Q&S COMMITTEE 18 JANUARY 2022

Exec Leads: Greg Dix & Georgina Galletly

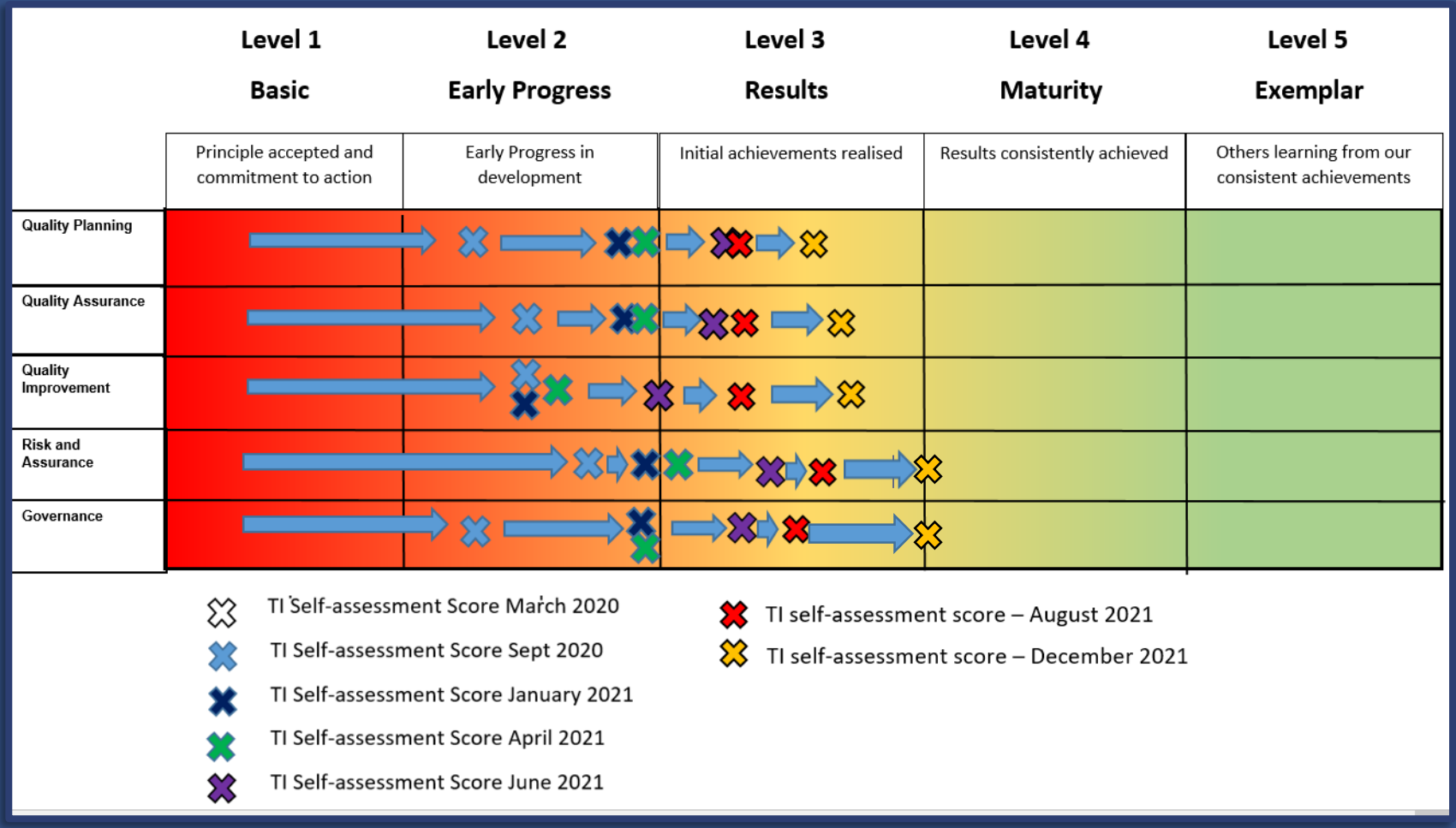
The following slides provide assurance to the Q&S Committee on the information and evidence supporting the self assessment for the Targeted Intervention domain for Quality & Governance.

The committee is asked to review the information and evidence provided, seeking any additional information outside of the committee for completeness.

The information presented informs the Board's self assessment against the maturity matrix as per slide 2.

