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature.
- Discuss any impact of legislative changes on role of Mental Health Act Hospital Managers.
- Highlight any impact of service changes on the ability to undertake the Mental Health Act Manager role effectively.

11.3 To achieve this, the Mental Health Act Monitoring Committee shall support the group to provide assurance that:

- Mental Health Act Hospital Managers are effectively equipped and trained to undertake their role.

- CTMUHB provides appropriate support to ensure the Discharge Panels operate effectively.
- CTMUHB is aware of the impact of any legislative or service changes impacting on the Discharge panel's considerations and recommendations.

11.4 The Hospital Managers Power of Discharge Sub Committee is authorised to request legal advice via the Mental Health Act Team Leader (within their respective delegated limits) without recourse to the Mental Health Act Monitoring Committee.

11.5 The Chair of the Hospital Managers Power of Discharge Sub Committee shall have reasonable access to the Chair of the Mental Health Act Monitoring Committee, Executive Directors and other relevant senior staff.

12. Accountability & Responsibility

12.1 The Hospital Managers Power of Discharge Sub-Committee is directly accountable to the Mental Health Act Monitoring Committee, for its performance in exercising the functions set out in these terms of reference.

12.2 Due to the sensitivity of the patient information received, the Hospital Managers Power of Discharge Sub-Committee Members will at all times be aware of the importance of confidentiality, and ensure that they comply with the CTMUHB's policies within this area of work.

12.3 The Sub-Committee shall embed CTMUHB's values, vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

12.4 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Sub Committee.

13. Reporting

13.1 The Hospital Managers Power of Discharge Sub-Committee, through its Chair and Members, shall work closely with the Mental Health Act Monitoring Committee, to provide advice and assurance through the:
- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

13.2 In doing so, the Hospital Managers Power of Discharge Sub-Committee shall contribute 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.

13.3 The Hospital Managers Power of Discharge Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive written update reports following each meeting which details the business undertaken on its behalf.

13.4 The Hospital Managers Power of Discharge Sub-Committee Chair, supported by the Sub-Committee meeting secretariat, shall:

- Report formally, regularly and on a timely basis to the Mental Health Act Monitoring Committee on the Sub-Committee's activities. This includes the submission of a routine Committee Highlight report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.
- Bring to the Mental Health Act Monitoring Committees attention any significant matter under consideration by the Sub-Committee.

14. Applicability of Standing Orders to Committee Business

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

- Quorum

15. Chairs Action on Urgent Matters

15.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

16. Review

16.1 These Terms of Reference shall be approved by the Mental Health Act Monitoring Committee and subject to review at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.

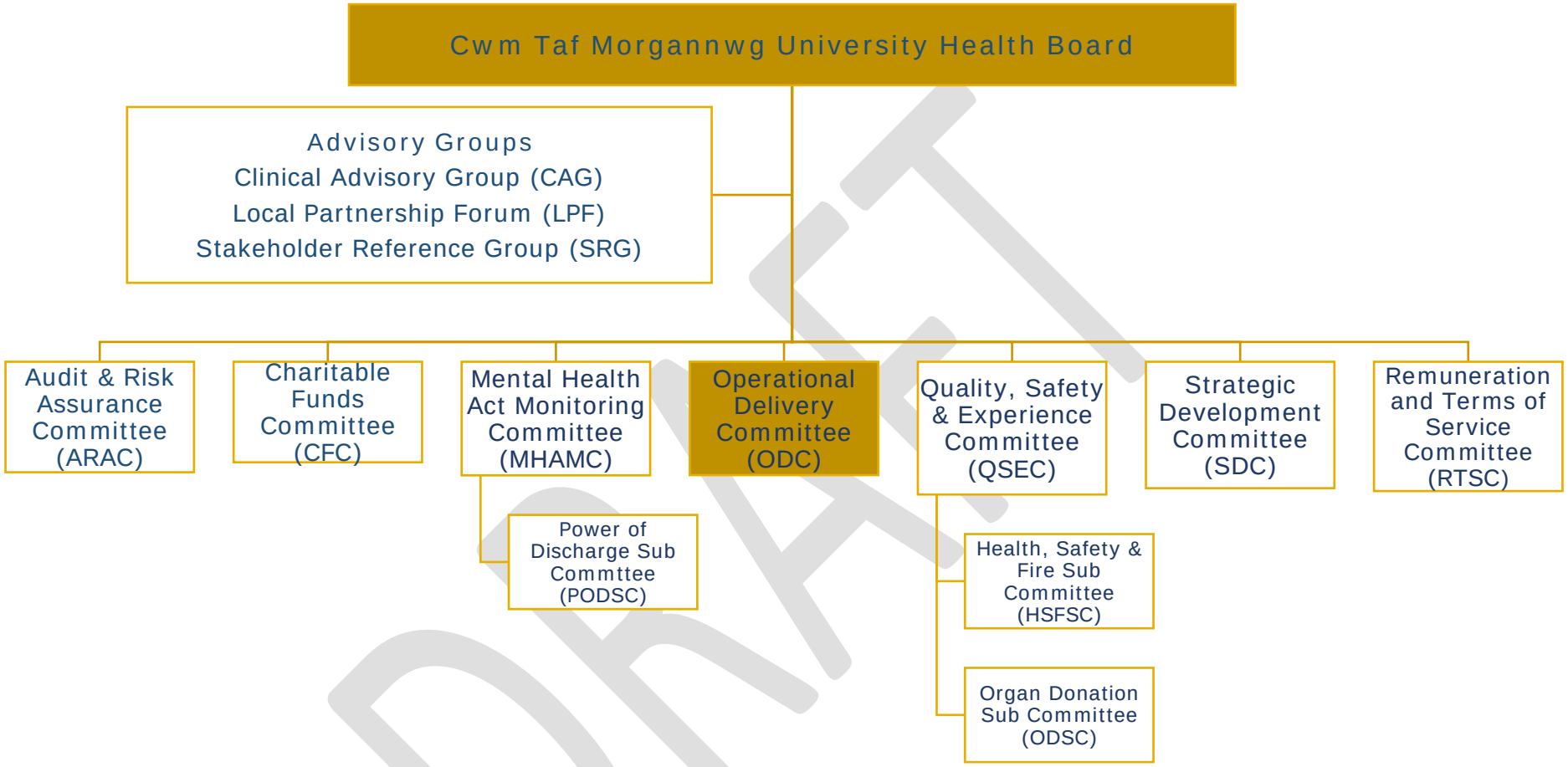
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

OPERATIONAL DELIVERY COMMITTEE (ODC)

Terms of Reference & Operating Arrangements
(Schedule 3.4 of the Standing Orders)

DRAFT

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Power of Discharge Sub Commttee (PODSC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)

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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

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Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 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".

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

2. Purpose

2.1 The purpose of the Committee is to provide assurance to the Board on the effectiveness of arrangements in place for securing the achievement of the Board's aims and objectives, in accordance with the standards of good governance determined for the NHS in Wales. In doing so, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of service delivery.

2.2 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 CTMUHB's Integrated Medium Term Plan.

3. Scope and Duties

3.1 The scope of the ODC Committee extends to the full range of CTMUHB responsibilities. This encompasses the delivery and performance management of all directly provided and commissioned services.

3.2 The business of the Committee will be driven by the key risks to the in-year delivery of the annual plan.

3.3 The ODC will have specific responsibilities with regards the following:

3.3.1 Our People

- Assurance on key risks to the delivery of the People Plan.

- Promote staff engagement and partnership working. Oversee the coherence and comprehensiveness of the ways in which CTMUHB engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications.
- Seek assurance that CTMUHB 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. Ensure that the arrangements to support the Speaking up Safely Framework are robust.
- Scrutinise plans for ensuring the development of leadership and management capacity, including CTMUHB's approach to succession planning.
- Ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including: Equality & Diversity Legislation, Welsh Language Standards.

3.3.2 Digital & Data

- Seek assurance that the arrangements for *Information Governance* are sufficient, effective and robust. This could include, however, is not exhaustive of;
    - application of legislation and regulation;
    - the arrangements to protect the integrity of data and information;
    - recommendations arising from national and local audits; and/or
    - self-assessments and the monitoring of arrangements to support the continued development of business intelligence and capacity.

- Seek assurance through:

    - Monitoring the Cyber Improvement Plan and associated actions.
    - the effectiveness and impact of the CTMUHB's Digital Transformation Plans and Projects being delivered by Digital and Data (Digital and Data Assurance Report)
    - The performance and delivery of the rollout of the local and core national IT systems which could have significant impact on CTMUHB's operational services and escalate to the Board as appropriate.
    - Management of Patient Medical Records (Medical Records Assurance Report)
    - the response and management of critical incidents.

It should be noted that in accordance with the Audit Committee Handbook the following activity will be considered at the Audit and Risk Assurance Committee.

- *Assurance on the arrangements for the Management of Cyber Risk*
- *Data loss incidents and breaches*

3.3.3 Planning Framework

- Monitor the process for the delivery of the expectations set out in the Integrated Medium Term Plan.
- Monitor and scrutinise the efficient prioritisation of capital schemes.
- Scrutinise and seek assurance that there is monitoring processes in place to ensure Capital Plans and Business Cases are managed in accordance with the Scheme of Delegation.
- Monitor the delivery of the Capital Programme.
- Escalation framework

3.3.4 Integrated Performance Dashboard

- Seek assurance that arrangements for the performance management and accountability of directly provided and commissioned services are sufficient, effective and robust, including:
  - the ongoing implementation of the Board's Integrated Performance Framework, enabling appropriate action to be taken when performance against set targets deteriorates, and support and promote continuous improvement in service delivery;
  - the effectiveness of current performance management arrangements.
  - the monitoring and delivery of activity on Long Term Agreements with neighbouring Health Board.

3.3.5 Financial Management / Performance

- Seek assurance that arrangements for financial management and financial performance are sufficient, effective and robust, including:
  - The annual allocation of revenue budgets, based on allocation of funding and other forecast income;
  - the monitoring of financial performance against revenue budgets and statutory financial duties;
  - the monitoring of performance against capital budgets;
  - the monitoring of progress against savings plans, cost improvement programmes and implementation of the efficiency framework;
  - the monitoring of budget expenditure variance and the corrective actions being taken to improve performance;
  - the monitoring of activity and financial information for external contracts to ensure performance within specified contract terms, conditions and quality thresholds;
  - the monitoring of arrangements to ensure efficiency, productivity and value for money;
  - the monitoring of delivery against the agreed Discretionary Capital Programme; and
  - the adequacy of standing financial instructions, including the application of capital and estates controls;
  - Scrutinise investments in line with Standing Financial Instructions and the Scheme of Delegation prior to submission to Board for approval.

3.3.6 Risk

- Scrutinise risks on the Organisational Risk Register that fall within the remit and control of the Committee.
- The business of the Committee will be driven by the strategic risks facing the organisation as captured in the Board Assurance Framework.

4. Membership

Members

4.1 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

4.2 The membership of the ODC Committee will be reviewed annually.

4.3 The Membership of the ODC is as follows:

In Attendance

Chief Operating Officer *(Executive Lead for the Committee)*
Executive Director for People
Executive Director of Finance
Executive Director of Strategy & Transformation
Executive Director of Nursing / Deputy CEO
Director of Digital
Deputy Chief Operating Officer(s)
Deputy Director of People
Governance Lead

By Invitation:

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

4.2 Other Executive 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.

5 Quorum & Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee, together with a third of the "In Attendance" members.

5.2 There is an expectation that the core Executive Directors noted in the "In Attendance" section will attend every Committee. Should any 'in attendance' officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet at least four times per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

8.1 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.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

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

11 Accountability, Responsibility & Authority

11.1 The ODC Committee is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The Committee shall embed CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 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

11.6 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.

11.7 At this stage, no sub Committees/task and finish groups have been established.

12 Reporting

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

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

12.2 In doing so, the Committee shall contribute 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.

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 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 Committees performance and operation, including that of any sub-committees established.

13 Applicability of Standing Orders to Committee Business

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

- Quorum

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15 In Committee (Private Meeting)

15.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

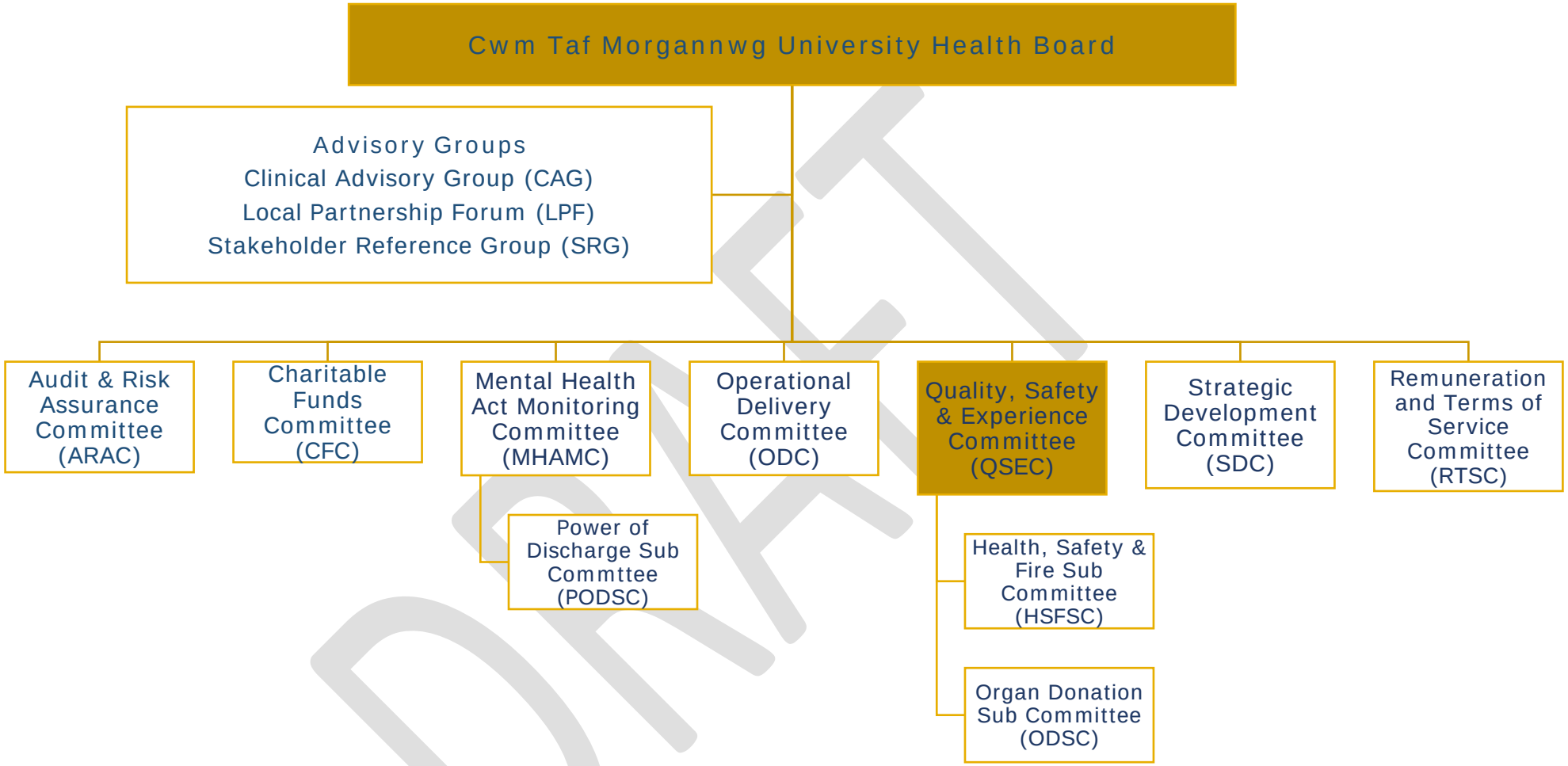
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC)

Terms of Reference & Operating Arrangements
(Schedule 3.5a of the Standing Orders)

DRAFT

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

DRAFT

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 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".

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

2. Purpose

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

2.2 The Committee will ensure the needs of its service users, carers, people and the public are at the centre of all its business.

2.3 The Committee will provide:

- *assurance* to the Board on the setting of local organisational Quality, Safety & Experience standards and supporting an organisational safety culture.
- evidence based and timely *advice* to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality, safety and experience of health care provided and secured by CTMUHB, and that at all levels, it has the right governance arrangements and strategies in place to ensure that the care planned or provided across the breadth of the organisation's functions, is based on sound evidence, clinically effective and meeting agreed standards.
- *assurance* to the Board in relation to CTMUHB's arrangements for safeguarding and improving the quality and safety of patient and citizen centred health improvement and care services in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales;

- *assurance* to the Board in relation to improving the experience of patients, carers, citizens and all those that come into contact with our services including those provided by other organisations or in a partnership arrangement.
- *assurance* that the Board is operating in accordance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- *assurance* that the Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate.

3. Scope and Duties

3.1 Provide advice to the Board on the adoption of a set of key indicators of quality, safety and experience of care against which the CTMUHB's performance will be regularly assessed and reported.

3.2 Assure the development and delivery of the enabling strategies within the scope of the Committee, aligned to organisational objectives and the Annual Plan/Integrated Medium Term Plan for sign off by the Board.

3.3 Oversee and monitor workplace health and safety, providing assurance to the Board on the development of related strategies and operating practices to ensure arrangements for staff workplace health and safety are in compliance with associated legislation.

3.4 To receive an assurance on delivery against relevant Planning Objectives aligned to the Committee, in accordance with Board approved timescales, as set out in CTMUHB's Annual Plan.

3.5 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Organisational Risk Register (ORR) as allocated to the Committee and provide assurance to the Board that risks are being managed effectively. Report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

3.6 Recommend acceptance of risks that cannot be brought within CTMUHB's risk appetite/tolerance to the Board through the Committee Update Report.

3.7 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.8 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.

3.9 Seek assurance on delivery against Planning Objectives aligned to the Committee, considering and scrutinising the processes that are developed

and implemented, supporting and endorsing these as appropriate.

3.10 Oversee the development and implementation of strengthened and more holistic approaches to triangulating intelligence to identify emerging issues and themes that require improvement or further investigation.

3.11 Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular, that sources of internal assurance are reliable, there is the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.

3.12 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.

3.13 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement. Patient Stories, Patient Charter and Board Members walkarounds will feature as a key area for patient experience and lessons learnt.

3.14 Provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with CTMUHB strategies.

3.15 Ensure that CTMUHB is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.

3.16 Ensure that CTMUHB is meeting the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

3.17 Agree actions, as required, to improve performance against compliance with incident reporting.

3.18 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

3.19 Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.

3.20 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.

3.21 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.

3.22 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

3.23 Oversee the arrangements for the approval of clinical and non-clinical written control documents.

3.24 Oversee the arrangements for the ongoing delivery of the CTMUHB's Research & Development Strategy.

3.25 Approve policies within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.

3.26 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance

3.27 Develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year.

3.28 Review and approve work plans for Sub-Committees to scrutinise and monitor the impact on patients of the Health Board's services and their quality.

3.29 Refer quality, safety and experience matters, which impact on people, planning, finance and performance to the relevant Board Committees and vice versa.

3.30 Agree issues to be escalated to the Board with recommendations for action

3.31 Hosted Bodies - The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by CTMUHB as appropriate. The Committee will consider any quality, safety and experience issues associated with services commissioned for Cwm Taf Morgannwg residents and those services provided by CTMUHB.

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

4. Membership

Members

4.1 The Membership of QSEC is as follows:

Chair	Independent Member
Vice Chair	Independent Member
Members	2 further Independent Members (including the Chair of the Audit, Risk & Assurance Committee and the Chair and/or Member of the Health, Safety & Fire Sub Committee).

4.2 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

Support to Committee Members

4.3 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 for People.

4.4 The membership of QSEC will be reviewed annually.

In Attendance

Executive Director of Nursing / Deputy CEO
Executive Medical Director
Executive Director of Allied Health Professions and Health Science
Executive Director of Public Health
Chief Operating Officer
Director of Corporate Governance / Board Secretary
Care Group Director representation: • Unscheduled Care • Planned Care • Diagnostics, Therapies, Pharmacy and Specialties • Mental Health and Learning Disabilities • Primary Care and Community • Children and Family
Deputy Executive Director of Nursing
Deputy Executive Medical Director or Assistant Medical Director (Quality & Safety)
Assistant Director of Quality & Safety
Assistant Director of Nursing and Peoples Experience
Llais Cymru/ Citizens Voice Body Representative (not counted for quoracy purposes)
Staff Side Representative

4.5 It is expected that the representative for the Sub Committee will attend the QSEC for presenting their update reports.

By Invitation:

4.6 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.

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

5 Quorum & Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee and one other Independent Member, together with a third of the In Attendance Members.

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

5.3 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

5.4 Any senior officer of CTMUHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.5 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.6 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.7 The Chair of CTMUHB reserves the right to attend any of the Committee's meetings as an ex officio member.

5.8 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the QSEC.

5.9 The Committee can arrange to meet with Internal Audit and External Audit (and, as appropriate, nominated representatives of Healthcare Inspectorate Wales), without the presence of officers, as required.

5.10 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

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet at least six times per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

8.1 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.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

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

11 Accountability, Responsibility & Authority

11.1 The QSEC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The Committee shall embed the CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 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.

11.6 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

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

11.8 At this stage, the Committee has established the following Sub Committee:

- *Health, Safety & Fire Sub Committee*
- *Organ Donation Sub Committee*

11.9 The Health, Safety & Fire 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".*

12 The Organ Donation Sub Committee supports the Health Boards obligation to influence policy and practice in order to ensure that organ and tissue donation is considered in all appropriate situations, and to identify and resolve any obstacles to this. It will also ensure that a discussion about organ and tissue donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals. It will also maximise the overall number of organs donated, through better support to potential donors and their families.

13 Reporting

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

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

13.2 In doing so, the Committee shall contribute 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.

13.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

13.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

13.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee,

of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

13.6 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 Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

14 Applicability of Standing Orders to Committee Business

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

- Quorum

15 Chairs Action on Urgent Matters

15.1 There may, occasionally, be circumstances where decisions which normally would have been 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 Committee, after first consulting with one other Independent Member and at least two other 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.

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

16 In Committee (Private Meeting)

16.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information

17 Review

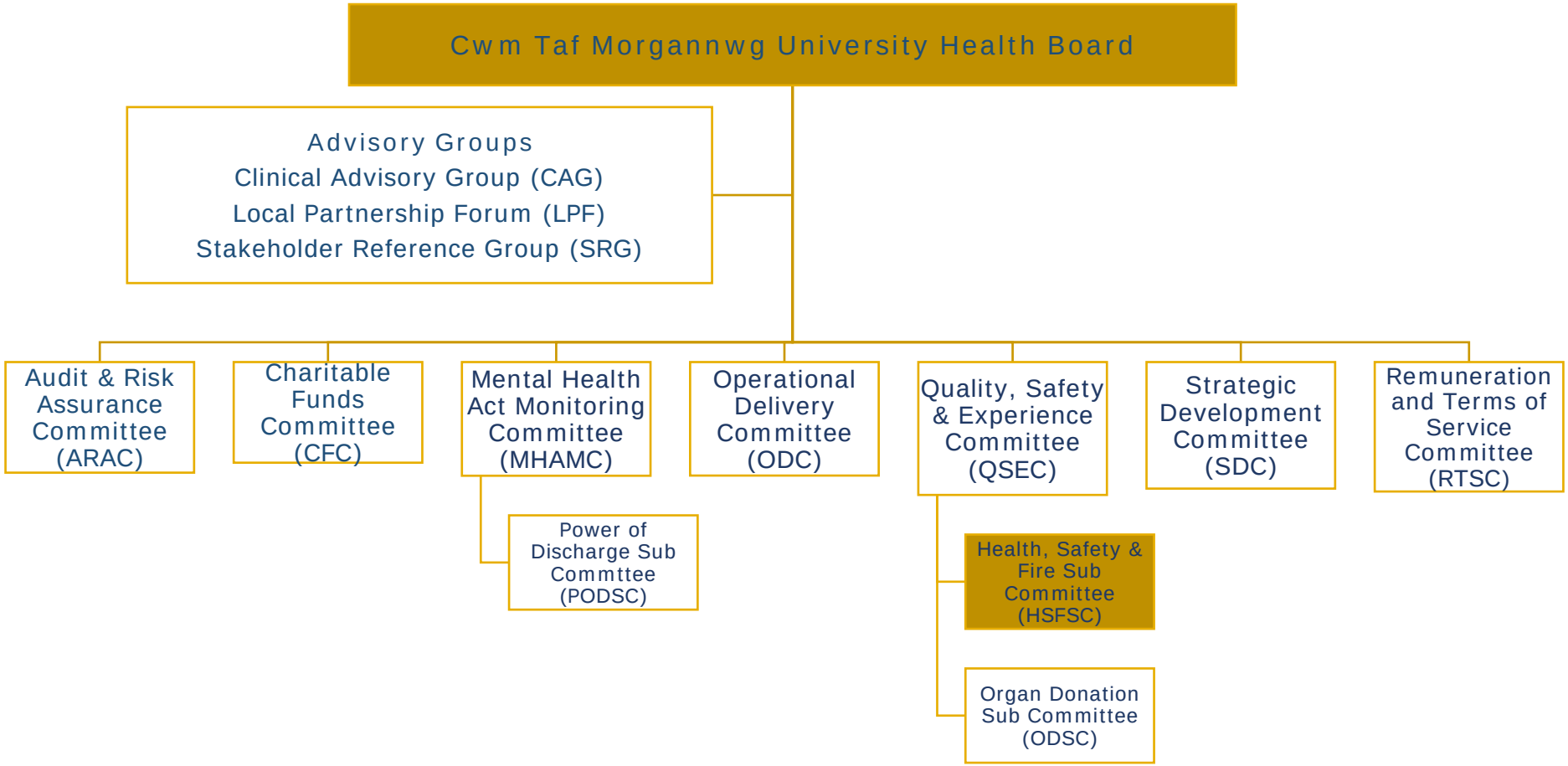
17.1 These Terms of Reference shall be approved at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

HEALTH, SAFETY & FIRE SUB COMMITTEE

Terms of Reference & Operating Arrangements
(Schedule 3.5b of the Standing Orders)

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
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Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 The Quality, Safety & Experience Committee, established as a Committee of the Board, has established a Health, Safety & Fire Sub Committee, the 'sub committee'.

1.2 CTMUHB has a 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".*

1.3 The main objectives of the sub committee is to:

- Promote a healthy and safe working environment for staff employed in CTMUHB through positive co-operation between Managers and Safety Representatives on health and safety issues.
- Provide a framework for agreeing and endorsing Health, Safety, Fire Policies and Strategies.
- Agree strategies that will ensure effective health safety and fire management within CTMUHB and monitor progress against the Strategy
- Act as a forum for monitoring the prevention of workplace accidents, avoidance of industrial injuries and disease and for instructing on preventative and remedial measures.

2. Purpose

2.1 The purpose of the sub committee is to:

- *Advise and assure* the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of CTMUHB's health and safety and fire safety policies, approve and monitor delivery against the Health Safety and Fire priority action plan and ensure compliance with the relevant standards for Health Services in Wales.
- This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues. Where appropriate, the committee will advise the board and the accountable officer on where and how, its health safety and fire management may be strengthened and developed further.

3. Scope and Duties

3.1 The Health, Safety & Fire Sub Committee will be concerned with the health, safety, fire and welfare of all staff employed throughout CTMUHB and those who may be affected by risks arising out of or in connection with work activities.

3.2 With regard to its role in providing advice to the Board and Quality, Safety & Experience Committee, the sub committee will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective health safety and fire function.

3.3 With regard to its role in providing advice to the Board, it will encompass:

- Staff health and safety;
- Premises health and safety;
- Violence and aggression (including security strategy);
- Fire safety;
- Risk assessment;
- Manual handling;
- Health, welfare, hazard substances, safety environment;
- Patient health and safety – patient falls (If RIDDOR Reportable), patient manual handling;
- Staff healthy lifestyle / health promotion activities;
- Estates Compliance Activity;
- Personal Protective Equipment;
- Staff health and well-being;
- Facilities Compliance Activity.

3.4 The subcommittee will support the Board with regard to its responsibilities for health safety and fire by:

- Receiving assurance that the health and safety action plan is on track for delivery;
- reviewing the comprehensiveness of assurances in meeting the Board and the accountable officer's assurance needs across the whole of the health board's activities, both clinical and non-clinical;
- Considering and endorsing policies as determined by the board.

3.5 To achieve this, the committee's programme of work will be designed to provide assurance that:

- objectives set out in the health safety and fire action plan are on target for delivery in line with agreed timescales;
- standards are set and monitored in accordance with the relevant standards for Health Services in Wales;
- robust proactive and reactive health and safety plans are in place across the health board;

- policy development and implementation is actively pursued and reviewed;
- where appropriate and proportionate health safety and fire incidents and ill health events are investigated and action taken to mitigate the risk of future harm;
- reports and audits from enforcing agencies and internal sources are considered and acted upon;
- employee health and wellbeing activities are in place in line with CTMUHB's commitment to be a public health practicing organisation and aligned to the corporate health standards;
- employee Health and safety competence and participation is promoted;
- decisions are based upon valid, accurate, complete and timely data and information.

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

4. Membership

4.1 The Membership of the Sub Committee is as follows:

Chair	Independent Member
Vice Chair	Independent Member of the Board
Attendees	• Executive Director for People (Executive Lead) • Deputy Chief Operating Officer – Acute Services (Care Group nominated lead in their absence) • Assistant Director – Health, Safety & Fire • Director of Corporate Governance / Board Secretary (or nominated deputy) • Chair of the Staff Side Health & Safety Committee • Assistant Director of Planning - (Capital and Estates)/ Strategic and Operational Planning or Head of Operational Estates • Divisional Director Of Facilities

4.2 By invitation the Sub Committee Chair may invite any other officers from CTMUHB or those outside the organisation where appropriate. The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.3 Member Appointments - The membership of the sub Committee shall be determined by the Quality, Safety & Experience Committee, based on the recommendation of the Sub Committee Chair. The membership of the Sub Committee will be reviewed annually.

5. Quorum

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

6. Meeting Secretariat

6.1 The secretariat will be as determined by the Director of Corporate Governance/Board Secretary.

7. Frequency of Meetings

7.1 Meetings shall meet no less than 4 times a year, and otherwise as the Chair of the Sub Committee deems necessary.

8. Withdrawal of Individuals in Attendance

8.1 The Sub 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.

9. Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10. Delegated Powers, Authority & Access

10.1 The sub committee is authorised by the Quality, Safety & Experience Committee to investigate or have investigated any activity within its terms of reference. In doing so, the sub committee shall have the right to inspect any information, records or documents of the health Board relevant to the committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

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

10.2 The sub committee is authorised by the Board to 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.

10.3 The sub committee may, subject to the approval of the Board/Quality, Safety & Experience Committee, establish task and finish groups to carry out on its behalf specific aspects of sub committee business.

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

10.5 The Executive Lead for health, safety and fire shall have unrestricted access to the chair of the Health, Safety and Fire Sub Committee.

11. Accountability & Responsibility

11.1 The Sub-Committee is directly accountable to the Quality, Safety & Experience Committee, for its performance in exercising the functions set out in these terms of reference.

11.2 Due to the sensitivity of potential staff/ patient information received, the Sub-Committee will at all times be aware of the importance of confidentiality, and ensure that they comply with the CTMUHB's policies within this area of work.

11.3 The Sub-Committee shall embed CTMUHB's values, vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.4 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Sub Committee.

12. Reporting

12.1 The Sub-Committee, through its Chair and Members, shall work closely with the Quality, Safety & Experience Committee and other appropriate forums to provide assurance in relation to:

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

12.2 In doing so, the Sub-Committee shall contribute 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.

12.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive written update reports following each meeting which details the business undertaken on its behalf.

12.4 The Sub-Committee Chair, supported by the Sub-Committee meeting secretariat, shall:

- Report formally, regularly and on a timely basis to the Quality, Safety & Experience Committee on the Sub-Committee's activities. This includes the submission of a routine Committee Highlight report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.
- Bring to the Quality, Safety & Experience Committees attention any significant matter under consideration by the Sub-Committee.

13. Applicability of Standing Orders to Committee Business

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

- Quorum

14. Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15. Review

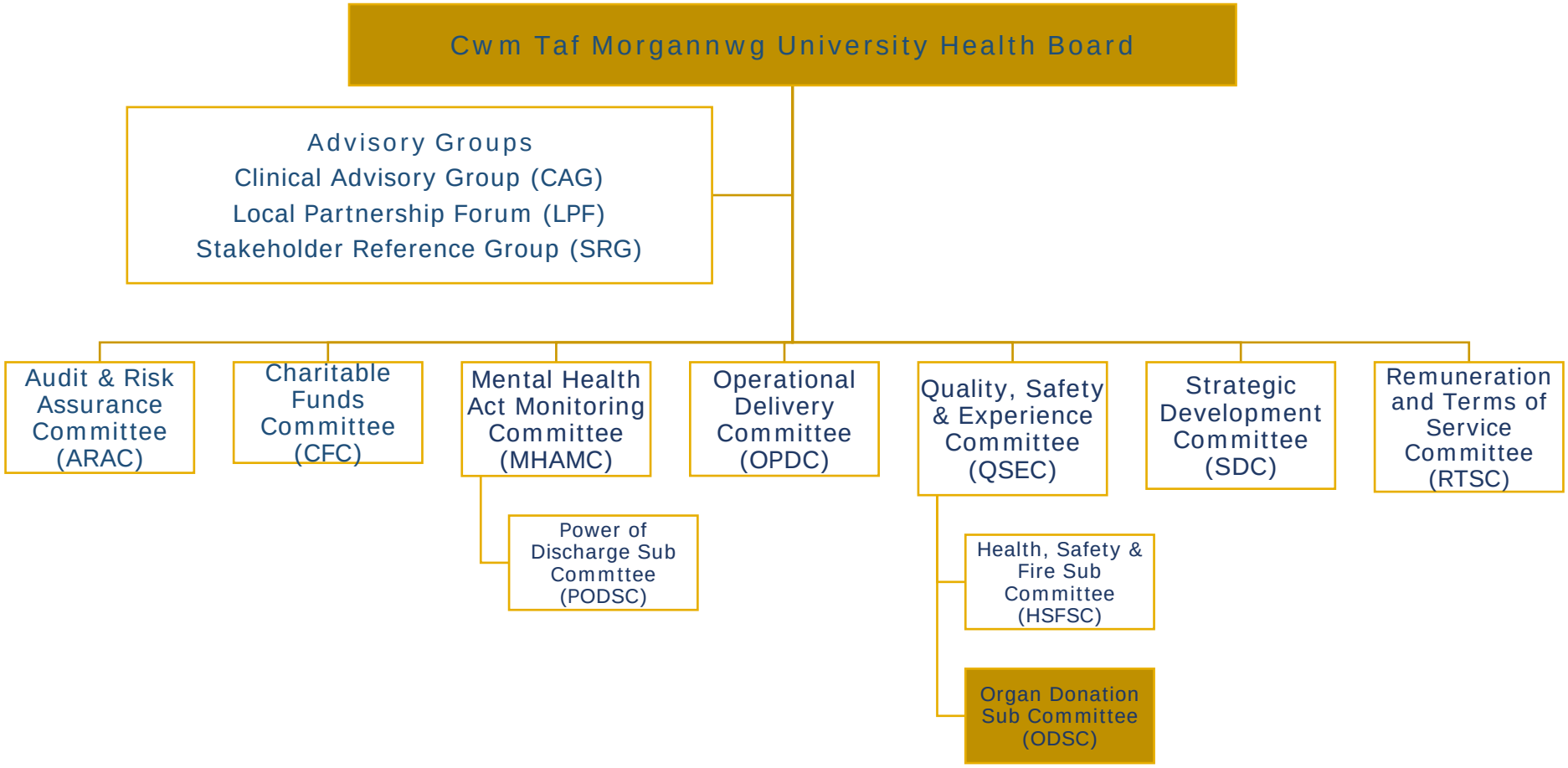
15.1 These Terms of Reference shall be approved by the Quality, Safety & Experience Committee and subject to review at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

ORGAN DONATION SUB COMMITTEE

Terms of Reference & Operating Arrangements
(Schedule 3.5c of the Standing Orders)

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
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Version 1				

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 The Quality, Safety & Experience Committee, established as a Committee of the Board, has established an Organ Donation Sub Committee.

2. Purpose

2.1 The purpose of the Organ Donation Sub Committee, the 'sub committee' is to:

- Influence policy and practice in order to ensure that organ donation is considered in all appropriate situations, and to identify and resolve any obstacles to this.
- Ensure that a discussion about organ donation features in all end of life care, wherever located and whenever appropriate, recognising and respecting the wishes of the individuals
- Maximise the overall number of organs donated, through better support to potential donors and their families.

3. Scope and Duties

3.1 To ensure the purpose is achieved, the Sub Committee is responsible for the following:

- To lead on donation policy and practice across the CTMUHB, to raise awareness, and to ensure that donation is accepted and viewed as usual, not unusual. To maximise organ donation.
- To ensure local policies and all operational aspects of donation are reviewed, developed and implemented in line with current and future national guidelines and policies.
- To monitor donation activity from all areas of the hospitals within CTMUHB - primarily from Critical Care areas, including Emergency Medicine. Rates of donor identification, referral, and approach to the family and consent to donation will be collected through the UK Transplant Potential Donor Audit (PDA), to ensure submission of the data to NHS Blood and Transplant (NHSBT) on an agreed basis and to receive and analyse comparative data from other hospitals.
- To report to the Medical Director not less than quarterly, and to the Board not less than six monthly, on comparative donation activity and any remedial action required.
- To participate in all relevant national audit processes; to review audit data on donation activity; to monitor standards, test adherence to local policy and instigate any required actions.
- To actively promote communication about donation activity to all appropriate areas of the hospital and to ensure that the information is received and understood.

- To ensure a discussion about donation features in all end of life care wherever appropriate and to ensure this is reflected in the local end of life policies, procedures and pathways.
- To support the Specialist Nurses for Organ Donation (SNOD) and Clinical Leads for Organ Donation (CLOD).
- To identify and ensure delivery of educational programmes to meet recognised training needs.

4. Membership

4.1 The Membership of the Sub Committee is as follows:

Chair	Independent Member In the absence of the Committee Chair the Medical Director or his/her nominated deputy will chair the meeting.
Vice Chair	Executive Medical Director or their nominated Deputy Medical Director
Attendees	Executive Director of Nursing / Deputy Chief Executive Clinical Leads for Organ Donation (CLODs) Specialist Nurses for Organ Donation (SNODs) Consultant – Intensive Care Unit Senior Nurse for Critical Care Medical representative for Emergency Medicine Senior Nurse representative for Emergency Medicine Senior Nurse for Theatres- Prince Charles Hospital Senior Nurse for Theatres- Royal Glamorgan Hospital Senior Nurse for Theatres- Princess of Wales Hospital Consultant Palliative Care/Lead Nurse for Palliative Care Pathology Representative Communication Team Representative Spiritual Care Representative Local Donor Family Primary Care Representative

4.2 By invitation the Sub Committee Chair may invite any other officers from CTMUHB or those outside the organisation where appropriate. The invitees may be asked to attend all or part of a meeting to assist it with its discussions on any particular matter.

4.3 Member Appointments - The membership of the sub Committee shall be determined by the Quality & Safety Committee, based on the

recommendation of the Sub Committee Chair. The membership of the Sub Committee will be reviewed annually.

5. Quorum

5.1 A Quorum of a third of the whole number, including the Independent Member of the Health Board as Chair of the Sub-Committee or the Vice Chair of the Sub Committee.

6. Meeting Secretariat

6.1 The secretariat will be appointed via the Medical Directorate.

7. Frequency of Meetings

7.1 The Sub Committee shall meet at least four times per annum and as otherwise directed by the Chair.

8. Withdrawal of Individuals in Attendance

8.1 The Sub 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.

9. Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10. Delegated Powers, Authority & Access

10.1 The Sub Committee is authorised to request legal advice via the Executive Medical Director without recourse to the Quality, Safety & Experience Committee.

10.2 The Chair of the Sub Committee shall have reasonable access to the Chair of the Quality, Safety & Experience Committee, Executive Directors and other relevant senior staff.

11. Accountability & Responsibility

11.1 The Sub-Committee is directly accountable to the Quality, Safety & Experience Committee, for its performance in exercising the functions set out in these terms of reference.

11.2 Due to the sensitivity of the patient information received, the Sub-Committee will at all times be aware of the importance of confidentiality, and ensure that they comply with the CTMUHB's policies within this area of work.

11.3 The Sub-Committee shall embed CTMUHB's values, vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.4 The requirements for the conduct of business as set out in the CTMUHB's Standing Orders are equally applicable to the operation of the Sub Committee.

12. Reporting

12.1 The Sub-Committee, through its Chair and Members, shall work closely with the Quality, Safety & Experience Sub Committee and other appropriate forums to provide assurance in relation to:

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

12.2 In doing so, the Sub-Committee shall contribute 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.

12.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive written update reports following each meeting which details the business undertaken on its behalf.

12.4 The Sub-Committee Chair, supported by the Sub-Committee meeting secretariat, shall:

- Report formally, regularly and on a timely basis to the Quality, Safety & Experience Committee on the Sub-Committee's activities. This includes the submission of a routine Committee Highlight report, as well as the presentation of an Annual Report within six weeks of the end of the financial year.
- Bring to the Quality, Safety & Experience Committees attention any significant matter under consideration by the Sub-Committee.

13. Applicability of Standing Orders to Committee Business

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

- Quorum

14. Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15. Review

15.1 These Terms of Reference shall be approved by the Quality, Safety & Experience Committee and subject to review at least on an annual basis or when changes in legislation may dictate, with approval thereafter ratified by the Health Board.

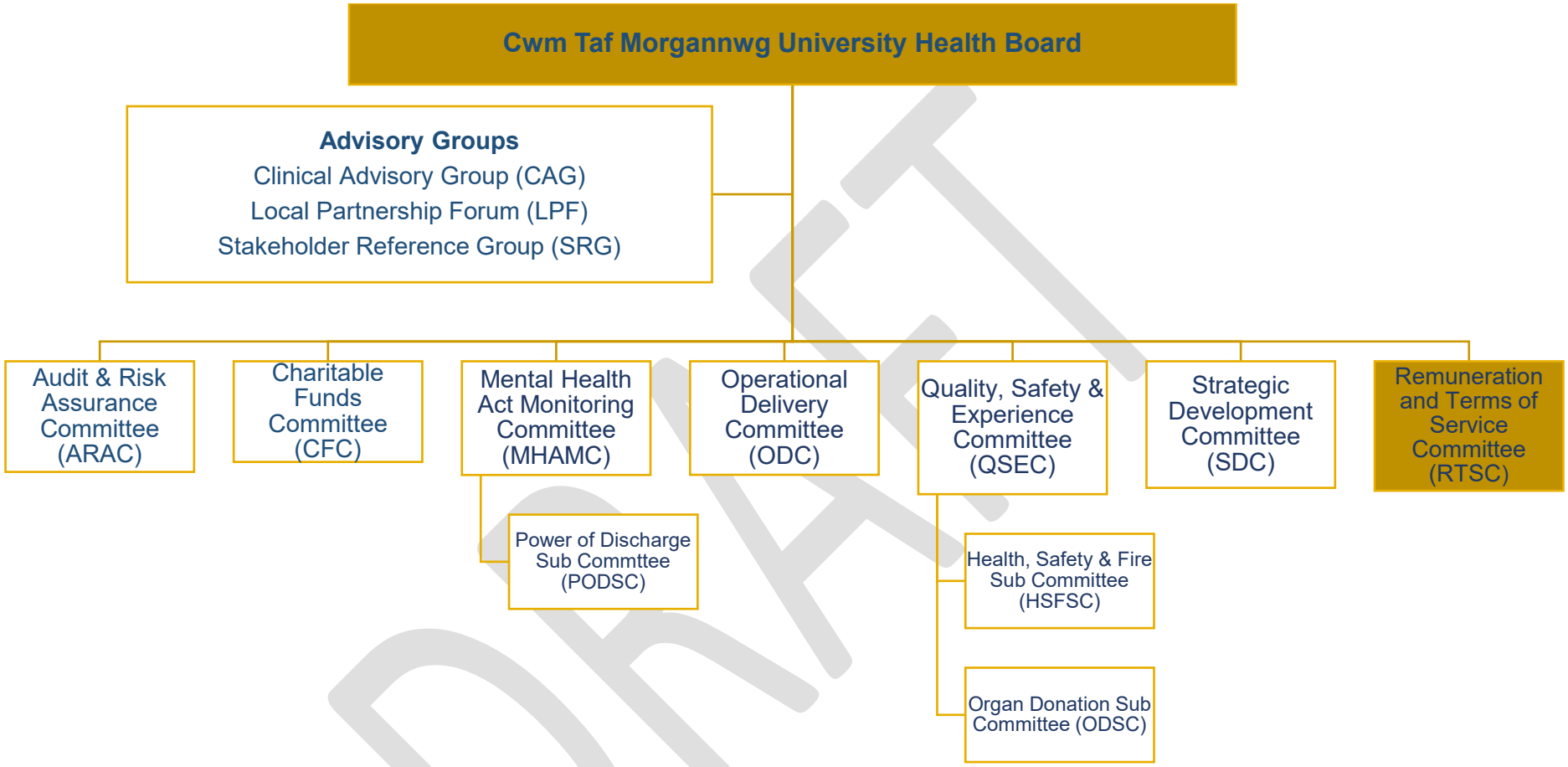
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

REMUNERATION & TERMS OF SERVICE COMMITTEE (RTSC)

Terms of Reference & Operating Arrangements
(Schedule 3.5 of the Standing Orders)

DRAFT

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk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DRAFT

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 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".

1.2 In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Remuneration & Terms of Service Committee (RTSC).** The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

1.3 Due to the nature of the business being considered at the RTSC these meetings will be held in private and papers/minutes will not be made publically available. A summary highlight report will be received at the Public Board meeting that follows.

2. Purpose

2.1 The purpose of the Remuneration & Terms of Service Committee is to act on behalf of the Board to:

- ***Approve***, on behalf of the Board, the remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; and
- ***Provide Assurance*** to the Board in relation to the CTMUHB's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales
- as appropriate the Committee will ***receive reports*** relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers (VSMs) of its hosted bodies
- Perform certain, specific functions on behalf of the Board.

2.2 The Committee shall have no powers to develop or modify existing pay schemes.

3. Scope and Duties

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Remuneration and Terms of Service Committee will comment specifically upon:

3.1 Remuneration and terms of service for the Chief Executive, Executive Directors, other Very Senior Managers (VSMs) and others not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by Welsh Government are applied consistently;

3.2 Objectives for Executive Directors and other Very Senior Managers (VSMs) and their performance assessment;

3.3 Performance management systems in place for those in the positions mentioned above and its application;

3.4 Proposals to make additional payments to Medical and Dental Consultants outside of normal terms and conditions;

3.5 Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the provision of the regulations and in accordance with Ministerial instructions, Welsh Government guidance;

3.6 Consider and approve Voluntary Early Release applications and redundancy/severance payments in respect of Executive Director/Director posts, in line with Standing Orders and extant Welsh Government guidance.

3.7 The Committee to be advised also of all Voluntary Early Release Scheme applications and severance payments;

3.8 Approve any Strategic Advisor arrangements, including scope and pay;

3.9 In developing remuneration packages the Remuneration and Terms of Service Committee will ensure that there is:

- A clear statement of responsibilities of the individual posts and their accountabilities of meeting objectives of the organisation
- A means of assessing the comparative job weight
- Comparative salary information from the NHS, other public sector organisations and industrial service organisations.

Circumstances where Welsh Government Approval is required

Circumstances in which Welsh Government approval is required from an accounting perspective for **individual end of employment payments**. These are set out in the NHS Wales Manual for Accounts under the Losses and Special Payments chapter, however, in summary, these are:

3.10 **Contractual Redundancy** – CTMUHB has delegated authority from a financial accounting perspective to pay contractual entitlements so Welsh Government approval is not needed. However, for Executive Directors, Welsh Government do need to be aware before any such contractual arrangements are signed off with the individual and approved by the Director General / CEO NHS Wales as Accounting Officer.

3.11 **Voluntary Early Release Scheme (VERS)** – organisations have delegated authority for payments up to £50,000 as set out on the VERS Model Scheme rule. Payments over this level require Welsh Government Accounting Officer approval, and there is a template Business Case to submit to Welsh Government for approval.

3.12 **Ex gratia / Settlement payment** – any payment amount above contractual entitlement requires Welsh Government approval. Given that cases will be based on individual circumstances there is no set template, however Welsh Government have developed a spreadsheet with options to demonstrate that the course of action is cost effective and demonstrates value for public sector money, as any such payments should only be exceptional. The Losses and Special payment chapter also outlines the principles to follow and the checklist that must be completed and signed off.

3.13 In all of the above scenarios (3.10-3.12) the **RTSC provides an essential role** and **must sign off the payment** prior to submission to Welsh Government for final approval.

4. Membership

Members

4.1 The Membership of RTSC is as follows:

Chair	CTMUHB Chair
Vice Chair	CTMUHB Vice Chair
Members	All Independent Members

Support to Committee Members

4.2 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 for People.

In Attendance

Executive Director For People
Deputy Director for People or the Assistant Director of Policy, Governance and Compliance *(Will attend to present papers and provide professional advice in order to facilitate the Committee deliberations)*
Director of Corporate Governance / Board Secretary

4.3 Apart from the issue of the Chief Executive's personal salary and remuneration, the Chief Executive will be invited to attend meetings when the remuneration of Executive Directors and other members of the Senior Management Team is on the agenda for discussion.

By Invitation:

4.4 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.

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

5 Quorum & Attendance

5.1 A quorum shall consist of no less than three of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

5.3 Any senior officer of CTMUHB or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Committee can arrange to meet with Internal Audit and External Audit without the presence of officers, as required.

5.7 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

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet **as and when required and at least once per annum** and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

8.1 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.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

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

11 Accountability, Responsibility & Authority

11.1 The RTSC is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The Committee shall embed the CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 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.

11.6 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

11.7 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.

11.8 At this stage, there are no sub committees established.

12 Reporting

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

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

12.2 In doing so, the Committee shall contribute 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.

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 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 Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook

13 Applicability of Standing Orders to Committee Business

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

- Quorum

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made normally be made by the Sub Committee will need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15 Review

These terms of reference and operating arrangements shall be reviewed on at least an annual basis

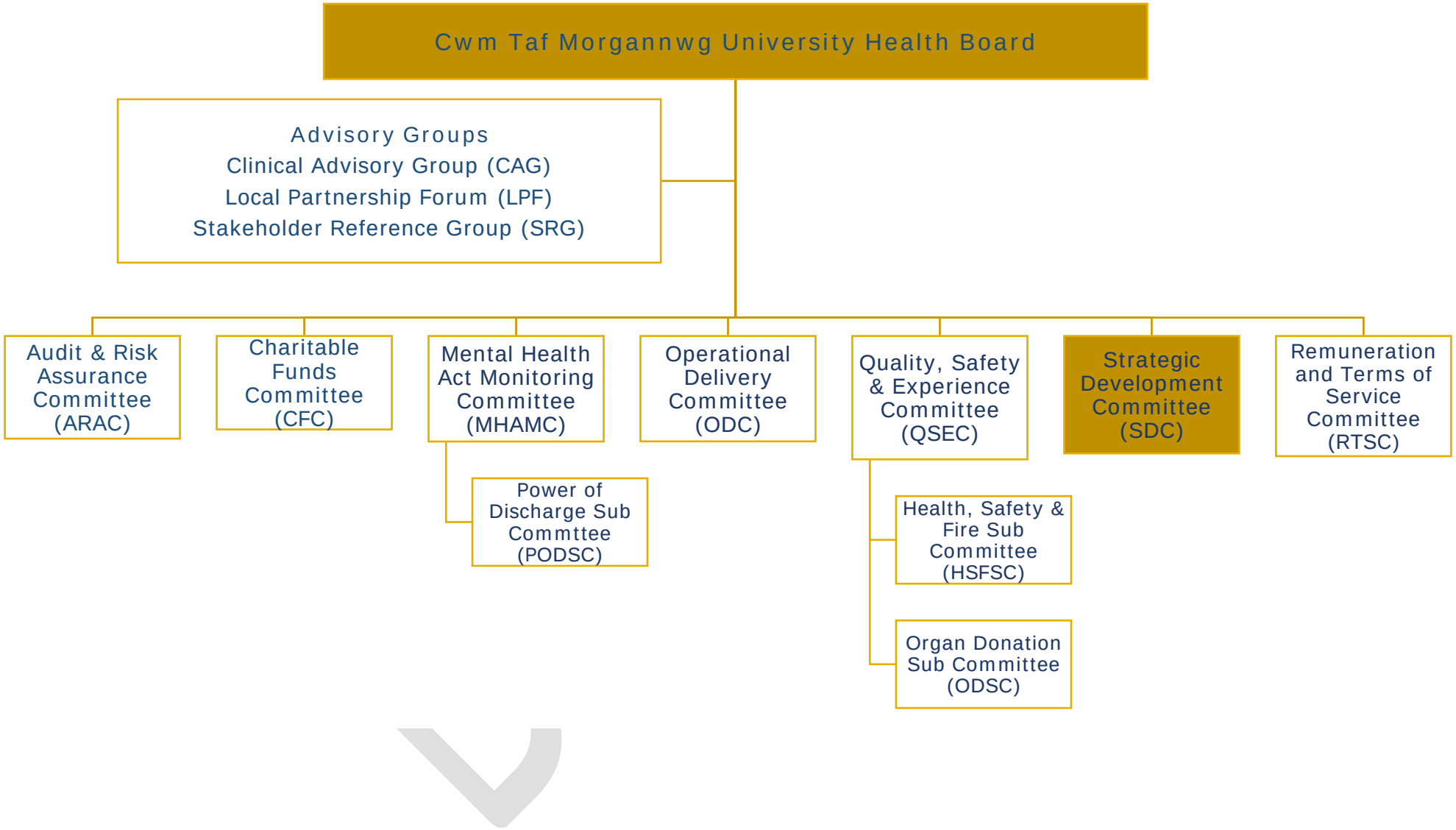
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

STRATEGIC DEVELOPMENT COMMITTEE (SDC)

Terms of Reference & Operating Arrangements
(Schedule 3.7 of the Standing Orders)

DRAFT

Last Approved: Health Board Meeting ( )
CTM_Corporate_Governance@wales.nhs.uk


Cwm Taf Morgannwg University Health Board
Advisory Groups
Clinical Advisory Group (CAG)
Local Partnership Forum (LPF)
Stakeholder Reference Group (SRG)
Audit & Risk Assurance Committee (ARAC)
Charitable Funds Committee (CFC)
Mental Health Act Monitoring Committee (MHAMC)
Power of Discharge Sub Commttee (PODSC)
Operational Delivery Committee (ODC)
Quality, Safety & Experience Committee (QSEC)
Health, Safety & Fire Sub Committee (HSFSC)
Organ Donation Sub Committee (ODSC)
Strategic Development Committee (SDC)
Remuneration and Terms of Service Committee (RTSC)

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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

DRAFT

Board Committee Arrangements: This schedule forms part of, and shall have effect as if incorporated in the Health Boards Standing Orders

1. Introduction & Constitution

1.1 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".

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

1.3 The business of the Committee will be driven by the strategic risks facing the organisation as captured in the Board Assurance Framework.

2. Purpose

2.1 The purpose of the Committee is to:

- Evidence based and timely strategic assurance to the Board to assist it in discharging its functions and responsibilities with regard to the:
  - Strategic direction;
  - Strategic planning and associated investments;
  - Long term financial sustainability
  - Setting our Culture;
  - People retention and succession planning.

- Scrutinise strategic risks on the Board Assurance Framework and their impact upon CTMUHB's ability to deliver its strategic ambitions. This will include assurance that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

- Assurance to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

- To provide assurance to the Board that, wherever possible, CTMUHB plans are aligned with partnership plans developed with Regional Partners, Local Authorities, Universities, Collaboratives, Alliances and other key partners.

2.2 The SDC business will also be informed by relevant national policies such as Healthier Wales, Wellbeing of Future Generations Act etc.

2.3 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. Scope and Duties

3.1 The scope of the SDC Committee extends to the full range of CTMUHB responsibilities.

3.2 The SDC Committee will focus on longer term strategic planning / horizon scanning. (Beyond in-year delivery)

3.3 The SDC will have specific responsibilities with regards the following:

3.3.1 Our Models of Care

Scrutinise and seek assurance on the strategic development of the following plans/programmes:

- Overarching CTM:2030 Strategy;
- Acute Clinical Services Plan;
- Strategic Digital Transformation Programmes;
- Integrated Community Services;
- Strategic Commissioning.
- Building Healthier Communities

3.3.2 Our Population / Working with Our Partners

Seek assurance on the strategic development of the following plans/programmes:

- Population Health Strategic Delivery Plan
- Partnership Engagement (PSB and RPB)

3.3.3 Our Commitment to Sustaining Our Future

Seek assurance on the strategic development of the following enabling activity /plans/programmes:

- Strategic Financial Position Updates
- Estates Performance
- People Plan
- Digital & Data Strategy
- Decarbonisation Strategy
- University Health Board designation
- Integrated Medium Term Plan (including Sign Off).

4. Membership

Members

4.1 The membership of the Committee shall be determined by the Board, based on the recommendation of CTMUHB Chair, taking into account 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.

4.2 The membership of the SDC Committee will be reviewed annually.

4.3 The Membership of the SDC is as follows:

Members

Chair	Independent Member
Vice Chair	Independent Member
Members	2 further Independent Members

In Attendance

Executive Director of Strategy & Transformation *(Executive Lead for the Committee)*
Executive Director for People
Executive Director of Finance
Executive Director of Public Health
Executive Director of Allied Health Professions and Health Science
Chief Operating Officer
Director of Digital (SIRO)
Director of Corporate Governance / Board Secretary
Deputy director of strategy and partnerships
Deputy Director for People

By Invitation:

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

4.5 Other Executive 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.

5 Quorum & Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee, together with a third of the "In Attendance" members.

5.2 There is an expectation that the core Executive Directors noted in the "In Attendance" section will attend every Committee. Should any 'in attendance' officer member be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

6 Meeting Secretariat

6.1 The Committee Secretariat shall be determined by the Director of Corporate Governance/Board Secretary.

7 Frequency of Meetings

7.1 The Committee will meet at least four times per annum and shall agree an annual schedule of meetings.

7.2 Any additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive(s).

7.3 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of and procedures of such Committee meetings.

8 Withdrawal of Individuals in Attendance

8.1 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.

9 Circulation of Papers

9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.

10 Access

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

11 Accountability, Responsibility & Authority

11.1 The SDC Committee is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

11.2 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in 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 the organisation.

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

11.4 The Committee shall embed CTMUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

11.5 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

11.6 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.

11.7 At this stage, no sub Committees/task and finish groups have been established.

12 Reporting

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

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

12.2 In doing so, the Committee shall contribute 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.

12.3 The Committee may establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each sub-committee or task and finish group meeting detailing the business undertaken on its behalf.

12.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub-Committees to meet its responsibilities for advising the Board on the adequacy of CTMUHB's overall assurance framework.

12.5 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report as well as the presentation of an annual report within six weeks of the end of the financial year and timed to support the preparation of the Accountability Report. This should specifically comment on the adequacy of the assurance framework, 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 Committee's self-assessment and evaluation.
- Bring to the Board's specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert CTMUHB Chair, Chief Executive or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

12.6 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 Committees performance and operation, including that of any sub-committees established.

13 Applicability of Standing Orders to Committee Business

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

- Quorum

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which would have been made by the Sub Committee will need to be taken between scheduled meetings. In these circumstances, the Sub Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee, after first consulting with one other Independent Member and at least two other members of the Sub 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.

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

15 In Committee (Private Meeting)

15.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

CTMUHB - BOARD ASSURANCE – STRATEGIC RISK PROFILE

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Key Assurance committee	Current score
1a	Sufficient capacity to meet elective demand	Improving Care	Chief Operating Officer / Executive Director of Strategy and Transformation	Quality, Safety & Experience Committee Operational Development Committee	16 (C4xL4)
1b	Sufficient capacity to meet emergency demand	Improving Care	Chief Operating Officer / Executive Director of Strategy and Transformation	Quality, Safety & Experience Committee Operational Development Committee	20 (C4xL5)
2.	Ability to deliver improvements which transform care and enhance outcomes	Improving Care	Executive Dir. Of Nursing, Midwifery / Executive Medical Director	Quality, Safety & Experience Committee Strategic Development Committee	16 (C4xL4)
3.	Sufficient workforce to deliver the activity and quality ambitions of the organisation	Sustaining our Future	Executive Director of People	Operational Delivery Committee Strategic Development Committee	20 (C5xL4)
4.	Community and Partner Engagement	Creating Health	Director of Communications, Engagement & Fundraising	Strategic Development Committee	12 (C4xL3)
5.	Delivery of a digital and information infrastructure to support organisational transformation	Improving Care	Director of Digital	Operational Delivery Committee Strategic Development Committee	16 (C4xL4)
6	Leadership and Management	Inspiring People	Executive Director for People	Operational Delivery Committee Strategic Development Committee	12 (C4xL3)
7	Culture, Values and Behaviours	Inspiring People	Executive Director for People	Strategic Development Committee	12 (C4xL3)
8	Fulfilling our Environmental and Social Duties and ambitions	Sustaining our Future	Executive Director of Strategy and Transformation	Strategic Development Committee	16 (C4xL4)
9	Healthy Life Expectancy	Creating Health	Executive Director of Public Health	Strategic Development Committee	20 (C5xL4)
10	Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government	Sustaining our Future	Executive Director of Finance	Operational Delivery Committee	16 (C4xL4)

6.5	26 September 2024	Board Meeting	Integrated Opportunities on Social Care

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Matt Jenkins, Regional Integration Director
Presented By:	Matt Jenkins, Regional Integration Director
Approving Executive Sponsor:	Linda Prosser, Executive Director of Strategy & Transformation
Report Purpose	For Noting
Engagement undertaken to date:	Through the Regional Partnership Board

Impact Assessment:	
Indicate the Quality/ Safety/ Patient Experience Implications:	To improve for older people and people living with frailty.
Related Health and Care Standard	Whole system approach, Person-centred, efficient, effective, culture
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No – will follow for each part of the program as it moves to delivery
Are there any Legal Implications /Impact.	Yes, in relation to the Regional Partnership Agreement
Are there any resource (capital/Revenue/Workforce Implications / Impact?	The intention is to increase allocative efficiency, using resources to better effect.
Link to Strategic Goals	Sustaining Our Future Inspiring People Improving Care Creating Health

Integrated Community Care System

for older people and people living with frailty

Population outcomes and shared performance metrics

Aligned/ integrated commissioning

Regional Needs Assessment, Market Stability Report, new Demand and Capacity tool

New Regional Partnership Agreement

(MoU and Section 33 Agreement)

Led through a unitary management structure

Delivered through integrated teams on a local footprint

Integrated Community Pathways

Urgent Community Response Pathway

Aligned SPA and Navigation Hub

Population Health Management Pathway

Progress

✓ Commenced redesign work for Integrated Hospital Discharge Teams (community-pull replacing hospital push)

✓ Progressing other aspects of Urgent Community Response pathway redesign and change – implications for re-alignment of the Regional Integration Fund

✓ LA engagement with Clinical Navigation Hub with a view to potential future alignment with Single Points of Access

✓ Dialogue about closer joint working on a cluster footprint ahead of S33

✓ RPB endorsement of the draft MoU and direction of travel for the proposed Section 33 agreement

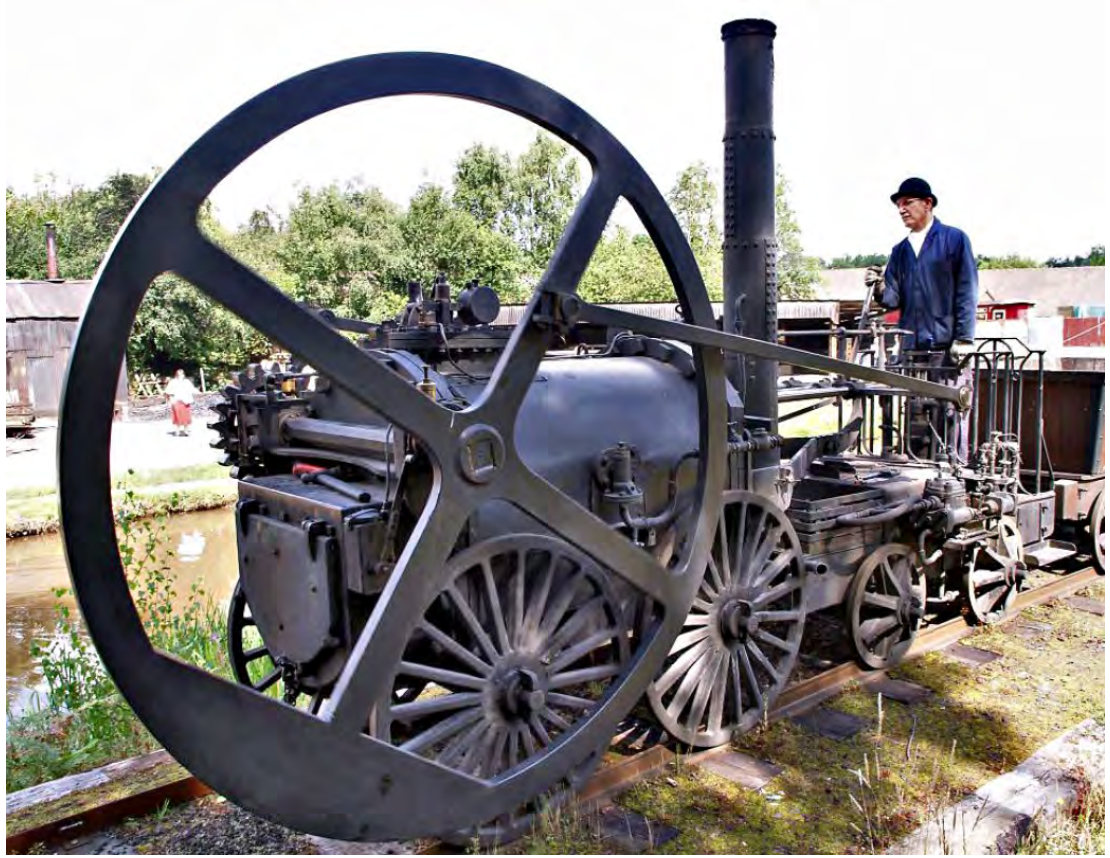
✓ Won support from the Health Foundation to develop a demand and capacity model for intermediate care

✓ Working closely with 6 Goals, Primary & Community Care, ECC Level 4 project and others so that 'the cogs turn together'

✓ Recruitment

"There is no single defining action, no one killer innovation, no solitary lucky break, no miracle moment. Rather, the process resembles relentlessly pushing a giant, heavy flywheel, turn upon turn, building momentum until a point of breakthrough, and beyond."

Jim Collins, Good to Great



Commissioning models

Organisation Centric	Aligned	Integrated
Individual organisations plan, fund, and manage services. This model often focuses on the specific priorities, capacities and resources of each organisation, rather than a coordinated, system-wide approach.	Aligned commissioning refers to the process where *different organisations coordinate* their commissioning activities to ensure consistency and reduce duplication. However, they still operate within their separate structures and budgets.	Integrated commissioning involves the *joint* decision-making, *shared* management of services and pooling of resources. It seeks to create a seamless approach to service delivery across health and social care sectors.
Characteristics: Autonomy in decision making, internal resource allocation decision making, siloed operations	Characteristics: coordination without integration, shared objectives, information sharing.	Characteristics: shared governance, holistic system design, joint funding and budgets.
Structure and governance: Separate structures, budgets, and governance	Structure and governance: Separate structures, budgets, and governance with coordination efforts.	Structure and governance: Joint decision-making with shared accountability.
Decision making independent decision making. Minimal external contact	Decision making: Independent decision-making within a coordinated framework.	Decision making: joint decision making within a coordinated framework.

A New Regional Partnership Agreement

Key points from RPB paper, August 2024:

Memorandum of Understanding endorsed – now moving to seek Statutory Organisations' agreement

Outline of 'Section 33' mechanism for the formal partnership agreement also endorsed

Staged approach to S33 - April 2025 as start point and annual reviews

Staff and wider stakeholder engagement

A Regional Section 33 Agreement

As a minimum the aim by April 2025 should be to have in place:

Overarching S33 document, collective ownership of vision and operational priorities

Reflecting Community Pathways 'optimal model' as agreed at RPB.

Aligned commissioning intentions. Following phases → integrated commissioning approach.

A Regional Joint Operational Management Board TOR to include clear relationship to statutory organisations, RPB and each locality Joint Partnership Board.

Notional pooled fund, where the funding for all services in the community pathways is described in a single presentation. Initially ownership of individual budget lines will remain unaltered. Commitment sought to establish risk sharing arrangements later for maximum value from collective resources.

Accompanying schedules to the S33 agreement describing the services as at April 2025 that will be operated through the agreement.

Timetable for development and inclusion of other services.

Redirect Regional Integration Fund allocations accordingly, and timetable for the remainder.

A timetable for creating and recruiting to new integrated management posts.

Conclusion

Momentum is building

Ambition and pragmatism, balancing short- and long-term

People, confidence and trust

Recommendation:	**The Board are asked to:** • *NOTE the presentation.*

Agenda Item
7.1

CTM Health Board

Integrated Performance Dashboard

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Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Linda Prosser	12/09/2024	Endorsed for Approval

Acronyms / Glossary of Terms	
ABUHB	Aneurin Bevan University Health Board
AMU	Acute Medical Unit
BCUHB	Betsi Cadwaladr University Health Board
BSW	Bowel Screening Wales
C.difficile	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
COO	Chief Operating Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
CTP	Care and Treatment Plan
CYP	Children and Young People
C&VUHB	Cardiff & Vale University Health Board

D2RA	Discharge to Recover then Assess model
DHCW	Digital Health and Care Wales
DNA	Did Not Attend
E.coli	Escherichia coli bacteraemia
ED	Emergency Department
ESD	Early Supported Discharge
FCE	Finished Consultant Episode
FUNB	Follow-up Outpatients Not Booked
HDUHB	Hywel Dda University Health Board
Hib/MenC	Haemophilus Influenzae type b and Meningitis C
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
Klebsiella sp.	Klebsiella sp. Bacteraemia
LA	Local Authority
LD	Learning Disabilities
LPMHSS	Local Primary Mental Health Support Service
MMR	Measles, Mumps, Rubella
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NOUS	Non Obstetric Ultra-Sound
PAC	Pre-operative Assessment Clinic
PADR	Personal Appraisal and Development Review
P.aeruginosa	Pseudomonas aeruginosa bacteraemia
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
POW	Princess of Wales Hospital
PoCD	Pathway of Care Delays
PTHB	Powys Teaching Health Board
PTR	Putting Things Right
QIM	Quality Improvement Measures
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment Times
S.aureus	Staphylococcus aureus bacteraemia
SBUHB	Swansea Bay University Health Board
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SCP	Single Cancer Pathway
SIs	Serious Incidents
SOS	See on Symptom
SSP	Specialist Screening Practitioner
WAST	Welsh Ambulance Service NHS Trust
WG	Welsh Government
WPAS	Welsh Patient Administration System
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. Situation/Background

Early in 2024, Welsh Government released the NHS Performance Framework for 2024/25. The framework supports the delivery of improvements in the Minister's areas of focus and is available to read at the following URL: https://www.gov.wales/nhs-wales-performance-framework-2024-2025-0

1.1 The UHB recently submitted to Welsh Government a balanced integrated medium-term plan (IMTP) for 2024-27.

During August 2024, the Former Cabinet Secretary for Health, Social Care and Welsh Language approved our IMTP and to ensure there is an ongoing focus on delivering and strengthening our plan, a number of accountability conditions have been stipulated by her. These are all current measures within the Performance Framework and our progress in delivering on these is shown in Quadruple Aim 2 of this report. For clarity the accountability conditions are listed below:

Key Performance Indicators	Definition & Target
Urgent and Emergency Care	Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival to admission, transfer or discharge. March 2024 baseline 20% Reduction by September 2024 Further 20% Reduction by March 2025
	Number of ambulance patient handovers over 1 hour. March 2024 baseline 30% Reduction by December 2024
Cancer	Percentage of Patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route). 60% performance by December 2024 70% performance by March 2025
Diagnostics	Number of patients waiting more than 8 weeks for a specified diagnostic. 95% to be zero by December 2024
Elective Care	Number of patients waiting over 52 weeks for a new outpatient appointment. March 2024 baseline 40% reduction by end of September 2024 Zero by March 2025
	Number of patients waiting more than 104 weeks for referral to treatment Zero by end of December 2024
Mental Health	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged 18 years and under.
	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults aged 18 years or over.
	80% for both by December 2024

2. Specific Matters for Consideration

This report sets out the UHB's performance against the Welsh Government's performance framework, the Cabinet Secretary's accountability conditions and a small number of local priority measures such as stroke care and ambulance red releases.

A one page summary (page 5) of the UHB's recent performance against the highest profile indicators within the Welsh Government framework, which have been the focus of the Executive Directors over the past quarter, is provided overleaf. Over the past month improvements have been noted in 11 out of the 18 areas.

2.1 Executive Performance Indicators

The direction of the arrow shows whether the quantum of the measure has increased, decreased or statistically no significant change.
The colour is intended to show whether this is positive [green], negative [red] or no significant change/remains within control limits [amber].

Quality

60 NRI's remain open >90 days ↓

This is a reduction of 12 on the previous period

The % of eligible patients thrombolysed was 33.3% ↑

Compared to last month the rate was zero

79.51 is the rate of E.coli per 100,000 population (2024/25) ↓

Compared to 2023/24 the rate was 85.13

The rolling 12 month mortality rate is 2.50% →

Compared to the equivalent period last year the rate was 2.72%

80.6% of complaints received a response within 30 days →

Compared to last month the rate was 82.5%

Population Health

72.1% of adults aged 65+ received the influenza vaccine during March 2024 →

Compared to the previous period the rate was 72.0%

As at end of Feb 2024 41.4% of frontline healthcare workers received the influenza vaccine ↓

Compared to the 2022/23 season, the uptake was 50%

5.65% of adults who smoke made a quit attempt during Quarters 1 to 4 of 2023/24 ↑

Compared to the previous year 4.5% attempted during the same period

91.6% of children aged 5 were up to date with their vaccinations ↑

Compared to the previous quarter the rate was 89.2%

Operational Performance

67.4% of patients were seen within 4 hours from arrival at an Emergency Department ↑

Compared to last month compliance was 64.8%

100% of GP Practices have achieved in-hours access standards during 2022/23 ↑

Compared to the previous year the rate was 98%

Provisionally 3,281 patients are waiting longer than 2 years for referral to treatment ↑

Compared to the previous period 2,956 patients had waited this length of time

50.4% of patients started their cancer treatment within 62 days →

Compared to the previous month the rate was 52.3%

People

6.80% of staff have been absent due to sickness during the 12 mth period (Aug 23 to Jul 24) →

Compared to the previous year the rate was 6.93%

Provisionally the CTMUHB Nursing & Midwifery turnover rate is provisionally 8.54% →

Compared to Aug 2023 the rate was 9.44%

64.8% of staff (excluding M&D) have received their PADR →

Compared to Aug 2023 the rate was 65.5%

80.7% of staff have completed Level 1 mandatory training ↑

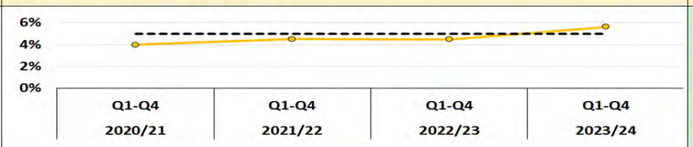
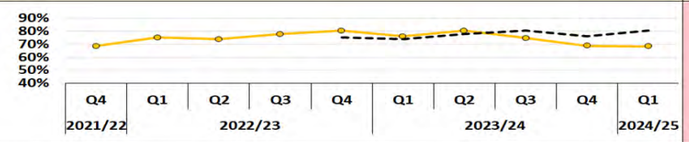
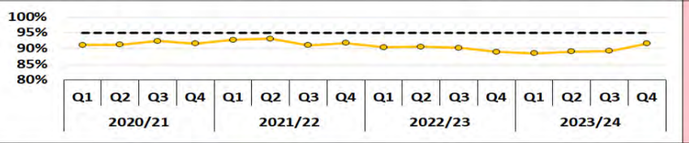
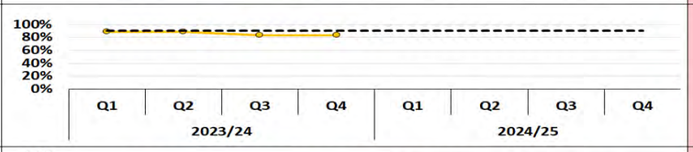
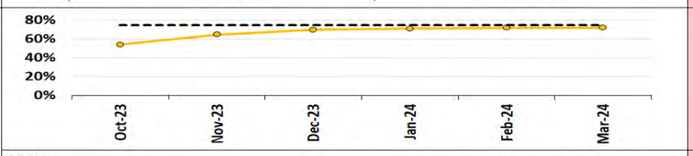
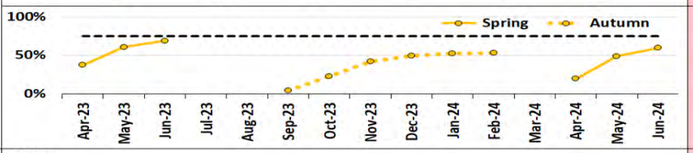
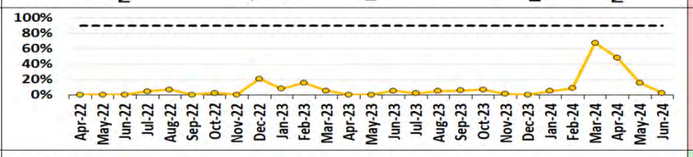
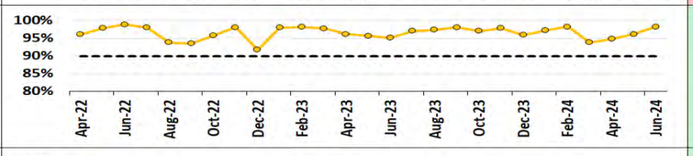
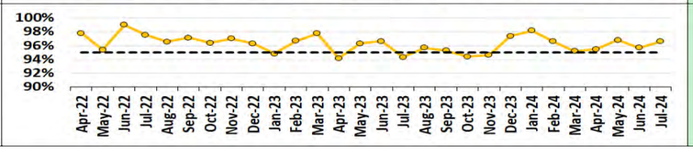
Compared to Aug 2023 the rate was 76.3%

Finance

The Month 04 financial position is £4.2m deficit. This is an increase from the previous month of £1.5m ↑

2.2 Welsh Government Performance Indicators: Quadruple Aim 1 - Improving Population Health & Wellbeing

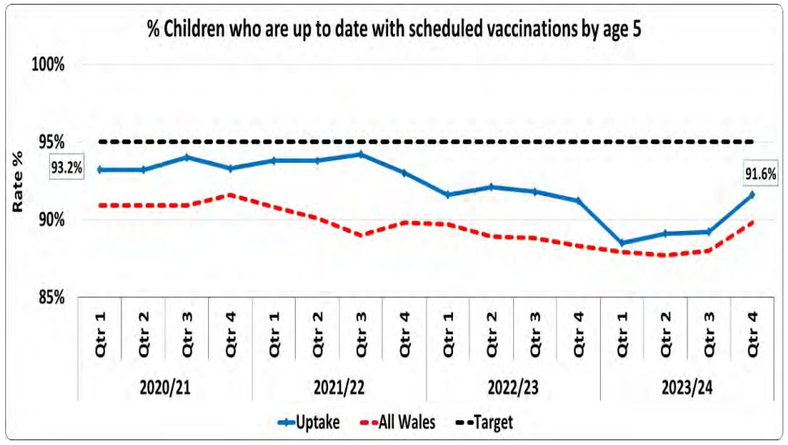
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management

	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Prevention	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% Annual Target		5.65%	Q1-Q4 2023/24
	Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% Annual Target	Data not available as yet		
	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 Qtr Improvement Trend		68.4%	Q1 2024/25
	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' pre-school booster, the Hib/MenC booster and the second MMR dose)	95%		91.6%	Q4 2023/24
	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 *(applicable during 01.04.24-30.06.24 & 01.01-31.03.25)*	90%		83.3%	
	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over *(applicable during 01.09.24 - 31.03.25)*	75%		72.4%	Data for 2024/25 will be available from Oct 2024
	Percentage uptake of the COVID-19 vaccination for those eligible - Spring & Autumn booster 2024: All eligible people *(applicable 01.04.24 - 30.06.24 & 01.09.24 - 31.03.25)*			59.6%	Jun-24
	Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%		2.1%	Jun-24
	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%		98.3%	Jun-24
	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	95%		96.6%	Jul-24

CTMUHB Improving Population Health & Wellbeing

% of children who are up to date with the scheduled vaccinations by age 5 - Target 95%

Age 5 schedule includes: '4 in 1' pre-school booster, the Hib/MenC booster and the second MMR dose)



(reporting frequency is quarterly & as expected there is a time lag of approx. 3 months)

Quarter 4 2023/24 Local Authority Uptake	
Merthyr Tydfil LA	84.6%
RCT LA	92.6%
Bridgend LA	93.2%
CTMUHB	91.6%

Quarter 4 2023/24 Welsh HB's Uptake	
ABUHB	88.7%
BCUHB	92.4%
C&VUHB	86.4%
CTMUHB	91.6%
HDUHB	88.9%
PTHB	94.5%
SBUHB	89.0%
All Wales	89.8%

What are the key challenges & actions in delivering vaccination targets?

Challenges:

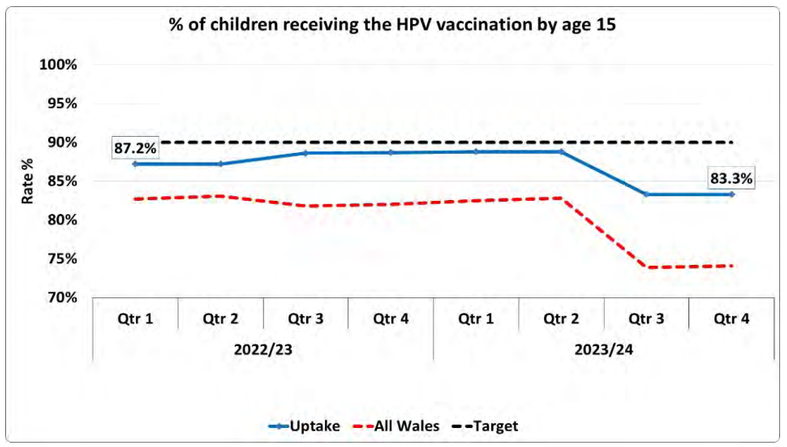
- Scheduled immunisations - achieving the Welsh Government uptake target (95%) for all scheduled childhood immunisation programmes and reducing inequalities. Changes to ages under 5 schedule will affect delivery.
- MMR uptake – Welsh Health Circular (2024) 008, received with the action that every school in Wales with 50 pupils or more on roll, has 90% of its pupils recorded as having received two doses of MMR (by July 2024).
- Influenza – although still below target, we are still in line within uptake in other HBs.
- Data systems – poor communication between data systems. Information between systems are still paper based and allow for human error in the transfer of data.
- Increasing diversity within our communities - affects accurate vaccination history for clients and the ability to provide information in required languages.
- Transition from Health Visiting to School Nursing – immunisation history and recall for any outstanding vaccines.

Actions:

- Scheduled immunisations – out of season training for vaccinators to support schedule changes. Practice Nurse Forum used to disseminate relevant information.
- Influenza – work is ongoing to expand the nursery programme into the Bridgend area. Fluenz/MMR mop up evaluation report will be used to inform future initiatives.
- Data systems –the National Immunisation Framework (NIF) have a programme of work to enhance connectivity between immunisation data systems.
- Increasing diversity within our communities – SOP created to enable translation of vaccine history in other languages.
- Transition from Health Visiting to School Nursing - ensure the immunisation profiling tool (HCWP2 Healthy Child Wales) is included in the development of the programme offer.

% of children receiving the Human Papillomavirus (HPV) vaccination by age 15 Target 90%

(reporting frequency is quarterly, and applicable during 01.04.24 to 30.6.24 & 1.1.25 to 31.03.25)



Quarter 4 2023/24 Local Authority Uptake	
Merthyr Tydfil LA	72.0%
RCT LA	85.2%
Bridgend LA	84.8%
CTMUHB	83.3%

Quarter 4 2023/24 Welsh HB's Uptake	
ABUHB	67.9%
BCUHB	75.7%
C&VUHB	59.9%
CTMUHB	83.3%
HDUHB	75.8%
PTHB	77.4%
SBUHB	88.2%
All Wales	74.1%

What are the key challenges in delivering vaccination targets & actions to tackle inequalities?

Challenges:

- Communication support - School Nursing Service has previously raised that they required more support to actively raise the profile of all vaccination programmes.
- Consent for immunisation – Paper: uptake of paper consent returns remains poor. E-consent for immunisation: creating an e-consent system that fulfils functionality (including collaboration with partners) and information governance requirements at both HB and all Wales levels.
- Personal data accuracy (address, contact number, school attended) – Recent Fluenz and MMR catch up programmes has further highlighted that addresses and contacts details are not always up to date.

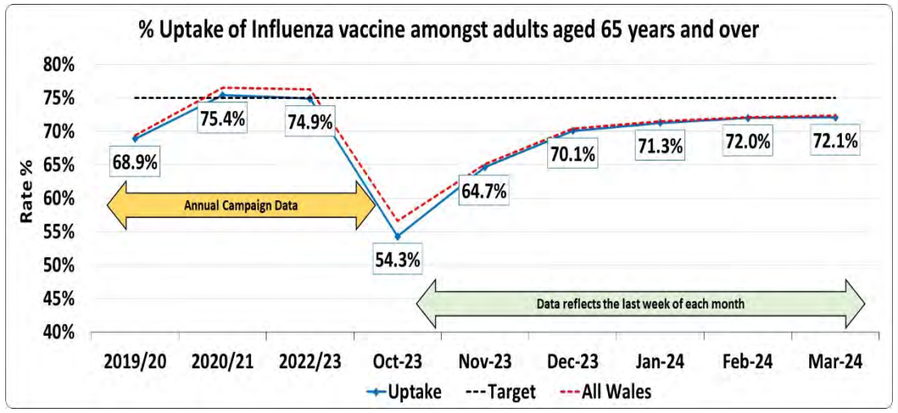
Actions:

- Communication support – communication is now included as a standing item in the Childhood Vaccination Group which meets monthly. There is an action (school nursing and communications team) to develop a calendar for pertinent times of the year when support is required.
- Uptake – additional visits to low uptake schools have been undertaken. Additionally, mop up clinics have been held in after school and in school holidays in the CVCs. Major mop up of MMR and HPV will be undertaken during the upcoming summer holidays in the CVCs.
- Consent for immunisation – *Paper*: progress has been made by engaging with parents and promoting immunisations on school platforms. Verbal consents are used for missing consent forms by the vaccinator contacting the parent on the day, and self-consents are being encouraged (Frazer Gillick competencies - assesses whether child is mature enough to consent). This has increased the percentage of children vaccinated. *E-consent*: still aim to replace paper consent with e-consent. Considerable work has been undertaken to create the platform, now in final testing.
- HPV - Sexual Health Newsletter for relevant partners included a focus on HPV (produced by the Local Public Health Team in collaboration with school immunisation lead). School nursing service have adopted a universal, enhanced and intensive approach to target areas known to have lower uptake rates with the aim of increasing these rates and reduce inequalities. Planning underway to invite those not up to date to CVC mop up clinics over the summer holidays.
- Personal data accuracy (address, contact number, school attended) - data cleansing pilot with RCT (initially) underway with the view of improving accuracies of personal data held by both organisations and also identifying/supporting electively home educated children. Following this pilot, aim to expand the process to Merthyr Tydfil and Bridgend. Validation of existing lists (where contacts are unavailable) via support from GPs and schools.

CTMUHB Improving Population Health & Wellbeing

% uptake of the influenza vaccination amongst adults aged 65 years & over - Target 75%

Please note that data for the 2024/25 flu season will not be available until October 2024.



Uptake Welsh HB's March 2024	
ABUHB	75.6%
BCUHB	73.9%
C&VUHB	72.8%
CTMUHB	72.1%
PTHB	69.9%
SBUHB	69.5%
HDUHB	69.1%
All Wales	72.4%

Challenges posed by the National Immunisation Framework (NIF) & actions being taken?

Challenges:

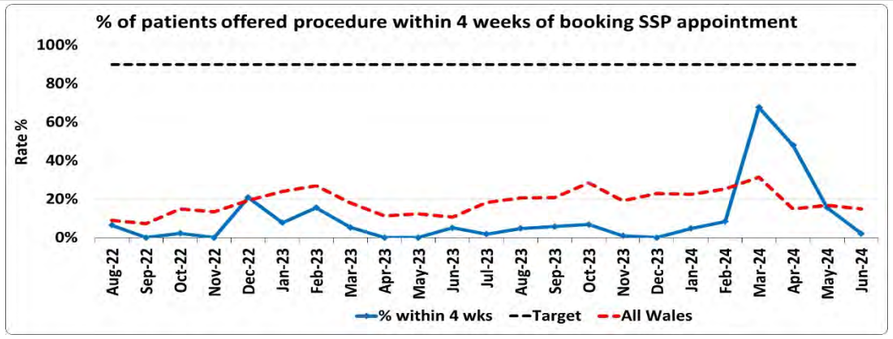
- Vaccine fatigue - in line with other HBs, CTM are experiencing a drop in vaccination uptake generically and especially since the pandemic. Understanding the underlying reasons and causes for this will be critical to allow any improvement in uptake.
- Joint Committee on Vaccination and Immunisation (JCVI) and Welsh Health Circulars (WHCs) and Vaccine Programme Wales (VPW) requests - the number of requests for immediate action on a range of vaccination programmes continues.
- Demand on vaccination services – there are continued changes to programme scheduling and introduction of new vaccination programmes. This will impact on the practical aspects related to update training, vaccination clinics and the storage of vaccines.
- GP services – delivery of changes to universal vaccination programmes such as Shingles and RSV will put added pressure onto GP services.
- Uptake of Flu and COVID-19 – poor uptake for care home & health board staff and those who are immune-suppressed and under 65's clinically at risk.
- Community pharmacies - ensuring that community pharmacies have sufficient vaccinators and capacity to provide flu vaccination, alongside demand to provide alternative clinical pharmaceutical services.

Actions:

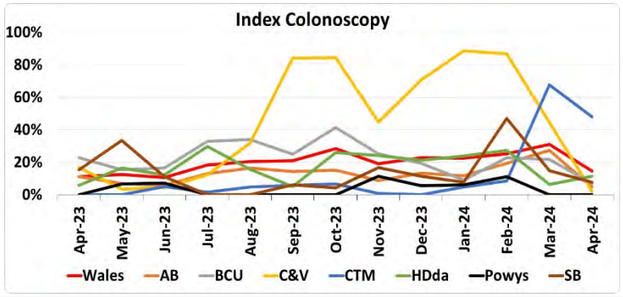
- Vaccine fatigue - ensure consideration for vaccine equity in all programme planning and increased communication.
- Joint Committee on Vaccination and Immunisation (JCVI) and Welsh Health Circulars (WHCs) – recruitment into the health protection system will add some resource but will not alleviate all the vaccination pressures in GP practices.
- Demand on vaccination services – maintain multi professional collaboration.
- Uptake of flu and COVID-19 - establishment of a sustainable model for vaccination of care home staff, explore the possibility of developing the role of flu champions in care homes, primary care and GP practices.
- Collaboration and programme alignment – multi-disciplinary approach across all professions to ensure consistent and opportunistic messaging to support the optimization of flu uptake.
- CTM to support national work regarding the HEIW vaccinator accreditation framework and:
  - Maintain current position regarding pharmacy opening hours on the weekend to improve access.
  - Utilise primary care clusters to support a collaborative approach to vaccination.
  - Engage with low level providers to support greater provision.

CTMUHB Planned Care Group - Index Colonoscopy

% patients offered index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment - Target 90% - June 2024 2.1%



Please note there is a time lag in reporting of 2-3 months



Status as at April 2024		
Health Board	Compliance	Rank
CTM	**48.0%**	**1st**
HDda	11.5%	2nd
SB	7.7%	3rd
BCU	6.9%	4th
AB	4.8%	5th
C&V	2.1%	6th
Powys	0.0%	7th

How are we doing & what actions are we taking? The decline in compliance during June is as a result of annual leave absence over the previous 6-week period and also due to the limited amount of BSW Endoscopists we have within CTM. We are planning to run additional weekend BSW lists, but we are currently overcoming issues regarding staffing and training.

As of the 9th September there were 168 patients waiting for an index colonoscopy, of which, 138 have a booked appointment. However, 77 of these patients will have waited longer than 4 weeks for their procedure and eight patients over 8 weeks. After a period of sickness within the team momentum has improved as staff members have returned to work. Internal additional ad hoc lists and flipping of symptomatic lists to overcome lost activity due to sickness has reduced the impact and current waits are around 12 weeks, with further plans over the next 6 weeks to bring the service in line with '4-week compliance'. Sustainability plans are ongoing to staff unfunded sessions (x2) at POW; this will continue to support the Optimisation Programme.

The operational challenges that have an impact on activity are:

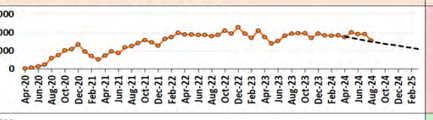
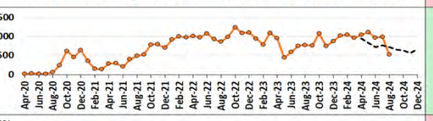
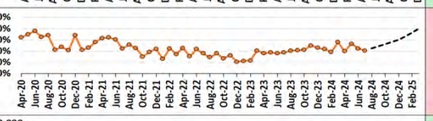
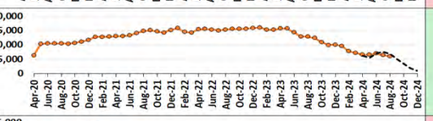
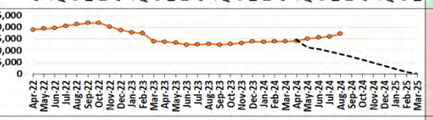
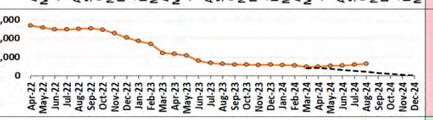
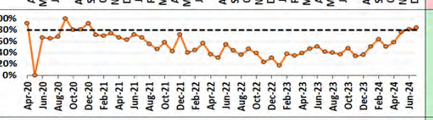
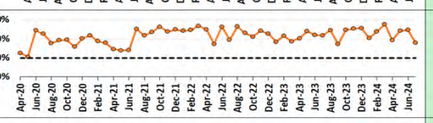
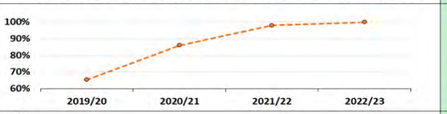
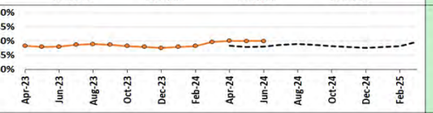
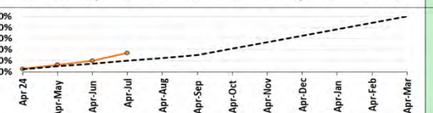
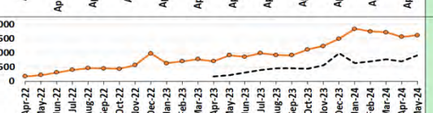
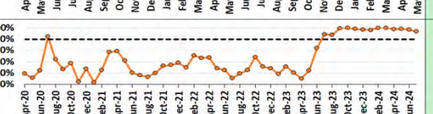
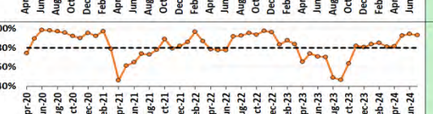
- Participant, patient choice and refusal remains an issue when booking dates across CTM.
- Providing cover for periods of leave and on-call commitments. This continues to be managed through 6/4/2-1 process which has seen an increase of adhoc cover, plus additional lists through backfilling of symptomatic lists and improvement to utilisation through productivity and efficiencies – continues to be monitored.
- Uptake and current conversion to surgery continues to be monitored and escalated.
- A period of long-term sickness has now ended, however backlog of patients to be booked still remains.

Actions being taken:

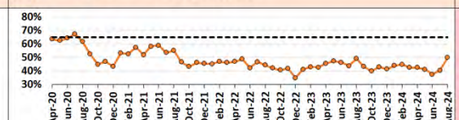
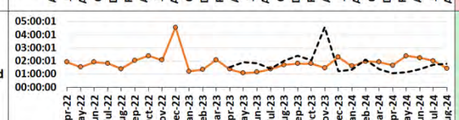
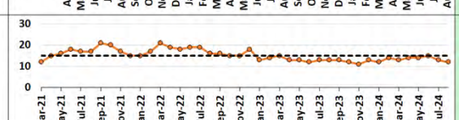
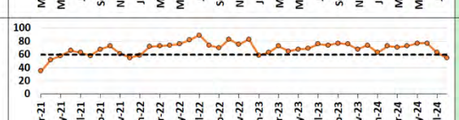
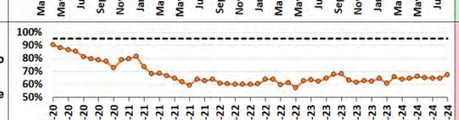
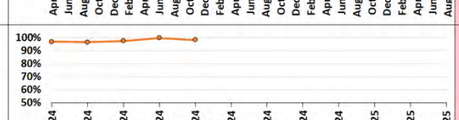
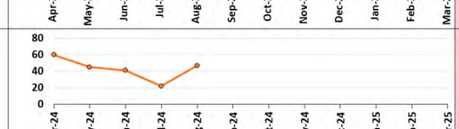
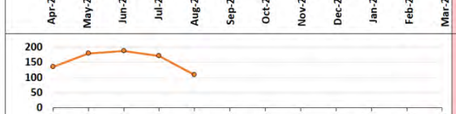
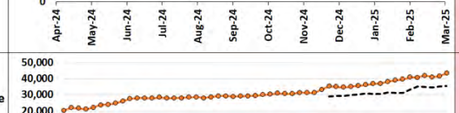
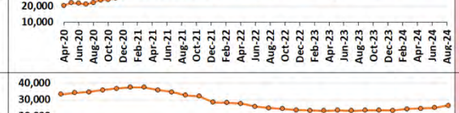
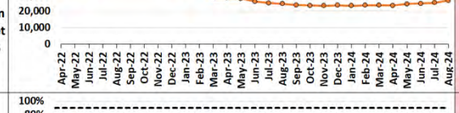
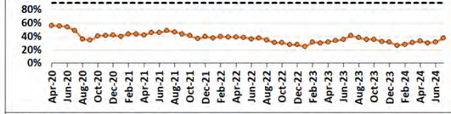
- Use of Text Remind and Broadcast Messenger to reduce patient choice (refusal of offer) and DNA rates.
- Insourcing – completed and supported backlog clearance.
- Participants continue to be booked direct to scope at SSP assessment resulting in better patient experience.
- Sustainability plan is ongoing to increase core lists to meet optimisation steps.
- The new endoscopy unit at PCH with 3rd room – workforce model and business case completed and approved; funding allocated and recruitment commenced.
- Working with theatre services to develop robust general anaesthetic provisions.

2.3 Welsh Government Performance Indicators: Quadruple Aim 2: Quality & Better Access to Services

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

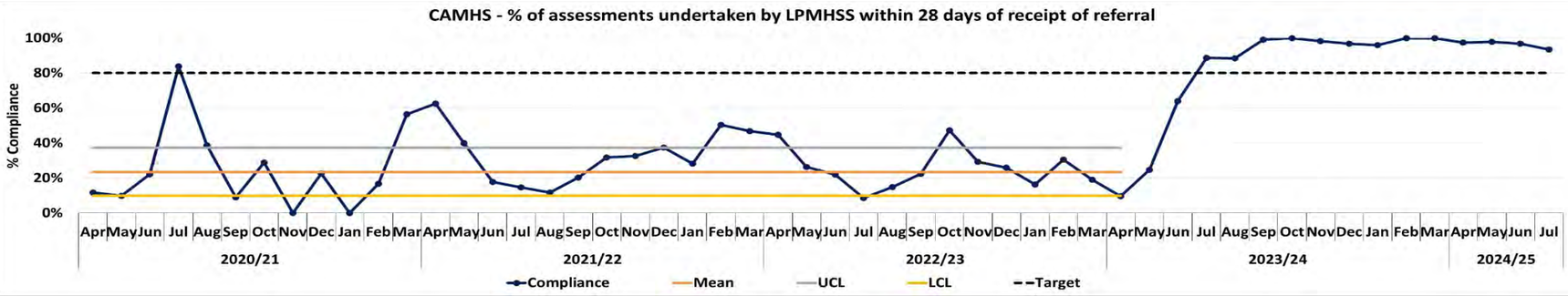
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Cabinet Secretary's Accountability Conditions	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	March 2024 baseline - 20% reduction by September 2024, further 20% reduction by March 2025		1,560	Aug-24
	Number of ambulance patient handovers over 1 hour	30% reduction on March 2024 baseline by December 2024		525	
	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	60% performance by December 2024 followed by 70% performance by March 2025		50.4%	Jul-24
	Number of patients waiting more than 8 weeks for a specified diagnostic	95% of modalities to be zero by December 2024		6,049	Aug-24
	Number of patients waiting over 52 weeks for a new outpatient appointment	March 2024 baseline - 40% reduction by end of September 2024, zero by March 2025		17,260	
	Number of patients waiting more than 104 weeks for referral to treatment	Zero by December 2024		3,281	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)	80% by December 2024		83.8%	Jul-24
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)	80% by December 2024		87.9%	
Services Delivered Close to Home	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%		100.0%	2022/23
	Percentage of patients (aged 12 yrs and over) with diabetes who received all eight NICE recommended care processes	Improvement compared to the same month in the previous year		40.0%	Jun-24
	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025		33.9%	Apr to Jul 2024
	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Increase compared to the same month in the previous year		1,632	May-24
	% 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)	80%		93.5%	Jul-24
	% 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%		93.5%	

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

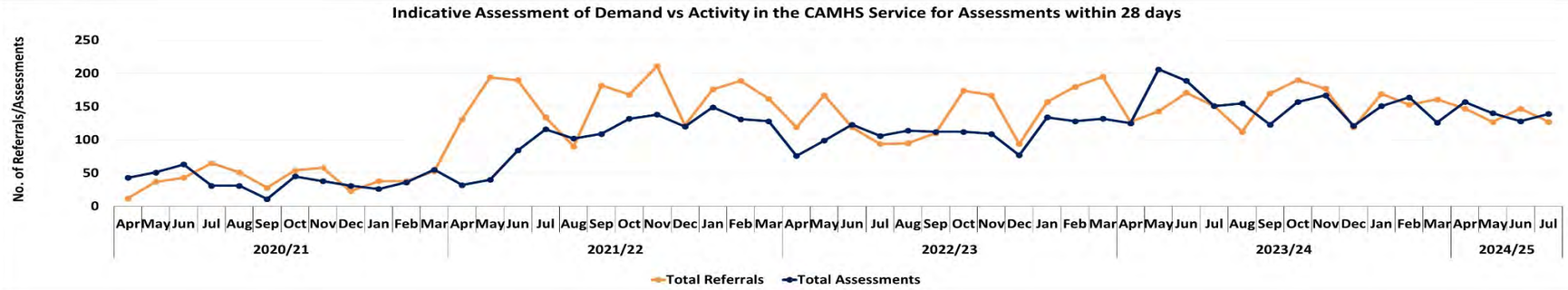
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Access Hospital Services Quickly	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		49.8%	Aug-24
	Median emergency response time to amber calls	12 Month Reduction Trend		01:27:00	
	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less		12	
	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	60 minutes or less		55	
	% 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	Improvement compared to the same month in the previous year, towards the national target of 95%		67.4%	
	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	100%		98.4%	
	Number of patients waiting more than 14 weeks for a specified therapy (all ages)	Zero		47	
	Number of patients (all ages) waiting more than 14 weeks for audiology			109	
	Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	Reduction compared to the same month in the previous year		43,374	
	Number of patients waiting more than 52 weeks for treatment	Month on month reduction towards the national target of zero by 30th June 2025		26,380	
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%		37.4%	Jul-24
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			59.2%	

CAMHS & Specialised Services – July 2024

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (93.5%) - Target 80%



Mental Health Measure Part 1a - the number of assessments undertaken within 28 days of referral - performance has notably improved in this area of the CAMHS service since the summer of last year. Compliance during July 2024 remained relatively stable at 93.5% and continues to exceed the WG target of 80%.

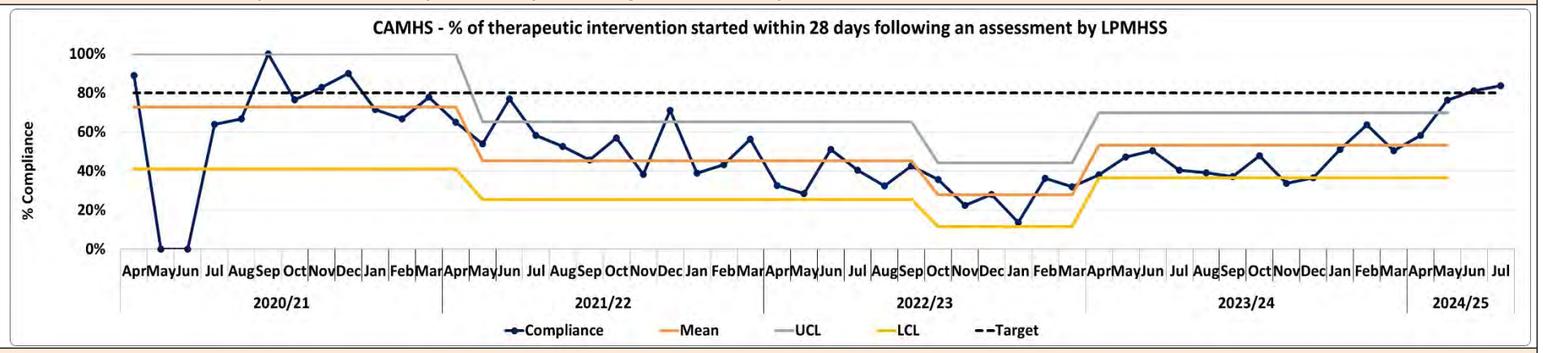


As seen in the chart to the left, the number of assessments each month is fairly stationary, given the variability in the number of working days in the month.

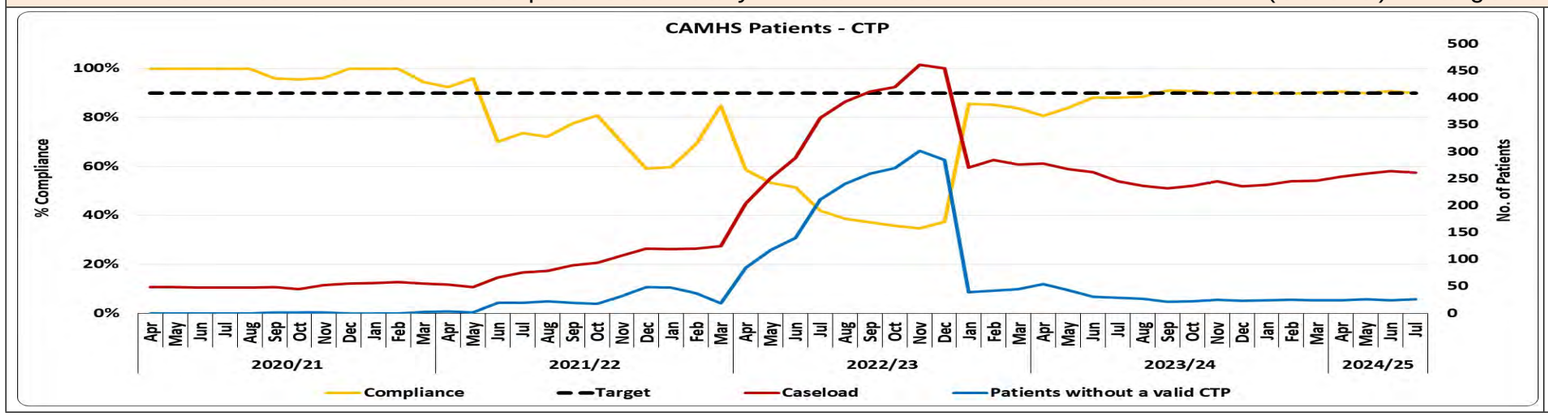
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (83.8%) - Target 80% by December 2024

Compliance for the proportion of therapeutic interventions starting within 28 days following an assessment by LPMHSS further improved during July to 83.8%, surpassing the WG set target of 80%.

The Directorate is continuing to develop its local groups and the digital SilverCloud offer. The Qlik information system is supporting the Directorate to monitor compliance on a real time basis which will help to manage compliance going forward and maintain the achievement of the set target.



% of HB residents who are in receipt of secondary MH services who have a valid CTP (90.0%) - Target 90%



Part 2 of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month observed a compliance rate of 90.0% during July, meeting the WG standard.

From the start of 2023, as shown in the chart to the left, we observe that caseloads have reduced around 45% from the peak seen in November 2022. The number of patients without a valid CTP at the end of the month currently stands at 26.

Part 3: There were no requests for a CAMHS assessment under Part 3 of the Mental Health Measure during July.

CAMHS & Specialised Services - continued

How are we doing and what actions are we taking?

Actions being taken:

- An improvement action plan and trajectory were developed to improve compliance in Parts 1 (a & b) and 2 of the Mental Health Measure. This has delivered improvement in all three areas with additional work required on Part 1b (therapeutic interventions).
- Part 1a: Further work is being planned to streamline the processes of the Single Point of Access and the Assessment Team to reduce duplication in the assessment and triage process. Additional work is focusing on balancing capacity with demand. Referral rates fluctuate during the year, but are often predictable with increases coinciding with events such as exams and the start of the new term. Demand & capacity training has helped us to focus on this area.
- Part 1b: We are working with the Third Sector to increase access to interventions and have agreed a programme of group work interventions with Mental Health Matters across the CTM region. Each course has 6 participants comprising of four sessions. We have ten groups starting each month which are being delivered in each of the three local authority areas. Referrals to the SilverCloud digital platform are increasing and there is multi-disciplinary engagement with the SilverCloud project management team hosted by Powys Teaching Health Board.
- Recently the Directorate took part in an NHS Executive All Wales workshop which was a good opportunity to share ideas.
- Part 2: A training programme for care co-ordinators has helped to improve the quality of Care Treatment Plans (CTPs). This includes some joint training between Adult Mental Health services and CAMHS.
- Monthly supportive meetings are in place with the NHS Executive, which is helping to improve compliance in all areas and in a sustainable way. The service has completed a self-assessment audit of CTP's which we plan to present at that meeting in due course.

When is improvement anticipated and what are the main areas of risk?

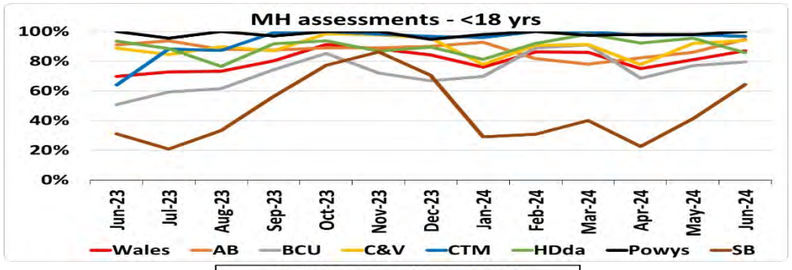
Outputs of improvements:

- Part 1a: Our approach to the management of this service includes closely monitoring the waiting times for assessment during the month. As at the end of July we had 58 patients on the waiting list (91 previous month), with no patient waiting beyond 30 days. The average waiting time has remained at 2 weeks.
- Part 1b: We carefully monitor the demand for interventions and our capacity to deliver services. The total number of interventions delivered was 74 with the average waiting time remaining at 3 weeks.
- As clinical teams have worked through the waiting list backlog our performance against the interventions target has steadily increased.
- During April we introduced referral-based access to the online digital platform SilverCloud to further help with interventions. All three of the remaining Band 5 registrant vacancies in the Intervention Team will be filled in September through the streamlining process.
- Part 2: The focus on quality in relation to CTP's will be supported by the results of the caseload audit that was completed during the end of 2023.

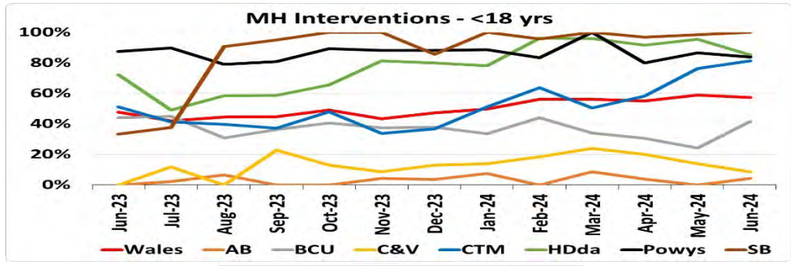
Main areas of risk:

- The CAMHS service experiences regular fluctuations in demand and this can have a negative effect on waiting times for assessment and treatment. The service is planning to temporarily increase capacity to help address this rise in referrals.
- The service is prioritising recruitment to vacant positions. Good progress has been made in filling community team gaps.
- Clinical colleagues continue to report rising acuity within their patient population, this may have an impact on delivery going forward.

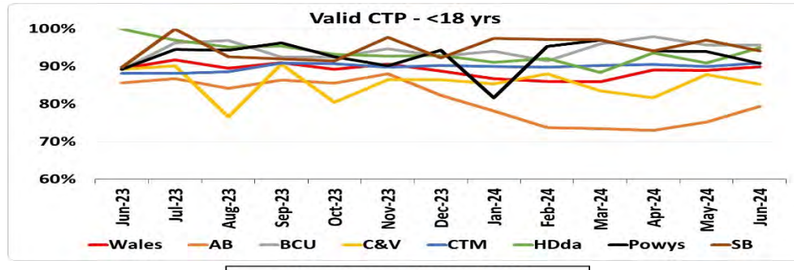
How do we compare with our peers?



Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
CTM	**96.9%**	**2nd**
AB	94.8%	3rd
C&V	94.1%	4th
HDda	85.7%	5th
BCU	79.6%	6th
SB	64.4%	7th



Status as at June 2024		
Health Board	**Compliance**	**Rank**
SB	100.0%	1st
HDda	85.1%	2nd
Powys	83.7%	3rd
CTM	**81.2%**	**4th**
BCU	41.6%	5th
C&V	8.6%	6th
AB	4.2%	7th

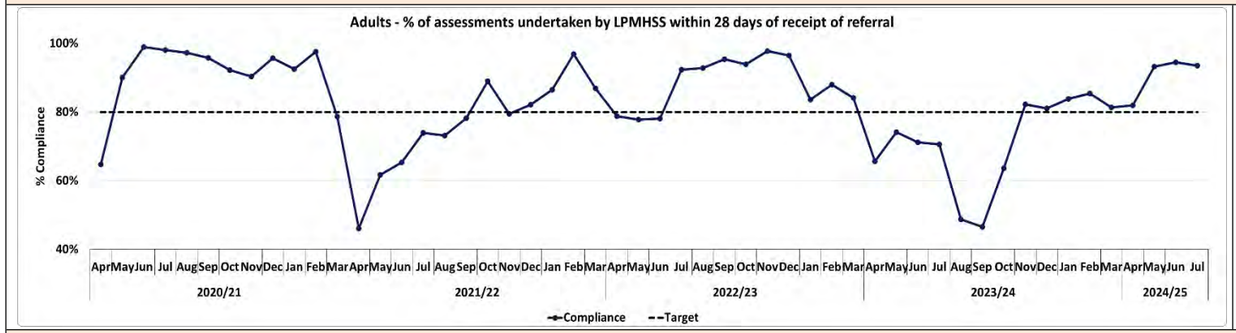


Status as at June 2024		
Health Board	**Compliance**	**Rank**
BCU	95.7%	1st
HDda	95.0%	2nd
SB	94.1%	3rd
CTM	**90.9%**	**4th**
Powys	90.8%	5th
C&V	85.3%	6th
AB	79.4%	7th

CTMUHB Mental Health & Learning Disabilities Care Group

Adult Mental Health Services – July 2024

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (93.5%) - Target 80%



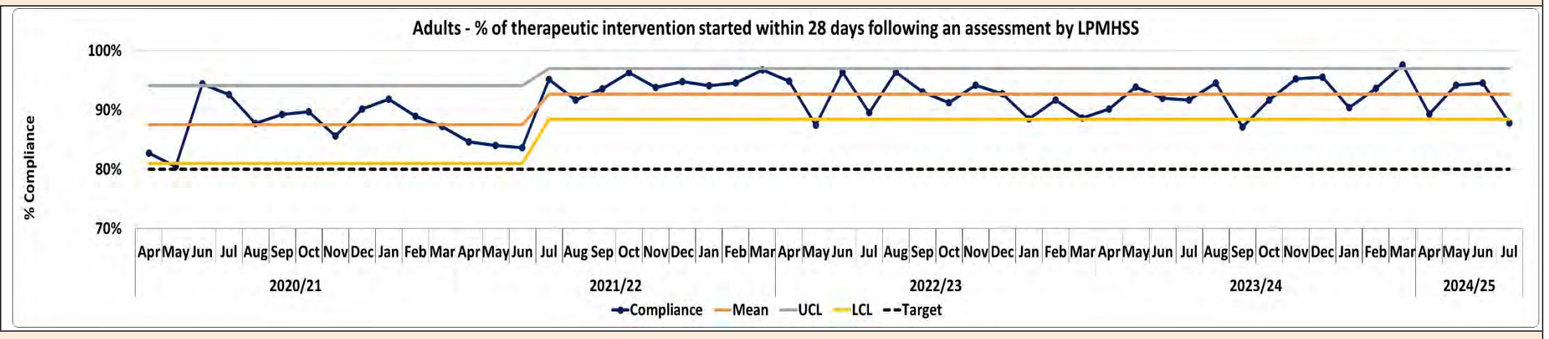
Part One of the Mental Health Measure relates to primary care assessment & treatment and has a target of 80% of referrals to be assessed within 28 days. The performance for the adult mental health services during July was 93.5% and continues to stand above the WG target.

Referrals during the month totalled 709, which is similar to those received during the equivalent period of 2023, with the 12 month average being 720 referrals each month. We continue to observe that volumes remain lower than pre-Covid levels, where referrals were in the region of 1,000 to 1,100.

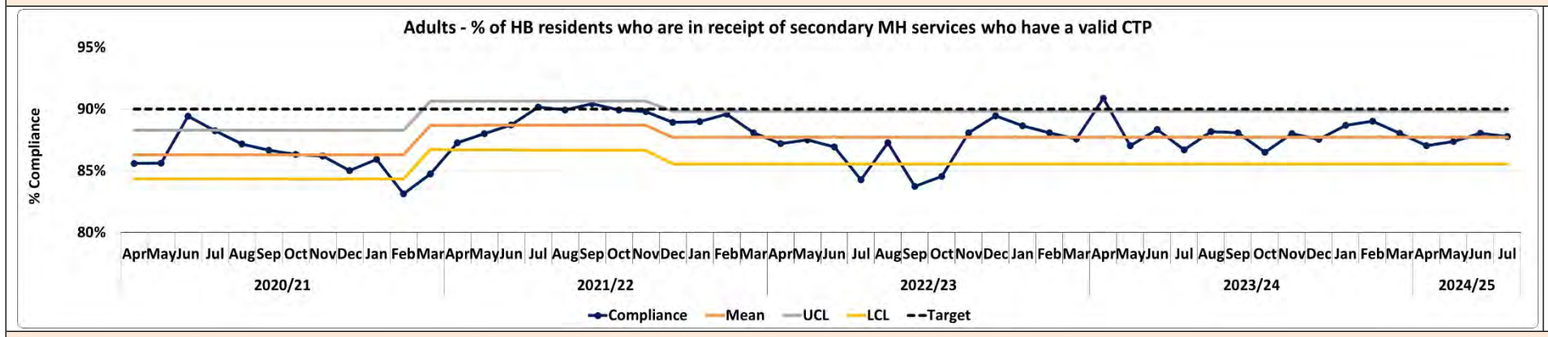
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (87.9%) - Target 80% by December 2024

Overall, the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS during July was 87.9%, a fall from 94.6% seen in the previous month, but continuing to stand above the WG target of 80%.

During the month, 376 of the 428 interventions commenced within the 28 day timeframe.



% of HB residents who are in receipt of secondary MH services who have a valid CTP (87.8%) - 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 saw a compliance of 87.8% during July and remains just below the 90% WG standard.

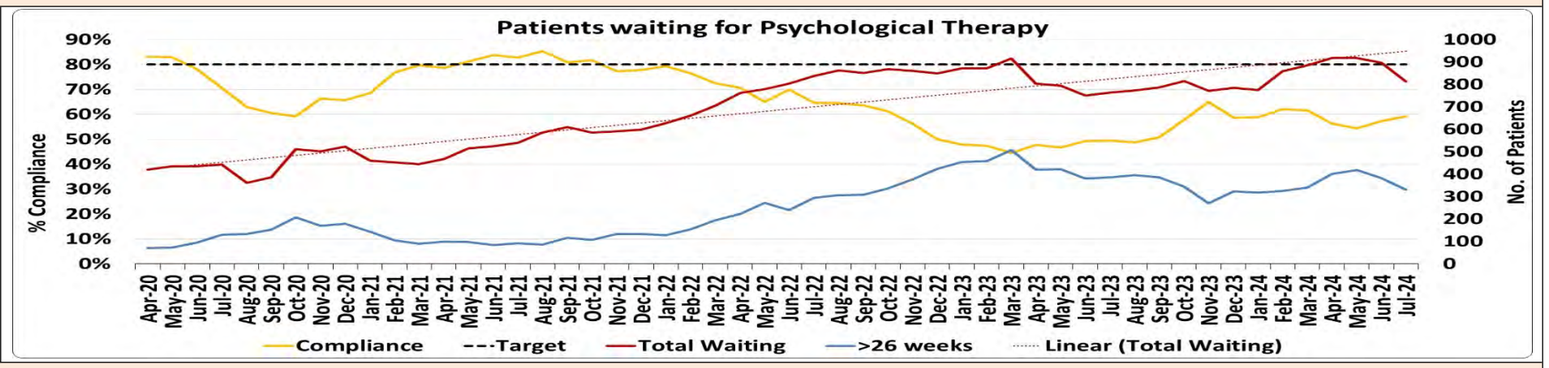
Part 3: There was one request for an adult assessment under Part 3 of the Mental Health Measure during July, with the outcome report being sent within the 10 working days timeframe.

% of patients waiting less than 26 weeks to start a Psychological Therapy (59.2%) - Target 80%

During July, Psychological Therapies compliance was 59.2%, with performance continuing to remain below the 80% target threshold set by WG. The last time CTM achieved the target was October 2021 (81.7%) and compliance during the past 12 months has ranged between 48.8% and 65.0%.

The chart to the right details the total waiting list volume (red) with the number of patients waiting more than 26 weeks for a Psychological Therapy (blue) and the proportion waiting less than 26 weeks (the WG target - yellow).

At the end of July the waiting list stood at 813 patients; almost double the volume seen pre-Covid and during the last 12 months the list has ranged between 771 and 918 patients.



Adult Mental Health Services continued on the next page...

Adult Mental Health Services - continued

How are we doing?

- Part 1a: Posts have been successfully recruited to in recent months and the impact of this is seen in the improved performance from May onwards. During July, performance remained above target and we continue to closely monitor sickness and absence rates to ensure our activity is balanced across all areas to fully utilise capacity.

All three local authority areas are above the target threshold of 80%; Merthyr Cynon area has improved compared to the previous month and increased to 92.9%, Rhondda Taff Ely has improved slightly to 92.7% as has Bridgend, increasing to 97%.

Part 1b: Performance continues to be above target at 87.9%.

Part 2: Overall compliance for both Adult, Older Adult and Learning Disability Services was 87.8% and compliance for the services is shown below:

- Adult Services – remained the same at 86.6%
- Older Adult Services – fell slightly to 92.4%, but remained above target
- Learning Disability Services – fell slightly from 86.7 to 85.6%.

Psychological Therapies: The overall position for Psychological Therapies waiting list for July 2024 stands at 813, which is a reduction of 84 compared to June. This is due in part to waiting list validation and group therapy sessions being undertaken in Bridgend LPMHSS.

The current performance of 59% of people waiting less than 26 weeks equates to 481 service users (332 patients >26 weeks) with performance better than the forecasted position of 52%.

What actions are we taking and when is improvement anticipated? What are the main areas of risk?

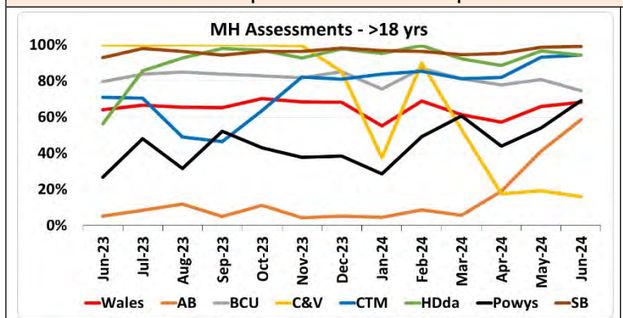
Part 1a:

- Focus on sickness management in teams where they are currently experiencing high levels of absence and strategic review of staff with frequent or long absence.
- Review of IT systems to support proactive performance management of the service through Qlik BI tool.
- Demand and capacity work – review of job plans to identify enough capacity.
- Review data input and reporting and ensure ongoing validation and management with introduction of weekly review meetings.
- Where possible appointments are being offered in nearby teams to ensure there is a balance. This is proving effective in reducing the amount of breach appointments in certain areas, thus reducing the time taken to improve compliance as staff return from sickness absence.

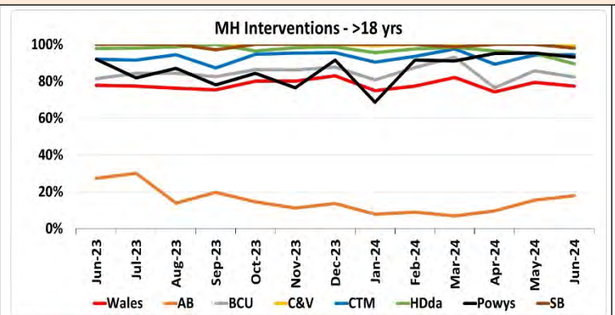
Part 2: The proportion of residents who have a valid care treatment plan, varies by the lead practitioner. Those where the lead is a medical consultant are low and achieving improvement is presenting challenges. Whilst the overall rate is 88%, only 14.3% of adults residents in Rhondda with a consultant leads have a valid CTP, with the rates for the Cynon and Merthyr at 33.3% and 47.6%, respectively. This underperformance has heavily impacted overall compliance in these localities. Social workers in Rhondda and Taff Ely, while close, still fall short of 90% compliance, and Occupational Therapists in multiple regions are notably low at around 33.3%. Additionally, a fall in discharges from 48 in April and May to 32 in June likely contributed to the compliance shortfall, indicating challenges in case management. However whilst the overall compliance rate is just below 90%, the improvements in CMHTs and specialised teams are promising and are offsetting these challenges to a large extent.

Psychological Therapies: The Psychological Therapies Waiting Lists associated with this WG metric is comprised of 8 waiting list service areas across adult and older adult mental health services. The area with the highest number of waiting patients is Local Primary Mental Health Support Services. There is ongoing work to clearly identify and record on the LPMHSS waiting lists the types of therapy service users are waiting for to allow efficient allocation of service users to staff resource. Inconsistent administration support in this area is also proving difficult but this will improve in due course as the new structure establishes.

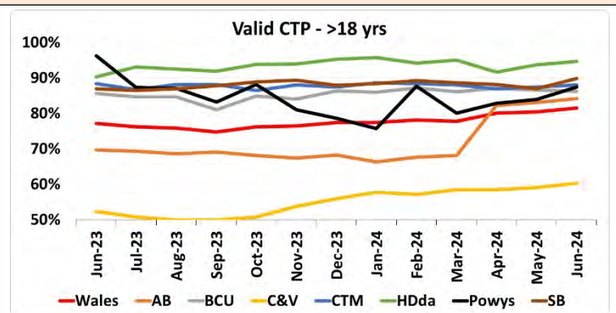
How do we compare with our peers?



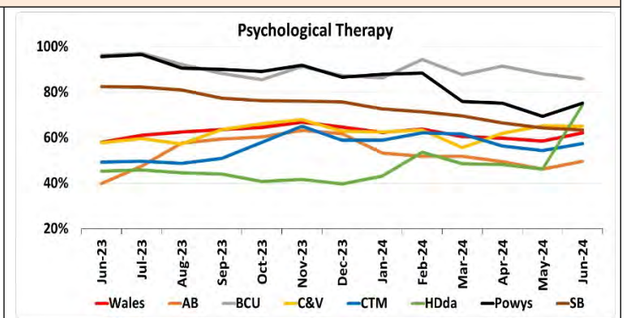
Status as at June 2024		
Health Board	**Compliance**	**Rank**
SB	99.1%	1st
CTM	**94.5%**	**2nd**
HDda	94.4%	3rd
BCU	74.7%	4th
Powys	69.2%	5th
AB	58.5%	6th
C&V	16.1%	7th



Status as at June 2024		
Health Board	**Compliance**	**Rank**
C&V	99.4%	1st
SB	98.1%	1st
CTM	**94.6%**	**3rd**
Powys	93.0%	4th
HDda	89.6%	5th
BCU	82.4%	6th
AB	17.9%	7th



Status as at June 2024		
Health Board	**Compliance**	**Rank**
HDda	94.7%	1st
SB	89.8%	2nd
CTM	**88.1%**	**3rd**
Powys	87.5%	4th
BCU	86.2%	5th
AB	84.2%	6th
C&V	60.3%	7th

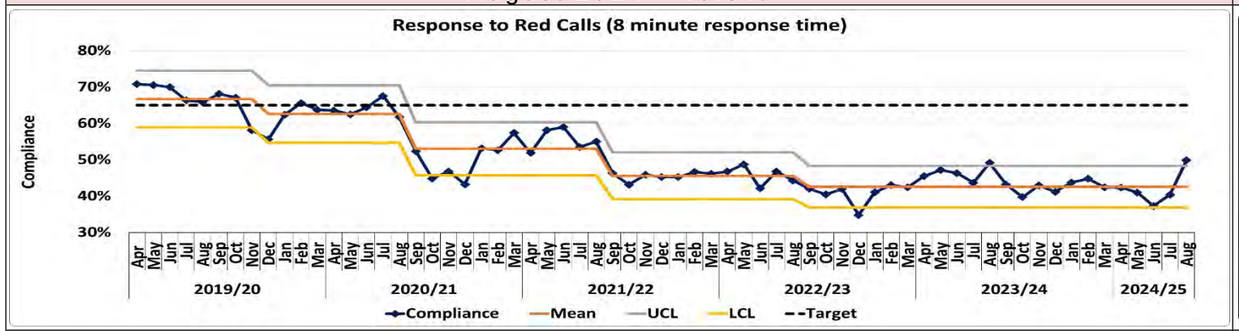


Status as at June 2024		
Health Board	**Compliance**	**Rank**
BCU	85.8%	1st
Powys	75.2%	2nd
HDda	74.4%	3rd
C&V	65.1%	4th
SB	63.3%	5th
CTM	**57.4%**	**6th**
AB	49.6%	7th

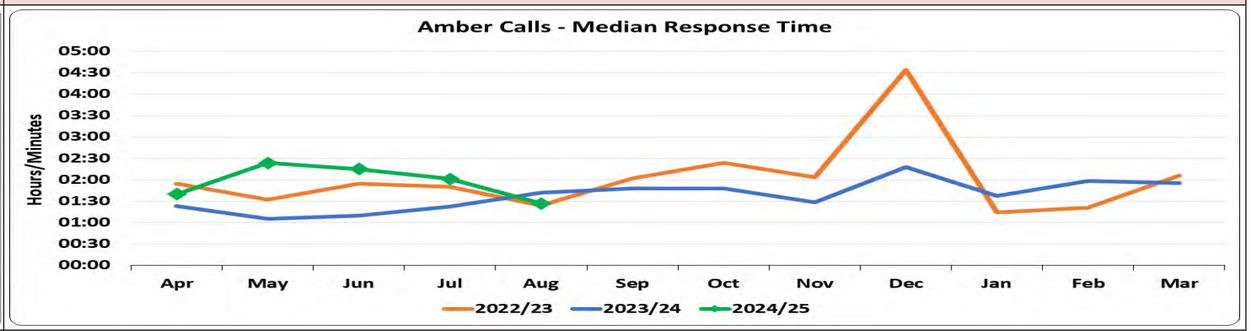
CTMUHB Unscheduled Care Group

Emergency Ambulance Services – August 2024

% of emergency responses to Red Calls arriving within 8 minutes (Target 65%)
August 2024 – 49.8%



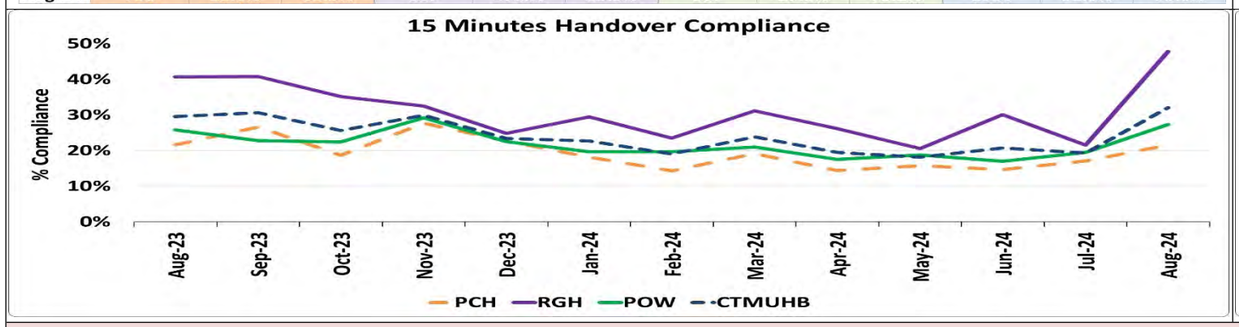
Median emergency response time to Amber Calls – Target is 12 month reduction trend
August 2024 - 1 hour 27 minutes

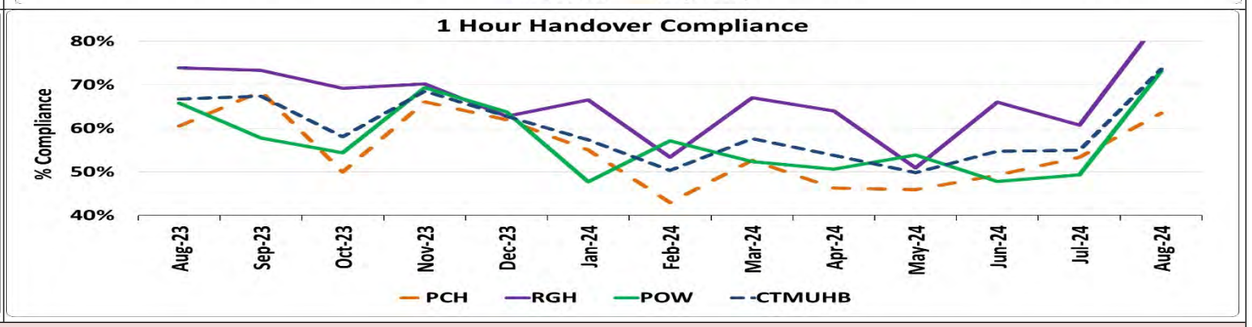


% of ambulance patient handovers within 15 minutes – Target is improvement compared to the same month in the previous year, towards the national target of 100% within 15 minutes.
Total handovers 1,990 of which 637 (32.0%) of handovers were within 15 minutes

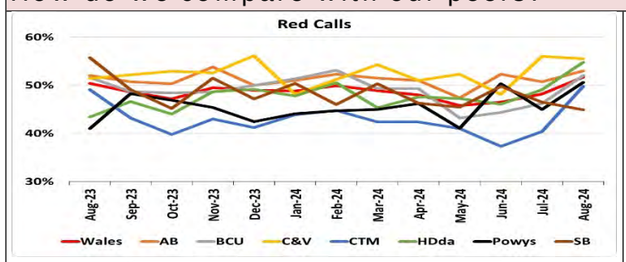
Period	PCH Handovers	PCH % <15 mins	PCH % <60 mins	RGH Handovers	RGH % <15 mins	RGH % <60 mins	POW Handovers	POW % <15 mins	POW % <60 mins	CTMUHB Total Handovers	CTMUHB % <15 mins	CTMUHB % <60 mins
Aug-23	869	21.6%	60.5%	832	40.6%	73.9%	644	25.8%	65.8%	2345	29.5%	66.7%
Sep-23	876	26.6%	68.5%	837	40.7%	73.4%	628	22.8%	57.8%	2341	30.6%	67.4%
Oct-23	971	18.6%	49.9%	928	35.1%	69.2%	673	22.4%	54.4%	2572	25.6%	58.0%
Nov-23	832	27.6%	66.1%	883	32.5%	70.2%	676	29.1%	69.4%	2391	29.9%	68.5%
Dec-23	863	22.7%	62.0%	833	24.8%	62.8%	676	22.5%	63.8%	2372	23.4%	62.8%
Jan-24	910	18.1%	55.1%	869	29.5%	66.5%	620	19.7%	47.7%	2399	22.6%	57.3%
Feb-24	805	14.3%	43.0%	783	23.5%	53.4%	525	19.6%	57.1%	2113	19.0%	50.4%
Mar-24	870	19.1%	52.6%	807	31.1%	67.0%	600	21.0%	52.3%	2277	23.8%	57.7%
Apr-24	856	14.4%	46.3%	819	26.1%	64.0%	587	17.5%	50.6%	2262	19.5%	53.8%
May-24	865	15.7%	45.9%	715	20.6%	50.9%	644	18.8%	53.9%	2224	18.2%	49.8%
Jun-24	796	14.7%	49.2%	759	30.0%	66.0%	596	16.9%	47.8%	2151	20.7%	54.8%
Jul-24	856	17.1%	53.4%	785	21.5%	60.8%	560	19.5%	49.3%	2201	19.3%	55.0%
Aug-24	756	21.6%	63.5%	667	47.8%	85.5%	567	27.3%	73.2%	1990	32.0%	73.6%

Number of ambulance patient handovers over 1 hour – Revised WG Target: 30% reduction from March 24 number by December 2024
525 handovers were over 1 hour (73.6% of handovers were within 1 hour)

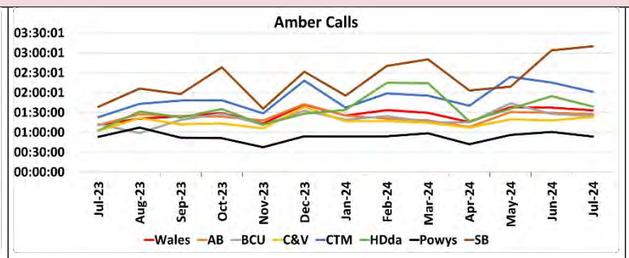




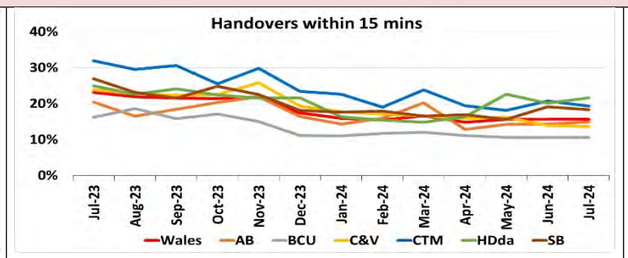
How do we compare with our peers?



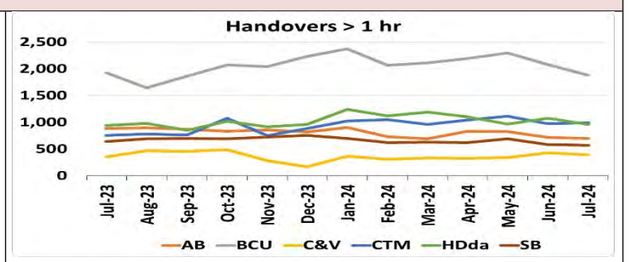
Status as at August 2024		
Health Board	Compliance	Rank
C&V	55.5%	1st
HDda	54.8%	2nd
AB	53.0%	3rd
BCU	52.0%	4th
Powys	50.6%	5th
CTM	**49.8%**	**6th**
SB	44.9%	7th



Status as at July 2024		
Health Board	Compliance	Rank
Powys	00:53	1st
C&V	01:23	2nd
BCU	01:24	3rd
AB	01:27	4th
HDda	01:38	5th
CTM	**02:01**	**6th**
SB	03:10	7th



Status as at July 2024		
Health Board	Compliance	Rank
HDda	21.6%	1st
CTM	**19.3%**	**2nd**
SB	18.3%	3rd
AB	14.9%	4th
C&V	13.6%	5th
BCU	10.6%	6th



Status as at July 2024		
Health Board	Compliance	Rank
C&V	395	1st
SB	573	2nd
AB	697	3rd
HDda	959	4th
CTM	**991**	**5th**
BCU	1,879	6th

Emergency Ambulance Services continued overleaf:

Emergency Ambulance Services continued – August 2024

How are we doing?

Response to Red Calls per WAST Operational Area				
Aug-24	Total Responses	Responses within 8	% within 8 mins	*12 Month Average*
Merthyr	124	78	**62.9%**	*55.6%*
RCT	323	150	**46.4%**	*37.5%*
Bridgend	209	99	**47.4%**	*42.6%*
CTM	656	327	**49.8%**	*42.3%*

Response to Red Calls: Response times to life-threatening calls for the CTM area improved this month to 49.8%; the highest level seen this past year and is similar to the level seen during the equivalent period of 2023, with the 12 month average for CTM recording a rate of 42.3%. Although an improved position, compliance remains low with the volume of Red Calls during August totalling 656, just below the 12 month average of 720.

As can be seen in the table above, there continues to be variance in response times across our region, with RCT borough once again experiencing the poorest response times during August at 46.4%.

The National compliance was 51.7%, similarly the highest level seen since August of last year, but continuing to remain below the minimum expected standard of 65% of Red Calls to be responded to within 8 minutes.

Median Response to Amber Calls: The median response times for serious, but not immediately life threatening calls was 87 minutes during August; 34 minutes shorter than the previous month and a quarter of an hour less than the equivalent period of last year. The chart (page 13, top right) demonstrates fluctuations with response times during the past twelve months ranging between 87 and 143 minutes.

Ambulance Handover Compliance: During August ambulance conveyances to ED totalled 1,990, which is 15% fewer than the equivalent period of last year. Performance against the 15 minute handover was 32.0% (the highest level seen during the past 12 months) with the number of patients and ambulance crews detained longer than an hour totaling 525; the lowest level seen since May 2023 (445). The 12 month average is 930 patient breaches which is similar to the equivalent time span of the previous year (Sep 22 to Aug 23).

Hospital Handovers in minute time groups								
Aug-24	0 - 15	15 - 30	30 - 45	45 - 60	60 - 120	120 - 180	180+	Total Handovers
PCH	163	174	82	61	127	81	68	756
RGH	319	136	76	39	48	28	21	667
POW	155	125	91	44	72	35	45	567
CTM	**637**	**435**	**249**	**144**	**247**	**144**	**134**	**1,990**

Immediate (Red) Release Requests: received when a WAST crew, which is currently with a patient at hospital, needs to be released to respond to an urgent call totalled 34 during July. The ED services were able to meet the expected standard of 100% with all release requests accepted.

	PCH			RGH			POW			CTMUHB		
Period	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance
Jul-23	16	16	**100.0%**	7	7	**100.0%**	11	10	**90.9%**	34	33	**97.1%**
Aug-23	10	10	**100.0%**	5	5	**100.0%**	10	10	**100.0%**	25	25	**100.0%**
Sep-23	16	16	**100.0%**	5	3	**60.0%**	11	11	**100.0%**	32	30	**93.8%**
Oct-23	13	13	**100.0%**	21	19	**90.5%**	19	19	**100.0%**	53	51	**96.2%**
Nov-23	16	16	**100.0%**	16	16	**100.0%**	3	3	**100.0%**	35	35	**100.0%**
Dec-23	19	19	**100.0%**	19	16	**84.2%**	6	6	**100.0%**	44	41	**93.2%**
Jan-24	21	21	**100.0%**	12	11	**91.7%**	12	11	**91.7%**	45	43	**95.6%**
Feb-24	18	17	**94.4%**	16	16	**100.0%**	6	6	**100.0%**	40	39	**97.5%**
Mar-24	10	10	**100.0%**	14	12	**85.7%**	5	5	**100.0%**	29	27	**93.1%**
Apr-24	11	11	**100.0%**	7	7	**100.0%**	5	5	**100.0%**	23	23	**100.0%**
May-24	10	9	**90.0%**	17	17	**100.0%**	11	11	**100.0%**	38	37	**97.4%**
Jun-24	13	12	**92.3%**	10	9	**90.0%**	12	11	**91.7%**	35	32	**91.4%**
Jul-24	10	10	**100.0%**	11	11	**100.0%**	13	13	**100.0%**	34	34	**100.0%**

Please note that due to changes in verification processes within WAST, the Red Release data now has a time lag and consequently, at the time of writing this report, the most reliable data available is to July 2024.

What actions are we taking & when is improvement anticipated?

- Site and USC collaborative approach to the development of the One Hour Ambulance Handover plan.
- Pre-emptive measures are already in place to create offload space by reassigning patients into bed spaces or an ambulance that may become fit to sit.
- Experience triage / Senior Decision Maker to maximise fit to sit decision, quick turn around and front loading of investigations.
- Proposal to introduce Urgent Treatment Centre (UTC) at PCH from the end of October/early November.
- Exploring feasibility of introducing Rapid Assessment & Treatment Model (RAT) at PCH following realignment of consultant roster.
- Improved access to Non-Emergency Patient Transport Service for quick turnarounds.
- Achieve NHS framework trajectories >4 hour waits – improvement plan in place across CTM with regular performance meetings held.
- Out of hours Senior Manager and Executive on call rota under review.
- 1 Hour Ambulance Handover Escalation Card developed and shared for comment prior to implementation.
- ED 4 and 12 hour Escalation Card developed and shared for comment prior to implementation.
- WAST Immediate Release SOP rolled out across the three sites.
- Reduce conveyance / pathway development with WAST – 8% higher than other HB's.
- Phase 1 of the SDEC unit on the PCH successfully launched.
- Strategic Transformation of Acute Medicine Programme (STAMP) established mid-July, followed by a 2-week reset of acute medicine at PCH in early August (including Phase 2 of SDEC). The aim being to reset the acute medicine footprint and creating a less than 72 hours AMU. This was achieved and has contributed to the gains in ED performance at PCH and closure of GP Assessment Unit (un-commissioned area).
- Unscheduled Care Senior leadership team proactively engaged and leading Programme for improvement and a Care Group Senior Leadership Team rota has been established to support flow.
- The successful collaborative Test of Change between WAST and RGH Emergency Department is to be rolled out across POW and PCH. This will ensure clinically safe and dignified pathways for patients into ED following arrival by ambulance by reducing, where possible, handover delays and to deliver early diagnosis and treatment.
- Bi-weekly team meetings established with WAST.

What are the main areas of risk?

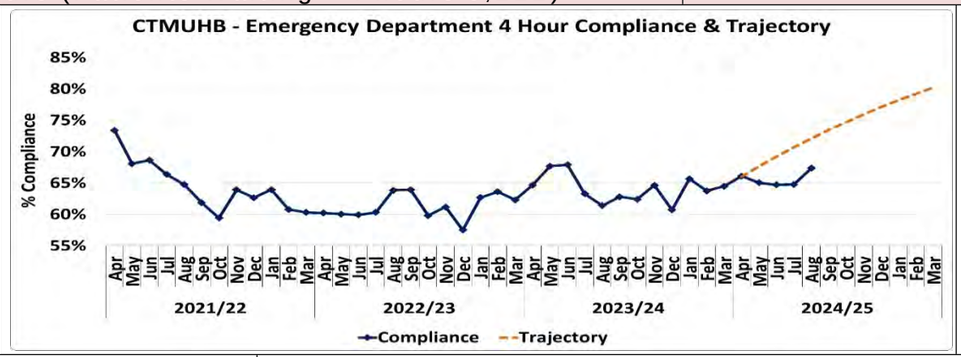
- Although some additional uncommissioned capacity areas have closed, some areas remain open across all sites, but is under daily review by Directorate Management Team.
- System flow remains highly impacted by capacity within social care.
- ED and ambulance activity reduced in August which may have contributed to the improved performance and reduction in surge capacity. Any increase in demand may result in uncommissioned capacity being utilised to manage demand.
- Persistent high escalation levels across all sites.
- Heavy reliance on locum and agency staff to support rotas across the three Emergency Departments.

