Bundle Health Board Meeting 26 September 2019

4.1 Board - TI Presentation UHB 26 Sept 2019.pptx

4.2 Maternity Services Improvement Update

4.2 Maternity Services Board Report UHB 26 Sept 2019.docx

4.3 Health Board Patient Experience Report & Concerns (Complaints, Claims and Patient Safety Incidents) - Update on High-Risk Events

4.3 Patient Experience and Concerns UHB 26 Sept 2019.docx

4.4 Integrated Performance Dashboard

4.4 Performance Summary Board Report UHB 26 Sept2019.doc

4.4.1 Appendix 1 - Performance Dashboard

4.4.1 Appendix 1 Performance Dashboard UHB 26 Sept 2019.pdf

4.5 Workforce & Organisational Development Metrics Report

4.5 Workforce and OD Metrics UHB 26 Sept 2019.docx

4.6 Finance Report Month 5 (2019/20)

4.6 Finance Report Month 5 UHB 26 Sept2019.docx

4.7 Public Service Ombudsman for Wales - Annual Letter 2018/19

4.7 PSOW Annual Letter Response UHB 26 Sept 2019.docx

4.7.1 PSOW Annual Letter 2018 19

4.7.1 PSOW Annual Letter 201819 UHB 26 Sept 2019.pdf

4.8 Organisational Risk Register

4.8 Org Risk Register UHB 26 Sept 2019.doc

5 PART 5. COMMITTEE CHAIRS/CHAMPION REPORTS

(Please note these items will not be discussed unless raised with the Committee Chair in advance)

5.1 Reports from Committee Chairs and Board Committee Minutes

5.1 Committee Chairs Report CTMUHB 26 September 2019.doc

5.1.1 Confirmed Minutes FPW 25 July 2019

5.1.1 Confirmed Minutes FPW 25 July 2019 UHB 26 September 2019.doc

5.1.2 Chair's Summary Report FPW 19 September 2019

5.1.2 Chairs Summary Report FP&W 19 September 2019 UHB 26 Sept 2019.docx

5.1.3 Chair's Summary Report PCC 24 July 2019

5.1.3 Chairs Summary Report PCCC 24 July 2019.docx

5.1.4 Confirmed Minutes of Stakeholder Reference Croup 13 June 19

5.1.4 SRG Minutes 130619 UHB 26 Sept 2019.docx

5.1.5 Chairs Summary Report Stakeholder Reference Group 15 August 2019

5.1.5 Chairs summary Report SRG 15 Aug 2019 UHB 26 Sept 2019.docx

5.1.6 Confirmed Minutes QSR Committee 9 July 2019

5.1.6 confirmed Minutes QSR Committee 9 July 2019 UHB 26 Sept 2019.doc

5.1.7 Confirmed Minutes QSR Committee 5 August 2019

5.1.7 Confirmed Minutes QSR Committee 5 Aug 2019 UHB 26 Sept 2019.doc

5.1.8 Chairs Summary Report QSR 5 September 2019

5.1.8 Chairs summary Report QSR 5 September 2019 UHB 26 Sept 2019.doc

5.1.9 Health Care Professionals

5.1.9 Chairs Summary Report HPF 12 July 2019 UHB 26 Sept 2019.docx

5.1.10 Confirmed Minutes MHAMC 2 April 2019

5.1.10 Confirmed mins MHAMC 2.4.19 UHB 26 Sept 2019.doc

5.1.11 Chairs Summary Report MHAMC 6 August 2019

5.1.11 Chairs Summary Report MHAMC 6 August.doc

5.1.12 WHSSC Minutes

5.1.12 2019.06.28 JC Minutes (Public) UHB 26 Sept 2019.pdf

5.1.13 WHSSC Briefing

5.1.13 2019-07 JC Briefing v1.0 UHB 26 Sept 2019.pdf

5.1.14 Unconfirmed EASC Minutes 23 July 2019

5.1.14 Confirmed EASC minutes 23 July 2019 EASC 10 Sept 2019.pdf

5.1.15	SSPC Assurance Report 18 July 2019 5.1.15 SSPC Assurance Report 18 July 2019 UHB 26 Sept 2019.doc
5.1.16	Minutes of NHS Collaborative Leadership Forum 13 May 2019 5.1.16 LF-1909-01 - Minutes of CLF 130519 v1 - Approved UHB 26 Sept 2019.docx
6	PART 6. OTHER MATTERS
6.1	Any Other Urgent Business
6.2	Date of next Public Board Meeting - Thursday, 28 November 2019

HEALTH BOARD MEETING

Thursday 26 September 2019
Ynysmeurig House, Abercynon
2.00pm

AGENDA

		Lead / Attachment	**Timings**
PART 1. PRELIMINARY MATTERS			
1.1	In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960 it has been resolved that representatives of the press and other members of the public are excluded from the first part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting has been held in private session.	Chair / Oral	
1.2	Welcome and Introductions	Chair / Oral	2pm
1.3	Apologies for Absence	Chair / Oral	2pm
1.4	Declaration of Interests	Chair / Oral	2:05pm
1.5	Unconfirmed Minutes of : • the meeting of the Health Board held on 31 July 2019	Chair **Attachment**	2:05pm
1.6	Action Log	Chair **Attachment**	2:10pm
1.7	Matters arising, not considered within the Action Log	Chair / Oral	2:15pm
The Patient Story: https://youtu.be/vEbICxlpAtM			
Part 2. CHAIR AND CHIEF EXECUTIVE REPORTS			
2.1	Chair's Report & Affixing of the Common Seal	Chair **Attachment**	2:30 – 2:35pm

2.2	Chief Executive's Report	Chief Executive **Attachment**	2:35 – 2:45pm
Part 3. ITEMS FOR APPROVAL / ENDORSEMENT			
3.1	Sexual Assault Referral Centres	Director of Nursing, Midwifery & Patient Care **Attachment**	2:45 - 2:55pm
3.2	Framework for Developing the Integrated Medium Term Plan (IMTP) for 2020-2023	Director of Planning & Performance **Attachments**	2:55 -3.05pm
3.3	Adult Thoracic Surgery for South Wales	Chief Executive **Attachment**	3.05 -3:10pm
3.4	Values and Behaviours	Director of Workforce and OD **Attachment**	3:10 – 3:20pm
Part 4. GOVERNANCE, PERFORMANCE AND ASSURANCE			
4.1	Targeted Intervention Update	Chief Executive **Presentation**	3:20 – 3:30pm
4.2	Maternity Services Improvement Update	Director of Nursing, Midwifery & Patient Care **Attachment**	3:30 – 3:40pm
4.3	Health Board Patient Experience Report & Concerns (Complaints, Claims and Patient Safety Incidents)	Director of Nursing, Midwifery & Patient Care **Attachment**	3:40 – 3:50pm
4.4	Integrated Performance Dashboard	Director of Planning & Performance **Attachment**	3:50 – 4:00pm
4.5	Workforce & Organisational Development Metrics Report	Director of Workforce & OD **Attachment**	4:00 – 4:10pm
4.6	Finance Report Month 5 (2019/20)	Director of Finance & Procurement **Attachment**	4:10 – 4:20pm
4.7	Public Service Ombudsman for Wales – Annual Letter 2018/19	Director of Nursing, Midwifery & Patient Care	4:25 – 4:35pm
4.8	Organisational Risk Register	Director of Governance / Board Secretary **Attachment**	4:35-4:50pm
Part 5. COMMITTEE CHAIRS / CHAMPION REPORTS			
5.1	Reports from Committee Chairs and Board Committee Minutes	Chair **Attachments**	4:50 – 4:55pm
Part 6. OTHER MATTERS			
6.1	Any Other Urgent Business	Oral	
6.2	Date of next Public Board meeting		

	Thursday 28 November 2019, 2:00pm	

MINUTES OF THE CWM TAF UNIVERSITY HEALTH BOARD MEETING HELD ON WEDNESDAY 31 JULY 2019, IN YNYSMEURIG HOUSE, NAVIGATION PARK, ABERCYNON

PRESENT:

Marcus Longley	– Chair
Sharon Hopkins	– Chief Executive (Interim)
Maria Thomas	– Vice Chair
Alan Lawrie	– Director of Primary, Community & Mental Health Services (In part)
Anne Phillimore	– Interim Director of Workforce & OD
Giovanni Isingrini	– Associate Member (In part)
Greg Dix	– Director of Nursing, Midwifery & Patient Care
James Hehir	– Independent Member
Jayne Sadgrove	– Independent Member
Kelechi Nnoaham	– Director of Public Health
Mel Jehu	– Independent Member (In part)
Nicola Milligan	– Independent Member
Paul Griffiths	– Independent Member
Phillip White	– Associate Member
Stephen Harrhy	– Board Director
Steve Webster	– Director of Finance

IN ATTENDANCE:

David Jenkins	– Independent Support to CTMUHB Chair
John Beecher	– Chair Cwm Taf Morgannwg Community Health Council (In part)
Cathy Moss	– Chief Officer, Cwm Taf Morgannwg Community Health Council (In part)
Cathy Madge	– 'Women Lead the Board' Training Programme (Observing)
Martin Turner	– Independent Member, Welsh Ambulance Services Trust (Observing)
Kath McGrath	– Deputy Chief Operating Officer/Assistant Director Medicine
Ruth Alcolado	– Deputy Medical Director
Julie Keegan	– Assistant Director Commissioning
Melanie Harries	– Delivery Unit
Nathan Couch	– Wales Audit Office (Observing)
Tim Burns	– Assistant Director Capital & Estates (In part)
Gwenan Roberts	– Head of Corporate Services
Felicity Waters	– Head of Communications & Media Management
Emma Walters	– Corporate Governance / Committee Secretariat

HB/19/084 **WELCOME AND INTRODUCTIONS**

The Chair **welcomed** everyone to the meeting including David Jenkins, Sharon Hopkins Chief Executive (Interim), John Beecher and Cathy Moss, Cwm Taf Morgannwg Cwm Health Council, Melanie Harries from the Delivery Unit, Cathy Madge from 'Women Lead the Board', Martin Turner from the Welsh Ambulance Services NHS Trust and Nathan Couch from the Wales Audit Office.

HB/19/085 **APOLOGIES FOR ABSENCE**

Apologies for absence were **received** from Dilys Jouvenat, Ian Wells, John Palmer, Kamal Asaad, Keiron Montague, Robert Williams, Ruth Treharne and Suzanne Scott-Thomas.

HB/19/086 **DECLARATIONS OF INTEREST**

There were none.

HB/19/087 **UNCONFIRMED MINUTES OF THE HEALTH BOARD MEETING HELD ON 30 MAY 2019**

Members **APPROVED** the minutes of the Health Board meeting held on 30 May 2019, as a true and accurate record, subject to the following amendments:

- Page 4 – References made to 2017/18 accounts to be changed to 2018/19 accounts;
- Page 10 – Resolution to be changed to 'The Board **RESOLVED** to: **NOTE** the position of *Cwm Taf Morgannwg* University Health Board against its responsibilities to report under section 25E of the Act'

HB/19/088 **ACTION LOG**

Members **RECEIVED** and **NOTED** the Action Log.

Page 2, Board Assurance Framework
Gwenan Roberts advised that the August Board Development Session would include a focussed discussion on Risk Management to influence the further development of the Board Assurance Framework.

Page 4, Patient Experience Report
Alan Lawrie confirmed that information on the Child and Adolescent Mental Health Services (CAMHS) had been provided to the Community Health Council.

Page 4, Workforce Metrics
Anne Phillimore advised that the review of mandatory training for staff was a significant area of work and would provide a date for anticipated completion with Gwenan Roberts.

Page 4, Welsh Language
Anne Phillimore advised that the Local Authority would be unable to assist the Health Board with Welsh Language translation and advised that this action could now be closed.

HB/19/089 **MATTERS ARISING**

There were no matters arising.

HB/19/090 **CHAIRS REPORT AND AFFIXING OF THE COMMON SEAL**

Marcus Longley presented the report and made Members aware of one factual error contained on page 3 of the report. Members **NOTED** that the Director of Therapies and Health Sciences would commence on 1 November 2019 and not October as stated within the report. Members **NOTED** that the new Medical Director would commence in September.

The Board **RESOLVED** to:

- **NOTE** the report
- **ENDORSE** the Affixing of the Common Seal to:
- **Reference :** Charity Commission
  The Audit Committee received information that the written consent had been received from the Charity Commission for the proposed changes to amend the objects of the charitable funds. The effective date for this change would be 1 April 2019 and the proposed change would need to be formally accepted by the Charity Commission prior to utilising this fund.

HB/19/091 **CHIEF EXECUTIVES REPORT**

The Chief Executive (Interim) provided an oral update.

Sharon Hopkins provided a brief overview of the work to date and the areas that were currently being addressed; these would be presented to Board in due course. Work included Targeted Intervention and Paediatrics Services move. Members were advised of the need to understand the learning that has been identified following the work undertaken on Maternity Services and how this applied to the rest of the organisation in terms of quality and governance.

Members **NOTED** that consideration would need to be given as to the shape of the new Cwm Taf Morgannwg University Health Board with staff being given the opportunity to share their views as to how the new organisation could be developed. Members **NOTED** that work on the organisation's Values and Behaviours would commence in the Autumn.

Sharon Hopkins advised that a framework would be developed which promoted the Health Board as an organisation that focussed on population health, supported by secondary care. Members **NOTED** the importance of the supporting structures which would need to be finalised quickly to enable the Health Board to undertake its business. Members **NOTED** that the consultation on the Clinical and Management Structures completed in July and further refinements and comments would be sought during August.

Members **NOTED** that there would be a significant amount of work to undertake in relation to improving the Quality Governance in CTM, with more work required to address skills gaps and staff empowerment issues.

Sharon Hopkins advised that there would be specific service fragilities that would require significant programmes of work to be put into place, most of which were as a result of national issues as opposed to local issues, for example medical recruitment.

Targeted Intervention

Members **NOTED** that areas of focus included the Nurse Staffing Level (Wales) Act 2016, the Human Tissue Authority (HTA) report and issues experienced in relation to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Members **NOTED** that the immediate issues for HTA and IR(ME)R had now been signed off by the relevant regulator.

In relation to quality governance, which included the Health Board's approach to concerns and reporting of serious untoward incidents, Welsh Government had requested that the Health Board focussed on four broad areas, which included Governance, Leadership & Culture and Quality. Members **NOTED** that these were significant areas of work and the Health Board was working with Welsh Government to identify which elements were in Targeted Intervention and the elements which would be business as usual.

Paediatric Service Moves

Members **NOTED** that the paediatric service moves were linked to the outcome of the South Wales Programme and that there was a need to ensure there were quality sustainable services in place across multiple sites, taking into consideration the issues being experienced with medical staff recruitment. Members **NOTED** the agreement previously made to consolidate paediatrics services on one single site (Prince Charles Hospital) with the initial anticipated date for the consolidation of services being either a July/September 2019 date.

Members **NOTED** that this was no longer felt to be feasible given some of the quality and safety issues that now needed to be addressed prior to the move taking place, with a revised proposed date for the move now being September 2020. Members **NOTED** that this would enable the links with other services to be addressed, for example, the inpatient paediatrics service links with Accident & Emergency department at the Royal Glamorgan Hospital. Members **NOTED** that a structured programme of work would now be put into place to ensure the moves take place by September 2020.

Members **NOTED** that work would need to be undertaken in relation to engaging with key stakeholders and members of the community. A number of conversations would need to take place regarding the remainder of services highlighted within the South Wales Programme. Sharon Hopkins advised that she would cascade a formal note on this matter in due course (**Added to the Action Log**).

In response to a question raised by Paul Griffiths regarding the anticipated timescales for the key pieces of work, Sharon Hopkins advised that timelines would vary for each programme, with the anticipated timeline for the values and behaviours programme of work being about 4-6 months. Members **NOTED** that this would commence in the autumn and would then need to be embedded throughout the organisation.

Maria Thomas sought assurance that a sustainability plan was in place for Paediatrics Services as a result of the deferred date of the move and the medical staffing issues. Ruth Alcolado advised that there would be a sustainable staffing plan in place leading up to the September 2020 move. In response to a question raised by John Beecher regarding whether any outcomes had been prescribed in the process of developing the plan, Ruth Alcolado advised that outcomes had been considered, the main relating to the provision of a sustainable and safe service.

Members **NOTED** that the pilot undertaken of the Paediatrics Assessment Unit identified that the majority of paediatric admissions did not require an overnight stay and could be managed on a more ambulatory basis.

Greg Dix advised that in recognition that the moves were going to take place in June, the Health Board now had a deficit of Paediatric Nurses across Royal Glamorgan Hospital. Members **NOTED** that work was now being undertaken with other Health Boards regarding the introduction of a rotation programme to assist with recruiting sufficient staff.

Marcus Longley asked what would happen if services could not be sustained up until September 2020. Ruth Alcolado advised that the position would need to be revisited, options would include a potential collapse of the services to Royal Glamorgan Hospital.

The Board **RESOLVED** to:

- **NOTE** the update provided

HB/19/092 **INTEGRATED MEDIUM TERM PLAN (IMTP) 2019 – 2022 PUBLIC FACING SUMMARY DOCUMENT**

Julie Keegan presented the report which presented the public facing summary of the Health Board's Integrated Medium Term Plan 2019-22 for approval. Members **NOTED** that the summary had been reviewed by the Community Health Council and members of the Stakeholder Reference Group.

The Board **RESOLVED** to:

- **NOTE** the contents of the summary.
- **APPROVE** the Public Facing Summary of the IMTP 2019 – 2022.

HB/19/093 **CARERS ANNUAL REPORT 2018/19**

Marcus Longley advised that he had held a conversation with a member of the public who attended the Annual General Meeting earlier today who raised some questions as to how the Health Board were engaging with carers.

Greg Dix presented the Annual Report for 2018/19 which was seeking approval for submission to Welsh Government which related to the implementation of the Cwm Taf Carers Strategy for 2016-19. Members **NOTED** that the report described the Health Board's approach to working with carers and that the draft Annual Report had been submitted to Welsh Government in May.

Greg Dix advised that work had now commenced on the 2019/20 plan and that there were many carers within the communities who were known to the Health Board. Marcus Longley asked how the Health Board knew what role carers undertook and advised that the member of the public who attended the AGM had been quite impressed as to how he had been able to express his views within the former Abertawe Bro Morgannwg University Health Board (ABMUHB).

Greg Dix advised that the work undertaken across the Health Board by partners and stakeholders was incredible and advised that there were many mechanisms in place to enable the Health Board to engage with carers; his previous experience in England highlighted that young carers needed a significant amount of additional support.

Phillip White advised that within ABMU, the work being undertaken around carers had been closely linked into the Regional Partnerships Board which was a good vehicle to drive the work forward. Gio Isingrini advised that Carers Champions had been identified within the Health Board with Carers Conferences also being held. Maria Thomas added that work had been commissioned by third sector partners with Carers representatives attending a number of groups and forums within the Health Board.

The Board **RESOLVED** to:

- **NOTE** the contents of this report and that the Annual Report was also being submitted for approval by the Cabinets in Merthyr Tydfil and Rhondda Cynon Taf CBCs.
- **APPROVE** the Annual Report for submission to Welsh Government.

HB/19/094 **ESTATES ANNUAL REPORT**

Tim Burns, Assistant Director Capital & Estates was in attendance for this item.

Tim Burns presented the Annual Estates Report for 2018/19 which highlighted achievements, risks, performance, governance and challenges relating to the estate.

Members **NOTED** that legacy information had been provided to the Health Board from the former ABMUHB which identified that the legacy backlog was circa £20m plus in the Bridgend area. Members **NOTED** that the report highlighted that the Health Board had increased by another 17 properties.

Members **NOTED** that performance had been sustained during 2018/19 with the risk adjusted backlog being sustained at £5m, which excluded the cost of the Ground & First Floor works at Prince Charles Hospital.

Members **NOTED** that Estates operating performance had improved year on year with 7,000 jobs per month being undertaken through the helpdesk. Members **NOTED** that in relation to energy, there had been an increase in unit costs for gas and electricity. Members **NOTED** that the opening position for the capital programme allocation had been £13.8m with the final position being £27m.

Members **NOTED** that achievements included the completion of the phase 1 Ground & First Floor works at PCH, the securing of Macmillan funding and the recertification of Internal Standards Organisation (ISO).

Members **NOTED** that work was being undertaken on the second phase of electrical works, with the main areas of challenge being at the Princess of Wales Hospital, Bridgend.

Phillip White made reference to the 3% target which had been directed by Welsh Government and the 6 detailed projects; he asked whether this target could be achieved. Tim Burns advised that a contract had been assigned and that Welsh Government had now deferred the projects until 2021. Members **NOTED** that monthly meetings were being held with Welsh Government.

Paul Griffiths advised that he felt the report lacked balance and suggested it had been successful in identifying the positive achievements but lacked detail regarding some of the challenges and advised he would like to see a more balanced report in the future. Sharon Hopkins advised that the main reason for the report was to try and identify a collective overview of Estates issues and would be happy to discuss the purpose of the report further with Ruth Treharne. Maria Thomas suggested that consideration may need to be given as to which forum the report should be presented to.

Maria Thomas advised that in relation to the POW site, it appeared that there was a significant backlog of work that needed to be undertaken with a number of fire risks that would need to be addressed, and questioned what the programme of work was in order to develop a Business Case. Tim Burns advised that in relation to fire risks at POW Members **NOTED** that work was being undertaken to make the alarm system as safe as possible in the shortest time. Members **NOTED** that the Executive Capital Management Group had approved investment for fire panels to be installed on the POW site in order that changes could be made at pace.

Sharon Hopkins advised that the report being presented related to the last year, with a number of issues now being identified on Estates for this year. Members **NOTED** that any further issues would be presented into various relevant Committees and Board would be sighted on any issues if it was felt necessary.

Marcus Longley asked whether the Princess of Wales Hospital was safe and Sharon Hopkins advised that further discussion linked to the risk appetite discussion for the Board would be held at the August Board Development Session; Members **NOTED** that the Estates Team would continue to work through the programme to address the issues in priority order with safety for patients and staff being key.

John Beecher advised that concerns had been raised with the Community Health Council (CHC) regarding signage at hospital sites with some patients experiencing problems in accessing the right departments at the right time. Tim Burns agreed to look into this matter.

Sharon Hopkins extended her thanks to Tim Burns and the Estates Team for all of the work they were undertaking which was significant and challenging.

The Board **RESOLVED** to:

- **APPROVE** the Estates Annual Report for 2018/19.

HB/19/095 **OVERARCHING PARTNERSHIP AGREEMENT FOR ADULT AND OLDER PEOPLES SERVICES**

Alan Lawrie presented the report which provided the Board with an update on the Bridgend County Borough Council and Cwm Taf Morgannwg University Health Board Overarching Partnership Agreement for Adult and Older Peoples Services (Section 33).

Alan Lawrie reminded Members that a brief discussion had been held at the Board meeting in March regarding three Section 33 agreements which related to Bridgend and included ARC, the Community Equipment Store and Intermediate Care Services. Members **NOTED** that Section 33 agreements allowed integrated teams to work in a very effective way across organisational boundaries and were legally binding obligations. Members **NOTED** that the services included in the agreement were:

- Short Term Assessment and Re-abling Team (Bridgestart and Community Reablement)
- Bryn y Cae Reablement Unit
- Acute Clinical Team

Members **NOTED** the series of outcomes and measures expected to be achieved outlined within the report and the governance arrangements that had been put into place.

The Board **RESOLVED** to:

- **ENDORSE** the content of this report and **SUPPORT** the Section 33 being signed for a further 3 years.

HB/19/096 **VALUES AND BEHAVIOURS**

Anne Phillimore presented the report which highlighted the work to develop a set of organisational values and behaviours for the new Cwm Taf Morgannwg University Health Board; the proposed methodology to develop them; and the potential benefits to the organisation, our people, and the population served.

Members **NOTED** that the report had been developed as a result of the Bridgend Boundary Change and the reports received from the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives. Members supported that Values and Behaviours would need to be addressed in order to underpin the development of the new organisation, with a rebuilding of trust required with partners, stakeholders and people within our communities.

Members **NOTED** that two separate approaches had been followed in the two previous organisations, with the development of a clear set of values in the former Abertawe Bro Morgannwg (ABMUHB) which had been heavily engaged on with the staff and *Cwm Taf Cares* in Cwm Taf UHB which had a very simple and powerful message but had not been developed in the same way. Anne Phillimore advised that the engagement sessions held with the staff in Bridgend had identified that developing new Values and Behaviours had been considered to be a positive approach. Members **NOTED** the proposal to adopt the approach followed in the former ABMUHB.

Members **NOTED** that the work would take approximately six months to undertake with a potential cost of £100k for the programme to be delivered. Marcus Longley welcomed the report and advised that this was a fundamental area of work. Nicola Milligan added that this work was closely aligned to the work being undertaken on bullying, harassment and abuse. James Hehir advised of the need to ensure this work was patient centred as this would help to restore the trust and confidence in the services being provided. Jayne Sadgrove echoed the comments made and advised that this was a fundamental area of work that would have needed to be undertaken as soon as possible.

John Beecher advised that the whole principle underpinning the work related to leadership, inclusivity and engagement and advised that he would be interested to see how this work would develop and how people and the CHC would be included in the process.

The Board **RESOLVED** to:

- **ENDORSE** the principle of developing a clear set of organisational values and behaviours for the new Cwm Taf Morgannwg University Health Board
- **ENDORSE** the proposed approach to developing these values and behaviours.

HB/19/097 **ORGANISATIONAL RISK REGISTER**

Gwenan Roberts presented the report the purpose of which was for the Health Board Members to review and discuss the organisational risk register and consider whether the assessed and recorded risks were appropriately assigned across the Committees of the Board. Members **NOTED** that the Organisational Risk Register was last considered by the Health Board in January 2019 and by the Quality Safety and Risk Committee and Executive Board in June 2019.

Members **NOTED** that all risks were being received quarterly by each Committee and each risk had been updated by all lead Executive Directors. Members **NOTED** that a discussion on the risk register would be held at the August Board Development Session and there would be a need to have a CTMUHB approach to the organisational risk register.

Nicola Milligan suggested that in relation to the risk regarding the failure to recruit, the issues relating to retention of staff also needed to be captured within this risk. Gwenan Roberts advised that there were a number of similar risks which would need to be connected together.

Paul Griffiths made reference to Risk 13, the Implementation of South Wales Programme Outcomes and questioned whether the correct score had been allocated to the risk and what the latest position was in relation to the South Wales Programme implementation. Sharon Hopkins advised that a review of all risks would need to be undertaken at the August Board Development Session with a refresh required of the risk register for Cwm Taf Morgannwg University Health Board.

Alan Lawrie advised that the risk register currently reflected the former Cwm Taf University Health Board area and Members **NOTED** that there were now Clinical Directorate Risk Registers in place which covered the whole of Cwm Taf Morgannwg.

Marcus Longley advised that he felt there were some risks which were not represented, including risks relating to staff engagement and risks associated with Transformation proposal bids. Maria Thomas advised that a discussion on transformation proposals had taken place at the Regional Partnerships Board where it was felt that the delivery of the plans was an important risk to recognise.

Stephen Harrhy advised that the key element within this work was the link to the strategic objectives and further discussion would need to be held as to how this could be framed. Careful consideration would need to be given as to which risks would need to be added to the register.

Steve Webster advised that consideration was being given to reconfiguration of the finance risks and advised of the need to plan the focus of the discussion at the August Board Development session. Members **NOTED** that external support had been secured to assist with the discussions.

Members **RESOLVED** to:

- **NOTE** the update provided within this report and the risks assigned to the Board and its Committees; and
- **ENDORSE** the updated risk register and the assignment of risks.

HB/19/098 **UPDATE ON MATERNITY SERVICES**

Greg Dix presented the report which provided the Board with an update on Maternity Services and included an update on actions taken since the last Board meeting and the known related implications of the special measures arrangements to date which were summarised in the report.

Members **NOTED** that a significant amount of work had been undertaken since the last Board meeting, with an extensive action plan put into place and a themed improvement programme which was being led by colleagues across the organisation. Members **NOTED** that progress would be reported at the Maternity Improvement Board.

Members **NOTED** that the first formal scrutiny meeting with the Independent Maternity Services Oversight Panel (IMSOP) had taken place on the 22 July 2019 and had been attended by Greg Dix and Ruth Treharne. Greg Dix advised that the discussion had been appropriately challenging regarding the delivery over the last 6 months with some positive feedback also received. Members **NOTED** that it was felt that pace was required in relation to the cultural elements and support was being provided by the Workforce & OD Team.

Members **NOTED** that there had been some success regarding the recruitment of midwives with 20 midwives secured to work across Prince Charles Hospital and Princess of Wales Hospital. Greg Dix advised that not all midwives had opted for Cwm Taf Morgannwg as their first choice organisation and advised that there would be a need to ensure that all midwives were being fully supported through a preceptorship programme.

In relation to the experience of women using the service, the majority of women were having a positive experience, with some women reporting poor experiences which were predominantly by night. Greg Dix advised that regrettably, a small proportion of midwives had exhibited behaviour which was not aligned to their professional code of conduct; Members **NOTED** that this had been challenged with an expectation that this would not recur, this would be closely monitored. Members **NOTED** that during the last two weeks the women surveyed had told of positive experiences which provided some level of assurance.

Members **NOTED** that work was being undertaken with the Team to undertake a review of risks within Maternity and a workshop had been arranged for the 12 August to discuss the development of an outcomes framework which would contain key indicators that would be measured. Marcus Longley referred to page 7 of the report which stated that there had been a delay in undertaking the clinical reviews. Greg Dix advised that an exercise had been undertaken to reconcile the lists of women who had contacted the Health Board and or Welsh Government which was now complete. This work would now assist the Independent Maternity Services Oversight Panel (IMSOP) to undertake a review of the database to ensure all women who had raised concerns had been captured.

Marcus Longley made reference to the number of incidents reported each month and questioned whether there was a benchmark which the Health Board could compare itself against as to whether the number of incidents were higher or fewer than expected. Greg Dix advised that the increase seen in the number of incidents could be seen as a positive indicator and advised that whilst there was an increase in the number of incidents reported, there were no serious incidents. Members **NOTED** that there was a National Reporting and Learning System in place which the Health Board could use to benchmark across the UK. Members **NOTED** the error contained on page 8 of the report regarding the number of incidents reported, the amended number were highlighted as 135 as opposed to 118.

Stephen Harrhy advised that he found the report to be helpful and suggested that it would be useful if it could be identified within the action plan as to what Board decisions would be required moving forward.

Greg Dix advised that the improvement programme continued to be developed by the Maternity Improvement Board and that any issues requiring approval would be presented to Quality, Safety & Risk Committee prior to discussion with the full Board.

Paul Griffiths advised that he had been encouraged by the report and the update presented and asked whether there was a detailed plan behind the schedule of actions which identified when actions would be completed. Greg Dix advised that the work in maternity was a continuous journey of improvement with some actions that could be easily timed and some of which would be ongoing actions. Greg Dix advised that he would welcome any guidance from Board Members regarding the presentation and content of the action plan. Sharon Hopkins recognised that it would be incredibly difficult to put timeframes against all of the programmes of work and suggested that a further discussion be held outside of the Board regarding finding the right balance.

Giovanni Isingrini left at 15.40pm.

Members **NOTED** that 'You Said We Did' signs had now been displayed across the Maternity Units and key messages of the week were also being distributed. Ruth Alcolado advised that feedback was being received from Health Education and Improvement Wales (HEIW) regarding trainees experience and the feedback received indicated that the training experience had improved over the last four months.

The Board **RESOLVED** to:

- **NOTE** the report.

HB/19/099 **PATIENT EXPERIENCE REPORT**

Greg Dix presented the report which provided the Board with a summary of the the service user feedback obtained via the Patient Advice and Liaison Service for Quarter 1, April to June 2019.

Members **NOTED** that the Team had tried to include more data analysis within the report and it had been recognised that there was currently an inconsistent approach of capturing patient user feedback, with a range of methodologies being used.

Members **NOTED** that work was being undertaken at an All Wales level as to how real time feedback could be obtained from patients, with the Friends and Family test introduced by Swansea Bay UHB being considered by the All Wales Group.

Members **NOTED** the proposal contained within the new Quality & Patient Safety Governance Framework to introduce a Patient Experience Forum, with the first meeting being held on the 21 August 2019 where options would be discussed for a local framework for Assuring User Experience in CTMUHB. Members **NOTED** that the outcomes of these discussions would be reported back to Board in due course.

Following discussion, Members supported the work being undertaken and **NOTED** the need for strong informatics systems and analytical support that would need to be in place.

The Board **RESOLVED** to:

- **NOTE** the report.

HB/19/100 **CONCERNS (COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS) – UPDATE ON HIGH RISK EVENTS**

Greg Dix presented the report which provided the Board with a summary of high-risk concerns since the last report to Board on 30 May 2019. Members **NOTED** that the Health Board had received All Wales guidance which had been issued by the Welsh Risk Pool as to the definitions of what would be classed as a complaint and what would be classed as a Patient Advice and Liaison Service (PALS) enquiry.

Members **NOTED** the increase in formal complaints contained on page 4 of the report which largely related to the addition of Bridgend complaints following the Bridgend Boundary Change. Members **NOTED** that enquiries which were being held for more than 2 days were now being included within the formal complaints remit. Members **NOTED** that work was being undertaken with the Team to improve the 30 day response rate which had deteriorated as a result of the increase in formal complaints being received.

Members **NOTED** that a significant reduction had been seen in the number of Serious Incidents, with 109 being received in Quarter 3, 58 in Quarter 4 and 66 in Quarter 1. Members **NOTED** that the reduction seen in Quarter 4 was as a result of the change to the reporting of pressure ulcers. Stephen Harrhy made reference to the variation in the numbers of complaints received regarding communication, with 36 being received for Princess of Wales Hospital compared to 5 at Prince Charles Hospital and 8 at Royal Glamorgan Hospital. Greg Dix advised that he had asked for a review to be undertaken as to the reasons behind this.

The Board **RESOLVED** to:

- **NOTE** the report.

HB/19/101 **PERFORMANCE DASHBOARD**

Julie Keegan presented the Performance Dashboard report which provided the Health Board with a summary of current performance across a range of indicators and key issues, in particular where there are current organisational challenges and achievement and/or the organisation is under formal escalation with the Welsh Government.

Members **NOTED** that the report had been discussed in detail at the Finance, Performance & Workforce Committee and **NOTED** that there was still variation of reporting of data in place between Cwm Taf Morgannwg/former Cwm Taf/Bridgend.

In relation to Referral to Treatment Time Targets (RTT), there had been a deterioration in performance which was likely to deteriorate further in July. Members **NOTED** that the Health Board would start to reporting patients that had not been reported previously and **NOTED** that the Delivery Unit were assisting the Health Board in addressing the position. The unreported waiting lists would be included in the next report and further clarity was being awaited on some lists as to whether or not they should be reported.

In relation to Diagnostics, the Health Board was meeting the trajectory. Members **NOTED** that there were still issues in Endoscopy which was reporting 1,300 patients waiting over 8 weeks and the Directorate was working to address the position.

In relation to Follow up Outpatients not Booked, work was continuing to be undertaken across all specialities using different approaches. Members **NOTED** that a reduction was being seen with plans in place in each specialty area to reduce further.

Kath McGrath advised that in relation to Unscheduled Care, there had been a difficult start to the year in relation to performance, with all 3 sites experiencing different areas of challenge, with RGH being heavily reliant on locums. The Delivery Unit were working with the Health Board to review systems and processes in place, particularly at PCH.

Members **NOTED** that in relation to Cancer Breaches, there had been a reduction in performance particularly in Urology and Lung. Kath McGrath advised that this was very unusual with some issues experienced with Endobronchial Ultrasound Bronchoscopy (EBUS) delays at Cardiff & Vale University Health Board. Paul Griffiths supported the discussion held and confirmed that a detailed discussion had been held at the Finance, Performance & Workforce Committee.

Members **NOTED** that a suggestion had been made at the last meeting for a summary of the issues to be developed and included at the start of the report. Paul Griffiths added that consideration would need to be given as to how the discussions held at Finance, Performance & Workforce could be cascaded appropriately to the Board.

Jayne Sadgrove made reference to page 7 of the report regarding the HMRC restrictions that had recently been reported in the media which impacted on the willingness of clinicians to undertake additional sessions. Jayne Sadgrove questioned how much of an impact this was having on the organisation and were there any financial implications to having to employ more locums.

Anne Phillimore advised that information had been shared with Steve Webster regarding the latest analysis of the impact on Waiting List Initiatives. Members **NOTED** that this was having an impact as Consultants were no longer wishing to undertake additional sessions. Members **NOTED** that the Consultation Document published in England had been criticised as it only referred to how this would impact on the Consultant workforce as it would also have an impact on Senior Managers and Nurses. Members **NOTED** that issues were being discussed with Welsh Government who were discussing further with the UK Government. Members **NOTED** that this was having a significant impact across the whole of the NHS in England and Wales.

Steve Webster advised that there were a number of solutions which could be considered, one being outsourcing which there was no resource for within the Health Board's plan.

Following discussion the Board **RESOLVED** to:

- **NOTE** the Integrated Performance Dashboard, this report and performance actions outlined to support the achievement of targets
- **NOTE** the work underway on the new integrated referral to treatment and diagnostic trajectories, building on those already agreed and set in the IMTP for the former Cwm Taf area
- **NOTE** the work underway with the Delivery Unit on a number of potentially unreported waiting lists areas and on unscheduled care in PCH, including the terms of reference for the associated Delivery Unit Reviews.

HB/19/102 **WORKFORCE AND ORGANISATIONAL DEVELOPMENT METRICS**

Anne Phillimore presented the report which provided an update on the key workforce metrics for May/June, with historic trends shown as appropriate. Members **NOTED** that the report had also been discussed at the Finance, Performance & Workforce Committee.

Members **NOTED** that although there had been a decrease in sickness absence in month, there had been an increase in overall sickness absence and the Health Board was now an outlier compared to the rest of Wales.

Members **NOTED** that additional support was being introduced into the Occupational Health Service with some difficulties being experienced with the Cohort system which impacted on the service.

Nicola Milligan made reference to the number of staff that had reportedly left the Health Board because of difficulties in obtaining a work life balance and advised that this was a significant number of staff when you consider the number of current whole time equivalent vacancies at PCH was 77. Anne Phillimore advised that a further review of this would need to be undertaken as the information recorded had been gathered by Managers and not the Workforce & OD team and advised that and update would be provided at a future meeting (**Added to Action Log**).

The Board **RESOLVED** to:

- **NOTE** the contents of the report.

HB/19/103 **MONTH 3 FINANCE UPDATE**

Steve Webster presented which highlighted the key messages in relation to the Month 3 financial position.

Members **NOTED** that there were risks in place relating to RTT performance; pensions and savings shortfalls were currently being covered by reserves which was making the Health Board vulnerable. Members **NOTED** that the Health Board was still awaiting the outcome of the Bridgend arbitration which also posed as a level of risk.

Members **NOTED** that key issues discussed at the Finance, Performance & Workforce Committee included:

- Savings – Concern was raised in relation to nursing pay expenditure and the Committee requested that a financial deep dive was undertaken in this area
- Princess of Wales (POW) – Concern was raised at the number of issues that were arising following the transfer which would have an impact on the full year effect. A deep dive would also be undertaken on POW and presented to a future Committee meeting
- The recurrent concern being greater than the in-year concern.

Members **RESOLVED** to:

- **NOTE** the Month 3 Finance Report.

HB/19/104 **INTEGRATED MEDIUM TERM PLAN 2019-2022 QUARTER 1 ACCOUNTABILITY REPORT**

Julie Keegan presented the report which provided an update on the progress made in implementing Cwm Taf Morgannwg Health Board's Integrated Medium Term Plan (IMTP) 2019-22 in the first Quarter of 2019/20 (April 2019 – June 2019).

Members **NOTED** that in a change from previous reports, and as required by Welsh Government, this report was directly in relation to the accountability conditions set out in the Health Board's 2019/20 Welsh Government Accountability letter.

Members **RESOLVED** to:

- **NOTE** the progress made against the Plan in Quarter 1 of 2019/20.
- **NOTE** the report which has been submitted in compliance with Welsh Government deadlines.

HB/19/105 **WINTER PLANNING EVALUATION REPORT 2018/19 AND PREPAREDNESS FOR WINTER 2019/20**

Kath McGrath presented the report which provided the University Health Board (UHB) with an evaluation of the robustness of the winter plan for 2018/19 and set out the next steps to ensure that lessons were learnt in readiness for next year.

Members **NOTED** that the plan had been developed with key partners and that even though the winter period had been less challenging, with no periods of adverse weather, the spring period had been more challenging.

Members **NOTED** that a review had been undertaken of POW data during the winter period which indicated that there had been more activity than other sites which would need to be considered for future planning.

Members **NOTED** that there had been very few cancellations across former Cwm Taf sites, infection control issues had been managed well although there had been a disappointing reduction in staff vaccination rates. Members **NOTED** that work had now commenced on the 2019/20 plan with all partners and thanks were extended to staff for the support they had provided during the winter period.

James Hehir made reference to the provision of dedicated parking spaces at RGH for Minor Injuries and asked whether the Estates team prepared the dedicated parking areas to ensure parking areas did not become icy.

Kath McGrath advised that whilst there were designated spaces she was unsure as to whether these could always be protected and added that there were dedicated pick up areas in place from the main Accident & Emergency areas.

Marcus Longley made reference to the table on page 7 of the report and advised that it was difficult to see why the report was called winter preparedness as the busiest month seemed to be July. Kath McGrath advised that what would be seen was the difference in acuity of patients, with no real winter pressures in terms of numbers of patients. Steve Webster questioned whether a review could be undertaken as to how much of the winter pressures related to acuity and what were the main reasons behind greater occupancy.

A discussion was held regarding staff vaccination rates and Greg Dix advised that all nurses had been trained to undertake vaccinations in order to support the immunisation programme. Kelechi Nnoaham advised that a comprehensive report was in the process of being developed for presentation to Executive Board which would include a review into the major reduction in staff vaccination rates.

Members **RESOLVED** to:

- **NOTE** the content of the report.

HB/19/106 **GENERAL DATA PROTECTION REGULATION (GDPR) UPDATE**

Gwenan Roberts presented the report which provided an update on governance arrangements since the introduction of new data protection legislation and the General Data Protection Regulation (GDPR) on 25 May 2018. Members **NOTED** that there was further work to undertake in order to align policies across the Cwm Taf Morgannwg footprint. Members **NOTED** that work was still being undertaken with Directorates regarding Freedom of Information requests and Subject Access requests.

Members **NOTED** that the asset register was constantly being updated and would be transferred to the SharePoint site to make it more accessible to staff. Gwenan Roberts advised that there had been six data breaches since 25 May 2018, with the most common breach being correspondence sent to the wrong address.

Members **NOTED** that GDPR would now be kept under review by the new Information, Communication and Technology Committee for which Terms of Reference were in the process of being developed. Members **NOTED** that the Committee would encompass the Digital Strategy Group and Information Governance Group and would be chaired by Ian Wells, Independent Member.

Sharon Hopkins advised that a review was being undertaken of supporting sub structures as there were a number of operational issues being presented to Committees which was not helpful.

Members **RESOLVED** to:

- **NOTE** the content of the report.

HB/19/107 **WELSH LANGUAGE ANNUAL MONITORING REPORTS AND STANDARDS**

Anne Phillimore presented the report which detailed the key risks and estimated costs associated with the implementation of the Welsh Language Standards.

Members **NOTED** that in line with statutory Welsh language requirements, the Health Board must comply with a set of 119 standards. Anne Phillimore advised that a number of applications had been submitted to the Welsh Language Commissioner requesting an extension against some of the standards, all of which had been accepted. Members **NOTED** that resources were being put into place to support the embedding of Welsh Language into the Health Board and **NOTED** that there was now a requirement to provide Welsh language provision for Primary Care facilities.

Members **NOTED** the requirement of providing bilingual correspondence to patients and that the Welsh Language Commissioner would be undertaking uninvited visits to ward. Anne Phillimore advised that as there was very little bilingual information contained on Wards, it would be likely that the Health Board would be criticised for this. Felicity Waters highlighted that the Health Board was not currently in a position to translate its Social Media accounts as a result of lack of resource which would need to be considered for further investment.

Members **RESOLVED** to:

- **NOTE** the report and the risk associated with the Welsh Language Standards.

HB/19/108 **COMMITTEE CHAIRS REPORT**

The Board **received** the report, which provided an update on the business discussions held at meetings of the Board's Committees. The following key updates were **NOTED**:

Quality Safety & Risk Committee

Members **NOTED** that the Committee discussed its Annual Report where a number of issues were raised by Members. Gwenan Roberts advised that the Committee would be holding a further meeting to discuss the concerns raised as it was felt that the Committee were not meeting its Terms of Reference.

Emergency Ambulance Services Committee

Stephen Harrhy advised that a development session had been held where a discussion took place regarding regional escalation. Members **NOTED** that the Chief Executive had given agreement for the Terms of Reference to be revised to highlight that WAST would now chair the regional calls. Members **NOTED** that progress was reported regarding the IMTP and that and update on the Amber Review would be presented to the September meeting.

The Board **RESOLVED** to:

- **NOTE** the contents of this report.
- **APPROVE** the minutes of the Committee meetings.
- **APPROVE** the Annual Report for the Finance, Performance & Workforce Committee and the revised Terms of Reference.
- **APPROVE** the revised Terms of Reference for the Stakeholder Reference Group.
- **APPROVE** the revised Terms of Reference for the Quality, Safety & Risk Committee.

HB/19/109 **WELSH HEALTH SPECIALISED SERVICES JOINT COMMITTEE BRIEFING – ADULT THORACIC SURGERY IN SOUTH WALES**

Sharon Hopkins advised that the briefing related to trying to obtain an agreement for Adult Thoracic Surgery Services in South Wales. Members **NOTED** that the Boards had a number of conditions that were needed in order to finalise the approval of the move.