Quality & Governance

Targeted Intervention Self-assessment – December 2021



Section 1 – Quality Planning

We want to be an organisation that puts quality at the heart of our planning work and it drives the strategic agenda. This mind-set is embedded across the organisation and feedback from patients and staff are triangulated with sources of quality information to inform quality planning.

See the following slides for how we're striving towards this:

Quality Planning

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
The Board establishes quality as a priority on its agenda, supported by high quality materials and information on quality, and has a robust sub-committee structure that promotes organisational learning and quality planning. **Quality is clearly driving the IMTP agenda, quality priorities are clear and run through all parts of the IMTP.** **Patient and staff feedback triangulated with other quality information is embedded within the business planning process and informs quality planning and the IMTP process.** **Quality primacy is embedded across the health board.**	• Quality is explicit within the IMTP, annual report and annual plan. Quality priorities are clearly expressed within the Quality Governance Framework. • The completion and implementation of the Patient Experience Strategy has been impeded by the pandemic response, this however has facilitated an opportunity to review and modernise how we gain patient, family and carer feedback, along with the impact of the regional integrated approach of delivering health services to the community. This is now being reviewed and will underpin the Health Board's approach to patient experience in the medium term. • The Once for Wales risk management model and CIVICA cloud based user feedback systems are keenly anticipated to support our understanding of service experience. CIVICA is being piloted in maternity & cardiology. • In addition to CIVICA the UHB is also rolling out its PROMS solution along with WREMS (Workforce Related Experience Measures) which is unique to CTMUHB. The data from CIVICA, PROMS & WREMS will be triangulated for holistic quality assurance. • Whilst we await wider roll out, CTMUHB continues to explore different, creative ways of gaining an insight into patient experience whilst negotiating the restrictions the Covid-19 pandemic places on this. 'Have your say cards', Greatix, concerns, incidents, compliments and Community Health Council feedback from patients, families, and carers continue to provide the Health Board with an opportunity to improve and build on the services we provide to the community. • The HB has implemented a quarterly Shared Listening and Learning Forum from February 2021. The forum has been established as part of the Health Board's framework for listening to and learning from incidents and patient or staff concerns and experiences, and to promote and support a learning culture. The impact on peoples experience and organisational learning will be a key consideration in determining effectiveness. A Listening & Learning Framework is in development to ensure that the organisation is able to share and embed learning and practice throughout, including a focus on bringing learning and research into the UHB. • Patient stories now form a regular part of the Board, sub-committee meetings and ILG Q&S meetings, giving situational insight into the experience of those using our services and how we can improve what we offer. • Executive and independent board member's patient safety walkabouts, which includes visiting ward and patient areas, in addition to primary and community sites have been recommenced.	Supportive documents • IMTP • Annual Report • Annual Plan • Quality Governance Framework • Q&SC Quality Dashboard Reports • CIVICA report received in relation to maternity and will be upward reported to the MNIB. • PROMS & WREMS data now available for further analysis on pilot area • Executive & IM feedback in relation to Walkabout's is being fed back to Management Board.

Section 2 – Quality Assurance & Control

We want to be an organisation that uses a quality strategy to provide clear priorities and that does this in an intelligent and data-supported way. We want intelligence to be from a variety of hard and soft sources and quality impact assessments consistently drive quality-based decisions.

See the following slides for how we're striving towards this:

Quality Assurance & Control

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
The health board has a quality strategy, with clear quality priorities that integrates into and drives our overall organisational strategy. All staff are aware of the quality priorities. **A quality impact assessment process is in place and drives quality based decisions. is embedded and all major decisions are made based on quality impact considerations.** **The health board receives high quality intelligence and information through both soft and hard sources to provide assurance that services are safe, and takes account of patient experience, outcomes, and quality improvement. Assurance sources are both internal and external and reinforce the same picture.** **Information on quality is of high quality, with limited data quality issues, is well summarised to provide assurance around quality of care. and triangulated to provide assurance around quality of care.**	• Although no formal strategy has yet been published CTM have developed structures throughout the organisation that support and facilitate good quality governance, articulating its quality priorities clearly through its **quality & safety framework**. Following the publication of the new National Quality & Safety Framework, the CTM Framework has been subject to a gap analysis and a refreshed version will be presented to Q&SC in March 22. • Centrally, the Patient Care and Safety Team encourage and facilitate triangulation and lead on work streams that foster strong collaborative approaches to generating effective and positive outcomes. • Within the ILGs the structures and processes are designed accordingly to meet the objectives set out within Chapter 3 of the IMTP for each ILG. • The Quality and Safety Framework supports a quality & safety culture. It achieves this in a number of ways including setting out the provisions for ward to board governance, reporting and organisational dissemination. The HB is exploring ways of improving service point to Board quality and safety assurance measures such as AMaaT and WESEE frameworks, which has already demonstrated good facilitation of triangulation of data within maternity. • Within the ILGs the CSGs report on Q&S issues and the ILGs hold Q&S meetings to facilitate oversight, monitoring, performance reporting, escalation and overall assurance. The meetings also consider intelligence and early warning opportunities • The work undertaken at ILG level, feeds into the Q&S committee where an open and transparent reporting and monitoring process occurs. The membership also ensures the UHB are robustly challenged and held to account. This meeting also supports and facilitates escalation. • An Executive Director led Patient Safety meeting is held weekly. A dashboard of quality related matrices is presented to facilitate a timely review of the previous week's metrics. The data shared at this meeting is circulated through to the ILG governance teams for verification and comment prior to being presented in the meeting. • CTM has set out detailed expectations for the ILGs and wider organisation. The organograms and structure charts outline the existing resource within the central and ILG teams. • Through upward reporting at each different level, through interrogation of data and through monitoring and tracking progress; the effectiveness of the ILG teams within the existing resource is monitored.	• Board and Quality and Safety Committee Report & Minutes • HIW/Audit Office Follow up review & action plan May 21 • Quality and Safety Framework • Organograms (HB, Central, ILG, CSG) / IMTP Structures • Quality Dashboard & Quality Metrics and SI Management report • Executive led meeting minutes • Performance Management Framework • SI Toolkit, SI Training Package, QA tool, QA audit outcomes • Gap analysis of the CTM Quality & Safety Framework completed. • Quality Impact Assessment Template and examples of completed QIA's. .

Quality Assurance & Control

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
Criteria continued from previous page	• Quality Impact Assessments are completed on any service delivery decisions to ensure the impact of any changes is understood, escalated and mitigated against. • Current work in in progress to identify an ideal model of Q&PSE resource within the ILG governance teams: a minimum standard to effectively manage quality and safety processes and to do this in a consistent, equitable manner across the organisation. • Through the Quality Assurance (QA) of incidents the UHB is assured that action plans are relevant to the investigations, the actions are SMART and that they progress. Since December 20, every SI presented for closure has a QA internally in line with the QA tool previously shared with the DU. • The AMAT system is widely used and increasing in uptake with regard to monitoring progress from action plans. Audits can be generated to monitor compliance, learning and /or effectiveness. The central team are working with the Audit team to improve the interface between the two systems. The Datix Management Group retain this on the agenda to ensure progress is made and quality is maintained. • Quality Impact Assessments are routinely used to demonstrate the effects of service change and or development. This has been particularly useful analysing the impact of service pause and change during the pandemic. High risk changes are escalated for executive oversight and approval. • Open incident management and assurance to closure of maternity and neonatal incidents. Development of assurance panels which have spread as a robust method of incident management and learning to other service groups within ILG's. Showcase event held on 29/11/21 for external stakeholders including WG, IMSOP, DU.	• Shared Listening & Learning TOR / Minutes • Targeted Intervention Risk Management Plan & Feedback from Risk Management Awareness Sessions • Datix Management Group TOR • Audit and Effectiveness TOR • Innovation & Improvement Board TOR • QIA template and examples • Success will be measured by the connection of the strategy to the everyday function of the HB – through our agreed quality governance architecture, quality metrics and performance, and in the experience of our staff and patients – connecting us to the overall vision and demonstrating how the thread provides connectivity to understanding the reason for our work. • Quality Assurance & Closure Panels TOR. Evidence of progress of closure of open mat/nn incidents. • Showcase Event recording available. • Feedback from Stakeholders to showcase event.

Section 3 – Quality Improvement

We want to be an organisation that has quality improvement embedded into the way we operate and constantly championed by our staff. We ensure there is the capacity and capability to take forward QI work and mechanisms are in place to support key organisational priorities through QI approaches. Our QI focus in aligned with our overall strategic goals and priorities.