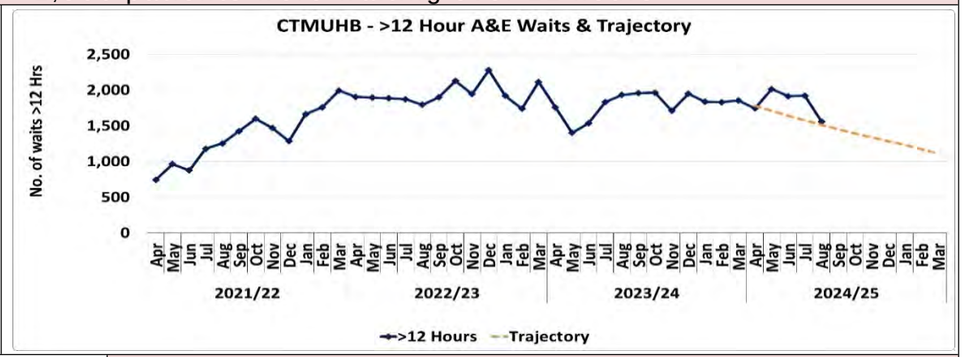
CTMUHB Unscheduled Care Group

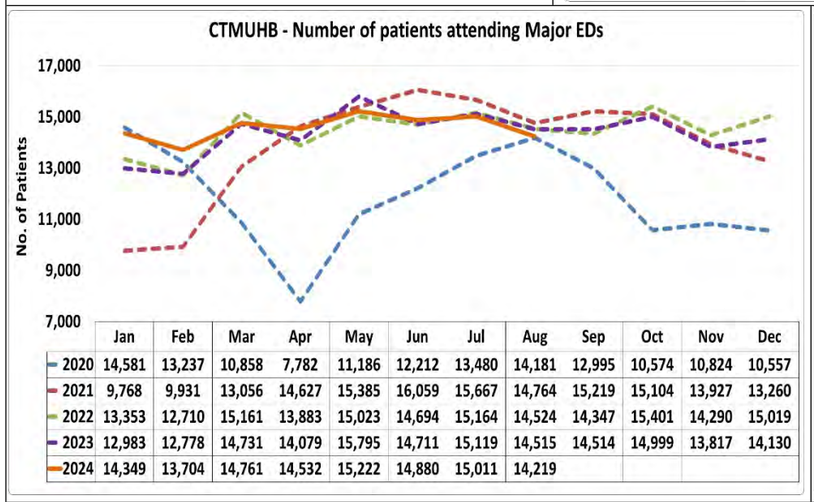
Emergency Unit Waits – August 2024 (Provisional Position) - Total Attendances = 15,664

% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge – Target is improvement compared to the same month in the previous year, towards the national target of 95%	Number of patients who spend 12 hours or more in all hospital major & minor emergency care facilities from arrival until admission, transfer or discharge – Revised Target is a 20% reduction on March 2024 number by September 2024 and a further 20% reduction by March 2025.
67.4% were seen within 4 hours (Patients Waiting >4 hours 5,111)	1,560 patients were waiting over 12 hours

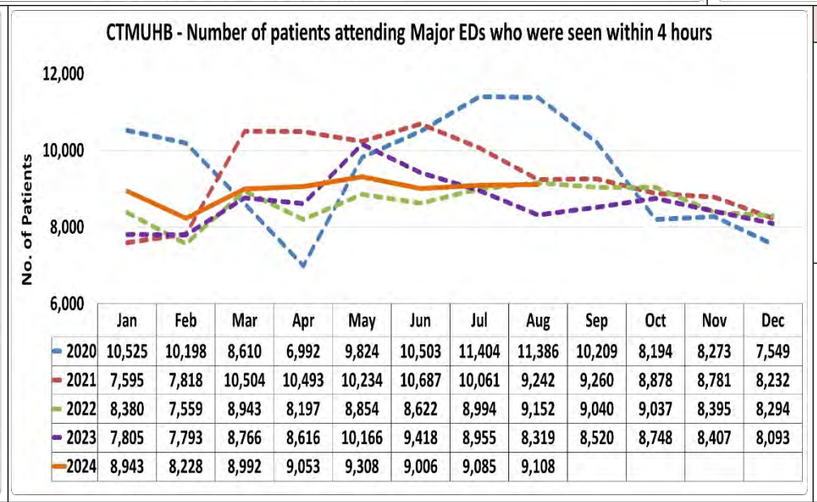
Period	CTMUHB		
	Attendances	4 Hrs %	> 12 Hrs
Aug-23	16,067	61.4%	1,932
Sep-23	16,127	62.8%	1,957
Oct-23	16,639	62.4%	1,965
Nov-23	15,298	64.6%	1,712
Dec-23	15,367	60.7%	1,949
Jan-24	15,744	65.7%	1,837
Feb-24	15,105	63.7%	1,831
Mar-24	16,251	64.5%	1,856
Apr-24	16,180	66.1%	1,745
May-24	16,947	65.1%	2,015
Jun-24	16,647	64.7%	1,915
Jul-24	16,821	64.8%	1,922
Aug-24	15,664	67.4%	1,560





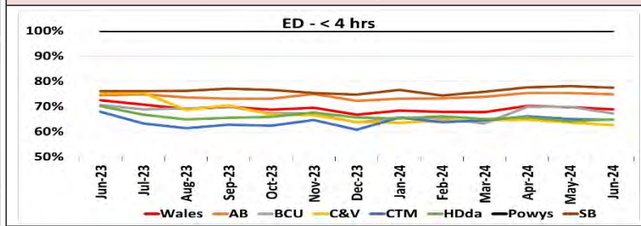


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	14,581	13,237	10,858	7,782	11,186	12,212	13,480	14,181	12,995	10,574	10,824	10,557
2021	9,768	9,931	13,056	14,627	15,385	16,059	15,667	14,764	15,219	15,104	13,927	13,260
2022	13,353	12,710	15,161	13,883	15,023	14,694	15,164	14,524	14,347	15,401	14,290	15,019
2023	12,983	12,778	14,731	14,079	15,795	14,711	15,119	14,515	14,514	14,999	13,817	14,130
2024	14,349	13,704	14,761	14,532	15,222	14,880	15,011	14,219				

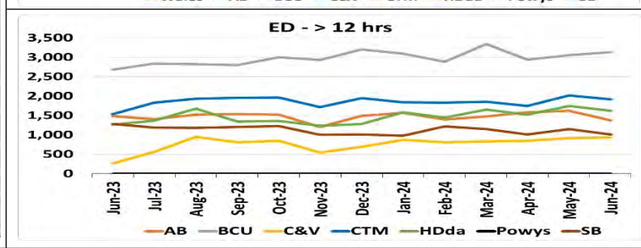


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	10,525	10,198	8,610	6,992	9,824	10,503	11,404	11,386	10,209	8,194	8,273	7,549
2021	7,595	7,818	10,504	10,493	10,234	10,687	10,061	9,242	9,260	8,878	8,781	8,232
2022	8,380	7,559	8,943	8,197	8,854	8,622	8,994	9,152	9,040	9,037	8,395	8,294
2023	7,805	7,793	8,766	8,616	10,166	9,418	8,955	8,319	8,520	8,748	8,407	8,093
2024	8,943	8,228	8,992	9,053	9,308	9,006	9,085	9,108				

How do we compare with our peers?



Status as at June 2024		
Health Board	Compliance	Rank
Powys	100.0%	1st
SB	77.5%	2nd
AB	74.9%	3rd
BCU	67.3%	4th
HDda	64.9%	5th
CTM	**64.7%**	**6th**
C&V	62.6%	7th



Status as at June 2024		
Health Board	Compliance	Rank
Powys	0	1st
C&V	933	2nd
SB	1,008	3rd
AB	1,374	4th
HDda	1,623	5th
CTM	**1,915**	**6th**
BCU	3,136	7th

How are we doing?

The chart above shows that throughout August the total number of ED attendances at our three acute hospital sites was slightly lower (2.0%) than those observed during August 2023, with overall numbers of Minor Injuries and ED attendances (15,664) down by 2.5% on those observed during the equivalent period of last year (16,067).

The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival at our emergency care facilities during August is provisionally 67.4%, which as it currently stands is higher than the performance seen during August 2023 (61.4%), but remaining well below the WG compliance target of 95%.

The twelve hours performance observed 1,560 patients waiting in excess of 12 hours and is 20% (372) fewer than the number of breaching patients observed during the same period of 2023. As can be seen in the chart top right, the performance during August falls just outside the predicted level, however it is not yet known whether this is related to lower attendance rates (lowest August period since 2020) or improvement in the flow of patients being seen in the “right place at the right time” given that Pathway of Care Delays remain high with 363 delays recorded during August 2024. (Further analysis will be provided in the coming months to ascertain reasons for improvement and whether it has been sustained).

What actions are we taking & when is improvement anticipated?

- Proposals to re-model integrated care delivery for inpatients suitable for care in the community.
- Weekly pan CTM senior team meetings established, supported by robust action plans with a view to the standardisation of ways of working and clinical pathways where possible.
- Proposal to introduce Urgent Treatment Centre (UTC) at PCH from the end of October/early November. This will improve patient experience and ED performance/waiting times once operational.
- Exploring feasibility of introducing Rapid Assessment & Treatment Model (RAT) at PCH following realignment of consultant roster.
- Improvement plan in place across CTM with regular weekly performance meetings.
- 4-hour compliance validation exercise completed in POW which saw an improved performance.
- 12-hour performance review in progress to understand and resolve exit blocks to improve performance.
- Plan to introduce incremental weekly reduction in the longest patients waiting.
- Recruitment of Patient Flow Co-ordinator in PCH & RGH sites to support patient flow & record accurate data.
- Review of validation process underway to develop a SOP in line with national guidance to improve data quality and ensure parity of data across the three ED departments.
- Development of electronic safety huddle being trailed in RGH to provide a real time picture of demand, capacity and risk level.
- Review MIU clinical criteria and potential available capacity to redirect a higher proportion of patients from ED.

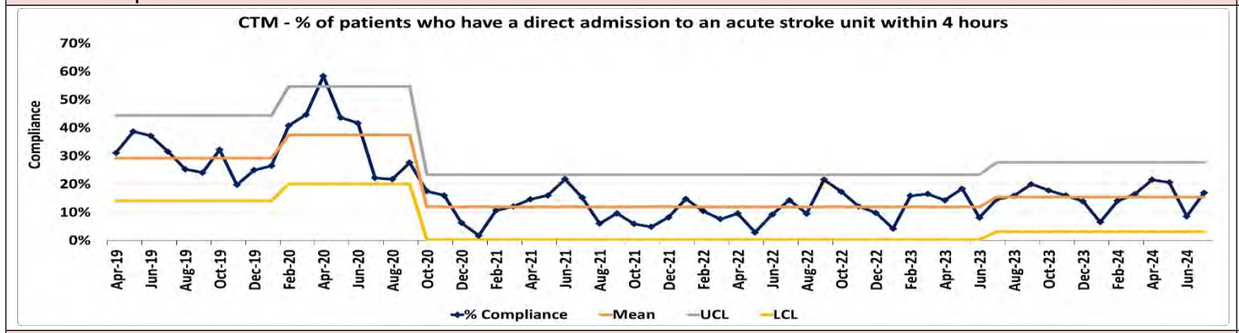
What are the main areas of risk?

- Additional uncommissioned capacity remains open across all sites.
- System flow remains highly impacted by capacity within social care.
- Any increase may result in uncommissioned capacity being utilised to manage demand.
- Persistent high escalation levels across all sites.
- Heavy reliance on locum and agency staff to support rotas across the three Emergency Departments. This will reduce as recruited posts receive start dates.

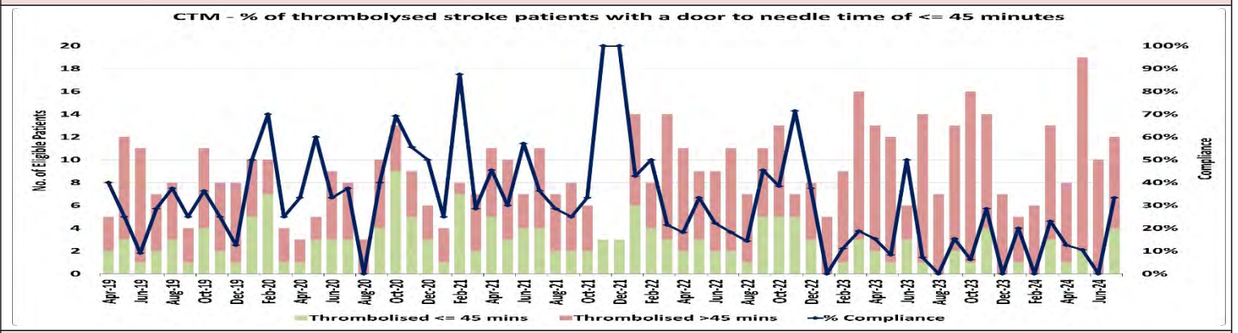
CTMUHB Unscheduled Care Group

Stroke Quality Improvement Measures (QIMs) – July 2024

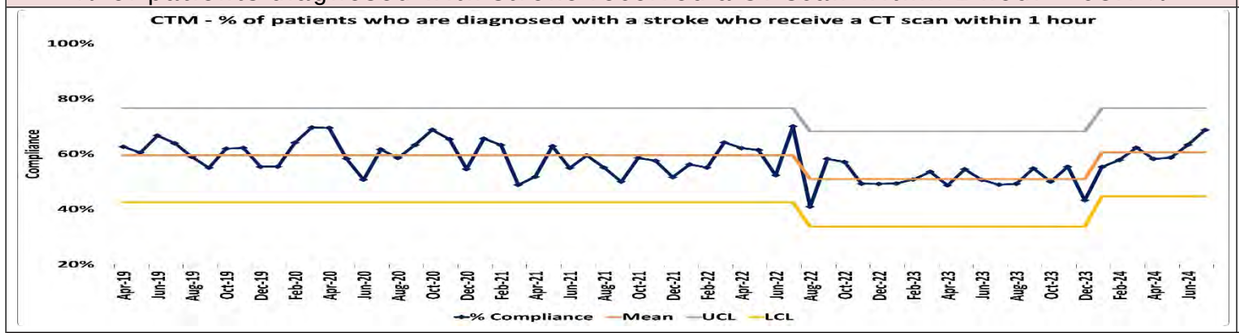
% compliance with direct admission to an acute stroke unit within 4 hours – 16.9%



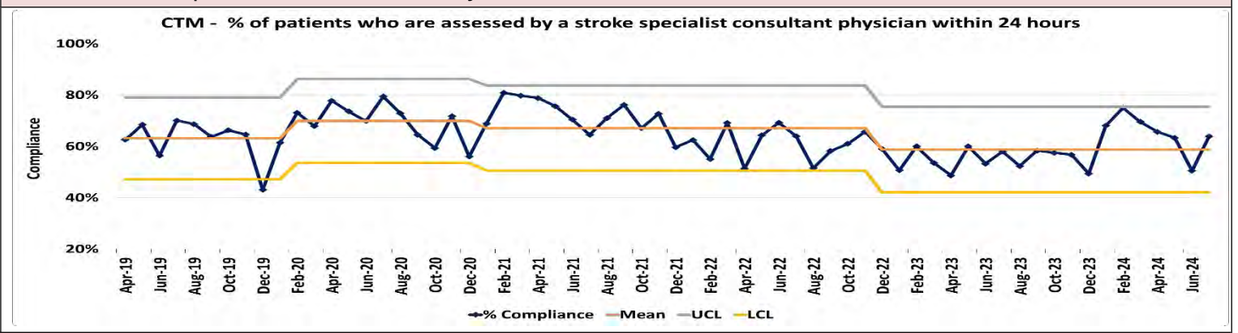
% of eligible patients thrombolysed door to needle time within 45 minutes – 33.3%



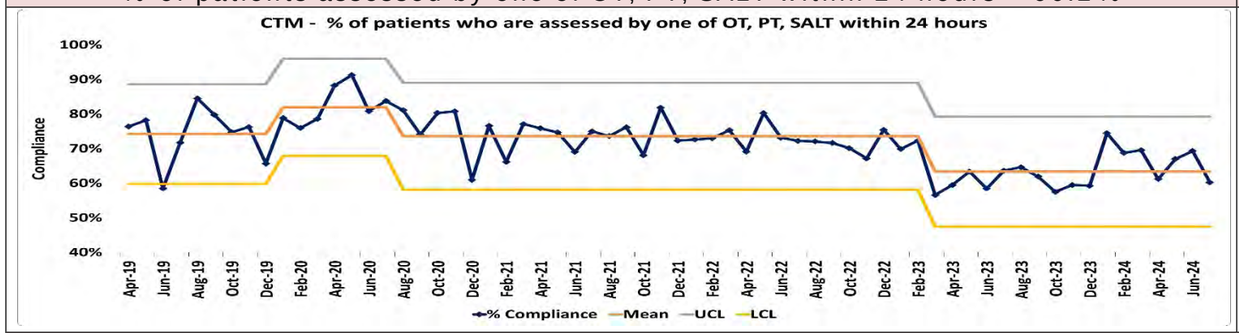
% of patients diagnosed with stroke received a CT scan within 1 hour – 68.7%



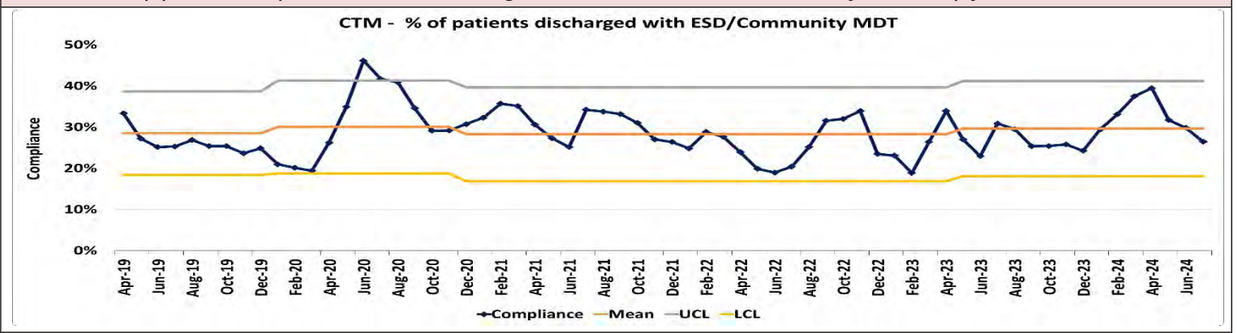
% of patients assessed by a stroke consultant within 24 hours – 63.9%



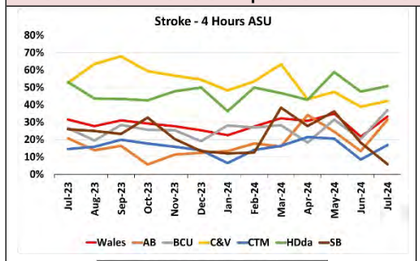
% of patients assessed by one of OT, PT, SALT within 24 hours – 60.2%



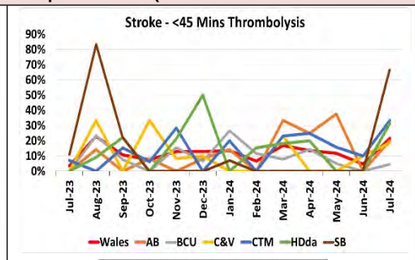
% of applicable patients discharged with ESD/Community Therapy MDT – 26.5%



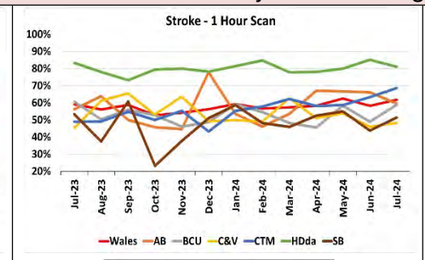
How do we compare with our peers? *(Please note that the data below is subject to change due to data being refreshed monthly)*



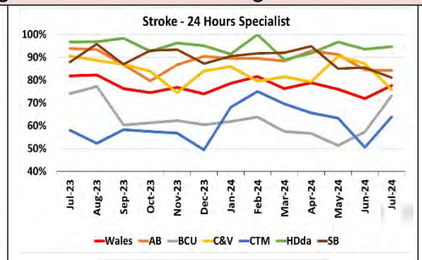
Status as at July 2024		
Health Board	**Compliance**	**Rank**
HDda	50.7%	1st
C&V	42.2%	2nd
BCU	37.0%	3rd
AB	31.5%	4th
CTM	**16.9%**	**5th**
SB	5.9%	6th



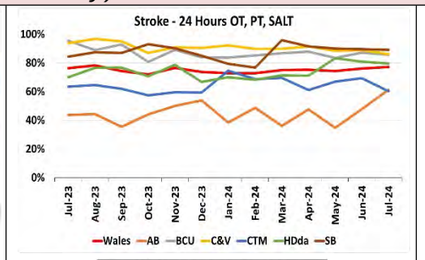
Status as at July 2024		
Health Board	**Compliance**	**Rank**
SB	66.7%	1st
CTM	**33.3%**	**2nd**
HDda	31.3%	3rd
AB	20.0%	4th
C&V	18.8%	5th
BCU	4.5%	6th



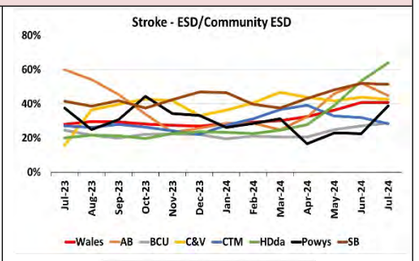
Status as at July 2024		
Health Board	**Compliance**	**Rank**
HDda	81.1%	1st
CTM	**68.7%**	**2nd**
AB	59.6%	3rd
BCU	58.9%	4th
SB	51.4%	5th
C&V	48.3%	6th



Status as at July 2024		
Health Board	**Compliance**	**Rank**
HDda	94.6%	1st
AB	84.2%	2nd
SB	81.1%	3rd
C&V	75.9%	4th
BCU	73.2%	5th
CTM	**63.9%**	**6th**



Status as at July 2024		
Health Board	**Compliance**	**Rank**
SB	89.2%	1st
C&V	86.2%	2nd
BCU	85.7%	3rd
HDda	79.7%	4th
AB	61.4%	5th
CTM	**60.2%**	**6th**



Status as at July 2024		
Health Board	**Compliance**	**Rank**
HDda	64.1%	1st
SB	51.4%	2nd
AB	44.8%	3rd
C&V	42.6%	4th
Powys	38.9%	5th
BCU	28.7%	6th
CTM	**28.3%**	**7th**

Stroke Quality Improvement Measures (QIMs) continued – July 2024

How are we doing?

Stroke Quality Improvement Measures - July 2024		PCH	POW	YCR	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	52	25	N/A	77
	No. of patients within 4	13	0		13
	% Compliance	25.0%	0.0%		16.9%
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	10	2	N/A	12
	No of patients within 45	4	0		4
	% Compliance	40.0%	0.0%		33.3%
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	58	25	N/A	83
	No. of patients within 1	41	16		57
	% Compliance	70.7%	64.0%		68.7%
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	58	25	N/A	83
	No. of patients within 24	31	22		53
	% Compliance	53.4%	88.0%		63.9%
% of patients who are assessed by one of OT, PT, SALT within 24 hours	Total admissions	58	25	N/A	83
	No. of patients within 24	31	19		50
	% Compliance	53.4%	76.0%		60.2%
% of applicable patients discharged with ESD/Community Therapy MDT (rolling 3 months)	Applicable Patients	107	98	18	223
	No. of patients with	36	22	1	59
	% Compliance	33.6%	22.4%	5.6%	26.5%

- During July, 16.9% (13 out of 77) of stroke patients were admitted directly to an acute stroke unit (ASU) within 4 hours. No stroke patients attending POW had care in line with the standard, with further evidence from the "reset fortnight" identifying that the LOS of patients on the unit is far longer than the requisite time required to ensure that there is available capacity due to the ASU providing both acute and rehab care on the one ward. At PCH, the 8 patients who presented in core hours were admitted in compliance with the standard, with only 5 of the 35 patients presenting outside core hours receiving the same quality of care. All 9 patients who self-presented to RGH and were then transferred to PCH, were not admitted within 4 hours of arrival at the RGH ED.
- 12 eligible patients were thrombolysed, although only 4 received treatment within 45 minutes. Contributing factors to this were that 56% of patients self-presented (no pre-alert), as well as a high number of patients presenting outside of stroke service hours.
- 68.7% of patients (57 out of 83) had a CT scan within an hour; an increase in performance for CT compared to last month. WAST are supporting taking patients to CT during handover delays. Challenges in the timely triage of self-presenters to the stroke pathway and the management of patients attending outside of stroke service hours are contributing to the number of patients not having a scan within one hour.
- 63.9% (53 out of 83) of stroke patients treated in July were seen by a specialist stroke physician within 24 hours of arrival at the hospital. Out of the 30 patients who did not have a specialist stroke review within 24 hours, 24 of these patients presented at the weekend, when there is no service.
- 60.2% (50 out of 83) of stroke patients were assessed by either an Occupational Therapist, Physiotherapist or Speech and Language Therapist within 24 hours of arrival. Based on the run chart overall compliance has observed a predictable pattern of variation since April 2023 (between 50% and 80%), the reasons largely remain the same in terms of patients not being able to get admitted to an ASU within a timely fashion and therefore reliant on a small workforce to see them as outlier which comes with challenges. Other reasons impacting performance are lack of 7-day service and self-presenting patients being held at RGH due to capacity/IPC constraints.
- The rolling 3-month discharge standard saw 59 out of 223 (26.5%) of applicable patients being discharged with Early Supported Discharge (ESD) or Community Therapy MDT. On review by the team, to the best of our knowledge, no patient was denied the ESD service in July. The fluctuation in performance may refer to less patients meeting the criteria, however, there is ongoing work by the therapy team to review the YCR referrals.

What actions are we taking & when is improvement expected?

- A locum Consultant has been appointed to the PCH service to cover maternity leave and started in post at the end of August. A further locum (12 months) is due to start in October to cover a post that has been vacant for a number of years. This will be the first occasion in a period of time when the health board will have 5 Stroke Consultants.
- ACP workforce and SSNAP co-ordinator proposal has been submitted and awaiting Care Group feedback to support expanding the workforce to enable 7 day stroke provision at PCH and POW sites.
- The impact of Brainomix AI software (reporting for CTs and CT angiograms) continues to be monitored. Review of 6-month data shows 119 CTAs completed, which is a significant increase compared previously. Data is taken through the Stroke Operational and Programme Board to review in high level detail.
- CT perfusion can now be undertaken at PCH and RGH. POW has had the software installed, but there is ongoing training required. There is no confirmed date at present but this is being regularly discussed through Stroke operational meetings. The full impact will not be seen for CT perfusion until workforce is expanded to support the new pathways. Review of data shows with the use of CTP, there could potentially be an 80% increase for thrombolysis which the current workforce could not manage.
- Reset fortnight took place for a two-week period starting on 12th August and we focused on POW stroke services. The first week we were able to create a daily ring-fenced bed by transferring suitable patients to other wards who did not need to be on ASU. During the second week this became increasingly more difficult and highlighted the severe impact of having no community rehab support. As part of the reset fortnight, we were able to identify the following opportunities to support improvement of a stroke patients pathway:

  - Working with radiology to set up ring-fenced MRI slots (with daily access to MRI slots this could prevent some patients from having to be admitted).
  - Review or develop internal SOP for diagnostic wait time (on the back of this, implement escalation policy if SOP not being followed). Some MRIs taking 3+ days to be undertaken.
  - Site team being added to Stroke Teams channel to support better communication for confirmed stroke patients (were seeing some none confirmed strokes being moved to the ward previously).

- Regional meetings with C&V now set back up from September with a new regional Programme manager in post, however the regional clinical lead role still remains vacant.

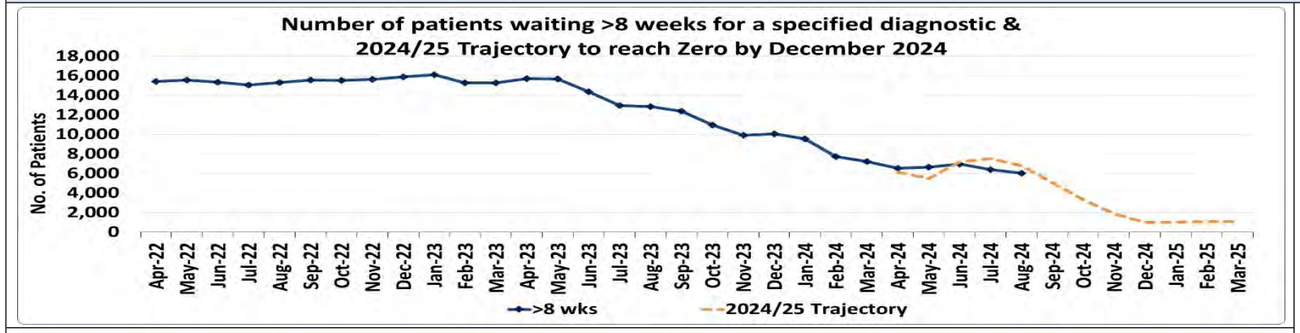
What are the main areas of risk?

- Small consultant workforce - currently the service is running a 1 in 6 on-call rota despite only having 4 substantive consultants.
- ACP/CNS workforce across POW and PCH - this would require investment to recruit further CNS/ACP workforce to extend hours and provide a 7-day service to support improved patient care and experience.
- Inpatient AHP resource does not meet national standards and is delivered Mon-Fri 9-5 p.m.
- Bridgend Early Supported Discharge service having limited capacity and often have to stop taking new referrals.
- Data quality - additional resource is required to support data input/performance reporting across both PCH and POW, which will support with performance monitoring and improvement. SSNAP Co-ordinator is included in the ACP workforce expansion paper.
- Ring-fencing stroke beds continues to be a challenge due to site pressures, as well as high numbers of clinically optimised patients awaiting social care, community hospital and nursing home.
- Limited stroke rehabilitation capacity for CTM patients, in particular patients at POW.
- Therapy rooms within ward areas are not fit for purpose in PCH and POW. Many patients are currently receiving therapy input at their bedside, which is not appropriate.
- Clinically optimised patients within acute stroke bed base due to lack of community support available.
- A number of stroke patients still continue to self-present to RGH where there is no specialist stroke provision. This impacts the ability to enact stroke pathway due to no pre-alert for these patients (impacting on timely care).
- Lack of psychology support available to our patient's post-acute stroke.

CTMUHB Diagnostics, Therapies, Pharmacies & Specialties Care Group

Diagnostics - August 2024 (provisional position)

Number of patients waiting >8 weeks for a specified diagnostic – revised Target is for 95% of modalities to be Zero by December 2024



Diagnostics >8 wks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/24	15,727	15,689	14,361	12,972	12,843	12,390	10,962	9,909	10,079	9,563	7,759	7,236
2024/25	6,549	6,646	6,989	6,403	6,049							

Number of Patients waiting >8 Weeks for a Diagnostic Test - August 2024		
Cardiology	Echo Cardiogram	830
Cardiology Services	Cardiac CT	20
	Cardiac MRI	3
	Diagnostic Angiography	51
	Stress Test	8
	DSE	38
	TOE	11
	Heart Rhythm Recording	8
	B.P. Monitoring	0
Bronchoscopy		2
Colonoscopy		115
Gastroscopy		108
Cystoscopy		895
Flexi Sig		35
Radiology	Non-Cardiac CT	1,510
	Non-Cardiac MRI	158
	NOUS	1,088
	Non-Cardiac Nuclear Medicine	45
Imaging	Fluoroscopy	119
Physiological Measurement	Urodynamics	152
Neurophysiology	EMG	399
	NCS	454
Total		6,049

How are we doing?

Diagnostics: Over the past 12 months good progress has been made to reduce the number of patients waiting more than 8 weeks prior to receiving their test and a reduction of over 51% has been observed.

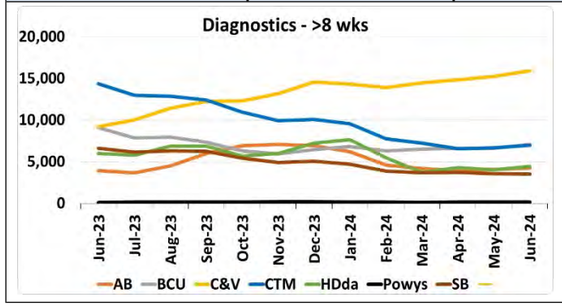
Provisionally, at the end of August, 6,049 patients had been waiting in excess of 8 weeks for a diagnostic procedure, which as it currently stands is an improvement of 5.5% (354) on the July reported position.

This month the NOUS service has observed a 26% (382) reduction in the number of breaching patients after seeing an increase at the start of this financial year; bringing the total number of patients waiting in excess of 8 weeks to 1,088.

There has been a continued reduction in the number of patients waiting longer than 8 weeks for an Echo Cardiogram; falling by 10% (96 patients) from the previous reported position, although there are currently 830 patients waiting more than the desired timescale for this diagnostic procedure. We have also seen a 30% reduction from the previous month in the number of patients waiting longer than 8 weeks for Non-Cardiac MRI, which currently stands at 158 patients waiting beyond 8 weeks.

During the month, the Endoscopy service remained fairly static in the number of patients breaching with the number of patients currently waiting beyond the target of 8 weeks standing at 1,155.

How do we compare with our peers?



Status as at June 2024		
Health Board	Compliance	Rank
Powys	157	1st
SB	3,493	2nd
AB	4,219	3rd
HDda	4,443	4th
CTM	**6,989**	**5th**
BCU	7,097	6th
C&V	15,938	7th

What actions are we taking & when is improvement anticipated?

Radiology: NOUS - business case developed and partly approved to address current backlog growth which includes a maintenance scheme. 2 training sonographers have commenced training and another 2 will commence training in January 2025, with 3 vacancies out to advert. Utilising locum agency sonographer at PCH. Timetable developed to co-ordinate SpR scanning lists across RGH & PCH. NOUS consultant waiting list initiatives arranged across all sites.
The service continues to maintain an improved MRI and CT reporting position. 3 Locum NHS Radiologists have started in post, with a further substantive 0.7 w.t.e Consultant joining mid-September. A further interview is taking place for 1 Locum NHS consultant with a sub-specialty interest in MSK.

The Mobile MRI unit has been operational since last week of April, which continues to deliver a reduction in >8 week waits and the overall waiting list numbers. Trajectories for CT and MRI developed and show scanning capacity shortfalls with the additional demand trends.

A business case has been submitted and partially approved for a sustainable solution to increase CT scanning capacity in 2024. An operational meeting has been arranged for the mobile CT solution to commence scanning end of September/early October. D&C has demonstrated a maintained increased growth in demand for CT.

Changes to the Breast template - increased >40 patient capacity and session slots. The current wait for first OPA is 14 days. The service has been able to support refresh training for a current NHS Locum Radiologist with a sub-special interest in Breast to enable permanent cover for all One Stop USC Breast clinics from October.

Endoscopy:
Productivity and efficiencies continue to be monitored weekly and utilisation maintained >90%. Endoscopy mobile unit continues at RGH to support crossover of the new unit at PCH going live at the end of September. The service has seen an increase in USC demand but has managed to maintain current USC waits.

What are the main areas of risk?

Neurophysiology:
- This is the only diagnostic procedure which CTM does not have a tactical plan in place by which to achieve the 8 week target by December 2024.
- We have asked Colleagues in Swansea Bay UHB to see if they have any additional capacity to offer and we await a response on what they might be able to help us with.
- JCC (Joint Commissioning Committee) conversations developing as a commissioned service but the reporting will remain with Health boards for the foreseeable future.

Radiology:
- D&C imbalance shown in most D&T services as demand has risen. CT colon demand likely to rise further as a result of the new BSW criteria and reduced age limit for screening patients; linked to Endoscopy additional capacity being commissioned. Pathology sampling has already seen this increase - currently being supported to outsourcing through the planned care recovery proposals.
- Sustained increase in In Hours and Out of Hours CT emergency demand. Additional outsourcing funding is currently in place to assist with timely reporting, to reduce the reporting backlog. Going forward a plan has been drafted in radiology to try and reduce any unnecessary demand and look at the opportunities to utilise currently unfunded CT sessions. The CT mobile solution will clear backlog waiting patients but sustainable staffing resource is needed to maintain waiting times and for safety purposes during OOH.
- NOUS waiting list has been maintained with additional resources for this year. Recruitment and training are underway to help build a resilient workforce but this will take time to embed. There are also national changes to obstetric protocols that will put further pressure on the service and reduce capacity to scan NOUS patients going forward.

Cardiac Physiology:
- Reduction of over 8 week echocardiograms continues. Additional scans commenced in July and will continue through to December.

Endoscopy:
- Across site working continues to improve, but WPAS interface still remains a risk to develop a pooled waiting list – working with our digital colleagues to overcome.
- GI pathway audit completed and action plan developed. This will allow the pan CTM endoscopy service to operate within a standardised approach.

Therapies – August 2024 (provisional position)

The 2024/25 Performance Framework is measuring three performance indicators for therapy services and from April 2024 there has also been a change in the reporting of Weight Management services. As this service is multi-disciplinary involving a number of different therapists all contributing to patient care, Weight Management services was over inflating waiting times for Dietetics. Consequently WG have decided that:

- *All waiting times for Weight Management services should be removed from the Diagnostic and Therapy Services (DATs) formal waiting times national submission from April 2024.*
- *All non-consultant led Weight Management services should be removed from the Referral to Treatment (RTT) waiting times national submission from April.*
- *Any Weight Management service waiting times, which are part of a consultant led RTT pathway, should be reported under the specialty of the consultant responsible for the overall pathway from April.*

Number of patients waiting >14 weeks for a specified therapy (excluding Audiology) - Target is Zero (August 2024 = 47)

Number of patients waiting >14 weeks for Audiology – Adult Hearing Aids - Target is Zero (August 2024 = 109)

% of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional – Target is 100% (August 2024 = 98.4%)

2024/25 Therapies >14 wks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Excluding Adult Hearing Aids	60	45	41	22	47							
Adult Hearing Aids	135	180	188	172	109							

Number of Patients waiting >14 Weeks for a Therapy - August 2024	Total Waits	Waits >14 wks	% >14 wks
Arts Therapy	23	6	26.1%
Dietetics	880	5	0.6%
Occupational Therapy	191	3	1.6%
Physiotherapy	1,372	20	1.5%
Podiatry	947	5	0.5%
Speech & Language	468	8	1.7%
Total	***3,881***	***47***	***1.2%***
Audiology *(Adult Hearing Aids)*	1,069	109	10.2%
Grand Total	**4,950**	**156**	**3.2%**

% of children waiting less than 14 Weeks for AHP - August	Total Waits	Waiting < 14 wks	% <14 wks
Arts Therapy	23	17	73.9%
Dietetics	226	226	100.0%
Occupational Therapy	78	75	96.2%
Physiotherapy	200	200	100.0%
Podiatry	100	100	100.0%
Speech & Language	338	332	98.2%
Total	**965**	**950**	**98.4%**

How are we doing?

During August there are provisionally 47 patients waiting in excess of 14 weeks for an initial therapy assessment, which is an increase of 25 patients from the July reported position and 109 adults waiting beyond the target for a hearing aid fitting which is a reduction of 63 patients form the previous reported position.

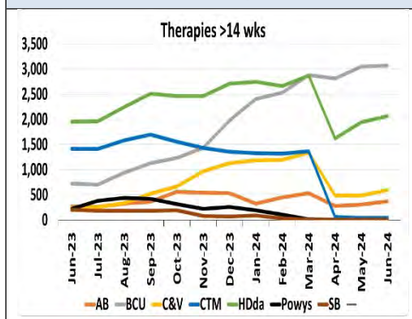
What actions are we taking & when is improvement anticipated?

Ensuring administrative staff are applying the RTT rules appropriately.

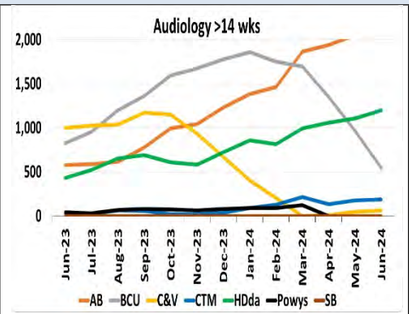
Considering the oppourtunity to intergrate Community Health Pathways into the Therapies triage processes with the intention to improve quality and appropriateness of referrals.

Adult hearing aids:
Audiology has been gradually reducing waiting times over the last 12 months. This has been achieved by sharing waiting lists across sites and training staff in new areas of work. From Autumn 2025, all our audiology wait times will be reported to WG. For this reason, and to ensure fair and equitable patient care, we are working to reduce *all* our wait times (not just the currently reportable adult 14 week RTT wait time). This means the rate of reduction in wait time may appear slower than expected and we still have some breaches. We are confident that we will meet this RTT by early 2025 and have zero breaches.

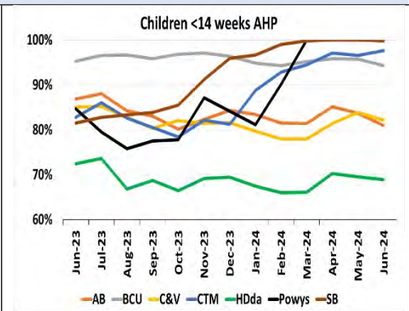
How do we compare with our peers?



Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	2	1st
SB	4	2nd
CTM	**41**	**3rd**
AB	371	4th
C&V	604	5th
HDda	2,065	6th
BCU	3,065	7th



Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	0	1st
SB	0	1st
C&V	63	3rd
CTM	**188**	**4th**
BCU	544	5th
HDda	1,198	6th
AB	2,135	7th



Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
SB	99.8%	2nd
CTM	**97.7%**	**3rd**
BCU	94.3%	4th
C&V	82.1%	5th
AB	81.0%	6th
HDda	68.9%	7th

What are the main areas of risk?

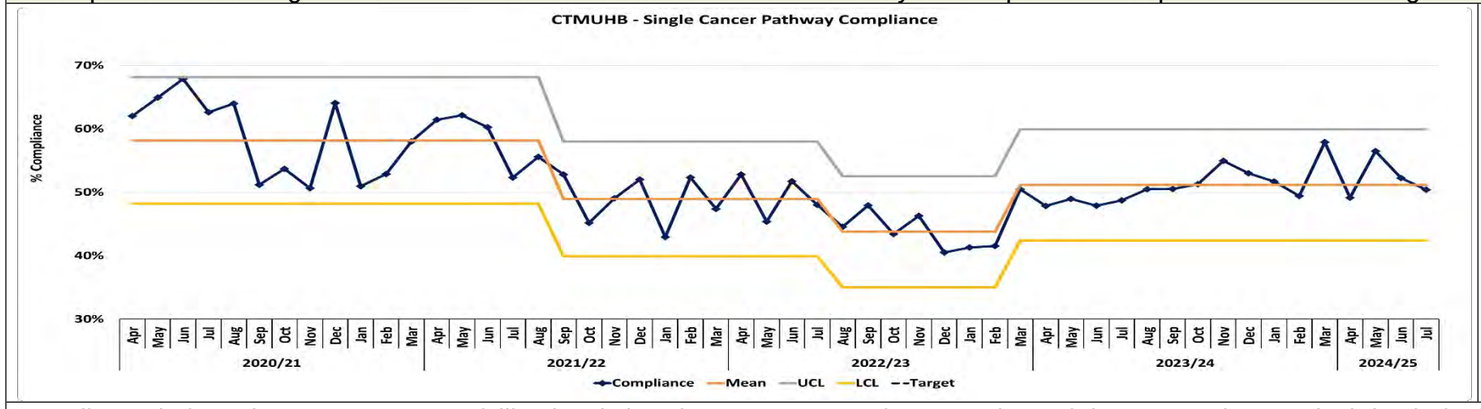
Ongoing growing demand for both musculoskeletal and pelvic health physiotherapy. Without additional resource we will see an increase in average waiting times and increase in breaching patients waiting more than 14 weeks.

Audiology are now required to see out of area patients. This change in approach will increase demand on our service and therefore increase wait times. This demand is unknown so the extent of the risk is unclear. As GPs become aware of the new approach, we may see the 'flood gates opening' and many more out of area referrals coming into the service. We are auditing the number of out of area patients and we hope an agreement can be put in place to ensure we have funding for these additional patient pathways and increased *life-long* hearing aid provision.

CTMUHB Planned Care Group

Single Cancer Pathway (SCP) July 2024 – 50.4%

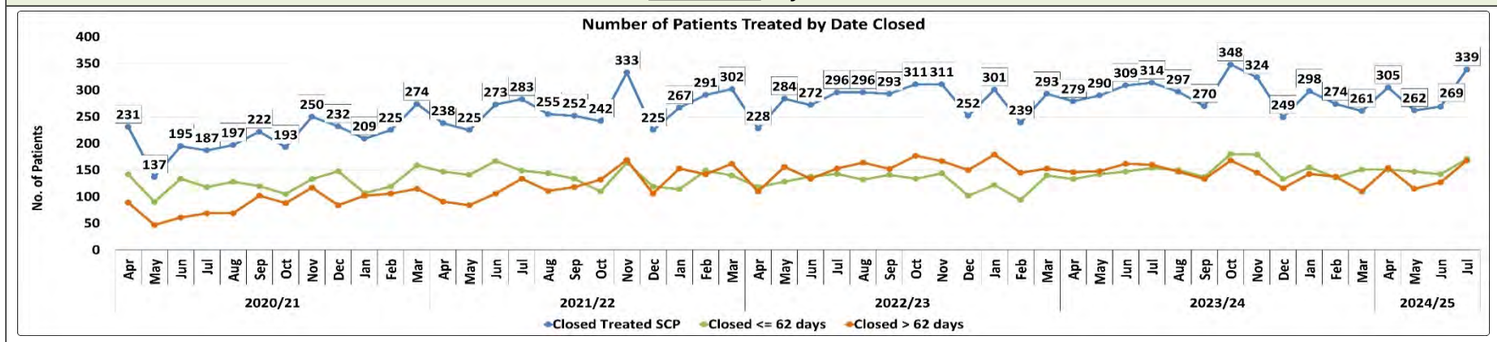
% of patients starting first definitive cancer treatment within 62 days from point of suspicion. Revised Target:60% performance by December 2024 & 70% performance by March 2025



CTMUHB - SCP % Treated Without Suspensions - July 2024				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated against Target of 60%
Head and neck	5	6	11	45.5%
Upper GI	17	16	33	51.5%
Lower GI	12	21	33	36.4%
Lung	26	21	47	55.3%
Sarcoma	1	1	2	50.0%
Skin (exc BCC)	51	8	59	86.4%
Brain/CNS	3	1	4	75.0%
Breast	15	19	34	44.1%
Gynaecological	6	8	14	42.9%
Urological	27	60	87	31.0%
Haematological	2	4	6	33.3%
Other	6	3	9	66.7%
Total	171	168	339	50.4%

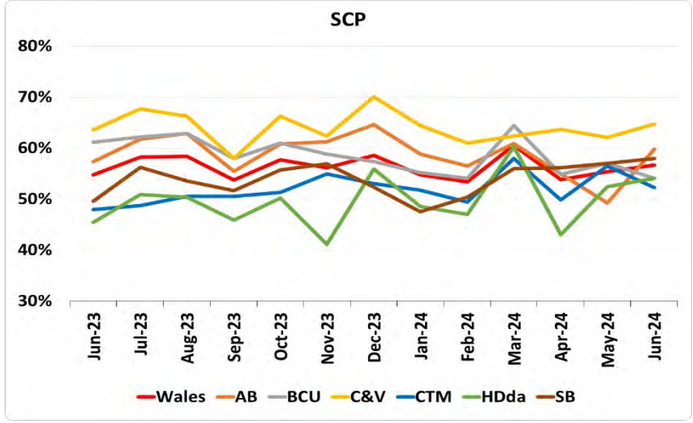
Compliance during July 2024 was 50.4%, falling just below the current mean of 51.2%. Three of the tumour sites reached the desired target threshold of 60% this period, as seen in the table above. Predicted compliance for August currently stands at 53.8%. Of greatest concern are the continuing delays at first outpatient (29%) and diagnostic stage (47%) and are the significant factors in not achieving the target. Diagnostic delays remain in radiology, endoscopy and pathology. Tertiary delays for diagnostics & treatments also continue.

Patients Treated by Closed Date



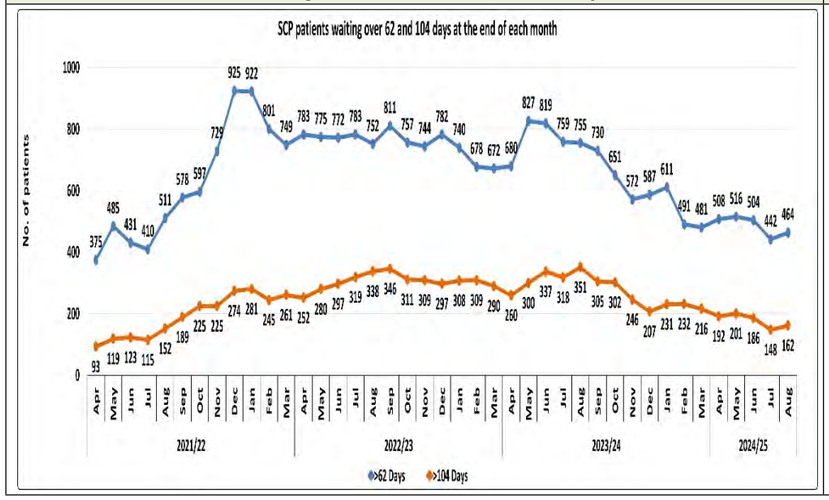
Cancer treatment volumes have not seen an increase during the past 12 months with the monthly average (Aug 23 to Jul 24) equating to 291 per month, which is the same as the volumes seen in the equivalent time span of 2022/23. Changes in treated volumes vary at a tumour site level, with reductions in Breast, Haematology and Urology balancing out increases in Skin and Lower GI.

How do we compare with our peers?



Status as at June 2024		
Health Board	Compliance	Rank
C&V	64.6%	1st
AB	59.8%	2nd
SB	57.9%	2nd
BCU	54.1%	4th
HDda	54.0%	5th
CTM	52.3%	6th

Patients currently waiting on a Cancer Pathway waiting in excess of 62 days



What actions are we taking & when is improvement anticipated?

- Merging of Lower GI MDTs. First merger RGH/PCH MDT scheduled for September 9th.
- Rollout of digital vetting continues.
- Continuing outsourcing of pathology.
- Increased focus on time to first appointment through capacity review, booking analysis and standing item in Friday cancer performance meeting.
- Focus on booking of flexible cystoscopies pan CTM to reduce waiting list.
- Demand & Capacity undertaken
- Increased clinic templates
- Weekly focused cancer assurance meeting in ENT service.

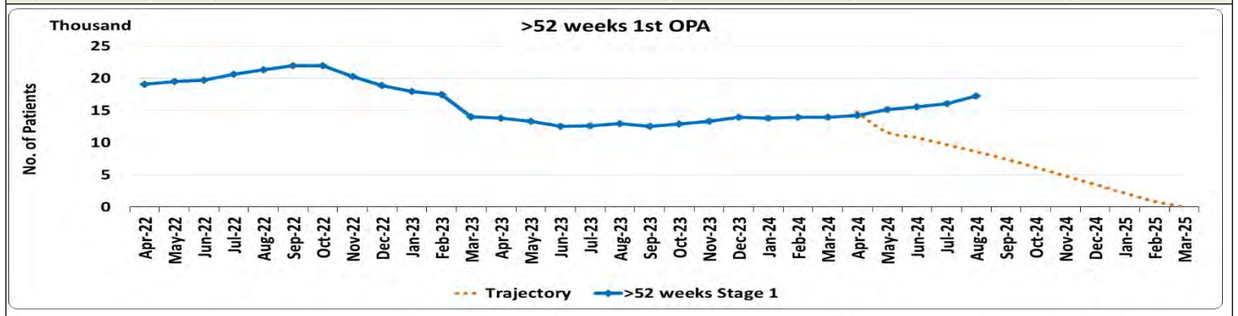
What are the main areas of risk?

- National shortage of isotope affecting breast and urology cancer pathways.
- Sustainability of CTM Pathology and impact when disaggregating services from SBUHB.
- Delays in tertiary investigations & treatments at SBUHB, Velindre Cancer Centre and C&VUHB.
- Implementation of genomic testing for new targeted therapies.
- Single clinician for laparoscopic nephrectomies – currently demand outweighing capacity.
- Increased wait in Bowel Screening Wales referrals.
- Sufficient capacity to meet component waits at first outpatient appointments in ENT.

CTMUHB Planned Care Group

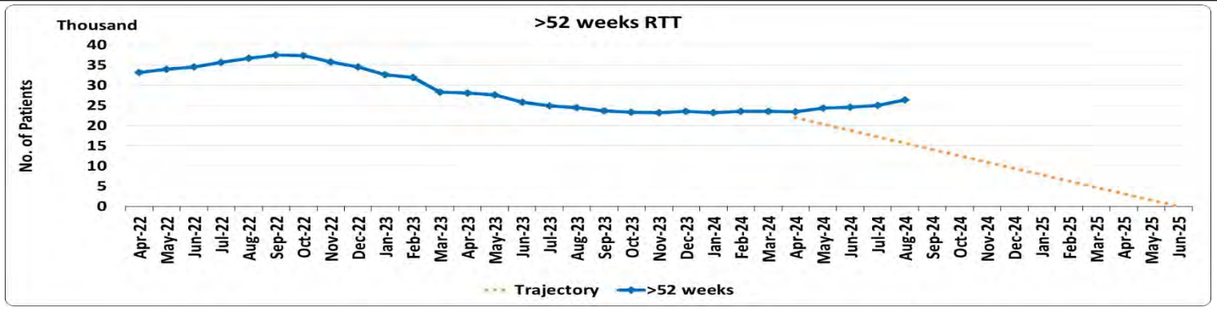
Referral to Treatment Times (RTT) – August 2024 (Provisional Position)

Number of patients waiting over 52 weeks for a new outpatient appointment (17,260) Target is 40% reduction on March 24 position by Sept 24 and Zero by March 25



The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of August is 17,260; an increase of 7.7% (1,233) on the July reported position and is above the desired trajectory equating to 8,673 patients waiting longer than forecasted, as shown above.

Number of patients waiting >52 weeks RTT (26,380) – Target is month on month reduction towards the national target of Zero by 30th June 2025

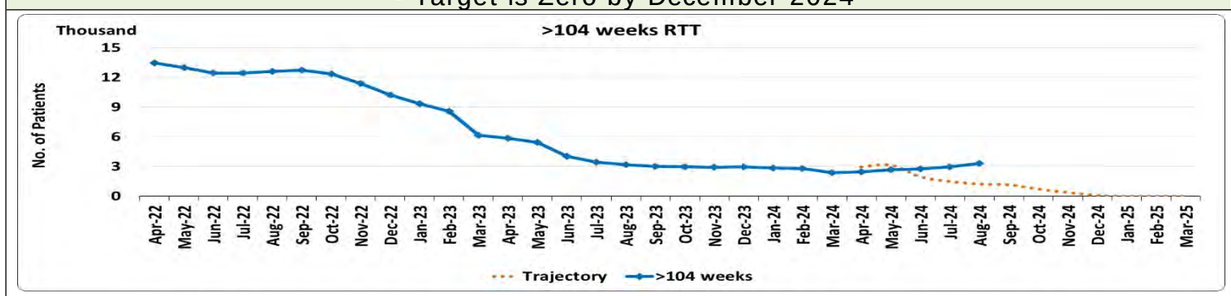


The provisional position across the Health Board for patients waiting over 52 weeks for referral to treatment at the end of August is 26,380, which as it currently stands is a 5.4% (1,349) increase on the July reported position resulting in 10,701 patients waiting longer than the forecasted level, as shown above.

Total number of open pathways per specialty - August 2024 (provisional)

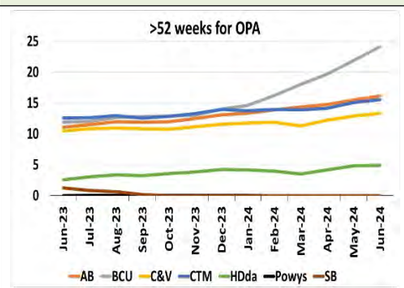
Specialty	Urgent patients waiting >12 Weeks	All patients waiting >36 to 52 Weeks	All patients waiting >52 Weeks to 104 Weeks	All patients waiting >104 Weeks	Total Open Pathways
Anaesthetics	158	255	337	0	1400
Breast Surgery	40	98	62	8	1001
Cardiology	1609	961	1022	0	6490
Colorectal	624	459	387	13	2773
Dermatology	1308	1014	1535	0	7264
Diagnostics	0	104	72	3	3841
Ear, Nose & Throat Service	1256	1797	3568	673	12400
Endocrinology	0	0	0	0	233
Gastroenterology	1480	573	885	37	4237
General Medicine	705	408	523	32	2974
General Surgery	618	783	757	94	5576
Geriatric Medicine	3	3	1	0	131
Gynaecology	1686	1846	1267	84	9139
Haematology (Clinical)	23	53	8	0	316
Nephrology	40	31	4	0	217
Ophthalmology	683	2488	4752	1296	16909
Oral Surgery	687	570	517	24	3209
Orthodontics	149	90	4	0	321
Orthopaedics	2300	2183	3794	725	13281
Paediatrics	222	367	190	0	3429
Pain Management	0	0	0	0	3
Rapid Diagnostic Centre	0	2	0	0	134
Respiratory Medicine	230	384	502	0	3130
Restorative Dentistry	41	25	81	38	242
Rheumatology	425	288	158	1	1963
Sport and Exercise Medicine	1	3	0	0	18
Therapies	0	0	0	0	1232
Urology	1576	1299	2264	168	8110
Vascular Surgery	78	173	409	85	1279
Total	**15,942**	**16,257**	**23,099**	**3,281**	**111,252**

Number of patients waiting >104 weeks RTT (3,281) - Target is Zero by December 2024

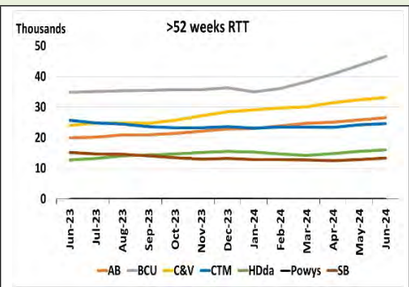


The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for referral to treatment at the end of August is 3,281. As it currently stands this is an increase of 325 patients from the reported July position and is above the anticipated number of waiting patients forecasted to be 1,219, as shown above.

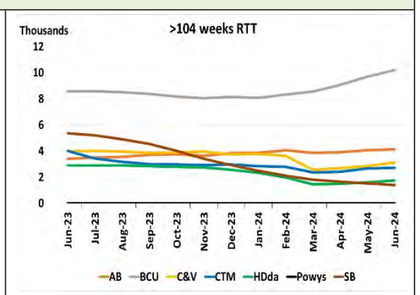
How do we compare with our peers?



Status as at June 2024		
Health Board	Compliance	Rank
Powys	0	1st
SB	0	1st
HDda	4,930	3rd
C&V	13,393	4th
CTM	**15,570**	**5th**
AB	16,142	6th
BCU	24,140	7th



Status as at June 2024		
Health Board	Compliance	Rank
Powys	24	1st
SB	13,312	2nd
HDda	16,006	3rd
CTM	**24,590**	**4th**
AB	26,546	5th
C&V	33,163	6th
BCU	46,659	7th



Status as at June 2024		
Health Board	Compliance	Rank
Powys	2	1st
SB	1,414	2nd
HDda	1,757	3rd
CTM	**2,738**	**4th**
C&V	3,139	5th
AB	4,152	6th
BCU	10,216	7th

RTT continued on the next page...

Referral to Treatment Times (RTT) continued - August 2024

What actions are we taking & when is improvement anticipated?

General Surgery - Plans for a second "Mega" clinic in September - stage 1, High Volume Low Complexity (HVLC) and additional clinic before December

- Backfilling sessions across the specialties to increase stage 1 access. Where we have experienced middle tier support, we are running clinics with a registrar to increase capacity.
- Admin validation ongoing on all stages and close working with Diagnostic teams to support areas requiring urgent expedites.
- Focus has been on >104 weeks for all stages and a reduction has been noted. Reduction to 52 week cohort stage 1 by March 2025 has commenced. For areas where reduction has been lower due to conflicts with cancer demand and vascular network activity, PCR bids have been submitted for additional funding to help ensure patients are seen and treated within target.
- WG funding secured to run "Mega" clinics on weekends for stage 1 Hernia and Lap Chole patients (up to 4 consultants seeing max 120 patients between them for 2 sessions)
- Discussions ongoing to reduce the stage 2 backlog of patients awaiting diagnostics at SBUHB

Vascular - Exploring additional lists on weekends at PCH to treat the long waiting patients from 104 week cohort by December and patients who require a theatre setting for their treatment.

- Exploring weekend new OPA clinics to help reduce stage 1 cohort. Also identifying veins only referrals in stage 1 cohort with a view to consider outsourcing.
- Discussions ongoing with Vascular Network regarding stage 1 vetting criteria for veins patients. To review vetting processes across the Health Boards to ensure equity in services provided.
- Review of clinic templates undertaken – templates altered to help reduce stage 1 cohort requiring appointment by December and March.
- Additional Vascular clinic to be set up in PCH from October.

Colorectal - Currently utilising locum to reduce colorectal stage 1 patients from the 52 week cohort

- Awaiting approval of funding to set up colorectal additional clinics; once in place will have a positive impact on the current waiting list.
- 2 new locum NHS consultants will commence September/October. This will cease the use of expensive agency locums.

Ophthalmology - The regional work is continuing with 110 patients already agreed to outsourcing (100 Spa Medica and 10 regional)

- Since April, 605 cataract patients have been sent to Vanguard with additional capacity offered to CTM as other HB's could not fill their capacity.
- Funding approval received for the Glaucoma diagnostic hub in YCC. Recruitment to begin in the next few weeks.
- SOP signed off for corneal service to restart in RGH in October.
- All new patients for motility (squints) are now being managed appropriately on one single pathway.

Validation ongoing on duplicate pathways.

Dermatology - WLI's co-ordinated throughout September to ensure 52 week position by end of December.

- Substantive consultant commenced early September.
- Review of all clinic templates – demand and capacity work completed and being reviewed.
- POW – flexibility with clinic appointments allowing for full utilisation.

Orthopaedics - Options to increase capacity are being explored.

- Focus on treat in turn.
- Offering Waiting List Initiatives
- Validation work ongoing
- Exploring capacity for theatre and outpatients to inform job planning.

Pain - Meeting set up to explore pain service - the service requires redesign and job planning

- Should see efficiency improvements over next couple of months
- Validation work ongoing

Urology - Validation of lists taking place, steady improvement anticipated over coming months.

- Ongoing meetings with pathology taking place to support sharing of information around demand and capacity.

Gynaecology - 156 weeks remain clear at all stages. There is sustained weekly reduction of the 104 and 52-103 weeks cohorts. Administrative and Clinical validation work ongoing to manage demand going into 2025.

{n.b. Stage 1 is initial Outpatient stage, Stage 2 is Diagnostics, Stage 3 is Follow-up and Stage 4 is Inpatient or Daycase treatment}

What are the main areas of risk?

General Surgery

- Reduced colorectal clinic capacity for non urgents, to accommodate urgent cancer demand
- Continuing delays with SBUHB patients for Endoscopy diagnostics (discussion with SB over pathway change)
- Spyglass delays (biliary investigation/treatment) - business case put forward.
- Backfill of sessions during summer months was reduced due to clinician leave. We anticipate backfill levels will increase during September.
- "Mega" clinics could be reduced due to limitations in funding from WG. To run proposed clinic numbers may require additional funds from within the directorate.
- Risk to Oncoplastic patients (breast cancer cosmetic improvements) awaiting treatment. Limited capacity at RGH as theatre sessions run bi-monthly with surgeon from SBUHB. Clinics also run bi-monthly - August clinic lost due to leave – scoping ad hoc clinic in September to establish capacity for long waiting stage 4 patients requiring oncoplastic review prior to surgery.

Vascular

- Additional clinics and theatres could be at risk due to large cohort of patients requiring appointment/treatment before December/March. Limited number of vascular clinicians available, risks burn out and reluctance to agree to multiple weekend or evening sessions. Would require up to 31 sessions of 8 patients per session to clear the >52 week stage 1 cohort by March.
- Capacity could be further impacted by clinicians being pulled to cover additional on calls at network due to sickness etc. between now and March 2025. We would have limited options for backfill of sessions due to consultants' current commitments at C&V.

Colorectal

- Loss of backfill clinics could impact waiting numbers for the 104 week and 52 week targets.
- Reduced colorectal clinic capacity due to USC demand.
- Interdependencies will need to be agreed for any additional clinics to go ahead.
- The closure of 4 theatres in December will also impact treatment volumes and long waiting patients.

Ophthalmology

- The patients being outsourced are not our longest waiting patients as these are complex. Patients are being outsourced from the >70 week cohort.

Dermatology

- Staff burnout

Orthopaedics

- Key operational posts being recruited to - ongoing process
- NCS and radiology delays are impacting wait times

Pain

- No substantive operational support in place; currently a band 4 supports but substantive role is a PA for Surgery.

Urology

- Pre-assessment delay currently affecting Urology pathway

Gynaecology

- Inpatient gynae cases remain as a risk for us due to small number of inpatient beds and not enough capacity on a weekly basis.
- Uptake of backfill lists to increase capacity at risk due to consultant rate card for surgeons and anaesthetists.
- Implementation of all actions recommended by the GIRFT programme are underway (Getting It Right First Time)*
- Further discussions underway around Service Level Agreement with Swansea Bay which could impact on waiting list split going forward.

**GIRFT is designed to improve treatment & care by reviewing health services. Undertaking clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.*

CTMUHB Planned Care Group

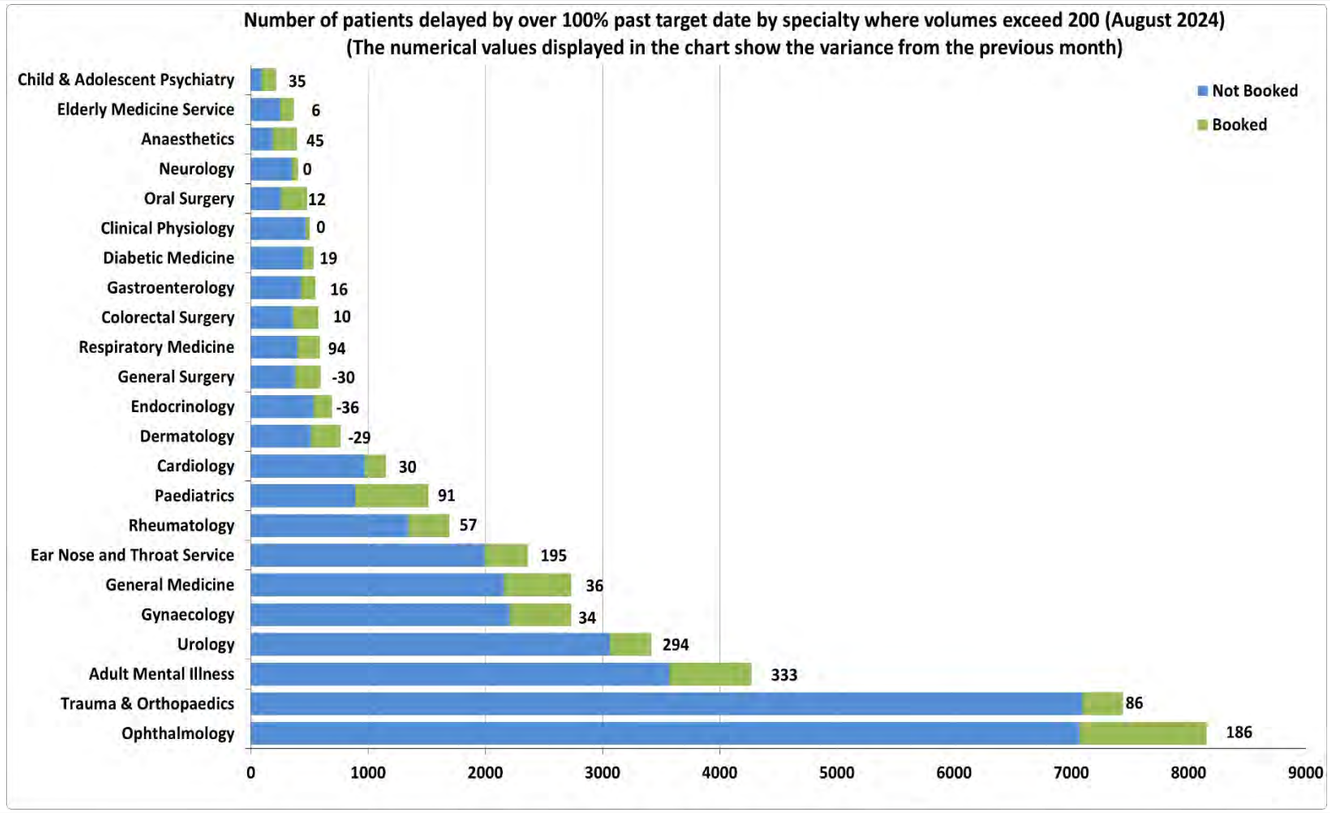
Follow-up Outpatients Not Booked (FUNB) – Provisional Position August 2024

Number of patients waiting for a Follow-up with documented target date

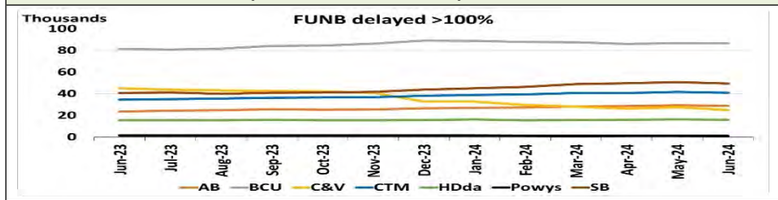
No. of patients waiting for follow-up appointment			
No documented target date	Not Booked	Booked	Total
0	88,006	57,468	145,474

Number of patients waiting for a Follow-up delayed over 100% - Target is Reduction compared to the same month in the previous year

No. of patients delayed over 100% past their target date			
Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
35,982	7,392	43,374	29.8%



How do we compare with our peers?



Status as at June 2024		
Health Board	Compliance	Rank
Powys	1,152	1st
HDda	16,062	2nd
C&V	24,915	3rd
AB	28,825	4th
CTM	**40,975**	**5th**
SB	49,585	6th
BCU	86,465	7th

How are we doing?

The number of patients waiting for a follow-up appointment in CTM at the end of August 2024 provisionally stands at 145,474, which is a growth of 7% on the number of patients waiting during the equivalent period of 2023. There are currently no patients without a documented target date. Of the patients waiting, 43,374 (29.8%) have waited more than 100% longer than their clinician advised.

From April to July this year, the average monthly follow up activity was 1,479 attendances higher (4.1%) at 37,597 in 2024/25 when compared with 2023/24 levels, but remains 1,909 (4.8%) lower than pre-covid activity volumes.

What actions are we taking & when is improvement anticipated?

General Surgery: Clinical Validation - secretaries providing consultants with lists monthly for review.

- SOS/PIFU processes are being shared again in each area.
- Breast Clinician reviewing FUNB patients in Monday AM session.

Colorectal: Clinical and administrative validation ongoing.

Ophthalmology: Work is ongoing with PIFU/SOS to help reduce the number of patients being added to the FUNB. Both clerical and clinical validation is key to reducing these high numbers.

Dermatology: Clinical conditions and directive to be introduced at RGH/PCH to align practices across the Speciality.

- Reintroduced Dept. Meeting at RGH/PCH with standard agenda item RTT/FUNB.
- Discussions have taken place with secretaries to introduce clinical conditions, recording of office-based decisions (non F2F apt WPAS) and training to be provided if required.
- RGH/PCH – Office space review to bring admin team together – ongoing.
- Redesign of outcome form

Orthopaedics: Exploring plan to move FUNB to PIFU/SOS - this work is ongoing

Pain: Meeting set up to explore pain service, the service needs redesign and job planning.

- Should see efficiency improvements over next couple months.

Urology: It has been agreed that consultants will undertake validation of FUNB lists in the event of any activity being taken down.

- A Teams channel with current lists has been set up to support ease of FUNB accessibility for consultants.
- The FUNB outcome form is also located on the channel for ease of process for the clinical team.

Gynaecology: Validation processes are underway across the Care Group for all patients exceeding their planned follow up timeframe.

- Obstetric administration staff supporting validation during POW Labour Ward closure.
- Validation project expected to complete end of November 2024 with validation of all patients >100% delay.

What are the main areas of risk?

General Surgery: Limited clinic capacity for F/UP - clinical validation ongoing

- Focus has been on RTT and SCP patients.

Ophthalmology: The risk is not enough clerical or clinical time to validate the high numbers on the FUNB.

Dermatology: Risk is greater at RGH/PCH as currently clinical priority is not identified and consultants/secretaries are not actively managing FUNB at the moment.

- Skin cancer patients not receiving regular ongoing surveillance.
- Blood monitoring/review missed for patients on systemic treatment.

Orthopaedics: Patient contact may result in asking for follow up in which case the FUNB numbers will remain high.

Pain: No operational support in place.

Urology: The FUNB lists will continue to increase if the actions opposite are not complied with.

- Subsequently monitoring of the lists on a weekly basis will take place to ensure steady reduction.

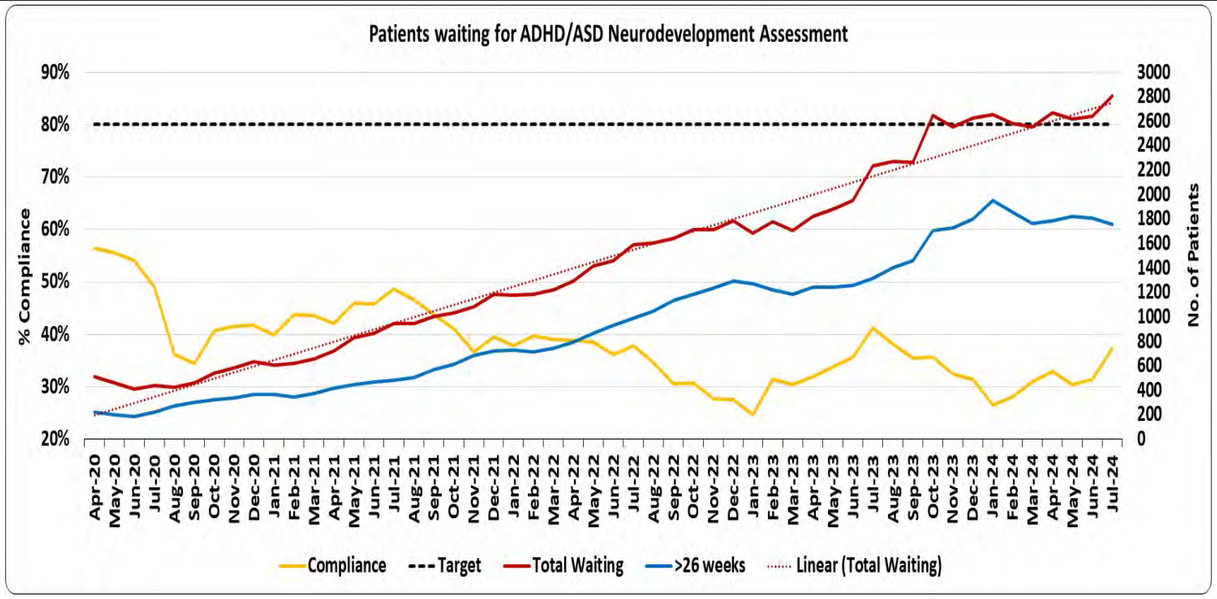
Gynaecology: Resource to undertake clinical validation.

Outpatient clinic capacity for booking all patients who require appointments. Competing demand of RTT/New outpatient activity.

CTMUHB Children & Families Care Group

% of patients waiting less than 26 weeks to start an ADHD/ASD Neurodevelopment Assessment (Target 80%)

July 2024 - 37.4%



How are we doing?

We have observed that the waiting list for assessment has grown incrementally year on year, from 510 patients at April 2020 to currently stand at 2,807 patients; with the greatest growth occurring during 2023/24. During the period analysed in the chart above, average monthly accepted referrals have increased from 38 to 248 per month, even with robust triage decisions at the point of referral being made.

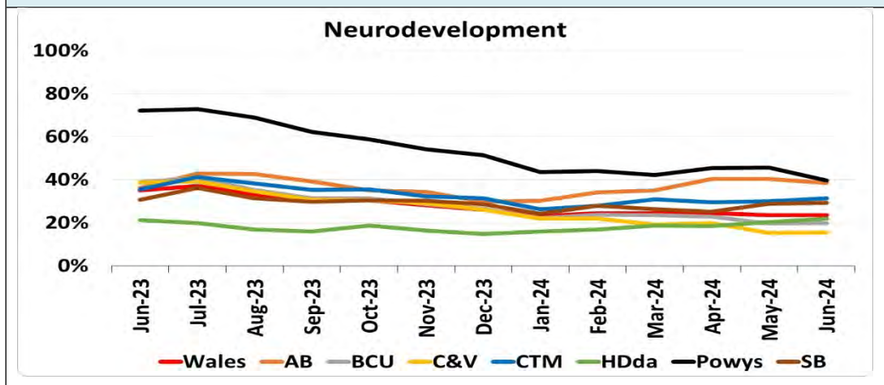
The yellow line on the chart above shows that correspondingly compliance with the 26 week access target for Neurodevelopmental remains low at 37.4%.

During the past 12 months the chart shows that compliance has been fluctuating between 26.5% and 38.3% with access remaining well below the WG target of 80% and will continue to be so until the backlog is addressed.

What actions are we taking & when is improvement anticipated?

- The Improvement Board is overseeing the impact of the Regional Partnership Board's allocation to Neurodevelopment (ND) services. Ongoing work in progress with local authorities, along with AHP posts to support pre/post diagnosis, with third sector agencies as additional funding has been made available until March 2025. The plans are for this to be spent on increasing the capacity within the workforce, namely locum SALT/CAMHS and additional/overtime hours for existing staff. As a service we are committed to starting an additional 500 new ND assessments over 2024/25 and at the end of Q1 over 200 assessments have already started, so this target seems achievable.
- Pharmacy input into ND is supporting post-diagnosis follow-up titration & monitoring, releasing medical colleagues to support the waiting list further.
- The service has undertaken a demand and capacity analysis. Re-alignment of the budgets and recruitment of AHP/Nursing colleagues means that now post holders have commenced, the available capacity will meet the current demand (if demand remains stable). However, this does not address the backlog of patients. 3.5 wte CNS/AHP staff have commenced and are actively supporting with the new patient and follow-up waiting lists. If we were able to recruit 2 x B7 AHP fixed term for two years, this would address the current backlog and result in no patient waiting over 52 weeks for an initial ND assessment by the end of March 2026. Currently there is no funding within the care group to support this, but remains on the agenda.
- Developing website in conjunction with local authorities and third sector will increase our self-management and "waiting well" offer, so that families feel supported whilst on the waiting list and informed of what the services provide before families start the assessment journey. Incorporating some of the "myth-busters" that families and referrers often report into the plans for our new co-produced referral paperwork will ensure that families and professionals know what to expect from the outset.
- Ongoing validation of waiting list, with transition and signposting to relevant services/agencies.
- We are forecasting that the waiting list over the coming months will decrease as additional staff commence in post and capacity meeting the demand. It is anticipated that the longest waiter at the end of March 2025 will be around 78 weeks (longest waiter at end of March 2023 and 2024 was >104 weeks), although achieving this target does involve seeing 1,800 new patients in total over 2024/25; with still a relatively small clinical team.

How do we compare with our peers?

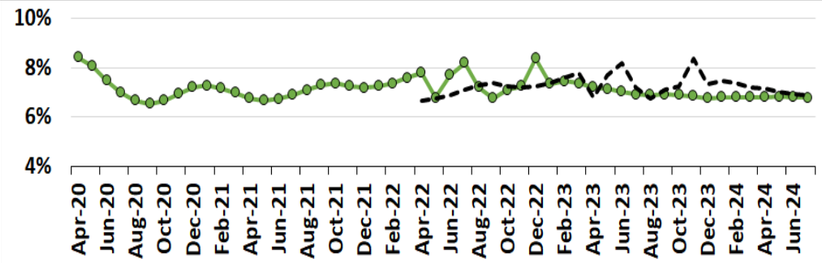
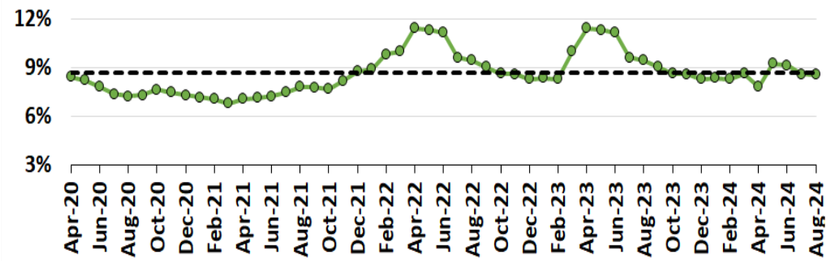
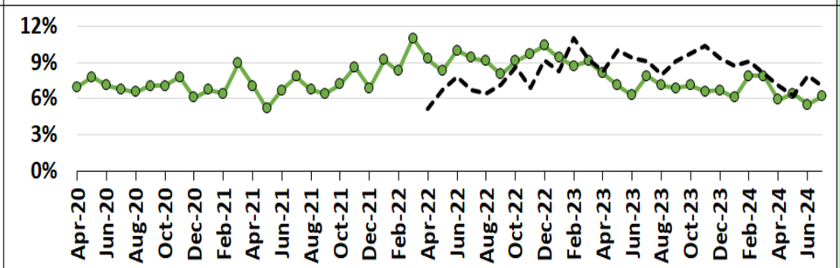
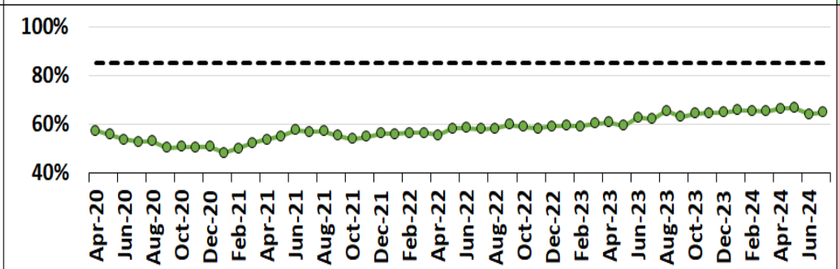


Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	39.6%	1st
AB	38.5%	2nd
CTM	**31.5%**	**3rd**
SB	29.4%	4th
HDda	21.9%	5th
BCU	19.9%	6th
C&V	15.5%	7th

What are the main areas of risk?

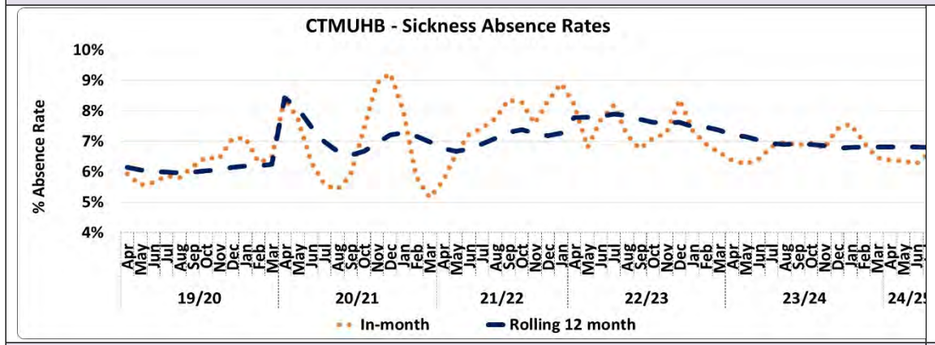
- A demand and capacity review was undertaken earlier in the year and templates have been implemented and fixed on WPAS to ensure forecast remains accurate. Vacancies within the ND team, namely ADHD nurses, have created additional waits for children/young people for ADHD assessments.
- The service has identified what is required to bridge the gap of the deficit in capacity to meet the demand. Without investment of 2 x B7 AHP for 2 years, the backlog of patients will remain an issue although current demand will be met. Reliance on short term funding does not provide a longer term solution, hence services are being reviewed with partners.

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable

	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved — Latest Position	Target Failed — Latest Position
Motivated & Sustainable Workforce	% of sickness absence rate of staff	12 Month Reduction Trend		6.8%	Jul-24
	Turnover rate for nurse & midwifery registered staff leaving NHS Wales	Rolling 12 month reduction against a baseline of 2019-20 (8.65%)		8.54%	Aug-24
	Agency spend as a percentage of the total pay bill	12 Month Reduction Trend		6.2%	Jul-24
Training & Development	Percentage 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%		64.8%	Aug-24

CTMUHB Workforce Metrics

% of sickness absence rate of staff – Target is 12 month reduction trend – July 2024 (6.8%)



The rolling twelve-month sickness rate to July 2024 is 6.8% and is slightly lower than the equivalent rolling period of the previous year (6.9%).

The in-month sickness rate is 6.6% and this too is slightly lower to the equivalent period of 2023 (6.83%).

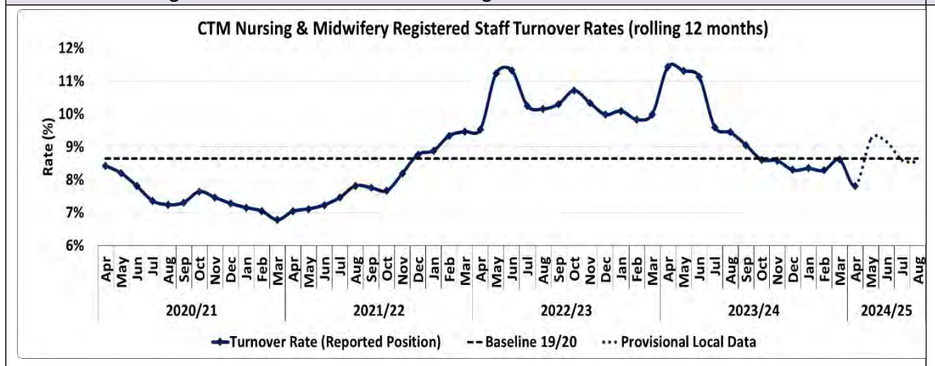
What actions are we taking & when is improvement anticipated? What are the risks?

The People Services Team continue to provide bespoke support to management groups where absence levels are particularly high or where there have been difficulties in progressing cases where individual absence levels have prompted action under the Managing Attendance Policy.

Training is available to increase understanding of line management responsibilities in the practical application of attendance management principles to support the health and wellbeing of employees in the workplace, support employees to return to work following a period of sickness absence and to support employees to sustain their attendance at work.

The People Services Team are also running a trial on access to advice routes at the end of September 2024 to ensure that colleagues receive timely and appropriate support in the management of people policies including Attendance Management.

Turnover rate for N&M registered staff leaving NHS Wales – Target is rolling 12 month reduction against a baseline of 2019/20



The provisional (locally sourced data) rolling 12 month turnover rate for registered N&M Staff at August 2024 has fallen to 8.54% with the reported position at April pleasingly reducing to 7.8%. The equivalent previous rolling 12 month period (May 2022 to April 2023) rates were 11.4%. (N.B. rates will be subject to change when HEIW data is received due to the inability to locally

What actions are we taking & when is improvement anticipated? What are the risks?

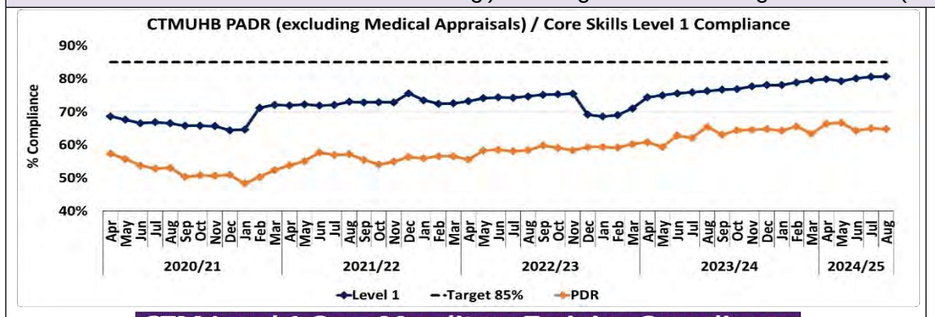
Our Retention Lead continues to work with key stakeholders to implement the actions within both the HEIW All Wales Nursing and Midwifery Retention plan and the CTM Retention Action Plan. Flexible working, promotion and work-life balance remain the principle reasons for staff leaving CTM and the Retention Lead is currently supporting ongoing retention priorities in relation to these areas. These are discussed at the CTM Retention Group, which aligns the work to other work streams around improved attraction, bolstered recruitment pipelines, our culture/ WRES/ED&I, wellbeing/employee experience offer.

The CTM Retention Group gives oversight, direction and engagement on the nurse retention and across other staff groups. The meetings are held on a bi-monthly basis with a wide stakeholder group. The next meeting being held end of September to focus on widening the Lateral Moves scheme, monitoring the HEIW and local actions through to completion, sharing best practice and next steps.

The Lateral Moves Scheme has been in place since February 2024, for Registered Nurses and Midwives only. There is now a focus on rolling out the Scheme to wider staff groups for fairness, equity and flexibility. It is anticipated that the Scheme will be extended to HCSWs in the first instance. An action plan and communication plan are being developed, in partnership. This is a much bigger group and a robust plan will be needed to support the Scheme and to agree an appropriate launch date. A timetable for rolling out to other staff groups is also being developed to widen the Scheme based on learning and feedback.

While it is positive that turnover is reducing it is difficult to say, at this stage, what is contributing to the lower rates or that the interventions are having an impact, but we continue to monitor in the CTM Retention Group.

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) – Target 85% - August 2024 (64.8% - Provisional)



CTM Level 1 Core Manditory Training Compliance August 2024	
Safeguarding Children	85.1%
Health, Safety and Welfare	84.7%
Safeguarding Adults	84.1%
Equality, Diversity & Human Rights	84.1%
Moving & Handling	83.1%
Information Governance	82.9%
Violence & Aggression	80.2%
Fire Training	79.4%
Infection Prevention and Control	76.7%
Resuscitation	66.9%
HB Overall Compliance	80.7%

PDR compliance is improving slowly, currently around 65%. Compliance for the past year has ranged between 63.1% and 66.7%, recognising that this remains below the WG target of 85%.

Currently, combined core mandatory training compliance is 72.5% with Level 1 disciplines at 80.7% and is improving in small increments, but continuing to remain below the required standard of 85%.

What actions are we taking & when is improvement anticipated? What are the risks?

PADR – *Your Conversation*:

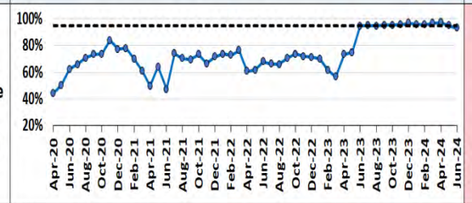
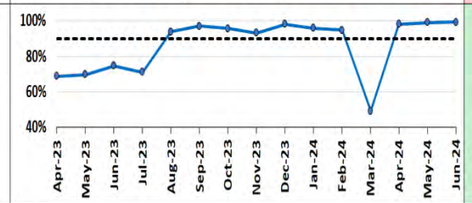
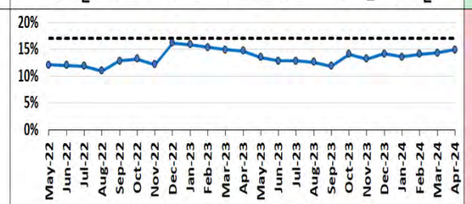
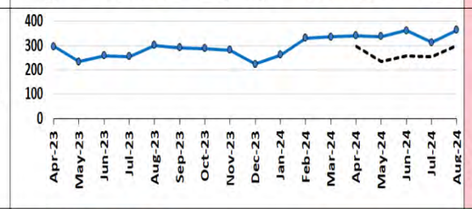
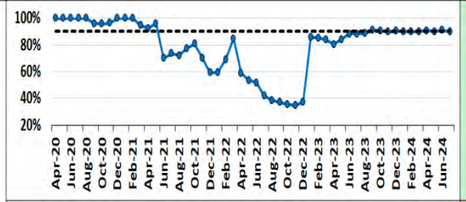
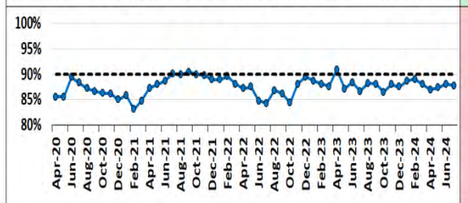
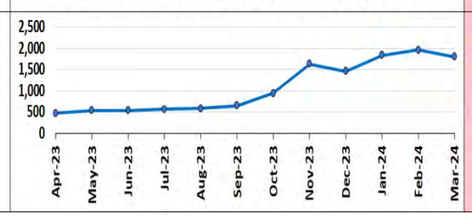
- "Making the most of PDR – *Your Conversation*" workshop developed and delivered with management teams. This is part of a full day educational offer, embedded into the emerging Leadership Development offer.
- Evaluation forms - feedback shaping improvements and modifications to the forms and associated process.
- Internal audit - PDR process being scoped with Shared Services - undertaking the audit autumn/winter 2024.
- CTM-specific PADR and Pay Progression FAQs developed and shared with affected staff on a monthly basis (i.e. managers with staff who are due to go through a gateway).
- Targeted communications being sent to managers with PADR compliance below 85%.
- Ongoing assessment to establish how best to capture Medical & Dental appraisals as part of overall figures, in collaboration with the ongoing data dashboard work.

Core Learning:

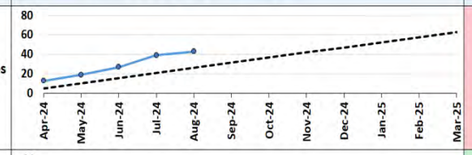
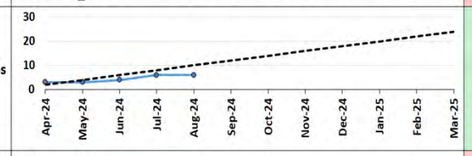
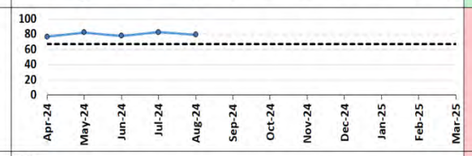
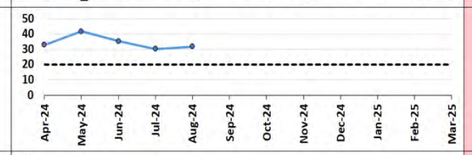
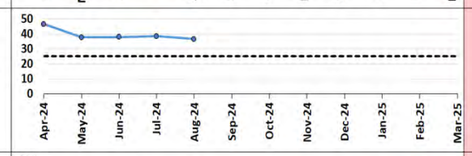
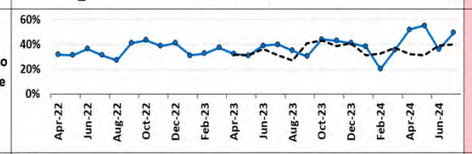
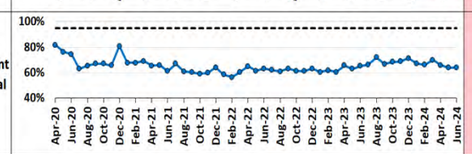
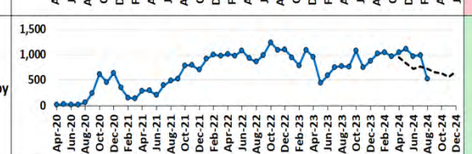
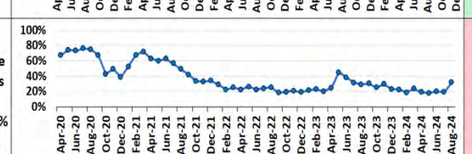
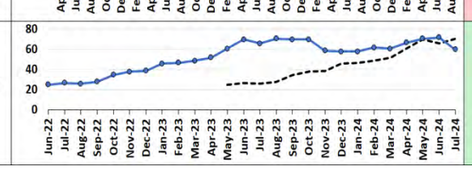
- Core Learning Working Group established to supplement the Core Learning Steering Group with a more focused space to work with Subject Matter Experts to continually drive up compliance.
- CTM Core Learning Review Report in final draft stage, capturing organisational Core Learning provision and performance, with a view to influence an All Wales review.
- All subjects now responsible for the administration of training co-ordination, freeing up Learning and Development resource to undertake organisational activities aimed at creating a culture of compliance.
- Support being given to the Care Group Core Learning Recovery Plans in order to improve compliance across the Health Board.
- Monthly drop-in sessions ongoing, with the Core Learning team attending different sites each month.
- Range of subject guides and educational materials in development to support staff to access their learning.

2.5 Welsh Government Performance Indicators: Quadruple Aim 4 - Improvement & Innovation enabled by data & focused outcomes

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

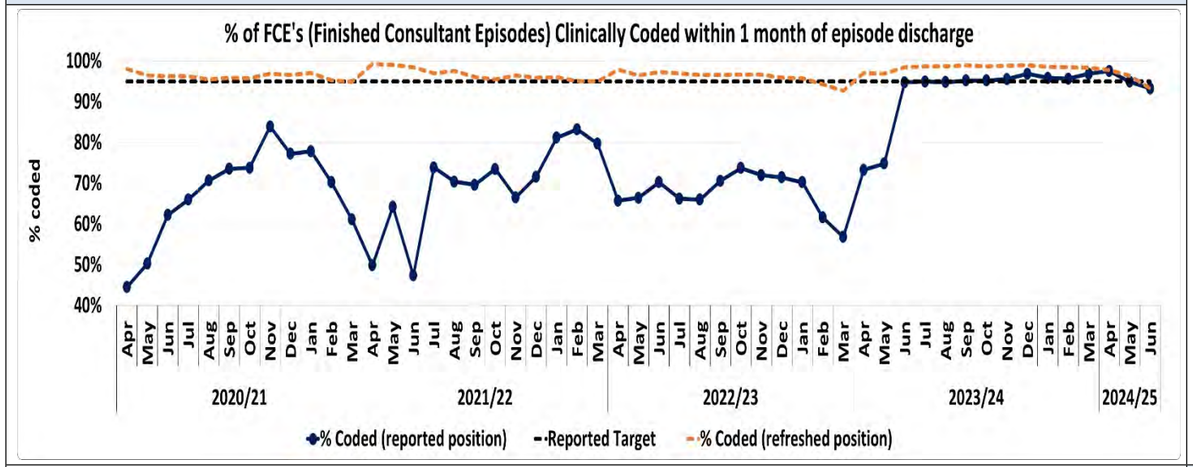
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Effective Services	% of episodes clinically coded within one reporting month post episode discharge end date	Maintain the 95% target or demonstrate a 12 month improvement trend		93.3%	Jun-24
Effective Services	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%		99.2%	Jun-24
Efficient Services	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	17% or more		14.9%	Apr-24
Efficient Services	Number of Pathways of Care delayed discharges	12 month reduction trend		363	Aug-24
People Centred Care	% 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%		90.0%	Jul-24
People Centred Care	% 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			87.8%	
People Centred Care	Number of service user feedback experience responses completed and recorded on CIVICA	Month on month improvement		1,803	Mar-24

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/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Safe Services	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	No more than 60 cases for 2024/25		43	Apr 24-Aug 24
Safe Services	Cumulative number of laboratory confirmed bacteraemia cases: Pseudomonas aeruginosa	No more than 24 cases for 2024/25		6	
Safe Services	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli	67.00 per 100,00 population		79.51	
Safe Services	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus (MRSA and MSSA)	20.00 per 100,00 population		31.70	
Safe Services	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	25.00 per 100,00 population		36.53	
Safe Services	% of confirmed COVID cases within hospital which had a definite hospital onset (>14 days after admission)	Reduction compared to the same month in the previous year		49.6%	Jul-24
Safe Services	% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	12 month improvement trend towards national target of 95%		64.3%	Jun-24
Safe Services	Number of ambulance patient handovers over 1 hour	30% reduction on March 2024 baseline by December 2024		525	Aug-24
Safe Services	Percentage of ambulance patient handovers within 15 minutes	Improvement compared to the same month in the previous year, towards the national target of 100% within 15 minutes		32.0%	
Safe Services	Number of National Reportable incidents that remain open 90 days or more	12 month reduction trend		60	Jul-24

Effective Services - Clinical Coding

% of episodes clinically coded within one reporting month post episode discharge end date. Target - Maintain the 95% target or demonstrate a 12 month improvement trend – June 2024 – 93.3%



Current Coded Position as at 1st September 2024				
2024/25	**Total FCE's**	**Coded FCE's**	**Uncoded FCE's**	**% Clinically Coded**
Apr-24	11,569	11,376	193	98.3%
May-24	11,812	11,480	332	97.2%
Jun-24	10,845	10,199	646	94.0%
Jul-24	11,653	8,566	3,087	73.5%
Aug-24	9,693	1,869	7824	19.3%
Total	**55,572**	**43,490**	**12,082**	**78.3%**

Uncoded 2024/25 (Apr - Aug 2024)	**12,082**	**21.7%**

How are we doing?

The reported position for June 2024 is 93.3% of the FCE's (Finished Consultant Episodes) for that month being coded within the requisite timescale and is just below the set target of 95%.

As of the start of September, the coded position from April to August currently stands at 78.3% with the backlog accrued during April to June largely coded (96.6%).

Compliance for the correction of errors within 35 days reached 99.2% during June with 125 of the 126 errors corrected within the requiste timescale.

The flow of information from the Maternity Triage Unit at Prince Charles Hospital continues to improve month on month, which is evident in the amount of additional maternity episodes that have been clinically coded.

Coding team are working with the urology and dermatology teams to record outpatient events including procedures to data standards in real time using FHIR forms.

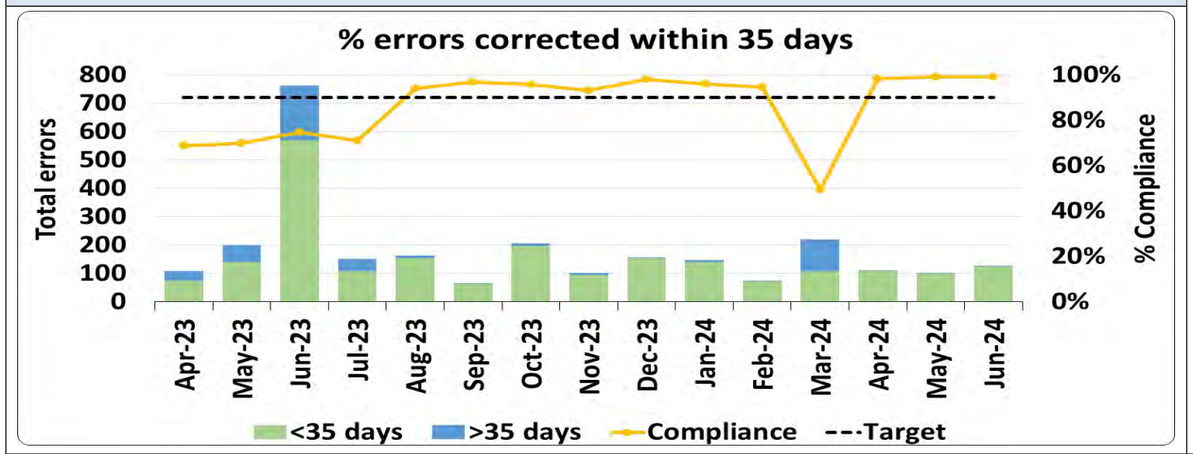
What actions are we taking & when is improvement anticipated? What are the main areas of risk?

The auto-coding system incorporating the validation functionality continues to be improved, however it has not been used for the past 2 months whilst it is being updated to incorporate the new coding standards and the hardware on which it runs is upgraded.

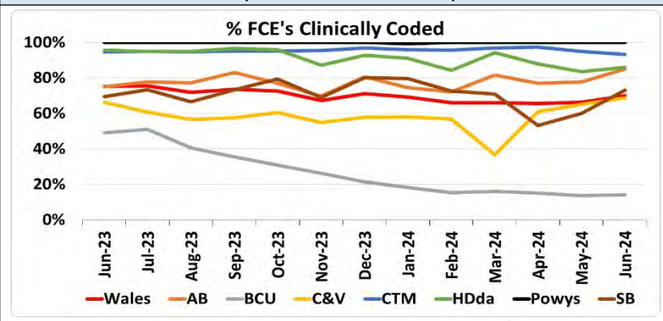
Changes in counting practices, which largely affect the Emergency and Assessment Departments, have led to an increase in admissions and an increasing, but welcome workload for the coding team.

Autocoding and coding at source activities are promulgating, enhancing the richness and availability of our clinical data and our care records, with the pathology improvement board having recently given approval for the autocoder to use pathology data within its algorithms.

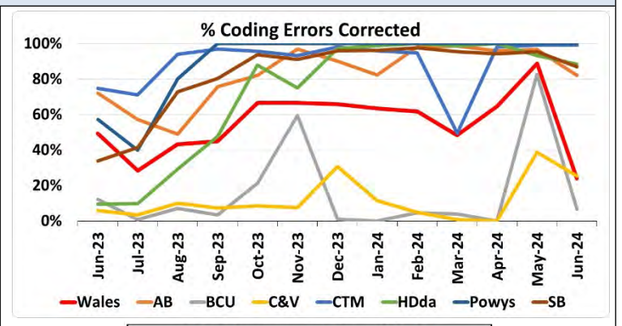
% of all classifications' coding errors corrected by the next monthly reporting submission following identification – Target 90% - June 2024 – 99.2%



How do we compare with our peers?



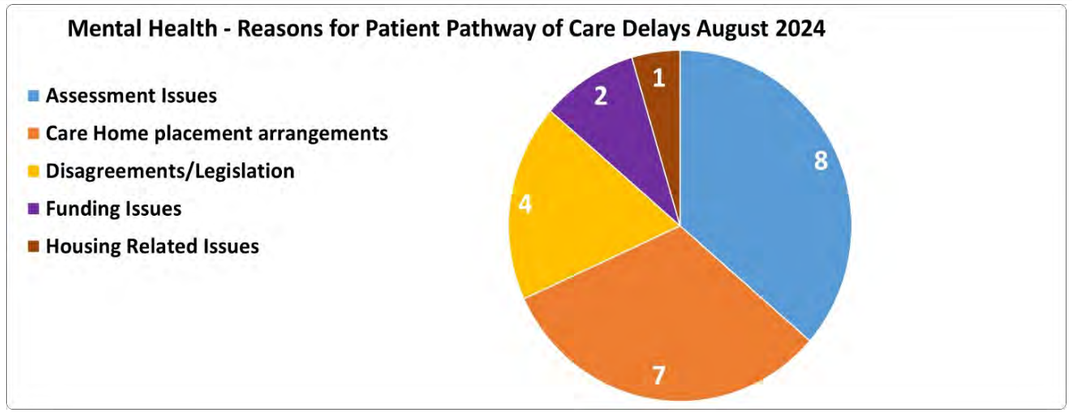
Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
CTM	**93.3%**	**2nd**
HDda	85.9%	3rd
AB	85.0%	4th
SB	73.1%	5th
C&V	68.8%	6th
BCU	14.2%	7th

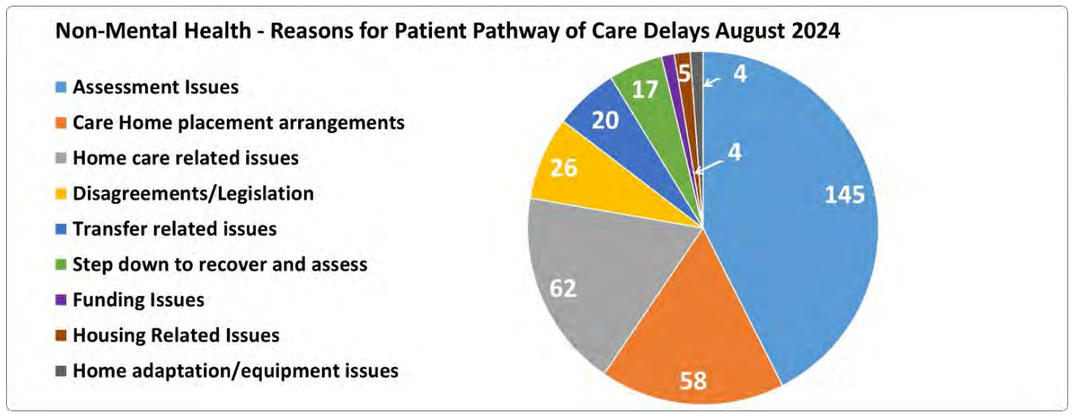


Status as at June 2024		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
CTM	**99.2%**	**2nd**
HDda	88.4%	3rd
SB	87.0%	4th
AB	82.1%	5th
C&V	25.4%	6th
BCU	6.6%	7th

Efficient Services – Pathways of Care Delayed Discharges - August 2024

Number of Pathways of Care delayed discharges
Target is 12 month reduction trend
Mental Health Delays = 22 / Non Mental Health Delays = 341





How are we doing?

On average, 311 Pathways of Care Delayed Discharges have been recorded each month for the past 12 months, with the vast majority (43.8%) related to delayed assessment, as per the table below (left) with 153 assessment delays during August as described in the table below (right) :

Reason for Delay	12 month average	
Assessment Issues	136	43.8%
Care Home placement arrangements	65	20.8%
Home care related issues	43	13.8%
Transfer related issues	19	6.1%
Disagreements/Legislation	19	6.1%
Step down to recover and assess	11	3.5%
Housing Related Issues	8	2.4%
NHS Bed related issues	3	0.8%
Funding Issues	4	1.4%
Home adaptation/equipment issues	4	1.2%
Total	**311**	

Assessment Delay Flag - August 2024	
Awaiting completion of assessment AHP	7
Awaiting completion of assessment by social care	52
Awaiting completion of assessment Nursing	37
Awaiting completion of assessment Pharmacy	2
Awaiting Continuing Healthcare (CHC) Assessment	15
Awaiting joint assessment	35
Awaiting Social worker allocation	5
Total Assessment Issues	**153**

Pathway of Care Delays increased during August and data analysis shows that there were recording issues in July and this has been managed through a revised process in August.

There was an increase in delays for care at home in RCT, with analysis showing that this may be attributed to the impending introduction of a new domiciliary care commissioning framework. This is set to be implemented mid September with the expectation that delays will decrease as a result.

What actions are we taking & when is improvement anticipated?

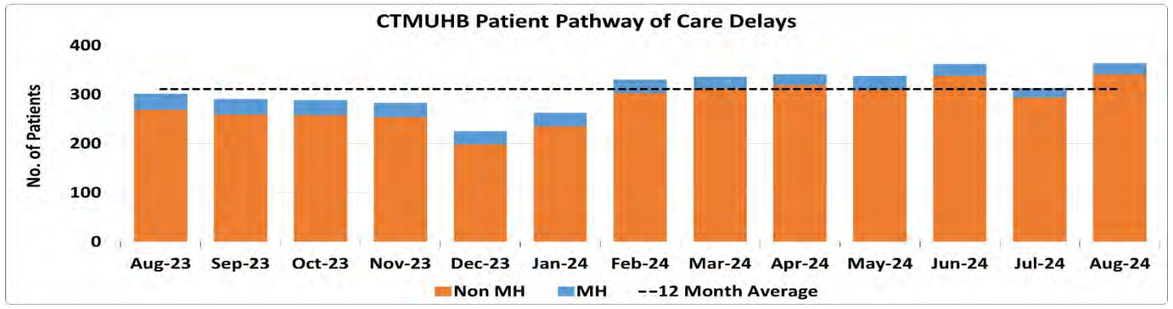
- Task & finish group set up to create integrated discharge team; aligned to discharge & clinical navigation hub.
- Commissioning review of Stay Well at Home (SW@H) to maximise discharge at the front door.
- Proposal to develop an Enhanced Community Care level 4 service to rapidly discharge P1 patients who are subject to delay.
- Change in governance of PoCD with responsibility transferred to lead for D2RA (Discharge To Recover & Assess).
- Action plan developed through Integrated Discharge Delivery Board.
- Revised PoCD improvement plan submitted to WG on behalf of the integrated board.
- Appointment of improvement nurse for Optimise Programme.
- Revision and re-writing of EWB (Electronic White Board).

Delays by Local Authority - August 2024

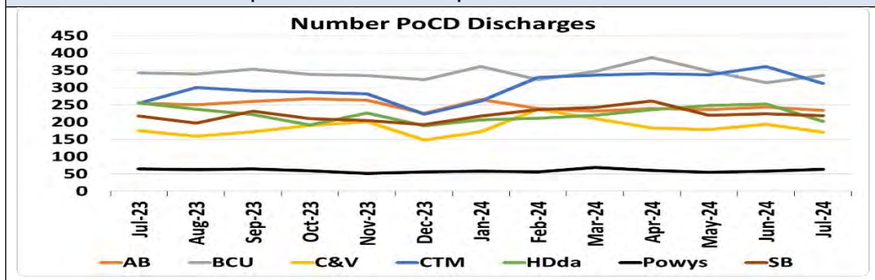
Healthcare Facility	Blaenau Gwent	Bridgend	Caerphilly	Cardiff	Merthyr Tydfil	Neath Port Talbot	Powys	Rhondda Cynon Taff	Swansea	Vale of Glamorgan	Total
PCH	3		2		11		1	12			29
POW		80				4		3		4	91
RGH		1	1					97			99
YCC			1		19			50	1		71
YCR											0
Glanrhyd		8		1				64			73
Grand Total	3	89	4	1	30	4	1	226		4	363

What are the main areas of risk?

Process: Escalation process of discharge delays, Discharge Hub, EWB, proportionate assessment.
Resources: Workforce gaps & resilience, new roles, training.
Capacity: Residential & Nursing home capacity/EMI, commissioning for intermediate and long term domiciliary care. Intermediate care beds.
Compliance: Discharge Policy (including reluctant discharge & choice), Time standards, EWB Data and PoCD Delay Codes.
Culture: Actions to address risk aversion, blame, silo working, approach to frailty.
Operating Model: No integrated or clear model, silo working, duplication and confusion, lack of ownership.



How do we compare with our peers?

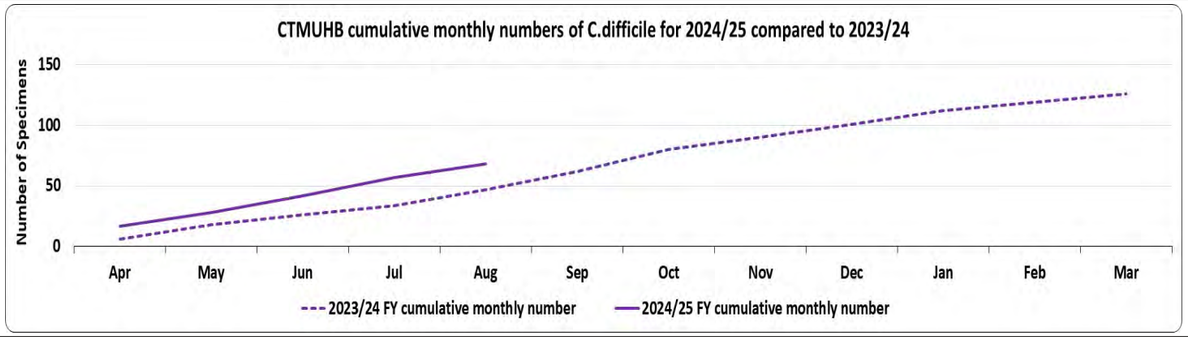


Status as at July 2024		
Health Board	**Compliance**	**Rank**
Powys	64	1st
C&V	171	2nd
HDda	203	3rd
SB	219	4th
AB	235	5th
CTM	**313**	**6th**
BCU	335	7th

CTMUHB Safe Services – Healthcare Acquired Infections

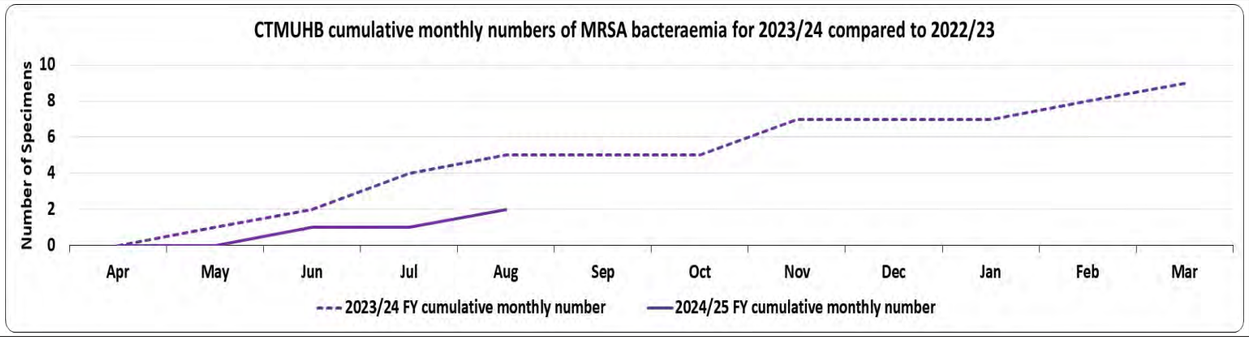
C.difficile

68 C.difficile cases have been reported by CTM for Apr-Aug 2024. This is 21 more cases than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 36.53, which compares to the All Wales rate of 50.66. In CTM, 38% of cases are hospital onset associated infections (based on specimen taken >2 days into an inpatient stay) with the remaining specimens being community onset (specimen taken in a community location or <3 days as hospital inpatient). The IPC team are working with the care groups to improve the RCA process in order to maximise opportunities for learning and sharing best practice.



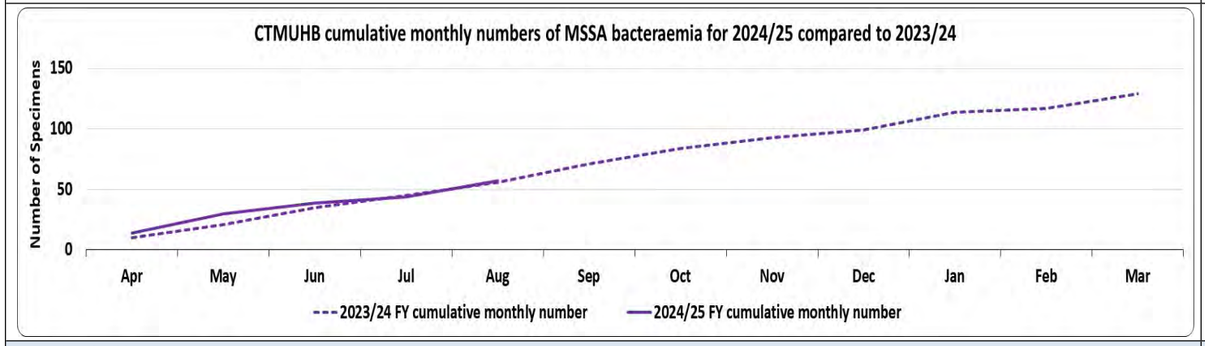
MRSA

Two community onset MRSA bacteraemia have been reported by CTM for Apr-Aug 2024. This is 3 less cases than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 1.07, which compares to the All Wales rate of 1.98.



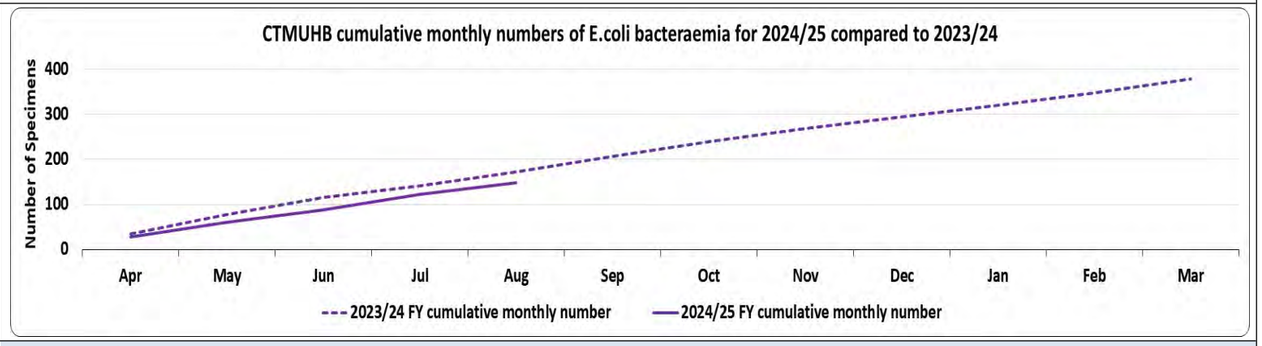
MSSA

57 MSSA bacteraemia have been reported by CTM for Apr-Aug 2024. This is 1 case more than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 30.62, which compares to the All Wales rate of 29.79. 74.0% of the specimens taken are community onset with around 10% of the total cases being associated with an IV device. Support is required to restart the IV Steering Group to provide direction for IV device management across CTM.



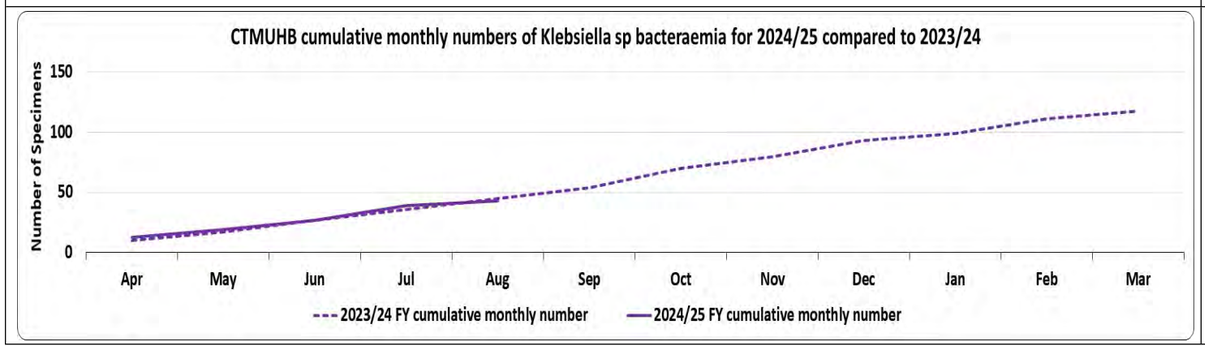
E.coli

148 E.coli bacteraemia have been reported by CTM for Apr-Aug 2024. This is 25 fewer cases than the equivalent period of 2023/24. The provisional rate per 100,000 population for 2024/25 is 79.51, which compares to the all Wales rate of 69.63. Community onset cases account for 79% of the specimens taken. A number of cases are linked to a urinary catheter. Urinary catheter management needs to be improved across the Health Board.



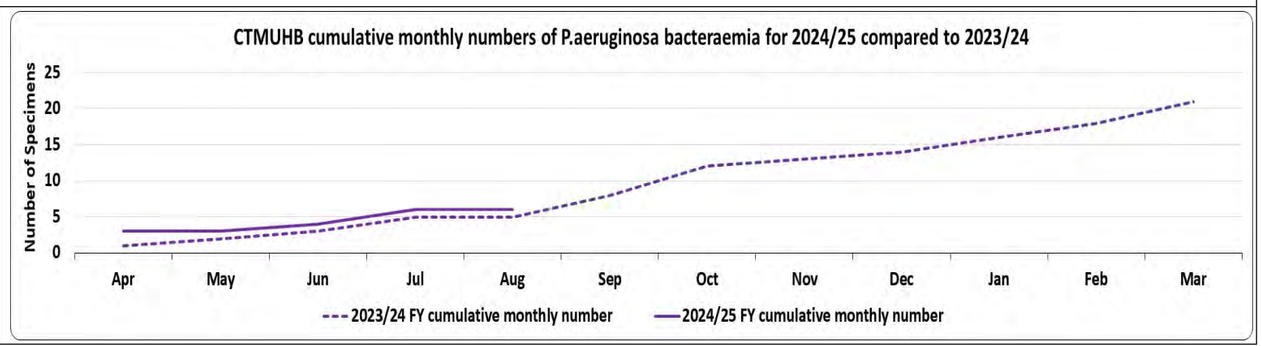
Klebsiella sp

43 Klebsiella sp bacteraemia have been reported by CTM for Apr-Aug 2024. This is 2 less cases than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 23.1, which compares to the All Wales rate of 22.7. Of the specimens taken, 79% are community acquired infections. Around 11% of the total cases are associated with a urinary catheter. IPC huddles are held to discuss both community onset and healthcare onset urinary catheter related bacteraemia.



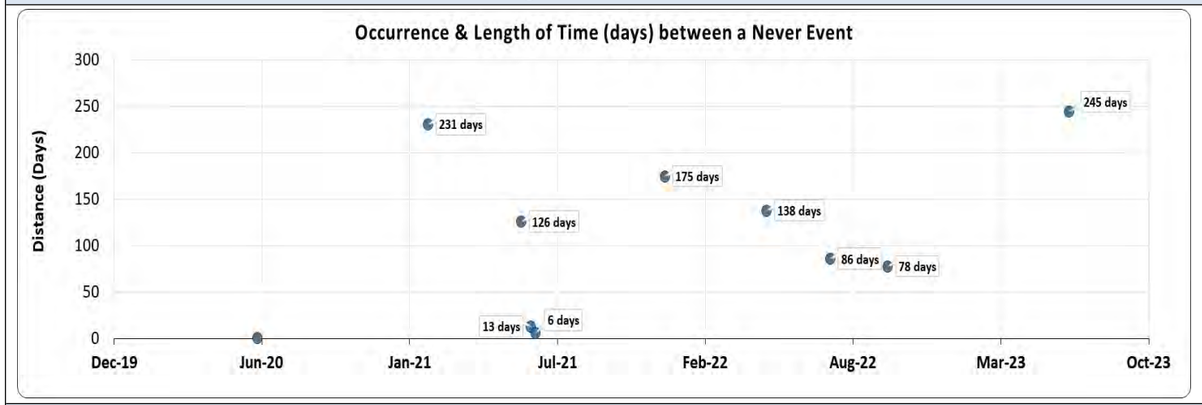
P.aeruginosa

6 P.aeruginosa bacteraemia have been reported by CTM for Apr-Aug 2024. This is 1 more case than in the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 3.22, which compares to the All Wales rate of 4.80. 33% of infections are community acquired infections.



Safe Services – Never Events & Nationally Reportable Incidents

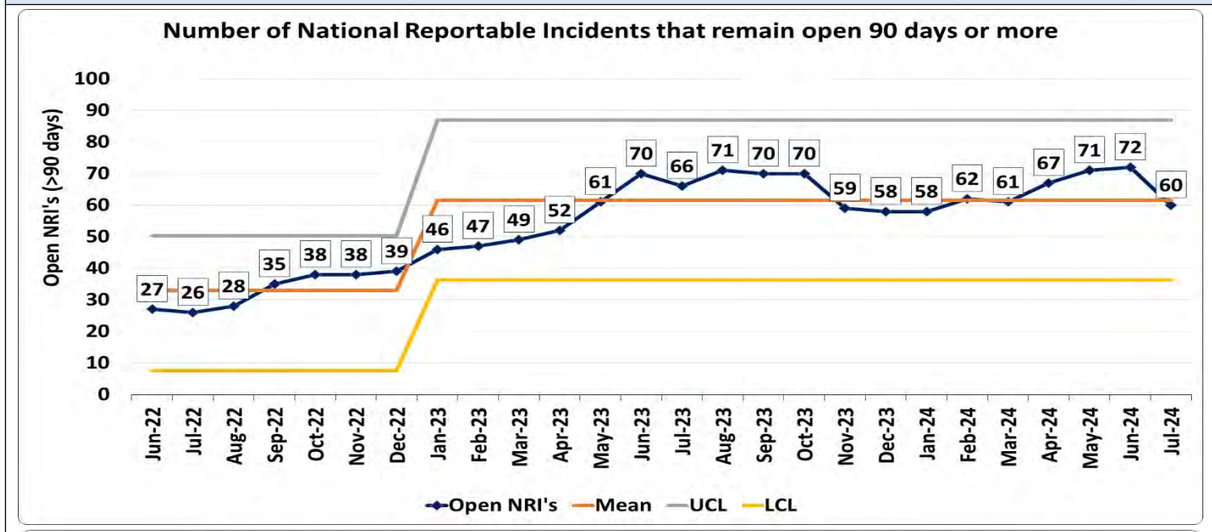
Number of Never Events – August 2024 - Zero

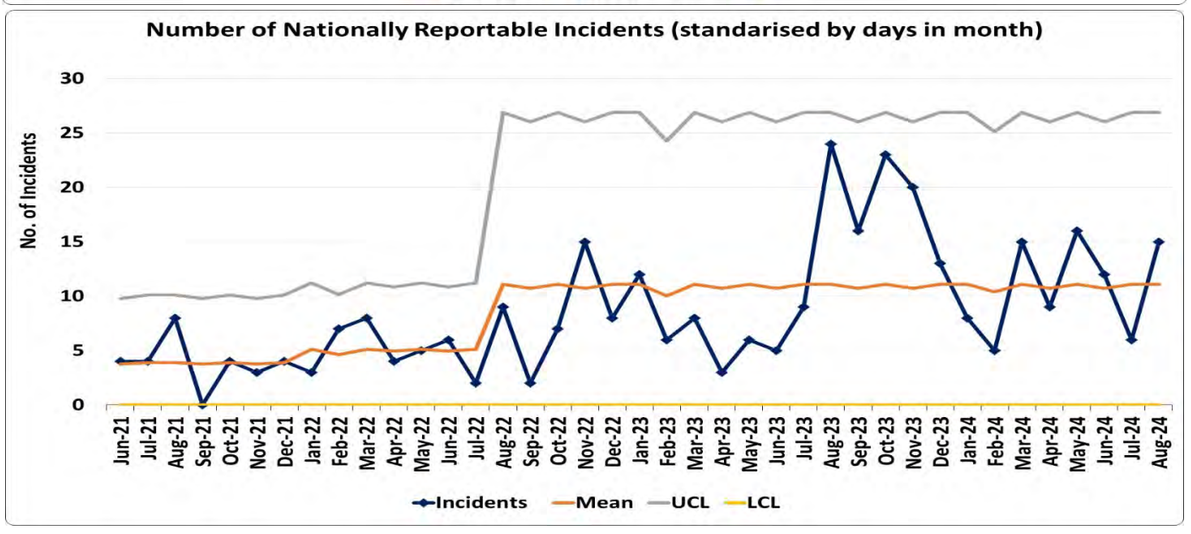


Never events are patient safety incidents that are defined as being wholly preventable. They are considered wholly preventable because guidance or safety recommendations are in place at a national level and should have been implemented by all providers in the healthcare system. This should act as a strong systemic barrier to prevent the serious incident from happening. Learning from what goes wrong in healthcare is crucial to preventing future harm.

There were no Never Events reported during August 2024, with the last occurrence being June 2023 (443 days ago), relating to a wrong side surgery and investigations are continuing.

Number of National Reportable incidents that remain open 90 days or more – Target is 12 month reduction trend – July 2024 - 60





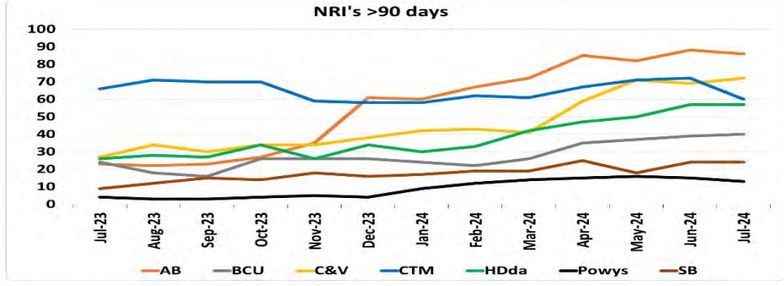
N.B. in order to allow for accurate reporting there is a time lag of approx. one month for the 90 days measure.

During August, 15 NRI notifications were submitted to the NHS Executive (NRI's are detailed in the table below), with a total of 181 incidents submitted during the last 12 months.

Provisionally, as at the 3rd September 2024, the Health Board had 69 open Nationally Reportable Incidents, of which 37 are overdue the timescale for completion. Focused work continues to take place to achieve the trajectory plan in place, ensuring ensure investigations are concluded and an outcome provided to patients and their families.

Type of Nationally Reportable Incidents	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Total
Admission / Transfer / Discharge		1	1	1	3		2	1	1			3	13
Behaviour (including violence and aggression)								1					1
Clinical Assessment, clinical diagnosis	3		5	3			2		1	2		2	18
Infection Prevention & Control	10	13	5	1				1		2	1	1	34
Infrastructure (Staffing/Facilities/Environment)	10	13	1										24
Maternity/Neonatal adverse occurrence				1	1	1	2	4	2	3		2	16
Medication		1										1	2
Monitoring/Observations												1	1
Patient/Service user death					1		2		1	2	1		7
Pressure Damage	2	7	8	5	3	3	5	1	4	3	4	3	48
Safeguarding							1						1
Slip, Trip or Fall						1							1
Treatment, Procedure	1	1		2			1	1	7			2	15
Grand Total	26	36	20	13	8	5	15	9	16	12	6	15	181

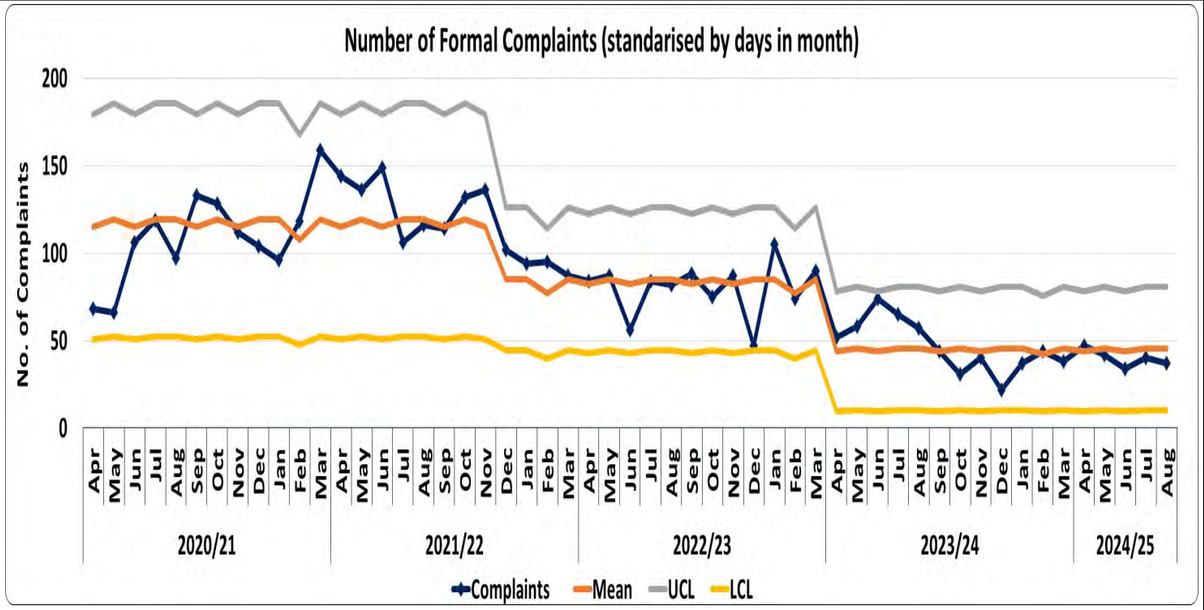
How do we compare with our peers?



Status as at July 2024		
Health Board	**Compliance**	**Rank**
Powys	13	1st
SB	24	2nd
BCU	40	3rd
HDda	57	4th
CTM	**60**	**5th**
C&V	72	6th
AB	86	7th

CTMUHB Focus on Putting Things Right

Number of formal complaints managed through Putting Things Right – August 2024 - 37 Formal Complaints

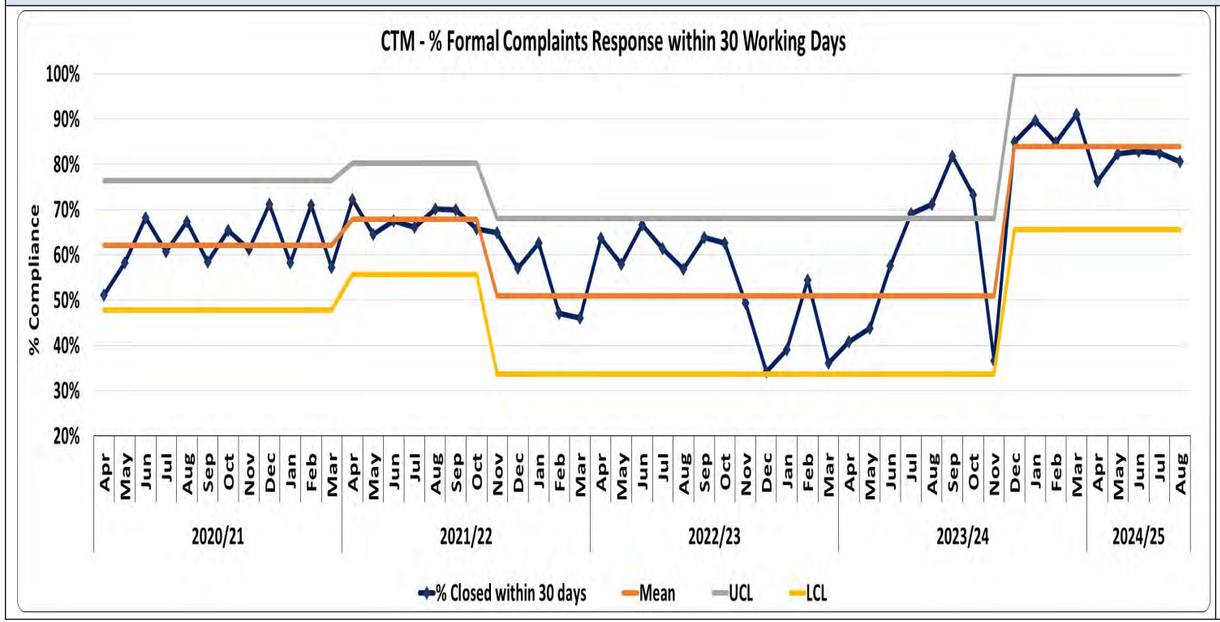


During August, 37 formal complaints were received within the organisation and managed in line with the 'Putting Things Right' regulations with volumes below the current mean of 45.

For those complaints received during August, the majority related to clinical treatment/assessment (30), with the top ten themes displayed in the table below.

Top Ten - Main Themes from Complaints during the last 12 month period	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Total
Clincial treatment/Assessment	33	23	33	16	31	34	28	38	39	33	28	30	366
Discharge Issues	0	0	0	0	0	3	6	3	0	1	1	1	15
Other	5	2	0	2	2	1	1	1	0	0	0	0	14
Medication	1	1	2	1	2	2	0	1	0	0	1	2	13
Attitude and Behaviour	1	0	2	1	0	0	1	1	1	0	2	1	10
Appointments	1	1	0	1	1	1	0	0	1	0	1	0	7
Accident/Falls	1	0	0	0	0	0	1	0	0	0	3	1	6
Patient Care	2	0	1	0	1	0	0	0	0	0	1	0	5
Referral	0	2	1	0	0	0	0	0	0	0	0	1	4
Assault	0	1	0	1	0	0	0	1	0	0	1	0	4

% formal complaints response within 30 working days – August 2024 – 80.6%



Compliance during August dipped to 80.6% and falls just below the current mean of 83.9%.

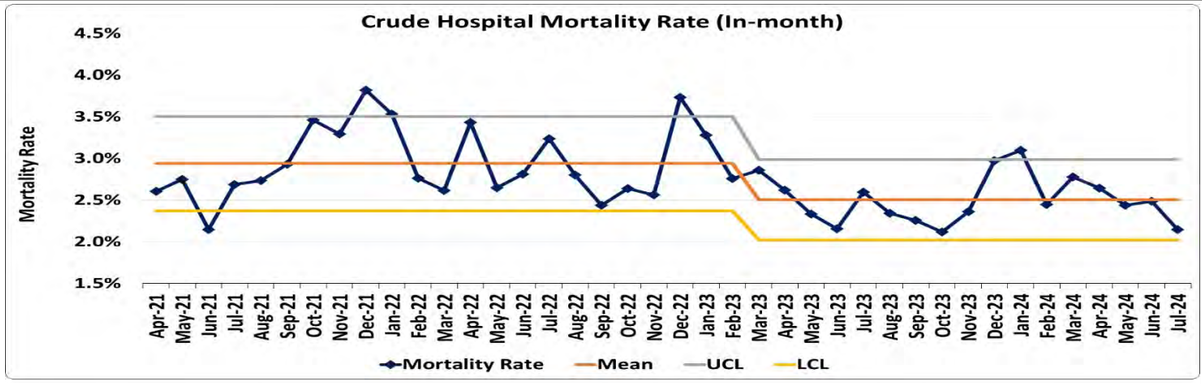
Whilst compliance has remained over the national target of 75% during the two month period, compliance has remained below the Health Board's internal target of 85%.

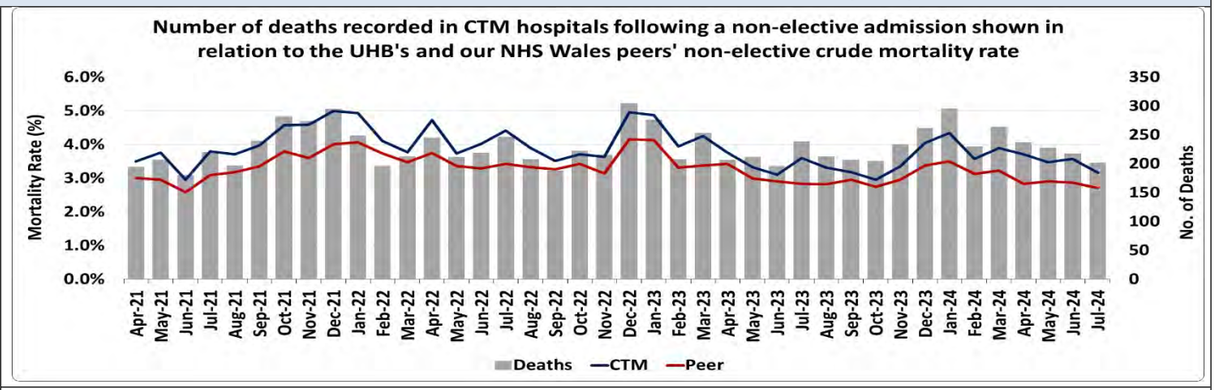
Compliance continues to be impacted by the availability of clinicians to provide comments and quality assure responses.

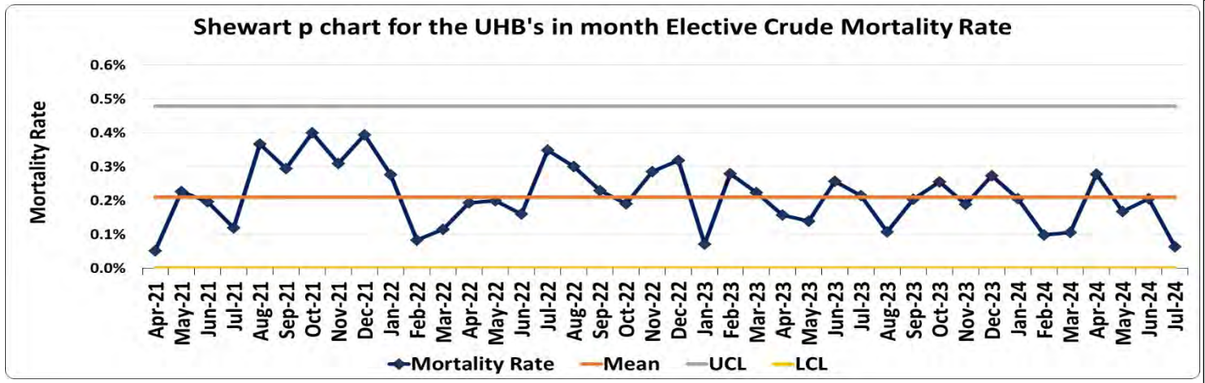
Daily complaints huddles are fully embedded to ensure open cases are reviewed and robust escalation is undertaken. As at 3rd September, the Health Board had 66 open formal complaints, of these, 21 complaints were open over 30 working days.

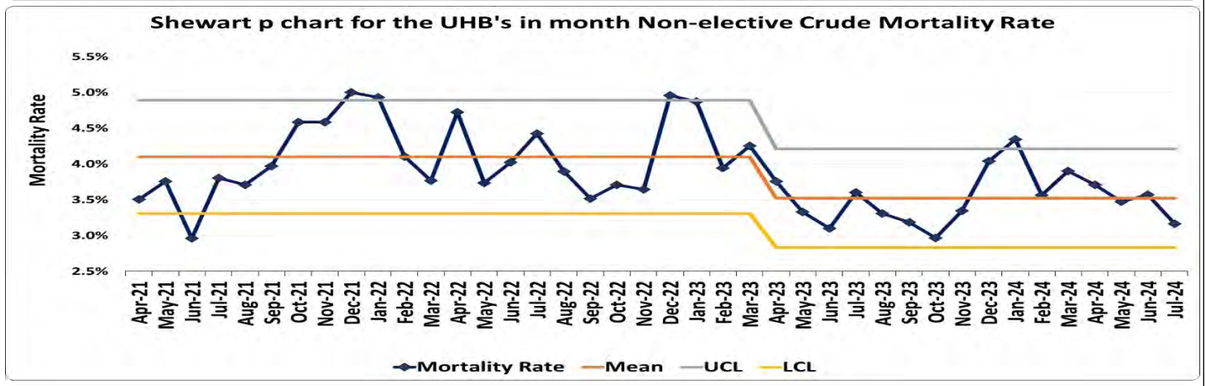
CTMUHB Focus on Mortality Rates

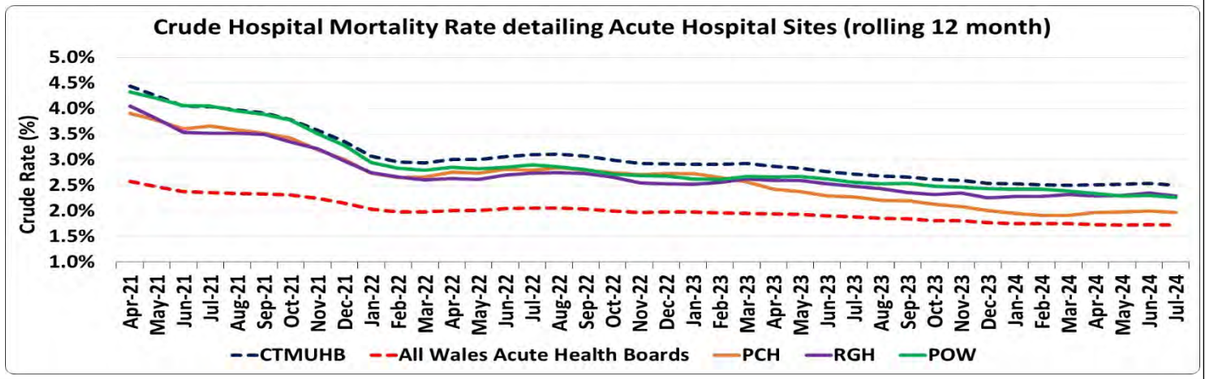
Crude Hospital Mortality Rates - *Please note the mortality data in this report is sourced from CHKS and is derived from the Admitted Patient Care (APC) dataset*











The observed increase in the growth of rate over the winter months is expected and in line with both previous years and our peers as seen in the chart above.

The various mortality indicators used by the Health Board (Crude, Standardised Hospital and Risk Adjusted) are also influenced by the changes in counting practice, with more patients now being admitted following a presentation to the Emergency Department.

As per WG policy the UHB's Multidisciplinary Mortality Review Screening Panel continues to review all deaths in line with the 2014 Palmer Report. Further information is available in previous report to Q&S committee (https://ctmuhb.nhs.wales/about-us/our-board/committees/quality-safety-committee/quality-safety-committee-documents/2022/15-november-2022/66-learning-from-mortality-reviews-update-20102022pdf/). A digital solution to improve the efficiency and effectiveness of the mortality review process has been implemented and in operation since the start of the year.

To aid quantitative approaches to monitoring and analysing trends in mortality, the CHKS dashboards are being revisited and the stage 1 review process is being digitised. Key benefits of which will be: the ability to improve access to the causes of death for patients dying in hospital, the ability to link mortality data to the wider patient record and the ability to digitally include information pertaining to the death within the deceased's health record.

Data linkage between the reason for death stated on the death certificate and Health Board held information has been undertaken, which may re-enforce or inform our actions to reduce avoidable deaths.

Finance Update – Month 5

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. Key Risks/Matters for Escalation

3.1 The key risks for the Performance quadrant are covered in the summary and main body of the report.

3.2 The key risks for the Quality quadrant are:

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Maintaining compliance with the 30 working days complaints response rate.
- Trajectory plan in place to reduce number of overdue Nationally Reportable Incidents.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Data to Knowledge

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below: Data to Knowledge
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	Efficient, Equitable, Person Centred, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
		This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's performance measures may result in impact to the patient's journey which may result in a risk of harm. Any potential harm could provide legal challenge.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's performance measures may result in impact to the trust and confidence in the Health Boards service provision.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Workforce and financial resources are required to address the Planned Care Recovery plans and improvement trajectories within the Health Board.	

5. Recommendation

5.1 The Board/Committee is asked to NOTE the Integrated Performance Dashboard.

2024-25 Finance Report

Month 5

Summary

Situation

This Finance report outlines our financial performance for Month 5 (i.e. the period to 31st August 2024).

This Finance report is discussed at the Board, the Planning, Performance & Finance Committee (PPFC) and the Executive Leadership Group (ELG) meetings.

A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at Month 5 (i.e. the Delegated budget position). This report is discussed at the PPFC and ELG meetings.

Background

Section 175 of the National Health Service (Wales) Act 2014 places two financial duties on Local Health Boards:

- A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
- A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers.

Our draft financial plan for 24/25 was submitted to Welsh Government (WG) at the end of March 2024. This plan showed a break even position with a net risk to the plan of £9.4m.

It is important to note that , even if the Health Board delivers a break-even position in 24/25, it will not achieve the 3 year break even duty due to the £24.2m deficit reported in 22/23. However, delivering a break even position in 24/25 will mean that it will be possible to achieve the 3 year break even duty in 25/26.

Summary

Assessment	Recommendation
Overall Revenue position - 2024/25: • The M5 position was a £0.2m surplus in month. • The M5 YTD position is now a £3.9m deficit. The main driver for the £3.9m YTD deficit is a £6.8m shortfall in savings delivery which is offset by other favourable variances of £(2.9)m. • The forecast break-even position has been maintained at M5. However, the level of risks that the Health Board is trying to manage increased significantly in M4 and remains high this month . Whilst the Health Board is continuing to develop further recovery plans, it is important to highlight that there is a significant risk that both the In year and the Recurrent forecasts could deteriorate in M6. • The net risks to the forecast break even position at M5 are £14.0m (M4: £16.1m) and these are summarised on Page 18. **Recurrent Revenue position:** • The b'fwd recurrent deficit at the end of 2023/24 was £19.4m. • As at M5 we are reporting a forecast underlying surplus at the end of 2024/25 of £(2.1)m. This remains consistent with the IMTP submission at the end of March. However, we are currently off plan at M5 and the £14.0m net risk shown in Page 18 represents a significant risk to both the In year forecast and the forecast recurrent position.	The Board, the PPFC and the ELG are asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 31st August 2024.