Two proposals had been submitted neither of which reached a majority view which resulted in a further proposal being put forward, with most parties present agreeing with the recommendations made. Members **NOTED** the proposal did not conflict with recommendations previously made to the Board and **NOTED** that a report would need to be presented to Board highlighting the revised proposal.

Members **RESOLVED** to:

- **NOTE** the update.

HB/19/110 **ITEMS FOR INFORMATION**

Six Year Suicide Report

Members **RECEIVED** and **NOTED** the report which provided an analysis and benchmark of suicide rates starting with the Wales position, then an overview of localised data some of which was for the former Cwm Taf area but some for Cwm Taf Morgannwg.

Marcus Longley advised that he found it difficult to draw any conclusions from the report. Kelechi Nnoaham questioned whether moving forward the Board would like to receive future reports for information only or for discussion. Maria Thomas advised that the report had been reported to the Primary & Community Care Committee previously.

A discussion was held in relation to some of the figures contained within the report and Kelechi Nnoaham advised that he felt that some of the figures within the report required further review. Sharon Hopkins questioned how this was being dealt with operationally and the purpose of the report being presented to a Committee.

Welsh Health Circulars

Members **RECEIVED** and **NOTED** the report.

Annual Report Public Services Ombudsman

Members **RECEIVED** and **NOTED** the report.

HB/19/111 **ANY OTHER URGENT BUSINESS**

Sharon Hopkins sought views from Members on their reflection on the Board meeting and how the time available could be best utilised. Sharon Hopkins recognised that there was duplication in the system which would be discussed further with Gwenan Roberts outside of the meeting. Paul Griffiths advised that he had found the meeting to be very open and helpful.

HB/19/112 **DATE OF NEXT MEETING**

The next scheduled meeting of the University Health Board, would take place on Thursday 26 September 2019 at 2.00pm.

SIGNED:.....
Professor M Longley, Chair

DATE:.....

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 1.6

HEALTH BOARD MEETING – 26 SEPTEMBER 2019
ACTION LOG

	Minute Ref.	Date	Agreed Action	Lead Director	Timescale	Status as at September 2019
1.	UHB/18/26	29/03/18	**Paediatrics, Neonatal & Obstetric Service change** Further to a request from a Community Councillor that engagement on potential changes be brought forward, and that the Councillor had arranged a public meeting on Friday 13 April 2018, the Health Board continues to engage with the public.	Chief Executive / Chief Operating Officer	Monthly Updates until March 2019	**Ongoing**
2.	UHB/18/56	31/05/18	**Chief Executives Update – General Data Protection Regulation (GDPR)** – Update report on the impact to the Health Board following the introduction of the GDPR in May 2018 to be presented at a future Board meeting once sufficient information is available to benchmark data before and after the introduction of the GDPR.	Director of Governance/ Board Secretary	April/May 2019	**Completed** Report presented to the July meeting
3.	UHB/18/60	31/05/18	**Concerns (Complaints, Claims & Patient Safety Incidents)** – Clarification to be sought from Welsh Government in relation to whether new guidance would be issued in relation to the Safer Storage of Medicines cabinets.	Director of Nursing, Midwifery & Patient Care	July 2018	**Ongoing** Update provided at the March meeting. Agreed that this would remain on the action log until completed

	Minute Ref.	Date	Agreed Action	Lead Director	Timescale	Status as at September 2019
4.	UHB/18/95	26/07/18	**Patient Experience Report –** Consideration to be given to the frequency of reporting following advice received from the Quality, Safety & Risk Committee A "Patient Story" is received by the Quality, Safety & Risk Committee at each meeting. A "Patient Experience" report is due to be received by the Board on a quarterly basis.	Director of Nursing, Midwifery & Patient Care	July 2018 Nov 2018	**On agenda**
5.	**HB/18/150**	29/11/18	**Board Assurance Framework (BAF)** Arrangements to be made for the Board Assurance Framework (BAF) to be considered by the Integrated Governance Committee/Board Development session in early 2019.	Director of Governance / Board Secretary	April 2019	**Board Development Session Risk Management held in August – Work continuing**
6.	**HB/19/021**	30/01/19	**Patient Experience Report** To be strengthened by including information on key measures, timelines, lessons to be learnt and equality dimensions, such as sensory loss.	Director of Nursing, Midwifery and Patient Care	March 2019	**Ongoing** **On agenda**
7.	**HB/19/029**	30/01/19	**Board Development Session** An additional development session to be arranged for the Board to discuss the Bridgend Boundary Change	Director of Governance / Board Secretary	Late March or Early April	**To be confirmed**
8.	**HB/19/044**	28/03/19	**Update on Maternity Services** Explanation and breakdown of the SUI cases to be circulated to Board members	Director of Nursing, Midwifery and Patient Care	May 2019	**In progress**

	Minute Ref.	Date	Agreed Action	Lead Director	Timescale	Status as at September 2019
9.	**HB/19/045**	28/03/19	**Concerns (Complaints, Claims & Patient Safety Incidents)** 2018 serious incidents data to be reviewed with and without pressure ulcers so that additional reassurance could be provide to Board on the data.	Director of Nursing, Midwifery and Patient Care	May 2019	**In progress**
10.	**HB/19/045**	28/03/19	**Concerns (Complaints, Claims & Patient Safety Incidents)** Review to be undertaken of incidents reported to determine whether any incidents had been reported for the Merthyr Tydfil & Cynon areas.	Director of Nursing, Midwifery and Patient Care	May 2019	**In progress**
11.	**HB/19/048**	28/03/19	**Section 33 Partnership Agreement** Advice to be sought from Legal & Risk in relation to whether there were any associated risks with the agreement whilst it was being finalised. Update to be provided to April Board Development Session	Director of Primary, Community & Mental Health Services	April 2019	**Completed** Report presented to July meeting
12.	**HB/19/56**	30/04/19	**Maternity Oversight Improvement Panel** 'Soft' information and data gained from performance report triangulation to be brought back to the Board when arrangements agreed	Director of Nursing, Midwifery and Patient Care	July 2019	**To be confirmed**
13.	**HB/19/65**	30/05/19	**Health Board enhanced escalation status** Special Measures in Maternity Services - update to be included in the report on Maternity Services at each Board meeting	Director of Nursing, Midwifery and Patient Care	July	**Ongoing** **On agenda**

	Minute Ref.	Date	Agreed Action	Lead Director	Timescale	Status as at September 2019
14.	**HB/19/69**	30/05/19	**Patient Experience Report** Proposal to roll out the real time feedback across to other wards to be provided Information on CAMHS to be provided to the Community Health Council	Director of Nursing, Midwifery and Patient Care	July	**Ongoing** **Completed**
15.	**HB/19/72**	30/05/19	**Workforce Metrics** Review of mandatory training for staff	Director of Workforce and OD	TBC	**To be confirmed**
16.	**HB/19/091**	31/07/19	**Paediatric Service Moves** A formal note relating to the services highlighted within the South Wales Programme be circulated	Chief Executive	TBC	**To be confirmed**
17.	**HB/19/102**	31/07/19	**Workforce and OD Metrics** To include a review of the reasons why staff leave the organisation	Director of Workforce and OD	TBC	**To be confirmed**

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.1** **26 September 2019**

University Health Board Report
CHAIR'S REPORT

Executive Lead: Chief Executive Officer
Author: Kathrine Davies, Interim Corporate Governance support
Contact Details for further information: Kathrine.davies2@wales.nhs.uk

Purpose of the University Health Board Report	
To provide an update to the Board on relevant matters and related areas of work progressed in my capacity as Chair of the University Health Board. The report also identifies where I have affixed the Common Seal of the Health Board on relevant documents and which requires the Board's endorsement.	
Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2018-2021, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	• Chair's diary • Documentation requiring the Affixing of the Common Seal
Engagement – Who has been involved in this work?	
The Chair Board Members Partner organisations Community Health Council	

University Health Board Resolution To:							
APPROVE		**ENDORSE**	√	**DISCUSS**		**NOTE**	√
Recommendation	The University Health Board is asked to: • **NOTE** the report • **ENDORSE** the Affixing of the Common Seal to						
Summarise the Impact of the University Health Board Report							
Equality and diversity	No specific impact identified.						
Legal implications	Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.						
Population Health	No impact						
Quality, Safety & Patient Experience	The number one focus of the Board and its business is to ensure good quality and safe patient care across all areas of its activity.						
Resources	No impact						
Risks and Assurance	No impact						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.						
Workforce	No impact						
Freedom of information status	Open						

CHAIR'S REPORT

1. SITUATION / PURPOSE OF REPORT

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

2. BACKGROUND / INTRODUCTION

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

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Progress is being made on a number of key areas and further update reports on related key issues feature prominently at Board and Committees of the Board which oversee and scrutinise the Board's business.

Health Board Appointments

Medical Director – I am pleased to advise that Nick Lyons commenced his post on the 2 September 2019.

Director of Therapies and Health Sciences – I am pleased to advise that Elizabeth Wilkinson will commence her post on the 1 November 2019.

Independent Member (Local Authority) - Interviews for the post of the Independent Member (LA) have been re-scheduled from the 19 September to the 7 October 2019.

Governance and Leadership Support to the Board/Targeted Intervention (Organisation) & Special Measures (Maternity)

Members will be aware that as previously reported David Jenkins has continued to provide governance and leadership support to myself and the Board and has been regularly attending and observing the work of the Board and its Committees.

Board Development 29 August 2019

Members will recall the very productive Board Development day held on 29 August 2019 which was held in Bridgend.

The first part of the session was a pre-meet with Members to discuss proposed changes to the Committee meetings and membership.

An excellent session was held on risk Management with Phillip Basham of Amberwing.

During the afternoon session Members received a very emotional story direct from a patient who recalled her experiences of Maternity Services.

Members received and discussed in detail the first report from the Independent Oversight Panel and received an update on the current position in relation to Targeted Intervention which included an update on values and behaviours.

Members received a presentation on Finances which included detail of the Month 4 financial position and a discussion on the arbitration letter that had been received from Welsh Government.

To finish off the day there was a visit to Princess of Wales Hospital where Members held a walk-around.

Cwm Taf Morgannwg 'Let's Talk' Sessions

The Chief Executive, Sharon Hopkins and myself held a serious of 'Let's Talk' sessions for staff which were held across all sites. The sessions allow staff the opportunity to come along and help shape what we want the new Cwm Taf Morgannwg Health Board to be as an organisation. Further sessions and workshops with staff and patients are planned for the autumn.

Special Board Briefing 19 September 2019

A special briefing for the Board was held on the 19 September 2019 to bring together representatives from the Independent Maternity Services Oversight Panel, HIW, WAO and the NHS Delivery Unit for the Board to receive oral feedback on progress of emerging issues resulting from the reviews being undertaken in relation to Special Measures.

Cwm Taf Morgannwg – Board Development Programme

Following a Welsh Government led tendering process, Deloitte has been awarded a contract to design and deliver a programme of Board Development for the CTMuHB Board.

A meeting was held with Deloitte on 12th September to discuss the process for the design of the programme, which will commence in late September with a view to the programme being agreed and delivered from early 2020.

Diary Commitments/Meetings attended since the last Board Meeting

- Attended the Ministerial Meeting with Chairs.
- Met with the Lead Chaplain, Carolyn Castle.
- Attended the All Wales Chairs Peer Group Meeting
- Held 1:1 reviews with Independent Members
- Attended the Welsh NHS Confederation Management Board Meeting.
- Visited Ward 20, Royal Glamorgan Hospital
- Visited Ward 6, Palliative Care, Ysbyty Cwm Cynon

- Accompanied the Older Peoples Commissioner on a visit to Occupational Therapy at Ysbyty Cwm Cynon
- Accompanied Andrew RT Davies AM and the CHC on a visit to Prince Charles Hospital
- Accompanied Suzy Davies AM on a visit to Princess of Wales Hospital
- Sat on various consultant appointment panels
- Attended meetings with families affected by the Maternity Services review

Meetings / discussions with Local Politicians

- Councillor Andrew Morgan, Leader, Rhondda Cynon Taf County Borough Council
- Councillor Huw David, Leader, Bridgend County Borough Council
- Councillor Kevin O'Brien, Leader, Merthyr Tydfil County Borough Council
- Owen Smith MP
- Vikki Howells AM
- Leanne Wood AM
- Mick Antoniw AM
- Dawn Bowden AM

Affixing of the Common Seal

The Common Seal of the University Health Board affixed to the following documents:

- **Reference 246:** Agreement between Cwm Taf Morgannwg University Health Board and Rhondda Cynon Taff County Borough Council - Additional Learning Needs Transformation Grant for 2019/2020.

- **Reference 247:** Agreement between Cwm Taf Morgannwg University Health Board and Bridgend County Borough Council – Overarching Partnership Agreement for Adult and Older Peoples Services.

- **Reference 248:** Supplemental Deed of Declaration of Trust of the charity called Cwm Taf Morgannwg NHS General Charitable Fund.

- **Reference 249:** Agreement between Bridgend County Borough Council and Cwm Taf Morgannwg University Health Board – Overarching Partnership Agreement for Adult and Older Peoples Services.

- **Reference 250:** Agreement between Richard Morgan and company Limited and Cwm Taf Morgannwg University Health Board – Lease relating to offices at Unit G1 Main Avenue, Treforest Industrial Estate, Treforest, Rhondda Cynon Taff, CF37 5YL.

- **Reference 251:** Agreement between Maxime Partnership CS Business Centre, North Road, Bridgend Industrial Estate Bridgend and Cwm Taf Morgannwg University Health Board – Removal of existing fence and installation of new anti-ligature fence with associated works at Ty Llydiard, Princess of Wales Hospital, Bridgend.

- **Reference 252:** Agreement between Maxime Partnership CS Business Centre, North Road, Bridgend Industrial Estate, Bridgend and Cwm Taf Morgannwg University Health Board – Alterations and refurbishment works to existing ward area to provide freestanding maternity unit and associated facilities at template 201, first floor, Royal Glamorgan Hospital, Llantrisant.

- **Reference 253:** Agreement between Cwm Taf Morgannwg University Health Board and Siemens Healthcare Limited of Faraday House, Sir Williams Siemens Square, Frimley Camberley, Surrey – Works carried out at Prince Charles Hospital, Merthyr Tydfil.

- **Reference 254:** Agreement between Cwm Taf Morgannwg University Health Board and Cardiff and Vale University Local Health Board – Deed of Surrender relating to Dental Suites at Cwm Gwyrdd Medical Centre.

- **Reference 255:** Agreement between Cwm Taf Morgannwg University Health Board and R.J Whaley, 3A Oakfields, Marshields, Cardiff, CF3 2EZ – Works for refurbishment of restaurant, Royal Glamorgan Hospital, Llantrisant.

- **Reference 256:** Agreement between Cwm Taf Morgannwg University Health Board and PJ Saunders Limited, Unit 9, The Beeches Industrial Estate, Talbot Green, CF72 9DY – Installation of new Anti-Ligature Works to PICU Admissions, Ward 21 and Ward 22, Royal Glamorgan Hospital, Llantrisant, CF72, 8XR.

4. RECOMMENDATION

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

- **NOTE** the report
- **ENDORSE** the Affixing of the Common Seal to the above listed documents.

Freedom of information status	Open

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 2.2** **26 September 2019**

University Health Board Report
CHIEF EXECUTIVE'S REPORT

Executive Lead: Chief Executive
Author: Director of Governance / Board Secretary
Contact Details for further information: Georgina Galletly, 01443 744818 or email Georgina.Galletly2@wales.nhs.uk

Purpose of the University Health Board Report
The purpose of this report is to keep the Board up to date with key issues affecting the organisation, some of which feature routinely within the Board's business, whereas others have previously been presented to the Board and/or its Management Board.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2019-2029, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	The development of this report has, where appropriate, been informed by updates provided by members of the Executive team. A number of the issues highlighted within the report are covered in more detail within the main agenda of the Board meeting.

Engagement – Who has been involved in this work?							
The Executive Team has contributed to the development of information contained within this report. It is also important to recognise, where appropriate, that a number of the related items are also scrutinised by Independent Member led Committees of the Board.							
University Health Board Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The University Health Board is asked to: • **DISCUSS** and **NOTE** the report.						
Summarise the Impact of the University Health Board Report							
Equality and diversity	There are no equality and diversity implications of this report – related issues will be or have been considered within individual service change / redesign updates referenced within this report.						
Legal implications	There are no legal implications contained within this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Population Health	No direct implications of this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Quality, Safety & Patient Experience	Ensuring that the Board and its Committee(s) make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.						
Resources	No specific implications.						
Risks and Assurance	Ensuring the Board is fully sighted on key areas of its business is essential to positive assurance processes and related risk management.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.						
Workforce	There are no direct implications on workforce in this report. However, specific impact, where relevant, will have been considered within individual reports referenced within this update.						
Freedom of information status	Open						

CHIEF EXECUTIVE'S REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to keep the Board up to date with key issues affecting the organisation. A number of issues raised within this report feature more prominently within reports of Executive Directors as part of the Board's business.

2. BACKGROUND / INTRODUCTION

This overarching report highlights for Board Members the key areas of activity of the Chief Executive, some of which is further referenced in the detailed reports that follow and also highlights topical areas of interest to the Board, where related work is in progress.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 NHS Wales Awards 2019

The Chief Executive attended the NHS Wales Awards Ceremony at the Exchange Hotel in Cardiff on the evening of 19th September 2019 and is delighted to report that the award for '*Providing services in partnership across NHS Wales'* was won by Cwm Taf Morgannwg UHB, Aneurin Bevan UHB, Swansea Bay UHB, Hywel Dda UHB and Cardiff and Vale UHB for work on the "South Wales Motor Neurone Disease Care Network".

CTMuHB was also successful in the following entries being shortlisted:

'Delivering person-centred services'

- Supporting Those Living with Dementia and Behaviours That Challenge Using a Psychologically Minded, Person-Centred Approach

'Empowering people to co-produce their care'

- Peer Support Volunteering

'Enriching the wellbeing, capability and engagement of the health and care workforce'

- LGBT Network & Diversity Street

'Improving health and wellbeing'

- Improving Health & Wellbeing through Taff Ely Cluster 'Sheds' Development

3.2 Emergency Medicine (A&E), Acute Medicine and Inpatient Paediatric Services

Following the Health Board consideration of the issues presented at their meeting in July 2019, a project is being established to determine the wider engagement of patients, communities, staff, CHCs, Local Authorities, Regional Health Boards, Welsh Government and other stakeholders in the implementation of the South Wales Plan to provide safe, quality, accessible and sustainable services for A&E, Acute Medicine and Inpatient Paediatric Services.

Further updates will be brought to Board as the project progresses towards the revised implementation date of September 2020.

3.3 Health Board Special Measures and Targeted Intervention

Members will be aware, that on 30 April 2019 and as a consequence of the recent publications of reports and their related serious findings, the Minister for Health & Social Services announced, that for Maternity Services, the Health Board was escalated to 'Special Measures', the highest level of escalation. In addition the Health Board's escalation level of 'enhanced monitoring', was been increased to 'targeted intervention'.

CTMuHB has an established programme for Maternity Improvement, led by Greg Dix, Executive Director of Nursing, Midwifery and Patient Experience and supported by the recently appointed Programme Director.

A programme approach is also being established to progress improvement in the areas of Targeted Intervention, namely 'Leadership & Culture', 'Trust & Confidence' and 'Quality & Governance'.

The second of Welsh Government's monitoring meetings with CTM was held on the 9th September where detail on the Health Board's plans and progress was shared. Encouraging feedback was received from Welsh Government on the information shared, whilst noting there remains much to do and some further learning expected from on-going, independent reviews due to report in the near future.

3.4 Adult Thoracic Surgery for South Wales

At its meeting held on 23rd July, WHSSC supported the recommendations going forward for a single site model for the delivery of thoracic surgery based at Morriston Hospital, Swansea. The six affected Health Boards, including CTMuHB, are being asked to provide unconditional approval of this model. The item is explored in further detail later on the Board agenda.

3.5 Brexit Preparedness

Members should note that the Management Board is provided with monthly updates on the work being undertaken to assess the potential risks that the

Health Board may face as a consequence of the British exit from the European Union (EU).

3.6 Mental Health Service Improvement Fund

The Health Board received confirmation that Cwm Taf Morgannwg University Health Board has been successful in our bid against the All Wales Mental Health Service Improvement Fund and will receive recurrent funding allocation of £2.282m.

3.7 Development Plan for CTMuHB

A plan for the development of CTMuHB continues to take shape, drawing on the learning from our regulatory reviews. A number of key programmes have already commenced and will continue to emerge and mature over the coming weeks and months.

'Let's Talk Culture' – Developing a set of Values and Behaviours - From Monday 4th – Friday 8th November, a series of 'In Your Shoes' and 'In Our Shoes' workshops will be held across CTMuHB. The ideas shared by staff, and patients from these workshops will be used to create the values and behaviours that the Board and wider organisation can own and use in our day to day work and shape the new organisation of Cum Taf Morgannwg University Health Board.

Development of an Operating Model for CTMuHB - Work continues on reflecting and analysing the responses received on the staff consultation relating to organisational structures issued earlier in the year, to inform the development of an Operating Model for the Health Board. Conversations will be on-going with staff across all groups on how the Operating Model will be implemented, influencing the subsequent design of structures. The next phase of 'Let's Talk' sessions are scheduled for the beginning of October and these will form part of the on-going commitment to engage and involve colleagues across the Health Board and support the timely implementation of the Operating Model across the organisation.

Capacity and Capability – we continue to strengthen our capacity and capability in the immediate term through short term secondments and appointments. These appointments are aimed at enabling focus and action on some of our most pressing issues including clinical governance, corporate governance, engagement and involvement, unscheduled care and acute hospital site management.

4. RECOMMENDATION

The University Health Board is asked to:

- **DISCUSS** and **NOTE** the report.

Freedom of information status	Open

Proposal for Regional Sexual Assault Referral Centre (SARC) Model for South, Mid and West Wales

Author:	Rachel Hennessy, Programme Director
Executive Lead:	Deputy Director Strategy and Planning, C&V UHB
Approved by:	SARC Project Board
Date document approved:	1st August 2019
Caring for People, Keeping People Well:	This proposal is key in delivering outcomes that matter to people and providing sustainable services through delivering care across sectors
Financial impact:	Section 6.
Quality, Safety, Patient Experience impact:	This proposal will provide a more accessible and sustainable service for some of the most vulnerable adults and children across South, Mid and West Wales
Health and Care Standard Number:	2.7 Safeguarding Children at Risk and 3.1 Safe and Clinically Effective Care
Equality Impact Assessment:	Section 7.

Assurance and Approval

- Financial scrutiny and assurance has been provided by the Chief Finance Officers for police and PCCs across South, Mid and West Wales July 2019
- Health boards have considered the financial proposal through their financial representation on the SARC Project and via CEO forum
- The SARC Project Board has approved the service model and costs associated with implementation of phase 1: adult and paediatric SARC hubs, commissioning and network on August 2019

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Executive Summary

This paper details the recommendations for the reconfiguration of Sexual Assault Referral Centres (SARCs) across South Mid and West Wales. This report is the culmination of work that commenced in 2013 in response to a Welsh Government review looking at the unmet need in SARC services and the lack of integration between services. Significant work has been undertaken in partnership with multiple agencies to develop a number of recommendations that together will significantly benefit the victims, survivors and their families who use SARC services across the region.

This Final Report was considered and approved by the SARC Project Board 1st August 2019. This report will considered and approved through internal governance structures of the commissioning organisations through the month of September 2019.

The proposed model will provide a more integrated service model that is driven by the needs of service users, supports the provision of services that meet clinical, forensic, quality and safety standards and guidance, and ensures that robust governance arrangements are in place.

The proposed model is based on a hub and spoke approach with three adult SARC hubs in Cardiff, Swansea and Aberystywth and two paediatric SARC hubs in Cardiff and Swansea. The SARC hubs will also act as a spoke for the local population and will be supported by additional spokes presently located in Risca, Merthyr Tydfil, Newtown and Carmarthen. There is also a commitment to developing an NHS led forensic medical service and establishing an All Wales SARC Delivery Network and commissioning framework.

The proposed model will be staged across three phases.

Phase 1 will support the implementation of the SARC hubs for children and adults and the establishment for the Network and commissioning roles.

The total costs of phase 1 will be split 50:50 between health and police, with each sector required to contribute £578,159 per year.

Proposed model phase 1	
Health contribution	£581,909
Police contribution	£581,909
total	**£1,163,817**

Costs have been agreed in principle for recommendation to individual Boards, by representatives of the commissioning organisations, including Police Chief Finance Officers, to support moving forward with phase 1

Phase 2 and 3

- Phase 2 will look at the provision of the SARC spokes. £1,180,191 was allocated in the original modelling work to accommodate this area for ISVAs (£785,740) and counselling (£394,450). Significant work will be required to look at therapeutic requirements and costs, which has been excluded from work to date.

- Phase 3 will look at the forensic medical examination service. £666,619 was identified as the associated cost of the FME service in the original modelling work.

There is a collective agreement across the commissioning organisations that phases 2 and 3 will required detailed service modelling work and costing. It is anticipated that each of these proposals and associated costs will need to be considered and approved by the Boards of the commissioning organisations.

Assuming there are no further increases costs following the detailed work required in stage 2 and 3 this would result in a total model costing £3,034,713.

For comparative purposes, this would mean an additional investment in the region of £1,375,353 across the commissioning organisations.

Regional model	
Costs of current model	£1,659,360
Costs of proposed model	£3,034,713
Difference	**£1,375,353**

Based on 50:50 split, Health Boards and police would each be required to contribute around **£1,517,357.**

1. SITUATION

This paper provides an overview of Phase 2 of the Sexual Assault Referral Centre (SARC) project since its inception in June 2018. It provides an overview of progress and outlines the key areas for discussion. There remains a commitment from all agencies to the delivery of a service that is clinically safe, sustainable and meets the needs of the population of Wales. It must also demonstrate value for money.

Further integration between health and the police in the delivery of forensic services continues to be a priority, with a joint commitment to the delivery, in the future, of a public sector provided forensic medical service. This paper needs to be considered in conjunction with the proposed financial framework to support the model (attachment 1). An overarching proposed timeline is also attached (attachment 2.)

On approval of this report by the SARC Project Board, the recommendations will need to be considered through internal governance structures for health, police and Police and Crime Commissioners (PCC) as the commissioning organisations. Any further changes to the service model or funding requirements will also need to be considered by the individual commissioning organisations through their internal governance structures.,

2. BACKGROUND

In 2013, Welsh Government commissioned a review to examine the extent to which the SARCs fulfilled the requirements of Public Health Wales service specifications, victims' needs, any unmet gaps in provision and the interdependencies between SARCs and other services. The findings from the review formed the case for change for a multi-agency review of sexual assault services across Mid, South and West Wales, led by the National Health Service (NHS) Wales Health Collaborative (phase 1). A Project Board was established comprising representatives from health, the police force and the third sector, to oversee the development of a service model.

Following an option appraisal process, a preferred model emerged which identified regional configuration of services comprising children's services located in two hubs at Cardiff and Swansea and adults services located in three hubs in Cardiff, Swansea and Carmarthen, supported by spokes in Risca, Merthyr Tydfil and Aberystwyth. Newtown was only established during the project phase. It was noted that it would be considered an additional spoke for the area of Dyfed Powys.

In December 2017, the model was agreed in principle, subject to a further review. Concerns were expressed by the Police and health organisations in Dyfed Powys that the proposed move to a single adult hub providing forensic examination services in Carmarthen would be detrimental to the population in the north of the region due to the geography.

In June 2018, Phase 2 of the SARC project was established. A commitment was given by the Project Board to review the proposed service models, costs and activity as well as the provision of FME services across the region (Phase 1 assumed the status quo remained).

The remainder of this paper provides details on the service models and recommendations made by the Project to support a regional SARC service model.

3. ASSESSMENT AND ASSURANCE

The definition of a SARC hub and SARC spoke as agreed through the SARC project is as follows:

SARC Hub: **'**A dedicated facility to provide immediate client care within the context of a partnership arrangement between police, health and the third sector. This should include an acute forensic examination with referral pathways in place to local services to support follow up care'.

In addition, the Hub should provide an acute health needs assessment which includes emergency contraception (with access to emergency Intrauterine Device (IUD) fitting) and Sexually Transmitted Infection (STI) risk including HIV and Hepatitis B with management and the provision of medication at first attendance where indicated. Emergency referral for other health needs can be initiated (mental health, accident and emergency) as well as social services referrals.

SARC Spoke: 'A dedicated facility to provide immediate and on-going client care within the context of a partnership arrangement between police, health and the third sector but does not provide forensic medical examinations'. The spoke should also provide support for victims engaged in criminal justice proceedings. A hub would also house a spoke facility for the local community.

The table in attachment 3 provides a more detailed outline of the services available at the hub and spokes.

The work to develop a preferred service model for the region is underpinned by these definitions, a set of key principles and a baseline data set (attachment 4).

A series of multi-agency option appraisal workshops have taken place and the outcomes used to inform the final model. The finding of the Equality Impact Assessment (EIA) undertaken in Phase 1 has also been considered.

3.1 Childrens Services

There remains a commitment to the original modelling work (2015), which identified two paediatric SARC hubs (Swansea and Cardiff) to provide paediatric acute and historic services across the region – ongoing support will be provided from the more local SARC spokes.

However, difficulties with recruitment of paediatricians in Swansea in 2018 resulted in a proposal to move to an interim model where acute presentations of children under the age of 14 from across the region are being seen at Ynys Saff SARC, Cardiff. Prior to this, children under the age of 13 were seen at Abertawe Bro Morgannwg (ABM) University Health Board (UHB) in hours, including acute presentations, for the population of Swansea and Ceredigion, Carmarthenshire, Pembrokeshire and parts of Powys. Historic cases will continue to be seen in Swansea, Cardiff and Abergavenny. Out of Hours acute paediatric cases up to 14 years of age will continue to be referred to Cardiff.

Due to the challenges associated with providing a sustainable service in Swansea, it was important to review the proposal for a two-hub paediatric model in terms of feasibility and achievability. On review there was support to increase the age of the paediatric hub to children up to 16 years, in line with national guidance and services in North Wales and an option appraisal exercise took place, the outcome of which was support for a two-hub model across the region.

Following this recommendation, a focus group comprising paediatricians across the region was bought together to look at the feasibility of the model and the necessary actions to support implementation. In line with the service model in England, the paediatricians also felt there would be benefits to developing their role so that they could undertake forensic and health assessment single handed rather than requiring the presence of a forensic examiner as well as a Paediatrician.

The focus group also acknowledged that in order to deliver a future service for children in Swansea (which replicates the in-hours service in Cardiff), appropriate accommodation still needs to be identified, that will meet forensic standards and standards associated with the provision of children's services. A formal options appraisal will need to be undertaken and costed. The outcome will need to be considered by the commissioning organisations. Options may include developing a combined adult and child hub on health premises in

Swansea, exploring the opportunity to 'lease' accommodation from the third sector, or paediatrics remaining stand-alone in an improved environment within Singleton or Morriston Hospital. Benefits of a joint model include the ability to access counselling, and staff experienced in the court process and police interviews, so overall better support for families. A joint model would also provide the benefits of being able to integrate adolescents into SARC services without them having to choose between adult and children's services

Both the interim and proposed service model for children have been developed with the intention of minimizing the number of cases needing to be seen out of hours, although an out of hours service will continue to be available in line with the existing service model.

The proposed service model recognises the importance of having an experienced workforce to ensure the quality received by children is of the highest standard. In order to achieve this standard a critical mass is required to enable clinicians to see a minimum number of children to develop and retain the skills and competencies required to provide a high quality service. It is important a child is seen by the most appropriate individual as the trauma of being seen by the wrong person may be as bad as the assault. At present, the small number of children accessing the service means that it is only possible to achieve this at two sites across the region. The aim is for the majority of children to be seen during the day, and as a minimum, be able to offer a paediatric assessment within 24 hours of referral. This may include the opportunities to explore an out-of-hours rota, which flexes across sites (Swansea and Cardiff) in the future.

In drawing together the conclusions of this work, a number of recommendations are being made to the project board.

In hours: proposal

- *Two paediatric SARC hubs (Swansea and Cardiff) will provide services for children up to their 16th birthday. Children can expect a joint examination with a paediatrician and forensic examiner for acute presentations and a single examination by a paediatrician for historic presentation.*
- *Children 16-17 will continue to have a forensic examination at the appropriate local SARC Hub by the Forensic Medical Examiner (FME). Health needs will be considered at each SARC with appropriate signposting. This model will be subject to review and open to change following evaluation of the model for younger children.*

Delivery of the in-hours proposal will require:

- Training of consultant paediatric workforce to manage older children. In general, paediatricians across the NHS see children up to the age of 16 years, except in certain circumstances e.g. cardiac/renal/cystic fibrosis etc .
- Identification of accommodation for paediatric SARC hub to considered as part of a formal multi-agency costed option appraisal.
- Identified sessions in paediatrician's job plans for SARC clinical service provision, training and peer review
- Financial resources to support training and appointment of suitable workforce

Out of hours: proposal

- *One paediatric SARC hub (Ynys Saff SARC) will provide services for children across the whole region up to their 16th birthday. Children can expect a joint examination with a paediatrician and forensic examiner.*
- *Children 16-17 will continue to have a forensic examination at the appropriate local SARC Hub by the FME. Health needs will be considered at each SARC with appropriate signposting. This model will be subject to review and open to change following evaluation of the model for younger children.*

Delivery of the out of hours model will require:

- Training of consultant paediatric workforce to manage older children
- Consideration of a regional consultant paediatric rota for in and out of hours service at Cardiff, supported by a daily fixed clinic and European Working Time Directive (EWTD) compliant.

Forensic examinations for children: proposal

- *Paediatricians will be appropriately trained to undertake forensic medical examination for children presenting at the paediatric SARC hubs.*

Delivery of forensic examinations by paediatricians will require:

- Paediatricians committed to working towards The Faculty of Forensic & Legal Medicine (FFLM) qualification
- Development of a training programme, with time given to paediatricians to undertake the training required.
- Flexibility built into FME contracts in order to support paediatricians seeing sufficient cases to be deemed competent to take on the role.

- Clarification of legislation around paediatricians trained to undertake a combined health/forensic medical examination being able to do so. In England this is a common model of care but may require support from Welsh Government in Wales to implement a similar model.

3.1.1. Children living in Powys

Powys covers a large geographical area in the middle of Wales. Services to support the population of Powys may be commissioned from Health Boards in both North and South Wales and from NHS England, taking into consideration the requirements of the population. Further consideration has been given to the proposed children's model, i.e. paediatric SARC Hubs in Swansea and Cardiff and the impact on children in North Powys. Since late 2016, when the SARC provision in Telford closed, there has been no formal pathway in place for children residing in North Powys. Betsi Cadwalader UHB have stepped in to support PTHB on an ad hoc informal basis in the interim.

When considering indicative travel times (Attachment 6) it was felt more equitable for children in North Powys to access SARC services in North Wales, rather than Cardiff or Swansea – ongoing support would be from the more local SARC spoke in Newtown. Whilst there has been no provision for North Powys resident requiring access to SARC services from North Wales previously, it is felt this would be the most beneficial model for children in this region requiring access to FME services. In concluding this the following recommendation is being made for children in North Powys:

- *There is a commitment to developing pathways for children up to their 16th birthday, who live in North Powys to access SARC services in Colwyn Bay, North Wales, if they require a forensic medical examination.*

Delivery of service for children in North Powys will require:

- Discussions with Betis Cadwalder/North Wales Police regarding the preferred model.
- Clear pathways to be developed
- A funding agreement to support cases being seen in North Wales

Timelines

The Interim children's model is for an initial period of twelve months. However, there are no plans to withdraw this service before the preferred service model is implemented.

On approval of the preferred model by the Project Board, work will commence immediately to put in place the enablers to support the implementation of the full children's service model. It is anticipated implementation will be incremental with a lead in time of one to two years.

Further work is required to determine the time frame to support paediatricians undertaking forensic examinations of children.

3.2 Adults services

Services are currently provided by third sector across the region with the exception of in Cardiff and Vale where the service is provided by NHS Wales. All SARCs across the region currently offer the facility for adults to undergo a forensic examination. They are currently located in Merthyr Tydfil, Risca, Ynys Saff Cardiff, Swansea, Carmarthen, Newtown and Aberystwyth.

In Phase 1, the SARC project agreed the principle of a 'hub and spoke' service model, based on national guidance. This resulted in a model with three hubs (Cardiff, Swansea, Carmarthen) and four spokes (Merthyr Tydfil, Risca, Aberystywth and Newtown – towns with existing SARCs). The decision on a hub and spoke model and the number of hubs in the region was made following an extensive option appraisal process, where consideration was given to safety and quality, sustainability and future proofing (including the ability to meet critical mass and minimum caseload requirements), access, equity, achievability and acceptability.

This model was agreed in principle subject to a further review following concerns raised by Dyfed Powys Police regarding access to forensic services for the population in the north of their region.

Phase 2 reviewed the model, activity, service specification and associated costs. The Project recognized the challenges associated with the geography of Dyfed Powys and the necessity for a model reflective of the needs of the local population. Therefore, after extensive discussion and review of the supporting information, a revised service model was agreed. The revised model supports the principles in Phase 1 - a single SARC hub for the Dyfed Powys region, supported by two spokes. However, it is proposed the SARC Hub is located in Aberystywth, with the two spokes in Newtown and Carmarthen. In this model, access to forensic services for the north of the region would be retained. Clients in the south of the region, would access the nearest SARC Hub at either Swansea or Aberystywth depending on where they are resident. This model will support the holistic needs of the clients, increased sustainability and the opportunity for greater integration between sectors, including a closer alignment with the sexual health services. It would also provide more equitable

coverage as part of a strategic model of sexual assault services across South, Mid and West Wales, with SARC hubs located in, Cardiff, Swansea and Aberystywth.

Data used to underpin the service planning process suggest there are approximately 1654 over 16 year olds with an initial presentation at a SARC across the region (2017/18). Of this figure only 306 underwent a forensic medical examination and therefore would be required to attend the SARC Hub in the recommended model.Tthe remaining 1348 would receive service from their nearest SARC spoke. Individuals presenting at the SARC Hub (306 cases) would return to their nearest SARC spoke or health board providing sexual health services, for follow-up support after the acute examination.

Table 1 gives an overview of how activity levels (The number of individuals presenting for a forensic and health examination, would change based on the introduction of three SARC hubs in Aberysywth, Cardiff and Swansea.

Table 1. changes in activity levels based on 2017/18 data

Region	**SARC**	**Current number requiring FME**	**Proposed number requiring FME**
Mid and West Wales	Aberystwyth*	13	24
	Newtown	11	0
	Carmarthen	30	0
South West Wales	Swansea*	**53**	**83****
South East Wales	Ynys Saff Cardiff*	86	199
	Risca	67	0
	Merthyr	46	0
	Grand total	**306**	**306**

*will be SARC hubs providing forensic and health examinations in the proposed model
** It is recognised that individual in the south of the region are more likely to attend Swansea SARC.

Whilst the preferred model clearly offers a number of benefits for clients accessing the service, there are a number of areas, which need to be considered when moving forward with implementation of the recommended service model.

Support will need to be provided for those who may incur longer travel times, when compared with the current model. Attachment 6 provides indicative travel times from various parts of the region to their nearest Hub. However, it also needs to be recognised that some individuals may chose not to be seen at their nearest SARC hub. The commissioning framework needs to address this and ensure that individuals are able to access services at any SARC Hub they choose across Wales without complications.

Concerns have been expressed that at times there could be multiple cases attending a single SARC Hub. This is not a unique situation and there are examples across the country where SARCs have multiple cases presenting at the same time. In these circumstance cases will be assessed, managed and prioritised based on the needs of victim rather than by the area in which they reside. This service will need to be supported by clear operational protocols and performance monitored closely. During phase 1 (2015/16) modelling work looking at a service model with three SARC hubs, calculated that based on current demand, very few days of the year would have more than one case presenting at the same time.

Welsh Government has also given approval for redevelopment of the SARC in Cardiff, which will have additional capacity to accommodate the increase in demand from Risca and Merthyr Tydfil SARCs resulting from the change in model as well as having the ability to accommodate potential increase in demand.

South East Wales proposal:

- *A single adult hub to support South East Wales, at Ynys Saff SARC, Cardiff (which will also provide spoke services to Cardiff and Vale population) supported by spokes in Risca and Merthyr Tydfil.*

South West Wales proposal:

- *A single adult hub to support South West Wales (will also support a proportion of Hywel Dda population) provided in Swansea, which will also provide spoke services to Swansea population.*

Mid and West Wales Proposal:

- *A single adult hub to support Mid and West Wales provided in Aberystwyth, (which will also provide spoke services), supported by additional spokes in Newtown and Carmarthen.*

When considering the overall model for the provision of adult services there are a number of other areas for consideration, which may help to address concerns relating to governance and access to services:

- Alignment of SARC hubs with health boards, allowing for strengthened governance processes.
- Services (both hub and spoke) may continue to be provided by the third sector, however, operational lines of governance and accountability for SARC provision would be through a health board for the SARC hub service, via the commissioning infrastructure.
- This model would provide the professional and clinical governance structure to support the appointment of clinical coordinators in each centre, alongside the third sector, creating a more integrated service. At present with the exception of Ynys Saff SARC Cardiff, there is no clinical input (with the exception of visiting FMEs) to provide a link between the SARCs and the health service requirements of the individual client accessing the service.
- Future opportunities may exist to provide outreach provision using health premises for follow up medical treatment and psychological support.
- Further consideration needs to be given to the benefits and opportunities for developing local SARC spokes in other areas of the region.
- Spokes continue to be provided by the third sector where appropriate. Whilst there will be a core service specification within a spoke, local police forces/PCCs may choose to commission additional services from the third sector/health to meet the requirements of the local population. That would be at the discretion of the local police force/PCC and outside the remit or costings of this proposal.
- A task & finish group will need to be established to develop the detailed work, including costs associated with the 'spokes' to support the SARC hubs. This will also need to consider therapeutic required.

Timelines

On approval of the proposed models, work will commence immediately to progress with the procurement process to support implementation of the new model. It is anticipated that elements of the new model would be in place 2020/21 but it will take up to three years to fully implement the 'hub and spoke' model.

3.3 Forensic Examination Service

This project promotes a Health delivered Forensic Medical Examination (FME) service as the preferred means of delivery in Wales, and has the commitment and support from Police and Health Services to achieve this. However, it is

realised the transition time may take five to ten years dependant on current contracts and the training of health professionals to undertake the roles.

Currently commissioned by individual police forces across the region: Gwent Police; South Wales Police and Dyfed Powys Police. Three private providers are commissioned alongside a number of self-employed doctors in Gwent. There are concerns with the current model regarding sustainability, clinical governance and limited engagement with local health services.

The proposed model to move towards and NHS provided FME service, if agreed, will require further work to develop a detailed costed model which will independently of this report need to be considered and agreed by the individual commissioning organisations.

In the interim, there is clear agreement that Health and the Police will take an integrated approach to developing and monitoring existing forensic services and wherever appropriate, as existing contracts end, there is a collective agreement to move forward with implementing the principles of the agreed model.

FME Proposal

- *'Two private providers for South Wales Police/Gwent Police and Dyfed Powys Police, with a move to single provider once current contractual arrangements come to an end.*
- *There is a commitment from Health organisations and police organisations to developing an NHS provided FME service throughout Wales.*

Delivery of the FME proposal will require:

- Identification of a lead commissioning police force to support the implementation of a single provider.
- A phased approach due to differing lengths of existing contracts.
- Establishing a task and finish (T&F) group comprising health and police organisations, to develop a detailed service model and associated costs, which addresses both health and forensic needs of the client and ensures standards and guidelines are met.
- Development of a clear model to support an NHS provided FME service, including training requirements which will need to be fully costed and appropriate funding streams identified if required. Due to time needed to train clinicians to carry out a forensic medical examination competently

and to national standards, training may need to start before current contracts have expired.

- Health to support police forces in monitoring and managing existing FME contracts.
- As current legislation stands there would need to be an open and transparent procurement process, which would require Health to tender for the service.

Timeline

On approval of the proposed models, work will commence to establish a joint health/police task and finish group to take forward the work required to move to a fully costed and detailed service model. It is anticipated that elements of the new model would be in place 2020/21 as forces move towards a single private provider for the region. However, it is anticipated it may take up to ten years to fully implement the preferred NHS provided FME services. This will also be subject to approval of funding by individual organisations.

4. COMMISSIONING INTENTIONS

As public bodies providing the funding to SARC services, there is a statutory obligation on health and the police to account for their spend and a requirement to go through an open and transparent public procurement process where a commercial contract is required, which in the current and proposed service model is the case. The exception to this will be the service at Cardiff and Vale (C&V) UHB and children's services at Swansea Bay UHB, which, as existing NHS services currently funded by NHS and Police, provides for the local population (and will not change), can be excluded from a procurement process. This exemption would be based upon case law & codified under the Public Contracts Regulations (Reg 12(7)) where public-to-public collaboration, which is purely in the public interest can be exempt from the regulations. This exemption would need to ensure it meets the tests required under law.

As health is the assumed lead commissioning organisation, following recommendation in phase 1, guidance has been sought from NHS Wales Shared Services regarding any formal processes required to formally appoint contracts between health as the lead organisation and the service provider/s. NHS Wales Shared Services are the All Wales organisation, which supports procurement of contracts, which cross several health regions. Shared Services will need to lead the procurement process and a procurement board established under the wider SARC project structure.

Currently the SARC services are provided predominantly by third sector and funded by the regional police and PCCs. The costing of the preferred model in phase 1 identified a significant increase in funding required. Forensic services

are currently commissioned by the police due to legal requirements, which will need to continue based on their current financial commitment to the provision of FME services.

