CTMUHB Public Board Meeting

Thu 29 May 2025, 09:00 - 13:00

The Hub, Royal Glamorgan Hospital

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 - 09:10
5 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

09:10 - 09:40
30 min

3. STAFF AND SERVICE USER EXPERIENCE

3.1. Shared Listening & Learning Story - Welsh Ambulance Services Trust (WAST)/CTMUHB Maternity Story

Discussion *Bethan Jones, Local Safety Champion Midwife, WAST*

- CTM public board meeting.pdf (8 pages)

3.2. Shift Patterns

Decision *Hywel Daniel, Executive Director for People*

- 3.2a Shift Patterns Report to Board UHB 29 May 2025.pdf (26 pages)
- 3.2b App 6 -EIAWLIA - Board Shift Patterns 29.05.25.pdf (8 pages)
- 3.2c App 7 QIA Shift Harmonisation CTMUHB - 2025.pdf (9 pages)

09:40 - 10:10
30 min

4. SETTING THE SCENE

4.1. Chairs Report

Decision *Jonathan Morgan, Health Board Chair*

- 4.1 Chair's Health Board Report UHB 29 May 2025 - JMv2.pdf (7 pages)

4.2. Chief Executives Report

Discussion *Paul Mears, Chief Executive*

- 4.2a CEO Board Update Report UHB 29 May 2025.pdf (8 pages)
- 4.2b MAG Report - English UHB 29 May 2025.pdf (69 pages)
- 4.2c WG response to MAG UHB 29 May 2025.pdf (25 pages)

10:10 - 11:00
50 min

5. BOARD GOVERNANCE ARRANGEMENTS

5.1. Action Log

Discussion *Jonathan Morgan, Health Board Chair*

- 5.1 Board Action Log UHB 29 May 2025.pdf (3 pages)

5.2. Matters Arising not Contained within the Action Log

Discussion *Jonathan Morgan, Health Board Chair*

5.3. Board Assurance Framework

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

- 5.3a BAF Report CP May 2025.pdf (4 pages)
- 5.3b Appendix 1 - BAF Report May 2025.pdf (54 pages)

5.4. Annual Review of the Risk Management Framework

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

- 5.4a Annual Review of the RMS and BAF - May 2025.pdf (5 pages)
- 5.4b Appendix 1 - Risk Management Strategy - Draft 19525.pdf (24 pages)
- 5.4c Appendix 2 - Risk Management Policy - Draft 19525.pdf (14 pages)
- 5.4d Appendix 3 - Risk Assessment Procedure - Draft 19.5.25.pdf (29 pages)

5.5. Board Committee and Advisory Group Highlight Reports

Where there are items contained within the alert/escalate section

5.5.1. Strategic Development Committee 3 April 2025

Discussion *Dilys Jouvenat, Independent Member*

- 5.5.1 SDC Highlight Report UHB 29 May 2025.pdf (6 pages)

5.5.2. Quality, Safety & Experience Committee 25 March 2025

Discussion *Carolyn Donoghue, Independent Member*

- 5.5.2 QSEC Highlight Report to Board 25.03.25 UHB 29 May 2025.pdf (10 pages)

5.5.3. Operational Delivery Committee 29 April 2025

Discussion *Rachel Rowlands, Independent Member*

- 5.5.3 ODC Highlight Report UHB 29 May 2025.pdf (7 pages)

5.6. Update on cluster of incidents within maternity services at the Princess of Wales Hospital (March – May 2025)

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

- 5.6 Spotlight cluster of incidents at PoW UHB 29 May 2025.pdf (6 pages)

11:00 - 12:00
60 min

6. DELIVERING OUR PLAN

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

Discussion *Vicki Oxley, Acting Executive Director of Strategy & Transformation*

6.1 HB Integrated Performance Dashboard UHB 29 May 2025.pdf (39 pages)

6.2. Financial Performance Report

Discussion *Sally May, Executive Director of Finance*

6.2.1. Month 12 Finance Report

Discussion *Sally May, Executive Director of Finance*

6.2.1 M12 Finance Report Full UHB 29 May 2025.pdf (21 pages)

6.2.2. Month 1 Finance Report

Discussion *Sally May, Executive Director of Finance*

6.2.2 M1 Finance Report UHB 29 May 2025.pdf (19 pages)

6.3. People Plan 2024-2025

Decision *Hayleigh Jones, Deputy Director for People*

6.3a Board Cover Paper People Plan UHB 29 May 2025.pdf (8 pages)
6.3b People Plan 2025-30 Final UHB 29 May 2025.pdf (18 pages)
6.3c Success measures People Plan 2025-30 final UHB 29 May 2025.pdf (5 pages)
6.3d People plan - one page summary UHB 29 May 2025.pdf (1 pages)

12:00 - 12:20
20 min

7. OUR POPULATION/WORKING WITH OTHERS

7.1. Annual Review of the Wellbeing of Future Generations Act Statement and Objectives

Decision *Philip Daniels, Executive Director of Public Health*

7.1 CTM Board May WBFGA UHB 29 May 2025.pdf (7 pages)

7.2. South East Wales Regional Joint Committee

Discussion *Jonathan Morgan, Health Board Chair*

7.2 South East Wales Regional Joint Committee UHB 29 May 2025.pdf (5 pages)

12:20 - 12:50
30 min

8. STRATEGIC PLANNING

8.1. Civil Contingencies & Business Continuity Report

Discussion *Vicki Oxley, Acting Executive Director of Strategy & Transformation*

8.1 CCM update for board may 2025 UHB 29 May 2025.pdf (6 pages)

12:50 - 12:55
5 min

9. CONSENT AGENDA

9.1. FOR APPROVAL

9.1.1. Unconfirmed Minutes of the meeting held on 27 March 2025

Decision *Jonathan Morgan, Health Board Chair*

9.1.1 Unconfirmed Public Board Meeting Minutes 27 March 2025 UHB 29 May 2025.pdf (21 pages)

9.1.2. Unconfirmed Minutes of the In Committee meeting held on 27 March 2025

Decision *Jonathan Morgan, Health Board Chair*

9.1.2 Unconfirmed In Committee Board Meeting Minutes 27 March 2025 UHB 29 May 2025.pdf (3 pages)

9.1.3. Standards of Good Governance and Probity

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

9.1.3a Standards of Good Governance & Probity UHB 29 May 2025.pdf (5 pages)
9.1.3b Draft Policy UHB 29 May 2025.pdf (21 pages)

9.1.4. Board Committee Annual Reports

Decision *Committee Chairs*

9.1.4a Board Committee Annual Reports UHB 29 May 2025.pdf (4 pages)
9.1.4b Appendix 1 Annual Report Mental Health Act Monitoring Committee UHB 29 May 2025.pdf (6 pages)
9.1.4c Appendix 2 Quality Safety Committee Annual Report 2024 2025 UHB 29 May 2025.pdf (12 pages)

9.2. FOR NOTING

9.2.1. Non-Routine Board Business (Forward Plan)

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

9.2.1 Non Routine Board Business Forward Plan 2025 UHB 29 05 25.pdf (4 pages)

9.2.2. Annual Cycle of Business

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

9.2.2 CTMUHB Board Cycle of Business 2025 UHB 29 May 2025.pdf (4 pages)

9.2.3. Board Committee and Advisory Group Highlight Reports

Information *Committee Chairs*

9.2.3a Board Committee and Advisory Group Highlight Reports UHB 29 May 2025.pdf (4 pages)
9.2.3b LPF Highlight Report UHB 29 May 2025.pdf (6 pages)
9.2.3c RTSC Committee Highlight Report -13.3.25 27.3.25 UHB 29 May 2025.pdf (4 pages)
9.2.3d SRG Chairs Highlight Report April 2025 UHB 29 May 2025.pdf (7 pages)
9.2.3e MHAMC Highlight Report 13 May 2025 UHB 29 May 2025.pdf (5 pages)

9.2.4. Internal Audit Annual Audit Plan

Information *Head of Internal Audit*

9.2.4 Internal Audit Plan 2025-26 UHB 29 May 2025.pdf (25 pages)

9.2.5. IMTP 2024-2027 – Quarter Four Review

Information *Vicki Oxley, Acting Executive Director of Strategy & Transformation*

9.2.5a IMTP 24-25 Q4 Review 2024 UHB 29 May 2024.pdf (6 pages)
9.2.5b Appendix 1 Ministerial Template 24-25 - Pathways of Care Q3 4 update.pdf (24 pages)
9.2.5c Appendix 2 Ministerial Template 24-25 Primary Community Care Access Q4.pdf (12 pages)
9.2.5d Appendix 3.1 IMTP USC SDEC Q3 4.pdf (7 pages)
9.2.5e Appendix 3.2 IMTP USC Ambulance Handover Q3 4.pdf (6 pages)
9.2.5f Appendix 4 IMTP ministerial priorities Planned Care - Q4.pdf (3 pages)

9.2.6. Public Services Board Update

Information *Philip Daniels, Executive Director of Public Health*

- 9.2.6a Public Service Board Update UHB 29 May 2025.pdf (3 pages)
- 9.2.6b Appendix 1 -Public Service Board Update.pdf (1 pages)

9.2.7. Annual Assurance Report on Compliance with the Nurse Staffing Level (Wales) Act

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

- 9.2.7a Nurse Staffing Report UHB 29 May 2025.pdf (6 pages)
- 9.2.7b Appendix A Nurse Staffing Report template (May report) - Adult Paeds -Final V1.pdf (15 pages)
- 9.2.7c Appendix C -SABR on Section 25B ward moves outside of Biannual acuity Audit Final V2.pdf (5 pages)

9.2.8. Highlight Report from the Joint Commissioning Committee (JCC)

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

- 9.2.8 JCC Highlight Report - JCC 18 March 2025 FInal UHB 29 May 2025.pdf (7 pages)

12:55 - 13:00
5 min

10. CLOSE OUT BUSINESS

10.1. Any Other Business

Information *Jonathan Morgan, Health Board Chair*

10.2. Meeting Feedback

Information *Jonathan Morgan, Health Board Chair*

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?

13:00 - 13:00
0 min

11. Private/Closed Session Business

Information *Jonathan Morgan, Health Board Chair*

The following reports will be received at the In Committee Session:

- Capital Update - Commercially Sensitive
- Verbal Update - Cluster of Maternity Incidents at Princess of Wales Hospital - Business Sensitive

13:00 - 13:00
0 min

12. Date and Time of the Next meeting

Information *Jonathan Morgan, Health Board Chair*

Thursday 31 July at 9:00am. The Health Board's Annual General Meeting will also be held on this date at 2:30pm

Welsh Ambulance Services University NHS Trust

Patient Story

Ymddiriedolaeth Brifysgol GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
University NHS Trust

Presentation: CTM Public Board Meeting
Version 1.0
Released: February 2025

Background

G6 P4 (X4 SVB 2006, 2008, 2013, 2022)

EDD 03/02/2024 -DCDA twins

- **Pregnancy Details:**
  - Dichorionic diamniotic (DCDA) twin pregnancy confirmed at 8 weeks
  - Booked with CTM at 11 weeks gestation
- **Timeline of Events:**
- **17/11/23:**
  - Routine antenatal appointment – reported back pain
  - Referred to Prince Charles Hospital (PCH) triage
  - Positive Fetal Fibronectin (FFN) >500
  - Transferred to Labour Ward for review
  - Plan made to transfer to a unit with an alongside Neonatal Intensive Care Unit (NICU)
- **18/11/23:**
  - *08:30:* NICU cots identified; awaiting maternal bed.
  - *11:45:* in-utero transfer agreed
  - Community midwife arranged for transfer
  - *14:10:* Transferred via ambulance to Level 1 unit
  - In utero transfer documentation completed
- **Outcome:**
- On review care provided within CTM was appropriate
- Remained admitted until 24/11/23 and was discharged home

Emergency Response Timeline

24/11/2023

16:11 – Contact was made to PCH triage for abdominal pain – plan to attend hospital

16:33 – Call placed to 999 “In labour with twins at 29+6 weeks”
16:34 – resources allocated
16:52 – First Paramedic on scene
- Additional 6 resources arrived over 30 minutes
- Included: Senior Paramedics, CHARU, DoM, MedServe, EMTs

16:59 – Twin 1 (Aneria) born
- SVB, good condition
- Immediate skin-to-skin, hat and blanket applied
- Baby placed in plastic bag, wrapped in towel with heat pad for thermal care

17:32 – Departed scene
- Pre-alert passed to Emergency Department and updates passed throughout
- Decision made to attend Maternity

17:54 – Arrival at PCH
- Maternity and Neonatal staff ready in foyer
- Efficient and effective transfer of care to receiving team

Emergency Response Timeline

Emergency Response Timeline – Twin 2 (Carreg)

17:28 – Second Emergency Ambulance (EA) arrived on scene

17:50 – Twin 2 (Carreg) born via SVB – Breech presentation
- Immediate skin-to-skin contact
- Hat applied, baby covered with towel
- Then transferred to plastic wrap, wrapped in towel, placed on heat pad, and wrapped in blanket for transport

18:15 – Dynamic risk assessment
- Decision to convey mother and baby in same EA due to time-critical condition and maternal stability
- Both moved to EA

- Midwife arrived – cross-border working support

While on EA:
- Postpartum haemorrhage (PPH) declared
- 3rd resource requested

18:36 – Third EA arrived on scene

18:36 – Twin 2 departed scene
- Hospital informed by crew

18:37 – Mother departed scene

- **18:58/18:59** – Arrival at PCH
  - Both twins in good condition, normothermic
  - Transferred to Neonatal Unit
  - Stabilised for transfer to Level 1 unit next day

[Cath Carreg Aneira v2 - YouTube]

Learning

Areas of good practice

- A rapid review was held collaboratively between WAST and CTM, reflecting the strong working relationship. This enabled the timely identification of learning and dissemination of positive care to staff. Whilst also ensuring a robust review of care for the woman, her babies and family.
- Positive collaboration of the MDT on Community Prompt Wales

Key Learning Points:

•Resource Coordination: The presence of multiple patients necessitated the deployment of multiple resources and staff to coordinate care effectively on scene.

•Interdepartmental Communication: Clear communication was required across several departments within Prince Charles Hospital (PCH). Initially, WAST communicated that the twins would be transferred to the Emergency Department; however, the neonatology team was positioned in Maternity. Following further discussions, the babies were received in Maternity.

•Time and resource taken to find neonatal cot and maternal bed spaces

•Improvements implemented:

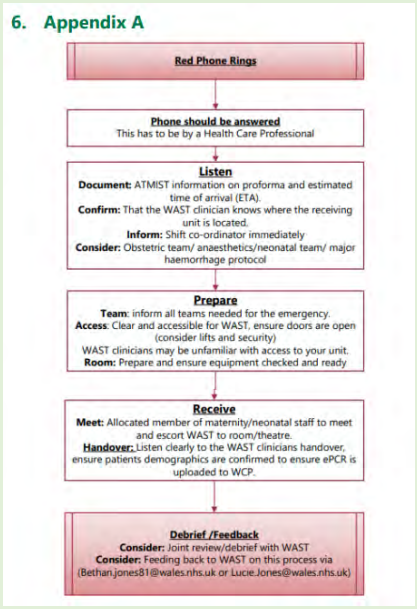
- Streamlined Access and Agreed Protocols: A single point of access was established with agreed-upon processes in place, enhancing efficiency and clarity.
- Integrated Collaboration: The collaboration between WAST and CTM, including the use of the maternity "red phone" and associated workstreams, supports a transparent, proactive, and system-led approach to developing integrated care solutions.
- Effective Communication Channels: The importance of robust communication was highlighted, particularly the need for ambulance crews to alert hospitals to clinical situations via a protected, dedicated line.

Learning

Maternity Red Phone

Went live on both sites 22/04/2024

- Single point of contact through a protected line for the ambulance service for patients being conveyed into the receiving units.
- JRCALC guidance available to ensure scope of practice and guidelines are understood between professions.



6. Appendix A

Red Phone Rings

Phone should be answered
This has to be by a Health Care Professional

Listen
Document: ATMIST information on proforma and estimated time of arrival (ETA).
Confirm: That the WAST clinician knows where the receiving unit is located.
Inform: Shift co-ordinator immediately
Consider: Obstetric team/ anaesthetics/neonatal team/ major haemorrhage protocol

Prepare
Team: inform all teams needed for the emergency.
Access: Clear and accessible for WAST, ensure doors are open (consider lifts and security)
WAST clinicians may be unfamiliar with access to your unit.
Room: Prepare and ensure equipment checked and ready

Receive
Meet: Allocated member of maternity/neonatal staff to meet and escort WAST to room/theatre.
Handover: Listen clearly to the WAST clinicians handover, ensure patients demographics are confirmed to ensure ePCR is uploaded to WCP.

Debrief /Feedback
Consider: Joint review/debrief with WAST
Consider: Feeding back to WAST on this process via (Bethan.jones81@wales.nhs.uk or Lucie.Jones@wales.nhs.uk)

Thank you for listening

For any questions and/or support, please contact either Mike Jenkins or Bethan Jones.

Mike.Jenkins@wales.nhs.uk

Bethan.Jones81@wales.nhs.uk

Agenda Item
3.2

CTM Health Board

Shift Pattern Harmonisation

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Nurse Director Hayleigh Jones, Deputy Director for People Nicola Evans Assistant Director of Workforce Sara Mason, Head of People Sue Holroyd, Assistant Director of Finance Donna White, Assistant Director of Finance
Cyflwynydd yr Adroddiad / Report Presenter	Hywel Daniel, Executive Director for People
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
Working Group with Trade Unions	2/12/2024	Initial discussion
Shared briefing paper with TUs in confidence and RCN	10/12/2024 16/01/2025	For comments at the meeting on 23 Jan
Working Group with Trade Unions	23/01/2025	To discuss briefing paper
Working Group with Trade Unions	11/02/2025	To agree next steps
Working Group with Trade Unions	25/02/2025	To agree questions and approach to staff questionnaire

Staff Questionnaire issued	3/03/2025-21/03/2025	Extract responses and analyse themes w/c 24 March 2025
Working Group with Trade Unions	3/04/2025	To share presentation on questionnaire results
Executive Leadership Group	19/05/2025	Endorsed recommendation for option 2
Operational Delivery Committee	19/05/2025	Endorsed recommendation for option 2

Acronyms / Glossary of Terms	
CTM UHB	Cwm Taf Morgannwg University Health Board
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
HR	Health Roster
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
OCP	Organisational Change Policy
TU	Trade Unions
WTR	Working Time Regulations
NMR	Nursing, Midwifery, Registrants
CT	Cwm Taf
HCSW	Health Care Support Worker

1. SITUATION /BACKGROUND

1.1 This report was considered at Executive Leadership Group and Operational Delivery Committee on 19 May 2025. Both meetings endorsed the recommended approach for Board approval.

1.2 Across Cwm Taf Morgannwg University Health Board (CTMUHB) staff work a range of different shift patterns to fit the specific requirements of each service. This paper relates specifically to discrepancies in the number of breaks and frequency of make-up shifts between CTM sites, for our NMR and HCSW communities who work 12.5-hour shifts.

1.3 In the main, staff working at former CT sites (such as Royal Glamorgan Hospital (RGH), Prince Charles Hospital (PCH), Ysbyty Cwm Cynon (YCC), Ysbyty Cwm Rhondda (YCR), Glanrhyd and Pinewood House) take one 30-minute unpaid break, whereas staff who work at Princess of Wales Hospital (POW) take two 30-minute unpaid breaks. The difference has implications for the number of additional make-up shifts the staff are required to work, with staff at POW having to work more frequent make-up shifts.

1.4 The issue first emerged following the transfer of Bridgend staff from the Swansea Bay University Health Board in 2019. Legal advice was obtained advising that staff who transferred into the organisation are protected by the Transfer of Undertakings (Protection of Employment) Regulations and should retain their terms and conditions of employment.

1.5 The issue has since been raised by staff and TUs at POW, who are concerned about the discrepancy and argue that it is unfair that they are required to attend work more frequently, due to the increased make-up shifts. The response to the critical incident at POW and the movement of staff across the CTM footprint expedited the need to address the variance of the shift pattern arrangements.

1.5 There has also been a perception from POW nursing staff that they are receiving less pay than colleagues in former CT sites. For clarification, all staff are paid at the same rates for the same working hours; the current difference relates to how breaks and make-up shifts are allocated across our sites.

Purpose

1.7 This paper addresses the discrepancy in NMR and HCSW shift patterns and break structures across different hospital sites within CTMUHB. It is recognised that the principles may apply to other staff groups and services.

1.8 Specifically, it aims to:

1. Analyse the current arrangements of 12.5-hour shifts across CTMUHB.
2. Evaluate the implications of different break structures on staff working hours and make-up shifts.

3. Assess the impact of these differences on staff perceptions of fairness and equity.
4. Explore options for harmonising shift patterns across all sites to ensure parity and fairness.
5. Consider the financial, workforce (including staff wellbeing) and operational implications of potential changes to shift patterns.
6. Examine the effects of different shift patterns on patient safety and care quality.

1.9 In developing the paper, several steps have been taken including a literature review (shown at Appendix 1), a staff questionnaire, and an assessment of the shift patterns in other Health Boards across Wales (see Appendix 2 which is available to Board Members via the Documents folder on Admincontrol).

Partnership Working

1.10 Since early December 2024, regular working groups have been held with trade union/professional body colleagues to discuss possible ways to resolve the discrepancy in shift patterns, breaks and make up shifts across CTMUHB for nursing, midwifery (NMR) and HCSWs. These dates are set out above. This included development of joint communication to staff to set out our initial work, the development of a staff questionnaire (agreed in partnership), and the development of a joint communications to staff to share the questionnaire results.

1.11 Following the results of the staff questionnaire, trade union colleagues (excluding UNISON), requested a further questionnaire to be issued with two questions, which TUs felt were missing from the original. This was declined by management on the basis that CTM staff had already completed the questionnaire in good faith, which had been developed in partnership. In addition, we had already committed to our workforce to reaching a decision on our shift pattern approach by June 2025, subject to Board approval. TUs were reminded of the opportunity to submit any further comments or considerations for alternative shift patterns to management by 17 April 2025. Formal comments were received from TUs (excluding UNISON) see Appendix 3. UNISON raised concerns that they had not be included in the formal response noted above and subsequently submitted their own response shown in Appendix 4. All comments have been considered and included in the development of this paper.

2. SPECIFIC MATTERS FOR CONSIDERATION

Current CTM Shift Pattern Arrangements

2.1 The table below outlines the current working arrangements with details of the different shift lengths and the implications for staff:

Former CT sites	POW
Shift lengths 7.00am/pm - 7.30pm/am allowing for 30 minutes handover.	Shift lengths 7.00am/pm - 7.30pm/am allowing for 30 minutes handover
Staff are in work for 12 ½ hours but have one half hour break and work 12 hours paid	Staff are in work for 12 ½ hours but have two half hour breaks so work 11 ½ hours paid
3 x 12-hour shifts = 36 per week.	3 x 11.5 shifts = 34.5 hours
They work 36 hours a week - so owe 1 ½ hours a week (if full time 37.5 hours)	They work 34.5 hours a week - so owe 3 hours a week (if full time 37.5 hours)
As a result, every 4 weeks they work a six-hour make-up shift (or a 12-hour make-up shift every 8 weeks)	As a result, every 2 weeks they work a six-hour make-up shift (or a 12-hour make-up shift every 4 weeks)

2.2 While staff are all paid the same basic hours and enhanced pay at the same rates, some perceive an inequity in pay due to the frequency of make-up shifts.

2.3 While the focus of this paper is on NMR and HCSWs, we are aware that other staff groups in the Health Board also work shifts more than 12 hours, and any decision on paid breaks will impact them, e.g., Administrative and Clerical roles, Ward Receptionists and Ward Clerks, Facilities, Primary and Community (transformation) and ODPs and this will need to be further explored.

2.4 We have excluded Theatres at this stage due to their varying shift patterns, which are different from those outlined above and will need further assessment. Community Paediatrics may also be out of scope due to the nature of the work (providing respite to families during the night), where taking a break is not always possible and may, in some instances, have to be paid.

Health Rostering

2.5 The workforce data for the paper has been underpinned by Health Roster information.

Literature Review

2.6 A literature review has been completed, included at Appendix 1 of this report.

2.7 In summary, the conclusion was that the impact of 12.5-hour shifts on nurse well-being and patient safety is complex. Whilst some studies suggest benefits like improved continuity of care and alignment with nurse preferences, many other studies highlight significant risks. Extended shifts totalling 12 hours or more are linked to increased errors, unfinished tasks and compromised patient

safety. They also correlate with higher burnout, job dissatisfaction and nurses' intention to leave.

2.8 Break structure is crucial, with research indicating that regular short breaks might be more effective that longer, less frequent ones. However, optimum break length and structure for 12.5-hour shifts remain unclear and practices vary widely.

Welsh Context

2.9 Shift patterns across Wales were considered and are shown in Appendix 2 (available to Board Members via the Documents folder within Admincontrol). This shows there is no consistent position across Wales, other than breaks being unpaid.

Staff Engagement

2.10 A staff questionnaire was developed in partnership with trade union and professional body colleagues. This was issued to staff via SharePoint and cascaded through Care Groups on 3 March and closed on 21 March 2025. The purpose of the questionnaire was to capture staff views to inform, and develop, a shift pattern which best serves our patients, their safety, wellbeing of our staff, and one which is fit for the future.

2.11 The key results from 1,464 staff who took part in the survey (968 of which were from NMR and 242 HCSW workforce) showed:

- 52% of overall respondents have a 30-minute break; 33% having one-hour break
- A preference for 12-hour shifts to support caring needs: 54% preferring rotating shifts days/nights and 64% showed a preference to 10–15-hour shifts
- Respondents reported dissatisfaction with current make-up shifts; current system variance perceived as unfair contributing to burnout
- 70% response noted that having consistent shift patterns was identified as the highest importance
- Clear themes throughout the survey for the need to have a work life balance and shift pattern consistency
- 56% reported related to current shift patterns with 41% experiencing weekly fatigue
- 57% reported that the shift pattern did not affect their overall physical and mental health

2.12 The survey results did show that responses at times contradicted each other i.e. staff reported fatigue but stated it did not affect their overall physical and mental health with a preference for longer shifts.

Working Time Regulations

2.13 The Working Time Regulations (WTR) 1998 mandate that employees working shifts longer than 6 hours are entitled to a minimum uninterrupted rest break of 20 minutes. However, breaks may be unpaid depending on the contract.

Weekly Rest Period

2.14 Staff are entitled to 24 hours of rest every week or 48 hours every two weeks. This means they must have at least one day off in 7 days or two consecutive days off in 14 days.

3 OPTIONS APPRAISAL

3.1 In considering the options below, an initial review of the Health Roster data was considered and showed 3,133 staff who work in the services covered by this paper (NMR and HCSWs) who work the different shift patterns. 675 work 12.5 hours (11.5 hours paid), and 2,458 work 12.5 hours (12 hours paid).

3.2 Initial scoping indicates that:

- harmonising all rosters to the unpaid 30-minute break shift pattern (former CT model) would incur increased costs in the region of £1.3m - £1.7m per annum and require an additional 29 WTE staff to cover the roster fully;

- harmonising all rosters to the unpaid 60-minute break shift pattern (POW model) would decrease costs by approximately £5m annually, excluding any impact of any short-term pay protection. It would also reduce the required establishment by 105 WTE.

3.3 In deciding the preferred approach to address the disparity in shift patterns, breaks and make-up shifts, the five following options have been considered. Each option appraisal outlines the financial, workforce and operational impact.

3.4 Option 1 - Do nothing

This would mean that we continue to have disparity in shift patterns across CTM UHB, exposing risks and challenges. Additionally, difficulty in supporting workforce flexibility to cover shifts as needed across different services/sites, costs, and potential increased sickness/turnover impacting patient care. Maintaining the status quo would be neutral from a finance and workforce perspective but this option is not recommended as it does not resolve the disparity between shift patterns, breaks and make-up shifts.

3.5 Option 2 - 12.5 Hours, unpaid 60-minute break (2 x 30 minute) consistent with the current POW shift pattern

- Financial Assessment

This option would result in an estimated cost reduction in the region of £5.0m p.a. and would require an estimated 105 WTE fewer (NMR and HCSWs) posts to cover this roster pattern consistently across all sites.

There may be an element of short-term pay protection relating to enhanced pay periods on weekends. Any short-term pay protection due would be calculated on an individual basis and would last for a maximum period of 12 months.

- Workforce Impact
  The breaks exceed the WTR minimum requirement for a 20-minute unpaid break for the length of the shift. If this shift pattern was adopted, the former CT staff would have to work more make-up shifts than they currently do to accommodate the additional break time. Noting the current arrangements still leaves a 6-hour make-up shift to be worked per year. This is because of the shortfall in hours by working 11.5 hours over 12 months. However, there are options around how this could be incorporated to support NMR and HCSW development. This would be an ongoing piece of work and would be led by Corporate Nursing.

  The reduction of 105 WTE could be managed via natural turnover, thereby reducing our vacancy gap and increasing workforce availability.

- Staff wellbeing and job satisfaction
  When considering the impact of 12.5-hour shifts with extended breaks on nurse wellbeing and job satisfaction, it is important to acknowledge both positive and negative aspects. Firstly, the increased workforce availability afforded by this model will allow us to ensure our workforce can take adequate breaks during their shifts. Increased flexibility and potential for improved work-life balance are also positive outcomes, but concerns such as cognitive anxiety, burnout, and increased time away from home should not be overlooked. Additionally, various factors including workload, staffing levels, and individual preferences play important roles. Taking a careful and constructive approach, along with regular monitoring, is crucial to ensure that the benefits of this shift pattern outweigh any negative effects on staff wellbeing.

- Professional Nursing Considerations
  Patient safety and care quality
  Implementing/continuing a 12.5-hour shift pattern with an unpaid 60-minute break presents a complex scenario for patient safety and care quality. While this pattern exceeds WTR minimum break requirements, potentially reducing fatigue-related errors, caution should be given to the extended shift duration.

  The proposed break structure offers a more extended rest period, which can be split into 2 x 30 minute breaks, which may help mitigate some of these risks.

  The impact on patient safety and care quality would need to be carefully monitored, particularly focusing on error rates, patient satisfaction, and completeness of care delivery.

Additionally, the potential increase in staff turnover and retirements could affect continuity of care and the overall experience level of the NMR and HCSW workforce, factors that are crucial for maintaining high standards of patient safety and care quality.

3.6 Option 3 - 12.5 Hours, unpaid 30-minute break, consistent with the current former CT shift pattern

- Financial Assessment
  This option would result in an estimated cost increase of £1.4m based on substantive staff costs or £1.7m if the increased gaps could only be covered via increased agency usage. An additional 29 WTEs would be required to cover this roster pattern consistently across all sites.

- Workforce Impact
  The breaks are above the WTR minimum requirement of a 20-minute unpaid break for the length of the shift. If this shift pattern was adopted, then POW staff would have to work fewer make-up shifts than they do currently, reducing their makeup shift from 12 hours to 6 hours.

  The increase in workforce numbers would require a targeted recruitment plan which may be difficult to fulfil due to availability. In the absence of successful recruitment, there is a likelihood of an increased reliance on bank and agency, which would further increase costs. Turnover rates may continue or increase. The latter would have to be monitored.

  This option is the RCN preference. UNISON also prefer this option.

- Work-life balance considerations
  Based on research, the proposal for 12.5-hour shifts with only a short 30-minute break raises concerns for staff health and wellbeing. Studies show that long shifts and short breaks can lead to increased stress, fatigue, and dissatisfaction amongst NMRs and HCSWs. This could affect the quality of patient care and overall job satisfaction. It is important to monitor staff well-being and consider additional support measures if this plan is implemented.

- Professional Nursing Considerations
  Patient safety and care quality
  A 12.5-hour shift with a 30-minute unpaid break could cause concern about patient safety and care quality. Research has consistently shown that shifts longer than 12 hours increase risks to patient safety. The limited break time in this model could increase the risk of errors and near misses, as NMR and HCSW may not have enough time to rest and recover during their shifts. The impact on care quality is also concerning, as nurses may struggle to complete all necessary care tasks, potentially compromising patient care.

  In conclusion, while the 12.5-hour shift plan may have some benefits, the combination of long shift length and limited break time presents substantial

risks to patient safety and care quality. These risks would need careful monitoring and mitigation if this option were to be implemented.

3.7 Option 4 - Early Shift 8 Hours, unpaid 30-minute break. Late shift 8 hours, unpaid 30-minute break. Night shift 10 hours, unpaid 30-minute break.

- Financial Assessment
  The reintroduction of a 3-shift roster pattern would increase costs by an estimated £9.0m due to the extended length of the day-time roster cover and would require an estimated 257 additional WTEs to cover this roster pattern consistently.

- Workforce Impact
  This option would require a significantly larger workforce to support the shift pattern, which will be challenging to source. Additional funding would need to be found to support the recruitment of NMR and HCSWs noting this would be difficult for NMR to source the additional workforce. This option is likely to increase bank and agency reliance.

- Work-life balance considerations
  This is not the preferred shift pattern by the NMR and HCSW workforce as it is less flexible and can impact work-life balance. Staff are expected to be in work for more days with fewer rest days. If introduced, there is a risk of increased turnover and an impact on attraction and recruitment. This is especially the case if neighbouring Health Boards are offering 12-hour shift options.

  This shift pattern could also impact staff undertaking bank shifts, should they wish to work additional shifts, with potential consequences for individuals. It could also impact the number of bank workers available to us when we need them.

- Professional Nursing Considerations
  Patient safety and care quality
  The proposed shift pattern comprises 8-hour early and late shifts, supplemented by a 10-hour night shift, potentially yielding benefits for patient safety and care quality in contrast to 12-hour shifts. Robust research consistently demonstrates that shifts exceeding 12 hours correlate with heightened error risks and compromised patient safety (Griffiths et al., 2014). The shorter shifts within this pattern may mitigate nurse fatigue, a pivotal factor in upholding patient safety.

  Nevertheless, the three-shift system will yield more frequent handovers, which could elevate communication errors but also offer increased opportunities for fresh patient assessments. The escalated staffing requisites could enhance nurse-to-patient ratios linked with superior patient outcomes. However, such advantage may be counteracted if positions remain vacant, resulting in heightened dependence on temporary staff.

While shorter shifts may engender diminished continuity of care within a 24-hour period, this prospect could be alleviated through enhanced handover processes. The provision of regular breaks is anticipated to sustain staff alertness and performance throughout the shift, vital for preserving cognitive function and reducing error risks.

Despite staffing challenges and increased handovers, evidence suggests that this shift pattern could positively influence patient safety and care quality. Success will hinge upon efficacious implementation, encompassing adequate staffing levels and provision of support for staff adjusting to the new pattern. Ongoing monitoring will be imperative to evaluate authentic impacts on patient safety and care quality.

- Staff wellbeing and job satisfaction
  The proposed 8-hour early/late shifts and 10-hour night shift pattern present potential benefits for staff wellbeing in contrast to 12-hour shifts. Literature suggests that shorter shifts are linked with reduced cognitive anxiety, musculoskeletal disorders, and sleep disturbance. However, the influence on job satisfaction is multifaceted. Some NMR and HCSW express a preference for 12-hour shifts due to increased rest days, as was indicated within the staff questionnaire.

  Increased handovers may yield mixed effects, potentially amplifying stress while also offering enhanced communication opportunities. Individual preferences, influenced by factors such as age and caregiving responsibilities, significantly contribute to shift pattern satisfaction (Dall'Ora et al., 2021). The heightened staffing requirements are critical; inadequate staffing may culminate in heightened workload and stress, potentially nullifying the benefits of shorter shifts. While this pattern may enhance staff wellbeing, its impact on job satisfaction is likely to fluctuate. Success hinges on adequate staffing, efficient handovers, and accommodation of individual preferences. Ongoing monitoring is imperative to comprehensively evaluate actual impacts.

3.8 Option 5: 12.5 Hours, Unpaid 45-minute break

- Financial Assessment
  This option would result in an estimated cost reduction in the region of £1.8m p.a. and would require an estimated 38 WTE fewer posts to cover this roster pattern consistently across all sites.

- Workforce Impact
  This break pattern exceeds the WTR minimum requirement for a 20-minute unpaid break for the length of the shift. This option would require fewer posts to support the shift pattern.

  There would be fewer shift handovers than in Option 4, meaning fewer opportunities for miscommunication and disruptions during shift changes.

This is a middle-ground between the two models that are currently in operation in CTM and represents a new pattern for all. This means that all NMR and HCSWs would need to through an organisational change process. The downside is that this represents a bigger change programme, impacting on a larger group of individuals and therefore also has potential to cause more unrest. However, it could also mean a fresh start for all rather than selecting the former CT or current POW model, and this could be seen as a compromise.

This model would need extra steps to manage staff schedules and rostering, beyond what is currently done for nursing and support staff. We would require consistent and accurate tracking of hours worked to determine when additional shifts need to be scheduled. Since the number of extra shifts needed to meet contracted salary hours can vary throughout the year, properly recording these hours is essential to ensure staffing levels are maintained as needed.

- Work-life balance considerations
  Based on research, the proposal for 12.5-hour shifts with short breaks raises concerns for staff health and wellbeing. Studies show that long shifts and short breaks can lead to increased stress, fatigue, and dissatisfaction among nurses. This could affect the quality of patient care and overall job satisfaction. It is important to monitor staff well-being and consider additional support measures if this plan is implemented.

- Professional Nursing Considerations
  Patient safety and care quality
  With only two shifts per day, fewer handovers reduce miscommunication and disruptions, enhancing continuity of care. However, longer shifts increase the risk of errors and compromise patient safety. A single 45-minute unpaid break may not sufficiently mitigate fatigue. Research has indicated that regular short breaks might be more effective than longer, less frequent ones.

  Implementing a 12.5-hour shift pattern with an unpaid 45-minute break is complex for patient safety and care quality. While this exceeds WTR minimum break requirements and may reduce fatigue-related errors (compared to shift with less breaks), extended shift durations require caution. Monitoring error rates, patient satisfaction, and care completeness is essential. Increased staff turnover and retirements could impact continuity of care and NMR and HCSW workforce experience, which are critical for high standards of patient safety and care quality.

4. KEY RISKS / MATTERS FOR ESCALATION

4.1 The following areas are highlighted:

- The implementation of any proposed changes is likely to impact on other staff groups as mentioned above, potentially impeding their ability to deliver safe, prompt, and high-quality services to patients.

- Any change of this scale risks disengagement, leading to reduced availability of NMR and HCSW skills in the event of increased sickness, turnover or employee relations issues.

- The timing of any organisational change will need to be carefully considered to ensure business continuity with such a large-scale change. A high-level implementation plan is included at Appendix 5.

- Risks include CTMUHB's reputation arising from potential industrial action, external communication or media influence.

- We have continued to ensure consistent involvement of TU colleagues and professional bodies, to mitigate potential risks and develop a collaborative approach. TUs (except for UNISON) have verbally and formally written to confirm their dissatisfaction with the staff questionnaire due to the decision taken not to add further questions after the closure date. This is decision was made on the basis that nothing further would be gained from re-issuing the questionnaire as staff had already taken time to complete and the timeline had already been communicated to staff.

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: Creating Health, Sustaining Health, Inspiring People and Sustaining Our Future
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))*	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	Efficient
	If more than one applies, please list below: Effective, Equitable, Person-centred, Timely and Safe

(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: Full QIA indicated with the highest score being 16, triggered by staff wellbeing concern and resource implications.	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	If no, please include rationale below: Yes attached as Appendix 6.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Potential impact on ways of working. Full legal advice will be sought to support smooth implementation.	
Enw da / Reputational	Yes (Include further detail below)	
	Potential impact on media coverage	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Potential to increase or decrease the resources required	

6. RECOMMENDATION

6.1 For existing staff, the recommendation to Board is to endorse the decision in principle to implement the shift pattern outlined in Option 2. This will be subject to consultation with those impacted.

6.2 Furthermore, Board is asked to endorse the decision to appoint new staff onto the shift pattern outlined in Option 2, with immediate effect. This will standardise the NMR and HCSW shift patterns, breaks and make-up shifts across CTMUHB.

6.3 It is noted that the evidence around an optimum shift pattern and break structure is complex and inconclusive. Therefore, this recommendation is a judgement-call, based on the best available evidence across a number of factors.

6.4 The rationale for this recommendation is that it is the most efficient shift pattern from both an operational and financial perspective and it ensures parity across our sites. Furthermore, we have a duty of care to ensure sufficient rest periods for all staff. This option affords increased workforce availability, which will enable all staff the ability to take the breaks they are entitled to. This option for 2 x 30 minute breaks may also have a positive impact on staff wellbeing and patient care, as research has indicated that regular short breaks may be more effective than longer, less frequent ones.

6.4 However, this will be a significant change programme impacting on c.3000 staff and is likely to cause significant unrest. We will consider wider factors to ensure this lands as successfully as possible, including ensuring our people have the ability to take the breaks they are entitled to and how training and development time is incorporated into make-up shifts. This will be an on-going piece of work led by Corporate Nursing.

7. NEXT STEPS:

7.1 A draft implementation plan is included at Appendix 5 which includes formal consultation with staff, TUs, and professional bodies, on the agreed shift pattern to be implemented. Any changes will be in accordance with the CTMUHB Organisational Change Policy (OCP).

7.2 It is noted in the implementation plan that all changes to current shift patterns are to be made on the same date across CTMUHB. There will be a three-month lead in period with an ambition to start the new agreed shift pattern in September/ October 2025. This will also allow for any rostering changes and pay protection arrangements to be actioned post consultation. This will require significant workforce and management support to ensure a smooth transition onto the new shift pattern.

7.3 All new entrants that commence employment with CTMUBH post 29th May will commence on the new agreed shift pattern. This will require work with hiring managers and rostering teams, to ensure smooth dual-running of shift patterns in the interim period.

7.4 It is imperative to consider the timing and strategy of any potential OCP actions to prevent disruption to services during the winter period when demands and resource allocation typically pose greater challenges. The proposed implementation plan potentially mitigates this.

7.5 We will develop a clear communication and engagement strategy to manage internal and external messaging about any proposed changes. A post-Board communication has been drafted and will be sent internally and to external stakeholders, once the Board decision in principle is made on 29 May 2025.

7.6 We will undertake further work to address the potential impact on other staff groups and services beyond NMR and HCSWs, and the impact on their own shift pattern and breaks, so there is consistency across CTMUHB.

8. Appendices:

- Appendix 1 – Literature Review
- Appendix 2 – Shift Pattern by Health Board (available to Board Members via the Documents folder on Admincontrol)
- Appendix 3 - Trade Union Response to Recent Shift Pattern Survey and Potential change to Shift Patterns
- Appendix 4 - Unison response to Recent Shift Pattern Survey and Potential change to Shift Patterns
- Appendix 5 – Implementation Plan
- Appendix 6 – EIAWLIA (attached under separate cover)
- Appendix 7- QIA (attached under separate cover)

APPENDIX 1 - Literature Review

In recent decades, there has been a noticeable shift towards longer working hours for nurses, with many countries adopting or expanding the use of 12.5-hour shifts. The reasons behind the popularity of these shifts include staffing shortages and efforts to improve continuity of care and reduce handovers (Dall'Ora et al., 2016). However, there is ongoing debate regarding the impact of 12.5-hour shifts on the quality of care, nurse well-being, and patient safety. A literature review was undertaken to critically assess the available evidence on 12.5-hour shifts in nursing, with a specific focus on the use and effects of different break structures within these shifts, and their implications for patient safety, quality of care, and nurse well-being. It is based on various international studies and systematic reviews.

The findings of the literature review identified:

Shift length and alignment to patient safety and error rates

The correlation between shift length and patient safety has been the subject of numerous studies, with several large-scale studies suggesting a link between longer shifts and reduced patient safety. In a seminal cross-sectional survey of 31,627 nurses across 12 European countries, including the UK, by Griffiths et al. (2014), nurses working 12 hours or more were nearly 30 per cent more likely to report poor quality of care than those working 8 hours or less (OR 1.30, 95% CI 1.10-1.53), and nearly 40 per cent more likely to report compromised patient safety (OR 1.41, 95% CI 1.13-1.76).

Supporting these findings, in the US, Stimpfel and Aiken (2013) found that the longer nurses worked shifts of 12 hours or longer, the more likely they were to report poor quality of care and patient safety issues. As the shift length increased, so did the likelihood that nurses reported providing poor quality of care. Specifically, nurses working 13 hours or longer were approximately 1.98 times more likely than those working 8–9-hour shifts to report poor quality of care.

The longer the shift, the higher the chance of error: this is a key issue in healthcare. Clendon and Gibbons (2015) did a systematic review of studies examining the relationship between 12-hour shifts and rates of error among nurses. They concluded that ‘12-hour shifts were associated with higher prevalence of errors and near misses than shorter shifts’.

Nurse Well-Being and Job Satisfaction

The effects of 12.5-hour shifts on nurse well-being are complicated. Some studies demonstrate a preference among certain nurses for longer shifts, while others highlight adverse effects on job satisfaction and burnout rates.

A meta-analysis of 12 European countries by Dall’Ora et al. (2015) examined the relationship between shift length and nurses’ job satisfaction, burnout and intention to leave work. Those working shifts of 12 hours or more were significantly more likely

to experience burnout (adjusted OR 1.26, 95% CI 1.09-1.46), job dissatisfaction (adjusted OR 1.51, 95% CI 1.26-1.79) and intention to leave their job (adjusted OR 1.29, 95% CI 1.12-1.48) than nurses working 8-hour shifts.

In their study of 22,275 nurses in the United States, Stimpfel et al. (2012) found that those working shifts lasting 10 hours or more were up to 2.5 times more likely to be burned out or dissatisfied at work than those working shorter shifts. Patient satisfaction was also poorer in hospitals where more nurses worked long shifts.

Break Structures and Their Importance

Evidence suggests the structure and spacing of breaks during a 12.5-hour shift can play a significant role in some of the problems of long working hours. Breaks are often missed, interrupted or delayed in nursing practice.

A scoping review by Nejati et al. in 2016 stated that many of the studies show rates of missed, interrupted, or delayed breaks of more than 30 per cent during nursing shifts and that nurses' regular breaks are linked to better physical and mental health outcomes.

A study conducted by Wendsche et al. (2017) sheds light on the importance of work breaks, emphasizing the significance of their duration and frequency in relation to well-being and performance. Their findings indicate that, more frequently, shorter breaks are more effective in sustaining performance levels and reducing fatigue compared to fewer, longer breaks.

Conclusion of literature review

The literature on 12.5-hour shifts and the break structures associated with them paints a complicated picture concerning their impact on nurse well-being and patient safety. Some studies indicate that these types of shifts may have benefits for continuity of care and nurse preferences, but a significant body of research shows high risks to patient safety and nurse well-being related to extended shifts.

The literature shows that when shifts are 12 hours or longer, there is an increased risk of errors, things left undone, and compromised patient safety. Prolonged shifts have also been associated with higher levels of burnout, dissatisfaction with jobs, and intention to leave among nurses.

The structure of these breaks is also crucial. Research shows that regular short breaks might be more effective than longer, less frequent breaks. But exactly how long should breaks be, and what is the optimal structure of a 12.5-hour shift? We have little idea, and current practices vary widely in healthcare settings.

We acknowledge that most of the existing research is based on cross-sectional designs and self-reported data, hindering causal inferences and the risk of introducing

bias. Future research will require longitudinal designs and objective patient safety and nurse well-being measures. Further research is also needed to identify the most effective shift length and break structures, to address the complex relationship between nurse wellbeing, patient safety and quality of care.

Appendix 3 - Trade Union Response to Recent Shift Pattern Survey and Potential change to Shift Patterns

Whilst the trade unions do not have any further proposals on shift patterns it is important, we take note of what those who took the time to complete the survey have told us. We do have a few points we would like to reinforce prior to any options or decisions.

The recent staff survey on shift patterns showed that 52% of respondents have a 30-minute break and that many were content with the current shifts particularly those working 12 hours. There were clear themes throughout the survey for the need to have a work life balance and shift pattern consistency. What was not clear as a result of the survey was the preferred length of break and the preferred length of make-up shift which was the issue which originally brought us to the point of initiating a survey given the concerns around inequity of the breaks and make-up shift raised by colleagues in POW.

Having reviewed the results, TU's did express concern that this was not clear and had hoped that the question could be clearly asked of staff however, with this in mind appreciating staff have been given a deadline of June for a decision and we understand there is a wish to not extend past that deadline, during a recent emergency meeting to discuss, we did ask for an extension to the deadline. Our request had been that we communicate the outcome of the survey but acknowledge there were a couple of questions that remained unanswered and asked that we delay with full communication by 1 month to go out and ask 2 simple questions:

- What length of break would you prefer
- What length of make up shift would you prefer if you had to work a make up shift

Our request had been to ensure all avenues had been addressed and whilst we acknowledge we had worked in partnership to complete the survey, like many surveys it did not on reflection answer the questions the trade unions had hoped would be answered. It was also felt by some members of TU partnership that without the extra couple of questions it could become unclear as to the purpose of the survey given that high numbers of staff already work 12 hours and the survey showed that 52% were content with the 12 hour shift therefore what is the purpose of changing. This request was denied.

Trade unions believe there are many factors that need to be considered when addressing shift patterns that are wider than finance and ask that staff are not used as a money saving exercise which will be of detriment to their well-being and ultimately quality of patient care.

The survey showed that despite contentment with the 12-hour shift, the long hours could impact the ability to attend medical appointments, reduced time with family and managing school runs. Respondents also reported the desire to work longer

hence fewer shifts to have more days off which was crucial to support time with family which they reported improves their mental well-being and is essential for physical health.

The 2024 NHS staff survey for CTM showed an increase in the negative response to “my organisation is committed to helping me balance my work and home life”. There was also an increase in the negative response to “I achieve a good balance between my work and home life”. There was an increase in the positive response to “I have unrealistic time pressures” along with an increase in the positive response to “how often do you feel exhausted at the thought of another day/night shift at work”.

If the option to address the inequity in breaks and address shift patterns is to move the whole of CTM in line with previous Swansea Bay, which would result in a further 12 hour shift to make up hours, hence one week of working 48 hours we risk the potential of further increasing the responses as mentioned on work/life balance with a potential impact on childcare arrangements and much less time at home.

The NHS 2024 survey for CTM also showed that 38% of respondents worked up to 5 hours of UNPAID overtime per week with 51% working between 1-11 of UNPAID hours per week. There is the potential that the move to two unpaid breaks per shift could increase the amount of unpaid hours worked given staff frequently report being unable to take any break with the survey showing 33 people reported not having any break. Trade unions are consistently hearing that staff are unable to take breaks as the area in which they work is so busy, this would compromise patient care. If staff are unable to take breaks and the current 30 minute break that exists in a majority of areas that work 12 hour shifts is increased to 60 minute there is a risk of an increase in staff unable to take a full 60 minute break claiming for the hour worked which could increase costs in the longer term.

Whilst the numbers are not currently huge, many staff have reduced their hours in order to avoid a 6 hour make up shift. Should the old CT footprint move to the POW working pattern with a 12 hour make up do we run the risk of more staff dropping their hours to avoid an even longer make up shift. The risk also exists that we will have greater numbers of sickness which could result in greater agency use and greater pressures on those in work. Higher numbers of sickness, greater use of agency and more staff reducing hours not to work a make-up shift risks a negative impact on patient care and safety, quality of services and an increase of costs in the long term.

63% of respondents work in the old CT footprint where staff have for around 17 years worked 12 hours with a 30 minute break if there was a move to a 12 hour make up shift we risk decreasing staff well-being as this creates an increased lack of flexibility plus we must keep in mind the potential anger and lack of engagement of our staff member based in those areas if we now based on finance shift them to the previous Swansea Bay shift pattern.

The Health Board has previously been heavily criticised for a focus on finance as opposed to quality. We ask that the cost savings not be the decision making factor in the short term which could have a longer term impact on staff well-being and ultimately quality of care but, that cost be triangulated with all other information we have from both the NHS staff survey and the recent shift pattern survey.

We also wish to reiterate that whilst we were involved in the shift pattern survey, we have expressed concern that the survey did not answer the question which initiated the survey and that despite requesting another short survey and a short delay in the June deadline to ensure we get the right results and the best outcomes for our staff and patients, this request was denied.

Appendix 4 - Unison response to Recent Shift Pattern Survey and Potential change to Shift Patterns

A recurring issue raised by our members is the lack of collaboration among staff, which has created a divisive atmosphere and a sense of exclusion. Staff are seeking fairness and consistency across all teams. However, these concerns have remained unaddressed for too long, leading to a significant decline in confidence in the Health Board's commitment to equitable treatment. Communication has been inadequate, accountability for this oversight is lacking, and many members feel disconnected from the wider Health Board.

One key concern is the expectation surrounding make-up shifts. Our members strongly advocate for a 6-hour make-up shift instead of the existing 12-hour requirement for POW-based staff. This adjustment would support a better balance between work and home life while alleviating strain caused by demanding shift schedules. A practical solution to facilitate this change would be the removal of one of the two current 30-minute breaks.

Additionally, it is important to recognise that staff regularly undertake unpaid work, often compensating for scheduling adjustments. Many members highlight that, due to staffing levels, they have consistently worked longer shifts, often exceeding 15 hours. These extended hours take a toll, and our members believe the proposed changes are both reasonable and necessary.
UNISON Cwm Taf Morgannwg is committed to improving workforce relations and ensuring fair treatment for all members. However, action must move faster. OCPs at HB requests often progress at a pace that members find uncomfortable, yet the current rate of change for this is too slow and painful. Urgent steps must be taken to restore confidence and foster collaboration.

Appendix 5 - Implementation Plan

Action ID	Action	Action owner	Comments	Progress	w/c 2nd June	w/c 9th June	w/c 16th June	w/c 23rd June	w/c 30th June	w/c 7th July	w/c 14th July	w/c 21st July	w/c 28th July	w/c 4th Aug	w/c 11th Aug	w/c 18th Aug	w/c 25th Aug	w/c 1st Sept	w/c 8th Sept	w/c 15th Sept	w/c 22nd Sept	w/c 29th Sept
	Pre consultation																					
1	Following the Board decision on 29th May, all new entrants wef 1st June, will commence on the new agreed shift pattern. Comms to be widely circulated to all appointing managers	SM / NE																				
2	Provisional Implementation plan to be scoped out, to include lead in times for pay protection and roster implications. To be finalised following consultation	SM / NE																				
3	Finalise consultation paper	SM / NE																				
4	Planning for group consultation meeting/s	SM / NE																				
5	Complete governance & approval of consultation paper	SM / NE																				

6	Meet with Staff side to discuss consultation paper and agree approach	SM / NE																				
	Formal consultation																					
7	Group consultation meeting/s to start consultation	SM / NE																				
8	Consultation period runs for 30 days	SM / NE	Starts on 30th June																			
	121s																					
9	Individual 121s to be arranged on request - To include Staff member, line manager & staff side	SM / NE																				
	Closing of consultation																					
10	Consultation closes	SM / NE	Ends on 29th July																			
11	Review and consideration of comments	SM / NE																				
12	Amend documents and issue feedback	SM / NE																				
	Implementation of change																					

13	Implementation plan to be finalised	SM / NE																				
14	Implementation plan to be shared with Staff side	SM / NE																				
15	Implementation plan launched	SM / NE																				
16	New shift pattern implemented across CTM	SM / NE																				

Equality Impact Assessment (EIA) & Welsh Language Impact Assessment (WLIA)	
SECTION 1	
Preparation - See the definition of 'policy' for EIAs & WLIA and review the guidance attached. - Click here for link to monthly drop in sessions to support you in completing the EIA & WLIA - Please contact the Organisational Development & Inclusion (OD&I) team on CTM_Equality@wales.nhs.uk or the Welsh Language Team on CTT_WelshLanguage@wales.nhs.uk for further support	
Title of policy or initiative	Board & Committee Report - Shift Patterns
Policy / Initiative Aims and Brief Description *Please see some possible considerations to help below:* 1. *What is the policy or initiative meant to achieve?* 2. *Why is the policy being written or the initiative being carried out?* 3. *Who are the target groups, or who will be affected by this?* 4. *What results would you like it to have?* 5. *How does it relate to other services/policies and the IMTP*	• Analyse the current arrangements of 12.5-hour shifts for our NMR and HCSW communities across CTMUHB • Evaluate the implications of different unpaid break structures on staff working hours and make-up shifts • Assess the impact of these differences on staff perceptions of fairness and equity • Explore options for harmonising shift patterns across all sites to ensure parity and fairness • Consider the financial, workforce (including staff wellbeing) and operational implications of potential changes to shift patterns • Examine the effects of different shift patterns on patient safety and care quality
Name of Author & Responsible Manager / Group	Deputy Executive Nurse Director Deputy Director for People Assistant Director of Finance Assistant Director of Finance Assistant Director of Workforce Head of People

Who is involved in undertaking this Equality Impact Assessment & Welsh Language Impact Assessment?	The proposed change (option 2) will impact nursing, midwifery and HCSWs currently working 12.5 hour shifts at former CT sites. It is recognised that the principles may apply to other staff groups and services at a later stage e.g. Administrative and Clerical roles, Ward Receptionists and Ward Clerks, Facilities, Primary & Community (Transformation) and ODP's.
Does the policy impact on any of the areas below *(further info in Section 1 of the guidance notes)* - Eliminating discrimination and/or harassment - Promoting equity of opportunity - Promoting good relationships and positive attitudes	Yes - it promotes equity of opportunity and parity of working conditions by introducing a consistent approach to shift patterns and break structures across our NMR and HCSW communities. The current differential treatment has been an area of staff discontent as staff perceive that it is unfair.

SECTION 2 – Understanding the Potential Impact for Equality, Diversity, Inclusion (EDI)

This section is about understanding where the policy or initiative may have an impact on the different groups identified in the guidance notes attached. This includes the 9 groups identified in the Equality Act 2010 plus an additional 2 areas. To help you complete this please read Section 2 of the guidance notes. Note briefly where the EDI related items could be relevant under '*Summary of potential impact*'.

Summary of potential impact: *(please include brief notes)*

By using 'Option 2' of the paper as the recommendation:

- Equity and parity of working conditions: In the main, staff working at former CT sites (such as Royal Glamorgan Hospital (RGH), Prince Charles Hospital (PCH), Ysbyty Cwm Cynon (YCC), Ysbyty Cwm Rhondda (YCR), Glanrhyd and Pinewood House) take one 30-minute unpaid break, whereas staff who work at Princess of Wales Hospital (POW) take two 30-minute unpaid breaks. The different break structure has implications for the number of additional make-up shifts the staff are required to work, with staff at POW having to work more frequent make-up shifts. The disparity has caused staff dissatisfaction and feelings of unfair treatment.

Implementing a harmonised approach to shift patterns/ breaks structures across CTM would ensure equal working conditions, parity and fairness.

- Impact on Work-Life Balance: Nurses at former CT sites, who have 1 x 30-minute unpaid break and work a 12-hour make-up shift every 8 weeks may enjoy greater flexibility, enhancing their work-life balance. In contrast, nurses at POW have 2 x 30 -minute unpaid breaks and work a 12-hour make-up shift every 4 weeks. By implementing a shift pattern with 2 x 30-minute unpaid breaks as standard, individuals will be required to work the extra make-up shift, which may have a negative impact on work-life balance. However, the POW model affords additional break time during each shift, which could impact positively on work-life balance.

- Flexibility and Staff Mobility: The requirement for additional make-up shifts may have an impact on flexibility, as individuals will need to coordinate additional shifts alongside personal and caring responsibilities. However, the proposal should have a positive impact on staff mobility as we will have a consistent model in place across CTMUHB.

- Consideration for Part-Time Workers: The impact on nurses working less than full-time requires further consideration.

- Age: Different shift patterns and length/ frequency of breaks could disproportionately affect older staff who may find longer shifts more physically demanding. Moving to a model of 2 x 30-minute breaks is likely to have a positive impact, reducing the strain over the shift. However, the requirement for additional make-up shifts will likely have a negative impact. If individuals are unable to work the additional make-up shift, they may decide to request to reduce their working hours. This would likely impact pension and pay and may disproportionately impact those closer to retirement.
- Disability: More frequent/ longer breaks are likely to have a positive impact on ability to effectively manage health conditions, depending on a person's disability. However, the requirement to work an extra make-up shift may have a negative impact, as coming to work and completing an extra shift is an additional strain. Individuals may decide to request to reduce their hours, in order to manage their health effectively, which may have a negative impact on pay and pension.

- Gender reassignment: Individuals undergoing gender reassignment might require more frequent breaks or flexible working patterns to manage medical appointments and recovery. More frequent/ longer breaks are likely to have a positive impact for those recovering or undergoing medical procedures. However, the extra

make-up shift may have a negative impact for similar reasons. Individuals may decide to request to reduce their hours in order to manage their medical needs, which may have a negative impact on pay and pension.

- Pregnancy and maternity: More frequent/ longer breaks are likely to have a positive impact on managing pregnancy health and returning to work following maternity leave. However, the extra make-up shift may have a negative impact, particularly when individuals are trying to balance childcare requirements. Individuals may decide to request to reduce their hours, in order to manage their childcare needs, which may have a negative impact on pay and pension.

- Race: There are no discernible impacts of the proposed change on race. There is a similar proportion of racial diversity across all sites, and so there is neutral impact for all individuals.

- Religion or belief: There is similar religious diversity across the sites. More frequent/ longer breaks are likely to have a positive impact on ability to observe religious practices during work hours. However, the extra make-up shift may have a negative impact. Requirements to observe religious practices during work time are currently managed on a case-by-case basis via adjustments, and this would continue to be the case.

- Sex: There is no gender imbalance in the distribution of staff across different sites. However, affected teams have a high percentage of staff who are women, who are more likely to have childcare responsibilities. The requirement for extra make-up shifts may have a negative impact, particularly to balance childcare requirements.
- Socio-economic status: Staff from lower socio-economic backgrounds might be more affected by the need to work an extra make-up shift, as this may reduce their ability to pick up additional hours or bank shifts.

Now, based on above, select whether your policy or initiative would have a positive, neutral or negative impact on the 11 protected characteristics identified (please note some groups may fall into different groups)

Outcome of impact assessment (put the name of each group in relevant boxes):

Positive impact	Neutral impact	Negative impact
Equity and parity of working conditions Staff mobility	Age Disability Gender reassignment Pregnancy and maternity	Sex Socio-economic status

	Race Religion or belief	

SECTION 3 – Strengthening or mitigating the identified impact for Equality, Diversity, Inclusion (EDI)

This section is about ensuring the policy or initiative is amended where necessary. This will ensure CTM UHB carries out its responsibility under the Public Sector Equality Duty in a way that promotes inclusion and addresses structural inequity. If no action is required (i.e. all groups fall under neutral impact), leave blank.

Consider what actions need to be taken to strengthen any positive impact of your policy/initiative for EDI, or what actions are needed to avoid or mitigate any negative impact. Please seek support from OD&I team where necessary.

Action to be taken	Completion date	Responsible person
Equality of Working Conditions Action: Implement a consistent approach to shift patterns and breaks across all hospitals to ensure equal working conditions and entitlements for our NMR and HCSW communities.	September 2025	People Directorate, plus Care Groups Managers
Impact on Work-Life Balance Action: Standardise break arrangements. Consider offering options for shorter, more frequent breaks to support staff wellbeing. Consider options for implementation of the additional make-up shift to reduce strain on impacted individuals.	September 2025	Corporate Nursing

Support Needed: Work with the OD&I team to develop guidelines that balance operational needs with staff well-being. Flexibility and Staff Mobility Action: Standardise break patterns across all hospitals to improve staff mobility and flexibility by providing consistent employment terms. Consideration for Part-Time Workers Action: Assess the impact of the new policy on part-time workers and consider adjustments to break schedules to accommodate their needs. For all staff with additional break requirements The policy will be alongside reasonable adjustments and existing processes. Diversity Distribution Monitor the diversity make-up of the teams. If there is a disproportionate representation of certain racial groups at different sites, the discrepancy in shift patterns and breaks could indirectly lead to discrimination.	September 2025 September 2025 May 2025 May 2025	Corporate Nursing People Directorate and Corporate Nursing Communications will be developed to confirm current approach Complete

At policy writing, May 2025, this is not currently a risk as the team diversity is not significantly different between sites. Reducing Negative Impact Implementing processes to reduce negative impacts, particularly for sex and socio-economic status. To be reviewed and agreed.	By September 2025	To be further informed via individual consultation approach in Summer 2025

SECTION 4 – Understanding the potential impact for Welsh Language

This section is about understanding where your policy or initiative is relevant to national legislation and CTM UHB's ambition for Welsh. To help you complete this please read Section 3 – *Welsh Language Checklist: What should I consider?* Note briefly where the Welsh language could be relevant under '*Summary of potential impact*'.

Summary of potential impact: *(please include brief notes)*
This is not likely to impact on Welsh language, however it should be noted that Welsh language skills are noted on Allocate Optima, the shift management system.

Now, based on above, select whether your policy or initiative would have a positive, neutral or negative impact on opportunities to use Welsh and not treating Welsh less favourably than English.

Outcome of impact assessment (put 'X' in relevant box):

Positive outcome	Neutral outcome	Negative outcome
	X	

SECTION 5 Strengthening or mitigating the identified impact for Welsh Language

This section is about ensuring the policy or initiative is amended where necessary in relation to Welsh Language This will ensure CTM UHB carries out its business in a way that promotes opportunities to use Welsh and does not treat Welsh less favourably. If no action is required, leave blank.

Consider what actions need to be taken to strengthen any positive impact of your policy/initiative for EDI, or what actions are needed to avoid or mitigate any negative impact. Please seek support from Welsh Language team where necessary.

Action to be taken	Completion date	Responsible person
N/A		

SECTION 6 Governance

Sign off by Responsible Manager/Group	
Date of completion	

(Please send copy to OD&I Team on CTM_Equality@wales.nhs.uk)

Please read this User Guide before completing the Quality Impact Assessment (QIA)

Purpose
The QIA tool enables the adjustment of services to undergo a quality assessment for adjustment of services. The aim of the tool is to identify any potential positive, negative or neutral impacts on quality in relation to the adjustment of services.
Step one - Please complete the QIA tool on tab 2 (Refer to question guidelines below for guidance on how to answer the questions fully).
Step Two - Save assessment in the template provided on tab 2. Sign off - the tool must be considered and signed off by the Care Group Senior Triumvirate Team.
Please contact the Cwm Taf Morgannwg Patient Safety Incident mailbox, email: CTHB_Patient_Safety@wales.nhs.uk

QIA Tool Question Guidelines
Section 1. Provide a brief overview of the proposal.
Complete all boxes wihtin Section 1.
Section 2. Screening Tool.
The screening tool enables all schemes, which have proposed service changes, to undergo an initial quality assessment. The aim of the tool is to identify any potential impacts on quality including positive, negative or neutral. If the score is >8 in any of the categories a full QIA will need to be completed.
Section 3. Provide a brief overview of the proposal.
Explain the purpose of the proposal including the problem, need for adjustment of service, the current situation/circumstances and outline how the model of service delivery will change. Additionally, state any expected results of the proposal including benefits to the patient, service, Care Group or Health Board.
Section 4. Consider how the adjustment of services will be of benefit or, if not adjusted will risk patient safety, experience, clinical
Section 4. Consider how the scheme could be of benefit or risk to patient safety, experience, clinical quality or whole system. Include any mitigations actions which have already been considered if appropriate.
For example,
Safe Care
Questions / Prompts (not exhaustive): • What is the impact on other NHS organisations? • What is the impact on other areas within CTMUHB? • Is there an impact on any aspect of shared risk? • Will the proposed scheme impact on the organisations duty to protect children, young people and adults? • What is the impact on patient safety? • What is the impact on preventable harm? • Will it affect the reliability of safety systems? • How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced? • What is the impact on clinical workforce capability care and skills?
Timely Care
Questions / Prompts (not exhaustive): • What is the impact on the timeliness of people's access to services across CTMUHB? • What is the impact on waiting lists?
Equitable Care
Questions / Prompts (not exhaustive): • Has consideration been given to patients, carers, the public and stakeholder engagement in line with the Welsh Equality Duties including Welsh language? • What is the impact on race, sex, gender reassignment, age, disability, sexual orientation, religion or belief (including those with no belief), marriage or civil partnership and pregnancy/ maternity for individual and community health access to services and experience?
Effective Care
Questions / Prompts (not exhaustive): • What is the impact on implementation of evidence based practice? • What is the impact on leadership? • Does it reduce or have a negative impact on variations in care provision to all groups? • Does it affect supporting staff to stay well/staff experience? • Does it promote self-care for people with long terms conditions? • Does it impact on ensuring that care is delivered in the most clinically and cost effective setting?

Efficient
Questions / Prompts (not exhaustive): • Does it eliminate inefficiency and waste by design? • Does it lead to improvements/deterioration in care pathways? • How else could this be improved?
Person Centred
Questions / Prompts (not exhaustive): • What is the likely impact on self-reported experience of patients and service users? (Response to concerns & feedback from service users). • How will it impact on the patient choice agenda? • Are there any avoidable risks associated with complaints, Clinical Negligence claims, National Reportable Incidents, poor patient and family experiences, or ability of patient to access service? • How will it impact on the compassionate care and personalised care agenda?
Financial Position
Questions / Prompts (not exhaustive): • This should include increases/decreases to variable costs that are not being currently incurred (£):
Section 5. Equality Impact Assessment
Is an Equality Impact Assessment required? If so, an EQIA must be completed.
Section 6. Next Steps
Following completion of the QIA, the proposal for adjusting the service should now be considered and signed off by Service Group Senior Triumvirate Team.
Section 7 . Sign off / Approval
The QIA must be considered and signed off by project lead and the Service Group Senior Triumvirate Team.

CTMUHB
Quality Impact Assessment Tool

1. Care Group	Corporate	Specific Service Area (to be adjusted)	Whole Health Board
		Scheme Savings Value	£ 5m

2. Quality Impact Screening Tool - must be completed

Domains of Quality	Potential / Actual Impact Question	Potential Impacts? Positive (P), Neutral (N), Adverse (A)	Mitigating actions or additional narrative (for use where full QIA not required, <12)	Impact Score	Likelihood Score	Score Likelihood x impact	Score 12 & Above = Full QIA
Safe	Could the proposal impact on any of the following? Impact on serious incidents, their reporting and learning, systems in place to safeguard patients /staff and prevent harm?	**Positive Impact:** Harmonising shift patterns could lead to more consistent reporting and learning from serious incidents across all sites, as staff would work under the same conditions. **Neutral Impact:** The proposal maintains current safety systems and protocols.	The proposal aims to harmonise shift patterns, which could lead to more consistent reporting and learning from serious incidents across all sites. However, there will need to be a process to monitor the impact closely to ensure patient safety is not compromised.	3	2	6	*No*
Safe	Could the proposal impact on staff safety and/or wellbeing?	**Positive Impact:** Standardising shift patterns may reduce perceived inequities and improve staff morale. **Neutral Impact:** The proposal does not introduce new safety measures but maintains existing ones. **Adverse Impact:** may adversely affect staff previously on shorter unpaid breaks by increasing their make-up shifts, potentially leading to reduced flexibility, and perceived inequity, especially among those already reporting burnout and dissatisfaction with current arrangements.	**Mitigating Action:** Introduce mandatory rest breaks and ensure compliance with Working Time Regulations (WTR). Provide access to mental health support and wellbeing programs to help staff manage the demands of longer shifts. **Additional Narrative:** While standardising shift patterns may improve staff morale by addressing perceived inequities, it is essential to ensure that staff have adequate rest and support to prevent burnout and maintain their well-being.	4	4	16	*Yes*
Timely	Could the proposal impact on care being provided in a timely way?	**Positive Impact:** Consistent shift patterns could improve staff availability and reduce delays in care delivery. **Neutral Impact:** The proposal does not directly address the timeliness of care. **Adverse Impact**: Increased staff turnover and sickness due to dissatisfaction with shift patterns could lead to delays in care.	Consistent shift patterns could improve staff availability and reduce delays in care delivery. However, it is important to have a plan in place to address any potential disruptions caused by staff turnover or sickness.	3	2	6	*No*
Effective	Could the service change impact on evidence based practice, clinical standards (NICE/JRCALC), clinical leadership and/or engagement?	**Positive Impact**: Harmonising shift patterns may facilitate better adherence to clinical standards and evidence-based practices by reducing variability in working conditions. **Neutral Impact:** The proposal does not directly address clinical leadership or engagement.	Harmonising shift patterns may facilitate better adherence to clinical standards and evidence-based practices by reducing variability in working conditions. However, it is essential to support staff with continuous professional development to maintain high standards of care.	2	3	6	*No*
Equitable	Could people be treated differently in terms of race, religion, disability, gender, sexual orientation pregnancy, gender reassignment, civil partnerships or age?	**Positive Impact**: Standardising shift patterns across all sites ensures fairness and equity among staff, reducing perceived disparities.	Standardising shift patterns across all sites ensures fairness and equity among staff, reducing perceived disparities. It is important to monitor the impact to ensure no unintended biases are introduced.	3	3	9	*No*
Person Centred	Could the proposal impact on patient choice, dignity and respect, service user experience? Could the proposal impact on eliminating discrimination, on eliminating harassment and or on promoting good community relations /positive attitudes?	**Positive Impact:** Consistent shift patterns may improve patient experience by ensuring more reliable and consistent care. **Neutral Impact:** The proposal does not directly address patient choice or dignity.	Consistent shift patterns may improve patient experience by ensuring more reliable and consistent care. However, it is important to actively engage with patients to ensure their needs and preferences are met.	3	2	6	*No*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

Staffing & Resources	Could the proposal impact on staff satisfaction, retention and recruitment, staff sickness and or public perception of the Trust or its services?	**Positive Impact**: Harmonising shift patterns could improve staff satisfaction by addressing perceived inequities. **Neutral Impact:** The proposal does not introduce new recruitment or retention strategies. **Adverse Impact:** A change to the shift pattern due to break structure could lead to increased staff sickness, turnover, and reliance on temporary staff, negatively impacting public perception. May require a significant consultation process across approximately 3,000 staff, demanding substantial workforce and management resources to coordinate engagement, manage rostering changes, all of which may strain existing capacity and delay other priorities.	Harmonising shift patterns could improve staff satisfaction by addressing perceived inequities. However, it is important to support staff through the transition and address any concerns to prevent increased sickness and turnover.	4	4	16	*Yes*
Summary rating = highest individual risk score **If the highest individual score is >12, please complete the Full QIA below**							16

3. Provide a brief overview of the service to be adjusted:

The proposal to standardise break structures for 12.5-hour shifts across all sites within Cwm Taf Morgannwg University Health Board (CTM UHB) involves moving to two 30-minute unpaid breaks. This change aims to address perceived inequities, particularly at Princess of Wales Hospital (POW), where staff currently take two 30-minute breaks and work more frequent make-up shifts compared to other sites. Implementing this change could have several benefits, including improved staff wellbeing and consistent patient care. However, it is essential to ensure mandatory rest breaks, provide well-being support, and closely monitor the impact on patient safety and staff satisfaction. Engaging with staff and stakeholders throughout the implementation process will be crucial to address concerns and ensure a smooth transition.

4. Full QIA

4.1. QIA Duty of Quality Standards Domain: SAFE CARE

Questions / Prompts (not exhaustive):
- **What is the impact on other NHS organisations?**
- **What is the impact on other areas within CTMUHB?**
- **Is there an impact on any aspect of shared risk?**
- **Will the proposed scheme impact on the organisations duty to protect children, young people and adults?**
- **What is the impact on patient safety?**
- **What is the impact on preventable harm?**
- **Will it affect the reliability of safety systems?**
- **How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced?**
- **What is the impact on clinical workforce capability care and skills?**

Brief Description & Actual / Potential Adverse Impacts:	**While implementing Option 2 will require a large-scale consultation and significant workforce coordination, it presents an opportunity to standardise shift patterns across CTMUHB, which may enhance consistency in care delivery and reduce variability in staffing models. With appropriate planning and support, the change can strengthen safety systems by ensuring equitable break structures that exceed minimum regulatory standards, potentially reducing fatigue-related errors. Ongoing monitoring and engagement will be essential to mitigate transitional pressures and maintain clinical capability and patient safety standards.**
Benefits :	Implementing Option 2 offers a consistent and standardised shift pattern across CTMUHB, addressing long-standing break structures and make-up shifts inequities. It aligns with Working Time Regulations by providing enhanced rest periods, which may support reduced fatigue and improved staff wellbeing when breaks are taken as intended. Financially, it delivers significant cost savings—estimated at £5 million annually—and reduces workforce requirements by approximately 105 WTE, easing staffing pressures in the long term. Operationally, it simplifies rostering and supports a unified approach to workforce planning, while also creating opportunities to embed training and development into make-up shifts, enhancing staff capability and retention.

Risk:	Implementing Option 2 carries several risks, particularly during the transition phase. The scale of change—impacting around 3,000 staff—requires extensive consultation, rostering adjustments, and pay protection coordination, all of which demand significant staffing and management resources. There is potential for disengagement among staff required to work more frequent make-up shifts, especially those previously on shorter unpaid breaks, which could affect morale, retention, and service continuity. If not carefully managed, these pressures may temporarily strain workforce capacity and increase reliance on temporary staffing, with knock-on effects for operational stability and patient care delivery.	
Current Risk Score (No Mitigations):	**16**	**HIGH**
Mitigation being taken:	To mitigate the risks associated with implementing Option 2, CTMUHB will undertake a structured and inclusive consultation process, supported by a detailed implementation plan and clear communication strategy. Workforce and management teams will be resourced to provide guidance on rostering, pay protection, and staff engagement. Regular monitoring of staff wellbeing, patient safety indicators, and service continuity will be established to identify and address emerging issues early. Additionally, opportunities to incorporate training and development into make-up shifts will help maintain morale and support professional growth during the transition.	
Mitigated Target Risk Score:	**12**	**MODERATE**

4.2. QIA Duty of Quality Standards Domain: TIMELY CARE		
Questions / Prompts (not exhaustive): **• What is the impact on the timeliness of people's access to services across CTMUHB?** **• What is the impact on waiting lists?**		
.	**The implementation of Option 2 has the potential to positively impact timely care by introducing consistent shift patterns across CTMUHB, which may improve workforce planning, reduce variability in staffing, and enhance continuity of care. However, during the transition period, there is a risk that increased dissatisfaction among staff, particularly those required to work more frequent make-up shifts, could lead to higher turnover or sickness absence. This may temporarily reduce staff availability and delay access to services in some areas. Careful implementation, supported by robust workforce planning and engagement, will be essential to minimise disruption and maintain timely care delivery.**	
Benefits :	Option 2 could improve timely care by standardising shift patterns across CTMUHB, enabling more consistent staffing levels and simplifying roster planning. This consistency may reduce delays in care delivery by improving staff availability and reducing variability across sites. Additionally, embedding development opportunities into make-up shifts could enhance workforce capability, supporting more responsive and efficient patient care.	
Risk:	While Option 2 aims to standardise shift patterns, there is a risk that increased dissatisfaction among staff, particularly those required to work more frequent make-up shifts, could lead to higher turnover, reduced morale, or increased sickness absence. These factors may temporarily reduce staff availability, placing pressure on rosters and potentially leading to delays in care delivery. If not carefully managed, this could impact the timeliness of access to services across CTMUHB, particularly in areas already experiencing workforce challenges.	
Current Risk Score (No Mitigations):	**6**	**LOW**
Mitigation being taken:		
Mitigated Target Risk Score:	**6**	**LOW**

4.3. QIA Duty of Quality Standards Domain: EQUITABLE CARE		
Questions / Prompts (not exhaustive): **• Has consideration been given to patients, carers, the public and stakeholder engagement in line with the Welsh Equality Duties including Welsh language?** **• What is the impact on race, sex, gender reassignment, age, disability, sexual orientation, religion or belief (including those with no belief), marriage or civil partnership and pregnancy/ maternity for individual and community health access to services and experience?**		
Brief Description & Actual / Potential Adverse Impacts:	**While Option 2 promotes fairness through standardised shift patterns, it may adversely affect equity if not carefully implemented. Staff with disabilities, caring responsibilities, or health conditions may find increased make-up shifts harder to manage, potentially impacting their work-life balance and access to development opportunities. Without appropriate support and flexibility, this could unintentionally disadvantage certain groups and affect their experience within the organisation.**	
Benefits :	Standardising shift patterns under Option 2 promotes fairness by ensuring all staff across CTMUHB operate under the same break and make-up shift structure, reducing long-standing disparities between sites. This consistency supports a more transparent and equitable working	

	environment, helping to address perceptions of inequality and fostering a stronger sense of inclusion. When implemented with flexibility and support, it can improve access to development opportunities and work-life balance for all staff, contributing to a more equitable experience across protected characteristics.		
Risk:	While Option 2 aims to promote fairness, there is a risk it may disproportionately affect staff with protected characteristics, such as those with disabilities, caring responsibilities, or pregnancy, who may find increased make-up shifts or longer unpaid breaks more challenging to manage. Without flexible implementation and reasonable adjustments, this could impact their ability to maintain work-life balance, reduce access to development opportunities, and lead to perceptions of exclusion, ultimately affecting equity in staff experience and retention.		
Current Risk Score (No Mitigations):	**9**	**MODERATE**	
Mitigation / Monitoring being taken:	To mitigate equity risks, CTMUHB will ensure inclusive consultation with staff and trade unions, with particular attention to the needs of those with protected characteristics. Flexible rostering, reasonable adjustments, and clear guidance on managing make-up shifts will be prioritised to support staff with caring responsibilities, disabilities, or health conditions. Monitoring will include regular reviews of workforce data, feedback mechanisms, and equality impact assessments to identify and address any unintended disparities in staff experience, retention, or access to development opportunities.		
Mitigated Target Risk Score:	**6**	**LOW**	

4.4. QIA Duty of Quality Standards Domain: EFFECTIVE CARE

Questions / Prompts (not exhaustive):
- **What is the impact on implementation of evidence based practice?**
- **What is the impact on leadership?**
- **Does it reduce or have a negative impact on variations in care provision to all groups?**
- **Does it affect supporting staff to stay well/staff experience?**
- **Does it promote self-care for people with long terms conditions?**
- **Does it impact on ensuring that care is delivered in the most clinically and cost effective setting?**

Brief Description & Actual / Potential Adverse Impacts:	**While Option 2 may support consistency in shift patterns, there is a potential adverse impact on effective care if staff experience reduced morale due to more frequent make-up shifts. This could affect engagement with evidence-based practice, reduce time for reflective learning, and limit participation in training or leadership development. If not carefully managed, these factors may contribute to variation in care delivery and reduce the capacity of staff to maintain high standards, particularly in high-pressure or complex clinical environments.**		
Benefits :	Option 2 supports more effective care by harmonising shift patterns, which can reduce variability in working conditions and promote more consistent adherence to clinical standards and evidence-based practice. Standardisation may also improve coordination across teams and sites, enhancing continuity of care. Additionally, embedding development opportunities into make-up shifts can strengthen clinical capability and support staff to maintain high standards of care delivery.		
Risk:	Option 2 may pose risks to effective care if increased make-up shifts and longer unpaid breaks lead to reduced morale or disengagement. These factors could limit participation in training, reflective practice, and leadership development, potentially affecting the consistent application of evidence-based care. If not carefully managed, this may result in variation in care quality and reduced capacity to deliver services in the most clinically and cost-effective way.		
Current Risk Score (No Mitigations):	**6**	**LOW**	
Mitigation / Monitoring being taken:	To mitigate risks to effective care, CTMUHB will embed training and development opportunities into make-up shifts to maintain clinical capability and support evidence-based practice. Leadership teams will monitor staff wellbeing, engagement, and turnover to identify early signs of fatigue or disengagement. Regular audits and feedback loops will ensure care quality remains consistent, and any variation in practice or service delivery is addressed promptly. This approach will help sustain high standards while supporting staff through the transition.		
Mitigated Target Risk Score:	**3**	**LOW**	

4.5. QIA Duty of Quality Standards Domain: EFFICIENT

Questions / Prompts (not exhaustive):
- **Does it eliminate inefficiency and waste by design?**
- **Does it lead to improvements/deterioration in care pathways?**
- **How else could this be improved?**

Brief Description & Actual / Potential Adverse Impacts:	**Option 2 has the potential to improve efficiency by standardising shift patterns across CTMUHB, reducing variation in rostering, and enabling more predictable workforce planning. This consistency may help eliminate inefficiencies linked to inconsistent break structures and make-up shift requirements, supporting smoother care pathways and better use of resources. However, the scale of implementation poses short-term risks, including disruption to staffing models, increased demand on management capacity, and potential disengagement if staff feel the change is driven by cost-saving rather than service improvement. Careful planning, clear communication, and ongoing monitoring will be essential to ensure the efficiency gains are realised without compromising staff experience or care delivery.**		
Benefits :	Option 2 supports greater efficiency by standardising shift patterns across CTMUHB, reducing variation in rostering and simplifying workforce planning. This consistency can help eliminate duplication, streamline scheduling, and reduce administrative burden. The model also enables better alignment of staffing to service demand, potentially improving care flow and resource utilisation. Additionally, the projected cost savings and reduced WTE requirement contribute to a more sustainable and cost-effective workforce model.		
Risk:	While Option 2 is designed to streamline shift patterns and reduce costs, its implementation carries short-term efficiency risks. The scale of change—impacting around 3,000 staff—requires significant management and administrative resources, which may temporarily divert attention from other priorities. If not carefully managed, the transition could lead to rostering challenges, increased reliance on temporary staffing, and reduced flexibility for staff with specific needs. These factors may disrupt service flow and offset some of the intended efficiency gains during the initial implementation phase.		
Current Risk Score (No Mitigations):	**16**	**HIGH**	
Mitigation / Monitoring being taken:	To manage the efficiency risks of implementing Option 2, CTMUHB will adopt a phased and well-resourced implementation plan, supported by clear communication and engagement with staff and trade unions. Dedicated workforce and management teams will oversee rostering changes, pay protection, and consultation processes to minimise disruption. Monitoring will include regular reviews of staffing levels, sickness absence, and temporary staffing reliance to ensure early identification of pressure points. Adjustments will be made as needed to maintain service continuity and protect public confidence during the transition.		
Mitigated Target Risk Score:	**9**	**MODERATE**	

4.6. QIA Duty of Quality Standards Domain: PERSON CENTRED

Questions / Prompts (not exhaustive):

- **What is the likely impact on self-reported experience of patients and service users? (Response to concerns & feedback from service users).**
- **How will it impact on the patient choice agenda?**
- **Are there any avoidable risks associated with complaints, Clinical Negligence claims, National Reportable Incidents, poor patient and family experiences, or ability of patient to access service?**
- **How will it impact on the compassionate care and personalised care agenda?**

Brief Description & Actual / Potential Adverse Impacts:	**While Option 2 aims to improve consistency in staffing, there is a potential adverse impact on person-centred care if staff experience increased fatigue or reduced morale due to more frequent make-up shifts. This could affect the quality of interactions with patients, responsiveness to concerns, and the ability to deliver compassionate, personalised care consistently. If staff are overstretched or disengaged, there may also be a higher risk of complaints or negative experiences, particularly in high-demand areas where continuity and attentiveness are critical to patient satisfaction.**		
Benefits :	Option 2 may enhance person-centred care by promoting more consistent staffing across CTMUHB, which can improve continuity, reliability, and responsiveness in patient interactions. Standardised shift patterns may reduce variability in care delivery, helping staff to better anticipate and meet individual patient needs. With improved predictability in workforce planning, staff may be better supported to deliver compassionate, personalised care, contributing to a more positive experience for patients and their families.		
Risk:	Option 2 may pose risks to person-centred care if increased make-up shifts lead to reduced morale, potentially affecting the quality of patient interactions and responsiveness to individual needs. If staff feel overstretched or disengaged, there may be a decline in compassionate care, increased complaints, or reduced ability to personalise care, particularly in high-pressure settings where continuity and attentiveness are essential to patient experience.		
Current Risk Score (No Mitigations):	**6**	**LOW**	
Mitigation / Monitoring being taken:	To mitigate risks to person-centred care, CTMUHB will ensure that implementation of Option 2 is supported by clear communication, staff engagement, and leadership visibility to maintain morale and compassion in care delivery. Monitoring will include patient feedback, complaints data, and staff experience surveys to identify any decline in personalised or responsive care. Where concerns arise, targeted support and adjustments to rostering or staffing models will be considered to protect the quality of patient interactions and uphold the principles of compassionate, person-centred care.		
Mitigated Target Risk Score:	**6**	**LOW**	

4.7. Impact on FINANCIAL POSITION:			
Questions / Prompts (not exhaustive): **• This should include increases/decreases to variable costs that are not being currently incurred (£):**			
Brief Description & Actual / Potential Adverse Impacts:	**Financially, this would reduce costs by approximately £5 million annually and require 105 fewer WTE posts, but it may trigger short-term pay protection for staff currently on different shift patterns, potentially impacting budgets in 2025/26 and 2026/27. While the change aligns with Working Time Regulations and could improve rest opportunities, it may also lead to increased make-up shifts, staff dissatisfaction, and potential claims for unpaid work if breaks are not consistently taken, posing longer-term financial and operational risks.**		
Benefits :	Option 2 offers significant financial benefits by standardising all Nursing and Midwifery and HCSW staff across CTM UHB to a 12.5-hour shift with two 30-minute unpaid breaks, resulting in an estimated annual cost saving of approximately £5 million. This is primarily due to a reduction in paid hours per shift, which would allow the Health Board to decrease its staffing requirement by around 105 whole-time equivalents (WTEs). These savings could help alleviate budgetary pressures and improve financial sustainability, particularly if managed alongside natural staff turnover and vacancy management strategies to minimise disruption.		
Risk:	Option 2 carries several financial risks despite its projected cost savings. The shift to a 12.5-hour day with two unpaid 30-minute breaks may trigger short-term pay protection obligations for staff currently on different patterns, potentially impacting budgets across two financial years. There is also a risk that staff unable to take the full 60-minute break due to workload pressures consistently may claim for unpaid work, increasing costs over time. Additionally, the increased frequency of make-up shifts could lead to dissatisfaction, higher turnover, and sickness absence, which may drive up reliance on bank and agency staff, undermining the anticipated savings and placing further strain on financial resources.		
Current Risk Score (No Mitigations):	**6**	**LOW**	
Mitigation / Monitoring being taken:	A formal consultation process will be undertaken with staff, trade unions, and professional bodies, ensuring transparency and engagement throughout the transition. A three-month lead-in period is planned to allow for adjustments to rostering and pay protection arrangements, with all changes implemented simultaneously across the Health Board to maintain consistency. Corporate Nursing will lead ongoing work to incorporate training and development into make-up shifts, supporting staff development and retention. Additionally, the impact on staff wellbeing, patient safety, and operational delivery will be closely monitored, with a clear communication strategy in place to manage internal and external messaging and reduce the risk of disengagement or industrial action.		
Mitigated Target Risk Score:	**4**	**LOW**	

Proposed date of service adjustment:	
dd/mm/yyyy	**Sep-25**
dd/mm/yyyy	

5. Equality Impact Assessment (EQIA)		
Is an EQIA assessment required? YES		**If YES, please complete an EQIA.**

6. Next steps		
Following completion of the QIA, the proposal for adjusting the service should now be considered and signed off by Service Group Senior Triumvirate Team.		
Decision:	Next steps:	The decision to proceed with Option 2—standardising Nursing and Midwifery and HCSW shift patterns to a 12.5-hour day with two 30-minute unpaid breaks—has been discussed and endorsed by both the Executive Leadership Group and the Operational Delivery Committee. The accompanying Quality Impact Assessment (QIA) and Equality and Welsh Language Impact Assessment (EIA) are now being submitted to the Public Board for formal discussion and a final decision.
Select option		

7. Approval	**Signature**	**Date**
Service Leads (clinical and operational)		
Care Group Director		

Care Group Nurse Director	#UNKNOWN!	21/05/2025
Care Group Medical Director		

Agenda Item
4.1

CTM Health Board

CHAIR'S REPORT

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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	Choose an item. Jonathan Morgan, Chair

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum 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 CTMUHB. 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. The report also highlights topical areas of interest to the Board.

2. Specific Matters for Consideration

2.1 Chair Update

2.1.1 Over the past 6 months our teams have been responding to a range of significant challenges managing our services whilst replacing the roof at the Princess of Wales Hospital in Bridgend, advancing the work around Llantrisant Health Park, and doing all possible to meet the 104-week waiting time target. All our staff have been amazing in driving the improvements in performance we have secured in difficult circumstances and I have been impressed with the collective effort of our staff.

2.1.2 During April the Cabinet Secretary for Health and Social Care held two events to set out his ambition for the NHS over the next 12 months and his response to the report of the Ministerial Advisory Group on Performance and Productivity. Both events set out a range of ambitions and actions for the NHS and Welsh Government to address the performance of the service.

2.1.3 Whilst we are naturally focussed on the potential for large scale transformation and improvement ensuring we maximise the outcomes for people, better use of our resources, and improving the effectiveness of what we deliver, there will always be room for addressing productivity and inefficiency, sometimes on a smaller scale. We have seen evidence of this in service areas where smaller changes have improved what we do and how we do it. It will be important for us to keep this in our minds as we address the key recommendations in the independent report. The CEO and I have already discussed undertaking a gap analysis to assess how we are able to meet what the report sets out.

2.1.4 Performance improvement is also a focus of our regional working with our neighbouring Health Boards and will move into a new super charged phase before the end of the year. On 2 April, the Cabinet Secretary wrote to the Chairs of Aneurin Bevan UHB, Cardiff and Vale UHB and me directing us to establish a Joint Regional Committee to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working. I have covered this in a report to today's Board for discussion.

2.2 Independent Member Update

2.2.1 I can confirm that Ian Wells, Independent Member Term of office ended on the 7th May 2025. Ian was an Independent Member for CTMUHB for a period of 6 years. I would like to formally thank Ian for his support and commitment to the Board and the digital agenda.

2.2.2 The recruitment process for the Independent Member, Digital is underway with interviews planned for the 4th June 2025.

2.2.3 I would like to extend a warm welcome to Neil Mesher who is attending his first Board meeting as our new Independent Member.

2.3 Aspiring Board Member Update

2.3.1 I am delighted to confirm that CTMUHB has been successful in receiving a Board placement from the Aspiring Board Members Programme. We are working with the 'Leadership Development and Delivery Manager – Culture & Inclusion' lead within Welsh Government to help support their induction with us and Gareth and I are meeting with the individual on 3rd June.

2.3.2 As Chair I wanted to lead this initiative by acting as a mentor for the individual who will be with us and I am very much looking forward to providing further updates to the Board on this exciting development in due course and look forward to welcoming our new colleague to the Board in the coming months.

2.4 Associate Board Member Update

2.4.1 I can confirm that Cllr Paul Deenik commenced his role as Associate Member on the 1st May 2025. Paul joined us at our Board Development session on the 15th May and I would now like to welcome Paul to his first public Board meeting with Cwm Taf Morgannwg UHB.

2.5 Board Development Session – 15 May 2025

2.5.1 The Board Development in May focussed entirely on Strategic Risk and covered the following key areas:

- Strategic Risk
- Setting the Risk Appetite for the next 12 months
- Review of the Risk Escalation Threshold
- Annual Review of Risk Management Strategy

2.5 Diary Commitments

- Local Authority Leaders/Chair/CEO Meeting

- Independent Members/Chair/CEO Meeting
- 1:1 Chief Executive
- 1:1 Director of Governance
- Chair Peer Group Meeting
- Leadership Group
- CTMUHB Public Board Meeting and In Committee Board Meeting
- Quarterly / End of Year Review
- Meeting with Mick Antoniw MS
- Chair / Vice Chair Visit to Platform YP Hangout
- Digital Healthcare Together Webinar
- Cabinet Secretary Priorities Meeting
- Meeting with David Rees MS
- Maesteg Engagement Meeting
- CTM Community Leaders' Network
- Meeting with Marcus Longley
- Meeting with Geoff Lloyd
- Cabinet Secretary Event following publication of Ministerial Group Report on NHS Wales Performance and Productivity
- International Day of Midwives Awards
- Meeting CTMUHB and Bridgend County Borough Council
- Shortlisting for Independent Member post
- Staff Q&A
- Meeting with Bridgend County Borough Councillors and Town Councillors
- Opening of New Clinical Unit - Meadow Lodge
- Introductory meeting with Paul Deenik, Associate Member
- Catch up meeting with Kath Palmer – Vice Chair

2.6 Meetings / discussions with Local Politicians

- MS/MP monthly meetings with Chair/CEO

3. Key Risks / Matters for Escalation

3.1 COMMON SEAL

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

- Minor Works Building Contract between Cwm Taf Morgannwg University Health Board and KS Barry (Plumbing & Heating) Limited whose Registered Office is at The Old Courtyard, 8A Kingston Road, Cardiff, CF11 6HU - relating to Phase 3 Domestic Hot Water Services Plan Upgrade at Rhymney Block, Prince Charles Hospital, Merthyr Tydfil.
- Minor Works Building Contract between Cwm Taf Morgannwg University Health Board and Highland Electrix (Bridgend) Ltd whose Registered Office is at 1a Attlee Street, Brynmenyn Industrial Estate, Brynmenyn, Bridgend, CF32 9TQ - relating to the electrical periodic testing of existing distribution boards at Prince Charles Hospital.

- Intermediate Building Contract between Cwm Taf Morgannwg University Health Board and Technical Facilities Management Limited whose Registered Office is at The Shard, Level 12, 32 London Bridge Street, Soutwark, London, SE1 9SG - relating to air handling unit replacement at maternity services, Princess of Wales Hospital, Bridgend.
- Minor Works Building Contract between Cwm Taf Morgannwg University Health Board and 2D Building Contractors Ltd whose Registered Office, Unit 19b, Ely Valley Business Park, Pontyclun, CF72 9DZ relating to The Hub – automated doors and DDA access
- Minor Works Building Contract between Cwm Taf Morgannwg University Health Board and Mitie Technical Facilities Management Limited, Level 12 The Shard, 32 London Bridge Street, London, SE1 9SG - respect of air conditioning upgrade at Royal Glamorgan Hospital, Ground Floor and First Floors.

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

3.2 Chairs Urgent Action – Regional Endoscopy Plan

3.2.1 Under Chairs Urgent Action, issued via email on the 14 April 2025, the Board were asked to approve the final version of the Regional Endoscopy Plan. Board Members were reminded that the Regional Endoscopy Plan was originally presented to the Board for approval in March 2025, where it was agreed that final approval of the plan would be undertaken via Chairs Urgent Action once final updates had been made. The Board resolved to APPROVE the Regional Endoscopy Plan

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	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))*	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: 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.
- RATIFY the Affixing of the Common Seal as captured in section 3.1
- RATIFY the Chairs Urgent Action

Agenda Item
4.2

CTM Health Board

CHIEF EXECUTIVE'S REPORT

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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	
CAMHS	Child and Adolescent Mental Health Services
IQPD	Integrated Quality, Performance and Delivery
IRCP	Integration and Rebalancing Care Fund
JET	Joint Executive Team
MAG	Ministerial Advisory Group
PD	Parkinson's Disease
SCP	Single Cancer Pathway
YCC	Ysbyty Cwm Cynon

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

Earlier this month, CTM joined Welsh Government colleagues for our end of year Joint Executive Team (JET) meeting which extended to include the quarterly review of progress against the escalation framework. This framework, last reported through Board in May 2024, is currently being updated to reflect the positive de-escalation changes we saw to our status earlier this year. Once the final 2025/26 version has been received, I will share this with the Board via a briefing session.

As a reminder, Child and Adolescent Mental Health Services (CAMHS) is now out of any form of escalation and has returned to 'routine arrangements'. Planned care and cancer were both de-escalated to 'enhanced monitoring'. Our complete status is summarised in the table below:

Area	Escalation Status
Planning and Finance	Enhanced Monitoring
Performance: Planned Care	Enhanced Monitoring
Performance: Cancer	Enhanced Monitoring
Performance: Urgent and Emergency Care	Targeted Intervention

For this year, the key focus areas and framework criteria for improving our waiting times are summarised in the below table:

Area	Improvement Priority
Planned Care	• Deliver the Welsh Government ambition of zero patients waiting in excess of 104 weeks from referral to treatment.

	• Provide outpatient appointments within 26 weeks for 75% of patients, and within 52 weeks for 100% of patients. • Ensure maximum wait time for diagnostic imaging and endoscopy does not exceed 8 weeks
Cancer	• Ensure >63% compliance with the Single Cancer Pathway measure (point of suspicion to receiving first definitive treatment within 62 days). • Link to above diagnostics – 8 weeks maximum wait time
Urgent and Emergency Care	• Ambulance conveyed patients completing handover to emergency departments within one hour of arriving at a hospital site. • Ensure maximum patient wait time from arrival at an emergency department for treatment, admission or discharge does not exceed 12 hours.

In line with the escalation framework, our performance improvement programme of work for planned care and cancer will continue to be monitored via monthly Integrated Quality, Performance and Delivery (IQPD) meetings, and urgent and emergency care will be the sole focus of the oversight meetings with Welsh Government colleagues.

2.2 Ministerial Advisory Group report

On 1 October 2024, the Cabinet Secretary for Health and Social Care announced the appointment of an external independent Ministerial Advisory Group (MAG) to report on Performance and Productivity in NHS Wales. The specific focus of the work examines performance and productivity within the clinical service areas of planned care, diagnostics, cancer and urgent and emergency care.

CTM hosted a half-day visit to the Royal Glamorgan Hospital site in January of this year, to facilitate a series of clinical tours and discussion workshops with senior members of our clinical and operational management teams.

The final report, issued April 2025 (attached as Appendix 1), details 29 recommendations. 18 of these recommendations have been accepted in full, with a further 11 having been accepted in part, as set out in the Welsh Government response to MAG (Appendix 2).

Gareth Watts, Director of Corporate Governance and Board Secretary, is currently undertaking a piece of work to align the Ministerial priorities, MAG recommendations, and the 2025/26 accountability conditions (pending receipt from Welsh Government) into a single document for the Board to review in July. This will help steer and concentrate efforts alongside our key strategic work plan for this year.

2.3 Cabinet Secretary Priorities for 2025/26

The Chairman, members of the executive team and I attended a session with the Cabinet Secretary for Health and Social Care on the 7th April where he set out his headline priorities for this year. These are:

- Prevention
- Primary Care and Community Services
- Digital
- Regional Working
- Developing leadership and the wider workforce

There were helpful discussions at the session with colleagues about how the NHS system would deliver these priority areas in collaboration with Welsh Government and we expect to see further elaboration of these priorities and the MAG recommendations from the Cabinet Secretary shortly.

There was a clear message at this session of the delivery expectations that the Cabinet Secretary places on the NHS to deliver our commitments as well as the priorities he has set out. As mentioned above, we are undertaking an assessment of where we as a Health Board are against these priority areas and this will be shared with Board colleagues shortly.

2.4 Maesteg Hospital Redevelopment Programme

As a Health Board, we are working hard to develop a Health and Wellbeing Centre project that includes health, local authority and third sector services that meet the needs of the Llynfi Valley, considering feedback we received from our staff and the community at our engagement events held in January and May 2023.

Earlier this month we held a number of briefing sessions with staff, local councillors and the League of Friends to update them on the current position of the project and the options being explored to deliver more healthcare services in Maesteg. We were able to explain the challenges of providing this range of services on the hospital site, given the particular challenges of the location and the layout of the site as well as the need for any new development to meet modern healthcare building standards.

Currently the resources allocated to this project from the Rebalancing Care and Support capital fund would not enable us to provide the range of services we would like to see delivered at the hospital site.

We have spent a significant amount of time and effort with Kier Construction and other partners considering a range of options for redeveloping Maesteg Community Hospital for the anticipated budget that enables us to deliver the identified much-needed services, but no option can be delivered without significantly impacting the services we can deliver. This has included reviewing alternative sites in Maesteg that could offer the potential to deliver the services required within the available capital funds. Through engagement with Bridgend County Borough Council, we have identified another site within the Llynfi Valley, close to Maesteg Town Centre, that could potentially meet the health and wellbeing needs of the community, and this is being evaluated by our construction partner as to the feasibility to inform an options appraisal of the way forward.

We will provide a further update to the board when we have the feasibility and options appraisal completed.

2.5 Digital Summit

The Minister for Mental Health and Wellbeing recently chaired a Digital Summit bringing together NHS organisations and Welsh Government to discuss the priorities for digital in the NHS in Wales. CTM was asked to present with colleagues from Betsi Cadwalladr UHB on the process we are currently undertaking to procure an Electronic Health Record for Mental Health services which was positively received. The Minister set out her digital priorities which are:

- NHS Wales app
- Digital Maternity
- National data architecture
- Mental Health
- Electronic Prescribing & Medicines Administration

2.6 Seren awards

I've been pleased to present two further Seren of the Month Awards since my last report to the Board.

The February 2025 Seren of the Month Winner was Anthony Hughes, Deputy Locality Manager - Primary Care and Communities. Anthony was nominated by the YCC Nursing and Management team for the work he has been doing to enhance patient experience at Ysbyty Cwm Cynon hospital.

His colleagues said:

"*Over the last few months Anthony has been going above and beyond to enhance the patients experience whilst they are in YCC hospital. Anthony has arranged for a local hairdresser to attend site and has set up a robust process for ensuing this in line with health and safety guidelines. In addition to this Anthony has worked with our local authority colleagues to arrange on site music therapy. This is not only for the visitors, patients and staff who attend YCC but also for the patients on the wards where the days can be very long.*

The benefits and impact that the music therapy has had and will continue to have on the patients is visible for all to see. We can't thank you enough for going the extra mile for all the patients and bringing some joy back into their lives. As our patients say it's the small, kind gestures that matter and have the biggest impact. Anthony, you have made that difference, we are so grateful for the time, commitment and innovative ideas that you bring to our team. You are amazing!"

The March 2025 Seren of the Month Winner was Dr James Bolt, Consultant Geriatrician. Dr Bolt was nominated for the incredible work he is doing to care for patients with Parkinson's Disease.

His colleagues said:

"*I would like to nominate Dr James Bolt for his care to the Parkinsons Patients. He goes above and beyond in his everyday care of these patients. He is completely dedicated to this group of patients. He has worked so hard, to introduce pump therapies to the HB, for patients who have advanced Parkinsons and this has been a huge success. The difference that his care has made to these patients is overwhelming and completely life changing. He was the first doctor in Wales to introduce this therapy, ensuring that CTMUHB was the first HB in Wales to offer the treatment to PD Patients. He is the most dedicated, professional, and hard-working consultant. He dedicates his own time to the care of these patients, often giving up his days off and his annual leave to undertake patient care. He has time for everyone. The feedback from his patients is truly amazing and the respect that they have for him is enormous. His input into patient care has significantly contributed to the HB success, and we are beyond lucky to have him as a colleague*."

I congratulate Anthony and Dr Bolt on their awards and thank them for their contributions to our organisation.

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:
	Not Applicable

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)*	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: 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):	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.

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

A report from the Ministerial Advisory Group on NHS Wales Performance and Productivity

April 2025

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

Report by the External Ministerial Advisory Group on NHS Wales Performance and Productivity

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Foreword

Dear Cabinet Secretary for Health and Social Care,

It gives me great pleasure to present the final report of the Ministerial Advisory Group (MAG) on improving the performance and productivity of NHS Wales in planned care, diagnostics, cancer and urgent and emergency care services.

As Chair of the MAG, I have endeavoured to ensure that the Group has adhered strictly to its terms of reference and not over-reached into other areas. This has been a challenge given that there is at best a blurred boundary between these services and, for example, local authority education and housing services or the full range of NHS primary care or mental health services.

As such, I will use the opportunity of this foreword to make some general reflections on the health and health services of Wales before signposting yourself and other readers through the rest of the document.

My first and most important reflection is that Wales should aspire to have the leading healthcare system in the world.

Wales has an excellent strategy in the 2018 'A Healthier Wales: Our Plan for Health and Social Care,'[1] and the health boards and the associated integrated care philosophy are a sound building block for achieving the Institute for Healthcare Improvement (IHI) triple aim[2] of improving the health of the population, improving patients' experience of care, and providing value for taxpayers' money by continuously reducing the cost of health care delivery.

Nonetheless, Wales starts from a challenging position.

On health, the Wellbeing of Wales report of 2024[3] shines a light on the structural health issues of the population in terms of its age profile, its geographical profile and its comparatively high levels of morbidity and mortality and reducing life expectancy compared with 2011/13. And health inequalities persist and worsen. Within the NHS itself waiting lists are at historically high levels and the service faces a very challenging financial position on both revenue and capital.

This is the starting point for our findings and recommendations on improving the experience of care and value for taxpayers' money across the four areas within the remit of our terms of reference.

In summary, it is the MAG's view that the operational performance of these core NHS services is in need of urgent attention and turnaround. This will require a new focus for leadership across the Welsh health care system away from the creation of the further strategy, policy and targets and towards a relentless focus on the delivery of existing

[1] A healthier Wales: long term plan for health and social care | GOV.WALES
[2] Improvement Area: Triple Aim and Population Health | Institute for Healthcare Improvement
[3] Wellbeing of Wales, 2024 [HTML] | GOV.WALES

performance and productivity commitments. Unless this is done there is a high risk that the incidence of patient harm will increase and that value for taxpayers' money will decrease.

The detailed recommendations are addressed throughout the body of this document and are listed in the Executive Summary. There is little that we recommend that could be described as new or radical and almost all of the core content of our recommendations features somewhere in the existing policy and planning framework. The challenge is effective implementation: finding the tools, the time and the tenacity.

In drawing our conclusions and recommendations we have worked within three broad criteria. Firstly, any recommendation should not require statutory legislation. Secondly that the recommendation should have practical utility in improving productivity and performance within a 24 month period. And thirdly that no recommendation should require the establishment of a committee or task and finish group that would need a life expectancy of more than three months. By necessity the recommendations are therefore more tactical and short-term than strategic or transformational, although we have aimed to ensure that they are aligned to the broader strategic direction and thinking of the Welsh system

Given the above, the golden thread running through our recommendations is that the following levers for change need to be pulled to maximum effect:

- A focus on using evidence-based standards and taking out unwarranted variation
- A strong and empowered clinical leadership voice
- Transparency of data and a commitment to "improving in public"
- Sharper accountability and performance management
- A reduction in bureaucracy and more effective operational management
- A narrowing of targets, and
- Aligning financial flows with performance priorities

Finally, I would like to thank my fellow MAG team members and colleagues across NHS Wales for the spirit in which they have embraced the MAG and its work. From the outset I asked that the work of the MAG be celebrated rather than tolerated and I believe that this has overwhelmingly been the case.

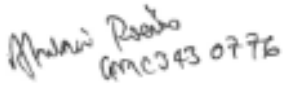
I hope that our report proves to be of value to the NHS in Wales and most importantly to the people of the land of my father. They deserve the best and you have the opportunity to give them the best: I hope you embrace it.

Yours sincerely,

Sir David Sloman (Chair)

MAG members:

Professor Tim Briggs



Dr Alastair Roeves

Professor Kevin Davies

Ed Rose

Professor Sally Lewis

Dr Tara Sood

Adam Roberts

Sir Paul Williams

1 Introduction to and approach of the Ministerial Advisory Group (MAG)

On 1st October 2024 the Cabinet Secretary for Health and Social Care announced the appointment of an external independent Ministerial Advisory Group (MAG) on Performance and Productivity in NHS Wales.

The Terms of Reference of the MAG specifies that the focus of the work is on performance and productivity within the clinical service areas of planned care, diagnostics, cancer and urgent and emergency care. Within this scope, the MAG was asked to offer external assurance on the effectiveness of current arrangements and to offer observations and recommendations on how these could be strengthened and improved.

The MAG was charged with completing its work by 31 March 2025.

From the outset the MAG was determined that its work should be clinically led, data driven and evidence based. A premium was placed on the practical utility of any recommendation, the evidence and data to support it, and its ability to have an impact within a 24 month period without the requirement for legislative change or additional bureaucracy.

In support of this approach the membership of the MAG retained a clinical majority at all times, and an even balance between those with deep working knowledge of the NHS in Wales and those with deep knowledge of healthcare systems elsewhere, in particular the NHS in England.

The MAG also ensured that its work was informed by front line clinicians as well as the input from NHS leaders and their teams across Welsh Government, NHS health boards and the broader Welsh NHS eco-system. Relevant strategy, policy and planning frameworks were also taken into consideration (see Annex A).

MAG members engaged with the health care system through both virtual and face to face meetings. They also undertook visits to six health boards in Wales (Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board, Hywel Dda University Health Board and Swansea Bay University Health Board) in order to meet with executive teams and clinical leaders.

A full list of those with whom the MAG engaged is detailed in Annex B.

Building on this work and drawing on its collective knowledge and experience of UK and international health care systems, the MAG has identified the areas of strength, variation and opportunities for improvement. These are described in the narrative and the recommendations that make up the remainder of this report.

2 Executive Summary

There are 29 recommendations in this report: these are summarised below with an indicative timeline for implementation.

Planned Care

- **Recommendation 1**
  All health boards should develop a plan to reduce referrals to outpatients in high volume specialities with a particular focus on unwarranted variation and ensure the adoption of new models and best practice in outpatient management. Timescale – within 3 months.

- **Recommendation 2**
  All health boards should work to reduce variation in outpatient waiting times by adopting best practices in outpatient service management. Timescale – within 6 months.

- **Recommendation 3**
  All health boards should take action to improve waiting list management.

  3a) Better prioritisation of available capacity for the longest-wait patients should become a pre-condition for receipt of additional funding from Welsh Government for elective recovery. Timescale - within 3 months.
  3b) HEIW should set up an accredited training programme for waiting list management. Timescale - within 6 months.
  3c) Welsh Government should set a target for all patients to be validated down to 36 weeks by the end of 2025/26 and introduce a new national dataset to track progress. Timescale – within 12 months.

- **Recommendation 4**
  4a) All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management to be overseen by the establishment of Health Board Theatre Optimisation Boards. Timescale – within 6 months.
  4b) Health boards should seek accreditation for all Surgical Hubs and this should be a condition of further funding. Timescale – within 12 months.

- **Recommendation 5**
  A clear and identified funding stream should be centrally retained to establish a national dedicated fund for the use of the independent sector. Timescale – within 6 months.

Diagnostics

- **Recommendation 6**
  Welsh Government should create a national plan for endoscopy to address the current backlog of long-waits. Timescale - within 6 months.

- **Recommendation 7**
  With the support of the Performance and Productivity Unit (PPU) (see Recommendation 19) regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future. This should include the full implementation of digital pathology as a key service enabler to address workforce shortages. Timescale – within 12 months.

- **Recommendation 8**
  Cardiff and Vale University Health Board should be required to submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound backlog over the course of 2025/26. Timescale – within 3 months.

Cancer

- **Recommendation 9**
  No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals. Timescale – within 3 months.

- **Recommendation 10**
  A ring-fenced fund, held centrally, should be created to directly fund the high-impact, nationally prescribed service changes described in Recommendation 9, which are monitored through the health board performance report (see Recommendation 21). Timescale – within 3 months.

- **Recommendation 11**
  The Welsh Government should establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care. Timescale – within 3 months.

- **Recommendation 12**
  The Cancer Network and the cancer arm of the Planned Care Recovery Programme should be merged to create a single team responsible for setting the strategic direction of cancer care in Wales and directing improvement activities to support this, led by a senior clinician and senior managerial lead, reporting to the National Medical Director and the Managing Director of the PPU. See Recommendations 19 and 20). Timescale – within 3 months.

- **Recommendation 13**
  Digital Health and Care Wales (DHCW) should develop a plan to begin collecting and publishing more granular tumour-level performance data from the beginning of the 2026/27 financial year at the latest. DHCW should also produce an options appraisal for the production of a linked dataset containing cancer and diagnostics waiting times data. Timescale – within 12 months.

Urgent & Emergency Care

- **Recommendation 14**
  Health boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care. Timescale – within 6 months.

  14a) Hospitals must ensure that all admitted patients are placed on D2RA pathways in line with the national Hospital Discharge Guidance, and delays by pathways should be published within 3 months.
  14b) Welsh Government should run an audit of use of trusted assessors across the 7 health boards and 22 local authorities in May 2025, repeated in October 2025. This should be published in November with justification from the health board and/or local authority where this has not been implemented.
  14c) A rapid study should be undertaken within 3 months, by Welsh Government working with health boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in emergency departments. This should be used to target investment in linked community services for winter and future budgets.

- **Recommendation 15**
  Health boards should ensure that no ambulance handover exceeds 45 minutes, with a focus on achieving the 15 minute handover target wherever possible. Timescale – within 6 months.

- **Recommendation 16**
  Progress against the Six Goals for Urgent & Emergency Care Programme should be reported publicly, using the monthly health board performance reports (see Recommendation 21). Timescale – within 3 months.

- **Recommendation 17**
  A consistent framework for escalation levels within the Urgent & Emergency care system should be introduced by October 2025, using the OPEL framework in England, adapted for the Welsh service where needed. Timescale – within 6 months.

The MAG identified several common themes and issues that affect all four key areas of focus. The following high-level recommendations are therefore applicable to each of these areas and cover the operating model and accountability framework, the system approach to productivity (including workforce), digital and data, and the role of regions and capital as levers for change.

Operating model and accountability framework

- **Recommendation 18**
  Welsh Government should consolidate all accountability and escalation meetings with health boards and trusts into individual monthly Performance and Productivity meetings, with a key focus on delivery against key areas of both performance and productivity, and progress against the recommendations of this report. Timescale – within 3 months.

- **Recommendation 19**
  A managing director should be appointed to directly manage and oversee the NHS Executive which will be renamed the Performance and Productivity Unit (PPU). Timescale – appointment within 3 months.

- **Recommendation 20**
  Medical leadership should be strengthened under the leadership of a new post of Medical Director of NHS Wales. This is a new post separate from and equal in status to the existing Chief Medical Officer post. Timescale – appointment within 3 months.

- **Recommendation 21**
  Health boards should commission the Welsh NHS Confederation to develop a standardised health board performance dashboard. The dashboard should be used in the public part of board meetings and to support the Performance and Productivity meetings. Timescale - within 3 months.

Measuring productivity

- **Recommendation 22**
  A total factor productivity model and workforce productivity model should be developed for NHS Wales and implemented in advance of the next budget. Timescale – within 12 months.

- **Recommendation 23**
  From the June health board meeting cycle of the 2025/26 annual year going forward, workforce head count and productivity data should be reported to the monthly public meeting of the health board. This should include data on both directly employed and the GMS and other independent contractor workforce. Working with the PPU the health boards should agree annual workforce productivity targets. Timeframe – within 3 months.

- **Recommendation 24**
  HEIW should work with the PPU (see Recommendation 19) to ensure that leadership programmes are in place to support the "threes at the top" of clinical services in health boards and trusts. Timescale – within 6 months.

Digital and Data

- **Recommendation 25**
  NHS Wales should commission from DHCW a comprehensive roadmap for the delivery of Missions 2 and 3 of its Organisational Strategy over a 24 month period, to be published within 6 months. No health board should move forward with any EMR or App development until the roadmap is agreed. Full consideration should be given to aligning the NHS Wales App with the NHS England App. Timescale – within 6 months.

- **Recommendation 26**
  The Cabinet Secretary for Health and Social Care should work with ministerial colleagues to prioritise the need to address Wales' data sharing policy and associated framework position with a view to accelerating the incorporation of datasets into the National Data Resource. Timescale – within 12 months.

The regions and capital as levers for change

- **Recommendation 27**
  In addition to the plan for pathology and endoscopy (Recommendations 6 and 7), health boards should work together as regions to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual and ongoing basis. To facilitate this work, resources and support will be provided by the PPU. Timescale – within 12 months.

- **Recommendation 28**
  The capital allocation should be uplifted on an ongoing annual basis and aligned to the annual planning and prioritisation process. Timescale – within 12 months.

- **Recommendation 29**
  Welsh Government should conduct a review of preferred options for generating non-exchequer capital for the Cabinet Secretary for Health and Social Care to consider ahead of 2026/27 capital round. Timescale – within 9 months.

3 Performance, Productivity, Financial and Organisational Context

The health and care system in Wales faces a major challenge. Demand is growing, costs are rising, public finances are stretched and a number of outcomes of care are falling behind relevant international comparators.

3.1 Performance context

There is evidence that outcomes, access measures and population health in Wales do not compare well with many European countries.

On health, the Wellbeing of Wales report of 2024[4] shines a light on the structural health issues of the population in terms of its age profile, its geographical profile and its comparatively high levels of morbidity and mortality and reducing life expectancy compared with 2011/13. On access measures, waiting lists are at historically high levels; specific details of access and performance in the areas of planned care, diagnostics, cancer and urgent and emergency care are described in the subsequent chapters of this report.

3.2 Productivity context

Whereas performance information is readily available there is less data and analysis of the productivity of the healthcare system. This issue is discussed in more detail in chapter 5.

3.3 Financial context

Pre-pandemic, Welsh Government commissioned external reviews from the Nuffield Trust ('A Decade of Austerity' 2014[5]), and The Health Foundation ('The path to sustainability' 2016[6]) which set out the conditions required for financial stability and sustainability of its NHS. This work suggested that stability was achievable through a combination of ongoing pay restraint, real terms funding growth to meet demand, with savings and productivity delivery in line with historic trends c1% - 1.5% per annum. However, these did not factor in the impact of the pandemic which, in common with other parts of the UK, led to a large increases in costs and demand which was supported by significant non-recurrent funding.

During recent years, health boards have found it increasingly difficult to deliver a sustainable financial position. Whilst additional funding has been allocated to the health budget and to the NHS this has largely been used to support pay awards, and unavoidable inflationary pressure and demand growth. This means that whilst the

[4] Wellbeing of Wales, 2024 [HTML] | GOV.WALES
[5] A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26 | Nuffield Trust
[6] The path to sustainability | The Health Foundation

revenue funding to support health in Wales is rising, there has been very little spare resource to support service transformation, and delivering a balanced budget has become increasingly difficult. This challenge is not unique to the NHS in Wales and is a common challenge across the UK and other healthcare systems and means that increased productivity will be needed to bridge the gap.

3.4 Organisational context

The National Health Services (Wales) Act 2006 established seven Local Health Boards (LHBs) in Wales, who have a statutory responsibility for planning, commissioning and providing services that meet the needs of the population they serve. This includes the responsibility across primary, community, and secondary care services alongside specialist services for the LHB area. In addition, NHS Wales comprises three NHS trusts, and two special health authorities, with a specific focus and remit.

The seven health boards are supported by the NHS Wales Joint Commissioning Committee (NWJCC) which commissions ambulance, 111 and specialised services on behalf of health boards. The NHS Wales Shared Services Partnership is an independent partnership directed by NHS Wales hosted by Velindre NHS Trust. The NHS Executive became operational on 1st April 2023, with a planned intent to operate on behalf of Welsh Government to provide strong leadership and strategic direction – enabling, supporting and directing NHS Wales to transform clinical services in line with national priorities and standards.

As an integrated planning system, the NHS Finance (Wales) Act 2014 introduced statutory duties for NHS bodies to prepare three-year plans that improve the health of the population, the provision of health care, and deliver financial balance over a three-year period.

The Health & Social Care Main Expenditure Group (MEG) is the budget for the Health, Social Care & Early Years Group in Welsh Government and is the largest budget area of Welsh Government, representing over half of the total budget. The budget includes the core funding for the NHS, supported by a financial operating model that has been largely designed to allocate resources to health bodies in order to discharge their statutory responsibilities. For the seven health boards resources are allocated to fund healthcare services for their resident population and should be considered alongside the NHS Wales planning framework which is the vehicle with which NHS bodies develop their plans to meet local requirements, ministerial priorities, and statutory duties.

Funding is a combination of un-hypothecated and hypothecated funding to support delivery of ministerial priorities and is largely driven by the Resource Allocation Formula. The formula is a needs-based population formula used to ensure the equitable distribution of additional allocations to health boards.

3.5 Meeting the challenge

The position on capital and revenue funding and the global workforce shortages mean that the challenges outlined above will, to a large extent, have to be met through improvements in productivity. This will necessitate clear structures, improved processes and focused leadership underpinned by excellence in operational management and service delivery. This will require alignment between a strong centre working with a collaborative group of health boards and trusts working collectively to a tighter set of objectives within a clear accountability framework and a commitment to transparency and 'improving in public'.

4 Detailed Findings

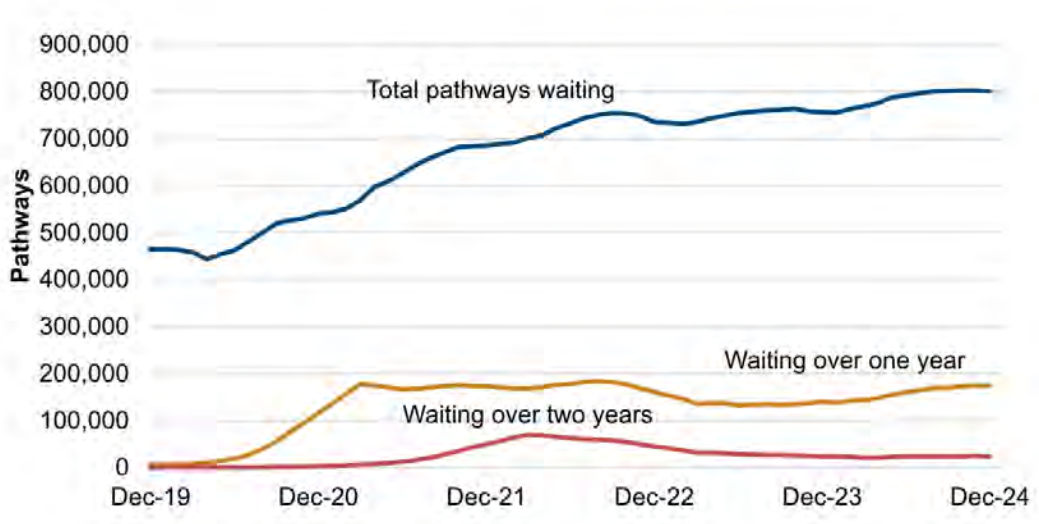
4.1 Planned Care and Diagnostics

Delays in elective care can have serious consequences for patients. As their condition worsens, they may need more medication, face frequent visits to doctors and hospitals (including emergency care), and see their treatments fail due to disease progression. In some cases, this can lead to permanent disability or even death.

The toll is not just physical. Patients may lose their ability to work, experience financial hardship, struggle with deteriorating mental health, and face additional stress within their families.

The main measure is the number of pathways where patients are waiting to start treatment. The graph below shows that this has been growing inexorably.

Patient pathways waiting to start treatment, December 2019 to December 2024[7]



Source: StatsWales, Referral to treatment

[7] NHS Activity and Performance Summary: December 2024 and January 2025 [HTML] | GOV.WALES

In December 2024, there were about 722,000 open consultant-led pathways in Wales[8], equivalent to 23 pathways (rather than patients) for every 100 Welsh citizens. For England, the figure in December was 13 open pathways for every 100 citizens. This means Wales would have to close more than 310,000 pathways before it reaches England's December level.

Currently there are 6 specialties that account for over 60% of the waiting lists: orthopaedics (including spinal surgery), ophthalmology, ENT, gynaecology, urology, and general surgery. Standardisation and adoption of the most common 29 pathways for these specialties would greatly improve productivity and efficiency.

Whilst in recent years some progress has been made to reduce very long waiting lists there has been little impact on the number waiting over one year.

The MAG identified the following key factors driving long waiting times:

- Growth in outpatient referrals
- Uneven adoption of best practice in referral management
- Unwarranted variation in outpatient management
- Poor waiting list management
- Sub-optimal theatre and surgical productivity
- The absence of protected high volume elective surgical capacity
- Sub-optimal use of the independent sector
- Bottle necks, capacity and management issues in diagnostics
- Very high numbers waiting in a few providers

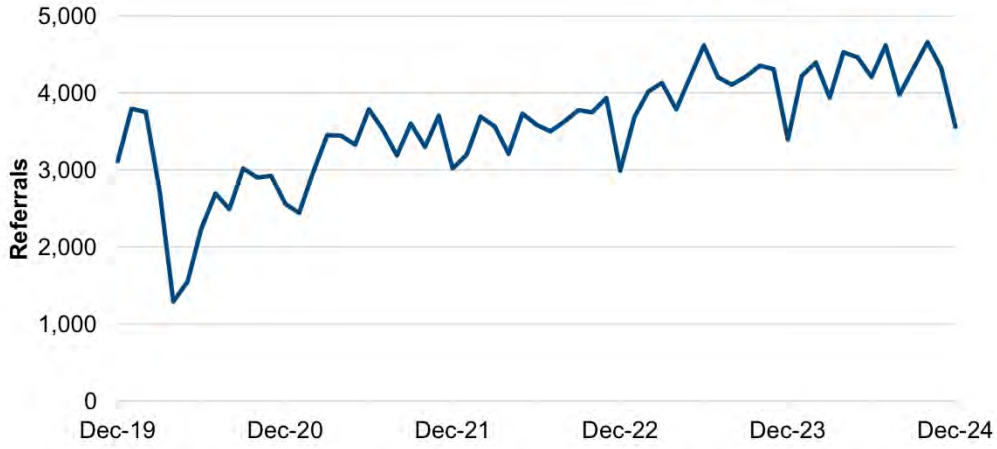
Each of these factors is considered in detail below.

Growth in outpatient referrals

Growth in outpatient referrals has exceeded population change with an average of 3,557 referrals for first outpatient appointments made per day in December 2024, an increase of 4.7% compared to December 2023. Whilst some of this growth relates to referrals between secondary care services, the bulk of referrals are from primary care. This is seen in other health systems and reflects pressure on primary care, changes in treatment guidelines, increased use of screening and patient choice.

[8] Whilst the graph shows over 800,000 pathways, the 722,000 has been calculated by removing some non-consultant led pathways which are not counted in England (see link above for further information).

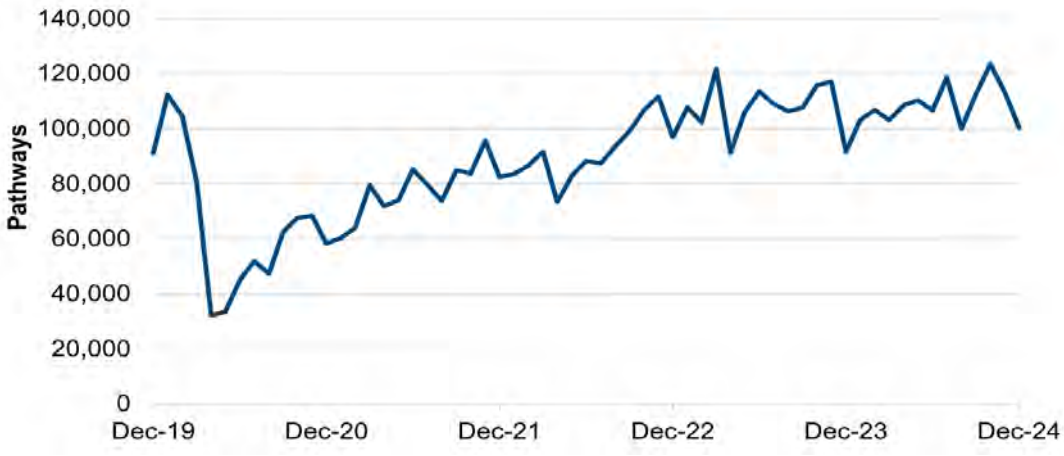
Average daily referrals for first outpatient appointment, December 2019 to December 2024



Source: StatsWales, Referrals

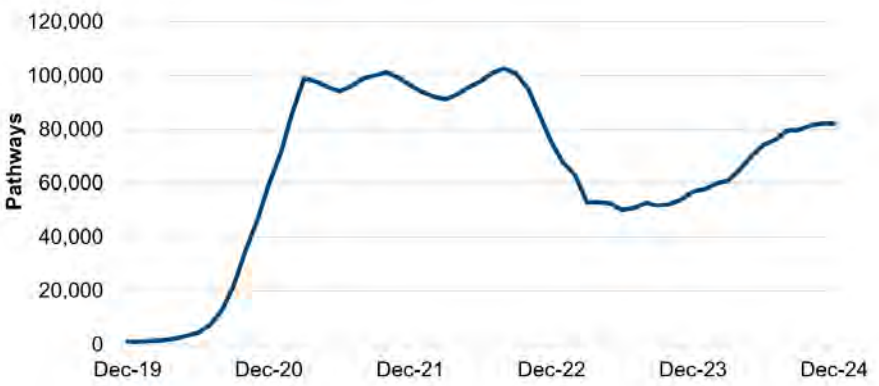
Welsh Government data shows that whilst the number of closed pathways – cases where patients have completed their outpatient journey – has steadily risen to pre-pandemic levels, this is not enough to address the backlog of new patients waiting to be seen and demand is greater than supply. As a result, the number of patients waiting more than a year has continued to increase.

Closed patient pathways, December 2019 to December 2024



Source: StatsWales, Referral to treatment

Pathways waiting more than a year for their first appointment, December 2019 to December 2024



Source: StatsWales, Referral to treatment

Uneven adoption of best practice in referral management

On its visits to the health boards, the MAG noted some examples of innovative schemes that offer patients and referrers alternatives to traditional consultant-led outpatient services;

- Swansea Bay University Health Board's primary care audiology service, where GPs can refer directly to audiologists based in the community for tinnitus, deafness and ear wax, leading to a reduction in ENT outpatient referrals.
- In Hywel Dda University Health Board, 30% of all referrals from primary care are diverted through advice and guidance and the 56% remainder who are seen in secondary care are either discharged at the first appointment and/or given a patient initiated follow up (PIFU) appointment.
- In Cardiff and Vale University Health Board, GP Clinical Editors have worked with radiology and MSK consultants and therapists to change the referral pathways for multiple spine, knee and shoulder conditions. By agreeing a community health pathway for each condition, GPs no longer have to refer to radiology for MRI or ultrasound scans prior to referral. The pathway directs them to refer to the community physiotherapy assessment service and has resulted in reductions in requests for scans of up to 92% with a consequent reduction in outpatient demand.

The Strategic Programme for Primary Care has identified a further 20+ services which are being provided in the community somewhere in Wales which if implemented at scale would reduce referral to outpatients.

Digitally enabled referral practice is inconsistently adopted. For example, in some health boards up to 40% of contacts between GPs and consultants are via e-Advice, a system that enables a clinical discussion between primary and secondary care without resort to outpatient referral. In other health boards electronic triage/grading of referral letters is not taking place, with a continued heavy reliance on traditional paper-based systems.

The table below shows the variable use of the consultant connect advice model. The MAG can see no reason why all health boards should not meet the level of the highest user.

Percentages of GP practices in Wales that requested advice and guidance via Consultant Connect in February 2025

	Practices making a call	Practices sending a message
Aneurin Bevan University Health Board	43.24%	48.7%
Betsi Cadwaladr University Health Board	27.72%	60.40%
Cardiff & Vale University Health Board	95.08%	1.64%
Cwm Taf Morgannwg University Health Board	36.54%	3.85%
Hywel Dda University Health Board	72.55%	33.33%
Swansea Bay University Health Board	64.58%	25.00%
Powys Teaching Health Board	56.25%	81.25%
All Wales	53.10%	35.24%

Source: NHS Executive management data based on health board returns on Consultant Connect activity

Given the above, the MAG believes that there is significant potential for reducing referrals to secondary care if all health boards adopt the range of interventions available. This includes full adoption of the National Community Health Pathway programme and full deployment of advice and guidance. The national funding for these schemes needs to continue.

Scope to improve outpatient management

During the health board visits, the MAG was informed of successful interventions aimed at improving outpatient flow and reducing waiting times. These included the extensive use of Patient Initiated Follow-Ups (PIFUs) - a national priority - which is a system that enables patients to be seen again if they develop a problem rather than being scheduled for a follow-up appointment. However, the adoption of PIFUs across and within the health boards was variable.