See the following slides for how we're striving towards this:

Quality Improvement

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
There is a clearly documented and understood Quality Improvement plan and strategy which is embedded into the way the health board operates, and championed by staff	• Organisational structure for Improvement and Innovation team put in place (see attached). • QI Mission statement in place *'Working together with our people, patients and partners to understand areas for quality improvement and developing the capability, capacity and delivery mechanisms across the whole health system to deliver improved outcomes for our patients and improved working practices for our people aligned to our Health Board Values and the principles of Prudent and Value Based Health Care.'* • New Innovation and Improvement board created (sub board of Management Board) and launched focusing on Capability, skills, culture and delivery of QI and innovation and bringing together cross organisational learning. Responsible for ensuring a QI plan linked to organisational strategy and priorities are in place (see attached). • Executive QI Lead in place (Director of Nursing) • Director of Improvement in place • Details of all centrally driven QI projects in place with LifeQI system and capturing of all other QI work across the HB in progress. LifeQI will act as the central QI work repository to track progress and record benefits. • Internal improvement intranet page launched including 'improvement mission' training and support. • ILG QI faculties in place to champion improvement within the organisation. • Improvement CTM formally launched w/c 22/11/21 with a number of events to engage with staff and start embedding improvement into everyone's roles.	• See appendix 1  iCTM Team • See appendix 2  Terms of Ref • See appendix 3  • SharePoint Improvement page http://ctuhb-intranet/dir/ImproveCTM/SitePages/Home.aspx • iCTM QI Twitter account https://twitter.com/QICTM • Use of all staff Facebook page • Intranet updates and focus articles on improvement • Simply do…ideas, staff ideas scheme and system launched • https://www.youtube.com/watch?v=IfBhxjwpJ3Q • Life QI system to manage and record ongoing QI projects • Patient Safety Twitter #SafetyCTMHB • World Patient Safety launch • Safeguarding Week

Quality Improvement

1) 'Results'/maturity definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change

There is significant capacity to take forward QI work across all areas of the HB.	• Organisational structure for Improvement and Innovation team put in place
	• Director of Improvement role recruited
	• Assistant Medical Director for QI in place
	• Additional roles recruited for the central QI team to business partner with each ILG
	• 3 ILG QI Faculties created with dedicated nurse, medical, pharmacy and therapies resource (with training undertaken)
	• 3 ILG QI Faculties launched across the HB week commencing 9th August 2021 with onsite roadshows
	• Skills and knowledge audit underway
	• 12 candidates put through new Improvement into Practice training in last month
	• Review underway of existing 600 plus individuals trained in QI
	• Improvement CTM formally launched w/c 22/11/21 with a number of events to engage with staff and start embedding improvement into everyone's roles.
	• Self service training and development for QI available at SharePoint.
	• Welsh Wound Innovation Service Improvement work
	• Urology department improvement work
	• GUM service improvement work
		• Central QI team support to PCH for improvement
		  • Review of Patient Safety Checklist
		  • ED improvement work
		• Commissioned joint work with Improvement Cymru / iCTM / PCH for flow and safety work across the HB
		• QI work with CAMHS being delivered
		• Falls Improvement work with MH / EMI patients being delivered.
		• HB investment into centralised QI resources to build capacity across CTMUHB
		iCTM Team
		• Improvement into Practice training course run for 12 individuals and successfully completed. Future courses booked in with next scheduled for January 22