Contracts that are currently in place with third sector are limited and agreements in the main are extended year on year with majority of agreements/contracts currently to April 2020.

Proposal

- *A formal procurement process, led by NHS Wales to appoint the hubs and spokes across the regional service model.*

This will require:

- Joint collaboration between health and the police to develop a clear service specification and in taking forward the procurement process.
- Development of a clear commissioning and procurement process to address separately the requirement for SARC hubs and spokes in line with agreed phasing of the service model. There will need to be a level of flexibility to ensure local needs are considered and additional finance streams can be accessed, alongside meeting core service requirements.
- Support from Welsh Government to manage any concerns associated with taking forward the process
- Resources from NHS Wales Shared Services to lead the procurement process.
- Agreement on the financial model to support the approved service model and appropriate funding identified. This funding will need to be ring-fenced once approved in order to account for the time it will take to go through the procurement process, award contracts and implement the model.
- Additional detailed assessment, legal input, a governance process/board in place, a definitive statement of service requirements and a panel of end users/stakeholders to assist with any evaluative work.

Timeline

It is anticipated that the actual procurement will take several months to complete, with non-FME contracts awarded and services in place by April 2020.

5. ESTABLISHING A SARC DELIVERY NETWORK AND A COMMISSIONING FRAMEWORK

It is recommended an All Wales SARC Welsh Delivery Network , comprising a multi-agency Operational Deliver Network alongside the joint commissioning board and lead commissioning organisation should be established. Unlike the SARC Project, the network would include north Wales.

The SARC Network would be a multiagency forum and provide a platform to engage with third sector and the public, as well as linking the different strands (health and Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) in Welsh Government. It would lead the development and implementation of an All Wales service strategy and act as a specialist point of contact. It would provide evidence based and timely advice to the Welsh Government and the lead commissioner to assist the service in discharging its functions and meeting their responsibilities. It would also be responsible for undertaking planning for the development and delivery of an integrated SARC service on an all Wales basis and determine services to be procured in Wales, advise, audit and monitor performance and clinical governance and lead in the development of care pathways and service specifications.

The SARC Network will also be the vehicle through which specialised SARC services for adults and children can be planned and commissioned on an all Wales basis in an efficient, economical and integrated manner and will provide a single decision-making framework with clear remit, responsibility and accountability. This will include the management of a ring-fenced budget.

The Network will also support the development, implementation and monitoring of a single database across the region which will monitor activity, performance, delivery against standards, outcome measures and support future service planning.

Phase 1 (2015/16) of the SARC Programme identified the need for an independent lead commissioning organisation from health, a joint commissioning board and a move to develop pooled budgets. In line with phase 1 (2015/16) recommendations, Phase 2 (2018/19) has looked further at developing the model needed to support the delivery of the SARC service for the region. The SARC model appears unique in that there does not appear to any other clear examples in Wales where funding is provided across health and another public body (other than local authority). It is recognised that to deliver this model, a formal commissioning structure is required, including a lead commissioning organisation, and a joint commissioning board.

The lead commissioning organisation will be responsible for develop the detailed service specification to support the procurement process, the service planning and contracting and commissioning of SARC services across the region. There will need to be an agreement on a form of collaborative

commissioning, rather than pooled budgets (policy does not currently allow for pooled budgets to be established between health and the police).

Some resource to support both the Network and the commissioning organisation have been identified in the workforce modelling (attachment 1a). Once the service model has been agreed and a lead commissioner identified, a commissioning framework will be developed and an Delivery Network established. As previously noted in section 3.3, the police will need to retain the commissioning lead for FME services.

As the host organisation for delivery of the SARC programme of work and as the largest service provider it is also recommended C&V UHB is appointed to host the Operational Delivery Group as part of the overarching Delivery Network.

Proposal

- *An All Wales SARC Delivery Network is established, comprising an Operational Delivery group and a joint Commissioning Board with a lead commissioning organisation A lead commissioning organisation is identified*
- *C&V takes on the role as lead provider organisation*

This will require:

- Formal recognition by Welsh Government of a SARC Welsh Delivery Network as the specialist advisory body on SARC services for Wales
- Support from Welsh Government, including finances for establishing a SARC Welsh Clinical Network including regional clinical leads and a network manager.
- Engagement from commissioners, providers and service users as appropriate
- Health Boards to identified a lead commissioning organisation

Timeline

Further discussions are required with the commissioning organisations to identify a lead commissioning organisation and develop the commissioning framework with clear governance structures and terms of reference. The appointment of the lead commissioning organisation needs to take place as a priority.

It is proposed that the Project Board will formally close and handover to the Network once the relevant lead organisations have been identified and the supporting structure established. A 6-12 month leading time is anticipated.

6. FINANCES

6.1 Financial assumptions

The financial model in phase 1 was based on a regional service model with three adult hubs and two paediatric hubs supported by four additional spokes alongside the spokes in the hubs and a regional component. The revised model retains a commitment to this service model. In addition, agreements supported by the project board in phase 1 have been upheld throughout phase 2. In line with this the following assumptions underpin the finance modelling work:

- Finance, Human Resources, Procurement and other corporate functions have been excluded and assumed to be absorbed within each organisation.
- Clinical supervision is managed within the resources identified in the proposed model.
- Cardiff infrastructure costs have been excluded.
- Out of Hours referrals will reduce due to extended opening times and proposed expansion to daily clinics.
- Paediatrician out of hours are minimal, and costs are based on the current model in Cardiff and Vale

The costs for the current model for comparative purposes have been reviewed and updated and are provided in detail in attachment 1a. The costs, including grants, which have been factored into the model, are those provided by representatives from health, police and third sector as nominated, who are member of the SARC finance T&F group.

Funding streams included relate only to those in health and police allocated to SARC services. They do not include any additional grants received by New Pathways for other service provision, which may or may not relate to SARC services

Management of the finances will be through the lead commissioner and associated joint commissioning board. The payment process will need to be determined once the lead commissioner and joint commissioning board is in place.

6.1 Revised Costs and Phasing

Following discussions between the commissioning organisations, an agreement has been reached to consider the implementation of the overall

model through a number of stages and align costs accordingly. This acknowledges that further detailed work to develop the model and associated costs for the 'spokes' and the FME services needs to be undertaken to ensure that each component accurately reflects the needs of the service. This programme of work is seen as a ten-year transformational programme of change.

Delivery of the service model has been split into three distinct stages:

- Phase 1: Implementation of SARC Hubs for adults and children, establishing the commissioning framework and network
- Phase 2: Implementation of SARC Spokes
- Phase 3: Implementation of FME model.

Costs have been agreed in principle for recommendation to individual Boards, by representatives of the commissioning organisations to support moving forward with phase 1

Attachment 1a shows the detailed costs associated with phase 1: Implementation of SARC Hubs for adults and children, establishing the commissioning framework and network and the proposed phasing of those costs in line with the agreed model for this part of the work (attachment 1b).

It is proposed that the implementation of Phase 1: Implementation of SARC Hubs for adults and children, establishing the commissioning framework and network will costs £1,163,817.

6.2 Financial Impact for commissioning organisations of Phase 1: Implementation of SARC Hubs for adults and children, establishing the commissioning framework and network

It was and continues to be acknowledged that the financial situation for the NHS and for the police service is increasingly challenging and, likewise, third sector organisations are at risk due to uncertainties in respect of funding from statutory bodies, grant funding and charitable funding.

In line with the financial modelling in Phase 1 (2015/16), costs have been spilt 50:50 between health boards and the police forces/police and crime commissioner offices. It was acknowledged that there is no specific guidance on the respective responsibilities of statutory partners for sexual assault services and services provided within SARCs other than responsibility for forensic medical examination within Wales, which remains with police forces. In light of this the Phase 1 Project Board agreed to take a pragmatic approach to recommendations for a future funding model. Thiswas a shared funding

model, with a 50:50 split between the NHS and the police/PCCs that would then be further split based on population shares.

Table 2. Distribution of Costs based on 50:50 split

Proposed model phase 1 (2015/16)	
Health contribution	£581,909
Police contribution	£581,909
total	**£1,163,817**

The costs currently incurred by Health Boards to support the interim children's model will be consider as part of the contribution by Health Boards to the final model and not as a cost they will incur in addition to that of the final model.

As identified in Phase 1 (2015/16), costs incurred by each Health Board will be based on a split by resident population. Table 3 outlines these anticipated costs by Health Board, based on the boundary changes, which came into being 1st April 2019. A similar pragmatic approach has been taken to the split by police force region. However, this is for visual purposes only and is only notional. Further work will be required by the police organisations to determine an appropriate proportional split of their funding contribution.

A more detailed piece of work will need to be undertaken led by the lead commissioning organisations and joint commissioning board to determine the final commissioning model.

Table3. Distribution or costs phase 1.

Estimated health board split*:-			phase 1
(based on population shares)	Resident populations	%	£
Cardiff & Vale	493446	20%	118,219
Aneurin Bevan	587743	24%	140,811
Cwm Taf Morgannwg	443368	18%	106,222
Swansea Bay	387570	16%	92,854
Hywel Dda	384239	16%	92,056
Powys	132515	5%	31,748
Total Health Boards	**2428881**	**100%**	**581,909**

Estimated police force region split*:-			phase 1
(based on population shares)	Resident populations	%	£
Dyfed Powys Police	516754	21%	122,201
Gwent Police	587743	24%	139,658
South Wales Police	1324384	55%	320,050
Total police region	**2428881**	**100%**	**581,909**

- **Revenue costs**

The workforce model has been develop in line with the principles of the service specification developed in Phase 1 (2015/16) and reviewed with existing SARC managers.

As advised by the finance team in Phase 1 (2015/16), the cost of the workforce are based on NHS Wales Agenda for Change (A4C) pay scale (mid-point and including on-costs). There was recognition that the pay structures differ in the public sector to the third sector and that there was no standard pay structure across the third sector. It is acknowledged, however, that these costs only apply to NHS provided services and therefore are notional as a procurement process will need to take place for SARC services outside those currently provided by the NHS.

- **Non pay costs**

Non-pay costs comprise all costs not associated with payment of the workforce. This includes general consumables, drugs, travel, ISO accreditation etc. Costs to support the non-pay have been identified in the financial model.

To support the deliver of Phase 1 (Implementation of SARC Hubs for adults and children and establishing the commissioning framework and network), the non-pay cost included in the financial case is based on the current non-pay costs incurred by Ynys Saff SARC as the only existing integrated SARC hub for the region providing health and forensic assessment. There is also an additional £20,000 included to reflect the anticipated increase in travel costs for service users associated with a move to three hubs. A clear operating policy will need to be developed to support this. The non-pay costs will need to be monitored closely by the joint commissioning board.

Costs associated with the three-yearly assessment for ISO accreditation are recognised in the financial case. Any work required to meet accreditation standards for Ynys Saff SARC, Cardiff will be included within the C&V UHB major capital business case currently going through the All Wales planning process. Costs associated with relocation of Aberystywth will need to be

included in any appropriate capital bid for Hywel Dda UHB as referenced above, as will those for the children's SARC hub in Swansea, led by Swansea Bay UHB. Further, discussions will need to take place regarding Swansea adult hub as the premises are owned outright by the third sector and have recently been subject to complete refurbishment. Clarification will need to be sought regarding the level of involvement by the police in developing the forensic requirements of the new build and assurance from the third sector that ISO requirements have been addressed

The police throughout the UK have always provided specialist forensic consumables to allow for quality assurance from suppliers. No changes to this model have been considered to date.

- **Capital Costs**

Capital costs have not been included in phase 1 or 2 as the focus of the project has been on reconfiguration of existing services.

Therefore, there is an assumption that equipment including scopes, consumables etc. that currently support forensic service at the SARC sites, that will no longer host a forensic facility, will be transferred to the new SARC Hubs.

Whilst it is not possible to go into significant detail regarding capital costs at this stage, it is possible to clarify some high level principles associated with management of capital costs. There is also an assumption that existing funding streams will continue until a formal change to the commissioning model is in place. Any changes to revenue and capital responsibilities outside those agreed by Boards in September, will also need to be agreed through a clear joint commissioning framework and will be developed through the proposed joint commissioning and procurement board, with representatives from health, police forces and police and crime commissioners

Where a SARC hub is located on health premises and requires capital investment, a business case for capital costs, which may collectively include the costs of equipment, fixtures, fittings and inclusion of examination facilities to meet ISO standards, would be developed by the Health Board hosting the SARC Hub and considered through existing NHS capital planning processes. Development of the business case would require endorsement from police colleagues.

There are currently two capital planning streams in the NHS. The process followed will depend on the level of investment required. Each Health Board has a discretionary capital programme, which addresses smaller capital

requirements. This would also be available to apply for replacement equipment. In addition, where major capital investment is required, it would be necessary to develop a formal business case by the hub host provider for consideration through the All Wales Capital Planning Programme.

Where a SARC hub is located on an NHS site, ongoing responsibility associated with the maintenance of the site will also be the responsibility of the host Health Board.

- **Transitional Costs**

Transitional costs to support the implementation of the recommended service model e.g. commissioning and Network development, have been built into the overarching finances. Health Boards will continue to support a Programme director to lead the work. Police forces have indicated a commitment to identifying resource to support the Programme Director in the next phase of the work.

- **Additional costs**

It is recognised that the costs associated with the recommended model are only those identified as 'direct costs'. Both health and the police incur significantly more costs associated with SARC service provision, as part of their wider service delivery.

Consideration will need to be given to how any unforeseen costs will be accommodated. This will need to be considered by the joint commissioning board.

6.3 Future costs associated with Phase 2 and Phase 3.

It is acknowledged that further work is required to develop detailed models and associated costs of delivery for the 'spoke' services and FME services. It is recognised that each proposed phase can be considered independently. Each phase will require a separate business case and approval from individual organisations to proceed with implementation. An organisation which currently incurs the costs associated with providing the services to be considered in phases 2 and 3, will continue to do so until a detailed model and financial framework has been agreed and the new model commissioned and implemented.

Phase 2 will look at the provision of the SARC spokes. £1,180,191 was allocated in the original modelling work to accommodate this area for ISVAs (£785,740) and counselling (£394,450) (figures have been uplifted for agenda for change banding and inflationary increases). Significant work will be required to look at therapeutic requirements and costs, which has been excluded from work to date.

Phase 3 will look at the forensic medical examination service. £666,619 (figure has been uplifted for inflation) was identified as the associated cost of the FME service in the original modelling work.

Assuming there are no further increases costs following the detailed work required in stage 2 and 3 this would result in a total model costing £3,034,713.

For comparative purposes, this would mean an additional investment in the region of £**1,432,995** across the commissioning organisations.

Table 4. Differences between current and proposed costs

Regional model	
Costs of current model	£1,601,758
Costs of proposed model	£3,034,713
Difference	**£1,432,995**

There is no additional funding identified to support the proposed increase in costs above the current service level at present. However, following the work of the NHS Wales Health Collaborative (2016), the Cabinet Secretary for Health wrote to Health Boards outlining his intention that future funding requirements as detailed in the NHS Wales Health Collaborative financial assumptions should be ring-fenced from 2016/17 onwards. This equals £1,684,453.

7. EQUALITY IMPACT ASSESSMENT

An EIA was undertaken in phase 1 (2015/16) of the project, which was used to inform the initial recommendation to the SARC Project Board. This work included review of national evidence and formal engagement with key stakeholders to identify the potential impact on protected characteristic groups The EIA has been updated to reflect the work in Phase 2 (2018/19) (attachment 6). As Phase 2 continues to follow the principles in Phase 1, the EIA continues to underpin the recommendations in this paper.

It is anticipated that further formal engagement will be required. This will need to be proportional and undertaken in collaboration between health organisations and police organisation. Advice is also being sought from the Community Health Councils in Wales, who had been engaged at the earlier stages of the Project in Phase 1.

8. RECOMMENDATIONS TO THE SARC BOARD

Significant work has taken place with partner agencies over the last 12 months in order to bring forward proposals for a regional SARC service model.

The Project Board are now asked to approved the following recommendations:

Recommendation 1.	There should be two paediatric hubs *(Swansea and Cardiff) providing in-hours services for children up to their 16th birthday.* *Training and recruitment of staff will be required and a costed optional appraisal to identify appropriate accommodation in Swansea that meets forensic standards and standards for children's services.*
Recommendation 2.	*There will be one paediatric hub (Ynys Saff SARC) that will provide services out of hours for children across the region up to their 16th birthday,*
Recommendation 3.	*Children 16-17 will have their forensic examination undertaken by an FME at the appropriate local SARC Hub at all times.* This will be subject to evaluation and review moving forward.
Recommendation 4.	*There will be a commitment to developing appropriately trained paediatricians to undertake forensic medical examination for children presenting at the paediatric SARC hubs.* *It is anticipated this will take 3-5 years due to training requirements.*
Recommendation 5.	*There is a commitment to developing pathways for children up to their 16th birthday, who live in North Powys to attend for service in Colwyn Bay, North Wales, if they require a forensic medical examination.*

Recommendation 6.	*There will be a single adult hub in South East Wales, at Ynys Saff SARC, Cardiff which will provide services to the populations of South East Wales* *SARC Spokes for the region will be in Risca and Merthyr Tydfil.* *Ynys Saff SARC Hub will also act as a spoke for Cardiff and Vale region.*
Recommendation 7.	*There will be a single adult SARC hub in South West Wales provided in Swansea, which will provide services to the population of South Dyfed Powys region and Swansea.* *Swansea SARC Hub will also act as a SARC spoke for the Swansea region.*
Recommendation 8.	*There will be a single adult SARC hub in Dyfed Powys provided in Aberystywth, which will provide service to the population of Mid and West Wales.* *SARC Spokes for the region will be in Newtown and Carmarthen.* *Aberystywth SARC Hub will also act as a SARC spoke for the Aberystywth region.*
Recommendation 9.	*There will be a commitment from Police organisation to move towards a single provider for FME services across the region.* *This will be phased over 3-5 years due to existing contractual arrangements.*
Recommendation 10.	*There will be a commitment from Health organisations and police organisations to developing an NHS provided FME service throughout Wales.*

	This will require a commitment to formal training of healthcare professionals and recognition within job plans for trainers and trainees on a regional basis. This will also require commitment to management of new/existing contracts with private providers to support the training of clinicians. *Funding will need to be clearly identified to support the training and running of an NHS provided model.* *It is anticipated this will take 5-10 years due to training requirements.*
Recommendation 11.	*There will be a formal joint procurement process (health and police), led by NHS Wales to appoint the hubs and spokes across the regional service model.* *Consideration will need to be given to ensuring there is flexibility in the process to meet local population needs alongside the core requirements of the new service model.*
Recommendation 12.	*An All Wales SARC Delivery Network is established, comprising an Operational Delivery group and a joint Commissioning Board with a lead commissioning organisation.*
Recommendation 13.	*A Lead commissioning organisation from health is appointed to establish and manage the contracts and commissioning framework as part of the Delivery Network*
Recommendation 14.	*C&V UHB is formally appointed to host the Operational Delivery Group as part of the Delivery Network*

Attachment 1 Proposed Financial Framework May 2019

	JULY 19 VERSION PHASE1 COSTS Proposed		
	wte	**band**	**£000s**
Adult SARC HUB			
Sarc Manager	2	8a	114,579
Regional SARC Co-ordinator - South East Wales, South West, Mid & West Wales	2	6	78,575
Crisis worker	5	4	132,797
clinical lead/nurse	2	6	78,575
Crisis workers on call out of hours (adults)	2.5	4	66,399
Children's SARC hub-			
Consultant	2		257,142
Crisis worker	2	4	53,118
clinical coordinator	1.32	4	35,058
Paediatric/sexual health nurse	1.64	6	64,430
Paediatrician on call costs (intensity banding)			41,606
Crisis workers on call (children)	1	4	26,559
Clinical Network/regional costs:-			
Clinical Lead (Adult)	0.2		25,714
Clinical Lead (Children)	0.2		25,714
Network Manager	0.5	8c	40,462
Network/Data support (inc in above)	0.5	5	15,945
Commissioning lead	0.5		28,644
Non pay spend			78,500
Total	**53.86**		**1,163,817**

Attachment 1b. staging of costs associated with implementation of the SARC hubs for adults and children

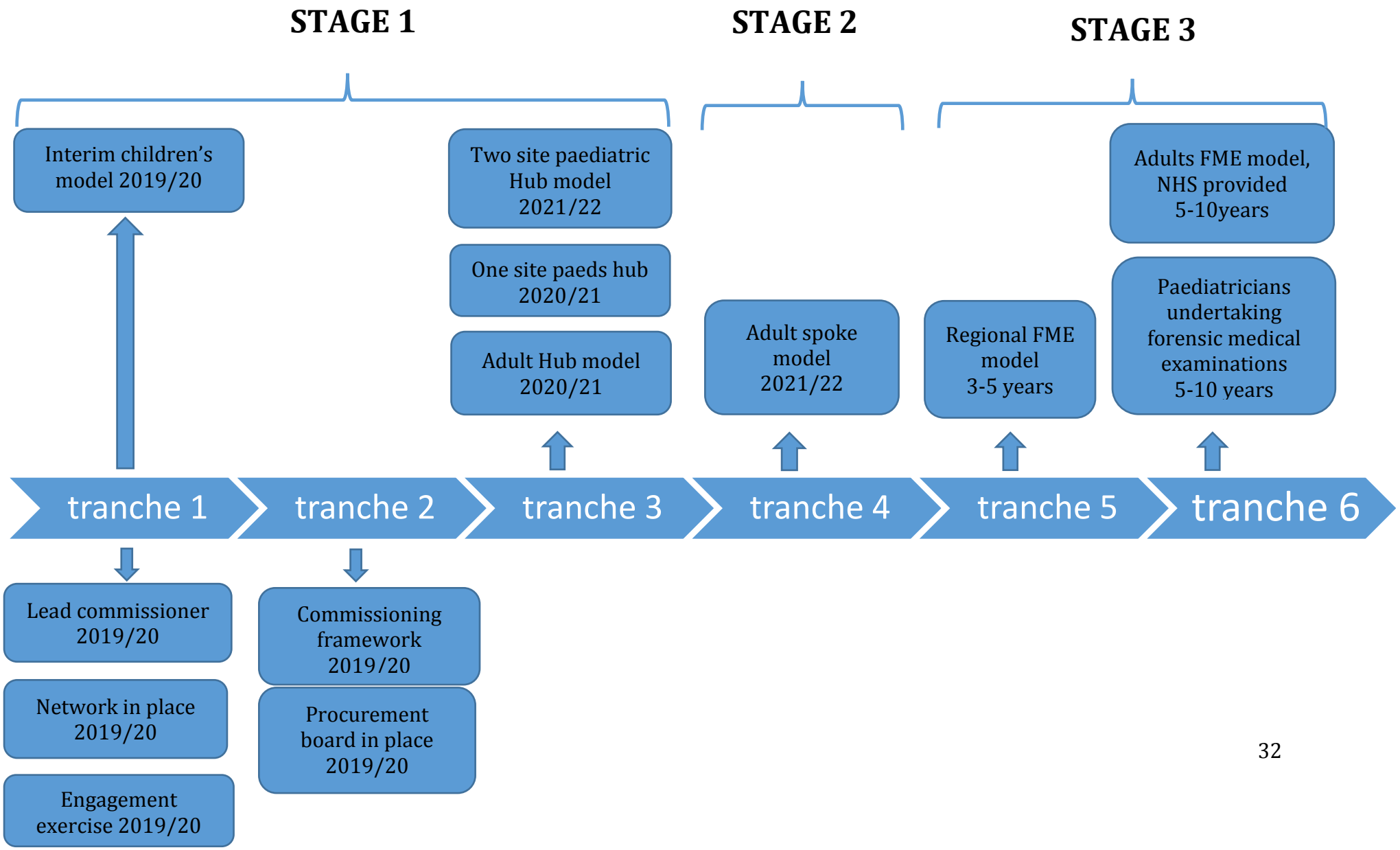
- This phasing excludes costs for ISVAs, Counselling and FME services.
- These costs will be in addition to the costs below and will continue to be paid by the current service contractor until the detailed costed models have been agreed and approved by each commissioning board.
- In the event that the service model for 'spokes' (ISVAs, Counselling) is agreed for implementation prior to 21/22, this figure may change.

phase 1 SARC hubs	**19/20 £**	**20/21 £**	**21/22**
Current costs	510,467		
Interim Children's Model	219,633		
Revised Hub Model (Adults)		470,925	470,925
Revised Children's Model		273,039	477,913
Lead Commissioner	14,322	28,644	28,644
Network	53,917	107,835	107,835
Non pay	58,176	78,500	78,500
Total	**856,515**	**958,943**	**1,163,817**
Current costs	510,467	510,467	510,467
Increased costs	**346,048**	**448,476**	**653,350**

Financial contribution based on population. Appropriate proportionality split to be further determined by police organisations.

	Population	%	year 1 19/20	Year 2 - 20/21	Year 3 - 21/22
Aneurian Bevan	587743	24%	61,409	114,249	140,825
Cardiff & Vale	493446	20%	51,557	95,919	118,231
Cwm Taf Morgannwg	443368	18%	46,325	86,184	106,232
Hywel Dda	384000	16%	40,122	74,644	92,007
Powys	132515	5%	13,846	25,759	31,751
Swansea Bay	387570	16%	40,495	75,338	92,863
Total Health Boards	**2428642**	**100%**	**253,753**	**472,092**	**581,908**
	Population shares	%	year 1 19/20	Year 2 - 20/21	Year 3 - 21/22
South Wales Police	1283000	54%	18,432	255,029	314,353
Gwent police	577000	24%	8,289	114,694	141,373
Dyfed Powys Police	515000	22%	7,399	102,369	126,182
total police	**2375000**	**100%**	**34,120**	**472,092**	**581,908**
grand total			**287,872**	**944,184**	**1,163,817**

Attachment 2. DRAFT TIMELINE



Attachment 3: Hub and Spoke service specification

Service Specification	**Hub**	**Spoke**
Twenty-four hour access to crisis support, first aid, safeguarding, specialist clinical and forensic care and ongoing support in a safe place	X	
The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance, the European Working Time Directive and agreed forensic standards	X	
Dedicated forensically approved premises and a facility with decontamination protocols following each examination to ensure high quality forensic integrity and a robust chain of evidence	X	
Access to forensic medical examiners (FME) and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children. Clients should also be able to choose the gender of the forensic examiner for their clinical examination.	X	
The forensic practitioners should be managed by health with joint funding from Health and Police to meet both health and forensic needs of the victim	X	
The medical consultation including risk assessment of self harm, together with an assessment of vulnerability and sexual health.	X	
There is immediate access to emergency contraception, post- exposure prophylaxis (PEP) or other acute, mental health or sexual health services. Follow-up as needed is coordinated through the spokes to local services	X	
Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant	X	X
Co-ordinated interagency arrangements are in place, including local third sector service organisations supporting victims and survivors.	X	X
Safeguarding boards (for children and adults) through will work with the Commissioning bodies to support the delivering of appropriate care pathways and standards across the service model.	X	X
Minimum dataset and appropriate data collection procedures in each SARC to ensure quality improvement and service user safety (including involvement with audit and risk management)	X	X
Access to support, advocacy and follow up through an independent sexual violence advisor (ISVA) service, to all victims, locally based, including support throughout the criminal justice process, should the victim choose that route		X
Access to appropriate therapeutic support for adults and children to support recovery from the trauma and trauma responses, provided by suitably qualified therapeutic professionals e.g. counsellors		X

Attachment 4: Key Principles underpinning service modelling

Childrens services

- National guidance (FFLM/ Royal College of Paediatric and Child Health (RCPCH) 2015) recommends that the service for the clinical evaluation of children will ideally see children up to the age of 18, but definitely up to their 16th birthday.
- Assessments for children must be undertaken by a qualified medical practitioner with appropriate competences (FFLM/ RCPCH 2012). Where one doctor does not have all the competences for an acute presentation, joint assessment with a paediatrician and forensic examiner is required.
- Paediatricians need to undertake a minimum of 20 forensic examinations per year, in order to maintain their skills. Consideration needs to be given as to how competencies can be maintained due to low numbers e.g. peer review.

Adult services

The option appraisal workshop in 2015, which looked at the service model for adults appraised options based on the following benefit criteria: safety and quality, sustainability and future proofing, access, equity, achievability, acceptability. The principles of this criteria have been considered when making the final recommendation for adult services,

Each SARC hub needs to:

- Be clinically safe and sustainable.
- Have clear clinical governance structures in place and lines of accountability
- Meet the service specification for a Hub
- Meet national guidance and standards associated with providing a SARC hub.

In addition to the above, each SARC spoke needs to:

- Meet the service specification for a spoke.

FME services

- Clinically safe and sustainable
- Forensic nurses are not able to examine children on their own
- FME practitioners cannot be directly employed by health, SLA will be required with police
- Any private contract arrangements will need to require the provider to identify a specific rota for FME SARC services.
- FME practitioners are able to prescribe Emergency Contraception (EC), human immunodeficiency virus (HIV), postexposure prophylaxis (PEP) etc on site (this excludes follow up treatment at present)
- Clear clinical governance structure in place

Each FME service must meet:

- service specification
- FFLM national guidance on training and supervision and provide evidence of doing so
- Minimum caseload requirements - FFLM recommends 20 cases per year
- European working time directive (EWTD) rota compliance minimum 1:6 non resident on call

Attachment 5: Baseline data set (2017/18) to underpin planning process

Table 1. Total number of cases and demographics

Age	<16	16-17	18+	total
No. individuals attending SARC	**440**	**170**	**1484**	**2094**

Table 2. Total number of cases and demographics

Age	<16	16-17	18+	total
Male	57	9	205	**271**
Female	382	160	1275	**1817**
Trans	1	1	4	**6**
Other	0	0	0	**0**
Prefer not to say	0	0	0	**0**
Total	**440**	**170**	**1484**	**2094**

Table 3. Assault type

Age	<16	16-17	18+	total
Acute	130	51	472	**653**
Non acute	210	76	338	**624**
Historic	100	43	672	**817**
total	**440**	**170**	**1484**	**2094**

Table 4. Breakdown by area of residency by health board *

	Health Bord	<16	16-17	18+	total
Area of residency by health board	Abertawe Bro Morgannwg UHB	106	40	236	**382**
	Aneurin Bevan UHB	70	30	354	**454**
	C&V UHB	120	32	424	**576**
	Cwm Taf UHB	60	36	172	**268**
	Hywel Dda UHB	53	21	187	**261**
	Powys HB	27	10	78	**115**
	other	4	1	33	**38**
Total		**440**	**170**	**1484**	**2094**

Table 5. Breakdown by area incident took place by police force

	Police Force	<16	16-17	18+	total
area incident took place:	Gwent police	69	32	317	**418**
	South Wales Police	282	104	825	**1211**
	Dyfed Powys Police	79	29	242	**350**
	other	10	5	100	**124**
total		**203**	**170**	**1484**	**2094**

Table 6. Acute Forensic medical examination undertaken

		<16	16-17	18+	total
forensic medical examination undertaken:	Yes	77	34	272	383
	No	240	101	1116	1457
	declined	114	35	15	164
	other	9	0	28	37
	unknown			53	53
Total		**440**	**170**	**1484**	**2094**

Table 7. Acute Forensic medical examinations undertaken by region by SARC

Region	SARC	<16*	16 - 17	18+	total
Mid and West Wales	Aberystwyth	0	1	12	13
	Newtown	2	0	11	13
	Carmarthen	3	6	24	33
	total	**5**	**7**	**47**	**59**
South West Wales	Swansea	5	7	46	71
	Sapphire Suite, Singleton Hospital	18	0	0	18
	total	**23**	**7**	**46**	**89**
South East Wales	Ynys Saff Cardiff,	33	5	81	119
	Risca	11	6	61	78
	Merthyr	5	9	37	51
	total	**49**	**20**	**179**	**248**
	Grand total	**77**	**34**	**272**	383

*Data is based on flows as health boards prior to new boundaries coming into place 1st April 2019. Prior to this date Bridgend residents flow to Ynys Saff SARC CandV UHB. There is no change intended to this flow at present. However, this activity will need to be acknowledged under Cwm Taf Morgannwg UHB post 1st April 2019 rather than Swansea Bay UHB (formerly ABM UHB).

**It is assumed that figures for SARCs other than Ynys Saff relate to children 14-16 as current model of care enables children >14 to have a forensic examination at a local SARC. Under the preferred model all children up until the age of 16 will be seen at a paediatric SARC hub.

NB: minimum caseload requirements are 20 cases per annum for a forensic examiner.

Attachment 6a: Indicative travel times; theaa.com

	Aberystwyth	Brecon	Cardiff	Carmarthen	Colwyn Bay	Fishguard	Haverford West	Llandrindod Wells	Merthyr	Machynllaeth	Newtown	Pembroke Dock	Risca	Swansea	Welshpool
Aberystwyth	0	1h 43	2h 33	1hr 20	2hr 19	1hr 28	1hr 43	1hr 08	2hr	32min	1hr 08	1hr 57	2hr 32	1hr 55	1hr 26
Brecon	1hr 43	0	1h 02	1h 13	4h 59	2h 08	1h 51	43min	30 min	1h 41	1hr 23	1hr 51	59min	1hr 04	1hr 40
Cardiff	2hr 33	1h 02	0	1hr 17	4hr 01	2hr 11	1hr 54	1hr 37	35min	2hr 34	2hr 16	1hr 50	25min	56min	2hr 34
Carmarthen	1hr 20	1h 13	1hr 17	0	3hr 35	59min	41min	1hr 22	1hr	1hr 48	1hr 59	41min	1hr 22	40min	2hr 16
Colwyn Bay	2hr 19	4h 59	4hr 01	3hr 35	0	3hr 42	3hr 56	2hr 30	3hr 36	1hr 47	1hr 54	4hr 11	3hr 53	4hr	1hr 35
Fishguard	1hr 38	2h 08	2hr 11	59min	3hr 42	0	25min	2hr 57	1hr 53	1hr 55	2hr 29	40min	2hr 14	1hr 32	2hr 47
Haverford West	1hr 43	1h 51	1hr 54	41min	3hr 56	25min	0	2hr	1hr 38	2hr 09	2hr 37	20min	2hr	1hr 18	2hr 55
Llandrindod Wells	1hr 08	43min	1hr 37	1hr 22	2hr 30	2hr 57	2hr	0	1hr 05	1hr 07	39min	2hr	1hr 33	1hr 41	57min
Merthyr	2hr	30 min	35min	1hr	3hr 36	1hr 53	1hr 38	1hr 05	0	2hr 02	1hr 44	1hr 34	36min	43min	2hr 02
Machynllaeth	32min	1h 41	2hr 34	1hr 48	1hr 47	1hr 55	2hr 09	1hr 07	2hr 02	0	45min	2hr 20	2hr 31	2hr 22	55min
Newtown	1hr 8	1hr 23	2hr 16	1hr 59	1hr 54	2hr 29	2hr 37	39min	1hr 44	45min	0	2hr 33	2hr 12	2hr 20	21min
Pembroke Dock	1hr 57	1hr 51	1hr 50	41min	4hr 11	40min	20min	2hr	1hr 34	2hr 20	2hr 33	0	2hr	1hr 18	2hr 54
Risca	2hr 32	59min	25min	1hr 22	3hr 53	2hr 14	2hr	1hr 33	36min	2hr 31	2hr 12	2hr	0	1hr 02	2hr 31
Swansea	1hr 55	1hr 04	56min	40min	4hr	1hr 32	1hr 18	1hr 41	43min	2hr 22	2hr 20	1hr 18	1hr 02	0	2hr 35
Welshpool	1hr 26	1hr 40	2hr 34	2hr 16	1hr 35	2hr 47	2hr 55	57min	2hr 02	55min	21min	2hr 54	2hr 31	2hr 35	0

Proposed pathways for Childrens Services - In-hours		
Paediatric Hub Cardiff	**Paediatric Hub Swansea**	**North Wales SARC**
Cardiff	Swansea	Machynllaeth
Merthyr	Aberystywth	Newtown
Risca	Carmarthen	Welsh Pool
Brecon	Fishguard	
Llandrinod Wells	Haverfordwest	
	Llandrindod Wells	
	Pembroke Dock	

Proposed Pathways for Adult services		
Cardiff SARC Hub	**Swansea SARC Hub**	**Aberystyth SARC Hub**
Cardiff	Swansea	Aberystwyth
Merthyr	Carmarthen	Fishguard
Risca	Fishguard	Llandrindod Well
Brecon	Haverfordwest	Machynllaeth
	Haverfordwest	Newtown
	Pembroke Dock	Welsh Pool

Proposed pathways based on indicative travel times

SEXUAL ASSAULT SERVICES PROJECT, SOUTH, MID AND WEST WALES - Phase 2
EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT
March 2018

About this document

This technical document has been produced to provide background evidence to support information provided within proposal for the reconfiguration of regional sexual assault services referral centre (SARC) model across South, Mid and West Wales.

This document is meant as a reference guide, it does not provide exhaustive detail. It aims to provide an overview of how the proposals for reconfiguration of SARC services may affect different groups within our population. It is a living document and will be added to by information gathered through all stages up to and including delivery of services where actual impact will be monitored.

This document builds on the initial EIA developed in Phase 1 of the Project, which includes evidence collected through engagement with clients of the SARCs, carers, equality groups and stakeholders

1. Background

In 2013, Welsh Government commissioned a review to examine the extent to which the SARCS fulfilled the requirements of Public Health Wales service specifications, victims' needs, any unmet gaps in provision and the interdependencies between SARCs and other services. The findings from the review formed the case for change for a multi-agency review of sexual assault services across mid, south and west Wales, led by the NHS Wales Health Collaborative (phase 1) - a Project Board was established comprising representatives from health, the police force and the third sector, to oversee the development of a service model.

In Phase 1, the SARC project developed a 'hub and spoke' service model, based on national guidance. This resulted in a model with three hubs (Cardiff Swansea, Carmarthen) and four spokes (Merthyr Tydfil, Risca, Aberystywth and Newtown) – towns where SARCs already existed.. The decision on a hub and spoke model and the number of hubs in the region made following an extensive option appraisal process, where consideration was given to safety and quality, sustainability and future proofing (including the ability to meet critical mass and minimum caseload requirements), access, equity, achievability and acceptability.

This model was agreed in principle subject to a further review following concerns raised by Dyfed Powys Police regarding access to forensic services for the population in the north of their region. In June 2018, Phase 2 of the SARC project was established. A commitment was given by the Project

Board to review the proposed service models, costs and activity as well as the provision of FME services across the region (Phase 1 assumed the status quo remained).

2. Case for Change

Sexual assault referral centres (SARCs) were created in 2007/08 through a Home Office funded initiative to improve the public service response to victims of rape and sexual abuse. There is a wide range of publications setting out legislation, standards and guidance which is relevant to the development of a holistic sexual assault service.

Within Wales, in 2010, Welsh Government published service specifications, developed by Public Health Wales, for services for adults and children who have or may have been sexually abused. In 2013, Welsh Government commissioned a review to examine the extent to which SARCs fulfil the requirements of the Public Health Wales service specifications, victims' needs, any unmet gaps in provision and the interdependencies between SARCs and other services.

The Wales Sexual Assault Referral Centre Review 2013 found that:

- The service provided to services users across Wales is inconsistent due to varying resources and service provision
- The national service guidelines, issued by Public Health Wales, state that "SARCs should be accessible to victims of recent rape or serious sexual assault" but there was also a view from frontline staff that the provision should be available to all victims (historic, acute, serious and less-serious assaults)
- Provision for child victims is inconsistent with variations in access to forensic medical examiners (FMEs) and paediatricians
- Preventative and education work is dependent on the commitment of staff over and above their case load
- There is good evidence of benefits to the criminal justice process but no evaluation of benefits to health services of the SARC provision
- The identified cost of the SARC service is supplemented by ad hoc funding from public agencies and services provided in kind (e.g. estate, equipment)
- There are inefficiencies in the processes relating to interdependencies with follow on services which are navigated by independent sexual violence advocates (ISVAs) on behalf of clients
- Demand is highly likely to increase over and above the increase experienced since the introduction of SARCs in Wales
- Regional centres were recommended in the Public Health Wales' service specifications, which is supported by the numbers of forensic examinations required

The 2013 review highlighted the lack of sustainable funding as an issue affecting:

- Impact on range of services available
- Retention of staff
- Efforts to raise funding (some funding streams are not available to all agencies)
- Capacity and capability to raise funds exists in all lead agencies

- Fairness of funding provision
- Reliance on shortfalls in funding being covered by police, Welsh Government and lead health boards on an ad hoc basis

'An Overview of Sexual Offending in England and Wales' published in January 2013 suggested that 15% of adult victims of serious sexual offences report the incident to the police which indicates potential additional demand for services. There is no comparable data for child victims.

2.1 The SARC Project and the service model

The overarching aim of the Project is to improve health outcomes for victims and survivors of sexual assault and abuse through improving access to services for victims and survivors of sexual assault and abuse and supporting them to recover, heal and rebuild their lives.

The sexual assault service for South, Mid and West Wales serves the populations of Aneurin Bevan University Health Board (UHB), Abertawe Bro Morgannwg UHB, Cardiff and Vale UHB, Cwm Taf UHB, Hywel Dda UHB and Powys teaching Health Board (THB). This includes the police forces, local authority and third sector partners who serve that population. Close alignment between the NHS, police and third sector is necessary to deliver specialist SARC services that are equitable, meet health needs, support forensic enquiry for any criminal investigation, address safeguarding issues (children and adults), and support the wider recovery and safety needs of victims and families.

North Wales have not been part of the initial service development work, but it is recognised that there are significant benefits from working across Wales and there should be a move to developing an All Wales networked service.

The service model addresses the needs of men, women and children of all age groups, but differentiates between children less than 16 years of age, those aged 16 to 17 years of age and adults (18+ years of age). It has be driven by the needs of the victims and provides assurance to all stakeholders that relevant clinical, forensic, quality and safety standards and guidance are being met, and that robust governance arrangements are in place.

The service model, has considered the acute phase (delivered by Sexual Assault Referral Centres (SARCs) and follow up (sexual assault services), as defined in the initial phase of the SARC project.

Options for the future configuration of SARCs were initially considered in Phase 1 of the project and a hub and spoke model was agreed as the preferred solution, with three adult SARC hubs and two paediatric SARC hubs supported by spokes, being the preferred configuration.

The definition of a SARC hub and SARC spoke as agreed through the SARC project is as follows:

SARC Hub: 'A dedicated facility to provide immediate client care within the context of a partnership arrangement between police, health and the third sector. This should include an acute forensic examination with referral pathways in place to local services to support follow up care'.

In addition, the Hub should provide an acute health needs assessment which includes emergency contraception (including emergency IUD fitting) and STI risk including HIV and Hepatitis B with management and the provision of medication at first attendance where indicated. Emergency referral for other health needs can be initiated (mental health, accident and emergency) as well as social services referrals.

SARC Spoke: 'A dedicated facility to provide immediate and on-going client care within the context of a partnership arrangement between police, health and the third sector but does not provide forensic medical examinations'. The spoke should also provide support for victims engaged in criminal justice proceedings. A hub would also house a spoke facility for the local community

2.2 Impact on Workforce

Proposals to reconfigure SARCs may affect staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board, police and local authority boundaries. Consideration will also need to be given to the potential impact on workforce associated with an open and transparent procurement process for both the overarching SARC services and the forensic medical examination services.

Appropriate advice will need to be sought from specialists where necessary including, legal, Human Resources, trade unions etc. to achieve an effective transition to any new arrangements. Individual organisations will be responsible for engaging with staff on proposals and agency specific policies. A partnership approach with trade union colleagues will be ensured

3. Equality and Human Rights

Under the Equality Act 2010 there is a legal duty to pay due regard to duties to eliminate discrimination, advance equality and foster good relations between those who share protected characteristics and those who do not. This means the needs of people from different groups must be considered and reasonable and proportionate steps wherever possible to eliminate or mitigate any identified potential or actual negative impact or disadvantag
e. The Equality Act 2010 gives people protection from discrimination in relation to the following "protected characteristics"[1]

- Age
- Disability

[1] Race; Sex; Gender Reassignment; Disability; Religion; belief/non belief; Sexual orientation; Age; Pregnancy and Maternity; and Marriage and Civil Partnerships: Equality Act 2010

- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

The Human Rights Act 1998 also places a positive duty to promote and protect rights for all. In Wales, we also have a responsibility to comply with the Welsh Language (Wales) Measure 2011 and All Wales Sensory Loss Standards for Accessible Communication and Information for People with Sensory Loss. We will take all our legal duties into consideration when we make decisions around reconfiguration of sexual assault service across the region.

This document is not intended to be a definitive statement of the potential impact of reconfiguration of sexual assault services and SARCs on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact of the service proposals and to take this into account in making recommendations and decision-making.

4. Equality Impact Assessment

EIA is an ongoing process running throughout the course of the decision making process, from the start through to implementation and review. It requires us to consider how the proposed reconfiguration of SARC services may affect a range of people in different ways. The EIA will help answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

Looking at a range of national research evidence and engagement with key stakeholders has helped us to consider the potential impact. In particular, we are aware that many people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage.

While socio-economic status is not a protected characteristic under the Equality Act 2010, there is a strong correlation between the protected characteristics and low socio-economic status, demonstrated by the findings of numerous research studies.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics.

A literature review was carried out as a first stage of gathering evidence to inform the EIA, which identified potential impacts of the proposal on protected characteristic groups. During Phase1 of the Project, there was also formal engagement with stakeholders to develop the service model. The outcome of this work is available in a separate report.