Additionally, other simple and proven interventions likely to yield significant productivity gains - such as reviewing and standardising outpatient clinical templates - have not yet been universally adopted.

The National Planned Care Programme has developed Further Faster guides for 16 specialties/subspecialties from the Getting in Right First Time (GIRFT) Programme[9] which describe the tools that can be used to optimise outpatient management. These include the standardisation of consultant specialty outpatient department (OPD) templates that specify the number of patients and the ratio of new to follow up patients

[9] The Getting It Right First Time (GIRFT) programme is designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

that should be seen in a four hour clinic. These blueprints, if fully adopted in Wales, would improve productivity and efficiency, and translate into improved quality of care by reducing waiting times for patients.

Waiting list management

The waiting list data suggests that differences in operational management practices are a significant cause of the intra-UK disparities. The number of patients waiting longer than a year reached a post-pandemic peak across England and Wales by Summer 2022. From this point onwards, the overall size of national waiting lists grew by 46% in England and 34% in Wales. Over the same period the NHS in England managed to reduce the number of patients waiting longer than a year by 50%, whilst in Wales the number increased by just under 1%.[10] This indicates that the NHS in England has been much more effective at treating non clinically urgent patients in date order, ensuring longer waiting patients are prioritised for treatment wherever possible even as the overall waiting list grows and average waiting times rise.

Put simply, the NHS in Wales has not been prioritising its available capacity for long-wait patients as rigorously as England. The latest data available to the MAG shows that there are just under 175,000 people waiting more than a year. Had the NHS in Wales instead been able to match the efforts of England, there would be 87,270 fewer patients waiting longer than a year for treatment than there are now.[11]

This is further evidenced in Welsh Government's Treat in Turn data[12] which shows that there is a 3 to 6-fold variation between health boards in terms of how effectively they are prioritising their longest waiting patients. For example, in the most recent data for ENT, almost 60% of planned procedures have been earmarked for the longest wait patients in Aneurin Bevan University Health Board, but the figure is only 10% in Cwm Taf Morgannwg University Health Board[13].

Ensuring that waiting lists are validated is a key part of the management of long waiting. The increase in the number of patients waiting rose from around 450,000 shortly before the pandemic to more than 800,000 today. During our visits MAG members were told that stretched clinical and administrative teams have been unable to perform regular checks on long-waiting patients as frequently as they did before the pandemic, resulting in far fewer patients being removed from the waiting list. In practice, this means many patients currently on waiting lists do not need to be there, potentially wasting appointments that could be used for other patients.

NHS Wales is aware of this and has issued guidance that validation should be a key focus for health boards. However, there is not currently any specific objective, nor any

[10] Whilst the two nations use slightly different data definitions, this analysis simply compares each nation's data to its own over the course of the last four years.
[11] StatsWales Referral to treatment
[12] NHS Executive management data based on health board returns on activity levels
[13] NHS performance for Welsh Local Health Boards: March 2025 [HTML] | GOV.WALES

national dataset which allows progress in each health board to be measured and tracked. The MAG were also told on the visits that the capacity to support the validation of lists is thin on the ground with relevant staff overstretched.

Equally, health boards did not appear to be aware of the OWLS scheme (Welsh Government legislation from August 2021 that enabled GPs to be remunerated for performing validations on their own patients at the health boards' request).

The MAG if of the view that the health boards should improve and implement best practice in prioritising available capacity for the longest-wait patients. Furthermore, such improvements should be a pre-condition for receipt of additional funding from Welsh Government for elective recovery. In order to ensure that health boards are fully held to account for these basic and essential processes around patient prioritisation Welsh Government should agree minimum standards based on the existing Treat in Turn dataset. Elective recovery funding for 2025/26 should be made conditional upon meeting these standards within a defined period of time.

The MAG also recommends that Health Education and Improvement Wales (HEIW) should set up an accredited training programme for operational teams in best practice in waiting list management. This is urgent and should commence within three months.

Recommendation 1:
All health boards should, within three months, develop a plan to reduce referrals to traditional outpatients in high volume specialities. Particular attention should be given to unwarranted variation and specialities where per capita referrals rates are above the national median.

Models that offer alternatives to traditional outpatient pathways should be rapidly identified and scaled. National Funding for Advice and Guidance and the National Pathways programme should continue.

From June 2025, progress should be reported monthly to health board and trust public meetings, and at individual monthly Performance & Productivity meetings (see Recommendation 18).

Recommendation 2:
All health boards and trusts should work to reduce variation in outpatient waiting times by adopting best practices in outpatient service management, using existing specialty GIRFT health board and trust reports, the 16 specialty specific Further Faster guides, mandatory electronic triage of referrals, and adoption of the 29 pathways across the 6 specialties with the longest waits.

From June 2025, progress should be reported monthly to health board and trust public meetings, and at individual monthly Performance & Productivity meetings (see Recommendation 18).

Recommendation 3:
All health boards and trusts should take action to improve waiting list management

3a) Better prioritisation of available capacity for the longest-wait patients should become a pre-condition for receipt of additional funding from Welsh Government for elective recovery. Welsh Government should agree minimum standards based on the existing Treat in Turn dataset, and elective recovery funding for 2025/26 should be made conditional upon meeting these in each individual health board within a defined period of time. **Timescale – within 3 months**

3b) HEIW should set up an accredited training programme for waiting list management, across both RTT and Cancer, aimed at Band 7 and Band 8 managers working in elective care. Over time, completion of this course should become an expectation for all managers working in these areas, in order to embed a consistent and shared set of skills across the country. **Timescale - within 6 months.**

3c) Welsh Government should set a target for all patients to be validated down to 36 weeks by the end of 2025/26, and introduce a new national dataset to track progress. If there is insufficient confidence this could be achieved in all health boards and trusts, Welsh Government should consider a nationally procured contract with an external company specialising in validation, to focus on areas unlikely to be able to complete this independently (although this could even be done on a once-for-Wales basis to cover the whole country, given the population size). This should be supported through Elective Recovery funding.

DHCW should also develop a new national dataset to track progress, either based on ROTT (removals from the list for reasons other than treatment) rates or manual health board and trust returns around the proportion of 36+ week waiters validated, which should be regularly discussed at the Performance and Productivity meetings described in Recommendation 18. **Timescale – within 3 months**

Improving theatre and surgical productivity

The MAG observed material variation in theatre productivity. This offers a significant opportunity for improved productivity and performance.

Welsh Government analysis shows that if between December and June 2024 90% of operating sessions had achieved the standard of seven cataract procedures per list then 2598 (42%) more patients could have been treated.[14] This would have been even greater if the GIRFT standard of eight to ten cataracts per four hour list was applied, a level of productivity agreed by the Royal College of Ophthalmologists.

In the same period meeting the standard of two patients per half day list for joint replacement would have allowed 632 (34%) more patients to be treated.

[14] NHS Executive management data based on health board returns on activity levels

There are similar issues related to late starts, early finishes, low theatre utilisation and lower than optimal use of day procedures. Addressing these inefficiencies does not require additional funding apart from the per patient cost of consumables and implants. GIRFT has already produced standards for theatre productivity including the minimum number of cases per list, day case rates and targets for theatre utilisation. The MAG supports the shift towards 'day case by default' in subspecialties such as joint implant surgery and the use of "Right Procedure Right Place" where patients are treated in procedure rooms rather than theatres. While time is needed for clinicians, managers, and patients to gain confidence in the safety of new approaches, the MAG believes that every health board should actively and rapidly adopt this best practice.

Prior to the MAG review a number of specialty reviews had already been requested and undertaken across all health boards in Wales from the GIRFT programme. These covered secondary care services such as gynaecology, orthopaedics, urology, ophthalmology, general surgery, theatres, and emergency departments (ED) and provided recommendations for service improvements. During the MAG visits we found that these recommendations had not been consistently implemented.

On the health board visits, MAG members heard that clinical leaders were keen to use the GIRFT programme and its associated tools. In discussion clinical leaders also identified the associated need for a clear and transparent link between individual job plans, appraisals and revalidation. In addition, clinicians asked for practical executive support for the rapid adoption of GIRFT standards and other good practice such as the Further Faster interventions and Patient Initiated Follow Up (PIFU).

Given the above, the MAG recommends that each health board should establish a Theatre Optimisation Programme Board that is co-led by a clinician and an operational manager with a remit to ensure immediate steps are taken to enhance theatre productivity in line with GIRFT standards. The national clinical lead for GIRFT and the implementation teams should work closely with the NHSE GIRFT Programme and the Wales National Clinical Specialty Working Groups to ensure all health board executive teams have reviewed and implemented the recommendations of GIRFT reviews in gynaecology, orthopaedics, urology, ophthalmology, general surgery, and theatre productivity. Performance data for theatre productivity and surgical hubs should be shared in the monthly Performance and Productivity meetings and at the local and national Theatre Optimisation Boards (see Recommendations 4 and 18).

In this context the MAG welcomed the Cabinet Secretary's letter of 20th December 2024 setting out priority enabling actions that NHS bodies should implement in 2025/26 on an 'adopt or justify' basis, including specific progress towards the delivery of GIRFT standards.

The need for protected high volume elective surgical capacity: Surgical Hubs

The MAG has reviewed the evidence supporting the protection of elective care beds from unscheduled care demand and concludes that designated Surgical Hubs, with clearly defined roles and ring-fenced facilities, can significantly enhance patient

experience, reduce waiting times, and improve safety by standardising practice and reducing the risk of cancellation due to emergency pressures. Surgical Hubs enable both outpatient and admitted surgical activities to be conducted for 48 weeks per year. Additionally, these hubs facilitate the exploration of new working methods, such as extended lists, weekend operations, high-flow lists, and super clinics for outpatient departments.

The MAG noted the successful implementation of Surgical Hubs in Wales and is aware that a number of surgical hubs have been identified (see Annex C) to form the first phase of a National Surgical Hub Implementation Programme. These hubs should be regarded as regional and national assets ensuring equitable access to timely care for all patients in Wales, regardless of their residence.

From the evidence of underperformance found at visits undertaken in six health boards, the MAG believes that every health board already possesses the necessary infrastructure in buildings and staff to establish dedicated Surgical Hubs, thereby accelerating productivity and performance improvements. All Surgical Hubs should be working towards 'day case by default' management of cases.

Given the size of the waiting lists, it is imperative that surgical hubs perform at optimum levels of productivity. In England, this objective has been supported by an accreditation process that uses a clear set of criteria around productivity, patient outcomes and patient and staff experience. We recommend that a similar process is established in Wales and that future waiting list funding could be contingent on compliance and adherence to the accreditation criteria.

Recommendation 4:
a) All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list). **Timescale – within 6 months.**

b) Health boards should seek accreditation for all current Surgical Hubs (listed in Annex C) from the National Medical Director (see Recommendation 20), within 6 months using standard GIRFT criteria including maximised theatre productivity (Annex D), and with all hubs to be accredited within 12 months. From June 2025, progress should be reported monthly to the public part of health board meetings, and the monthly Performance and Productivity meeting (see Recommendation 18).

Sub-Optimal use of the independent sector

There is a cultural reluctance, and a financial disincentive, to use capacity in the independent sector in Wales, despite this offering an opportunity to reduce long waits in key specialties.

Some of the largest groups of long-waiters in Wales represent high volume, low complexity cases suitable for independent sector providers. The specialty with the largest number of long-waiters in Wales (almost 25% of all patients waiting longer than a year) is ophthalmology[15], and more than half of these patients waiting for treatment are waiting for cataract surgery[16]. Numerous independent sector providers are capable of performing large volumes of cataract surgeries. In fact, more than one-third of all private sector admissions for self-pay and insured patients in Wales are for this procedure.[17] To genuinely prioritise the reduction of long-wait times on a longer-term basis, the increased utilisation of the independent sector would be a rapid and efficient solution.

With minimal consequences for failing to meet standards regarding long-waits, and a challenging financial backdrop, there is often little incentive for health boards to subcontract work to the independent sector in the first place. Contracting of the independent sector at health board level was described to us as "feast or famine", with short-term contracts often issued near the end of the year, rather than arrangements intended to supplement NHS capacity in a more planned way. This type of localised, short-term contracting is unlikely to provide optimal value for money and does not incentivise the independent sector to invest in the capacity and infrastructure necessary for sustainable support to the NHS in Wales.

The MAG is supportive of Welsh Government's efforts to actively expand use of the independent sector in recent months and believes this should become a more significant component of recovery plans in 2025/26. Beginning with ophthalmology as a test-case, NHS Wales should therefore agree national-level contracts with the independent sector, managed at regional level. These should be multi-year, and volumes agreed on the basis of realistic assessments of what the NHS will be able to achieve and how many long-wait patients would be better served at an alternative provider. The MAG understands that Welsh Government has calculated that almost 30,000 cataract patients are likely to still be waiting longer than 36 weeks at the end of 2025/26, so this should be the minimum volume of procedures contracted out to the independent sector.[18]

[15] StatsWales ,Referral to treatment
[16] NHS Executive management data based on health board returns on speciality data
[17] https://www.phin.org.uk/news/PHIN-Private-market-update-December-2024-Wales
[18] NHS Executive management data based on health board returns on activity levels

Recommendation 5:
A clearly identified funding stream should be centrally retained to establish a national dedicated fund for the use of the independent sector. This fund should be used where there are longer term sustainability challenges in demand/capacity that cannot be addressed through health boards delivering improvement using the new productivity standards and the other GIRFT interventions described in this report.

NHS Wales should enter into nationally negotiated, multi-year contract with the independent sector for ophthalmology in the first instance, with consideration given to replicating this arrangement for orthopaedics or dermatology if this first phase produces positive results. Contracts should then be regionally managed, modelling the success of the Southeast Wales cataract contracting in 2024/25, ensuring equity of access for all patients across the regional footprints.

In the longer-term, Welsh Government should commission an options appraisal on the opening up of choice of provider to referring clinicians and their patients in some specific, highly pressured specialties, and to include these independent providers on the choice menu.
Timescale – within 6 months.

Diagnostic capacity and bottle necks

Diagnostic delay causes anxiety and prolonged morbidity for patients and, for time-sensitive diagnoses, worsens outcomes.

Diagnostics have a critical role in ensuring timely and effective patient care. The programme for transforming and modernising planned care and reducing NHS waiting lists[19] commits that the NHS in Wales will eliminate waits of more than 8 weeks for diagnostics by 2026, but there has been little sign of progress with between 39,000 and 51,000 patients in this position each month over the past three years[20].

During the visits by the MAG, teams across Wales reported significant increases in demand, driven by changing clinical guidelines, screening and risk thresholds. The percentage of requests that are deemed urgent has also risen. For example, the proportion of histopathology tests relating to suspected cancer has risen from just over 10% in 2018 to more than 30% today[21]. One pathology team said, "*our USC histopathology demand has increased from 28% of our workload to 62% over 6 years*." The complexity of diagnostic information required for clinical decision-making has also increased and MDTs are often needed to support that activity. Coordination of MDTs can be challenging to schedule, leading to delays and consuming large amounts of radiologist and pathologist time. The MAG was told that often the impact on diagnostics was not fully considered when new guidelines were introduced. For example, changes

[19] Our programme for transforming and modernising planned care in Wales and reducing the waiting lists
[20] StatsWales, Diagnostic and therapy services
[21] NHS Executive management data based on health board returns on activity levels

to obstetric guidelines have put a strain on the capacity of non-obstetric ultrasound. These problems have particular significance for cancer services (see section 4.2).

The National Diagnostic Programme (part of the Planned Care Programme) has brought a welcome focus on these issues, although the availability of capital and workforce and the lack of data to inform planning are holding back progress.

Short term action is required to address the challenges within endoscopy and pathology and similarly with a localised issue in non-obstetric ultrasound. These are considered in more detail below. Imaging, with a few exceptions, has fewer pressing concerns and is not subject to any recommendations within this report.

Endoscopy

Endoscopy is under serious pressure, accounting for more than a third of all long wait patients, and has significant workforce constraints. For example, 35% ERCPists (those able to perform Endoscopic Retrograde Cholangio-Pancreatography) are due to retire within 5 years. Most units do not have a sustainable capacity model for the future with the exception of Swansea Bay University Health Board, who have sufficient space and a workforce plan that includes multiprofessional training. Over-reliance on non-recurrent funding is destabilising efforts to develop a sustainable workforce. Large sums of money are being spent on outsourcing and insourcing, neither of which are sustainable.

Comparing the number of endoscopy suites on a weighted population basis, Wales is adequately resourced at a national level, but this hides significant under-provision in Betsi Cadwaladr specifically, at 2.5 rooms per 100,000 >55 years compared to a national average of 3.5.[22]

Given the above, it is recommended that Welsh Government produces a national endoscopy transformation plan to be managed and delivered on a regional basis. The plan should be based on the following four pillars:

- Capital funding should be approved and allocated to BCUHB to create the three additional rooms required to adequately serve its population.

- A focus on improving utilisation and making the best use of existing capacity. The number of rooms in Wales relative to population size suggests under-utilisation must be a key driver of long waiting lists, but the lack of any national dataset means it is impossible to determine how well existing assets are being used. Rectifying this issue should be central to the national plan, with a national dataset and peer review process created around the widely accepted benchmark of ten points per endoscopy session (eight points for a training list). FIT status should be actively influencing decisions about colonoscopy, as indicated in Recommendation 9.

[22] MAG analysis following meetings with the health board

- Workforce planning to address the need for trained endoscopy practitioners and non-medical endoscopists (NMEs). HEIW should be commissioned to create a national training plan for expanded supply of NMEs, alongside a dataset to benchmark the proportion of endoscopies undertaken by NMEs in each health board.
- Rolling out of capsule sponge to relieve demand pressures, with a recent independent evaluation concluding it was "feasible, safe and acceptable", as well as "substantially reducing the endoscopy burden for routine reflux referrals".[23]

Recommendation 6
Welsh Government should create a national plan for endoscopy to address the current backlog of long-waits. This should include prioritised capital for Betsi Cadwaladr University Health Board to bring it line with other health boards. In all other areas the focus should be on appropriate utilisation of existing resources, creating a national utilisation dataset (using GIRFT productivity benchmarks) which is reviewed regularly at the new Performance and Productivity Meeting (see Recommendation 18). HEIW should be commissioned to establish a new programme to expand Non-Medical Endoscopist training to rapidly expand the available workforce. Capsule sponge should be rolled out with a view to reducing demand for intervention endoscopy.
Timescale – within 6 months

Pathology

Pathology is the service that is almost universally under the most pressure, with median turnaround times twice as high as before the pandemic and running up to two months for routine tests in some health boards.[24] Some of the pathology estate is not fit for purpose and other sites do not have enough space for the equipment needed to adopt solutions which will help sustainability such as Digipath. There is a significant shortage of pathologists and in certain parts of Wales the service is critically fragile. [25]

Action is required to ensure that all regions have the necessary infrastructure to support digital pathology to agreed national standards through the prioritisation of the implementation of Digipath, thereby strengthening the resilience and productivity of services as the immediate priority. In parallel, the health boards should work together to develop regional plans for the transformation of pathology services. The plans should include workforce strategies for the training, recruitment, and retention of pathology staff, and capital plans to address critical estate and equipment issues.

[23] Use of a Non-Endoscopic Capsule-Sponge Triage Test for Reflux Symptoms: Results From the NHS England Prospective Real-World Evaluation - PMC

[24] MAG analysis following meetings with the Cancer Network
[25] MAG analysis following meetings with the Cancer Network

Recommendation 7
With the support of the proposed Performance and Productivity Unit (see Recommendation 19) regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future. The plan should include the full implementation of digital pathology as a key service enabler and address workforce, estate and equipment shortfalls. Timescale – within 12 months.

Targeting the longest waits

Whilst the MAG considered endoscopy and pathology to be the main modalities in need of systemic change, the single biggest driver of long diagnostic waits in Wales is in fact much more localised. Just under a third of all patients waiting longer than 8 weeks for their test in Wales are waiting for Non-Obstetric Ultrasound, compared to just 5% prior to the pandemic. Two-thirds of all of these patients are in a single health board: Cardiff and Vale University Health Board.[26] The MAG therefore also recommends that specific performance management arrangements are put in place with this health board to resolve this issue, with the independent sector being brought in to clear the backlog if sufficient progress is not being made within 3 months.

Recommendation 8
Cardiff and Vale University Health Board should submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound (NOU) backlog over the course of 2025/26 and should be held to account for the delivery of this. Independent Sector capacity should be employed if the health board has not made sufficient progress by the end of Quarter 1. **Timescale – within 3 months.**

4.2 Cancer

Cancer is the leading cause of death in Wales. The UK has one of the highest cancer mortality rates of all OECD countries and Wales has the second highest cancer mortality in the UK.[27] Given the known link between waiting times and mortality[28] the Welsh Government is rightly concerned that the backlog of patients waiting longer than the 62 day target is at its highest ever level[29], and that no health board has met the overall target (that 75% of patients should start their first definitive treatment within 62 days of first suspicion of cancer) since August 2020.[30]

Foundations are in place

Many of the foundations for improving the current level of cancer performance in Wales are already in place. The MAG was particularly impressed by the implementation of the

[26] StatsWales, Diagnostic and therapy services
[27] Cancer Services in Wales | Audit Wales
[28] Cancer waiting times: Latest updates and analysis
[29] NHS Executive management data based on health board returns on waiting lists
[30] Cancer Services in Wales | Audit Wales

single Suspected Cancer Pathway since 2019. This pathway has provided a national standard that is both relatively comprehensive in its patient coverage and sufficiently clear and straightforward to drive focus at both national and local levels. While some points of contention remain, such as the status of patients on adjuvant treatment, the MAG did not consider that any further changes to the standard were necessary at this time.

The quality and comprehensiveness of national data and analysis was also notable. The NHS Wales Executive has created excellent national business intelligence (BI) products within a relatively short period. Whilst some areas require further development, the MAG was impressed overall with the breadth and depth of insight available, which give the system the tools it needs to identify and co-ordinate the areas of required improvement.

MAG members also encountered numerous commendable proposals and ideas for performance improvement, both at the national and local levels. It is evident that cancer leaders are well-informed about the latest best practices being implemented in other nations and health systems and know which of these could bring about improvements in Wales.

Performance challenges are therefore not attributable to a lack of clarity regarding the headline standard that needs to be achieved, nor a lack of analytical insight about where the problems lie, nor the absence of knowledge about what needs to be done. Instead, the visits and interviews undertaken by the MAG suggested a chronic, and in some cases growing, inability to translate ideas into meaningful change.

Problems with planning and delivery

The years since the pandemic have seen a plethora of plans, summits, policy documents and best-practice recommendations, and this dilution of focus is a key contributing factor to the poor progress in actual delivery of meaningful change for patients.

There is no shortage of good ideas for improving cancer performance in Wales. Across the Welsh Government's 2021 *Quality Statement for Cancer*[31], the NHS Wales Executive's 2022 *Programme for transforming and modernising planned care and reducing waiting lists in Wales*[32] and the Cancer Network's 2023 *Cancer Improvement Plan*[33], there is an admirable level of aspiration and a wide range of sensible initiatives and pathway changes. But the resulting agenda is too broad and often too high level to result in any nationally significant and consistent change.

[31] The quality statement for cancer [HTML] | GOV.WALES
[32] Transforming and modernising planned care and reducing NHS waiting lists | GOV.WALES
[33] executive.nhs.wales/functions/networks-and-planning/cancer/cancer-improvement-plan-docs/full-plan/

Much of the content in these documents is the cumulative sum of individual health boards' own priorities rather than a set of clear, evidenced national priorities. The centre has too often appeared to view its role as to aggregate local ideas for improvement, rather than set out a clear, evidence-based national direction of travel. Whilst there is a strong focus on National Optimal Pathways (NOPs), these aggregate numerous desirable improvements and are often non-specific on how they should be delivered. The NHS Wales Executive itself accepts it cannot currently accurately measure if these are being implemented and relies on high-level health board self-assessment. In being asked to describe the relationship between these various national plans and the reality of local planning decisions at health board or trust, interviewees used words such as "*irrelevant*" and "*theoretical*."

One of the consequences of this approach is that, even where good ideas are proposed, there tends to be unwarranted variation in how they are implemented and a failure to realise the full benefits. In England, symptomatic FIT testing, for example, has meant Lower GI referrals for suspected cancer are 14% lower than expected this year, with more than 80% of these referrals now accompanied by a FIT test. This has supported a rate of performance improvement double that of all other cancers. In Wales, however, referrals are only 8% lower than expected, with only 70% of referrals accompanied by a FIT test and little observable impact on performance. Whilst all health boards told the MAG they were "*implementing FIT*," the situation appeared emblematic of the inconsistent and highly localised approach to implementing proven innovations. In the words of one interviewee, "*it is being done differently in almost every area*," and there did not appear to be any rigorous tracking of how FIT status is being used at triage, and in endoscopy departments, to focus resources on those with a higher risk of cancer. Teledermatology was another area where it was clear that there were multiple delivery models in use, with variable success and impact on performance.

The response to this lack of thorough implementation is too often to create another plan or initiative, despite the evidence this is no more likely to be delivered than the previous ones. Indeed, throughout this recent period of multiple plans being published, performance has flat lined within a range of c. 55-60%[34], whilst the backlog of patients waiting for care has steadily ticked upwards to a record high of 5,500[35]. Despite this, Welsh Government decided to announce an *increase* in the target from 75% to 80% by 2026 – another example of reaching for new policies or initiatives in preference to focusing on delivery of existing plans.

To break out of this dynamic, NHS Wales should identify the single highest-impact pathway change for each of the five tumour types it has already identified as driving poor performance: skin, lower GI, breast, gynaecology and urology. These should then form the basis of a much narrower, focused set of national support activities and accountability conversations with health boards over the course of 2025/26, alongside the continued local focus health boards will have on their more unique challenges. Together these tumour types account for three-quarters of all 62-day breaches,

[34] StatsWales, Cancer waiting times

[35] NHS Executive management data based on health board returns on waiting lists

meaning making progress in these areas would have a significant impact on national performance overall.

Recommendation 9
No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals. At the centre of this, drawing on the NOPs, NHS Wales should identify the single highest-impact pathway change for each of the five tumour types it has already identified as driving poor performance: skin, lower GI, breast, gynaecology and urology. These should then form the basis of a much narrower, focused set of national support activities and accountability conversations with health boards, alongside the continued local focus health boards will have on their more unique challenges. For Lower GI, this focus should be more consistent implementation of symptomatic FIT, with a new dataset created across endoscopy departments to assess whether capacity is being appropriately prioritised for FIT positive patients. For gynaecology, this should be the consistent provision of post-menopausal bleeding services; for breast the provision of breast-pain services; and for skin the more standardised provision of teledermatology services in primary care. In all cases, national specifications should ensure these initiatives are based in a primary care setting wherever possible, thereby reducing referrals to secondary care as a whole rather than substituting Single Cancer Pathway referrals for non-urgent referrals. **Timescale – within 3 months**

Misaligned financial flows

For cancer, financial flows in NHS Wales do not sufficiently incentivise performance improvement, with minimal amounts of funding hypothecated for specific improvement initiatives and minimal consequences for success or failure.

Whilst the MAG acknowledges the advantages of the current allocation model to health boards, it believes that stronger financial incentives are necessary for the NHS to improve performance in specific areas where a consistent national approach is required. There are numerous examples where improvement initiatives have been launched without dedicated ring-fenced funding, which means that even well-evidenced changes are therefore not necessarily fully implemented by health boards. When ring-fenced funding is available, such as the recent £1 million provided for performance improvement, it is often distributed based on local bids rather than national priorities. This approach appears to encourage competition among health boards for resources rather than fostering a strategic, nationally led agreement on what is optimal for the entire health system.

There is likewise no positive correlation between financial flows and performance improvements. In fact, many of the health boards the MAG consulted felt the opposite was true; that any additional funding made available mid-year would be directed to areas making the least progress, rather than those that had successfully implemented improvement initiatives. One interviewee stated that "*they [the NHS Wales Executive] will express frustrations, write us some letters, but ultimately there are no*

consequences." There was also frustration with these arrangements at the centre; two separate interviewees within the NHS Wales Executive said, "*we have no carrots and no sticks*." The MAG members were told that an internal paper within Welsh Government had been drawn up on "Levers for Change" in 2022 which considered different forms of financial incentives, but this does not appear to have resulted in any decisions or changes to date. It is the view of the MAG that the current approach is demonstrably not achieving the desired results and new incentive structures would be worth experimenting with.

The evidence base for the most effective pathway structures in cancer services is significantly stronger than in most other clinical areas, and the size of the NHS in Wales offers an opportunity to implement these consistently. Welsh Government should therefore strengthen the link between financial flows and interventions that drive improvement nationally, using clearly defined and transparent financial reward or financial clawback mechanisms. To complement this, the Welsh Government should also establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care (and aligned with the relevant NOPs and Community Health Pathways). Given the five tumour types driving the majority of long waits nationally, initial incentives could include increased safety netting for FIT negative patients, the provision of breast-pain services, or the development of teledermatology arrangements outside of secondary care. The effectiveness of both sets of financial incentives should be independently evaluated a year after implementation, to begin to build an evidence base around the deployment of these types of incentives in Wales.

Recommendation 10
A ring-fenced fund, held centrally, should be created to directly fund the high-impact, nationally prescribed service changes described in Recommendation 9, which are monitored through the health board performance report (see Recommendation 21).
This fund could be created from a restructuring of the various, smaller ring-fenced amounts held centrally where there is limited evidence of impact; or alternatively by retaining a proportion of any new funds invested into the Welsh NHS in future financial years. Health boards must demonstrate the use of these funds for the specified initiatives using transparent national data collections, or else the funding should be withheld or subject to a clearly defined and transparent claw-back mechanism (depending on the approach used). **Timescale - within 3 months.**

Recommendation 11
The Welsh Government should establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care.
Given the five tumour types driving the majority of long waits nationally, initial incentives could include increased safety netting for FIT negative patients, the provision of breast-pain services, or the development of teledermatology arrangements outside of secondary care. This will require changes in contracts at the cluster and practice level including updating the governance framework indicators by July 2025.
Timescale - within 3 months.

Leadership and oversight

National leadership of cancer policy and delivery is unnecessarily fragmented and complex, with three different teams responsible for policy (the Cancer Network), implementation (the Planned Care Recovery Programme) and oversight (Performance and Assurance).

Although the MAG was informed that these teams convene every six weeks to coordinate their actions, the current structure has resulted in diffused national ownership of the cancer improvement agenda, with no single individual clearly accountable for defining and coordinating improvement activities across Wales. Teams that should notionally be part of a single performance improvement architecture are instead pursuing duplicated health board engagement processes, clinical leadership roles, and strategy development. This is a key driver behind the emergence of multiple plans and lack of prioritisation of improvement efforts discussed under Recommendation 9. It has also created the conditions where too many leaders are able to say that issues crucial to improving cancer performance are "*someone else's job*." The MAG did not speak to a single interviewee who felt the current arrangements were working well.

In response to the recent Audit Wales review,[36] which stated that national leadership arrangements "need to be clarified and strengthened as a matter of urgency", Welsh Government has proposed a new Cancer Board to sit above these three functions. Whilst this may bring about some improvement, the MAG believes that this alone will not adequately clarify the roles of the constituent bodies reporting to it, nor how their respective work should influence one another, and that the integration of these separate teams needs to take place at a more fundamental, day-to-day level rather than via a higher-level board attempting to improve co-ordination.

The MAG considers that the Cancer Network should formally merge with the cancer arm of the Planned Care Recovery Programme, creating a single team which is responsible for setting out the strategic direction of cancer care in Wales and directing improvement activities. This combined team should be under the leadership of a single managerial

[36] Cancer Services in Wales | Audit Wales

lead and clinical lead that report to the Managing Director of the PPU and the National Medical Director (see Recommendations 18 and 19), and should be appointed via an open, competitive process and together be held accountable for improvements in cancer performance nationally. This single leadership team should then direct the work of both the strategy development and delivery aspects of the team's work. The team should work closely with the Performance and Productivity Unit (see Recommendation 19) to ensure health boards are held to account for the priority improvement initiatives described in Recommendation 9 and should direct the application of the financial incentives described in Recommendation 10.

Recommendation 12
The Cancer Network and the cancer arm of the Planned Care Recovery Programme should formally merge to create a single team responsible for setting the strategic direction of cancer care in Wales and directing improvement activities to support this, led by a senior clinician and senior managerial lead, reporting to the Managing Director of the proposed Performance and Productivity Unit and the National Medical Director. (see Recommendation 19 and 20). Timescale – within 3 months.

Improving data on performance

Whilst the quality and comprehensiveness of data required for cancer performance improvement in Wales is generally good, there are some further areas for development which could strengthen the current approach.

Overall, the MAG was impressed with the quality and comprehensiveness of data on cancer performance in Wales, as well as the work undertaken by the NHS Executive to create national dashboards and BI tools to support performance improvement. There were only two areas in which it felt further improvements should be made. The first of these relates to the granularity of tumour-level performance data which is collected and published nationally. It is impossible currently, for example, to compare health board performance on prostate cancer (which is contained within a wider "urology" category with bladder and other cancers), despite this likely being one of the most challenged tumour types nationally. The second of these relates to diagnostics data, where the lack of linkages between national cancer and diagnostic datasets means it is not possible to identify the exact bottlenecks in some more complex pathways, despite the fact this could be a useful guide for national capital planning and other purposes. The first of these issues should be easily resolvable by Digital Health and Care Wales (DHCW), and the second should be the subject of a more detailed options appraisal.

Recommendation 13
Digital Health and Care Wales (DHCW) should develop a plan to begin collecting and publishing more granular tumour-level performance data from the beginning of the 2026/27 financial year at the latest. DHCW should also produce an options appraisal for the production of a linked dataset containing cancer and diagnostics waiting times data, producing pathway-level insights into the key diagnostic drivers of long-waits at health board and at national level.
Timescale – within 12 months.

Cancer diagnostics

There is no national prioritisation or national planning for appropriate diagnostic capacity across Wales as a whole, even in areas driving poor cancer performance.

Members of the MAG were particularly concerned about the quality of endoscopy and pathology facilities observed in several health boards. Lower GI and upper GI cancers – the two tumour types heavily reliant on endoscopy for diagnosis – currently account for a quarter of all 62-day breaches. Median turnaround times in pathology, meanwhile, have doubled since the pandemic from 6 days to 12 days. The MAG heard that there were not clear national plans in place to develop capacity in these areas, with health boards left to put forward their own plans rather than the centre forming a clear idea of what national capacity was needed for Wales as a whole.

These issues are addressed through Recommendations 6 and 7 in the Diagnostics section of this report.

4.3 Urgent & Emergency Care

A system under pressure

Patients using ambulance services and emergency departments are experiencing long waits and while the clinical care is generally good, these delays impact detrimentally on patient experience and outcomes. Long ambulance waits outside hospitals mean that patients have to wait longer for an ambulance which again increases the clinical risk.

Emergency Department (ED) attendances in 2024 were 8.7% higher than 2017 partly driven by population changes but also possibly by changes in how patients use the service. Ambulance call-out rates have not grown at the same rate, although there has been a recent spike in (Red) 999 calls. However, response times are 50% longer for life threatening (Red) 999 calls than in 2019. For serious but not immediately life threatening (Amber) calls they are over 200% longer, on average.[37] Fewer than 70% of patients were admitted, discharged or transferred from the emergency departments within 4 hours in 2023/24, compared to over 82% in 2015/16, and a target of 95%. Over one in 10 attendances currently exceed 12 or more hours[38].

The pressure on emergency services is only partly due to rising demand. The main cause of extended time patients spend in the emergency department and other pressures is a lack of flow through hospitals. There were over one million attendances across Wales in 2023-24, the highest on record[39] but the problem comes when the emergency department (ED) cannot move the patient on to an inpatient ward, an

[37] Ambulance Service Indicators - NHS Wales Joint Commissioning Committee
[38] StatsWales, Emergency department, Ambulance services
[39] https://www.gov.wales/trends-nhs-urgent-and-emergency-care-activity-march-2024-html

appropriate alternative or be safely and easily discharged home. The result of this is overcrowding and busy-ness in the ED. This leads to patients being kept on trolleys and in corridors for extended periods and is a stressful environment for patients and staff.

The main reason that patients cannot be moved on to more appropriate settings is that Wales has a very large number of beds occupied by people who no longer need to be in a hospital but need a variety of other services or are waiting for decisions to be made about their care. These include waiting for:

- community services providing home healthcare
- for patients to choose a care home
- assessment by social care or for a social care funding package to be approved
- a place in a community hospital or care home to become free
- wait to transfer to a specialist centre

These delays are not solely as a result of problems with the system outside of the hospital. A significant number are the result of processes inside hospital caused by factors such as waiting for a doctor to approve documentation or waiting for drugs to take home. These challenges are exacerbated by the poor state of the digital infrastructure in hospitals across Wales.

Pathway of care delays (POCDs) account for around 1 in 7 (1500) of occupied acute beds, compared to 1 in 25 in 2019/20 (estimated based on available data).[40] The MAG observed multiple instances of frail patients being cared for in the corridors of emergency departments alongside high numbers of clinically optimised patients in the frailty wards. This is not good care, as unnecessary time spent in hospital can be detrimental to a patient's health and recovery. This is especially true for older patients, who have a greater risk of physical and cognitive decline including losing muscle mass, acquiring infections and other problems (Chen et al[41]). As a result, they may need a more intensive package of care when they are finally discharged than if they had gone home earlier.

This congestion and lack of flow also leads to longer ambulance handovers as if the emergency department is unable to move patients on then it cannot accept new ones. Over 260,500 hours were lost to handover delays in 2023/24 compared to 112,057 hours in 2019/20. The Welsh Ambulance Services University NHS Trust (WAST) estimated that a quarter of the fleet were outside of a hospital on average throughout December 2024, with an estimated cost of £46 million of productive time across 2024. More importantly, it means that while the ambulance crew is caring for a patient who cannot be offloaded, they are not available to answer calls from others whose need may be greater.

[40] NHS Executive management data based on health board returns on pathway of care delays
[41] https://onlinelibrary.wiley.com/doi/10.1002/gps.5687

Lost hours for the ambulance service following notification to handover at emergency departments, April 2016 to March 2024

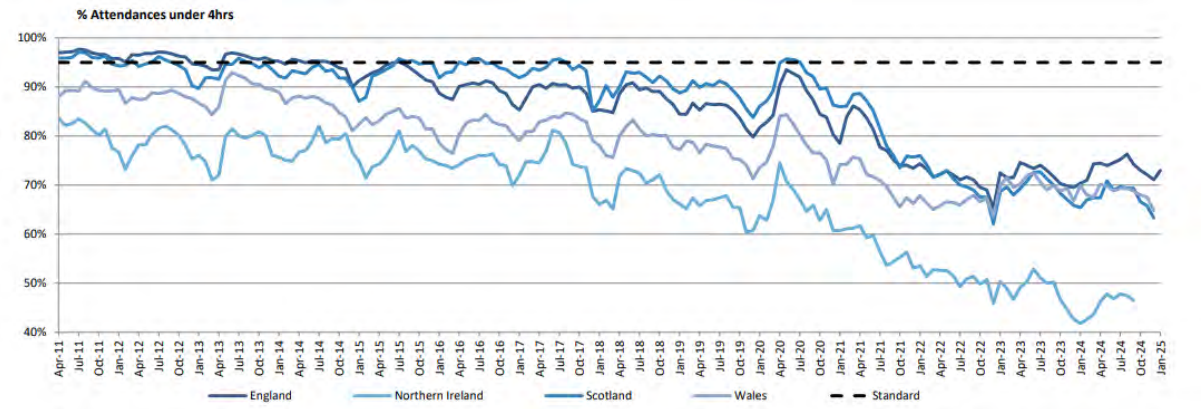
Source: Ambulance Service Indictors, Ambulance Service Indicators - NHS Wales Joint Commissioning Committee

These delayed pathways of care are not just an issue for patients and carers: they are also a significant cost to the health and care sector and the country as a whole. At an estimated £124 million a year, this equates to £1 in every £60 spent in the health and care sector. Adding the c.£50 million loss of ambulance productivity due to handover delays, the total cost is 0.9% of the total revenue spending for Wales.

There has been action in this area and there is a focus on improvement of urgent and emergency care (UEC) in Wales. Following decline against the 4-hour ED standards across the UK, improvement started earlier in Wales, remaining relatively stable since 2021/22 (see chart below). The Six Goals Programme for Urgent and Emergency Care (6 Goals)[42] is well regarded, with comprehensive coverage of the entire UEC pathway. In 2024 the GIRFT programme were commissioned to conduct detailed reviews of all 12 Emergency Departments across Wales.

The MAG observed several developing models of care that offer alternatives to admission, including Same Day Emergency Care (SDEC) models, and hospital at home or virtual ward services to ensure more people receive the care they need at home. Expansion of these services would undoubtedly provide a better patient experience for patients who are able to be managed by these services and support overall UEC flow and capacity, and opportunities here need to be explored and developed. We are also aware of the growing demand for diagnostics within the UEC pathway, to support earlier diagnosis, enhance the effectiveness of SDEC, and avoid admissions wherever possible. However, the recommendations in this report are targeted at where significant improvement is urgently needed, covering discharge delays, ambulance handovers, management of pressures in real time and increasing focus on the 6-goals programme.

[42] Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES



Source: StatsWales, Emergency department; NHS England, Statistics » A&E Attendances and Emergency Admissions; Department of Health, Emergency care waiting times | Department of Health ; Public Health Scotland, Monthly A&E Activity and Waiting Times - Datasets - Scottish Health and Social Care Open Data

Address delayed pathways of care

For all the reasons explained above, the predominant concern about urgent care raised by staff, the GIRFT reviews and as evidenced in the data is the pathways of care delays. This is one of the most significant barriers affecting NHS productivity and if it is to be resolved it will require a whole systems strategic shift in thinking, funding and governance. Delays are function of processes, partnerships between organisations, and of capacity in the community.

Recent lessons learned from the 50 day challenge to improve process management, together with the adoption of the Discharge to Recover then Assess (D2RA) Pathway and Trusted Assessor Model will, if mandated, yield some welcomed and immediate improvements in patient flow and long term care.

Trusted assessor

With 22 local authorities across Wales, strong partnerships with the seven health boards are essential. Research shows that the more local authorities are involved in a hospital's discharge processes the longer is the length of stay (Fernandez et al[43]). Nearly half of the POCDs are due to 'assessment issues' rather than capacity (46% in January 2025) highlighting the need for better partnership working.

In this context, the trusted assessor model should be a 'Once for Wales' requirement for all health boards and local authorities.[44] An audit should be run in May 2025 to establish where this is not happening, repeated in October 2025 with an expectation of full compliance. This should be published in November, along with a justification from the health board and/or local authority where this has not been achieved alongside a realistic timetable for subsequent implementation.

[43] https://pmc.ncbi.nlm.nih.gov/articles/PMC6158346/#:~:text=The%20results%20suggest%20that%20the,post%2Doperative%20lengths%20of%20stay.

[44] https://executive.nhs.wales/functions/six-goals-uec/goal-6/goal-6-resources/trusted-assessor-role-guidance-pdf/

Discharge to Recover then Assess (D2RA)

NHS Wales has clear guidance[45] on processes for D2RA Pathways, based on the discharge to assess model proven to improve in length of hospital stay.[46] This guidance requires "*patients must be placed onto a D2RA Pathway*" and that "*for D2RA Pathways 1-3, patients must leave hospital within 48 hours (maximum) of being declared clinically optimised to do so*". The number of patients that are not discharged within 48 hours should be made public by pathway by hospital site, with those on pathway 0 used as a proxy for where hospital processes require improvement.

The capacity of services in the community

This is the biggest challenge for pathway of care delays and will require longer term solutions. The First Minister has stated that improving access to social care is one of her top four priorities[47], and an efficient health care system is not possible without a fully functioning social care system. However, not all delays are due to social care. Improving capacity of social care and community services will take time, so access to care at home must be prioritised for the pathways with the greatest delays, both POCDs and 12+ hour ED attendances.

Expansion of community services for adults with frailty would reduce delays, and the associated 12+ hour ED attendances. Alternatively, where patients on heart failure pathways are experiencing the longest delays, heart-failure virtual wards could be used to improve quality and efficiency. But the current data do not allow this level of insight.

Data should ideally be collected at patient level to inform this. However, lessons from England show this can take time to implement. Given the urgency, a rapid study should be conducted within three months to identify pathways with longest delays, particularly for cohorts that frequently experience long ED stays. Detailed demand and capacity analysis should then be performed across health and care services, with gaps backed by the investment required to provide care at home. Although this would primarily focus on reduced discharge delays, boosted capacity in the community would also provide alternatives to admission.

[45] https://www.gov.wales/sites/default/files/publications/2025-01/hospital-discharge-guidance-january-2025.pdf
[46] https://pmc.ncbi.nlm.nih.gov/articles/PMC6484156/
[47] "We have listened, we have learned and we will deliver" - FM announces Welsh Government priorities | GOV.WALES

Recommendation 14
Health boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care. Timescale – within 6 months.

a) **Hospitals must ensure that all admitted patients are placed on D2RA pathways in line with the national Hospital Discharge Guidance, and delays by pathways to be published within 3 months.**
The Performance and Productivity Unit (see Recommendation 19) should then use pathways of care delays for patients requiring no onward care (pathway 0) as a proxy for where hospital processes must be improved to reduce delays.

b) **Welsh Government to run an audit of use of trusted assessors across the 7 health boards and 22 local authorities in May 2025, repeated in October 2025.** This should be published in November with justification from the health board and/or local authority where this has not been achieved alongside a realistic timetable for subsequent implementation.

c) **A rapid study should be undertaken within 3 months, by Welsh Government working with health boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in ED.** This should be used to target investment in linked community services for winter and future budgets.

Address ambulance/ED handover delays

Long ambulance handover delays are a very significant issue across Wales with evident variation in performance. Ambulances are taking fewer people to hospital than before the pandemic, with 11,000 conveyances in January 2025 compared to 15,000 in January 2020[48]. Hours lost due to ambulance handover delays have doubled for the same period. The level of rapid improvement in certain sites across the UK shows what can be achieved with the right focus.

Following the implementation of absolute maximum handover time of 45 minutes in London, systems across England are now being asked to do the same.[49] NHS Wales should now do the same by October 2025, ahead of winter. This does not replace the 15 minute target but ensures ambulances can be released more rapidly back to the community. Where local circumstances mean a 45 minute maximum would be too great a risk to patient safety, an alternative should be agreed, with justification in the health board public board reports.

WAST needs to build on its work to hold or further reduce the number of conveyances to hospital by continuing the recent increase in cases treated at scene and increasing the

[48] Ambulance Services Indicators-NHSWJCC
[49] https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance

use of alternatives to hospital. This will need the support of a range of other services and will require active management and coordination to ensure that community and social care services can be rapidly mobilised when support is required. Attention to care homes and advanced care planning for patients at the end of life can also help reduce conveyances to hospital for those patients who wish to remain at home.

Recommendation 15
Health Boards should ensure that no ambulance handover should exceed 45 minutes, with a focus on achieving the 15 minute handover target wherever possible.
Where the 15 minute handover time target is not possible, an absolute maximum handover time of 45 minutes should be introduced by October 2025.
Timescale – within 6 months

Strengthen reporting, measurement and escalation

The Six Goals for Urgent and Emergency Care (6 Goals) Programme[50] covers improvement across the pathway, but published data does not reflect this.

The 6 Goals Programme is well regarded, with comprehensive coverage of the entire Urgent and Emergency Care (UEC) pathway. Improvement is supported by management data that are organised around each of the 6 goals, yet the data presented to the public are not. This is particularly evident in the new quarterly performance report for health boards[51], which presents the formal performance standards on ambulance response times and time spent in ED, not the breadth of the 6 Goals Programme.

Advancements in other areas of the pathway that enhance the care patients receive at or closer to home therefore go unrecognised. Conversely, lack of progress developing services closer to home will not be apparent to a health board's population.

To ensure alignment between operational focus and public commitment, the monthly health board performance reports should provide an assessment of progress against the established goals, utilising the information compiled for the Six Goals Board, starting from June's publication. The reports should include both validated and unvalidated data against the four hour standard to enhance transparency, in accordance with requests from the GIRFT programme and the Royal College of Emergency Medicine (RCEM). It may also include additional metrics used in the recent GIRFT reviews of the emergency departments if these represent an improvement on the current metrics. This should then be considered by the clinical group reviewing the current performance standards, to ensure future recommendations cover the whole UEC pathway.

[50] Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES
[51] https://www.gov.wales/nhs-performance-welsh-local-health-boards-december-2024-html

Recommendation 16
Progress against the Six Goals for Urgent & Emergency Care Programme should be reported publicly, using the health board performance reports (see Recommendation 21). Timescale – within 3 months.

Health boards should ensure that performance reports are aligned with the 6 Goals metrics before winter 2025/26 and made public from June. The report should include both validated and unvalidated four hour performance data. The clinical group reviewing performance standards should ensure that performance metrics cover the full UEC pathway.

Consistent measurement of pressure across Wales would allow faster more appropriate action in real time.

The nature of the UEC pathway means that service pressures and performance challenges can arise in real time. Wales has a clear structure for the escalation of real time pressures, centred on a daily call chaired by WAST. A new framework for Urgent and Emergency Care System Escalations has been developed, with recommended actions aligned with the 6 Goals Programme. This ensures that both short term escalation and long-term improvement are driven by the same underlying principles.

However, the escalation levels (1, 2, 3, or 4) are not objective and that resulting variation in application makes providing an appropriately targeted and consistent response difficult.

In England, this problem has been resolved with a clear and objective method to determine operational pressures escalation levels (OPEL). This has been developed by clinical and operational staff and is underpinned by a sophisticated digital system providing near real time data. As a result, pressures across the country are measured in a consistent way, allowing for a faster targeted response, including implementation of mutual aid.

Given the OPEL model was clinically led, and has been tested, NHS Wales should adopt this by October 2025, or a version with minor changes to adapt to the Welsh service. This would improve the real-time response to pressures in Wales and improve understanding of pressures across the Wales – England border. In alignment with the broader digital strategy, a digital solution should be explored to ensure the consistency and timeliness of reporting.

Recommendation 17
A consistent framework for escalation levels within the Urgent & Emergency care system should be introduced by October 2025, using the OPEL framework in England, adapted for the Welsh service where needed.
This recommendation should be enabled by the development of a “Once for Wales” digital support tool.

5 Making change happen

As part of its review the MAG considered a number of key enablers to improving productivity and performance, namely:

- operating model and accountability frameworks
- the system approach to productivity (including workforce)
- digital and data
- the regions and capital as levers for change.

5.1 Operating model and Accountability frameworks

The Parliamentary Review of Health and Social Care in Wales 2018[52] called for a clearer distinction between the national executive function responsible for strategically developing and managing the NHS, and the national civil service function responsible for supporting and advising ministers on the development of departmental and cross-governmental policy. From the evidence the MAG has gathered and the comments received this is considered to be sound advice.

When policy and delivery are synchronised and aligned they together make a powerful lever for change. However, from what the MAG has seen and heard there is a chasm between the ambitious agenda set by A Healthier Wales: Our Plan for Health and Social Care and the reality of performance on the ground, where services continue to be challenged to recover from the impact of the Covid-19 pandemic proceeded by over a decade of austerity.

The MAG heard from Welsh Government about its intent to strengthen and simplify the planning environment by increasing its expectations for the delivery of a smaller number of ministerial priorities as evidenced in the planning framework for 2025/26. This simplification will need to be supported by a strengthened focus by health boards on the delivery of the priority enablers that would improve productivity and performance. These are currently delivered to some extent across Wales but with a degree of variation that offers a significant opportunity for improvement.

The MAG supports this approach as this is not the time to over-burden the service with policy initiatives and excessive process and bureaucracy. Instead, the NHS needs a clear focus and a strong guiding hand underpinned by a performance improvement and management framework that drives service productivity and improves access and outcomes. As discussed elsewhere in this report, this needs to be complemented by

[52] Parliamentary Review of Health and Social Care in Wales Final Report

investment in operational management capability and better alignment of financial flows.

According to a background briefing paper presented to the MAG, the NHS Wales Executive (the Executive) was established in April 2023 to play this pivotal role, in support of Welsh Government.

"The purpose of the Executive is to drive improvements in the quality and safety of care and work on behalf of the Welsh Government and provide strong leadership and strategic direction - enabling, supporting and where necessary, directing the NHS in Wales to transform clinical services in line with national priorities and standards."

It was apparent in discussion across the Welsh health care system that the Executive has not reached this level of aspiration nor maturity.

It is the view of the MAG that one of the root causes of this is that the Executive is not an executive in any sense of the word. It has no executive function and no formal authority within the governance structure. It is in fact a resource of some 400 WTE people who have been brought together from a number of previous national bodies such as the Delivery Unit, Finance Delivery Unit, NHS Collaborative, and Improvement Cymru with the objective of creating a central and coordinated source of capacity and capability where the sum would be greater than the former disconnected parts. At the moment this is best described as early work in progress.

Some of this Executive resource is deployed in support of the work of the Value and Sustainability Board (VSB) and its five work streams (Workforce, Medicines/Prescribing, Continuing Healthcare/Funded Nursing Care, Non-pay & Procurement and Clinical Variation/Service Configuration). The MAG received consistent positive feedback about the work of the VSB from all stakeholders and believes it has the potential to be the building block for future work on productivity.

However, elsewhere there is a widely held and perceived view that at the centre of the NHS Wales there is an over-emphasis on policy creation, process management, and the generation of more objectives and targets overlayed with increasing layers of complexity and bureaucracy. This has served to blur the lines of accountability, with little to show in terms of improved productivity and performance.

As an example, post-pandemic it is evident that more - if not all - health boards have been placed in the performance management escalation machinery, with an associated increase in Welsh Government intervention. The result of this is that there are multiple interactions and meetings between Welsh Government and the health boards. There is a widely held view that this has increased the layers of complexity with the potential to blur accountability and obstruct progress, not least by placing an emphasis on reporting rather than action.

The MAG was told that "there are too many targets and insufficient sense of priority" and that "there are too many bodies confusing accountability". A recently departed health board CEO told the MAG "I've never seen as complicated a picture of who is

accountable for what", whilst a current health board CEO said, "we have made it so complicated that we are stifling ourselves".

Welsh Government has set out its intention to simplify this landscape and this has been progressed in the planning framework for 2025/26. The MAG supports this direction of travel but consider this needs to happen at greater pace to deliver the step change in productivity and performance required.

The MAG also heard from many sources that the clinical leadership voice is not strong or central enough in the current operating model. There are excellent clinical leaders in Wales but the work of the clinical networks, the medical directors in the health boards and the clinicians sitting in various roles in the current NHS Executive resource are not sufficiently aligned or anchored to the existing governance architecture. There is also cost-inefficient duplication and confusion about roles, as highlighted in the recent Audit Wales report on cancer services.

The MAG believes that strengthening and empowering clinical leadership at all levels - nationally, regionally, and within health boards and trusts - is crucial for addressing immediate performance and productivity challenges, as well as long-term clinical service transformation and sustainability.

Finally, another of the consistent messages the MAG heard was that there should be stronger central direction and a clearer mandate to the NHS in Wales where interventions are known to have proven benefit and utility. It is evident that the Cabinet Secretary for Health and Social Care has received the same message, as reflected in his letter to NHS Wales Chairs on 20th December, mandating a series of enabling actions on the basis of "adopt or justify." The MAG strongly concurs with this approach.

The MAG reflections above were supported by the Chief Executives who wrote to the MAG with the following suggested pointers to inform the recommendations its report (full list at Annex E):

- *Provide a clear operating framework describing the role of the NHS Executive and its relation to health boards/trusts with regard to oversight/performance management/delivery assurance.*

- *Streamline the various national groups/boards overseeing performance with the NHS Leadership Board being the single place to oversee quality/performance/ finance at a national level. Below this hold NHS Wales organisations to account through monthly meetings to review the same topics at a local level thus streamlining the multiple local assurance meetings currently in this space.*

- *Consider a role for a National Medical Director who has experience in direct service delivery and medical leadership who will drive and lead the national discussions with medical staff and support difficult service/clinical change discussions.*

- *Align expectations of efficiency and productivity in the planning framework for NHS organisations to ensure clear expectations of adoption of agreed clinical standards e.g. GIRFT/INNU.*

In parallel the MAG heard from Welsh Government of its frustration with a lack of progress in the delivery and implementation of key priorities such as GIRFT by health boards, resulting in a consequent increase in direction and escalation.

In light of the above, the following four recommendations are made:

Recommendation 18
Welsh Government should consolidate all holding to account and escalation meetings with health boards to single individual monthly performance and productivity meeting with each health board and trust. The meeting should focus on delivery against key areas of performance and productivity, and the recommendations of this report.

The CEO of NHS Wales should chair each Performance and Productivity meeting. The meetings should be attended by the CEO of the health board, and at a minimum the medical director, nursing director, finance director and those responsible for operational performance.

The outputs of performance meetings should be shared with the Cabinet Secretary and the Chair of the relevant health board or trust, with items escalated for discussion as appropriate. This would help clarity and delineate of the role of the Chief Executive and the Chair of each health board and trust, allowing the Chief Executive to focus on operational performance and allowing the Chair to focus on board governance, culture and managing the strategic relationship with the elected leadership of the local authorities and other key stakeholders. It would also alleviate the onerous duplication of time and effort created by the parallel operational oversight machinery currently in place between the Cabinet Secretary/health board/trust Chair and the NHS Wales/health board/trust CEOs.

The monthly performance meetings should replace all relevant existing monthly escalation and performance meetings. This should therefore replace the current JET, IQPD, oversight and escalation, and system NHS Performance Board meetings. The Oversight and Escalation framework should be enacted through these performance meetings.

The associated reduction in escalation interactions and meetings should allow health boards and trusts more time to focus on the immediate performance and productivity task. In parallel Welsh Government should consider strengthening the incentive and sanctions associated with delivery and non-delivery.

Recommendation 19
A managing director should be appointed to directly manage and oversee the NHS Executive which will be renamed the Performance and Productivity Unit (PPU). Timescale – appointed within 3 months.

The Managing Director (MD) should be of sufficient seniority to support the CEO of NHS Wales in holding their NHS colleagues to account. The Managing Director should be accountable to the CEO NHS Wales and be a member of the Welsh Government Executive Director Team (EDT). The Managing Director should have direct line management accountability for the budget and resources of the NHS Executive. This resource of around 400 WTE should be renamed the Performance and Productivity Unit (PPU). The Managing Director should ensure that these resources are transparently aligned to the single goal of improving the productivity and performance of the NHS across Wales. The Managing Director should review the options for how this resource is deployed, including out-posting to health boards and regions to support specific improvement interventions.

Recommendation 20
Medical leadership should be strengthened under the leadership of a new post of Medical Director of NHS Wales. This is a new post separate from and equal in status to the existing Chief Medical Officer post. The creation of this new post is essential to driving and delivering the performance and productivity agenda. Timescale – appointed within 3 months.

The Medical Director's priority responsibilities should include:

- Developing an organisational culture that supports the development of a continuously improving, clinically led and data driven NHS in Wales.
- To anchor and align the clinical leadership capacity and capability within the PPU and NHS Wales to the corporate performance, productivity and clinical transformation agenda.
- Through the health board and trust medical directors and the associated clinical leadership teams, to drive the implementation of GIRFT recommendation detailed in this report and reiterated by the Cabinet Secretary in his letter to NHS Chairs on 20th December 2024.
- Through the health board and trust medical directors and the associated clinical leadership teams, to provide the clinical leadership to drive and support the recommendations detailed elsewhere in this report with regard to planned care, urgent care, cancer and diagnostics.
- To work with the regions, health boards and clinical networks to support, develop and implement regional solutions to fragile services as discussed later in this report.
- Through the health board and trust medical directors and the associated clinical leadership teams, to drive and prioritise the implementation of HealthPathways (Pathway Alliance Programme).
- Through the health board and trust medical directors and the associated clinical leadership teams, to drive the implementation of the Value and Sustainability Board agenda including high value pathway interventions and the medicines management work programme.
- To put in place mechanisms to ensure the alignment of job plans, appraisal and revalidation.

This revised performance management framework should be supported by the development of a standard performance dashboard that is used by all health boards as part of their monthly board meetings. This performance report should be discussed in the public part of the board meeting as a means of both increasing public transparency on performance and enabling health boards to compare performance (apples with apples) and hence to identify good practice and share learning.

It is recognised that currently all health boards produce their own performance reports set against the key metrics of the performance framework and publish these at health board meetings. However, as noted above the MAG consider that there is value in standardising the format and content of this reporting across the health boards.

Recommendation 21
Health boards should commission the NHS Welsh Confederation to develop a standardised health board performance dashboard. The dashboard should be used in the public part of board meetings and to support the P&P meetings. Timescale - this should be operational within 3 months.

5.2 Measuring productivity

Productivity

While there are multiple lenses on performance and clear progress on productivity in the five work streams of the Value & Sustainability Board (VSB) there is currently no single national measurement of the overall productivity of NHS Wales.

As such it is not possible to make an evidence-based assessment of the relative productivity, or the extent of improvement in productivity over time, or to set clearer expectations on productivity improvement to ensure maximum value for the Welsh taxpayer.

The MAG proposes that a national model to track productivity should be produced ahead of the next national budget to help inform spending decision and productivity requirements. This should track national Total Factor Productivity as a minimum and be developed in a way that allows for health board level productivity metrics and targets across primary, community, acute and mental health services. Given the model established by the ONS for UK and England, this may be a useful starting point for consideration.

Recommendation 22
A total factor productivity model and workforce productivity model should be developed for NHS Wales and implemented in advance of the next budget. Timescale – within 12 months.

Tracking workforce productivity

The annual spending on workforce by the Welsh NHS in 2023/24 was £5.9 billion, 58% of the total budget[53]. It is to be welcomed that workforce is one of the priority work streams of the Value and Sustainability Board, but by its own admission this area has received less attention than the other five priority areas. The notable exception is the excellent work on developing and implementing an agency control framework and international recruitment strategy to support a reduction in the reliance on agency workforce. This has reduced agency expenditure from £325m to £173m over the period 2022/23 to 2024/25.

As shown in the table below, between 2019 and 2024 there has been a 15.14% increase in the number of staff employed within the Health Boards across Wales, ranging from 8.77% in Cwm Taf Morgannwg to 22.54% in Hywel Dda.

Health Board	2019-JUN	2024-JUN	Difference	% increase
Aneurin Bevan University Health Board	11,387.46	12,961.70	1,574.24	13.82
Betsi Cadwaladr University Health Board	15,318.62	17,894.29	2,575.68	16.81
Cardiff and Vale University Health Board	12,824.02	14,885.25	2,061.23	16.07
Cwm Taf Morgannwg University Health Board	10,247.88	11,146.79	898.91	8.77
Hywel Dda University Health Board	8,389.40	10,280.65	1,891.25	22.54
Powys teaching Health Board	1,773.23	2,080.41	307.18	17.32
Swansea Bay University Health Board	11,153.98	12,609.59	1,455.61	13.05
All Wales	**71,094.59**	**81,858.68**	**10,764.10**	**15.14**

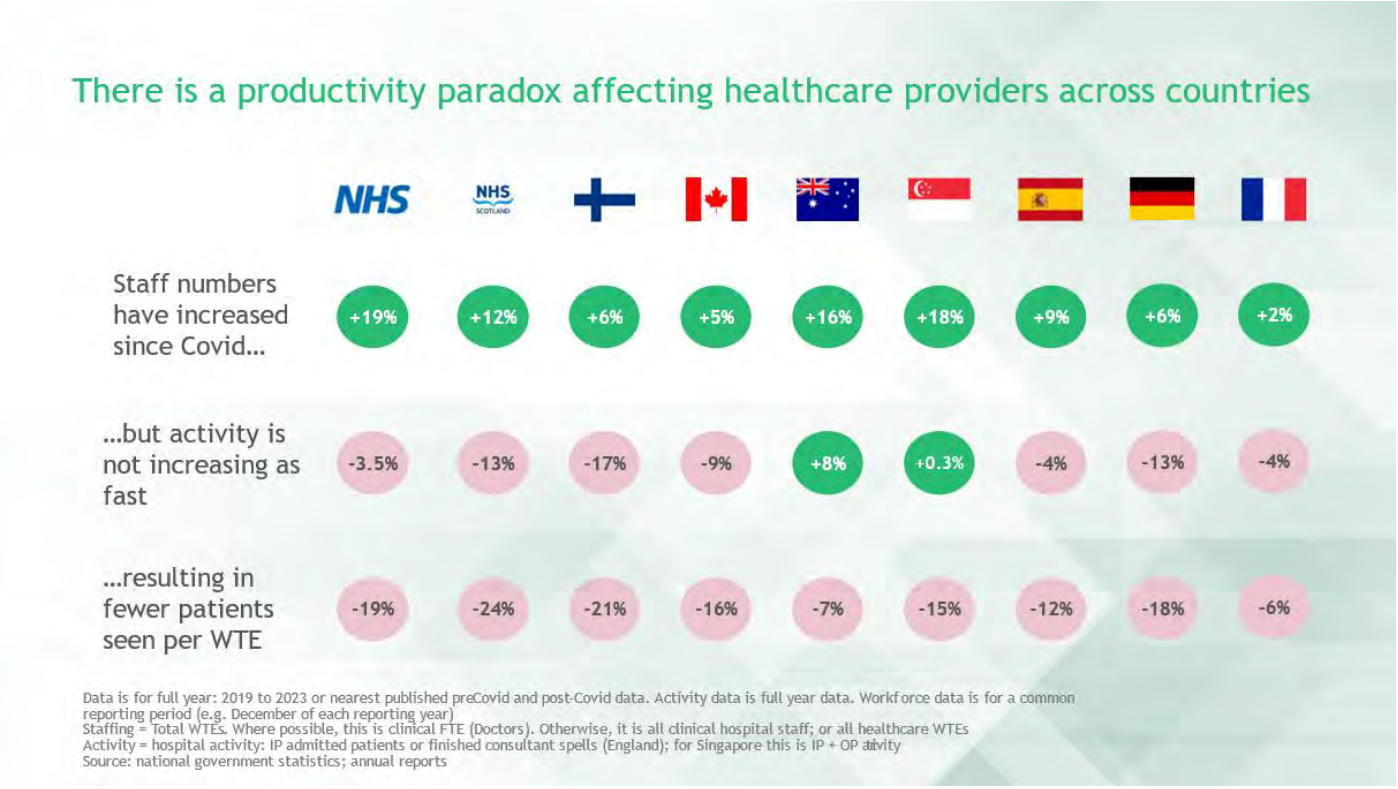
Source: StatsWales, NHS staff summary

Primary Care (GMS) staffing numbers have also increased although materially less so.[54] Across Wales there was an increase of 1.8 FTE staff per practice between September 2021 and September 2024, although the number of practices reduced by 20 (5.1%) in the same period. The largest increases occurred in direct patient contact workers (including Allied Health Professionals and Pharmacists) and administrative/non-clinical groups. However, comparing the same six months periods (April to September) in consecutive years, StatsWales[55] shows a 1.4% reduction in GMS activity from 2023/24 to 2024/25, representing a reduction of almost 136,000 appointments offered in general practice, out of a total of 9.62 million in the same period. The relative increase in hospital staff compared to primary care staff appears counterintuitive in the context of local and national policy "left shifts" from hospital to community and from sickness to prevention.

This overall increase in staffing levels across the Welsh NHS is mirrored in health care systems elsewhere. However, these health care systems are also performing proportionally less work and attending to fewer patients per staff member than they did

[53] NHS Summarised Accounts for 2023/24 gen-ld16720-saesneg-yn-unig.pdf
[54] StatsWales, General practice workforce
[55] StatsWales, General practice activity

five years ago. This trend is evident in the schematic below[56]. It would be surprising if Wales did not exhibit a similar pattern, although a detailed analysis has yet to be published. It is recommended that this analysis should be completed with 3 months of the receipt of this report. This should subsequently be reported quarterly as trend data in the monthly standardised health board performance report.



Recommendation 23
From the June health board meeting cycle of the 2025/26 annual year going forward workforce head count, full time equivalent staffing and productivity data should be reported to the monthly public meeting of each Health Board. This should include data on both directly employed and the GMS and other independent contractor workforce. Timescale – within 3 months.

Leadership development and management training

A step change in productivity will not occur without strong leadership and management, particularly at the level of the clinical service or division within the health boards and trusts. This is invariably driven through a triumvirate of a lead doctor and a lead nurse working alongside a lead manager and increasingly complimented by a lead allied health professional. These triumvirates need to be properly supported and resourced, with appropriate leadership and management development and training.

[56] BCG consulting. National government statistics; annual reports.

Time did not allow the MAG to fully consider and explore the extent to which leadership and management development is appropriately resourced and supported at national, regional and/or local level although undoubtedly there will be much good work in place. We would however recommend that current programmes are reviewed to ensure that they are aligned to the productivity and performance agenda, including the recommendations made elsewhere in this report about waiting list management and the implementation of GIRFT reports.

Recommendation 24
HEIW should work with the PPU to ensure that leadership programmes are in place to support the "threes at the top" of clinical services in health boards and trusts.
Timescale – within 6 months

5.3 Digital and data

Digital

People are increasingly used to interacting digitally with services at work and home through high quality apps and interfaces, but the NHS is not keeping pace with their experiences elsewhere.

Everyone that the MAG spoke to is frustrated by the current state of play. Failing to act will perpetuate the current pattern of fragmentation, inefficiency and slow digital adoption. Conversely, a consistent adoption and use of existing (let alone emergent) technologies would greatly improve operational performance and productivity, through for example electronic test requesting, better waiting-list management and referral management, and the introduction of ambient notetaking. This later intervention can make significant improvements in clinical productivity and reduce cognitive load and the risk of burnout.

Internationally health systems are developing digital systems to help patients access services and to help staff deliver high quality care. Digitisation of the NHS in Wales lags behind comparable national health care systems elsewhere. This is particularly the case for hospitals and community services. This is shown in the results of applying an internationally recognised measure of the adoption of digital systems called HIMSS Electronic Medical Record Adoption Model. All health boards were assessed at level 1 or below against the model (see table on the next page). The highest level of HIMSS adoption is level 7, with 0 being the lowest. Across Europe, the average level of adoption is 2 to 3.

Total HIMSS assessment for Wales including breakdown of aggregate score

	Total		Share by Stage						
Name	**Stage**	**Share**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Cwm Taf Morgannwg UHB	0	42%	64%	52%	61%	35%	40%	38%	38%
Cardiff and Vale University Health Board	1	22%	90%	34%	33%	18%	9%	14%	17%
Morriston Hospital	1	66%	93%	73%	78%	75%	71%	65%	59%
Betsi Cadwaladr University Health Board	1	59%	95%	80%	84%	77%	66%	65%	43%
Velindre Cancer Centre	1	58%	96%	83%	88%	65%	45%	53%	53%
Hywel Dda University Health Board	1	48%	90%	70%	69%	64%	43%	48%	37%
Aneurin Bevan University Health Board	1	47%	95%	81%	74%	45%	39%	39%	40%
Powys	1	47%	94%	48%	59%	32%	44%	43%	42%

Source: Digital Health & Care Wales[57]

The MAG would suggest that a nationally mandated digital health strategy with a realistic investment plan, interoperability standards and AI-driven decision support is crucial to transforming the productivity and performance of the Welsh healthcare system.

The Welsh Government published its digital strategy in 2023. Digital Health and Care Wales (DHCW) was established in 2021 and according to its 2023/24 Annual Report has a budget of £186m[58]. In 2024 it published its Organisational Strategy 2024-2030[59]. A one-page schematic of its strategic objectives is shown on the next page.

[57] The basis for the calculations is from the independent HIMSS EMRAM maturity assessments
[58] DHCW Annual Report 2023-2024
[59] https://dhcw.nhs.wales/files/dhcw-strategies-and-frameworks/digital-health-and-care-wales-organisational-strategy-2024-2030/

As such the issue is not a lack of strategy but a need for urgency in implementation.

The MAG therefore proposes that DHCW is commissioned to produce a road map for the delivery of Missions 2 and 3 of the strategy over a 24-month period. This roadmap should guide investment, with defined delivery milestones and accountability mechanisms, as well as clear roles and appropriate autonomy for health boards and trusts to act to meet local needs.

The roadmap should provide options for an Electronic Medical Record (EMR) for Wales, and it should also give full consideration to the merits of aligning the NHS Wales App with the NHS England App, thereby offering the potential for more rapid progress at lower cost. Until the roadmap is complete, no investment should be made in EMR or App development by any individual health board or trust.

Elsewhere in this report the MAG has recommended the development of a consistent framework for escalation levels within the urgent and emergency care system (see Recommendation 17). This recommendation should be enabled by the development of a “Once for Wales” digital support tool. This should allow for data to flow from health boards to a central system, allowing partners across Wales to manage pressures in real-time with a single version of the truth. This has successfully been achieved in other countries and should form part of this roadmap.

Recommendation 25
NHS Wales should commission from DHCW a comprehensive roadmap for the delivery of Missions 2 and 3 of its Organisational Strategy over a 24-month period, to be published within 6 months. No health board or trust should move forward with any EMR or App development until the roadmap is established. Full consideration should be given to aligning the NHS Wales App with the NHS England App. Timescale – within 6 months.

Data

The MAG was impressed by the quality of the data and the analytical expertise within the NHS Executive and elsewhere in Wales. This data can and should be put to work harder in the interests of improving performance and productivity and should be one of the key tasks for the new Managing Director of the PPU (see Recommendation 19).

The MAG was also pleased to learn that the new Welsh Emergency Care Data Set (WECDS) will be implemented by all health boards with major emergency departments, minor injuries units and same day emergency care services by the end of March 2026 including the delivery of two vanguard sites before or soon after 31 March 2025. It is important that these timelines are met and any obstacles removed.

However, data teams in and across Wales including those within DHCW have been held back from progressing work to support performance and productivity due to the lack of a policy position and framework on data sharing.

For example, primary care data cannot be routinely used for secondary purposes. One result of that is an inability to gain a whole pathway view of the data to inform performance management, resource allocation, quality, value and the transformation of services. In many ways this is the real purpose and prize for the health board integrated delivery model. More broadly, AI technologies to drive automation and productivity cannot be deployed unless there is consolidation of disparate datasets onto a large-scale data platform at the national level.

As such, there is an imperative to make urgent progress on the policy and legislative framework for data sharing.

Recommendation 26
The Cabinet Secretary should work with Ministerial colleagues to address Wales' data sharing policy and associated framework position with a view to accelerating the incorporation of datasets into the National Data Resource. Timescale – within 12 months.

5.4 The regions and capital as levers for change

The strategy for health and care in Wales is detailed in the 2018 'A Healthier Wales: Our Plan for Health and Social Care'. Given the scale of service transformation and

investment required, successful implementation is likely to require a clear route-map with detailed actions for the next one, three, five, and ten-year cycle. This would need to be based around the mission of adopting a population-based approach to prevention, shifting towards primary and community care, and strengthening partnerships, especially with social care. This would involve service transformation at national, regional and health board and trust level.

Although beyond the MAG terms of reference, there are a number of associated steps that could be taken quickly which would have a beneficial short-term impact on productivity and performance, namely developing effective regional planning and delivery machinery and optimising the availability and strategic allocation and use of capital.

Accelerating regional planning

The seven health boards are ideally placed to deliver an integrated care service, working to achieve the Institute for Healthcare Improvement (IHI) triple aim of improving patients experience of care, improving the health of the population, and providing value for taxpayer 'money by continuously reducing the per capita cost of health care delivery.

Currently, the approach to annual planning is based around the health boards. However, challenges to the resilience of a number of services means there is also a need to strengthen the process for planning at a wider regional footprint as it is inevitable that in the future some services will need to be commissioned, organised and delivered at supra-health board level. Otherwise access for patients, patient safety and value for money could be compromised by duplication or sub-optimal scale units.

Although not formally acknowledged in the legislative framework of the NHS in Wales, it is widely recognised that there are de facto three regional NHS geographies, namely North Wales (Betsi Cadwaladr University Health Board), Mid Wales (Powys Teaching Health Board, Hywel Dda University Health Board and Swansea Bay University Health Board) and South Wales (Cwm Taf Morgannwg University Health Board, Cardiff & Vale University Health Board and Aneurin Bevan University Health Board). These have the potential to provide a mechanism for addressing issues that require a supra health board approach.

During the course of the MAG visits and discussions with the health boards there was wide-spread acknowledgement of the need to accelerate regional working, as this was at variable stages of development with limited change in service models across regional footprints. Where formal discussion had started, progress appeared slow given the immediacy of the challenges including a list of seventy fragile services.

In his letter to Health Boards dated 20th December 2024 the Cabinet Secretary says "*I am concerned by some of the challenges that some health boards have faced in reaching agreement with each other on commissioning and providing services across organisational boundaries, and at the slow progress on regional working. This strikes to*

the heart of demonstrating how organisations can work effectively on a collaborative regional and national basis. I expect organisations to be proactive in reaching local agreements on relevant areas through the frameworks that have been set. Where these are not delivered, this will be regarded as a failure to develop a clear plan for the year ahead."

It is the view of the MAG that one of the main challenges lies in the capacity and commitment required, particularly for the health boards given their need to balance this regional work with their day-to-day health board responsibilities. This work is none the less essential and it is recommended that each region should develop focussed annual plans aligned to the performance and productivity agenda and supported by the resources of the PPU. In addition to improving cancer services, there are two other areas that should be a priority.

- **Diagnostic infrastructure** - This is critical to performance and productivity across all four of the focus areas of the MAG terms of reference. As noted elsewhere in this report, these services are fragile, in particular endoscopy and pathology. In this context the NHS in Wales should designate endoscopy and pathology services as the two priority fragile service that need to be addressed at national and regional levels. The specific recommendations on these areas are detailed in the diagnostics section of this report.

- **Fragile services -** At present there are eighteen acute sites in Wales for a population of approximately 3.2 million. Over seventy services are spread over these sites and bodies and are considered to be fragile, with resulting challenges in terms of sustainability, productivity and outcomes. Regional level planning will be required to develop solutions. Plans to transform services should be clinically led, evidence based, data driven, and should engage with Llais at the outset.

Recommendation 27
In addition to pathology and endoscopy (see Recommendations 6 and 7), health boards within each region should work together to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual basis. To facilitate this work, resources and support should be provided by the PPU as required. Timescale – within 12 months.

Capital as a lever for strategic change

Capital can be one of the most powerful levers for change and in other sectors of the economy has been a major driver of productivity growth. Lord Darzi observed about the NHS in England that '*in recent years it appears the NHS has been subject to a kind of capalitsation in reverse and forced to increase labour in relation to capital rather than the other way round.*'[60] One of the constant messages we heard is that the lack of sufficient capital investment in modern buildings, diagnostics and digital infrastructure is a significant barrier to improving productivity and performance. The MAG agrees that

[60] Independent investigation of the NHS in England - GOV.UK

the improvements and the associated service transformation required will not be achievable without short, medium and long-term capital investment.

As in England, NHS Wales has been challenged by having insufficient capital funding to meet service demands and the backlog maintenance bill is currently estimated to be £1.34 billion which is more than twice the annual capital budget and a larger proportion of the NHS budget than that for England.

The recent confirmation of an increase in the capital budget from £479m to £554m for 2025/26 is welcomed. However, unless the trend to increase the capital budget on an ongoing basis continues, it is difficult to envisage how a step change in longer term planning, productivity and performance can be delivered.

Discretionary capital is allocated to organisations, and this has increased from £83m to £100m for 2025/26. There are also a number of targeted investments to improve infrastructure such as emergency departments. These relatively small investments should be increased where possible as they can have a rapid and visible effect and improve patient experience, staff morale and efficiency.

The productivity challenge and the problem of fragile services will also require a strategic approach to investment. Some of these will require regional solutions and these should not be the result of negotiated trade-offs between health boards that avoid contentious issues. Compromise often gives rise to suboptimal solutions and a poor return on capital invested. As such all proposals for regional solutions should be the product of rigorous and independent and clinically led appraisals and include consideration of all options for non-exchequer sources of capital.

The development of a ten-year capital prioritisation framework by Welsh Government working with NHS bodies is positive. This should give a clear sense of the scale of potential capital investment required to meet service demands and their relative priority for NHS bodies. However, tough choices will need to be made. For instance, a greater spend on digital rather than buildings may not be popular but could provide a faster route to service transformation.

It is the view of the MAG that future plans to modernise the infrastructure cannot rely exclusively on an increase in public sector capital. Schemes as MIMs, PPIs, PFIs, leasing, or use of service contacts to leverage private sector capital could and should be further explored. The funding of the new Velindre Cancer Centre through the use of the mutual investment model shows that this can be done, although the availability of revenue funding to support these developments is crucial.

The MAG heard from NHS bodies that there may be scope to boost the capital allocation from the further sales of land or buildings. The MAG understands that NHS Wales has already made substantial progress in improving the utilisation of the estate and disposing of redundant land and buildings. Given the low-rise nature of parts of the NHS estate, this could be a further opportunity as part of longer-term plans. This should also be considered in the context of the broader piece of work looking at estates rationalisation in NHS Wales and maximising the use of public assets for public benefit

through continuing to work collaboratively with public sector partners in areas such as housing and economic development.

Recommendation 28
It is recommended that the health budget capital allocation is uplifted on an ongoing annual basis and is aligned to the annual planning and prioritisation process. Timescale – within 12 months.

Recommendation 29
Reliance on routine capital will not fully meet the capital requirements of service modernisation and transformation across NHS Wales.
Welsh Government should conduct a review of preferred options for generating non-exchequer capital for the Cabinet Secretary to consider ahead of 2026/27 capital round. Timescale – within 9 months.

6 Conclusion

Improvements on productivity and performance will only be delivered if there is alignment between a strong centre working with a collaborative group of health boards and trusts working collectively to a tight set of objectives within a clear accountability framework and a commitment to transparency and 'improving in public'.

In accordance with its Terms of Reference and a self-imposed criteria of short term utility, this report contains 29 recommendations. The implementation of the recommendations will be contingent on pulling the following levers of change to maximum effect:

1. A sharper focus on a tighter list of priorities.

2. The need to accelerate the adoption of validated best practice and to bring those with low levels of adoption close to the current best performers.

3. The importance of applying evidence-based standards for how care is organised and being challenging where this is not implemented.

4. The importance of leadership in making these changes, in particular medical leadership.

5. A greater focus on and improvement in basic operational management processes.

6. Transparent and rigorous accountability arrangements with a streamlined set of meetings – allowing boards and trusts to get on with driving change whilst ensuring that they are efficiently held accountable for performance.

7. Maximising the availability and return on investment of capital and better alignment of financial flows with the objectives of the system.

Annex A

Strategy, policy and planning frameworks taken into consideration by the MAG (only publicly available published documents have links included below):

Welsh Government Framework Documents

NHS Wales Planning Framework 2025-2028 (including letters to Chairs, Key Metrics and enabling actions) – Issued 20 December 2024 - Letter to Chairs: NHS Wales Planning Framework 2025/28; Letter to NHS CEOs: Supporting Governance Arrangements; Annex 1: Key Metrics; Annex 2: Enabling Actions.

NHS Wales Performance Framework 2025-2026 – Published 13 January 2025 - NHS Wales performance framework 2025 to 2026 | GOV.WALES.

NHS Wales Planning Framework 2024-2027 – Published 06 March 2024 - NHS Wales planning framework 2024 to 2027 | GOV.WALES.

NHS Wales Performance Framework 2024-2025 – Published 28 February 2024 - NHS Wales performance framework 2024 to 2025 | GOV.WALES.

NHS Oversight and Escalation Framework – Published 23 January 2024 - NHS oversight and escalation framework | GOV.WALES.

Unified Contract Assurance Framework – Published 02 October 2023 - Unified contract assurance framework: health boards and practices | GOV.WALES; Update provided to MAG 23 December 2024 - Summary Indicators and Weightings 2024.

Welsh Government Statements/Press Releases

Oral Statement: NHS Winter Pressures | GOV.WALES – Published 07 January 2025

Oral Statement: Waiting Times | GOV.WALES – Published 19 November 2024.

Written Statement: Initial response to the NHS Wales Accountability Review | GOV.WALES – Published 12 November 2024.

Written Statement: A Healthier Wales Actions Refresh | GOV.WALES – Published 04 December 2024.

Written Statement: Draft Budget 2025 to 2026 | GOV.WALES – First published 10 December 2024 – Updated 21 January 2025.

Written Statement: Improving Eye Care Services | GOV.WALES – Published 20 December 2024.

Ministerial Advisory Group: NHS Wales accountability review | GOV.WALES – Published 12 November 2024.

A Healthier Wales - Action refresh 2024-25 | GOV.WALES – First published 08 June 2018 – Updated 09 December 2024.

Report of the commission on public service governance and delivery | GOV.WALES – Published 12 August 2014.

Review of Health and Social Care in Wales: final report | GOV.WALES – Published 16 January 2018.

NHS Activity and Performance Summary: October and November 2024 | GOV.WALES – Published 19 December 2024.

NHS Activity and Performance Summary: November and December 2024 | GOV.WALES – Published 23 January 2025.

NHS Activity and Performance Summary: December 2024 and January 2025 | GOV.WALES – Published 20 February 2025.

Senedd Debates

NDM8785 Plaid Cymru Debate - NHS waiting times / Webcast - NDM8785 Plaid Cymru Debate - NHS waiting times – Debated in Senedd 15 January 2025.

Ministerial Summit Reports

Cancer summit: 18 September 2024 | GOV.WALES – Published 23 December 2024.

Welsh Health Circulars

Health board allocations: 2024 to 2025 (WHC/2023/048) | GOV.WALES – Published 08 January 2024.

Health board allocations: 2025 to 2026 (WHC/2024/051) | GOV.WALES – Published 27 January 2024.

Audit Wales Reports

Cancer Services in Wales | Audit Wales – Published 14 January 2025.

Other publications

Reflections on NHS Wales' escalation process: applying the observe, orient, decide and act loop | British Journal of Healthcare Management – Published 07 November 2024.

OECD Reviews of Health Care Quality: United Kingdom 2016 | OECD – Published 12 February 2016.

An Independent Evaluation of Wales' Suspected Cancer Pathway Programme Report | NHS Wales Executive – Published March 2024.

Sowing Seeds: High Performance Organisations | AcademiWales – First published 25 April 2016 – Updated 30 August 2018.

Independent investigation of the NHS in England | GOV.UK – First published 12 September 2024 – Updated 15 November 2024.

NHS England: Reforming elective care for patients | NHS ENGLAND – First published 06 January 2025 – Updated 09 January 2025.

Hospital of the Future: A Framing Paper | REFORM UK – Published 09 December 2024.

NHS England: NHS Delivery and Continuous Improvement Review: Recommendations | NHS ENGLAND – Published 19 April 2023.

Raising NHS capital funds: options for government | NHS Confederation – Published 17 October 2024.

Capital efficiency: How to reform healthcare capital spending | NHS Confederation – Published 11 February 2025.

Documents shared in response to meetings or information requests from members

Inpatient and Outpatient Waiting lists for each Health Board Sept-Dec 2024

Waiting List Information as of 06 January 2025

Diagnostic Analysis - 23 January 2025

Consultant Connect Activity Data Oct 2023 - Dec 2024

Information on the Ministerial decision to establish the NHS Wales Executive

Information on the National Strategic Clinical Networks

Aneurin Bevan UHB Annual Plan 2024/25

Betsi Cadwaladr UHB Three-Year Plan 2024/27

Cardiff & Vale UHB Annual Plan 2024/25

Cwm Taf Morgannwg UHB Three-Year Plan 2024/27

Hywel Dda UHB Annual Plan 2024/25

Powys Teaching HB Integrated Plan 2024/29

Accountability Review - Levers for Change Proposals October 2022

Outpatient Transformation Programme Update - 20 November 2024

Outpatient Transformation from the Medical Directors Forum – 04 October 2024

Eye Care Measures Performance in Southwest Wales – 23 September 2024 - provided by NHS Executive

Swansea Bay UHB Baseline against De-escalation Criteria – 16 October 2024

Swansea Bay UHB Cancer Performance – 21 October 2024 – provided by NHS Executive

Swansea Bay UHB Integrated Quality, Performance and Delivery meeting slide pack – 14 October 2024 – provided by NHS Executive

Swansea Bay UHB Joint Executive Team meeting data pack – 14 November 2024

NHS Leadership Board Organisation Performance Report 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 1: Improved Health & Wellbeing 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 2: More Accessible 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 3: Motivated & Sustainable 2024/25 – 22 October 2024

NHS Leadership Board Quad Aim 4: Improvement & Innovation 2024/25 – 22 October 2024

NHS Leadership Board NHS Performance Dashboard – 22 October 2024

Annex B

Members of the MAG engaged with the following people/organisations during their review:

25 October 2024 – Welsh Government. First Minister and Cabinet Secretary for Health and Social Care.

5 November 2024 – Welsh Government NHS Planning Team.

07 November 2024 – NHS Wales Executive Urgent & Emergency Care Six Goals Programme.

07 November 2024 – Welsh Government.

08 November 2024 – Welsh Ambulance Services University NHS Trust.

21 November 2024 – Welsh Government.

22 November 2024 – NHS Wales Executive Urgent & Emergency Care team and Getting it Right First-Time team.

26 November 2024 – NHS Wales Executive Planned Care and Diagnostics team and Welsh Government.

29 December 2024 – NHS Wales Executive Cancer Programme and Welsh Government.

5 December 2024 - NHS Wales Executive, and Welsh Government NHS Finance team.

10 December 2024 – Welsh Government NHS Escalation and Intervention team.

12 December 2024 – NHS Wales Executive Diagnostics team.

13 December 2024 – Welsh Government.

16 December 2024 – NHS Wales Executive Planned Care Programme.

16 December 2024 – NHS Wales Executive Performance & Assurance team.

19 December 2024 – Royal College of Emergency Medicine.

14 January 2025 – Chair of Academy of Royal Colleges.

15 January 2025 – NHS Wales health board Chairs.

15 January 2025 – Welsh Government.

17 January 2025 – NHS Wales Chief Executives.

20 January 2025 – Betsi Cadwaladr UHB external visit MAG.

21 January 2025 – Swansea Bay UHB external visit MAG.

21 January 2025 – Hywel Dda UHB external visit MAG.

22 January 2025 – Cwm Taf Morgannwg external visit MAG.

22 January 2025 – Cardiff & Vale UHB external visit by MAG.

25 January 2025 – Aneurin Bevan UHB external visit by MAG.

27 January 2025 – Chair and Chief Executive of Health Education & Improvement Wales.

28 January 2025 – Chair and Chief Executive of Llais.

29 January 2025 – Welsh Government.

29 January 2025 – Welsh Government, and NHS Wales Executive.

03 February 2025 – Welsh Government.

03 February 2025 – Chair and Chief Executive of Powys Teaching HB.

04 February 2025 – Chair and Chief Executive of Digital Health Care Wales.

06 February 2025 – Chair and Chief Executive of Welsh Ambulance Services NHS Trust.

06 February 2025 – Welsh Government, and NHS Wales Executive.

06 February 2025 – Chair and Chief Executive of Velindre University NHS Trust.

07 February 2025 – NHS Wales Executive Planned Care Programme.

11 February 2025 – Chair and Chief Executive of Public Health Wales.

12 February 2025 – Welsh Government.

17 February 2025 – National Clinical Lead for Cancer and NHS Wales Executive Cancer Strategic Network.

20 February 2025 – Welsh Government and Cabinet Secretary for Health and Social Care.

21 February 2025 – NHS Wales Health Collaborative.

21 February 2025 – Welsh Ambulance Services University NHS Trust.

28 February 2025 – NHS Wales Health Collaborative.

07 March 2025 – Welsh Government.

10 March 2025 – Welsh Government.

10 March 2025 - Welsh Government.

11 March 2025 - Welsh Government.

18 March 2025 – Welsh Government.

19 March 2025 – Cabinet Secretary for Health and Social Care.

Annex C

Suggested locations for surgical hubs

Number of Theatres at Existing Hubs and/or Non-Acute Elective Sites and Sites in Development: [61]

Region	Site	In Patient (IP) Day Case (DC)	Theatres	%	In Development	Theatres
North	Abergele	IP	4	10	Llandudno IP	2
	Llandudno	DC	1			
	Total		***5***			
South East	Llandough	IP/DC	11	41	Llantrisant Health Park IP/DC	12
	Nevill Hall	IP/DC	3			
	St Woolos	IP	2			
	Ystryd Fawr	IP&DC	4			
	Total		***20***			
South West	Neath Port Talbot	IP/DC	7	45		
	Prince Phillip	IP/DC	6			
	Singleton	IP/DC	9			
	Total		***22***			
Powys	Brecon	DC	1	4		
	Llandrindod	DC	1			
	Total		***2***			
Grand Total			**49**			14

[61] Source: Elective Optimisation Audit 2024. Caveat - interpretation applied to data provided

Annex D

Operating Principles for Surgical Hubs

All Surgical Hubs must meet strict criteria of operation which includes:

- Use GIRFT documents to guide the setting up and running of the surgical hubs and the best use of theatre staff.
- Define the number of cases per list for Orthopaedics, Spines, Urology, Gynaecology, ENT, Ophthalmology and General Surgery at GIRFT standards.
- Develop best practices in theatre productivity, with theatre utilisation capped at 85%.
- Extend theatre start times and finish times; utilise the whole day from 08.30-17.00 daily with capped theatre utilisation at 85%.
- Develop pathways to achieve best-in-class length of stay (LoS), such as hip and knee replacements with a LoS of less than two days, while increasing the number of day cases.
- Conduct pre-operative assessments using questionnaires, ensuring that only patients requiring face-to-face evaluations are seen.
- Establish a pool of patients prepared to be admitted across hub sites to minimise same-day cancellations and optimise the utilisation of available spaces.

Annex E

Comments from Chief Executives NHS Wales

National system

- Provide a clear operating framework describing the role of the NHS Executive and its relation to Health Boards/Trusts with regard to oversight/performance management/delivery assurance
- Streamline the various national groups/boards overseeing performance with the NHS Leadership Board being the single place to oversee quality/performance/finance at a national level. Below this hold NHS organisations to account through monthly meetings to review the same topics at a local level thus streamlining the multiple local assurance meetings currently in this space.
- Consider a role for a National Medical Director who has experience in direct service delivery and medical leadership who will drive and lead the national discussions with medical staff and support difficult service/clinical change discussions
- Align expectations of efficiency and productivity in the planning framework for NHS organisations to ensure clear expectations of adoption of agreed clinical standards e.g. GIRFT/INNU
- Design an up to date model for counting/paying for activity which sets a standard 'price' for activity against which health boards can assess their own efficiency/cost effectiveness. This would also support the move to more regional working.

Cancer

- Establish a single overarching cancer board to provide a coherent vision, strategy and policy position on all aspects of Cancer in Wales, supported by a single national delivery group led by the service (Health Boards / Trusts) and responsible for driving performance improvement, with regional and local sub-structures as required, taking into account the various models currently in use elsewhere across the UK.
- Consider whether Velindre University NHS Trust should (as the provider of the largest dedicated cancer centre in Wales) collaborate more with and explore opportunities for learning from the NHS England Cancer programme and be more aligned to the way in which the Clatterbridge, Royal Marsden and Christie support at a national and regional level.
- Consider (designed with input from experts at a UK level) delivering an operational development programme for COOs and ops managers across the statutory health bodies, to equip operational leaders with the latest skills and proven techniques in delivering cancer performance improvement.
- Consider whether there should be a dedicated cancer / USC diagnostic service, or at least protected capacity and pathways for USC pathway patients

Unscheduled Care

- Develop a plan to move to the 'Scheduled Emergency Care' model which senior leaders from NHS Wales have experienced in Denmark. This model has potential to unlock capacity issues in EDs, improve performance and encourage greater citizen responsibility.
- Develop shared performance scorecard for health and social care which holds both Health Boards and Local Authority for whole system performance.

Workforce

- Establish an Ops Academy to provide consistent training for operational managers/clinical leaders to ensure consistency of approach to waiting list management/flow management as well as best practice on service redesign and efficiency and productivity
- Consider how clinicians can be incentivised through contractual models to focus on productivity and efficiency i.e. moving away from time-based contracts for the elective part of their work

Digital and Data

- Prioritise investment to accelerate deployment of an Electronic Patient Record system across organisations to improve efficiency and productivity of staff and as a means to standardise pathways as well as providing better activity and outcomes data
- Set Digital Maturity targets for NHS Wales, which would in the short term, improve the uptake of the functionality already available such as electronic prioritisation of referrals and electronic test requesting which deliver efficiencies and provide opportunities for re-direct and demand management, reducing variation.
- The current policy environment does provide the levers needed to easily share information compliantly. Prioritise the development of digital and data policy for NHS Wales in order to collect, store and share data and information to support patient care, operational management, strategic planning, benchmarking and performance improvement and population health management. This will need to include overcoming the barriers to the sharing of primary care data as a matter of urgency.
- Expand the information and functionality available in the NHS Wales App to enable interaction between patient and clinician to shift to digital channels
- Implement plan for effective pan Wales and pan UK benchmarking to support performance improvement through an agreed range of datasets i.e. a 'model system' or something similar

Estates and Infrastructure

- Consider how the NHS could work with infrastructure partners to maximise opportunities with existing estate as well as exploring alternative models of capital funding to support improvements and new built infrastructure.

Report by the External Ministerial Advisory Group on NHS Wales Performance and Productivity

Government Response

A number of the recommendations from the Ministerial Advisory Group (MAG) have resource, capacity and timescale implications. These will be considered further by Welsh Government Officials as the next steps set out below are developed.

Recommendation 1

All health boards should, within three months, develop a plan to reduce referrals to traditional outpatients in high volume specialities.

- Particular attention should be given to unwarranted variation and specialities where per capita referrals rates are above the national median.
- Models that offer alternatives to traditional outpatient pathways should be rapidly identified and scaled. National Funding for Advice and Guidance and the National Pathways programme should continue
- From June 2025, progress should be reported monthly to health board and trust public meetings, and at individual monthly Performance & Productivity meetings (see Recommendation 18).

Welsh Government Response: Accept

Outpatient transformation is an integral aspect of the Planned Care Programme and is included as a core element of the optimising planned care approach.

Alternative models have already been progressed nationally through the national pathways work and Planned Care Programme. Implementation of these models has been reflected as one of the Cabinet Secretary for Health & Social Care's 35 priority enabling actions in the NHS Wales planning framework and is expected to feature clearly as part of planned care plans for 2025/26. We agree that delivering these at scale is essential.

Delivering on this recommendation is an implementation requirement for health boards who should set out clear delivery plans to the proposed timescales which should be progressed through their response to the priority enabling actions.

High referral rates may well be warranted within population groups, and the report sets out that it is the unwarranted variation that must be addressed. Therefore, health boards are expected to identify and tackle unwarranted variation in implementing this recommendation.

Progress will be monitored and reviewed through health board performance meetings.

Recommendation 2

All health boards and trusts should work to reduce variation in outpatient waiting times by adopting best practices in outpatient service management.

- Using existing specialty GIRFT health board and trust reports, the 16 specialty specific Further Faster guides, mandatory electronic triage of referrals, and adoption of the 29 pathways across the 6 specialties with the longest waits.
- From June 2025, progress should be reported monthly to health board and trust public meetings, and at individual monthly Performance & Productivity meetings (see Recommendation 18).

Welsh Government Response: Accept

Outpatient transformation is an integral aspect of the Planned Care Programme and included as a core element of the optimising planned care approach.

Alternative models have already been progressed nationally through the national pathways work and Planned Care Programme. Implementation of these models has been reflected as one of the Cabinet Secretary for Health & Social Care's 35 priority enabling actions in the NHS Wales planning framework and is expected to feature clearly as part of planned care plans for 2025/26.

Delivering on this recommendation is an implementation requirement for health boards who should set out clear delivery plans to the proposed timescales which should be progressed through their response to the priority enabling actions. These will be monitored and reviewed at health board's performance meetings.

The NHS Executive has established a series of clinical implementation network outpatient guides (playbooks) setting out best practice. Health boards have individual GIRFT reports outlining the position and opportunities for improvement. These will need to be integrated into health board plans within three months.

Recommendation 3

All health boards should take action to improve waiting list management.

3a) Better prioritisation of available capacity for the longest-wait patients should become a pre-condition for receipt of additional funding from Welsh Government for elective recovery. Welsh Government should agree minimum standards based on the existing Treat in Turn dataset, and elective recovery funding for 2025/26 should be made conditional upon meeting these in each individual Health Board within a defined period of time.
Timescale – within 3 months

3b) HEIW should also set up an accredited training programme for waiting list management, across both RTT and Cancer, aimed at Band 7 and Band 8 managers working in elective care. Over time, completion of this course should become an expectation for all managers working in these areas, in order to embed a consistent and shared set of skills across the country. Timescale - within 6 months.

3c) Welsh Government should set a target for all patients to be validated down to 36 weeks by the end of 2025/26, and introduce a new national dataset to track progress. If there is insufficient confidence this could be achieved in all health boards and trusts, Welsh Government should consider a nationally procured contract with an external company specialising in validation, to focus on areas unlikely to be able to complete this independently (although this could even be done on a once-for-Wales basis to cover the whole country, given the population size). This should be supported through Elective Recovery funding.

DHCW should also develop a new national dataset to track progress, either based on ROTT (removals from the list for reasons other than treatment) rates or manual health board and trust returns around the proportion of 36+ week waiters validated, which should be regularly discussed at the Performance and Productivity meetings described in Recommendation 18. Timescale – within 3 months.

Welsh Government Response: Accept

Effective waiting list management is an integral aspect of the Planned Care Programme and is included as a core element of the optimising planned care approach. The impact of this is monitored and assessed through the Planned Care Programme.

The Welsh Government has undertaken a review of RTT guidance which will be published on the Welsh Government website in April 2025 to support effective waiting list management. The implementation of the review will include support for additional training.

A key feature of the Planned Care Plan for 2025/26, continuing on the focus provided in 2024/25, is to incentivise best practice as per the planning framework priority

enabling actions. This will deliver improvements in both the utilisation of core capacity and treat in turn metrics.

Minimum standards for treat in turn rates have been agreed and shared with health boards, and will continue to be monitored on a monthly basis. Weekly Welsh Government performance monitoring will commence internally from 2nd May 2025.

The clinical implementation networks are providing a clinical view by specialty to strengthen patient listing criteria within the optimisation frameworks.

A clear validation expectation and guidance has been provided to health boards. Performance will be monitored on a monthly basis from the beginning of May 2025.

Decisions by the Cabinet Secretary for Health & Social Care on the allocation of any 2025/26 elective recovery funding will be related to and contingent upon health boards' ability to deliver a range of productivity and efficiency improvements, and stated expectations such as delivering the priority enabling actions.

In the strategic priority area relating to Leadership and Succession in their 2025/26 remit letter, HEIW have been directed to strengthen the training and development of operational management and delivery. This will include engagement with organisations and key policy leads on the roll-out of priorities for 2025/26.

Strengthening a consistent approach to validation will be progressed as part of the Planned Care Plan for 2025/26. There are a number of databases in place that allow this dataset to be progressed during 2025/26, and further work will be undertaken with DHCW and across the system to refine these and deliver on this recommendation. The 36 week cohort will be validated as part of this work.

Recommendation 4

a) All health boards should reduce unwarranted variation in treatment waiting times and adopt best practice in theatre management. This can be achieved through the implementation of the existing GIRFT review reports including the theatre reviews. This recommendation should be supported by the establishment of local Theatre Optimisation Boards, with a remit to deliver increased productivity within theatre sessions including the implementation of best practice standards of cases per session, particularly in ophthalmology and orthopaedics (in ophthalmology 8 cataracts in a 4 hour theatre session if a training session and 10 if consultant only, and in elective orthopaedics a minimum requirement of 4 Joints or their equivalent in an all day orthopaedic elective list). Timescale – within 6 months.

b) Health boards should seek accreditation for all current Surgical Hubs (listed in Annex C) from the National Medical Director (see Recommendation 20), within 6 months using standard GIRFT criteria including maximised theatre productivity (Annex D), and with all hubs to be accredited within 12 months. From June 2025, progress should be reported monthly to the public part of health board meetings, and the monthly Performance and Productivity meeting (see Recommendation 18).

Welsh Government Response: 4a – Accept; 4b – Accept in part

Recommendation 4a – Accept

Addressing unwarranted variation in waiting times by adopting best practices in theatre management is a key component of the national Planned Care Programme. This programme supports and monitors implementation, and has developed the necessary intelligence and dashboards to facilitate delivery through theatre intelligence.

Through the NHS Wales planning framework the Cabinet Secretary for Health & Social Care has made it clear he expects to see progress in reducing unwarranted variation and this is expected to feature clearly as part of planned care plans for 2025/26. Progress on implementation will be monitored and published.

Health boards will need to establish theatre optimisation boards if these are not already in place locally, with clear outcomes which will be monitored and reviewed at health board performance meetings.

Further work may be required to further define what is considered to be ‘unwarranted variation’, and whilst implementing the actions to address this recommendation is deliverable in the timescales it may not be feasible to address all unwarranted variation within 6 months.

Recommendation 4b – Accept in part

The Welsh Government agrees that all surgical hubs that are being established should meet consistent standards and delivery specifications in terms of productivity, quality, and throughput.

In order to deliver such a standardised approach, we propose however that this be led by the Welsh Government itself, given that it is able to rely on powers of direction should that be necessary.

Therefore the Welsh Government will set out the delivery standards for surgical hubs and expect health boards to ensure that surgical hubs operate to the required standards. This will be subject to ongoing monitoring and review.

Recommendation 5

A clearly identified funding stream should be centrally retained to establish a national dedicated fund for the use of the independent sector. Timescale – within 6 months.

- This fund should be used where there are longer term sustainability challenges in demand/capacity that cannot be addressed through health boards delivering improvement using the new productivity standards and the other GIRFT interventions described in this report.
- NHS Wales should enter into nationally negotiated, multi-year contract with the independent sector for ophthalmology in the first instance, with consideration given to replicating this arrangement for orthopaedics or dermatology if this first phase produces positive results. Contracts should then be regionally managed, modelling the success of the South East Wales cataract contracting in 2024/25, ensuring equity of access for all patients across the regional footprints.
- In the longer-term, Welsh Government should commission an options appraisal on the opening up of choice of provider to referring clinicians and their patients in some specific, highly-pressured specialties, and to include these independent providers on the choice menu.

Welsh Government Response: Accept in part

NHS Wales utilises the independent sector through various local and regional arrangements. This includes both insourcing and outsourcing from a variety of providers across health boards, as well as national arrangements facilitated by the National Joint Commissioning Committee and its predecessor organisation.

The use of the independent sector varies for a range of factors, largely driven by local health board demand and capacity plans, availability of local private providers against health board delivery models, specialty specific issues, and plans to deliver on improving access at specialty level within available resources.

From a policy perspective, it is expected that internal capacity and solutions to deliver improvements in productivity are maximised before considering the need for any independent sector solutions.

The Welsh Government considers that if there are long term sustainability challenges in available capacity to meet demand, and these cannot be resolved through core activities and productivity opportunities outlined in this report and the priority enabling actions, then contracting the independent sector on both a short and longer term basis will be considered. This will require evaluating available funding to support additional solutions. This is expected to be a feature of the planned care plan for 2025/26, along with strengthened regional and national arrangements as needed.

Recommendation 6

Welsh Government should create a national plan for endoscopy to address the current backlog of long-waits.

- This should include prioritised capital for Betsi Cadwaladr University Health Board to bring it line with other health boards. In all other areas the focus should be on appropriate utilisation of existing resources, creating a national utilisation dataset (using GIRFT productivity benchmarks) which is reviewed regularly at the new Performance and Productivity Meeting (see Recommendation 18). HEIW should be commissioned to establish a new programme to expand Non-Medical Endoscopist training to rapidly expand the available workforce. Capsule sponge should be rolled out with a view to reducing demand for intervention endoscopy. Timescale – within 6 months

Welsh Government Response: Accept

The Welsh Government previously produced the National Endoscopy Programme action plan 2019-2023, which set out a number of aims for each health board. Health boards have subsequently been tasked to develop regional recovery plans. These were considered by the national programme but limited assurance was provided. As a result, the Deputy CEO NHS Wales has directed the National Endoscopy Programme team to support and monitor the implementation of these plans on a regional basis. Progress to date has been varied.

The focus of the National Endoscopy Programme team is to improve performance against productivity and efficiency measures across the system. Work will be undertaken to enable endoscopy data to be included in the existing dashboards.

The Welsh Government agrees that managing and delivering endoscopy transformation on a regional basis is crucial, and will support that regional focus, with a set of national expectations, as set out in the report.

The non-medical endoscopy training programme is part of HEIW's IMTP and a training academy will be developed as part of the Southeast Wales Centre of Excellence and Llantrisant Health Park solution. Capsule sponge endoscopy is being rolled out by the Planned Care Programme and we will expect further progress in roll-out over the next 6 months.

We recognise the under-provision of endoscopy suites in North Wales; an endoscopy delivery plan has been requested from Betsi Cadwaladr University Health Board for assessment by the Welsh Government.

Recommendation 7

With the support of the proposed Performance and Productivity Unit (see Recommendation 19) regions should develop a plan to create a regional pathology service which is safe, sustainable and fit for the future. The plan should include the full implementation of digital pathology as a key service enabler and address workforce, estate and equipment shortfalls. Timescale – within 6 months.

Welsh Government Response: Accept

The requirement for clear plans on a regional basis to establish sustainable pathology services is recognised by the Welsh Government, and the National Diagnostics Board has commissioned regional pathology plans from each region.

It is anticipated that the development of outline plans by region is deliverable within 6 months, however this will be dependent on the necessary capacity being available in each region. It is also anticipated that developing regional solutions may require significant capital and/or revenue investment which is yet to be identified. Further consideration will therefore be required on next steps once outline plans by each region have been developed.

Recommendation 8

Cardiff and Vale University Health Board should submit a clear plan detailing how it intends to clear its Non-Obstetric Ultrasound (NOU) backlog over the course of 2025/26. Timescale – within 3 months.

- They should be held to account for the delivery of this. Independent Sector capacity should be employed if the health board has not made sufficient progress by the end of Quarter 1.

Welsh Government Response: Accept

It is recognised and accepted that there are significant and specific modality and health board challenges that require solutions as part of developing planned care and diagnostic solutions in 2025/26. These include the requirement for a plan to address the Non-Obstetric Ultrasound backlog in Cardiff & Vale University Health Board. It should be noted that this will require additional resources which will need to be identified.

Recommendation 9

No additional cancer performance plans should be produced for 2025/26 and 2026/27. Instead, there should be an immediate focus on implementing a narrow but nationally mandated set of deliverables drawn from existing policy proposals.

- At the centre of this, drawing on the NOPs, NHS Wales should identify the single highest-impact pathway change for each of the five tumour types it has already identified as driving poor performance: skin, lower GI, breast, gynaecology and urology. These should then form the basis of a much narrower, focused set of national support activities and accountability conversations with health boards, alongside the continued local focus health boards will have on their more unique challenges. For Lower GI, this focus should be more consistent implementation of symptomatic FIT, with a new dataset created across endoscopy departments to assess whether capacity is being appropriately prioritised for FIT positive patients. For gynaecology, this should be the consistent provision of post-menopausal bleeding services; for breast the provision of breast-pain services; and for skin the more standardised provision of teledermatology services in primary care. In all cases, national specifications should ensure these initiatives are based in a primary care setting wherever possible, thereby reducing referrals to secondary care as a whole rather than substituting Single Cancer Pathway referrals for non-urgent referrals. Timescale – within 3 months

Welsh Government Response: Accept

The Welsh Government accepts the principle of this recommendation, and the interventions described are underway by the NHS Executive.

As the report acknowledges, further work is required to develop the impact assessment of the pathway changes proposed and how they are implemented on a consistent basis across all health boards along with the impact of improving performance and productivity in both 2025/26 and on an ongoing basis.

Where possible, approved triage tests are being applied in primary and community care to better risk stratify cancer referrals. As the report acknowledges, this will not always be possible and there are some investigations which will still need to be triaged in secondary care. Decisions on downgrading referrals or discharging with safety netting will need to be determined by the relevant clinical community or in line with national clinical guidance based on the changes to the specific pathway proposed.

Recommendations that relate to primary care will be taken into account as part of primary care negotiation and contracting arrangements for 2025/26.

We will make progress on this recommendation within the suggested three month timeframe, though individual elements may have dependencies which take us beyond that timeframe.

Recommendation 10

A ring-fenced fund, held centrally, should be created to directly fund the high-impact, nationally prescribed service changes described in Recommendation 9, which are monitored through the health board performance report (see Recommendation 21).

- This fund could be created from a restructuring of the various, smaller ring-fenced amounts held centrally where there is limited evidence of impact; or alternatively by retaining a proportion of any new funds invested into the Welsh NHS in future financial years. Health boards must demonstrate the use of these funds for the specified initiatives using transparent national data collections, or else the funding should be withheld or subject to a clearly defined and transparent claw-back mechanism (depending on the approach used). Timescale - within 3 months.

Welsh Government Response: Accept

The Welsh Government accepts the principle of this recommendation and the need to review discrete policy funding streams for specific initiatives with a view to consolidating these. Where existing investments are of limited value these should be redirected to stronger national initiatives. This will require an evidence based review of each investment to inform if it should be maintained and scaled up on an all Wales basis or redirected to other high value interventions.

A detailed assessment of the potential performance impact of the high-impact nationally prescribed service changes, and the impact of those interventions that are already funded via the Cancer programme will be undertaken to support this.

It is recognised that there is the potential to hypothecate a proportion of future funding to support cancer services; this would be part of the choices available to the Cabinet Secretary for Health & Social Care in setting future budgets depending on budget availability and other choices and priorities.

Additional resource and capacity will be required to undertake this review and deliver recommendations within the three month timescale proposed.

Recommendation 11

The Welsh Government should establish financial incentives in primary care to improve cancer performance, focusing on in-depth diagnostic work-up and subsequent safety-netting in order to reduce referral volumes and provide more diagnostic information for patient triage in secondary care.

- Given the five tumour types driving the majority of long waits nationally, initial incentives could include increased safety netting for FIT negative patients, the provision of breast-pain services, or the development of tele-dermatology arrangements outside of secondary care. This will require changes in contracts at the cluster and practice level including updating the governance framework indicators by July 2025. Timescale - within 3 months.

Welsh Government Response: Accept

Work is underway to support a wide range of diagnostic tests within primary care. In order to take forward this recommendation, the Welsh Government will work with clinical experts, starting with FIT/colorectal and telederm/skin, in order to understand how this could be embedded into community diagnostics services and scaled with dedicated funding in the contract or under cluster plans. Many clusters already operate minor operations (MOPS) clinics and undertake tele-dermatology for suspected skin cancer patients in a primary care setting.

We will explore how funding can be better used specifically to drive service delivery and performance, along with the practical implementation elements which the report refers to.

Since service delivery changes would involve contractual negotiations, delivering this recommendation *in full* is unlikely within 3 months.

Recommendation 12

The Cancer Network and the cancer arm of the Planned Care Recovery Programme should formally merge to create a single team responsible for setting the strategic direction of cancer care in Wales and directing improvement activities to support this, led by a senior clinician and senior managerial lead, reporting to the Managing Director of the proposed Performance and Productivity Unit and the National Medical Director. (see Recommendations 19 and 20).
Timescale – within 3 months.

Welsh Government Response: Accept in part

The Welsh Government sets the strategic direction for NHS Wales and is supported in doing so by the NHS Executive. The NHS Executive has no powers of direction, though Ministers do have relevant powers to issue directions. Action is underway to address this recommendation, and the NHS Executive is forming a single cancer team that merges both the network and planned care functions. This will report to the Director of Networks & Planning in the NHS Executive.

The National Clinical Director of NHS Wales (see Recommendation 20) will chair the new national cancer leadership board which has been established to provide the single point of system oversight, and we envisage that the Managing Director of the NHS Executive will also sit on the board.

Recommendation 13

Digital Health and Care Wales (DHCW) should develop a plan to begin collecting and publishing more granular tumour-level performance from the beginning of the 2026/27 financial year at the latest.

- DHCW should also produce an options appraisal for the production of a linked dataset containing cancer and diagnostics waiting times data, producing pathway-level insights into the key diagnostic drivers of long-waits at health board and at national level. Timescale – within 12 months.

Welsh Government Response: Accept

The Welsh Government accepts the principle of this recommendation and of collecting and publishing more granular level tumour performance data.

The Cabinet Secretary for Health & Social Care has announced a cancer data development road map which forms part of DHCW's 2025/26 remit letter. This will include cancer sub type reporting and better reporting of diagnostic data.

Further consideration will be undertaken with DHCW of what can begin to be reported by 2026/27, along with the feasibility of developing a fully linked dataset across cancer and diagnostics.

Recommendation 14

Health Boards should make improvement in processes, partnerships and investment in specific community pathways to reduce delayed pathways of care. Timescale – within 6 months.

14a) Hospitals must ensure that all admitted patients are placed on D2RA pathways in line with the national Hospital Discharge Guidance, and delays by pathways should be published within 3 months.

14b) Welsh Government should run an audit of use of trusted assessors across the 7 health boards and 22 local authorities in May 2025, repeated in October 2025. This should be published in November with justification from the health board and/or local authority where this has not been implemented.

14c) A rapid study should be undertaken within 3 months, by Welsh Government working with health boards, to identify which patient groups/pathways consistently experience the longest pathway of care delays, especially when associated with long time spent in emergency departments. This should be used to target investment in linked community services for winter and future budgets.

- The Performance and Productivity Unit (see Recommendation 19) should then use pathways of care delays for patients requiring no onward care (pathway 0) as a proxy for where hospital processes must be improved to reduce delays.

Welsh Government Response: Accept

Enabling improvements in pathways of care delays is accepted and recognised as a priority of the Welsh Government, including as part of one of the First Minister's priorities of improving access to social care, and the actions of the Cabinet Secretary for Health & Social Care's 50-day challenge in 2024/25. Ensuring ongoing improvements feature as part of the Six Goals for Urgency & Emergency Care Programme (Six Goals) plan for 2025/2026 which will focus in greater detail on patient flow. Detailed dashboards reviewing these metrics are in place and will be reviewed frequently with the escalation process used as necessary to support continued progress.

In relation to publishing delays by pathways, this information is already available; The Welsh Government will develop a process for its routine publication.

An audit of pathways of care is currently being undertaken by the NHS Executive. This MAG recommendation aligns to the findings to date, and a further audit of

compliance with the trusted assessor guidance will be commissioned as part of a phase 2 audit on completion of the initial review in the coming months.

A rapid study to identify patient groups / pathways consistently experiencing the longest delays will be commissioned via the NHS Executive's Six Goals programme building on recent work undertaken as part of the 50-day challenge. Digital Health and Care Wales (DHCW) will be engaged regarding the feasibility of linking patient level data between Emergency Department (ED) and inpatient wards to enable an understanding of any relationship between long stays in ED and long inpatient stays / pathway of care delays. In that context work on linking ambulance, Emergency Department and inpatient data for non-injured fallers (or people who have fallen with minor injury or illness) has already been undertaken and Welsh Government officials have directed health boards to invest existing programme (Six Goals) funding towards the delivery of a 24/7 community-based falls response services.

Health boards are anticipated to deliver on the required improvements through utilising existing resources and funding streams. This includes working with partners on the necessary investment in community pathways through Regional Partnership Boards and prioritising existing funding streams such as the Regional Integration Fund.

Recommendation 15

Health Boards should ensure that no ambulance handover will exceed 45 minutes, with a focus on achieving the 15 minute target wherever possible. Timescale – within 6 months.

- Where the 15 minute handover time target is not possible, an absolute maximum handover time of 45 minutes should be introduced by October 2025.

Welsh Government Response: Accept in part

The expectation of health boards to deliver the ambulance patient handover guidance has been established as one of the enabling actions in the NHS planning framework for 2025/2026 (this guidance includes an expectation for 15-minute ambulance patient handovers).

Subsequently, a national ambulance patient handover improvement delivery group has been established and work is now underway. This is clinically led and supported by the Welsh Government and other national system leaders.

The intention is for a plan to be developed in the first quarter of 2025/26 to assess the potential readiness of NHS Wales to deliver a maximum emergency 45-minute ambulance patient handover time within six months and identify any associated delivery challenges, communications requirements, and risks.

The recommendation is accepted “in part” in relation to the timeframe for implementation overall.

Recommendation 16

Progress against the Six Goals for Urgent & Emergency Care Programme should be reported publicly, using the monthly health board performance reports (see Recommendation 21). Timescale – within 3 months.

- Health boards should ensure that performance reports are aligned with the 6 Goals metrics before winter 2025/26 and made public from June. The report should include both validated and unvalidated four hour performance data. The clinical group reviewing performance standards should ensure that performance metrics cover the full UEC pathway.

Welsh Government Response: Accept

A rapid assessment of Six Goals data will be undertaken to determine what can accurately and reliably be reported publicly over and above the information already available and integrated into existing health board and committee reports. This will also explore the potential to more effectively signpost existing published information where available.

All national statistics are validated and published having been subject to robust quality assurance mechanisms. Welsh Government statisticians receive data from health boards via DHCW after the relevant guidance has been applied.

The implementation of the Welsh Emergency Care Data System over the next 6 to 18 months will enable publication of a more clinically robust and consistent data set which will support implementation of more intelligent quality measures and will include updating current waiting times guidance.

A new emergency ambulance performance framework has been agreed and a second phase review of 999 incidents not categorised as an *arrest* or *emergency* is underway. It is anticipated that this will report to the Cabinet Secretary for Health & Social Care in June 2025.

A scoping review of Emergency Department measures has been undertaken. An ED performance framework will be developed based on learning from the ambulance measures work and is anticipated to be submitted to the Cabinet Secretary for Health & Social Care for consideration during the first quarter of 2025/2026. This will include performance metrics for the full UEC pathway.

Recommendation 17

A consistent framework for escalation levels within the Urgent & Emergency care system should be introduced by October 2025, using the OPEL framework in England, adapted for the Welsh service where needed. Timescale – within 6 months.

- This recommendation should be enabled by the development of a “Once for Wales” digital support tool.

Welsh Government Response: Accept in part

The NHS Wales escalation status framework was launched in December 2024. For clarity this relates to the operational escalation status of organisations on a day-to-day basis in response to operational capacity and challenges, as opposed to the intervention and escalation framework which is related to the performance of NHS bodies in Wales.

In developing the NHS Wales escalation status framework consideration was given to comparable frameworks in place elsewhere, including the OPEL framework.

We acknowledge however that there is currently variation in the consistency with which NHS Wales bodies report and that there is a need to standardise this approach. An initial outline of the approach required to increase standardisation is underway and further consideration will be given to the actions required on a system basis to address any variation.

Recommendation 18

Welsh Government should consolidate all accountability and escalation meetings with health boards and trusts into individual monthly Performance and Productivity meetings, with a key focus on delivery against key areas of both performance and productivity, and progress made with the recommendations of this report. Timescale – within 3 months.

- The CEO of NHS Wales should chair each Performance & Productivity meeting. The meetings should be attended by the CEO of the health board, and at a minimum the medical director, nursing director, finance director and those responsible for operational performance.
- The outputs of performance meetings should be shared with the Cabinet Secretary and the Chair of the relevant health board or trust, with items escalated for discussion as appropriate. This would help clarity and delineate of the role of the Chief Executive and the Chair of each health board and trust, allowing the Chief Executive to focus on operational performance and allowing the Chair to focus on board governance, culture and managing the strategic relationship with the be elected leadership of the local authorities and other key stakeholders. It would also alleviate the onerous duplication of time and effort created by the parallel operational oversight machinery currently in place between the Cabinet Secretary/health board/trust Chair and the NHS Wales/health board/trust CEOs.
- The monthly performance meetings should replace all relevant existing monthly escalation and performance meetings. This should therefore replace the current JET, IQPD, oversight & escalation, and system NHS Performance Board meetings. The Oversight and Escalation framework should therefore be enacted through these performance meetings.
- The associated reduction in escalation interactions and meetings should allow health boards and trusts more time to focus on the immediate performance and productivity task. In parallel Welsh Government should consider strengthening the incentive and sanctions associated with delivery and non-delivery.

Welsh Government Response: Accept in part

The Welsh Government recognises the need to streamline and simplify existing accountability and delivery arrangements where this is required, and is taking steps to do so. This includes actions such as reducing the number of priorities, providing clear direction in the planning framework and developing a new approach to support the Cabinet Secretary for Health & Social Care to hold NHS Wales Chairs to account in 2025/26.

It is recognised that the frequency of interaction with health bodies, especially health boards, has increased due to the rise in escalation status of NHS Wales bodies and increasing actions or direction required from Welsh Government to enable progress in key priority areas.

We will consider how best to implement the recommendation reflecting the principle which the MAG report acknowledges (and with which we agree) that we should aim

to streamline the number of meetings whilst ensuring strengthened focus and accountability (recognising also that heightened escalation requires additional scrutiny in order to improve delivery, and that we should allow differentiation and earned autonomy to reflect progress). We will set out our conclusions within one month.

Recommendation 19

A managing director should be appointed to directly manage and oversee the NHS Executive which will be renamed the Performance and Productivity Unit (PPU). Timescale – appointment within 3 months.

- The Managing Director (MD) should be of sufficient seniority to support the CEO of NHS Wales in holding their NHS colleagues to account. The Managing Director should be accountable to the CEO NHS Wales and be a member of the Welsh Government Executive Director Team (EDT). The Managing Director should have direct line management accountability for the budget and resources of the PPU, which will include the functions and resources which currently reside in the NHS Wales Executive. This resource of around 400 WTE should be renamed the Performance and Productivity Unit (PPU). The Managing Director should ensure that these resources are transparently aligned to the single goal of improving the productivity and performance of the NHS across Wales. There are options for how this resource is deployed, including out-posting to Health Boards and regions to support specific improvement interventions.

Welsh Government Response: Accept in part

The Cabinet Secretary for Health & Social Care has set out his intention to strengthen the operational leadership of the NHS Executive, streamline the organisation and ensure it has the right capacity and skill mix in the right areas to undertake the functions we require. This includes ensuring that resources and funding are fully aligned with Welsh Government priorities and expectations, including the key goal of delivering improvements in performance.

We will appoint a Managing Director. This individual cannot however simultaneously be a member of the Executive Director Team (EDT) in the Welsh Government. There is a legal distinction between the NHS Executive staff employed by NHS Wales and hosted by Public Health Wales, and members of the EDT who are employees of Welsh Government. The Managing Director will necessarily work closely with the EDT.

We agree with the need to rename the NHS Executive to better reflect its function and we believe that a reference to performance in its title is important to give the necessary visibility to this overarching priority. Given that the NHS Executive will have important ongoing responsibilities in relation for example to improvement, value and sustainability and clinical expertise in service improvement (all of which are

underpinned by that commitment to better performance) we are proposing that it be renamed NHS Wales Performance and Improvement.

Recommendation 20

Medical leadership should be strengthened under the leadership of new post of Medical Director of NHS Wales. This is a new post separate from and equal in status to the existing Chief Medical Officer post. Timescale – appointment within 3 months.

- The Medical Director's priority responsibilities should include:
  - Developing an organisational culture that supports the development of a continuously improving, clinically led and data driven NHS in Wales.
  - To anchor and align the clinical leadership capacity and capability within the PPU and NHS Wales to the corporate performance, productivity and clinical transformation agenda.
  - Through the health board medical directors and the associated clinical leadership teams, to drive the implementation of GIRFT recommendation detailed in this report and reiterated by the Cabinet Secretary in his letter to NHS Chairs on 20th December 2024.
  - Through the health board medical directors and the associated clinical leadership teams, to provide the clinical leadership to drive and support the recommendations detailed elsewhere in this report with regard to planned care, urgent care, cancer and diagnostics.
  - To work with the regions, health boards and clinical networks to support, develop and implement regional solutions to fragile services as discussed later in this report.
  - Through the health board medical directors and the associated clinical leadership teams, to drive and prioritise the implementation of HealthPathways (Pathway Alliance Programme).
  - Through the health board medical directors and the associated clinical leadership teams, to drive the implementation of the Value & Sustainability Board agenda including high value pathway interventions and the medicines management work programme.
  - To put in place mechanisms to ensure the alignment of job plans, appraisal and revalidation.

Welsh Government Response: Accept in part

The Welsh Government agrees that there is a requirement to strengthen medical leadership to deliver improved productivity and performance, including the wider areas set out in this recommendation (e.g. implementation of GIRFT, HealthPathways, value & sustainability) as well as the specific productivity and performance recommendations in the MAG report.

The Welsh Government's Chief Medical Officer holds the role of Medical Director for NHS Wales and is supported by two DCMOs; a Deputy Chief Medical Officer (NHS)

and a Deputy Chief Medical Officer (Public Health & Protection). This structure has been strengthened in the last year.

We propose that the Deputy Chief Medical Officer (NHS) will be appointed National Clinical Director of NHS Wales. They will hold specific delegated responsibility to provide medical leadership to the NHS Executive. This would provide the strengthened clinical leadership for all the work of the NHS Executive, in the way envisaged by the recommendation and is consistent with our statutory arrangements which require that decisions and direction on medical leadership for organisations must ultimately come from the Welsh Government (on behalf of Ministers).

Recommendation 21

It is recommended that health boards commission the Welsh NHS Confederation to develop a standardised health board performance dashboard. The dashboard should be used in the public part of board meetings and to support the Performance and Productivity meetings. Timescale - within 3 months.

Welsh Government Response: Accept

National performance dashboards on an all-Wales basis which are based on the national performance framework are produced monthly and provided to the NHS Wales Leadership Board.

Health boards have access to the national performance dashboard and have developed local versions of the national dashboard for their public board in local reports. There is some variability and inconsistency driven by the inclusion of local metrics and priorities.

The Welsh Government will review the performance metrics in the national dashboards and for consistency will establish a local standardised template (and discuss this with local health boards and the Welsh NHS Confederation on a Wales-wide basis). We will complete this within three months. We will then require health boards to ensure that a local dashboard in the standard format is used in public boards in order to allow consistent and comparative analysis. This can of course be supplemented by local intelligence to allow deep dives into local issues, but not presented in a way which has the effect of de-standardising the performance dashboard.

Recommendation 22

A total factor productivity model and workforce productivity model should be developed for NHS Wales and implemented in advance of the next budget. Timescale – within 12 months.

Welsh Government Response: Accept

The Welsh Government acknowledges the challenge reflected in the MAG report on workforce productivity which is faced by a number of healthcare systems.

Specifically, the report references that the growth in the workforce has increased since the Covid-19 pandemic at a rate that outstrips activity growth over the same period. The Welsh Government recognises this challenge, however the analysis in the report represents medical workforce and some core activity measures only, and the basis of comparison across systems is not consistently comparable.

It is also acknowledged that the priority of NHS Wales through the Value & Sustainability Board and other arrangements has been to focus on specific actions to address variation and improve productivity such as reducing agency expenditure, and the detailed actions to improve productivity have been prioritised over the development of a high-level measurement of system productivity. It is recognised that there would be a benefit in developing a strengthened system-wide measurement of productivity, alongside the detailed actions being taken.

Over the next 12 months the Welsh Government will develop this work, considering the model and methodology to deploy, and whether to develop that in-house, or utilise external models.

Recommendation 23

From the June health board meeting cycle of the 2025/26 annual year going forward workforce head count and productivity data should be reported to the monthly public meeting of the health board. This should include data on both directly employed and the GMS and other independent contractor workforce. Working with the PPU the health boards should agree annual workforce productivity targets. Timeframe – within 3 months.

Welsh Government Response: Accept

As set out in the response to Recommendation 22, the Welsh Government recognises the challenge set out by the MAG in relation to workforce productivity.

Workforce headcount and whole time equivalent data already features as part of board reporting across NHS bodies. The MAG suggests that other productivity data should be reported on a monthly basis to Boards alongside workforce data. We agree this would be helpful.

In order to take forward this recommendation, we propose that following the development of the workforce productivity or total productivity model in Recommendation 22, that this be used as the basis for reporting at a health board level. In the meantime, NHS bodies should explore and consider this recommendation and adopt a local approach if data allows and as a minimum should

report to monthly public board meetings on the implementation of the enabling actions in the 2025/28 Planning Framework which relate to productivity enhancement.

Recommendation 24

HEIW should work with the PPU (see Recommendation 19) to ensure that leadership programmes are in place to support the "threes at the top" of clinical services in health boards and trusts. Timescale – within 6 months.

Welsh Government Response: Accept

The importance of effective leadership development programmes to support NHS Wales leaders is recognised and is a feature of a significant amount of activity within the NHS in Wales.

The principle is acknowledged that it is important to consider if additional leadership programmes are required, or existing programmes should be strengthened, to support the continued development of performance & productivity and the service transformation agenda.

Health Education and Improvement Wales (HEIW) have been directed through the 2025/26 remit letter from Welsh Government to strengthen the leadership programme supporting operational managers in this financial year. This work is being progressed.

The 'threes at the top' are referred to in the report as a lead doctor, a lead nurse and a lead manager (plus a lead allied health professional). The Welsh Government further believes that this recommendation should apply to all leadership roles required to support the delivery of this agenda over time.

Recommendation 25

NHS Wales should commission from DHCW a comprehensive roadmap for the delivery of Missions 2 and 3 of its Organisational Strategy over a 24 month period, to be published within 6 months. No health board should move forward with any EMR or App development until the roadmap is established. Full consideration should be given to aligning the NHS Wales App with the NHS England App. Timescale – within 6 months.

Welsh Government Response: Accept in part

DHCW have been provided with a remit letter from Welsh Government setting out the priorities for 2025/26. The development of the national architecture is work in progress.

Mission 2 of the remit letter includes diagnostics, EMPA, the NHS Wales App, WPAS, Welsh Clinical Portal, vaccines and national architecture, and most of these programmes should be significantly progressed within 24 months.

Welsh Government has also commissioned DHCW to lead work on the National Target Architecture in collaboration with NHS Wales to map the current state architecture and define the future state to support future investments in digital transformation.

The sub-recommendations are accepted in relation to EMR/ EHR development at health board and trust level not moving forward until the roadmap is established.

The National Data Resource (NDR) programme includes a standards-driven Care Data Repository to ensure interoperability, and a secure data environment. The NHS Wales Technical Planning Guidance 2025-28 includes an action for health boards and trusts to have plans in place to flow data into the National Data Resource and make fuller use of APIs associated with NDR.

The Cabinet Secretary for Health & Social Care has set out specific expectations to the system in relation to the NHS App in 2025/26 and there are specific components which are the priority for this stage of development. It is recognised that there should be comparable functionality for the NHS App across both Wales and England, with the associated benefits that would bring, and this will be considered in the onward development and implementation of the app. However, the order in which the functions are developed and rolled out need to reflect the priorities of NHS Wales.

Recommendation 26

The Cabinet Secretary should work with ministerial colleagues to prioritise the need to address Wales' data sharing policy and associated framework position with a view to accelerating the incorporation of datasets into the National Data Resource. Timescale – within 12 months.

Welsh Government Response: Accept

A plan has been developed with the activities and actions required to provide the required clarity to the system through a combination of legislative and policy proposals.

Recommendation 27

In addition to the plan for pathology and endoscopy (see Recommendations 6 and 7), health boards should work together as regions to identify two priority fragile services to be addressed in 2025/26 and thereafter a further two on an annual and ongoing basis. To facilitate this work, resources and support will be provided by the PPU. Timescale – within 12 months.

Welsh Government Response: Accept in part

The Welsh Government recognises that sustainable service solutions that deliver the best outcomes for the population may require a strengthened approach at a regional level. The Cabinet Secretary for Health & Social Care has set out this expectation to health boards in Wales and has implemented actions to strengthen regional working and the associated delivery structures and mechanisms.