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Executive Summary

Overall Revenue Position

- The M5 position was a £0.2m surplus and the M5 YTD position is now a £3.9m deficit. The main driver for the £3.9m YTD deficit is a £6.8m shortfall in savings offset by favourable variances of £(2.9)m.
- The forecast break-even position has been maintained at M5. However, the level of risks that the Health Board is trying to manage increased significantly in M4 and remains high this month. Whilst the Health Board is continuing to develop further recovery plans, it is important to highlight that there is a significant risk that both the In year and the Recurrent forecasts could deteriorate in M6.
- The net risks to the forecast break even position at M5 are £14.0m (M4: £16.1m) and these are summarised on Page 18.

Savings Position

- Actual savings in M5 was £1.7m which was £0.5m below the M5 target of £2.2m. The M5 YTD savings is now £4.3m which is £6.7m below the M5 YTD target of £11.0m.
- The M5 forecast In year savings is £12.3m, which is £14.0m below the £26.3m target. This is a £0.2m improvement from M4. These savings plans have been risk assessed as £11.3m Green and £1.0m Amber.
- The M5 forecast Recurrent savings is £13.2m, which is £13.1m below the £26.3m target. This represents a £1.9m deterioration from M4.

Cash

- The closing cash balance at 31st August 2024 was £1.8m and the forecast cash balance at the end of the financial year is zero.

Capital

- The latest Capital Resource Limit for 2024/25, issued on the 25th June 2024, is £60.9m
- Expenditure to M5 was £19.3m.
- The outturn capital position is forecast to be balanced against the CRL target.

Summary
Income & Expenditure Account

	M4 Actual	M4 YTD	Year End Forecast
	£m	£m	£m
01. Revenue Resource Limit	(118.6)	(572.1)	(1469.)
02. Capital Donation / Government Grant Income	(0.0)	(0.0)	(0.1)
03. Welsh NHS Local Health Boards & Trusts Income	(6.9)	(32.0)	(76.8)
04. WHSSC Income	(1.2)	(5.4)	(12.9)
05. Welsh Government Income (Non RRL)	(0.2)	(0.3)	(0.9)
06. Other Income	(4.1)	(19.8)	(47.9)
Total Allocations & Income	**(130.9)**	**(629.6)**	**(1607.7)**
08. Primary Care Contractor	13.4	65.6	158.3
09. Primary Care - Drugs & Appliances	9.5	42.7	104.7
10. Provided Services - Pay	56.3	282.1	678.1
11. Provider Services - Non Pay	8.9	47.3	112.6
12. Secondary Care - Drugs	4.2	24.2	59.7
13. Healthcare Services Provided by Other NHS Bodies	26.4	116.2	277.7
14. Non Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0
15. Continuing Care and Funded Nursing Care	6.1	29.1	69.9
16. Other Private & Voluntary Sector	1.2	5.3	12.4
17. Joint Financing and Other	1.2	(3.2)	(2.9)
18. Losses Special Payments and Irrecoverable Debts	0.2	9.6	16.5
22. DEL Depreciation\Accelerated Depreciation\Impairments	3.2	14.6	35.0
23. AME Donated Depreciation\Impairments	0.1	0.3	85.7
25. Profit\Loss Disposal of Assets	(0.0)	(0.1)	(0.1)
Total Expenditure	**130.7**	**633.5**	**1607.7**
Grand total	**0.2**	**(3.9)**	**0.**

Key Points:

- The Summary I&E account shows the Health Board's Income & Expenditure by the categories used in the Monthly Monitoring Returns submitted to WG.
- The year to date position is reporting a deficit of £3.9m.
- The Year end forecast remains a breakeven position.
- The key risks to this forecast position are shown on Page 18.

Year to Date Performance and Forecast

	Current Month	YTD	Year end Forecast
	£m	£m	£m
Month 1	0.9	0.9	0
Month 2	1.4	2.3	0
Month 3	0.4	2.7	0
Month 4	1.4	4.1	0
Month 5	(0.2)	3.9	0

Key Points:

- The main driver for the £0.2m underspend in M5 is a £0.5m shortfall in savings delivery offset by other favourable variances of £(0.7)m.
- The M5 YTD overspend of £3.9m includes a £6.8m shortfall in savings offset by other favourable variances of £(2.9)m.
- The forecast break-even position has been maintained at M5. However, the level of risks that the Health Board is trying to manage increased significantly in M4 and remains high this month . Whilst the Health Board is continuing to develop further recovery plans, is important to highlight that there is a significant risk that both the In year and the Recurrent forecasts could deteriorate in M6.
- Further details of the key drivers for the YTD position and year end forecast are provided overleaf.

Year to Date Performance and Forecast

	M5 YTD	M5 Forecast
	£'m	£m
Savings shortfall v £26.3m target	6.7	14
Operating overspends:		
AB arbitration outcome	0.8	1.9
AB activity variances	0.4	1.0
POW temporary maternity closure	0.0	0.5
Unscheduled Care Medical pay overspends	1.7	3.8
Primary Care Prescribing growth above plan	1.5	3.5
Net Other Operating Variances	0.4	(2.1)
Sub total	4.8	8.6
Financial plan improvements:		
Reduction in Contracting & Commissioning costs (excluding AB UHB)	(2.1)	(5.0)
Agency costs	(1.0)	(2.4)
Energy costs	(0.5)	(1.1)
Non pay inflation	(0.4)	(1.0)
Pay contingency v 23/24 anticipated recurrent allocation	(0.4)	(1.0)
Non pay reserve for planned care activity increases	(0.3)	(0.8)
Other Reserves	(0.5)	(1.1)
Sub total	(5.2)	(12.4)
Accountancy gains	(2.6)	(6.3)
Total overspend	3.9	3.8
Further improvement needed to achieve planned break-even position		(3.8)
M5 Year-end forecast		0

Key Points:

- The total overspend of £3.8m includes a forecast overspend on Delegated budgets of £25.8m , offset by a forecast underspend on non Delegated budgets of £22.0m.
- A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at Month 5 (i.e. the Delegated budget position). This report is discussed at the PPFC and ELG meetings.
- **Minimum further savings of £3.8m are required in order to achieve the forecast break-even position for 2024/25. The Health Board also needs to manage the key risks to the forecast break even position. These risks are estimated at £14.0m and are summarised on Page 18.**

Forecast Underlying Position

Underlying Deficit	Plan	M1 F/Cast	M2 F/Cast	M3 F/Cast	M4 F/Cast	M5 F/Cast
	£'m	£'m	£'m	£'m	£'m	£'m
B'Fwd Core Plan Deficit 23/24	19.4	19.4	19.4	19.4	19.4	19.4
Allocation & Income Changes	(50.4)	(50.4)	(50.4)	(50.4)	(50.4)	(50.4)
Cost Pressures & Investment	55.2	55.2	55.2	55.2	55.2	55.2
Savings Target	(26.3)	(26.3)	(26.3)	(26.3)	(26.3)	(26.3)
Grand Total	**(2.1)**	**(2.1)**	**(2.1)**	**(2.1)**	**(2.1)**	**(2.1)**

Key Points:

- The b'fwd recurrent deficit at the end of 23/24 was £19.4m.
- **As at M5 we are reporting a forecast underlying surplus at the end of 2024/25 of £(2.1)m, which is consistent with the IMTP submission at the end of March. However, we are currently off plan at M5 and the £14.0m net risk shown in Page 18 represents a significant risk to both the in year forecast and the forecast recurrent position.**

Pay Expenditure Trends

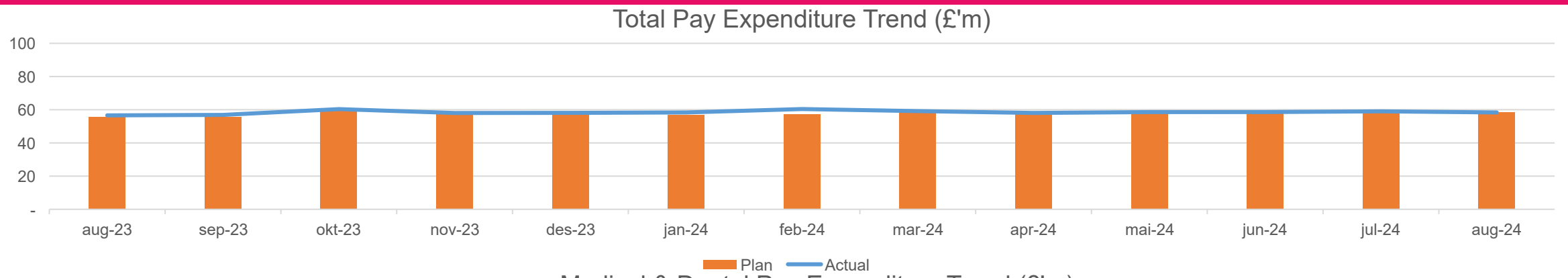
Staff Group	Qtr4 Ave £'m	Apr-24 £'m	May-24 £'m	Jun-24 £'m	Qtr1 Ave £'m	Jul-24 £'m	Aug-24 £'m
Administrative & Clerical	7.4	7.5	7.6	7.6	7.6	7.6	7.5
Medical And Dental	15.5	15.5	15.4	15.3	15.4	15.9	15.4
Nursing And Midwifery Registered	19.0	17.9	18.3	18.4	18.2	18.2	18.1
Add Prof Scientific And Technical	1.6	1.7	1.7	1.7	1.7	1.7	1.7
Additional Clinical Services	7.5	7.3	7.5	7.5	7.4	7.4	7.6
Allied Health Professionals	3.7	3.6	3.6	3.6	3.6	3.6	3.6
Healthcare Scientists	1.1	1.2	1.1	1.1	1.1	1.1	1.1
Estates And Ancillary	3.3	3.5	3.4	3.3	3.4	3.4	3.3
Students	0.1	0.0	0.0	0.0	0.0	.0	.0
Grand Total	**59.3**	**58.1**	**58.6**	**58.6**	**58.4**	**59.0**	**58.3**

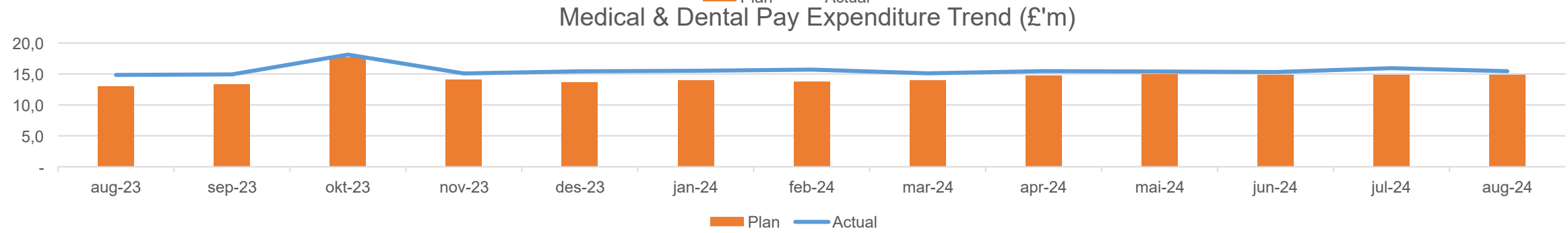
Spend category	Qtr4 Ave £'m	Apr-24 £'m	May-24 £'m	Jun-24 £'m	Qtr1 Ave £'m	Jul-24 £'m	Aug-24 £'m
Core	50.3	49.9	50.2	50.7	50.3	50.3	50.0
Agency	3.9	3.3	3.6	3.2	3.4	3.7	3.4
Overtime	1.9	1.5	1.4	1.4	1.4	1.5	1.5
ADH	1.9	2.0	2.1	1.9	2.0	2.2	2.1
Bank	1.2	1.1	1.3	1.1	1.2	1.2	1.3
WLI	0.1	0.2	0.1	0.2	0.2	0.2	0.1
Grand Total	**59.3**	**58.1**	**58.6**	**58.6**	**58.4**	**59.0**	**58.3**

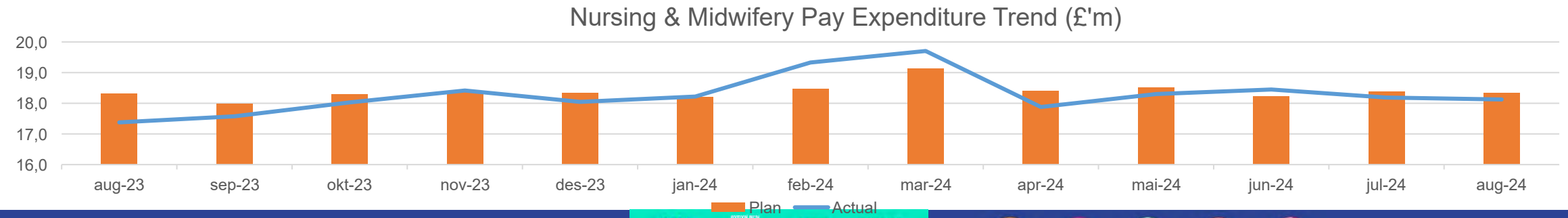
Key Points:

- Total expenditure in M5 was £58.3m, which is £0.1m lower than the Q1 average of £58.4m. There were no significant movements between M5 and Q1 average at an individual Staff Group level.
- Core pay costs in M5 was £0.3 lower than the Q1 Average.
- All of the variable pay expenditure categories remained consistent when compared to Q1 average.

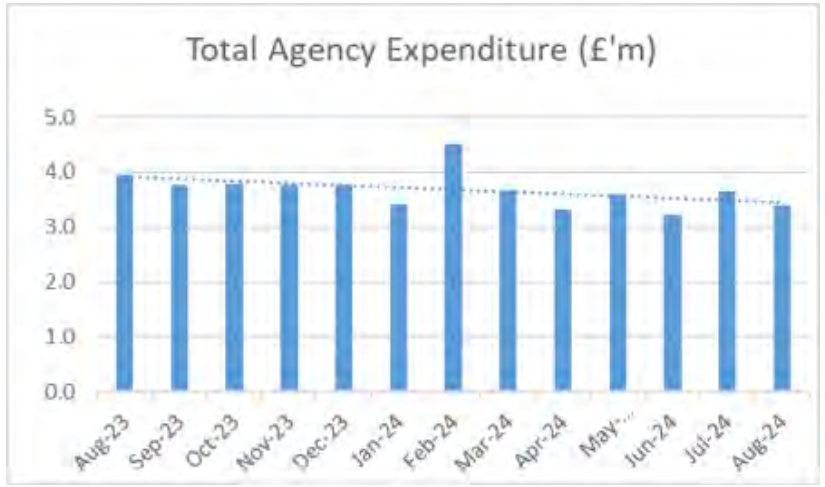
Pay Expenditure Trends

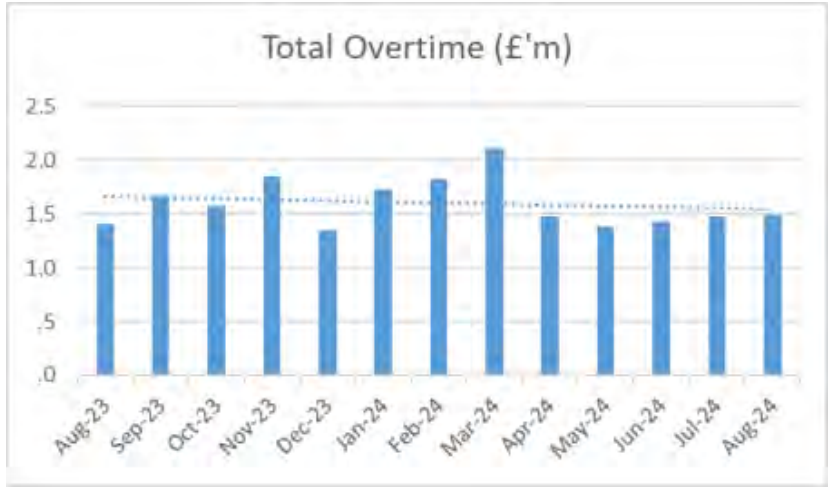


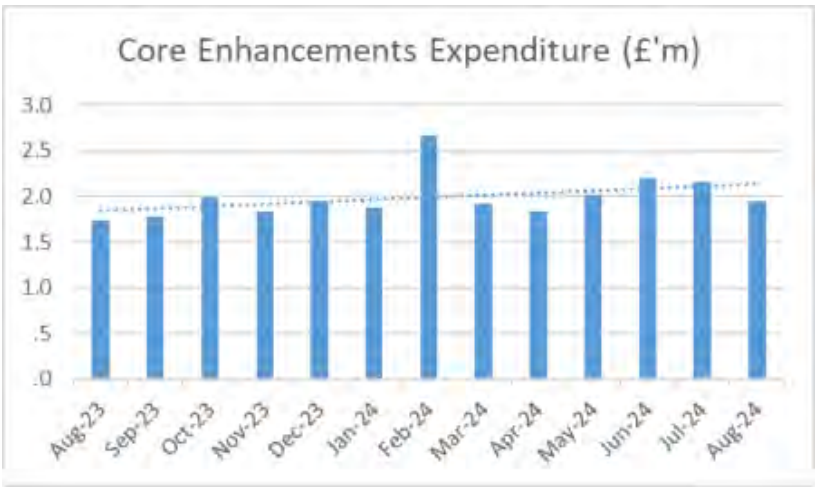


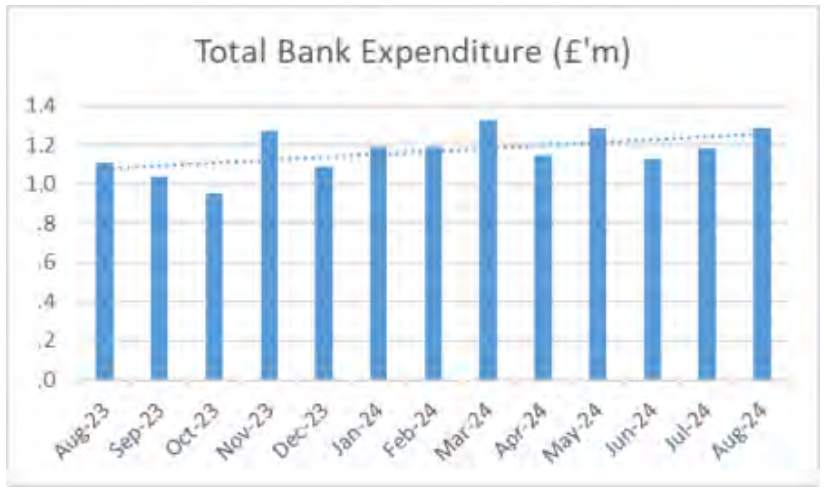


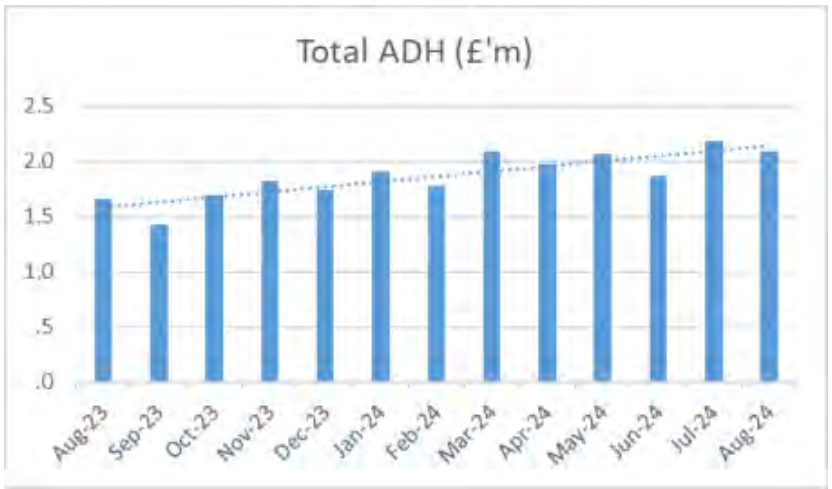
Variable Pay Expenditure Trends











Key Points :

- Agency spend – £0.3m decrease in M5 and overall a downward trend.
- Overtime payments- static in M5 and trend broadly flat.
- Core enhancements - £0.3m decrease in M5 but an increasing trend.
- Bank - £0.1 increase in M5 and an increasing trend.
- ADH spend – small decrease in M5 but an increasing trend.

Non Pay Expenditure Trends

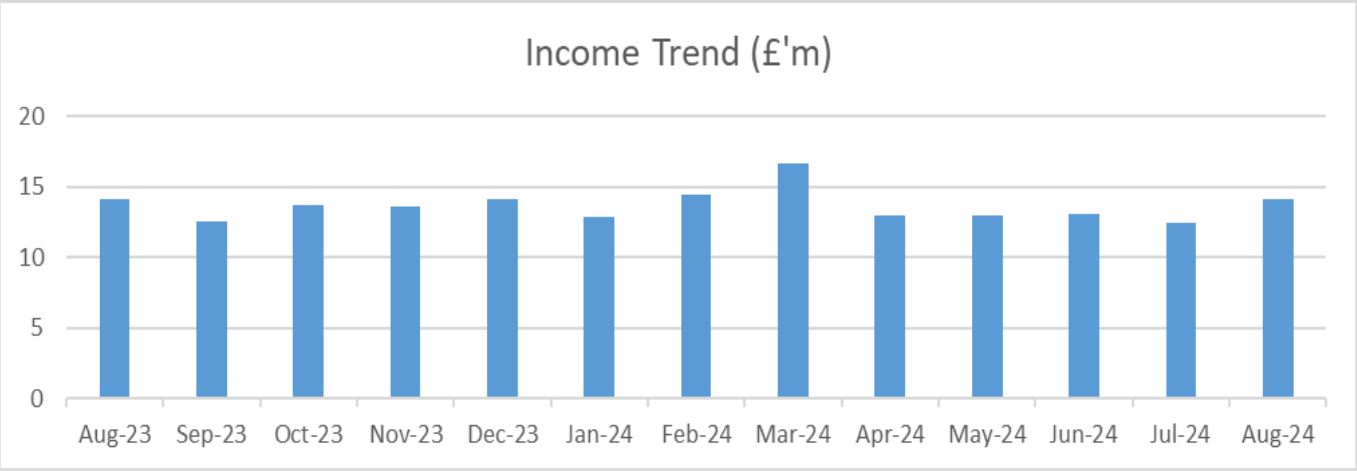
Non Pay Group	Apr-24 £'m	May-24 £'m	Jun-24 £'m	Qtr1 Ave £'m	Jul-24 £'m	Aug-24 £'m
Primary Care Contractors	11.6	12.8	11.9	12.1	12.4	12.6
Primary Care Drugs	8.8	7.9	8.3	8.3	8.1	9.5
Provider Non Pay	9.6	11.2	10.2	10.3	8.6	7.7
Secondary Care Drugs	4.7	5.4	4.2	4.8	5.6	4.2
Healthcare Commissioning	22.5	22.9	22.6	22.6	21.8	26.4
CHC & FNC	6.0	6.8	6.4	6.4	4.8	6.7
Other	4.9	4.2	5.1	4.7	5.2	7.0
Total Expenditure	**68.1**	**71.2**	**68.7**	**69.3**	**66.6**	**74.2**

Key Points:

- The total spend in M5 of £74.2m was £4.9m higher than the Q1 average. The main movements were:
  - Increase in Primary Care Drugs £1.2m – Recognition of increased volume growth beyond forecast following confirmation of Q1 PAR data.
  - Decrease in Provider Non-Pay £2.6m – Reclassification of RIF expenditure £1.7m together with reduction in levels of expenditure in Clinical Supplies & Services and Establishment Expenses across several areas with no significant individual issues.
  - Increase in Healthcare Commissioning of £3.8m – £3.1m of 23/24 pay award funding for LTAs together with Improved activity and NICE data relating to Velindre LTA £650k plus other LTA activity increases of £250k.
  - Other of £2.3m – Reclassification of RIF expenditure £1.7m together with Clinical Negligence settlements £0.2m and Depreciation of £0.3m.

Income Trends

Income Group	Apr-24 £'m	May-24 £'m	Jun-24 £'m	Qtr1 Ave £'m	Jul-24 £'m	Aug-24 £'m
Welsh NHS Income	6.6	6.6	6.3	6.5	5.7	6.9
JCC Income	1.0	1.0	1.1	1.0	1.0	1.2
Primary Care Contractor Income	1.0	1.1	1.0	1.0	1.2	1.1
CHC Income	0.4	0.4	0.4	0.4	0.6	0.6
Other Income	4.0	3.8	4.3	4.0	3.9	4.3
Total Income	**13.0**	**13.0**	**13.1**	**13.0**	**12.4**	**14.1**



Key Points:

- The total Income in M5 of £14.1m is £1.1m higher than the Q1 average of £13.0m. This is primarily due to:
  - Welsh NHS Income £0.4m – The 23/24 pay award allocation increase of £0.9m (£2.2m full year) offset by a reduction in income relating to ABUHB activity performance of £0.4m.
  - JCC Income £0.2m – The 23/24 pay award allocation relating to JCC (£0.4m full year).
  - Other Income £0.3m – The 23/24 pay award for HEIW (£660k full year).

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,232.3	29.7	25.0	86.7	1,373.6
Anticipated Allocations:					
Emergency/Urgent Care	1.4				1.4
RLW Social Care	2.4				2.4
2024/25 RLW Pay award	2.6				2.6
IFRS 16 Adjustment	(3.0)				(3.0)
WRP Recovery	(4.6)				(4.6)
Trainees	1.5				1.5
Depreciation	90.4				90.4
AHW Prevention & Early Years	0.9				0.9
Other	2.7			1.1	3.8
Total Allocations	**1,326.5**	**29.7**	**25.0**	**87.8**	**1,469.0**

Key Points:

- As at M5 the confirmed Revenue Resource allocation was £1,373.6m.
- The forecast position assumes a further £103.0m of additional allocations offset by a reduction of £7.6m for IFRS 16 adjustments and Welsh Risk Pool (WRP) recovery to give a Total allocation of £1,467.5m.

Income Assumptions - NHS

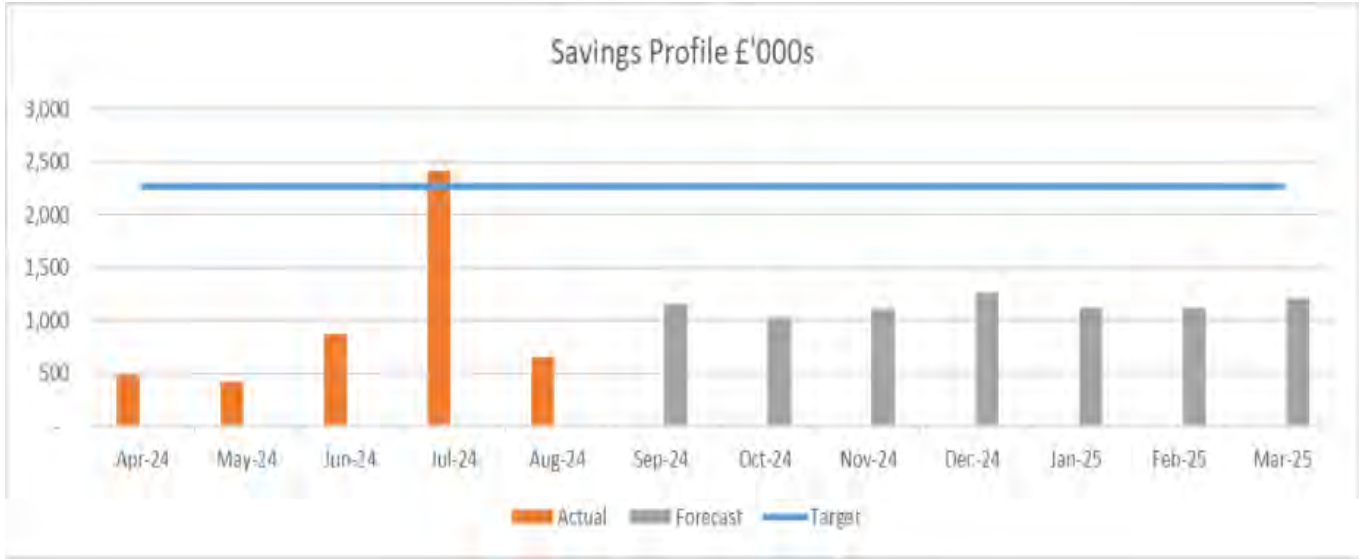
	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	29.8	(2.4)	27.4
Aneurin Bevan University	20.9	2.1	23.0
Betsi Cadwaladr University	0	0.3	0.3
Cardiff & Vale University	17.2	1.2	18.3
Cwm Taf Morgannwg University	0	0	0
Hywel Dda University	0.6	0.4	1.0
Powys	5.1	1.2	6.3
Public Health Wales	3.3	1.3	4.6
Velindre	0	11.8	11.8
NWSSP	0	0	0
DHCW	0.3	1.2	1.5
Wales Ambulance Services	0	0.1	0.1
JCC	12.1	0	12.1
HEIW	0	16.9	16.9
NHS Wales Executive	0	0	0
Total	**89.3**	**34.0**	**123.3**

Key Points :

- With the exception of ABUHB, all LTAs and SLAs were agreed by the 30 June deadline.
- Most of the LTA documentation has been signed by both parties but work continues to progress the final documentation and signing of our LTAs with :
  - Cardiff & Vale UHB
  - Velindre NHS Trust
- The Health Board submitted its arbitration documentation for the ABUHB LTA dispute to WG on 1st July 2024. WG ruled in favour of ABUHB and the £1.9m impact has been factored into the year end forecast (see page 8). There is also a further risk of £1.1m regarding the LTA activity baseline which has not been agreed with ABUHB. This risk has been included in the Risk Table (page 18).

Savings

	Month 5			Month 4		
	YTD	24/25	Rec	YTD	24/25	Rec
	£m	£m	£m	£m	£m	£m
Savings target	11.0	26.3	26.3	8.8	26.3	26.3
Actual and Forecast Savings	(4.3)	(12.3)	(13.2)	(2.6)	(12.1)	(15.1)
Total	6.7	14.0	13.1	6.2	14.2	11.2



Key Points:

- Actual YTD savings in M5 was £4.3m which was £6.7m below the target of £11.0m.
- The M5 forecast In year savings is £12.3m, which is £14.0m below the £26.3m target. This is a £0.2m improvement from M4.
- The £12.3m forecast savings plans have been risk assessed as £11.3m Green and £1.0m Amber. The estimated savings delivery risk at M5 is 0.7m (70% of the Amber schemes). This risk is included in our M5 Risk assessment on Page 18.
- The M5 forecast Recurrent savings is £13.2m, which is £13.1m below the £26.3m target. This represents a £1.9m deterioration from M4.

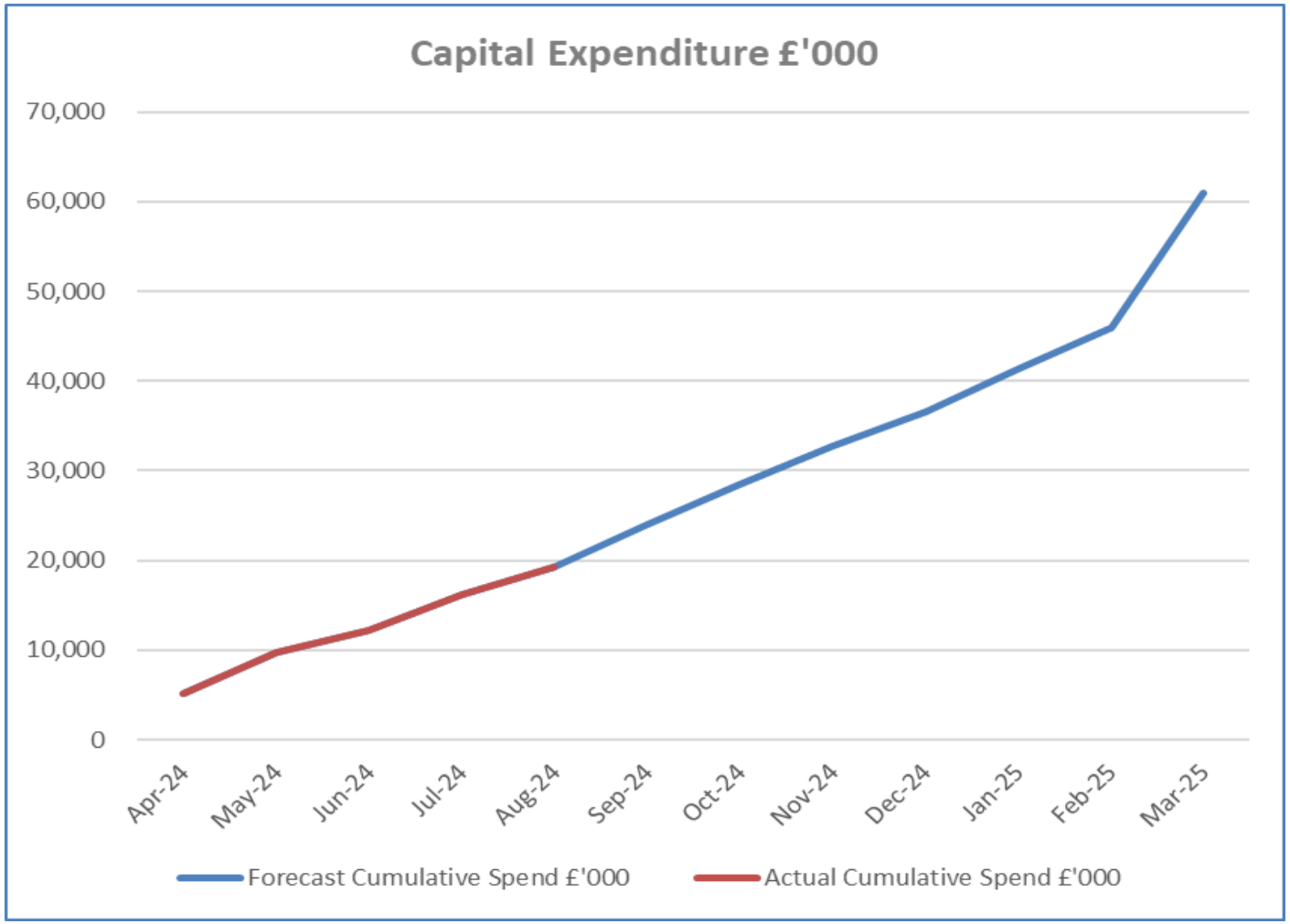
Risk Management
Risks and Opportunities

	M5 £m	M4 £m	Comment
Funding risks:			
Risk of the 24/25 pay award not being fully funded	tbc	tbc	Further clarification needed on the WG funding assumptions for 24/25.
Other risks:			
Delivery risk on latest savings forecast	0.7	2.1	70% of the Amber schemes totalling £1.0m.
Delivery risk on forecast improvement in Delegated position compared to straight line of the M5 YTD position	4.3	0	
Other cost pressure risks	2.2	2.6	50% of the High and Medium risks identified by Care Groups, over and above their M5 forecasts.
Further improvement needed to achieve planned break-even position	3.8	5.9	See Page 8.
Primary Care Prescribing Growth greater than plan	0	4.8	Following the M3 prescribing data, the forecast position has been adjusted in M5 to include an estimated overspend on Primary Care prescribing of £3.5m.
ABUHB LTA Dispute- Activity Risk	1.1	1.1	Risk relating to the ABUHB LTA Activity baseline dispute at 63.5% marginal rate. See page 16.
SEW Cataract Business Case	0.9	0.9	Risk relating to the CTM funding level for the SEW Cataract Business Case.
Joint Commissioning Committee expenditure being greater than M4 forecast.	1.0	1.0	Current reports indicate high levels of risk in achieving the latest JCC forecast.
Potential pay banding disputes including retrospective application	tbc	tbc	
Total Risks	**14.0**	**18.4**	
Opportunities			
Further Balance sheet opportunities in 24/25	tbc	(1.0)	£6.3m now included in year-end forecast at Page 8 (M4: £5.0m).
Review of Annual leave provision	tbc	tbc	
Retrospective vat recoveries – Microsoft contract	tbc	tbc	Updated assessment from DHCW indicates a potential £2.3m benefit, but high level of risk.
Potential reduction in Energy costs	0.0	(1.0)	Now included in M5 forecast
Other	0.0	(0.3)	Now included in M5 forecast
Total Opportunities	**0.0**	**(2.3)**	
Total	**14.0**	**16.1**	

Key Points :

- As at M5 we are reporting an estimated net risk of £14.0m, a reduction of £2.1m from M4.
- It is important to highlight that, at this stage, there is a significant risk that the In year and Recurrent forecasts could deteriorate in M5.

Capital Expenditure



Key Points:

- The latest Capital Resource Limit for 2024/25, issued on the 25th June 2024, is £60.8m.
- This is supplemented by a forecast £0.1m of donated funds in this financial year giving an overall programme of £60.9m.
- Expenditure to M5 was £19.3m.
- The outturn capital position is forecast to be balanced against the CRL target.

Statement of Financial Position

Balance Sheet	Opening Balance (01/04/2024) £'000	Closing Balance as at M04 £'000	Closing Balance as at M05 £'000
Non Current Assets			
Property, Plant & Equipment	730,452	735,144	734,900
Intangible Assets	2,092	2,092	2,092
Trade and Other Receivables	67,191	63,977	67,191
Total Non-Current Assets	799,735	801,213	804,183
Current Assets			
Inventories	7,367	7,353	7,336
Trade and Other Receivables	77,735	100,240	94,797
Cash and Cash Equivalents	1,485	7,293	1,804
Non Current Assets Classified as Held for Sale	0	0	0
Total Current Assets	86,587	114,886	103,937
Current Liabilities			
Trade and Other Payables	161,743	161,743	161,743
Provisions	36,955	36,955	36,955
Total Current Liabilities	198,698	198,698	198,698
Non-Current Liabilities			
Trade and Other Payables	18,437	26,900	13,483
Provisions	65,735	72,504	70,583
Total Non-Current Liabilities	84,172	99,404	84,066
TOTAL ASSETS EMPLOYED	603,452	617,997	625,356
Financed By:			
General Fund	493,867	508,412	515,771
Revaluation Reserve	109,585	109,585	109,585
TOTAL	603,452	617,997	625,356

Key Points :

There were a small number of significant movements on the balance sheet between M4 and M5:

- Trade and Other payables have decreased by £13m. The Pharmacy accrual has reduced by £10m due to the timing of the payments at month end. The remaining reduction is a general decrease in trade creditors.
- The cash balance has reduced by £5m. This was a planned reduction following the high balance reported in M4.

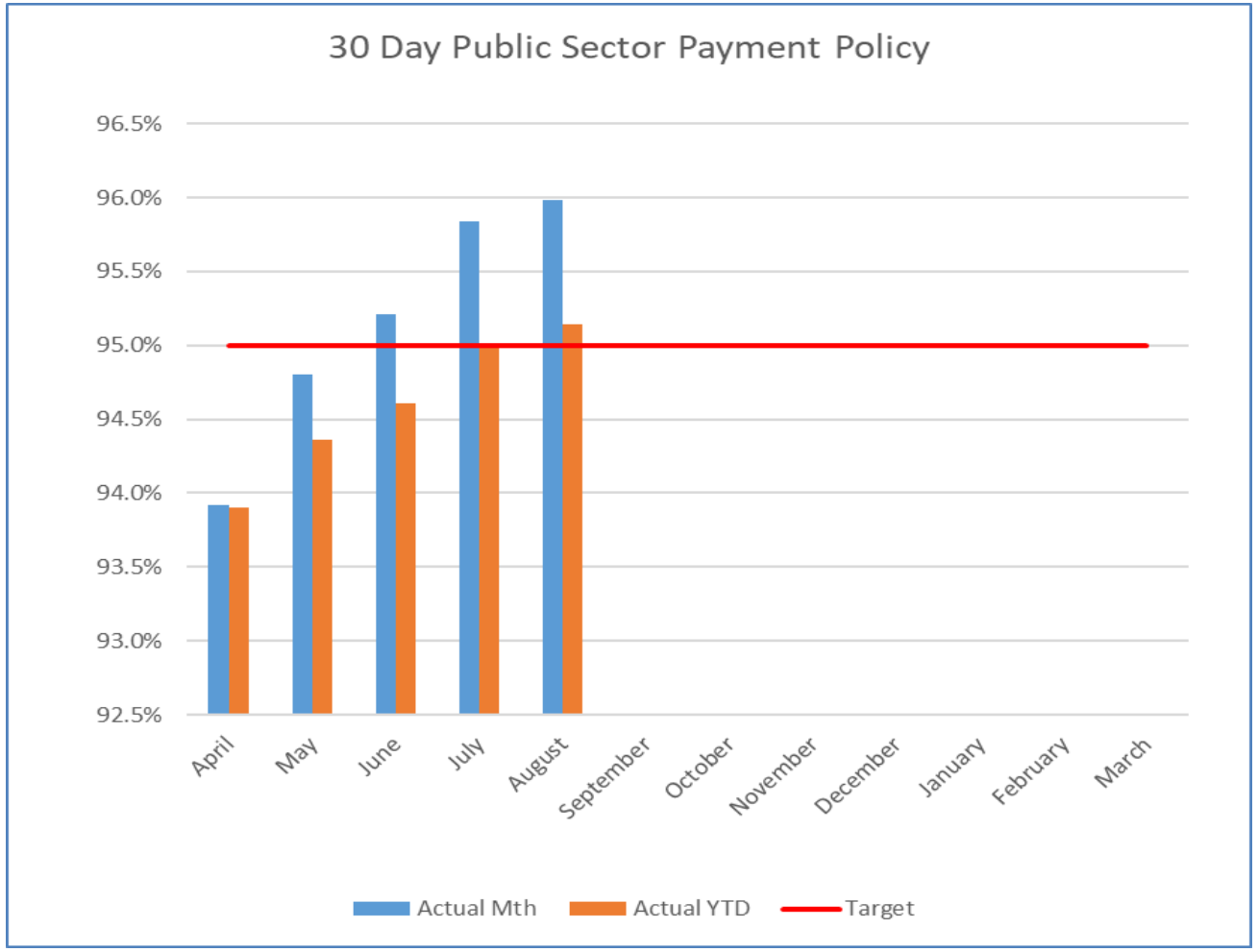
Cash Flow Forecast

Cashflow	Actual/Forecast												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
Receipts													
WG Revenue Funding	104,060	121,501	110,845	123,671	122,274	113,500	115,500	123,500	116,500	111,500	110,500	84,621	1,357,972
WG Capital Funding	6,000	3,000	3,600	5,300	3,900	3,500	4,800	4,400	5,900	6,000	5,900	11,497	63,797
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Welsh NHS Org'ns	13,521	8,976	10,095	10,090	10,783	11,000	11,000	11,000	11,000	11,000	11,000	11,000	130,465
Other	6,489	5,527	3,110	1,968	4,648	5,200	5,200	5,200	5,200	5,200	5,200	5,200	58,142
Total Receipts	130,070	139,004	127,650	141,029	141,605	133,200	136,500	144,100	138,600	133,700	132,600	112,318	1,610,376
Payments													
Primary Care Services	18,876	30,646	10,140	18,812	29,598	10,563	19,746	27,156	19,325	17,889	17,889	9,081	229,721
Salaries and Wages	(262)	(169)	0	300	0	0	0	0	0	0	0	131	0
Non Pay Expenditure	44,837	57,323	58,000	56,289	54,911	57,000	57,000	57,000	57,000	57,000	57,000	57,000	670,360
Capital Payments	5,476	6,126	3,568	2,845	4,105	5,500	5,500	5,500	5,500	5,500	5,500	8,100	63,220
Other	59,061	48,104	52,532	59,439	58,482	53,000	53,000	53,000	53,000	53,000	53,000	52,942	648,560
Total Payments	127,988	142,030	124,240	137,685	147,096	126,063	135,246	142,656	134,825	133,389	133,389	127,254	1,611,861
Net Cash In/Out	2,082	(3,026)	3,410	3,344	(5,491)	7,137	1,254	1,444	3,775	311	(789)	(14,936)	
Balance B/F	1,485	3,567	541	3,951	7,295	1,804	8,941	10,195	11,639	15,414	15,725	14,936	
Balance C/F	3,567	541	3,951	7,295	1,804	8,941	10,195	11,639	15,414	15,725	14,936	0	

Key Points within the Cash Flow Forecast :

- The closing cash balance at 31st August 2024 was £1.8m and the forecast cash balance at the end of the financial year is zero.
- We are assuming that the 24/25 pay awards will be fully funded and these will be included in the M6 forecast.
- Cash assumptions and profiles will be reassessed once the pay award is received.

Public Sector Payment Policy



Key Points:

- The percentage for the number of non-NHS invoices paid within the 30 day target in August was 95.8%
- The cumulative percentage to M5 is now 95.0%.
- We are forecasting to achieve the 95% target by the end of the year.

Agenda Item
8.1

CTM Health Board

Update on Acute Clinical Services Plan

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Vicki Wallace Deputy Director of Strategy & Partnerships
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ACSP	Acute Clinical Services Plan
CTM	Cwm Taf Morgannwg

1. Situation /Background

1.1 CTM 2030: Our Health, Our Future was launched in 2021. Since that date, work has been underway to further understand our population health needs and engage with our communities and our staff, to better articulate what this will mean for the population of CTM.

1.2 There are three key strategic themes to CTM2030:
- Building healthier communities
- Integrated community services
- Acute clinical services plan

1.3 These strands are underpinned by quality, governance, digital, public health, finance, workforce, communication and engagement and value based healthcare plans.

1.4 This report specifically refers to the development of the ACSP.

2. Specific Matters for Consideration

2.1 The key areas of focus since the previous update in May 2024 include:

- The future appointment of an ACSP Programme Director. A job description has been delivered and is currently going through a job matching process.

- Understanding the resourcing needed to deliver the ACSP programme. This is being taken forward by the Executive Director of Strategy and Transformation and the Deputy Director of Strategy and Partnerships meeting with each of the executive teams to explore the resourcing needs for programme delivery and how this will be achieved. It is recognised that the resourcing elements must be in place before any pre-engagement process commences, as the health board has to ensure delivery of the programme. This may lead to a delay in previously shared timelines as it is currently unlikely that the pre-engagement phase will be able to commence as originally planned in the Autumn as resources are not yet identified.

- Care groups are revisiting the baseline work to ensure they reflect an accurate service description. This will then inform the production of a base model, which will include activity, workforce and finance data. The base model will be used in the future to understand the impact of potential scenarios.

- Learning from other areas, especially the approach taken in Hywel Dda University Health Board which produced an issues paper last year (equivalent to a Case for Change document) and is currently in phase 2 of their programme, which is the production of options.

3. Key Risks / Matters for Escalation

3.1 There is a key risk around how the development and delivery of the ACSP is articulated to staff, the public and our partners. Experience has highlighted that plans have to be evidence based and clear as otherwise misinformation can circulate and gain traction. The communication and engagement of the ACSP moving forward must be transparent and decision making understood.

3.2 There is a key risk that the resources needed to deliver the ACSP in full will not be available. This relates to finance (capital and revenue), workforce (frontline and support), engagement, estate and digital resources, Realistic resourcing plans will be set out within the ACSP, but experience to date has shown that these may not always be delivered due to internal and external influences.

3.3 There is a risk to the timescales related to delivery if the resources (as set out in 3.2) are not in place.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Sustaining our future Inspiring People
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: A Prosperous Wales A Resilient Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Effective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
	If more than one applies please list below: Person Centred Efficient Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Will be considered as part of the development of the options
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Will be considered as part of the development of the options
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	There may be a negative reputational impact on the HB if the delivery of the ACSP is not successful	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	There will be resource implications to the delivery of the ACSP. The options appraisal process will include resource implications.	

5. Recommendation

5.1 The Board is asked to note and discuss the contents of this paper.

6. Next Steps

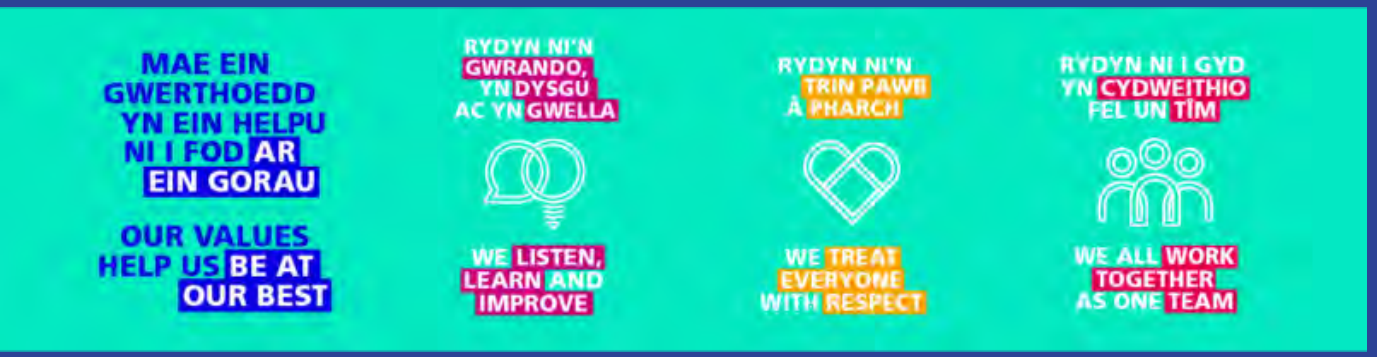
6.1 The next steps for the development of the ACSP include:
- review of governance processes
- recruitment of a programme director
- full understanding of resources needed to deliver the programme
- commence the development of a base model

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

Cwm Taf Morgannwg UHB

Llantrisant Health Park Infrastructure Programme
Update to the Health Board



26th September 2024
09:00 – 13:00

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

cwmtafmorgannwg.wales

PRESENTATION SCOPE

Update on the Llantrisant Health Park Programme:

- Installation of the Mobile MRI
- Outcome of Site Infrastructure Surveys
- Approach to Patient Pathway Development
- Latest design development and planning progress
- Programme
- Next Steps
- Questions

THE MOBILE MRI ON LHP

- The mobile MRI become operational on 20th April 2024 and is now scanning on average **90 patients per week**
- Since opening the range of scans has increased from the initially planned musculoskeletal scans which has further improved the patient wait position.
- To date **2,333 Patient Areas** have been scanned (eg, Whole Spines are 3 area sections for 1 patient) equating to having **successfully scanned 1,907 Patients** from the mobile
- Since the MRI has become operational there has been a significant reduction in MRI waits, with total waits showing a reduction of ca 50% and 8 week waits showing a marked reduction, dropping from 1000 in April to less than 250.
- Patient Feedback has been positive with feedback focussing the ease of access, availability of parking, professional and friendly staff, clean and welcoming facilities and a friendly less imposing environment than a main hospital
- With the mobile MR contract ceasing in September, the service are planning to instal a mobile CT for the autumn period until demolition works commence

SITE INFRASTRUCTURE UPDATE

Site Infrastructure Update

- Over the winter period, as a first phase of the RIBA 2 design works, the design team focused on the **detailed infrastructure issues and risks** around the on site buildings.
- The desk top report at time of site purchase by Arup **indicated a number of structural, civil and M&E engineering items** that may require early follow up and investigation
- Dec/Jan saw a series of detailed engineering surveys being undertaken on a site wide basis resulted in a technical report provided on 15th February. **This report identified a number of risks and constraints** within the building infrastructure
- The report contents were shared with the SRO and with NWSSP-SES who concluded **a full option appraisal around how to proceed** should be developed.
- A detailed options appraisal was undertaken and identified that the shortest programme and lowest cost solution would be to **demolish the existing buildings and replace with modern modular buildings.**
- This option would also support increased capacity as well as preserving space for future expansion.

SITE INFRASTRUCTURE UPDATE

Site Infrastructure Update

- From the options appraisal a demolition and rebuild option offered the following benefits:
  1. Shortest programme and lowest cost per M2
  2. Sustainable and efficient buildings with a 40+ year lifespan
  3. Potential to host additional temporary capacity whilst main works ongoing
  4. Able to accommodate all planned services
  5. Able to support capacity for the planned services
  6. Additional expansion space on site

- Presented to WG at Infrastructure Investment Board and included in Strategic Overview Document included as the proposed way forward in all design works.

APPROACH TO CLINICAL PATHWAY DEVELOPMENT

The patient is at the centre of everything we do from design, delivery, quality and outcomes.

The ambition is to *Transform services* and deliver an exemplar unit providing the very best outcomes and experience to our patients.

Learning from best practice globally, including Clinical visits to exemplar facilities within the UK.

Aiming to be the first purpose built, GiRFT accredited, Surgical Hub in Wales, delivering HVLC surgery to our patient population.

- *A blueprint for other surgical hubs across Wales.*

Developing clinical models, staffing structure/roles and supporting infrastructure in order to deliver the vision.

A transition from day surgery to outpatient surgery.

Delivering day case arthroplasty as routine.

Day case surgery to become Outpatient surgery.

PRINCIPLES FOR DEVELOPING THE CLINICAL PATHWAY

- Clinical pathways influence the design
- Efficiency and patient and staff experience fundamental to the development of the unit
- Supporting infrastructure will be designed to meet GIRFT Surgical Hub accreditation, including flexibility to support future innovation.
- Challenging current practice and delivery.
- Planning for zero day length of stay as default.
- All aspects of clinical pathways will be standardised.
- Productivity to meet or exceed GiRFT guidelines.
- Supporting physical infrastructure is comfortable but will not encourage unnecessary overnight stays.
- Ring-fenced unit and staff.
- Regular, job-planned, consultant sessions delivered at LHP.
- Whole MDT team approach, competency frameworks to support staff working across traditional role boundaries.
- Stand-alone unit- satellite site of the Royal Glamorgan for logistics only.

CLINICALLY DRIVEN PROGRAMME

- Clinical Reference Groups with regular meetings defining the design and pathway development.
  - Clinical project team in place to support development and delivery.
  - Architect embedded in clinical design team.
  - Regional clinical engagement to support further development of individual pathway design.
- Engaging with and learning from exemplar units across the United Kingdom to inform the development of clinical pathways and physical infrastructure.
- Review of literature and evidence base to support pathway development.
- GiRFT principles embedded in all aspects of clinical design.
- Clinically developed protocols supporting standardisation, innovation and patient safety.
- Robust governance with senior clinical MDT agreement and sign-off
- Early adoption pathways across CTM and the SEW Region in preparation for go-live.

DESIGN DEVELOPMENT UPDATE AND PLANNING APPLICATION

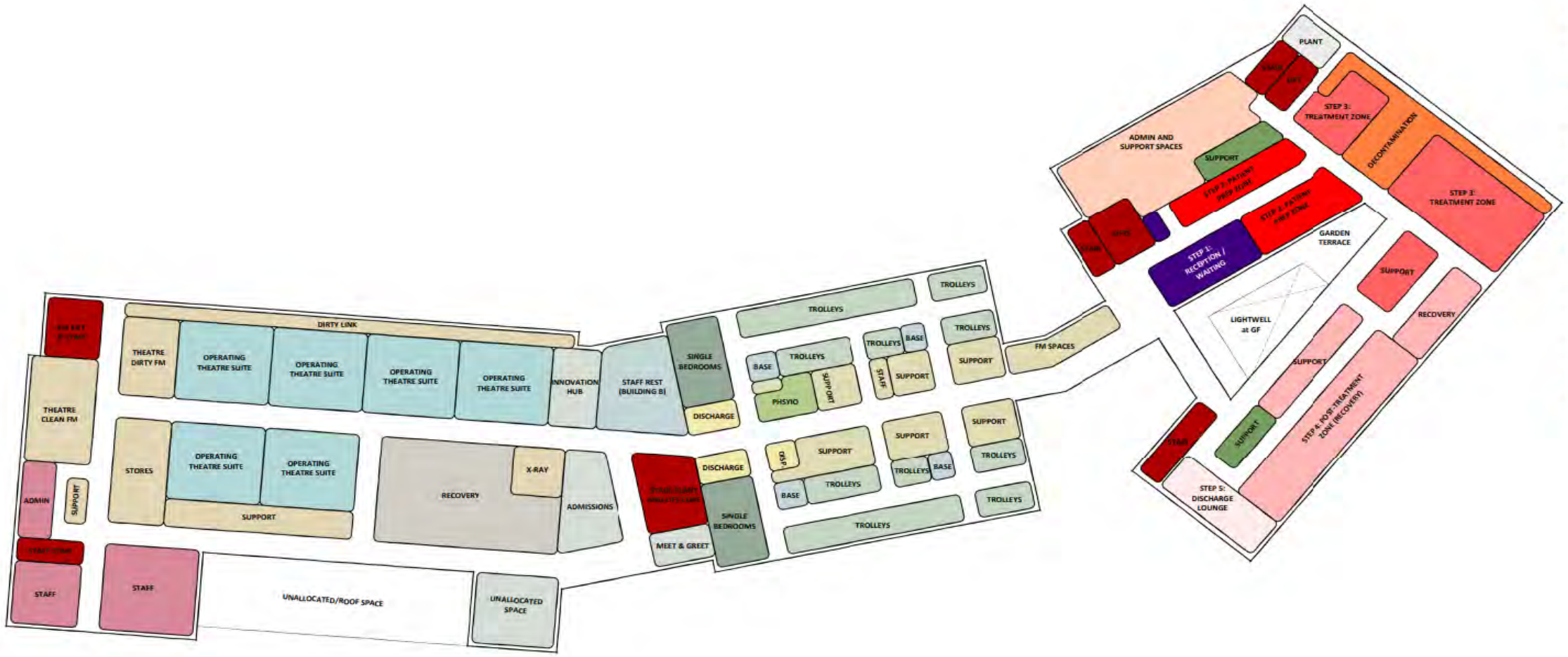
- Pathway work has informed the design process which has considered how the space can be used to promote efficient pathways for staff and patients and support the delivery of high volume care
- The summary massing plans on the following slides set out the work completed to date for the clinical services, this still retains some development space on the undeveloped plateau for a potential phase 2 development
- Plans have been shared with RTE planning department as part of the formal pre application process to ensure that this programme can continue on an expedited timeframe
- The plans have been shared with a number of clinical colleagues to confirm flow and efficiency assumptions however the next phase of design will increase the level of clinical input to the design
- The following slides set out the developed plans to date

SITE OVERVIEW

PROPOSED SITE LAYOUT

GROUND FLOOR LAYOUTS

FIRST FLOOR LAYOUTS



SECOND FLOOR LAYOUTS

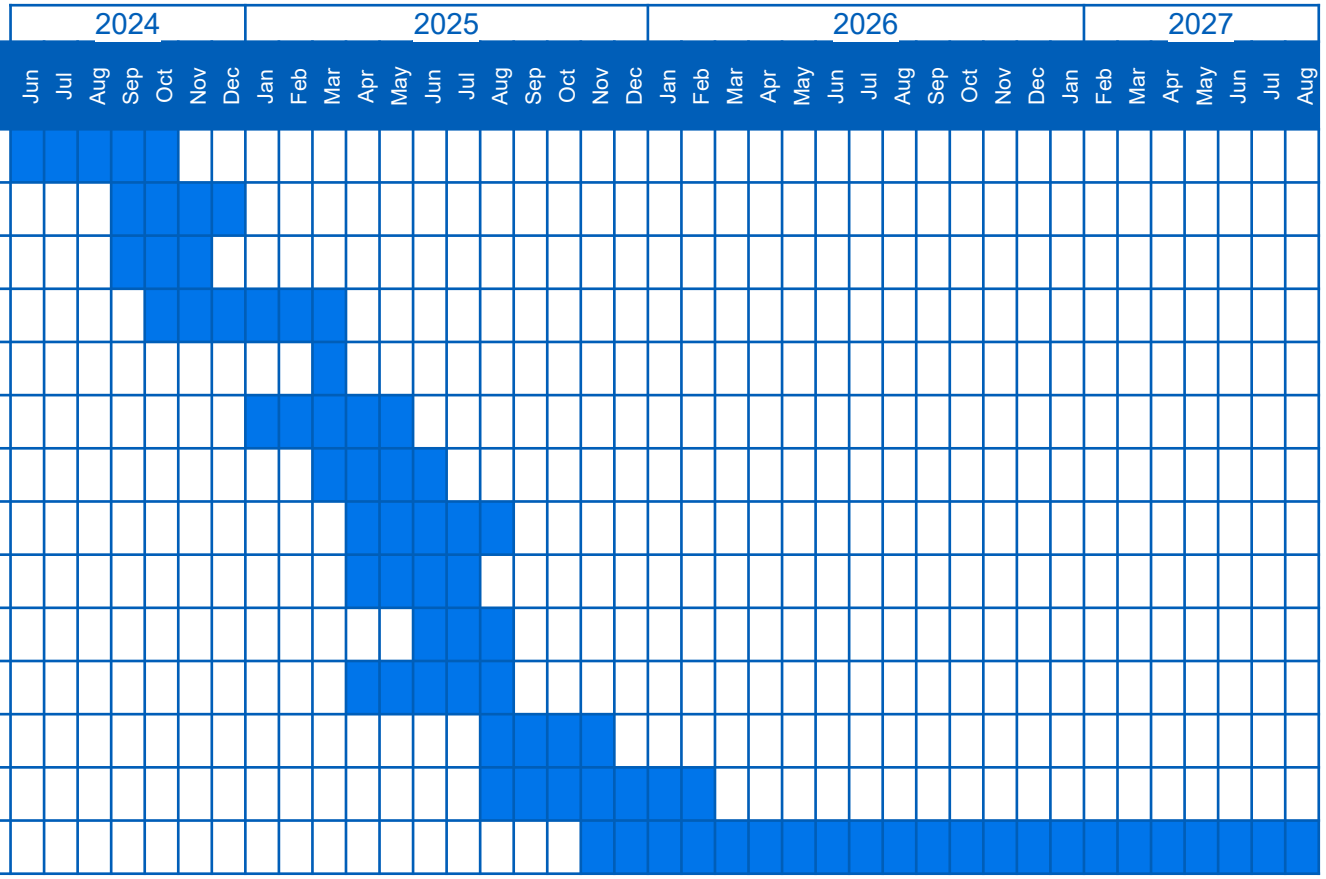
PROGRAMME UPDATE

- Latest programme shows a completion date of 31st August 2027
- Essential to shorten the programme and requirement for further conversation with Welsh Government around opportunities
- Split the programme into phases:
  Phase 0 – Demolitions
  Phase 1 – CDC
  Phase 2 – Theatres and bedded area
- Opportunity to bring on a modular contractor ASAP to develop a design and build solution, will need WG coverage – opportunity to consider a single stage business case incorporating a cost not to exceed approval to enable ongoing approval as long as capital costs do not exceed allowance could mitigate times
- Investigation of single short business case for CDC based on English approach and an option re the Phase 2 to look at business case approval of a capital limit, not to exceed funding level to enable uninterrupted progress through design and construction phases

PROGRAMME UPDATE CONT

4a. Programme – Key Milestones

Task/Stage	Start	Finish	Duration (weeks)
RIBA 2	18/06/2024	15/10/2024	17
SAB Pre-application	11/09/2024	11/12/2024	13
Planning - Pre-application	11/09/2024	05/11/2024	8
RIBA 3 Design	09/10/2024	11/03/2025	20
RIBA 3 Stage Approval	12/03/2025	12/03/2025	0
Planning - PAC (Pre-Application Consultation)	15/01/2025	09/05/2025	16
RIBA 4 Design	12/03/2025	23/06/2025	14
Planning - Detailed	09/04/2025	04/08/2025	16
SAB Application	09/04/2025	07/07/2025	12
RIBA 4 Stage Approval	23/06/2025	23/06/2025	0
Business Justification Case (BJC)	26/03/2025	18/08/2025	20
Mobilisation	19/08/2025	11/11/2025	12
Module Manufacture	19/08/2025	17/02/2026	24
Construction	12/11/2025	31/08/2027	88



NEXT STEPS

- Strategic overview document submitted to WG for endorsement and to enable further fee release
- Urgent discussion with WG and key stakeholders on opportunities around shortening the programme especially for amendments to business case requirements
- RIBA 2 design stage completes on 15th October
- Move straight into RIBA 3 design stage whilst appointment of a modular construction partner is ongoing – design team to novate across on contractor appointment
- Demolitions tender pack developed and issued in early October, business case to be developed and works to commence early 2025.
- Ongoing Infrastructure Investment Board reviews and Shared Service technical design reviews
- Planning pre application commences on 11th September as formal commencement of planning process
- Workstreams for finance, workforce and Digital to be confirmed and plans developed alongside infrastructure programme

QUESTIONS?

Recommendation:	The Board are asked to:
	• *NOTE the presentation.*

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item	9.1.1

Unapproved Minutes of the Public Board Meeting

Date and Time of Meeting	25th July 2024, commencing at 9am
Venue	In Person at Coleg Y Cymoedd in Nantgarw Virtual Teams option available for Board Members

Members Present	Jonathan Morgan	Chair
	Kath Palmer	Vice Chair
	Helen Lentle	Independent Member – Legal
	Dilys Jouvenat	Independent Member – Third Sector
	Rachel Rowlands	Independent Member – Community
	Ian Wells	Independent Member – Digital & Data
	Carolyn Donoghue	Independent Member – University
	Geraint Hopkins	Independent Member – Local Authority
	Lynda Thomas	Independent Member – Corporate Business (Joined via Teams)
	Paul Mears	Chief Executive Officer
	Greg Dix	Deputy Chief Executive / Executive Director of Nursing
	Gethin Hughes	Chief Operating Officer
	Linda Prosser	Executive Director of Strategy & Transformation
	Lauren Edwards	Executive Director of Therapies & Health Science
	Philip Daniels	Executive Director of Public Health
	Sally May	Executive Director of Finance (Joined via Teams)
	Anne Morris	Associate Board Member – Chair of the Stakeholder Reference Group
	Lisa Curtis-Jones	Associate Board Member – Director of Social Services (Merthyr Tydfil)
	Sally Bolt	Associate Board Member – Chair of the Clinical Advisory Group
In Attendance	Gareth Watts	Director of Corporate Governance / Board Secretary
	Stuart Morris	Director of Digital
	Simon Blackburn	Director of Communications, Engagement & Fundraising
	Sallie Davies	Deputy Executive Medical Director
	Ceri Bear	Llais Cymru Representative
	Elizabeth Stevenson	Llais Cymru Representative

Guest Speakers	For Item 3.1 – Taff Vale Practice – Proposed Branch Closures	
	Amanda Ellis	Borough Councillor for Ynysybwl
	David Miller	Medical Director – Primary Care and Community
	Dr Steffan Reed	General Practitioner – Taff Vale Practice
	For Item 5.1 – Listening and Learning Story	
	Joanne Cotter	Patients Mother
	Dawn Parry	Senior Nurse – Acute Paediatrics
	Leah Panniers	Head of Nursing – Children & Young People
	Clare Wright	Consultant Clinical Psychologist & Systemic Psychotherapist
	For Item 8.4 – Development of a plan to address Delayed Discharge	
	Julia Wilkinson	Clinical Service Group Manager – Community Health
	Paula Cornelius	Head of Occupational Therapy
	Lucie Williams	Director of Nursing – Primary Care and Community
	Adam Cook-Young	Clinical Practitioner
	Guy Griffiths	Operational Manager – Community Health and Wellbeing Team
Public Observers	Nil	
Meeting Support	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	The Chair welcomed everyone to the meeting, particularly those joining for the first time and guests and colleagues joining for specific agenda items. The format of the proceedings were also noted by the Chair.
1.2	Apologies for Absence
	Apologies for absence were noted from: • Patsy Roseblade, Independent Member – Audit & Finance • Nicola Milligan, Independent Member – Trade Union • Hywel Daniel, Executive Director for People • Dom Hurford, Executive Medical Director (Sallie Davies deputising in D Hurford's absence)
1.3	Declarations of Interest
	No declarations of interest were noted prior to or during the meeting.

2.	CONSENT AGENDA BUSINESS
2.1	The Chair invited L Prosser to clarify the required action by the Board in relation to agenda item 10.2.5, "NHS Emergency Planning Annual Report" which is on the consent agenda. L Prosser advised that whilst the Major Incident Plan is extant and will be submitted to Welsh Government with the Annual Report, hence its inclusion in the papers, it is recognised that the plan requires updating in respect of the new operating model and that review is underway. It is anticipated that the plan will return to the Board in September 2024 for approval. The Chair then asked members if there were any items from the consent agenda that Board Members wished to bring forward to the main agenda for discussion. There were NONE.
3.	MAIN AGENDA PART 1
5.1	Primary Care Update – Taff Vale Practice - Proposed Branch Closures
	The Chair invited G Hughes to introduce this item to the Board. Gethin Hughes, Chief Operating Officer, CTMUHB G Hughes informed the Board that the purpose of receiving this item today was to consider the recommendation from the Primary Care Contract Variation Group to support the proposed closure of two branch surgeries within the Taff Vale Practice. G Hughes clarified that this was not a decision being driven by the Health Board, but as the commissioner of primary care services, the Board has the final authority to approve or dismiss the request. This would need to assess whether the board have received sufficient assurance that the journey to this decision has been appropriately scrutinised, that due process had been followed, and that there will be ongoing assurance that the patients in the affected branch surgeries (Cilfynydd and Ynysybwl) continue to access a timely primary care provision. G Hughes invited Dr Steffan Webb to outline the challenges that the Taff Vale Practice have encountered, which has led to the recommendation being put forward to the Board. Dr Steffan Webb, GP / Partner – Taff Vale Practice S Webb thanked the Board for the opportunity to address the Board in person with what has been a very difficult decision of the Taff Vale Practice. He highlighted the following points: • Considerable change to the provision of healthcare access with increased urgent/acute demand. • Sustainability of the running of the branch surgeries due to challenges in staff retention, particularly in administrative positions. • Working conditions in the branch surgeries in terms of isolation and how this impacts staff morale and recruitment.

- Disrepair of the branch surgery buildings in Cilfynydd and Ynysybwl.
- Challenges in providing the appropriate centralised training environment, supervisory support and multi-disciplinary working arrangements across the five sites impacting the ability to attract staff to join the practice.
- Challenge to the Taff Vale Practice's ability to provide a primary care model fit for the future which requires a multidisciplinary approach at single sites.

S Webb assured the Board that these changes would not impact acute/same day appointments which are currently offered at the Rhydyfelin practice and have been for the last couple of years (since the impact and response to the Covid-19 Pandemic). He recognised that routine appointments will be impacted, however, he advised that new arrangements have been implemented to reduce the wait time for routine appointments from six to two weeks, which has been seen as a positive change. He also stressed that across the remaining three sites the capacity for appointments has been increased and the service provision at Glyncoch widened.

In concluding, S Webb wished to stress to the Board that this was not a decision that the practice had arrived at lightly. He noted that the practice recognises the impact on the communities of Cilfynydd and Ynysybwl, particularly in terms of ease of access, and that it is with regret that the service has become unsustainable. He ended by reiterating that the decision made is to support the future sustainability of the Taff Vale Practice for the 17000 patients it serves across all its sites, spanning an area of 35 square miles, and that they are committed to delivering an action plan to mitigate the impact on the affected communities.

The Chair next invited Cllr Amanda Ellis, Borough Councillor for Ynysybwl, to represent the views of her constituents, and in the absence of Hywel Gronow, Borough Councillor for Cilfynydd, who unfortunately was unable to attend the Board, the views of the Cilfynydd constituents.

Cllr Amanda Ellis, Borough Councillor for Ynysybwl

Cllr Ellis provided a joint statement for Cilfynydd and Ynysbwl, and whilst recognising the difficult decision and position of the Taff Vale Practice highlighted the following key concerns, and drew attention to annex 2 contained within the Board report.

- The views of the residents have been sought and it is clear from annex 2 that the decision is not supported.
- Public transport arrangements are not sufficient to provide timely and efficient access to the three remaining branch sites (Rhydyfelin, Glyncoch and Dewi Sant Health Park). Residents are also concerned in terms of increased cost implications for additional travel, unreliability of the service, limited access for those requiring additional support and inadequate provision for wheelchair users and those with pushchairs.

- Fear that those requiring care will not attend the GP due to access difficulties, particularly those that may have mobility needs, resulting in potential undiagnosed conditions.
- Parking at Dewi Sant Health Park and the main practice in Rhydyfelin is extremely difficult.
- Whilst residents may recognise that the distance to the surgery in Glyncoch may be shorter, there are concerns in terms of public transport access as the surgery is based at the top of a steep hill which is not a stop on the bus route.

In concluding the joint statement Cllr Ellis reiterated that the recommendation is rejected by the communities impacted and posed the following questions. Cllr Ellis also asked the Board to consider if they have received sufficient assurance to make a decision which aligns to the values of the Health Board.

- What does the Community Transport Developments look like?
- How will the practice manage patients who arrive late for their appointments as a result of unreliable public transport arrangements?
- Has the Health Board considered increasing the use of Sardis Road car park for staff in order to release car parking spaces for patients at Dewi Sant Health Park? Noting the continuing impact of this also being a vaccination clinic site.
- What is the criteria and capacity for Home Visits?
- What will be done to support recruitment of staff for surgery sites moving forward?
- Is the closure of the Ynysybwl site being driven by the retirement of the General Practitioners and their wish to sale the site?
- Have all avenues been explored and why is this different to previous promises to open sites over the last few years – why should residents believe the mitigating action will be taken this time?
- What reassurance can be provided in terms of the impact on the other surgery sites within the Taff Vale Practice and also those outside of their practice if patients choose to register elsewhere?

The Chair invited David Miller, Medical Director for CTMUHB's Primary Care and Community Care Group to respond to Cllr Ellis's questions as well as outlining the Care Groups position.

David Miller, Medical Director for CTMUHB's Primary Care and Community Care Group

D Miller stressed that this recommendation is based on the future sustainability of the Taff Vale Practice for its entire patient population and their commitment to deliver the mitigations outlined in the reports to support the communities who will be impacted by the closure of the Cilfynydd and Ynysybwl surgeries.

D Miller advised that when the Primary Care Contract Variation Group first received the application no decision was made and a public engagement exercise

	was commenced with the involvement of Llais Cymru. He drew attention to the correspondence from the Regional Director of Llais Cymru (Appendix 4) which noted that they welcomed the open approach the Health Board and Taff Vale Practice had taken in regards the engagement around the proposed service change. In response to the questions posed by Cllr Ellis, D Miller highlighted the following points: • The concerns of the communities have been recognised and the impact acknowledged in the proposal. • The difficult decision to close the two sites was accepted by the Primary Care Contract Variation Group noting the extremely complex challenges being faced. • The decision supports the direction of travel for the practice in terms of meeting national policies such as Healthier Wales and the Primary Care Model which would not be possible across all five sites. • In terms of access and quality of service provided, it was reiterated that the two branch sites had not been opened since pre-covid-19 pandemic and there had been no significant concerns raised previously. • The Public Transport concerns are recognised and there is a commitment to work with the Local Authority to improve the service, particularly the points raised in relation to the Dewi Sant Health Park. • The Primary Care and Community Care Group are committed to work on a robust action plan with Taff Vale Practice to mitigate the concerns and hold the practice to account for delivery of the mitigating actions they have set out. • Home visit demands will be monitored. • Engagement with Community Pharmacies and Community Centres is being explored to increase the services they can offer closer to home and within the communities impacted. • The role of the Health Board as commissioner of the primary care service includes monitoring the impact of this decision across all its primary care providers. S Webb added that there had been no previous plans to close the two branch sites. He acknowledged that the Covid-19 Pandemic had triggered the closure due to the availability of staff to manage all sites. He noted that there was an attempt to reopen previously, however, the buildings had since gone in to a state of disrepair and staffing capacity was also a significant factor that prevented the practice in regrettably not being able to re-open the two sites. S Webb also noted that home visit appointment capacity had been increased and that access to these appointments is based on clinical need. He also stressed that no patient will be refused an appointment with the GP if they arrive late for their appointment due to public transport challenges. He noted that the length of wait following late arrival will again be based on clinical need.

	Prior to opening the discussion for questions from Board Members, G Hughes reiterated that this was a decision reached by balancing the access of communities to branch sites against the ability of Taff Vale Practice to sustain a service to all 17000 patients across their patch against a backdrop of increasing population health needs with greater complexity and changing workforce models in primary care practice. Llais Cymru did not wish to make a formal representation to the Board as their position is clearly outlined in the Regional Director letter in appendix 4. The Chair invited questions from Board Members. G Hopkins queried whether there is any data to support how many patients may have encountered transport challenges during the temporary closures? In response, S Webb advised that this data is not collected, however, his reflections are that there has only been a small number of concerns raised. He provided assurance that when access challenges are raised with the practice they will manage this on a case by case basis by offering home visits, video consultation, phone call etc. based on clinical need. R Rowlands firstly declared that whilst a resident of Ynysybwl she is not a registered patient of Taff Vale Practice. R Rowlands posed the following questions: • What efforts had been undertaken before the Covid-19 Pandemic to address the challenges being faced? What other solutions have been considered? • How confident are the practice that if patients register with other branch surgeries or surgeries outside the Taff Vale Practice that patients will not be impacted with longer waiting times for appointments? • More detail is required in the action plan to address the impact of winter weather conditions, how many patients on the practice list have access needs. • The transport links is clearly a significant issue that needs to be prominent in the mitigating actions. • How are we learning from this experience as an opportunity to better understand our communities and what is important to them? In response, D Miller confirmed the following from the Primary Care and Community Care Group position: • Reassurance that the public engagement was undertaken in good faith and whilst it may not have changed the recommendation before the Board it has influenced and shaped the mitigating action that will be taken forward. • Should the recommendation be approved those communities affected will receive correspondence outlining the decision and mitigating plans. This correspondence will also be shared with other practices as appropriate. • It is recognised that whilst this is currently a position Taff Vale Practice is facing, it is acknowledged that other practices have similar challenges and the Primary Care Team at the Health Board will continue to respond, support and monitor the position in all practices.

- Whilst the action plan currently outlines high level headlines it will be built upon and it is the intention of the Taff Vale Practice to establish a Patient Participation Group to support the development of the mitigating action in a collaborative way.

P Mears commented that this is a stark reflection of the reality being faced in primary care services across CTMUHB, Wales and the UK as a result of growing demand, an ageing population and challenges in terms of finance and estate. He stated that the Health Board needs to elevate the primary care discussions to address challenges and work with its communities, stakeholders and partners to consider how best the primary care model is delivered. He further stressed the importance of the Health Board working within its partners to influence a community based model of transport for patients. He also noted the opportunity to work with Pharmacies to provide alternative models of care to protect GP capacity.

H Lentle welcomed the discussion on the longer term actions that will be taken, however, sought assurance on the immediate/short term actions which will be implemented to ensure that the service to patients affected is managed whilst the longer term plans are explored i.e. online calls, home visits and asked how the Board will monitor the position.

J Morgan stated that should the Board take a decision on this action today it needs to be assured that lessons will be learnt and that it will help shape the future of the primary care provision. He stressed the need to ensure that communities feel connected through effective transport provision and urged G Hopkins and Cllr Ellis to take this forward in their roles in terms of the robustness of commissioning plans for local transport services as this needs to be achieved in partnership.

In response, primary care colleagues provided the Board with examples of activity which demonstrated the commitment to reshaping the primary care provision.

P Mears recognised the need to ensure that the mitigating actions needed to be described clearly in communication to patients.

P Daniels reflected upon the inverse care law where those that need the care the most often have the least access and are less likely to have their voices heard. He stressed the importance of proportionate universalism in ensuring that the resourcing and delivery of services is at a scale and intensity proportionate to the degree of need. He commented that advances in technology is providing a supportive shift, however the Health Board must continue to focus upon those in greatest need.

In bringing this item to a close G Hughes concluded that the Health Board as commissioners will need to hold the practice to account in delivering the actions as it is the responsibility of the Health Board to protect its population's needs. He confirmed that all the comments, suggestions and areas of improvement

	identified will be captured within a robust action plan and proposed that the Primary Care Team share further updates at future Planning, Performance & Finance Committees in terms of securing Board oversight and assurance on delivery of the mitigating actions. The Chair concluded discussions by seeking the Board Members decision on the recommendation to close the two branch sites (Cilfynydd and Ynysybwl). Unanimous approval was reached in support of the recommendation put forward. The Chair thanked Cllr Ellis for joining the Board today and hoped that she found that the discussions demonstrated the utmost importance the Board applied to this decision. Cllr Ellis thanked the Board for their time and noted that she looked forward to working with the Board in future.
Resolution:	NOTED the process that has been undertaken including the level of response from the public engagement programme and the submission from Llais Cymru. NOTED the recommendation of the Primary Care Contract Variation Group to support the permanent closure of Ynysybwl Branch Surgery and Cilfynydd Branch Surgery. APPROVED the application to permanently close the branch sites located in Cilfynydd and Ynysybwl.
Action:	Primary Care and Community Care Group to provide future updates to the Planning, Performance & Finance Committee for assurance and oversight of the implementation of the mitigating actions that will be taken in response to the closure of the two branch sites.
4.	BREAK
5.	MAIN AGENDA PART 2
5.1	Listening and Learning Story
	The Chair welcomed D Parry and Joanne Cotter to the Board and thanked Joanne for her bravery in sharing her story. D Parry explained how Joanne's son, baby Elijah, was admitted to the paediatric ward, required transfer to a tertiary centre and following that to a specialist cardiac unit where the he sadly passed away. She reflected how the learning from Joanne's story has led to lessons being learned to improve patient experience. J Cotter shared her story of her maternal care and Elijah's subsequent admission to the paediatric unit. She drew attention to episodes of poor communication from health care professionals that she experienced whilst in the care of the Health Board and how these had significantly impacted her during this deeply distressing and heart breaking time.

	Board Members expressed their sincere condolences for Joanne's loss and their sincere apologies for the poor experiences she received. The Board were extremely impacted by Joanne's powerful story and once again thanked her for her bravery and strength in sharing her experience with the Board and allowing the Board to learn lessons. D Parry reflected on the learning which had been identified and shared the improvement actions that have been implemented as a result. She also noted that Joanne had agreed to join the relevant patient experience forums within the Health Board to share her story and identify opportunities to help others. P Mears stressed the importance of colleagues recognising the impact of their words with each interaction they have with patients and/or their families and directed Clinical Executives to explore how the Health Board can continue to build communication skills training into ongoing training as a regular refresher and embed the learning from real time experiences shared by patients and their families. C Donoghue recognised the power and impact of hearing lived stories and perspectives and how this can influence change. She reflected on her recent "15 Steps" visit in maternity and how this provided a really broad range of feedback. S Bolt in her role as Chair of the Clinical Advisory Group committed to sharing Joanne's story with colleagues in that forum to increase awareness and learning. G Dix explained how the Health Board is analysing its complaints in terms of communication themes and that regrettably the data supports the experience Joanne shared, and therefore this is an area of focus. He also reflected on the role of the Patient Experience Forum and how he will ensure they will hear Joanne's story. G Hughes reflected how having heard Joanne's story he urges all Board members to share this story so that everyone in the Health Board knows Elijah's name and that in hearing Elijah's name this will trigger a reflection to prevent Joanne's experiences being repeated. In concluding, J Morgan reiterated the commitment of the Board to learn from Joanne's story.
Resolution:	The powerful story was RECEIVED by the Board and learning recognised.
Action:	To collectively as a Board take forward the learning from Joanne's shared experience.
6	SETTING THE SCENE
6.1	Chairs Report
	The Chair presented the report and highlighted the key matters for Members' attention.

Resolution:	The Board NOTED the report and ENDORSED the Affixing of the Common Seal.
6.1.1	Action Log
	The Chair presented the action log and drew Members attention to actions that remain open and in progress.
Resolution:	The action log was NOTED.
6.2	Chief Executive's Report
	P. Mears presented the overarching report that highlights key areas of activity of the Chief Executive, drawing particular attention to the Health Board's escalation status, the Acute Clinical Service Plan and the change in title for the Executive Director of Therapies and Health Science. He also drew attention to the Executive Director priorities that highlighted the key strategic focus of the Executive Team over the next 12 months. It was noted that these priorities will be received by the Board on a quarterly basis and will also align to key dependencies and strategic risks captured in the Board Assurance Framework. K Palmer expressed concern that the primary care transformation process lacked visibility in the priorities for the Executive Team. In response, P Mears provided assurance that there is a session planned with Primary Care colleagues to develop a strategy to support the Primary Care Future Model of Care. He also noted that the Acute Clinical Services Plan programme of work also addresses the broader out of hospital services. Whilst not captured in the report due to timings, P Mears took the opportunity to advise the Board that the Health Board had received a "Letter Before Action" relating to a Judicial Review application relating to the Emergency Medical Retrieval and Transfer Service (EMRTS) Service Review. He confirmed that the legal team has been instructed to support the Health Board in responding to the action.
Resolution:	The Board NOTED the report.
Action:	Corporate Governance Team – add Executive Priorities to Board Cycle of Business.
7.	GOVERNANCE, RISK AND ASSURANCE
7.1	Board Committee and Advisory Group Highlight Reports
7.1.1	Digital & Data Committee 21 May 2024
	I. Wells presented the report that updated members on the items the Digital and Data Committee wished to escalate to the Board following the meeting held on 21 May 2024. He drew particular attention the concerns raised by the Committee on National IT Programmes and referred to the spotlight presentation (agenda item 8.3) and advised that the digital and data arrangements for the new Joint Commissioning Committee are being finalised.

Resolution:	The Board NOTED the report.

7.1.2	Quality & Safety Committee 16 May 2024
	C Donoghue presented the report that updated members on the items the Committee wished to escalate to the Board following the meeting held on 16 May 2024. She also took the opportunity to update the Board on the following escalation matters considered by the Committee on the 23rd July 2024: • Powerful Listening and Learning story received on the onboarding of patients with experiences of a patient and staff members shared. She expressed the concerns raised by the Committee relating to the challenges this brings in providing safe, effective and dignified care. • The fragility of stroke services was an area of significant focus in terms of the activity underway to mitigate the risks and challenges in this area. • Positive escalation was noted in terms of the Mental Health and Learning Disabilities commitment to quality improvement priorities, Health Inspectorate Wales acceptance of the Ty Llidiard action planning meaning all actions now closed, and the collaborative work of the Unscheduled Care Group and the Welsh Ambulance Service to review learning around emergent care. It was noted that the highlight report noting the other matters considered will be received at the Board meeting in September 2024. L Thomas asked that the onboarding listening and learning story be shared with the entire Board.
Resolution:	The Board NOTED the report.
Action:	Corporate Governance Team to share listening and learning story relating to onboarding with all Board members.
7.1.3	Population Health & Partnerships Committee 20 May 2024
	C Donoghue presented the report that updated members on the items the Committee wished to escalate to the Board following the meeting held on 20 May 2024, drawing particular attention to the concerns relating to the risk of rising childhood obesity rates.
Resolution:	The Board NOTED the report.
7.1.4	Stakeholder Reference Group Highlight Report 11 July 2024
	A. Morris presented the report that updated Members on the items the Stakeholder Reference Group wished to escalate to the Board following the meeting on 11 July 2024, and sought approval from the Board to support the group's recommendation to extend membership to a member of the CTMUHB Racial Equality Network.
Resolution:	The Board NOTED the report and APPROVED RATIFICATION the change to SRG membership to include representation from the Racial Equality Network.

7.1.5	Hosted Bodies Audit & Risk Committee Highlight Report 20 June 2024
	G Watts provided Members with an update on the items the Hosted Bodies Audit & Risk Committee wished to escalate to the Board following the meeting held on the 20 June 2024. He drew attention to the key matters being taken forward following the establishment of the Joint Commissioning Committee (JCC) on the 1st April 2024. He also noted the appointment of Georgina Galletly as the Transformation Director at the JCC, and advised he is working closely with G Galletly to ensure that there are appropriate governance and accountability arrangements established.
Resolution:	The Board NOTED the report.
7.2	Escalation Status
	The Chair, advised Board Members that an update on Escalation status was included in the Chief Executives report at agenda item 6.2.
Resolution:	Not applicable.
7.3	Board Assurance Framework
	G. Watts presented the Board Assurance Framework update report which was received by the Executive Leadership Group on 15 July 2024 and highlighted the following points: • Strategic Risk 1 – *Sufficient Capacity to meet elective and emergency demand.* This risk has now been split to represent elective and emergency care separately due their differing trajectories. These are now represented as Strategic Risk 1a and 1b in Appendix 1. • The Executive Director of Finance is developing a new Strategic Risk for the BAF in relation to Capital and Estates which is being developed and risk assessed by the Assistant Director of Planning (Capital and Estates), with the support of the Assistant Director of Governance & Risk as required. • The People Team are undertaking a thorough review of the following risks to ensure they remain reflective of the current risks. This has been delayed due to staffing capacity within the team. o Strategic Risk 6 - Leadership and Management o Strategic Risk 7 – Culture, Values and Behaviours I Wells sought clarity on why the report retained strikethrough narrative identified in red colour font. In response, C Hamblyn advised that to ensure transparency prior to any previous updates being removed the Board will have visibility ahead of it being removed in the next iteration of the report. K Palmer challenged the assessment of the risk score for the strategic risk relating to digital and data and queried if this should be increased in light of ongoing challenges around national programmes and the electronic patient record. Following discussion and points also raised by L Curtis Jones, S Morris agreed this was a fair challenge and he will review the score outside of the meeting.

Resolution:	The Board APPROVED the updates reflected in the Board Assurance Framework.
Action:	S Morris to review the risk score of Strategic Risk 5 - Delivery of a digital and information infrastructure to support organisational transformation.
8.	DELIVERING OUR PLAN
8.1	Integrated Performance Dashboard Point 1
	The Chair invited G Hughes to present on the operational performance section of the report. G Hughes drew particular attention to the following key areas: • Cancer performance remains a high priority with a focus on improving the target of patients starting their cancer treatment within 62 days. Although an improvement was noted in May the position remains volatile and the picture will change as a result of the significant activity underway. • Compliance for the proportion of therapeutic interventions starting within 28 days following an assessment by Local Primary Mental Health Support Service greatly improved during May to 76.3%, falling just short of the target. Whilst still in Targeted Intervention for Children and Adolescent Mental Health Services (CAMHS) this has been reduced to monitoring through the Integrated Quality Performance and Delivery (IQPD) meetings. • Diagnostics: Over the past 12 months the number of patients waiting less than 8 weeks prior to receiving their test has more than halved. The mobile scanner at the Llantrisant Health Park has supported this position. Additional work is planned this weekend to improve the position on cardiac investigations. In summary, the Health Board is on track with its diagnostic plans. • Referral to Treatment (RTT) performance is on track with CTMUHB having the lowest cohort in Wales. Number of interventions across specialities and it is hoped that the position will be zero by the end of August. • Unscheduled Care still seeing significant demand upon services similar to volumes that would be expected in January. This can be attributed to volume, acuity of patients, current infection control challenges and operational pressures. • 15 Minute Handover continues to be an area of significant concern and links were made back to the Quality & Safety Committee's escalation to the Board around onboarding. Target set to achieve a 10% reduction in handover delays by Christmas. • Index rate for Bowel Screening improved, however, continued volatility should be recognised. The Health Board is working closely with Public Health Teams to increase the number of approved endoscopists. The Chair invited G Dix to present the key quality performance highlights. G Dix drew particular attention to the following: • C Difficile infections are increasing with data suggesting that 30% are hospital onset infections. Whilst patients are developing the infection whilst

	in hospital there are minimal numbers of cross contamination. The challenges of antibiotic resistance was noted. • The Health Board is seeing a continued reduction in E.coli infections with a significant focus on catheter care in terms of maintenance and insertion. • Lapses in infection control precautions such as handwashing, bare below the elbow and personal protective equipment have been identified and this is an area of focus for the newly appointed Head of Nursing for Infection Prevention Control (IPC) in reviewing audit activity and reiterating the importance of challenging in the moment. S Blackburn advised that the Communication and Engagement Team will be using its communication channels for an IPC awareness campaign over the next 6 months. • Continued drop in formal complaints. Noted an improvement in the management of on the spot complaints and the increased Patient Advice and Liaison Service (PALS) is positively impacting this position. • Analysis of complaint themes underway with communication being the key theme identified. The People Performance section was noted. I Wells queried the reference to Spa Medica in relation to the regional ophthalmology activity. In response, G Hughes explained that Spa Medica were providing additional capacity for cataracts surgery and are now part of the regional capacity plan. K Palmer sought clarity on the visibility at Board of the learning disability service and Board level oversight of commissioning services. G Hughes agreed to address this issue with K Palmer outside the meeting. L Curtis-Jones sought assurance that the Board were learning from others in relation to the adult mental health targets. In response, G Hughes assured the Board that benchmarking and sharing of good practice is undertaken. He noted that workforce reconfiguration in a tiered approach is underway, however, noted the capacity challenges. He further noted that as a result of waiting list initiatives and outsourcing the position is improving but recognised that this is not at the pace the Health Board would like. L Curtis-Jones also drew attention to poor compliance with the target for ADHD / ASD Neurodevelopment Assessment (ND). Following discussion which recognised the increasing demand and the need to work collaboratively with education partners to target the right patients, L Prosser agreed to bring a report back to Board on ND Services activity. The Covid-19 hospital infection rates were queried by the Chair and the Board were assured that the service teams are risk assessing daily with support from IPC colleagues to take responsive risk based action where needed, decisions are also taken with a view to balance the challenges ward closures would bring in terms of the onboarding / ambulance handover activity.

	The Chair commended G Hughes and the operational teams for the concerted efforts being taken to improve performance which is a key area of focus of the Health Minister as well as the Health Board. P Mears echoed the thanks and also noted that the Health Board needs to work with primary care to ensure the optimal design of health pathways from primary care to secondary care which will help the performance trajectories. It was agreed that a future Board Development Session would be used to explore this activity and invites would be extended to the Service Director and Medical Director of the Primary Care and Community Care Group as well as Community Pharmacists. R Rowlands referenced the recent report published by the Older People's Commissioner for Wales, "Access to GP Practices in Wales: Older people's experiences – Progress update" and was assured that this had been shared with key colleagues within the Health Board. P Daniels noted that he is part of a programme of work that is designing as system wide health protection strategy with key partners. He noted that the newly appointed Head of Nursing for IPC is part of those discussions. The Chair thanked the Board for the robust scrutiny of the report.
Resolution:	The report was NOTED
Action:	G Hughes to contact K Palmer outside the meeting to discuss the visibility at Board of the learning disability service. L Prosser to bring a report back to a future Board meeting on Neurodevelopment Services activity. G Hughes and G Watts – to identify a session in the Board Development programme for further exploration on the optimal design of health pathways from primary care to secondary care, with invites extended to the Service Director and Medical Director of the Primary Care and Community Care Group as well as Community Pharmacists.
8.2	Month 3 Finance Update
	S May presented the Month 3 Finance update report highlighting the following key areas of assessment: Overall Revenue position - 2024/25: • The M3 position was a £0.4m deficit in month. • The M3 YTD position is now a £2.7m deficit. • The main driver for the £2.7m YTD deficit is a £4.8m shortfall in savings delivery compared to the straight-line YTD savings target of £6.6m (£2.2m per month), plus adverse operating variance of £1.0m. These cost pressures have been offset by £3.1m of other improvements.

	• As at M3 the Health Board is continuing to forecast a break even position for 24/25. This is consistent with the break-even plan submitted to Welsh Government. • The key risks to the forecast break even position at M3 are estimated at £9.2m and these are summarised on Page 18 of the report. The main risk is the delivery of the £26.3m savings target. Recurrent Revenue position: • The brought forward recurrent deficit at the end of 2023/24 was £19.4m. • The planned recurrent surplus at the end of 2024/25 is £2.1m. However, the Health Board is currently off plan at M3 and this presents a risk to the both the 'In year' forecast and the 'recurrent forecast'. A detailed review of the forecast recurrent position will be undertaken at M6. S May concluded by stating that the key focus is on expenditure and delivery of saving plans. The Chair referenced the reduction in Contracting & Commissioning costs compared to the financial plan and queried how this was achieved. In response, S May explained the activity which had led to the improving position. S May also took the opportunity to advise the Board that in relation to LTA arrangements the Health Board is again in arbitration with Aneurin Bevan University Health Board and is awaiting the views of Welsh Government in response.
Resolution:	The Board NOTED the report.
8.3	Spotlight Report on Digital – Update on the Strategic Outline Case for an Integrated Healthcare System
	S Morris noted that this report provides the Board with an update on the work undertaken since the Board development session in March 2024 and also a request to approve the development of specifications for the evaluation and procurement of a strategic partner(s) for development of the Health Board's core Integrated Health Care System / Electronic Patient Record (EPR). S Morris stressed the importance of this development as it is central to the Health Boards Digital First Strategy and enabling CTM2030, regional working and any future Clinical Transformation Plans. The Board were assured that the developments would be modular based to support any capacity challenges as a result of the change and to be able to control and focus on any 'pinch points' along the way. The modular approach will be based on a process of assessment and informed decision making based on risk and need. S Morris recognised that this programme of work will require significant investment, and whilst no financial commitment is being sought at this meeting he advised that any procurement / commitment of investment will require

	subsequent approval in alignment with the Health Board Standard Financial Instructions. P Mears supported this proposal recognising that this activity is fundamental to the digital transformation journey to deliver care to the population and to be an employer of choice for our clinical workforce. C Donoghue endorsed this recommendation, however, expressed concerns in relation to the lack of pace of national programmes of work that has led to the Health Board being in this position. I Wells confirmed his support and noted the importance of a modular approach and the need to maintain validity of data. S Davies welcomed the clinical engagement in this activity as this will be vital to its success. G Hughes commented how this would allow the Health Board to transform the way in which it offers services to patients and staff. S May advised that Welsh Government and Ministerial approval are likely to be required for these schemes and reiterated S Morris's point that any approval will be sought in accordance with the appropriate process for capital and revenue business cases. In concluding the item the Chair commended S Morris for his efforts and significant progress being made in this area.
Resolution	The Board NOTED the contents of the report and APPROVED the development of specifications to procure a Strategic Partner(s) for the implementation of a Modular Integrated Care System / Electronic Patient Record.
Action	No actions identified. The next steps were set out in the report.
8.4	Development of Plan to address Delayed Discharge Issues
	In response to a patient story the Board received in March 2024, which focussed on a patients discharge journey, the Board received a detailed presentation on the development of an integrated reablement service within Cwm Taf Morgannwg. Following the presentation which was welcomed by Board Members G Hughes explained how this is a practical approach to help address the discharge challenges faced by the Health Board which is impacting the health and continued wellbeing of its patients. P Mears welcomed the solution focussed approach as the benefits could clearly be demonstrated, however, he did acknowledge that caution should be taken to

	mitigate the risk of destabilising domiciliary care agencies and asked that the Health Board work jointly with social care to explore joint opportunities for future career pathways. This concern was recognised by L Curtis-Jones who stated she was keen to work jointly on this plan. P Mears reiterated the importance that this is delivered in tandem with social care colleagues as it is fundamental to the success of the patient receiving the appropriate care at home. A Cook-Young in response to a question posed by the Board confirmed that this model would have supported an improved discharge for the patient whose story he shared in March 2024. G Hopkins queried the use of the transformation fund in this initiative and asked if the initiative "Staying Well at Home" still exists, In response, L Prosser advised that the fund is supporting the staying well at home activity, however, is not sufficient to deliver all of what is required as outlined in this plan. I Wells sought assurance that patients discharged will have the appropriate support in place to access care in an emergency. G Hughes provided assurance that patients will only be discharged if deemed fit to do so and that in supporting their discharge there will be numerous care contacts throughout the day, district nursing visits where appropriate and provision of a Lifeline services where required. C Donoghue commended the team on the plan and requested that the evaluation of the service be built in from the start which G Hughes confirmed was captured within the Business Case. L Thomas reflected upon similar approaches underway in NHS England and offered to share learning if colleagues would find it helpful. Following further detailed discussion the involvement of third sector agencies was also recognised as a key support offering to patients once discharged. In concluding the item G Hughes drew attention to the following next steps outlined within the presentation: Working to a timeline to establish the revised service for late autumn • Completion of the Business Case (to come to Planning, Performance & Finance Committee in August) • Finalise the clinical staffing model including training competencies • Deliver the OCP for the revision to the existing services • Develop the operating model of the service Due to the timeframes set out the Board were asked to formally delegate approval of the business case to the Planning, Performance & Finance Committee in August which was agreed with an invite extended to all Board members.

Resolution	The Board NOTED the contents of the presentation and APPROVED the delegation of approval of the business case to the Planning Performance and Finance Committee in August 2024.
Action:	Corporate Governance Team – to extend invite to the August Committee to all Board Members noting that it will be considering the business case for the plan to address delayed discharge.
9	STRATEGIC PLANNING
9.1	Acute Clinical Services Plan
	L. Prosser presented the plan update and drew Members attention to key updates.
Resolution:	The Board NOTED the contents of the report.
10.	CONSENT AGENDA
10.1	FOR APPROVAL
10.1.1	Unconfirmed Minutes of the meeting held on 30 May 2024
Resolution	The Minutes were APPROVED.
10.1.2	Unconfirmed Minutes of the In Committee meeting held on 30 May 2024
Resolution	The Minutes were APPROVED.
10.1.3	Unconfirmed Minutes of the Extra Ordinary Board Meeting held on 11 July 2024
Resolution	The Minutes were APPROVED.
10.1.4	Committee Annual Reports
Resolution	The Committee Annual Reports were APPROVED.
10.1.5	Annual Duty of Quality Report
Resolution	The Annual Duty of Quality Report was APPROVED
10.1.6	Update to the Scheme of Delegation
Resolution	The update was APPROVED
10.2	FOR NOTING
10.2.1	Board Annual Cycle of Business
Resolution	The Annual Cycle was NOTED.
10.2.2	Board Forward Work Programme
Resolution	The Board Forward Work Programme was NOTED.
10.2.3	Board Committee and Advisory Group Highlight Reports

Resolution	The Highlight reports were NOTED.
10.2.4	Annual Plan Quarterly Update
Resolution	The Annual Plan was NOTED.
10.2.5	NHS Emergency Planning Annual Report - CTMUHB Return to Welsh Government
Resolution	The Annual Report was NOTED. Please see update under section 2 of these minutes.
10.2.6	Core Supporting Professional Activities (SPA) Guidance for CTM Consultants and Department Managers
Resolution	The Guidance was NOTED. P Mears drew attention to this significant guidance and its potential impact.
11	**CLOSE OUT BUSINESS**
11.1	Any Other Business
	The Chair advised that he had not been notified of any other business.
11.2	How did we do in this meeting
	The Chair sought any comments which attendees may wish to make in respect of improvement at that point or within two weeks of the meeting to provide feedback in respect of the issues that were covered and in the way in which the meeting had been run and how future meetings could be improved.
12	**PRIVATE / IN COMMITTEE SESSION**
12.1	The Chair advised there were no items requiring In Committee discussion on this occasion.
13	**DATE AND TIME OF THE NEXT MEETING**
13.1	The next scheduled meeting of the Board held in public will take place on Thursday 26 September 2024. The CTMUHB Annual General Meeting will also be held on Thursday 26 September 2024.
14	**CLOSE OF MEETING**

Agenda Item
9.1.2

CTM Health Board

Board Committee Annual Reports

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Audit & Risk Committee	15/08/2024	Endorsed for Board Approval
People & Culture Committee	07/08/2024	Endorsed for Board Approval

Acronyms / Glossary of Terms	

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

2.1 The Audit & Risk Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2023 – March 2024 and is attached at Appendix 1 for Board approval.

2.2 The People & Culture Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2023 – March 2024 and is attached at Appendix 2 for Board approval.

3. Key Risks / Matters for Escalation

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Safe

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to APPROVE the following Board Committee Annual Reports for the period 2023/2024:

- Audit & Risk Committee;
- People & Culture Committee.

Appendix 1

Audit & Risk Committee

Committee Annual Report 2023-2024

AUDIT & RISK COMMITTEE
ANNUAL REPORT 2023-2024

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2023-2024.

I would like to recognise the significant commitment of all the officers of the Committee who have supported and contributed to the work carried out and for their continued dedication in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales and Local Counter Fraud Services.

Going forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long term aim to help further strengthen the governance arrangements of the Health Board.

Patsy Roseblade
Chair of the Audit & Risk Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for Cwm Taf Morgannwg University Health Board (CTMUHB), which culminates in the production of the Accountability Report including the Governance Statement.

The Terms of Reference for the Committee were reviewed and were formally approved by the Board in May 2023. As part of the wider review being undertaken in relation to the Effective Management of Board Business the terms of reference are being reviewed and will be reviewed by the Board in September 2024.

Members will be aware that all papers relating to the Committee (unless closed or 'in-committee') are available on the Health Board website.

This report sets out the role and functions of the Audit & Risk Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective arrangements in place – through the design and operation of the Health Board system of 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.

The Organisation's system of internal control has been designed to identify the potential risks that could prevent Cwm Taf Morgannwg UHB achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur, and seeks to manage them efficiently, effectively and economically. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, the assurance framework may be strengthened and developed further.

The Committee's Terms of Reference are reviewed annually and are included within the Standing Orders for the Cwm Taf Morgannwg UHB.

3.2 MEMBERSHIP

The membership of the Audit & Risk Committee comprises of four Independent members, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2023-2024 is outlined in table 1 below:

Table 1 – Composition & Membership of the Audit & Risk Committee April 2023-March 2024

Name	Period
Members	
Patsy Roseblade (Committee Chair) Independent Member	April 2023 – March 2024
Jayne Sadgrove UHB Vice Chair/Independent Member	April 2023 – August 2023
Kath Palmer UHB Vice Chair/Independent Member	November 2023 – March 2024
Ian Wells Committee Vice Chair/ Independent Member	April 2023 – March 2024
Carolyn Donoghue Independent Member	April 2023 – July 2023
Geraint Hopkins Independent Member	July 2023 – March 2024

3.3 ATTENDEES

As Executive leads for the Committee the Executive Director of Finance and the Director of Corporate Governance/Board Secretary attend every meeting as do members and are often accompanied by members of the respective teams. The Committee's work is also informed by reports provided by Audit Wales, Internal Audit, Local Counter Fraud Services and CTMUHB personnel. Although they are not members of the Committee, auditors and other key personnel are expected to attend each meeting of the Audit & Risk Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed by the Audit & Risk Committee.

3.4 ATTENDANCE AT AUDIT & RISK COMMITTEE 2023-2024

During the year, the Committee met on seven occasions.
*Two Extra Ordinary meetings were held during this period - one of which was devoted to the draft Approval of the Annual Accounts (21 June 2023) and one

of which was devoted to the Approval of the Annual Accounts and Annual Report (26 July 2023). All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

In Attendance	19 April 2023	21 June 2023	26 Jul 2023*	16 Aug 2023	24 Oct 2023	19 Dec 2023	22 Feb 2024	Total
Patsy Roseblade Committee Chair/Independent Member	✓	✓	✓	✓	✓	✓	✓	7 / 7
Jayne Sadgrove – Health Board Vice Chair/Independent Member (until August 2023	✓	✓	X					2 / 3
Ian Wells – Independent Member/Committee Vice Chair	✓	✓	✓	X	✓	✓	✓	6 / 7
Carolyn Donoghue – Independent Member (until July 2023)	✓	✓						2 / 2
Kath Palmer Health Board Vice Chair/Independent Member (from November 2023)						✓	✓	2 / 2
Geraint Hopkins – Independent Member (from July 2023)			X	✓	X	X	X	1 / 5

4. AUDIT COMMITTEE BUSINESS

The Audit & Risk Committee provides an essential element of the Health Board's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

A Consent agenda approach was adopted across all Board and Committee meetings during 2020 and has continued to be used since. This enabled a number of reports to be received by Members for approval/noting, with an opportunity provided to Members to raise questions against these items in advance of the meeting.

The Audit & Risk Committee agenda broadly followed a standard format, comprising of specific sections, which are outlined below:

4.1 Main Areas of Audit & Risk Committee Activity – Part 1

The agenda for each meeting followed a standard format, broken down into the following 6 main parts:

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda for Approval/Noting

The following written reports were received by the Audit & Risk Committee and considered accordingly:

- Unconfirmed Minutes;
- Action Log;
- Committee Annual Cycle of Business;
- Forward Work Programme;
- Amendment to the Standards of Behaviour Framework Policy – Declarations of Interest Form;
- Declarations of Interest & Gifts and Hospitality Report;
- Clinical Audit Annual Plan and Clinical Audit Annual Report 2023-2024;
- Audit Wales – Annual Audit Enquiries Letter Response;
- Audit & Risk Committee Annual Report;
- Audit & Risk Committee Terms of Reference;
- Audit & Risk Committee Effectiveness Self-Assessment;
- Annual Report Timetable 2023-2024.

It is important to note any member of the committee can request that an item planned for the consent agenda can be moved to the main agenda for discussion.

3. Main Agenda

4. Sustaining Our Future

The following reports were received for discussion:

- Local Counter Fraud Report;
- Counter Fraud Annual Report;
- National Fraud Initiative Progress and Outcomes;
- Counter Fraud Annual Self Review;
- Counter Fraud Draft Work Plan;
- Procurement and Scheme of Delegation Report;
- Post Payment Verification Annual Report and End of Year Update;
- Draft Annual Report and Draft Annual Accounts 2022-2023;
- Losses and Special Payments Report;
- Medical Rostering Six Monthly Progress Report;
- Medical Variable Pay – Rates Agreed above Cap;
- Financial Control Procedure – Medical Variable Pay – Summary of Authorised Breaches;
- Changes to the Welsh Risk Pool Agreement;
- CTMUHB ISO14001 Certification Progress Report;
- National Commissioning Review and the Establishment of the New NHS Wales Joint Commissioning Committee (JCC) Progress Report.

5. Improving Care

The following reports were received for discussion:

- Audit Recommendations Tracker;
- Audit Tracker Automation Update;
- Annual Review - Risk Management Framework
- Consultant Job Planning – Six Monthly Progress Reports;
- Medical Rostering Progress Report;
- Organisational Risk Register;
- Internal Audit – Prince Charles Hospital Redevelopment Programme Integrated Audit Plan 2022-2023;
- Annual Internal Audit Plan and Internal Audit Charter;
- Learning from Events Report;
- Endoscopy JAG Accreditation Closure Report – Progress and Associated Risk Mitigation Verbal Report;
- National Review of Consent to Examination & Treatment Standards in NHS Wales – Final Welsh Risk Pool Report;
- Draft Annual Report and Annual Accounts 2022-2023.

Also received under this section were reports from:

- Internal Audit

NHS Wales Shared Services Partnership are the appointed Internal Auditors to the Health Board and provide an update on progress against the internal audit annual plan of business at each meeting together with finalised reports for each area that was subject to audit.

Each report contained an assessment on the level of assurance provided. Follow-up action was agreed for recommendations raised, which informed future audit plans.

- External Audit

The Auditor General for Wales (AGW) is the statutory external auditor for the Health Board. The AGW has a wide range of audit and related functions, including auditing the accounts of the Health Board, and reporting on the economy, efficiency and effectiveness with which the Health Board has used their resources. The AGW undertakes his work using staff and other resources provided by Audit Wales. The Engagement Lead and or the Financial Audit Manager from Audit Wales provide an Audit Position Statement at each meeting, summarising progress against its planned financial audit work. Additionally, the Performance Audit Manager will attend work to update the Committee on performance audit work in relation to local audit work, national studies and the Structured Assessment

4.2. MAIN AREAS OF AUDIT COMMITTEE ACTIVITY – PART 2 HOSTED BODIES

During 2023/2024 The organisations hosted by the Health Board are the Welsh Health Specialised Services Committee (WHSSC), the Emergency Ambulance Services Committee (EASC) and the National Imaging Academy for Wales (NIAW). On the 1st April 2024, the NHS Wales Joint Commissioning Committee (JCC) was established in response to the findings of an independent review commissioned by Welsh Government into the national commissioning arrangements undertaken by the Emergency Ambulance Services Committee (EASC), the Welsh Health Specialised Services Committee (WHSSC) and the National Collaborative Commissioning Unit (NCCU). From April 01 2024, the JCC replaced EASC and WHSSC and has assumed responsibility for the services previously commissioned by these committees.

Regular, standing agenda reporting to the CTMUHB Audit & Risk Committee for Hosted Organisations include;

- Internal and External Audit Plans
- Internal and External Audit Reports with completed management action plans
- Progress reports against audit recommendations (Audit Tracker) NB - to be highlighted to Joint Committee and/or Lead Sponsor if progress is deemed unsatisfactory
- Assurance Framework Report and Risk Register
- Compliance and activity governed by CTMUHB Standards of Behaviour Policy (i.e. Declarations of Interest, Gifts & Hospitality)
- Single Tender Actions
- Breach or waivers to Standing Orders and/or Standing Financial Instructions

To support the Audit & Risk Committee requirements for EASC, WHSCC and the NIAW the Health Board's Audit & Risk Committee is separated into two parts, specifically Part 1 for Health Board business and Part 2 for the Hosted bodies. The relevant officers attend for the relevant components of the meeting.

The Director of Corporate Governance/Board Secretary for CTMUHB also attends both parts of the meetings. The CTMUHB Executive Director of Finance also commenced attending the Hosted Bodies part of the meeting from February 2023.

The WHSSC, EASC and NIAW have shared the same External and Internal Audit teams and Local Counter Fraud Services (LCFS) with CTMUHB. All these factors enable CTMUHB to take necessary assurances from the hosted bodies, particularly in relation to the Accounts and the Annual Governance Statement and vice-versa for areas carried out by CTMUHB as part of its hosting responsibilities.

4.3. WORK/ACTION LOG

In order to monitor progress and any necessary follow up action, in line with recognised 'house style' templates a work log is maintained to capture all agreed actions from the Audit & Risk Committee and Joint Committees. This provides an essential element of assurance both to the Committee and from the Committee to the Board.

5. INTERNAL AUDIT - OVERALL SUMMARY

In overall terms for the year 2023/2024, the Head of Internal Audit opinion provided Reasonable Assurance to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the relevant assurance domains. The full opinion report was presented to the Audit & Risk Committee in July 2024 and is available on the link here

A breakdown of the internal audits results presented to the Audit & Risk Committee and the Board in 2023-2024 is presented at Appendix 1 for information.

A breakdown of the Audit results for the Hosted Bodies presented to the Audit & Risk Committee and the Board in 2023-2024 is presented at Appendix 2 for information.

A number of follow up audits were also undertaken within key assurance areas, a list of which is detailed in appendix 1 & 2, together with the respective assurance ratings.

6. EXTERNAL AUDIT

6.1 Audit Wales Audit Wales provide a progress report at each meeting, covering both probity and performance audits. The audit strategy, audit letters and statements of responsibilities were received and the ISA 260[1] Report was approved as part of the Accounts approval process.

The following performance reports and management responses were also discussed during the year, with attendance from UHB Officers where considered appropriate:

- Audit Wales Audit & Risk Committee Update (at each meeting);
- Audit Wales Audit Plan 2023;
- Audit Wales Forward Work Programme 2023-2026;
- Audit Wales/Healthcare Inspectorate Wales Joint Review Follow Up Report;
- Audit Wales Structured Assessment;
- Audit Wales Audit of Accounts Report Addendum;

6.2 Approval of the Annual Accounts

A meeting of the Audit & Risk Committee was convened on 26 July 2023 to scrutinise the 2022-2023 Annual Accounts prior to approval by the Health Board including the letter of representation to Auditors and the Annual Governance Statement. The 2022-2023 Annual Accounts were scrutinised and approved by the Board on 27 July 2023. The meeting also scrutinised the Accounts and Statements for 2022-2023 from the Health Board's hosted organisations as appropriate. The 2023-2024 sign off accounts will be reported in the 2024-2025 Annual Committee Report.

7. PRIVATE MEETING WITH AUDITORS

In line with recognised good practice a private meeting between Audit Committee members, Internal Audit, External Audit and the Local Counter Fraud Specialist can be held as and when required. This provides an opportunity for free and frank discussion. The Audit & Risk Committee Chair also meets privately with Internal Audit and External Audit on occasions. This process will continue for 2024-2025.

8. LINKS WITH OTHER COMMITTEES

8.1 Other Sub Committees

The Audit & Risk Committee has close links with the Quality & Safety Committee and other Committees of the Board. Through either specific meetings or the regular Independent Member meetings there is an opportunity

[1] Auditors are required by International Standard on Auditing (ISA) 260 - Communication with those Charged with Governance - to communicate audit matters of governance interest to those charged with governance. It is important that those charged with governance have an understanding of all significant issues that have arisen from the audit process. In the UK and Ireland this must be done in a written format. The communication is done through the issuance of an Audit Completion Report known as the ISA 260 Report. This outlines the findings of the auditors and any other issues the auditor may wish to raise with management.

for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

During 2023-2024, a Committee Referral process continued to be adopted for all Committees where the following three questions were posed by the Committee Chair for each referral request:

- What are you referring?
- Why are you referring it?
- What is the outcome that you are anticipating for this referral?

The Chair of the Audit & Risk Committee provided a report to the Board after each meeting via the Committee Highlight Report.

9. LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to help reduce and maintain the incidence of fraud (and/or corruption) within CTMUHB to an absolute minimum. Work is undertaken in accordance with Welsh Government Directions to NHS Bodies on Counter Fraud Measures with adoption of Government Functional Standards: Counter Fraud NHS Requirements with which the Health Board is expected to comply.

Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan.

The Health Board commissions its Counter Fraud service from Swansea Bay UHB via Service Level Agreement. The Health Board maintains an accredited counter fraud specialist resource of 2.6 FTE. This is in line with comparable sized Health Board's within NHS Wales.

The Counter Fraud Team received 50 new referrals for investigation in 2023/24 with 13 investigations carried over from 2022/23. 44 investigations were closed in 2023/24 which resulted in the application of 5 civil sanctions. This investigation work led to the recovery of £33,438 of Health Board funds and an overall identified fraud prevention figure of £46,446.

A review of compliance with Government Functional Standards: Counter Fraud NHS Requirements is undertaken annually. The Health Board was required to self-assess on a RAG rated basis against these Standards across 12 requirement areas. The Health Board achieved an overall Green rating following review with improvement identified as required in relation to Requirement 3 – Risk Assessment which was assessed as Amber rated and Requirement 1b - Accountable individual which was rated Red due to a lack of nominated Fraud Champion, following the departure of the Director of Corporate Governance during this self-assessment period. Work plan actions have been agreed to improve these areas for 2024/25 and Green ratings are anticipated at the next review.

As part of its work, the Counter Fraud Department has a regular annual programme of raising fraud awareness within the Health Board for which a number of days are then allocated and included as part of an agreed Counter Fraud Work-Plan which is signed off, by the Health Board's Executive Director of Finance, on an annual basis.

In addition to this and in an attempt to promote an Anti-Fraud Culture within the Health Body, a quarterly newsletter is produced which is then made available to all staff on the Health Board's Intranet and all successful prosecution cases are also publicised in order to obtain the maximum deterrent effect. The Counter Fraud Team also deliver awareness sessions to staff, both general awareness aimed at all staff and bespoke sessions based on risks faced by staff assessed to be in roles at a higher level of potential exposure to fraud.

10. ASSURANCE TO THE BOARD

The Audit & Risk Committee provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the guidance contained in the NHS Wales Audit Committee Handbook.

10.1 Internal Control & Risk Management - In addition to the audit reports received by the Committee during the reporting period, a wide range of internally generated 'governance' reports/papers were produced for consideration by the Audit & Risk Committee.

10.2 Governance Statement - For the period 2023-2024 the Health Board produced its Governance Statement, which explains the processes and procedures in place to enable the Health Board to carry out its functions effectively. The Statement was produced following a review of CTMUHB's governance arrangements undertaken by the Board with the support of and the Board Secretary/Director of Corporate Governance. The Statement brings together all disclosures relating to governance, risk and control for the organisation. The Governance Statement is captured in the CTMUHB's Annual Report which is available via this link

10.3 Tracking of Audit Recommendations
The Committee has increased the focus on tracking the implementation of agreed audit recommendations and the clarity of reporting of this, which achieved improvement during the year and laid the foundations for the further improvements now being made in 2024/2025, in particular the transition to an automated system using AmAT.

10.4 Audit Committee Effectiveness Survey - A Committee Effectiveness Survey was undertaken in 2022-2023 to obtain feedback from Committee members on potential areas for development.

The statements used in the survey were devised in accordance with the guidance outlined within the NHS Audit Committee Handbook.

11. CONCLUSION AND FORWARD LOOK

The Audit & Risk Committee in discharging its scrutiny and assurance role on behalf of the Board considers that on the basis of the risk based work completed by the Committee during 2023-2024, that there are effective measures in place and that there are no outstanding issues that the Audit & Risk Committee wishes to bring to the attention of the Board.

The Directors have been held to account and have responded positively in dealing with any concerns raised by the Auditors and the Audit & Risk Committee.

This Annual Report will be supplemented by the annual self-assessment process, which will be undertaken via Microsoft Office Forms, which reviews the individual and collective function of the Committee against the NHS Audit Committee Handbook best practice guidance and helps to inform the work of the Committee going forward.

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2024-2025 in respect of:

- Reviewing audit outcomes and ensure actions are taken as a result of learning.
- The transition to an automated system for tracking audit recommendations and inspections, with the ambition to introduce trends and themes into reporting.
- Discharging effectively the Board approved Committee Terms of Reference, including the changes made in response to the Effective Management of Board Business Review.
- Increased reporting in relation to Declarations of Interest for the organisation.
- Ensuring all parties discharge their responsibilities appropriately as outlined within the Audit Charter.
- Continue to strengthen processes and resources in place to prevent and respond to fraud activity.

Appendix 1

List of Internal Audits Undertaken within Cwm Taf UHB 2023-2024 and Assurance Ratings

	Internal Audit Assignment	Assurance Rating 2023-2024
1	Arrangements for financial savings – centralised processes	Substantial
2	PCH – Quality – site supervisor role	Substantial
3	PCH – Validation of management actions	Substantial
4	Adult Mental Health CSG – Governance Arrangements	Reasonable
5	Adult Mental Health CSG – Risk Management	Reasonable
6	Adult Mental Health CSG – Workforce	Reasonable
7	Adult Mental Health CSG – Planning & Performance	Reasonable
8	Deprivation of Liberty Safeguards (DoLS)	Reasonable
9	Arrangements for financial savings – Enabling schemes	Reasonable
10	IT Infrastructure	Reasonable
11	IT service management	Reasonable
12	Leadership and management development	Reasonable
13	Management of controlled drugs	Reasonable
14	Risk management	Reasonable
15	Technical resilience	Reasonable
16	Welsh Risk Pool (Draft)	Reasonable
17	Follow up – Radiology workforce	Reasonable
18	Follow up – Medical variable pay (Draft)	Reasonable
19	Follow up – Digital operating model	Reasonable
20	Follow up – Reasonable offer (Draft)	Reasonable
21	PCH – Financial management and change control	Reasonable
22	PCH – Delivery of key project objectives (Draft)	Reasonable
23	Decarbonisation	Limited

24	Estates assurance (Draft)	Limited
25	Arrangements for financial savings – Care group processes	Limited
26	Gastro-Intestinal pathways – Demand management	Limited
27	Interventions Not Normally Undertaken (INNU)	Limited
28	Performance management of 4 hour target	Limited
29	Follow up – Patient pathway appointment management	Limited
30	Annual Governance Statement	Advisory & Non Opinion

	Substantial Assurance Rating	3
	Reasonable Assurance Rating	19
	Limited Assurance Rating	7
	Advisory & Non Opinion	1
	Total	30

**NB – the above does not include the internal audit ratings for the reviews undertaken for the hosted bodies.*

List of Internal Audits Undertaken 2023-2024 and Assurance Ratings within

The Welsh Health Specialised Services Committee (WHSCC)
&
The Emergency Ambulance Services Committee (EASC)

	Internal Audit Assignment	Assurance Rating 2023-2024
Welsh Health Specialised Services Committee (WHSCC)		
1	WHSCC – Welsh kidney network	Substantial
2	WHSSC – Integrated commissioning plan development process	Substantial
Emergency Ambulance Services Committee (EASC)		
1	EASC – Adult critical care transfer service	Substantial

PEOPLE & CULTURE COMMITTEE

Annual Report
2023-2024

FOREWORD

I am pleased to present this second Annual Report of the CTMUHB Committee which outlines the activity between 1st April 2023 to 31st March 2024.

The purpose of the Committee is to advise the Board on all matters relating to staff and workforce planning, the delivery of the organisational development and other related strategies to drive continuous improvement.

During the year my fellow Independent Members - Nicola Milligan as Vice Chair, Mel Jehu, Lynda Thomas have once again offered considerable knowledge and wide-ranging experience to the Committee. In July 2023 we welcomed our newest member, Geraint Hopkins who replaced Mel Jehu as a Member and whose knowledge and expertise has helped to strengthen the membership of the Committee. I would like to extend my thanks to Mel Jehu for his outstanding contribution to the Committee as a Member of the Committee from its onset.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Independent Members which are essential to the effectiveness of the Committee.

The People & Culture Committee is continuing to mature and build on its work plan and remit as outlined in the terms of reference. The contribution made thus far in terms of providing the Board with assurances in this regard has been important.

I commend this Annual Report to you.

Dilys Jouvenat
Chair of the People & Culture Committee 2023/2024
Independent Member

People & Culture Committee
Annual Report 2023/2024

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee for the year 2023/2024 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 'Cycle of Business' for 2024-25 was approved by the Committee at their February 2024 meeting. This is an important component in ensuring that the Committee effectively carries out its role.

1.3 The Annual Report reflects the Committee's responsibilities in terms of the development and monitoring of the Governance and Assurance framework with respect to people and culture issues.

2. Role and Responsibilities

2.1 The primary purpose of the 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 also provides 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. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Committee Vice-Chair, Executive Lead and Meeting Secretariat develop the final agenda using the cycle of business and forward work plan. Committee meeting dates being set out in advance.

3.2 The secretariat for the meeting is determined by 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

4.1 The revised Terms of Reference for the People & Culture Committee were last approved by the Board in November 2023 and are available on the Health Boards website via the following link: Standing Orders - Cwm Taf Morgannwg University Health Board (nhs.wales). As part of the wider review being undertaken in relation to the

Effective Management of Board Business the terms of reference are being reviewed and will be reviewed by the Board in September 2024. The people elements will be captured within the new Committee structure and the People & Culture Committee in its current form will no longer exist.

4.2 The Committee are asked to review the Terms of Reference, as part of the Annual Cycle of Business as a separate item on the agenda.

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 As of July 2023 the Committee revised its Independent Member membership of the Committee with a new member, Geraint Hopkins who replaced Mel Jehu.

5.3 During the year the Committee met on four occasions, May, August and November 2023 and February 2024.

Independent Member attendance at these three meetings was follows:

Name	People & Culture Committee
Dilys Jouvenat (Committee Chair)	4 out of 4
Nicola Milligan (Committee Vice-Chair)	4 out of 4
Mel Jehu (until July 2023)	0 out 1
Lynda Thomas	2 out of 4
Geraint Hopkins	2 out of 3

5.4 The Committee requires the routine attendance at its meetings of other Health Board Officers for advice, support and information. 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 People & Culture Committee operates a Consent Agenda system for routine business consideration.

5.6 All of the meeting papers for this Committee during 2023/2024 are available publically via the CTMUHB website. If there were circumstances where the matter cannot be legitimately considered in the public domain the Committee would convene an in-committee meeting. The Committee held one In Committee session in November 2023.

6. Committee Activity 2023/2024

6.1 The Committee prioritise its work plan and the following topics were considered at its four meetings during 2023/24:

- Values & Behaviours Framework
- Workforce Metrics Analysis

- Employee Experience & Wellbeing
- Employee Relations
- Values and Behaviours
- Culture
- Strategic Equality Plan
- Organisational Risk Register
- Disclosure & Barring Service Assurance
- Equality, Diversity & Inclusion (including Welsh Language and Black and Asian Ethnic Minority (BAME)
- Strategic Workforce Planning
- Recruitment and Retention
- Welsh Language Standards Annual Report
- Equality Annual Report
- Gender Equality Annual Report
- National Community Nursing Specification
- Development of the Inspiring People Plan
- Implementation of the speaking Up Safely Framework
- Staff Recognition
- Outcome of the NHS Wales Staff Survey
- Revalidating Quality Review
- Development of the CTM People Plan
- Development of a Strategy for Implementation of Basic Life Support Training and other Resuscitation Training provided across CTM.
- WHC/2023-046 – All Wales Control Framework for Flexible Workforce Capacity – Baseline Return to Welsh Government
- Job Planning Data Incident – Learning and Plan for Improvement
- Retention Update on the Lateral Moves Scheme Phase Two Implementation of New Leadership & Management Service Structure
- Spotlight: Presentation on Pharmacy – Collective Leadership
- Spotlight: Supported Intern Apprenticeships – Video
- Spotlight: Presentation on Widening Access

During 2023-24 the Committee approved the following policies:

- Flexible Working Policy
- Overtime and Additional Hours
- Alcohol and Substance Misuse
- Employee Wellbeing
- Re-location Expenses
- Learning & Development
- Staff Bank
- Death in Service
- Honorary Contract Procedure Policy

6.2 Highlight Reports prepared following each meeting provide a summary of the reports and any decisions reached. These are available under the Health Board meeting papers page on our website.

6.3 The Committee Chair is able to refer and receive items from other Board Committees as felt appropriate. There are three questions that the Committee are required to consider: What is the issue being referred? Why are the Committee seeking the referral? What is the outcome anticipated as a result of the referral.

The Committee is able to receive referrals from other Committees and during this period there were two referrals made:

- Audit & Risk Committee - Local Counter Fraud Report – Fitness to Practice
- Quality & Safety Committee – Development of a Strategy for Implementation of Basic Life Support Training and other Resuscitation Training provided across CTM

7. Achievements and Plans

7.1 This being the fourth annual report, the Committee is continuing to mature in terms of the responsibilities it has defined within its Terms of Reference available on our website.

8. Committee Effectiveness & Performance

8.1 The Committee is committed to reviewing its effectiveness by producing an Annual Report, 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.

8.2 A 'Committee Effectiveness Questionnaire' was issued following the August 2023 meeting, the outcome was reported to the Committee in November 2023 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 by way of a 'Highlight Report' to the Board.

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 seek to ensure that it conducts its business in accordance with legislation and best practice and make improvements to its effectiveness on an ongoing basis.

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.

Agenda Item
9.1.3

CTMUHB Health Board Meeting

Joint Commissioning Committee Governance Framework

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Jacqui Maunder, Committee Secretary JCC Gareth Watts, Director of Corporate Governance and Board Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance and Board Secretary
Noddwr yr Adroddiad / Report Sponsor	Paul Mears, Chief Executive

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	Date	Outcome
Sub Committee Structure Chair of the JCC Chief Commissioner JCC SLT Working Group of NHS Wales DoCG / Board Secretaries SLT Development Day JCC Development Day NHS Wales Directors of Corporate Governance (DoCG) peer group	August 2024	Noted Feedback has assisted in developing the drafts
NHS Wales Joint Commissioning Committee (JCC)	17 September 2024	Endorsed
Hosting Agreement and Memorandum of Agreement Chief Commissioner	06 September 2024	Noted Feedback has assisted in developing the drafts

DoCG / Board Secretary CTMUHB NHS Wales Directors of Corporate Governance (DoCG) peer group		
NHS Wales Joint Commissioning Committee (JCC)	17 September 2024	Endorsed

Acronyms / Glossary of Terms	
JCC	NHS Wales Joint Commissioning Committee
LHB	Local Health Board
HBs	Heath Boards
SFI's	Standing Financial Instructions
SOs	Standing Orders
MoA	Memorandum of Agreement
DoCG	Directors of Corporate Governance
SoD	Scheme of Delegation
HA	Hosting Agreement
CTMUHB	Cwm Taf Morgannwg University Health Board
ToR	Terms of Reference
ARC	CTMUHB Audit and Risk Committee

1. SITUATION/BACKGROUND

The purpose of this report is to present an update on developing the final elements of the NHS Wales Joint Commissioning Committee's (JCC) *("Joint Committee*") governance framework and to request that the 7 x Health Board (HB) Board meetings approve the documents at their September 2024 Board meetings.

In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework is reserved to HBs. On the 17 September 2024 the Joint Committee reviewed and endorsed the proposed sub-committee structure, the accompanying terms of reference, the hosting agreement (HA) and the memorandum of agreement (MoA) for submission to individual HB Board meetings in September 2024 for final approval.

A background report and the documents accompanying were presented to the NHS Wales Directors of Corporate Governance (DoCG) peer group on 6 September 2024 and the documents were discussed and subsequently refined to reflect the advice and discussion, resulting in the final proposal presented to the Joint Committee for endorsement on 17 September 2024. The group supports the documents being presented to the HBs for final approval recognising that the documents will be kept under review with a formal review proposed in April 2025 following a full year of operation of the JCC to be conducted in partnership with HB DoCGs.

1.1 JCC Governance Framework

The Governance Framework for the JCC contains a number of key components which, combined, set out the legislative framework, constitution and ways of working for the JCC in its operations and handling of business. These documents are an integral part of the wider governance framework of HBs and have been developed within that context.

The Governance Framework of the JCC contains the following elements and an update on each element is provided in Figure 1 below.

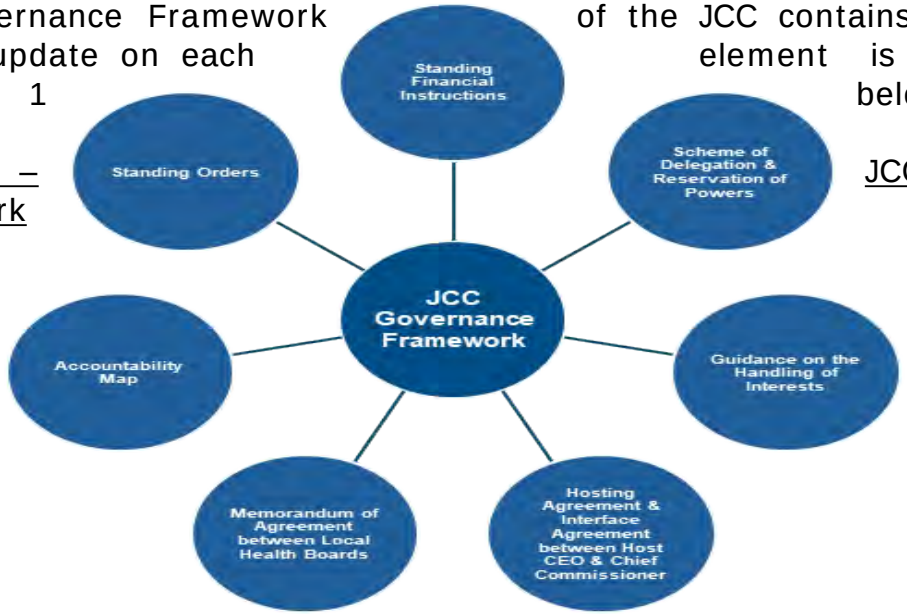


Figure 1 – JCC Governance Framework

1.2 Standing Orders and Standing Financial Instructions

The 7 x HBs approved the JCC Standing Orders (SOs) and Standing Financial Instructions (SFIs) in March 2024, and the Joint Committee adopted the JCC Standing SO's and SFIs at its inaugural meeting on 8 April 2024, and they were included as a schedule to each of the Health Boards (HBs) own SOs and have effect as if incorporated within them.

The Joint Committee were advised that work was ongoing during the transition phase to finalise other elements of the governance framework including the Hosting Agreement (HA), the Memorandum of Agreement (MoA) and the Scheme of Delegation (SoD).

2. MEMORANDUM OF AGREEMENT (MoA)

To ensure the effective operation of the JCC as a Joint Committee, a MoA between all 7 x HBs has been established, which sets out the commitment and ways of working, including the agreed roles and responsibilities of the Chief Executive Officers of each constituent HB as individual officer members of the JCC. The MoA is presented at Appendix 1 for approval by the 7 x HBs at the September HB Board meetings.

It is acknowledged that whilst the JCC continues to transition into the new organisation, work will continue to focus on ensuring clarity of role and relationship of the JCC with HBs as commissioners and providers, and with the newly formed NHS Executive.

The draft MoA is presented to the Board for approval noting a formal review will be undertaken in April 2025 in partnership with HB DoCGs.

3. HOSTING AGREEMENT (HA)

A HA between the Host Body Cwm Taf Morgannwg University Health Board (CTMUHB) and the six other HBs has been established to outline the accountability arrangements and resulting responsibilities of the Host Body and the JCC and its team. This is supported by an Interface Agreement between the Host Body Chief Executive Officer and the Chief Commissioner of the JCC Team, detailing the relationship and accountabilities of the two Officers given it is intended they both hold respective Accountable Officer responsibilities delegated by Welsh Government (WG).

As Hosts our roles and responsibilities are set out in Section 2 of the HA.

During engagement on the development of the draft HA, it has been identified that further work is required to ensure clarity on roles and responsibilities of the JCC in relation to:

- The Handling of Concerns; and
- Consultation & Engagement relating to service change

Work has already commenced with the establishment of working groups with HB representation to develop protocols in relation to each of these areas. Engagement with DoCGs and other HB Executive leads will be essential in ensuring the processes are agreed and reflect the statutory responsibilities of the HBs and the role and delegations of the JCC.

Draft protocols will be developed and shared with DoCGs for review and comment prior to submission to the Joint Committee in November 2024. Subject to the detail and proposed approach, the protocols may then require an amendment to

the Scheme of Delegation (SoD) which, if necessary, will be brought back to the Joint Committee for endorsement before final approval by HB Boards.

Noting the development of the supporting protocols described above, the HA is presented at Appendix 2 for approval by the 7 x HBs at the September HB Board meetings.

4. PROPOSED JCC SUB-COMMITTEE STRUCTURE

Section 5.5 of the JCC SO's stipulate that the Joint Committee may and, where directed by the HB Boards jointly, or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the HBs, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent HBs.

As a minimum, it shall ensure that there are joint sub-Committee arrangements which cover the following aspects of Joint Committee business:

- Audit and Risk
- Quality, Safety and Outcomes
- Planning and Performance.

To fulfil the provisions of the SOs the sub-committee structure outlined in Figure 2 below was presented to the Joint Committee at their development session on 22 August 2024, and to the JCC meeting on 17 September 2024 and were supported and endorsed.

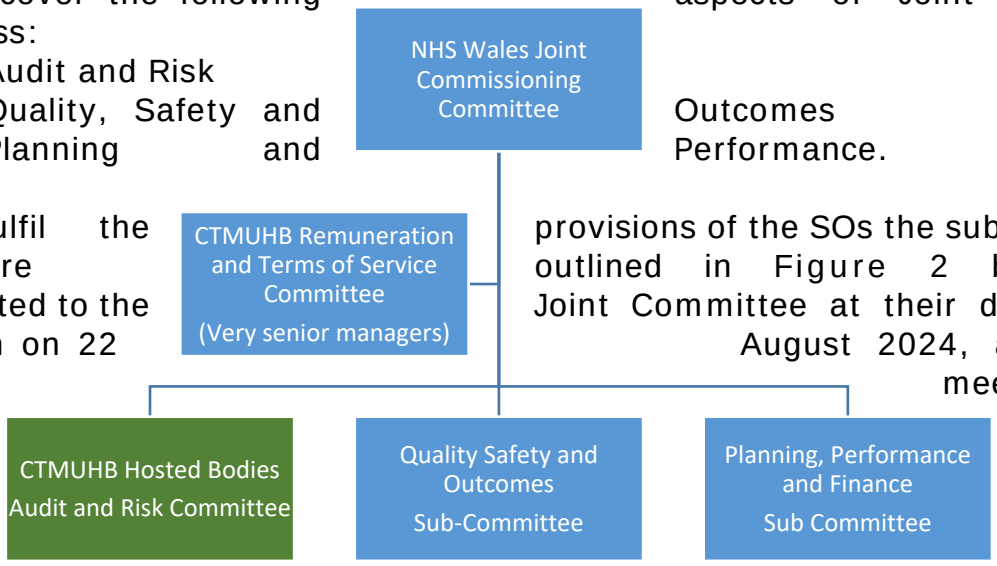


Figure 2 – Proposed JCC Sub-Committee Structure

The Terms of Reference (ToR) have been drafted for both the Quality, Safety and Outcomes sub-committee at Appendix 3, and for the Planning, Performance and Finance sub-committee at Appendix 4. The draft Terms of Reference for both sub-committees have been shared and discussed with HB DoCGs, with their comments and contributions reflected in the final proposed versions attached. The documents are presented for approval by the 7 x HBs at the September HB Board meetings.

The JCC will continue to utilise the CTMUHB Audit and Risk Committee for Hosted Bodies. The ToR for the CTMUHB Audit and Risk Committee (ARC) for Hosted Bodies are contained within the CTMUHB ARC ToR. Revised ToRs of the new Audit and Risk Assurance Committee are presented to this meeting for approval. An update will be taken to the JCC meeting scheduled for 12 November 2024 confirming the new ToR for the ARAC for Hosted Bodies.

It is proposed that the new sub-committee structure comes into force on 1 December 2024, to coincide with the appointment of the new Joint Committee Lay Members. As the sub committees are meetings held in public, the papers will be published on the JCC website.

The revised statutory sub-committee structure no longer includes the legacy sub-committees of the Welsh Health Specialised Services Committee (WHSSC), specifically the All Wales Individual Patient Funding Request (IPFR) panel, the WHSSC Management Group (MG) and the Welsh Kidney Network (WKN). Consideration of the most appropriate reporting arrangements in the new governance model for the JCC will take account of the proposed establishment of a new JCC Collaborative Commissioning Leadership Group (CCLG) to be chaired by the Chief Commissioner. Until the proposals for the new CCLG are fully developed, the current transition reporting arrangements for the IPFR panel, Specialised Services Management Group and the WKN continue reporting directly to the Joint Committee. The JCC Director of Transition & Transformation is working with the Interim Chief Commissioner and representation from the Joint Committee to draft ToR for the proposed CCLG which will then be shared with HB CEOs prior to being brought back to the Joint Committee on 12 November 2024.

Objectives / Strategy	
Dolen i Nod(au) Strategol BIP CTM /Link to JCC Strategic Goal(s)	Not Applicable
	The JCC was established on 1 April 2024. Draft Strategic Objectives are being presented for approval at the September Joint Committee Meeting.
Dolen i Feysydd Strategol BIP CTM /Link to JCC Strategic Areas	Not Applicable
	The JCC was established on 1 April 2024. Draft Strategic Objectives are

	being presented for approval at the September Joint Committee Meeting.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	If more than one applies, please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies, please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	Consideration has been given to the Duty of Quality as set out in section 1A of the NHS (Wales) Act 2006 ("the 2006 Act") as it applies to the Welsh Ministers. The Duty of Quality places Ministers under an additional duty to exercise their functions in relation to the health service with a view to securing

		improvement in the quality of health services. The establishment of the new JCC arrangements will support the delivery of the Duty of Quality requirements.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	A Regulatory Impact Assessment is contained with the Explanatory Memorandum to The National Health Service Joint Commissioning Committee (Wales) Regulations 2024.
Cyfreithiol / Legal	In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework terms of reference is reserved to HBs. National Health Service Joint Commissioning Committee (Wales) Directions 2024 National Health Service Joint Commissioning Committee (Wales) Regulations 2024	
Enw da / Reputational	There is no direct impact on the reputation of the Local Health Boards or the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

Board Members are asked to Approve:

- the terms of reference (ToR) for the JCC Quality, Safety and Outcomes Sub-Committee
- the terms of reference (ToR) for the JCC Planning, Performance & Finance Sub-Committee
- the Memorandum of Agreement (MoA) and the Hosting Agreement (HA) for the JCC
- the continuation of the transitional reporting arrangements for the IPFR Panel, WKN and Specialised Services Management Group pending the establishment of a new Collaborative Commissioning Leadership Group (CCLG).

Board Members are asked to Note:

- the terms of reference (ToR) for the CTMUHB Audit and Risk Committee (ARC) for hosted bodies are contained within the CTMUHB ARC ToR which are under and presented to this meeting, separately for approval.

6. NEXT STEPS

6.1 JCC Scheme of Delegation (SoD) and Reservation of Powers

A SoD from HBs to the Joint Committee and from the Joint Committee to Sub-Committees and the Chief Commissioner was agreed in March 2024 as part of the governance framework for the establishment of the JCC.

Work to develop the SoD to reflect the new Sub-Committees and delegations beyond the Chief Commissioner is ongoing and will be influenced by the development of the operating model for the new JCC.

Any proposed amendments following discussion with the Director of Corporate Governance of CTMUHB as Host Body, will be brought back to the HB DoCGs for engagement and consultation prior to Joint Committee consideration and final HB Board approval.

Work to develop the SoD is ongoing and will be finalised following the approval of the JCC hosting agreement and memorandum of agreement, and following discussion with the DoCG of CTMUHB as Host Body to confirm within its respective SoD and Reservation of Powers any functions delegated to the Chief Commissioner and Joint Commissioning Committee Team as the employer and provider of administrative (e.g. finance, workforce) services.

6.2 Review

A formal review of the governance framework for the JCC will be undertaken in April 2025 in collaboration with the HB DoCGs following a full year of operation as the new JCC.

MEMORANDUM OF AGREEMENT

RELATING TO THE

NHS WALES JOINT COMMISSIONING COMMITTEE

Established under the National Health Service Joint Commissioning Committee (Wales) Directions 2024

THIS MEMORANDUM OF AGREEMENT is made on the 01 April 2024 BETWEEN

1. ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ

2. BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

3. CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes y Coed Road, Cardiff CF14 4HH

4. CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taf, CF45 4SN.

5. HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park, Carmarthen SA31 3BB.

6. POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS.

7. SWANSEA BAY UNIVERSITY HEALTH BOARD having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR

WHEREAS:

A. In accordance with the National Health Service Joint Commissioning Committee (Wales) Directions 2024 (the Directions) the Local Health Boards (LHBs) are required to establish a Joint Committee for the purpose of jointly exercising the relevant functions from 1 April 2024.

B. The relevant functions of the Joint Committee are the planning, securing and commissioning of:
   a. specialised services for:
      (i) cancer and blood disorders,
      (ii) cardiac conditions,
      (iii) mental health and vulnerable groups,
      (iv) neurosciences, and

(v) women and children,

b. services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
c. emergency medical services,
d. non-emergency patient transport services,
e. emergency medical retrieval and transfer services,
f. NHS 111 services,
g. sexual assault referral centres, and
h. other services as directed by the Welsh Ministers.

C. The National Health Service Joint Commissioning Committee (Wales) Directions 2024 provides that the host Local Health Board (the Host LHB) must provide administrative support for the operation of the Joint Committee and establish the NHS Wales Joint Commissioning Committee Team (JCCT); and that the Host Local Health Board will be Cwm Taf Morgannwg University Health Board (CTMUHB).

D. The National Health Service Joint Commissioning Committee (Wales) Regulations 2024 (the Regulations) make provision for the constitution and membership of the NHS Wales Joint Commissioning Committee including its procedures and administrative arrangements.

E. Each of the seven LHBs functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and tertiary services for the citizens in their respective areas. The JCC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning, securing and commissioning of services delegated to it and will establish the Joint Committee for the purpose of jointly exercising those functions.

F. The Directions and Regulations require that the Chief Executives of each of the 7 LHBs listed as Parties to this Agreement be members of the Joint Committee. This Agreement defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the Joint Committee. This is in accordance with their objective to make collective decisions as to the provision of national services as described above and in the interests of NHS Wales and the health needs of their individual populations. The NHS Wales JCC Standing Orders provides further detail on this.

AGREEMENT

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1. INTERPRETATION

'the Act'	the National Health Service (Wales) Act 2006 (C.42)
'Chair (JCC)'	the person appointed by Welsh Ministers to lead the NHS Wales Joint Commissioning Committee and to ensure it successfully discharges its overall responsibility on behalf of the LHBs.
'Chief Commissioner'	Chief Commissioner of the NHS Wales Joint Commissioning Committee and Associate Member of the JCC
'Chief Executives'	the Chief Executives of the constituent LHBs and members of the JCC
'Committee Secretary'	the person appointed by the JCC as its principal advisor on all aspects of governance.
'Dispute Process'	the arbitration process agreed with Welsh Government.
'Host LHB'	Cwm Taf Morgannwg University Local Health Board (CTMUHB)
`JCC`	The NHS Wales Joint Commissioning Committee
'JCCT'	The JCC Team employed by the host Health Board (CTMUHB), including the Chief Commissioner, to provide the relevant services.
'LHB'	Local Health Board established in accordance with section 11(2) of the Act
'Provider LHB'	a LHB which provides relevant services to the JCC as identified within the Directions:

2. CORPORATE IDENTITY

2.1 The corporate identity for the Joint Committee will be in accordance with the Corporate Identity Guidelines issued by Welsh Government to LHBs.

2.2 The NHS Wales Joint Commissioning Committee will be referred to as the 'NHS Wales Joint Commissioning Committee acting on behalf of Local Health Boards' on stationery and signage.

3. PRINCIPLES

3.1 The Joint Committee is a statutory committee established under sections 12 (1)(b) and (3), 13(2)(c), (3)(c) and (4)(c) and 203(9) and (10) of the Act.

3.2 The LHBs are required to establish a Joint Committee for the purpose of jointly exercising the relevant functions from 1 April 2024.

3.3 Each LHB is accountable, through its statutory responsibilities, to use its resources to plan, fund, design, develop and secure the delivery of services for their population.

3.4 In performing its role, the Joint Committee and each individual Chief Executive as a member, shall work in the wider interest of NHS Wales. In so doing, they shall work with all of the Joint Committee's appropriate partners and stakeholders in the best interests of NHS Wales. In so doing, the Joint Committee will take account of the following key principles:

3.4.1 Collaboration should be designed to deliver changes in services and demonstrable population benefit;

3.4.2 Collaboration should ensure a more extensive and consistent use of evidence supported by a robust analysis of need;

3.4.3 Collaboration must not diminish clinical engagement;

3.4.4 Collaboration should support LHBs in working together more effectively, in an open and transparent way, for the benefit of the local population;

3.4.5 Collaboration must enhance resource utilisation in the planning process to reduce duplication and overlap;

3.4.6 Collaboration should focus upon articulating need, reviewing evidence of good practice, designing models of care and producing clear service specification;

3.4.7 Collaboration should promote equity in service delivery.

3.5 Each LHB acknowledges the following principles:

3.5.1 The accountability arrangements of the JCC, its members and the JCC Team, are as set out in the agreed Accountability Map attached at Annex A.