There was general acknowledgement of the case for change and the feedback gathered fell within a number of key themes:

- Structure / continuity of care - general support for a hub and spoke model but there must be clear and effective working relationships between the hubs and spokes and support groups to ensure continuity of care
- Service model – importance of self-referral and holistic provision
- Information / communication – need for improved communication and information mechanisms for survivors which will improve service awareness and trust
- Funding – needs sustainable funding and development should not damage funding opportunities
- Access to support services – the requirement for support through independent sexual violence advisors (ISVAs) and counsellors, and referral on to continuing support services, was strongly emphasised
- Access - timeliness of access to the right person and the need for trust in the service
- Workforce – capacity to meet the needs of each victim, support for staff and taking opportunities to improve joint working across related services, e.g. sexual assault and domestic violence

United Nations Convention on the Rights of the Child

Children under the age of 18 are protected by the United Nations Convention on the Rights of the Child (UNRNC). Providers have a duty to protect, promote and fulfil the rights of the child. The UNRNC should be considered in conjunction with the Human Rights Act and the duty to promote fairness, respect, equality, dignity and autonomy. Due regard must be given to the specific needs of a person of his/her age, and in particular the right to maintain contact with family members. The convention recognises that children themselves, not adults, are entitled to be involved in decisions that affect them.

4.1 Potential impact on protected characteristic groups

This section of the document, recognises the potential impact on protected characteristic groups as identified in Phase 1 of the Project and incorporates the views collected through engagement with clients of the SARCs, carers, equality groups and stakeholders.

4.1.1. Gender

There is evidence from the Crime Survey for England and Wales (CSEW 2013/14) and research papers to show that women and girls are at greater risk than men in terms of sexual assault and are more likely than men to have experienced intimate violence[2] across all headline types of abuse. The 2013/14 CSEW report found that overall 19.9% of women and 3.6% of men having experienced sexual assault (including attempts) since the age of 16.

Though women make up the larger portion of sexual violence, the Report of the Independent Review into the Investigation and Prosecution of Rape in London, 2015, (Angiolini)[3] suggests that men feel a sense of isolation in being able to report such crimes, due to the emphasis placed on "violence against women and girls." There may be some hesitation from men in accessing services which are traditionally focused towards women and girls, and therefore put men who have been victims of sexual violence at a disadvantage in access to SARCs.

4.1.2 Age

Age is a risk factor for sexual assault. The CSEW found that, among both men and women, the prevalence of intimate violence was higher for younger age groups. Young women were more likely to be victims of any sexual abuse in the last year; 6.7% of women aged between 16 and 19 compared with all older age groups (for example, 2.0% of women aged between 25 and 34). In considering children, more than one third of all rapes recorded by the police are committed against children under 16 years of age[4].

Potential impact: Young people may have different needs and will require a joint assessment with a paediatrician and forensic examiner. When treating children, the service model will additionally follow the standards and criteria outlined for children's services[5].

[2] Intimate violence is the collective tem used by the CSEW to describe domestic abuse, sexual assault and stalking
[3] Report of the Independent Review into the Investigation and Prosecution of Rape in London (2015) Angiolini
[4] Crime in England and Wales 2005/06 Home Office Statistical Bulletin (via Call to End Violence Against Women and Girls Equality Impact Assessment (March 2011) HM Government)
[5] http://www.england.nhs.uk/wp-content/uploads/2014/04/d15-major-trauma-0414.pdf).

There is a need to consider further the transitional needs of young adults aged between 16 and 18 to ensure that they receive appropriate care, an age-appropriate setting. Whilst they will be treated as adults for examination purposes, legally they are still considered children and it is important to ensure that their holistic needs are considered within this context.

4.1.3. Race

Ethnicity can increase vulnerability due to the isolated nature of some communities, cultural expectations and issues such as lack of appropriate interpretation facilities.
Women and girls from a black, minority-ethnic (BME) background may find it more difficult to leave an abusive situation due to cultural beliefs or a lack of appropriate services. Forced marriages, Female Genital Mutilation (FGM) (see detail under 'gender' on previous page) and so called 'honour'-based violence are more likely to be prevalent in (although not limited to) certain communities, although the data on these crimes is limited[6].

Research found around BME women's experience of sexual violence services is not tailored well to the needs of the communities, and should be thought about locally and to specifically develop practice which meets the needs of BME women and girls (Between the Lines, 2015, Thiara, Roy and Ng[7]). This research further suggests a number of gaps existing within service responses to BME women experiencing sexual violence, suggesting engagement with these communities in the delivery of SARC services. The research itself identified the current engagement with BME women as generally inaccessible, making it even more difficult for BME women to access services and disclose pertinent information in an already difficult and complex situation. Services should not be "one size fits all," but meet the needs of the locally identified groups, in order to ensure SARCs are accessible for the at risk populations in that area.

The Between the Lines (2015) report also addresses the cultural barriers between service professionals and the communities, including; cultural taboos, stigma, and language. It is crucial that those professionals responsible for sexual assault services and the SARCs are appropriately educated on the specific cultural practices or beliefs which may impact on Black and Minority Ethnic (BME) women and girls' access to services, and what may prevent them from accessing such services. The research suggests, although this research is women specific, knowledge gained around the need of culturally sensitive services can be effectively transferred to the larger BME groups.

Potential Impact - there is a need to consider requirements of those clients who may require translation or interpretation services, and access to volunteers or staff who can converse in their first language. Cultural issues are also important to take into account.
There is also a need for support and training for staff in SARCs to develop expertise in responding to the needs of BME community. Overall, it is important that the local community is adequately engaged in order to determine which services and professional practice best suits the needs of the

[6] Call to End Violence Against Women and Girls Equality Impact Assessment (March 2011) HM Government
[7] Between the Lines: Service Responses to Black and Minority Ethnic (BME) Women and Girls Experiencing Sexual Violence, May 2015 by Dr. Ravi K. Thiara, Sumanta Roy and Dr. Patricia Ng

BME women and girls in that area, as needs are diverse and accessible services is of the upmost importance in the safety and lives of those accessing SARCs across South, Mid, and West Wales.

4.1.4. Disability

The Looking into Abuse (2013)[8] report states that sexual abuse is prevalent among people with learning disabilities and that it is commonly linked with other physical and psychological abuse. Disabled women may be around twice as likely to be assaulted or raped, and more than half of all women with a disability may have experienced some of form of domestic violence in their lifetime[9].

Potential impact - people with learning disabilities should have a greater access to safety/abuse awareness courses that are developed specifically to meet their needs. Information and services provided in SARCs needs to be evaluated and made accessible to people with learning disabilities. The report

As well as physical disability, there is a need to consider learning disabilities and mental health. Communication needs in these client groups may be more challenging and care should be adapted accordingly, for example, where there is a need for BSL interpretation services.
There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss[10] that apply directly to emergency and unscheduled care (in addition to primary care and other secondary care services) and these outline the staff training requirements, communication systems and equipment and patient needs information which should be provided by health boards. BSL interpreters will be required for the deaf community.

4.1.5. Marriage and civil partnership

The CSEW reported that women who were separated had the highest prevalence of any domestic abuse in the last year (22.1%) compared with all other groups by marital status (such as married (3.7%), cohabiting (8.9%) or divorced (15.5%). Married men experienced less domestic abuse (2.1%) compared with all other groups by marital status except widowed (3.9%, difference not statistically significant).

The pattern was slightly different for sexual assault with single women (4.1%) being more likely to be victims compared with those who were married (1.0%), cohabiting (1.6%), divorced (2.6%) or widowed (0.3%). This is likely to be strongly related to age.

4.1.6. Pregnancy and maternity

Evidence has shown many victims of domestic abuse experience such abuse whilst pregnant. Studies show 30% of domestic violence starts during pregnancy and up to 9% of women are thought to be abused during pregnancy or after giving birth[11].

[8] Looking into Abuse: research by people with learning disabilities, Looking into Abuse Research Team (2013) University of Glamorgan, Rhondda Cynon Taff People First and New Pathways

[9] Hague, G. Thiara, R. K. Magowan, P. (2008) *Disabled Women and Domestic Violence Making the Links* Women's Aid (via Call to End Violence Against Women and Girls Equality Impact Assessment (March 2011) HM Government)

[11] EqIA Part 1 – Gender-based violence, domestic abuse and sexual violence (Wales) Bill (June 2014) Welsh Government

4.1.7. Religion or belief (including lack of belief

Certain types of violence disproportionately impact on women from some communities and these have been noted under 'race'.

Potential impact - staff need to consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them[12]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered. As previously a comprehensive cultural awareness toolkit is available for this purpose.

4.1.8. Sexual orientation

UK surveys have found that the prevalence of violence in intimate Lesbian, Gay, Bisexual, Transgender (LGBT) relationships usually mirrors that in heterosexual relationships, with approximately one in four to one in three individuals in LGBT relationships experiencing domestic abuse at some point. Men are more likely to report violence than women[13].

Research for the South Wales Police and Crime Commissioner found that the SARCs appeared to be accessible for LGB communities with 7% of adult referrals coming from LGB communities. Research by Angiolini in 2015[14] further suggests that gay men face greater barriers in reporting than their heterosexual counterparts, and that SARCs may not be well enough equipped to address these cases. A specialist LGBT service in London urged that there is a wider recognition and discussion around LGBT reporting and need for a greater understanding around the barriers they face in accessing SARCs.

The Unhealthy Attitudes report by Jones and Somerville[15] provides some clear statistics and information about views and attitudes among health and social care staff which may lead to improper treatment of LGBT people, further emphasizing the need for training on LGBT issues among the workforce. The report states that "Almost three in five (57 per cent) of health and social care practitioners in Wales with direct responsibility for patient care don't consider sexual orientation to be relevant to an individual's health needs." It further reports that "Just one in twenty patient-facing staff said they have received training on the health needs of lesbian, gay and bisexual people or trans people's health needs (both four per cent)."

Potential impact: Professionals and staff should be trained to appropriately meet the needs of LGBT groups, as well as people with other protected characteristics.

*4.1.9. Trans**

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth.

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[12] http://www.gmc-uk.org/guidance/ethical_guidance/21179.asp

[13] EqIA Part 1 – Gender-based violence, domestic abuse and sexual violence (Wales) Bill (June 2014) Welsh Government

[14] Report of the Independent Review into the Investigation and Prosecution of Rape in London (2015) Angiolini

[15] Unhealthy Attitudes: The treatment of LGBT people in health and social care organisations in Wales, Stonewall Cymru, November (2015)

As a group which already experiences disproportionate levels of mental ill-health it is vitally important that matters of sexual assault are handled appropriately as to not cause further avoidable mental health issues.

The Trans Mental Health Study (2012[17]) provided data on participant experiences of sexual violence. 17% of participants reported they had experienced domestic violence as a result of their trans identity, 11% stating they had experienced reoccurring domestic violence. The study also stated that 14% of participants had been sexually assaulted due to their gender identity, and 6% of participants reported being raped as a result of being trans. It was also noted in this study that a large proportion of trans people worry about being sexually assaulted or abused in the future, further impacting on their overall mental health

The 2015 report by Angiolini[16] also suggests that trans individuals face great obstacles in reporting sexual violence, and that services are ill-informed and ill-equipped to understand and handle these crimes. There is a lack of understanding and knowledge around trans issues generally, which transfers into the realm of sexual violence. It is important that these gaps in knowledge are addressed as to allow for proper case handling around sexual violence in the trans community

Potential Impact - In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015[19] Trans* people must be accommodated in line with their gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's Gender Recognition Certificate or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

4.1.10. Welsh Language

Public services have a responsibility to comply with the Welsh Language (Wales) Measure 2011. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. Whilst we recognise that Welsh and English are Wales' official languages, Wales has many different voices. Like two-thirds of the world's population many people in Wales are bilingual or multilingual. This is particularly important in traumatic situations where people are more likely to need to communicate in their first language.

Potential impact - Service users who prefer to communicate in the medium of Welsh may be required to access specialist services which do not have sufficient Welsh speaking staff (this may also be the case for languages other than English). This could affect the service user's ability to

[16] Report of the Independent Review into the Investigation and Prosecution of Rape in London (2015) Angiolini

communicate with service providers in their preferred language. Meeting the information and communication needs of victims who speak Welsh will need to be taken into account.

The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups - people with mental health problems; those with learning disabilities; older people and young children. However it is important to recognise groups of other individuals who have suffered life changing conditions that may benefit from community through the medium of welsh. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)[17]. Our consideration of equality takes account of this.

- Training – consistency of training for all staff including in relation to the needs of those with protected characteristics to ensure awareness of and responsiveness to cultural differences
- Children and young people – need to ensure equity of access to sexual assault services and health needs
- Equality impact assessment - must promote equality, ensure services are inclusive and services are known as being inclusive and services must make reasonable adjustments to meet needs of those with protected characteristics, regardless of service structure

4.2 Summary of findings to support Phase 1.

Sexual assault tends to be closely associated with gender and age with women and girls at greater risk of sexual abuse than men. However, victims of sexual abuse can be from across the whole spectrum of society, from all age groups, all ethnicities, religions and beliefs, people with disabilities and people from the LGBT community. The research suggested cultural barriers to accessing services for BME women and girls and, also, barriers for LGBT communities requiring wider recognition and discussion around LGBT reporting. The model and configuration of sexual assault services proposed aims to support anyone affected by sexual abuse.

There is a correlation between the evidence from research and from the feedback from engagement. Whilst some protected groups are more at risk than others, no negative impacts on the protected groups are anticipated from the proposed service development. It is anticipated that the work through the project has served to raise awareness of the needs of protected groups which can be used to inform current services and the proposals for the future configuration. They can also be shared with related policy developments, in particular implementation in Wales of the Violence against Women, Domestic Abuse and Sexual Violence (2015) Act. There was recognition that sexual assault services need to be properly resourced to respond to growing demand and to ensure services across the whole pathway of care can be planned on a sustainable basis. Also, the need for equality training for staff, information and signposting, was frequently highlighted through the engagement process.

The service proposals do not introduce any additional obstacles; improving standardisation for access and specialist treatment should improve outcomes across all social groups.

[17] More than just words: Strategic Framework for Welsh Language Services in Health, Social Services and Social care (2012)

The impact on protected groups will continue to be assessed following decision making and through implementation, and continuing engagement to identify any negative effects that may arise and associated mitigation measures.

5. Phase 2. Implementation Planning Phase 2018-2019

In June 2017, Phase 2 of the SARC project was established. A commitment was given by the Project Board to review the proposed service model taking into consideration the impact on the population, whilst also considering work previously undertaken in phase 1, which included the EIA.

Phase 2 reviewed the model, activity, service specification, victim and family needs, expected standards of care including clinical governance and associated costs. The Project recognized the challenges associated with the geography of Dyfed Powys and the necessity for a model reflective of the needs of the local population. It also acknowledged that, due to the small number of cases in the region, it would be difficult forthree SARC Hubs to develop a critical mass required to support the workforce in retaining their knowledge, skills and competencies necessary to maintain safe standards of care. Therefore, after extensive discussion and review of the supporting information, a revised service model has been agreed. The revised model supports the principles in Phase 1 - a single SARC hub for the Dyfed Powys region, supported by two spokes. However, it is proposed the SARC Hub is located in Aberystywth, with two additional spokes in Newtown and Carmarthen.

As a result, in the revised model access to forensic services in the north of the region would be retained including clients from the Powys area. Clients in the south of the region, would access forensic services from the SARC hub in Swansea.

For some of the population in the Dyfed Powys region, the transfer of forensic services from Newtown to Aberystwyth, may result in an increased journey if a forensic examination is required. However, travel times have been evaluated and would be maintained within a 2-hour timeframe for most residents in the north Dyfed-Powys region. Similarly, for individuals in the south of Dyfed Powys who would be travelling to Swansea for a forensic examination, travel time would be maintained within a two hour time frame, as far as possible, with the advantage of having more robust transport infrastructure. To address travel around the region, appropriate arrangements will need to be made, in conjunction with the local police force, to support the client to attend the SARC Hub where necessary. . Follow up therapeutic support would continue to be provided from the spoke services within Newtown SARC and Carmarthen SARC, and Aberystywth, which will also act as a spoke. Any follow-up required with regard to sexual health will be managed by pathways to one of the eight Sexual and Reproductive Health clinics within HDUHB and close to the clients home.

Stakeholders from Dyfed-Powys Police and HDUHB feel that this model provides equitable, safe and sustainable services to their clients and will future proof care in an unpredictable financial climate.

The benefits for an individual living in the north of the Dyfed-Powys region with the placement of the Hub in Aberystwyth, include:

- minimal travel time for the population compared to the model in Phase 1 where forensic examinations would be provided from Carmarthen for the whole of the region;
- The service will be holistic, providing a more complete forensic examination with health assessment to be undertaken in line with FFLM guidance and best practice standards;
- The service will have better links with local services such as sexual health and third sector.
- The service will be more likely to attract the specialist workforce required to run a safe and sustainable service.
- A critical mass of individuals will create more opportunities for the workforce to develop and retain necessary skills and competencies
- Greater opportunity for integration between sectors, including health, resulting in a more seamless service for the individual

The recommendation for the SARC adult hub in Dyfed Powys being in Aberystywth, supports the development of an overarching strategic picture of sexual assault referral centers across Wales with proposed SARC Hubs located in Colwyn Bay, Cardiff, Swansea and Aberystywth, supported by more local SARC spokes.

6. Next Steps

The needs of protected groups will continue to be an ongoing consideration during the implementation phase of the project and Health boards, Police and third sector will need to ensure that stakeholders are engaged throughout, venues are accessible and information is provided in a variety of required alternative formats in order to maximise opportunities for participation wherever required.

Attachment 8: GLOSSARY

ABM	Abertawe Bro Morgannwg
BME	Black and Minority Ethnic
C&V	Cardiff and Vale
CSEW	Crime Survey for England and Wales
EC	Emergency Contraception
EIA	Equality Impact Assessment
EWTD	European Working Time Directive
FFLM	Faculty of Forensic & Legal Medicine
FGM	Female Genital Mutilation
FME	Forensic Medical Examiner
HIV	human immunodeficiency virus
ISVA	Independent Sexual Violence Advisor
IUD	Intrauterine Device
LGBT	Lesbian, Gay, Bisexual, Transgender
NHS	National Health Services
PCC	Police and Crime Commissioners
PEP	post-exposure prophylaxis
SARC	Sexual Assault Referral Centre
STI	Sexually transmitted infection
THB	Teaching Health Board
UHB	University Health Board
VAWDASA	Violence Against Women Domestic Abuse Sexual Assault
WHSSC	Welsh Health Specialist Services Committee

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 3.2** **26 September 2019**

University Health Board Report

FRAMEWORK FOR DEVELOPING THE INTEGRATED MEDIUM TERM PLAN (IMTP) 2020 - 23

Executive Lead: Director of Planning and Performance
Author: Assistant Director of Planning & Partnerships
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Purpose of the University Health Board Report

The purpose of this report is to provide an update on work which has been initiated to develop the local Planning Framework for the period 2020- 2023, to ensure the development of the Health Board's Integrated Medium Term Plan (IMTP). In doing so, the report invites the Board to discuss and endorse a set of draft priorities for the Health Board and the approach being set out to develop the Health Board and local Business Unit IMTP's.

Governance

Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within its 3 Year Integrated Medium Term Plan 2019- 2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aims' are being progressed, these in summary are; • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report relates to the all aspect of developing the IMTP.
Supporting evidence	A full version of the Health Board's IMTP 2019-2022 and supporting annexes are available electronically via the following web link: Cwm Taf Morgannwg IMTP 2019-22.

Engagement – Who has been involved in this work?

The development of the IMTP for 2020–2023 will build upon the internal and external engagement processes of previous years and will include key stakeholders serving and residing within the within the Bridgend County Borough Council footprint.

University Health Board Resolution To:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	
Recommendation	Members of the University Health Board are asked to: • **DISCUSS** and **ENDORSE** the draft 2020/21 priorities for the Health Board and the approach being set out to develop to the Health Board and local Business Unit IMTP's. • **DISCUSS** and **ENDORSE** the draft financial planning assumptions, for inclusion in the 2020/21 Health Board Local Planning Framework.						
Summarise the Impact of the University Health Board Report							
Equality and diversity	An overarching Equality Impact Assessment of the IMTP 2019-22 has been completed and considered by the UHB's Equality & Welsh Language Forum. This will be repeated as part of developing the new IMTP.						
Legal implications	A number of indicators monitor progress in relation to legislation, such as the compliance to national targets and measures and compliance to statutory duties.						
Population Health	Assessment of Population Health including a range of actions to improve Population Health, predicated on the Health Needs Assessment will be included in the Plan and developed in a number of supporting plans in further detail.						
Quality, Safety & Patient Experience	Quality, Safety and Patient Experience will be a major theme running throughout the IMTP and is based on the Health Board's Quality and Patient Safety Governance Framework.						
Resources	There are a range of resource implications for the delivery of the Plan which will be re-visited and revised as required, as part of the ongoing planning and risk management processes.						
Risks and Assurance	Principal risks to delivery and mitigating actions are identified in the current Plan and will be re-visited with a view to updating these. In terms of the forthcoming planning process, the Health Board's Integrated Planning Group will keep risks under review and develop mitigating actions accordingly.						
Health and Care Standards	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.						
Workforce	The IMTP identifies a range of areas that will impact on workforce which include developing the workforce, realigning staff numbers and using indicators to monitor progress in relation to Workforce, such as sickness and Personal Development Review rates.						
Freedom of information status	Open						

FRAMEWORK FOR DEVELOPING THE INTEGRATED MEDIUM TERM PLAN (IMTP) 2020 - 23

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide an update on work which has been initiated to develop the Local Planning Framework for the period 2020 - 2023, to ensure the development of the Health Board's Integrated Medium Term Plan (IMTP).

In doing so, the report invites the Board to discuss and endorse a set of draft priorities for the Health Board and the approach being set out to develop to the Health Board and local Business Unit IMTP's.

2. BACKGROUND / INTRODUCTION

On 31 July 2019, the Health Board (HB) approved the following key assumptions and timeline:

- Priorities will largely be related to firmly establishing the new organisation and reducing its escalation status. Service change will be limited to a small number of key priorities
- The final 2020/21 HB Local Planning Framework will be issued in September 2019 following the receipt of the NHS National Planning Framework and Health Board approval
- A final IMTP, including appendices and Welsh Government (WG) templates will be submitted to November 2019 Board for approval
- The HB will retain a two stage approach to internally commissioned IMTPs
- Service Groups will not be sufficiently established for them to submit narrative plans to inform the final November HB IMTP. Key templates completed in collaboration will provide the bottom up detail required for the HB IMTP
- Service Groups will produce IMTPs for submission by February 2020 and approval in March 2020.

These assumptions took into account the following considerations:

- Escalation status of the Health Board – targeted intervention
- Escalation status of Maternity Services – special measures
- The 2019/20 Welsh Government IMTP accountability letter
- The organisation wide restructure
- Publishing of the HB Quality and Patient Safety Governance Framework
- The development of a Clinical Services Strategy, and
- The strategic management of the Swansea Bay UHB SLA's.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Context Changes

Subsequent to the approval of the key assumptions above, Welsh Government have announced that the submission date for 2020-23 IMTPs will be deferred until 31 January 2020.

This is due to: the timing of Brexit and the potential for contingency planning to impact on the production of IMTPs; financial uncertainty associated with Brexit; and the forthcoming introduction of the NHS Executive which will also draw upon planning capacity within Welsh Government (WG). As a consequence, the final IMTP, including appendices and WG templates will be submitted to January 2020 Board for approval. Scrutiny by Committees of the Board, including Finance, Workforce and Performance and Quality, Safety and Risk will lead up to the submission to Board.

3.2 Draft Priorities

As a result of the key assumptions approved by Board, and discussion with the Executive Team, the following priorities have been drafted for discussion and endorsement by Board:

1. The continued development of the new Cwm Taf Morgannwg UHB, focusing on engaging and empowering our people, embedding our values and behaviours, and a clear structure and operating model
2. The response to the escalation status of the HB: growing clinical and community leadership and robust, simplified and safe decision making; learning through quality improvements and strengthening involvement of patients, staff and partners in service redesign
3. The implementation of the HB Quality and Patient Safety Governance Framework
4. The development of the 10 year HB Integrated Healthcare Strategy
5. The steps to complete the service change set out in the South Wales Programme, particularly emergency medicine (A&E), acute medicine and inpatient paediatric services
6. Delivery of regional and national service change plans, including Major Trauma services
7. The continued implementation of the Regional Partnership Board transformation ambition and further alignment of Primary Care Clusters and Mental Health Localities
8. Delivery against the NHS Wales Delivery and Outcomes Framework
9. Planning for recurrent financial balance.

Following endorsement, the draft priorities will be included in the draft Local Planning Framework for Health Board approval in September.

3.3 Planning Process and Timeframe for Business Unit Plans

Whilst the Health Board is going through a period of organisational change, and in the lead up to the submission of the Health Board IMTP to Welsh Government, planning activity will be targeted at the Assistant Director tier of management, described below as Business Units, before developing the operational detail at the directorate tier.

As part of the planning cycle for 2020/21, Business Units will be asked to plan within a 4 stage process:

	Stage 1	Stage 2	Stage 3	Stage 4
Deadline	**11 Oct 2019**	**21 Oct 2019**	**7 Feb 2020**	**March 2020**
Business Unit Plans	Identify priorities using a Strengths, Weaknesses, Opportunities and Threats Model (SWOT) with no more than 10 priorities detailed within Appendix Ai	Collaborative discussion and decision on UHB priorities for the UHB IMTP.	Develop and submit an Business Unit plan including an Appendix Aii for each Directorate	Plan feedback and approval

The SWOT, priorities template and quality impact assessment tool described at Stage 1 are contained in **Appendix 1**. As a result of this approach, based on current structures and therefore subject to change as the organisational restructure consultation process is completed, Business Unit IMTPs will be commissioned as per **Appendix 2**.

3.4 Commencing the Planning Process

In order to meet the timelines set out above, the Assistant Directors have been instructed to begin Stage 1 planning as soon as possible. The letter in **Appendix 3** has been sent to Assistant Directors outlining the draft HB priorities, the expectations on them and their teams for the 11 October 2019 and the purpose of the collaborative Health Board priority setting event on 21 October 2019. Following this, on 4 November 2019, a wider engagement event will be held with Clinical Directors, Heads of Nursing, Directorate Managers and Business Partners. By this point, the NHS Wales Planning Framework and the Health Board Local Planning Framework will have been issued and we will have greater clarity on our organisation structure.

3.5 Local Planning Framework 2020/21

The Health Board's Local Planning Framework 2020/21 will set the parameters for the development for the Health Board's IMTP and will articulate the expectations of the clinical and corporate IMTPs, as well as providing practical guidance and advice.

The Welsh Government Framework is due to be issued in mid-September 2019. Following this, the draft Local Planning Framework 2020/21 will be submitted to Board for approval.

Contained within the Local Planning framework, the financial framework will be driven by a number of factors and considerations:

1. The level of the recurrent 2019/20 deficit taking into account:-

- The agreed financial plan revision to reflect recurrent Bridgend cost pressures over and above the £7.4m taken into arbitration (£2.1m) and an indicative c £2m investment into organisational capability and governance.

- The outcome of the Bridgend arbitration, under which there is no recurrent funding for the £7.4m allocation.
- Any unavoidable overspends and recurrent savings shortfalls in 2019/20, which prior to M4 directorates were forecasting would add £2.4m and £2.8m respectively to the underlying deficit (i.e. total £5.2m). The final figure will depend on the extent to which these overspends can be managed out and shortfalls in savings eradicated.

2. The level of Welsh Government support around transitioning Bridgend back to breakeven and around Targeted Intervention (TI). It is assumed that TI support will cover actual costs.

3. The level of aspiration we have around re-investing savings in service development, dependent on our confidence in delivery of savings.

4. Other factors which will also be important include :-

- The level of unavoidable cost pressures, which includes in particular the level of underlying demand and capacity (D&C) imbalance requiring investment in capacity and productivity to bring this back into balance.
- The Welsh Government budget and how this is allocated to Health Boards, including the use of a new allocation formula and process.
- Preparing in 2020/21 for 2021/22, which is the year when transformation funding ends, and continued investment in out of hospital services can only be afforded through a level of cost release from secondary care – approximately £6m pa.

A range of financial scenarios is shown in the table below, which are expressed as "optimistic", "mid-range" and "pessimistic."

	Planned recurrent deficit from 19/20	Impact of Bridgend arbitration outcome	Support for Bridgend transition to breakeven	Unplanned recurrent deficit from 19/20	Non-earmarked allocation growth in 20/21	Inflation and demand pressures	Local & national service development	Efficiency savings required to break even	Resulting 2020/21 financial outcome	Efficiency savings as % of total budget excluding primary care including prescribing
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pessimistic scenario	3.5	7.4	0	6	-24	37	2	-31.9	0	-3.5%
Mid range scenario	3.5	7.4	-1.5	4	-27	35	3	-24.4	0	-2.7%
Optimistic scenario	3.5	7.4	-3	2	-30	33	5	-17.9	0	-2.0%

The Welsh Government has committed to the Public Accounts Committee that all Health Boards will break even in 2020/21. The level of efficiency savings required for the Health Board to breakeven ranges from an overall average of 2.0% in the optimistic scenario to 3.5% in the pessimistic scenario. Where we fall between the two depends partly on how successful we are in improving our financial position and our operational delivery in 2019/20, and partly on the choices we make in planning for 2020/21. Consideration of the development of these scenarios will form part of the collaborative IMTP priorities discussion to be held on the 21 October 2019 and will inform the development of a strategic financial plan.

There are a number of considerations around how the eventual financial plan is delivered internally in a way which is consistent with the new operating model for the Health Board which will be developed through the autumn. Particular aspects of this needing to be considered will include:

- Greater devolution to management structures above the current directorates
- Accountability for delivery of service within overall financial envelopes allowing for cost pressures, developments and savings
- Greater linkage between savings achieved and the ability to re-invest

The publication of the Local Planning Framework 2020/21 will signal the formal commissioning of the Health Board's IMTP 2019-2022 and accompanying clinical and corporate IMTPs.

4. RECOMMENDATION

Members of the Board are asked to:

- **DISCUSS** and **ENDORSE** draft 2020/21 priorities for the Health Board and the approach being set out to develop to the Health Board and local Business Unit IMTP's.
- **DISCUSS and ENDORSE** the draft financial planning assumptions, for inclusion in the 2020/21 HB Local Planning Framework.

Freedom of information status	Open

UHB Priorites

1. The continued development of the new Cwm Taf Morgannwg UHB, focusing on engaging and empowering our people, embedding our values and behaviours, and a clear structure and operating model.

2. The response to the escalation status of the UHB: growing clinical and community leadership and robust, simplified and safe decision making; learning through quality improvements and strengthening involvement of patients, staff and partners in service redesign.

3. The implementation of the UHB Quality and Patient Safety Governance Framework.

4. The development of the 10 year UHB Integrated Healthcare Strategy.

5. The steps to complete the service change set out in the South Wales Programme, particularly emergency medicine (A&E), acute medicine and inpatient paediatric services.

6. Delivery of regional and national service change plans, including Major Trauma services.

7. The continued implementation of the Regional Partnership Board transformation ambition and further aligning Primary Care Clusters and Mental Health Localities.

8. Delivery against the NHS Wales Delivery and Outcomes Framework.

9. Planning for recurrent financial balance.

Quality Themes

Safe

Effective

Timely

Efficient

Equitable

People-centred

Workforce / OD Themes

Education /Development

OD Intervention

Productivity /Efficiency

Recruitment (Specify WTE)

Restructure /Reduction (Specify WTE)

Skill /banding mix change (Specify WTE)

Source of Investment

Recycled Business Unit Investment

UHB Invest to Save

WG Ringfence

UHB Investment

Other

2020/2021 - 2022/23 BUSINESS UNIT PLAN
SWOT Analysis

Business Unit Title:

Strength	Weakness

Opportunity	Threat

2020/2021 - 2022/23 BUSINESS UNIT PLAN
KEY PRIORITES DELIVERY TRACKER

Business Unit Title:

Risk: High R | Mod A | Low G

Description of Priorities											Measuring Change										
											Expected Quality Outcome		Expected Impact								
Ref No.	Description of action proposed priority	Lead	Which UHB priority does this link to ? (select from drop down)	Key Risks	Key Co-dependencies (Internal/External)	Year 1 Key Actions Q1	Q2	Q3	Q4	Year 2 Key Action	Year 3 Key Action	What are the intended outcomes in terms of:- Signifigant Quality Theme (select from drop down)	Outcome Impact Description	Specify the planned value of the impact as numeric value. Note, appropriate currency to be identified by the Business Unit: Workforce & OD Implications (select from drop down)	WTE Change	Finance Rev £ Cost/(Saving)	Source of Investment (select from drop down)	Finance Cap £	Source of Investment (select from drop down)	Performance / Activity	QIA Risk Score	Delivery Status RAG Rated
1																					
2																					
3																					
4																					
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Cwm Taf Morgannwg UHB
Quality Impact Assessment

Please complete all shaded fields:-

Scheme No:

Directorate

Scheme Name

Scheme Overview

Project Lead

Project Owner

QIA author name

Quality Indicator(s)

KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)

	Details	Consequence	Likelihood	Score
Patient Safety				**0**

	Details	Consequence	Likelihood	Score
Clinical Effectiveness				**0**

	Details	Consequence	Likelihood	Score
Patient Experience				**0**

	Details	Consequence	Likelihood	Score
Staff Experience				**0**

Overall Risk Score	0

	Details
Mitigation	

Signed (Lead Clinician/Manager)		**Date**	
Signed - Executive Lead		**Date**	
Comments - Executive Lead			

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 3.3** **26 September 2019**

University Health Board Report
ADULT THORACIC SURGERY FOR SOUTH WALES

Executive Lead: Chief Executive
Author: Head of Corporate Services
Contact Details for further information Gwenan.roberts@wales.nhs.uk

Purpose of the University Health Board Report	
To provide the Board an update on the progress with the Adult Thoracic Surgery plans for South Wales and the meeting held on 23 July 2019. A letter has been received from the Chair of the Welsh Health Specialised Service Committee (WHSSC) confirming the outcome of the meeting as unanimous approval of all recommendations and asking the Board to confirm is unconditional approval for a single adult thoracic surgery centre based at Morriston hospital, Swansea (letter attached at **Appendix 1**).	
Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2019-2022, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all the above objectives.
Supporting evidence	The supporting reports are available on http://www.whssc.wales.nhs.uk/sitesplus/documents/1119/2019.07.16%20JC%20%28Public%29%20Bundle.pdf
Engagement – Who has been involved in this work?	
Welsh Health Specialised Services Committee (WHSSC) Joint Committee of the Health Board	

University Health Board Resolution To:							
APPROVE	√	**ENDORSE**		**DISCUSS**		**NOTE**	
Recommendation	The University Health Board is asked to: • **APPROVE** (and ratify) the Welsh Health Specialised Services Joint Committee agreement for a single adult thoracic surgery centre based at Morriston hospital, Swansea.						

Summarise the Impact of the University Health Board Report	
Equality and diversity	Equality Impact Assessment undertaken by the WHSSC team
Legal implications	No specific legal implications identified
Population Health	Aim to improve the health of populations by providing the highest quality care in an expert location
Quality, Safety & Patient Experience	Aim to improve patient experience
Resources	Previously identified and agreed plan of action
Risks and Assurance	Identified within the supporting appendices
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.
Workforce	Identified within the supporting appendices
Freedom of information status	Open

ADULT THORACIC SURGERY FOR SOUTH WALES

1. SITUATION / PURPOSE OF REPORT

Members will be aware that adult thoracic surgery for south Wales has been considered by the Welsh Health Specialised Services Joint Committee (WHSSC) at meetings in May and June 2019 and aimed to bring this matter to a satisfactory conclusion at the meeting held on 23 July 2019. A letter has been received from the Chair of the WHSSC confirming the outcome of the meeting as unanimous approval of all recommendations and asking the Board to confirm is unconditional approval for a single adult thoracic surgery centre based at Morriston hospital, Swansea (letter attached at **Appendix 1**).

The consolidated report was received at the WHSSC meeting on 23 July 2019 that set out the background and made various recommendations reflecting input from Welsh Government and health boards addressing the various relevant caveats received. This report and its appendices are attached for information but are lengthy (**Appendix 2-8**).

2. BACKGROUND / INTRODUCTION

At the WHSS Joint Committee meeting held on 23 July 2019, a report was received that:

1. summarised the outstanding issues from the November 2018 Joint Committee meeting regarding the single site model for thoracic surgery based at Morriston Hospital, Swansea and the progress in addressing those issues
2. made recommendations regarding the future thoracic surgery consultant workforce model and emergency thoracic surgery cover for the Major Trauma Centre (MTC).

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Members will recall at that the last meeting of the CTM Board Sharon Hopkins advised that the WHSS Committee was trying to obtain an agreement for Adult Thoracic Surgery Services in South Wales. WHSSC Members **NOTED** that the collective Boards in south Wales had a number of conditions that were needed in order to finalise the approval of the move. At that time, two proposals had been submitted neither of which reached a majority view which resulted in a further proposal being put forward, with most parties present agreeing with the recommendations made. Members should **NOTE** the proposal did not conflict with recommendations previously made to the Board.

The latest proposals built on the consensus previously achieved regarding the additional and fourth thoracic consultant post at the University Hospital of Wales, Cardiff, to support the opening of the Major Trauma Centre (MTC), the funding for which would be included within the MTC business case and approved for 12 months. This appointment would need to be subject to an ongoing evaluation and extended if necessary. Also during this time the two

thoracic centres would develop plans to work together developing a single emergency rota.

WHSSC Members acknowledged that because of the uncertainty regarding the future consultant workforce requirements for the single thoracic surgery unit at Moriston Hospital, it was proposed that additional funding for two posts was allocated with the MTC business case when it is considered in September 2019. This would be in addition to the existing establishment of six posts. However, Members should note that the funding release is dependent on an ongoing review of the real world experience from the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTC) on emergency cover for major trauma centres. This will ensure that a fully informed recommendation will be presented to the WHSSC Joint Committee well in advance of the move to a single site and that the new centre opens with the right number of consultant thoracic surgeons to ensure a safe and sustainable service.

The outputs for the WHSSC meeting on the 23 July were as follows:

- Noted the work that had been undertaken by the medical directors of CVUHB and SBUHB as well as the WHSS Team to develop workforce proposals for the consultant thoracic surgical service
- Supported the appointment of an additional consultant thoracic surgeon, funded through the MTC work stream, to support implementation of the MTC from April 2020 initially on an interim basis, pending clarity of the level of need;
- Supported the allocation of funding for an additional two consultant surgeons (in addition to the existing establishment of six) from the MTC business case when the new single centre at Morriston Hospital is opened – the funding release for which will be dependent on consideration by the Joint Committee of the real world experience of the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres;
- Noted the information set out in the May Joint Committee paper which provided assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises; and
- Supported the recommendation going forward to the six affected health boards and agreed that they be asked to confirm their support for the recommendation made by the WHSSC Joint Committee

4. RECOMMENDATION

The University Health Board is asked to:

- **APPROVE** (and ratify) the Welsh Health Specialised Services Joint Committee agreement for a single adult thoracic surgery centre based at Morriston hospital, Swansea.

Freedom of information status	Open

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Your ref/eich cyf:
Our ref/ein cyf: VH.KS
Date/dyddiad: 24th July 2019
Tel/ffôn: 01443 443443 ext. 8131
Fax/ffacs: 029 2080 7854
Email/ebost: Vivienne.harpwood3@wales.nhs.uk

The Chair and the Board Secretary:

Anuerin Bevan UHB
Cardiff & Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB

Dear Colleague

Re: Adult Thoracic Surgery for South Wales

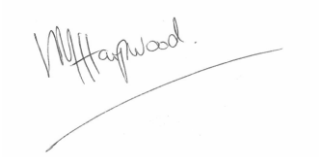
I am writing to provide an update on developments at yesterday's WHSSC Joint Committee meeting.

You will be aware that we considered adult thoracic surgery for south Wales at meetings in May and June 2019, and were trying to bring this matter to a satisfactory conclusion at yesterday's meeting. To achieve this we prepared a consolidated paper that set out the background and made various recommendations reflecting input from Welsh Government and health boards. We anticipated that the same paper would be forwarded to you for consideration at your next Board meeting with an endorsement on behalf of the Joint Committee.

I am very pleased to report that the Joint Committee unanimously approved all of the recommendations set out in the paper at its meeting yesterday. On that basis, I am now asking your Board to confirm its unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea.

I am attaching the Joint Committee paper and appendices for you to circulate to your Board which, together with this letter, should provide your directors with assurance that the relevant caveats have been addressed.

Yours sincerely



Professor Vivienne Harpwood
Chair

cc Andrew Goodall, Chief Executive, NHS Wales
Simon Dean, Deputy Chief Executive, NHS Wales

Welsh Health Specialised Services Commit
3a Caerphilly Business Park
Caerphilly
CF83 3ED

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
3a Parc Busnes Caerffili
Caerffili
CF83 3ED

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

		Agenda Item	2.1
Meeting Title	**Joint Committee**	Meeting Date	23/07/2019
Report Title	Adult Thoracic Surgery for South Wales – Consultant workforce		
Author (Job title)	Director of Planning		
Executive Lead (Job title)	Managing Director	Public / In Committee	Public

Purpose	• To **summarise** for members the outstanding issues from the November 2018 Joint Committee meeting regarding the single site model for thoracic surgery based at Morriston Hospital, Swansea and the progress in addressing those issues. • To **make recommendations** regarding the future thoracic surgery consultant workforce model and emergency thoracic surgery cover for the Major Trauma Centre (MTC).

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	08/07/2019
Recommendation(s)	Members are asked to: • **Note** the work that has been undertaken by the medical directors of CVUHB and SBUHB as well as the WHSS Team to develop workforce proposals for the consultant thoracic surgical service; • **Support** the appointment of an additional consultant thoracic surgeon, funded through the MTC work stream, to support implementation of the MTC from April 2020 initially on an interim basis, pending clarity of the level of need; • **Support** the allocation of funding for an additional two consultant surgeons (in addition to the existing establishment of six) from the MTC business case when the new single centre at Morriston Hospital is opened – the funding release for which will be dependent on consideration by the Joint Committee of the real world experience of the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal		

	professional advice of the SCTC on emergency cover for major trauma centres; • **Note** the information set out in the May Joint Committee paper which provided assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises; and • **Support** the recommendations going forward to the six affected health boards and agree that they be asked to confirm their unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea.

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base	✓	
Equality and Diversity		✓	Population Health	✓		Legal Implications	✓	

1.0 SITUATION

At an extra-ordinary meeting held on 28 June 2019, the Joint Committee received a paper that addressed the brief agreed at the meeting held in May 2019. This was for the WHSSC Team to develop a commissioning proposal which would provide the Joint Committee with additional information and clarification, building on the work of the CVUHB and SBUHB medical directors, enabling members to make a decision regarding future consultant work force planning for thoracic surgery services when they are located at a single site at Morriston Hospital, Swansea.

However, after protracted discussion and careful consideration, members proposed two alternative motions that were voted on but neither motion achieved the required two-thirds majority to succeed. Members agreed that the Managing Director of WHSSC would seek advice from Welsh Government on next steps. This latest paper therefore takes into consideration the discussion at the previous meeting and advice from Welsh Government and seeks to present recommendations that reflect much of the common ground between the differing views of members and commences by reflecting on the matters presented at the May and June meetings.

Additionally it should be noted that a requirement was identified in the November 2018 meeting that the above issue, as well as assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises *(Report attached as Appendix A for ease of reference)*, should be formally considered by the Joint Committee to allow a recommendation to be made to the six affected health boards in order that they can confirm their unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea. Details regarding these other issues can be found in the table attached as Appendix B for ease of reference, which was considered by the Joint Committee in May 2019.

2.0 BACKGROUND

At the May meeting the Joint Committee was presented with a workforce proposal for consultant thoracic surgeons developed by the medical directors of CVUHB and SBUHB *(Proposal attached as Appendix C for ease of reference)*. The Joint Committee, however, requested that the WHSS Team undertake further work to provide additional information and clarification regarding the work force model for thoracic surgery for consideration at the June meeting to enable members to take a decision. This additional information *(which can be found in Appendices D, E and F)* was considered, however members could not achieve the necessary two-thirds majority to reach a decision; therefore the WHSSC Managing Director was asked to seek advice from Welsh Government.

3.0 ASSESSMENT

3.1 Advice from Welsh Government

Following the June meeting advice on the next steps was sought from Welsh Government representatives. They indicated that it was their expectation that the recommendation to the six affected health boards would go through normal WHSSC processes and therefore the matter would need be reconsidered at the next Joint Committee meeting. They confirmed that they expected Joint Committee members to ensure that in coming to a recommendation they balanced the risks and benefits to the wider population of south and mid Wales. They also stated that they recognised the challenge of implementing two major service changes in similar timescales and confirmed that they supported consideration of the appointment of additional consultant thoracic surgical staff for the new MTC through the MTC business case. This arrangement would need to be closely monitored by WHSSC and kept under review as part of the developments of both the major trauma network and the final thoracic surgery provision.

3.2 Key points of discussion at June 2019 meeting

There was consensus at the June Joint Committee meeting that the appointment of an additional (fourth) consultant surgeon, at the University Hospital of Wales, prior to the opening of the MTC in 2020 would be important in supporting the establishment the new major trauma service. This post has subsequently been included in the MTC business case submitted to the MTN Programme Board.

There was disagreement on the optimal number of consultant surgeons to support the new single centre based at Morriston Hospital, Swansea when it opens, which is anticipated to be in around two years' time. The recommendation from the CVUHB and SBUHB medical directors is that eight surgeons are needed; however work undertaken by the WHSS Team using current activity data, taking into account a 20% increase in activity, benchmarking and external advice, is that approximately, six surgeons are needed. This discrepancy appears to have arisen because of uncertainty regarding future strategic challenges and was reflected in differing views amongst committee members on the optimal number of surgeons to support the single centre.