Consideration will be provided to the resources and support required to deliver this agenda as part of the realignment of the resources within the NHS Executive as outlined in the response to Recommendation 19.

These changes will likely require significant investment in either capital or revenue terms (or both), but may also present the opportunity to improve the utilisation of resources and deliver greater resilience in service and workforce terms. Detailed options appraisals and robust cases will be required to support material changes along with ensuring necessary consideration for both the impact assessment associated with any changes and engagement with the public and stakeholders.

The Welsh Government expectation is that on a regional basis health boards prioritise this agenda and make significant progress in the next 12 – 24 months in areas of identified local and regional priority. The recommendation is accepted “in part” only in relation to the question of timescale, though recognising that urgent progress is required.

Recommendation 28

The capital allocation should be uplifted on an ongoing annual basis and aligned to the annual planning and prioritisation process. Timescale – within 12 months.

Welsh Government Response: Accept in part

It is recognised that the health capital budget requires consistent and sustained recurrent increases in available funding. This is required on a longer-term basis in order to provide funding certainty to longer-term capital programmes.

Significant work and progress has been made on the longer-term capital requirements of the service and the ten-year outlook and prioritisation framework.

This recommendation is beyond the authority of the Health Social Care & Early Years Group and the Health & Social Care MEG. Decisions on future budgets are subject to decision by the wider Welsh Government and Cabinet on future budget setting which will depend on the overall budget approach and resource availability.

Recommendation 29

Welsh Government should conduct a review of preferred options for generating non-exchequer capital for the Cabinet Secretary for Health and Social Care to consider ahead of 2026/27 capital round. Timescale – within 9 months.

Welsh Government Response: Accept

The Welsh Government recognises that alternative sources of capital and different solutions may be required to meet the scale of the capital challenge facing the NHS. These have already been deployed as outlined in the MAG report in examples such as the Mutual Investment Model.

A review of the different options for alternative sources to traditional capital has been undertaken. This will be considered in detail against future priority capital schemes to consider where specific alternative sources are realistic options, which, as the MAG report recommends can be considered in advance of the 2026/27 capital round.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Board Action Log

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
30.05.2024	3,1		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	Director of Social Services	25-jul-24	Open	**In progress** 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 Further review to be undertaken of the response provided in relation to action log entry 3.1 to determine whether the Board would be provided with an update on what systems of shared learning had been put into place with Local Authorities. Response to be shared outside the meeting.
30.05.2024	3,1		Listening & Learning Story	Report to be presented to a future meeting outlining the key actions required that needed to be taken forward	Care Group Nurse Director, Mental Health & Learning Disabilities	Executive Director of Nursing/Deputy CEO	28-nov-24	Open	**In progress** Report to be presented to the November 2024 Board meeting. As a result of capacity constraints within the Team, this will now be presented to the **July 2025** Board meeting
28.11.2024	4,2		Chief Executives Report	National piece of work being undertaken in relation to CAMHS service to be presented to the Childrens Board to ensure there was multi-agency oversight in place on the plan	Chief Executive Officer	Chief Executive Officer	To be confirmed	Open	**In progress**
28.11.2024	5,1		Update Report on the Princess of Wales Hospital	Discussion to be held at a future Board Briefing session on risk log and backlog position of the estates issues across all Health Board premises Regular updates to be provided to the Board at future meetings on progress being made in this area.	Executive Director of Finance Executive Director of Finance/Chief Operating Officer	Executive Director of Finance Executive Director of Finance/Chief Operating Officer	30.01.2025	Open	**Part Completed** Discussion held at the Board Development Session held on 15th May in relation to risk and the estates backlog position across all Health Board premises. Further updates on progress on the works being undertaken at the Princess of Wales Hospital to be scheduled into the forward work programme
30.01.2025	3,1	Page 3	Listening & Learning Story	Multi-agency thematic review action plan to be shared with Board Members once it had been submitted to and accepted by the inspectorate.	Mental Health & Learning Disabilities Care Group Nurse Director	Chief Operating Officer	Completed	Open	**Completed - Proposed for Closure** Improvement plans shared with Members by email on 24 March 2025

30.01.2025	5,4	Page 7	Board Assurance Framework	Focussed discussion on Estates and Capital risks to be held at the May 2025 Board Development session.	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	15.05.2025	Open	**Completed - Proposed for Closure** Focussed discussion held at the Board Development session held on the 15 May 2025 in relation to the Board Assurance Framework, with particular focus placed on Estates risks
30.01.2025	6,3	Page 13	Stroke Services Update	Update to be presented to a future meeting on the progress being made on regional discussions regarding stroke services.	Chief Operating Officer	Chief Operating Officer	29.05.2025	Open	**In progress** Awaiting update from Chief Operating Officer for sharing with the Board
30.01.2025	6,5	Page 13	Primary Care & Community Development	Further update on progress in regards to Primary Care and Community Development to be presented to a future Board meeting at the most appropriate time.	Chief Operating Officer	Chief Operating Officer	31.07.2025	Open	**In progress** The Chief Operating Officer has advised that this update will be presented to the July 2025 Board meeting
30.01.2025	6,5	Page 14	Primary Care & Community Development	Consideration to be given to receiving some listening and learning stories at future meetings in relation to patients who had been part of preventative programmes for example, and how this had made a difference	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	25.09.2025	Open	**In progress** This is in the process of being considered by the Executive Director of Strategy & Transformation. Consideration being given to a story related to the work being undertaken on Housing to be shared at the **September 2025** Board meeting
27.03.2025	3,1	Page 3	Listening & Learning Story - Planned Care	Thanks to be extended from the Board to the relative of the patient for allowing for their story to be shared	Care Group Nurse Director, Planned Care	Chief Operating Officer	mar-25	Open	**Proposed for Closure** Planned Care Nurse Director has confirmed that the Board's thanks had been extended to the relative of the patient and was pleased to hear that her husband's story had been heard by the Board
27.03.2025	3,1	Page 3	Listening & Learning Story - Planned Care	Discussion to be held with the team outside this meeting to determine how the story could be shared more widely	Director of Communications, Engagement and Fundraising	Director of Communications, Engagement and Fundraising	mar-25	Open	**In progress** Awaiting confirmation that discussion has been held
27.03.2025	3,2	Page 6	Staff Survey Results 2024 and People Plan	Thematic results of the staff survey to be share with Board Members once available	Executive Director for People	Executive Director for People	mai-25	Open	**In progress** Thematic results will be shared with Board Members in due course

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Board Action Log

the action originated from	reference	Reference Page Number	m Title / Summary	Nature of Action	Lead Officer	Lead Executive	Timescale for action to be completed	Status of Action	Narrative Progress Update
25.07.2024	7,3		Board Assurance Framework	Review the risk score of Strategic Risk 5 - Delivery of a digital and information infrastructure to support organisational transformation.	Director of Digital	Director of Digital	26-sep-24	Closed	**Completed** Completed. While some reports have been withheld (likely to never be shared) the risk has been reviewed and the Director of Digital has advised he is content with the current level
30.01.2025	6,5	Page 15	Primary Care & Community Development	Consideration to be given to including a GP in the Board structure, either as an Associate Member or as a co-opted Member	Assistant Director of Governance & Risk	Director of Corporate Governance/ Board Secretary	27.03.2025	Closed	**Completed** Update on next steps has been included in the Chairs Report which is on the agenda for the March 2025 meeting

Agenda Item
5.3

CTM BOARD

BOARD ASSURANCE FRAMEWORK REPORT

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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	Cally Hamblyn, Assistant Director of Governance & Risk
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	April / May 2025	Reviewed and signed Off
Executive Leadership Group	Via email 6 May 2025	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 & Assurance Committee and the assigned risks to the other Board Committees as appropriate.

3. Key Risks / Matters for Escalation

3.1 Please refer to Appendix 1 which outlines the key risks for discussion and review. Amendments have been highlighted in red.

3.2 There have been no significant changes to the strategic risks this period in terms of status and scoring.

3.3 Further to discussion at the January 2025 Board meeting the Board Development Session scheduled for May 2025, will be dedicated to risk with particular focus on reviewing the Strategic Risks escalated to the BAF and consideration of new risks relating to Capital and Estates and the Integrated Care Model. Any updates to the BAF arising from that discussion will be reflected in the July iteration of the BAF.

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
	Ageing Well

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	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 *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 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 Board is asked to APPROVE the updates to the BAF Report for May 2025 as captured in Appendix 1.

6. Next Steps

6.1 Strategic Risks captured in the BAF will be reviewed at the Board Development Session in May 2025.

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, Safety & Experience Committee Operational Delivery Committee	16 (C4xL4)	No Change to Risk Score this period. ⟷
1b	Sufficient capacity to meet emergency demand Click Here for Risk1b	Improving Care	Chief Operating Officer	Quality, Safety & Experience Committee Operational Delivery Committee	20 (C4xL5)	No Change to Risk Score this period. ⟷
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, Safety & Experience Committee Strategic Development Committee	16 (C4xL4)	No Change to Risk Score this period ⟷
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	Operational Delivery Committee Strategic Development Committee	16 (C4xL4)	No Change to Risk Score this period. ⟷
4.	Community and Partner Engagement Click Here for Risk 4	Creating Health	Director of Communications, Engagement & Fundraising	Strategic Development Committee	12 (C4xL3)	No Change to Risk Score this period. ⟷
5.	Delivery of a digital and information infrastructure to support organisational transformation Click Here for Risk 5	Improving Care	Director of Digital	Operational Delivery Committee Strategic Development Committee	16 (C4xL4)	No Change to Risk Score this period. ⟷
6	Risk Closed January 2025.					
7	Culture, Values and Behaviours Click Here for Risk 7	Inspiring People	Executive Director for People	Strategic Development Committee	12 (C4xL3)	No Change to Risk Score this period. ⟷
8	Fulfilling our Environmental and Social Duties and ambitions Click Here for Risk 8	Sustaining our Future	Executive Director of Strategy and Transformation	Strategic Development Committee	16 (C4xL4)	No Change to Risk Score this period. ⟷
9	Healthy Life Expectancy Click Here for Risk 9	Creating Health	Executive Director of Public Health	Strategic Development Committee	20 (C5xL4)	No Change to Risk Score this period. ⟷
10	Risk Closed March 2025.					

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				9	
	4		*3,4,8,7,8*	4,7, 10 *1a,2,5,9,10*	2,3, 5,8, 1a *1b*	1b
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

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 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.

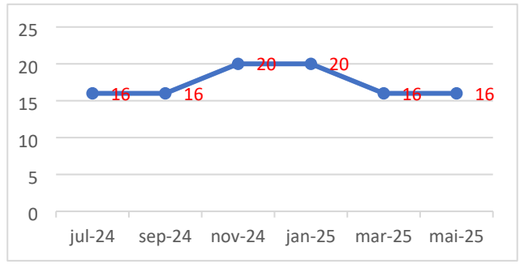
Risk Lead	• Chief Operating Officer • Executive Director of Strategy & Transformation	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee (Performance Targets)

	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 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 made on >104 week • 8 theatres across CTMUHB remain closed • 2 mobile endoscopy treatment rooms opened 4th March 2025 • 4 Mobile theatres to open mid-April 2025 • 2 Prince Charles Hospital (PCH) theatres to open end of April 2025 • Critical incident declared at Princess of Wales (POW) on 9th October 2024 due to the roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc. cardiac) and trauma capacity • There has been continuous planning on clinical pathways and diversion of emergency intakes, which again has impacted on the capacity and resilience across the full CTMUHB system. • There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTMUHB acute and community. • There has also been significant reallocation of internal capacity at POW and Royal Glamorgan Hospital (RGH) to respond to the critical incident. • Planning continues recovery phase following critical incident with the impact not yet quantified. • There has been continuous improvement against trajectories for elective demand for a range of services including Mental Health and Learning Disabilities.

	• 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 PCH 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 be completed as part of the Critical incident response and reduce the number of operating theatres until early summer 2025. 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 the incident, 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.

Current Control Measures

Productivity, improvement and transformation programme (PIT)

- Increase Planned Care Capacity
- Transform the way Planned Care is delivered
- Prioritise both diagnosis and treatment
- 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
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.

Current Control Measures Cont.

IMTP – investment agreed by Board.

Specific Improvement Groups/Boards

- PIT programme
- Planned Care recovery
- 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

Recovery Planning post critical incident at POW.

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

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

Commissioning Group established to oversee the delivery of the optimised integrated care model

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
- 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

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 Programme Board (Formerly 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

Sources of Assurance (Internal and External)

- Integrated Performance Report
- Harm Reviews
- Assessment Dashboard
- Update reports on specific services experiencing pressure, e.g. Ophthalmology, Urology
- Performance RTT, Cancer trajectories
- 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.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. 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	• Increased utilisation • Reduction in patient attendances • Reduction in patient follow up appointments • Reduction in demand • Reduced paper and manual process • Increase in data information	• Decreased CAN/DNA rate • Increased utilisation • Decreased missed opportunities • Reduction in referral demand Reduction in waiting list
2. 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.	• Performance monitoring • Patient identification • Improved pathway monitoring	• Increase in performance SCP Decrease in waiting list back log

	• Canisc replacement ongoing. Implementation of Breast, Urology & lower GI datasets • Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance		
3. 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 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.	• More capacity • Reduced waste • Consolidated pathways • Increase in workforce Increased utilisation	• Increase in activity • Reduced fellow sessions • Reduction in waiting times Reduction in >104 week wait

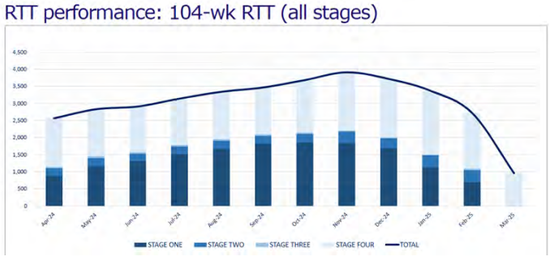
Linked National Priority Measures

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).

Current Performance Highlights

RTT performance: 104-wk RTT (all stages)



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

Critical incident declared at Princess of Wales on 9th October 2024. Severe water ingress with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity.

Associated Risks escalated to the Organisational Risk Register		
5932	Roof covering replacement works to resolve identified roof integrity issue and consequent risk of tiles falling internally and externally from weakened roof at POWH Phase 1.	20
5961	Remedial roof works to resolve the water ingress at POWH.	20
4491	Failure to meet the demand for patient care at all points of the patient journey	20
5417	Paediatric dentistry – General Anaesthetic theatre list. New risk escalated to the Organisational Risk Register in March 2024.	20
3567	New risk escalated to the Organisational Risk Register in May 2025. Capacity of Cellular Pathology Service – Space	16

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.	

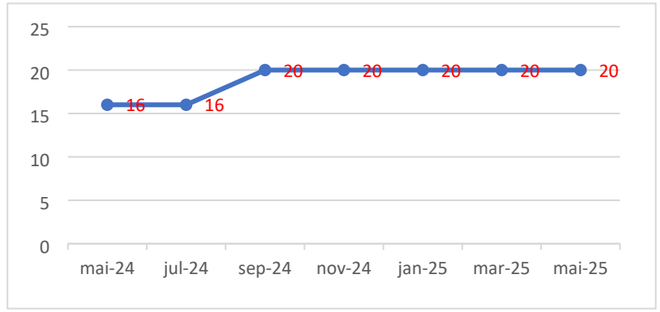
Risk Lead	• Chief Operating Officer	Assurance committee	• Quality, Safety & Experience Committee • Operational Delivery Committee (Performance Targets)

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	5	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 this period.

Risk Score Trajectory



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

- Critical incident declared at Princess of Wales on 9th October 2024. Roof integrity issues with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity
- Impact of a temporary centralisation of stroke into one site.
- There has been continuous planning on clinical pathways and diversion of emergency intakes that again has impacted on the capacity and resilience across the full CTMUHB system.
- There has been a requirement to deescalate and close 190 inpatient beds on the POW site. With re-provision of the capacity across CTMUHB acute and community.
- There has also been significant reallocation of internal capacity at POW and RGH to respond to the critical incident.
- Planning continues on recovery phase following critical incident with the impact not yet quantified.
- 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 despite critical incident remains unchanged, due to the following potential impacts.
  - There has been a reduction and re-alignment of bed capacity at POW and RGH.
  - There has been a diversion of emergency intakes from POW to RGH.

	• 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 un-commissioned 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.

Current Control Measures

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 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. Outpatients and Planned Services within USC: utilisation of SOS and PIFU; additional advice & guidance services
3. Diagnostics: regional and community diagnostic centres; straight to test pathways; diagnostic pathway best practice
4. GiRFT/SEDIT:
   Clinical Implementation Networks: Emergency Medicine

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

1. Increased efficiency: streamlining processes to reduce waiting times, eliminate unnecessary delays. Ensuring patients receive the care in the lowest acuity setting for their needs.
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. Reducing overcrowding within the UEC system to reduce harm and improve patients and staff experience.
3. Optimised resource utilisation: making better use of the available resource, including staff, equipment, and facilities, to ensure maximum productivity and minimal waste. Lowering the number of avoidable attended to ED by directing patients to more appropriate urgent and community settings.
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 high-quality care and minimising harm.
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.

Programme

- 6 Goals Programme Board
- Diabetes Programme Board
- Stroke Programme Board (Paused), Stroke Service re-design programme in operation to support development of service due to temporary centralisation of Stroke services.
- Orthogeriatric Programme
- MTC Programme Board
- Strategic Transformation of Acute Medicine (STAMP)
- Improving Care Board
- Operational Management Board
- Speciality Specific and Cancer Improvement Trajectories Completed.

IMTP – investment agreed by Board.

Specific Improvement Groups/Boards

- Optimise Project Board
- Orthogeriatric Project
- 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

Recovery Planning post critical incident at POW

Lessons learnt from Winter Planning process currently being analysed from a lesson 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.

Sources of Assurance (Internal and External)

- 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 &
- 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.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. 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 • STAMP roll out across all sites • UTC Pilot PCH • Reconfiguration of ED footprint – ambulatory footprints at POW • Re-alignment of clinical pathways • Internal Professional Standards • Re-alignment of ward capacity • Establish un-commissioned 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. • Urgent Care Summit to develop a whole system approach to improvement in: • Admission Avoidance	• Improved patient flow • Sustainable workforce • Care closer to home	• Improved performance • Reduction in patients >12hrs • Improved community response • Reduced LoS in the Emergency Department • Reduced harm associated with increased waiting times

	• Integrated Front Door • Acute Hospital Flow and Discharge • Integrated Discharge • Agree improvement trajectories for 2025/26		

Linked National Priority Measures

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,

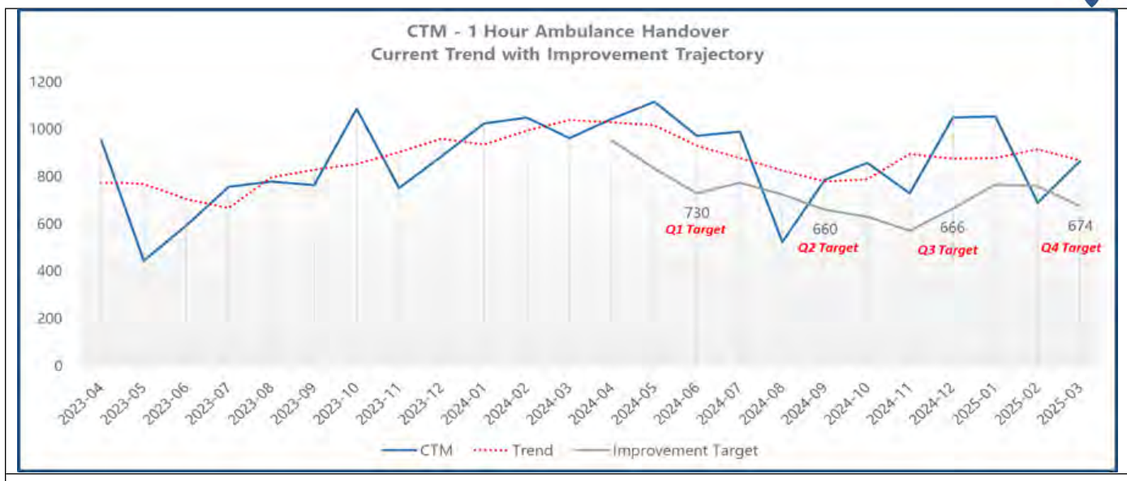
Access to Timely Planned Care Services in USC

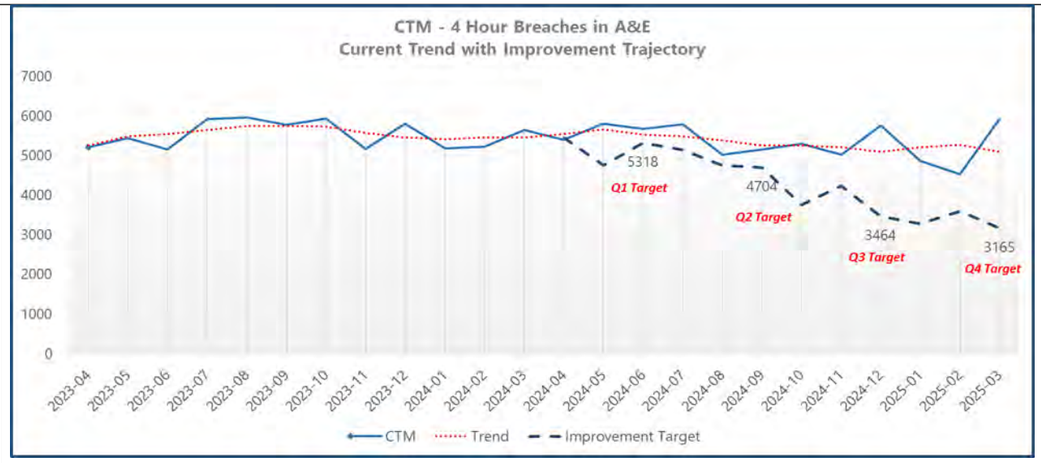
- As per Planned Care BAF

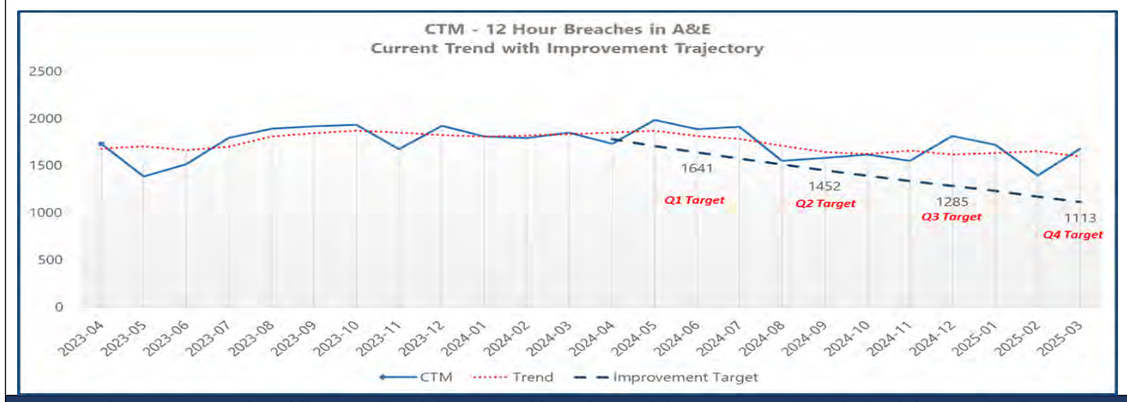
Current Performance Highlights

Emergency Department Performance:

- 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 where patients may become fit to sit.
- Experience triage / Senior Decision Maker to maximise fit to sit decision, quick turnaround and front loading of investigations.
- Urgent Treatment Centre (UTC) at PCH went live 1st November for a 3-month trial. This was extended through March. Exploring funding to extend past April 2025.
- 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.
- Formulations of ED Delivery Plan and Improvement Targets, including;
  - Improvement in 4-hour handover by April 2025
  - 80% of patients handed over within 1 hour by July 2025
  - 100% of patients handed over within 4 hours by July 2025
  - 50% reduction in 12-hour ED waits by July 2025
  - Zero tolerance for patients waiting >48hours
- Reduce conveyance / pathway development with WAST – 8% higher than other HB's.
  - Nav Hub/Care Home pathway development
  - SDEC
  - Extend UTC
- Implementation of STAMP across all 3 acute sites.
- Bi-weekly team meetings established with WAST.
- D&C mapping to identify invest to save opportunities for additional medical recruitment across all 3 ED's.







Were there any significant incidents affecting this strategic Risk this period:
Critical incident declared at Princess of Wales on 9th October 2024. Severe water ingress with immediate impact on clinical pathways, bed capacity, all theatre elective capacity (inc cardiac) and trauma capacity. An urgent temporary move of the Stroke Services was agreed due to the fragility of the Consultant workforce at PCH. The Stroke Service moved from PCH to RGH on Wednesday 8th January 2025

Associated Risks escalated to the Organisational Risk Register		
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

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

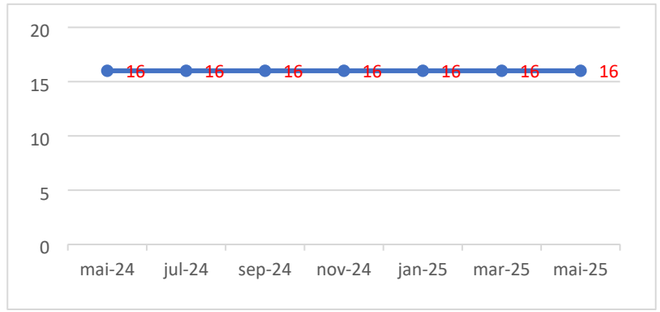
Risk Leads	• Executive Nurse Director • Executive Medical Director	Assurance committee	• Quality, Safety & Experience Committee • Strategic Development Committee

	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 to risk score 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 due to the current challenges and complexities being faced by teams across all sites. It is anticipated that the risk score may remain quite static 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.

Current Control Measures

Quality Frameworks and Policies

- Strategic review of Infection, Prevention & Control (IP&C) has been completed and has been aligned to the IP&C Strategy 2024-2027. 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. A work plan has been developed to imbed the strategy and a new operating model for IPC. Strategy launched, ongoing Organisational Change Programme.
- Development of the CTM Safeguarding Strategy 2024-2027 – endorsed at Health Board meeting in January 2025.
- Quality & Safety Framework in place.
- 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 CTM Learning Academy Framework is being presented to the Quality, Safety & Experience Committee in January 2025 and to the March 2025 Board Meeting;
- The Incident Management Framework was launched in June 2022 to reflect national changes in national incident reporting; following consultation across 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;
- Superseded by CTM Learning Academy framework.
- Listening & Learning Framework established. Shared Listening and Learning Forum meets at least four times per annum with two Shared Learning events each year. Last event took place on 13 November 2024, and a further event in late spring/early summer 2025 is planned.
- Quality Strategy. A Quality Strategy, Annual Action Plan supports the achievement of the deliverables within the Quality Strategy.
- Ward Accreditation Programme Framework established and is in the process of being rolled out. We have currently completed 27 wards with 8 white and 19 reaching Bronze accreditation. There is a rolling programme in place for 2025 which includes Maternity & Mental Health.
- Nursing and Midwifery delivery plan was received at the May 2024 Quality & Safety Committee and formally launched in July 2024.
- Duty of Quality and Candour established within CTMUHB. CTMUHB is represented on an All Wales basis where any discussions are held in terms of reviewing the framework. Adhoc support is available from the NHS Executive as required. Progress is also being made against the Annual Quality Report in readiness for publication in the forthcoming months.
- CTM Allied Health Professionals and Health Care Science Delivery Plan.
- Assistant Medical Director for Quality & Safety commenced in February 2025.
- Mortality Board established and inaugural meeting held in December 2024. Agreement with Archus to establish a robust process for data monitoring.
- People Experiences Framework
- Harm Free Care

Learning from Experience

- New Patient Experience Forum established, with the inaugural meeting held in April 2024, with regular meetings to be held moving forwards. Patient Experience Forum revitalised and an operational group also now established to support this activity. The first bi-annual report from the forums will be received at Quality, Safety & Experience Committee in March 2025.
- 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. Following discussion at the Board Development Session in December 2024, the revised approach to walkarounds will commence in April 2025.
- 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.
- The mortality team is finalising a standardised mortality dashboard which will establish a consistent process for mortality scrutiny, with key information regularly reported to a Mortality Board. The aim is to complete this in Q4. This has been expanded to include reports from the Medical Examiner service and integrated into the mortality learning reports.
- Working with the COO and wider operational teams, the Deputy Executive Nurse Director has mapped the harm free care agenda, including Hydration and Nutrition, Inpatient Falls and Pressure Damage Steering Groups through the existing Improving Care Board structure, resulting in planned bi-annual reporting to Quality, Safety & Experience 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 & Experience 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 - 2025 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;

Current Control Measures Contd.

- 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 2025 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 1,800 individuals registered and using the system. Over 270 staff ideas generated since its launch.
- RADAR (Recognition of Acute Deterioration & Resuscitation) Committee. – Training standards and compliance. Current framework and structure for RADAR under review and will be subject to further discussion over the coming weeks. Activities of RADAR are now integrated into business as usual within the Unscheduled Care Group structure.
- There is an End of Life provision plan which is being managed by the Primary Care, Care Group alongside Palliative Care.
- Advanced Clinical Practice Board established to provide governance oversight concerning advanced practice professionals.

Innovation & Improvement Programmes

- On the back of the success of the 2023 and 2024 events, there is a 2025 Quality Improvement showcase scheduled for mid-year. Additionally, a Value Based Healthcare Showcase event is planned for March 2025.
- Improvement Community of Practice implemented with over 30 QI champions currently in place.
- Healthcare Pathways Programme continues as exceeding expectations.
- Theatre Utilisation Group is now captured within the Productivity Improvement and Transformation Programme for Planned Care activity. There is also a Strategic Transformation of Acute Medicine Programme for Unscheduled Care activity. Both programmes report into the Operational Management 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 2025-2028 business plan.
- Leading for Patient Safety with Improvement Cymru and Institute for Healthcare Improvement (IHI) launched. Phase 1 completed. Phase 2 launched in October 2024 focusing on Acute Deterioration, Deconditioning and Quality Management Systems; Improvement and Innovation CTM are actively supporting a number of services, a full list is available from iCTM;
- ICTM developed and delivering a QI Capacity and capability programme;
- Monthly Quality Improvement (QI) training continuing and ongoing on a monthly basis, over 490 CTM people trained in numerous improvement techniques.
- Investigation and Putting Things Right (PTR) Training commenced during July 2022; The delivery of investigation and PTR training is under review as part of the updated PTR regulations implementation. All Wales PTR training is currently out for consultation across NHS Wales organisations.
- Value Based Healthcare programme in place aligned to national Value in Health priorities; business case proposals received for 2024-2025 investment currently being reviewed.
- 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 Service Improvement; Groups established end of 2024
- 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 final report has been issued.
- 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 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. Reviewing the process documentation and guidance for Duty of Quality and Duty of Candour to ensure accessible training and proper recording on our Electronic Staff Record (ESR). The PTR training will also incorporate Duty of Candour.
- 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 Quality, Safety & Experience Committee and Board.
- Medical Collaborative Group is being formed and re-invigorated to enhance collaboration between primary and secondary care.
- Clinical Pathways Group have been established to approve any changes to clinical pathways that impact patient flows across CTMUHB.
- Improving Care Board has developed a portfolio of improvement programme and projects.
- National Safe Care Collaborative Programme Commenced.

- CTM Learning Academy – The vision of the CTM Learning Academy is to “Develop an ambitious and capable integrated multi-professional clinical workforce, improving patient and population health outcomes & wellbeing. To develop and deliver an inter-professional and collaborative learning approach, meeting the individual educational needs of each profession whilst also enabling and benefitting from diversity of thought and skill set.”. There are 4 Strategic Aims:
  - Establishing underpinning processes for Education Quality, Governance and sustainability
  - Developing and Transforming our Current workforce
  - Developing our Future Workforce
  - Developing a Culture of Interprofessional Learning and Collaboration.

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. Research strategy in final draft form, currently out for wider consultation. It is anticipated that the strategy will be presented to Board in July 2025. ~~Executive Director of Nursing planning to present to Board in March 2025.~~

Flow Efficiencies and Productivity
- ‘Optimise’ – optimise flow improvement programme rolled out across all three acute sites.
- Medical Workforce & Nursing Workforce Productivity Programmes established. Medical Workforce Productivity Programme encompasses a performance and escalation group as well as a framework group for establishing standard practice at CTM.

Sources of Assurance (Internal and External)

External Reports
HIW / AW – Quality Governance Arrangements Joint Review Follow-Up – August 2023:
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 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

HIW Deprivation of Liberty Safeguards Report 2024 - The Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2022-23 provides an overview of the implementation of DoLS in Wales. The report highlights a significant increase in the number of applications received by local authorities and health boards, with ongoing delays in allocation, assessment, and authorisation processes. These delays result in many individuals being deprived of their liberty without legal protection. The report also notes variations in the use of conditions and the need for improved procedures for urgent authorisations. The Welsh Government is considering strengthening the current DoLS system to better protect the human rights of individuals who lack mental capacity. CTMUHB has been actively addressing the Deprivation of Liberty Safeguards (DoLS) through various measures to oversee and respond to the increasing demand.

Internal Audit review on “Embedding the Quality Framework” completed and final report has been received. Reasonable assurance has been provided by the Audit, recommendations are being acted upon and managed via the audit tracker.

Internal Audit – Peoples Experience – resulted in Substantial Assurance.

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 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.
- Medicines Safety Group, Access to Medicines Group established. Replacing the Medicines Formulary Committee with a broader remit.
- 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); partially complete. New Directors now require training, safeguarding team leading a short review to ensure appropriate level of training, L2/3 for clinical and non-clinical directors (to be completed by May 2025).
- 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.
- 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;
- Harm Free Care Agenda ~~Community Acquired Pressure Damage / Falls Reduction Collaborative / Hydration and Nutrition Group;~~
- Patient Safety Solutions – safety alerts and notices;
- Mental Capacity Act (LPS);
- 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.
- Internal Audit undertook a review which considered the processes and procedures implemented by the Health Board to ensure compliance with the Duty of Candour. The final report is awaited, and any recommendations will be acted upon and managed via the Audit Tracker
- Internal Audit review undertaken on embedding the Quality Framework. Final report received and reasonable assurance allocated. Recommendations are being acted on and being managed via the Audit Tracker
- Staff survey closed. Higher response rate received than in previous years. The final CTM response rate was 26.7% which equates to 3553 members of staff. This is the highest rate among the Health Boards of our size in Wales and CTM's highest response rate to date.
- Ward Accreditation Programme is embedded across the Health Board in Inpatient Areas.
- Performance and Escalation Group (PEG) for Medical Workforce Matters.

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. Discussed at Board Development session held on 12 December 2024. Revised process agreed for implementation from the 1 April 2025;
- 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;
- 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;
- Discussions are urgently progressing in relation to regional stroke services developments. Stroke monitoring and evaluation dashboard established to identify potential impact of moving to a temporary single site stroke service for CTM. Teams have established daily huddles to monitor qualitative feedback from Teams in terms of impact of moves.
- Regular Director of Therapies & Health Sciences Team quality assurance visits to clinical services.

External Assurance

- 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 has been completed and considered at the January 2025 Quality, Safety & Experience Committee.
- Health Education Improvement Wales (HEIW)– undertake regular reviews of services with respect to medical training of resident doctors.
- Ombudsman's Annual Letter;
- Internal Audit Review – CSG & Care Group Quality Assurance. August 2022 – outcome of Reasonable Assurance;
- 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;

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Roll out of the Clinical Ward/Department Assurance Programme.	Rolling programme commenced and 10 wards have been completed.	Ward/Department Accreditation is an "improvement tool that evaluates the quality of patient care in an inpatient setting. The program was implemented across Cwm Taf Morgannwg clinical areas in April 2024. The program aims to provide a measurement of quality and standards of care which Assurance for its Wards and Areas (Bronze, Silver, and Gold awards) Extending program into Mental Health and Maternity plus a further 20 areas across the acute site throughout 2025.	Currently 27 wards completed with 8 white and 19 reaching Bronze accreditation.
2. Strategy & Framework Reviews and Development Safeguarding Strategy	Complete in terms of Safeguarding Strategy.	The Safeguarding strategy and framework gives a comprehensive approach to	Phase 1 of development of Safeguarding Dashboard

o Safeguarding Strategy completed and submitted to safeguarding executive committee on 21.10 24 o Development of a safeguarding dashboard o	Timeframe for Safeguarding dashboard is planned to be available in draft by the end of May 2025.	Safeguarding. It provides a framework for identifying risks, responding to concerns, and promoting a culture of vigilance and responsibility throughout our organisation.	underway. As there are multiple systems in use with data housed it is essential to scope what data is on which system and how these can amalgamate into one dashboard. There is a robust work plan which is in ace to support implementation of the safeguarding strategy and framework. The monitoring of these actions will be overseen thorough the safeguarding executive committee
3. Data and Audit - Real-time performance and quality data accessible via electronic systems across the organisation;	• Mortality Data Improving – CTMUHB are now collecting data on mortality with a plan to standardise the way mortality is reported through the Care Groups with oversight from a Mortality Board, which is now established. Agreement with Archus to establish a robust process for data monitoring.	Visibility and granularity of data will be available to support clinical decision making and learning, as well as identifying areas that may require greater focus.	Monitoring the performance data dashboards to determine if improvements are being made and sustained.
	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.	CTMUHB has actively participated in the NHS Executive's rollout of the National Quality & Safety Framework. This Framework ensures we measure quality across the six domains of quality and is consistent with all NHS Wales organisations. The domains being: • Safe Care • Timely Care • Equitable Care • Effective Care • Efficient Care • Person-Centred Care The Framework enables CTMUHB to benchmark our quality performance indicators against other NHS Wales organisations. In addition to the Framework, the Q&S team utilises the NHS Executive's Beacon Dashboard to maintain alignment with other organisations across NHS Wales. The NHS Executive workstream has also supported benchmarking of our Annual Q&S	CTMUHB has seen notable improvements in productivity across the Quality & Safety agenda. Our Learning Processes, including the Listening & Learning Framework with its central repository and bi-annual Listening & Learning event, have supported improvements in cascading learning across CTMUHB. By focusing on timeliness and effective care, CTMUHB has significantly enhanced its concerns response compliance. CTMUHB is now recognised as an exemplar for concerns management across NHS Wales. Our team regularly benchmarks our performance against similar NHS organisations.

		Report, thus ensuring a level of consistency with other organisations across NHS Wales.	CTMUHB's position in relation to NRI compliance has also improved over significantly over the last year.
	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.	• Improved decision making and therefore improved patient care • Improved oversight of patient care form ward / team to Board against evidence-based standards and local indicators • Stimulate clinical team discussion and quality improvement areas • Decision making • Real time insights to ensure mobilisation of support, adjustments and actions where needed	To be captured in next iteration.
	~~Improving Care Board has developed a portfolio of improvement programme and projects. Monthly governance meetings established. Move to control next period.~~ Complete.	~~Programmes of work in improving care board are dynamically assessed and changed based on business need. The board is there to assure improvement portfolio, which includes:~~ ~~• Planned Care (PIT)~~ ~~• Six Goals~~ ~~• Frailty Transformation~~ ~~• Primary Care & Community Transformation~~ ~~• Mental Health & LD~~ ~~• Harm Free Care~~ ~~• Stroke~~ ~~• LHP~~ ~~SBUHB Disaggregation~~	~~Each project and programme have clear project documentation, including deliverables, workstreams and benefits. Each one has key measures of success and improvement.~~
	~~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.~~ Programme commenced.	~~The Collaborative will take forward 4 key elements to support CTMUHB in its quality assurance and delivery framework. These include:~~ ~~• Deconditioning~~ ~~• Acute Deterioration~~ ~~• Duty of Quality Leaders~~ ~~Leading Quality and Safety Improvement~~	~~Measures will be determined for each workstream.~~
4. 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	Embed Quality Improvement into everyone's day to day jobs, providing them with the tools, skills and ability to make improvements within their areas.	Rolling programme of challenges for staff with measures around ideas, engagement and implementation.

	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.	Ensuring our people have the skills and empowerment to make changes and improvements. To ensure as a Health Board we have the ability to track patient experience and use this data to continually improve our services to patients, families and communities.	PREMS data now being routinely provided to Care Groups and to Q&S Committee.
5. Improving flow and efficiencies and productivity	• Medical & Nursing Workforce Productivity Programmes operating within the transformational programme governance structure and delivering to plan.	Medical: Medical Workforce Productivity Programmes - Ensuring that the workforce meets the requirements of the Health Board – job planning, financial prudence (monitoring medical spend and exploration of potential savings and efficiencies), workforce establishment. Nursing: CTMUHB has been actively working on the Nursing Workforce Productivity Programme as part of its broader strategy to improve efficiency and effectiveness within the health board. Key actions under this programme include: • Bank Modernisation Action Plan: This includes proactive recruitment across 12 months. • Flexible Working Policy: Launched with accompanying promotion and implementation of an oversight mechanism in place which aligns to retention as a key initiative. • Internal Lateral Moves Scheme: For Band 5 Nurse and Midwives, launched in February 2024, and expanded to include Band 2 Health Care Support Workers and Band 5 Midwives in December 2024/5. • Framework agency reduction: to achieve a 20% reduction in the use of framework agency registered nurses	Medical: Improved financial control on medical spend and improved productivity in terms of outpatients and theatres efficiencies. Ensuring appropriate management of contracts Nursing: Nursing productivity: • Processes and installing of KPIs for the bank service (partially achieved). • Implementation and use of flexible working policy (implemented and active). • Implementation of lateral moves scheme (implemented and being actively utilised). Demonstrated progress against a reduction in framework agency spend (partially complete, progress across the care groups, await year end position).

Linked National Priority Measures

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
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 – 2023-2024 – Development of a Nursing and Midwifery vision underway.

National Patient Experience Framework.

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

Current Performance Highlights

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

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 escalated to the Organisational Risk Register

4632	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	20
6111	Medical Examiner Delays. New risk escalated March 2025. New risk escalated to the Organisational Risk Register in March 2025.	20
5903	Unfunded Continuing Care Packages / unfilled packages. New risk escalated to the Organisational Risk Register in March 2025	20
5045	Access to Neurology Inpatient and Outpatient Services for CTM Residents	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
4691	New Mental Health Unit	15

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: Enough 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.

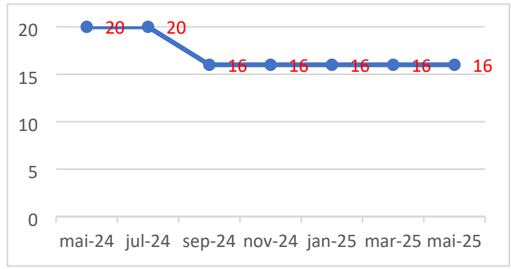
Risk Lead	• Executive Director for People	Assurance committee	• Operational Delivery Committee • Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; 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*	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 has been explored but is expensive and not sustainable. This is a short-medium term solution whilst alternative plans are implemented 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 wellbeing of our workforce is at the heart of all we do, and we remain focussed on reducing the impact on the workforce if sickness and turnover rates remain high. Sickness rates decreased slightly to 7.01 in February 2025, compared to 7.96 in January. The rolling 12 months sickness rate was 6.89 Turnover reduced to 10.16% in February 2025 and again to 9.51% in March 2025. Job Planning compliance is at 35% as at end of March 2025. Agency spend at M12 is £37.8m.

	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 previously and was reported too high, on the basis of the points below • Non-delivery of key objectives/services due to loss of several key staff – there are references in the risk register at a risk score of 20 for failure to deliver some services e.g. immunology in secondary care, stroke services, laboratory information system, sustaining cancer targets, imaging and failure to meet the demand for patient care at all points of the patient journey but there are controls in place and action plans to address any shortfalls • Ongoing unsafe staffing levels or competence/skill mix. The same as above • The number of staff attending mandatory/professional training - mandatory training for CTMUHB is 80.7% as at March 2025. The workforce risk remains significant. The reduction in the likelihood is to correct the scoring which places the risk score more appropriately represented 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 across CTMUHB with Care Groups, Services, Professional Leads and Heads of People, 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.

Current Control Measures
Recruitment • Vacancy Scrutiny Panel. • Bank modernisation action plan which includes proactive recruitment across 12 months. • Online recruitment through Trac. • Review of the CTM 'reducing the time to hire, ownership of the journey' aligned to the NWSSP Recruitment Modernisation Group. • The Mental Health and Learning Disabilities Care Group have offered 3 roles to Psychiatrists from ANCIPS (India) in January 2025 with their arrival due from June-2025. CTM has also submitted a funding application for additional medical staff as part of the potential funding allocation proposed by WG. The posts included in this submission are those with key shortages or high levels of agency reliance. • 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. Initial focus is on job description standardisation which is a key action for the MWPP Framework Group for a once for CTM approach which is still being explored through the MWPP: Framework meetings. • Attraction and Resourcing Key priorities: Through the development of an Attraction and Resourcing Working group the following priorities have been identified: Increasing visibility of vacancies through social media strategy implemented with increased social media presence presenting job vacancies, working with local partner organisations to raise visibility of CTM vacancies including presence in Careers fairs, and distribution lists. Raising our employer brand through the development on our career's website, and building CTM assets, promoting CTM as an employer of choice learning to inform future events. • Trialling on-the day recruitment events in Facilities to widen reach and improve accessibility for applicants • Actively involved in senior key critical appointments across the Health Board. • Reviewing the CTM approach to the selection process to standardise the approach to the use of psychometrics and assessment centres to improve appointment decision making. • Work experience pathway established. • A 'Loop' app launched in July 2024 to improve access for bank workers to book shifts.

- Non-Consultant rate card was launched 19 October 2023 and Consultant rate card launched on 24 June 2024 to provide consistent rates of pay.
- Reviewing M&D fixed term contracts and agreeing a more robust approach and controls with the Executive 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 and HEIW Retention Community of Practice. 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 has been in place since 2023 but re-focussed during June 2024 to ensure appropriate stakeholders, priorities and alignment with other Groups/Committees. A retention action plan has been developed which includes national and local actions and this group will have oversight. Career development opportunities, e.g. Apprenticeships, Qualifications & in-house learning and development offer e.g. Leadership & management programmes
- The Moving on questionnaire is under review with aim of increasing completion rates and providing us with a valuable data on turnover. This is being reviewed to establish links to other workforce data and to ensure the process is robust.
- The Starting Well Survey was relaunched in January 2025 with a focus on Attraction, Onboarding, Employee Experience and Retention and will improve understanding.
- Internal Lateral Moves Scheme for Band 5 Nurse and Midwifes was launched in February 2024. The scheme was expanded to include, Band 2 Health Care Support Workers and Band 5 Midwives in December 2024. A revised timescale for Band 5 Allied Healthcare Professionals and Health Care Scientists is being worked through with service leads.
- All Wales Flexible Working Policy launched with accompanying promotion and implementation of oversight mechanism in place which align to retention as a key initiative. Work is taking place to move the Flexible Working requesting process onto ESR to allow for better data intelligence and a more robust monitoring process.
- 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
- Retention Lead appointed to take up post in June 2025 to take the agenda forwards.

Temporary staffing solutions

- Workforce Efficiencies Programme in place with dedicated lead to drive the savings programme for 25/26 around nursing and medical and dental. Review of Retinue M&D Bank to ensure better controls and improved active management by Retinue. Contract being extended to October 2025 with a new tendering process to run alongside for a new contract to be implemented in October 2025.
- Further update of the FCP and SOP and will incorporate the requirements for the workforce efficiencies programme.
- Bank Modernisation Programme
- Development of and Bank KPIs in January 2025.as part of the Nurse Productivity Programme.

Day-to-day management of staffing levels

- Electronic rostering
- ~~A e-job planning cleanse was completed along with confirmed the sign off managers~~
- Job Planning Guide and communication issued (agreed with the LNC) reduced presumed sign off period for job plans from 10 weeks to 4 weeks commenced from 1 March 2025.
- Medical job planning compliance to achieve 90% by June 2026.
- Junior doctor rota monitoring. A rota monitoring paper and scheduler has been developed and is implemented prioritising activity and meet CTMUHB responsibilities to be shared at Operational Management Board in May 2025.
- Sickness absence management process

Workforce Planning

- Health Education Improvement Wales (HEIW) Workforce Planning Tool and Skills for Health modelling tool.
- Development of tool for workforce modelling/forecasting, including projecting the impact of interventions. Internal action plan and next steps underway include working with HEIW on the Workforce Modelling Tool.
- HEIW all Wales Strategic Workforce Plans across: AHP, Dental, Genomics, Mental Health, Perinatal, Pharmacy and Primary Care. Nursing is in development. Guidance for Radiology is also available.
- The Head of Workforce Planning and Head of People Analytics are aligned to the HEIW Workforce Planning Network.
- Focussed discussions are in development with Care Groups to look at the education commissioning submission for the 20 PAs graduating in 2025.
- SWP Audit actions in progress and reported via the audit tracker reported at the Audit and Risk Committee.
- Medical establishments in development to align ESR and ledger data to be agreed with Care Groups in May 2025. ~~Work has progressed with medical and dental establishment reporting will be agreed with Care Group during next few months.~~ Work to plan and prepare for the Registered Nurse Associate (RNA)in CTM is underway across workforce planning, clinical education and corporate nursing. There has been a slight delay as HEIW Education Training Commissioning Templates are not requesting HB numbers for the RNA in this year’s return as expected.

Sources of Assurance (Internal and External)
• Workforce and Organisational Development Metrics report (includes key performance indicators such as staff in post, turnover, sickness) which is regularly reported to the CTM Operational Delivery Committee and UHB LPF. Data also included in Integrated Performance Report to the Board; and included in Nursing Productivity and Medical Productivity Programmes which reports into Values & Effectiveness Board. • Medical Workforce Productivity Programme (MWPP): Performance and Escalation Group (PEG) meeting includes data on bank usage, agency spend, waiting list initiative (WLI) usage/spend, job planning compliance and trajectories, sickness absence. The Framework meeting which reports to the PEG focuses on consistent practices and policy application 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 must be approved by the Board and submitted to HEIW. The next cycle of IMTP Education Commissioning commenced in October 2024 for a draft submission to HEIW at end of January 2025, with a final Board approved submitted by 31 March 2025. • Quarterly data return submitted to Welsh Government for NHS vacancy statistics • A suite of BI People dashboards launched (Care Group and Nursing Dashboards). The Nursing dashboard, and dashboards are in development with the nursing dashboard was 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 for phase 2. • Establishment reporting being developed in in partnership with Care Groups, Heads of People, Digital and Finance, development For Medical and Dental is to be completed in May 2025 with a plan for roll out to other staff groups in development. • ~~In partnership with Finance, the development of establishment reporting has commenced with the aim of a phased approach to implementation~~ • In partnership with Digital, developing taking a CTM strategic approach to the use of Robotics. • In partnership with the National Data Resources (NDR), piloted ONS's data Masterclass within the people directorate to Building enhance data and analytical capability for leaders to improve data driven decisions. Exploration is being undertaken with the NDR to incorporate a masterclass into CTMs Leadership programme • Positive Review of Workforce Planning Arrangements undertaken by Audit Wales with six recommendations which have been developed into an action plan with agreed deadlines. Working towards the SWP Audit Wales recommendations outlined in the audit report. 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 and key stakeholders at the Physician Associate Recruitment Group and Medical Associate Profession (MAPs) groups. • Attraction questionnaire developed to seek information on the elements which influenced staff joining CTM. 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. T&F Groups are being set up to develop information and data on workforce pipelines. • Work is underway aligned to activity and finance to review the workforce data modelling that is needed to inform the ACSP service plans. • Horizon scan work is being finalised as one of the actions under the underway in accordance with the Audit Wales SWP 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 and has since been launched. A review of how this will impact on CTM is being considered. Assessment of the CTM progress against HEIW Strategic Workforce plans was undertaken and discussed at People and Culture in August 2024. • Initial discussions are underway to prepare for the work and communications required for the Future NHS Workforce System with the all- Wales and England plan to transition to a new supplier in the summer, 2025. Implementation and roll out planned for 2027-2030. • A review of our medical workforce systems (due to contractual expiry during April – June 2025) is underway to develop a proposal to meet our current and future requirements and with improved interoperability between systems and alignment to the new future NHS workforce system (where time and information is available to join up). This is now being aligned to the Workforce Efficiencies Programme.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. 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	Developed an all-encompassing workforce planning approach. This will include establishment control and improved workforce analytics to understand the CTM vacancy position, to support better workforce decisions to fill gaps and reduce reliance on temporary variable pay. Enhancement of our people data (quality & provision), analytics and intelligence. This will support the development of our workforce both for now and the future.	To identify the CTM vacancy position. This will be initially for medical and dental workforce aligned to CG service needs. This will be completed in May 2025. This will include substantive staff in post and bring medical variable pay (agency, WLI and bank usage/spend) alongside job planning compliance.	Clarity and visibility on our CTM workforce gaps and rationale for overspend. This can be used to inform, and drive CG/Service workforce plans to find more affordable and sustainable workforce options.

	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. This has been postponed until the return of the Maternity Services to POWH. A further date to be arranged.	Improved data quality and provision of analytics and intelligence to inform current and future trends.	This will provide a narrative to tell the organisational story and what actions are needed to mitigate risks.
	• 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. A dedicated workforce planning support has been appointed to align the workforce requirements and deliverables for LHP.	To support the development of a workforce plan to support the delivery of the all Wales Perinatal workforce plan.	Ensure workforce plans are in place to meet the current and future workforce demand.
	• 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.	Development of an LHP workforce plan. The workforce section of the Outline Business Case is in development for submission in May 2025.	To ensure there is an affordable and sustainable workforce plan to meet the ambitions of LHP and ensure delivery of the plans.
	• 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.	Due to changing demographics of our patients and workforce, the need for alternative workforce models to address shortages in skills/workforce availability.	Reduce vacancies through improved retention and attraction. Reducing over reliance on temporary workforce where more sustainable options may be available.
	• 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 - Delayed until May 2025.	Providing information around what changes are predicted in the future that could impact on the workforce. This will include changes to work through technology or approaches to work due to generational shifts which need to be considered for future workforce demands and supply. The PA Working Group will provide a CTM approach to employing and supporting Physician Associates in the organisation. To develop an agreed CTM approach to recruitment and practice for RNAs aligned	Consideration of future changes in workforce plans to ensure they remain flexible and agile to meet changing population and workforce needs. Clarity on the use of and approach to Physician Associates in CTM aligned to all Wales Governance and agreed standards. This will also set out the governance and infrastructure for PAs to ensure maximum benefits from the role within multi-disciplinary teams.

	• The Head of Workforce Planning is representing CTM on the All Wales Registered Nursing Assistant Band 4 post to support the development of a CTM action plan.	to professional registration and standards.	Effective use of RNAs to support high quality patient care and appropriate skill mix to support patient care across the nursing workforce and multi-disciplinary team. Reducing workforce gaps in skills/posts and temporary spend where appropriate.
	• Workforce planning alignment to the ACSP to promote opportunities to maximise workforce productivity, integrated working, redesign and new role developments.	Development of a workforce plan that supports a multi-skilled, flexible workforce to meet current and future needs.	Agreed approaches to deliver the workforce required, aligned to professional standards, which is affordable and sustainable.
	• SWP Audit Wales Recommendations Action Plan in place and progress and updated at People & Culture Committee in August 2024.	Regular reporting at Strategic Development Group on strategic workforce plans providing governance and oversight on the approach.	Organisational oversight and commitment to the direction and align of the workforce to deliver the objectives and ambitions of CTM 2030.
2. 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 Operational Delivery Committee.	CTM delivery against the all Wales Nurse Retention Plan and CTM Retention Plan.	Reduced turnover (increased retention) of workforce to reduce vacancies. Retaining skills and expertise especially in areas where workforce is in short supply or will be in the future.

Linked National Priority Measures
Workforce • 23. Agency spend as a percentage of the total pay bill 27. Percentage sickness rate of staff

Current Performance Highlights

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

Associated Risks escalated to the Organisational Risk Register		
5753	Inadequate Special School Nurse Provision. New risk escalated March 2025	20
4973	Clinical Medical Cover within CTM Adult Mental Health Services. New risk escalated March 2025	16
5576	Palliative Medicine Staffing	16

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

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.

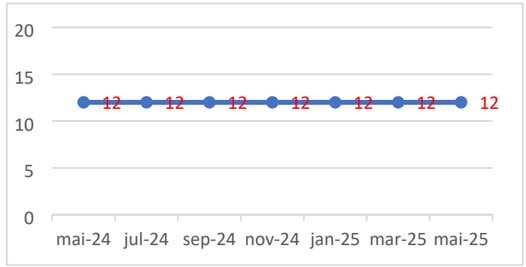
Lead Director	Director of Communications, Engagement & Fundraising.	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	3	12
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; 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*	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. The approval of the Integrated Medium-Term Plan will allow for investment into the engagement function in order to support the Acute Clinical Services Plan. Digital capacity with the Communication and Engagement Team has been impacted on a short-term basis due to the unexpected absence of their digital lead. This may impact the ability to progress some areas of activity at this time.
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.

Current Control Measures

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
- CTM Leaders Forum - New Terms of Referenced developed with a further review scheduled for 2025.
- Staff Q&A
- (Staff) Leaders' Forum
- 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
- 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
- CTM Strategic Engagement Forum (established Sept 24). Chaired by Head of Engagement and Involvement.
- A collaboration with Veterans is being established through the development of a forum with partners from the Veteran Hubs, wider Armed Forces community, third sector organisations, Primary Care and CTMUHB.

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

Sources of Assurance (Internal and External)

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.

On the 7 April 2025, the Welsh Language Commissioner published her five-Year Plan, within which she encouraged others to speak with CTM as an example of good practice, this endorsement provided CTMUHB with the opportunity to showcase the work being done across the health board to enable our staff to learn and use the Welsh language.

Reports to other committees
- Community Health Council briefing papers to Quality, Safety & Experience Committee.

External
Activity commissioned from Opinion Research Services will provide detailed intelligence of stakeholders within CTM communities, including those at the hyperlocal level, enabling greater effectiveness and efficiency of public engagement and involvement activities.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
Review the Becoming and Engaging Organisation Strategy	• Revisit to ensure the principles support the direction of travel, particularly their 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. Consultation desk review now complete. This will be removed on the next iteration. The content of the review is informing engagement planning going forward. • 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. • External expertise commissioned from Opinion Research Services (ORS) in October '24, to develop stakeholder mapping. Outputs will provide broader and richer understanding of population characteristics, key influencers, and effective methods of involvement and engagement. Outputs will be delivered in last quarter 24/25. This work has begun, and interviews are scheduled to take place with Independent Members and key senior Health Board staff throughout January 2025. • Collaboration with South East Wales Health Boards to formalise Regional Communication and Engagement plans and activity.	1. Alignment across health board strategy and change programmes. 2. Ensure Board awareness and continued relevance of strategy with current strategic and operational ambitions and objectives. 3. A more informed approach to public engagement and consultation activities relating to significant services change, based upon legal precedence and best practice and resulting in reduced risk of judicial review. 4. Identification and commissioning of an external provider with requisite experience and ability to lead development of stakeholder mapping to inform strategic service change. 5. Increased efficiency of public engagement planning and actions through shared data, targeting and delivery. Development of shared objectives and identification of opportunities for collaborative engagement activities. 6. Broader and richer understanding of population characteristics, key influencers, and effective methods of involvement and engagement 7. Joined up working and efficient and effective use of shared capacity across the three South East Wales Health Boards.	1. Consistency of narrative across strategic resources and change plans. 2. Continued Board support for BHT strategy and for development of involvement. engagement and consultation resources aligned accordingly. 3. Delivery of a best-practice effective engagement and consultation plan to support strategic service change with minimal challenge and mitigating against judicial review. 4. Securing of partner to delivery through procurement process on budget and against expected schedule. 5. Delivery of shared engagement and involvement plans and delivery, realised through partnership working. Greater reach/traction of activities, with higher rates of participation/interaction. 6. Provision of a stakeholder map by ORS to be used for targeted involvement/engagement/consultation 7. Development and implementation of a Regional Communication and Engagement Plan.

Linked National Priority Measures

Nil

Current Performance Highlights

- Survey shared with all CTMUHB staff, to audit effectiveness of internal communications and engagement and opportunities to improve, including implementation of new engagement platforms.
- CTMUHB chaired Stakeholder Engagement Forum creating productive outputs, developing single plan for engagement priorities for 25/26 with Public Health, People, Welsh language, RPB.
- Revised approach to CTM2030 Leaders' Network to be implemented in April, to improve focus on enabling community groups to take actions that improve health and wellbeing of communities.

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

None identified.

Associated Risks escalated to the Organisational Risk Register

Nil

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.

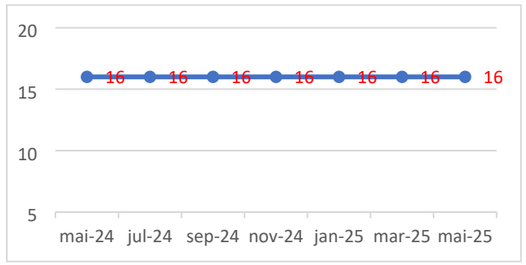
Risk Lead	Director of Digital	Assurance committee	• Operational Delivery Committee • Strategic Development Committee

	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 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.

Current Control Measures

- 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

Sources of Assurance (Internal and External)

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 Disaggregation Programme
- Medical Records Assurance Report

Reports to other committees

- Progress updates against Population Health Strategy
- Planning, Performance & Finance

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. 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. Through various programmes we are investing in a business change capability Timeframe: 2-3-year programme of work	Raising digital literacy across the Health Board and community Implementing industry standard approach to Business Change aligning with Workforce	Less calls to the IT Service desk Easier to deploy new digital solutions
2. 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.	Developing capabilities to support service change enabled by digital and data technology.	We are building our wider Digital training capability and skills facilitate training Increase confidence and capability of all of our staff in the use of digital and data technology for all of the workforce
3. 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.	Reduce risks for critical assets	Reduction in risk exposure scores across key management platforms
4. 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	Improved response to cyber threat	Awareness and improvement to the cyber improvement

	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.		
5. 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. We have invested in new tooling that will enable us to discover all connected assets to help build and maintain an asset register	Greater insight into digital assets Greater understanding of risk profile	Improved cyber posture
6. 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.	Standardisation of working practises and processes.	Reduction in variation in working practises and processes across CTMUHB
7. 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.	Sufficiently sized Digital and Data function able to meet the needs of the UHB whilst enabling Digital Transformation.	Improved project and programme delivery timeframes. Improved user experience with BAU digital services. Reduction in number of digital incidents and problems. Faster rollout of equipment purchased via capital.
8. 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	Better data flow and reporting across whole health board	Single PAS – WPAS merger completed

	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		
9. 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.	Improved system integration. Improved data integration. Flexibility in system replacement.	Improved data driven decision making. Reduction of costs for systems. Reduction of vendor lock-in.
10.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.	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).	Greater confidence and assurance in our services, ability to benchmark and improve services.

11. 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)	Improved working relationships with critical suppliers Improvement in timescales for delivery of functionality	Improved system availability Increased productivity
12. 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 In addition to the ePMA funding the Health Board has agreed to fund the Patient Centred Contact Transformation Programme as part of the Savings Delivery Programme (SDP). This will enable us to fundamentally change the patient experience and interactions with us as a Health Board while growing our Digital and Data capabilities.	Increased capacity facilitated through various Digital programme	Working with ChangeHub to broaden understanding of transformation that is enabled via Digital. Successful delivered transformation through the implementation of digital solutions.
13. Delayed delivery of the digital patient notes programme	Resourcing required to increase activity and accelerate completion of the programme The current contract for patient record scanning (Cito) is due to expire in March 2026, the Digital Transformation (Medical Records) team are working on a new business case for consideration by the Executive Team. Timeframe: 2-3-year programme of work.	Large volumes of paper are still required to be stored. Historical records are not being scanned and there for will still require accessible storage areas	Remains a key element for our digital journey / alongside reduction and removal of paper from day to day clinical use
14. No resourced function within CTMUHB focussing on benefits realisation	As part of the funding from WG for a Mental Health Single Record the team will be employing a new Head of Digital Business Change and Benefits to take this work forward.	Invest in enhancing benefits realisation capability within the Digital function – working with ChangeHub to ensure standardised approach across the wider Health Board	Improved ability to articulate, track, monitor and realise benefits of digital transformation programme
15. 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 July 2024 Board approved	Reduction paper-based processes – undertaking process re-engineering replacing process with automated clinical workflow. Reusable digital data to enhance decision making	Improved productivity Reduction in errors associated with paper-based records and processes

	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.		
16. Recruitment challenges due to short term funding allocations leading to an increased use of 3rd party contractors and fixed term contract 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.	Adequate resourcing pool within Digital and Data	Reduction in contingent staff costs
17. CTMUHB lack the Digital and Data assets and capabilities to enable the move of clinical services to the community and closer to home, which underpin ACSP.	Business case for the Mental Health EHR has been approved and funded. Options appraisals need to be undertaken for digitising the community services, running virtual care service, seamless integration of data and enabling more seamless care.	Transformational shift to integrated health and care services between the UHB and the and enhanced community care capacity across the system.	Reduction in ambulance transfer Reduction in length of stay Admission avoidance Improved patient experience and flow
18. Challenges with National Programmes and interdependencies on CTMUHB digital programmes.	The Digital and Data IMTP submission has now been approved, this includes funding to engage a strategic partner to support and develop our digital and data strategic roadmap, and a procurement activity is underway. The Ministerial Advisory Group (MAG) report has now been published which highlights challenges with Digital Transformation across NHS Wales, the UHB is analysing the detail of the report.	Speed up delivery of digital transformation. Improved utilisation of cutting-edge clinical technologies e.g. AI. Improved digital maturity as measured against the HIMSS Electronic Medical Record Adoption Model. (CTMUHB is currently at stage 0).	Improved operational performance and productivity. E.g. better electronic test requesting, better waiting-list management and referral management. Improved patient access to clinical services. Enabling staff to deliver high quality care.

Linked National Priority Measures

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

Current Performance Highlights

Work continues with the alignment of our Health Board systems with the team now focused on completing the technical elements and moving to a single Welsh Patient Administration System (WPAS) in May 2025. A successful dry run test was undertaken on the weekend of 26th April and we are currently looking at defects and issues raised from the testing. Confidence grows in the ability to go live in May, however there are still outstanding issues with WPRS and data quality that will need to be resolved.

Cyber Security continues to be a core element of the Digital and Data programme, with further development and additional capabilities to support our Cyber Security Assurance Plan. This has included the recent procurement of cyber tooling that will provide a better understanding of our digital assets (Armis) and improve our ability to manage security patching (ManageEngine).

Excellent progress has also been seen in the electronic Prescribing for secondary care (ePMA) programme. The programme is now actively engaging across the Health Board, working in partnership with our supplier Nervecentre, to implement a first go-live in the Autumn of 2025. The ePMA Project held their first round of roadshows in early April to start engaging with staff and raise awareness of the upcoming roll out of ePMA. They were held at each of the main DGH sites, PoW, RGH and PCH with over 200 staff dropping in to see what the new system looks like and what it will mean for them going forward.

The team are working with Local Authorities and Betsi Cadwaladr University Health Board on the procurement of a Mental Health solution. This procurement is due to commence on the w/c 5 May 2025. Welsh Government have provided full funding for this work for the next 4 years.

The Digital & Data team awarded a contract to Systems C to implement its Badgernet solution for Maternity Services. This clinically led programme is currently working to an implementation timeline of March 2026.

Phase 1 of the Patient Self Checking project has procured 25 replacement media players and 3 replacement kiosks (hardware) which are due to be delivered by 25 April 2025.

Due to current usage in core outpatient services, RGH has been determined as priority for replacement. Other sites included in phase 1 are PCH, YCR, YCC, and Dewi Sant.

It is anticipated that all sites will be live with the new system by the end of June 2025. The system is currently under development and a demo will be held to stakeholders alongside the eOutcomes form on 29 April 2025. A rolling plan for installation will be determined on receipt of hardware with the RGH as priority site. Project working groups are held weekly and the first Project Implementation Group is scheduled for 1 May 2025.

Between January and March 2025, Medical Records Library staff have had the busiest 3 months in the last 3 years.

- Williamstown Records Hub staff moved 140,169 paper records.

- Princess of Wales (POW) Library staff moved 122,990 paper records.

- Jointly, the teams validated and destroyed 18,548 records and redistributed library contents across sites to rectify challenging working conditions at POW. This work continues – approximately 305 is complete to date.

On hospital sites, Medical Records staff prepared 60,799-day forward folders for outpatients and admissions.

Short-notice cancellation and changes to Outpatient clinics continue to be received, creating very high levels of re-work required to cancel patients and re-book them; this has adverse effects on the entire department and on patients. Notably, cancelling patients at short notice causes them to be re-booked out of turn, as subsequent clinics are already booked some weeks ahead, with available capacity only on later dates. This re-work has an impact on the ability to support additional clinics to reduce waiting times.

Between January and March 2025:
- 174 requests were made with under 1 weeks' notice
- 524 requests were made with under 6 weeks' notice

- 4 requests were recorded that contained insufficient or incorrect information and could not be actioned.

The Business Intelligence team successfully completed the migration from Qlik to PowerBI – by the end of the March 2025 deadline (the date the Qlik contract expired). New BI dashboards continued to be released including those underpinning the organisation's work on productivity, innovation and transformation.

The UHB is taking a lead development role for Wales on the integration of the National PROMs system and the new Capsule sponge results, which it is anticipated may replace 40% of gastroscopies in the medium term.

Primary Care API Testing has re-commenced, this is critical to enable CTMUHB 2030 and integrated seamless service provision for our residents.

With over a month to go until the deadline, Clinical Coding completeness for the financial year 2024/2025 stands at 88.2%. We anticipate that with the use of the autocoder we will again achieve the 95% target.

In 2024/25, the Digital and Data team directly managed and processed c£9.2m of Capital Investments, comprising of £2.8m of discretionary capital and £6.4m of All Wales Capital Programme (AWCP) / Digital Prioritisation Investment Fund (DPIF) capital.

Discretionary capital focussed on a rolling replacement of hardware, statements of need (i.e. staff equipment, both general plus ringfenced investment in therapies, community and mental health), Welsh Nursing Care Record (WNCR), continued delivery of the Infrastructure Review, Bridgend specific investments to enable disaggregation, Jayex patient calling system refresh, devices in readiness for the BadgerNet maternity system, and investment in a server access security authentication system (DuoMFA) and replacement/supplementary web filtering and access system (iBoss.)

The AWCP/DPIF funding enabled the formal commencement of the Electronic Prescribing programme in line with the original programme of work (digital medicine management portfolio, including significant investment in devices and also network improvements by replacing wireless LAN controllers and small site legacy core switches), ARMIS (Security Monitoring solution) and ISE security appliance/software to identify and securely manage devices accessing the network, end user devices patch management solution, VxRail server upgrades to support the National Data Resource (NDR) and the production environment, cyber vault expansion, network improvements (start of NEXUS switches replacement), significant investment in replacement user devices (including laptops purchased during COVID, legacy Windows 10 devices, and iGel thin client devices), and additional devices to support the implementation of the mental health system.

Most of the investment, particularly AWCP/DPIF, was released to CTMUHB in the final months of 2024/2025, requiring significant effort on the part of technical teams to validate requirements, the Business Administration team, and the Capital and Procurement teams in Finance, to deliver on time and to budget.

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 escalated to the Organisational Risk Register

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
6102	Patient pathways - working in two WPAS instances – Escalated to the Organisational Risk Register March 2025.	20
~~5226~~	~~Risk of damage to records and equipment due to leaking roof in the Williamstown Records Hub. Escalated to the Organisational Risk Register March 2025.~~ Risk de-escalated from the Organisational Risk Register in May 2025.	~~20~~
6053	Failure to secure an alternative Clinical System for GP practices on Vision. Escalated to the Organisational Risk Register March 2025.	20
4337	Integrated Patient Records across the Health Board	16
4671	NHS Computer Network Infrastructure unable to meet demand	16

2795	EUC: Unsupported Windows 10 Desktop Operating Systems. New risk escalated March 2025 due to increase in risk score.	16
6039	Increased cost of VMWare Licensing, New risk escalated March 2025.	16
5669	Increased cost of Citrix Subscription. This risk has been re-escalated to the Organisational Risk Register as the risk score increased from a 12 to a 16.	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

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: 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

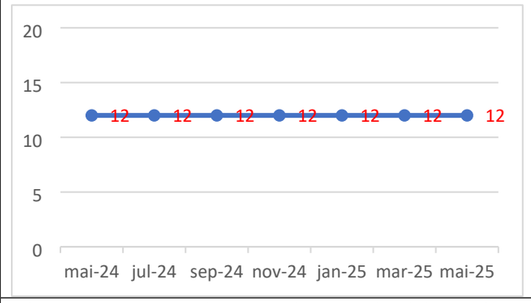
Risk Lead	Executive Director for People	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	3	12
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; 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*	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. Changes in People Leadership function has paused broader work in this area, post holders in place from December 2024, with strategic engagement on this risk planned.
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.

Current Control Measures

Policies and Frameworks

- Workforce Policies, e.g. Respect and Resolution, Standards of Behaviour.
- Values and Behaviours Framework – co-produced with staff.
- Emerging Culture Plan, developed in 2023/24, assessment of work to date planned with forward strategy development, for example People Plan development, Inspiring People Board activity.
- 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.

Communication and Engagement re: values & culture

- Stakeholder Analysis was undertaken in Autumn 23 to support emerging culture
- Soft launch of Restorative, Just and Learning principles with Speak Up Safely Launch in October 2023 undertaken.
- Developed Inclusion Communication Plan with monthly topic focus, which is currently being rolled out.

Putting Values into Practice

- 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
- 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 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.

Sources of Assurance (Internal and External)

- National Staff Survey was conducted in autumn 2023 with results published in spring 2024. 26.7% response rate to NHS Wales 2024 Staff Survey with results expected Q4 2025Annual 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.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. 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 Staff briefing planned for March 2025 to re-socialise our values in response to heightened climate against inclusion work. Bespoke staff	Ensuring that everyone, from leadership to individual contributors, understands and embraces our core values. Building trust between leadership and staff through modelling values consistently	Increased understanding of our values (measured through employee surveys and feedback). Observable behaviour that reflects these values in day-to-day interactions. Levels of employee engagement.

	and team development sessions available to explore shared commitments.		
2. 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.	Fostering a positive culture, to improve communication, manage behaviours and conflict effectively, and support learning and restorative practices. These initiatives focus on creating a safe, supportive environment where employees feel empowered, heard, and valued. Promote an environment where employees feel safe and confident to speak up about concerns, issues, or suggestions without fear of retaliation.	Increased participation and engagement. Initially increased BHD cases then reduced. Increased number of employees reporting concerns or providing feedback through the "Speak Up Safely" platform Work In Confidence. Reduction in instances of conflict or unresolved issues, indicating proactive problem-solving
1. Cultural Health Check diagnostic tool now been superseded by the Affina OD diagnostic model	• National Staff Survey complete and results made available from March 2024 staff engagement sessions available for booking to explore organisation results and develop our People Plan 2025-2030	Establish a clear baseline of the organisation's current culture, identifying strengths and areas for improvement	High participation rates in the staff survey, indicating employee engagement and trust in the process. Clear, actionable insights from the survey data that inform the development of the Culture Plan. Development of specific action plans that address the identified high-level priorities.

Linked National Priority Measures

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

Current Performance Highlights

1. RJL and SUS: Exploration and engagement with programme leads and members in late 2024 surmised that both the Restorative, Just and Learning (RJL) and Speaking Up Safely (SUS) programmes had slowed or stalled in recent months, but acknowledged that, whilst not published or released as yet, there has been significant work undertaken to develop products in support of both. Having explored programme structures, plans and outputs, a workshop was held in late January 2025 to which all members of both working groups were invited. The workshop was attended by around 20 colleagues, each sharing their views on what, across each programme, should: Start, Stop, Continue & Change. All comments reviewed and four key themes emerged: 1. Vision and positioning, 2. Comms and Engagement, 3. Programme and Activity, 4. Deployment.
2. Team Development: Further bespoke team development sessions held across CTM with the OD team working to explore team challenges, foster better working relationships and meaningful work contributions.
3. Our People Plan & Staff Survey Results: Work underway to develop our People Plan 2025-30 with a focus on roadshows during March and April 2025 which are available for staff to book onto. The roadshow will explore our NHS Staff Survey results and how we create and lead an environment in which everyone can thrive, ensure we have the right people, with the right skills, in the right place both now and our future and Attract, grow and retain great people – a CTM people want to work in.
4. Annual Equality Report: Publishing an Annual Equality Report (AER) is crucial not only to meet statutory obligations but also from an ethical standpoint. It demonstrates our commitment to transparency and accountability, ensuring that organisations like Cwm Taf Morgannwg University Health Board (CTM UHB) are actively working towards eliminating discrimination and promoting equality. CTM's AER has been developed for 2023/24 with performance highlights in this period.

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

None identified for inclusion in the BAF.

Associated Risks escalated to the Organisational Risk Register

Nil

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

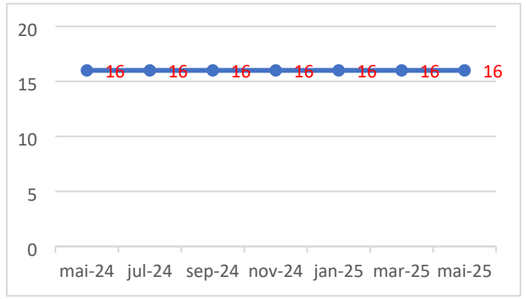
Risk Lead	Executive Director of Strategy and Transformation	Assurance committee	Strategic Development Committee

	Consequence	Likelihood	Score
Initial	4	5	20
Current	4	4	16
Target	4	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; 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*	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.

Current Control Measures

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

Public Services Board Climate Change Action Group (Director Level) being established in 2025.

The Targeted Estates Fund (TEF) application for "Whole CTMUHB- Decommissioning of nitrous oxide plus gas capture" has been awarded. The next steps are for the Capital Department to assign a project manager to oversee the works. The project is scheduled for the 2025-2026 financial year.

Sources of Assurance (Internal and External)

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.

Innovation Activity – Sustainability Manager exploring opportunities around innovation and sustainability.

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 / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Climate Adaptation Plan (moving away from mitigation). Plan to be produced in line with national deadline of April 2026.	Climate/Environmental Adaptation 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	The intended impact of this mitigation is to better enable the future sustainability of the services provided by CTMUHB in response to the current and expected impacts of climate change.	Long term success indicators due to the nature of the risk.
2. Dedicated resource to manage and deliver Net Zero programme across the whole Health Board. Completed – Resource now in place.	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.	This action has been completed as Sustainability Manager now in post.	

	Propose to delete this completely given that this is no longer a gap		
3. 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.	Procurement processes always consider the carbon impact as part of the decision-making process.	Reduction in carbon footprint associated with procurement processes over the medium to long term.
4. 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.	Tackling inequality is a focus of decision making.	Long term success indicators due to the nature of the risk.
5. 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. Working alongside community partners to access identify and access opportunities for community support. Ongoing.	Impact of cost of living rises are reduced where possible.	Long term success indicators due to the nature of the risk.
6. Access to capital opportunities needed to deliver decarbonisation plan is limited	Decarb action plan currently being costed. Access to alternative funding streams utilised when appropriate	Capital works set out within the decarbonisation action plan are completed when funding is secured.	Long term success indicators due to the nature of the risk.

Linked National Priority Measures

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

Current Performance Highlights

Decarbonisation Report return completed April 2025.

Annual Carbon Emissions report. Completed – submitted to Welsh Government September 2024. Next due September 2025.

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

Associated Risks escalated to the Organisational Risk Register

5374	Fulfilling our environmental and social duties. New risk escalated March 2023.	16

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.

Risk Lead	Executive Director of Public Health	Assurance committee	Strategic Development Committee

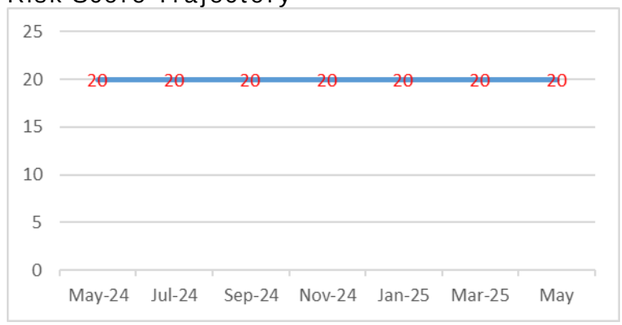
	Consequence	Likelihood	Score
Initial	5	4	20
Current	5	4	20
Target	4*	2	8
Risk Appetite	Cautious *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

*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.

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*	Whilst not inevitable, the current trajectory indicates increasing health risks reduced healthy life expectancy and widening inequalities. Capacity to support a prevention and population health approach continues to be a challenge linked to short term funding and competing priorities for existing resources across the health board.
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.

Current Control Measures
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 approved.
- CTM Health Protection Strategy drafted and approved.
- 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
- 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

Sources of Assurance (Internal and External)

Wellbeing and socio-economic duties
- Wellbeing Statement accompanying Annual Plan
- Progress reports against the Annual Plan

Reports to Board
- Creating Health Programme
- 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.

Gaps in Controls / Assurances	Actions taken to Mitigate Gaps	Intended Impact of Mitigating Actions	Indicators of Success (following implementation of mitigating actions)
1. Delay in developing health protection / immunisation capacity	Recurrent funding for 24/25 onwards now secured. Increase in allocation of £1.06ms, however, total allocation remains below the Welsh "Fair Shares value". All Hazards Health Protection plan signed off for implementation. Development of a HP strategy and associated priorities. Scoping exercise to follow to identify any continuing gaps in HP provision against the budget allocated for 2025-2026.	The funding for Health Protection would be sufficient to deliver all key priorities in the Health Protection strategic plan.	Priority areas allocated identified and fully funded Any residual gaps in funding the strategic plan identified An uplift in funding to a sufficient level to enable full delivery of the Health Protection strategic plan.
2. Strategic Focus on prevention/ inequalities	CTM2030 strategy; Creating Health Portfolio board Creating Health Delivery Plan drafted in Q4 2023/24. Health Protection Strategy. Vaccine equity strategy	Decreased variation in access and outcomes across the population of CTM. Increased prevention activities will avoid harm and reduce the financial burden of chronic disease.	Delivery of the outcomes associated with the Health Protection strategic plan Delivery of the milestones in the Creating Health Delivery Plan Measurable improvement in the difference in outcomes between least and most deprived as measured in the creating health dashboard Measurable increase in investment in prevention activities/programmes across the Health Board.
3. 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.	The use of Population Health Management (PHM) data to inform strategic planning and operational delivery maximised.	PHM priorities defined as part of the Local Public Health Team portfolio. A clearly defined strategic plan for the delivery of PHM in CTM. A robustly resourced PHM function in CTM.
4. 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	Decreased variation in access and outcomes across the population of CTM Increased focus and alignment of resources to meet the needs of vulnerable groups	Measurable improvements in outcomes for vulnerable groups. Less variation in access and outcomes across the CTM population. Improvement in outcomes associated with the Vaccine Equity Plan. Delivery of outcomes associated with vulnerable groups highlighted in the HP Strategic plan.

			Measurable improvement in the difference in outcomes between least and most deprived as measured in the creating health dashboard.
5. Coherent prevention (1,2,3) for high burden diseases	Partnership work underway with PHW to address diabetes, with links to CVD, MSK etc.	Consistency and alignment with national programmes of work focussed on prevention and the burden of chronic disease. Clearly defined primary, secondary and tertiary CTM prevention programmes where appropriate.	CTM representation at all relevant partnership boards and programmes of work. Chronic Disease Risk Reduction as a programme of work in the Local Public Health Team portfolio Improvement in outcomes for patients with chronic disease
6. Ability to influence wider system partners/ determinants of health	Engagement in partnership fora (RPB, PSB, Leaders groups)	Improved collaboration and partnerships to adopt a whole system approach to impact wider determinants of health for the CTM population.	CTM representation at all relevant partnership boards and programmes of work. Collaborative projects delivered in partnership influence wider determinants.

Linked National Priority Measures

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)
- 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
- Percentage of adult smokers who make a quit attempt via smoking cessation services
- Percentage of adult smokers who make a quit attempt via smoking cessation services who are co-validated as quit at 4 weeks
- Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)
- Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment
- Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks
- Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life

Current Performance Highlights

Please refer to Integrated Performance Dashboard - Quadruple Aim 1.

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

No

Associated Risks escalated to the Organisational Risk Register

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	15
5820	Potential inability to deliver all elements of the Health Protection Strategic priorities as a result of reduced allocation of funding.	12
6179	New risk escalated to the Organisational Risk Register in May 2025 High and increasing prevalence of overweight and obesity in children and adults	

Agenda Item
5.4

CTM Health Board

Annual Review: Risk Management Framework

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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	Cally Hamblyn, Assistant Director of Governance & Risk
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
Board Development Session	15 May 2025	Detailed Review Completed
Audit, Risk & Assurance Committee	22 May 2025	Endorsed for Board Approval
Executive Management Board	27 May 2025	For Noting
Health Board Meeting	29 May 2025	Approval pending

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 As good governance on an annual basis the Health Board reviews its risk management framework which is made up of the following suite of documents:

1. Risk Management Strategy
    - Risk Appetite Statement
    - Risk Domain & Scoring Matrix
    - Board Assurance Framework
2. Risk Management Policy
3. Risk Assessment Procedure

1.2 A Board Development Session was held on the 15 May 2025, which focussed on the Risk Management Strategy for CTMUHB and its continued adoption for a further 12 months.

1.3 The Risk Management Policy and Risk Assessment Procedure were reviewed and approved in 2022, other than minor changes they remain extant and are therefore proposed for further approval with the next review date set for May 2028.

2. Specific Matters for Consideration

2.1 This section is broken down into the review of the relevant component parts of the framework as identified in section 1 above.

2.2 *Risk Management Strategy (Appendix 1 to this report)*
The purpose of the strategy is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

Considering the detailed review at the Board Development Session on the 15 May 2025, the following changes were made:

- *Risk Appetite Statement (Appendix 2 of the Risk Management Strategy)*
    - To avoid confusion the “Assets and Estates” risk was updated to include just one appetite which is “Open”.
    - The ‘Technological advances” risk was updated to capture research and innovation in its descriptor.

- *Risk Domain Scoring Matrix (Appendix 2 of the Risk Management Strategy)* - There were no changes proposed in this year’s review to the matrix or risk score escalation threshold.

- *Board Assurance Framework (BAF) (Appendix 5 of the Risk Management Strategy)*

  The BAF is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation.

  There were no changes to the concept of the BAF.

  Considering the detailed review at the Board Development Session in May 2025, the Strategic/Principal risks have been updated and the updated Risk Management Strategy reflects the position agreed at the Board Development Session.

  The Strategic/Principal Risks are subject to change following their regular review by the Board at all routine meetings.

2.3 Risk Management Policy (Appendix 2 to this report)

The Risk Management Policy remains extant. Minor changed were made in terms of name changes for the Board Committee meetings.

2.4 Risk Assessment Procedure (Appendix 3 to this report)

The Risk Assessment Procedure remains extant.

3. Key Risks / Matters for Escalation

3.1 The principal risks are outlined in the BAF as outlined in section 2.2, which is reviewed at all routine public meetings of the Health 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 /	A Healthier Wales
	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))*	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))*	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:	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): Completed – No potential negative impact identified	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)* / 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 Risk Management Strategy (Appendix 1), which includes:
  - APPROVAL of the Risk Appetite Statement and agree that it is implemented for the next 12 months with assurance that it is set to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.
  - APPROVAL of the Risk Domain & Scoring Matrix and its continued application and the risk escalation threshold.
  - APPROVAL that the Board Assurance Framework remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board as discussed in detail at the Board Development Session on the 15th May 2025.
- APPROVE the Risk Management Policy (Appendix 2).
- APPROVE the Risk Management Procedure (Appendix 3).

6. Next Steps

6.1 If approved the documents will be uploaded to the Health Board's internal and external websites.

RISK MANAGEMENT STRATEGY & BOARD ASSURANCE FRAMEWORK

Ref:	RM 01
Document Author:	Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance / Board Secretary
Approval / Effective Date:	
Review Date:	
Version:	Version 11 - Draft

Target Audience:

People who need to review this document in detail	All Staff with the responsibility for undertaking risk assessments. All staff who approve risks as a risk owner or manager.
People who need to have a broad understanding of this document	All staff.
People who need to know that this document exists	All staff.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 20.11.2020
	Outcome: No potential negative impact identified.
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	23.11.2020
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Approval Route:

Where	When	Why
Audit & Risk Committee	18th April 2024	Endorse for Board Approval
Health Board	30th May 2024	Approved
Executive Leadership Group	7th October 2024	Approved an updated risk escalation process

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

1. Introduction and Aims

1.1 Cwm Taf Morgannwg University Health Board (CTMUHB) is committed to developing and implementing a Risk Management Strategy (and Board Assurance Framework) that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Medium Term Plan (IMTP). The Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon strategic objectives. It will be considered alongside other key management tools, such as workforce, performance, quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.2 The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

1.3 It aims to:

- set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation;
- set out responsibility for Board committees, in particular, the Audit, Risk & Assurance Committee; and
- describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives;

1.4 The objectives of CTMUHB's Risk Management Strategy (and Board Assurance Framework) are to:

- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
- ensure that risk management is an integral part of CTMUHB's culture;
- maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;
- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- minimise avoidable financial loss;
- ensure that CTMUHB meets its obligations in respect of Health and Safety and Quality and Safety;
- Manage all potential risks CTMUHB are exposed to;

- supports the calibration of risk scoring so the Health Board can achieve a consistent and moderated approach to risk assessment;
- supports an informed understanding of risk in order for the Health Board to be able to appropriately scrutinise risk treatment options; and
- compliment the Risk Management Policy and Risk Assessment Procedure.

2. Scope

2.1 The Risk Management Strategy (and Board Assurance Framework) covers the management of Strategic/Principal and Organisational risks and the process for the escalation of risks for inclusion on the Organisational Risk Register and Board Assurance Framework.

2.2 A risk can be defined as: "the chance of suffering harm caused by a hazard, loss or damage or the possibility that the CTMUHB will not achieve an objective".
Risk is the uncertainty surrounding events and their outcomes that may have a significant effect, either enhancing or inhibiting:

- Achievement of aims and objectives
- Operational performance
- The meeting of stakeholder expectations

Types of Risk

2.3 *Strategic/Principal Risks:* are significant risks that have the potential to impact upon the delivery of Strategic Objectives and are reviewed and monitored by the Executive Leadership Group (ELG)/ Executive Management Board (EMB), Board Committees and the Board.

2.4 *Organisational Risks:* are risks that are mainly operational in nature and arise from the CTMUHB's day-to-day activities.

2.5 The Board Assurance Framework (BAF) is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation. It also summarises the controls and assurances that are in place or plans to mitigate them. The BAF aligns strategic/principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

2.6 The BAF identifies the assurances reported to Board and Committees in relation to the strategic/principal risk identified. It also highlights the gaps in controls and assurances. This enables the development of an action plan for closing the gaps and mitigating the risks, which is subsequently monitored by the Board for implementation.

2.7 This Strategy applies to all Staff directly employed by CTMUHB and/or those that hold any form of contract (including agency, honorary, locum etc).The culture of risk management and discussion of risk with partners and stakeholders, where appropriate should be encouraged.

2.8 The Risk Management Strategy is intended to cover all the potential risks that the organisation could be exposed to.

3. Risk Management Organisational Structure

The Board

3.1 Executive Directors and Independent Members share responsibility for the effective management of risk and compliance with relevant legislation. In relation to risk management, the Board is responsible for:

- articulating the Strategic Objectives/Goals of CTMUHB;
- articulating the Strategic/Principal Risks of CTMUHB;
- protecting the reputation of CTMUHB;
- providing leadership on the management of risk;
- approving the risk appetite for CTMUHB;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- reviewing and approving risks on the Board Assurance Framework;
- endorsing risk related disclosure documents;
- approving the Risk Management Strategy and Board Assurance Framework on an annual basis.

Audit, Risk & Assurance Committee

3.2 The Audit, Risk & Assurance Committee has a specific role in relation to undertaking an annual review of the effectiveness of the Risk Management Strategy and the Board Assurance Framework.

3.3 In relation to risk management, the Audit, Risk & Assurance Committee shall review the establishment and maintenance of an effective system of

internal control and risk management. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion and/or other appropriate independent assurance, prior to endorsement by the Board.
- the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation. This will be addressed by ensuring there is a periodical review that risk registers are in place and updated for corporate and clinical areas.
- the CTMUHB's organisational risk register and the adequacy of the scrutiny of risks by assigned Committees. This will be addressed by ensuring all significant risks (i.e. those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) are assigned to a Board Committee for scrutiny, and ensuring that updates on actions to mitigate the risks are provided at each committee meeting.
- the Board Assurance Framework.
- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements. By identifying and assessing regulatory, legal and code of conduct issues that could have been prevented by more effective management of risk and assurance of controls in place.
- the operational effectiveness of policies and procedures, through regular review of policies and procedures.
- the effectiveness of risk identification, management, escalation and monitoring. This will be addressed by reviewing the number of risk registers in place, the frequency of updates to the risk register and the escalation of high risks to the Care Group /Central Function and Organisational Risk Registers.

All Board Committees

3.4 All Board Committees have a role to play in ensuring effective risk management in particular they will:

- Receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny.
- will receive updates in terms of actions taken to mitigate the risks and provide feedback and challenge to risk owners on the actions taken and any further action required.

Executive Leadership Group (ELG) / Executive Management Board (EMB)

3.5 The ELG/EMB undertake the following duties:

- Promote a culture within CTMUHB, which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within CTMUHB.
- Ensure appropriate actions are applied to organisational risks.
- Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised.
- Ensure Care Groups and Central Directorate Functions Risk Registers are appropriately rated, and action plans agreed to control them.
- Review the risks on the Organisational Risk Register (those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) to determine whether they will impact on the CTMUHB's Strategic Objectives/Goals, and if so, the risk will be added to the Board Assurance Framework (BAF) aligned to the appropriate Strategic/Principal Risk.
- Review the Organisational Risk Register and Board Assurance Framework prior to its presentation to the Board and Committees as appropriate.
- Review and monitor the implementation of the Risk Management Strategy and Board Assurance Framework.
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Governance Statement, outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.
- Approve documentation relevant to the implementation of the Risk Management Strategy and Board Assurance Framework.
- Provide assurance to the Board that there is an effective system of risk management across the Organisation.

Care Groups /Local Services Groups / Corporate Central Functions Leads

3.6 Care Groups, Local Service Groups / Corporate Central Functions are responsible for risks within their areas of operation and providing assurance to the ELG/EMB on the operational management and any support required in relation to the management of risk.

3.7 These functions are responsible for the implementation of the Risk Management Strategy and relevant policies, which support the CTMUHB's risk management approach.

3.8 Specifically they will:

- promote a risk culture which encourages open and honest reporting of risk with local responsibility and accountability;
- use the Datix Risk Management system for recording and reviewing risk.
- ensure a forum for discussing risk, risk management and organisational learning is maintained within their system group area of responsibility;
- co-ordinate the risk management processes which includes risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- update ELG/EMB on the management and mitigation of risk for their area;
- provide reports to the ELG/EMB and appropriate Committee of the Board that will contribute to the organisational monitoring and auditing of risk;
- escalate service risks graded 15 and above all those not able to be managed to the Strategic Risk Owner for consideration and review at the ELG for escalation to the Organisational Risk Register and Board Assurance Framework;
- contribute to the organisational monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the moderation and calibration of risks across CTMUHB to avoid duplication, ensure compliance and alignment with the Risk Management Strategy and ensure shared learning across CTMUHB;
- review and updating of existing risks, consider new risks for inclusion and escalate/de-escalate risks as appropriate to the Executive Team Member assigned as the Strategic Risk Owner for the risk being escalated.

3.9 CTMUHB's 'Risk Management Process – Service to Board' is included at Appendix 3.

4. Duties

4.1 The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

All Staff

4.2 All members of staff are accountable for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager.

4.3 In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for CTMUHB and attend/complete risk management training as appropriate.

4.4 They will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Health Board's business;
- report all incidents/accidents and near misses;
- comply with the Health Board's incident and 'near miss' reporting procedures;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed; and
- be aware of the Health Board's Risk Management Strategy and Policy documents, ~~and~~ Board Assurance Framework and processes and the local strategy and procedures and comply with them.

All Managers (Leaders of Teams, Service Managers, Area Leads etc)

4.5 The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework.

4.6 Managers at all levels of the Organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/area operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff attend relevant mandatory and local training programmes.

4.7 Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

Director of Corporate Governance

4.8 The Director of Corporate Governance will, with the support of the Assistant Director of Corporate Governance & Risk:

- work closely with the Chair, Chief Executive, Chair of the Audit, Risk & Assurance Committee and Executive Directors to implement and maintain the Risk Management Strategy and Board Assurance Framework and related processes, ensuring that effective governance systems are in place;
- work with the Board of CTMUHB to develop a shared understanding of the risks to the CTMUHB's strategic objectives/goals;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein;
- monitor the action plans and reporting to the Health Board and relevant Committees.

Executive Directors

4.9 Executive Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

4.10 Specifically they will:

- act as strategic risk owner for risks within their remit escalated to the Organisational Risk Register;

- use the Datix Risk Management system for recording and reviewing risk;
- communicate to their staff CTMUHB's strategic objectives and ensure that Care Group, Clinical Service Group and Corporate Directorates and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk;
- co-ordinate the risk management processes which include risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- provide reports to the appropriate Committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process;

  and

- ensure that the BAF and the risk management reporting timetable are delivered to the Health Board.

Chief Executive

4.11 The Chief Executive as Accountable Officer of the Health Board has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance.

4.12 The Chief Executive has overall accountability and responsibility for:

- ensuring CTMUHB maintains an up-to-date Risk Management Strategy and Board Assurance Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place which provides assurance to the Health Board in relation to the management of risk and internal control;
- putting in place and maintaining an effective system of risk management and internal control.

4.13 The Welsh Government requires the Chief Executive to sign a Governance Statement on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Internal Audit

4.14 Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the Health Board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards and good practice. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Risk Committee as appropriate.

5. Risk Management Process

5.1 CTMUHB is committed to developing a pro-active and systematic approach to risk management.

5.2 Appendices 2 and 3 outline the risk management and risk quantification process.

Risk Assessment

5.3 Each service within CTMUHB needs to identify risks through the completion of risk assessments and ensure that risk assessments are completed and regularly reviewed on an ongoing basis.

5.4 The management of risk in terms of Service to Board escalation is articulated in Appendix 3.

Board Assurance Framework (BAF)

5.9 CTMUHB's Board Assurance Framework was last approved by the Board in May 2024. The BAF is reviewed on annual basis by the Audit, Risk & Assurance Committee for onward approval by the Board.

5.10 The BAF will be articulated via a Board Assurance Report (BAR) presented to Board that brings together the Health Board's strategic goals and the principal/strategic risks, which may prevent them from being achieved.

5.11 The BAR identifies the controls in place to manage these risks and the assurances, which show whether they are working.

5.12 The BAR will:

- Incorporate action plans for the strategic risks within the "Mitigating Actions" section of the BAR which are closely aligned to the gaps in controls and/or assurances;
- link to key measures of performance and National Priority Measures;
- align strategic risks to operational risks on the Organisational Risk Register.

5.13 The benefits of the BAF include:

- that it is designed specifically for Board-level oversight
- it is a structured and evidence-based assessment of the key risks facing the CTMUHB.
- can be used to shape cycles of business and the work of the Board & Committees
- enables Independent Members to focus their scrutiny and constructive challenge
- supports strategic decision-making

5.14 The table below articulates how the BAF differs from the Organisational Risk Register:

Board Assurance Framework	Organisational Risk Register
• Strategic/Principal risks aligned to the Health Board's four strategic priorities • Includes only nine principal risks • Risks identified advised by the Executive Team and agreed by Board ('top down') • Decisions to add, remove or re-score risks are taken by the Board • Risks are organisation-wide in scope	• Mostly operational risks arising from the CTMUHB's day-to-day activities • Includes over 50 of the highest level (currently scored over 15) risks • Risks usually identified by individual services or departments ('bottom up') • Agreed by Executive Leadership Group following triage by Care Group / relevant leads • Some are organisation-wide, others are specific to services or directorates, but require involvement by the Executive Team or other services

5.15 CTMUHB will monitor and ensure the BAF remains up to date by the following activity:

- Each strategic/principal risk has a Lead Executive(s);
- The Assistant Director of Governance and Risk will review the risk score, action plan and current performance with the Lead Executive(s) in readiness for reporting to the Board;
- Each principal risk has a lead Board Assurance Committee;
- More than one Board Committee will monitor some principal risks. These committees will scrutinise and seek assurances on the principal risks which they own;
- The Board should consider annually whether the principal risks are comprehensive, or if risks need to be added / removed / changed.

5.16 The Audit, Risk & Assurance Committee, as a Committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

Risk Quantification and Escalation & De-escalation

5.17 The approach to quantifying risk is described in Appendix 2. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target risk score (after completion of actions). A risk-scoring

matrix to describe the quantification of risk is also included in the Procedure.

5.18 The process of risk escalation and de-escalation will be monitored by the Audit, Risk & Assurance Committee, through monitoring new risks hitting threshold scores and being escalated as appropriate and/or current risks having their risk grading reduced so that the risks are appropriately de-escalated from the Organisational Risk Register.

5.19 The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and where it should be reported. The Board defines as “High” any risk that has the potential to damage the Organisation’s objectives. Please refer to Appendix 3.

Risk Appetite

5.20 At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.

5.21 Decisions on accepting risks may be influenced by the following:

- the likely consequences are insignificant;
- a higher risk consequence is outweighed by the chance of a much larger benefit;
- occurrence is rare;
- the potential financial costs of minimising the risk outweighs the cost consequences of the risk itself;
- reducing the risk may lead to further unacceptable risks in other ways.

5.22 Therefore, a risk with a high numerical value may be acceptable to the organisation, but that decision would be taken at an appropriate level.

5.23 The Board will review its risk appetite on an annual basis to ensure that progress is being made to the ‘risk appetite’ the Health Board wishes to achieve.

5.24 The matrix has the following risk levels:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

5.25 CTMUHB's Risk Appetite Statement is included at Appendix 4.

6. Information / Support

6.1 Support and guidance is available from the Assistant Director of Governance & Risk via cally.hamblyn2@wales.nhs.uk.

6.2 Risk Assessment templates and training information is available via the following site on SharePoint:
http://ctuhb-intranet/dir/HealthandSafety/default.aspx

7. Appendix 1 - Definitions

Assurance	Confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved. Sources of assurance include; reviews, audits, inspections both internal & external.
Assurance rating	This is the rating which has been given regarding the level of assurance: (1)= Management Reviewed Assurance (2)= Board Reviewed Assurance (3)= External Reviewed Assurance
Control Measures	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.
Current Risk Rating	The risk rating whilst risk responses are in the process of being implemented. Some controls are probably in place but others required are still being actioned & will be shown as gaps in control & actions until implemented.
Initial Risk Rating	The risk rating before any controls have been put in place.
Risk Actions	Actions required to mitigate the risk. Actions should be SMART & have clear owners assigned. This will allow action progress to be tracked & monitored & issues with action completion to be visible & dealt with.
Risk Appetite	At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.
Risk Assessment	Risk assessment is a process that is made up of three separate processes: risk identification, risk analysis, and risk evaluation. Risk identification is a process that is used to find, recognize, and describe the risks that could affect the achievement of objectives. Risk analysis is a process that is used to understand the nature, sources, and causes of the risks that you have identified and to estimate the level of risk. It is also used to study impacts and consequences and to examine the controls that exist. Risk evaluation is a process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.
Risk Description	A structured statement describing the risk usually containing the following elements: sources, events, causes and consequences / impact. A well-written risk statement captures three main parts; If, Then, Resulting In.

Risk Management	Risk management refers to a coordinated set of activities and methods that is used to direct an organization and to control the many risks that can affect its ability to achieve objectives. The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.
Risk Owner	Senior person best placed to keep an eye on the risk with decision making authority. This person is accountable for the Risk & should be aware of its current status.
Risk Rating	This is calculated by multiplying consequence x likelihood (impact x probability). Consequence: is the outcome of an event and has an effect on objectives. Likelihood: is the chance that something might happen. Likelihood can be defined, determined, or measured objectively or subjectively.
Risk Treatment	This is a risk modification process. It involves selecting & implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls. Treatment options include; Avoidance / Remove the source of the risk Reduction Transference Retain / Accept the risk Also known as the four T's – Treat, Transfer, Tolerate & Terminate
Strategic Risk Owner	Usually the Executive Director in relation to the risk area.
Target Risk Rating	When action is taken to treat risks, it may eradicate the possibility of the risk occurring. However, actions are often more likely to reduce the probability of the risk occurring, leaving the residual risk. The remaining level of risk after all treatment plans have been implemented is the residual risk. Generally the target level is the level at which the organisation is saying it's happy to live with. All agreed controls are in place & assurance is being provided that controls are working as planned. At this point the risk should be closed unless further actions are deemed required.

8. Appendix 2 - **Risk Domain and Scoring Matrix**

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low-level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event, which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	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.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	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.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss of service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

9. Appendix 3 – Risk Management Process – Service to Board Escalation Service to Board Risk Escalation in CTMUHB

This process should be read in conjunction with the Risk Assessment Procedure available here: Risk Assessment Procedure.docx

Further tools and support for undertaking risk assessments is available on the dedicated Risk page on SharePoint available here: Risk Assessment - Undertaking Risk Assessments.

Training on risk is available to book on ESR please search for course: 110 Risk Management Strategy and Risk Assessment and Training Awareness.

A step-by-step guide for completing a risk assessment on the Datix Web Module is available here: Risk Assessment - Undertaking Risk Assessments – "DatixRiskWeb User Guide V6". The Risk Scoring & Domain Matrix is a key reference point when scoring risks and is available in the Risk Assessment Procedure

1. Risk Assessment

Risk identified and a risk assessment needs to be undertaken. A risk assessment should be completed directly into the Datix Risk Web Module or via completing a hard copy of the risk assessment form to upload to Datix Web Module following completion.

2. Risks scored with a risk score of between 1 and 6 (Low) and 8 and 10 (Moderate)

Any risks identified and evaluated as having a low/moderate rating, can be managed locally within the relevant area i.e., local/Directorate level risk register.

These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed, and become controls under business as usual. These risks are recorded locally in the local/Directorate risk register within each service area/department.

All risks should be reviewed and updated as per the frequency captured in the Risk Assessment Procedure and Risk Scoring and Domain Matrix.

Escalation via Care Group / Central Directorate Senior Team is not required unless there is a novel or contentious matter that should have visibility or further input, or support is needed.

Risk scored with a risk score of 12 (Moderate)

Risks identified as having a moderate rating i.e., a score of 12 are managed at a local level but should also be escalated to Care Group / Central Directorate Senior Team for visibility and review.

Risk owners should also add a note to the "Escalation Status" in the Datix Web Module indicating where in the process the risk is i.e. escalated and to be considered by the Care Group Senior Leadership Team.

The review at the escalated level should be undertaken on at least a quarterly basis.

The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings, Health, Safety & Fire meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

Risk scored with a risk score of 15 and above and/or is novel and contentious

Risks identified as having a high rating i.e. a score of 15 and above and/or is novel and contentious, will still be managed in the service/area for which they were identified, however they should be escalated immediately to a Care Group / Central Directorate level.

High level risks should be monitored at least monthly if scored 20 and above or bi-monthly if 15 and above. The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

Once escalated, it will be for the Care Group Senior Team / Central Corporate Director to consider if the risk should also be escalated to the Organisational Risk Register, managed via the Assistant Director of Governance & Risk.

If the Care Group/Central Director consider that this risk should be escalated to the Organisational Risk Register, it will do so as follows:

- Include in highlight report / update report to the next Operational Management Board meeting which meets monthly;
- Once the Operational Management Board have reviewed the risk and support escalation the "Yes to escalate" in the Datix Web Module, the box should be ticked which will generate a notification to the Assistant Director of Governance & Risk; and
- Risk owners should also add a note to the "Escalation Status" in the Datix Web Module, indicating where in the process the risk is i.e. escalated and to be considered at Operational Management Board on (date). Once approved for escalation, the date it was escalated to the Organisational Risk Register should also be captured in this box.

The risk should continue to be reviewed by the area for which it has been identified and in addition on a bi-monthly basis updates for the Organisational Risk Register will be requested.

Once escalated to the Organisational Risk Register, these risks will be reviewed at Public Board Committees, where assurance as to the robust monitoring and review will be sought.

De-escalation of Risks from the Organisational Risk Register

If because of successful mitigation, a risk score can be reduced below the threshold for escalation, "Datix Web Module escalation status" should be updated, as well as the rationale for risk score changes. This demonstrates robust and proactive management.

Endorsed by the Operational Management Board on the 2nd October 2024

Approved by the Executive Leadership Group on the 7th October 2024

10. Appendix 4 – Risk Appetite Statement

Cwm Taf Morgannwg University Health Board

Risk Appetite Statement

1. Introduction:

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's risk appetite.[1]

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - its risk appetite – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.[2]

The challenge for the Board in managing risk whilst balancing quality & safety, people, performance activity and financial duties is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk-based decision.

2. Cwm Taf Morgannwg University Health has adopted the following Risk Appetite Matrix:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. Cwm Taf Morgannwg University Health Boards Risk Appetite Statement:

The Health Boards risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives.

The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

The risk appetite statement was last reviewed on the 15 May 2025.

- Quality and Safety risks - *(including physical and/or psychological harm) of its patients, people and the population)* – the Health Board has adopted a Cautious stance for quality and safety risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.

- People risks - *(including physical and/or psychological harm) to people directly engaged by the Health Board as staff or volunteers* – the Health Board has adopted a Cautious stance for people risks, with a preference for consideration of the impact on the well-being of staff, including insufficient staffing numbers, unmanageable workload, burnout, or any safety risks, tolerating a cautious degree of residual risk and choosing the option most likely to result in a positive, healthy experience of work for our people, while also balancing service provision to our population.

- Operational Performance risks – the Health Board has adopted an Open stance for Operational Performance risks, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its patients, people and the population.

- Reputation / Adverse Publicity (Trust in Confidence) risks - the Health Board has adopted a Cautious stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.

- Business Continuity risks - the Health Board has adopted a Cautious stance for Business Continuity Risks. The Board will receive ongoing assurance from the testing of business continuity plans.

[1] Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0
[2] The Orange Book – Section A

- Legal / Regulatory Compliance risks – the Health Board has adopted a Cautious stance for Legal, Regulatory and Compliance risks, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. The Board will receive assurance that compliance regimes are in place.

- Data and Information Management risks – the Health Board has adopted a Cautious stance for data and information management risks seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. There is acceptance for the need for operational effectiveness with risk mitigated through careful management of information sharing and limiting distribution.

- Financial stability risks – the Health Boards stance for financial risk is varied as follows:
    - Averse for financial propriety, statutory and regularity risks with a determined focus to maintain effective financial control framework accountability structures.
    - Averse – in terms of risks related to the Health Boards qualification of accounts, associated process and deviation from reporting timescales.
    - Cautious - in terms of risks related to the Health Board's financial breakeven duties set out in the NHS Wales Finance Act (Wales) 2014, recognising the need to ensure appropriate balance with the Duty of Quality.
    - Cautious – In relation to the Health Boards budget, spend with the intention that it should maximise the use of resource each year. The Health Board will seek safe delivery options with little residual risk that only yield some upside opportunities. The Board would receive ongoing assurance through reporting structures that policies and procedures are in place to comply with HMT guidance.

- Assets and Estates risks – the Health Board has adopted an Open stance for assets and estates respectively, seeking value for money but with a preference for proven delivery options have that a cautious residual risk. this means that the Health Board will us solutions for purchase, rental, disposal, construction, and refurbishment that ensures it protects the public purse from as much risk as possible, producing good value for money whilst fully meeting organisational objectives.

- Technological advances (Research and Innovation)- the Health Board has adopted an Open stance for risks associated with technological advances recognising that advances in research and innovation in relation to system and technology developments can enable improved delivery. Responsibility for non-critical decisions may be devolved in accordance with the Scheme of Delegation. Plans aligned with functional standards and organisational governance.

10. Appendix 5 – Board Assurance Framework (Strategic / Principal Risks)

A detailed review of the Strategic / Principal risks was completed at the Board Development Session on the 15th May 2025. There is a dynamic approach to the review of the Strategic / Principal risks and is therefore is subject to change following approval at Board meetings throughout the year. At the time of updating this Strategy, the Board have identified the following key Strategic Risks:

The latest Board Assurance Framework report will be available from the Health Board's Public Board Meeting papers available here: Board Meetings & Papers - Cwm Taf Morgannwg University Health Board

Risk no	Strategic Goal	Strategic / Principal Risk	Lead(s) for this Risk	Assurance committee
1	Improving Care, Sustaining our Future	a) Enough capacity to meet emergency and elective demand b) Enough capacity to meet emergency demand	Chief Operating Officer	Quality, Safety & Experience Committee Operational Delivery Committee
2.	Improving Care, Sustaining our Future	Ability to deliver improvements which transform care and enhance outcomes	Executive Director of Nursing Executive Medical Director	Quality, Safety & Experience Committee Operational Delivery Committee
3.	Sustaining our Future, Improving Care and Inspiring People	Enough workforce to deliver the activity and quality ambitions of the organisation *(including Culture, Values and Behaviours)*	Executive Director for People	Quality, Safety & Experience Committee Operational Delivery Committee
4.	Creating Health, Sustaining our Future	Effective Community and Partner Engagement in service changes and developments	Executive Director of Strategy & Transformation Director of Communications, Engagement & Fundraising	Strategic Development Committee
5.	Improving Care, Sustaining our Future	Delivery of a digital and information infrastructure to support organisational transformation	Director of Digital	Operational Delivery Committee Strategic Development Committee
6.	Improving Care, Sustaining our Future	Ability to maintain a safe and fit for purpose estate infrastructure	Executive Director of Finance	Operational Delivery Committee
7.	Sustaining our Future, Creating Health	Fulfilling our Environmental and Social Duties and ambitions	Executive Director of Strategy & Transformation	Strategic Development Committee
8.	Creating Health, Sustaining our Future	Prevention and early Intervention to support Healthy Life Expectancy	Executive Director of Public Health	Strategic Development Committee
9.	Sustaining our Future	Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government	Executive Director of Finance	Operational Delivery Committee
10.	Sustaining our Future, Improving Care	Ability to develop a fit for the future estate to reflect our future clinical service model	Executive Director of Finance	Strategic Development Committee
11.	Creating Health, Sustaining our Future, Improving Care	Delivery of an Integrated Care Model	Chief Operating Officer	Strategic Development Committee

RISK MANAGEMENT POLICY

Document Type:	Non Clinical Organisational Wide Policy
Ref:	RM 02
Author:	Cally Hamblyn, Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance
Approved By:	
Approval / Effective Date:	
Review Date:	
Version:	Version 6 - Draft

Target Audience:

People who need to know about this document in detail	Risk Handlers, Owners and Managers.
People who need to have a broad understanding of this document	All employees of the Health Board.
People who need to know that this document exists	All employees of the Health Board. Board Members, Stakeholders.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 20.11.2020 Outcome: No potential negative impact identified.
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	23.11.2020
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Contents

1. PURPOSE

1.1 The purpose of this Policy is to lay the foundations for an effective risk management system and ensure that:

- all risks that could cause harm are identified and that control mechanisms are implemented;
- that satisfactory management arrangements are in place for assessing the risk;
- staff know how to undertake a risk assessment and are able to identify and take action to mitigate risk;
- all legal requirements are met.

1.2 This Policy sets out the approach to risk management in Cwm Taf Morgannwg University Health Board (CTMUHB).

1.3 The Policy aligns to all the Health and Care Standards, however, specifically:

- Governance, Leadership & Accountability;
- Standard 2.1 – Managing Risk and Promoting Health & Safety.

1.4 In accordance with the Values and Behaviours of the organisation, CTMUHB will:

- *All work together as one team* to ensure that the culture of risk management is effectively promoted to staff ensuring that they understand that the 'risk taker is the risk manager' and that risks are owned and managed appropriately;
- embed both the principles and mechanisms of risk management into the organisation;
- *We will listen and learn* and involve staff at all levels in the process;
- *We will treat everyone with respect in the implementation and management of this policy.*

2. POLICY STATEMENT

2.1 CTMUHB recognises that no organisation can operate in a risk-free environment. Risk however is not something to be feared, rather if it is understood and managed properly it can benefit the organisation, its staff and key stakeholders.

2.2 CTMUHB will manage risks at all levels. Strategic risks will be identified by the Board and managed by the Executive Team, whereas operational risks will be identified and managed at the most appropriate level.

2.3 The organisation will maintain a risk management system which will enable and empower staff to identify, assess, manage and appropriately treat risks.

3. POLICY COMMITMENT

3.1 CTMUHB is committed to the effective management of risk throughout the organisation and will develop and maintain the appropriate systems to allow such management.

3.2 The organisation will lay out clearly the roles and responsibilities of all staff when it comes to the management of risk, and these can be found both here and in the Risk Management Procedure, or where appropriate in the relevant process document.

3.3 All staff are required to understand their role and responsibilities and to comply with the requirements of both this policy and all relevant processes.

3.4 All staff will be expected to use the appropriate corporate systems for risk management. At the time of developing this policy, risk is managed through the Datix platform and the use of risk registers (for operational risk) and the Board Assurance Framework for strategic risks.

3.5 Whilst there is no specific mandatory training requirement for staff in Risk Management, those staff who have specific responsibilities will have the appropriate training in order to allow them to carry out the roles.

4. INTRODUCTION

4.1 This policy introduces the CTMUHB position and expectations in relation to risk management. The document outlines the Board responsibilities and expectations, describes the way CTMUHB categorises risk and the risk architecture of the organisation. For more detail in the procedures to be followed for managing risk, please refer to the associated document 'Risk Management Procedure'.

5. SCOPE/AIMS AND OBJECTIVES OF POLICY

Scope

5.1 This is a Policy which is intended to cover the identification, assessment and management of risk in all forms. The policy and associated procedures relating to risk will apply to all staff, contractors and visitors. In the interests of brevity, the term staff is used throughout this document to refer to staff, contractors, agency staff, volunteers, secondees and visitors.

5.2 Organisations hosted by CTMUHB e.g. Joint Commissioning Committee and the National Imaging Academy for Wales, are responsible for ensuring that structures and reporting mechanisms are in place to implement the requirements of this Policy.

5.3 Due to CTMUHB's contractual relationship with independent contractors, e.g. General Practitioners, dentists, optometrist etc. the Health Board

clinical governance processes will provide assurance to the Board that these services are safe and meet set standards.

5.4 Contractors and Contracted Services: before contracts are finalised, the competence of contractors will be assessed in relation to health and safety as detailed in CTMUHB's Control of Contractors Policy.

Aim

5.5 The aim of this document is to outline the high-level arrangements within which CTMUHB will achieve a holistic and effective approach to risk management.

Objectives

5.6 This policy will:

- Explain the role and expectations of the Board in relation to risk management;
- Detail the high-level responsibilities for implementing this policy;
- Signpost the specific policies and procedures which CTMUHB will publish to ensure that all staff understand what is required of them;
- Explain the arrangements for complying with all relevant legislation.

6. STRATEGIC CONTEXT

6.1 CTMUHB has developed and agreed Strategic Goals which Strategic/Principal risks have been set against

6.2 In order to deliver against the Strategic Goals and Strategic Priorities, it is necessary to understand the environment in which we operate, and to have clear visibility on what might get in the way of delivering them. Therefore, an effective Risk Management System is necessary. Risk Management starts at the top of the organisation, with the Board setting our direction and our risk appetite, and then permeates down through every level.

7. ROLES AND RESPONSIBILITIES

The Board

7.1 In order for the Board to discharge its responsibilities, it needs to receive assurances that the organisation is effectively managing its risks to ensure delivery of its mission and objectives. The principle assurance tools for the Board are the Board Assurance Framework Report and the Organisational Risk Register.

7.2 The Board will scrutinise the Board Assurance Framework Report at all routine meetings for the purpose of challenge and receiving assurance.

7.3 The role of the Committee is to provide the Board with assurances that appropriate arrangements for effective internal control, and for the identification and management of risk.

7.4 In order to undertake this role the Audit, Risk & Assurance Committee receives routine risk reports in accordance with the organisations Risk Management Strategy.

7.5 The functions and membership of the Committee is set out in the terms of reference and standing orders.

Other Board Committees / Board Sub Committees

7.6 Board Committees and Board Sub Committees will receive routine reports on risks assigned to them as the assuring committee.

7.7 The functions and membership of the Committee is set out in the terms of reference and standing orders.

Chief Executive

7.8 The Chief Executive as Accountable Officer of the Health Board has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance.

7.9 The Chief Executive has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Strategy and Board Assurance Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board that is in-line with our organisational values;
- ensuring that there is a framework in place which provides assurance to the Health Board in relation to the management of risk and internal control;
- putting in place and maintaining an effective system of risk management and internal control.

7.10 The Welsh Government requires the Chief Executive to sign an Annual Governance Statement on behalf of the Board. This outlines how risks

are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

7.11 Operationally, the Chief Executive has designated responsibility for implementation of this policy and associated procedure to the Director of Corporate Governance.

Director of Corporate Governance

7.12 The Director of Corporate Governance with the support of the Assistant Director of Governance & Risk will:

- work closely with the Chair, Chief Executive, Chair of the Audit, Risk & Assurance Committee and Executive Directors to implement and maintain the Risk Management Strategy and Board Assurance Framework and related processes, ensuring that effective governance systems are in place;
- work with the Board of CTMUHB to develop a shared understanding of the risks to the Health Board's strategic objectives;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- develop and oversee the effective execution of the Board Assurance Framework and ensure effective processes are embedded to rigorously manage the risks therein;
- monitor the action plans and reporting to the Health Board and relevant Committees.

Executive Directors / Other Board Level Directors

7.13 Executive Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

7.14 Specifically they will:

- act as strategic risk owner for risks within their remit escalated to the Organisational Risk Register;
- ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk;

- co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- provide reports or contribute to reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting; and
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process.

All Staff

7.15 All members of staff are accountable for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager.

7.16 In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for CTMUHB and attend/complete risk management training as appropriate.

7.17 They will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Health Board's business;
- report all incidents/accidents and near misses;
- comply with the Health Board's incident and 'near-miss' reporting procedures;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work and the notification to their

line manager of any perceived risk which may not have been assessed; and

- Be aware of the Health Board's Risk Management and Board Assurance Framework and processes and the local strategy and procedures and comply with them.

Internal Audit

7.18 Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the Health Board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards and good practice. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Risk Committee as appropriate.

8. CATEGORIES OF RISK

8.1 *Strategic/Principal Risks:* are significant risks that have the potential to impact upon the delivery of Strategic Objectives and are reviewed and monitored by the Executive Leadership Group / Executive Management Board, Board Committees and the Board.

8.2 *Organisational Risks:* are risks that are mainly operational in nature and arise from the CTMUHB's day-to-day activities.

9. CORE ELEMENTS OF RISK MANAGEMENT

9.1 Risk Management is the assessment, analysis and management of risks. It is simply a way of recognising which events (hazards) may lead to harm in the future and minimising their likelihood of occurrence (how often?) and consequence(s) (how bad).

9.2 Acceptable / tolerable risk is defined based on the following principles:

- tolerability does not mean acceptability. It refers to a willingness to live with risk to secure certain benefits, but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk;
- no person should knowingly be exposed to serious avoidable risk;

- it is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing is even greater.

9.3 Given that acceptable risk is defined as:
"A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been managed as far as is considered to be reasonably practicable. The potential benefits should outweigh the potential harm."

9.4 Identification and reporting of risk: the identification of risk within CTMUHB must be addressed in a proactive as well as a reactive way. The proactive approach to the identification of risk relies upon robust risk assessment and a comprehensive dynamic organisational risk register. Risks must be reported via the Datix Risk Management System. The organisation relies upon the accurate reporting of incidents by all its staff. The data analysis of this source of risk identification will continue to be a crucial part of monitoring progress and lessons learnt from incidents. Evaluation, audit, service reviews, complaints and litigation must also be utilised as a source of data for the identification and reporting of risk.

9.5 CTMUHB must ensure that the processes to identify and report risk are open and accessible to all staff, patients and public. This may result in an increase in the number of incidents identified within the Health Board. Any media interest will be managed in a positive way, by reassuring the public that increased reporting is essential to the prevention of serious incidents and the increase in incident reporting is a major step forward in improving the quality and safety of patient care.

9.6 The Risk Assessment Procedure sets out the process to be followed. The Risk Assessment Procedure will support this Policy by explaining:

- when to undertake a risk assessment;
- how to undertake a risk assessment;
- what is a generic risk assessment;
- the principles of risk assessment; and
- the risk assessment process.

9.7 Learning lessons from risk identification and other concerns (incidents, claims and complaints) is key to preventing and minimising the likelihood of reoccurrence. Please refer to the Health Board's Being Open Policy. Lessons learned can be shared using the newly

established Shared Listening and Learning Forum with the Health Board which supports the values of CTMUHB that *We Listen, Learn and Improve* and *We Treat everyone with Respect.* This will mean that staff feel reassured that the investigation of incidents will be undertaken in a fair and open way.

9.8 As part of a Just and Learning Culture, on occasion there may potentially be a serious breach of professional practice, or possible criminal activity revealed, indicating the need for further investigation under the Health Board's Disciplinary or Capability Policies (agreed at an all Wales level). All such cases will be considered individually, however, formal disciplinary action may result where:

- an individual persists in unsafe practice;
- there is a deliberate failure to report, or attempt to cover up an incident;
- there have been repeated unreported errors or violations;
- there is evidence of malicious activities (including malicious reporting of untrue allegations against a colleague);
- there has been an act of gross misconduct (e.g. treating patients whilst under the influence of drugs or alcohol);
- a breach of the criminal law (e.g. theft or assault) or professional conduct has occurred.

9.9 Communication with staff, patients and public – it is important that communication relating to risk management is both transparent and effective for staff and patients. The communication of risk management issues will be available through the Health Board and Board Committee papers available on the Health Board's website Click Here. The patients and the public have an important role to play in the identification and reduction of risk. Further work will be undertaken to build on the current involvement of patients and public in service development. Gaining their perspective and involvement in risk management will support the identification and reduction of risk throughout the organisation.

9.10 CTMUHB works with a number of external partners including Social Services and the Voluntary Sector. It is important that a clear process for communication with these partners regarding risk is implemented. Healthcare Inspectorate Wales (HIW), Welsh Risk Pool (WRP), Health and Safety Executive (HSE), South Wales Fire & Rescue Service, Internal Audit and External Audit have a role in the monitoring and evaluation of organisational risk issues. CTMUHB will continue to work

collaboratively with these agencies in the continuous improvement of risk management and risk reduction.

9.11 Partnership Working - Risk management does not exist in isolation and is one of the enabling systems within Governance frameworks. The risk management processes must continue to enable the organisation to identify unacceptable risks, these can then be minimised to meet high quality care for patients.

10. LEGISLATIVE REQUIREMENTS

10.1 The risk assessment provision of the Management of Health and Safety at Work Regulations (1999) requires employers to assess the risks created by their undertaking, so as to identify the measures they need to have in place to comply with their duties under health and safety legislation.

10.2 As such, the assessment provision of the Management of Health and Safety at Work Regulations are superimposed over all other workplace legislation including the general duties in the Health and Safety at Work Etc. Act 1974.

10.3 This Policy is the overarching document for implementing the Risk Management Strategy and is intended to meet all legal and internal requirements.

11. IMPLEMENTATION/POLICY COMPLIANCE

11.1 There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate Workforce and Organisational Development policy.

12. EQUALITY IMPACT ASSESSMENT STATEMENT

12.1 This policy has been screened for relevance to Equality. No potential negative impact has been identified.

12.2 Advice and guidance should be sort from the Equality Team prior to implementing any risk management measures that could have a potential impact on equality.

13. TRAINING IMPLICATIONS

13.1 The effectiveness of managing risk within CTMUHB relies upon the knowledge of staff, patients and public regarding risk identification and reporting.

13.2 It is important that all staff are aware of their responsibilities regarding risk management. The identification and management of risk must be a core competency of the annual personal review and appraisal process.

13.3 A range of training and education relating to risk management is available aimed at the specific needs of staff members. Where required the education and training programmes can also be extended to our independent contractor colleagues to support their responsibilities in the management of risk and safety.

13.4 All Managers must ensure:

- that all members of staff receive sufficient training to fulfil their individual duties, to ensure compliance with this policy, and to understand the importance of identifying and controlling risks;
- that adequate risk assessment training is given to appropriate members of staff in their specific duties as defined within the Risk Management Strategy. It is essential that risk assessments are completed by competent members of staff, who have sufficient experience of the working procedures and have received the appropriate training.

14. REVIEW AND MONITORING ARRANGEMENTS

14.1 All Departmental Heads will regularly monitor to ensure that measures to control risks are being fully implemented and remain effective. They will arrange for managers to continually review risk assessments and risk registers, in accordance with the frequency set out in the Risk Assessment Procedure and Risk Management Strategy.

14.2 This Policy will be formally reviewed every three years or sooner should there be any service or legislative changes that require an earlier review to be undertaken.

15. GETTING HELP

15.1 Risk Management support and guidance is available from:

Assistant Director of Governance & Risk:Cally.Hamblyn2@wales.nhs.uk

Or visit:

http://ctuhb-intranet/dir/HealthandSafety/default.aspx

16. RELATED POLICIES

16.1 This policy should be read in conjunction with the following policies and procedures:

- Risk Management Strategy;
- Risk Management Procedure;
- Health & Safety Policy;
- Incident Reporting Policy;
- Being Open Policy.

17. REFERENCES

- Bateman, Mike. (2006) Tolley's Practical Risk Assessment Handbook. Elsevier.
- Control of Substances Hazardous to Health Regulations 2002.
- Controls Assurance and Corporate Governance Agenda.
- Corporate Manslaughter Act 2007.
- Display Screen Equipment Regulations 1992.
- Financial controls documentation.
- Health and Safety at Work Etc. Act 1974.
- Health and Safety Executive. (2006) Five Steps to Risk Assessment.
- Health and Safety Executive. Health and Safety at Work etc. Act 1974.
- Health and Safety Executive. (2000) Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and guidance L21. HSE Books.
- Health and Safety Executive. (1998) Successful Health and Safety Management HSG65. HSE Books.
- Management of Health and Safety at Work Regulations 1999.
- Manual Handling Operations Regulations 1992 (as amended).
- Medicines and Healthcare products Regulatory Agency – Medical Device Alerts.
- National Patient Safety Agency. (2008) A Risk Matrix for Risk Managers.
- Noise at Work Regulations.
- Personnel Protective Equipment Regulations 1992.
- Provision and Use of Work Equipment Regulations 1998.
- Regulatory Reform Act.
- Health and Care Standards.
- Statutory duty of quality in the NHS by meeting the requirements of the Clinical Governance agenda.
- Welsh Risk Management Standards.
- Workplace (Health, Safety & Welfare Regulations) 1992.

These references are not exhaustive and may be subject to change and amendment.

RISK ASSESSMENT PROCEDURE

Document Type:	Non Clinical Procedure
Ref:	RM 04
Author:	Cally Hamblyn, Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance
Approved By:	
Approval / Effective Date:	
Review Date:	
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Target Audience:

People who need to know about this document in detail	Risk Handlers, Owners and Managers.
People who need to have a broad understanding of this document	All employees of the Health Board.
People who need to know that this document exists	All employees of the Health Board. Board Members, Stakeholders.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 20.11.2020 Outcome: No potential negative impact identified.
Welsh Language Standard	No
Date of approval by Equality Team:	23.11.2020
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

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If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

1. INTRODUCTION

1.1 Risk is present in any organisation, in its service and business activities, people, management and support systems, buildings, equipment and supplies. Healthcare is a high-risk activity and clinicians and managers should not be discouraged from taking some risks in developing more effective/innovative methods of treatment. It is important however, that such risks are taken as a result of an objective decision to do so based on reliable information and an understanding of the possible outcome. All employees should fully comply with the requirements of the Risk Assessment Procedure. If a member of staff becomes aware of a risk they must take immediate remedial action and report their concerns to their supervisor or manager.

1.2 The purpose of this Risk Assessment Procedure is to provide clear instructions on the identification of risks and the process and management of those risks, with regard to risk assessment. This will enable Cwm Taf Morgannwg University Health Board (CTMUHB) to actively monitor, manage, prioritise and develop a consistent approach to all risk assessments in order to protect the safety of patients, staff, visitors, contractors and members of the public, equipment, finances, premises and the environment. This Procedure aligns to the Risk Management Policy; Risk Management Strategy and Health and Safety Policy.

1.3 This Procedure aligns to all of the Health and Care Standards, however, specifically:

- Governance, Leadership & Accountability
- Standard 2.1 – Managing Risk and Promoting Health & Safety.

1.4 Risk assessment is an essential part of any risk management system. Risk assessment methods are used to decide on priorities and to set objectives for eliminating hazards and reducing risks. Wherever possible risks are eliminated, if they cannot be eliminated, they are minimised by the use of physical controls or, as a last resort, through systems of work and personal protective equipment.

1.5 In order to minimise risk it is vital that remedial/ mitigating action is taken immediately or as soon as reasonably practicable following the identification of the risk.

1.6 A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been managed as far as is considered to be reasonably practicable. The potential benefits should outweigh the potential harm.

1.7 The general duties of CTMUHB to its employees in section 2 of the Health and Safety at Work etc. Act 1974 implies the need for risk assessment. This duty was extended by section 3 to anybody else affected by its activities including contractors, visitors, patients and members of the public. However, the Management of Health and Safety at Work Regulations 1999 lays down the following requirements:

"Every employer shall carry out a suitable and sufficient assessment of the risk to the health and safety of their employees and to anyone else who may be affected by their activity, so that the necessary preventative and protective measures can be identified."

1.8 The Approved Code of Practice (ACOP) to the Regulations state:

"Suitable and sufficient is not defined in the Regulations. In practice it means the risk assessment should do the following:

The risk assessment should identify the risks arising from or in connection with work. The level of detail in a risk assessment should be proportionate to the risk. Once the risks are assessed and taken into account, insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks. The level of risk arising from the work activity should determine the degree of sophistication of the risk assessment."

1.9 A suitable and sufficient risk assessment should:

- identify the significant risks;
- identify and prioritise the measures required to comply with any relevant statutory provisions;
- remain appropriate to the nature of the work and valid over a reasonable period of time.

1.10 CTMUHB, as an employer, must demonstrate a clear commitment to carrying out risk assessments. The organisation will:

- enable a consistent approach to managing risks that exist and the actions necessary to reduce them;

- produce a risk register;
- determine roles and responsibilities for the assessing and reporting of risks.

1.11 This procedural document covers both clinical and non-clinical risk assessment.

1.12 CTMUHB will work with colleagues, independent contractors and others outside the organisation to share knowledge, information, and training in making quality improvements. This will require a high level of management commitment, professional competence and adequate resources.

2. PURPOSE

2.1 The purpose of carrying out a risk assessment is to enable the organisation to effectively take the measures necessary for the safety and health protection of staff, patients and everyone who is on CTMUHB sites. These measures include prevention of occupational risks and prevention and/or reduction in risks to patients and users.