3.5.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services for residents within their area. Refer to Standing Order 2.19

3.5.3 That any decision taken and approved by the Joint Committee in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB. Refer to Standing Order 2.22

3.5.4 That their respective Chief Executives have an individual responsibility to contribute to the performance of the role of the Joint Committee and to share in the decision making in the interests of the wider population of NHS Wales. At the same time, they acknowledge their own Chief Executive's individual accountability to their constituent LHB and their obligation to act transparently in the performance of their functions. Refer to Standing Orders 6 and the Accountability Map at Annex A.

3.5.5 That each Chief Executive, as a member of the Joint Committee, will require the JCC Team of the Joint Committee to ensure that in the timetabling of the annual work Price sufficient time will normally be allowed to enable each Chief Executives to consult with their own LHB and appropriate local partners and stakeholders.

3.5.6 That when an individual Chief Executive is unable to attend a meeting of the Joint Committee, they may nominate a deputy to attend on their behalf. The nominated deputy must be an Executive Director (and

hold office in accordance with regulation 3(2) of the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009) of the same organisation who can fully engage and take decisions in the absence of the CEO. Nominated deputies will formally contribute to the quorum and will have delegated voting rights. Refer to Standing Order 7.2

3.6 Each Chief Executive will agree to advise the Chair of any circumstances where there is an actual or perceived conflict of interest, including where it is considered that there may be a conflict of interest between the performance of the functions of the Joint Committee and the effect of any such decision on the scope of the services which the constituent LHB provides. Refer to Standing Order 8.5

3.6.1 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may vary dependent on the type of interest declared and further detail on the options takes are set out within the JCC's Guidance on the Handling of Interests.

3.7 The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must be acting clearly in the interests of the JCC and of the population of Wales, rather than furthering direct or indirect financial, personal, professional or organisational interests. The Joint Committee's aim is to always achieve collective decision making in a collaborative manner through consensus. The Joint Committee will have a collective responsibility to try to resolve and minimise any local challenges or any disproportionate impact of national decisions on any one LHB or a specific geographical area. Refer to Standing Order 6.8

3.8 The Joint Committee will make decisions based on a majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote. In order to ensure balanced and collective decision, Members are not permitted to abstain during voting, given that the JCC must discharge its collective duty for the population of Wales. Refer to Standing Order 7.20

4. ROLE OF THE NHS WALES JOINT COMMISSIONING COMMITTEE

As set out in Standing Order 2.20, the Joint Committee's role is to:

- Determine a long-term strategy for the commissioning of services delegated to the JCC
- Produce an Integrated Medium-Term Plan which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)
- In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards and will, for the relevant functions:
    - Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered
    - Develop policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
    - Determine annually those services that should be commissioned on a regional or national basis
    - Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers
    - Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales
- Ensure the JCC operates within an appropriate governance framework.

5. ANNUAL WORK PROGRAMME AND PLANNING

5.1 The Joint Committee will operate its annual work programme, reporting and planning requirements in-line with Standing Orders. Refer to Standing Order 7.8 and 9.2

5.2 The Joint Committee Chair shall report formally, regularly and on a timely basis to the LHB Boards on the Committee's

activities. This includes written submission of Chair summary or highlight reports throughout the year and an in-person attendance at every LHB, meeting annually with Board Members. Refer to Standing Order 9.1

5.3 The Joint Committee will operate its business in-line with its delegated powers and Scheme of Delegation and Reservation of Powers and any Scheme of Delegation to Officers. Refer to Standing Order 4 and 5

6. ROLE OF JOINT COMMITTEE CHAIR

6.1 The LHBs acknowledge that the Regulations require that the Chair be appointed by the Cabinet Secretary for Health and Social Care as an independent appointment and in accordance with the Nolan Principles. It is further acknowledged that The Chair is accountable to the Cabinet Secretary for Health and Social Care in respect of their performance as Chair of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners. The Cabinet Secretary for Health and Social Care undertakes a performance appraisal of the Joint Committee Chair and sets objectives accordingly. This is set out within the Accountability Map at Annex A.

6.2 As a Joint Committee of LHBs, the Joint Committee Chair will have a bi-lateral relationship with each of the Chairs of the 7 LHBs, in respect of the Joint Committee's role carried out on their behalf and to ensure that the Joint Committee's governance framework remains appropriate to the overarching governance framework of the 7 LHBs. This is set out within the Accountability Map at Annex A.

7. STATUS AND ROLE OF THE CHIEF COMMISSIONER AS AN ASSOCIATE MEMBER

7.1 The Joint Committee will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers. Refer to Standing Order 6.15

7.2 The LHBs acknowledge that the Chief Commissioner will be an Associate Member of the Joint Committee and attend on an ex-officio basis. In accordance with the Directions, the Chief

Commissioner will not have the right to vote in any meetings or proceedings of the Joint Committee. Refer to Standing Order 6.5

7.3 The Associate Member will be entitled to engage and participate in the discussions. It will be the responsibility of the Joint Committee Chair to secure that they may seek to influence and/or challenge the decision making by their participation during the course of the debate.

7.4 The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services, by the Joint Committee, on behalf of the 7 LHBs. Refer to Standing Orders 6.15 and the Accountability Map at Annex A.

7.5 In respect of personal performance this will include an annual performance review undertaken by the Committee Chair. This will take into account those functions delegated from the host, as set out within the Hosting Agreement, and will therefore be informed by the Chief Executive of the Host Body. Feedback from other Joint Committee members will also be sought in informing the appraisal of the Chief Commissioner. Refer to Standing Orders 6.15 and the Accountability Map at Annex A.

7.6 As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host Body in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. As the employer, the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair. Refer to Standing Orders 6.15 and the Accountability Map at Annex A.

7.7 As a Joint Committee of LHBs, the Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs. Refer to Standing Orders 6.15 and the Accountability Map at Annex A.

7.8 The Chief Commissioner will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the LHBs and will be accountable to the Director General/NHS Wales Chief Executive in this regard. Further detail on this

accountability relationship is set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body.

8 ROLE OF COMMITTEE SECRETARY

8.1 The LHBs acknowledge that the role of the Committee Secretary, is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary will be required to act as the guardian of good governance within the Joint Committee. The role of the Committee Secretary is set out within Standing Order 6.16.

8.2 The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team. Refer to Standing Orders 6.16 and the Accountability Map at Annex A.

8.3 As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs. Refer to Standing Orders 6.16 and the Accountability Map at Annex A.

8.4 As an employee of the Host Body (CTMUHB), the Committee Secretary will also have a relationship with the Host Body's Director of Corporate Governance with regard to the governance of those functions delegated to the JCC Team via the Hosting Agreement. Refer to Standing Orders 6.16 and the Accountability Map at Annex A.

9 RELATIONSHIP WITH HOST

9.1 Cwm Taf Morganwwg University Health Board is appointed as the Host Body under Ministerial Direction and is accountable for the delivery of the functions of host body, as required by the NHS Wales Joint Commissioning Committee (Wales) Directions 2024 (the JCC Directions). As the host body they are required to provide administrative support for the operation of the JCC and establish the JCC Team. Refer to Standing Orders 1.7

9.2 The Board of the Host Body will not be responsible or accountable for the planning, funding and securing of those services delegated to the JCC by the 7 LHBs, or as directed by Welsh Ministers, save in respect of residents within the areas served. Refer to Standing Orders 1.7

9.3 A Hosting Agreement between the Host Body (CTMUHB) and the six other Local Health Boards outlines the accountability arrangements and resulting responsibilities of the Host Body and the JCC and its team. This is supported by an Interface Agreement between the Host Body Chief Executive Officer and the Chief Commissioner of the JCC Team, detailing the relationship and accountabilities of the two Officers given they both hold respective Accountable Officer responsibilities delegated by Welsh Government.

10 AUDIT, PROCUREMENT AND FINANCIAL MANAGEMENT

10.1 The Joint Committee's Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions for the regulation of the NHS Wales Joint Commissioning Committee's financial proceedings and business. Refer to Standing Orders 3.1

10.2 The JCC's Standing Financial Instructions (SFIs) form an annex to the JCC's Standing Orders, which form a schedule to each LHBs own Standing Orders and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. These SFIs align with the JCC's Scheme of Delegation and Reservation of Powers and are also be underpinned by an operational Scheme of Delegation which provides delegated authorisation levels and other delegated responsibilities in respect of financial management

and control.

10.3 The Hosting Agreement between the Host Body (CTMUHB) and the six other Local Health Boards outlines the arrangements in place in respect of accounting, audit, procurement and contracting arrangements.

11 FINANCIAL PRINCIPLES

11.1 The following represent the key financial principles to be adhered to by the LHBs:

- To achieve financial neutrality and stability, where possible, for LHBs;
- To adopt a fair and practical approach to the challenges of establishing the Joint Committee and to the functioning of the Joint Committee
- To ensure that a risk sharing methodology will be reviewed and agreed annually.

12 BUDGET AND FUNDING

12.1 In accordance with the Joint Committee's Standing Orders, the Joint Committee must agree the total budget to plan and secure the Relevant Services delegated to it. The Joint Committee must also agree the appropriate contribution of funding required from each LHB. Refer to Standing Order 2.20

12.2 Each year the Joint Committee will prepare an Integrated Medium-Term Plan which shall outline an appropriate level of funding for the provision of services and determine the contribution from each LHB to allow the JCC to plan and secure those services, including the running costs of the JCC Team. Refer to Standing Order 2.20 and Standing Financial Instructions 1.3

12.3 Each LHB shall be bound by the decisions of the JCC in the exercise of its delegated functions and will be required to make available to the Joint Committee the level of funds outlined within the agreed Integrated Medium-Term Plan, as per point 12.2 above.

12.4 The funds shall be drawn down in cash on a monthly basis from each of the LHB's as proposed by the Director of Finance for the Joint Committee.

12.5 On a monthly basis, the Director of Finance for the Joint Committee shall prepare a report to the Joint Committee which outlines the performance of the Joint Committee, highlighting any variances from the original annual plan, in total, and also broken down to each LHB level.

12.6 In cases where the performance report highlights an adverse variance to the Integrated Medium-Term Plan or where the report anticipates future unfunded cost pressures, the Joint Committee will be required to put in place contingency measures to ensure that a break-even position is maintained.

12.7 In cases where the performance report highlights a favourable variance to the annual plan, the Joint Committee shall be required to return the funding to each LHB in accordance with the risk sharing agreement.

12.8 The Joint Committee will comply with all Welsh Government financial monitoring arrangements. The Director of Finance of the Joint committee is responsible for ensuring that a financial monitoring return is submitted to Welsh Government in the prescribed format and to the required deadlines.

12.9 Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its delegated functions. Any disputes over the level of funding proposed by Joint Committee shall be handled in-line with the dispute process set out at XX.

12.10 The Hosting Agreement between the Host Body (CTMUHB) and the six other Local Health Boards outlines the arrangements in place in respect of accounting between the Joint Committee and the Host Body.

13 GIFTS AND HOSPITALITY

13.1 The Host Body's Standards of Behaviour Policy (Incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria) applies to the Joint Committee's Chair, Lay Members and Chief Commissioner, and prohibits Joint Committee members from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way. Refer to Standing Order 8.9.

13.2 The recording of gifts, hospitality and sponsorship for the JCC's Officer Members will be undertaken in accordance with the respective LHB's Standards of Behaviour Policy and reporting arrangements. Refer to

Standing Order 8.9.

14 DISPUTES AND ARBITRATION

14.1 In accordance with the principles set out in this Agreement, the Local Health Boards (LHBs) will seek to work cooperatively with each other as constituent members of the Joint Committee, with the Joint Committee as a whole, and with the JCC Team. Where there is an impasse which cannot be resolved by means of conciliation between appropriate individuals, then as a last resort the following process should be followed.

14.2 In the event of any dispute between LHB(s) and the JCC and/or JCC Team, all parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and trying to resolve the issues. All reasonable efforts must be made before escalating any disputed issues.

14.3 If a dispute cannot be resolved in accordance with the provisions of paragraph 14.2 it shall be referred to the Chief Commissioner and the Chief Executive of the respective LHB for further discussion.

14.4 If a dispute cannot be resolved in accordance with the provisions of paragraph 14.3, the respective LHB Chief Executive and the Chief Commissioner should have a further meeting with the other six LHB Chief Executives (as parties to this agreement and officer members of the Joint Committee) to determine if the matter can be resolved in-line with the principles of this Memorandum of Agreement.

14.5 If a dispute cannot be resolved in accordance with the provisions of paragraph 14.4 it shall be referred to the Chair of the JCC and the Chair of the respective LHB for further discussion. The LHB Chair may wish to engage its wider Board on this matter.

14.6 If a dispute still cannot be resolved in accordance with the provisions of paragraph 14.5, it shall be referred to the Welsh Government Director General for Health and Social Services and ultimately onwards to the Cabinet Secretary for Health and Social Care for resolution.

15 CONCERNS AND CLAIMS (PUTTING THINGS RIGHT)

15.1 Section 13 of the Hosting Agreement sets out the procedures to be followed for the management of concerns in respect of those services commissioned by the JCC and/or the functions delivered by the JCC Team.

16 COMMUNICATION

16.1 The Committee Secretary and the Directors of Corporate Governance of the respective LHBs will ensure robust communication methods are in place to support the effective operation of the Joint Committee.

16.2 Each LHB will ensure that they utilise appropriate mechanisms to facilitate active debate amongst stakeholders, professionals and communities served to ensure appropriate independent representation and participation.

16.3 Each LHB is responsible for responding to individual enquires concerning their individual geographical population. Where it is an issue relating to a decision made by the Joint Committee, then the Committee Secretary will be responsible for co-ordinating the response in consultation with the respective LHBs.

16.4 Where a request under the Freedom of Information Act or Data Protection Act is received by the JCC/JCCT Team, the request will be dealt with in accordance with the Host Body's procedures. Where the request is considered to be an issue relating to a public body covered by the FOI Act then the request will be forwarded to that particular body to deal with.

17 ROLE OF PUBLIC HEALTH

17.1 A Service Level Agreement will be entered into between the Host LHB and Public Health Wales, should the Joint Committee consider it necessary and appropriate, describing the services which Public Health Wales will provide to the Joint Committee and the process of engagement which will take place.

18 EQUALITY AND DISCRIMINATION

18.1 The LHBs undertake, in relation to the provision of the Relevant Services by the Joint Committee to the public or any member of the public, to exercise the role of the Joint Committee so as to have regard to the need to eliminate discrimination, and other prohibited conduct, in accordance with human rights and equality legislation.

19 REVIEW

19.1 This Agreement will be reviewed on an annual basis or as Standing Orders and Standing Financial Instructions are amended.

SIGNED under hand and delivered the XX 2024:

SIGNED and DELIVERED by Aneurin Bevan University Local Health Board acting by Nicola Prygodzicz, Chief Executive
SIGNED and DELIVERED by Betsi Cadwaladr University Local Health Board acting by Carol Shillabeer, Chief Executive
SIGNED and DELIVERED by Cardiff and Vale University Local Health Board acting by Suzanne Rankin, Chief Executive

SIGNED and DELIVERED By Cwm Taf Morgannwg University Local Health Board acting by   Paul Mears Chief Executive
SIGNED and DELIVERED by Hywel Dda University Local Health Board acting by   Phil Kloer, Interim Chief Executive
SIGNED and DELIVERED by Powys Teaching Local Health Board acting by   Hayley Thomas, Chief Executive
SIGNED and DELIVERED by Swansea Bay University Local Health Board acting by   Richard Evans, Interim Chief Executive

ANNEX A

NHS Wales Joint Commissioning Committee - Accountability Map
APPROVED – March 2024

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Health Boards	Health Board Chief Executives are equal members of the Joint Committee, delegated to act on the behalf of respective Boards.	The JCC is a Joint Committee of the 7 LHBs. Ultimately all 7 LHBs are bound by the decisions taken by the JCC, in-line with the powers delegated to it from the 7 LHBs or as directed by the Minister for Health and Social Services. The JCC is accountable to Health Boards via respective CEOs as set out below.		As a Joint Committee of Health Boards, each of the 7 LHB's ultimately remain accountable to Welsh Government for planning, securing and delivering health services to their respective populations.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Joint Committee		The Joint Committee will report to the individual LHBs on its activities. It is formally accountable to the individual LHBs, via the respective CEO as a JCC Member and a LHB Board Member, in respect of its role carried out on the LHB's behalf.		The Joint Committee may form part of the NHS performance management system, via the Chief Commissioner, as determined by Welsh Government. Ultimately, the 7 LHBs remain accountable for the performance of those activities delivered via the JCC on their behalf. The individual accountability of the Committee Chair is set out below.

To / From	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Committee Chair		As a Joint Committee of LHBs, the Committee Chair will have a bi-lateral relationship with each of the Chairs of the 7 LHBs, in respect of the JCC's role carried out on their behalf and to ensure that the JCC's governance framework remains appropriate to the overarching governance framework of the 7 LHBs.	The Committee Chair will have a relationship with the Host Body's CEO given their respective accountability arrangements with regard to the Chief Commissioner (Tier 1 Director) (as described further below under Chief Commissioner arrangements and set out within the Hosting Agreement). The arrangements to support the relationship between the Chair and the Host Body CEO are further detailed in the Hosting Agreement.	The Committee Chair is accountable to the Minister for Health and Social Services in respect of their performance as Chair of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners. The Minister for Health and Social Services undertakes a performance appraisal of the Committee Chair and sets objectives accordingly.

To / From	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Lay Members	On a day-to-day basis, Lay Members are responsible to the Committee Chair for discharging their roles as Lay Members of the JCC (and any subsequent sub-Committee). The Committee Chair will undertake performance appraisals of Lay Members on behalf of the Minister for Health and Social Services.			The Committee Lay Members are appointed by, and are accountable to, the Minister for Health and Social Services in respect of their performance as Lay Members of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners.

To / From	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Chief Commissioner (Tier 1 Director)	The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services. In respect of personal performance this will include an annual performance review undertaken by the Committee Chair. This will take into account those functions delegated from the host, as set out within the Hosting Agreement, and will therefore be informed by the Chief Executive of the Host Body. Feedback from other Joint Committee members will also be sought in informing the appraisal of the Chief Commissioner.	As a Joint Committee of LHBs, the Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs.	As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host LHB (CTMUHB) in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. In this regard, the Host Body CEO will inform the annual performance review of the Chief Commissioner, undertaken by the Committee Chair. As the employer, the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair. The governance and issues relating to the hosting of the JCC will be incorporated into the standard business of the existing Host Body's Audit Committee. The assurance for the governance and issues relating to the hosting of the JCC will be to the Host Body's Board. Issues relating to the functions of the JCC delegated from the 7 LHBs will be fed into a separate Host Body Audit Committee for the JCC specifically, operating within its own work cycle as required. The assurance for this will be to the 7LHBs.	The Chief Commissioner will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the Health Boards, and will be **accountable** to the Director General/NHS Wales Chief Executive in this regard. Further detail on this accountability relationship will be set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body. The Chief Commissioner will have a relationship with Welsh Government officials, with regard to informing and discharging policies relating to the resources and functions delegated to the JCC. The Chief Commissioner and Officers of the JCC Team may seek advice where matters present a conflict with the Host Body as a provider of services commissioned by the JCC. Detail on the handling of conflicts between the Chief Commissioner and the JCC Team are further described within the Hosting Agreement.

To / From	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Tier 2	Tier 2 roles will have a relationship with the JCC Chair and the wider Committee, recognising the professional advice that these roles will provide. Tier 2 roles will be accountable to the Chief Commissioner (Tier 1 Director) for their performance as an employee of the Host Body and a member of the JCC Commissioning Team.	As a Joint Committee of LHBs, Tier 2 roles will have a relationship with the Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs.	Tier 2 roles will be accountable to the Chief Commissioner (Tier 1 Director) for their performance as an employee of the Host Body and a member of the JCC Commissioning Team. Where Tier 2 roles have regulated professional accountabilities, these roles will be professionally accountable to the appropriate member of the Executive Team of the Host Body (CTMUHB) and will be explicitly set out within the Hosting Agreement.	The Chief Commissioner and Officers of the JCC Team may seek advice from Welsh Government where matters present a conflict with the Host Body as a provider of services commissioned by the JCC. Detail on the handling of conflicts between the Chief Commissioner and the JCC Team are further described within the Hosting Agreement. Tier 2 Officers will have a relationship with Welsh Government officials with regard to informing and discharging policies relating to the resources and functions delegated to the JCC.

To / From	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Committee Secretary	The Committee Secretary is accountable to the JCC Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner (Tier 1 Director) for	As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs.	As an employee of the Host Body (CTMUHB), the Committee Secretary will have a relationship with the Director of Corporate Governance of the Host Body (CTMUHB) with regard to the governance of those functions delegated to the JCC Team via the Hosting Agreement.	The Committee Secretary will have a relationship with the Head of NHS Governance within Welsh Government, as a Senior Governance Professional within NHS Wales.

	their performance as an employee of the Host Body and a member of the JCC Commissioning Team.			

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Host Body	The Chief Executive of the Host Body for those elements set out within the Hosting Agreement will ensure the Chief Commissioner is discharging their responsibilities as an employee of the host body. The Host Body CEO and Chair with have a relationship with the JCC Chair relating to the Hosting Agreement, particularly in relation to any disputes between the JCC Team and the Host Body. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.	The Host Body will enter into an agreement with 6 other LHBs for the delivery of the Hosting Agreement to support the effective functioning of the JCC on their behalf. The 6 LHBs will have a relationship with the Host Body CEO and Chair relating to the Hosting Agreement, particularly in relation to any disputes between the JCC Team and the Host Body. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.	The Host Body's CEO will be responsible to the Board of the Host Body for the effective delivery of the Hosting Agreement. The Chair of the Host Body will have a relationship with the JCC Chair and the 6 LHB CEOs, relating to the Hosting Agreement, particularly in relation to any disputes between the JCC Team and the Host Body. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.	CTMUHB is appointed as Host Body for the JCC under Ministerial Direction, ultimately CTMUHB is therefore accountable to the Minister for Health and Social Services for the effective delivery of the Hosting Agreement. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.

HOSTING AGREEMENT

RELATING TO THE

NHS WALES JOINT COMMISSIONING COMMITTEE

THIS MEMORANDUM OF AGREEMENT is

BETWEEN

(1) CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD ("Cwm Taf Morgannwg CTMUHB") having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taf, CF45 4SN.

And

ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having Headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ

BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes y Coed Road, Cardiff CF14 4HH

HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park, Carmarthen SA31 3BB.

POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS

SWANSEA BAY UNIVERSITY HEALTH BOARD having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR

A. Cwm Taf Morgannwg University Health Board (CTMUHB) has been identified as Host LHB to provide administrative support for the running of the JCC and to establish the NHS Wales Joint Commissioning Committee Team (JCCT).

B. This Agreement should be read in conjunction with the Memorandum of Agreement made between the seven Local Health Boards themselves which defines the governance arrangements for the JCC and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the JCC.

C. The purpose of this Agreement is to outline what the accountability arrangements and resulting responsibilities mean for each party.

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1. INTERPRETATION

'the Act'	the National Health Service (Wales) Act 2006 (C.42)
'Chair (JCC)'	the person appointed by the Minister to lead the NHS Wales Joint Commissioning Committee and to ensure it successfully discharges its overall responsibility on behalf of the LHBs.
'Chief Commissioner'	Chief Commissioner of the NHS Wales Joint Commissioning Committee and Associate Member of the JCC
'Chief Executives'	the Chief Executives of the constituent LHBs and members of the JCC
'Committee Secretary'	the person appointed by the JCC as its principal advisor on all aspects of governance. Refer to Standing Orders: The Role of the Committee Secretary.
'Dispute Process'	the arbitration process agreed with Welsh Government.
'Host LHB'	Cwm Taf Morgannwg University Local Health Board (CTMUHB)
`JCC`	The NHS Wales Joint Commissioning Committee
'JCCT'	The JCC Team employed by the host Health Board including the Chief Commissioner to provide the relevant services.
'LHB'	Local Health Board established in accordance with s 11(2) of the Act
'NHS Wales'	the comprehensive health service for Wales established by the NHS (Wales) Act 2006 (C.42)
Provider LHB'	a LHB which provides relevant services to the JCC as identified within the Directions.

'Provider Trust'	the Trust which provides emergency ambulance services to the JCC
'Relevant Services'	As per the Directions:

a) specialised services for
   1. cancer and blood disorders,
   2. cardiac conditions,
   3. mental health and vulnerable groups,
   4. neurosciences, and
   5. women and children,

a) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,

b) emergency medical services,

c) non-emergency patient transport services,

d) emergency medical retrieval and transfer services,

e) NHS 111 services,

f) sexual assault referral centres, and

other services as directed by the Welsh Ministers.

'Role of the Joint Committee'	the role ascribed to the JCC in section 4 of this Agreement.

2. ROLES AND RESPONSIBILITIES OF CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD

The responsibilities of CTMUHB are:

2.1 To appoint and employ such officers as may be required to support the commissioning of the Relevant Services and provide all necessary corporate services and management support, to include human resources, estates, procurement, banking and accountancy services, as may be required, including the processing of orders and the making of payments to providers of the Relevant Services, with such JCCT officers;

2.2 To provide advice to the Joint Commissioning Committee on compliance with CTMUHB policies, Standing Financial Instructions (JCC and Host Body versions as appropriate), Procurement Rules, Human Resource policies and other procedures;

2.3 To be the legal entity which enters into agreed procurement arrangements to include, but not restricted to, quotations, tenders, procurement contracts, service level agreements and terms of engagement commissioned by the JCCT, on behalf of the JCC, and to ensure that the individuals appointed and employed to support the functions of the JCC carry out those tasks which are stated as annexes to the Standing Orders to be the role of the JCC;

2.4 To have in place such appropriate governance arrangements and Schemes of Delegation as may be necessary and required on the part of CTMUHB to enable the JCCT's role to be carried out;

2.5 To hold the management budget for the JCC/Relevant Services and make payments and receive income as necessary.

2.6 To be authorised to appoint lawyers and other professional advisors in line with approved procurement procedures, and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the JCC.

2.7 CTMUHB will not be responsible or accountable for the commissioning of the Relevant Services save in respect of the residents within the geographical area of responsibility of CTMUHB.

2.8 In fulfilling its obligations and responsibilities under this Agreement, CTMUHB shall not be required to do or not do and shall not do or omit to do anything which does not comply with CTMUHB statutory powers and duties, Standing Orders and Standing Financial Instructions (JCC and Host Body versions as appropriate) corporate governance requirements generally, procurement requirements or any legal obligations not covered by the foregoing.

2.9 In line with the Welsh Risk Pool Services All Wales Policy on Insurance, NHS Indemnity and related risk management for potential losses and special payments CTMUHB provide the indemnity for the Chair (and Lay Members) of JCC. Should any claim or legal matter arise this would be processed by Legal and Risk Team responsible for CTMUHB.

3. EMPLOYMENT OF STAFF

3.1 All officers, including the Chief Commissioner, who are part of the JCCT, are to be employed by CTMUHB. The legal status of the employees would be CTM employees and with respect to any employment litigation with respect to JCCT members, CTM would be held liable.

3.2 As employees of CTMUHB, all JCCT members will be required to abide by CTMUHB policies, procedures and guidance and will be entitled to be treated as any other employee of CTMUHB and have the benefit of all applicable policies and procedures.

3.3 The CTMUHB Remuneration and Terms of Service Committee will provide advice to the CTM Board on the remuneration and the terms of service of the Chief Commissioner and any other members of the JCCT who fall within the Framework set out by the Welsh Government and are paid at executive and senior pay terms and conditions of service.

3.4 As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host LHB (CTMUHB) in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. In this regard, the Host Body CEO will inform the annual performance review of the Chief Commissioner, undertaken by the Committee Chair.

3.5 All other members of the JCCT will be accountable to the Chief Commissioner for their performance as an employee of CTMUHB and a member of the JCCT.

3.5 The human resource services which will be provided are identified at Appendix B.

4. PROCEDURES FOR TENDERS & PROCUREMENT Estates, Facilities and IT Support; Others (Communications; Corporate Support; Welsh Language; Equality and Diversity; Risk Management; Concerns and Information Governance)

4.1 CTMUHB will provide all the support services to the JCC as described at Appendix C.

4.2 Agreed procurement arrangements via quotations, tenders, procurement contracts, service level agreements and terms of engagement will be entered into and signed by CTMUHB on behalf of the JCC in accordance with the CTMUHB procurement policy and Standing Financial Instructions.

4.3 CTMUHB shall not execute or, through performance create, any third party contract in respect of the JCC unless authorised to do so by the Chief Commissioner or an officer of the JCCT to whom the Chief Commissioner has delegated authority in line with the approved Scheme of Delegation

4.4 The seven Health Boards will provide sufficient funds and other relevant resources to meet the requirements of all third party contracts entered into by Cwm Taf Morgannwg in pursuance of paragraph 4.3.

4.5 CTMUHB shall provide the Chief Commissioner (as appropriate) with drafts of all third party contracts and the JCC shall be entitled to require CTMUHB to use its reasonable endeavours to negotiate such amendments to the terms of such contract as the Chief Commissioner and/or the JCC reasonably see fit.

5. GOVERNANCE ARRANGEMENTS

5.1 The JCCT will utilise CTMUHB arrangements to assist it in discharging its governance responsibilities.

5.2 Where the JCC utilises CTMUHB sub-committee arrangements such as the Audit and Risk Committee, and the Remuneration and Terms of Service Committee, CTMUHB will ensure that the appropriate responsibilities are afforded to the JCC and the agenda is constructed to ensure relevant issues are to be properly managed to allow the JCC to satisfy itself from a risk management and controls assurance perspective.

5.3 The JCCT will adopt the risk assessing mechanisms of CTMUHB. Any adaptation to the agreed risk processes of the Host Body, which may be required owing the specific functions of the JCC/JCCT, should only be made after consulting with the Host Body Executive Director of Finance and the Director of Corporate Governance/Board Secretary.

5.4 As part of the agreed accountability arrangements, the Chief Commissioner will have accountability to the Chief Executive of CTMUHB in respect of ensuring adherence to all relevant legislation, policies and procedures. This accountability will be formalised in the form of quarterly meetings to take place between the Chief Commissioner and the Chief Executive of CTMUHB and will include a discussion on the Hosting arrangements as a standing agenda item.

5.5. Tier 2 roles, within the JCCT , which have regulated professional accountabilities e.g. the Medical Director will be professionally accountable to the relevant CTMUHB Executive Director e.g. the CTMUHB Executive Medical Director.. Arrangements will be established to put in

place quarterly meetings where any issues can be discussed and for re-validation.

5.6 CTMUHB will also work with members of the JCCT to establish regular meetings between relevant members of the CTMUHB Executive Team including the Executive Director of Finance, Executive Director of People and Director of Corporate Governance; and senior members of the JCCT including those responsible for finance and governance.

5.5 The Chief Commissioner will provide reports from the JCC to the Cwm Taf Morgannwg Board in line with the CTMUHB scheme of delegation to enable CTMUHB to assure itself that appropriate control measures are in place with respect to Hosting Arrangements.

5.6 The Chief Commissioner, with support from the Committee Secretary will produce an Annual Governance Statement for the JCC/JCCT.

6. BUDGET AND FUNDING

6.1 The JCC will transfer funds to CTMUHB on a quarterly basis in advance to allow CTMUHB to perform its functions on behalf of the JCC, provided that the JCC may attach conditions to the expenditure of such funds.

6.2 The seven Health Boards will meet the CTMUHB overhead costs reasonably incurred in the support of the JCC as may be agreed by the JCC acting reasonably at all times.

6.3 The Chief Commissioner or their Director of Finance will authorise the transfer of funds to CTMUHB in line with agreed funding levels, which funds shall be accounted for by CTMUHB as income to the JCC.

6.4 CTMUHB will set up and manage an Income and Expenditure Account for the JCC, namely a JCC Account. This includes all the income for the JCC received from the LHBs and all other JCC expenditure. This account shall be separate from all other CTMUHB funds. The Chief Commissioner or their Director of Finance will make decisions relating to expenditure from this account provided that CTMUHB shall not at any time be obligated to operate the JCC Account in deficit.

6.5 The Chief Commissioner and their Director of Finance shall be responsible for ensuring that all relevant reports, financial information and commentary are provided to CTMUHB so that the appropriate monitoring return can be prepared.

6.6 The Chief Commissioner and their Director of Finance will provide all the necessary information to the CTMUHB Executive Director of Finance to ensure that a consolidated set of financial statements can be prepared in

accordance with deadlines set out and agreed with Welsh Government and Audit Wales.

7. OWNERSHIP OF ASSETS

7.1 All assets (including intellectual property rights) acquired by CTMUHB in connection with the JCC and JCCT shall belong to CTMUHB but be held upon trust for the JCC and JCCT.

7.2 CTMUHB shall, to the extent it is legally entitled to do so, transfer ownership and any other rights in such assets to such party or body as the JCC shall require and within such timescales as are reasonably required.

7.3 In the event that any income is derived from such assets or from their disposal, such revenues shall be regarded as part of the JCC income and accounted for accordingly.

8. ACCOUNTABILITY ARRANGEMENTS

8.1 The accountability arrangements of the Joint Commissioning Committee Team (JCCT) and the Chief Commissioner and their relationship with CTMUHB are set out in Appendix D.

9. DUTY OF CARE

9.1 CTMUHB shall be responsible for ensuring that all reasonable skill, care and diligence are exercised in carrying out those services, which it is required to perform under this Agreement properly and efficiently in accordance with this Agreement and the Memorandum of Agreement and its overall responsibilities under the Act and all other appropriate legislation. CTMUHB shall keep the JCC informed of any foreseeable or actual changes in circumstances which are likely to affect its ability to comply with the terms of this Agreement as the Host LHB.

10. CWM TAF MORGANNWG ORGANISATION

10.1 CTMUHB shall provide and maintain an organisation having the necessary facilities, equipment and employees of appropriate experience, to undertake the specific functions and provide all the services identified in this Agreement.

10.2 All personnel deployed on work relating to the Agreement must have appropriate skills and competence.

11. LEGISLATION

11.1 CTMUHB shall ensure that it, and its employees and agents, shall in the course of this agreement comply with all relevant legislation, Welsh Government Directions and Guidance and procedures.

11.2 Where responsibilities for compliance with legislation is delegated to the JCCT it will be set out within the Scheme of Delegation e.g. Duty of Quality, Safeguarding, the Equality Act 2010 etc.

12. INTERNAL AND EXTERNAL AUDIT

12.1 CTMUHB, through the NHS Wales Shared Services Committee arrangements, will provide an effective independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Government.

12.2 CTMUHB will ensure that relevant external audit arrangements are established with the Auditor General for Wales, which give due regard to the functions of the JCC.

13. MANAGEMENT OF CONCERNS (INCLUDING INCIDENTS, COMPLAINTS & CLAIMS)

13.1 Section 14 of the Memorandum of Agreement sets out the procedures to be followed for the handling of disputes and arbitration relating to the business of the JCC/JCCT.

13.2 Where a matter is regarded as an individual concern in respect of those services commissioned by the JCC and/or the functions delivered by the JCC Team, CTMUHB will only be responsible for the management of those concerns where liability in Tort is established, which relate to its geographical area of responsibility. In such circumstances, the Chief Executive of CTMUHB will be responsible for investigating and responding to the concern in accordance with *The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*.

13.3 Individual concerns relating to patients resident outside CTMUHB's geographical area of responsibility will be referred to the Chief Executive of the LHB in the appropriate geographical area.

13.4 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

13.5 Individual concerns relating to emergency ambulance services will be referred to the Chief Executive of the provider organisation.

14. MANAGEMENT OF FOIA / DPA REQUESTS

14.1 For the purposes of Freedom of Information and Data Protection, CTMUHB is the organisation registered with the Information Commissioner's Office (ICO). In common with all other CTMUHB employees, members of the JCCT will be required to follow all the relevant CTMUHB information governance and data protection rules, policies and procedures, including the policy on Records Management and Schedule for the Retention and Destruction of Records. As the legal entity and organisation registered with the ICO, CTMUHB, would be held liable for any data breach or fine issued by the ICO which arose from activity within the JCCT.

14.2 Where a request under the Freedom of Information Act or Data Protection Act is received by the JCC/JCCT, the request will be dealt with in accordance with CTMUHB procedures. Where the request is considered to be an issue relating to a public body covered by the FOI Act then the request will be forwarded to that particular body to deal with.

15. NOTICES

15.1 Any notices served in respect of matters covered by this Agreement shall be sent to the Chief Executive on behalf of CTMUHB and the Chief Commissioner (as appropriate) on behalf of the JCC.

16. DISPUTE

16.1 In the event of any dispute between CTMUHB and those involved in the JCC/JCCT, all parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and trying to resolve the issues. All reasonable efforts must be made before escalating any disputed issues.

16.2 If a dispute cannot be resolved in accordance with the provisions of paragraph 16.1 it shall be referred to the Chief Commissioner and the Chief Executive of CTMUHB for further discussion.

16.3 If a dispute cannot be resolved in accordance with the provisions of paragraph 16.2 it shall be referred to the Chair of the JCC and the Chair of CTMUHB for further discussion.

16.4 If a dispute cannot be resolved in accordance with the provisions of paragraph 16.3, CTMUHB and/or the Chief Commissioner should have a further meeting with the other six LHBs to determine if the matter can be resolved.

16.5 If a dispute still cannot be resolved in accordance with the provisions of paragraph 16.4, it shall be referred to the Welsh Government Director General for Health and Social Services and ultimately onwards to Cabinet Secretary for Health and Social Care for resolution.

17. GENERAL

17.1 This agreement shall be capable of being varied only by a written instrument signed by a duly authorised officer or other representative of each of the parties.

17.2 No third party shall have any right under the Contracts (Rights of Third Parties) Act 1999 in connection with this Agreement.

17.3 This Agreement shall be governed and construed in accordance with the laws of England and Wales.

17.4 In the event of the Cwm Taf Morgannwg Board determining (acting reasonably) that the performance by CTMUHB of its obligations under this Agreement is having a detrimental or prejudicial effect on the CTMUHB ability to fulfil its core functions, the Cwm Taf Morgannwg Board may instruct the Chief Commissioner and CTMUHB Chief Executive to review the operation of this Agreement.

17.5 In carrying out a review of this Agreement further to clause 17.4, the Chief Commissioner and CTMUHB Chief Executive shall consider the source and manner of any detriment identified by the Cwm Taf Morgannwg Board further to clause 17.4 and shall put forward such amendments and variations to this Agreement and the associated governance arrangements between the JCC and CTMUHB as they may consider appropriate. At this point given CTMUHB is directed to host the

JCC by Welsh Ministers, the Welsh Government should also be advised of this.

17.6 The Cwm Taf Morgannwg Board shall consider the recommendations made further to clause 17.5 and may recommend to the JCC and the Chief Executive of CTMUHB that this Agreement and the associated governance arrangements are amended accordingly.

SIGNED under hand and delivered the XX 2024.

SIGNED and DELIVERED by Cwm Taf Morgannwg University Local Health Board acting by …….. [Paul Mears] Chief Executive
SIGNED and DELIVERED by Aneurin Bevan University Local Health Board acting by …….. [Nicola Prygodzicz] Chief Executive
SIGNED and DELIVERED by Betsi Cadwaladr University Local Health Board acting by …….. [Carol Shillabeer] Chief Executive
SIGNED and DELIVERED by Cardiff and Vale University Local Health Board acting by …….. [Suzanne Rankin] Chief Executive

SIGNED and DELIVERED by Hywel Dda University Local Health Board acting by …….. [Phil Kloer] Interim Chief Executive
SIGNED and DELIVERED by Powys Teaching Local Health Board acting by …….. [Hayley Thomas] Chief Executive
SIGNED and DELIVERED by Swansea Bay University Local Health Board acting by …….. [Richard Evans] Interim Chief Executive

APPENDIX A

Role of the Joint Commissioning Committee (JCC) (refer to Standing Order 2.20):

The role of the JCC is to:

- Determine a long-term strategy for the commissioning of services delegated to the JCC
- Produce an Integrated Medium-Term Plan which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)
- In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards and will, for the relevant functions:

• Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered
• Develop policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
• Determine annually those services that should be commissioned on a regional or national basis
• Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers
• Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales
Ensure the JCC operates within an appropriate governance framework

From the Standing Orders (2.20)

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APPENDIX B

EMPLOYMENT OF STAFF

Identified human resources services to be provided by Cwm Taf Morgannwg University Health Board

Service	Description
Recruitment and Selection	• To provide a comprehensive recruitment and selection service which complies with employment legislation and standards of good practice as directed by the Welsh Government.
Employee Relations	• To provide support to the Joint Commissioning Team (JCCT) in the management of sensitive issues relating to all employment policies including discipline, grievance, collective disputes, performance and capability, allegations of bullying and harassment whistle blowing and sickness absence etc.
Policy Development	• To develop, implement and advise on employment policies and procedures which comply with employment legislation and NHS guidance; and • To provide training to JCCT Managers in the interpretation and use of policies and procedures.
Remuneration and Payroll	• To provide advice on pay and associated terms and conditions of employment; • To provide a comprehensive payroll service; and • To undertake the matching and evaluation of all new and revised roles, including and re-banding which may be necessary. Ensure that Welsh Government is advised of any roles which require evaluation under Executive and Senior Pay arrangements and any approved roles at that level go through the Host Body Remuneration Committee processes.
Training and Organisational Development	• To provide appropriate training and development to members of the JCC and JCCT

HR administration	• To maintain securely employment records for Chair, Lay Members and JCCT and provide accurate workforce data and information as required.
Well-Being and Occupational Health	• To provide a comprehensive well-being and Occupational Health service to members of the JCCT

APPENDIX C

3.1 Procedures for Tenders & Procurement

Service	Description
Procurement (Tendering and ordering goods and services)	• Tendering for goods & services in accordance with SOs and SFIs • Entering into procurement contracts and Agreements • Raise orders for properly approved requisitions
Creditor Payments (Payment of suppliers, contractors and service providers) JCC Finance Team	• Pay all duly authorised invoices • Deal with supplier queries etc. • Provide management information on payment performance in accordance with WG requirements
Systems maintenance and administration (ORACLE)	• Process feeders into JCC ledgers and maintain financial management system • Maintain passwords and hierarchies (cost centre and approval) • Oracle training as and when required including external training if required • Access to help desk facility • Undertake testing of upgrades • Liaise with Oracle Central Team and All Wales groups
Accounting Services (bank accounts, annual accounts consolidation, VAT) JCC Finance Team	• Provision of bank accounts and petty cash facilities • Consolidation of Annual Accounts and other returns as required by WG • Provide VAT advice and consolidate VAT returns, including access to contracted out VAT advisory services • Payment of Tax, National Insurance and Superannuation to appropriate authorities • Reconciliation of all accounts due against the payroll system
Financial Governance (internal and external	• Responsible for the securing of internal audit service via external contract

audit, counter fraud, audit committee) JCC Finance Team	• Access to Local Counter Fraud Specialist • Advice on financial procedures and other issues of governance • Ensure appropriate external audit provision in place.

3.2 Estates, Facilities and IT Support

Service	Description
Estates Maintenance	• To provide an efficient service in response to all aspects of estates maintenance in the running of the JCC offices.
Fire Safety	• To provide professional advice and support in relation to all aspects of Fire Safety ensuring compliance with legislation and guidance issued by the Welsh Government; and • To provide appropriate training to the Chair and Lay members of the JCC and officers who comprise the JCCT.
Health and Safety	• To provide a Health and Safety Policy statement as and when required. The Policy must comply with the requirements of the Health and Safety at Work Act. All other relevant rules and regulations must be observed at all times; • To be responsible for the testing, where appropriate, labelling and recording of all portable appliances in their ownership under the Electricity at Work Act 1989; • To provide advice and support on the operational delivery of health and safety arrangements in the JCC offices in accordance with CTMUHB policies and procedures; and • To provide appropriate training to the Chair and Lay members of the JCC and officers who comprise the JCCT.
IT Support	• To provide a comprehensive IT support service including : o User registration; o Resolution of faults reporting via the Helpdesk o Purchase and set up new IT equipment; o Supply of printing consumables • To provide support in relation to the management of files and databases; • To ensure the secure storage of data, back up, restore and recovery

3.3 Others

Service	Description
Communications (including internet and intranet)	• To provide some communications support on a range of activities to the JCC in addition to the JCC's own communications service.
Corporate Support	• To provide access to the Director of Corporate Governance and Board Secretary for advice and support on Corporate Governance matters as required. • To co-ordinate the Audit and Risk Committee, and Remuneration and Terms of Service Committee agenda and papers, circulate and take minutes of the meetings. • To provide access to the range of groups and committees including Information Governance Group, Equality Forum etc.
Welsh Language	• Offer advice and information about the Welsh Language • Promote and encourage the use of Welsh within the workplace • Encourage the use of bilingual aids within the workplace such as signage, stationery etc. • Provide Welsh Language taster lessons for staff • Give bilingual front-line telephone training • Translate small in-house, day-to-day, translations • Help co-ordinate the translation of larger documents • Attend public meetings to provide a Welsh Language service for Welsh speakers.
Equality, Diversity and Inclusion	• To provide advice and information to the JCC and JCCT; • To develop a work plan and meet quarterly to review progress against the plan;

	• To ensure that relevant training is provided to the members of the JCC and JCCT in relation to awareness raising and impact assessment; • To provide an assurance mechanism on behalf of the LHBs that robust processes are in place to meet the Equality and Diversity agenda
Risk Management	• To work with the Committee Secretary to provide advice and information on all areas of Risk Management to the JCC/JCCT; • To support the development of a Risk Assurance Framework for the JCC • To provide support (structure and advice) for the use of DATIX to facilitate the management of risk within the JCCT • To develop a work plan and meet quarterly to review progress against the plan
Concerns	• To provide training and awareness for all staff in relation to the management of concerns; • To provide advice and support in relation to the concerns process; • To provide support (structure and advice) for the use of DATIX to facilitate the management of concerns within the JCCT. • To be responsible for all claims relating to staff and services commissioned which relate to CTMUHB Residents
Information Governance	• To provide timely advice to all information governance related enquires; • To process requests made under the Freedom of Information and Data Protection Acts; • To provide training and awareness for all staff in all areas of Information Governance

APPENDIX D

Accountability Arrangements

1. The NHS Wales Joint Commissioning Committee (Wales) Directions 2024 state that the LHBs will jointly exercise the Delegated Functions from 1 April 2024. https://www.legislation.gov.uk/wsi/2024/135/contents/made

2. This means that the Delegated Functions are those of the individual constituent LHBs and not CTMUHB.

3. The Directions state that CTMUHB will exercise its functions so as to provide administrative support for the running of the JCC and establish the JCCT.

4. The membership of the JCC consists of the Chief Executives of the seven LHBs or their nominated representative, the Chair and not more than five non-officer (lay) members who are appointed by the Cabinet Secretary for Health and Social Care. In addition the Chief Commissioner will be an Associate Member of the JCC.

5. The Chair is directly accountable to the Cabinet Secretary for Health and Social Care at Welsh Government

6. As per point 4, the Chief Commissioner will attend meetings as an Associate Member of the JCC and will have such responsibilities as may be prescribed by the JCC.

7. The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the JCC on behalf of the seven LHBs to the JCC for the planning, securing and commissioning of relevant services.

8. The Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the seven LHBs in respect of the role and functions delegated to the JCCT by the JCC on behalf of the seven LHBs.

9. As an employee of CTMUHB the Chief Commissioner will be accountable to the Chief Executive of CTMUHB in respect of the responsibilities delegated to the Chief Commissioner set within the Hosting Agreement in this regard, CTMUHB CEO will inform the

annual performance review of the Chief Commissioner undertaken by the Committee Chair.

10. In respect of the effective management and controls of finances and resources, as delegated by the seven LHBs, the Chief Commissioner will be accountable to the Director General/NHS Wales Chief Executive for propriety and regularity. Further detail on this accountability relationship is set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body.

11. The Chief Executive of CTMUHB is only accountable to the Director General and Chief Executive of the NHS in Wales in so far as the functions relate to administrative support.

12. The Chief Executives of the Constituent LHBs are individually accountable to the Director General and Chief Executive of the NHS in Wales.

13. The Director of Finance for CTMUHB is only accountable to the Director of Finance for the NHS in Wales insofar as their functions relate to administrative support.

14. JCCT Tier 2 roles will be accountable to the Chief Commissioner (Tier 1 Director) for their performance as an employee of the Host Body and a member of the JCCT.

15. Tier 2 roles, which have regulated professional accountabilities, will be professionally accountable to the relevant CTMUHB Executive Director.

16. The governance and issues relating to the hosting of the JCC will be incorporated into the standard business of the existing Host Body's Audit Committee. The assurance for the governance and issues relating to the hosting of the JCC will be to the Host Body's Board.

17. Issues relating to the functions of the JCC delegated from the seven LHBs will be fed into a separate Host Body Audit Committee for the JCC specifically, operating within its own work cycle as required. The assurance for this will be to the seven LHBs.

NHS WALES JOINT COMMISSIONING COMMITTEE
SUB COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Joint Commissioning Committee Standing Orders

QUALITY, SAFETY & OUTCOMES SUB-COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

DRAFT

Document Author:	Committee Secretary
Lead Director	Director of Nursing & Quality
Approved By	Joint Commissioning Committee
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1. INTRODUCTION

In accordance with JCC Standing Order 5.5 , the NHS Wales Joint Commissioning Committee (Joint Committee)) may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the LHBs, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

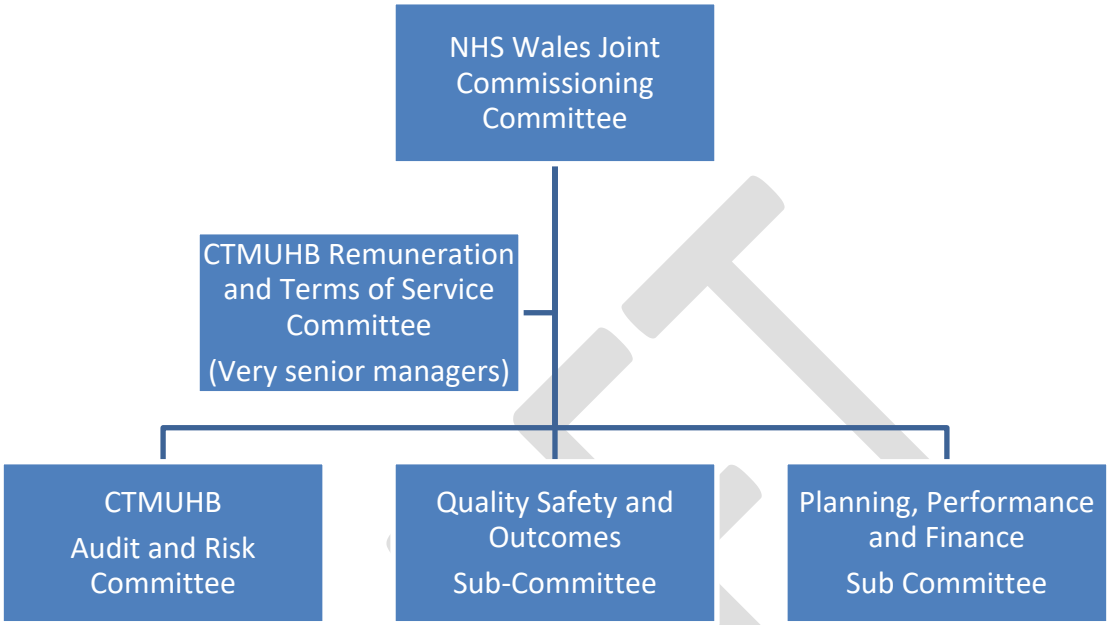
In accordance with Standing Orders (and the JCC scheme of delegation), the Joint Committee shall nominate annually a sub-committee to be known as the Quality, Safety and Outcomes Sub-Committee. The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this sub-committee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

2. CONSTITUTION & PURPOSE

The purpose of the Quality, Safety and Outcomes Sub-Committee. "the Sub-Committee" is to be assured that the Joint Committee is commissioning appropriate, high quality and safe services from providers (Health Boards, Trusts and private sector providers) on behalf of Health Boards in Wales. This will be achieved by:

- Providing scrutiny and assurance to the JCC for the Quality Safety and Outcomes of services commissioned from providers including Health Boards, Trusts and private providers who are accountable for the provision of safe, quality services)
- Reporting to and providing advice to the Joint Committee, including escalation of issues that require urgent consideration and action by the Joint Committee
- Addressing concerns delegated by the Joint Committee ensuring that individual LHB Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of the services commissioned may impact on primary and secondary and vice versa (whole pathway) and contribute to the achievement of the Duty of Candour; and

- Providing assurance to the Joint Committee in relation to improving the experience of patients, carers, citizens and those that come into contact with the services commissioned by the JCC.



3. SCOPE AND DUTIES

3.1 The Quality, Safety & Outcomes Sub-Committee will, in respect of its provision of advice to the JCC:

- Monitor and support the development and implementation of the Commissioning Assurance Framework ensuring that there is continuous improvement in the commissioning of safe, effective and sustainable services for the people of Wales
- Consider the quality, patient safety and outcome implications arising from the development of commissioning strategies, including developments outlined in the agreed JCC Integrated Medium Term Plan (IMTP)
- Ensure that all aspects of commissioning activity, through regular reporting to the sub-committee consider quality, safety and outcomes as part of the commissioning of services
- Receive, when required, items for urgent consideration and escalation
- Ensure a robust process is in place for the development and approval of evidence-based service specifications, focussed on quality and safety of service provision, for all services commissioned by the JCC

- Have responsibility for the commissioning risks designated to the Sub-Committee for monitoring ensuring that quality, safety and outcomes of services commissioned are a priority for the organisation
- Monitor and scrutinise risk management and assurance arrangements for the risks designated to the Sub-Committee for monitoring from the perspective of clinical and patient safety risks
- receive assurance from provider organisations that concerns management arrangements are robust and reported through the appropriate governance routes; and
- Receive assurance that patient safety incidents, complaints and claims (relating to the services commissioned by the JCC) are routinely monitored and are considered a critical part of the evaluation of services in the JCC commissioning cycle.

4. AUTHORITY

4.1 The Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference.

The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the JCCs procurement, budgetary and other requirements.

The Sub-Committee will ensure that it is aware of and receives relevant reports on the activities and reports of external independent regulators and agencies, such as Healthcare Inspectorate Wales, Care Quality Commission, National Audit Office and Audit Wales, that relate to the commissioning of services.

4.2 Sub Groups

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

4.3 Strategy

Oversee and monitor the development and implementation of the JCCs Strategies for patient quality, safety and outcomes:

- Patient Quality, Safety and Outcomes
    - Provide assurance to Joint Committee on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for the Joint Committee
    - Provide assurance to the Joint Committee in relation to the Commissioning Assurance Framework.
    - Contribute to and oversee the development of effectiveness of the Joint Committee's Annual Quality Statement and the Annual Governance Statement
    - Monitor quality via the Quality Dashboard.
- Monitor and receive reports on the organisation's progress with embedding and implementing the Quality Health & Care Standards
- Ensure arrangements are in place to review and act on Clinical Audit activity which responds to National and Local priorities applicable to the business and services commissioned by the JCC as part of the commissioning cycle.
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response.

4.4 Organisational Risk

Regularly review and provide assurance to the Joint Committee on the risks included on the organisational Risk Register and assigned to the Sub-Committee by the Joint Committee.

4.5 Quality Improvement activities

The Commissioning Assurance Framework provides the framework for quality improvement projects supporting compliance with the Duty of Quality. The Quality, Safety and Outcomes Sub-Committee will:

- Provide scrutiny and assurance to the JCC that priorities relating to quality, safety and outcomes are progressing.

4.6 Patient Experience

- Receive and review progress reports relating to Patient Experience and the requirements identified in the Commissioning Assurance Framework
- Ensure that the JCC engages with and co-operates with representatives of Llais as appropriate on ongoing patient engagement or major service change. (S.O. 7.7)

4.7 Concerns

- Receive as presented within the quarterly quality report, reports on Concerns relating to the services commissioned by the JCC (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with emphasis on ensuring that lessons are learnt and are built into the evaluation of services as part of the JCC commissioning cycle.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) relating to commissioned services from across NHS Wales, in accordance with the legislation under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) contributing to HB approaches providing information related to the services commissioned to support them in complying with their have legal and contractual requirements.

5. DELEGATED POWERS

Although health boards have delegated authority to the Joint Committee and subsequently to this Sub-Committee for the exercise of certain planning, securing and commissioning functions as set out within these terms of reference, each Health Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

This Sub Committee is responsible for providing scrutiny and assurance to the JCC that Quality, Safety and Outcomes are being managed appropriately within the evaluation of services as part of the JCC commissioning cycle.

The Sub-Committee will:

- Seek assurance that the JCC's Commissioning Assurance Framework remains appropriate, is aligned to the Duty of Quality and is embedded in practice.

- Seek assurance that arrangements for capturing the experience of patients, citizens and carers are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- Contribute information from the commissioning perspective to HBs in their implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned through the commissioned service lens.

- Seek assurance that arrangements for the provision of high quality, safe and effective healthcare are sufficient, effective and robust, including:
  - the commissioning assurance framework arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services
  - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities
  - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response
  - the development of the Joint Committee's Annual Quality Statement including annual quality priorities; and
  - performance against key quality focussed performance indicators and metrics.

- Seek assurance on the arrangements in place to support Improvement and Innovation, including:
  - an overview of the research and development activity for commissioning within the organisation
  - alignment of the commissioning of services with the national objectives published by Health and Care Research Wales (HCRW);
  - an overview of the quality improvement activity for commissioned services within the organisation.

- Seek assurance that arrangements for commissioned services are compliant with mental health legislation are sufficient, effective and robust, including:
  - the Mental Health Act 1983
  - Mental Health Act Code of Practice for Wales and associated regulations (2016);
  - the Mental Capacity Act 2005 Code of Practice and associated regulations;

- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
- the Mental Health Measure (Wales) 2010.

The Sub-Committee will seek assurances on the management of strategic risks delegated to the Sub-Committee by the Joint Committee, from the JCC Risk Register.

6. ACCESS

7.1 The Chair of the Quality, Safety and Outcomes Committee shall work closely with the Director of Nursing and Quality and have reasonable access to the JCC Directors and other relevant senior staff within the JCC Team.

7. SUB COMMITTEE PROGRAMME OF WORK

Each year the Joint Committee will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's Commissioning Assurance Framework and Corporate Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the Joint Committee throughout the year.

8. MEMBERSHIP

9.1 The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of the Joint Committee and lay members, taking account of the balance of skills and expertise necessary to deliver the subcommittee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.

The Chair of the Joint Committee and the Chair of the Sub-Committee, receive from nominations from the CEOs of Local Health Boards

Members:
A minimum of (4) members, comprising

Chair	Lay (Independent) Member of the Joint Committee
Vice Chair	Lay (Independent) Member of the Joint Committee
Members	Three Lay (Independent) Members (including the Chair) and one representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board.

Notwithstanding the requirement to maintain a quorum, the Joint Committee CEO Member may on occasion nominate a suitably senior deputy to attend the Sub Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed. Agreement should be received from the Chair of the Sub Committee for this.

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

Attendees

- JCC Director of Nursing and Quality (Lead Director for the Committee)
- JCC Medical Director
- JCC Director of Commissioning for Specialised Services
- JCC Director of Commissioning for Ambulance and 111
- JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG)
- Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Committee Chair
- Llais Representative
- Staff side representative.

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

By Invitation:

- The Chief Commissioner, and other directors / staff may be invited to attend when the Committee is discussing areas of risk or matters that are the responsibility of that director / member of staff.
- The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

8.2 Secretariat

The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

8.3 Member Appointments

The membership of the Sub-Committee shall be determined by the Chair of the Joint Committee, 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.

8.4 Support to the Sub-Committee Members

The Committee Secretary, on behalf of the Sub-Committee Chair, shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

9. SUB-COMMITTEE MEETINGS

9.1 Quorum

A quorum shall be at least three members comprising of two Lay (Independent) Members, and one representative health board Chief Executive Officer or designated deputy.

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

9.2 Frequency of Meetings

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

Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.

Additional meetings may be held with the chairs of the LHBs Quality and Safety Committees where there is a requirement.

Members will be required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.

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

9.3 Withdrawal of individuals in attendance

The Sub-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.

9.4 Circulation of Papers

The JCC Committee Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

9.5 Circulation of Minutes

The Committee Secretariat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.

The JCC Committee Secretariat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.

The Sub-Committee highlight report will also be shared with Sub-Committee members and HB Directors of Corporate Governance / Board Secretaries.

10. REPORTING AND ASSURANCE ARRANGEMENTS

The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the Joint Committee on the Committee's activities. This includes:
  - Assurance that Quality Safety and Patient Outcomes are being managed appropriately
  - oral updates on activity,
  - submission of written Sub-Committee highlight reports throughout the year
  - to receive annual reports, which will incorporate key information on quality, safety and outcomes.
- Bring to the Joint Committee's specific attention any significant matters under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, Chief Commissioner, HB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the JCC and HBs.

The Sub-Committee shall provide a written, annual report to the Joint Committee 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 Sub-Committees self-assessment and evaluation.

The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Quality Safety and Patient Outcomes are being managed appropriately, for inclusion on HB Quality and Safety Committee agendas.

The Joint Committee may also require the Sub-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 Sub-Committee's assurance role relates to a joint or shared responsibility.

The JCC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

11. RELATIONSHIP WITH THE JOINT COMMITTEE AND ITS SUB-COMMITTEES / GROUPS

Although the Joint Committee has delegated authority to the sub-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, safety and outcomes of healthcare for its commissioned services through the effective governance of its organisation.

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

The sub-committee, through the Sub-Committee Chair and members, shall work closely with the Joint Committee's other Sub-Committees to provide advice and assurance to the Joint Committee through the:

- joint planning and co-ordination of JCC 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 JCCs overall risk and assurance arrangements.

The Sub-Committee, through its Chair and Members, shall work closely with LHB Quality and Safety Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of specialised services may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the Joint Committee's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

The Sub-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.

12. DEALING WITH MEMBERS INTERESTS DURING MEETINGS

Declarations of interest will be a standing agenda item for all meetings.

Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the JCC Standing Orders

13. APPLICABILITY OF STANDING ORDERS TO SUB COMMITTEE BUSINESS

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

This Sub-Committee is a scrutiny committee and therefore where a decision is required the matter will be referred to the JCC Team or JCC, as appropriate.

14. REVIEW

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

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NHS WALES JOINT COMMISSIONING COMMITTEE
SUB COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Joint Commissioning Committee Standing Orders

PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

DRAFT

Document Author:	Committee Secretary
Lead Directors	Director of Finance and Information Director of Planning and Performance
Approved By	Joint Commissioning Committee
Issue Date	
Review Date	
Version	5

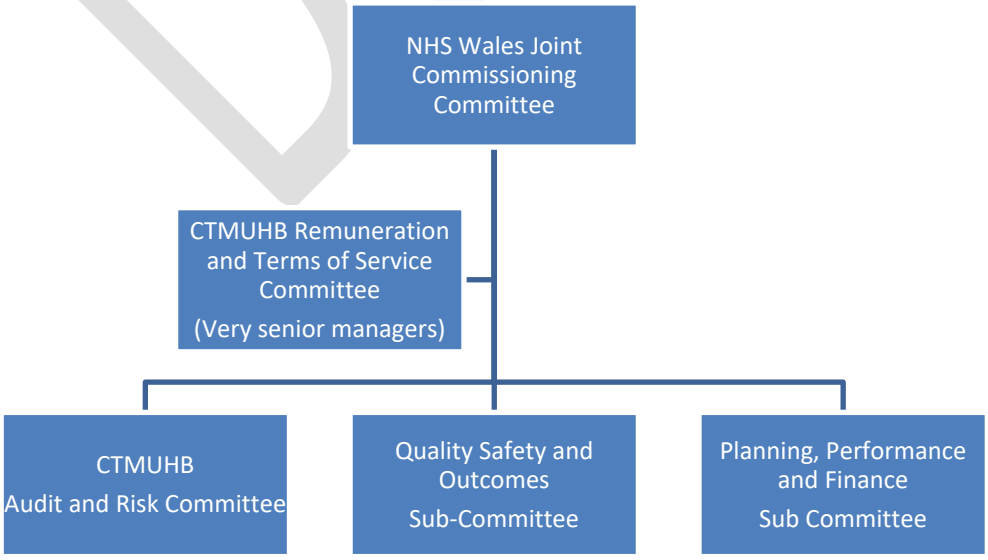
1. INTRODUCTION

In accordance with JCC Standing Order 5.5 , the NHS Wales Joint Commissioning Committee (NWJCC – the Joint Committee) may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the JCC either to undertake specific functions on the JCC's behalf or to provide advice and assurance to others (whether directly to the JCC or on behalf of the JCC to each LHB Board and/or its other committees). The JCC shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.

In accordance with Standing Orders (SOs) (and the JCC Scheme of Delegation), the Joint Committee shall nominate annually a sub-committee to be known as the Planning, Performance and Finance Sub-Committee. The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this sub-committee are set out below.

2. CONSTITUTION & PURPOSE

The purpose of the Planning, Performance and Finance Sub-Committee is to be assured that the Joint Committee is effectively managing the strategic planning, performance and financial duties outlined in the Joint Committees SOs and Standing Financial Instructions (SFIs) relating to planning, securing and commissioning the services delegated to the JCC.



3. SCOPE AND DUTIES

The Sub-Committee will provide scrutiny and assurance in relation to the duties below:

Planning

- Monitor the process for the development of the Integrated Medium Term Plan (IMTP) in line with the relevant SOs, SFIs and the NHS Wales Planning Framework
- Receive assurance on the delivery of the IMTP
- Scrutinise the alignment of service, workforce, digital and financial commissioning plans in the IMTP (as appropriate to the business of the NWJCC)
- Scrutinise the development and delivery of strategic or major service plans through the agreed Service Transformation Programme in the IMTP.

Commissioning

- Advise on and assure the development and implementation of the NWJCC's Commissioning Framework (organisational approach to commissioning).

Performance

- Advise on and assure the development and implementation of the NWJCC's Performance Management Framework
- Monitor in-year performance against the financial plan and activity targets that support the relevant metrics agreed by the Joint Committee
- Monitor overall performance of commissioned services against the JCC's IMTP and the national targets for NHS Wales (Ministerial Priorities).

Organisational Risk Register

- Regularly review the planning, performance and finance risks included on the JCC Risk Register and assigned to the Sub-Committee by the JCC.

Finance

- Monitor delivery of financial plans and delivery of savings Programmes
- Monitor risk to financial delivery including mitigating actions to appropriately manage the risks
- Robustly challenge and support progress against delivery of savings plans to achieve financial plans to ensure consideration of impact on services

- Scrutinise investments in line with the Standing Financial Instructions (SFIs) and the Scheme of Delegation prior to submission to the Joint Committee for approval
- Monitor activity and productivity including operational efficiency and effectiveness
- Monitor delivery of financial plans and delivery of savings Programmes; and
- Scrutinise financial savings plans.

The Sub-Committee, in monitoring and scrutinising the above areas, will discuss and recommend corrective action where necessary. This will include the transformation, recommissioning and value in health care approach.

The Sub-Committee will monitor the development of appropriate Key Performance Indicators (KPIs) across all parts of the organisation.

Where necessary, the Sub-Committee will undertake detailed "deep dives" of specific areas. These reviews will be supported by appropriate benchmarking information to ensure all of the JCCs commissioned services are striving to achieve "best in class" in relation to planning, performance and finance.

4. AUTHORITY

Although health boards have delegated authority to the Joint Committee and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each health board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

This Sub Committee is responsible for providing scrutiny and assurance to the JCC that Planning, Performance and Finance are being managed appropriately within the commissioning cycles.

4.1 Authority

The Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference. The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with procurement, budgetary and other policy requirements.

4.2 Organisational Risk

Regularly review and provide assurance to the Joint Committee on the planning, performance and finance risks included on the organisational Risk Register and assigned to the Sub-Committee by the Joint Committee.

4.3 Sub Groups

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

5. DELEGATED POWERS

Although the Joint Committee has delegated authority to the Sub-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.

6. ACCESS

6.1 The Chair of the Planning, Performance and Finance Sub-Committee shall work closely with the Director of Finance and Information and the Director of Planning and Performance and have reasonable access to the Directors and other relevant senior staff within the JCC Team.

7. SUB COMMITTEE PROGRAMME OF WORK

Each year the Joint Committee will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's IMTP and Corporate Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the Joint Committee throughout the year.

8. MEMBERSHIP

8.1 The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of the Joint Committee and lay members, taking account of the balance of skills and expertise necessary to deliver the subcommittee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.

The Chair of the Joint Committee and the Chair of the Sub-Committee, receive a nomination from the CEOs of Local Health Boards as outlined below.

Members:
A minimum of (4) members:

Chair	Lay (Independent) Member of the JCC
Vice Chair	Lay (Independent) Member of the JCC
Members	Three Lay (Independent) Members and one representative Chief Executive or designated nominated deputy who must be an Executive Director from a HB.

Notwithstanding the requirement to maintain a quorum, JCC CEO Member may on occasion nominate a suitably senior deputy to attend the Sub Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed. Agreement should be received from the Chair of the Sub Committee for this.

Attendees
- JCC Director of Planning and Performance (co-lead JCC Director)
- JCC Director of Finance & Information (co-lead JCC Director)
- Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Committee Chair
- Staff side representative.

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

By Invitation:

- The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk or matters that are the responsibility of that Director / member of staff.

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

8.2 Secretariat

The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

8.3 Member Appointments

The membership of the Sub-Committee shall be determined by the Chair of the Joint Committee, 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.

8.4 Support to the Sub-Committee Members

The Committee Secretary, on behalf of the Sub-Committee Chair, shall:

- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

9. SUB-COMMITTEE MEETINGS

9.1 Quorum

A quorum shall be at least three members comprising of two Lay (Independent) Members, and one representative health board Chief Executive Officer or designated deputy.

For effective governance, the Director of Finance and Information and the Director of Planning and Performance are required to attend all meetings.

9.2 Frequency of Meetings

Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.

Additional meetings may be held with the chairs of the LHBs Planning, Performance and Finance Committees where there is requirement.

Members will be required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.

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

9.3 Withdrawal of individuals in attendance

The Sub-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.

9.4 Circulation of Papers

The JCC Committee Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

9.5 Circulation of Minutes

The Committee Secretariat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.

The JCC Committee Secretariat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.

The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

10. REPORTING AND ASSURANCE ARRANGEMENTS

The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the Joint Committee on the Committee's activities. This includes:
  - Assurance that Planning, Performance and Finance are being managed appropriately
  - oral updates on recent activity

  - submission of written Sub-Committee highlight reports throughout the year
  - to receive annual reports, which will incorporate key information on planning, performance and finance

- Bring to the Joint Committee's specific attention any significant matters under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, Chief Commissioner, HB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the JCC and HBs.

The Sub-Committee shall provide a written, annual report to the Joint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, 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 Sub-Committees self-assessment and evaluation.

The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Planning, Performance and Finance are being managed appropriately, for inclusion on suitable HB Sub Committee agendas.

The Joint Committee may also require the Sub-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 Sub-Committee's assurance role relates to a joint or shared responsibility.

The JCC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

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11. RELATIONSHIP WITH THE JOINT COMMITTEE AND ITS SUB-COMMITTEES / GROUPS

Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the effective planning, performance and financial management of healthcare for commissioned services through the effective governance of its organisation.

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

The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the Joint Committees other Sub-Committees to provide advice and assurance to the JCC through the:

- joint planning and co-ordination of JCC 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 JCCs overall risk and assurance arrangements.

The Sub-Committee, through its Chair and members, shall work closely with LHB Planning, Performance and Finance Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

The Sub-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.

DRAFT

12. DEALING WITH MEMBERS INTERESTS DURING MEETINGS

Declarations of interest will be a standing agenda item for all meetings.

Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the JCC Standing Orders.

13. APPLICABILITY OF STANDING ORDERS TO SUB COMMITTEE BUSINESS

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

This Sub-Committee is a scrutiny and assurance committee and therefore where a decision is required the matter will be referred to the JCC Team or Joint Committee, as appropriate.

14. 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 endorsement ratified by the Joint Committee.

DRAFT

Agenda Item
9.1.4

CTM Health Board

Putting Things Right Annual Report

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
PTR	Putting Things Right

1. Situation /Background

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the "Health Board"), including complaints, incidents, claims and redress between 1st April 2023 and 31st March 2024.

2. Specific Matters for Consideration

The key areas to note from within the Putting Things Right annual report for 2023/2024 include:

- Reduction in the number of formal complaints received
- Improvement in compliance with the 30 working day target
- Decrease in the number of Public Service Ombudsman for Wales referrals received
- Decrease in number of new claims received
- Increase in number of cases referred to Redress from the incident process
- Themes arising from complaints and patient safety incidents remain consistent with previous years

3. Key Risks / Matters for Escalation

The key risks / matter for escalation associated with the Putting Things Right Annual report relate to:

- Maintaining compliance with the 30 working day target
- Effective and timely management of Ombudsman Cases
- Reducing the number of open nationally reportable incidents
- Timely conclusion of redress cases

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Learning, Improvement & Research

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd*Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality*Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language	If no, please include This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	The report outlines clinical negligence, personal injury and redress activity within the Health Board.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

The Board are asked to approve the content of the report.

6. Next Steps

Improvement actions identified within the report to continue to be monitored via the Quality & Safety Committee and Weekly Quality & Safety Executive Meeting.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT

Annual Report 2023/2024

Head of Concerns & Business Intelligence

PUTTING THINGS RIGHT ANNUAL REPORT 2023/2024

1.0 Introduction

2.0 How we manage Concerns

3.0 Complaints

4.0 Redress

5.0 Claims

6.0 Inquests

7.0 Public Service Ombudsman for Wales

8.0 Patient Safety Incidents and Reportable Serious Incidents

9.0 Never Events

10.0 Learning from Events Reports

11.0 Conclusion

PUTTING THINGS RIGHT ANNUAL REPORT 2023/2024

SUMMARY OF ACTIVITY

568 Formal Complaints Received

122 Redress

130 Claims

76 Ombudsman

23,791 Patient Safety Incidents

145 NRI's

1 Never Event

286 Inquests

1.0 Introduction

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the "Health Board"), including complaints, incidents, claims and redress between 1st April 2023 and 31st March 2024.

Putting Things Right (2013) was established to review the existing processes for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales. The aim is to provide a single, more integrated and supportive process for people to raise concerns which:

- Is easier for people to access;
- People can trust to deliver a fair outcome;
- Recognises a person's individual needs (language, support, etc.);
- Is fair in the way it treats people and staff;
- Makes the best use of time and resources;
- Pitches investigations at the right level of detail for the issue being looked at; and
- Can show that lessons have been learnt

2.0 How we manage concerns

To support the effective management of complaints, patient safety incidents and redress, the Health Board has implemented the Concerns Policy and Procedures along with the Incident Management Framework. These should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

During 2023/2024, the Health Board made progress in implementing its Care Group operating model, with a focus on embedding Quality & Safety Governance structures. A key development was the establishment of a Central Quality & Safety Governance Team that works in collaboration with Care Groups to develop robust governance frameworks that support clinical services in identifying and addressing adverse events, ensure appropriate support for patients and their families and facilitate continuous improvement through the timely identification of lessons learned.

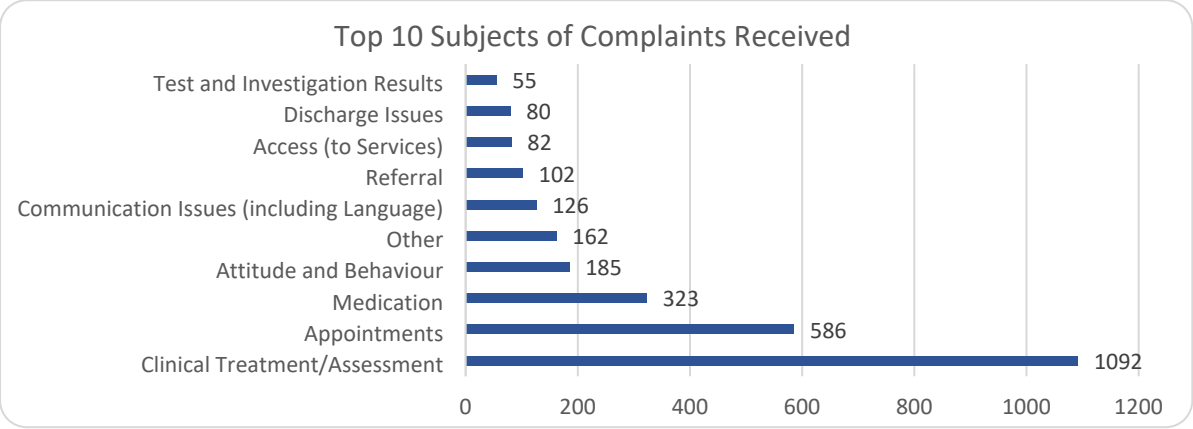
3.0 Complaints

Complaints Received during 2023/2024

During 2023/2024 at total of 2,958 complaints were received by the Health Board, representing a small decrease when compared with the previous year (2022/2023).

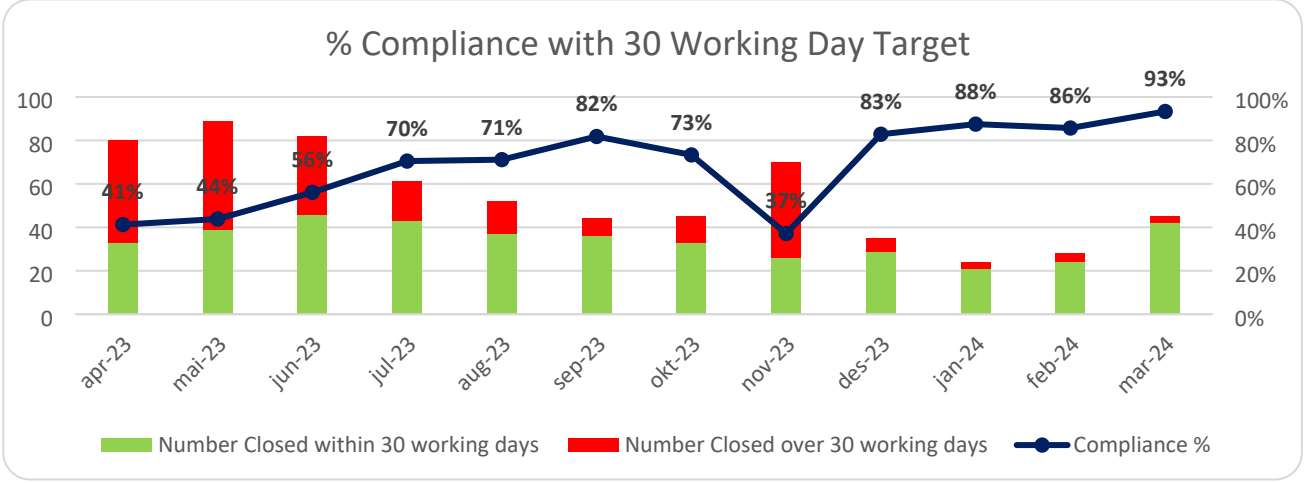
Of the new complaints received during 2023/2024, 568 complaints were managed via putting things right, a significant decrease from the 863 received during 2022/2023. The remaining 2,390 were managed as early resolution complaints.

Complaints will often highlight a number of issues of concern regarding the services or care and treatment being provided by the Health Board. Identification of these complaints assists in highlighting themes and trends, to inform areas for focused improvement work. The top 10 complaints for 2023/2024 are provided in the chart below:



Complaints Closed during 2023/2024

A total of 655 complaints managed via Putting Things Right ("PTR") were closed during 2023/2024. Of these 409 (62%) were responded to within 30 working days. During November 2023, focused work was undertaken to address the number of historic cases open (those over 30 working days) and provide a final response to patients or their families. As a result this focused work there was a planned decrease in the compliance with the 30 working day target to 37%. Compliance returned to above the national target of 75% for the remainder of the year as reflected in the chart below.



During 2023/2024 to improve compliance with the 30 working day target to respond to complaints a number of actions were undertaken which include:

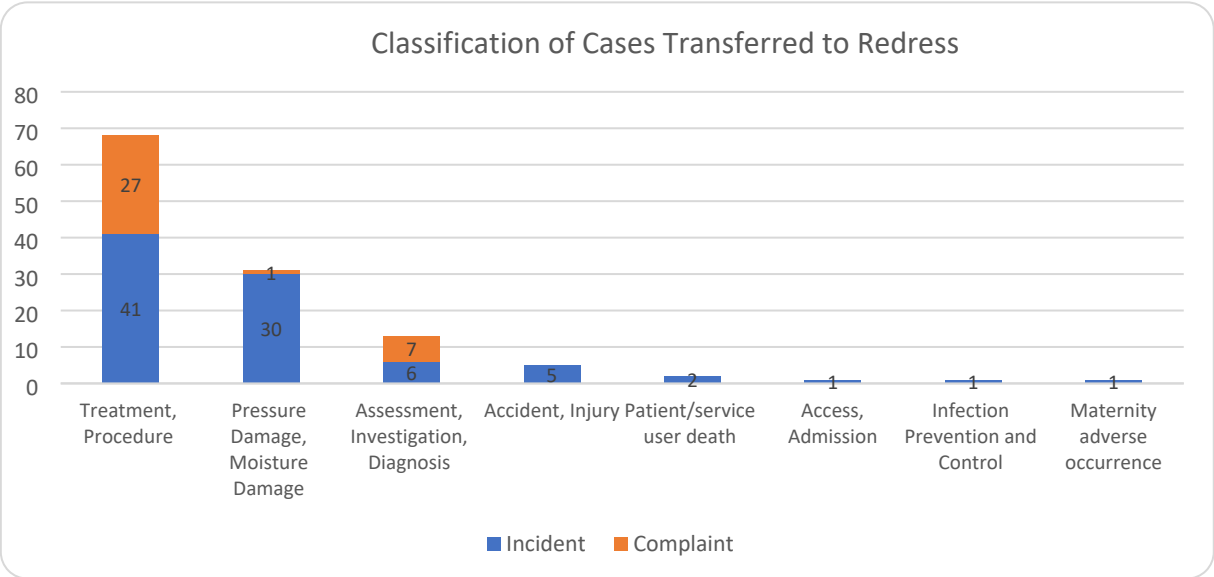
- Robust triaging of complaints received to ensure appropriate management resulting in an increase complaints managed via the early resolution process
- Implementation of a revised process for the management of formal complaints that highlights the requirement for early escalation.
- Daily Complaint Team Huddles embedded to review cases and support the escalation process
- Focused work undertaken during November 2023 to address the number of historic cases open (those over 30 working days) and provide a final response to patients or their families
- Reporting of compliance with the 30 working day target at weekly Executive Quality & Safety Meeting
- Enhanced process for managing MP/MS correspondence
- Monitoring in place to ensure that are updates are provided to all complainants where cases have been open over 30 working days

4.0 Redress

New Cases Transferred to Redress during 2023/2024

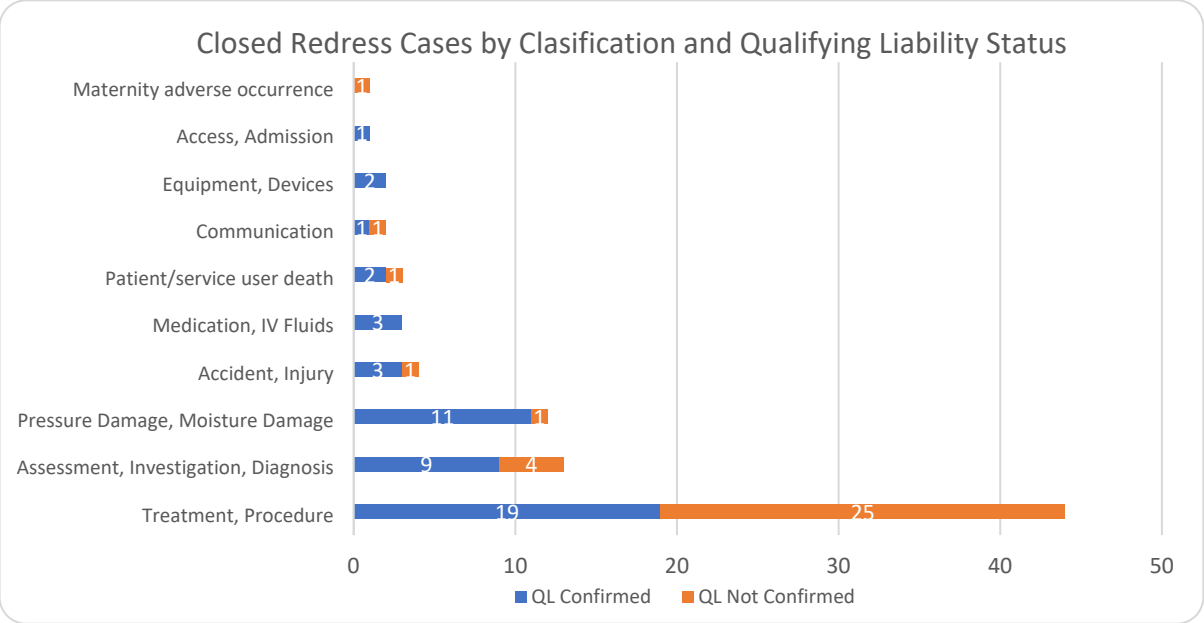
If during the investigation of a complaint or incident a breach of duty of care is identified which has potentially resulted in harm to the patient, there may be a qualifying liability. At this stage, the complaint will transfer into the Redress process for a further detailed investigation.

Between 01.04.23 and 31.03.24, 122 cases were referred to Redress for review of breach of duty and for consideration as to whether the case is suitable for Redress. 87 were referred from the incident process and 35 from the complaint process. A breakdown of the classification of cases transferred to Redress is provided in the chart below:



Redress Cases Closed during 2023/2024

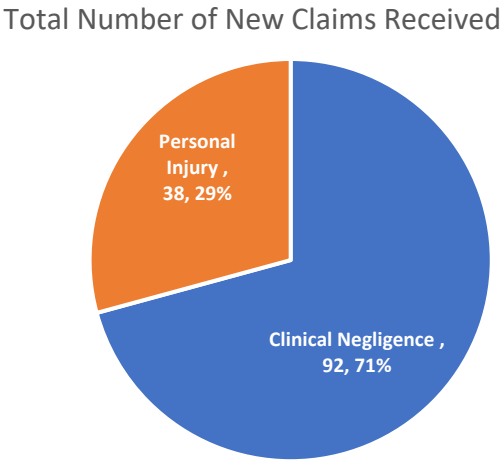
It should be noted that Redress cases will not always be referred and closed within the same financial year. Therefore, the cases closed during 2023/2024 may have been received in previous years. 85 redress cases were closed between the 01.04.23 and 31.03.24, of these 51 were concluded with confirmation of a qualifying liability. A breakdown of closed redress cases by classification and qualifying liability status is provided in the chart below.



5.0 Claims

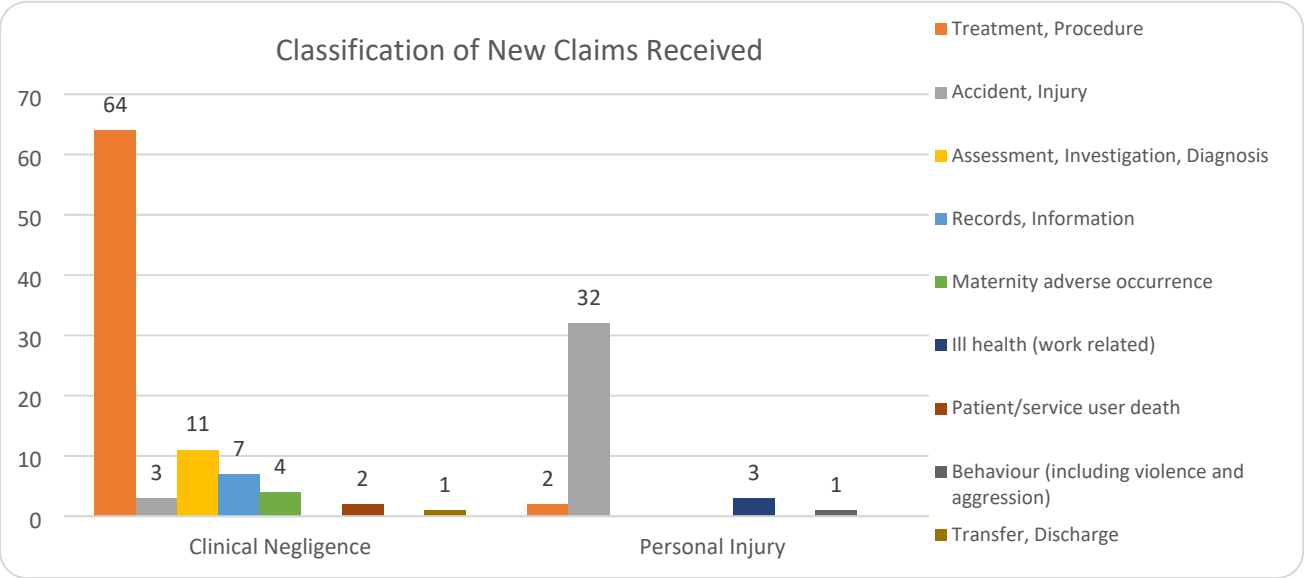
Where a case is of a higher value than £25,000, it will be transferred out of the Redress process and managed as a claim.

<u>New Claims Received during 2023/2024</u>
Between the 01.04.23 and 31.03.24 the Health Board received notification of 130 new claims. These take the form of a clinical negligence and personal injury claims.



A breakdown of the classification of new claims received during 2023/2024

is provided in the chart below.



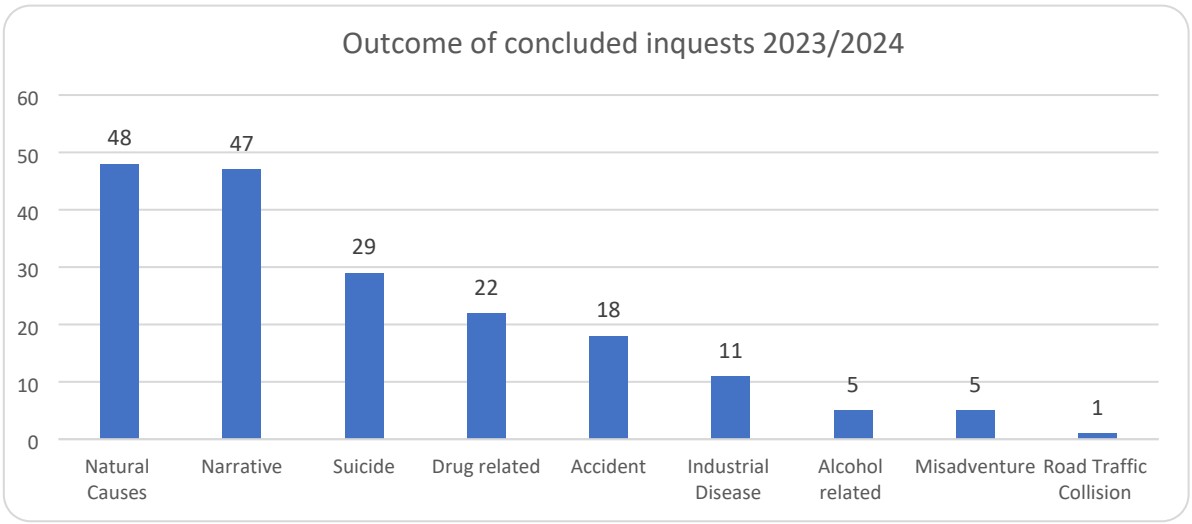
Claims Closed during 2023/2024

During 2023/2024 a total 69 claims were closed. Of these, 52 were concluded with an admission of liability or risk based settlement.

6.0 Inquests

An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected. The Health Board must provide information in line with the directions of Coroner.

Between the 01.04.23 and 31.03.24 the Health Board received notification of 286 new inquests. During the same period 197 inquests were concluded with the following outcome. It should be noted that inquests will not always be referred and closed within the same financial year.

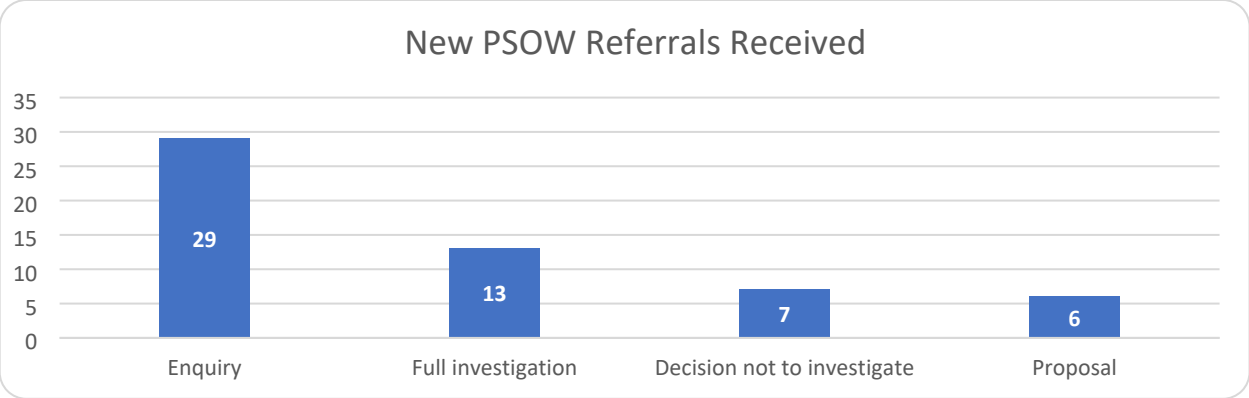


On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. During 2023/2024 the Coroner issued one regulation 28 report to the Health Board. A further regulation 28 was issued to Welsh Government for improvement action on a national level as a result of learning from a Cwm Taf Morgannwg UHB inquest.

7.0 Public Service Ombudsman for Wales (PSOW)

The Public Service Ombudsman for Wales (PSOW) has the power to review complaints about public services in Wales. If a complainant is not content with the response they receive from the Health Board, they can request the PSOW to review the case independently.

Between 01.04.23 and 31.03.24 the Health Board received notification of 55 referrals to the PSOW. Of these, 13 were proceeded to full investigation. A breakdown of PSOW referrals is provided in the chart below.



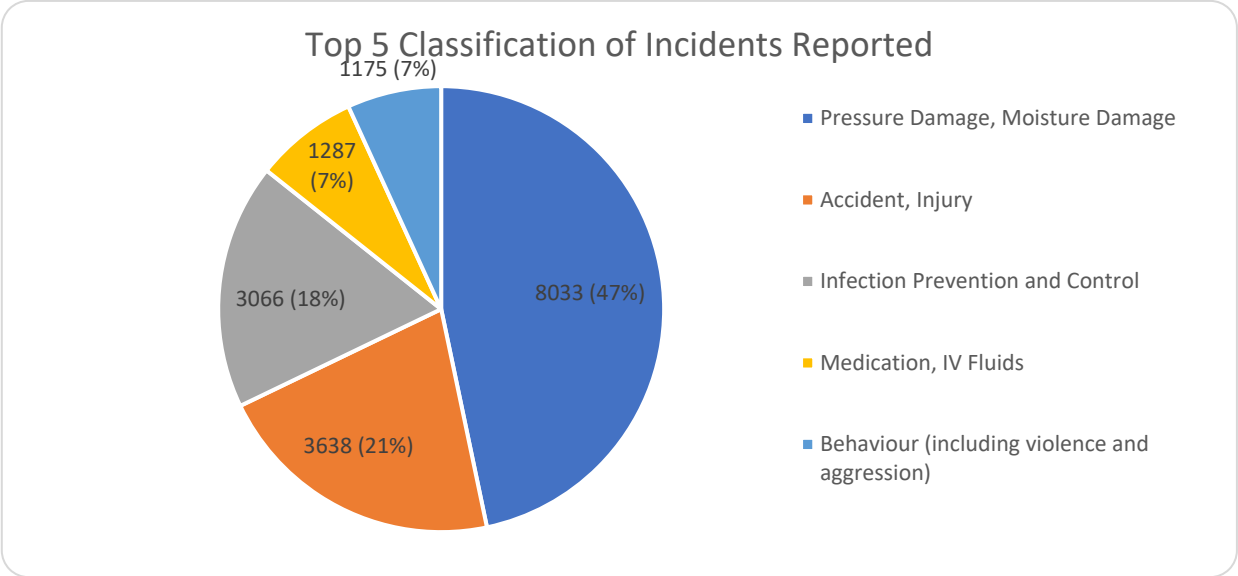
During 2023/2024 the PSOW issued 31 final reports to the Health Board. Of these, 8 were fully upheld and 15 partially upheld, whereby the Health Board accepted the recommendations and implemented actions to address the learning identified. A summary of the outcome of PSOW investigation final reports is provided in the table below.

PSOW Final Reports Issued	Total
Upheld - Section 27	7
Partially Upheld – Section 27	15
Not Upheld – Section 27	8
Upheld - Section 23	1
Total	31

8.0 Patient Safety Incidents and Nationally Reportable Incidents

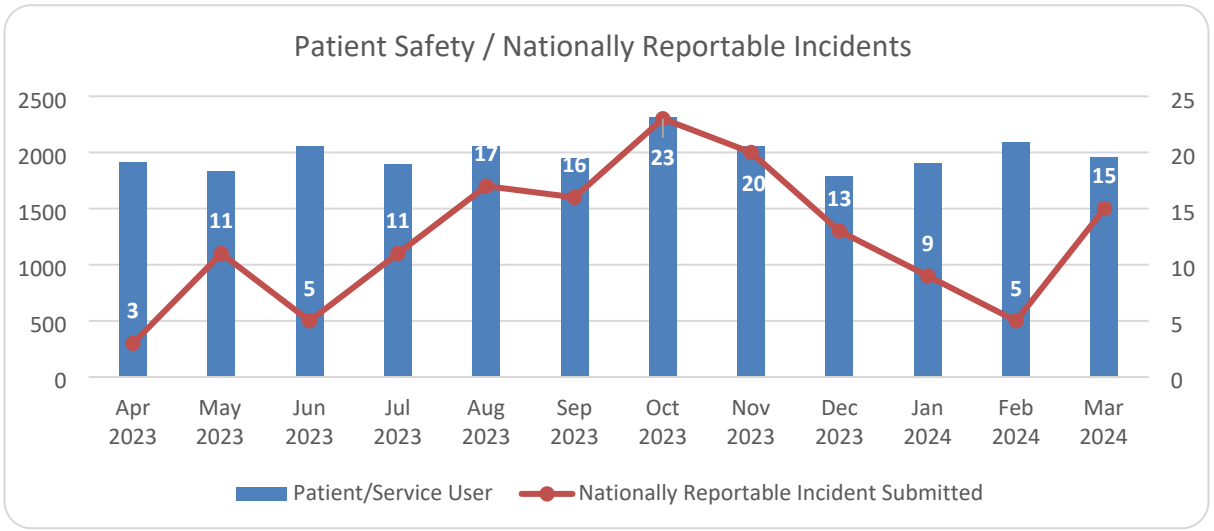
There were 26,940 incidents reported between 01.04.23 and 31.03.24, of which 23,791 (88%) were reported as the patient being the person affected (patient safety incidents).

Accounting for 70% (17,199) the top five Patient Safety incidents reported for the year relate to: Pressure Damage/Moisture Damage; Patient Falls; Infection Prevention & Control; Medication, IV Fluids; Behaviour (including violence and aggression). A breakdown of these is provided in the chart below.



Within the time period, 148 nationally reportable incident notifications were submitted to the NHS Executive (Delivery Unit). As a result of a change in the Nationally Reportable Incident criteria, a direct comparison with the previous year is not available.

The incident reporting trend for 2022/2023 is reflected in the chart below.



9.0 Never Events

Never Events are patient safety incidents that are wholly preventable, where there is guidance and safety measures that provide strong systemic protective barriers available at a national level.

Never events have the potential to cause serious harm or death, although serious harm or death does not have to occur for it to be classed as a never event.

The Health Board reported 1 never events between 01.04.23 and 31.03.24, which relate to the administration of medication by the wrong route.

10.0 Learning from Event Reports

The Health Board is required to submit a signed Learning from Events Report (LFER), within 60 working days of the decision to settle a case, to the Welsh Risk Pool. During 2022/2024, 109 Learning from Events Reports were triggered for submission.

A summary of activity for Learning from Events Reports due during 2023/2024 is summarised below:

	Claims	Redress	Total
Number of LFERs Due	71	45	116
Number of LFERs submitted	70	45	115
Number of LFERs Approved	36	36	72

All cases considered for reimbursement by the Welsh Risk Pool (WRP) are scrutinised for evidence of the lessons learned and improvement actions taken by the Health Board. Reimbursement, both interim and final reimbursement, will be deferred until the WRP Committee is satisfied with learning and the actions taken in a case. Between 01.04.22 and 31.03.23, the WRP deferred 90 cases for reimbursement for the Health Board.

11.0 Conclusion

The key areas to note in relation to Concerns for 2023/2024 include:

- Reduction in the number of formal complaints received
- Improvement in compliance with the 30 working day target
- Decrease in the number of Public Service Ombudsman for Wales referrals received
- Decrease in number of new claims received
- Increase in number of cases referred to Redress from the incident process
- Themes arising from complaints and patient safety incidents remain consistent with previous years

Agenda Item
9.1.5

CTM Health Board

Welsh Language Standards Annual Performance Report 2023-24

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Ben Screen, Welsh Language Lead
Cyflwynydd yr Adroddiad / Report Presenter	Ben Screen, Welsh Language Lead
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Welsh Language Steering Group	23/05/2024	Comments received on draft report
People & Culture Committee	07/08/2024	Endorsed for Board approval

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Each financial year the Health Board is required to publish a Welsh Language Standards Annual Report, in accordance with the Welsh Language Standards. The report covers various reporting responsibilities detailed under the individual standards. It also highlights the actions taken by the Health Board in year, to not only achieve compliance with the standards, but to continually improve the quality and consistency of the delivery of Welsh language services to our patients and service users.

1.2 The deadline for publication of the annual report is 31 October 2024, which is six months after the end of the financial year, to which it relates.

2. Specific Matters for Consideration

2.1 The Board is requested to endorse the report for publication.

2.2 The Board is also requested to note the progress made during the reporting year, to help create a thriving Welsh language culture and identity, by improving staff skills and awareness for the benefit of our patients and the communities we serve.

2.3 Work has continued under the 5-theme lens for Welsh language development, with a selection of key achievements noted below.

2.3.1 Under the Communications & Engagement Theme:

- A continued focus on behaviour and cultural change, based on a recognised behaviour change methodology, working in co-operation with staff to improve awareness and break down barriers to better Welsh language provision. This culminated in the 'Hiraeth Campaign' in March 2024;

- Development of an internal engagement framework to structure messaging around Welsh, focusing on learning and development, sharing success stories of using Welsh, patient experience stories and regular information on what support is available to support the use of Welsh; and

- Website and leaflet developed and promoted to ensure patients know what their language rights are under the Welsh Language Standards.

2.3.2 Under the Action Planning & Monitoring Theme:

- Continued use of the e-whiteboards to record patient language need;
- PREMs data for services that have included a question on language need show that patients are able to use Welsh in many areas;
- In-Patient Active Offer Policy developed, to ensure patients on in-patient wards are asked which language they need to use;
- A dip sample of 86 areas across the Health Board showed high levels of awareness of the Welsh Language Standards among managers;
- Case studies in report from Therapies, Paediatrics, Maternity, Radiology and Facilities show how the Welsh language has been embraced; and
- New Equality and Welsh Language Impact Assessment created, fully inclusive of the Welsh language policy framework.

2.3.3 Under the Employee Experience & Bilingual Workplace Theme:

- Welsh included under 'Inclusivity' in new Leadership Competency Model, with first content to be used with 'Inspire';

2.3.4 Under the Governance & Accountability Theme:

- The Welsh Language Steering Group has continued to meet and strengthen; and
- Evidence of the Welsh language being discussed at key management meetings across the Health Board.

2.3.5 Under the Workforce Planning and Recruitment Theme:

- Work has continued with Learn Welsh Glamorgan for all levels of Welsh, supporting staff across the organisation to access quality Welsh language teaching provision. This has included the Health Board successfully taking advantage of the fully-funded Confidence Raising Scheme, to develop under-confident Welsh speakers.

3 Key Risks / Matters for Escalation

3.1 The report includes a full assurance assessment detailing areas where compliance has not been reached.

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Inspiring People
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Wales of Vibrant Culture & Thriving Welsh Language
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken a Quality Impact Assessment Screening?		
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is a covering paper for a statutory report; no policy decision has been made.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Report highlights areas of non-compliance with statutory duties.	
Enw da / Reputational	Yes (Include further detail below)	
	Report must be published by October 2024, and detail included within it highlights non-compliance with statutory duties.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5 Recommendation

5.1 The Board is asked to APPROVE the Welsh Language Annual Report for publication on or before the 31 October 2024.

6 Next Steps

6.1 Operational plan formulated for Welsh language development for 2023-24, taking account of current position against the Standards as noted in the report. Progress with this plan is being monitored via the Welsh Language Development Dashboard.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Welsh Language Standards Annual Performance Report for Cwm Taf Morgannwg University Health Board 2023/24

Y Gymraeg yn CTM
Welsh at CTM
Cymraeg

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Mae'r ddogfen / ffurflen hon hefyd ar gael yn Gymreag.

This document / form is also available in Welsh

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About this report

This report is about what Cwm Taf Morgannwg University Health Board (CTMUHB) has done this year to provide our services in Welsh in line with the Welsh Language Standards. [1] We talk about our strategic approach to embedding Cymraeg throughout our organisation and what we have done this year to promote our language and its use in the care we give and services we provide. We are keen to share with you again this year how hard we have worked to weave bilingualism into all we do, and the initiatives we have implemented as part of this. Welsh is important to us as it is to many in the communities we care for. This report talks about the concrete steps we have taken which shows this commitment.

The report has also been written to comply with Welsh Language Standard 120, which requires us to publish a report on how we have complied with the Welsh Language Standards in our compliance notice. Our compliance notice sets out what we have to do by law in Welsh, and is available to read **here** in Welsh and **here** in English. If you would like advice in a clearer format on what your rights are to use Welsh with the Health Board, please see this patient information leaflet in Welsh **here** and in English **here**.

This report was presented to our People and Culture Committee, a sub-committee of the Board, in August 2024 and approved for publication.

We would welcome your comments on this report and our bilingual services. If you would like to get in touch with us, please send us a message at **CTT_WelshLanguage@wales.nhs.uk** in Welsh or English. You can also give feedback on specific services you may have used via the Patient Reported Experience Measure questionnaires, available **here** in Welsh and **here** in English.

[1] Any reference to 'year' in this report refers to the financial year, from April 1st 2023 to March 31st 2024.

OUR YEAR IN NUMBERS

506 We shared, including 30 of our Welsh Language Packs, 10 'Use your Welsh here' posters to encourage use of Welsh and over 180 lanyards and badges for staff with Welsh language skills

8% Increase of **8%** in number of staff who have recorded their Welsh language skills, giving us an **88%** completion rate of Welsh language skills data across CTMUHB

1,200,000 We translated over **1.2 million** words into Welsh

14,347 There were **14,347** visits to our Welsh language website, an increase of 2,950 visits to our Welsh language content compared with last year

29 Continued use of our in-patient flow system, the digital e-whiteboards, with **29** vulnerable patients having their language need recorded as Welsh across **17** wards at **4** hospital sites

100 We spoke to nearly **100** members of staff as part of our drop-in sessions at our sites, and over **40** patients, giving us the opportunity to promote Welsh and resources with our staff and talk to patients about their language rights

20 We launched our Internal Communications Framework in November 2023, sharing **20** pieces of strategic communications since with each update having an average of over **1000** views

10 **10** out of the **12** Patient Reported Experience Measure surveys which asked about patients use of Welsh recorded that the majority were able to use Welsh 'always' or 'usually', meaning **638** of the patients asked were able to use Welsh at least most of the time during their care this year

9000 Over **9000** members of staff have completed the all-Wales language awareness course this year, resulting in **77%** of all staff at CTMUHB having completed it

64 **64** members of staff have had support to learn Welsh or improve their confidence from the Health Board this year

2182 We received **2,182** requests for translation with an average of **178** requests a month

98% Completion rate of the question related to language need on the Welsh Nursing Care Record was **98%**, as a further positive measure that the active offer is being made with in-patients

522 Since launching our newly 522 designed SharePoint page in March 2024, we shared 16 digital resources on it with 522 views in the first fortnight

51 **51** members of staff came to our first ever session to change language behaviour, 'Cymraeg a Fi/Welsh and Me' as part of our Hiraeth campaign

86 **86** departments took part in our audit over the summer to measure compliance with Welsh Language Standards, with **74%** of managers reporting they and their team understand the importance of care in Welsh

8 Welsh language has been a specific agenda item in **8** senior management meetings this year, including **2** formal Board sub-committee meetings.

6 Our Welsh Language Steering Group has met **6** times this year, with lots of good practice shared and progress celebrated

15 We have begun to take advantage of the Codi Hyder/Confidence Raising scheme with Learn Welsh Glamorgan, with **15** members of staff being supported as of March 2024

Chief Executive's Foreword

I am pleased to present this year's Welsh Language Standards Performance Report. This year has seen us take further steps on our journey to becoming a leading organisation in our approach to embedding and growing our language at Cwm Taf Morgannwg University Health Board, and this report and the achievements described in it are testament to the effort and commitment of staff across our organisation to Welsh and its speakers.

Our approach to Welsh at CTMUHB is one of continued commitment to cultural and behavioural change among our staff. Welsh is about much more than compliance; it is a living, breathing language spoken by over 50,000 of our population and hundreds of our staff. It was positive this year to note that two Health Board officers were asked to present our work around cultural and behavioural change at a cohort of Leading in a Bilingual Country, facilitated by Academi Wales and Cymraeg 2050 within Welsh Government, sharing best practice with other senior leaders across the Welsh public sector. Some of the work presented at that event is discussed below and shows that CTMUHB can indeed lead on this agenda. I hope you enjoy reading about the initiatives this year to foster a healthy Welsh language culture in CTMUHB, and while there is always more to do, about which we have been transparent in this report, it is clear from this report and previous reports that there has been a sustained trend of improvement in our bilingual provision.

Welsh belongs to us all and we are proud of our contribution this year to the use of Welsh in our communities and our healthcare sites and the long-term future of our language.

Paul Mears,
Chief Executive Officer, Cwm Taf Morgannwg University Health Board

Executive Summary

Readers of this report are invited to compare this report with previous reports and we are confident that over the last 5 years since Welsh Language Standards were first introduced within Cwm Taf Morgannwg University Health Board, a positive performance trajectory can be seen not only in compliance with the Standards but also in the detail we are able to provide and the quality of our reporting. CTMUHB still has work to do in many areas to offer a truly bilingual health service to our population, and where this is the case we have made this clear in the report. However, clear evidence is also provided of the positive developments and it is important that these are recognised.

These developments include:

1. A better strategic response to Welsh language policy, with Welsh included as a strategic priority in Health Board planning as part of its 'People Plan' supported by a 5-lens framework which structures annual operational planning for Welsh language development;
2. Better monitoring arrangements in terms of audit activity, data sources on compliance and the delivery of bilingual services and a clearer method of recording and displaying progress;
3. Progress on assessing business change regarding the impact on Welsh with a compliant methodology developed, with acknowledgement work is still needed around how we consult and carry out research and considering the impact on Welsh;
4. Increased maturity in terms of internal governance and accountability, with a steering group and highlight reports on compliance to Board and evidence of Welsh being discussed in senior management meetings across CTMUHB;
5. A more informed approach to the internal discourse on Welsh, using behaviour change insights to structure our internal communication around Welsh;
6. An increase in bilingual services across CTMUHB with data sources showing clearly many of our patients are benefitting from Welsh language provision, with acknowledgement that this is still inconsistent;
7. A clear plan is now in place for improving how we approach recruitment with actions to be completed by December 2024, and good progress on developing a credible offer to learn Welsh at work in co-operation with partners.

Further detail on these areas of progress is detailed throughout this report. Appendix 1 includes a full assessment for the first time on our position against all Welsh Language Standards, and how we are working to ensure we monitor progress effectively. We hope this level of transparency is welcomed.

Strategic context

Welsh is just as important to us as it is to the communities we care for and serve. Therefore, we want to ensure we are doing all we need to do so that this rhetoric meets reality in the day-to-day interactions of our patients with our services. This requires an appropriate strategic response to make the improvements we want to see in our bilingual services.

Last year in our Welsh Language Standards report, we introduced our 5 themes to give appropriate strategic direction to operational planning for Welsh language development (see bottom of the graphic below). The graphic below goes beyond this and shows how this 5-theme lens fits into wider Health Board planning, further evidencing our maturity as an organisation committed to embedding Cymraeg into everything we do.

IMTP

The Integrated Medium Term Plan is a statutory planning document produced annually, setting out how NHS organisations will use their resources over a 3-year period to deliver high quality healthcare services which address population needs. Our work around Welsh language development and the main priorities during its planning cycle were included in the submission for the 2023/24 financial year.

People Plan and CTM 2030

Structuring the submission to the IMTP for the People Directorate where Welsh language sits is the People Plan for CTMUHB and its 10 priorities, the 8th of which is to "Create a thriving Welsh language culture and identity, improving skills and awareness." This ensures Welsh language development is a priority for how CTMUHB approaches organizational development in all its aspects over the next 6-year period as part of CTMUHB's organizational strategy 'CTM 2030'.

Welsh Language 5-theme strategic lens

Sitting under the People Plan is the 5-theme lens outlined in our last Welsh Language Standards Performance report. These 5 themes are Communications & Engagement, Action Planning & Monitoring, Employee Experience & Our Bilingual Workplace, Governance & Accountability and Recruitment & Workforce Planning. The 5 themes structure operational planning annually for Welsh, and so structure this annual report. The focus of each theme is explained in the relevant section

Operational planning for Welsh language development

Each year the 5 themes above structure a broad operational plan outlining what pieces of work and initiatives will take priority for that reporting year. Where there are areas needing improvement or requirements still not being adequately met, these delivery plans ensure they can be dealt with. This plan is discussed at our Welsh Language Steering Group.

The remainder of this report is structured via the 5-theme lens described above, and details our performance in developing Welsh at CTMUHB.

Theme 1: Communications & Engagement

Embedding Welsh across a large and complex healthcare system will mean a change in our organisational culture, which will mean enabling people to change their behaviours. But change in behaviour does not happen in a vacuum, and our staff will need the support and resources to do more in Welsh. Accepting this means we can start to think strategically about what needs to happen to encourage the change in behaviours we need to see across the system, so that whenever a person who speaks Welsh wants to use Welsh, they are able to do so without any friction or resistance. This is why we have put Communications and Engagement as the first of our five themes we focus on. This **is what we have continued to do this year** under this theme.

Last year we described how we developed an internal Welsh Language Promotion Plan with specific initiatives based on recognized behaviour change methodologies. Below we outline further progress on that plan.

Our internal Communications and Engagement Framework for Welsh

In November 2023 the Communications & Engagement Team and the Welsh Language Team co-operated on a new strategic framework to structure regular and consistent messaging around Welsh throughout the organisation, focusing on the fortnightly-staff update and other internal media channels such as the intranet. These updates have an average viewer count of over 1,000 members of staff each time they are shared.

Effective communication is essential to driving organizational change and there is lots of evidence that strategic internal communication improves employee engagement and commitment to organizational change initiatives, such as developing Welsh. [2]

The framework and the categories below structure the updates. The categories are based on the three elements of a recognized behaviour change methodology, COM-B. COM-B encompasses **Capability** (knowing how to do a behaviour), **Opportunity** (having the means or resources to carry out a behaviour) and **Motivation** (having the will to want to carry out a behaviour). [3]

The '**Da Iawn**' category focusses on celebrating individual examples of best practice from staff across the organisation in complying with Welsh language standards. This allows good practice to be shared and adopted elsewhere but also builds in social proof. Social proof is an important concept in spreading behaviour change as staff are much more likely to adopt behaviours that support compliance with Welsh Language Standards if they see their own colleagues performing them. 'Da iawn' is aligned to the 'Motivation' aspect of COM-B.

The second aspect, '**It's More Than Just Words: Patient Experience**' focuses on how complying with Welsh language standards can positively impact the experience of our service users. Showing the real-world impact of behaviours on patients is an important motivator for NHS staff. This aspect is also aligned to the 'Motivation'

[2] Hargie, O., & Tourish, D. (2009). Auditing Organisational Communication: A Handbook of Research, Theory, and Practice. Routledge; Men, L.R., & Stacks, D.W. (2013). The impact of leadership style and employee empowerment on perceived
[3] A more technical discussion can be found here: Mitchie, S. et al. (2011), The behaviour change wheel: a new method for characterising and designing behaviour change interventions. Implementation Science 6(42)

aspect of COM-B.

Thirdly, '**Staff Support**' shares regular reminders about how staff are able to access resources, advice or support to embed Welsh in how they carry out their role to deliver their services. This aspect is aligned to 'Capability' and 'Opportunity' within COM-B.

Finally, '**Skills, Learning & Development**' shares regular updates and reminders about various opportunities for staff to develop their Welsh language skills and other training & development opportunities related to Welsh. This last aspect is aligned to 'Capability' in the COM-B model.
Some examples for each category can be seen on page 12. These content cards are an excellent example of increasing collaboration between the Welsh Language Team and other enabling services, in this case our Communications and Engagement Team, but also of the impact of exemplary care staff across CTMUHB provide daily.

Our Hiraeth Campaign

In March 2024, the Organisational Development & Inclusion, Communications & Engagement and the Welsh Language Teams worked together on an internal staff engagement campaign throughout the month with the aim of raising cultural awareness, creating a space for discussion around Welsh language and identity, promoting the Welsh language resources on offer and the wider enabling services of the Welsh Language Team.

We chose to call our campaign 'Hiraeth', meaning grief or sadness after the lost or departed, longing, yearning, nostalgia, wistfulness or homesickness. 'Hiraeth' is personal to the individual but could be linked to the feeling of having lost Welsh or a connection to Wales, and a strong desire to regain this aspect of one's personal connection to Wales and Welsh heritage. We wanted to give staff the chance to (re)connect with our language, in a positive way that focused on their relationship to it. By offering staff the opportunity to 'regain' this aspect of their heritage a further aim was to contribute to a more inclusive culture, and a greater sense of 'belonging' to Welsh.

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Da iawn
It's more than just words: Da iawn

Yn gynharach y mis hwn, gwahoddodd y Tîm Mamolaeth y Tîm Iaith Gymraeg i ymweld â Chanolfan Geni Tirion a gwnaeth y cyfraniadau Cymraeg di-ri y mae'n eu gwneud ar draws y wardiau ar gyfer ei staff a'i gleifion argraff fawr arno.

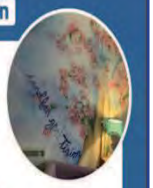
O gefnogaeth ragweithiol y tîm, mae cleifion mamolaeth a theuluoedd yn gallu cyfathrebu'n well mewn iaith y maen nhw'n gyffordus yn ei defnyddio, sy'n gwneud cymaint o wahaniaeth i'w profiad.

Da iawn, tîm!!

Earlier this month, the Maternity Team invited the Welsh Language Team to visit the Tirion Birth Centre and they were so impressed with the countless Cymraeg contributions they make across the wards for their staff and patients.

From the team's proactive support, maternity patients and families are able to better communicate in a language they are comfortable using, which makes such a difference to their experience.

Da iawn, tîm!!



Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Profiad y claf
It's more than just words: Patient experience

Ym mis Awst, ysgrifennodd rhiant claf ag anghenion dysgu ychwanegol at y Bwrdd Iechyd i ddiolch i un o'n hymgynghorwyr, Dr David Samuel am y gofal rhagorol a gafodd eu mab, Iwan...

"Mae'r ffaith ei fod o [Dr David Samuel] hefyd yn siarad Cymraeg wedi cefnogi Iwan i ddeall beth sy'n digwydd iddo. Mae hyn yn ganmoladwy iawn.

Cafodd Iawn, 21, sydd â Syndrom Down a Chlefyd Crohn, gefnogaeth lawn yn ei anghenion cyfathrebu a chanmolodd rhieni'r claf y Bwrdd Iechyd am ddefnyddio'r Gymraeg gydag Iwan.

Byddai llawer o oedolion ifanc ag anableddau dysgu yn ei chael hi'n anodd iawn aros dros nos yn yr Ysbyty sy'n amgylchedd anghyfarwydd heb eu rhieni neu ofalwyr."

In August, a parent of a patient with additional learning needs wrote to the Health Board to thank one of our consultants, Dr David Samuel for the exemplary care that their son, Iwan received...

"The fact that he [Dr David Samuel] is also a Welsh language speaker has also supported Iwan in understanding what is happening to him. This is most commendable.

Iwan, 21, who has Down's Syndrome and Crohn's Disease, was fully supported in his communication needs and the patient's parent commended the Health Board for using Welsh with Iwan.

Many young adults with a learning disability would find it incredibly challenging to stay overnight in hospital which is an unfamiliar environment without their parents or carers."

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Da iawn
It's more than just words: Da iawn

Yn gynharach y mis hwn, derbyniodd un o'n Therapyddion Iaith a Lleferydd, Lowri Roberts, adborth gwych gan YGG Llantrisant ar ôl cefnogi plentyn gydag atal dweud a darparu gwybodaeth ddefnyddiol i'w gyd-ddisgyblion ar

"Bu Lowri Roberts yn gweithio gyda disgybl o'n hysgol i helpu gydag atal dweud ac roedd y disgybl yn falch iawn o allu gwneud hynny yn Gymraeg. Bu'n fuddiol iawn cael Lowri i ddod i'r dosbarth i gyflwyno gyda'r disgybl yn Gymraeg.

O gefnogaeth Lowri, roedd yr athro a'r disgyblion bellach yn gallu cefnogi'r disgybl a'i helpu i deimlo'n llaw ymwybodol o'i atal dweud. Roedd yn hanfodol bod y disgybl yn gallu gwneud hyn yn iaith yr ysgol er mwyn iddo deimlo'n gyfforddus.

Da iawn, Lowri!

Earlier this month, one of our Speech and Language Therapists, Lowri Roberts, received great feedback from YGG Llantrisant after supporting a child with a stammer and providing their classmates with helpful information on how to support them at school. Here's what the teacher had to say...

"Lowri Roberts worked with a pupil from our school to help with stuttering and the pupil was delighted to be able to do that in Welsh. It was very beneficial to be able to get Lowri to come to class to present with the pupil in Welsh.

From Lowri's support, the teacher and pupils were now able to support the pupil and help them feel less conscious of their stuttering. It was essential that the pupil was able to do this in the school's language so that they could feel comfortable.

Da iawn, Lowri!

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Sgiliau, dysgu a datblygu
It's more than just words: Skills, Learning and Development

Cymraeg. Mae'n perthyn i ni i gyd. Un o'r prif rwystrau sy'n atal llawer ohonom rhag defnyddio ein Cymraeg yw diffyg hyder.

Ar **ddydd Iau 28 Mawrth**, rydym yn cynnal sesiwn lle gallwch chi feddwl a dysgu mwy am eich perthynas unigryw eich hun â'n hiaith. Byddwn yn ystyried rhai cysyniadau a all fod yn broblematig, fel cywirdeb a rhuglder, a byddwn yn trafod ffyrdd o ddatblygu eich gallu i ddefnyddio eich Cymraeg, ar ba bynnag lefel, yn hyderus. Efallai eich bod yn meddwl nad yw'r sesiwn hon ar eich cyfer chi. Yna efallai ei fod ar eich cyfer chi!

Cadwch lygad am ein diweddariadau staff eraill am ragor o wybodaeth!

Cymraeg. It belongs to us all. One of the main barriers that stops lots of us from using our Welsh is a lack of confidence.

On **Thursday 28th March**, we are holding a session where you can think and learn more about your own unique relationship to our language. We'll explore some concepts that can be problematic, such as accuracy and fluency, and we'll discuss ways to develop your ability to use your Welsh, at whatever level, with confidence. Maybe you think this session isn't for you. If so, it definitely is!

Keep an eye out for our other staff updates for more information!

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Profiad y claf
It's more than just words: Patient experience

Yn gynharach eleni, cwblhaodd un o'n Therapyddion Galwedigaethol, Celyn, asesiad gyda chlaf yn y Gymraeg yn YTS. Rhannodd y stori deimladwy hon gyda ni am glaf a oedd wedi cael profedigaeth yn ddiweddar ac a oedd yn cael trafferth bod yn glaf mewnol...

"Roedd yn tawelu ei meddwl gan nad oedd hi fel arfer yn siarad llawer o Saesneg gartref. Roedd hi wedi mynd trwy brofedigaeth yn ddiweddar a dywedodd wrthyf fod gwneud yr asesiad yn Gymraeg yn gysur iddi.

Fe wnaeth fy ngalluogi i feithrin perthynas â hi yn gyflym ac rwy'n meddwl bod cwblhau'r asesiad yn Gymraeg wedi caniatáu iddi ymgysylltu mwy â'r asesiad a chynllunio rhyddhau.

Mae'n wir yn fwy na geiriau. Da iawn, bawb.

Earlier this year, one of our Occupational Therapists, Celyn, completed an assessment with a patient in Welsh in PCH. He shared this touching story with us of a recently bereaved patient who was struggling with being an inpatient...

"She found it reassuring as she didn't usually speak much English at home. She had gone through a recent bereavement and told me that doing the assessment in Welsh was comforting to her.

It allowed me to build a rapport with her quickly and I think completing the assessment in Welsh allowed her to engage with the assessment and discharge planning more."

It really is more than just words. Da iawn pawb.

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Cof Cymorth
It's more than just words: Staff support

P'un a ydych chi'n cynnal digwyddiad, yn creu taflen neu'n codi arwydd syml, gallwn ni helpu gyda hynny.

Anfona neges aton ni yn CTT.welsh_translation@wales.nhs.uk a byddwn yn dychwelyd unrhyw gyfieithiad atoch mewn dim o dro.

Whether you're holding an event, producing a leaflet or putting up a simple sign, we can help with that.

Just drop us a message at CTT.welsh_translation@wales.nhs.uk and we will get any translation back to you rapidly.

This is what we did as part of our 'Hiraeth' Campaign:

- Introduced our Welsh Language tutor under the 'Codi Hyder' scheme (see page 49) and shared some inspiring staff stories about their language journey, linking this to how it has enabled them to reconnect with our language and culture;
- Relaunched our brand-new, bilingual SharePoint page. We also added it to the homepage of our intranet, under 'Essential Links'. It includes over 16 different resources, a quick link to book Welsh language 'Taster' sessions and other information on learning Welsh, guidance on embedding Welsh into services (see below), staff and patient videos talking about the importance of Welsh to them and information on using Welsh at work;
- Held several drop-in sessions across our sites, to share resources and chat with staff and patients;
- Held an all-staff event, facilitated by the National Centre for Learning Welsh.

The all-staff event will be the first of many cultural development sessions aimed at breaking down the psychological barriers they face to using their Welsh due to confidence, and the pervasive misconception that 'fluency' is needed to speak and enjoy our language. The event also discussed our relationship to our language, what it means to us and how best we can continue to promote its use in a way that fosters a sense of belonging. The event was attended by staff from various different specialties, from Finance to Medicine and Sterile Services to the Patient Experience Team.

A qualitative and quantitative evaluation of the campaign showed that:

- We spoke to over 40 people about Welsh and the Welsh language offer as part of the drop-in sessions, the majority of whom did not know the extent of what was available to support them to use Welsh beforehand;
- There were over 580 unique views of the SharePoint page in the first fortnight of its launch;
- Over 50 members of staff came to the all-staff event;
- 4 members of staff booked onto a Taster Session following the event, with a further 9 members of staff booking on a Taster session via the campaign, and 7 members of staff registered for the 'Codi Hyder' Scheme;
- When words such as 'fluent' are removed from the discourse around Welsh, staff who attended the event said they felt much more confident and safer using the Welsh they have. This will be a theme we will continue to explore via more of these sessions;
- Welsh is much more than a matter of compliance or just a matter of vocabulary, grammar or skills; language is a holistic concept with which staff have an emotional, cultural and psychological relationship that must be considered when practicing language planning and policy at CTMUHB.

Three comments from attendees describe well how the session was received:

> Roedd angerdd y cyflwynydd yn heintus - mae fy nghymhelliad i ddefnyddio'r iaith wedi cynyddu lot [The presenter's passion was infectious – my motivation to use Welsh has really increased]

> I am more open to the opportunities to use my Welsh in work without worrying about using some English words. This is the start of a long journey…

> It was great to hear from other colleagues with similar experiences to me and encouraging to have a shared passion for the language with so many others in CTM.

This was the first of a planned, coordinated campaign around the concept of Hiraeth and we aim to continue this cultural change approach aligned to Hiraeth as part of our wider Cultural Plan for CTM.

Promoting Welsh and compliance with Standards

In addition to a regular, consistent methodology for internal communications and a dedicated campaign, there have also been other activities carried out to promote Welsh and compliance with Standards throughout the year.

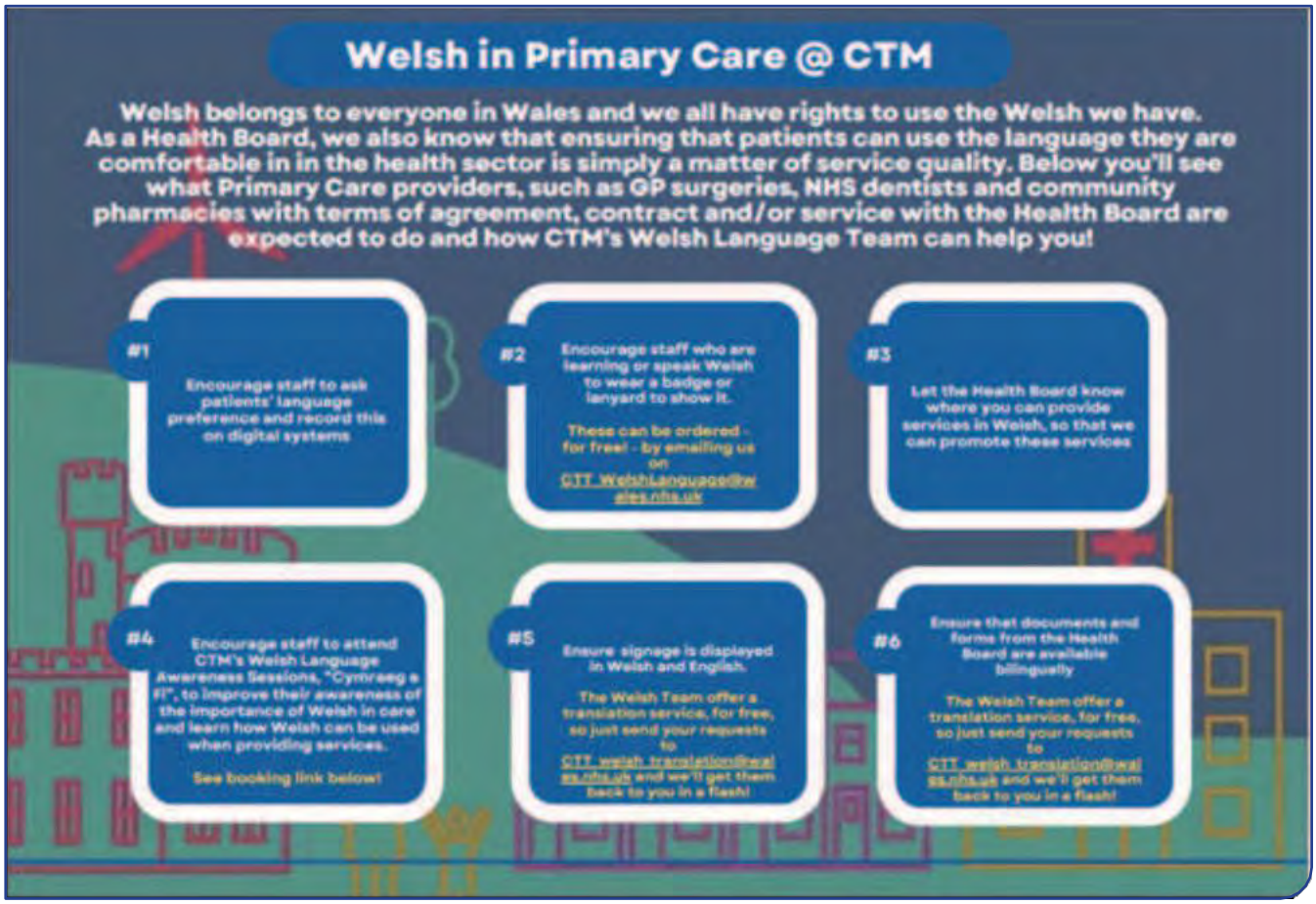
Activity	Description
Face-to-face drop-in sessions at sites	Aside from the drop-in sessions as part of Hiraeth mentioned above, sessions were also held in November. The Welsh Language Team therefore has been present at the Royal Glamorgan Hospital, Princess of Wales Hospital, Prince Charles Hospital, Glanrhyd, Maesteg Community Hospital, Keir Hardie Health Park, Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda and Dewi Sant Hospital near busy spots at least twice as part of dedicated drop-in sessions this reporting year. The impact of these sessions can be seen in the infographic on page 5 in terms of conversations held and resources shared.
SharePoint	There is a dedicated section of our intranet for promoting Welsh in the Health Board, linked to on the homepage of our intranet and structured around the below sections. This has been redeveloped to take full advantage of MS Office 365 features including usage data: • Latest News where the content cards shared above are regularly uploaded; • 'Why Welsh at CTM' sharing video content of staff and patients at CTM talking in their own words about what Welsh means to them; • Learning Welsh at Work, outlining the offer and with the ability to book on to sessions; • Advice on embedding Welsh in services and complying with Standards; • Resources (see below); • Corporate Welsh Language Policy for CTMUHB (new policy in development); • My Rights as a Welsh-speaking employee; • Meet the Team; • Welsh Language Annual Reports; • A comment section.
Resources	The following standard resources have been developed to support staff: 1. The 'A3 Requirements Poster' as a quick reference poster on the most common things we do in Welsh and English when providing services day-to-day; 2. The 'document/form available in Welsh' image, to add to documents or forms to promote the Welsh version; 3. The bilingual 'Feelings and Emotions poster' to use with vulnerable patients to ask how they are feeling; 4. The 'Give It a Go in Meetings' poster, to encourage use of Welsh in meetings; 5. The 'Give It a Go Poster' with lots of useful health-related words and phrases for clinical staff;

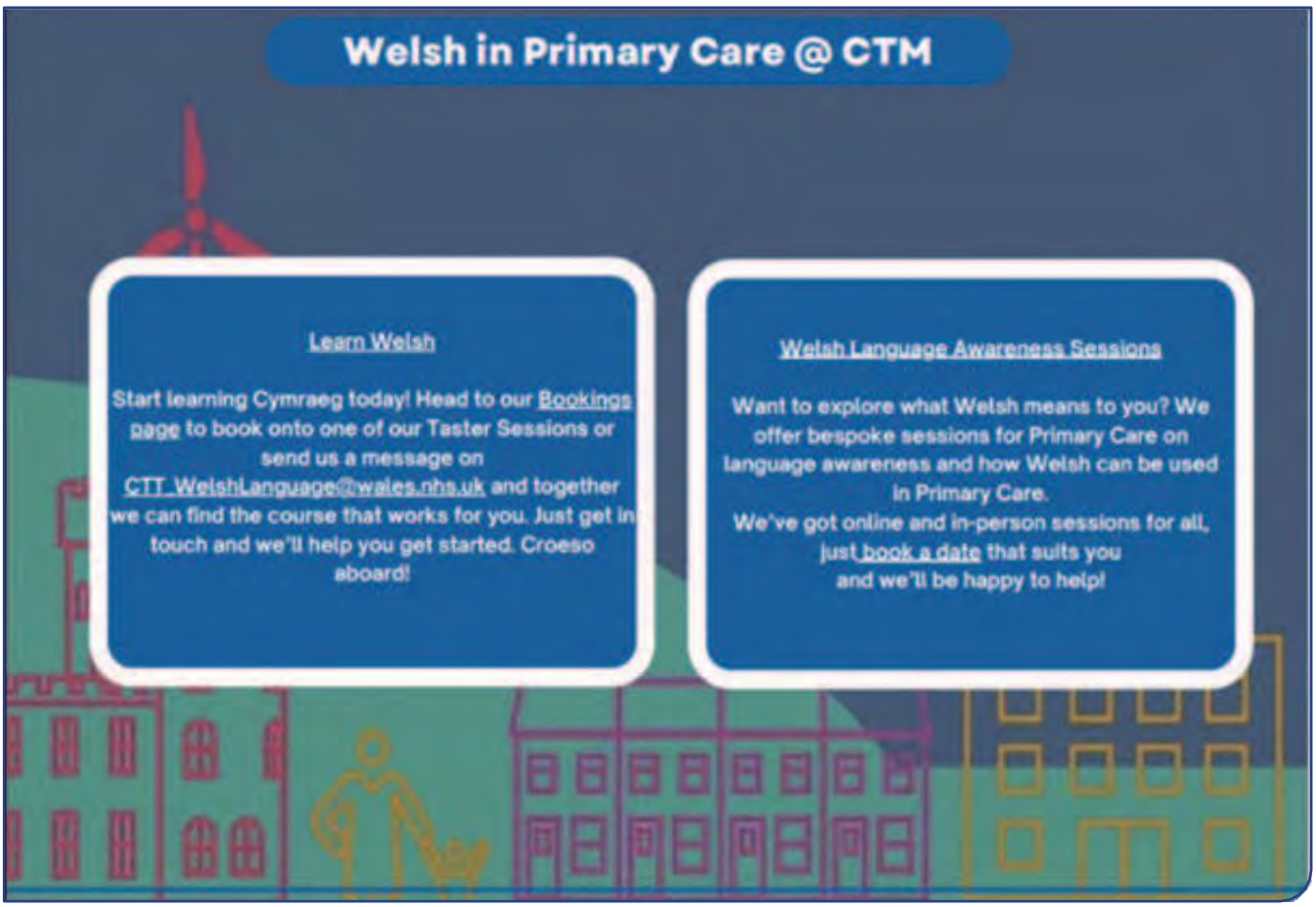
	6. The 'Phonetics Poster for Receptions and the Phones' to support use of some Welsh and basic greetings at reception and on the phone with phonetic transcriptions; 7. The 'Use your Welsh Here' poster to welcome the use of Cymraeg by patients; 8. The 'Standard Email and Out-of-Office template' document, to help staff form a bilingual email signature and out-of-office message; 9. The 'Teams Background Template' to have a corporate Teams background with a bilingual job title, with instructions in the file on how to change it; 10. Instructions on how to show that staff speak Welsh on MS Teams, by using the 'Add Pronouns' function for language; 11. The 'Answering the Telephone' guide to help provide a Welsh language service when answering the telephone; 12. Welsh Language Standard 37 Screening Assessment Tool for documents. If staff are unsure whether a document needs to be bilingual, this can be used to check; 13. Explanatory training video and guide about how to use Welsh in meetings.
Advice guides	Advice guides on complying with Service Delivery Standards and also a specific guide on using Welsh in Communications & Engagement are available on SharePoint, and regularly shared with staff. These have been written using the 'Welsh Voice/Llais y Gymraeg' verbal strategy, designed using corporate branding for CTMUHB and structured via 'Why' we offer services in Welsh, 'How' staff are supported to do so and 'What we do' in Welsh operationally in line with Welsh Language Standards, with case studies and examples also included.
Individual site visits	The Welsh Language Team have also carried out individual site visits this year as part of the support offer, including to Tirion Birth Centre (RGH), Tair Afon Birth Centre (PCH), Special Care Baby Unit (PCH), Ward 17/18 (RGH), Emergency Department (PCH) & Radiology Diagnostics Management Team (all sites)
Language awareness	CTMUHB like all NHS Wales organisations has mandated an e-learning module on ESR on language awareness. This has been completed by 77% of our staff, which is an increase of 37% or approximately 4,000 additional members of staff compared to last reporting year. This is an important way of engaging with staff around the Welsh language and the difference bilingual provision makes. The Welsh Language Team have also offered the following language awareness sessions internally, using CTMUHB's own language awareness content designed last reporting year: • Public Health Team away day (50 members of staff) • Health Visiting Team (20 members of staff)

Promoting Welsh in Primary Care

We reported last year on how we worked specifically with one dental Primary Care provider. Towards the end of this reporting year, we created a standard information sheet setting out the Six Duties with which all Primary Care providers with a contract with CTMUHB are expected to adhere to, as per the NHS Wales (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales) Regulations (2019). We also included clear information noting how Primary Care providers can be supported by the Health Board to meet those duties. This included promoting our free translation service and an offer of awareness sessions specific to Primary Care.

This standardized offer will continue to be shared throughout the next reporting year, and further engagement with Primary Care providers is a priority as set out in the 2024-25 operational plan for Welsh language development.





Promoting our Welsh Language Services with the Public

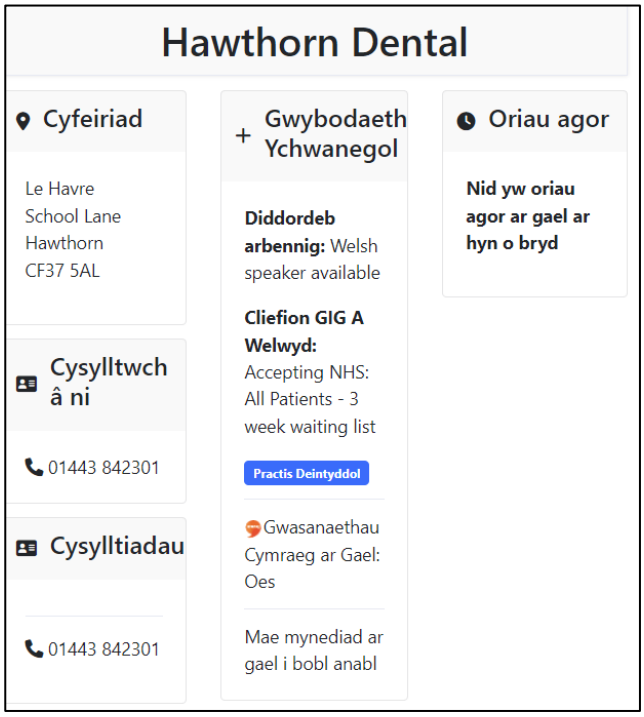
People have rights to use Welsh with CTMUHB and we have a legal duty under the Standards to promote those rights. This year we:

- Redesigned our external webpage to focus on patient rights to use Welsh, giving clear advice to patients on what they can expect to do in Welsh when interacting with CTMUHB and with Primary Care;
- Created a new patient information leaflet for patients available digitally and in print so that patients have a clear resource that explains what rights they have to use Welsh with the Health Board and what they can expect from Primary Care providers.

Both these new resources will be useful in effectively promoting our bilingual provision with the public. Interpreting a compliance notice, a legal document, is effortful and so it is crucial we have clearly written guidance for patients.

We also talked about our drop-in sessions above in November 2023 and as part of our Hiraeth Campaign; these were also an opportunity to speak to nearly 40 members of the public on their rights to use Welsh with the Health Board.

For Primary Care, a specific section on our website also notes which providers are able to provide a service or part of a service in Welsh, with an example provided below. When searching for a Primary Care provider under 'Find your local NHS service', patients are able to see for many providers whether they can offer any provision in Welsh.



Aside from clear advice on what is available in Welsh, we detail what we have done to be pro-active in our service delivery based on the Active Offer concept in the next section.
Further information on how this work under Communications & Engagement has helped CTMUHB comply with the Welsh Language Standards can be seen below.

How work under this theme cross-references with the Welsh Language Standards

Cross-referencing work under Communications & Engagement with Welsh Language Standards	
What we did	**How this supports compliance**
Internal engagement framework	This allows us to share consistent and regular messaging on: • Complying with Service Delivery Standards in general; • Training opportunities for Welsh (supporting **Standards, 99(a), 100, 101 & 102**).
Hiraeth Campaign	This supported: • **Standard 99(a), 100** and **101** by promoting the national Confidence Raising scheme in CTMUHB and opportunities to learn Welsh at work, and • **Standard 102** via the Cymraeg a Fi/Welsh and Me session, improving awareness of the use of Welsh and supporting positive behaviour change by breaking down psychological barriers to language use.
Drop-in sessions	This supported: • Complying with Service Delivery Standards in general; • Promoting the Welsh language with the public (**Standard 60**) and • Providing lanyards and badges to Welsh speaking staff (**Standard 105**).
SharePoint and our re- sources	This work: • Supports compliance with Service Delivery Standards in general; • Ensures compliance with **Standard 104** by providing a wording for bilingual email and out-of-office signatures; • Ensures compliance with **Standard 94** by having a designated intranet page for Welsh; • Promotes opportunities to use and enjoy Welsh at work (promoting **Standards 81, 82, 83, 84, 85, 86, 87, 88 & 89**, and promoting **Standards under the Welsh Language Standards (No. 8) Regulations 2022** as relevant to regulatory bodies some staff are registrants of) and • **Standard 99(a), 100** and **101** by promoting the internal offer to learn Welsh at work.
Advice guides	These guides support compliance with Service Delivery Standards in general.
Individual site visits	This supported compliance with Service Delivery Standards in general.
Language awareness sessions	This work: • Ensured compliance with **Standard 102**, by ensuring staff have access to a language awareness offer and are completing it; • Supported compliance with Service Delivery Standards in general.
Promoting Welsh in Pri- mary Care	This work supported compliance with **Standards 66, 67 & 68**.
Promoting our Welsh Language Services to the public	This work supported compliance with **Standard 61 & 65**

Theme 2: Action Planning & Monitoring

The right organisational culture and an enabling, more supportive approach for our staff are two critical elements in ensuring we provide our services bilingually and in complying with our language equality duties for Welsh. Communications and engagement are key to this.

Another important element to this is our approach to improvement plans, monitoring compliance and having controls in place. These identify gaps in provision to ensure we have the checks and balances in place to put things right when needed.

Management controls to monitor compliance

The Health Board has management controls in place to monitor compliance with Welsh Language Standards.

Our Welsh Language Team

Part of the controls we have in place is the Welsh Language Team led by CTMUHB's Welsh Language Lead. The Team is responsible as an enabling service for offering advice on complying with the Standards, monitoring compliance and working with managers to improve their bilingual provision strategically and operationally, providing language awareness and specific support to teams to meet their duties in the compliance notice, professional translation, managing and promoting our offer to learn Welsh at work, and creating and sharing various resources to support the use of Welsh across the organisation.

Auditing

As part of monitoring compliance, regular observational audits on sites are carried out as well as departmental audits carried out by relevant leads in those areas. This year a dip sample was also taken to gather baseline trends across CTMUHB, completed by 86 departmental managers across each Care Group. It asked detailed questions around compliance with Service Delivery Standards. The aim was to gather a detailed enough baseline to measure current progress in embedding the Standards, and prioritize work based on weaknesses identified.

These results, along with observational audit results, site visits, data from translation requests received and results of Patient Reported Experience Measures (PREMs, see below) also form the business intelligence for the overall compliance tracker finalised last reporting year. This allows CTMUHB to monitor how the Welsh Language Standards are being embedded and to provide an overall maturity score (see below).
The general trend across the sample was that:

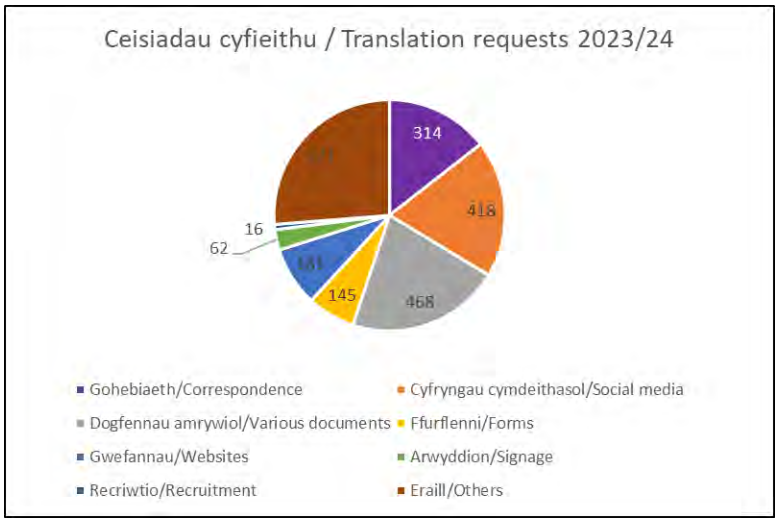
- There appears to be a strong base of support for Welsh and bilingual provision among managers, with a large majority of managers reporting their team had a good knowledge of why we offer services in Welsh, what they are expected to do in Welsh in the context of their specialty and where to get support and advice where needed. This means that where we need to improve, this is not usually due to a lack of understanding of the requirements;
- CTMUHB appears to broadly comply with many of the Service Delivery Standards all or the majority of the time (see Appendix 1), although there needs to be work around those Standards which require oral skills in Welsh, such as answering main and departmental telephones, providing health education courses and reception services;
- The Active Offer is a concept most managers and their teams appear to understand and practice, with a minority of managers reporting they 'never' ask language preference pro-actively. This is crucial for the take-up of Welsh language services. More work on the Active Offer is detailed below.

It is clear from this audit that work needs to continue around recruiting Welsh speaking staff to frontline roles and providing opportunities to learn Welsh at work, both of which are areas of focus for the Health Board (see Theme 5).

Use of the translation service

Translation data is important for monitoring as translation is often needed to reach compliance with several Standards, from social media to forms and from signs to the use of Welsh internally. The service received 2,182 requests this reporting year, translating 1.2 million words.

The graph below shows the type of requests received as a proportion of all requests. Judging by the type of requests received, a trend of at least Medium Assurance of compliance with Standards 1, 4, 5, 6, 37, 38, 39, 41, 45, 47 and 112 can be seen. For example, it is unlikely that CTMUHB cannot report at least Medium Assurance for Standard 38 and ensuring forms are bilingual given the translation service received 145 requests (12 a month on average) for form-related content.



Strategy and Transformation work: Service redesign and third-party commissioning

In relation to any service change or service redesign, engagement is often carried out with patients and our community, and any information, proposals or questionnaires in relation to service change or engagement as part of the process would be communicated in both English and Welsh. Any service change notices are put out to our communities via the Communications and Engagement Team bilingually. Should we need to write out to patients or GPs to inform them that a service is changing, this is done in both English and Welsh. Work has also begun to ensure compliance in this area around Policy Making Standards (in terms of impact assessments (see below) as well as how we consult on service change.

