Planning, Performance & Finance Committee

Tue 22 August 2023, 14:00 - 17:00

Virtual Via Teams

Agenda

14:00 - 14:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Patsy Roseblade, Chair

1.2. Apologies for Absence

Patsy Roseblade, Chair

For Noting

1.3. Declarations of Interest

Patsy Roseblade, Chair

For Noting

14:05 - 14:10
5 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 27 June 2023

Patsy Roseblade, Chair

For Approval

2.1.1 Unconfirmed Minutes 27.6.23 PPF Committee 22 August 2023.pdf (10 pages)

2.1.2. Unconfirmed 'In Committee' Minutes of the Meeting held on 27 June 2023

Patsy Roseblade, Chair

For Approval

2.1.2 Unconfirmed IC Minutes 27.06.23 PPf Committee 22 August 2023 - v2.pdf (2 pages)

2.2. Items for Noting

2.2.1. Months 3 & 4 Monitoring Returns - To follow

Sally May, Director of Finance

For Noting

2.2.2. Action Log

Patsy Roseblade, Chair

For Noting

2.2.2 Action Log PPF Committee 22.8.23.pdf (6 pages)

14:10 - 14:15
5 min

3. MAIN AGENDA

3.1. Matters Arising Not Previously Raised on the Action Log

Patsy Roseblade, Chair

14:15 - 14:30
15 min

4. GOVERANCE

4.1. Organisational Risk Register

Cally Hamblyn, Assistant Director of Governance & Risk

for Discussion/Noting

4.1a Organisational Risk Register July 2023 - Cover Paper - PPF.pdf (3 pages)
4.1b Appendix 1 - Master Organisational Risk Register - Approved by ELG 17.7.2023.pdf (3 pages)

4.2. Outcome of the Committee Self-Effectiveness Survey & Action Plan

Cally Hamblyn, Assistant Director of Governance & Risk

For Approval

2.1.3 Outcome of Committee Self Effectiveness Survey PPF Committee 22 August 2023 v2 CH.pdf (4 pages)
2.1.3a CTM IM Scrutiny Toolkitv7(inc all-Wales additions) APPROVED 23.2.22.pdf (21 pages)

14:30 - 15:30
60 min

5. IMPROVING CARE

5.1. Integrated Performance Dashboard

Executive Directors

For Discussion/Noting

5.1 PPF Integrated Performance Dashboard PPFC 22 August 2023.pdf (23 pages)

5.2. Planned Care Recovery Programme & Update on Ophthalmology Improvement Plan

Gethin Hughes, Chief Operating Officer

For Discussion/Noting

5.2 Planned Care and Ophthalmology Improvement Plan PPF Committee 22 August 2023 LT minor additions.pdf (6 pages)

5.3. Civil Contingencies & Business Continuity 2022-23 Annual Report

Linda Prosser, Director of Strategy & Transformation/Jason Evans EPRR Lead

For Discussion/Noting

5.3 Civil Contingencies & Business Continuity Report 2022-23 PPF Committee 22 August 2023.pdf (13 pages)

5.4. Manchester Arena Inquiry Recommendations – CTMUHB Assurance

Linda Prosser, Director of Strategy & Transformation/Jason Evans EPRR Lead

For Discussion/Noting

5.4a Manchester Arena Reccs - Assurance PPFC 22 August 2023.pdf (10 pages)
5.4b SWLRF letter 11.05.23 PPFC 22 August 2023.pdf (2 pages)

15:30 - 16:00
30 min

6. SUSTAINING OUR FUTURE

6.1. Month 3 Finance Report and Verbal Update on Month 4 - To follow

Sally May, Director of Finance

For Discussion/Noting

6.2. Month 3 Finance Performance Report - To follow

Sally May, Director of Finance

For Discussion/Noting

16:00 - 16:10
10 min

7. OTHER MATTERS

7.1. Forward Work Plan

Patsy Roseblade, Chair

For Noting

7.2. Committee Highlight Report to Board

Patsy Roseblade, Chair

7.3. Any Other Urgent Business

Patsy Roseblade, Chair

7.4. How did we do today?

Patsy Roseblade, Chair

16:10 - 16:15
5 min

8. DATE AND TIME OF NEXT MEETING

TUESDAY 24TH OCTOBER 2023 AT 2.00 PM

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE PLANNING, PERFORMANCE & FINANCE COMMITTEE HELD ON 27 JUNE 2023, AS A VIRTUAL MEETING WHICH WAS HELD VIA MICROSOFT TEAMS

PRESENT

Mel Jehu	-	Independent Member (Chair)
Nicola Milligan	-	Independent Member
Ian Wells	-	Independent Member
Carolyn Donoghue	-	Independent Member
Patsy Roseblade	-	Independent Member
Geraint Hopkins	-	Independent Member

IN ATTENDANCE

Linda Prosser	-	Executive Director of Strategy & Transformation
Sally May	-	Executive Director of Finance
Gethin Hughes	-	Chief Operating Officer
Sarah James	-	Deputy Chief Operating Officer – Acute Services
Julie Denley	-	Deputy Chief Operating Officer – Mental Health, Primary Care and Community Services
Alan Martin	-	Head of Operational Estates
Paul Dalton	-	Internal Audit and Assurance (Observing)
Sara Utley	-	External Audit (Observing)
Cally Hamblyn	-	Assistant Director of Governance & Risk
Kathrine Davies	-	Corporate Governance Manager (Meeting Secretariat)

PART 1. PRELIMINARY MATTERS

1.1.0 WELCOME AND INTRODUCTIONS

The Chair **welcomed** everyone to the meeting including Alan Martin, Head of Operational Estates for Agenda Item 6.4 Reinforced Autoclaved Aerated Concrete (RAAC) Investigation

1.2.0 APOLOGIES FOR ABSENCE

Apologies were received from Tim Burns, Assistant Director of Capital and Estates.

1.3.0 DECLARATIONS OF INTERESTS

There were none declared.

PART 2. CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 'UNCONFIRMED' MINUTES OF THE PLANNING, PERFORMANCE & FINANCE COMMITTEE MEETING HELD ON 4 MAY 2023

Resolution: The minutes were **APPROVED** as a true and accurate record subject to one minor amendment.

2.1.2 'UNCONFIRMED' MINUTES OF THE PLANNING, PERFORMANCE & FINANCE IN COMMITTEE MEETING HELD ON 4 MAY 2023

Resolution: The minutes were **APPROVED** as a true and accurate record subject to one minor amendment.

2.1.3 DRAFT COMMITTEE ANNUAL REPORT 2022-23

The Chair advised Members that following the meeting the Committee Annual Self-Assessment Survey link would be circulated to members for completion and review at the August 2023 meeting.

Resolution: The Revised Terms of Reference were **ENDORSED FOR BOARD APPROVAL.**

2.2 FOR NOTING

2.2.1 MONTHLY MONITORING RETURNS TO WELSH GOVERNMENT

Resolution: The Committee **NOTED** the Monitoring Returns for Months 12, 1 & 2.

2.2.2 ACTION LOG

Resolution: The Committee **NOTED** the Action Log.

3.0 MAIN AGENDA

3.1.0 MATTERS ARISING NOT PREVIOUSLY CONTAINED WITHIN THE ACTION LOG.

There were none.

4.0 GOVERANCE

4.1.0 ORGANISATIONAL RISK REGISTER

C. Hamblyn presented the report that outlined the high-level organisational risks that had been assigned to the Committee, and highlighted the management actions and mitigation.

C Hamblyn drew attention to risks 4491 and 4456, which had previously been identified by Members of requiring review, and confirmed that a review was underway by the respective Care Groups. An update will be available at the next meeting.

N. Milligan referred to risk 4491 where the mitigating action noted that a harm review was being piloted in ophthalmology, and raised concern that the service was currently without a Head Orthoptist or Band 8a, and queried what impact that would have on any harm review due to the Head Orthoptist having responsibility for governance and accountability. In response, G. Hughes advised that recruitment was underway for a Head Orthoptist. He advised that he would seek and provide an update to all Members outside of the meeting in terms of N Milligan's specific query.

N. Milligan referred to Risk 4458 which was linked to the Six Goals that stated the task and finish groups had completed their delivery of the agreed objectives. However, she highlighted that there were no outcomes or updates to reflect the activity undertaken within this risk update or on the specific agenda item regarding the Six Goals Programme.

G. Hughes advised that with regard to risk 4458 this would be addressed under the Six Goals update on the agenda.

P. Roseblade referred to risk 4772 and the software update for the laundry and advised that it stated there would be an update in April, she also queried if there was an Infection, Prevention, Control impact to this risk. C. Hamblyn assured P. Roseblade that the facilities team were reviewing this risk and she would highlight the query raised. It was noted that an update on the risk had also been captured within the Action Log.

Resolution: The report was **NOTED**.

Action: To provide an update on the recruitment of the Orthoptist Post to Members of the Committee outside of the meeting.

Action: To highlight the query on the laundry risk 4772 with the facilities team.

5.0 IMPROVING CARE

5.1.0 SIX GOALS FOR URGENT AND EMERGENCY CARE

S. Hughes provided an update on progress to date with the Six Goals.

C. Donoghue referred to page 3 of the report where it had stated that task and finish groups for the stroke pathway had completed the delivery of agreed objectives and transitioned into business-as-usual operational delivery, and queried whether they were seeing any impact of this. S. James advised that there was still a significant amount of work in relation to stroke services and it was embedded within the Six Goals programme. It was noted that it is the responsibility of the Care Groups working with the Chief Operating Officers team and external partners to improve upon the delivery of the stroke pathway.

C. Donoghue queried what the rapid 90-day development plan referred to on page 5 of the report was. In response, S. James advised that the 90-day development plan was a robust plan where they would attempt to reset thinking, for example they recently did this in the Royal Glamorgan Hospital with the zero tolerance to four hour waits and had made some headway and the handover delays had significantly improved. She added that they were hoping to roll this initiative out in the Princess of Wales hospital shortly.

C. Donoghue referred to the e-whiteboards and sought clarity on what this was. S. James invited C. Donoghue to visit the sites to see how the e-whiteboards worked which was revolutionising the way patient data was used and provided one list and one picture of the patient journey from start to finish, providing information on where they were on their pathway and enabling staff to act promptly upon the needs of the patient.

I Wells advised that the Digital and Data Committee had received a demonstration on the e-whiteboards at their June 2023 meeting, and this was proposed for a future Board Development Session.

I Wells also queried whether social care would be able to access the e-whiteboard technology. In response, S. James confirmed that it is was the ambition that part 1 of the project would provide one list that both health and social care colleagues could use.

M. Jehu referred to the workstreams and queried whether there were timescales that they worked to. S. James confirmed that it depended on which workstream it was as some had start and finish points but others were still ongoing. She added that they had got to the point now where they were able to close down the following workstreams as they were now embedded into the Care Groups as part of the day-to-day business and confirmed that these were - Minor Injury Unit, Emergency Department and Non-Invasive Pathway.

In referencing the social care setting and engagement with other organisations, M. Jehu queried whether all partner agencies were working at the same level of pace. S. James confirmed that this was the case and there was positive engagement from the beginning with monthly meetings of the Six Goals Board being held with all partners involved.

In response, M. Jehu queried whether there was a clear line of sight between the strategic intent of the senior staff involved and the staff who had the responsibility of carrying out the operational delivery. G. Hughes confirmed that there was positive engagement with all staff involved.

Resolution: The Report was **NOTED.**

5.2.0 INTEGRATED PERFORMANCE DASHBOARD

L. Prosser presented the report providing the Committee with a summary on performance against a number of key quality and performance indicators. L. Prosser confirmed that there were no changes to the format of the report and changes were expected in September 2023. She handed over to G. Hughes to present the key performance matters contained within the report.

I Wells referred to the ambulance handover data which was very positive and noted how the Health Board had been commended by the Emergency Ambulance Services Committee (EASC). He also referred to the follow up patients not booked (FUNB) and in particular ophthalmology, and queried when this would start to see improvements. G. Hughes advised that it was important to highlight that with regard to FUNB, previously the engagement strategy with the clinicians was not as robust as it could have been. He added that they were now working closely with the Clinical Director and hoping that FUNB would be changed to Patient Initiated Follow Up (PIFU).

With regard to Ophthalmology, G. Hughes advised that it was more challenging, however, they had recently undertaken a review of

Glaucoma and had developed a number of improvements ensuring that high risk patients were followed up.

C. Donoghue referred to page 12 where it mentioned that there were no ring-fenced patient beds due to challenges with patient flow and sought clarity on that statement. She also referred to diagnostics and the numbers of referrals which supported the evidence of having to do things differently. G. Hughes advised that it was all linked primarily to orthopaedics where they have to operate patients on a closed pathway and they were unable to mix orthopaedic patients with any other patients.

N. Milligan referred to page 7 with regard to bacteraemia where it stated that the target failed and queried whether that was correct as the target was 55 and 22 and was showing 85 and 40. G. Hughes confirmed that they run at a rate higher than the target so to achieve the target it would need to be 21 or lower.

N. Milligan referred to stroke performance which appeared to have transitioned into 'business as usual' activity, and drew Members attention to the stroke data figures for February 2023 compared to June which were showing that the figures had decreased. G. Hughes advised that stroke was a priority with a decision made to invest in additional capacity. He added that they recognised that they were making marginal improvements in the way in which the stroke service was resourced and set up, however, it was challenging to achieve the level of compliance due to patient flow.

N. Milligan in response, added that she did appreciate the flow difficulties but to be seen by a stroke specialist you did not need to be in a dedicated 'stroke' bed and that element would not be impacted by flow. G. Hughes advised that there were challenges during the weekends where there was only one stroke physician covering two sites.

P. Roseblade referred to community care on page 4 of the report and the number of new patients accessing NHS dental services and advised that it would be useful to see the number of patients that had tried to access NHS dental services. J Denley advised that she did not know the exact number, however, advised that there was now a requirement in the NHS dental contract for dentists to register a proportion of new patients. She added that the Health Board maintains a list of patients waiting and a mechanism of signposting them to dentists offering NHS treatment.

P. Roseblade referred to the contract for stroke thrombectomy undertaken at Bristol and that patients were more likely to be thrombolysed within that critical window, however, on looking at the

data that did not appear to be happening. G. Hughes advised that extended hours were now being offered at Bristol so there was better coverage for the teams and patients. He added that the window for thrombectomy was restricted as it was only available for patients to get there by 8pm. However, it was now extended until 10pm and they did have some very positive stories of patients that have got to Bristol and how quickly they could recover.

P. Roseblade referred to the Ophthalmology improvement plan and queried when they would receive an update. G. Hughes advised that an update on the improvement plan will be scheduled for a future meeting and also noted positively that they a new corneal surgeon had been appointed

P. Roseblade was pleased to note the improvements in performance relating to patients aged 60 and over with a fractured hip. She also congratulated the teams on achieving 100% performance on red releases.

In relation to previous discussions regarding access to dentistry services, M. Jehu, sought clarity in relation to the numbers of young people accessing dental services. J. Denley advised that the 'Designed to Smile' service had now been reinstated in schools which would hopefully start to see an impact.

Resolution: The report was **NOTED**

Action: To provide an update on the Ophthalmology Improvement Plan for the Committee.

5.3.0 MENTAL HEALTH 2022-23 SERVICE IMPROVEMENT FUNDING AND UPDATE

J. Denley presented the report that provided the Committee with an overview of the Service Improvement Funding awarded by Welsh Government for Mental Health for the years 2022-23 and 2023-24.

I Wells advised that it was positive to see the investment in this area and queried whether there was any fragility of services due to the way that the funding was allocated. J. Denley helpfully described the process and funding model.

In response to a query from P. Roseblade, J Denley confirmed that the funding was recurrent.

M. Jehu queried when the Health Board would start to see outcomes from the funding allocated and when it would start to see an impact. J. Denley confirmed that they were required to report back

to Welsh Government on individual submissions and the annual objectives related to the service plans for the Care Groups.

Resolution: The Committee **NOTED** the additional mental health funding allocation and approach by the Mental Health and Learning Disability Care Group.

5.4.0 OPHTHALMOLOGY STRATEGY AND CATARACTS BUSINESS CASE

The Chair in introducing the item expressed concern in relation to the limited time afforded to Members to consider this item in order to provide robust scrutiny and reflections, the Chair therefore stated that Members were not in a position to agree any decision at this meeting.

In response, L Prosser assured the Committee that although it was originally anticipated that the committee would be asked to make a decision in relation to this regional service there were still governance and financial considerations ongoing which had altered the position. L Prosser therefore confirmed that no decision was expected from Members at this meeting, however a briefing to support a future decision would be helpful.

L Prosser continued to provide a helpful overview as to the background and progress to date that will hopefully support Members in reaching a decision at the appropriate time.

It was further noted that due to the challenging timescales associated with the service commencing in July 2023, Chairs Urgent Action may need to be undertaken. However, the governance process would be outlined in due course once the outstanding issues were resolved.

Resolution: Following discussion on this matter the Committee **NOTED** the update, and supported the need for any urgent action, subject to allowing sufficient consideration time of any documentation.

6.1.0 MONTH 12 MOVEMENTS FROM FORECAST

S. May presented the report that provided the Committee with a summary of the movements in the Month 12 Delegated position.

Resolution: The Committee **NOTED** the report.

6.2.0 MONTH 2 FINANCE REPORT

S. May presented the Month 2 Finance Report.

P Roseblade queried whether there would be an advantage to dedicate time at this Committee, inviting Care Groups experiencing difficulties in achieving their savings to come along and assure them that the Board were aware of the challenges and scrutiny is being afforded. G. Hughes explained the significant levels of scrutiny being afforded to this area and the frequency of reporting. He suggested that some of the Care Groups could attend the Committee to provide presentations, however, this would require a 'private' session due to the commercially sensitive content.

S. May advised that given the extent of the deficit and the deficit across Wales the savings support was reported via the Executive Leadership Group. She added that Care Groups will be subject to significant scrutiny in terms of the processes in place to manage savings targets and suggested a further update is provided to Board next year with regard to the scale of the savings delivery which would be beneficial for the Board to understand the challenges.

C. Donoghue stressed the importance of ensuring that any invitation to Care Groups added value to the process and did not create additional pressure.

S. May advised that the savings were really important but the real test will be the expenditure, however it was too early to see the whole picture at Month 2.

Resolution: The Committee **NOTED** the report.

6.3.0 MONTH 2 FINANCE PERFORMANCE REPORT

S. May presented the Month 2 Performance Report.

Resolution: The Committee **NOTED** the report.

6.4.0 All Wales Reinforced Autoclaved Aerated Concrete (RAAC) Investigation

A. Martin presented the report that provided an update on the survey and inspections carried out across the Health Board sites.

Members of the Committee agreed that the outcome of this should be highlighted to the Board as a positive escalation and captured within the Committee Highlight Report to Board.

Resolution: The Committee **NOTED** that following inspections from James and Nicholas and WSP Consulting Structural Engineers no RAAC has been identified in buildings owned by CTMUHB or in buildings where CTMUHB hold the head lease that were constructed between 1960 and 1995.

7.0.0 OTHER MATTERS

7.1.0 HIGHLIGHT REPORT TO BOARD

Resolution: The Committee **AGREED** that the report would be prepared by the Governance Team following the meeting.

7.2.0 FORWARD WORK PLAN

The Chair asked Members of the Committee if they had any items that they would like to include for future meetings to let the Governance Team know.

Resolution: The Committee **NOTED** the Forward Work Plan

7.3.0 ANY OTHER URGENT BUSINESS

There was none.

7.4.0 HOW DID WE DO TODAY?

The Committee felt that an appropriate balance had been struck in terms of open discussions with a strategic focus as well as organisational values being taken into account.

M. Jehu advised that due to the changes in Independent Member membership of the Committees, P. Roseblade would be taking over as Chair of the Committee from the August 2023 meeting. M. Jehu congratulated P. Roseblade and thanked all members for the support they had provided to him in his role as Chair.

7.5.0 CLOSE OF THE MEETING – DATE AND TIME OF NEXT MEETING:

The next full meeting of the Committee was scheduled to be held on 22 August 2023.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE PLANNING, PERFORMANCE & FINANCE 'IN COMMITTEE' HELD ON 27 JUNE 2023, AS A VIRTUAL MEETING WHICH WAS HELD VIA MICROSOFT TEAMS

PRESENT

Mel Jehu	-	Independent Member (Chair)
Carolyn Donoghue	-	Independent Member
Nicola Milligan	-	Independent Member
Patsy Roseblade	-	Independent Member

IN ATTENDANCE

Linda Prosser	-	Executive Director of Strategy & Transformation
Sally May	-	Executive Director of Finance & Procurement
Gethin Hughes	-	Chief Operating Officer
Sarah James	-	Deputy Chief Operating Officer – Acute Services
Julie Denley	-	Deputy Chief Operating Officer – Mental Health, Primary Care & Community Services
Paul Blake	-	Consultant Colorectal and General Surgery
Cally Hamblyn	-	Assistant Director of Governance & Risk
Kathrine Davies	-	Corporate Governance Manager (Meeting Secretariat)

PART 1. PRELIMINARY MATTERS

1.1.0 WELCOME AND INTRODUCTIONS

The Chair **welcomed** everyone to the meeting including Paul Blake, Consultant Colorectal and General Surgery, in attendance for Agenda Item 2.1.1.

1.2.0 APOLOGIES FOR ABSENCE

Apologies for absence had been received from Ian Wells, Independent Member and Geraint Hopkins Independent Member.

1.3.0 DECLARATIONS OF INTERESTS

There were no declarations received.

PART 2. MAIN AGENDA

2.1 ITEMS FOR APPROVAL

2.1.1 IMPLEMENTATION OF ROBOTIC SURGERY WITHIN CTMUHB

G. Hughes and P. Blake presented the report and Business Case for the development of Robotic Surgery for CTMUHB.

The Committee noted the benefits that robotic surgery would have for patients and staff.

C. Hamblyn informed the Committee that the Health Board would be receiving a presentation on this transformational activity at the July 2023 meeting, in terms of the benefits realisation relating to quality and safety, patient experience, public health and population health benefits as well as the technological advances.

Resolution: The Committee **NOTED** and **SUPPORTED** the business case and **ENDORSED FOR BOARD APPROVAL**.

2.2 ITEMS FOR NOTING

2.2.1 UNCONFIRMED MINUTES OF THE IN COMMITTEE MEETING HELD ON THE 4 MAY 2023

Resolution: The Committee **NOTED** the Minutes as a true and accurate record subject to one amendment.

3.0.0 OTHER MATTERS

3.1.0 ANY OTHER URGENT BUSINESS

There was none.

3.1.2 CLOSE OF THE MEETING – DATE AND TIME OF NEXT MEETING:

- 27TH June 2023 at 2:00 pm

ACTION LOG: PLANNING, PERFORMANCE & FINANCE COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at 8.8.23)
4.1.0	June 2023	**Organisational Risk Register** To provide an update on the recruitment of the Orthoptist Post to Members of the Committee outside of the meeting.	Chief Operating Officer	August 2023	**Completed** Post has now been approved and the recruitment process will follow.
5.1.0	June 2023	**Integrated Performance Dashboard** To provide an update on the Ophthalmology Improvement Plan for the Committee.	Chief Operating Officer	August 2023	**In Progress** On Agenda – August 2023 Meeting.
4.1.0	May 2023	**Organisational Risk Register** To query whether the Laundry Risk 4772 had been completed	Chief Operating Officer	June 2023	**Completed** The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August.
4.1.0	May 2023	**Organisational Risk Register** Risks being undertaken as part of TI process to be updated for next meeting.	Chief Operating Officer	June 2023	**Completed**

4.1.0	May 2023	**Organisational Risk Register** Risk 4491 to be updated by the next meeting.	Chief Operating Officer	June 2023	**Completed** Further update contained Organisational Risk Register Report for August 23 meeting.
5.1.0	May 2023	**Planned Care Recovery** To discuss the WISE Pain Service outside of the meeting.	Chief Operating Officer	June 2023	**In progress** The WISE evaluation report will be available in November 2023 and will be discussed at the Population, Health & Partnerships Committee. G Hughes to contact N Milligan in the meantime to discuss.
5.4.0	February 2023	**Sepsis Compliance Report** To provide a report on Digitisation to a future meeting	Director of Digital	June 2023	**In progress** On Agenda for October 2023 meeting.
PREVIOUSLY COMPLETED ACTIONS					
5.3.0	October 2022	**Integrated Performance Dashboard** To receive a deep-dive into Mental Health	Chief Operating Officer	May 2023	**Completed** Received at May 2023 meeting.
5.3.0	May 2023	**Spotlight: Mental Health Activity & Performance** To query whether harm reviews are undertaken for patients waiting over six months for psychological therapies. To query the amount of patients that do not attend for the CAMHS Service.	Assistant Director of Primary, Community & mental Health	June 2023	**Completed** The MH&LD have reviewed their process for supporting people waiting over 26 weeks for a Psychological Intervention. They contact people at set intervals on the waiting list to also then check if they want remain on the list and revisiting the priority need at that time. Any reported harm at that

					stage is then managed both clinically and where appropriate through Datix in order that service undertakes a comprehensive review of circumstances and processes to inform learning. The Care group considered what added value harm reviews would bring and feel the current process allow for identification and learning from harm but critically also the opportunity to address the harm early as typically harm reviews are done retrospectively once a person had received their clinical appointment so the potential to address the harm was lost. They tend to sit outside the usual governance arrangements and incident reporting via datix is more robust and can be analysed and tracked. In terms of psychological therapy the 'waiting well' project will provide that additional support more proactively.
5.1.0	May 2023	**Planned Care Recovery** To query the issue with funding for ODPs	Chief Operating Officer	June 2023	**Completed** ODPs have now been recruited into posts from the

					streamlining process this year. The Planned Care Group will continue to recruit into any ODP vacancies if needed as is normal practice outside of the streamlining process if required.
2.2.2	May 2023	**Action Log** To be fully reviewed and old completed actions removed.	Assistant Director of Governance & Risk	June 2023	**Completed** Action Log reviewed and updated.
4.1.0	May 2023	**Organisational Risk Register** To query the introduction of an 'issues log'.	Assistant Director of Governance & Risk	June 2023	**Completed** AD Governance & Risk and Chief Operating Officer have discussed this request and suggested the following approach. "Issues" which are activity that is happening are captured in the performance reports and updates received from the COO and Care Group functions. In terms of risks that are stagnant due to reasons beyond the control of the Health Board, these will be further strengthened to consider their Risk Treatment options i.e. Treat, Tolerate, Transfer etc. The AD Governance & Risk will

					work through this next step in its maturity journey with colleagues with a view to presenting the Organisational Risk Register in this way before the end of the calendar year. It is built into the Work Programme.
4.1.0	February 2023	**Organisational Risk Register** Share the update on Risk 4071 outside of the meeting.	Assistant Director of Governance & Risk	April 2023	**Complete** Update sent via Email 2.3.23
5.1.0	February 2023	**Planned Care Recovery and Cancer Delivery programme** To that an overarching cover report is received for future iterations of this item.	Deputy Chief Operating Officer	April 2023	**Complete** An overarching report will be included going forward
5.1.0	February 2023	**Targeted Intervention** Review the reporting for Executive Leadership Group on page 6 of the slides in terms of the governance reporting framework.	Deputy Chief Operating Officer	April 2023	**Complete** The Chief Operating Officer has clarified that the structure captured on slide 6 of the presentation slides received at the February 2023 meeting was reflecting information flow rather than a hierarchy of decision/reporting. Therefore, no changes have been made.

6.1.0	February 2023	**Month 10 Finance Report** To schedule quarterly Estates Update Reports for the Committee on the Cycle of Business and Forward Plan.	Governance Team	April 2023	**Complete** Items added to Forward Plan and Annual Cycle of Business. Report scheduled for June 2023 meeting.

AGENDA ITEM
4.1

PLANNING, PERFORMANCE & FINANCE COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	22nd August 2023
FOI Status	Open
If closed please indicate reason	Not applicable – Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, Chief Executive
Report purpose	FOR REVIEW & APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
Service, Function and Executive Formal Review	June/July	RISKS REVIEWED
Operational Management Board	12.7.2023	ENDORSED FOR ELG
Executive Leadership Group	17.7.2023	REVIEW AND EXECUTIVE SIGN OFF RECEIVED
Audit & Risk Committee	22.8.2023	RISKS REVIEWED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Planning, Peformance & Finance Committee to review and discuss the organisational risk register and

consider whether the risks escalated to the Organisational Risk Register are in accordance with the Risk Management Strategy.

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

2.1 Care Groups and Central leads are continuing to review and update their assigned risks taking into account feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve over the next 12 months.

2.2 The Operational Management Board now signs off the Organisational Risk Register in terms of Care Group risks prior to submission to the ELG.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **457** members of staff trained to date. Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June and July and continues into August.