2.2 The law expects CTMUHB to follow the hierarchy of control (see section 7). Most risks cannot be totally eliminated and these risks will need to be managed to ensure that people and the organisation is protected as far as reasonably practicable. The risk assessment:

- can identify risk to patients' safety;
- will enable CTMUHB to identify the risks to which employees are exposed whilst they are at work;
- will identify risks to the safety of persons not in the CTMUHB's employment arising out of or in connection with any work being undertaken by the organisation;
- can be regarded as an important management decision making tool;
- can highlight the benefits of positive action taken, the consequence of no action and the costs involved;
- will identify any risks related to the premises and organisation of CTMUHB;
- will enable CTMUHB to plan, introduce and monitor preventative measures to ensure that risks are adequately controlled;
- will identify where staff need appropriate training;
- will provide information to make changes, improve facilities, and services.

2.3 It is important that risk assessments are developed where a risk has been identified or revised following an incident, when circumstances change, when new technology, research, and new regulations and procedures are introduced, and at regular intervals depending on the level of risk.

2.4 Following an incident there is a requirement to review the risk assessment and in doing so incorporate the outcome from the investigation and/or root cause analysis. The review date for the risk assessment will need to be based on any actions identified within the investigation or root cause analysis to ensure that appropriate mitigating action has been taken within the specified period.

3. DEFINITIONS

3.1 Hazard - A hazard is something which has the potential to cause harm. In the context of operational business risk, it is sometimes easier to use the term threat instead, and the word harm should be read as harm to what you are trying to achieve. In other words, if there is something which has the potential to stop you achieving your objectives, this is a hazard (or threat).

3.2 Risk - Risk is the likelihood that the harm will be realised e.g. the chance that somebody could be harmed by the hazard, together with an indication of how serious the harm could be. The key thing here is that for anything to be described as a risk there MUST be some level of uncertainty connected with it. If there is no uncertainty, then you do not have a risk – you have a problem or an issue.

Some examples of hazards and the associated risk are shown below.

Hazard	Risk
walking on uneven floor surfaces	slips, trips or falls
climbing up or down steep stairs or ladders	falling down stairs or the collapse of the ladders
use of electrical equipment	electrical shock or burns
behavioural problems	assault on staff
medication error	wrong drug, wrong patient resulting in patient harm

Hazard	Risk
misdiagnosis	no treatment, wrong treatment, delayed treatment resulting in short or long term ill health or injury
mislabelling of specimens	delay to or incorrect treatment, tests have to be redone, increased time and cost

3.3 Problem / Issue – is simply something which is happening or has happened and needs to be dealt with. These are not managed through the risk management system and are therefore not further referred to within this document.

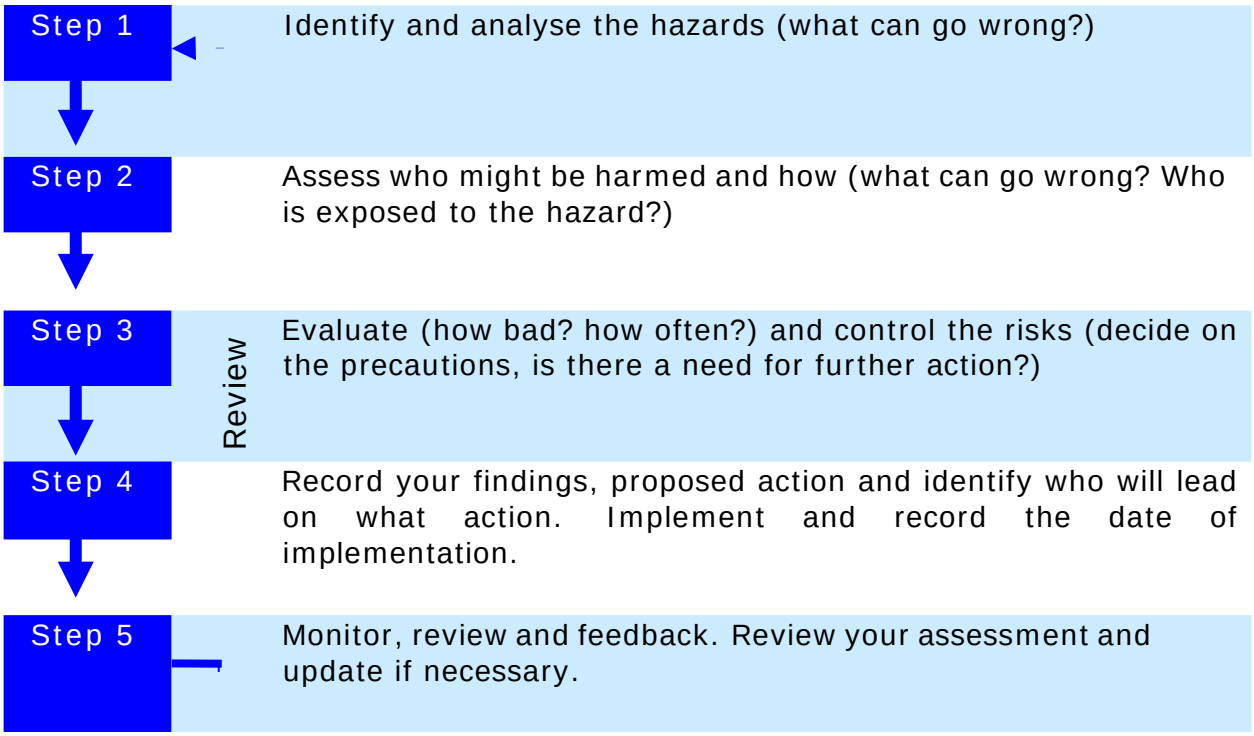
3.4 The extent of risk takes into account the number of people who might be exposed to a risk and the consideration for them. In the first example above, factors that would greatly increase the risk include holes in the floor, wet surfaces, poor lighting etc. Those risks can be effectively reduced by measures such as ensuring that the floor is in a good condition, spillages are prevented or cleared promptly, and lighting is adequate.

3.5 Risk assessment - A risk assessment is a careful and systematic examination of what in the work activity could cause injury, harm or loss to people, the environment or business, so that a decision can be made whether further actions need to be taken or control measures introduced in order to prevent harm or loss. Patients, employees and others have a right to be protected from harm.

3.6 The risk rating is calculated by multiplying the consequence (severity) score by the likelihood of occurrence score in accordance with the Risk Domain and Scoring Matrix (Appendix 1). The time spent on a risk assessment should therefore be proportionate to the nature and degree of the risk.

4. THE FIVE STEP RISK ASSESSMENT PROCESS

4.1 The risk assessment process can be divided into the following five steps:



5. STEP ONE – IDENTIFY AND ANALYSE THE RISKS

5.1 A positive, proactive and planned approach is required so that identifying risk becomes part of the work culture, a natural, normal part of managing, supervising, and decision making and undertaking your role. It is important to understand not only what is likely to go wrong but also how and why people or the organisation could be harmed or suffer loss. Concentrate on the significant risks, which could result in serious harm or affect a number of people. Risks can be identified through:

- walking around and inspecting the working area with colleagues, safety coordinators, managers or safety representatives;
- discussions with staff and users;
- checking that policies, procedures and guidelines are in use;
- carrying out audits;
- comparing previous adverse incidents, complaints, specific claims and ill health statistics and trends that have occurred within the area, the Health Board or the NHS;
- referring to manufacturer's instructions;

- examining clinical practices;
- examining professional standards or guidelines.
- Considering gaps in skill mix
- Considering any impact of workforce capacity constraints
- Risks relating to non-compliance with standards / targets /legislation/regulation
- Considering risks that may impact on stakeholder / patient experience and/or trust and confidence in the Health Board.

5.2 It is important to consider any long-term risks to health for patients (such as falls, pressure damage and hospital acquired infections), staff and others (such as high levels of noise or exposure to harmful substances, as well as safety hazards).

5.3 When the risks have been identified they then need to be analysed, and the following questions asked:

- what could go wrong?
- how could it happen?
- how severe would the effect be?
- how often are they likely to happen?
- how much are they likely to cost?

5.4 Undertaking a Risk Assessment - Those carrying out the assessment must:

- understand the requirements of risk assessment;
- have received risk assessment training;
- have a comprehensive knowledge of the working procedures or activities taking place in the work area;
- have the ability and authority to get all the necessary information;
- have the knowledge and skill to make correct decisions about the risks and precautions needed.

5.5 When undertaking the risk assessment, it is important to plan the approach. Consider the work practice and procedure in the workplace. This could include the clinical treatment of patients, physical, environmental, use of chemicals or general activities.

5.6 Think about the risks they could present;

- discuss with the staff and safety representatives to obtain their opinions;
- contact the Care Group Quality Governance Team and/or Central Quality & Patient Safety Team, Health, Safety and Fire team or the Assistant Director of Governance & Risk for their view and advice;
- consider manufacturer's instructions and data sheets, which will also give information on hazards;

- look at the controls that are in operation and evaluate if they are sufficient or if they can be improved on;
- consider the condition of the patients and the environment in which care is provided;
- decide on the actions, and determine accordingly what procedures and systems will be implemented to reduce or remove the risk;
- consider contingency planning, the assessment should take into account any emergency situations.

5.7 Collaborative Session - A collaborative session should be set up which can include a cross section of staff, as it is important to try to avoid subjectivity when evaluating risks. Therefore, where possible, a multi-disciplinary team should be used since no single person can reasonably be expected to know everything about all subjects, and it is often easier to view a subject with which one is unfamiliar in an objective way.

5.8 The importance of the team becomes apparent when setting risk priorities as different people will have different views on the relative significance of the risk for example:

- some individuals will want to give priority to issues that are required by law;
- some will pick the one which most worries staff or could have a greater impact on the patient or quality of care.
- others will decide by frequency;
- others by how disruptive the action will be;

5.9 All staff who are included should feel able to take a full share in the discussion, in accordance with the organisational values – *We will all Work together as One Team and We will Treat Everyone with Respect.* Experience from risk management workshops demonstrates that it is the people working within systems who can often identify risks and problems.

5.10 The idea is to identify service issues which present a risk to patients, stakeholders, or staff, either to their immediate safety or to the ability to manage and care for them; risks to staff, visitors or the business of CTMUHB that could cause harm, disruption or loss to the organisation.

5.11 Risks are specific to each area and specialty, it is the responsibility of the staff on each ward, department and service area to use the procedures and standards available, identify the risks present and ensure compliance in all areas.

5.12 Where risks are identified they should be listed on the Risk Identification Form (Appendix 2) which can be used to list all of the activities or tasks.

6. STEP TWO – ASSESS WHO MIGHT BE HARMED AND HOW

6.1 Once the risks to be assessed have been identified you need to consider who might be harmed (groups of people rather than named individuals) and how. Some individuals or groups may be more at risk than others. It is not enough to merely identify all clinical staff or all those who come into contact with patients.

6.2 The persons affected will range from those involved in the task including staff members, patients, students etc. People sharing the workplace (facilities staff etc.) must also be considered and it is important to think about how the work affects others present. In each case identify how they might be harmed, i.e. what type of injury or ill health might occur, examples could include:

- nursing staff who may suffer from a back injury due to practicing poor lifting techniques;
- visitors, other patients, nursing, clinical or facilities staff could be infected with, for example, clostridium difficile.

6.3 To help in the assessment of risk it is important that there are appropriate policies, procedures, good practice standards and guidelines in place. They must be suitable and sufficient, up-to-date and used.

7. STEP THREE – EVALUATE AND CONTROL THE RISKS

7.1 Consider how likely it is that each hazard could cause harm. Assess the possible consequences and examine what controls are already in place and how the work is organised. Then compare this with the good practice and see if there is more you should be doing. Identifying new controls will not in itself reduce the risk, the controls must be implemented in order to reduce the risk. See section 7.4 on the Risk Domains and Scoring Matrix to see how to evaluate and score the risks in conjunction with Appendix 1 Risk Domains and Scoring Matrix.

7.2 Can you get rid of the risk altogether? Many risks can never be eliminated and, if prevention is not reasonably practicable,

consideration must be given as to how risks can be controlled or be made less likely. After introducing effective precautions and controls there may still be a certain amount of residual risk remaining.

7.3 It is important to remember that if an incident has already occurred then the controls are not working effectively and control mechanisms will need to be reviewed, tightened, and the risk assessment updated.

7.4 Risk Domains and Scoring Matrix - As part of the risk assessment process the risk must be allocated a risk score which can be obtained through using the Risk Domain and Scoring Matrix in Appendix 1.

7.5 The Risk Domain and Scoring Matrix domains are:

- Safety & Wellbeing – Patients/Staff/Public
- Quality/Complaints/Assurance/Patient Outcomes
- Workforce Organisational Development/Staffing/Competence
- Statutory Duty, Regulation, Mandatory Requirements
- Adverse Publicity or Reputation
- Business Objectives or Projects
- Financial Stability & Impact of Litigation
- Service/Business Interruption
- Environmental/Estate/Infrastructure
- Health Inequalities / Equity

Risk assessment is subjective, and it is suggested that if one or more risk domains apply that the one that features as the highest risk is used for the purposes of scoring the risk.

7.6 Risk Scoring - In order to effectively assess a risk, it is necessary to consider two factors: Consequence (Impact) and Likelihood.

CTMUHB uses a common form of risk scoring referred to as a 5x5 risk matrix. Consequence and Likelihood are assessed on a scale of 1 to 5, and then the two scores are multiplied to arrive at the final risk score (between 1 and 25 with 1 being the lowest).

The scoring is a very subjective process and so some guidance on what different likelihoods and impacts would look like is provided as detailed in Appendix 1 Risk Domain and Scoring Matrix.

It is important to remember that these descriptors are provided only as guidance and you should not attempt to be too scientific with your assessment.

There are three different scores to be arrived at in assessing any risk and entering the scoring on the Datix Risk Management Module.

1. Initial (Inherent) Risk Score - This is the risk, considered without taking account of any controls. Sometimes called the raw risk score, this is important as it shows the true severity of the risk should it ever be realised.
2. Current (Residual) Risk Score - This is the risk, considered with any existing controls taken into account. The current risk score will almost always be lower than the initial risk, and the important point is that the greater the difference between the two scores, the greater the reliance on the control environment.
3. Target Risk Score - This is the risk score that the Risk Owner, having decided to treat the risk, needs to be actively working towards. The target score is usually lower than the initial score and it must be accompanied by an action plan to achieve the target (Mitigating action that will be taken to reduce the risk).

7.7 Risk Treatment and Risk Decision Making - There are four options when deciding how to treat a risk and this is known as the 4T approach to risk decision-making.

1. Terminate - This is where the activity that could lead to the risk being realised is itself terminated so that the risk can no longer occur.
2. Transfer - This is where a third party, usually on the payment of a premium agrees to take on the risk on your behalf. The most common form of risk transference is in insurance, whereby we pay insurance companies a premium to accept (usually a financial) risk on our behalf. This is a rare form of operational risk treatment and so anyone considering this as an option should contact the Strategic Risk Lead for advice.
3. Tolerate - This is where the risk has been assessed and the Risk Owner has determined that the risk is acceptable – in other words it is within our risk appetite. Once this decision has been taken, although the risk should be kept under regular review, there would not normally be any requirement for an action plan.
4. Treat - This is where the risk has been assessed and the Risk Owner has determined that it still presents an unacceptable level of exposure and so needs further treatment. Treatment may be in

the form of investment in resources, contingency planning or any other action that may help to reduce the risk further.

7.8 Controls and Assurances

A control is something which is actively working to control a risk. For a control to be valid it must be:

- Actively working at the time (i.e. not planned for some future date)
- Something which is actually within our control

The whole network of controls for a particular risk is called the risk's 'control environment.'

An assurance on the other hand is something which provides evidence that a control is effective.

7.9 Controlling the risk - There are many techniques for controlling risk, many of which require little or no financial outlay. They are:

- physical controls, for example where equipment, materials, drugs and dangerous or valuable items can be locked away;
- system controls which may involve restricting access to hazardous areas, recording attendance of staff at manual handling courses, ensuring that staff are trained and comply with set policies and procedures.

7.10 When considering the cost of a risk, it is important that one does not simply consider the direct financial impact of loss of, or damage to, property or personal injury. There may be other expenses involved, such as hiring temporary staff, or the effect of the untoward incident on staffing levels. Neither should the consequences of the event or activity throughout the rest of the organisation be overlooked, for example a fire in the kitchen not only affects provision of meals to patients and staff, but also may impact on income generation activity.

7.11 Putting controls in place need not be expensive. For example, placing a mirror on a dangerous blind corner to help prevent vehicle accidents is a low-cost precaution considering the risks. Failure to take simple precautions can cost you a lot more if an accident does happen.

7.12 Hierarchy of Control - The law requires you to do everything reasonably practicable to protect people from harm. Whenever possible the risk should be avoided altogether, otherwise all practical

steps must be taken to minimise identified dangers by applying the principles below:

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- Elimination by changing the process or activity;
- Reduce by substituting with something less hazardous;
- Isolate through enclosure or automation or prevent access to the hazard by guarding or segregation of people;
- Control - safe system of work that reduces the risk to an acceptable level, written procedures that are known, understood, followed and regularly updated;
- Personal protective equipment or clothing which must be used as a last resort when no other precautions are available;
- Discipline if the above are not followed this could result in the Health Board disciplinary procedures being evoked.

7.13 Risk assessments can also identify where health surveillance is required. Where there is a likelihood that a disease or condition may occur as a result of the work, health surveillance will improve the protection and the health of employees. Occupational Health and Wellbeing Department should be involved to provide advice and support.

7.14 It is important to involve colleagues in the process so that you can be sure that what you propose to do will work in practice and will not introduce any new hazards.

8 STEP FOUR – RECORD THE FINDINGS AND IMPLEMENT THEM

8.1 The next stage is to complete a risk assessment. The Datix Risk Management module is the system mandated for use in the Health Board for recording risk assessments. If you do not have readily available access to Datix when completing the risk assessment then the paper copy of the risk assessment form can be used for the purposes of initial assessment, However, the risk must be entered onto the Datix System within 5 working days.

8.2 Risks can only be added by colleagues who have received training and who are authorised to access the system. It is important that all information on the completed Risk Assessment Forms is transferred onto the Datix Risk module and not stored separately in electronic or paper form. The reason for this requirement is that the information

to inform reports and/or escalation will be extracted from Datix and therefore information must be available via the system.

8.3 Utilising Datix also allows for triangulation and theming of risk with incidents, claims and complaints and for the identification of themes to support lessons learned within the Health Board.

8.4 When completing the risk assessment it must be suitable and sufficient, but also straightforward enough for everybody to understand. You need to be able to show that:

- a thorough review was made;
- you dealt with all the obvious significant risks taking into account the number of people who could be involved;
- the precautions are reasonable;
- the solutions are realistic, sustainable and effective.
- you have considered whether the risk is one which could be wider than your area e.g. impacting all acute sites within the Health Board, and whether appropriate calibration has been applied and the risk rating accurately reflects a risk that may have a wider impact. This will ensure that a consistent approach for the organisation is applied.

8.5 When writing the risk description the following format of "If, Then, Resulting In" should be used, for example:

- If: the Health Board fails to recruit sufficient medical and dental staff.
- Then: the Health Board's ability to provide high quality care may be reduced.
- Resulting In: a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may also impact patient safety and experience and staff wellbeing and experience.

Articulating the risk descriptor in this way will support those not in your specific service area with an understanding of the risk. Supporting documentation such as Safe Systems of Work, reports etc can be added to the risk record in Datix to further support the risk assessment and controls. Risks escalated to the Organisational Risk Register are also published in the public domain and therefore its important risks can be understood by the lay person.

8.6 It is essential that appropriate control measures are in place and maintained. It is therefore necessary to record all significant findings of a risk assessment.

8.7 It is important that the risk assessment is:

- implemented within each ward, department, service group, central function and/or Care Group;
- brought to the attention of staff who are affected by this;
- updated when any change occurs.

8.8 Whilst the recording of the risk assessment is an important legal requirement, it is equally as important that the mitigating actions /recommendations for improvement identified during the assessment are continually monitored and reviewed through to implementation. It should be noted that risk assessments could be requested in support of litigation challenge such as Personal Injury claims, therefore ensuring risks assessments are clear, appropriate and robust is vitally important not only for this purpose but also to ensure all colleagues involved in the activity understand the risks and control measures that need to be adhered to.

8.9 Risk Acton Planning - Risk action planning is no different to any other form of action planning and there are clear advantages to using the tried and tested SMART process for developing an action plan.

S - Specific
M - Measureable A
- Achievable
R - Relevant T
– Timescale

8.10 This system is adequately detailed in management training and so no further explanation is provided here, except to say that in this context 'Relevant' must mean that the action once complete (either on its own or in conjunction with other actions) will have some effect on the control environment.

8.11 Action Plans must be entered into the Datix Risk Module in the action module in order for the mitigating action to reduce the risk to be captured and provide assurance as to the measures being taken to reach the target risk score.

9 STEP FIVE - MONITOR, REVIEW AND FEEDBACK

9.1 It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review~~ing~~. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

9.2 All findings must be recorded and retained and staff must be informed of the findings.

9.3 Control measures can be monitored by:

- routine inspection of control measures;
- ensuring correct use of control measures;
- ensuring full implementation of systems and policies;
- ensuring staff are fully aware of risks;
- monitoring to measure performance;
- reviewing incident statistics;
- undertaking regular environmental safety inspections, clinical audits and quality audits;
- implementing appropriate training programmes.

9.3 The Executive Leadership Group and Board Committee(s) will review and scrutinise risks graded 15 and above all those that are novel and contentious. Please refer to Appendix 4 Service to Board escalation reporting.

9.4 Local Groups within Central Support Functions or Care Groups will have a monitoring role and will periodically:

- review the risk assessment reports;

- review and monitor the risk register;
- call for a review of working practices;
- examine the training system and records.

10.0 DOCUMENTATION

10.1 The documentation required for reporting and how to access the Datix system for completing a risk assessment can be located on the intranet, under Risk Assessment or Click Here.

11.0 COMPLETED RISK ASSESSMENTS

11.1 Following completion of the risk assessment, all staff in the area must be informed of the outcome of the risk assessment and must know what their responsibilities are as a result.

11.2 Risk assessments which are specific to an individual patient must be included in their care plan and will not form part of the risk assessment database.

11.3 Once the controls have been implemented the action plan must be updated and the risk score reviewed. If new systems or controls cannot be implemented until a later date, for example new equipment purchased, the original risk score may stay the same.

11.4 For timescales in relation to the retention of risk assessments please refer to CTMUHB's Records Management Policy / Retention Schedule.

11.5 When a risk assessment is entered and/or updated on the Datix Risk Module please use the "Progress Notes" section to record any changes or updates including the rationale for amending risk scores. A record of the changes is automatically generated so that an audit trail can be made of all amendments. For risk assessments which were undertaken prior to the introduction of the risk assessment database the electronic or paper copy must be kept for the time specified.

12.0 RISK REGISTER

12.1 This is the final part of the process, in which once approved and agreed for escalation the risk appears on the appropriate risk register in order that it can be managed at the appropriate level. When risk assessments are entered into Datix a risk register can be generated. When a risk assessment has been reviewed the risk register will be updated. There are specific report templates which have been set up

depending on which department, ward, group or committee require the information.

12.2 Where Care Groups and Central functions consider that a risk requires escalating to the Organisational Risk Register (i.e. risks scoring 15 and above or which are novel and/or contentious) these must be escalated via the mechanism in the Datix Risk Module so that the Assistant Director of Governance & Risk is notified as the lead for co- ordinating the submission of the Organisational Risk Register to the Executive Team meetings and Board Committees as appropriate.

13.0 TRAINING

13.1 It is essential to ensure all staff involved in undertaking risk assessments receive the appropriate training. For available training please use the 'contact us' section on the risk intranet page: Risk Assessment - Contact Info.

14.0 RESPONSIBILITIES

14.1 Responsibility for ensuring that CTMUHB has a risk assessment system lies with the Chief Executive, who delegates responsibility to the Executive Lead for this area. The responsibilities of the Chief Executive, Directors, Managers and Employees are as those set out in the Risk Management Policy, Risk Management Strategy and Health and Safety Policy.

15.0 NON-CONFORMANCE

15.1 There is a requirement of all designated staff to comply with the provisions of this Procedure and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate People Services policy.

16.0 EQUALITY IMPACT ASSESSMENT STATEMENT

16.1 This Procedure has been subject to a full equality assessment and no impact has been identified.

16.2 Advice and guidance should be sort from the Equality Team prior to implementing any risk management measures that could have a potential impact on equality.

17.0 RESEARCH

- Bateman, Mike. *Tolley's Practical Risk Assessment Handbook*. Elsevier. 2006.
- Cardiff and Vale University Health Board. *Risk Assessment and Risk Register Procedure.* 2011.
- Health and Safety Executive. *Five Steps to Risk Assessment.* 2006.
- Health and Executive. *Health and Safety at Work etc. Act 1974.*
- Health and Safety Executive. *Management of Health and Safety at Work Regulations 1999. Approved Code of Practice and guidance* L21 HSE Books 2000.
- Health and Safety Executive. *Successful Health and Safety Management HSG65*. HSE Books. 1998.
- National Patient Safety Agency. *A Risk Matrix for Risk Managers*. 2008.
- National Patient Safety Agency. *Healthcare Risk Assessment made easy.* 2007.

APPENDIX 1 - RISK DOMAINS & SCORING MATRIX

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	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.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of sever key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

1-6	Low	This type of risk is considered low and should be reviewed and progress on actions updated at least every six months.
8-12	Moderate	This type of risk is considered moderate and should be reviewed and progress on actions updated at least quarterly
15-25	High	This type of risk is considered high and should be reviewed and progress on actions updated, at least every two months. If scored 20 or above the risk should be reviewed on a monthly basis.

19.0 APPENDIX 2 – RISK IDENTIFICATION FORM

RISK IDENTIFICATION FORM	
Clinical Service Group / Department / Function	
Specific Location – i.e. site, ward, department	

C = Consequence L = Likelihood R/S = Risk Score – C x L

Task / Activity / Clinical Procedure including hazards / risks (more than one task can be entered in this section)	If risk score is 8 or more, then a full risk assessment is required					
	C	L	R/S	Comments / Justification of Score	Date Assessed	Lead Assessor(s)

This document should be reviewed following a change in working practice or procedure; an incident; a change in legislation; when a new risk has been identified.

20.0 APPENDIX 3 – RISK ASSESSMENT FORM (THIS DOES NOT REPLACE THE NEED TO ADD RISKS TO DATIX)

RISK ASSESSMENT FORM	
SERVICE GROUP	
SPECIALITY	
SUB- SPECIALITY	
CARE GROUP / CENTRAL FUNCTION	
HOSPITAL / SITE	
LOCATION EXACT (Ward, Department etc)	
LINKED TO ANY OF THE FOLLOWING (Claim, Complaint, Incident, Inquest, Redress or Safety Alert)	
RISK DOMAIN – (See Appendix 1 Risk Domain Matrix and Scoring)	
RISK TYPE (Organisational, Clinical, Fire or Health and Safety)	

RISK CATEGORY (e.g. patient injury, patient handling, Security, etc)	
ACTIVITY / TASK / CLINICAL PROCEDURE (Complete the relevant details of the activity being assessed)	
DESCRIPTION OF HAZARD / RISK (Describe the hazard / risk and the nature of any injury or loss that might arise from it) Please use the 'If, Then, Resulting In' format.	
THOSE AT RISK	Staff ☐ Patients ☐ Visitors ☐ Young Persons / Work Experience ☐ Contractors ☐ Other ☐ (Please state)

WHAT IS THE INITIAL RISK SCORE *(This is the risk, considered without taking account of any controls. Sometimes called the raw risk score, this is important as it shows the true severity of the risk should it ever be realised)*					
Consequence - C	Please select	**Likelihood - L**	Please select	**Risk Score and Colour**	Please select

CURRENT CONTROL MEASURES IN PLACE: (What is currently being done to reduce the risk of the hazard giving rise to loss or injury)

WITH THESE <u>CURRENT</u> CONTROL MEASURES THE LEVELS OF RISK ARE: *(This is the risk, considered with any existing controls taken into account. The current risk score will almost always be lower than the initial risk, and the important point is that the greater the difference between the two scores, the greater the reliance on the control environment)*					
Consequence - C (table 1)	Please select	**Likelihood - L** (table 2)	Please select	**Risk Score and Colour** (table 3)	Please select

Mitigating Action Plan (List further action needed to adequately control hazards / risks)				
No.	**Action(s) Required**	**By Whom?**	**By When?**	**Cost** (State actual or estimated)

WITH THE ABOVE CONTROLS, THE <u>TARGET</u> LEVELS OF RISK WILL BE: *(This is the risk score that the Risk Owner, having decided to treat the risk, needs to be actively working towards. The target score is usually lower than the initial score and it must be accompanied by an action plan to achieve the target (Mitigating action that will be taken to reduce the risk).*					
Consequence - C	Please select	**Likelihood - L**	Please select	**Risk Score and Colour**	Please select

Assessor(s)			
Date of Assessment		**Date for Review***	

* Dependent upon initial risk score

THIS SECTION TO BE COMPLETED BY DESIGNATED MANAGER / CLINICAL LEAD			
Does this risk require capital funding?		**Yes** ☐ **NO** ☐	
Does this risk require escalation to the next senior level?		**Yes** ☐ **NO** ☐	
Approval Status *(If Assessor/Reporter Only please choose "Awaiting Review". If Manager of risk please choose "Risk Approved")*			
Strategic Risk Owner (a member of the Executive Director leadership Team)			
Strategic Goal (Improving Care, Creating Health, Inspiring People, Sustaining Our Future)			
Is this risk to be escalated for consideration for adding to the organisational risk register (i.e. score of over 15)? **Only to be completed by Function Heads and agreed with Strategic Risk Lead **			
Comments / feedback to risk assessor:			
Name		**Date**	

21.0 APPENDIX 4 – RISK MANAGEMENT PROCESS – SERVICE TO BOARD ESCALATION

Service to Board Risk Escalation in CTMUHB

This process should be read in conjunction with the Risk Assessment Procedure available here: Risk Assessment Procedure.docx

Further tools and support for undertaking risk assessments is available on the dedicated Risk page on SharePoint available here: Risk Assessment - Undertaking Risk Assessments.

Training on risk is available to book on ESR please search for course: 110 Risk Management Strategy and Risk Assessment and Training Awareness.

A step-by-step guide for completing a risk assessment on the Datix Web Module is available here: Risk Assessment - Undertaking Risk Assessments – "DatixRiskWeb User Guide V6".

The Risk Scoring & Domain Matrix is a key reference point when scoring risks and is available in the Risk Assessment Procedure

1. Risk Assessment

Risk identified and a risk assessment needs to be undertaken.

A risk assessment should be completed directly into the Datix Risk Web Module or via completing a hard copy of the risk assessment form to upload to Datix Web Module following completion.

2. Risks scored with a risk score of between 1 and 6 (Low) and 8 and 10 (Moderate)

Any risks identified and evaluated as having a low/moderate rating, can be managed locally within the relevant area i.e., local/Directorate level risk register.

These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed, and become controls under business as usual. These risks are recorded locally in the local/Directorate risk register within each service area/department.

All risks should be reviewed and updated as per the frequency captured in the Risk Assessment Procedure and Risk Scoring and Domain Matrix.

Escalation via Care Group / Central Directorate Senior Team is not required unless there is a novel or contentious matter that should have visibility or further input, or support is needed.

Risk scored with a risk score of 12 (Moderate)

Risks identified as having a moderate rating i.e., a score of 12 are managed at a local level but should also be escalated to Care Group / Central Directorate Senior Team for visibility and review.

Risk owners should also add a note to the "Escalation Status" in the Datix Web Module indicating where in the process the risk is i.e. escalated and to be considered by the Care Group Senior Leadership Team.

The review at the escalated level should be undertaken on at least a quarterly basis.

The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings, Health, Safety & Fire meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

Risk scored with a risk score of 15 and above and/or is novel and contentious

Risks identified as having a high rating i.e. a score of 15 and above and/or is novel and contentious, will still be managed in the service/area for which they were identified, however they should be escalated immediately to a Care Group / Central Directorate level.

High level risks should be monitored at least monthly if scored 20 and above or bi-monthly if 15 and above. The forums for which these risks are monitored will be at the discretion of the Care Group / Central Directorate, although it is suggested that this is undertaken via the QSRE meetings or equivalent in Care Groups and Governance Meetings, at a Central/Corporate Directorate Level.

Once escalated, it will be for the Care Group Senior Team / Central Corporate Director to consider if the risk should also be escalated to the Organisational Risk Register, managed via the Assistant Director of Governance & Risk.

If the Care Group/Central Director consider that this risk should be escalated to the Organisational Risk Register, it will do so as follows:

- Include in highlight report / update report to the next Operational Management Board meeting which meets monthly;
- Once the Operational Management Board have reviewed the risk and support escalation the "Yes to escalate" in the Datix Web Module, the box should be ticked which will generate a notification to the Assistant Director of Governance & Risk; and
- Risk owners should also add a note to the "Escalation Status" in the Datix Web Module, indicating where in the process the risk is i.e. escalated and to be considered at Operational Management Board on (date). Once approved for escalation, the date it was escalated to the Organisational Risk Register should also be captured in this box.

The risk should continue to be reviewed by the area for which it has been identified and in addition on a bi-monthly basis updates for the Organisational Risk Register will be requested.

Once escalated to the Organisational Risk Register, these risks will be reviewed at Public Board Committees, where assurance as to the robust monitoring and review will be sought.

De-escalation of Risks from the Organisational Risk Register

If because of successful mitigation, a risk score can be reduced below the threshold for escalation, "Datix Web Module escalation status" should be updated, as well as the rationale for risk score changes. This demonstrates robust and proactive management.

Endorsed by the Operational Management Board on the 2nd October 2024

Approved by the Executive Leadership Group on the 7th October 2024

Agenda Item
5.5.1

CTM Health Board

Highlight Report from the Strategic Development Committee

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Dilys Jouvenat, Independent Member (Chair of Committee on this occasion)
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Victoria Oxley, Interim 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
(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 Strategic Development Committee at its meeting on 3 April 2025.

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

2. Purpose of this Meeting

2.1 In summary, the purpose of the Strategic Development Committee is to:

- Provide 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.

- Provide 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.

- 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.

3. Highlight Report

Alert / Escalate	Positive Escalation The Committee congratulated the team on the significant amount of work undertaken on the Starting Well and Growing Well Strategy evidenced through the update provided and recognised how CTMUHB is the first area in Wales to explore the baby and toddler voice and many other areas cited in the update.

Advise	Strategy Group Deep Dives: *Starting Well and Growing Well Strategy* – the committee welcomed the wider understanding provided through the update and noted that the future work will also articulate the evidence base and impact of the activity being driven forward highlighting how the investments now support longer term benefits for the future. In terms of *Building Healthier Communities,* the Committee were excited to learn how '3 communities' - chosen as testbeds to experiment with how we change CTMUHB's relationship with local people. The '3 communities' project forms part of the 'CTM Offer' where CTMUHB have started to listen differently to CTM communities and to learn from and with them. Financial Update - The Committee noted the position as reported at the Board on the 27 March 2025, remained unchanged in terms of the financial position and the financial plans articulated in the Integrated Medium-Term Plan. Integrated Medium Term Plan (IMTP) - The Committee noted that the IMTP was submitted on the 31 March 2025, with the caveat that the MDS section followed a little after the deadline date. An acknowledgement of the submission has been received by Welsh Government and a formal response is now awaited. Wellbeing of Future Generations Act (WBFGA) Statement and Objectives – The Committee welcomed the detailed update and endorsed an additional Wellbeing Objective on the commitment to embed the Welsh Language for onward approval by the Board.
Assure	Acute Clinical Services Plan (ACSP) – Programme Update The Committee welcomed an ACSP presentation presented by the new Programme Director for the ACSP outlining the Governance Framework Structure at a glance and highlighting the 7 core workstreams of the programme. The Committee endorsed the Governance Structure and the scope of the Terms of Reference for the ACSP Programme Board. Staff Survey and People Plan - The Committee received a detailed update on the development of the People Plan and how the feedback from the Staff Survery will be a golden thread into the drafting of the People Plan. The approach of co-development and co-production with staff provided assurance to the Committee as to how staff feedback will be addressed as well as

	using appreciative enquiry as a key tool. The themes were explored briefly with the Committee as well as the engagement and timelines leading to a People Plan being established. Digital and Data – Delivery Roadmap - An overview of the CTMUHB Digital and Data Roadmap over the next 5 years was provided to the Committee. Attention was drawn to the interdependencies, complexities, risks and key success factors. The importance of connecting all strategic development activity / change programmes was recognised as critical to the sucessful delivery and transformation of services. The Committee asked that where risks around interdependencies with providers impact the delivery roadmap significantly that these be escalated through the relevant Programme Board Risk Log, Board Assurance Framework (Digital Strategic Risk) and the highlight report from the Committee to the Board.
Inform	Public Services Board (PSB) Update - The February PSB update was noted drawing attention to the specific areas of the workstreams being driven forward. The summary statement commented that there will be a focus on leadership for climate adaption at the next PSB. Ongoing work to embed the findings from the review in terms of engagement with strategic partnerships and formalising structures of our workstreams was also recognised. Area Planning Board (APB) Update - The March 2025 Area Planning Board update was received with a focus upon substance misuse. The significant amount of work underway was recognised and the Committee requested further refinement of the updates in future in terms of focus and outputs. Closed Session Item due to Business Sensitivities – Regional Partnership Board - Regional Integration Fund (RIF) – The Committee received an update on the funding allocation and application of the RIF and how the budget supports a wide range of ongoing and new initiatives focused on driving integration and delivering sustainable improvements in health and social care across the region.
Appendices	Nil

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Sustaining Our Future
	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	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))*	Effective If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine 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 due to the nature / purpose of this Highlight Report.
Cydraddoldeb a'r Gymraeg	Yes: ☐	No: ☒

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?*	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 due to the nature / purpose of this Highlight 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)	
	There are areas of the updates within the Highlight Report which refer to financial / resource challenges.	

5. Recommendation

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

Agenda Item
5.5.2

CTM Health Board

Highlight Report from the Quality, Safety & Experience Committee

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Watts, Director of Corporate Governance/Board Secretary
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 & Experience Committee at its meeting on 25 March 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the Quality, Safety & Experience 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	Stroke Unit Temporary Centralisation – The Committee received a detailed presentation on the temporary centralisation of the Stroke Unit at the Royal Glamorgan Hospital. This included details of workforce challenges, environmental issues and on-going improvements: 1. Workforce Challenges: o The relocation of the nursing team from Prince Charles Hospital (PCH) to Royal Glamorgan Hospital (RGH) was difficult due to life complexities and transport challenges1. o Despite multiple engagements and wellbeing support, 31 out of 34 staff applied for lateral transfers or posts within the first few weeks. o The environment at RGH was different from PCH, which posed challenges for the team1.

- Shift harmonization and different processes and approaches were also challenging.

2. Environmental Challenges:
   - The bathrooms at RGH were less user-friendly and spacious for stroke patients.
   - There were fewer cubicles on the ward.
   - Environmental audits and feedback led to some quick improvements, such as assessments in bathrooms and ordering privacy and dignity rails.
   - Medium-term improvements included exploring capital works to create larger bathroom spaces.
3. Improvement Cycles:
   - Structured huddle formats were implemented to support the team.
   - Therapy prioritisation increased the number of patients sitting out across the unit.
   - Standardised handovers and visiting times were established.
   - Ongoing challenges around patient flow and bed allocation were addressed through improvement cycles.
4. Ward Integration:
   - The PCH team would be repatriated to their base site on April 14th.
   - An acute rehab team from Ysbyty George Thomas will support the stroke unit at RGH1.
   - Ongoing support and training will be provided to the new team1.
5. Monitoring and Evaluation:
   - Quality and safety monitoring showed no significant concerns in terms of harm levels.
   - A quality dashboard for stroke was built for regular visual updates1.
   - Patient experience feedback was growing, with positive feedback from patients and relatives.

The Committee also expressed some concern that there may be cases of inequity between the three local authority areas of CTM due to the differences in provision around community beds and stroke rehabilitation. The Committee was reassured by the Executive that the Allied Health Professionals Service is currently looking at the whole stroke pathway and where resources are committed so that the health board can manage and address any inequities that exist.

	It was agreed that an update report on progress on addressing these challenges would be presented at a future committee meeting. Diagnostics, Therapies, Pharmacy & Sciences Care Group Highlight Report Reference was made to a patient complaint that was received in relation to the new weight management drug. The Health Board is trying to manage a group of patients within our population and advised that the new drugs in this area need to be supported by people with expertise with a strong shared decision management tool and behaviour change model as opposed to the drug being easily accessed through primary care. The Committee suggested that they felt uneasy with the current position particularly as this has wider implications for the population. The Director of Public Health had heard anecdotally that some patients were ordering this drug via high street pharmacies privately, with no screening process in place to manage this, which was concerning given the long-term implications of this drug were not yet known. The Committee supported the approach being taken in Wales in ensuring that specialist input was being put into place for this drug but this needs to be closely monitored. Maternity Incidents at Princess of Wales Hospital The Committee received a report on a cluster of maternity incidents that had occurred at POWH. The Committee held a detailed discussion and noted that immediate make safes had been put into place with learning identified, which had led to some immediate changes being implemented. Given its nature this matter would be escalated to Public Board.
Advise	Clinical Governance Report: • It was agreed that the scoring of the Weight Management risk which had been proposed for reducing would be re-reviewed and return to its original scoring of 20. • Nursing Directorate - The need for additional leadership at RGH due to increased pressure following the POW moves was noted due to the extra pressures currently being faced on the RGH site. • Medical Directorate - Reference was also made to some high-profile coroner cases, in recent months. The Directorate are compiling responses to the coroner for the two section Regulation 28 that have been received. The Committee was reassured that it was process that was the

focus of the Regulation 28's. CTM continue to have a comparatively low mortality rate. Indeed, the fourth lowest in Wales. The other area of focus is the medical examiner service, and you probably have seen nationally that there is an issue here which is delaying the release of bodies to families and that clearly will cause some upset and distress. Some of that is due to the way the Medical Examiner Service works, and the health board is working with the Medical Examiners Service to try and make that as efficient as possible.

- There are some delays within the health board also which again the health board is working hard at and improving the communication between the services and within teams, which is hoped will result in fewer delays with the Medical Examiner Service.

Allied Health Professionals and Scientists

- In terms of learning and recommendations from coroners, inquests, teams have been supporting learning and implementation. Delivery of Psychological Services remains a challenge. There have been some innovative ways that the teams are working to try and address those backlogs, including group sessions, weekend delivery and intensive input. Also, the involvement of PROMS and PREMS so that the impact can be properly measured.

Children & Families Care Group Highlight Report

- The Committee noted the highlight report for this Care Group area, and it was agreed that additional narrative would accompany the data in future so the Committee could fully understand how the health board was performing in this area.

Unscheduled Care Group Highlight Report

- The Committee noted the positive updates regarding the move of the medical day unit and the significant improvements that had been made regarding incident management. Members also noted the positive experiences that had been achieved regarding the opening of two wards at Ysbyty George Thomas during the critical incident at the Princess of Wales Hospital. The bed base at YGT would soon be increasing to 58 and noted that

positive feedback was being received from patients and staff in regard to the ward and hospital environment.

Planned Care Group Highlight Report

- The Committee noted the details of the staff experience QR code that was created in Prince Charles Hospital in surgery, the senior nursing team there held a month of a QR code of what is it like working as a nurse in surgery in PCH. This is now being rolled out across all Planned Care as the health board wants to understand what it's like working in intensive care in which will help leadership and Organisational Development focus on the key areas. So they can identify and improve the experience.

Mental Health Care Group

- The Committee noted that whilst medical staffing remained a challenge for the care group, the care group director daily oversight of the position had now been stood down given that the system of monitoring, oversight and allocation of medical resource had significantly improved alongside a small reduction in vacancies. Members noted that the Directorate were now managing the oversight of their medical staffing issues and noted that at present the Care Group were not proposing to reduce the risk score as medical staffing challenges remained in place. The Committee were reminded that a Regulation 28 had been received regarding the Electronic Clinical Record and welcomed the update provided that work was progressing in relation to the procurement exercise. The Committee also welcomed the news that the In-Patient Improvement Board was being stood down because of the progress made and the sustained changes that were being seen, which had been recognised by Healthcare Inspectorate Wales in further inspections.

Primary Care Group Update

- Reference was made to the Paediatric General Anaesthetic Dental Lists and the Committee sought clarity as to whether there was any indication as to when this would likely be resolved. The Committee was advised that an update on this would be included in the detailed report being presented to the May meeting of the Committee and added that at present an exact date for resolution could not be provided as the position was dependent on theatre list availability, which could then be impacted by other

factors such as major trauma. In response to a query as to whether the issues would take months or years to resolve, it was advised that it was most likely this would take years to resolve as opposed to months, given the numbers of patients currently awaiting treatment.

Diagnostics, Therapies, Pharmacy & Specialties

- Reference was made to the update provided within the alert section of the report regarding Allied Health Professionals and the concerns about the higher-than-average number of clinical incidents, which did not triangulate with the update provided as part of the presentation on stroke services, which implied that the number of incidents was on par with other areas. The Committee Chair requested further clarity on the discrepancies identified and asked for an update to be presented to the next meeting clarifying the position.

Patient, Safety, Quality and Experience Dashboard

- It was reported that the Duty of Candour is helping to identify matters that would have previously been reported as locally reportable incidents. An update on which will be given at the next meeting which identifies whether the locally reportable incidents were now being picked up via the Duty of Candour.

Coroners Inquests Case Activity and Lessons Learned

- The Committee sought clarity as to the reasons behind the increase in cases. The Committee was advised that the increase in cases was because of there being a significant backlog within the Coroner's office which meant that they had increased their capacity to address the backlog, which was then impacting on the workload of the Health Board's Claims and Inquests Team.

- Questions were asked about the rise in the number of Regulation 28s which had previously been rare. The Committee were advised that there was something around threshold. The Team RAG rates the cases and were often surprised when a Regulation 28 was received, which may not have been the case in previous years. It was also noted that the organisation was also stretched as a system, with care lapses regrettably being seen, resulting in incidents occurring. Members noted that the increase in inquests were also having an impact on the numbers of Regulation 28s being received. Receiving a Regulation 28 remains serious for the health board and executives recognise that they need to do all they can to prevent any future deaths.

	The Organisational Risk Register was received. Members noted the continued positive uptake of Risk Management Awareness training sessions. It was also agreed that the risk scoring for the Weight Management Service would be re-reviewed.
Assure	The Committee noted within the Clinical Executive Report • The Medical Directorate - highlighted the implementation of health pathways, where CTM are exceeding their targets. • Allied Health Professionals and Scientists -The expansion of the Merthyr Pippin service into the Rhondda and Taff Ely area was discussed with partners from over 100 organisations signing up to support that systems approach. A thematic spotlight presentation regarding Safe Care Partnership 2 and developing a Quality Management System was welcomed as it brought together a wide range of different strands of work. Committee • Shared Listening and Learning Story – A colleague shared a presentation which outlined her personal experience regarding care and treatment received at the Snowdrop Breast Centre. The positive feedback will be shared with the team at the Snowdrop Breast Centre.
Inform	In the Consent Agenda the following was approved: • Unconfirmed Minutes of the meeting held on 21 January 2025 • Unconfirmed Minutes of the In Committee meeting held on 21 January 2025 • Asbestos Management Plan • Water Safety Plan The following were noted • Non-Routine Committee Business (Forward Plan) • Committee Annual Cycle of Business 2025 • Healthcare Inspectorate Wales Improvement Plan Tracker Report
Appendices	Nil.

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))* / 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
5.5.3

CTM Health Board

Highlight Report from the (Operational Delivery Committee)

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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	Rachel Rowlands, Independent Member, (Chair of Operational Delivery Committee)
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
Not applicable.		

Acronyms / Glossary of Terms	
Nil.	

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Operational Delivery Committee at its meeting on 29 April 2025.

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

2. Purpose of this Meeting

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 The Committee ensures 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. Highlight Report

Alert / Escalate	Positive Escalation • The Committee commended the Digital and Data Directorate and wider Service Teams for the progress made, and their commitment to deliver the Bridgend Patient Administration System disaggregation. The open and transparent updates were welcomed as a robust source of assurance. • Positive to note the continued reduction in staff turnover at the end of March and the positive impact of the Lateral Move Scheme for registered nurses, midwives and healthcare support workers which mitigates the potential risk of them leaving the health board. • The Committee noted that the Navigation Hub maintained a high level of performance and will be used to implement a robust single point of access for urgent treatment pathways. The Committee were delighted to note that the hub has successfully recruited new GPs, with a waiting list of GPs wishing to work in the hub. Assurance was sought that

	GPs are not being drawn away from community practices but are often those who prefer a portfolio career.
Advise	• The Committee received a detailed overview of the current volume of live Employee Relations case work activity, Summarising the data analysis at quarter four and contextual narrative of an annual 2024 case review that was undertaken. Following the recommendation from the People Team the proposal for a new Employee Relations Dashboard, which would inlcude a clearer analysis of longer-term casework trends as well as early indicators from live cases, was supported. • The Workforce Metrics Report highlighted to the Committee the positive trajectory in terms of a reduction in staff turnover and the success of the Lateral Move Scheme. Areas of improvement were identified in terms of sickness absence rates, maintaining Performance and Development Review compliance and improving visibility and branding around recruitment activity. The Committee supported the work to improve and enhance the format and content captured within the workforce metrics report. • Finance Report - The Committee were advised of the summary financial position at Month 12, highlighting a £99k surplus (rounded to £100k) pre-audit, meeting the revenue control total set by Welsh Government. It was noted that CTMUHB achieved the three-year break-even position for capital. The significant increase in the capital resource, mostly transacted in the latter part of the year as slippage was highlighted to the Committee. • Financial Performance Report –the brought forward recurrent deficit impacting the current financial year, with an underlying position of £19.4 million deficit instead of the intended £2.1 million surplus was recognised. The Committee were assured that the areas of overspend are monitored through monthly finance performance reviews to address the challenging positions. • Estates Performance Report – The Committee were made aware of the key highlights and/or risks in relation to operational maintenance, challenges relating to retaining senior Estates Officers, national performance indicators and energy performance. The risk relating to high-risk backlog maintenance and the potential impact on strategic development plans was discussed by the Committee, recognising the impact a deteriorating estate can have in terms of service disruption and affecting patient care and

	operational delivery. It was noted that the future strategy will have an emphasis on securing capital resources and addressing high-risk areas, while balancing operational needs and compliance requirements.
Assure	• Digital and Data Delivery Report - The Director of Digital provided assurance to Members as to the success of the 'dry run' of the disaggregation of Bridgend Patient Administration System to transfer to the Welsh Patient Administration System. The Committee recognised the anticipated disruption to digital systems during the 'go live' weekend which is planned for 16th to the 19th May 2025, however, noted the learning from the 'dry run' and the controls in place to mitigate the risks. Further updates were also noted in relation to other Digital, National and Regional Systems which led to detailed discussion at the Committee. • The Committee received a summary of the progress in quarter four for the Integrated Medium-Term Plan (IMTP), which highlighted the positive delivery across several areas. The Committee welcomed the proposal to develop a new tabulated format for quarterly updates to improve accessibility and alignment to the Integrated Performance Dashboard. Attention was drawn to the enabling actions within the IMTP, which involves collaboration across the organisation to address areas such as six goals and planned care. It was noted that work is underway on how to represent these enabling actions without duplicating other areas and aims to align them with regular reports on individual programs, this approach was agreed by the Committee. • Integrated Performance Dashboard – The Committee received an update from the Chief Operating Officer which focussed on Urgent Care, Referral to Treatment Time, Diagnostics, Mental Health and Cancer performance trajectories. Following a question from a Member the Committee also recognised the challenges around vaccination uptake. • Six Goals Highlight Report- the Committee were provided with the performance context in relation to the improvement in unscheduled care despite the reduction of 75 beds due to the critical incident at the Princess of Wales Hospital Site. The Committee were pleased to note the key achievements highlighted in the update and were apprised of the priorities for the forthcoming year, recognising the associated risks and challenges.

	• Outpatient Activity Programme Update – An update on increasing productivity and efficiency in outpatient services was noted and the various strategies that formed the programme of activity were highlighted. The key areas of focus were noted along with the assurance on the monitoring and review which is through continuous review of Key Performance Indicators and speciality-specific plans to manage performance. • Primary Care and Community Services Update – An update on Paediatric Dental Services noted that that regular theatre lists will commence in May 2025 at Prince Charles Hospital. The capacity challenges in Specialist Care Dentistry under anaesthetic was discussed with the Committee noting the opportunities to explore vanguard theatres and optimising theatre provision at the Princess of Wales Hospital.
Inform	• The Committee welcomed the Head of Adult Speech and Language Therapy from the Diagnostics, Therapies, Pharmacy & Specialties Care Group to the meeting to share the fantastic engagement undertaken in Therapies to support the NHS 2024 Staff Survey, and the beneficial impact as a result. It was recognised that the reflections shared should be replicated by other Groups and Directorates in CTMUHB. • Private 'In' Committee Session A private Committee meeting was held to discuss the following business sensitive matters: o Organisational Risk Register – Cyber / Business Sensitive Risks o Capital Quarterly Update – An update on all current major capital projects as well as plans for the 2025-2026 discretionary programme.
Appendices	None 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	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))*	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))*	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:	If no, please include rationale below: Highlight report so 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: Highlight Report so 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)* /	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

5. Recommendation

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

Agenda Item
5.6

CTM Health Board

Spotlight Report
Update on cluster of incidents within maternity services at the Princess of Wales Hospital (March – May 2025)

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Director of Midwifery & Nursing, Children & Families Care Group Head of Midwifery & Neonates, Children & Families Care Group (Bridgend) Medical Director, Children & Families Care Group
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Head of Midwifery & Neonates, Children & Families Care Group (Merthyr & Cynon)
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 /Forum Individuals	Date	Outcome
Maternity and Neonatal Safety Board	20/03/2025	Approved
Quality, Safety & Experience Committee	25/03/2025	Approved
Children & Families Care Group Maternity & Neonatal	24/04/2025	Approved

Programme Board (Monitoring & Oversight)		
Quality, Safety & Experience Committee	20/05/2025	NOTED

Acronyms / Glossary of Terms	
BR+	Birthrate Plus (workforce acuity / staffing tool)
CTMUHB	Cwm Taf Morgannwg University Health Board
EWN	Early Warning Notification
MEWS	Maternity Early Warning Score
MNPB	Maternity & Neonatal Programme Board
MNSB	Maternity & Neonatal Safety Board
NRI	Nationally Reportable Incident
NEWTT 2	Newborn Early Warning Track & Trigger
PACE	Playfulness, Acceptance, Curiosity & Empathy (A trauma informed care approach)
PALS	Patient Advisory Liaison Service
PROMPT	Practical Obstetric Multi-Professional Training
QSE	Quality, Safety & Experience

1. Situation /Background

1.1 Three maternity nationally reportable incidents at the Princess of Wales Hospital Cwm Taf Morgannwg University Health Board (CTMUHB) occurred between 8th March and 13th March 2025.

1.2 A further nationally reportable incident occurred on 10th May 2025.

1.3 All incidents have occurred since the re-opening of the maternity unit on 17th February 2025.

1.4 All four cases are Nationally Reportable Incidents (NRI) and Early Warning Notifications (EWN) were submitted to Welsh Government on 14th March 2025, the fourth case was reported on 13th May 2025.

2. Specific Matters for Consideration

2.1 Staff de-brief and support for well-being in place.

2.2 Investigating Officers and Family Liaison Officers appointed.

2.3 Of the March incidents, two incidents are being investigated internally (multi-professional approach, external support requested to investigate one incident). The incident from 13th May will be externally reviewed.

2.4 A review of clinical outcomes across both obstetric units has been completed. The review found that outcomes across both units were broadly the same with the exception of major obstetric haemorrhage and increase in 3rd/4th degree tear in vaginal births – no themes identified within the review of cases.

2.5 Incidents and clinical outcome review presented at Maternity and Neonatal Safety Board on 20th March 2025; Quality, Safety and Experience Committee on 25th March 2025; Maternity and Neonatal Programme Board (oversight and assurance) on 24th April 2025.

2.6 A RAPID Multi professional review for incident number 4 took place on 12th May 2025.

2.7 Discussion with Care Group and Executive team held on 13th May to agree further action.

3. Key Risks / Matters for Escalation

3.1 Immediate make safes for all incidents have been completed.

3.2 Introduction of dedicated recovery area completed, standardising provision of care across both obstetric units.

3.3 Monitoring and compliance audits for fluid balance and MEWS (Maternity Early Warning Score) completed.

3.4 Hysterectomy equipment available in obstetric theatre environment during the temporary closure of the theatres at Princess of Wales Hospital.

3.5 Additional support and actions include:

3.5.1 Well-being service undertaking PACE review to support teams returning to PoW.

3.5.2 Handover times reviewed to align with Prince Charles Hospital.

3.5.3 '15 steps challenge' with service users undertaken in April, Patient Advisory Liaison Service (PALS) team undertaking unannounced visits.

3.5.4 Fortnightly partnership meetings in place with trade union colleagues

3.5.5 Midwifery workforce review commenced April 2025 across all sites to ensure Birthrate + safe staffing compliance.

3.5.6 Increased training and support for teams in line with the All Wales Incident Management Framework.

3.5.7 Launch of national MEWS and NEWTT 2 on 6th May 2025, working with critical care and resuscitation service colleagues.

3.5.8 Additional learning opportunities including emergency skills and drills underway. Multi-professional obstetric training (PROMPT) compliance at 82% in March 2025.

3.5.9 Multi-Disciplinary risk-assessed booking system introduced for elective caesarean sections and induction of labour.

3.5.10 Flow and acuity monitored via Birthrate Plus acuity tool, senior midwives attend wider site escalation meetings daily.

3.5.11 Team-building events planned for clinical leads and senior leaders within maternity and neonatal services in June 2025.

3.5.12 Support requested to ensure dedicated elective obstetric theatre cover (nursing, obstetric and anaesthetic) at Princess of Wales Hospital

3.5.13 Senior midwifery presence increased within maternity (intrapartum care).

3.5.14 Increased Clinical Director presence at Princess of Wales Hospital

3.5.15 External review of cases commenced.

3.5.16 Clinical Director and Head of Midwifery prospectively reviewing all elective activity to ensure safe, timely care is provided in the most appropriate setting.

3.5.17 Obstetric consultant attendance for all obstetric procedures (e.g. instrumental and caesarean section birth). To include a comprehensive review of the national trigger list and provide assurance around compliance.

3.6 Ongoing monitoring and review will be via the following activities:

3.6.1 Maternity and Neonatal Programme and Safety Boards continue to monitor performance and improvements.

3.6.2 Continue to work with national maternity and safety programme to ensure learning is adopted and embedded across all sites.

3.6.3 Continue to work with critical care / outreach teams to further enhance care of critically ill and deteriorating patients.

3.6.4 Ensure all investigations are progressed in accordance with the national incident management framework and learning is embedded across all service areas.

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: • Creating Health • Inspiring our 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
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: • Culture and Valuing People • Leadership • Learning, Improvement and Research • 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))*	Safe
	If more than one applies please list below: • Timely • Efficient • Equitable • Effective • Person Centred
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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. (At the time of writing)	
Enw da / Reputational	Yes (Include further detail below)	
	Trust and confidence could be impacted which may impact the reputation of the health board.	
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 improvements made and actions taken to date.

6. Next Steps

6.1 Ongoing monitoring and review will continue as outlined in section 3.6 of this report.

Agenda Item
6.1

CTM Health Board

Integrated Performance Dashboard

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open / Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jose Roper, Senior Performance Monitoring Officer
Cyflwynydd yr Adroddiad / Report Presenter	Victoria Oxley, Interim Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Victoria Oxley, Interim 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
Victoria Oxley	14/05/2025	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
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
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
LA	Local Authority
LD	Learning Disabilities
LPMHSS	Local Primary Mental Health Support Service
MMR	Measles, Mumps, Rubella
NOUS	Non Obstetric Ultra-Sound
PAC	Pre-operative Assessment Clinic
PADR	Personal Appraisal and Development Review
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
POW	Princess of Wales Hospital
PoCD	Pathway of Care Delays
PTHB	Powys Teaching Health Board
QIM	Quality Improvement Measures
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment Times
SBUHB	Swansea Bay University Health Board
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SCP	Single Cancer Pathway
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

During January 2025 the Welsh Government released the NHS Performance Framework for 2025/26, supporting the delivery of improvements in the Minister's areas of focus and is available to read at the following URL: [NHS Wales performance framework 2025 to 2026 | GOV.WALES]

There are minimal revisions to this years framework, compared to those set in 2024/25, as listed below:

	Performance Measure	Detail of Revision
5	% of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	Reporting Frequency: Dates revised to reflect 2025-26 reporting
6	% uptake of the influenza vaccination amongst adults aged 65 years and over	Reporting Frequency: Dates revised to reflect 2025-26 reporting
7	Reporting Frequency: Dates revised to reflect 2025-26 reporting.	Reporting Frequency: Dates revised to reflect 2025-26 reporting
13	% of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Target: Dates revised to reflect 2025-26 reporting
19	% of emergency responses to red calls arriving within (up to and including) 8 minutes	To note: this measurewill be subject to change following the review of the national ambulance target
37	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Target: Baseline updated to 2024-25
..	Number of patients waiting more than 52 weeks for referral to treatment	Removed

2. Specific Matters for Consideration

This report sets out the UHB's performance against the Welsh Government's performance framework and a small number of local priority measures such as ambulance red releases, lost hours and hip fracture recovery.

A one page summary 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 9 out of the 17 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

25 NRI's remain open >90 days ↓

This is a reduction of 2 on the previous period & the lowest level observed in the last 12 months

81.98 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 2.63% →

Compared to the equivalent period last year the rate was 2.51%

75.0% of complaints received a response within 30 days ↓

Compared to last month the rate was 85.7%

Population Health

As at Q3 2024/25 - 4.21% of adults who smoke made a quit attempt with predicted performance for 2024/25 being 5.61% →

Compared to the previous year, 5.65% of smokers made a quit attempt

Provisionally, 69.4% of adults aged 65+ received the influenza vaccine for the 2024/25 season →

The 2023/24 campaign saw a compliance rate of 72.2%

90.1% of children aged 5 were up to date with their vaccinations →

Compared to the previous quarter the rate was 89.2%

Operational Performance

66.3% of patients were seen within 4 hours from arrival at an Emergency Department →

Compared to last month compliance was 65.3%

100% of GP Practices have achieved in-hours access standards during 2023/24 →

The rate the previous year was also 100%

As at end of Dec 2024; 16 out of 24 KPI's for recovery from hip fracture are red i.e. scoring less than 75%
(please refer to page 17)

Provisionally 1,191 patients are waiting longer than 2 years for referral to treatment ↑

Compared to the previous period 856 patients had waited this length of time

60.7% of patients started their cancer treatment within 62 days →

This is the same rate as the previous month

People

6.89% of staff have been absent due to sickness during the 12 mth period (Apr 24 to Mar 25) →

Compared to the previous year the rate was 6.83%

The CTMUHB Nursing & Midwifery reported turnover rate for Dec 2024 is 4.94% ↓

Compared to Dec 2023 the rate was 8.30%

As at April 2025, 67.7% of staff have received their PADR →

Compared to April 2024 the rate was 66.4%

As at April 2025, 80.8% of staff have completed Level 1 mandatory training →

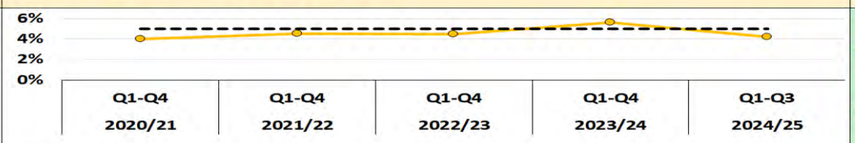
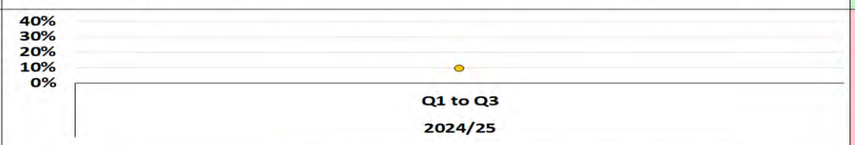
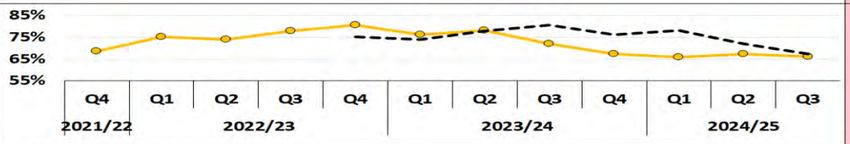
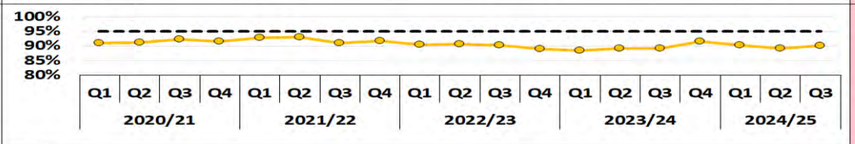
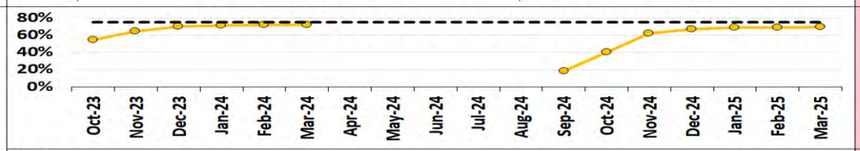
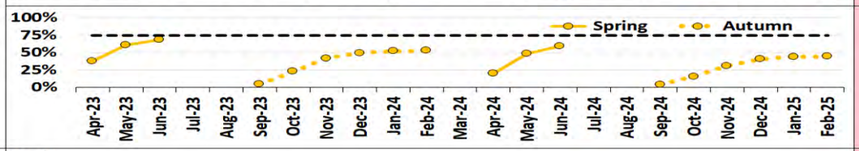
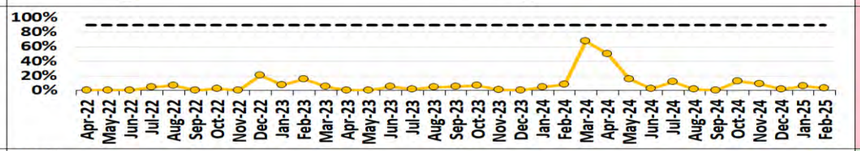
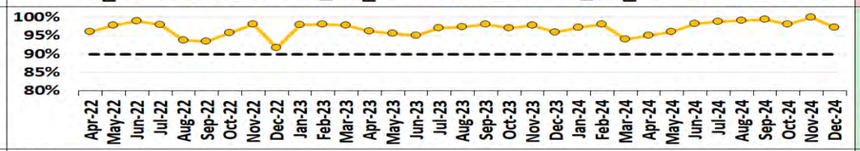
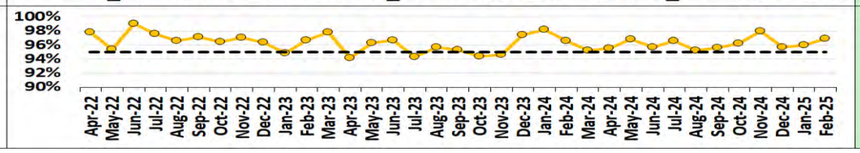
Compared to April 2024 the rate was 79.9%

Finance

The Month 12 YTD financial position is reporting a £0.1m underspend for 2024/25 ↓

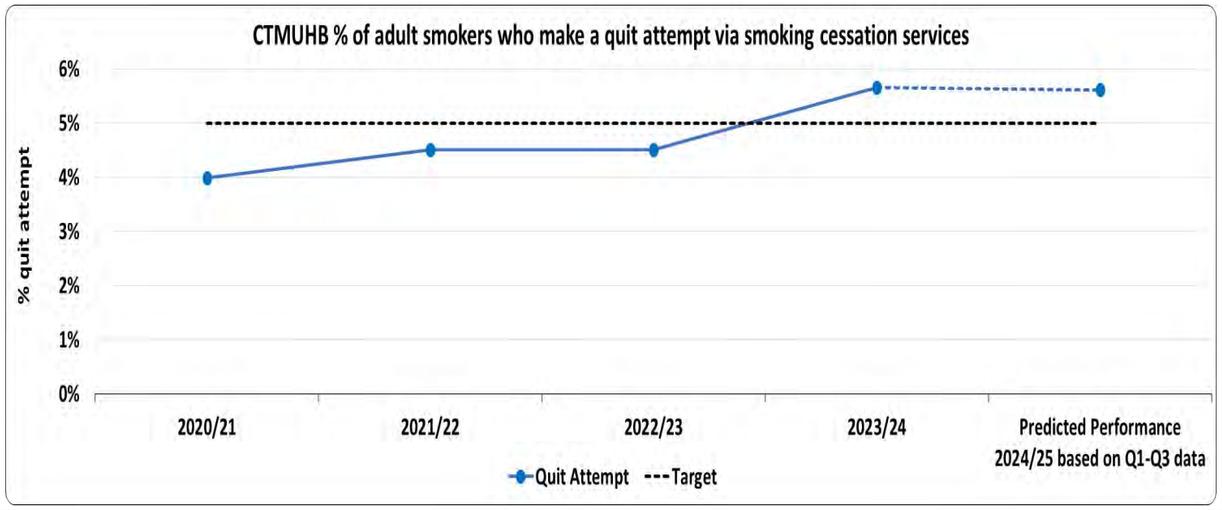
2.2 Welsh Government Performance Indicators: Quadruple Aim 1 - Improving Population Health & Wellbeing

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: Hit Target / Target Failed — Latest Position	
Prevention	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% Annual Target		4.21% on the basis of this extrapolation compliance should hit 5.61% at year end	Q1-Q3 2024/25
	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		9.30%	
	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		66.2%	Q3 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%		90.1%	Q3 2024/25
	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 *(applicable during 01.04.25-30.06.25 & 01.01.26-31.03.26)*	90%		79.3%	
	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over *(applicable during 01.09.25 - 31.03.26)*	75%		69.4%	as at 25th March 2025
	Percentage uptake of the COVID-19 vaccination for those eligible - Spring & Autumn booster 2025: All eligible people *(applicable 01.04.25 - 30.06.25 & 01.09.25 - 31.03.26)*			44.8%	Feb-25
	Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%		3.10%	Feb-25
	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%		97.2%	Dec-24
	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	95%		96.9%	Feb-25

CTMUHB Improving Population Health & Wellbeing

% of adult smokers who make a quit attempt via smoking cessation services – 5% Annual Target	% of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks – 40% Annual Target
To Quarter 3, 2024/25 = 4.21% (Predicted performance for 2024/25 = 5.61%)	Quarter 1 to Quarter 3, 2024/25 = 9.30%



CTMUHB		
Estimated number of smokers	Estimated % of CTMUHB population who are smokers	Estimated number of smokers needing to access smoking cessation to reach 5% of smokers
53,868	**14.7%**	**2,700**
Number of smokers treated by the smoking cessation service	Number of treated smokers followed up at their 4 week post quit date and who were CO-validated as successfully quitting during the quarter	
Q1 - Q3 2024/25		
2,268	**211**	
4.21%	**9.30%**	

What are the key challenges & actions in delivering smoking cessation targets?

Challenges:

Resource - Meeting the 5% target is a significant milestone for CTM, reflecting the hard work of the team. However, further progress against the target will be limited by capacity within smoking cessation services.

Achieving the national ambition of reaching 5% smoking prevalence by 2030 will require a reduction from nearly 54,000 to 18,000 smokers over the next 5 years – a reduction of two thirds which will require significant further resource. It should be noted however that reaching 5% smoking prevalence would yield significant improvements in population health with resultant reductions in Health Board activity.

CO validation of 4 week quits: It is proving very challenging to meet this new target and it is unlikely to be met in 2024/25. This is for a number of reasons, including:

- A large proportion of clients are receiving remote support via telephone rather than face to face and it is logistically very difficult to obtain CO readings (collected in person) in this situation.
- The majority of clients prefer a remote service and find it flexible and accessible.

It is also useful to note that other Health Boards are experiencing similar challenges in achieving the target.

(It should be noted that all clients are followed up at 4 weeks to assess their quit status and this is recorded as self-reported if CO validation cannot be undertaken. Consequently, taking this into consideration the overall quit rate for Q1 & Q2 2024/25 is 47%).

Actions:

A plan is being implemented to reduce smoking prevalence to 5% by 2030, including meeting the smoking cessation targets as a key outcome and this is accountable to the Creating Health Board. Presently, prevalence is c.14.7% with the all Wales rate being 12.8%. The plan includes actions to address the challenges as follows:

Resource -

- Continued support to increase the number of Community Pharmacies delivering smoking cessation & improve quit rates.

CO validation of 4 week quits:

- Self-reported and CO validated quit data is being collected locally to give a fuller picture.
- The Help Me Quit community service is piloting models of face to face and hybrid delivery in community venues to enable CO validation.
- Input to a national review of the Community Pharmacy smoking cessation service specifications and advocate for inclusion of routine CO validation when clients collect their pharmacotherapy which would enable the target to be met. This review is due to be completed in Q1 2025/26.

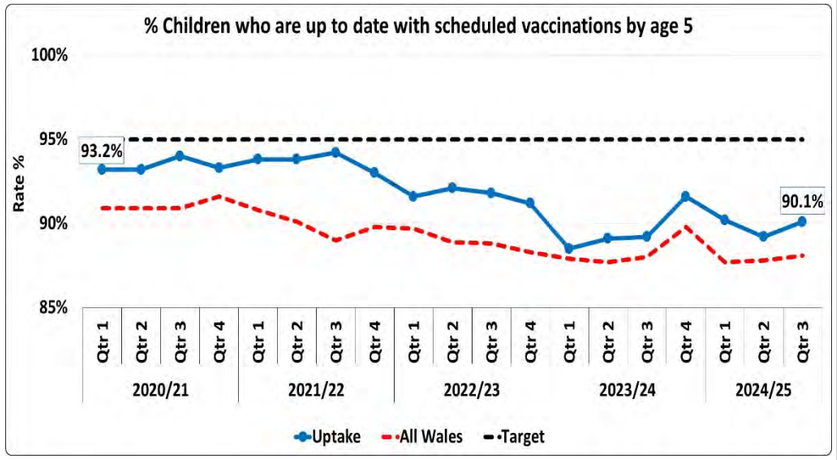
Other actions to develop and promote smoking cessation services include:

- Implementation of Help Me Quit (HMQ) in Hospital model, ensuring we support inpatients to stay smoke-free or initiate a quit attempt during their hospital stay.
- Ensuring all pregnant smokers are identified and offered support to quit with the Help Me Quit for Baby service.
- Implementing a communications plan to promote uptake of HMQ services.
- Increasing awareness and referrals from Primary Care, including a MECC pilot (Making Every Contact Count) with Optometry practices.

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 3 2024/25 Local Authority Uptake	
Merthyr Tydfil LA	85.6%
RCT LA	90.3%
Bridgend LA	91.8%
CTMUHB	90.1%

Quarter 3 2024/25 Welsh HB's Uptake	
ABUHB	87.1%
BCUHB	90.4%
C&VUHB	83.3%
CTMUHB	90.1%
HDUHB	90.4%
PTHB	91.6%
SBUHB	87.5%
All Wales	88.1%

What are the key challenges & actions in delivering vaccination targets?

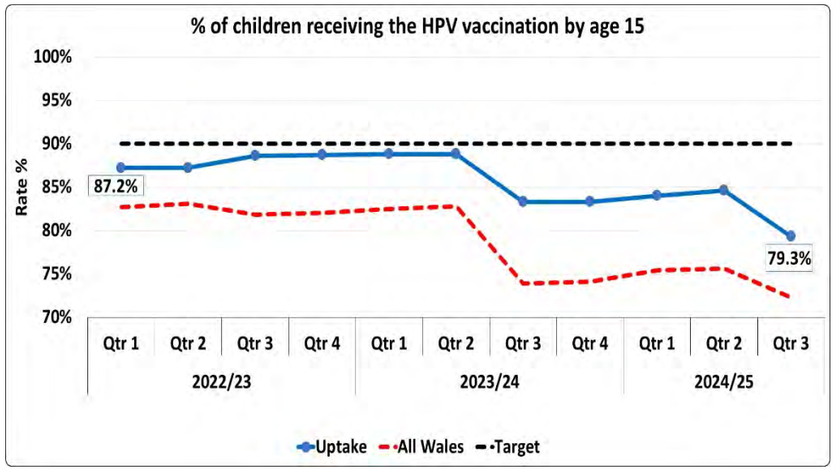
Challenges:

- Scheduled Immunisations – There are proposed changes to the schedule due to start July 25 and sharing the message of the changes will be challenging.
- MMR uptake – 95% uptake of 2 doses of MMR is needed to prevent transmission, smaller outbreaks of measles have been identified in Wales in the past 2 years.
- Influenza – challenges in delivering to 3 year old's attending LA nurseries in Merthyr & RCT areas. Combined uptake for 2 & 3 years old at the end of the season is 44.2%% (43.6% in 3 year olds which compares to 54.5% in 2023/24) year).
- Data systems – poor communication between data systems. Information between systems are still paper based and allow for human error in the transfer of data.
- Transition from Health Visiting to School Nursing – immunisation history and recall for any outstanding vaccines.

Actions:

- Scheduled immunisations – vaccinator out of season training to support schedule changes. Practice Nurse Forum and newsletter used to disseminate relevant information. National work to provide education and resources to support the proposed changes to the childhood schedule is underway.
- MMR uptake – uptake 1 dose at 2nd birthday 94.0% & 2 doses at 5th birthday is 91.6%; these are both higher than the Welsh average. Missing doses were offered during the fluenz mop up. Measles alert resources shared with practices.
- Influenza – planning for the delivery of fluenz to children who attend LA nurseries in Merthyr and RCT areas.
- Data systems – Work is ongoing at a national level to resolve this.
- Transition from Health Visiting to School Nursing - The ISSAC (Immunisation Standards for School Age Children) and VIS's (Vaccine Information Statements) standards are currently being reviewed by VPDP (Vaccine Preventable Disease Programme).

% 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 3 2024/25 Local Authority Uptake	
Merthyr Tydfil LA	76.1%
RCT LA	79.4%
Bridgend LA	80.2%
CTMUHB	79.3%

Quarter 3 2024/25 Welsh HB's Uptake	
ABUHB	66.1%
BCUHB	69.5%
C&VUHB	67.1%
CTMUHB	79.3%
HDUHB	73.5%
PTHB	76.5%
SBUHB	84.4%
All Wales	72.3%

What are the key challenges in delivering vaccination targets & actions to tackle

Challenges:

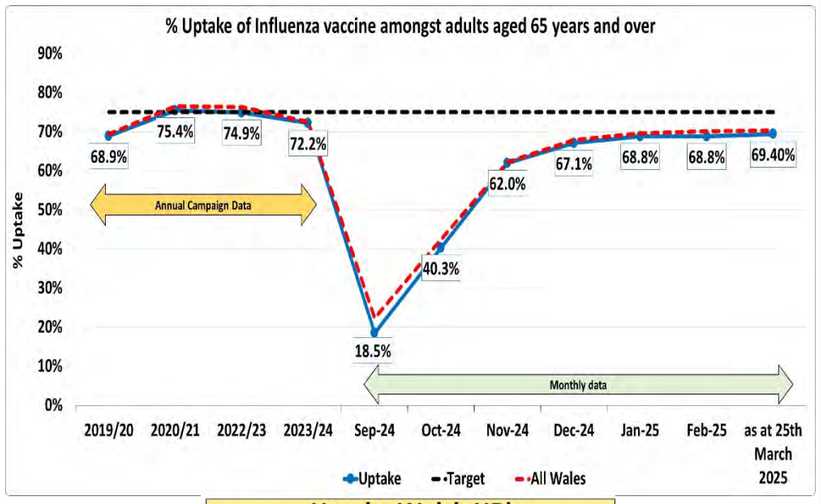
- Communication support - School Nursing Service continues to engage with schools and CTM comms. to utilise all social media platforms available. Staff deliver information to pupils in assemblies and are aiming to increase visibility at parents evening in secondary schools to raise the profile of all immunisations.
- Personal data accuracy (address, contact number, school attended) – Recent Fluenz and MMR catch up programme has further highlighted that a number of address and contact details are not always up to date.

Actions:

- Communication support – is now included as a standing item in the monthly Childhood Vaccination Group. The immunisation calendar details all Immunisation programmes for academic year - schools informed during summer term. There is an action (school nursing and communications team) to develop a calendar for pertinent times of the year when support is required. At an All Wales level, PHW have been asked to increase variety of assets and comms. developed to support immunisation programmes e.g. TV/Radio and alternative social media platforms, to have a wider reach and engagement with children and young people.
- Uptake – utilising a targeted approach with those schools with low uptake rates. Working with head teachers and school staff to raise importance of immunisation programmes. Undertaking large number of phone calls to parent/carers to obtain consents and utilising Frazer competency assessment that allows pupils to self consent in the absence of a consent form. Working with HB colleagues to facilitate catch up sessions in CVC's, which proved successful during August 2024.
- 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 continues.
- E-Consent for immunisation – The E.consent system for School Nursing Service went live at the start of May, as a pilot in one school. Outcome depending it is anticipated that the system will be extended across the service during the next vaccination cycle.

CTMUHB Improving Population Health & Wellbeing

% uptake of the influenza vaccination amongst adults aged 65 years & over Target 75%



Uptake Welsh HB's to 25th March 2025 for the 2024/25 Seasonal Influenza	
ABUHB	72.9%
BCUHB	73.0%
C&VUHB	70.0%
CTMUHB	69.4%
HDUHB	25.4%
PTHB	69.2%
SBUHB	68.5%
All Wales	70.3%

Challenges posed by the National Immunisation Framework (NIF) & actions being taken?

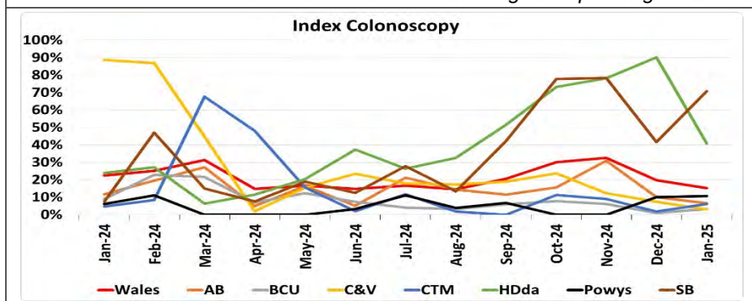
Challenges:

- Vaccine fatigue – across all heath boards and vaccination campaigns there is an increasing apathy towards vaccination particularly since the COVID-19 Pandemic.
- Joint Committee on Vaccination and Immunisation (JCVI) and Welsh Health Circulars (WHCs) instructed a change in priority to the start of the adult flu vaccination campaign, moving the required start date back to 1st October 2024, a delay on the usual September start.
- Demand on vaccination services – the winter campaigns of Flu and COVID were impacted by the introduction of the year round RSV campaign.
- Uptake of Flu & COVID -19 – Staff uptake of flu in CTM has fallen this year to 34.4% (All Wales 33.9%) the offer of Fluenz to 3-year olds who attend LA nursey schools in RCT and Merthyr was a challenge. COVID-19 vaccination uptake dropped to 44.8% of the eligible population.
- Community pharmacies – pharmacies continue to balance an increasing demand for clinical services against limited resources including trained vaccination staff and appropriate consultation space. The impact of central procurement of vaccines in 2025/26 is not known at this stage, although the potential for increased vaccination rates via pharmacy remains realistic.
- Actions:
- Vaccine fatigue - Vaccine Programme Wales is supporting health boards with the establishment of a misinformation and vaccine literacy group in line with and the HB vaccine equity strategic plan. The HPT will be attending the community leaders' network with hopes of establishing community links to engage with the public. The Specialist Immunisation team is engaging with public groups and undertaking vaccination awareness session with many groups of staff.
- Demand on vaccination services – additional nurse posts in the HPT have been advertised this week and planning is underway for the winter campaign for 2025/26 working with primary care providers.
- Uptake of flu and COVID-19 – An online booking system for staff vaccinations was positive with additional recommendations, including stronger communication & additional peer/walkabout opportunities; these will be included in the winter planning. New models of delivering fluenz to 3-year old's in LA nursery schools are being planned. The spring COVID-19 vaccination campaign starts on 1st April 2025 with a smaller targeted population.
- CTM will continue to support the national community pharmacy premises improvement grants program, which saw 7 pharmacies awarded funding to increase and optimise consultation room facilities in 2024/25.
- Pharmacy technicians in CTM undertook more than 1,600 vaccinations in 2024/25, over 9% of the total vaccinations recorded by pharmacies. CTM will continue to encourage pharmacy contractors to accredit staff via HEIW's vaccinator accreditation framework and increase the number of vaccinators available within community pharmacies.
- CTM will continue to engage with national vaccine procurement program to optimise delivery of vaccination by community pharmacy contractors.

CTMUHB Planned Care Group - Index Colonoscopy

% patients offered index colonoscopy procedure within 4 weeks of booking Specialist Screening Practitioner assessment appoint. - Target 90% - Feb 2025 = 3.1%

Please note there is a time lag in reporting of 2-3 months



Status as at January 2024		
Health Board	Compliance	Rank
SB	70.8%	1st
HDda	40.8%	2nd
Powys	10.8%	3rd
AB	6.5%	3rd
CTM	**6.1%**	**5th**
BCU	3.2%	6th
C&V	3.0%	7th

How are we doing & what actions are we taking? SSP sickness absence continues which is delaying assessments and limiting the amount of BSW Endoscopists we have within CTM. We have also had sickness across the BSW Endoscopist team and also in colonoscopy, which will affect our BSW waits. We are actively supporting a consultant with supervised lists to enable the consultant to go forward to be assessed for BSW.

As of the 2nd May 2025 there were 166 patients waiting for an index colonoscopy, of which, 129 have a booked appointment. Unfortunately, 89 patients will have waited longer than 4 weeks for their procedure and of these, 53 patients are over 8 weeks. There are 15 planned surveillance/repeat patients waiting; 14 with booked dates.

The operational challenges that have an impact on activity are:

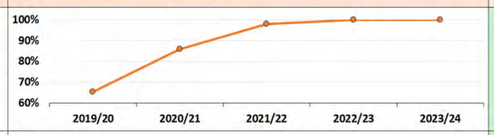
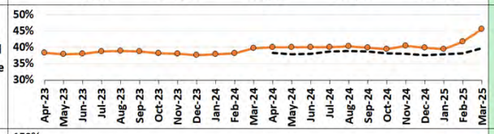
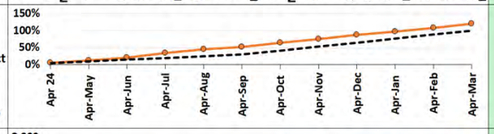
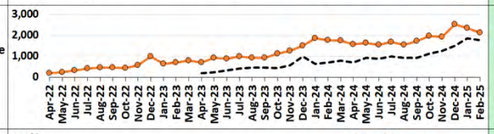
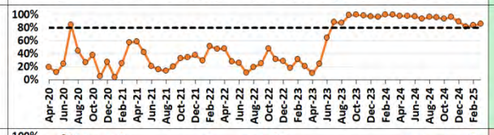
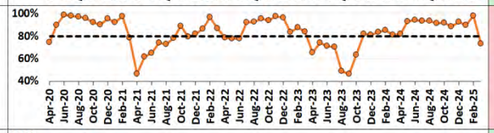
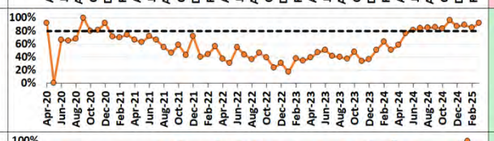
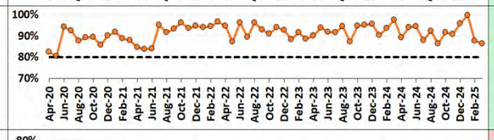
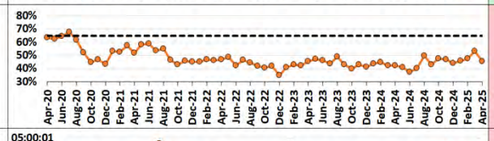
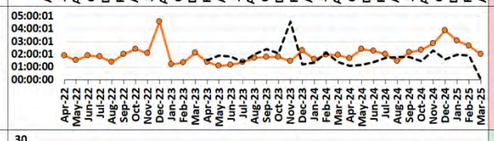
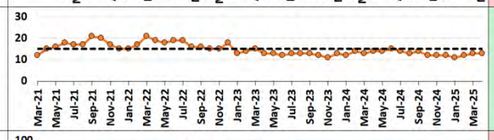
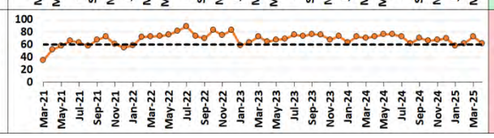
- Participant, patient choice and refusal remains an issue when booking dates across CTM.
- Providing cover for periods of leave and on-call commitments. This continues to be managed through 6/4/2-1 process which has seen an increase of adhoc cover, plus additional lists through backfilling of symptomatic 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.

Actions being taken:

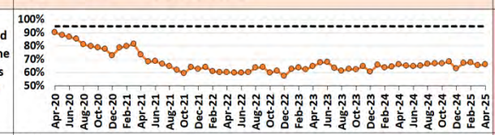
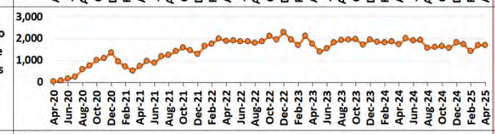
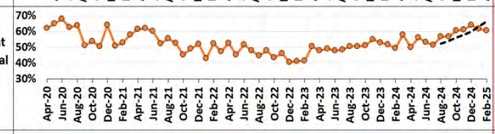
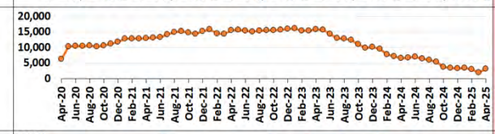
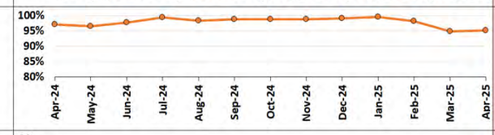
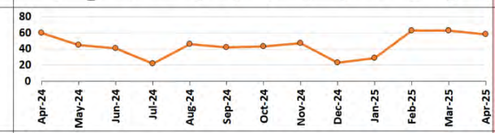
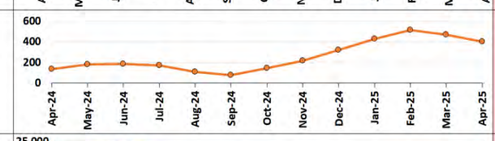
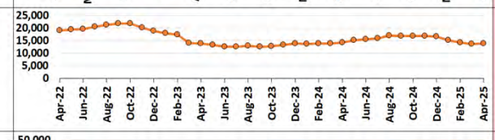
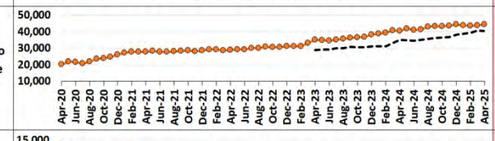
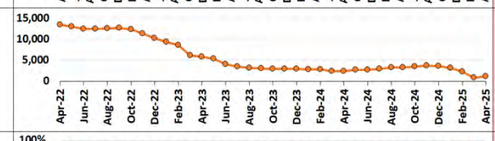
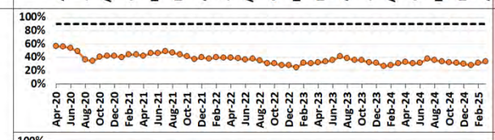
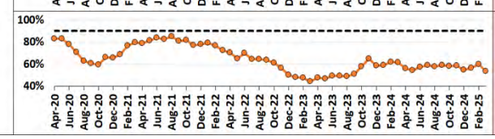
- Use of Text Remind and Broadcast Messenger to manage patient choice and reduce refusal of offer and DNA rates.
- Participants continue to be booked direct to scope at SSP assessment resulting in better patient experience.
- Sustainability plan is ongoing to increase core lists to meet optimisation steps.
- 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: Hit Target / Latest Position	Target Failed
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%	2023/24
	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		45.5%	Mar-25
	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 2025 and 100% by by 31 March 2026		120.6%	Apr 2024 to Mar 2025
	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Increase compared to the same month in the previous year		2,120	Feb-25
	% 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%		85.8%	Mar-25
	% 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%		73.5%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)	80%		92.0%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)	80%		86.8%	
Access Hospital Services Quickly	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		45.5%	Apr-25
	Median emergency response time to amber calls	12 Month Reduction Trend		01:55:00	Mar-25
	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less		13	Apr-25
	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	60 minutes or less		62	

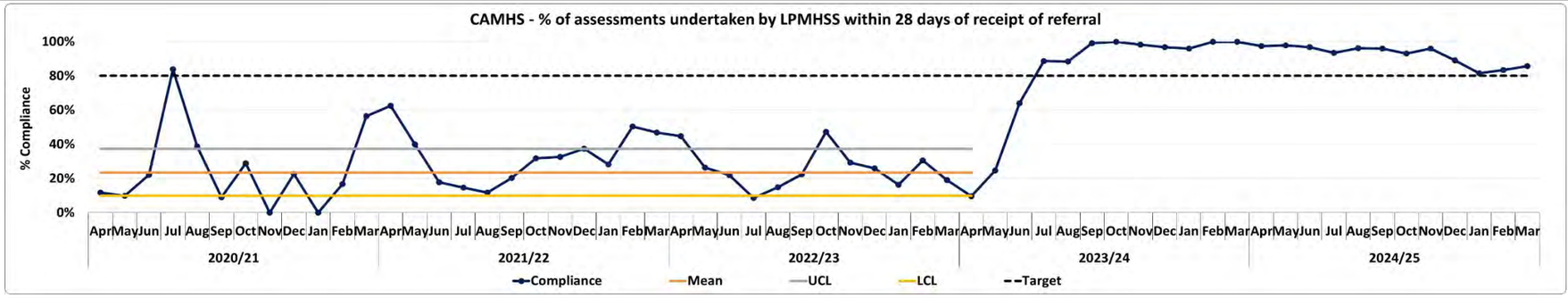
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

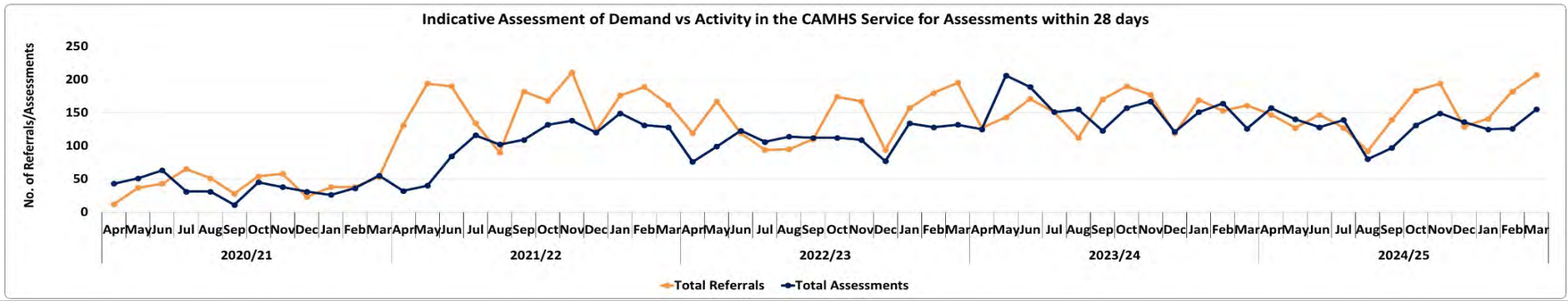
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Hit Target / Green = Target Met / Red = Under	Target Failed
Access Hospital Services	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Improvement compared to the same month in the previous year, towards the national target of 95%		66.3%	Apr-25
	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	Reduction compared to the same month in the previous year, towards the national target of zero		1,685	
	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	12 month improvement trend towards a national target of 80% by 31 March 2026		60.7%	Mar-25
	Number of patients waiting more than 8 weeks for a specified diagnostic	Zero		3,081	
	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	100%		95.2%	
	Number of patients waiting more than 14 weeks for a specified therapy (all ages)	Zero		58	
	Number of adults waiting more than waiting more than 14 weeks for all audiology pathways (to include new & existing pathways for hearing aids, tinnitus & balance	Month on month reduction		402	Apr-25
	Number of patients waiting over 52 weeks for a new outpatient appointment	Zero		13,912	
	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		44,554	
	Number of patients waiting more than 104 weeks for referral to treatment	Zero		1,191	
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%		33.7%	Mar-25
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			53.4%	

CTMUHB Mental Health & Learning Disabilities Care Group

CAMHS & Specialised Services – March 2025

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (85.8%) - Target 80%





Mental Health Measure Part 1a - the number of assessments undertaken within 28 days of referral saw a compliance rate of 85.8% during March 2024.

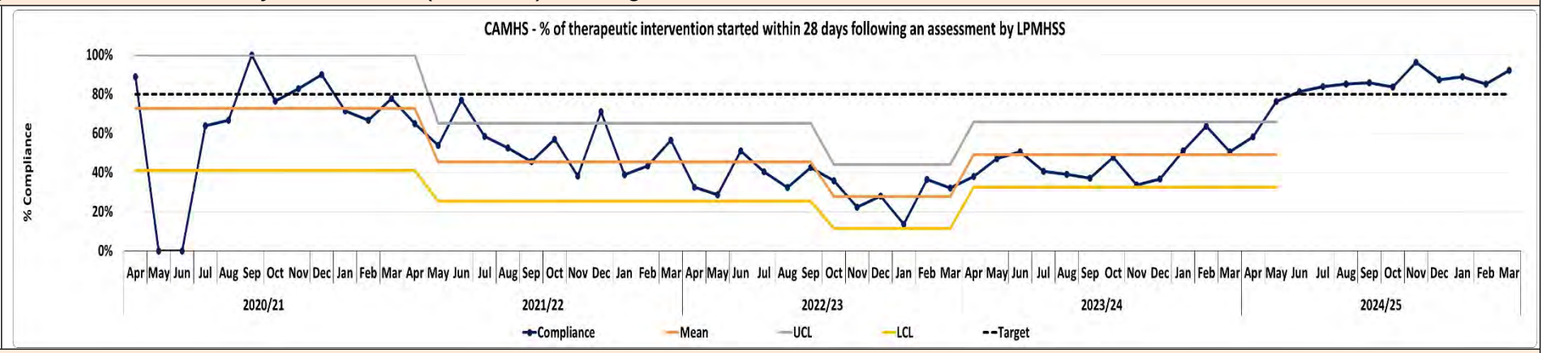
Since the summer of 2023, performance has notably improved in this area of the CAMHS service with compliance continually maintained above the WG target of 80%.

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.

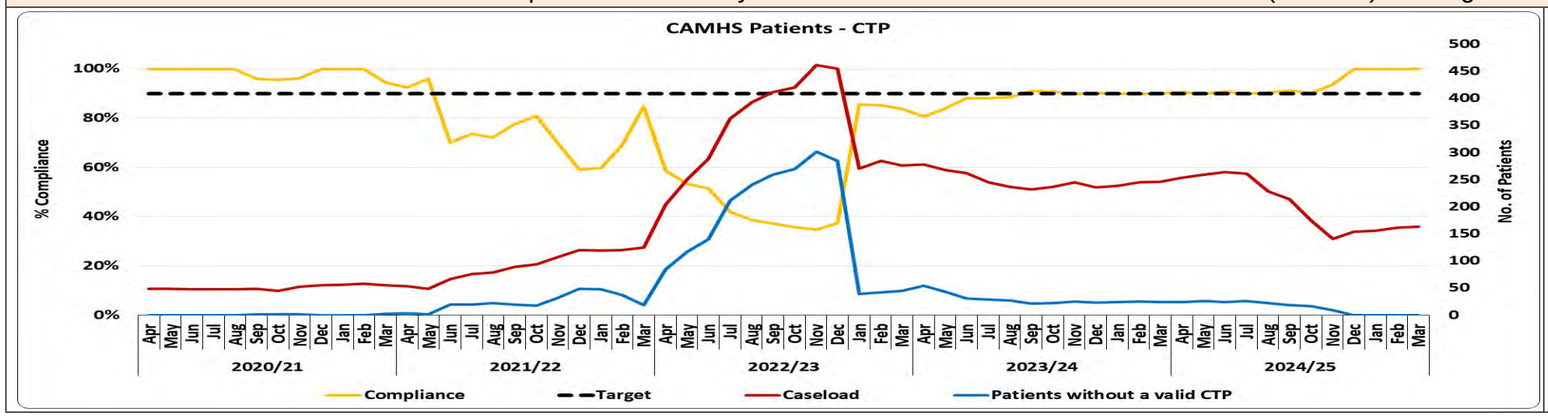
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (92.0%) - Target 80%

Compliance for the proportion of therapeutic interventions starting within 28 days following an assessment by LPMHSS reached 92.0% during March and continues to surpass the WG set target of 80%.

The Directorate continues to develop its local groups and the digital SilverCloud offer. Business information is supporting the Directorate to monitor compliance on a real time basis which is helping to manage compliance and maintain the achievement of the set target.



% of HB residents who are in receipt of secondary MH services who have a valid CTP (100%) - 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 continued to observe a compliance rate of 100% during March and stands above the WG set target of 90%.

Part 3: There were no requests made for a CAMHS assessment under Part 3 of the Mental Health Measure during March.

CAMHS & Specialised Services - continued

How are we doing and what actions are we taking?

Actions being taken:

- An improvement action plan and trajectory was implemented to improve compliance in Parts 1 and 2 of the Mental Health Measure. This has successfully delivered improvement in all three areas.
- 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, with ten groups starting each month and delivered in each of the three local authority areas. Referrals to the SilverCloud digital platform continue to increase and there is multi-disciplinary engagement with the SilverCloud project management team hosted by Powys Teaching Health Board.
- Part 2: A training programme for care co-ordinators has helped to improve the quality of Care Treatment Plans (CTPs), including joint training between Adult Mental Health services and CAMHS.
- Monthly supportive meetings are in place with the NHS Executive, helping to improve compliance in all areas and in a sustainable way.

When is improvement anticipated and what are the main areas of risk?

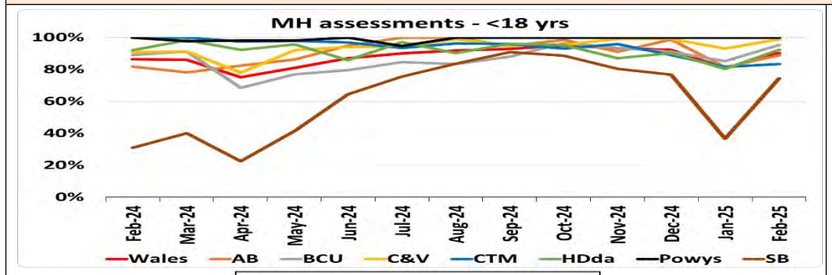
Outputs of improvements:

- 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 March we had 188 patients on the waiting list, an increase of 44 patients on the previous month, although the average waiting time remains at 3 weeks.
- Part 1b: We carefully monitor the demand for interventions and our capacity to deliver services. The total number of interventions delivered in March was 75, which is similar to the monthly average delivered throughout 2024/25. The average waiting time for intervention is also 3 weeks.
- As clinical teams have worked through the waiting list backlog our performance against the interventions target has steadily increased.
- The introduction of referral-based access to the online digital platform SilverCloud early last year further helped with interventions.
- Part 2: The results of the caseload audit completed at the end of last year is helping us to focus on quality in relation to CTP's.

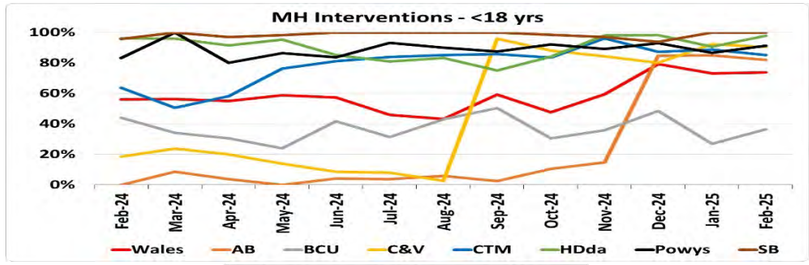
Main areas of risk:

- 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 which may have an impact on delivery going forward.

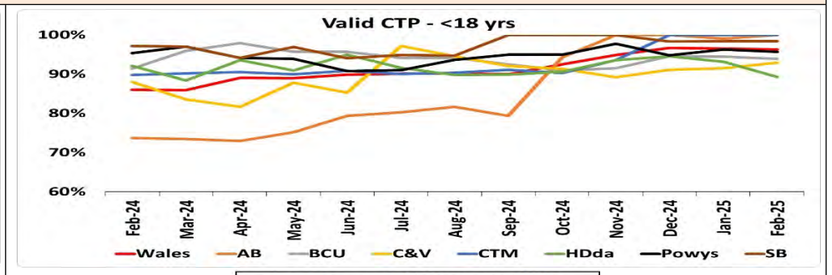
How do we compare with our peers?



Status as at February 2025		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
C&V	99.0%	2nd
BCU	95.3%	3rd
HDda	92.2%	4th
AB	88.7%	5th
CTM	**83.3%**	**6th**
SB	74.3%	7th



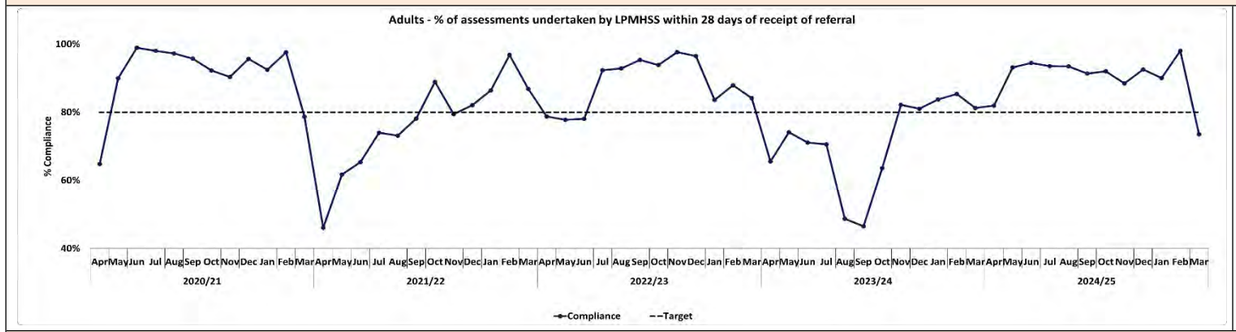
Status as at February 2025		
Health Board	**Compliance**	**Rank**
SB	100.0%	1st
HDda	97.7%	2nd
Powys	91.2%	3rd
C&V	90.3%	4th
CTM	**85.1%**	**5th**
AB	82.0%	6th
BCU	36.4%	7th



Status as at February 2025		
Health Board	**Compliance**	**Rank**
AB	100.0%	1st
CTM	**100.0%**	**1st**
SB	98.4%	3rd
Powys	95.7%	4th
BCU	93.9%	5th
C&V	92.9%	5th
HDda	89.3%	7th

Adult Mental Health Services – March 2025

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (73.5%) - 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 March fell steeply to 73.5% and falls below the WG target of 80% for the first time since October 2023.

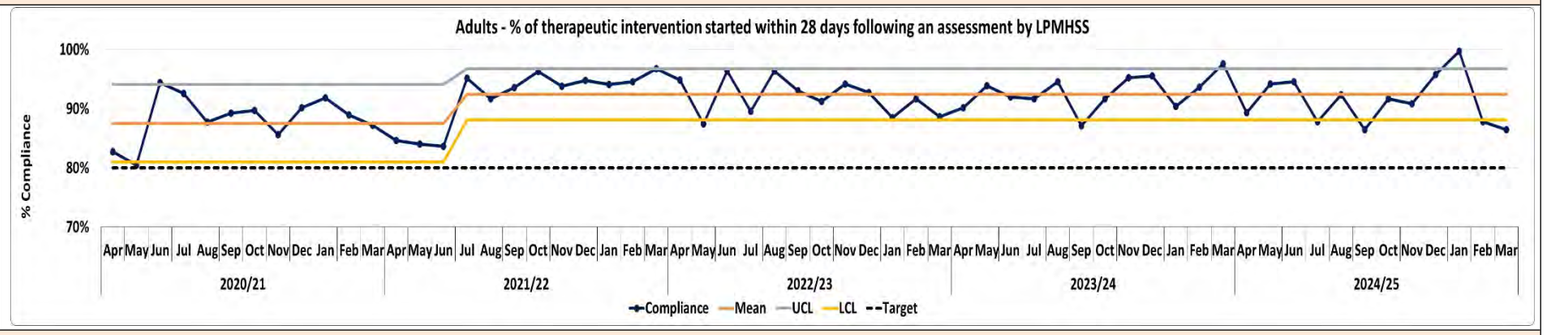
The decline in performance was due to a reduction in capacity to process referrals and manage the appointment booking system. There was also a reduction in the number of available clinical appointments during the month of March. The team also has one vacant post and a long term sickness absence. Plans are being enacted to rebalance the administrative capacity to support referral and appointment processes.

After seeing a fall in referrals during February (714), referrals during March increased to 1,157, which is similar to volumes seen pre-Covid. The average number of monthly referrals during 2024/25, were 769, with the previous year recording 709 per month.

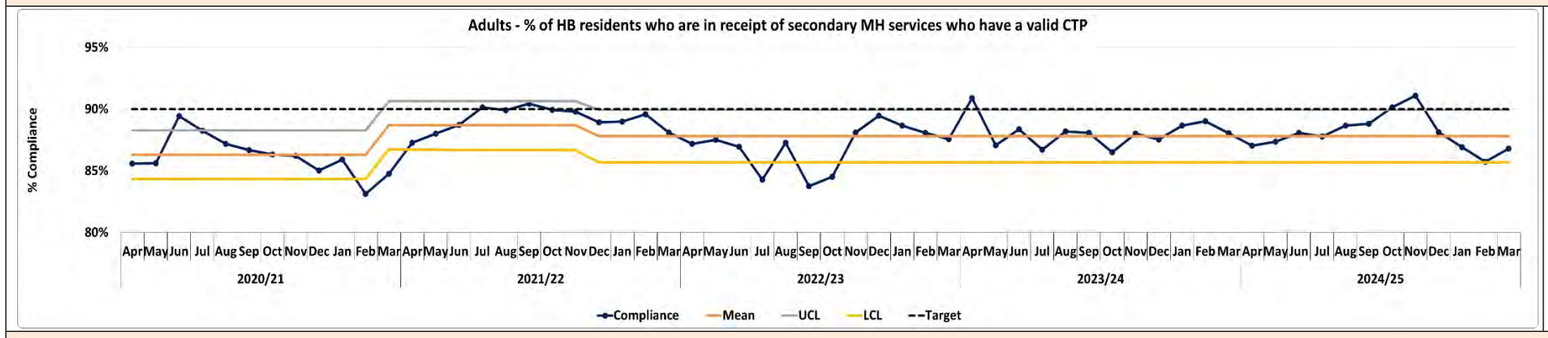
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (86.5%) - Target 80%

Overall, the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS during March dropped further to 86.5%, but continues to surpass the WG target of 80%.

During the month, 249 of the 288 interventions commenced within the 28 day timeframe.



% of HB residents who are in receipt of secondary MH services who have a valid CTP (86.8%) - 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 rate of 86.8% during March, a slight improvement on the previous period, but remaining below the 90% WG standard.

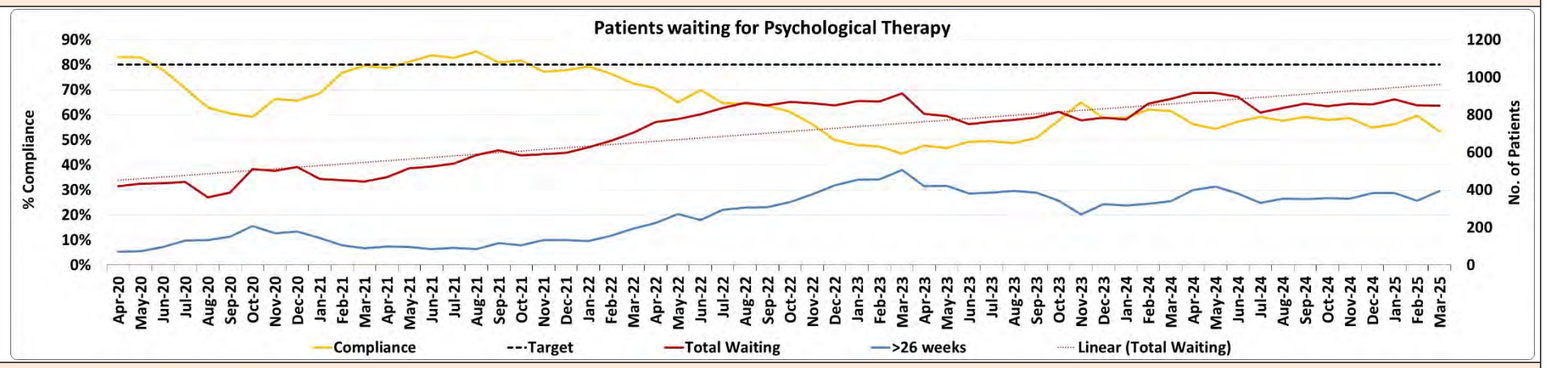
Part 3: There were no requests made for an adult assessment under Part 3 of the Mental Health Measure during March.

% of patients waiting less than 26 weeks to start a Psychological Therapy (53.4%) - Target 80%

During March, Psychological Therapies compliance fell to 53.4%, 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 fluctuated between 53.4% and 59.7%.

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 March the waiting list stood at 848 patients; just over double the volume seen pre-Covid and during the last 12 months the list has ranged between 813 and 918 patients.



Adult Mental Health Services continued on the next page...

Adult Mental Health Services - continued

How are we doing?

Part 1a: During March, performance across all teams fell sharply to below the target of 80%. A combination of increased demand and a reduction in capacity of both admin and clinical staff contributed to the fall in performance.
Part 1b: Performance continues to be above target at 86.5%.
Part 2: Overall compliance for both Adult, Older Adult and Learning Disability Services was 86.6%, compliance for the services is shown below:

- Adult Services – increased slightly to 85.3%
- Older Adult Services – marginal increase to 91.9%
- Learning Disability Services – fell from 89.9% to 86.7%.

Psychological Therapies: The overall waiting list position at the end of March stands at 848 patients, which is similar to the previous month. Those patients waiting over 26 weeks currently stands at 395 service users. 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. As at March, the area with the highest number of waiting patients is Local Primary Mental Health Support Services.

What actions are we taking and when is improvement anticipated? What are the main areas of risk?

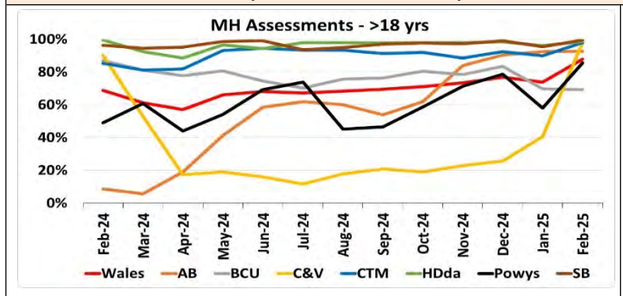
Part 1a:

- Nursing capacity: Vacancies and sickness within the clinical teams has impacted the overall service capacity due to the cancellation of appointments and reduced number of assessments available. Vacancies have now been appointed to in all areas, but awaiting start dates. Sickness across the teams is being managed through appropriate polices and procedures. Overtime and bank is being used to increase capacity. An improvement is expected in May.
- Administrative shortages: Vacancies and some sickness within the admin teams have delayed referral processing and hindered patient booking, directly affecting our ability to meet the 28-day target. Outcomes and waiting list validation has suffered. Across the service there are 3 vacancies which equates to a 44% loss in admin support. The admin pressures have been escalated to ensure visibility and support at the highest levels. Plans are being enacted to rebalance the admin capacity to support referral and appointment processes and urgent target admin recruitment.
- Part 2: For Adult Services, compliance was 87% in March which is attributed to reduced medical capacity, local authority compliance and administration vacancies.
- Medical capacity: Sickness and vacancies have contributed to reduced capacity for CTP appointment reviews, although staff have since returned to work. Vacancies contribute to a reduction in available sessions with medics for completion of CTP reviews. This is being mitigated through the use of locum doctors. The proposed Outpatient redesign model proposes transfer of CTP cases to Advanced Clinical Practitioners who are proven to be more efficient in terms of CTP compliance and there is ongoing exploration of redirection of medical vacancy funds in Cynon CMHT to enable this.
- Local authority: LA compliance for CTP's remains below target. Service Managers within the LA are aware of the issue, citing sickness as the main contributory factor. They have reported actions to improve which include use of agency and monitoring performance through supervision. Multi-agency meetings have been established between CTM and LA, with on-going discussions around compliance and ways to improve.
- Admin shortages: Vacancies and sickness within the admin teams are a contributory factor to efficient waiting list management effecting the ability to meet compliance targets. Across the service there are 4 vacancies. The administrative pressures have been escalated through OMB, QSE, and SMT to ensure visibility and support at the highest levels.
- Service Redesign. There is not a consistent approach to CMHT inclusion criteria across the service due to historic locality working. We are in the process of reviewing secondary care services as one of the IMTP priorities. This will include a demand and capacity review.

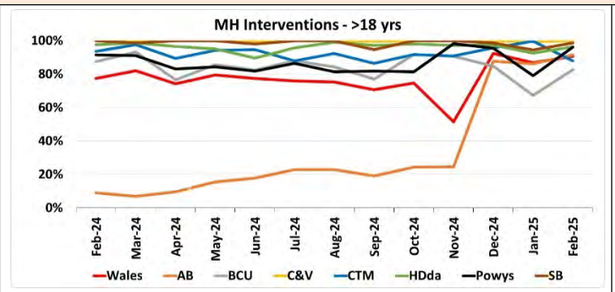
Psychological Therapies: There is ongoing work to clearly identify and record on the LPMHSS waiting list the types of therapy service users are waiting for to allow efficient allocation of service users to staff resource. Inconsistent admin support in this area is also proving difficult, but this will improve as the new structure evolves.
Actions taken to improve position:

- ProblemShared remaining sessions have been optimised by enrolling LPMHSS service users.
- Development and implementation of an access policy.
- Demand and capacity analysis.
- Recruitment into vacancies.

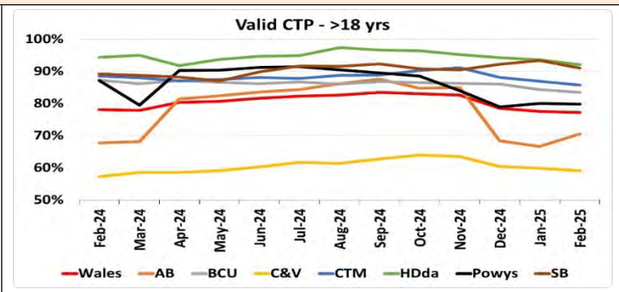
How do we compare with our peers?



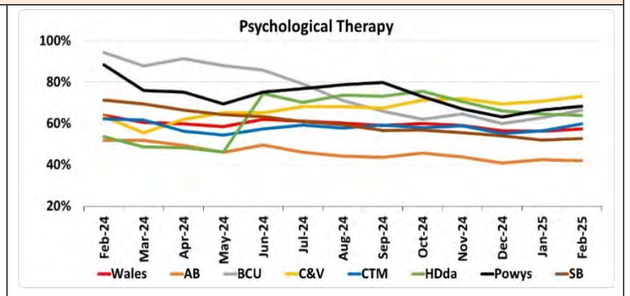
Status as at February 2025		
Health Board	Compliance	Rank
SB	99.6%	1st
HDda	98.7%	2nd
CTM	**98.0%**	**3rd**
C&V	98.0%	3rd
AB	92.8%	5th
Powys	85.5%	6th
BCU	69.2%	7th



Status as at February 2025		
Health Board	Compliance	Rank
C&V	100.0%	1st
SB	98.7%	2nd
HDda	96.3%	3rd
Powys	96.2%	4th
AB	91.5%	5th
CTM	**87.8%**	**6th**
BCU	82.7%	7th



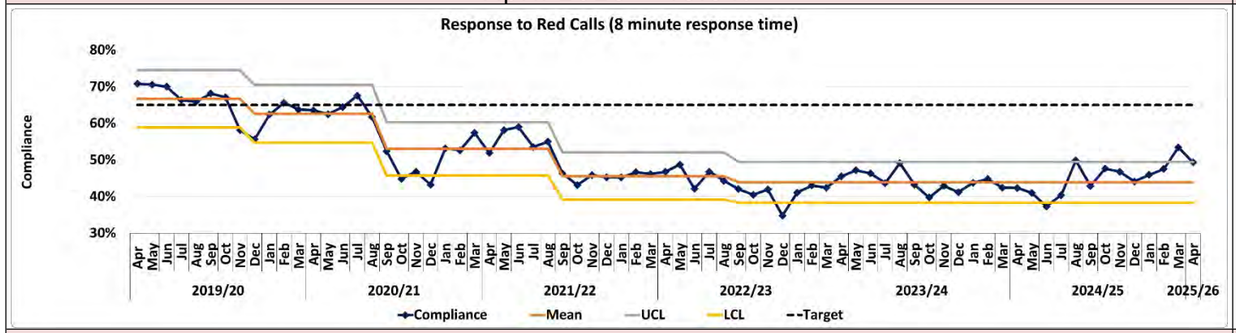
Status as at February 2025		
Health Board	Compliance	Rank
HDda	92.1%	1st
SB	91.0%	2nd
CTM	**85.7%**	**3rd**
BCU	83.4%	4th
Powys	79.8%	5th
AB	70.5%	6th
C&V	59.1%	7th



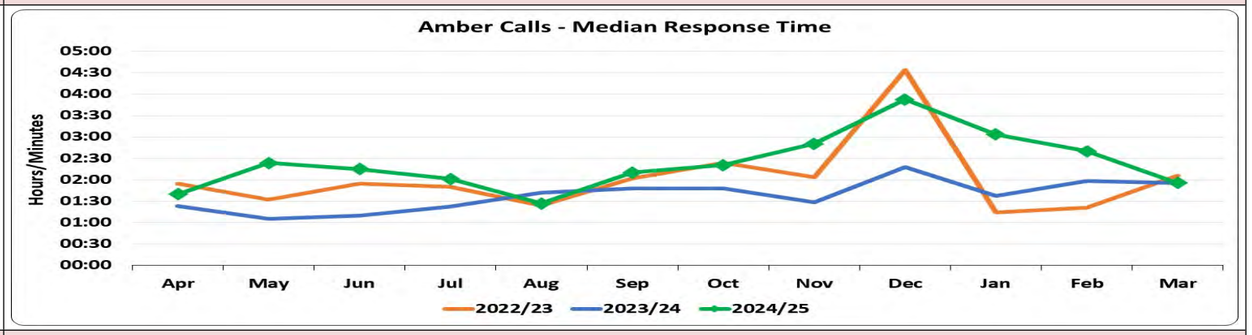
Status as at February 2025		
Health Board	Compliance	Rank
C&V	73.1%	1st
Powys	68.2%	2nd
BCU	66.4%	3rd
HDda	63.8%	4th
CTM	**59.7%**	**5th**
SB	52.6%	6th
AB	42.0%	7th

Emergency Ambulance Services – April 2025

% of emergency responses to Red Calls arriving within 8 minutes (Target 65%)
April 2025 – 45.5%



Median emergency response time to Amber Calls – Target is 12 month reduction trend
March 2025 - 1 hour 55 minutes *(N.B. there is a time lag in the data of approx. 1 month)*

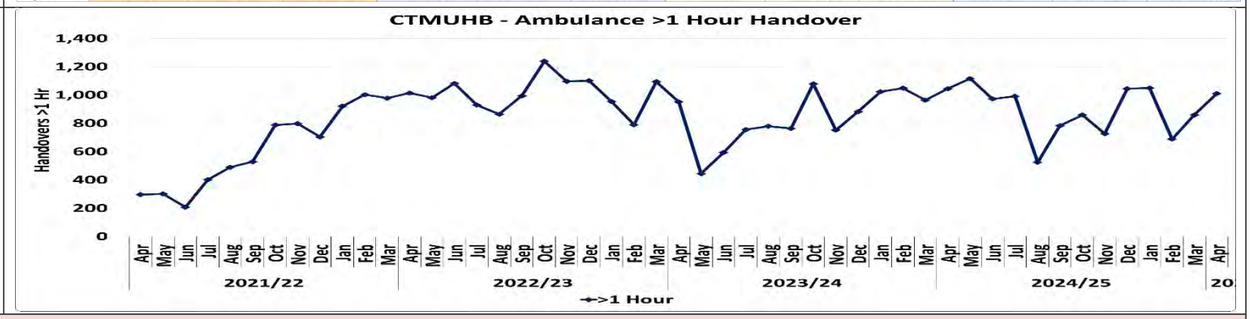


% of ambulance patient handovers within 15 minutes – Target is improvement compared to the same month in the previous year, towards the national target of 100% within 15 minutes.
Total handovers – 2,031 of which 330 (16.2%) of handovers were within 15 minutes

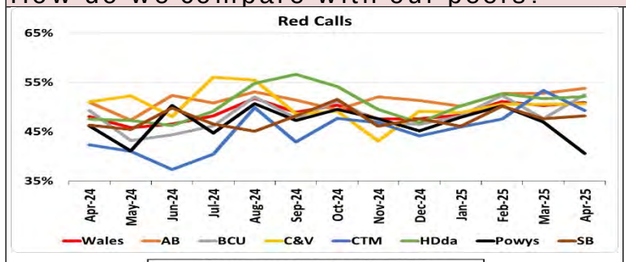
Number of ambulance patient handovers over 1 hour – Target Zero

1,011 handovers were over 1 hour (50.2% of handovers were within 1 hour)

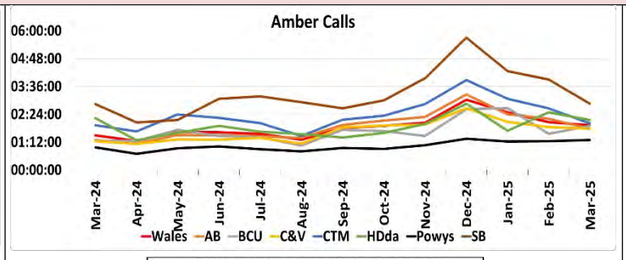
	PCH			RGH			POW			CTMUHB		
Period	Handovers	% <15 mins	% <60 mins	Handovers	% <15 mins	% <60 mins	Handovers	% <15 mins	% <60 mins	Total Handovers	% <15 mins	% <60 mins
Apr-24	856	14.4%	46.3%	819	26.1%	64.0%	587	17.5%	50.6%	2262	19.5%	53.8%
May-24	865	15.7%	45.9%	715	20.6%	50.9%	644	18.8%	53.9%	2224	18.2%	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%
Sep-24	822	22.9%	61.4%	751	25.8%	61.0%	547	24.7%	68.2%	2120	24.4%	63.0%
Oct-24	811	17.6%	47.7%	808	30.3%	61.4%	475	28.2%	74.1%	2094	24.9%	59.0%
Nov-24	806	20.7%	58.9%	792	39.8%	66.3%	391	24.8%	67.0%	1989	29.1%	63.4%
Dec-24	782	15.3%	48.2%	909	24.4%	53.7%	416	18.3%	47.4%	2107	19.8%	50.4%
Jan-25	788	16.8%	51.9%	950	17.3%	45.1%	371	23.7%	59.8%	2109	18.1%	50.2%
Feb-25	639	19.2%	60.9%	787	28.8%	58.8%	316	21.2%	63.6%	1742	23.9%	60.4%
Mar-25	694	15.6%	59.1%	873	21.8%	50.5%	378	20.6%	61.9%	1945	19.3%	55.8%
Apr-25	741	13.6%	49.4%	893	17.2%	47.0%	397	18.9%	58.9%	2031	16.2%	50.2%



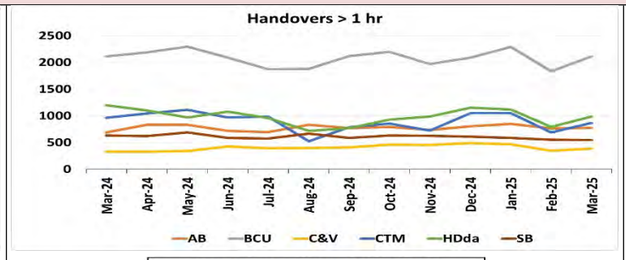
How do we compare with our peers?



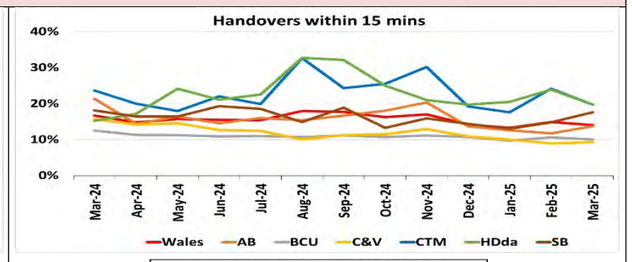
Status as at April 2025		
Health Board	Compliance	Rank
AB	53.8%	1st
BCU	52.5%	2nd
HDda	52.1%	3rd
C&V	50.7%	4th
CTM	**49.3%**	**5th**
SB	48.2%	6th
Powys	40.6%	7th



Status as at March 2025		
Health Board	Compliance	Rank
Powys	01:17	1st
C&V	01:46	2nd
AB	01:47	3rd
BCU	01:54	4th
CTM	**02:00**	**5th**
HDda	02:09	6th
SB	02:51	7th



Status as at March 2025		
Health Board	Compliance	Rank
C&V	391	1st
SB	550	2nd
AB	775	3rd
CTM	**866**	**4th**
HDda	988	5th
BCU	2,118	6th



Status as at March 2025		
Health Board	Compliance	Rank
CTM	**19.7%**	**1st**
HDda	19.7%	1st
SB	17.6%	3rd
AB	13.7%	4th
BCU	10.0%	5th
C&V	9.3%	6th

Emergency Ambulance Services continued overleaf:

Emergency Ambulance Services continued – April 2025

How are we doing?

Response to Red Calls per WAST Operational Area				
Apr-25	Total Responses	Responses within 8	% within 8 mins	*12 Month Average*
Merthyr	138	77	**55.8%**	*59.3%*
RCT	381	189	**49.6%**	*41.1%*
Bridgend	223	100	**44.8%**	*44.5%*
CTM	742	366	**49.3%**	*45.5%*

Response to Red Calls: Response times to life-threatening calls for the CTM area during April was just under 50%, with the 12 month average being 45.5%. The volume of Red Calls during March totalled 742; just below the twelve month average of 782 and slightly higher than the equivalent period of 2024 (713).

The National compliance was 50.9% and continues 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 1 hour and 55 minutes during March; just over an hour shorter than the previous month, but the same as the equivalent period of 2024. The chart (page 14, top right) demonstrates fluctuations with response times ranging between 87 and 232 minutes during the past twelve months.

Ambulance Handover Compliance & Lost Hours: During April, ambulance conveyances to ED totalled 2,031, which is 8.5% (193) fewer than the equivalent period of last year. Performance against the 15 minute handover continues to remain low at 16.2%, with the number of patients and ambulance crews detained longer than an hour totaling 1,011. The 12 month average is 886 patient breaches, which is around 5% higher than the equivalent time span of the previous year (May 23 to Apr 24).

During April there were a total of 3,053 hours lost to the ambulance service following notification to handover at our emergency departments, representing a 12.5% (435 hours) reduction on the same period of 2024 *(waits longer than 15 minutes are counted)*.

Hospital Handovers in minute time groups								
Apr-25	0 - 15	15 - 30	30 - 45	45 - 60	60 - 120	120 - 180	180+	Total Handovers
PCH	101	115	102	48	129	104	142	741
RGH	154	116	84	66	158	97	218	893
POW	75	71	50	38	56	35	72	397
CTM	**330**	**302**	**236**	**152**	**343**	**236**	**432**	**2,031**

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 27 during March. The ED services were able to meet all but one of those requests, with the expected standard being 100%.

	PCH			RGH			POW			CTMUHB		
Period	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance
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	9	9	**100.0%**	11	11	**100.0%**	9	9	**100.0%**	29	29	**100.0%**
Aug-24	11	10	**90.9%**	4	4	**100.0%**	8	8	**100.0%**	23	22	**95.7%**
Sep-24	9	9	**100.0%**	10	10	**100.0%**	12	11	**91.7%**	31	30	**96.8%**
Oct-24	23	23	**100.0%**	10	10	**100.0%**	6	6	**100.0%**	39	39	**100.0%**
Nov-24	16	16	**100.0%**	11	10	**90.9%**	3	3	**100.0%**	30	29	**96.7%**
Dec-24	18	18	**100.0%**	18	17	**94.4%**	10	9	**90.0%**	46	44	**95.7%**
Jan-25	14	14	**100.0%**	25	24	**96.0%**	9	8	**88.9%**	48	46	**95.8%**
Feb-25	6	6	**100.0%**	11	11	**100.0%**	4	4	**100.0%**	21	21	**100.0%**
Mar-25	11	11	**100.0%**	10	10	**100.0%**	6	5	**83.3%**	27	26	**96.3%**

N.B. 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 end of March 2025 (data may be subject to change).

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 where patients may become fit to sit.
- Experience triage / Senior Decision Maker to maximise fit to sit decision, quick turnaround and front loading of investigations.
- Urgent Treatment Centre (UTC) at PCH, trial went live November 2024. Exploring funding to extend beyond May.
- 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.
- Formulations of ED Delivery Plan and Improvement Targets, including;
  - 80% of patients handed over within 1 hour by July 2025
  - 100% of patients handed over within 4 hours by July 2025
  - WG Ministerial Advisory Group targets announced in May - potentially supersede the above
- Reduce conveyance / pathway development with WAST – 8% higher than other HB's.
  - Nav Hub/Care Home pathway development
  - SDEC
  - Extend UTC
- Implementation of Strategic Transformation of Acute Medicine Programme (STAMP) across all 3 acute sites.
- Acute Clinical Service Plan workshop to be held – Date TBC
- Bi-weekly team meetings established with WAST.
- D&C mapping to identify Invest to Save opportunities for additional medical recruitment.
- Additional medical workforce appointments agreed for PCH (1 Locum Consultant, 1 substantive Consultant, 5 Junior Clinical Fellows and 1 Specialty doctor post to support sustainable service delivery, reduction in ADH spend, increase support for Paediatric Emergency Medicine sessions and increase consultant cover to 22.30 hrs).
- Additional medical workforce appointments for POW in progress, awaiting financial approval against out-turn funding.

What are the main areas of risk?