3.3. Conclusion

Building on the consensus regarding the additional (fourth) post, to support the opening of the MTC, and the content of the letter from Dr Andrew Goodall, NHS Wales Chief Executive, funding for the post within the MTC business case should be approved for 12 months. This appointment would need to be subject to an ongoing evaluation and extended if necessary. Also during this time the two thoracic centres would develop plans to work together developing a single emergency rota. The cost of the locum appointment is estimated to be

£135,000 based on £125,000 salary (including associated on costs) and would be funded from the MTC work stream.

Because of the uncertainty regarding the future consultant workforce requirements for the single thoracic surgery unit at Moriston Hospital, it is proposed that additional funding for two posts is allocated with the MTC business case when it is considered in September 2019. This would be in addition to the existing establishment of six posts. However funding release is dependent on an ongoing review of the real world experience from the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres. This will ensure that a fully informed recommendation can be brought back to the Joint Committee well in advance of the move to a single site and that the new centre opens with the right number of consultant thoracic surgeons to ensure a safe and sustainable service.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the work that has been undertaken by the medical directors of CVUHB and SBUHB as well as the WHSS Team to develop workforce proposals for the consultant thoracic surgical service;
- **Support** the appointment of an additional consultant thoracic surgeon, funded through the MTC work stream, to support implementation of the MTC from April 2020 initially on an interim basis, pending clarity of the level of need;
- **Support** the allocation of funding for an additional two consultant surgeons (in addition to the existing establishment of six) from the MTC business case when the new single centre at Morriston Hospital is opened – the funding release for which will be dependent on consideration by the Joint Committee of the real world experience of the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres.
- **Note** the information set out in the May Joint Committee paper which provided assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises; and
- **Support** the recommendations going forward to the six affected health boards and agree that they be asked to confirm their unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea.

5.0 APPENDICES / ANNEXES

Appendix A	Thoracic Surgery Post Public Consultation Lessons Learned Report
Appendix B	Arrangements for addressing the additional assurances requested by Health Boards
Appendix C	Consultant workforce arrangements suggested by the medical directors of SBUHB and CVUHB
Appendix D	Detailed workforce planning document
Appendix E	Comments received on draft workforce planning document and WHSSC responses
Appendix F	Notes from the discussion with external expert panel

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Implementation of the Plan Governance and Assurance
Link to Integrated Commissioning Plan	Re-configuration of existing service
Health and Care Standards	Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Care for Those with the greatest health need first Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	
Resources Implications	
Risk and Assurance	
Evidence Base	
Equality and Diversity	
Population Health	
Legal Implications	

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	08 July 2019	Reviewed and approved
Choose an item.		

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Thoracic Surgery Public Engagement & Consultation

A Review of the conduct of the project and key lessons learned

Paul Williams (Cwm Taf LHB - Welsh Health Specialised Services Committee)

Abstract: This document provides an overview of the delivery of a formal public consultation on the location of adult thoracic surgery services for the population of South Wales together with a description of the lessons learned during the conduct of the project.

Project Title:	Thoracic Surgery Public Consultation
Program Title:	Provision of Adult Thoracic Surgery in South Wales
Author:	Assistant Planning Manager WHSSC
Report Title	Review of the conduct of the project and key lessons learnt
Brief description of context	WHSSC is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population, and have delegated the responsibility for commissioning a range of specialised services to WHSSC. Specialised services generally have a high unit cost as a result of the nature of the treatments involved. They are a complex and costly element of patient care and are usually provided by the NHS. The particular features of specialised services, such as the relatively small number of centres and the unpredictable nature of activity, require robust planning and assurance arrangements to be in place to make the best use of scarce resources and to reduce risk. Specialised services have to treat a certain number of patients per year in order to remain sustainable, viable and safe. This also ensures that care is both clinically and cost effective. Thoracic surgery is one of the specialised services that WHSSC commissions for the people of Wales. For patients living in North Wales this service is provided by Liverpool Heart and Chest Hospital NHS Foundation Trust. This is one of the largest thoracic surgical centres in the United Kingdom, with six consultant surgeons, serving a catchment area that spans across the north west of England and North Wales. Patients in northern Powys access the thoracic surgery service at Heartlands Hospital, Birmingham, which has recently become part of the University Hospitals Birmingham NHS Foundation Trust. By contrast, in South Wales there are two smaller services based at Morriston Hospital, Swansea and the University Hospital of Wales, Cardiff. The service at Morriston has two consultant surgeons, whereas the service at the University Hospital of Wales, has three consultant surgeons. There has been concern for a number of years that these two smaller services are not sustainable, and may not be able to fully meet the needs of the population of South Wales.

	The Thoracic Surgery Review Project comprised two distinct stages. Stage One aim was to determine the service model for South Wales, i.e. one thoracic surgery centre or two and depending on the outcome of Stage One, Stage Two's aim was be to determine the location of the service centre. A Project Board was established to form recommendations on the future provision of adult thoracic surgery in South Wales. The Project Board was informed by a review of the adult thoracic surgery services which was undertaken by the Royal College of Surgeons. Following an extensive engagement exercise across South Wales, in which the views of service users and other stakeholders were sought on the information required in order to make a recommendation on the future provision of thoracic surgery services in South Wales, the Project Board recommended that a single thoracic surgery centre should be developed for South Wales. WHSSC sought advice from the Board of Community Health Councils and Legal Services on the requirement to engage or consult on each of these two stages. The advice provided for stage one was that whilst it is not necessary to carry out formal consultation, engagement was necessary. Following the recommendation from the Project Board, an Independent Panel was convened to review the options for locating the centre and to make a recommendation on the preferred location for the single thoracic surgery centre. The Independent Panel recommended that Morriston Hospital should be the location for the proposed single thoracic surgery centre. The recommendation from the Project Board and the recommendation from the Independent Panel were considered and endorsed by the WHSSC Joint Committee for further consideration by the six affected health boards, subject to further discussions with the Community Health Councils about the need for public consultation. Following the discussions with the Community Health Councils, it was agreed that the affected health boards, with assistance from WHSSC, should be asked to consider undertaking a formal public consultation in which they would ask the public, staff and interested organisations for their views on the recommendations of the Independent Panel to locate the single thoracic surgery centre at Morriston Hospital.
Brief description of project	WHSSC in order to support the decision making process for the review of Thoracic Surgery services in South Wales entered into a period of public engagement utilising public meetings and digital channels throughout the South Wales region. Responses were requested for four questions

	1. Is there any other information you think we should consider to decide whether we need one or two thoracic surgery centres in South Wales? 2. Is there any other information you think we should include in the criteria that will be used by the independent panel? 3. Do you have comments on the process we are using to inform recommendations on future thoracic surgery services? 4. Do you have any other comments on the information presented in this document? In total we received 78 responses including feedback captured during the public meetings the most common themes were • Travel impact • Co-location with other services and infrastructure • Capacity in general with current services and ability to deliver a future high class service. • Comments on the process and or documentation adopted. The recommendation from the Project Board and the recommendation from the Independent Panel were considered and endorsed by the WHSSC Joint Committee for further consideration by the six affected health boards, subject to further discussions with the Community Health Councils about the need for public consultation. Following the discussions with the Community Health Councils, it was agreed that the affected health boards, with assistance from WHSSC, should be asked to consider undertaking a formal public consultation in which they would ask the public, staff and interested organisations for their views on the recommendations of the Independent Panel to locate the single thoracic surgery centre at Morriston Hospital. To ensure the consultation process was meaningful, consideration was given to key messages to be shared with the public and the evidence available to support the proposed development of a single adult thoracic surgery centre at Morriston Hospital, serving patients from South Wales. The key messages included: • Over the last year, patients in Wales with lung cancer have waited longer than they should have for surgery • Patients in Wales with lung cancer have some of the lowest survival rates in Europe, although we know we have expert surgeons • Patients who need surgery, but do not have lung cancer, have very long waiting times, and our doctors and nurses tell us this is affecting the quality of care they can provide • Thoracic surgery is becoming increasingly specialised and better outcomes come from larger centres (elsewhere in the UK and Europe, services are being reorganised into larger centres) and

	• Changes in the way surgeons practise mean we cannot continue to staff our two units in the way we have done in the past • The Royal College of Surgeons undertook a review of the services in south Wales and recommended that in order to provide sustainable and high-quality thoracic surgery, there should only be one hospital delivering the adult service – "It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales. The review team considered that this reconfiguration was in the best interests of patient care and was the most sustainable option for thoracic surgery going forward. It was considered that changes to cardiac and adult thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future..." • An Independent Panel, made up of a range of clinical experts from north Wales and England, patients or their relatives, an equalities representative, representatives from the third sector (voluntary and charity organisations) and an independent Chairperson, were asked to look at the options and make recommendations on the location for the single centre using the criteria developed during the engagement process and agreed by the Project Board. The Independent Panel recommended that Morriston Hospital should be the location for the proposed single adult thoracic surgery centre. • The surgical element of care forms only one part of the overall service patients will receive, and patients will continue to see their local respiratory consultant and have their diagnostic tests at the same hospital where they would currently. • Patients resident in the areas served by Abertawe Bro Morgannwg University Health Board (ABMUHB), Hywel Dda University Health Board (HDUHB) or those areas of Powys Teaching Health Board where patients receive their secondary care at either ABMUHB or HDUHB, would continue to have their thoracic surgery at Morriston Hospital, Swansea. • Patients who would have had their thoracic surgery in UHW, Cardiff, would in future receive their surgical care at Morriston Hospital, Swansea. This includes patients who live in the areas covered by Aneurin Bevan University Health Board, Cardiff & Vale University Health Board, Cwm Taf University Health Board and parts of Powys Teaching Health Board where patients receive their secondary care at one of these health boards. • Evidence shows that thoracic surgery patients are likely to have better outcomes (survive longer, with fewer complications from their disease or treatment) and quicker recovery when treated in larger thoracic surgery centres; • A larger single adult thoracic surgery centre will be more resilient, i.e. more able to cope with unpredictable changes such as episodes of staff sickness, vacancies and changes to national government policy. The consultation asked people to respond to two questions: 1 The Independent Panel recommended that the adult thoracic surgery centre serving patients from South and West Wales and South Powys should be located in Morriston Hospital Swansea. Do you agree or disagree with the proposal?

	2 If we develop the adult thoracic surgery centre for South East and West Wales and South Powys in Morriston Hospital in Swansea, what are the important things that you would like us to consider about the planning and delivery of the new service? The consultation plan outlined the methods and proposed process for the consultation that will support delivery of the following objectives: • To seek the views of stakeholders on the proposed model for delivering adult thoracic surgery services in South Wales. • To describe and explain the proposed model for delivering adult thoracic surgery services in South Wales. • Ensure awareness and information about the consultation reaches the majority of health board stakeholders and provides opportunities for feedback. • Provide stakeholders with a range of opportunities, taking account of accessibility, for staff and other key stakeholders to give their views by the close of the consultation exercise • To ensure that the consultation process complies with legal requirements, Welsh Government guidance and duties. Advice on the documentation was sought from the Health Boards and Community Health Councils within the regions, in order to ensure that it was fit for purpose. WHSSC was responsible for printing and distributing hard copies of the consultation document, which was available in Welsh and Easy Read formats. The consultation document detailed: • The background to the consultation • The need for change • The proposals for change and rationale for the proposed model • How people can participate in the consultation and give their views The full consultation document in English and Welsh was available in standard and easy read versions also in electronic format. Versions were available in Audio (in English and Welsh) and British Sign Language format on the website. All

	versions of the document included details of how people could respond online, by email, by phone or by freepost. Other formats would be produced as appropriate on request. A full range of supporting and technical documents were available online, providing background information to support and inform the public consultation. These included: • Equality Impact Assessment; • Pre-consultation documents and reports; • Relevant documentation from national bodies (e.g. Royal College of Surgeons); • Other information to inform the decision making process and demonstrate that the options have been thought through and can be implemented; • An initial list of frequently asked questions which were updated as queries arise during the consultation In addition to these documents, a standard presentation was compiled and made available for health boards to use at public and stakeholder events. Alongside the main consultation document the following methods for sharing information were employed: • Website A web page for the consultation was created via WHSSC at the following address: http://www.whssc.wales.nhs.uk/thoracic-surgery-services-in-south-wales There was both an English and Welsh web page and a short film produced outlining the key elements of the consultation. • Public Sessions Across the consultation period there are a number of planned sessions led by health boards in each region. This provided the opportunity for staff, stakeholders and the wider public to provide feedback on the proposals in the consultation document. Members of the WHSSC Executive team supported these sessions. • Mid-Point Review A formal review meeting was held approximately half way into the consultation to consider responses to the consultation, address any issues of concern and consider the need to make adjustments to the approach for the

	remainder of the consultation period. This was coordinated by WHSSC, and included the engagement leads from each of the health boards, as well as representatives from the Community Health Councils. A report was produced following the meeting, summarising the key themes from the responses received to date, and was shared with the health boards and Community Health Councils. The report identified a number of actions including additional work around a key issue that had emerged during the first half of the consultation around the arrangements for delivering Thoracic Surgery support to the Major Trauma Centre. This work was subsequently included in the evidence pack provided to HBs with the consultation outcome. • Post Consultation Phase 804 responses were received with the majority being submitted via the online form. Each individual response was recorded on a log which was regularly shared with affected health boards and CHC's Where notes from staff or public events were provided these were also captured and included within the analysis and consideration of implementation actions but were not been recorded as individual responses. On behalf of the six affected health boards, WHSSC received and logged responses to the consultation, the outcomes of which was reported to the WHSSC Joint Committee in September, prior to submission to each of the health boards, together with a recommendation on the proposal, for consideration at public board meetings to be held before the end of October 2018. WHSSC worked with the health board engagement leads, and provided them with the responses specific to their health board area and region. WHSSC officers reviewed, collated and analysed the responses and outcomes with regards to any national, regional or crosscutting themes, in order to enable the Joint Committee and affected health boards to have an informed discussion on the outcome of the consultation. WHSSC officers shared all of the responses with the Community Health Councils and health board engagement leads, and reviewed and collated the responses and outcome for each health board area. This information was also shared with the Community Health Councils for consideration as part of their role in reviewing and formulating an official response to the consultation.
	Final Project Review A formal review meeting was held in the spring of 2019 to consider conduct of the consultation and address any issues of concern.

	This was coordinated by WHSSC, and included the engagement leads from each of the health boards, as well as representatives from the Community Health Councils. This report was produced following the review meeting, and summarises the key findings under four headings • Key project successes • Project shortcomings and solutions • Lessons learnt • Follow-up Actions
Key project successes	**Please describe what has worked well.** **What have been the key successes of this project?** • The primary success of the process was to deliver a regional engagement and consultation. • There was a due regard to equity of opportunity, the approach adopted resulted in a wide range of stakeholders sharing their views. This was supported by the availability of materials in multiple formats. • As themes and questions developed throughout the consultation period WHSSC worked collaboratively with CHC's and HB's to produce a living Frequently Asked Questions process to signpost or address issues raised. • High Response Rate with 804 individual responses across all affected populations. Strong engagement with clinicians. • Feedback from CHC's and HB's was that WHSSC demonstrated a genuine desire to engage and consult, as evidenced by WHSSC Executive support at public and staff meetings. **What factors supported this success?** The adoption of a two stage process with engagement followed by consultation allowed WHSSC to refine and adapt internal processes and in particular shape its communication strategy.

	There was an opportunity to learn from the public consultation on Major Trauma and in particular the approach to collaborative working. Regular contact with Health Board and CHC's was a core component of the process and space was created to have conversations throughout the consultation period. The Mid-Point Review was very useful in framing the quantitative and qualitative approach taken and offering an opportunity to discuss and tailor the process, including providing the opportunity to undertake additional work on a specific issue in response to feedback received during the first half of the consultation. As noted above there was a genuine desire to engage and consult and WHSSC executive team took an active leadership role throughout the process. There was a recognition that subject matter experts existed within the HB's and CHC's, collaborative working and transparency were taken as key lessons from the major trauma consultation and informed the WHSSC process throughout.
Project shortcomings and solutions	**Please describe what have been the main challenges of this activity?** Above all else the fact that conducting a two stage engagement and consultation process was a new endeavour for WHSSC. When planning the process and materials to be adopted consideration was given to build sufficient flexibility in the timeline to ensure all activity was completed in order to account for the agreed recommendation and decision making processes within Joint Committee and the Health Boards. However, it is recognised that the pre consultation stage included a number of challenges which resulted in the timeline being stretched, in effect the contingency was utilised at the start of the process. Examples of early pressures within the timeline included; There was a degree of uncertainty regarding the need for a public consultation. Time was lost when WHSSC were gathering the views of the CHC's. Engagement leads felt that their earlier involvement would have been beneficial, building on their expertise and local relationships. Timescales need to take account of the decision-making timescales for CHCs as well as HBs. Once the need for a consultation was agreed there was a significant amount of activity dedicated to producing and reaching consensus on the material. The decision to include an agree/disagree question was an example of early uncertainty over what was being consulted upon. Post consultation there were challenges over the governance and decision making process and in particular the ability to share materials with CHC's prior to the HB meetings. **How were they overcome (if they were)?**

In recognition of the uniqueness of the activity from a WHSSC perspective collaboration with Health Boards and CHC's was adopted throughout the process.

The timeline although stretched did have a sufficient contingency to allow the process to be completed in time.

The governance around the recommendation and decision making process was complex and reflected the uniqueness of WHSSC's position outside but acting on behalf of the Health Boards. To mitigate WHSSC continued to engage with Health Boards and CHC's throughout the process, for example by providing regular copies of the responses logged. The mid-point review was extremely helpful in enabling joint working to resolve a number of issues.

Were the project objectives attained? If not, what changes need to be made to achieve these results in the future?

Objective 1: To seek the views of stakeholders on the proposed model for delivering adult thoracic surgery services in South Wales.

804 responses have been received, with the majority being submitted via the online form. Each individual response was recorded on a log which was regularly shared with affected health boards and CHC's.

Where notes from staff or public events were provided, these have also been captured and included within the analysis and consideration of implementation actions, but they have not been recorded as individual responses.

In response to the question

The Independent Panel recommended that the adult thoracic surgery centre serving patients from South and West Wales and southern Powys should be located in Morriston Hospital, Swansea. Do you agree or disagree with the proposal?

- 339 or 42.16% agreed with the proposal.
- 428 or 53.23% disagreed with the proposal.
- 34 or 4.23% neither agreed nor disagree with the proposal.
- 3 or 0.37% did not answer the question.

A number of themes were identified when analysing the responses. These "key" themes have been used as the basis of analysis of the responses.

Many of the 804 respondents expressed multiple views across their responses and therefore the total number of issues identified within the themes is 1,441.

The key themes were as follows:

- Implementation and Improvement
- Accessibility

- Major Trauma Centre
- Workforce
- Other

Objective 2: To describe and explain the proposed model for delivering adult thoracic surgery services in South Wales.

Advice on the documentation was sought from the health boards and Community Health Councils within the regions, in order to ensure that it was fit for purpose.

WHSSC was responsible for printing and distributing hard copies of the consultation document, which will be available in Welsh and Easy Read formats.

The consultation document detailed:

- The background to the consultation
- The need for change
- The proposals for change and rationale for the proposed model
- How people can participate in the consultation and give their views

The full consultation document in English and Welsh was available in standard and easy read versions in both hard copy and electronic format. Versions were also be available in Audio (in English and Welsh) and British Sign Language format on the website. All versions of the document included details of how people could respond online, by email, by phone or by freepost. There were no requests for other formats although the plan included provision for them to be produced as appropriate on request.

A full range of supporting and technical documents were available online, providing background information to support and inform the public consultation. These included:

- Equality Impact Assessment;
- Pre-consultation documents and reports;
- Relevant documentation from national bodies (e.g. Royal College of Surgeons);
- Other information to inform the decision making process and demonstrate that the options have been thought through and can be implemented;
- An initial list of frequently asked questions which was updated as queries arose during the consultation

In addition to these documents, a standard presentation will be compiled and made available for health boards to use at public and stakeholder events.

A review was held at the half way point of the consultation with representation from the affected health boards and CHCs to consider the processes and responses to date in light of the consultation plan and national guidance.

Actions arising from the mid-way review were:

- A mechanism was agreed for reporting by health boards of any exceptions to the published consultation plan;
- An agreement was reached for the provision of the verbatim responses, together with high level quantitative analysis, to health boards and CHCs on a weekly basis;
- The addition of a new FAQ relating to the requirements of the Major Trauma Centre for emergency support from consultant thoracic surgeons;
- The addition of a new FAQ relating to the lay membership of the Independent Panel;
- Steps were taken to ensure that work was undertaken to provide outline arrangements for delivering thoracic surgery support to the Major Trauma Centre (for the small number of cases where this may be required). This information was included in the evidence pack that will be submitted to health boards with the consultation outcome.

Objective 3: Ensure awareness and information about the consultation reaches the majority of health board stakeholders and provides opportunities for feedback.

In order to assess the public reach of the consultation, respondents were asked if they were an employee of the NHS. Respondents were also asked if they were replying on behalf of an organisation. Where respondents indicated that they were replying on behalf of a health board this has been discounted from the organisation's total number in recognition that any staff responding were doing so as an individual/group and not corporately.

Not specified	NHS Employee	Organisation	Elected Representative	Grand Total
416	369	16	3	804
51.74%	45.90%	1.99%	0.37%	100%

In line with the statutory duty placed on each health board under the Wales Public Sector Equality Duty 2011, an equality impact assessment (EIA) was undertaken on the proposals for a single adult thoracic surgery centre for South Wales

At the consultation mid-way review, held in July 2018, the opportunity was taken to review the characteristics of respondents to assess whether the consultation was reaching the relevant groups. No issues were identified at the mid-way review which required changes to the consultation plan process. The distribution of responses across the protected characteristics did not change significantly from this point.

The equality monitoring process indicates that overall the consultation did have broadly representative input from affected protected categories and from the relevant age distribution.

Objective 4: Provide stakeholders with a range of opportunities, taking account of accessibility, for staff and other key stakeholders to give their views by the close of the consultation exercise.

The table below quantifies the response method used

Health Board of Residence	Email	Hard Copy	Online form	Grand Total
Abertawe Bro Morgannwg UHB	8	13	177	198
Aneurin Bevan UHB	2	8	44	54
Cardiff & Vale UHB	12	32	291	335
Cwm Taf UHB	1	16	25	42
Hywel Dda UHB	1	38	66	105
Powys THB	2	4	6	12
Not indicated	12	9	37	58
Grand Total	**38**	**120**	**646**	**804**

Public events were arranged throughout the consultation period and a schedule was published on the WHSSC website.

Attendees were asked to submit their individual responses and a record of themes identified has been provided. No themes were identified which have not been represented in the analysis of responses from the standard response methods.

A number of staff and stakeholder events were held through the consultation period. Attendees were asked to submit their individual responses and a record of themes identified has been provided. There were no themes identified which have not been represented in the analysis of responses from the usual response methods.

	Objective 5: To ensure that the consultation process complies with legal requirements, Welsh Government guidance and duties. A consultation plan was developed, in collaboration with health board engagement leads, to support the consultation process. The consultation document, response form and covering letter were prepared by WHSSC and formally approved by the six affected health boards at board meetings in June 2018. The consultation document was also available in the Welsh language, an Easy Read format and as a BSL signed video. An Equality Impact Assessment ("EIA") was also completed and used to inform the consultation plan and the stakeholders that should be consulted. In order to assess the demographic profiles of respondents, the hard copy and online versions of the consultation document included a series of survey questions in multiple choice format The consultation was developed to meet the requirements of the framework for Welsh NHS bodies and Community Health Councils established in 'Guidance on Engagement and Consultation on Changes to Health Services' issued by Welsh Government in March 2011 and the principles in 'National Principles for Public Engagement in Wales' developed by Participation Cymru and endorsed by Welsh Government in 2011. In addition, the consultation was designed to satisfy the 'Sedley criteria' (often referred to as the 'Gunning principles') originally set out in 1985 and endorsed by the Supreme Court in *R (Moseley) v Haringey London Borough Council in 2014* and subsequent judicial developments in which guidance on the requirements of fair consultation was set out and which has also been taken into account.
Lessons learnt	**What could have been done differently/ better?** This was a new endeavour for WHSSC and it was a steep learning curve for organisational understanding of the complexities of delivering a regional engagement and consultation. The support and advice of the subject matter experts was sought at an early stage as was the views of the CHC's. It is recognised by WHSSC that the advice of engagement experts regarding the need for public consultation should have been accepted at an earlier stage. A greater understanding of the role of the CHC's would have avoided delay at the outset.

	The process delivered a regional consultation but delivery was undertaken at a local level and although the process included regular checks and updates the activity undertaken locally reflected local circumstances and therefore included inherent inconsistencies. A suggested approach would to be adopt a program management approach with a fully developed handling plan to account for and where possible remove any inconsistencies. Such an approach would ensure greater clarity on roles and responsibilities and facilitate robust governance in relation to reporting, escalation and communication across the programme. Transparency was at the heart of the process up to the decision making stage at Health Boards. There is a recognition of some frustrations within CHC's with the ability to obtain, assess and comment on material before it is public. Although every effort was made to identify an effective communication strategy within the overall consultation plan there were a few examples, where communication between stakeholders could have been improved: • Communication management around the alignment of the publication of recommendations and decisions statements from different health boards could have been better aligned? • Improving the communication between the local CHCs and their Health Boards for example by establishing a formal communication channel via the Directors of Planning at each Health Board • Clarity of communication and explanation of the Gunning principles **What would you recommend to improve future programming or for other similar projects elsewhere** A theme that emerged from the Major Trauma consultation was around the need for improved collaborative working across NHS bodies. This has led to the establishment of a Cross Health Board Consultation working group which includes representation from WHSSC. The conduct of the engagement and consultation has always been mindful of the guidance and relevant legislation and case law but there is a gap in the guidance on collaborative which should be addressed. NHS bodies should engage with the Consultation Institute and consider the commissioning of training for all staff to increase awareness of the law and guidance regarding engagement and consultation. **What mistakes should be avoided if the initiative were to be replicated?**

	The recommendation and decision making process was reflective of this being a regional process and it is recognised that there were frustrations with CHC's with regard to the availability of the supporting material before it was made public. Consideration should be made to detailing the flow of information and gaining commitments on confidentiality if shared prior to being in the public domain. The overall timeline of the activity was flexed early and without scope for extension due to the agreed decision making process deadlines significant pressure was placed on the analysis of the data. This pressure was exacerbated by a large number of late submissions. Although overcome by allocating additional resource future program management should include a strategy for mitigation for slippage in the timeline.
Follow-up Actions	As part of the Final Review, follow-up actions and areas for exploration were: • WHSSC to contribute to the Cross Health Board Consultation Working Group • Regular meetings to be held between WHSSC and HB Engagement Leads • Regular meetings to be held between WHSSC and the CHC's • Improved communication between WHSSC and the HB DoPs • Agreement that to avoid the issue around information in the public domain the process is adopted that it can be shared in confidence to the CHC executive. • WHSSC to engage with all staff to increase awareness of engagement.

Appendix B : Arrangements for addressing the additional assurances requested by Health Boards

Health Board	Further Assurance Required	Ownership	How the issues are being addressed and actions taken
Hywel Dda UHB	To clarify arrangements for families of thoracic patients as to whether they would have access to family accommodation on the Morriston site.	Thoracic Surgery Implementation Project Board	Update from SBUHB: The existing accommodation for relatives provided at the bottom of the Morriston site will be available for families of thoracic patients, the level of demand required for the expanded thoracic service will be considered according to the agreed service model and if necessary additional accommodation will be included in the business case which will be developed by ABMU for the provision of the new Thoracic Unit.
Hywel Dda UHB	To give further consideration to the issues of transport as raised by people in the Hywel Dda area.	Thoracic Surgery Implementation Project Board	Further work will be undertaken with NEPT when the commissioning framework has been agreed. The commissioning framework will include an assessment of patient numbers and will form the basis on which the NEPT service can be planned. The commissioning framework will be completed by May of 2019.
Hywel Dda UHB	As it was noted that the response provided by WHSSC did not address concerns about parking, WHSSC to provide a response to the issue of	Thoracic Surgery Implementation Project Board	Update from SBUHB: The Health Board confirms that over recent months the parking issues at Morriston had greatly improved due to the demolition of empty accommodation and outdated

	parking raised by people in the Hywel Dda area.		buildings on the site. In addition work is underway to improve access to the Morriston site which will enable planning permission to be sought to further improve car parking on the site.
Hywel Dda UHB	It was noted that there was a lack of clarity on whether appropriate services in Hywel Dda were ready and established to provide onward care after local people had been discharged back to their own Health Board and as such a response is required as to how local services receiving patients discharged from Morriston will provide adequate care.	Thoracic Surgery Implementation Project Board	The implementation project board, led by SBUHB, is establishing a service model working group to develop the detail of how the service will be organised to deliver the service specification. This will include the pathway for discharge back to local services following admission for thoracic surgery.
Hywel Dda UHB	In addition, concerns were expressed around the pathway, with this process offering the opportunity to consider pathways and improve the patient journey. Reference was made to a risk of an over-focus on certain services, such as those relating to cancer, when there are others which are significant, such as benign respiratory disease.	Thoracic Surgery Implementation Project Board	The implementation project board, led by SBUHB, is establishing a working group specifically for benign conditions.
Swansea Bay UHB	The CHC has asked that ABMU Health Board provide more detail to assure the public in the ABM area that any further costs identified during implementation	WHSSC to SBUHB	Under the governance process for implementation of the single thoracic surgery centre, the business case will be developed through the implementation board, on which all involved Health Boards

	would be met by all involved health boards and not solely by ABMU.		are represented, agreed by SBUHB Board and finally approved by the Joint Committee. The costs will be agreed as part of this scrutiny and approval process. The revenue costs of service delivery will be funded by the 6 Health Boards that refer into the service according to the risk share mechanism for specialised services. Any additional costs that will be incurred during the transition period (as the previous services are decommissioned and the new service commissioned) will be identified through the implementation project and funding agreed through the Joint Committee and allocated according to the risk share.
Swansea Bay UHB	The CHC has asked the Health Board to clarify whether families of thoracic patients would have access to existing family accommodation on the Morriston site and to give further consideration to the issues of transport and accommodation raised by people in the ABM area;	SBUHB to provide to WHSSC	The existing accommodation for relatives provided at the bottom of the Morriston site will be available for families of thoracic patients, the level of demand required for the expanded thoracic service will be considered according to the agreed service model and if necessary additional accommodation will be included in the business case which will be developed by SBUHB for the provision of the new Thoracic Unit.

			SBUHB already offers flexible visiting hours which enables families and visitors to attend anytime from 11am to 8pm, 7 days a week, which can improve access for them to see relatives/loved ones. Assistance with travelling costs for those patients who use their own or a family member's transport will be able to reclaim mileage if they are on any of the recognised benefits under the "help with health costs" scheme (including income support, universal credit, pension credit guarantee or if you live permanently in a care home where the Local Authority helps with your costs).
Swansea Bay UHB	The CHC have asked that the Health Board provide a response to the issue of parking raised by people in the ABM area	SBUHB to provide to WHSSC	The Health Board confirms that over recent months the parking issues at Morriston had greatly improved due to the demolition of empty accommodation and outdated buildings on the site. In addition work is underway to improve access to the Morriston site which will enable planning permission to be sought to further improve car parking on the site.
Swansea Bay UHB	Co-dependencies of services: the CHC have asked the Health Board to give further consideration to the issues raised and provide assurance that any impact and necessary mitigation has been considered.	SBUHB to provide to WHSSC	The requirement for additional theatres, critical care capacity, pathology, radiology and other clinical services which will need additional capacity to underpin the new thoracic centre, and the costs associated with these, will be incorporated into the

			business case being developed by SBUHB and the costs therefore incorporated into the WHSSC IMTP so that the costs are shared across the involved Health Boards and not borne only by SBUHB.
Swansea Bay UHB	Staffing: The CHC considered that the response from WHSSC did not fully address concerns about the need for a strong multi-disciplinary team or respond to concerns that staff may not transfer from Cardiff. Therefore the CHC have asked that the Health Board give this further consideration.	SBUHB to provide to WHSSC	Careful staff consultation processes will be developed and undertaken jointly by SBUHB and CVUHB to ensure any issues with continuity and sustainability of staffing for the single unit are identified early and actions taken to mitigate appropriately. We will ensure that appropriate staffing options for minimising risks of loss of staffing are included in the business case as appropriate.
Cwm Taf Morgannwg UHB	The Health Board requested that that they receive a progress report from WHSCC in 6 months' time.	WHSSC to provide progress report	The report to Joint Committee in May 2019 will be forwarded to Health Boards for their May Board meetings.
Cardiff & Vale UHB	After careful consideration of all of the issues and listening to the representations made from both the Senior Clinical Consultant body and the Community Health Council the Board approved all of the recommendations with the caveat to ensure patient safety, the board would regularly be reviewing the detailed workforce model and medical rotas to provide 24/7 thoracic surgery cover for the Major Trauma	WHSSC to CVUHB	The current position with regard to the issue of thoracic surgical cover for the MTC is included in the Joint Committee report May 2019.

	Centre and if it was not assured within six months the Board would withdraw its approval.		
ABUHB	ABUHB confirmed no additional assurances were required by the Board.		
Powys THB	The Thoracic Surgery developments should not negatively impact on other services for Powys residents from Morriston Hospital; reassurances that outreach/outpatient services would be maintained at Nevill Hall and Glangwili [if the main adverse impact is around travel, and the main mitigation is to keep as much of the pathway as close to home as possible, then we need a level of reassurance that neighbouring service reconfigurations won't lead to these services moving from the nearest hospitals for our residents]	Thoracic Surgery Implementation Board	The implementation project, led by SBUHB, has held a clinical summit where the model was discussed, and is establishing a service model working group to develop the detail. This work will design a model to meet the service specification which requires that out-reach clinics form a key part of the service.

DRAFT: Major Trauma Centre: Management of emergency patients with thoracic injuries

Consultant workforce requirements

Situation

This paper sets out the combined view of the Cardiff and Vale and Swansea Bay University Health Board Medical Directors for the Consultant workforce requirements required to implement a sustainable Consultant workforce plan to support the management of emergency patients with acute thoracic injuries as part of the Major Trauma Network for South and West Wales and South Powys. Currently, thoracic surgical services are based at the University Hospital of Wales in Cardiff and at Morriston Hospital in Swansea.

Background

In March 2018, all six Health Boards approved the establishment of the trauma network, in line with the recommendations of earlier independent panel review and following a period of public consultation. This included:

- A major trauma network for South and West Wales and South Powys
- The adults' and childrens' major trauma centres should be on the same site.
- The major trauma centre should be at University Hospital of Wales, Cardiff.
- Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network.

In November 2018, the five south Wales Health Boards and Powys Health Board, considered the outcome of the public consultation and recommendations on the future of thoracic surgery in south Wales. All Health Boards confirmed, with some caveats and requests for further assurance, their approval of the recommendation for a single thoracic surgery centre at Morriston Hospital, Swansea.

The establishment of the Major Trauma Centre in Cardiff, and a tertiary Thoracic service in Swansea will require the availability of a consultant thoracic surgeon to be available to provide advice and to attend either centre in an emergency 24 hours a day, 365 days of the year. This represents a significant increase in the commitment to out-of-hours work from the current model.

Analysis

The current consultant workforce in thoracic surgery in Cardiff and Vale UHB (CAV) and Swansea Bay UHB (SB) are:

Cardiff and Vale	3 consultants
Swansea Bay	3 consultants (2 in post; 1 vacant post)

For the purposes of this paper it is assumed that, other than the additional volume of out-of-hours work, that the demand for thoracic surgical services remains at the current level. However, it should be noted that during the current planning discussions regarding the establishment of the tertiary thoracic service it has been highlighted that there is likely to be an additional volume of work (e.g. rib fixation) that is not part of current demand. From data presented at the recent first Thoracic Clinical Summit (15.3.2019) in Bridgend it is likely there will be 1200 cases per year and expected growth of 20% in the number of surgical cases.

The external review of the service, provided by the Royal College of Surgeons, considered that 5 surgeons would be sufficient to cover such a rota. However, this does not take into account:

- There is no existing on-call rota and therefore all out-of-hours workload will be in addition to current workload.
- There is a requirement to provide timely input across two geographically separate sites in order to provide safe and effective cover to the MTC as well as improve the outcomes in Thoracic Surgery.
- Taking annual leave and study leave into account, the prospective cover for 5 consultants equates to a 1 in 4 rota, which is not sufficiently robust to deal with sickness or unexpected absence.

The additional workload associated with out-of-hours cover is detailed below and takes into account:

- The Direct Clinical Care (DCC) sessions required to have a consultant thoracic surgeon present on the UHW site between 9am and 5pm Monday to Friday – as has been agreed.
- The additional workload of the on-call rota for out of hours (covering weekday evenings 5pm – overnight, and 24 hours at weekends), with a conservative estimate that this will involve approximately 2 hours/week of additional work.
- Estimated daily hours includes time taken for providing telephone advice, for review of postoperative patients, as well as the more significant annual workload of emergency management of MTC patients. This estimate includes the approximate 5-8 cases that following immediate resuscitative care require the emergency on-site attendance of a thoracic surgeon.

Table 1. Additional DCC sessions required

Daytime

UHW presence	Sessions/week	Sessions/year	Sessions/week per 42 weeks
Monday-Friday	10	506	12.0

Out of hours

7days/week; 365 days/year	Sessions/week	Sessions/year	Sessions/week per 42 weeks
Estimated 2h/day	3.7	194.1	4.62

Total DCC **16.67**

An intensity banding supplement would also apply in recognition of the frequency of the rota.

This additional volume of DCC activity could only be accommodated through the appointment of 2 additional posts, with the addition of Supporting Professional Activity sessions for post-holders' professional development, as required by the Welsh Consultants' Contract:

Post 1	8 DCC; 2 SPA = 10 sessions
Post 2	8 DCC; 2 SPA = 10 sessions

It is not proposed that these new posts' clinical commitments are isolated to the additional activities identified above, but rather that the sessions are distributed as part of a wider group job plan amongst the new posts and all existing post-holder, to ensure equal distribution of workload supporting the MTC as well as tertiary activity. It is anticipated this would be accommodated with a 1 in 8 "hot" on-call covering the Thoracic Centre in Morriston Hospital and a separate quieter 1 in 8 on-call covering the Cardiff and Vale MTC at the University Hospital of Wales. This would mean an on call overall of 1 in 4 and means there would not be a situation where either centre is not physically covered by a Consultant Thoracic Surgeon.

The sessional requirements and job plans of the whole Consultant body would be subject to a review after 6 months operational working of the new Thoracic Surgical service.

Again data and discussion at the first Thoracic Clinical Summit indicated that each surgeon would require approximately 150 operations a year to maintain their clinical skills. With 8 surgeons, even before the expected increase in number of operations this is achieved with 1200 operations annually.

Recommendation

It is recommended that the appointment of two additional thoracic surgery consultants is required to ensure that appropriate expertise is available 24 hours/day 365 days/year to provide safe and sustainable support for the MTC in Cardiff and the tertiary thoracic service in Swansea.

Dr Graham Shortland
Executive Medical Director, Cardiff and Vale UHB

Dr Richard Evans
Executive Medical Director, Swansea Bay UHB

April 2019

Thoracic Surgery Single Site Consultant Workforce Model- Consultation 07.06.19

Context

The Joint Committee of Welsh Health Specialised Services Committee (a committee of all the health board chief executives and 3 independent members) considered in November 2018 the recommendations that thoracic surgery should move to a single site model and that single site should be located at Morriston Hospital, Swansea. The committee supported this recommendation but asked for a number of assurances regarding the future model and specifically asked for a workforce plan, within 6 months, which described how thoracic surgical cover would be provided to the Major Trauma Centre at UHW, Cardiff.

In May 2019 a proposal regarding the workforce model was submitted by the two provider (Swansea Bay and Cardiff and Vale University Health Board) medical directors to the Joint Committee however the committee deferred a decision and requested that Dr Sian Lewis (and the WHSS Team) bring a WHSSC workforce assessment back to the Joint Committee by the end of June 2019. They asked that this assessment take into consideration a number of matters and some uncertainties raised in the paper and during the meeting.

This paper summarises this initial assessment of the optimal consultant work force model. There are a number of assumptions in this modelling work and this paper is therefore being circulated for comments which will be incorporated into the final submission to the Joint Committee. In addition the WHSS team is establishing a panel of expert external advisors who will also provide feedback.

The timescale for this consultation process is extremely challenging; we apologise for this but we are working within the requirements of the Joint Committee. To help with this rapid turn-around it is important that your comments are returned on the attached template and reference the relevant line within the paper. Also it is important that you provide wherever possible independent evidence rather than opinion to substantiate your comments.

Background

The following assessment is based on;

- a number of points made in the RCS Invited Review 2016,
- the WHSSC Service Specification for Thoracic Surgery
- NHS England Service Specification for Thoracic Surgery
- The current activity levels of the two units plus 20% additional workload

The Thoracic Surgery Implementation Group is working to define the service model so this assessment is also based on a number of assumptions. These assumptions come from comparators with other thoracic surgery centres, presentations made by two consultants (MK and PK) at the recent thoracic clinical summits in March and May 2019.

The RCS Invited Review (2016) stated that;

"In line with units of a similar size it was considered that five consultant thoracic surgeons were required to service a population of 2.4 million people safely. This would provide adequate emergency on-call cover as well as other services to ensure adequate patient throughput. RCS Invited Review 2016".

Additionally the "review team concluded that there were too many separate MDT meetings per week and considered that it would be appropriate to merge meetings. This would place fewer burdens on consultant surgeons attending multiple MDT meetings".

The RCS also recommended that;

Five consultant thoracic surgeons should be employed to meet service demands. Each of the consultants' job plans should include:

- one in five on-call duty which includes weekend cover
- At least one specified operating day
- Fair distribution of MDTs with adequate cross-over cover
- Attendance at out-patient clinic

It is acknowledged that at this point the location of the MTC had not been determined.

The independent panel and the final recommendation from Joint Committee including further mitigations required by Health Boards means that there are other fixed points;

- A commitment to 6 consultant on the basis that this would allow 9.00am to 5.00pm onsite cover at the UHW site and an additional 20% workload (based on outturn + 20%).
- A commitment to the development of the skills of the trauma team to manage immediate thoracic trauma.
- That there will be an on-call thoracic surgery rota which also provides cover to the MTC, and will be in the form of remote advice to the trauma team 24/7 plus attending the MTC in the rare event that their specialist surgical intervention skills are required to support the trauma team;
- There will be a thoracic surgery presence on the University Hospital of Wales site 5 days a week for advice and support for major trauma and other clinical services as required.
- That we will obtain and act upon advice from the Wales Cancer Network to improve the way our multi-disciplinary teams work, ensuring that wherever possible care is delivered closer to home.

Further advice provided to WHSSC at the time of the consultation noted that the Intercollegiate Surgical Curriculum Programme has recently been updated (16th November 2017) to include the requirement that surgeons trained in trauma will allow them to practice independently for injuries to the thorax.

The extant Thoracic Surgery Service Specification Version: 1.0 notes the following key points

With regard to minimum volumes (these are based on the NHS England Service specification)

- The thoracic surgery unit should undertake a minimum of 150 primary lung resections per year.
- The thoracic surgery unit should have a minimum of 3 full time general thoracic surgeons.

Regarding emergency cover and on-call arrangements

- Providers are required to have 24/7 emergency cover by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues.
- The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies.
- Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.
- A sustainable on call rota should not be more frequent that 1 in 4.

Assessment

Demand Analysis

This demand analysis is based on an estimated population of 2.2 million people.

The table below shows the activity outturn for all procedures over the last 3 years

Table 1 Thoracic Surgery Outturn by Centre

	SBUHB	CVUHB	Total
2016/17	421	615	1036
2017/18	474	646	1120
2018/19	422	672	1094

Source: Provider contract monitoring returns to WHSSC

This shows a fairly static position of approximately 1100 cases per year. For planning purposes this would mean approximately 1300 cases based on outturn plus 20%.

Table 2 shows the casemix for the two centres combined as reported to the Society for Cardiothoracic Surgery in 2017/18.

Table 2 Casemix for Morriston/UHW Combined 2017/18

Procedure	Number of Cases
Lung resections – primary malignant	458
Lung Resection – others	101
Mesothelioma Surgery	16
Pleural procedures	170
Chest wall/diaphragmatic	97
Mediastinal	57

Other	10
Endoscopic	62
Total	**971**

Table 3 Number of primary lung resections

Year and Source	SBUHB	CVUHB	Combined
2016/17 SCTS*	159	194	353
2017/18 SCTS*	162	279	441
2018/19 WHSSC	168	273	441**

*excludes exploratory procedures with no resection
** forecast from M11

Surgical resection is currently the only curative option for lung cancer, therefore long term survival rates are closely related the number of resections carried out at a centre. The table below shows the resection rate for patients across south Wales based on the hospital of referral. This shows a significant variance in lung resection rates from 27% to 13%. The best resection rate across the UK is reported from Papworth Hospital at 28%. The aim with a single centre is to consistently increase the resection rate to be amongst the best in the UK and to do this across the region.

Table 4 Lung Cancer Audit 2018 (2017 data)

	Resection rate	Total cases	Number resected
Bronglais General Hospital	15.40%	56	9
Prince Philip Hospital	18.40%	188	35
Withybush General Hospital	15.10%	97	15
Princess of Wales Hospital	27.00%	106	29
Morriston Hospital	22.90%	294	67
University Hospital Llandough	17.10%	290	50
The Royal Glamorgan Hospital	23.10%	152	35
Prince Charles Hospital Site	18.30%	133	24
Nevill Hall Hospital	13.10%	106	14
Royal Gwent Hospital	18.80%	268	50
South Wales	**19.40%**	**1690**	**328**
Wales	**18.30%**	**2179**	**399**

Proposed Activity Requirements

MDTs

At the recent clinical summit meetings the two clinical leads suggested the following MDT configuration based on six surgeons with two surgeons covering each MDT to ensure that there is always a surgical presence at the MDT and to improve consistency of decision making.