2.4 Risks on the organisational risk register have been updated as indicated in red.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **Principal / Strategic Risks (Board Assurance Framework)**
The organisational risks captured in Appendix 1 are aligned to the Principal/Strategic Risks reported to the Board via the Board Assurance Framework Report. These risks as assigned to the Planning, Performance & Finance Committee are:

- Risk No. 1 - Sufficient capacity to meet emergency and elective demand. Risk Score 16.
- Risk No. 3 - Finance Revenue Resources. Risk Score 20.

3.2 **NEW RISKS**
Nil as assigned to this Committee.

3.3 **CHANGES TO RISKs**
a) Risks where the risk rating INCREASED during the period
Central Function Risks – Strategy and Planning

- Datix Risk ID – 5207 - Care Home Capacity. Risk score reduced from a 15 to a 10.

Central Function Risks – Facilities

- Datix Risk ID 4772 - Replacement of press software on the 13 & 10 stage CBW presses. Risk score reduced from a 15 to a 12.

Rationale for changes captured in Appendix 1.

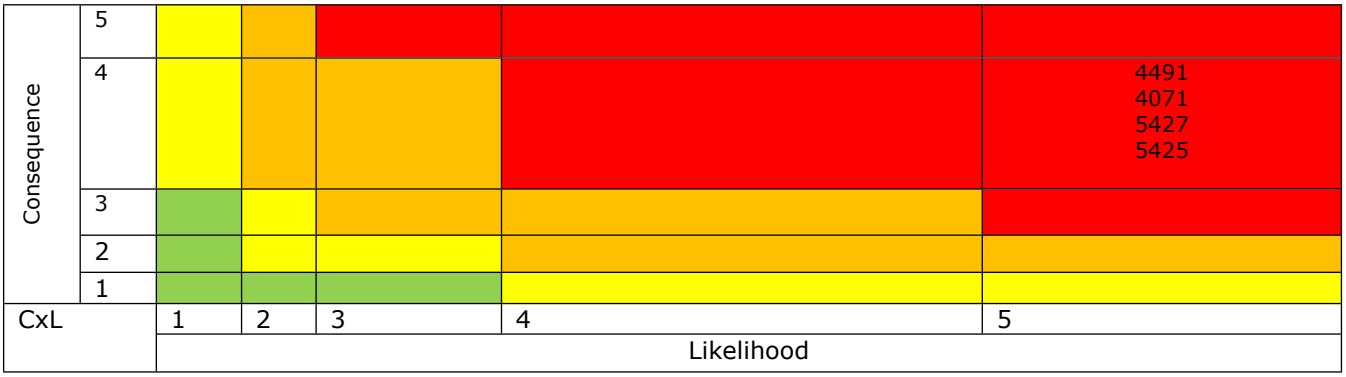
3.4 **CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER**

Unscheduled Care Group

- Datix Risk ID 4458- Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches). Risk Closed.

Rationale for closure captured in Appendix 1.

3.5 **Organisational Risk Register - Visual Heat Map by Datix Risk ID (Risks rated 15 and above):**



4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5425 (Replacing 5153)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent years.	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May. Update June 2023 - Supplementary paper submitted to WG by the 31st May 2023. Response awaited. Review 31.8.2023.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	↔	28.04.2023	2.6.2023	31.8.2023
5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May. Update June 2023 - Supplementary paper submitted to WG by the 31st May 2023. Response awaited. Review 31.8.2023.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	↔	28.04.2023	2.6.2023	31.8.2023
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Boards ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focussing on its outcome matrices to ensure it captures investment return effectively. The risk will be further reviewed on the 31.8.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	16.6.2023	31.8.2023
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update June 2023 - Action plan in response to Welsh cancer patient experience survey finalised. Roll out of Canisc replacement piloting with the Breast MDT. Implementation of weekly performance meetings with highlight report to COO weekly. Action plans developed for high risk challenged areas - Gynaecology, Lower GI, & endoscopy with support from the DU to implement required changes.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	19.06.2023	31.08.2023

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5207	Executive Director of Strategy & Transformation	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority Update June 2023 -Risk reduced as the situation has not escalated as anticipated last summer. Consider again at next review point. Review 31.10.2023.	Quality & Safety Committee Planning, Performance & Finance Committee	10 ↓ 15	5	Central Planning Function propose for de-escalation as the situation has not escalated as anticipated last summer. Consider again at next review point - 31.10.2023.
4772	Chief Operating Officer	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then**: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with	June 2023 - Health Board is now ready for the installation of the software upgrade to the 13-stage press. Prior to the software upgrade, specialist engineering work is required. This work has been requested and we are waiting for confirmation of when the engineers will attend site. The upgrade is anticipated to be completed before the end of August The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August. There is no IPC impact associated with this risk.	Quality & Safety Committee Planning, Performance & Finance Committee	12 ↓ 15	4	The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August.

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4458	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Review 26.06.2023 - to combine with risk 3826.	Quality & Safety Committee Planning, Performance & Finance Committee	Jul-23	The Unscheduled Care Group propose that this risk is captured within Datix ID 3826 - Emergency Overcrowding and recommend this risk is closed.

AGENDA ITEM
2.1.3

PLANNING, PERFORMANCE & FINANCE COMMITTEE

OUTCOME REPORT: PLANNING, PERFORMANCE & FINANCE COMMITTEE EFFECTIVENESS SURVEY

DATE OF MEETING	22 August 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Cally Hamblyn, Assistant Director of Governance & Risk
EXECUTIVE SPONSOR APPROVED	Chief Executive

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 The Chair of the Planning, Performance and Finance Committee is required to present an annual report to the Board outlining the Committee's business through the financial year to provide an assurance. As part of this process, the Committee are required to undertake an annual self-assessment questionnaire in relation to Committee effectiveness.

1.2 Members of the Committee are asked to discuss and review the feedback set out in this report which relating to its activities and performance during 2022/23.

1.3 Members should note that eight responses were received out of a total of 12 which accounted to 66%.

2. SUMMARY REPORT

Positive Assurance	**1. Committee Effectiveness:** **Members/Attendees:** • The Committee recognised that there were approved Terms of Reference in place defining the role of the Committee and that they were reviewed annually to take into account governance developments and the remit of other Committees within the organization • It was acknowledged that the Committee had an approved a Cycle of Committee Business. • It was recognised in the main that the Committee approved an Annual Report on its work and performance for each previous year. **2. Committee Business** • It was considered that the Committee are adequately supported by the meeting secretariat. • Feedback received through the survey supported that the Committee is Chaired effectively. • There was clear consensus that the Committee had sufficient authority and resources to perform its role effectively. • There was a clear consensus that the Committee met sufficiently frequently to deal with planned matters and there was sufficient time allowed for questions and discussions. • The Committee were satisfied that the boundaries between this Committee and other Committees were clearly defined with appropriate cross-referral if required. **3. Behaviour, Culture and Values** • There were no concerns raised in relation to meeting behaviours and the culture and values exhibited in the meetings. Positive responses in terms of the Committee being managed in a courteous and professional manner. **4. Training & Development**

	• It was felt in the main that Members/Attendees considered that they had the skills and knowledge to carry out their role in respect of this Committee.
Areas of Note	**1. Committee Effectiveness** • The Terms of Reference were reviewed at its May 2023 meeting as part of the annual review. • The Committee received and approved its Annual Report for 2022-23 at its June 2023 meeting and it was subsequently submitted to the Board in July 2023. • A Committee Cycle of Business has been implemented to further complement the Forward Work Programme and was approved by the Committee at their February 2023 meeting. This Cycle of Business is routinely updated as required. **2. Committee Business** • The Committee operates the Consent Agenda for routine business consideration. Members are aware that should they consider that any item on the consent agenda requires further assurance and scrutiny, it can be moved to the main agenda for discussion. As with all Board Committees, the Committee, where sufficiently urgent can consider any item 'Out of Committee' via 'Chairs Urgent Action'. • The Committee has held 'In Committee' private meetings when the subject matter has been commercially sensitive. The minutes of those meetings are published in the 'public' Committee papers to demonstrate the Health Board's commitment to openness and transparency. • Highlight reports are produced following each meeting so that the Board is kept informed of the nature of the issues considered and any decisions reached. These reports are also available as part of the 'public' papers to demonstrate the Health Board's commitment to openness and transparency. • The overall consensus with regard to the greater use of Welsh Language at meetings was that there was no additional requirement for this.
Areas Requiring Further Consideration	**Committee Effectiveness - Areas for action/improvement** were identified as follows: • Members of the Committee felt that whilst virtual meetings have been a positive experience overall and that it provided flexibility, feedback reflected that occasional face-to-face meetings would be of value.

	• The Committee considered whether they were adequately supported by Executive Directors in terms of attendance, quality and length of papers and responses to challenges and questions. Feedback reflected that on the whole the support was very good but could be further improved upon by ensuring that reports were submitted in a timely manner and that reports could be more concise with increased focus on obstacles to improvement.
Action Plan	In response to the areas of improvement identified the following actions are proposed: • The Committee could consider meeting face to face during the year to allow for networking and relationship building which is sometimes lost when utilising a virtual format. Committee could propose to meet in person at least twice a year. • Executive Leads/Sponsors are asked to reflect on the feedback in relation to the improvements noted in terms of timeliness, brevity and focus. Once capacity has improved the Corporate Governance function intend to recommence training and education around report writing and presenting at Board and Committee meetings. • The Independent Member (IM) Scrutiny Toolkit is a helpful reference point for IM's and Executive Leads in clarifying their roles in terms of Board Committee meetings and this is attached as an appendix to this report should it be helpful to revisit.
Appendices	Independent Member Scrutiny Toolkit.

3. Recommendation

3.1 The Committee is asked to **NOTE** the report.

INDEPENDENT MEMBER (IM) SCRUTINY & ASSURANCE TOOLKIT

BACKGROUND

- Health Boards are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties.
- Health Boards principle role is to ensure the effective planning and delivery of the local NHS system.
- Board membership comprises of Executive Directors & IMs, who form part of the corporate decision-making body and have equal voting rights.
- IMs are involved at a strategic level - responsibility for operational decisions sits below Board.
- Each organisation has a range of committees which are responsible for providing advice and assurance to the Board on areas within their remit. This is the primary area where scrutiny is focused.

OVERVIEW OF IM SCRUTINY ROLE

- To participate as members of identified Committees and Board with regular attendance, with the expectation that papers will be made available one calendar week before each meeting to allow them to be read ahead of the meeting
- Responsible for supporting the Chair in being clear about the information needed in order to discharge their role, including assurance and scrutiny
- Satisfying themselves of the integrity of financial and quality intelligence, including getting out and about, observing and talking to patients and staff (walkarounds/ambassadorial role).
- Sharing collective responsibility for decisions.

DIVERSE NATURE OF IM ROLE


Strategy


Support


Stretch


Stakeholder


Scrutiny


Safety

The role can change from meeting to meeting as well as during a meeting as the agenda progresses

INDEPENDENT MEMBER FOCUS

Oversight	Insight	Foresight
Assurance and Compliance Systems and processes. Monitor performance and track how things are going. Understanding the risks inherent to the Health Board's activities– risk appetite and tolerance of failures.	What is going on and Why? Pause, step back and look at the big picture. Bring people together – look at the interactions between various parts of the organisation and its partners. Discover the Important things Determine What Indicators Matter. Real-time data driven decision-making.	What could happen in the future? Constant horizon scanning for opportunities and threats. Embrace multiple viewpoints and listen to diverse voices. Clear thinking about "what" must be anticipated or undertaken. Forecasting policy implications Leading for the Future – aligned to the strategic direction Scenario based decision making.

AGENDA PLANNING

- Maximise the use of the Consent Agenda to ensure that adequate time is made on the Main Agenda for business critical, strategic matters.
- Agenda planning meetings are key and include both Chairs and Vice-Chairs.
- Consider the length of the meeting – is adequate time aligned to each item to allow for appropriate focus on the issue – enabling appropriate challenge to gain assurance?
- Are there a mix of topics on the agenda (strategic / assurance) which balance the remit of the meeting?
- Ensure that each agenda item has a clear purpose and desired outcome.
- Use the Risk Register, Integrated Performance Dashboard, information gained from walkabouts and staff sessions plus stakeholder feedback, benchmarking and audit reports to steer and plan the agenda to focus on business critical activity.

FOCUS OF PAPERS

- Exception based reporting. Report templates are key as they guide to the purpose and the desired outcome.
- Is it clear why items are being presented? If not, make this point in the meeting. Focussed papers help manage the effectiveness of meetings avoiding them running over time.
- Ask yourself “so what?”. If this isn’t clear, let the presenter know.
- Appropriate challenge leads to assurance – acknowledging that some further actions may be necessary to manage risks
- Minimise duplication – ‘Less is More’ – avoid information overload i.e. discourage the use of appendices.
- Encourage visualisation tools by praising them when they are used – interactive, presentations, videos.
- Look for consistency across papers – aligned to strategic objectives, consistency of messaging and praise when you see this.

REPORT PRESENTERS

- Teeing-up discussion – be clear that you will be taking the paper as read and seek only new or changed information from the presenter over that which is covered in the report.
- Ensure a consistent approach. Some presenters are more engaging or have a topic that may interest you more – don't get swayed by this, manage the item for the purpose it is there.
- Is there contradictory evidence, are there clear logical explanations showing an improving trend?.
- Feedback / request changes if you consider that you are not receiving the right information at the right time in the right way – also use triangulation to help bolster the position – are all the necessary steps being taken to address the position?.

EXECUTIVE COLLABORATION

- Executive portfolio representation in meetings and integrated executive working - are the right people in the room? If not, why not? Bring other officers into the discussion to add their perspective on an issue out of their portfolio to add richness to the discussion.
- Encourage Executives to call upon one another to share presentations of items as appropriate.
- Consider if it would be helpful to have a meeting with the Executive lead prior to a Board Committee taking place to set out the points which may need further clarification at the Committee?

ROLE OF THE COMMITTEE CHAIR

- Setting the tone, tee-up the desired focus of discussion. Keep everyone focussed - Adhoc presenters may need support if not familiar with the setting.
- Consider if it would be helpful for the Committee Chair to have a pre-meet with other IMs ahead of the meeting to look at the issues and decide how these are best managed during the meeting?
- Ensure you have read the Chairs Brief and that it has been shared with the Vice Chair.
- Managing the Time – set clear expectations for presenters on timings. This can be planned at agenda planning stage by including timings on the agenda, and reiterated when introducing the agenda item at the meeting. Do not allow discussions to stray into operational territory.
- Lead by example and consider how other IM's can complement the Chair – tag team each other.
- Give the Vice-Chair an opportunity to Chair Committees under the guidance of the Committee Chair (at least once per annum)
- Clearly sum-up the conclusions of the discussion, suggest SMART objectives be used to measure delivery of actions, noting the resolution agreed to ensure everyone is clear on the outcome and next steps

MEETING CULTURE

- Commitment
- Enthusiasm
- Preparedness
- Style of contributions – scrutiny which constructive/supportive challenge, not criticism/deconstructive feedback.
- Use the right questions for the right circumstances – use powerful questions (e.g. what do we need to do to ensure….)
- Consider whether there are strong personalities influencing items.
- Create the right atmosphere in the room, encouraging openness and transparency with professionalism
- Adherence to Virtual Meeting Etiquette principles.

IM LISTENING

Passive listening (focusing on encouraging speaker to open up)

- Avoid being judgemental or defensive
- Avoid expressions like ‘that’s good’, ‘excellent’, ‘that’s right’,
- Instead use responses such as:
  - Tell me more about…
  - Is there something else we could be doing to improve…
  - I’m interested to hear what you think of …
  - I’d like to hear what you feel about …

Active listening (to check understanding)

- It seems that you…
- Let me see if I understand you

IM QUESTIONING

- Asking concise, strategic and purposeful probing questions to clarify issues. Your role is to scrutinise the information presented and seek assurance that the Health Board is achieving its strategic objectives.
- Recognise the difference between being reassured and receiving assurance
- Often the most 'obvious' or simple questions lead to the most insightful answers – remember to ask about the obstacles and risks to delivery and what can be done to support delivery.
- Avoid venturing into the operational detail, remain focussed on the what, why and when rather than the 'how'.
- Avoid commentary.
- Use secondary 'follow-up' questions to ensure you gain the assurance you need.
- Triangulation of intelligence – seek opportunities to cross-reference reports, comments made and different perspectives/contributions.
- Ensure questions are not just confined to the consent agenda.
- Questions asked on consent agenda may be worthy of exploring further in the main meeting.
- Equitable questioning / contributions are essential, mentor new Members as necessary.

EXAMPLES OF ISSUES TO CONSIDER AND QUESTIONS TO ASK;

Does the management response accurately reflect the audit recommendations?

How do we know that the assurances provided draw appropriate attention to risks, weaknesses and/or areas for improvement which should be addressed?

How is learning shared across the Health Board to avoid duplication and learn lessons?

What assurance is being provided that the recommendations are being implemented, monitored and followed up?

How was this issue escalated to ensure due process was followed?

What sources of secondary or independent evidence could support the perspective set out in the report?

What are the obstacles including risks to delivery and how can actions be supported?

ASSURANCE ‘V’ REASSURANCE

Assurance: being assured because the Committee/Board has *reviewed* reliable sources of information (evidence) and *is satisfied* with the course of action

Reassurance: being *told* by the Executive and staff that performance actions are satisfactory

ORGANISATIONAL INSIGHT

- What assurance can you provide that the plans are meaningful and underpinned by robust evidence?
- How do we know that we have an appropriate level of understanding of the purpose and work of the organisation when setting strategy?
- How do we know that the Board has clearly articulated and communicated its risk appetite?
- How do we know we are monitoring performance and quality against the most appropriate standards?
- How does the issue under discussion support the achievements of the Health Board's strategic goals?
- What assurance can you provide that demonstrates that there is effective and accurate budgeting and in-year forecasting?

ORGANISATIONAL INSIGHT

- Triangulate – what has been seen / heard during walkabouts and what appears in reports.
- Ensure regular contact and discussion with senior leaders at the organisational level
- Obtain softer intelligence outside of the meeting – e.g. site visits
- Where appropriate, consider a deep-dive – aligned to key indicators – risk register, integrated dashboard and audit reports (Internal & External), explore stakeholder feedback and benchmarking data.

CROSS-COMMITTEE WORKING

- Minimise cross-committee referrals to remove unnecessary duplication
- Referring where appropriate:
    - What are you referring?
    - Why are you referring it?
    - What is the outcome that you are anticipating from this referral?
- Regular catch-ups with other Committee Chairs

GOVERNANCE FRAMEWORK

- Standing Orders
- Standards of Behaviour Policy (Nolan Principles)
- IM Role Descriptions
- Board Secretary – is a source of advice and support to the Health Board Chair and other Board Members. Has the role of being the guardian of good governance.
- Business Intelligence – scrutiny of service delivery performance reports including the organisational annual report.
- Risk Register & Board Assurance Framework – aid understanding of issues requiring scrutiny.

ESCALATION TO THE BOARD

- The Committee Chair will approve the Highlight Report to the Board following each meeting
- Focussed updates – using the Highlight Report Template
- ‘Assurance’ versus ‘Reassurance’
- ‘Cascade’ versus ‘Escalate’
- Where ‘escalate’ it will ensure discussion on the main agenda at Board

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AGENDA ITEM
5.1

PLANNING, PERFORMANCE & FINANCE COMMITTEE

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting	(22/08/2023)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jose Roper, Senior Performance Monitoring Officer
Presented by	Linda Prosser, Executive Director of Strategy & Transformation
Approving Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Linda Prosser	11/08/2023	Choose an item.

ACRONYMS	
AMU	Acute Medical Unit
BSW	Bowel Screening Wales
C.difficile	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
COO	Chief Operating Officer
CTM	Cwm Taf Morgannwg
CTP	Care and Treatment Plan
CYP	Children and Young People

D2RA	Discharge to Recover then Assess model
DHCW	Digital Health and Care Wales
DNA	Did Not Attend
E.coli	Escherichia coli bacteraemia
ED	Emergency Department
ESD	Early Supported Discharge
FCE	Finished Consultant Episode
FUNB	Follow-up Outpatients Not Booked
Hib/MenC	Haemophilus Influenzae type b and Meningitis C
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
Klebsiella sp.	Klebsiella sp. Bacteraemia
LA	Local Authority
LD	Learning Disabilities
LPMHSS	Local Primary Mental Health Support Service
MMR	Measles, Mumps, Rubella
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NOUS	Non Obstetric Ultra-Sound
PAC	Pre-operative Assessment Clinic
PADR	Personal Appraisal and Development Review
P.aeruginosa	Pseudomonas aeruginosa bacteraemia
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
PMB	Post Menopausal Bleeding
POW	Princess of Wales Hospital
PTR	Putting Things Right
QIM	Quality Improvement Measures
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment Times
S.aureus	Staphylococcus aureus bacteraemia
SALT	Speech and Language Therapy
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SCP	Single Cancer Pathway
SIs	Serious Incidents
SOS	See on Symptom
SSNAP	Sentinel Stroke National Audit Programme
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

1.1 During June 2023, Welsh Government released the NHS Performance Framework for 2023/24. The document is available at the following URL:
https://www.gov.wales/sites/default/files/publications/2023-06/nhs-wales-performance-framework-2023-2024.pdf

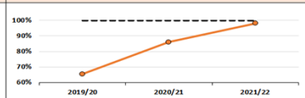
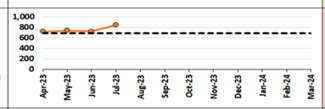
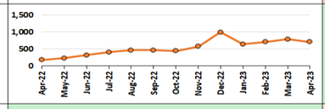
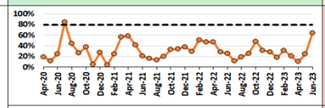
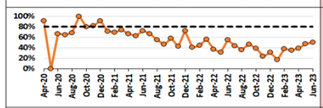
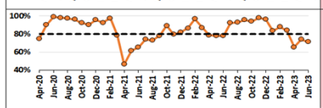
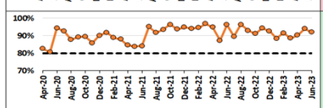
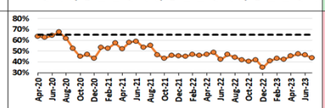
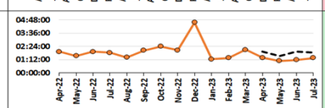
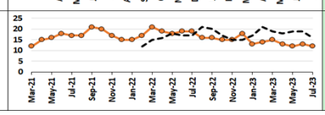
The performance framework reflects the Minister's areas of focus, and has fewer measures than previous years. Whilst civil servants have indicated that there will be a wider suite of assurance frameworks overseen by the policy and Executive leads within Welsh Government in areas such as finance, quality and safety and Public Health and Protection, the timing of their release has not yet been communicated.

Consequently this report sets out the UHB's performance against a number of areas within the new performance framework, and against a small number of local priority measures such as stroke care. Each of these have all Wales definitions and methodologies.

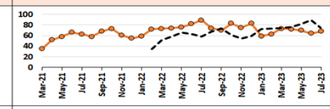
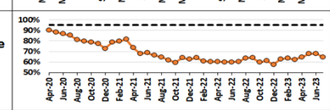
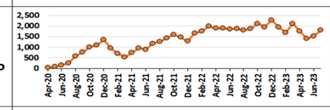
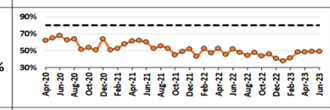
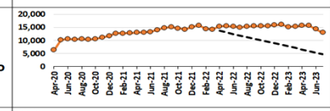
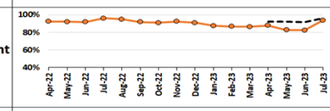
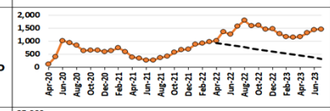
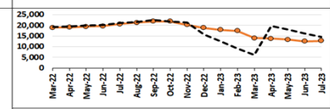
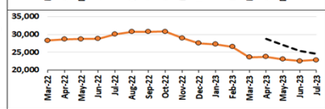
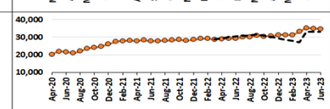
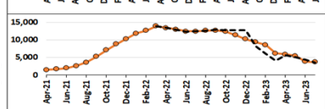
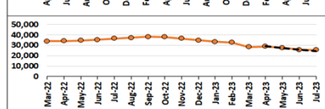
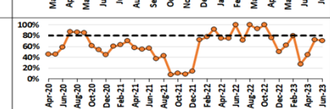
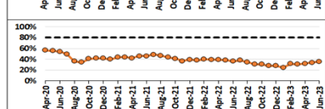
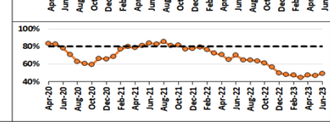
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Quadruple Aim 2: Quality & Better Access to Services

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Performance Measure	Target	*Key:* Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
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%		98.0%	2021/22
	Qualitative report providing assurance on GP access improvement	Evidence of Improvement	Data not available as yet		
	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 2023 and 100% by 31 March	Data not available as yet		
	Allied Health Professionals accessible by Health Board and Regional Partnership Board footprint	Annual increase compared to baseline assessment	Data not available as yet		
	Qualitative report detailing progress to embed the National Framework for the Delivery of Bereavement Care in Wales and the National Bereavement Pathway	Evidence of Improvement	Data not available as yet		
	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by 31 March 2024		842	Jul-23
	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	An increase on the number in the equivalent month in the previous year		711	Apr-23
	Qualitative report detailing progress to develop a whole schools approach to CAMHS in reach services	Evidence of Improvement	On Track	N/A	Sep 22 - Mar 23
	% 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%		64.0%	Jun-23
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)			50.5%	
	% 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)			71.1%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)			92.0%	
Access Hospital Services Quickly	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		43.7%	Jul-23
	Median emergency response time to amber calls	12 Month Improvement Trend		01:21:00	Jul-23
	Median time from arrival at an emergency department to triage by a clinician	12 month reduction trend		12	Jul-23

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Performance Measure	Target	*Key:* Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Access Hospital Services Quickly	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	12 month reduction trend		68	Jul-23
	% 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 2022-23, towards the national target of 95%		64.5% National Target not met but improvement from July 22 (60.3%)	
	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	Improvement trajectory towards a national target of zero by 31 March 2024		1,803	
	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of 80% by 31 March 2026		48.9%	Jun-23
	Number of patients waiting more than 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by 31 March 2024		13,089	
	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	12 month improvement trend		93.9%	
	Number of patients waiting more than 14 weeks for a specified therapy (all ages)	Improvement trajectory towards a national target of zero by 31 March 2024		1,465	
	Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero		12,773	Jul-23
	Number of patients waiting over 36 weeks for a new outpatient appointment			22,798	
	Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	Improvement trajectory towards the national target of zero		35,334	
	Number of patients waiting more than 104 weeks for referral to treatment			3,687	
	Number of patients waiting more than 52 weeks for treatment			25,515	
	% of patients waiting less than 28 days for a first outpatient appointment for Specialist Child and Adolescent Mental Health Services (sCAMHS)	80%		70.8%	Jun-23
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment			35.7%	
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			49.3%	

National Performance Trajectory – please note that the following scorecard is in development & trajectory data will be revised in future iterations of this report