An example of compliance with Service Delivery Standards in this area however was in relation to the recent changes in Breast Services. Another example is the Drymester Project, a campaign from Greater Manchester Health & Social Care Partnership which aims to spread the correct guidance about risks of drinking alcohol during pregnancy and to help parents go alcohol-free. As part of the project CTMUHB adopted the Drymester campaign and resources were translated into Welsh by the Welsh Language Team. Drymester was launched across CTMUHB during 2023, and other Health Boards are now also considering utilising the Drymester resources.

In terms of commissioning third parties to provide services, our standard Service Level Agreement contains

relevant references to the Welsh Language Standards. This ensures that when commissioning services, the legal agreement entered into ensures that compliance with Welsh Language Standards can be contractually enforced. It also commits the Health Board to ensure that the support needed by commissioned parties to provide services in Welsh is clearly communicated, and details on accessing relevant support is included in the award letter to third parties.

The Active Offer and evidence of caring in Welsh at CTMUHB

The Active Offer, or asking the patient their language preference pro-actively, is essential in providing bilingual services for many different reasons. A strong Active Offer approach can lead to increases in the take-up of Welsh language services and below several data points are discussed that evidence how CTMUHB is embedding the Active Offer approach, and how we are offering care in Welsh to those who need it.

Active Offer emphasized in guidance

The guidance on complying with Standards referenced above in Theme 1 discusses the Active Offer and why this is important. Before staff turn to what the requirements of them are, they are introduced to the Active Offer and patient experience stories that explain its importance.

In-patient Active Offer Policy

This year CTMUHB ratified its first policy for practicing the Active Offer with in-patients, including for those in-patients who for whatever clinical reason may not be able to express their language need themselves. The policy was supported by the Executive Director for Nursing & Patient Experience, shared at the March 2024 Operational Management Board meeting attended by all senior operational managers before approval at a meeting of the Quality & Safety Committee, a sub-committee of the Board.

The policy document explains the regulatory compliance background of the policy and the data points that will be used to monitor implementation. An attached appendix to the policy then explains the research behind the importance of the Active Offer and first-language care for bilingual patients, before outlining a protocol which is structured via three themes, Surrounding (ensuring a ward environment conducive to the use of Welsh), Asking (at what point during the established admission process should language choice be asked and what to do if the
patient cannot express this themselves) and Recording (on which clinical systems to record language need if not already recorded).

Having a stand-alone policy relating to in-patient admission for Welsh speakers, supported by an Executive Board member and approved via formal governance processes, is a significant step forward for CTMUHB in its Active Offer approach, and testament to the support the Welsh language has within senior nursing management.

E-whiteboards

Our e-whiteboards are a large, electronic display on wards to allow clinical staff to gather various pieces of information about patients at a glance, with symbols denoting various information placed on a bed on a graphical representation of the ward (PICTURE 1 HERE (E-WHITEBOARD).
This system allows staff to note that in-patients are Welsh-speaking, currently using the Welsh flag symbol and the words ‘Welsh speaker’. This allows us to record the language preference and need of in-patients in an acute or community hospital bed and for that preference or need to be visible to all staff who use the digital whiteboards.

The e-whiteboards also allow staff other than nursing staff to know a patient is Welsh-speaking, for example junior doctors, consultants, or physiotherapists during their interactions with an in-patient. Another useful feature of the system is the List View, which allows staff to click on a symbol and see all patients for whom that symbol has been used and where that patient is located. This would allow staff to see which patients are Welsh-speaking, and plan ward rounds and therapy accordingly.

The e-whiteboard system is also linked to our E-TOC system, or Electronic Transfer of Care Record, also developed by CTMUHB, which is used when discharging patients to social care. When completing this electronic form, staff are prompted to ask whether the patient has been asked what their language preference is, which would allow social care staff to see that a patient is Welsh-speaking and plan accordingly. This question must be answered before the record can be transferred, meaning staff are much more likely to ensure they have asked language preference. The e-whiteboard and ETOC systems are innovative solutions developed by CTMUHB and will make a considerable difference to patient care for our Welsh-speaking communities.

These are also excellent examples of considering real human behaviour when providing services; by asking language preference and recording this for staff and patients, we're making it much easier for staff to identify Welsh-speaking patients and for patients to express their language need, thereby removing friction and effort which often hinder bilingual provision. These systems also facilitate the default offering of bilingual services, by allowing staff to identify Welsh-speaking patients on wards and within social care and arranging Welsh-medium care in advance, without the patient needing to express this themselves repeatedly throughout the system.

An example of how recording in-patient language need internally can mean patients not having to repeat their language need as they move through the system is the case of Patient A, [4] who was admitted to Ward B2 at Ysbyty Cwm Rhondda and their language need recorded as Welsh, before being transferred to the Royal Glamorgan Hospital. Their language need did not need to be asked again once admitted there as it was already recorded on the system.

This year, the e-white board Welsh language symbol was used at the following sites:

E-whiteboard use 2023-24	
Hospital site and number of patients	**Ward**
RGH (13)	10, 14, 17, 2, 4, 5, 8, Critical Care Unit (CCU)
PCH (6)	10, 3, 9, CCU
YCR (2)	B2
POW (8)	10, 15, 6, 7, 9

[4] Patient's name withheld for confidentiality.

We are pleased to see continued use of the e-whiteboard, across multiple wards and multiple hospitals.

Welsh Nursing Care Record (WNCR)

The WNCR is a digital system that transforms the way nurses record, store and access patient information. Instead of making notes on paper at a patient's bedside, nurses use tablet computers to collect information and store it securely in the WNCR. This allows carers have access to the same up-to-date information throughout a patient's healthcare journey.

The language preference field is mandatory within the 'Communication Needs' section of the assessment. Nurses can save assessments that are incomplete in a 'draft' format (as they may get called away, need information from the patient's family, or the patient may be unresponsive and unable to answer), but must complete all questions within the section to mark it as 'Complete'.

Across CTMUHB wards where the WNCR is used, the following numbers of patients were recorded as Welsh being their preferred language. This not only shows the use of Welsh across CTMUHB (Welsh was the second highest language recorded after English), but that the Active Offer is being made and recorded across wards.

WNCR use for Welsh language	
Site	**Ward**
PCH	53
POW	41
RGH	84
YCC	1
YCR	1

Other digital systems and recording language preference

CTMUHB uses various national systems to record patient data. These include the following main systems, and the ability to record language preference on them is shown. This allows us to ensure the Active Offer is practiced by using systems that allow us to record language need. Staff can then use this information to pro-actively offer services in Welsh.

System	Where language preference is recorded
Patient Administration System (PAS)	Under 'Demographics'
Welsh Clinical Portal (WCP)	Pulls data from PAS,
EMIS	Under 'Contact Information'
Welsh Clinical Communication Gateway	Under 'Language of Choice'
Choose Pharmacy	In 'Main Patient Demographics' section
Community Child Health 2000	Displays "First language" and "Second language" as one character field (e.g. 'W' for Welsh). This is displayed on the child's record.
Welsh Radiology Information System	Under 'Demographics'

Patient Reported Experience Measures

A further evidence base of whether patients can use Welsh in their interactions with the Health Board is data from Patient Reported Experience Measures (PREMs). These surveys are completed by patients cared for by various specialties, sometimes for specific treatments, and for in-patients and out-patients across the Health Board. The data this reporting year shows that, of those patients who completed a survey and answered the question around their ability to use Welsh if they wanted to, the majority were able to do so. Data for Emergency Departments and the Palliative Care team are important as this will allow further interventions there to improve these scores. It should be noted however that over 160 patients reporting they used Welsh at CTMUHB's emergency care departments is very positive, and it is unlikely a number this high would be reported were there not a good level of Welsh language provision in them, even if this may be inconsistent. The PREMs themselves are also bilingual and 58 patients completed them in Welsh.

In the table below, results of PREMs that included a question on Welsh are shown. All questions included a 'Not applicable' answer, but to calculate the proportion of patients who were able to use Welsh where they wanted to, these 'N/A' numbers have been removed. The results have also been categorised by Red – Amber – Green, red meaning majority completing wanted to use Welsh but couldn't, Amber meaning that the picture is inconsistent, and Green meaning the majority who wanted to use Welsh were in fact able to.

Survey Name	Question	Number reporting they were able to use Welsh and % of all relevant responses	
Adult Mental Health - Patient Experience Survey	Were you able to speak Welsh to staff if you needed to?	'Definitely'	6 (50%)
		'Generally'	1 (8%)
		'Not really'	5 (48%)
CTM Patient Experience Questionnaire	Were you able to speak in Welsh to staff if you needed to?	'Always'	2 (22%)
		'Usually'	3 (33%)
		'Sometimes'	2 (22%)
		'Never'	2 (22%)
CTM Patient Experience - Gynae & Sexual Health	Able to speak in Welsh or your preferred language to staff if you needed to?	'Always'	95 (90%)
		'Usually'	2 (2%)
		'Sometimes'	3 (3%)
		'Never'	5 (5%)
Easy Read - Your NHS Care	If you speak Welsh, were you able to speak Welsh to staff?	'I was always able to speak Welsh'	3 (33%)
		'I was usually able to speak Welsh'	1 (11%)
		'I was able to speak Welsh sometimes'	2 (22%)
		'I was not able to speak Welsh'	3 (33%)
Emergency Department Survey	Were you able to speak in Welsh to staff if you needed to?	'Always'	127 (31%)
		'Usually'	35 (8%)
		'Sometimes'	42 (10%)
		'Never'	208 (50%)
Heart Failure - PREM Survey	Were you able to speak in Welsh to staff if you needed to?	'Always'	113 (77%)
		'Usually'	2 (1%)
		'Sometimes'	25 (17%)
		'Never'	6 (4%)
Mental Health Clinic - Patient Experience Survey	Were you able to speak in Welsh to staff if you needed to?	'Always'	0
		'Usually'	0
		'Sometimes'	1 (50%)
		'Never'	1 (50%)

Palliative Care Team Patient Survey	Are you able to speak Welsh to the team, if you need to?	'Always'	0
		'Usually'	0
		'Sometimes'	0
		'Never'	3 (100%)
Parents / Carers Questionnaire - Outpatients	Were you able to communicate in a language of your choice?	'Yes'	12 (100%)
		'Usually'	0
		'Sometimes'	0
		'Never'	0
Parents / Carers Questionnaire	Were you able to communicate in a language of your choice?	'Yes'	40 (100%)
		'Usually'	0
		'Sometimes'	0
		'Never'	0
Patient Experience Survey - Endoscopy	Were you able to speak Welsh to staff if you needed to?	'Always'	122 (91%)
		'Usually'	6 (4.5%)
		'Sometimes'	2 (1.5%)
		'Never'	3 (2%)
Pelvic Health / Urogynaecology clinic-Therapies	Were you able to speak Welsh to staff if you needed to?	'Always'	21 (77%)
		'Usually'	1 (3%)
		'Sometimes'	0 (0%)
		'Never'	5 (18%)
Physio PREM	Were you able to speak Welsh to staff if you needed to?	'Always'	1 (100%)
		'Usually'	0
		'Sometimes'	0
		'Never'	0
Therapies patient experience survey	Were you able to speak Welsh to staff if you needed to?	'Always'	11 (46%)
		'Usually'	3 (12.5%)
		'Sometimes'	6 (25%)
		'Never'	4 (16%)
Wellness Improvement Service (WISE) Questionnaire	Were you able to speak in Welsh or your preferred language to staff if you needed to?	'Always'	30 (90%)
		'Usually'	1 (3%)
		'Sometimes'	0 (0%)
		'Never'	2 (6%)

Lanyards and badges

Another important method of promoting our services in Welsh and pro-actively informing patients of who our Welsh speaking staff are is sharing lanyards and badges (pin or embroidered) with staff, and sharing the national 'Use your Welsh here' poster. This is facilitated by:

- Ensuring lanyards are available at the general office of each main hospital site;
- Lanyards, badges and the 'Use Your Welsh here' poster are promoted on the SharePoint site described under Theme 1 with an email address to order more;
- Email signature 'Welsh speaker' logos are provided via SharePoint for staff to add to the emails;
- ID badge ordering forms ask if the staff member can speak Welsh and if so the 'Iaith Gwaith' symbol is added;
- Order forms for scrubs and ward-based staff uniforms contain a space where staff can request that the 'Iaith Gwaith' symbol is embroidered on to it and they are reminded of this in the guidance.

Over 180 further badges and lanyards have been given to Welsh speaking staff this year by the Welsh Language Team via these methods, and site visits confirm many of our staff wear them.

Pro-actively promoting the bilingual website

Last reporting year we added a message to our website to encourage users to use the Welsh version. Adding this message made it clearer where the button to change the language to Welsh was located. We plan to make this even better next reporting year, but adding this message alone has added over 3,000 new site visits to Welsh language content, with the number of sites visits on the Welsh side rising from 11,397 in 2023/24 to 14,347 this reporting year.

Following a complaint last year and a subsequent investigation by the Welsh Language Commissioner, CTMUHB worked with Digital Health and Care Wales to improve the content management system used for its website (Mura). To help ensure that content is always added bilingually:

- A message now appears to ensure that content posters are reminded of the need for the page to be bilingual and that content in Welsh must be uploaded at the same time;
- When a page is created, an automatic 'dummy' page is created on the Welsh language site, so that were a member of public to click on 'Welsh' on a page, they will not get an error message if the content, for some reason, is not available in Welsh and they would be directed to the health information in English to avoid missing content;
- An audit method has been added as an assurance mechanism, so that any pages not in Welsh can be easily found.

These measures will help ensure our bilingual site remains bilingual.

Qualitative evidence of the Active Offer

As well as numerical data on how we have embedded the Active Offer approach as part of monitoring our bilingual service delivery, qualitative evidence is also important. Several patient experience stories have been shared this year, two of which can be seen on page 11. This is further evidence of how CTMUHB provides its care in Welsh, and that this provision is being pro-actively offered.

Case studies: Giving context to progress at CTMUHB

A selection of case studies below give some background to compliance with Welsh Language Standards at CTMUHB.

Case study 1: Radiology

Radiology teams across CTMUHB have made considerable effort during this year to embed Welsh a lot more into our service delivery. The first step we took was to look at our current position and benchmark against the Welsh Language Standards. This then allowed us to form an action plan. Early in the process, managers in the team also met with the Welsh Language Lead so that queries and concerns could be raised and it was great to have the opportunity to have an open discussion for the first time on Welsh language and what support is available to do more in Welsh.

Our letters are now bilingual, our patient leaflets are bilingual, most of our temporary signage is bilingual, and our check-in kiosks are also bilingual, offering the patient both languages pro-actively on arrival. We have used resources also to support staff to use Welsh on the phone and at reception, and there has been an increase in the amount of courtesy Welsh used.

Within Radiology we have a good number of Welsh-speaking staff, all of whom wear a lanyard to show this to staff and patients. We're keen to grow this number and one of our Radiographers has registered for the Codi Hyder/Confidence Raising scheme.

In all, there's been much more engagement with the Welsh language in Radiology and this will be seen and heard by our patients.

Case study 2: Facilities

Facilities are crucial to the life of CTMUHB and patient care. Staff within Facilities are responsible for patient feeding, moving patients, staff uniforms, the canteen and staff catering, the list goes on. A few initiatives this year show how we have embedded Welsh.

We now produce our in-patient menus bilingually, allowing in-patients to choose their food in Welsh. Using Welsh when in a vulnerable and emotional state in any capacity can be a comfort to many and so it's great to have these yn Gymraeg. We also renamed the Central Production Unit, producing food for in-patients, to 'Maeth', giving it a Welsh-only name. Having been shortlisted for an award in London, it was excellent to see the Welsh word 'Maeth' displayed with the prominent red Welsh dragon.

We have also been successful in bringing Starbucks to CTMUHB. All of the signage is bilingual; where else can you buy a 'Latte Te Chai' or an 'Americano Gwyn' in Starbucks in Welsh if not in the Royal Glamorgan! Other

things we have done are ensure our staff menus are bilingual, ensure staff can order the Welsh language badge for their uniform in Welsh and ensure our temporary signage is in Welsh.

Case Study 3: In-patient Paediatrics

There are over 28,000 children across CTMUHB who can speak Welsh, so having a welcoming, bilingual environment on our in-patient wards comes naturally to us. In our bilingual in-patient booklet, we encourage our patients to use Welsh with us and explain what the orange 'Iaith Gwaith' symbol means. Our environment is bilingual, from both permanent and temporary signage to our displays. We also renamed our wards this year, with bilingual names with the Welsh on top. For Su'mai Shw mae Day, we marked the occasion for the children with activities and shared Welsh language books. Our play room also has bilingual books and games.

We have Welsh-speaking nursing staff and a Welsh Language Champion, and it's fair to say we have a healthy culture towards the use of Welsh on the wards. Our Senior Nurse at PCH is also taking part in the Codi Hyder/Confidence Raising Scheme.

One impactful change we made this year was to amend our in-patient admission documentation so that we can record whether or not the family has been asked what their language of need is. This allows us to ensure that families have in fact been asked and that this has then been recorded.

Case study 4: MH&LD

We have a good experience of the quality and speed of Welsh translation services. We are aware of the Welsh language module of mandatory training and we monitor the uptake of this training. Our Welsh speaking staff wear lanyards and badges to identify themselves to others and to support the active offer of care in the Welsh language. We have a list of our Welsh speaking staff who can support colleagues to deliver services using the Welsh language to those service users who prefer this. There are also lots of resources available for teams to support them to use Welsh. Teams within Mental Health & Learning Disabilities have received some of these resources and are using them with patients, with some resources displayed on wards. One resource that has been particularly useful is the 'Feelings & Emotions' poster, which allows patients to express their feelings without having to speak. They are taken out by Community Psychiatric Nurses and have proved to be useful for this purpose. We have also received lots of badges and lanyards and these have allowed us to show patients we speak Welsh.

Case study 5: Maternity

Maternity services across CTMUHB have committed Welsh Language Champions, in our Patient Experience Midwife working across three sites and our deputy Ward Sister at PCH for neonates. This has meant we have been able to ensure our displays are bilingual, that in-patient information for mothers at the bedside is bilingual and that our signage is bilingual. Some resources shared with us from the Welsh Language Team have also been displayed. We have a few Welsh speaking members of staff and this allows us to use Welsh with mothers and their families. We have also been supported by the Welsh Language Team who visited our sites this year and gave us some pointers on how we could further improve our bilingual offering.

We have also been involved in arranging baby showers for our new-borns, and an invite is extended to the Mudiad Meithrin and other groups so that Welsh medium education is promoted. We also ensured all our materials were bilingual from the start.

Case study 6: Therapies

We have seen such great change in the Therapies areas. Therapies are a huge part of the care CTMUHB provides to our population and provide care in many different settings from the home to in-patient wards to schools, so changes we have seen really do impact massively on the Health Board's bilingual offering and our bilingual ethos at CTMUHB.

Here are some of the main changes we have seen:

- Welsh greetings are consistently used in meetings, and staff often practise key phrases in them for use with both staff and the public. Conversational Welsh between staff members is encouraged and part of practice. This has been a shift in behaviour. Until relatively recently conversations were held in English. Staff now feel comfortable and are encouraged to talk in whatever language they feel happy. In a staff meeting e.g., during a break some conversations will be happening in Welsh and some in English. It feels very inclusive;
- A really visually clear commitment to Welsh as well is our signage; it is consistently bilingual with Welsh first;
- Welsh language is now routinely considered in our planning. Here are three examples:
  - When developing branding for the new falls prevention service, consideration of translation to Welsh was considered at the beginning;
  - A therapies recruitment campaign ensured that all resources and communication was bilingual;
  - The planning of a National Speech and Language Therapy careers event has included the development of a bilingual booking and all resources will be shared in both Welsh and English. The event is planning to run two session side by side, one Welsh, one English.
- Our documentation has been changed so that we make the Active Offer, with preferred language the first question.

Some key challenges have also been overcome. Our patient letters via Myrddin are now produced bilingually and we ensure new ones are bilingual and uploaded.

The Public Health Dietetics team work closely with the translation team to consistently ensure that all service materials are produced bilingually, these include:

- Service promotional materials (posters, business cards and infographics);
- Self-referral, evaluation and booking forms;
- Bilingual slides at service launch events supported by bilingual speaking professionals;
- Promotional videos and cooking demonstrations.

The resulting feedback has been received from stakeholders following a launch event:

Excellent Welsh Language provision today

Great to be able to converse in Welsh and have the slides available to us bilingually

The team made a real effort to make sure Welsh language speakers were easily identifiable and available

This really does impact the patients. Here is one patient story related to Speech & Language services, shared with us from a local school, which was also shared as part of our internal communications framework (see page 11 above)

Welsh Language Impact Assessments: Screening and monitoring change for its impact on Welsh

From February 2024 onwards this reporting year, CTMUHB overhauled its process of assessing the impact of organisational change on Welsh, ensuring a compliant methodology is in place. This is a significant monitoring and control mechanism to ensure Welsh is considered at the right time. The template used to assess impact now entails the following:

1. Firstly, the manager is required to explain the nature of the change (such as development, policy, strategy, plan or any relevant activity where change is involved), via a series of structured questions;
2. Secondly, the manager is then required to outline the potential impact on Welsh using the guidance provided. That guidance references all relevant legislation and policy for Welsh in NHS Wales;
3. Thirdly, the manager is required to note whether the identified impact would have a Positive, Neutral or Negative impact on Welsh;
4. Finally, the manager is required to note what actions they will take to increase the positive effects on Welsh, or what actions they will take to mitigate or negate any negative effects identified.

Policy, covering paper and report templates have also been changed, ensuring that it is possible to ascertain whether decisions or reports put before senior management meetings, committee meetings and meetings of the Board have been subject to a Welsh Language Impact Assessment specifically and what the outcome of that assessment was.

Welsh Language Impact Assessments completed since this process was overhauled are outlined below. The process of monitoring the completion rate and quality of WLIAs will be a focus for next reporting year as per the operational plan for Welsh Language Services, now that the assessment methodology is adequate.

Brief description	Summary of impact	Outcome of assessment	Required actions
Welsh Language Active Offer Policy (see above)	This policy is designed to have a significant impact on the Welsh language as it is a policy specifically written to increase the pro-active provision of bilingual services, in this case in the case of in-patient admission. As the policy itself is required under the Welsh Language Standards, the policy itself outlines in detail the impact of this policy. When implemented, the policy will have a significant positive outcome on Welsh.	POSITIVE	No further actions noted due to the nature of the policy.
Section 17 Mental Health Act Leave of Absence Policy & Procedure	The proposed policy does not impact on Welsh Speakers. All patient information leaflets and forms are available in both English & Welsh and the patient's preference is established when they are fist detained under the Act.	NEUTRAL	None noted, however relevant documents already bilingual and admission procedure includes asking language need
Hospital Managers Scheme of Delegation Policy	The policy is required to ensure that the Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions and compliance with the statutory requirements of the Mental Health Act 1983 are in line with the legal and good practice framework.	NEUTRAL	None noted

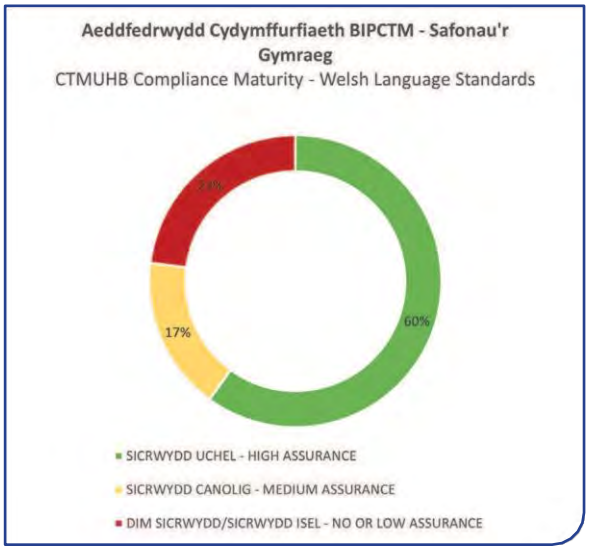
Section 132, 132A and 133 Patients right to Information Policy	This policy aims to provide staff with the delegated responsibility under the Mental Health Act, with the knowledge to undertake those responsibilities. The objective is to ensure staff have the necessary knowledge and tools to ensure the authorisation, implementation and recording and monitoring of section 132 is done so in accordance with legislative and good practice requirements.	NEUTRAL	None noted

Welsh Language Compliance Tracker

The data above from several monitoring sources, including the dip sample audit, observational audits, departmental audits, site visits, data from translation, PREMs and EIA submissions allow for a Welsh Language Compliance Tracker to be maintained which tracks progress with compliance with all Standards. It records compliance for each standard using the following framework:

High Assurance	The organisation complies with all requirements under all circumstances except for on rare occasions
Medium Assurance	The organisation is usually fully compliant, but there is non-compliance at some times or in relation to some requirements
Low Assurance	The organisation complies at some times or in relation to some of the requirements, but does not comply fully and consistently
No Assurance	The organisation does not comply with the requirements at all, or complies on rare occasions or in only a few respects

CTMUHB is able to record High Assurance with 60% of all Standards and Medium Assurance with 17% . Further monitoring detail is provided in Appendix 1, including an individual assurance assessment for each standard with which CTMUHB must comply.



All standards for which 'High Assurance' can be recorded are given a score of 1, and all other Standards '0' allowing for an overall maturity score to be given. CTMUHB is able to record High Assurance with **60%** of all Standards. Further monitoring detail is provided in Appendix 1, including an assurance score for each standard with which CTMUHB must comply.

On Standards 8, 9, 10, 16 & 106 where No and Medium Assurance is reported in Appendix 1, CTMUHB received an enforcement notice following an investigation in August 2023. CTMUHB was then required to submit an action plan to the Welsh Language Commissioner under Section 80 of the Welsh Language (Wales) Measure 2011 which was approved, with all actions to be completed by December 2024. Progress on meeting those actions is being monitored and our next annual report will show how we have completed those actions.

Theme 3: Employee Experience and Our Bilingual Workplace

A thriving Welsh language culture, as part of a rich tapestry of languages and cultures, makes CTMUHB a unique place to work and will over time mean better Welsh language services for our patients and service users. It will also allow a more inclusive environment for the hundreds of our staff who speak Welsh to develop. This theme looks at the work we are doing to weave Welsh into all aspects of our organisational life.

Our values and behaviours

This year, and as part of our internal promotion plan, we have talked about Welsh through our internal communications methods a lot more. There are many reasons for this:

Our organisational values and behaviours form a framework which encourage the right behaviours at work. These are:

- We listen, learn and improve;
- We treat everyone with respect;
- We all work together as one team.

These values foster a culture of learning, conducive to developing Welsh language skills at work. They also foster a culture of respect and understanding, essential for different languages, Welsh included, to be used and enjoyed. Finally they encourage co-operation and functional and healthy teams, essential for Welsh to develop and thrive.

They appear all over CTMUHB from desktops to walls, and are bilingual.

Starting work at CTMUHB

From applying for a post to having an interview in Welsh, the processes and systems CTMUHB has in place are making it increasingly possible to use Welsh right from the start of a person's employment.

Aspect	What we do
Bilingual job descriptions and adverts	New posts when banded are translated so that the manager has both job descriptions and person specifications to pro-actively to advertise
Applying for a post	Trac, the recruitment system used by NHS Wales, notes applicants may apply in Welsh. It is not possible to set different closing dates for posts based on language of application and all applicants are informed of the decision made via Trac at the same time.
Pro-actively offering an interview in Welsh	Trac asks applicants whether they wish to have an interview in Welsh.
Informing candidates of the assessment outcome	When applicants apply in Welsh, they receive information from the Trac system in Welsh of the outcome (informing them of whether they have been successful or unsuccessful in being selected for interview, and whether they have been offered the post). Translation requests received also suggest that managers ensure they send bilingual communication to applicants where they communicate with them outside of Trac.
Offering the contract in Welsh	When applicants apply in Welsh, they receive their contract of employment in Welsh automatically via email when offered the post.

CTMUHB fully acknowledges it has more to do in this area, particularly around job descriptions and adverts, but the above is a significant contribution to facilitating the use of Welsh at the start of employment for new members of staff.

Internal communications around Welsh

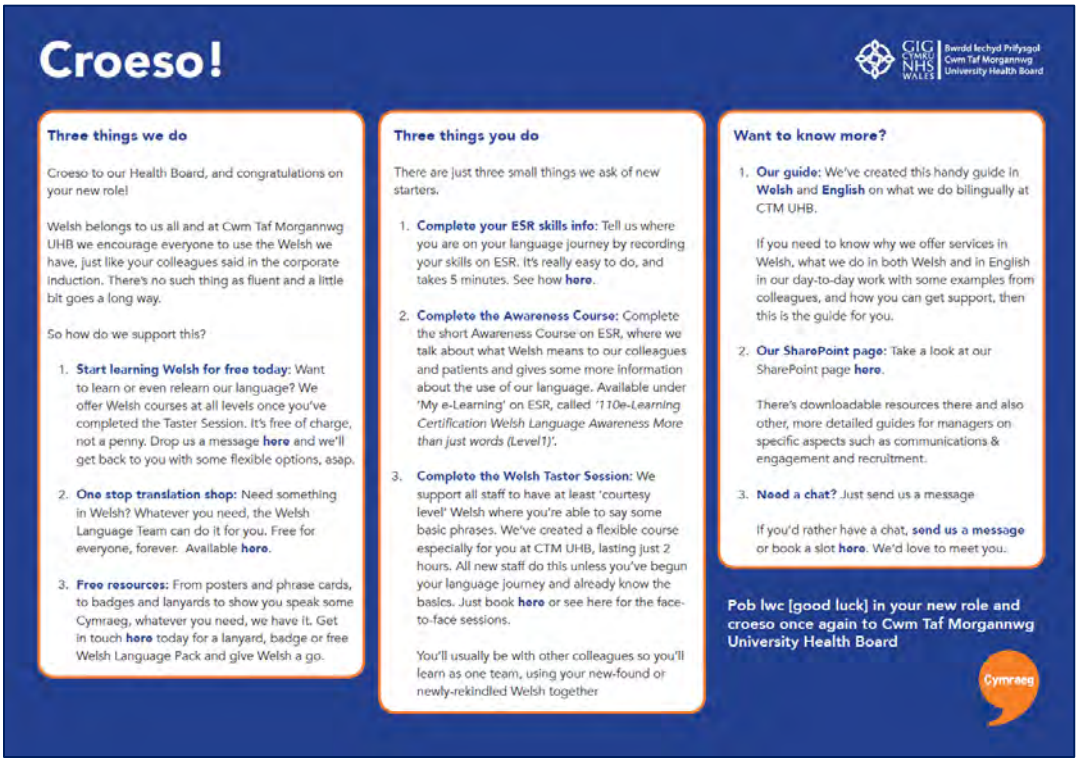
The internal communications framework for Welsh and our Hiraeth campaign were described in detail above but for the purposes of this third theme, it is important to note that internal communications have a significant impact on an organisation's ethos. Including regular messaging around Welsh therefore adds in its own way to our bilingual organisational culture.

Corporate induction

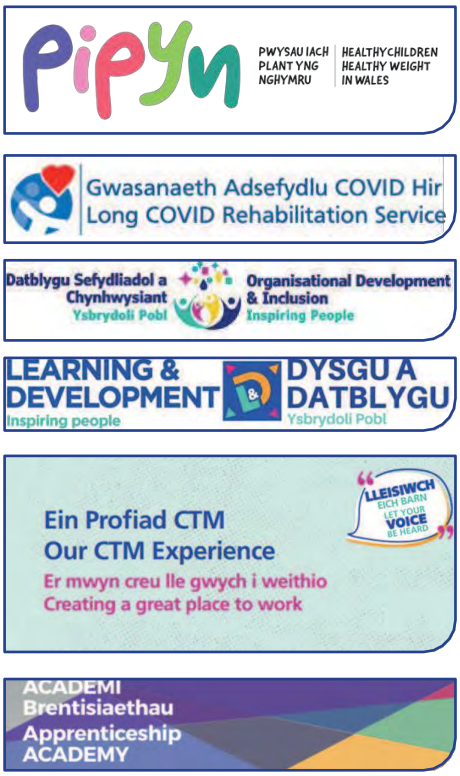
Inductions are an important opportunity to imprint our organisational values and expectations around behaviour to our new employees, and a way of ensuring they understand our approach to bilingual services at CTMUHB. The welcome video at the start of the corporate induction programme is bilingual with both Welsh and English thread through the content, with Welsh-speaking staff using Welsh throughout one single video. This sends a clear message that CTMUHB is an organisation where Welsh and English are both used and respected equally, with a healthy bilingual ethos.

Our video specifically for the Welsh language element to the induction, 'Welsh at CTM' created professionally, is used as part of corporate induction. The video's core message is that Welsh is just as important to us as it is to many in the communities we care for and serve. It also encourages staff to use the Welsh they have. The video explains what support there is for staff to use Welsh at work and what resources are available, again targeting those barriers often identified by healthcare staff to doing more in Welsh. Using patient stories and staff testimony, the video is another tool in our behaviour change armory.

This year we also developed a Welcome Sheet/Taflen Groeso, which is sent to all new starters, setting out our offer for staff (Learning Welsh, translation and resources), what staff need to do at the start of the employment (note their Welsh Language skills on ESR, complete the Welsh language awareness course and complete the 2-hour Courtesy Welsh course) and where to go for further advice and support. It's also been added to the corporate induction Welsh language section.



The linguistic landscape and our corporate identity



A visual bilingual environment encourages people to use their Welsh and shows our commitment to Welsh and its use. All permanent signage across our sites is bilingual. Increasingly, temporary workplace signage is also bilingual including in important areas such as the canteen. This year, over 60 requests were received for temporary signage. These communal areas are important as all staff spend their time there at some point during their working day.

Our corporate identity, internally and externally, also contributes to our bilingual ethos. A selection of logos can be seen below showing the vast majority of examples of presenting our corporate identity, internally and externally, has incorporated Welsh.

Internal meetings

This year a new resource was developed to facilitate the use of Welsh in meetings, consisting of a guide on how best to arrange and hold bilingual meetings and best practice, key phrases in Welsh and a video showcasing a bilingual meeting. This video will support staff on how to use key phrases and have a model meeting in Welsh to refer to.

Internal people policies and people protocols

All people policies are available in Welsh, including policies relating to behaviour in the workplace, health and well-being at work, salaries and workplace benefits, performance management, absence from work, working conditions and working patterns. They are published on our intranet.

The All-Wales Disciplinary Policy and Procedure notes that employees may respond to allegations against them in Welsh, and the All-Wales Respect and Resolution Policy notes that employees may raise an allegation in Welsh, respond to one in Welsh and that any proceedings must be held in Welsh where an employee has exercised this right. The All-Wales Raising Concerns Policy also notes that an individual may raise an issue or concern in Welsh and that they should be advised of this at the outset. It also notes that any subsequent proceedings should be conducted in Welsh or a simultaneous translation service provided.

Leadership Competency Model

Following work to renew and update our leadership offer for managers at CTMUHB, as part of our Culture Plan for the organisation, a Leadership Competency Model has been developed. This model currently has been set out along ten core competencies around Leading Self, Leading Others and Leading Systems. One of those ten competencies is 'Inclusion' and this will include specific competencies around the Welsh language for managers and leaders at Band 6, 7 and 8. Work will now continue over the next reporting period on what that content will look like for Welsh. This is an exciting step forward for Welsh and will contribute to a culture of not only compliance with Standards but also of a thriving Welsh language.

IT and software

CTMUHB uses Microsoft on its work machines allowing us to offer common workplace software in Welsh. Our SharePoint page for Welsh promotes the availability to use MS Office and MS Teams in Welsh and includes instructions on how to change it.

A Welsh language spellchecker is also available to download via the Software Centre on all computers and laptops for CTMUHB staff.

Our IT Helpdesk also offers the ability to speak to a member of IT in Welsh when phoning and includes a bilingual greeting. IT have also created a bilingual form for new starters to set them up with IT.
How we use Welsh internally and our internal bilingual ethos is a developing area for CTMUHB and work included in our operational plan for Welsh for 2024/25 includes further work in this area.

Theme 4: Governance and accountability

The way we communicate with staff and support them, the processes we have in place to strategically develop Welsh in our organisation and creating a bilingual ethos at work are three all-important factors to developing Welsh in CTMUHB.

The fourth theme that brings this together, governance and accountability, refers to the structures we have in place to monitor progress, the assurance processes and appropriate oversight in place to ensure we're meeting our legal requirements, and our approach to policy risks when we may fail to meet those requirements. This theme is about knowing how well we're doing, knowing where we need to improve, and having the right structures in place to drive improvement and challenge where necessary

Our Welsh Language Steering Group (WLSG)

The role of the WLSG is to lead strategically to improve the environment that supports and values the Welsh Language and its role in the delivery of safe and high-quality services to our patients. The group is chaired by the Executive Director for People and consists of senior leaders from each Care Group who have the influence and authority to see through change in their areas, as well as senior clinicians who value Welsh and who can act as influential champions in the clinical areas.

The Group's agendas allow senior Health Board leadership to focus on particular areas and priorities, and allow for a high-level business forum to take place where Welsh language and culture can be discussed and work to further embed Welsh to be planned and agreed, including the annual operational plan for Welsh language services. The Group's terms of reference govern the Group's activities.

Accountability route for Welsh language compliance

The WLSG provides advice and assurance to the Board and its sub-committees in relation to the organisation's compliance with our statutory Welsh Language Standards duties, to ensure we treat the Welsh language no less favourably than the English Language, and ensure progress with the five-year More than Just Words Strategic Plan. Assurance is provided through bi-annual written report updates to the People and Culture Committee, a sub-committee of the Board. This provides a robust accountability route for reporting progress and risks in relation to compliance to Board.

This reporting year two written and oral reports to the People & Culture Committee were provided, one in August 2023 and one February 2024. The compliance tracker discussed above on page 35 was also shared in the February report, giving a full overview of current progress and areas of risk, as well as the decision notice and action plan following enforcement activity received in August 2023.

For the first time at the February meeting of the People and Culture Committee, the written and oral highlight report was provided in Welsh with simultaneous translation. This significantly raised the status of the Welsh language in the Health Board, and was the first time Welsh was used at a formal Board Committee meeting as part of its reporting arrangements.

Welsh at senior management meetings

Aside from formal Committee and Board reporting, Welsh language compliance and the support available has been formally discussed at the following senior management meetings:

- CTMUHB full Operational Management Board;
- Children and Families Care Group Operational Board;
- Paediatrics Quality Governance Meeting;
- Therapies Quality Governance Meeting;
- Mental Health and Learning Disabilities Governance Meeting;
- The Leadership Forum.

Complaints

During the 2023-24 reporting year, CTMUHB received one complaint in relation to signage at our carpark on the Princess of Wales Hospital site. The complainant claimed the signs were not bilingual, however upon inspection the majority were. As CTMUHB was in the process of renewing the contract, it was also possible to

commit to ensuring via the specification for the tender that any small number of dated signs not bilingual would be replaced. The complaint was not taken further.

Theme 5: Recruitment & Workforce Planning

This is the final of our five themes **and work under this theme will aim to analyse the size of our bilingual workforce and where necessary, increase the number of Welsh-speaking staff we have. This part of the report will also publish how many staff we have who speak Welsh and to what level, and how many jobs we have advertised as needing skills in Welsh as part of this. We can't offer the public a truly bilingual health service in the CTMUHB area unless we have the right number** of bilingual staff; this final theme **recognises this and details how we're working to build our Welsh-speaking workforce.**

Our bilingual workforce

All staff in CTMUHB are expected to note their Welsh language skills on ESR, our workforce information system. We do this by noting whether we have skills in writing Welsh, listening/speaking in Welsh and reading in Welsh and at what level, from 0 to 5. These mean the following:

0: No ability in this skill at all,

1: Entry level,

2: Foundation,

3: Intermediate,

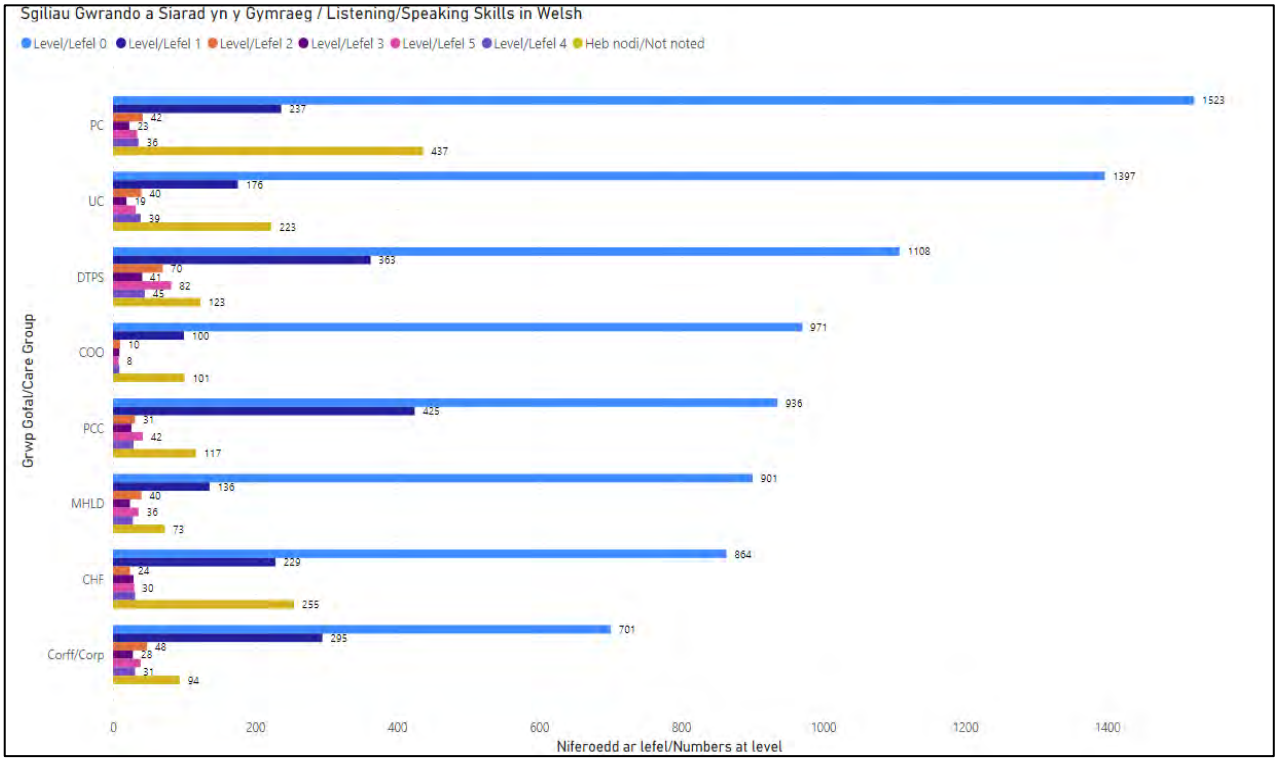
4: Higher,

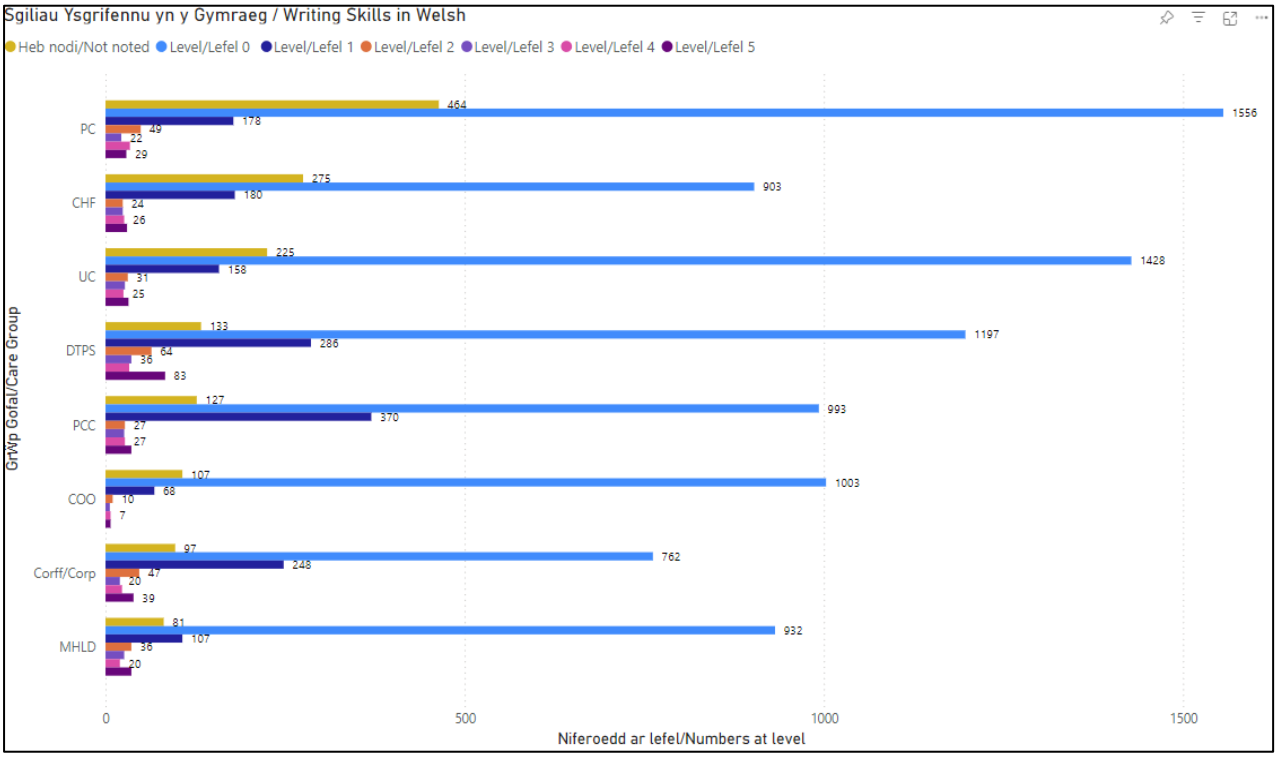
5: Proficient.

We have encouraged staff throughout the year to note their Welsh language skills on ESR in co-operation with colleagues in our Learning& Development team, by specifically targeting non-compliant staff. Information on how to note skills is also included on the core SharePoint site for Learning & Development where all mandatory training is promoted. The percentage of staff who have recorded their Welsh language skills on ESR as of March 2024 is **88%** for listening and speaking in Welsh and **88%** for both writing Welsh and reading Welsh, which is an increase on last year where it was **80%** on average.

Turning to the linguistic profile of CTMUHB's workforce, the graphs below illustrate how many of our staff have skills in Welsh in Listening/Speaking, Reading & Writing for each Care Group that forms the Health Board. The abbreviations for each group mean the following:

- PC: Planned Care/Gofal Wedi'i Gynllunio;
- UC: Unscheduled Care/Gofal Heb ei Drefnu;
- DTPS: Diagnostics, Therapies, Pharmacy and Healthcare Sciences/Diagnosteg, Therapïau a Gwyddorau Iechyd;
- COO: Chief Operating Officer's Group/Grŵp y Prif Swyddog Gweithredu;
- PCC: Primary Care & Communities/Gofal Sylfaenol a Chymunedau;
- MHLD: Mental Health & Learning Disabilities/Iechyd Meddwl ac Anableddau Dysgu;
- CHF: Children & Families/Plant a Theuluoedd;
- Corporate Services/Gwasanaethau Corfforaethol.


Sgiliau Gwrando a Siarad yn y Gymraeg / Listening/Speaking Skills in Welsh
Level/Lefel 0
Level/Lefel 1
Level/Lefel 2
Level/Lefel 3
Level/Lefel 5
Level/Lefel 4
Heb nodi/Not noted
Grwp Gofal/Care Group
PC
UC
DTPS
COO
PCC
MHLD
CHF
Corff/Corp
0
200
400
600
800
1000
1200
1400
Niferoedd ar lefel/Numbers at level


Sgiliau Ysgrifennu yn y Gymraeg / Writing Skills in Welsh
Heb nodi/Not noted
Level/Lefel 0
Level/Lefel 1
Level/Lefel 2
Level/Lefel 3
Level/Lefel 4
Level/Lefel 5
GrWp Gofal/Care Group
PC
CHF
UC
DTPS
PCC
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MHLD
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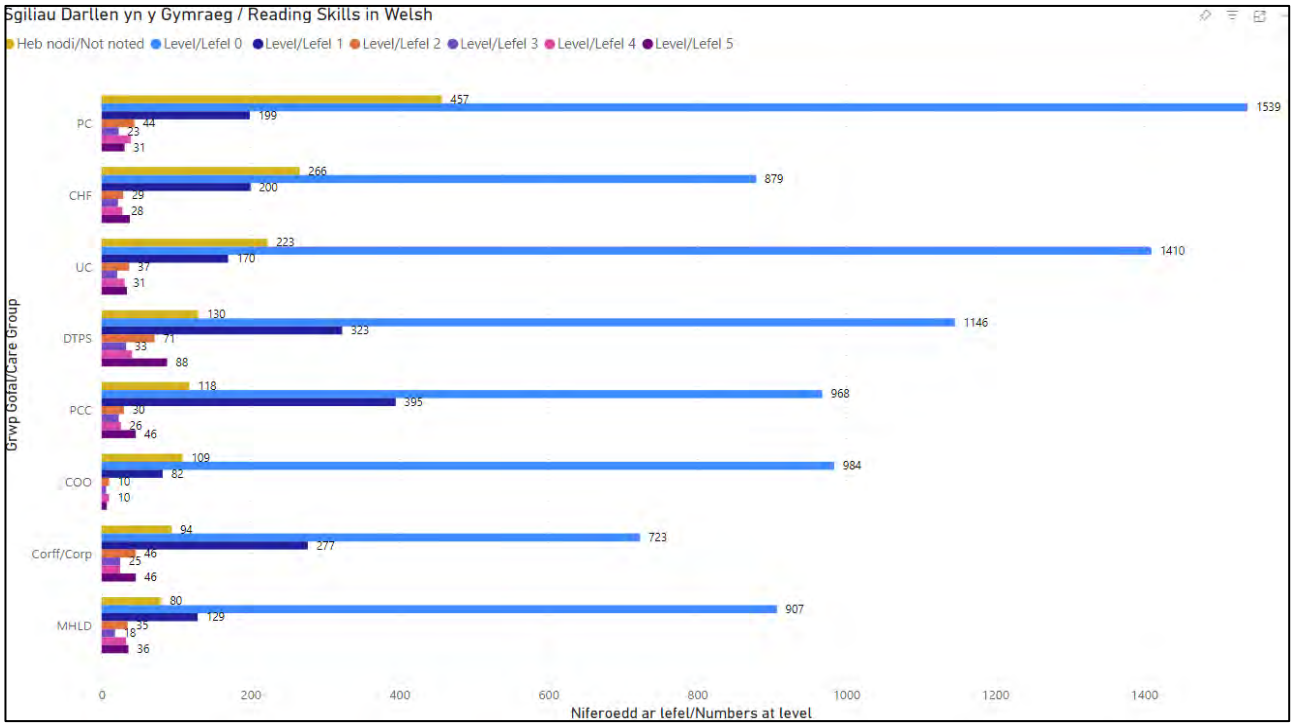
Niferoedd ar lefel/Numbers at level



In terms of our ability to offer services in Welsh, staff with level 4and 5 in a skill will generally be able to use this skill in most situations with patients and colleagues, hence the 'higher' descriptor. It can reasonably be inferred as a result that the number of staff in CTMUHB able to speak Welsh is currently at least 551 (of those who've recorded their skills), when combining those staff who've noted Level 4 or 5 for Listening/ speaking.

As we improve the number of staff who have recorded their skills in Welsh, a year-on-year increase can be seen in the numbers of staff with skills in Welsh.[5]

Level	Listening/Speaking in Welsh			
	2022/23	2023-24	Difference	Difference as %
Level 0	7740	8401	+661	+8.5%
Level 1	1871	1961	+90	+4.8%
Level 2	295	305	+10	+3.4%
Level 3	197	199	+2	+1%
Level 4	223	248	+25	+11%
Level 5	284	303	+19	+6.7%

[5] As in previous years, skills of those staff working in hosted bodies has been removed from the data.

Level	Reading in Welsh			
	2022/23	2023-24	Difference	Difference as %
Level 0	7873	8556	+683	+8.6%
Level 1	1702	1775	+73	+4.3%
Level 2	292	302	+10	+3.4%
Level 3	159	171	+12	+7.5%
Level 4	225	233	+8	+3.5%
Level 5	302	326	+24	+8%
Level	**Writing in Welsh**			
	2022/23	**2023-24**	**Difference**	**Difference as %**
Level 0	8092	8774	+682	+8.4%
Level 1	1511	1595	+84	+5.5%
Level 2	290	288	-2	-0.7%
Level 3	173	187	+14	+8&
Level 4	188	195	+7	+3.7%
Level 5	262	292	+30	+11%

This is the third consecutive year that the known number of staff with skills in Welsh has increased.

Using workforce data

Workforce data on Welsh language skills is important. This year, data on Welsh language skills was added to HealthRoster, the system used to plan shifts. All staff with Level 3 in Speaking/Listening and above were added. This will allow managers to know which of their staff speak Welsh and would allow them to plan shifts accordingly where necessary. This will also facilitate compliance with our In-Patient Admittance Policy under Standard 24 described above.

Assessing and advertising posts

The number of posts advertised by CTMUHB and the skills in Welsh needed for those posts are below.

Skills needed in Welsh for posts	
Skills category	**Number**
Welsh language skills are essential	9
Welsh language skills are desirable	2757
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	215
Total Number of vacancies advertised 01/04/2023 - 31/03/2024	2981

The requirement is that CTMUHB carries out a meaningful assessment of the language skills needed for a post, before selecting the appropriate category and advertising it as such. Not only has the number of posts where skills are needed in Welsh stayed roughly the same (9 this year, 10 last year), but the number of posts where skills in Welsh are essential is still low. The type of posts for which the manager decided no skills were needed or were desirable would also suggest more work is needed.

CTMUHB is currently working through a significant action plan, the majority of which is concerned with how we treat Welsh in recruitment. The deadline for submission of evidence that we have completed that work is December 2024.

We have this year also made it a requirement for all new starters to have at least 'courtesy-level Welsh' or to learn once in post. This will make a significant difference to the skills our workforce have in Welsh, and as noted below, we are currently offering an internal course to facilitate this.

Whilst there is work to do, it is important to bear in mind that due to improved data, it has become clear that CTMUHB does appear to have a large number of Welsh speaking staff and that where we do need to increase that number, work is underway.

Learning Welsh at work

Knowing how many Welsh speaking staff we have and recruiting people with the right skills to the post are essential and work has been ongoing in these areas. Equally as important is developing the language skills of our existing staff. Learning Welsh at work has been mentioned at several points in this report in terms of how and where opportunities are promoted. This section will focus on what we offer and the uptake.

- Taster sessions

We have offered 'Taster sessions', or two-hour sessions to learn the basics of Welsh throughout the year. We have also begun to offer these internally via the Welsh Language Team which has allowed CTMUHB to increase the number of staff able to take part, and will support us in ensuring all new staff have at least courtesy-level Welsh. This year 34 members of staff have taken part in a taster session.

- Online self-directed courses

The self-directed online course, 'Croeso' from the National Centre for Learning Welsh has also been promoted and this year 7 members of staff have completed Part 1 and 3 have completed Part 1 and 2.

- Learning Welsh in the community

Some staff members prefer to learn with classes (Mynediad and Sylfaen) that are provided in the community due to their own needs but which are funded by CTMUHB as they will use those skills at work. This year 9 members of staff have started Mynediad (Entry) and 1 member of staff has started Sylfaen (Foundation).

- Confidence Raising Scheme

This exciting scheme aims to support staff who may lack the confidence to use the Welsh they have and works to support them to be more confident in their skills. The scheme began towards the end of the reporting year and as of March 2024, 15 members of staff had started with the first cohort filled. This is a promising scheme which could have a significant impact on our aim of having a bilingual workforce and further cohorts will be supported throughout 2024/25.

This means 64 members of staff have been supported to step into Welsh at work or via employer funding this year with hundreds of hours of learning Welsh being provided. This is also an increase of 22 members of staff on last year.

The impact of these opportunities on our staff can be read below.

I recently commenced the Dysgu Cymraeg course after being inspired by completing the mandatory learning on ESR. Being new in post, I thought it was amazing that CTMUHB encourage, support and offer to fund this learning. I've always enjoyed learning new skills, and I hope that being able to speak Welsh will enable me to improve the quality of care I provide for my Welsh speaking patients, promoting inclusivity and making a difference to their experience of receiving health care within CTMUHB.
I have found the flexibility of learning online via teams classroom brilliant, being a very busy single mum it means I can learn from home with an added bonus of my children listening in the background and picking up additional Welsh words contributing to their learning. I am thoroughly enjoying the lessons, the tutor is very engaging and makes the lesson fun. I also enjoy chatting with the other students who are from all over the world, showing that learning Welsh isn't just for those of us native to Wales.
Lyndsey, Lung Health Check Clinical Nurse Specialist

If nothing else being more mindful (and inclusive) of speaking/writing what Welsh I can when I can and at the start and end of meetings etc is more than I have done in my working career and has been valuable. Diolch yn fawr
Anonymous via impact feedback

"I have wanted to learn Welsh for as long as I can remember. I loved learning languages in school, I took Welsh for GCSE and AS level but I let it go as I was finding it difficult to balance with my other studies. This is something I have regretted for over 20 years. Being born in Wales but not being able to speak Welsh is something that has always bothered me - how many other countries in the world have a population who don't all speak their national language? There is so much beauty in the Welsh language and culture, and I am very proud to be a part of the effort to reclaim them for our future generations.

I started learning Welsh as an adult with Dysgu Cymraeg in 2020 after I saw an article on the CTM intranet promoting a virtual course and offering workplace funding. I am now halfway through completing Lefel Sylfaen and I intend to complete as many levels as I am able to. While I am not yet at a level where I can converse fluently in Welsh, I am able to practice with my Welsh speaking colleagues, which further increases my confidence, and I hope that one day I will be able to use what I have learned both in and out of the workplace.

Being a "Dysgwr Cymraeg" has become a huge part of my identity and has made me a part of an ever growing, very welcoming community. Dw i wrth fy modd yn Dysgu Cymraeg."

Kim, Occupational Therapist

Appendix 1: Full Welsh language assurance assessment

WELSH LANGUAGE STANDARDS ASSURANCE ASSESSMENT FOR THE 2023-24 REPORTING YEAR			
Class of Standard: Service Delivery Standards			
Activity	**Standard(s)**	**Assurance level**	**Brief description**
Correspondence	1, 4, 6 & 7	HIGH ASSURANCE	• Responding to Welsh correspondence in Welsh • Sending correspondence in Welsh at same time as English correspondence • Not treating Welsh correspondence from the UHB less favourably than English version • Stating we welcome correspondence in Welsh on correspondence from the UHB
	5	LOW ASSURANCE	• Sending all correspondence (including email to external organisations) in Welsh and English unless language preference of the receiver is known
Telephony	8	HIGH ASSURANCE	• Greeting callers to main telephone lines bilingually
	9	HIGH ASSURANCE	• Informing a caller a service is available in Welsh
	10	NO ASSURANCE	• Dealing with calls to main telephone lines in Welsh
	11	HIGH ASSURANCE	• Not treating Welsh less favourably when advertising main telephone numbers
	12	HIGH ASSURANCE	• Having the same contact number for both Welsh and English main telephone services
	13	HIGH ASSURANCE	• Stating we welcome calls in Welsh where we publish our main telephone numbers
	14	HIGH ASSURANCE	• Where we collect performance indicators, ensuring we also collect data as relevant to the Welsh language to ensure we do not treat Welsh less favourably
	15	HIGH ASSURANCE	• Informing persons calling, in Welsh, that they can leave a message in Welsh
	16	NO ASSURANCE	• Informing persons calling, in Welsh, when a Welsh language service will be available where one isn't available
	17	LOW ASSURANCE	• Dealing with calls to departmental telephone lines in Welsh

	18	LOW ASSURANCE	• Greeting callers to departmental telephone lines bilingually
	19	LOW ASSURANCE	• Where the UHB makes calls to individuals on a specific matter, asking whether that individual wishes to receive future calls in Welsh from the UHB, recording that wish and making those calls in Welsh
	20	HIGH ASSURANCE	• Any automated telephone systems in place in the UHB also fully available in Welsh.
Internal meetings	21, 22, 22A & 22CH	MEDIUM ASSURANCE	• Asking those invited to a meeting whether they wish to use Welsh and facilitating the us of Welsh
In-patients and the Active Offer	23 & 23A	HIGH ASSURANCE	• Asking in-patients at admission their language preference and recording this
	24	HIGH ASSURANCE	• Having a ratified policy in place on asking in-patients at admission their language preference, for those patients who may not be able to note this themselves.
Case conferences	25	MEDIUM ASSURANCE	• Offering and providing case conference in Welsh when involving the patient
Public meetings and events	26, 27, 28 & 29 & 31	HIGH ASSURANCE	• Treating Welsh no less favourably when advertising and promoting public meetings and events, sending invitations and inviting speakers to public meetings and events, ensuring an interpreter is available at all public meetings and events and not treating the Welsh language less favourably in any way during the course of the meeting or event
	30, 32 & 33	MEDIUM ASSURANCE	• Displaying material and public events and meetings in Welsh and English
Displayed material	34	MEDIUM ASSURANCE	• Displaying material in public (in all contexts)
Documents & Forms	36, 37 & 38	MEDIUM ASSURANCE	• Documents and forms available in Welsh, and noting on English versions that a Welsh version is available

Websites and digital media	39, 40 & 41	HIGH ASSURANCE	• Each text of the webpage available in Welsh including the homepage and new and amended pages
	42	HIGH ASSURANCE	• Noting clearly on each webpage that it is available in Welsh with a direct link
	43	HIGH ASSURANCE	• Providing interface and menus in Welsh on each page
	44	HIGH ASSURANCE	• Apps produced or commissioned by the Health Board available in Welsh
	45	MEDIUM ASSURANCE	• Not treating Welsh less favourably on corporate and departmental social media
	46	HIGH ASSURANCE	• Responding to Welsh messages in Welsh on social media (comments & DMs etc.)
Signage	47	MEDIUM ASSURANCE	• Displaying all signs including temporary signs in Welsh
	48 & 49	HIGH ASSURANCE	• Ensuring all signs including temporary signs in Welsh which is correct and with the Welsh in a position where it is likely to be read first
Reception services	50 & 52	LOW ASSURANCE	• Offering a bilingual service at receptions and displaying a sign at reception welcoming the use of Welsh
	53	HIGH ASSURANCE	• Where staff members provide a reception service and can in fact speak Welsh, ensuring they wear a badge to convey that
Grants	54, 55 & 56	HIGH ASSURANCE	• Publishing documents relating to grants in Welsh, • Stating we welcome applications for grants in Welsh, and not treating an application for a grant submitted in Welsh any less favourably and • Informing a person who submitted an application for a grant in Welsh of the outcome in Welsh.
Tenders for contracts	57, 58 & 59	LOW ASSURANCE	• Publishing invitations to tender in Welsh where relevant • Stating tenders may be submitted in Welsh and that Welsh tenders submitted in Welsh will be treated no less favourably, and • Informing a tenderer of the outcome in Welsh where they submitted the tender in Welsh.
Promoting Welsh language services	60 & 61	HIGH ASSURANCE	• Promoting the Welsh language services we provide.

Corporate identity	62	HIGH ASSURANCE	• Treating Welsh no less favourably in how the UHB forms, revises and presents its corporate identity
Education courses for patients	63	LOW ASSURANCE	• Where health education courses are offered, undertaking an assessment of the demand for them in Welsh and offering them in Welsh
Public address systems	64	HIGH ASSURANCE	• Recorded messages over address systems being bilingual, with the Welsh message played first
Primary Care	65	HIGH ASSURANCE	• Designating an area on our website to promote Primary Care providers who are able to provide a service or part of a service in Welsh
	66	HIGH ASSURANCE	• Providing and promoting a translation service for Primary Care
	67	HIGH ASSURANCE	• Providing and promoting lanyards and badges that convey Primary Care staff speak Welsh
	68	HIGH ASSURANCE	• Providing courses, information or events so that Primary Care staff develop an awareness of the Welsh language and how it can be used in the workplace
Class of Standard: Policy Making Standards			
Activity	**Standard(s)**	**Assurance level**	**Brief description**
Assessing policy decisions for impact	69, 70 & 71	MEDIUM ASSURANCE	• Assessing new policies or reviewing and revising policies for the impact on Welsh
	72, 73, & 74	LOW ASSURANCE	• Consulting on policy and considering the impact on Welsh
	75, 76 & 77	LOW ASSURANCE	• Research to assist policy making and considering the impact on Welsh
Assessing policy decisions for impact within Primary Care	78	HIGH ASSURANCE	• Having a policy to ensure decisions taken in regard to Primary Care consider the impact on the use of Welsh and treating Welsh no less favourably
	78A	HIGH ASSURANCE	• Publishing a review of that policy under Standard 78 five years after publishing it
Class of Standard: Operational Standards			
Activity	**Standard(s)**	**Assurance level**	**Brief description**
Policy on internal use of Welsh	79	NO ASSURANCE	• A policy on using Welsh internally for the purpose of promoting and facilitating the use of the language

Contracts of employment in Welsh	80	HIGH ASSURANCE	• When offering a new post to an individual, asking that the individual whether he or she wishes for the contract of employment or contract for services to be provided in Welsh and if so provide it in Welsh
Paper correspondence relating to employment	81	NO ASSURANCE	• Paper correspondence relating to various aspects of employment sent to an employee
Workforce policies in Welsh	82	HIGH ASSURANCE	• Workforce policies relating to specific matters available in Welsh
Complaints by and against staff	83, 84 & 85	HIGH ASSURANCE	• Noting in policies and procedures that complaints may be made in Welsh or responded to in Welsh, holding meetings relating to complaints in Welsh, and informing parties of decisions relating to complaints in Welsh
Disciplinary procedures	86, 87 & 88	HIGH ASSURANCE	• Noting staff may respond to allegations in Welsh in documents and when bringing proceedings against them, holding meetings about allegations in Welsh and informing staff of the outcome in Welsh
Spelling and grammar software	89	HIGH ASSURANCE	• Providing staff with computer software for checking spelling and grammar in Welsh
Intranet	90, 91, 93 & 95	NO ASSURANCE	• Certain intranet pages being bilingual
	94	HIGH ASSURANCE	• Having a specific intranet page for promoting Welsh
Assessing Welsh language skills of employees	96	HIGH ASSURANCE	• Assessing the Welsh language skills of staff
Staff training	97	MEDIUM ASSURANCE	• Providing training on certain workplace matters such as Health and Safety
Training on using Welsh	98	HIGH ASSURANCE	• Training on using Welsh in meetings, interviews and complaint and disciplinary procedures
Basic Welsh lessons and using Welsh in managerial roles	99	MEDIUM ASSURANCE	• Providing a basic Welsh lesson and training on using Welsh in managerial roles
Providing further Welsh lessons	100 & 101	HIGH ASSURANCE	• Providing Welsh lessons for staff beyond a basic Welsh lesson

Welsh language awareness	102	HIGH ASSURANCE	• Providing Welsh language awareness training
Corporate induction	103	HIGH ASSURANCE	• Providing Welsh language awareness material as part of corporate induction
Logo and wording for emails	104	HIGH ASSURANCE	• Providing a logo so staff can show they speak Welsh in emails and a template so that they can create a bilingual out-of-office message
Providing lanyards and badges	105	HIGH ASSURANCE	• Providing badges and logos to staff so that they can show they speak Welsh
Assessing vacant posts	106 & 106A	NO ASSURANCE	• Assessing vacant posts for what skills are needed in Welsh based one of 4 categories, and where 'Welsh Essential', 'Desirable' or 'Need to Be Learnt', noting this when advertising and advertising the post in Welsh
Encouraging applications in Welsh	107	HIGH ASSURANCE	• When advertising a post, stating that applications may be submitted in Welsh, and that an application submitted in Welsh will not be treated less favourably
Welsh language recruitment material	107A	NO ASSURANCE	• Publishing application-related information in Welsh such as all application forms, assessment method information and job descriptions
Applications made in Welsh	107B	HIGH ASSURANCE	• Not treating an application for a post made in Welsh less favourably than an application made in English
Candidate's use of Welsh in interviews	108	HIGH ASSURANCE	• Ensuring that application forms for posts provide a space for applicants to indicate that they wish an interview or other method of assessment in Welsh, and if so offering this
Informing candidates of outcome	109	HIGH ASSURANCE	• Informing an applicant of the decision in relation to an application for a post in Welsh if the application was made in Welsh.
5-year strategy on providing clinical consultations in Welsh	110	HIGH ASSURANCE	• Publishing a strategy for every 5-year period around offering clinical consultations in Welsh
	110A	HIGH ASSURANCE	• Publishing a review of the strategy for every 5-year period around offering clinical consultations in Welsh
Workplace signage	111, 112 & 113	MEDIUM ASSURANCE	• Accurate bilingual workplace signage, with Welsh in a position it is more likely to be read first

Workplace recorded announcement	114	HIGH ASSURANCE	• Workplace audio announcements
Class of Standard: Record Keeping Standards			
Activity	**Standard(s)**	**Assurance level**	**Brief description**
Record of complaints	115	HIGH ASSURANCE	• Keeping a record of all complaints received regarding Welsh language standards
Record of skills	116	HIGH ASSURANCE	• Keeping a record of Welsh languages skills as assessed under Standard 96
Record of skills needed for vacant posts	117	HIGH ASSURANCE	• Keeping a record, in relation to each financial year, of the number of new and vacant posts which were categorised (in accordance with standard 106) as posts where - o (a) Welsh language skills are essential; o (b) Welsh language skills need to be learnt when appointed to the post; o (c) Welsh language skills are desirable; or o (ch) Welsh language skills are not necessary
Standards which deal with supplementary matters			
Activity	**Standard(s)**	**Assurance level**	**Brief description**
Supplementary matters as relevant to Standards	118	HIGH ASSURANCE	• Publishing the compliance notice on our website
	119	HIGH ASSURANCE	• Having a complaints procedure that notes how the UHB will deal with complaints relating to the Welsh Language Standards, and publishing it on the website
	120	HIGH ASSURANCE	• Publishing an annual report on compliance
	121	HIGH ASSURANCE	• Releasing to the Welsh Language Commissioner any information he or she has requested in relation to Standards

Eitem Agenda
9.1.5

Bwrdd CTM

Adroddiad Perfformiad Blynyddol Safonau'r Gymraeg 2023-24

Dyddiad y Cyfarfod / Dyddiad y Cyfarfod	26/09/2024
Statws Cyhoeddi / Cyhoeddi	Agored/ Cyhoeddus Ddim yn berthnasol
Awdur yr Adroddiad	Ben Screen, Arweinydd Y Gymraeg
Llwynydd yr Adroddiad / Report Cyflwynydd	Ben Screen, Arweinydd Y Gymraeg
Noddwr Gweithredol yr Adroddiad / Noddwr Gweithredol yr Adroddiad	Hywel Daniel, Cyfarwyddwr Gweithredol Pobl

Adroddiad yr Adroddiad / Pwrpas yr Adroddiad	I'w gymeradwyo

Ymrwymiad (mewnol/allanol) a wnaed hyd yma (gan gynnwys derbyn/ystyried yn y **Pwyllgor/Grŵp)**		
Pwyllgor / **Grŵp** / Unigolion	Dyddiad	Canlyniad
Grŵp Llywio'r Gymraeg	23/05/2024	Sylwadau a dderbyniwyd ar yr adroddiad drafft
Y Pwyllgor Pobl a Diwylliant	07/08/2024	Cefnogwyd am gymeradwyaeth Bwrdd

Acronymau / Geirfa Termau	

1 Sefyllfa/Cefndir

1.1 Bob blwyddyn ariannol mae'n ofynnol i'r Bwrdd Iechyd gyhoeddi Adroddiad Blynyddol Safonau'r Gymraeg, yn unol â Safonau'r Gymraeg. Mae'r adroddiad yn ymdrin â gwahanol gyfrifoldebau adrodd y manylir arnynt o dan y safonau unigol. Mae hefyd yn amlygu'r camau a gymerwyd gan y Bwrdd Iechyd yn ystod y flwyddyn, nid yn unig i sicrhau cydymffurfiaeth â'r safonau, ond i wella'n barhaus ansawdd a chysondeb darpariaeth gwasanaethau Cymraeg i'n cleifion a defnyddwyr gwasanaeth.

1.2 Y dyddiad cau ar gyfer cyhoeddi'r adroddiad blynyddol yw 31 Hydref 2024, sef chwe mis ar ôl diwedd y flwyddyn ariannol y mae'n ymwneud â hi.

2 Materion Penodol i'w Hystyried

2.1 Gofynnir i'r Bwrdd nodi'r cynnwys a chymeradwyo'r adroddiad i'w gyhoeddi.

2.2 Gofynnir hefyd i'r Bwrdd nodi'r cynnydd a wnaed yn ystod y flwyddyn adrodd, wrth greu diwylliant a hunaniaeth Gymraeg lewyrchus, drwy wella sgiliau ac ymwybyddiaeth staff er budd ein cleifion a'r cymunedau yr ydym yn eu gwasanaethu.

2.3 Mae gwaith wedi parhau o dan lens 5 thema ar gyfer datblygu'r Gymraeg, gyda detholiad o gyflawniadau allweddol wedi'u nodi isod.

2.3.1 O dan y Thema Cyfathrebu ac Ymgysylltu:

- Ffocws parhaus ar ymddygiad a newid diwylliannol, yn seiliedig ar fethodoleg newid ymddygiad gydnabyddedig, gweithio mewn cydweithrediad â staff i wella ymwybyddiaeth a chwalu rhwystrau i ddarpariaeth Gymraeg well. Yn goron ar hyn oedd 'Ymgyrch Hiraeth' ym mis Mawrth 2024;

- Datblygu fframwaith ymgysylltu mewnol i strwythuro negeseuon o amgylch y Gymraeg, gan ganolbwyntio ar ddysgu a datblygu, rhannu hanesion llwyddiant o ddefnyddio'r Gymraeg, hanesion profiad cleifion a gwybodaeth reolaidd am ba gymorth sydd ar gael i gefnogi'r defnydd o'r Gymraeg; a

Gwefan a thaflen wedi'u datblygu a'u hyrwyddo i sicrhau bod cleifion yn gwybod beth yw eu hawliau iaith o dan Safonau'r Gymraeg.

2.3.2 O dan y Thema Cynllunio Gweithredu a Monitro:

- Defnydd parhaus o'r e-fyrddau gwyn i gofnodi anghenion iaith cleifion;
- Mae data PREMs ar gyfer gwasanaethau sydd wedi cynnwys cwestiwn ar angen iaith yn dangos bod cleifion yn gallu defnyddio'r Gymraeg mewn sawl maes;
- Datblygu Polisi Cynnig Rhagweithiol Cleifion Mewnol, i sicrhau y gofynnir i gleifion ar wardiau mewnol pa iaith y mae angen iddynt ei defnyddio;
- Dangosodd sampl ar hap o 86 o feysydd ar draws y Bwrdd Iechyd lefelau uchel o ymwybyddiaeth o Safonau'r Gymraeg ymhlith rheolwyr;
- Mae astudiaethau achos yn yr adroddiad o Therapïau, Pediatreg, Mamolaeth, Radioleg a Chyfleusterau yn dangos sut mae'r Gymraeg wedi'i chofleidio; a
- Asesiad newydd o'r Effaith ar Gydraddoldeb a'r Gymraeg wedi'i greu, sy'n ystyried fframwaith polisi'r Gymraeg yn llawn.

2.3.3 dan Thema Profiad Gweithiwr a Gweithle Dwyieithog:

- Cymraeg wedi'i chynnwys o dan 'Cynwysoldeb' yn y Model Cymhwysedd Arweinyddiaeth newydd, gyda'r cynnwys cyntaf i'w ddefnyddio gydag 'Inspire';

2.3.4 dan y Thema Llywodraethu ac Atebolrwydd:

- Mae Grŵp Llywio'r Gymraeg wedi parhau i gyfarfod a chryfhau; a
- Tystiolaeth bod y Gymraeg yn cael ei thrafod mewn cyfarfodydd rheoli allweddol ar draws y Bwrdd Iechyd.

2.3.5 O dan Thema Cynllunio'r Gweithlu a Recriwtio:

- Mae gwaith wedi parhau gyda Dysgu Cymraeg Morgannwg ar gyfer pob lefel o Gymraeg, gan gefnogi staff ar draws y sefydliad i gael mynediad at ddarpariaeth addysgu Cymraeg o safon. Mae hyn wedi cynnwys y Bwrdd Iechyd yn manteisio'n llwyddiannus ar y Cynllun Codi Hyder a ariennir yn llawn, i ddatblygu siaradwyr Cymraeg di-hyder.

3 Risgiau Allweddol / Materion i'w Uwchgyfeirio

3.1 Mae'r adroddiad yn cynnwys asesiad sicrwydd llawn sy'n manylu ar feysydd lle na lwyddwyd i gydymffurfio.

4 Asesiad

Amcanion / Strategaeth	
Dolen i Nod (au) BIP CTM / Dolen i Nod (au) Strategol BIP CTM	Ysbrydoli Pobl
	Os oes mwy nag un yn berthnasol, rhestrwch isod:
Dolen i Feysydd Strategol BIP CTM / Dolen i Feysydd Strategol BIP CTM	Ddim yn berthnasol
	Os oes mwy nag un yn berthnasol, rhestrwch isod:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant *150623-guide-to-the-fg-act-en.pdf (cenedlaethaudyfodol.cymru)*	Cymru â diwylliant bywiog lle mae'r Gymraeg yn ffynnu
	Os oes mwy nag un yn berthnasol, rhestrwch isod:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Dolen i Hwyluswyr Ansawdd (*Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))*	Diwylliant a Gwerthfawrogi Pobl
	Os oes mwy nag un yn berthnasol, rhestrwch isod:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Dolen i Feysydd Ansawdd (*Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))*	Canolbwyntio ar yr unigolyn
	Os oes mwy nag un yn berthnasol, rhestrwch isod:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Effaith Amgylcheddol/Cynaliadwyedd (5R)	Na - Ddim yn berthnasol
	Os oes mwy nag un yn berthnasol, rhestrwch isod:

ASESIADAU EFFAITH		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?*	Ydy ☐	Na: ☒
	Canlyniad:	Os na, cynhwyswch y rhesymeg isod:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Cydraddoldeb a'r Gymraeg *A ydych wedi cynnal Sgriniad Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?*	Ydy ☐	Na: ☒
	Canlyniad ar gyfer Cydraddoldeb (dileer fel y bo'n briodol): CADARNHAOL/NIWTRAL NEGYDDOL Canlyniad ar gyfer y Gymraeg (dileer fel y bo'n briodol): CADARNHAOL/NIWTRAL NEGYDDOL	Os na, cynhwyswch y rhesymeg isod: Mae hwn yn bapur clawr ar gyfer adroddiad statudol; nid oes unrhyw benderfyniad polisi wedi'i wneud.
Cyfreithiol / Legal	Ydw (Cynhwyswch fanylion pellach isod)	
	Adroddiad yn amlygu meysydd o ddiffyg cydymffurfio â dyletswyddau statudol.	
Enw da / Reputational	Ydw (Cynhwyswch fanylion pellach isod)	
	Rhaid cyhoeddi'r adroddiad erbyn mis Hydref 2024, ac mae'r manylion sydd ynddo yn amlygu diffyg cydymffurfiaeth â dyletswyddau statudol.	
Effaith Adnoddau *(Pobl /Ariannol) /* Effaith Adnoddau *(Pobl /Ariannol)*	Nid oes unrhyw effaith uniongyrchol ar adnoddau o ganlyniad i'r gweithgaredd a amlinellir yn yr adroddiad hwn.	

5 Argymhelliad

5.1 Gofynnir i'r Bwrdd GYMERADWYO Adroddiad Blynyddol y Gymraeg i'w gyhoeddi ar neu cyn 31 Hydref 2024.

6 Camau Nesaf

6.1 Lluniwyd cynllun gweithredol ar gyfer datblygu'r Gymraeg ar gyfer 2023-24, gan ystyried y sefyllfa bresennol yn erbyn y Safonau fel y nodir yn yr adroddiad. Mae cynnydd gyda'r cynllun hwn yn cael ei fonitro drwy Ddangosfwrdd Datblygu'r Gymraeg.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Adroddiad Perfformiad Blynyddol Safonau'r Gymraeg ar gyfer Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg 2023/24

Y Gymraeg yn CTM
Welsh at CTM
Cymraeg
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Ein hymgyrch Hiraeth 12
Hyrwyddo'r Gymraeg a chydymffurfio â Safonau 15
Hyrwyddo'r Gymraeg mewn Gofal Sylfaenol 17
Hyrwyddo ein Gwasanaethau Cymraeg gyda'r cyhoedd 18
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Gwaith Strategaeth a Thrawsnewid: Ailgynllunio gwasanaethau a chomisiynu trydydd parti 23
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Lanyards a bathodynnau 30
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Astudiaethau achos: Rhoi cyd-destun i gynnydd yn BIPCTM 31
Astudiaeth Achos 1: Radioleg 31
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Astudiaeth Achos 5: Mamolaeth 33
Astudiaeth Achos 6: Therapïau 33
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Traciwr Cydymffurfiaeth y Gymraeg 37
Thema 3: Profiad 38
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Am yr adroddiad hwn

Mae'r adroddiad hwn yn sôn am beth mae Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg wedi'i wneud eleni i ddarparu ei wasanaethau yn Gymraeg yn unol â Safonau'r Gymraeg.[1] Rydyn ni'n sôn am ein dull strategol o wreiddio'r Gymraeg ym mhob rhan o'n sefydliad a beth rydyn ni wedi'i wneud eleni i hybu ein hiaith a'i defnydd yn y gofal rydyn ni'n ei roi a'r gwasanaethau rydyn ni'n eu darparu. Rydyn ni'n awyddus i rannu gyda chi eto eleni pa mor galed rydyn ni wedi gweithio i blethu dwyieithrwydd ym mhopeth a wnawn, a'r mentrau yr ydym wedi'u gwneud yn rhan o hyn. Mae'r Gymraeg yn bwysig i ni fel y mae i lawer yn y cymunedau yr ydym yn gofalu amdanyn nhw. Mae'r adroddiad hwn yn sôn am y camau pendant rydyn ni wedi'u cymryd sy'n dangos yr ymrwymiad hwn.

Mae'r adroddiad hefyd wedi'i ysgrifennu o dan Safon y Gymraeg 120, sy'n ei gwneud yn ofynnol i ni gyhoeddi adroddiad ar sut rydyn ni wedi cydymffurfio â Safonau'r Gymraeg yn ein hysbysiad cydymffurfio. Mae ein hysbysiad cydymffurfio yn nodi beth mae'n rhaid i ni ei wneud yn ôl y gyfraith yn Gymraeg, ac mae ar gael i'w ddarllen **yma** yn Gymraeg ac **yma** yn Saesneg. Os hoffech chi gael cyngor mewn fformat cliriach ar eich hawliau i ddefnyddio'r Gymraeg gyda'r Bwrdd Iechyd, gweler y daflen wybodaeth hon i gleifion yn Gymraeg **yma** ac yn Saesneg **yma**.

Cyflwynon ni'r adroddiad hwn i'n Pwyllgor Pobl a Diwylliant, un o is-bwyllgorau'r Bwrdd, ym mis Awst 2024 a chafodd ei gymeradwyo i'w gyhoeddi.

Byddem yn croesawu eich sylwadau ar yr adroddiad hwn a'n gwasanaethau dwyieithog. Os hoffech chi gysylltu â ni, anfonwch neges aton ni yn **CTT_WelshLanguage@wales.nhs.uk** yn Gymraeg neu Saesneg. Gallwch hefyd roi adborth ar wasanaethau penodol y gallech fod wedi'u defnyddio drwy'r holiaduron Mesurau Profiadau a Adroddir gan Gleifion, sydd ar gael **yma** yn Gymraeg ac **yma** yn Saesneg.

[1] Mae unrhyw gyfeiriad at 'flwyddyn' yn yr adroddiad hwn yn cyfeirio at y flwyddyn ariannol, o Ebrill 1 2023 i Fawrth 31 2024.

EIN BLWYDDYN MEWN RHIFAU

506

Rhannon ni 30 o'n pecynnau Cymraeg, 10 poster Iaith Gwaith a dros 180 o gortynnau gweddf i staff gyda sgiliau Cymraeg

8%

Cynnydd o **8%** yn nifer y staff sydd wedi cofnodi eu sgiliau Cymraeg, gan sicrhau cyfradd gwblhau o 88% o ddata sgiliau Cymraeg i ni ar draws BIPCTM.

1,200,000

Cyfieithwyd dros **1.2 miliwn** o eiriau i'r Gymraeg

14,347

Bu **14,347** o ymweliadau â'n gwefan Gymraeg, cynnydd o 2,950 o ymweliadau â'n cynnwys Cymraeg o gymharu â'r llynedd.

29

Defnydd parhaus o'n system llif cleifion mewnol, yr e-fyrddau gwyn digidol, gyda **29** o gleifion bregus yn cael cofnod o'u hanghenion iaith fel Cymraeg ar draws 17 ward mewn 4 safle ysbyty

100

Siaradon ni gyda dros 100 aelod o staff yn rhan o'n sesiynau galw heibio ar ein safleoedd, a dros 40 o gleifion, gan roi'r cyfle i ni hybu'r Gymraeg a siarad am hawliau iaith

20

Lansiwyd ein Fframwaith Cyfathrebu Mewnol ym mis Tachwedd 2023, gan rannu **20** darn o gyfathrebu strategol ers hynny gyda thros 1000 o bobl yn gweld pob diweddariad ar gyfartaledd.

10

Nododd **10** o'r **12** arolwg a holwyd ynghylch defnydd cleifion o'r Gymraeg fod y mwyafrif yn gallu defnyddio'r Gymraeg 'bob amser' neu 'fel arfer', sy'n golygu bod **638** o'r cleifion a holwyd yn gallu defnyddio'r Gymraeg o leiaf y rhan fwyaf o'r amser yn eu gofal eleni

9000

Mae dros **9000** o staff wedi cwblhau cwrs ymwybyddiaeth iaith Cymru gyfan eleni, gan olygu bod 77% o holl staff BIPCTM wedi ei gwblhau.

64

Mae **64** aelod o staff wedi cael cymorth i ddysgu Cymraeg neu i wella eu hyder gan y Bwrdd Iechyd eleni

2182

Cawsom **2,182** o geisiadau am gyfieithiad gyda chyfartaledd o 178 cais y mis

98%

Cyfradd gwblhau'r cwestiwn yn ymwneud ag angen iaith ar Gofnod Gofal Nyrsio Cymru oedd **98%**, fel mesur cadarnhaol pellach bod y cynnig rhagweithiol yn cael ei wneud gyda chleifion mewnol

51

Daeth 51 aelod o staff i'n sesiwn gyntaf erioed i newid ymddygiad staff, 'Cymraeg/Fi'

86

Cymerodd **86** o adrannau ar draws yr holl Grwpiau Gofal ran yn ein harchwiliad dros yr haf i fesur cydymffurfiaeth â Safonau'r Gymraeg, gyda 74% o reolwyr yn nodi eu bod nhw a'u tîm yn deall pwysigrwydd gofal yn Gymraeg

51

Daeth **51** aelod o staff i'n sesiwn gyntaf erioed i newid ymddygiad iaith, 'Cymraeg a Fi/Welsh and Me' fel rhan o'n hymgyrch Hiraeth

8

Mae'r Gymraeg wedi bod yn eitem agenda benodol mewn **8** cyfarfod uwch reolwyr eleni, gan gynnwys **2** gyfarfod ffurfiol o Bwyllgor Bwrdd.

6

Mae ein Grŵp Llywio'r Gymraeg wedi cyfarfod **6** gwaith eleni, gan rannu llawer o arferion da a dathlu cynnydd

15

Rydyn ni wedi dechrau manteisio ar gynllun Codi Hyder/Confidence Raising gyda Dysgu Cymraeg Morgannwg, gyda **15** aelod o staff yn cael eu cefnogi ym mis Mawrth 2024

Rhagair y Prif Weithredwr

Mae'n bleser gennyf gyflwyno Adroddiad Perfformiad Safonau'r Gymraeg eleni. Eleni rydym wedi cymryd camau pellach ar ein taith i ddod yn sefydliad blaenllaw yn ein dull o wreiddio a thyfu ein hiaith ym Mwrdd Iechyd Prifysgol Cwm Taf Morgannwg, ac mae'r adroddiad hwn a'r cyflawniadau ynddo yn dyst i ymdrech ac ymrwymiad staff ar draws ein sefydliad i'r Gymraeg a'i siaradwyr.

Mae ein hymagwedd at y Gymraeg yn BIPCTM yn un o ymrwymiad di-ball i newid diwylliannol ac ymddygiadol ymhlith ein staff. Mae'r Gymraeg yn ymwneud â llawer mwy na chydymffurfio; mae'n iaith fyw ac yn iach sy'n cael ei siarad gan dros 50,000 o'n poblogaeth a channoedd o'n staff. Roedd yn gadarnhaol nodi eleni y gofynnwyd i ddau o swyddogion y Bwrdd Iechyd gyflwyno ein gwaith ar newid diwylliannol ac ymddygiadol mewn carfan o Arwain mewn Gwlad Ddwyieithog, a hwyluswyd gan Academi Wales a Cymraeg 2050 o fewn Llywodraeth Cymru, gan rannu arfer gorau ag uwch arweinwyr eraill ar draws y sector cyhoeddus yng Nghymru. Rydyn ni'n trafod peth o'r gwaith a gyflwynwyd yn y digwyddiad hwnnw isod, ac mae'n dangos y gall BIPCTM arwain ar yr agenda hon. Rwy'n gobeithio y byddwch yn mwynhau darllen am y mentrau eleni i feithrin diwylliant Cymraeg iach yn BIPCTM, ac er bod mwy i'w wneud bob amser, rhywbeth rydyn ni wedi bod yn dryloyw yn ei gylch yn yr adroddiad hwn, mae'n amlwg o'r adroddiad hwn ac adroddiadau blaenorol bod tuedd barhaus o wella wedi bod yn ein darpariaeth ddwyieithog.

Mae'r Gymraeg yn perthyn i bob un ohonom ac rydyn ni'n falch o'n cyfraniad eleni at y defnydd o'r Gymraeg yn ein cymunedau a dyfodol hirdymor ein hiaith.

Paul Mears,
Chief Executive Officer, Cwm Taf Morgannwg University Health Board

Crynodeb Gweithredol

Gwahoddwn ddarllenwyr yr adroddiad hwn i gymharu'r adroddiad hwn ag adroddiadau blaenorol ac rydyn ni'n hyderus, dros y 5 mlynedd diwethaf ers gosod Safonau'r Gymraeg am y tro cyntaf ar Fwrdd Iechyd Prifysgol Cwm Taf Morgannwg, fod taflwybr perfformiad da i'w weld nid yn unig o ran cydymffurfio â Safonau'r Gymraeg ond hefyd yn y manylion y gallwn eu darparu ac ansawdd ein hadroddiadau. Mae gan BIPCTM waith i'w wneud o hyd mewn sawl maes i gynnig gwasanaeth iechyd gwirioneddol ddwyieithog i'n poblogaeth, a lle mae hyn yn wir rydyn ni wedi gwneud hyn yn glir yn yr adroddiad. Fodd bynnag, darparwn dystiolaeth glir hefyd o ddatblygiadau cadarnhaol ac mae'n bwysig cydnabod hyn.

Ymhlith y datblygiadau hyn mae:

1. Ymateb strategol gwell i bolisi iaith, gyda'r Gymraeg yn cael ei chynnwys fel blaenoriaeth strategol yng nghynlluniau'r Bwrdd Iechyd fel rhan o'i 'Gynllun Pobl', wedi'i gefnogi gan fframwaith 5 lens sy'n strwythuro cynllunio gweithredol blynyddol ar gyfer datblygu'r Gymraeg;
2. Gwell trefniadau monitro o ran gweithgarwch archwilio, ffynonellau data ar gydymffurfio a darparu gwasanaethau dwyieithog, a dull cliriach o gofnodi ac arddangos cynnydd;
3. Cynnydd ar asesu newid busnes ar gyfer ei effaith ar y Gymraeg gyda methodoleg sy'n cydymffurfio wedi'i datblygu, ond cydnabyddwn fod dal i fod angen gwaith ynghylch sut rydym yn ymgynghori ac yn cynnal ymchwil o ran ystyried yr effaith ar y Gymraeg;
4. Gwell aeddfedrwydd o ran llywodraethiant mewnol ac atebolrwydd, gyda Grŵp Llywio ac adroddiadau amlygu ar gydymffurfiaeth i'r Bwrdd a thystiolaeth bod y Gymraeg yn cael ei thrafod mewn cyfarfodydd uwch reolwyr ar draws BIPCTM;
5. Dull mwy gwybodus o drafod y Gymraeg yn fewnol, gan ddefnyddio mewnwelediadau newid ymddygiad i strwythuro ein cyfathrebu mewnol o amgylch y Gymraeg;
6. Cynnydd mewn gwasanaethau dwyieithog ar draws BIPCTM gyda ffynonellau data yn dangos yn glir bod llawer o'n cleifion yn elwa ar ddarpariaeth Gymraeg, ond gan gydnabod bod hyn yn dal yn anghyson;
7. Mae cynllun clir bellach yn ei le ar gyfer gwella'r ffordd yr ydym yn ymdrin â recriwtio gyda chamau gweithredu i'w cwblhau erbyn Rhagfyr 2024, a chynnydd da ar ddatblygu cynnig credadwy i ddysgu Cymraeg yn y gwaith mewn cydweithrediad â phartneriaid.

Mae rhagor o fanylion am y meysydd cynnydd hyn drwy gydol yr adroddiad hwn. Mae Atodiad 1 yn cynnwys asesiad llawn am y tro cyntaf o'n sefyllfa yn erbyn yr holl Safonau, yn dilyn gwaith i sicrhau ein bod yn monitro cynnydd yn effeithiol, a gobeithiwn y bydd darllenwyr yn croesawu'r lefel hon o dryloywder.

Cyd-destun strategol

Mae'r Gymraeg yr un mor bwysig i ni ag ydy hi i'r cymunedau rydyn ni'n gofalu amdanyn nhw ac yn eu gwasanaethu. Felly, rydyn ni am sicrhau ein bod yn gwneud popeth y mae angen i ni ei wneud fel bod y rhethreg hon yn adlewyrchu'r realiti yn y modd y mae ein cleifion yn rhyngweithio â'n gwasanaethau o ddydd i ddydd. Mae hyn yn gofyn am ymateb strategol priodol i wneud y gwelliannau rydyn ni am eu gweld yn ein gwasanaethau dwyieithog.

Y llynedd yn ein hadroddiad Safonau'r Gymraeg, fe wnaethom gyflwyno ein 5 thema i roi cyfeiriad strategol priodol i gynllunio gweithredol ar gyfer datblygu'r Gymraeg (gweler gwaelod y graffig isod). Mae'r graffig isod yn mynd y tu hwnt i hyn ac yn dangos sut mae'r lens 5 thema hon yn cyd-fynd â chynlluniau ehangach y Bwrdd Iechyd, gan roi tystiolaeth bellach o'n haeddfedrwydd fel sefydliad sydd wedi ymrwymo i ymgorffori'r Gymraeg ym mhopeth a wnawn. evidencing our maturity as an organisation committed to embedding Cymraeg in all we do.

Cynllun Tymor Canolig Integredig

Mae'r Cynllun Tymor Canolig Integredig yn ddogfen gynllunio statudol a gyhoeddir yn flynyddol, sy'n nodi sut y bydd sefydliadau'r GIG yn defnyddio eu hadnoddau dros gyfnod o 3 blynedd i ddarparu gwasanaethau gofal iechyd o ansawdd uchel sy'n mynd i'r afael ag anghenion y boblogaeth. Cafodd ein gwaith ar ddatblygu'r Gymraeg a'r prif flaenoriaethau yn ystod ei gylch cynllunio eu cynnwys yn y cynllun ar gyfer blwyddyn ariannol 2023/24.

Cynllun Pobl a CTM 2030

Mae'r Cynllun Pobl ar gyfer BIPCTM a'i 10 blaenoriaeth yn strwythuro'r cyflwyniad i'r CTCI ar gyfer y Gyfarwyddiaeth Pobl lle mae'r Gymraeg wedi'i lleoli, a'r 8fed o'r rhain yw "Creu diwylliant a hunaniaeth Gymraeg ffyniannus, gan wella sgiliau ac ymwybyddiaeth." Mae hyn yn sicrhau bod datblygiad y Gymraeg yn flaenoriaeth ar gyfer sut mae BIPCTM yn ymdrin â datblygu sefydliadol yn ei holl agweddau dros y 6 blynedd nesaf, yn rhan o strategaeth sefydliadol y Bwrdd Iechyd, 'CTM 2030'.

Lens strategol 5 thema i'r Gymraeg

Yn rhan o'r Cynllun Pobl mae'r lens 5 thema a amlinellwyd yn ein hadroddiad perfformiad diwethaf ar Safonau'r Gymraeg. Y 5 thema hyn yw Cyfathrebu ac Ymgysylltu, Cynlluniau Gweithredu a Monitro, Profiad Gweithwyr a'n Gweithle Dwyieithog, Llywodraethu ac Atebolrwydd a Chynllunio'r Gweithlu a Recriwtio. Mae'r 5 thema yn strwythuro cynllunio gweithredol yn flynyddol ar gyfer y Gymraeg, ac felly'n strwythuro'r adroddiad blynyddol hwn. Rydyn ni'n egluro ffocws pob thema yn yr adran berthnasol.

Cynllunio gweithredol ar gyfer datblygu'r Gymraeg

Bob blwyddyn mae'r 5 thema uchod yn strwythuro cynllun gweithredol bras sy'n amlinellu pa ddarnau o waith a mentrau fydd yn cael blaenoriaeth ar gyfer y flwyddyn adrodd honno. Lle mae meysydd y mae angen eu gwella neu ofynion heb gael eu bodloni'n ddigonol o hyd, mae'r cynlluniau cyflawni hyn yn sicrhau y gellir ymdrin â nhw. Mae'r cynllun hwn yn cael ei drafod yn ein Grŵp Llywio'r Gymraeg.

Mae gweddill yr adroddiad hwn wedi'i strwythuro drwy'r lens 5 thema a ddisgrifir uchod, ac mae'n manylu ar ein perfformiad o ran datblygu'r Gymraeg yn BIPCTM.

Thema 1: Cyfathrebu ac Ymgysylltu

Bydd gwreiddio'r Gymraeg ar draws system gofal iechyd mawr a chymhleth yn golygu newid yn ein diwylliant sefydliadol, a fydd yn golygu galluogi pobl i newid eu hymddygiad. Ond dydy newid ymddygiad ddim yn digwydd mewn gwagle, a bydd angen y gefnogaeth a'r adnoddau ar ein staff i wneud mwy yn Gymraeg. Mae derbyn hyn yn golygu y gallwn ddechrau meddwl yn strategol am beth sydd angen digwydd i annog y newid mewn ymddygiad mae angen i ni ei weld ar draws y system, fel bod pobl sy'n siarad Cymraeg yn gallu defnyddio'r Gymraeg yn heb unrhyw rwystrau neu drafferth. Dyma pam rydyn ni wedi gosod Cyfathrebu ac Ymgysylltu fel y gyntaf o'n pum thema rydym yn canolbwyntio arnynt. Dyma beth rydyn ni wedi parhau i'w wneud eleni o dan y thema gyntaf hon.

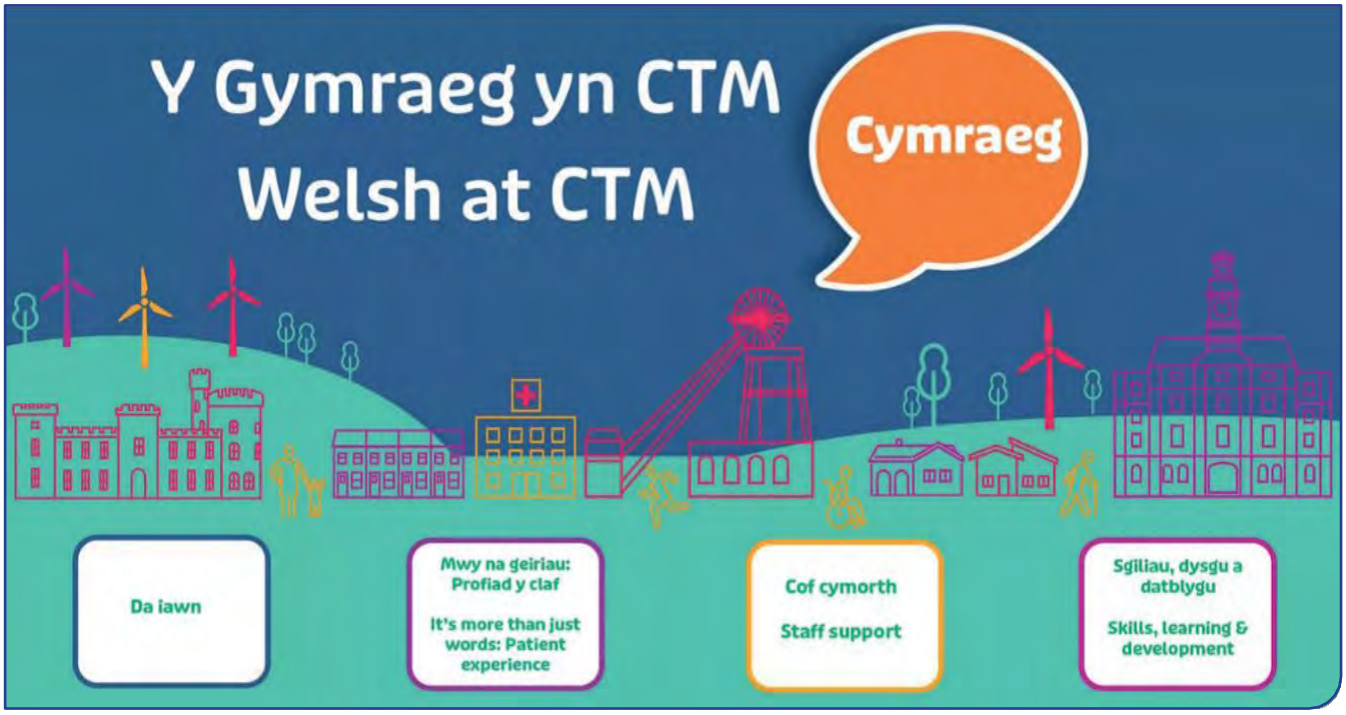
Y llynedd disgrifion ni sut y bu i ni ddatblygu Cynllun Hyrwyddo'r Gymraeg mewnol gyda mentrau penodol yn seiliedig ar fethodolegau newid ymddygiad cydnabyddedig. Isod rydyn ni'n amlinellu cynnydd pellach ar y cynllun hwnnw.

Ein Fframwaith Cyfathrebu ac Ymgysylltu mewnol ar gyfer y Gymraeg

Ym mis Tachwedd 2023 bu'r Tîm Cyfathrebu ac Ymgysylltu a Thîm y Gymraeg yn cydweithio ar fframwaith strategol newydd i strwythuro negeseuon rheolaidd a chyson am y Gymraeg ar draws y sefydliad, gan ganolbwyntio ar y diweddariad staff bob pythefnos a sianeli cyfryngau mewnol eraill megis y fewnrwyd. Mae dros 1,000 o aelodau o staff yn gweld y diweddariadau hyn bob tro y cân nhw eu rhannu ar gyfartaledd.

Mae cyfathrebu effeithiol yn hanfodol i ysgogi newid sefydliadol ac mae llawer o dystiolaeth bod cyfathrebu mewnol strategol yn gwella ymgysylltiad cyflogeion ac ymrwymiad i fentrau newid sefydliadol, megis datblygu'r Gymraeg. [2]

Mae'r fframwaith i'w weld isod ac mae'r categorïau isod yn strwythuro'r diweddariadau. Mae'r categorïau yn seiliedig ar dair elfen methodoleg newid ymddygiad gydnabyddedig, sef COM-B. Mae COM-B yn cwmpasu [Capability] neu Gallu (gwybod sut i gyflawni'r ymddygiad), [Opportunity] neu Cyfle (bod â'r modd neu'r adnoddau i gyflawni ymddygiad) a [Motivation] neu Cymhelliant (bod â'r ewyllys i fod eisiau cyflawni ymddygiad). [3]



Mae categori '**Da Iawn**' yn canolbwyntio ar ddathlu enghreifftiau unigol o arfer gorau gan staff ar draws y sefydliad wrth gydymffurfio â safonau'r Gymraeg. Mae hyn yn galluogi i arfer da gael ei rannu a'i fabwysiadu mewn mannau eraill, ond mae hefyd yn cynnwys 'prawf cymdeithasol' [social proof]. Mae prawf cymdeithasol yn gysyniad pwysig wrth ledaenu newid ymddygiad gan fod staff yn llawer mwy tebygol o fabwysiadu ymddygiadau sy'n cefnogi cydymffurfiaeth â Safonau'r Gymraeg os ydyn nhw'n gweld eu cydweithwyr eu hunain yn cyflawni'r ymddygiadau hyn hefyd. Mae 'Da iawn' yn cyd-fynd ag agwedd 'Cymhelliant' COM-B.

[2] Hargie, O., & Tourish, D. (2009). Auditing Organisational Communication: A Handbook of Research, Theory, and Practice. Routle dge; Men, L.R., & Stacks, D.W. (2013). The impact of leadership style and employee empowerment on perceived organizational reputation. Journal of Communication Management, 17(2), 171-192.
[3] Gellir dod o hyd i drafodaeth fwy technegol yma: Mitchie, S. et al. (2011), The behaviour change wheel: a new method for characterising and designing behaviour change interventions. Implementation Science 6(42)

Mae'r ail agwedd, '**Mae'n Fwy Na Geiriau: Profiad y Claf**' yn canolbwyntio ar sut y gall cydymffurfio â Safonau'r Gymraeg effeithio'n gadarnhaol ar brofiad ein defnyddwyr gwasanaeth. Mae dangos effaith ymddygiadau yn y byd go iawn ar gleifion yn gymhelliant pwysig i staff y GIG. Mae'r agwedd hon hefyd yn cyd-fynd ag agwedd 'Cymhelliant' COM-B.

Yn drydydd, mae '**Cymorth Staff**' yn rhannu negeseuon atgoffa rheolaidd ynghylch sut mae staff yn gallu cael gafael ar adnoddau, cyngor neu gymorth i ymgorffori'r Gymraeg yn y modd y maen nhw'n darparu eu gwasanaethau. Mae'r agwedd hon yn cyd-fynd â 'Gallu' a 'Chyfle' o fewn COM-B.

Yn olaf, mae '**Sgiliau, Dysgu a Datblygu**' yn rhannu diweddariadau a negeseuon atgoffa rheolaidd am gyfleoedd amrywiol i staff ddatblygu eu sgiliau Cymraeg a chyfleoedd hyfforddi a datblygu eraill sy'n ymwneud â'r Gymraeg. Mae'r agwedd olaf hon yn cyd-fynd â 'Gallu' yn y model COM-B.

Mae rhai enghreifftiau ar gyfer pob categori i'w gweld ar dudalen 13. Mae'r cardiau cynnwys hyn yn enghraifft wych o gydweithio cynyddol rhwng Tîm y Gymraeg a gwasanaethau galluogi eraill, sef ein Tîm Cyfathrebu ac Ymgysylltu yn yr achos hwn, ond hefyd o effaith gofal rhagorol dyddiol gan ein staff ar draws BIPCTM.

Ein hymgyrch Hiraeth

Ym mis Mawrth 2024, bu'r Timau Datblygu Sefydliadol a Chynhwysiant, Cyfathrebu ac Ymgysylltu a'r Gymraeg yn cydweithio ar ymgyrch ymgysylltu â staff fewnol drwy gydol y mis gyda'r nod o godi ymwybyddiaeth ddiwylliannol, creu gofod ar gyfer trafodaeth am y Gymraeg a hunaniaeth, hyrwyddo'r adnoddau Cymraeg sydd ar gael a gwasanaethau galluogi ehangach tîm y Gymraeg.

Dewison ni alw ein hymgyrch yn 'Hiraeth'. Mae 'Hiraeth' yn bersonol i'r unigolyn ond gellid ei gysylltu â'r teimlad o golli'r Gymraeg neu gysylltiad â Chymru, ac awydd cryf i adennill yr agwedd hon o'n cysylltiad personol â Chymru a threftadaeth Cymru. Roedden ni am roi cyfle i staff (ail)gysylltu â'n hiaith, mewn ffordd gadarnhaol a oedd yn canolbwyntio ar eu perthynas â hi. Trwy gynnig cyfle i staff 'adennill' yr agwedd hon o'u hetifeddiaeth, nod pellach oedd cyfrannu at ddiwylliant mwy cynhwysol, a gwell ymdeimlad o 'berthyn' i'r Gymraeg.

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Da iawn
It's more than just words: Da iawn

Yn gynharach y mis hwn, gwahoddodd y Tîm Mamolaeth y Tîm Iaith Gymraeg i ymweld â Chanolfan Geni Tirion a gwnaeth y cyfraniadau Cymraeg di-ri y mae'n eu gwneud ar draws y wardiau ar gyfer ei staff a'i gleifion argraff fawr arno.

O gefnogaeth ragweithiol y tîm, mae cleifion mamolaeth a theuluoedd yn gallu cyfathrebu'n well mewn iaith y maen nhw'n gyffordus yn ei defnyddio, sy'n gwneud cymaint o wahaniaeth i'w profiad.

Da iawn, tîm!!

Earlier this month, the Maternity Team invited the Welsh Language Team to visit the Tirion Birth Centre and they were so impressed with the countless Cymraeg contributions they make across the wards for their staff and patients.

From the team's proactive support, maternity patients and families are able to better communicate in a language they are comfortable using, which makes such a difference to their experience.

Da iawn, tîm!!

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Profiad y claf
It's more than just words: Patient experience

Yn mis Awst, ysgrifennodd rhiant claf ag anghenion dysgu ychwanegol at y Bwrdd Iechyd i ddiolch i un o'n hymgynghorwyr, Dr David Samuel am y gofal rhagorol a gafodd eu mab, Iwan...

"Mae'r ffaith ei fod o [Dr David Samuel] hefyd yn siarad Cymraeg wedi cefnogi Iwan i ddeall beth sy'n digwydd iddo. Mae hyn yn ganmoladwy iawn.

Cafodd Iwan, 21, sydd â Syndrom Down a Chlefyd Crohn, gefnogaeth lawn yn ei anghenion cyfathrebu a chanmolodd rhieni'r claf y Bwrdd Iechyd am ddefnyddio'r Gymraeg gydag Iwan.

Byddai llawer o oedolion ifanc ag anableddau dysgu yn ei chael hi'n anodd iawn aros dros nos yn yr Ysbyty sy'n amgylchedd anghyfarwydd heb eu rhieni neu ofalwyr."

In August, a parent of a patient with additional learning needs wrote to the Health Board to thank one of our consultants, Dr David Samuel for the exemplary care that their son, Iwan received...

"The fact that he [Dr David Samuel] is also a Welsh language speaker has also supported Iwan in understanding what is happening to him. This is most commendable.

Iwan, 21, who has Down's Syndrome and Crohn's Disease, was fully supported in his communication needs and the patient's parent commended the Health Board for using Welsh with Iwan.

Many young adults with a learning disability would find it incredibly challenging to stay overnight in hospital which is an unfamiliar environment without their parents or carers."

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Da iawn
It's more than just words: Da iawn

Yn gynharach y mis hwn, derbyniodd un o'n Therapyddion Iaith a Lleferydd, Lowri Roberts, adborth gwych gan YGG Llantrisant ar ôl cefnogi plentyn dydag atal dweud a darparu gwybodaeth ddefnyddiol i'w gyd-ddisgyblion ar

"Bu Lowri Roberts yn gweithio gyda disgybl o'n hysgol i helpu dydag atal dweud ac roedd y disgybl yn falch iawn o allu gwneud hynny yn Gymraeg. Bu'n fuddiol iawn cael Lowri i ddod i'r dosbarth i gyflwyno gyda'r disgybl yn Gymraeg.

O gefnogaeth Lowri, roedd yr athro a'r disgyblion bellach yn gallu cefnogi'r disgybl a'i helpu i deimlo'n llaw ymwybodol o'i atal dweud. Roedd yn hanfodol bod y disgybl yn gallu gwneud hyn yn iaith yr ysgol er mwyn iddo deimlo'n gyfforddus.

Da iawn, Lowri!

Earlier this month, one of our Speech and Language Therapists, Lowri Roberts, received great feedback from YGG Llantrisant after supporting a child with a stammer and providing their classmates with helpful information on how to support them at school. Here's what the teacher had to say...

"Lowri Roberts worked with a pupil from our school to help with stuttering and the pupil was delighted to be able to do that in Welsh. It was very beneficial to be able to get Lowri to come to class to present with the pupil in Welsh.

From Lowri's support, the teacher and pupils were now able to support the pupil and help them feel less conscious of their stuttering. It was essential that the pupil was able to do this in the school's language so that they could feel comfortable.

Da iawn, Lowri!

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Sgiliau, dysgu a datblygu
It's more than just words: Skills, Learning and Development

Cymraeg. Mae'n perthyn i ni i gyd. Un o'r prif rwystrau sy'n atal llawer ohonom rhag defnyddio ein Cymraeg yw diffyg hyder.

Ar **ddydd Iau 28 Mawrth**, rydym yn cynnal sesiwn lle gallwch chi feddwl a dysgu mwy am eich perthynas unigryw eich hun â'n hiaith. Byddwn yn ystyried rhai cysyniadau a all fod yn broblematig, fel cywirdeb a rhuglder, a byddwn yn trafod ffyrdd o ddatblygu eich gallu i ddefnyddio eich Cymraeg, ar ba bynnag lefel, yn hyderus. Efallai eich bod yn meddwl nad yw'r sesiwn hon ar eich cyfer chi. Yna efallai ei fod ar eich cyfer chi!

Cadwch lygad am ein diweddariadau staff eraill am ragor o wybodaeth!

Cymraeg. It belongs to us all. One of the main barriers that stops lots of us from using our Welsh is a lack of confidence.

On **Thursday 28th March**, we are holding a session where you can think and learn more about your own unique relationship to our language. We'll explore some concepts that can be problematic, such as accuracy and fluency, and we'll discuss ways to develop your ability to use your Welsh, at whatever level, with confidence. Maybe you think this session isn't for you. If so, it definitely is!

Keep an eye out for our other staff updates for more information!

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Profiad y claf
It's more than just words: Patient experience

Yn gynharach eleni, cwblhaodd un o'n Therapyddion Galwedigaethol, Celyn, asesiad dyda chlaf yn y Gymraeg yn YTS. Rhannodd y stori deimladwy hon dyda ni am glaf a oedd wedi cael profedigaeth yn ddiweddar ac a oedd yn cael trafferth bod yn glaf mewnol...

"Roedd yn tawelu ei meddwl gan nad oedd hi fel arfer yn siarad llawer o Saesneg gartref. Roedd hi wedi mynd trwy brofedigaeth yn ddiweddar a dywedodd wrthyf fod gwneud yr asesiad yn Gymraeg yn gysur iddi.

Fe wnaeth fy ngalluogi i feithrin perthynas â hi yn gyflym ac rwy'n meddwl bod cwblhau'r asesiad yn Gymraeg wedi caniatáu iddi ymgysylltu mwy â'r asesiad a chynllunio rhyddhau.

Mae'n wir yn fwy na geiriau. Da iawn, bawb.

Earlier this year, one of our Occupational Therapists, Celyn, completed an assessment with a patient in Welsh in PCH. He shared this touching story with us of a recently bereaved patient who was struggling with being an inpatient...

"She found it reassuring as she didn't usually speak much English at home. She had gone through a recent bereavement and told me that doing the assessment in Welsh was comforting to her.

It allowed me to build a rapport with her quickly and I think completing the assessment in Welsh allowed her to engage with the assessment and discharge planning more."

It really is more than just words. Da iawn pawb.

Y Gymraeg yn CTM
Welsh at CTM

Mwy na geiriau: Cof Cymorth
It's more than just words: Staff support

P'un a ydych chi'n cynnal digwyddiad, yn creu taflen neu'n codi arwydd syml, gallwn ni helpu gyda hynny.

Anfona neges aton ni yn CTT_welsh_translation@wales.nhs.uk a byddwn yn dychwelyd unrhyw gyfieithiad atoch mewn dim o dro.

Whether you're holding an event, producing a leaflet or putting up a simple sign, we can help with that.

Just drop us a message at CTT_welsh_translation@wales.nhs.uk and we will get any translation back to you rapidly.

Dyma beth wnaethon ni ni yn rhan o'n hymgyrch 'Hiraeth':

- Cyflwyno ein tiwtor Cymraeg o dan y cynllun 'Codi Hyder' (gweler tudalen 51) a rhannu rhai straeon ysbrydoledig gan staff am eu taith iaith, gan gysylltu hyn â sut mae wedi eu galluogi i ailgysylltu â'n hiaith a'n diwylliant;
- Ail-lansio ein tudalen SharePoint ddwyieithog newydd sbon. Fe wnaethon ni hefyd ei hychwanegu at hafan ein mewnrwyd, o dan 'Essential Links'. Mae'n cynnwys dros 16 o adnoddau gwahanol, dolen hwylus i drefnu sesiynau 'Blasu' ar y Gymraeg a gwybodaeth arall am ddysgu Cymraeg, canllawiau ar wreiddio'r Gymraeg mewn gwasanaethau (gweler isod), fideos staff a chleifion yn sôn am bwysigrwydd y Gymraeg iddyn nhw a gwybodaeth ar ddefnyddio'r Gymraeg yn y gwaith;
- Cynnal sawl sesiwn galw heibio ar draws ein safleoedd, i rannu adnoddau a sgwrsio â staff a chleifion;
- Cynnal digwyddiad i'r holl staff, wedi'i hwyluso gan y Ganolfan Dysgu Cymraeg Genedlaethol.

Y digwyddiad i'r holl staff fydd y cyntaf o lawer o sesiynau datblygu diwylliannol gyda'r nod o chwalu'r rhwystrau seicolegol y mae staff yn eu hwynebu i ddefnyddio'u Cymraeg oherwydd hyder, a'r camsyniad rhy gyffredin bod angen 'rhuglder' i siarad a mwynhau ein hiaith. Bu'r digwyddiad hefyd yn trafod ein perthynas â'n hiaith, beth mae'n ei olygu i ni a'r ffordd orau i ni barhau i hybu ei defnydd mewn modd sy'n meithrin ymdeimlad o berthyn. Roedd y digwyddiad yn agored i'r holl staff, gyda staff yn mynychu o wahanol arbenigeddau, o Gyllid i Feddygaeth a Gwasanaethau Di-haint i Dîm Profiad y Claf.

Dangosodd gwerthusiad ansoddol a meintiol o'r ymgyrch y canlynol:

- Buon ni'n siarad â dros 40 o bobl am y Gymraeg a'r cynnig Cymraeg yn rhan o'r sesiynau galw heibio, a'r mwyafrif ohonyn nhw ddim yn gwybod beth oedd ar gael i'w cefnogi i ddefnyddio'r Gymraeg cyn hynny;
- Bu dros 580 o ymweliadau unigryw â'r dudalen SharePoint yn ystod pythefnos cyntaf ei lansiad;
- Daeth dros 50 aelod o staff i'r digwyddiad holl staff;
- Trefnodd 4 aelod o staff Sesiwn Blasu yn dilyn y digwyddiad, gyda 9 aelod arall o staff yn trefnu sesiwn Blasu trwy'r ymgyrch, a 7 aelod o staff yn cofrestru ar gyfer y cynllun 'Codi Hyder';
- Pan fydd geiriau fel 'rhugl' yn cael eu tynnu o'r disgwrs am y Gymraeg, dywedodd staff a fynychodd y digwyddiad eu bod yn teimlo'n llawer mwy hyderus a mwy diogel yn defnyddio'r Gymraeg sydd gyda nhw; Bydd hon yn thema y byddwn yn parhau i'w harchwilio trwy fwy o'r sesiynau hyn;
- Mae Cymraeg yn llawer mwy na mater o gydymffurfiaeth neu ddim ond mater o eirfa, gramadeg neu sgiliau; Mae iaith yn gysyniad cyfannol y mae gan staff berthynas emosiynol, diwylliannol a seicolegol gyda fe y mae'n rhaid ei ystyried wrth ymarfer cynllunio ieithyddol a pholisi iaith yn BIPCTM.

Mae tri sylw gan fynychwyr yn disgrifio'n dda y croeso gafodd y sesiwn:

> Roedd angerdd y cyflwynydd yn heintus - mae fy nghymhelliad i ddefnyddio'r iaith wedi cynyddu lot

> Rwy'n fwy agored i'r cyfleoedd i ddefnyddio fy Nghymraeg yn y gwaith heb boeni am ddefnyddio rhai geiriau Saesneg. Dyma ddechrau taith hir…

> Roedd yn wych clywed gan gydweithwyr eraill sydd â phrofiadau tebyg i mi ac yn galonogol gweld angerdd pawb dros yr iaith gyda chymaint o bobl eraill yn CTM.

Hon oedd y gyntaf mewn ymgyrch gynlluniedig o amgylch y cysyniad o Hiraeth a'n nod yw parhau â'r ymagwedd newid diwylliannol hon sy'n cyd-fynd â Hiraeth yn rhan o'n Cynllun Diwylliannol ehangach ar gyfer CTM.

Hyrwyddo'r Gymraeg a chydymffurfio â Safonau

Yn ogystal â methodoleg reolaidd, gyson ar gyfer cyfathrebu mewnol ac ymgyrch bwrpasol, mae gweithgareddau eraill hefyd wedi'u cynnal i hyrwyddo'r Gymraeg a chydymffurfiaeth â Safonau drwy gydol y flwyddyn.

Gweithgaredd	Disgrifiad
Sesiynau galw heibio wyneb yn wyneb ar safleoedd	Ar wahân i'r sesiynau galw heibio yn rhan o Hiraeth a grybwyllwyd uchod, cynhalion ni sesiynau hefyd ym mis Tachwedd. Mae Tîm y Gymraeg felly wedi bod yn bresennol yn Ysbyty Brenhinol Morgannwg, Ysbyty Tywysoges Cymru, Ysbyty'r Tywysog Siarl, Glanrhyd, Ysbyty Cymunedol Maesteg, Parc Iechyd Keir Hardie, Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda ac Ysbyty Dewi Sant ger mannau prysur o leiaf ddwywaith yn rhan o sesiynau galw heibio pwrpasol y flwyddyn adrodd hon. Gellir gweld effaith y sesiynau hyn yn y ffeithlun ar dudalen 6 o ran y sgyrsiau a gynhaliwyd ac adnoddau sydd wedi eu rhannu.
SharePoint	Mae adran bwrpasol o'n mewnrwyd ar gyfer hybu'r Gymraeg yn y Bwrdd Iechyd, ac mae dolen i'r dudalen hon ar hafan ein mewnrwyd. Mae wedi'i strwythuro o amgylch yr adrannau isod. Mae'r dudalen hon wedi'i hailddatblygu i fanteisio'n llawn ar nodweddion MS Office 365 gan gynnwys data defnydd: • Newyddion Diweddaraf lle mae'r cardiau cynnwys sydd i'w gweld uchod yn cael eu huwchlwytho'n rheolaidd; • 'Pam Cymraeg yn CTM' sef fideo o staff a chleifion CTM yn siarad yn eu geiriau eu hunain am beth mae'r Gymraeg yn ei olygu iddyn nhw; • Dysgu Cymraeg yn y Gweithle, yn amlinellu'r cynnig gyda'r gallu i archebu lle ar sesiynau; • Cyngor ar wreiddio'r Gymraeg mewn gwasanaethau a chydymffurfio â Safonau; • Adnoddau (gweler isod); • Polisi Iaith Gymraeg Corfforaethol ar gyfer BIPCTM (polisi newydd yn cael ei ddatblygu); • Fy Hawliau fel gweithiwr sy'n siarad Cymraeg; • Cwrdd â'r Tîm; • Adroddiadau Blynyddol y Gymraeg; • Adran sylwadau.
Adnoddau	Mae'r adnoddau safonol canlynol wedi'u datblygu i gefnogi staff: 1. 1. Y 'Poster Gofynion A3' fel poster cyfeirio cyflym ar y pethau mwyaf cyffredin a wnawn yn Gymraeg a Saesneg wrth ddarparu gwasanaethau o ddydd i ddydd; 2. 2. Y ddelwedd 'dogfen/ffurflen ar gael yn Gymraeg', i'w hychwanegu at ddogfennau neu ffurflenni i hyrwyddo'r fersiwn Gymraeg; 3. 3. Y poster 'Teimladau ac Emosiynau' dwyieithog i'w ddefnyddio gyda chleifion bregus i ofyn sut maen nhw'n teimlo; 4. 4. Poster 'Rhoi Cynnig Arni mewn Cyfarfodydd', i annog defnydd o'r Gymraeg mewn cyfarfodydd;

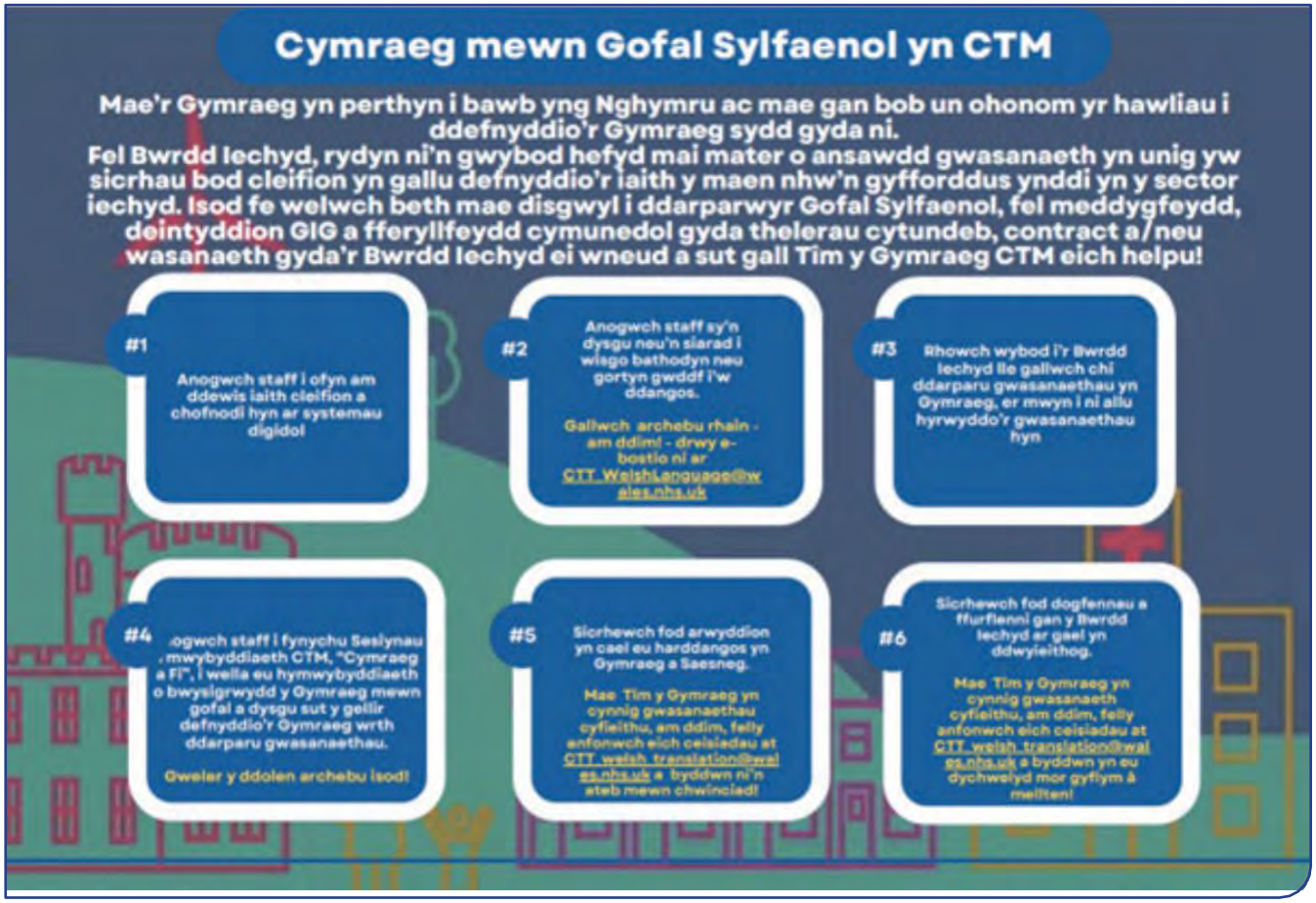
	6. Y Poster 'Rho Gynnig Arni' gyda llawer o eiriau ac ymadroddion defnyddiol yn ymwneud ag iechyd ar gyfer staff clinigol; 7. Y 'Poster Cymraeg ar y Ffôn ac ar y Dderbynfa' i helpu staff i ddefnyddio rhai cyfarchion Cymraeg sylfaenol yn y dderbynfa ac ar y ffôn gyda thrawsgrifiadau ffonetig; 8. Poster 'Defnyddiwch eich Cymraeg Yma' i groesawu'r defnydd o'r Gymraeg gan gleifion; 9. Y ddogfen 'Templed E-bost a Neges Allan o'r Swyddfa' safonol, i helpu staff i ffurfio llofnod e-bost dwyieithog a neges allan o'r swyddfa; 10. Y 'Templed Cefndir Teams' i gael cefndir Teams corfforaethol gyda theitl swydd dwyieithog, gyda chyfarwyddiadau yn y ffeil ar sut i'w newid; 11. Cyfarwyddiadau ar sut i ddangos bod staff yn siarad Cymraeg ar MS Teams, trwy ddefnyddio'r swyddogaeth 'Ychwanegu Rhagenwau' ar gyfer iaith; 12. Y canllaw 'Ateb y Ffôn' i helpu i ddarparu gwasanaeth Cymraeg wrth ateb y ffôn; 13. Offeryn Asesu Sgrinio ar gyfer dogfennau o dan Safon y Gymraeg 37 Os yw staff yn ansicr a oes angen i ddogfen fod yn ddwyieithog, gellir ei defnyddio i wirio; 14. Fideo hyfforddiant esboniadol a chanllaw ar sut i ddefnyddio'r Gymraeg mewn cyfarfodydd.
Canllawiau cyngor	Mae canllawiau cyngor ar gydymffurfio â Safonau Cyflenwi Gwasanaethau a hefyd arweiniad penodol ar ddefnyddio'r Gymraeg mewn Cyfathrebu ac Ymgysylltu ar gael ar SharePoint, ac yn cael eu rhannu'n rheolaidd â staff. Mae'r rhain wedi'u hysgrifennu gan ddefnyddio strategaeth lafar 'Llais y Gymraeg', maen nhw wedi eu dylunio gan ddefnyddio brandio corfforaethol ar gyfer BIPCTM a'u strwythuro drwy 'Pam' rydym yn cynnig gwasanaethau yn Gymraeg, 'Sut' mae staff yn cael eu cefnogi i wneud hynny a 'Beth rydym yn ei wneud' yn Gymraeg o ddydd i ddydd yn unol â Safonau'r Gymraeg, gydag astudiaethau achos ac enghreifftiau hefyd.
Ymweliadau safle unigol	Mae Tîm y Gymraeg hefyd wedi cynnal ymweliadau safle unigol eleni yn rhan o'r cynnig cymorth, gan gynnwys Canolfan Geni Tirion (RGH), Canolfan Geni Tair Afon (PCH), Uned Gofal Arbennig Babanod (PCH), Ward 17/18 (RGH), Adran Achosion Brys (PCH) a Thîm Rheoli Diagnosteg Radioleg (pob safle)
Ymwybyddiaeth iaith	Mae BIPCTM, fel holl sefydliadau GIG Cymru, wedi gwneud modiwl e-ddysgu ar ESR ar ymwybyddiaeth iaith yn orfodol. Mae hyn wedi ei gwblhau gan 77% o'n staff, sy'n gynnydd o 37% neu tua 4,000 o aelodau ychwanegol o staff o gymharu â'r flwyddyn adrodd ddiwethaf. Mae hon yn ffordd bwysig o ymgysylltu â staff ynghylch y Gymraeg a'r gwahaniaeth y mae darpariaeth ddwyieithog yn ei wneud.

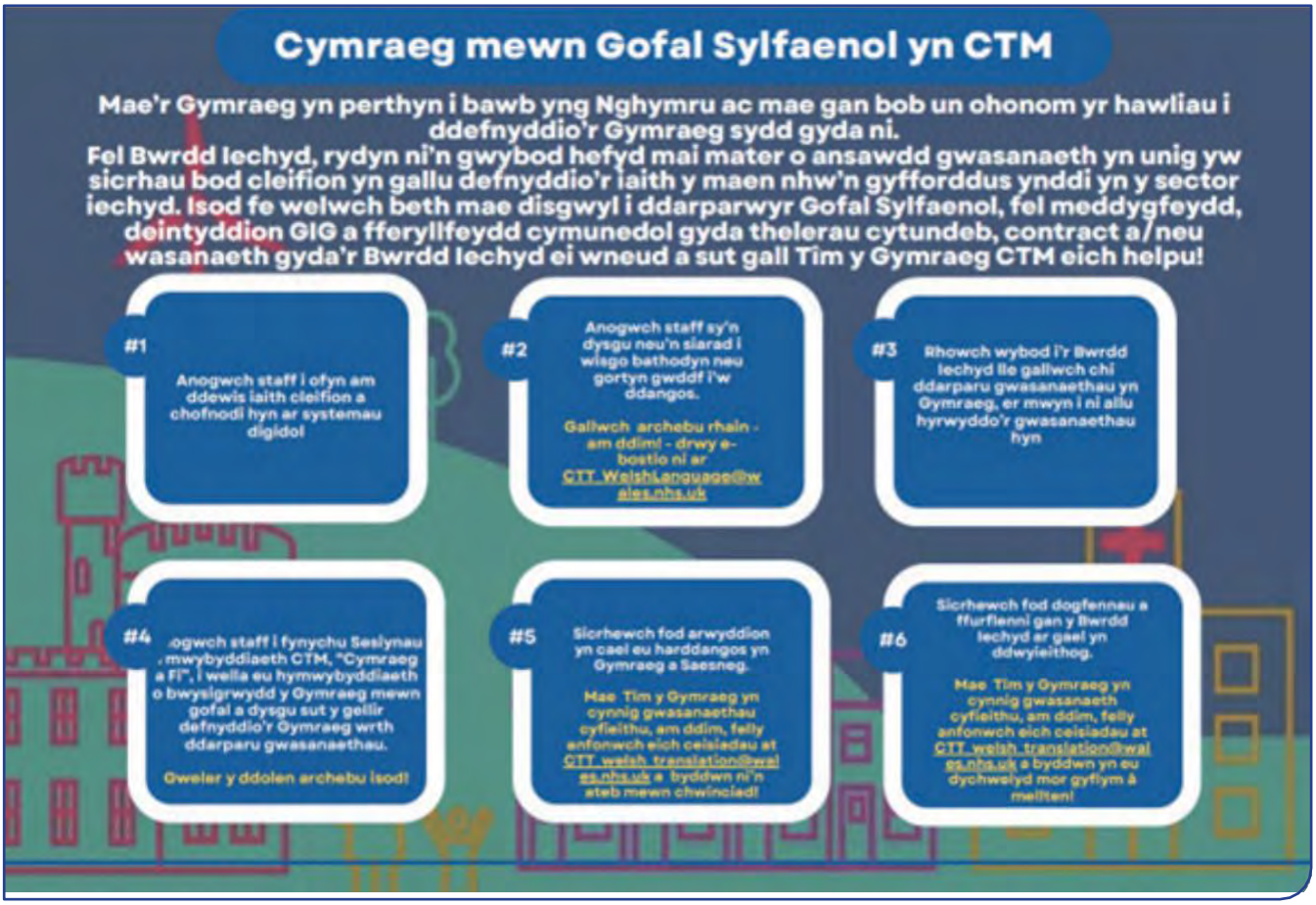
	Mae Tîm y Gymraeg hefyd wedi cynnig y sesiynau ymwybyddiaeth iaith canlynol yn fewnol, gan ddefnyddio cynnwys ymwybyddiaeth iaith BIPCTM a ddyluniwyd y llynedd: • Diwrnod cwrdd-i-ffwrdd Tîm Iechyd y Cyhoedd (50 aelod o staff) • Tîm Ymwelwyr Iechyd (20 aelod o staff)

Hyrwyddo'r Gymraeg mewn Gofal Sylfaenol

Gwnaethon ni adrodd y llynedd ar sut roedden ni'n gweithio'n benodol gydag un darparwr Gofal Sylfaenol deintyddol. Tua diwedd y flwyddyn adrodd hon, fe wnaethon ni greu taflen wybodaeth safonol yn nodi'r Chwe Dyletswydd y disgwylir i bob darparwr Gofal Sylfaenol sydd â chontract gyda BIPCTM gadw atyn nhw, yn unol â Rheoliadau GIG Cymru (Gwasanaethau'r Gymraeg mewn Gofal Sylfaenol) (Diwygiadau Amrywiol) (Cymru) (2019). Fe wnaethon ni hefyd gynnwys gwybodaeth glir arni gan nodi sut y gall y Bwrdd Iechyd gefnogi darparwyr Gofal Sylfaenol i gyflawni'r dyletswyddau hynny. Roedd hyn yn cynnwys hyrwyddo ein gwasanaeth cyfieithu rhad ac am ddim a chynnig sesiynau ymwybyddiaeth penodol i Ofal Sylfaenol.

Bydd y cynnig safonedig hwn yn parhau i gael ei rannu drwy gydol y flwyddyn adrodd nesaf, ac mae ymgysylltu pellach â darparwyr Gofal Sylfaenol yn flaenoriaeth fel y nodir yng nghynllun gweithredol datblygu'r Gymraeg 2024-25.





Hyrwyddo ein Gwasanaethau Cymraeg gyda'r cyhoedd

Mae gan bobl hawliau i ddefnyddio'r Gymraeg gyda BIPCTM ac mae gyda ni ddyletswydd gyfreithiol o dan y Safonau i hyrwyddo'r hawliau hynny. Eleni rydyn ni wedi:

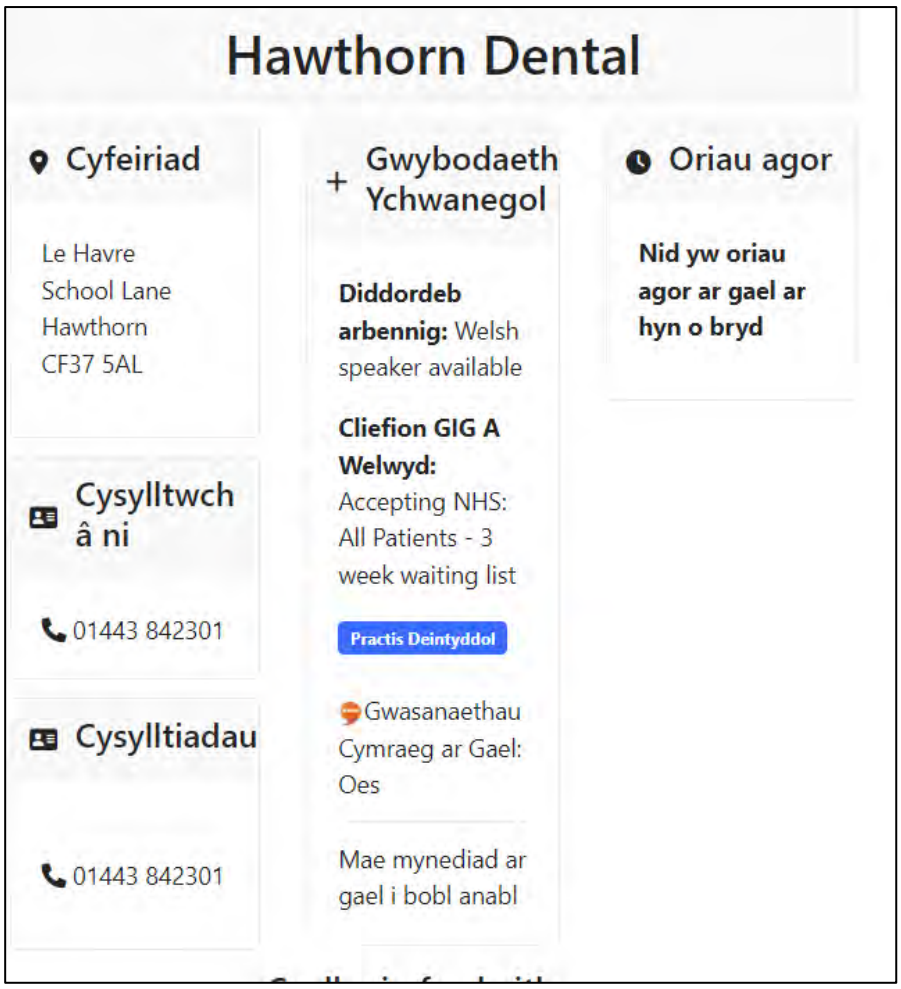
- Ailgynllunio ein tudalen we allanol i ganolbwyntio ar hawliau cleifion i ddefnyddio'r Gymraeg, gan roi cyngor clir i gleifion am beth gallan nhw ddisgwyl ei wneud yn Gymraeg wrth ryngweithio â BIPCTM a Gofal Sylfaenol;
- Creu taflen wybodaeth newydd i gleifion sydd ar gael yn ddigidol ac mewn print fel bod gan gleifion adnodd clir sy'n egluro pa hawliau sydd gyda nhw i ddefnyddio'r Gymraeg gyda'r Bwrdd Iechyd, a beth gallan nhw ei ddisgwyl gan ddarparwyr Gofal Sylfaenol.

Bydd y ddau adnodd newydd hyn yn ddefnyddiol i hyrwyddo ein darpariaeth ddwyieithog yn effeithiol gyda'r cyhoedd. Mae dehongli hysbysiad cydymffurfio, dogfen gyfreithiol, yn ymdrechgar ac felly mae'n hanfodol ein bod wedi ysgrifennu canllawiau clir i gleifion.

Buon ni hefyd yn siarad am ein sesiynau galw heibio uchod ym mis Tachwedd ac yn rhan o'n hymgyrch Hiraeth; roedd y rhain hefyd yn gyfle i siarad â bron i 40 aelod o'r cyhoedd am eu hawliau i ddefnyddio'r Gymraeg gyda'r Bwrdd Iechyd.

Ar gyfer Gofal Sylfaenol, mae adran benodol ar ein gwefan hefyd yn nodi pa ddarparwyr sy'n gallu darparu gwasanaeth neu ran o wasanaeth yn Gymraeg, gydag enghraifft isod. Wrth chwilio am ddarparwr Gofal Sylfaenol felly o dan 'Dod o hyd i'ch Gwasanaeth GIG lleol', mae cleifion yn gallu gweld ar gyfer llawer o

ddarparwyr a allan nhw gynnig unrhyw ddarpariaeth yn Gymraeg ai peidio.



Ar wahân i gyngor clir am beth sydd ar gael yn Gymraeg, rydyn ni'n manylu ar beth rydyn ni wedi'i wneud i fod yn rhagweithiol wrth ddarparu gwasanaethau yn seiliedig ar y cysyniad 'Cynnig Rhagweithiol' yn yr adran nesaf.

Mae rhagor o wybodaeth am sut mae'r gwaith hwn o dan Gyfathrebu ac Ymgysylltu wedi helpu BIPCTM i gydymffurfio â Safonau'r Gymraeg i'w gweld isod.

Croesgyfeirio gwaith o dan Gyfathrebu ac Ymgysylltu â **Safonau'r** Gymraeg	
Beth wnaethon ni	Sut mae hyn yn cefnogi cydymffurfiaeth
Fframwaith ymgysylltu mewnol	Mae hyn yn ein galluogi i rannu negeseuon cyson a rheolaidd ar: • Cydymffurfio â Safonau Cyflenwi Gwasanaethau yn gyffredinol; • Cyfleoedd hyfforddi yn y Gymraeg (yn cefnogi **Safonau, 99(a), 100, 101 a 102**).
Ymgyrch Hiraeth	Roedd hyn yn cefnogi: • Safon **99(a), 100** a **101** drwy hyrwyddo cynllun cenedlaethol Codi Hyder yn BIPCTM a chyfleoedd i ddysgu Cymraeg yn y gwaith, a • **Safon 102** drwy'r sesiwn Cymraeg a Fi/Welsh & Me, gwella ymwybyddiaeth o'r defnydd o'r Gymraeg a chefnogi newid cadarnhaol mewn ymddygiad drwy chwalu rhwystrau seicolegol i ddefnydd y Gymraeg.
Sesiynau galw heibio	Roedd hyn yn cefnogi: • Cydymffurfio â Safonau Cyflenwi Gwasanaethau yn gyffredinol; • Hyrwyddo'r Gymraeg ymhlith y cyhoedd (**Safon 60**) a • Darparu cortynnau gwddf a bathodynnau i staff sy'n siarad Cymraeg (**Safon 105**).
SharePoint a'i adnoddau	Mae'r gwaith hwn: • Yn cefnogi cydymffurfiaeth â Safonau Cyflenwi Gwasanaethau yn gyffredinol; • Sicrhau cydymffurfiaeth â **Safon 104** drwy ddarparu geiriad ar gyfer llofnodion e-bost a negeseuon tu allan i'r swyddfa dwyieithog; • Sicrhau cydymffurfiaeth â **Safon 94** drwy gael tudalen fewnrwyd benodedig ar gyfer y Gymraeg; • Hyrwyddo cyfleoedd i ddefnyddio a mwynhau'r Gymraeg yn y gwaith (hybu **Safonau 81, 82, 83, 84, 85, 86, 87, 88 ac 89**, a hyrwyddo Safonau o dan Reoliadau Safonau'r Gymraeg (Rhif 8) 2022 fel sy'n berthnasol i gyrff rheoleiddio mae rhai staff wedi cofrestru gyda nhw) a • Safon **99(a), 100 a 101** drwy hyrwyddo'r cynnig mewnol i ddysgu Cymraeg yn y gwaith.
Canllawiau cyngor	Mae'r canllawiau hyn yn cefnogi cydymffurfiaeth â Safonau Cyflenwi Gwasanaethau yn gyffredinol.
Ymweliadau safle unigol	Roedd hyn yn cefnogi cydymffurfiaeth â Safonau Cyflenwi Gwasanaethau yn gyffredinol.
Sesiynau ymwybyddiaeth iaith	Mae'r gwaith hwn: • Sicrhau cydymffurfiaeth â **Safon 102**, drwy sicrhau bod gan staff fynediad at gynnig ymwybyddiaeth iaith ac yn ei gwblhau; • Cefnogi cydymffurfiaeth â Safonau Cyflenwi Gwasanaeth yn gyffredinol.
Hyrwyddo'r Gymraeg mewn Gofal Sylfaenol	Mae'r gwaith hwn: Cefnogi cydymffurfiaeth â **Safonau 66, 67 a 68**.
Hyrwyddo ein Gwasanaethau Cymraeg i'r cyhoedd	Roedd y gwaith hwn yn cefnogi cydymffurfiaeth â **Safon 61 a 65**

Thema 2: Cynlluniau Gweithredu a Monitro

Mae'r diwylliant sefydliadol cywir a dull galluogi sy'n fwy cefnogol o'n pobl yn ddwy elfen hanfodol i sicrhau ein bod yn darparu ein gwasanaethau'n ddwyieithog ac i gydymffurfio â'n dyletswyddau cydraddoldeb iaith ar gyfer y Gymraeg. Mae cyfathrebu ac ymgysylltu yn allweddol i hyn.

Elfen bwysig arall o hyn yw ein hymagwedd at gynlluniau gwella, monitro cydymffurfiaeth a sicrhau bod **pwyntiau rheoli ar waith. Mae'r rhain yn nodi bylchau yn y ddarpariaeth er mwyn sicrhau bod gennym y prosesau yn eu lle i unioni pethau pan fo angen.**

Mesurau rheoli i fonitro cydymffurfiaeth

Mae gan y Bwrdd lechyd fesurau rheoli ar waith i fonitro cydymffurfiaeth â Safonau'r Gymraeg.

Ein Tîm y Gymraeg

Rhan o'r mesurau rheoli sydd gennym ar waith yw Tîm y Gymraeg o dan arweiniad Arweinydd y Gymraeg BIPCTM, sy'n gyfrifol fel gwasanaeth galluogi am gynnig cyngor am gydymffurfio â'r Safonau, monitro cydymffurfiaeth a gweithio gyda rheolwyr i wella eu darpariaeth ddwyieithog yn strategol ac yn weithredol, darparu ymwybyddiaeth iaith a chefnogaeth benodol i dimau i gyflawni eu dyletswyddau yn yr hysbysiad cydymffurfio, cyfieithu proffesiynol, rheoli a hyrwyddo ein cynnig i ddysgu Cymraeg yn y gwaith, a chreu a rhannu adnoddau amrywiol i gefnogi'r defnydd o'r Gymraeg ar draws y sefydliad.

Archwilio

Yn rhan o fonitro cydymffurfiaeth, rydyn ni'n cynnal archwiliadau arsylwi rheolaidd ar safleoedd yn ogystal ag archwiliadau adrannol gan arweinwyr perthnasol yn y meysydd hynny. Eleni cymerwyd sampl ar hap hefyd i gasglu tueddiadau gwaelodlin ar draws BIPCTM, a gwblhawyd gan 86 o reolwyr adrannol ar draws pob Grŵp Gofal. Gofynnodd gwestiynau manwl ynghylch cydymffurfio â Safonau Cyflenwi Gwasanaethau. Y nod oedd casglu gwaelodlin digon manwl i fesur y cynnydd presennol wrth wreiddio'r Safonau, a blaenoriaethu gwaith yn seiliedig ar y gwendidau a nodwyd.