Lung Cancer MDT	New Cases/Year (NLCA) 2015)	Surgeon Responsible	Surgeon Cover
SBU HB Morriston MDT (Singleton, Morriston, Neath)	311	Surgeon 1	Surgeon 4
Hywel Dda MDT GGH (GGH, BGH, WGH,PPH)	311	Surgeon 2	Surgeon 5
CTM HB MDT POW	108	Surgeon 3	Surgeon 6
Prince Charles MDT	126	Surgeon 4	Surgeon 1
ABUHB NHH, Gwent	257	Surgeon 5	Surgeon 2
Royal Glamorgan & C&V MDT	407	Surgeon 6	Surgeon 3

With the advent of the new Cwm Taf Morgannwg Univeristy Health Board it could be feasible that PoW, Prince Charles and Royal Glamorgan join as one MDT but for planning purposes the arrangement suggested by the Clinical Summit have been used. It will however be important that any agreed final model reflects the input of the All Wales Cancer Network and the output of their peer review programme.

As suggested also by the two clinical leads, if six surgeons were in post this would provide each surgeon with the following new cases.

Lung cancer MDTs	Total New Cases (NLCA 2015)
Surgeon 1	311 + 126 = 437
Surgeon 2	311 + 257 = 568
Surgeon 3	108 + 407 = 515
Surgeon 4	126 + 311 = 437
Surgeon 5	257 + 311 = 568
Surgeon 6	407 + 108 = 515

Outpatient and Pre-assessment Clinics

The 2018/19 contract monitoring returns for the two centres for outpatient activity is as follows

Cardiff & the Vale University Health Board

New outpatients: 521

Follow Up: 1085

Swansea Bay (inc Bridgend)

New outpatients: 313

Follow Up: 616

Based on the information from other centres in England pre-assessment/outpatient clinics need to run daily and this is usually at the thoracic centre so in this case Morriston. Additionally the two clinical leads further proposed the need for clinics in the peripheral hospitals for cases identified at the MDT. The suggestion is therefore that in addition to the daily clinics in Morriston there are:

- two clinics/week in Cardiff
- one each in the other Health Board areas which could rotate around the hospitals within the Health Board. This would need to be confirmed once the implementation group have finalised their work on the service model.

Pre-habilitation

It is proposed that this occurs at all hospitals but is not consultant led.

Operating Lists

The RCS recommended that each surgeon should have at least one operating list per week. Information from the surgeons at both UHW and Morriston suggest that the most efficient way is to run a long list, essentially equivalent to 3 consultant session days. Advice from both centres also suggests that around 4 cases per long day is an appropriate number.

The planned activity is around 1300 cases/ year, although it is likely to be less than this at the outset based on current figures. So for 4 cases per 3 session list = 325lists/year = 6.25 lists/week.

On call

The RCS report suggested a one in five on-call duty which includes weekend cover for five surgeons so it is proposed that this is a one in six for six surgeons which with prospective cover would equate to around 1 in 5.

Major Trauma Centre

The concerns about cover for the major trauma are acknowledged and it is understood that the "go live" date of April 2020 is a key driver for the urgency required in agreeing the consultant workforce configuration.

Advice provided by the Major Trauma Network Clinical Lead suggests that a thoracic surgeon would need to attend the MTC to deal with an emergency 3 to 8 times per year.

Advice from the two thoracic centres varies one centre stating that they are rarely called in out of hours and the other suggesting that they are called 1 to 2 times per month.

Should there only be one on call rota covering the thoracic surgical centre and the MTC the concern is clearly that the surgeon will be required in both places at the same time. The analysis below is based on the NCEPOD Report from 2003 which carried out a comprehensive review of non-elective surgery. The analysis is based on the figures quoted in that report which are for combined cardiothoracic surgery. We have taken advice from the President of the Society of Cardiothoracic Surgeons regarding the relevance of this analysis to current clinical practice and whilst there have been some changes, including increasing use of rib fixation, it was felt that there was unlikely to be a material difference in the frequency of clinical emergencies. These figures, because they include cardiac emergencies are therefore likely to overestimate of the thoracic surgery emergency workload.

From this analysis, the probability of a thoracic surgery emergency and an MTC emergency arising on the same day is 1 in every 429 days.

The probability of this occurrence in the same hour i.e. at exactly the same time is 1 in every 6,857 days i.e. once every 18.8 years.

Calculation of Thoracic Surgery On Call Probability									
NCEPOD 2003 Non Elective Surgery in the NHS									
Percentage of Non-elective operating									
Cardiothoracic surgery	17.10%								
Operating Time of Day									
	Weekday 08:00 to 17:59	Weekday 18:00 to 23:59	Weekend 08:00 to 17:59	Weekend 18:00 to 23:59	Night 00:00 to 07:59	Total			
Cardiothoracic (n)	120	21	13	2	9	165			
Percentages	72.7%	12.7%	7.9%	1.2%	5.5%	100.0%			
Total Percentage On call window						27.3%			
South Wales Thoracic Surgery total						1,100			
Non elective @17.1% based on cardiothoracic average NEL						188			
Estimated allocation to time of day	137	24	15	2	10	188			
Total in on call window						51			
Probability per day of thoracic case on call						**0.1397**			
Major Trauma Thoracic Surgery Activity						8	per annum		
Weekend						2.3	per annum		
Weekday						5.7	per annum		
Weekday out of hours						3.8	per annum		
Total major trauma estimated for weekend and out of hours						6.1	per annum		
Probability per day of major trauma thoracic case on call						**0.0167**			
Cumulative probability of thoracic case on call and major trauma thoracic case same day						**0.0023**			
Estimated frequency of occurrence same day - 1 in every						429	days	1.2	years
Estimated frequency of occurrence same hour (day * 16 hours) - 1 in every						6,857	days	18.8	years
Assumptions									
1. Thoracic non elective rate equivalent to average across cardiothoracic surgery - in practice cardiac likely to be higher									
2. Assumes all cases performed by surgeon visiting on site and not by advice									
3. Both of these assumptions likely to overstate frequency of occurrence									

On this basis and given the commitment to the development of the skills of the trauma team to manage immediate thoracic trauma the likelihood of the surgeon being required to be in both centres at the same time during the night or on weekends ie when there is no surgeon on site at UHW is extremely low. It is therefore suggested that both the MTC and the thoracic surgical centre can be covered by one on call rota once the surgical centre is established.

Required Consultant Workload Total number of Sessions/week

The following table takes all the analysis above and provides a breakdown across the activities of the number of consultant sessions required per week.

Activity	**Per Week**	**Total sessions Per week**
Theatre sessions	6.25 X 3 session lists	18.75
Pre-assessment and Outpatient clinics	Morriston daily Cardiff 2/week Glangwili/PPH (alternate weeks) Gwent/NHH (alternate weeks)	10

	PoW/PCH/RGH (1 every 3 weeks)	
MDT	6 (not full sessions)	3
On call	Intensity Payment	Intensity Payment
Travel	5 estimate	5
Ward Rounds M-F	5	5
Admin	5	5
Total		**46.75**

Admin and SPAs will need to be added to the above depending upon the number of surgeons.

Specimen Job Plan – 10.5 sessions 7.5:3 split

Theatre 3.0
OPD/pre-assessment 1.0
MDT 0.5
Admin 1.0
Ward Round 1.0
Travel 1.0
SPA 3.0

Based on the above split then 6.2 consultants would be required.

On an 8.5 session DCC with 2 SPAs

Theatre 3.0
OPD 2.0
MDT 0.5
Admin 1.0
Ward Round 1.0
Travel 1.0
SPA 2.0

Based on the above then 5.5 consultants would be required.

We do not know the number of sessions included in the current establishment of thoracic surgeons but we do know that the Welsh average is over 10 and the average number of SPAs is less than 3.

Covering the MTC from April 2020

As stated the planned go live date for the MTC is April 2020. It is not expected that the thoracic surgical centre will be established for around 2 years as capital infrastructure is required.

There is a clear level of anxiety about how the thoracic work will be covered at the MTC from April 2020 especially given that the trauma teams and the resuscitative surgeons may not be experienced in working in an MTC. Additionally the majority of work for thoracic surgeons in an MTC is rib fixations. It is suggested that similar to other centres, rib fixations can be undertaken by

orthopaedic surgeons. However it is recognised that this will take some time to become practice at the MTC and that thoracic surgeons are likely to be required to undertake the rib fixations in the short term.

Given all this the recommendation is that an additional locum thoracic surgeon is appointed at UHW for between 6 and 12 months in the first instance, to provide additional support from April 2020 and that the two thoracic consultant teams develop plans to work together. During this time where there are regular reviews of the emergency activity levels.

The advantage of this recommendation is that the MTC is better supported and that during the period that the locum is in place some of the assumptions in this paper can be tested especially regarding the need for a thoracic surgeon to attend the MTC in an emergency. It will also allow the thoracic surgery implementation group to complete its work on the model and will then allow a further discussion at Joint Committee on the long term model including consultant workforce when the implementation business case is presented.

Cost of additional locum – this is estimated to be in the order of £150,000 including on-costs, travel, intensity allowance etc.

Recommendation

To note the analysis and that this would draw the conclusion that the number of thoracic consultant surgeons required for the workload is around 5.5 to 6.2 wte consultants required depending upon exact job plan and DCC/SPA split.

To note that the amount of operating time is the crucial driver and that for the predicted activity (outturn plus 20%) 6.25 lists will be required every week. To enable every surgeon to have one full operating list this means that around 6 surgeons will be required.

Given the low probability of the surgeon being required to attend the MTC and the thoracic surgery centre at exactly the same time that there should be one call rota.

In recognition of the concerns regarding support to the MTC when it opens in April 2020 that a short term locum consultant is appointed in UHW. This will not impact on the total recommended numbers of consultants but will enable support for the MTC and to test and build confidence in the system whilst the final service model is being determined. Also that during this time the two thoracic centres develop plans to work together.

Appendix 1

The Liverpool Thoracic Centre Model
(presented at Clinical Summit May 2019)

Information from the Liverpool thoracic centre was presented at the Clinical Summit in May 2019. It was noted at this meeting that for a population of around 2.8 million people Liverpool have

5.5 wte thoracic surgeons working on a team based approach

They operate on a hub and spoke model which supports 10 peripheral hospitals

Weekly Clinics with attendance in person by thoracic surgeon.

- All new patients travel to LHCH.

Weekly Lung MDTs:

- 4 major MDTs with direct attendance & cross cover.
- Others by VC.

- MDTs: High Risk cases MDT, Lung cancer MDTs and Specialist MDTs.

Trauma support

- Trauma centre is 7 miles away.
  - Self-sufficient and independent.
- Chest trauma cases -
  - Phone Thoracic Consultants directly.
  - Thoracic Surgeons only contacted after local decision to open chest has been made.
  - Occasionally have to go to site.
  - Clinic every Thursday am. Patients seen by MS.
- Rib Fractures delt by Orthopaedic Surgeons who are now self-sufficient.

Golden Jubilee Hospital Clydebank

This centre covers a population of around 2.2m people. They are currently advertising for a consultant thoracic surgeon to join their team.

They have 4 full time thoracic surgeons + 1 mixed practice. (their current advert is for a vacancy in their full time establishment)

They cover 9 MDTs

1:4 on call with prospective cover & part of trauma team with MTC in Glasgow

Addendum Following Consultation

To note that surgery is not the only cure for lung cancer as there are radiotherapy techniques that are also curative but recognising that surgery has the best 5 year survival rates.

Clarity that the proposal, subject to fully being agreed via the implementation group, is that each MDT is supported by 2 surgeons.

The MDT numbers for Aneurin Bevan are not correct.

Other Changes Recommended Following Consultation

The locum consultant should be appointed for 12 months and not 6 to 12 months.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Thoracic Surgery Single Site Consultant Workforce Model

Consultation on draft Thoracic Surgery Single Site Consultant Workforce Model

Stakeholder comments table

14th June 2019

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
1.	Medical Director 1	2	21-23		The outturn + 20% is likely to be at the lower end of potential activity increase.	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
2.	Medical Director 1	2	30-32		This advice and support could be provided virtually and without the physical presence of a thoracic surgeon.	This was agreed through consultation. However the interim model suggested would allow further evaluation of the demand and if needed reconsideration by boards in the future.
3.	Medical Director 1	4	14-15	Table 4	The figures across sites differ greatly reflecting both the case mix and the risk approach of individual surgeons. UK guidelines promote offering surgery to higher risk groups, so increasing resection rates. This stance needs to be encouraged in the single site model, properly supported by detailed patient discussion, full physiological assessment and with extensive pre-habilitation.	We agree. This is one of the opportunities of a new service and the presence of 2 surgeons in each MDT.
4.	Medical Director 1	7	1-10		Three session days are advantageous though would require careful job plan diary work to ensure adequate lower intensity clinical activities on preceding and following days. Three session days place extra pressures on theatre staff however and also potentially compromise time for training of junior staff.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
5.	Medical Director 1	7	15 et seq	Major Trauma Centre	The quoted and extrapolated figures reflect my experience in supporting major trauma. Additionally, the specific skills required in a thoracic surgical emergency context are straightforward and trauma surgeons can be instructed in these.	The external expert advisors supported your view.
6.	Medical Director 1	8	6-8		I would fully endorse this view.	Thank you
7.	Medical Director 1	10	4-17		I would fully endorse this view and for the reasons outlined	Thank you
8.	Medical Director 1	10	21-27		I would fully endorse the view that 6 thoracic surgeons wold be the acceptable number to provide a comprehensive thoracic surgical service for the relevant population.	Thank you
9.	Consultant Respiratory Physician 1	2	30		Is this a realistically a good use of a consultants time, 9-5 delivering advice and "waiting" for something to happen. This needs more robust thinking as to how the clinician would function in UHW if required to be there.	This was agreed through consultation. However the interim model suggested would allow further evaluation of demand and if needed reconsideration by boards in the future.
10.	Consultant Respiratory Physician 1	4	6		Surgery isn't the only cure as there are radiotherapy techniques that have radical intent. However, it has the best 5 year survival rates	We agree and will correct this.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
11.	Consultant Thoracic Surgeon 1	General			We are very excited to take part in this consultation and assist in shaping a single thoracic surgery centre of excellence for South Wales. In order to do that and provide Wales with an innovative, safe and sustainable single centre we would like to present our comments to the workforce model consultation.	Thank you
12.	Consultant Thoracic Surgeon 1	3	25		Although the estimated amount of activity is calculated to be 1300 per year, we estimate it to be at least 1500 cases, (so 30% of current activity as presented in the thoracic clinical summit), taking into consideration the predicted increase of activity due to lung cancer screening in Wales (10-20% Manchester experience), the 2019 NICE guidelines that will increase the cohort of the operable patients and the predicted increase of activity due to awareness campaign by public health wales. We should also take into consideration the discussed and agreed need to increase surgery for benign disease (Estimated 100-150 new patients)	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
13.	Consultant Thoracic Surgeon 1				In order to accommodate the above needs, we will need 2 theatre rooms available every day, working 8am - 5pm (as per England's specification) corresponding to 3 DCC because they include preoperative and postoperative management of the patients. A long 12 hours list is neither acceptable nor recommended as it impacts on all staff and their work-life balance and creates recruitment and retention issues. 12 hour thoracic list in Morriston is done only because of lack of theatre capacity and it's against any accepted practice. This could have a negative impact on patients' safety.	The RCS review recommended this was the optimal model. This can be revisited during implementation. The implementation group is identifying theatre requirements and current planning is based on two as described at the Clinical summit in March although this will need to be finalised. The exact operating times will need to be agreed with the surgeons at implementation to achieve the greatest efficiency balanced with workforce well-being considerations.

14.	Consultant Thoracic Surgeon 1				The proposal of 6 theatre days per week is inadequate as it is below the present theatre availability. Presently in UHW, we have 4 theatre lists per week and we additionally covered 34 extra theatre lists and cross covered 28 lists (leave). That corresponds to 5 theatre lists per week. Despite this we still have long waiting lists and breachers. Morriston has 2 long lists per week and a regular waiting initiative list on Saturdays. This corresponds to 3 theatre lists per week. Overall between UHW and Morriston presently we have access to 8 theatre lists. According to our calculations of 1500 cases per year and 2,5 cases per list we would need 10-11 lists weekly.	The suggestion in the paper is that each theatre list is 3 consultant sessions ie 3 x 3.75 hours. This was based on current practice at one of the centres. Regardless of how lists are configured there is a need to deliver 1100 procedures currently, rising to 1300 in line with 20% increase that is being used for planning purposes. This may rise in the future as you suggest and we will constantly keep this under review as we would for any of our commissioned services. Our external advice suggests that for the number of primary lung resections that are currently being undertaken in south Wales and allowing for a 20% increase then 6 surgeons would give sufficient operating time. Their view was that increasing this number based on current and 20% projected increase would be at the margins of acceptable operating numbers per surgeon. We acknowledge that if lung cancer screening is introduced (estimated to be at least 3 years away) then the number of primary lung resections may increase and should this happen we will review the number of surgeons required.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
15.	Consultant Thoracic Surgeon 1				We believe that it's unsafe and against current guidelines (Major Trauma Centre specification, GIRFT report) and recommendations to provide cover from a 42 miles distance.	Our external advice (see separate appendix) says that GIRFT is opinion rather than evidence based guidance and the advice from professional bodies is more relevant. The advice from the SCTS is that given the rare need for a thoracic surgeon to attend the MTC in an emergency then it is not a good use of resource to appoint additional consultants simply to cover this rare event. The clinical Lead for Major Trauma Networks in England also supported this view. We recognise however that support to the MTC when it opens in April 2020 is of significant concern and that is why we are recommending the appointment of a locum thoracic surgeon at UHW from April 2020 to provide this support and to develop and test the system so that we have much greater clarity on the requirements and we recommend that the workforce model is re-assessed prior to the thoracic surgery centre opening.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
16.	Consultant Thoracic Surgeon 1				The appointment of the 4th consultant will be essential to facilitate 1 in 5 on call rota and maintain the high-quality patient care and outcomes during this transitional period. This would require investment in infrastructure as additional ward beds, outpatients' clinic, theatre equipment, secretarial support and two additional theatre lists would be essential. It should be advertised as a locum for 6-12 months initially with view to substantive post. This would make the post attractive and would make recruitment easier in view of shortage of thoracic surgeons in UK. This transitional phase with 4 consultants in UHW would allow us to prospectively evaluate the needs of the MTC and Thoracic services in general.	We agree that an interim appointment has many advantages. We are however unable to commit to the job description without agreement with the provider organisation.
17.	Consultant Thoracic Surgeon 1				The appointment of the 4th consultant would be ideal if infrastructure can be provided. If not available, we respectfully propose that the two surgeons from nearby centres provide cover for 2 in 5 days of on call. This would help evaluate the feasibility of providing an on call service for the MTC from a distance.	We agree and have suggested that both options are developed.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
18.	Consultant Thoracic Surgeon 1				As a centre of excellence we should cover all the specialized MDTs such as interstitial lung disease, mesothelioma, COPD, chest wall deformities, sarcoma, metastatic (G.I.) etc. There was also the recommendation that we have 2 surgeons per MDT which doesn't reflect on the document. The need for high risk MDT/second opinion was also emphasized in many occasions including our recent thoracic workshops. This should be weekly with attendance of all the consultants.	Apologies if the document was not clear, the intention is that there are 2 surgeons covering each MDT. The cover for specialised MDTs will need to be agreed as part of implementation. Additionally advice from the Welsh cancer Network suggests that the number of MDTs could be rationalised from that suggested in the paper although they welcome the model of 2 surgeons/MDT.
19.	Consultant Thoracic Surgeon 1				PAs are not calculated correctly in the WHSCC proposal, since they don't include on call supplement, correct number of MDTs ,theatre sessions and outpatient clinics, and the presence in UHW from 9-5. In the proposal from WHSCC, the activity is even lesser than the current one. Proposed revised level of activity for the single Thoracic surgery centre is provided below.	This raises questions as to how the current service can be delivered and does not bench mark with any other centre in the UK.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response

Activity	Per Week	Total sessions per week
Theatre sessions	10 x 3 DCC(8am -5pm)	30
Pre assessment and outpatient clinics	**-**Morriston daily 6 per week -LLandough 1 per week UHW 1 per week -Gwent 1 per week -WEST SOUTH WALES MDT**?**	9 + west south wales
MDT	6 x 2 (2 surgeons per MDT) High risk MDT(6 X 0.5) 6 specialised MDT(monthly)	6 3 1.5
On call	1 in 6 (1-2 according to amount of work required)	6-12
Travel	5	5
Ward rounds	6	6
Admin	6	6
UHW 9-5 cover	10	10
Cross cover clinic and theatre	?	?
Total		**83.5 – 89.5 ?+**

Appendix E

CONFIDENTIAL Comments forms with attachments such as research articles, letters or leaflets were not accepted

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
20.	Consultant Thoracic Surgeon 1				15 sessions are required per week for UHW 9-5 cover without calculating cross-cover.	Questions have been raised during this consultation on the need for 5 day cover at UHW. However it is acknowledged that this was part of the original considerations by Boards. Cover at UHW is however not expected to be additional to out-patients etc. If surgeons are based at UHW it could reasonably be expected that they would be doing some type of activity – out-patients, preassessment, admin, MDTs etc.
21.	Consultant Thoracic Surgeon 1				In conclusion for a single centre to excel we will need at least 10-12 theatre lists per week and a service equivalent to 83-89 PAs at a consultant level. We should not embark on a centre of excellence with suboptimal provisions.	These calculations do not bench mark with any other centre in the UK.
22.	Trauma Network	1	38	Background	Needs to include the NHSE quality indicators and service specification for major trauma services.	Accept that the Trauma Network should be delivered based on recommended standards. Joint Committee at its meeting in March 2019 however confirmed that a phasing of standards was expected. The expert advice on the models and requirements in England is provided in appendix G.

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23.	Trauma Network	2	24	Background	This is part of the trauma team and has a limited application. It is not a substitute for having a thoracic surgeon for performing an Emergency Thoracotomy in theatre.	We discussed this with external advisors including the Clinical Lead for Major Trauma in England and representatives from the SCTS. Their advice and comments are provided in Appendix G but to summarise their advice was that the need for a thoracic surgeon to attend the MTC in an emergency would be rare and as such recruiting additional surgeons to cover this eventuality would not be a good use of resource nor would the jobs be attractive and we would be unlikely to recruit to such posts.
24.	Trauma Network	2	36	Background	This is not the case. The presence of a trauma surgeon is not a replacement for the presence of a thoracic surgeon	See the comments above.
25.	Trauma Network	7	16	Major Trauma Centre	This may well be a driver, but WHSSC should recognise as the principle commissioning body for the MTN that South Wales is the only region in the UK, where funding has not been secured for a MTN. South Wales is the only outlier and this poses significant clinical, strategic, reputational and political risks.	The need for an MTN has been recognised by WHSSC.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
26.	Trauma Network	7	19	Major Trauma Centre	This needs further clarification and should be edited as follows – "estimates from providers in NHSE indicates 2-5 cases/year for Resuscitative Thoracotomy and 5-8 cases/year for Emergency Thoracotomy. In total 7-13 cases, which may potentially require intervention from a thoracic surgeon. This is more comparable with UHW data.	We will note based on your advice. The Clinical Lead for Major Trauma in England suggested that there would be likely to be a requirement to attend the MTC at UHW in an emergency around 4 times/year based on experience in his own trauma centre. However our recommendation is that an additional locum surgeon is appointed at UHW from April 2020 and this will allow the need to be tested and we recommend that the workforce model is re-assessed in the months prior to the thoracic surgical centre go live date.
27.	Trauma Network	7	22	Major Trauma Centre	The information contained in comment number 5 is more in keeping with the lower end of the obtained English data. Ultimately changes in patient flow with the development of the MTN will be accurately captured in year 1 (TARN dataset) and visible to WHSSC to give a much more informed picture. However, see caveat under comment number 8.	We propose that the interim model will allow formal assessment.

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28.	Trauma Network	7	25	Major Trauma Centre	I am not convinced that you can base the analysis on data that is based 16-year-old data – the incidence of penetrating trauma has increased in that time. Again, changes in patient flow with the development of the MTN will be accurately captured in year 1 (TARN dataset) and visible to WHSSC to give a much more informed picture. However, see caveat under comment under 8 (*comment 29 in this table)*.	The advice we have taken supports the analysis that this would be a rare event. However we support your view that this needs testing hence the recommendation regarding the appointment of an additional locum surgeon.

29.	Trauma Network	10	4	Covering the MTC from April 2020	The appointment of locum consultant for 6-12mths based at the MTC is welcome and will allow the MTC to go live next year from a thoracic cover perspective. The risks of not establishing the MTN next year are significant and cannot be justified based on the current impasse. However, the assessment needs to include some information on the chances of successful recruitment to a locum post over a substantive post. The paper states that it will be around 2 years until centralisation occurs, so a 2- year appointment would be sensible. Data on activity cannot be determined accurately over 1 year – variation exists year by year and therefore a longer period would be required to assess activity. In the event that this post is unfilled, the current impasse will continue. Recruitment into a substantive post will be more attractive and could invite the opportunity to appoint a lead surgeon to take forward the service change. Whilst this may exceed the total number of recommended consultants, it serves to bring a number of other advantages.	We have been informed that there is a potential locum candidate. The advice we have been given is that the amount of operating is the crucial factor in successful recruitment and if there is unsufficient operating available this would have a detrimental effect on ability to recruit as the job would be unattractive,

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30.	Consultant Medical Oncologist	4	6	Primary lung resections	It isn't true that "Surgical resection is currently the only curative option for lung cancer". Series show an 11% 10 year survival for chemoradiotherapy in inoperable tumours. It is accepted that the highest cure rates come from surgery.	We agree and will correct
31.	Consultant Medical Oncologist	5	12	MDTs	Could add that the lung cancer services are due to be peer reviewed in Q3 2019	Point noted thank you and explored with the Welsh Cancer Network. The peer review will be useful to inform the implementation process.
32.	Wales Cancer Network	3	24/25/26	Demand Analysis	These figures do not consider the requirement of the Single Cancer Pathway in Wales and implementation of National Optimal Pathway for lung cancer. Surgical treatment will need to be performed within a maximum of 62 days from point of suspicion, ideally treating within 49 days. Evidence in recent studies indicate delaying surgery beyond 37 days from diagnosis leads to a worsening of long term overall survival (Yang et al 2016)	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes

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33.	Wales Cancer Network	3	24/25 /26	Demand Analysis	These figures do not factor the recent international evidence for low dose CT screening for lung cancer in a high risk population (targeted lung health check programme). NELSON (as well as other trials) presentation data suggests a 50% increase in surgical resection numbers following implementation of a target health check programme.	See above
34.	Wales Cancer Network	6	6-7	Table MDTs	While this table uses 2015 'new referral' numbers and Table 4 2018 uses 'total cases' numbers I presume these should be roughly the same. However, when looking at the table on this page the total added numbers do not correlate e.g. ABUHB =257 although Royal Gwent/Neville = 268 + 106	The referenced year in each of the two tables is different, hence the numbers are different.
35.	Medical Director 2	General			The field of lung cancer and requirements for the management of patients with lung cancer may change in the next few years for example if lung cancer screening is adopted in Wales and the approach to workforce model considerations and arrangements needs to allow some flexibility	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes

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36.	Medical Director 2	General			There is likely to be a different requirement for thoracic surgery input during the initial year or so of the MTC becoming operational (ie whilst orthopaedic surgeons are trained in rib fixation etc) compared to when the MTC is established.	We agree and that is why we propose an interim arrangement
37.	Medical Director 2	General			The actual activity of the proposed thoracic surgeon based at UHW in the daytime when the MTC is established would need to be specified clearly as there is a risk that activity could be minimal if it only involved input for patients with complex major trauma.	This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. See also response above.
38.	Medical Director 2	General			The establishment of a single site thoracic surgery centre is extremely important for our population and for South Wales, as is the establishment of the Trauma Network and the MTC. Both are long overdue for Wales, and there is likely to need to be a degree of compromise to ensure that progress on both programmes of work are not delayed.	We agree

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
39.	Consultant Thoracic Surgeon 2	2	16 to 17	MTC	Agree that the location of the MTC had not been determined at that time. However, the RCS clearly stated that Thoracic Surgery does not need to be at the same site as the MTC. This was known to UHW, Cardiff at the time of their bid for the MTC. Did they give plans on how the UHW Health Board would arrange Thoracic surgery cover for the MTC if thoracic surgery were to move to Swansea?	This is outside the scope of this paper
40.	Consultant Thoracic Surgeon 2	2	21, 22,		Do not agree and will not support …all 6 surgeons being involved with "onsite cover" for UHW site. For a fair equitable service across South Wales the surgeon covering the UHW lung MDT should be the surgeon available to cover UHW once a week as is the practice at Liverpool Heart and Chest Hospital (LHCH) for the MTC there.	Point noted. The exact job plan configuration would need to be agreed at the implementation stage. The working assumption however is that the thoracic surgical team will operate as 1 team and will cross cover to deliver the service model.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
41.	Consultant Thoracic Surgeon 2	2	30, 31		Do not agree and will not support …surgeons providing a thoracic surgery "presence" at UHW 5 days a week for advice and support (but will back 5 days a week on call telephone support for advice). Comment: This is totally unfair on hospitals in other Health Boards. May be ok for a physician but for a surgeon is a complete waste of time. Time that will be better spent in theatre ensuring timely surgery for cancer and other patients.	This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. Also see response above.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
42.	Consultant Thoracic Surgeon 2	2	36 to 39		Strongly agree and fully support that trauma surgeons appointed at MTC Cardiff are trained and able to practice independently for injuries to the thorax. A positive step in making the MTC Cardiff an independent, self-reliant flag ship specialty and not dependant on help from elsewhere (for example, Swansea or Bristol). An "on site on call thoracic surgeon" may not necessarily be available immediately but a thoracic trained trauma surgeon will be immediately available. Appointing an interested thoracic surgeon who is also trained in trauma (Thoraco-Trauma Surgeon) as a member of the trauma team will help him/her support and train the team and colleagues. This may give an opportunity for any current thoracic surgeon not wishing to move to Swansea a chance to stay back at UHW Cardiff and be part of the Major Trauma Team.	Thank you

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43.	Consultant Thoracic Surgeon 2	3	11, 12		(Instead of "the full range") Should read as, "Surgeons on the rota should be able to deal with "**a"** range of thoracic surgical emergencies, **excluding** oesophageal injuries, which will be dealt by upper GI surgeons, great vessel injuries, which will be dealt by cardiac surgeons, Tracheal neck injuries, which will be dealt by ENT surgeons and paediatric injuries, which will be dealt by the MTC at Bristol. Help from allied specialties, for example, ENT and cardiac surgery for thoracic tracheal and hilar injuries will be required as patients may have to be placed on cardio-pulmonary bypass to deal with these extremely rare situations. Paediatric cardiothoracic trauma will be dealt by MTC Bristol. COMMENT: It is highly important for the UHW Cardiff Health Board, which is demanding an on site Thoracic surgery cover, to seriously consider the fact that Thoracic surgeons currently working in South Wales do not meet this requirement of "…able to deal with a full range of thoracic surgical emergencies." They either have no experience or very little experience in dealing with such injuries in the past 10- 15 years. It is unsafe and unreasonable of the UHW Health Board Management to expect from thoracic surgeons in this disposition	Point noted. The expert advice suggested that there were a range of professionals who could and should support thoracic surgical emergencies dependent upon their nature. This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
					to attend to and deal with major thoracic injuries in a completely alien theatre or emergency room environment and work with an unfamiliar trauma team staff safely. It is much better and a unique opportunity for the UHW HB Management team to embrace the proposition of training the MTC Trauma Surgeons to deal with such emergencies (ref page 2 line 37 and 38), and help develop an independent, self-reliant, highly skilled Trauma Team making the MTC at UHW a flag ship MTC for the UK. There will be a 24/7 thoracic on call telephone back-up support for advice from the Single Thoracic Centre at Swansea.	
44.	Consultant Thoracic Surgeon 2	3	13, 14		Training the Trauma surgeons or appointing "Thoraco-Trauma" surgeons by the MTC Cardiff as described above will help address this.	We agree

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
45.	Consultant Thoracic Surgeon 2	5	6,7	MDTs	Some MDTs will have to merge. Support of the chest physicians and the cancer network will be essential to achieve this, so that there are 6 major MDTs across South Wales. The table is a guidance and combinations can change to make the cover practical. However, it will be important to ensure that for each surgeon there is equity of number of new cases discussed at each MDT.	We agree and this point has been supported by the representative from the Cancer Network who suggested that the number of MDTs should be no more than 6 but could potentially be fewer.
46.	Consultant Thoracic Surgeon 2	6	25	Prehabilitation	COMMENT: To add that the prehab service will work with thoracic nurses, allied health practitioners, dieticians, Macmillan nurses, pain team etc to help the single centre provide a complete package of holistic care to patients along the entire patient pathway.	Point noted.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
47.	Consultant Thoracic Surgeon 2	7	3, 4,5	Operating Lists	Taking into consideration that the single centre will be a teaching centre and following LHCH model, the most efficient way to run theatres will be "a minimum of" one full day and one half day per surgeon with 3 cases per full day list (two long and one short) running from 8:00am to 6:30 pm (including post op care). An ideal model would be two theatre days per surgeon per week. EVIDENCE: Taking into consideration future impact of lung cancer screening and expected increase in number of lung resections, the centre will be expected to perform ~1300 cases per year. Dividing this by three cases equals 433.3 cases. Over 50 weeks per year this works out to 8.6 lists per week. Taking into account cancellations due to theatre staff sickness, bank holidays, audit days, Hospital Infections, etc., = 10 lists per week or 2 theatres running 5 days a week for elective and emergency work is what it will take to provide timely high standard of surgical care to patients and training to future surgeons and staff.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation. There are clearly a range of views (see comments above) and the exact configuration will need to be agreed as part of implementation taking into consideration optimal efficiency and staff well-being.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
48.	Consultant Thoracic Surgeon 2	7	15-40	MTC	Brilliant piece of work – shows the reality of the situation! Shows that having a surgeon on site 5 days a week at UHW provides miniscule patient care if any, and is a complete waste of money and time.	Point noted.
49.	Consultant Thoracic Surgeon 2	8	13	Required Consultant Workload- Theatre sessions	Theatre sessions per week 6.5 is not adequate. Minimum 8.6 x4 sessions per week EVIDENCE: As demonstrated above under "Operating Lists"	See response above.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
50.	Consultant Thoracic Surgeon 2	9	5-12	Job Plan	…7.5:3 split then "6.2 consultants would be required." EVIDENCE/COMMENT: theatre sessions per surgeon required = 4 and NOT 3.0 as described under "Operating Lists." Also job plan in SBUHB Wales is 7:3 with 3 SPAs for each consultant. Unlike NHS England where each session is 4 hours long, each session in NHS Wales is 3 and a half. So cannot compare work covered by NHS England consultants with NHS Wales's consultants. The RCS and NHS England thoracic surgeons should be always made aware of this when obtaining any consultation regarding job plans, theatre lists etc from them.	Points noted however the advice we have received is that 6 surgeons is sufficient to cover the anticipated thoracic surgical workload. Comparison with other centres also support 6 surgeons as being sufficient.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
51.	Consultant Thoracic Surgeon 2	9	8	MDT	Disagree with MDT 0.5 EVIDENCE: DCC does not take into account other specialist MDTs that will need cover. For example, Sarcoma MDT; Interstitial Lung Disease MDT; Mesothelioma MDT; Colo-rectal MDTs per Health Board; Emphysema-LVR MDT; Radiology MDT; Base hospital Specialist MDT.	Point noted. This was based on the advice we received from other centres. This can be reviewed.
52.	Consultant Thoracic Surgeon 2	9	14		COMMENT: Based on the above split then a minimum of 7.3 consultants would be required. Eliminating UHW MTC cover every week (which is a complete waste of good money, time and does not make any sense whatsoever) will bring the number of consultants required to ~6 consultants.	Point noted.

53.	Consultant Thoracic Surgeon 2	10	19, 22	Recommendations	Disagree with, " ..workload is around 5.5 to 6.2." Should read, " minimum 6.5 to 7.5." EVIDENCE: As described above. COMMENTS- RECOMMENDATIONS: Each consultant covers two Lung cancer MDTs (visiting the main peripheral MDT and cross covering the second with V/C link); two clinics (visiting one peripheral clinic of the main MDT and servicing the second base hospital clinic for other MDTs and emergency work arising from on-call); minimum one full day and one half day theatre (ideally two lists per week); each surgeon covers one or two specialist MDTs; and 1:5 on call. Note: In the process of visiting the peripheral MDT and its clinic the visiting thoracic surgeon will face requests for advice and opinion from chest physicians and others and many times see inpatients, A&E trauma and other patients. This will take up DCC time. This has not been considered. EVIDENCE: First-hand experience when working for Birmingham Heartlands Hospital, Southampton and the Royal Brompton Hospital. Visiting peripheral MDTs many times involved seeing patients in the ward, ED for opinion and management.	Point noted and see response above. Benchmarks from other centres and the advice we have received suggests that 6 surgeons is sufficient. This can be tested and re-assessed however prior to implementation.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
54.	Consultant Thoracic Surgeon 2	9	19	OPD	**All surgeons will NOT provide UHW onsite cover**. This should be provided by the surgeon covering the UHW Lung MDT and its clinic once a week as is done by Mr M Shackcloth once a week at Liverpool Heart and Chest Hospital for the MTC there. It is mandatory that patients from all of South Wales Health Boards covered by the Single Site Thoracic Service at SBUH receive a fair and equitable service. UHW Cardiff should not get any preferential, special treatment – No post code lottery care!	Please see response above.
55.	Consultant Thoracic Surgeon 2	9	40,41	MTC work	Totally agree. This can and should be dealt by Trauma and Orthopaedics as is done at LHCH.	Thank you
56.	Consultant Thoracic Surgeon 2	FINAL COMMENT			Thank you for your hard work.	Thank you
57.	Health Board CEO 1	1	8	Context	Each of the Welsh Health Boards considered the WHSSC recommendation and agreed this subject to a number of conditions being met.	Point noted.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
58.	Health Board CEO 1	1	14		It would be useful to make clear that the two medical directors provided the paper as requested by WHSS (letter dated 28th December 2018 from Sian Lewis to Dr Shortland and Dr Evans).	Point noted and is reflected in the conclusions in the Joint Committee paper.
59.	Health Board CEO 1	1	19		The matters and uncertainties referred to should be included.	They are included in the Joint Committee paper
60.	Health Board CEO 1	1	24 25		The establishment of an Expert Panel does seem at variance with the timing of the Consultation document.	We were constrained by the very tight timescales
61.	Health Board CEO 1	1	37-38		There should be a note that neither of these documents include support required for an MTC	Both the English and Welsh Service Specifications went to widespread stakeholder consultation. This was not raised in our consultation as an issue. It is only since the recommendation to locate at Morriston this has been raised.
62.	Health Board CEO 1	1	41		It would be helpful if the assumptions are made clear within the document	Apologies if this is not clear.
63.	Health Board CEO 1	2	16	Backgro und	It is important that the opinions of the RCS Invited Review are considered in the context that they were made prior to the decision to locate the MTC in a different Health Board to the site of the Thoracic Centralisation.	The RCS were aware of the work around the location of the MTC as were the Independent Panel

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64.	Health Board CEO 1	2	39	Background	We have been unable to find any reference within the Intercollegiate Surgical Curriculum Programme that describes surgeons being trained to "practice independently for injuries to the thorax". The curriculum describes training to include a subset of thoracic surgical skills, this does not equate to a mandate for independent practice.	https://www.iscp.ac.uk/static/public/Trauma_Surgery_TIG_Syllabus_2018.pdf
65.	Health Board CEO 1	7	9	Operating lists	The calculation of 6.25 lists per week seems overly optimistic. C&V currently run 4 lists per week delivering 672 cases per annum. On a simplistic basis, the forecast activity of 1300 cases would suggest that circa 8 operating lists would be required per week.	See response above. The calculations were done on a long day and 4 cases per 3 sessions ie 11.15 hours. The operating hours at the two centres are different currently and the sessions are currently being calculated differently at both sites.
66.	Health Board CEO 1	3	7, 13-14 7		This guidance regarding emergency cover needs to be referenced from the source Cardiothoracic Surgery GIRFT Programme National Specialty Report 2018. Please can it be clarified that the specification does not deal with thoracic cover to an MTC	Point noted however please see response above regarding the status of the GIRFT report.

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67.	Health Board CEO 1	7		Major Trauma Centre	There is no reference in this section to the NHSE standards for Major Trauma that have been agreed as the standards for commissioning in the Wales Trauma Network. The standards clearly document the need for a Cardiothoracic surgeon to be available within 30mins to attend a trauma patient and this is not reflected anywhere in the paper.	Point noted however the paper refers to cardiothoracic surgeons and the issue here relates to thoracic surgeons which needs to be emphasised. Please also see appendix G which gives detail on the advice we have received regarding thoracic surgeons need to attend the MTC in an emergency.
68.	Health Board CEO 1	7	19	Major Trauma Centre	Figures supplied by the existing thoracic Surgeons in C&V suggest this is an underestimate and the more likely volume is 5-11 p.a.	The development of an interim model will allow this to be fully assessed

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
69.	Health Board CEO 1	7	22	Major Trauma Centre	It would have been helpful if the centres providing these two varying opinions were clarified. Indeed it is most common in Cardiff and Vale that currently Thoracic trauma is most often managed by our Cardiac surgeons. This is not a sustainable position going forward as new and recent Cardiac Surgeons being appointed are not skilled in thoracic trauma. The GIRFT report specifically recommends ending the practice of using dedicated cardiac surgeons to provide emergency thoracic cover. Furthermore the SAC and SCTS UK Cardiothoracic Surgery Workforce Report 2019 describes increasing practice of splitting the specialty into cardiac and thoracic surgery	Please see appendix G which gives further advice from the SCTS and the National Clinical Director for Trauma for England.
70.	Health Board CEO 1	8	3	Major Trauma Centre	See comment 3 above The coverage of the MTC by a single rota from the surgical centre, when established, does not provide thoracic surgical cover consistent with the standards of a MTC and best practice.	Please see response above and the further advice in appendix G

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71.	Health Board CEO 1	9	39	Covering the MTC from April 2020	The MTC has described the development of a tier of resuscitative surgeons within the existing workforce to cover the general surgical element of major trauma operating. We have not proposed that these surgeons are on an on-call rota to cover thoracic surgery as this would directly contradict the recommendations of the Cardiothoracic Surgery GIRFT Programme National Specialty Report 2018? The trauma team already have the skill to perform resuscitative thoracotomy (open the chest and perform a limited range of interventions). It is the arrangements beyond this that are of concern. It is not in the remit of the trauma team to go beyond these initial limited interventions and provide definitive thoracic surgery.	Please see response above.

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72.	Health Board CEO 1	11	All	The Liverpool model	Based on the data presented at the Summit in May we have concerns about generalising the Liverpool experience to the WTN. The activity levels 2011-16 in UHW were significantly higher than Liverpool and it is only 7 miles away from its MTC. The description of trauma support to the MTC lacks meaningful detail.	Please see response above
73.	Health Board CEO 2	2	16-17	Background	The statement that "the location of the MTC had not been determined" should have been followed by a clarification that this materially affects the consultant workforce plans, particularly in regard to providing cover for 2 separate sites.	The advice we have been given is that the location of the MTC should not affect the consultant numbers.
74.	Health Board CEO 2	7	1-9	Operating lists	Current operating lists on each site average approximately 3 cases per list, which would equate to the need for 8-9 lists per week when job plans are annualised. The calculations of workload for surgery do not factor-in pre-operative and post-operative care.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation.

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75.	Health Board CEO 2	7	16-40	Major Trauma Centre	The calculation of work associated with the requirement to cover out-of-hours 7 days/week 365 days/year fails to adequately recognise the burden of work at evenings and weekends: Firstly, the establishment of a single thoracic surgical centre on one site will substantially increase the probability of post-operative complications from elective cases which would require consultant input during evenings and weekends. Secondly, the stated infrequency of phone calls or call-outs in the out-of-hours period is immaterial in relation to the essential requirement – which is to be available immediately when requested. For the person who is on-call on any given day, the expectation is that they will be able to attend either unit in the event of an emergency and must therefore make adequate provision in their home/family lives in order to travel at any hour to the relevant site. This is a significant burden and not recognised adequately in the proposal.	The advice we have received is that the burden of out of hours work is low. We have also been advised that operating 2 rotas is neither desirable or required and would be difficult to recruit to.

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76.	Health Board CEO 2	General			It is disappointing that the paper underestimates the volume of work and the challenge of providing consultant cover for the establishment of two high-profile and geographically separate services. We do not consider that 6 consultants would be able to provide this sustainably. The paper prepared by the Medical Directors, which might usefully have been included as an appendix in order to compare and contrast the different approaches, recommended a total of 8 consultants and made adequate provision for out-of-hours cover. We believe that a total of 8 consultants remains the most pragmatic solution to establish the service safely. The paper noted the requirement for 8 surgeons to adequately cover the MTC: "that the sessions are distributed as part of a wider group job plan amongst the new posts and all existing post-holder, to ensure equal distribution of workload supporting the MTC as well as tertiary activity. It is anticipated this would be accommodated with a 1 in 8 "hot" on-call covering the Thoracic Centre in Morriston Hospital and a separate quieter 1 in 8 on-call covering the Cardiff and Vale MTC	We came to our conclusion regarding the optimal number of consultants based not only on mathematical modelling of the clinical activity but benchmarking with a range of providers across the UK. In addition we subsequently tested this model with the President of the SCTS and an expert panel of thoracic surgeons who are members of the SCTS who also support the conclusion.