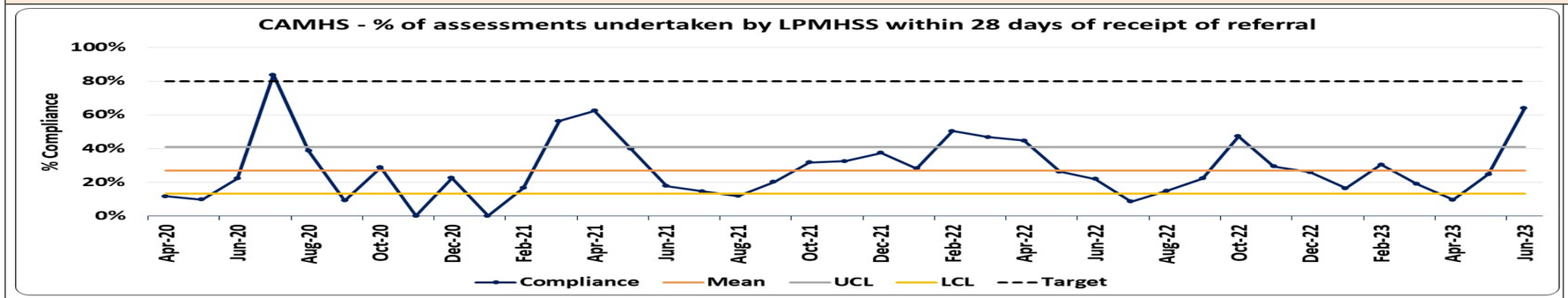
2023/24 National Performance Trajectory

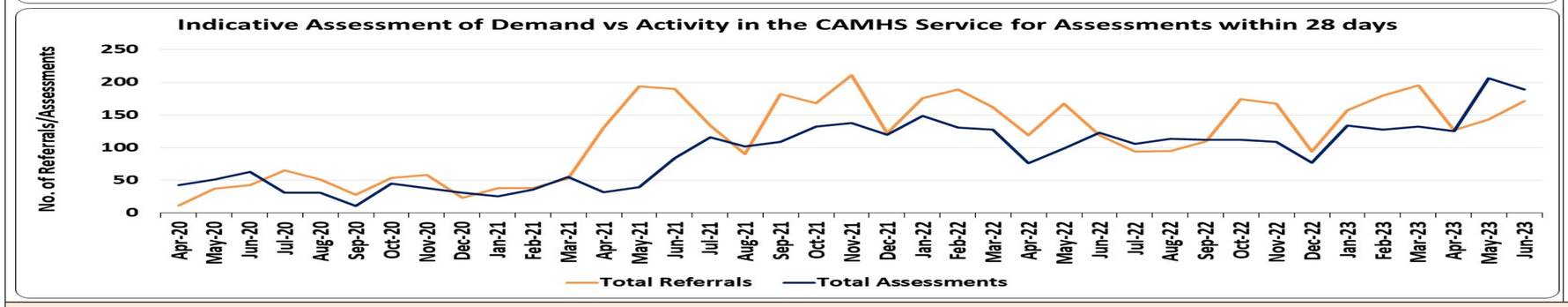
Key: National Target Met | National Target Failed | Trajectory | Actual

Measure	Performance Against Target	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by March 2024 Current Period 842													
Trajectory		685	719	719	719	719	719	719	719	719	719	719	719	719
Actual		685	719	735	723	842								
Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023 Current Period 12,773													
Trajectory		14,017	19,704	18,010	16,317	14,475	12,628	11,271	9,974	8,699	7,424	6,247	5,199	4,187
Actual		14,017	13,812	13,334	12,558	12,773								
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024 Current Period 22,798													
Trajectory		23,569	28,693	27,055	25,021	24,180	23,276	22,373	21,462	20,564	19,601	18,638	17,777	16,916
Actual		23,569	23,741	22,992	22,523	22,798								
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by June 2023 Current Period 3,687													
Trajectory		6,151	6,020	5,357	5,902	5,071	4,068	3,080	2,119	1,210	413	231	107	0
Actual		6,151	5,855	5,430	3,858	3,687								
Number of patients waiting more than 52 weeks for treatment	Improvement trajectory towards a national target of zero by 2025 Current Period 25,515													
Trajectory		28,339	29,187	27,520	25,841	24,659	22,933	21,642	20,340	19,072	17,380	15,954	14,647	13,366
Actual		28,339	28,852	27,569	25,755	25,515								
Number of patients waiting over 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by March 2024 Current Period 13,089													
Actual		15,299	15,727	15,689	14,361	13,089								
Trajectory		15,299	15,727	15,726	15,310	14,998	14,507	12,750	11,031	9,696	8,670	7,679	6,721	5,795
Number of patients waiting over 14 weeks for a specified therapy	Improvement trajectory towards a national target of zero by March 2024 Current Period 1,465													
Trajectory		1,145	1,173	1,323	1,442	1,465								
Actual		1,145	1,173	1,323	1,442	1,465								
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Improvement trajectory towards a national target of reduction by March 2024 Current Period 35,334													
Trajectory		33,208	35,795	35,625	35,455	35,285	35,115	34,945	34,775	34,605	34,435	34,265	34,095	33,925
Actual		33,208	35,260	34,874	34,819	35,334								
Number of patients waiting more than 62 days for their first definitive cancer treatment from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of reduction by March 2024 Current Period 779													
Trajectory		640	538	529	516	512	511	490	455	450	424	404	396	392
Actual		654	656	785	779									
Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of reduction by March 2024 Current Period 48.9%													
Trajectory		48.4%	58.3%	59.0%	60.3%	60.9%	61.3%	62.8%	64.8%	65.4%	67.2%	69.1%	69.6%	69.8%
Actual		48.4%	48.6%	49.1%	48.9%									
Number of ambulance patient handovers over 1 hour	Improvement trajectory towards a national target of zero by March 2024 Current Period 756													
Trajectory		1,094	952	397	256	255	357	329	407	419	465	390	351	316
Actual		1,094	952	445	594	756								
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by March 2024 Current Period 1,803													
Trajectory		2,092	1,716	1,754	1,754	1,313	1,313	1,313	724	724	724	724	724	724
Actual		2,092	1,760	1,402	1,536	1,803								

CTM Child & Adolescent Mental Health Services (CAMHS) – June 2023

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (64.0%) - Target 80%





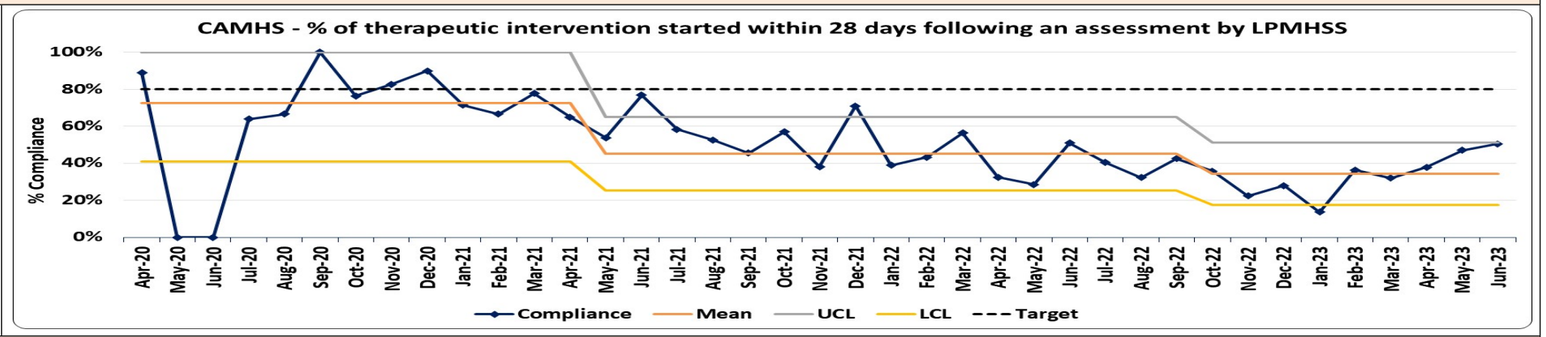
A marked improvement is observed in the number of assessments undertaken within 28 days of referral, with compliance reaching 64.0%. This is the highest level of attainment since July 2020 (94%). The number of assessments carried out this month totalled 189 and is 47% higher than the 12 month average (129).

Compliance remains below the WG's minimum expected standard of 80% and the last time the target was met was also in July 2020, however performance levels are seeing signs of recovery as the backlog reduces and average waiting times for assessment improve (please see action section overleaf).

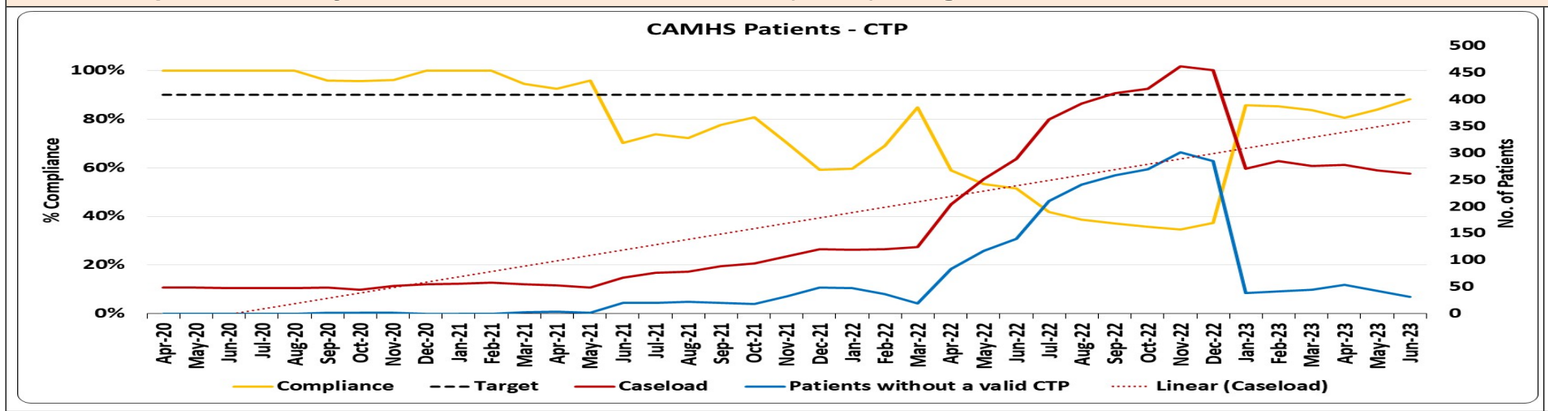
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (50.5%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS, whilst remaining low, improved to 50.5%, with 50 of the 99 interventions during June commencing within 28 days. Compliance is at its highest level seen since June of last year, but continues to lie below the 80% threshold, with the last time the target being met was December 2020 (90%).

A reduction in the backlog of patients waiting for interventions, is leading to a gradual improvement in compliance



Please note that this measure is part of Quadruple Aim 4 - People Centred Care - but has been included in this section for ease of reference with the Mental Health Priorities - % of HB residents who are in receipt of secondary MH services who have a valid CTP (88.2%) - 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 improved further to 88.2% during June and just falling short of the WG standard of 90%.

As seen in the chart to the left; from January 2023, we observe that caseloads have fallen, on average by 40% from the peak seen in November 2022 (462). The number of patients without a valid CTP at the end of the month stands at 31.

Part 3: There were no requests for a CAMHS assessment under Part 3 of the Mental Health Measure during June.

Cont'd…CAMHS

How are we doing and what actions are we taking?	When is improvement anticipated and what are the main areas of risk?

Actions being taken:

- An improvement action plan and trajectory has been developed to improve compliance in Parts 1a & b and part 2 of the Mental Health Measure.
- Additional capacity has been introduced temporarily from the Nurse Bank whilst progress is made on recruitment to vacant posts.
- **Part 1a**: a workshop has been held to discuss the interface between our Single Point of Access, Crisis and Part 1 assessment teams. The aim going forward will be to try and reduce duplication in the assessment process. The service is exploring the use of digital assessment tools used elsewhere in Wales and across the UK to help provide some further support for our assessment activity.
- **Part 1b:** our interventions team is developing the range of group work which it offers. This will help to increase the capacity of the service where appropriate. Good progress is also being made on diversifying the range of providers with some Third Sector initiatives to help increase the volume of available group work.
- **Part 2:** a training program for Care Co-ordinators is helping to improve the quality of CTPs, whilst compliance with the required annual review is improving. This includes some joint training between Adult Mental Health services and CAMHS
- Monthly supportive meetings are in place with the NHS Executive which is helping to improve compliance in all areas and in a sustainable way.

Outputs of improvements:

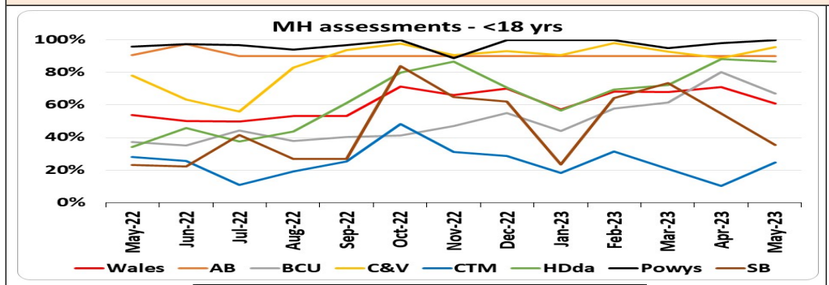
- **Part 1a:** The service has introduced some additional capacity to help with assessments. This has been sustained with 206 assessments being completed in May and 189 in June 2023. The waiting list has reduced from 182 on 26/05/23 down to 127 on 23/06/23. The average wait during this time frame has reduced from 2.1 to 1.7 weeks.
- **Part 1b:** The improvement actions are helping to deliver performance, which for June, is above the improvement trajectory. Current indicators suggest continued improvement going forward. Improvement actions which are helping to raise capacity include; development of group work treatment programs together with Third Sector and digital initiatives.
- **Part 2:** There has been a focus on providing additional capacity and time to support care co-ordinators to complete CTPs with their patients. As part of the improvement plan, a revised operational policy has been developed. A central register of all care co-ordinated patients is now in place which helps facilitate ongoing monitoring. There was a rise in compliance from 84% in May to 88% in June. This is against a target of 90% of Care Co-ordinated patients having an up to date Care & Treatment Plan.

Main areas of risk:

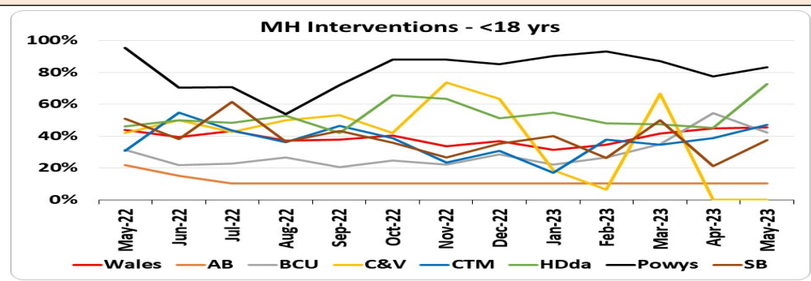
- The CAMHS service experiences regular fluctuations in demand, this can have a negative effect on waiting times for assessment and treatment. Going forward further work is required to better predict the impact of this fluctuating demand on the service and increasing capacity in response to temporary rises.
- The service is prioritising recruitment to vacant positions. The service needs to maintain high staffing levels to sustain performance in the three areas under review.
- Clinical colleagues have reported rising acuity within their patient population, this may have an impact on delivery going forward.

How do we compare with our peers?

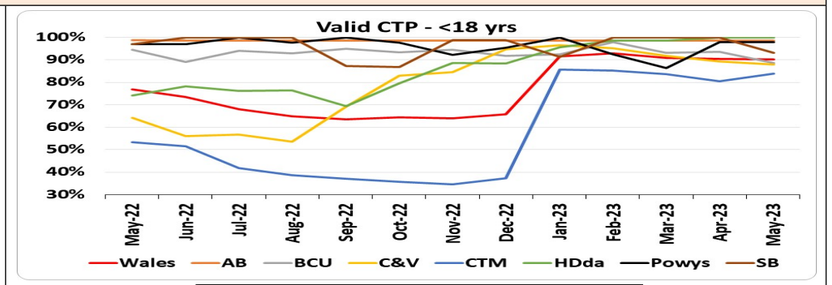
Note: AB unable to submit data from Jul-22, therefore Jun-22 data has been used as a proxy



Status as at May 2023		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
C&V	95.7%	2nd
AB	90.1%	3rd
HDda	86.6%	4th
BCU	67.0%	5th
SB	35.4%	6th
CTM	**24.6%**	**7th**



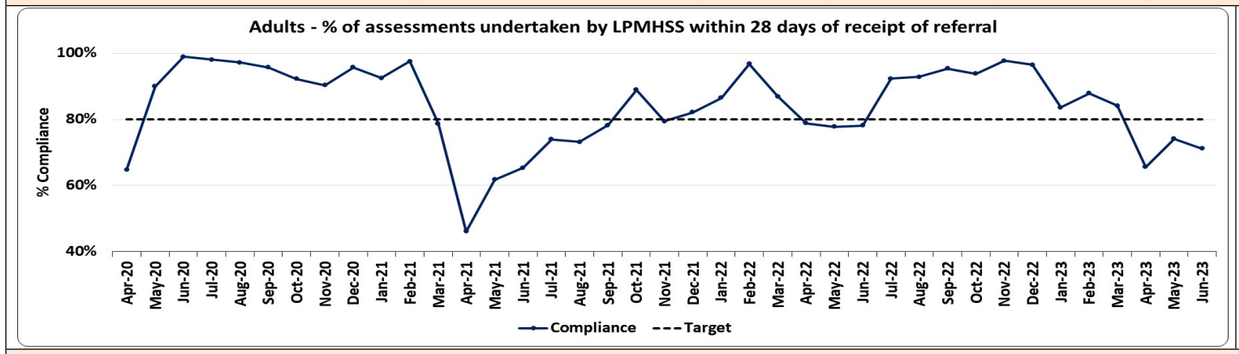
Status as at May 2023		
Health Board	**Compliance**	**Rank**
Powys	83.3%	1st
HDda	72.9%	2nd
CTM	**47.1%**	**3rd**
BCU	42.3%	4th
SB	37.7%	5th
AB	10.3%	6th
C&V	0.0%	7th



Status as at May 2023		
Health Board	**Compliance**	**Rank**
HDda	100.0%	1st
AB	98.6%	2nd
Powys	98.0%	3rd
SB	93.2%	4th
BCU	88.7%	5th
C&V	88.1%	6th
CTM	**84.0%**	**7th**

CTM Mental Health Services (excluding CAMHS) – June 2023

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (71.1%) - Target 80%

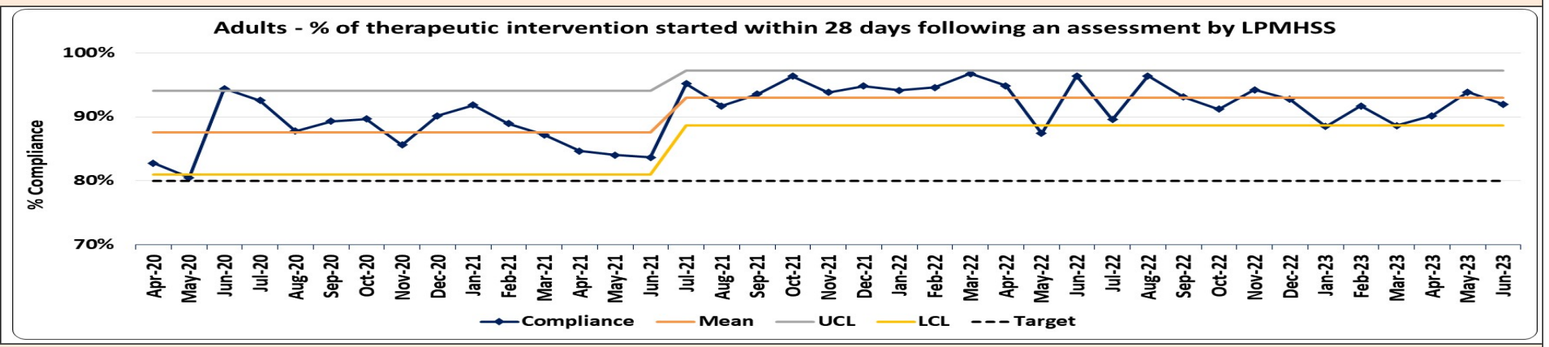


Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target of 80% of referrals to be assessed within 28 days. The compliance for the adult mental health services during June dipped to 71.1% and remains below the 80% target for the third month in succession after previously maintaining compliance from July of last year.

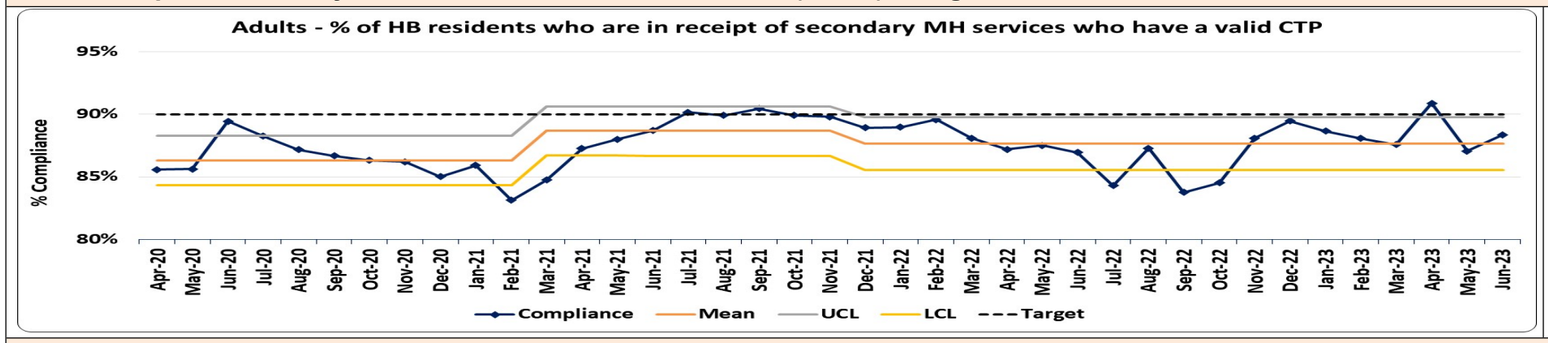
Referrals during June increased further by 8.7% from the previous month, bringing the total to 799, with a similar increase on the 12 month average of 737. However, volumes continue to remain lower than pre-Covid levels, where referrals were in the region of 1,000 to 1,100.

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (92.0%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS also fell slightly to 92.0% during June with 321 of the 349 interventions commencing within the 28 day timeframe and remaining above the WG target of 80%.



Please note that this measure is part of Quadruple Aim 4 - People Centred Care - but has been included in this section for ease of reference with the Mental Health Priorities - % of HB residents who are in receipt of secondary MH services who have a valid CTP (88.4%) - Target 90%



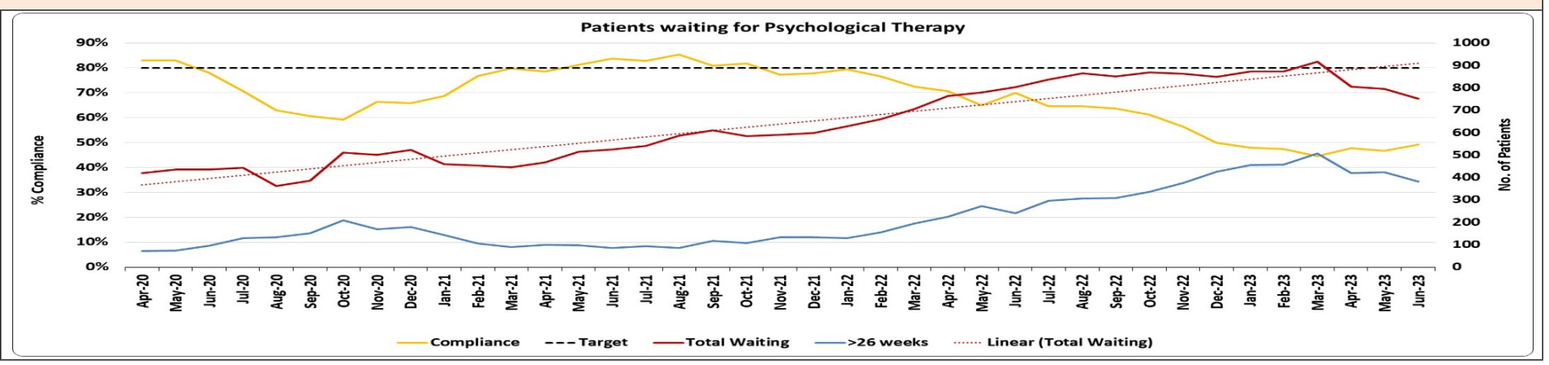
Part Two of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month reached 88.4% during June and resting just below the 90% WG standard.

Part 3: There were no outcome of assessment reports sent during June.

% of patients waiting less than 26 weeks to start a Psychological Therapy (49.3%) - Target 80%

During June, Psychological Therapies compliance was 49.3% (46.8% May) and remaining well below the 80% compliance threshold set by WG.

The chart to the right depicts 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). We observed a continuing reduction in the number of patients waiting for the third month in succession. At the end of June the waiting list stood at 751 patients down from the peak of 916 in March.



Adult Mental Health Services continued on the next page…

Cont'd…Mental Health Services (excluding CAMHS)

How are we doing?

Part 1a: Adult mental health services performance has declined from 74.1% in May to 71.1% in June and remains below the WG target of 80%.

Both Merthyr Cynon and Rhondda Taff Ely areas have fallen below the threshold of 80% (74.1% & 73% respectively), where in the previous month were above 80%. The Bridgend area is currently at 56.9%, which has improved from 31.4% in the previous month.

Reduced capacity due to staff absences and vacancies has impacted on services to meet the performance targets for June.

Part 1b: Performance continues to be above target at 92%.

Part 2: Overall compliance for both Adult, Older Adult and Learning Disability Services has increased to 88.4%, falling below the target threshold of 90%

- Adult Services improved 86.3%
- Older Adult Services improved to 94.3%
- Learning Disability Services has fallen to 91.5%

Psychological Therapies: The overall position for Psychological Therapies waiting list for June 2023 stands at 751 patients, which is a reduction of 44 from May's position.

The number of patients waiting over 26 weeks has fallen to 381 patients, equating to a 10% reduction.
The current performance of 49% of people waiting less than 26 weeks is lower than the trajectory target of 52% at June 23. A factor linked to this shortfall is that 17% (16 out of 92) of clients who have been offered outsourced therapy and have indicated that their personal circumstances make digital methods of delivery unsuitable at this time and remain on the waiting list. The trajectory modelling assumed this uptake would be higher.

There has been a reduction in waiting list volumes in most teams with a significant reduction in Primary Care Merthyr & Cynon waiting list of 23%. This equates to a reduction of 28 service users, reducing from 120 to 92. This has been due to bi-annual validation work (Opt-in letters to patients circulated).

What actions are we taking and when is improvement anticipated? What are the main areas of risk?

Part 1a: Actions to improve performance are:

- Focus on sickness management where the teams are currently experiencing high levels.
- Review of IT systems
- Demand and capacity work – review of job plans
- Review data input and reporting

Improvements in Part 1a compliance are anticipated in Quarter 2 (2023/24) in line with staff scheduled to return from sickness.

Part 1b: Compliance continues to remain above target.

Part 2: Targeted work on non-compliant CTPs is ongoing. Work will continue with Community Mental Health Team leads and Local Authority partners to ensure any non-compliant CTPs are prioritised based on reducing risk. The primary risk to sustained improvements remains the reduction in staffing capacity caused by sickness and turnover. Managers are monitoring compliance weekly to mitigate reductions.

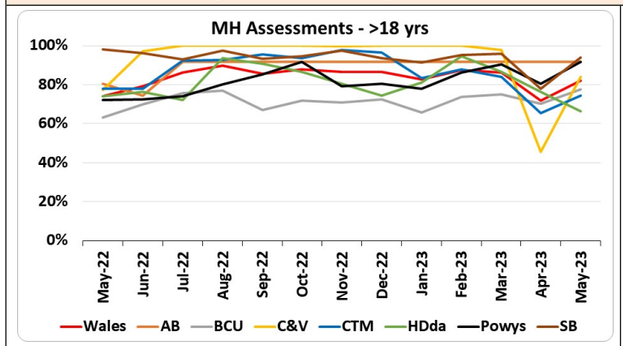
Improvements in Part 2 compliance are anticipated in Quarter 2 in line with staff scheduled to return from sickness.

Psychological Therapies: Actions taken to improve position:

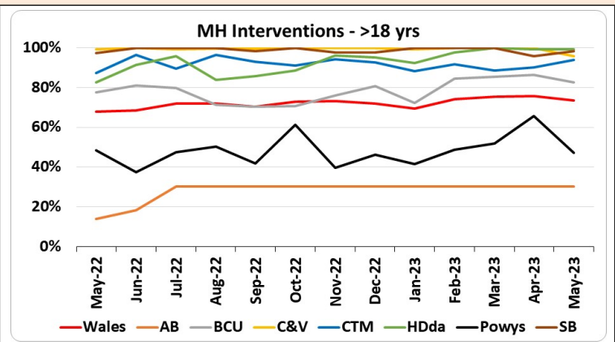
- Detailed Psychological therapies recovery programme overseeing a number of improvement plans, including development of a minimum dataset and a performance and accountability framework
- Ongoing waiting list and data validation including application of access policy
- Demand and capacity review
- Recruitment to vacant posts and use of locums to increase capacity
- Outsourcing of patients on the waiting list subject to available resource

How do we compare with our peers?