Quality Improvement

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
Standardised approaches to improvement tools and methods have been developed for the health board, with staff trained to use them. / methods are embedded for the health board, with staff competent in using them.	• Skills and knowledge audit underway • 12 candidates put through new Improvement into Practice training in last month • Review underway of existing 600 plus individuals trained in QI • Standardised training package agreed • Further training plan being developed • Internal improvement intranet page launched including 'improvement mission' training and support. • Working with WOD to build into all staff and leadership training QI, Innovation, Change and Value Based Healthcare. Also focus on self empowerment and psychological safety	• Standardised training packages • Standardised improvement methodology, process and tools developed and implemented. http://ctuhb-intranet/dir/ImproveCTM/Toolkit/_layouts/15/start.aspx#/SitePages/Home.aspx • Improvement into Practice training course run for 12 individuals and successfully completed. Future courses booked in with next scheduled for January 22
There are systems for supporting improvement and innovative work, including objectives and rewards for staff. data systems, and processes for evaluating and sharing results of improvement work.	• LifeQI system along with QI training • All QI projects start with scoping, problem statement and objectives for improvement • Staff Ideation Scheme in development, including element of gamification / reward for right behaviours and engagement with improvement. Improvement CTM formally launched w/c 22/11/21 with a number of events to engage with staff and start embedding improvement into everyone's roles. Simply Do Ideas system purchased to engage with staff on challenges, ideas and solutions. • IP Policy being reviewed for innovation to ensure appropriate reward for staff • Staff thank you scheme being utilised for QI thank you • Case studies produced and articles for improvement and shared through all staff messages to continue improvement narrative and share lessons learnt. • Working with Patient Safety Team to further share information and lessons learnt across improvement, patient safety and quality management • In addition to CIVICA the UHB is also rolling out its PROMS solution along with WREMS (Workforce Related Experience Measures) which is unique to CTMUHB. The data from CIVICA, PROMS & WREMS will be triangulated for holistic quality assurance	• LifeQI population in progress • See appendix 4  • Staff Ideas Scheme and system launched • PROMS & WREMS data now available for further analysis on pilot area • https://www.youtube.com/watch?v=lfBhxjwpJ3Q

Quality Improvement

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
Visible and focused Board leadership and effective governance - ensuring all improvement activities aligned with organisation's vision. **NO FURTHER CRITERIA PAST 'RESULTS' WHICH HAVE BEEN ACHIEVED**	• Executive QI Lead in place (Director of Nursing) • Director of Improvement in place • New Improvement and Innovation Board created and started meeting with pan HB representatives. Responsible for ensuring a QI plan linked to organisational strategy and priorities are in place • Director of Improvement working closely with Executive Director for Strategy and Transformation to develop a single and aligned organisational strategy which QI forms a fundamental enabler and ongoing element. • QI regularly included as a topic in the CEO all staff Q&A monthly sessions / with Director of Improvement joining the CEO on occasion for specific focus on improvement • Datix and SIs regularly reviewed to identify focus areas for QI. Close working between the iCTM team and Assistant Director for Quality and Safety	• Weekly Improvement in Focus comms out to staff • CEO monthly Q&A • Weekly Director Led Patient Safety Meeting where Datix themes and trends discussed and actions agreed

Quality Improvement

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indictors of change
Staff understand the systems in place and are empowered to undertake QI work, and this work informs local improvement. QI is a core part of staff roles and they are empowered to undertake QI work. This work informs local and health board wide improvement.	• All RNs required as part of role profile to complete IC Bronze and Silver levels • Head of Quality and Safety Nursing role profile has specific QI and Quality in their JDs • Local ILG QI Faculties to embed and encourage a culture of improvement across the HB • Top down encouragement on QI and allowing people the freedom to make changes • AMD for QI for medical engagement • Improvement CTM formally launched w/c 22/11/21 with a number of events to engage with staff and start embedding improvement into everyone's roles. Simply Do Ideas system purchased to engage with staff on challenges, ideas and solutions. • QI Central Team and Faculties working across the HB when 'pulled' to support improvement and building capability within teams for them to improve and sustain.	• RN Standard role profiles • Head of Quality and Safety nursing's role profile in place • Staff Ideas Scheme and system launched
Staff and departments can access data and information, often real time information to help inform improvement. Staff and departments can access intelligence (both qualitative and quantitative) easily to facilitate improvement.	• Staff have access to Qlik View to access real time and historical information and data. This solution allows self service from the data warehouse for staff to use directly in improvement. • Departments have access to Datix systems to review themes and trends for incidents or SIs to identify areas for QI focus • Specific work undertaken with teams where needed to understand data collection mechanisms and analysis to aid with identifying areas for improvement or helping measure improvement impacts and benefits • HB recently purchased Civica system to gather PREMS data and this is currently being developed for implementation. Once live real time patient feedback and historical data will be available to aid improvement work • Improvement CTM formally launched w/c 22/11/21 with a number of events to engage with staff and start embedding improvement into everyone's roles. Simply Do Ideas system purchased to engage with staff on challenges, ideas and solutions.	• PROMS & WREMS data now available for further analysis on pilot area • QlikView available to staff • Datix systems available • PREMS CIVICA report received in relation to maternity and will be upward reported to the MNIB.