Mae'r canlyniadau hyn, ynghyd â chanlyniadau archwiliadau arsylwi, ymweliadau safle, data o geisiadau cyfieithu a dderbyniwyd a chanlyniadau Mesurau Profiadau a Adroddir gan Gleifion (PREMs, gweler isod) hefyd yn ffurfio'r wybodaeth fusnes ar gyfer y traciwr cydymffurfio cyffredinol a gwblhawyd y flwyddyn adrodd ddiwethaf. Mae hyn yn galluogi BIPCTM i fonitro sut mae Safonau'r Gymraeg yn cael eu gwreiddio a darparu sgôr aeddfedrwydd gyffredinol (gweler isod).

Y duedd gyffredinol ar draws y sampl oedd hyn:

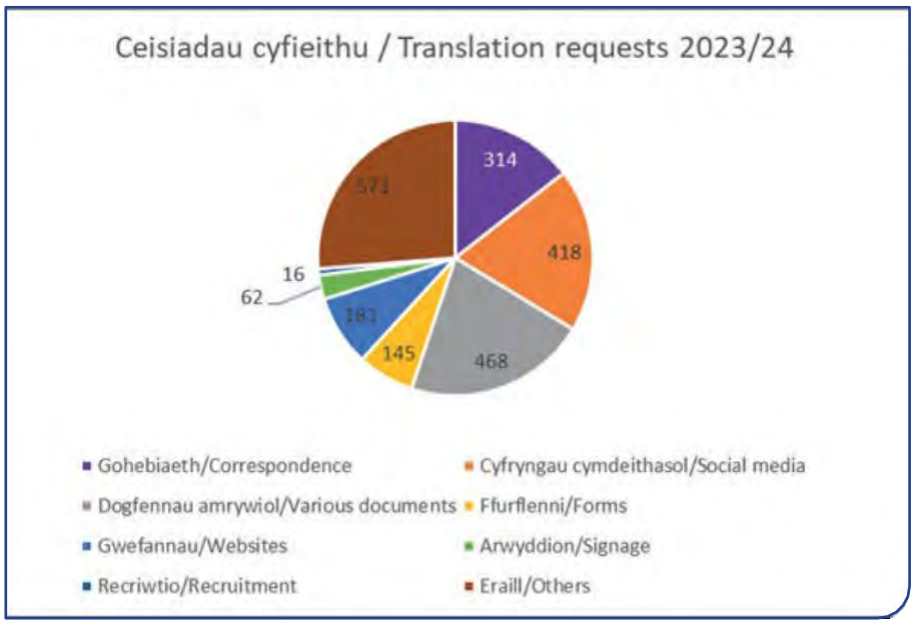
- Mae'n ymddangos bod sylfaen gref o gefnogaeth i ddarpariaeth Gymraeg a dwyieithog ymhlith rheolwyr, gyda mwyafrif helaeth o reolwyr yn dweud bod gan eu tîm wybodaeth dda am pam rydyn ni'n cynnig gwasanaethau yn Gymraeg, beth mae disgwyl iddyn nhw ei wneud yn Gymraeg yng nghyd-destun eu harbenigedd a ble i gael cymorth a chyngor lle bo angen. Mae hyn yn golygu, lle mae angen i ni wella, nad yw hyn fel arfer oherwydd diffyg dealltwriaeth o'r gofynion;
- Mae'n ymddangos bod BIPCTM yn cydymffurfio'n fras â llawer o'r safonau cyflenwi gwasanaeth drwy'r amser neu'r rhan fwyaf o'r amser (gweler Atodiad 1), er bod angen gweithio o amgylch y Safonau hynny sy'n gofyn am sgiliau llafar Cymraeg, megis ateb prif rifau ffôn a rhifau ffôn adrannol, darparu cyrsiau addysg iechyd a gwasanaethau derbynfa;
- Mae'r Cynnig Rhagweithiol yn gysyniad y mae'n ymddangos bod y rhan fwyaf o reolwyr a'u timau yn ei ddeall ac yn ei ymarfer, gyda lleiafrif o reolwyr yn dweud nad ydyn nhw 'byth' yn gofyn am ddewis iaith yn rhagweithiol. Mae hyn yn hanfodol ar gyfer y nifer sy'n defnyddio gwasanaethau Cymraeg. Mae rhagor o waith ar y Cynnig Rhagweithiol isod

Mae'n amlwg o'r archwiliad hwn bod angen parhau â'r gwaith o recriwtio staff sy'n siarad Cymraeg i rolau rheng flaen a'r gwaith o ran dysgu Cymraeg yn y gwaith, y ddau ohonyn nhw yn feysydd ffocws i'r Bwrdd lechyd (gweler Thema 5).

Defnydd **o'r** gwasanaeth cyfieithu

Mae data am ddefnydd o gyfieithu yn bwysig ar gyfer monitro gan fod angen cyfieithu yn aml i gydymffurfio â nifer o Safonau, o'r cyfryngau cymdeithasol i ffurflenni ac o arwyddion i ddefnyddio'r Gymraeg yn fewnol. Derbyniodd y gwasanaeth 2,182 o geisiadau y flwyddyn adrodd hon, gan gyfieithu 1.2 miliwn o eiriau.

Mae'r graff isod yn dangos y math o geisiadau a dderbyniwyd fel cyfran o'r holl geisiadau. A barnu yn ôl y math o geisiadau a dderbyniwyd, gellir gweld tuedd o Sicrwydd Canolig o leiaf o gydymffurfio â Safonau 1, 4, 5, 6, 37, 38, 39, 41, 45, 47 a 112. Er enghraifft, mae'n annhebygol na all BIPCTM adrodd o leiaf Sicrwydd Canolig ar gyfer Safon 38 a sicrhau bod ffurflenni'n ddwyieithog, o ystyried bod y gwasanaeth cyfieithu wedi derbyn 145 o geisiadau (12 y mis ar gyfartaledd) am gynnwys sy'n gysylltiedig â ffurflenni.



Gwaith Strategaeth a Thrawsnewid: Ailgynllunio gwasanaethau a chomisiynu trydydd parti

Mewn perthynas ag unrhyw newid gwasanaeth neu ailgynllunio gwasanaeth, mae ymgysylltiad yn aml yn digwydd gyda chleifion a'n cymuned, a byddai unrhyw wybodaeth, cynigion neu holiaduron mewn perthynas â newid gwasanaeth neu ymgysylltu fel rhan o'r broses yn cael eu cyhoeddi yn Gymraeg ac yn Saesneg. Rydyn ni'n rhannu unrhyw hysbysiadau newid gwasanaeth i'n cymunedau drwy'r Tîm Cyfathrebu ac Ymgysylltu ac maen nhw'n ddwyieithog. Pe bai angen i ni ysgrifennu at gleifion neu feddygon teulu i'w hysbysu bod gwasanaeth yn newid, rydyn ni'n gwneud hyn yn Gymraeg ac yn Saesneg. Mae gwaith hefyd wedi dechrau i sicrhau cydymffurfiaeth yn y maes hwn ynghylch Safonau Llunio Polisi (o ran asesiadau effaith (gweler isod) yn ogystal â sut rydym yn ymgynghori am newid gwasanaeth.

Fodd bynnag, enghraifft o gydymffurfio â Safonau Cyflenwi Gwasanaethau yn y maes hwn oedd y newidiadau diweddar yng Ngwasanaethau'r Fron. Enghraifft arall yw Prosiect 'Drymester', ymgyrch gan Bartneriaeth Iechyd a Gofal Cymdeithasol Manceinion Fwyaf sy'n ceisio lledaenu'r canllawiau cywir am risgiau yfed alcohol yn ystod beichiogrwydd ac i helpu rhieni i fynd yn ddi-alcohol. Yn rhan o'r prosiect, mabwysiadodd BIPCTM ymgyrch 'Drymester' a chyfieithwyd adnoddau i'r Gymraeg gan Dîm y Gymraeg. Lansiwyd 'Drymester' ar draws BIPCTM yn ystod 2023, ac mae Byrddau Iechyd eraill bellach yn ystyried defnyddio'r adnoddau.

O ran comisiynu trydydd parti i ddarparu gwasanaethau, mae ein Cytundeb Lefel Gwasanaeth safonol yn

cynnwys cyfeiriadau perthnasol at Safonau'r Gymraeg. Mae hyn yn sicrhau, wrth gomisiynu gwasanaethau, fod y cytundeb cyfreithiol yr ymrwymir iddo yn ei gwneud yn bosibl gorfodi cydymffurfiaeth â Safonau'r Gymraeg drwy gontract. Mae hefyd yn ymrwymo'r Bwrdd Iechyd i sicrhau bod y cymorth sydd ei angen ar bartïon a gomisiynir i ddarparu gwasanaethau yn Gymraeg yn cael ei gyfathrebu'n glir, ac mae manylion ar gael cael gafael ar gymorth perthnasol wedi'u cynnwys yn y llythyr dyfarnu i drydydd partïon.

Y Cynnig Rhagweithiol a thystiolaeth o ofalu yn Gymraeg yn BIPCTM

Mae'r Cynnig Rhagweithiol, neu ofyn yn rhagweithiol i'r claf beth yw ei ddewis iaith, yn hanfodol er mwyn darparu gwasanaethau dwyieithog am lawer o wahanol resymau. Gall dull Cynnig Rhagweithiol cryf arwain at gynnydd yn y nifer sy'n defnyddio gwasanaethau Cymraeg, ac islaw mae sawl pwynt data yn cael eu trafod sy'n dangos sut mae BIPCTM yn gwreiddio dull y Cynnig Rhagweithiol, a sut rydym yn cynnig gofal yn Gymraeg i'r rhai sydd ei angen.

Pwysleisio'r Cynnig Rhagweithiol yn y canllawiau

Mae'r canllawiau ar gydymffurfio â Safonau y cyfeirir atyn nhw uchod yn Thema 1 yn trafod y Cynnig Rhagweithiol a pham mae hyn yn bwysig. Cyn i staff felly droi at beth yw'r gofynion, cân nhw eu cyflwyno i'r Cynnig Rhagweithiol a straeon profiad cleifion sy'n egluro ei bwysigrwydd.

Polisi Cynnig Rhagweithiol i Gleifion Mewnol

Eleni cymeradwyodd BIPCTM ei bolisi cyntaf ar gyfer ymarfer y Cynnig Rhagweithiol gyda chleifion mewnol, gan gynnwys ar gyfer y cleifion mewnol hynny nad ydyn nhw efallai, am ba bynnag reswm clinigol, yn gallu mynegi eu hangen iaith eu hunain. Cefnogwyd y polisi gan y Cyfarwyddwr Gweithredol dros Nyrsio a Phrofiad y Claf, cafod ei rannu yng nghyfarfod o'r Bwrdd Rheoli Gweithredol ym mis Mawrth a fynychwyd gan yr holl uwch reolwyr gweithredol, cyn ei gymeradwyo mewn cyfarfod o'r Pwyllgor Ansawdd a Diogelwch, un o is-bwyllgorau'r Bwrdd.

Mae'r ddogfen bolisi yn egluro cefndir cydymffurfiaeth reoleiddiol y polisi a'r pwyntiau data a ddefnyddir i fonitro sut caiff ei weithredu. Mae'r atodiad sydd ynghlwm i'r polisi wedyn yn egluro'r ymchwil y tu ôl i bwysigrwydd y Cynnig Rhagweithiol a gofal iaith gyntaf i bobl ddwyieithog, cyn amlinellu protocol sydd wedi'i strwythuro drwy dair thema, sef Amgylchedd (sicrhau amgylchedd ward sy'n ffafriol i ddefnyddio'r Gymraeg), Gofyn (ar ba adeg yn ystod y broses dderbyn sefydledig y dylid gofyn am ddewis iaith a beth i'w wneud os na all y claf fynegi hyn ei hun) a Cofnodi (ar ba systemau clinigol i gofnodi angen iaith os nad yw wedi'i gofnodi eisoes).

Mae creu polisi annibynnol sy'n ymwneud â derbyn cleifion mewnol ar gyfer siaradwyr Cymraeg, wedi'i gefnogi gan aelod o'r Bwrdd Gweithredol ac wedi'i gymeradwyo drwy brosesau llywodraethu ffurfiol, yn gam mawr ymlaen i BIPCTM yn ei ddull Cynnig Rhagweithiol, ac yn dyst i'r gefnogaeth i'r Gymraeg ymhlith uwch reolwyr nyrsio.

E-fyrddau gwyn

Mae'r system hon yn galluogi staff i nodi bod cleifion mewnol yn siarad Cymraeg, gan ddefnyddio symbol baner Cymru a'r geiriau 'siaradwr Cymraeg'. Mae hyn yn ein galluogi i gofnodi dewis iaith ac angen iaith cleifion mewnol mewn gwely acíwt neu ysbyty cymunedol ac i'r dewis hwnnw neu'r angen hwnnw fod yn weladwy i'r holl staff sy'n defnyddio'r e-fyrddau gwyn digidol.

Mae'r e-fyrddau gwyn hefyd yn galluogi staff heblaw staff nyrsio i wybod bod claf yn siarad Cymraeg, er

enghraifft meddygon iau, meddygon ymgynghorol neu ffisiotherapyddion yn ystod eu hymwneud â chlaf mewnol. Nodwedd ddefnyddiol arall o'r system yw'r 'Golwg Rhestr', sy'n galluogi staff i glicio ar symbol a gweld yr holl gleifion y defnyddiwyd y symbol hwnnw ar eu cyfer a lle mae'r claf hwnnw wedi'i leoli. Byddai hyn yn galluogi staff i weld pa gleifion sy'n siarad Cymraeg, a chynllunio cylchdro ward a therapi yn unol â hynny.

Mae'r system e-fwrdd gwyn hefyd yn gysylltiedig â'n system E-TOC, neu Gofnod Trosglwyddo Gofal Electronig, a ddatblygwyd gan BIP CTM yn fewnol hefyd, a ddefnyddir wrth ryddhau cleifion i ofal cymdeithasol. Wrth lenwi'r ffurflen electronig hon, mae staff yn cael eu hannog i ofyn i'r claf beth yw ei ddewis iaith, a fyddai'n galluogi staff gofal cymdeithasol i weld bod claf yn siarad Cymraeg a chynllunio'n unol â hynny. Mae'n rhaid ateb y cwestiwn hwn cyn y gellir trosglwyddo'r cofnod, sy'n golygu bod staff yn llawer mwy tebygol o sicrhau eu bod wedi gofyn am ddewis iaith. Mae'r systemau e-bwrdd gwyn a'r ETOC yn atebion arloesol a ddatblygwyd gan BIP CTM a byddan nhw'n gwneud gwahaniaeth mawr i ofal cleifion ar gyfer ein cymunedau Cymraeg eu hiaith.

Mae'r rhain hefyd yn enghreifftiau gwych o gymryd ymddygiad pobl go iawn i ystyriaeth wrth ddarparu gwasanaethau; drwy ofyn am ddewis iaith a chofnodi hyn ar gyfer staff a chleifion, rydyn ni'n ei gwneud yn llawer haws i staff adnabod cleifion sy'n siarad Cymraeg ac i gleifion fynegi eu dewis iaith, gan ddileu'r ffrithiant a'r ymdrech sy'n aml yn llesteirio darpariaeth ddwyieithog. Mae'r systemau hyn hefyd yn hwyluso'r ddarpariaeth ddiofyn o wasanaethau dwyieithog, trwy alluogi staff i adnabod cleifion Cymraeg eu hiaith ar wardiau ac o fewn gofal cymdeithasol a threfnu gofal cyfrwng Cymraeg ymlaen llaw, heb fod angen i'r claf fynegi hyn dro ar ôl tro drwy'r system.

Enghraifft o sut y gall cofnodi angen iaith cleifion yn fewnol olygu nad yw cleifion yn gorfod ailadrodd eu hangen iaith wrth symud drwy'r system yw achos Claf A, [4] a dderbyniwyd i Ward B2 yn Ysbyty Cwm Rhondda, cyn cael ei drosglwyddo i Ysbyty Brenhinol Morgannwg. Nid oedd angen gofyn eto am angen iaith ar ôl i'r claf gael ei derbyn yno gan ei fod eisoes wedi'i gofnodi ar y system.

Eleni, defnyddiwyd symbol iaith Gymraeg yr e-fwrdd gwyn yn y safleoedd canlynol:

Defnydd o'r e-fwrdd gwyn 2023-24	
Safle ysbyty a nifer y cleifion	Nifer y cleifion
RGH (13)	10, 14, 17, 2, 4, 5, 8, Critical Care Unit (CCU)
PCH (6)	10, 3, 9, CCU
YCR (2)	B2
POW (8)	10, 15, 6, 7, 9

[4] Cuddiwyd enw'r claf er mwyn cyfrinachedd

Mae'n wych gweld defnydd o hyd ar yr e-fwrdd gwyn o ran y Gymraeg, ar draws nifer o wardiau mewn nifer o'n hysbytai..

Cofnod Gofal Nyrsio Cymru

System ddigidol yw hon sy'n trawsnewid y ffordd y mae nyrsys yn cofnodi, storio a chyrchu gwybodaeth cleifion. Yn hytrach na gwneud nodiadau ar bapur wrth erchwyn gwely claf, mae nyrsys yn defnyddio cyfrifiaduron llechen i gasglu gwybodaeth a'i storio'n ddiogel yn y system, fel bod gofalwyr yn gallu cael gafael ar yr un wybodaeth drwy gydol taith gofal iechyd claf.

Mae'r maes dewis iaith yn orfodol yn adran 'Anghenion Cyfathrebu' yr asesiad. Gall nyrsys gadw asesiadau anghyflawn mewn fformat 'drafft' (gan y gallen nhw gael eu galw i ffwrdd, bydd angen gwybodaeth arnyn nhw gan deulu'r claf, neu efallai na fydd y claf yn ymateb ac yn methu ag ateb), ond rhaid iddyn nhw ateb pob cwestiwn yn yr adran cyn cael marcio'r cofnod fel 'Wedi gorffen'.

Yn BIPCTM, ac ar draws wardiau lle defnyddir y system hon, cofnodwyd y niferoedd canlynol o gleifion gyda Cymraeg fel dewis iaith. Mae hyn nid yn unig yn dangos y defnydd o'r Gymraeg ar draws BIPCTM (Cymraeg oedd yr ail iaith uchaf a gofnodwyd ar ôl Saesneg), ond bod y Cynnig Rhagweithiol yn cael ei wneud a'i gofnodi ar draws wardiau.

Defnydd WNCR ar gyfer y Gymraeg	
Safle	Nifer y cleifion
PCH	53
POW	41
RGH	84
YCC	1
YCR	1

Systemau digidol eraill a chofnodi dewis iaith

Mae BIPCTM yn defnyddio systemau cenedlaethol amrywiol i gofnodi data cleifion. Mae'r rhain yn cynnwys y prif systemau a ganlyn, a dangosir y gallu i gofnodi dewis iaith arnyn nhw. Mae hyn yn ein galluogi i sicrhau bod y Cynnig Rhagweithiol yn cael ei ymarfer drwy ddefnyddio systemau sy'n ein galluogi i gofnodi anghenion iaith. Gall staff wedyn ddefnyddio'r wybodaeth hon i gynnig gwasanaethau yn Gymraeg yn rhagweithiol.

System	Where language preference is recorded
Patient Administration System (PAS)	Under 'Demographics'
Welsh Clinical Portal (WCP)	Pulls data from PAS,
EMIS	Under 'Contact Information'
Welsh Clinical Communication Gateway	Under 'Language of Choice'
Choose Pharmacy	In 'Main Patient Demographics' section
Community Child Health 2000	Displays "First language" and "Second language" as one character field (e.g. 'W' for Welsh). This is displayed on the child's record.
Welsh Radiology Information System	Under 'Demographics'

PREMs

Sail dystiolaeth bellach ynghylch a all cleifion ddefnyddio'r Gymraeg wrth ryngweithio â'r Bwrdd Iechyd yw data o Fesurau Profiadau a Adroddir gan Gleifion (PREMs). Mae cleifion yn cwblhau'r arolygon hyn o wahanol arbenigeddau, weithiau ar gyfer triniaethau penodol, gan gynnwys cleifion mewnol a chleifion allanol ar draws y Bwrdd Iechyd. Mae data'r flwyddyn adrodd hon yn dangos, o'r cleifion hynny a gwblhaodd arolwg ac a atebodd y cwestiwn ynghylch eu gallu i ddefnyddio'r Gymraeg os oedden nhw'n dymuno, fod y mwyafrif yn gallu gwneud hynny. Mae data ar gyfer Adrannau Achosion Brys a'r tîm Gofal Lliniarol yn bwysig gan y bydd hyn yn caniatáu ymyriadau pellach yno i wella'r sgoriau hyn. Dylid nodi fodd bynnag fod dros 160 o gleifion yn dweud eu bod wedi defnyddio'r Gymraeg yn adrannau gofal brys BIPCTM yn gadarnhaol iawn, ac mae'n annhebygol y byddai nifer mor uchel â hyn yn nodi hynny pe na bai lefel dda o ddarpariaeth Gymraeg ynddyn nhw, hyd yn oed os gallai hynny fod yn anghyson. Mae'r PREMs eu hunain hefyd yn ddwyieithog ac fe gwblhaodd 58 o gleifion arolwg yn Gymraeg.

Yn y tabl isod, dangosir canlyniadau PREMs a oedd yn cynnwys cwestiwn ar y Gymraeg. Roedd pob cwestiwn yn cynnwys ateb 'Amherthnasol', ond i gyfrifo cyfran y cleifion a oedd yn gallu defnyddio'r Gymraeg lle roedden nhw'n dymuno, mae'r rhifau 'Dd/B' hyn wedi'u dileu. Mae'r canlyniadau hefyd wedi'u categoreiddio dan Goch – Ambr – Gwyrdd, coch yn golygu bod y mwyafrif oedd eisiau defnyddio'r Gymraeg heb allu gwneud hynny, Oren yn golygu bod y darlun yn anghyson, a Gwyrdd yn golygu bod y mwyafrif oedd eisiau defnyddio'r Gymraeg wedi gallu gwneud hynny.

Enw'r arolwg	Cwestiwn	Nifer yn adrodd eu bod yn gallu defnyddio'r Gymraeg a % yr holl ymatebion perthnasol	
Iechyd Meddwl Oedolion - Arolwg Profiad y Claf	Oeddech chi'n gallu siarad Cymraeg â'r staff os oedd angen?	'Yn bendant'	6 (50%)
		'Yn gyffredinol'	1 (8%)
		'Ddim mewn gwirionedd'	5 (48%)
Holiadur Profiad Cleifion CTM	Oeddech chi'n gallu siarad yn Gymraeg â'r staff os oedd angen?	'Always'	2 (22%)
		Fel arfer	3 (33%)
		Weithiau	2 (22%)
		Byth	2 (22%)
Profiad Cleifion CTM - Gynae ac Iechyd Rhywiol	Wedi cael y cyfle i siarad Cymraeg neu eich iaith ddewisol gyda'r staff os oedd angen gwneud hynny?	'Bob amser'	95 (90%)
		'Fel arfer'	2 (2%)
		'Weithiau'	3 (3%)
		'Byth'	5 (5%)
Hawdd ei Ddeall - Y Gofal Rydych chi'n ei Gael gan y GIG	Os ydych chi'n siarad Cymraeg, oeddech chi'n gallu siarad Cymraeg â staff?	'Ro'n i wastad yn gallu siarad Cymraeg'	3 (33%)
		'Roeddwn i'n gallu siarad Cymraeg fel arfer'	1 (11%)
		'Ro'n i'n gallu siarad Cymraeg weithiau'	2 (22%)
		'Doeddwn i ddim yn gallu siarad Cymraeg'	3 (33%)
Arolwg yr Adran Argyfwng	Oeddech chi'n gallu siarad yn Gymraeg â'r staff os oedd angen?	'Bob amser'	127 (31%)
		'Fel arfer'	35 (8%)
		'Weithiau'	42 (10%)
		'Byth'	208 (50%)
Methiant y Galon - Arolwg PREM	Oeddech chi'n gallu siarad yn Gymraeg â'r staff os oedd angen?	'Bob amser'	113 (77%)
		'Fel arfer'	2 (1%)
		'Weithiau'	25 (17%)
		'Byth'	6 (4%)
Clinig Iechyd Meddwl - Arolwg Profiad y Claf	Oeddech chi'n gallu siarad yn Gymraeg â'r staff os oedd angen?	'Bob amser'	0
		'Fel arfer'	0
		'Weithiau'	1 (50%)
		'Byth'	1 (50%)

Arolwg Cleifion y Tîm Gofal Lliniarol	Ydych chi'n gallu siarad Cymraeg â'r tîm, os oes angen?	'Bob amser'	0
		'Fel arfer'	0
		'Weithiau'	0
		'Byth'	3 (100%)
Holiadur Rhieni/Gofalwyr - Cleifion Allanol	Oedd modd i chi gyfathrebu mewn iaith o'ch dewis?	'Oedd'	12 (100%)
		'Fel arfer'	0
		'Weithiau'	0
		'Byth'	0
Holiadur Rhieni/Gofalwyr	Oedd modd i chi gyfathrebu mewn iaith o'ch dewis?	'Oedd'	40 (100%)
		'Fel arfer'	0
		'Weithiau'	0
		'Byth'	0
Arolwg o Brofiad Cleifion – Endosgopi	Oeddech chi'n gallu siarad Cymraeg â'r staff os oedd angen?	'Bob amser'	122 (91%)
		'Fel arfer'	6 (4.5%)
		'Weithiau'	2 (1.5%)
		'Byth'	3 (2%)
Clinig Iechyd Pelfig / Wrogaenecoleg - Therapïau	Oeddech chi'n gallu siarad Cymraeg â'r staff os oedd angen?	'Bob amser'	21 (77%)
		'Fel arfer'	1 (3%)
		'Weithiau'	0 (0%)
		'Byth'	5 (18%)
PREM Ffisiotherapi PH	Oeddech chi'n gallu siarad Cymraeg â'r staff os oedd angen?	'Bob amser'	1 (100%)
		'Fel arfer'	0
		'Weithiau'	0
		'Byth'	0
Arolwg Profiad Cleifion Therapïau	Oeddech chi'n gallu siarad Cymraeg â'r staff os oedd angen?	'Bob amser'	11 (46%)
		'Fel arfer'	3 (12.5%)
		'Weithiau'	6 (25%)
		'Byth'	4 (16%)
Holiadur Gwasanaeth Gwella Lles (WISE).	Oedd modd i chi siarad Cymraeg neu eich iaith ddewisol gyda'r staff os oedd angen gwneud hynny?	'Bob amser'	30 (90%)
		'Fel arfer'	1 (3%)
		'Weithiau'	0 (0%)
		'Byth'	2 (6%)

Lanyards a bathodynnau

Dull pwysig arall o hyrwyddo ein gwasanaethau yn Gymraeg a rhoi gwybod i gleifion yn rhagweithiol pwy yw ein staff sy'n siarad Cymraeg yw rhannu cortynnau gwddf a bathodynnau (pin neu wedi'u brodio) gyda staff, a rhannu'r poster cenedlaethol 'Defnyddiwch eich Cymraeg yma'. Mae hyn yn cael ei hwyluso trwy:

- Sicrhau bod cortynnau gwddf ar gael yn swyddfa gyffredinol pob prif safle ysbyty;
- Hyrwyddo cortynnau gwddf, bathodynnau a'r poster 'Defnyddiwch Eich Cymraeg Yma' ar y wefan SharePoint a ddisgrifir o dan Thema 1 gyda chyfeiriad e-bost i archebu mwy;
- Darparu llofnodion e-bost gyda logo 'siaradwr Cymraeg' trwy SharePoint i staff eu hychwanegu at waelod e-byst;
- Mae ffurflenni archebu bathodynnau adnabod yn gofyn a yw'r aelod o staff yn gallu siarad Cymraeg ac os felly ychwanegir y symbol 'Iaith Gwaith';
- Mae ffurflenni archebu sgrybs a gwisgoedd staff wardiau yn cynnwys gofod lle gall staff ofyn i'r symbol 'Iaith Gwaith' gael ei frodio arno ac maen nhw'n cael eu hatgoffa o hyn yn y canllawiau.

Mae dros 180 o fathodynnau a chortynnau gwddf pellach wedi'u rhoi i staff sy'n siarad Cymraeg eleni gan Dîm y Gymraeg drwy'r dulliau hyn, ac mae ymweliadau safle yn cadarnhau bod llawer o'n staff yn eu gwisgo.

Hyrwyddo'r wefan ddwyieithog yn rhagweithiol

Y flwyddyn adrodd ddiwethaf fe wnaethon ni ychwanegu neges at ein gwefan i annog defnyddwyr i ddefnyddio'r fersiwn Gymraeg. Roedd ychwanegu'r neges hon yn ei gwneud hi'n gliriach ble roedd y botwm i newid yr iaith i'r Gymraeg. Rydyn ni'n bwriadu gwneud hyn hyd yn oed yn well y flwyddyn adrodd nesaf, ond mae ychwanegu'r neges hon yn unig wedi ychwanegu dros 3,000 o ymweliadau safle newydd at gynnwys Cymraeg, gyda nifer yr ymweliadau â safleoedd ar yr ochr Gymraeg yn codi o 11,397 yn 2023/24 i 14,347 yn ystod y flwyddyn adrodd hon. .

Yn dilyn cwyn y llynedd ac ymchwiliad dilynol gan Gomisiynydd y Gymraeg, bu BIPCTM yn gweithio gydag Iechyd a Gofal Digidol Cymru i wella'r system rheoli cynnwys a ddefnyddir ar gyfer ei wefan (Mura). Er mwyn helpu i sicrhau bod cynnwys yn cael ei ychwanegu'n ddwyieithog bob amser:

- Mae neges bellach yn ymddangos i sicrhau bod y rhai sy'n postio cynnwys yn cael eu hatgoffa o'r angen i'r dudalen fod yn ddwyieithog a bod rhaid uwchlwytho cynnwys yn Gymraeg ar yr un pryd;
- Pan fydd tudalen yn cael ei chreu, mae tudalen 'dymi' awtomatig yn cael ei chreu ar y safle Cymraeg, felly pe bai aelod o'r cyhoedd yn clicio ar 'Cymraeg' ar dudalen, ni fyddan nhw'n gweld neges gwall os yw'r cynnwys, am ryw reswm, heb fod ar gael yn Gymraeg a bydden nhw'n cael eu cyfeirio at y wybodaeth iechyd yn Saesneg i osgoi colli cynnwys;
- Ychwanegwyd dull archwilio fel mecanwaith sicrwydd, fel y gellir dod o hyd i unrhyw dudalennau nad ydyn nhw yn Gymraeg yn hawdd.

Bydd y mesurau hyn yn helpu i sicrhau bod ein gwefan ddwyieithog yn parhau i fod yn ddwyieithog.

Tystiolaeth ansoddol o'r Cynnig Rhagweithiol

Yn ogystal â data rhifol ar sut rydym wedi gwreiddio dull y Cynnig Rhagweithiol yn rhan o fonitro ein darpariaeth o wasanaethau dwyieithog, mae tystiolaeth ansoddol hefyd yn bwysig. Mae sawl hanes profiad claf wedi'u

rhannu eleni, dwy ohonyn nhw i'w gweld ar dudalen 12. Mae hyn yn dystiolaeth bellach o sut mae BIPCTM yn darparu ei ofal yn Gymraeg, a bod y ddarpariaeth hon yn cael ei chynnig yn rhagweithiol.

Astudiaethau achos: Rhoi cyd-destun i gynnydd yn BIPCTM

Mae detholiad o astudiaethau achos isod yn rhoi rhywfaint o gefndir i gydymffurfio â Safonau'r Gymraeg yn BIPCTM.

Astudiaeth Achos 1: Radioleg

Mae timau radioleg ar draws BIPCTM wedi gwneud ymdrech fawr yn ystod y flwyddyn hon i ymgorffori'r Gymraeg lawer mwy yn ein gwasanaethau. Y cam cyntaf gymeron ni oedd edrych ar ein sefyllfa bresennol a meincnodi yn erbyn Safonau'r Gymraeg. Roedd hyn wedyn yn ein galluogi i lunio cynllun gweithredu. Yn gynnar yn y broses, roedd rheolwyr y tîm hefyd wedi cyfarfod ag Arweinydd y Gymraeg fel bod modd codi ymholiadau a phryderon, a braf oedd cael y cyfle i gael trafodaeth agored am y tro cyntaf ar y Gymraeg a pha gymorth sydd ar gael i gwneud mwy yn Gymraeg.

Mae ein llythyrau bellach yn ddwyieithog, mae ein taflenni cleifion yn ddwyieithog, mae'r rhan fwyaf o'n harwyddion dros dro yn ddwyieithog, ac mae ein ciosgau cofrestru hefyd yn ddwyieithog, gan gynnig y ddwy iaith yn rhagweithiol i'r claf wrth gyrraedd. Rydyn ni hefyd wedi defnyddio adnoddau i gefnogi staff i ddefnyddio'r Gymraeg ar y ffôn ac yn y dderbynfa, a bu cynnydd yn y defnydd o Gymraeg lefel cwrteisi.

O fewn Radioleg mae gyda ni nifer dda o staff sy'n siarad Cymraeg, ac mae pob un ohonyn nhw yn gwisgo cortyn gwddf i ddangos hyn i staff a chleifion. Rydyn ni'n awyddus i gynyddu'r nifer hwn ac mae un o'n Radiograffwyr wedi cofrestru ar gyfer y cynllun Codi Hyder.

At ei gilydd, bu llawer mwy o ystyriaeth o'r Gymraeg ym maes Radioleg a bydd cleifion yn gweld ac yn clywed hynny.

Astudiaeth Achos 2 Cyfleusterau

Mae Cyfleusterau yn hanfodol i fywyd BIPCTM a gofal cleifion. Mae staff o fewn Cyfleusterau yn gyfrifol am fwydo cleifion, symud cleifion, gwisgoedd staff, y ffreutur ac arlwyo staff, mae'r rhestr yn un hir. Mae ambell fenter eleni yn dangos sut rydyn ni wedi gwreiddio'r Gymraeg.

Rydyn ni'n cynhyrchu ein bwydlenni cleifion mewnol yn ddwyieithog, fel bod modd i gleifion mewnol ddewis eu bwyd yn Gymraeg. Mae defnyddio'r Gymraeg mewn cyflwr bregus ac emosiynol mewn unrhyw fodd yn gallu bod yn gysur i lawer ac felly mae'n wych cael y rhain yn Gymraeg. Fe wnaethom hefyd ailenwi'r Uned Gynhyrchu Ganolog, sy'n cynhyrchu bwyd i gleifion mewnol, i 'Maeth', gan roi enw Cymraeg yn unig iddi. Ar ôl cyrraedd y rhestr fer am wobr yn Llundain, roedd yn wych gweld y gair Cymraeg 'Maeth' yn cael ei arddangos gyda'r ddraig goch Gymreig yn amlwg ar y logo.

Rydyn ni hefyd wedi bod yn llwyddiannus wrth ddod â Starbucks i BIPCTM. Mae'r holl arwyddion yn ddwyieithog; ble arall allwch chi brynu 'Latte Te Chai' neu 'Americano Gwyn' yn Starbucks yn Gymraeg os nad yn CTM! Pethau eraill rydyn ni wedi'u gwneud yw sicrhau bod bwydlenni ein staff yn ddwyieithog, sicrhau bod staff yn gallu archebu'r bathodyn Cymraeg ar gyfer eu gwisg yn Gymraeg a sicrhau bod ein harwyddion dros dro yn Gymraeg.

Astudiaeth Achos 3: Cleifion mewnol Paediatreg

Mae dros 28,000 o blant ar draws BIPCTM sy'n gallu siarad Cymraeg, felly mae sicrhau amgylchedd croesawgar, dwyieithog ar ein wardiau cleifion mewnol yn dod yn naturiol i ni. Yn ein llyfryn cleifion mewnol dwyieithog, rydym yn annog ein cleifion i ddefnyddio'r Gymraeg gyda ni ac yn egluro beth mae'r symbol oren 'Iaith Gwaith' yn ei olygu. Mae ein hamgylchedd yn ddwyieithog, o arwyddion parhaol a dros dro i'n harddangosfeydd. Fe wnaethom hefyd ailenwi ein wardiau eleni, gydag enwau dwyieithog gyda'r Cymraeg ar y brig. Ar gyfer Diwrnod Su'mai Shw Mae, fe wnaethom ddathlu'r achlysur gyda'r plant gyda gweithgareddau a rhannu llyfrau Cymraeg. Mae gan ein hystafell chwarae hefyd lyfrau a gemau dwyieithog.

Mae gyda ni staff nyrsio sy'n siarad Cymraeg a Phencampwr y Gymraeg, ac mae'n deg dweud bod gyda ni ddiwylliant iach tuag at ddefnyddio'r Gymraeg ar y wardiau. CMae ein Uwch Nyrs yn PCH hefyd yn cymryd rhan yn y Cynllun Codi Hyder.

Un newid effeithiol a wnaethom eleni oedd newid ein dogfennaeth derbyn cleifion mewnol fel y gallwn gofnodi a ofynnwyd i'r teulu beth yw iaith angen ai peidio. Mae hyn yn ein galluogi i sicrhau bod teuluoedd wedi cael eu holi am hyn a bod hyn wedyn wedi'i gofnodi.

Astudiaeth Achos 4: Iechyd Meddwl ac Anableddau Dysgu

Mae gennym brofiad da o ansawdd a chyflymder gwasanaethau cyfieithu Cymraeg yn CTM. Rydym yn ymwybodol o'r modiwl iaith Gymraeg sy'n hyfforddiant gorfodol ac rydym yn monitro'r nifer sy'n manteisio ar yr hyfforddiant hwn. Mae ein staff sy'n siarad Cymraeg yn gwisgo cortynnau gwddf a bathodynnau i ddangos eu hunain i eraill ac i gefnogi'r cynnig rhagweithiol o ofal yn y Gymraeg. Mae gennym restr o'n staff sy'n siarad Cymraeg sy'n gallu cefnogi cydweithwyr i ddarparu gwasanaethau yn Gymraeg i'r defnyddwyr gwasanaeth hynny sy'n ffafrio hyn. llawer o adnoddau ar gael i dimau i'w cefnogi i ddefnyddio'r Gymraeg. Mae timau o fewn Iechyd Meddwl ac Anableddau Dysgu wedi derbyn rhai o'r adnoddau hyn ac yn eu defnyddio gyda chleifion, gyda rhai adnoddau wedi'u harddangos ar wardiau. Un adnodd sydd wedi bod yn arbennig o ddefnyddiol yw'r poster 'Teimladau ac Emosiynau', sy'n galluogi cleifion i fynegi eu teimladau heb orfod siarad. Mae Nyrsys Seiciatrig Cymunedol yn mynd gyda nhw ac maen nhw wedi bod yn ddefnyddiol at y diben hwn. Rydyn ni hefyd wedi derbyn llawer o fathodynnau a chortynnau gwddf ac mae'r rhain wedi ein galluogi i ddangos i gleifion ein bod yn siarad Cymraeg.

Astudiaeth Achos 5: Mamolaeth

Mae gan wasanaethau mamolaeth ar draws BIPCTM Hyrwyddwyr y Gymraeg ymrwymedig sef ein Bydwraig Profiad y Claf sy'n gweithio ar draws tri safle a'n dirprwy Brif Nyrs Ward yn PCH ar gyfer babanod newydd-anedig. Mae hyn wedi golygu ein bod wedi gallu sicrhau bod ein harddangosfeydd yn ddwyieithog, bod gwybodaeth cleifion mewnol i famau wrth erchwyn y gwely yn ddwyieithog a bod ein harwyddion yn ddwyieithog. Mae rhai adnoddau a rannwyd gyda ni gan Dîm y Gymraeg hefyd wedi cael eu harddangos. Mae gennym ychydig o aelodau staff sy'n siarad Cymraeg ac mae hyn yn caniatáu i ni ddefnyddio'r Gymraeg gyda mamau a'u teuluoedd. Rydym hefyd wedi cael ein cefnogi gan Dîm y Gymraeg a ymwelodd â'n safleoedd eleni ac a roddodd rai awgrymiadau i ni ar sut y gallem wella ein darpariaeth ddwyieithog ymhellach.

Rydyn ni hefyd wedi bod yn trefnu partïon bwmp ar gyfer ein babanod newydd-anedig, a chafodd gwahoddiad ei roi i'r Mudiad Meithrin a grwpiau eraill er mwyn hybu addysg cyfrwng Cymraeg. Fe wnaethom hefyd sicrhau bod ein holl ddeunyddiau yn ddwyieithog o'r cychwyn cyntaf.

Astudiaeth Achos 6: Therapïau

Rydyn ni wedi gweld newid mawr yn y meysydd Therapïau. Mae Therapïau yn rhan enfawr o'r gofal y mae BIPCTM yn ei ddarparu i'n poblogaeth ac mae'n cynnwys darparu gofal mewn llawer o leoliadau gwahanol, o'r cartref i wardiau cleifion mewnol i ysgolion, felly mae'r newidiadau rydyn ni wedi'u gweld yn cael effaith aruthrol ar ddarpariaeth ddwyieithog y Bwrdd Iechyd ac ar ethos ddwyieithog y Bwrdd Iechyd hefyd.

Dyma rai o'r prif newidiadau rydyn ni wedi'u gweld:

- Defnyddiwn ni gyfarchion Cymraeg yn gyson mewn cyfarfodydd, ac mae staff yn aml yn ymarfer ymadroddion allweddol ynddyn nhw i'w defnyddio gyda staff a'r cyhoedd. Rydyn ni'n annog staff i siarad Cymraeg sgyrsiol. Mae hyn wedi bod yn newid mewn ymddygiad. Tan yn gymharol ddiweddar yn Saesneg y byddwn yn sgwrsio. Mae staff bellach yn teimlo'n gyfforddus ac yn cael eu hannog i siarad ym mha bynnag iaith y maen nhw'n teimlo'n hapus ynddi. Mewn cyfarfod staff e.e. yn ystod egwyl, bydd rhai sgyrsiau yn digwydd yn Gymraeg a rhai yn Saesneg. Mae'n teimlo'n gynhwysol iawn;
- Ymrwymiad clir i'r Gymraeg hefyd y gellir ei weld yw ein harwyddion; maen nhw'n gyson ddwyieithog gyda'r Gymraeg yn gyntaf;
- Mae'r Gymraeg bellach yn cael ei hystyried yn rheolaidd yn ein cynllunio. Dyma dair enghraifft:
  - Wrth ddatblygu brandio ar gyfer y gwasanaeth atal codymau newydd, ystyriwyd ar y dechrau fod angen cyfieithu i'r Gymraeg;
  - Sicrhaodd ymgyrch recriwtio ar gyfer Therapïau fod yr holl adnoddau a chyfathrebu yn ddwyieithog;
  - Roedd gwaith cynllunio ar gyfer digwyddiad gyrfaoedd Therapi Iaith a Lleferydd cenedlaethol wedi cynnwys datblygu ffurflen trefnu slot ddwyieithog a bydd yr holl adnoddau'n cael eu rhannu yn y Gymraeg a'r Saesneg. Mae'r digwyddiad yn bwriadu cynnal dwy sesiwn ochr yn ochr, un Gymraeg ac un Saesneg.
- Mae ein dogfennaeth wedi cael ei newid fel ein bod yn gwneud y Cynnig Rhagweithiol, gyda dewis iaith yn gwestiwn cyntaf.

Mae rhai heriau pwysig wedi'u goresgyn hefyd. Mae ein llythyrau cleifion trwy Myrddin bellach yn cael eu cynhyrchu'n ddwyieithog, ac rydyn ni'n sicrhau bod rhai newydd yn ddwyieithog ac yn cael eu huwchlwytho.

Mae tîm Deieteg Iechyd y Cyhoedd yn gweithio'n agos gyda'r tîm cyfieithu i sicrhau'n gyson fod holl ddeunyddiau'r gwasanaeth yn cael eu cynhyrchu'n ddwyieithog, gan gynnwys:

- Deunyddiau hyrwyddo gwasanaeth (posteri, cardiau busnes a ffeithluniau)
- Ffurflenni hunangyfeirio, gwerthuso a bwcio;
- Sleidiau dwyieithog mewn digwyddiadau lansio gwasanaeth a gefnogwyd hefyd gan weithwyr proffesiynol dwyieithog;
- Fideos hyrwyddo ac arddangosiadau coginio.

Mae'r adborth dilynol wedi'i dderbyn gan randdeiliaid yn dilyn digwyddiad lansio:

Excellent Welsh Language provision today

Great to be able to converse in Welsh and have the slides available to us bilingually

The team made a real effort to make sure Welsh language speakers were easily identifiable and available

Mae hyn wir yn effeithio ar gleifion. Dyma un hanes am glaf yn ymwneud â gwasanaethau Iaith a Lleferydd, a rannwyd gyda ni o ysgol leol. Roedden ni hefyd wedi rhannu hyn yn rhan o'n fframwaith cyfathrebu mewnol (gweler tudalen 11 uchod)

Asesiadau Effaith ar yr Iaith Gymraeg: Sgrinio a monitro newid am ei effaith ar y Gymraeg

O fis Chwefror 2024 ymlaen y flwyddyn adrodd hon, ailwampiodd BIPCTM ei broses o asesu effaith newid sefydliadol ar y Gymraeg, gan sicrhau bod methodoleg sy'n cydymffurfio yn ei lle. Mae hwn yn fecanwaith monitro a rheoli sylweddol i sicrhau bod y Gymraeg yn cael ei hystyried ar yr adeg gywir. Mae'r templed a ddefnyddiwn i asesu effaith bellach yn cynnwys y canlynol:

1. Yn gyntaf, mae'n ofynnol i'r rheolwr esbonio natur y newid (fel datblygiad, polisi, strategaeth, cynllun neu unrhyw weithgaredd perthnasol lle mae newid) trwy gyfres o gwestiynau strwythuredig;
2. Yn ail, mae'n ofynnol wedyn i'r rheolwr amlinellu'r effaith bosibl ar y Gymraeg gan ddefnyddio'r canllawiau a ddarperir. Mae'r canllawiau hynny'n cyfeirio at yr holl ddeddfwriaeth a pholisi perthnasol ar gyfer y Gymraeg yn GIG Cymru;
3. Yn drydydd, mae'n ofynnol i'r rheolwr nodi a fyddai'r effaith a nodwyd yn cael effaith Bositif, Niwtral neu Negyddol ar y Gymraeg;
4. Yn olaf, mae'n ofynnol i'r rheolwr nodi pa gamau y bydd yn eu cymryd i gynyddu'r effeithiau cadarnhaol ar y Gymraeg, neu ba gamau y bydd yn eu cymryd i liniaru neu nacáu unrhyw effeithiau negyddol a nodir.

Mae templedi polisi, papurau clawr blaen a thempledi adroddiadau hefyd wedi'u newid, gan sicrhau ei bod yn bosibl canfod a yw penderfyniadau neu adroddiadau a roddwyd gerbron cyfarfodydd uwch reolwyr, cyfarfodydd pwyllgor a chyfarfodydd y Bwrdd wedi bod yn destun Asesiad o'r Effaith ar y Gymraeg yn benodol, a beth yw canlyniad yr asesiad hwnnw.

Amlinellir isod yr Asesiadau o'r Effaith ar y Gymraeg a gwblhawyd ers ailwampio'r broses hon. Bydd y broses o fonitro cyfradd cwblhau ac ansawdd yr asesiadau hyn yn ffocws ar gyfer y flwyddyn adrodd nesaf yn unol â'r cynllun gweithredol ar gyfer Gwasanaethau Cymraeg, nawr bod y fethodoleg asesu yn ddigonol.

Disgrifiad byr	**Crynodeb o effaith**	**Canlyniad yr asesiad**	**Camau gweithredu gofynnol**
Polisi Cynnig Rhagweithiol y Gymraeg (gweler uchod)	Cynlluniwyd y polisi hwn i gael effaith sylweddol ar y Gymraeg gan ei fod yn bolisi a ysgrifennwyd yn benodol i gynyddu'r ddarpariaeth ragweithiol o wasanaethau dwyieithog, yn yr achos hwn yn achos derbyn cleifion mewnol. Gan fod y polisi ei hun yn ofynnol o dan Safonau'r Gymraeg, mae'r polisi ei hun yn amlinellu effaith y polisi hwn yn fanwl. Pan gaiff ei weithredu, bydd y polisi yn cael effaith gadarnhaol sylweddol ar y Gymraeg.	CADARNHAOL	Ni nodwyd unrhyw gamau pellach oherwydd natur y polisi.

Polisi a Gweithdrefn Absenoldeb o'r Gwaith o dan Adran 17 y Ddeddf Iechyd Meddwl	Nid yw'r polisi arfaethedig yn effeithio ar siaradwyr Cymraeg. Mae'r holl daflenni a ffurflenni gwybodaeth i gleifion ar gael yn y Gymraeg a'r Saesneg a sefydlir dewis iaith y claf pan fydd yn cael ei gadw'n gyntaf dan y Ddeddf.	NIWTRAL	Dim wedi'i nodi, fodd bynnag mae dogfennau perthnasol eisoes yn ddwyieithog a'r drefn dderbyn yn cynnwys gofyn am anghenion iaith
Polisi Cynllun Dirprwyo Rheolwyr Ysbytai	Mae'n ofynnol i'r polisi sicrhau bod gan y Bwrdd Iechyd drefniadau llywodraethu priodol ar waith i fonitro ac adolygu'r modd y mae swyddogaethau'n cael eu harfer a bod cydymffurfiaeth â gofynion statudol Deddf Iechyd Meddwl 1983 yn unol â'r fframwaith cyfreithiol ac arfer da.	NIWTRAL	Ni nodwyd dim.
Adran 132, 132A a 133 Polisi Hawl Cleifion i Wybodaeth	Nod y polisi hwn yw rhoi i staff y cyfrifoldeb dirprwyedig o dan y Ddeddf Iechyd Meddwl, gyda'r wybodaeth i ymgymryd â'r cyfrifoldebau hynny. Yr amcan yw sicrhau bod gan staff y wybodaeth a'r offer angenrheidiol i sicrhau bod adran 132 yn cael ei hawdurdodi, ei gweithredu, ei chofnodi a'i monitro yn unol â gofynion deddfwriaethol ac arfer da.	NIWTRAL	Ni nodwyd dim.

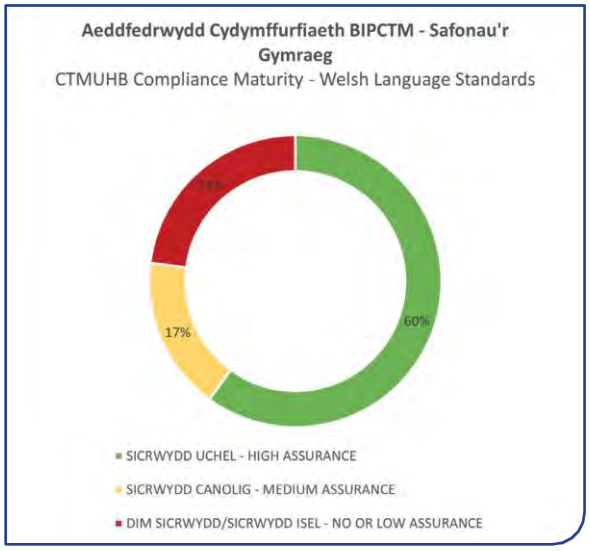
Traciwr Cydymffurfiaeth y Gymraeg

Mae'r data uchod o sawl ffynhonnell fonitro, gan gynnwys yr archwiliad hapsampl, archwiliadau arsylwi, archwiliadau adrannol, ymweliadau safle, data o gyfieithu, PREMs ac asesiadau o'r effaith ar y Gymraeg yn caniatáu i ni gynnal Traciwr Cydymffurfiaeth y Gymraeg sy'n olrhain cynnydd o ran cydymffurfio â'r holl Safonau. Mae'n cofnodi cydymffurfiaeth ar gyfer pob safon gan ddefnyddio'r fframwaith a ganlyn:

Sicrwydd Uchel	Mae'r sefydliad yn cydymffurfio â'r holl ofynion o dan bob amgylchiad ac eithrio ar adegau prin.
Sicrwydd Canolig	Mae'r sefydliad yn cydymffurfio'n llawn fel arfer, ond mae diffyg cydymffurfiaeth ar rai adegau neu o ran rhai gofynion
Sicrwydd Isel	Mae'r sefydliad yn cydymffurfio ar rai adegau neu o ran rhai o'r gofynion, ond ddim yn cydymffurfio'n llawn ac yn gyson
Dim Sicrwydd	Nid yw'r sefydliad yn cydymffurfio â'r gofynion o gwbl, neu mae'n cydymffurfio ar adegau prin neu o ran ychydig o agweddau'n unig

Mae BIPCTM yn gallu cofnodi Sicrwydd Uchel gyda 60% o'r holl Safonau a Sicrwydd Canolig gyda 17% ohonynt . Darperir manylion monitro pellach yn Atodiad 1, gan gynnwys asesiad sicrwydd unigol ar gyfer pob safon y mae'n rhaid i BIPCTM gydymffurfio â hi.

O ran Safonau 8, 9, 10, 16 a 106 lle adroddir Dim Sicrwydd a Sicrwydd Canolig yn Atodiad 1, derbyniodd BIPCTM hysbysiad gorfodi yn dilyn ymchwiliad ym mis Awst 2023. Roedd yn ofynnol wedyn i BIPCTM gyflwyno cynllun gweithredu i Gomisiynydd y Gymraeg o dan Adran 80 o Fesur y Gymraeg (Cymru) 2011 a gymeradwywyd ganddi, gyda'r holl gamau i'w cwblhau erbyn Rhagfyr 2024. Mae cynnydd ar gyflawni'r camau gweithredu hynny yn cael ei fonitro a bydd ein hadroddiad blynyddol nesaf yn dangos sut rydyn ni wedi cwblhau'r camau hynny.



Thema 3: Profiad
Gweithwyr a'n Gweithle Dwyieithog

Mae diwylliant Cymraeg ffyniannus, yn rhan o dapestri cyfoethog o ieithoedd a diwylliannau, yn gwneud BIPCTM yn lle unigryw i weithio, a thros amser bydd yn golygu gwell gwasanaethau Cymraeg i'n cleifion a defnyddwyr gwasanaethau. Bydd hefyd yn caniatáu amgylchedd mwy cynhwysol i'r cannoedd o'n staff sy'n siarad Cymraeg ddatblygu. Mae'r thema hon yn edrych ar y gwaith rydyn ni yn ei wneud i blethu'r Gymraeg i bob agwedd o'n bywyd sefydliadol.

Ein gwerthoedd a'n hymddygiadau

Mae ein gwerthoedd a'n hymddygiad sefydliadol yn ffurfio fframwaith sy'n annog yr ymddygiadau cywir yn y gwaith. Y rhain yw:

- Rydym yn gwrando, yn dysgu ac yn gwella;
- Rydym yn trin pawb â pharch;
- Rydym i gyd yn gweithio fel un tîm…

Mae'r gwerthoedd hyn yn meithrin diwylliant o ddysgu, sy'n ffafriol i ddatblygu sgiliau Cymraeg yn y gwaith. Maen nhw hefyd yn meithrin diwylliant o barch a dealltwriaeth, sy'n hanfodol ar gyfer gwahanol ieithoedd, gan gynnwys y Gymraeg, i gael eu defnyddio a'u mwynhau. Yn olaf, maen nhw'n annog cydweithrediad a thimau effeithiol ac iach, sy'n hanfodol i'r Gymraeg ddatblygu a ffynnu.

Maen nhw'n ymddangos ar hyd a lled BIPCTM o fyrddau gwaith i waliau, ac maen nhw'n ddwyieithog.

Dechrau gweithio yn BIPCTM

O wneud cais am swydd i gael cyfweliad yn Gymraeg, mae'r prosesau a'r systemau sydd gan BIPCTM yn ei gwneud hi'n gynyddol bosibl i ddefnyddio'r Gymraeg o ddechrau cyflogaeth unigolyn.

Agwedd	Beth rydyn ni'n ei wneud
Disgrifiadau swydd a hysbysebion dwyieithog	Mae swyddi sydd newydd eu bandio yn cael eu cyfieithu fel bod gan y rheolwr y ddau ddisgrifiad swydd yn rhagweithiol i'w hysbysebu
Gwneud cais am swydd	Mae Trac, y system recriwtio a ddefnyddir gan GIG Cymru, yn nodi y gall ymgeiswyr wneud cais yn Gymraeg. Dydy hi ddim yn bosibl pennu dyddiadau cau gwahanol ar gyfer swyddi yn seiliedig ar iaith y cais a chaiff pob ymgeisydd ei hysbysu o'r penderfyniad a wneir trwy Trac ar yr un pryd.
Cynnig cyfweliad yn Gymraeg yn rhagweithiol	Mae Trac yn gofyn i ymgeiswyr a ydyn nhw'n dymuno cael cyfweliad yn Gymraeg.
Rhoi gwybod i ymgeiswyr am ganlyniad yr asesiad	Pan fydd ymgeiswyr yn gwneud cais yn Gymraeg, maen nhw'n derbyn gwybodaeth o system Trac yn Gymraeg am y canlyniad (yn eu hysbysu a ydyn nhw wedi bod yn llwyddiannus neu'n aflwyddiannus wrth gael eu dewis ar gyfer cyfweliad, ac a ydyn nhw wedi cael cynnig y swydd). Mae ceisiadau cyfieithu a dderbynnir hefyd yn awgrymu bod rheolwyr yn sicrhau eu bod yn anfon gohebiaeth ddwyieithog at ymgeiswyr lle maen nhw'n cyfathrebu â nhw y tu allan i Trac.
Cynnig y cytundeb yn Gymraeg	Pan fydd ymgeiswyr yn gwneud cais yn Gymraeg, maen nhw'n derbyn eu contract cyflogaeth yn Gymraeg yn awtomatig drwy e-bost pan gynigir y swydd iddyn nhw.

Mae BIPCTM yn cydnabod bod gyda ni fwy i'w wneud yn y maes hwn, yn enwedig o ran swydd ddisgrifiadau a hysbysebion, ond mae'r uchod yn gyfraniad mawr at hwyluso'r defnydd o'r Gymraeg ar ddechrau cyflogaeth i aelodau newydd o staff.

Cyfathrebu mewnol o amgylch y Gymraeg

Disgrifion ni'r fframwaith cyfathrebu mewnol ar gyfer y Gymraeg a'n hymgyrch Hiraeth yn fanwl uchod ond at ddibenion y drydedd thema hon, mae'n bwysig nodi bod cyfathrebu mewnol yn cael effaith fawr ar ethos sefydliad. Mae cynnwys negeseuon cyson am y Gymraeg felly yn ychwanegu yn ei ffordd ei hun at ein diwylliant sefydliadol dwyieithog.

Ymsefydlu corfforaethol

Mae ymsefydlu corfforaethol yn gyfle pwysig i wreiddio ein gwerthoedd a'n disgwyliadau sefydliadol ynghylch ymddygiad ymhlith gweithwyr newydd, ac yn ffordd o sicrhau eu bod yn deall ein hymagwedd at wasanaethau dwyieithog yn BIPCTM. Mae'r fideo croeso ar ddechrau'r rhaglen ymsefydlu gorfforaethol yn ddwyieithog gyda'r Gymraeg a'r Saesneg yn llinyn cyson drwy'r cynnwys, gyda staff yn defnyddio'r Gymraeg a'r Saesneg mewn un fideo unigol. Mae hyn yn anfon neges glir bod BIPCTM yn sefydliad lle mae'r Gymraeg a'r Saesneg yn cael eu defnyddio a'u parchu'n gyfartal, gydag ethos ddwyieithog iach.

Mae ein fideo sy'n benodol ar gyfer yr elfen Gymraeg, 'Cymraeg yn CTM' a grëwyd yn broffesiynol, yn cael ei ddefnyddio fel rhan o ymsefydlu corfforaethol. Neges greiddiol y fideo yw bod y Gymraeg yr un mor bwysig i ni ag ydy hi i lawer yn y cymunedau rydym yn gofalu amdanyn nhw ac yn eu gwasanaethu. Mae hefyd yn annog staff i ddefnyddio'r Gymraeg sydd gyda nhw. Mae'r fideo yn egluro pa gymorth sydd ar gael i staff ddefnyddio'r Gymraeg yn y gwaith a pha adnoddau sydd ar gael, gan dargedu'r rhwystrau hynny a nodir yn aml gan staff gofal iechyd rhag gwneud mwy yn Gymraeg. Gan ddefnyddio hanesion cleifion a thystiolaeth staff, mae'r fideo yn arf arall yn ein harfdy newid ymddygiad.

Eleni rydyn ni hefyd wedi datblygu Taflen Groeso, sy'n cael ei hanfon at bob dechreuwr newydd, yn nodi ein cynnig i staff (Dysgu Cymraeg, cyfieithu ac adnoddau), beth sydd angen i staff ei wneud ar ddechrau eu cyflogaeth (nodi eu sgiliau Cymraeg ar ESR, cwblhau'r cwrs ymwybyddiaeth iaith a chwblhau'r cwrs Cymraeg Cwrteisi 2 awr) a lle i fynd am gyngor a chymorth pellach. Mae hefyd wedi'i hychwanegu at yr adran ymsefydlu corfforaethol ar y Gymraeg.

Croeso!

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Tri pheth 'dyn ni'n wneud

Croeso i'n Bwrdd Iechyd a llongyfarchiadau ar dy swydd newydd!

Cymraeg – mae'n perthyn i ni i gyd. Rydyn ni'n annog pawb i rannu'r Gymraeg sydd gyda nhw a does dim y fath beth â 'rhugl'! Defnyddia'r Gymraeg sydd gyda ti yw'r neges.

Felly sut ydyn ni'n cefnogi hyn?

1. **Eisiau ailafael yn dy Gymraeg?** Mae pob math o gyrsiau codi hyder ar gael, yn rhad ac am ddim. Anfona neges aton ni **yma** am hyn. Dyn ni'n trefnu sesiynau sgwrsio hefyd yn gyson felly dere i ddweud shw mae, gweler yma.
2. **Siop cyfieithu un stop:** Rho gynnig ami yw'r neges a chyfieithu beth sydd 'da ti a gallwn daflu golwg drosto fe i ti os hoffet ti. Gallwn gyfieithu unrhyw beth i ti hefyd, dim ond anfon gair aton ni sydd eisiau, **yma**.
3. **Adnoddau am ddim:** O laniaradau i fathodynnau Cymraeg i bosteri a chardiau ymadrodd, mae popeth 'da ni. Rho wybod yma os hoffet ti adnoddau. Dyn ni'n dy annog dî yn arbennig i gymryd laniard neu fathodyn – rhanna dy Gymraeg a dangos i bobl dy fod ti'n siarad ein hiaith! Archeba laniard, bathodyn neu adnoddau **yma** a bydd e 'da ti mewn dim o dro.

Tri pheth rwyt ti'n wneud

Dyn ni'n gofyn am dîl pheth bach gan bob aelod newydd o staff

1. **Cwblhau dy wybodaeth iaith ar ESR:** Rho wybod i ni am dy sgiliau iaith ar ESR, fel ein bod yn gwybod faint o staff Cymraeg sydd gyda ni. Mae'n hawdd iawn gwneud, gweler sut **yma**.
2. **Cwblhau'r cwrs ymwybyddiaeth iaith:** Rwyt ti'n darllen hwn yn Gymraeg, felly bydd dî'n gwybod pa mor bwysig yw'n hiaith ni. Ond mae lot o bethe yn y cwrs ymwybyddiaeth iaith ar ESR fydd yn newydd i lawer o bobl, 'sdîm ots faint o Gymraeg sydd 'da nhw. Mae ar gael o dan 'My e-Learning' neu 'Fy e-Ddysgu' os yw dy ESR yn Gymraeg, ac enw'r cwrs yw *'110e-Learning Certification Welsh Language Awareness More than just words (Level 1)'*
3. **Rhanna dy Gymraeg:** Rwyt ti'n deall hyn felly does dîm disgwyl i ti wneud y Sesiwn Blasu fel cydweithwyr sydd hieb lot o Gymraeg ar hyn o bryd. Ond beth am rannu dy Gymraeg gyda nhw, i annog mwy o ddefnydd ar ein hiaith gyda'n gilydd a chefnogi cydweithwyr i ddefnyddio'r Gymraeg sydd gyda nhw, hyd yn oed geiriau bach fel 'bore da'?

Eisiau gwybod mwy?

1. **Ein canllaw:** Dyn ni wedi creu'r canllaw defnyddiol hwn yn **Gymraeg** a **Saesneg** am beth dyn ni'n wneud yn ddwyieithog yn BIP CTM.

   Os nwyt ti angen gwybod beth dyn ni'n wneud yn ein dwy iaith ni yn y gwaith o ddydd i ddydd gydag enghreifftiau gan gydweithwyr, dyma'r canllaw i ti.
2. **Ein tudalen SharePoint:** Picia draw

   Dere draw **yma** - mae adnoddau i'w lawrlwytho yma, gwybodaeth am sut allî dî ddefnyddio'r Gymraeg yn y gwaith mewn technoleg ac atî, a chanllawiau mwy manwl i reolwyr am bethau penodol fel cyfathrebu ac ymgysylltu a recriwtio.
3. **Am gael sgwrs bach?** Anfona neges

   Os yw'n well 'da ti gael sgwrs, rho wybod i ni **yma** neu trefna slot. Bydden ni wrth ein boddau yn cwrdd â ti.

Pob lwc yn dy swydd newydd a chroeso mawr unwaith eto i Fwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Cymraeg

Y dirwedd ieithyddol a'n hunaniaeth gorfforaethol

Mae amgylchedd gweledol dwyieithog yn annog pobl i ddefnyddio'u Cymraeg ac yn dangos ein hymrwymiad i'r Gymraeg a'i defnydd. Mae pob arwydd parhaol ar draws ein safleoedd yn ddwyieithog. Yn gynyddol, mae arwyddion dros dro yn y gweithle hefyd yn ddwyieithog gan gynnwys mewn meysydd pwysig fel y ffreutur. Eleni, derbyniwyd dros 60 o geisiadau am arwyddion dros dro. Mae'r mannau cymunedol hyn yn bwysig gan fod yr holl staff yn treulio eu hamser yno ar ryw adeg yn ystod eu diwrnod gwaith.

Mae ein hunaniaeth gorfforaethol, yn fewnol ac yn allanol, hefyd yn cyfrannu at ein hethos dwyieithog. Mae detholiad o logos i'w gweld isod sy'n dangos bod y mwyafrif helaeth o enghreifftiau o gyflwyno ein hunaniaeth gorfforaethol, yn fewnol ac yn allanol, wedi ymgorffori'r Gymraeg.

Cyfarfodydd mewnol

Eleni datblygon ni adnodd newydd i hwyluso'r defnydd o'r Gymraeg mewn cyfarfodydd, yn cynnwys canllaw ar y ffordd orau o drefnu a chynnal cyfarfodydd dwyieithog ac arfer gorau, ymadroddion allweddol yn Gymraeg a fideo yn arddangos cyfarfod dwyieithog. Bydd y fideo hwn yn cefnogi staff ar sut i ddefnyddio ymadroddion allweddol a gweld cyfarfod model yn Gymraeg i gyfeirio ato.

Polisïau gweithlu mewnol a phrotocolau gweithlu

Mae polisïau'r gweithlu sy'n ymwneud ag agweddau hanfodol ar fywyd fel gweithiwr yn BIPCTM ar gael yn Gymraeg, gan gynnwys polisïau sy'n ymwneud ag ymddygiad yn y gweithle, iechyd a lles yn y gwaith, cyflogau a buddion yn y gweithle, rheoli perfformiad, absenoldeb o'r gwaith, amodau gwaith a patrymau gwaith. Cân nhw eu cyhoeddi ar ein mewnrwyd.

Mae Polisi a Gweithdrefn Disgyblu Cymru Gyfan yn nodi y gall gweithwyr ymateb i honiadau yn eu herbyn yn Gymraeg, ac mae Polisi Parchu a Datrys Cymru Gyfan yn nodi y gall gweithwyr gwyno am rywun yn Gymraeg, ymateb i gŵyn yn Gymraeg a bod yn rhaid i unrhyw achos gael ei gynnal yn Gymraeg pan fo cyflogai wedi arfer yr hawl hon. Mae Polisi Mynegi Pryderon Cymru Gyfan hefyd yn nodi y gall unigolyn godi mater neu bryder yn Gymraeg ac y dylid ei hysbysu o hyn o'r cychwyn cyntaf. Mae hefyd yn nodi y dylid cynnal unrhyw drafodion dilynol yn Gymraeg neu ddarparu gwasanaeth cyfieithu ar y pryd.

Model Cymhwysedd Arweinyddiaeth

Yn dilyn gwaith i adnewyddu a diweddaru ein harlwy arweinyddiaeth ar gyfer rheolwyr yn BIPCTM, yn rhan o'n Cynllun Diwylliant ar gyfer y sefydliad, mae Model Cymhwysedd Arweinyddiaeth wedi'i ddatblygu. Mae'r model hwn ar hyn o bryd yn gweithio ar sail deg cymhwysedd craidd yn ymwneud ag Arwain eich Hun, Arwain Eraill ac Arwain Systemau. Un o'r deg cymhwysedd hynny yw 'Cynhwysiant' a bydd hyn yn cynnwys cymwyseddau penodol yn ymwneud â'r Gymraeg ar gyfer rheolwyr ac arweinwyr Band 6, 7 ac 8. Bydd gwaith yn parhau dros y cyfnod adrodd nesaf ar y cynnwys hwnnw ar gyfer y Gymraeg. Mae hwn yn gam cyffrous ymlaen i'r Gymraeg

a bydd yn cyfrannu at ddiwylliant o gydymffurfio â Safonau ond hefyd yn cyfrannu at ddiwylliant Cymraeg ffyniannus.

TG a meddalwedd

Mae BIPCTM yn defnyddio Microsoft ar ei beiriannau gwaith sy'n ein galluogi i gynnig meddalwedd gweithle cyffredin yn Gymraeg. Mae ein tudalen SharePoint Cymraeg yn hyrwyddo'r gallu i ddefnyddio MS Office ac MS Teams yn Gymraeg ac yn cynnwys cyfarwyddiadau ar sut i'w newid.

Mae gwiriwr sillafu Cymraeg hefyd ar gael i'w lawrlwytho o'r Ganolfan Feddalwedd ar bob cyfrifiadur a gliniadur ar gyfer ein staff.

Mae ein Desg Gymorth TG hefyd yn cynnig y gallu i siarad ag aelod o TG yn Gymraeg wrth ffonio ac yn cynnwys cyfarchiad dwyieithog. Mae TG hefyd wedi creu ffurflen ddwyieithog ar gyfer dechreuwyr newydd i'w sefydlu gyda TG.

Mae sut rydym yn defnyddio'r Gymraeg yn fewnol a'n hethos dwyieithog mewnol yn faes sy'n datblygu ar gyfer BIPCTM ac mae'r gwaith sydd wedi'i gynnwys yn ein cynllun gweithredol ar gyfer y Gymraeg ar gyfer 2024/25 yn cynnwys gwaith pellach yn y maes hwn.

Thema 4: Llywodraethu ac Atebolrwydd

Mae'r fffordd rydyn ni'n cyfathrebu â staff ac yn eu cefnogi, y prosesau sydd yn eu lle i ddatblygu'r Gymraeg yn strategol yn ein sefydliad a chreu ethos dwyieithog yn y gwaith yn dri ffactor holl bwysig i ddatblygu'r Gymraeg yn BIP CTM.

Mae'r bedwaredd thema sy'n dod â hyn ynghyd, sef llywodraethu **ac atebolrwydd, yn cyfeirio at y strwythurau sydd gyda ni ar waith i fonitro cynnydd, y prosesau sicrwydd a goruchwyliaeth briodol sydd ar waith i sicrhau ein bod yn bodloni ein gofynion cyfreithiol, a'n hymagwedd at risgiau** polisi pan fyddwn o bosibl yn methu â **bodloni'r gofynion hynny. Mae'r thema** hon yn ymwneud â gwybod pa mor dda **rydyn ni'n gwneud, gwybod lle mae angen i ni wella, a rhoi'r strwythurau cywir yn eu lle i ysgogi gwelliant a herio lle bo angen.**

Grŵp Llywio'r Gymraeg

Rôl Grŵp Llywio'r Gymraeg yw arwain yn strategol i wella'r amgylchedd sy'n cefnogi ac yn gwerthfawrogi'r Gymraeg a'i rôl wrth ddarparu gwasanaethau diogel ac o ansawdd uchel i'n cleifion. Mae'r grŵp yn cynnwys uwch-arweinwyr o bob Grŵp Gofal sydd â'r dylanwad a'r awdurdod i sicrhau newid yn eu meysydd, yn ogystal ag uwch-glinigwyr sy'n gwerthfawrogi'r Gymraeg yn y sefydliad ac sy'n gallu gweithredu fel hyrwyddwyr dylanwadol yn y meysydd clinigol.

Mae agendâu'r Grŵp yn caniatáu i uwch arweinwyr y Bwrdd lechyd ganolbwyntio ar feysydd a blaenoriaethau penodol, ac yn hwyluso cynnal fforwm lefel uchel lle gellir trafod y Gymraeg a diwylliant Cymru a chynllunio a chytuno ar waith i ymgorffori'r Gymraeg ymhellach, gan gynnwys y cynllun gweithredol blynyddol ar gyfer gwasanaethau Cymraeg. Mae cylch gorchwyl y Grŵp yn llywodraethu gweithgareddau'r Grŵp.

Llwybr atebolrwydd ar gyfer cydymffurfio â deddfwriaeth Gymraeg

Mae Grŵp Llywio'r Gymraeg yn rhoi cyngor a sicrwydd i'r Bwrdd a'r is-bwyllgorau mewn perthynas â chydymffurfiaeth y sefydliad â'n dyletswyddau statudol Safonau'r Gymraeg, i sicrhau nad ydym yn trin y Gymraeg yn llai ffafriol na'r Saesneg, ac yn sicrhau cynnydd gyda cynllun strategol Mwy na Geiriau. Rhoddir sicrwydd trwy adroddiadau ysgrifenedig ddwywaith y flwyddyn i'r Pwyllgor Pobl a Diwylliant, un o is-bwyllgorau'r Bwrdd. Mae hyn yn darparu llwybr atebolrwydd cadarn ar gyfer adrodd ar gynnydd a risgiau mewn perthynas â chydymffurfiaeth i'r Bwrdd.

Yn ystod y flwyddyn adrodd hon darparwyd dau adroddiad ysgrifenedig a llafar i'r Pwyllgor Pobl a Diwylliant, un ym mis Awst 2023 ac un ym mis Chwefror 2024. Rhannwyd y traciwr cydymffurfio a drafodir uchod ar dudalen 37 hefyd yn adroddiad mis Chwefror, gan roi trosolwg llawn o'r cynnydd presennol a'r meysydd risg, yn ogystal â'r hysbysiad penderfyniad a chynllun gweithredu yn dilyn camau gorfodi a dderbyniwyd ym mis Awst 2023.

Am y tro cyntaf yng nghyfarfod mis Chwefror, darparwyd yr adroddiad amlygu ysgrifenedig a llafar yn Gymraeg. Cododd hyn statws y Gymraeg yn sylweddol yn y Bwrdd lechyd, a dyma'r tro cyntaf i'r Gymraeg gael ei defnyddio mewn cyfarfod ffurfiol o Bwyllgor y Bwrdd yn rhan o'i drefniadau adrodd.

Y Gymraeg mewn cyfarfodydd uwch reolwyr

Ar wahân i adroddiadau ffurfiol y Pwyllgor a'r Bwrdd, mae cydymffurfiaeth â deddfwriaeth y Gymraeg a'r cymorth sydd ar gael wedi'u trafod yn ffurfiol yn y cyfarfodydd uwch reolwyr canlynol:

- Bwrdd Rheoli Gweithredol llawn BIPCTM;
- Bwrdd Gweithredol Grŵp Gofal Plant a Theuluoedd;
- Cyfarfod Llywodraethu Ansawdd Pediatreg;
- Cyfarfod Llywodraethu Ansawdd Therapïau;
- Cyfarfod Llywodraethu lechyd Meddwl ac Anableddau Dysgu;
- Fforwm Arweinyddiaeth CTM.

Cwynion

Yn ystod blwyddyn adrodd 2023-24, derbyniodd BIPCTM un gŵyn yn ymwneud ag arwyddion yn ein maes parcio ar safle Ysbyty Tywysoges Cymru. Honnodd yr achwynydd nad oedd yr arwyddion yn ddwyieithog, ond ar ôl eu harchwilio roedd y mwyafrif yn ddwyieithog. Gan fod y Bwrdd lechyd yn y broses o adnewyddu'r

cytundeb, roedd hefyd yn bosibl ymrwymo i sicrhau trwy fanyleb y tendr y byddai unrhyw nifer fechan o arwyddion dyddiedig nad ydynt yn ddwyieithog yn cael eu newid. Nid aethpwyd â'r gŵyn ymhellach.

Thema 5: Recriwtio a Chynllunio Gweithlu

Dyma'r olaf o'n pum thema a bydd gwaith o dan y thema hon yn anelu at ddadansoddi maint ein gweithlu dwyieithog a lle bo angen, cynyddu faint o'n staff sy'n siarad Cymraeg. Bydd y rhan hon o'r adroddiad hefyd yn cyhoeddi faint o staff sydd gyda ni sy'n siarad Cymraeg ac i ba lefel, a faint o swyddi rydyn ni wedi'u hysbysebu fel rhai sydd angen sgiliau yn y Gymraeg. Allwn ni ddim cynnig gwasanaeth iechyd gwirioneddol ddwyieithog i'r cyhoedd yn ardal BIP CTM oni bai bod gyda ni'r nifer cywir o staff dwyieithog; mae'r thema olaf hon yn cydnabod hyn ac yn manylu ar sut rydyn ni'n gweithio i adeiladu ein sylfaen o staff sy'n siarad Cymraeg.

Ein gweithlu dwyieithog

Mae disgwyl i holl staff BIPCTM nodi eu sgiliau iaith ar ESR, ein system gwybodaeth gweithlu. Gwnawn hyn drwy nodi a oes gyda ni sgiliau ysgrifennu Cymraeg, sgiliau gwrando/siarad yn Gymraeg a sgiliau darllen yn Gymraeg, ac ar ba lefel o 0 i 5. Mae'r rhain yn golygu'r canlynol:

0: Dim gallu yn y sgil hon o gwbl,

1: Lefel Mynediad,

2: Sylfaenol

3: Canolradd,

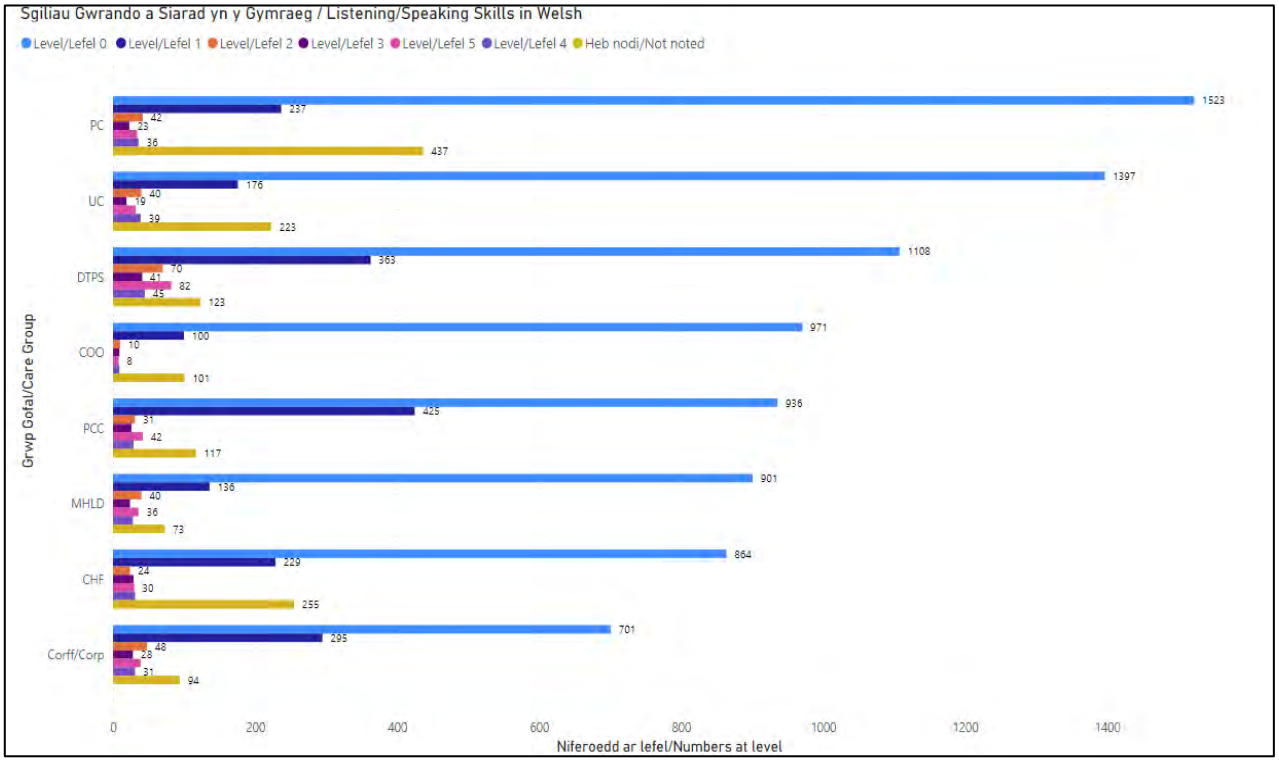
4: Uwch,

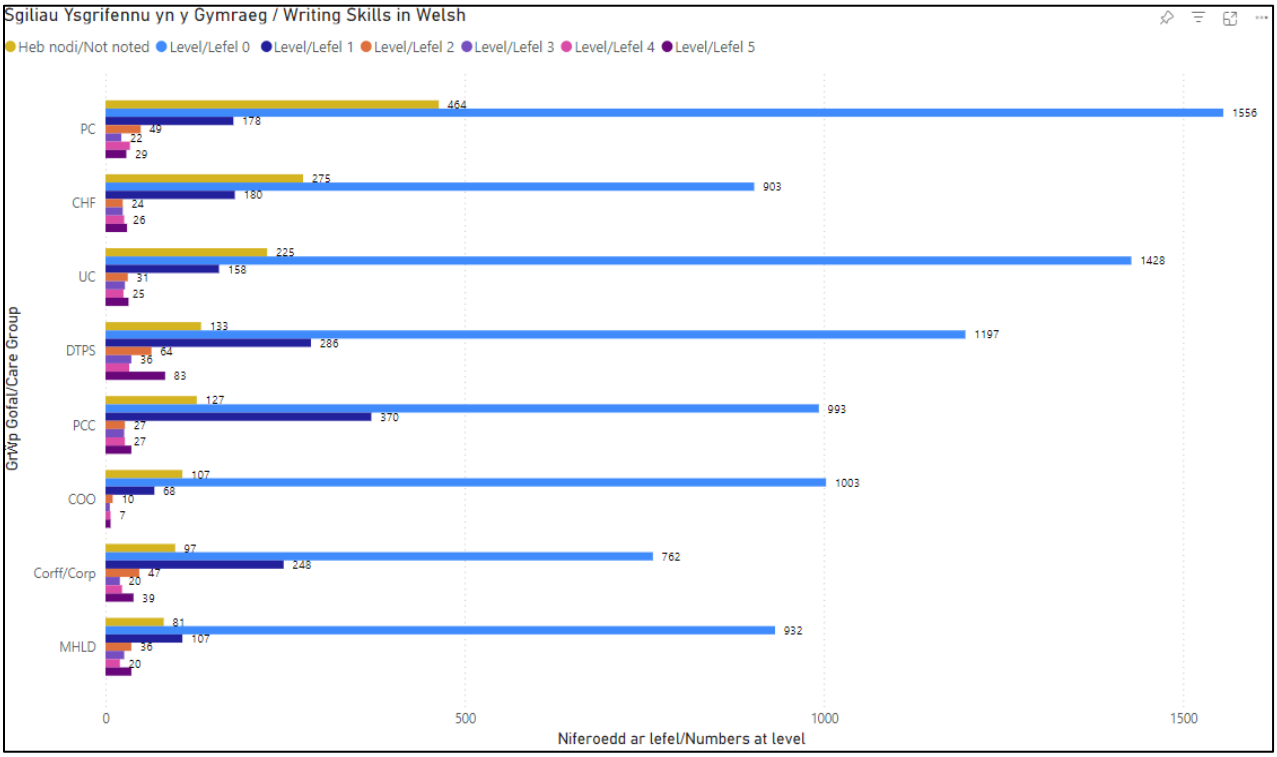
5: Hyfedredd.

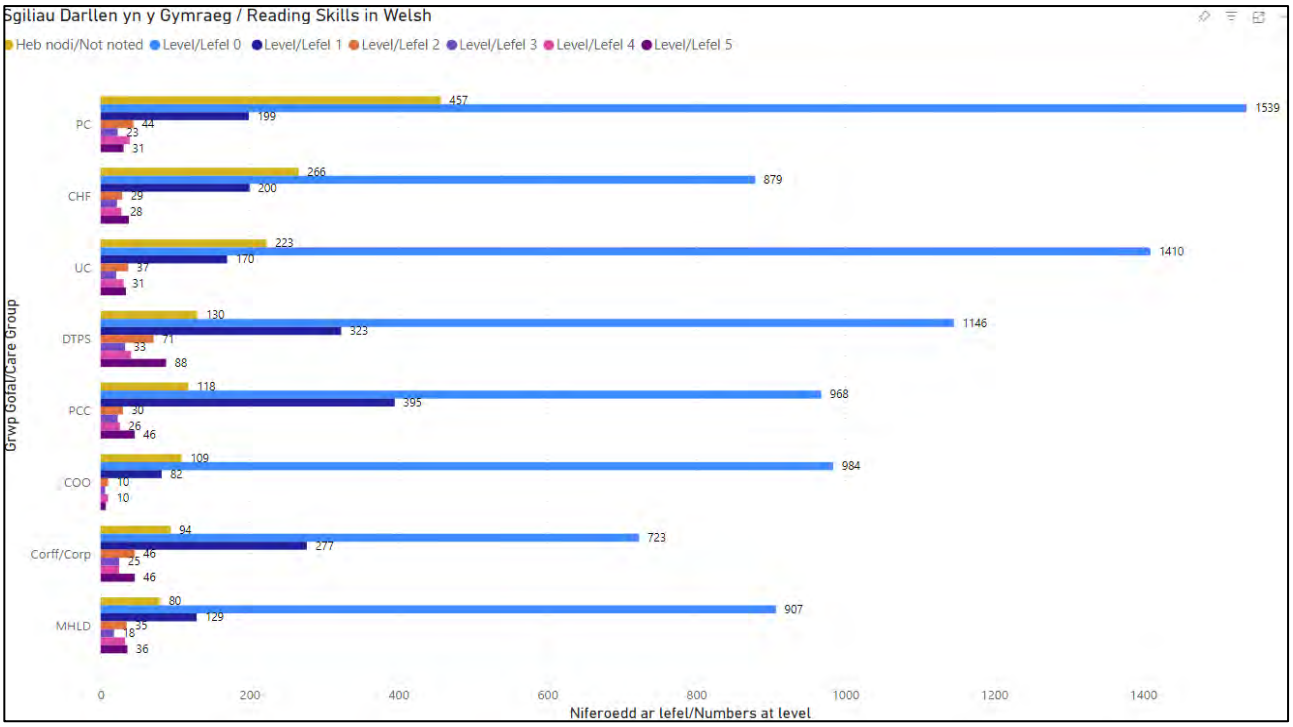
Rydyn ni wedi annog staff trwy gydol y flwyddyn i nodi eu sgiliau iaith ar y Cofnod Staff Electronig mewn cydweithrediad â chydweithwyr yn ein tîm Dysgu a Datblygu, gan dargedu'n benodol staff sydd heb gofnodi eu sgiliau. Mae gwybodaeth am sut i nodi sgiliau hefyd wedi'i chynnwys ar wefan graidd SharePoint ar gyfer Dysgu a Datblygu lle mae'r holl hyfforddiant gorfodol yn cael ei hyrwyddo. Canran y staff sydd wedi cofnodi eu sgiliau Cymraeg ar ESR yw 88% ar gyfer gwrando a siarad Cymraeg ac 88% ar gyfer ysgrifennu Cymraeg a darllen Cymraeg, sy'n gynnydd ar y llynedd pan oedd yn 80% ar gyfartaledd.

Gan droi at broffil ieithyddol gweithlu BIPCTM, mae'r graffiau isod yn dangos faint o'n staff sydd â sgiliau yn y Gymraeg mewn Gwrando/Siarad, Darllen ac Ysgrifennu ar gyfer pob Grŵp Gofal sy'n ffurfio'r Bwrdd Iechyd. Mae'r byrfoddau ar gyfer pob grŵp yn golygu'r canlynol:

- PC: Planned Care/Gofal Wedi'i Gynllunio;
- UC: Gofal Heb ei Drefnu/Gofal Heb ei Drefnu;
- DTPS: Diagnostics, Therapies, Pharmacy and Healthcare Sciences/Diagnosteg, Therapïau a Gwyddorau Iechyd;
- COO: Chief Operating Officer's Group/Grŵp y Prif Swyddog Gweithredu;
- PCC: Primary Care & Communities/Gofal Sylfaenol a Chymunedau;
- MHLD: Mental Health & Learning Disabilities/Iechyd Meddwl ac Anableddau Dysgu;
- CHF: Children & Families/Plant a Theuluoedd;
- Corporate Services/Gwasanaethau Corfforaethol.


Sgiliau Gwrando a Siarad yn y Gymraeg / Listening/Speaking Skills in Welsh
Level/Lefel 0
Level/Lefel 1
Level/Lefel 2
Level/Lefel 3
Level/Lefel 5
Level/Lefel 4
Heb nodi/Not noted
Grwp Gofal/Care Group
PC
UC
DTPS
COO
PCC
MHLD
CHF
Corff/Corp
Niferoedd ar lefel/Numbers at level
0
200
400
600
800
1000
1200
1400


Sgiliau Ysgrifennu yn y Gymraeg / Writing Skills in Welsh
Heb nodi/Not noted
Level/Lefel 0
Level/Lefel 1
Level/Lefel 2
Level/Lefel 3
Level/Lefel 4
Level/Lefel 5
Grwp Gofal/Care Group
PC
CHF
UC
DTPS
PCC
COO
Corff/Corp
MHLD
Niferoedd ar lefel/Numbers at level
0
500
1000
1500



O ran ein gallu i gynnig gwasanaethau yn Gymraeg, bydd staff gyda lefel 4 mewn sgil yn gyffredinol yn gallu defnyddio'r sgil hon yn y rhan fwyaf o sefyllfaoedd gyda chleifion a chydweithwyr, a dyna pam mai 'Uwch' yw enw'r lefel. Gellir casglu'n rhesymol o ganlyniad mai'r nifer o staff yn BIPCTM sy'n gallu siarad Cymraeg ar hyn o bryd yw 551 o leiaf (o'r rhai sydd wedi cofnodi eu sgiliau), wrth gyfuno'r staff hynny sydd wedi nodi Lefel 4 neu 5 ar gyfer gwrando/siarad.

Wrth i ni wella nifer y staff sydd wedi cofnodi eu sgiliau yn y Gymraeg, gwelir cynnydd flwyddyn ar ôl blwyddyn yn niferoedd y staff sydd â sgiliau yn y Gymraeg.[5]

Lefel	Gwrando/Siarad yn Gymraeg			
	2022/23	2023/24	Gwahaniaeth	Gwahaniaeth fel %
Lefel 0	7740	8401	+661	+8.5%
Lefel 1	1871	1961	+90	+4.8%
Lefel 2	295	305	+10	+3.4%
Lefel 3	197	199	+2	+1%
Lefel 4	223	248	+25	+11%
Lefel 5	284	303	+19	+6.7%

[5] Fel mewn blynyddoedd blaenorol, mae sgiliau'r staff hynny sy'n gweithio mewn cyrff lletyol wedi'u tynnu o'r data

Lefel	Darllen yn Gymraeg			
	2022/23	2023/24	Gwahaniaeth	Gwahaniaeth fel %
Lefel 0	7873	8556	+683	+8.6%
Lefel 1	1702	1775	+73	+4.3%
Lefel 2	292	302	+10	+3.4%
Lefel 3	159	171	+12	+7.5%
Lefel 4	225	233	+8	+3.5%
Lefel 5	302	326	+24	+8%
Lefel	**Ysgrifennu yn Gymraeg**			
	2022/23	**2023/24**	**Gwahaniaeth**	**Gwahaniaeth fel %**
Lefel 0	8092	8774	+682	+8.4%
Lefel 1	1511	1595	+84	+5.5%
Lefel 2	290	288	-2	-0.7%
Lefel 3	173	187	+14	+8&
Lefel 4	188	195	+7	+3.7%
Lefel 5	262	292	+30	+11%

Dyma'r drydedd flwyddyn yn olynol i'r nifer hysbys o staff sydd â sgiliau yn y Gymraeg gynyddu.

Defnyddio data gweithlu

Mae data gweithlu ar sgiliau yn y Gymraeg yn bwysig. Eleni, ychwanegwyd data ar sgiliau Cymraeg at HealthRoster, y system a ddefnyddir i gynllunio sifftiau. Ychwanegwyd yr holl staff â Lefel 3 mewn Siarad/ Gwrando ac uwch. Bydd hyn yn galluogi rheolwyr i wybod pa rai o'u staff sy'n siarad Cymraeg a byddai'n caniatáu iddyn nhw gynllunio sifftiau yn unol â hynny lle bo angen. Bydd hyn hefyd yn hwyluso cydymffurfiaeth â'n Polisi Derbyn Cleifion Mewnol o dan Safon 24 a ddisgrifir uchod.

Asesu a hysbysebu swyddi

Mae nifer y swyddi a hysbysebwyd gan BIPCTM a'r sgiliau Cymraeg yr oedd eu hangen ar gyfer y swyddi hynny isod.

Sgiliau yr oedd eu hangen yn y Gymraeg ar gyfer swyddi	
Categori sgiliau	**Nifer**
Sgiliau yn Gymraeg yn hanfodol	9
Sgiliau yn Gymraeg yn ddymunol	2757
Angen dysgu sgiliau Cymraeg wrth benodi i'r swydd	0
Sgiliau Cymraeg heb fod yn angenrheidiol	215
Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2023 - 31/03/2024	2981

Y gofyniad yw bod BIPCTM yn cynnal asesiad ystyrlon o'r sgiliau iaith sydd eu hangen ar gyfer swydd, cyn dewis y categori priodol a'i hysbysebu felly. Nid yn unig mae nifer y swyddi lle mae angen sgiliau yn y Gymraeg wedi aros tua'r un peth (9 eleni, 10 y llynedd), ond mae nifer y swyddi lle mae sgiliau Cymraeg yn hanfodol yn dal yn isel. Mae'r math o swyddi y penderfynodd y rheolwr nad oedd angen sgiliau ar eu cyfer neu a oedd yn ddymunol hefyd yn awgrymu bod angen mwy o waith.

Mae BIPCTM ar hyn o bryd yn gweithio drwy gynllun gweithredu sylweddol, y rhan fwyaf ohono'n ymwneud â sut rydym yn trin y Gymraeg wrth recriwtio. Y dyddiad cau ar gyfer cyflwyno tystiolaeth ein bod wedi cwblhau'r gwaith hwnnw yw Rhagfyr 2024.

Eleni rydyn ni hefyd wedi ei gwneud yn ofynnol i bob dechreuwr newydd feddu ar o leiaf 'Cymraeg ar lefel cwrteisi' neu ddysgu unwaith y mae yn y swydd. Bydd hyn yn gwneud gwahaniaeth sylweddol i sgiliau ein gweithlu yn y Gymraeg, ac fel y nodir isod, rydyn ni ar hyn o bryd yn cynnig cwrs mewnol i hwyluso hyn.

Er bod gwaith i'w wneud, mae'n bwysig cofio, oherwydd data gwell, ei bod wedi dod yn amlwg ei bod yn ymddangos bod gan BIPCTM nifer fawr o staff sy'n siarad Cymraeg a lle mae angen i ni gynyddu'r nifer hwnnw, mae gwaith ar y gweill.

Dysgu Cymraeg yn y Gwaith

Mae gwybod faint o staff sy'n siarad Cymraeg sydd gennym a recriwtio pobl gyda'r sgiliau cywir i'r swydd yn hanfodol ac mae gwaith wedi bod yn mynd rhagddo yn y meysydd hyn. Yr un mor bwysig yw datblygu sgiliau iaith ein staff presennol. Mae dysgu Cymraeg yn y gwaith wedi cael ei grybwyll ar sawl pwynt yn yr adroddiad hwn o ran sut a ble mae cyfleoedd yn cael eu hyrwyddo. Bydd yr adran hon yn canolbwyntio ar beth rydyn ni'n ei gynnig a'r nifer sy'n manteisio arno.

- Sesiynau blasu

Rydyn ni wedi cynnig 'Sesiynau Blasu', neu sesiynau dwy awr i ddysgu hanfodion y Gymraeg drwy gydol y flwyddyn. Rydyn ni hefyd wedi dechrau cynnig y rhain yn fewnol drwy Dîm y Gymraeg sydd wedi galluogi BIPCTM i gynyddu nifer y staff sy'n gallu cymryd rhan, a bydd yn ein cefnogi i sicrhau bod gan bob aelod newydd o staff Gymraeg lefel cwrteisi o leiaf. Eleni mae **34** aelod o staff wedi cymryd rhan mewn sesiwn flasu.

- Cyrsiau hunangyfeiriedig ar-lein

Mae'r cwrs ar-lein hunangyfeiriedig, 'Croeso' gan y Ganolfan Dysgu Cymraeg Genedlaethol hefyd wedi cael ei hyrwyddo ac eleni mae **7** aelod o staff wedi cwblhau Rhan 1 a **3** wedi cwblhau Rhan 1 a 2.

- Dysgu Cymraeg yn y gymuned

Mae'n well gan rai aelodau o staff ddysgu gyda dosbarthiadau (Mynediad a Sylfaen) sy'n cael eu cynnig yn y gymuned oherwydd eu hanghenion eu hunain ond sy'n cael eu hariannu gan BIPCTM gan y byddan nhw'n defnyddio'r sgiliau hynny yn y gwaith. Eleni mae **9** aelod o staff wedi dechrau Mynediad ac **1** aelod o staff wedi dechrau Sylfaen.

- Cynllun Codi Hyder

Nod y cynllun cyffrous hwn yw cefnogi staff a allai fod â diffyg hyder i ddefnyddio'r Gymraeg sydd gyda nhw a'u cefnogi i fod yn fwy hyderus yn eu sgiliau. Dechreuodd y cynllun tua diwedd y flwyddyn adrodd ac ym mis Mawrth 2024, roedd 15 aelod o staff wedi dechrau gyda'r garfan gyntaf wedi'i llenwi. Mae hwn yn gynllun

addawol a allai gael effaith fawr ar ein nod o gael gweithlu dwyieithog a bydd carfannau pellach yn cael eu cefnogi drwy gydol 2024/25.

Mae hyn yn golygu bod 64 aelod o staff wedi cael cymorth i gamu i'r Gymraeg yn y gwaith neu drwy gyllid cyflogwr eleni gyda channoedd o oriau o ddysgu Cymraeg yn cael eu darparu. Mae hyn hefyd yn gynnydd o 22 aelod o staff ers y llynedd.

Gellir darllen effaith y cyfleoedd hyn ar ein staff isod.

Dechreuais y cwrs Dysgu Cymraeg yn ddiweddar ar ôl cael fy ysbrydoli gan gwblhau'r modiwl gorfodol ar ESR. Gan fy mod yn newydd yn fy swydd, roeddwn yn meddwl ei bod yn anhygoel bod BIPCTM yn annog, yn cefnogi ac yn cynnig ariannu'r dysgu hwn. Rydw i bob amser wedi mwynhau dysgu sgiliau newydd, ac rwy'n gobeithio y bydd gallu siarad Cymraeg yn fy ngalluogi i wella ansawdd y gofal rwy'n ei ddarparu ar gyfer fy nghleifion sy'n siarad Cymraeg, gan hybu cynhwysiant a gwneud gwahaniaeth i'w profiad o dderbyn gofal iechyd o fewn BIPCTM.
Rydw i wedi ffeindio'r hyblygrwydd o ran dysgu ar-lein drwy'r ystafell ddosbarth ar Teams yn wych, gan fy mod yn fam sengl brysur iawn mae'n golygu fy mod yn gallu dysgu o gartref gyda bonws ychwanegol bod fy mhlant yn gwrando yn y cefndir ac yn codi geiriau Cymraeg ychwanegol sy'n cyfrannu at eu dysgu. Rwy'n mwynhau'r gwersi'n fawr, mae'r tiwtor yn ddifyr iawn ac yn gwneud y wers yn hwyl. Rwy hefyd yn mwynhau sgwrsio gyda'r myfyrwyr eraill sydd o bob rhan o'r byd, gan ddangos nad yw dysgu Cymraeg ar gyfer y rhai ohonom sy'n frodorol i Gymru yn unig.
Lyndsey, Nyrs Glinigol Arbenigol ar gyfer Gwiriad Iechyd yr Ysgyfaint

Os dim byd arall mae bod yn fwy ystyriol (a chynhwysol) o siarad/ysgrifennu'r hyn y galla' i yn Gymraeg pan alla i ac ar ddechrau a diwedd cyfarfodydd ac ati yn fwy na beth rwy wedi'i wneud yn fy ngyrfa hyd yma ac wedi bod yn werthfawr. Diolch yn fawr!
Yn ddienw trwy adborth traweffaith

"Rydw i wedi bod eisiau dysgu Cymraeg gyhyd ag y galla i gofio. Roeddwn i wrth fy modd yn dysgu ieithoedd yn yr ysgol, cymerais y Gymraeg ar gyfer TGAU a lefel AS ond fe wnes i adael iddo fynd gan fy mod yn ei chael hi'n anodd cydbwyso gyda fy astudiaethau eraill. Mae hyn yn rhywbeth rwy wedi difaru ers dros 20 mlynedd. Mae cael fy ngeni yng Nghymru ond methu â siarad Cymraeg yn rhywbeth sydd wastad wedi fy mhoeni - faint o wledydd eraill yn y byd sydd â phoblogaeth sydd ddim i gyd yn siarad eu hiaith genedlaethol? Mae cymaint o harddwch yn yr iaith Gymraeg a'r diwylliant Cymreig, ac rwy'n falch iawn o fod yn rhan o'r ymdrech i'w hadennill ar gyfer cenedlaethau'r dyfodol.

Dechreuais ddysgu Cymraeg fel oedolyn gyda Dysgu Cymraeg yn 2020 ar ôl i mi weld erthygl ar fewnrwyd CTM yn hyrwyddo cwrs rhithwir ac yn cynnig cyllid gan y gweithle. Rydw i bellach hanner ffordd drwy gwblhau Lefel Sylfaen ac yn bwriadu cwblhau cymaint o lefelau ag y gallaf i. Er nad ydw i eto ar lefel lle galla i sgwrsio'n rhugl yn y Gymraeg, rwy'n gallu ymarfer gyda fy nghydweithwyr sy'n siarad Cymraeg, sy'n cynyddu fy hyder ymhellach, a gobeithio un diwrnod y bydda i'n gallu defnyddio'r hyn rwy wedi'i ddysgu yn y gwaith a tu hwnt i'r gwaith.

Mae bod yn "Dysgwr Cymraeg" wedi dod yn rhan enfawr o fy hunaniaeth ac wedi fy ngwneud yn rhan o gymuned groesawgar iawn sy'n tyfu trwy'r amser. Dwi wrth fy modd yn dysgu Cymraeg.

Kim, Therapydd Galwedigaethol

Atodiad 1: Asesiad sicrwydd llawn y Gymraeg

ASESIAD SICRWYDD SAFONAU'R GYMRAEG AR GYFER BLWYDDYN ADRODD 2023-24			
Dosbarth o Safon: Safonau Cyflenwi Gwasanaethau			
Gweithgaredd	**Safon(au)**	**Lefel sicrwydd**	Disgrifiad byr
Gohebiaeth	1, 4, 6 - 7	SICRWYDD UCHEL	• Ymateb i ohebiaeth Gymraeg yn Gymraeg • Anfon gohebiaeth yn Gymraeg ar yr un pryd â gohebiaeth Saesneg • Peidio â thrin gohebiaeth Gymraeg gan y BIP yn llai ffafriol na'r fersiwn Saesneg • Yn datgan ein bod yn croesawu gohebiaeth yn Gymraeg ar ohebiaeth gan y BIP
	5	SICRWYDD ISEL	• Anfon pob gohebiaeth (gan gynnwys e-byst at sefydliadau allanol) yn Gymraeg a Saesneg oni bai bod dewis iaith y derbynnydd yn hysbys
Teleffoni	8	SICRWYDD UCHEL	• Cyfarch galwyr i'r prif linellau ffôn yn ddwyieithog
	9	SICRWYDD UCHEL	• Rhoi gwybod i'r galwr bod gwasanaeth ar gael yn Gymraeg
	10	DIM SICRWYDD	• Delio â galwadau i brif linellau ffôn yn Gymraeg
	11	SICRWYDD UCHEL	• Peidio â thrin y Gymraeg yn llai ffafriol wrth hysbysebu prif rifau ffôn
	12	SICRWYDD UCHEL	• Bod gyda'r un rhif cyswllt ar gyfer prif wasanaethau ffôn Cymraeg a Saesneg
	13	SICRWYDD UCHEL	• Yn datgan ein bod yn croesawu galwadau yn Gymraeg pan fyddwn yn cyhoeddi ein prifrifau ffôn
	14	SICRWYDD UCHEL	• Pan fyddwn yn casglu dangosyddion perfformiad, sicrhau ein bod hefyd yn casglu data sy'n berthnasol i'r Gymraeg er mwyn sicrhau nad ydym yn trin y Gymraeg yn llai ffafriol
	15	SICRWYDD UCHEL	• Hysbysu personau sy'n galw, yn Gymraeg, y gallant adael neges yn Gymraeg
	16	DIM SICRWYDD	• Hysbysu personau sy'n galw, yn Gymraeg, pryd y bydd gwasanaeth Cymraeg ar gael pan nad yw un ar gael
	17	SICRWYDD ISEL	• Delio â galwadau i linellau ffôn adrannol yn Gymraeg
	18	SICRWYDD ISEL	• Cyfarch galwyr i linellau ffôn adrannol yn ddwyieithog

	19	SICRWYDD ISEL	• Lle mae'r BIP yn gwneud galwadau i unigolion ar fater penodol, gofyn a yw'r unigolyn hwnnw'n dymuno derbyn galwadau yn Gymraeg yn y dyfodol gan y BIP, cofnodi'r dymuniad hwnnw a gwneud y galwadau hynny yn Gymraeg
	20	SICRWYDD UCHEL	• Unrhyw systemau ffôn awtomataidd sydd gan y BIP ar gael yn gyflawn yn Gymraeg.
Cyfarfodydd mewnol	21, 22, 22A & 22CH	SICRWYDD CANOLIG	• Gofyn i'r rhai a wahoddwyd i gyfarfod a ydynt yn dymuno defnyddio'r Gymraeg a hwyluso'r defnydd o'r Gymraeg
Cleifion mewnol a'r Cynnig Rhagweithiol	23 & 23A	SICRWYDD UCHEL	• Gofyn i gleifion mewnol wrth eu derbyn beth yw eu dewis iaith a chofnodi hyn
	24	SICRWYDD UCHEL	• Bod â pholisi wedi'i gadarnhau ar gyfer gofyn i gleifion mewnol wrth eu derbyn beth yw eu dewis iaith, ar gyfer y cleifion hynny nad ydynt efallai'n gallu nodi hyn eu hunain.
Cynadleddau achos	25	SICRWYDD CANOLIG	• Cynnig a darparu cynhadledd achos yn Gymraeg pan fydd hyn yn cynnwys y claf
Cyfarfodydd a digwyddiadau cyhoeddus	26, 27, 28 & 29 & 31	SICRWYDD UCHEL	• Peidio â thrin y Gymraeg yn llai ffafriol wrth hysbysebu a hyrwyddo cyfarfodydd a digwyddiadau cyhoeddus, anfon gwahoddiadau a gwahodd siaradwyr i gyfarfodydd a digwyddiadau cyhoeddus, sicrhau bod cyfieithydd ar gael ym mhob cyfarfod a digwyddiad cyhoeddus a pheidio â thrin y Gymraeg yn llai ffafriol mewn unrhyw ffordd yn ystod y cyfarfod neu ddigwyddiad
	30, 32 & 33	SICRWYDD CANOLIG	• Arddangos deunydd a digwyddiadau cyhoeddus a chyfarfodydd yn Gymraeg a Saesneg
Deunydd wedi'i arddangos	34	SICRWYDD CANOLIG	• Arddangos deunydd yn gyhoeddus (ym mhob cyd-destun)
Dogfennau a Ffurflenni	36, 37 & 38	SICRWYDD CANOLIG	• Dogfennau a ffurflenni ar gael yn Gymraeg, a nodi ar fersiynau Saesneg bod fersiwn Gymraeg ar gael

Gwefannau a chyfryngau digidol	39, 40 & 41	SICRWYDD UCHEL	• Testun ar y dudalen we ar gael yn Gymraeg gan gynnwys yr hafan a thudalennau newydd a diwygiedig
	42	SICRWYDD UCHEL	• Nodi'n glir ar bob tudalen we ei bod ar gael yn Gymraeg gyda dolen uniongyrchol iddi
	43	SICRWYDD UCHEL	• Darparu rhyngwyneb a dewislenni yn Gymraeg ar bob tudalen
	44	SICRWYDD UCHEL	• Apiau a gynhyrchir neu a gomisiynir gan y Bwrdd Iechyd ar gael yn Gymraeg
	45	SICRWYDD CANOLIG	• Peidio â thrin y Gymraeg yn llai ffafriol ar gyfryngau cymdeithasol corfforaethol ac adrannol
	46	SICRWYDD UCHEL	• Ymateb i negeseuon Cymraeg yn Gymraeg ar gyfryngau cymdeithasol (sylwadau a negeseuon ac ati)
Arwyddion	47	SICRWYDD CANOLIG	• Arddangos pob arwydd gan gynnwys arwyddion dros dro yn Gymraeg
	48 & 49	SICRWYDD UCHEL	• Sicrhau bod pob arwydd gan gynnwys arwyddion dros dro yn Gymraeg a sicrhau bod y Gymraeg yn gywir a'i bod mewn safle lle mae'n debygol o gael ei darllen yn gyntaf
Gwasanaethau derbynfa	50 & 52	SICRWYDD ISEL	• Cynnig gwasanaeth dwyieithog mewn derbynfeydd ac arddangos arwydd yn y dderbynfa yn croesawu'r defnydd o'r Gymraeg
	53	SICRWYDD UCHEL	• Lle mae aelodau staff yn darparu gwasanaeth derbynfa ac yn gallu siarad Cymraeg mewn gwirionedd, sicrhau eu bod yn gwisgo bathodyn i gyfleu hynny
Grantiau	54, 55 & 56	SICRWYDD UCHEL	• Cyhoeddi dogfennau sy'n ymwneud â grantiau yn Gymraeg, • Yn datgan ein bod yn croesawu ceisiadau am grantiau yn Gymraeg, ac nad ydym yn trin cais am grant a gyflwynir yn Gymraeg yn llai ffafriol a • Hysbysu person a gyflwynodd gais am grant yn Gymraeg o'r canlyniad yn Gymraeg.
Tendrau am gontractau	57, 58 & 59	SICRWYDD ISEL	• Cyhoeddi gwahoddiadau i dendro yn Gymraeg lle bo'n berthnasol • Datgan y gellir cyflwyno tendrau yn Gymraeg ac na fydd tendrau a gyflwynir yn Gymraeg yn cael eu trin yn llai ffafriol, a • Rhoi gwybod i dendrwr am y canlyniad yn Gymraeg os cyflwynodd y tendr yn Gymraeg.

Hyrwyddo gwasanaethau Cymraeg	60 & 61	SICRWYDD UCHEL	• Hyrwyddo'r gwasanaethau Cymraeg a ddarparwn.
Hunaniaeth gorfforaethol	62	SICRWYDD UCHEL	• Peidio â thrin y Gymraeg yn llai ffafriol yn y modd y mae'r BIP yn ffurfio, yn adolygu ac yn cyflwyno ei hunaniaeth gorfforaethol
Cyrsiau addysg i gleifion	63	SICRWYDD ISEL	• Lle cynigir cyrsiau addysg iechyd, cynnal asesiad o'r galw amdanynt yn Gymraeg a'u cynnig yn Gymraeg
Systemau annerch cyhoeddus	64	SICRWYDD UCHEL	• Negeseuon wedi'u recordio dros systemau annerch yn ddwyieithog, gyda'r neges Gymraeg yn cael ei chwarae gyntaf
Gofal Sylfaenol	65	SICRWYDD UCHEL	• Dynodi man ar ein gwefan i hyrwyddo darparwyr Gofal Sylfaenol sy'n gallu darparu gwasanaeth neu ran o wasanaeth yn Gymraeg
	66	SICRWYDD UCHEL	• Darparu a hyrwyddo gwasanaeth cyfieithu ar gyfer Gofal Sylfaenol
	67	SICRWYDD UCHEL	• Darparu a hyrwyddo cortynnau gwddf a bathodynnau sy'n cyfleu bod staff Gofal Sylfaenol yn siarad Cymraeg
	68	SICRWYDD UCHEL	• Darparu cyrsiau, gwybodaeth neu ddigwyddiadau fel bod staff Gofal Sylfaenol yn datblygu ymwybyddiaeth o'r Gymraeg a sut y gellir ei defnyddio yn y gweithle

Dosbarth o Safon: Safonau Llunio Polisi

Gweithgaredd	Safon(au)	Lefel sicrwydd	Disgrifiad byr
Asesu effaith penderfyniadau polisi	69, 70 & 71	SICRWYDD CANOLIG	• Asesu polisïau newydd neu adolygu a diwygio polisïau ar gyfer yr effaith ar y Gymraeg
	72, 73, & 74	SICRWYDD ISEL	• Ymgynghori ar bolisi ac ystyried yr effaith ar y Gymraeg
	75, 76 & 77	SICRWYDD ISEL	• Ymchwil i gynorthwyo llunio polisi ac ystyried yr effaith ar y Gymraeg
Asesu effaith polisi o fewn Gofal Sylfaenol	78	SICRWYDD UCHEL	• Sicrhau bod polisi i sicrhau bod penderfyniadau mewn perthynas â Gofal Sylfaenol yn ystyried yr effaith ar y defnydd o'r Gymraeg a pheidio â thrin y Gymraeg yn llai ffafriol
	78A	SICRWYDD UCHEL	• Cyhoeddi adolygiad o'r polisi hwnnw o dan Safon 78 bum mlynedd ar ôl ei gyhoeddi

Dosbarth o Safon: Gweithredu mewnol			
Gweithgaredd	**Safon(au)**	**Lefel sicrwydd**	Disgrifiad byr
Polisi ar ddefnydd mewnol o'r Gymraeg	79	DIM SICRWYDD	• Polisi ar ddefnyddio'r Gymraeg yn fewnol er mwyn hybu a hwyluso'r defnydd o'r iaith
Cytundebau cyflogaeth yn Gymraeg	80	SICRWYDD UCHEL	• Wrth gynnig swydd newydd i unigolyn, gofyn i'r unigolyn a yw'n dymuno i'r contract cyflogaeth neu gontract am wasanaethau gael ei ddarparu yn Gymraeg ac, os felly, ei ddarparu yn Gymraeg.
Gohebiaeth bapur yn ymwneud â chyflogaeth	81	DIM SICRWYDD	• Gohebiaeth bapur yn ymwneud ag agweddau amrywiol ar gyflogaeth a anfonir at weithiwr cyflogedig
Polisïau gweithlu yn Gymraeg	82	SICRWYDD UCHEL	• Polisïau gweithlu sy'n ymwneud â materion penodol sydd ar gael yn Gymraeg
Cwynion gan ac yn erbyn staff	83, 84 & 85	SICRWYDD UCHEL	• Nodi mewn polisïau a gweithdrefnau y gellir gwneud cwynion yn Gymraeg neu ymateb iddynt yn Gymraeg, cynnal cyfarfodydd sy'n ymwneud â chwynion yn Gymraeg, a hysbysu partïon o benderfyniadau sy'n ymwneud â chwynion yn Gymraeg
Gweithdrefnau disgyblu	86, 87 & 88	SICRWYDD UCHEL	• Nodi y gall staff ymateb i honiadau yn Gymraeg mewn dogfennau ac wrth ddwyn achos yn eu herbyn, cynnal cyfarfodydd ynghylch honiadau yn Gymraeg a hysbysu staff o'r canlyniad yn Gymraeg
Meddalwedd sillafu a gramadeg	89	SICRWYDD UCHEL	• Darparu meddalwedd cyfrifiadurol i staff ar gyfer gwirio sillafu a gramadeg y Gymraeg
Mewnrwyd	90, 91, 93 & 95	DIM SICRWYDD	• Rhai tudalennau mewnrwyd yn ddwyieithog
	94	SICRWYDD UCHEL	• Cael tudalen fewnrwyd benodol ar gyfer hyrwyddo'r Gymraeg
Asesu sgiliau iaith gweithwyr	96	SICRWYDD UCHEL	• Asesu sgiliau Cymraeg staff
Hyfforddiant staff	97	SICRWYDD CANOLIG	• Darparu hyfforddiant ar faterion penodol yn y gweithle megis lechyd a Diogelwch
Hyfforddiant ar ddefnyddio'r Gymraeg	98	SICRWYDD UCHEL	• Hyfforddiant ar ddefnyddio'r Gymraeg mewn cyfarfodydd, cyfweliadau a gweithdrefnau cwyno a disgyblu

Gwersi Cymraeg sylfaenol a defnyddio'r Gymraeg mewn rolau rheoli	99	SICRWYDD CANOLIG	• Darparu gwers Gymraeg sylfaenol a hyfforddiant ar ddefnyddio'r Gymraeg mewn rolau rheoli
Darparu gwersi Cymraeg pellach	100 & 101	SICRWYDD UCHEL	• Darparu gwersi Cymraeg i staff y tu hwnt i wers Gymraeg sylfaenol
Ymwybyddiaeth o'r Gymraeg	102	SICRWYDD UCHEL	• Darparu hyfforddiant ymwybyddiaeth iaith Gymraeg
Ymsefydlu corfforaethol	103	SICRWYDD UCHEL	• Darparu deunydd ymwybyddiaeth o'r Gymraeg fel rhan o ymsefydlu corfforaethol
Logo a geiriad ar gyfer e-byst	104	SICRWYDD UCHEL	• Darparu logo fel y gall staff ddangos eu bod yn siarad Cymraeg mewn e-byst a thempled er mwyn iddynt allu creu neges allan o'r swyddfa ddwyieithog
Darparu cortynnau gwddf a bathodynnau	105	SICRWYDD UCHEL	• Darparu bathodynnau a logos i staff fel y gallant ddangos eu bod yn siarad Cymraeg
Asesu swyddi gwag	106 & 106A	DIM SICRWYDD	• Asesu swyddi gwag ar gyfer pa sgiliau sydd eu hangen yn y Gymraeg yn seiliedig ar un o 4 categori, a lle mae 'Cymraeg yn Hanfodol', 'Dymunol' neu 'Angen Dysgu', nodi hyn wrth hysbysebu a hysbysebu'r swydd yn Gymraeg
Annog ceisiadau yn Gymraeg	107	SICRWYDD UCHEL	• Wrth hysbysebu swydd, datgan y caniateir i geisiadau gael eu cyflwyno yn Gymraeg, ac na fydd cais a gyflwynir yn Gymraeg yn cael ei drin yn llai ffafriol.
Deunydd recriwtio Cymraeg	107A	DIM SICRWYDD	• Cyhoeddi gwybodaeth sy'n ymwneud â cheisiadau yn Gymraeg fel pob ffurflen gais, gwybodaeth am ddulliau asesu a disgrifiadau swydd
Ceisiadau a wneir yn Gymraeg	107B	SICRWYDD UCHEL	• Peidio â thrin cais am swydd a wneir yn Gymraeg yn llai ffafriol na chais a wneir yn Saesneg
Defnydd ymgeiswyr o'r Gymraeg mewn cyfweliadau	108	SICRWYDD UCHEL	• Sicrhau bod ffurflenni cais am swyddi yn rhoi lle i ymgeiswyr nodi eu bod yn dymuno cael cyfweliad neu ddull arall o asesu yn Gymraeg, ac os felly, cynnig hyn.
Rhoi gwybod i ymgeiswyr am y canlyniad	109	SICRWYDD UCHEL	• Rhoi gwybod i ymgeisydd am benderfyniad mewn perthynas â chais am swydd yn Gymraeg os gwnaed y cais yn Gymraeg.

Strategaeth 5 mlynedd ar ddarparu ymgynghoriadau clinigol yn Gymraeg	110	SICRWYDD UCHEL	• Cyhoeddi strategaeth ar gyfer pob cyfnod o 5 mlynedd yn ymwneud â chynnig ymgynghoriadau clinigol yn Gymraeg
	110A	SICRWYDD UCHEL	• Cyhoeddi adolygiad o'r strategaeth ar gyfer pob cyfnod o 5 mlynedd yn ymwneud â chynnig ymgynghoriadau clinigol yn Gymraeg
Arwyddion gweithle	111, 112 & 113	SICRWYDD CANOLIG	• Arwyddion gweithle dwyieithog cywir, gyda'r Gymraeg mewn sefyllfa lle mae'n fwy tebygol o gael ei darllen yn gyntaf
Anerchiadau wedi'u recordio yn y gweithle	114	SICRWYDD UCHEL	• Cyhoeddiadau sain yn y gweithle

Dosbarth o Safon: Safonau Cadw Cofnodion

Gweithgaredd	**Safon(au)**	**Lefel sicrwydd**	Disgrifiad byr
Cofnod o gwynion	115	SICRWYDD UCHEL	• Cadw cofnod o bob cwyn a dderbynnir ynghylch safonau'r Gymraeg
Cofnod o sgiliau	116	SICRWYDD UCHEL	• Cadw cofnod o sgiliau Cymraeg fel y'u hasesir o dan Safon 96
Cofnod o'r sgiliau sydd eu hangen ar gyfer swyddi gwag	117	SICRWYDD UCHEL	• Cadw cofnod, mewn perthynas â phob blwyddyn ariannol, o nifer y swyddi newydd a gweigion a gafodd eu categoreiddio (yn unol â safon 106) fel swyddi lle - o (a) mae sgiliau Cymraeg yn hanfodol; o (b) mae angen dysgu sgiliau Cymraeg pan benodir i'r swydd; o (c) bod sgiliau Cymraeg yn ddymunol; neu o (ch) Nid yw sgiliau Cymraeg yn angenrheidiol

Safonau **sy'n** ymdrin â Materion Atodol

Gweithgaredd	**Safon(au)**	**Lefel sicrwydd**	Disgrifiad byr
Materion atodol fel sy'n berthnasol i Safonau	118	SICRWYDD UCHEL	• Cyhoeddi'r hysbysiad cydymffurfio ar ein gwefan
	119	SICRWYDD UCHEL	• Sicrhau bod trefn gwyno sy'n nodi sut y bydd y BIP yn ymdrin â chwynion yn ymwneud â Safonau'r Gymraeg, a'i chyhoeddi ar y wefan
	120	SICRWYDD UCHEL	• Cyhoeddi adroddiad blynyddol ar gydymffurfiaeth
	121	SICRWYDD UCHEL	• Rhoi i Gomisiynydd y Gymraeg unrhyw wybodaeth y mae ef neu hi wedi gofyn amdani mewn perthynas â Safonau

Agenda Item
9.2.1

CTM Health Board

BOARD ANNUAL CYCLE OF BUSINESS

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Nil	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
None identified.	

1. Situation /Background

1.1 The 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 Committee is effectively carrying out its role.

1.2 The Cycle of Business covers the period 1 January 2024 to 31 December 2024.

2. Specific Matters for Consideration

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

3. Key Risks / Matters for Escalation

3.1 Please refer to Appendix 1 – Board Cycle of Business for further detail.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Safe
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to NOTE the Annual Cycle of Business for 2024.

6. Next Steps

6.1 There are no next steps required.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item 10.2.1

Health Board

Cycle of Business

(1st January 2024 – 31st December 2024)

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 2024 to 31st December 2024.

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 2024 – 31st December 2024)

Item of Business	Executive Lead	Reporting period	25 Jan 2024	Feb 2024	28 Mar 2024	April 2024	30 May 2024	11 July 2024	25 July 2024	Aug 2024	26 Sep 2024	Oct 2024	28 Nov 2024	Dec 2024
Shared Listening & Learning														
Listening & Learning Story	Executive Director of Nursing	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Setting the Scene														
Chairs Report *(Including affixing of the Common Seal and Chairs Urgent Action Requests)*	Health Board Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Action Log	Health Board Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Chief Executives Report (to include updates on Targeted Intervention – Programme for Continuous Improvement in response to Targeted Intervention)	Chief Executive	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Executive Priorities Update	Chief Executive	Quarterly							⚑				⚑	
Delivering our Plan														
Integrated Performance Report (Quality, People & Operational Performance)	Executive Director of Strategy & Transformation	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Financial Performance Report	Executive Director of Finance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Governance, Risk and Assurance														
Board Assurance Framework	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Board Committee & Advisory Group Highlight Report (where there are matters identified for escalation)	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Working in Partnership Reports (to include Joint Committee Highlight Reports)	Executive Director of Strategy & Transformation	As and when required	⚑		⚑		⚑		⚑		⚑		⚑	
Joint Committee Annual Update	Director of Corporate Governance	Annually											⚑	
Nurse Staffing Levels (Wales) Act Reports	Executive Director of Nursing	Bi-Annually					⚑						⚑	
Audit Wales Structured Assessment & Audit Letter	Audit Wales	Annually	⚑											
Audit Wales Annual Audit Report	Audit Wales	Annually			⚑									
Annual Review of the Standing Orders	Director of Corporate Governance	Annually			⚑ Defer to May 2024		⚑ Defer to Sept 2024				⚑			

Item of Business	Executive Lead	Reporting period	25 Jan 2024	Feb 2024	28 Mar 2024	April 2024	30 May 2024	11 July 2024	25 July 2024	Aug 2024	26 Sep 2024	Oct 2024	28 Nov 2024	Dec 2024
Board Effectiveness Self-Assessment	Director of Corporate Governance	Annually			Defer to May 2024									
Risk Management Strategy	Director of Corporate Governance	Annually												
Annual Report (including Performance Report, Accountability Report and Remuneration Report)	Director of Corporate Governance	Annually												
Annual Statutory Accounts	Executive Director of Finance	Annually												
Charitable Funds Annual Report and Accounts	Executive Director of Finance	Annually												
Strategic Planning														
Integrated Medium Term Plan – Approval	Executive Director of Strategy & Transformation	Annually												
Clinical Services Plan Progress Updates	Executive Director of Strategy & Transformation	All Regular Meetings												
Regional Partnerships Board & Public Services Board 6 Monthly Report	Executive Director of Strategy & Transformation	Bi-Annually												
Winter Plan Update	Chief Operating Officer	Annually												
Consent Agenda – For Approval														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings												
Amendments to the Standing Orders (Terms of Reference)	Director of Corporate Governance	As and When required												
Committee Annual Reports	Director of Corporate Governance	As and When Required												
Consent Agenda – For Noting														
Board Cycle of Business	Director of Corporate Governance	All Regular Meetings												
Board Forward Work Programme	Director of Corporate Governance	All Regular Meetings												
Committee Highlight Reports	Director of Corporate Governance	All Regular Meetings												
Putting Things Right Annual Report	Executive Director of Nursing	Annually												

Item of Business	Executive Lead	Reporting period	25 Jan 2024	Feb 2024	28 Mar 2024	April 2024	30 May 2024	11 July 2024	25 July 2024	Aug 2024	26 Sep 2024	Oct 2024	28 Nov 2024	Dec 2024
Safeguarding Annual Report	Executive Director of Nursing	Annually	⚑											
Carers Annual Report	Executive Director of Nursing	Annually									⚑			
Clinical Education Annual Report	Executive Medical Director	Annually											⚑	
Infection Prevention & Control Annual Report	Executive Director of Nursing	Annually									⚑			
Civil Contingencies & Business Continuity Report	Executive Director of Strategy & Transformation	Annually					⚑							
Welsh Language Standards Annual Report	Executive Director for People	Annually									⚑			
Director of Public Health Annual Report	Executive Director of Public Health	Annually					⚑ Defer to Sept 2024				⚑ Defer to Nov 2024		⚑	
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually					⚑							
Capital Update	Executive Director of Finance	Quarterly			⚑ Defer to May 2024		⚑						⚑	
Annual Plan Quarterly Update	Executive Director of Strategy & Transformation	Quarterly			⚑				⚑				⚑	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 9.2.2

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 received from the Assistant Director of Governance & Risk following discussion at Executive Leadership Group	Additional Item	Major Incident and Critical Business Continuity Plans	Director of Strategy & Transformation	25 May 2023 – 28 September 2023. To be Deferred – Was January 2024. Was March 2024 – Was May 2024 – Was July 2024 – Was 26 September 2024. Now 28 November 2024
Email request received from the Assistant Director of Governance & Risk	Additional Item	Estates, Facilities Performance Management System annual report	Director of Finance	Planned for 28 September 2023 – Now 30 November 2023 – To be deferred from November – date to be confirmed – Now 26 September 2024 – On agenda
Identified as a report coming forward within the Chief Executive Report presented to the July Board	Additional Item	Llantrisant Health Park Update – To include the year one+ Plan	Chief Executive	In progress Received and noted at the meeting held on 30 November 2023. Further update to be presented to the Board in July 2024 – Now 26 September 2024 – On agenda
Email Request received from the Deputy Director for People	Additional Item	Development of the CTM People Plan	Executive Director for People	Planned for 28 March 2024 – Was 30 May 2024 – Was 25 July 2024 – was 26 September 2024 – Now March 2025
Email request from the Executive Director for People	Additional Item	Agency Reduction Plan and Decision Making Framework for CTM	Executive Director for People	Date to be confirmed

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 Assistant Director of Governance & Risk	Additional Item	Community Diagnostic Hub & Endoscopy Procurement Process and Business Case	Executive Director of Strategy & Transformation	Was planned for 28 March 2024 Progress report discussed at the In Committee Board meeting held on 30 May 2024. This is now planned for the 28 November 2024 Board
Email request from the Assistant Director of Governance & Risk	Additional Item	Maesteg Community Hospital Development – Outline Business Case	Executive Director of Strategy & Transformation	Planned for 28 November 2024
Email request received from the Strategic Planning & Commissioning Manager	Additional Item	CTM Baby & Toddler Voice	Executive Director of Strategy & Transformation	Planned for 30 May 2024 – It has now been proposed that a briefing on this matter will be given at a future Board Development Session
Suggestion made at agenda planning session that it would be helpful if this item could be received at the July Board	Additional Item	Workforce Planning	Executive Director for People	Was Planned for 25 July 2024 – Discussion held at agenda planning that this may be more suitable for a Board Briefing topic at this stage – Verbal update on Strategic Workforce Planning to be presented to the 26 September 2024 Board meeting
Identified as an item that would be presented to Board at the Digital & Data Committee held in May 2024	Additional Item	Digital Cellular Pathology Business Case	Director of Digital	Was planned for 25 July 2024 – Was deferred to 26 September 2024. Now deferred to the 28 November 2024

Email request received from the Director of Corporate Governance/Board Secretary following request received from Medical Director/CEO	Additional Item	Organ Donation & Transplantation - Presentation	Executive Medical Director	Was planned for 25 July 2024 – Now 26 September 2024 – On agenda
Email request received from the Deputy Director of Strategy & Partnerships	Additional Item	CTM Annual Carbon Emissions Report	Executive Director of Strategy & Transformation	Planned for the 26 September 2024 – 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
CEO requested an update to come forward at the March Board	Additional Item	Development of Plan to address Delayed Discharge Issues	Chief Operating Officer	Completed Presentation received at the meeting held on 25 July 2024
Email request received from the Assistant Director of Governance & Risk	Additional Item	Annual Report for Quality – For approval	Executive Director of Nursing/Deputy CEO	Completed Received and approved at the meeting held on 25 July 2024
Email request received from the Director of Corporate Governance for this to be added to the agenda	Additional Item	Taff Vale Practice – Proposed Branch Closures	Chief Operating Officer	Completed Received and approved at the meeting held on 25 July 2024
Chair has requested that this item is added to the agenda	Additional Item	Spotlight Report on Digital - Update on the Strategic Outline Case for an Integrated Health Care System	Director of Digital	Completed Received and approved at the meeting held on 25 July 2024
Suggestion made at ELG that this item needed to be added to the agenda for Board	Additional Item	Job Planning and SPA	Medical Director	Completed Received and noted at the meeting held on the 25 July 2024

Agenda Item
9.2.3

CTM Health Board

Board Committee and Advisory Group Highlight Reports

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

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

2.1 A number of Committee/Advisory Groups have been held since the Board last met in July 2024.

3. Key Risks / Matters for Escalation

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* /	Safe
	If more than one applies please list below:

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒ This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

- Quality & Safety Committee 23 July 2024 (On main agenda)
- Population Health & Partnerships Committee 1 August 2024 (Appendix 1);
- People & Culture Committee 7 August 2024 (On main agenda);
- Remuneration & Terms of Services Committee 14 August 2024 and 11 September 2024 (Appendix 2);
- Hosted Bodies Audit & Risk Committee 15 August 2024 (Appendix 3);
- CTMUHB Audit & Risk Committee 15 August 2024 (Appendix 4);
- Planning, Performance & Finance Committee 27 August 2024 (Appendix 5);
- Digital & Data Committee 28 August 2024 (Appendix 6);
- Mental Health Act Monitoring Committee 4 September 2024 (On main agenda)

Agenda Item
9.2.3 Appendix 1

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE POPULATION HEALTH & PARTNERSHIPS COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Committee Chair and Executive Lead.	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
PSB	Public Service Board
PSRS	Population Segmentation and Risk Stratification
HW	Healthy Weights

1. Situation /Background

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 1st August 2024.

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

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 this 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 were no matters requiring escalation on this occasion.
ADVISE	• A detailed presentation was received by the Committee on the strategic development activity relating to Starting Well, Growing Well. • A strategic update on Mental Health was received, noting the progress to date for the Mental Health and Learning Disability Care Group on the strategic priorities. • A strategic update on Learning Disabilities was received, noting the update on progress in relation to the three year plan for specialist Learning Disability Services. • The Committee received an update on Building Healthier Communities (BHC), noting the progress on the work being undertaken on housing, which forms a key part of the BHC portfolio. • A report was received on the Consultation Response – Rebalancing Care and Support Programme, noting the CTM response to the recent Consultation on the Rebalancing Care and Support Programme that had been

	submitted on the 9th July 2024 and had previously been circulated to the Committee.
ASSURE	• The Committee received the Organisational Risk Register and reviewed the assigned risks, noting the updates in terms of the mitigating actions identified within the report. • The Committee received an update on the Population Health Management Programme noting the progress to date on the population segmentation and risk stratification approach to population health management within Cwm Taf Morgannwg. • A report was received on Health Protection System. The Committee noted the progress in relation to the development of a Health Protection Service and overarching Strategic Plan.
INFORM	• The Committee received a report on the Regional Partnership Board - Community Care System noting the update of the work undertaken through the RPB, health and social care service development for people living with frailty in the Cwm Taf Morgannwg Region, centring on two community-based pathways, namely 'Urgent Community Response' and 'Population Health Management', supported by a Navigation Hub. • A report was received on the Public Service Board noting current activities of the Cwm Taf Morgannwg Public Service Board and an update of the Board's activities since the last meeting of the Committee. • The Committee received and noted the Strategy Groups Update. • The Committee Annual Cycle of Business for 2024-25 was noted. • The Outcome of the Committee Annual Self Effectiveness Survey Response and Improvement Plan was APPROVED. • The Unconfirmed Minutes of the Meeting held on the 20 May 2024 were APPROVED.

	• The Unconfirmed In-Committee Minutes of the Meeting held on the 20 May 2024 were APPROVED.
APPENDICES	Not Applicable

Objectives / Strategy		
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care	
	If more than one applies please list below:	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well	
	If more than one applies please list below:	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales	
	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective	
	If more than one applies please list below:	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

4. Recommendation

4.1 Members of the Board are asked to NOTE the report.

Agenda Item
9.2.3 Appendix 2

CTM Health Board

Highlight Report from the Remuneration & Terms of Service Committee

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Not applicable.	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
JCC	Joint Commissioning Committee

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Remuneration & Terms of Service Committee at its meetings on 14th August 2024 and 11th September 2024.

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

2. Purpose of this Meeting

2.1 The purpose of this Committee is to provide:

- *advice* to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government.
- *assurance* to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.
- *receive reports* relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers of hosted bodies.

3. Highlight Report

Alert / Escalate	Nil
Advise	<u>14th August 2024:</u> Interim Chief Commissioner, NHS Wales, Joint Commissioning Committee Extension of Secondment / Level of Remuneration The Committee approved an extension to the fixed term contract for Interim Chief Commissioner role and an increase in remuneration up to the 31 January 2025, with the opportunity to further extend until 31st March 2025 if required. Extension of Fixed Term Contract – Director of Commissioning, Ambulance Services and 111 The Committee approved an extension to the current fixed term contract until the 31 October 2024. Redundancy Cases The Committee approved seven redundancy cases. The Committee received assurance on the specific individual circumstances of this case and the efforts made in terms of seeking re-deployment opportunities.

	11th September 2024: Pension Flexibility The Committee approved an individual application to exercise the 'partial retirement' provision within the available pension flexibilities arrangements.
Assure	Nil
Inform	14th August 2024 WG Independent Review into the ESP process. The Health Board's responses to the baseline questions asked as part of the WG Independent Review into the ESP process was received and discussed by the Committee. 11th September 2024 Updates were noted on the following items: • Pay Review – Agenda For Change and ESP • JCC Chief Commissioner Role
Appendices	Nil

4. Assessment

5. Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Sustaining Our Future If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People If more than one applies please list below:
Dolen i Feysydd Ansawdd	Equitable

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: N/A Not required for this type of report.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	In terms of the resource impact of each individual case.	

6. Recommendation

6.1 The Board is asked to NOTE the highlights outlined in section 3 of this report.

Agenda Item
9.2.3 Appendix 3

CTM Health Board

Highlight Report from the Hosted Bodies Audit & Risk Committee

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance Gareth Watts, Director of Corporate Governance & Board Business

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
JCC	Joint Commissioning Committee
CTM	Cwm Taf Morgannwg
NIAW	National Imaging Academy Wales

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 15TH August 2024.

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

2. Purpose of this Meeting

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. From 1 April 2024, this comprises the NHS Wales Joint Commissioning Committee (JCC) and the National Imaging Academy Wales (NIAW). 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.

Highlight Report

Alert / Escalate	• There were no matters for alert or escalation on this occasion.
Advise	• The Committee received and noted the Internal Audit Review – Emergency Ambulance Services Committee Adult Critical Care Transfer Service.
Assure	• The JCC Organisational Risk Register was received. Members noted the updated transitional amalgamated risk register for the JCC and changes to the risks outlined in the report as at the 30 June 2024 and the further work planned to fully develop the CTM Risk Management Strategy for the JCC and the steps required to implement it.

	• The Committee received and APPROVED the JCC Financial Control Procedures. Members noted that all Financial Control Procedures inherited by the JCC had exceeded their 3 year review cycle and would now be reviewed for continued fitness of purpose and where necessary would be amended in light of how the JCC operates. • The JCC Audit Tracker was received. Members noted that this was the first iteration of the amalgamated JCC audit recommendations tracker incorporating the audit recommendations of the predecessor organisations EASC and WHSSC.
Inform	• The Unconfirmed Minutes of the meeting held on 20 June 2024 were APPROVED.
Appendices	• Nil

3. Assessment

4. Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality	Not Applicable If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to NOTE the highlights outlined in section 3 of this report.

Agenda Item
9.2.3 Appendix 4

CTM Health Board

Highlight Report from the CTMUHB Audit & Risk Committee

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance Gareth Watts, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the CTMUHB Audit & Risk Committee at its meeting on 15th August 2024.

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

2. Purpose of this Meeting

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 Joint Commissioning Committee (JCC) and the National Imaging Academy Wales (NIAW). 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.

Highlight Report

Alert / Escalate	There were no matters to alert or escalate on this occasion.
Advise	• The Internal Audit Progress Report was received. Members noted that one report had been finalised, six reports were in draft and there was ongoing fieldwork in relation to seven reviews. • The Audit Recommendations Tracker report was received and discussed. Members noted the progress they were making in transitioning to an automated system and

	suggested further areas of improvement that could be made to the report dashboard. • The Audit Wales Audit & Risk Committee Update was received and noted. • The Audit Wales Report – Minor Injuries Unit Follow Up was received and noted. • Committee Members received an update on Business Sensitive Risks and the Audit Recommendations Tracker during the 'In Committee' session of the Committee. • The Committee received and noted an update and presentation on the Joint Advisory Group (JAG) on GI Endoscopy. • The Committee discussed the outcome of the Committee Referral that had been made to the People & Culture Committee at a previous meeting, seeking assurance on the recruitment processes for agency staff to ensure that checks were in place to mitigate any risk of fraudulent activity as highlighted in the Local Counter Fraud report. The Committee were not satisfied that the response was robust enough to provide the assurance they required. It was agreed that the People & Culture Committee would be asked to re-look at this again at their next meeting to be held in November 2024.
Assure	• The Local Counter Fraud report was received. Members noted the detail on the tasks and actions undertaken with the four strategic counter fraud work areas. Particular focus was placed on the learning from a counter fraud case involving a neonatal ward manager at the Princess of Wales Hospital. • The Organisational Risk Register Report was received and noted. Members discussed the risk on the 'Health Protection Funding Allocation', 'Weight Management Service', 'Failure to Provide Evidence of Learning from Events' and 'Infrastructure Failures' and agreed that these would be reviewed for the next iteration of the Risk Register. • The Procurement and Scheme of Delegation report was received. • The Losses and Special Payments report was received and noted for the period April to June 2024. Reference was made to the penalties received on the Learning from Events Reports and assurance was provided to Members as to the scrutiny that is applied to these matters. • The Committee received, noted and APPROVED the report on the Breaches to the Standing Orders in July 2024. • The Internal Audit Review – Prince Charles Hospital (PCH) Key Project Objectives was received. Members noted that the review had been allocated a 'Reasonable' Assurance rating.

	• The Internal Audit Review – PCH Redevelopment Programme Integrated Audit Plan 2024-25 was received and noted. • The Internal Audit Review – Technical Resilience Updated Management Actions was received. Members noted the updated management response and that the review had been allocated a 'Reasonable' Assurance rating.
Inform	• The Unconfirmed Minutes of the meeting held on 20 June 2024 were APPROVED; • The Unconfirmed In Committee Minutes of the meeting held on 20 June 2024 were APPROVED; • The Unconfirmed Minutes of the Extra Ordinary meeting held on 10 July 2024 were APPROVED; • The Annual Cycle of Business for 2024-25 was received and noted; • The Declarations of Interest and Gifts and Hospitality Report was received and noted. • The Committee Annual Report 2023-24 was APPROVED; • The Forward Work Programme was received and noted.
Appendices	None identified.

3. Assessment

4. Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not Required
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not Required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to NOTE the highlights outlined in section 3 of this report.

Agenda Item
9.2.3 Appendix 5

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE PLANNING, PERFORMANCE & FINANCE COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Choose an item. Linda Prosser, Executive Director of Strategy & Transformation Gethin Hughes, Chief Operating Officer Sally May, Executive Director of Finance & Procurement

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
YTD	Year to Date
WG	Welsh Government
CAMHS	Child & Adolescent Mental Health Services

1. Situation /Background

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Planning, Performance & Finance Committee which took place on 27th August 2024.

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

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

2.1 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	There were no matters requiring escalation on this occasion.
ADVISE	• The Business Case for the Plan to Address Delayed Discharge Issues was received and APPROVED (in line with the authority delegated to the Committee by the Board at the July 2024 Public Board meeting) at the 'CLOSED' In Committee Meeting. • The Month 4 Finance report was received. Members noted that at M4 the Health Board were reporting the following: Overall Revenue Position 2023-24: • The M4 position was reporting a £1.5m deficit in month. • The M4 YTD position was now a £4.1m deficit. The main driver for the £4.1m YTD deficit was a £6.2m shortfall in savings delivery which was offset by other favourable variances of £2.1m. • As at M4 the Health Board are continuing to forecast a break even position for 2024/25. However, the level of risks that the Health Board was now trying to manage had increased significantly in M4. A detailed review of these risks and

	associated recovery plan actions would be undertaken for the M5 Monitoring Return submission to WG. It was important to highlight that, at this stage, there is a significant risk that the In year and Recurrent forecasts could deteriorate in M5. • The net risks to the forecast break even position at M4 were £16.1m (M3: £9.2m) Recurrent Revenue position: • The brought forward recurrent deficit at the end of 2023/24 was £19.4m. • The planned recurrent surplus at the end of 2024/25 was £2.1m. However, the Health Board are currently off plan at M4 and this presents a significant risk to the recurrent forecast. A detailed review of the forecast recurrent position will be undertaken for the M5 Monitoring Return submission to WG. Savings: • Actual savings in M4 was £0.8m which was £1.4m below the M4 target of £2.2m. The M4 YTD savings was now £2.6m which is £6.2m below the M4 YTD target of £8.8m. • The M4 forecast In year savings was now £12.1m, which is £14.2m below the £26.3m target. These savings plans have been risk assessed as £9.1m Green and £3.1m Amber. The estimated savings delivery risk at M4 have been estimated at £2.1m. • The M4 forecast Recurrent savings is £15.1m, which is £11.2m below the £26.3m target
ASSURANCE	• The Committee received the Organisational Risk Register and reviewed the Planning, Performance & Finance assigned risks, noting the updates in terms of the mitigating action identified within the report. • A report was received and noted on the Estates Operational Performance and Energy Performance. • A detailed review of the Integrated Performance Dashboard was undertaken with particular focus and scrutiny in the following areas: - Child & Adolescent Mental Health Services (CAMHS) Performance - Unscheduled Care - Cancer - Stroke

	- Diagnostics - Delayed Transfers of Care - Ambulance Red Calls • A presentation was received and noted on Planned Care Recovery. • A verbal report was received and noted on Taff Vale Practice Proposed Branch Closures.
INFORM	• The Committee received for information the Monthly Monitoring Returns to Welsh Government for Months 2, 3 and 4. • The Committee Annual Cycle of Business 2024-25 was received and noted. • The Value Based Healthcare Steering Group Highlight Report was received and noted. • The Forward Work Plan was received and noted. • The Action Log was received and noted. • The Minutes of the Meeting held on 25th June 2024 were APPROVED.
APPENDICES	NOT APPLICABLE

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	Not Applicable
	If more than one applies please list below:

Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*		
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Not Applicable If more than one applies please list below:	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Not Applicable If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐ Outcome:	No: ☒ If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐ Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	No: ☒ If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	

Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4. Recommendation

4.1 Members of the Board are asked to NOTE the report.

Agenda Item
9.2.3 Appendix 6

CTM Health Board

HIGHLIGHT REPORT FROM THE CHAIR OF THE DIGITAL & DATA COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Ian Wells, Digital & Data Committee Chair / Independent Member
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stuart Morris, Director of Digital

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
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 the 28 August 2024.

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

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 Digital technologies, 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 line 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	There were no items to escalate on this occasion.

ADVISE	• Members received the spotlight topic presentation on progress of Digital and Data Programmes. Committee members sought assurance that a robust approach to the Connecting Care / Mental Health Solution for CTMUHB will continue acknowledging the complexities around the approach that is being taken, and the role of Welsh Government, Digital Healthcare Wales and the potential joint working opportunities with other Health Boards involved in the process and potential solutions.
	
	• The Committee received the Medical Records Assurance Report and raised;
	
	  • Concerns about the number of misfiled and unidentified patient records. It was emphasised that these issues should be advised to Board and action taken to feed any remedial actions into the Health Board's Patient Saftey governance arrangements.
	  • Issues regarding the health and safety risks within certain medical records facilities from a volume of records requiring to be stored and the retrieval of records.
	  • The possibility of an administrative review to explore opportunities to assign additional staff to the function to support the digitisation process.
	
	• The Committee received the Organisational Risk Register and reviewed the risks escalated.
	
	• DIGITAL AND DATA IN COMMITTEE MEETING;
	
	  Committee Members were updated on the following:
	
	  • Business Sensitive risks on the Organisational Risk Register;
	  • Cyber Improvement plan; The continued delivery of effective clinical services
	  • Digital Critical Incidents; Digital & Data incidents that occurred over the period.

ASSURE	The Information Governance Group Highlight Report was received, and the Committee were assured that the Health Boards' compliance rates have reached their highest level to date. The Committee received an update on the internal audit review – Technical Resilience (Updated Management Actions) and were assured that the Digital team can meet the identified timelines for the issued actions. Additionally, it was

	confirmed that requests from the Audit Committee had been addressed in the management responses. The Digital and Data Assurance Report, was received by the Committee.
INFORM	The Committee Approved the following items at the meeting: • Freedom of Information Policy • Information Asset Procedure The Committee received the following items for noting in the meeting: • All Wales Independent Member Network Highlight Report • Committee Annual Cycle of Business • Committee Forward Work Plan 2024-25
APPENDICES	NOT APPLICABLE

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Not Applicable

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board are asked to NOTE the contents of the report.

Agenda Item
9.2.4

CTM Health Board

Estates and Energy Performance Annual Report

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tim Burns, Assistant Director (Capital & Estates
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance & Procurement
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May Executive Director of Finance & Procurement

Pwrpas yr Adroddiad / 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	27/08/2024	NOTED

Acronyms / Glossary of Terms	
EFAB	Estates funding advisory Board
PPM	Planned Preventative maintenance

PART A - ESTATES PERFORMANCE

1. SITUATION/BACKGROUND

The purpose of Part A of this report is to provide the Board with the 2023/24 estates operational planned and reactive maintenance performance data and to note the CTM's estates performance against the 2022/23 all Wales national key performance indicators.

1.1 Operational Maintenance Performance Indicators

The Estates department provides an essential 24 hour, 365 days a year service in the delivery of planned, reactive and help desk maintenance across the estate.

The department measure and monitor a range of indicators related to the service it provides to the organisation. These include the:

- % of statutory jobs undertaken each month.
- % of mandatory jobs undertaken each month.
- % of helpdesk requests completed each month.