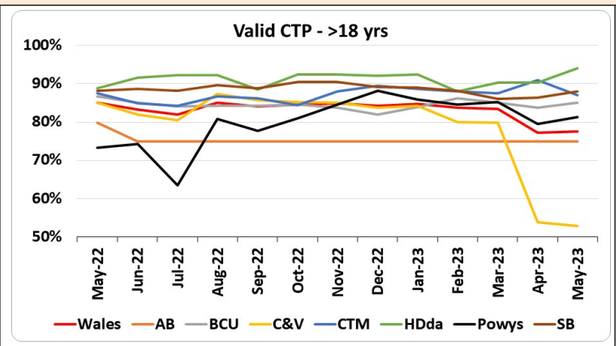
Note: AB unable to submit data from Jul-22, therefore Jun-22 data has been used as a proxy



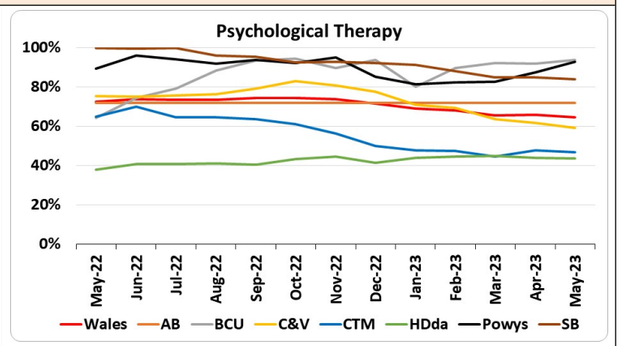
Status as at May 2023		
Health Board	**Compliance**	**Rank**
AB	91.9%	1st
BCU	77.5%	2nd
C&V	84.0%	3rd
CTM	**74.3%**	**4th**
HDda	66.5%	5th
Powys	91.6%	6th
SB	93.9%	7th



Status as at May 2023		
Health Board	**Compliance**	**Rank**
HDda	99.2%	1st
SB	98.2%	2nd
C&V	95.7%	3rd
CTM	**93.9%**	**4th**
BCU	82.6%	5th
Powys	47.2%	6th
AB	30.2%	7th



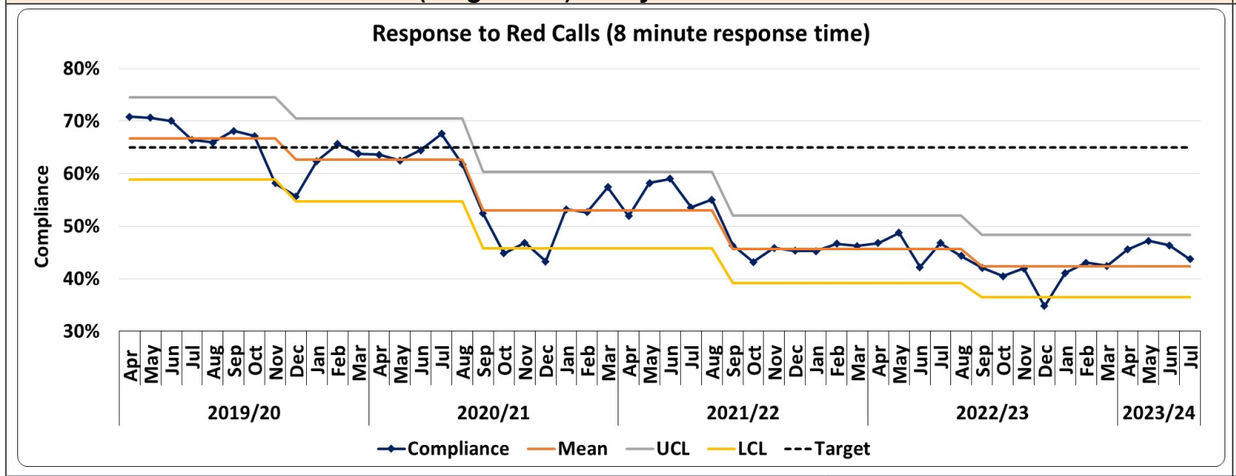
Status as at May 2023		
Health Board	**Compliance**	**Rank**
HDda	94.2%	1st
SB	88.1%	2nd
CTM	**87.1%**	**3rd**
BCU	85.0%	4th
Powys	81.3%	5th
AB	75.0%	6th
C&V	52.8%	7th



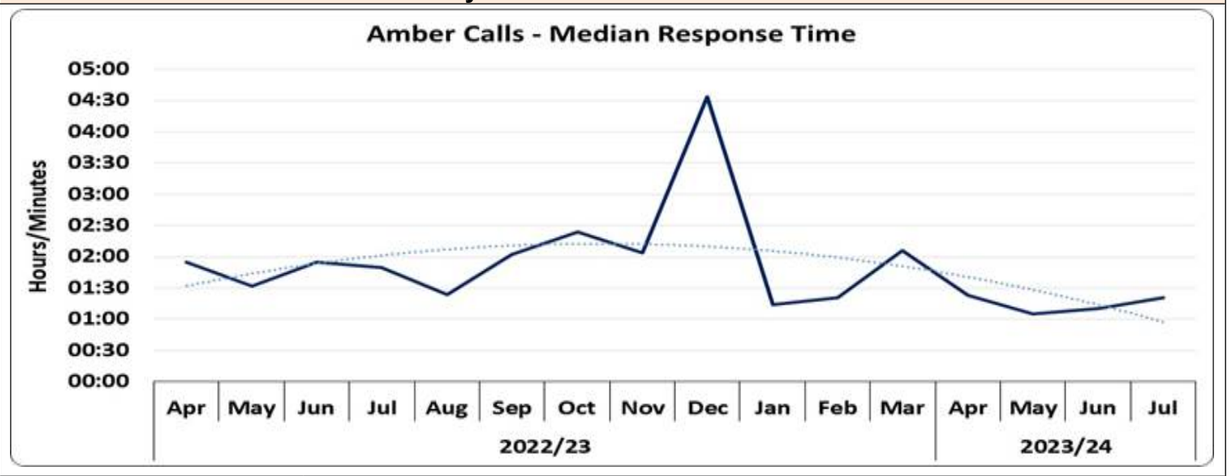
Status as at May 2023		
Health Board	**Compliance**	**Rank**
BCU	93.8%	1st
Powys	93.0%	2nd
SB	84.0%	3rd
AB	72.0%	4th
C&V	59.2%	5th
CTM	**46.8%**	**6th**
HDda	43.5%	7th

Emergency Ambulance Services – Response to Red Calls & Median Response Times to Amber Calls – July 2023

Response to Red Calls - % of emergency responses to Red Calls arriving within 8 minutes (Target 65%) July 2023 – 43.7%



Median emergency response time to amber calls – Target is 12 month improvement trend July 2023 - 1 hour 21 minutes



How are we doing?

Response to Red Calls per WAST Operational Area			
Jul-23	Total Responses	Responses within 8	% within 8 mins
Merthyr	118	70	59.3%
RCT	299	108	36.1%
Bridgend	171	79	46.2%
CTM	588	257	43.7%

Response to Red Calls: Response times to life-threatening calls fell to 43.7% in July with the National compliance also falling to 52.6%. The minimum expected standard is for 65% of Red Calls to be responded to within 8 minutes. As can be seen in the table above, there is variance in response times across our region, with RCT borough experiencing the poorest response times during July, as has been the case since November of last year.

The volume of Red Calls during July for the CTM area totalled 588, just one fewer than the previous month and similar to the same period of 2022. The current volume lies below the 12 month average of 605 per month.

Median Response to Amber Calls: The median response times for serious, but not immediately life threatening calls was 81 minutes during July, which is an improvement of just over 26% (29 minutes) on the same period last year. Despite the chart (top right) depicting fluctuations in the median response times, we observe that the overall trend shows a reduction.

What actions are we taking & when is improvement anticipated?

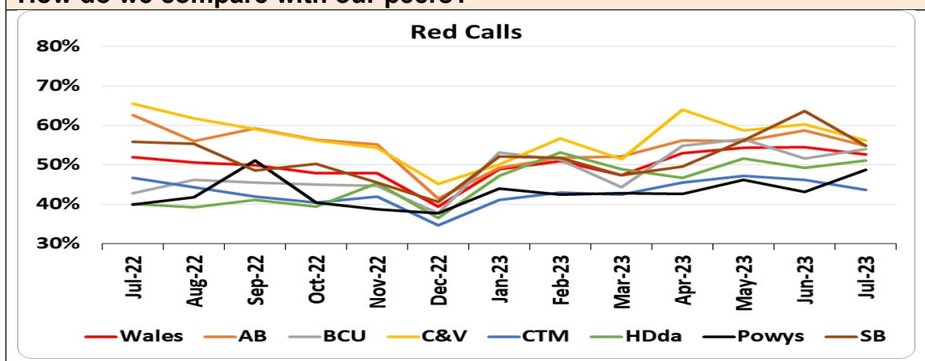
- Weekly data v improvement "deep dive" against trajectories
- Weekly performance/assurance meetings in place
- Navigation Hub increased utilisation
- Pan CTM Emergency Pressure Escalation Procedure Policy – Launch 14th August 2023
- Zero tolerance > 4 hours – launched POW 31st July 2023
- Re-set RGH zero tolerance > 4 hours - 7th August 2023
- Robust out of hours and weekend planning process in place
- Update Safe to Start process pan CTM
- Unscheduled Care Senior leadership team proactively engaged and leading programme for improvement

What are the main areas of risk?

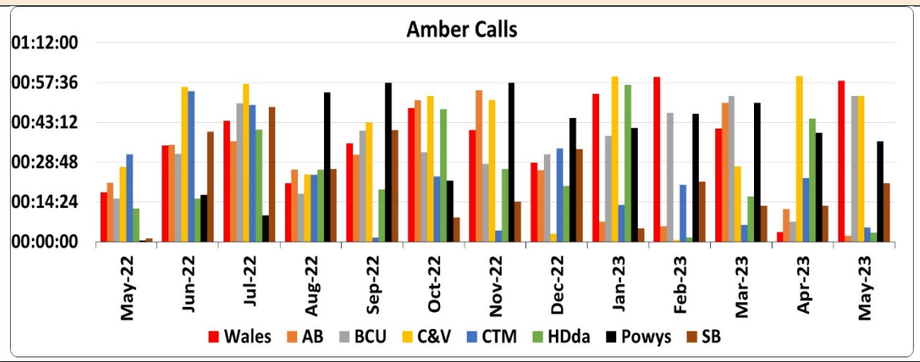
Additional uncomissioned capacity remains open across all sites, aligned to COVID and winter 2022/23.

Winter 2023/24 – winter planning meetings established and first meeting held.

How do we compare with our peers?



Status as at July 2023		
Health Board	Compliance	Rank
C&V	56.2%	1st
SB	54.9%	2nd
AB	54.8%	3rd
BCU	54.1%	4th
HDda	51.2%	5th
Powys	48.7%	6th
CTM	43.7%	7th



Status as at May 2023		
Health Board	Compliance	Rank
AB	0.2%	1st
HDda	0.2%	2nd
CTM	0.4%	3rd
SB	1.5%	4th
Powys	2.5%	5th
C&V	3.7%	6th
BCU	3.7%	7th

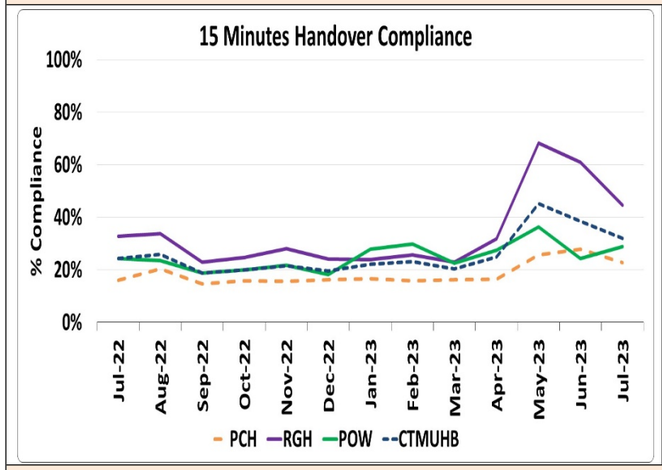
Emergency Ambulance Services - Handover Compliance – July 2023

Number of ambulance handovers within 15 minutes – Target Improvement

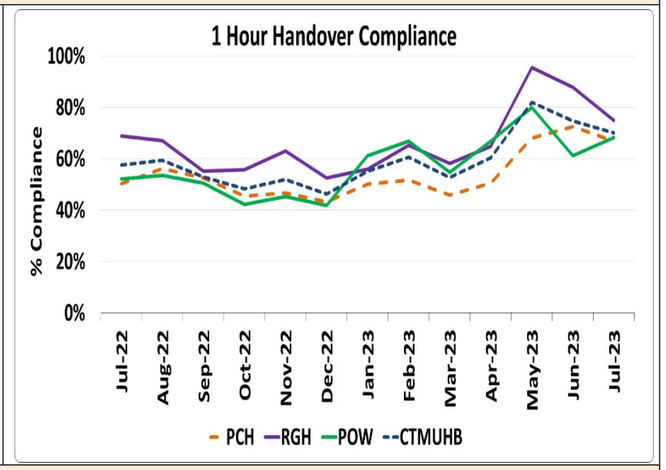
Total handovers 2,525 of which 806 handovers were within 15 minutes (31.9%)

Number of ambulance handovers over 1 hour – Target Zero - Please note that this measure is Quadruple Aim 4 but has been included in this area for ease of reference

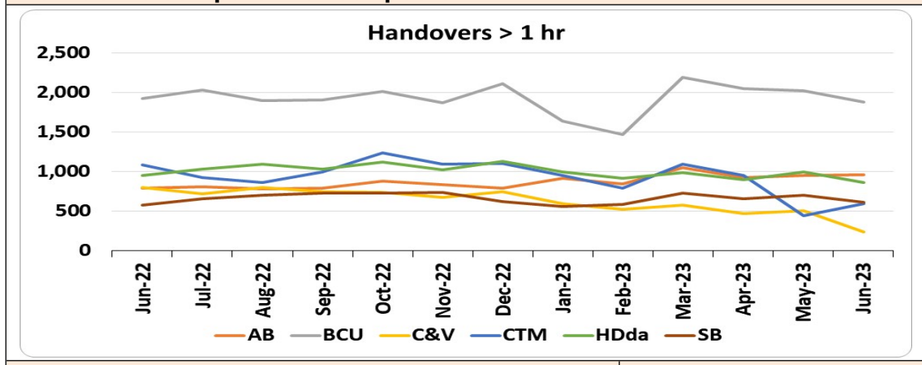
756 handovers were over 1 hour (70.1% of handovers were within 1 hour)



	PCH			RGH			POW			CTMUHB		
Period	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %	Total	% within	% within 1
Jul-22	798	16.0%	50.3%	791	32.7%	68.8%	596	24.3%	52.2%	2185	24.3%	57.5%
Aug-22	808	20.4%	56.1%	748	33.7%	67.1%	568	23.6%	53.5%	2124	25.9%	59.3%
Sep-22	761	14.6%	52.4%	759	22.9%	55.2%	591	18.8%	50.4%	2111	18.8%	52.9%
Oct-22	984	15.8%	45.5%	821	24.7%	55.7%	587	19.9%	42.2%	2392	19.9%	48.2%
Nov-22	909	15.6%	46.8%	773	28.1%	63.0%	597	21.8%	45.2%	2279	21.5%	51.9%
Dec-22	775	16.3%	43.2%	745	24.0%	52.5%	527	18.2%	41.7%	2047	19.6%	46.2%
Jan-23	812	16.5%	50.1%	750	23.9%	56.0%	564	27.8%	61.2%	2126	22.1%	55.1%
Feb-23	750	15.7%	51.7%	734	25.7%	65.1%	518	29.7%	66.8%	2002	23.0%	60.5%
Mar-23	849	16.3%	45.9%	873	22.9%	58.1%	593	22.6%	54.6%	2315	20.4%	52.7%
Apr-23	857	16.3%	50.5%	830	31.7%	64.8%	711	27.4%	66.8%	2398	24.9%	60.3%
May-23	831	25.8%	68.0%	962	68.3%	95.5%	678	36.3%	79.9%	2471	45.2%	82.0%
Jun-23	875	27.8%	72.5%	822	60.9%	87.7%	649	24.2%	61.2%	2346	38.4%	74.7%
Jul-23	940	22.7%	66.9%	864	44.6%	75.0%	721	28.8%	68.2%	2525	31.9%	70.1%

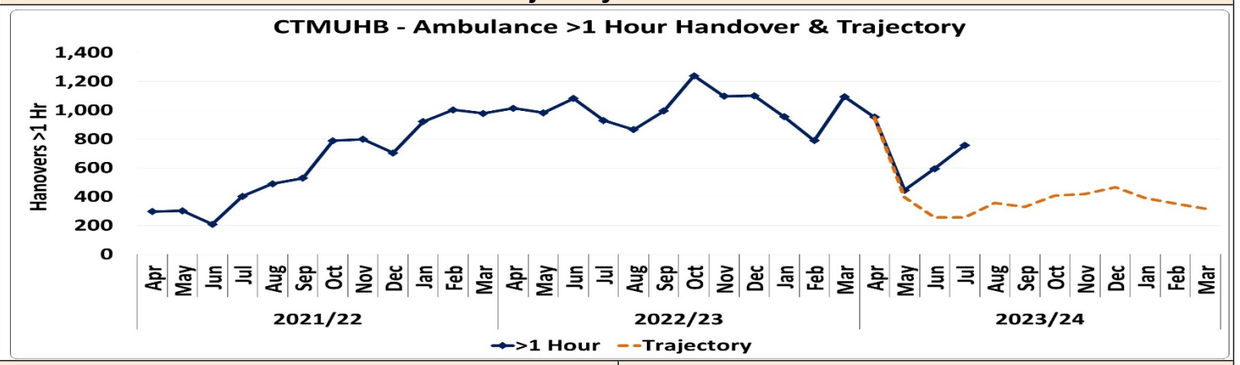


How do we compare with our peers?



Status as at June 2023		
Health Board	Compliance	Rank
C&V	241	1st
CTM	**594**	**2nd**
SB	615	3rd
HDda	863	4th
AB	961	5th
BCU	1,883	6th

Reduce >1 Hour Ambulance Handover Trajectory



How are we doing?

Ambulance conveyances to ED are 15.6% higher in July 2023 than they were in July of last year, with performance against the 15 minute and 60 minutes handover improving by 7.6 and 12.6 percentage points respectively.

Performance however, has deteriorated further in comparison to June, at 31.9% (38.4% in June) and 70.1% (74.7% in June) respectively. In total there were 756 patients and ambulance crews detained for greater than an hour.

During 2022/23, the number of patients waiting more than 1 hour for their transfer of care averaged 1,012 patients per month. Thus far, the average for this year equates to 687 patients and as it currently stands represents a 32% reduction in the number of patient breaches.

What actions are we taking & when is improvement anticipated?

As per the actions on the previous page with:

- Focused improvement programme to reduce Ambulance Handover delays "go live" at Royal Glamorgan hospital – 28 April 2023 - reset 7th August 2023
- Roll out to Princess of Wales Hospital – 31st July 2023
- Plan roll out Prince Charles Hospital – August 2023

What are the main areas of risk?

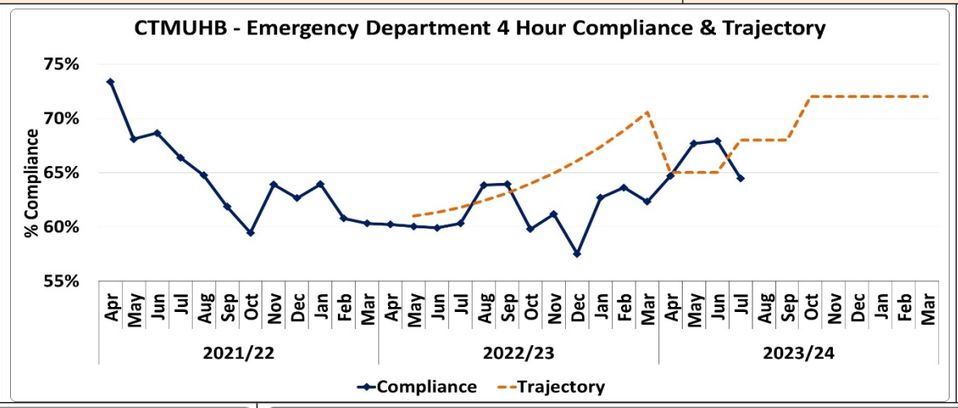
System flow remains highly impacted by capacity within social care.

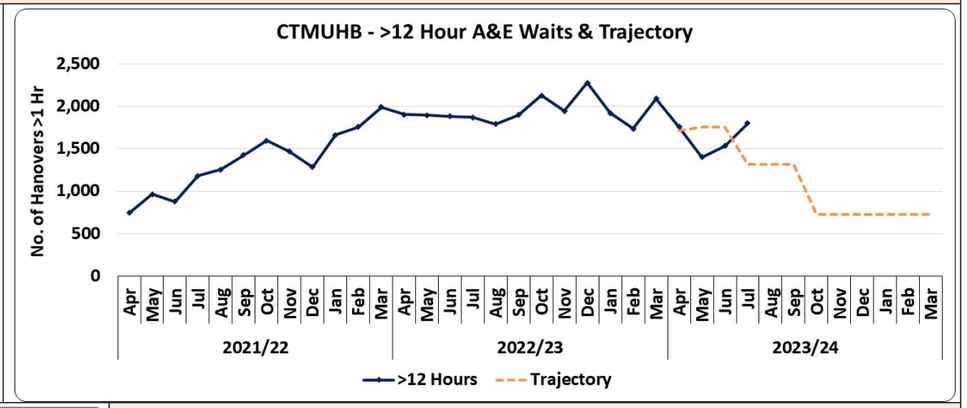
Activity has increased resulting in uncommissioned capacity being utilised to manage demand.

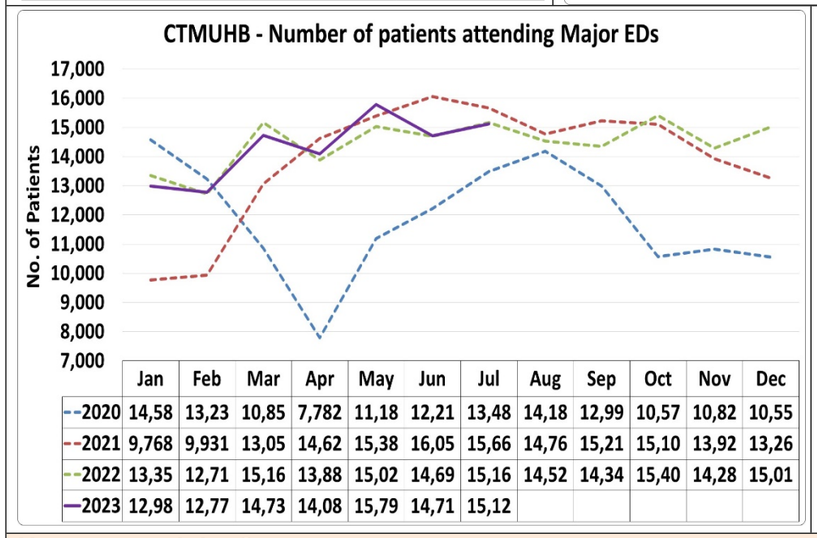
Emergency Unit Waits – July 2023 (Provisional Position) - Total Attendances 16,798

% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge - Target Improvement compared to the same month in 2022/23, towards the national target of 95%	Number of patients who spend 12 hours or more in emergency care facilities from arrival to admission, transfer or discharge - Target Improvement trajectory towards a national target of Zero by 31st March 2024
64.5% were seen within 4 hours (Patients Waiting >4 hours 5,966)	**10.7% of patients were waiting over 12 hours (1,803)**

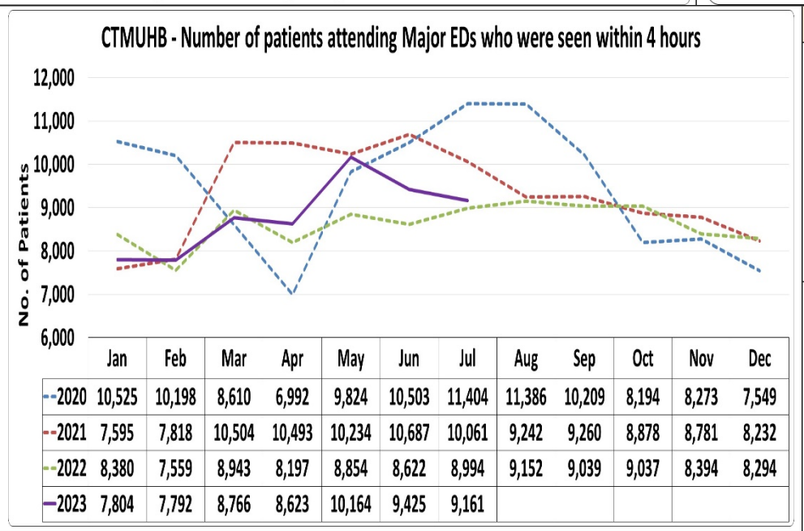
Period	CTMUHB		
	Attendances	4 Hrs %	> 12 Hrs
Jul-22	15553	60.3%	1873
Aug-22	14858	63.8%	1794
Sep-22	14715	63.9%	1900
Oct-22	15830	59.8%	2128
Nov-22	15225	61.2%	1946
Dec-22	15829	57.5%	2280
Jan-23	13882	62.7%	1920
Feb-23	13722	63.6%	1740
Mar-23	15844	62.3%	2092
Apr-23	15508	64.7%	1760
May-23	17526	67.7%	1402
Jun-23	16682	67.9%	1536
Jul-23	16798	64.5%	1803





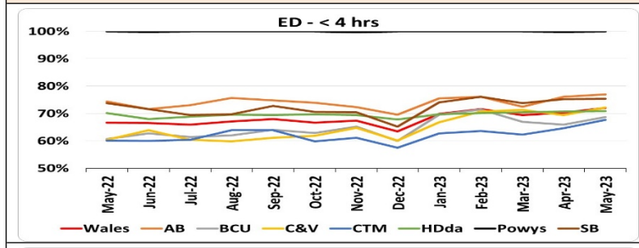


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	14,58	13,23	10,85	7,782	11,18	12,21	13,48	14,18	12,99	10,57	10,82	10,55
2021	9,768	9,931	13,05	14,62	15,38	16,05	15,66	14,76	15,21	15,10	13,92	13,26
2022	13,35	12,71	15,16	13,88	15,02	14,69	15,16	14,52	14,34	15,40	14,28	15,01
2023	12,98	12,77	14,73	14,08	15,79	14,71	15,12					

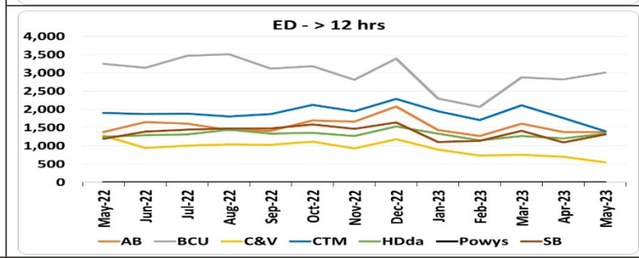


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	10,525	10,198	8,610	6,992	9,824	10,503	11,404	11,386	10,209	8,194	8,273	7,549
2021	7,595	7,818	10,504	10,493	10,234	10,687	10,061	9,242	9,260	8,878	8,781	8,232
2022	8,380	7,559	8,943	8,197	8,854	8,622	8,994	9,152	9,039	9,037	8,394	8,294
2023	7,804	7,792	8,766	8,623	10,164	9,425	9,161					

How do we compare with our peers?



Status as at May 2023		
Health Board	Compliance	Rank
Powys	100.0%	1st
AB	77.0%	2nd
SB	75.3%	3rd
C&V	72.2%	4th
HDda	70.9%	5th
BCU	68.7%	6th
CTM	**67.7%**	**7th**



Status as at May 2023		
Health Board	Compliance	Rank
Powys	0	1st
C&V	547	2nd
SB	1,312	3rd
HDda	1,337	4th
AB	1,373	5th
CTM	**1,402**	**6th**
BCU	3,012	7th

How are we doing?

Demand for ED has been 10% higher during this financial year than the equivalent time span of 2022 and attendances during July being 8% higher than the same period of last year.

The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival at our emergency care facilities during July was 64.5%, a fall from the previous two months where performance remained stable at just under 68% and continuing to remain below the compliance target of 95%.

The improved 12 hours performance observed during May has not been sustained in subsequent months with the number of patients who were waiting in excess of 12 hours increasing to 1,803 during July; the highest level seen since March of this year and is similar to the volumes observed in the equivalent period of 2022 (1,873).

What actions are we taking & when is improvement anticipated?