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					at the University Hospital of Wales. This would mean an on call overall of 1 in 4 and means there would not be a situation where either centre is not physically covered by a Consultant Thoracic Surgeon" The proposal is based on a tight mathematical calculation of sessions but leaves very little room for the eventuality that the workload is higher than anticipated and/or sessions cannot be practically worked as described. The proposal lacks a pragmatic perspective of the wider picture: that this is a shortage specialty; that it is more difficult to recruit to Wales; and that the current workforce is fragile. The existing Thoracic surgeons are currently highly engaged in the process and are actively contributing to the Thoracic workshops – this could easily be lost and would be difficult to retrieve.	
77.	Consultant Cardiothoracic Surgeon	General			Largely very supportive of the proposals but with the following comments:	Thank you

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
78.	Consultant Cardiothoracic Surgeon				The main issue is the basic activity plan on which the modelling is based i.e. 4 case per theatre list is unrealistic. The most efficient of list in either of the HB delivers just over 3 case prelist on an extended days working 8-630 theatre and quite often we struggle to get to 2.5 case per list – developing these calculation leads to consultant workforce between 6.5-7.5 surgeons.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation.
79.	Consultant Cardiothoracic Surgeon				The annual activity on the SCTS report would suggest annualised case throughput per surgeon of somewhere between 150+/-50 cases depending on the case mix developing this calculation would suggest that 8 surgeons would be needed especially if the MTS is to be supported between 9-5	This does not benchmark with any other UK centre and is not consistent with the advice we have been given. Please see responses above.
80.	Consultant Cardiothoracic Surgeon				Are we modelling on 42, 50 week per year of activity?	52 weeks per year with prospective cover which benchmarks with other UK centres.
81.	Consultant Cardiothoracic Surgeon				The need to upskill trauma surgeons at the MTC needs to be supported by the Consultant Thoracic Workforce	We agree and have therefore suggested an interim arrangement with an additional thoracic surgeon located at the MTC from April 2020.

Appendix E

CONFIDENTIAL Comments forms with attachments such as research articles, letters or leaflets were not accepted

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
82.	Consultant Cardiothoracic Surgeon				Equity of access to surgical treatment for chest wall injury across the trauma network in south wales can best be delivered by chest trauma MDT bases approach where all significant chest wall injury cases are reviewed.	We suggest this should be looked at via implementation.
83.	Medical Director 3	1	39	Background	Also need to take into account the potential introduction of a targeted lung cancer screening programme in Wales - increase in number of patients with early stage disease treated by surgery	We have discussed this with the representative from the Cancer Network. Lung cancer screening is unlikely to be introduced for another 3 years and as we do with all other commissioned services, we will review any activity changes regularly.
84.	Medical Director 3	2	22	Background	Only 2 OP clinics per week proposed on this site, so not sure what the consultants are going to do with the rest of their time?	This point has been noted.
85.	Medical Director 3	4	6	Demand Analysis	Cure can also be obtained from treatment with radical radiotherapy	Point noted.
86.	Medical Director 3	5	6 (Table)	MDTs	411 patients within ABUHB in 2015	Point noted. We will amend the figures.
87.	Medical Director 3	6	1 (Table)	MDTs	Requires recalculation to 722 - significantly more than any other pair of surgeons, which may place ABUHB at a disadvantage	Point noted. Information was based on that presented at the March clinical summit. The distribution between the surgeons will need to be amended as part of the implementation process.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
88.	Medical Director 3	6	23	MDTs	Anticipate no change to weekly surgical clinic at RGH	Point noted.
89.	Medical Director 3	8	13	Required Consultant Workload Total number of Sessions /week	Why daily at Morriston if patients are to be seen closer to home - could there not be a pre-assessment service in Cardiff?	Accept this point and this would be the aspiration but we are advised will depend upon the availability of anaesthetists.
90.	Medical Director 3	10	5	Covering the MTC from April 2020	Clarification is required as to whether this is a 4th surgeon at UHW	Yes that is the recommendation to support the concerns being expressed regarding the MTC.
91.	Medical Director 3	10	27	Recommendation	Does this take into account speed of access? The National Optimal Lung Cancer Pathway requires surgery with 21 days of decision to treat.	In discussion with the representative from the Cancer Network this suggested number of surgeons and anticipated activity does take this into account.

Appendix E

CONFIDENTIAL Comments forms with attachments such as research articles, letters or leaflets were not accepted

Thoracic Surgery Consultant Work-force Model Expert Advice.

Teleconference 18.06.19

Attending:

Chris Moran, NHS England National Clinical Director

Rajesh Shah, Clinical Lead for Thoracic Surgery Manchester NHS Foundation Trust, Chair of the Specialty Advisory Committee on Training and co-opted member of the Society of Cardiothoracic Surgeons (SCTS) Executive Committee.

Juliet King, Thoracic Surgeon, Guys & St Thomas NHS Foundation Trust, member of the SCTS Thoracic Committee

Steve Woolley, Thoracic Surgeon, Liverpool Heart & Chest Hospital, Co-chair of Thoracic Committee, SCTS and co-opted member of SCTS Executive Committee

Sian Lewis, Managing Director, WHSSC

Karen Preece, Director of Planning, WHSSC

Background:

Members of the panel were each provided with the consultation document in advance of the meeting and further background information was provided by Karen Preece at the start.

Below is a summary of the discussion organised into themes rather than a chronological summary of the discussion.

1. **Clarity on the interface of thoracic surgeons in the immediate management of trauma patients:**

There was unanimous agreement amongst the thoracic surgeons present that the Getting it Right First Time (GIRFT) review 2018 recommendation that thoracic trauma should only be covered by thoracic surgeons and not by cardiac surgeons reflected an opinion and did not have an underlying evidence base. They expressed the view that the professional perspective of the SCTS which is that surgeons on the Trauma Team should have training and the competence to perform resuscitative thoracotomy in ED or the operating theatre and that both cardiac and thoracic surgeons are competent to stop bleeding within the thorax, was more relevant.

There are just over one hundred thoracic surgeons in the UK. There are 22 Major Trauma Centres for adults in England, 1 in Northern Ireland and proposals for 3 in Scotland and 1 in Wales. It is highly unlikely that 100 surgeons will be able to provide comprehensive thoracic trauma care for 27 MTCs in the UK, either in the short or medium term. Thus, suggested by GIRFT cannot be delivered. The position of the SCTS is therefore that a pragmatic approach should be taken to providing cover by trained cardiac and thoracic surgeons.

The **Chair of the SAC** noted that the current training programme means that both cardiac and thoracic trainees have the competency to manage emergency thoracic trauma and all existing consultants should have this competency. If they do not then they should be offered the opportunity of further training.

He suggested there were 2 models of care for emergency thoracic surgery, first resuscitative trauma surgeons, secondly, on-site cardiac or thoracic surgeons if present. He emphasised again both cardiac and thoracic surgeons should be competent and stated that dual cover was not a good use of resources. His view was that thoracic trauma requiring immediate surgical intervention was rare and that this was best managed by resuscitative trauma surgeons with input from onsite cardiac or thoracic surgeons for the very rare event when additional support is needed. He noted there is a wide variation across the UK in models of cover and highlighted that Brighton was a MTC with no thoracic surgeons and only cardiac surgeons. He emphasised there was no single right answer and suggested we request sight of the draft guidance from the SCTS on the management of thoracic trauma. (***Paper requested; not yet available)***

The **National Clinical Director (NCD) for Trauma in England** explained that the commissioning standard in England was that MTCs have the capability within the Trauma Team to undertake resuscitative thoracotomy and that cardiac and thoracic surgeons were not part of the Trauma Team (available within 5 minutes) but should be available within 30 minutes to attend an emergency case. There are a number of working models in England with some MTCs having both cardiac and thoracic surgery on site and others having cover from a separate hospital site. The requirement for resuscitative thoracotomy is rare in MTCs that mainly deal with blunt trauma (as is the case in south Wales) and he estimates four times per year for the south Wales population.

The Co-chair of the SCTS Thoracic Committee noted that the one of the centres in the UK with the most experience of penetrating trauma injuries was Kings College Hospital in London and that in this centre support was provided by cardiac surgeons. This model works well there as they have no on site thoracic cover.

The member of the SCTS thoracic committee noted that the way in which cardiothoracic trauma is covered in the UK is variable, and likely to change further as cardiac and thoracic services become independent of each other. However in setting up the new South Wales service it would be important to have clear local guidance and rostering as to who is contacted in the event of major thoracic trauma where specialist intervention may be required. She believed that this would not necessitate a thoracic surgeon being on site at the MTC.

2. **Clarity on the interface of trauma surgeons in managing trauma patients with other specialties:**

Rib fracture fixation is rarely required as an emergency procedure within a few hours of injury but MTCs need the capability to provide this operation within 48

hours of the decision to operate. It must be performed by surgeons competent in this technique. Ideally, the service is provided jointly by thoracic and orthopaedic surgeons but this service may be provided by thoracic surgeons alone or by orthopaedic surgeons as long as thoracic surgical advice and back-up is available. All three models are in service in the UK with successful outcomes. Given the service requirement and geographical separation, the provision of rib fracture surgery by trained orthopaedic surgeons with back-up from the thoracic surgeons may be the best service model for South Wales.

The member of the SCTS thoracic committee suggested that providing an on-site thoracic surgeon at the opening of the MTC offered a fantastic opportunity for training and development of trauma and orthopaedic teams. She emphasised the importance of support for poly-trauma patients and that regular trauma ward rounds from thoracic surgeons would be important when services were centralised at Swansea. She felt this could be undertaken to coincide with clinics being held at UHW. It would be very important to ensure that onsite out of hours cover is provided at Swansea and that robust rostering should be made explicit in job plans.

The **NCD Trauma in for England** said that it is a pre-requisite in England that trauma teams have the capability for resuscitative thoracotomy and thoracic surgeons have a role to support this training.

3. **Expert advice on the level of activity required to maintain a consultant surgeons skills:**

The SAC Chair stated that thoracic surgeons need at least one full day operating time and that the evidence is that the greater number of operations the surgeons undertake, the better the outcomes. He felt that 8 surgeons would mean that the operating time for individual surgeons would be too low. In addition it would not represent a good use of resources. He suggested it might be a problem to recruit into such a post.

The member of the SCTS thoracic committee explained that a thoracic surgeon needs to undertake at least 50 primary lung resections per year and in her view 8 surgeons would mean this target may be difficult to meet. This view was supported by the Co-Chair of the SCTS Thoracic Committee. Although planning predicts a 20% increase in activity it is not clear at this stage whether this will mean a significant increase in the primary lung resections.

4. **Development of indicative job plans for consultant thoracic surgeons**

The member of the SCTS thoracic committee noted that 6 surgeons represented a "good number" and would allow sufficient time for Supporting Professional Activity sessions (SPAs).

The **Chair of the SAC** confirmed that in his centre there were 6 thoracic surgeons for a population of around 3.2 million.

There was agreement by **all thoracic surgeons** present that on current activity 6 surgeons represented the right number however there should be a further assessment if activity changes for example due to lung cancer screening.

There was discussion around the likely volume of out of hours work at the future single centre. The consensus was that this depended on adequate theatre capacity and if this was in place then semi-elective surgery would take place within working hours and there would be relatively little out of hours work. The **Chair of the SAC** advised that operating two rotas was unnecessary and not a good use of time, emphasising that well trained trauma surgeons or cardiac surgeons were competent in stopping bleeding.

Summary:

Chris Moran NCD for Trauma NHS England noted the discussion had been very helpful for him as MT Lead and summarised as follows:

1. The professional advice is that 6 thoracic surgeons is the right number
2. Trauma Teams must have the capability to perform resus thoracotomy
3. Cardiac surgeons at the MTC need to provide emergency assistance to stem massive thoracic haemorrhage
4. A rib fracture fixation service in Cardiff needs to be based in orthopaedics with back-up from thoracic surgery
5. The thoracic surgeons need to take ownership of complex thoracic trauma and this will require good communication and regular ward rounds in the MTC (probably best coincided with the days that thoracic outreach clinics are scheduled at the MTC).

(18.06.19)

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 3.4** **Date of Meeting**

Executive Board Report
CWM TAF MORGANNWG UHB – 'LET'S TALK CULTURE' *#OurCTM*

Executive Lead: Director of Workforce and Organisational Development
Author: Michelle Hurley-Tyers, Workforce and OD Project Manager
Contact Details for further information: michelle.hurley-tyers@wales.nhs.uk

Purpose of the University Health Board Report
The aim of this report is to provide information to the Board on the creation of the Cwm Taf Morgannwg values and behaviours, as part of the shaping of our new organisation's culture.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined in the 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.
Supporting evidence	• NHS Wales 2018 Staff Survey results for Cwm Taf • Review of Cwm Taf University Health Board maternity services 2018

Engagement – Who has been involved in this work?
Collaboration with stakeholders has included: Cwm Taf Morgannwg Executive Team, Workforce & OD, Staff Side, Procurement and Communications.

Health Board Resolution To:-							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	
Recommendation	The Board is asked to: • **DISCUSS** and **NOTE** contents of this report						
Summarise the Impact of the Health Board Report							
Equality and diversity	There are no equality and diversity implications contained within this report.						
Legal implications	None						
Population Health	None						
Quality, Safety & Patient Experience	The proposed approach has the potential to improve the quality and safety of our services, and to improve patient experience.						
Resources	Resource implications include financial resources for an approved supplier, which are outlined within the report; along with people resources throughout the organisation.						
Risks and Assurance	Related risks and implications are referenced, as appropriate, within the report.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary and related annexes take into account primarily focus on: Staff and resources						
Workforce	It is anticipated that the programme of work described will have a positive impact upon the organisation's workforce.						
Freedom of information status	Open						

CWM TAF MORGANNWG UHB – 'LET'S TALK CULTURE' *#OurCTM*

1. SITUATION

The aim of this report is to provide information to the Board on the creation of the Cwm Taf Morgannwg values and behaviours, as part of the shaping of our new organisation's culture.

This is an opportunity to bring together the best of the former Cwm Taf and Bridgend, as part of the former ABMu, to create a compelling, shared cultural narrative and engaging values, to shape attitudes, behaviours and decision-making in the new Cwm Taf Morgannwg.

2. BACKGROUND

A number of cultural imperatives have arisen over recent months, as a result of various mechanisms such as the reports into Maternity Services and our Staff Survey results. These have shone a light on a number of areas for improvement. While the Royal College of Obstetricians and Gynecologists (RCOG) report was specific to Maternity Services, it also identified failings in culture and leadership which are likely to impact the organisation more widely. The Staff Survey highlighted issues around bullying and harassment, stress, senior leadership and a lack of belief from our people that anything would change. In addition, the Health Board received a research-based presentation from Professor Naomi Chambers earlier in the year, which highlighted the need for NHS Boards to ensure there is an organisational focus on improving patient experience and staff engagement i.e. defining and driving a culture in which staff can thrive.

3. ASSESSMENT

A procurement process to deliver our values and behaviours work commenced in August 2019, with development of a project specification with clear deliverables, which was circulated to all providers on the National 'Behavioural Insights (RM6004)' Framework. This process closed on Monday 2nd September 2019, with no proposals being submitted from the providers on the framework.

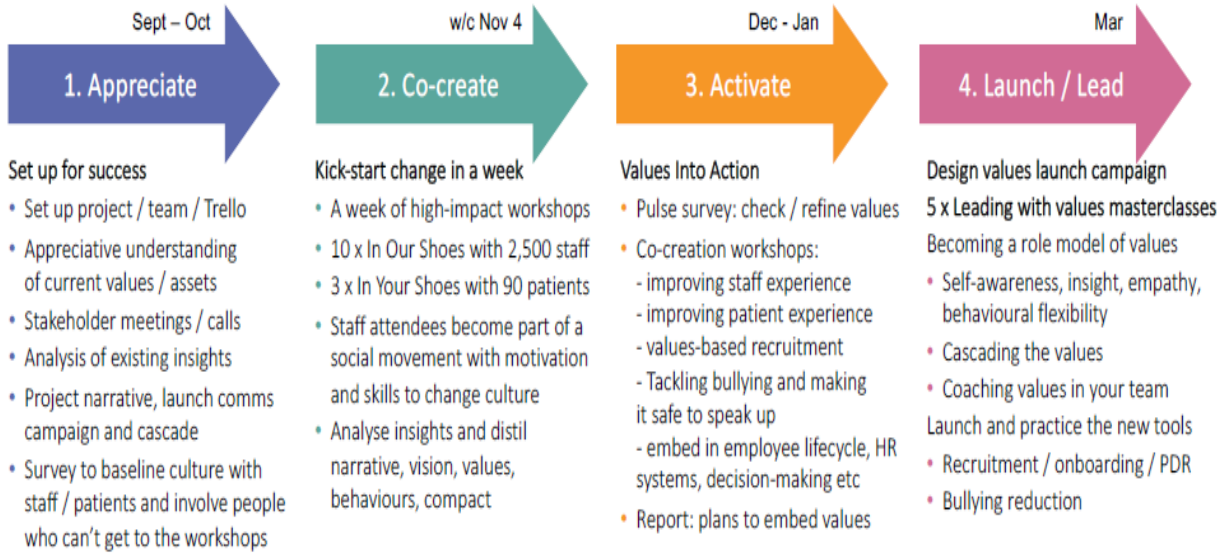
As no submissions were received, the Health Board approached April Strategy to determine whether they could meet the requirement of the project specification. April Strategy (April) previously worked with neighbouring NHS Wales Health Boards, crucially including the former ABMu following the Andrews Review, to develop similar work. April submitted a proposal which was evaluated against the specification, and subsequently April were invited to provide some additional detail. Following this process April were awarded the contract to work alongside the Health Board to produce our values and behaviours framework.

During the procurement process, members of the Organisational Development team alongside the Communications team, have been working on branding and communication for this work.

As you may have seen, we launched on Friday 13th September 2019 with an e-mail from Dr Sharon Hopkins, Interim Chief Executive, inviting staff to use the opportunity to shape our new organisation.

> "'Let's Talk Culture' is your opportunity to be part of shaping what we want *#OurCTM* to be as an organisation.
>
> From Monday 4th to Friday 8th November, we'll be hosting a series of 'In Your Shoes' and 'In Our Shoes' workshops at various locations near you. Some workshops will involve just us, talking about our experiences. Others will also involve our patients, focusing on their experiences."

Below is a brief summary of the high level deliverables to be expected during September 2019 to March 2020. A detailed project plan is currently being finalised which will be owned in partnership with April and an internal project team. To complement this work, a comprehensive communications and engagement plan is being finalised to encourage maximum involvement of our staff and patients.



3.1 April Strategy

April bring significant experience and expertise in healthcare culture transformation, into a tailored programme specific to the needs of the Health Board. Building on what is already working, they aim to engage thousands of staff and patients in a conversation – through online surveys and a series of big, impactful workshops – to co-create our new values, i.e. what's important to us as a new organisation.

The approach is designed to build a social movement for values-led ways of working. People involved will leave the process clear about how we all want to work together, skilled to encourage the right behaviours through appreciation and to speak up about poor behaviours, and motivated to do so – with an understanding of how the new values will contribute not only to a better workplace and safer care, but also to a healthier community.

The outcomes will be a cultural narrative, unique values and underpinning behaviours which will have strong ownership across the organisation, reflecting the views of thousands of staff and patients. In 'design thinking' workshops they will then co-create systems to embed values into how the Health Board recruits, on-boards, appraises, develops and progresses staff, and into how staff and leaders behave and the decisions they make each day. Finally they will launch the new values and behaviours to staff, and train leaders to cascade and role model them.

4. RECOMMENDATION

The Board Members are asked to:

- **DISCUSS** and **NOTE** the content of this report which outlines the planned approach for the creation of the new Cwm Taf Morgannwg values and behaviours, as part of the cultural narrative for the new organisation.

Freedom of information status	Open

Special Measures/Targeted Intervention

CTM Management Board 18th September 2019

Targeted Intervention

- Leadership & Culture
- Quality & Governance
- Rebuilding trust & confidence – engagement with patients, staff and stakeholders

Special Measures

- Maternity

Development Plan for CTMuHB

- Golden Threads
  - Open, Transparent, Engaging, Involving
  - Clinically led, managerially supported

- Programmes of work with clear outcomes to;
  - respond and learn
  - understand and build on strengths
  - support improvement
  - support de-escalation (maturity matrix)

- Enablers – Tools, capacity, capability (embedding/day job)

Development Plan for CTMuHB

Wide Ranging, reflecting on lessons learnt.

Key components include;

- **Culture** – Values & behaviours, value based recruitment, clarity of vision and purpose
- **Operating Model** – Subsequent structures, business flow, decision-making, performance management and accountabilities
- **Capability & Capacity** - Building capacity and capability for improvement, health intelligence and data quality, refresh & refocus Leadership Programme to strengthen management competencies

Programme Management

Targeted Intervention 'De-escalation' Programme

Programme Lead – Director of Corporate Governance

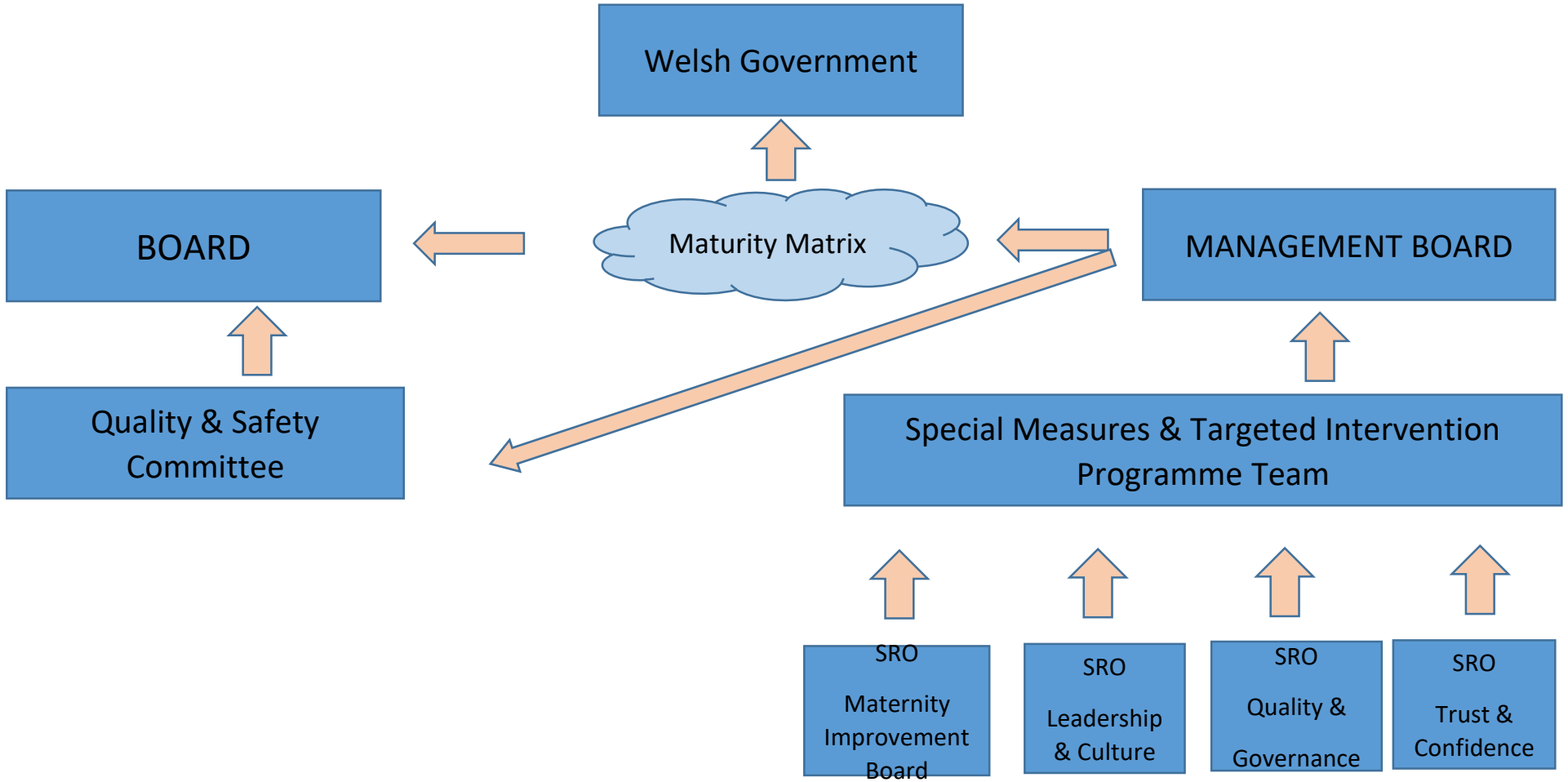
Programme Support – PMO (pending funding request)

Programme Workstreams;

- Leadership & Culture - SRO - Director of Workforce & OD
- Quality & Governance – SRO – Director of Therapies and Health Sciences
- Rebuilding Trust & Confidence – SRO – Head of Communications

Maternity Improvement Programme (see later slides)

Programme Reporting (proposed)



Leadership & Culture (early) Programme Plan

- Values and Behaviours
  - Procurement process concluded
  - Phase 1 – development of Values and Behaviours to conclude by March 2020
    - HB wide engagement on programme to commence w/c 9th Sept 2019
  - Phase 2 – embed & deliver the desired culture and operating model
- Executive Development
  - Life Tree (Joe Lafferty) leading on Executive Team Development Programme
  - First session delivered, subsequent sessions planned
- Leadership & Management Development
  - Refreshing & refocussing leadership development offerings alongside work on operating model, strategic direction & values and behaviours
- Employee Experience
  - Enhancing our Health & Wellbeing offer to staff – counselling, occupational psychology & more soft services such as mindfulness

Trust & Confidence (early) programme plan

- Focus on Engagement and Involvement
- Positive news programme established
- Organisational tone – openness, transparency
- Social media positive feedback messages
- Public Engagement Programme – Public 'drop-in' forums across the region
- Stakeholder Engagement Programme – regular, keeping in touch meetings, formal briefings and open events with AMs, Council Leaders, CHCs
- Board visibility – informal walkabouts of regional patch
- AM/MP/Council Leaders Engagement Events – 27th Sept and then ¼ly
- Let's Talk
  - CEO/Executive - Staff engagement events (August complete, October scheduled)
  - Community engagement events
- Staff survey being run in October (internally) including seeking views on freedom to speak up and bullying
- Freedom to 'Speak Up' Programme to ensure trusted routes for open reporting & learning

Quality & Governance (early) programme plan

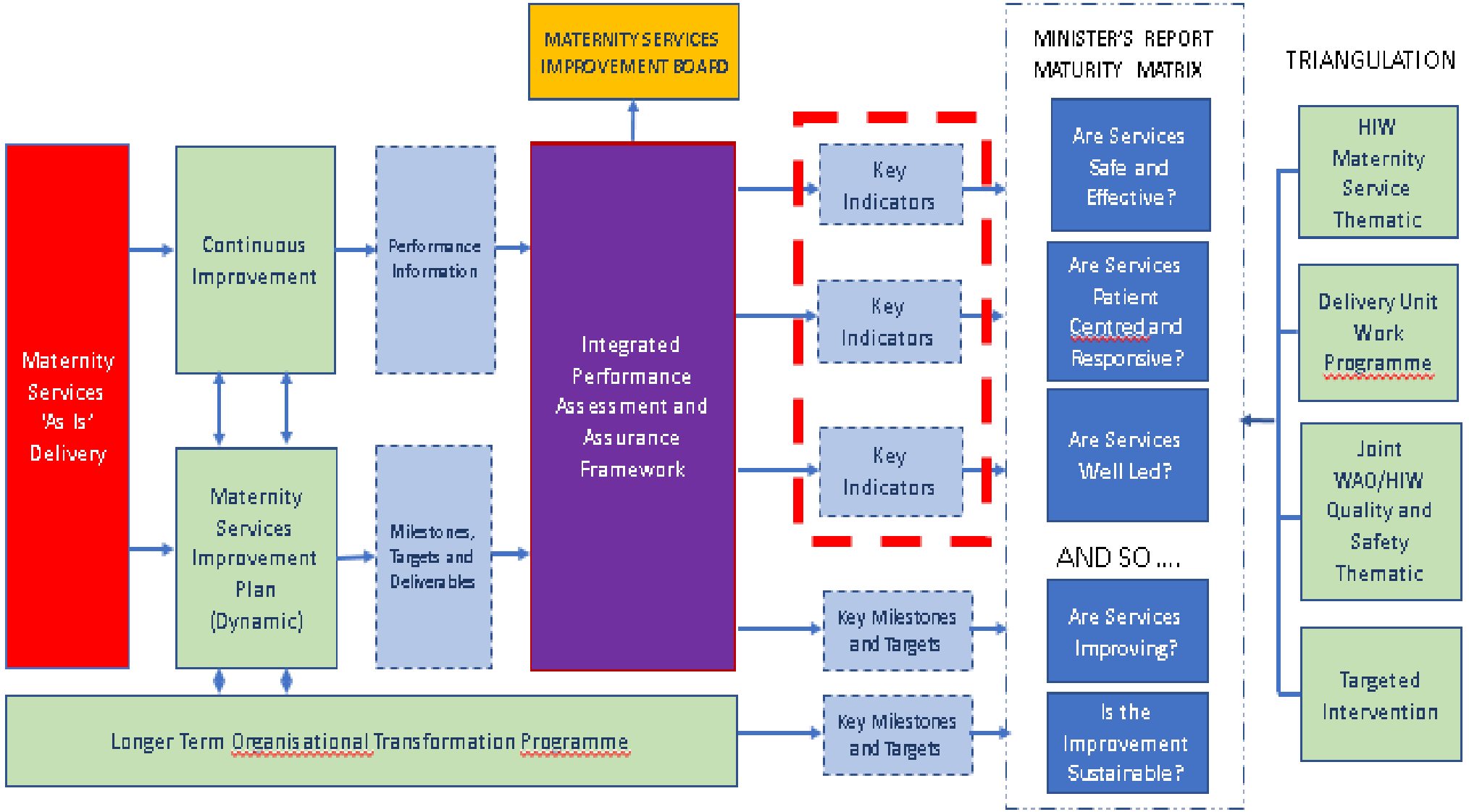
- Quality Governance
  - Quality Governance Framework
  - DU – concerns and serious incidents
  - Health Intelligence (data quality)

- Corporate Governance
  - Review and strengthen, drawing on all external reviews and advisors (David Jenkins, HIW, WAO, DU etc)
  - Refocus of Quality & Safety Committee
  - Executive and operational management systems and gaps to be addressed
  - Clarify roles and responsibilities for IMs, Execs, Board, Committees and Management in a refreshed assurance framework for CTM

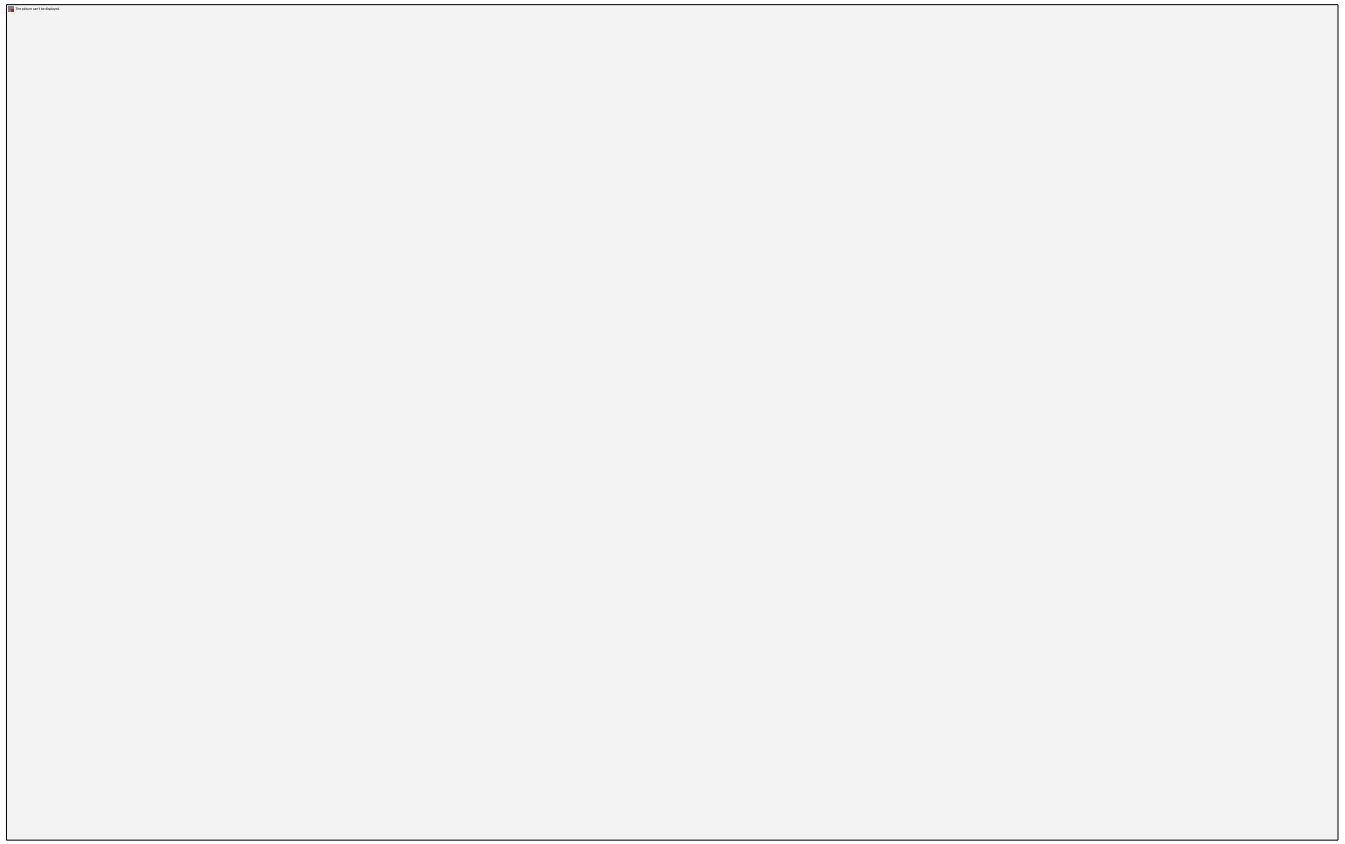
- Board Development
  - Specification & Procurement complete
  - Inception meeting held on 12th September 2019
  - Board Effectiveness Survey
  - Peer Survey
  - Appraisals and Objective setting meetings

Special Measures - Maternity Improvement Programme

- Revised Programme Structure
- Programme Director now in post (mid August) and team starting to take shape
- Stakeholder workshop 12th August 2019
- Development of Performance assessment & assurance framework
- Quality and Patient Safety Governance Framework
- Aligned to HIW domains and principles underpinning Maternity Vision
    - Safe and Effective Care
    - Quality of Women's and Families' Experience
    - Quality of Management and Leadership


MATERNITY SERVICES IMPROVEMENT BOARD
Maternity Services 'As Is' Delivery
Continuous Improvement
Performance Information
Integrated Performance Assessment and Assurance Framework
Maternity Services Improvement Plan (Dynamic)
Milestones, Targets and Deliverables
Longer Term Organisational Transformation Programme
Key Indicators
Key Indicators
Key Indicators
Key Milestones and Targets
Key Milestones and Targets
MINISTER'S REPORT MATURITY MATRIX
Are Services Safe and Effective?
Are Services Patient Centred and Responsive?
Are Services Well Led?
AND SO ....
Are Services Improving?
Is the Improvement Sustainable?
TRIANGULATION
HIW Maternity Service Thematic
Delivery Unit Work Programme
Joint WAO/HIW Quality and Safety Thematic
Targeted Intervention

Assurance Arrangements



Key focus of attention (11 priority actions)

1) Consultant cover
2) Middle grade medical training
3) Governance framework
4) Guidelines and protocols
5) Leadership and culture
6) Midwifery staffing

Evidence submitted for scrutiny to IMSOP

Women's feedback (2 week period)

Everyone does a brilliant job.

Staff have all been supportive.

Midwives all fantastic.

Midwives helped mum remain calm.

Paul - Anaesthetist - his level of care was outstanding, amazing and helped everyone remain calm.

All staff have been perfect

Staff so professional.

Would highly recommend PCH, level of care is real not forced.

Staff always seen discretely watching over women and babies throughout the night.

Staff have been great.

All care has been amazing.

Staff have been fantastic

Staff always kept Dad informed and involved

Staff have all been lovely

Fantastic Service

Staff have all been wonderful.

Staff have all been fantastic all doing an amazing job.

Cannot thank staff enough.

Staff have all been marvellous.

Would highly recommend Prince Charles Maternity Unit.

Feel very lucky to have given birth at Prince Charles Maternity Unit.

Well looked after by staff.

Happy with care received.

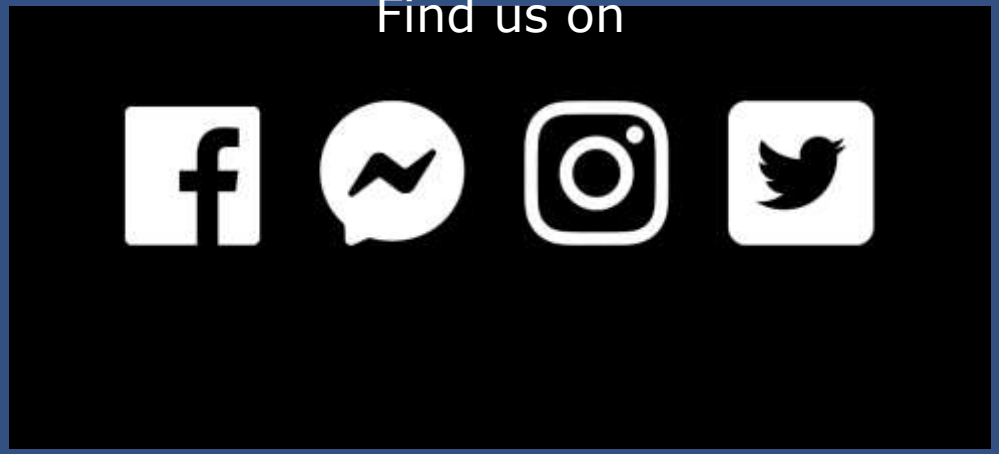
Stacey - Midwife has been absolutely amazing.

Challenges

- Requirements and pace of work v's capacity and capability
- IMSOP's confidence in programme delivery – two key issues
- Internal programme team development
- No substantive HoM or CD (CD appointed)
- Continued focus on emotional support for maternity staff

@cwmtafmorgannwg

Find us on



Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.2** **26 September 2019**

University Health Board Report
UPDATE ON MATERNITY SERVICES

Executive Lead: Director of Nursing, Midwifery & Patient Care
Author: Maternity Improvement Director / Head of Midwifery / Risk and Governance Midwife
Contact Details for further information: ana.llewellyn@wales.nhs.uk

Purpose of the Health Board Report
The purpose of this report is to provide the Board with an update on Maternity services. An update on actions taken since the last Board meeting and the known related implications of the special measures arrangements to date is summarised in this report.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within its approved 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives in summary are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all of the above objectives.
Engagement – Who has been involved in this work?	
Maternity Services Management Team and Clinical Staff; Patient Care and Safety Team	

Health Board Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **DISCUSS** and **NOTE** the reviews currently being led and/or supported by being external bodies.						

Summarise the Impact of the Health Board Report	
Equality and diversity	There are no specific implications relating to equality and diversity within this report.
Legal implications	The focus of the reviews compliment the Board Assurance Framework and the Health Board's Standing Orders.
Population Health	Equity is one of the tenets of quality in its broadest sense and will be better served by the implementation of any recommendations made as part of the review process contained in this paper.
Quality, Safety & Patient Experience	This report relates to the way in which quality, safety and patient experience is being externally reviewed, the recommendations of which and should therefore influence the design and delivery of the Board's strategic objectives.
Resources	The resource implications resulting from any recommendations will require full attention within services and directorates, and corporates. Implications should be considered via clinical business meetings, included in risk registers where appropriate and detailed within directorate integrated medium term plans.
Risks and Assurance	Recommendations resulting from external reviews should enable greater transparency and rigour in relation to the articulation of risk and assurance at all levels within the Health Board.
Health & Care Standards	Health & Care Standards are referenced throughout the core business of the Quality Safety & Risk Committee www.wales.nhs.uk/siteplus/documents/1064/Easy%20Read%20Standards%20FINAL%20December%202010.pdf
Workforce	There are no new implications associated with this report
Freedom of information status	Open

UPDATE ON MATERNITY SERVICES

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide the Board with an update on Maternity services, following the publication by Welsh Government on 30 April 2019, of the external review undertaken by the Royal College of Obstetricians and Gynaecologists (RCOG) & Royal College of Midwives (RCM).

2. BACKGROUND / INTRODUCTION

2.1 Background

In November 2018, the Maternity improvement accountability structure was created to ensure rigour towards the oversight of the programme of improvement. On the appointment of Greg Dix, Executive Director of Nursing, Midwifery and Patient Care in April 2019 and following the publication of the above reports, it was agreed that a robust programme management infrastructure be applied with a dedicated team to deliver the recommendations as set out within the external reports.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Maternity Improvement Programme

The Independent Maternity Services Oversight Panel (IMSOP) has been appointed by Welsh Government to oversee the programme of improvement and transformation of maternity services, to provide advice and support but also to add rigour and challenge to the organisation as it responds to the recommendations of the RCOG and RCM.

IMSOP and Welsh Government held a workshop on 12 August 2019, which was also attended by Health Board representatives, to consider a performance and assurance framework. The approach of aligning the performance management to the Healthcare Inspectorate Wales (HIW) domains of Safe and Effective Care, Quality of Management and Leadership and Quality of Patient Experience was endorsed at the formal IMSOP meeting on 19 August.

As a consequence of this new performance management approach, the maternity improvement programme is also aligning its work to the three HIW domains.

3.2 Directorate Risk Register

The directorate currently has 31 risks on the risk register. From September 2019 onwards, these risks will be reviewed via a risk management meeting established as part of the newly developed governance framework.

There will be representation from obstetrics, gynaecology & integrated sexual health at the meeting. The risks are as follows:

Risks scored at 20

- **Complaints management in maternity services** – capacity by the team to manage the increase in concerns following the publication of the joint report of the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwifery (RCM).

  Mitigation – A women's experience midwife is in post and with the support of the senior team completion of responses is being prioritised and under regular review.

- **Non Compliance of theatre standards in obstetric theatre in Prince Charles Hospital and lack of planned out of hours cover for opening the second obstetric theatre in an emergency.**

  Mitigation – maternity services currently provide a second theatre scrub nurse as needed. A business case is in development with the support of the Surgery Service Group to develop sustainable cover for a second theatre.

- **Lack of dedicated substance misuse services for pregnant women in the Royal Glamorgan & Prince Charles Hospital.**

  Mitigation – women are currently seen in general antenatal clinics. Support is provided as required by midwifery staff. Plans for a dedicated service will from part of CTM's Integrated Medium Term Plan (IMTP) for 2021/22.

- **Non-compliance of Gap & Grow standards implemented to reduce stillbirth rates across Wales –** due to scanning capacity issues the standards have not been fully implemented

  Mitigation – Like many other maternity units across Wales there has been a need to amend the frequency of scanning from 2-3 weeks to 3-4 weeks. Capacity has been identified in other CTM non-acute sites and plans are being formulated to move low-risk scanning off the acute sites to increase scanning capacity for 'Gap & Grow'. This is being progressed through a Task and Finish group.

Risks Scored at 16

- **Capacity of the obstetric services in the new unit at Prince Charles Hospital –** concerns regarding sufficient bed capacity for a service increasing activity due to the consolidation of obstetric services at Prince Charles Hospital.

Mitigation – staff are using the escalation guideline, when capacity is problematic women are offered transfer to Princess of Wales Hospital. Senior managers are available to support clinical decision making, particularly out-of-hours. The ward pharmacist pilot saw an increase in the number of women being discharged without any delays due to ward based dispensing.

This has made a compelling case for the substantive appointment of a dedicated pharmacy resource. This case will be made jointly with medicine management teams through the IMTP for 2021/22.

- **Governance Structure in Obstetrics, Gynaecology services**

  Mitigation A governance administrator is providing additional support. Further assurance may be required and the Directorate team are reviewing cross-site roles to provide additional capacity.

- **Information Technology (IT) Systems in Princess of Wales Hospital (PoWH) and existing Cwm Taf services –** there are two maternity information systems for women receiving antenatal care which are not currently linked.

  Mitigation – IT directorate supporting the service to obtain data from the WPAS maternity information system in PoWH. Currently however, women receiving antenatal care in RGH and birthing in PoWH are to be entered onto separate systems.

- **Midwifery Staffing in the Health Board –** insufficient midwifery staffing to safely cover the rosters.

  Mitigation – additional overtime payments currently maintained until new midwives commence in October 2019. Specialist midwives and senior midwifery managers supporting rosters by assisting clinically.

- **Administration of intravenous antibiotics to neonates on the postnatal ward in PoWH –** this activity was previously undertaken by special care staff, the postnatal ward does not have a dedicated area to check and make up the antibiotics.

  Mitigation – midwives are currently being trained by nursing staff in special care and drugs are being made up in the small main clinical room.

3.3 Patient Experience, Concerns and Incidents

A monthly integrated patient experience report is produced using information from the Datix Risk Management System which is verified by the Concerns Team.

The Health Board's Quality and Patient Safety Governance Framework is using triangulated data to drive quality improvement. The maternity senior leadership team must have access to the voice of the patient, whether expressed through compliment, concern, face-to-face, in writing or by a third party, at any stage in the care pathway. The information must be analysed, triangulated and interpreted so that learning, quality improvement and service development are evidenced.