Section 4 – Risk & Assurance

We want to be an organisation that has a mature understanding and use of risk management ensuring mechanisms are in place identifying, recording, managing and escalating risk across the organisation including with our committees. Our Board Assurance Framework needs to guide and drive Board discussions and highlight where we have assurance gaps.

See the following slides for how we're striving towards this:

Risk & Assurance

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

cwmtafmorgannwg.wales

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indicators of change

Robust risk management arrangements are in place for identifying, recording, managing and escalating risks across the organisation, with risks managed from ward to board through clear escalation arrangements. The board have developed and articulated their risk appetite.	• Organisational Risk Register updated regularly with each update approved by Management Board. Status: Achieved since May 2020. Organisational Risk Register received at every Board meeting and Board Committee (assigned risks) Status: Achieved September 2020
	• Strategy and Policy Documents up to date and approved in January 2021.
	• Clear process map for Service to Board Escalation of risk. Status: Achieved January 2021
	• Risk Training Awareness Session – rolling monthly programme established– 1 hour open session on a monthly basis. Status: Achieved January 2021. Due to the success of this programme of training monthly sessions have now been scheduled throughout 2022.
	• Risk Training: work ongoing on an All Wales Basis. The Training Needs Analysis has been completed. Module 1 of the training has been submitted to the Learning Management System Team for finalising and uploading- October 2021. Development of Module 2 will commence in December 2021.
	• The ILGs are continuing to work to both rationalise and standardise the risks across the localities, the initial cleansing of risks was completed by the deadline of the end of October 2021 and presentations from each locality were received at the Board Development Session on the 21st October.
	• At the Board Development Session on the 21st October 2021, Board Members reviewed the current Risk Appetite Statement and escalation process and discussed a revised approach which is now being developed. This activity will form part of the work being taken forward to develop a revised Board Assurance Framework. Timeframe: 31st December 2021.
	• Once for Wales Risk Module – the Health Board is represented on the All Wales working group to influence to help shape the new risk module. There is also local engagement with risk leads in functions to seek their feedback on developments being led by the All Wales Group to see if they work in the service. Timescale for the new module is April 2022.
		Internal Assurance
		• Organisational Risk Register updated regularly – see Board and Committee papers: Board Papers - Cwm Taf Morgannwg University Health Board (nhs.wales) Committees - Cwm Taf Morgannwg University Health Board (nhs.wales)
		• Risk Management Strategy, Policy and Procedure available here: Policies - Cwm Taf Morgannwg University Health Board (nhs.wales)
		• Service to Board escalation flow captured in the Risk Management Strategy.
		• Training Attendance records and testimonies: **257** members of staff have received the Risk Training Awareness Session since January 2021.
		Testimonies:
		  • *"It was refreshing to have a session around risk that was "real" and with good fundamental examples.*
		  • *The session was dynamic and easy to follow, which made me feel that I could tap back into any upcoming sessions to refresh any element I may struggle with." Nursing*
		• All Wales Training Needs Analysis and Draft Module 1 can be made available upon request.
		• Slide presentation from Board Development Session on the 21st October 2021 available upon request.
		• Programme of dates for 2022.
		
		External / Independent Assurance
		• Audit Wales Structured Assessment Report 2020 – received in the Audit & Risk Committee in October 2020.
		• Internal Audit Report on Risk Management February 2021 – Reasonable Assurance Rating. Draft/Final Internal Audit Report (nhs.wales)