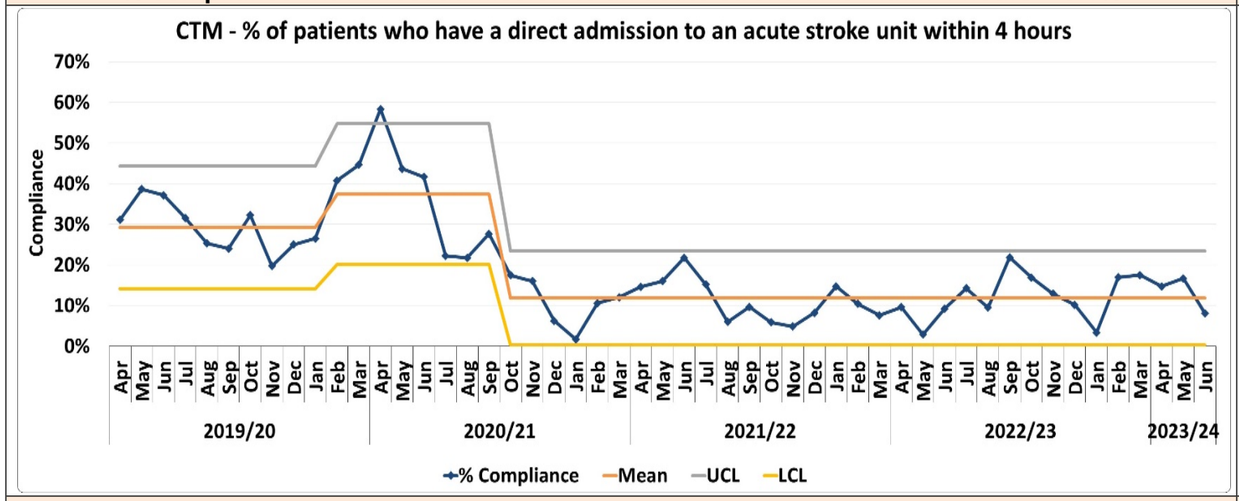
- <4 Hour Trajectories agreed / >12 Hours to be agreed
- Weekly data v improvement "deep dive" against trajectories
- Weekly performance/assurance meetings in place
- Progress development of medical SDEC within PCH and POW incorporating frailty
- Audit of reporting measures being undertaken across CTM by the health boards internal audit colleagues - ongoing.
- Ambulance Lost Hours improvement driving flow from ED
- Capital requirements for the SDEC implementation at PCH has been approved and capital design tender process underway. Draft design under review.
- Clinical pathway group established to support SDEC

What are the main areas of risk?

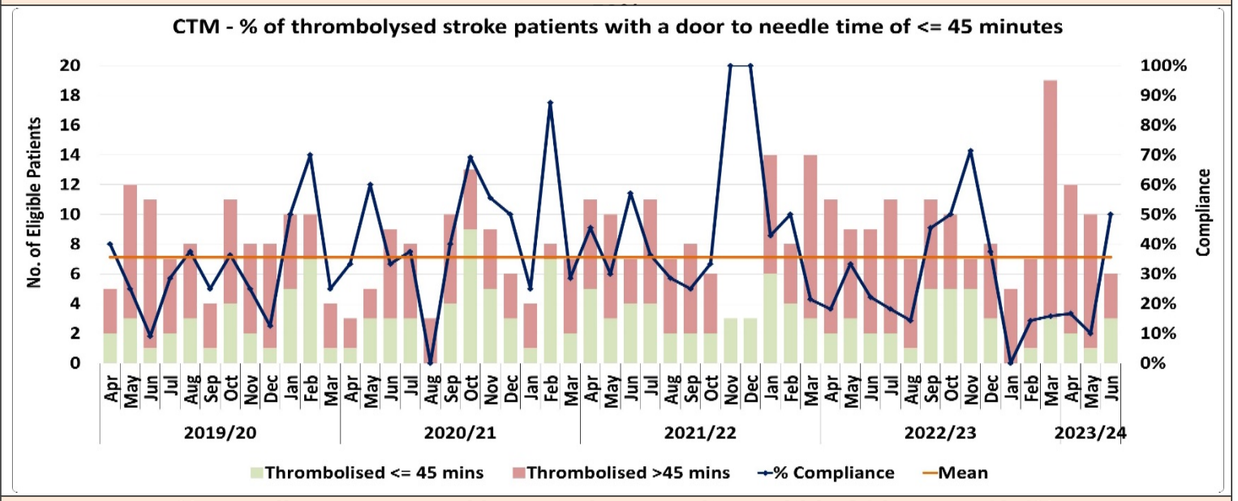
- Aspiration of care group to deliver December 2023 to support seasonal pressures. Risk around delivery of Capital Programme in timescale required.
- Funding confirmation required for medical/nursing workforce to provide SDEC at PCH.

CTMUHB – Focus on Stroke Quality Improvement Measures (QIMs) – June 2023 *(please note that Stroke Measures are not included in the 2023/24 Performance Framework)*

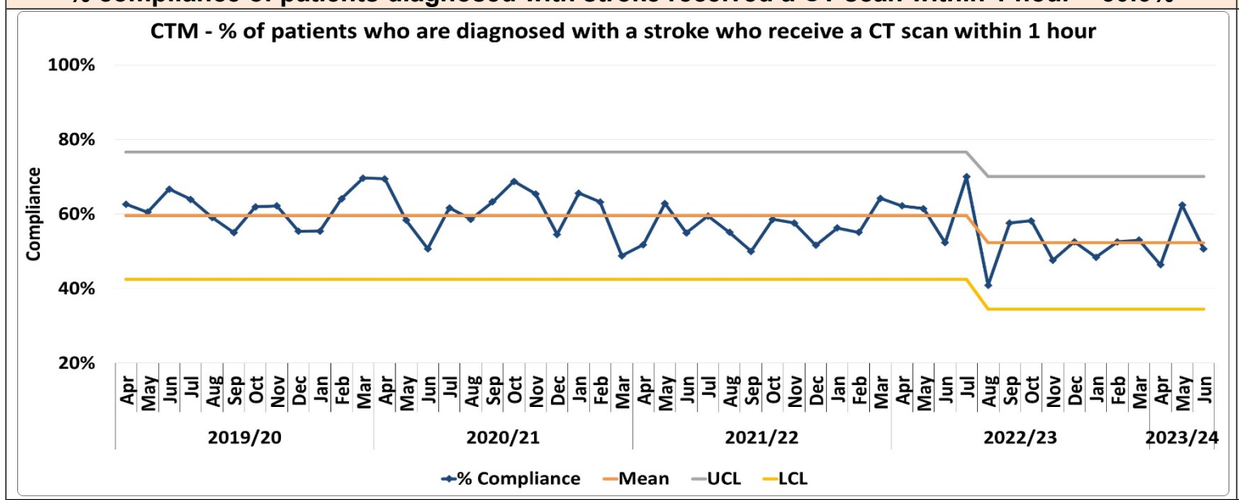
% compliance with direct admission to an acute stroke unit within 4 hours – 8.1%



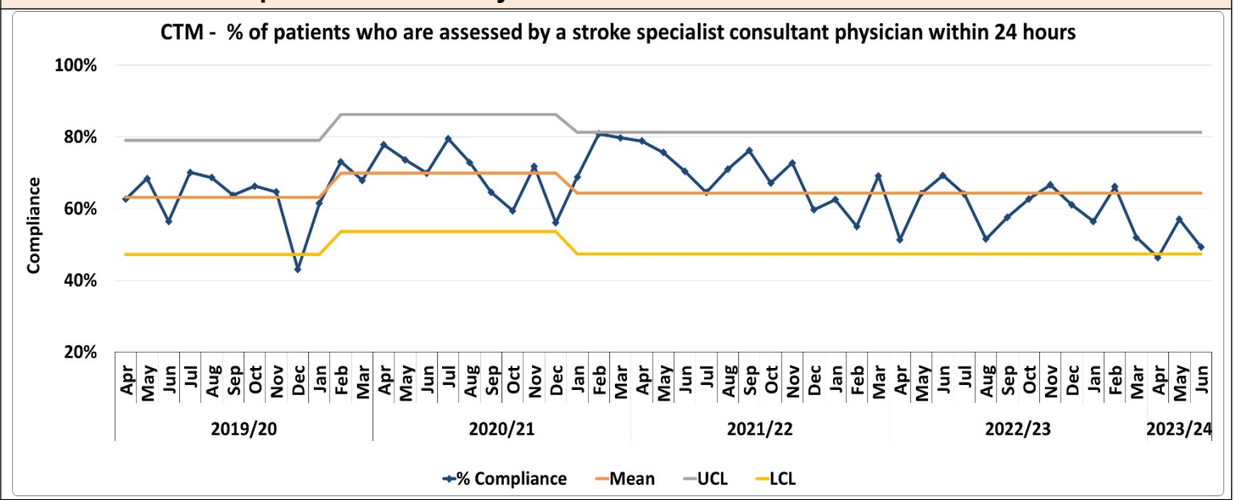
% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes –



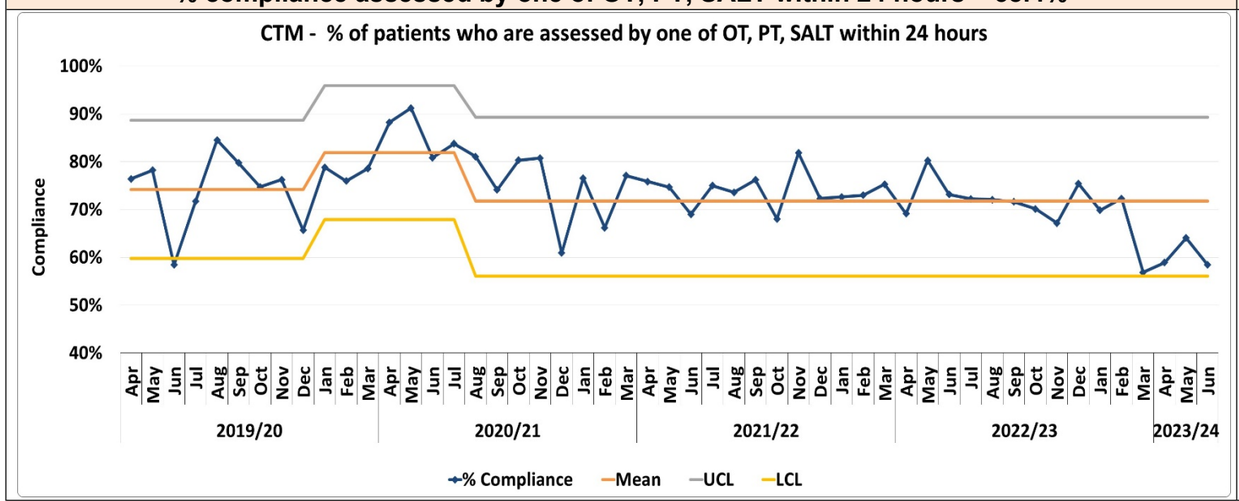
% compliance of patients diagnosed with stroke received a CT scan within 1 hour – 50.6%



% compliance assessed by a stroke consultant within 24 hours – 49.4%



% compliance assessed by one of OT, PT, SALT within 24 hours – 58.4%



Stroke Quality Improvement Measures – June 2023

Stroke QIMs - June 2023		PCH	POW	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	43	31	74
	No. of patients within	4	2	6
	% Compliance	**9.3%**	**6.5%**	**8.1%**
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	3	3	6
	No of patients within	1	2	3
	% Compliance	**33.3%**	**66.7%**	**50.0%**
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	46	31	77
	No. of patients within	23	16	39
	% Compliance	**50.0%**	**51.6%**	**50.6%**
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	46	31	77
	No. of patients within	20	18	38
	% Compliance	**43.5%**	**58.1%**	**49.4%**
% of patients who are assessed by one of OT, PT, SALT within 24 hours	Total admissions	46	31	77
	No. of patients within	22	23	45
	% Compliance	**47.8%**	**74.2%**	**58.4%**

Contd…Stroke Quality Improvement Measures (QIMs) – June 2023

How are we doing?

During June, just 8.1% (6 out of 74 admissions) of stroke patients were admitted directly to an acute stroke unit within 4 hours.

Three of the six eligible patients were thrombolysed within 45 minutes (50.0%) and 50.6% of patients (39 out of 77 diagnosed patients) had a CT scan within an hour.

There were also 38 out of the 77 stroke patients (49.4%) seen by a specialist stroke physician within 24 hours of arrival at the hospital.

Around 58% (45 out of 77) stroke patients were assessed by either an Occupational Therapist, Physiotherapist or Speech & Language Therapist within 24 hours of arrival.

Direct admission to acute stroke unit within 4 hours has been a challenge, but a recent Task & Finish group has prioritised the acute stroke beds in both stroke units and re-established ring fenced beds. We would expect to see significant improvement in future months as a result of this.

What actions are we taking and when is improvement expected?

Referrals to Bristol for thrombectomy are predominantly limited by Bristol's opening hours. The Bristol service has recently extended its opening hours to 8 am to midnight (need to be in Bristol by 10 pm), and hope to extend to 24/7 thrombectomy in the autumn. There is a major clinical risk in supporting 24/7 thrombectomy locally due to a 1 in 4 Stroke Consultant rota.

CTM have recently implemented radiographer approved CT and CT angiograms to minimise delays in getting CT angiograms in patients presenting with acute strokes.

There is an ongoing project to implement Brainomix AI software reporting for CTs and CT angiograms, which would minimise delays in referral for thrombectomy. There is a need to identify £20k per annum for a 3 year contract to purchase Brainomix. £20k has been agreed via the Therapies underspend for 2023/24 however, a further £40k is required to secure the 3 year contract.

A National review of the Stroke Self Presenters by the DU has been completed in CTM - awaiting outputs from the review.

The USC CG Stroke Programme Board has been established, First meeting 27th July and a Stroke Operational Group will be established to meet monthly.

What are the main areas of risk?

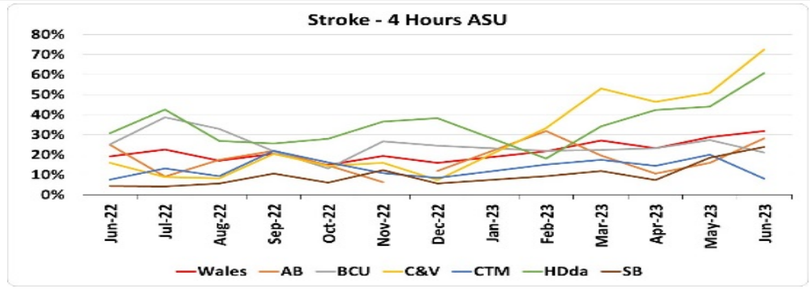
There is concern regarding clinical capacity to ensure resilience and to improve outcomes for patients via the provision of a 7 day service.

There were no applicants for the PCH 3rd Consultant vacancy. The post has been re-advertised and enquiries are being made regarding a Locum, given the pressures on the service.

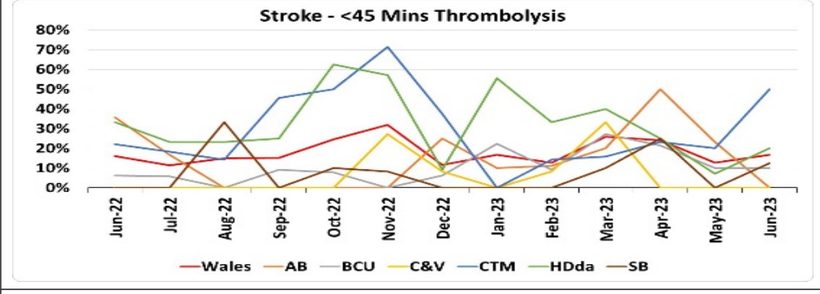
There is ongoing discussions about the possibility of funding two SAS doctors using this funding instead of filling the consultant vacancy, the scoping for this is continuing.

There are only 2 CNS roles at PCH. Funding is required for a 3rd CNS which would significantly enhance the service for patients and performance.

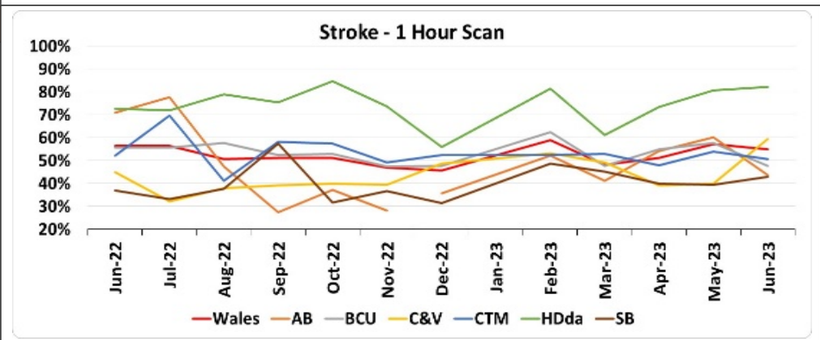
How do we compare with our peers?



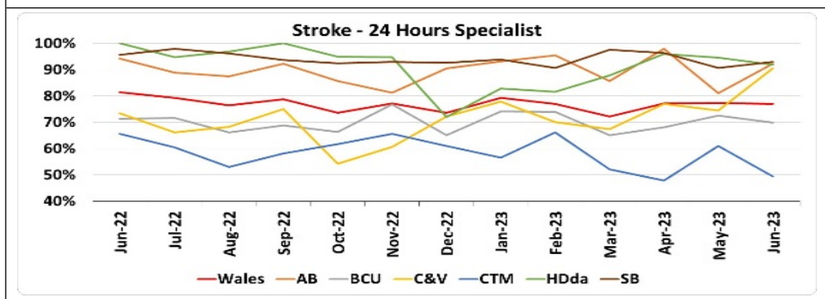
Status as at June 2023		
Health Board	**Compliance**	**Rank**
C&V	72.5%	1st
HDda	60.8%	2nd
AB	28.2%	3rd
SB	23.8%	4th
BCU	21.0%	5th
CTM	**8.1%**	**6th**



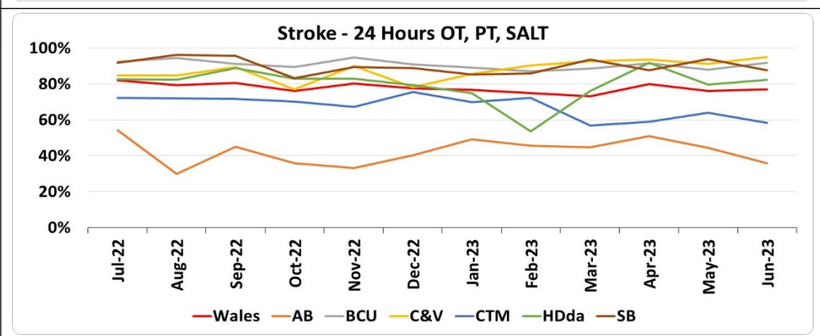
Status as at June 2023		
Health Board	**Compliance**	**Rank**
CTM	**50.0%**	**1st**
HDda	20.0%	2nd
SB	12.5%	3rd
BCU	10.0%	4th
AB	0.0%	5th
C&V	0.0%	6th



Status as at June 2023		
Health Board	**Compliance**	**Rank**
HDda	82.3%	1st
C&V	59.5%	2nd
CTM	**50.6%**	**3rd**
BCU	47.7%	4th
AB	43.6%	5th
SB	42.9%	6th



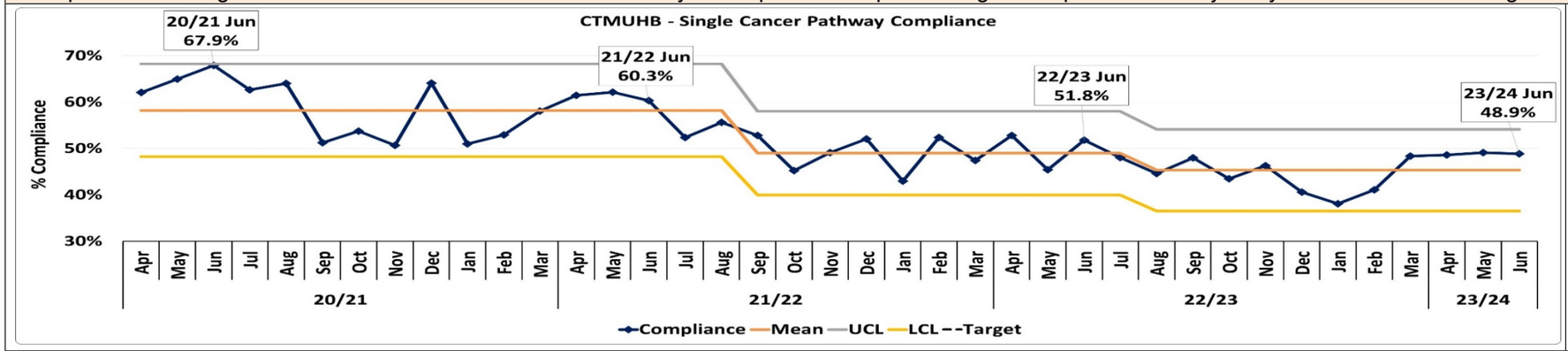
Status as at June 2023		
Health Board	**Compliance**	**Rank**
SB	92.9%	1st
AB	92.3%	2nd
HDda	91.9%	3rd
C&V	90.5%	4th
BCU	69.8%	5th
CTM	**49.4%**	**6th**



Status as at June 2023		
Health Board		
Health Board	**Compliance**	**Rank**
C&V	95.2%	1st
BCU	91.9%	2nd
SB	87.7%	3rd
HDda	82.3%	4th
CTM	**58.4%**	**5th**
AB	35.9%	6th

Single Cancer Pathway (SCP) – June 2023

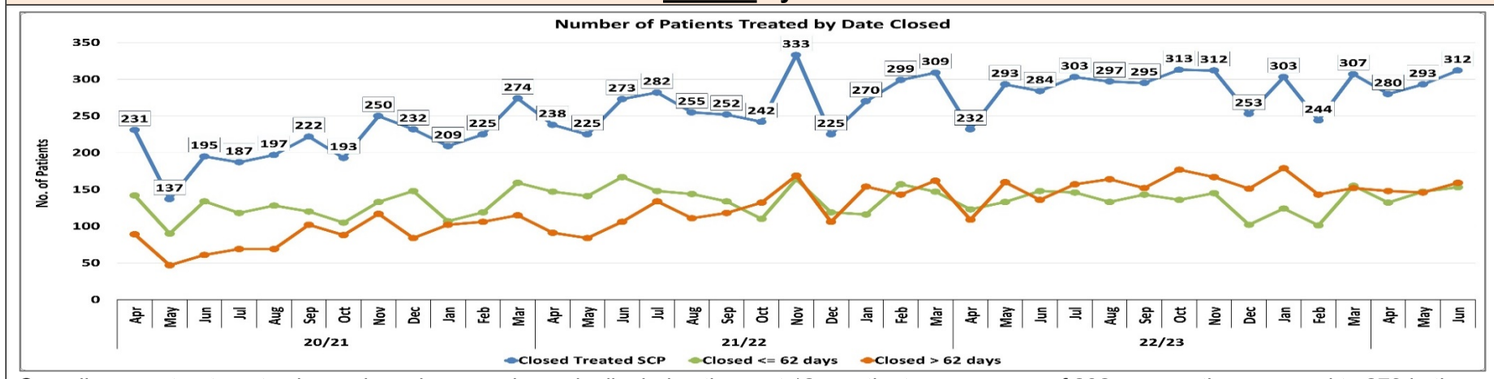
% of patients starting first definitive cancer treatment within 62 days from point of suspicion.Target is Improvement Trajectory towards a national target of 80% by 31st March 2026 **Compliance June 2023 – 48.9%**



CTMUHB - SCP % Treated Without Suspensions - June 2023				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated in Target Without Suspensions
Head and neck	3	4	7	42.9%
Upper GI	9	14	23	39.1%
Lower GI	9	21	30	30.0%
Lung	28	18	46	60.9%
Sarcoma	2	0	2	100.0%
Skin (exc BCC)	54	12	66	81.8%
Brain/CNS	0	1	1	0.0%
Breast	21	20	41	51.2%
Gynaecological	0	14	14	0.0%
Urological	18	45	63	28.6%
Haematological	5	10	15	33.3%
Other	3	0	3	100.0%
Total	152	159	311	48.9%

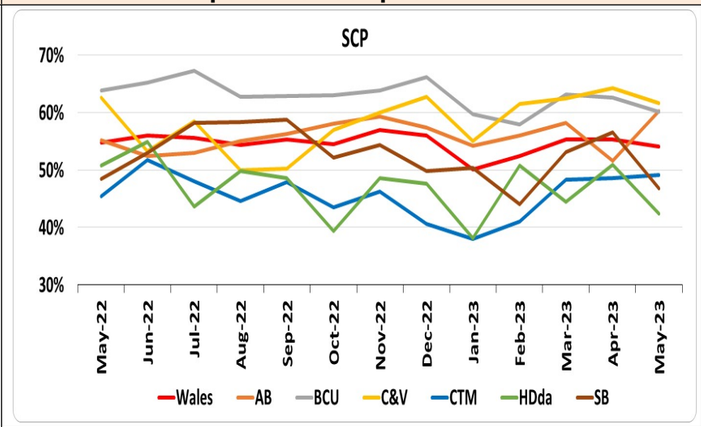
Performance for June remained fairly stable at 48.9%, with three of the tumour sites reaching the desired target threshold, as seen in the table above. Predicted compliance for July currently stands at 49.4%. Delays at first outpatient (33%) and diagnostic stage (50%) continue to be the biggest concern and significant factor for not achieving target. Diagnostic delays remain in endoscopy and pathology. Tertiary delays for diagnostics & treatments continue. Performance is being negatively affected by outstanding pathology at the time of reporting. No reduction in backlog position.

Patients Treated by Closed Date



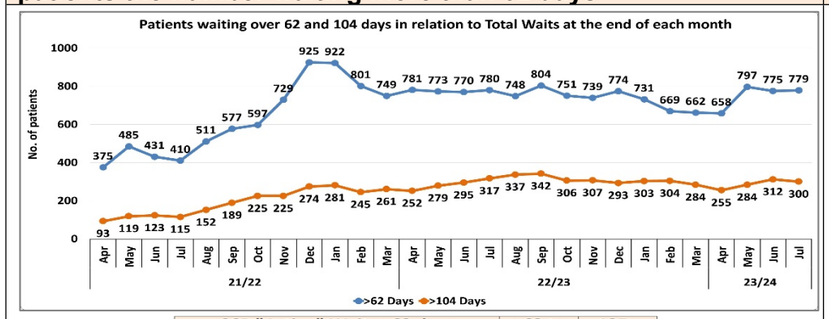
Overall cancer treatment volumes have increased marginally during the past 12 months to an average of 292 per month, compared to 273 in the previous 12 month period. This represents an average monthly increase of 7%.

How do we compare with our peers?



Status as at May 2023		
Health Board	Compliance	Rank
C&V	61.7%	1st
AB	60.2%	2nd
BCU	60.1%	3rd
CTM	**49.1%**	**4th**
SB	46.8%	5th
HDda	42.4%	6th

Patients currently waiting on a Cancer Pathway and of those patients the number waiting more than 62 days



SCP "Active" Waits >62 days (end of July 2023)	>62 to 124 days	125+ days
Sarcoma	2	3
Breast	21	
Gynaecological	171	30
Haematological (exc acute leukaemia)	2	2
Head and neck	12	4
Lower GI	162	112
Lung	13	5
Skin (exc BCC)	15	6
Upper GI	45	20
Urological	103	43
Other	8	
Total	554	225

What actions are we taking & when is improvement anticipated?

- Ongoing discussions with Bowel Screening Wales (BSW). Awaiting feedback re: BSW reporting – concern there is variation throughout Wales
- Insourcing in progress to assist with BSW cohort
- Streamlining of haematuria pathway to ensure standardisation across CTM
- Weekly meetings with DU support the endoscopy transformation
- Merging of Lower GI departments, along with centralisation of operating on one site for major cases & standardisation of all pathways. Proposal currently in development for COO.
- Backfilling and additional lists where possible
- Transfer of POW Gynae Post Menopausal Bleeding (PMB) patients to Gynae hub for scanning. Exploring all options to facilitate hysteroscopy in Gynae hub @ RGH
- Disaggregation of SLA and centralisation of Gynaecology service to RGH
- Outsourcing of pathology
- New Urology consultant commenced post
- Radiology STT (Straight to Test) MRI trial being worked through in Gynae

What are the main areas of risk?