The maintenance programme is managed via the Planet Facilities Management system; this enables the scheduling and operation of all planned and reactive maintenance jobs. The performance is reported quarterly to the Estates and Capital Governance Board, and monthly at the Estates Operational Management team meetings.

The department carry out over 66,000 jobs per annum, the split is noted in table 1 with the corresponding completion ratios noted in table 2.

Table 1- Total number of Jobs

	2022/23	2023/24
Statutory PPM Jobs	15,958	15,983
Mandatory PPM Jobs	13,901	14,235
Response Desk Jobs	38,962	36,281

Table 2 - Completion Ratios

	2022/23	2023/24
Statutory PPM Jobs	91%	89%
Mandatory PPM Jobs	91%	91%
Response Desk Jobs	69%	72%

In light of the retention and recruitment challenges within the department, which are noted below, it is encouraging to report that the performance level in 2023/24 were broadly comparable with the previous year.

During 2023/24 the estates' operational function was digitized and estates operatives were provided with mobile devices so that they are now able to work in real time, this has helped to smooth the effect of the staff shortages with performance not being materially affected.

It should be noted that for a range of reasons, all jobs cannot be completed each month, the risk is minimised wherever possible by ensuring that where a particular statutory planned job is not undertaken one week/month, then it is undertaken on the following cyclical occasion. This is monitored by the Operational Head of Estates and senior operational estates managers at their monthly operational management meetings.

1.2 Recruitment and retention

During the last 2 years the department has experienced significant challenges recruiting staff, table 3 below shows the number of times posts have been advertised before an appointment has been made. There is a particular problem appointing engineering staff with electricians being the most challenging. Posts have been advertised on 11, 9 and 7 occasions at Prince Charles, Royal Glamorgan and Princess of Wales Hospitals respectively.

The national skills shortage is driving up salaries in the private sector that this and other Health Boards are unable to compete with.

This issue has been raised with CTM's Organisational Development department to see what can be done to reverse this recruitment and retention trend.

Table 3

Date	Position	Location	Times out to advert
2022	Supervisor	PCH	8
2024	Operational Estates manager	PCH	4
2023	Estates Officer	PCH	4
2023	Electrician	PCH	5
2023	Estates Officer	POW	3
2023	Electrician	POW	7
2023	Contracts Manager	DSH	4
2024	Supervisor	POW	2
2023	Electrician	PCH	4
2023	OMM	POW	3

2023	Fitter	POW	3
2023	Fitter	PCH	4
2023	Electrician	RGH	3
2022	Electrician	RGH	9
2022	Fitter	PCH	5
2023	Supervisor	POW	2
2023	Operational Estates Manager	RGH	2
2022	Electrician	YCR	7
2022	Electrician	PCH	11
2022	Electrician	YCR	4
2022	Operational Estates Manager	POW	4
2022	Contracts Manager	N/A	3
2022	Estates Officer	PCH	3

2.0 All Wales National Key Performance Indicators

The most recently published All Wales Estates Condition and Performance indicators (2022/23) measure the percentage of the estate that is in a reasonable standard and fall within estate code category B or above. Table 4 below shows CTM's position as a comparator against the other Health Boards in Wales.

Table 4

National Key Performance Indicators

Percentage of the estate which is of reasonable standard and therefore falls within Estatecode category 'B'/'F' or above:

	Physical Condition (%)	Statutory & safety compliance (%)	Fire safety compliance (%)	Functional suitability (%)	Space utilisation (%)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	94	94	84	98	92
BETSI CADWALADR UNIVERSITY HEALTH BOARD	68	74	64	74	93
CARDIFF & VALE UNIVERSITY HEALTH BOARD	55	86	87	69	97
CWM TAF MORGANNWG UHB	97	83	97	100	96
HYWEL DDA UNIVERSITY HEALTH BOARD	88	89	67	90	99
POWYS TEACHING LHB	67	80	72	71	86
SWANSEA BAY UNIVERSITY HEALTH BOARD	77	82	91	87	97
VELINDRE UNIVERSITY NHS TRUST	55	95	98	88	99
WELSH AMBULANCE SERVICES NHS TRUST	56	93	93	40	99

Table 5 shows the backlog costs for all of the Health Boards and Trusts in Wales.

Note Table 5 excludes PCH areas that are part of the PCH Ground and First Floor Major Capital Project

In CTM the costs of the backlog programme are gathered by the estates teams from the following sources:-

- Local knowledge / experience of similar projects carried out;
- Costs based on professional judgement and experience;
- Costs from contractor quotations;
- Estimates from appointed consultants;
- 5 facet survey for the Bridgend estate;
- Targeted surveys for high-risk issues.

A proportionate level of risk assessed information to plan the discretionary works and statutory compliance programmes and respond to Welsh Government initiatives such as EFAB funding and end of year slippage is contained within CTM's

three year back log plan and risk register. This is evidenced by the approvals received from Welsh Government following scrutiny by NHS Wales Specialist Estates services. The level and detail of costs will develop as and when proposals are firmed up and projects are approved to proceed. Our approach is to rely on our internal assessment of the backlog programme, supplemented by externally contracted, targeted survey information for high-risk areas as required. The revenue cost of undertaking 5 yearly six facet survey across all sites is cost prohibitive. For example, during 2024-25, detailed roof surveys have been undertaken at Princess of Wales and Glan Rhyd Hospitals in the Bridgend locality.

Estate risks are identified through the recognised governance process. CTM has well-established multi -disciplinary groups, with attendance at all groups by an Authorising engineer from NHS Wales Specialist Estates Services providing professional advice for high and low voltage electricity, fire, water, ventilation, medical gases and decontamination who report into the Directorate Health, Safety and Governance Board and subsequently onto the Board's corporate risk register if necessary. Annual reports for each of these specialist area are reported at the Health, Safety and Fire Sub Committee.

Table 5

Backlog Maintenance Costs

*Target to be agreed

	High Risks (£)	Significant Risks (£)	Moderate Risks (£)	Low Risks (£)	Risk Adjusted Cost (£)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	59,686,358	33,784,332	50,634,820	54,932,056	177,150,530
BETSI CADWALADR UNIVERSITY HEALTH BOARD	98,236,455	99,436,454	73,464,222	48,600,749	256,752,414
CARDIFF & VALE UNIVERSITY HEALTH BOARD	33,737,189	86,234,976	34,295,219	15,602,440	107,388,244
CWM TAF MORGANNWG UHB	28,014,850	36,337,925	43,756,445	962,525	66,149,895
HYWEL DDA UNIVERSITY HEALTH BOARD	12,900,000	104,861,864	10,830,817	7,990,359	118,525,353
POWYS TEACHING LHB	5,329,209	25,198,096	13,578,148	10,541,952	31,623,885
SWANSEA BAY UNIVERSITY HEALTH BOARD	9,248,200	53,783,860	49,456,920	12,530,760	28,292,008
VELINDRE UNIVERSITY NHS TRUST	153,142	2,083,743	5,502,432	2,991,901	2,063,073
WELSH AMBULANCE SERVICES NHS TRUST	283,153	3,669,750	2,514,340	820,728	4,649,810

CTM has been fortunate to have received additional capital allocations from Welsh Government which includes EFAB funding; this is a WG targeted improvement programme intended to assist NHS organisations in Wales with investment to improve compliance, infrastructure, physical condition, Health and Safety risk and decarbonisation, the Health Board were awarded circa £7m for this in addition to this the Health Board were awarded £5.7m to address backlog and high-risk issues. Given the significant backlog position it should be noted that there is a continuation of EFAB funding of c£6.3m in 2024/25

The risk adjusted backlog for CTM is circa £66M. The ground and 1st floors of Prince Charles Hospital are excluded from these numbers as there is a c £300M refurbishment programme currently on going. The PCH Major Capital Project is governed via a Project Board, with Sally May as SRO.

It is important to highlight the estates risks associated with roofs, fire compartmentation and engineering infrastructure at Princess of Wales Hospital and Glan Rhyd. This is after significant capital investment (circa £20m)over the last 5 years since CTMUHB's formation which represents a significant proportion of the available discretionary capital Detailed survey work is presently on going on these sites, the conclusion of which will be reported at a future Board. There remains an extant fire enforcement notice on the Princess of Wales Theatres and remediation programme, with Linda Prosser as SRO, is subject to ongoing development.

The Royal Glamorgan Hospital has had Environmental Modernisation Strategic Outline Programme (SOP) approval from Welsh Government. The first element of the works which was the installation of stand by electrical generator plant and supporting infrastructure was completed in 2023/24; the business case development for the mechanical work will commence in 2024/25.

3.0 Resetting the base line

NHS Shared Services Partnership- Specialist Estate Services (NWSSP–SES) have collected Estates and Performance Monitoring system data (EFPMS) on behalf of Welsh Government since 2001-02. The importance of robust EFPMS data cannot be over- emphasised as it is used to brief Ministers, Senior WG officials and NHS organisations. Following discussions between WG and NWSSP –SES two important updates have been agreed regarding EFPMS in Wales. These updates will be implemented immediately for the 2023/24 data collection exercise which is being introduced to provide a more accurate picture of the NHS estate. The data will now be collected and submitted in line with table 6 below and will be reported in this format to the Board in the 2023/24 Estates Annual report

Table 6

Site GIA	No Inpatient Beds	1 – 9 Inpatient Beds	10+ Inpatients Beds
Up to 150m^2	Not Reported	Not Reported	Individually reported at site level.
151m^2 – 499m^2	Other Reportable Sites	Other Reportable Sites	Individually reported at site level.
500m^2 or more	Individually reported at site level.	Individually reported at site level.	Individually reported at site level.

4.0 NHS Wales Prioritisation

The challenging financial climate that all Health Boards are facing has resulted in the need for clear and effective prioritisation of capital schemes with the maintenance backlog position across Wales currently estimated at circa £1.2 billion. Welsh Government continue to report that the future years capital programme remains under extreme pressure. As a result, WG has launched an all-Wales capital prioritisation exercise.

The NHS Infrastructure Investment Board (IIB) in Welsh Government has agreed a framework which will provide a basis for future investment decision making. NHS Organisations were asked to complete an investment form for all potential business cases requiring funding from the All Wales Capital Programme. The investment criteria set out below are the areas that will be scored by IIB, each area has also been given a percentage weighting as indicated.

- Fit with Priorities and Policy 25%
- Clinical Impact 20%
- Value for money 16%
- Statutory Compliance and Risk 13%
- Equity & Community 13%
- Wider Benefits and Climate Change 13%

The priority list of schemes submitted to WG a number of which will reduce backlog are detailed in table 7 along with an estimated cost profile.

Table 7

		2024-25	2025-26	2026-27	Further Years	Total
Priority	Scheme	£m	£m	£m	£m	£m
1	Llantrisant Health Park Infrastructure Programme	12.27	67.42	74.05		**153.74**
2	POW Theatres - Fire Safety Requirements	0.50	15.00	0.50		**16.00**
3	PCH - Phase 3		23.20	23.20	11.60	**58.00**
4	POW Programme of infrastructure work	1.00	15.00	45.00	189.00	**250.00**
5	Endoscopy Scope Decontamination POW	3.00	2.00			**5.00**
6	RGH Mechanical Infrastructure	0.50	3.00	2.50	3.00	**9.00**
7	Diagnostic Imaging Replacements	2.00	3.00	2.00		**7.00**
8	Additional ward facilities on 3 major DGH sites	2.00	4.00	3.00	3.00	**12.00**
9	Phased Outpatient Reconfiguration	1.00	2.00	3.00		**6.00**
10	Consolidation of Mental Health Services	1.00	3.00	5.00	41.00	**50.00**
11	ITU - reconfiguration		0.50	1.00	13.50	**15.00**
12	HSDU Single Site Decontamination			0.50	13.50	**14.00**
13	Third Eye Theatre at POW				5.00	**5.00**
14	Regional Pathology		0.50	1.00	48.50	**50.00**
15	Interventional Cardiology Unit				5.00	**5.00**
16	Emergency Dept South			0.50	11.50	**12.00**
17	Reconfiguration of Obs & Gynae South				20.00	**20.00**
18	Mortuary capacity PCH				5.00	**5.00**
19	Diagnostic Imaging Replacements				19.00	**19.00**
20	Centralised haematology day unit				3.00	**3.00**
21	Expand Central Production Unit			0.50	11.00	**11.50**
22	Single CTM Contact Centre				2.00	**2.00**
		23.27	**138.62**	**161.75**	**404.60**	**728.24**

Feedback from the submission is expected from WG during the Autumn.

Part B - ENERGY PERFORMANCE 2022/23

5.0 Energy Efficiency

The purpose of Part B of this report is to provide the Board with the 2022 /23 energy performance levels for its estate and show how they compare against Welsh Government's key performance indicators and the other Health Board's in Wales and to demonstrate the ongoing and planned works to reduce energy consumption and reduce emissions.

CTM recognises that it has a responsibility to be energy and resource efficient by minimising unnecessary energy usage, reducing emissions & the impact on the environment and through its Green working group are actively engaged in responding to NHS Wales Decarbonisation Strategic delivery plan.

5.1 Energy Targets

The NHS Wales Decarbonisation Strategic Delivery Plan is aligned to Welsh Ministers ambition for the public sector to be net zero by 2030. As the largest public sector organisation in Wales, the NHS has an important role to play to contribute towards this target.

The reduction of energy usage will deliver benefits of:

- Reducing cost which enables savings made to be reinvested.
- Minimizing the impact on the environment.

5.2 Monitoring

CTM utilises a software package to monitor the consumption and cost of energy. The trend graph below in table 9 shows that the emissions were reducing, albeit with small margins. Acceleration in carbon reduction is required in future years to meet the Welsh Government's Net Zero target by 2030.

The CTM's 'Strategic Assessment of Energy Efficiency Opportunities' report has been undertaken with consultancy support from the Welsh Government Energy Service (WGES), which recommends six detailed projects. This initial assessment identified the potential for a 13% carbon saving that can be achieved across the six audited sites.

5.3 All Wales Benchmarks

The most recently published All Wales Dashboards are for 2022 / 2023 and are shown in table 8, this confirms that energy consumption (kWh/m^2) in CTM has decreased from 407 to 400 whilst CO2 (Kg/m^2) emissions has reduced from 84 to 82.

Table 8

2021 – 2022

Energy Performance and Carbon Dioxide (CO_2) Emissions

	Net Energy Consumption (kWh/m^2)	CO_2 Emissions* (kg/m^2)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	412	84
BETSI CADWALADR UNIVERSITY HEALTH BOARD	439	91
CARDIFF & VALE UNIVERSITY HEALTH BOARD	412	83
CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD	407	84
HYWEL DDA UNIVERSITY HEALTH BOARD	491	107
POWYS TEACHING LHB	382	77
SWANSEA BAY UNIVERSITY HEALTH BOARD	440	91
VELINDRE UNIVERSITY NHS TRUST	394	86
WELSH AMBULANCE SERVICES NHS TRUST	171	38

2022 - 2023

Energy Performance and Carbon Dioxide (CO_2) Emissions

	Net Energy Consumption (kWh/m^2)	CO_2 Emissions* (kg/m^2)
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	341	70
BETSI CADWALADR UNIVERSITY HEALTH BOARD	382	82
CARDIFF & VALE UNIVERSITY HEALTH BOARD	344	78
CWM TAF MORGANNWG UHB	400	82
HYWEL DDA UNIVERSITY HEALTH BOARD	472	103
POWYS TEACHING LHB	343	68
SWANSEA BAY UNIVERSITY HEALTH BOARD	415	82
VELINDRE UNIVERSITY NHS TRUST	367	81
WELSH AMBULANCE SERVICES NHS TRUST	141	31

5.4 CARBON REDUCTION AND ENERGY MANAGEMENT

CTM is committed to achieve the challenging targets set out in the NHS Wales Decarbonisation Strategic Delivery Plan. This plan sets out a series of aims and initiatives for Health boards in Wales to address in order to contribute towards Wales decarbonisation targets, including the aim for the public sector in Wales to be net zero by 2030. For building energy this translates to a 34% reduction in CO_2 emissions by 2030, with an interim 16% reduction in CO_2 by 2025.

CTM has an Environment & Sustainability Group which is the over-arching steering group for the decarbonisation agenda in the Health Board. In

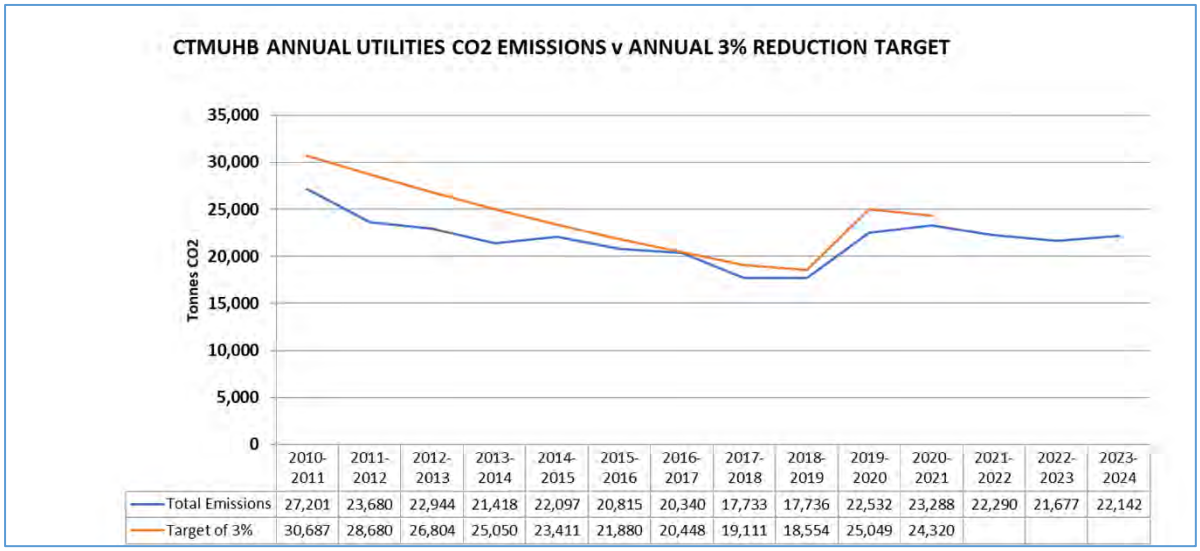
addition, it has the Green CTM Group which is the staff working group actively engaged in responding to the *NHS Wales Decarbonisation Strategic Delivery Plan*. The group gathers ideas and engagement from staff about how the Health Board can deliver carbon net zero by 2030 in line with this delivery plan. CTM also has a dedicated Green Space intranet site, the home to the climate change work.

In terms of the carbon emissions from the energy usage of our buildings, the Capital & Estates Teams are committed to tackling these and to continually drive to reduce the carbon footprint of our building energy emissions. Set against the challenges of a growing estate and demand for services, this challenge can only be achieved through a major step-change in the way we manage and use energy.

In terms of our energy costs, in 2023-24 this stood at £15.7 million, which, whilst a decrease on the previous year's historic high are still over double the costs from prior to the Covid pandemic and other global volatility challenges. Although consumption decreased marginally it is vital that the drive continues to reduce energy usage and the resulting carbon emissions.

Prior to the introduction of the National Decarbonisation Strategic Delivery Plan, our progress was measured against a 3% year-on-year reduction target and, although this has now been withdrawn table 9 still provides a useful illustration of the long-term direction of travel for energy and carbon reduction:

Table 9



	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
Total Emissions	27,201	23,680	22,944	21,418	22,097	20,815	20,340	17,733	17,736	22,532	23,288	22,290	21,677	22,142
Target of 3%	30,687	28,680	26,804	25,050	23,411	21,880	20,448	19,111	18,554	25,049	24,320			

(Note – the step increase in 2019 represents the addition of Bridgend area estate into the previous Cwm Taf estate)

5.5 RE- FIT FUTURE PLANS

The key plan within CTM is to improve energy consumption and emissions and to deliver the transformational level of change required is to enter into a programme called Re:Fit. This is a Welsh Government backed energy performance contracting framework that supports public sector bodies wishing to implement energy efficiency and decarbonisation measures across the estate through a long-term partnership (typically 10 years) based on a guaranteed savings arrangement.

CTM have recently selected its preferred Re:Fit partner company and it is anticipated that substantive works to start the first phase of energy and carbon reduction projects will commence in 2024-25. The types of initiatives likely to form part of the first phase of Re:Fit include solar photovoltaic generation installations, the rapid roll-out of LED lighting and low carbon heating systems.

5.6 CURRENT ACTIVITY

In terms of specific projects and activity delivered within CTM's Estates and Capital Teams, much has been achieved in recent years and the team continues to work hard to build on these schemes.

These include:

- Onsite generation – The Health Board now employs a variety of onsite energy generation technologies e.g., Solar Photovoltaics (PV), gas turbine CHPs, Absorption Chillers, Biomass boilers.

- In the last 2 years there have been significant new Solar PV installations across the estate, including at Dewi Sant, Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda & Keir Hardie Health Park. This has increased the installed solar PV capacity by almost 700 kilowatts.

- Further major PV installations commencing at Glanrhyd Hospital, Williamstown Medical Records Store and NIAW (National Imaging Academy Wales) at Pencoed totalling over 500 kilowatts. Together this

will result in approximately 1.2 Megawatts of new solar PV across our estate.

- LED Lighting upgrades (internal & external) continue with the UHB now having converted approximately 40% of the estate.

- Air Source Heat Pumps (a low carbon heating technology) are currently in use at Keir Hardie Health Park.

- Insulation & other building fabric improvements (including window replacement) undertaken, where funding available.

- Monitoring & targeting – the Health Board is pro-active in utilising Building Energy Management Systems such as Team Sigma, and Automatic Meter Reading.

- Voltage optimisation technology has been installed at a number of sites which was able to deliver savings in electrical consumption.

Clearly these are positive developments, however they are by themselves relatively small scale and are not able to deliver the transformative change required to reduce carbon emissions in line with national aims. This makes it clear why moving ahead with the Re:Fit partnership is seen as the best option to deliver the scale and pace of carbon reduction activity required.

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies, please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies, please list below:

Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies, please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Efficient
	If more than one applies, please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

6.0 Recommendation

The Board are requested to note the contents of the report.

Agenda Item
9.2.5

CTM Health Board

Nurse staffing Levels Annual Three year report 2021-2024

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tanya Tye, Nurse Staffing Act Lead
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore- Dix, Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
NSLWA	Nurse Staffing Levels Wales Act
CGND	Care Group Nurse Directors
CNO	Chief Nursing Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
WBC	Ward Based Caterer

1. Situation /Background

1.1 The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 (hereafter referred to in this document as the Act) was introduced into law in March 2016, coming into effect in April 2018 for all acute adult medical and surgical ward areas. From the 1st October 2021, the second duty of the Nurse Staffing Levels (Wales) Act was extended to paediatric inpatient wards.

1.2 Section 25E of the Act requires Health Boards/Trusts to report compliance in maintaining the nurse staffing level for all wards to which Section 25B pertain. Furthermore, The Health Board (HB) must submit a three year report to the Welsh Government, this is the second period that covers from 6th April 2021 to 5th April 2024. To facilitate this, a process of submitting an annual assurance report, using a nationally agreed template, to each Health Board has been agreed and implemented via the All-Wales Nurse Staffing programme.

1.3 The Board is asked to formally receive and note the following:-

- The 2021-2024 three-year report which has been produced using the agreed NHS Wales reporting template. This report was previously submitted to Board in May 2024 as a caveated report due to the timeframe for closing serious incident reports and the statutory timeframe set out by the Act. This is the final, updated version of the report which will be presented to the board in September 2024 and then Welsh Government in October 2024.

2 Specific Matters for Consideration

2.1 Three-year report 2021-2024

To provide assurance that Cwm Taf Morgannwg University Health Board is compliant with Section 25E of the NSLWA. Due to the requirements of the Act and the availability of data relating to the quality indicators and complaints about nursing care, this is the full report for noting by the Board in September 2024 with submission to Welsh Government in October 2024.

2 Key Risks / Matters for Escalation

2.1 Financial Impact

The table below shows the additional temporary financial investments that were agreed by the Care group nurse directors and their finance leads to support temporary increases in the ward establishments.

Ward	21/22 spend	22/23	23/24
PCH Ward 9	£189k	£189k	£15k
RGH Ward 19	£481k	£481k	£0k
RGH Ward 20	£288k	£288k	£55k
PoWH Ward 18	No cost implications - Specialty change only		

At present we are unable to benchmark against similar wards in the Health Board due to differences in bed numbers and patients admitted to the ward area, wards are currently undergoing a resetting period and future reports this data will where possible be added. There is a requirement to formally report any impact on issues relating to safety or quality of care, which are attributed to non-compliance with the NSA staffing levels. Specifically, these incidents cover:

- Hospital-acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).
- Medication-related never events.

There are adjusted definitions cited for paediatric inpatient areas, which include:

- Hospital-acquired pressure damage (grade 3, 4, and unstageable).
- Infiltration/extravasation injuries
- Medication-related never events.

In addition for all Section 25B wards complaints wholly or partially related to nursing care are also reported.
All incidents and concerns referenced to in this report have been reviewed and assessed by Heads of Nursing and Care group Nurse Directors via relevant internal assurance panel meetings.

3 Conclusion

3.1 In summary, the reporting year 2023-2024 demonstrated a significant number of developments and initiated project, affecting the wider workforce thus providing the oversight and assurance of quality of care and staffing level compliance. One such example would be the implementation of Safe Care across 33 wards within CTM.

3.2 SafeCare is part of the Allocate Health Roster system which provides information relating to patient acuity, dependency and staffing, supporting triangulation of data that assists with risk assessments and support decision-making in real time.

3.3 A significant focus on workforce recruitment and retention has been undertaken, the highlights are as follows:

- Between April 2023 & April 2024, the international recruitment programme, supported 40 internationally nurses to gain their Nursing Midwifery Council registration and obtain a substantive post in CTM.
- A further 11 internationally educated nurses already working in CTM in a Healthcare Support Worker capacity achieved their registration through a local adaptation program.
- A total of 103.55wte nurses were recruited via the student streamlining process during the September 2023 and March 2024 streamlining process.
- The launch of the Lateral Move policy in February 23 to support the opportunity in expanding clinical expertise and career development.
- Employment of a lead for recruitment and attraction in CTM.
- Continuing to actively influence future works through the All-Wales Nurse Staffing Programme and HEIW strategic workforce program.

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	Choose an item.	
	The nurse staffing act is a legal requirement for compliance	
Enw da / Reputational	Yes (Include further detail below)	
	The Nurse Staffing Act is reportable to Welsh Government	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	There may be requirements for financial input if staffing is required	

5 Recommendation

5.1 The Board is asked to Note:

Three yearly report 2021-2024:

- The three yearly report outlines the Health Board's position in line with the responsibilities defined by the NSLWA, acknowledging that the full report is to be presented to Health Board for noting in

September 2024 before submission to Welsh Government in October 2024

6 Next Steps

6.1 Assurance period 2024-2025

- To strengthen the utilisation of Safe Care in the daily operations of the ward management, providing oversight with the acuity and dependency of patients in the acute ward setting.
- Work alongside recruitment and attraction health board leads to refine nurse recruitment processes maximising all streams (streamlining, IEN's, internal development of staff OU/ flexi-route nursing).
- Realignment of services within both planned and unscheduled care across the Health Board.

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	Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Cwm Taf Morgannwg University Health Board (CTM UHB)		
Reporting period	The reporting period is 6th April 2021- 5th April 2024. A caveated version of this three-yearly report was presented to Board in May 2024, this is the final version of the report reflecting all serious incident reports that occurred during the reporting period and is to be presented to the Health Board in September 2024, with final submission for presentation to Welsh Government October 2024. Note: where the number remains as a single digit, this reflects the area that have never deviated and remains the same every year.		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Health Board	**26th May 2022** Appendix A	**25th May 2023** Appendix B	**30th May 2024** Appendix C
Number of adult acute medical inpatient wards where section 25B applies	Number of wards at lowest and highest point during this period. **15-19**	Number of wards at lowest and highest point during this period. **16-17**	Number of wards at lowest and highest point during the reporting period. **16-17**
Number of adult acute surgical inpatient wards where section 25B applies	Number of wards at lowest and highest point during the reporting period. **12-16**	Number of wards at lowest and highest point during the reporting period. **15-18**	Number of wards at lowest and highest point during the reporting period. **15-16**

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Number of paediatric inpatient wards where section 25B applies	Number of wards at lowest and highest point during the reporting period. 3	Number of wards at lowest and highest point during the reporting period. 3	Number of wards at lowest and highest point during the reporting period. 3
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards** 1	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards** 0
	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute surgical inpatient wards** 1	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute surgical inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute surgical inpatient wards** 0
	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0
Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	**Reporting Period 2021-2022 Highlights** The annual assurance report from April 6th 2021- April 5th 2022 explains how the Health Board (HB) has maintained compliance with the Nurse Staffing Levels (Wales) Act 2016, (this will be referred to as 'the Act'). The impact of COVID-19 has resulted in legacy nurse staffing levels in some areas with temporary staffing increases in the wards' staffing to accommodate some service delivery changes. The narrative below explains how the nursing establishment has been adapted to ensure safe delivery of care. Following the directive set out by the Chief Nursing Officer (CNO) in March 2020 clarifying the status of Section 25B wards, an additional three wards were included with them being repurposed to either an adult acute medical or surgical inpatient ward, requiring reporting compliance under Section 25A (S25A) of the Act. • 3 wards increased staffing temporarily due to a change in speciality to a high-care area (PCH ward 3, RGH ward 7, PoWH ward10) • 5 wards decreased staffing due to the relocation of the ward area (RGH wards 2 & 9, PoWH Wards 7, 8 & 11)		

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	• 6 wards received increases in nurse staffing due to Covid-19 temporarily for 6 months (PCH ward 9, RGH ward 1, PoWH wards 5, 6, 9, 11) The Covid-19 virus predominantly affected patients with respiratory complications resulting in a high demand for acute medical care, requiring a number of surgical wards to be converted to acute medical inpatient wards. During this period, fluctuating numbers of admissions and infection prevention constraints resulted in wards continually assessed and changed accordingly to minimising risk and ensure admitting capacity. To maintain oversight of staffing numbers daily staffing meetings held on a daily basis, allowing patient acuity and staffing numbers to be reviewed and where necessary redeployment of staff to mitigate risks while maintaining compliance with the Act, Further details are outlined in the annual assurance reports. Highlighted in the previous three-year report the Health Board (HB) during the pandemic, the Health Board commissioned a field hospital to support patients as step down facility and support rehabilitation. At the peak of the pandemic, this facility reached 98 beds and continued during this reporting period. Staff were redeployed from alternative areas that had been temporarily been stood down and a community ward that had temporarily decommissioned for rebuilding. This remained open until 2022 when the “field hospital” was decommissioned. **Reporting period 2022- 2023 Highlights** A detailed outline of the HB's compliance with the Nurse Staffing Levels (Wales) Act 2016 is in the annual assurance report 6th April 2022- 5th April 2023. During this period, while Covid-19 remained in circulation, some surgical services were restarted which led to repurposing of wards from medical speciality to surgical to accommodate. The three wards (PCH ward 3, RGH ward 7, PoWH ward10) used as temporarily high-care Covid-19 area returned to acute medical or surgical wards bringing them back under Section 25B (S25B) of the Act. Across the District General Hospital (DGH) sites, several ward moves were undertaken to ensure services demands were attained. These temporary changes resulted in two bi-annual re-calculations of the Nursing staffing Levels Temporary funding for COVID-19 ‘uplifts’ to the establishment were removed during this period following the biannual acuity audits, this ensured wards increased or decreased staffing accordingly. **Reporting period 2023-2024 Highlights** During the third year of the reporting period, the Health Board undertook a service remodelling and transitioned from an Integrated Locality Group model to the creation of Care Groups. Changes in ward allocation as a result of the service realignment, resulted in staffing level adjustments, reflecting patient acuity, pathways, and flow over the three-year reporting period. With the number of changes taking place during this period, as well as to maintain oversight and assurance, a report of acuity, staffing levels and untoward incidents was provided to the Heads of Nursing on a weekly basis. They were required to review, update and maintain a log for decisions made with associated rationales. As a result of clinical areas demonstrating maintained stability, an adjustment to the monitoring process was made to monthly reporting.

Informing patients	Following each biannual acuity audit presentation to the Board, Heads of Nursing are provided with updated bilingual ward templates to be updated and displayed outside their ward areas. However, the RCN Progress and Challenge Report (2023) highlighted that the wards in CTMUHB were not always updating them. To address this, the templates have been recirculated to all ward areas that are covered by the act and reminders of the need to update and display. The senior nursing team are responsible for completing regular audits to provide assurance of compliance to be collated digitally via the Audit Management and Tracking (AMaT) system. Further improvements to ensure compliance with the Act have been implemented across CTM which includes: • Introduction of ward boards at every ward entrance. This provides a dedicated area to display the up-to-date template allowing this information to be visible for all patients and relatives entering the ward. • The All-Wales Nurse Staffing Act (NSA) Leads in partnership with Health Education Improvement Wales (HEIW) are exploring the production of QR codes for the patient leaflets which will be displayed at ward level in addition to hard copies being available for distribution.

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Section 25E (2a) Extent to which the nurse staffing level is maintained As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.				
	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	**Number of wards: 29**		
		RN: 600.77 WTE (whole time equivalents)		
		HCSW: 452.34 WTE (whole time equivalents)		
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards CALCULATED during first cycle (May)	**Number of wards: 31**	**Number of wards: 32**	**Number of wards:33**
		RN: 632.89 wte	**RN: 644.94 wte**	**RN: 654.24 wte**
		HCSW: 464.21 wte	**HCSW: 496.96 wte**	**HCSW: 494.99 wte**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards FUNDED during first cycle (May)	**Number of wards: 31**	**Number of wards: 32**	**Number of wards: 33**
		RN: 632.89 wte	**RN: 644.94 wte**	**RN: 654.24 wte**
		HCSW: 464.21 wte	**HCSW: 496.96 wte**	**HCSW:654.24 wte**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards CALCULATED during second cycle (Nov)	**Number of wards: 34**	**Number of wards: 33**	**Number of wards: 33**
		RN: 648.01 wte	**RN: 672.97 wte**	**RN: 647.23 wte**
		HCSW: 531.80 wte	**HCSW: 514.90 wte**	**HCSW: 504.7 wte**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards FUNDED during second cycle (Nov)	**Number of wards: 34**	**Number of wards: 33**	**Number of wards: 33**
		RN: 684.01 wte	**RN:672.97 wte**	**RN: 647.23 wte**

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		HCSW: 531.80 wte	**HCSW: 514.90 wte**	**HCSW: 504.7 wte**
		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster) (Two surgical wards in PoWH have the same Band 7 across 2 wards This explains the deficit of 1 Band 7 in the 2023/2024 figures compared to wards above)	**WTE: 30**	**WTE: 33**	**WTE:32**

Accompanying narrative:

Over the last 3 years, Covid19 affected the clinical presentation of patients requiring a high demand on acute medical services which has resulted in a number of wards under section 25B being repurposed. This is due to Covid19 predominantly affecting individual's respiratory systems which is classified as an acute medical speciality. Further details can be found in the annual assurance reports attached as appendices (A, B, C). During the same reporting period, some areas required temporary funding, which have now been reviewed and adjusted as necessary following the outcomes of the biannual acuity audits. There continues to be an ongoing focused piece of work to address the partial absence of ward-based caterers at the Princess of Wales site to bring into alignment across the health Board.

Band 7 Ward Managers remain supernumerary to the agreed establishments in line with the statutory guidance.

CTMUHB remains committed to staff recruitment and retention, organising biannual student streamlining events and participating in the All-Wales recruitment of internationally educated nurses (IENs). Over these three years the Health board has recruited 358 internationally educated nurses, 11 completing an adaptation program specifically designed for CTM as an internal pathway, with a further, 429.72 whole-time equivalent student nurses employed through the streaming process into CTM.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included in the data for this report. Further information is provided within the annual assurance report (Appendix D) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

	Required establishment (WTE) of paediatric inpatient wards prior to extension of the 2nd duty of the Act (October 2021)	**Number of wards: 3** **RN: 93.97 wte** **HCSW: 19.1 wte**		
Extent to which the required establishment has been maintained within paediatric inpatient wards		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of paediatric inpatient wards CALCULATED during first cycle (May)		**Number of wards: 3**	**Number of wards: 3**
			RN: 93.97 wte	**RN: 93.81 wte**
			HCSW: 19.1 wte	**HCSW: 19.1 wte**
	Required establishment (WTE) of paediatric inpatient wards FUNDED during first cycle (May)		**Number of wards:3**	**Number of wards: 3**
			RN: 93.97 wte	**RN:93.81 wte**
			HCSW: 19.1 wte	**HCSW: 19.1 wte**
	Required establishment (WTE) of paediatric inpatient wards CALCULATED during second cycle (Nov) NB: The 1st calculation (2021/2022) was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act on 1st October 2021.	**Number of wards: 3**	**Number of wards: 3**	**Number of wards: 3**
		RN: 93.97 wte	**RN: 93.97 wte**	**RN:93.20 wte**
		HCSW: 19.1 wte	**HCSW: 19.1 wte**	**HCSW:20.31 wte**
	Required establishment (WTE) of paediatric inpatient wards FUNDED during second cycle (Nov) NB: The 1st calculation (2021/2022) was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act on 1st October 2021.	**Number of wards: 3**	**Number of wards: 3**	**Number of wards: 3**
		RN: 93.97 wte	**RN: 93.97 wte**	**RN:93.20 wte**
		HCSW: 9.1 wte	**HCSW: 19.1 wte**	**HCSW:20.31 wte**
		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 3**	**WTE: 3**	**WTE: 3**
	Accompanying narrative: The extension of the Act incorporating paediatrics came into effect in October 2021 and was reported to Board in November 2021. Biannual reviews have taken place on the three-paediatric wards with amendments made to two of the wards in the third year of the reporting period with all establishments funded. Recalculations have taken place using the triangulated methodology set out in Section 25C of the Act. It is			

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	noted, that due to vacancies in PCH, this has resulted in the use of a temporary workforce via the staff bank to cover any deficits to ensure the planned roster is met. Recruitment and retention remains a focus for the Health board with the appointment of an attraction and retention lead for CTM now in post and ongoing focus to fill registered nursing vacancies. For more details of individual wards and their required establishments, refer to the annual assurance reports. Band 7 Ward Managers remain supernumerary to the agreed establishments in line with the statutory guidance. In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals contributing to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information provided within the annual assurance report (Appendix D) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.
Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards	NHS Wales is committed to utilising a national informatics system as a central repository for collating data to evidence the extent to which the nurse staffing levels are maintained and to provide assurance that all reasonable steps have been taken to provide the recommended nurse staffing levels. Extensive work has been undertaken across NHS Wales to implement a national system to enable health boards to meet the reporting requirements of the Act on a Once for Wales approach to ensure consistency. The Allocate Safe Care system has been rolled out across Wales over the previous 3-year reporting period, progressing at varying speeds in each HB. This has resulted in reliance on the existing Healthcare Monitoring System (HCMS), which has been adapted to ensure consistency in data collection, and analysis to support reporting until this is fully embedded across all Wales. In CTMUHB, the Allocate Safe Care system has been implemented since July 2023, with ongoing training to ensure user competency. Since January 2024, Safe care has replaced the HCMS and will be the sole system used for data collection moving forward. This system includes the functionality to capture professional judgments and red flags, ensuring that all reasonable steps and mitigation measures are documented following assessments.
Extent to which the planned roster has been maintained within paediatric inpatient wards	The process and systems used within paediatrics inpatients wards align with those used within the adult medical and surgical wards through the use of Safe Care and the narrative outlined above is the same.
Process for maintaining the nurse staffing level	The Health Board is required, as detailed within the statutory guidance, to ensure that "All Reasonable Steps" are taken to maintain the nurse staffing levels in 25B wards. Through the All-Wales Nurse Staffing programme, Executive Nurse Directors across Wales have agreed and issued further clarification on what constitutes the 'All Reasonable Steps' to maintain the nurse staffing levels at the calculated levels.

for Section 25B wards	It is the responsibility of the Ward sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards. This is escalated and approved by the senior nurse confirming that the decision-making, risk assessments and deployment of nurses is authorised. To provide analysis and oversight, workforce meetings are attended by Nursing, Finance, Workforce and Roster teams, held on a monthly basis. These metrics and presented to the Nursing and Midwifery workforce steering group. There are well-established processes on each of the acute sites to review nurse-staffing levels on a daily basis via the safe to start meetings. This supports decision making when considering staff deployment to other clinical areas based on risk assessments that review the hospital as whole to balance the risk and take actions to mitigate the risk, which may include the deployment of staff to maintain safe staffing levels. During 2022 /2023, Safe Care was implemented for use on the S25B Wards as well as some of the section 25A wards across the acute sites. Nursing teams report at their Safe to start meetings any Level 4 & 5 patients, whilst further analysis of details such as patient acuity and dependency can be viewed on the Safe Care system daily. This is intended to inform staffing and to record operational decisions relating to staff deployment. The Health Board is also reliant upon temporary staffing for both registered nurses and HCSWs to maintain the required nurse staffing levels. The use of 'Allocate' rostering has provided a standardised approach to rostering and booking temporary staffing via the staff Bank Office. The Nurse Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for CTM UHB was published in March 2020. The purpose of this operating framework is to support the calculation and maintenance of the nurse staffing levels in adult acute medical and surgical wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. Within the acute hospitals, nurse staffing levels are reviewed three times a day and where required, staff are deployed accordingly using all reasonable steps together with professional judgement to inform decision making as to the appropriate nurse staffing levels required. There are embedded processes within the nursing structures on each of the acute sites for reviewing nurse staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meeting. To ensure compliance with the 2016 Act, a Once for Wales approach is being developed with the use of a national system to record and review the nurse staffing levels and collate the data required to inform the reporting requirements. This includes an agreement to implement the rostering software 'Allocate' nationally. CTM already utilises this system however, further discussions are ongoing with 'Allocate' with regard to adaptations to the Safe Care system and the implementation of a national system to aid reporting of incidents & concerns. Following a January 2023 acuity audit, HEIW and DHCW were unable to produce the visuals, therefore an internal solution was utilised by CTM through Qliksense. CTM have a number of key initiatives to support Nurse staffing levels as outlined below:- • Safe Care to provide overview of staffing on a daily basis • Use of Temporary staffing via Nurse bank/ agency/ overtime

- Establishment meetings held monthly by Heads of Nursing, Workforce, Finance and Roster team

Recruitment and Retention

- The Health Board continues to recruitment internationally educated nurses and is part of the All-Wales initiative, which has brought 358 WTE nurses across three acute hospital sites across this reporting period and more recently into the acute sector
- Through Student streamlining CTM has recruited 429.72 wte newly registered nurses.
- Of a total of 82 wte nurses who successfully applied for Flexi student programme, 77 of these have subsequently taken up a registered nurse role within CTMUHB in the last 3 years
- The creation of a “Lateral movement” policy for band 5 nurses to seamlessly move into vacancies was implemented in February 2024 has been positively received. This policy will support easy transition for individuals to move into new roles to gain wider clinical expertise, supporting career progression, and remain in the health board.
- Establishing a Band 5, 6 & 7 development programmes alongside the CTMUHB Leadership programmes
- Exploration of innovative training opportunities in partnership with the University South Wales.

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Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e., 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	Year 1	48	2	0	40
	Year 2	10 (14)	2 (2)	0	25 (11)
	Year 3	55	2	0	6
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	9	6 (initial level of harm reported as severe)	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	Year 1	3	2	0	0
	Year 2	4	1	0	0
	Year 3	1	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	Year 1	3	1	0	0
	Year 2	1	1	0	0
	Year 3	0	0	0	0

Inpatient Acute adult medical and surgical wards

The Once for Wales incident reporting system was updated in April 2022 to include mandatory fields to be competed to ensure that staffing levels are considered when a fall, hospital acquired pressure ulcer or medication error is reported. All incidents have been reviewed by the Heads of Nursing on the three acute hospital sites via internal weekly scrutiny panel meetings. Following these panels, any incidents where inappropriate nurse-staffing levels are deemed to have been a contributing factor are shared wider for learning.

Hospital acquired pressure ulcers

There has been a decrease in reportable incidents relating to skin damage compared to the previous three-year reporting period. Of the 104 incidents reported, 8 were deemed unavoidable, notwithstanding an indication that the nurse staffing levels were not consistently maintained. It was concluded that all appropriate risk assessments and mitigation were in place at the time the incidents occurred. All incidents and subsequent learning have been shared for wider learning across the health board.

9 incidents remain open and under investigation, these will be reported in the next reporting period 2024-2025 in the annual assurance report.

Falls

Overall, there has been a decrease in reportable falls incidents compared to the previous three year reporting period a total of 6 falls where serious harm or Death occurred were recorded (To note this figure was taken from initial reporting of the incident and a subsequent number were downgraded). Following scrutiny 3 of these were deemed to have occurred when the nurse staffing levels were not maintained and were unavoidable as all measures were in place. 2 of these were considered to have happened when there was a failure to maintain the nurse staffing levels. All incidents and subsequent learning has shared for wider learning across the health board

6 incidents remain open and under investigation, these will be reported in the next reporting period 2024-2025 annual assurance report.

Medication Errors

The reporting criteria for these “never events” are set by Welsh Government. There has been no medication errors reported in this period, which is a decrease by 1 since the last three year reporting period, 2018-2021

Complaints about nursing care

There has been a total of 130 incidents reported in this period specifically relating to nursing care. Following investigation, it was determined that none of these related to noncompliance of nurse staffing levels. All learning from these complaints have been shared across the HB.

All Wales Update

Based on a review of the Health Boards first three yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021. This included a series of recommendations to improve and refine the reporting process. As a result, a sub-group of the All-Wales Nurse Staffing Group was established, with the key objective of improving and refining the reporting process. This initiative aims to standardise reporting in line with the Duty of Candour set out in the Quality & Engagement Act (2020), and broaden the scope of incidences of harm to provide more meaningful data by including moderate risk falls and medication error incidents.

The work of the reporting sub-group included the measures for the adult medical and surgical inpatient wards presented to Executive Nurse Directors in August 2023. The changes to the adult ward measures were agreed upon, with the amendments coming into effect at the beginning of the next reporting period i.e., April 2024.

The quality indicators for the adult inpatient wards were agreed as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right, PTR))

The data to be reported for each of the above was agreed as follows:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level were identified as a contributing factor, even when planned roster had been maintained.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards

3 year report 2021-2024
CTMUHB

incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Infiltration and extravasation injuries	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current reporting period.	Year 1 (*)	0	0	0	5	1
	Year 2	0	0	0	7	1
	Year 3	0	0	22	7	5
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	0	0	2	3	2
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	Year 1 (*)	0	0	0	0	1
	Year 2	0	0	4	0	1
	Year 3	0	0	1	0	0
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had been maintained	Year 1 (*)	0	0	0	0	0
	Year 2	0	0	0	0	0
	Year 3	0	0	0	1	0

NB (*) for year 1 paediatrics inpatients only reported incidences and complaints from the 1st October 2021 when the 2nd duty of the Act was extended

Paediatric Inpatient wards

The work of the reporting sub-group, as mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e., April 2024.

The quality indicators for the paediatric inpatient wards were agreed as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above was agreed as follows:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

CTM Reporting 2021- 2023

During this reporting period there were10 complaints recorded and 9 untoward incidents where planned roster numbers were not met. Following investigation by the Head of Nursing for Children & Young People through stablished governance routes, there was partial evidence to suggest decreased nurse staffing levels were a contributory factor in some incidents. Any Lessons identified, have been disseminated across the HB through high-level quality and safety meetings as well as ward areas.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	The Health Board is committed to reviewing and learning from all incidents that occur and has a robust process through which incidents are reviewed and investigated to ensure lessons are learnt, corrective action are taken, risks are minimised and wider sharing occurs During this reporting period the actions taken by the Health Board to maintain the nurse staffing levels in section 25B wards have been challenging and have required a multifaceted approach to address situations when nurse staffing levels are not maintained. All of the incidents included in this report have been examined both by the Care group operational and corporate leads to review whether the nurse staffing levels were maintained at the time of the incident and, if not, whether failure to maintain the nurse staffing level contributed to any harm experienced by the patient. To assist in maintaining nurse staffing levels on hospital wards, Safety Huddles were implemented in 2017, these continue to be led by the Heads of Nursing to ensure that all reasonable steps and mitigating actions are taken, these include: • Access and availability of temporary staff, bank and agency • Block booking of temporary staffing through agencies • Moving staff from other areas – this is risk assessed on a shift-by-shift basis and a new tool to monitor this practice is in development • Ensuring the e-roster has been examined and signed off by the Senior Nurse • The Ward Sister or Senior Nurse working within the ward numbers • Balancing staffing and safety through periods of surge, where the option to consider repurposing of in patients beds considering risk to patient care and safety while maintaining patient flow Since the establishment of the Care groups, there has been consistency in the use of assurance panels, reviewing and investigating untoward incidents relating to falls, skin damage and medication errors. This consistent approach provides assurance of analysis into contributing factors, including adequate nurse staffing levels and wider learning opportunities. Some of the challenges as a result of the COVID-19 pandemic for 25B wards reported included difficulties in updating reporting systems due to operational pressures and the lack of a robust national IT system. Over the last three year reporting period, there have been 4 incidents attributed to deficits in the planned nurse staffing levels as a contributory factor; 2 hospital acquired pressure damage and 2 inpatient falls. It should be noted that neither of the incidents met the harm threshold for National Reported Incident reporting criteria set by Welsh Government. All 4 incidents were reviewed via the Care Group

Final

	quality and safety, safeguarding processes staffing was deemed a contributing factor. In respect to these incidents, feedback has been provided to the wards sisters/charge nurses and steps taken to address the issues raised. It should be noted that it is not yet possible to draw any conclusions or trends as to cause and effect with the small numbers of serious incidents provided in this report. The required level of analysis will be enabled through the ongoing collection of data in conjunction with the Once for Wales incident reporting system introduced in September 2021.
Conclusion & Recommendations	This is the second three-yearly assurance report providing details as to the compliance of the Nurse Staffing Levels (Wales) Act. It remains clear that year 1 of the COVID-19 pandemic continued to pose significant challenges for the Health Board resulting in the need to repurpose clinical areas in response to the service demands at the time. Following a return to 'business as usual', wards have now been realigned to meet post-Covid19 requirements with work ongoing across the Care groups led by Nurse Directors to ensure efficacy and accuracy in the alignment. The ongoing work extends to ensuring areas have appropriate nurse staffing levels to provide the delivery of high-quality nursing care and positive outcomes and experiences for patients. In summary, during the reporting period the Health Board has: • Set out to achieve progress in meeting the requirements of the Nurse Staffing Levels (Wales) Act 2016. • Continued to progress nurse recruitment in order to fill vacancies with the short to medium term investment into recruitment of registered nurses within the Health Board including 358 overseas registered nurses (year 1-211, year 2-96, year 3-51), 429.72wte Student Nurses from the Streamlining process. • Committed to increasing maturity in the availability of information to nurse leaders to support and inform clinical decision making, including the creating of The Nursing Nurse staffing levels (Wales) Act (2016) Operating Framework and Escalation Policy and All Reasonable Steps. • Continued to make improvements to the information provision for patients and the public in relation to Nurse staffing levels in our hospitals • Refined governance systems and processes in line with the 2016 Act and revised organisational structure. • Has incorporated the extension of the Act into Paediatric inpatient areas (October 2021). • Implemented the rollout of Safe Care as well as updates to the incident reporting system to provide information and augmented intelligence enabling operational and management teams to utilise systems effectively to inform local decision making and inform the reporting requirements of the Act. Recommendations and work programmes associated with the 2016 Act in 2024-2027, to ensure that the Health Board continue to meet its statutory duty under the 2016 Act includes the following priorities: • To review and update the current sign off process for the templates, placing ownership to and empowering the operational teams to complete the relevant processes ready for final approval.

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	• Work with the senior nursing team and ward managers on the Section 25B wards within the Health Board to ensure nurse staffing levels are appropriate with the undertaking of recalculations and updating of templates as required by the Act when needed. • Review recruitment and retention initiatives within the HB both 'grow your own', local and international recruitment • Understand how the incident reporting system can align the data and dashboard to illustrate the required reporting metrics for the NSA templates and reports ensuring accuracy and accessibility.

Final

Appendix A Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board	Cwm Taf Morgannwg University Health Board (CTMUHB)		
Date annual assurance report is presented to Board	26th May 2022 The reporting period is from April 6th 2021- April 5th 2022		
	Adult acute medical inpatient wards	Adult acute surgical inpatient wards	Paediatric inpatient wards
During the last year the lowest and highest number of wards	Lowest 15 and highest 19	Lowest 12 and highest 16	3
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0	1 Ward 8 at POWH – surgical ward	0
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing levels (Wales) Act 2016 (hereafter referred to in this document as the Act) came into effect in April 2018. When referring to section 25B wards in this report, these are the adult acute medical and surgical inpatient wards within the Health Board (HB). From the 1st October 2021 the second duty of the Nurse staffing Levels (Wales) Act was extended to paediatric inpatient wards. Therefore, from the 1st October when discussing section 25B wards it will also include paediatric inpatient wards as well as adult acute medical and surgical inpatient wards. Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical and paediatric inpatient wards. The calculation is undertaken bi-annually in January and June as per agreement within the once for Wales approach. The triangulated methodology prescribed in section 25C of the Act sets out the principles to calculating		

	the nurse staffing levels. Due to the continuing Covid-19 pandemic during this reporting period and the pressure this placed in the acute settings in hospitals, the Welsh Government informed Health Boards that they were not mandating for the bi-annual audit in January 2021 to be undertaken. In response with the 'Once for Wales' approach Executive Nurse Directors agreed that their Organisations would defer this bi-annual audit and subsequent calculations of nurse staffing levels until June 2021. January 2021 staffing calculation In order to maintain oversight with compliance of the 2016 Act, the Health Board did not undertake the formal bi-annual acuity audit but it did conduct a review of the Section 25B wards in February/March 2021, where calculations were solely reliant on the professional judgement of the Ward Sisters/Senior/Lead and Heads of Nursing to complete the nurse staffing establishment templates. A Board report was presented on the 27th May 2021 regarding compliance in maintaining the nurse staffing level for their Section 25B wards. June 2021 Staffing Calculation For each inpatient ward identified under Section 25B for the June 2021 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 each acute hospital to generate the report: • Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager and ward administrators (in Princess of Wales (PoW) only). • Patient acuity data for the month of June 2021. • Care quality indicators data from the previous 24 months (falls, medication errors, pressure damage and serious incidents). • Workforce related metric data, mandatory training compliance, vacancy, recruitment and sickness. • Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system 'Qlik Sense', a system which allows live information to be available to the 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 were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and by the ILG Directors of Nursing. The final templates were endorsed by the Executive Nurse Director. Paediatric inpatient wards As outlined above, a similar methodology and approach was used for the paediatric inpatient wards in calculating their staffing levels and subsequent calculations. Following this initial triangulation in September 2021, these wards will now align to the 6 monthly cycle used for the adult acute medical and surgical inpatient wards. A Board report was presented on the 25th November 2021 regarding compliance in maintaining the nurse staffing levels for their Section 25B wards.
Informing patients	The statutory guidance states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). The statutory requirements to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed. Bilingual poster templates are displayed at the ward entrance The poster template identifies the information of the nurse staffing numbers calculated for the identified period and the date that the calculation undertaken and signed off by the designated person. To ensure transparency and consistency across Wales, the All Wales Adult Acute Medical & Surgical Inpatient Work Stream Group redesigned the informing patient's templates, which were issued to section 25B wards within the Health Board following the June 2021 bi-annual acuity audit and calculation. All Section 25B informing patient templates within CTMUHB have been updated accordingly. Paediatric inpatient wards have paediatric specific informing patient templates which were issued following the initial calculation and are being used within CTMUHB.

	All Section 25B wards have patient information leaflets available for informing patients of the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy read versions) can be provided to answer any more detailed questions a patient or a visitor may have about the Act, a children and young person's poster is visible on all paediatric inpatient wards.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

Extent to which the required establishment has been maintained within adult acute medical and surgical wards.

	Period Covered 6/4/21= 5/4/22		
	Number of Wards:	RN (WTE)	HCSW (WTE)
Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	31	632.89	464.21
WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	31	632.89	464.21
Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	34	684.01	531.80
WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	34	684.01	531.80

Accompanying narrative:

During the last reporting period there has been a number of wards under section 25B that have changed (for more details of individual wards and their calculated nurse staffing levels, refer to Appendix B). Prior to the Covid-19 Pandemic the 25B wards within CTMUHB were relatively stable regarding their required staffing establishment, however in response to the pandemic there have been a number of wards repurposed frequently across CTMUHB to meet demand. At the time of this report there are still 5 ward areas across CTMUHB which continue to be repurposed into high care respiratory or ITU and therefore remain outside of the Section 25B wards. These are currently:

	• Ward 9 in PoWH has been repurposed from an acute surgical ward into a Covid-19 high care admissions area. • Ward 3 in PCH has been repurposed from an acute orthopaedic surgical ward into a Covid-19 high care area and Ward 4 has been converted temporarily from an acute trauma surgical ward into ITU due to building works. • Ward 3 in RGH has been repurposed from an acute Trauma & Orthopaedics surgical ward into a Covid-19 admission ward. Ward 7 has been repurposed from an acute surgical ward into ITU surge capacity Wards added to section 25B within CTMUHB: • Ward 10 in RGH, is currently an elective surgical green pathway ward area. • Ward 20 in RGH has been repurposed from a rehabilitation ward to an acute medical ward. • Ward 21 PoWH is currently an adult acute short stay surgical unit. • Protected Elective Surgical Unit (PESU) in PCH, is currently a green elective surgical ward. Wards no longer within Section 25B • Ward 8 in PoWH is currently relocated to Ward A in Ysbyty'r Seren and has been repurposed into a rehabilitation ward therefor no longer sits within the Act. • Ward 11 in PoWH was a respiratory ward during Covid-19 but has now been decommissioned and is closed. • Ward 15 in PoWH was an Acute elderly ward during Covid-19 but has now been repurposed into a rehabilitation ward therefor no longer sits within the Act Whilst at the second bi-annual calculation in November 2021 there appears to be an additional staffing establishment requirement, this is primarily due to wards either being repurposed and/or reopened and then being included into the section 25B of the 2016 Act. These actions were taken to support capacity within the CTMUHB hospitals in relation to the on-going COVID-19 pandemic. When required, the ILGs Nurse Directors have realigned their budgets to meet the ongoing staffing requirements for section 25B wards.

Extent to which the required establishment has been maintained within paediatric inpatient wards		Period Covered 1/10/21 – 5/4/22					
		Number of Wards:	Number of Wards:	Number of Wards:			
	Funded establishment (WTE) of paediatrics inpatient wards prior to 1st October 2021	3	3	3			
	Required establishment (WTE) of paediatrics inpatient wards calculated during second calculation cycle (Nov)	3	3	3			
	WTE of required establishment of paediatrics inpatient wards funded following second (Nov) calculation cycle	3	3	3			
	Accompanying narrative: During the initial calculation, the nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps. There have been ongoing challenges in relation to filling registered nurse vacancies following the first calculation which has meant that some posts identified are still to be recruited into. The new calculation has been completed using the same processes and is unchanged from the initial calculation. A focus on the recruitment processes continues to enable timely appointment of new staff, and a new recruitment and retention plan has been developed. As the longer-term effects of the pandemic on nurses is not fully understood, the nursing retention plan has been revised to reflect the new challenges posed in terms of staff wellbeing.						
Extent to which the planned roster has been maintained within both adult medical and surgical wards and paediatric inpatient wards		Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL	20 698	12 287	724	1812	5875	79.9(%)
Extent to which the planned roster has been maintained within adult acute medical and surgical wards		Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL	19 661	11 989 61 %	714 3.6%	1197 6.1 %	5761 29.3%	79.2%

	Accompanying narrative: When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and Health boards/Trusts were using a variety of e-rostering and reporting systems. During the first reporting period Health boards/Trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system ((HCMS) in lieu of a single ICT solution) to enable each Organisation to demonstrate the extent to which the nurse staffing levels across the Health board/Trust. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Over the last 3 years extensive work has been undertaken to inform the development of the Safecare system that continues to be implemented within Health Boards and Trusts within Wales through a phased approach. Each Health Board/Trust is at different stages of implementation, CTMUHB will begin the process to implement the use of Safecare shortly, this process will take approximately 18 months from start to finish to embed the system. The implementation of this national IT system will ensure consistency in recording and reporting data across organisations and support the 'Once for Wales' approach'. For the first reporting period (April 2018-April 2021) this Health Board, together with all other Health board/Trusts in Wales, provided a narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. During the latter part of the second reporting period (April 2021-April 2024) because of a robust national IT system being implemented, it is anticipated that Health Boards/Trusts can collate, review and report more information relating to the extent that nurse staffing levels have been maintained. In addition, Health Boards/Trusts will be able to demonstrate the extent to which the planned roster has been maintained and whether the deployment of nurse staffing was appropriate to meet the needs of patients sensitively. During year 1 of the current reporting period (April 2021-April 2024) Heath boards/Trusts have utilised 2 systems to enable the capture and analysis of data, the HCMS and Safecare. Due to the COVID-19 pandemic Health boards/Trusts have experienced extreme operational pressures which has impacted on the Organisations ability to implement Safecare within the desired timeframe.

	The Health Board will continue to utilise the HCMS to demonstrate the extent to which the nurse staffing levels across their Section 25B wards are being met. The use of the HCMS system will be used until Safecare is introduced within the Health Board over the next 18 months. When using HCMS, the nurse in charge of the ward assesses on a shift by shift basis the deployed workforce against the planned rostered workforce, they will then make a professional judgement as to whether the ward is adequately staffed or inadequately staffed for that shift. This data is extracted from HCMS into the Power BI app. The completeness of the data is higher in the paediatric inpatient wards compared to the inpatient acute adult wards (95% vs 79.2%) this equates to approximately 5163 missing shifts without data entered. Mitigating factors and caveats for this could be: 1. That the figures were obtained during COVID-19 pandemic and the hospital wards were extremely busy and therefore the data was not captured daily as per protocol. 2. Due to the amount of internal ward moves within each HB site, the tracking of data for each of the wards within section 25B is not 100% accurate as the system has not allowed for in inputting of key variables including if a ward closed or opened midway through the year the data reported will be for the entire time period and not for when the ward open or closed. It is the responsibility of the Sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards. It is the responsibility of the Senior Nurse to sign off the planned roster to authorise and confirm that it reflects an appropriate deployment of the nurse staffing resource that sits within the establishment for each ward. The monthly Nursing Establishment Meetings undertaken on each of the acute hospital sites focus on workforce management, effective rostering, efficiency of temporary staffing and staff well-being. The Health Board's Nursing and Midwifery Workforce group continues to be the forum where all the above key performance metrics are scrutinised. Utilisation of the Adult Nursing staffing Levels Wales Act (2016) Operating Framework & Escalation Policy has enabled the nurse in charge of the ward to assess, on a shift by shift basis the deployed workforce against the planned rostered workforce, they will then make a professional judgement as to whether the ward is adequately staffed for that shift and escalate and action accordingly.

<table>
<tr><td></td><td>In addition, one hospital in the Health Board has embedded ‘Safe 2 Start’ daily meetings Attendance includes, Head of Patient Flow, Head of Nursing, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on key quality and safety metrics relating to patient care and Emergency Department demand. At the meeting the Ward Managers and Senior Nurses work together to problem solve staffing challenges to support any areas of the greatest need and move staff accordingly to ensure that wards and departments are in a safe to start position. The aim is to replicate these Safe 2 Start meetings on the other two acute hospital sites.</td></tr>
<tr><td>Extent to which the planned roster has been maintained within paediatric inpatient wards</td><td>
<table>
<tr><td></td><td>Total number of shifts</td><td>Shifts where planned roster met and appropriate</td><td>Shifts where planned roster met but not appropriate</td><td>Shifts where planned roster not met but appropriate</td><td>Shifts where planned roster not met and not appropriate</td><td>Data completeness</td></tr>
<tr><td>TOTAL</td><td>1 037</td><td>298
28.7 %</td><td>10
1%</td><td>615
59.3%</td><td>114
11%</td><td>95(%)</td></tr>
</table>
Accompanying narrative:
On the 1st October 2021 the second duty of the 2016 Act was extended to paediatric inpatient wards therefore this report contains information from the 1st October 2021 until 5th April 2022.

Prior to the extension date the ward managers and senior nurses calculated their nurse staffing levels for each paediatric inpatient ward and this was presented to the Board in September 2021. The process and systems used within paediatric inpatient wards align to those that are used within the adult medical and surgical inpatient wards, including the HCMS and Safecare modules.

Daily acuity scoring has meant that nursing teams have been able to assess their patient’s acuity on a daily basis to ensure that the correct nursing numbers and skill mix can be deployed. Utilisation of the Paediatric Operating Framework & Escalation Policy has enabled the nurse in charge of the ward to assess, on a shift by shift basis the deployed workforce against the planned rostered workforce. They will then make a professional judgement as to whether the ward is adequately staffed or inadequately staffed for that shift and escalate and action accordingly.</td></tr>
<tr><td>Process for maintaining the Nurse staffing level</td><td>The NSLWA statutory guidance requires that the Health Board takes ‘all reasonable steps’ to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. Any actions taken to maintain the staffing levels support the premise that all reasonable steps have been taken. The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health</td></tr>
</table>

	Board supports the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical and paediatric inpatient wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. Strategic/corporate steps taken to maintain staffing levels The Heads of Nursing within the Health Board chair monthly workforce meetings to discuss their wards current vacancies and recruitment plans. As part of this meeting, the Allocate/Rostering department provide feedback and scrutiny of the ward rosters for efficiencies and compliance against key metrics to ensure that all rosters are completed as per policy. All nurse rosters are subject to an approval process monitored by the senior nurse team to ensure maintenance of a safe and effective roster. Operational steps taken to maintain staffing level Within the Acute Hospitals staffing levels are reviewed three times a day and if required staff are deployed accordingly using All Reasonable Steps together with professional judgement to draw on information at a local and national level to inform their decision as to the appropriate staffing levels required. The All Wales Executive Nurse Directors have agreed, and through the All Wales Nurse Staffing programme group have issued, further clarification on what constitutes the 'All Reasonable Steps' which are statutorily required to be taken in order to maintain the nurse staffing levels at the calculated levels. This document has been in place within health Board since November 2019. There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings. The COVID-19 pandemic has had a profound effect within the three DGHs and how the hospitals have responded to maintain patient safety and their staff that work within the wards. To assist in process of maintaining the extent to which staffing levels are maintained since November 2020 the Heads of Nursing for the 3 principal hospital sites have provided monthly staffing profiles for all their section 25B wards. Over the past year recruitment has been challenging for the Health Board. Within the last year and going into next reporting period the Health Board has devised a series of interactive meetings for student nurses who are entering the streamlining process to promote 'working for Health Board'. During this reporting period we have successfully recruited through streamlining 188 student nurses.

	The Health Board has been an active member in the newly established All Wales International Registered Nurse Programme and will be recruiting 100 nurses into CTM UHB, starting in the 1st quarter of 2022/2023. There is also representation at the All Wales forums exploring the creation of career frameworks for registered nurses, advanced clinical practitioners and Band 4 nursing roles. Strategic/corporate steps taken to maintain staffing levels • Planned recruitment of identified posts across the Health Board. • Roster completion – ensuring that all rosters are completed as per policy and that all rosters are developed to ensure that the correct number of staff are able to be provided, underpinned by a suite of rostering metrics. • Roster approval process – all nurse rosters are subject to an approval process monitored by the senior nurses to ensure safe and effective roster. Operational steps taken to maintain staffing level • Robust systems of daily staff planning, and patient flow and acuity held on each acute site to inform plans for ensuring appropriate staffing levels are in place, risk assessed and managed where required, for the forthcoming 24 hours. Within Paediatrics, staff are also deployed across sites where risks are identified to ensure appropriate clinical skills met. • Escalation process to manage staffing deficits clearly articulated in an operating framework and nurse staffing escalation policy. • Signposting for staff to wellbeing support mechanisms and facilities. • Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required. • Enhanced overtime payment rates to substantive staff for a defined period to secure additional workforce capacity.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	62	48	14	26 increase (22 closed last year)	3	3
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	4	2	2	0	2	1
Medication errors never events	0	0	0	0	-	-
Any complaints about nursing care	51	40	11	1233% Increase compared to last year (3 cases closed last year)	-	-
NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)						
Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	0	0	N/A	0	0
Medication	0	0	0	N/A	0	0

errors never events						
Infiltration/ extravasation injuries	5	5	0	N/A	4	Unable to comment as not documented as part of the Datix
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0	0	0	N/A	0	0
Any complaints about nursing care	1	0	1	N/A	1	1
NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)						

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
	Inpatient Acute Adult Medical and Surgical Wards During the last year (6/4/21-5/4/22) there has been 5 incidents where not maintaining the planned nurse staffing level was deemed to have contributed to these incidents, 3 hospital acquired pressure damage and 2 falls. There has been an increase in the amount of complaints received relating to nursing care, however, of the closed complaints, failure to maintain the nurse staffing level has not be a contributing factor. The total analysis for the impact of not maintaining the staffing level for this reporting period cannot be made due to 27 open incidents still being investigated. From 1st April 2022, the updated Once for Wales datix reporting system includes a mandatory field ensuring that ward staffing levels are always considered when a fall, medication error or pressure damage is reported. All the incidents and complaints included in this report have been reviewed by the Heads of Nursing in the three Acute Hospitals via their internal weekly, scrutiny panel meetings. The incidents which identified that the nurse staffing levels were a contributing factor and subsequent learning from these has been shared more widely.

	Paediatrics Inpatient wards Between 1st October 2021 to 5th April 2022, there has been 1 complaint where not maintaining the planned roster could have been a contributing factor and 4 extravasation injuries that occurred when the planned roster had not been maintained. All the incidents and complaints included in this report have been reviewed by the Head of Nursing for Children & Young People via their governance meetings, who identified that the nurse staffing levels were a contributing factor and lessons learnt from the incidents have been shared more widely.
Conclusion & Recommendations	In summary, 2021-2022 has been a challenging year due to the continued impact of COVID-19 pandemic within the Health Board and its communities. Meeting the staffing levels for the 25B wards has been difficult due to higher levels of sickness and staff requiring to shield at home. The repurposing of wards including retraining of staff to meet the clinical demands during the COVID-19 pandemic and the temporary re-deployment of staff to support the additional demands including high care respiratory wards, ITU and the temporary Field Hospital has placed additional pressure on the Health Board. However, despite these challenges there continues to be successes and achievements within this reporting period: • Paediatric inpatient wards have successfully been incorporated into section 25B wards via the extending the 2nd duty of Act on 1st October 2021. • The majority of the wards that were repurposed to meet the clinical demands during the COVID-19 pandemic are returning to either there originally specialty/designation, or be utilised to support a new clinical model. • 211 of the 216 overseas Registered Nurses who were recruited into the Health Board during 2020/2021, remain working within CTMUHB. • 188 nurses have been recruited via the student streamlining process. Next steps for 2022-2023 • The first bi-annual acuity audit and report for inpatient paediatric wards will be undertaken. • Plans to implement ‘Safecare’ within the Health Boards Section 25B wards. • The CNO has provided 18 months funding for the recruitment of a designated AWNSA Lead. It is anticipated that this individual will be in post by July/August 2022. As part of the All Wales overseas RN recruitment programme, there will be 100 nurses recruited into CTM UHB between April 2022- November 2022.

Appendix B Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board	Cwm Taf Morgannwg University Health Board (CTMUHB)		
Date annual assurance report is presented to Board	25th May 2023 The reporting period is from April 6th 2022- April 5th 2023		
	Adult acute medical inpatient wards	Adult acute surgical inpatient wards	Paediatric inpatient wards
During the last year the lowest and highest number of wards	Lowest 16 and highest 17	Lowest 15 and highest 18	3
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	1 - PoWH ward 18 changed from surgery to medicine July 22		0
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to in this document as the Act) came into effect in April 2018 for Adult Acute Medical and Surgical inpatient wards. From the 1st October 2021 the second duty of the Nurse staffing Levels (Wales) Act was extended to paediatric inpatient wards. When referring to Section 25B wards in this report, these are the adult acute medical and surgical inpatient and Paediatric inpatient wards within the Health Board (HB). Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all of these wards. The calculation is undertaken bi-annually in January and June as per agreement within the once-for-Wales approach.		

Final

The triangulated methodology set in section 25C of the Act, sets out the principles to calculate the nurse staffing levels. This is a summary of the findings at each acuity audit period.

January and June 2022 staffing calculation

For the January 2022 bi-annual acuity audit each Section 25B ward was analysed using the data captured from various digital systems. The data was collated and analysed to assess compliance with the nurse staffing recommendations.

The data from the following areas were reviewed and examined with the Ward Sister, Senior Nurse, and Lead Nurse responsible for the ward and the Heads of Nursing from each acute hospital to generate the report:

Key Areas of Data capture:

- Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager.
- Patient acuity data for the month of January and June 2022.
- Care quality indicators data from the previous 6 months (falls, medication errors, pressure damage and serious incidents).
- Workforce-related metric data, mandatory training compliance, vacancy, recruitment and sickness.
- Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system Datix reporting, a system that allows live information to be available to the Ward Managers, Heads of Nursing and ILG Nurse Directors (now known as care group 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 were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and the ILG Directors of Nursing. The final templates were endorsed by the Executive Nurse Director.

Final

	A report from each audit was presented separately to the Board giving an overview of the findings and assurance regarding compliance in maintaining the nurse staffing levels for their Section 25B wards. January 2022 audit was presented on the 25th May 2022 and June audit was presented on the 24th November 2022.
Informing patients	The statutory guidance states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). The statutory requirements are to inform patients of the nurse staffing levels by ensuring that the most up-to-date information is displayed on wards in relation to the staffing levels agreed. To ensure transparency and consistency across Wales, the All Wales Adult Acute Medical & Surgical Inpatient Work Stream Group redesigned the templates to ensure compliance with this guidance for CTMUHB, bilingual poster templates are displayed either outside or inside the ward entrance for all 25B wards that are included in the Act including Paediatrics. The poster template identifies the information of the nurse staffing numbers calculated for the identified period and also the date that the calculation was undertaken and signed off by the designated person. following the June 2022 bi-annual acuity audit and calculation all eligible wards were issued the new template to be completed and displayed with the responsibility to ensure they are completed correctly with oversite given to Ward manager and Senior nurses to ensure compliance. Paediatric inpatient wards have paediatric specific templates which were issued following the initial calculation and are being used within CTMUHB. All Section 25B wards have patient information leaflets available for informing patients about the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy-read versions) can be provided to answer any more detailed questions a patient or a visitor may have about the Act, children and young person's poster is visible on all paediatric inpatient wards.

Final

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

Extent to which the required establishment has been maintained within adult acute medical and surgical wards.		Period Covered 06/04/22- 05/04/23		
		Number of Wards:	RN (WTE)	HCSW (WTE)
	Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	32	644.94	496.96
	WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	32	644.94	496.96
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	33	672.97	514.90
	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	33	672.97	514.90

Accompanying narrative:

Following the Covid-19 Pandemic S25B, across CTMUHB, there has been a period of resetting and wards have been realigned. This has led to some wards changing specialty and service delivery. This has also been influenced by the surgical recovery programme (for more details of individual wards and their calculated nurse staffing levels, refer to Appendix B).

Wards that have been added to S25B

- Ward 7 PCH reverted from Covid-19 to a general surgical and orthopaedic ward

Wards no longer within Section 25B

- Protected Elective Surgical Unit (PESU) in PCH, closed in December 2022 now used as a surge area.

<table>
<tr><td></td><td>

- Ward 21 PoWH is currently a community ward housing Llynfi Ward
- Ward 19 PoWH, which had previously been located on Ward 8 (moved to its 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 15 PoWH, has been repurposed to Care of the Elderly Rehabilitation ward and is deemed to sit outside of S25B.

In November 2022 calculations is evidence to suggest additional staffing establishment requirement, this is primarily due to wards either being repurposed from Covid wards and/or reopened and then being included into the section 25B of the 2016 Act.

In partnership with Finance leads and Care groups directors, , the Care Group (Formally ILGs) Nurse Directors will review and realign their budgets accordingly to meet the ongoing staffing requirements for section 25B wards.
</td></tr>
<tr><td>Extent to which the required establishment has been maintained within paediatric inpatient wards</td><td>
<table>
<tr><td></td><td colspan="3">Period Covered 06/04/22- 05/04/2023</td></tr>
<tr><td></td><td>Number of Wards:</td><td>RN (WTE)</td><td>HCSW (WTE)</td></tr>
<tr><td>Required establishment (WTE) of paediatric inpatient wards calculated during first cycle (May)</td><td>3</td><td>93.97</td><td>19.1</td></tr>
<tr><td>WTE of required establishment of paediatric inpatient wards funded following first (May) calculation cycle</td><td>3</td><td>93.97</td><td>19.1</td></tr>
<tr><td>Required establishment (WTE) of paediatric inpatient wards calculated during second calculation cycle (Nov)</td><td>3</td><td>93.97</td><td>19.1</td></tr>
<tr><td>WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle</td><td>3</td><td>93.97</td><td>19.1</td></tr>
</table>
</td></tr>
<tr><td></td><td>Accompanying narrative:
During the initial calculation, the nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps. There have been ongoing challenges in relation to filling registered nurse vacancies following the first calculation which has meant that some posts identified are still to be recruited into.</td></tr>
</table>

	The new calculation has been completed using the same processes and is unchanged from the initial calculation. A focus on the recruitment processes continues to enable timely appointment of new staff, and a new recruitment and retention plan has been developed. As the longer-term effects of the pandemic on nurses is not fully understood, the nursing retention plan has been revised to reflect the new challenges posed in terms of staff wellbeing.						
Extent to which the planned roster has been maintained within both adult medical and surgical wards and paediatric inpatient wards		Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL						
Extent to which the planned roster has been maintained within adult acute medical and surgical wards		Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
	TOTAL						
	Accompanying narrative: When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and Health boards/Trusts were using a variety of e-rostering and reporting digital systems. During the first reporting period, Health boards/Trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system (HCMS) (in lieu of a single ICT solution) to enable each organisations to demonstrate the extent to which the nurse staffing levels across the Health Board/Trust. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required.						

Final

<table>
<tr><td></td><td colspan="7">Following the January bi-annual audit it was identified fthat Health Education Improvement Wales (HEIW) was unable to extract the data required to inform the creation of the visualisers via the business intelligence system due to the national changes made to the Health Care Monitoring System (HCMS). Despite liaison between HEIW and Digital Health Care Wales (DHCW), a solution was not found and as a result, Health Boards/Trusts sought local solutions. Work within the Health Board Informatics team, is looking into a solution to provide this information, therefore for this Board paper this data is currently unavailable, however, it is anticipated that the data will be available for subsequent reports as well the 3 yearly compliance report due in May 2024.</td></tr>
<tr><td rowspan="3">Extent to which the planned roster has been maintained within paediatric inpatient wards</td><td></td><td>Total number of shifts</td><td>Shifts where planned roster met and appropriate</td><td>Shifts where planned roster met but not appropriate</td><td>Shifts where planned roster not met but appropriate</td><td>Shifts where planned roster not met and not appropriate</td><td>Data completeness</td></tr>
<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Accompanying narrative:
Due to the challenges encountered with IT (Information Technology) platform change for HCMS, CTMUHB has been unable to access the information when using the Power BI digital application this is not unique to CTM and is an issue raised across the whole of Wales, CTMUHB ICT alongside Clinical Audit are working on a solution to provide this information for the HB, therefore for this Board paper, this data is currently unavailable. Safecare digital platform, will be implemented and operational across CTMUHB in all 25B wards by November 2023, which will allow reports to be generated to capture data through one system, therefore data will be used using a blended source for the 3 yearly compliance report and the Annual Assurance report due in May 2024.</td></tr>
<tr><td>Process for maintaining the Nurse staffing level</td><td colspan="7">Strategic/corporate steps taken to maintain staffing levels
• Planned recruitment of identified posts across the Health Board.
• Roster completion – ensuring that all rosters are completed as per policy and that all rosters are developed to ensure that the correct number of staff are able to be provided, underpinned by a suite of rostering metrics.
• Roster approval process – all nurse rosters are subject to an approval process monitored by the senior nurses to ensure a safe and effective roster.</td></tr>
</table>

	• As part of the Health board recruitment program, over the last year and going into the next reporting period (April 2023- April 2024) the Health Board have implemented a series of interactive meetings for student nurses who are entering the streamlining process to promote 'working for the Health Board'. During this reporting period, we have successfully recruited through streamlining 131.71wte student nurses. • The Health Board has been an active member in the newly established All Wales International Registered Nurse Programme and has recruited 96 nurses into CTM UHB, during 2022/ 2023. There is also representation at the All Wales forums exploring the creation of career frameworks for registered nurses, advanced clinical practitioners and Band 4 nursing roles. Operational steps taken to maintain staffing level • Robust systems of daily staff planning, and patient flow and acuity held on each acute site (Safe to Start) to inform plans for ensuring appropriate staffing levels are in place, risk assessed and managed where required, for the forthcoming 24 hours. Within Paediatrics, staff are also deployed across sites where risks are identified to ensure appropriate clinical skills met.Escalation process to manage staffing deficits clearly articulated in an operating framework and nurse staffing escalation policy. • Signposting for staff to well-being support mechanisms and facilities. • Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required. • Enhanced overtime payment rates to substantive staff for a defined period to secure additional workforce capacity. The NSLWA statutory guidance requires that the Health Board takes 'all reasonable steps' to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health Board supports the process of calculation and maintenance of nursing staffing levels in all S25B wards and paediatric inpatient wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. Strategic/corporate/ heads of nursing responsibilities to maintain staffing levels The Heads of Nursing within the Health Board chair monthly workforce meetings to discuss their wards' current vacancies and recruitment plans. To support these meetings, the Allocate/Rostering team provides

	feedback and scrutiny of the ward rosters to review efficiencies and compliance against key metrics and in line with the rostering policy. All nurse rosters are subject to an approval process monitored by the senior nurse team to ensure the maintenance of a safe and effective roster. Ward level responsibilities to maintain staffing level Since November 2019 , the All Wales Executive Nurse Director, through the All Wales Nurse Staffing programme forum implemented a guidance document to support what constitutes 'All Reasonable Steps' to support decision-making in relation to ensure maintaining safe staffing levels. This is a statutory requirement to be taken in order to maintain the nurse staffing levels at the calculated levels. Within the Acute Hospitals, staffing levels are reviewed three times a day and where required staff are deployed accordingly to risk and using All reasonable steps and professional judgement to aid decision making. . Across CTUHB, there are well- established processes for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	16	10	6	Decrease	4	1
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	2	2	0	Same	1	1
Medication errors never events	0	0	0		0	0

Any complaints about nursing care	35	25	10	Decrease	0	0

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	0	1		0	0
Medication errors never events	0	0	0		0	0
Infiltration/ extravasation injuries	7	7	0	Increase of 2	5	3
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0	0	0		0	0
Any complaints about nursing care	1	1	0		0	0

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

Section 25E (2c) Actions taken if the nurse staffing level is not maintained

Inpatient Acute Adult Medical and Surgical Wards

During the last year (6/4/22-5/4/23) there has been 2 incidents where not maintaining the planned nurse staffing level was deemed to have contributed to these incidents, 1 hospital acquired pressure damage and 1 falls. There has been an reduction in the amount of complaints received relating to nursing care, however, of the closed complaints, failure to maintain the nurse staffing level has not be a contributing factor.

The total analysis for the impact of not maintaining the staffing level for this reporting period cannot be made due to 16 open incidents still being investigated.

	From 1st April 2022, the updated Once for Wales datix reporting system includes a mandatory field ensuring that ward staffing levels are always considered when a fall, medication error or pressure damage is reported. All the incidents and complaints included in this report have been reviewed by the Heads of Nursing in the three Acute Hospitals via their internal weekly, scrutiny panel meetings. The incidents which identified that the nurse staffing levels were a contributing factor and subsequent learning from these has been shared more widely. Paediatrics Inpatient wards During the last year (6th April 2022- 5th April 2023) there has been 3 complaints where not maintaining the planned roster could have been a contributing factor and 5 extravasation injuries that occurred when the planned roster had not been maintained. All the incidents and complaints included in this report have been reviewed by the Head of Nursing for Children & Young People via their governance meetings, who identified that the nurse staffing levels were a contributing factor and lessons learnt from the incidents have been shared more widely.
Conclusion & Recommendations	In summary, 2022-2023 has been a year of resetting following the COVID-19 pandemic within the Health Board and its communities and getting back to business as usual. There continue to be ongoing temporary staffing uplifts within PCH and RGH until March 2023 at a cost pressure. • The majority of the wards that were repurposed to meet the clinical demands during the COVID-19 pandemic have returned to either there original specialty/designation, or been utilised to support a new clinical model. • The start of the implementation programme of 'SafeCare' to Section 25B wards within the HB (15 live wards using safe care, with a further 20 wards to implement) • The recruitment of AWNSA Lead (when) • As part of the All Wales overseas RN recruitment Programme, the HB recruited, trained and register (NMC Registration) 96 internationally educated nurses • 138.17wte. nurses have been recruited via the student streamlining process. Next steps for 2023-2024

	• To continue to embed SafeCare into the daily routine of ward staff. • Phase two of International Educated Nurse recruitment. • Further resetting and development within planned care that will predominately affect the surgical S25B wards within the Health Board.

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Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Cwm Taf Morgannwg University Health Board (CTM UHB)		
Date annual assurance report is presented to Board	May 2024 Reporting period is from April 6th 2023- April 5th 2024		
	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest 16- Highest 17	Lowest 15- Highest 16	3
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	PoWH- Ward 18 changed speciality from Surgery to Medical	Nil	Nil
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to in this document as the Act) came into effect in April 2018 for Adult Acute Medical and Surgical inpatient wards. From the 1st October 2021 the second duty of the Nurse staffing Levels (Wales) Act was extended to paediatric inpatient wards. When referring to Section 25B wards in this report, these are the adult acute medical and surgical inpatient and Paediatric inpatient wards within the Health Board (HB). Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all of these wards. The calculation is undertaken bi-annually in January and June with an annual paper being presented in November combining both audit results into one paper as per agreement within the once-for-Wales approach. The triangulated methodology set in section 25C of the Act, sets out the principles to calculate the nurse staffing levels. This is a summary of the findings at each acuity audit period.		

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	January and June 2023 Staffing calculations For both Biannual acuity audits in 2023 each Section 25B ward was analysed using the data captured from various digital systems. The data collated and analysed to assess compliance with the nurse staffing recommendations. The data from the following areas were reviewed and examined with the Ward Sister, Senior Nurse, and Lead Nurse responsible for the ward and the Heads of Nursing from each acute hospital to generate the report: Key areas of data capture: • Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager. • Patient acuity data for the month of January and June 2023. • Care quality indicators data from the previous 6 months (falls, medication errors, pressure damage and serious incidents, Paediatric specific infiltration and extravasation). • Workforce-related metric data, mandatory training compliance, vacancy, recruitment and sickness. • Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system Datix (that allows information to be available to the Ward Managers, Heads of Nursing and Care Group Nurse Directors) for review. • Finance data which gives assurance that all workforce models included in the Nurse Staffing Act has 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 were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and the Care Group Nurse Directors with the final templates endorsed by the Executive Director of Nursing. A report from each audit was presented separately to the Board giving an overview of the findings and assurance regarding compliance in maintaining the nurse staffing levels for their Section 25B wards. January 2023 audit was presented on the 25th May 2023 and June 2023 audit was presented on the 30th November 2023.
Informing patients	The statutory guidance states that “Local Health Boards (LHBs) and Trusts “must make arrangements to inform patients of the nurse staffing level” (paragraph 20). The statutory requirements are to inform patients of the nurse staffing levels by ensuring that the most up-to-date information is displayed on wards in relation to the staffing levels agreed. To ensure transparency and consistency across Wales, the All Wales Adult Acute Medical & Surgical Inpatient Work Stream Group redesigned the templates to ensure compliance with this guidance. In CTMUHB, bilingual poster templates are displayed at the ward entrance for all 25B wards included in the Act. These are audited for compliance

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	and shared with the senior nursing teams The template identifies the information of the nurse staffing numbers calculated for the identified period and the date the calculation undertaken and signed off by the designated person. Following the June 2023 bi-annual acuity audit and calculation all eligible wards were issued the new template to be completed and displayed with the responsibility to ensure they are completed correctly with oversight given to Ward manager and Senior nurses to ensure compliance. Paediatric inpatient wards have Paediatric specific templates which were issued following the June 2023 bi-annual acuity audit and are being used within CTMUHB. All Section 25B wards have patient information leaflets available which informs patients and relatives with the information relating to the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy-read versions) can be provided to answer any more detailed questions. , A child and young person friendly poster is visible on all paediatric inpatient wards. To ensure all the information is readily at hand, there is a shared drive for nurse staffing act resources which is available for staff across CTMUHB to access through the SharePoint system.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

34Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2023 following January audit Second cycle: autumn 2023: following June audit		**Period Covered 06/04/2023-05/04/2024**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	**33**	654.24 (including Band 7)	494.99
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	**33**	654.24 (including Band 7)	494.99
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	**33**	647.23 (including Band 7)	504.7

	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	**33**	647.23 (including Band 7)	504.7
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 32 (1 B7 covers 2 areas in PoWH)**		

Accompanying narrative:

CTMUHB undertakes any re-calculations using the triangulated methodology and compare to the current funded establishments to determine any workforce gaps with joint decisions from both the designated person, Service Group representatives, finance and workforce colleagues. Band 7 managers are supernumerary to the funded establishment and these are reflected in the table in Appendix B.

Changes to the staffing from the May 2023 cycle to November 2023 cycle is due to the following:-

Prince Charles Hospital (PCH)

Ward 9 medical ward- Gastrology HCSW decrease by 5.69wte this has been a temporary increase since May 2021 however following review, a decision has been made to reduce back to original level as no distinctive changes to quality indicator metric.

Royal Glamorgan Hospital (RGH)

Ward 19 medical ward- Respiratory initially increased to support a Non-Invasive Ventilation (NIV) bay RN decreased by 5.68wte as there is not the anticipated activity on the ward area to support the increase in staffing at present.

Princess of Wales Hospital (PoWH)

Ward 18 has changed speciality from Surgery to Medicine in June 2023 and remains as a medical ward.

There are two pieces of work being undertaken at Princess of Wales hospital which will affect nursing numbers required. Firstly, the Facilities department is undertaking a service review across the inpatient ward areas to ensure there are ward based caterers available on all wards to ensure consistency across site. Secondly a review of controlled access wards, this will reduce the number of Health care support workers allocated to provide enhanced care for patients who are high risk of wandering off the ward. For more details of individual wards and their calculated nurse staffing levels please refer to appendix B

The Care Group Nurse Directors and service leads are currently undertaking remodelling of services across CTMUHB and alignment of wards accordingly to meet the ongoing staffing requirements for Section 25B wards.

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There are specific key programs of work that are being undertaken to address recruitment and retention challenges such as student streamlining events, recruitment events across the HB and universities as well as participating in the All wales internationally educated nurse recruitment program. More recently CTUHB has launched a Lateral Move policy to support a streamline process for nurses to move across the HB to gain experiences across the Health Board rather than move to another Health Board.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the required establishment has been maintained within paediatric inpatient wards
NB: First cycle: spring 2022 following January audit
Second cycle: autumn 2022: following June audit

	Period Covered 06/04/2023-05/04/24		
	Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
Required establishment (WTE) of paediatric inpatient wards calculated during first cycle (May)	**3**	**93.81**	**19.1**
WTE of required establishment of paediatric inpatient wards funded following first (May) calculation cycle	**3**	**93.81**	**19.1**
Required establishment (WTE) of paediatric inpatient wards calculated during second calculation cycle (Nov)	**3**	**93.20**	**20.31**
WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle	**3**	**93.20**	**20.31**
WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 3**		

Accompanying narrative:

The nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps.

The new calculation has been completed using the same processes and has changed from the initial calculation for PoWH to support the addition of a Band 4 Nursery Nurse. There is also adeduction of 0.61 wte RN to support the workforce March-September due to the anticipated reduction in activity and acuity, which has been evidenced through previous years. The

	staffing will increase back during the winter months to accommodate the increased acuity as previously experienced during this period. This will be managed operationally through roster management. In paediatrics at Prince Charles Hospital there has been ongoing challenges filling registered nurse vacancies following the previous calculation meaning that the validity of the calculation remains untested at present . To support ongoing recruitment Paediatric services support the Health Boards student streamlining and recruitment events both internally and externally throughout the year. *In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.*
Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>	CTMUHB can confirm that all requirements of 'the Act' have been met during this reporting period. 'All reasonable steps' described in the statutory guidance have been utilised. CTMUHB, hold daily safe to start huddles a by workforce, rostering, nursing teams and finance colleagues. CTMUHB continue to embed SafeCare into the daily routine on an 'live' basis and encourage the use of raising red flags and professional judgements which provides explanation of understanding of ward activity, this support staffing decisions and reporting requirements Recording of patient acuity using the Welsh Levels of Care is embedded in practice with scrutiny undertaken During the introduction of SafeCare staff were given an update on the Welsh Levels of Care, sessions are provided as requested.
Extent to which the planned roster has been maintained within <u>paediatric inpatient wards</u>	The process and systems used in paediatric inpatient wards align to those used in the adult medical and surgical inpatient wards, seeing SafeCare being rolled out in January 2023 SafeCare has enabled HBs to capture the data required to inform the reporting requirements under section 25E of 'the Act' from this date
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data required under section 25E of the 2016 Act, and Health boards/Trusts were using a variety of e-rostering and reporting digital systems. Each health board/trust is committed to implementing Allocates 'Safecare' system with each organisation at various stages of implementation with priority given to section 25B wards. Whilst the SafeCare system has been implemented, Health boards/Trusts have also been using the Health Care Monitoring system (HCMS) which has been adapted to ensure consistency in the data collection and analysis to aid reporting. CTMUHB implemented SafeCare into Section 25B wards by July 2023 and have commenced rollout to additional areas, due to the infancy of the system and difficulty with generating reports, the decision was taken to use HCMS for both acuity audits in 2023.

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	NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.
Process for maintaining the Nurse staffing level	**Strategic/corporate steps taken to maintain staffing levels** • Planned recruitment of identified posts across the Health Board. • Roster management – ensuring that all rosters are completed as per policy and that all rosters are developed to ensure that the correct number of staff are able to be provided, underpinned by a suite of rostering metrics. • Roster approval process – all nurse rosters are subject to an approval process monitored by the senior nurses to ensure a safe and effective roster. • Ward managers / off ward staff deployed 'into numbers' to meet planned roster where all other options have been explored. • Staff numbers enhanced via temporary staffing (redeployment of staff from other areas within the organisation, overtime, bank or agency). • Reflecting on the last reporting period (April 2023- April 2024) the Health Board have implemented a series of interactive meetings for student nurses who are entering the streamlining process to promote 'working for the Health Board'. CTMUHB, have successfully recruited through streamlining 103.55wte nurses. • The Health Board has been an active member in the All Wales International Registered Nurse Programme and has recruited 40 internationally educated nurses into CTMUHB, during 2023/ 2024, the HB has had an 11 addition internal nurse who have successful passed the OSCE (Objective structured Clinical Exam) exam to enable to register as registered nurses. • There is representation at the All-Wales forums exploring the creation of career frameworks for registered nurses, Advanced Clinical Practitioners and Band 4 nursing roles. • Launch of the lateral move policy to support staff to move across the Health board to gain experience **Operational steps taken to maintain staffing level** • Robust systems of daily staff planning, and patient flow and acuity held on each acute site (Safe to Start) to inform plans for ensuring appropriate staffing levels are in place, risk assessed and managed where required, for the forthcoming 24 hours. Within Paediatrics, to mitigate risks across all sites staff are deployed to ensure appropriate clinical skills met. • Escalation process to manage staffing deficits clearly articulated in an operating framework and nurse staffing

escalation policy.
- Signposting for staff to well-being support mechanisms and facilities.
- Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required.
- Enhanced overtime payment rates to substantive staff for a defined period to secure additional workforce capacity.

The NSLWA statutory guidance requires that the Health Board takes 'all reasonable steps' to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health Board supports the process of calculation and maintenance of nursing staffing levels in all S25B wards and Paediatric inpatient wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

Strategic/corporate/ heads of nursing responsibilities to maintain staffing levels
The Heads of Nursing within the Health Board chair monthly workforce meetings to discuss their wards' current vacancies and recruitment plans. To support these meetings, the Allocate/Rostering team provides feedback and scrutiny of the ward rosters to review efficiencies and compliance against key metrics and in line with the rostering policy. All nurse rosters are subject to an approval process monitored by the senior nurse team to ensure the maintenance of a safe and effective roster.

Ward-level responsibilities to maintain staffing level
Since November 2019 , the All Wales Executive Nurse Directors, implemented a guidance document to support what constitutes 'All Reasonable Steps' to support decision-making in relation to ensure maintaining safe staffing levels. This is a statutory requirement in order to maintain the nurse staffing levels at the calculated levels.

Across CTMUHB, Safe to Start meetings take place three times a day. This processes allows the sharing of information from across the whole site using patient acuity, staffing levels and patient flow information to support risk based decision making and deployment of staff where necessary to meet clinical demands and mitigate risks.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards				
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Hospital acquired pressure damage (grade 3, 4 and unstageable)**	**Falls resulting in serious harm or death (i.e. 4 and 5 incidents).**	**Medication errors never events**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	55	0	0	6
Total number of incidents/ complaints not closed and to be reported on/during the next year	9	6 (Initial level of harm reported as severe)	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	1 (2)	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster)was considered to have been a contributing factor	0 (2)	0	0	0

For the annual period 2023-2024 the following information supports the below:-

Reportable Pressure Damage (Grade 3, 4 and ungradable)

There has been a total of 55 reportable hospital acquired pressure ulcers during the period 2023-2024, with 2 incidents identified where planned nurse staffing level were deemed as a contributory factor . Following a scrutiny panel review by the Head of Nursing - one of the pressure areas was downgraded from Grade 3 to a Grade 2 and therefore not reportable and deemed unavoidable as all measures in Place. The second, while a staffing shortfall was identified, the scrutiny panel deemed the skin damage as unavoidable as all measures were in place for this patient in line with the risk assessments.

Reportable Falls (Resulting in severe harm or death)

There are 6 reported falls with an initial level of harm recorded as severe, as the investigation is still ongoing it is not possible to assess if staffing levels were a contributory factor. The outcomes will be reported in the next annual assurance report.

Reportable Medication Errors (Never events)

No medication never events have been reported in the reporting period 2023-2024

Reportable complaints about nursing Care

There has been 6 complaints received in this reporting year in relation to nursing care, following investigation, there are no contributory factors reported relating to nurse staffing levels.

All the incidents and complaints included in this report have all been reviewed via their internal weekly, scrutiny panel meetings, by the Heads of Nursing . Any incidents where nurse-staffing levels were identified as a contributory factor and learning was identified these have been shared widely.

Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), and broaden the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication error incidents.

The reporting sub group presented the recommendations for the amended measures to the Executive Nurse Directors in August 2023 who agreed to the changes being proposed with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the adult medical and surgical wards will be as follows:

- *Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

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The data to be reported for each of the above will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/ complaints not closed and to be reported on/during the next year*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Hospital acquired pressure damage (grade 3, 4 and unstageable)**	**Falls resulting in serious harm or death (i.e. 4 and 5 incidents).**	**Complaints**	**Infiltration and extravasation injuries (specifically reportable for Paediatrics)**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	0	0	22	7	5
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period			2	3	2
Number of closed incidents/ complaints occurring when the			1		

nurse staffing level (planned roster) was not maintained					
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor				1	

Additional narrative

One of the incident under extravasation injury, nurse staffing compliance was considered to be a contributory factor which resulted in a formal complaint. On investigation it was determined that the incident was attributed to the agency nurse caring for the patient , hence the incident being attributed to Staffing levels.

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained

Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)

Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	As discussed, all reasonable steps are implemented to mitigate/ reduce risk where the nurse staffing level has not been maintained, due to the demand for services it is not always possible to close beds as a way to mitigate the risk. The teams on the district general hospital (DGH) sites undertake safe to start meetings thrice daily to discuss staffing, mitigate risk and implement plans to help maintain rosters and patient safety. The SafeCare system enables the team to have a strategic view across the site. Senior nurse leadership is available across 24 hours 7 days a week to enable professional decisions to take place.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	Due regard has been given to review and ensuring sufficient nurses are within Section 25A areas in the HB:- • Ward managers in the community hospitals undertake regular meetings with the lead nurses and Heads of nursing, escalating to Care group Nurse Directors as required. • Mental Health services in CTMUHB are currently undertaking an establishment review across the directorate, where staffing is identified as below agreed level this is escalated in line with the agreed process • Section 25A adult ward areas undergo monthly establishment reviews and staffing levels discussed and escalated with senior nurses and Heads of Nursing
	Conclusion & Recommendations
	In summary, there has been continued support for the Nurse Staffing Levels (Wales) Act 2016 during the period 2023-2024. The Heads of Nursing conduct the biannual triangulated reviews and review staffing on a monthly basis during establishment Meetings. Temporary funding for some areas have continued at a cost pressure whilst further work is undertaken to remodel wards to ensure patients and clinical areas are able to provide the correct level of care. **Highlights of reporting period** • SafeCare system has been implemented to all Section 25B areas with further roll out to Community hospital wards, Maternity, and Mental Health commencing March 2024. • An All Wales review of the specific question relating to the Nurse staffing Act on Datix. This has resulted in a set of amended questions which will go live April 2024. It is envisaged these improvements will provide a more robust complete data set for reportable incidents and complaints. To ensure consistency of data reporting across Wales, further work is in process to develop an All Wales Nurse Staffing report template. • As part of the All Wales overseas RN recruitment Programme, the HB recruited, trained 40 internationally educated nurses, with a further 11 health board staff from the local International adaptation program gaining their NMC registration. • Further 138.17wte registrants recruited via the student streamlining process.

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Next steps for 2024-2025

- Explore how Safe Care can be utilised to enhance daily staffing meetings on the acute sites.
- In partnership with Workforce and Organisational development colleagues, through data gained via exit interviews and staff surveys, gain an insight and understanding to the themes that underpin the obstacles to staff retention.
- To develop a coherent recruitment strategy for the short and medium term in line with the HB IMTP and CTM 2030 strategy.
- Further resetting and development in planned care service group, predominately affecting the surgical S25B wards in the Health Board.
- Work alongside our Business Intelligence team to ensure CTM have a robust process to provide a consistent and standardised review of incidents of patient harm, ensuring lessons are learnt for the benefit of all patients and to support any agreed changes to the reporting parameters of the quality indicators and the enhancements within Datix.
- Roll out of the Lateral Move policy to support staff retention

The Board is asked to:

- Receive the report as assurance that the statutory requirements relating to section 25B wards under the Act 2016
- Note the ongoing reasonable steps taken to monitor & as far as possible maintain the Act 2016.
- Note that the most recent bi-annual calculation (January 2024) of Section 25B wards will be reported through the internal governance process and included in the November 2024 Annual Assurance Report in a “Once for Wales” approach.

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Agenda Item
9.2.6

CTM Health Board

Annual Unpaid Carer's Report 2023/24

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience & David Watkins, Carer's Coordinator. Cwm Taf Morgannwg University Health Board.
Cyflwynydd yr Adroddiad / Report Presenter	Becky Gammon, Assistant Director of Nursing and People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director Executive Director of Nursing
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
CTM Carers Steering Group (quarterly basis)	Click or tap to enter a date.	Updates provided to RPB
Quality & Safety Committee	23/07/2024	NOTED

Acronyms / Glossary of Terms	
BCBC	Bridgend County Borough Council
CBC	County Borough Council
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
RPB	Regional Partnership Board
WG	Welsh Government
RIF	Regional Integrated Fund

1. Situation /Background

1.1 CTM Carers Partnership Group was established in 2019, this group oversees the CTM Carers Statement of Intent and brings together representatives from local councils, the health board, and the third sector to promote carers' wellbeing and develop supportive services.

Funding sits within the RPB to ensure parity of support across the CTM footprint.

1.2 Carers Statement of Intent: Created in 2019/20, this statement outlines five primary aims focused on identifying carers, providing information and support, empowering carers, and maximizing resources for their benefit

Aim 1: Identify carers of all ages and acknowledge their contributions.

Aim 2: Provide up-to-date, relevant, and timely information, advice, and assistance to carers of all ages.

Aim 3: Offer support, services, and training to meet the needs of carers of all ages.

Aim 4: Empower carers of all ages by giving them a voice and more control over their lives.

Aim 5: Collaborate to maximise resources for the benefit of carers of all ages.

These aims are under review, with a planning and consultation exercise led by the CTM RPB involving all the stakeholder groups and alignment with the four national priorities for carers in 2020/21 as designated by WG (appendices available on request). Updates expected at end of 2024. Additionally, WG are leading a Rapid Review Task and Finish Group to review the ongoing work undertaken by Local Authority and Health Boards to ensure it is embedded in the relevant organisations

1.3 CTMUHB has been progressing work on identifying and supporting unpaid staff carers through the Corporate Unpaid Carer's Lead. Working alongside the CTMUHB Retention and Workforce Planning Lead we will support staff carers to balance work and their caring duties in order to remain in employment and maintain their emotional health and wellbeing.

2. Specific Matters for Consideration

2.1 Previously, the CTM Carers Partnership were responsible for commissioning carers' services using the WG Carers Grant, which was allocated to health

boards across Wales (CTM Region's value in 2022/23 was £161,000). The distribution process has changed, with CTM RPB now receiving the funding and disseminating via the RIF.

2.2 The RIF funds the Corporate Unpaid Carers Coordinator position within CTMUHB. The primary focus is to identify carers upon hospital admission, support/involve them during the hospital discharge process, and work with local authorities/voluntary sector to assist and support carers post-discharge to reduce patient re-admission from a holistic aspect.

2.3 The CTM Carers "End of Year progress report" is written by the CTM Regional Partnership Board and is pending authorisation for circulation.

2.4 During the 2023/24 financial year the RIF approved £196,732.00 of short break funding. The Short Breaks Scheme is aimed at providing unpaid carers in the Cwm Taf Morgannwg area with opportunities to take breaks from their caregiving responsibilities, thereby promoting their mental and physical wellbeing.

2.5 To proactively facilitate awareness of unpaid carers within the HB and community setting the Corporate Unpaid Carer's co-ordinator has facilitated a number of actions:

- Optimise: Collaborated with the Optimise Development Team to ensure carer referrals are seamlessly passed to local authorities via the Electronic Transfer of Care system. Efforts are underway to develop a dedicated carer icon for the patient electronic whiteboard.
- Allied Health Professionals (AHPs): Engaged with the Clinical Director of Therapies to explore collaborations with allied health professionals aimed at upskilling carers to provide additional support and low-level rehabilitation for discharged patients.
- Carers Week: Organised a series of activities for Carers Week in July, including recording three patient carer stories, preparing a comprehensive social media campaign, and procuring pamper packs for carers.
- Staff Carers Café: Established and agreed upon the Terms of Reference for the group in preparation for its re-launch during Carers Week (June 24).
- Age Connects Morgannwg: Coordinated with trusted assessors to identify and support carers on hospital wards effectively.
- Presentations: Delivered presentations to senior and paediatric nursing heads, and the strategy and information team, focusing on carer awareness and integration with current workstreams.
- Collaboration with Carers Trust: Worked collaboratively with Carers Trust to develop and deliver carer awareness training programs for staff.
- Third Sector Engagement: Coordinated with third sector organisations and the three community voluntary councils on social prescribing and carer support initiatives.

- Innovation Cwm Taf Morgannwg (ICTM) Engagement: Presented to the ICTM team to raise awareness of the carers agenda and ensure their voices are considered in future workstreams.
- Patient Experience Collaboration: Partnered with the People's Experience team to identify and support carers effectively.
- Community Engagement Events: Participated in multiple community events to connect with carers in community settings.
- CTM2030 Engagement: Coordinated with the Head of Engagement and Involvement to ensure carers are included in future strategic plans.

3. Key Risks / Matters for Escalation

3.1 Funding for the CTMUHB Corporate Unpaid Carers Coordinator position is renewed annually. The RPB, initially set up for five years, distributes funding through the Regional Integrated Fund (RIF). This funding cycle will end in two years, with uncertainty about continuation beyond the initial period.

3.2 CTMUHB remains committed to collaborating with partners to advance national priorities and enhance the support available to carers. Our focus will be on addressing the issues that matter most to carers, including enabling carers to have a fulfilling life beyond their caregiving responsibilities, identifying, recognising, and supporting carers to ensure they can continue their caregiving roles effectively, and providing timely and accurate information and advice to carers as needed.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Person Centred

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is not a policy or service review.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No change to service provision
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 To NOTE the report highlighting the work and activity that has been undertaken to support carers across the health board footprint internally and the continued engagement with third sector stakeholders.

6. Next Steps

6.1 To continue the coproduction work with RPB and third sector stakeholders with the opportunity to increase awareness and ensure the carer's voice is heard within care and community settings.

Agenda Item
9.2.7

CTM Health Board

Infection Prevention & Control Annual Report 2023 – 2024

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Bethan Cradle Head of Infection, Prevention and Control at time of Annual Report
Cyflwynydd yr Adroddiad / Report Presenter	Filipe Leitao, Head of Infection Prevention and Control
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Tabled and noted at Infection, Prevention & Control Committee	16/07/2024	Received and Noted

Acronyms / Glossary of Terms	
AMR	Anti-microbial Resistance
ANTT	Aseptic Non Touch Technique
ARI	Acute respiratory infection
BBE	Bare Below Elbow
CAUTI	Catheter Associated Urinary Tract Infection
HCAI	Health Care Associated Infection
IP&C	Infection, Prevention and Control
LAB	Line Associated Bacteraemia
PPE	Personal protective equipment
PPS	Point Prevalence Study
PII	Period of Increased Incidence

1. Situation /Background

1.1 The Infection, Prevention and Control annual report provides a detailed analysis of the surveillance data, audit, education / training and policies developed to support and direct patient care.

1.2 This report covers the date range of April 2023 to March 2024

2. Specific Matters for Consideration

2.1 The key achievements are outlined on pages 3 to 4 of the report, they include:

2.2 All Acute Respiratory Infection (ARI) outbreaks across the UHB have continued to be managed by the IP&C team. Multidisciplinary Period of Increased Incidence (PII) meetings are held to discuss each outbreak and learning is shared widely to influence and inform practice.

2.3 All healthcare associated Clostridium difficile and preventable bacteraemia e.g., Catheter Associated Urinary Tract Infection (CAUTI) and Line Associated Bacteraemia (LAB) have been investigated by the IP&C team, with occasional Patient Care & Safety involvement, to understand whether Duty of Candour has been breached.

2.4 The IP&C team introduced local improvement goals and shared monthly infographic reports to support ownership of local data. The IP&C team are planning to develop Care Group HCAI improvement goals for the upcoming financial year.

2.5 The IP&C team continue to support the mandatory IPC/ANTT training program and have delivered a number of hand hygiene, bare below elbow (BBE) and personal protective equipment (PPE) training sessions.

2.6 The IPC Strategy 2024 - 2027 has been developed and awaiting ratification in the upcoming Q&S Committee meeting.

2.7 The IP&C team achieved reasonable and substantial assurance following an internal decontamination audit performed in July 2024.

2.8 The UHB achieved the Pseudomonas aeruginosa HCAI improvement goal.

2.9 The IP&C team participated in the national HALT-4 Point Prevalence Study (PPS). The survey determined the number of residents in long term facilities receiving antibiotics for an infection. Four care homes within the CTM boundary took part in the survey and results were shared with Public Health Wales colleagues.

2.10 Welsh Government (WG) HCAI/AMR improvement goals – these have remained the same as the previous financial year.

2.11 The Improvement goals for reducing healthcare associated infections includes five key surveillance organisms; Clostridium difficile, Staph aureus bacteraemia (combined target), E.coli bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia.

2.12 The UHB is working towards the goals set out in the UK AMR Strategy, the 5-year ambitions outlined in the UK National Action Plan 2019-2024 and the addendum published in May 2022. The 4-nations are in the process of developing the next 5-year National Action Plan.

2.13 Local improvement goals were agreed for each of the then Integrated Locality Groups (ILG), based on the wider Health Board targets for reducing healthcare associated infections. A monthly infographic demonstrating the local and Health Board position was shared with the relevant stakeholders and discussed at local IPC meetings. Assurance is provided to IPC committee on a quarterly basis

3. Key Risks / Matters for Escalation

3.1 At the July 2024 Infection Prevention and Control Committee meeting the members resolved to:

3.2 Note to implement the New IPC Strategy.

3.3 Note the overall poor compliance of the IPC Audits.

3.4 Continue to support the decontamination agenda for both Primary and Secondary Care Services.

3.5 Support refurbishment of Capital Project Schemes including Llantrisant Health Park.

3.6 Deliver a comprehensive surveillance auditing and training programme.

3.7 Continue working on all the improvement works.

4. Assessment

4.1 The Priorities for 2024- 2025 can be found on pages 28 and 29 of the Annual Report, these include:

4.2 The implementation of the IPC Strategy (2024-2027). The IPC team will provide an integrated service across primary, community and secondary care services. More emphasis will be placed on making improvements in primary care to advance patient care and safety and influence a reduction in C. difficile, S. aureus and gram-negative infections.

4.3 The continued support of the decontamination agenda for both primary and secondary care services.

4.4 The support of refurbishment and capital project schemes ongoing across the Organisation, including Llantrisant Health Park.

4.5 The aim to deliver a comprehensive surveillance, audit and training program.

4.6 The support of clinical teams to reduce healthcare associated infections.

4.7 The development of local HCAI improvement goals for the 5 mandatory surveillance organisms in line with the new Care Group model.

4.8 The involvement in national work to standardise IPC practice/procedures/ audit and investigative tools.

4.9 The following improvement work will recommence:

4.10 Develop and introduce a robust root cause analysis process for all HCAI/CAI cases of C. difficile and preventable infections.

4.11 Establish a CAUTI/IV device improvement group to support a reduction in device associated bacteraemia.

4.12 Support improvements in IPC practice.

4.13 Work towards achieving bronze accreditation for ANTT.

4.14 Support maternity services to improve surveillance and reporting of C-section surgical site infections

5. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	Leadership Data to Knowledge Learning, Improvement and Research Culture and Valuing people:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	Efficient Equitable Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	This is not required as the report is an Annual Report comprising of factual data, progress and priorities for 2024- 2025

Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	This is not required as the report is an Annual Report comprising of data, progress and priorities for 2024- 2025. If copies of the Annual Report in the Welsh language are requested these can be provided.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

6. Recommendation

6.1 The Board is asked to NOTE this report.

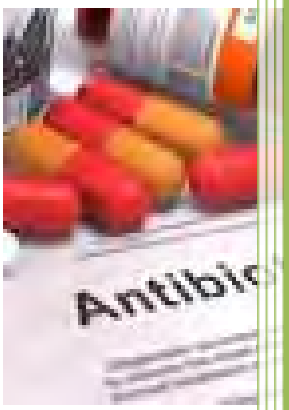
7. Next Steps

7.1 As detailed in section 4.9 focus will be on recommencing the 5 topics of improvement work.

Enc. 4

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Infection Prevention & Control Annual Report 2023-2024



July 2024
Draft V1

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1. Executive Summary

Cwm Taf Morgannwg University Health Board (CTMUHB) strives to deliver safe and effective care, enhanced value across the diverse communities and improved health and wellbeing. Quality and Safety is at the heart of everything we do and the organisational strategy; CTM 2030 'Our Health, Our Future', outlines the significance of service improvement, 2030 and beyond.

Healthcare associated infections (HCAI) remains a key patient safety issue, which results in a significant burden of disease and financial cost to the NHS in Wales. CTMUHB is committed to reducing HCAI and adopts a zero tolerance to all preventable infections. There are effective management arrangements, assurance systems and reporting processes in place to support and drive the infection prevention and control (IP&C) agenda.

Our goal is to be the best in Wales and we are making incremental changes to improve patient safety and deliver the HCAI improvement goals set by Welsh Government.

The Infection Prevention Control Team (IP&CT) cover secondary care services across the UHB but have minimal input in the primary care sector. There is a strategic review planned to determine the direction of IPC across the CTM footprint. The aim is for the IP&CT to provide an integrated service across primary, community and secondary care services. The UHB will not achieve the improvement goals without investment in primary care.

Improving IPC practices will reduce healthcare associated infections and the need for antimicrobials, which in turn will preserve their effectiveness.
We must use the lessons learned from the pandemic to strengthen our focus on the IPC agenda to improve the quality of our health and care services.

The IPC service continues to strengthen across the Health Board which is supported by a comprehensive range of infection prevention and control policies and procedures which act as a resource for clinical staff.

The annual report provides a detailed analysis of the surveillance data, audit, education / training and policies developed to support and direct patient care. The information has been collected and produced by the IP&CT for April 2023 to March 2024.

Key achievements

- The IP&CT have continued to manage Acute Respiratory Infection (ARI) outbreaks across the UHB. Multidisciplinary Period of Increased Incidence (PII) meetings are held to discuss each outbreak and learning is shared widely to influence and inform practice.
- All healthcare associated Clostridium difficile and preventable bacteraemia e.g., Catheter Associated Urinary Tract Infection (CAUTI) and Line Associated Bacteraemia (LAB) have been investigated by the IP&CT, with

occasional Patient Care & Safety involvement, to understand whether Duty of Candour has been breached.

- The IP&CT introduced local improvement goals and shared monthly infographic reports to support ownership of local data. The IP&CT are planning to develop Care Group HCAI improvement goals for the upcoming financial year.
- The IP&CT continue to support the mandatory IPC/ANTT training program and have delivered a number of hand hygiene, bare below elbow (BBE) and personal protective equipment (PPE) training sessions.
- The IPC Strategy 2024 - 2027 has been developed and awaiting ratification in the upcoming Q&S Committee meeting.
- The IP&CT achieved reasonable and substantial assurance following an internal decontamination audit performed in July 2024.
- The UHB achieved the Pseudomonas aeruginosa HCAI improvement goal.
- The IP&CT participated in the national HALT-4 Point Prevalence Study (PPS). The survey determined the number of residents in long term facilities receiving antibiotics for an infection. Four care homes within the CTM boundary took part in the survey and results were shared with Public Health Wales colleagues.

2. Healthcare associated infections (HCAI): statistics and performance

Effective infection prevention and control (IPC) must be everybody's responsibility and central to everyday healthcare practice. Effective IPC practice is based on the best available evidence to reduce preventable infections, improve the quality of care delivered and maximise outcomes for patients.

Welsh Government (WG) HCAI/AMR improvement goals for 2023- 2024

The HCAI and AMR improvement goals for 2023/24 remained the same as the previous financial year. The improvement goals for reducing healthcare associated infections includes five key surveillance organisms; Clostridium difficile, Staph aureus bacteraemia (combined target), E.coli bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia.

The UHB is working towards the goals set out in the UK AMR Strategy, the 5-year ambitions outlined in the UK National Action Plan 2019-2014 and the addendum published in May 2022. The 4-nations are in the process of developing the next 5-year National Action Plan (NAP).

Local improvement goals were agreed for each of the Integrated Locality Groups (ILG), based on the wider Health Board targets for reducing healthcare associated infections. A monthly infographic demonstrating the local and Health Board position was shared with the relevant stakeholders and discussed at local IPC meetings. Assurance is provided to IPC committee on a quarterly basis.

Number and rate of *C. difficile*, *S.aureus* bacteraemia, *E. coli* bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia per 100,000 population, April 2023 - March 2024.

	C. difficile		MRSA		MSSA		E. coli		Klebsiella sp.		Pseudo aer	
	No. of Cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
CTM	126	28.38	9	2.03	129	29.05	378	85.13	118	26.57	21	4.73
All Wales	1218	38.89	57	1.82	802	25.61	2274	72.61	736	23.50	145	4.63

Data taken from HCAI mandatory surveillance summary, HARP. April 2023 – March 2024.

Lower than the same period of previous FY

Higher than the same period of previous FY

Same as the same period of previous FY

* The numbers/rates included in the table above have been taken from the HARP database. There are some anomalies compared to the local numbers included in the narrative below due to different cut off dates for collecting information.

(A) *Clostridium difficile* Infection (CDI):

The reduction expectation for 2023/24 was 25 cases per 100,000 population, which equates to no more than 112 cases per year. CTM exceeded the improvement goal and ended the year with a rate of 28.38 per 100,000 population, which is lower than the all-Wales rate of 38.89.

12 additional cases reported 2023/24 compared to the previous year and CTM achieved the second lowest rate in Wales.

126 cases of C.difficile infection was reported April 2023 – March 2024.

CTMUHB cumulative monthly numbers of C. difficile
in April 23 – March 24 against the equivalent period in 2022/23.

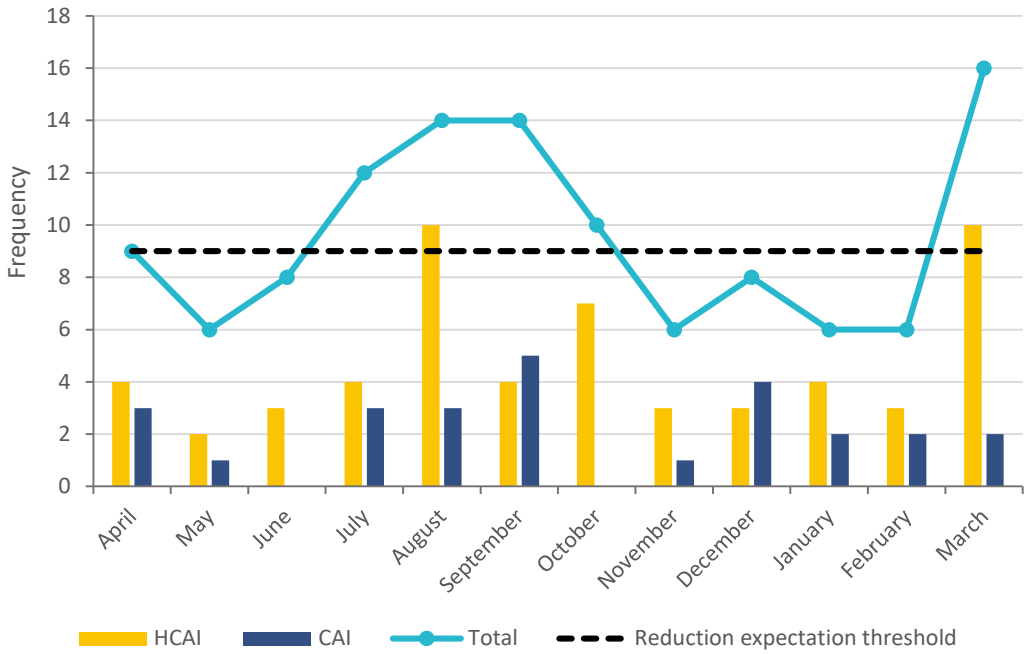
2023/24 2022/23

- 44% (56/126) of cases were categorised HCAI, based on sample sent >48 hours post admission to hospital or recent admission within past 4 weeks.
- 29% (36/126) of cases were deemed to be community acquired infections as the sample was either sent within 48 hours of the patients' admission or the patient had no recent admission in the past 4 weeks.
- 49% (34/70) of the total samples were sent from GP practices. Only 3 of the 34 patients had a hospital admission in the past 4 weeks.
- A seasonal increase in cases was reported between August and October 2023.

The RCA process for investigating C.difficile cases must be strengthened across secondary care and re-introduced in primary care. Common risk factors and themes of learning have been identified through the RCA/huddle process. Focused improvement work is required in the upcoming financial year to address the learning points associated with C.difficile infection.

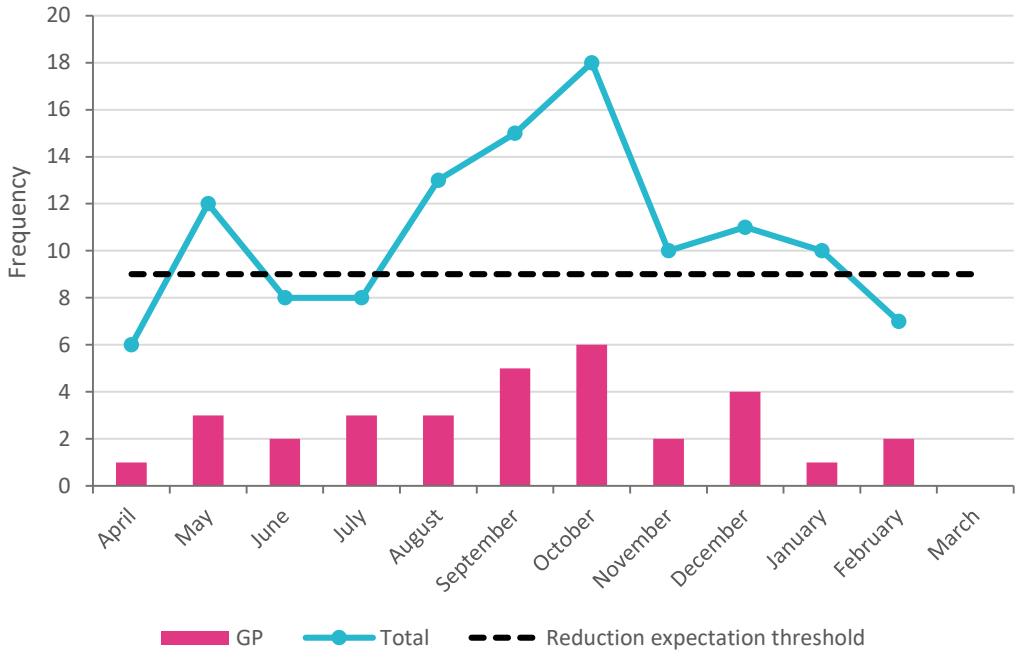
7% of the C.difficile cases were classed as a recurrent infection. The majority of cases were identified in Bridgend. Faecal Microbiota Transplant (FMT) is currently offered to patients in Rhondda Taf Ely and Merthyr Cynon. Further discussion required with key stakeholders to explore the extension of service across the Health Board.

Distribution of *C. difficile* infections (Threshold ≤9 cases/month)



⁺HCAI and CAI infections relate to infections identified in inpatient settings.
*Total includes infections identified in GP practices

Distribution of *C. difficile* infections, specimens from GP practices



*Total includes infections identified in inpatient settings

CDI Mortality Data

An incident form was submitted for all healthcare associated cases of C. difficile infection and updated if C.difficile was included on the death certificate.

Direct attributable cause of death (CDI on any part of death cert.)++

	2020/21	2021/22	2022/23	2023/24
RGH	2	1	0	4
PCH	2	2	2	1
POW	7	5	1	0
Total	11 (10%)	8 (5%)	3 (3%)	5 (4%)

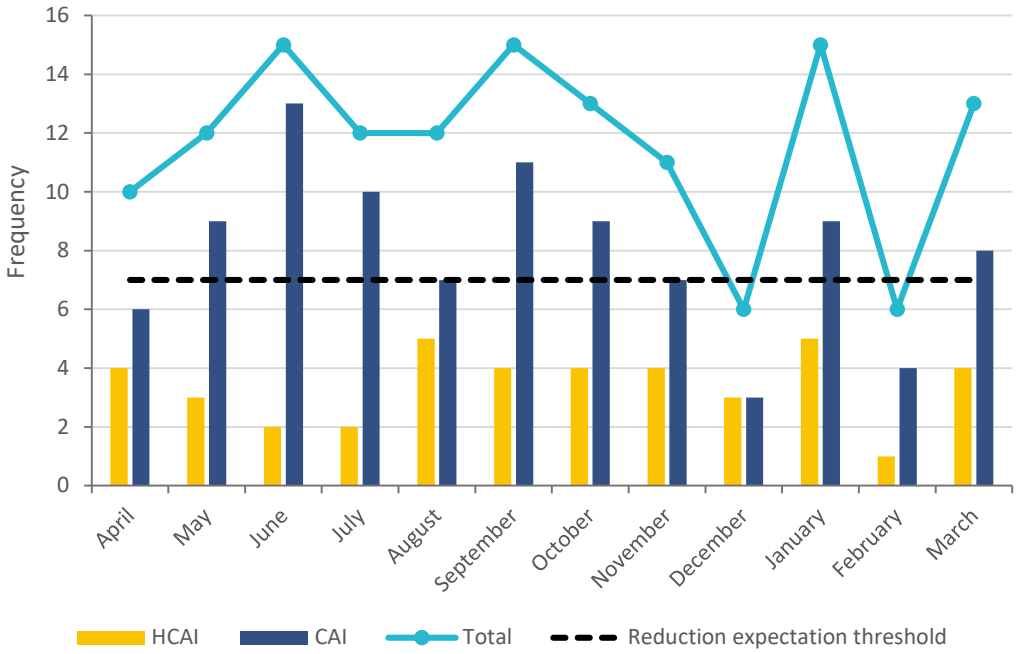
Three of the cases were deemed unavoidable following a multidisciplinary review.

(B) *Staphylococcus aureus* Bacteraemia (MSSA & MRSA)

The reduction expectation for 2023/24 was a combined target (MRSA and methicillin sensitive S.aureus) of 20 per 100,000 population, which equates to no more than 90 cases per year.

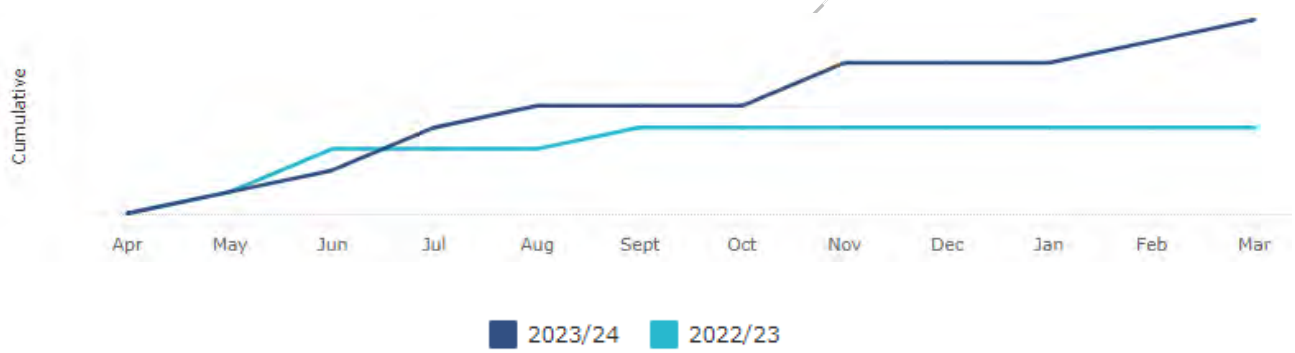
CTM achieved a rate of 31.30 per 100,000 population, which was higher than the All-Wales rate of 27.49.
CTM reported more cases than the set monthly target for a total of 10 months.

Distribution of S.aureus bacteraemia (threshold **≤7** cases/month)



MRSA

CTMUHB cumulative monthly numbers of MRSA bacteraemia
April 23 - March 24 in comparison to the equivalent period in 2022/23



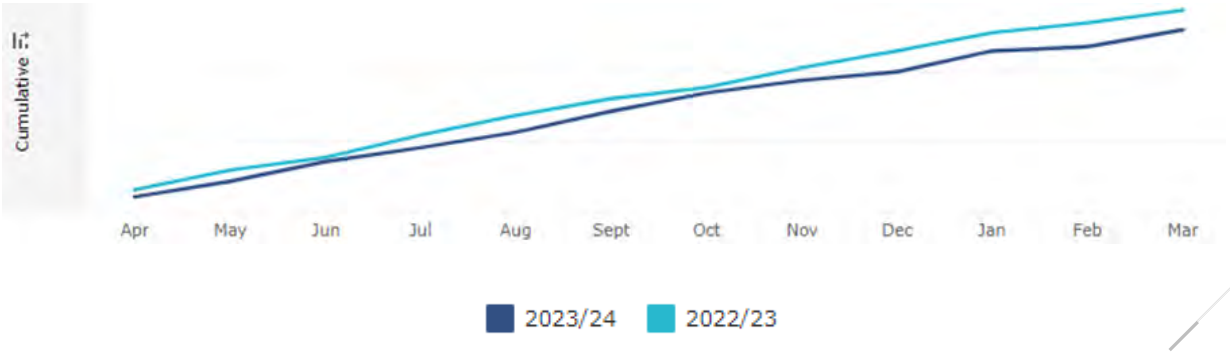
CTM reported 9 cases of MRSA bacteraemia April 2023 – March 2024. This is double the number compared to the previous year. The rate of MRSA bacteraemia was 2.03 per 100,000 population. CTM achieved the third lowest rate of MRSA bacteraemia in Wales.

- 78% of the cases were community acquired infections
- One community acquired case was deemed preventable from an IPC perspective. The bacteraemia was associated with a PICC line and managed by Velindre NHS Trust.

MSSA

130 cases of MSSA reported April 2023 – March 2024. This is approximately 9% less than the previous year. The rate of MSSA bacteraemia was 29.28 per 100,000 population. CTM achieved the third lowest rate of MSSA bacteraemia in Wales.

CTMUHB cumulative monthly numbers of MSSA bacteraemia for April 23 to March 24 against the equivalent period in 2022/23



- 24% (31/130 cases) were healthcare associated infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks. Of the 31 cases, 26% (8/31) had a preventable source –
    - 8 IV device associated bacteraemia;
        - 6 linked to a PVC
        - 1 linked to a PICC line
        - 1 linked to a vascath

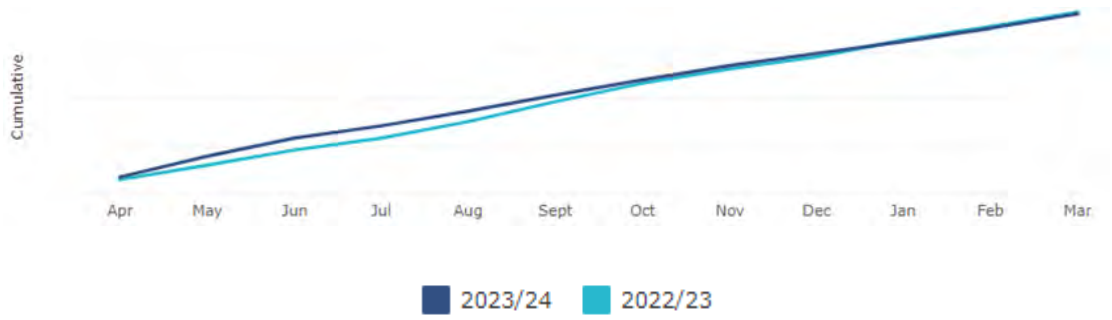
- 76% (99/130 cases) were community acquired infections. Of those cases, 8% (8/99) had a preventable source -
    - 7 IV device associated bacteraemia;
        - 6 linked to a Permacath
        - 1 linked to a central line
    - 1 case associated with a urinary catheter

The IPC Team investigate all preventable bacteraemia and work with clinical teams to share learning from incidents to influence and improve patient care.

Preventable MSSA bacteraemia is now considered a moderate risk. The Patient Care and Safety team arrange a rapid review to discuss the preventable infection and determine whether duties of candour and quality have been breached.

(C) E. coli bacteraemia

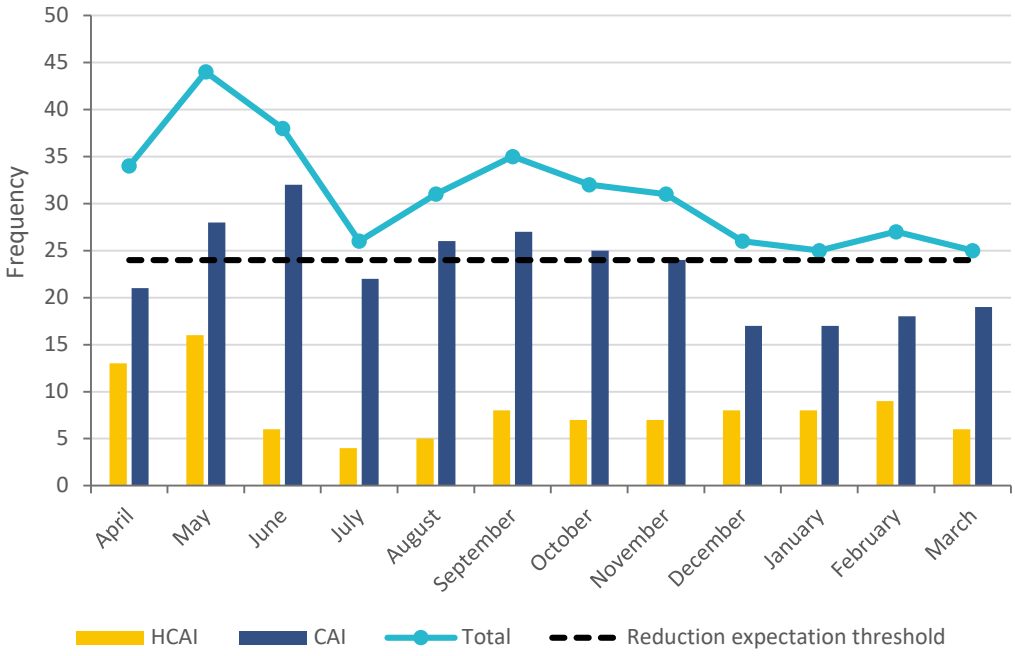
CTMUHB cumulative monthly numbers of E. coli bacteraemia for April 23 to March 24 against the equivalent period in 2022/23



The reduction expectation for 2023/24 was 67 cases per 100,000 population, which equates to no more than 301 cases.

378 E.coli bacteraemia cases were reported April 2023 – March 2024, which is approximately 1% less than the previous financial year. The rate of E. coli bacteraemia for CTM was 85.13 per 100,000 population, which is higher than the All-Wales rate of 72.61. CTM had the third highest rate of E.coli bacteraemia in Wales.

Distribution of E.coli bacteraemia (threshold ≤25 cases/month)



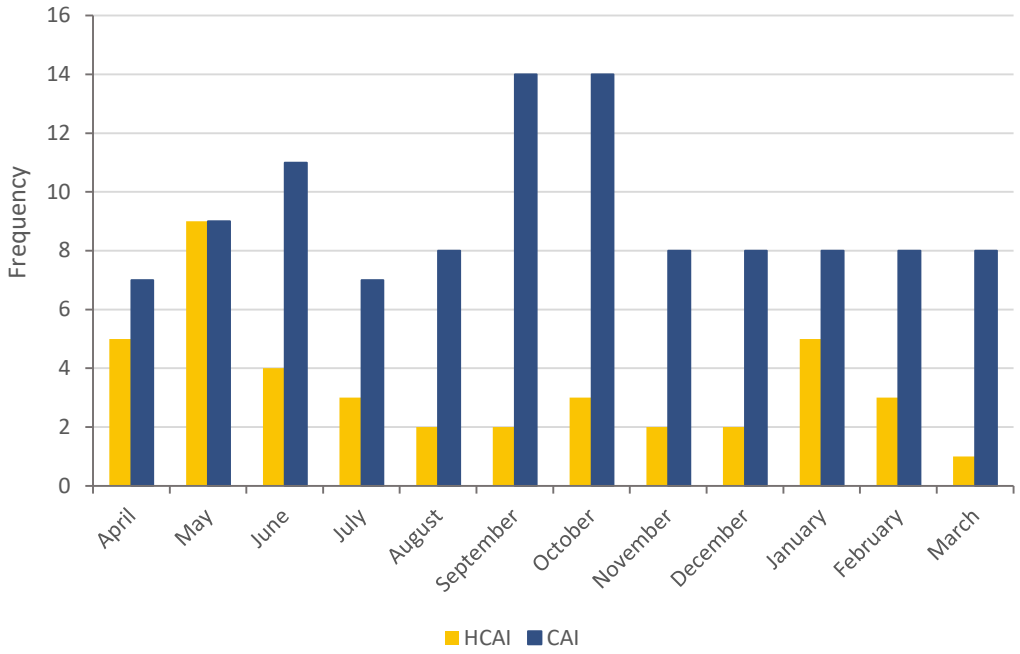
- 22% (82/378) of the cases were healthcare associated

infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks. Of the 82 cases, 35% (29/82) had a preventable source –

- o 1 IV device associated bacteraemia (central line)
- o 28 cases associated with a urinary catheter

- 78% (296/378) of the cases were deemed to be community acquired infections. 3% were associated with a urinary catheter (8/296).

Counts of E.coli bacteraemia where urinary tract infection or urosepsis was identified as the source of infection.



(D) Klebsiella spp. bacteraemia

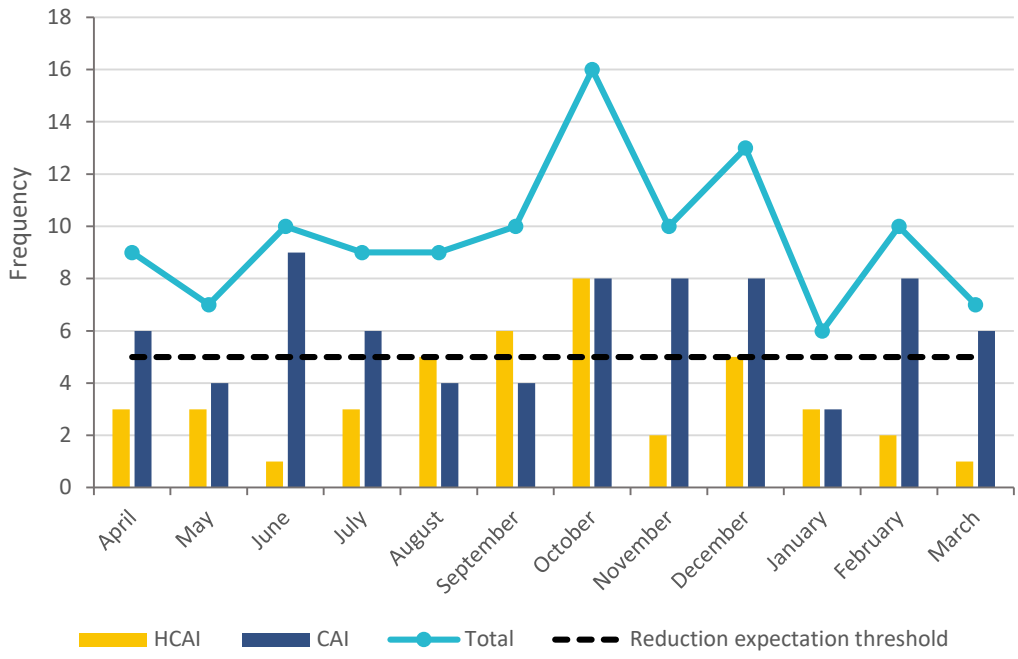
CTMUHB cumulative monthly numbers of Klebsiella spp. for April 2023 to March 24 against the equivalent period in 2022/23.

A 10% reduction compared to 2017/18 figures was expected for this period.

118 cases of Klebsiella spp. bacteraemia were reported between April 2023 – March 2024, which is approximately 28% more than the equivalent period in 2022/23. The rate of Klebsiella spp. bacteraemia was 26.57 per 100,000 population, which is higher than the all Wales rate of 23.53.
CTM had the third lowest rate of Klebsiella spp. bacteraemia in Wales.

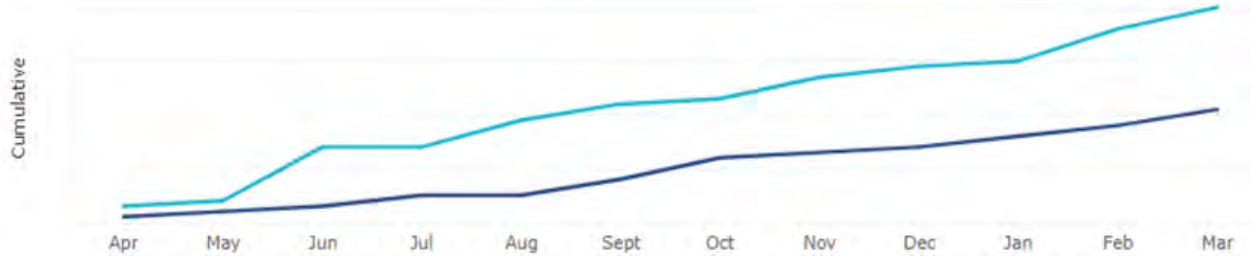
- 32% (38/118) of the cases were healthcare associated infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 13% (5/38) had a preventable source -
  - 1 IV device associated bacteraemia (central line)
  - 4 cases associated with a urinary catheter
- 68% (80/118) were deemed a community acquired infection and 10% of cases were associated with a urinary catheter (8/80).

Distribution of Klebsiella spp. Bacteraemia (threshold ≤5 cases/month)



(E) Pseudomonas aeruginosa bacteraemia

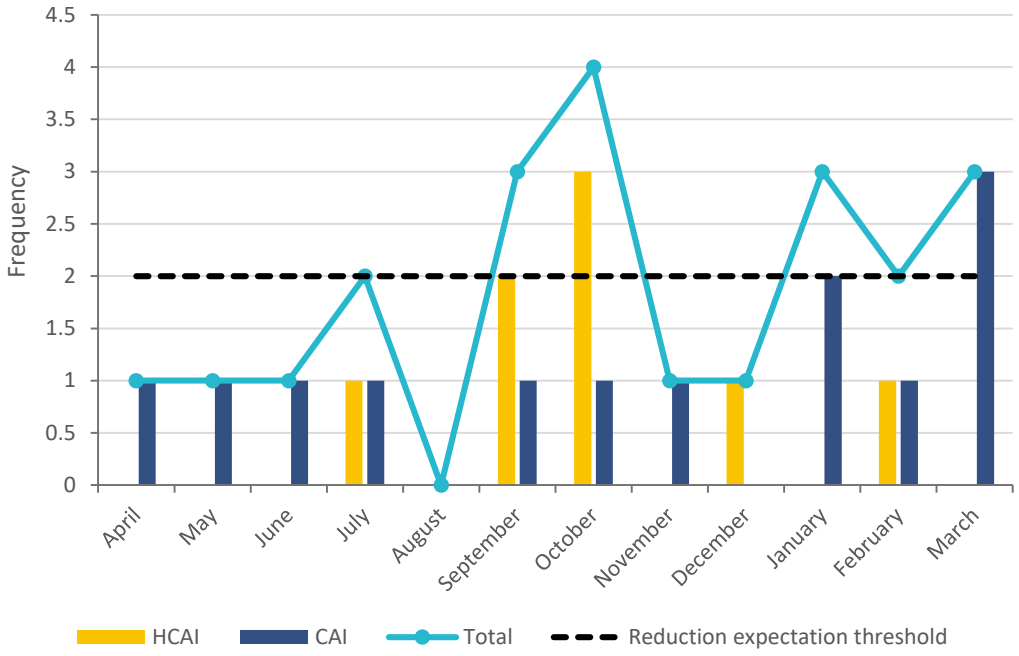
CTMUHB cumulative monthly numbers of Pseudomonas aeruginosa for April 23 to March 2024 against the equivalent period in 2022/23



A 10% reduction compared to 2017/18 figures was expected for this period. 21 cases of P. aeruginosa bacteraemia were reported April 2023 – March 2024, which is approximately a 90% reduction in comparison to the same period in 2022/23. The rate of P. aeruginosa bacteraemia in CTM was 4.73 per 100,000 population, which is above the All Wales rate of 4.66. CTM achieved this HCAI improvement goal.

- 33% (7/21) of the cases were deemed to be healthcare associated infections, based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks. 14% (3/21) of the cases were deemed to be preventable –
  - 1 IV device associated bacteraemia (midline)
  - 2 cases were associated with a urinary catheter
- 67% (14/21) of the cases were deemed to be community acquired infections and 14% had a preventable source –
  - 1 IV device associated bacteraemia (PICC line)
  - 1 case was associated with a urinary catheter

Distribution of *Pseudomonas aeruginosa* bacteraemia (threshold ≤1 case/month)



(F) Preventable infections

Clinical line infections

Clinical line infections should be reported via the Datix system. It's the responsibility of the clinical team to alert the relevant stakeholders. Therefore, infection rates are not always comparable.

In 2023/24, 11 clinical line infections were investigated and discussed in a multidisciplinary huddle. 73% of the clinical line infections were associated with a PVC.

IV device related bacteraemia

There was a 28% increase in IV device related bacteraemia compared to the same period in 2022/23.

The IP&CT continue to investigate all IV device associated bacteraemia and the investigations are shared with the clinical teams to influence and inform practice. At the end of 2023, central line study days were organised by the nurse education team for clinical staff in the UHB. The sessions incorporated PICC line management, troubleshooting and ANTT theory/practical sessions. BD representatives also delivered ward based ChloraPrep and PosiFlush refresher sessions to all clinical areas across the Health Board.

The IV steering group needs to be re-established and further work is required to arrange timely IPC huddles and improve compliance with IPC/ANTT training.

Urinary catheter associated bacteraemia

There has been a 37% increase in urinary catheter associated bacteraemia compared to the same period in 2022/23. The majority of cases are considered healthcare associated infections. The IPC team investigate both community and healthcare acquired CAUTI and a 'huddle' is arranged to discuss the cases individually.

A urinary catheter PPS has been undertaken in Royal Glamorgan and Prince Charles Hospital. The IP&CT will continue the urinary catheter PPS across the remaining hospital sites in CTM. The PPS provides baseline data in relation to urinary catheter usage, care bundle compliance and device management. The data will support the planned introduction of all-Wales urinary catheter passports across secondary care.

3. Surveillance

Surgical Site Infection Surveillance (SSI)

CTMUHB participate in the mandatory surveillance of Surgical Site Infections (SSI) for Orthopaedic and C. section surgery. Using standardised methods, allows Health Boards across Wales to analyse their SSI data and improve the quality of care delivered. National surveillance also allows hospitals/ Health Boards to benchmark performance indicators.