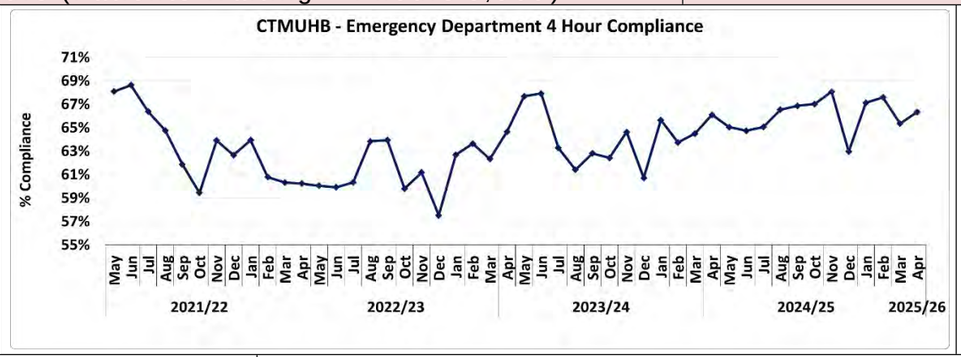
- Although some additional uncommissioned capacity areas have closed, some areas remain open across all sites, but is under daily review by Directorate Management Team.
- System flow remains highly impacted by capacity within social care.
- Persistent high escalation levels across all sites.
- Clinical Decision Making capacity is insufficient to meet demand in line with WG targets. Subsequently there is a heavy reliance on locum and agency staff to support rotas across the three Emergency Departments. That being said, demand and capacity exercise and realignment of out-turn funding has identified opportunities to invest in more Emergency Medicine posts.

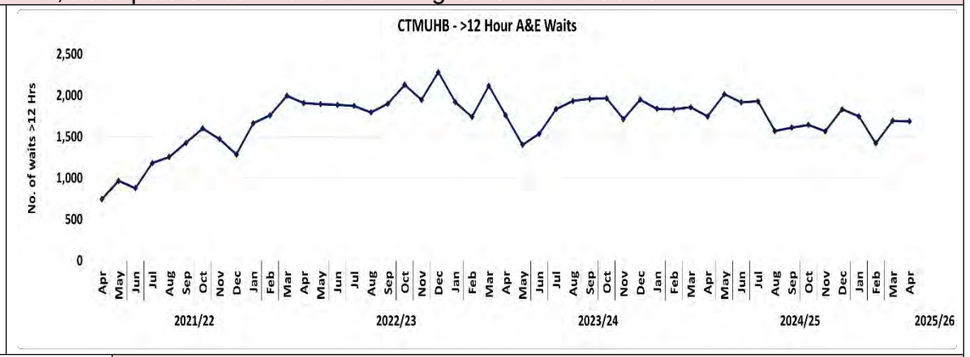
CTMUHB Unscheduled Care Group – Please note 2025/26 trajectories for improvement are still in development

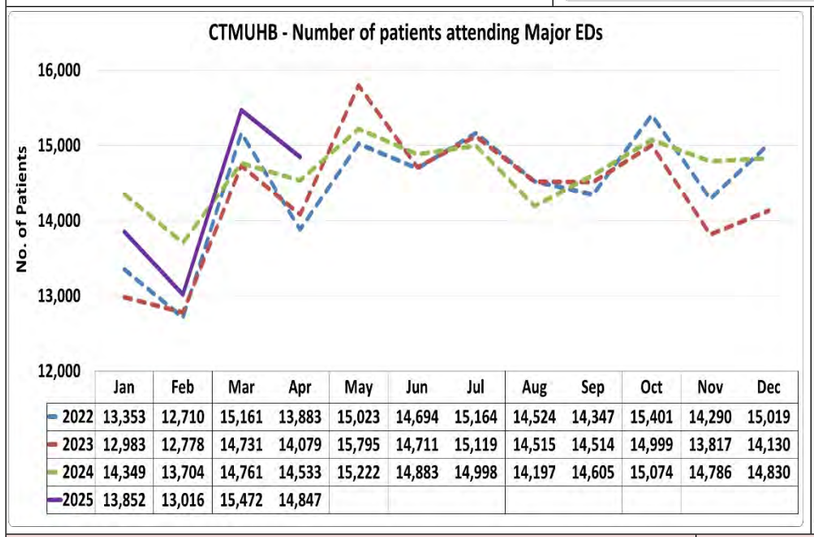
Emergency Unit Waits – April 2025 (Provisional Position) - Total Attendances = 16,542

% 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 – Target is reduction compared to the same month in the previous year, towards the national target of zero
66.3% were seen within 4 hours (Patients Waiting >4 hours 5,569)	1,685 patients were waiting over 12 hours

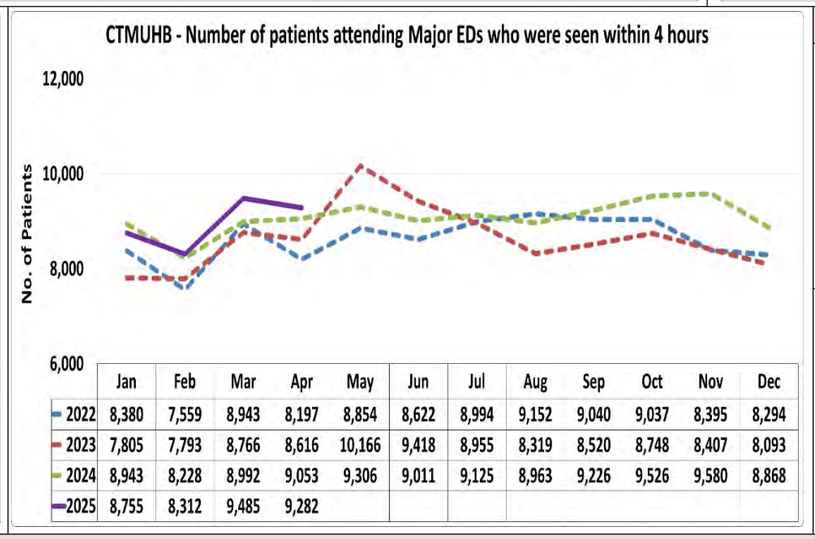
Period	CTMUHB		
	Attendances	4 Hrs %	> 12 Hrs
Apr-24	16,181	66.1%	1,745
May-24	16,947	65.0%	2,015
Jun-24	16,650	64.7%	1,915
Jul-24	16,808	65.1%	1,928
Aug-24	15,640	66.5%	1,569
Sep-24	16,241	66.9%	1,610
Oct-24	16,822	67.0%	1,642
Nov-24	16,334	68.1%	1,566
Dec-24	16,095	63.0%	1,832
Jan-25	15,507	67.1%	1,745
Feb-25	14,524	67.6%	1,419
Mar-25	17,323	65.3%	1,692
Apr-25	16,542	66.3%	1,685





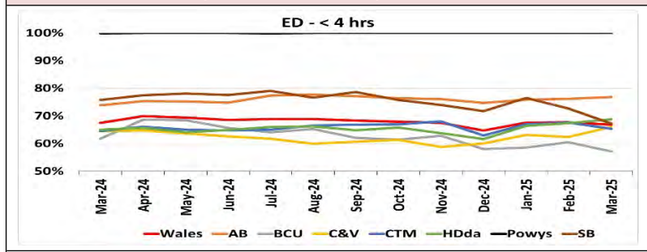


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	13,353	12,710	15,161	13,883	15,023	14,694	15,164	14,524	14,347	15,401	14,290	15,019
2023	12,983	12,778	14,731	14,079	15,795	14,711	15,119	14,515	14,514	14,999	13,817	14,130
2024	14,349	13,704	14,761	14,533	15,222	14,883	14,998	14,197	14,605	15,074	14,786	14,830
2025	13,852	13,016	15,472	14,847								

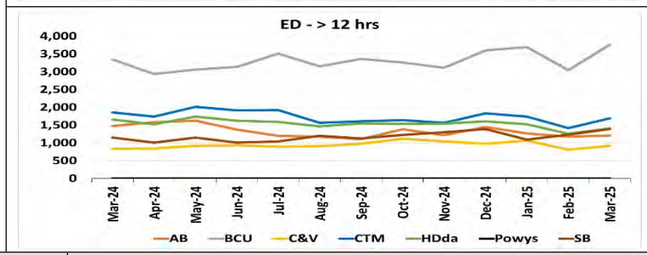


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2022	8,380	7,559	8,943	8,197	8,854	8,622	8,994	9,152	9,040	9,037	8,395	8,294
2023	7,805	7,793	8,766	8,616	10,166	9,418	8,955	8,319	8,520	8,748	8,407	8,093
2024	8,943	8,228	8,992	9,053	9,306	9,011	9,125	8,963	9,226	9,526	9,580	8,868
2025	8,755	8,312	9,485	9,282								

How do we compare with our peers?



Status as at March 2025		
Health Board	Compliance	Rank
Powys	100.0%	1st
AB	76.8%	2nd
HDda	68.8%	3rd
SB	67.4%	4th
C&V	66.1%	5th
CTM	**65.3%**	**6th**
BCU	57.2%	7th



Status as at March 2025		
Health Board	Compliance	Rank
Powys	0	1st
C&V	915	2nd
AB	1,210	3rd
SB	1,392	4th
HDda	1,412	5th
CTM	**1,692**	**6th**
BCU	3,763	7th

How are we doing?

The chart above shows that throughout April the total number of ED attendances at our three acute hospital sites was around 2% higher than those observed during April 2024 and 5.35% higher than the same period of 2023. Overall numbers of Minor Injuries and ED attendances totalled 16,542, which is 2.2% higher than those observed during the equivalent period of last year (16,181).

The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival at our emergency care facilities during April is provisionally 66.3%, which as it currently stands is the same as the 12 month average, but continuing to remain well below the WG compliance target of 95%.

The twelve hours performance observed that 1,685 patients were waiting in excess of 12 hours and for the past year the rate of 12 hour patient breaches has been around 11% of the total attendances.

What actions are we taking & when is improvement anticipated?

- Weekly pan CTM senior team meetings continue, supported by robust action plans with a view to the standardisation of ways of working and clinical pathways where possible.
- Introduction Urgent Treatment Centre (UTC) at PCH at the end of 2024 is slowly starting to improve patient experience and ED performance/waiting times.
- Exploring feasibility of introducing Rapid Assessment & Treatment Model (RAT) at PCH following realignment of consultant roster.
- Implementation of STAMP across all 3 acute sites.
- Development of ED Internal Professional Standards.
- Job planning underway to identify time that can be reallocated to “shop floor” activity
- Developing plans for additional ACP post to support 7/7 Acute Medicine in RGH & PCH
- Invest to save Consultant, Middle Grade and Junior Clinical Fellow posts approved for PCH, awaiting funding for POW.
- Developing plans to also support additional COTE consultant to provide “Front Door Frailty” at PCH.
- Formulations of ED Delivery Plan and Improvement Targets, including:
  - 50% reduction in 12-hour ED waits by July 2025.
  - Zero tolerance for patients waiting >48 hours.

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 and further invest to save opportunities are realised.
- Recruitment to Medical Workforce due to availability

CTMUHB Unscheduled Care Group

Hip Fracture – Key Steps in Recovery From Injury - *Please note the next update is expected June 2025*

Data sourced from the National Hip Fracture Database (NHFD)

Data reported Quarterly – latest period to December 2024

National Falls & Fragility Fracture Audit Programme

Annualised values based on cases averaged over 12 months to end of December 2024 (except KPI's 6 & 7 which are delayed to allow for follow up data to be included). Source National Hip Fracture Database

Key Steps		KPI - Expected WG target of 75%	Wales Average	NHFD overall performance	PCH	RGH	POW
					Average cases		
					231	318	228
Getting to the right place	0	Admission to specialist ward	13%	9%	36%	8%	33%
	1	Prompt orthogeriatric review	72%	89%	0%	0%	56%
Getting up after surgery	2	Prompt surgery	55%	58%	71%	55%	80%
	3	NICE compliant surgery	67%	70%	54%	70%	59%
	4	Prompt mobilisation	75%	82%	62%	57%	73%
	5	Not delirious post op	60%	66%	0%	1%	77%
Getting back home again	6	Return to original residence	75%	74%	75%	65%	74%
	7	Bone medication	58%	51%	1%	12%	52%

RAG Rating Definitions	
Red: Greater than 10% below 75% expectation	R
Amber: Within 10% of 75% expectation	A
Green: At or above 75% expectation	G

Please note that the critical incident declared at POW during October 2024 will have a direct impact on the KPI's above due to the system changes that were required to safely decant the POW site.

Improvement actions & risks

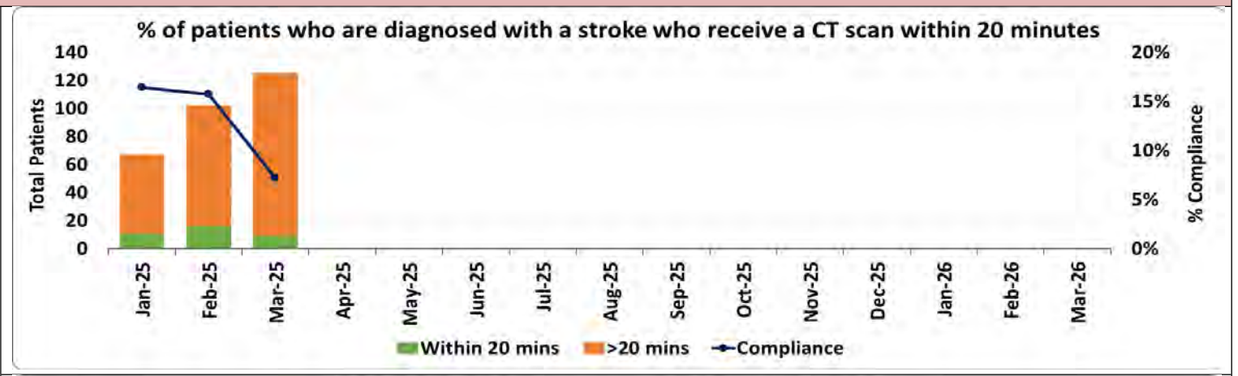
(please note that the information below is updated quarterly)

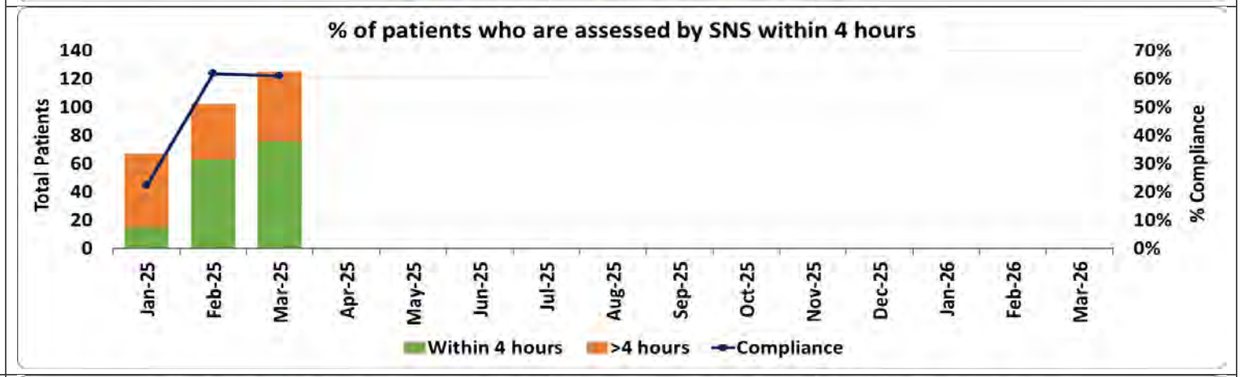
KPI	PCH	RGH	POW
0. Admitted to specialist ward - With nerve-block within 4 hours.	We endeavour to keep a dedicated hip fracture bed on the orthopaedic ward. Upon diagnosis of a hip fracture the patient can be 'fast tracked' to a bed on the orthopaedic ward.	Patient flow and bed availability continues to be an issue. Whilst a vacant bed dedicated for hip fracture patients is planned for, insufficient bed capacity results in this not always being operationally possible.	We endeavour to admit majority of hip fracture patients to the trauma ward, but due to lack of bed availability in general throughout the hospital and long waits in ED it has not been possible to admit the patients to the trauma ward in a timely manner. These patients are transferred to the trauma ward on most occasions after surgery. However, since the POW critical incident in October we do not currently have any trauma intake.
1. Prompt orthogeriatric assessment - Assessed by a senior geriatrician (ST3+) within 72 hours of presentation.	Awaiting recruitment of orthogeriatrician. Business case is near completion and currently with CTM'S planning team.	RGH has no orthogeriatrician service. Care of the Elderly teams are unable to see fracture hip patients due to other work commitments. No orthogeriatrician or Care of the Elderly team input is available - referral to the medical on call team if the patients becomes acutely unwell. Discuss at next Strategic Frailty Fracture Group.	Until October 2024, there had been a notable improvement with the appointment of the Orthogeriatric consultant. The critical incident will impact this KPI for the year ahead.
2. Prompt surgery - Surgery by the day following presentation with hip fracture.	Over the last year we have implemented an all day trauma list, six days a week and most bank holidays; improving our efficiency in getting patients to theatre quickly.	We now have an all day Saturday trauma list and improvements in this KPI should be reflected in the year ahead.	Service has been impacted by the critical incident in October but some of the recurring themes are: staff shortages in theatre, lack of junior medical staff and trauma other than fracture hip needing to be addressed. Theatre utilisation is not optimum.
3. NICE compliant surgery - Surgical procedure consistent with the recommendations of NICE CG124.	We have, until recently used uncemented hemiarthroplasties for our hip fractures. We are, currently, changing our default hemi to a cemented version, as per NICE recommendations.		There is some difference of opinion on preference of treatment as well as probably inconsistent classification of the fracture type account for marginally less then expected performance. There appears to be a problem in data input. We will have to look at the data and the diagnosis updated/uploaded on NHFD to reflect on this figure.
4. Prompt Mobilisation after surgery - Mobilised out of bed (standing or hoisted) by the day after operation.		Physio education and documentation ongoing. MDT education all patients to be mobilised day 1 post-op	We are working to improve this KPI with regular training of nursing and physiotherapy staff, however this has been impacted by the critical incident and there being no inpatient acute trauma service since the declaration.
5. Not delirious when tested - Not delirious (<4 on 4AT test) when tested in the week after operation.		Clerking proforma use and education ongoing. Orthogeriatric Service would regularly review and improve this aspect.	With an orthogeriatric team in place, improvements are being made, but will take time to be reflected in the yearly rolling data
6. Return to original residence - Discharged back to original residence, or in that residence at 120 day follow-up.			There is shortage of staff in community as well as in hospital with shortage of beds which leads to longer hospital stay, delayed discharge and delayed support to be able to go to original place of residence.
7. Bone protection medication - Either i.v. medication at discharge or at 120 day follow-up.	This would be improved with a Fracture Liaison Service and orthogeriatric provision.	No orthogeriatrician or Fracture Liaison Service and no trauma co-ordinator. COTE have recently provided treatment proforma for T&O team to carry out blood tests and prescribing. We require a full orthogeritrician service to provide a swifter service to our patients.	With an orthogeriatric team in place, improvements are being made but will take time to be reflected in the yearly rolling data. However the critical incident will impact this KPI in the year ahead.

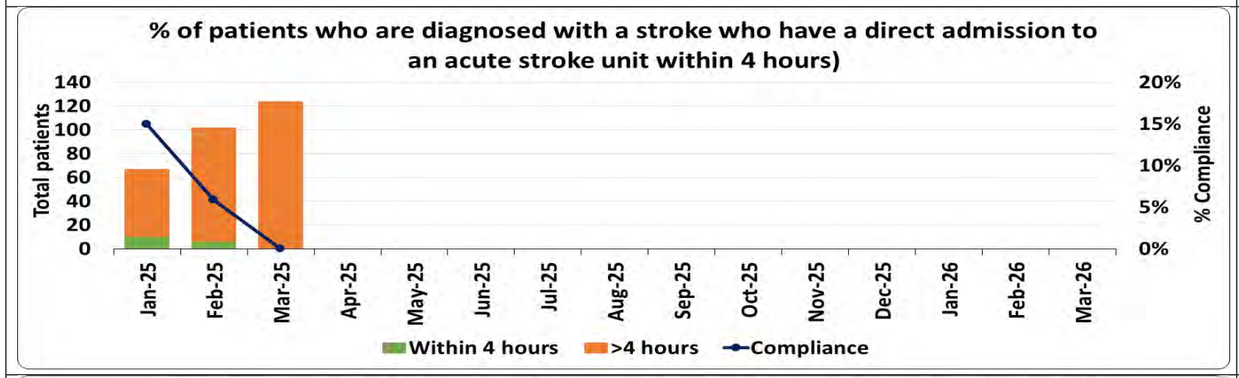
Stroke Quality Improvement Measures (QIMs) – March 2025

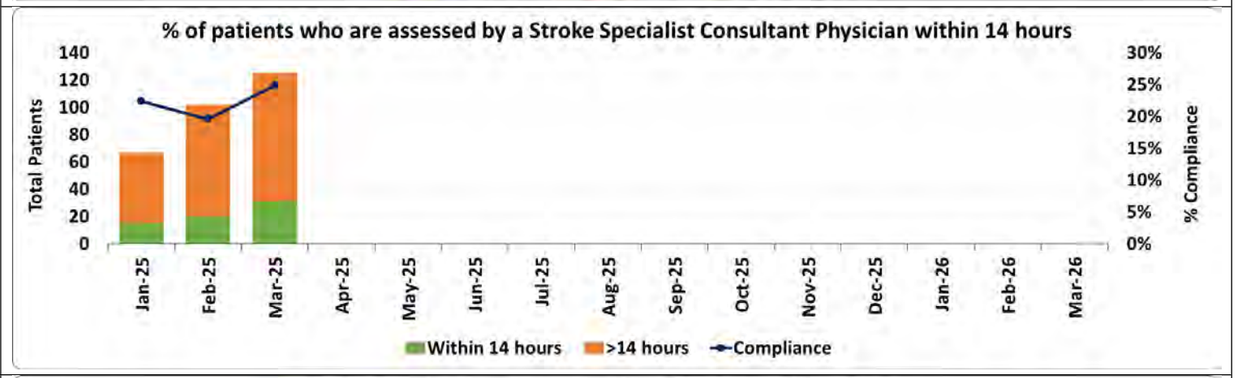
The national SSNAP data standards were amended at the end of September 2024, with new targets introduced, as shown below:

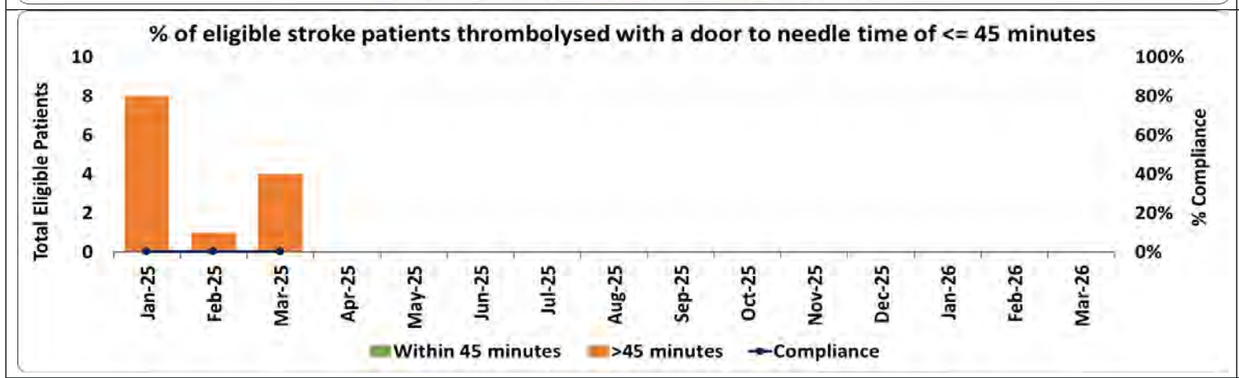
Stroke Quality Improvement Measures Current month stats: March 2025		
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit (< 4 hours)		
Admissions	**No. within 4 hrs**	**% Compliance**
124	0	0.0%
Percentage of eligible stroke patients thrombolysed with a door to needle time of <= 45 mins		
Eligible Patients Thrombolysed	**Thrombolysed <= 45 mins**	**% Compliance**
4	0	0.0%
% of patients who are diagnosed with a stroke who receive a CT scan within 20 minutes		
Patients diagnosed as stroke	**Scanned <= 20 mins**	**% Compliance**
125	9	7.2%
% of patients who are assessed by SNS within 4 hours		
Assessments	**Assessed <=4 hrs**	**% Compliance**
125	76	60.8%
% of patients who are assessed by a stroke specialist consultant physician within 14 hours		
Assessments	**Assessed <=14 hrs**	**% Compliance**
125	31	24.8%
% of patients who are assessed by OT & PT within 24 hours		
Assessments	**Assessed <=24 hrs**	**% Compliance**
110	0	0.0%

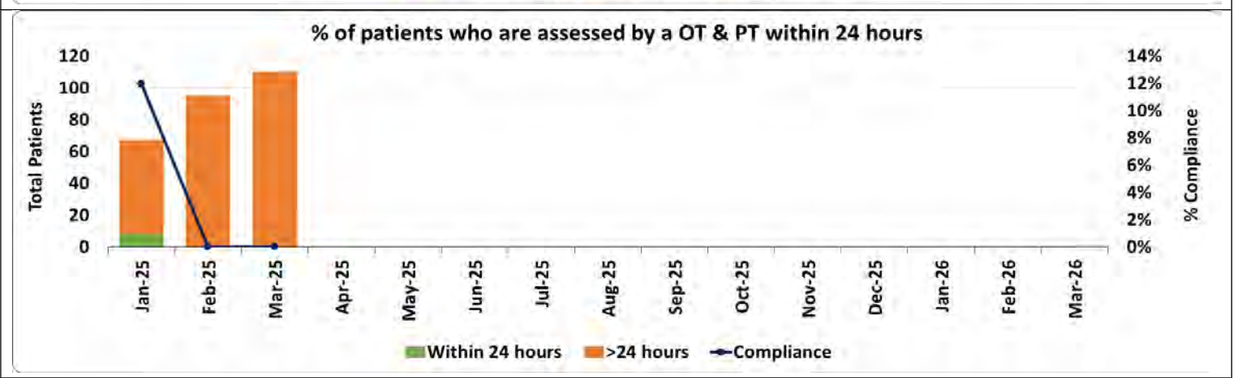












Stroke continued on the next page...

CTMUHB Unscheduled Care Group

Stroke Quality Improvement Measures (QIMs) – March 2025

How are we doing?

- Stroke services have been maintained within the CTM footprint and temporarily consolidated on the RGH site due to the critical incident at POW and the need for urgent service change at PCH due to senior specialist medical workforce challenges. Currently the stroke service senior medical team comprises of 2 substantive and 2 locum consultants. Following a recent advert, interview is scheduled for June and we hope to appoint an additional stroke consultant to start late 2025.
- Despite the temporary centralisation, there are flow constraints to the Stroke Unit with patients attending on all three acute sites for transfer to a stroke bed. The configuration of the Stroke Unit separates the acute and step-down rehabilitation patients between Ward 20 and Ward 19 at RGH, with acute stroke patients being admitted to Ward 20. Central monitoring has been installed on Ward 20 to support the acutely unwell patients.
- 4 eligible patients were thrombolysed, although none of these received it within the 45-minute window. The target and ambition is to achieve 20% of patients being thrombolysed for CTM.
- 7.2% of patients (9 out of 124) had a CT scan within 20 minutes. This KPI has changed from CT scan within 1 hour to CT scan within 20 minutes which has had a significant impact on performance outcomes.
- 60.8% of patients (76 out of 125) were assessed by a Stroke Nurse Specialist within 4 hours. This is a new SSNAP target introduced implemented in October and we will continue to monitor this performance. The stroke nurse workforce is now consolidated at RGH with some weekend cover provided which will support this performance measure.
- 24.8% of patients (31 out of 125 were seen by a Consultant Stroke Physician within 14 hours – this standard has changed from 24 hours. This standard will continue to be difficult to achieve whilst the consultant provision is a five-day service.
- No patients were assessed by Occupational Therapy and Physiotherapy within 24 hours due to patient flow constraints to the stroke unit; no patients arrived on the unit within 24 hrs. On admission to the stroke unit 68% of patients are seen within 24 hours by OT, 65% by Physiotherapy and 61% by Speech and Language Therapy. There have also been vacancies and sickness impacting on capacity and the lack of 7-day working will mean 100% is not achievable.

What actions are we taking & when is improvement expected?

- Following the temporary centralisation of stroke services at RGH, the senior medical workforce has combined, although there is an ongoing reliance on locum staff. The resident doctors (previously on the POW and PCH sites) have combined to one team and are now rostered to rotate through both sides of the Stroke Unit to support the full hospital stroke pathway. The consultant position will improve with recruitment later in the year, and a return from maternity and long-term absence. The combined Stroke Nurse workforce is also supporting stroke patients arriving at RGH.
- A plan has been submitted to increase the rehabilitation bed base at YCR (from 8 to 27 beds). This expansion would require additional therapy provision to ensure patients access stroke-specific therapy rehabilitation. This expansion would improve timely access to rehabilitation and aid flow, supporting improved admission to the Stroke Unit within 4 hours.
- There is a dedicated therapy bay within the Stroke Unit at RGH which is a positive addition to the unit and enables patients to have access to therapy in a suitable environment within the ward. This has been a great improvement on the previous limited therapy spaces in POW and PCH. A number of complex factors are affecting current utilisation, but improvement plans across the pathway and professions will have a positive impact.
- The Therapy workforce quickly moved to working as one team across the stroke unit following the move to RGH, to ensure appropriate use of skill mix and flexibility of staffing across the acute and rehab sections of the unit. The therapy teams have offered training and support to nursing colleagues who have moved to the unit who may not have worked in stroke care recently/previously.
- Following a request for a quality and assurance review to Ward 20, an improvement action plan has been developed.
- The temporary move to RGH will remain in place for up to 12 months and a comprehensive programme of service review and improvement is now in place to ensure that the stroke clinical pathway will offer CTM patients the best care possible at all points along the pathway, from acute presentation to discharge to the community.
- Daily MDT Stroke Unit Improvement huddles have been established to cover ‘wins, concerns of the day and rapid problem solving’. These are proving very beneficial, with the sessions being used to feedback actions and improvements to the MDT. An overarching action plan has been developed to support the recommendations from the quality and assurance visit, along with the improvement work with oversight from Care Group Senior Leadership team and Executive teams.
- PCH - TIA clinics have been centralised to the RGH site to support building a more resilient consultant rota. POW clinics are unable to move just yet due to the ICT infrastructure (POW still on SB systems).
- Central monitoring has now been installed on the stroke Unit at RGH which will decrease the need for additional 1:1 staffing for patients.

What are the main areas of risk?

- Following the temporary move of PCH Stroke Service, most of the temporary deployed stroke nursing workforce from PCH has either returned to PCH or other HBs via lateral moves or new appointments. The nursing workforce from YGT (originally RGH based) has moved back to RGH to support the Stroke Unit (Ward 19). There is a need for training and education to support for stroke specific skills. Training plan in place but, upskilling will take time and impacts on current rehab interventions.
- High vacancy rate within the Ward 20 template of the Unit and reliance on bank and agency staff. Plan to recruit via streamlining and adverts in process for RN and HCA posts. Review of lateral move requests to ensure they do not destabilise workforce. Upcoming vacancies and lateral moves within the nursing teams - mitigation plan in place.
- High reliance on locum consultants to enable the service to run adequately.
- Unable to move POW TIA clinics to RGH until at least May due to different ICT systems.
- Lack of office accommodation for secretarial, therapies and consultant staff at RGH and delays in moving the MDM room to within the ward template.
- RGH demand – increased diagnostic demand for Doppler, Echo and MRI.
- Increased pressure on WAST due to having to transfer self-presenters; mitigated by commissioned EMS crew.
- The ability to report data has been disrupted by a combination of the changes in how SSNAP requires data to be recorded manually. SSNAP reporting has now been re-established.
- Lack of 7/7 working for CNS, Medical or Therapy teams.
- Lack of psychology support available to our patients post-acute stroke.
- The lack of flow into and out of the Stroke Unit for patients who no longer need to be on the acute pathway especially.
- Ring-fencing stroke beds continues to be a challenge

CTMUHB Diagnostics, Therapies, Pharmacies & Specialties Care Group

Diagnostics - April 2025 (provisional position)

Number of patients waiting >8 weeks for a specified diagnostic – Target is Zero

Diagnostics >8 wks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/25	6,549	6,646	6,989	6,403	6,031	5,417	3,764	3,412	3,329	3,426	3,037	1,933
2025/26	3,081											

Number of Patients waiting >8 Weeks for a Diagnostic Test April 2025		
Cardiology	Echo Cardiogram	23
Cardiology Services	Cardiac CT	9
	Cardiac MRI	4
	Diagnostic Angiography	93
	Stress Test	4
	DSE	4
	TOE	0
	Heart Rhythm Recording	0
	B.P. Monitoring	0
Bronchoscopy		0
Colonoscopy		429
Gastroscopy		235
Cystoscopy		278
Flexi Sig		340
Radiology	Non-Cardiac CT	353
	Non-Cardiac MRI	37
	NOUS	813
	Non-Cardiac Nuclear Medicine	6
Imaging	Fluoroscopy	14
Physiological Measurement	Urodynamics	156
Neurophysiology	EMG	278
	NCS	5
Total		3,081

How are we doing?

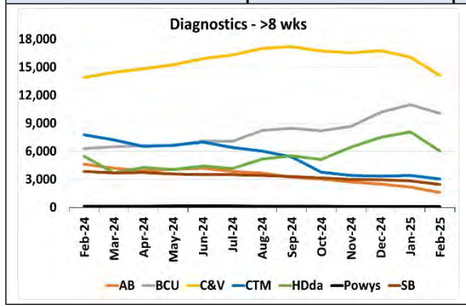
Diagnostics: During 2024/25, investment schemes allowed good progress to be made in reducing the number of patients waiting more than 8 weeks prior to receiving their diagnostic test, achieving a 70% reduction over the course of the year.

Provisionally, at the end of April, 3,081 patients had been waiting in excess of 8 weeks for a diagnostic procedure, which as it currently stands is more than double the number of patient breaches seen in the previous month. This is mainly attributable to increases in patients waiting longer than desired for some radiology diagnostics, namely NOUS and non-Cardiac CT as a result of the additional funding initiatives ceasing.

Cardiology diagnostic tests have remained fairly stable with 137 patients currently waiting beyond 8 weeks for their diagnostic test.

Waiting times for Diagnostic Endoscopy have, this month, seen a slight improvement with an 8% reduction in the number of patients waiting more than the target of 8 weeks, however the number of patient breaches remains high at 1,282 patients.

How do we compare with our peers?



Status as at February 2025		
Health Board	Compliance	Rank
Powys	79	1st
AB	1,619	2nd
SB	2,447	3rd
CTM	**3,037**	**4th**
HDda	6,017	5th
BCU	10,067	6th
C&V	14,086	7th

What actions are we taking & when is improvement anticipated?

Radiology:

- Trajectories for NOUS and CT show scanning capacity shortfalls with the additional demand trends.
- Further additional funding has been requested to staff the unfunded CT sessions at POW via a business case. D&C has demonstrated a maintained increased growth in demand for CT.
- A maintenance business case for additional funding has been submitted for NOUS to enable Super Saturday WLI and additional Sonographer sessions.
- Continuing to observe a sustained improved breast performance; CTM best performing HB for breast services.
- A business case has been submitted to continue with the MSK injections backlog, including FLGI/USGI.
- Additional agency/bank locum radiographers booked at RGH to cover vacancies and to provide additional radiographer support to theatre for elective T&O work.
- Radiology reporting timescales are at an appropriate level due to the uplifted outsourcing budget.

Endoscopy:

- Ongoing clinical & clerical validation of long waiting surveillance patients.
- Clinicians carrying out additional weekend lists during May and June.
- At the beginning of March the new temporary diagnostic endoscopy facilities located at RGH opened. The Vanguard unit will increase endoscopy and surgical capacity across CTM. To minimise disruption to services caused by roof replacement work at POW, CTM has worked with Vanguard to replace capacity whilst the work is ongoing.
- Approval has now been given to extend the Endoscopy insourcing team for a further 2 months to support high volume low complexity (HVLC) endoscopy at PCH.
- A locum consultant will start on the POW site in May and will undertake a new patient clinic weekly in RGH, as well as backfilling available endoscopy lists. In addition, a specialist doctor is due to commence shortly.

What are the main areas of risk?

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 revised 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.
- There are no additional CT funded schemes running at present and there is an observed growth in patients breaching >8 weeks.
- The business case for additional CT staffing is yet to be approved.
- Sustained increase In Hours/Out of Hours CT emergency demand at RGH.
- Increased pressure at RGH due to changes in pathways since the POW Critical Incident - bolstered by temporary staff.
- NOUS waiting list has been maintained with additional resources for 2024/25. Recruitment and training are underway to help build a resilient workforce, but this will take time to embed. National changes to obstetric protocols will put further pressure on the service and reduce capacity to scan NOUS patients going forward.
- Further approval for the maintenance plan is required to continue WLI/additional clinics into 2025/26.
- There has been an observed growth in the >8 week NOUS position since all the additional funded initiatives ceased end of March 25.
- Further pressure is being observed where Planned Care RTT WLI schemes are increasing demand on Radiology Services and driving increased waiting list numbers.
- There are no ongoing approved waiting list schemes currently running with an expected continued growth in waiting numbers and patients breaching >8 weeks.

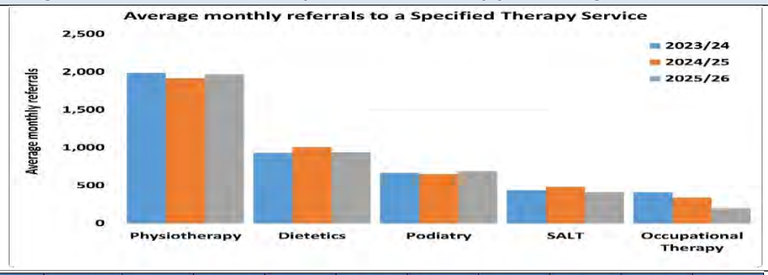
Endoscopy:

- Across site working continues to improve, but WPAS interface still remains a risk to develop a pooled waiting list.
- GI pathway audit completed and action plan developed. This will allow the pan CTM endoscopy service to operate within a standardised approach.
- Hitting our 8 week diagnostic target due to the USC demand.
- Lack of clinician uptake for additional theatre sessions
- BSW Endoscopy capacity remains a significant risk due to the shortage of available BSW accredited Endoscopists.
- Two wte vacancies in POW with the risk that no suitable candidates are available to fill these posts.

Therapies - April 2025 (provisional position)

Number of patients (all ages) waiting >14 weeks for a specified therapy – Target is Zero

Number of Patients waiting >14 Weeks for a Therapy April 2025	Total Waits	Waits >14 wks	% >14 wks
Dietetics	816	6	0.7%
Occupational Therapy	191	0	0.0%
Physiotherapy	1,476	48	3.3%
Podiatry	595	0	0.0%
Speech & Language	469	4	0.9%
Total	**3,547**	**58**	**1.6%**



Therapies >14 wks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/25	**60**	**45**	**41**	**22**	**46**	**42**	**43**	**47**	**23**	**29**	**63**	**63**
2025/26	**58**											

% of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy – Target 100%

% of children waiting less than 14 Weeks for AHP April 2025	Total Waits	Waiting < 14 wks	% <14 wks
Dietetics	179	178	99.4%
Occupational Therapy	67	67	100.0%
Physiotherapy	458	410	89.5%
Podiatry	39	39	100.0%
Speech & Language	309	307	99.4%
Total	**1,052**	**1,001**	**95.2%**

AHP	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/25	97.1%	96.6%	97.7%	99.4%	98.4%	98.8%	98.8%	99.1%	99.6%	98.2%	95.4%	94.8%
2025/26	95.2%											

Therapies - How are we doing?

During April there were 58 patients waiting in excess of 14 weeks for an initial therapy assessment, which is similar to the equivalent period of 2024.

What actions are we taking & when is improvement anticipated?

- Continue to ensure administrative staff are applying the RTT rules appropriately.
- Exploring the opportunity to integrate Community Health Pathways into the Therapies triage processes with the intention to improve quality and appropriateness of referrals. Engagement with Primary care service to deliver first line interventions to enable improved access and timeliness for those needing AHP provision.
- Admin team continue to work on improving use of WPAS and pursuing set up of text and remind function for greater efficiency – already initiated in the Children's Speech & Language Therapy service.

What are the main areas of risk?

Ongoing increase in referrals to physiotherapy services, with no additional resource investment resulting in increased waiting times. Monitoring staff wellbeing, as this has been highlighted as an area of concern with staff.

Concerns remain in being able to see referred patients in a timely manner in line with RTT and clinical presentation/pathology. Year on year increase in referrals to Speech & Language Therapy service which, in combination with increase in complexity, will increase waiting times and possible breaches without additional workforce resource.

Insufficient Dietetic staffing in Type 1 Diabetes leading to 6 adult patients waiting >14 weeks. This is likely to continue.

Audiology Services – April 2025 (provisional position)

Number of adults waiting more than 14 weeks for all audiology pathways Target - Month on Month Reduction

Adult Audiology >14 wks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024/25	**135**	**180**	**188**	**172**	**109**	**80**	**144**	**219**	**320**	**428**	**514**	**471**
2025/26	**402**											

Audiology - How are we doing?

There are 402 adults waiting beyond the target for a hearing aid fitting, which is a reduction of 69 patients waiting longer than 14 weeks from the previous reported position.

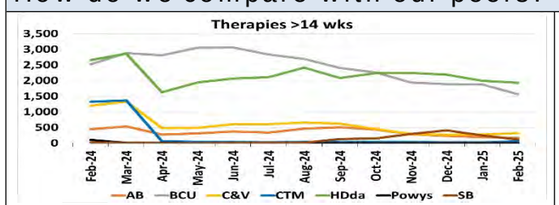
What actions are we taking & when is improvement anticipated?

During the coming year, all our audiology wait times are due to be reported to WG. For this reason and to ensure fair and equitable patient care, we are working to reduce all our wait times and not just the currently reportable 14 week RTT wait time. This means the rate of reduction in wait time may appear slower than expected and we anticipate that we will continue to have some patient breaches.

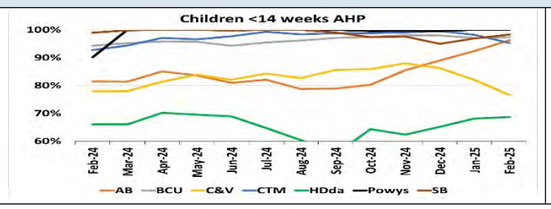
What are the main areas of risk?

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 yet unknown, so the extent of the risk is unclear. As GPs become aware of the new approach, we may see 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.

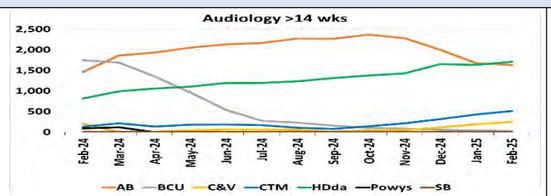
How do we compare with our peers?



Status as at February 2025		
Health Board	**Compliance**	**Rank**
Powys	2	1st
CTM	**63**	**2nd**
SB	113	3rd
AB	171	4th
C&V	322	5th
BCU	1,565	6th
HDda	1,932	7th



Status as at February 2025		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
SB	98.4%	2nd
BCU	97.4%	3rd
AB	96.2%	4th
CTM	**95.4%**	**5th**
C&V	76.7%	6th
HDda	68.7%	7th

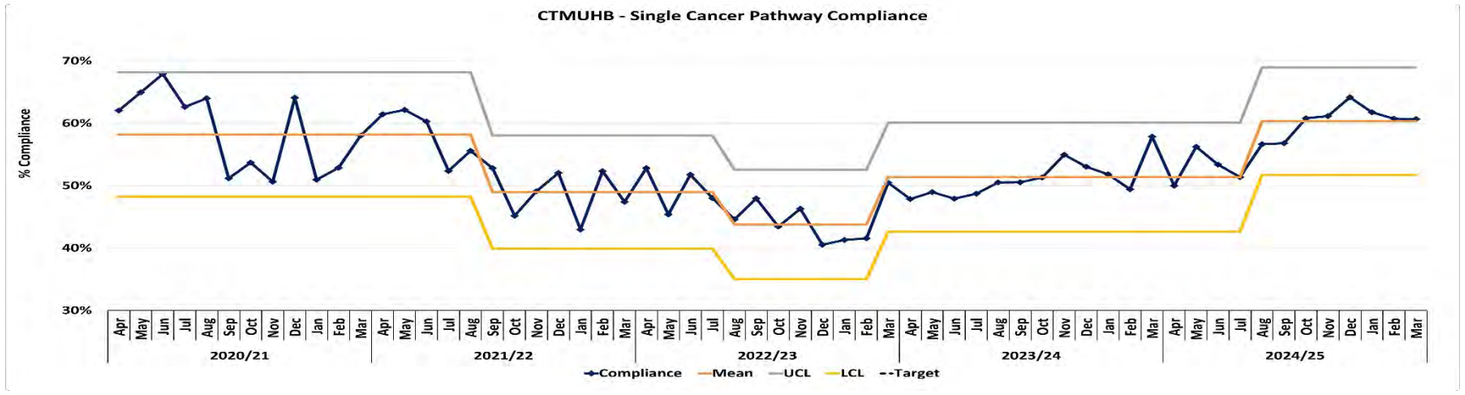


Status as at February 2025		
Health Board	**Compliance**	**Rank**
Powys	0	1st
SB	0	1st
BCU	31	3rd
C&V	248	4th
CTM	**514**	**5th**
AB	1,634	6th
HDda	1,711	7th

CTMUHB Planned Care Group

Single Cancer Pathway (SCP) March 2025 – 60.7%

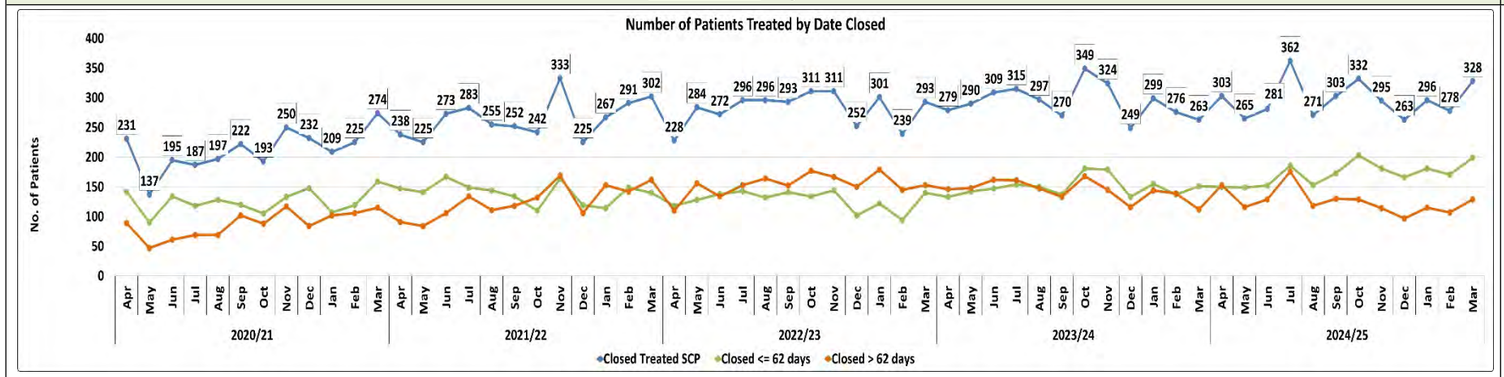
% of patients starting first definitive cancer treatment within 62 days from point of suspicion. Target for 2025/26 - 12 month improvement trend towards a national target of 80% by 31st March 2026 (prior to 31st March 2025 the target was set at 70%)



CTMUHB - SCP % Treated Without Suspensions - March 2025				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated against Target of 70%
Head and neck	10	6	16	62.5%
Upper GI	11	13	24	45.8%
Lower GI	8	19	27	29.6%
Lung	24	16	40	60.0%
Sarcoma	0	1	1	0.0%
Skin (exc BCC)	67	2	69	97.1%
Brain/CNS	3	0	3	100.0%
Breast	36	3	39	92.3%
Gynaecological	6	7	13	46.2%
Urological	25	52	77	32.5%
Haematological	6	8	14	42.9%
Children's	1	0	1	100.0%
Other	2	2	4	50.0%
Total	199	129	328	60.7%

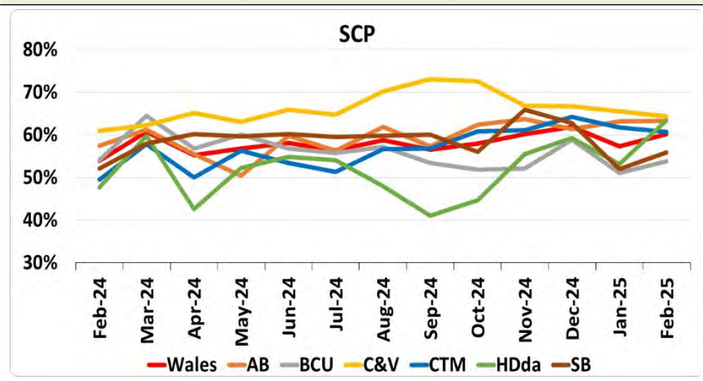
Compliance during March was 60.7% and rests around the current mean. To 31st March 2025, the WG expectation is 70% of patients to be treated within 62 days. Four of the tumour sites reached the desired target threshold of 70% this period, as seen in the table above. Predicted compliance for April currently stands at 60.8%. The delays at first outpatient (19%) and diagnostic stage (58%) continue to be the most significant factors in not achieving the target and remain our greatest concern. Diagnostic delays remain in radiology, endoscopy and pathology with tertiary delays for diagnostics & treatments also continuing.

Patients Treated by Closed Date



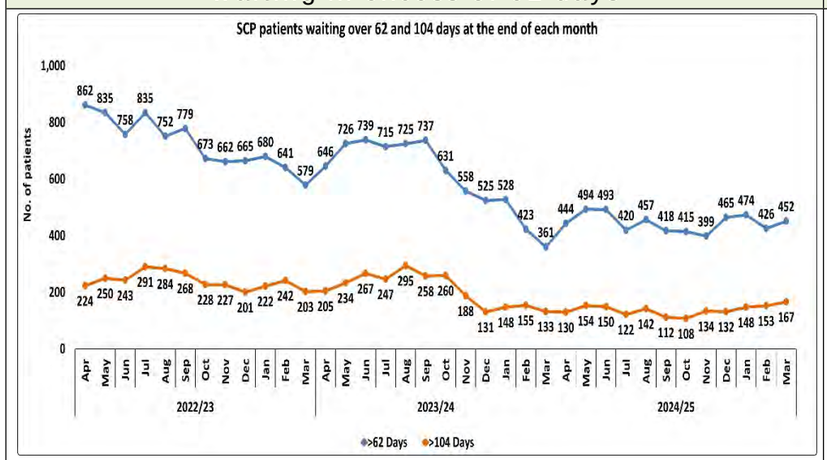
Cancer treatment volumes have seen a small increase during the past 12 months with the monthly average (Apr 24 to Mar 25) equating to 298 treatments per month and the monthly average seen in the equivalent time span of 2023/24 being 293.

How do we compare with our peers?



Status as at February 2025		
Health Board	Compliance	Rank
C&V	64.4%	1st
HDda	63.5%	2nd
AB	63.3%	3rd
CTM	60.7%	4th
SB	55.9%	5th
BCU	53.8%	6th

Patients currently waiting on a Cancer Pathway waiting in excess of 62 days



What actions are we taking & when is improvement anticipated?

- Rollout of digital vetting continues.
- Continuing outsourcing of pathology.
- Vanguard mobile endoscopy units on the Royal Glamorgan site will increase endoscopy capacity (patient procedures started first week of March).
- Increased focus on time to first appointment through capacity review, booking analysis and standing item in the regular Friday cancer performance meeting.
- Urology diagnostic task & finish group setup to improve urology diagnostic performance.
- Focus from Gynaecology specialty on improving performance with support of NHS Executive.

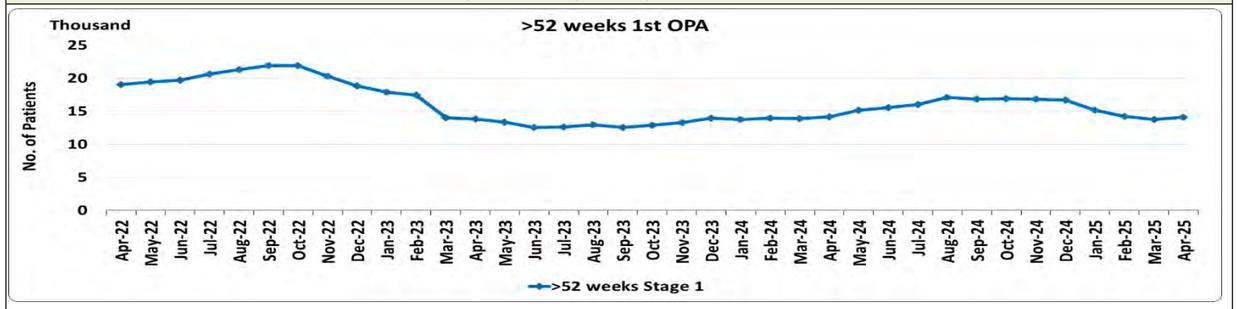
What are the main areas of risk?

- 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.
- Long wait for Bowel Screening Wales referrals.
- Admin and nursing resource to undertake additional outpatient lists.
- Business continuity issues due to relocation of POW activity, despite prioritisation of cancer activity.
- Loss of endoscopy capacity following removal of capacity at POW.
- Single consultant for laparoscopic nephrectomies.
- Disaggregation of Bridgend population from Swansea Bay WPAS to CTM WPAS is taking up considerable digital and administration resource.

CTMUHB Planned Care Group

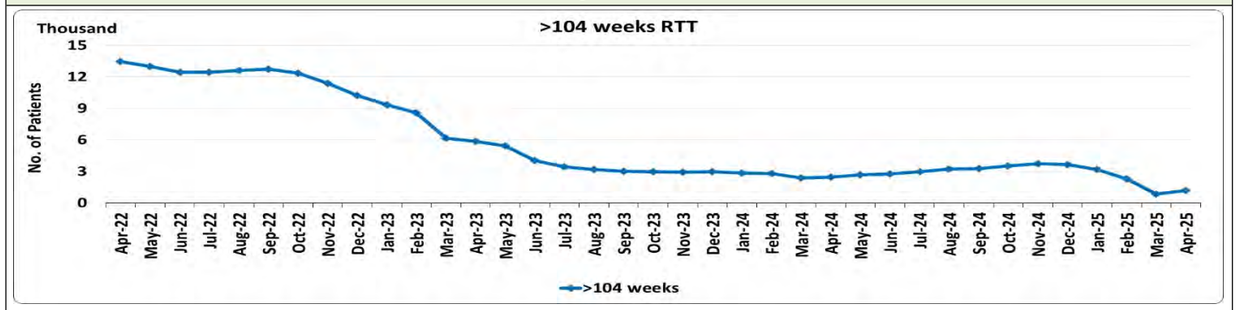
Referral to Treatment Times (RTT) – April 2025 (Provisional Position)

Number of patients waiting over 52 weeks for a new outpatient appointment (13,912) Target is Zero



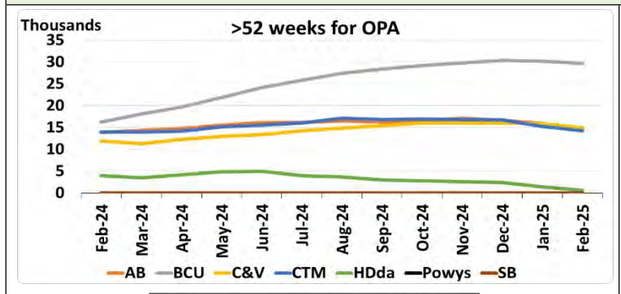
The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of April is 14,101; a 2.7% (372) increase on the March reported position and is similar to the position reported during April 2024.

Number of patients waiting >104 weeks RTT (1,191) Target is Zero

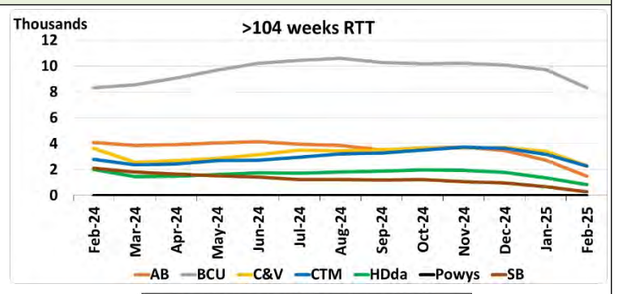


The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for referral to treatment at the end of April is 1,191. As it currently stands this is an increase of 335 patients from the reported March position, but is a 50% reduction on the same period last year.

How do we compare with our peers?



Status as at February 2025		
Health Board	Compliance	Rank
Powys	0	1st
SB	0	1st
HDda	638	3rd
CTM	**14,216**	**4th**
AB	14,493	5th
C&V	14,982	6th
BCU	29,673	7th



Status as at February 2025		
Health Board	Compliance	Rank
Powys	0	1st
SB	280	2nd
HDda	829	3rd
AB	1,486	4th
CTM	**2,277**	**5th**
C&V	2,292	6th
BCU	8,341	7th

Total number of open pathways per specialty - April 2025 (provisional)

Specialty	All Urgent patients waiting >12 Weeks	Patients waiting >52 Weeks for 1st OPA	All patients waiting >52 Weeks to 104 Weeks	All patients waiting >104 Weeks	Total Open Pathways
Anaesthetics	152	357	384	1	1646
Breast Surgery	8	0	2	0	563
Cardiology	1493	261	798	0	6471
Clinical Immunology	76	81	81	0	312
Colorectal	396	0	236	0	2750
Dermatology	614	754	779	0	5497
Diagnostics	0	0	2	0	4127
Ear, Nose & Throat Service	843	2927	4016	190	11908
Endocrinology	0	0	0	0	367
Gastroenterology	1137	189	317	1	3477
General Medicine	659	405	456	0	2865
General Surgery	850	180	741	0	5516
Geriatric Medicine	15	1	2	0	435
Gynaecology	2085	813	1782	15	9314
Haematology (Clinical)	69	68	69	0	498
Nephrology	73	26	28	0	285
Ophthalmology	784	4004	4884	0	16297
Oral Surgery	406	430	676	0	2959
Orthodontics	81	32	32	0	468
Orthopaedics	2705	1417	4474	975	14217
Paediatrics	93	110	296	2	3210
Pain Management	0	0	0	0	1
Rapid Diagnostic Centre	0	0	1	0	140
Respiratory Medicine	166	376	522	0	3091
Restorative Dentistry	26	45	45	0	165
Rheumatology	298	160	282	0	1946
Sport and Exercise Medicine	0	0	0	0	9
Therapies	0	0	0	0	996
Urology	1737	1190	2094	7	8516
Vascular Surgery	23	275	307	0	1030
Total	**14,789**	**14,101**	**23,306**	**1,191**	**109,076**

RTT continued on the next page...

Referral to Treatment Times (RTT) continued - April 2025

What actions are we taking & when is improvement anticipated?

Cardiology
- Extensive validation being undertaken.
- D&C plan completed and additional capacity required to achieve trajectory identified.

Diabetes & Endocrine
- Focus on RGH and pooling of waiting lists to reduce long waits being progressed.

ENT:
- Plan for Stage 1-4 to be clear >104 weeks by the end of June.
- Ongoing plan in place to clinically validate all those stage 4 patients waiting over 52 weeks.

Gastroenterology:
- Clinicians have been requested to carry out additional clinics – weekend clinics planned for May and June.
- Validation of the waiting lists, including surveillance endoscopy patients, continues.
- Approval has been given to extend the insourcing team within Endoscopy for a further 2 months.
- Locum Consultant starts in POW in May. The Consultant will also undertake a weekly new patient clinic in RGH to help support the backlog of stage 1 patients.
- Specialist Doctor commencing in Gastro Services pending employment checks. This will improve the number of clinicians on the ward and on call rota.
- Weekly evening telephone clinic set up for suitable patients with a Senior Registrar. 10 new patients per week and the clinic has been running since April and booked through to May.
- Clinical validation of the stage 1 waiting list is ongoing with a significant number of patients being discharged.

General Surgery:
- Theatre sessions will increase when the PCH Theatre refurbishment is completed in May.
- Vanguard theatres have come online from 10th April at RGH; all long waiting cases are under review for suitability for treatment in the Vanguard.
- Once the POW roofing refurbishment is completed, hopefully by September 2025, this will also allow the expansion of theatre sessions.
- Backfilling of any vacant sessions where possible, ensuring maximised capacity to meet the internal RTT target of 78 weeks and SCP targets.
- Clinical note reviews are being undertaken for all patients in the over 52 week cohort.
- The merge of the WPAS system with POW will enhance the booking of patients.
- Awaiting roll out of e-vetting to include all sites to improve turnaround time.

Gynaecology:
- Administrative and clinical validation work is ongoing to manage demand into 2025.
- Clinical validation & re-allocation of long waiting patients into general Gynae clinics to expedite first appointment.
- Weekly theatre meetings held to ensure theatre capacity is allocated to USC and long waiting patients.
- Working with theatre teams to secure all backfill available.

OMFS:
- We will continue to be clear >104 week by the end of June 2025

Ophthalmology:
- Will maintain zero 104 week waits in May
- Additional clinics for medical retina agreed with further clinics being requested for high-risk patients
- Total responses suitable to outsource is 936 (referrals sent to New Medica is 591, referrals sent to Spa Medica is 7, 338 remain to be outsourced). We plan to outsource an additional 936 with letters being sent by the regional team.

Orthopaedics:
- Regular RTT meetings continue; focus on treat in turn and offering WLI where possible
- Providing independent sector with case details for outsourcing, utilising Vanguard for as many cases as possible
- Validation work continues
- Exploring workforce sustainability and a change in workforce to realign roles
- Exploring how to continue elective activity at other sites
- Digital dictation agreed and pending implementation.
- Service Manager newly appointed to support the above.

Paediatrics:
- Regular RTT and performance review meetings continue.

Respiratory
- Extensive validation being undertaken and sleep patients managed in line with new RTT guidance.
- D&C plan completed and additional capacity required to achieve trajectory identified.

Rheumatology
- Pooling of patients across site being implemented to reduce long waits.

Urology:
- WLI's planned to achieve 8-week diagnostic target
- Continuous validation.

(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?

ENT:
- Difficulties accommodating long waiting inpatients due to clinically urgent and USC demand.

Gastroenterology:
- Lack of clinician uptake for additional clinics.
- Due to the demand of Endoscopy USC's, very little 8-week diagnostic partial booking is taking place.
- Not enough throughput of Transnasal Endoscopy patients at the moment due to constraints within the RGH Endoscopy unit.
- Consultant vacancies in POW (2.0 wte) - significant risk if there are no suitable candidates to fill these posts.
- BSW – our waiting times are rising slowly due to the limited number of bowel screening endoscopists and constraints relating to the use of the insourcing team at weekends.
- Waiting list demand is still significantly greater than capacity, need to review vetting process to ensure inappropriate referrals are not added to the waiting list.
- Service provision of Endoscopic Retrograde Cholangiopancreatograpy (ERCP's) at POW likely to be impacted due to decontamination issues, with the potential to impact capacity elsewhere.

General Surgery:
- The closure of 2 PCH theatres in December 2024 for refurbishment purposes will delay urgent and routine patient surgery, with cancer surgery being the priority. This may result in an increase in emergency admissions and will add to the already long waiting list of patients awaiting surgery.
- Relocation of PCH Day Surgery has meant the reduction from 15 trolleys to 10. Throughput of patients with existing theatre sessions will further reduce, this is also as a result of no elective beds at PCH site.
- Vanguard Theatres RGH – due to the criteria of what can be undertaken in the theatres we are limited with cases we can treat. Any cases unsuitable will require treatment in the main theatre at RGH or PCH, for which there is limited capacity.
- New process for WLI approval has been implemented, however we are seeing a delay in the agreement of these sessions which will impact the sessions selected for backfill.
- Reliant on interdependencies for the investigations to take place, which can be lengthy in wait, due to the USC demand taking priority. Interdependencies will need to provide additional support to meet patient demand in the middle stages of the patient pathway.

Gynaecology
- Inpatient gynae cases remain as a risk due to small number of inpatient beds and not enough capacity on a weekly basis.
- Equipment currently being shared across POW DSU / PCH / RGH / Vanguard – limitations in the amount of equipment available impacting on allocation of patients.

Ophthalmology:
- Regional team untimely returning unsuitable patients.

Orthopaedics:
- Closure of POW elective and trauma services.
- Gaps in the admin & clerical establishment.
- Current lack of digital dictation preventing more streamlined working although now agreed and pending implementation.

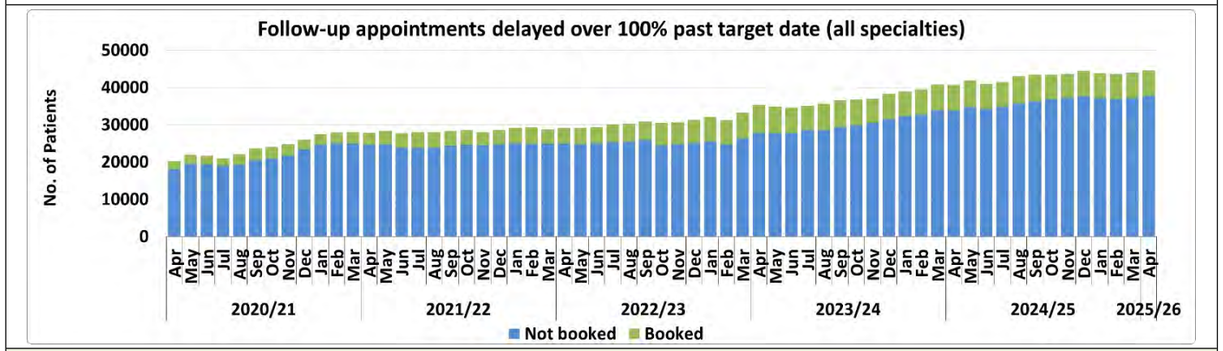
CTMUHB Planned Care Group

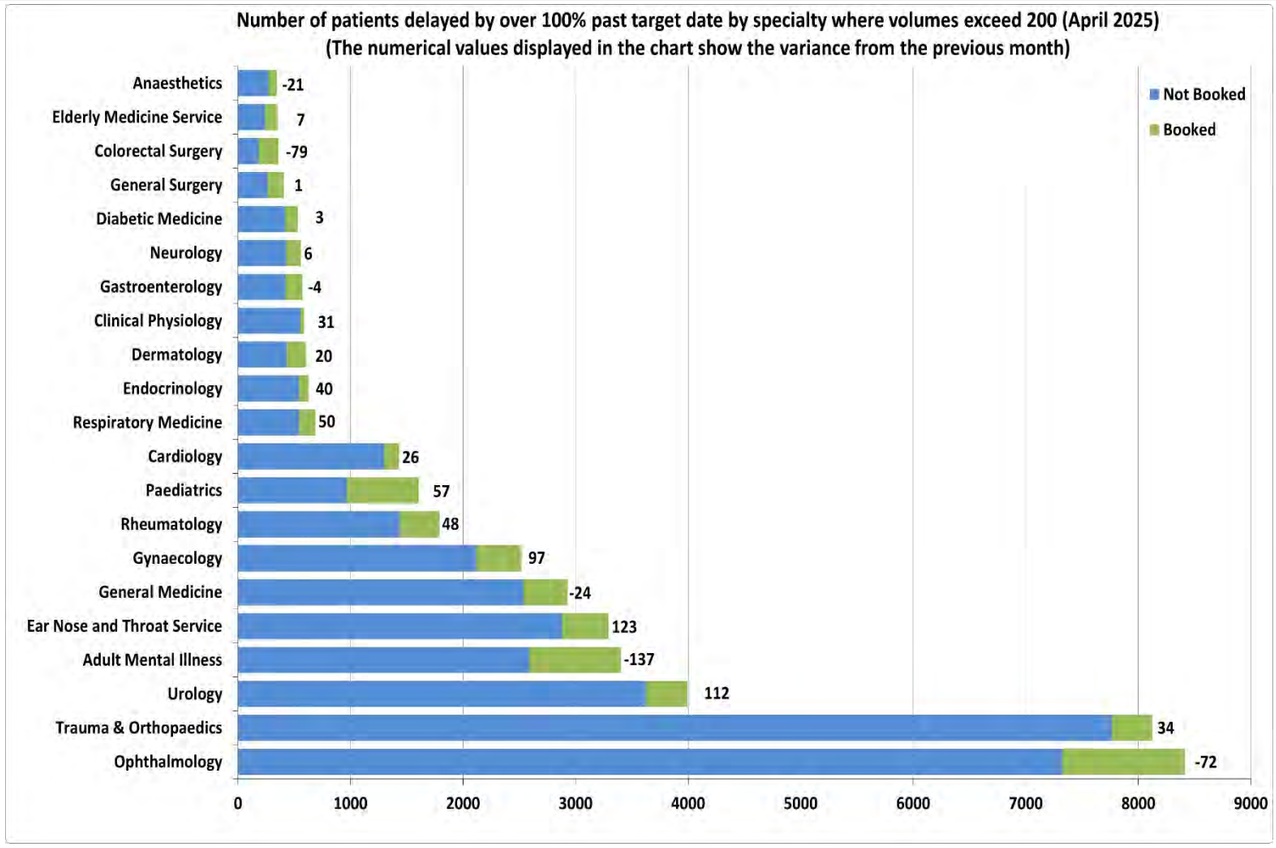
Follow-up Outpatients Not Booked (FUNB) – Provisional Position April 2025

Number of patients waiting for a Follow-up with documented target date

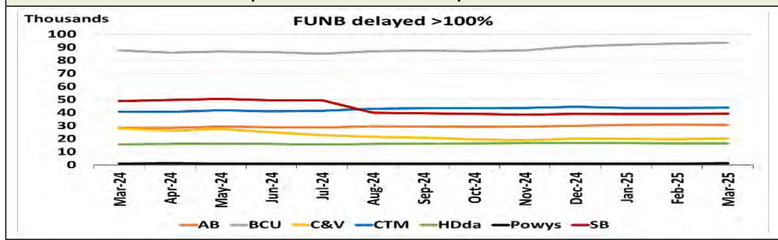
Number of patients waiting for a Follow-up delayed over 100% - Target Reduction compared to same month in the previous year

No. of patients waiting for follow-up appointment				No. of patients delayed over 100% past their target date			
No documented target date	Not Booked	Booked	Total	Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
0	92,045	58,319	150,364	37,801	6,753	44,554	29.6%





How do we compare with our peers?



Status as at March 2025		
Health Board	Compliance	Rank
Powys	1,318	1st
HDda	16,504	2nd
C&V	20,282	3rd
AB	30,702	4th
SB	39,297	5th
CTM	**43,955**	**6th**
BCU	93,521	7th

How are we doing?

The number of patients waiting for a follow-up appointment in CTM at the end of April 2025 provisionally stands at 150,364, which is a growth of 5.2% on the number of patients waiting during the equivalent period of 2024.

There are currently no patients without a documented target date.

Of the patients waiting, 44,554 (29.6%) have waited more than 100% longer than their clinician advised.

During 2024/25, the average monthly follow-up activity was 1,482 (4.1%) attendances higher at 37,660, when compared with 2023/24 levels, but remains 1,846 (4.7%) lower than pre-Covid activity volumes.

What actions are we taking & when is improvement anticipated?

ENT: Requires extensive clerical and clinical validation with over 6000 patients currently waiting over target

- Ongoing work with PIFU and SOS Outcomes

General Surgery:

- Clinical and administrative validation ongoing.
- With the loss of theatre sessions the focus has been on the virtual reviewing of follow-up patients with the aim to make appropriate patient discharges. Improvement expected over the coming months.
- Additional training and support to be given to the admin team to ensure all PIFU/SOS outcomes are actioned accurately.
- FUNB numbers are monitored and validated weekly, with the promotion of SOS and PIFU, this should reduce the FUNB patient lists.
- Consultants are being provided with the FUNB waiting lists to review and provide advice on the next stage - face to face appointment required or discharge with advice.

Gastroenterology:

- Ongoing clinical and administrative validation.
- Consultants are working through their FUNB lists to prioritise and validate. Aim to increase FUNB throughput with registrars being added to clinic template

Ophthalmology: FUNB remains a problem with validation proving unsuccessful due to high volume – a solution is being sought.

Orthopaedics:

- Validation work ongoing
- Exploring workforce sustainability & realignment of workforce
- Exploring additional clinic capacity
- Exploring moving patients to a PIFU / SOS pathway
- Service Manager newly appointed will provide support to the above.

Gynaecology:

- Validation processes continue for all patients exceeding their planned follow up timeframe.

Urology: The WPAS merger should help to reduce admin errors causing duplicates & better pathway management.

What are the main areas of risk?

General Surgery:

- Limited face to face clinic capacity for FUNB.
- Medical Records staff are often short on resource and cannot always accommodate additional clinic sessions.
- Consultants need to engage with the SOS and PIFU patient outcomes.

Gastroenterology:

- Due to the ongoing validation of RTT lists, patients are being added to the FUNB list following the start of treatment.

Orthopaedics:

- Gaps in the admin & clerical establishment
- Unsure of long-term impact from POW site disruption
- Workforce currently not large enough to manage demand and backlog.

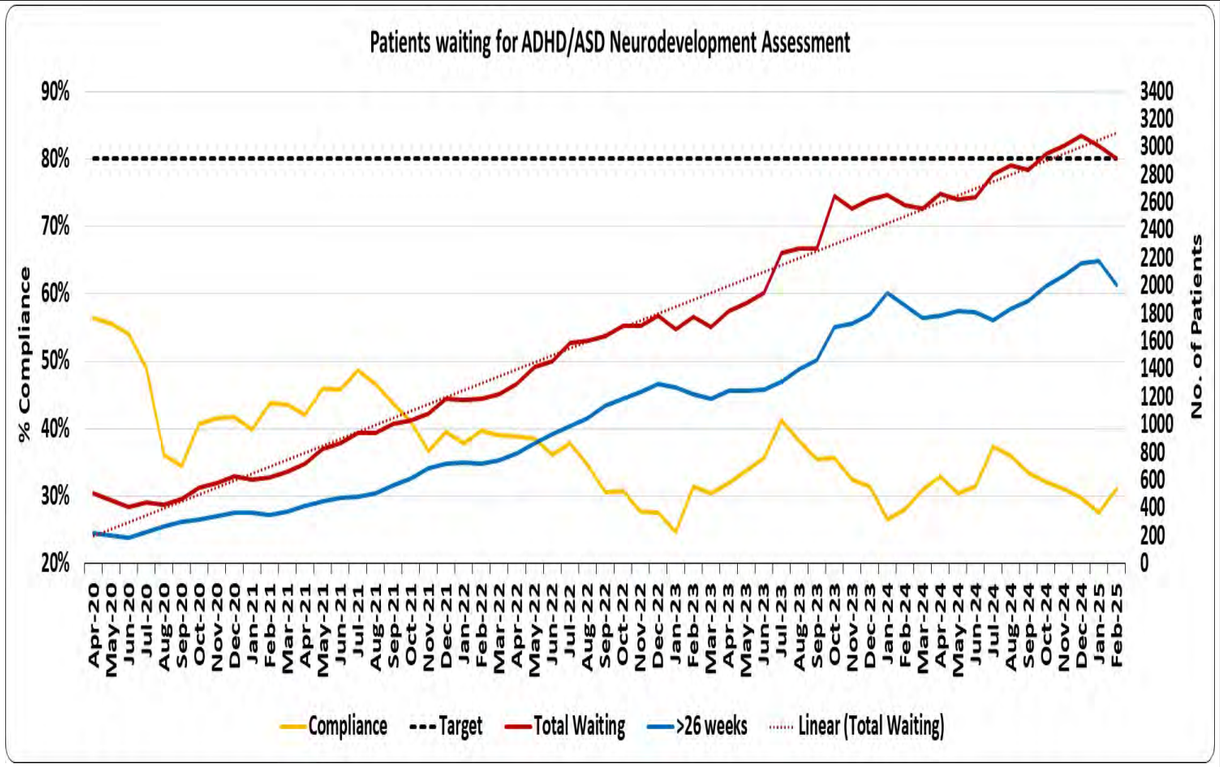
Gynaecology:

- Insufficient resource to undertake clinical validation.
- Insufficient 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%)

March 2025 - 33.7%



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 2,863 patients (Mar 25); 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 196 per month, despite 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 33.7%.

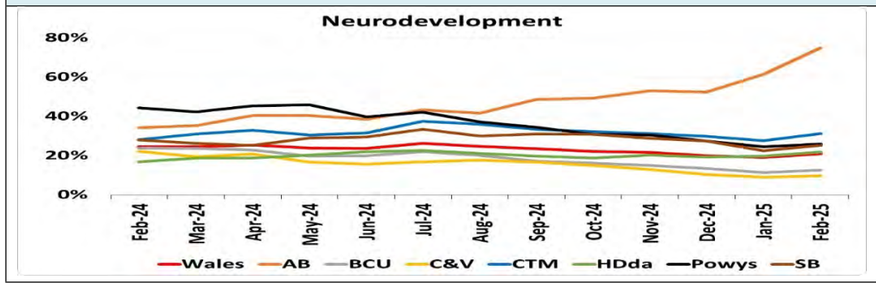
During the past 12 months compliance has been fluctuating between 27.6% and 37.4%, with access remaining well below the WG target of 80% and will continue to be so until the backlog is addressed.

Funding via NDIP allocated for 2024/25 allowed an additional 745 new patients and 1,050 follow up patients to be seen in addition to core activity.

What actions are we taking & when is improvement anticipated?

- The Improvement Board is overseeing the impact of the Regional Partnership Board's allocation to ND services. Work continues with local authorities, along with AHP posts to support pre/post diagnosis with third sector agencies, as additional funding has been made available. In 2024/5 this was used to increase capacity within the workforce, namely locum SALT/CAMHS and additional/overtime hours for existing staff, this will continue into 2025/26. We have been able to recruit 3.0 wte B7 ND Practitioners on a fixed-term basis until March 2026, of which 1.2 wte are already in post. We have also been able to recruit a 0.4 wte Locum SLT to support with the waiting list. Staff within the core ND team, as well as within other departments, are also anticipated to be willing to continue with additional hours to reduce the backlog.
- Pharmacy input supporting post-diagnosis follow-up titration & monitoring helps to release medical colleagues to support the waiting list further. The Pharmacy department have agreed to release an additional 0.2 wte Pharmacist and 0.2 wte Pharmacy technician to support this work.
- 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. CNS/AHP staff recruited in 2024/5 are actively supporting with the new patient and follow-up waiting lists.
- 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 anticipate that the waiting list over the coming months will decrease as additional staff commence in post and capacity meeting the demand. Currently, the longest waiting patients have been waiting 100 weeks (3 children), with next longest wait being 94 weeks (4 children). Average waiting times are now around 19-22 months for 4-18 year olds, and 12 months for children referred to us when they were 2 or 3 years old; which we will be able to maintain and continue to improve upon.
- Following the ND event held at the end of 2024 with leads from Health, Education, Social Care, 3rd Sector and Parent/Carer Network, it is expected that WG/NHS Executive will publish new guidelines shortly which support CTM model. Agreement sought to pilot `fast-track´pathway for autism referrals in children/young people aged 5 or above to reduce adding to ND waiting list for full assessment. A pilot has commenced in Merthyr/RCT where the first cohort of 18 children will be able to receive an autism diagnosis without needing to stay on the waiting list. A similar pilot has commenced in Bridgend, where it is anticipated that 70 children nominated by schools will be able to receive an autism diagnosis and be removed from the waiting list without needing an initial appointment.
- Supporting our regional partners to develop skills in using ND profiling tools either while/before a referral to ND assessment team is being considered.
- New paperwork for referrals for school-aged children has been launched which we anticipate will start to reduce the number of inappropriate referrals we receive, although we are unlikely to be able to measure the full impact of this until the end of 2025.

How do we compare with our peers?

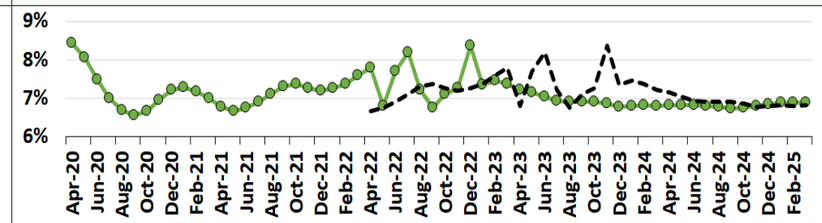
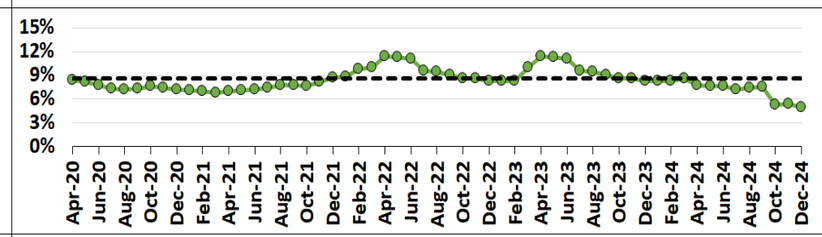
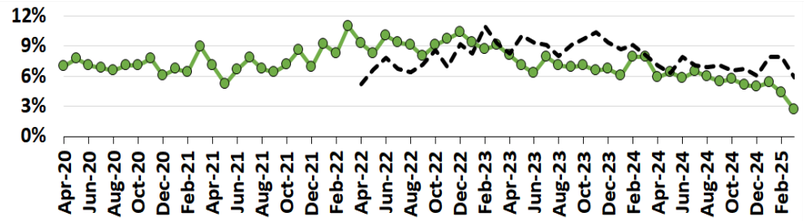
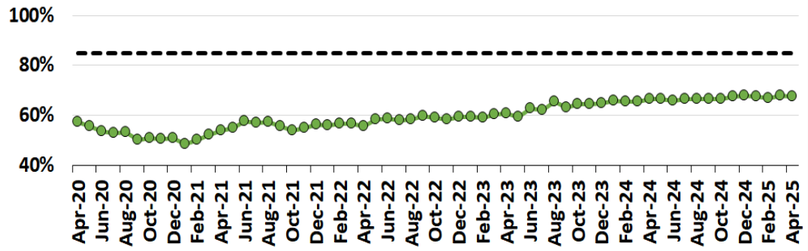


Status as at February 2025		
Health Board	**Compliance**	**Rank**
AB	74.8%	1st
CTM	**31.1%**	**2nd**
Powys	25.9%	3rd
SB	25.2%	4th
HDda	21.8%	5th
BCU	12.5%	6th
C&V	9.6%	7th

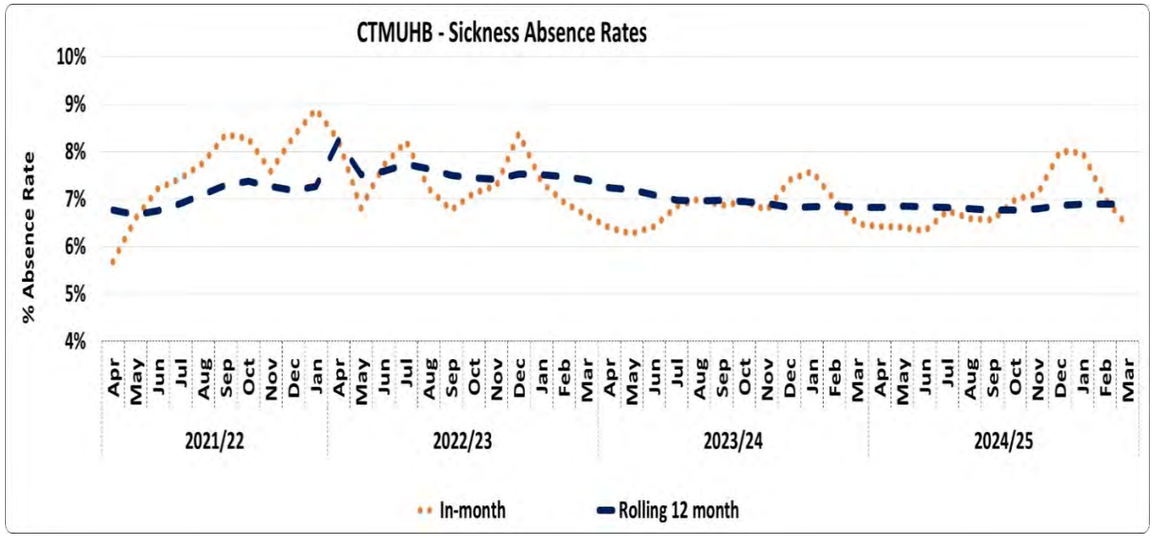
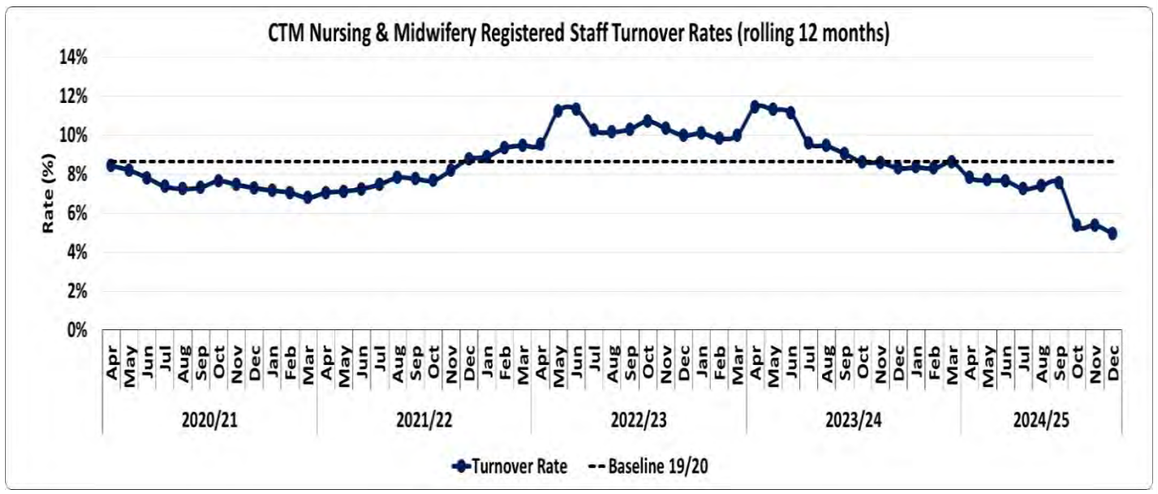
What are the main areas of risk?

- A demand and capacity review was undertaken early last year with templates implemented and fixed on WPAS to ensure forecast remains accurate. Vacancies within the ND team, namely ADHD nurses, had created additional waits for children/young people for ADHD assessments, although these are now starting to be brought back in line in terms of waiting times with assessments for autism, as the posts have been recruited to.
- During last year, the service had identified what was required to bridge the gap of the deficit in capacity to meet the demand at the time (investment of 2 x B7 AHP for 2 years). However, trends show an increase in demand of approximately 20% year on year and whilst NDIP funding has allowed us to maintain our position, this will not improve waiting times alone.

2.4 Welsh Government Performance Indicators: Quadruple Aim 3 - A Motivated & Sustainable Workforce

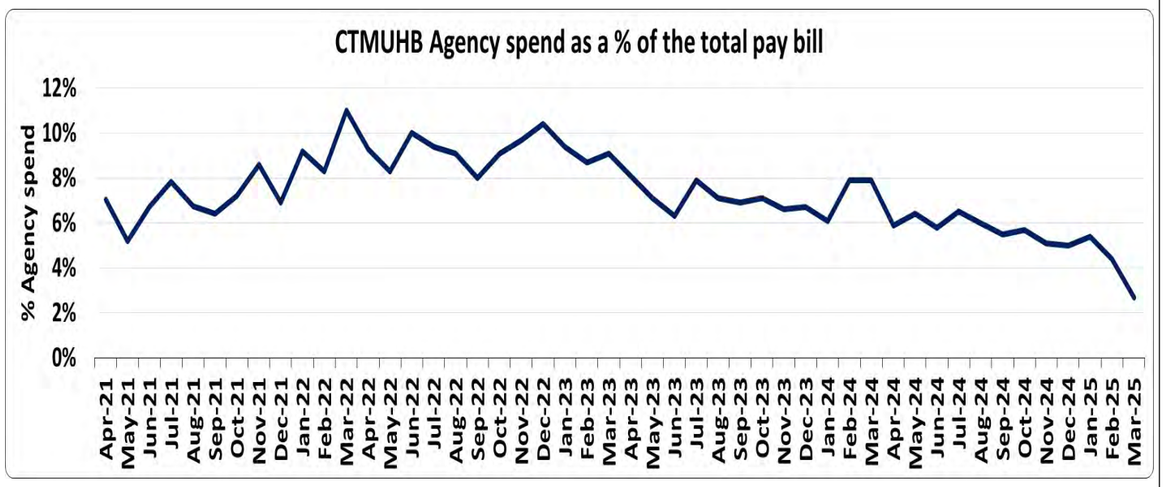
Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable					
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Hit Target / Target Failed — Latest Position	
Motivated & Sustainable Workforce	% of sickness absence rate of staff	12 Month Reduction Trend		6.9%	Mar-25
	Turnover rate for nurse & midwifery registered staff leaving NHS Wales	Rolling 12 month reduction against a baseline of 2024-25		4.94%	Dec-24
	Agency spend as a percentage of the total pay bill	12 Month Reduction Trend		2.7%	Mar-25
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%		67.7%	01/04/2025 (N.B. there is a time lag in reporting medical staff appraisals and consequently data for Feb to Apr 2025 does not currently include medical staff)

CTMUHB Workforce Metrics

% of sickness absence rate of staff – Target is 12-month reduction trend March 2025 (6.89%)	What actions are we taking & when is improvement anticipated? What are the risks?
	The rolling twelve-month sickness rate to March 2025 is 6.89% and is at a similar level to the equivalent rolling period of the previous year (6.83%). The in-month sickness rate is 6.43% and is also similar to March 2024 (6.48%), however the rate continues to remain higher than our desired target of 4.5%. The Health Board's primary sickness reason for both long & short term absence remains Anxiety/Stress/Depression/other psychiatric illness, resulting in 38.0% & 24.6% respectively, of the total days lost to sick absence. The second highest reason is Other known causes (not elsewhere classified) at 10.0% of the days lost. The staff group with the highest sickness level is Estates and Ancillary with 9.80%, which is a marginal decrease on their last reported position of 9.91% at the end of February. Actions we are taking: • The reduction in sickness absence rates and the focus of activity remains under three broad areas - awareness, skills development and case management. • We are in the process of developing a heat mapping exercise (e.g. sickness, turnover, employee relations, V&A, organisational change) on a quarterly basis that would help identify those departments across the whole HB that may require a targeted intervention from the People Directorate. This will enable a more targeted approach to support those areas where employee experience, retention and sickness levels may be problematic. • A key focus will be facilitating a return to work of their staff as soon as they are fit to do so in some capacity, whether that be a therapeutic return, phased return to work or a temporary short term deployment. • The PST are encouraging managers to engage with their employees around reasonable adjustments requested, utilising the Reasonable Tailored Adjustments Agreement within the Managing Attendance at Work Policy. The aim of this approach is to encourage managers and employees to review adjustments so they can amend as required to suit both service needs and employee wellbeing. This approach supports both retention of employees and may reduce employment relation issues to support our employees staying well in work. Risks: • Failure to reduce sickness rates impacts on health and wellbeing across our workforce and their employee experience, especially if this increases demand/pressure on others to deliver services. • There is a high risk of increased use of variable pay to fill workforce gaps. • Impact on staff morale and motivation including productivity and engagement.
Turnover rate for N&M registered staff leaving NHS Wales – Target is rolling 12 month reduction against a baseline of 2024-25	**What actions are we taking & when is improvement anticipated? What are the risks?**
 *Please note that there is a time lag in reporting due to the inability to locally monitor staff leaving NHS Wales.*	The *reported* position at December 2024, for N&M registered staff leaving NHS Wales, reduced further to 4.94%. The equivalent timespan of the previous year saw rates of 8.3%. (January 2023 to December 2023). This trend is also reflected in the Medical and Dental turnover, with a rate of 6.78% at the end of April 2025 compared to 8.57% at the end of April 2024. Healthcare Support Worker (HCSW) turnover remains high at 10.10% at April, but this is down from a peak of 12.75% at November 2023. The turnover rates continue to be monitored with Care Groups and Professional Groups to ensure there is a continued reduction for improved workforce sustainability. Actions we are taking: • A new Retention Lead is joining CTM in June to help drive and progress retention initiatives to support a reduction in turnover. • We are reviewing the Lateral Moves Scheme to continuously improve the Scheme with a view to extending to other nurses and midwives, other than Band 5 & and Band 2 HCSW's, in an effort to retain them in CTM and within Wales. • Reviewing nursing and midwifery shift patterns across the UHB, supporting a fair and consistent approach and is fit for the future. • A review of our Moving On Questionnaire for improved engagement and to better inform the reason(s) for people leaving. Risks: • Potential loss of talent, skills & expertise affecting patient care. • Potential increase of variable pay. • Potential impact on staff morale and motivation, productivity and staff engagement. • Increased sickness absence due to the impact of increased vacancies and possible difficulties in filling vacant posts.

CTMUHB Workforce Metrics

Agency spend as a percentage of the total pay bill – Target 12 month reduction trend – March 2025 – 2.7%



What actions are we taking & when is improvement anticipated? What are the risks?

As at March 2025 the CTM agency spend as a percentage of the total pay bill currently stands at 2.7% and is the lowest rate observed, as seen in the chart to the left; with the overall agency spend for 2024/25 (YTD) totalling 4.8%.

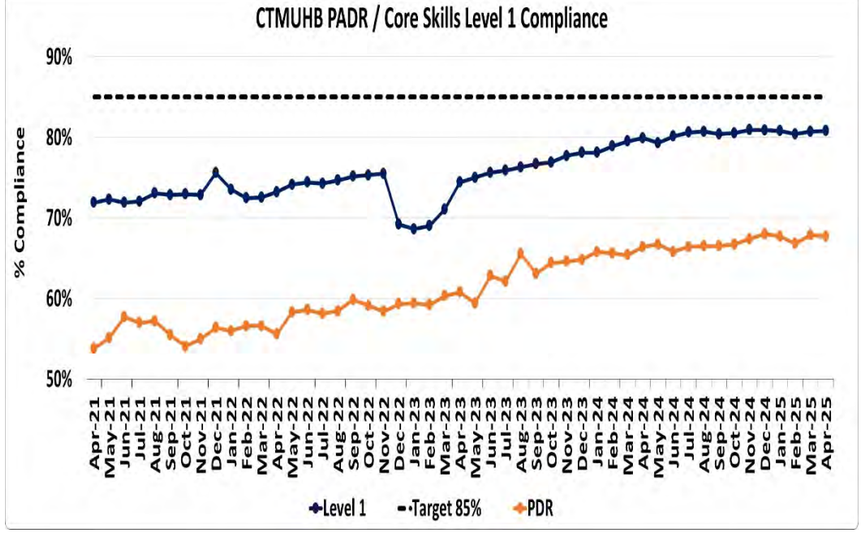
Actions we are taking:

- Appointed a dedicated workforce productivity & efficiency lead to drive and support the delivery of reduced agency spend within 2025/26.
- Medical & dental and nursing & midwifery programmes have been established to identify the areas of focus to deliver the £4m and £3m respective savings and improvements.
- Programme of work to look at agency to bank conversion for nursing/midwifery and medical/dental is being assessed, with further scoping for bank to substantive conversion.
- Over recruitment models are being explored to mitigate the use of high cost spend.
- Workforce controls have been implemented to mitigate the use of high cost agencies.
- AHP rate card review and a clear trajectory to bring rates in line with AFC and enhancement reduction.
- Review of employee relation cases that are attracting high cost temporary spend.
- Plan to reduce the medical enhanced rate from 10% to 5%.
- Roster optimisation and controls to ensure areas are not working outside of allocated budgets.

Risks:

- Failure to reduce variable pay within 2025/26 to meet the UHB savings target and inability to invest in service transformation.
- Lack of sustainable and affordable workforce solutions to meet workforce gaps.

% headcount by organisation who have had a PADR / medical appraisal in the previous 12 months (excluding M&D in training) – Target 85%



CTM Level 1 Core Manditory Training Compliance April 2025	
Equality, Diversity & Human Rights	86.3%
Health, Safety and Welfare	86.2%
Safeguarding Adults	85.9%
Safeguarding Children	84.8%
Moving & Handling	84.5%
Information Governance	81.6%
Violence & Aggression	79.4%
Fire Training	78.9%
Infection Prevention and Control	77.7%
Resuscitation	62.7%
HB Overall Compliance	80.8%

What actions are we taking & when is improvement anticipated? What are the risks?

Overall, PADR compliance is improving slowly, currently standing at 67.7% (excludes medical appraisals). Compliance for the past year has ranged between 65.8% and 68.0%, recognising that this remains below the WG target of 85%. For Medical Appraisals, the position at the end of 2024/25 was 94.3% for secondary care staff and within primary care the position was 99.5%, giving the overall M&D appraisal position of 95.9%. This gives a combined PDR/appraisal rate of 70% for 2024/25.

PDR – Your Conversation:

Overall PADR compliance remains stable and work continues to improve this compliance rate with:

- Full educational offer available, taking staff through PADR process from a systems (ESR), individual and manager perspective.
- "Making the most of PDR – Your Conversation" workshop being delivered with management teams to encourage engagement in development conversations.
- CTM-specific PADR and Pay Progression FAQs and more general guidance continually updated.
- A full review of the PADR process & education commences May following receipt of the Shared Services internal audit (final draft expected 15th May). This will include improved manager guidance.

Core Learning:

Overall Health Board compliance for Level 1 remains buoyant at 80.7% at end of March 2025, with compliance for all levels of training at 73.6%.

Ongoing work aimed at continuing to improve compliance rates:

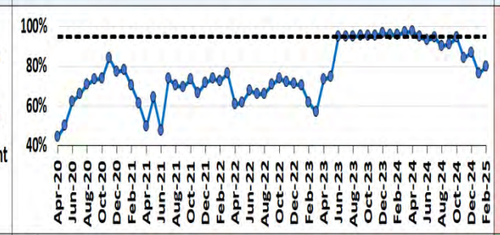
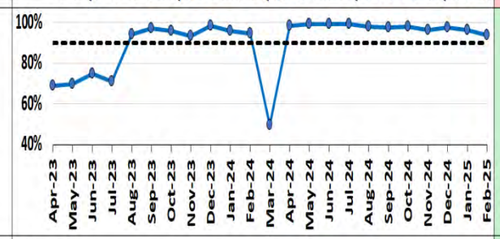
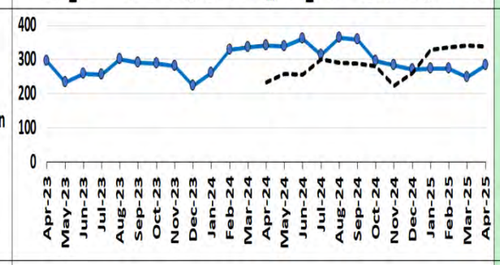
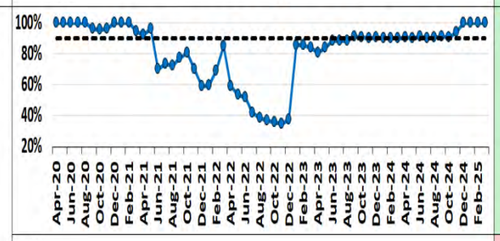
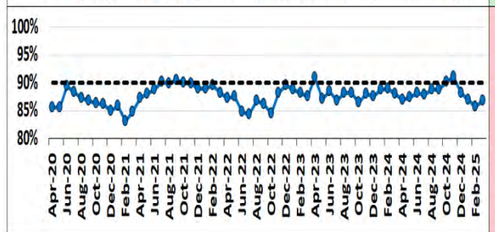
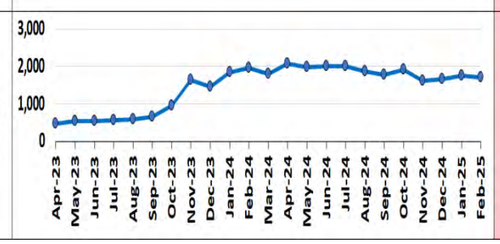
- Subject Matter Experts and associated training teams are continuing to provide greater numbers of face to face training sessions.
- Learning and Development team supporting in the design of eLearning packages to shift face to face sessions to virtual modules, increasing the options for compliance.
- Improved usage and training of local training co-ordinators to use full ESR functionality to manage booking processes more effectively and minimise 'did not attends'.
- Provision of the appeals process, Core Learning Drop-in Sessions across CTM and the development of improved subject guides, all aimed at removing barriers to compliance.

We are actively participating in an external review of NHS Wales statutory and mandatory training, with a view to exploring opportunities to reduce, rationalise and improve the quality and impact of the current training offer. The report will be shared in early summer.

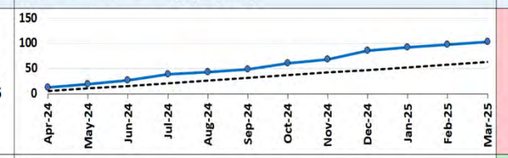
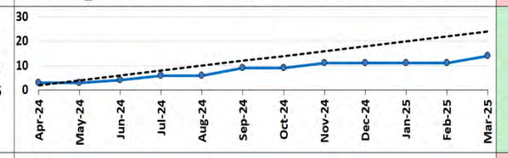
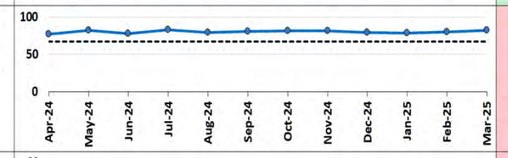
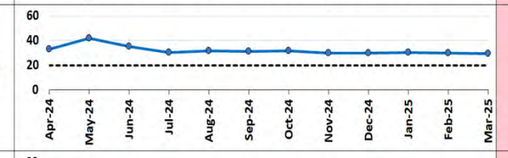
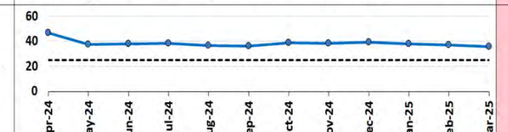
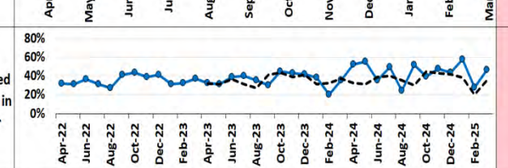
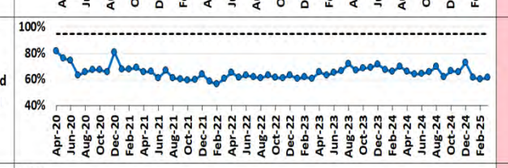
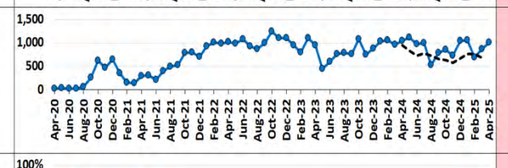
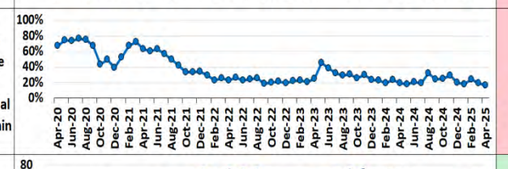
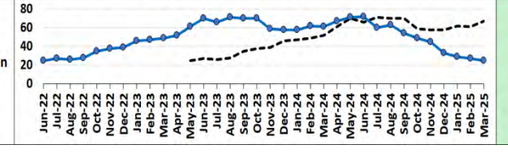
Risks:

- Lack of objectives aligning to CTM strategic ambitions.
- Impact on morale, motivation and employee experience.
- Loss of dedicated time for a conversation for individual and manager to discuss work performance and provide two-way feedback, development opportunities and career aspirations.
- Impact on the pay progression process and individual receipt of timely increments.

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

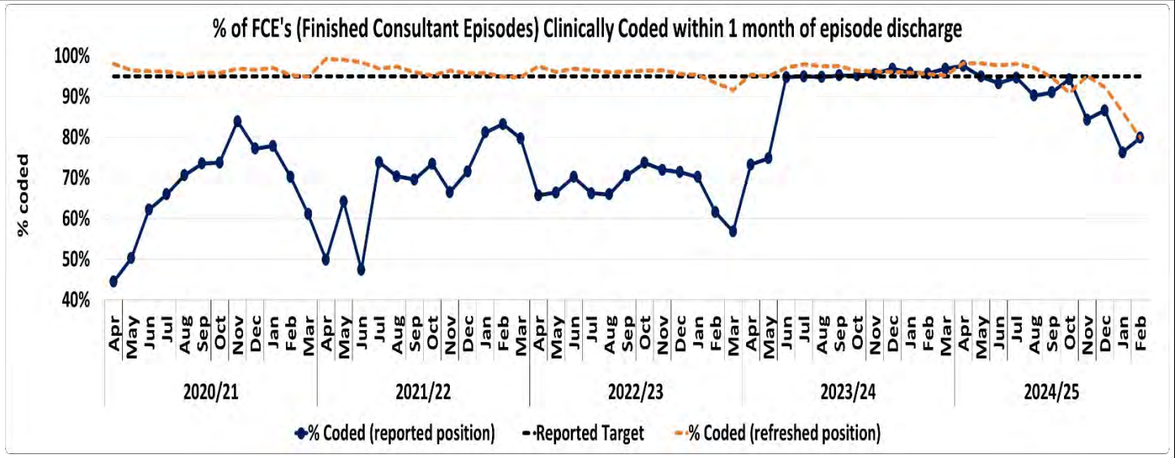
	Performance Measure	Target	Key: Trend ---Target/Trajectory	Key: Hit Target / Target Failed Green = Target Met / Red = Under	
Effective Services	% of episodes clinically coded within one reporting month post episode discharge end date	Maintain the 95% target or demonstrate a 12 month improvement trend		79.9%	Feb-25
	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%		93.5%	
Efficient Services	Number of Pathways of Care delayed discharges	12 month reduction trend		284	Apr-25
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%		100.0%	Mar-25
	% 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			86.8%	
	Number of service user feedback experience responses completed and recorded on CIVICA	Month on month improvement		1,706	Feb-25

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 / Target Failed Latest Position	
Safe Services	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	No more than 60 cases for 2024/25		103	Apr 24-Mar 25
	Cumulative number of laboratory confirmed bacteraemia cases: Pseudomonas aeruginosa	No more than 24 cases for 2024/25		14	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli	67.00 per 100,00 population		81.98	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus (MRSA and MSSA)	20.00 per 100,00 population		29.50	
	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	25.00 per 100,00 population		35.58	
	% 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		46.4%	Mar-25
	% 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%		61.4%	Mar-25
	Number of ambulance patient handovers over 1 hour	Zero		1,011	Apr-25
	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		16.2%	
	Number of National Reportable incidents that remain open 90 days or more	12 month reduction trend		25	Mar-25

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 – February 2025 – 79.9%



Current Coded Position as at 3rd March 2025				
2024/25	**Total FCE's**	**Coded FCE's**	**Uncoded FCE's**	**% Clinically Coded**
Apr-24	11,615	11,534	81	99.3%
May-24	11,873	11,808	65	99.5%
Jun-24	10,938	10,858	80	99.3%
Jul-24	11,949	11,841	108	99.1%
Aug-24	10,581	10,495	86	99.2%
Sep-24	10,644	10,461	183	98.3%
Oct-24	11,494	11,316	178	98.5%
Nov-24	10,890	10,601	289	97.3%
Dec-24	10,390	10,025	365	96.5%
Jan-25	10,604	10,143	461	95.7%
Feb-25	9,885	8850	1035	89.5%
Mar-25	11,089	8244	2845	74.3%
Total	**131,952**	**126,176**	**5,776**	**95.6%**
2025/26	**Total FCE's**	**Coded FCE's**	**Uncoded FCE's**	**% Clinically Coded**
Apr-25	10,327	1,861	8,466	18.0%
Uncoded 2024/25 (Apr 2024 - Mar 2025)		**5,776**	**4.4%**	

How are we doing?

The reported in-month position for February 2025 is 79.9% of the FCE's (Finished Consultant Episodes) for that month being coded within the requisite timescale, falling short of the set target of 95%, due to the downtime experienced as a result of the auto-coding system being upgraded and disruption caused as a result of the POW roof incident.

However, as of the start of May, the overall coded position from April 2024 to March 2025 stands at 95.6%, indicating the service is on track to meet the 98% target for 2024/25 in our formal submission in July 2025.

Compliance for the correction of errors within 35 days was 93.5% during February with 101 of the 108 errors corrected within the requiste timescale.

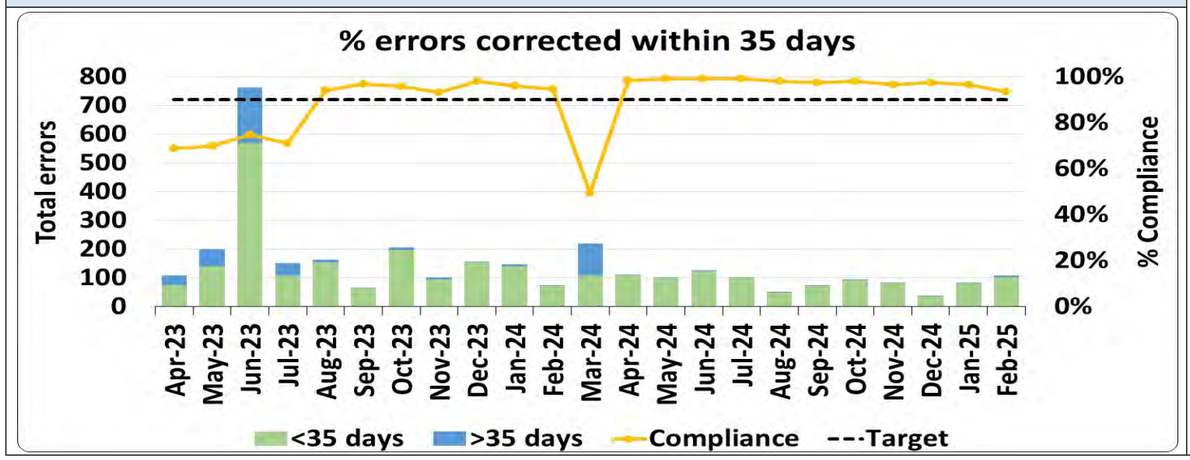
What actions are we taking & when is improvement anticipated? What are the main areas of risk?

The upgrades to the autocoding system incorporating the validation functionality, the new coding standards and more performance hardware have been completed, with the autocoder operational, following a 4 month downtime.

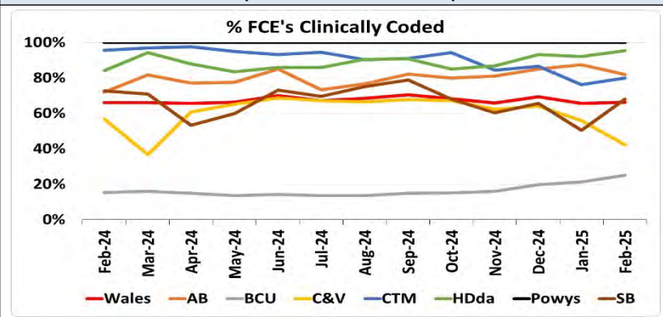
The changes in ward moves associated with the POW roof have had a disruptive impact on coding demand patterns and changes to the flow and availability of the medical record. Best endeavours are being relied upon until a more consistent pattern of service activity is observed which will enable coding capacity and processes to be re-appraised. Positively, we are seeing improvements in the quality of data following the move, as colleagues observe at first hand the benefit of accurate data being recorded.

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.

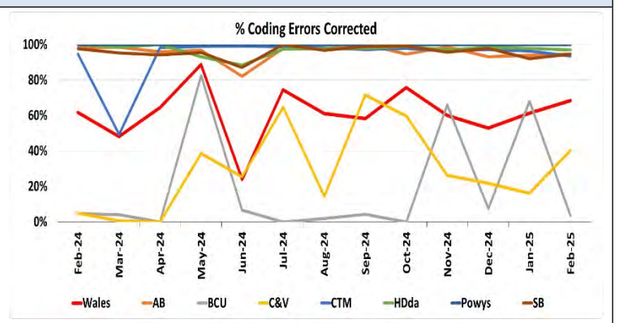
% of all classifications' coding errors corrected by the next monthly reporting submission following identification – Target 90% - February 2025 – 93.5%



How do we compare with our peers?



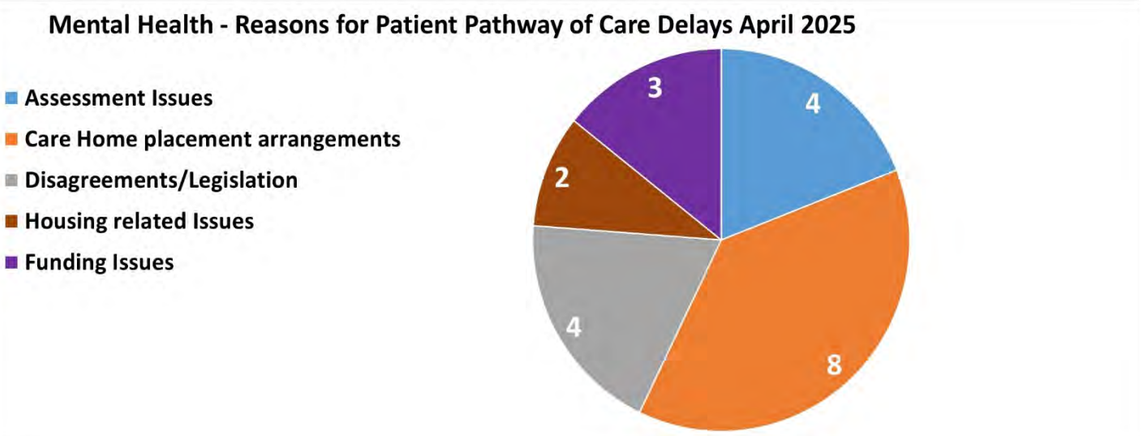
Status as at February 2025		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
HDda	95.4%	2nd
AB	81.9%	3rd
CTM	**79.9%**	**4th**
SB	68.0%	5th
C&V	42.3%	6th
BCU	25.1%	7th

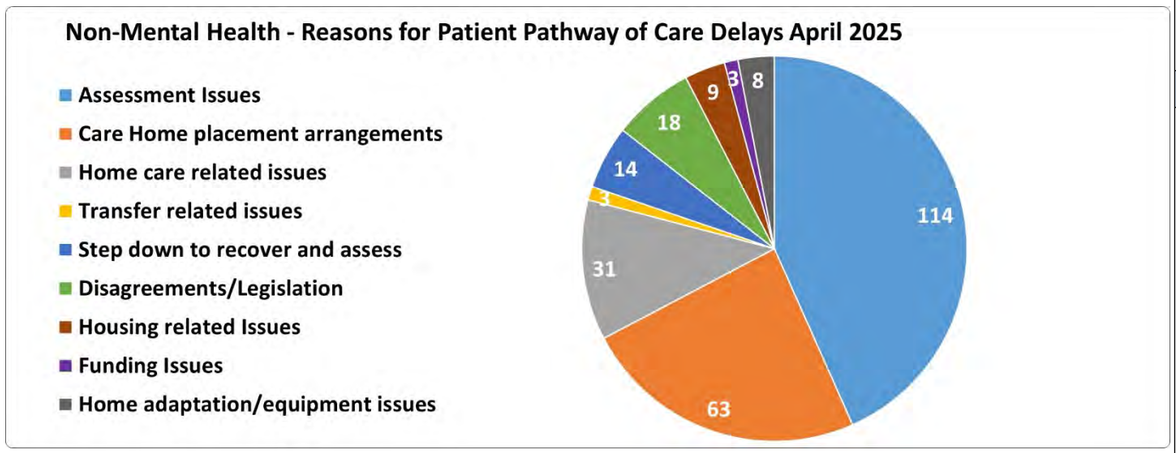


Status as at February 2025		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
HDda	96.9%	2nd
AB	94.6%	3rd
SB	94.6%	3rd
CTM	**93.5%**	**5th**
C&V	40.2%	6th
BCU	3.6%	7th

Efficient Services – Pathways of Care Delayed Discharges - census date 16th April 2025

Number of Pathways of Care delayed discharges
Target is 12 month reduction trend
Mental Health Delays = 21 / Non Mental Health Delays = 263





How are we doing?

284 Pathways of Care Delayed Discharges were reported in the April snapshot census. This is 21 (7%) delayed patients lower than the 12 month average of 305.

Assessment issues account for the majority of delays; 39.8% (118) as detailed in the table below:

Reason for Delay	Apr-25	12 month average	
Assessment Issues	118	122	39.8%
Care Home placement arrangements	71	59	19.2%
Home care related issues	31	48	15.6%
Transfer related issues	3	21	7.0%
Disagreements/Legislation	22	23	7.4%
Step down to recover and assess	14	14	4.5%
Housing Related Issues	11	8	2.6%
NHS Bed related issues	0	3	0.9%
Funding Issues	6	5	1.6%
Home adaptation/equipment issues	8	4	1.4%
Total	**284**	**305**	

Assessment Delay Flag - April 2025	
Awaiting Social worker allocation	7
Awaiting completion of assessment by social care	21
Awaiting completion of assessment Nursing	35
Awaiting Continuing Healthcare (CHC) Assessment	11
Awaiting joint assessment	18
Awaiting completion of assessment AHP	16
Awaiting completion of best interest decision	8
Mental Capacity Assessment Delays	2
Total Assessment Issues	**118**

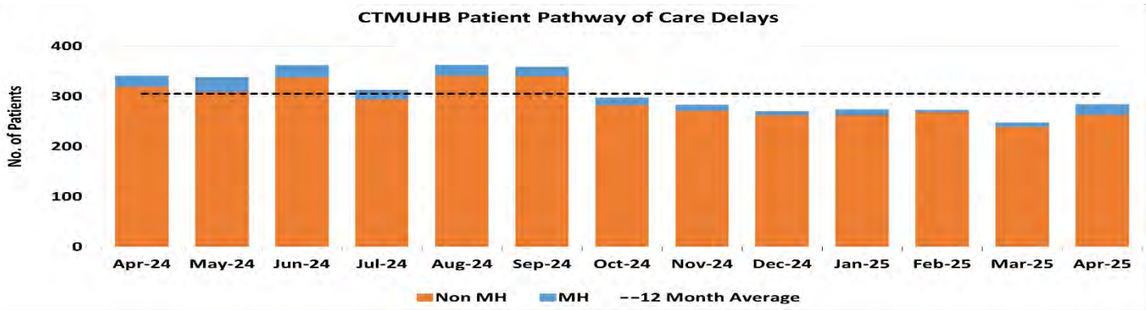
What actions are we taking & when is improvement anticipated?

- Continued work to reduce delays for Nursing Needs Assessment. Task and Finish group set up to develop digital roll-out and auditable process.
- Hospital@home service aimed at Pathway 1 (supported home first) delays operational, however the main delay continues to be assessment delays.
- Bed days for delays for disagreement have increased.
- Review of the Trusted Assessor role to align with social care queries for Pathway 1 discharges.
- Integrated Care Home Commissioning Group to review processes and capacity into care homes.
- Re-designing of EToC (Electronic Transfer of Care) planned for re-launch in May.
- 100 day LoS reviews continue in community hospitals with no change in court of protection delays as yet.

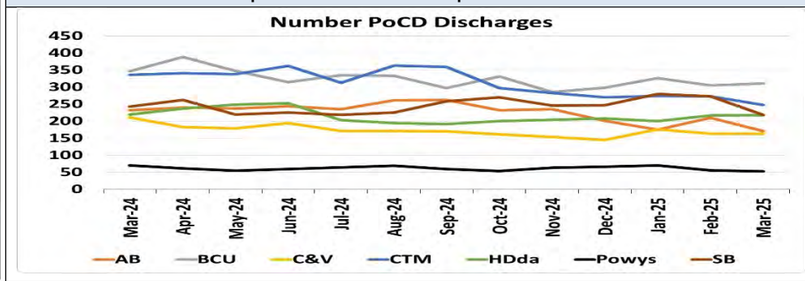
Delays by Local Authority - April 2025										
Healthcare Facility	Bridgend	Caerphilly	Merthyr Tydfil	Neath Port Talbot	Powys	Rhondda Cynon Taff	Cardiff	Vale of Glamorgan	Other	Total
PCH		4	9	1		15				29
POW	38			3				2		43
RGH	14		2			46	1			63
YCC	3	1	8		1	38		1	1	53
YCR	4		1			43				48
YGT	12		1			19				32
Glanrhyd	13									13
Ty Llidiard						1				1
Pinewood House						2				
Grand Total	84	5	21	4	1	161	1	3	1	282

What are the main areas of risk?

- Number of patients and days lost waiting for a care home continue to rise with no actions to address these issues in place.
- Development of the Integrated Discharge Team has been delayed.
- Community capacity of registrant to support the D2RA process.



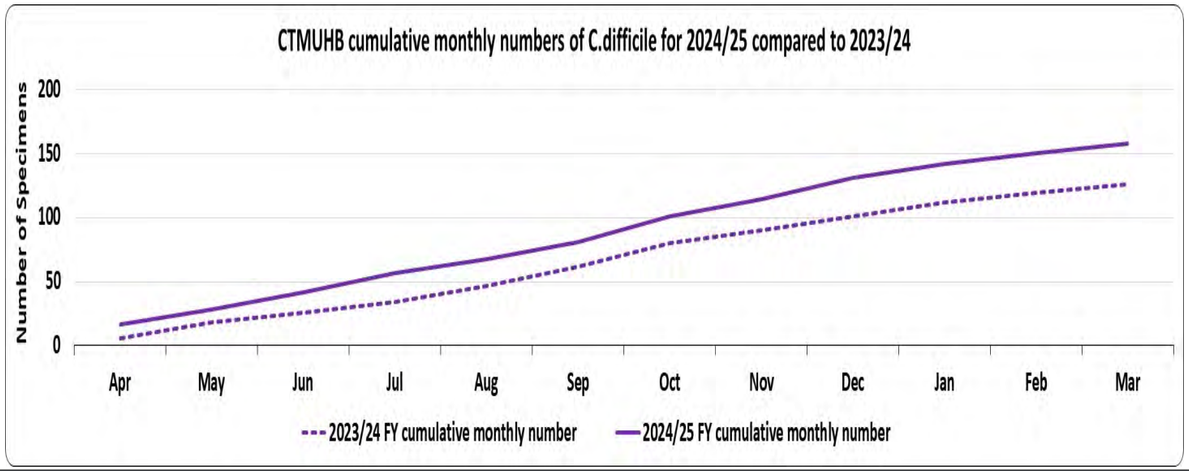
How do we compare with our peers?



Status as at March 2025		
Health Board	Compliance	Rank
Powys	53	1st
C&V	163	2nd
AB	171	3rd
HDda	218	4th
SB	219	5th
CTM	**248**	**6th**
BCU	311	7th

CTMUHB Safe Services – Healthcare Acquired Infections – April 2024 to March 2025 (2025/26 data is not expected until June 2025)

C.difficile

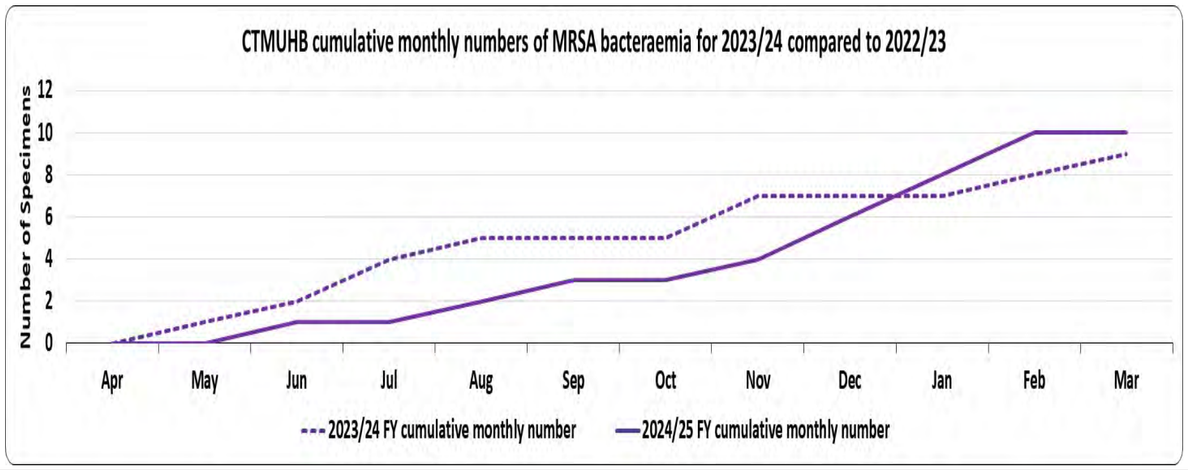


158 C.difficile cases have been reported by CTM for the period April 2024 to March 2025. This is 32 more cases than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 35.58, which compares favourably to the All Wales rate of 47.39.

In CTM, 41% 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, but it is essential to ensure that there is capacity and work pathways created to work with primary care, with the support of microbiology antimicrobial stewardship as well as microbiology to ensure cases are reviewed and lessons learned are acted upon.

IPC has created alerts into ICNet to ensure that the team is alerted when there are any admissions of patients with known previous Cdiff. Work is being done to raise awareness on the need to review PPI at first opportunity as well as antimicrobial stewardship. The reduction of C.difficile cases can only be achieved with a co-ordinated effort between primary and secondary care.

MRSA

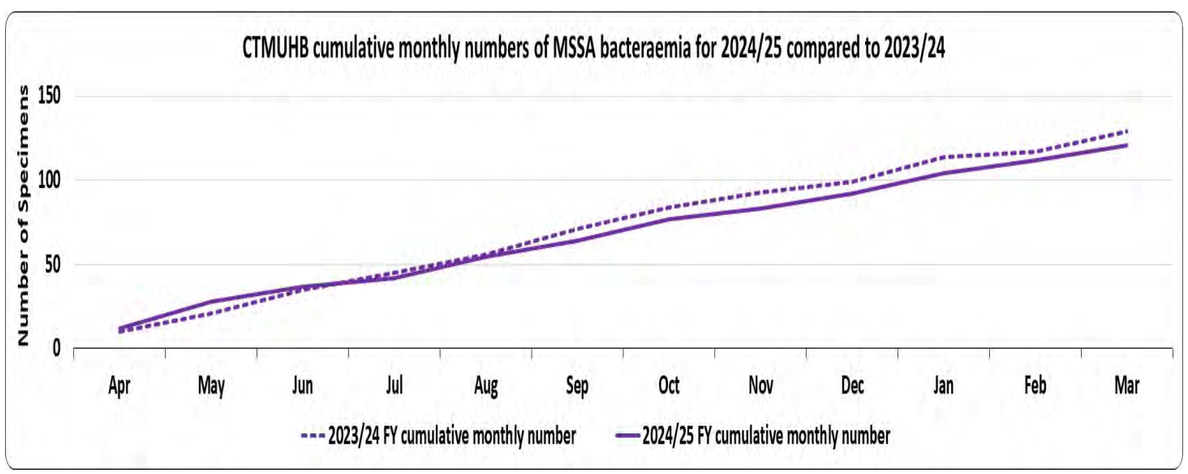


10 MRSA bacteraemia have been reported by CTM for April 2024 to March 2025, with 8 cases being community onset and the remaining 2 cases, hospital onset. This is 1 case more than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 2.25, which is just below the All Wales rate of 2.27.

CTM is re-instating ANTT (Aseptic Non-Touch Technique) training as mandated for all the professionals. It is essential to work towards increasing the overall compliance with IPC fundamental (mandatory) training, being that only the administrative and clerical group is currently scoring above 80% compliance, with Medical and Dental staff group with a compliance of 28.59%.

It is important to understand the route of this infection in the community and it is essential that there is co-ordination between primary and secondary case towards achieving the zero goal. In general, the reduction of MRSA is entwined with MSSA and more detail is explained below.

MSSA



121 MSSA bacteraemia have been reported by CTM for April 2024 to March 2025. This is 8 cases less than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 27.25, which compares to the All Wales rate of 28.16.

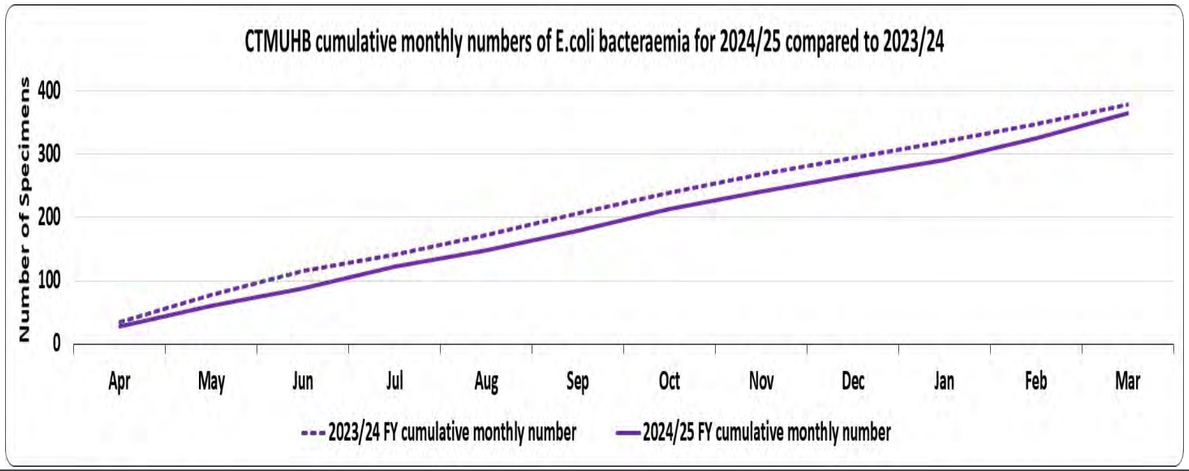
76% of the specimens taken are community onset and around 3% of the cases at PCH, 5.88% POW and 12.5% at RGH are associated with lines.

It is essential to focus on understanding the community onset cases, alongside adequate reviews from the positive cases. With support from epidemiology there is a need to understand if this is affecting specific pockets of population, geography or is it a general problem, as well as ensuring that lessons learned are incorporated into the primary care practice.

Regarding the hospital onset cases, CTM's ANTT training is being reinstated as mandatory and it is essential that we achieve high rates of compliance with this training as well as with training in IPC Levels 1 & 2 and ensuring adequate compliance with the completion of the insertion and maintenance bundles for invasive devices (IPC Level 1 is at 82.9% and Level 2 is at 69.73%).

CTMUHB Safe Services – Healthcare Acquired Infections – April 2024 to March 2025

E.coli

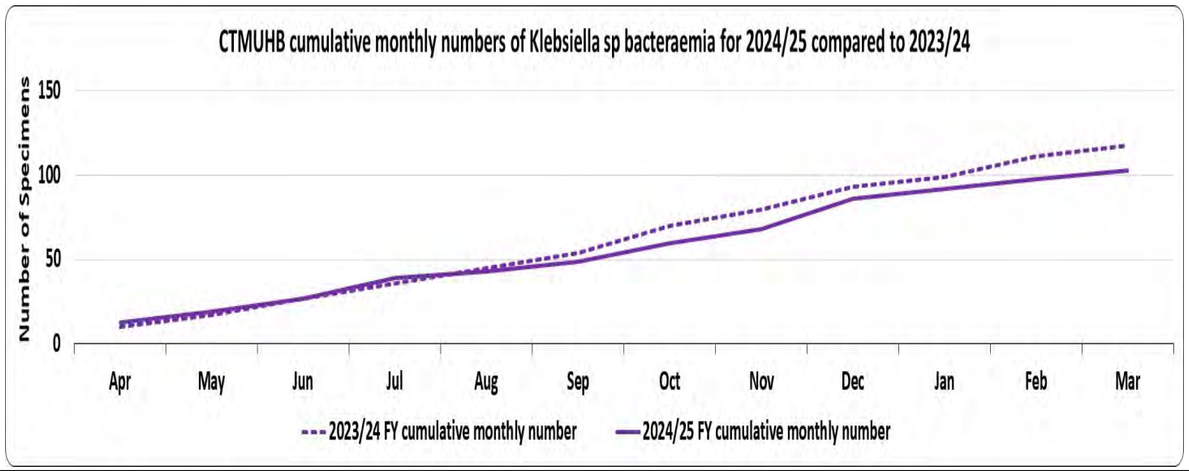


364 E.coli bacteraemia have been reported by CTM for April 2024 to March 2025. This is 14 fewer cases than the equivalent period of 2023/24. The provisional rate per 100,000 population for 2024/25 is 81.98, which is higher than the all Wales rate of 69.64.

Community onset cases account for 80% of the specimens taken and a number of cases are linked to a urinary catheter. Urinary catheter management needs to be improved across CTM. The Health Board currently has a catheter passport available, but is still being rolled out across CTM and it will be essential to also have it used in the community to ensure we can achieve the WG goals for E.coli reduction in a sustainable way. The re-instatement of ANTT will be essential to make this reduction sustainable and that all clinical leaders take ownership to ensure that their staff are completing the IPC mandatory training.

It is essential to ensure that there are defined roles and a community oriented plan to review, disseminate and monitor the implementation of lessons learned in the community in order to achieve the goal of reducing, not just E.coli, but other Gram Bacteraemia.

Klebsiella sp

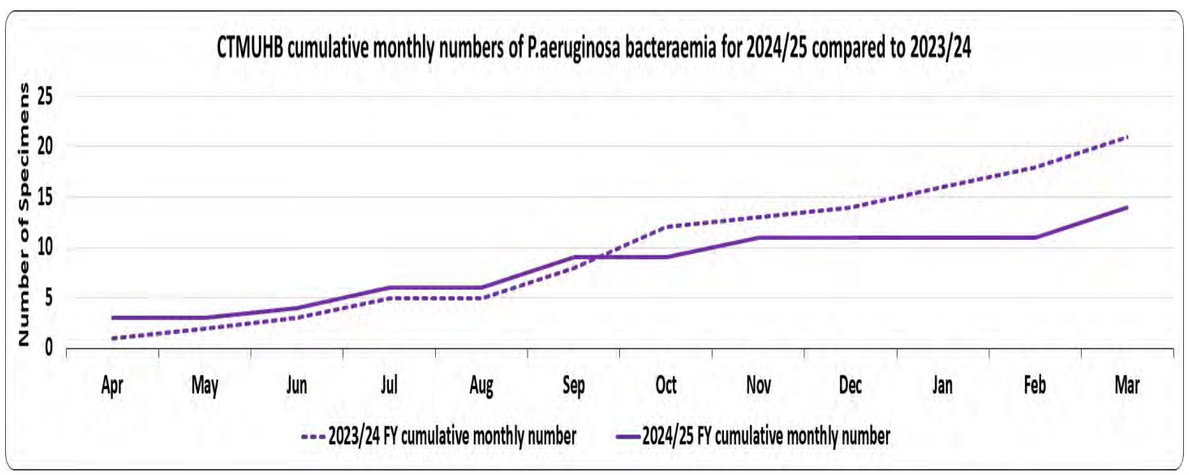


103 Klebsiella sp bacteraemia have been reported by CTM for April 2024 to March 2025. This is 15 fewer cases than the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 23.20, which compares to the All Wales rate of 22.64.

Of the specimens taken, 74% are community acquired infections. Around 15% of the cases are associated with a urinary catheter. IPC huddles and investigations have been set to discuss the hospital onset cases and community onset cases have been referred to the lead of bowel and bladder services for follow-up.

Again, work is required to strengthen IPC training compliance, in particular ANTT, completion of insertion and maintenance bundles as well as ensure full rollout of catheter passport for both inpatients and community.