- 83% of all patients on the active SCP are at 1st outpatient or diagnostic stage
- Resources required to effectively plan and implement the Wrapper / Canisc replacement Programme.
- Delays in pathology & endoscopy continue with SBUHB pathology for POW patients remaining at 6/52
- Delays in tertiary investigations & treatments at SBUHB, Velindre Cancer Centre and C&VUHB.
- Bowel Screening Wales diagnostic colonoscopy now accounts for 57% of lower GI backlog. Increased volume of patients being referred in primary care are now symptomatic.
- Significant delays for PMB at NPT Hospital - current waits 9/52
- Implementation of genomic testing for new targeted therapies
- PAC
- Centralisation of Breast service delayed due to SBUHB issues re: managing demand

Diagnostics & Therapies – July 2023 (Provisional Position)

Number of patients waiting more than 8 weeks for a specified diagnostic – Target is improvement trajectory towards a national target of Zero by 31st March 2024

CTMUHB - Number of Patients waiting more than 8 Weeks for a Diagnostic Test		
Cardiology	Echo Cardiogram	746
Cardiology Services	Cardiac CT	1
	Cardiac MRI	2
	Diagnostic Angiography	100
	Stress Test	27
	DSE	65
	TOE	1
	Heart Rhythm Recording	89
	B.P. Monitoring	0
Bronchoscopy		4
Colonoscopy		572
Gastroscopy		682
Cystoscopy		635
Flexi Sig		658
Radiology	Non-Cardiac CT	626
	Non Cardiac MRI	879
	NOUS	7,176
	Non-Cardiac Nuclear Medicine	49
Imaging	Fluoroscopy	105
Physiological Measurement	Urodynamics	104
Neurophysiology	EMG	252
	NCS	316
Total		13,089

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	15,437	15,579	15,363	15,080	15,315	15,570	15,547	15,651	15,886	16,114	15,294	15,299
2023/24	15,727	15,689	14,361	13,089								

Number of patients (all ages) waiting more than 14 weeks for a specified therapy – Target is improvement trajectory towards a national target of Zero by 31st March 2024

CTMUHB - Number of Patients waiting more than 14 Weeks for a Therapy	
Arts Therapy	1
Audiology	22
Dietetics	1,239
Occupational Therapy	21
Physiotherapy	0
Podiatry	1
Speech & Language	181
Total	1,465

Therapies	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	1,019	1,370	1,265	1,570	1,795	1,589	1,615	1,452	1,474	1,284	1,175	1,145
2023/24	1,173	1,323	1,442	1,465								

Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional – Target is 12 month improvement trend

CTMUHB - % of children waiting more less than 14 Weeks for AHP	
Dietetics	92.0%
Occupational Therapy	93.8%
Physiotherapy	100.0%
Podiatry	100.0%
Speech & Language	82.4%
Total	93.9%

AHP	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	92.4%	92.2%	91.9%	96.1%	94.9%	92.0%	91.0%	92.3%	90.9%	87.6%	86.8%	86.5%
2023/24	87.8%	82.9%	82.6%	93.9%								

How are we doing?

Diagnostics: At the end of July 13,089 patients had been waiting in excess of 8 weeks for a diagnostic procedure, which as it currently stands is a reduction of almost 9% (1,272) on the number of patients waiting over 8 weeks that was reported at the end of June.

Endoscopy observed a further improvement, albeit slight, of around 1.5% in the number patients waiting in excess of eight weeks (36 patients), although the number of patients currently breaching the target now stands at 2,551.

The NOUS service continues to have the highest volume of breaching patients with 7,176 currently waiting over 8 weeks for a scan, however a reduction of 10.6% (851) is observed from the June reported position.

Therapies: There are provisionally 1,465 patients breaching the 14 week target for therapies in July, an increase of 1.6% (23 patients) on the reported position for June.

The Dietetic service accounts for over 84% of the total patients waiting beyond the 14 week target for therapies.

What actions are we taking & when is improvement anticipated?

Endoscopy: Awaiting approval on business paper for Endoscopy workforce. Detailed staff numbers identified in business paper, inadequate workforce currently and unable to work without overtime or agency staff.

Endoscopy Transformation Programme ongoing with developments and improvement already underway.

BSW – Recovery plan developed which includes a short term plan to clear current backlog to run alongside the sustainable plan.

Radiology: Planned care recovery actions underway and NOUS backlog scheme progressing well.

Booking has continued through July with additional weekend and evening slots for NOUS. Now starting to see a steady reduction in the patients waiting over 8 weeks.

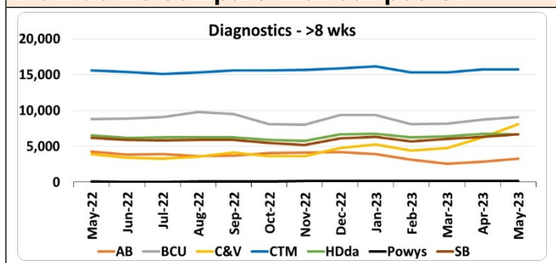
Additional Planned Care Recovery (PCR) bids submitted to support reporting capacity, cardiac physiology and extension/expansion of Cancer Navigator post.

Trajectories for CT and MR developed and will be looking to draft plans to potentially use more capacity on weekends after the summer period.

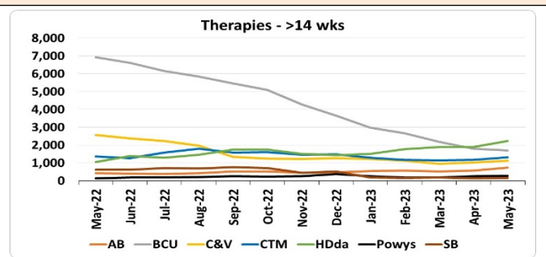
What are the main areas of risk?

- Demand and Capacity imbalance shown in most diagnostic and therapy services as demand has risen. Also CT colon demand likely to rise further with new BSW protocols for earlier screening for younger patients.
- Observed significant increase in CT Out of Hours demand, with no change to current workforce resource.
- Radiology service continues to hold a number of Consultant vacancies. Looking to re-advertise with good potential to recruit in the next 2 months.
- Current financial pressures, which will result in a reduction in agency locum use and cessation of additional work.
- Reduction in PCR funding for outsourcing has impacted on reporting creating backlog. Additional WLI work within other departments has increased workload
- Endoscopy – faces challenges with competing priorities with the service trying to deliver and maintain the cancer pathway, accommodate longest waiters for delivery of the RTT targets 156 & 104 weeks, hit the 8 week diagnostic target whilst reducing the backlog of overdue surveillance patients. BSW still remains a challenge due to backlog which continues to impact on CTM's overall LGI diagnostic waits – short and long term plan developed. Further request around screening reporting across Wales and the anomalies of tracking screening participants.
- BSW – Down to 210 participants waiting for screening colonoscopy with waits now down to 18 weeks (2 week target). The need for an urgent budget review – ongoing with the finance team. Next steps in the optimisation plan due to commence in October and the need to increase lists to 10 per week going forward. Currently delivering 4 lists per week.
- Neurophysiology Services – following a recent reduction in the availability of Neurology services in CTM, capacity for Nerve Conduction Studies has been significantly reduced. This will have a direct impact on delivery for the Orthopaedic targets going forward.

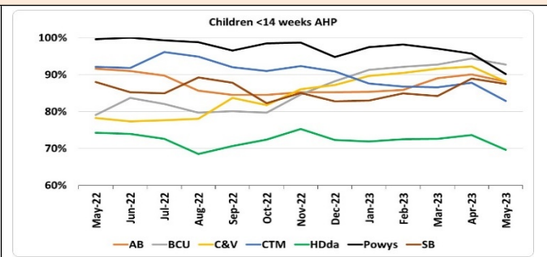
How do we compare with our peers?



Status as at May 2023		
Health Board	Compliance	Rank
Powys	160	1st
AB	3,254	2nd
HDda	6,671	3rd
SB	6,671	4th
C&V	8,113	5th
BCU	9,099	6th
CTM	**15,689**	**7th**



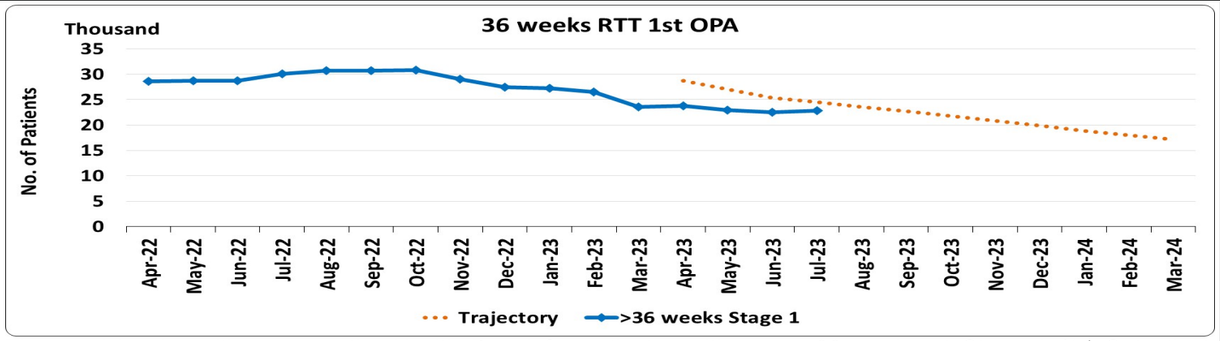
Status as at May 2023		
Health Board	Compliance	Rank
SB	149	1st
Powys	273	2nd
AB	732	3rd
C&V	1,121	4th
CTM	**1,323**	**5th**
BCU	1,704	6th
HDda	2,229	7th



Status as at May 2023		
Health Board	Compliance	Rank
BCU	92.7%	1st
Powys	90.1%	2nd
AB	88.1%	3rd
C&V	88.1%	4th
SB	87.5%	5th
CTM	**82.9%**	**6th**
HDda	69.6%	7th

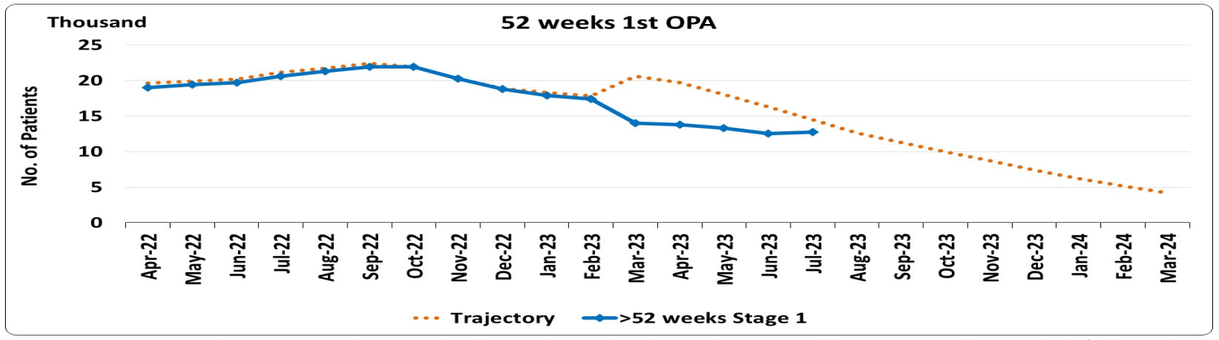
Referral to Treatment Times (RTT) – July 2023 (Provisional Position)

Number of patients waiting **over 36 weeks** for a **new outpatient appointment (22,798)** - Target is Improvement Trajectory towards a national target of Zero



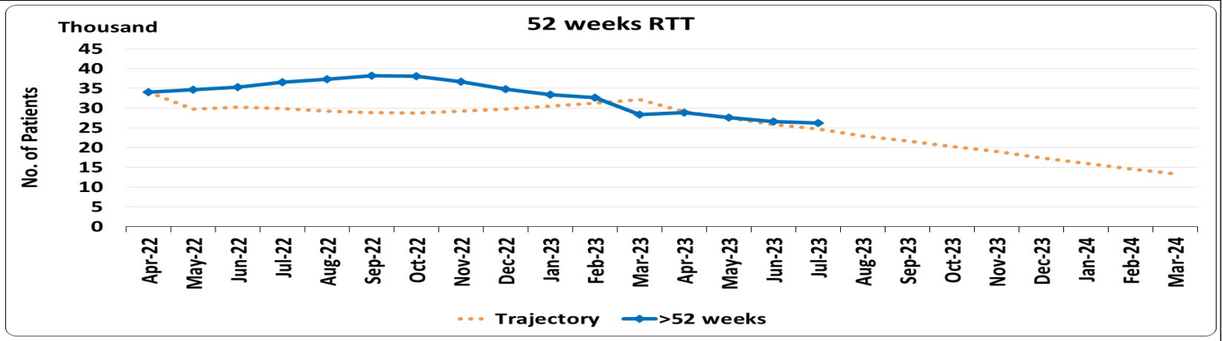
The provisional position across the Health Board for patients waiting over 36 weeks at Stage 1 (1st Outpatient Appointment) at the end of July is 22,798, which as it currently stands is an increase (275) from the June reported position. (N.B. includes the 12,773 Stage 1 patients waiting over 52 weeks).

Number of patients waiting **over 52 weeks** for a **new outpatient appointment (12,773)** - Target is Improvement Trajectory towards a national target of Zero



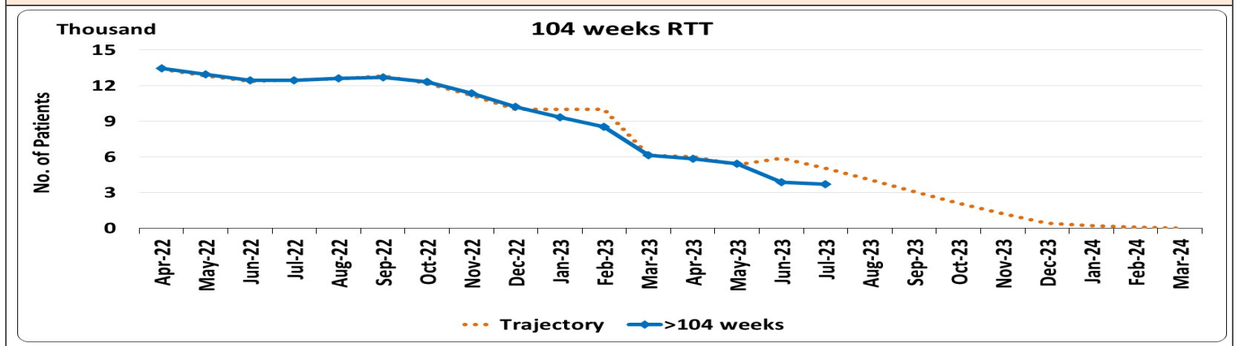
The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of July is 12,773, an increase of 1.7% (215) from the June reported position.

Number of patients waiting **>52 weeks RTT** (**25,515)** – Target is Improvement Trajectory towards a national target of Zero



The provisional position across the Health Board for patients waiting over 52 weeks for referral to treatment at the end of June is 25,515, a small reduction of 0.9% (240) from the June reported position.

Number of patients waiting **>104 weeks (3,687)** - Target is Improvement Trajectory towards a national target of Zero



The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for referral to treatment at the end of July is 3,687, a reduction of 4.4% (171) from the reported June position.

Total number of open pathways per specialty - July 2023 (provisional)

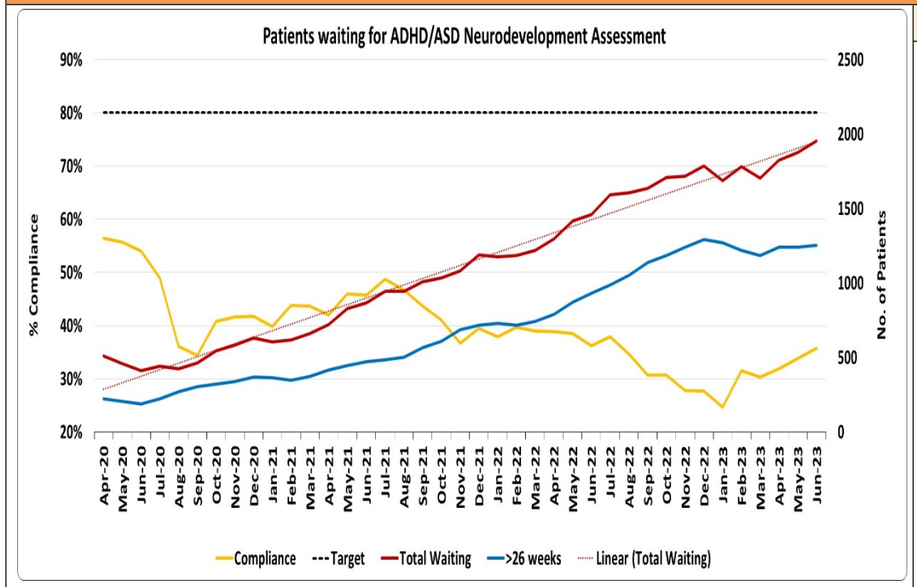
Specialty	Urgent patients waiting >12 Weeks	All patients waiting >36 to 52 Weeks	All patients waiting >52 Weeks to 104 Weeks	All patients waiting >104 Weeks	Total Open Pathways
Anaesthetics	136	188	254	34	1078
Cardiology	924	820	205	3	5148
Care of the Elderly	3	0	0	0	65
Dermatology	1650	1300	1709	158	8119
Endocrinology	3	56	2	0	394
Gastroenterology	1079	560	570	58	3889
General Medicine	508	346	177	0	2550
Nephrology	27	5	0	0	160
Respiratory Medicine	119	235	151	12	2049
Rheumatology	360	126	88	25	1475
Sport and Exercise Medicine	0	0	0	0	9
Thoracic Medicine	19	10	0	0	546
Geriatric Medicine	2	0	0	0	50
Diagnostics	0	946	1540	69	8308
Therapies	0	297	48	3	3232
Ophthalmology	470	2136	4478	422	14569
Oral Surgery	643	568	367	42	3334
Orthodontics	73	28	1	0	297
Restorative Dentistry	28	26	69	7	180
Ear, Nose & Throat Service	708	1573	3998	554	12392
Gynaecology	988	1240	1535	390	8555
Paediatrics	228	294	31	0	2880
Haematology (Clinical)	30	17	0	0	273
General Surgery	722	1190	2365	363	8449
Orthopaedics	1988	2299	4592	916	13802
Urology	1093	976	2070	494	7265
Colorectal	657	615	945	112	3538
Breast Surgery	396	229	320	25	1318
Rapid Diagnostic Centre	0	0	0	0	124
Total	**12854**	**16080**	**25515**	**3687**	**114048**

RTT continued on the next page…

Cont'd…Referral to Treatment Times (RTT) – June 2023

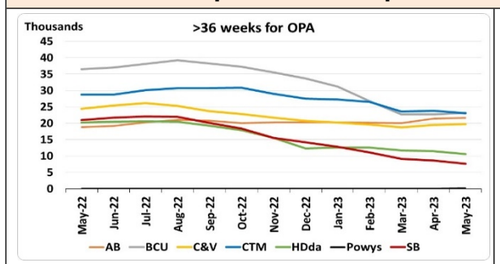
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
Critical Care Reconfiguration project ongoing, business case to be submitted in September. Number of medical and trauma patients outliers in planned care beds remain a pressure, with further consideration of the options necessary. ITU rotas remain fragile, awaiting feedback on reconfiguration plans. Additional OP clinic space is needed in order to introduce a registrar rota for Upper GI clinics to increase capacity No patients waiting more than 156 weeks at the end of July. Pre-Assessment capacity continues to be an issue across CTM Restorative Dentistry waiting list continuing to grow with no contingency due to sole consultant.	• Recruitment of additional Upper GI consultants is being reviewed with a substantive appointment as of September, but in the meantime agency to cover. • New Corneal consultant has been appointed and the Corneal service will be brought to POW from September. • Breast Cancer Navigator post has been approved • ENT – barriers to undertaking weekend working in principle have been resolved, although the option is on hold given wider environment. • 517 stage 1 patients sent to Vanguard for consideration of cataract surgery • Consideration of outsourcing long waiting glaucoma patients • Weekend clinics for longest waiting outpatients new and follow up glaucoma patients in August – 154 slots available. • Ongoing validation of waiting lists taking place – targeting stage 2, 3 and 4.	• HSDU capacity and infrastructure risk – ability to manage increased activity and risks to core capacity due to rotas not fit for purpose. • Pre-Operative Assessment – delays to access and timely management of patients in RGH, also delays accessing ECHO's, Manometery and NCS. • No funding for increase in Ward Fifteen beds in excess of 15. • Complex ENT remains a clinical and operational risk. Workforce and funding challenge for delivery of theatre sessions, MDT provision. Business case is required to address this. • Nurse recruitment remains challenging, despite student streamlining and open adverts initiatives • Manual handling equipment remains outdated. Risks and cost of mitigation under review • Currently unable to fund a second Restorative Consultant

% of patients waiting less than 26 weeks to start an ADHD/ASD Neurodevelopment Assessment (35.7%) -Target 80%

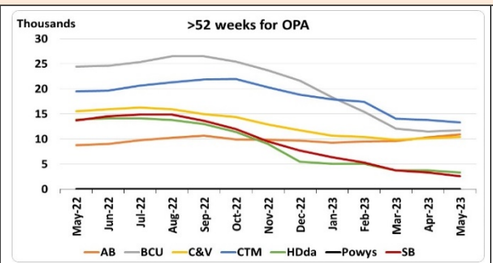


How are we doing?	What actions are we taking & when is improvement anticipated?	What are the risks?
The yellow line on the chart to the left shows that compliance with the 26 week access target for neurodevelopmental service is continuing on a steady improvement trajectory. Performance in June was 35.7% in June, which compares to 26% in December 2022. However access remains well below the WG target of 80%. Additional short term investment into the service used to deliver WLIs has ensured that no children is now waiting >104 weeks for an assessment. Plans to sustain this position up until the end of March 2024, requires further WLIs to address the 82 shortfall presently identified.	Children & Families are looking to utilise Neurodevelopmental (ND) RPB funding for waiting list reduction. Community connector posts are being drafted working with LA to support pre/post diagnosis, along with AHP posts. Pharmacy input is being secured to support post-diagnosis follow-up titration and monitoring, which will release medical colleagues to support the waiting list further. The ND Improvement Programme is looking at service redesign, spanning early intervention, assessment, education and transition. A workshop took place on 4th July 2023 with the wider multi-disciplinary team to review pathways, devise a single point of access and provide a pan CTM approach. A follow up meeting with the QI team has been arranged to re-design the pathway and develop a new service specification As of 1st August, the SLA with SBUHB managing >11 ASD patients residing in Bridgend has been repatriated.	Demand continues to outstrip core funded capacity. A better understanding is needed of what is currently offered by the third sector and wider community services and what gaps exist – funding provided via RBP will undertake a scoping exercise of this with a view to forming relationships and links. Resource constraints on multidisciplinary provision that lead to assessment outcomes. Identifying constraints that are impacting on the ability to deliver timely services. Reliance on short term funding does not provide a longer term solution, hence services are being reviewed with partners

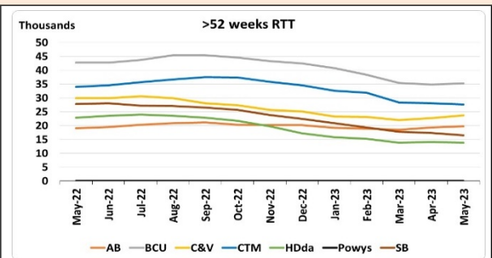
How do we compare with our peers?



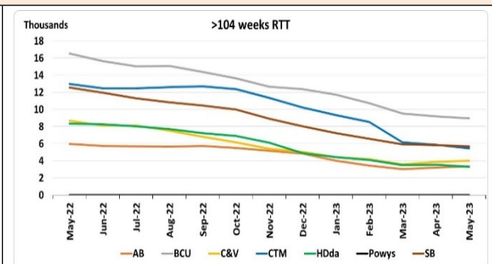
Status as at May 2023		
Health Board	Compliance	Rank
Powys	98	1st
SB	7,672	2nd
HDda	10,628	3rd
C&V	19,667	4th
AB	21,658	5th
CTM	**22,992**	**6th**
BCU	23,210	7th



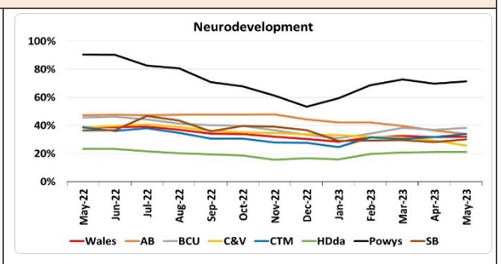
Status as at May 2023		
Health Board	Compliance	Rank
Powys	3	1st
SB	2,567	2nd
HDda	3,351	3rd
C&V	10,447	4th
AB	10,935	5th
BCU	11,772	6th
CTM	**13,334**	**7th**



Status as at May 2023		
Health Board	Compliance	Rank
Powys	14	1st
HDda	13,781	2nd
SB	16,522	3rd
AB	19,756	4th
C&V	23,618	5th
CTM	**27,569**	**6th**
BCU	35,289	7th



Status as at May 2023		
Health Board	Compliance	Rank
Powys	0	1st
HDda	3,313	2nd
AB	3,363	3rd
C&V	4,004	4th
CTM	5,430	5th
SB	**5,706**	**6th**
BCU	8,953	7th



Status as at May 2023		
Health Board	Compliance	Rank
Powys	71.3%	1st
BCU	38.2%	2nd
AB	34.0%	3rd
CTM	**33.8%**	**4th**
SB	30.2%	5th
C&V	25.6%	6th
HDda	21.0%	7th

Follow-up Outpatients Not Booked (FUNB) – Provisional Position July 2023

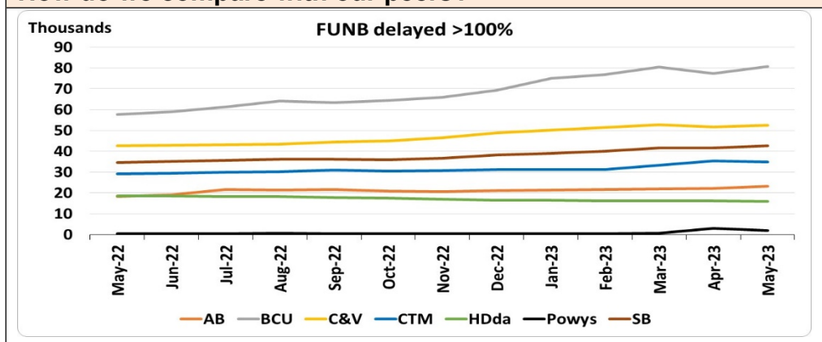
Number of patients waiting for a Follow-up with documented target date

No. of patients waiting for follow-up appointment			
No documented target date	Not Booked	Booked	Total
0	83,235	52,513	135,748

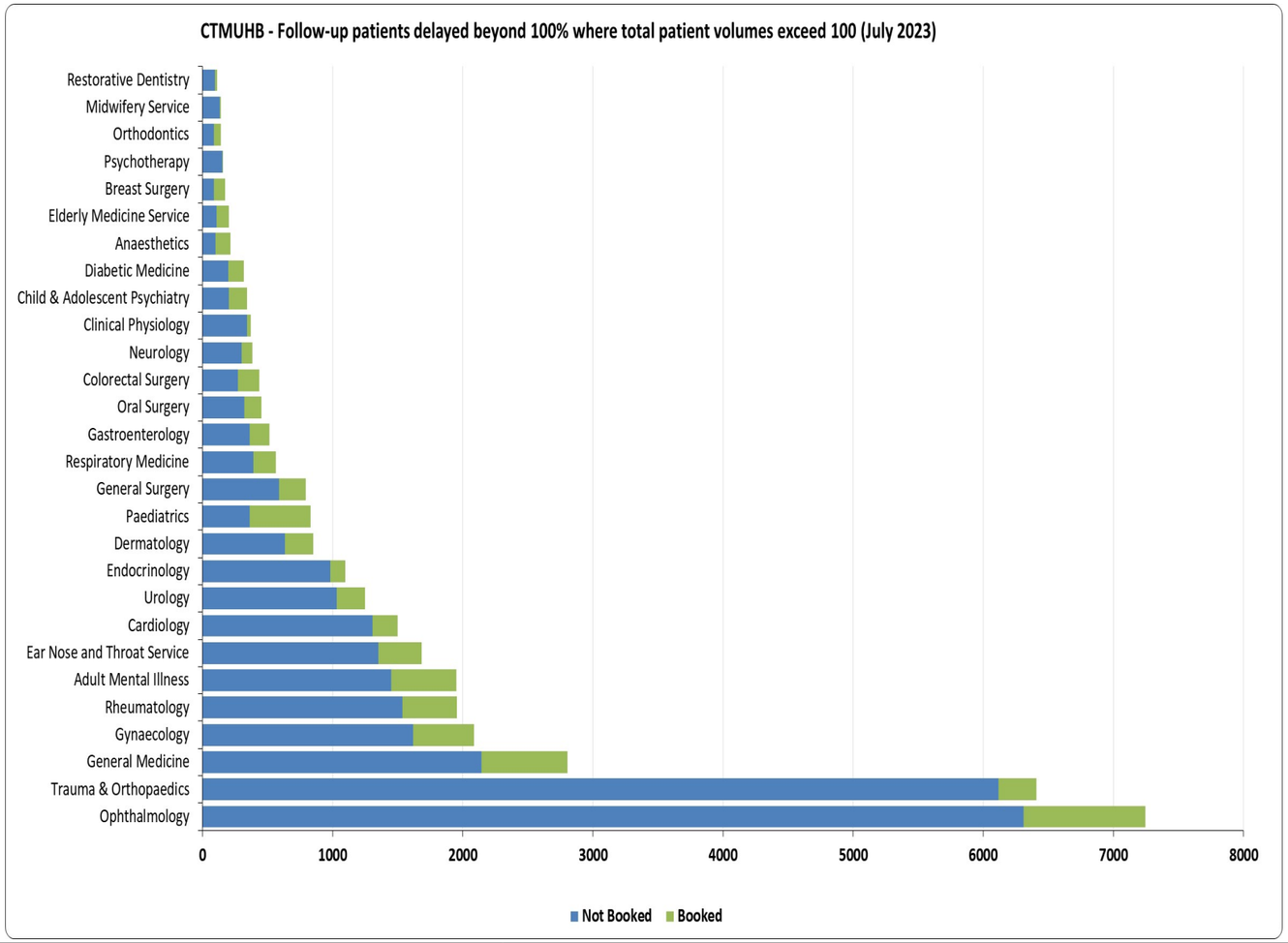
Number of patients waiting for a Follow-up delayed over 100% - Target: Improvement trajectory towards a national target of Zero

No. of patients delayed over 100% past their target date			
Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
28,813	6,521	35,334	26.0%

How do we compare with our peers?