Risk & Assurance

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indicators of change
A Board Assurance Framework (BAF) is in place and drives Board discussions with a good understanding of assurance gaps and work progressing to address these. / good understanding of assurance, with limited gaps to address.	• The Health Board's Board Assurance Framework (BAF) is currently informed by the review and scrutiny of the Integrated Performance Dashboard and the Organisational Risk Register which are routinely reported to the Board and Committee meetings as outlined in the Risk Management Strategy. • Procurement process now complete to award contract to GGI to work in partnership with CTM in review of BAF (January 2022) & delivery of bespoke Board Development Programme (to March 2022). • The risk management improvement plan includes the actions to revise the approach to the Board Assurance Framework and separate Board Assurance Report. Anticipated to be finalised by January 2022. • Committee Highlight Reports received on the main agenda of the subsequent Board meeting for assurance and are presented by the Chair of each Committee. • Re-introduction of IM/Exec buddy walkabouts in Sept 2021 to support more formal sources of assurance.	**Internal Assurance** • Risk Management Strategy, Policy and Procedure available here: Policies - Cwm Taf Morgannwg University Health Board (nhs.wales) • Where issues escalated from committees, these are included in the Escalate' section of the Committee Highlight Report to the Board to promote discussion and wider scrutiny. • Organisational Risk Register updated regularly – see Board and Committee papers: Board Papers - Cwm Taf Morgannwg University Health Board (nhs.wales) Committees - Cwm Taf Morgannwg University Health Board (nhs.wales) **External Assurance** • Audit Wales Structured Assessment Report 2020 – received in the Audit & Risk Committee in October 2020. • Internal Audit Report on Risk Management February 2021 – Reasonable Assurance Rating. Draft/Final Internal Audit Report (nhs.wales) • Audit Wales Structured Assessment Report – Phase 2 – November 2021 – commented "We found that the Health Board has made good progress to improve risk management arrangements, although work to develop a Board Assurance Framework is still underway and needs to ensure that the risks to achieving strategic priorities are appropriately articulated.". This report will be received at the Audit & Risk Committee in December 2021 along with the Health Board's management response.
The Board committees are proportionate in their scrutiny of quality, resources, performance. With a committee responsible for scrutinising Quality and Safety reflecting the health boards Quality strategy and Quality and Safety framework, using sub-groups to improve oversight of Q&S across the whole organisation.	• Risks on the Organisational Risk Register are assigned to an "assuring" Committee and received at the respective Committee for detailed scrutiny and assurance. • Agendas for the Board and Committee meetings have been reviewed to reflect items under each of the new organisational strategic objectives to ensure balance. • Committee agenda planning meetings held - refer to current organisational risk register to inform key agenda items • IM Scrutiny Toolkit • Committee Highlight Reports on agendas presented by Committee Chairs to ensure more visibility over levels of scrutiny afforded at Committees • Committee Review deferred due to new Chair • Board Report Writing Training delivered routinely on a rolling programme – 70 staff trained as at Oct 2021 • Clinical Advisory Group (previously HPF) established and reporting routinely to Board • Clear signposting on CTM website when Board & Committee papers are published to allow questions and issues to be raised on any aspect of Board business.	**Internal Assurance** • Board Papers - Cwm Taf Morgannwg University Health Board (nhs.wales) Committees - Cwm Taf Morgannwg University Health Board (nhs.wales) 68 staff trained as at October 2021 on the Board Report Writing and Presenting Training. **External Assurance** • Audit Wales Structured Assessment Report 2020 – received in the Audit & Risk Committee in October 2020. • Structured Assessment (Phase 2) – Dec 2021 "The Health Board has effective Board and committee arrangements".

Section 5 – Governance

We want to be an organisation that has clear lines of accountability and responsibility. Governance and assurance systems are in place with performance issues escalated through clear structures. Any complaints, concerns or serious incidents that arise are managed in a timely way and we learn lessons from them.

See the following slides for how we're striving towards this:

Governance

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indicators of change

There are clear governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated appropriately through clear structures and processes. These structures and processes are regularly reviewed and improved, with cross directorate/locality organisational learning.	• Last governance review conducted in Dec 2019 with revised Committee structure in place.
	• Board Committee Effectiveness: There is a programme in place to ensure Committees of the Board review the following activity on an annual basis.
	  ○ Terms of Reference and Operating Arrangements
	  ○ Committee Effectiveness Annual Surveys
	  ○ Committee Cycle of Business
	  ○ Annual Committee Reports on Activity to the Board
	• Standing Orders and Standing Financial Instructions regularly updated and published on the Health Board's website.
	• Board Annual Self Assessment of its effectiveness undertaken during 2020-2021 including its compliance with the Corporate Governance code. Reported in the Annual Report for 2020-2021.
	• Board self assessment conducted Nov 2019 and Feb 2021 (Deloitte) showing marked improvement.
	• A training programme for Board and Committee Report Writing and Awareness sessions commenced in 2021 and continues to delivery monthly training to staff to support the improvement in quality of Board & Committee reports.
	• Committee review proposal deferred until 3 months post-appointment of new Chair, to align with new HB Strategic Objectives (CTM 2030)
	• Introduction of reflective practice following all Committee and Board meetings to aide continuous improvement of the management of meetings and Board business.
	• Learning Framework being established (due Jan 2022) to learn from good practice as well as claims, incidents, complaints and patient feedback.
	• Review of Operating Model undertaken (Dec 2021) will pick up on opportunities to strengthen cross ILG learning.
		• Audit Wales Structured Assessment 2020
		• HIW/AW Joint Follow-Up Report
		• David Jenkins Report
		• Annual Board self-assessment of effectiveness.
		• Committee self assessments and annual reports to Board.
		• CTMUHB Annual Report 2020-2021.
		• Standing Orders and SFI's – Published on Health Board's website.
		• 68 staff trained as at October 2021 on the Board Report Writing and Presenting Training. Testimonies:
		• "To be honest I found it all really helpful, particularly I found explanations around terminology useful as we tend to hear a lot of things talked about all the time but we don't quite like to ask what some of that terminology means. I enjoyed the tips on good report writing especially the do's and don'ts and really enjoyed other staff members sharing their experiences on what works well and what to avoid. I found the information around presenting a paper useful."
		• I found all aspects of the session insightful and informative, particularly the section regarding the accountability for decision making at Management Board and Committee level.
		• Also knowing that final QA responsibility rests with ILG and the exec sponsor will certainly focus my attention when I am QA'ing reports in future
		• I found the content of the session well balanced and the hints on distilling the report content to key milestone moments, and ensuring reference is made to solutions and next steps was very helpful – albeit challenging to condense into 4 pages max.
		
		• Qs included on each agenda to support reflective feedback;
		• "How did we do in this meeting?"
		• Is there anything we should do more or less of?
		• Have we managed our time well and allowed open and balanced discussion?
		• Have we considered our values and acted in a way that supports embedding our values across CTM?
		• Have we maintained a strategic focus?
		• Have we received sufficient assurance from a range of sources?
		• Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

Governance

1) 'Results'/ 'Maturity' definition benchmarks	2) Evidence of activity showing leading indicators of change	3) Evidence of outputs showing feedback / metrics – lagging indicators of change
The health board has clear lines of accountability and responsibility for quality and patient safety from Board to Division, Groups, Directorate. The form and function of the divisional/group/directorate quality and safety and governance groups are clearly defined and in place. Individual roles and responsibilities are supported by a clear meeting structure.	• There is an operating model in place which is closely monitored and will be reviewed in line with previous plans. • ILG structures are in place along with System groups with defined roles and responsibilities.	• Audit Wales Structured Assessment 2020 • HIW/AW Joint Follow-Up Report
Complaints and concerns are managed in a timely manner and provide / drive learning and information service planning	• Concerns/PTR transferred to DoG August 2021. • WRP Review commissioned to identify opportunities to improve claims management (due Nov 2021). • Internal Audit into Concerns to identify opportunities for improvement in concerns/redress management (due Nov 2021). • Listening & Learning Forum continues to meet with representation from each ILG and Corporate learning. • Learning Framework being developed (due Jan 2022). • Quality Improvement project underway with all key ILG stakeholders to review concerns management process and facilitate change ensuring alignment to IA and WRP recommendations. • Training regarding action planning and learning to be delivered as part of the new OfWCMS incident functionality implementation	• WRP Review Scope/Brief • Internal Audit Scope/Brief • Shared Listening & Learning Forum ToRs, minutes and presentations • Quality Improvement project • Incident functionality implementation with populated action points
All Serious Incidents are identified, reported and investigated. A culture of staff reporting patient safety incidents for learning and improvement is embedding / embedded across the health board	• Through the Quality Assurance (QA) of incidents the UHB is assured that action plans are relevant to the investigations, the actions are SMART and that they progress. Since December 20, every SI presented for closure has a QA internally in line with the QA tool previously shared with the DU. • The AMAT system is widely used and increasing in uptake with regard to monitoring progress from action plans. Audits can be generated to monitor compliance, learning and /or effectiveness. The central team are working with the Audit team to improve the interface between the two systems. The Datix Management Group retain this on the agenda to ensure progress is made and quality is maintained.	• Shared Listening & Learning TOR / Minutes • Targeted Intervention Risk Management Plan & Feedback from Risk Management Awareness Sessions • Datix Management Group TOR