P.aeruginosa



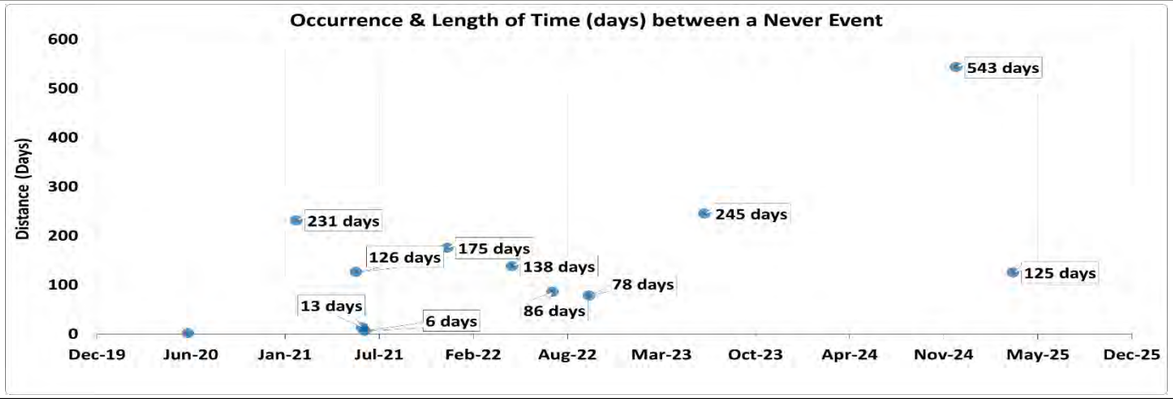
14 P.aeruginosa bacteraemia have been reported by CTM for April 2024 to February 2025. This is 7 fewer cases than in the equivalent period in 2023/24. The provisional rate per 100,000 population for 2024/25 is 3.15, which compares favourably to the All Wales rate of 5.24.

57% of infections are community acquired infections. Investigations are being held into the hospital onset cases to identify themes and lessons to be learned towards the reduction goal.

It is essential to reinforce education and training on Hand Hygiene practices, ensure work towards robust insertion and maintenance bundle completion for catheters and cannulas across CTM. Ensure that areas of augmented care are quickly alerted for findings in the water systems and ensure that all staff that require attend ANTT training.

Safe Services – Never Events & Nationally Reportable Incidents

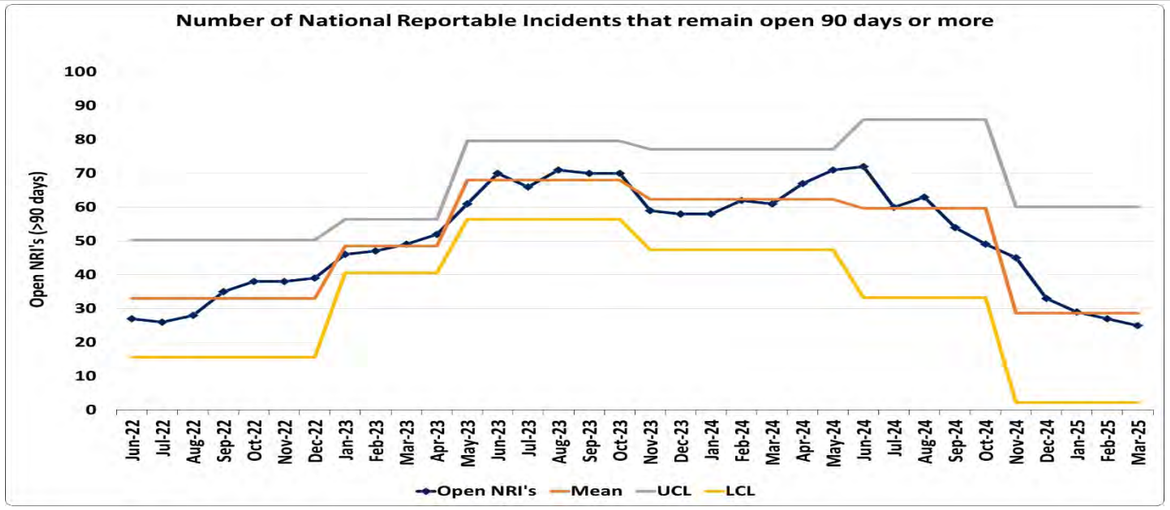
Number of Never Events – April 2025 - One

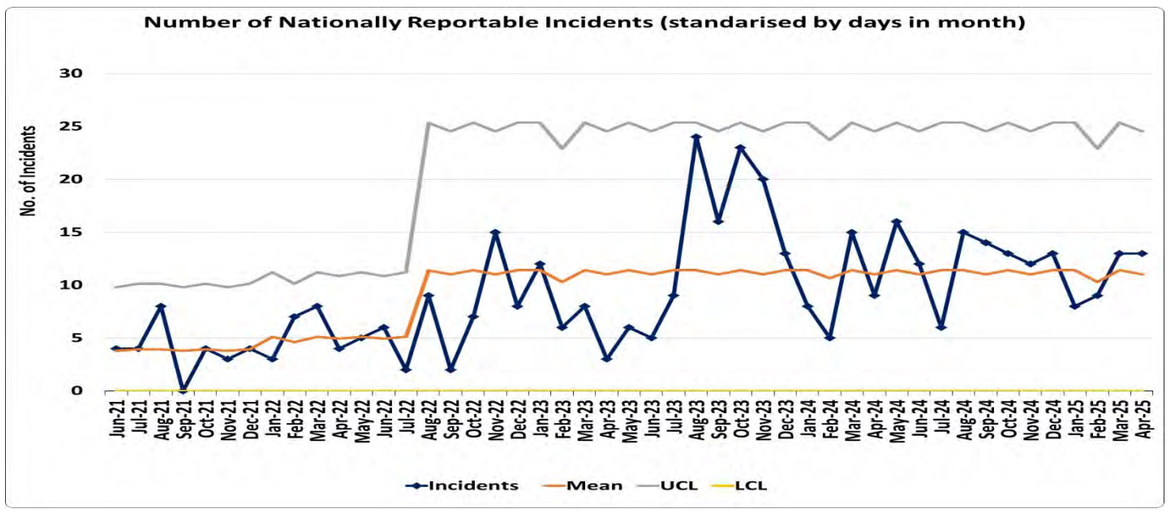


Never events are serious patient safety incidents within clinical practice that, by definition, should never happen. They are considered wholly preventable because national guidance or safety recommendations are in place and should have been implemented by all providers in the healthcare system. This 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.

During the past year there have been 2 Never Events reported, December 2024 relating to wrong site surgery and April 2025 relating to wrong implant prosthesis. Investigations in relation to both are ongoing.

Number of National Reportable Incidents that remain open 90 days or more – Target is 12 month reduction trend – March 2025 – 25





N.B. in order to allow for accurate reporting there is a time lag of approx. one month for the 90 days measure.

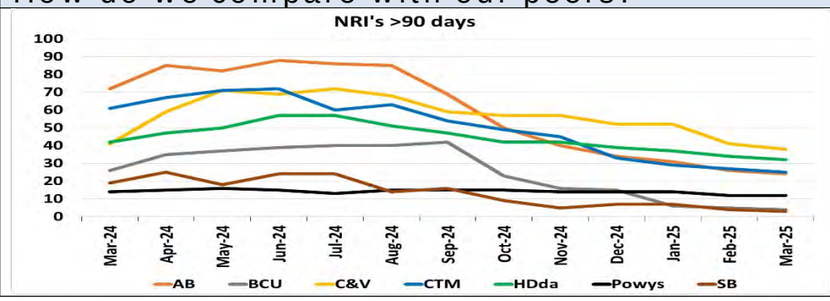
As at March 2025, 25 National Reportable Incidents remained open past the 90 days timeframe.

During April, 13 NRI notifications were submitted to the NHS Executive (NRI's are detailed in the table below), with a total of 143 incidents submitted during the past 12 months.

As at the 02.05.25, the Health Board currently has 59 open Nationally Reportable Incidents, of which 29 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families.

Type of Nationally Reportable Incidents	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Total
Pressure Damage	4	3	4	3	3	8	6	6	2	4	5	3	51
Maternity/Neonatal adverse occurrence	2	3		2	1	3	1	2	4	1	3	0	22
Infection Prevention & Control		2	1	1	3			2			3	3	15
Admission / Transfer / Discharge	1			3	3					1	1	5	14
Treatment, Procedure	6			2	1		3	1		2			15
Patient/Service user death	1	2	1				2		1	1		1	9
Clinical Assessment, clinical diagnosis	1	2		2	2	1							8
Medication				1	1								2
Slip, Trip or Fall						1		1					2
Equipment/Devices												1	1
Monitoring/Observations				1									1
Communication							1						1
Diagnostic											1		1
Transport									1				1
Grand Total	15	12	6	15	14	13	13	12	8	9	13	13	143

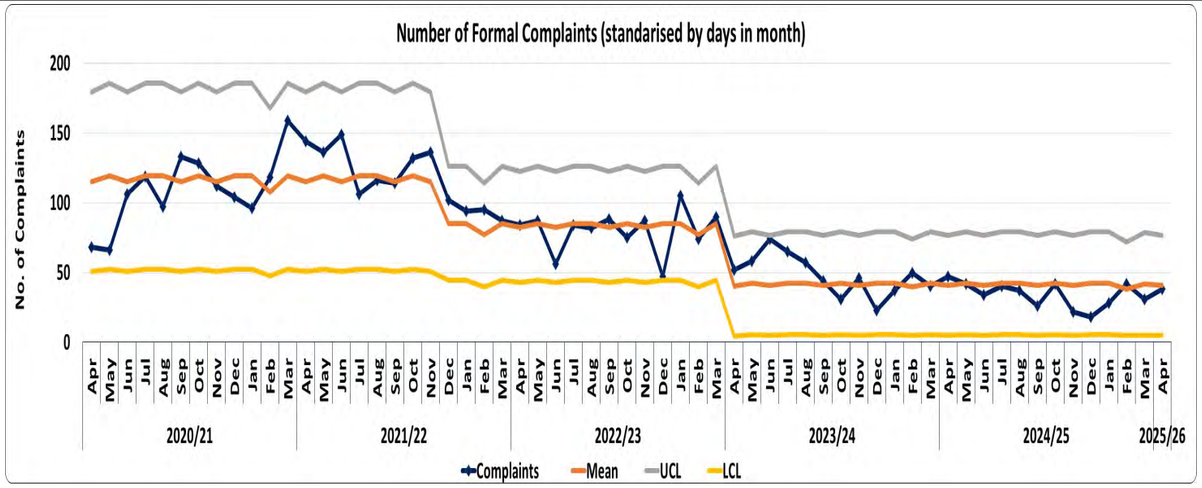
How do we compare with our peers?



Status as at March 2025		
Health Board	Compliance	Rank
SB	3	1st
BCU	4	2nd
Powys	12	3rd
AB	24	4th
CTM	**25**	**5th**
HDda	32	6th
C&V	38	7th

CTMUHB Focus on Putting Things Right

Number of formal complaints managed through Putting Things Right – April 2025 - 38 Formal Complaints

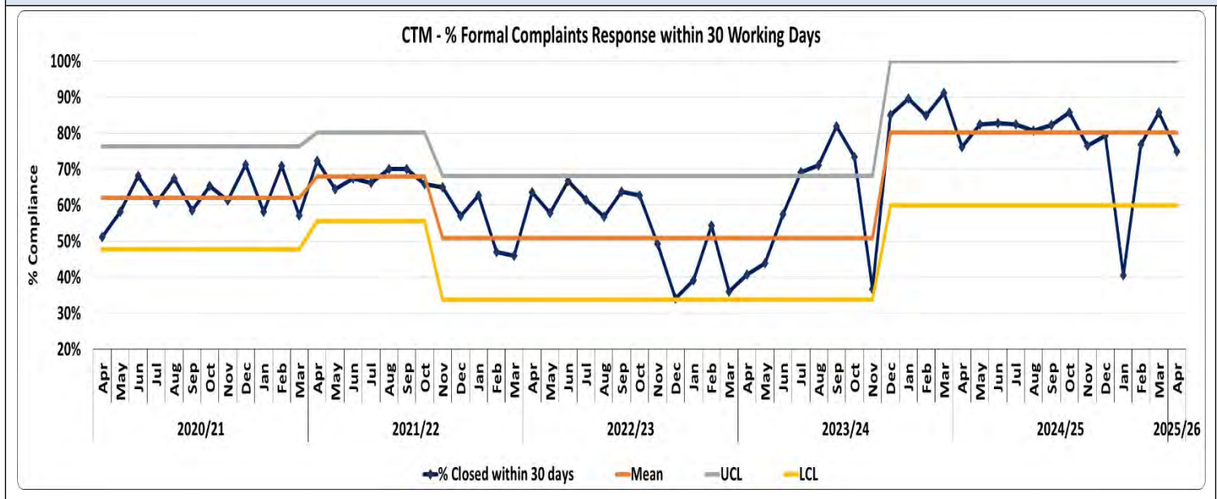


During April 2025, 38 formal complaints were received within the organisation and managed in line with the 'Putting Things Right' regulations.

For those complaints received during April, the majority related to clinical treatment/assessment (31), with the top ten themes during the past 12 months displayed in the table below.

Top Ten - Main Themes from Complaints during the last 12 month period	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Total
Clinical Treatment/Assessment	33	33	29	35	23	24	15	18	24	32	26	31	323
Discharge Issues	0	1	2	1	2	7	1	0	2	1	1	0	18
Patient Care	0	1	1	0	0	2	3	0	3	2	1	3	16
Communication Issues (including Language)	1	1	0	1	2	4	1	1	1	2	0	0	14
Medication	0	1	2	3	0	3	1	0	2	0	0	1	13
Attitude and Behaviour	2	0	1	1	0	1	0	1	1	2	1	1	11
Access (to Services)	0	0	0	0	2	0	2	0	0	0	0	1	5
Accident/Falls	1	0	3	1	0	0	0	0	0	0	0	0	5
Appointments	1	0	1	0	1	0	1	0	0	1	0	0	5
Other	0	0	0	1	0	1	0	0	1	0	1	0	4
Test and Investigation Results	0	1	0	0	0	1	0	0	2	0	0	0	4
Referral	0	0	0	1	0	1	0	1	0	0	0	1	4

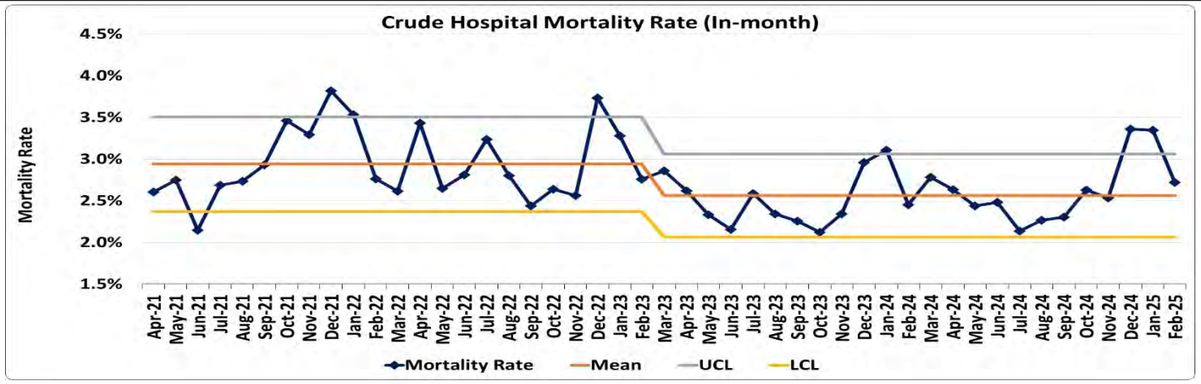
% formal complaints response within 30 working days – April 2025 – 75.0%

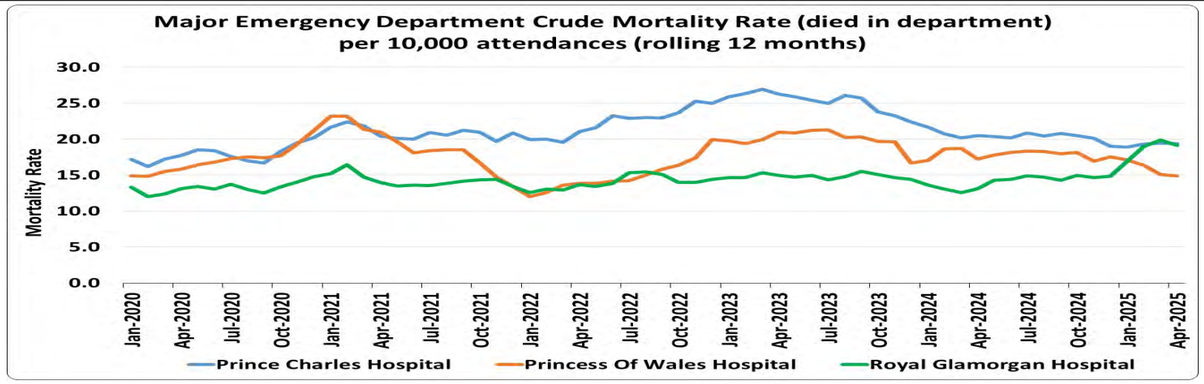


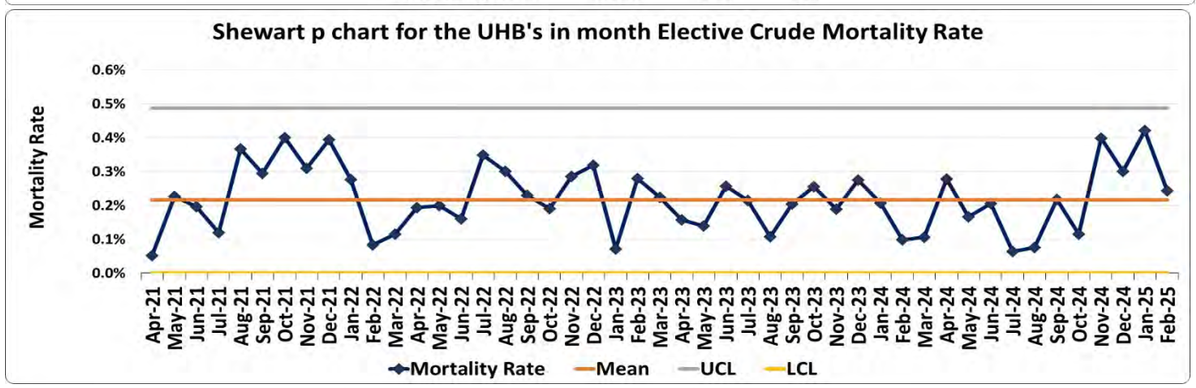
During April, compliance for formal complaints responded to within 30 working days, fell to 75%, falling below the current mean of 80%, but hitting the set target of 75%.

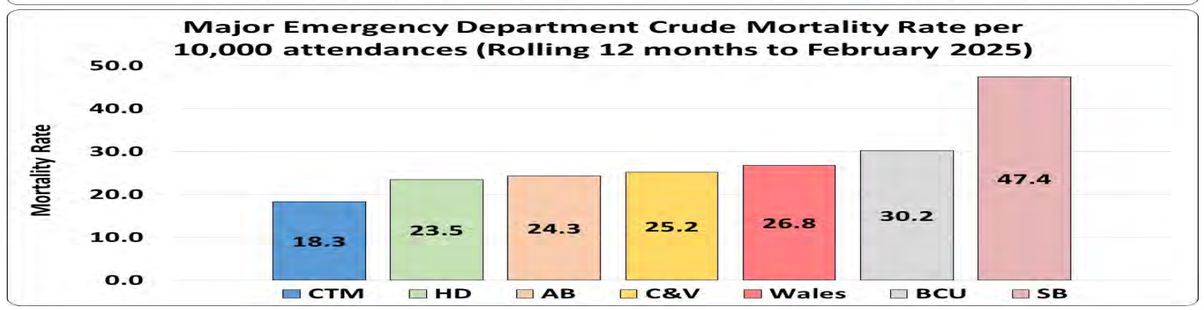
As at 02.05.25, the Health Board had 64 open formal complaints. Of these, 21 complaints were open over 30 working days. A review of all complaints procedures is currently being undertaken to identify opportunities to improve efficiency in processes, along with embedding the importance of timely escalation.

CTMUHB Focus on Crude Hospital Mortality Rates

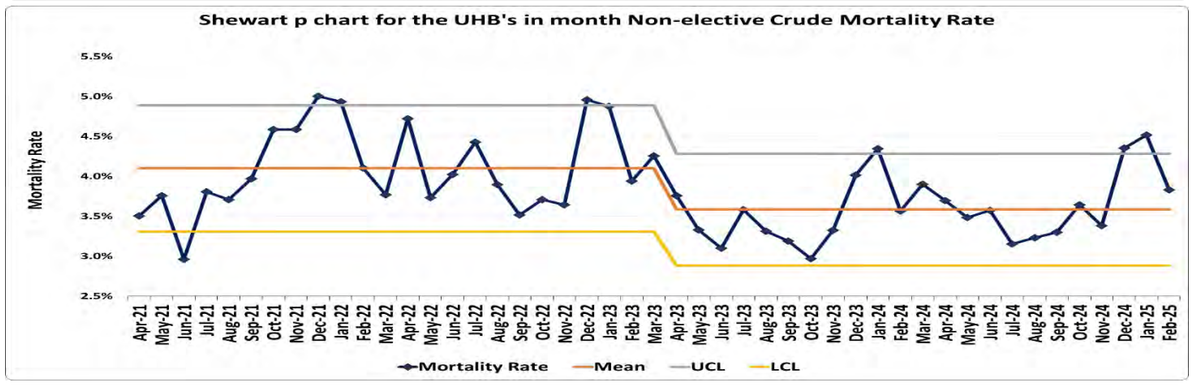


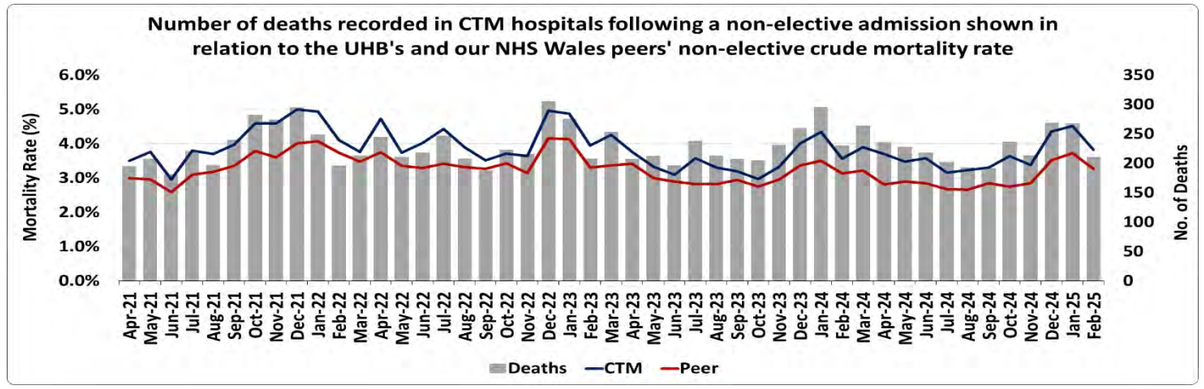


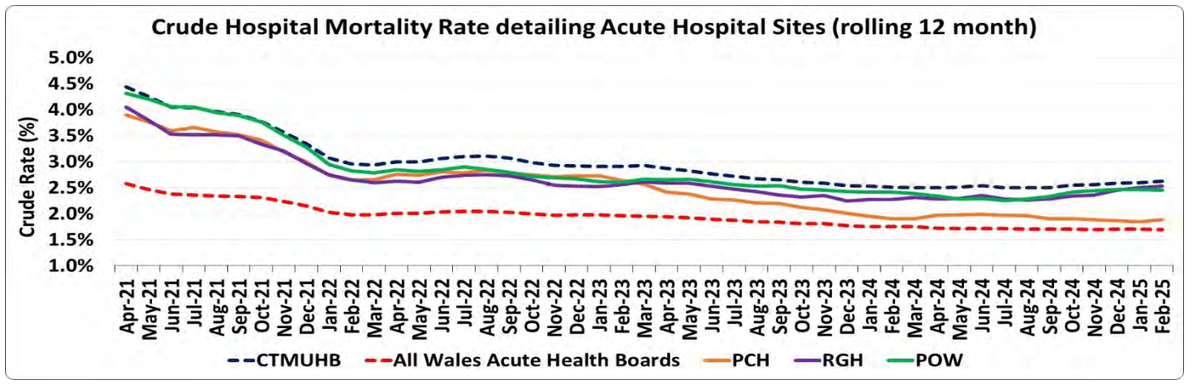




Based on these crude rates shown in the charts above, the mortality rates in CTM's three major emergency departments are the lowest in Wales.







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 are also influenced by the changes in clinical practice. With more patients now being admitted following a presentation to the Emergency Department we are observing a lower ED crude mortality rate but a higher inpatient crude mortality rate.

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 reports 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 has been in operation since the start of 2024.

Finance Update – Month 01

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.

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))*	Data to Knowledge
	If more than one applies please list below: Data to Knowledge
Dolen i Feysydd Ansawdd	Effective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	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 is asked to NOTE the Integrated Performance Dashboard.

2024-25 Finance Report

Month 12

Summary

Situation

This Finance report outlines our Draft financial position for Month 12 (i.e. the period to 31st March 2025). As this report covers the full year position, it will remain a draft position pending completion of the final audit and approval of annual accounts.

This Finance report is discussed at the Board, the Operational Delivery Committee (ODC) and the Executive Management Board (EMB) 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 12 (i.e. the Delegated budget position). This report is discussed at the ODC and EMB 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 through the Draft position is reporting a small surplus in 2024/25 the Health Board will not achieve the 3 year break even duty due to the £24.2m deficit reported in 22/23. However, delivering a small surplus position in 24/25 will mean that it will be possible to achieve the 3 year break even duty in 25/26 if the submitted plan is achieved.

Summary

Assessment	Recommendation
Pending final audit and approval of annual accounts, the Draft M12 position is summarised below: **Overall Revenue position - 2024/25:** • The M12 position reported a £0.1m deficit and the M12 YTD position is now a £0.1m Surplus. • The Health Board has met its Revenue Control Total set by Welsh Government to achieve a financial break even position against the revenue resource limit in 2024/25. **Overall Capital position - 2024/25:** • The Health Board has met the duty to achieve a 3 year break even position against the capital resource limit in 2024/25. **Recurrent Revenue position:** • The brought forward recurrent deficit at the end of 2023/24 was £19.4m and the planned recurrent surplus at the end of 24/25 was £(2.1)m. • The forecast underlying deficit at the end of 2024/25 remains consistent with the IMTP submission at £7.9m. • It is important to highlight that the 2024/25 pay award funding has currently been issued on a non-recurrent basis, pending further WG review of identified costs. Consequently, there is a risk that the recurrent forecast could deteriorate further if the allocation is less than that anticipated.	The Board, the ODC and the EMB are asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 31st March 2025.

Contents

Executive Summary

Overall Revenue Position

- The M12 draft position reported a deficit of £0.1m and the M12 YTD position is now a £0.1m surplus.
- The forecast recurrent position has been maintained at £7.9m in M12 (M11 : £7.9m).
- The Health Board has achieved its Control Total target to achieve a Revenue break even position in 2024/25.
- The reported position for 2024/25 remains a Draft Position pending final audit.

Savings Position

- Actual savings in M12 was £1.6m which was £0.6m below the M12 target of £2.2m. The M12 YTD savings is now £14.7m and is £11.6m below the M12 YTD target of £26.3m.
- The M12 forecast Recurrent savings is £14.5m, which is £11.8m below the £26.3m target. This represents a £1.0m deterioration from M11.

Cash

- The closing cash balance at 31st March 2025 was £5.2m.

Capital

- The latest Capital Resource Limit for 2024/25, issued on the 28th Feb 2025, was £94.8m.
- Expenditure to M12 was £94.7m, with a small surplus of £63k.
- The Health Board has achieved its Control Total target to achieve a Revenue break even position in 2024/25.
- The Health Board has met the duty to achieve a 3 year break even position against the capital resource limit in 2024/25.

Summary
Income & Expenditure Account

	M12 Actual	M12 YTD
	£m	£m
01. Revenue Resource Limit	(299.0)	(1641.9)
02. Capital Donation / Government Grant Income	(0.0)	(0.0)
03. Welsh NHS Local Health Boards & Trusts Income	(7.3)	(76.4)
04. WHSSC Income	(1.1)	(13.0)
05. Welsh Government Income (Non RRL)	(1.5)	(2.4)
06. Other Income	(5.4)	(50.8)
Total Allocations & Income	**(314.2)**	**(1784.4)**
08. Primary Care Contractor	17.7	174.7
09. Primary Care - Drugs & Appliances	8.2	103.6
10. Provided Services - Pay	108.7	772.1
11. Provider Services - Non Pay	12.5	120.4
12. Secondary Care - Drugs	5.2	60.4
13. Healthcare Services Provided by Other NHS Bodies	30.2	295.0
14. Non Healthcare Services Provided by Other NHS Bodies	0.0	0.0
15. Continuing Care and Funded Nursing Care	7.6	71.9
16. Other Private & Voluntary Sector	9.5	20.7
17. Joint Financing and Other	7.3	19.9
18. Losses Special Payments and Irrecoverable Debts	0.4	2.7
22. DEL Depreciation\Accelerated Depreciation\Impairments	2.2	37.8
23. AME Donated Depreciation\Impairments	104.9	105.5
25. Profit\Loss Disposal of Assets	(0.0)	(0.2)
Total Expenditure	**314.2**	**1784.3**
Grand total	**(0.0)**	**0.1**

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 M12 year to date position is reporting a surplus of £0.1m.

Year to Date Performance and Forecast

	Current Month	YTD	Year end Forecast
	£m	£m	£m
Month 1	0.9	0.9	0.0
Month 2	1.4	2.3	0.0
Month 3	0.4	2.7	0.0
Month 4	1.4	4.1	0.0
Month 5	(0.2)	3.9	0.0
Month 6	(0.6)	3.3	0.0
Month 7	(0.1)	3.2	0.0
Month 8	(2.8)	0.4	0.0
Month 9	(0.2)	0.2	0.0
Month 10	0.0	0.2	0.0
Month 11	(0.3)	(0.1)	0.0
Month 12	0.1	(0.1)	0.0

Key Points:

- The M12 YTD underspend of £0.1m includes a £11.6m shortfall in savings offset by other favourable variances of £(11.7)m.
- Further details of the key drivers for the YTD are provided overleaf.

Year to Date Performance and Forecast

	M12 Year-end £m	M11 Year-end forecast £m
Savings Shortfall	11.6	11.5
Operational Variances	17.5	17.6
Financial Plan Improvements	(14.6)	(14.6)
Additional Financial Allocation	(7.5)	(7.5)
Accountancy Gains	(7.0)	(7.0)
Grand Total	**(0.1)**	**0.0**

Key Points:

- The break-even position includes an overspend on Delegated budgets of £28.0m , offset by a forecast underspend on non Delegated budgets of £28.1m.
- A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at Month 12 (i.e. the Delegated budget position). This report is discussed at the Operational Delivery Committee (ODC) and Executive Management Board (EMB) meetings.
- The Health Board has achieved its Control Total target to achieve a Revenue break even position in 2024/25.

Forecast Underlying Position

Underlying Position	Plan £m	M12 Recurrent £m	M11 Recurrent £m
Savings Shortfall		11.8	10.8
Operational Variances		17.4	18.4
Financial Plan Improvements		(13.8)	(13.8)
Additional Financial Allocation		**(7.5)**	**(7.5)**
Accountancy Gains		0	0
Grand Total	**(2.1)**	**7.9**	**7.9**

Key Points:

- The brought forward recurrent deficit at the end of 2023/24 was £19.4m and the planned recurrent surplus at the end of 24/25 was £(2.1)m.
- The forecast underlying deficit at the end of 2024/25 remains at £7.9m.
- It is important to highlight that the 2024/25 pay award funding has currently been issued on a non-recurrent basis, pending further WG review of identified costs. Consequently, there is a risk that the recurrent forecast could deteriorate if the allocation is less than anticipated

Pay Expenditure Trends

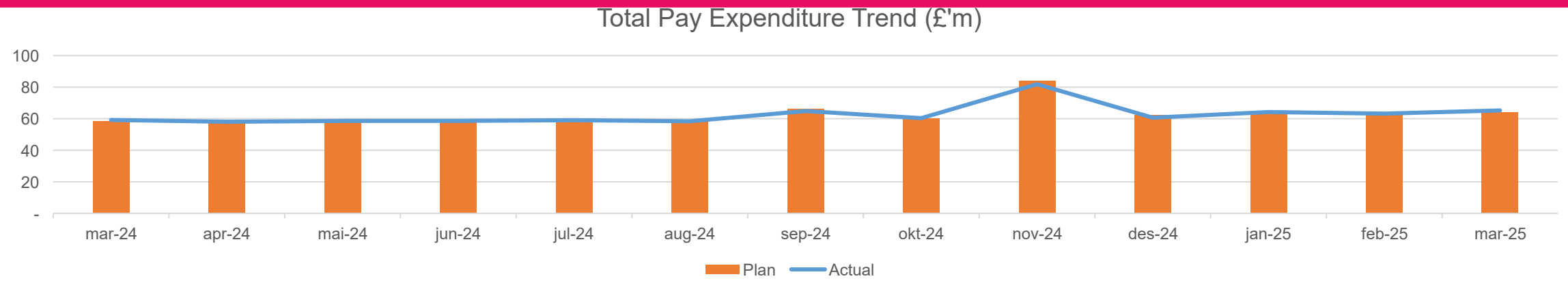
Staff Group	Qtr3 Ave £'m	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m
Administrative & Clerical	8.9	8.2	8.1	8.3	8.2
Medical And Dental	18.2	17.5	16.7	18.1	17.4
Nursing And Midwifery Registered	21.1	20.0	20.0	20.0	20.0
Add Prof Scientific And Technical	2.2	2.1	1.9	1.9	2.0
Additional Clinical Services	8.2	7.8	8.0	8.1	7.9
Allied Health Professionals	4.2	3.9	3.9	4.0	3.9
Healthcare Scientists	1.2	1.2	1.1	1.2	1.2
Estates And Ancillary	3.7	3.5	3.4	3.7	3.5
Students	0.0	0.0	.0	.0	.0
Grand Total	**67.6**	**64.2**	**63.2**	**65.2**	**64.2**

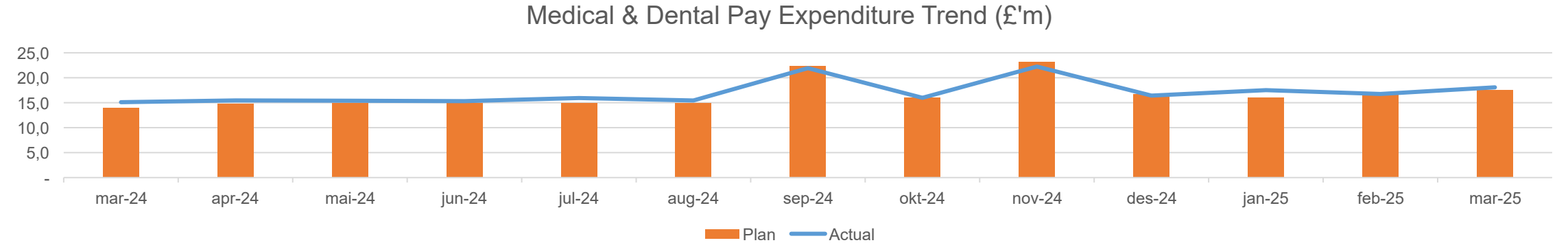
Spend category	Qtr3 Ave £'m	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m
Core	59.7	56.1	55.5	56.2	55.9
Agency	2.9	3.3	2.8	3.0	3.0
Overtime	1.6	1.6	1.7	2.0	1.8
ADH	1.9	1.6	1.7	2.1	1.8
Bank	1.4	1.4	1.4	1.6	1.4
WLI	0.1	0.2	0.1	.4	.2
Grand Total	**67.6**	**64.2**	**63.2**	**65.1**	**64.2**

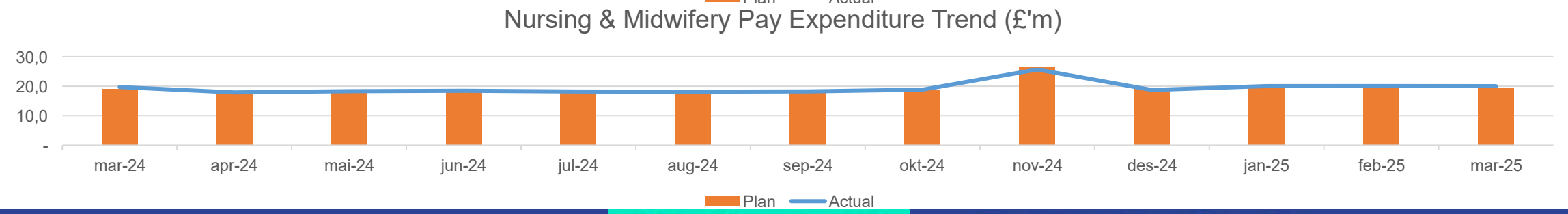
Key Points:

- The Medical & Dental pay award was processed in M6 including arrears. The arrears processed were circa £6.8m and the estimate of the In-year pay award is circa £0.7m per month.
- The 2024/25 pay award for all staff groups was processed in M8 including arrears. The impact of the pay award in M8 was estimated at £22.8m or £2.8m per month.
- The 24/25 new A4C increment points were processed in M10, along with some additional elements of the Medical & Dental pay award,
- Total pay expenditure in M12 was £65.2m. This is higher than recent periods but in line with expectations and recognises year end accounting impacts together with plans to increase capacity to support reduction in waiting times.
- When compared with the Q4 averages, the following variable pay movements occurred:
  - Increase in Core costs of £0.3m
  - Increase in Overtime costs of £0.2m
  - Increase in ADH's of £0.3m
  - Increase in bank of £0.2m
  - Increase in WLI of £0.2m

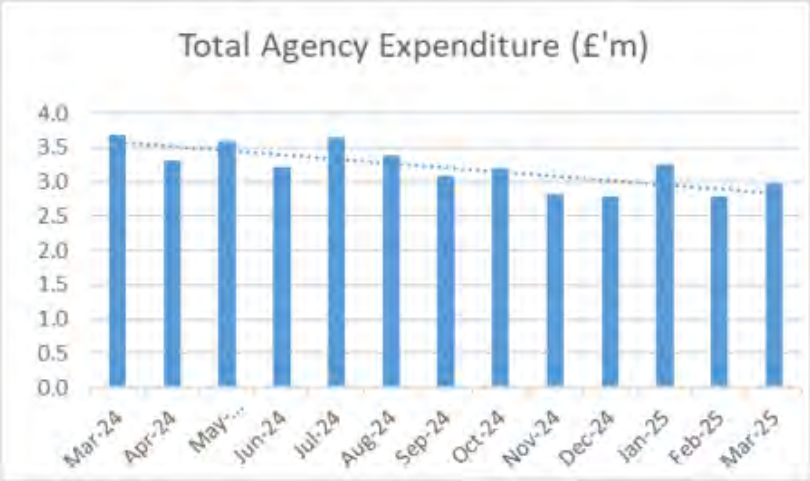
Pay Expenditure Trends

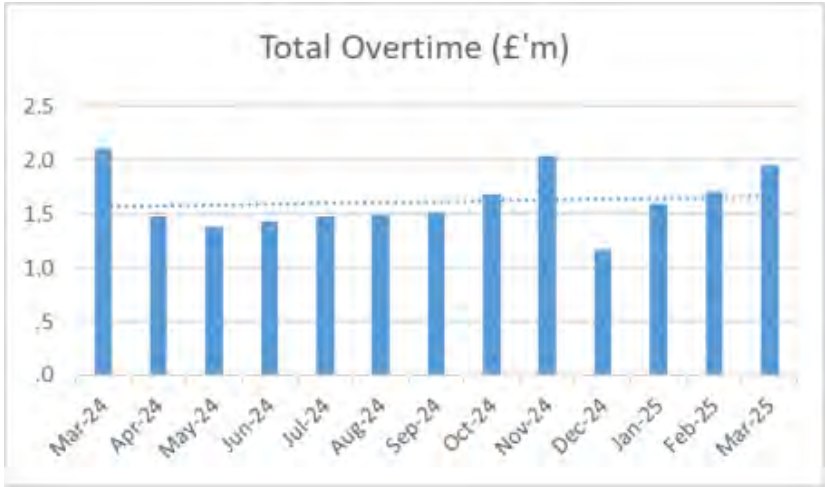


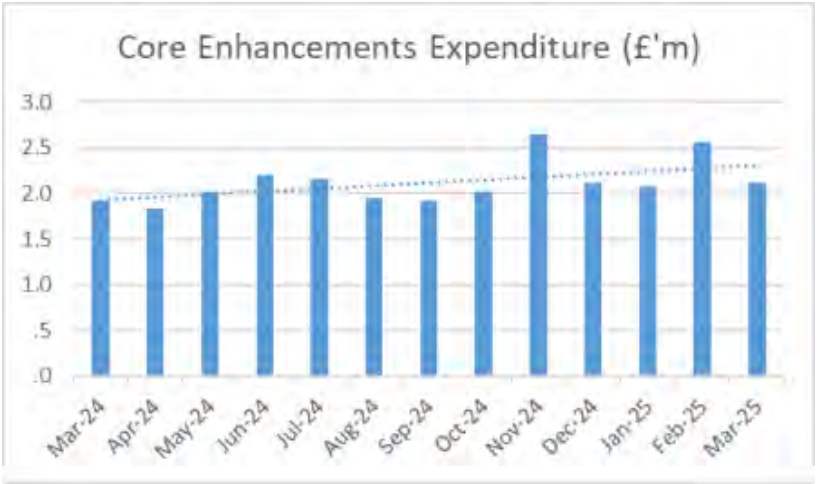


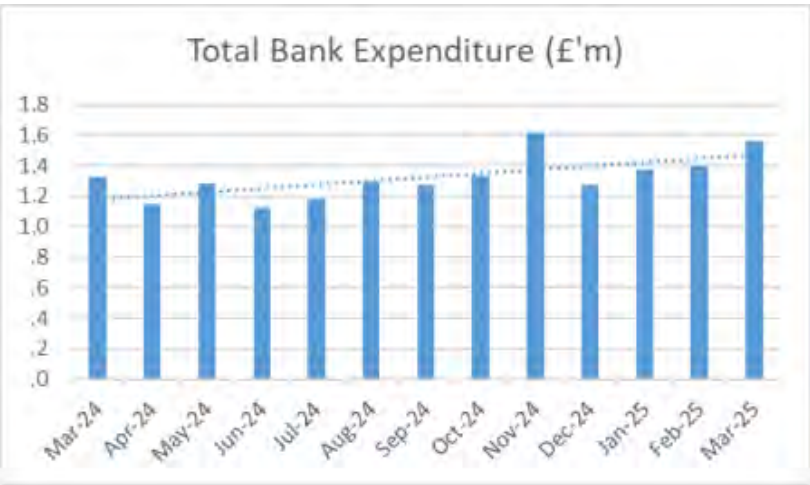


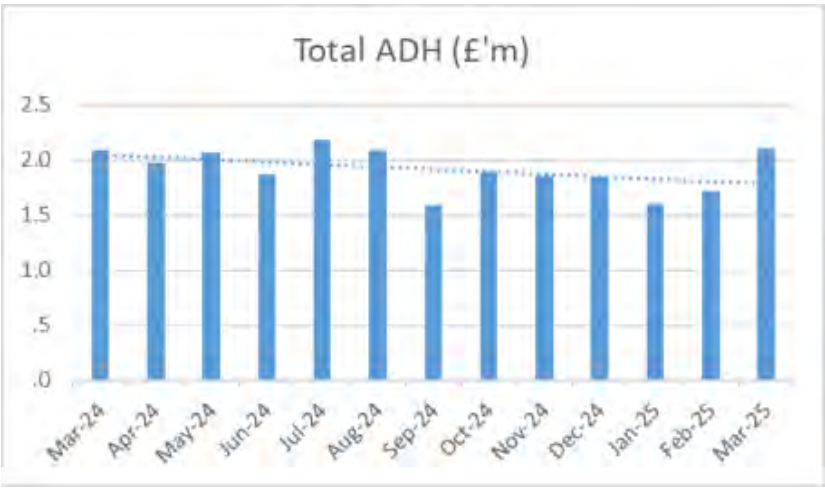
Variable Pay Expenditure Trends









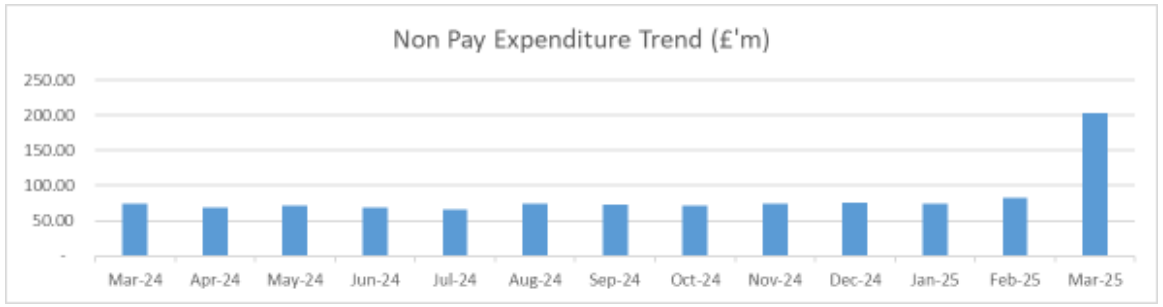


Key Points :

- Agency spend – Increase in M12 of £0.2m and overall a downward trend.
- Overtime payments- £0.2m increase in M12 and a increasing trend.
- Core enhancements – £0.5m decrease in M12 and increasing trend.
- Bank – Increase in M12 and an increasing trend.
- ADH spend – £0.2m increase in M12 and a downward trend.

Non Pay Expenditure Trends

Non Pay Group	Qtr3 Ave £'m	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m
Primary Care Contractors	12.6	13.6	21.7	16.0	17.1
Primary Care Drugs	9.2	7.9	8.1	8.2	8.1
Provider Non Pay	9.9	10.2	8.8	14.8	11.2
Secondary Care Drugs	5.4	5.2	4.2	5.2	4.9
Healthcare Commissioning	25.0	24.3	24.5	29.7	26.2
CHC & FNC	6.4	7.0	6.2	7.8	7.0
Other	5.3	6.4	9.8	121.3	45.8
Total Expenditure	**73.9**	**74.6**	**83.2**	**203.0**	**120.3**



Key Points:

- The total spend in M12 of £203m was £119.8m higher than M11. The main movements were:
  - Primary Care Contractors of £5.7m – decrease in M12 Recognition of arrears processed in M11 together with increase in Community Pharmacy Contract, matched with corresponding allocations.
  - Increase in Primary Care Drugs of £0.1m – Similar to prior months levels.
  - Increase Provider Non-Pay of £6.0m – Final reconciliations of Agreement of Balances and the grossing up of previously netted off expenditure and Income.
  - Increase in Secondary Care drugs of £1.0m – Return to prior months levels after Lower than anticipated treatments of NICE/HCD during February
  - Increase in Other of £111.5m – Year end recognition of Capital AME adjustments.

Income Trends

Income Group	Qtr3 Ave £'m	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m
Welsh NHS Income	6.4	5.3	6.0	7.6	6.3
JCC Income	1.0	1.0	1.3	1.1	1.2
Primary Care Contractor Income	1.2	1.0	1.4	1.0	1.1
CHC Income	0.6	0.7	0.5	0.6	0.6
Other Income	4.3	4.3	4.3	6.2	4.9
Total Income	**13.6**	**12.3**	**13.6**	**16.6**	**14.6**

Key Points:

- The total Income in M12 of £16.6m is £3.0m higher than M11. This is the result of:
  - NWSSP dividend £0.4m
  - Laundry £0.5m
  - LTA income £0.8m
  - WG income RIF £1.2m

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,487.4	32.2	26.5	95.8	1,641.9
Anticipated Allocations:					
Total Allocations	1,487.4	32.2	26.5	95.8	1,641.9

Key Points:

- As at M12 the confirmed Revenue Resource Limit (RRL) allocation was £1,641.9m.
- There are no further anticipated allocations

Income Assumptions - NHS

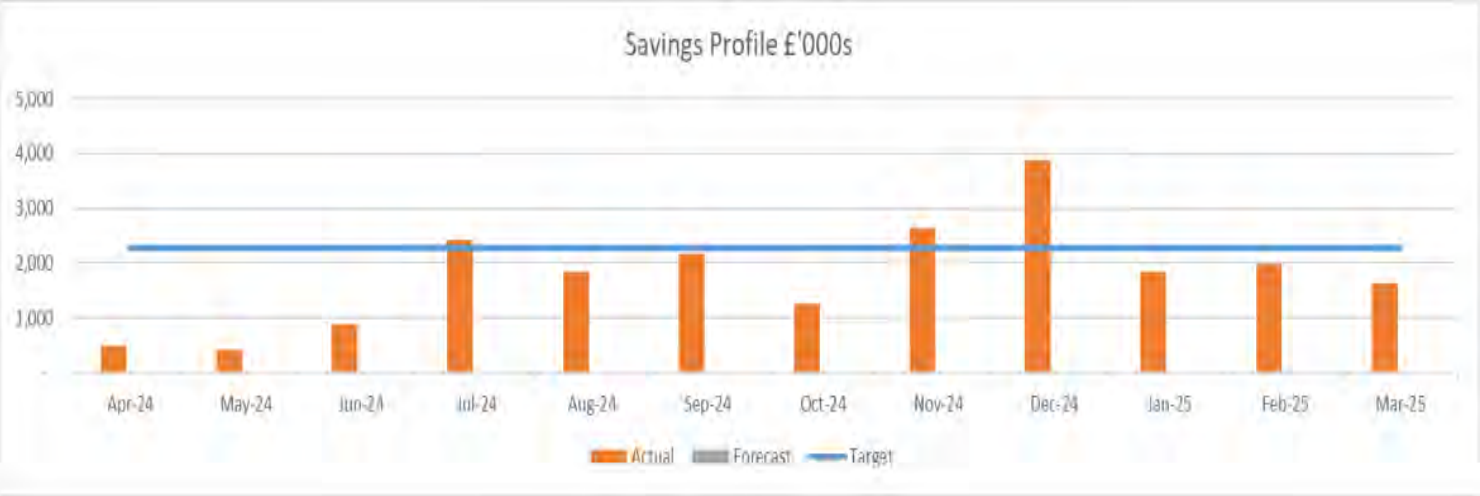
	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	22.4	0	22.4
Aneurin Bevan University	17.8	1.5	19.3
Betsi Cadwaladr University	0	0.4	0.4
Cardiff & Vale University	17.2	0	17.2
Cwm Taf Morgannwg University	0	0	0
Hywel Dda University	0.6	0.3	0.9
Powys	5.1	2.9	8.1
Public Health Wales	3.3	1.6	4.9
Velindre	0	9.3	9.3
NWSSP	0	0	0
DHCW	0.6	1.0	1.5
Wales Ambulance Services	0	0.1	0.1
JCC	13.2	0	13.2
HEIW	0	17.5	17.6
NHS Wales Executive	0	0	0
Total	**80.2**	**34.6**	**114.7**

Key Points :

- All LTA agreements have been agreed and signed for 2024/25.
- Good progress has been made in signing agreements on 2025/26 LTAs by the 31st March 2025.

Savings

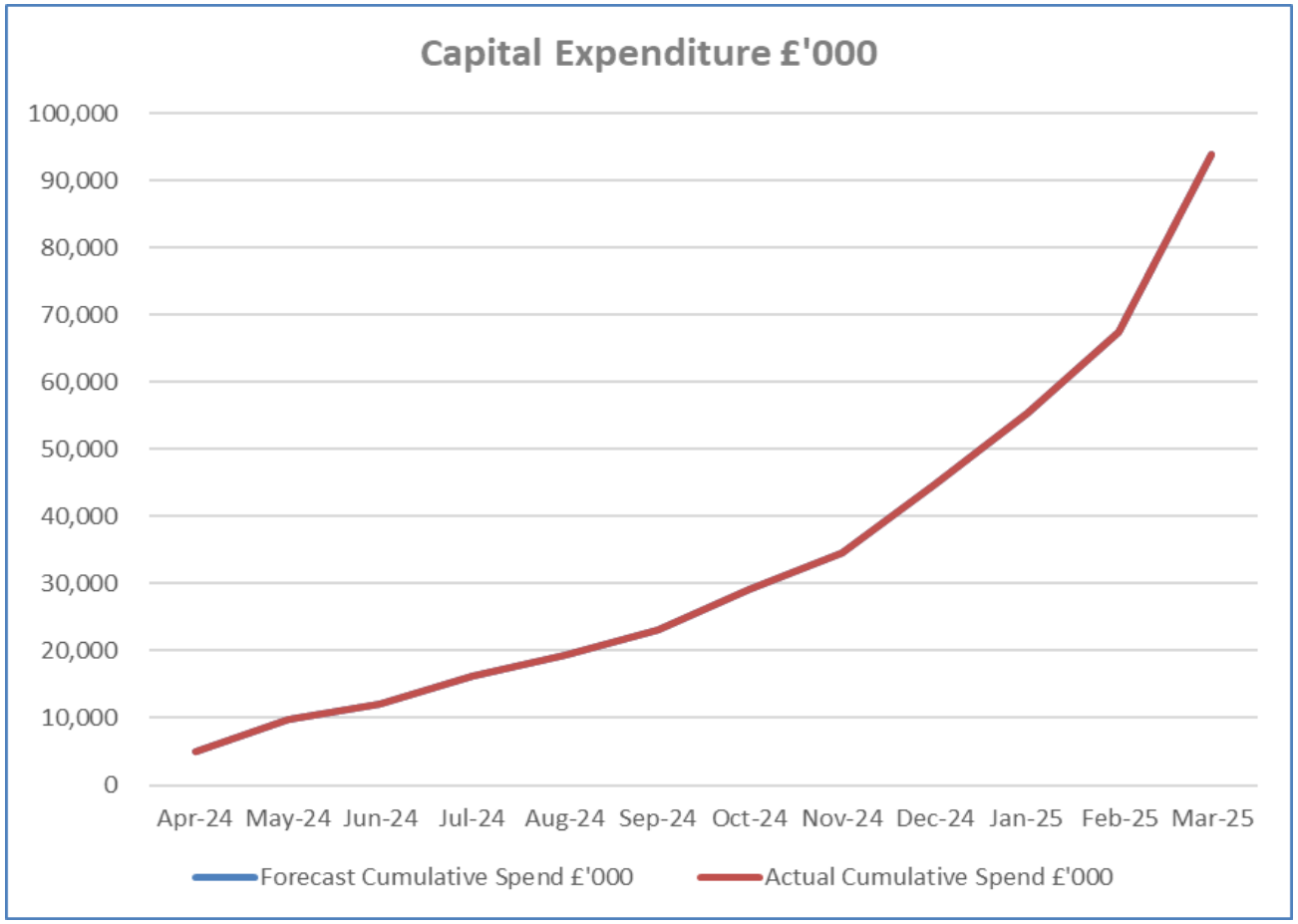
	Month 12			Month 11		
	YTD	24/25	Rec	YTD	24/25	Rec
	£m	£m	£m	£m	£m	£m
Savings target	26.3	26.3	26.3	24.1	26.3	26.3
Actual and Forecast Savings	(14.7)	(14.7)	(14.5)	(13.1)	(14.8)	(15.5)
Total	**11.6**	**11.8**	**11.8**	**11.0**	**11.5**	**10.8**



Key Points:

- The M12 YTD savings is now £13.1m ,which is £11.6m below the YTD target of £26.3m.
- The forecast In year savings of £14.7m is £11.6m below the £26.3m target. This is £0.6m worse than M11
- The M12 forecast Recurrent savings of £14.5m is £11.8m below the £26.3m target, this is a £1.0m deterioration compared to M11.

Capital Expenditure



Key Points:

- The latest Capital Resource Limit (CRL) for 2024-25 of £94.8m was issued on the 28th February 2025
- Expenditure to M12 was £94.7m.
- The outturn capital position is balanced against the CRL target.

Statement of Financial Position

Balance Sheet	Opening Balance (01/04/2024) £'000	Closing Balance as at M11 £'000	Closing Balance as at M12 £'000
Non Current Assets			
Property, Plant & Equipment	730,452	761,704	686,792
Intangible Assets	2,092	2,092	2,010
Trade and Other Receivables	67,191	67,191	94,247
Total Non-Current Assets	799,735	830,987	783,049
Current Assets			
Inventories	7,367	7,032	7,719
Trade and Other Receivables	77,735	118,124	105,851
Cash and Cash Equivalents	1,485	5,666	5,225
Non Current Assets Classified as Held for Sale	0	0	287
Total Current Assets	86,587	130,822	116,082
Current Liabilities			
Trade and Other Payables	161,743	161,743	190,926
Provisions	36,955	36,955	44,209
Total Current Liabilities	198,698	198,698	235,135
Non-Current Liabilities			
Trade and Other Payables	18,437	28,543	18,447
Provisions	65,735	89,839	99,688
Total Non-Current Liabilities	84,172	118,382	118,135
TOTAL ASSETS EMPLOYED	603,452	644,729	545,861
Financed By:			
General Fund	493,867	535,144	446,342
Revaluation Reserve	109,585	109,585	99,519
TOTAL	603,452	644,729	545,681

Key Points :

The main changes in the balance sheet figures from M11 to M12 include the following::

- **Trade and Other payables have increased by £19.1m since M11.** This is due to an increase of £14.5m in the general payables control account at year end and an increase of £11.1m in Non-NHS accruals, this is offset by a decrease in the PANISU creditor of £6.1m due to the early payment of Pensions and NI for M12.
- **Provisions have increased by £17.1m**, this is due to an increase in the clinical negligence provision of £15.8m, with smaller increases of £1.3m in other provisions.
- **Trade and Other Receivables have increased by £11.8m.** This is mainly due to an increase in the Welsh Risk Pool Debtors of £15.9m as detailed above. There is a net increase of £2.6m in NHS/Non-NHS manual accruals offset by a reduction in Non-NHS Prepayments of £7.7m.

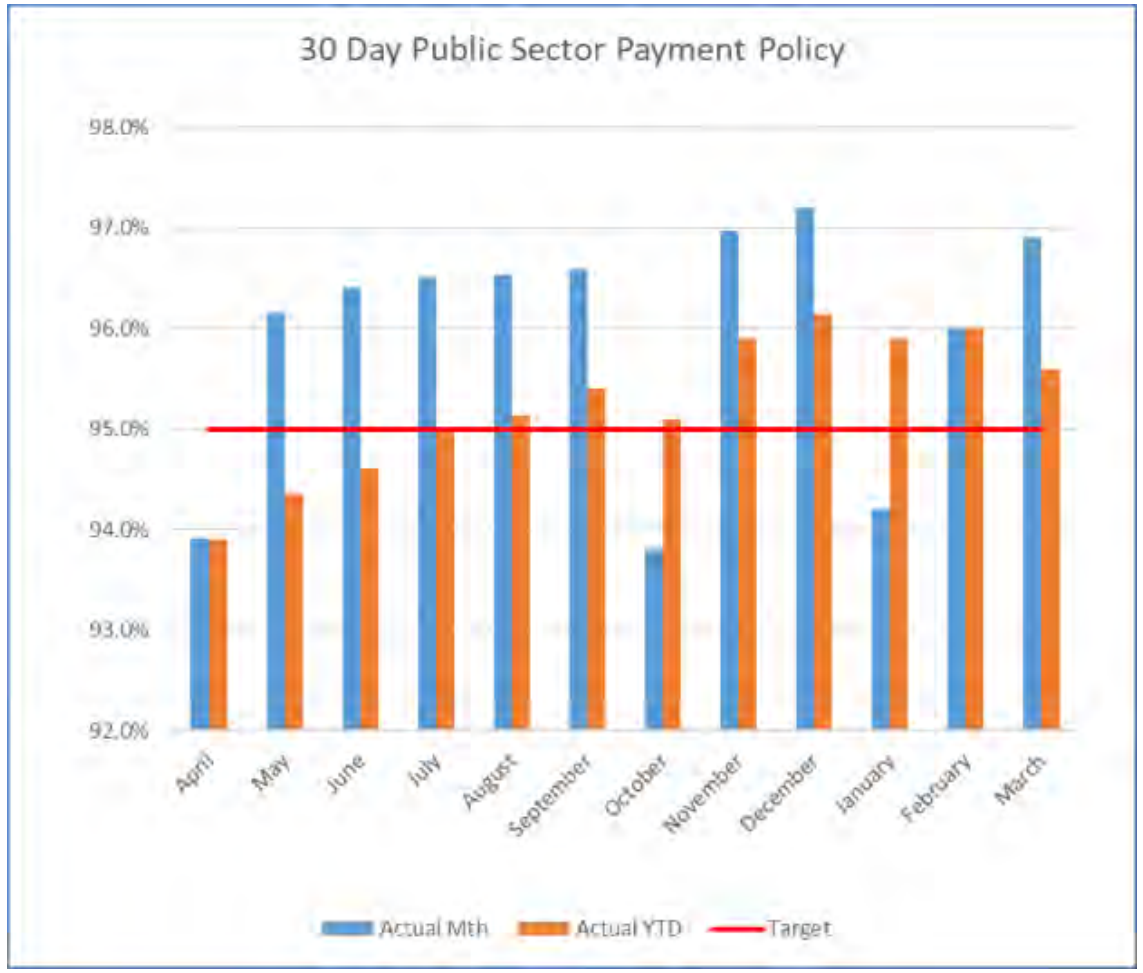
Cash Flow Forecast

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	115,153	110,593	141,166	136,104	119,474	127,432	118,441	1,450,714
WG Capital Funding	6,000	3,000	3,600	5,300	3,900	3,500	4,800	3,500	7,700	9,300	11,200	30,755	92,555
Sale of Assets	0	0	0	0	0	0	0	0	0	150	0	0	0
Welsh NHS Org'ns	13,521	8,976	10,095	10,090	10,783	10,967	10,075	8,641	9,104	13,664	9,645	12,661	128,222
Other	6,489	5,527	3,110	1,968	4,648	5,427	3,417	3,909	4,925	7,069	6,450	8,419	61,358
Total Receipts	130,070	139,004	127,650	141,029	141,605	135,047	128,885	157,216	157,833	149,657	154,727	170,276	1,732,999
Payments													
Primary Care Services	18,463	30,299	9,946	19,043	29,494	9,023	19,011	31,274	20,061	20,331	26,377	11,622	244,944
Salaries and Wages	151	178	194	69	104	132	50	0	0	0	0	0	878
Non Pay Expenditure	44,837	57,323	58,000	56,289	54,911	61,312	59,057	68,266	70,172	60,409	61,609	67,477	719,622
Capital Payments	5,476	6,126	3,568	2,845	4,105	3,004	4,171	5,379	7,791	7,295	12,189	30,506	92,455
Other	59,061	48,104	52,532	59,439	58,482	56,688	50,916	53,187	58,925	54,621	58,253	61,112	671,320
Total Payments	127,988	142,030	124,240	137,685	147,096	130,159	133,205	158,106	156,949	142,656	158,428	170,717	1,729,259
Net Cash In/Out	2,082	(3,026)	3,410	3,344	(5,491)	4,888	(4,320)	(890)	884	7,001	(3,701)	(411)	
Balance B/F	1,485	3,567	541	3,951	7,295	1,804	6,692	2,372	1,482	2,366	9,367	5,666	
Balance C/F	3,567	541	3,951	7,295	1,804	6,692	2,372	1,482	2,366	9,367	5,666	5,225	

Key Points within the Cash Flow Forecast :

- The cash balance at the end of M12 was £5.2m, this is within our target balance of keeping cash balances below £6m.

Public Sector Payment Policy



Key Points:

- The percentage for the number of non-NHS invoices paid within the 30 day target in March was 96.9%
- The cumulative percentage to M12 is now 95.6%.

2025-26 Finance Report

Month 1

Summary

Situation

This Finance report outlines our financial performance for Month 1 (i.e. the period to 30th April 2025).

This Finance report is discussed at the Board, the Operational Delivery Committee (ODC) and the Executive Management Board (EMB) 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 1 (i.e. the Delegated budget position). This report is discussed at the ODC and EMB 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 25/26 was submitted to Welsh Government (WG) at the end of March 2025. This plan showed a breakeven position with a net risk to the plan of £41.8m.

As the Health Board has achieved a breakeven position over the last 2 financial years (2023/24 & 2024/25), delivering the breakeven plan in 2025/26 would allow the Health Board to meet its financial duties if the submitted plan is approved by WG.

Summary

Assessment	Recommendation
Overall Revenue position - 2025/26: • The M1 position reported a £1.7m deficit against our plan. • The current year forecast break-even position has been maintained at M1. • The risks to the breakeven forecast are significant (M1: £37.8m) there remain a number of risks and opportunities that may impact the breakeven forecast and these are summarised on Page 19. **Recurrent Revenue position:** • The brought forward recurrent deficit at the end of 2024/25 was £7.9m, the submitted IMTP for 2025/26 plans for an in year recurrent surplus of £9.6m giving an underlying recurrent surplus of £1.7m by the end of 2025/26. • As at M1 we are reporting a forecast underlying surplus at the end of 2025/26 of £1.7m. This is consistent with the IMTP submitted on the 31st March 2025 and will be reviewed at the end of Quarter 2.	The Board, the Operational Delivery Committee (ODC) and the Executive Management Board (EMB) are asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 30th April 2025.

Contents

Executive Summary

Overall Revenue Position	• The M1 position reported a deficit of £1.7m. The forecast current year break-even position has been maintained at M1. • The forecast recurrent position has been retained at £1.7m surplus in M1. • The net opportunities/risks to the forecast break even position at M1 are significant at £34.9m (IMTP: £41.8m) which are summarised on Page 19.
Savings Position	• Actual savings in M11 was £0.6m which was £2.0m below the M1 target of £2.6m. • The M1 forecast In year savings is £17.3m, which is £14.0m below the £31.3m target. • The M1 forecast Recurrent savings is £18.6m, which is £12.7m below the £31.3m target
Cash	• The current and forecast cashflow position will be available for M2 reporting.
Capital	• The current and forecast Capital position will be available for M2 reporting.

Summary
Income & Expenditure Account

	M1 Actual	M1 YTD	Year End Forecast
	£m	£m	£m
01. Revenue Resource Limit	(119.6)	(119.6)	(1495.1)
02. Capital Donation / Government Grant Income	(0.0)	(0.0)	(0.0)
03. Welsh NHS Local Health Boards & Trusts Income	(6.0)	(6.0)	(71.3)
04. WHSSC Income	(1.1)	(1.1)	(12.4)
05. Welsh Government Income (Non RRL)	(0.1)	(0.1)	(0.1)
06. Other Income	(3.9)	(3.9)	(47.6)
Total Allocations & Income	**(130.7)**	**(130.7)**	**(1626.6)**
08. Primary Care Contractor	13.7	13.7	170.0
09. Primary Care - Drugs & Appliances	9.1	9.1	110.4
10. Provided Services - Pay	61.2	61.2	734.0
11. Provider Services - Non Pay	8.7	8.7	118.7
12. Secondary Care - Drugs	4.8	4.8	61.8
13. Healthcare Services Provided by Other NHS Bodies	23.4	23.4	284.8
14. Non Healthcare Services Provided by Other NHS Bodies	0.0	0.0	0.0
15. Continuing Care and Funded Nursing Care	6.5	6.5	80.8
16. Other Private & Voluntary Sector	0.9	0.9	13.9
17. Joint Financing and Other	1.5	1.5	19.4
18. Losses Special Payments and Irrecoverable Debts	0.2	0.2	2.5
22. DEL Depreciation\Accelerated Depreciation\Impairments	2.5	2.5	30.2
23. AME Donated Depreciation\Impairments	0.0	0.0	0.1
25. Profit\Loss Disposal of Assets	(0.0)	0.0	0.0
Total Expenditure	**132.4**	**132.4**	**1626.6**
Grand total	**1.7**	**1.7**	**0.0**

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 M1 year to date position is reporting a deficit of £1.7m.
- We are currently forecasting a year end break-even position.

Year to Date Performance and Forecast

	Current Month	YTD	Year end Forecast
	£m	£m	£m
Month 1	1.7	1.7	0.0

Key Points:

- The M1 YTD overspend of £1.7m includes a £2.1m shortfall in savings offset by other favourable variances of £(0.3)m.
- Further details of the key drivers for the YTD are provided overleaf.

Year to Date Performance and Forecast

	Delegated Year to Date £m	Non Delegated Year to Date £m	Total M1 Year to Date £m	M1 Year-end forecast £m	IMTP £m
Savings Shortfall	1.7	0.3	2.0	14.0	0.0
Operational Variances	0.5	(0.8)	(0.3)	(0.3)	0.0
Financial Plan Improvements	0.0	0.0	0.0	0.0	0.0
Additional Financial Allocation	0.0	0.0	0.0	0.0	0.0
Accountancy Gains	0.0	0.0	0.0	0.0	0.0
Other Mitigating Actions	0.0	0.0	0.0	(13.7)	0.0
Grand Total	**2.2**	**(0.5)**	**1.7**	**0.0**	**0.0**

Key Points:

- The M1 position is reporting a £1.7m deficit (Overspend) against the plan, of which £2.2m relates to delegated budgets offset with 0.5m underspend within non delegated budgets and reserves.
- The Main driver of the deficit position is the £2.0m shortfall in savings delivery compared to the straight-line target of £2.6m per month, which has been slightly offset by favourable operating variances.
- A separate Finance Performance report has been prepared which sets out the Delegated financial performance of the individual Care Groups and directorates as at Month 1 (i.e. the Delegated budget position). This report is discussed at the Operational Delivery Committee (ODC) and Executive Management Board (EMB) meetings.

Forecast Underlying Position

Underlying Position	Plan £m	Delegated Recurrent @ M1	Non Delegated Recurrent @ M1 £m	Total Recurrent @ M1 £m	IMTP Recurrent £m
Initial Financial Plan	**(1.7)**	**0.0**	**(1.7)**	**(1.7)**	**(1.7)**
Savings Variances	0.0	7.9	4.8	12.7	0.0
Operational Variances	0.0	0.0	0.0	0.0	0.0
Financial Plan Variances	0.0	0.0	0.0	0.0	0.0
Additional Financial Allocations	0.0	0.0	0.0	0.0	0.0
Accountancy Gains	0.0	0.0	0.0	0.0	0.0
Other Mitigating Actions	0.1	(7.9)	(4.8)	(12.7)	0.0
Grand Total	**(1.7)**	**(0.0)**	**(1.7)**	**(1.7)**	**(1.7)**

Key Points:

- The B'fwd recurrent deficit at the end of 2024/25 was £7.9m, the submitted IMTP for 2025/26 plans for an in year recurrent surplus of £9.6m giving an underlying surplus of £1.7m by the end of 2025/26.
- The latest savings returns have indicated recurrent savings of £18.6m compared to the plan of £31.3m, giving rise to a recurrent shortfall of £12.7m. At M1 we are anticipating this shortfall will be met by year end through £12.7m of further mitigating actions.
- As at M1 we are continuing to report a forecast underlying surplus at the end of 2025/26 of £1.7m. This is consistent with the IMTP submitted on the 31st of March 2025 and will be reviewed at the end of Q1.

Non Delegated Reserves

Reserves	Plan £m	Issued @ M1	Balance Remaining £m	Anticipated Commitments £m	Current Year Forecast £m	Recurrent Forecast £m
Brought Forward Commitments	3.2	(1.6)	1.6	(1.6)	0.0	0.0
Brought Forward Planned Care	11.9	(0.0)	11.9	(11.9)	0.0	0.0
Recurrent Investment Plans	6.3	(0.0)	6.3	(6.3)	0.0	0.0
Non Recurrent Investment Plans	1.0	(0.0)	1.0	(1.0)	0.0	0.0
Cost Pressures – Inflation	3.8	(0.0)	3.8	(3.8)	0.0	0.0
Cost Pressures – Growth/Demand	3.2	(0.2)	3.0	(3.0)	0.0	0.0
Cost Pressures – POW Non Rec	10.0	(0.0)	10.0	(10.0)	0.0	0.0
Savings Target yet to be identified	(9.6)	4.8	(4.8)	4.8	0.0	0.0
Planned Deficit/Surplus	0.0	0.0	0.0	0.0	0.0	(1.7)
Grand Total	**29.8**	**3.0**	**32.8**	**32.8**	**0.0**	**(1.7)**

Key Points:

- The approved plan identified £39.4m of reserves yet to be issued to delegated budgets, as at M1 £1.8m has been issued with £37.6m remaining. As at M1, there is no anticipated slippage or release from the reserves.
- The Savings target of £31.3m identified £21.7m to be issued to Delegated budgets with the £9.6m remaining to be issued as central executive led programmes identified opportunities for the care groups/directorates to deliver. As at M1 £4.8m has been issued to recognise Primary Care Prescribing Cat M savings, with a further £4.8m remaining yet to be issued.

Pay Expenditure Trends

Staff Group	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m	Apr-25 £'m
Administrative & Clerical	8.2	8.1	8.3	8.2	8.5
Medical And Dental	17.5	16.7	18.1	17.4	16.6
Nursing And Midwifery Registered	20.0	20.0	20.0	20.0	19.5
Add Prof Scientific And Technical	2.1	1.9	1.9	2.0	2.0
Additional Clinical Services	7.8	8.0	8.1	7.9	7.9
Allied Health Professionals	3.9	3.9	4.0	3.9	4.0
Healthcare Scientists	1.2	1.1	1.2	1.2	1.1
Estates And Ancillary	3.5	3.4	3.7	3.5	3.7
Students	0.0	.0	.0	.0	.0
Grand Total	**64.2**	**63.2**	**65.2**	**64.2**	**63.3**

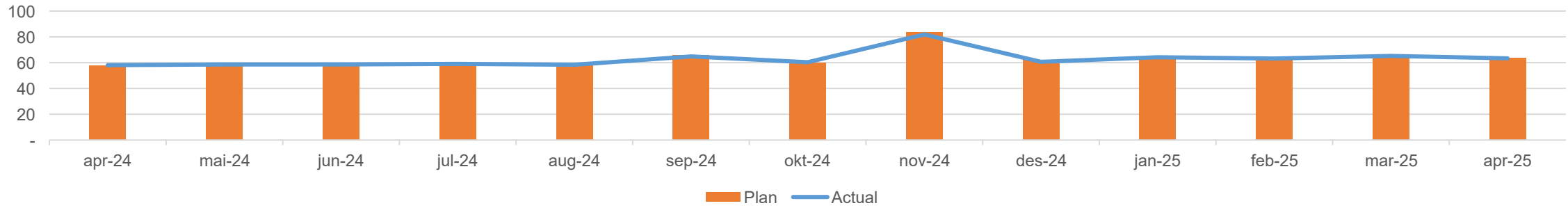
Spend category	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m	Apr-25 £'m
Core	56.1	55.5	56.2	55.9	56.4
Agency	3.3	2.8	3.0	3.0	2.2
Overtime	1.6	1.7	2.0	1.8	1.5
ADH	1.6	1.7	2.1	1.8	1.7
Bank	1.4	1.4	1.6	1.4	1.4
WLI	0.2	0.1	.4	.2	.0
Grand Total	**64.2**	**63.2**	**65.1**	**64.2**	**63.2**

Key Points:

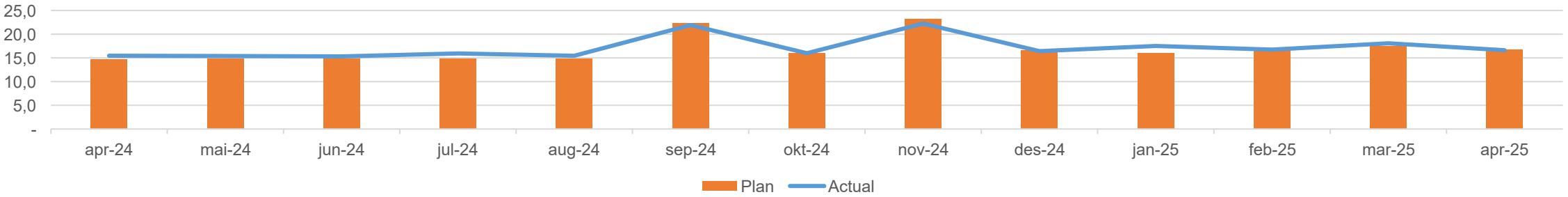
- Total pay expenditure in M1 was £63.3m. This remains consistent with the Q3 average costs but reduced from Q4 averages when adjusted for the 25/26 NI & RLW increases.
- When compared with the Q4 averages, the following variable pay movements occurred:
  - Increase in Core costs of £0.5m
  - Decrease in Agency of £0.8m
  - Decrease in Overtime costs of £0.3m
  - Decrease in ADH's of £0.1m
  - Decrease in WLI of £0.2m

Pay Expenditure Trends

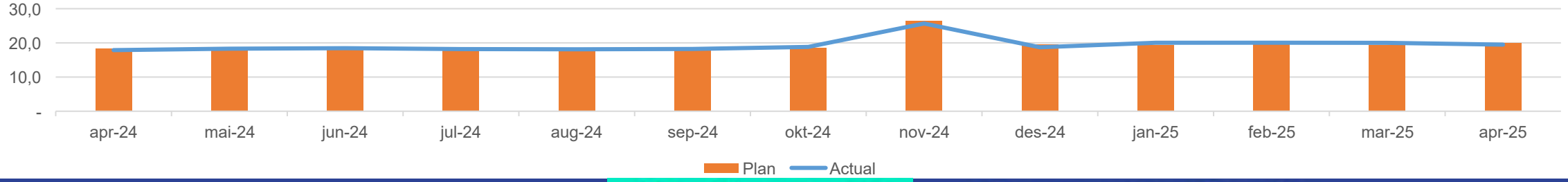
Total Pay Expenditure Trend (£'m)



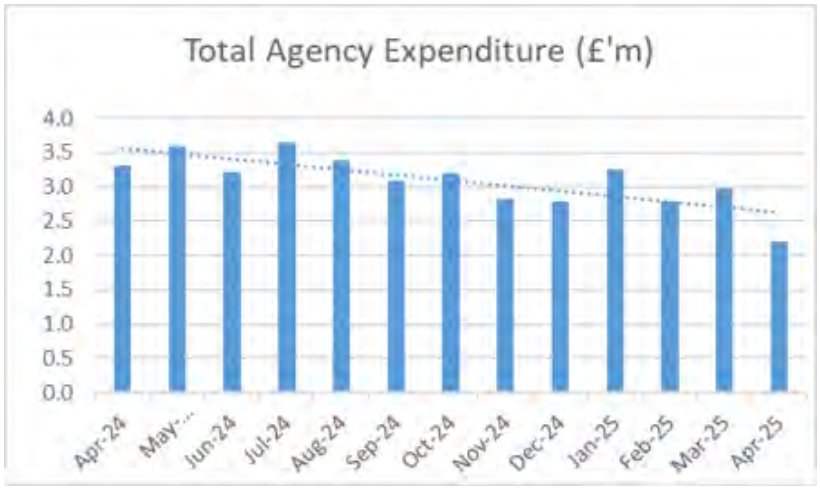
Medical & Dental Pay Expenditure Trend (£'m)

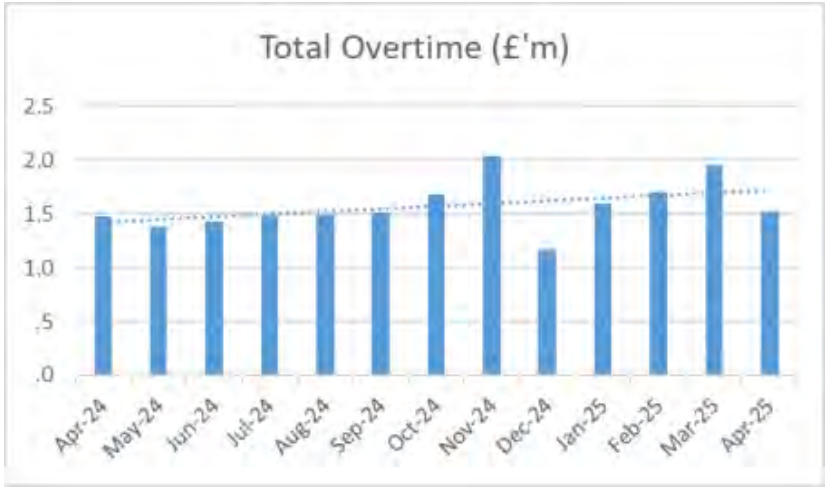


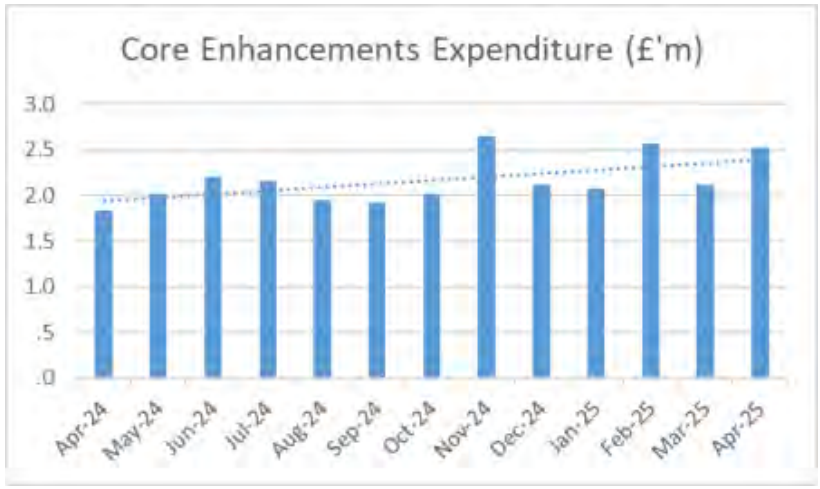
Nursing & Midwifery Pay Expenditure Trend (£'m)

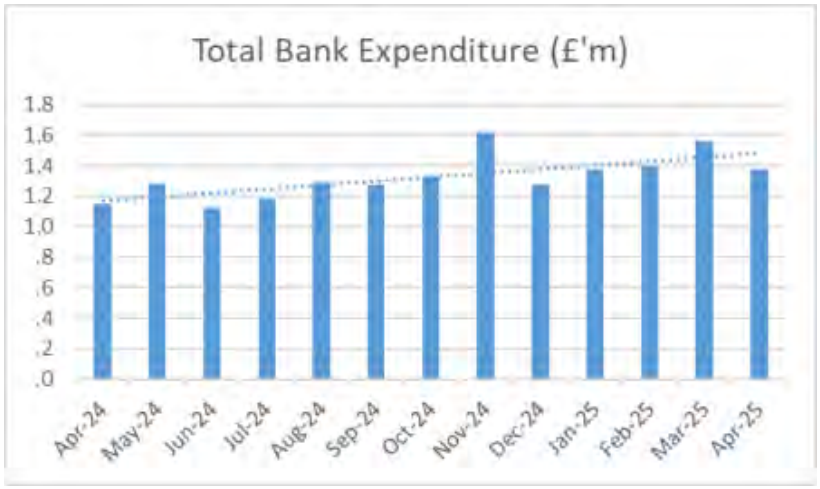


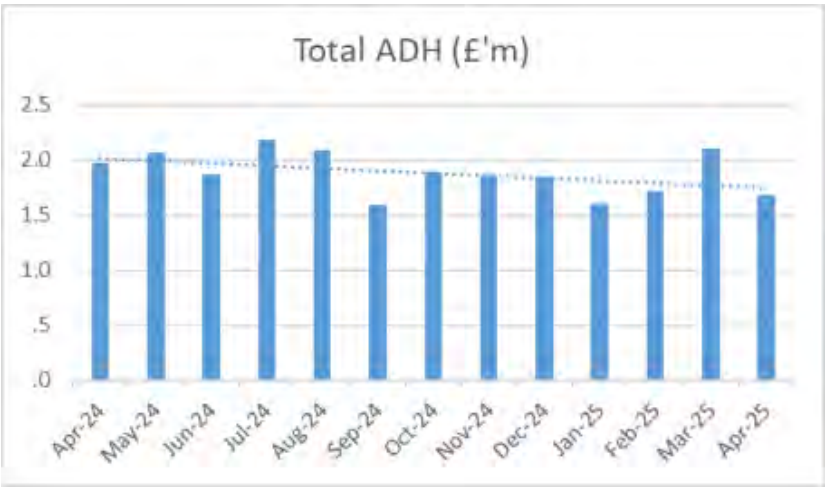
Variable Pay Expenditure Trends











Key Points :

- Agency spend – Decrease in M1 of £0.8m and overall a downward trend.
- Overtime payments- £0.5m decrease in M1 and an increasing trend.
- Core enhancements – £0.5m increase in M1 and increasing trend.
- Bank – Decrease in M1 of £0.2m and an increasing trend.
- ADH spend – £0.4m decrease in M1 and a downward trend.

Non Pay Expenditure Trends

Non Pay Group	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m	Apr-25 £'m
Primary Care Contractors	13.6	21.7	16.0	17.1	12.9
Primary Care Drugs	7.9	8.1	8.2	8.1	9.1
Provider Non Pay	10.2	8.8	14.8	11.2	10.0
Secondary Care Drugs	5.2	4.2	5.2	4.9	4.8
Healthcare Commissioning	24.3	24.5	29.7	26.2	23.4
CHC & FNC	7.0	6.2	7.8	7.0	6.9
Other	6.4	9.8	121.3	45.8	1.2
Total Expenditure	**74.6**	**83.2**	**203.0**	**120.3**	**68.3**

Key Points:

- The total spend in M1 of £68.3m was £134.7m Lower than M12. The main movements were:
  - Primary Care Contractors of £3.1m – decrease in M1, due to prior months recognition of Central Pension Adjustment and increase in Community Pharmacy Contract, both matched with corresponding allocations Offset with movement in NCL.
  - Increase in Primary Care Drugs of £0.9m – As at M1 estimated expenditure has been reported as we are still awaiting Mar-25 actual data. This will be revised and refreshed when actual data is confirmed from M1 onwards.
  - Decrease Provider Non-Pay of £4.8m – Decrease when compared to M12 as there were accruals and accounting adjustments made in prior month for year end reporting.
  - Decrease in Secondary Care drugs of £0.4m - Lower than anticipated treatments of NICE/HCD during April.
  - Decrease in Other of £111.5m – Prior months year end recognition of Capital AME adjustments. Also reduction in private provider work undertaken at the end of last year.

Income Trends

Income Group	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Qtr4 Ave £'m	Apr-25 £'m
Welsh NHS Income	5.3	6.0	7.6	6.3	6.0
JCC Income	1.0	1.3	1.1	1.2	1.1
Primary Care Contractor Income	1.0	1.4	1.0	1.1	1.2
CHC Income	0.7	0.5	0.6	0.6	0.6
Other Income	4.3	4.3	6.2	4.9	3.9
Total Income	**12.3**	**13.6**	**16.6**	**14.6**	**12.8**

Key Points:

- The total Income in M1 of £14.6m is £2.0m lower than M12, and appears to have returned to prior months levels.
- The material movements are:
  - Welsh NHS Income – Decreased by £1.6m. This is due to year end accounting adjustments and transactions.
  - Other income – Decreased by £2.3m. This is due to year end accounting adjustments and transactions.

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,254.8	31.2	25.0	82.5	1,393.5
Anticipated Allocations:					
Pay award funding 24/25	50.1				50.1
Employers NI	14.8				14.8
POW Roof	10.0				10.0
Same Day Urgent Care	2.7				2.7
Substance Misuse	4.1				4.1
Exceptional RLW Social Care 22/23	2.6				2.6
RLW 25/26	2.3				2.3
Medicine Electronic Prescribing	2.2				2.2
RTT Waiting Times Q3	3.0				3.0
GP Pay Expenses Uplift				3.0	3.0
24/25 Recurrent GMS Contract Agreement				3.7	3.7
Other	1.4		1.5	0.1	3.0
Total Allocations	**1,348.1**	**31.2**	**26.5**	**89.3**	**1,495.1**

Key Points:

- As at M1 the confirmed Revenue Resource Limit (RRL) allocation was £1,393.5m.
- We are anticipating a further £101.6m of funding.

Income Assumptions - NHS

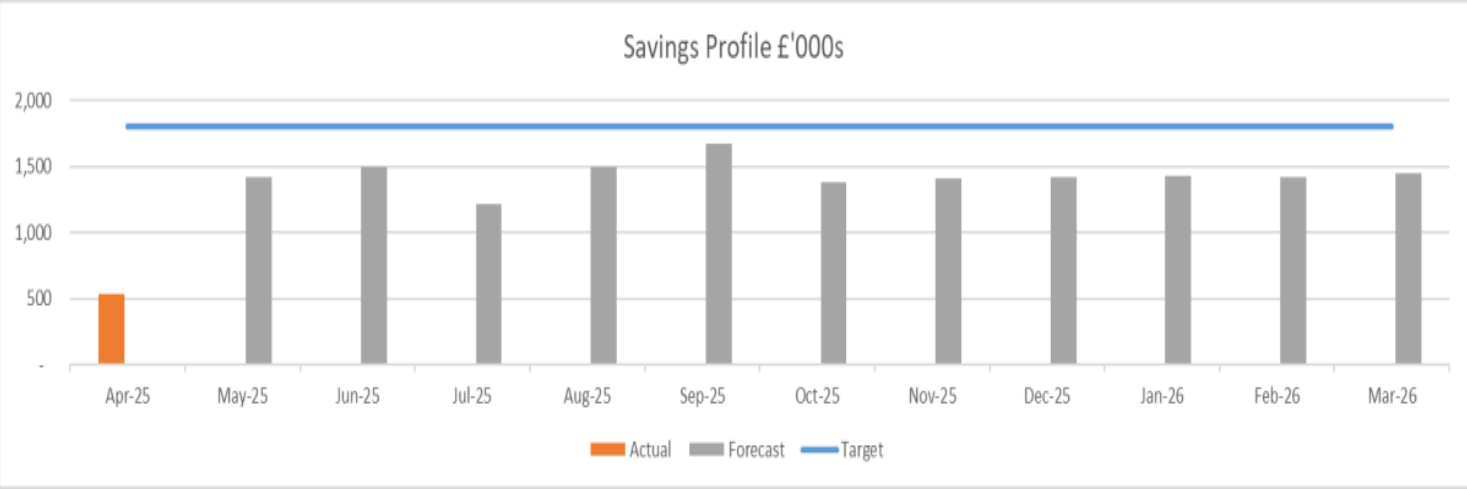
	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	29.8	(7.4)	22.4
Aneurin Bevan University	17.8	1.5	19.3
Betsi Cadwaladr University	0.0	0.4	0.4
Cardiff & Vale University	18.4	(1.2)	17.2
Cwm Taf Morgannwg University	0.0	0.0	0.0
Hywel Dda University	0.6	0.3	0.9
Powys	5.1	2.9	8.1
Public Health Wales	1.2	3.7	4.9
Velindre	0.0	9.3	9.3
DHCW	0.6	0.9	1.5
Wales Ambulance Services	0.0	0.1	0.1
JCC	12.2	0.1	12.3
HEIW	0.0	17.5	17.5
NHS Wales Executive	0.0	0.0	0.0
Total	**85.7**	**28.2**	**113.8**

Key Points :

- Income assumptions have been agreed with the corresponding organisations.
- Healthcare agreements are being progressed. The LHB is looking to agree all LTA documents by the 14th June.

Savings

	Month 1		
	YTD	25/26	Rec
	£m	£m	£m
Savings target as at M1	2.6	31.3	31.3
Actual and Forecast Savings	(0.6)	(17.3)	(18.6)
Total	**2.0**	**14.0**	**12.7**



Key Points:

- The M1 YTD savings is now £0.6m ,which is £2.0m below the YTD target of £2.6m.
- The forecast In year savings of £17.3m is £14.0m below the £31.3m target.
- The M11 forecast Recurrent savings of £18.6m is £12.7m below the £31.3m target.

Risks & Opportunities

	M1 £m	IMTP £m	Comment
Funding risks:			
Outstanding WG recurrent allocations for 2024/25 pay awards	3.0	3.0	Further clarification needed on funding assumptions for 24/25
Risk of the 2025/26 pay award not being fully funded	Tbc	Tbc	Further clarification needed on funding assumptions for 25/26
Risk of 2025/26 Employers NIC increase not being fully funded	Tbc	Tbc	Further clarification needed on funding assumptions for 25/26
WG recurrent allocation for RLW on Social Care not being fully funded	0.8	0.8	Further clarification needed on funding assumptions for 25/26
Risk of POW Critical Incident – Vanguard costs not supported by WG funding	5.4	5.4	Further clarification needed on funding assumptions for 25/26
POW Critical Incident – On going impact of temporary arrangements	4.6	4.6	Further clarification needed on funding assumptions for 25/26
Other risks:			
Delivery Risk on Identified Savings Plans	2.6	2.6	
Delivery Risk on Savings plans yet to be identified	14	18	
Delegated Risk Assessments – High Risk	2.9	2.9	
Delegated Risk Assessments – Medium Risk	4.5	4.5	
Band 2/3 dispute	Tbc	Tbc	
Further industrial action in 25/26.	Tbc	Tbc	
Total Risks	**37.8**	**41.8**	
Opportunities			
Balance sheet opportunities in 25/26	Tbc	Tbc	
Retrospective vat recoveries – Microsoft contract	(2.9)	Tbc	
WG Funding Opportunities	Tbc	Tbc	
Total Opportunities	**(2.9)**	**(Tbc)**	
Net Risk	**34.9**	**41.8**	

Key Points:

- As at M1 we have material risks to the forecast, amounting to £37.8m.
- There is a small number of potential opportunities that can help mitigate the identified risks by £2.9m.

Agenda Item
6.3

CTM Health Board

People Plan 2025-2030

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Hayleigh Jones, Deputy Director People
Cyflwynydd yr Adroddiad / Report Presenter	Hayleigh Jones, Deputy Director People
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 /Forum Individuals	Date	Outcome
ELG	24/02/2025	Approved comms and engagement plan
Strategic Development Committee	03/04/2025	Approved comms and engagement plan
Staff consultation/ site visits	1 March to 1 May 2025	Staff consultation sessions
Trade Union engagement, including discussion at LNC and LPF	March- April	Feedback received from Unison 30/4/25 Feedback received from BMA 5/5/25

Updates at Care Group SLTs	Throughout April	
Independent Member briefings	End April/ May	
ELG	19 May 2025	Endorsed People Plan for Board approval

Acronyms / Glossary of Terms	
SDC	Strategic Development Committee
LNC	Local Negotiating Committee
LPF	Local Partnership Forum
ELG	Executive Leadership Group

1. Situation /Background

1.1 Our People Plan for 2025-2030 has been created with input from our workforce and Trade Union partners. It describes our hopes, ambitions, and the steps we need to take to continue to build a CTM that we are proud of and where everyone can thrive, to support the achievement of CTM2030.

1.2 A communications and engagement approach for our People Plan was agreed at ELG on 24 February and endorsed via SDC on 3 April. The underlying principle behind our communication and engagement approach has been co-development. Involving staff in the development of our People Plan not only ensures the plan is tailored to their needs, it also strengthens trust and engagement. We want our People Plan to resonate, and for our people to see their own feedback and experiences accurately reflected within it.

1.3 Timing has also been a driving factor. We received our high-level Staff Survey results in February. 3,560 of our staff members completed the survey and shared feedback about their experiences of CTM. This is our highest Staff Survey response rate to date. We are keen to maintain this momentum, keep the conversation alive and demonstrate swift and tangible action, on the back of the Staff Survey.

1.4 We are using the People Plan as one of our response mechanisms to the Staff Survey. The People Plan will complement local action plans, recognising that whilst local ownership is critical in order to drive up staff engagement, there are several cross-cutting areas within the Staff Survey that need to be addressed at a corporate level.

1.5 We also want our People Plan to provide a sharper focus, through a more robust list of people priorities, all enabled by practical, deliverable actions. Up until now, CTM has had 10 people priorities, but limited definitive action plans, prioritised deliverables or success measures underneath these. Within People Directorate, we need to ensure we are focussing resource on the items that will have the biggest impact.

1.6 In order to develop our People Plan, between 1 March and 1 May, People Directorate engaged directly with over 550 frontline staff and leaders, across a mix of sites and staffing groups. We held a variety of different types of engagement sessions, in order to maximise opportunity to contribute. These have consisted of site-visits and walkarounds, more formal roadshows held at each of our main sites, a short MS form that people were invited to complete, and bespoke sessions at existing meetings (i.e. Clinical Advisory Group, Senior Nurse Forum, Community Paeds team, Inspire, EDI working group, F2 offsite).

1.7 We asked colleagues to share what matters most to them and what we need to do in the next five years to bring our vision for a great CTM to life. We have also drawn upon the wealth of information from the 3,560 people who responded to the 2024 Staff Survey, in addition to internal and external evidence reviews. Relevant strategy, policy and planning frameworks have also been taken into consideration, including the recent Ministerial Advisory Group report on NHS Wales Performance and Productivity.

2. Summary of Findings

2.1 What we heard is that, when we are at our best, CTM feels like family. This sense of community sets us apart from other organisations and is what keeps many of us working here. We are welcoming, friendly, team-oriented and connected to one another. We regularly go above and beyond our duties and we unite to deliver extraordinary things for our patients. We heard a consistent theme about dedication to the individual's immediate team and the unwavering passion for providing the best possible care. Colleagues shared incredible examples of the difference we are making for patients and communities, even under immense pressure. And described examples of great managers who have made an impact on their experience at CTM. These stories shared some common ingredients; visible, approachable leaders and managers, who provide clear direction, understand their people as individuals, keep the team well informed and instill hope and reassurance, even when things are difficult.

2.2 However, we also heard frustrations about cumbersome processes, policies and systems that hinder rather than help. There was a resounding desire for us to simplify things, cut through bureaucracy, and equip our people with access to better equipment, estates and facilities, freeing up time to focus on what truly matters.

2.3 There was also a clear requirement for great management to become the norm, rather than the exception; managers who coach and develop you, who recognise everyone's contributions, connect you to the wider organisation and who make tough prioritisation decisions about what is feasible. Our staff are tired and pressing workloads and competing priorities continue to be an issue. And, whilst CTM's sense of family is something to be proud of, it can also mean we shy away from having challenging conversations with one another. We also heard the need to reduce inequities between teams and to continue to strive for fair, consistent, and inclusive treatment across CTM, making sure everyone feels that they belong within CTM and can voice their ideas and concerns.

3. Specific Matters for Consideration- 4 core themes

3.1 Synthesising the different data sources and feedback has resulted in 4 consistent themes, all of which require focussed attention and provide the foundations of our People Plan.

3.2 Underneath each of the 4 themes, we have developed a 'People Promise', that encapsulates our ambition. We have also developed a high-level list of actions, that have been prioritised for delivery by 2026, or in 2027-2030. The actions are intended to be specific and tangible. Many were suggested directly by our staff members. There is a mixture of more tactical quick-wins to generate momentum, and longer term strategic activities. There is little within our People Plan that could be described as new or radical, but we are confident that these actions will make a difference.

1. Getting the Basics Right

Our People Promise - what this means for you:

We will strive to provide modern, reliable IT systems and safe, well-maintained facilities, making your working day easier and more efficient. We will ensure we have simple policies in one place, and provide you with access to meaningful information and effective communications. We will simplify bureaucracy, allowing you to dedicate more time to what truly matters.

2. Great Management and Leadership

Our People Promise - what this means for you:

Everyone in CTM has a great line manager, ensuring you feel supported and inspired to perform at your best. Our line managers have the tools, time and development to create an empowering environment for their teams, by knowing them as individuals, setting clear expectations and having regular and effective conversations about the things that matter.

3. Inclusive and Health Environment

Our People Promise – what this means for you:

An environment where you can belong, where every voice is heard, every contribution is valued, and where you feel accepted for the difference you make. We look after each other, but we also hold each other to account for our actions and behaviours, learning and rebuilding from error. Together, we make CTM a workplace to be proud of.

4. Modern workforce - skills for the future

Our People Promise- what this means for you:

Our services are appropriately resourced to meet the needs of our population and we offer modern, flexible and fulfilling career paths and adequate rest and recovery measures. Everyone is supported to learn, grow, and get ready for what is next - so the whole of CTM is prepared for the future.

A full copy of the proposed People Plan is attached.

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	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 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 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))*	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: No requirement for an EIA for the overarching People Plan, albeit individual processes/ policies within the plan will need to be impact assessed at the appropriate point in time. A Welsh version of the people plan will be produced.
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)	
	Most of the actions will be owned within People Directorate and we will allocate resource appropriately. Other actions will be owned by colleagues in other Directorates- specifically there is a reliance on Comms, Estates, Facilities, Digital – all of whom have been engaged in the development of the proposed plan.	

5. Recommendation

5.1 It is recommended that the Board Approves the People Plan, for publication to our wider workforce during the Summer.

6. Next Steps

6.1 A full communications and engagement plan is currently under development. Supporting products will include a supplementary one-page visual summary of our People Promises (attached), and a Welsh translation of our People Plan.

6.2 Line manager and leadership engagement will be critical. We need our leadership community to understand the ambitions within our People Plan, and to translate this during regular discussions with their teams, so that all individuals understand what it means for them. We therefore intend to run

a launch event for our leadership community and will use corporate communications channels to promote the plan to as wide a range of internal audiences as possible.

6.3 Regular progress reviews will be held via SDC, with regular check-point discussions on key actions at LNC and LPF. We intend to re-engage with our workforce directly on an annual basis, on the back of our Staff Survey results, and update our People Plan actions accordingly to ensure it remains a living document.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CYNLLUN POBL
PEOPLE PLAN
2025–2030

CREATING A CWM TAF MORGANNWG
WHERE EVERYONE CAN THRIVE.

CONTENTS

WE ARE CWM TAF MORGANNWG

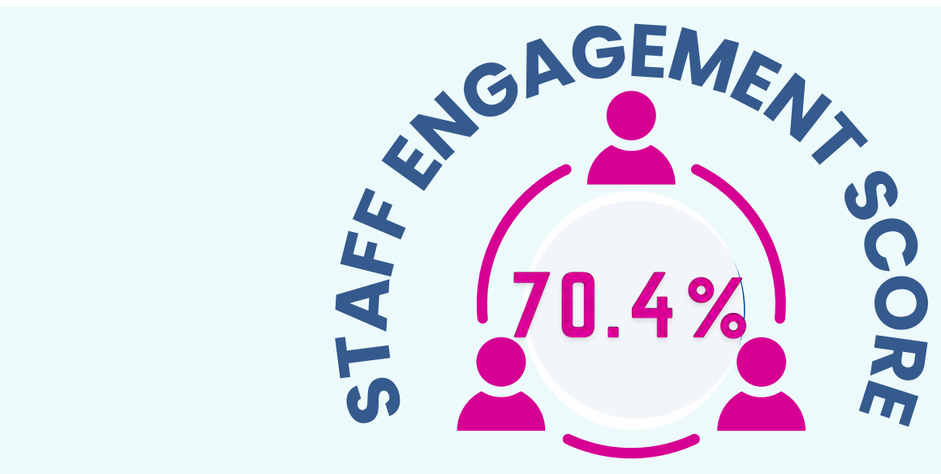
BASED ON DATA CAPTURED FROM ESR MAY 2025

THE HEALTH BOARD EMPLOYS

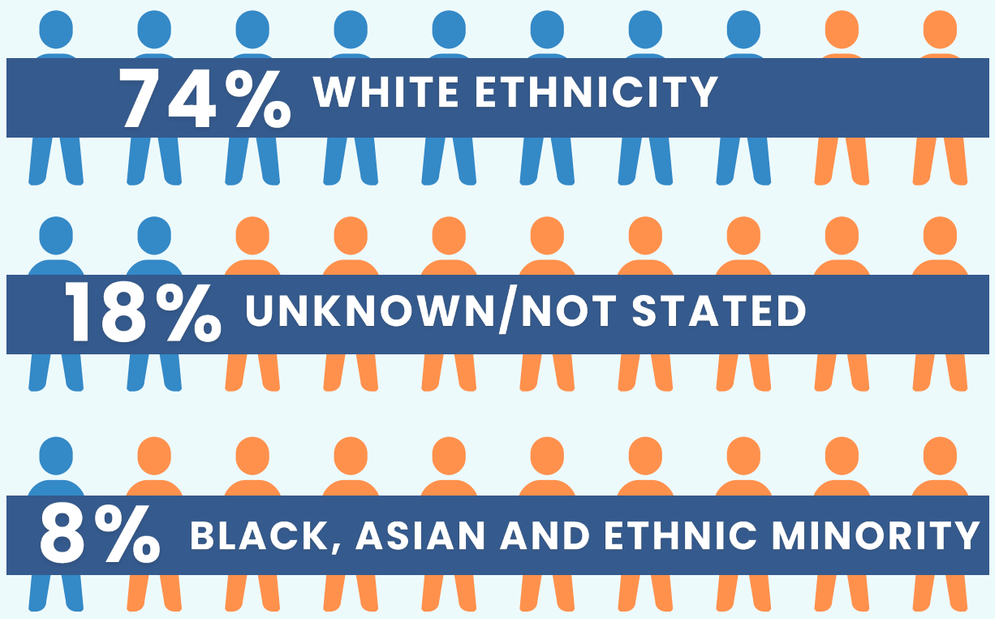
13,207 STAFF IN POST

WHICH TRANSLATES TO

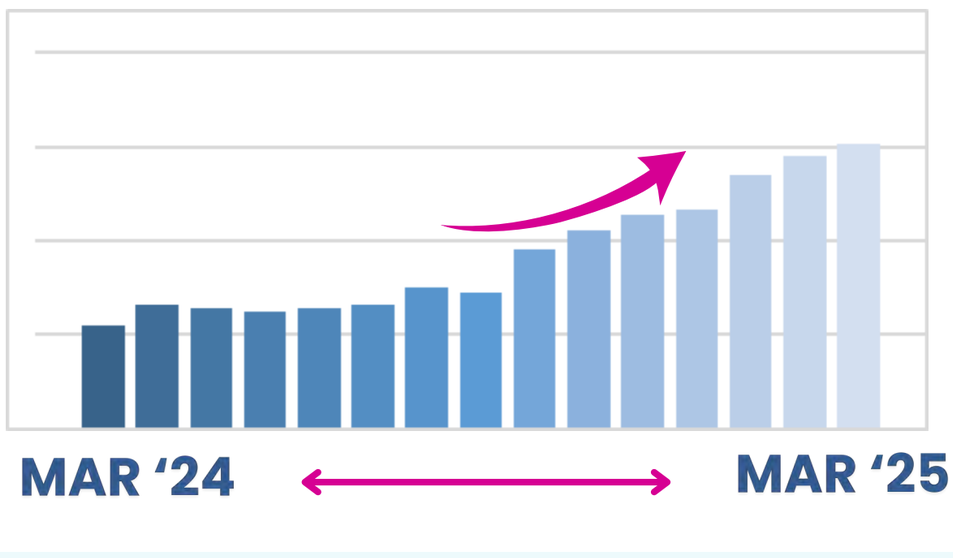
11,511 WTE
(WHOLE TIME EQUIVALENT)

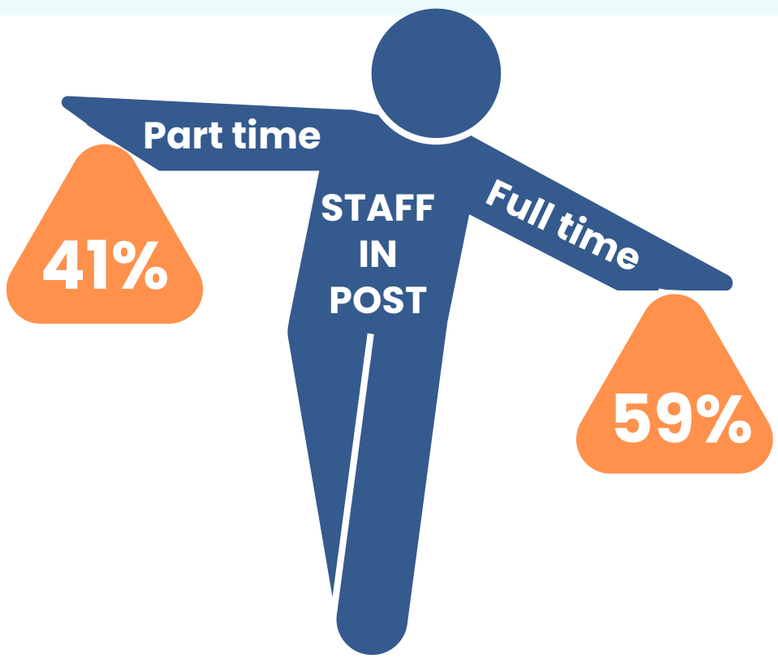


OUR STAFF ENGAGEMENT SCORE IS BASED ON RESPONSES TO SEVEN SURVEY QUESTIONS.

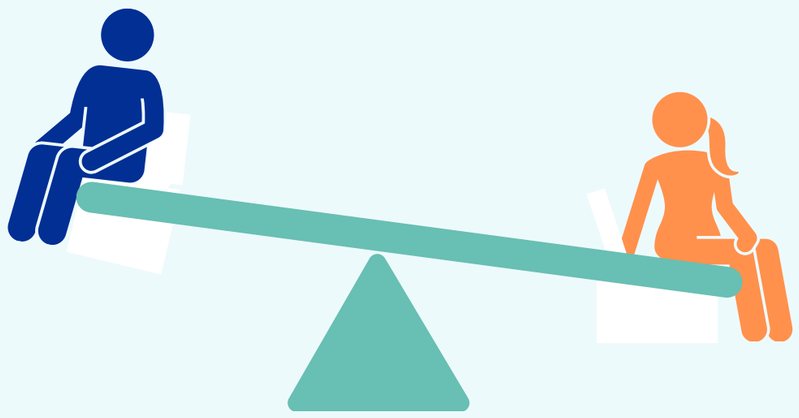


STAFF IN POST HAS INCREASED 2.6% (292 STAFF WTE =2.6%)



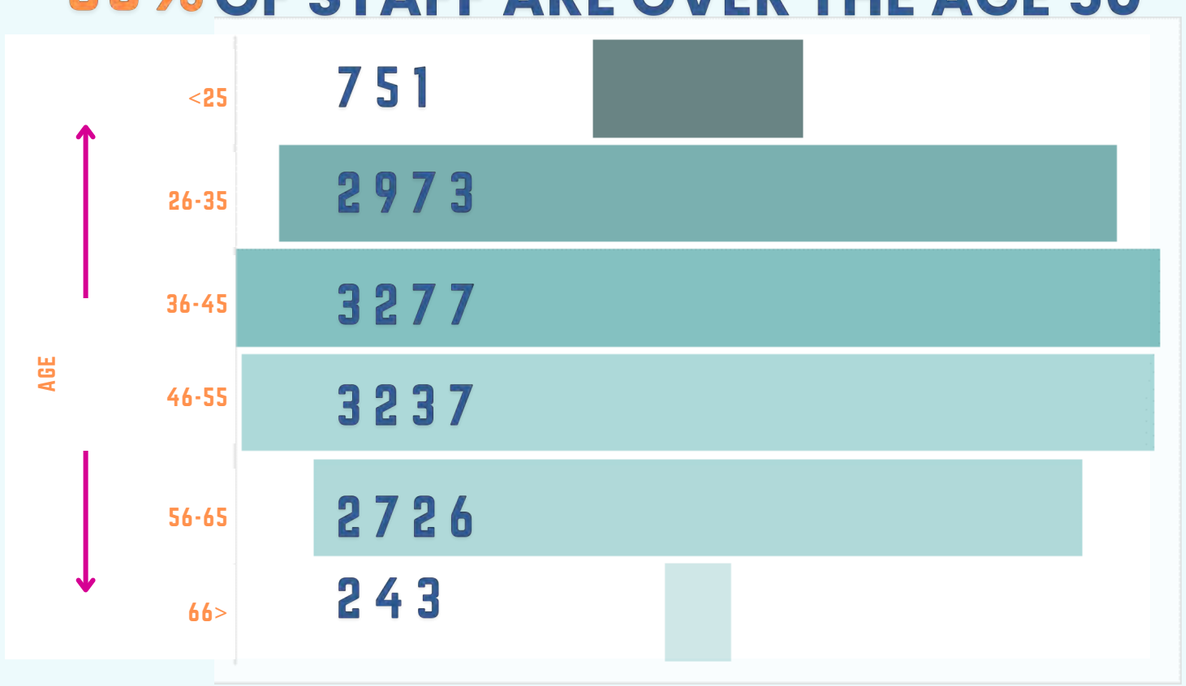


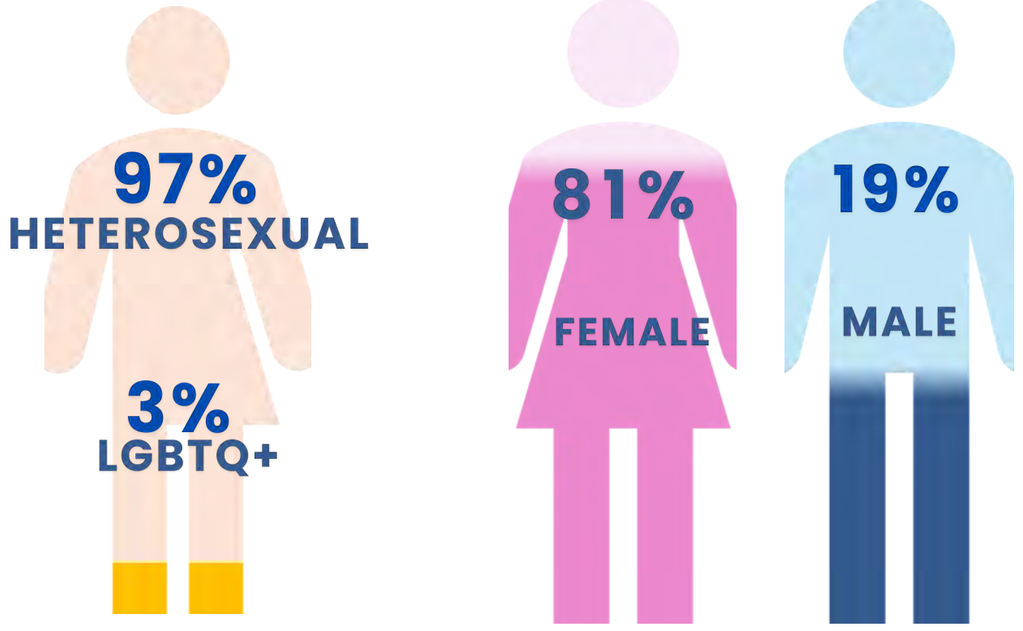
76%
OF STAFF LIVE WITHIN THE CWM TAF MORGANNWG REGION



GENDER PAY GAP
The median hourly pay gap narrowed **from 13.86%** (2020/21) **to 11.48%** (2023/24).

58% OF STAFF ARE OVER THE AGE 50





THIS DATA IS BASED ON OUR CURRENT DECLARATION RATES. WE'D ENCOURAGE ALL STAFF TO COMPLETE THEIR DIVERSITY DATA IN ESR, IN ORDER TO BUILD A MEANINGFUL PICTURE OF CTM.

FOREWORD FROM CHIEF EXECUTIVE AND CHAIR

We are pleased to introduce our People Plan 2025-2030 for Cwm Taf Morgannwg University Health Board (CTMUHB). Our People Plan summarises the priority actions that we need to take to support the achievement of our 10-year strategy, CTM2030 Our Health, Our Future, and to create a CTM where everyone can thrive.

Firstly, this foreword is an opportunity for us to record our sincere thanks to the 13,207 colleagues who make up the CTMUHB workforce and demonstrate exceptional dedication to our patients and our organisation every day. The last year has been marked with significant operational challenges that have demanded unprecedented levels of resilience, flexibility, and collaboration from teams. We are justly proud of the way in which staff have responded, and continue to respond, to the demands upon us. Thank you.

We know that the CTM of 2030 will be fundamentally different from the organisation we work in today. The world of work is changing at a pace never imagined, with growing evidence of links between staff wellbeing, quality of care and retention. This is evolving alongside digital technologies, automation, remote working and new advances based on artificial intelligence. Meanwhile, existing ways of working, models of care and regional boundaries are being transformed, as we adapt to the changing needs and expectations of our population. We know we will need to work in radically different ways if we are to be able to tackle waiting lists and deliver the care that our communities need. This has been reinforced by the recent recommendations from the Ministerial Advisory Group on NHS Wales Performance and Productivity.

Meeting these future challenges relies heavily on you, our colleagues. Therefore, our People Plan needs to be shaped by you, for you. ln February, we received the high-level results of the annual NHS Staff Survey. We were pleased to see that the overall CTM response rate increased this year, representing the voices of 3,560 staff - the highest rate of any similar sized health board in Wales. We will strive to continue to improve our response rate, year on year, to ensure the feedback generated is as representative as possible.

The priority now is responding to the feedback you provided, and our People Plan will help to inform how we make meaningful and lasting action. Local managers and leaders remain accountable for addressing local issues via their staff survey action plans, but we recognise that our collective efforts are required, via the People Plan, in order to address cross-cutting themes and deliver ongoing improvements.

Working in partnership remains a cornerstone of CTMUHB's values and consequently this plan was co-created by those most impacted by our work: our staff, trade union colleagues, leaders and members of the people profession itself. It draws on the diversity of voices from across our workforce and sets out a roadmap for action. The People Plan places a much sharper focus than we've ever had before on our people priorities up to 2030. It will be a living document and we will continue to seek your views on what we can do to make the biggest difference.

Meeting the challenges and opportunities of work and healthcare in 2030 will involve transforming our ways of working, as we accelerate opportunities for regional working across Wales, move care from hospitals to the community, shift from treatment to prevention, and embrace new forms of technology. This will be fundamental to the CTM that we all want to see, and be part of, in 2030.

Thank you for taking the time to both contribute to and read our People Plan, which we hope will resonate with you.

PAUL MEARS,
CHIEF EXECUTIVE

JONATHAN MORGAN,
CHAIR

CROESO I'N CYNLLUM POBL | WELCOME TO OUR PEOPLE PLAN

Our People Plan for 2025-2030 has been created with input from across our workforce and trade union partners. It describes our hopes, ambitions, and the steps we need to take to continue to build a CTM that we are proud of and where everyone can thrive. We want our People Plan to provide a sharper focus, through a more robust list of people priorities, all enabled by practical, deliverable actions.

Throughout March and April 2025, we had the opportunity to speak with over 550 frontline staff and leaders, through a variety of site visits, team meetings and engagement sessions. We asked you to share what matters most to you and what we need to do in the next five years to bring our vision for a great CTM to life. We have also drawn upon the wealth of information from the 2024 Staff Survey, 3,560 staff responses, in addition to internal and external evidence reviews. Relevant strategy, policy and planning frameworks were also taken into consideration, including the Ministerial Advisory Group report on NHS Wales Performance and Productivity. Our sincere thanks go to all who have engaged in the People Plan's development so far.

What we heard from you is that, when we are at our best, CTM feels like family. This sense of community sets us apart from other organisations and is what keeps many of us working here. We are welcoming, friendly, team-oriented and connected to one another. We regularly go above and beyond our duties and we unite to deliver extraordinary things for our patients. We heard a consistent theme about dedication to your immediate team and the unwavering passion for providing the best possible care. You shared incredible examples of the difference we are making for patients and communities, even under immense pressure.

You also described examples of great managers who have made an impact on your experience at CTM. These stories shared some common ingredients; visible, approachable leaders and managers, who provide you with clear direction, understand you as individuals, keep you well informed and instill hope and reassurance even when things are difficult.

> *'I absolutely love being a nurse. I'm proud of the care I and my colleagues give. We are under immense pressure every single day but support each other in and out of work.'*

> *'CTM is like a family. The camaraderie is brilliant. Your team lifts you and you take that home with you.'*

However, we also heard your frustrations about cumbersome processes, policies and systems that hinder rather than help. You want things to be simple and user-friendly, with better equipment, estates and facilities, allowing you more time to focus on what truly matters.

You expressed the need for managers who coach and develop you, who recognise everyone's contributions, connecting you to the wider organisation and who make tough prioritisation decisions about what is feasible. Many staff are tired and in need of rest and respite, yet pressing workloads and competing priorities continue to be an issue. And, while CTM's sense of family is something to be proud of, it can also mean we sometimes shy away from having challenging conversations with one another. We also heard the need to reduce inequities between teams and to continue to strive for fair, consistent, and inclusive treatment across CTM, making sure everyone feels that they belong within CTM and can voice their ideas and concerns.

> *'I want to stop having to fight IT systems and complicated policies and processes. Less time on tick-boxes means more time could be spent with patients and families'*

> *'We need to give staff hope and reassurance. The media often paints the NHS as a 'broken' system and this takes its toll.'*

To address this feedback, our People Plan has been built around four core themes that require focused attention. These four themes are:

1. Getting the Basics Right;
2. Great Management and Leadership;
3. Building an Inclusive and Healthy Culture;
4. Modern Workforce - Skills for the Future.

Each theme will be supported by a People Promise, which sets out our overarching ambition, and a delivery plan, alongside our local Staff Survey action plans, which are tailored to each area of our organisation. There is little within our People Plan that could be described as new or radical, but we are confident, based on the best available evidence, that these actions will make a difference.

Our People Plan is rightly ambitious – but we know it is achievable if we work together.

OUR PEOPLE PROMISES

1. GETTING THE BASICS RIGHT

Everything within our People Plan is underpinned by **getting the basics right**. We know that time is precious. By reducing the amount of effort required to navigate processes and systems, we can help our people to deliver their very best where it matters most.

Our People Promise - what this means for you:

- We will strive to provide you with modern, reliable IT systems and well-maintained facilities, making your working day easier and more efficient.
- We will have simple policies in one place, and provide you with access to meaningful information and effective communications.
- We will simplify bureaucracy, allowing you to dedicate more time to what truly matters.

2. GREAT MANAGEMENT AND LEADERSHIP

The second core theme in our People Plan is to enable and ensure our people experience **great management and leadership.** With the right leadership, we believe that everyone can flourish.

Our People Promise - what this means for you:

- Everyone in CTM has a great line manager, ensuring you feel supported and inspired to perform at your best.
- Our line managers have the tools, time and development to create an empowering environment for their teams, by knowing them as individuals, setting clear expectations and having regular and effective conversations about the things that matter.

3. BUILDING AN INCLUSIVE AND HEALTHY ENVIRONMENT

Our third theme is to build **an inclusive and healthy environment.** The NHS was built on the principles of social justice and equity, yet we know this is not always the lived experience for some groups of staff.

Our People Promise - what this means for you:

- An environment where you can belong, where every voice is heard, every contribution is valued, and where you feel accepted for the difference you make.
- We look after each other, but we also hold each other to account for our actions and behaviours, learning and rebuilding from mistakes.
- Together, we make CTM a workplace to be proud of.

4. MODERN WORKFORCE – SKILLS FOR THE FUTURE

Finally, we know we need to enable a **modern workforce**, with **the right skills and resources** to meet both the challenges of today and of the future. We know that workload remains a pressing concern for many. We also know that delivery of care is changing. Our efforts need to focus on moving care from hospitals to the community, shifting from treatment to prevention, embracing new forms of technology, and working more collaboratively with other Health Boards within our region. This will require all of us to work differently, increasingly in multi-professional teams and with more varied roles.

Our People Promise - what this means for you:

- Our services are appropriately resourced to meet the needs of our population and we offer modern, flexible and fulfilling career paths and adequate rest and recovery measures.
- Everyone is supported to learn, grow, and get ready for what is next - so the whole of CTM is prepared for the future.

DELIVERING OUR PEOPLE PLAN

Getting the basics right

Our ambitions for CTM's People Plan depend on strong foundations. In a better CTM, we will strive to deliver modern, reliable IT systems and equipment that all work well together. We will be able to reduce reliance on paper and will only need to input the information we need to capture once – simply, quickly and easily. We will do things once for CTM, wherever practical, to reduce duplication of effort. Our policies and processes will make things easier, rather than more confusing. And we will strive to have an improved estate and sufficient facilities for staff.

> *'I love my job but I'm so very tired of not being given what I need to do my role safely and effectively.'*

> *'A good day is one in which the basics are right- I can park, the computer switches on first time, and I get a break.'*

To get the basics right, by 2026, we will:

- Create more concise, user-friendly and easily accessible people policies and procedures, simplifying forms and streamlining administrative processes;

- Make it easier for you to contact the right support teams, so that you can get the help that you need quickly and efficiently through accessible, credible and expert people services;

- Review our recruitment and selection approaches to speed up vacancy filling. Embed fair, efficient and inclusive vacancy filling processes, underpinned by improved automation and process simplification, helping to address staff shortages;

- Review and streamline our Core Learning offer, removing requirements that are not adding value to free up your time;

- Explore opportunities with Welsh Government to enable a fair and consistent approach to protected time for learning and professional development;

- Review our internal communications mechanisms and channels to ensure we get the right messages to you at the right time;

- Introduce a coordinated room booking system and process across the whole CTM estate to make organising ourselves easier;

- Reduce the number of meetings and volume of emails, which can often feel overwhelming. We will ensure meeting invites have a clear purpose and agenda, make 25/ 55-minute meetings the default and actively plan breaks into longer meetings encouraging staff to get up and walk about;

- Reduce bureaucracy and simplify our governance frameworks, so that reporting lines and accountabilities for effective and empowered decision making are clear and understandable;

- Review options for car parking facilities/ active travel. We will look at innovative and creative solutions, and encourage staff to consider different commuting options;

- Review our estates footprint, considering the Acute Clinical Services Plan and aspirations within the Fatigue and Facilities (F&F) Charter. We will highlight any facilities and estates requirements through the financial planning process, prioritising capital investment accordingly.

Between 2027 and 2030, we will:

- Take steps towards delivering modern, reliable IT systems that talk to one another, enabling us to input and access meaningful information simply, quickly and easily;

- Influence the design and successful implementation of the new ESR2 (Electronic Staff Record) system, with a focus on the end-user so it is accessible and easy to navigate, improving workforce data and reporting;

- Complete the roll-out, evaluation and continued improvement of all of our people policies and procedures, ensuring all policies are in the new simple, streamlined format.

Great Management and Leadership

We have heard your feedback that having access to great management and leadership is not a ‘nice to have’ - it is essential. Our line managers are vital to how we feel at work and to our ability to provide high-quality clinical services, and we need to set them up for success.

There are already many examples of inspirational and impactful managers and leaders across CTM. Our challenge is to ensure that all our managers are given the skills and time to effectively lead and manage their teams, so that all our people are supported to perform at their best.

> *‘Effective leadership must go beyond visibility- coaching, staff recognition and transparent decision-making are essential for building trust.’*

> *‘We need to set our managers up for success. Great management cannot be the exception to the rule- it is essential.’*

To deliver this ambition, by 2026, we will:

- Develop a new line management induction programme, recognising the critical influence that direct line managers have on employee engagement;

- Develop a bite-size learning and development offer for line managers. This will include modules on our key people policies and processes, plus a focus on core skills such as having difficult conversations;

- Create appropriate support mechanisms for managers and offer a safe space for advice, reflection, and challenge. This will include signposting to existing resources, establishing peer networks of managers and developing proposals for a coaching community;

- Promote our targeted management support offer, which includes bespoke interventions for teams that are struggling;

- Enable clear communications routes from the Executive Leadership Team, to ensure all managers are clear on our long-term vision for CTM and feel equipped to regularly talk about this with their teams.

Between 2027 and 2030, we will

- Radically improve our change leadership capability, ensuring managers and leaders at all levels feel equipped to successfully lead their teams through change;

- Review and benchmark how many direct reports managers have across CTM, to ensure an effective and efficient management structure;

- Create a clear view of what we expect from line managers in CTM, including a review of job design/ job planning and objectives;

- Review our recruitment and selection processes into management roles;

- Complete the roll-out, evaluation and continued improvement of our management learning and development offer, reaching all managers in CTM;

- Continue to embed great Leadership, through the completion and evaluation of our Inspire (Leading Systems) programme, and the development of a revised learning offer for Ignite (Leading Self) and Aspire (Leading Others) programmes.

Building an inclusive and healthy environment

We know that you want to feel safer to speak up, and to feel heard when you share ideas, suggestions, and concerns. You also want to see that timely action is taken to address feedback, without fear of repercussions.

You want to see our Values consistently embedded in everything we do. And you want to see a fairer and more inclusive CTM, where we tackle bullying, harassment, discrimination and bias. Tackling these issues is crucial to fostering a safe and respective workplace, where all staff feel heard and supported, including when something goes wrong, and where everyone's contribution is recognised.

To enable this, by 2026, we will:

- Raise the bar on our behaviours and bring our Values to life, by clearly articulating our expectations under each of our Values and actively holding one another to account for living up to these;

- Develop an environment where we all feel safe and confident to call out inappropriate behaviour. We will implement well-defined, easily accessible reporting routes, including anonymous reporting channels, and ensure that concerns are met with support and action;

- Develop our commitment to an anti-racist CTM, in line with our Workforce Race Equality Standard (WRES) objectives. This will start with awareness training for CTM's Board members and the roll-out of mandatory Anti-Racism e-learning for all staff;

> *'We need to act on and learn from issues when they arise, not wait and hope it goes away.'*

> *'Individual success is nice, but a sense of team success creates a real buzz.'*

- Support our people through sickness, helping them to successfully stay well and return to work. This will be enabled via easily accessible and proactive Occupational Health and Wellbeing services, ensuring expert guidance is readily available;

- Review and evaluate our reward and recognition schemes, ensuring that achievement and contribution are valued at both a team and individual level, long service is recognised, and that we actively provide feedback and celebrate success.

Between 2027 and 2030 we will:

- Actively tackle the diversity gap in entry into disciplinary and casework proceedings, and in appointments and progression, ensuring a fairer CTM;

- Understand and reduce our pay gaps year-on-year, with an initial focus on reducing our gender pay gap in 2026, before moving our attention to piloting ethnicity and disability pay gap reporting from 2027 onwards;

- Continue to develop, enable and effectively communicate evidence-based health and wellbeing lifestyle choices for our people, including the provision of staff vaccinations, healthy food choices, sleep, hydration and activity levels.

Modern workforce - Skills for the Future

Delivering our People Plan relies on having people with the right skills, in the right place, to deliver the current and future health and care needs of our population. Outside of work, people are increasingly used to interacting digitally via high-quality apps and chatbots, and we are not keeping pace with this. We know we need to embrace digital transformation and artificial intelligence (AI), alongside moving care from hospitals to the community, maximising opportunities for regional collaboration, and shifting from treatment to prevention. This will provide us all with the opportunity to work differently.

We have also heard your feedback that workload continues to be an issue and that you need your teams to be resourced appropriately and vacancies to be filled quickly. You want to have time for development, greater transparency about opportunities to grow in CTM, and more flexibility about how to do your work. We heard examples of people joining bank rotas, becoming locums, or leaving CTM all together, and we know that if we do not take radical action to become a modern and flexible employer, we risk continuing to lose good people.

We know we need to build flexibility into our ways of working and create capacity for you to develop, by reviewing the number and experience of staff working in different settings; developing more advanced and extended clinical roles and providing more clarity on career pathways within CTM.

> *'We stay on unpaid to manage our workload- datix, liaising with GP for end-of-life patients, getting antibiotics for someone you visited at 3pm. These things cannot wait.'*

To achieve this, by 2026, we will:

- Enhance and expand our lateral moves scheme, to support flexible working and aid retention;

- Address key skills shortages, reducing our reliance on locums, agency and overtime. We will fill pressing gaps and develop sustainable future pipelines in key areas such as Emergency Medicine, Stroke and Endoscopy;

- Review inconsistencies in our shift pattern arrangements, to ensure our people have fair and sufficient rests and breaks away from work. Our initial focus will be on our nursing, midwifery and HCSWs;

- Through digital enablement, transform the way we deliver patient contact, with less reliance on paper systems;

- Remove silo working within and across our Care Groups and review the effectiveness of our new structure;

- Overhaul the quality and accessibility of our workforce data and embed establishment controls by Care Group, to manage and monitor the staffing structure within each area and ensure our services are appropriately staffed;

- Track workforce productivity and enable efficiencies via our Savings Delivery Programme, including a reduction in the reliance on agency workforce, to enable investments where they will have the biggest impact;

- Evolve our flexible and hybrid working offer, giving staff more choice (wherever possible) over when, where and how they work, to improve work-life balance, productivity, job satisfaction and retention.

Between 2027 and 2030 we will:

- Develop long-term workforce plans so that we fully understand our staffing needs and are properly prepared for future trends and risks. This work will consider the current and future shape and skills of our workforce, and how we maximise opportunities to attract, recruit, retain and develop talent;

- Work together as one CTM, to consider the wider impact of our workforce plans, ensuring alignment across our whole system. Our workforce plans will be co-produced from primary to secondary care, across services, Care Groups and professional groups, and with input from our partners. They will consider our skills and Welsh Language requirements so that we have people with the right skills in the right place to support our population;

> *'Our career paths need to better consider people's experience and skills and help them move around CTM. There is so much we can offer.'*

- Make it easier to understand the full variety of future career options available to you, and the skills and development required to get you there, via publishing clear career pathways;

- Review our entry points into CTM (apprenticeships, internships, work experience), and our partnership engagement, to ensure these opportunities support our long-term workforce planning ambitions;

- Accelerate the design, development, and implementation of regional collaboration opportunities, including Llantrisant Health Park (LHP) in the immediate term (2025/26), introducing multi-disciplinary teams who have the skills to design and deliver cutting-edge diagnostics and treatments, improving patient experience and reducing hospital stays;

- Work with our Board to enable strong regional relationships beyond CTM boundaries. Develop our leaders to spot opportunities for wider collaboration, moving increasingly from a 'One CTM' approach, to a 'One Region / System' approach;

- Enhance the use of artificial intelligence (AI) and robotics to improve efficiency, assist with diagnostics and streamline processes. Prepare our people with the skills they need to work effectively alongside new technologies and complete everyday tasks in a different ways, freeing up your time to focus on other activities.

GOVERNANCE

Our People Plan will be governed through a structured and transparent framework, with regular staff updates on progress. Accountability for delivering outcomes is cross-cutting and must sit at all levels of CTM, however progress will be formally monitored via CTM's Strategic Development Committee.

Each of the four core themes will be supplemented by a detailed delivery plan, with named action owners, timelines, and success measures.

We will ensure there are regular opportunities for staff input and will formally refresh and revise the People Plan on an annual basis, in consultation with our workforce. Ongoing discussion between CTM leadership and trade union partners will take place via regular updates at Local Partnership Forum (LNC) and the Local Negotiating Committee (LNC).

We recognise that our People Plan will need to adapt through its 5-year lifecycle and will learn, innovate and improve based on evolving staff needs and evidence of what works.

SUCCESS MEASURES

To determine the success of our People Plan, and enable us to course-correct and identify new actions, we will track several key workforce metrics and indicators.
Our success measures include quantitative data, such as our vacancy and retention rate, diversity pay gaps, sickness absence rates and casework statistics, in addition to more qualitative data sources, such as our Staff Survey results, regular pulse checks, feedback from staff and Trade Union colleagues, and the stories we tell one another about how it feels to work at CTM.

Our full list of success measures can be accessed here.