Status as at May 2023		
Health Board	Compliance	Rank
Powys	1,902	1st
HDda	15,867	2nd
AB	23,270	3rd
CTM	**34,874**	**4th**
SB	42,534	5th
C&V	52,592	6th
BCU	80,792	7th



How are we doing?

The number of patients waiting for a follow-up appointment in Cwm Taf Morgannwg UHB, at the end of July 2023, provisionally stands at 135,748 which is an increase of over 18% on the patients waiting during the equivalent period of 2022. There are currently no patients without a documented target date

Of the patients waiting, 35,334 (26%) have been waiting more than 100% longer than their clinician advised, representing an increase of around 18% on the equivalent period last year.

As it currently stands, combined outpatient activity levels during July 2023 continue to be below pre-Covid levels (around 15% fewer) but 3.6% higher than the equivalent period of 2022, with the provisional July figures below for new and follow-up patients compared to prior the pandemic:

- Total New Patients seen: 15,934 which is a reduction of around 9% on the 11 month average preceding the Covid pandemic (April 19 to Feb 20) of 17,491.
- Total Follow-up Patients seen: 39,506 which is a 17.6% reduction on the 11 month average preceding the Covid pandemic (April 19 to Feb 20) of 39,506.

What actions are we taking & when is improvement anticipated?

General Surgery

- Ongoing validating of the FUNB list with regular consultant input.
- Return to normal capacity for follow up appointments.
- Virtual clinics and clinical validation on going to ensure PIFU/SOS pathways are in place.

Orthopaedics

- Ongoing consultant validation of their FUNB list as significant numbers are not anticipated to require a follow up appointment.
- Booking of all follow ups into clinics to reduce the FUNB holding list, utilising any spare capacity.
- Utilise any surplus capacity from the SBUHB disaggregation to reduce FUNB in the interim.

What are the main areas of risk?

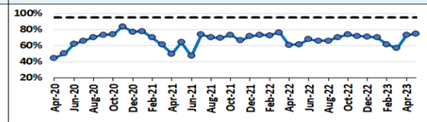
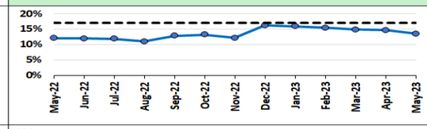
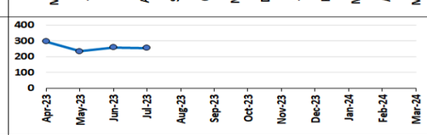
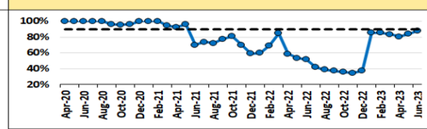
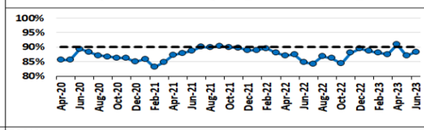
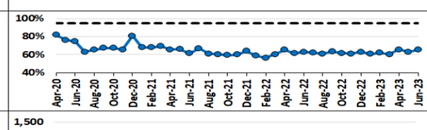
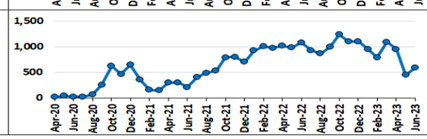
General Surgery: Capacity deficiency in clinics to manage new and follow up patients appropriately.

Orthopaedics: Administrative support to remove patients from the FUNB after validating.

Therapy services are presently excluded from this measure, although therapy services are sighted and are incorporating follow up and 'treatment' access into their service plans.

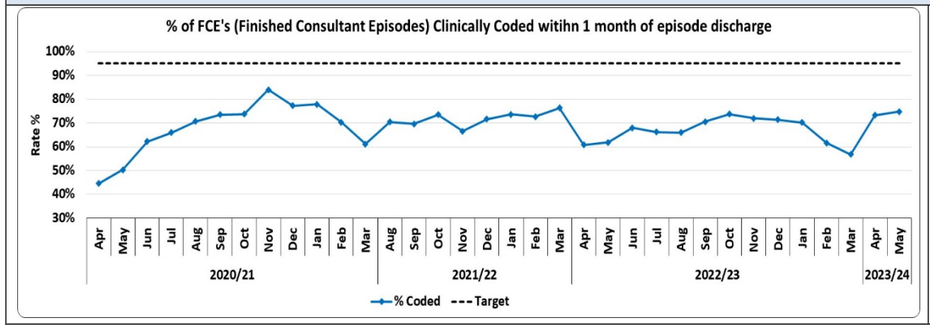
Quadruple Aim 4: Improvement & Innovation enabled by data & focused outcomes

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes

	Performance Measure	Target	Key: Trend — Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Effective Services	% of episodes clinically coded within one reporting month post episode discharge end date	Maintain the 95% target or demonstrate an improvement trend over 12 months		74.8% National target not met but an improvement from May 22 (61.8%)	May-23
	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	Current Status - 1st April to 31st July 2023 Total FCE's: 48,447 / Total FCE's Coded: 37,044 / Errors Outstanding: 117 / % Errors Outstanding: 0.32%	*Please note that this is interim data locally sourced*	1st April to 31st July 2023
	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 Programme	Delivery of Foundational Economy initiatives and/or evidence of improvements in decision making process	Majority on track, but scope to improve	N/A	Sep 22 - Mar 23
	Report detailing evidence of NHS Wales embedding Value Based Health and Care within organisational strategic plans and decision-making processes	Evidence of activity undertaken to embed a Value Based Health Care approach (as described in the reporting template)	On Track	N/A	
Efficient Services	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	17% or more		13.5	May-23
	Number of Pathways of Care delayed discharges	12 month reduction trend		255	Jul-23
	Qualitative report detailing progress against the health boards' plans to reduce pathways of care delays	Evidence of Improvement	Data not available as yet		
	Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan		Majority on track, but scope to improve	N/A	Sep 22 - Mar 23
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%		88.2%	Jun-23
	% 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			88.4%	
Safe Services	% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	95%		65.4%	Jun-23
	Number of ambulance patient handovers over 1 hour	Improvement trajectory towards achievement of zero ambulance patient handover delays >1 hour by March 2024		756	Jul-23

Effective Services - Clinical Coding

% of episodes clinically coded within one reporting month post episode discharge end date – Target is Maintain the 95% target or demonstrate an improvement trend over 12 months



The reported position for May 2023 equates to 74.8% of the FCE's (Finished Consultant Episodes) for that month have been coded within the requisite timescale. Indicative position for June suggest we have improved to 96%+ meeting the new standard

As of 31st July 2023 the number of FCE'S for 2023/24 currently stands at 48,447 and of those 76.5% have been clinically coded, the backlog being FCEs that completed in April and May.

How are we doing?

Plans are in place to address April and May backlog over the next 4 months, predominantly reliant upon the coding managers focussing on this activity and the core team focussing on the in month demand.

Teams are working with heads of departments to improve the flow of the medical record and improving the availability of the Clinical Information on other clinical systems, with challenges most notable in paeds and maternity. Agile process with the Cardiology department to enhance the completeness of the record, and to support the heart failure audit is close to completion.

CTM has been engaging with one other welsh health board who have shown an interest in trialling our auto-coder Clivseco and has expressed a wish to further explore the options of assisting us with the further development of the auto-coded system.

Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification – Target 90%

Current Status - 1st April to 31st July 2023			
Total FCE's	Total FCE's Coded	Errors Outstanding	% Errors Outstanding
48,447	37,044	117	0.32%

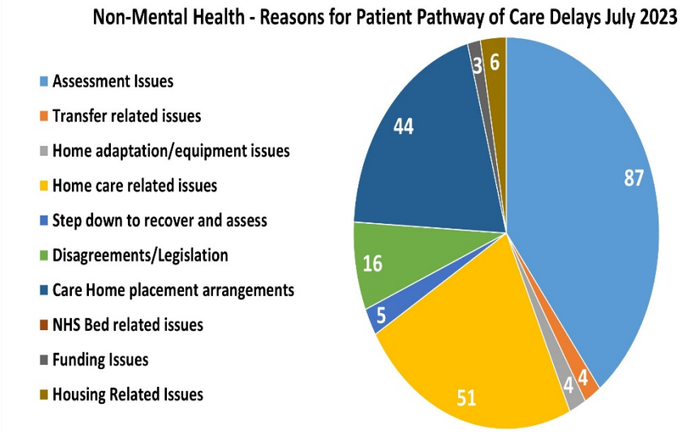
Please note that this is locally sourced interim data

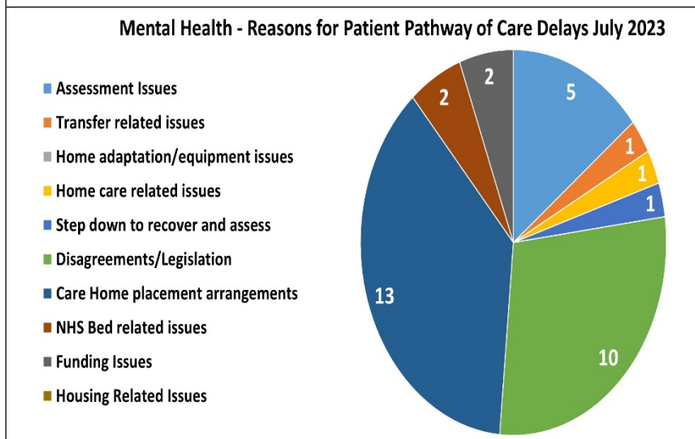
What actions are we taking & when is improvement anticipated? What are the risks?

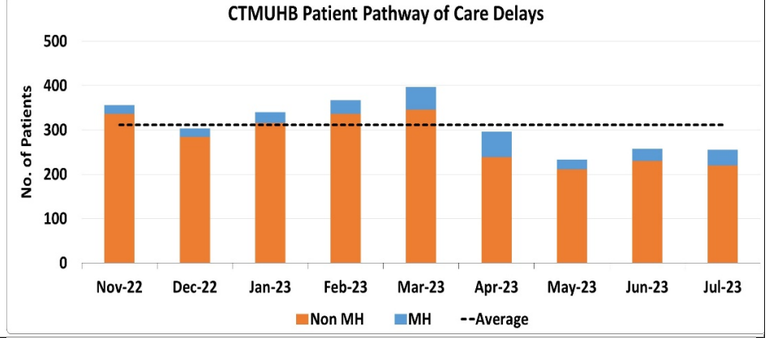
The auto-coding system incorporating the validation functionality continues to be improved and its output is increasingly being incorporated within the operational coding process.

A dashboard, providing the coding team with drill through access to their key performance measures, went live on June 21st and it is anticipated that this will support the early review of any coding errors without the need for DHCW audit.

Efficient Services - Number of Pathways of Care delayed discharges – Target is 12 month reduction trend







Delays by Local Authority - July 2023								
Healthcare Facility	Powys	Bridgend	Caerphilly	Merthyr Tydfil	Neath Port Talbot	Rhondda Cynon Taff	Vale of Glamorgan	Total
Pinewood House						2		2
PCH	2		6	4		8		20
POW		95			2		2	99
RGH						43		43
YCC				30		23		53
YCR		1				37		38
Grand Total	2	96	6	34	2	113	2	255

Please note that the new reporting arrangements came into effect 1st April 2023 and whilst we continue to embed the model of D2RA throughout CTMUHB, data quality issues remain.

The total number of patients who have been clinically optimised for discharge and are currently awaiting their next stage of care (census 19th July) equates to 255 patients i.e. 220 non-Mental Health patients and 35 Mental Health patients, as is shown in the pie charts to the left. Since November 2022 to date, patient delays have averaged 312 per month, as observed in the chart above.

What actions are we taking & when is improvement anticipated & what are the main areas of risk?

Actions:

- The Integrated Discharge Delivery Board (IDDB) has been agreed as the accountable body to address delays and stalled performance to discharge, with Pathways of Care Delays (PoCD) scrutinised monthly and remedial action put in place.
- The IDDB has agreed a detailed action plan which will address the top 4 reasons for delay and have nominated a lead for each:
  - Assessment: CSG Manager Communities
  - Domiciliary Care: Head of Adult Services RCT
  - Residential Care: Head of Adult Services
  - Dispute: CSG Manager Communities
- Agreed and approved validation and scrutiny process for PoCD prior to submission to WG.
- PoCD process agreed and date for implementation October 2023. Process includes a consistent stranded patient review across all acute and community sites.
- Agreed consistent performance metrics with workstream 3 (optimal flow) to ensure appropriate reporting across the system – flow and discharge/D2RA
- First phase of eToC rollout in POW complete.
- Revised paperwork completed, changed to Electronic White Board (EWB) consulted and in progress.

Risks:

- Significant risk of non-approved 6 Goals funded post for the D2RA Hub Operation Manager, which has been aligned with operational activities within discharge hub. Will require review and realignment to support delivery of agreed plans. Risk Assessment completed as request by WG.
- PoCD have been difficult to baseline for improvement trajectory due to data quality. Tracking progress will commence from October. Process aligned with D2RA which will have to be revised due to operational manager's post not being approved.

2.1 Finance update – Month 4

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.

- £3M of the accrual which is 6/ of £6.0m.

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

3.1 The key risks for the **Performance** quadrant are covered in the summary and main body of the report.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.
Related Health and Care standard(s)	Choose an item.
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes. The work reported in this summary and related annexes take into account many of the related quality themes.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not yet assessed
Legal implications / impact	Yes (Include further detail below)

	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report. There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the Integrated Performance Dashboard.

5.2	22 August 2023	PPF Committee	Planned Care & Ophthalmology Improvement

FOI Status:	Open
If closed please indicate reason:	Not applicable – public report
Prepared By:	Tarek Allouni, Planned Care Ops Director
Presented By:	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor:	Chief Operating Officer
Report Purpose	Please Select: For noting
Engagement undertaken to date:	Extensive engagement over a number of years

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Will improve patient care, safety and experience significantly by reducing waiting times
Related Health and Care Standard	Safe Care, Timely Care, Effective Care
Has an EQIA been undertaken?	No. This will be completed as soon as possible.
Are there any Legal Implications /Impact.	Yes. There is always the possibility of legal action if harm comes to patients.
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes Plans require adequate staff to carry out the patient care. This may have revenue implications
Link to Strategic Goals	Please Select: Improving Care and Creating Health

5.1 Planned Care Recovery Programme

Tasks Competed

- Reduction in number of specialities breaching
- Theatre Productivity Group set up with Medical Director as Chair
- Pre assessment transformation lead appointed and working to create regional POA process
- Weekly meeting with operational leads regarding performance/breach monitoring
- ENT Visit planned to C&V undertaken visit July 23
- GiRFT meeting re Hernia productivity
- GiRFT for general Surgery T&F group
- GiRFT for ophthalmology – Glaucoma and Cataracts

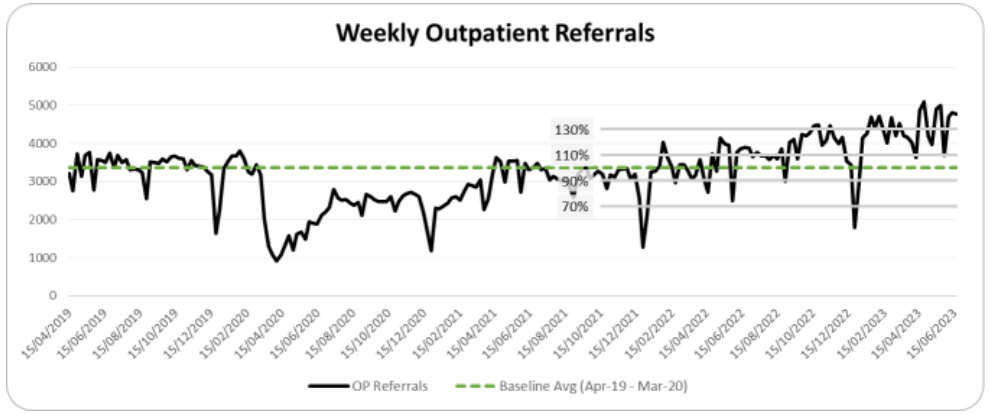
Next Steps

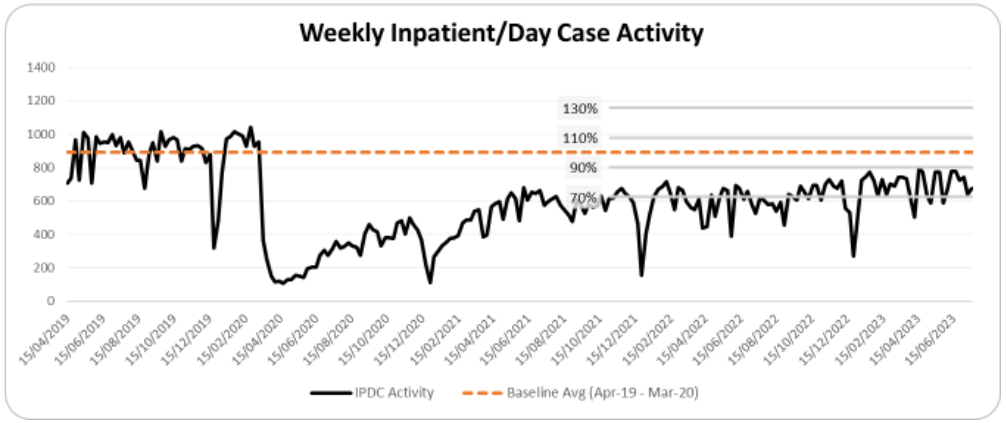
- GiRFT meeting for theatres at POW
- ENT Visit planned to C&V undertaken visit July 23
- Theatre perfect month for Sept 23 planned
- INNU agreement and implementation
- T&O SLA disaggregation
- Use of consultant connect and digital solutions
- Use of WISE service
- Focus on validation and low speciality reduction
- Focus on

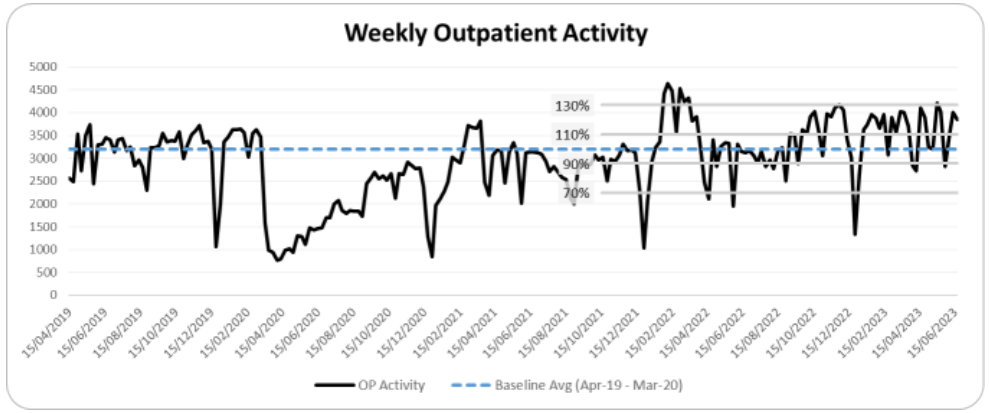
Risks

- Workforce – Especially A&C
- Number of areas that require transformation
- Clinical engagement
- Diagnostics
- Pre-assessment
- Demand levels continue at higher levels
- WPAS system
- Digital solution – Text remind and Digital dictation

5.1 Planned Care Recovery Programme







Additional Tasks Competed

- ID Medical insourcing for full theatre utilisation
- Additional activity
- Increase in backfill rate

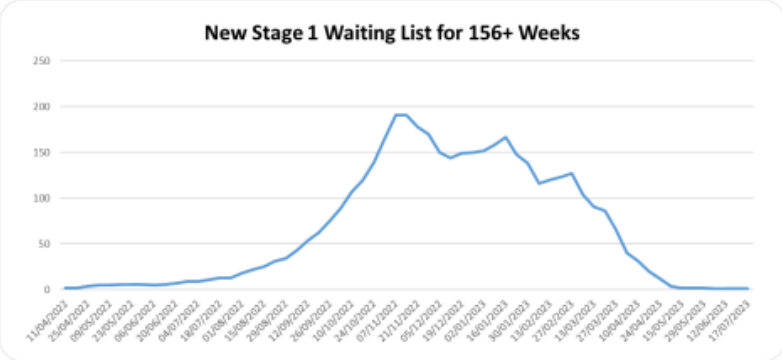
Next Steps

- CTMUHB 642 overarching process to be imbedded
- Health pathways with primary care development to reduce demand
- Service transformation
- Theatre workforce paper submission for ELG
- Review of theatre change and baseline as Trauma capacity increased across CTMUHB

Risks

- Workforce – Especially A&C
- Number of areas that require transformation
- Clinical engagement
- Diagnostics
- Pre-assessment
- Demand levels continue at higher levels
- WPAS system
- Digital solution – Text remind and Digital dictation

5.4 Ophthalmology Improvement Plan Progress



Area	Action update
Get it right first time (GIRFT)	• External review of both Glaucoma and Cataract services • Reports pending
Preassessment	• A bi-monthly task and finish group has been established. • The aim of this group is to standardise our processes to ensure that patients can safely have their surgery performed on any CTM site. • Development of standard operating procedure and update and review of all clinical guidelines to ensure safe and effective care.
Nursing	• Workforce model is currently under review, with aim is to ensure that the nursing teams across the CTM sites work as one. • Review being completed of all JD's across CTM to ensure that they are all up to date and fit for purpose. • Development of the role of the nurse practitioner and nurse led services. • Planned review of all clinical guidelines and standard operating procedures. • Enrolment of all ophthalmology specialist staff to undertake the Agored course "Fundamentals in ophthalmology" • Recently recruited 2x new band 6 ophthalmic specialist nurses who need to undergo intravitreal injection training. • Ongoing development of non-registered nursing staff, specifically looking at the development of a protocol for the safe administration of eye drops in our ophthalmology clinics. • Nurse Practitioner training nursing teams across sites from September in order to undertake slit lamp training

5.4 Ophthalmology Improvement Plan Progress

Area	Action update
Referral Refinement	Continuation of established referral refinement schemes within practices in CTM: • Independent Prescribing • Wet AMD • Diabetic Retinopathy • Glaucoma - 23/24 funding to be approved
Workforce	• Cornea consultant now appointed pending September start • Glaucoma consultant on maternity leave – locum post advertised – 2 very good candidates, anticipating to appoint both candidates • Head of Optometry post is vacant - out to advert • Head of Orthoptics post vacant - out to advert • All consultants to have job plans in Sep/Oct
Performance	• At the end of June no cataract patients waiting for a new appointment over 104 weeks, and continues to reduce • No patients waiting all stages at end of July for >156 weeks • Waiting times for stage 1 cataracts >52 weeks continue to reduce • Longest waiting over target date patients being booked • Reduction of patients without a HRF factor from 709 in May to 539 in June. • To aim for 0 patients waiting for a first appointment over 52 weeks by end of March 2024 • High Volume Friday cataract list in Bridgend non training list - so has 7 patients on the list • Additional laser clinics booked to see high risk patients waiting for PRP laser • Continuous clerical validation of the lists • Additional weekend clinics for long waiting new and follow-up glaucoma patients (capacity for 36 new patients and 90 follow-ups in August) • Additional weekend clinics for long waiting stage 1 cataracts in June (140 patients) • Review being undertaken for all clinic templates • Review being undertaken with aim of condensing some theatre lists in order to fully utilise all staff and theatre capacity • Q2 Allocation of patients sent to Vanguard (517 in total)

Recommendation:	**The Board or Committee are asked to:** *Committee members are asked to note the work underway within Planned Care to improve the waiting times situation across the surgical specialties and specifically within Ophthalmology.*

AGENDA ITEM
5.3

PLANNING, PERFORMANCE & FINANCE COMMITTEE

CIVIL CONTINGENCIES AND BUSINESS CONTINUITY ANNUAL REPORT 2022-23

Date of meeting	22 August 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jason Evans, Emergency Preparedness, Response and Recovery Manager
Presented by	Linda Prosser, Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Health Board	25th May 2023	NOTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
EPRR	Emergency Preparedness, Response and Recovery
EPRRM	Emergency Preparedness, Response and Recovery Manager
CCA	Civil Contingencies Act 2004
PPE	Personal, Protective Equipment
PHW/E	Public Health Wales/England

SWLRF	South Wales Local Resilience Forum
I,P&C	Infection, Prevention and Control
MI	Major Incident
WG	Welsh Government
MERIT	Medical Emergency Response Intervention Team
VHF	Viral Haemorrhagic Fever

1. SITUATION/BACKGROUND

1.1 Cwm Taf Morgannwg University Health Board is a Category 1 Responder under the Civil Contingencies Act 2004 and therefore has the following duties placed upon it under this act and must:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency; and
- Provide advice and assistance to businesses and voluntary organisations about business continuity management (Local Authorities only).

1.2 This report covers the work and actions of CTMUHB in relation to Emergency Preparedness, Response and Recovery (EPRR) during 2022-23, aligning with the Annual Return that the Health Board is mandated to submit to Welsh Government.

1.3 Appendix A of this report provides additional detail in relation to the work completed by the EPRR Manager, Assistant Director of Transformation and the Executive Director of Strategy and Transformation to support the organisation's duties as a Category 1 responder.

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

The Annual Report provides an oversight of how CTMUHB is performing against its duties under the Civil Contingencies Act 2004. Specific areas of compliance to note are:

2.1 Assessing the risk of emergencies occurring and using this to inform contingency planning:

2.1.1 CTMUHB has demonstrated a reasonable compliance with the need to assess risks through its existing risk assessments and plans and the HB's response to new risks. This includes:

a. Pre-planning and operational response to instances of industrial action. Utilising data and cross organisational/sector and external partner collaboration to ensure effective pre-plans are in place along with robust strategic, tactical and operational response structures to maintain patient, staff and organisational safety through challenging industrial action periods.
b. Responding to the publication of findings from the Manchester Arena Inquiry and the implementation of Martyn's Law (See appendix). CTMUHB EPRRM is in consultation with Facilities/Estates leads to ensure organisational compliance.
c. Working collaboratively via the SWLRF multi agency structures to develop plans to ensure that adequate mortuary provision is in place across the region to maintain dignity.
d. Response to the notification of adverse weather events, and the subsequent risk assessed activation of HB severe Weather plans.
e. Contributing to the amendment and update of the SWLRF Community Risk Register through engaging in the evaluation and analysis of risk that has the potential to impact on our services. Work is ongoing with partners to align existing plans and develop additional plans where needed.
f. Ongoing work for the completion and testing/exercising of a pan Wales Mass Casualties Dashboard.
g. Following recent Executive attendance at the National Tier 1 Exercise 'Mighty Oak' regarding a notional National Power Outage, the EPRRM is developing cross department plans regarding possible energy insecurities.

2.2 Putting in place emergency plans:

2.2.1 CTMUHB has demonstrated reasonable compliance with this requirement through update/publication of a number of plans ready to form the basis of a range of emergency responses. Existing plans are under review in line with agreed timescales to develop the following:

- The Business Continuity Policy
- Business Continuity Guidance for Managers
- Lockdown Procedural Guidance
- Helicopter Landing Procedures (Prince Charles and Royal Glamorgan Hospitals).
- Bomb Threat and Suspicious Packages.
- Severe Weather –Ice and Snow
- Severe Weather - Heatwave
- VIP visit/attendance
- Pandemic Operational Plan
- Ebola Escalation Procedure
- Viral Haemorrhagic Fever (VHF) – Management of suspected cases Procedure
- Continued further discussion and work on the Emergency Pressures escalation Policy in partnership with operational colleagues

2.2.2 Work has commenced and is ongoing to review plans and address structural changes in relation to revised Care Group Structures within CTMUHB.