Orthopaedic SSI surveillance

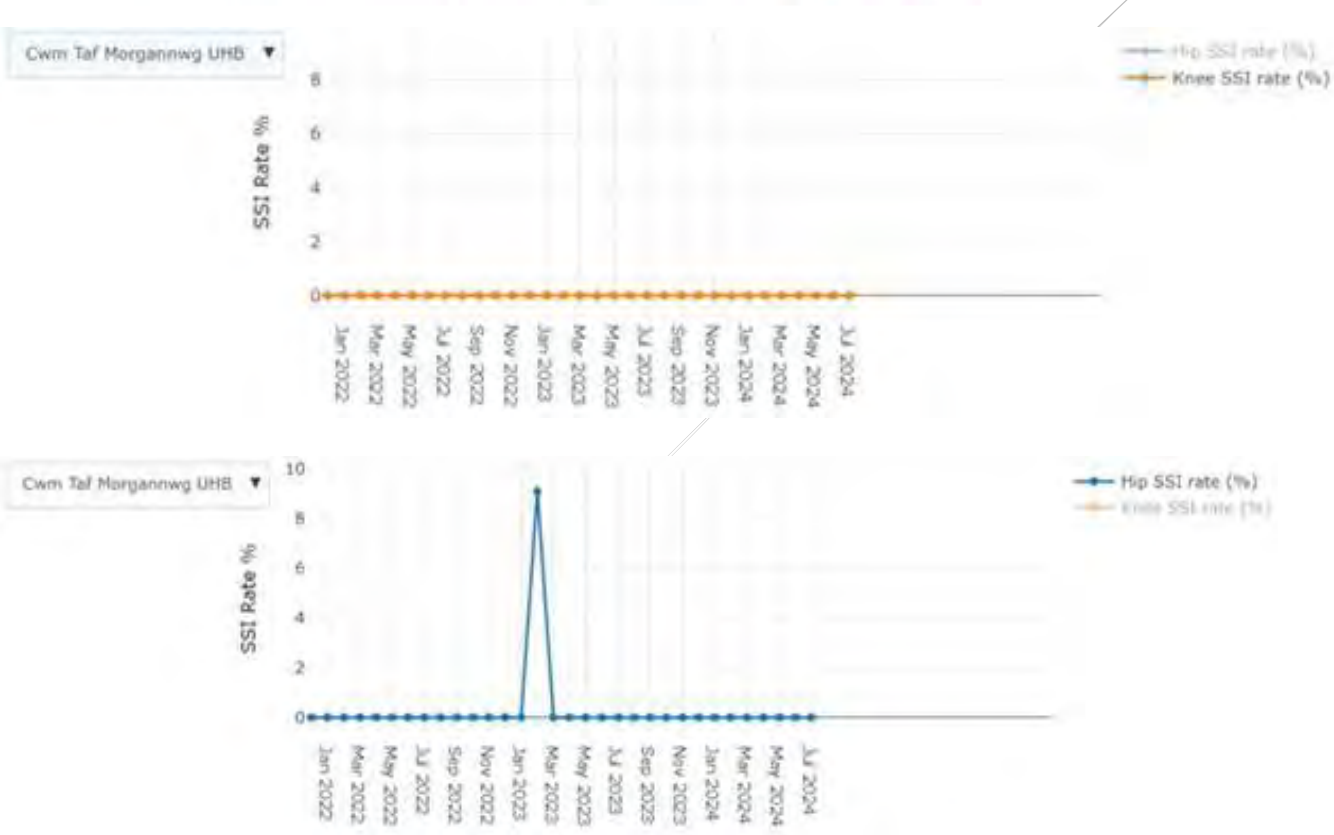
There has been one orthopaedic SSI reported for CTMUHB.
The following SSI data has been provided by the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Program (HARP) team.

Breakdown of revisions

	Cwm Taf Morgannwg UHB		
	Procedures	*Revisions*	*Revision rate*
Overall	**479**	**39**	**8.1%**
Procedure types			
Hip	244	28	11.5%
Knee	228	11	4.8%
Other/unknown	7	0	0.0%
Age groups			
Under 65	161	8	5.0%
65-74	167	10	6.0%
75-84	122	18	14.8%
85 and over	26	2	7.7%
Unknown	3	1	33.3%
Sex			
Male	213	10	4.7%
Female	259	27	10.4%
Unknown	7	2	28.6%

Primary Procedures

	Cwm Taf Morgannwg UHB		
	Procedures	*SSI*	*SSI rate*
Overall	**476**	**1**	**0.2%**
Procedure types			
Total hip	216	0	0.0%
Total knee	191	0	0.0%
Partial knee*	26	0	0.0%
Other/unknown	43	1	2.3%
Age groups			
Under 65	153	0	0.0%
65-74	157	1	0.6%
75-84	104	0	0.0%
85 and over	24	0	0.0%
Unknown	38	0	0.0%
Sex			
Male	203	1	0.5%
Female	232	0	0.0%
Unknown	41	0	0.0%



All Wales primary hip and knee SSI rates

C-section SSI

HARP provide a quarterly C-section SSI report. The all-Wales rate is no longer included in the narrative.

An upsurge in C-section SSIs was identified in Prince Charles Hospital between April and September 2023. Conversely, Princess of Wales Hospital reported a downward trajectory compared to the previous financial year. CTMUHB were not included in the quarter 4 report, as several months of data required validation. Public Health Wales colleagues supported the process. Following evaluation, there appeared to be an element of over-reporting in Prince Charles Hospital. The Consultant Nurse for HARP will lead the improvement work for the UHB, which will consist of robust training programs, systems and standardisation for surveillance/reporting processes.

Due to gaps in the data submitted, the following should be interpreted with caution.

Hospital and CTM data from 1st July 2022 – 30th June 2023

	SSI rate	Change	Data received**	Valid data**
Prince Charles				
Q3 2022 - Q2 2023	5.0%	↓ 12%	100%	97%
Q3 2019 - Q2 2022*	5.7%		91%	83%
Cwm Taf Morgannwg UHB				
Q3 2022 - Q2 2023	3.9%	↓ 17%	99%	97%
Q3 2019 - Q2 2022*	4.7%		89%	81%
Princess of Wales				
Q3 2022 - Q2 2023	2.4%	↓ 33%	99%	99%
Q3 2019 - Q2 2022*	3.5%		85%	74%

*Previous three years data for the hospital/health board.

Prince Charles Hospital

Princess of Wales Hospital

4. IPC Policies Approved in 2023/24

The following Infection Prevention and Control policies, procedures and guidelines were agreed at the Infection Prevention & Control Committee meetings in 2023/24. All documents are made accessible for staff via the Intranet following final approval at Quality and Safety Committee meetings.

IPC15	Creutzfeldt-Jacob Disease (CJD) Procedure for Infection Prevention & Control	18.04.23
IPC21	Meningitis Policy	18.04.23
IPC25	Measles Policy	18.04.23
IPC04	Hand Hygiene Procedure	11.07.24
FAC23	Waste Segregation Procedure	11.07.24

5. Internal Audit Programme and performance

All clinical areas complete monthly hand hygiene, BBE, PPE and environmental audits via the AMaT system. The senior nursing teams monitor/follow up on the audit findings and directly report to the IPC site and IPC committee meetings.

The IPC team has a rolling annual audit programme, which includes inpatient areas and clinical departments for independent verifications. Audit scores and results are shared with the Ward Manager and Senior Nursing teams for information, action and escalation. Infection Prevention and Control training is provided as required to address non-compliance identified during the audit process.

There has been incessant staff sickness/shortages within the IP&CT. As a result of this, the audit program wasn't achieved for 2023/24, however, the vast majority of inpatient areas were completed. PII audits and C.difficile assurance checks were carried out in response to increased incidence/ outbreaks of infection and identification of C.difficile cases. Non-compliance with IPC policies/ practice was addressed at the time of the audit.

<u>Audit Results</u>

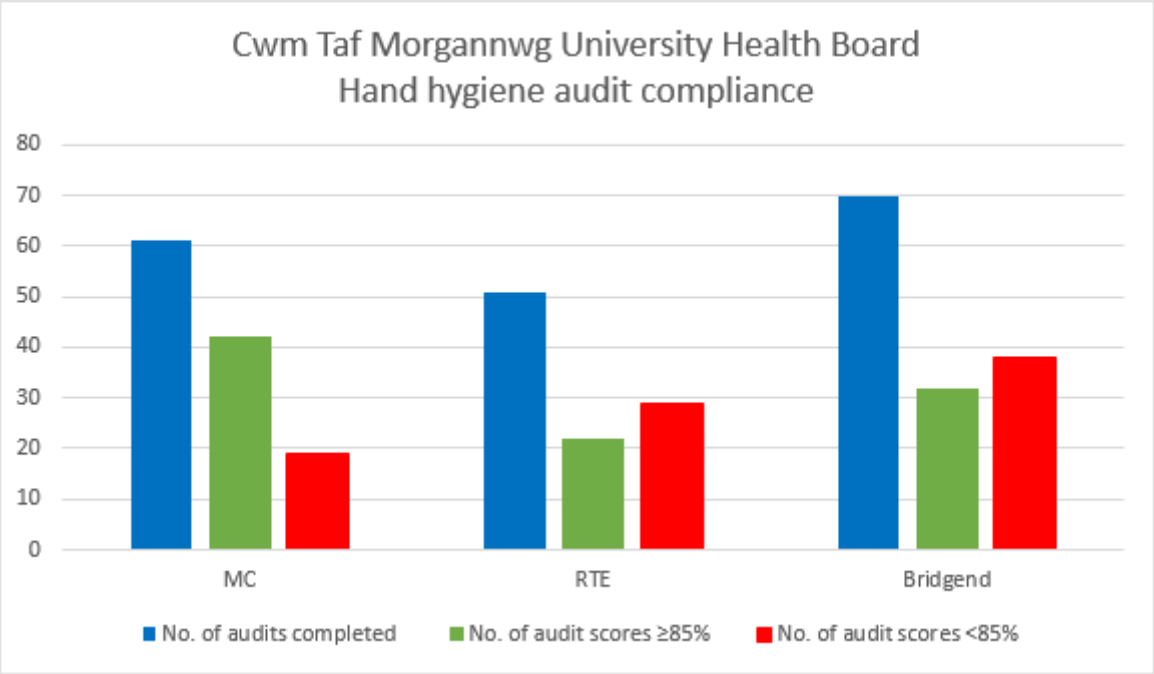
A) Hand Hygiene Audits

Hand hygiene audits are based on the WHO's "5 moments for hand hygiene", which applies to all staff working in the clinical area.

Hand hygiene is the single most important measure to prevent cross infection. Clinical engagement is paramount to improve compliance with hand hygiene practices. Infection prevention and control is everybody's business and

all staff must practice standard infection prevention and control precautions at all times.

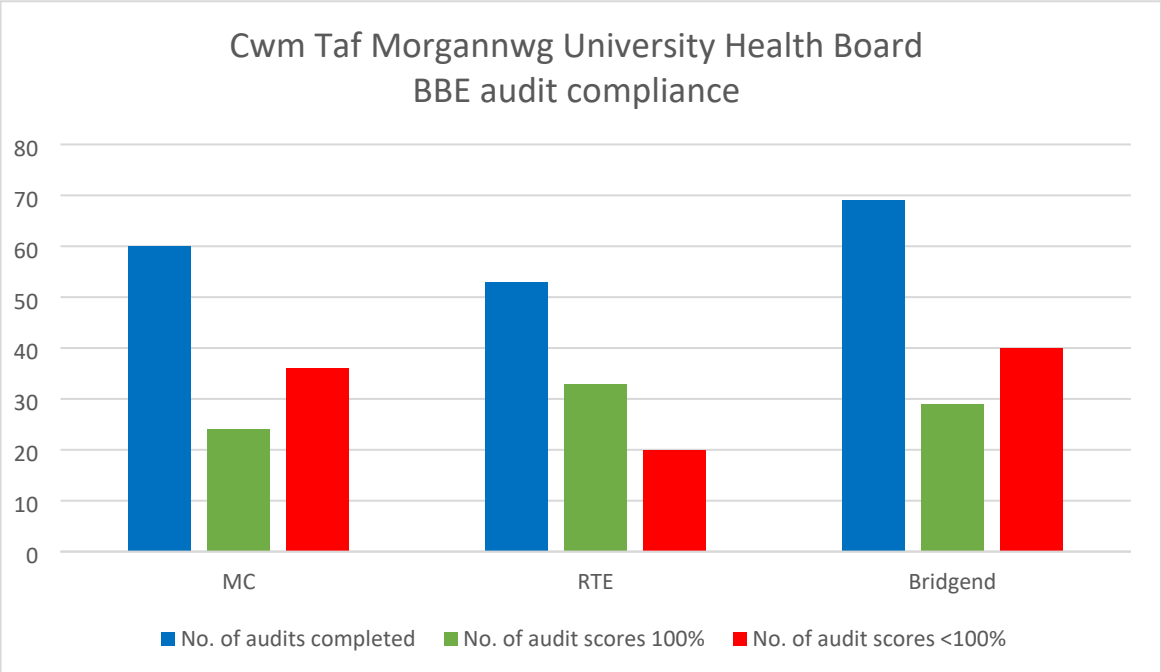
182 hand hygiene audits were completed in 2023/24 but only 53% (96/182) achieved a score of ≥85%. The IPC team provide hand hygiene training in response to poor audit scores where possible.



B) Bare Below the Elbow Audit

It is the responsibility of all clinical staff, irrespective of grade or profession to be bare below the elbow in the clinical environment.

182 audits were performed in 2023/24. 47% (86/182) of the audits achieved a score of 100%. Following review, 16% (31/182) of registered nurses, 33% (60/182) of doctors and 18% (32/182) of HCSWs were non-compliant with BBE practices.



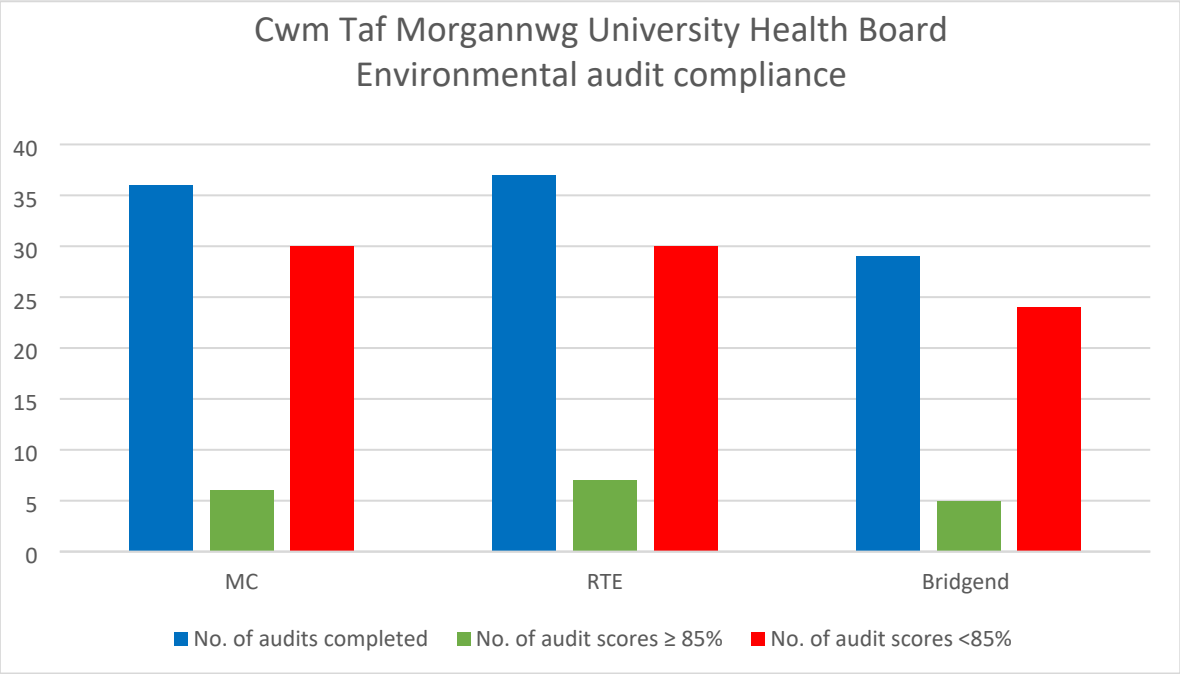
C) Environmental Cleanliness Audits

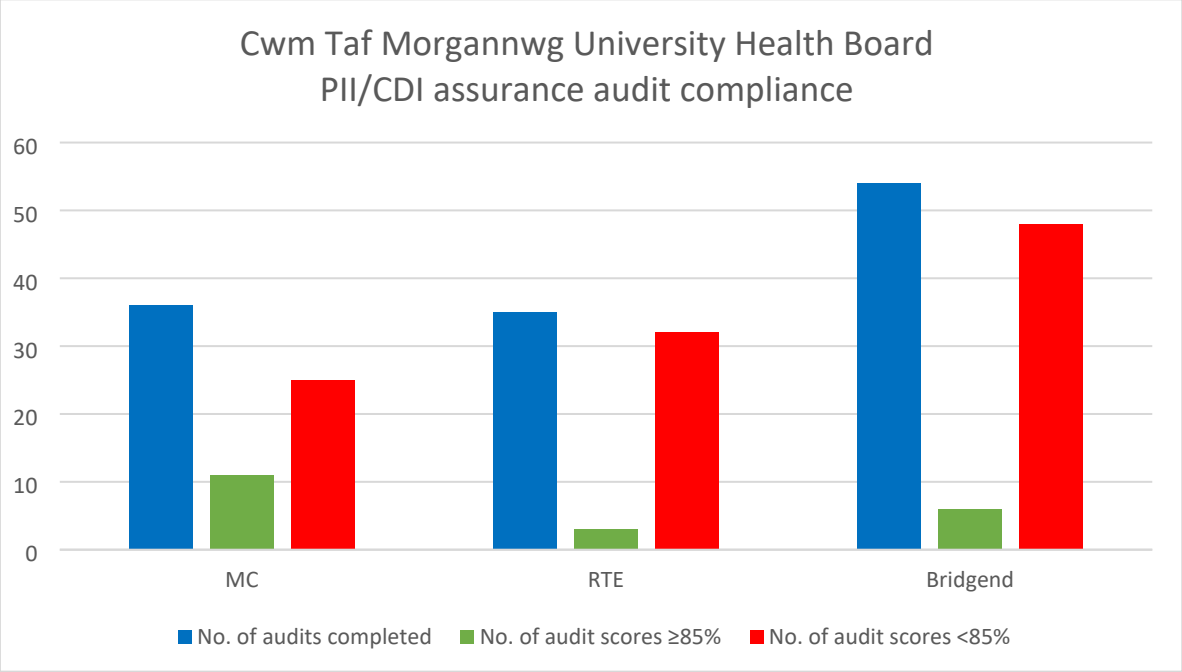
The following environmental audit scores, not only reflect standards of cleaning for housekeeping and nursing staff but also includes any maintenance/ estates issues identified during the audit process.

The increased cleaning hours provided by Welsh Government during the Covid-19 pandemic, was discontinued in 2023. Out of hours cleaning following patient transfer/discharge has now become the responsibility of nursing staff, resulting in either non-compliance due to staffing levels/ time or a possible impact on patient care and safety. Incident reports have been requested for such instances. Furthermore, critical staff shortages within the Facilities team have resulted in intermittent omissions with enhanced cleaning requests and a noticeable deterioration in cleaning standards.
There is an all-Wales task and finish group reviewing the current cleaning standards for Wales. The document will provide a consistent approach for training requirements, cleaning terminology/ frequency and roles and responsibilities.

102 environmental audits and 125 C.difficile and periods of increased incidence assurance checks were completed in 2023/24. Only 14% (14/102) of the audits achieved a score of ≥85%.

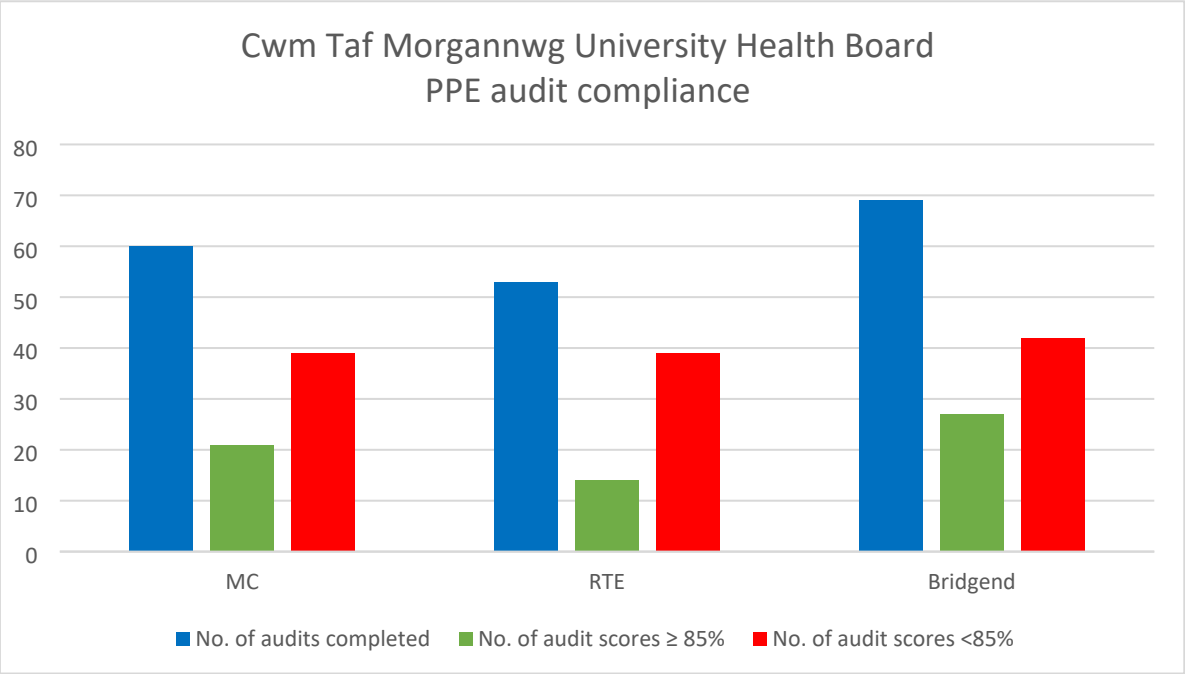
Poor audit scores have been reported across the Health Board. The audit reports have been circulated to nursing, facilities and estates colleagues.





D) Personal Protective Equipment (PPE) Audits

182 PPE audits were performed during 2023/24, only 34% (62/182) of the audits achieved a score ≥ 85%. The IPC team provide PPE training in response to poor audit scores where possible.



6. Outbreaks and Incidents

The IP&CT complete an incident report for each outbreak/ period of increased incidence and a multidisciplinary meeting is arranged. Following review, learning is shared widely to inform and influence clinical practice.
A National Reportable Incident (NRI) may be instigated if duty of care is breached or there is severe disruption to service.

Diarrhoea and Vomiting (D&V)

In order to reduce the risk of transmission, healthcare staff must apply standard infection prevention and control precautions and comply with IPC policies and procedures. Prompt assessment and identification of outbreaks is essential. Furthermore, admission areas must complete an IPC clinical risk assessment to identify possible infection prevention and control risks.

	2021/22	2022/23	2023/24
Total no of Ward Closures & Bay Restrictions (Due to Suspected / Confirmed Viral Diarrhoea and Vomiting)	8	10	9
No. of Patients	50	69	48
No. of Staff	15	32	19 (this may not be accurate)
No. of Bed Days lost	65	4	26

The IPC team advised 7 ward closures as a result of suspected/confirmed Norovirus during 2023/24. Only one ward remained open at risk due to operational pressures on site.

No. of Norovirus Outbreaks on Closed wards	2021/22	2022/23	2023/24
Confirmed	1	3	45
Suspected	2	2	3

There has been an increase in Norovirus cases compared to the same period in 2022/23. Public Health Wales hot labs have been introduced in Prince Charles and Princess of Wales Hospital. The hot labs provide a rapid turnaround service for MRSA, CPO, C.difficile and Norovirus results. Hence, the noted increase in Norovirus positive results.

7. Acute Respiratory Infections (ARIs)

Since the end of the Covid-19 pandemic, there continues to be a high incidence of ARI outbreaks. The IPC team have been integral to interpreting and implementing updated national guidance, providing advice for individual cases of ARI and managing outbreaks of infection to support a timely resolution.

The IPC team advised 102 ward closures for an ARI outbreak during 2023/24, however, only 26% (27/102) of wards remained closed due to operational pressures across the Health Board.
The majority of ARI outbreaks were identified in Royal Glamorgan Hospital and medical wards were the main areas of concern.

No. of ARI outbreaks in CTM	Covid-19	Influenza A/B	Other/mixed ARI	Total
Royal Glamorgan Hospital	28	3	13	44
Ysbyty Cwm Rhondda Hospital	3	0	0	3
Prince Charles Hospital	11	3	4	18
Ysbyty Cwm Cynon Hospital	4	1	2	7
Princess of Wales Hospital	24	0	4	28
Parc Prison	1	0	0	1
Glanrhyd Hospital	1	0	0	1

Period of Increase Incidence (PII)

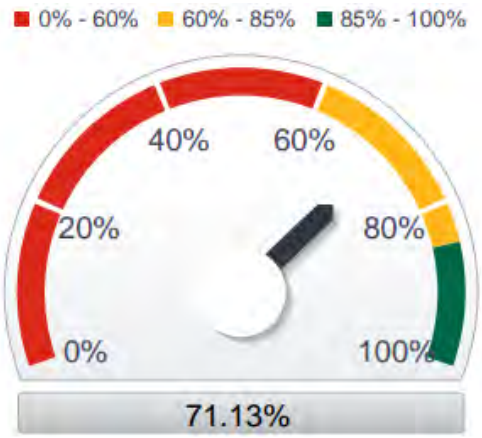
The following PII's were reported in 2023/24.

Location	Period	Organism	Cases
POW Ward 8	May 2023	C.difficile	5
RGH Ward 8	May/June 2023	GDH positive Toxin negative	7 (3 linked via WGS)
POW Ward 6	June 2023	C.difficile	6 (3 linked via WGS)
PCH NNU	July 2023	MRSA	3
RGH Ward 9	September/October 2023	VRE	6 (2 linked via WGS)
POW Wards 18 & 19	September 2023	C.difficile	2 (linked via WGS)
RGH Ward 19	October 2023	C.difficile	2 (linked via WGS)
POW A&E	December 2023	Possible VHF	1
RGH Ward 20	January – March 2024	MARO Klebsiella pneumoniae	5 (2 sets of two typing identical)
POW Ward 15	March 2024	C.difficile	2 (linked via WGS)
PCH Ward 6 & ITU	March 2024	GDH positive Toxin negative	4

8. Education and Training Activities

The IPC team offer a blended approach to training through face-to-face sessions and eLearning. Three levels of IPC training are provided. IPC is a core mandatory training requirement.

Improving compliance with IPC training is a major focus for the ILGs. Compliance is discussed at the IPC site and IPC committee meetings.



Combined Compliance % for all
3 Levels of IPC Training
Up to March 2024

Compliance % by Subject Level up to March 2024

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110|LOCAL|Infection Prevention and Control Management Training - No specified renewal|	1141	1141	386	33.83%	1	33.74%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	3997	3997	3341	83.59%	60	82.09%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	8230	8230	5782	70.26%	377	65.67%

Overall Compliance % for each Care Groups up to March 2024

Care Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Bank Care Group	1	1	1	100.00%	0	100.00%
110 Chief Operating Officer Care Group	1164	1168	882	75.51%	39	72.17%
110 Children & Families Care Group	1400	1548	1042	67.31%	71	62.73%
110 Corporates and Hosted Care Group	1309	1325	1135	85.66%	17	84.38%
110 Diagnostics, Therapies & Specialities Care Group	1588	1752	1261	71.97%	43	69.52%
110 Mental Health & Learning Disabilities Care Group	1177	1298	1000	77.04%	51	73.11%
110 Planned Care Care Group	1906	2228	1393	62.52%	77	59.07%
110 Primary & Community Care Group	1512	1625	1253	77.11%	62	73.29%
110 Unscheduled Care Care Group	2137	2423	1542	63.64%	78	60.42%

Aseptic Non-Touch Technique (ANTT)

Aseptic Non-Touch Technique (ANTT) is a comprehensive practice framework for all invasive procedures, from major surgery to maintenance of invasive devices and will affect every directorate and varying disciplines of staff.

All health board employees who perform aseptic procedures as part of their role must complete the ANTT eLearning package which is available via NHS learning Wales. Following the training, their competence is assessed in the clinical areas by designated ANTT trainers.

The IPC Team continue to coordinate and support the roll out of ANTT across the Health Board. Responsibility for monitoring compliance and DOPS assessment has been handed to the ILG teams.

The UHB ANTT Steering Group must be re-established to progress the ANTT roll out across the Health Board and support the Bronze/Silver/Gold accreditation process. ANTT was temporarily “unmandated” at the end of 2023/24, in order to review the ANTT requirements on ESR and update roles with the relevant levels of competency. Therefore, ANTT compliance is not available for the last financial year.

9. Commissioning of new Builds/Refurbishments

The IPC team provide expert IPC advice during the commissioning phase for new builds and refurbishment projects. IPC input must be sought early in the process to ensure advice can be offered in relation to the engineering aspects of IPC and to ensure national guidance and building notes are adhered to.

Derrogations are submitted if IPC advice, national guidance and building standards cannot be met.

10. Decontamination

Centralised Decontamination Facility/JAG Accreditation, Princess of Wales Hospital

The plan for the central decontamination facility in Princess of Wales Hospital has been temporarily halted, as an executive steer for decontamination services across the UHB is required for forward planning.

The endoscopy unit in POW is no longer an accredited service. The annual review for JAG accreditation was undertaken in December 2023. Service improvements are required by the end of July 2024, in order to achieve full JAG accreditation status. Endoscopy are currently sitting as an assessed service.

Mobile Endoscopy Unit, Royal Glamorgan Hospital

A mobile endoscopy unit continues to be used at the RGH site. The contract has been extended for an additional 6 months.

Chemical supply incident

Notification of a chemical supply issue affecting the UK was received in July 2023. The manufacturer (Getinge) detected a quality issue with the Aperlan Poka Yoke Agent A and B chemical bottles. Aperlan is used for the endoscope decontamination process and the shortage would primarily affect Endoscopy, Urology and ENT services across CTM. The care group for planned care arranged daily multidisciplinary operational meetings where updates were received and contingency plans established, to maintain emergency/cancer services across the UHB. Getinge circulated a Field Safety Notice (FSN) for the

defective chemical bottles and stock was released in a controlled manner. The supply issue was rectified by mid-August 2023.

Robotic assisted Surgery
Robotic assisted surgery was introduced to the UHB at the end of January 2024. The Sterile Service Department in RGH is re-processing/sterilising the robotic equipment.

Audit plan
The Decontamination Officer has commenced the annual decontamination audit program. To date, the Sterile Service Departments and Endoscopy units have been completed. Additional decontamination audit tools will be developed for USS probes and dental units.

Decontamination equipment replacement

There have been two porous load sterilisers successfully replaced in the Sterile Service Departments in Royal Glamorgan and Princess of Wales Hospital.

11.0 Challenges this year and priorities for 2024/25

Challenges faced in the past year:

- Increased workload for the IPC team due to the number of ARI outbreaks and periods of increased incidence, vacancies and long-term sickness within the team.
- Unable to support primary care due to the lack of a dedicated IPC resource.
- Unable to achieve annual audit programme.
- Unable to progress with planned improvement work.

Priorities for 2024/25 –

- Implement the IPC Strategy (2024-2027). The IPC team will provide an integrated service across primary, community and secondary care services. More emphasis will be placed on making improvements in primary care to advance patient care and safety and influence a reduction in C. Difficile infection, S. aureus and gram-negative bacteraemia.
- Continue to support the decontamination agenda for both primary and secondary care services.
- To support refurbishment and capital project schemes ongoing across the Organisation, including Llantrisant Health Park.
- Deliver a comprehensive surveillance, audit and training program.

- Recommence improvement work to -
    - Develop and introduce a robust root cause analysis process for all HCAI/CAI cases of C. difficile and preventable infections.
    - Establish a CAUTI/IV device improvement group to support a reduction in device associated bacteraemia.
    - Support improvements in IPC practice.
    - Work towards achieving bronze accreditation for ANTT.
    - Support maternity services to improve surveillance and reporting of C-section surgical site infections.
- Support clinical teams to reduce healthcare associated infections.
- Develop local HCAI improvement goals for the 5 mandatory surveillance organisms in line with the new Care Group model.
- Involved in national work to standardise IPC practice/procedures/ audit and investigative tools.

Agenda Item
9.2.8

CTM Health Board

Annual Letter 2023/2024
Public Services Ombudsman for Wales

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Nigel Downes, Assistant Director of Quality & Safety
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Deputy Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Quality & Safety Committee	18/09/2024	DISCUSSED

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PSOW	Public Service Ombudsman for Wales
PALS	Patient Advisory Liaison Service

1. Situation /Background

The role of the Public Services Ombudsman for Wales (PSOW) is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. The PSOW also undertakes investigations into public services under their own initiative.

As part of their role, the PSOW provides an annual letter to Health Boards in Wales updating on the work of their office, share key issues for Health Boards and to highlight any particular issue for organisations, together with actions Health Boards are required to undertake.

The PSOW's letter always coincides with their Annual Report, this year it is titled: "A New Chapter Unfolds". It is noted in the letter that public services continue to be in the spotlight, and under considerable pressures.

Overall, from across Wales, the PSOW office has received:

- 17% increase in number of people requesting help of the PSOW
- Almost 10,000 enquiries and complaints
- PSOW caseload increase by 37% since 2019

2. Specific Matters for Consideration

2.1 Cwm Taf Morgannwg University Health Board (CTMUHB) data 2023/24:

Over the year 2023/24, it was reported that the PSOW received the following for CTMUHB:

- 109 complaints (down from 134 complaints in 2022/23)
- 0.25 per 1000 residents (down from 0.30 per 1000 residents in 2022/23)
- 58% of complaints received by the PSOW were in relation to clinical treatment in hospital
- 14% of complaints received by the PSOW related to complaints handling
- 6% of complaints received by the PSOW were in relation to clinical treatment outside hospital
- 123 recommendations were made during the year to CTMUHB
- 121 recommendations due during the year, and 60% were complied with in the timescale agreed (remainder complied with outside of agreed timescale)

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

2.2 Public Interest Report

The PSOW published one Public Report in the Public Interest relating to CTMUHB – in October 2023. The case concerned treatment delivered at the Emergency Department of Princess of Wales Hospital, Bridgend. The PSOW noted they were pleased that compliance with all recommendations is complete.

2.3 Handling of PSOW Complaints and Responses

The letter notes that the PSOW has raised serious concerns about CTMUHB's handling of complaints and responses to the PSOW office. As outlined in the PSOW letter, CTMUHB's performance is affecting the PSOW's office's ability to handle complaints in a timely manner, undermining the trust and confidence of service users who have complained about the Health Board. The PSOW is continuing to engage closely with the Chief Executive on this and request the Board considers this matter to scrutinise the Health Board's performance on complaint handling.

Actions being taken to address the handling of complaints from PSOW office:

To address the issues in relation to the management of PSOW cases, the following improvement actions are being implemented. A comprehensive review of the PSOW case management processes has been undertaken, along with the following:

Ombudsman Huddles

- The CTMUHB Team have instituted three-times per week Ombudsman Huddles to:
  - Review new and ongoing cases
  - Assign action items

- Identify escalation needs
- Update on upcoming deadlines

Executive Oversight

- A weekly meeting, led by the Executive Director of Nursing, has been established to monitor Ombudsman Case Management progress

Digital

- Digital platform for real-time updates, fostering improved collaboration and transparency

Regular Reporting

- Every Week, an updated Ombudsman Case overview tracker will be distributed to all PSOW handlers, ensuring consistent information dissemination
- These initiatives aim to streamline CTMUHB's PSOW case management, improve communication, and enhance overall efficiency in handling PSOW cases

It is also noted within the letter that the PSOW Improvement Team are continuing to meet regularly with CTMUHB to discuss compliance with PSOW recommendations and complaints standards. The PSOW notes they have seen real benefit coming from these conversations, as well as improved working relationships. The PSOW noted that they wanted to pass on thanks to Kellie Jenkins-Forrester and the Concerns' team for their work with the PSOW Improvement Team/Officers.

2.4 Action to be taken by CTMUHB:

- Present the PSOW's Annual Letter (Appendix A) to the Board at the next available opportunity and notify the PSOW of when these meetings will take/have taken place

- Consider the data in the PSOW letter, alongside CTMUHB's own data, to understand more about CTMUHB's performance on complaints. This should include any patterns or trends and CTMUHB's compliance with PSOW recommendations

- Ensure that Board members consider CTMUHB's performance on complaint handling and considers whether any further action needs to be taken to improve its performance

- Provide the PSOW with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality

- Inform the PSOW of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

3. Assessment:

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality (*Duty of Quality Statutory Guidance (gov.wales)*)	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:

Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

4. Recommendation

Members of the Board are asked to:

- NOTE the content of the report and PSOW letter (Appendix A)
- DISCUSS the content of the report and flag areas (if not already identified) where further assurance is required
- SUPPORT the direction in developing a wider reach of quality reporting and locality based assurance reports

5. Next Steps

- Continue to monitor PSOW activity via the quality & safety dashboard, with key areas escalated to the weekly Quality & Safety Executive Meeting as required.

- Inform the PSOW of the outcome of the Health Board's considerations and proposed actions on the matters/actions identified above by 31 October 2024.

Ombwdsmon
Ombudsman
Cymru • Wales

Ask for: Communications

01656 641150

Date: 9 September 2024

Caseinfo@ombudsman.wales

Jonathan Morgan
Cwm Taf Morgannwg University Health Board

By email only
CTM_BoardMember@wales.nhs.uk
paul.mears@wales.nhs.uk

Annual Letter 2023/24

Dear Jonathan

Role of PSOW

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

Purpose of letter

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Overview of 2023/24

This letter, as always, coincides with my Annual Report – "A New Chapter Unfolds" – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

Public Service Complaints and compliance with recommendations

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 109 complaints about Cwm Taf Morgannwg University Health Board, we closed 129 (some complaints were carried over from the previous year) and intervened in 30% of cases. Further information on the complaints we dealt with last year can be found in the appendices.

We published one public report in the public interest relating to your Health Board in October 2023. As you will be aware, this case concerned treatment delivered at the Princess of Wales Hospital's Emergency Department and I am pleased that compliance with our recommendations is complete.

Also, we have raised our serious concerns about the Health Board's handling of complaints and responses to my office with your Chief Executive. As we have outlined, the Health Board's performance is affecting my office's ability to handle complaints and undermining the trust and confidence of service users who have complained about the Health Board. We are continuing to engage closely with the Chief Executive on this and ask that you ensure the Board considers this matter to scrutinise the Health Board's performance on complaint handling.

In total, we made 123 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 121 recommendations were due and 60% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, Groundhog Day 2: An opportunity for cultural change in complaint handling? I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 4% of complaints made to Cwm Taf Morgannwg University Health Board's complaints went on to be referred to PSOW. I would encourage all Health Boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

Colleagues from my Improvement Team continue to meet regularly with Cwm Taf Morgannwg University Health Board to discuss compliance with our recommendations and our complaints standards work. We have seen real benefit come from these conversations, as well as improved working relationships, and we would like to pass on our thanks to Kellie Jenkins-Forrester and their team for their work with our officers.

Action we would like your organisation to take

Further to this letter can I ask that Cwm Taf Morgannwg University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.

- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

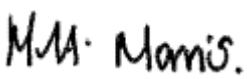
- Ensure that Board members consider the Health Board's performance on complaint handling and considers whether any further action needs to taken to improve its performance.

- Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

Cc. Paul Mears, Chief Executive, Cwm Taf Morgannwg University Health Board.

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30

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Appendix B - Received by Subject

Cwm Taf Morgannwg University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	1	1%
Adult Mental Health	4	2%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	6	3%
Child and Adolescent Mental Health	0	0%
Clinical treatment in hospital	63	58%
Clinical treatment outside hospital*	7	6%
Complaints Handling	15	14%
Covid-19	0	0%
Continuing care	0	0%
De-Registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	1	1%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	0	0%
Medication > Prescription dispensing	0	0%
Non-medical services	1	1%
Nosocomial*	0	0%
Other*	6	6%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	2	2%
Poor/No communication or failure to provide information	1	1%
Prisoner Care	0	0%
Recruitment and appointment procedures	0	0%
Referral to Treatment Times	0	0%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	0	0%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	**109**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Cwm Taf Morgannwg University Health Board		% Share
Out of Jurisdiction	29	22%
Premature	14	11%
Other cases closed after initial consideration	38	29%
Early Resolution/ voluntary settlement*	16	12%
Discontinued	4	3%
Other Reports - Not Upheld	5	4%
Other Reports Upheld*	22	17%
Public Interest Reports*	1	1%
Special Interest Reports*	0	0%
Total	**129**	

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% of Interventions
Aneurin Bevan University Health Board	73	195	37%
Betsi Cadwaladr University Health Board	81	256	32%
Cardiff and Vale University Health Board	34	158	22%
Cwm Taf Morgannwg University Health Board	39	129	30%
Hywel Dda University Health Board	55	154	36%
Powys Teaching Health Board	3	21	14%
Swansea Bay University Health Board	41	141	29%
Total	**326**	**1054**	**31%**

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Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2023/24. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2023/24. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix E shows compliance performance for all Health Boards.

Agenda Item
9.2.9

CTM Health Board

Decarbonisation emission reporting 2023-24

Dyddiad y Cyfarfod / Date of Meeting	26/09/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Calum Shaw, Sustainability Manager
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser, Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Executive Leadership Group	27/08/2024	Approved

Acronyms / Glossary of Terms	
WG	Welsh Government
WGES	Welsh Government Energy Service
tCO2e	Tonnes carbon dioxide equivalent
DAP	Decarbonisation Action Plan

1. Situation /Background

1.1 Welsh Government declared a Climate Emergency in 2019 and set the ambition for the public sector to be net zero by 2030. WG's NHS Decarbonisation strategy delivery plan recognises that the NHS is the largest public sector body in Wales and is uniquely placed to mitigate the impact of climate change for the people of Wales.

1.2 The WG annual carbon emission submission, Welsh Public Sector Net Zero Carbon reporting, started in 2019 to enable greater scrutiny and monitoring of the decarbonisation agenda, supporting national and local work to target reductions of high-emission services and/or practices. This report was approved by ELG on the 27th August 2024 and returned to WG on the 2nd September 2024.

1.3 The CTMUHB Decarbonisation Strategy with corresponding action plan has been approved by the board.

1.4 To provide coordination, accountability and ongoing leadership to the decarbonisation and green agenda, an Environmental Sustainability Group was established in 2022. This Group reports to the Population Health & Partnership Committee.

1.5 The 2018/19 baseline emissions for CTMUHB are 87,467 tCO2e. A recent report from the WGES to the HB has indicated that given changes to the operational boundaries since 2018/19, CTMUHBs baselines position would be 126,000 tCO2e, c30% higher than our current baseline. There are, however, no plans to change the baseline emissions of any UHB.

2. Specific Matters for Consideration

2.1 Annual carbon emission report (appendix 1) shows an annual increase from 142,679 tCO2e (2022-23) to 143,918 tCO2e (2023-24). Further work will be required to understand some of the annual variations but where possible these have been explained below.

2.2 Our carbon emissions template has been submitted in line with WG reporting guidance. A summary of the annual change in emissions is below:-

Emission category	**2022/23**	**2023/24**	**Annual change**	**Explanatory commentary**
	tCO2e consumed			
Buildings	25,906	23,810	-2,096	Variance mainly due to reduction in natural gas usage.
Supply chain	105,927	108,915	2,988	We have seen an increase in emissions due to additional reported spend. However, this data has been streamlined by NWSSP with more spend being transitioned to supplier specific emissions rather than a generic methodology. This has limited the increase to our emissions. .

Medical/ F-Gases	0	1,263	1,263	Previously reported under fleet and equipment. Reporting has been centralised and seen an increase due to reporting methodology.
Waste	1,360	1,126	-234	New waste regulations have impacted the waste reporting for this year, in particular recycling. Larger reductions could have been gained.
Fleet and equipment & other assets	1,450	407	-1,043	Fleet – no change to reporting, however we have seen a large decrease in fleet vehicles.
Business travel and commuting & homeworking	8,031	8,397	366	We believe business travel has reduced due to increased working from home and some managers not being required at sites. Commuting has used the same reporting approach as previous years. Homeworking emission have increased as we have established a more accurate assessment of our reported data and methodology.
Grand total	142,674	143,918	1,244	Total reporting has increased, mainly as a result of higher supply chain emissions.
Renewables	198	1,264	1,066	Change is due to increase in onsite PV and inclusion of biomass in renewable reporting. On site renewables have a positive carbon impact on the UHB emissions, through a reduction in energy demand.
Land use	Negligible	Negligible	0	Some aspects of land use across our estate sequester (reduce) carbon and others increase carbon. Overall position is negligible.

2.3 CTMUHB is not on track to meet the 16% carbon reduction target by 2025 and 34% by 2030. This is a trend seen across the Welsh NHS. Work is ongoing to better understand how these targets can be met. It is expected that a revised national Strategic delivery plan will be published in 2025.

3. Key Risks / Matters for Escalation

3.1 Further work is required to fully understand the annual changes; however, reporting is more consistent that previous years.

3.2 Additional work is required to take advantage of funding schemes and accelerate carbon reduction across the HB.

3.3 The DAP is due for a review and update by April 2025. As part of this process, key risks and issues will be identified and added to the qualitative return moving forward.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Globally Responsible Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Efficient
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below: Refine Reuse Repurpose Recycle

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: The development of this report does not impact on the Welsh language.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	There may be a negative reputational impact on the HB if the HB is unable to meet the Net Zero Targets.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 Board is asked to note and discuss the contents of this paper and attached report.

6. Next Steps

6.1 This report will be used to review actions for the next iteration of the DAP.

APPENDIX 1 – CTMUHBs Annual Carbon Emission Reporting 2023/24

Benchmarking data

This sheet contains the following tables:

Energy use in building benchmarks
Water use and waste benchmarks
Commuting benchmarks
Public transport £/passenger km benchmarks
Waste density factors

Energy use in building benchmarks

The source of building energy benchmarks is the Chartered Institution of Building Services (CIBSE) Energy Benchmarking tool. Organisations are free to use alternative sources of benchmark energy data but any data sources should be carefully documented, along with rationale for selection. Benchmarks for other building types are available through the tool, which can be accessed via the link below:

https://www.cibse.org/Knowledge/Benchmarking

Note: Values are correct as of 20/05/2022

Name	Description	Fossil-thermal typical benchmark (kWh/m2)	Electricity typical benchmark (kWh/m2)
Local authority buildings	Town Hall	132	85
Local authority buildings	Community Centres	139	47
Local authority buildings	Residential care homes	319	83
Local authority buildings	Depots	311	39
Local authority buildings	Sheltered housing	432	68
Public buildings	Library	117	76
Public buildings	Museum	121	55
Public buildings	Fire station	223	69
Public buildings	Police station	190	134
Offices	Local Government office	108	89
Offices	Air conditioned, standard	178	226
Schools	Primary	122	43
Schools	Secondary	113	51
Schools	Special	157	51
Schools	Secondary, with swimming pool	187	36
Hospital	General Acute	303	118
Hospital	Teaching/specialist	267	132
Hospital	Cottage hospital	492	78
Education (Higher)	Catering / bar	118	108
Education (Higher)	Lecture room/conference facility	150	93
Education (Higher)	Library or learning centre	112	103
Sports and recreation	Swimming pool	644	192
Sports and recreation	Combined centre	598	152
Sports and recreation	Dry sports centre (local)	343	105

Waste density table

Water use and waste benchmarks

The source of building water benchmarks is a publication by the Better Buildings Partnership (2017 Real Estate Environmental Benchmarks: January 2018). Organisations are free to use alternative sources of benchmark water data but any data sources should be carefully documented, along with rationale for selection.

Name	Good practice benchmark (litre/person/working day)	Typical practice benchmark (litre/person/working day)
Offices	24	36

Waste benchmarks have been taken from WRAP (Waste & Resources Action Programme) Green Office: A Guide to Running a More Cost-effective and Environmentally Sustainable Office .

Name	Good practice benchmark (quantity per person per year)
Offices	less than 200kg

Public transport £/passenger km benchmarks

Where only data on total cost by travel mode is available, and in the absence of any more accurate local estimates, the following estimates of £/passenger km can be used to estimate kilometres travelled from spend.

Travel mode	£/passenger km	Source
Rail	0.1632	Table 12.10 Revenue per passenger kilometre and revenue per passenger journey. Office of Rail and Road. UK Government
Bus	0.315639178	https://www.gov.uk/government/statistical-data-sets/bus-statistics-data-tables - Number of journeys (BUS01a)
Taxi	£1.69	https://www.walesonline.co.uk/news/wales-news/dragon-taxis-cardiff-cost-fares-17767633
Air	-	http://www.webflyer.com/travel/mileage_calculator/ Calculate distance travelled for each of the journeys taken. Option to choose top ten frequent trips and work out an average £/passenger km to apply to remainder.

Commuting benchmarks

The average commuting distance in Wales average is 9.5 miles/ 15.3 km and the modal split is shown in the table below. Data source: 'The Car and the Commute: The journey to work in England and Wales' report by the RAC Foundation

Travel mode	% split	Source
Car	64%	https://www.racfoundation.org/assets/rac_foundation/content/downloadables/car-and-the-commute-web-version.pdf
Car passenger	6.60%	
Taxi/ mini cab	0.40%	
Walking	9.50%	
Moped/ Motorbike	0.60%	
Bus	4.50%	
Rail	1.90%	
Cycling	1.40%	
Work from home	10.40%	
Other	0.50%	

Where your organisation has information on the estimated volume of waste collected rather than the weight, the following density factors can be used to estimate the weight.
These density conversion factors were developed by the Environment Agency for the 1998/99 commercial and industrial waste survey in England and have since been used across the UK by all of the Agencies including SEPA. The factors were derived from a number of different sources including published research, advice from the waste management industry and some original research at the time (source: https://www.sepa.org.uk/media/163323/uk-conversion-factors-for-waste.xlsx).

Density factors for waste

Waste type	EWC code	Waste Description	Density conversion factor (kg per litre)
Aggregates	17 01 07	mixtures of concrete, bricks, tiles and ceramics other than those mentioned in 17 01 06	0.66
Anatomical waste	18 01 02	Body parts and organs including blood bags and blood preserves (except 18 01 03)	0.2877
Asbestos	17 06 01*	insulation materials containing asbestos	0.28
Asphalt	17 03 02	bituminous mixtures other than those mentioned in 17 03 01	0.9
Average construction	17 09 04	mixed construction and demolition wastes other than those mentioned in 17 09 01, 17 09 02 and 17 09 03	0.32
Batteries	20 01 33*	batteries and accumulators included in 16 06 01, 16 06 02 or 16 06 03 and unsorted batteries and accumulators containing these batteries	1.35
Bricks	17 01 02	bricks	0.66
Clinical waste	18 01 03*	wastes whose collection and disposal is subject to special requirements in order to prevent infection	0.225
Clothing	20 01 10	clothes	0.2
Commercial and industrial waste	20 03 01	mixed municipal waste	0.26
Concrete	17 01 01	concrete	0.93
Household residual waste	20 03 01	mixed municipal waste	0.26
Infectious waste	18 01 03*	wastes whose collection and disposal is subject to special requirements in order to prevent infection	0.225
Insulation	17 06 04	insulation materials other than those mentioned in 17 06 01 and 17 06 03	0.25
Medical contaminated sharps waste	18 01 01	sharps (except 18 01 03)	0.19
Medicinal waste	20 01 32	medicines other than those mentioned in 20 01 31	0.9
Metals	17 04 07	mixed metals	0.27
Mineral oil	13 03 10*	other insulating and heat transmission oils	0.9
Mixed glass	20 01 02	glass	0.3332
Mixed metal cans	20 01 40	metals	0.23
Mixed paper	20 01 01	paper and cardboard	0.2105
Mixed plastics	20 01 39	plastics	0.14
Mixed recycling	20 03 01	mixed municipal waste	0.26
Mixed WEEE	20 01 36	discarded electrical and electronic equipment other than those mentioned in 20 01 21, 20 01 23 and 20 01 35	0.2131
Non infectious offensive waste	18 01 04	wastes whose collection and disposal is not subject to special requirements in order to prevent infection(for example dressings, plaster casts, linen, disposable clothing, diapers)	0.21
Organic food and drink	20 01 08	biodegradable kitchen and canteen waste	0.2
Organic garden	20 02 01	biodegradable waste	0.38
Organic mixed	20 02 01	biodegradable waste	0.38
Plasterboard	19 12 07	wood other than that mentioned in 19 12 06	0.24
Waste Soils	20 02 02	soil and stones	0.86
Tyres	16 01 03	end-of-life tyres	0.4657
Wood	20 01 38	wood other than that mentioned in 20 01 37	0.1855

23-Jul-24 Version 14

Introduction and Organisation Data

This spreadsheet is the required format for Welsh public sector organisations reporting their carbon emissions for the **2023 - 2024 reporting period**.
It is based on the Welsh Public Sector Net Zero Carbon Reporting Guide.

The following updates have been applied to this version of the template:

- Emission factors have been updated where appropriate
- Various bug fixes
- Medical gases updated and split out
- The summary sheet has been updated to be more comprehensive
- Additional organisations added
- Fleet split out from buildings
- Site level data can be submitted for building energy consumption
- More details can be entered for renewables

Please send the completed form to **netzeroreporting@energyservice.wales** by **2nd September 2024**

Organisational information

Organisational information	Organisation type	NHS Wales
Organisational information	Organisation name	Cwm Taf Morgannwg University Health Board
Organisational information	Financial year period for reporting	Financial year 2023/24
Organisational information	Date of report submission	02/09/2024
Organisational information	Person responsible for this report	Victoria Wallace
Organisational information	Email address of person responsible for this report	victoria.wallace@wales.nhs.uk
Organisational information	Total financial budget /spend/ turnover £	£ 1,393,256
Organisational information	Number of Full Time Equivalent employees	11,222
Organisational information	Building internal floor area equivalent to the energy data reported (sq m)	300,922
Organisational information	Region of Wales	South East Wales

Cell colour codes

- Information cell or question
- Information entry. Some cells have drop down lists
- Activity data. Numeric data entry
- Calculated data
- Summary data
- Not used

Boundary information

Buildings in scope	Do you own buildings that you occupy?	Y	Please complete the 'Buildings' table in Buildings, fleet & other assets sheet. See section 7.2 of the guidance for further information.
Buildings in scope	Do you lease buildings that you occupy?	Y	Please complete the 'Buildings' table in Buildings, fleet & other assets sheet. See section 7.2 of the guidance for further information.
Buildings in scope	Do you lease out buildings that you own to organisations to deliver public services on your behalf?	N	
Buildings in scope	Do you lease out buildings that you own to other public bodies?	Y	If that public body is also reporting, these emissions are out of scope for your organisation. See section 7.2 of the guidance
Buildings in scope	Do you lease out buildings that you own to private organisations for their own purposes?	N	
Streetlighting in scope	Do you own and operate streetlighting or signage	N	
Fleet and equipment in scope	Do you own or lease fleet and equipment?	Y	Please complete the 'Fleet' table in Buidlings, fleet & other assets. See section 7.4 of the guidance for further help
Agriculture in scope	Do you have farms with livestock (not leased out)?	N	
F-gases in scope	Do you have air conditioning or refrigeration systems that require refrigerant gas top-ups, or do you use anaesthetic gases?	Y	Please complete the 'Other gases' table in Buidlings, fleet & other assets. See section 7.5 of the guidance for further help
Business travel in scope	Do staff travel for work using their own cars or other transport modes (not fleet vehicles)	Y	Please complete the 'Business travel' table in Business travel, commute, home tab. See section 8.2 of the guidance for further help
Commuting in scope	Do staff commute to offices or other sites?	Y	Please complete the 'Commuting' table in Buidlings, fleet & other assets. See section 8.3 of the guidance for further help.
Homeworking in scope	Do any staff work from home?	Y	Please complete the 'Homeworking' table in Buidlings, fleet & other assets. See section 8.4 of the guidance for further help
Supply chain in scope	Do you purchase goods and services?	Y	Please complete the 'Supply chain emissions tab'. See section 10 of the guidance for further help
Land use in scope	Do you own and manage land for providing public services, with a total of more than 10 hectares?	Y	Please complete the 'Land Use emissions' sheet. See section 12 of the guidance for further information.
Waste in scope	Does your organisation produce waste from operations that is collected from your premises by a third party organisation?	Y	Please complete the 'Operational Waste' table in the Waste sheet. See section 9.2 of the guidance for further information.
	Does your organisation produce waste from operations and also operate the collection service of this waste?	N	
	Do you run waste collection services that collect and dispose of municipal waste?	N	
	Do you contract out a waste collection service that collect and dispose of municipal waste?	N	

Reporting comments

Reporting comments	Please provide comments on scope and completeness of your report and any significant changes in methods compared to last year. This comment will be included in your individual organisation report output once data have been reviewed and compared across all organisations. If you wish for some of the comment to be excluded from that report please make that clear.	

Peer review (optional)

Peer review	Peer organisation that has reviewed the data and calculations	
	Date of last review	
	Name of reviewer	
	Brief comments of the review outcomes	

Summary of results

This section provides a summary of the reported emissions for Cwm Taf Morgannwg University Health Board for Financial year 2023/24

You do not need to input any information into this sheet.

Please note, 'Outside of scopes' emissions are not included in 'Total' emissions or 'High' and 'Low' estimates.

Total emissions

	Units of $kgCO_2e$						
	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Total emissions	**14,605,129**	**6,393,213**	**122,920,344**	**143,918,686**	**145,753,997**	**142,052,142**	**3,550,819**

Buildings & stationary assets

	Units of $kgCO_2e$						
Categories	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Buildings	13,015,487	6,393,213	4,401,290	**23,809,990**	*24,412,257*	*23,207,722*	3,552,648
Streetlighting	-	-	-	**-**	-	-	-
F gases	-	-	-	**-**	-	-	-
Medical gases	1,262,966	-	-	**1,262,966**	1,389,262	1,136,669	-
Buildings & stationary assets total	***14,278,453***	***6,393,213***	***4,401,290***	***25,072,955***	***25,801,520***	***24,344,391***	***3,552,648***

Transport

	Units of $kgCO_2e$						
Categories	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Fleet and equipment	326,677	-	80,738	**407,415**	*427,785*	*387,044*	13,788
Business travel	-	-	1,381,016	**1,381,016**	*1,484,592*	*1,277,440*	-
Commuting	-	-	6,201,196	**6,201,196**	*6,984,278*	*5,418,113*	-
Homeworking	-	-	814,685	**814,685**	*977,622*	*651,748*	-
Transport total	**326,677**	**-**	**8,477,635**	**8,804,311**	**9,874,278**	**7,734,345**	**13,788**

Waste

	Units of $kgCO_2e$						
Categories	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Organisational waste	-	-	1,126,012	**1,126,012**	*1,182,312*	*1,069,711*	-
Municipal waste	-	-	-	**-**	-	-	-
Project waste	-	-	-	**-**	-	-	-
Waste	**-**	**-**	**1,126,012**	**1,126,012**	***1,182,312***	***1,069,711***	**-**

Supply chain - Tier 1 and Tier 2 combined

	Units of $kgCO_2e$						
Categories	Direct	Indirect	Indirect	Total	Estimated range	Estimated range	Outside of scopes
	Scope 1	Scope 2	Scope 3		High	Low	
Agriculture, forestry and fishing			114.59	114.59	114.59	114.59	
Mining and quarrying			-	-	-	-	

Manufacturing			17,186,765.17	17,186,765.17	17,186,765.17	17,186,765.17	
Electricity, gas, steam and air conditioning supply			39,994.47	39,994.47	39,994.47	39,994.47	
Water supply; sewerage, waste management and remediation activities			191,122.36	191,122.36	191,122.36	191,122.36	
Construction			3,803,190.13	3,803,190.13	3,803,190.13	3,803,190.13	
Wholesale and retail trade; repair of motor vehicles and motorcycles			19,386,634.57	19,386,634.57	19,386,634.57	19,386,634.57	
Transportation and storage			1,675,581.47	1,675,581.47	1,675,581.47	1,675,581.47	
Accommodation and food service activities			313,810.00	313,810.00	313,810.00	313,810.00	
Information and communication			795,387.47	795,387.47	795,387.47	795,387.47	
Financial and insurance activities			245,471.50	245,471.50	245,471.50	245,471.50	
Real estate activities			284,542.62	284,542.62	284,542.62	284,542.62	
Professional, scientific and technical activities			2,425,355.82	2,425,355.82	2,425,355.82	2,425,355.82	
Administrative and support service activities			2,881,314.14	2,881,314.14	2,881,314.14	2,881,314.14	
Public administration and defence; compulsory social security			8,677,885.39	8,677,885.39	8,677,885.39	8,677,885.39	
Education			271,457.21	271,457.21	271,457.21	271,457.21	
Human health and social work activities			49,961,705.60	49,961,705.60	49,961,705.60	49,961,705.60	
Arts, entertainment and recreation			113,036.98	113,036.98	113,036.98	113,036.98	
Other service activities			662,038.08	662,038.08	662,038.08	662,038.08	
Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use			-	-	-	-	
Supply chain - Tier 1 and Tier 2 combined			**108,915,408**	**108,915,408**	**108,915,408**	**108,915,408**	

Land based and agriculture

	Units of $kgCO_2e$						
Categories	**Direct**	**Indirect**	**Indirect**	**Total**	**Estimated range**	**Estimated range**	**Outside of scopes**
	Scope 1	**Scope 2**	**Scope 3**		**High**	**Low**	
Land based emissions	-	-	-	-	*172,764*	103,658	**138,211**
Land based removals	-	-	-	-	- *192,284*	- *115,371*	- 153,827
Agriculture	-	-	-	-	-	-	-
Total land based and agriculture	**-**	**-**	**-**	**-**	**- *19,521***	**- *11,712***	**- 15,617**

Renewables

	Units of kWh	
Categories	**Total generated**	**Total exported**
	Scope 1	**Scope 2**
Onsite renewables - heat	792,499	-
Onsite renewables - electricity	471,587	-
Offsite renewables - electricity	-	-
Onsite renewables - CHP	-	-
Purchased renewables - heat	-	
Purchased renewables - electricity	-	
Renewables	**1,264,086**	**-**

Cell colour codes: Information cell or question | Activity data. Numeric data ent
Information entry. Some cells hav | Calculated data

Building, fleet and other assets

Guidance for users

This sheet contains three tables - buildings, streetlighting, and other gases.

Please see Section 7 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

Instructions for users

- Use the [+] symbols to the left of column A to show/hide the data tables for entry
- Input information into the orange and blue cells. Grey cells should not be edited.
- Activity data entered in the 'data' column should only be in units specified in the 'units' column drop down list. If your data is in units that are not included in this drop down list, you will need to convert it before entering it into this sheet (see conversion sheet)
- When completing a row, fill in the columns from left to right. The drop down lists in later columns will change to provide valid combinations based on your previous selections.
- You can copy and paste between rows but please avoid copying data from one column to another, as this is likely to break the drop down lists.
- Fill in the notes column with a description of the method and data source used for each row
- Please note that the 'Outside of scopes' emissions are not included in the 'Total emissions'
- Building level data can be provided now, if providing building level data please add the name of the site, if aggregating all buildings then use the name 'All sites'

Buildings

No errors in this table

Emission data breakdown (kg CO_2e)

Site name	Ownership structure	Fuel/emission source	Category 1	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF ($kgCO_2e$/unit)	Total emissions ($kgCO_2e$)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Aberdare Health Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	126,844	kWh	126,844	kWh	0.2131	27,035.39		Data complete	23,203.44	-	-	-	3,831.96	*27,711.28*	*26,359.51*	-
Aberfan Health Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	25,432	kWh	25,432	kWh	0.2131	5,420.55		Data complete	4,652.25	-	-	-	768.30	*5,556.06*	*5,285.04*	-
ARC	Buildings we lease out to deliver serv	Natural gas	All natural gas	Tier 3	2.5%	65,873	kWh	65,873	kWh	0.2131	14,040.10		Data complete	12,050.08	-	-	-	1,990.02	*14,391.10*	*13,689.10*	-
Bryncethin Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	34	kWh	34	kWh	0.2131	7.25		Data complete	6.22	-	-	-	1.03	*7.43*	*7.07*	-
Carnegie	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	208,661	kWh	208,661	kWh	0.2131	44,473.78		Data complete	38,170.13	-	-	-	6,303.65	*45,585.83*	*43,361.94*	-
Cefn Yr Afon	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	164,722	kWh	164,722	kWh	0.2131	35,108.67		Data complete	30,132.42	-	-	-	4,976.25	*35,986.39*	*34,230.95*	-
Central Processing Unit 20, 21 & 22	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	406,376	kWh	406,376	kWh	0.2131	86,614.54		Data complete	74,337.93	-	-	-	12,276.62	*88,779.91*	*84,449.18*	-
Cwm Gwyrth Medical Centre	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	162,978	kWh	162,978	kWh	0.2131	34,736.96		Data complete	29,813.39	-	-	-	4,923.57	*35,605.38*	*33,868.53*	-
Dewi Sant Health Park	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	1,366,071	kWh	1,366,071	kWh	0.2131	291,162.91		Data complete	249,893.90	-	-	-	41,269.00	*298,441.98*	*283,881.83*	-
East Glamorgan Laundry	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	10,784,379	kWh	10,784,379	kWh	0.2131	2,298,570.96		Data complete	1,972,774.87	-	-	-	325,796.09	*2,356,035.23*	*2,241,106.69*	-
Ferndale Medical Centre	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	132,875	kWh	132,875	kWh	0.2131	28,320.83		Data complete	24,306.68	-	-	-	4,014.15	*29,028.86*	*27,612.81*	-
Glanrhyd Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	783,531	kWh	783,531	kWh	0.2131	167,000.96		Data complete	143,330.48	-	-	-	23,670.47	*171,175.98*	*162,825.93*	-
Glanrhyd Hospital Leased to SBUHB	Buildings we lease out to another pul	Natural gas	All natural gas	Tier 3	2.5%	2,084,904	kWh	2,084,904	kWh	0.2131	444,374.20		Data complete	381,389.25	-	-	-	62,984.95	*455,483.55*	*433,264.84*	-
Hirwaun Medical Centre	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	111,510	kWh	111,510	kWh	0.2131	23,767.12		Data complete	20,398.40	-	-	-	3,368.72	*24,361.30*	*23,172.94*	-
Kier Hardie Health Park	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	490,708	kWh	490,708	kWh	0.2131	104,588.98		Data complete	89,764.69	-	-	-	14,824.29	*107,203.70*	*101,974.25*	-
Kier Hardie Health Park GP's	Buildings we lease out to another pul	Natural gas	All natural gas	Tier 3	2.5%	4,121	kWh	4,121	kWh	0.2131	878.35		Data complete	753.85	-	-	-	124.50	*900.30*	*856.39*	-
Kier Hardie Health Park Pharmacy	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	3,080	kWh	3,080	kWh	0.2131	656.47		Data complete	563.42	-	-	-	93.05	*672.88*	*640.06*	-
Llwyn Yr Eos Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	1	kWh	1	kWh	0.2131	0.21		Data complete	0.18	-	-	-	0.03	*0.22*	*0.21*	-
Maerdy Surgery	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	30,611	kWh	30,611	kWh	0.2131	6,524.40		Data complete	5,599.64	-	-	-	924.76	*6,687.51*	*6,361.29*	-
Maesteg Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	538,346	kWh	538,346	kWh	0.2131	114,742.49		Data complete	98,479.06	-	-	-	16,263.43	*117,611.05*	*111,873.93*	-
Maesteg Hospital Leased to Bron Y Garn	Buildings we lease out to another pul	Natural gas	All natural gas	Tier 3	2.5%	57,215	kWh	57,215	kWh	0.2131	12,194.74		Data complete	10,466.28	-	-	-	1,728.47	*12,499.61*	*11,889.88*	-
Maritime Resource Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	60,578	kWh	60,578	kWh	0.2131	12,911.53		Data complete	11,081.47	-	-	-	1,830.06	*13,234.32*	*12,588.74*	-
National Imaging Academy Wales	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	96,417	kWh	96,417	kWh	0.2131	20,550.22		Data complete	17,637.46	-	-	-	2,912.76	*21,063.97*	*20,036.46*	-
North Cornelly Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	42,739	kWh	42,739	kWh	0.2131	9,109.34		Data complete	7,818.20	-	-	-	1,291.15	*9,337.08*	*8,881.61*	-
Ozmore Vale Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	33,621	kWh	33,621	kWh	0.2131	7,165.94		Data complete	6,150.25	-	-	-	1,015.69	*7,345.09*	*6,986.80*	-
Old Trust HQ 71 Quarella Road	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	230,487	kWh	230,487	kWh	0.2131	49,125.75		Data complete	42,162.74	-	-	-	6,963.01	*50,353.90*	*47,897.61*	-
Pencoed Primary Care Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	77,664	kWh	77,664	kWh	0.2131	16,553.22		Data complete	14,206.99	-	-	-	2,346.23	*16,967.05*	*16,139.39*	-
Pinewood House	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	156,959	kWh	156,959	kWh	0.2131	33,454.07		Data complete	28,712.34	-	-	-	4,741.73	*34,290.42*	*32,617.72*	-
Pontypridd & District Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	431,395	kWh	431,395	kWh	0.2131	91,947.07		Data complete	78,914.62	-	-	-	13,032.44	*94,245.74*	*89,648.39*	-
Pontypridd Health Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	153,749	kWh	153,749	kWh	0.2131	32,769.90		Data complete	28,125.14	-	-	-	4,644.76	*33,589.14*	*31,950.65*	-
Porth Dental	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	51,332	kWh	51,332	kWh	0.2131	10,940.85		Data complete	9,390.11	-	-	-	1,550.74	*11,214.37*	*10,667.33*	-
Porthcawl Primary Care Centre	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	192,050	kWh	192,050	kWh	0.2131	40,933.33		Data complete	35,131.50	-	-	-	5,801.83	*41,956.66*	*39,910.00*	-
Prince Charles Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	11,338,209	kWh	11,338,209	kWh	0.2131	2,416,613.69		Data complete	2,074,086.40	-	-	-	342,527.29	*2,477,029.03*	*2,356,198.35*	-
Prince Charles Hospital Creche	Buildings we lease out to deliver serv	Natural gas	All natural gas	Tier 3	2.5%	2,403	kWh	2,403	kWh	0.2131	512.17		Data complete	439.58	-	-	-	72.59	*524.98*	*499.37*	-
Princess of wales Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	14,997,284	kWh	14,997,284	kWh	0.2131	3,196,505.01		Data complete	2,743,437.06	-	-	-	453,067.95	*3,276,417.63*	*3,116,592.38*	-
Princess of wales Hospital SMTL	Buildings we lease out to another pul	Natural gas	All natural gas	Tier 3	2.5%	7,137	kWh	7,137	kWh	0.2131	1,521.17		Data complete	1,305.56	-	-	-	215.61	*1,559.20*	*1,483.14*	-
Princess of wales Hospital Stores	Buildings we lease out to another pul	Natural gas	All natural gas	Tier 3	2.5%	13,460	kWh	13,460	kWh	0.2131	2,868.85		Data complete	2,462.22	-	-	-	406.63	*2,940.57*	*2,797.13*	-
Quarella Road Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	56,320	kWh	56,320	kWh	0.2131	12,003.98		Data complete	10,302.56	-	-	-	1,701.43	*12,304.08*	*11,703.88*	-
Royal Glamorgan Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	18,031,591	kWh	18,031,591	kWh	0.2131	3,843,233.94		Data complete	3,298,499.58	-	-	-	544,734.36	*3,939,314.79*	*3,747,153.09*	-
Royal Glamorgan Hospital	CHP plant that we own	Natural gas	All natural gas	Tier 3	2.5%	601,720	kWh	601,720	kWh	0.2131	128,249.95		Data complete	110,071.99	-	-	-	18,177.96	*131,456.20*	*125,043.71*	-
Talbot Green Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	62,518	kWh	62,518	kWh	0.2131	13,325.02		Data complete	11,436.35	-	-	-	1,888.67	*13,658.14*	*12,991.89*	-
Tonteg Hospital	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	225,192	kWh	225,192	kWh	0.2131	47,997.18		Data complete	41,194.13	-	-	-	6,803.05	*49,197.11*	*46,797.25*	-
Tonypandy Health Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	62,595	kWh	62,595	kWh	0.2131	13,341.43		Data complete	11,450.44	-	-	-	1,890.99	*13,674.97*	*13,007.90*	-
Trealaw Resource Centre	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	73,689	kWh	73,689	kWh	0.2131	15,705.99		Data complete	13,479.85	-	-	-	2,226.14	*16,098.64*	*15,313.34*	-
Treharris Primary Care Centre	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	253,891	kWh	253,891	kWh	0.2131	54,114.06		Data complete	46,444.01	-	-	-	7,670.05	*55,466.91*	*52,761.20*	-
Ty Calon Lan	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	89,284	kWh	89,284	kWh	0.2131	19,029.90		Data complete	16,332.63	-	-	-	2,697.27	*19,505.64*	*18,554.15*	-
Tylorstown Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	38,113	kWh	38,113	kWh	0.2131	8,123.36		Data complete	6,971.97	-	-	-	1,151.39	*8,326.45*	*7,920.28*	-
Tynewydd Branch	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	22,501	kWh	22,501	kWh	0.2131	4,795.84		Data complete	4,116.08	-	-	-	679.76	*4,915.73*	*4,675.94*	-
Tynewydd Surgery	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	34,621	kWh	34,621	kWh	0.2131	7,379.08		Data complete	6,333.18	-	-	-	1,045.90	*7,563.56*	*7,194.61*	-
Unit 1 Charwood Court	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	44,025	kWh	44,025	kWh	0.2131	9,383.44		Data complete	8,053.45	-	-	-	1,330.00	*9,618.03*	*9,148.86*	-
Unit 1 Viaduct House	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	41,033	kWh	41,033	kWh	0.2131	8,745.73		Data complete	7,506.12	-	-	-	1,239.61	*8,964.37*	*8,527.09*	-
Unit 2 Gwaun Elai	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	87,551	kWh	87,551	kWh	0.2131	18,660.53		Data complete	16,015.61	-	-	-	2,644.92	*19,127.04*	*18,194.01*	-
Unit 3 Gwaun Elai	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	106,081	kWh	106,081	kWh	0.2131	22,609.99		Data complete	19,405.28	-	-	-	3,204.71	*23,175.24*	*22,044.74*	-
Unit 4 Gwaun Elai	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	108,036	kWh	108,036	kWh	0.2131	23,026.68		Data complete	19,762.91	-	-	-	3,263.77	*23,602.34*	*22,451.01*	-
WHSSC Unit G1 Treforest Ind Est	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	15,193	kWh	15,193	kWh	0.2131	3,238.22		Data complete	2,779.24	-	-	-	458.98	*3,319.18*	*3,157.26*	-
Williamstown	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	476,943	kWh	476,943	kWh	0.2131	101,655.12		Data complete	87,246.67	-	-	-	14,408.45	*104,196.50*	*99,113.74*	-
Ynyshir Medical Centre	Buildings we lease in from other orga	Natural gas	All natural gas	Tier 3	2.5%	68,816	kWh	68,816	kWh	0.2131	14,667.37		Data complete	12,588.44	-	-	-	2,078.93	*15,034.05*	*14,300.68*	-
Ynysmeurig House	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	81,466	kWh	81,466	kWh	0.2131	17,363.58		Data complete	14,902.49	-	-	-	2,461.09	*17,797.67*	*16,929.49*	-
Ynyswen Clinic	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	41,908	kWh	41,908	kWh	0.2131	8,932.23		Data complete	7,666.19	-	-	-	1,266.04	*9,155.53*	*8,708.92*	-
Ysbyty Cwm Cynon	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	2,635,185	kWh	2,635,185	kWh	0.2131	561,660.50		Data complete	482,051.56	-	-	-	79,608.94	*575,702.01*	*547,618.99*	-
Ysbyty Cwm Rhondda	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	1,405,658	kWh	1,405,658	kWh	0.2131	299,600.44		Data complete	257,135.51	-	-	-	42,464.93	*307,090.45*	*292,110.43*	-
<< 5 Ysbyty Georze Thomas	Buildings we own and occupy	Natural gas	All natural gas	Tier 3	2.5%	481,919	kWh	481,919	kWh	0.2131	102,715.70		Data complete	88,156.93	-	-	-	14,558.77	*105,283.59*	*100,147.81*	-

Streetlighting

No data entered

Emission data breakdown (kg CO_2e)

Blank	Type of lighting	Fuel/emission source	Category 1	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF ($kgCO_2e$/unit)	Total emissions ($kgCO_2e$)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes

Other gases

No data entered

Emission data breakdown (kg CO_2e)

Site name	Type	Gas	Not used	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF ($kgCO_2e$/unit)	Total emissions ($kgCO_2e$)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
	F gas								kg												
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Fleet & Equipment

Guidance for users

This sheet contains two tables - fleet and equipment (fuel) and fleet (distance).

Please see Section 7 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

Instructions for users

- Input information into the orange and blue cells. Grey cells should not be edited.
- Activity data entered in the 'data' column should only be in units specified in the 'units' column drop down list. If your data is in units that are not included in this drop down list, you will need to convert it before entering it into this sheet (see conversion sheet)
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- You can copy and paste between rows but please avoid copying data from one column to another, as this is likely to break the drop down lists.
- Fill in the notes column with a description of the method and data source used for each row
- Please note that the 'Outside of scopes' emissions are not included in the 'Total emissions'

Fleet and equipment - fuel

No errors in this table

Emission data breakdown (kg CO_2e)

Type	Fuel	Category 1	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF ($kgCO_2e$/unit)	Total emissions ($kgCO_2e$)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
All fleet	Diesel	Average biofuel blend	Tier 3	5%	115,099	litres	1,209,230	kWh	0.3072	359,426.62	AWAITING REPORT	Data complete but requires	289,097.80	-	-	-	70,328.82	*377,397.95*	*341,455.29*	12,092.30
All fleet	Petrol	Average biofuel blend	Tier 3	5%	17,917	litres	169,531	kWh	0.2931	47,987.96	AWAITING REPORT	Data complete but requires	37,578.77	-	-	-	10,409.18	*50,387.35*	*45,588.56*	1,695.31

Fleet - distance

No data entered

Emission data breakdown (kg CO_2e)

Type	Fuel	Size	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF ($kgCO_2e$/unit)	Total emissions ($kgCO_2e$)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes

Business travel, commuting and homeworking

Guidance for users

This sheet contains three tables - business travel, commuting and homeworking.

Please see Section 8 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

Instructions for users

- Input information into the orange and blue cells. Grey cells should not be edited.
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- Fill in the notes column with a description of the method and data source used for each row
- Please note that the 'Outside of scopes' emissions are not included in the 'Total emissions'

Note for fossil fuel vehicles:
- Small Car = up to 1.4 litre for Petrol and up to 1.7 litre for Diesel
- Medium Car = 1.4-2.0 litre for Petrol and 1.7-2.0 litre for Diesel (if its 1.4 petrol or 1.7 Diesel use "Medium")
- Large Car = above 2.0 litre for both Petrol and Diesel
- Average = size unknown

Cell colour codes:

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Business travel

No errors in this table

Emission source	Category 1	Category 2	Methodology used	RSD	Data	Units	Converted data	Standard units	Total EF (kgCO2e/unit)	Total emissions	Notes	Ease of collection	Emission data breakdown (kg CO2e) Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Private car	Average	Unknown fuel	Tier 3	8%	4,081,373	Vehicle miles	6,566,929	Vehicle km	0.210298588	1,381,015.93		Data complete but requires	-	-	1,094,303.80	-	286,712.13	*1,484,592.12*	*1,277,439.73*	-

Commuting

No errors in this table

Emission source	Category 1	Category 2	Methodology used	RSD	Data	Units	Converted data	Standard units	Total EF (kgCO2e/unit)	Total emissions	Notes	Ease of collection	Emission data breakdown (kg CO2e) Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Private car	Average	Unknown fuel	Tier 2	13%	27,801,113	Vehicle km	27,801,113	Vehicle km	0.210298588	5,846,534.91	Using WG Net Zero Reporting Guidance (8.3.1 Table 22: Commuting assumptions), 11,222 staff in CTMUHB x 64% for Car split x Average commuting distance in Wales 15.3 km x Average number of working days 253 = ((11222*0.64)*15.3)*253. PLEASE NOTE: Commuting RSD doesn't correspond with the RSD provided in the Welsh Government Reporting Guidance for Commuting (Table 21).	Data complete but requires	-	-	4,632,738.29	-	1,213,796.61	*6,577,351.77*	*5,115,718.04*	-
Motorbike	Average	Petrol	Tier 2	13%	260,635	Vehicle km	260,635	Vehicle km	0.143235005	37,332.12	Using WG Net Zero Reporting Guidance (8.3.1 Table 22: Commuting assumptions), 11222 staff in CTMUHB x 0.6% for Moped / Motorcycle split x Average commuting distance in Wales 15.3 km x Average number of working days 253 = ((11222*0.006)*15.3)*253. PLEASE NOTE: Commuting RSD doesn't correspond with the RSD provided in the Welsh Government Reporting Guidance for Commuting (Table 21).	Data complete but requires	-	-	29,627.54	-	7,704.58	*41,998.63*	*32,665.60*	-

Public Transport	Taxi	Taxi - Regular	Tier 2	15%	173,757	Passenger km	173,757	Passenger km	0.185585797	32,246.82	Using WG Net Zero Reporting Guidance (8.3.1 Table 22: Commuting assumptions), 11,222 staff in CTMUHB x 0.4% for Taxi split x Average commuting distance in Wales 15.3 km x Average number of working days 253 = ((11222*0.004)*15.3)*253.	Data complete but requires	-	-	25,822.88	-	6,423.95	*37,083.85*	*27,409.80*	-
Public Transport	Bus	Average local bus	Tier 2	15%	1,954,766	Passenger km	1,954,766	Passenger km	0.127080395	248,412.41	Using WG Net Zero Reporting Guidance (8.3.1 Table 22: Commuting assumptions), 11222 staff in CTMUHB x 4.5% for Bus split x Average commuting distance in Wales 15.3 km x Average number of working days 253 = ((11222*0.045)*15.3)*253.	Data complete but requires	-	-	199,680.10	-	48,732.31	*285,674.27*	*211,150.55*	-
Public Transport	Rail	National rail	Tier 2	15%	825,346	Passenger km	825,346	Passenger km	0.044429138	36,669.39	Using WG Net Zero Reporting Guidance (8.3.1 Table 22: Commuting assumptions), 11,222 staff in CTMUHB x 1.9% for Rail split x Average commuting distance in Wales 15.3 km x Average number of working days 253 = ((11,222*0.019)*15.3)*253.	Data complete but requires	-	-	29,269.20	-	7,400.19	*42,169.80*	*31,168.98*	-

Homeworking **No error** **No errors in this table** **Emission data breakdown (kg CO2e)**

Emission source	Number of FTE	% working hours at home	Methodology used	RSD	Data	Units	Converted data	Standard units	Total EF (kgCO2e/unit)	Total emissions	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Homeworking	11,222	13%	Tier 2	20%	1,402.8	FTE years	1,402.8	FTE years	580.8	814,685.22	based on estimated homeworking per staff group (allied health professionals, healthcare scientists, add prof scientific & technic, add clinical services, medical & dental, nursing & midwifery, students at 5%. Admin & clerical at 40% and Estates & ancilary at 10%	Data complete but requires	-	-	814,685.22	-	-	*977,622.26*	*651,748.17*	-

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Medical gases (NHS only)

Guidance for users

This sheet contains one table - medical gases.

Please see Section 7 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

Instructions for users

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- You can copy and paste between rows but please avoid copying data from one column to another, as this is likely to break the drop down lists.
- Fill in the notes column with a description of the method and data source used for each row
- Please note that the 'Outside of scopes' emissions are not included in the 'Total emissions'

Medical gases

No errors in this table

Emission data breakdown (kg CO_2e)

Type	Gas	Not used	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF (kgCO_2e/unit)	Total emissions (kgCO_2e)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Medical gas	Entonox		Tier 3	10%	2,843,368.00	Litres	2,843,368	Litres	0.278	790,456.30			790,456.30	-	-	-	-	*869,501.93*	*711,410.67*	-
Medical gas	Nitrous oxide		Tier 3	10%	670,600.00	Litres	670,600	Litres	0.559	374,865.40			374,865.40	-	-	-	-	*412,351.94*	*337,378.86*	-
Medical gas	Sevoflurane		Tier 3	10%	493.50	Litres	494	Litres	197.860	97,643.91			97,643.91	-	-	-	-	*107,408.30*	*87,879.52*	-
Medical gas								Litres						-	-	-	-			-
Medical gas								Litres						-	-	-	-			-
Medical gas								Litres						-	-	-	-			-
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Indirect emissions from the supply chain

Guidance for users

This sheet contains two tables: Tier 1 supply chain spend based estimates and Tier 2 supply chain more accurate estimates **based on reported carbon.**
Please see Section 11 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

The Tier 1 table is based on the Defra source 'Conversion factors KgCO2 per £ spent, by SIC code 2020', rounded to 3 d.p.
www.gov.uk/government/statistics/uks-carbon-footprint

This table only covers indirect emissions from the supply chain and is an estimate of the indirect GHG emissions resulting from expenditure on procuring goods and services. The emission factors were calculated by the University of Leeds as an update to the dataset used previously which were factors for 2011.
This table also includes a number of activities that are likely to be covered in your operational emissions, such as fuel use and transmission and distribution, travel and water. If you have captured that activity in the Operational emissions tab, you should remove the related expenditure from this table as otherwise you will be double counting your emissions. However, the information in this table may still be useful for a rough initial calculation of the relative importance of these activities in the first instance.

Instructions for users:

• Input information into the orange and blue cells. Grey cells should not be edited. Fill in the notes column describing the data source used and any data exclusions.
• Identify the amount spent on different product and service groups (in actual prices in £s, including VAT).
• Categroies that are likely to be accounted for elsewhere in this data collection form have been highlighted with an orange box.
• In Tier 1, the amount of spend is automatically multiplied by the conversion factor to get total emissions in kilograms of carbon dioxide equivalent (kg CO_2e).
• If you wish to use a higher tier (Tier 2) method for part of your supply chain emissions, you can record these in the second table below. Please include notes about your method and the amount of spend that these emissions account for. Please **DO NOT** subtract this spend from the data reported in the Tier 1 table (i.e any emissions reported in the Tier 2 table should also be included in the total spend for that category in the Tier 1 table). Any emissions calculated by Tier 2 methods are included in column J of the Tier 1 table to provide an overall total without double counting.

Supply chain - tier 1 methodology

No errors in this table

Supply chain group	SIC code (SIC 2007)	Product category	Methodology	RSD	Amount spent by product category (£)	Units	Emission factor (kgCO_2e per £ spent)	Total kg CO_2e	Notes on data source and exclusions	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Agriculture, forestry and fishing	01	*Products of agriculture, hunting and related services*	*Tier 1*	25%	£0.00	£	*1.974*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Agriculture, forestry and fishing	02	*Products of forestry, logging and related services*	*Tier 1*	25%	£410.99	£	*0.279*	114.6			0.0	0.0	114.6	0.0	0.0	114.6	114.6	0.0
Agriculture, forestry and fishing	03	*Fish and other fishing products; aquaculture products; support services to fishing*	*Tier 1*	25%	£0.00	£	*0.523*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mining and quarrying	05	*Coal and lignite*	*Tier 1*	25%	£0.00	£	*1.117*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mining and quarrying	06	*Crude petroleum and natural gas*	*Tier 1*	25%	£0.00	£	*0.660*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mining and quarrying	08	*Other mining and quarrying products*	*Tier 1*	25%	£0.00	£	*0.534*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mining and quarrying	09	*Mining support services*	*Tier 1*	25%	£0.00	£	*0.345*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	10.1	*Preserved meat and meat products*	*Tier 1*	25%	£177,398.61	£	*0.772*	136,993.4			0.0	0.0	136993.4	0.0	0.0	136993.4	136993.4	0.0
Manufacturing	10.2 -3	*Processed and preserved fish, crustaceans, molluscs, fruit and vegetables*	*Tier 1*	25%	£0.00	£	*0.721*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	10.4	*Vegetable and animal oils and fats*	*Tier 1*	25%	£0.00	£	*0.976*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	10.5	*Dairy products*	*Tier 1*	25%	£233,413.17	£	*0.962*	224,593.0			0.0	0.0	224593.0	0.0	0.0	224593.0	224593.0	0.0
Manufacturing	10.6	*Grain mill products, starches and starch products*	*Tier 1*	25%	£0.00	£	*0.755*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	10.7	*Bakery and farinaceous products*	*Tier 1*	25%	£18,822.55	£	*0.451*	8,481.3			0.0	0.0	14216.4	0.0	0.0	14216.4	14216.4	0.0
Manufacturing	10.8	*Other food products*	*Tier 1*	25%	£14,244.76	£	*0.661*	9,410.5			0.0	0.0	9410.5	0.0	0.0	9410.5	9410.5	0.0
Manufacturing	10.9	*Prepared animal feeds*	*Tier 1*	25%	£0.00	£	*0.912*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	11.01-6	*Alcoholic beverages*	*Tier 1*	25%	£0.00	£	*0.707*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	11.07	*Soft drinks*	*Tier 1*	25%	£1,796.88	£	*0.332*	596.7			0.0	0.0	596.7	0.0	0.0	596.7	596.7	0.0
Manufacturing	12	*Tobacco products*	*Tier 1*	25%	£0.00	£	*0.203*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	13	*Textiles*	*Tier 1*	25%	£44,148.19	£	*0.771*	34,031.7			0.0	0.0	18997.3	0.0	0.0	18997.3	18997.3	0.0
Manufacturing	14	*Wearing apparel*	*Tier 1*	25%	£88,167.40	£	*0.791*	69,762.0			0.0	0.0	64499.5	0.0	0.0	64499.5	64499.5	0.0
Manufacturing	15	*Leather and related products*	*Tier 1*	25%	£472,594.36	£	*0.734*	347,089.7			0.0	0.0	312665.7	0.0	0.0	312665.7	312665.7	0.0
Manufacturing	16	*Wood and of products of wood and cork, except furniture; articles of straw and plaiting materials*	*Tier 1*	25%	£24,224.32	£	*0.475*	11,498.0			0.0	0.0	11498.0	0.0	0.0	11498.0	11498.0	0.0
Manufacturing	17	*Paper and paper products*	*Tier 1*	25%	£380,410.75	£	*0.707*	268,903.6			0.0	0.0	224459.1	0.0	0.0	224459.1	224459.1	0.0
Manufacturing	18	*Printing and recording services*	*Tier 1*	25%	£422,648.43	£	*0.382*	161,339.3			0.0	0.0	161339.3	0.0	0.0	161339.3	161339.3	0.0
Manufacturing	19	*Coke and refined petroleum products*	*Tier 1*	25%	£0.00	£	*1.930*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	20.3	*Paints, varnishes and similar coatings, printing ink and mastics*	*Tier 1*	25%	£118,313.40	£	*1.331*	157,417.0			0.0	0.0	87770.2	0.0	0.0	87770.2	87770.2	0.0
Manufacturing	20.4	*Soap and detergents, cleaning and polishing preparations, perfumes and toilet preparations*	*Tier 1*	25%	£127,376.21	£	*0.719*	91,567.3			0.0	0.0	91592.1	0.0	0.0	91592.1	91592.1	0.0
Manufacturing	20.5	*Other chemical products*	*Tier 1*	25%	£631,717.68	£	*1.381*	872,436.2			0.0	0.0	255956.4	0.0	0.0	255956.4	255956.4	0.0
Manufacturing	20A	*Industrial gases, inorganics and fertilisers (all inorganic chemicals) - 20.11/13/15*	*Tier 1*	25%	£60,447.15	£	*1.357*	82,056.6			0.0	0.0	82056.6	0.0	0.0	82056.6	82056.6	0.0
Manufacturing	20B	*Petrochemicals - 20.14/16/17/60*	*Tier 1*	25%	£0.00	£	*0.820*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	20C	*Dyestuffs, agro-chemicals - 20.12/20*	*Tier 1*	25%	£0.00	£	*1.076*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	21	*Basic pharmaceutical products and pharmaceutical preparations*	*Tier 1*	25%	£19,601,770.56	£	*0.621*	12,172,605.1			0.0	0.0	8381799.0	0.0	0.0	8381799.0	8381799.0	0.0
Manufacturing	22	*Rubber and plastic products*	*Tier 1*	25%	£398,103.43	£	*0.576*	229,394.3			0.0	0.0	133386.3	0.0	0.0	133386.3	133386.3	0.0
Manufacturing	23.5-6	*Cement, lime, plaster and articles of concrete, cement and plaster*	*Tier 1*	25%	£0.00	£	*1.088*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	23OTHER	*Glass, refractory, clay, other porcelain and ceramic, stone and abrasive products - 23.1-4/7-9*	*Tier 1*	25%	£7,066.61	£	*1.203*	8,500.3			0.0	0.0	8500.3	0.0	0.0	8500.3	8500.3	0.0
Manufacturing	24.1-3	*Basic iron and steel*	*Tier 1*	25%	£0.00	£	*1.410*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	24.4-5	*Other basic metals and casting*	*Tier 1*	25%	£0.00	£	*0.997*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	25.4	*Weapons and ammunition*	*Tier 1*	25%	£0.00	£	*0.392*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	25OTHER	*Fabricated metal products, excl. machinery and equipment and weapons & ammunition - 25.1-3/25.5-9*	*Tier 1*	25%	£759,344.12	£	*0.459*	348,570.6			0.0	0.0	347634.2	0.0	0.0	347634.2	347634.2	0.0
Manufacturing	26	*Computer, electronic and optical products*	*Tier 1*	25%	£526,112.72	£	*0.382*	200,843.2			0.0	0.0	88054.0	0.0	0.0	88054.0	88054.0	0.0
Manufacturing	27	*Electrical equipment*	*Tier 1*	25%	£1,186,965.96	£	*0.495*	587,828.8			0.0	0.0	587828.8	0.0	0.0	587828.8	587828.8	0.0
Manufacturing	28	*Machinery and equipment n.e.c.*	*Tier 1*	25%	£1,320,800.34	£	*0.336*	443,282.6			0.0	0.0	422543.6	0.0	0.0	422543.6	422543.6	0.0
Manufacturing	29	*Motor vehicles, trailers and semi-trailers*	*Tier 1*	25%	£7,266.80	£	*0.359*	2,605.3			0.0	0.0	2606.4	0.0	0.0	2606.4	2606.4	0.0
Manufacturing	30.1	*Ships and boats*	*Tier 1*	25%	£0.00	£	*0.132*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	30.3	*Air and spacecraft and related machinery*	*Tier 1*	25%	£0.00	£	*0.359*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	30OTHER	*Other transport equipment - 30.2/4/9*	*Tier 1*	25%	£1,401.60	£	*0.190*	265.9			0.0	0.0	265.9	0.0	0.0	265.9	265.9	0.0
Manufacturing	31	*Furniture*	*Tier 1*	25%	£157,806.94	£	*0.376*	59,393.5			0.0	0.0	62402.6	0.0	0.0	62402.6	62402.6	0.0
Manufacturing	32	*Other manufactured goods*	*Tier 1*	25%	£14,476,112.32	£	*0.672*	9,733,484.5			0.0	0.0	5218478.7	0.0	0.0	5218478.7	5218478.7	0.0
Manufacturing	33.15	*Repair and maintenance of ships and boats*	*Tier 1*	25%	£0.00	£	*0.218*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	33.16	*Repair and maintenance of aircraft and spacecraft*	*Tier 1*	25%	£0.00	£	*0.429*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	33OTHER	*Rest of repair; Installation - 33.11-14/17/19/20*	*Tier 1*	25%	£1,489,855.55	£	*0.187*	278,556.5			0.0	0.0	236621.6	0.0	0.0	236621.6	236621.6	0.0
Electricity, gas, steam and air conditioning supply	35.1	*Electricity, transmission and distribution*	*Tier 1*	25%	£20,121.80	£	*1.882*	37,859.9			0.0	0.0	37859.9	0.0	0.0	37859.9	37859.9	0.0

Electricity, gas, steam and air conditioning supply	35.2-3	*Gas; distribution of gaseous fuels through mains; steam and air conditioning supply*	*Tier 1*	25%	£1,383.72	£	*1.543*	2,134.6			0.0	0.0	2134.6	0.0	0.0	2134.6	2134.6	0.0
Water supply; sewerage, waste management and remediation activities	36	*Natural water; water treatment and supply services*	*Tier 1*	25%	£19,597.99	£	*0.246*	4,812.2			0.0	0.0	4812.2	0.0	0.0	4812.2	4812.2	0.0
Water supply; sewerage, waste management and remediation activities	37	*Sewerage services; sewage sludge*	*Tier 1*	25%	£27,390.33	£	*0.361*	9,891.3			0.0	0.0	9891.3	0.0	0.0	9891.3	9891.3	0.0
Water supply; sewerage, waste management and remediation activities	38	*Waste collection, treatment and disposal services; materials recovery services*	*Tier 1*	25%	£0.00	£	*1.257*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Water supply; sewerage, waste management and remediation activities	39	*Remediation services and other waste management services*	*Tier 1*	25%	£51,025.70	£	*3.457*	176,418.9			0.0	0.0	176418.9	0.0	0.0	176418.9	176418.9	0.0
Construction	41.2	*Buildings and building construction works*	*Tier 1*	25%	£54,685,624.32	£	*0.305*	16,679,463.4			0.0	0.0	2784062.8	0.0	0.0	2784062.8	2784062.8	0.0
Construction	42.1-2	*Constructions and construction works for civil engineering*	*Tier 1*	25%	£406,161.94	£	*0.388*	157,600.0			0.0	0.0	71729.1	0.0	0.0	71729.1	71729.1	0.0
Construction	42.99	*Specialised construction works*	*Tier 1*	25%	£3,609,061.87	£	*0.310*	1,119,775.9			0.0	0.0	947398.2	0.0	0.0	947398.2	947398.2	0.0
Wholesale and retail trade; repair of motor vehicles and motorcycles	45	*Wholesale and retail trade and repair services of motor vehicles and motorcycles*	*Tier 1*	25%	£308,755.16	£	*0.210*	64,945.5			0.0	0.0	28250.9	0.0	0.0	28250.9	28250.9	0.0
Wholesale and retail trade; repair of motor vehicles and motorcycles	46	*Wholesale trade services, except of motor vehicles and motorcycles*	*Tier 1*	25%	£30,596,967.41	£	*0.020*	621,425.4			0.0	0.0	840402.5	0.0	0.0	840402.5	840402.5	0.0
Wholesale and retail trade; repair of motor vehicles and motorcycles	47	*Retail trade services, except of motor vehicles and motorcycles*	*Tier 1*	25%	£111,182,972.22	£	*0.174*	19,350,603.9			0.0	0.0	18517981.1	0.0	0.0	########	########	0.0
Transportation and storage	49.1-2	*Rail transport services*	*Tier 1*	25%	£10,786.80	£	*0.746*	8,047.4			0.0	0.0	8047.4	0.0	0.0	8047.4	8047.4	0.0
Transportation and storage	49.3-5	*Land transport services and transport services via pipelines, excluding rail transport*	*Tier 1*	25%	£2,337,220.99	£	*0.603*	1,409,711.3			0.0	0.0	1139435.3	0.0	0.0	1139435.3	1139435.3	0.0
Transportation and storage	50	*Water transport services*	*Tier 1*	25%	£0.00	£	*2.355*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Transportation and storage	51	*Air transport services*	*Tier 1*	25%	£5,233.82	£	*1.522*	7,966.7			0.0	0.0	1256.1	0.0	0.0	1256.1	1256.1	0.0
Transportation and storage	52	*Warehousing and support services for transportation*	*Tier 1*	25%	£44,371.71	£	*0.244*	10,816.4			0.0	0.0	10816.4	0.0	0.0	10816.4	10816.4	0.0
Transportation and storage	53	*Postal and courier services*	*Tier 1*	25%	£1,154,666.19	£	*0.249*	287,950.4			0.0	0.0	516026.3	0.0	0.0	516026.3	516026.3	0.0
Accommodation and food service activities	55	*Accommodation services*	*Tier 1*	25%	£131,918.60	£	*0.324*	42,800.5			0.0	0.0	40078.9	0.0	0.0	40078.9	40078.9	0.0
Accommodation and food service activities	56	*Food and beverage serving services*	*Tier 1*	25%	£948,089.36	£	*0.289*	273,866.7			0.0	0.0	273731.1	0.0	0.0	273731.1	273731.1	0.0
Information and communication	58	*Publishing services*	*Tier 1*	25%	£360,352.11	£	*0.080*	28,907.3			0.0	0.0	24160.9	0.0	0.0	24160.9	24160.9	0.0
Information and communication	59	*Motion picture, video and TV programme production services, sound recording & music publishing*	*Tier 1*	25%	£43,682.40	£	*0.110*	4,811.1			0.0	0.0	4811.1	0.0	0.0	4811.1	4811.1	0.0
Information and communication	60	*Programming and broadcasting services*	*Tier 1*	25%	£0.00	£	*0.119*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Information and communication	61	*Telecommunications services*	*Tier 1*	25%	£984,721.85	£	*0.105*	103,599.7			0.0	0.0	102889.7	0.0	0.0	102889.7	102889.7	0.0
Information and communication	62	*Computer programming, consultancy and related services*	*Tier 1*	25%	£10,761,681.49	£	*0.131*	1,414,586.4			0.0	0.0	493866.3	0.0	0.0	493866.3	493866.3	0.0
Information and communication	63	*Information services*	*Tier 1*	25%	£1,107,405.81	£	*0.169*	187,530.0			0.0	0.0	169659.5	0.0	0.0	169659.5	169659.5	0.0
Financial and insurance activities	64	*Financial services, except insurance and pension funding*	*Tier 1*	25%	£7,110,316.05	£	*0.110*	784,321.9			0.0	0.0	222755.5	0.0	0.0	222755.5	222755.5	0.0
Financial and insurance activities	65.1-2	*Insurance and reinsurance services, except compulsory social security*	*Tier 1*	25%	£111,555.43	£	*0.076*	8,441.5			0.0	0.0	8441.5	0.0	0.0	8441.5	8441.5	0.0
Financial and insurance activities	66	*Services auxiliary to financial services and insurance services*	*Tier 1*	25%	£142,097.66	£	*0.100*	14,274.5			0.0	0.0	14274.5	0.0	0.0	14274.5	14274.5	0.0
Real estate activities	68.12	*Real estate services, excluding on a fee or contract basis and imputed rent*	*Tier 1*	25%	£385,511.71	£	*0.111*	42,927.3			0.0	0.0	42927.3	0.0	0.0	42927.3	42927.3	0.0
Real estate activities	68.2IMP	*Owner-Occupiers' Housing Services*	*Tier 1*	25%	£5,324,914.93	£	*0.040*	210,980.4			0.0	0.0	210980.4	0.0	0.0	210980.4	210980.4	0.0
Real estate activities	68.3	*Real estate services on a fee or contract basis*	*Tier 1*	25%	£360,773.72	£	*0.085*	30,634.9			0.0	0.0	30634.9	0.0	0.0	30634.9	30634.9	0.0
Professional, scientific and technical activities	69.1	*Legal services*	*Tier 1*	25%	£337,622.76	£	*0.058*	19,540.8			0.0	0.0	10646.7	0.0	0.0	10646.7	10646.7	0.0
Professional, scientific and technical activities	69.2	*Accounting, bookkeeping and auditing services; tax consulting services*	*Tier 1*	25%	£152,920.41	£	*0.128*	19,611.6			0.0	0.0	19611.6	0.0	0.0	19611.6	19611.6	0.0
Professional, scientific and technical activities	70	*Services of head offices; management consulting services*	*Tier 1*	25%	£6,327,038.30	£	*0.094*	592,724.4			0.0	0.0	573430.0	0.0	0.0	573430.0	573430.0	0.0
Professional, scientific and technical activities	71	*Architectural and engineering services; technical testing and analysis services*	*Tier 1*	25%	£775,217.57	£	*0.156*	120,978.5			0.0	0.0	98311.4	0.0	0.0	98311.4	98311.4	0.0
Professional, scientific and technical activities	72	*Scientific research and development services*	*Tier 1*	25%	£1,791,707.87	£	*0.186*	332,590.5			0.0	0.0	280384.2	0.0	0.0	280384.2	280384.2	0.0
Professional, scientific and technical activities	73	*Advertising and market research services*	*Tier 1*	25%	£184,642.66	£	*0.110*	20,346.2			0.0	0.0	20346.2	0.0	0.0	20346.2	20346.2	0.0
Professional, scientific and technical activities	74	*Other professional, scientific and technical services*	*Tier 1*	25%	£8,872,094.18	£	*0.191*	1,698,348.4			0.0	0.0	1422625.7	0.0	0.0	1422625.7	1422625.7	0.0
Professional, scientific and technical activities	75	*Veterinary services*	*Tier 1*	25%	£0.00	£	*0.087*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Administrative and support service activities	77	*Rental and leasing services*	*Tier 1*	25%	£777,860.47	£	*0.135*	104,838.4			0.0	0.0	99534.8	0.0	0.0	99534.8	99534.8	0.0
Administrative and support service activities	78	*Employment services*	*Tier 1*	25%	£33,939,740.82	£	*0.118*	3,992,271.3			0.0	0.0	1933765.4	0.0	0.0	1933765.4	1933765.4	0.0
Administrative and support service activities	79	*Travel agency, tour operator and other reservation services and related services*	*Tier 1*	25%	£59,054.40	£	*0.140*	8,295.0			0.0	0.0	8295.0	0.0	0.0	8295.0	8295.0	0.0
Administrative and support service activities	80	*Security and investigation services*	*Tier 1*	25%	£87,717.57	£	*0.095*	8,369.0			0.0	0.0	8369.0	0.0	0.0	8369.0	8369.0	0.0
Administrative and support service activities	81	*Services to buildings and landscape*	*Tier 1*	25%	£824,633.51	£	*0.171*	141,232.1			0.0	0.0	101187.0	0.0	0.0	101187.0	101187.0	0.0
Administrative and support service activities	82	*Office administrative, office support and other business support services*	*Tier 1*	25%	£6,798,793.99	£	*0.118*	802,600.6			0.0	0.0	730163.0	0.0	0.0	730163.0	730163.0	0.0
Public administration and defence; compulsory social security	84	*Public administration and defence services; compulsory social security services*	*Tier 1*	25%	£50,944,345.71	£	*0.170*	8,677,886.7			0.0	0.0	8677885.4	0.0	0.0	8677885.4	8677885.4	0.0
Education	85	*Education services*	*Tier 1*	25%	£2,709,753.90	£	*0.103*	277,965.7			0.0	0.0	271457.2	0.0	0.0	271457.2	271457.2	0.0
Human health and social work activities	86	*Human health services*	*Tier 1*	25%	£168,310,394.37	£	*0.292*	49,135,137.2			0.0	0.0	46071560.5	0.0	0.0	########	########	0.0
Human health and social work activities	87	*Residential care services*	*Tier 1*	25%	£22,458,396.61	£	*0.165*	3,708,877.8			0.0	0.0	3708803.1	0.0	0.0	3708803.1	3708803.1	0.0
Human health and social work activities	88	*Social work services without accommodation*	*Tier 1*	25%	£1,402,914.49	£	*0.129*	181,342.0			0.0	0.0	181342.0	0.0	0.0	181342.0	181342.0	0.0
Arts, entertainment and recreation	90	*Creative, arts and entertainment services*	*Tier 1*	25%	£25,215.66	£	*0.202*	5,090.6			0.0	0.0	5090.6	0.0	0.0	5090.6	5090.6	0.0
Arts, entertainment and recreation	91	*Libraries, archives, museums and other cultural services*	*Tier 1*	25%	£25,958.38	£	*0.164*	4,252.1			0.0	0.0	4252.1	0.0	0.0	4252.1	4252.1	0.0
Arts, entertainment and recreation	92	*Gambling and betting services*	*Tier 1*	25%	£0.00	£	*0.095*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Arts, entertainment and recreation	93	*Sports services and amusement and recreation services*	*Tier 1*	25%	£465,406.48	£	*0.223*	103,694.2			0.0	0.0	103694.2	0.0	0.0	103694.2	103694.2	0.0
Other service activities	94	*Services furnished by membership organisations*	*Tier 1*	25%	£926,274.83	£	*0.121*	112,112.5			0.0	0.0	112091.1	0.0	0.0	112091.1	112091.1	0.0

Other service activities	95	*Repair services of computers and personal and household goods*	*Tier 1*	25%	£6,799.99	£	*0.110*	744.9			0.0	0.0	744.9	0.0	0.0	744.9	744.9	0.0
Other service activities	96	*Other personal services*	*Tier 1*	25%	£7,586,464.74	£	*0.077*	581,978.9			0.0	0.0	549202.1	0.0	0.0	549202.1	549202.1	0.0
Activities of households as employers; undifferentiated goods- and services-producing activities of households for own use	97	*Services of households as employers of domestic personnel*	*Tier 1*	25%	£0.00	£	*0.009*	-			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

If you wish to use a higher tier method for part of your supply chain emissions, you can record the emissions in the table below together with the equivalent spend associated with those emissions. Include brief notes about your method for calculating the emissions, or a reference to further information.
DO NOT subtract this spend from the data reported in the Tier 1 table (i.e any emissions reported in the table **below** should also be included in the total spend for that category in the table **above**. Duplicated emissions will be reconciled when compiling the data. The 'Supply chain group' and 'SIC code' columns will automatically fill once a category has been selected in the 'Product category' column.

Supply chain - tier 2 methodology

No errors in this table

Supply chain group	SIC code (SIC 2007)	Product category	Methodology	RSD	Spend for which Tier 2 method accounts	Unit	Total EF (kgCO2e/unit)	Calculated emissions (kgCO2e) for this spend	Notes on data source and methods	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Agriculture, forestry and fishing	02	Products of forestry, logging and related services	Tier 2		411	£	£0.28	114.59			0.0	0.0	114.6	0.0	0.0	114.59	114.59	0.0
Manufacturing	10.1	Preserved meat and meat products	Tier 2		177,399	£	£0.77	136993.37			0.0	0.0	136993.4	0.0	0.0	136993.37	136993.37	0.0
Manufacturing	10.5	Dairy products	Tier 2		233,413	£	£0.96	224592.95			0.0	0.0	224593.0	0.0	0.0	224592.95	224592.95	0.0
Manufacturing	10.7	Bakery and farinaceous products	Tier 2		18,823	£	£0.76	14216.36			0.0	0.0	14216.4	0.0	0.0	14216.36	14216.36	0.0
Manufacturing	10.8	Other food products	Tier 2		14,245	£	£0.66	9410.46			0.0	0.0	9410.5	0.0	0.0	9410.46	9410.46	0.0
Manufacturing	11	Soft drinks	Tier 2		1,797	£	£0.33	596.67			0.0	0.0	596.7	0.0	0.0	596.67	596.67	0.0
Manufacturing	13	Textiles	Tier 2		44,148	£	£0.43	18997.32			0.0	0.0	18997.3	0.0	0.0	18997.32	18997.32	0.0
Manufacturing	14	Wearing apparel	Tier 2		88,167	£	£0.73	64499.53			0.0	0.0	64499.5	0.0	0.0	64499.53	64499.53	0.0
Manufacturing	15	Leather and related products	Tier 2		472,594	£	£0.66	312665.70			0.0	0.0	312665.7	0.0	0.0	312665.70	312665.70	0.0
Manufacturing	16	Wood and of products of wood and cork, except furniture; articles of straw and plaiting materials	Tier 2		24,224	£	£0.47	11497.95			0.0	0.0	11498.0	0.0	0.0	11497.95	11497.95	0.0
Manufacturing	17	Paper and paper products	Tier 2		380,411	£	£0.59	224459.09			0.0	0.0	224459.1	0.0	0.0	224459.09	224459.09	0.0
Manufacturing	18	Printing and recording services	Tier 2		422,648	£	£0.38	161339.26			0.0	0.0	161339.3	0.0	0.0	161339.26	161339.26	0.0
Manufacturing	20	Paints, varnishes and similar coatings, printing ink and mastics	Tier 2		118,313	£	£0.74	87770.23			0.0	0.0	87770.2	0.0	0.0	87770.23	87770.23	0.0
Manufacturing	20	Soap and detergents, cleaning and polishing preparations, perfumes and toilet preparations	Tier 2		127,376	£	£0.72	91592.13			0.0	0.0	91592.1	0.0	0.0	91592.13	91592.13	0.0
Manufacturing	21	Other chemical products	Tier 2		631,718	£	£0.41	255956.36			0.0	0.0	255956.4	0.0	0.0	255956.36	255956.36	0.0
Manufacturing	21	Basic pharmaceutical products and pharmaceutical preparations	Tier 2		19,601,771	£	£0.43	8381799.02			0.0	0.0	8381799.0	0.0	0.0	########	########	0.0
Manufacturing	22	Rubber and plastic products	Tier 2		398,103	£	£0.34	133386.27			0.0	0.0	133386.3	0.0	0.0	133386.27	133386.27	0.0
Manufacturing	26	Computer, electronic and optical products	Tier 2		526,113	£	£0.17	88054.04			0.0	0.0	88054.0	0.0	0.0	88054.04	88054.04	0.0
Manufacturing	27	Electrical equipment	Tier 2		1,186,966	£	£0.50	587828.75			0.0	0.0	587828.8	0.0	0.0	587828.75	587828.75	0.0
Manufacturing	28	Machinery and equipment n.e.c.	Tier 2		1,320,800	£	£0.32	422543.59			0.0	0.0	422543.6	0.0	0.0	422543.59	422543.59	0.0
Manufacturing	29	Motor vehicles, trailers and semi-trailers	Tier 2		7,267	£	£0.36	2606.38			0.0	0.0	2606.4	0.0	0.0	2606.38	2606.38	0.0
Manufacturing	31	Furniture	Tier 2		157,807	£	£0.40	62402.56			0.0	0.0	62402.6	0.0	0.0	62402.56	62402.56	0.0
Manufacturing	32	Other manufactured goods	Tier 2		14,476,112	£	£0.36	5218478.71			0.0	0.0	5218478.7	0.0	0.0	########	########	0.0
Electricity, gas, steam and air conditio	35	Electricity, transmission and distribution	Tier 2		20,122	£	£1.88	37859.91			0.0	0.0	37859.9	0.0	0.0	37859.91	37859.91	0.0
Water supply; sewerage, waste manag	36	Natural water; water treatment and supply services	Tier 2		19,598	£	£0.25	4812.16			0.0	0.0	4812.2	0.0	0.0	4812.16	4812.16	0.0
Water supply; sewerage, waste manag	37	Sewerage services; sewage sludge	Tier 2		27,390	£	£0.36	9891.33			0.0	0.0	9891.3	0.0	0.0	9891.33	9891.33	0.0
Water supply; sewerage, waste manag	39	Remediation services and other waste management services	Tier 2		51,026	£	£3.46	176418.86			0.0	0.0	176418.9	0.0	0.0	176418.86	176418.86	0.0
Construction	41	Buildings and building construction works	Tier 2		54,685,624	£	£0.05	2784062.82			0.0	0.0	2784062.8	0.0	0.0	########	########	0.0
Construction	43	Specialised construction works	Tier 2		3,609,062	£	£0.26	947398.21			0.0	0.0	947398.2	0.0	0.0	947398.21	947398.21	0.0
Wholesale and retail trade; repair of m	45	Wholesale and retail trade and repair services of motor vehicles and motorcycles	Tier 2		308,755	£	£0.09	28250.92			0.0	0.0	28250.9	0.0	0.0	28250.92	28250.92	0.0
Wholesale and retail trade; repair of m	46	Wholesale trade services, except of motor vehicles and motorcycles	Tier 2		30,596,967	£	£0.03	840402.51			0.0	0.0	840402.5	0.0	0.0	840402.51	840402.51	0.0
Wholesale and retail trade; repair of m	47	Retail trade services, except of motor vehicles and motorcycles	Tier 2		111,182,972	£	£0.17	18517981.14			0.0	0.0	18517981.1	0.0	0.0	########	########	0.0
Transportation and storage	51	Air transport services	Tier 2		5,234	£	£0.24	1256.12			0.0	0.0	1256.1	0.0	0.0	1256.12	1256.12	0.0
Transportation and storage	52	Warehousing and support services for transportation	Tier 2		44,372	£	£0.24	10816.40			0.0	0.0	10816.4	0.0	0.0	10816.40	10816.40	0.0
Transportation and storage	53	Postal and courier services	Tier 2		1,154,666	£	£0.45	516026.26			0.0	0.0	516026.3	0.0	0.0	516026.26	516026.26	0.0
Accommodation and food service activ	55	Accommodation services	Tier 2		131,919	£	£0.30	40078.93			0.0	0.0	40078.9	0.0	0.0	40078.93	40078.93	0.0
Accommodation and food service activ	56	Food and beverage serving services	Tier 2		948,089	£	£0.29	273731.07			0.0	0.0	273731.1	0.0	0.0	273731.07	273731.07	0.0
Information and communication	58	Publishing services	Tier 2		360,352	£	£0.07	24160.87			0.0	0.0	24160.9	0.0	0.0	24160.87	24160.87	0.0
Information and communication	59	Motion picture, video and TV programme production services, sound recording & music publishing	Tier 2		43,682	£	£0.11	4811.13			0.0	0.0	4811.1	0.0	0.0	4811.13	4811.13	0.0
Information and communication	61	Telecommunications services	Tier 2		984,722	£	£0.10	102889.71			0.0	0.0	102889.7	0.0	0.0	102889.71	102889.71	0.0
Information and communication	62	Computer programming, consultancy and related services	Tier 2		10,761,681	£	£0.05	493866.25			0.0	0.0	493866.3	0.0	0.0	493866.25	493866.25	0.0
Information and communication	63	Information services	Tier 2		1,107,406	£	£0.15	169659.50			0.0	0.0	169659.5	0.0	0.0	169659.50	169659.50	0.0
Financial and insurance activities	64	Financial services, except insurance and pension funding	Tier 2		7,110,316	£	£0.03	222755.50			0.0	0.0	222755.5	0.0	0.0	222755.50	222755.50	0.0
Financial and insurance activities	66	Services auxiliary to financial services and insurance services	Tier 2		142,098	£	£0.10	14274.46			0.0	0.0	14274.5	0.0	0.0	14274.46	14274.46	0.0
Real estate activities	68	Real estate services, excluding on a fee or contract basis and imputed rent	Tier 2		385,512	£	£0.11	42927.34			0.0	0.0	42927.3	0.0	0.0	42927.34	42927.34	0.0
Real estate activities	68	Real estate services on a fee or contract basis	Tier 2		360,774	£	£0.08	30634.86			0.0	0.0	30634.9	0.0	0.0	30634.86	30634.86	0.0
Professional, scientific and technical ac	69	Legal services	Tier 2		337,623	£	£0.03	10646.70			0.0	0.0	10646.7	0.0	0.0	10646.70	10646.70	0.0
Professional, scientific and technical ac	69	Accounting, bookkeeping and auditing services; tax consulting services	Tier 2		152,920	£	£0.13	19611.60			0.0	0.0	19611.6	0.0	0.0	19611.60	19611.60	0.0
Professional, scientific and technical ac	70	Services of head offices; management consulting services	Tier 2		6,327,038	£	£0.09	573430.02			0.0	0.0	573430.0	0.0	0.0	573430.02	573430.02	0.0
Professional, scientific and technical ac	71	Architectural and engineering services; technical testing and analysis services	Tier 2		775,218	£	£0.13	98311.40			0.0	0.0	98311.4	0.0	0.0	98311.40	98311.40	0.0
Professional, scientific and technical ac	72	Scientific research and development services	Tier 2		1,791,708	£	£0.16	280384.23			0.0	0.0	280384.2	0.0	0.0	280384.23	280384.23	0.0
Professional, scientific and technical ac	73	Advertising and market research services	Tier 2		184,643	£	£0.11	20346.22			0.0	0.0	20346.2	0.0	0.0	20346.22	20346.22	0.0
Professional, scientific and technical ac	74	Other professional, scientific and technical services	Tier 2		8,872,094	£	£0.16	1422625.66			0.0	0.0	1422625.7	0.0	0.0	########	########	0.0
Administrative and support service act	77	Rental and leasing services	Tier 2		777,860	£	£0.13	99534.80			0.0	0.0	99534.8	0.0	0.0	99534.80	99534.80	0.0
Administrative and support service act	78	Employment services	Tier 2		33,939,741	£	£0.06	1933765.43			0.0	0.0	1933765.4	0.0	0.0	########	########	0.0
Administrative and support service act	79	Travel agency, tour operator and other reservation services and related services	Tier 2		59,054	£	£0.14	8295.02			0.0	0.0	8295.0	0.0	0.0	8295.02	8295.02	0.0

Administrative and support service act	80	Security and investigation services	Tier 2		87,718	£	£0.10	8368.98			0.0	0.0	8369.0	0.0	0.0	8368.98	8368.98	0.0
Administrative and support service act	81	Services to buildings and landscape	Tier 2		824,634	£	£0.12	101186.95			0.0	0.0	101187.0	0.0	0.0	101186.95	101186.95	0.0
Administrative and support service act	82	Office administrative, office support and other business support services	Tier 2		6,798,794	£	£0.11	730162.97			0.0	0.0	730163.0	0.0	0.0	730162.97	730162.97	0.0
Public administration and defence; cor	84	Public administration and defence services; compulsory social security services	Tier 2		50,944,346	£	£0.17	8677885.39			0.0	0.0	8677885.4	0.0	0.0	########	########	0.0
Education	85	Education services	Tier 2		2,709,754	£	£0.10	271457.21			0.0	0.0	271457.2	0.0	0.0	271457.21	271457.21	0.0
Human health and social work activitie	86	Human health services	Tier 2		168,310,394	£	£0.27	46071560.51			0.0	0.0	46071560.5	0.0	0.0	########	########	0.0
Human health and social work activitie	87	Residential care services	Tier 2		22,458,397	£	£0.17	3708803.06			0.0	0.0	3708803.1	0.0	0.0	########	########	0.0
Human health and social work activitie	88	Social work services without accommodation	Tier 2		1,402,914	£	£0.13	181342.03			0.0	0.0	181342.0	0.0	0.0	181342.03	181342.03	0.0
Arts, entertainment and recreation	90	Creative, arts and entertainment services	Tier 2		25,216	£	£0.20	5090.63			0.0	0.0	5090.6	0.0	0.0	5090.63	5090.63	0.0
Arts, entertainment and recreation	91	Libraries, archives, museums and other cultural services	Tier 2		25,958	£	£0.16	4252.11			0.0	0.0	4252.1	0.0	0.0	4252.11	4252.11	0.0
Arts, entertainment and recreation	93	Sports services and amusement and recreation services	Tier 2		465,406	£	£0.22	103694.24			0.0	0.0	103694.2	0.0	0.0	103694.24	103694.24	0.0
Other service activities	94	Services furnished by membership organisations	Tier 2		926,275	£	£0.12	112091.14			0.0	0.0	112091.1	0.0	0.0	112091.14	112091.14	0.0
Other service activities	95	Repair services of computers and personal and household goods	Tier 2		6,800	£	£0.11	744.86			0.0	0.0	744.9	0.0	0.0	744.86	744.86	0.0
Other service activities	96	Other personal services	Tier 2		7,586,465	£	£0.07	549202.08			0.0	0.0	549202.1	0.0	0.0	549202.08	549202.08	0.0
Manufacturing	20A	Industrial gases, inorganics and fertilisers (all inorganic chemicals) - 20.11/13/15	Tier 2		60,447	£	£1.36	82056.55			0.0	0.0	82056.6	0.0	0.0	82056.55	82056.55	0.0
Manufacturing	23OTHER	Glass, refractory, clay, other porcelain and ceramic, stone and abrasive products - 23.1-4/7-9	Tier 2		7,067	£	£1.20	8500.26			0.0	0.0	8500.3	0.0	0.0	8500.26	8500.26	0.0
Manufacturing	25OTHER	Fabricated metal products, excl. machinery and equipment and weapons & ammunition - 25.1-3/25.5-9	Tier 2		759,344	£	£0.46	347634.17			0.0	0.0	347634.2	0.0	0.0	347634.17	347634.17	0.0
Manufacturing	30OTHER	Other transport equipment - 30.2/4/9	Tier 2		1,402	£	£0.19	265.87			0.0	0.0	265.9	0.0	0.0	265.87	265.87	0.0
Manufacturing	33OTHER	Rest of repair; Installation - 33.11-14/17/19/20	Tier 2		1,489,856	£	£0.16	236621.59			0.0	0.0	236621.6	0.0	0.0	236621.59	236621.59	0.0
Electricity, gas, steam and air conditior	35.2-3	Gas; distribution of gaseous fuels through mains; steam and air conditioning supply	Tier 2		1,384	£	£1.54	2134.55			0.0	0.0	2134.6	0.0	0.0	2134.55	2134.55	0.0
Construction	42.1-2	Constructions and construction works for civil engineering	Tier 2		406,162	£	£0.18	71729.10			0.0	0.0	71729.1	0.0	0.0	71729.10	71729.10	0.0
Transportation and storage	49.1-2	Rail transport services	Tier 2		10,787	£	£0.75	8047.42			0.0	0.0	8047.4	0.0	0.0	8047.42	8047.42	0.0
Transportation and storage	49.3-5	Land transport services and transport services via pipelines, excluding rail transport	Tier 2		2,337,221	£	£0.49	1139435.27			0.0	0.0	1139435.3	0.0	0.0	########	########	0.0
Financial and insurance activities	65.1-2	Insurance and reinsurance services, except compulsory social security	Tier 2		111,555	£	£0.08	8441.54			0.0	0.0	8441.5	0.0	0.0	8441.54	8441.54	0.0
Real estate activities	68.2IMP	Owner-Occupiers' Housing Services	Tier 2		5,324,915	£	£0.04	210980.41			0.0	0.0	210980.4	0.0	0.0	210980.41	210980.41	0.0
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Cell colour codes: Information cell or question | Activity data. Numeric data entry
Information entry. Some cells have drop down lists | Calculated data

Organisational, municipal and project waste

Guidance for users

This tab has three tables for entering waste data - every effort has been made to include relevant waste types. If the waste type is not available, choose the closest match and write in the notes what waste type it is.
The first table is for organisational waste - this is waste produced by your organisation in day to day operations. You can choose from a range of waste types and disposal routes (some disposal routes are not applicable for certain waste types and therefore these option combinations are not available in the drop down lists).
The second table is for municipal waste collections and is only relevant to Local Authorities who provide this service. There is a question at the start of this table about operation of waste vehicles and recording of fuel used. This question has to be answered. Your answer will determine whether the emission factors applied in this table include the waste transport emissions (they may be already included elsewhere).
The third table is for construction project waste, where this is collected separately. You do not need to complete this table if it is not relevant to your organisation.
Please note: if your organisation has reported organisational waste based on tonnage, you should remove expenditure on waste collection services in your supply chain data to avoid double-counting.
Please see Section 9 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

Instructions for users

- Input information into the orange and blue cells. Grey cells should not be edited.
- Activity data entered in the 'data' column should only be in units specified in the 'units' column drop down list. If your data is in units that are not included in this drop down list, you will need to convert it before entering it into this sheet (see conversion sheet)
- When completing a row, fill in the columns from left to right. The drop down lists in later columns will change to provide valid combinations based on your previous selections.
- You can copy and paste between rows but please avoid copying data from one column to another, as this is likely to break the drop down lists.
- Fill in the notes column with a description of the method and data source used
- Please note that 'Outside of scopes' emissions are not included in the 'Total emissions'

Organisational waste

No errors in this table

Emission data breakdown (kg CO2e)

Waste type	Disposal	Blank	Methodology used	RSD	Data	Units	Converted data	Standard units	Total EF (kgCO2e/unit)	Total emissions	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Anatomical waste	High temperature incineration		Tier 3	5%	13	tonnes	13.00	tonnes	1074.00	13,962.00	ANATOMICAL	Data complete l	-	-	13,962.00	-	-	14,660.10	13,263.90	-
Medicinal waste	High temperature incineration		Tier 3	5%	11	tonnes	11.00	tonnes	1074.00	11,814.00	MEDICINAL	Data complete l	-	-	11,814.00	-	-	12,404.70	11,223.30	-
Medical contaminated sharps waste	High temperature incineration		Tier 3	5%	137	tonnes	137.00	tonnes	1074.00	147,138.00	MEDICINAL SHARPS	Data complete l	-	-	147,138.00	-	-	154,494.90	139,781.10	-
Non infectious offensive waste	Combustion		Tier 3	5%	362	tonnes	362.00	tonnes	82.00	29,684.00	TIGER WASTE	Data complete l	-	-	29,684.00	-	-	31,168.20	28,199.80	-
Infectious waste	Autoclave treatment and combustion		Tier 3	5%	921	tonnes	921.00	tonnes	402.00	370,242.00	ORANGE BAG	Data complete l	-	-	370,242.00	-	-	388,754.10	351,729.90	-
Clinical waste	High temperature incineration		Tier 3	5%	11	tonnes	11.00	tonnes	1074.00	11,814.00	SHARPS	Data complete l	-	-	11,814.00	-	-	12,404.70	11,223.30	-
Organic food and drink	Anaerobic digestion		Tier 3	5%	313	tonnes	313.00	tonnes	8.91	2,789.59	FOOD WASTE	Data complete l	-	-	2,789.59	-	-	2,929.07	2,650.11	-
Mixed recycling	Recycling		Tier 3	5%	258	tonnes	258.00	tonnes	21.28	5,490.45	TINS/PLASTIC/CARD	Data complete l	-	-	5,490.45	-	-	5,764.97	5,215.93	-
Mixed paper	Recycling		Tier 3	5%	835	tonnes	835.00	tonnes	21.28	17,769.47	CONFIDENTAIL WASTE	Data complete l	-	-	17,769.47	-	-	18,657.95	16,881.00	-
Mixed recycling	Recycling		Tier 3	5%	71	tonnes	71.00	tonnes	21.28	1,510.94	CARDBOARD	Data complete l	-	-	1,510.94	-	-	1,586.48	1,435.39	-
Batteries	Recycling		Tier 3	5%	4	tonnes	4.00	tonnes	21.28	85.12	BATTERIES	Data complete l	-	-	85.12	-	-	89.38	80.87	-
Mixed WEEE	Recycling		Tier 3	5%	30	tonnes	30.00	tonnes	21.28	638.42	WEEE	Data complete l	-	-	638.42	-	-	670.35	606.50	-
Commercial and industrial waste	Landfill		Tier 3	5%	1,033	tonnes	1,033.00	tonnes	496.68	513,073.86	BLACKBAG - BULK WASTE (INCL pops)	Data complete l	-	-	513,073.86	-	-	538,727.55	487,420.16	-

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Project waste

No data entered

Emission data breakdown (kg CO2e)

Waste type	Disposal	Blank	Methodology used	RSD	Data	Units	Converted data	Standard units	Total EF (kgCO2e/unit)	Total emissions	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
										-										
										-										
										-										
										-										
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Tier 1 methodology for land-based emissions

No errors in this table

Current land use type	Soil type	Previous land use type (select the same type as current if >20 years under same use)	Methodology	RSD estimate (+/-%)	Land area in hectares (ha)	Unit	Converted data	Standard units	Emission factor (tCO_2/ha/year)	Total kg CO_2e	Source of data (e.g. estates team digital maps or estimates)	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
Forest land	Mineral	Forest land	Tier 1	25%	24	ha	24	ha	*-5.42*	- 132,361	Measurements from CAD	**Data complete and ea**	-	-	-	-	-	- 165,451	- 99,271	- 132,361
Grassland	Mineral	Grassland	Tier 1	25%	15	ha	15	ha	*-1.44*	- 21,466	Measurements from CAD	**Data complete and ea**	-	-	-	-	-	- 26,833	- 16,100	- 21,466
Settlements	Mineral	Settlements	Tier 1	25%	66	ha	66	ha	*2.10*	138,211	Measurements from CAD	**Data complete and ea**	-	-	-	-	-	172,764	103,658	138,211
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			
			Tier 1			ha	-	ha					-	-	-	-	-			

If you wish to use a higher tier method to report your land use emissions, record these in the table below.

Tier 2 methodology for land-based emissions

No data entered

Land use type	Soil type	Not used	Methodology used (IPCC equivalent Tier)	RSD estimate (+/-%)	Land area in hectares (ha)	Unit	Converted data	Standard units	Emission factor (tCO_2/ha/year)	Emission kg CO_2e	Notes on data sources	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-
						ha	-	ha					-	-	-	-	-			-

Agriculture

No data entered

Emission data breakdown (kg CO_2e)

Agriculture emission source	Category 1	Not used	Methodology	RSD	Data	Units	Converted data	Standard units	Total EF ($kgCO_2e$/unit)	Total emissions ($kgCO_2e$)	Notes	Ease of collection	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	High	Low	Outside of scopes

Cell colour codes: Information cell or question | Activity data. Numeric data entry | Information entry. Some cell | Calculated data

Renewables

Guidance for users

This sheet allows users to provide information about any renewable energy that an organisation generates or purchases. It has two tables, one for renewables generated onsite/offsite by your organisation, and one for any renewable electricity or heat that your organisation purchases.

If your organisation purchases renewable electricity (e.g. through a green tariff) which is reported in this sheet, the activity data should also be included in the 'Buildings' table in the 'Buildings, fleet &other assets' sheet. This is because the Welsh Public Sector has agreed to use a locational based approach to accounting; all the renewable electricity in the grid is already accounted for in the average grid factor. If individual organisations account for this green electricity as zero carbon and the grid average also includes it as a zero carbon component, the benefit is being double counted.

Please see Section 12 of the Welsh Net Zero Public Sector Reporting Guide for further guidance.

Instructions for users

- Input information into the orange and blue cells. Grey cells should not be edited.
- Activity data should only be in kWh unit. If your data is in other units, you will need to convert it before entering it into this sheet (see conversion sheet)
- When completing a row, fill in the columns from left to right. The drop down lists in later columns will change to provide valid combinations based on your previous selections.
- You can copy and paste between rows but please avoid copying data from one column to another, as this is likely to break the drop down lists.
- Fill in the notes column with a description of the method and data source used

Onsite and offsite renewables

Generating site name	Location	Renewable Type	Technology	Methodology used	Type of ownership	Age (years)	RSD	Total MWe capacity (at inverter)	Total kWh generated	kWh consumed by reporting organisation	kWh exported to grid	kWh exported to other PSB	Name of other Public Sector Body	Notes	Ease of collection
Dewi Sant Health Park	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	2	3%		59,413	59,413					
Glanrhyd Taith Newydd	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	9	3%		13,683	13,683					
Kier Hardie Undergraduate	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	9	3%		7,570	7,570					
Kier Hardie Health Park	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	2	3%		56,994	56,994					
New Surgery Pencoed	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	13	3%		3,372	3,372					
Porthcawl Primary Care Centre	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	5	3%		4,363	4,363					
POWH Ty Llidiard	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	9	3%		5,951	5,951					
RGH Y Bwthyn NGS Macmillan	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	5	3%		1,111	1,111					
Ty Calon Ian	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	3	3%		8,069	8,069					
Ysbyty Cwm Cynon	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	2	3%		141,254	141,254					
Ysbyty Cwm Rhondda	Onsite	Renewable electricity	Rooftop Solar PV	Tier 3	Private (Welsh)	2	3%		169,807	169,807					
Ysbyty Cwm Cynon	Onsite	Renewable heat	Biomass boiler	Tier 3	Private (Welsh)	12	5%		119,268	119,268					
Ysbyty Cwm Rhondda	Onsite	Renewable heat	Biomass boiler	Tier 3	Private (Welsh)	15	5%		673,231	673,231					

Purchased renewables

If you purchase renewable electricity that is supplied through the UK grid, you must also include this electricity in the buildings table.

Renewable Type	Agreement	Methodology used	RSD	Total kWh purchased	Not used	Not used2	Notes	Ease of collection

Buildings	Streetlighting	Fleet & equipment	Agriculture	Waste	Business travel	Commuting	Homeworking	Land use	Type	Category 1	Category 2	Standard units	Other typical unit	Converted data	Direct	Indirect generation	Indirect service	Indirect T&D	Indirect WTT	Outside of scopes	Total EF (kgCO2e/unit)
														Rounded to 3.d.p							
Y	N	N	N	N	N	N	N	N	Natural gas	All natural gas	Gross CV	kWh	m3	11.208	0.18293				0.03021		**0.213**
Y	N	Y	N	N	N	N	N	N	LPG	All LPG	Gross CV	kWh	litres	7.28	0.21450				0.02548		**0.240**
Y	N	N	N	N	N	N	N	N	Kerosene	All kerosene	Gross CV	kWh	litres	10.301	0.24677				0.05153		**0.298**
Y	N	Y	N	N	N	N	N	N	Gas oil	All gas oil	Gross CV	kWh	litres	10.598	0.25650				0.05913		**0.316**
Y	N	N	N	N	N	N	N	N	Bioenergy	Wood pellets	Gross CV	kWh	tonnes	5193	0.01074				0.03744	0.35000	**0.398**
Y	N	N	N	N	N	N	N	N	Bioenergy	Wood chips	Gross CV	kWh	tonnes	4087	0.01074				0.00792	0.35000	**0.369**
Y	N	N	N	N	N	N	N	N	Bioenergy	Biogas	Gross CV	kWh	tonnes	6105	0.00022				0.02841	0.19902	**0.228**
Y	N	N	N	N	N	N	N	N	Coal	Domestic	Gross CV	kWh	tonnes	8366	0.34721				0.05629		**0.404**
Y	Y	Y	N	N	Y	Y	N	N	Grid electricity	Consumption based		kWh				0.20707		0.01792	0.04987	0.11507	**0.390**
Y	N	N	N	N	N	N	N	N	Heat and steam	Onsite		kWh				0.17965			0.03341		**0.213**
Y	N	N	N	N	N	N	N	N	Heat and steam	District		kWh				0.17965		0.00945	0.035168		**0.224**
Y	N	N	N	N	N	N	N	N	Water	Mains supply		m3	litres	0.001			0.17668				**0.177**
Y	N	N	N	N	N	N	N	N	Water	Mains treatment		m3	litres	0.001			0.20132				**0.201**
Y	N	N	N	N	N	N	N	N	Water	Onsite supply		m3	litres	0.001			0				**0.000**
Y	N	N	N	N	N	N	N	N	Water	Onsite treatment		m3	litres	0.001			0				**0.000**
N	N	Y	N	N	N	N	N	N	Diesel	Average biofuel blend		kWh	litres	10.506	0.23908				0.05816	0.01	**0.307**
N	N	Y	N	N	N	N	N	N	Diesel	100% mineral diesel		kWh	litres	10.554	0.25193				0.05913		**0.311**
N	N	Y	N	N	N	N	N	N	Petrol	Average biofuel blend		kWh	litres	9.462	0.22166				0.0614	0.01	**0.293**
N	N	Y	N	N	N	N	N	N	Petrol	100% mineral petrol		kWh	litres	9.702	0.24171				0.06253		**0.304**
Y	N	Y	N	N	N	N	N	N	Biodiesel	HVO		kWh	litres	9.931	0.00358				0.028037458	0.24468835	**0.276**
N	N	Y	N	N	N	N	N	N	Biodiesel	ME		kWh	litres	9.568	0.01751				0.046779891	0.24979097	**0.314**
N	N	Y	N	N	N	N	N	N	Biopetrol	100% biopetrol		kWh	litres	9.206	0.00152				0.029745432	0.252553957	**0.284**
N	N	N	Y	N	N	N	N	N	Farmland soils	Improved grassland		hectares	km2	100	289.22						**289.220**
N	N	N	Y	N	N	N	N	N	Farmland soils	Arable land		hectares	km2	100	1186.2						**1186.200**
N	N	N	Y	N	N	N	N	N	Livestock	Dairy cattle		Head			4726.078723						**4726.079**
N	N	N	Y	N	N	N	N	N	Livestock	Non-dairy cattle		Head			1870.974378						**1870.974**
N	N	N	Y	N	N	N	N	N	Livestock	Pigs		Head			228.3410091						**228.341**
N	N	N	Y	N	N	N	N	N	Livestock	Poultry		Head			4.593303585						**4.593**
N	N	N	Y	N	N	N	N	N	Livestock	Horses		Head			785.853915						**785.854**
N	N	N	Y	N	N	N	N	N	Livestock	Sheep and goats		Head			139.1166578						**139.117**
N	N	Y	N	N	N	N	N	N	Van	Average	Diesel	Vehicle km	Vehicle miles	1.609	0.23128				0.05660		**0.288**
N	N	Y	N	N	N	N	N	N	Van	Average	Petrol	Vehicle km	Vehicle miles	1.609	0.20132				0.05594		**0.257**
N	N	Y	N	N	N	N	N	N	Van	Average	LPG	Vehicle km	Vehicle miles	1.609	0.25504				0.03028		**0.285**
N	N	Y	N	N	N	N	N	N	Van	Average	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609		0.06762		0.00586	0.01633		**0.090**
N	N	Y	N	N	N	N	N	N	Van	Average	Unknown	Vehicle km	Vehicle miles	1.609	0.23037				0.05658		**0.287**
N	N	Y	N	N	N	N	N	N	HGV	Average rigid	Diesel	Vehicle km	Vehicle miles	1.609	0.82313				0.20019		**1.023**
N	N	Y	N	N	N	N	N	N	HGV	Average articulated	Diesel	Vehicle km	Vehicle miles	1.609	0.90644				0.21916		**1.126**
N	N	Y	N	N	N	N	N	N	HGV	Average HGV	Diesel	Vehicle km	Vehicle miles	1.609	0.87205				0.21135		**1.083**
N	N	Y	N	N	N	N	N	N	Pool car	Average	Diesel	Vehicle km	Vehicle miles	1.609	0.16983				0.04145		**0.211**
N	N	Y	N	N	N	N	N	N	Pool car	Average	Petrol	Vehicle km	Vehicle miles	1.609	0.16391				0.04551		**0.209**
N	N	Y	N	N	N	N	N	N	Pool car	Average	Hybrid	Vehicle km	Vehicle miles	1.609	0.11898				0.03109		**0.150**
N	N	Y	N	N	N	N	N	N	Pool car	Average	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609	0.06588	0.02579		0.00223	0.02440		**0.118**
N	N	Y	N	N	N	N	N	N	Pool car	Average	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609		0.05043		0.00437	0.01215		**0.067**
N	N	Y	N	N	N	N	N	N	Pool car	Average	Unknown fuel	Vehicle km	Vehicle miles	1.609	0.16664				0.04366		**0.210**
N	N	N	N	N	Y	Y	N	N	Private car	Small	Diesel	Vehicle km	Vehicle miles	1.609			0.13931		0.03392		**0.173**
N	N	N	N	N	Y	Y	N	N	Private car	Medium	Diesel	Vehicle km	Vehicle miles	1.609			0.16716		0.04079		**0.208**
N	N	N	N	N	Y	Y	N	N	Private car	Large	Diesel	Vehicle km	Vehicle miles	1.609			0.20859		0.05100		**0.260**
N	N	N	N	N	Y	Y	N	N	Private car	Average	Diesel	Vehicle km	Vehicle miles	1.609			0.16983		0.04145		**0.211**
N	N	N	N	N	Y	Y	N	N	Private car	Small	Petrol	Vehicle km	Vehicle miles	1.609			0.14080		0.03907		**0.180**
N	N	N	N	N	Y	Y	N	N	Private car	Medium	Petrol	Vehicle km	Vehicle miles	1.609			0.17819		0.04949		**0.228**
N	N	N	N	N	Y	Y	N	N	Private car	Large	Petrol	Vehicle km	Vehicle miles	1.609			0.27224		0.07572		**0.348**
N	N	N	N	N	Y	Y	N	N	Private car	Average	Petrol	Vehicle km	Vehicle miles	1.609			0.16391		0.04551		**0.209**
N	N	N	N	N	Y	Y	N	N	Private car	Small	Hybrid	Vehicle km	Vehicle miles	1.609			0.10150		0.02703		**0.129**
N	N	N	N	N	Y	Y	N	N	Private car	Medium	Hybrid	Vehicle km	Vehicle miles	1.609			0.10904		0.02831		**0.137**
N	N	N	N	N	Y	Y	N	N	Private car	Large	Hybrid	Vehicle km	Vehicle miles	1.609			0.15244		0.03884		**0.191**
N	N	N	N	N	Y	Y	N	N	Private car	Average	Hybrid	Vehicle km	Vehicle miles	1.609			0.11898		0.03109		**0.150**
N	N	N	N	N	Y	Y	N	N	Private car	Small	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.05144	0.00258	0.01317		**0.067**
N	N	N	N	N	Y	Y	N	N	Private car	Medium	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.08313	0.00188	0.02220		**0.107**
N	N	N	N	N	Y	Y	N	N	Private car	Large	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.09916	0.00245	0.02635		**0.128**
N	N	N	N	N	Y	Y	N	N	Private car	Average	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.09168	0.00223	0.02440		**0.118**
N	N	N	N	N	Y	Y	N	N	Private car	Small	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.04440	0.00383	0.01070		**0.059**
N	N	N	N	N	Y	Y	N	N	Private car	Medium	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.04846	0.00420	0.01167		**0.064**
N	N	N	N	N	Y	Y	N	N	Private car	Large	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.05336	0.00462	0.01285		**0.071**
N	N	N	N	N	Y	Y	N	N	Private car	Average	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.05043	0.00437	0.01215		**0.067**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Unknown fuel	Vehicle km	Vehicle miles	1.609			0.14037		0.03749		**0.178**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Unknown fuel	Vehicle km	Vehicle miles	1.609			0.17246		0.04496		**0.217**
N	N	N	N	N	Y	Y	N	N	Hire car	Large	Unknown fuel	Vehicle km	Vehicle miles	1.609			0.22612		0.05780		**0.284**
N	N	N	N	N	Y	Y	N	N	Hire car	Average	Unknown fuel	Vehicle km	Vehicle miles	1.609			0.16664		0.04366		**0.210**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Diesel	Vehicle km	Vehicle miles	1.609			0.13931		0.03392		**0.173**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Diesel	Vehicle km	Vehicle miles	1.609			0.16716		0.04079		**0.208**
N	N	N	N	N	Y	Y	N	N	Hire car	Large	Diesel	Vehicle km	Vehicle miles	1.609			0.20859		0.05100		**0.260**
N	N	N	N	N	Y	Y	N	N	Hire car	Average	Diesel	Vehicle km	Vehicle miles	1.609			0.16983		0.04145		**0.211**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Petrol	Vehicle km	Vehicle miles	1.609			0.14080		0.03907		**0.180**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Petrol	Vehicle km	Vehicle miles	1.609			0.17819		0.04949		**0.228**
N	N	N	N	N	Y	Y	N	N	Hire car	Large	Petrol	Vehicle km	Vehicle miles	1.609			0.27224		0.07572		**0.348**
N	N	N	N	N	Y	Y	N	N	Hire car	Average	Petrol	Vehicle km	Vehicle miles	1.609			0.16391		0.04551		**0.209**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Hybrid	Vehicle km	Vehicle miles	1.609			0.10150		0.02703		**0.129**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Hybrid	Vehicle km	Vehicle miles	1.609			0.10904		0.02831		**0.137**
N	N	N	N	N	Y	Y	N	N	Hire car	Large	Hybrid	Vehicle km	Vehicle miles	1.609			0.15244		0.03884		**0.191**
N	N	N	N	N	Y	Y	N	N	Hire car	Average	Hybrid	Vehicle km	Vehicle miles	1.609			0.11898		0.03109		**0.150**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.05144	0.00258	0.01317		**0.067**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.08313	0.00188	0.02220		**0.107**
N	N	N	N	N	Y	Y	N	N	Hire car	Large	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.09916	0.00245	0.02635		**0.128**
N	N	N	N	N	Y	Y	N	N	Hire car	Average	Plug-in Hybrid Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.09168	0.00223	0.02440		**0.118**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.04440	0.00383	0.01070		**0.059**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.04846	0.00420	0.01167		**0.064**
N	N	N	N	N	Y	Y	N	N	Hire car	Large	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.05336	0.00462	0.01285		**0.071**
N	N	N	N	N	Y	Y	N	N	Hire car	Average	Battery Electric Vehicle	Vehicle km	Vehicle miles	1.609			0.05043	0.00437	0.01215		**0.067**
N	N	N	N	N	Y	Y	N	N	Hire car	Small	Unknown fuel	Vehicle km	Vehicle miles	1.609			0.14037		0.03749		**0.178**
N	N	N	N	N	Y	Y	N	N	Hire car	Medium	Unknown fuel	Vehicle km	Vehicle miles	1.609			0.17246		0.04496		**0.217**

Source: UK Government GHG Conversion Factors for Company Reporting 2023

Fuels	Refrigerant & other	Bioenergy	UK electricity	Heat and steam	WTT - fuels	WTT - bioenergy	Transmission and distribution	WTT - UK & overseas elec	WTT- heat and steam	Water supply	Water treatment	Waste disposal	Business travel- air	WTT- business travel- air	Business travel- sea	WTT- business travel- sea	Business travel- land	WTT- passenger vehicles & travel land	UK electricity for EVs	UK electricity T&D for EVs	Freighting goods	WTT - delivery vehs & freighting	Homeworking	Outside of scopes
Y					Y																			
Y					Y																			
Y					Y																			
Y					Y																			
		Y				Y																		Y
		Y				Y																		Y
		Y				Y																		Y
Y					Y																			
			Y				Y	Y																
Y						Y																		
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Y					Y																			
		Y				Y																		Y
		Y				Y																		Y

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Land use emission factors (kgCO2e/ha)

			Previous landuse	Previous landuse	Previous landuse	Previous landuse	Previous landuse	Previous landuse
	Current land use	Soil type	Forest land	Cropland	Grassland	Wetlands	Settlements	Other land
Y	Forest land	Mineral	-5.42	-0.95	-0.62	*No emission factor available*	-0.65	*No emission factor available*
Y	Forest land	Organic	-7.27	0.32	0.82	*No emission factor available*	0.71	*No emission factor available*
Y	Cropland	Mineral	11.04	1.08	4.52	*No emission factor available*	-3.85	*No emission factor available*
Y	Cropland	Organic	*No emission factor available*	18.34	-0.25	*No emission factor available*	-0.27	*No emission factor available*
Y	Grassland	Mineral	11.91	-1.89	-1.44	*No emission factor available*	-6.72	*No emission factor available*
Y	Grassland	Organic	6.96	0.28	0.02	*No emission factor available*	-0.15	*No emission factor available*
Y	Wetlands	Mineral	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*
Y	Wetlands	Organic	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*
Y	Settlements	Mineral	39.40	7.48	13.50	*No emission factor available*	2.10	*No emission factor available*
Y	Settlements	Organic	15.94	0.43	0.12	*No emission factor available*	*No emission factor available*	*No emission factor available*
Y	Other land	Mineral	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*
Y	Other land	Organic	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*	*No emission factor available*