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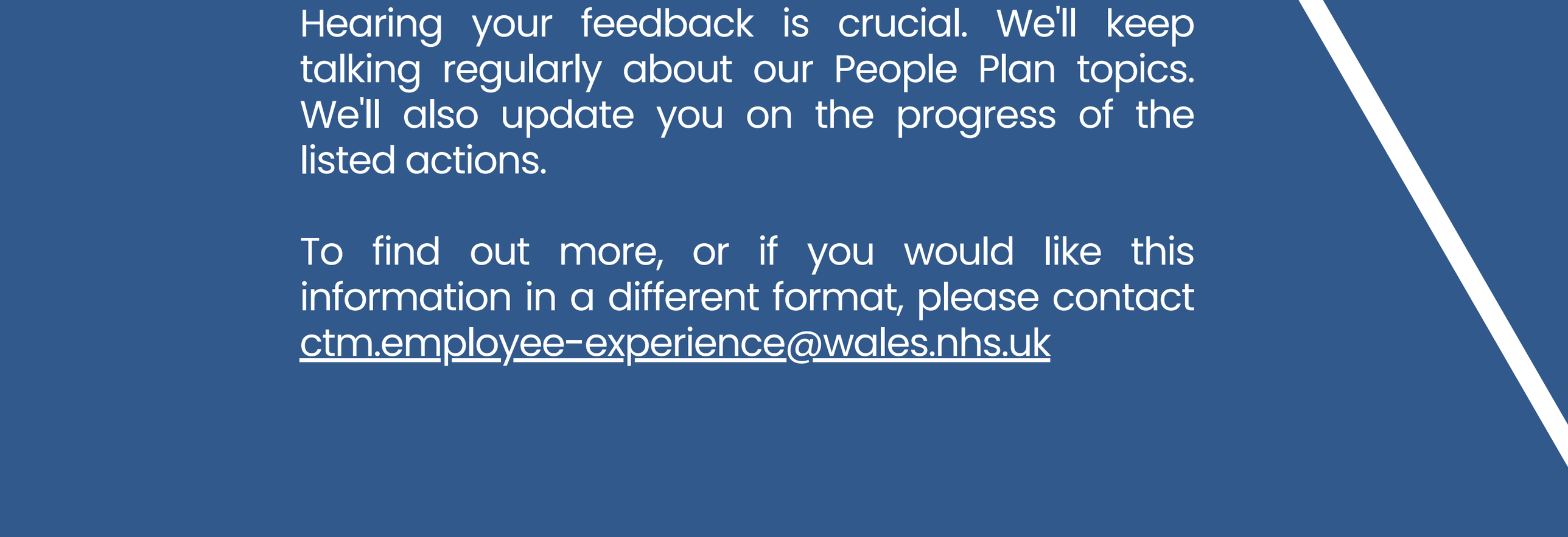
University Health Board

Stay involved in the conversation

Hearing your feedback is crucial. We'll keep talking regularly about our People Plan topics. We'll also update you on the progress of the listed actions.

To find out more, or if you would like this information in a different format, please contact ctm.employee-experience@wales.nhs.uk



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CYNLLUN POBL | PEOPLE PLAN

SUCCESS MEASURES

2025–2030

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EMPLOYEE ENGAGEMENT AND SATISFACTION: -

- Employee surveys: Regular surveys, including the annual NHS Wales Staff Survey, to gauge overall satisfaction, engagement, and morale;

- Pulse checks and staff conversations: Short surveys on specific issues (as needed) and ongoing conversations about the People Plan, to monitor staff sentiment;

- Retention rates: the percentage of staff who stay with CTM over a specific period;

- Turnover rates: the number of staff leaving CTM and why, recognising that a certain level of churn is healthy;

- Casework: the volume, types and duration of employee relations casework including disciplinary, capability, grievances;

- Leadership and management: 360 feedback on manager and leadership effectiveness.

RECRUITMENT: -

- Time to hire: the average time taken to fill open positions;

- Quality of hire: the performance and retention of new hires;

- Diversity: the demographics of applicants, to identify any areas of drop-out/ bias throughout the recruitment process;

- Vacancy rates: the percentage of true vacancy gap against funded establishments.

TRAINING, DEVELOPMENT AND PDRS: -

- Training completion rates: the percentage of employees completing required training programmes;

- Skill development: improvements in employee skills and competencies through assessments and feedback;

- Personal Development Reviews (PDRs): evaluation of employee performance against their set goals and objectives;

- Welsh language: the number and proficiency of Welsh speaking staff.

PRODUCTIVITY AND EFFICIENCY: -

- Productivity: output and efficiency levels across teams and departments;

- Efficiency: rostering, financial efficiencies, including reduced reliance on bank and agency staff;

- Shape of the workforce; breakdown of roles/bands/hierarchies;

- Job planning compliance;

- Medical Appraisals and Revalidation.

HEALTH AND WELLBEING:

- Absence: the frequency and reasons for sick absences, including any hot-spots.

- Wellbeing surveys: assessment of health and wellbeing through a dedicated survey;

- Occupational health and Wellbeing services: quality and speed of access to occupational health and wellbeing services.

DIVERSITY AND INCLUSION: -

- Diversity: the representation and progression of different demographic groups, including tracking any biases within existing policies or processes;

- Pay gaps: the difference in earnings between different groups of people, including understanding and narrowing our gender, race and ethnicity pay gaps.

FEEDBACK AND COMMUNICATION: -

- Feedback mechanisms: review of channels which staff use to provide feedback and suggestions;

- Communication effectiveness: assessment of the clarity and effectiveness of our internal communications, and the extent to which staff engage with our channels.

GOVERNANCE AND COMPLIANCE: -

- Policy evaluation: compliance and usability of our organisational policies and procedures;

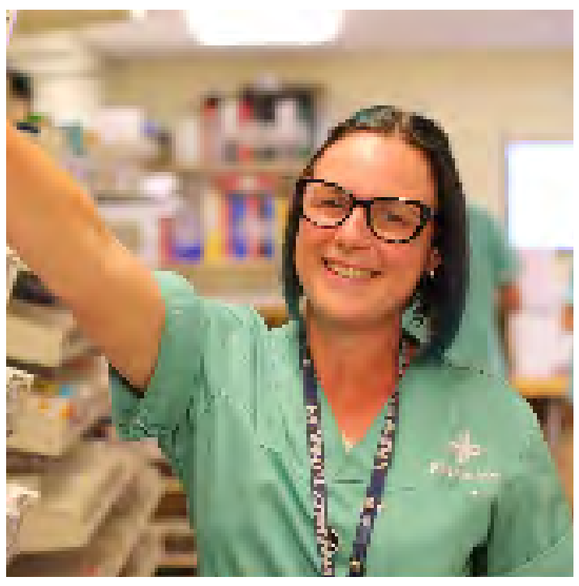
- Audit results: findings from internal and external audits.

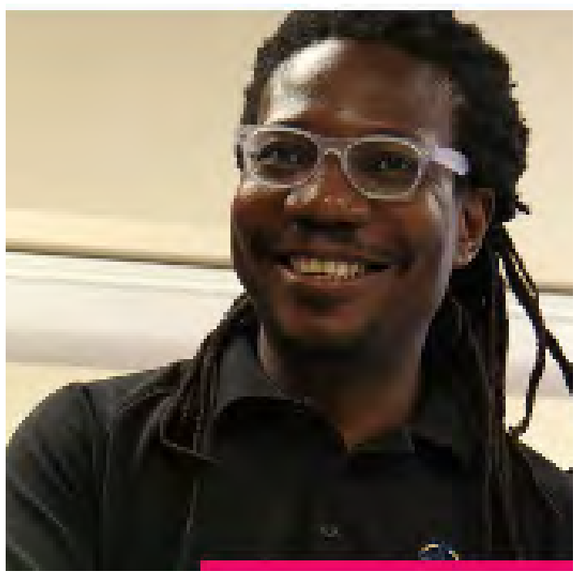
INNOVATION AND IMPROVEMENT: -

- Innovation metrics: the number of new ideas and initiatives generated by staff;

- Process improvements: the impact of implemented changes on efficiency and effectiveness.

Using a balanced mix of these measures will provide a comprehensive view of how well our People Plan is performing and where adjustments may be needed.





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OUR PEOPLE PLAN 2025-2030

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Informed by our Staff Survey 2024 results plus dedicated engagement sessions.

Shaped by you, for you. Reflects the voices of over 4,000 frontline staff, leaders and trade union partners.

Sets out 4 priority areas, with clear actions to continue to build a CTM2030 where everyone can thrive.

Our People Promises

GETTING THE BASICS RIGHT

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- Our services are appropriately resourced to meet the needs of our population and we offer modern, flexible and fulfilling career paths and adequate rest and recovery measures.
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ACCESS THE FULL PEOPLE PLAN HERE

DUMMY QR CODE

Agenda Item
7.1

CTM Health Board

Annual Review of the WBFGA Statement and Objectives

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Kate May Assistant Director of Public Health Vicki Oxley Deputy Director of Strategy and Partnerships
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Philip Daniels, Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group /Forum Individuals	Date	Outcome
Executive Leadership Group Strategic Delivery Group	31.03.25 03.04.25	Endorsed Endorsed

Acronyms / Glossary of Terms

CTMUHB	Cwm Taf Morgannwg University Health Board
FGA	Future Generations Act
NWSSP	NHS Wales Shared Services Partnership
WBFGA	Well-being of Future Generations Act

1. Situation /Background

1.1 The Well-being of Future Generations (Wales) Act is about improving the social, economic, environmental and cultural well-being of Wales.

1.2 The Act gives a legally-binding common purpose – the 7 well-being goals – for national government, local government, local health boards and other specified public bodies. It details the ways in which specified public bodies must work, and work together to improve the well-being of Wales.

1.3 The Well-being goals are depicted in the image below:

1.4 The Act places a duty that the public bodies will be expected to carry out. The well-being duty states: Each public body must carry out sustainable development. The action a public body takes in carrying out sustainable development must include: setting and publishing objectives ("well-being objectives") that are designed to maximise its contribution to achieving each of the well-being goals, and taking all reasonable steps (in exercising its functions) to meet those objectives.

1.5 This means that each public body listed in the Act must work to improve the economic, social, environmental and cultural well-being of Wales. To do this they must set and publish well-being objectives.

2. Specific Matters for Consideration

2.1 CTMUHB's Wellbeing Objectives are fully aligned and integrated with the CTM2030: Our Health, Our Future strategy and our ambition to being a population health organisation.

2.2 Our current Wellbeing Objectives are:

- Work with communities and partners to reduce inequality;
- Promote wellbeing and prevent ill-health;
- Provide high quality, evidence based, and accessible care;
- Ensure sustainability in all that we do, economically, environmentally and socially; and
- Co-create with staff and partners a learning and growing culture.

2.3 During 2024-2025 a review of the CTM wellbeing objectives was led by Philip Daniels, Executive Director of Public Health. Whilst there was good read across to six out of seven of the wellbeing goals in the WBFGA, it was recognised that a reflection of our ongoing activities and commitments to the Welsh Language was needed.

2.4 Therefore, it is recommended that an additional objective is added: Embed the Welsh language in all we do, recognising the importance of Welsh in people's care and our contribution as an anchor organisation to the wider aim in Wales of reaching a million Welsh speakers

2.5 We have evidenced our commitment to delivering the Goals through many different initiatives over the last year, including but not limited to:

- Co-produced with regional stakeholders from across the early years' system and families our Baby and Toddler Voice Statements. Using the voice of the baby the statements provide an early years' focus to the United Nations Children's Rights Charter and aim to motivate infant oriented actions and policies at both community and societal levels.

- Continued to identify partnership opportunities with local groups, organisations and charities for supporting people's health and wellbeing needs. This has included for example, the CTM Neurodevelopment Improvement Programme which is a collaborative, multi-agency mechanism aimed at driving continuous improvement for all services across the region to enable neurodivergent people of all ages to lead fulfilling lives;

- Making significant progress in enhancing its bilingual services; Over 200 staff members were supported in learning Welsh during 2024/25, with increased use of Welsh and positive experiences reported. Initial steps for strategic workforce planning for bilingual skills were taken, including development of guidance on assessing Welsh language skills and a gaps analysis for clinical provision. We have seen improved compliance with Welsh Language Standards and focussed internal communications have improved engagement with the Welsh Language agenda across the health board. A national awareness campaign highlighted Welsh language successes and patient rights, with Facebook content reaching over 10,000

views. A comprehensive linguistic profile of all staff was produced and a 5-year Strategic Plan was created to support the ongoing progress towards offering clinical consultations in Welsh and addresses any gaps. Our presence at the Eisteddfod was also a huge success.

- Working closely with NWSSP to understand how we can spend our budgets within Wales and the value that can be gained from doing so. Supporting Welsh companies also provides more local jobs and training within the local supply chain. Local supply chains are better for the environment and more resilient to global changes. Increasing local employment also has the benefit of increasing spend within the local area and hopefully the cycle continues.

- A real focus on delivering the decarbonisation action plan and working towards Net Zero; adaptation planning; innovation opportunities; and staff and public engagement to support delivery. Over the last year this has included developments such as our clinical waste recycling project, working in conjunction with Natural UK, a Welsh Company, putting CTMUHB on the map worldwide in regards to how we approach the reuse of some clinical waste.

3. Key Risks / Matters for Escalation

3.1 In 2024/25, a submission was not made to the FGA Commissioner as CTMUHB had taken part in the pilot work to produce the documentation used for submissions. CTMUHB will complete a submission using the current process in 2025/26.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People Improving Care Sustaining Our Future
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	A Prosperous Wales
	If more than one applies please list below: A resilient Wales A healthier Wales A more equal Wales

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Wales of cohesive communities A Wales of vibrant culture and thriving Welsh language A globally responsible Wales
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: Whole systems perspective
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)	Yes - Reuse
	If more than one applies please list below: Refine Reduce Recycle Repurpose

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: Would be undertaken as part of each project to support delivery
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: Would be undertaken as part of each project to support delivery
Cyfreithiol / Legal	Yes (Include further detail below)	
	The Act is legally binding	
Enw da / Reputational	Yes (Include further detail below)	
	There would be a negative reputational impact on the health board if we did not deliver the Act	
Effaith Adnoddau	Yes (Include further detail below)	

(Pobl /Ariannol) / Resource Impact *(People / Financial)*	There may be resource impact relating to the different projects CTMUHB delivers as part of our responsibilities

5. Recommendation

5.1 The Board is asked to note the update included in this paper
5.2 The Board is asked to approve the additional Well-being objective linked to our ongoing commitment to embedding the Welsh Language.

6. Next Steps

6.1 To continue to consider and enact the Well-being of Future Generations (Wales) Act within CTMUHB activity and decision making.
6.2 To complete a submission to the FGA Commissioner in 2025/26.

Agenda Item
7.2

CTM Health Board

SOUTH EAST WALES REGIONAL JOINT COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Watts, Director of Corporate Governance/Board Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair of the Board
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
Board – the Board was briefed and the letter from the Cabinet Secretary was circulated to Board members via email	3 April 2025	The letter was noted

Acronyms / Glossary of Terms	
UHB	University Health Board

1. Situation /Background

1.1 On 2 April 2025, the Cabinet Secretary wrote to the Chairs of Aneurin Bevan UHB, Cardiff and Vale UHB and Cwm Taf Morgannwg UHB directing the three of us to establish a Joint Regional Committee to exercise the facilitation and oversight of regional planning to drive effective collaboration and regional working. This direction was given pursuant to the Welsh Ministers' power in section 12(3) of the National Health Service (Wales) Act 2006.

2. Specific Matters for Consideration

2.1 The letter states that the three Boards are collectively responsible for determining the Joint Committee's priorities. This should be informed by a collective review of existing collaboration arrangements and the improvements required of escalation status under the Escalation and Intervention Framework. This exercise should identify areas that need attention and can be strengthened, while avoiding unnecessary duplication. The Cabinet Secretary expects the establishment of the Joint Committee to bring greater focus on:

- regional planning and delivery of service models;
- improved outcomes and a reduction in inequalities in access;
- potential for service transformation, including new regional workforce models;
- establishing new relationships and/or resetting existing ones;
- exploring regional solutions to advance sustainable service provision and improve quality and outcomes, while addressing workforce, infrastructure, and financial constraints under the National Clinical Framework and the Value and Sustainability Board; and
- providing coordinated support to the health boards, with a particular focus on priority areas through the NHS Executive.

2.2 To enhance collaboration in integrated care, the Cabinet Secretary has also directed us to invite representatives from Powys Teaching Health Board and Velindre NHS Trust to be Associate Members of the Joint Committee.

2.3 The Cabinet Secretary would like the Joint Committee to be formally established in Quarter 3 of 2025/26.

3. Key Risks / Matters for Escalation

3.1 The lead in time allows for the appropriate preparations to be made for the supporting governance arrangements, including a clear scheme of delegation.

3.2 The three Directors of Corporate Governance are working through a draft term of reference that sets the ways in which the new Joint Committee will work which will require approval by all three Boards.

3.3 The terms of reference may require additional schedules or appendices but fundamentally it should be capable of articulating the full governance construct (its administration, who will attend, how it will work and, crucially, its decision-making powers and the relationship with normal HB sovereignty and wider accountability), the scope of the Committee (what is in and what is not), its purpose, priorities and objectives and any other matters that arise during the work to produce it.

3.4 The Cabinet Secretary's letter is quite specific that the Joint Committee be formally established in Quarter 3. Subsequent discussion with WG has confirmed that the Cabinet Secretary is keen that this is adhered to so that the final ratification and assumption of duties is undertaken by the new Chairs of Aneurin Bevan and Cardiff and Vales so there is ownership from the outset. The intended timetable is:

- September 2025 – Terms of Reference presented to the respective Boards for approval.
- October 2025 25 – first meeting of the South East Wales Regional Joint Committee.

3.5 If, for some reason, there is any slip in timings it still allows us to take to Boards for approval in November and first meeting in December and hit the time stipulation of the Cabinet Secretary.

3.6 Given there is already a South East Wales Regional Delivery Group and Regional Oversight Board in place it is suggested that the work on the Joint Committee be made a standing item at both so that the Directors of Corporate Governance can attend and update as required but also seek information and guidance.

3.7 As and when substantive updates are available the Director of Corporate Governance will update 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: 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
	A Healthier Wales

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)*	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 *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 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)	
	Ensuring that the Regional Joint Committee is appropriately set up in accordance with the Welsh Ministers' powers	
Enw da / Reputational	Yes (Include further detail below)	

	Ensuring that we set the Regional Joint Committee up successfully to manage the expectations of the Cabinet Secretary
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 note the direction given by the Cabinet Secretary and the resultant actions.

6. Next Steps

6.1 The Board will be updated on progress with a view to agreeing the Terms of Reference of the new Joint Committee at the September Public Board meeting.

Agenda Item: 8.3	29th May 2025	CTMUHB Public Board Meeting	Civil Contingencies & Business Continuity Report

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Melanie Jones, Civil Contingencies Manager
Presented By:	Vicki Oxley, Acting Executive Director of Strategy & Transformation
Approving Executive Sponsor:	Vicki Oxley, Acting Executive Director of Strategy & Transformation
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	N/A

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	N/A
Related Health and Care Standard	Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No this is an update on work planning. The work within the plan will take into consideration the equality and welsh language.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Improving Care

Civil Contingencies & Business Continuity Report - Summary.

As a Category 1 Responder, the Health Board must fulfil its statutory duties in relation to Emergency Preparedness, Response and Recovery (EPRR) under the Civil Contingencies Act (CCA) 2004 and in line with Emergency Guidance issued by Welsh Government (WG). There is a robust governance structure for oversight of the EPRR functions with an executive lead for EPRR and formal reporting structures to sub-committee and the board.

The Health Board's Strategic Emergency Preparedness, Response and Recovery Group continues to oversee planning and preparedness within the HB and work is ongoing to further develop and embed operational EPRR functions across revised care group structures. This is to ensure that pre-planning for foreseeable and unforeseen events is embedded within processes and procedures.

During 2024-2025 key achievements for the health board were:

The review and updating of the health board's Major Incident Plan and the development of site-specific plans for the three acute hospital sites.

Agreement of a memorandum of understanding with the Office of the Coroner for action in the event of a mass fatalities exercise.

Signing the Charter for Families Bereaved by Public Tragedy.

Amongst the key actions for 2025-2026 are:

Grow the EPPR capacity inline with other health boards, providing resilience within the heath board.

Pandemic framework review

Incident management training needs analysis and delivery plan

Work with Facilities/Estates colleagues to deliver the Protect Duty and Security Assessments in line with Martyn's Law.

Civil Contingencies & Business Continuity Report – 2024/25 achievements.

The review and updating of the health board's Major Incident Plan and the development of site-specific plans for the three acute hospital sites. This was a significant update of the old major incident plan working with all departments across the CTMUHB footprint to ensure everyone is prepared for any event. The document is in the process of final sign off prior to being uploaded and shared on the intranet.

Agreement of a memorandum of understanding with the Office of the Coroner for action in the event of a mass fatalities exercise. Following a review of the South Wales Local Resilience Forum (SWLRF) Mass Fatalities Framework it was noted that in the event of a Major Incident occurring in South Wales, a significant loss of life could have a considerable impact on business-as-usual for mortuary facilities. To this extent a MOU has been agreed between the Office of the Corner and CTMUHB to offer mutual aid. This designates the PCH mortuary and UHW mortuary as initial sites for receiving remains in the South Wales area. Having the MOU and the designated sites enables a rapid stand up of the facilities and retrieval of the remains from the site. This is coordinated and stood up by a Coroner's Officer representing the Senior Coroner and will be part of the SWLRF Mass Fatalities Framework which provides guidance on the initial strategic actions to be taken during a mass fatalities incident, and describes the tactical actions to be taken.

Signing the Charter for Families Bereaved by Public Tragedy (18/03/25) The Charter for Families Bereaved by Public Tragedy calls for a cultural shift in public bodies' engagement with bereaved families, ensuring the lessons of the 1989 Hillsborough disaster and its aftermath are learned to prevent those who are affected by public tragedy in the future from having the same experience. It has been further highlighted following the Manchester Arena Bombing and the experiences of those families. By signing this pledge the health board, along with many other public bodies, pledges to 6 commitments:

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.
2. Place the public interest above our own reputation.
3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.
4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.
5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.
6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Civil Contingencies & Business Continuity Report – 2025/26 key actions.

Amongst the key actions for 2025-2026 are:

Grow the Emergency Preparedness, Planning, Response and Recovery(EPPRR) capacity. Funding has been secured for a band 7 and a band 6 role to join the Planning and Transformation team to work with the Civil Contingencies Manager. This will enable faster progress of updating and testing the contingency plans in the health board. It will bring CTMUHB capacity in line with other health boards providing resilience within the EPPRR team and provide wider support for control and command in the event of any major incident.

Pandemic framework review. This autumn will see one of the largest 4 nations pandemic exercise – Pegasus. The EPRR and Health Protection team will be working on local plans to ensure we are ready for this test, but also use this test to ensure our plans are fit for purpose. Lessons have been learnt from COIVD-19 and it is import that the good practice and changes needed are taken forward into our current pandemic plans.

Incident management training needs analysis and delivery plan. This work will ensure that our new Major Incident plan is shared and tested and updated as required. It will also look at our business continuity plans linking plans together and making sure all relevant staff have access and are aware of the policies and procedures.

Work with Facilities/Estates colleagues to deliver the Protect Duty and security assessments in line with the Terrorism (Protection of Premises) Act, known as Martyn's Law . Under the Act premises that fall within scope are required to consider and, where appropriate, take steps to reduce their vulnerability to acts of terrorism and have public protection procedures in place. Public protection procedures are those which should be followed by people working at the premises if an act of terrorism were to occur at the premises, or in the immediate vicinity. The procedures are expected to reduce the risk of physical harm being caused to individuals and relate to evacuation, invacuation (moving people to a safe place), locking down the premises, and communicating with individuals on the premises. Enhanced duty premises are premises where it is reasonable to expect that 800 or more individuals (including staff numbers) may be present.

Specific Matters for Consideration:

The continued support of all areas in the health board to develop and prepare for a variety of emergency scenarios.

Key Risks / Matters for Escalation:

The small workforce and loss of organisation knowledge from the health board following the EPRR manager leaving. This may mean executives are asked to provide additional support within the health board whilst the new Civil Contingencies Manager gains that knowledge of people and places.

Recommendation

The Board are asked to:

- *Note the changes in the work force and the diversity and changing environment this area of work can encounter.*

Next Steps

The Board will be updated as this plan of work progresses.

Agenda Item	9.1.1

Unapproved Minutes of the Public Board Meeting

Date and Time of Meeting	Thursday 27 March 2025 9:30am
Venue	The Hub, Royal Glamorgan Hospital, Llantrisant

Members Present	Jonathan Morgan	Health Board Chair
	Paul Mears	Chief Executive Officer
	Greg Dix	Executive Director of Nursing/Deputy CEO
	Carolyn Donoghue	Independent Member
	Patsy Roseblade	Independent Member
	Sally May	Executive Director of Finance
	Anne Morris	Associate Member
	Gethin Hughes	Chief Operating Officer (In part)
	Dom Hurford	Executive Medical Director
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Sciences
	Linda Prosser	Executive Director of Strategy & Transformation
	Hywel Daniel	Executive Director for People
	Hayley Proctor	Independent Member
	Dilys Jouvenat	Independent Member
	Geraint Hopkins	Independent Member (In part – left at 12:40pm)
	Helen Lentle	Independent Member
	Rachel Rowlands	Independent Member
	Philip Daniels	Executive Director of Public Health
	Ian Wells	Independent Member (Virtually)
	Lisa Curtis Jones	Associate Member (Virtually – In part))
In Attendance	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business
	Stuart Morris	Director of Digital
	Simon Blackburn	Director of Communications, Engagement and Fundraising

	Matt Jenkins	Regional Integration Director
	Claire Taylor	Acting Regional Director, Llais Cymru
	Hannah Williams	Assistant Director of Leadership & Culture
	Melanie Barker	Deputy Director of Allied Health Professions and Health Science
	Sharon O Brien	Care Group Nurse Director – Planned Care (In part)
	Eloise Davies	Senior Nurse for Surgery (In part)
	Nikki Price	Ward Manager, Ward 6 (In part)
	Neil Mesher	Incoming Independent Member (In part)
	Ian Green	Chair, NHS Wales Joint Commissioning Committee (Virtually - In part)
	Georgina Galletly	Transformation Director, NHS Wales Joint Commissioning Committee (Virtually - In part)
	Stacey Taylor	Director of Finance & Information, NHS Wales Joint Commissioning Committee (Virtually - In part)

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. The Chair extended his thanks to the Members of the Board who were attending their last meeting, namely Ian Wells, Independent Member for Digital, whose term ends on 7 May 2025, Anne Morris, Associate Member whose term ends on 30 April 2025 and Linda Prosser, Executive Director of Strategy and Transformation who would be retiring from the Health Board on 11 April 2025. The Chair extended his thanks to all three members for the support they had provided to the Board during their time in post.
1.2	Apologies for Absence
	Apologies for absence were received from: • Kath Palmer, Vice Chair • Gareth Watts, Director of Corporate Governance/Board Secretary • Sally Bolt, Associate Member

1.3	Declarations of Interest
	There were no interests declared.
2.	CONSENT AGENDA BUSINESS
2.1	The Chair 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.	SHARED LISTENING AND LEARNING
3.1	Listening & Learning Story – PLANNED CARE
	S. O'Brien, E. Davies and N Price shared the patient story that related to a patient and their relatives experience of care received within planned care. The Chair advised that previously, the Cabinet Secretary for Health & Social Care asked all Health Board Chairs to present their plans to address urgent and emergency care. The Chair advised that this presentation included an update on the work being undertaken at Prince Charles Hospital and the commitment that had been made to roll out the work into Royal Glamorgan Hospital. The Chair commented on how he was pleased to see the real impact this work had on patient and staff experience, particularly in respect of length of stay, and the speed of which length of stay had been reduced from 24 hours to 6 hours, which was a remarkable shift. The Chair added that he welcomed the patient story that was shared and asked for thanks to be extended on behalf of the Board to the patient's relative for allowing for their story to be shared. D Hurford reflected on how this initiative embraced the aim of ensuring services are patient centred and how they could be flexed from the more traditional models to ensure that the patients were discharged home as soon as possible to spend time with their families not only benefited the patients but also the quality and efficiency of the service provided. He commended the initiative as an excellent way forward and urged other colleagues to try this pilot or other ideas they may have to improve patient care in their areas. G Hughes welcomed such a fantastic patient experience story and reflected that he was present on Ward 6 at the time when the team were arranging this for the patient, and added that it was touching to hear the impact this had for the patient and his family. G Hughes advised that the fact that the wife of the patient was now applying to work on the ward was testament to the compassion and patient focus being epitomised on Ward 6. G Hughes sought assurance that this story is shared and that it would be helpful if the team shared their reflections on what made it possible as all teams will wish to strive to improve the patient experience in similar ways in their areas. The Team advised that it helped initially to identify the need for the service, as well as having positive senior support in place who trusted the team to bring their ideas into fruition. The Team advised that there were initial concerns amongst team members regarding change, however, this was no

	longer the case, with staff now welcoming the changes implemented. The Team also advised that they regularly obtained team members input and feedback on the changes that were proposed. Members noted that over the last 18 months, there had been no concerns raised by patients or their relatives regarding the new model, with mainly positive feedback being received. R Rowlands echoed the comments made on this being a positive initiative and agreed with the comments made by G Hughes in regard to sharing lessons learned. R Rowlands drew attention to the reference made to the draining procedure that the patient could not receive with within the community and therefore the patient required admission to hospital for this to be undertaken, and sought to understand whether this would feature in the plans to deliver care closer to home in order to avoid hospital admission. G Dix advised that this was mainly as a result of the length of time it takes for the draining procedure and the District Nursing resource that would need to be allocated to ensure the patient was being closely monitored. C Donoghue also extended her thanks to the Team for sharing the fantastic story and added that sharing the positive change culture to other parts of the organisation was important. G Dix commented that he was incredibly proud of the team, particularly in relation to the environment they had created in encouraging staff to try new ways of working that may benefit patient care, and added that this story demonstrated the excellent leadership of the Ward Manager, N Price. I Wells advised that he was privileged a few weeks ago to visit ward 6 and added that it was clear to see what a fantastic team was in place, with the ward working efficiently whilst also being incredibly busy. S Blackburn welcomed a further discussion with the team outside the meeting as to how the story could be shared further across the health board The Chair advised that all too often in the healthcare environment, the word transformation is often applied to very large-scale projects and added that smaller scale projects were often within a more contained environment where the impact was clearly so positive and wonderful to see. The Chair advised that over the coming year, whilst the Health Board would be implementing large transformation projects, there were smaller scale services that could be delivered differently, with consideration needing to be given as to why a particular service was being delivered in the way that it was and whether this could be delivered differently which would make a difference to patients, their families and staff. The Chair advised that further thought would need to be given to this moving forward with consideration to be given as to how this story could be shared with other teams who had creative and innovative ideas on doing things differently within their areas of work.
Resolution:	The Listening & Learning Story was NOTED

Actions:	Thanks to be extended from the Board to the relative of the patient for allowing for their story to be shared. Discussion to be held with the team outside this meeting to determine how the story could be shared more widely.
3.2	Staff Survey Results 2024 and People Plan
	H. Daniel presented the report and highlighted key items for the attention of Board Members. C Donoghue made reference to the statement made by H Daniel regarding the systemic issues that may lead to burnout and queried whether some examples could be provided. H Daniel advised that there were a number of factors that could contribute to burnout, both in and out of work, including the extent in which people were expected to go beyond their contracted hours, the nature of the work, the inability to pause and reflect and low staffing levels. Members noted that a holistic approach was being taken to address some of these issues, with focus being placed on lifestyle issues in addition to workforce issues. Members also noted that burnout was a feature within the UK wide healthcare system. C Donoghue stressed that it was evident how much depends on the leadership and the culture of learning and support at all levels and added that a significant amount was expected from staff in senior roles, who also needed development and support to enable them to continue to carry out their roles effectively. H Daniel advised that this matter was regularly being discussed by Executive colleagues, particularly regarding what development programmes were available to staff. Members noted that wellbeing sessions were also being held for Managers. P Mears advised that he welcomed the increase in staff survey response rate and noted the ambition to achieve an improved response rate next year. P Mears confirmed that the Executive Team regularly discussed the need to support managers and leaders, particularly within areas where management could be strengthened. P Mears advised that consideration needed to be given as to how the organisation could support its staff with a range of support packages, in addition to the organisations expectations of staff making a commitment to key matters, for example, adhering to the organisations policies and procedures. H Daniel advised that this could be a key feature within the People Plan that was in the process of being developed. P Roseblade made reference to the key words that had been picked out from the survey results and added that she could not determine if they were positive or negative, with some of the words highlighted having both positive or negative connotations. P Roseblade also made reference to the themes and the negative experiences, given that 86% of the staff who had completed the survey indicated that they have encountered negative experiences. P

	Roseblade queried whether a more detailed analysis could be undertaken to try and better understand the position across the whole organisation given that only a quarter of staff had completed the survey. H Daniel advised that more detail on the key words highlighted would be included in the thematic analysis that was currently being undertaken which he would be happy to share with Members once completed. In relation to behaviour, H Daniel agreed that whilst it would be helpful if more pulse surveys could be undertaken, there was data available at Care Group level which was helping to identify some of the hot spot areas and people's experiences within their teams, and added that steps would be taken to address some of the issues highlighted. Members noted that the People Services Team were proactively offering their support to Teams who appeared to be experiencing challenges. R Rowlands referred to bullying, harassment and discrimination, and the update provided by H Williams on what makes an effective team, and queried how many reported incidents related to bullying, harassment and discrimination and how many of these were upheld, given that one of the messages staff needed to be made aware of was that each reported incident was investigated and acted upon where necessary. H Daniel advised that this data was not measured routinely and advised that bullying, harassment and discrimination were three very different matters. H Daniel advised that awareness was in place that there was under reporting of incidents in all three areas, particularly regarding discrimination and bullying. H Daniel made reference to sexual safety and added that most recently there had been a number of sexual safety cases reported with the health board, and added that robust action had been taken on each case, which included a review of historic cases where it was felt that inappropriate sanctions had been taken. Members noted that this had resulted in an increase in staff reporting incidents of this nature. R Rowlands made reference to burnout and queried whether the detailed analysis would highlight where burnout was particularly prevalent. H Daniel advised that whilst the data had improved, further improvement was required on granularity, which was in the process of being addressed by Health Education Improvement Wales. P Daniels agreed with the statement made by P Mears earlier in the meeting regarding the expectations of staff, particularly in relation to provision of vaccinations to staff. H Proctor commented that whilst the corporate message regarding speaking up and reporting was good, she felt unsure whether this message was being translated at a local level. Members noted a discussion was held at the most recent meeting of the Local Partnerships Forum where it was highlighted that staff felt that they had to 'put up' with difficult staff and patient interactions. P Mears advised that strong emphasis needed to be placed on addressing this at a local level.

	D Jouvenat referred to the target audience in relation to the People Plan and advised that it appeared as if people were last but one in regard to the audience, when people should be first. D Jouvenat also commented on the engagement and noted that digital had been identified as a risk and sought clarity as to how engagement would be undertaken with staff who were digitally excluded within the organisation. Members noted that the People Plan would be received at the April meeting of the Strategic Development Committee where the plan would be discussed in more detail. H Daniel confirmed that the main audience for this plan were our people and added that the People Services team were engaging with staff both digitally and in person. Members noted that engagement sessions had been held in person to date, which had generated rich information and noted engagement would continue to be undertaken with the Board regarding the development of the plan. S Morris added that in relation to the digital inclusion/exclusion challenge, several digital programmes included engagement with staff in relation to the opportunities digital programmes would generate in terms of understanding the gaps in knowledge and experience. The Chair extended his thanks to H Daniel for presenting the report and advised that he looked forward to receiving further updates in due course.
Resolution:	The Board - NOTED the 2024 Staff Survey results - ENDORSED the intended approach for prompt and transparent sharing of the data, supported by local action planning, plus a refresh of our CTM People Plan
Action:	Thematic results of the staff survey to be share with Board Members once available.
3.3	Annual Equality Report 2023-2024
	H. Daniel presented the report and highlighted key matters for Members attention. D Jouvenat commented that she was pleased to see this report included on the agenda for discussion given the importance of the subject and extended her congratulations to the Team on the work that had been undertaken in this area over the past year. She also welcomed the inclusion of the Welsh language elements within the report. P Mears agreed that it was highly important that this item had been placed on the main agenda and advised that the organisation had encountered a significant amount of scrutiny of this agenda over the past few months, from external organisations and through media enquiries. Members noted that the Executive Team had held a discussion on the need to be mindful that over the next 12 months, leading up to the Welsh elections, there could be a significant

	amount of negative messaging on several topics, including equality. A discussion had also been held on how to ensure all staff continue to feel valued and respected, in light of the potential negative messaging they may face. P Mears recognised that a significant amount of work had been undertaken in this area, both with staff and with communities. The Chair advised that he had recently attended a staff 'Question & Answer' session, where he made it clear that, developing and supporting the equality agenda was not just about complying with the law, which was fundamentally important, but also about developing the health board as an organisation that respects, celebrates and sees the value in having a diverse workforce. The Chair recognised that there would be challenges in the political environment over the next 12 months and added it would be important for the Board to be advised of the importance that was being placed on this agenda, particularly in regard to how it expected people to behave and be treated, ensuring that dignity, respect and professionalism and hard work is afforded by all.
Resolution:	The Board APPROVED the Annual Equality Report for 2023/2024.
4.	SETTING THE SCENE
4.1	Chairs Report and Affixing of the Common Seal
	The Chair presented the report and highlighted the key matters for Members attention.
Resolution:	The Board • NOTED the report • RATIFIED the Affixing of the Common Seal • RATIFIED the Chairs Urgent Action taken to APPROVE the Charter for Families Bereaved by Public Tragedy
4.1.1.	Report from the Stakeholder Reference Group – Approval of Stakeholder Reference Group Nomination
	L. Prosser presented the report which was seeking approval of the nomination received for the Chair of the Stakeholder Reference Group. The Chair advised that once approved he would arrange to meet with new Chair of the Stakeholder Reference Group to discuss the role further.
Resolution:	The Board APPROVED the nomination received for the Chair of the Stakeholder Reference Group.
4.2	Chief Executives Report
	P Mears presented the report and highlighted the key matters for Members attention.
Resolution:	The Board NOTED the report
4.3	Princess of Wales Hospital Roof Incident – Internal Review
	The Chair advised that Board members recall that at the November Board an update was provided that the Chair and Chief Executive had commissioned and

internal review of the issues that had been experienced in regards to the Princess of Wales Hospital (PoWH) roof.

P. Mears presented the report and highlighted key matters for Members attention. P Mears extended his thanks to G Watts for producing the report and advised Members that a critical friend review was also being undertaken by Welsh Government. Members noted that the following conclusions had been drawn from the report:

- The underlying issues with respect to the roof were not identified or communicated to CTMUHB at the time of transfer as no high-level risks with respect to the roof were flagged.
- The health board estates team prioritised the high areas of risk which had been flagged for PoWH. This included fire and electrical safety.
- The underlying issues around lack of ventilation in the roof, which resulted in rotten battens could not have been identified at an earlier date without a full intrusive survey, which due to their disruptive nature are not normally viewed as suitable for hospital sites.

The report also identified the following lessons learnt:

- Retaining and safe storage of records and prime documentation – The review highlights that important documentation relating to PoWH is no longer available. Further work may also be required to determine what other records are no longer available and a clear strategy on digitalising records, where possible, is taken forward.

- Corporate memory of estates issues - There is less corporate memory with relation to the estates in the Bridgend part of the Health Board's footprint – and consideration needs to be given whether further work is required to identify issues with assets from the Bridgend area given the Health Board lacks the same amount of corporate memory that it has for its other sites from the legacy Cwm Taf area.

- Adviser management - It transpires that information in a survey produced for a former Health Board and passed on to CTMUHB included inaccurate information. It remains important that appropriate quality assurance and review is performed for any estates-based work which is undertaken by a contracted third party to ensure the accuracy of information.

- Corporate Governance and Oversight - The Board has made a commitment to have further discussions on estates issues soon including a stocktake of its current estate to establish whether there are other underlying issues. These discussions as well as a consideration of estate risks management and visibility, will be held over the coming months, including at the May 2025 Board Development session, demonstrating

	the increasing importance the Board attaches to the effective management of its estate. S May provided an update on the Critical Friend review, which focussed on the lessons learned in respect of the transfer of estate between NHS organisations, undertaken by Welsh Government and members noted the draft summary of findings POWH was transferred from Abertawe Bro Morgannwg University Health Board (ABMU) to Cwm Taf Morgannwg University Health Board (CTM) in April 2019, with very limited documentation, other than a recent 4 facet survey. The Phase1 Roofs backlog maintenance was assessed as substantial, with risk assessed by ABMU as significant, but not high. 1. The acquisition and disposal process in Estate code should be followed, including the acquirer commissioning condition surveys where relevant. 2. Full estate information (e.g. land titles, architectural drawings, building information, guarantees etc) should be available and transferred. 3. Lifecycle maintenance plans should be available and transferred. These should be prepared in line with the Risk Based Methodology for establishing and Managing Backlog and aligned with surveys provided as part of the transfer. 4. Future planning for hospital and NHS buildings towards the end of life with substantial backlog should use the risk based approach to managing backlog. 5. Sufficient Health Board time should be devoted to the stewardship of assets, particularly those approaching end of life. The second aspect of the Critical Friend Review was to look at the subsequent CTM surveys and actions leading up to the surprise of an emergency roof replacement project and identify learning and recommendations from this. These include: 1. The root cause of failure of the Phase 1 roof was likely to be the non-existence of ventilation within the roof construction over a forty year period, leading to the wholesale decaying of the roof battens and the weakened structure supporting the concrete roof tiles. Given the height of the roofs and safe inspection access limitations, this is only likely to be identified by a specific invasive survey. Such a survey was commissioned, following multiple water ingresses after a storm, and reported on 9th October 2024. This was the first time the specific problem with the Phase 1 Roofs was identified. Combined with the large scale of the roofs (some 600,000 tiles equivalent to 166 terraced houses) this came as a surprise to all. 2. The previous visual survey of all POWH buildings, which reported in April 2024, was commissioned followed leaks in winter 2023/24. It suggested some immediate and a full 5-10 year programme of replacement of all tiles on the Phase 1 roof. The scope of this survey excluded intrusive

surveys and the report makes no reference of the need for any. At this point the Phase 1 roof risk was re-assessed to red and escalated.

3. Given the nature and scale of the roof failure, consideration about what further action is needed to inform other organisations about the risk of a similar issue.
4. The impact of this large scale emergency project on CTM's current strategic, service and estate plans should be reviewed, given the guarantee for the new roof effectively extends the asset life by further 40 years. Action - CTM

R Rowlands made reference to the original risk assessment information, which was sent over in the transfer, and noted that there was no water ingress at the time and the risk had been assessed as significant rather than high. R Rowlands queried at what point do we understand how close significant is too high, and if something was considered significant, what time period should these issues be addressed by. S May advised that the Assistant Director of Capital & Estates would be able to explain this in more detail at the May Board Development session where a discussion would be held on Estates risks and added that these sorts of surveys were always non-intrusive with findings always being estimated. S May added that the health board had a significant level of high-risk backlog of estates issues within the wider Bridgend estate, which again would be discussed in more detail at the next Board Development session. R Rowlands advised that from a Board level perspective, she would be keen to know as a Board Member how close to high is significant, and were there plans in place to address the risks.

The Chair stressed the need to ensure that the assurance levels were where they needed to be regarding the Board's knowledge and awareness on the estate, given that the health board owned a number of premises. The Chair added that this may be useful in the future when considering the reshaping of services, with some buildings that could be used in different ways and others that would be appropriate for disposal.

R Rowlands made reference to the recent visit to Princess of Wales Hospital, where it was recognised that there was water ingress in different parts of the hospital, and that maybe those observations were not joined up, and sought clarity as to whether there was confidence that there was sufficient estate management in place on all hospital sites to ensure the issues experienced did not reoccur. S May referred to a report that was received at a previous Planning, Performance & Finance Committee which referred to attracting and maintaining estates professionals into the organisation. Members noted that the health board was competing with the private sector who were offering significantly better rates of pay for estates professionals and noted that a discussion had been held with H Daniel on the need to develop a recruitment and retention plan given the high turnover of staff in this sector, which was a significant risk for the health board.

	P Roseblade made reference to the estate that had been inherited from the former Abertawe Bro Morgannwg Health Board and the residual estate within the former Cwm Taf footprint, and queried, now that the health board had learnt of the importance of an intrusive survey, would it be deemed to have not learned lessons if it did not then conduct intrusive surveys on buildings that were beyond their expected useful life. S May advised that a balanced approach needed to be taken and added that Welsh Government, Shared Services and Specialist Estates would be reviewing the guidance as to when an intrusive survey needed to be undertaken, given the associated risks. Members noted that this would be addressed on a case by case basis. D Jouvenat referred to the lessons learnt and the importance of having the detailed plans available and queried whether there was confidence that the health board were able to do this at present. S May advised that in relation to the estate that the health hoard had built, for example, Royal Glamorgan Hospital, there was confidence that appropriate records were in place. Confidence was also in place in relation to Prince Charles Hospital, which had been subject to significant surveys as a result of the ground and first floor redevelopment. Members noted there were concerns regarding availability of detailed plans for premises within the Bridgend estate and noted that a request had been submitted to Swansea Bay University Health Board for these to be shared. S May advised that support may be required from Shared Services to address this. I Wells made reference to the detailed surveys and advised that from reading the report, it appeared that the way in which funding was provided by Welsh Government in order for the health board to undertake maintenance, would make it very difficult if a number of estates issues were identified following inspection of premises. S May advised that maintenance could either be capital or revenue, dependent on the nature of the work that needed to be undertaken. S May advised that in relation to the wider capital funding allocation and backlog maintenance elements, the health board had a constrained discretionary capital allocation, of which a quarter of £12m would need to be spent on statutory compliance and backlog maintenance. Members noted that a Targeted Estates Fund (TEF) had now been introduced, where bids are submitted to secure funds. S May advised that she would provide the Board with an update at the next meeting as to what had been secured against the TEF for the next two years. P Mears advised that this position was not unique to CTM, with every NHS organisation in Wales and the UK having significant issues with backlog maintenance. P Mears advised that in addition to the learning points that had been identified following this review, a wider conversation was required on the amount of money being spent on buildings which were not fit for purpose in regard to 21st century provision of healthcare. Members noted that the Executive Team were discussing the use of facilities across the CTM footprint. P Mears advised he would welcome a further discussion on the future of estates at a future Board Development session.

	The Chair extended his thanks to G Watts for preparing the report and to P Mears for presenting the report and added that he would welcome further discussion on the Health Board's estate at a future Board Development session.
Resolution:	The report was NOTED
Action:	Further discussion to be held at a Future Board Development session in relation to the future of estates
5.	BOARD GOVERNANCE ARRANGEMENTS
5.1	Joint Commissioning Committee Annual Update
	This item was taken immediately following agenda item 3.3. Colleagues from the Joint Commissioning Committee (JCC) shared their presentation and highlighted key matters for Members attention. L Prosser thanked JCC colleagues for their presentation and noted the challenges faced with a 1.77% uplift, while committing to a 4% uplift for JCC. L Prosser emphasised the importance of aligning access to specialised interventions with peer groups and endorsed the team's focus on value. S Taylor highlighted the challenges faced by JCC, including the loss of Welsh Government funding and the need to consider preventative care. I Green stressed the importance of collective decision- making for specialist services and driving greater productivity through the ambulance service. P Mears paid testament to JCC colleagues as to how well the transition of the JCC had been managed since its launch in April 2024, and added that he was pleased to see the organisation taking shape and welcomed the positive conversations and relationships the JCC had formed with Health Boards. P Mears agreed that clarity was required in relation to the strategy for specialist services in Wales, given that one of the challenges the JCC were trying to address was in relation to historic arrangements that had been put into place for a variety of reasons, many of which would require a review. Members noted that a national decision would need to be made as to what level of service provision needed to be delivered in Wales, recognising that to provide those specialist services well, with the correct clinical staff and resources would be costly. P Roseblade referred to the 4% uplift and queried what percentage of this would be spent on direct delivery of patient care and what percentage of this would be spent on additional staffing, given the Organisational Change Process (OCP) that the organisation had just gone through. S Taylor confirmed that none of the 4% uplift would be spent on staffing, with the OCP being delivered within the resources that were historically approved for the JCC to operate in. S Taylor confirmed that there had been no increase in staffing costs and added that in order to deliver its savings target, a review would be required on its running costs to deliver efficiencies.

	S Blackburn queried what role the JCC felt it could or should play in managing public engagement and consultation in relation to those services which are being reshaped on a regional or national basis, for example, Stroke services. S Taylor referred to the legal and statutory requirements of Health Board's regarding larger service changes, which meant that some of the responsibilities would sit with Health Board's as per their standing orders. However, S Taylor advised that consideration could be given to how organisations could operate collaboratively in that space and added that it was important that organisations were joined up in their thinking and communications processes in terms of managing messaging collectively. Members noted that the JCC operates on behalf of the seven Health Boards to deliver on the priorities that they see fit. I Green added that it was important that consideration needed to be given as to how the JCC could support and work collaboratively with Health Boards around broader public engagement and communications. The Chair made reference to the matter in regards to dealing with difficult issues, for example, the issues regarding the Emergency Medical Retrieval Transport service consultation, and advised that whilst this arrangement had worked well, in terms of bringing people together to point of consensus for the types of decisions that were required, further consideration needed to be given to potentially difficult decisions and how they were being made, particularly given Health Board's may have differing views regarding the decision required. I Green advised that there was a mechanism in place within the JCC in regard to ensuring consensus was reached on decisions that needed to be made, with a mechanism in place for when consensus could not be reached. The Chair extended his thanks to I Green, S Taylor and G Galletly for attending the meeting to share their presentation and added that the health board looked forward to continuing to work with the Team.
Resolution:	The presentation was NOTED.
5.2	Action Log
	The action log was received.
Resolution:	The Action log was NOTED.
5.3	Matters Arising not Contained within the Action Log
	There were no matters arising
5.4	Board Assurance Framework
	C. Hamblyn presented the report and highlighted the key matters for Members attention. The Chair advised that this report was a useful way of pulling together the Board's understanding of its risk profile and added that the narrative contained within the report and the actions that were being taken to address the risks was clear. The Chair added that this framework was an important part of the governance framework and advised that he was pleased that some time would

	be spent on discussing this in more detail at the Board Development session scheduled for the 15th May 2025. D Jouvenat welcomed the addition of the impact column which highlighted the anticipated impact of the mitigations, which provided Members with greater assurance.
Resolution:	The Board resolved to NOTE the Board Assurance Framework and APPROVED the updates to the BAF Report for March 2025 as captured in Appendix 1.
5.5	Board Committee and Advisory Group Highlight Reports
5.5.1	Audit, Risk & Assurance Committee 13 February 2025
	P. Roseblade presented the report and highlighted the matters contained within the alert/escalate section.
Resolution:	The Board resolved to NOTE the report
5.5.2	Mental Health Act Monitoring Committee 4 December 2024
	G Hopkins presented the report and highlighted the positive matters contained within the alert/escalate section. In drawing attention to the update on the increase in single Doctor assessments rather than two Doctor assessments, D Hurford provided assurance that was proving just as effective.
Resolution:	The Board resolved to NOTE the report
5.6	Audit Wales Structured Assessment and Audit Letter
	This item was received and discussed directly following the break at 11:20am. D Griffiths & N Couch presented the report and highlighted the key matters for Members attention. D Griffiths extended his thanks to the Board for their co-operation throughout the review and extended particular thanks to G Watts and C Hamblyn for their support and input. D Griffiths added that Audit Wales had a very good working relationship with G Watts and C Hamblyn and advised that he valued the effort they had put in to supporting the work of Audit Wales. The Chair extended his thanks to D Griffiths, N Couch and the Audit Wales Team for the way in which they had worked collaboratively with the Health Board.
Resolution:	The Board resolved to NOTE the report.
5.7	Annual Board Effectiveness Self-Assessment.
	The Chair presented the report and highlighted key items for Members:

	• the significant progress which the Board has continued to make over the last twelve months. Of particular significance was the de-escalation for Quality and Governance, Leadership and Culture, and Trust and Confidence, to Routine Arrangements during 2024-25. • The closing off of the Audit Wales/HIW Quality Governance Review which demonstrated the good progress the Board has made in addressing the recommendations.in September of last year, the Board came together to discuss further developing itself as an effective and cohesive Board and completed the skills matrix for the first time. • In January the Board implemented a new committee structure which will go some way to support in the on-going development of the Board. In concluding the update, the Chair thanked all Board members and everyone who contributed to the work including the Corporate Governance team for their efforts in driving the Board for continuous improvement. The Chair added that he remained ambitious for this Board and believed it could continue to improve and develop in its effectiveness going forward and provide the leadership needed to deliver better outcomes for our communities and patients, which is the ultimate goal. The Chair extended his thanks to all Independent Members for being generous with their time in going through the annual appraisal process and for contributing their feedback in relation to the Chairs appraisal.
Resolution:	The Board resolved to APPROVE the Self-Assessment Maturity Rating of Level 4 as outlined in the report.
6.	DELIVERING OUR PLAN
6.1	Integrated Medium Term Plan 2025-2028
	L. Prosser and S May presented the report and highlighted the key matters for Members attention. P Mears extended his thanks to the Teams for producing this plan which had been a labour intensive process over the last few months and added that it would be important to stop and reflect that the Board would have managed to deliver a financially balanced plan for the last three years, which would increase the credibility of the health board with external partners. P Mears advised that the position remained challenging and focus needed to be placed on delivering the savings plans and stressed the importance of the Board being provided with regular assurance on savings plan delivery. Members noted that despite the challenging position, the health board was still investing in a number of clinical service areas and was also ensuring the right resource was being placed on the Board's digital ambitions, which was a key enabler in delivering greater productivity and efficiency. The Chair advised that it was interesting to see the list of areas to deliver on within the IMTP narrative in the new financial year, and added that looking at

	the range of activity that the Health Board was attempting to engage in and bring to fruition, was remarkable. The Chair added that it would be helpful if the Board could take time to reflect on progress made in delivering the plan at a future Board Development session. The Chair advised that it was testament to the work that had been undertaken by colleagues that the Board was able to submit a balanced plan and added that following Welsh Government approval of the plan, which is pending, he would like further consideration to be given to engaging with stakeholders to share the ambition of the Board over the next 12 months. R Rowlands made reference to the 6.9% real living wage and employers national insurance increase and advised that she expected this to be higher given that the real living wage increase was 10% and the national insurance increase was in addition to this, and sought clarity as to how the 6.9% had been calculated. S May advised that this related to Continuing Healthcare contracts and was based on an overall position and added that there was a standardised approach that was used each year, a percentage of which was shared across Wales.
Resolution:	The Board resolved to: • ENDORSE the plan for inclusion in the formal submission to Welsh Government. • APPROVE the IMTP documents for submission to Welsh Government.
6.2	Integrated Performance Dashboard
	Executive Directors presented the report and highlighted the key matters for Members attention. G Hughes presented his update in relation to the operational performance section at 10:46am and the discussion on the update provided is captured below The Chair highlighted the significant performance improvements, especially for patients waiting over 104 weeks, which had been a media focus. Over the past few months, there have been notable improvements across various services, not just within Cwm Taf Morgannwg but also in other Health Boards. The Chair mentioned the public recognition from Welsh Government, particularly for CAMHS services, where CTM is the only health board in Wales with a positive performance. The de-escalation in performance strategy and planning has positively impacted patients and staff. The Chair also noted the significant improvements in breast cancer services following the centralization of services at the Snowdrop Breast Centre." The Chair noted the challenge in achieving the 70% target for the Single Cancer Pathway by March 2025. G Hughes explained that the performance against the 28-day diagnostic target, used to determine if a patient has cancer, was high. He added that slower performance in tertiary pathways was

now evident due to increased efficiency in internal pathways, resulting in quicker patient diagnoses.

P Mears advised that whilst it was encouraging to see the improvement that had been made across multiple areas of performance within the organisation, there were still one in four patients who had been waiting over two years for an operation, which was not where the health board wished to be. P Mears advised that there were some areas in the coming year, through the work that had been undertaken in relation to productivity, in which there would be opportunities to do things better in terms of using the current resources and redesigning ways of working.

P Mears made reference to the impact regional working had had on the position regarding cataracts, with a positive outcome delivered in regard to addressing the numbers of patients waiting for treatment. Members noted that waiting lists had reduced significantly, with no patients waiting over two years for cataract surgery. G Hughes advised that a decision had been made by the health board to focus on treating the clinically urgent patients first, prior to addressing routine activity.

I Wells referred to the Ophthalmology position and updated on some personal experiences his family had received regarding awaiting cataract surgery and commended the fantastic service received. Members noted that the improvements made regarding the waiting list position had been positively received within the community, given the difference it is making.

G Hopkins advised that he had also received positive praise regarding the improvements made on the position within ophthalmology and queried why it was taking two years for patients to be treated, given this was a 15 minute procedure. G Hughes referred to a piece of work that was being undertaken with Ophthalmic teams regarding the principle of a high volume, low complexity list. G Hughes advised that within other Health Board's outside of Wales, most cataract lists would have a minimum of 10 cases on a list, and added that whilst CTM were not currently operating all of its lists with this number of cases, there were some lists that were operating with 10 cases. G Hughes made reference to the complexities behind this given that whilst the operation takes a very small period of time, many of the patients were older and not easily manipulated, which posed as a risk to them potentially moving during the operation, meaning that they would need to be given greater levels of sedation. Members noted that the Surgi Cube had now been implemented at the Princess of Wales Hospital, which had enabled the health board to undertake cataract operations outside of an operating theatre, with surgeons now injecting topical anaesthesia which meant that an anaesthetist did not need to be present.

The Chair advised that it would be important for the Board to note that there had been an improvement in 11 out of 17 Executive performance indicators.

	The other aspects of the Performance Dashboard report were noted with no further comments made by the Clinical Executives.
Resolution:	The report was NOTED
6.2	Month 11 Finance Update
	S May presented the report and highlighted the key matters for Members attention. Members noted that a break even position was being forecast and that in relation to capital expenditure, the month 11 position was at £67m and that the health board needed to get to a position of £94m, which the it was forecasting a delivery against. Members recognised that a small capital team had undertaken a significant amount of work to maximise year end flexibilities to facilitate delivery.
Resolution:	The report was NOTED
7.	OUR POPULATION / WORKING WITH OTHERS
7.1	Subsidy Control
	Members received the report and noted that the report had been received and discussed at the Strategic Development Committee held on 13 March 2025.
Resolution:	The Board formally APPROVED the regional team's request to lodge the Subsidy on the health board's behalf.
8.	STRATEGIC PLANNING
8.1	Digital Cellular Pathology Business Case
	M Barker presented the report and highlighted key items for Members attention. H Proctor welcomed the Business Case which she fully supported and advised that this would strengthen clinical governance, clinical safety with diagnosis and staff learning and development. D Jouvenat advised that the Business Case had been presented to and endorsed by the Strategic Development Committee, who were keen to recommend this to the Board for approval. D Jouvenat advised that she considered this to be an exciting project which would have significant impact on services across the organisation. P Roseblade advised that she fully supported the Business Case and sought clarity as to whether this business case had already been included in the IMTP. The Executive Team confirmed that this was already included. R Rowlands advised she was also fully supportive of the plan and referred to the indicative £71k and queried whether this was the higher end of the indicative amount. M Barker advised that the £71k was the actual cost, with the higher amounts contained within the report being indicative costs. The Chair extended his thanks M Barker for presenting the report.
Resolution:	The Board resolved to APPROVE the National Digital Cellular Pathology Business Case.
8.2	CTM Learning Academy

	G. Dix presented the report and highlighted the key matters for Board Members attention. D Jouvenat advised that she was pleased to see this report being presented to the Board for approval today and added that the establishment of the Learning Academy would be an important step forward and would assist with attracting staff into the organisation and would also provide opportunities for development. G Hughes advised that when this was presented to the Operational Management Board, the sheer volume of students coming through to CTM compared to any other Health Board in Wales was recognised. Members noted that the health board had programmes in place that were not in place within other Health Board's and G Hughes commended the efforts of J Gilbertson and the Team for their work in this area. In response to a query raised by R Rowlands, G Dix confirmed that there would be a communications programme implemented to cascade the messages regarding the establishment of the Learning Academy.
Resolution:	The Board APPROVED the formal establishment and launch of the CTM Learning Academy.
9.	CONSENT AGENDA
9.1	FOR APPROVAL
9.1.1	Unconfirmed Minutes of the meeting held on 30 January 2025
Resolution:	The Minutes were APPROVED
9.1.2	Amendments to the Model Standing Orders
Resolution:	The amendments were APPROVED.
9.1.3	Major Incident Plan and Site-Specific Procedures
Resolution:	The plan was APPROVED.
9.2	FOR NOTING
9.2.1	Board Forward Work Programme
Resolution:	The Board Forward Work Programme was NOTED.
9.2.2	Board Annual Cycle of Business
Resolution:	The Annual Cycle of Business was NOTED.
9.2.3	Board Committee and Advisory Group Highlight Reports
Resolution:	The reports were NOTED.
9.2.4	Audit Wales Annual Audit Report

Resolution:	The report was NOTED.
9.2.5	Highlight Report from the Joint Commissioning Committee
Resolution:	The report was NOTED.
9.2.6	NHS Wales Shared Services Partnerships Committee Assurance Report
10.	CLOSE OUT BUSINESS
10.1	Any Other Business
	There was no other business to report.
10.2	Meeting Feedback
	The Chair asked Members to submit any feedback to him within two weeks of this meeting.
11.	PRIVATE / IN COMMITTEE SESSION The Chair confirmed that there would be an In Committee session being held following this meeting to discuss the following item which was commercially sensitive: • Strategic Vision for the Llantrisant Health Park and Regional Endoscopy Plan
12.	DATE & TIME OF THE NEXT MEETING The next meeting is scheduled to take place on Thursday 29 May 2025 at 9:00am.
13.	CLOSE OF MEETING

Agenda Item	9.1.2

Unapproved Minutes of the Closed Board Meeting

Date and Time of Meeting	Thursday 27 March 2025 13:00pm
Venue	The Hub, Royal Glamorgan Hospital, Llantrisant

Members Present	Jonathan Morgan	Health Board Chair
	Paul Mears	Chief Executive Officer
	Carolyn Donoghue	Independent Member - University
	Patsy Roseblade	Independent Member - Finance
	Greg Dix	Executive Director of Nursing/Deputy CEO
	Sally May	Executive Director of Finance
	Philip Daniels	Executive Director of Public Health
	Gethin Hughes	Chief Operating Officer
	Dom Hurford	Executive Medical Director
	Lauren Edwards	Executive Director of Allied Health Professionals and Health Sciences
	Ian Wells	Independent Member – Digital (Virtually)
	Linda Prosser	Executive Director of Strategy & Transformation
	Hywel Daniel	Executive Director for People
	Hayley Proctor	Independent Member – Trade Union
	Dilys Jouvenat	Independent Member – Third Sector
	Helen Lentle	Independent Member – Legal
In attendance	Cally Hamblyn	Assistant Director of Governance & Risk
	Emma Walters	Head of Corporate Governance & Board Business
	Simon Blackburn	Director of Communications, Engagement & Fundraising
	Stuart Morris	Director of Digital

Agenda Item	Meeting Business
1.	PRELIMINARY MATTERS
1.1	Welcome and Introductions
	The Chair welcomed everyone to the meeting.
1.2	Apologies for Absence
	Apologies for absence were received from: • Kath Palmer, Vice Chair • Gareth Watts, Director of Corporate Governance/Board Secretary • Geraint Hopkins, Independent Member
1.3	Declarations of Interest
	There were no interests declared.
2.	MAIN AGENDA
2.1	Strategic Vision for Llantrisant Health Park and Regional Endoscopy Plan
	L. Prosser presented the report and highlighted key areas for Members attention. Members noted the Strategic Overview of the Llantrisant Health Park Programme. In relation to the Regional Endoscopy Plan, Members noted that this plan was also being presented to Aneurin Bevan and Cardiff & Vale University Health Boards for approval and noted that Welsh Government were keen for this plan to be implemented. L Prosser advised that given some further amendments would need to be made to the Regional Endoscopy Plan, the final version of the plan would be circulated to the Board outside the meeting seeking approval via Chairs Urgent action. Members expressed their support of the plan and the Chair advised that he would be happy to endorse the final version of the plan via Chairs Urgent Action.
Resolution:	The Board: • NOTED the analysis of the attached documents; • NOTED and endorsed the local assessment and requirements • ENDORSED the commitment to the commissioning of activity through an independent service provider contract for endoscopy, noting the financial requirements as set out in section 3 of this report and section 6 of the plan. • AGREED TO APPROVE the final version of the Regional Endoscopy Plan via Chairs Urgent Action
3.	ANY OTHER BUSINESS
3	Any Other Business
	The Chair provided the Board with an update on the latest position regarding the absence of the Vice Chair and the cover arrangements that would be put

	into place during the absence. The Chair advised that he was seeking the support of the Board to submit a recommendation to the Cabinet Secretary for C Donoghue to be appointed as acting Vice Chair for a period of three months. The Board provided their support to this proposal.
4.	DATE & TIME OF THE NEXT MEETING The next meeting is scheduled to take place on Thursday 29 May 2025
5.	CLOSE OF MEETING

Agenda Item
9.1.3

CTM Health Board

Review: Standards of Good Governance and Probity (in Public Service Roles) Policy

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public For Future Publication
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Gareth Watts, Director of Corporate Governance / Board Secretary
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	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
Shared with the following functions for comment: • Fraud • Procurement • People Team • Charitable Funds • Finance	16/04/2025	Comments received have been incorporated.
Executive Management Board for endorsement	28/04/2025	Policy title updated.

Audit, Risk & Assurance Committee	22/05/2025	Endorsed for Board Approval

Acronyms / Glossary of Terms	
WHSSC	Welsh Health Specialised Services Committee
EASC	Emergency Ambulance Services Committee

1. Situation /Background

1.1 The purpose of this Policy is to set out the Cwm Taf Morgannwg University Health Board (CTMUHB) commitment to ensuring that its Employees and Independent Board Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Board Members are supported in delivering that requirement.

2. Specific Matters for Consideration

2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	28 February 2025
Informal Consultation with interested parties	16 April 2025.
Formal Consultation	22 April 2025
Executive Management Board	28 April 2025
Committee / Board – For approval	Audit, Risk Assurance Committee – May 2025 Board – May 2025

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

3. Key Risks / Matters for Escalation

3.1 In response to the review and consultation the following amendments have been made:

- Following feedback from EMB the policy has been retitled from Standards of Behaviour Policy to Standard of Good Governance and Probity (in Public Service Roles) Policy, so it more clearly describes the nature of the policy.
- Placed in new policy format which changed since the policy was last reviewed in 2022.
- Updated and corrected defective hyperlinks in the current policy documents
- Changed reference from Audit & Risk Committee to Audit, Risk and Assurance Committee and removed Management Board and replaced with Executive Management Board.
- Updated it to refer to the Joint Commissioning Committee and not WHSSC and EASC

- Included vouchers and gift vouchers as items colleagues should not accept in addition to cash
- Updated the reference to Raising Concerns to the wider umbrella term of Speaking up Safely.
- Sign posted colleagues to further information in relation the CTM Charitable Funds where appropriate
- Removed App 1 and App 5 from the current policy.
- Removed App 5 as covered in the Counter Fraud and Bribery Policy.
- Removed App 2-4 which is the forms and included links to the Corporate Governance dedicated SharePoint page.
- Minor grammar and typographical changes.
- Added link to ABPI Code of Practice.
- Instead of being specific about formal request to senior staff for declarations being in April it is now captured as the first quarter of the financial period for the forthcoming year.

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))*	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:	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): EIA completed and policy will require translation in Welsh once approved as well as the dedicated website pages.	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) /* 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 APPROVE the Standards of Behaviour Framework Policy.

6. Next Steps

6.1 The policy will be uploaded to the CTMUHB Intranet page once approved.

Standards of Good Governance and Probity (in Public Service Roles) Policy

Document Type:	Non Clinical Organisational Wide Policy
Ref:	GC03
Author:	Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance
Approved By:	Health Board
Approval / Effective Date:	(00/00/0000)
Review Date:	(00/00/0000)
Version:	8

Target Audience:

People who need to know about this document in detail	This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board.
People who need to have a broad understanding of this document	As above.
People who need to know that this document exists	As above.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 28.2.2025 Outcome: Supported with amendments made as required.
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	4.3.2025
Aligns to the following Wellbeing of Future Generation Act Objective	Co-create with staff and partners a learning and growing culture

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

1. Introduction

1.1 The purpose of this Policy is to set out the Cwm Taf Morgannwg University Health Board (CTMUHB) commitment to ensuring that its Employees and Independent Board Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Board Members are supported in delivering that requirement.

2. Context and Background

2.1 The Welsh Government's *Citizen-Centred Governance Principles* apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

2.2 CTMUHB is strongly committed to the Health Board being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

2.3 The Board expects all Independent Board Members and Employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.

2.4 The "Seven Principles of Public Life", or the "Nolan Principles" form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

1. Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends;
2. Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties;
3. Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit;
4. Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position;
5. Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their

decisions and restrict information only when the wider public interest clearly demands it;

6. Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest, and;

7. Leadership – Individuals should promote and support these principles by leadership and example.

2.5 In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must always remain beyond suspicion. They can achieve the "Seven Principles" above by:

- Ensuring that the interests of patients remain paramount;
- Being impartial and honest in the conduct of their official business;
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money;
- Not abusing their official position for personal gain or to benefit family or friends;
- Not seeking advantage or to further private business or other interests during their official duties, and;
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

2.6 This Policy re-states and builds on the provisions of CTMUHB Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations can be made.

3. Aim

3.1 The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance / refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

3.2 CTMUHB is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported to deliver this requirement.

4. Objective

4.1 The objective of this Policy is to clarify the relative responsibilities of Individuals / committees in the discharge of this Policy and adherence to the Standards of Behaviour Framework.

5. Scope

5.1 This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board.

5.2 Any reference in this Policy to the Health Board should also be applied to any bodies that CTMUHB hosts such as the Joint Commissioning Committee (JCC) and the National Imaging Academy Wales (NIAW) Programme.

6. Roles and Responsibilities

6.1 Chair - the Chair should:

- Ensure that Independent Members are aware of the requirements contained within this Policy.
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Independent Board Members PRIOR to the event.

6.2 Chief Executive - is the "Accountable Officer" with overall responsibility for ensuring that the Health Board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

6.3 Executive Directors have overall responsibility for their areas -and must ensure that:

- Employees are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.
- They lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate PRIOR to the event.
    - They review the contents of the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship on an annual basis to assist with the verification of the accuracy of the information contained within it.
    - During periods of annual leave and prolonged absence they will ensure that they delegate the responsibilities to their Directorate

as appropriate to Clinical Directors, Managers or Head of Nursing or an Assistant Director.

6.4 Director of Corporate Governance / Board Secretary - The Director of Corporate Governance/Board Secretary has delegated responsibility for ensuring that the Health Board is provided with competent advice and support regarding the contents and application of this Policy and the Standards of Behaviour Framework. They will ensure that: -

- A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Board Members. The Register will include details of Directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.

- Arrangements are in place to prompt specific groups of Employees and Independent Board Members to complete a Declaration of Interest Form on initial employment with the Health Board and at periodic intervals thereafter as follows:
  - Board Members and Board Level Directors – Annually in the first quarter of the financial year for the forthcoming financial period.
  - Consultants, Very Senior Managers (VSM), Staff at Band 8d and 9 - Annually in the first quarter of the financial year for the forthcoming financial period.
- A Register of Gifts, Hospitality and Sponsorship whether, accepted or declined, is maintained.

- Appropriate information from the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship is published on the Health Board Website in accordance with the requirements of the Freedom of Information Act Publication Scheme and staff information will therefore be publicised on the website including as part of the report to the Audit, Risk & Assurance Committee annually providing openness and transparency for CTMUHB.

- Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality and Sponsorship and the effectiveness of the arrangements in place will be provided on a quarterly basis to the Executive Management Board and Audit, Risk & Assurance Committee.

6.5 Line Managers / Departmental Managers - Line/Departmental Managers will:

- Ensure that this policy and the Standards of Behaviour Framework is brought to the attention of Employees for whom they are responsible, and that they are aware of its implications for their work;

- Ensure that Employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Behaviour Framework will be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate;
- Support their Employees in the application of the Policy and the Standards of Behaviour Framework, seeking advice from the Director of Corporate Governance / Board Secretary if required.

6.6 Employees and Independent Members - All Employees, including those on Honorary Contracts will ensure that they:

- Understand this Policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification;
- Are not in a position where their private interests and NHS duties may conflict;
- Declare to the Health Board for recording in the Register of Interests any relevant interests:
    - At the commencement of employment
    - Whenever a new interest arises, and
    - If asked to do so at periodic intervals by the Health Board.

"Relevant interests" will include: -

- Directorships, including Non-Executive Directorships held in private companies or PLCs, apart from dormant companies
- Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less
- A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team
- Sponsorship or funding from a known NHS supplier or associated company/subsidiary
- A position of authority in a charity or voluntary body in the field of health and social care
- Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests
- Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.
- Inform patients and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a patient. The fact that the patient has been informed must be recorded appropriately.
- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board, Board Committee or Board Sub Committee meetings, during procurement processes.

- Declare to the Health Board for recording in the Register of Gifts, Hospitality and Sponsorship any offer of a gift, hospitality or sponsorship which requires recording.
- Obtain permission from their Director before accepting gift, hospitality or sponsorship which require recording.
- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Health Board.
- Note: Employees should also refer to appropriate Professional Codes of Conduct and documents issued by the Welsh Government which will complement this Policy and the Standards of Behaviour Framework.
- It is the individual's (i.e. the employee or Independent Member) responsibility to make a declaration should their circumstances change within these timescales.

It is recommended that where there is doubt, a declaration of interest should be made

6.7 Procurement Department - The Procurement Department (provided by the NHS Wales Shared Services Partnership) scrutinise the Registers for Declarations of Interest and Gifts, Hospitality, Sponsorship and Honoraria to ensure that there is no opportunity for conflict of interest. A detailed protocol will specify the arrangements for undertaking this process and it will include:

- Details of the stages of the procurement process at which the Registers will be consulted;
- The arrangements for checking of the Registers;
- The arrangements for ensuring that all those involved in the procurement are given the opportunity to declare any relevant interest
- The arrangements for communicating this information to the Director of Corporate Governance / Board Secretary for its inclusion in the Register of Interests, and;
- The actions to be taken if there is a perceived conflict of interest at any point in the procurement process.

If an Employee is requested to participate in the procurement process, they will be asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared. If they have not previously completed a Declarations of Interest Form, they will be asked to do so before participating in the procurement process.

7. Register of Interests

7.1 The Director of Corporate Governance / Board Secretary will maintain Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship. Appropriate information from these Registers is available on the Health Board website.

7.2 The Register is available for public inspection. Enquiries should be made to the Director of Corporate Governance/Board Secretary via the following email: CTM_Corporate_Governance@wales.nhs.uk

8. Declarations of Interest at Meetings

8.1 It is a requirement that at the beginning of every Health Board, Board Committee, Board Sub Committee or decision making / formal Health Board meeting that the members of the Board and those in attendance be invited to declare their interests in relation to any items on the agenda.

8.2 Where a potential conflict is material or the member has a financial / pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall note vote upon it. The potential conflict and the action will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

8.3 Where it becomes evident part way through a meeting that there may be a potential conflict the individual must declare their interest immediately. Under certain circumstances the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance / Board Secretary should always be sought prior to such a decision being made. From time to time, employees may need to declare interests at other Health Board or Partnership meetings. Such declarations will be recorded as if it were a Board, Board Committee or Board Sub Committee meeting, and the individual will be asked to withdraw from discussions pertaining to that agenda item.

8.4 The Declarations of Interest Register form is available here:
Hard Copy Format: CTM UHB Declaration of Interest Form (Updated 07-06-2024).docx
Online Submission: Declarations of Interest - Home

9. Gifts, Hospitality and Sponsorship

9.1 Gifts - A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events / conferences.

It is an offence to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received, they should be returned clearly advising why they cannot be accepted.

The appropriate Director and the Director of Corporate Governance / Board Secretary should be advised immediately.

9.2 Gifts from Patients / Service Users or their relatives

Employees may accept, subject to it not contravening their professional Codes of Conduct, gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards. There is no requirement to declare such gifts.

Where a gift is offered by patients or their relatives that is likely to be over £25 in value it should be politely declined. In some cases, the gift may have been delivered and it may be difficult to return it, or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of the Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Sponsorship and Honoraria Form declaring that the gift has been received must be completed.

Personal gifts of cash, vouchers or gift-cards from patients or their relatives are not acceptable. It may only be accepted as a donation to an appropriate Charitable Fund and recorded as such. The Cwm Taf Morgannwg NHS Charity team can provide advice regarding appropriately accepting, banking and receipting such items in accordance with the Charitable Funds Financial Control Procedures. The Charity team can be contacted via the following email: ctm.charity@wales.nhs.uk

9.3 Gifts from Suppliers / Commercial Organisations - No gifts, unless they are of low intrinsic value e.g. pens, calendars, etc. are allowable from suppliers, contractors and other commercial organisations. All such offers of gifts should be politely declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined a Gifts, Hospitality, Sponsorship and Honoraria Form should be completed. This will allow the Health Board to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstance's suppliers may send gifts to all its clients as custom and practice e.g. hampers at Christmas. Whilst such practices should be discouraged and it is not acceptable for staff to personally accept these gifts, following discussion with the supplier / commercial organisation and the appropriate Director it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds. The Cwm Taf Morgannwg NHS Charity team can provide support with the recognition and receipt of such items.

Gifts of cash (including gift vouchers/cards) from suppliers / commercial organisations are not acceptable in any circumstances.

9.4 Gifts from Dignitaries / Overseas Organisations - There may be occasions when visits are made by dignitaries or overseas organisations who consider it "culturally custom and practice" to exchange gifts. In such cases Employees should seek guidance from the Director of Corporate Governance / Board Secretary and declare these gifts on a Gifts, Hospitality, Sponsorship and Honoraria Form. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the "gift culture" and may include decisions to "keep and display in public", "donate to an internal user group", "auction for charity" etc.

9.5 Hospitality - Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours. Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.

Any acceptance of hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the hospitality likely, or could it be likely, to influence you? The onus is on the individual to make sure that the acceptance of hospitality will not be misconstrued.

9.6 Acceptable Hospitality - Acceptable hospitality includes:

- Offers of food and non-alcoholic drink, provided it is equivalent to that offered in similar circumstances by the NHS, can be accepted during working visits and does not need to be recorded in the Gifts, Hospitality and Sponsorship Register.
- Other hospitality that may be accepted includes instances where:
    - There is a genuine need to impart information or represent the Organisation at Stakeholder Community Events e.g. Local Authority or Charitable organisations which have an association with the Health Board.
    - An employee has been invited to receive an award or prize in connection with the work of the organisation or their role within it.
    - An employee is invited to a Society or Institute Dinner or Function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Health Board.
- These types of hospitality must be authorised prior to their acceptance by a Corporate or Clinical Director and a Gifts, Hospitality, Sponsorship and Honoraria Form must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the

minimum number of Employees to achieve the purpose of representing the Health Board should attend.

9.7 Unacceptable Hospitality - Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend / overnight break
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below)
- Use of a company flat or hotel suite
- Attendance at a function or event restricted to Employees which is not for the purposes of training or organisational development
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event
- Entertainment and / or tickets / hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories, then advice should be sought from their line manager in the first instance or if complex from the Director of Corporate Governance / Board Secretary.

Employees should report any case where an offer of hospitality is pressed which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

9.8 Sponsorship - Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts and research and development.

No sponsorship should be accepted without the prior agreement of the appropriate Corporate / Clinical Director. A Gifts, Hospitality, Sponsorship and Honoraria Form should also be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and / or declined this should also be declared.

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could It be likely, to influence you? The onus is on the individual to make sure that the acceptance of any sponsorship will not be misconstrued.

9.9 Commercial Sponsorship for Attendance at Courses / Conferences - Employees may accept commercial sponsorship for attendance at relevant conferences and courses, but only where the employee seeks permission in advance from their Executive Director. The sponsorship should only be extended to the number of Employees who would have normally attended if funded by the Health Board. The Director must be satisfied that acceptance will not compromise purchasing decisions in any way.

9.10 Commercial Sponsorship to attend demonstrations / technical evaluations - Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting.

Such sponsorship is not appropriate, and the Health Board will meet the costs of such a visit to protect the integrity of subsequent purchasing decisions.

9.11 Commercial Sponsorship – "Linked Deals" - Pharmaceutical companies and other suppliers, for example, may offer to sponsor, wholly or partially, a post or equipment for the Health Board. The Health Board will not enter such arrangements, unless it has been made abundantly clear to the company concerned that the sponsorship will have no effect on purchasing decisions within the Health Board. Where such sponsorship is accepted, the Director of Finance shall ensure appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement.

Under no circumstances should managers of the Health Board agree to "linked deals" whereby sponsorship is linked to the purchase of products, or to supplies from sources.

9.12 Sponsorship of events in the context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations - The pharmaceutical industry and allied commercial sector representatives may organise meetings in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value. An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable.

The Association of the British Pharmaceutical Industry

9.13 Miscellaneous Payments / Honoraria - Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one-off payment or honoraria is offered.

If this activity is to be undertaken during hours when the employee is contracted to work for the Health Board the payment should be made to

the Health Board. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Sponsorship and Honoraria Form and it should be authorised by the appropriate Executive Director.

9.14 Honoraria received for work undertaken DURING Health Board hours - When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Health Board hours, any honoraria paid must be received back to the Health Board revenue budget to reimburse the Health Board for the employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is *not* managed by the employee who has provided their services during Health Board time.

To avoid personal tax implications, the Health Board employee is urged to request the Honoraria is paid directly to the Health Board. This is then seen as reimbursement to the Health Board to cover the loss of employee time, and not honoraria. This money will then be transferred into the Health Board revenue budget. The Health Board employee who has undertaken the work must not be the budget holder for the budget receiving the funds in lieu of the honorarium due to a conflict of interest.

If the employee receives the honoraria directly and then reimburses the Health Board, the employee remains liable for the payment of both tax and National Insurance Contributions (NIC), regardless of the destination of the honoraria.

Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave)_Individuals are personally liable for the payment of both tax and NICs on any honoraria payments received. Following their first honoraria declaration Individuals will be asked to sign a "Declaration Statement" confirming that they understand their responsibilities, and this will be held on file by the Director of Corporate Governance / Board Secretary.

The Declaration of Honoraria Statement is available here: Gifts, Hospitality, Sponsorship & Honoraria - Home

If such an employee wishes to suggest a donation may be made to the Cwm Taf Morgannwg University Health Board Charitable Funds in lieu of an honorarium, this must be received into the Charity's general fund, and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore

lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, staff should seek advice from the Director of Corporate Governance / Board Secretary and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria have been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.

9.15 Bequests left in a Patient's or Service User's Will - On occasion's staff are left bequests in a service user's will which they become aware of before the service user is deceased or because they have been informed by the deceased service user's legal representative. In such circumstances the member of staff must immediately inform their manager. It should be borne in mind that staff cannot benefit from a bequest by virtue of their position as a Health Board employee, undertaking their duties. If a member of staff receives a bequest, they should contact the Executive Director of Finance and the Director of Corporate Governance / Board Secretary.

9.16 Gifts by way of inducement or reward - The Prevention of Corruption Acts, 1906 and 1916, prohibit staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

- Doing or refraining from doing anything in their official capacity; or
- Showing favour or disfavour to any person in their official capacity.

A breach of the provisions of these Acts renders staff liable not only to dismissal but to prosecution under the Acts, and it is expected that the Health Board would deal severely with any such breaches.

Staff should be aware that the Health Board is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Executive Director of Finance.

9.17 The Declaration Form – Gifts, Hospitality, Honoraria and Sponsorship form is available here: Gifts, Hospitality, Sponsorship & Honoraria - Home

10.0 The Bribery Act 2010 - The Bribery Act 2010 came into force on 1st July 2011. It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers. Broadly, the Act defines bribery as:

"Giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith"

10.1 The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before.

10.2 The Bribery Act 2010 made it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". The maximum penalty for bribery is up to 10 years imprisonment, with an unlimited fine.

10.3 In addition, the Act introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

10.4 Bribery does not have to involve cash, or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

10.5 Some examples are captured below:

- Bribery to secure or keep a contract;
- Bribery to secure an order;
- Bribery to gain any advantage over a competitor;
- Bribery of a local, national or foreign official to secure a contract;
- Bribery to turn a blind eye to a health safety issue or poor performance or substitution of materials or false labour charges;
- Bribery to falsify an inspection report or obtain a certificate.

10.7 The impact of other Health Board policies which should be considered by staff include:

- Speaking up Safely Speaking Up Safely - Home

- The NHS Wales All Wales Social Media Policy. NHS Wales Social Media Policy
- The Counter Fraud Bribery and Corruption policy Counter Fraud Bribery and Corruption Policy.docx

11.0 Research, Development & Innovation

11.1 All Research, Development and Innovation activity sponsored by commercial companies, including those sponsored by the Pharmaceutical Industry must be approved by the appropriate mechanisms. It will be governed by specific policies and procedures.

11.12 The Research, Development and Innovation Leads along with the Corporate Governance Department will be able to offer advice and support in this area.

12.0 Charitable Funds

12.1 There may be occasions when commercial organisations offer to pay monies into Charitable Funds as a way funding attendances at courses or conferences. Monies may only be paid into Charitable Funds from commercial companies if it is a donation or sponsorship. It can only be used to fund expenditure which is in line with the terms of the funds use as set out within the Charitable Funds Policy.

12.2 Expenditure from Charitable Funds does not fall within the remit of this policy, however there may be a close association with the Standards of Behaviour Framework. For more information on Charitable Funds, please contact the Cwm Taf Morgannwg NHS Charity team via the following email: ctm.charity@wales.nhs.uk

13.0 Secondary Employment & Private Practice

13.1 Secondary Employment - Staff should inform their line manager of any secondary employment and ensure that any secondary employment or private practice does not affect their Health Board employment. A declaration of interest form should be recorded. There should be no conflict with their normal contractual employment obligations to the Health Board, and such work should not involve the use of any confidential or commercial information obtained during their employment with the Health Board.

13.2 Where employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to carry out their duties as an employee of the Health Board. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment. Employees have a responsibility to ensure that their line manager is made aware

of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Directive; this is available via the following link. http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm

13.3 An employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases. An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal. Such action will only be taken following advice from the Workforce & Organisational Development Department.

13.2 Private Practice - There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties. The time spent in private practice does not count towards the 48 hours of the Working Time Directive Regulations, however, health and safety law indicate that no employee of the Health Board should work in a way detrimental to their health and performance.

Additional information and advice is available for staff in the Financial Control Procedure 'Private Patients'. Policies - Finance

Failure to notify their line manager of secondary employment and/or private practice may invoke the Health Board's Disciplinary Policy.

14.0 Failure to adhere to the Standards of Behaviour Framework Policy

14.1 If any Health Board employee fails to declare an interest as defined within this policy, the Standards of Behaviour Framework, or the guidance that will be published to support it and then:

- participates in a decision-making process where special favour is shown to unfairly award a contract; or
- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends.

14.2 Disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary policy. Under some circumstances failure to follow this policy could be considered gross misconduct.

14.3 In addition to any potential disciplinary action being taken if there is any suspicion that fraud, corruption and / or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within the Health Board in line with the Health Boards Counter Fraud policies.

14.4 Furthermore, if a member of staff breaches the Standards of Behaviour Framework this could in certain circumstances result in notification / reporting to the appropriate professional codes of conduct /registration / memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC) etc. This could incur registrations being revoked and employees no longer being able to be employed in their current position within the Health Board.

14.5 This is also extended to include the inappropriate acceptance of any gifts, hospitality or sponsorship. Failure to declare a relevant interest by an Independent Member of the Health Board will be reported by the Chair and to the Cabinet Secretary for Health and Social Services, Welsh Government.

15.0 Equality, Diversity, Inclusion and Welsh Language

15.1 An Equality Impact Assessment and Welsh Language Assessment has been completed and is available upon request from the Director of Corporate Governance / Board Secretary.

16.0 Resources

16.1 The implementation and management of the arrangements associated with this Policy do not present any significant resource implications to the Health Board.

17.0 Training

17.1 There are no training implications arising from this Policy. However, awareness of the importance of compliance will require reference in induction programmes, during Individual Performance Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when Employees are invited to make declarations.

18.0 Implementation

18.1 The Register of Declarations, Gifts, Hospitality, Sponsorship and Honoraria will be maintained by the Director of Corporate Governance / Board Secretary who will also be responsible for issuing periodic invitations to declare interests.

18.2 Directors and managers need to be aware of their responsibilities for advising Employees accountable to them of their responsibilities in connection with the policy.

19.0 Audit & Monitoring

19.1 The Director of Corporate Governance / Board Secretary will review the operation of the policy and Standards of Behaviour Framework as necessary and at least once a year a report on the findings of the review will be submitted to the Audit, Risk & Assurance Committee.

19.2 Directors will review the operation of the Policy within their Department.

19.3 Audit Wales and the NWSSP Internal Audit Service may also review the arrangements from time to time and their findings are also reported to the Audit, Risk & Assurance Committee.

19.4 Staff should note under the Freedom of Information Act 2000 the information contained within the Health Board Register will be subject to disclosure to any member of the public on request. The information will also be routinely reported to the Audit, Risk & Assurance Committee for oversight and scrutiny.

20.0 Retention and Archiving

20.1 In cases of complaints / claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Director of Corporate Governance / Board Secretary will therefore ensure that copies of this policy are archived and stored in line with the Records Management Strategy, Retention Schedule, and are made available for reference purposes should the situation arise.

21.0 Distribution

21.1 The Standards of Behaviour Framework Policy will be available via the Health Board intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

21.1 The Standards of Behaviour Framework Policy will be available via the Health Board intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

22.0 Review

22.1 Review of this Policy and the Standards of Behaviour Framework must be undertaken no later than three years after the date of approval.

23.0 Further Information

23.1 Further information and support in the completion of the forms can be obtained from Director of Corporate Governance / Board Secretary. CTM_Corporate_Governance@wales.nhs.uk

23.2 There is also a dedicated SharePoint page which includes further guidance, support and the required declaration forms. Declarations of Interest, Gifts, Hospitality, Sponsorship & Honoraria - Home

24.0 Legislative and NHS Requirements

24.1 This policy aims to ensure it complies with the requirements set out in: -

- (DGM (93)84) Standards of Business Conduct for NHS Staff
- WHC (2005)016 – The NHS and Sponsorship by the Pharmaceutical Industry
- WHC (2006)090 - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
- Director General, Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
- Commercial Sponsorship - Ethical Standards for the NHS, Department of Health (November 2000)
- Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011)
- Code of Conduct for Healthcare Support Workers in Wales, Welsh Assembly Government (January 2011)
- General Medical Council – Conflicts of Interest (September 2008)
- Health Board Standing Orders, Reservation and Delegation of Powers (March 2012)
- Nursing and Midwifery Council, The code - Standards of conduct, performance and ethics of nurses and midwives (May 2008)
- Royal College of Psychiatrists, Good Psychiatric Practice, Relationships with Pharmaceutical and Other Commercial Organisations (2008)
- Association of the Pharmaceutical Industry (ABPI), Code of Practice for the Pharmaceutical Industry (November 2011)
- The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010)
- The Bribery Act 2010 / NHS Protect – Bribery Act Guidance

DRAFT

Agenda Item
9.1.4

CTM Health Board

Board Committee Annual Reports

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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
Mental Health Act Monitoring Committee	13/05/2025	Endorsed for Board Approval
Quality, Safety & Experience Committee	20/05/2025	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 Mental Health Act Monitoring Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2024 – March 2025 and is attached at Appendix 1 for Board approval.

2.2 The Quality, Safety & Experience Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2024 – March 2025 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 *(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
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 2024/2025:

- Mental Health Act Monitoring Committee;
- Quality, Safety & Experience Committee;

Cwm Taf Morgannwg University Health Board

Annual Report 2024-2025

Mental Health Act Monitoring Committee

Date:

May 2025

MENTAL HEALTH ACT (MHA) MONITORING COMMITTEE
DRAFT ANNUAL REPORT 2024-2025

1. FOREWORD

I am delighted to share the Annual Report for the Mental Health Act Monitoring Committee for the year 2024-2025. This report outlines the Committee's activities and achievements up to March 2025, in accordance with our Terms of Reference.

I would like to express my appreciation to the officers of the Health Board, our Local Authority Partners, and South Wales Police. Their unwavering support and dedication have been instrumental in helping us meet our targets and deadlines.

This year marked a significant change in our committee's leadership. After serving as Chair of the Mental Health Act Monitoring Committee, I transitioned to the role of Vice Chair at the end of December 2024. It is my pleasure to welcome Kath Palmer, Health Board Vice Chair, as the new Chair of the Committee, starting from January 2025.

Throughout the year, the Committee has remained committed to fostering a collaborative culture aimed at enhancing services for the Cwm Taf Morgannwg community. As Vice Chair, I have ensured that our work aligns with the Committee's Terms of Reference and that our efforts are well-coordinated with the Mental Health Act Operational Group.

Geraint Hopkins,
Vice Chair of the Mental Health Act Monitoring Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The MHA Monitoring Committee is chaired by an Independent Member and monitors the Health Board's compliance with the statutory requirements of the MHA. The Committee has continued to evolve with changes to report format and agenda content during the year.

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

The Committee meets on a quarterly basis and, following each meeting, produces a highlight report which is then submitted to the next Board meeting to highlight key issues and risks.

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

The Committee considers:

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

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

3. MEMBERSHIP

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

Independent membership of the Committee during 2024-2025 was as follows:

Geraint Hopkins (Chair of the Committee until December 2024)	Independent Member (From August 2023)
Kath Palmer (Chair of Committee from January 2025)	Vice Chair (From November 2023)
Dilys Jouvenat	Independent Member (From July 2023 – December 2024)
Helen Lentle	Independent Member (From March 2024)
Hayley Proctor	Independent Member (From February 2025)

4. MEETINGS

The MHA Monitoring Committee met on four occasions during 2024/25 and its forward work programme was reviewed to ensure that issues were appropriately prioritised.

The four dates on which it met during 2024-25 were as follows:

- 5th June 2024
- 4th September 2024
- 4th December 2024
- 19th February 2025

Attendance 2024-2025		5th Jun 2024	4th Sept 2024	4th Dec 2024	19th Feb 2025	Total
Geraint Hopkins (Chair until December 2024)	Independent Member	✓	✓	✓	x	3 / 4
Dilys Jouvenat	Independent Member	✓	✓	✓	✓	4 / 4
Kath Palmer (Chair From Jan 2025)	Health Board Vice Chair, Independent Member	✓	✓	✓	✓	4 / 4
Helen Lentle	Independent Member	✓	x	✓	✓	3 / 4
Hayley Proctor (Feb 2025)	Independent Member				✓	1 / 1

All of the above meetings were quorate.

5. MAIN AREAS OF MHAM COMMITTEE ACTIVITY

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

- Part 1 - Preliminary Matters
- Part 2 - Consent Agenda
- Part 3 - Main Agenda
- Part 4 - Governance
- Part 5 - Improving Care
- Part 6 - Other Matters

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB.

Part 2 - Consent Agenda

This section has included receiving the following:

FOR APPROVAL
- Unconfirmed Minutes of previous Meetings
- Committee Annual Report

FOR NOTING
- Committee Annual Self-Assessment
- Annual Cycle of Business
- Terms of Reference
- Action Log

Part 3 - Main Agenda

This section has included reports throughout the year which included:
- Matters Arising not Contained within the Action Log

Part 4 - Governance

This section has included reports throughout the year which included:
- Organisational Risk Register

Part 5 – Improving Care

This section has included reports throughout the year which included:
- MHA Operational Group – Deep Dives
- MHA Quarterly Activity Report – Breaches / Analysis of Unlawful Detentions
- Risks Relating to Monitoring of the MHA
- Crisis Care Concordat National and Local Update
- Strategic Update from South Wales Police
- Strategic Update from Local Authority Partners

Part 6 – Other Matters

This section has included reports throughout the year which included:

- Committee Highlight Report to Board
- Forward Work Programme
- Any Other Urgent Business

Policies Approved by Committee;

- Policy for Section 140 Mental Health Act 1983
- MH09 Operational Procedure for HM Hearings
- Procedure for allocation of responsible clinicians and nominated deputy, mental health act 1983

Other Reports Presented to Committee;

- Progress report on Power of Discharge Committee
- Crisis Care Concordat National and Local Update

Links with Other Committees/Boards

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

6. ACTION LOG

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

7. GOVERNANCE

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

8. ASSURANCE TO THE BOARD

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

The MHA Monitoring Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2024-2025, there are effective measures in place to scrutinise and monitor the application of the MHA.

Appendix 1

Quality, Safety & Experience Committee

Committee Annual Report 2024-2025

QUALITY, SAFETY & EXPERIENCE COMMITTEE
ANNUAL REPORT 2024-2025

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 2024-2025. As a result of the review undertaken into the effective management of Board Business, the name of this Committee changed in January 2025 from the Quality & Safety Committee to the Quality, Safety & Experience Committee.

During the year, I have been supported by Kath Palmer, Vice Chair (and Vice Chair of the Committee), Dilys Jouvenat, Nicola Milligan, Patsy Roseblade, Helen Lentle and Hayley Proctor who have contributed their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my sincere thanks to all the officers of the Committee for their commitment in supporting the Committee in discharging its responsibilities through robust reporting. I would particularly like to extend my thanks to colleagues within the Corporate Governance Team for the support they provided me throughout the year. 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, Llais Cymru and Healthcare Inspectorate Wales colleagues.

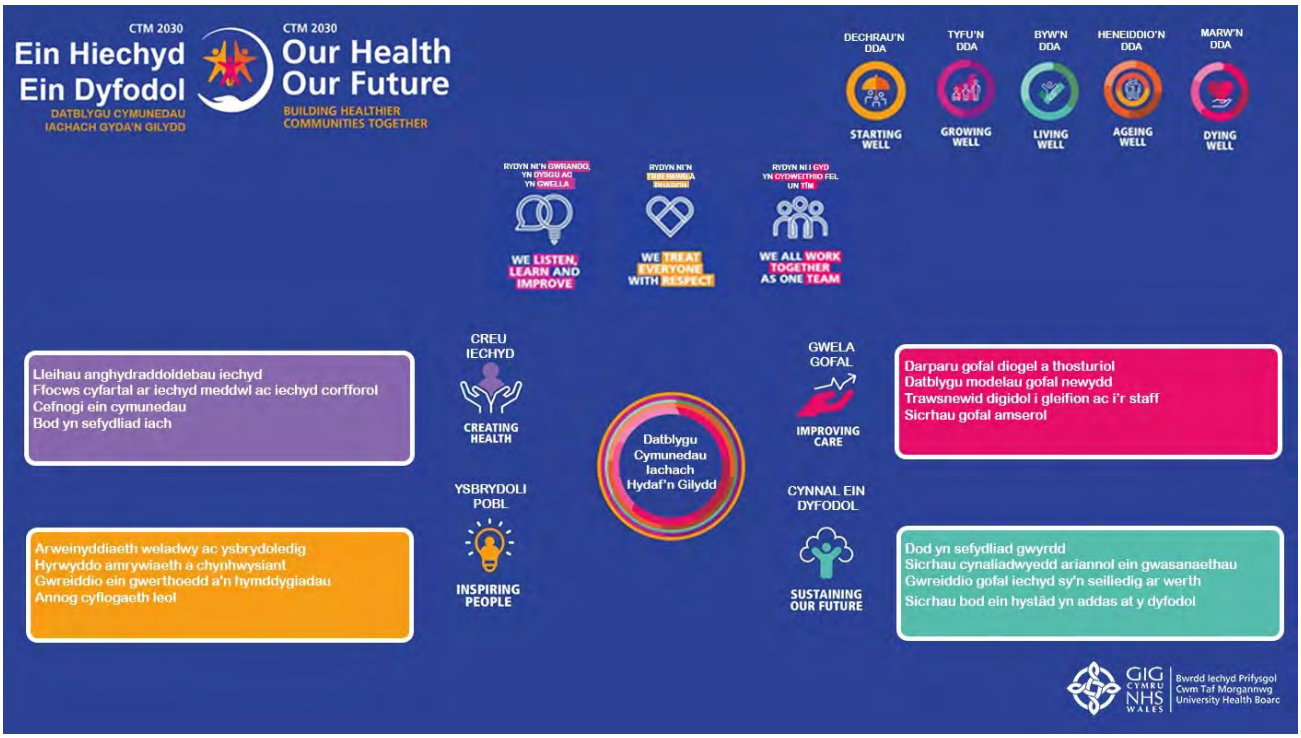
Going forward the Committee will continue to pursue a full programme of work covering quality and safety of care for our population together with matters affecting the health and safety of our workplaces with the aims of promoting learning and further strengthening the governance and assurance arrangements of the Health Board.

Carolyn Donoghue
Chair of the Quality, Safety & Experience Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Quality, Safety & Experience Committee "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.

The Committee has embraced the Strategic Goals in how it manages its agenda to ensure that its activity supports the 'CTM2030: Our Health, Our Future' Strategy and the Values and Behaviours of the Health Board.



The Committee meets every other month, with the key function to provide scrutiny on behalf of the Board on all matters relating to Quality, Safety and Experience.

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 Quality & Safety 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 Committee's Terms of Reference are reviewed annually and are available via the following link.

3.2 MEMBERSHIP

The membership of the Quality, Safety & Experience Committee comprises of six Independent members (this changed to four Independent Members in January 2025 as a result of the review undertaken into the effective management of Board Business), enabling the Committee to provide robust scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2024-2025 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality, Safety & Experience Committee Apr 2024-March 2025

Name	Period
Members	
Carolyn Donoghue (Committee Chair) Independent Member	April 2024 – March 2025
Kath Palmer (Committee Vice Chair) Vice Chair	April 2024 – March 2025
Nicola Milligan Independent Member	Apr 2024 – July 2024
Dilys Jouvenat Independent Member	April 2024 – December 2025
Patsy Roseblade Independent Member	April 2024 – March 2025
Helen Lentle Independent Member	April 2024 – March 2025
Hayley Proctor Independent Member	November 2024 – March 2025

3.3 ATTENDANCE AT QUALITY, SAFETY & EXPERIENCE COMMITTEE 2024 - 2025

During the year, the Committee met on six occasions in public. Five In Committee sessions were also held. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

Public Meeting - In Attendance	16 May 2024	23 July 2024	18 Sept 2024	19 Nov 2024	21 Jan 2025	25 Mar 2025	Total
Independent Members							
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓	✓	✓	✓	✓	✓	6/6
Kath Palmer Vice Chair/Independent Member	✓	✓	✓	✓	✓	x	5/6
Dilys Jouvenat – Independent Member	✓	✓	X	x			2/4
Nicola Milligan – Independent Member (until July 2024)	✓	✓					2/2
Hayley Proctor – Independent Member (from November 2024)				✓	✓	✓	3/3
Patsy Roseblade Independent Member	✓	✓	✓	x	✓	✓	5/6
Helen Lentle – Independent Member (from January 2024)	✓	✓	✓	✓		✓	5/5

In Committee Meeting - In Attendance	16 May 2024	23 July 2024	18 Sept 2024	19 Nov 2024	21 Jan 2025	25 Mar 2025	Total
Independent Members							
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓		✓	✓	✓	✓	5/5
Kath Palmer Vice Chair/Independent Member	✓		✓	✓	✓	x	4/5
Dilys Jouvenat – Independent Member	✓		X	x			1/3
Nicola Milligan – Independent Member (until July 2024)	✓						1/1
Hayley Proctor – Independent Member (from November 2024)				✓	✓	✓	3/3
Patsy Roseblade Independent Member	✓		✓	x	✓	✓	4/5
Helen Lentle – Independent Member (from January 2024)	x		✓	✓		✓	3/4

3.4 ATTENDEES

The Committee's work is informed by reports provided by leads within CTMUHB, Llais Cymru (formerly Cwm Taf Community Health Council), Healthcare Inspectorate Wales, Audit Wales and Internal Audit. Although not members of the Committee, colleagues from these areas are invited to attend each meeting of the Quality, Safety & Experience 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.

4. QUALITY & SAFETY COMMITTEE BUSINESS

The Quality, Safety & Experience Committee provides an essential element of the Health Board's overall assurance framework. All meetings continued to be held virtually via Microsoft Teams during 2024/2025 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Quality, Safety & Experience Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2024/2025 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Quality, Safety & Experience Committee are highlighted at full Board by the Committee Chair via the Committee highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

During the course of 2024-2025, there was one item referred to the Quality, Safety & Experience Committee from the Audit, Risk & Assurance Committee, the details of which are outlined below:

- A detailed discussion required on the reasons for the increases in medical negligence claims with the appropriate executives all being present to answer questions and provide assurance to the committee.

The item above has been scheduled for discussion at the Quality, Safety & Experience Committee taking place on 20 May 2025.

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and from the Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference & Operating Arrangements
- Committee Annual Report
- Highlight Reports from the Committee to the Health Board meetings

- Annual Committee Effectiveness Self-Assessment Survey
- Annual Cycle of Committee Business

The Corporate Governance Team maintain a “Committee Effectiveness Tracker” to ensure the above activity is undertaken at the appropriate times during the year.

Committee Annual Self-Assessment

The Committee is in the process of completing its Annual Self-Assessment for 2024-2025, any learning and themes identified following the assessment will be presented to the Committee for review and consideration.

7. ASSURANCE TO THE BOARD

The Quality, Safety & Experience Committee considers that on the basis of the work completed by the Committee during 2024 - 2025, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2025-2026 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Listening and Learning Stories (Patient and Staff)
- Learning lessons and sharing best practice
- Maternity & Neonate Services oversight and scrutiny (via the Childrens and Families Care Group Highlight Report)
- Dental Services
- Stroke Services
- Quality Governance arrangements
- Compliance with the Nurse Staffing Levels (Wales) Act
- Quality improvement initiatives
- Scrutiny of any Regulatory and Inspectorate Body reports
- Monitoring the activity considered by the Health, Safety & Fire Sub Committee established in August 2019

In addition the Committee Chair will meet with the lead officers and the Chair of the Board to discuss progress of the work of the Committee.

The Annual Cycle of Committee Business has continued to be presented to each meeting of the Committee during 2024/2025, alongside the Forward Work Programme. This supports and helps identify the key areas of focus for the Committee and is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.

8. LINKS WITH OTHER COMMITTEES

The Quality, Safety & Experience Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Audit, Risk and Assurance Committee, Operational Delivery Committee and the Strategic Development Committee.

As a Sub Committee of the Quality, Safety & Experience Committee, regular highlight reports are received from the Health Safety & Fire Sub Committee. These reports are received via the main agenda when there are items contained within the alert/escalate section, and the consent agenda when there are no items requiring escalation to the Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity 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.

APPENDIX 1

1. Main Agenda

During 2024 – 2025 the following items were received:

- Patient Experience/Listening & Learning Stories;
- Spotlight Presentations on:
    - Maternity/Neonates Metrics and Assurance Framework;
    - Mental Health & Learning Disabilities Quality Improvement Priorities;
    - Diagnostics, Therapies, Pharmacy & Specialties Care Group;
    - Sexual Safety & Safeguarding Briefing;
    - Welsh Ambulance Services NHS Trust (WAST) Joint Investigation Framework Thematic Review;
    - Stroke Unit Temporary Centralisation
- Report from the Clinical Executives;
- Organisational Risk Register – Committee Assigned Risks;
- Infection Prevention & Control End of Year Update;
- Infection, Prevention & Control Strategy;
- New NICE Guidance Process;
- Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chairs Report;
- NHS Wales Joint Commissioning Committee;
- Patient Safety, Quality & Experience Dashboard;
- Nursing & Midwifery Delivery Plan;
- Mental Health Adult Inpatient Improvement Programme;
- Stroke Services Progress Reports;
- Mortality Indicators and Mortality Reviews;
- Committee Annual Self Assessment;
- Body Store Recommendations from Welsh Government;
- Evaluation of the Success of the Falls and Pressure Damage Programme;
- Annual Report for Quality;
- CTMUHB Quality Strategy Work Plan Update;
- Health, Safety & Fire Sub Committee Highlight Reports;
- HMP Parc and Young Persons Unit – a Year on Report;
- Update on Dental Services;
- Human Tissue Authority Reportable Incident Reporting (verbal update also received via In Committee session);
- Impact and Governance around the Management of Medication Shortages;
- Ward Accreditation Progress Report;
- Coroners Cases/Inquests/Case Activity & Lessons Learned;
- Duty of Candour Annual Report;
- CTMUHB Welsh Risk Pool and Legal & Risk Services Annual Review 2023-2024 (an update was also received at an In Committee session on this matter);
- Covid 19 Inquiry Verbal Update;

- Safeguarding Strategy 2024-2027;
- Pressure Ulcer Prevalence Audit 2024;
- Safe Care Partnership 2 and Developing a Quality Management System.

Care Group Highlight Reports continued to be received from the following areas:

- Planned Care;
- Unscheduled Care;
- Children & Families;
- Diagnostics, Therapies, Pharmacy & Sciences;
- Primary Care and Community;
- Mental Health & Learning Disabilities.

The following reports were received at the In Committee Sessions:

- MBRRACE-UK Perinatal Mortality Report: 2022 Births;
- Bridgend Health Visiting Service Update;
- CCTV Cameras Prince Charles Hospital Mortuary Department;
- Listening & Learning Story – Experience of Care received from the CAMHS Services;
- Organisational Risk Register – Committee Assigned Closed Risks;
- Nationally Reportable Incident Cluster Deep Dive – Maternity & Neonatal Services, Princess of Wales Hospital

2. Consent Agenda

During 2024 – 2025 the following items were received on the Consent Agenda for Approval/Endorsement:

- Welsh Language Active Offer Policy;
- Committee Annual Report 2023-2024;
- Committee Terms of Reference;
- Putting Things Right Annual Report;
- Energy Policy;
- Management of High Voltage Electrical Systems Policy;
- CTM Learning Academy;
- Asbestos Management Plan Policy;
- Medical Gases Management Policy;
- Water Safety Plan.

During 2024 – 2025 the following items were received on the Consent Agenda for Noting/Information:

- Action Log;
- Committee Annual Cycle of Business;
- Committee Forward Work Programme;
- Clinical Policies Highlight Report;
- Controlled Drugs Local Intelligence Network Annual Report;
- Cancer Services Annual Report;
- CTMUHB Nosocomial Covid-19 Incident Management Programme Closure Report;
- Human Tissue Authority Act Progress Report;

- Healthcare Inspectorate Wales Action Plan Tracker (also periodically received via the main agenda);
- Recognition of Acute Deterioration and Resuscitation Committee Annual Report;
- Clinical Audit Quarterly Update Report and Clinical Audit Forward Plan for 2025/2026;
- Annual Unpaid Carers Report 2023/2024;
- Joint Commissioning Committee Quality & Patient Safety Committee Chairs Report;
- Infection, Prevention & Control Annual Report;
- Individual Patient Funding Request Annual Report;
- All Wales Learning from Events Framework;
- National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement;
- Safeguarding & Public Protection Annual Report;
- Prescribing Annual Report;
- Clinical Education Annual Report;
- Antimicrobial Resistance Report;
- Organ Donation Committee Annual Report and Organ Donation Sub Committee Highlight Report;
- Access to Medicines Committee Annual Update;
- Report from the Medicines Safety Group;
- CTMUHB Infant Feeding Strategy 2025 - 2030

Health Board Meeting – Non Routine Board Business Forward Plan

(1st January 2025 to the 31st December 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
November 2023	Reference made within the Highlight Report from the Local Partnerships Forum that this item would be presented to a future Board Meeting	Deputy Director of People	Development of the CTM People Plan	Reference made within the Highlight Report from the Local Partnerships Forum that this item would be presented to a future Board Meeting	Deputy Director of People	Executive Director for People	28 March 2024	On agenda Deferred to 30 May 2024/25 July 2024/26 September 2024/27 March 2025 This will now be presented to 29 May 2025 Board Meeting
3 January 2024	Request received from the Assistant Director of Governance & Risk for this item to be added to the forward work programme for Board	Assistant Director of Governance & Risk	Agency Reduction Plan and Decision Making Framework for CTM	To be added to Board Forward work programme following receipt of Welsh Health Circular in January 2024 which identified specific actions for Board/Committees	Deputy Director of People	Executive Director for People	To be agreed	In Progress Awaiting confirmation from the Executive Director for People as to whether this item is still applicable for Board
6 June 2024	Request received by email from the Assistant Director of Transformation	Assistant Director of Transformation	Maesteg Community Hospital Development – Outline Business Case	To be presented to the Board for approval	Assistant Director of Transformation	Executive Director of Strategy & Transformation	28 November 2024/27 March 2025	In Progress Will now be presented to January 2026 Board
	Request received from the Director of Digital asking for this to be added to the Board agenda	Director of Digital	Business Case for Connecting care	To be presented to Board for approval	Director of Digital	Director of Digital	28 November 2024	In progress Awaiting revised date for presentation
4 September 2024	Request received by email from the Assistant Director of Governance & Risk	Chief Executive Officer	Accountability Conditions	To be presented to Board for information and awareness	Chief Of Staff	Chief Executive Officer	28 November 2024 – Deferred to 29 May 2025	In progress Will now be presented to the Board meeting taking place on 31 July 2025 and will feature as part of the Reflection on Cabinet Secretary Priorities, Productivity, Ministerial Advisory Group report
15 November 2024	Request received by email from Chief of Staff	Chief of Staff	Section 33 Agreement	To be presented to Board for approval	Regional Integration Director	Executive Director of Strategy & Transformation	27 March 2025	In progress This item will now be presented to the Board meeting on 31 July 2025 for approval

24 February 2025	Request received by email from the Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	Annual Review of the WBFGA Statement and Objectives	To be presented to Board for approval	Deputy Director of Public Health/Deputy Director of Strategy & Partnerships	Executive Director of Strategy & Transformation	29 May 2025	On agenda This is on the agenda for the May 2025 meeting.
28 February 2025	Request received by email from the Assistant Director of Governance & Risk	Assistant Director of Governance & Risk	Standards of Behaviour Policy	To be presented to Board for approval	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29 May 2025	On agenda This is on the agenda for the May 2025 meeting.
1 April 2025	Request made by the Chair and CEO from debrief meeting held on 1 April 2025	Assistant Director of Governance & Risk	Update on Maternity Incidents at POW	To be presented to Board for discussion	Director of Midwifery	Executive Director of Nursing	29 May 2025	On agenda This is on the agenda for the May 2025 meeting.
11 April 2025	Request made by the Director of Corporate Governance Board Secretary	Director of Corporate Governance/Board Secretary	Establishment of the Regional Joint Committee	To be presented to Board for noting	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29 May 2025	On agenda This is on the agenda for the May 2025 meeting.
16 April 2025	Request made by the CEO at the agenda planning session held in April 2025 for this to be added to the agenda	Director of Corporate Governance/Board Secretary	Reflection on Cabinet Secretary Priorities, Productivity, Ministerial Advisory Group	To be presented to Board for discussion	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	29 May 2025	In progress Was planned for the 29 May 2025 meeting. This will now be presented to the 31 July 2025 meeting
16 April 2025	Request made by the CEO at the agenda planning session held in April 2025 for this to be added to the agenda	Executive Director of Strategy & Transformation	Outline Business Case for Llantrisant Health Park	To be presented to the Board for approval	Executive Director of Strategy & Transformation	Executive Director of Strategy & Transformation	29 May 2025	In progress Was planned for the 29 May 2025 meeting. Will now be presented to an Extra Ordinary Board scheduled for the 10 June 2025
17 April 2025	Request made by email by the Deputy Director for People for this to be added to the agenda for May Board	Deputy Director for People	Recommendation on Shift Patterns	To be presented to the Board for discussion	Deputy Director for People	Executive Director for People	29 May 2025	On agenda This is on the agenda for the May 2025 meeting.
15/05/2025	Reference made to this item by the CEO in the Board Development Session held on 15 May 2025	Executive Director of Finance	Strategic Estates Partnership	To be presented to Board for discussion	Executive Director of Finance	Executive Director of Finance	31 July 2025	In progress Will be presented to the July Board
16/05/2025	Request received by email from the Director of Corporate Governance	Executive Medical Director	Transforming Access to Medicines Service Business Case	To be presented to the Board for approval	Executive Medical Director	Executive Medical Director	31 July 2025	In progress Will be presented to the July Board
19/05/2025	Reference made within the report to Board in relation to establishment of South East Wales Regional Joint Committee	Director of Corporate Governance/Board Secretary	South East Wales Regional Joint Committee Terms of Reference	To be presented to the Board for approval	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	25 September 2025	In progress Will be presented to the September Board
19/05/2025	Request received by email from the Executive Director of Public Health	Executive Director of Public Health	Healthy Weight Roadmap	To be presented to the Board for approval	Executive Director of Public Health	Executive Director of Public Health	31 July 2025	In progress Will be presented to the July Board

19/05/2025	Request received by email from the Executive Director of Public Health	Executive Director of Public Health	Health Protection Framework	To be presented to the Board for approval	Executive Director of Public Health	Executive Director of Public Health	31 July 2025	In progress Will be presented to the July Board
19/05/2025	Reference made to this item at the Briefing session held with Strategic Development Committee Members on 19 May 2025	Chief Operating Officer	Full Business Case – Llantrisant Health Park	To be presented to Board for Approval	Chief Operating Officer	Chief Operating Officer	25 September 2025	In progress Will be presented to September Board
21/05/2025	Request received by email from the Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	Research & Development Strategy 2025 – 20230	To be presented to Board for approval	Executive Director of Nursing/Deputy CEO	Executive Director of Nursing/Deputy CEO	31 July 2025	In progress Will be presented to the July Board
Completed Items								
April 2023	Email request received from the Assistant Director of Governance & Risk following discussion at Executive Leadership Group	Assistant Director of Governance & Risk	Major Incident and Critical Business Continuity Plans	Following discussion at Executive Leadership Group it was requested that this item was presented to Board	Civil Contingencies Manager	Executive Director of Strategy & Transformation	25 May 2023	Completed Received and approved at the Board meeting held on 27 March 2025
21 May 2024	Identified as an item for Board at the Digital & Data Committee held on 21 May 2024	Director of Digital	Digital Cellular Pathology Business Case	To be presented to Board for approval	Director of Digital	Director of Digital	25 July 2024/26 September 2024/28 November 2024/30 January 2025	Completed Received and approved at the Board meeting held on 27 March 2025
4 November 2024	Request received by email from the NHS Wales Joint Commissioning Committee	NHS Wales Joint Commissioning Committee	Annual Update from the Joint Commissioning Committee	To be presented to Board for noting	NHS Wales Joint Commissioning Committee	NHS Wales Joint Commissioning Committee	27 March 2025	Completed Received and discussed at the Board meeting held on 27 March 2025
16 January 2025	Request received by email from the Assistant Director of Clinical Education	Executive Director of Nursing	CTM Learning Academy	To be presented to Board for approval (request made to receive this on the main agenda for discussion)	Assistant Director of Clinical Education	Executive Director of Nursing	27 March 2025	Completed Received and approved at the Board meeting held on 27 March 2025
24 January 2025	Request received by email from the Head of Organisational Development and Inclusion	Head of Organisational Development and Inclusion	Annual Equality Report 2023 – 2024	To be presented to Board for approval	Head of Organisational Development and Inclusion	Executive Director for People	27 March 2025	Completed Received and approved at the Board meeting held on 27 March 2025
20 January 2025	Request received by email from the Assistant Director of Transformation	Assistant Director of Transformation	Charter for Families Bereaved by Public Tragedy	To be presented to Board for approval	Assistant Director of Transformation	Executive Director of Strategy & Transformation	27 March 2025	Completed Received and approved at the Board meeting held on 27 March 2025
18 February 2025	Request received by email from the Assistant Director of Transformation	Assistant Director of Transformation	South East Wales Endoscopy Plans	To be presented to Board for approval	Assistant Director of Transformation	Executive Director of Strategy & Transformation	27 March 2025	Completed Received and approved at the Board meeting held on 27 March 2025
19 February 2025	Request received by email from the Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	Subsidy Control	To be presented to Board for approval	Director of Corporate Governance/Board Secretary	Director of Corporate Governance/Board Secretary	27 March 2025	Completed Received and approved at the Board meeting held on 27 March 2025

CTMUHB Board – Annual Cycle of Board Business

(1st January 2025 to the 31st December 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Board matters and facilitate the management of agendas and Board business. The Annual Cycle of Board Business will be complemented by a "Non-Routine Board Business (Forward Plan)" for 'one-off' Adhoc items raised during the course of meetings.

The role of the Board is set out in CTMUHB's standing orders which is available here: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

The Board meets at least 6 times per annum.

Board Chair:	Board Vice Chair	Executive Leads for Agenda Planning
• Jonathan Morgan, UHB Chair	• Kath Palmer, Vice Chair	• Gareth Watts, Director of Corporate Governance & Board Business

CTMUHB Board Business:

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
Committee Governance Arrangements																
1. Action Log	Director of Corporate Governance / Board Secretary	All Regular Meetings													If all actions are complete	If there are actions in progress / overdue actions
2. Minutes of the previous meeting (Public and Closed Session)	Director of Corporate Governance / Board Secretary	All Regular Meetings														X
3. Non-Routine Committee Business (Forward Plan)	Director of Corporate Governance / Board Secretary	All Regular Meetings														X
4. Annual Cycle of Business	Director of Corporate Governance / Board Secretary	All Regular Meetings													Except for the annual review in November	Annual Review only
5. Annual Report (including Performance Report. Accountability Report and Remuneration Report)	Director of Corporate Governance / Board Secretary	Annually							TBC						X	
6. Annual Statutory Accounts	Executive Director of Finance	Annually							TBC						X	

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
7. Board Effectiveness Self-Assessment	Director of Corporate Governance / Board Secretary	Annually			⚑										X	⚑
8. Board Assurance Framework	Director of Corporate Governance / Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		X	⚑
9. Board Committee and Advisory Group Highlight Reports	Director of Corporate Governance/Board Secretary	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑		⚑ (where there are no matters to escalate)	⚑ (where there are matters to escalate)
10. Board Committee Annual Reports	Director of Corporate Governance & Board Business	Annually							⚑						⚑	X
11. Annual Review of Standing Orders	Director of Corporate Governance/Board Secretary	Annually									⚑				X	⚑
12. Amendments to Standing Orders	Director of Corporate Governance/Board Secretary	As and when required			⚑										⚑	X
13. Joint Committee Annual Update	Director of Corporate Governance/Board Secretary	Annually			⚑										X	⚑
14. Audit Wales Structured Assessment and Audit Letter	Audit Wales	Annually			⚑										X	⚑
15. Audit Wales Annual Audit Report	Audit Wales	Annually			⚑										X	⚑
16. Risk Management Strategy	Director of Corporate Governance/Board Secretary	Annually					⚑								X	⚑
17. Charitable Funds Annual Report and Annual Accounts	Executive Director of Finance	Annually	⚑												X	⚑
18. Internal Audit Annual Audit Plan	Head of Internal Audit	Annually					⚑								⚑	X
19. Executive Director of Public Health Annual Report	Executive Director of Public Health	Annually									⚑				X	⚑
20. Welsh Language Standards Annual Report	Executive Director for People	Annually									⚑				⚑	X

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
21. Putting Things Right Annual Report	Executive Director of Nursing/Deputy Chief Executive	Annually														X
22. Safeguarding Annual Report	Executive Director of Nursing/Deputy Chief Executive	Annually														X
23. Carers Annual Report	Executive Director of Nursing/Deputy Chief Executive	Annually														X
24. Clinical Education Annual Report	Executive Medical Director	Annually														X
25. Infection Prevention & Control Annual Report	Executive Director of Nursing/Deputy Chief Executive	Annually														X
26. Ombudsman's Annual Letter and Annual Report	Executive Director of Nursing/Deputy Chief Executive	Annually														X
Staff and Service User Experience																
27. Shared Listening & Learning Story	Executive Director of Nursing / Deputy CEO	All Regular Meetings													X	
Setting the Scene – Service Delivery																
28. Chairs Report (including Affixing of the Common Seal and Chairs Urgent Action Requests)	Health Board Chair	All Regular Meetings													X	
29. Chief Executives Report (t include updates on Targeted Intervention – Programme of Continuous Improvement in response to Targeted Intervention)	Chief Executive	All Regular Meetings													X	
30. Executive Priorities Update	Chief Executive	Quarterly													X	
Delivering our Plan																
31. Integrated Performance Report (Quality, People & Operational Performance)	Executive Director of Strategy & Transformation	All Regular Meetings													X	
32. Financial Performance Report	Executive Director of Finance	All Regular Meetings													X	

Items of Business	Executive Lead / Or External Representative	Reporting Frequency	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Consent Agenda	Main Agenda
33. Annual Plan Quarterly Update	Executive Director of Strategy & Transformation	Quarterly														X
34. Capital Update	Executive Director of Finance	Quarterly			Defer to May Board										X	
35. Nurse Staffing Levels (Wales) Act Reports	Executive Director of Nursing/Deputy Chief Executive	Bi-Annually													X	
36. Working in Partnerships Updates	Executive Director of Strategy & Transformation	As and When Required													X	
37. Regional Partnerships Board 6 Monthly Report	Executive Director of Strategy & Transformation	Bi-Annually					Defer to July Board									X
38. Public Services Board 6 Monthly Report	Executive Director of Public Health	Bi-Annually														X
Strategic Planning																
39. Integrated Medium Term Plan Approval	Executive Director of Strategy & Transformation	Annually													X	
40. Acute Services Clinical Plan Progress Report	Executive Director of Strategy & Transformation	All Regular Meetings			Not required for this meeting		Not required for this meeting								X	
41. Winter Plan Update	Executive Director of Strategy & Transformation/ Chief Operating Officer	Annually													X	
42. Civil Contingencies & Business Continuity Report	Executive Director of Strategy & Transformation	Annually													X	
43. Emergency Preparedness, Planning & Recovery Annual Report	Executive Director of Strategy & Transformation	Annually														X
44. Llantrisant Health Park Update	Chief Executive Officer	Bi-Annually					Deferred to EO meeting in June 2025								X	

Agenda Item
9.2.3

CTM Health Board

Board Committee and Advisory Group Highlight Reports

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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 March 2025.

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:

- Local Partnerships Forum 18 March 2025 (appendix 1)
- Quality, Safety & Experience Committee 25 March 2025 (on main agenda)
- Remuneration & Terms of Services Committee 13 March and 27 March 2025 (appendix 2)
- Strategic Development Committee 3 April 2025 (on main agenda)
- Operational Delivery Committee 29 April 2025 (on main agenda)
- Stakeholder Reference Group 30 April 2025 (appendix 3)
- Mental Health Act Monitoring Committee 13 May 2025 (appendix 4)

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item
9.2.3 Appendix 1

CTM Health Board

Highlight Report from the Local Partnership Forum

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Nerys Heightley, Business Support Manager
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Hywel Daniel, Executive Director for People
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	
Welsh Government	WG
Princess of Wales Hospital	POW
Royal Glamorgan Hospital	RGH

Prince Charles Hospital	PCH
Integrated Medium Term Plan	IMTP

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Local Partnership Forum, at its meeting on 18th March 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the LPF is to provide regular and formal dialogue between the Executive Directors and trade union / staff organisation colleagues. The meeting allows all parties to engage with each other to inform, debate and to seek to agree local priorities, on workforce and health service issues.

2.2 The LPF will provide the formal mechanism for consultation, negotiation and communication between the trade union organisations and the Health Board's management.

2.3 The meeting agenda is structured in two parts. Part 1 is the Business Part focused on operational matters, primarily with members of the People Directorate. Part 2 provides opportunity for engagement on Health Board strategic matters.

3. Highlight Report

Alert / Escalate	• There were no items requiring escalation to the Board on this occasion.
Advise	• A number of areas were escalated to the LPF by Care Groups, including the unknown date of return of Trauma & Orthopaedics to POWH which is causing staff uncertainty, the lack of provision of a pelvic floor service within CTMUHB or outside of the Health Board with options currently being explored with NHS England, the work being undertaken with Managers to address the bank holiday pay dispute being raised by staff within Radiology at POWH and the staffing issues within Radiology which

	are in the process of being addressed in partnership with Trade Union colleagues and the People Services Team. • The impact of the National Minimum Wage (NMW), in respect of staff wishing to purchase items through a salary sacrifice scheme was discussed. It was confirmed that should such a purchase reduce a staff member's pay below this level, their application will not be approved. This matter was discussed recently with HMRC who confirmed the Health Board's approach was correct. It was noted that the Health Board has a supportive process in place to assist those staff who are already benefiting from such a scheme, but their rate of pay falls below the NMW rate. This process involves pausing the staff payments until their pay rises to the NMW rate again. • Concerns were raised from TU colleagues regarding staff not feeling empowered to report inappropriate behaviour that they receive from patients. The staff impression is that the Health Board just expects them to put up with poor behaviour from patients. The behaviours discussed were situations where patients are confrontational and staff left feeling intimidated, without having the skills to de-escalate the situation. The group discussed ways in which this could be addressed and learning from processes in the Mental Health team would be sought. • The draft plan for a staff recognition event, in September 2025, was shared, including potential venues, attendee considerations, and award categories. The event aims to celebrate staff achievements and foster engagement.
Assure	• The Workforce Metric Report showed the 12-month rolling turnover has continued to reduce across the last 12 months, from 11.38% at the end of February 2024 to 10.17% at the end of January 2025. Healthcare Support Worker (HCSW) turnover remains high at 10.60% at January 2025, but this is down from a peak of 12.75% in November 2023. The rolling 12-month sickness rate reported at the end of December 2024 was 7.98%. Overall Health Board compliance for level 1 subjects remains buoyant at 80.76% as at February 2025 (+1.91% year on year). Overall PDR compliance remains stable at 65.94% as at February 2025. With regard to recruitment, year to date, the average position is reporting 77.6 days

	against a 71-day target to fill our vacancies, at the end of January 2025.
Inform	• A Welsh Health Circular has confirmed the hourly rate for Band 1 – 3 staff will increase from £12.00 to £12.60 from 1 April 2025, to comply with the Real Living Wages, which is higher than the NMW. • The Workforce Planning Team are exploring with HEIW the ability to increase the number of places for mental health support workers. They are currently working on the Education Commissioning, which is due to be submitted by 31 March 2025. The impact of registered Nursing Associates on training pathways was discussed, noting that the training requirements may change and affect the current pathways. • The staff survey results were shared, highlighting an increase in response rate and a slight drop in the engagement score. The People Directorate are looking at ways the organisation can address the key themes identified in the survey, such as staffing, management, and wellbeing. • An update on the development of the IMTP was shared, which aims to meet statutory requirements and improve healthcare services. A ministerial template has been completed for the measurable areas which will go to Board this month for approval. The plan will include a focus on population health, women's health, reducing inequalities and plans for a women's hub, following receipt of national guidance. WG has asked for further details on our plan for diabetes and the Creating Health Strategic Plan which has been approved by the Board. Further submissions from Care Groups were submitted last week, before confirming the plan. • The key points from the finance update were shared. The M10 position saw a small surplus and the M10 YTD position is now a £0.2m deficit. The forecast position for year-end is a break-even position, should the M10 position be maintained. This situation is being helped due to the WG providing the Health Board with an additional £7.5m to fund continued demand and inflationary pressures.

	The forecast recurrent position has deteriorated to £10.7m in M10 (£9.5m in M9). The net risks to the forecast break even position at M10 are £1.0m (£2.7m in M9). The latest Capital Resource Limit for 2024/25, issued on the 10 February 2025, was £92.98m. Expenditure to M10 was £55.3m
Appendices	• Not Applicable

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: Creating Health Improving Care Sustaining our Future
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 Prosperous Wales
	If more than one applies, please list below: A Resilient Wales A Healthier Wales A More Equal Wales
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: Leadership Learning Improvement 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))*	Person Centred
	If more than one applies, please list below: Effective Efficient Equitable 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:	If no, please include rationale below: NA
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: NA
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 from the Local Partnership Forum held on the 18 March 2025, outlined in section 3 of this 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	29/05/2025
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 meeting on the 13 March 2025 and 27 March 2025.

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	13 March 2025 Appointment to the Executive Director of Strategy & Transformation The Committee approved the appointment and remuneration arrangements proposed for the appointment to the role of Executive Director of Strategy and Transformation. 27 March 2025 Appointment to the Interim Executive Director of Strategy & Transformation on a Temporary Secondment Basis The Committee approved the appointment and remuneration arrangements proposed for the appointment to the role of Interim Executive Director of Strategy and Transformation on a temporary secondment basis whilst the commencement of the substantive post holder is awaited. Redundancy Case The Committee approved a retrospective redundancy matter.
Assure	Nil

Inform	Nil
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 *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Equitable 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	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate):	If no, please include rationale below: N/A

Have you undertaken an Equality and Welsh Language Impact Assessment Screening?	POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	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 Stakeholder Reference Group

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Victoria Oxley, Interim Executive Director of Strategy & Transformation
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Victoria Oxley, Interim Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Victoria Oxley, Interim 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
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
IMTP	Integrated Medium Term Plan
SRG	Stakeholder Reference Group
POWH	Princess of Wales Hospital

PCH	Prince Charles Hospital
UNCRC	United Nations Convention on the Rights of the Child
CTMUHB	Cwm Taf Morgannwg University Health Board
WHO	World Health Organisation
NEST Framework	Nurturing, Empowering, Safe, Trust- Framework

1. Introduction

1.1 This report has been prepared to provide the Board with details of the key issues considered by the CTMUHB Stakeholder Reference Group at its meeting on 30th April 2025.

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

2. Purpose of this Meeting

2.1 The purpose of the CTMUHB Stakeholder Reference Group is to provide independent advice on any aspect of UHB business. This may include: -

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

2.2 The CTUHB Stakeholder Reference Group will: -

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

3. Highlight Report

Alert / Escalate	There were no items requiring escalation to the Board on this occasion.

Advise	• Introduction and welcome to the new Chair Members noted that confirmation had been received from the Cabinet Secretary that Councillor Deenik has been confirmed as a CTM Associate Board Member and Chair of the SRG. This will be for an initial period of 2 years from 1 May 2025 until 30 April 2027. • Thanks, extended to preceding Chair Elizabeth Beadle thanked Anne Morris for her hard work, commitment and tenure as Chair, and noted that Anne will continue as a Member of the SRG.
Assure	• Robotic Surgery An enlightening and informative presentation by Mr Paul Blake, Consultant Colorectal Surgical Lead for Robotic Surgery offered an overview of the introduction and use of Robotic Surgery in CTMUHB. In Wales, over 2,200 people are diagnosed with colorectal cancer every year. Robotic Surgery has been identified as a key technology to deliver the greatest impact for improving outcomes for patients, allowing surgeons to perform complex procedures with more flexibility, precision and control than conventional techniques. CTMUHB is striving towards a centre of surgical excellence, offering patients the most advanced form of minimally invasive surgery, reducing post-operative recovery time, blood loss, pain, complications and use of ITU beds. A film was shared from a patient discussing her experience of Robotic Surgery https://www.youtube.com/watch?app=desktop&v=_yuWpEcxf2s&feature=youtu.be Revolutionary robotic technology to transform surgery at CTM - Cwm Taf Morgannwg University Health Board • CTM Infant Feeding Strategy and Breastfeeding Workplace Policy Members received a presentation from the Infant Feeding Coordinator and the Neonatal Infant Feeding Coordinator on the CTM Infant Feeding Strategy and Breastfeeding Workplace Policy, and noted the aims of the strategy The aims of the Infant Feeding Strategy are:

- To ensure families are supported to make choices in relation to feeding and nurturing their child.
- To increase the numbers of mothers providing breastmilk to their babies.
- To create a supportive culture by normalising breastfeeding.
- To work collaboratively to drive improvements in health and wellbeing across the population of CTMUHB, including the promotion of secure parent-infant relationships.
- To support families who choose to formula feed to do so safely and responsively.