2.2.3 An agreed 'Scheme of Work' has commenced to update the organisation's '*Major Incident and Critical Business Continuity Procedural Guidance'.* Cross Care-Group working groups are in place across all acute sites and are revising and developing site specific MI guidance plans to enhance MI response within CTMUHB.

Executive level governance is in place and the EPRRM is working with Acute Site General Manager to ensure a uniformed approach is developed and implemented across the organisation in line with the legislative requirements of the CCA 2004 and WG Guidance.

2.3 Put in place Business Continuity Management arrangements:

2.3.1 Amongst the range of BCM plans that exist within CTMUHB the following are examples of plans that have been activated in 2022-23:

- Provision of assurance through adverse weather occurrences that has included 'Storm Eunice'
- Provision of assurance through periods of Industrial Action
- Health Board support to multi-agency approach for emergency relocation and healthcare provision for Ukrainian refugees
- Addressing issues surrounding increase in instances of Paediatric Strep 'A'
- Addressing security issues surrounding protests in relation to Covid Vaccinations
- Suspected Viral Haemorrhagic Fever Incident – Princess of Wales
- Loss of Electricity Supply – Royal Glamorgan Hospital
- Loss of data due to cable breach – Royal Glamorgan Hospital.

2.4 Collaborative Working

2.4.1 As a Category 1 responder under the Civil Contingencies Act 2004 and to ensure that CTMUHB engages and shares information with relevant partners - CTMUHB have active membership on the South Wales Local Resilience Forum, the Welsh Health Emergency Planning Advisory Groups, the Welsh Health and Social Services Group, Local Authority Planning Groups and a number of other strategic and tactical working and task and finish groups that underpin the above.

2.4.2 Participation in such groups has resulted in the ability of CTMUHB to adopt and take assurance from national plans, such as the National Supply Disruption Plan that is managed by the NHS Wales Shared Services Partnership (NWSSP), future National Health Surveillance plans and processes through Public Health Wales/England. It also ensures that CTMUHB are linked into the development and amendment of Strategic and Tactical regional and national planning, and are updated on emerging risks utilizing shared situational awareness to ensure the best planning and response is in place.

2.4.3 CTMUHB has an internal Strategic Emergency Preparedness, Response and Recovery Group, chaired by the Executive Director of Strategy and Transformation. This group brings together representatives of each Care Group with the aim of providing Strategic focus on emergency preparedness response and recovery.

2.4.4 Plans are in place to develop a Tactical EPRR Group to underpin the Strategic Group and ensure that lessons identified from local, regional and national incidents and threats are actioned appropriately. The group will also provide robust assurance of BCM planning across CTMUHB.

2.4.5 The ethos of developing and embedding EPRR within CTMUHB is ongoing and discussions are ongoing to embed EPRR within operational groups already in place and those emerging following the recent structural review and Care Group implementation.

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

3.1 Work has commenced to update the organisation's 'Major Incident and Critical Business Continuity Procedural Guidance'. Cross Care Group working groups are in place across all acute sites and are revising and developing site specific MI guidance plans to enhance MI response within CTMUHB. Executive level governance is in place and the EPRRM is working with Acute Site General Manager to ensure a uniformed approach is developed and implemented across the organisation in line with the legislative requirements of the CCA 2004 and WG Guidance.

3.2 There is a need to ensure that the Health Board's Care Groups continue to develop, review and update plans for their areas and to ensure that risks are evaluated and adequate measures put in place to mitigate the impact of such risks. Plans are in place to develop a robust governance/assurance framework via the Strategic EPRR Group to ensure this is in place and provide relevant levels of support to achieve.

3.3 There is a requirement that all Health Board and Care Group plans and guidance align to the relevant standards, ISO 22301 and statutory guidance from WG and NHS Wales. This requires continued significant engagement with internal and external stakeholders.

3.4 The Health Board and its nominated responsible person for EPRR must maintain adequate resourcing for EPRR. Plans are in place to

theme EPRR within operational level care group meetings and instil EPRR 'champions' across the organisation to support. In addition it is planned to enhance the resourcing of EPRR within current budgets via increased awareness of planning team members to provide ongoing support across care group and in embedding pan CTMUHB.

3.5 There is a need to consider mandating areas of EPRR training i.e. Major Incident Training for those on the on call rota and those involved in the enacting of CTMUHB MI Plans whether site specific or organisational wide. Business Continuity Training for relevant managers, in order that all relevant persons receive training as required under the Civil Contingencies Act 2004, and that training and development meets the required standards under the National Occupational Standards and other statutory guidance from WG and NHS Wales.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	Yes (Include further detail below)
	The Civil Contingencies Act 2004 places legal requirements on Organisations. These powers have been conferred on WG who now have the power to inspect and examine and Organisation's emergency preparedness.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Committee is asked to: **NOTE** the Civil Contingencies and Business Continuity Annual Report.

Appendix A: Civil Contingencies and Business Continuity Annual Report

Major incident and business continuity plans

The Emergency Planning Response and Recovery Manager (EPRRM) role has reviewed key policies and procedures in line with the expectations of the Civil Contingencies Act and Welsh Government expectations, namely:

- The Business Continuity Policy
- Business Continuity Guidance
- Lockdown procedural guidance
- Helicopter Landing Procedures (Prince Charles and Royal Glamorgan Hospitals).
- Bomb Threat and Suspicious Packages.
- Severe Weather –Ice and Snow
- Severe Weather - Heatwave
- VIP visit/attendance
- Continued further discussion and work on the Emergency Pressures escalation Policy in partnership with operational colleagues

Work has commenced to update the organisation's 'Major Incident and Critical Business Continuity Procedural Guidance'. Cross Care Group working groups are in place across all acute sites and are revising and developing site specific MI guidance plans to enhance MI response within CTMUHB. Executive level governance is in place and the EPRRM is working with Acute Site General Managers to ensure a uniformed approach is developed and implemented across the organisation in line with the legislative requirements of the CCA 2004 and WG Guidance.

The EPRRM supports Local Authority (LA) planning groups such as the Event Safety Advisory Groups for each LA within CTMUHB, providing advice and ensuring that HB requirements are factored in to the planning of major events and that information that may affect HB activity is relayed back to the organisation.

The EPRRM is also part of other LA's Emergency Planning forums and has been involved in areas of planning such as:

- Control of Major Accidental Hazard (COMAH) Registered site emergency response planning – Royal Mint
- Landslide (Tips) Response planning
- Prevention of Terrorism through active participation on the LA's Protective Security Preparedness Group

Operational Support

The Executive Director of Strategy and Transformation, deputised by the Assistant Director of Transformation are active participants on the SWLRF Strategic Co-ordination Group. The Assistant Director of Transformation and the EPRRM actively attend the SWLRF Tactical Co-ordination Group meetings. These forums deal with Strategic and Tactical preparedness, response and recovery for the range of issues that can be found on the SWLRF risk register.

The EPRRM also sits on a number of SWLRF sub groups such as the:

- Training and Development group
- Humanitarian Assistance Group
- Severe Weather Group
- Mass Casualties Group

The Executive Director and Assistant Director also sit on other Strategic Groups such as the WG Health and Social Services (Planning and Response) Group. This group provides health surveillance and global and national health information, advice and shares issues and best practice for health and social care partners.

The EPRRM sits on the Welsh Ambulance Service Pre Hospital Group. This group plans the pre hospital response to mass casualty events and the training of HB staff for their duties as Major Emergency Response Team members, along with multi-agency procedures and protocols during such events.

The EPRRM role has supported the ongoing review of the CTMUHB Emergency Pressures Escalation procedure. The purpose of this Escalation procedure is to provide an operational approach to the effective management of capacity, flow and escalation across all areas within CTMUHB.

The EPRRM forms part of the IP&C Strategic Committee and Tactical Cell and has liaised with Infection, Prevention Control Leads on the PPE issues and guidance from WG and PH. The EPRRM is currently liaising with PHW to review the PPE and procedures for dealing with Highly Infectious diseases including Viral Haemorrhagic Fever type diseases, Ebola and SARs.

The EPRRM provides evaluation of meteorological data in relation to the potential impact to the HB operations, impact on HB premises and infrastructure and the impact on staff travel etc. This includes liaison with Facilities, Estates and construction contractors to ensure that weather warnings and response plans are in place.

Training and Development

The EPRRM role has delivered training and development in the following areas:

- Tactical Hospital Major Medical Incident Management and Support Courses
- Major Incident Loggist Courses
- Strategic/Gold level Multi Agency Major Incident protocol and procedural training
- On Call Familiarisation sessions with new Senior Managers on Call.
- Business Continuity for managers.

The EPRRM also co-ordinates multi agency training for senior and executive managers in conjunction with the SWLRF Co-ordinator and provides training support to the roles of the Medical Emergency Response Intervention Team (MERIT) teams, for which CTMUHB in partnership with all HBs across Wales sanctions the provision of trained emergency nurses to assist in the event of mass casualty major incidents.

Exercises/Conferences:

The EPRRM has recently had direct involvement through the SWLRF Training and Exercising Group with the development and delivery of a Tier 1 – National Power Outage Strategic Pan UK Exercise – Exercise 'Mighty Oak' involved the notional National Power Outage over a 7 day period.

CTMUHB provided Executive Level Strategic Leads who fully participated in the exercise as part of its Strategic Command and Coordination Group. Identified national and organisational learning from the exercise is currently being utilised to amend and strengthen organisational BCM planning.

The EPRRM has represented the organisation at recent 'Health Prepared Wales' health specific conference and at the 'Wales EPRR Conference' providing feedback as required.

The Tactical Hospital Major Medical Incident Management and Support Courses have a table top exercise as part of the course. This a mass casualty incident based on a bombing of a shopping mall – CTMUHB training programme ensures that on call Exec/Senior managers are exposed to this exercise.

The EPRRM has developed a no-notice abduction exercise in partnership with the maternity department and facilities colleagues. This exercise has been successfully carried out at PCH on 2 occasions within 2022-23 and is scheduled to be implemented across all CTMUHB maternity sites during 2023-24.

Martyn's Law

Background -
On Monday 19 December 2022, the UK Government announced enhanced details for the Protect Duty, now to be known as 'Martyn's Law' in tribute to Martyn Hett, who was killed alongside 21 others in the Manchester Arena terrorist attack in 2017.

Why do we need Martyn's Law -
Throughout the UK we need to improve security and ensure robust, proportionate, and consistent measures at public places to make sure we can better prepare and improve public security, in light of possible future attacks.
The UK Government are aware through engagement with industry that without legal compulsion, counter terrorism security efforts often fall behind legally required activities. The prioritisation, consideration and application of security processes and measures is currently inconsistent.

Who will be in scope –
Premises will fall within the scope of the Duty where "qualifying activities" take place. This will include locations for purposes such as entertainment and leisure, retail, food and drink, museums and galleries, sports grounds, public areas of local and central Government buildings (e.g., town halls), visitor attractions, temporary events, Places of Worship, *health*, and education.
It is proposed that the Duty will apply to eligible locations which are either: a building (including collections of buildings used for the same purposes, e.g., a campus); or location/event (including a temporary event) that has a defined boundary, allowing capacity to be known. Eligible locations whose maximum occupancy meets the above specified thresholds will be then drawn into the relevant tier.
Therefore, premises will be drawn into the scope of the Duty if they meet the following three tests:

- That the premises is an eligible one – i.e., building or event with a defined boundary.
- That a qualifying activity takes place at the location; and
- That the maximum occupancy of the premises meets a specified threshold – either 100+ or 800+

How will it work –
The Bill will impose a duty on the owners and operators of certain locations to increase their preparedness for and protection from a terrorist attack by requiring them to take proportionate steps, depending on the size and nature of the activities that take place there.

Proportionality is a fundamental consideration for this legislation. It will therefore establish a tiered model, linked to the activity that takes place at a location and its capacity:

1) **A standard tier** will drive good preparedness outcomes. Duty holders will be required to undertake simple yet effective activities to improve protective security and preparedness. This will apply to qualifying locations with a maximum capacity of over 100. This could include larger retail stores, bars, or restaurants.
2) **An enhanced tier** will see additional requirements placed on high-capacity locations in recognition of the potential catastrophic consequences of a successful attack. This will apply to locations with a capacity of over 800 people at any time. This could include live music venues, theatres, and department stores.

Following initial assessment it is likely that CTMUHB premises will be '*within scope*' and fall within '*enhanced tier*' requirements.

CTMUHB premises will thus require an enhanced security risk assessment and security plan considered to a 'reasonably practicable' standard. This will allow the assessment to balance risk reduction against the time, money and effort required to achieve a successful level of security preparedness - a recognised standard in other regulatory regimes (including Fire and Health and Safety).

AGENDA ITEM
5.4

PLANNING, PERFORMANCE & FINANCE COMMITTEE

CTMUHB ASSURANCE
MANCHESTER ARENA INQURY – RECOMMENDATIONS

Date of meeting	22/08/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jason Evans – Emergency Preparedness, Response and Recovery Manager
Presented by	Linda Prosser – Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
EPRR	Emergency Preparedness, Response and Recovery
CCA	Civil Contingencies Act
SWLRF	South Wales Local Resilience Forum
ACC	Assistant Chief Constable
SWP	South Wales Police

MIP	Major Incident Plan
MACG	Multi Agency Coordinating Group
JESIP	Joint Emergency Services Interoperability Principles
SCG	Strategic Coordinating Group
TCG	Tactical Coordinating Group
CPD	Continuous Personal Development
EMRTS	Emergency Medical Retrieval and Transfer Service
MERIT	Medical Emergency Response Intervention Team
SLA	Service Level Agreement

1. SITUATION/BACKGROUND

1.1 Cwm Taf Morgannwg University Health Board (CTMUHB) is a Category 1 Responder under the Civil Contingencies Act 2004 and thus must comply with the following duties placed upon it under the act. CTMUHB has the duty to:

- Assess the risk of emergencies occurring and use this to inform contingency planning;
- Put in place emergency plans;
- Put in place Business Continuity Management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance co-ordination;
- Co-operate with other local responders to enhance co-ordination and efficiency; and

1.2 To address the legislative requirements above, CTMUHB has developed the following infrastructure:

- 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.

- A Strategic Emergency Preparedness, Response and Recovery Group to oversee planning and preparedness within the HB. 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 unforeseeable events are embedded within processes and procedures and becomes part of everyday working.
- The CTMUHB EPRR function is fully embedded within all-Wales health emergency planning and response structures to ensure uniformity of preparedness and response across NHS Wales.
- Collaborative working is a key function within EPRR and the CTMUHB EPRR manager works closely with all-Wales external partners as part of the South Wales Local Resilience Forum (SWLRF), forming an integral part of local and national multi-agency response planning and exercising and plays an active part in a number of task and finish groups as part of the SWLRF to ensure preparedness.

1.3 CTMUHB along with all other SWLRF Category 1 responding organisations has recently been in receipt of a letter from SWLRF Chair - ACC Mark Travis (South Wales Police).

The purpose of the letter is to highlight recent recommendations published as part of the Manchester Arena Inquiry Report and to request assurance from Category 1 responding organisations that organisational preparedness is in place or being worked towards to address relevant recommendations.

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

The following recommendations have been received via ACC Travis' letter dated 11th May 2023 and the relevant organisational assurance position is highlighted below:

2.1 ***Your organisation holds a current Major Incident plan (MIP) that has been the subject of a recent review and update. That this plan has either been tested / exercised or has been successfully used within a challenging operational scenario. This plan should support the legal requirements of the Civil Contingencies Act 2004 and wider legislation and policy relevant to your own organisations.***

RAG Status – Amber

Organisational Assurance Position

CTMUHB has an up to date, live overarching MIP in place that is due for review during 2024. This plan has been shared and approved by WG colleagues. However to enhance organisational incident management support, a full review has been initiated and task and finish groups are in place to develop site specific plans for our acute sites and support elements from community sites that would be required to support a major incident/mass casualty event of this nature.

The purpose of the revised plan will be to provide full instruction on actions to be taken by all staff/care groups and will be provided in dedicated 'action card' format which will form part of MI training/exercising. The revised plan will include full information on JESIP principles and actions to support the actuation of MACG.

Elements of the CTMUHB MIP have been utilised during a number of critical incidents within 2022/23, these have included national data outages and acute site power outages. The major incident management aspect of the plan including the establishment of incident management structures has been utilised successfully.

A Welsh Government MIP and Mass Casualty live exercise is planned for October 2023. This will test the national casualty dispersal plan along with CTMUHB's internal MIPs. CTM EPRR Manager is embedded within the WG exercise planning group. The internal element of the exercise will look to test Gold/Silver and Tactical Response Cells actuation in line with the MIP.

2.2 ***The staff in your organisation who operate at a strategic, tactical and operational level, have the confidence and clarity of how to declare a Critical or Major Incident and understand how to invoke the trigger plan to initiate a Strategic and/or Tactical Co-ordination Group (SCG/TCG). Please note the activation process is currently changing to a new and improved automated process based upon lessons learnt in the Dyfed Powys LRF.***

RAG Status – Green

Organisational Assurance Position

CTMUHB has an embedded 24/7 on call structure with both tactical and strategic on call incident management rotas in place. Mass casualty/MI training is ongoing and is scheduled for completion by September 2023.

A training needs analysis has been developed and will feed into an enhanced training programme for CTM incident managers for implementation post September 2023. The programme will provide information and guidance on incident management issues and familiarise incident managers with the revised MI plan and site specific action that will be required. The training plan will incorporate training relevant to Wales wide NHS National Occupational Standards relating to Health Incident Management which are currently under development by NHS Executive colleagues and will be circulated shortly. Resource requirements to facilitate delivery are currently under development. Ongoing training and exercising against NOS will be required and will be captured within CPD logs.

CTMUHB are currently developing an improved call management system through switchboard/informatics to enable receipt of the revised MACG actuations in line with the soon to be introduced system via SWLRF – The EPRR manager leads a T&F Group to address.

2.3 ***That your Major Incident Plan is simplified for first responders. It is recommended that first responders have simple, printed and readily available advice and guidance to assist effective decision making under the stress and pressure of responding to complex and highly traumatic multi-agency incidents. These guides are frequently called action cards. The content and method of delivery needs to be determined by each organisation.***

RAG Status - Amber

Organisational Assurance Position

The current CTMUHB MI Plan incorporates 37 Action Card/Guidance Notes for staff. Whilst this provision addresses the requirement, there is a plan to further enhance the provision within the revised MI Plan and will include in-depth but simple action card based site specific operating principles for all staff.

The revised site specific training programme will follow the launch of the plan and will ensure staff are familiar with required actions and have an appreciation of the importance of their actions and how they enhance the whole HB ability to 'flex' for a MI actuation.

2.4 ***The ability to establish a command structure with Strategic, Tactical and Operational Commanders in the earliest stages of an incident***

RAG Status - Green

Organisational Assurance Position

CTMUHB has a robust on call incident management structure that can be called upon on a 24/7 basis. This includes 120 of our managers trained to tactical and 22 to strategic health incident management levels.

Training provided is accredited and approved by WG colleagues as best practice across Wales.

Our strategic incident managers are also currently embarking on a 'Wales Gold' multi-agency strategic training programme facilitated by the SWLRF which accredits them to operate within the SCG environment during a MI scenario within Wales.

The above CTMUHB On Call system is currently under review to ensure the capability provides the best fit and support to effectively manage any incident scenario whether in/out of hours.

A review of the position of Strategic/Tactical Hospital Incident Rooms is ongoing to ensure their locations provide a best fit for revised plans and enable a robust/specific 'command/incident management structure' to be developed and communicated for the incident type faced.

2.5 ***The ability to quickly provide competent ground assigned commanders and staff who are both operationally and occupationally competent.***

2.6 ***The ability to implement the JESIP Doctrine***

2.7 ***The formulation and sharing of METHANE messaging***

2.8 ***The ability to agree and attend an "at scene" RVP – Rendezvous Point***

2.9 ***The ability to agree and attend an FCP – Forward Control Point***

RAG Status - Green

Organisational Assurance Position

Whilst CTMUHB is a category 1 responder and must comply with the requirements of the CCA 2004, it does not provide a scene specific MI response. On scene command for health is provided by WAST/EMRTS and thus their commanders receive the relevant training as highlighted above.

2.10 ***Where relevant, the ability to deploy your responders in hazardous environments with sufficient equipment to protect the public and themselves***

RAG Status - Green

Organisational Assurance Position

Reference is made to deployment in hazardous environments within the current MI plan, however CTMUHB will not be required to carry out the function of a designated 'on scene responder'. This role is provided by WAST/EMRTS for health in Wales.

CTMUHB provides trained MERIT nurse support to national MI response via an all Wales SLA. MERIT nurses are fully trained/accredited and provided with all relevant PPE for use within the hazardous environment. The response is fully supported and resourced through CTMUHB emergency departments. The CTMUHB EPRR Manager is embedded within the MERIT training and delivery group.

Decontamination/De-robe facilities are available at our acute sites. Equipment and training is provided via the Infection Prevention and Control Team.

2.11 ***The staff that you personally appoint to attend the LRF must be of sufficient seniority, confidence and competence for this demanding role. They must attend LRF meetings with consistency.***

2.12 ***The staff that you personally appoint to attend an SCG or TCG must be of sufficient seniority, confidence and competence for this demanding role. They must have attended and be qualified through suitable training. They must maintain their competence.***

RAG Status - Amber

Organisational Position

CTMUHB has a fully functioning SMOC/Executive 24/7 on call incident management function. To ensure the function complies with MEN recommendations, the recently completed Training Needs Analysis will guide the enhancement of training provision for the future. National Occupational Standards in relation to Health Incident Management will be implemented to ensure all Wales compliance.

Our strategic incident managers are also currently embarking on a 'Wales Gold' multi-agency strategic training programme facilitated by the SWLRF which accredits them to operate within the SCG environment during a MI scenario within Wales. Recent lobbying of SWLRF leads has ensured that Wales Gold training space for CTMUHB has now increased from 2-6 places annually. To enhance this provision, consideration will be given to developing CTMUHB specific Gold/Silver multi-agency training.

Consideration is also being afforded to the provision of CPD logs for incident managers at all levels to ensure maintenance of competence is evidence against NOS.

CTMUHB On Call incident management rota is currently under review to ensure the capability provides the best fit and support to effectively manage any incident scenario whether in/out of hours.

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

3.1 CTMUHB EPRR position is reported annually to WG/NHS Executive colleagues. Assurance has been provided and received in relation to the EPRR position in relation to Manchester Arena Recommendations.

3.2 CTMUHB is in a positive position in relation to Manchester Arena Recommendations, but work continues in many areas to further enhance and develop MI plans and accompanying MI training.

3.3 The EPRR Manager is working to ensure cross organisational 'buy in' and support for any required enhancements.

3.4 Momentum should be maintained to ensure the importance and awareness of incident management is understood and that the continued development, implementation and embedding of site specific MI plans is maintained.

3.5 Whilst at present it is difficult to present tangible costs to address the required levels of assurance, fully costed option appraisals will be provided to highlight and seek agreement for any additional future funding requirements that may emerge from required work streams.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Information update only
Legal implications / impact	Yes (Include further detail below)
	The Civil Contingencies Act 2004 places legal requirements on Organisations. These powers have been conferred on WG who now have the power to inspect and examine and Organisation's emergency preparedness
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Whilst at present it is difficult to present tangible costs to address the required levels of assurance, fully costed option appraisals will be provided to highlight and seek agreement for any additional future funding requirements.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 Receive the content of report as assurance against Manchester Arena Inquiry Recommendations letter provided by SWLRF Chair ACC Mark Travis.

6. Appendix

6.1 **SWLRF Chair Letter to responder organisations**

FCLDC SWLRF
Fforwm Cydnerth Lleol De Cymru
South Wales Local Resilience Forum

Dear Chief Executive, Chief Officer / Senior Partner,

Re: Manchester Arena Inquiry Volume 2 Emergency Response (MAI) – Response to the initial lessons IDENTIFIED

I will keep this communication both brief and simple for clarity and to reduce demands upon your time. I am writing to you with an initial response to the findings from the tragic events at the Manchester Arena (MAI) on the 22nd of May 2017. I can confirm that as your LRF we will be working with colleagues from Welsh Government and the other Welsh LRFs to review the extensive findings in much greater detail, in particular, all of the MAI recommendations from Volume 2, Emergency Response. I have attached links to the relevant reports in **Appendix 1.**

In considering the detail of the report I would draw your attention to the following areas as a priority. I have followed the approach of the Joint Decision Model and I would describe this as our initial or working strategy, pending a longer term and more in depth operational response. Can I please ask that you personally reassure yourself of the following matters.

1. Your organisation holds a current Major Incident plan (MIP) that has been the subject of a recent review and update. That this plan has either been tested / exercised or has been successfully used within a challenging operational scenario. This plan should support the legal requirements of the Civil Contingencies Act 2004 and wider legislation and policy relevant to your own organisations. It is strongly recommended that your MIP includes and is guided by the doctrine of JESIP which is included in **Appendix 2.**

This is referenced in the MAI at point no R1, page no 138.

2. The staff in your organisation who operate at a strategic, tactical and operational level
    a. Have the confidence and clarity of how to declare a Critical Incident (CI) or Major Incident (MI) and to then how they share this decision with key partners.
    b. When the decision is made to call an incident as CI or MI, staff understand how to invoke the trigger plan to initiate a Strategic and / or Tactical Co-ordination Group (SCG/TCG). Please note the activation process is currently changing to a new and improved automated process based upon lessons **learnt** in the Dyfed Powys LRF. This process will go live at the end of May, beginning of June 2023. I have attached the current and future processes. You will be advised formally of the exact date and time of the transfer of processes.

The CI and MI definitions are attached in **Appendix 3.**
The current and **new** SWLRF mobilisation plan is attached in **Appendix 4.**

3. That your MIP is simplified for first responders. It is recommended that first responders have simple, printed and readily available advice and guidance to assist effective decision making under the stress and pressure of responding to complex and highly traumatic multi-agency incidents. These guides are frequently called action cards. The content and method of delivery needs to be determined by each organisation.

    Whilst not a direct recommendation you may wish to consider making the JESIP APP (Application) available to relevant staff. This APP is very user friendly and is available in both IOS and Android. The APP includes advice and guidance for first responders with a direct link to What3Words to deliver an effective METHANE briefing.

Some elements of your MIP or response protocols may seem so routine as to not be considered as necessary to be tested or reviewed. I would urge you to consider the following issues –

a. The ability to establish a command structure with Strategic, Tactical and Operational Commanders in the earliest stages of an incident – Minutes 0 to 60.
b. The ability to quickly provide competent ground assigned commanders and staff who are both operationally and occupationally competent.
c. The ability to implement the JESIP Doctrine including
    i. The formulation and sharing of METHANE messaging
    ii. The ability to agree and attend an "at scene" RVP – Rendezvous Point
    iii. The ability to agree and attend an FCP – Forward Control Point
    iv. Where relevant, the ability to deploy your responders in hazardous environments with sufficient equipment to protect the public and themselves
d. Clarity on your Article 2 ECHR responsibilities to save life, reduce harm and to work in collaboration.

This is referenced in the MAR at point no R45, R52, R63 page no's 144, 145,147.

4. The staff that you personally appoint to attend the LRF must be of sufficient seniority, confidence and competence for this demanding role. They must attend LRF meetings with consistency.

This is referenced in the MAR at point no R99, R100, page no 154.

5. The staff that you personally appoint to attend an SCG or TCG must be of sufficient seniority, confidence and competence for this demanding role. They must have attended and be qualified through suitable training. They must maintain their competence.

This is referenced in the MAR at point no R99, R101 page no 154.

I apologise that this correspondence may appear to be direct and action focussed. It is clear from the findings of the MAR that where these recommendations are not delivered the collective consequences expose the public, our staff and public confidence to significant risk. The role of the LRF is preparedness. If we all take the above steps we provide our staff with key foundations to interoperability, which in turn will provide greater clarity, grip and help to achieve our strategic aims of saving life, reducing harm and working in collaboration.

Please could I ask that you acknowledge receipt of this letter by **30th May 2023**

Thank you for taking the time to consider this request

Yr eiddoch yn gywir /Yours sincerely,

Mark Travis
Assistant Chief Constable
South Wales Police

Chair of South Wales Local Resilience Forum

Prif Gwnstabl Cynorthwyol
Heddlu De Cymru

Cadeirydd Fforwm Gwydnwch Lleol De Cymru