New Infant Feeding Strategy launched - Cwm Taf Morgannwg University Health Board

- CTMUHB Breastfeeding at Work Policy

Members received and noted the CTMUHB Breastfeeding at Work Policy and noted the aims and intentions of the policy:

- Support employee wellbeing, boosting morale, staff retention, recruitment and breastfeeding continuation
- Reflect the CTMUHB 2030 Strategy: Reducing inequalities and promoting health.
- Support the CTMUHB Infant Feeding Strategy.
- Recognise the importance of equality, health and safety and human rights. The WHO recommends breastfeeding for up to 2 years (or beyond).

- CTM Baby and Toddler Voice

Members received an update on the CTM Baby and Toddler Voice initiative and noted the importance of a secure parent infant relationship across the first 1000 days (from pregnancy to the age of two) and the launch of the CTM Baby and Toddler Voice statements across CTM on the 17 March 2025.

CTM Baby and Toddler Voice Statements Launched - Cwm Taf Morgannwg University Health Board

Inform	• IMTP Update Members received an update on the IMTP which had been completed and submitted to Welsh Government at the end of March 2025. Members noted that the IMTP contained a balanced financial plan and identified areas for future investment, however this plan requires significant savings to be delivered by the health board. Members noted that further consideration would be given to the suggestion made during the meeting for SRG members to provide input to the performance indicators used by the health board. The reporting framework to the health board will be changing this year and the feedback will also be able to be shared with the SRG for their views. • Service Change Update Members received an update on key service changes within the Health Board, including the review being undertaken of the impact and evaluation of the stroke service changes, the closure of Cefn y Afon Rehabilitation Unit and the ongoing monitoring to ensure services were fit for purpose and the continued work being undertaken at POW to address the works required to the roof. It was agreed that monthly service change updates prepared for Welsh Government would be shared with the SRG for their consideration. • Any Other Business It was noted that parking disruption in the RGH have been raised as a consequence of the temporary increase in surgical and endoscopy procedures following the installation of the new Vanguard Facilities. This has resulted in an impressive number of patients accessing services. Any updates will be available through the Health Board's social media feeds. An issue with the use of the *My Health Online* appt was raised with several Members detailing difficulties in ordering medication online. An alternative suggestion proposed was to liaise directly with pharmacies to negotiate repeat prescriptions. This will be explored with Pharmacy and Digital colleagues.
Appendices	

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))* / 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	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A

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:
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
9.2.3e

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE MENTAL HEALTH ACT MONITORING COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
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, Vice Chair of the Mental Health Act Monitoring Committee
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

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 13 May 2025.

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	There were no areas to alert/escalate on this occasion.
ADVISE	• The Organisational Risk Register has been received and reviewed. Members were assured that discussions regarding the 'Right Care, Right Person' initiative are continuing. • The Committee received the Annual Self-Assessment and acknowledged positive feedback alongside identified areas for improvement. Training needs were discussed, with Members asked to clarify specific requirements to support their development effectively. • The Committee ENDORSED the Committee Annual Report for Board approval, with acknowledgement of member contributions and efforts throughout the year. • The Committee reviewed the MHA Quarterly Activity Report, noting significant findings including a reduction in adult detentions, the application of doctors' and nursing holding powers, the use of the adolescent bed, lapses in sections, and positive feedback from Health Inspectorate Wales. • The Committee reviewed risks related to monitoring the Mental Health Act, focusing on challenges with medical staffing and the necessity for a national transport solution.

	It was agreed that the Mental Health Act team would oversee these risks and escalate issues as needed. • Members received an update from Local Authority Partners highlighting key themes, including changes in recording systems, challenges with police support, and concerns regarding proposed amendments to the mental health bill. • The Committee received a report from the Power of Discharge Committee during an in-Committee meeting. It was agreed to conduct a review of governance arrangements, including consideration of establishing a Vice Chair role for enhanced oversight.
ASSURE	• The Committee NOTED the Deep Dive Spotlight on Older Persons Mental Health Detentions within the RCT Area, which provided assurance that detention levels remained stable overall, with an investigated Q1 spike confirmed to be within normal limits. • The Committee NOTED the MHA Operational Group Report, which showcased positive feedback from Health Inspectorate Wales and emphasised ongoing efforts related to Section 117 aftercare.
INFORM	• The Committee approved the minutes from the meeting on 19th February and noted the forward work plan and annual cycle of business.

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 /	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: ☐	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

Internal Audit Plan
2025/26

Cwm Taf Morgannwg University Health Board

Contents

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

1. Introduction

This document sets out the Internal Audit Plan for 2025/26 (the 'Plan') detailing the audits to be undertaken and information of the corresponding resources. It also contains the Internal Audit Mandate and Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board's Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit, Risk and Assurance Committee (or the 'Audit Committee'), with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the key findings and agreed actions from internal audit reviews may be used by Cwm Taf Morgannwg University Health Board's (the 'Health Board's' or the 'organisation's') management to improve governance, risk management, and control within their operational areas.

In January 2025 new Global Internal Audit Standards (the 'Standards') became effective and apply to UK public sector audits from 1 April 2025 to align with the financial year. These new standards replace the previous guidance: the Public Sector Internal Audit Standards. The new Standards are accompanied by a UK public sector application note (the 'Application Note'), which provides public sector interpretations and additional requirements for the Standards The new Standards require that a risk based internal audit plan is created that supports the achievement of the organisation's objectives.

Accordingly, this document sets out the risk-based approach and the Plan for 2025/26. The Plan will be delivered in accordance with the Internal Audit Mandate and Charter and the agreed KPIs, which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by other organisations on behalf of NHS Wales. These are: Digital Health and Care Wales (DHCW); NHS Wales Shared Services Partnership (NWSSP); and the NHS Wales Joint Commissioning Committee (JCC), which replaced EASC and WHSSC from April 2024. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for the JCC), but the results, as in previous years, are reported to the relevant health organisations and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Global Internal Audit Standards

The Plan has been developed in accordance with Principle 9: Plan Strategically, which includes Standard 9.4 – Internal Audit Plan, of the Standards, and the accompanying Application Note, which provides public sector interpretations and additional requirements for the Standards, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals.
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks.
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work.
- confirmation of the audit resources required to deliver the Internal Audit Plan.
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning considers the NHS Wales Planning Framework and other NHS Wales priorities and is mindful of significant national changes that are taking place. In addition, the Plan aims to reflect the significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging

issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Mandate and Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the 'audit universe'). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Director of Corporate Governance (Board Secretary) and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at health boards only.

Therefore, our Plan is made up of several key components:

1) Consideration of key governance and risk areas: We have identified several areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover the Governance, the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management, and an overall assessment of Digital and Information Technology. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers strategic risks and priorities from the Board Assurance Framework and the risks identified in the organisational risk register, together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up - this is follow-up work on previous 'limited' and 'unsatisfactory' assurance reports as well as other medium and high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by several organisations. This may be advisory work to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that may impact on the Health Board, namely NHS Wales Shared Services Partnership (NWSSP), Digital Health and Care Wales (DHCW), and the JCC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the final business case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the

Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- A review of the Health Board's vision, values and forward priorities as outlined in the Integrated Medium Term Plan (IMTP) and long term strategy.
- An assessment of the Health Board's governance and assurance arrangements and the contents of the organisational risk register.
- Risks identified in papers to the Board and its Committees (in particular the Audit, Risk and Assurance Committee, the Operational Delivery Committee, and the Quality, Safety and Experience Committee).
- Strategic risks identified within the Board Assurance Framework and significant risks identified within the organisational risk register and assurance processes.
- Discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility, including compliance and ethics programmes.
- Cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions).
- New developments and service changes.
- Legislative requirements to which the organisation is required to comply.
- Planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC.
- Work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV), where appropriate.
- Work undertaken by other review bodies, including Audit Wales and Healthcare Inspectorate Wales (HIW).
- Coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with the executive team and independent members to discuss current areas of risk and related assurance needs.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Board Assurance Framework and organisational risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also considers corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2025/26

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan refers to key strategic risks identified within the organisational risk register and related systems of assurance, together with the proposed audit response within the outline scope.

When developing the audit scope, in discussion with the responsible executive director(s) and operational management, the scope, objectives and audit resource requirements, and timing will be refined in each area.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

Most of the audit work will be undertaken by our regionally based teams with support from our national capital and estates team, in terms of capital audit and estates assurance work, and from our digital and IT team, in terms of information governance, IT security and digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose. To this end, the need for flexibility and a revisit of the focus and timing of the proposed work will be necessary at some point during the year.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the executive team

and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales, as your External Auditor, will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The Plan has been put together based on the planning process described in this document. The Plan includes sufficient audit work to be able to give an annual Head of Internal Audit opinion in line with the requirements of Standard 11.3 – Communicating Results, and Application Note 10B – Overall conclusions and annual reporting.

Audit & Assurance Services confirms that it has the necessary human, financial and technological resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan is required during the year over and above the total indicative resource requirement a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, as in previous years, capital audit work in relation to the Prince Charles Hospital refurbishment project will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. A provision for this work was included by the Health Board in its business case submission.

6. Action required

The Audit and Corporate Governance Committee is invited to consider the Internal Audit Plan for 2025/26 and:

- approve the Internal Audit Plan for 2025/26;
- approve the Internal Audit Mandate and Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Paul Dalton
Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2025/26

Planned output, Outline scope, Review reference	Risk reference	Executive Lead/Responsible Director	Planned quarter to start
1. Continuing Health Care To include controls process for approvals.	5903	Chief Operating Officer	Q1
2. Outpatient booking process Compliance with policy.	SRR1a	Chief Operating Officer	Q3
3. Medical annual leave and rostering To consider the annual leave and rostering processes. Focus TBC.	SRR3	Chief Operating Officer	Q4
4. Operational response to critical incident To consider the actions taken by the Health Board to instigate and manage the critical incident.	5932	Chief Operating Officer	Q1
5. Medical sickness records To ensure medical staff have followed the sickness process for short term sickness - compliance with policy.	SRR3	Medical Director/ Director of People	Q2
6. Speaking up safely (SuS) To review the arrangements in place for staff to raise concerns through the Speaking Up Safely process, and how these are reviewed, resolved and reported.	SRR7	Director of Governance/ Director of People	Q4
7. Risk management Focus to be determined, but likely to focus on Board Assurance Framework.	-	Director of Governance	Q3
8. Establishment of new committee structure To consider the operating effectiveness of the new committee structure.	SRR3	Director of Governance	Q4
9. Clinical coding To consider the Health Board's process and plan for timely and accurate clinical coding. Focus on waiting list patients. Work to be undertaken by our digital team. Deferred from 2024/25.	SRR6/4672	Director of Digital	Q1/Q2

Planned output, Outline scope, Review reference	Risk reference	Executive Lead / Responsible Director	Planned quarter to start
10. Cyber Security Focus on governance and risk appetite. Would ensure that there is no overlap with Cyber Resilience Unit (CRU).	4664	Director of Digital	Q3
11. Bridgend Disaggregation Post project implementation to ensure the single PAS is operating effectively.	SRR5/4337	Director of Digital	Q3
12. Welsh Risk Pool (WRP) Annual review as required by the WRP standards.	-	Director of Nursing	Q4
13. Falls management New programme and comes together with harm free events.	SRR2	Director of Nursing	Q3
14. Ward audits Consideration of the process with particular focus on safe to start and quality metrics.	SRR2	Director of Nursing	Q4
15. Long term strategy Consideration of implementation and reporting and governance arrangements.	SRR4	Director of Strategy	Q4
16. Stroke management process Focus on process and outcomes. Possible consideration of deployment of action plans to improve stroke performance and risk mitigations. Deferred from 24/25.	SRR1/4632	Dir of AHP&HS	Q2
17. Financial systems To agree focus, but to consider arrangements between the Health Board and NWSSP.	-	Director of Finance	Q4
18. Savings To consider the process, governance, reporting and management of mitigating actions. Focus on the four centrally lead schemes.	SRR10/5765	Director of Finance	Q2
19. Princess of Wales Hospital (PoW) roof replacement	5932	Director of Finance	Q3

Planned output, Outline scope, Review reference	Risk reference	Executive Lead / Responsible Director	Planned quarter to start
This audit of the PoW roof replacement project recognises the approved Welsh Government funding provision and the targeted completion during Autumn 2025. The audit will focus on the project delivery arrangements through to completion and handover.			
20. Estates assurance – Asbestos Management To evaluate the controls and practices in place within the Health Board to ensure that the key asbestos regulatory requirements are adequately addressed and appropriate management arrangements were embedded within the organisation.	SRR8	Director of Finance	Q2
Follow up work			
21. End of life care management To re-audit objectives from the previous year limited assurance report.	-	Chief Operating Officer	TBC
22. Gastro-Intestinal demand management To re-audit objectives from the previous year limited assurance report.	-	Chief Operating Officer	TBC
23. Medical job planning To re-audit objectives from the previous year limited assurance report.	-	Medical Director	TBC
24. Additional medical pay To re-audit objectives from the previous year limited assurance report.	-	Medical Director/ Director of People	TBC
25. Interventions not normally used (INNU) To re-audit objectives from the previous year limited assurance report.	-	Chief Operating Officer	TBC
26. Capital systems Previous year limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee.	-	Director of Finance	TBC

Planned output, Outline scope, Review reference	Risk reference	Executive Lead / Responsible Director	Planned quarter to start
27. Estates assurance Previous limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee.	-	Director of Finance	TBC
28. Digital benefits realisation Previous year limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee.	-	Director of Digital	TBC
29. Vaccination policy implementation Previous year limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee.	-	Director of Public Health	TBC
30. Decarbonisation Previous limited assurance report. To review the progress made against actions agreed in the original audit report. Timing of follow up work will be after management have reported actions as closed to the Audit Committee.	-	Director of Strategy	TBC
Other activity			
NHS Wales - Joint Commissioning Committee (JCC) We plan to meet with the JCC to identify a programme of work for 2025/26.	-	-	-
Integrated Audit and Assurance plans			
Management of Prince Charles Hospital capital project See Separate Integrated Audit & Assurance Plan (IAAP).	-	Director of Finance	Q1-Q4

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2025/26
Audit plan 2025/26 agreed/in draft by 30 April	⚑	To deliver plan
Audit opinion 2024/25 delivered by 31 May	⚑	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	⚑	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	⚑	95%
Report turnaround management response to draft report [15 working days maximum]	⚑	80%
Report turnaround draft response to final reporting [10 working days]	⚑	95%

Appendix C: Internal Audit Mandate and Charter

1 Introduction

1.1 This Mandate and Charter is produced and updated annually to comply with the Global Internal Audit Standards (introduced from 1 April 2025 for the UK Public Sector). The Standards (with specific reference to Standard 6.1 Internal Audit Mandate and 6.2 Internal Audit Charter) require the production and maintaining of an Internal Audit Mandate and Charter that, at a minimum, sets out:

- The purpose of Internal Auditing;
- a commitment to adhere to the Global Internal Audit Standards;
- the Mandate, including the scope and types of services to be provided, and the Board's responsibilities and expectations regarding management's support of the internal audit function; and
- the organisational position and reporting relationships, including Independence.

The Mandate and Charter are complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Mandate and Charter:

- Board means the Board of Cwm Taf Morgannwg University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Cwm Taf Morgannwg University Health Board. The Chief Executive has made arrangements within this Mandate and Charter for an operational interface with internal audit activity through the Director of Corporate Governance (Board Secretary).

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of the Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives.
- the appropriate assessment and management of risk, and the related system of assurance.
- the arrangements to monitor performance and secure value for money in the use of resources.
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets.
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence is described in the Global Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit mandate and charter.
- approving the risk based internal audit plan.
- approving the internal audit resource plan.
- receiving outcomes of all internal audit work together with the assurance rating. and

- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Mandate and Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Mandate and Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Global Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any

committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Director of Corporate Governance will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Director of Corporate Governance in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, the Joint Commissioning Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Global Internal Audit Standards and the UK Public Sector Application Note in discharging its responsibilities.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes several Key Performance Indicators, and we will agree with each Audit Committee which of these they want

reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance.
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice.
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned.
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the organisational risk register.
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance.
- ensuring effective co-ordination, as appropriate, with external auditors and other regulators.
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation’s risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Mandate and Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Mandate and Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales equirements of the Mandate & Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement.
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work.

- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan'.
- effective co-operation with external auditors and other review bodies functioning in the organisation. and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Director of Corporate Governance.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:

  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

  b) Disclose any qualification to that opinion, together with the reasons for the qualification.

  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies.

  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual

Governance Statement.

e) Compare work undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria. and

f) Provide a statement of conformity in terms of compliance with the Global Internal Audit Standards and associated internal quality assurance arrangements.

- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage.
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director.
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations.
- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken.
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate, or disagreement remains then the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately.
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Director of Corporate Governance. The Head of Internal Audit may present the draft report to the Audit Committee where no

management response is forthcoming.

- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Director of Corporate Governance and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Director of Corporate Governance and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access is granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Global Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Global Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Mandate and Charter

14.1 This Internal Audit Mandate and Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit, Risk and Assurance Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
May 2025

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Mandate and Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to independent members or officers including those designated as Accountable Officer. They are prepared for the sole use of Cwm Taf Morgannwg University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given regarding the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Cwm Taf Morgannwg University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Global Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023. Please note that new Global Internal Audit Standards apply from April 2025, and all future audit work will comply to these new Standards.

Agenda Item
9.2.5

CTM Health Board

IMTP 2024-2027 – Quarter Four Review

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Elizabeth Beadle, Assistant Director of Transformation
Cyflwynydd yr Adroddiad / Report Presenter	Victoria Oxley, Interim Executive Director of Strategy and Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Victoria Oxley, Interim Executive Director of Strategy and 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
Operational Delivery Committee	29/04/2025	NOTED

Acronyms / Glossary of Terms	
CAMHS	Child & Adolescent Mental Health Services
WAST	Welsh Ambulance NHS Trust

1. Situation /Background

1.1 Developing an integrated medium term (three-year) plan (IMTP) is a statutory duty for all Welsh health boards alongside the associated duty to achieve a financial break-even position during the three-year period, in accordance with section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014)

1.2 The Board approved the 2024-2027 draft plan for submission to Welsh Government on 28th March 2024.Welsh Government formally approved the Health Board's three-year plan in the summer.

1.3 The 2024-2027 plan is presented as a balanced three-year financial plan, although risks to delivery were assessed and noted during the plan development process.

2. Specific Matters for Consideration

2.1 Following formal approval of the Health Board's IMTP in March 2024, work commenced on delivery of the agreed plans.

2.2 This report provides a summary of the progress to the end of the year.

2.3 The primary measure of impact for the delivery of the IMTP is in the integrated performance report (IPR). This is not replicated here. The secondary measure of progress is in delivery of the actions as set out in the IMTP. Each care group has developed high level plans on a page, supported by more detailed service plans. In addition, there are six ministerial templates which provide detail of actions and milestones for delivery and are included as appendices to this report. These cover the five primary ministerial areas of focus as set out in the NHS Wales Planning Framework 2024-25:

2.3.1 Enhancing care in the community, with a focus on reducing delayed pathways of care
2.3.2 Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.
2.3.3 Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.
2.3.4 Planned Care and Cancer, with a focus on reducing the longest waits.
2.3.5 Mental Health, including CAMHS, with a focus on delivery of the national programme.

2.4 This report focuses on the delivery of actions as set out in the ministerial templates. However, for diagnostic and therapies there was not a specific template requirement for the IMTP, so a summary of key actions has been provided.

Pathways of care

2.5 The two key work programmes in this area are the further progress of the navigation hub and the development of a health board-wide model of integrated teams and focus on the development of Extended Community Care plus redesign of the community hospital model to improve flow and reduce package of care delays.

2.6 Key progress and deliver in quarter four is set out below:

Scoping mandate for care homes to contact the Clinical Navigation Hub before 999 unless deemed a life-threatening emergency

- Care home performance: during January 2025 84.4% of care home referrals avoided conveyance. This represented a slight drop in performance from the previous period.
- WAST continue to roll out the LUSCII project which is a new initiative with the Welsh Ambulance service which will see staff in some care homes trained to apply wearable tech on patients so observations can be monitored remotely by the WAST clinical desk until a resource is deployed.

Overall Navigation Hub Performance

- Navigation Hub performance averaged 85.18% during January and February. March data is being validated. The highest successful intervention rate since January 2024 is 87.4%.

Package of care delays

- The target of 20% reduction in total delays target was achieved and exceeded.
- The target of a 24% reduction in days delayed target was achieved and exceeded.
- The 28% reduction in assessment delays target was achieved and exceeded.

Primary Care Access

2.7 Progress continues to be made across a number of areas.

- General Medical services continue to deliver 100% compliance with all national access standards for in-hours.
- General dental services exceeded the anticipated patient contacts set as milestones for quarters two and three. Quarter four data is awaited pending completion of final validation of March data.

Urgent and Emergency Care

2.8 Same Day Emergency Care (SDEC): Preparation has been undertaken to launch STAMP at the Princess of Wales Hospital during April and May.

2.9 Proposals to recruit additional COTE consultants have been submitted as part of the IMTP planning for 2025-2028, to ensure equity of provision of frailty services at the front door across all sites.

2.10 SDEC activity, both medical and surgical has increased across all sites (based on January data).

- RGH Medical – 37%
- POW Medical – 24%
- PCH Medical – 15%
- RGH Surgical – 53%
- POW Surgical – 17%

2.11 Ambulance handover performance for March is undergoing validation. Pre-emptive measures already in place to create space for handovers by reassigning patients into bed spaces or where patients may become fit to sit.

Planned Care

2.12 The final referral to treatment time delivery for March 2025 was 892.

2.13 The Productivity, Innovation and Transformation Board meets regularly to provide a structure to deliver improvement.

Mental Health and CAMHS

2.14 Performance in Q4 maintained compliance with the national targets, with 81.6% of assessments undertaken by the Local Primary Mental Health Service within 28 days of receipt of referral (against a target of 80%).

2.15 88.8% of therapeutic interventions commenced within 28 days.

Diagnostics

2.16 2.13 Work has continued to progress on the regional diagnostic programme which is facilitated by the health board on behalf of the South East Wales region. Business cases for community diagnostic hubs for radiology services and regional endoscopy services were considered by the health board in November and a regional endoscopy plan has been completed which has been considered by Aneurin Bevan and Cardiff and Vale Health Boards. Final approval is pending and this will enable the next phase of the programme to begin, including procurement for a preferred supplier.

3. Key Risks / Matters for Escalation

3.1 This report presents the end of year performance against the 2024-25 measures in our IMTP. The new IMTP for 2025-2028 has been completed and approved by the board on 27th March. Work will commence on implementing these plans, with quarterly updates provided for the Operational Development Committee and 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	Ageing Well
	If more than one applies please list below: All are applicable.
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))*	Effective
	If more than one applies please list below: All quality domains apply.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Choose an item.
	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)* / Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.
	Resources for delivery of the IMTP are included in the financial plan.

5. Recommendation

5.1 The Board is requested to:

5.1.1 Note the progress of the IMTP actions and performance as set out in the report and the appended documents.

5.1.2 Note the completion of the 2025-2028 IMTP and the plan to provide quarterly updates.

6. Next Steps

6.1 This report completes the reporting on the 2024-2025 actions of the IMTP and the committee will receive quarterly updates on progress of 2025-2026 actions alongside the formal reporting mechanisms in place for the requirements of the NHS Wales Performance Framework, via the Integrated Performance Report.

NHS WALES PLANNING FRAMEWORK 24-27- Primary and Community Care

Priority area(s) to deliver 24/25:				
Key focus should be on delivering	• **Enhancing care in the community, with a focus on reducing delayed pathways of care** • **Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.** • **Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.**			
Ref 1:	Development of Urgent and Emergency Care pathways through the development of the Navigation Hub.			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 1:	• Development of a hub which is able to focus on urgent and emergency calls within the community and to sign post individuals to the right care • Implement and embed pathways with ED to reduce unnecessary conveyance to hospital	• Provide clinical support to Care Homes to ensure that the navigation hub as first point of access not WAST or GP • Implement and develop advice line for professionals working in the community • Role of the Hub into the redesign of community services	• Continue maintain delivery of services within the hub • Explore ways for additional resources to expand the hub • Develop confidence within the Hub between stakeholders to ensure the resource is being utilised • Further exploring the role of the Hub as single point of access for community service model	As quarter 3 • Produce a comprehensive vision for the Hub as the SPA and oversight of ECC.
Progress synopsis	Following pathways established • Recognition of Life Extinct for Unexpected Death - ROLE Pathway • Supply of emergency drugs to support EOL patients • Discussions with Emergency Department around redirection Pathways • Professional Advice Line established for health community nursing teams • Discussions around Occ Health through additional AHP funding • Urgent and Emergency Dental Triage & appointments	Established pathways continue to be delivered to support. • 111Press2 for Mental Health • Nursing Home Pathway has been introduced and tested for nursing homes. Focus on encouraging homes to utilise as confidence grows • C3 Radius PTAS - Pulling cases directly from ambulance stack (weekends Mon to Fri service only). • National antiviral scheme introduced for patients at highest risk of hospitalisation • Continue to monitor GDS waiting lists	All pathways introduced in Q1 and Q2 continue. Antiviral numbers significantly increasing putting pressure on the resource. • Discussions commence with LA colleagues around support for residential homes. • Appointment of Occ Health practitioners being undertaken • Hub GP to oversee stack secured over a number of weekends when pressures in ED and acute being escalated and • Continue to monitor GDS waiting lists	All pathways continue to be delivered • Antiviral activity starts to reduce • Continued to provide adhoc delivery of PTAS over the weekend where pressures reported as high and BC called. • OT now placed in Hub • Vision paper produced in draft. • Weekly reporting of activity and successful intervention by the hub on the PTAS service • Continue to monitor GDS waiting lists

Priority area(s) to deliver 24/25:				
Progress synopsis	As above. The Development of the Navigation Hub is progressing well. It is shaping into a centre which is able to divert patients who would otherwise be on route to ED to more appropriate alternative services who are able to support their needs in an alternative setting. The development of the Hub is not in isolation and is a key part of the development of the new integrated model for community services.			
Ref 1				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
	• As above	•	•	•
Progress Synopsis	As above			
Outcomes of delivering Ministerial Priorities:				
Ref 1:				
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 1:	• Continue to deliver pathways already implemented • Review and refine pathways as is required to maximise outcomes • Commencement of Advanced Paramedic Practitioners (joint programme with WAST) • Seek funding from Regional Capital Fund for scoping exercise for alternative premises to support future development of the Hub	• Continue to deliver pathways already implemented • Report in progress and outcomes through internal governance structure • Review first Q deliver of Advanced Paramedic Practitioners • Review impact of Occupational Health input • Work to progress the Hub being the SPA for community services • Review of the respiratory ECC • Deliver the oversight for the residential home in one locality to test principle • Mandate all Care Homes to use Hub as a first	• Continue to deliver pathways already implemented • Report in progress and outcomes through internal governance structure • Explore more opportunities for • Evaluate the residential home pathways to collect learning and explore continuation	• If successful in bid, consider evaluation of the scoping exercise to seek alternative premises and IT infrastructure. • Evaluate all pathways to ensure value based delivery and outcomes

Priority area(s) to deliver 24/25:				
		contact before other routes for escalation		
Progress update 24-25	• Paramedics have been engaged within the Navigation Hub team since Jan 24. Working well and embedding into team • 2 x Occupational Therapist engaged within the Nav Hub Team • Respiratory Virtual Wards commenced Jan 2024. Positive outcomes and recurrent funding to continue service has been sought. • Navigation Hub continues to support Nursing Homes – exploring POCT to support rollout to Residential Homes.	<u>Scoping mandate for care homes to contact the CNH before 999 unless deemed a life threatening emergency:</u> • Work has begun to train Care Homes. • WAST are rolling out the LUSCII project which is a new initiative with the Welsh Ambulance service which will see staff in some care homes trained to apply wearable tech on patients so observations can be monitored remotely by the WAST clinical desk until a resources is deployed. <u>Service model for Allied Health Professionals to support people to stay well at home in conjunction with service provision delivered via Navigation Hub:</u> • The MDT is building with OTs and paramedics now complementing the team. This will be further developed as part of the Enhanced Community Care programme <u>7-day duty therapy support to the Primary Care Navigation Hub to support specialist AHP triage of referrals</u>	**Overall performance:** number of successful interventions via Navigation Hub – 87.4% highest since January 2024 **Care homes performance:** number of successful care home referrals and conveyance avoidance via Navigation Hub – 84.4% has dropped by 5% in the last 6 months **WAST ED conveyances:** since January 2024 remains high at an average 1917 patients conveyed per month, where on average around 491 patients are brought into EDs from care homes, which contributes to a quarter of monthly conveyances to ED for this cohort of patients. **Targeted interventions:** Development of Clinical Navigation Hub as a central coordination for Enhanced Community Care model (ECC level 4) in progress – phase 3 of ECC delivery (Jul – Sep 2025) CTM Falls & Finish Group set up – secured funding for 25 training sessions with St Johns Ambulance for care homes, procurement of 25 lifting equipment kits completed and in progress of distribution to community (care homes). Gaps established in urgent falls response in Merthyr Tydfil – work with PLT re integrated community model, realignment of RIF under review WAST are rolling out the LUSCII project, a new initiative with the Welsh Ambulance service. Staff in five care homes initially to be trained to apply wearable tech on patients so observations can be monitored remotely by the WAST clinical desk until a resource is deployed. Virtual ward for respiratory pathway restarted in December 2024 Targeted interventions re care home conveyances – national and local actions – further plans to be confirmed **POCD:** • 20% reduction in total delays target achieved and exceeded • 24% reduction in days delayed target achieved and exceeded • 28% reduction in assessment delays target achieved and exceeded

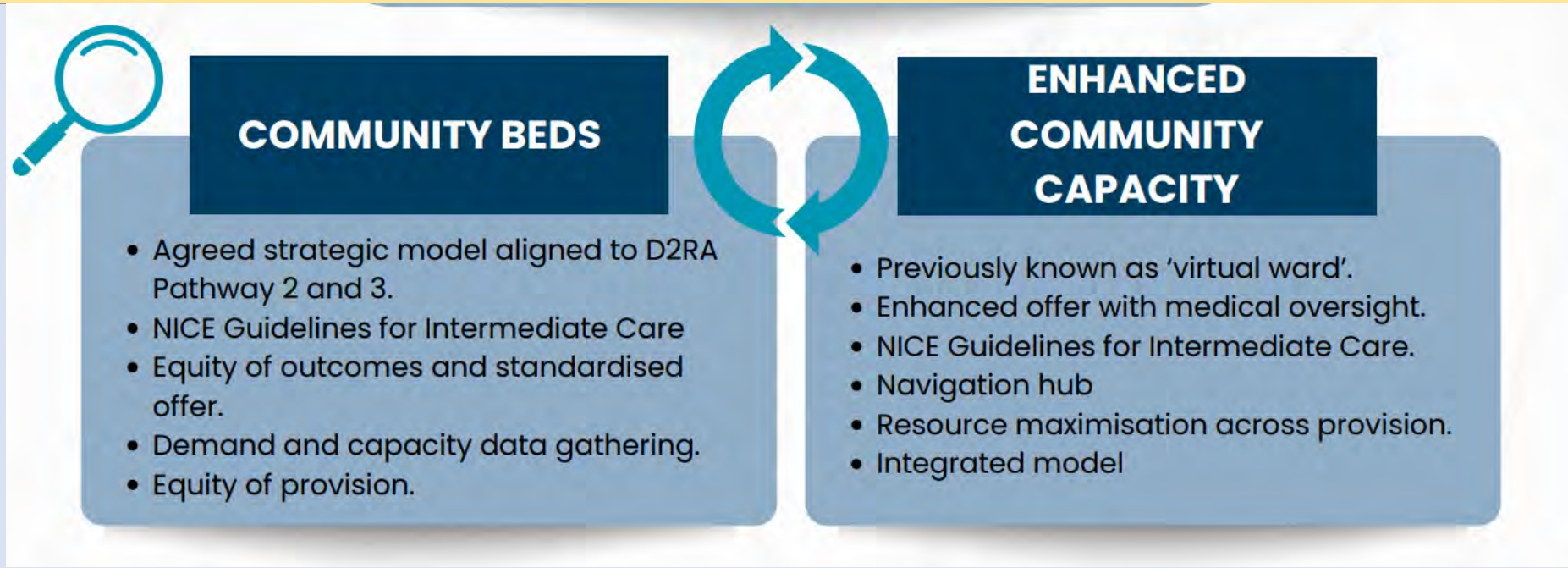
Priority area(s) to deliver 24/25:				
		• 5-day provision in place, referrals received out of hours or weekends are being picked up by team during the week. Additional cover for 7-day provision would require funding. <u>7-day rapid access to AHP intervention focusing on admission avoidance</u> • Current provision covers 5-day working model, investment required to extend to 7-day provision		
Overarching outcome measures/ metrics:				
The Hub will have an impact on the whole system, taking pressure of primary and community and specifically avoiding unnecessary hospital admissions and keeping people safe at home. The measures are 1. Reduction in unnecessary conveyance by WAST to ED 2. Reduction in admissions into hospital **3.** Increased number of patients who have fallen being supported to get up and stay in own home (safely).				
Baseline position 23/24	**Quarter 1** **76% successful intervention rate**	**Quarter 2** **79% successful intervention rate**	**Quarter 3** **86% successful intervention rate**	**Quarter 4** **87% successful intervention rate**
Performance Trajectories 24/25	**Quarter 1** Maintain 87% average successful navigation hub Nav Hub to be first point of contact for 100% prior to WAST Appoint Nav Hub Lead	**Quarter 2** Maintain 87% average successful navigation hub Mandate all care homes (nursing and residential) to make the Nav Hub the first point of contact prior to other emergency calls Nav Hub to maintain point of contact for 100% prior to WAST	**Quarter 3** Maintain 87% average successful navigation hub Nav Hub to maintain first point of contact for 100% prior to WAST	**Quarter 4** Maintain 87% average successful navigation hub Nav Hub to maintain first point of contact for 100% prior to WAST

Priority area(s) to deliver 24/25:				
Performance review	Average 87% successful intervention rate maintained in Q1. Deep dive being undertaken to review those not successful to understand reason Working with WAST colleagues to ensure the pathways is embedded as first point of contact		83.7% in December 2024	85.18% in January – February and March data being validated. Highest successful interventions since January 2024 – 87.4%.
Risks	**Risks of Non-Delivery**		**Mitigations**	
	Impact on the wider system in terms of potential increased urgent care access elsewhere in the system.		Continues to work to develop pathways and see ways to fund the development of the hub. May involve shift in investment.	
	Risks to Delivery		**Mitigations**	
	Availability of clinical workforce Employment contract issues		Ensure that the working environment and support remains robust and Hub is an enjoyable place to work in Being cognisant of National Developments and align local policies and application	
Critical Enablers	**Finance**			
	Funding is made up from 6 goals, Further faster. Detail expenditure plan is currently being worked through as part of Q1 budget reviews.			
	Workforce			
	• The development of the Hub is not being undertaken in isolation and is forming part of the wider development of the integrated community model. It is likely to be the case that some resource will shift from other areas to support the Hub in the absence of any additional funding. Through a workforce planning change skill mix in key priority areas – increase workforce capacity and skill mix • Support and improve wellbeing of our teams • Strong & resilient inter-professional leadership & delivery			
	Digital			
	• Improve the availability of performance data for priority areas to inform service planning, monitoring and evaluation • Digital is key for the Hub to be successful and an increase use of new technology to support patients to live well in the community will be a focus for 24-27			
	Other (Specify)			
	Estate & Facilities enablers:			

Priority area(s) to deliver 24/25:	
	• The Hub is growing at a pace and with it comes a need for more appropriate premises which also has the infrastructure to support the integrated monitoring hub and also remote monitoring and create environments suitable for integrated teams and patients to access
Prevention & Population Health	**Opportunities identified:**
	There is an association between health literacy and deprivation. It is accepted that we have challenges with our population accessing health and wellbeing services and understanding the link between lifestyle and wellbeing/chronic conditions. A focus needs to be on finding different ways to engage and connect with patients and this requires different approaches to impact behavioural change. Evidence suggests a longer LoS for patients in areas of deprivation.

NHS WALES PLANNING FRAMEWORK 24-27- Primary and Community Care

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care				
Key focus should be on delivering	• **Enhancing care in the community, with a focus on reducing delayed pathways of care** • **Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.** **Urgent and Emergency Care, with a focus on delivery of the 6 goals programme**			
Ref 2:	To transform the community services into a single CTM wide model of integrated teams and focus on the development of Extended Community Care and redesign of the community hospital model to improve flow and POCDs			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 2:	 The Planning Milestones for the redesign of community integrated model is as detailed above. Alongside this work is another significant work programme to **Redesign our Community Hospitals.** Ensuring that the whole pathways for patients is reviewed and reprioritised and along with enhanced community care. The focus on will be on rehabilitation, complex and step up and step down beds.			

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care	
	
Progress synopsis	In respect of redesign of community integrated teams a formal Commissioning Group between Health (PC&C and AHP) and LA colleagues is established and meet on a regular monthly basis to progress the work programme. 1. Integrated service model has been agreed at LLG and RPB. 2. Outline model for the integrated teams has been agreed at ILG and RPB. 3. Pathways for urgent and population health defined and agreed 4. Focus agreed for care homes, ACP, and falls 5. Mapping of workforce and associated work-streams completed across LA and Health have been mapped. 6. Workforce and financial plans will finalised for end Q3. 7. Workstream established and meeting regularly to align integrated services redesign with Navigation Hub as being first point of contact 8. Gap analysis for community nursing specification and principles has been completed. Details of funding gap have been shared with WG. 9. Regular meetings for nursing specification and principles taking place 10. Civica has been rolled out to District Nursing day services but not as yet to District Nurse night service but exploring options for the Navigation Hub.

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care				
	In respect of community hospital redesign a programme board has been established and is working alongside the wider Frailty Strategic Programme. Model has been agreed in principle and is waiting final sign off by the Design Authority.			
Outcomes of delivering Ministerial Priorities:				
Ref 2:				
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 2:	• To align the work programme with the Navigation Hub with the community service redesign • Implement community nursing principles • Implement community nursing specification • Implementation of Civica District Nurse Establish the work streams • Map the current workforce and the funding streams associated • Map the current gaps in workforce teams • Undertaken engagement sessions with other stakeholders • Undertake engagement sessions with teams to share and discuss the vision • sing scheduling system • Advertise posts required and identified as part of the Further fast funding • Additional community nursing to ensure that the District Nurse Principles are met as well as focus on frailty nurses, ACP, clinical support for the Navigation Hub. To	• Integration of Urgent Community Pathway: @Home, SW@H 1 and 2, ACT, Community Wellbeing Teams • Further, Faster, Together funding allocation plan to address capacity gaps and planning • Streamed pathways for services: • @Home, SW@H 1 and 2, ACT, Community Wellbeing Teams • Establish capacity in mobile response units • Set up clinical triage with appropriate MDT within Navigation Hub capacity **Community Hospitals** • Operational embedding of new discharge policy and evaluation • Implementation of accredited training for trusted assessors • Discharge toolkit • Business case for Integrated Discharge Team with Section 33 agreement • Monthly review and update of PoCD action plan	• Integration of Urgent Community Pathway: new AHP resource, community AHPs, front door assessment services • Establish step-up criteria and pathways for community beds • (interdependent) with Community Hospital bed modelling programme delivery) • Establish criteria for step down pathways to community services **Community Hospitals** • Sign-off for implementation • plan for Integrated Discharge Team • Full implementation • of Integrated Risk Escalation Framework • Straight to service model for all Pathway 1	• Integration of Urgent Community Pathways. • Completion of • integration of UEC Community Team coordinated via Hub: for Up to 7 days for 'Acute MDT Response' Step-up bed Reablement • Further demand and capacity review plan for future modelling and commissioning **Community Hospitals** • Audit of D2RA pathways and MADE reviews implemented quarterly on each site • Demand and capacity modelling for all D2RA pathways with integrated commissioning plan for intermediate care. • Monthly review and update of PoCD action plan

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care				
	ensure the opportunity to enhance the AHCP workforce is maximised by shifting resource where it is required. Ongoing **Bed base - Community Hospitals** • New Discharge Policy and user-friendly Discharge Toolkit including choice protocol, • reluctant discharge and homelessness pathway • Data Dashboard to include key performance metrics with capacity for daily • reporting • Daily, weekly and monthly SitRep for each acute and community site containing data related to demand and capacity in patient flow: number of planned discharges • per day, number of patients awaiting beds, bed capacity, transport allocation, number of internal and external delays per ward and per site Operational embedding of re-developed eWhiteboards/eToC/SDN • Operational development and embedding of Discharge Hub as central coordination for flow and discharge activities and daily reporting via Virtual Network meetings (acute, community hospitals, discharge teams and social care).	Demand and capacity modelling for residential/ nursing placements	discharges for Trusted Assessors • Monthly review and update of PoCD • Integrated strategic commissioning place for residential care aligned to pooled fund.	

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care				
	• Continue delivery of Pathways of Care Delays Action Plan and activities supporting effective management of discharge Implementation of Trusted Assessor model across CTM by April 24 – including recruitment and role embedding with integrated site teams (Therapies, Discharge Liaison Nurses, hospital based social care staff)			
Overarching outcome measures/ metrics: 1. Implement a whole system approach to integrated care 2. More people to be cared for in their own homes or home of choice 3. Reduction in duplication 4. Reduction in silo working 5. Reduction in various 'hand offs' and referrals 6. Implementation of Seamless Care 7. Reduction in unnecessary admissions 8. Reduction in unnecessary bed days 9. Increase in the response offered to patients in urgent need 10. Supporting D2RA process 11. Improve flow across the whole system **12.** Increase amount of people receiving enhanced community care **13.** Reduce admission rates **14.** Reduce POCD **15.** Reduction in waits for social care in the community hospitals				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Progress Update 24/27	• New Community Hospital Model has been approved by Operational Management Board and Executive Team. • Implementation plan just being finalised • Workforce model complete • New JDs drafted for ANPs in Community Hospitals out on TRAC and being progressed			

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care				
	• D2RA Process implemented • Discharge Hub in place, and further staff being recruited (band 6 and band 3) • All wards using EWTBs • POCD data being monitored on monthly basis and feeding into the action plan. • Scrutiny continues to take place at the Integrated Discharge Board • Discharge Policy approved and continues to be embedded in Q1. • Unscheduled Dashboard has been implemented • LOS and DPOC not yet reducing but analysis being undertaken to understand why			
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	Appointment of the Diabetes Nurse Specialist in DN Improvement in outcome measures set out above.	Improvement in outcome measures set out above.	Improvement in outcome measures set out above.	Improvement in outcome measures set out above.
Risks	**Risks of Non-Delivery**		**Mitigations**	
	CTM will continue to have different models of community services across the CTM footprint		Concerted commitment and effort by all partners to drive the work forward. Monthly reporting and escalation into the governance structure.	
	Risks to Delivery		**Mitigations**	
	No dedicated resource to support either the redesign and the implementation could delay a 'go live'. Complex and intensive work is carried by those as well as existing role		Concerted effort and commitment by all partners to drive the work forward. Monthly reporting into the HB governance structure	
Critical Enablers	**Finance**			
	The plan is for the model redesign to be cost neutral. A full financial analysis will be worked up as part of the plans			

Priority area(s) to deliver 24/25: Primary and Community Care, with a focus on improving access and shifting resources into primary and community care	
	Workforce
	A detailed workforce plan will be worked through as part of the programme board. Focus needs to be developing a wider MDT model of nursing and therapists for reablement.
	Digital
	Digital technology will be a key part of the programme in order to support patients at home and remotely but to also give them independence
	Other (Specify)
	Collaboration through partnerships is critical enabler
Prevention & Population Health	**Opportunities identified: Development of robust community services which are linked to the hub will produce a system which can prevent individuals from going into hospital and early intervention should result in them being supported at home sooner. Population management for LTC will be a key pathways to follow the UEC pathways.**

NHS WALES PLANNING FRAMEWORK 24-27- Primary and Community Care

Priority area(s) to deliver 24/25: Enhanced Community Services				
Key focus should be on delivering	• **Enhancing care in the community, with a focus on reducing delayed pathways of care** • **Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.** • **Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.**			
Ref 3:	**Flow and Discharge: To reduce Pathway of Care Delays through the robust process for assessing and reviewing PoCD and redesign of community hospitals.**			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 3	▪ Design and delivery of D2RA, ▪ Roll out of 'Optimise' all community hospitals ▪ Structured board rounds and ▪ involvement of MDT ▪ Accurate data input and recording on eWhiteboards ▪ Implementation of ▪ SitRep for monitoring and scrutiny of flow and ▪ discharge processes ▪ SAFER, Red2Green ▪ and Preventing deconditioning Guidance ▪ Establishment of Board to overview redesign of community hospital bed and workforce profile	▪ Trusted Assessor role fully implemented and supporting appropriate ▪ discharge on all 3 sites ▪ Development of Training Modules to support new guidance – mandatory modules ▪ Development of 'Train the Trainer' type toolkit for ward managers, MDT representatives and social care colleagues to support scaling up of the improvement project ▪ Assessment of current Community Hospital Model	▪ End PJ Paralysis plan including educational material, staff coaching, resources for patients and families. ▪ Scaling up Functional Rehabilitation Programme across inpatient areas ▪ Drafting of optimum model for community hospitals with focus on medical model	• Work to embed the D2RA continued • Governance structure for oversight of POCD continues to embed and to report internally and nationally • Focus on embedding the understanding and need for quality of data on eWhiteboards across all teams. • Focus work taken place where data quality requires attention • Draft model for community hospitals and medical workforce model proposal considered by OMB.
Progress synopsis	• Integrated Discharge Delivery Board established with governance and assurance of PoCD delays • Integrated Discharge Policy approved March 2024 in line with national guidance • Revised PoCD reporting, validation and escalation process established • Stranded patient reviews established with MADE methodology with 1st MADE review in PoW 04/24 • Re-launch of redesigned Supported Discharge Notification form and electronic Transfer of Care • Re-launch of redesigned eWhiteboards system with internal and external delay codes aligned to Pathways of Care Delays and D2RA reporting. • Launch of Red2Green/SAFER in acute and community sites – phased and structured project implementation ongoing with anticipated completion date November 2024			

Priority area(s) to deliver 24/25: Enhanced Community Services	
	• Use of standardised data across health and social care to manage/report on flow and discharge • D2RA/Discharge Hub established as an integrated model and management of discharge in acute and community services supporting implementation of trusted assessor model in place and operational Integrated Discharge Delivery Board (health & social care) overseeing discharge data and discharge delays and form action plans to address barriers to timely and effective discharge. • Draft model for community hospitals and medical modelling approved by Operational Management Board and now awaiting scrutiny and approval by Design Executive. • Opportunities being sought to enhance the Enhanced Community Services – Current delivery through community teams (CHWT & integrated network in Bridgend). Additional services commenced in Q1 for respiratory patients out of the Navigation Hub. • Greater evaluation around the current Enhanced Community Services and this will be taken into consideration for the community services redesign

Outcomes of delivering Ministerial Priorities:				
Ref 3:	Robust Pathways of Care Delays Data Collection and System Validation Process Robust governance and monitoring of delivery POCD improvement actions Downward trend in Average Length of Stay from Emergency Admission in Acute Hospitals Downward trend in Average Length of Stay – Community Hospitals Outcomes needs to be aligned with the Healthy Days at Home and the ECC agreed measures			
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 3:	• New Discharge Policy and user-friendly Discharge Toolkit including choice protocol, • reluctant discharge and homelessness pathway • Data Dashboard to include key performance metrics with capacity for daily • reporting • Daily, weekly and monthly SitRep for each acute and community site containing data related to demand and capacity in patient flow: number of planned discharges • per day, number of patients awaiting beds, bed capacity, transport allocation, number of internal and external delays per ward and per site • Operational embedding of re-developed eWhiteboards/eToC/SDN • Operational development and embedding of Discharge Hub as central coordination for flow and discharge activities and daily reporting via Virtual Network meetings	• Operational embedding of new discharge policy and evaluation • Implementation of accredited training for trusted assessors • Discharge toolkit • Business case for Integrated Discharge Team with Section 33 agreement • Monthly review and update of PoCD action plan Demand and capacity modelling for residential/ nursing placements	• Sign-off for implementation • plan for Integrated Discharge Team • Full implementation • of Integrated Risk Escalation Framework • Straight to service model for all Pathway 1 discharges for Trusted Assessors • Monthly review and update of PoCD • Integrated strategic commissioning place for residential care aligned to pooled fund.	• Audit of D2RA pathways and MADE reviews implemented quarterly on each site • Demand and capacity modelling for all D2RA pathways with integrated commissioning plan for intermediate care. • Monthly review and update of PoCD action plan

	(acute, community hospitals, discharge teams and social care). • Continue delivery of Pathways of Care Delays Action Plan and activities supporting effective management of discharge • Implementation of Trusted Assessor model across CTM by April 24 – including recruitment and role embedding with integrated site teams (Therapies, Discharge Liaison Nurses, hospital based social care staff) Community Hospital • Focus on two D2RA bed-based pathways of care Effective discharge - reduction of 'Red' days during person's hospital stay			
Robust Pathways of Care Delays Data Collection and System Validation Process Robust governance and monitoring of delivery POCD improvement actions Downward trend in Average Length of Stay from Emergency Admission in Acute Hospitals Downward trend in Average Length of Stay – Community Hospitals				
Baseline 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	Target improvement of LoS: 1) Reduce super stranded patients by 25% by end of Q2. 50% of patients within standard measures. POCD – reduction of	Increase home first pathways (0 and 1) to 95% to reduce delays associated with residential placements Further reduction in POCD by 15%	Increase home first pathways (0 and 1) to 95% to reduce delays associated with residential placements Further reduction in POCD by 15%	Further reduction in POCD by 15%

	assessment delays by 15% per quarter Reduction in red days Evaluate outcomes of Respiratory ECC			
Risks	**Risks of Non-Delivery**		**Mitigations**	
	May lead to patient harm as patients will either be admitted into hospital when it could be avoided or result in a longer stay in hospital		Escalation through governance routes if non delivery or delay is a reality	
	Risks to Delivery		**Mitigations**	
	Protected time and resource to focus on the programme. Non compliance by ward staff		Monitoring against milestones Working with key partners to make happen	
Critical Enablers	**Finance**			
	Redesign needs to be cost neutral and financial plans are in the process of being finalised			
	Workforce			
	Community Hospitals: Higher ratio of therapies to nursing / medical staff - Reduction in medical supervision - Pathway 2 bridging - Care will be delivered by roles similar to domiciliary care workers - Oversight from registrants will be a 'light touch - reablement approach - Pathway 3 - similar ratio to current community beds with allocated medical support and RNS. Clear interventions provided for - Pathway 2 (rehabilitation/reablement) with specified standards and workforce - Pathway 3 with specified standards and workforce			
	Digital			
	Improved information management, data sharing/ technology – enabling D2RA driven care provision i.e. utilisation of E-Whiteboards system			
	Other (Specify)			
	n/a			
	Opportunities identified:			

Prevention & Population Health	The whole redesign of community services (including bed based care) is focused on prevention. Early and timely intervention is the key factor underpinning the programmes.

NHS WALES PLANNING FRAMEWORK 24-27- Primary and Community Care

Priority area(s) to deliver 24/25:				
Key focus should be on delivering	• **Enhancing care in the community, with a focus on reducing delayed pathways of care** • **Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.** • **Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.**			
Ref 4:	Further Faster – The specific areas of this programme is to further support the programmes of work identified for the Ministerial priorities, i.e. community nursing, EOL, making communities resilient through Navigation Hub and anticipatory for the top 5% of the population at risk of frailty			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 4:		• Through Commissioning Group development work with LA colleagues to identify what would make the greatest impact. • Care Homes identified as being the greatest need for both health and social care. Especially around falls. • Development and scoping of what would be needed • Additional eyes on clinician employed to support urgent and emergency pathway	• Testing concept with residential homes. • Further work to develop pathways and employ the resource for the respiratory ECC	• Focus was on supporting the Navigation Hub to develop the urgent and emergency response to Care Homes and professional teams. Additional 'eye on clinician' supporting the triaging doctor. Enabled a home visiting service.
Progress synopsis	The aim was not to utilise the funding for new and additional projects but to utilise it to enhance the existing work to develop capacity and capability within the community teams, further supporting frailty and also ECC.			
Outcomes of delivering Ministerial Priorities:				
Ref 4 :				
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref 4:	• Undertake recruitment of additional community staff	▪ Continued recruitment of additional District Nursing staff ▪ Focus on frailty to support those in top 5% risk of frailty	▪ Review the first few	Review the first few months of delivery to

Priority area(s) to deliver 24/25:				
	required to increase capacity for 24/7 provision • Work with Palliative Care Consultant Development of plan to delivery ACP education and training • Work to gain demand and capacity information in respect of District Nursing Further development of the Navigation Hub to support professional teams focusing on Advanced Nurse Practitioner role especially around supporting care homes • Focus on Falls response in care homes and wider communities • Further progressing risk stratification work to enable Anticipatory care planning for 0.5% people most at risk of urgent care • Focus on EoL and especially around ACP. Work with Palliative Care Consultant Development of plan to delivery ACP education and training	▪ Focus on supporting care homes where need is identified by the Navigation Hub ▪ Validate data being identified from the risk stratification	months of delivery to assess outcomes and learning ▪ Review and assess impact on the District Nursing Principle	assess outcomes and learning Review and assess impact on the District Nursing Principle
Overarching outcome measures/ metrics:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Baseline position 23/24	▪ 24/7 service being delivered ▪ Assessment of needs for District Nursing Principles assessed. All teams are coterminous	As Q1 and in addition • Recruitment of the band 4 role taken place and demonstrated that enhanced skill mix and career framework in place for HCSW.	As Q1&2	Identification of Further Faster funding to improve 24/7 provision to reflect demand largely influenced by

Priority area(s) to deliver 24/25:				
	to general practice populations. Providing continuity for patients and professionals. ▪ All Team leaders in place with SPQ ▪ 12WTE achieved in all but 1 team but this is due to joining of 2 small teams. Team is now more resilient. ▪ Further work to be done around administration			deprivation.. Additional RGN posts to be recruited
Progress update 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	• Navigation Hub continues to deliver supporting Care Homes • Additional GP in the Navigation Hub to provide eyes on to patients has been engaged. • Finalising the recruitment process for the additional District Nursing Posts to enhance the weekend working. • Review of Marie Curie provision to ensure it is meeting the needs of EOL patients and is maximising capacity. • 2 x Occupational Therapists in place in the			

Priority area(s) to deliver 24/25:				
	Hub since January 24 to support patients who have fallen. Linking in with wider therapy falls team and @home team. • Respiratory Virtual Ward delivering since January to support patients at risk of escalation and supporting at home and avoiding admission • Workshop undertaken in June to develop enhanced Extended Community Care model			
Performance Trajectories 24/25	**Quarter 1** Maintain position of: All teams are coterminous with clusters All teams have RCN with SPQ 15% admin Increase number of RCN by 10WTE	**Quarter 2** Maintain position of: All teams are coterminous with clusters All teams have RCN with SPQ Have optimum administration support in place for DN teams Have a falls response team in place	**Quarter 3** Maintain position of: All teams are coterminous with clusters All teams have RCN with SPQ	**Quarter 4** Maintain position of: All teams are coterminous with clusters All teams have RCN with SPQ
Risks	**Risks of Non-Delivery** • Failure to recruit into the additional community nursing posts will lead to CTM not attaining the district nursing principles and standards set. • Failure to have appropriate ACP in place will lead to patients being admitted into hospital •		**Mitigations** • Robust recruitment plan • Delivery programme of ACP training and advice. Raise awareness of the need for ACP	
	Risks to Delivery • Failure to recruit will have a negative impact on our ability to delivery and therefore less resilience over the winter of 2024 and more patients accessing acute when it could be avoided.		**Mitigations** Will need to put additional resource into acute which is what we are trying to avoid	

Priority area(s) to deliver 24/25:	
Critical Enablers	**Finance**
	The forecast to date is full spend of the £1.8million
	Workforce
	Final plans are being worked through as priority areas are tweaked and discussions continue with LA colleagues and clusters
	Digital
	At this point in time digital is not critical but will be a key enabler are the plans over the year progresses.
	Other (Specify)
	Costs for additional community equipment to support patients at home will also need to be prioritied.
Prevention & Population Health	**Opportunities identified:**
	Keeping patients safe at home will be key to our resilience as we approach winter. Promotion of the importance of lifestyle and the impact of this on peoples ability to manage LTCs will continue through WISE and other wellbeing and health promotion schemes. Delivery of the NIF programme will be key to keeping individuals protected

NHS WALES PLANNING FRAMEWORK 24-27- TEMPLATES

The Ministerial templates support the development of organisational IMTPs/ plans along with the Minimum Data Set (MDS).

Templates are required for commitments aligned to the national programmes which continue to support delivery of services and reinforce best practice through quality, efficiency and patient experience.

A template will be required to detail milestones, actions and risks etc for the following areas:

- **Enhancing care in the community, with a focus on reducing delayed pathways of care**
- **Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.**
- **Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.**
- **Planned Care and Cancer, with a focus on reducing the longest waits.**
- **Mental Health, including CAMHS, with a focus on delivery of the national programme.**

Progress on these expectations has been referenced in the planning framework and will be a focus of the planning process for 2024-25.

Completing the template will provide detailed delivery points including baseline, milestone and actions to demonstrate how the priority will be implemented. The detail contained in the template should align to the narrative plan.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

This template has been co-produced with Assistant Directors of Planning

MINISTERIAL TEMPLATE BLANK

All organisations are expected to complete the templates proportionate to their direct or supporting roles and functions.

The completed templates must be collated and submitted alongside the organisation's plan and the completed Minimum Data Set by 29 March 2023.

Send to: HSS-planningteam@gov.wales

The blank template below needs to be replicated as required for each priority identified. Additional rows can be expanded as necessary.

Priority area(s) to deliver 24/25:					
Key focus should be on delivering	**Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.** ***Support sustainability and development of robust primary care services through the commissioning of services which are value based and support system pathways and new models of care***				
Ref:	New priority/ Continued from 23/24 **(Delete as appropriate)**				
Ref:					
Resume of planning Milestones 23/24:					
	Quarter 1	**Quarter 2**		**Quarter 3**	**Quarter 4**

Ref:	Priority	Key actions	Metrics (performance indicator/ outcome/ output)	Timescale Qtr./ Year	Update – May 2023	Q4 Update
	General Medical Services and Access	1. Continuing to support practices to find ways to improve access to GMS services 2. Ensure that each practice establishes a PPG 3. Undertake the sustainability desktop exercise on quarterly basis to identify practices at risk 4. Salaried GP Service re-design	1. Ensure 100% compliance of phase 1 & 2 GMS Access Standards 2. Monitor Concerns and complaint for trends, issues and hotspots	Q1-Q4 2023	• Self-assessments received. All 46 practices report 100% compliance. Evidence is being verified. Access forum due to meet on the 24th May. • Sustainability desktop exercise repeated. 4 practices identified at risk have been de-escalated to green following intervention by the PC Team. Continue to support those in need with action plan. Review	1. All contracts have been reviewed to reflect the unified contract variations. 2. Teams actively monitoring and supporting GP practices who are facing sustainability concerns and exploring options which can be pursued. 6 practices receiving direct support. 3. Rolling programme of Practice Development Visits (PDV) is now in place to ensure monitoring and assurance is gained

Priority area(s) to deliver 24/25:						
					undertaken to ensure changes are embedded. • GMS Practice Development Visit completed and action plan is in the process of being produced for areas of improvement and trends and themes.	4. Health Inequalities programme continues to focus in the North Bridgend Cluster.
	Dental Services Contract Reform and Access	1. Robust commissioning of dental services in areas of need during the re-tender of dental contracts 2. Review of CDS / DTU services 3. Development of model and workforce plan 4. Engagement with teams and stakeholders 5. Encourage participation in the ACD programme	1. Monitor the urgent and emergency activity 2. Monitor the follow up activity 3. Monitor will be determined by the national dental contract measures 4. MOS activity 5. CDS activity 6. D2S & Gwen a Byth activity	Q1-Q4 2023	• Activity is being reported into the Heath Boards Performance and Improvement Board. • 3 contracts handed back. 1 tender completed and another tender for large contract in Bridgend due to take place. 3rd was taken on by neighbouring practice. Provides opportunity to redistribute dental contract to meet needs of population. • Practices have agreed to work	• No further contract resignations have been received and all contracts have been re-tendered. • New contractor in Bridgend due to commenced in January 2024 and patients are being allocated centrally via the waiting list. • Urgent & Emergency Dental Service continues to manage calls and waiting list – demand is increasing. • First dental collaborative has met and is being

Priority area(s) to deliver 24/25:						
					with the HB to offer additional urgent access appointments. • Urgent and Emergency appointments now handled through Navigation Hub • Review of salaried Dental Services taking place to ensure in line with WHC and to maximise efficiencies and activity. Part of wider OCP process • HEIW workforce planning event due to take place 24th May • Regular meetings with LDS to ensure smooth transition for contract reform • Engagement with dentists regarding ACD regularly taking place.	funded centrally in the absence of it being included in contract reform. • Regular reporting of Dental activity reported into the Care Group's Planning, performance and Finance Board and through to Operational Management Board. • Final end year and mitigations 2022/23 completed. • Mid-year reviews currently taking.
	Optometry Services Contract	1. Preparation for the phasing of the new	1. Monitoring will be determined by the national	Q1-Q4	• Preparing for the implementation of the new contract.	• Additional post is in the process of

Priority area(s) to deliver 24/25:						
	Reform and Access	optometry contract 2. Engagement with contractors, WG and other contractors on an ongoing basis. 3. Development of team so it is in place to and ready to take on the additional workload 4. Once contract details finalised prepare a plan for the engagement and commissioning of the services from each contractor 5. Further support the shift of activity done traditionally in eye care services from hospital to community optometry, e.g. wet AMD, HCQ, glaucoma and cataract.	measures as agreed by the contract 2. Continue to monitor uptake of the specialist services such as glaucoma, cataract, diabetic retinopathy, IPOS and EHEW and low vision services		• A part of wider HB OCP ensuring the resources are in the team to enable them to manage this additional work. • Regular dialogue with SEWROC. • Optometry collaboratives established. • Delivery of specialist eye care services undertaken in conjunction with secondary are and activity/progress reported through to Care Group and Board governance process. • Joint meetings taking place to discuss the implementation of other specialist services, such as wet AMD and HCQ.	being recruited into as part of OCP • All practices participating in WGOS1-3. • WGOS4 services are in place and further refinement to comply with national pathways is taking place. Good engagement from the Clinical Director and teams in the Hospital Eye Care Service.
Progress synopsis	Please see above		Please see above		Please see above	Please see above
Ref:						

Priority area(s) to deliver 24/25:				
Progress synopsis				
Outcomes of delivering Ministerial Priorities:				
Ref:	Outcome metrics comply with the national metrics agreed in the contracts and deliver accessibility for patients.			
Ref:				
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	1.Implement the new independent contract changes and metrics for 25-26 as directed 2.Support sustainability by ensuring a contingency and mitigation plans are in place in the event of contract resignations 3 scoping meeting to discuss workshop around new models of care 4, considerations of priorities from Acute Clinical Services Plan to formulate plan for shift in services	1. Assess and support sustainability by ensuring a contingency and mitigation plans are in place in the event of contract resignations 2. Continue to explore and implement new models of care across PC through a workshop with LMC and clusters 3. Workshop/mtg to review ACSP and look at opportunities	1.Assess and support sustainability by ensuring a contingency and mitigation plans are in place in the event of contract resignations 2.develop service specifications to support the ACSP priorities 3 Mid-Year review of contracts and delivery	1. Continue to maximise delivery of the out of hospital services for optometry, dental and GMS in line with the clinical services plan
Delivery update	Q1 update GMS • Monitoring of escalation levels at practice level continues weekly • Continuing to supporting practices who are reporting level 3 and 4 • Exploring new models of Practice Model			100% GMS achieved and the expectation is that this will continue into next year.

Priority area(s) to deliver 24/25:				
	• Work to enhance resilience community teams wrapped around GMS Dental • New dental metrics implemented from 1st April, new CVN notices to be signed by contract holders for 24/25 • Practices on contract reform mandated to provide urgent access via Urgent up and take on 25% of New patients from waiting list • 1st June: new practice opened [Bridgend] to replace closed NHS contract • Reduced contracts from 23/24 remain reduced going into 24/25 in order to re-commission activity during 24/25 • Monthly monitoring of dental access / waiting lists • New operational management structure commenced for salaried dental services	• Practices continue to be monitored on a monthly basis against revised targets for 24/25 • High utilisation of patients accessing urgent care via HB urgent dental hub, fill rate of appointments between 90-98% in Q2 • Urgent additional orthodontic services commissioned due to immediate retirement of 2 specialists in Community Dental. 208 patients referred under new contract to complete treatment. • 14,300 patients on HB dental wating list- validation exercise commenced in Q2 to reduce backlog • SCD Dental: End of Q1, 47 patients in system for GA, Q2= 48 patients remain waiting for treatment under GA. Primary care invited to attend 642 to bid for ad-hoc lists for the service to	• Mid year review process undertaken: 74% practices on target, 26% under target- figures are not indicative to YE achievement • Following validation exercise of the dental waiting list, numbers reduced to 12,289 patients at end of Q3 • New practice established in Q1 has already accepted 2,348 patients from waiting list • EOI undertaken and HB approval given to invest £1m to improve access to dental services. Practices to deliver from Jan'24 creating access for additional 4,704 patients who will be allocated solely from HB waiting list • Second orthodontic contract commissioned for CDS patients, 238 patients [previously	• Forecast year end figures show that 33% of practice will fail to achieve all metrics and will have a financial clawback instigated/. 66% will meet targets or threshold to roll over activity into 25/26. • Due to commissioning £1m activity/validation of list exercise, waiting list has reduced to 8364, reduction of +30% from Q3. • In total for 24/25, 10,817 new patients were allocated to practices • As of end March numbers waiting for a) paediatric GA remain high, 702 in system with 527 requiring assessment. 6% reduction from Q3, b)Special care GA 41 patients in the system for assessment/GA, the slight rise in patients waiting could be due to only 5 GA lists available in Q4, compared to 8 in Q3.

Priority area(s) to deliver 24/25:				
	• Discussions with Secondary Care Colleagues to reduce backlog waiting lists for Paediatric GA and Special Care GA • 24 June: 1st dental collaborative group established	increase no. of patients seen • Paeds GA: Backlog of 876 children waiting for dental treatment under GA. validation exercise commences in Q2 to reduce backlog.	waiting list 2.5 years] will be seen from Jan 2025 [Q4]. • Review of CDS structure continues, OCP to create new Band 5 nursing posts for specialist services/creation of central booking team to increase clinic utilisation figures, improving access to patients • SCD Adults -- due to additional GA lists via 642 process, 37 SCD patients remain in system in Q3 • Paeds GA: validation exercise and ad hoc lists have reduced backlog 746 children in system, 560 will convert to GA. The cancellation of all regular GA and ad hoc lists will increase backlog in Q4.	
	Optometry • Enhanced Optometry Contract implemented. • Implementation plan for WGOS4 submitted. • Enhanced Services (Glaucoma Refinement/Diabetic Retinopathy/WetAMD	• Increase of WGOS 5 appointments provided 1278 [Q2] compared to 1,274 [Q1]. • Small increase in WGOS 2 in Q2 compared to Q1, however growth is	• Glaucoma Filtering WGOS 4 implemented in Oct, claims will be seen in Q4. • Expression of Interest exercise completed for new optometrist provider in Parc Prison-	• 24/25 Forecast end of year data for optometry services compared to 23/24 shows: a)WGOS 1- annual increase of 3% b)WGOS 2- annual increase 25%

Priority area(s) to deliver 24/25:				
	progressed and brought in line with WGOS4	significant compared to previous year 23/24[21%] • Local Urgent Wet AMD scheme transitioned to WGOS 4 [Sep] Q1-80 claims, compared to 34 claims in Q2 • Glaucoma Filtering WGOS 4 developed for implementation in Q3 [anticipated referral refinement for 134 patient p/m reduces flow into HES • Glaucoma monitoring [local pathway] Q2 45 claims, compared to 53 in Q1. • Diabetic Retinopathy local scheme continues. 339 claims in Q2 compared to 255 in Q1 [increase 25%] • Implementation of M365/NHS email for optometrists- this improves improve quality and timely submission of referrals	new contract to start April 2025. • Development of Eye Care Needs Assessment commenced Q3, deadline for WG sign-off end Q4 WG sign off • Transformation monies approved by WG to identify patients on Opthalmology list suitable for WGOS pathways • Primary/secondary care developing HCQ screening pathway to enable screening in practices [1000 patients in HES]	c)WGOS3 – 38% decrease d)WGOS 5- 36% increase • Work continues to introduce WGOS 4 pathways. a) Since implementation of the Glaucoma filtering pathway in Oct'24: 38 patients assessed in Q3 compared to 124 in Q4 b) Wet AMD filtering commenced Sep'24 [153 patients treated], 72 patients in Q3, 81 in Q4 c) Glaucoma monitoring to be implemented during Q1 2025. d) HCQ pathway implementation has been delayed due Opthalmology capacity - challenges will need to be addressed with an aim to introducing pathway later in 25/26. Currently 1147 patient backlog in Opthalmology . e) Med Ret- challenges to be overcome in Opthalmology to enable implementation during 25/26. Local scheme continues with a 34% increase in referrals, however reduction in numbers seen from

Priority area(s) to deliver 24/25:				
				appointment from 75% to 68% • New provider appointed for Parc Prison, optometrist starts on 3 April. • Eye care assessment completed and submitted to WG.
Overarching outcome measures/ metrics:				
Key metrics will be as per the NHS Wales Performance Framework 2024-2025 and will include access requirements: 11. Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours 13. Percentage of primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)				
Baseline position 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	Improvement trajectory			
Performance delivery 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	• 100% of GP practices achieved Access Standards • 95% of practices have achieved the GDS contract value			• GMS as previously reported at 100% and this is expected to be the case next year. • Forecast year-end figures show that 33% of practice will fail to achieve all metrics and will have a financial clawback instigated/. 66% will meet targets or threshold to roll over activity into 25/26.

Priority area(s) to deliver 24/25:				
Risks	**Risks of Non-Delivery**		**Mitigations**	
	Impact on patient care in terms of primary care access Impact on the wider system in terms of potential increased urgent care access elsewhere in the system.			
	Risks to Delivery		**Mitigations**	
	Key risks for primary and community care are: • Levels of demand across all elements of primary care. • Ability to recruit key staff across all staff groups and to compete with other Health Board areas where deprivation and workload is less and therefore jobs are more attractive. • Delivery of recurrent cash releasing savings when service delivery is to shift into the community		Continue to monitor the current position of contractors and provide proactive support Continue to explore ways to monitor demand Direct resources where they will have maximum impact and positive outcomes Designing systems and process which mutually support all elements across the Care Group	
Critical Enablers	**Finance**			
	Workforce			
	• Through a workforce planning change skill mix in key priority areas – increase workforce capacity and skill mix • Support and improve wellbeing of our teams • Strong & resilient inter-professional leadership & delivery			
	Digital			
	• Improve the availability of performance data for priority areas to inform service planning, monitoring and evaluation • Increase use of technology to support patients to live well in the community, e.g. remote monitoring through telehealth, virtual wards, and digital options to support more prudent delivery of care for example wound care. • IT and digital infrastructure to support the Navigation Hub which will be the single point of access for community services and remote monitoring			

Priority area(s) to deliver 24/25:	
	Other (Specify)
	Estate & Facilities enablers: • Development of an integrated Primary Care and Community estates plan supporting out of hospital delivery aligned to clinical services strategy • Identification of premises which has the infrastructure to support the integrated monitoring hub • Create environments suitable for integrated teams and patients to access
Prevention & Population Health	**Opportunities identified:**
	There is an association between health literacy and deprivation. It is accepted that we have challenges with our population accessing health and wellbeing services and understanding the link between lifestyle and wellbeing/chronic conditions. A focus needs to be on finding different ways to engage and connect with patients and this requires different approaches to impact behavioural change.

NHS WALES PLANNING FRAMEWORK 24-27- TEMPLATES

The Ministerial templates support the development of organisational IMTPs/ plans along with the Minimum Data Set (MDS).

Templates are required for commitments aligned to the national programmes which continue to support delivery of services and reinforce best practice through quality, efficiency and patient experience.

A template will be required to detail milestones, actions and risks etc for the following areas:

- **Enhancing care in the community, with a focus on reducing delayed pathways of care**
- **Primary and Community Care, with a focus on improving access and shifting resources into primary and community care.**
- **Urgent and Emergency Care, with a focus on delivery of the 6 goals programme.**
- **Planned Care and Cancer, with a focus on reducing the longest waits.**
- **Mental Health, including CAMHS, with a focus on delivery of the national programme.**

Progress on these expectations has been referenced in the planning framework and will be a focus of the planning process for 2024-25.

Completing the template will provide detailed delivery points including baseline, milestone and actions to demonstrate how the priority will be implemented. The detail contained in the template should align to the narrative plan.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

This template has been co-produced with Assistant Directors of Planning

MINISTERIAL TEMPLATE BLANK

All organisations are expected to complete the templates proportionate to their direct or supporting roles and functions.

The completed templates must be collated and submitted alongside the organisation's plan and the completed Minimum Data Set by 29 March 2023.

Send to: HSS-planningteam@gov.wales

The blank template below needs to be replicated as required for each priority identified. Additional rows can be expanded as necessary.

Priority area(s) to deliver 24/25:

Implementation of Same Day Emergency Care services that complies with Ministerial priorities:
· Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2
· Is accessible at key times evidenced by the emergency care demand profile in of each hospital
· Is direct access and bypasses Emergency depts
· Delivers a service for at least medical and surgical same day care
· Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook.
· Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme

Key focus should be on delivering	Unscheduled Care Group - Ministerial Pr

Ref:	Continued from 23/24 **(Delete as appropriate)**
Ref:	

Resume of planning Milestones 23/24:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	Implementation of Same Day Emergency Care services	Implementation of Same Day Emergency Care services	Implementation of Same Day Emergency Care services	Implementation of Same Day Emergency Care services
Progress synopsis	No key milestones in Q1.	No key milestones in Q2.	The 3 acute sites are at different points of development. Prince Charles Hospital update; -There is a defined SDEC area however WAST will not have access to SDEC initially however this will follow at later phases. - Medical SDEC environments will be identified by end of year. - Staffing models will exist against defined environments, however for phase 2 onwards additional resource will be required to achieve full realisation of the plans. -SDEC opening hours may be phased starting 8-8. - Medical SDEC will pull from ED/Assessment Units of appropriate patients upon opening – ED will form part of phase 2 however GP	Prince Charles Hospital - the capital work is due to be handed over during Q4 with plan to officially implement SDEC during March 2024. The scheme was prioritised by the HB's Capital Board for delivery from its capital funding for 23/24. The delivery model has been developed for SDEC at PCH setting out the flows which will be phased with later phases contingent on additional nursing and medical staffing – over and above significant existing HB resource and an SDEC grant contribution.

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			expectant patients will form part of Phase 1 and the Frailty development is already operating within the CDU/AMU. Royal Glamorgan Hospital update; - AECU in place in RGH. - Direct access to AECU for GP expected patients arriving by ambulance. - Appropriate patients are directed to AECU where possible. - Staffing establishment in place however not benchmarked against standards (Nurse Safe Staffing Act doesn't cover AECU/SDEC areas). - Defined opening hours, however during winter months AECU used overnight and on weekends as surge capacity. - Suitable patients from ED/Assessment Units are identified continually throughout the day and at PTWR and morning huddle.	

Outcomes of delivering Ministerial Priorities:	
Ref:	
Ref:	

Planned Milestones 24/25

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	-Establishment of a 24 hour Navigation Hub -Expanding and Defining Existing Services -Creation of a Directory of Services	- SDEC development phase 2/GP stream - Develop workforce model to support phase 2	- Scope development of WAST direct access -Implement phase 2	-Explore phase 3 for SDEC PCH Explore Virtual Wards utilising data -Direct to SDEC ED referrals

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Ref:	-CTM Navigation Hub deployed fully and accessible by GP's, WAST and Nursing Homes to refer patients in to secondary care -Map existing services -Referral routes identified for Existing Services -Gap Analysis completed with opportunity to centralise if possible -Directory of Services to support patients on a pathway approach	-Navigation Hub to have ability to book pre-arranged slots for Medical SDEC on acute sites -Data to be captured to understand value of running seven day services against cost on all three acute sites -Second Phase E Whiteboard development to begin, incorporating an SDEC viewer to support patients and data collection	The Navigation Hub will be able to direct WAST to offload in a defined SDEC area - Medical SDEC environments will be identified - Staffing models will exist against defined environments - Medical SDEC will have defined opening hours, and organisational policy will be to not bed down in SDEC - Medical SDEC will pull from ED/Assessment Units of appropriate patients upon opening	-Consistent data reports in relation to Medical SDEC numbers -Clinically led review of data to understand if setting up of virtual wards would add value -Discussion to consider value from an individual site basis against having an organisational stance (a virtual ward for CTM) -Pilot of direct referrals in to Medical SDEC from ED Nurse Triage
Delivery update	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	Updates on Navigation Hub in Pathways of care document.			

Overarching outcome measures/ metrics:

Baseline position 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	-Navigation Hub to develop workforce model to support 24 hour implementation -Discussion with WAST/NCCU to increase utilisation of Navigation Hub -Navigation Hub to be expanded to take GP Calls from Primary Care to direct appropriately -Medical Same Day Emergency Care approach to be standardised across Cwm Taf Morgannwg	-Booking system to be confirmed through work between Navigation Hub and Secondary Care -Data collection to be cleansed to support validity and accuracy of information -Process mapping to support the design of the second phase E Whiteboard development -Assumption that the Medical SDEC viewer for the E Whiteboard will be in a standalone unit -Build in a marker to support identification of patients who may be on an	-Medical Same Day Emergency Care will be added as a disposition for the Navigation Hub for WAST -WAST will not be allowed to bypass the Navigation Hub, as the Hub will maintain system oversight -Discussion and formalisation around communication strategy for colleagues in WAST/NCCU -Areas defined specifically for Medical Same Day Emergency	-ICT colleagues to collaborate in design of virtual ward -Business case to be designed and submitted to support virtual ward set up and working -Data to inform strategy against delivery of virtual ward -Acute Medical leads asked to design pilot of direct referrals from ED -Nurse triage in to Medical SDEC -Data capture and reporting to be set up to monitor outcomes of

Priority area(s) to deliver 24/25: <u>Implementation of Same Day Emergency Care services that complies with Ministerial priorities:</u> · Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2 · Is accessible at key times evidenced by the emergency care demand profile in of each hospital · Is direct access and bypasses Emergency depts · Delivers a service for at least medical and surgical same day care · Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook. · Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme				
	-Submission of Capital Estates request to improve environments -Continue against current recruitment plans -Process Map current pathways against data points with support from Performance and Information	SDEC pathway but "overnight" – these may remain in Assessment Units -Review current demand data to understand any additional workforce requirements	Care will exist on three acute sites -A CTM Standard Operating Procedure for Medical SDEC will be defined to demonstrate how the areas will function to support flow	patients to demonstrate value
Performance update	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	-<u>Prince Charles Hospital</u> - Capital work completed, Medical SDEC unit is open and taking direct referrals from ED and GPs. Further pathways are being mapped, to be implemented when Medical and Nursing workforce in place. -Recruitment of 2 x WTE consultants with one in post and the second to start mid-August 2024. Further medical and nursing recruitment ongoing. -<u>Princess of Wales Hospital-</u> Capital Estates plans in development. -SOPs in draft and development across all sites to standardise SDEC approach, including not bedding into Medical SDEC units.	E-whiteboard dashboard is in place for medical SDEC. Capital works completed at RGH.	Work planned for PoWH has been postrponed to Q4 due to the critical incident. Rollout of Strategic Transformation of Acute Medicine (STAMP) to RGH however changes in flow and demand and bed capacity due to the POW Roof Critical Incident impacted on its progress. Virtual Ward for Respiratory Pathway implemented in December.	Preparation for STAMP to be launched at POW in April/May. On-going planning to develop and improve services across Acute Sites and Community – See 6 Goals Report. Proposals/plans for investment to recruit additional COTE Consultants to ensure equity of provision for front door Frailty provision across the 3 sites. Proposals/plans for additional Acute Physicians to support the demand required for STAMP. Increase in SDEC activity medical and surgical across all sites (based on January 2025 data): RGH Medical – 37% POW Medical – 24% PCH Medical – 15% RGH Surgical – 53% POW Surgical – 17% Planning continuing for the pilot of the Doccla Virtual Ward at RGH Urgent Treatment Centre (UTC) – successful pilot in PCH supporting

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				demand at the front door. 728 patients seen since November 2024 with 75% discharged from UTC with no further intervention needed. Funding for the pilot ceases 31/03/25. UTC Project team are currently working through a benefits evaluation paper to justify the extension of the project.

Risks	**Risks of Non-Delivery**	**Mitigations**
	Current constraints within the medical workforce in order to deliver on all three sites. Financial risk to deploy workforce model seven day Current data demonstrates poor value where seven day services have been trialled within Cwm Taf Morgannwg, with increased cost for very little patient benefit Capital works required in order to provide fit for purpose estates to allow the complete segregation of SDEC services on Prince Charles and Princess of Wales Hospital sites	Getting the right patient to the right place on time leading to a reduced admission rate Decreased congestion in Emergency Departments Decreased bed waits within the Emergency Department by offering an agreed, safe alternative stream
	Risks to Delivery	**Mitigations**
Critical Enablers	**Finance**	
	There is a capital requirement of £120,000 to support the development of an identified appropriate environment within Prince Charles Hospital footprint. There is a capital requirement of £20,000 to support the development of an identified appropriate environment within Princess of Wales footprint. Revenue requirements for staff recruitment are costed and within scope for therapies as described above. Revenue in place to recruit an additional 2 x WTE consultant posts, but would still leave a shortfall against aim of 7.4WTE on each acute site.	
	Workforce	
	As part of a standardised offering across Cwm Taf Morgannwg, we aim for a 7.4WTE consultant workforce aligned with Medical SDEC on each acute site - A therapy recruitment plan is in place to improve access within Medical SDEC to support early intervention with patients. This equates to the following across the organisation: o 2 x Band 6 OT o 1 x Band 6 Physio o 1 x Band 7 Physio o 1 x Band 7 Falls AHP Lead o 1 x Band 6 Speech and Language Therapist o 1 x Band 6 Dietician o 4 x Band 4 Health Care Support Workers	
	Digital	
	Other (Specify)	

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Prevention & Population Health	**Opportunities identified:**

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Progress on these expectations has been referenced in the planning framework and will be a focus of the planning process for 2024-25.

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Key focus should be on delivering	 Unscheduled Care Group - Ministerial Pr			
Ref:	Continued from 23/24			
Ref:				
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	Implementation of CTM Emergency Pressures Escalation Procedure. Building existing plans to provide a pan CTM approach to the effective management of capacity and escalation across all areas within the Cwm Taff Morgannwg University Health Board. Review of workforce and Demand and Capacity modelling required for each site ED Digital Project Group to be established Support implementation of WPAS merger	Reduction in ambulance lost hours Roll out of >1 and 12 escalation hour action card Completion of Demand and Capacity modelling for all 3 sites Undertake patient profiling exercise to better understand ED demand Electronic tracker to support deep dive into patient pathway stages in ED to identify delays / barriers impacting on flow Heightened focus on exit blocks and hospital flow Realignment of workforce as part of an invest to save programme to secure a substantive and sustainable staffing model and reduce expensive agency spend Development of an Urgent Treatment Centre for GP referrals at PCH Relocation of Paediatric area in RGH to work towards compliance with national standards Implementation of RATs on PCH site Mapping of patient pathways and data capture across ED to standardise reporting	Emergency Pressures Escalation Plans ability to respond to seasonal variation Secure enhanced, timely support for non-emergency patient transfer service Work with WAST to facilitate transfer of patients to Radiology Continued engagement with GIRFT/SEDIT	Emergency Pressures Escalation Levels shared pan CTM

Priority area(s) to deliver 24/25: <u>Health boards must honour commitments that have been made to reduce handover waits.</u> This will be supported by: The provision of equitable Emergency Pressure Escalation procedures				
		Site wide engagement with Internal Professional Standards Engagement with GIRFT/SEDIT		
Progress synopsis	• Trajectories agreed; • Weekly performance meetings in place; • Ambulance Handover Escalation Card in place • Focused improvement programme to reduce Ambulance Handover delays "go live" at Royal Glamorgan Hospital. • Workforce reviews commenced • Demand and capacity modelling commenced in PCH • Digital Project Group commenced and programme of work agreed (Electronic huddle, cas card, GP discharge letters and live validation • Standardisation of coding and drop down list to support WPAs merger completed	• Review adherence to escalation procedure/action and outcomes; • Roll out of handover improvement plan at Prince Charles and Princess of Wales Hospitals; • RCA for any delay >4 hours; • Progress patient flow work streams through Six Goals Programme. • UTC Project Group commenced in July and programme of work agreed • Local engagement with a view to implementation of Internal Professional Standards commenced on PCH site specialties • GIRFT/SDEIT visits too plan in June. Continued engagement with National Programme to continue	• Review escalation level reporting across CTM by day; • Review ability/timeliness in de-escalation; • Review action cards and supporting documents; • Ensure plans resilient to respond to seasonal variation.	• Launch of WAST • ICT colleagues to collaborate in reporting escalation levels on the intranet
Ref:	**4 Hour Ambulance Handovers:** Q1 No more than 750 ambulances over 4 hours	**4 Hour Ambulance Handovers:** Q2 No more than 510 ambulances over 4 hours	**4 Hour Ambulance Handovers:** Q1 No more than 360 ambulances over 4 hours	**4 Hour Ambulance Handovers:** Q1 No more than 150 ambulances over 4 hours
Progress synopsis	Q1 – **452**	Q2 – **421**	Q3 – **619**	Q4 – 802
Outcomes of delivering Ministerial Priorities:				
Ref:	15 minute handover improved from 19.6% (2022) to 26.2% (2023)			
Ref:	1 hour handover improved from 51.8% (2022) to 63.8% (2023)			
Ref:	4 hours handover improved from 81.3% (2022) to 90.8% (2023)			
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**

Priority area(s) to deliver 24/25: <u>Health boards must honour commitments that have been made to reduce handover waits.</u> This will be supported by: The provision of equitable Emergency Pressure Escalation procedures				
Ref:	• 2024/25 trajectories to be reviewed and agreed. • Agree reporting and monitoring processes in line with new Directorate (following OCP process); • Refine operational processes across acute hospital sites in response to ongoing feedback from each 4hour breach exception report; • Review the impact of the collaborative pilot between WAST and RGH to 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; • Explore test of change to introduce a Discharge Lounge into RGH to reduce crowding within the ED.	• Refine operational processes across acute hospital sites in response to ongoing feedback from each 4hour breach exception report; • Possible roll out of WAST protocol across all CTM sites.	• Refine operational processes across acute hospital sites in response to ongoing feedback from each 4hour breach exception report; • Emergency Pressures Escalation Plans ability to respond to seasonal variation.	• Refine operational processes across acute hospital sites in response to ongoing feedback from each 4hour breach exception report;
Ref:	**4 Hour Ambulance Handovers:** 730	**4 Hour Ambulance Handovers:** **s** 660	**4 Hour Ambulance Handovers:** 666	**4 Hour Ambulance Handovers:** 674
Delivery review	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
		Review of D&C data completed in PCH, and ongoing in RGH and PoWH Operational processes: • Action card being developed for 4 hour breaches backed up by exception report data	Urgent Treatment Centre at PCH implemented in Nov 24 to support demand in ED. Rollout of Strategic Transformation of Acute Medicine (STAMP) to RGH however changes in flow and demand and bed capacity due to the POW Roof Critical	Preparation for STAMP to be launched at POW in April/May. On-going planning to develop and improve services across Acute Sites and Community – See SDEV template and 6 Goals Report.

Priority area(s) to deliver 24/25: <u>Health boards must honour commitments that have been made to reduce handover waits.</u> This will be supported by: The provision of equitable Emergency Pressure Escalation procedures				
		• Outcomes to be reviewed quarterly and reported through the board Work is progressing to explore the WAST protocol.	Incident impacted on its progress. Developments relating to the Nav Hub resulted in 7592 calls of which 6477 (85%) avoided conveyance to EDs between January 24 and January 25. Virtual Ward for Respiratory Pathway implemented in December.	Pre-emptive measures already in place to create offload space by reassigning patients into bed spaces or an ambulance where patients may become fit to sit.

Overarching outcome measures/ metrics:				
Ref:	15 minute handover rates			
Ref:	**1 hour handover rates – 24/25 performance trajectory**			
Ref:	**4 hours handover rates – 23/24 actual position**			
Ref:	Ambulance lost hours			
Baseline position 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	Q1 – **452**	Q2 – **421**	Q3 – **619**	Q4 – **802**
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	730	660	666	674
Performance actual	974	788	1050	Tbc following validation.

Risks	**Risks of Non-Delivery**	**Mitigations**
	Right patient, right place, right time	Getting the right patient to the right place on time leading to a reduced admission rate
	Risks to Delivery	**Mitigations**
	In hour v out of hours response Inpatient hospital flow Intelligent diverts	Decreased congestion in Emergency Departments Decreased bed waits within the Emergency Department Shared risk across the organisation Timely de-escalation and return to “Steady State”

Critical Enablers	**Finance**
	Workforce
	Digital
	Other (Specify)

	Opportunities identified:

Priority area(s) to deliver 24/25: Health boards must honour commitments that have been made to reduce handover waits. This will be supported by: The provision of equitable Emergency Pressure Escalation procedures	
Prevention & Population Health	

Priority area(s) to deliver 24/25:				
Key focus should be on delivering	***104-week target for stage 4 RTT (all specialities)***			
Ref:	Continued priority from 2023/24			
Ref:	**Focus areas: ENT, Gynae, Ophthalmology, T&O and Urology (92% of target cohort)**			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	5,902	3,080	413	0
Progress synopsis	3,985 (Jun 23)	3,195 (Sep 23)	3,060 (Dec 23)	2,637 (Mar 24)
Outcomes of delivering Ministerial Priorities:				
Ref:	Reason for non-delivery: Focus on number of specialities, insufficient internal capacity to meet demand, added workforce pressures, service structures and strike action			
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	1,949	1,148	75	0
Delivery	2,905	3,462	3,714	892
Overarching outcome measures/ metrics: RTT performance				
Baseline position 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	3,985 (Jun 23)	3,158 (Sep 23)	3,037 (Dec 23)	2,637 (Mar 24)
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	1,949	1,148	75	0
Risks	**Risks of Non-Delivery**		**Mitigations**	
	Patient care, increased waiting times, additional complexity/deterioration of condition		Service-level plans to deliver target	
	Risks to Delivery		**Mitigations**	
	Continued impact of industrial action 92% of cohort in five areas with increasing demand and capacity challenges. Delays in key diagnostic areas and pathology		Increased theatre capacity, cross-cover and insourcing	
Critical Enablers	**Finance**			
	Delivery of the planned care recovery plan, reference full financial IMTP			
	Workforce			
	Recruitment to critical posts, fully established workforce to provide adequate capacity and reduction in elective activity to cover unplanned sessions			
	Digital			
	Digital dictation, single WPAS system, TOMs development and text remind service			
	Other (Specify)			
	Increase theatre productivity, Maximise day case & GA opportunities, POA development			
Prevention & Population Health	**Opportunities identified:**			
	Continued development of transformation, innovation and digital opportunities in designing services and treatment pathways. Shifting resources and making sure that more patients can be seen, diagnosed and treated in Primary Care and the community. Develop longer term disease prevalence modelling aligned to clinical services plan. Maximise opportunities for regional working			

Priority area(s) to deliver 24/25:				
Key focus should be on delivering	***52-week target for stage 1 RTT (all specialities)***			
Ref:	Continued priority from 2023/24			
Ref:	**Focus areas: Cardiology, Dermatology, ENT, Ophthalmology, T&O and Urology (79% of cohort)**			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	16,317	11,271	7,424	4,187
Progress synopsis	13,047 (Jun 23)	13,101 (Sep 23)	14,154 (Dec 23)	14,591 (Mar 24)
Outcomes of delivering Ministerial Priorities:				
Ref:	Reason for non-delivery: insufficient internal capacity to meet demand, added workforce pressures, service structures and strike action			
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	10,774	7,433	3,487	0
Delivery	16,150	17,428	16,946	14,201
Overarching outcome measures/ metrics: RTT performance				
Baseline position 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	13,047 (Jun 23)	13,101 (Sep 23)	14,154 (Dec 23)	14,591 (Mar 24)
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	10,774	7,433	3,487	0
Risks	**Risks of Non-Delivery**		**Mitigations**	
	Patient care		Service-level plans to deliver target	
	Risks to Delivery		**Mitigations**	
	Continued impact of industrial action 79% of cohort in five areas with increasing demand and capacity challenges		Capacity mapping and improvement initials through OP transformation prog.	
Critical Enablers	**Finance**			
	Delivery of the planned care recovery plan, reference full financial IMTP			
	Workforce			
	Recruitment to critical posts, fully established workforce to provide adequate capacity			
	Digital			
	Digital dictation, single WPAS, full rollout of WPRS, Virtual outpatients, Consultant connect, text remind service			
	Other (Specify)			
	Reducing PC referrals through Health pathways programme			
Prevention & Population Health	**Opportunities identified:**			
	Continued development of transformation, innovation and digital opportunities in designing services and treatment pathways. Shifting resources and making sure that more patients can be seen, diagnosed and treated in Primary Care and the community. Develop longer term disease prevalence modelling aligned to clinical services plan. Maximise opportunities for regional working			

Priority area(s) to deliver 24/25:				
Key focus should be on delivering	***75% Cancer target, suspected to FDT (all specialities)***			
Ref:	Continued priority from 2023/24			
Ref:	**Focus areas: All areas**			
Resume of planning Milestones 23/24:				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	60.3%	62.8%	67.2%	69.8%
Progress synopsis	47.6% (Jun 23)	50.6% (Sep 23)	53.4% (Dec 23)	56.5% (Mar 24)
Outcomes of delivering Ministerial Priorities:				
Ref:	Reason for non-delivery: Diagnostic & Pathology capacity, ongoing service redesign, increasing USC demand			
Planned Milestones 24/25				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	67%	68%	69%	70%
Delivery	53.9%	57.0%	63.4%	TBC (final pos. 02/05)
Overarching outcome measures/ metrics: First definitive treatment ≤ 62 days from susp. cancer				
Baseline position 23/24	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	47.6% (Jun 23)	50.6% (Sep 23)	53.4% (Dec 23)	56.5% (Mar 24)
Performance Trajectories 24/25	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
	67%	68%	69%	70%
Risks	**Risks of Non-Delivery**		**Mitigations**	
	Patient care and timely diagnosis		Service-level plans to deliver target	
	Risks to Delivery		**Mitigations**	
	Diagnostic and pathology capacity, regional/tertiary service capacity constraints		Regional collaborative working	
Critical Enablers	**Finance**			
	Delivery of the planned care recovery plan, reference full financial IMTP			
	Workforce			
	Recruitment to critical posts, fully established workforce to provide adequate capacity			
	Digital			
	Single WPAS, full rollout of WPRS, cancer tracker			
	Other (Specify)			
Prevention & Population Health	**Opportunities identified:**			
	Continued development of transformation, innovation and digital opportunities in designing services and treatment pathways. Shifting resources and making sure that more patients can be seen, diagnosed and treated in Primary Care and the community. Develop longer term disease prevalence modelling aligned to clinical services plan. Maximise opportunities for regional working			

Agenda Item
9.2.7

CTM Health Board

Public Service Board Update

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Hamond (CTM PSB)
Cyflwynydd yr Adroddiad / Report Presenter	Philip Daniels, Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health

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	
CTM PSB	Cwm Taf Morgannwg Public Services Board

1. Situation /Background

1.1 The Cwm Taf Morgannwg Public Services Board brings together key local partners in the Merthyr Tydfil, Bridgend and Rhondda Cynon Taf local authority areas. Our purpose is to improve the economic, social, environmental and cultural well-being in our area by strengthening joint working.

It published an assessment of well-being in 2022 that is available along with a series of summary reports and published the Well-being Plan for 2023-2028.

1.2 The previous Cwm Taf and Bridgend Public Services Boards came together in May 2023 to form the Cwm Taf Morgannwg Public Services Board.

2. Specific Matters for Consideration

2.1 The PSB appointed a new chair, Paul Mee, Chief Executive of Rhondda Cynon Taf County Borough Council in December 2024.

2.2 The highlight report for February 2025 (appendix 1) details current activities against its wellbeing plan.

3. Key Risks / Matters for Escalation

3.1 None

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	Starting, growing, living, aging, 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)*	Choose an item.
	The work of the PSB relates to all goals of the WBFGA
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	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)	Yes - Reuse
	Refine, reduce, recycle, repurpose

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- external update
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):	If no, please include rationale below: Not required- external update
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 update.

6. Next Steps

6.1 Continued engagement with the CTM PSB.

BWRDD GWASANAETHAU CYHOEDDUS
PUBLIC SERVICES BOARD
CWM TAF MORGANNWG

PSB Update Date: February 2025

SUMMARY STATEMENT - CURRENT POSITION - FUTURE PRIORITIES

Focus on leadership for climate adaption at the next PSB. Ongoing work to embed the findings from the review in terms of engagement with strategic partnerships and formalising structures of our workstreams.

OVERALL RAG

STATUS UPDATE/ ACTIONS TAKEN by Workstream:

Workstream	Update March 2025	RAG
Climate Change Risk Assessment	The PSB has signed off the risk assessment for use within partner organisations. The PSB will commit their March meeting to working on their next steps for an adaptation plan. The risk assessment task group are working on a communications plan to share appropriately the messages from the risk assessment to different stakeholders, including work on a webinar for third sector organisations led by RCT Climate Action Network.	
Workforce Well-being Sub-board	The sub board is preparing information to connect staff with volunteering opportunities in green spaces. The first information will be shared in April. The Neurodivergence task group have prepared an advice sheet for managers to be shared in time for neurodivergence week in March.	
Active Travel Charter	Individual organisations are getting the charter signed off through their internal mechanisms prior to a launch at the PSB in June.	
Young Voices Project	The first meeting for the engagement sub group has been set for April. The project will link with the Bridgend College Young Leaders Programme and refresh the recruitment of young people for reverse mentoring.	
PSB Development	Paul Mee, Chief Executive, RCTCBC was appointed as the new PSB Chair in January. SE Wales PSB Network have extended their membership to include the Cardiff Capital Region team to maintain a link on shared areas of work such as active travel, transportation and Poverty. Their future programme includes Community Safety Partnerships, Shaping Places for Well-being and Well-being Assessment.	
Data Dashboard and Website	The final set of indicators for the data dashboard have been agreed and Data Cymru have started to build the dashboard which will be provided to the three PSBs before the end of March. The data task group will meet again to see the new dashboard. The website is being prepared to hold the background information from the Climate change risk assessment and the data dashboard and an updated page to inform on the PSB workstreams.	
Bridgend Food partnership	Proposals for a sub board bringing together working across CTM and with Healthy Weight programme are being prepared for discussion at the PSB in June.	

KEY METRICS:

A range of metrics will be aligned to each individual work programme building on the data dashboard work.

Risks/Issues	Description & Mitigation	RAG
Recruit young people to the reverse mentoring offer	Meeting with the three colleges in March to secure commitment to the scheme.	
Secure leaders commitment to a climate adaptation action plan	The PSB meeting in March will focus on leadership in climate action and seek to agree next steps.	
Make better use of links through PSB members to other partnerships and network	A template to map members involvement in partnerships and networks is being sent to all PSB members.	
More formal terms of reference and action plans	Work continues to finalise the terms of reference and action plans for all sub boards and commit to having these in place for all new sub boards and task groups.	

DECISIONS/ ESCALATIONS TO BOARD:

To use PSB members networks to share and influence.

Agenda Item
9.2.7

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CTM Health Board

Annual Assurance Report on Compliance with the Nurse Staffing Level (Wales) Act

Dyddiad y Cyfarfod / Date of Meeting	29/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tanya Tye, Senior Nurse Professional Practice & Nurse Staffing Lead
Cyflwynydd yr Adroddiad / Report Presenter	Greg 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 /Forum Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
NSLWA	Nurse Staffing Levels Wales Act
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
PoW	Princess of Wales Hospital
YGT	Ysbyty George Thomas Hospital
HB	Health Board
WTE	Whole Time Equivalent
RN	Registered Nurse
HCSW	Health Care Support Worker
SAU	Surgical Assessment Unit
SBAR	Situation, Background, Assessment, Recommendation framework

1. Situation /Background

1.1 The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to as "the Act") was introduced in March 2016 and came into effect in April 2018 for all acute adult medical and surgical ward areas. From 1st October 2021, the second duty of the Act was extended to include paediatric inpatient wards.

1.2 In accordance with Section 25E of the Act, the Health Board is required to report annually its compliance with maintaining the nurse staffing level in all wards to which Section 25B applies. This annual assurance report covers the period from 6th April 2024 to 5th April 2025.

1.3 The template report has been developed using the nationally agreed-upon and endorsed by the All-Wales Nurse Staffing Programme.

1.4 The Board is asked to receive and note the following formally:

- The contents of the 2024/2025 Nurse Staffing Levels (Wales) Annual Assurance Report (Appendix A) and the ward staffing levels (Appendix B is available in the documents folder on Admincontrol (not published)).
- The application of the triangulated methodology prescribed under Section 25C of the Act, which outlines the principles for calculating nurse staffing levels.
- A critical incident at Princess of Wales Hospital during the reporting period resulted in the relocation of several wards across the Health Board. Further details are provided in the SBAR (Appendix C), with a summary of the ward relocation listed in (Appendix D available in documents folder on Admincontrol (not published)).

2. Specific Matters for Consideration

2.1 2024–2025 Annual Assurance Report: The report outlines the progress made by the Health Board in meeting the statutory requirements of the Act for the period 6th April 2024 to 5th April 2025 (Appendix A).

2.2 Adult and Paediatric inpatient wards where Section 25B applies

The table below illustrates the number of wards at the beginning and end of the reporting period from 6th April 2024 to 5th April 2025.

	January 2024	June 2024
Number of Acute Medical inpatient Wards	17	17
Number of Acute Surgical inpatient Wards	15	16
Number of Paediatric inpatient wards	3	3

2.3 Changes Following Acuity Audits: As a result of the acuity audits conducted in January and June 2024, the following changes to nurse staffing levels were implemented (table 1):

Breakdown of staffing costs (proposed Uplifts/ decreases following June 2024 acuity audit)		
Site and Ward	Additional requirements	Financial cost
RGH Ward 3	Uplift 1 HCSW night	£127,570
PoWH Ward 4	Uplift 2 RN night Decrease 1 HCSW night	I2S scheme using £476,305 of 'out turn' funding savings of £247,249
PoWH Ward 5	Uplift 1 HCSW day and night	£213,677 (I2S scheme)
PoWH Ward 7	Uplift 1 HCSW day and night	£218,095
PoWH ward 8	Uplift 1 HCSW day and night	£218,095
PoWH Ward 9	Uplift 1 HCSW day and night	£218,095
PoWH Ward 10	Uplift 1 HCSW day and night	£206,000
PoWH Ward 11	Uplift 1 HCSW day	£95,915

Royal Glamorgan Hospital (RGH)	Princess of Wales Hospital (PoWH)

2.4 The following will be formally reported in the November 2025 paper, however for noting; following the January 2025 acuity audit the following wards were repurposed or the wards were repurposed into Section 25A wards.

2.5 Ward relocation

PCH (Prince Charles Hospital)
Ward 10 moved to RGH ward 19, following this ward 10 is now used as a surge capacity area.

2.6 Wards repurposed and now fall under Section 25A of the Nurse Staffing Level (Wales) Act (NSLWA 2016)

Site	Ward	Change
RGH	9	Surgical Assessment Unit (SAU)
RGH	10	Day surgery
RGH	11(PoWH 9)	Day surgery
YGT	Dinas	Was RGH ward 19 changed to rehabilitation

Ysbyty George Thomas Hospital (YGT)

2.7 Ward locations remaining closed following the critical incident

Princess of Wales Hospital
The following wards were closed due to the critical incident Wards 5, 6, 7, 8, 9,10. See Appendix D for additional information.

3. Key Risks / Matters for Escalation

3.1 For the reporting period (6/4/2024 to 5/4/2025) table 1 above shows the staff changes and financial costings for these changes.

3.2 There is a requirement to formally report any impact on safety or quality of care issues, which are attributed to non-compliance with the NSA staffing levels. Specifically, these incidents cover for adult wards (these can be found in Section 25E (2b) of the Annual Assurance Report on compliance with the Nurse Staff Level (Wales) Act Appendix A):

- Hospital-acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication resulting in moderate, severe harm and 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 moderate, severe and never events.

3.3 In addition, for all Section 25B wards complaints wholly or partially related to nursing care are also reported (Appendix A, section 25E(2a)).

3.4 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.

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)*	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	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: The NSLWA 2016 is Law and does not impact quality
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): NEUTRAL Outcome for Welsh Language (delete as appropriate): NEUTRAL documents for patients are available in welsh language if required.	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	This report is the assurance the Health Board is complying with the NSLWA 2016	
Enw da / Reputational	Yes (Include further detail below)	
	To ensure compliance with the NSLWA 2016, therefore proposed changes may have some reputational impact	
Effaith Adnoddau *(Pobl /Ariannol)* / Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Due to the changes to patient acuity and dependency there will be some financial impact due to the need to source additional staffing as and when risk assessed as doing so.	

5. Conclusion

5.1 In summary, the reporting year 20024-2025 has presented significant challenges due to the critical incident declared at Princess of Wales. This situation has necessitated several ward relocations throughout the Health Board, as well as the repurposing of wards into Section 25A areas.

5.2 The use of the Safecare system has started to be used in the Safe2start meetings, specifically supporting the deployment of staff, mitigation of professional judgment decisions, and the identification and management of red flags raised by the clinical teams.

5.3 Recruitment and retention of staff has been a focus in this reporting period with the following highlights

- Lateral move scheme supporting 33 individuals to remain in the health board in areas where they have an interest, with another 59 applications at various stages in the lateral move scheme.
- A total of 137.01 WTE staff recruited through the streamlining scheme.

6. Recommendation

6.1 The Board is asked to NOTE the annual assurance report 2024-2025:

- Assurance that the statutory requirements for section 25B wards have been completed
- Ongoing review of ward moves following the Princess of Wales Critical incident and support to the senior nursing team on the creation of new templates when wards relocate.

7. Next Steps

7.1 Assurance period 2025-2026

- Continue to support staff in embedding SafeCare into their daily roles and in raising professional judgements/ red flags to mitigate risk.
- once-for-Wales approach to reporting. Collaborate with colleagues across Wales to establish a unified approach to reporting that will benefit all regions.
- Collaborate with the attraction and retention leads to enhance nurse recruitment through student streamlining and a lateral move scheme.
- Support unscheduled care and planned care following the critical incident in Princess of Wales Hospital.

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 (CTMUHB)		
Date annual assurance report is presented to Board	This report is to be presented to Board 29th May 2025 (NB: Include data from April 6th 2024- April 5th 2025) This annual report refers only to year 2024/2025 but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October 2027 for the reporting period from April 2024- April 2027.		
	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- Highest 17	Lowest 13- Highest 17	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	Although no calculations occurred outside the biannual acuity audits, 9 medical wards were relocated due to a critical incident at Princess of Wales Hospital. This resulted in one medical ward being reclassified from Section 25B to Section 25A, as its remit changed to a rehabilitation ward	Although no calculations occurred outside the biannual acuity audits, 10 surgical wards were relocated due to a critical incident at Princess of Wales Hospital. Following the January 2025 acuity audit, five surgical wards were reclassified from Section 25B to Section 25A, as their primary purpose changed to day surgery or rehabilitation.	0
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to as "the Act") came into effect in April 2018 for Adult Acute Medical and Surgical inpatient wards. From 1st October 2021, the second duty of the Act was extended to include paediatric inpatient wards. These wards will be referred to as Section 25B wards 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 and a May paper presented to Board which forms part of the three-year report into Welsh Government. These reports are as per agreement within the once-for-Wales approach. The triangulated methodology, as outlined in Section 25C of the Act, sets out the principles for calculating nurse staffing levels.		

FINAL

	January and June 2024 Staffing calculations For the Biannual acuity audits in 2024 each Section 25B ward was analysed using the data captured from various digital systems including SafeCare and Datix. The data below was reviewed in collaboration with the Ward Sister, Senior Nurse, and Lead Nurse responsible for the ward, as well as the Heads of Nursing from each acute hospital and Care Group Nurse Directors, to generate the report. The 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 full details are in Appendix B **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 2024. • six months (falls, medication errors, pressure damage, and serious incidents, including paediatric-specific infiltration and extravasation). Since June 2024, work has been ongoing with Care Group Nurse Directors to ensure data captured is sufficiently detailed to support in-depth triangulation for staffing decisions. • Workforce-related metric data, mandatory training compliance, vacancies, recruitment and sickness. • Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system Datix and SafeCare (that allows information to be available to the Ward Managers, Heads of Nursing and Care Group Nurse Directors) for review. • Financial data confirming that all workforce models under the Nurse Staffing Act include a 26.9% uplift, with the supernumerary Band 7 Ward Sister/Charge Nurse factored into the ward's overall workforce plan. A critical incident at the Princess of Wales Hospital (PoWH) was declared in October 2024, due to this incident a number of wards had to move locations across site and across the Health Board one of these wards moved from Section 25B to Section 25A of the Act. As a result of the January 2025 acuity audit, a further five surgical wards were moved from Section 25B to Section 25A of the Act. This was due to changes in their primary purpose, shifting from acute surgical wards to day surgery or Surgical Assessment Unit (SAU) formats (full details of all PoWH ward moves are available in Appendix C)
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 and to ensure compliance with this guidance, bilingual poster templates are displayed either outside or inside the ward entrance for all 25B wards that are included in the Act including

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	Paediatrics. These are audited for compliance 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 was undertaken and signed off by the designated person. Following the June 2024 bi-annual acuity audit and calculation all eligible wards were issued the new templates, these are displayed with the responsibility to ensure they are completed correctly with oversight given to ward sister/ charge nurse and Senior nurses to ensure compliance. Paediatric inpatient wards have paediatric specific templates which were issued following the June 2024 bi-annual acuity audit and are being used within CTMUHB, these are updated following each acuity audit. 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 are 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. The annual assurance report was presented to Board on 30th May 2024 and an annual paper to Board in 28th November 2024, the All Wales Nurse Staffing Programme have updated the informing patient posters and these will be used following this paper being presented to Board in May 2025.

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

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2024 following January audit Second cycle: autumn 2024: following June audit		**Period Covered: -** 06/04/2024-05/04/2025		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	**31**	**619.32**	**493.60**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	**31**	**619.32**	**493.60**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	**32**	**635.30**	**523.75**

	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	**32**	**635.30**	**523.75**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 32**		
	Accompanying narrative: As mentioned, during this reporting period the Health Board declared a critical incident at the Princess of Wales Hospital (PoWH) site in October 2024, which impacted a number of wards, including 13 Section 25B ward areas. To ensure the safety of patients and staff, the affected wards were relocated both on-site and off-site. These relocations were physical moves only, with an agreement that a full acuity audit would be conducted in January 2025, allowing time for any service changes to be embedded. In instances where bed numbers decreased, the funded establishment remained unchanged, with additional staff deployed as needed to cover vacancies during this interim period. A full breakdown of the ward moves is provided in Appendix C. Following the January 2025 acuity audit, one medical ward and five surgical wards were reclassified as Section 25A areas. This reclassification was due to changes in ward function and activity. As part of the wider response to the critical incident and to maintain patient flow and service continuity, six wards were repurposed as Section 25A areas in January 2025. As a result, the total number of wards under Section 25B of the Act is now 26. 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 <u>paediatric inpatient wards</u> NB: First cycle: spring 2024 following January audit		**Period Covered 06/04/2024-05/04/2025**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)	**3**	**93.81**	**19.1**
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle	**3**	**93.81**	**19.1**

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Second cycle: autumn 2024: following June audit	**Required establishment (WTE) of paediatric inpatient wards calculated during second calculation cycle (Nov)**	**3**	**94.01**	**20.31**
	WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle	**3**	**94.01**	**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. There has been no change from the initial calculation; however, please note the following update for

Princess of Wales Hospital (PoWH):

A Band 4 Nursery Nurse has been added to the calculation, and 0.61 WTE Registered Nurse has been deducted to support the workforce during the spring/summer months (March–September). This adjustment is based on an anticipated reduction in patient activity and acuity during these months, as evidenced by trends in previous years. Staffing levels will be increased again during the winter months to accommodate the predicted rise in acuity. This seasonal variation will be operationally managed through careful planning of annual leave and other staffing considerations.

Prince Charles Hospital:

Has fully recruited into existing vacancies, and current staffing levels are appropriate for the acuity and dependency of their paediatric patients.

It is important to note that, following the critical incident at Princess of Wales Hospital, Royal Glamorgan Hospital had to relocate their Paediatric Assessment Unit (PAU) into their Outpatients Department. As a result, the remaining two units experienced increased admissions, due to Royal Glamorgan Hospital being unable to surge capacity into their PAU during peak times.

Paediatric services continue to support the Health Board's 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

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	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 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	31420	17000 (49%)	3929 (15%)	6303 (24%)	2962 (8%)	95%

Accompanying narrative:
This is the first year the HB has managed to pull this data from the SafeCare system therefore unable to compare to previous years. This shows a data completeness of 95%, there is work being undertaken in relation to the classification of shifts to ensure the data is assured. Where there has been shifts where planned roster has not been met all appropriate steps have been taken to ensure staffing levels were maintained whether by redeployment of staff or asking the supernumerary Band 7 to work within the numbers or having additional temporary staffing supporting the shift.

Extent to which the planned roster has been maintained within 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	5638	2057(42%)	127 (14%)	3131 (31%)	172 (9%)	96 %

Accompanying narrative:
This is the first year the HB has managed to pull this data from the SafeCare system therefore unable to compare to previous years. This shows a data completeness of 96%, there is work being undertaken in relation to the classification of shifts to ensure the data is assured. Where there has been shifts where planned roster has not been met all appropriate

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	steps have been taken to ensure staffing levels were maintained whether by redeployment of staff or asking the supernumerary Band 7 to work within the numbers or having additional temporary staffing supporting the shift.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	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. Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards. 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. The Health Board also hold daily safe2start huddles as well as monthly establishment meetings to review nursing workforce establishments attended by Workforce, Rostering, Nursing teams and finance colleagues. CTMUHB continue to embed SafeCare into the daily routine on an almost 'live' basis with more work around the escalation/ use of raising of red flags and professional judgements which provides greater understanding of ward activity, this supports staffing decisions and reporting requirements. The recording of patient acuity using the Welsh Levels of Care is embedded in practice with scrutiny undertaken if required, sessions are set up on a monthly basis for training and areas can ask for additional support if required.
Process for maintaining the Nurse staffing level	**Strategic/ Corporate steps to taken to maintain staffing levels** • Continued recruitment into identified vacancies across the Health Board. • Roster Management – All rosters are completed in line with policy and are developed to ensure the appropriate number of staff are rostered, underpinned by a suite of rostering metrics. • Roster Approval Process – All nurse rosters are subject to an approval process monitored by senior nurses to ensure safe and effective rostering. • Ward Managers and off-ward staff are deployed "into numbers" to meet the planned roster once all other options have been exhausted. • Staff numbers are enhanced via temporary staffing solutions, including redeployment from other areas within the organisation, overtime, bank, or agency staff. • The Health Board continues to participate in student nurse streamlining events and hosts local recruitment events both in-person and online to promote itself as an employer of choice. CTMUHB successfully recruited 137.01 WTE nurses through the streamlining process (September 2024: 99.48 FTE | March 2025: 37.53 FTE).

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	• The Health Board launched a Lateral Move Scheme to support internal staff transfers for Band 5 Nurses and Band 2 Healthcare Support Workers. This has enabled the retention of 33 nurses, with a further 60 in process **Operational steps taken to maintain staffing levels** • Robust daily systems of staff planning and reviews of patient flow and acuity are in place on each acute site via "Safe2Start" meetings. These inform 24-hour staffing plans, with risks assessed and managed accordingly. Within Paediatrics, staff are deployed across sites to ensure appropriate clinical skills are available when risks are identified. • A clear escalation process to manage staffing deficits is outlined in the Health Board's Operating Framework and Nurse Staffing Escalation Policy. • Staff are signposted to well-being support mechanisms and facilities. • Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required. • The SafeCare system is used to deploy staff, including Ward Managers and Senior Nurses, to mitigate professional judgments and red flags raised by clinical staff. • Enhanced overtime payment rates are offered to substantive staff for defined periods to increase 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 (including 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 chair monthly workforce meetings to review current ward vacancies and recruitment plans. The Allocate/Rostering Team provides data and scrutiny of ward rosters to assess compliance with efficiency and key metrics, as outlined in the Rostering Policy. • All nurse rosters are reviewed and approved by the Senior Nurse Team to ensure safe and effective staffing. • These meetings are attended by the Nurse Staffing Lead, Finance, and Workforce colleagues. **Ward level responsibilities to maintain staffing levels** Since November 2019, the All Wales Executive Director of Nursing Group has implemented a guidance document outlining what constitutes 'All Reasonable Steps' to support decision-making in maintaining safe staffing levels. This is a statutory requirement under the Act.

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	Within CTMUHB, there are well-established daily operational processes for reviewing staffing levels and making risk-based decisions regarding staff deployment. Every acute hospital holds Safe2start meetings three times daily to review staffing. Following risk assessments, staff are deployed where possible using professional judgment and in line with the 'All Reasonable Steps' guidance. The SafeCare IT system is used to: • Record staff moves • Flag professional judgment calls • Highlight red flags related to staffing risks • These are addressed through mitigation actions by senior nursing staff, providing documented evidence of efforts to reduce or manage identified 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	Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).	Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).	Medication administration 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))
	TOTAL	TOTAL	TOTAL	TOTAL
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	18	1	2	21
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	3	0	2	1
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	3	0	0	1

Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	15	1	0	20
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.	0	1	0	0

The following information has been attained from the business intelligence team who have gathered the data from the datix system for the annual period 6th April 2024- 5th April 2025, using the levels of harm and asking for the Closed cases.

Reportable Pressure Damage (Grade 3, 4 and unstageable)
There has been a total of 18 reportable Hospital acquired pressure ulcers during the reporting period 2024-2025, the Head of Nursing undertake scrutiny panels for Pressure ulcers where these are discussed and deemed avoidable/ unavoidable any lessons learnt from these incidents are shared with the wider teams not only on the specific DGH site but across the Health Board. There were 3 instances where nurse staffing levels were an attributing factor, lessons learned have been shared through Professional Forum Group (PFG) and through training sessions, ward staff attend the scrutiny panels to be able to see the process

Reporting Falls (Resulting in moderate, severe harm or death)
There has been 1 reportable falls during the reporting period 2024- 2025, this fall occurred where nurse staffing had been maintained however this was a contributing factor, staff involved in this incident have reflected and lessons learned have been shared for further learning across CTMUHB.

Reportable medication errors (level 3,4,5 and Never events)
There have been 2 reportable medication errors which have been investigated through internal process and taken to scrutiny panel, planned roster was not met however it was not deemed to be an attributing factor. Any lesson learnt from these incidents have been shared wider across the Health Board

Reportable complaints about nursing care (managed under PTR)
There have been 21 reportable complaints about nursing care and managed under the PTR process, these have been investigated through internal process and any lesson learnt from these incidents have been shared wider across the Health Board. 1 of these complaints have been linked as nurse staffing levels not being met as a contributing factor.
The changes to the data provided for the above table is because there has been training for staff and improved use of the Nurse staffing question in the investigations and Datix module.

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

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and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.

The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult ward's 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.
Since EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA.

Previously, we anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen.
It must be noted that previous NSLWA reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.
The quality indicators for the adults in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication administration 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 will be:

- Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- 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.

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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	**Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).**	**Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).**	**Medication administration 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 (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).	0	0	1	3	5
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	0	0	0	2	0
Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0	0
Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained	0	0	0	1	5

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.	0	0	1	0	0

Reportable medication errors (level 3,4,5 and Never events)
One of the incidents under medication errors, nurse staffing was maintained however it was considered to be a contributory factor, learning has been shared across the care group

Reportable infiltration and extravasation incidents
There were three incidents, two of these when the planned roster was not maintained but staffing was not deemed to be a contributory factor and one of these occurred when staffing was maintained but again staffing was not a contributory factor. Lessons have been shared across the Health Board.

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 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:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication administration 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 incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).
- 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. Teams on the Acute District General Hospital (DGH) sites conduct Safe2start meetings three times daily to review staffing, assess risks, and implement plans to support roster maintenance and ensure patient safety. The SafeCare system provides a bird's-eye view of staffing across the site, allowing for more informed and responsive decisions. Senior nurse leadership is available 24 hours a day, 7 days a week, ensuring that professional decisions can be made at any time of day. The Health Board has established a learning repository, where any relevant events are uploaded for shared learning across the organisation. In cases where medication errors occur, teams are invited to a review panel, where the incident is discussed. This promotes transparency and gives staff an opportunity to engage with the review process and learn from the event.
	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 sister/ charge nurses in the Community hospitals undertake regular meetings with the lead nurses and Heads of nursing. • Group Nurse Directors maintain oversight of their respective areas, with senior nursing teams escalating risks, identifying gaps, and reviewing staffing levels accordingly. • Within CTMUHB Mental Health Services, is currently undertaking an establishment review across the directorate. Where staffing levels are identified as being below the agreed level, these are escalated following the appropriate process. • Section 25A Adult Ward areas, Emergency and Outpatient Departments, undergo monthly establishment reviews with staffing levels discussed and escalated with senior nurses and Heads of Nursing • Ongoing education and training for nursing staff across the Health Board ensures they have the required skills and knowledge to perform their role effectively. Some staff are also supported to undertake further education modules to their areas.

	The All-Wales Nurse Staffing Programme have just commissioned a Section 25A work stream to develop Operational Guidance for section 25A areas which the nurse staffing lead is part of the membership.
	Conclusion & Recommendations
	In summary, there has been continued support for the Nurse Staffing Levels (Wales) Act 2016 during the period 2024-2025. 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** • The SafeCare system has been rolled out to all Section 25B areas, with implementation in Community Hospital wards, Maternity, and Mental Health services commencing in March 2024. • An All Wales review of the specific Datix question related to the Nurse Staffing Act has been completed. This has resulted in a revised set of questions, due to go live in April 2024. These changes aim to provide more robust and complete data regarding reportable incidents and complaints. Further work is underway to develop an All Wales Nurse Staffing Report from Datix, promoting consistent reporting across Wales. • 137.01 WTE nurses have been recruited through the student streamlining process. • 33 nurses have successfully used the Lateral Move Scheme, with an additional 59 currently in process. **Next steps for 2025-2026** • To continue to promote the use of SafeCare to enhance daily staffing meetings on the acute sites. • Working in partnership with Workforce and Organisational development colleagues, gain an insight and understanding of the themes that underpin the obstacles to staff retention. This will include analysis data from Exit interviews, staff feedback and staff surveys. • Develop a coherent recruitment strategy for both the short and medium term, aligned with the Health Board Integrated Medium Term Plan and Cwm Taf 2030: Our Health Our Future strategy. • Following the Princess of Wales critical incident, some Care Groups have reorganised wards to ensure patient flow and staffing is accurate. • Continue collaboration with Care Groups to ensure biannual acuity audits accurately capture patient acuity and dependency levels, enabling appropriate staffing levels and support efforts to recruit and retain staff.

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Agenda Item
7.3 Appendix C

Quality, Safety & Experience Committee

SBAR on Section 25B ward moves outside of biannual acuity audit

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author *If you do not wish for your name to be included in the public domain, please only include your job title*	Tanya Tye Senior Nurse Professional Practice & Nurse Staffing Act Lead
Cyflwynydd yr Adroddiad / Report Presenter *If you do not wish for your name to be included in the public domain, please only include your job title*	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
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 /Forum Individuals	Date	Outcome

Acronyms / Glossary of Terms	
NSLWA	Nurse Staffing Levels (Wales) Act 2016
Section 25B (S25B)	Inpatient Adult Acute Medical and Surgical Wards and Inpatient Paediatric wards
Section 25A (S25A)	Any area within the Health Board where nursing care is undertaken
PoWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YGT	Ysbyty George Thomas Hospital
PAU	Paediatric Assessment Unit
DSU	Day Surgery Unit

1. Situation /Background

1.1 In October 2024, a critical incident was reported at the Princess of Wales Hospital (PoWH), necessitating the relocation of inpatient wards, including 12 wards covered under Section 25B of the Nurse Staffing Levels (Wales) Act 2016.

1.2 The affected wards and their respective relocations are detailed in the table below. A comprehensive analysis of the impact on nurse staffing levels and the associated costs is provided in Appendix A.

Site	Ward	New location
Princess of Wales Hospital (PoWH)		
PoWH	5	RGH 19
PoWH	6	PoWH 16
PoWH	7	RGH 15
PoWH	8	PoWH 19
PoWH	9	RGH 11
PoWH	10	PoWH 18
PoWH	11	RGH 18
PoWH	16	PoWH 21
PoWH	18	RGH 2
Royal Glamorgan Hospital (RGH)		
RGH	2	RGH 9
RGH	3	RGH 16
RGH	9	RGH 7
RGH	15	RGH 19 is now on RGH Ward 1
RGH	19	RGH 3
Section 25A wards		
RGH	11	The Day Surgery Unit (DSU) ward is now closed (temporarily)
RGH	18	The Paediatric Assessment Unit (PAU) is temporarily closed
PoWH	21	Glanrhyd Hospital, Angelton ward 3
PoWH	19	Ysbyty George Thomas Hospital (YGT) Fernhill ward
RGH	1	Unfunded/ established ward areas is closed
RGH	20	YGT Dinas ward (was Section 25B now Section 25A)

2. Specific Matters for Consideration

2.1 The ward relocations are temporary and have been implemented in response to the critical incident at Princess of Wales Hospital. Any further changes involving Section 25B wards will be documented and reported as set out in the requirements of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA).

3. Key Risks / Matters for Escalation

3.1 The critical incident may lead to temporary adjustments in the wards' capacity and staffing levels, which may have financial implications and affect funding for the affected wards.

3.2 For the initial ward relocations, no financial impact was observed since there were no changes to staffing establishments; only physical moves of the wards took place. The senior nursing teams will assess acuity and staffing levels during the biannual acuity audit in January 2025. Any changes that may incur financial costs will be identified at that time.

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 *(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 the rationale below: This is a paper to highlight the changes made following the critical

		incident, therefore this is just to update the board No impact on Quality of care
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):	If no, please include the rationale below: The Changes have no impact on Equality and Welsh Language
Cyfreithiol / Legal	Yes (Include further detail below)	
	There is a legal requirement under the Nurse Staff Levels (Wales) Act to report any changes to the 25B wards within the Health Board	
Enw da / Reputational	Yes (Include further detail below)	
	To ensure compliance with the Nurse Staffing Levels (Wales) Act	
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.	
	No Additional resources are needed at present	

5. Recommendations

5.1 Ward templates will be issued to all Section 25B wards affected by the Hospital incident; this is to ensure continued compliance with Section 25E of the NSLWA (2016)

5.2 The Heads of Nursing/ lead nurses/ senior nurses are to notify the Health Board's Nurse Staffing Lead of any further changes to ward locations, bed numbers or staffing numbers.

This should ensure:

- Timely updates to staffing templates
- Accurate documentation of changes
- Compliance with statutory reporting requirements under the Nurse Staffing Levels (Wales) Act 2016

5.3 The January 2025 biannual acuity audit will incorporate all section 25B wards in their temporary ward locations, which have been a result of the critical incident. Any changes will be reported in line with the NSLWA operational guidance.

6. Next Steps

6.1 January 2025 biannual acuity audit has now been completed. Staffing levels for each Section 25B ward will be calculated using the triangulated methodology, incorporating permanent and temporary ward locations.

6.2 Following the January Biannual acuity audit, a paper will be written to outline any changes. These will be formally reported in the November 2025 Board paper, informing of any changes to ward staffing levels. These changes are to include rationale, costings, and whether these are temporary or permanent changes. An interim report will be written for the Executive Director of Nursing to share with the Executive Leadership Team.

6.3 Heads of nursing to continue to notify the Nurse Staffing Act Lead of any changes to ward locations, bed numbers and/or staffing as set out in the Nurse Staffing Levels Wales Act 2016.

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee (JCC)

Dyddiad y Cyfarfod / Date of Meeting	18/03/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Jacqui Maunder – Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor - JCC Interim Chief Commissioner
Noddwr yr Adroddiad / Report Sponsor	Stacey Taylor JCC Interim Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	April 2025	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer (CEO) Members of the Joint Committee with a summary of the key issues considered by the Joint Commissioning Committee (JCC) at its public meeting on 18 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee is set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

3. HIGHLIGHT REPORT

(Links to reports highlighted March 2025 - NHS Wales Joint Commissioning Committee)

Status	Update
Alert / Escalate	• The Joint Commissioning Committee Foundation Plan 2025-2026 was approved in readiness for inclusion in Health Board Integrated Medium Term Plans (IMTPs) and submission to Welsh Government by 31 March 2025 with the following conditions: o Develop an executive summary, o Include an acknowledgment of the level of risk including provider risk that this plan is highlighting, o Establish robust accountability process to monitor the delivery of the plan, o Recognise the on-going conversations with providers around deliverability and savings targets that could impact on the plan, o Acknowledge the limited capacity to undertake the transformation programmes identified within the Plan and the collaboration required from Health Boards in delivery; and o Representations with Welsh Government on the position in relation to non-recurrent funding that could impact on the plan. • Positron Emission Tomography Emission Centre (PETIC) (prostate-specific membrane antigen (PSMA) PET Scan - An urgent piece of work to be undertaken to identify how scan capacity can be identified and be prioritised according to clinical need and responsibility for health equity. Wider piece of work on equity of access will feature as transformation piece of work detailed in the approved foundation plan.
Advise	• The Chair confirmed that Huw George, Deputy CEO and Executive Director of Operations and Finance at Public Health Wales (PHW), will be the Interim Chief Commissioner from 1 April 2025 for 12 months. He will start in shadow form on a part-time for two days a week during March and become full-time on 1 April 2025 at which point he will hold Accountable Officer status for the

Status	Update
	JCC. Stacey Taylor will continue as the current Interim Chief Commissioner until 1 April 2026. • An update was received from the Interim Chief Commissioner: o Quarter 4 Progress & Future Priorities: Work continues under transition to establish 'routine business' for the JCC. Priorities included finalising and implementing the final organisational structure and developing the Foundational Annual Plan for 2025/26 for approval, o Work on finalising and implementing the Scheme of Delegation, o Key achievements were highlighted; and o Next developments include securing Public Health expertise, completion of internal reviews for Traumatic Stress Wales (TSW) and the Welsh Kidney Network (WKN). • Members received reports from each of the three Commissioning Directors: • Update from the Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups. Members noted: o Work on the new Mother and Baby Unit (MBU) in Chester had commenced with a provisional operational date of October 2025; and o The review of TSW service had concluded, and discussions are ongoing to consider the recommendations. Further discussions would take place related to the future strategy of the Mental Health portfolio at the April JCC Strategy Session. Members approved the establishment of an NHS Wales Continuing Healthcare (CHC) Cooperation Programme subject to funding from WG being secured and assurance to the Chief Commissioner that there is a plan and resilience in place to establish as a co-operation forum. • Update from the Director of Commissioning for Ambulance and 111 provided updates on: o The judgment in relation to the judicial review of the JCC decision to develop the Emergency Medical Retrieval and Transfer Services (EMRTS) was anticipated by end of March 2025,

Status	Update
	o Pending the outcome of the judicial review further work on the delivery of Recommendation 4 - the bespoke road-based service was paused, o During March 2025, the JCC will meet with Health Board representatives in stakeholder workshops to review and discuss the recommendations within the WAST Manchester Arena Inquiry report, o Welsh Government are establishing a new clinically-led 'national ambulance patient handover improvement implementation group'. This work will be a key enabler in supporting the JCC to reduce risks and improve productivity in emergency ambulance services; and o A verbal update was provided on the Health and Social Care Committee's recommendations on emergency ambulance response targets. The long-term vision for Non-Emergency Patient Transport Services (NEPTS) 'The Future Vision' was approved. • The update from the Director of Commissioning for Specialised Services included: o An update on the work of the Specialised Services Collaborative Commissioning Group, o With the planned care funding from the Welsh Government (WG), Swansea Bay University Health Board (SBUHB) aims to meet the 104-week target for Plastic Surgery patients by the end of March 2025. However, maintaining this target through 2025/26 may be challenging without additional funding above the contract baseline, o Capacity gaps in outreach plastic surgery services in north Wales (now in escalation), o Obesity surgery waiting times; and o Neonatal and Paediatric Intensive Care services remain at an escalated risk level. • Strategic Planning (Foundation Annual Plan 2025/26): o NHS Wales Planning guidance highlighted a 1.77% budget uplift with a 2% efficiency savings target, o Highlighted the importance of collaboration and prioritisation of resources,

Status	Update
	o Key priorities include urgent care and planned care recovery, o Early estimates suggest the JCC will require between 5.5%-6.4% financial growth requirement, o The substantial cost drivers such as inflationary pressures, increased demand and NICE technology approvals were highlighted, o The Foundation Plan for 2025/26 was approved subject to caveats (see Alert Section above); and o A JCC strategy workshop will be dedicated to support the work to develop the JCC long term strategy and the IMTP for 2026/2029.
Assure	• Governance & Risk Management: o Updated financial delegated limits were approved for the new Interim Chief Commissioner with effect from 1 April 2025, o The Risk register was received, with each of the risks assigned to one of the sub-committees for monitoring and scrutiny, o The Corporate Governance Report was received which provided the timeline for approval of the Annual Governance Statement (AGS). Details on the approach to the Committee Effectiveness was provided and the forward plan of Business was presented; and o Members noted that the Health Board Standing Orders (and subsequently JCC Standing Orders) would be updated to reflect the recently issued WHC which reduced the timescale for publication of board papers to 5 clear working days.
Inform	• The Committee received the Month 10 Finance Report and the Month 9 Performance Report, • The Committee received the following assurance reports: ▪ CTMUHB Audit and Risk Committee Assurance Report, ▪ Quality Safety and Outcomes Sub-Committee, ▪ Planning Performance & Finance Sub-Committee, ▪ Individual Patient Funding Request (IPFR) Panel assurance report; and ▪ Welsh Kidney Network Board (WKN) assurance report.
Appendices	None

Status	Update

Note that an “in committee” meeting was also held. A formal update will be given to the next public JCC meeting on 20 May 2025 under the Corporate Governance report.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality Reduce Duplication Improve Equality and Population Health Facilitate Integration
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 More Equal Wales
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: Learning, improvement and research Whole systems perspective Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Efficient All of the domains of quality apply
	If more than one applies please list below: Effective; equitable; person centred; timely and safe
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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 a summary of the latest meeting of the JCC
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 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 summary of the latest meeting of the JCC
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 Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- Note the highlights outlined in Section 3 of this report.