3.4 Workforce and Organisational Development, Education and Development.

The Clinical Director interviews resulted in an appointment being made and the successful candidate commencing on 9 September 2019. Interviews for the Directorate Manager led to the appointment of a substantive Directorate Manager. The post of Director of Midwifery is currently out to advert.

The sickness rate in maternity has recently reduced from 12% to 11%. This is mostly long term sickness and these individuals are being supported as per usual health board processes.

Vacancy rates have reduced in part as a result of changing the establishment from 148.8 Whole Time Equivalent (WTE) to 132 WTE (CT) awaiting Birthrate Plus evaluation on the new service model. This is due to be reported in October 2019. It was anticipated that recruitment of the new student midwives would result in 20 appointments resolving all vacancies. This subsequently reduced to 16 and therefore an advert for Band 6 midwives is being placed to fill vacancies.

3.5 Leadership and Culture

An organisational development (OD) plan has been developed that details a number of actions at different stages, all sessions will be provided by external Consultants. The Health Board is currently considering tender applications.

Alongside the focus of the Maternity Services OD Plan and Culture Plan, the organisation is developing a values and behaviour framework which will clearly be beneficial for the whole organisation, including maternity services, and will be integrated into the maternity improvement work streams.

3.6 Women's Experience and Engagement

A number of workshops with senior midwifery professionals have been held to develop an understanding of the future work plan. The short-term focus is on the development of a number of engagement events. The Health Board is being supported by the IMSOP engagement lead. An interim engagement strategy has been developed.

The Putting Things Right Team are working with the Consultant Midwife and are engaged in twice weekly real-time reviews of women's experience. The findings are considered and acted on immediately. Themes identified through the feedback are discussed in the Midwifery Forum with actions being taken forward through Directorate Business meetings where wider engagement is needed in providing solutions.

3.7 Regional Maternity Patient Flows

A Regional Contingency Maternity Group has been established in response to the shifting activity flows across South Wales which meets fortnightly. A number of issues have been raised through this group that have led to regional Chief Executive collaboration and decision making.

The Regional Obstetrics Planning Group meets fortnightly to develop service and workforce implementation plans to address the revised service flows at the request of the Chief Executives of Aneurin Bevan, Powys, Cardiff and Vale, and Cwm Taf Morgannwg University Health Boards. These changes are in addition to existing baseline activity and the planning work of the contingency group continues to meet fortnightly.

4. RECOMMENDATION

The Health Board is asked to:

- **DISCUSS** and **NOTE** the report.

Freedom of information status	Open

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.3** **26 September 2019**

University Health Board Report
PATIENT EXPERIENCE and CONCERNS (PATIENT FEEDBACK, including, COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS)

Executive Lead: Director of Nursing, Midwifery & Patient Services; Medical Director
Author: Ruth Friel, Head of Patient Experience
Contact Details for further information: Ruth.friel@Wales.nhs.uk

Purpose of the Health Board Report
The purpose of this report is to provide the Board with a summary of Concerns and Patient Experience. This report has combined the Patient Experience and Concerns reports and covers the period since the last Concerns and Patient Experience reports to board and is from 1 July 2019 up to 31 August 2019.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined within the 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aims' are being progressed, these in summary are; • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses mainly on improving quality, safety and patient experience.
Supporting evidence	Putting Things Right – raising concern about the NHS in Wales (2013). http://www.wales.nhs.uk/governance-emanual/putting-things-right Framework for Assuring Service User Experience, (2015) Welsh Government

	Listening & learning to improve the experience of care, (2015). http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Listening%20and%20Learning%20to%20Improve%20the%20Experience%20of%20Care.pdf Cwm Taf Morgannwg University Health Board: The Quality and Patient Safety Governance Framework

Engagement – Who has been involved in this work?

The information within the report has been provided by the corporate Patient Experience and Concerns team, from records held on the Datix risk management system and also from the Health and Care standards monitoring system.

Health Board Resolution to:

APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√

Recommendation	The Health Board is asked to: • **NOTE** the report

Summarise the Impact of the Health Board Report

Equality and diversity	Concerns are managed within the framework of Putting Things Right, ensuring that all issues are dealt with equitably. There are no specific implications relating to equity and diversity within this report.
Legal implications	Concerns are managed in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2013.
Population Health	There are no population health implications of this report.
Quality, Safety & Patient Experience	The experience summarised within this report reflect issues relating to quality of care, patient safety, and patient experience.
Resources	The resource implications relate to ensuring the right resource is in place to ensure that the functions of quality governance can be effectively provided across the health board at service and corporate levels. The cost of settling, claims and redress payments should also be considered, along with staff resource to ensure robust and timely investigations of concerns raised.
Risks and Assurance	The data within this report reflect financial, clinical and reputational risks. The Quality and Patient Safety Governance Framework is established to identify, mitigate and manage risk along with provide assurance.

Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported relates specifically to Standard 3.1 Safe and Clinically Effective Care, and Standard 6.3 Listening & Learning from Feedback.
Workforce	There are no workforce implications associated with this report.
Freedom of Information Status	Open.

PATIENT EXPERIENCE and CONCERNS (PATIENT FEEDBACK, including, COMPLAINTS, CLAIMS AND PATIENT SAFETY INCIDENTS)

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide the Board with a summary of Concerns and Patient Experience. This report has combined the Patient Experience and Concerns reports and covers the period since the last Concerns and Patient Experience reports to board and is from 1 July 2019 up to 31 August 2019.

2. BACKGROUND / INTRODUCTION

Concerns are managed in accordance with the All Wales *Putting Things Right* Guidance (2013). Putting Things Right requires organisations to thoroughly investigate concerns in a timely manner. Patient activity for this period needs to be taken in to context when reviewing concerns and there were just under 179,320 attendances at outpatients, in patients and A&E departments. (This number only includes A&E attendances and not in and out patients at Princess of Wales site. Information services are working on the capture and verification of attendances for all of the Health Board).

The Health Board's assurance processes are expressed through the Quality and Patient Safety Governance Framework which includes the complaints and claims scrutiny panels and the directorate governance arrangements.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The report provides information in relation to concerns received by the Health Board. These are received in a number of ways, including via complaints, clinical negligence claims and patient safety incidents. The report outlines serious incidents reported to Welsh Government and Regulation 28 reports, (prevention of future death reports) received from Her Majesty's Coroner. The report highlights the current position in relation to the review of patient safety incidents and non-compliance with Patient Safety Solutions. The report includes information from Real Time patient surveys, the Health and Care monitoring system and information held within Datix relating to the Patient Advocacy Liaison Service (PALS). This information is also distributed to the directorates via the individual quarterly risk, incidents and concerns reports and shared at the directorate clinical governance and clinical business meetings.

Please note the overall the volume of service user feedback is proportionately low and where there is a high volume of feedback, e.g. the Health and Care monitoring system and individual directorate/ speciality surveys, then sometimes there is limited qualitative data to outline the service user's experience. Consideration of the different methodologies for capturing, analyzing and reporting patient/service user experience will form part of the patient experience sub group's work programme and a paper will be presented at Board in November 2019.

3.1 Complaints managed through the Putting Things Right (PTR) Regulations

In April 2019, Welsh Government revised, clarified and standardised the way in which complaints are reported by NHS organisations. The changes mean that all complaints that take longer than 1 working day to resolve, are now required to be reported as a formal complaint, i.e. using the Putting Things Right Regulations. This change has resulted in an increase in the number of complaints being managed through the Putting Things Right Regulations and consequently improved compliance with the 30 working day response target.

Performance against the 30 day target during July and August was 90%, an improvement on June's 70% (the national response target is 75%). Obstetrics, Gynaecology and Sexual Health, Acute Medicine and the Accident and Emergency departments experience delays in responding to concerns within the timeframe. Whilst the former is supported as part of the improvement overseen by the Maternity Programme Board, the latter has been allocated additional dedicated support to expedite response and learning, and an improvement trajectory is currently being agreed.

The chart below illustrates a subsequent increase in formal complaints, which can be attributed to the boundary change to incorporate Bridgend post April 2019. An increase in complaints in the Princess of Wales site since July has also been noted and further analysis is being undertaken to gain a better understanding for the increase.

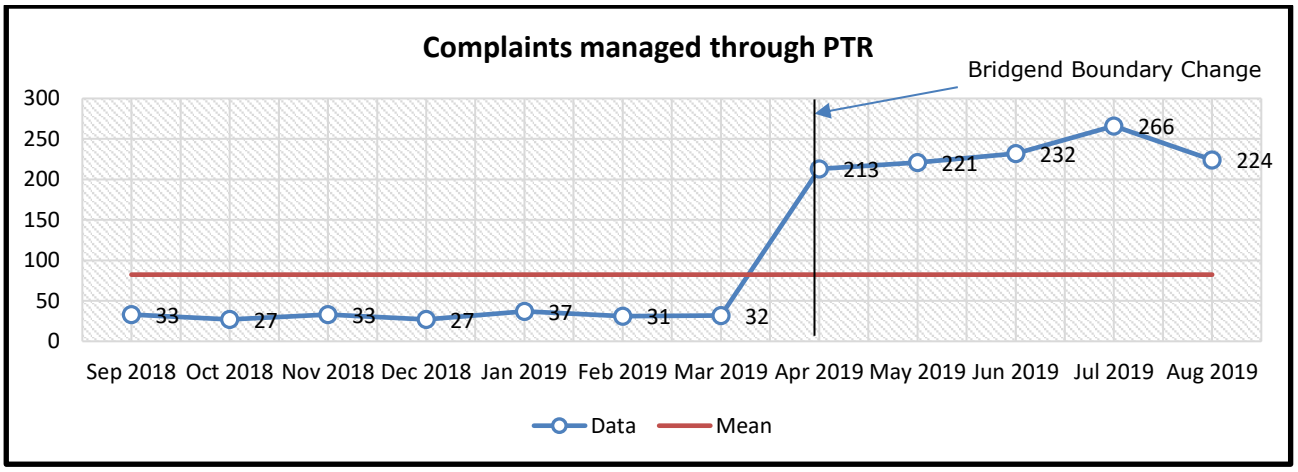


Chart 1: Complaints managed through the Putting Things Right Regulations September 2018 – August 2019

3.1.1 Complaint Trends

The Health Board received 490 complaints during July and August, 176 (36%) of these were dealt with via Early Resolution and managed by the Patient Advocacy Liaison Service (PALS) team. The majority of the early resolution complaints related to delayed appointments and communication issues and resolved within 1 working day. The service user feedback obtained via the Patient Advocacy Liaison service is outlined in Appendix 1.

The highest number of complaints are linked to those areas with the highest activity and or acuity levels. These areas are Acute Medicine and the Accident and Emergency Departments. The top 3 themes that emerge from complaints are delays, communication and treatment errors and these are similar to other directorates and sites as well as other Health Boards in Wales. During 2019 -2020, the way in which themes are identified will be refined and reflected within this report. Further scrutiny of the top 3 themes for complaints received suggest that:

Delays: complaints relating to delays and are mainly in relation to waiting times, specifically in Head and Neck, Accident and Emergency and General Surgery. There is little variance across the 3 sites. Also delays have been reported in specialities such as urology, dermatology and rheumatology. The surgical directorate team continues to formally review Referral to Treatment (RTT) waiting times on a weekly basis through the Health Board's monitoring process. An additional general surgeon has been employed to improve internal elective capacity, the impact is being closely monitored.

Communication: Most of complaints related to communication were made following attendance at acute medical and Accident and Emergency departments, with the Princess of Wales Hospital receiving most of these type of complaints. The complaints mainly relate to patients not being advised on the treatment plan and the details of their conditions.

Treatment Errors: These mainly relate to delays in treatment rather than actual treatment errors, there is no trend for a particular area or speciality. The changes to refine the report mentioned earlier will assist with more detail of these type of complaints.

3.1.2 Complaint Response Times

Performance with meeting the 30 day target for responding to complaints received during July and August was 90%, an improvement on June's performance which was 70%. The national response target time within 30 working days is 75%. As of 31 August 2019, there were 287 formal complaints currently being managed. The directorates with the most overdue response times over 30 working days are Obstetrics, Gynaecology and Sexual Health, Acute Medicine and the Accident and Emergency departments. The management of complaints is part of the maternity improvement programme and targeted intervention work to improve complaints response times is being progressed. Staffing resource has been redeployed to Acute Medicine and Accident and Emergency services in both the Royal Glamorgan and Prince Charles Hospitals to support timely responses.

3.1.4 Compliments

The PALS team record compliments received via *Have Your Say* cards, social media and emails. The Obstetrics, Gynaecology and Sexual Health Services have the highest number of compliments (30) for this period.

3.1.5 Real Time patient experience feedback

The total resource available undertake Real Time at present is deployed within maternity and mental health services. The feedback for this period are positive and the results of the Real Time surveys are in Appendix 2. The success of this method is recognised and a business case has been developed to support extension into other areas. Where Real Time is unavailable, the Health and Care Monitoring system is the main source of feedback.

3.2 Patient Safety Incidents

The number of patient safety incidents being reported has increased due to the increased volume of patients since the Bridgend boundary change on 1st April, 2019. A total of 3288 patient safety incidents were reported during July and August 2019 compared to 2820 in the previous 2 months. Incident reporting, including near misses, helps inform the identification of themes and trends and therefore, learning and improvement. The way in which the Heath Board learns from concerns will be strengthened through implementing the Quality and Patient Safety Governance Framework and incorporating all recommendations made by regulators, along with the Independent Maternity Oversight panel and others. The position for incident reporting over a 12 month period within the Health Board overall is reflected in the chart below:

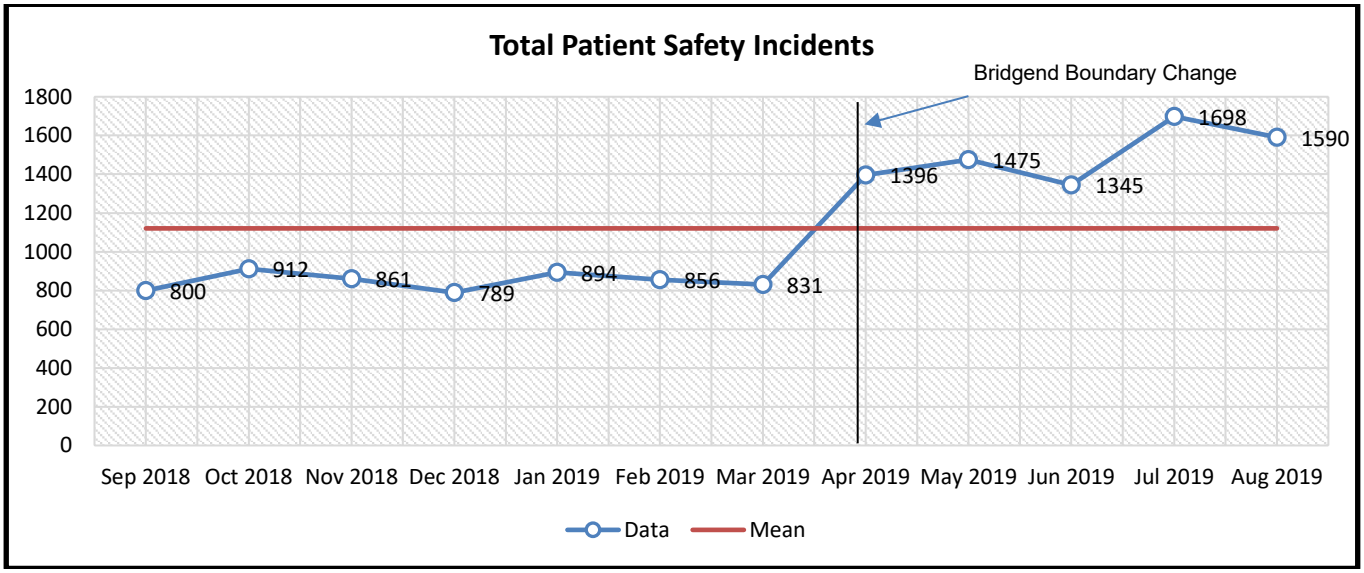


Chart 2: Reported Patient Safety Incidents

July 2019 shows the largest number of Incidents reported.

The incident reporting trend for the last 2 months in the 3 District General Hospitals is expressed in the graph below.

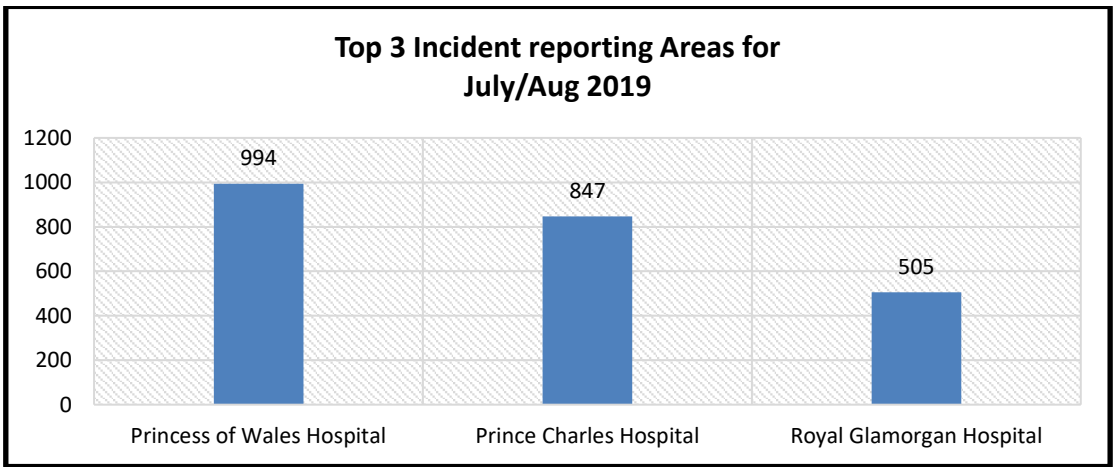


Chart 3: Top 3 reporting Areas for July/Aug 2019

Most of the patient safety incidents reported relate to pressure damage and falls, both of these events have specific reporting requirements set by Welsh Government. Building on practice within the Princess of Wales Hospital, pressure damage scrutiny panels have been established in both other District General Hospitals. Incidents are scrutinised and learning and improvement identified which is then taken back to the clinical areas by panel members. Falls improvement work is gathering pace following the revision of the organisations falls policy accompanied by a series of targeted learning sessions within areas where there is a high incidence of falls identified as preventable.

Princess of Wales Hospital reported the most incidents during July 2019, slips, trips & falls, pressure damage and delays were the most reported. Further analysis is being undertaken to understand the differences in reporting between sites. The level of harm associated with an incident is recorded at the time of reporting. Most incidents were reported as resulting in no or low harm:

Severity	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Total
No Harm	388	377	484	447	393	471	463	453	716	791	720	862	846	7411
Low	364	337	328	319	314	327	303	276	529	526	499	596	535	5253
Moderate	84	79	90	89	72	80	79	90	128	133	103	217	185	1429
Severe	1	3	5	2	2	8	4	6	15	6	9	22	16	99
Death	3	3	5	4	7	6	7	6	8	16	8	7	12	92
Total	**840**	**799**	**912**	**861**	**788**	**892**	**856**	**831**	**1396**	**1472**	**1339**	**1704**	**1594**	**14284**

Table 1: Severity of the Incidents reported 01 August 2018-31 August 2019

The Quality and Patient Safety Governance Framework identifies the means by which directorates, localities and services can structure governance and reporting arrangements that support identification, investigation, leaning and improvement, along reporting to the Quality Safety and Risk Committee.

3.3 Serious Incidents

Serious incidents are acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm, including those where the injury required treatment to prevent death or serious harm, abuse, never events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that

cause widespread public concern resulting in a loss of confidence in healthcare services. Welsh Government should be notified within 24 hours of a serious incident occurring. The chart below illustrates the number of serious incidents reported to Welsh Government between September 2018 and August 2019.

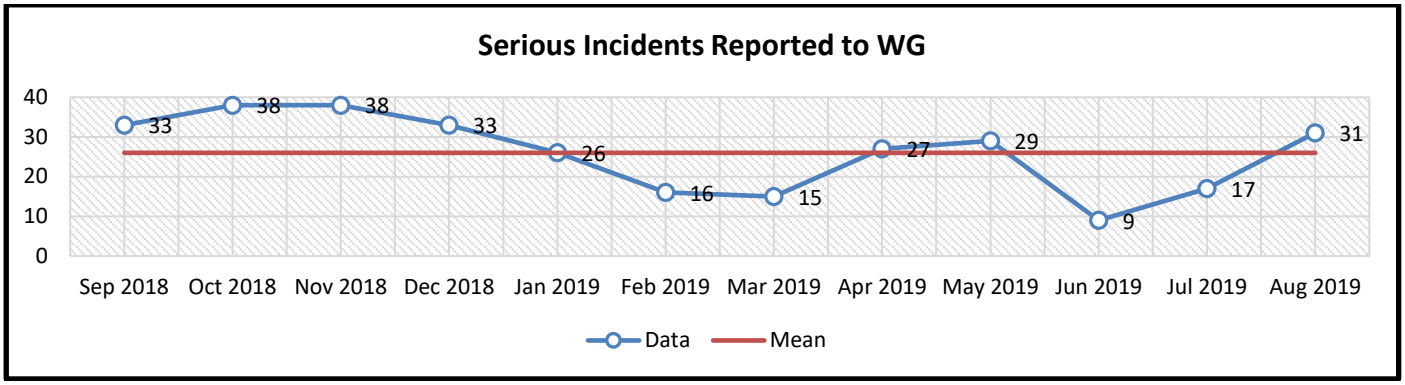


Chart 4: Serious Incidents Reported to Welsh Government

During July and August 2019, 48 serious incident reports were notified to Welsh Government. Most of the serious incidents relate to in patient falls (38%). Other incidents resulted from delay in ophthalmology service provision, infection, self-harm and unexpected or trauma related deaths occurred in a person's own home. The chart below identifies Serious Incident by site during this period:

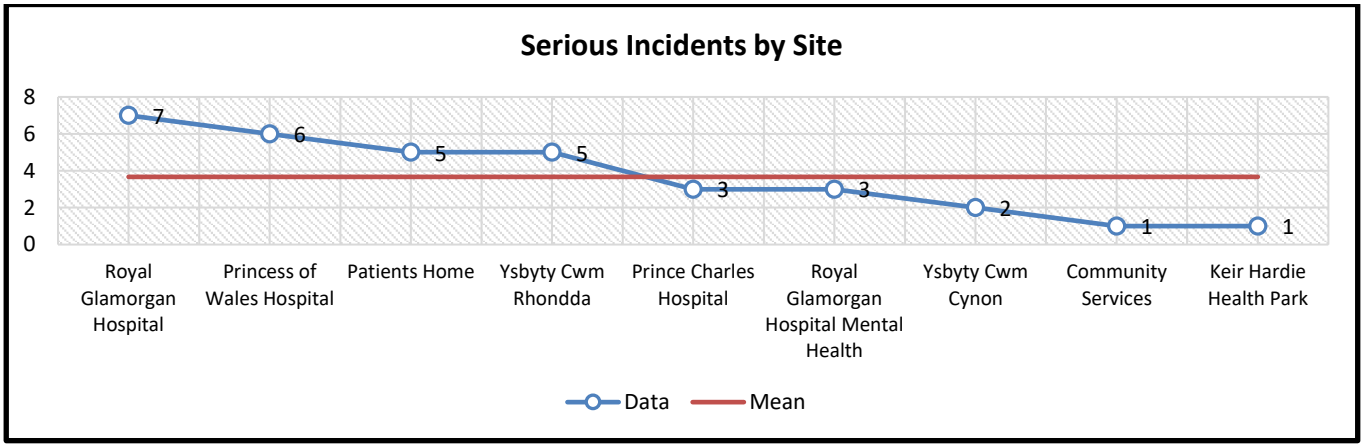


Chart 5: Serious Incidents by site

Targeted work is being undertaken throughout 2019 to reduce the number of outstanding serious incident investigations. This includes weekly scrutiny of all open serious incident investigations, along with additional clinical resource to support the most complex investigations. Learning events that take place as part of the investigative process assist in ensuring all learning is identified to help inform improvement and information is available to inform discussion at directorate governance and clinical business meetings. The additional external scrutiny from the Delivery Unit, Welsh Audit Office and Health Inspectorate Wales will support improvements in the way in which incident report is utilised to inform learning.

3.3 No Surprises

Welsh Government are notified of sensitive issues via a process known as 'no surprises'. During June 2019, 13 notifications were submitted, 5 during July 2019 and 6 during August 2019: Four notifications related to staff shortages in June two of which related to A&E in the Royal Glamorgan site.

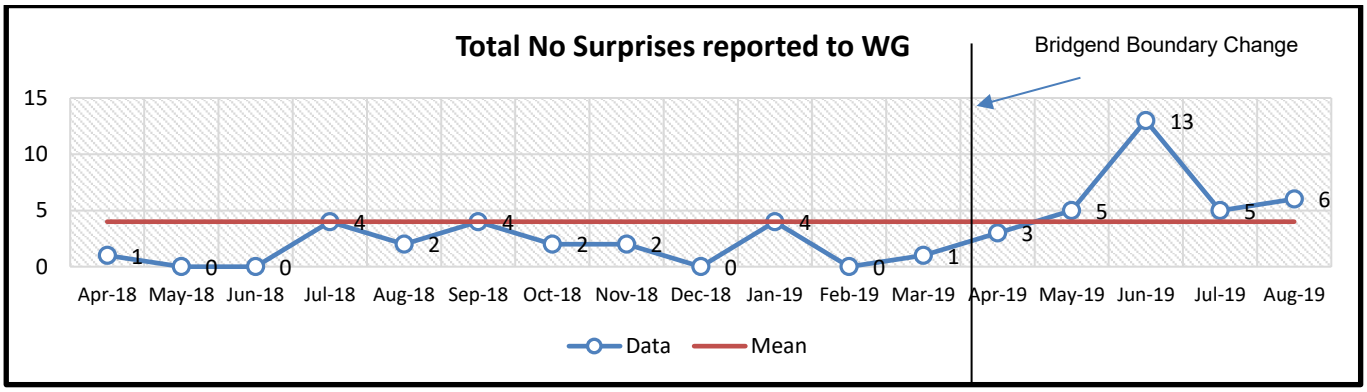


Chart 6: No surprises reporting April 2018 - August 2019

The category within which the notification have been made are illustrated below:

Category	June 2019	July 2019	Aug 2019
Patient related	1	1	4
Staff related	4	3	1
Service related (including staffing)	6	1	1
Media	1	0	0
Environmental	1	0	0
Total	**13**	**5**	**6**

Table 2: Categories for no surprises

3.7 Patient Safety Solutions

Patient Safety Solutions are issued in two formats:

- **ALERTS**: this requires prompt action with a specified implementation date to address high risk/significant safety problems.
- **NOTICE**: This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas, and take immediate action.

The Health Board is currently non-compliant with 1 alert and 3 notices. A summary of these is provided in the table in **Appendix 3**, along with the actions in place to reach compliance and a revised timescale.

Performance for all Health Boards and Trusts in Wales can be found at http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data

4. RECOMMENDATION

The Health Board is requested to:

- **NOTE** the report.

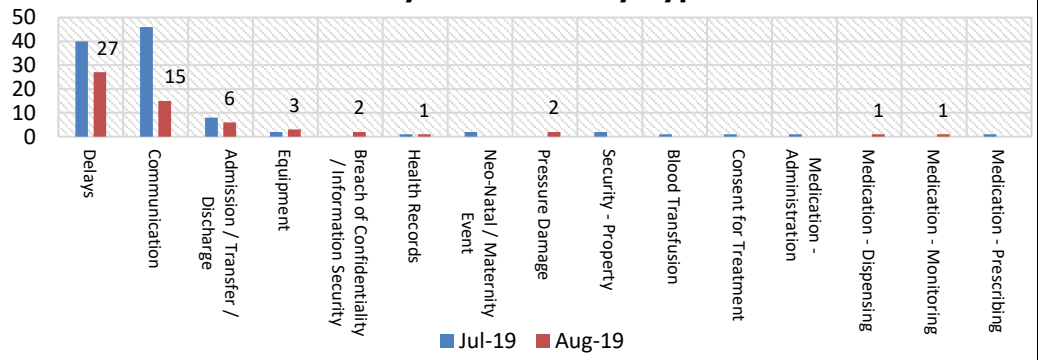
Freedom of Information Status	Open.

Appendix 1

Total PALS Received: 174

Period: July-August 2019

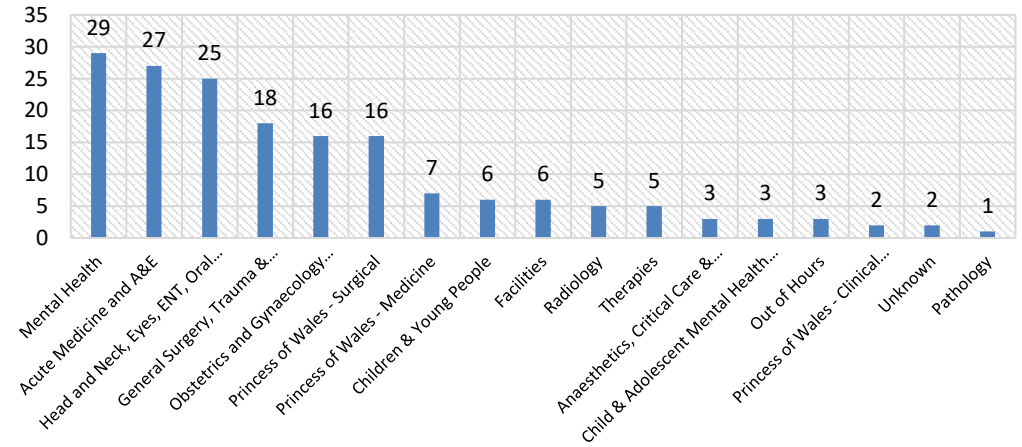
Early Resolution by Type



Top 3 Types of Complaints

	July-19	Aug-19
Communication	46	15
Delays	40	27
Admission/Discharge/Transfer	8	6

Directorates



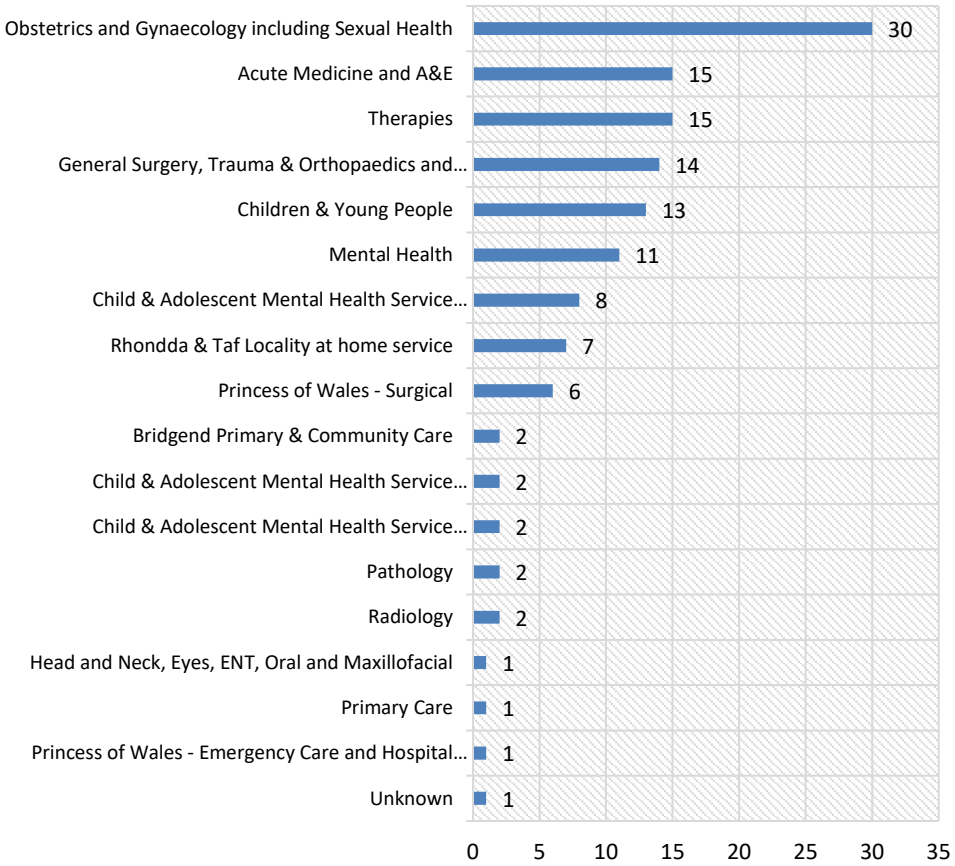
Concerns and Actions

During the month of July and August 2019 the PALS received 174 enquiries, 142 were resolved within the 1 working day target. The top three areas are General Surgery, T &O / Urology, Acute Medicine and A&E and Head & Neck.

Examples of PALS complaints received:

Delays with appointments: These mainly related to delays in ophthalmology appointments. There is ongoing work reviewing the waiting lists as part of the Referral to Treatment meetings. Any harm identified while on a waiting list directorates are requested to report as a patient safety incident.

Communication: There have been delays with patients being unable to get through to various departments via Switchboard. The feedback was shared with the Facilities Manager and a technical fault which has been resolved.

Number of Compliments Received	Examples of Compliments received
	**Compliments** have been received via Thank You cards, Have Your Say cards, Social Media and Email. The information is recorded in Datix to monitor trends. A copy of all compliments are sent to the area and or persons named. The Wordle below has captured the compliments for July and August reported in Datix. The larger the print the more frequent the word has been used. 

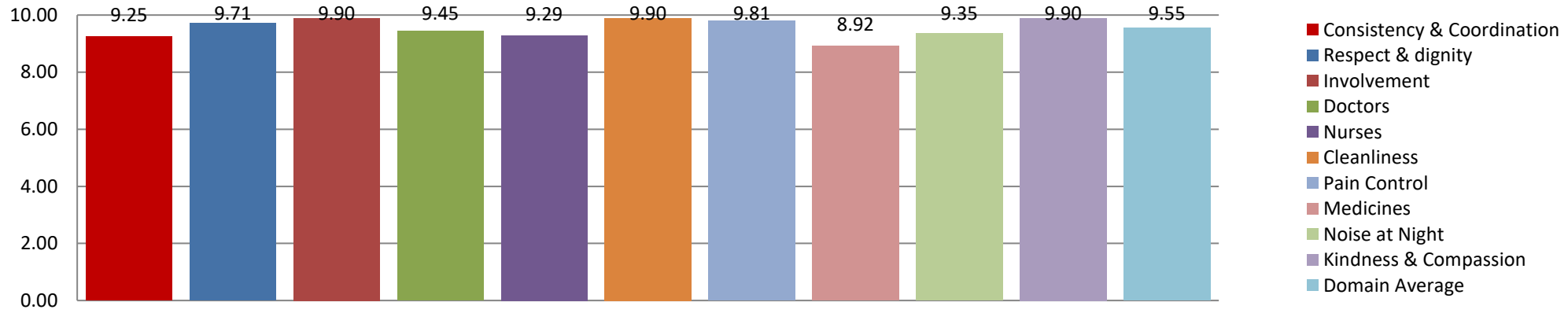
Actions

A copy of all compliments are sent to the area and where individuals are named, a copy of the compliment is shared with them.

Appendix 2

Period: July – August 2019

Maternity Service Real-Time Service User feedback 1 July- 31 August 2019

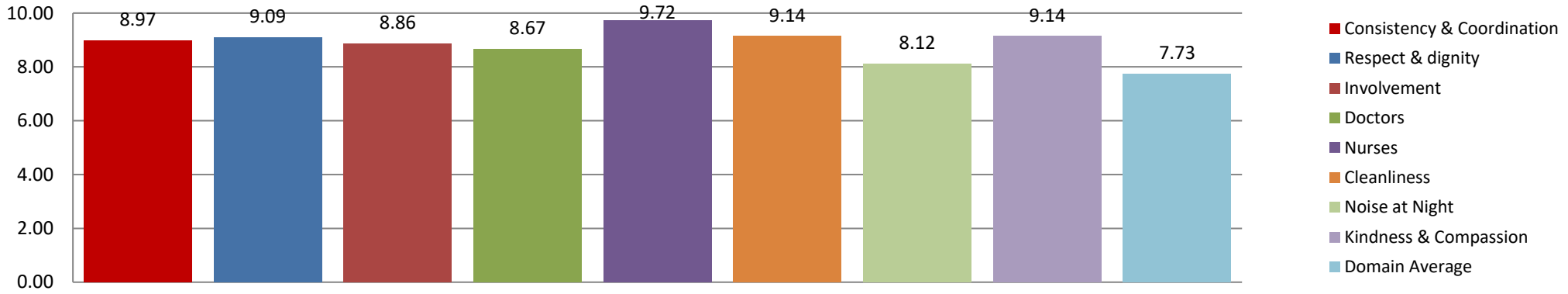


Score 0-10

How are we doing	What actions are we taking?
Total maternity surveys completed: 234 out of 417 total women who have given birth during July and August, 2019. **<u>Strong</u> performance in the following domains** Staff treating patients with Kindness & Compassion - 9.90 Cleanliness around the wards – 9.90 Showing patients Respect and Dignity at all times – 9.71 Confidence and Trust from the Doctors – 9.45 Confidence and Trust from the Nurses – 9.29 **<u>Improvement</u> required in these domains** Medicines management 8.92	Overall the feedback is very positive. The surveys have increased to twice a week from week commencing July 8th and the results will continue to be reported weekly to the Executive Director of Nursing Midwifery and Patient Care. During this reporting period, some of the improvement work includes: • A pilot of a designated pharmacist for the maternity ward to improve pain management and effective discharge. • Laminated colour coded bears placed in the cots of high risk babies to alert staff of the additional neonatal care required on the postnatal ward.

Period: July – August 2019	

Mental Health Admissions Unit Real-Time Service User feedback 1 July- 31 August 2019



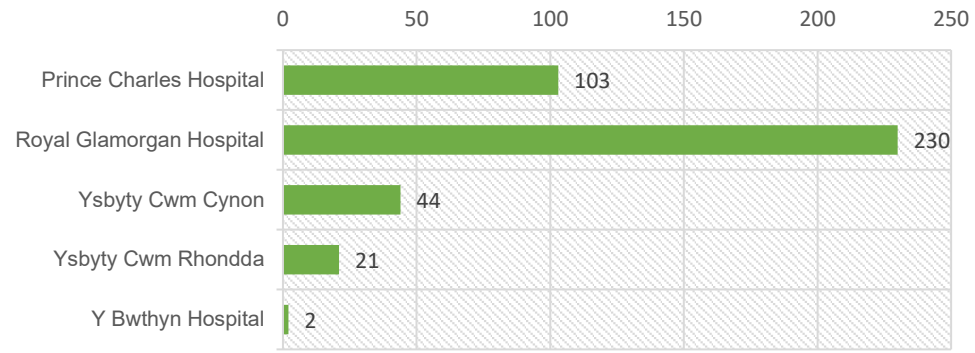
Score 0-10

How are we doing	What actions are we taking?
Total surveys completed: 28 and these are long stay patients. **<u>Strong</u> performance in the following domains** Showing patients respect and dignity at all times – 9.09 Confidence and trust from the nurses – 9.72 Cleanliness around the wards – 9.14 Staff treating patients with kindness & compassion - 9.14 **<u>Improvement</u> required in these domains** Noise at night 8.12 Confidence and trust from the Doctors 8.67	The survey is carried out on the Mental Health Unit on a fortnightly basis. Overall the feedback is positive. Any issues identified are dealt with at the time. The report is shared with the management team for the area as well as the Executive Director of Nursing Midwifery & Patient Care and areas identified for improvement are being worked through to gain a better understanding of these issues and will form part of the directorate's improvement action plan.

Health Care Monitoring System Patient Surveys completed during July – August 2019

Period: July – August 2019

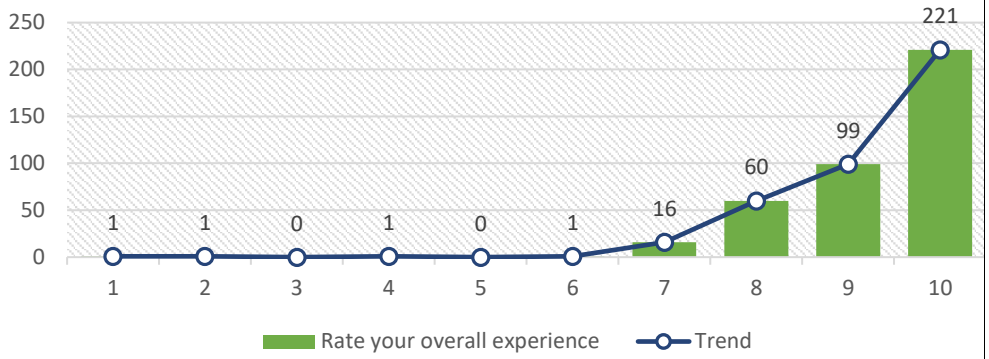
Patient surveys sample size, by site (Jul - Aug 2019)



(Princess of Wales wards do not complete the HCS survey monthly)

Overall Score

Rate your overall experience
1 is bad and 10 is good (Jul - Aug 2019)



How are we doing

- Overall feedback was good in terms of care provided by nurses and doctors.
- Staffing levels was a common theme across all survey responses for this period, particularly to care for patients with dementia.
- One survey noted that their experience would have been poor had their initial complaint not been dealt with effectively, resulting in them revising their Health Care Monitoring survey results from 2 to 10.

What actions are we taking?

Work aligned to the Nurse Staffing Act (NSA) is improving staffing levels across all medical and surgical wards.

Delivery of dementia friends training for staff, dementia friendly adaptations to environments and the hub in YGT where they have a programme of activities for people living with dementia and their carers/family.

Percentage Surveys where the overall satisfaction with Care Received was (1=bad, 10=good)	Percentage Surveys where the overall satisfaction with Care Received was rated as 9 or 10 (1=bad, 10=good)	What are the areas of risk?
92.4%	76.7%	Maintaining nurse and health care support worker staffing levels, procceses are in place at Ward, Directorate and organisational level

Source: H&SC Audit Tool

Appendix 3 – Patient Safety Solutions Non-Compliant & Outside of Timescale

No. Patient Safety Alerts & Notices Name & ID	Issued	Progress update & Outstanding Actions	Executive Lead	Deadline for completion & RAG status
PSA008 Nasogastric tube misplacement: continuing risk of death and severe harm	22.05.17	CE strips non marked being used (WG agreement) so HB remains non-compliant. Further work is being undertaken by the suppliers of the PH strips to either CE mark the product, alternatively another supplier will need sourcing for supplying Wales or possible changes to PH testing practice will be required.	Medical Director	30.10.17 In progress No Anticipated date of compliance as waiting for an All Wales solution.
PSN030 The safe storage of medicines: cupboards	04.04.16	WG have provided all Health Boards with a self-assessment tool to complete. CTUHB have completed self-assessment tool and awaiting approval. Areas of non-compliance have been identified and actions taken to minimise the risk.	Director of Primary, Community and Mental Health	26.08.16 In progress No anticipated date of compliance available due to the requirement of modernisation of all medicines storage across the HB
PSN046 Resources to support safer bowel care for patients at risk of autonomic dysreflexia.	23.10.18	The notice has been disseminated to all Clinical Areas. There is currently a Protocol in place which refers to Patients with spinal cord injuries. The Health Board's Bladder and Bowel Health Service deliver a management of bowel dysfunction course approximately 6 times a year throughout the Organisation. Uptake of training in this area requires improvement. Every clinical area, District Nurse base, Residential & Nursing Home has a welcome to the bladder & bowel health service resource file.	Medical Director	29.03.19 In progress Anticipated date of compliance 30.09.19

No. Patient Safety Alerts & Notices Name & ID	Issued	Progress update & Outstanding Actions	Executive Lead	Deadline for completion & RAG status
		The Guideline is being reviewed and a Standard Operating Procedure is being developed which will included more detailed information highlighted in the notice. This needs to be approved before compliance can be confirmed.		
PSN049 Tracheostomy Guidelines replaces PSN043	09.04.19	Progress to date includes the establishment of a multi-professional group across all sites to take forward the recommendations of the notice. An action plan has been devised with a medical expert lead and this is being worked through by that group. Outstanding actions include: • Review of Guidelines. The guidelines are to include paediatric management, along with information, forms and a checklist for movement and transfer of patients. • Explore whether the funding is still available from the Critical care network the establishment of a multi-disciplinary Tracheostomy Team. • External training 'Train the Trainer' to be attended by Health Board Leads. • A baseline audit is to be undertaken. Audit requirements added to Corporate Audit Forward Plan (Tier 2).	Medical Director	01.07.19 Anticipated date of compliance 30.09.19

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.4** **26 September 2019**

University Health Board Report
INTEGRATED PERFORMANCE DASHBOARD

Executive Lead: Director of Planning and Performance
Author: Assistant Director of Commissioning and Head of Performance
Contact Details for further information: Julie Keegan and Elaine Williams

Purpose of the Health Board Report
The purpose of this report is to provide Health Board members with a summary of current performance, by exception, across a range of indicators and key issues arising from the Performance Dashboard as reported to the Management Board and Finance Performance and Workforce Committee at their meetings in September 2019.

Governance	
Link to Health Board Strategic Objective(s)	The Health Board's overarching role is to ensure its Strategy outlined within 3 Year Integrated Medium Term Plan and the related organisational objectives, aligned with the 'Quadruple Aim' are being progressed. This report relates to the performance elements of the Integrated Medium Term Plan (IMTP) and its objectives in particular.
Supporting evidence	The Integrated Performance Dashboard is available on request as supporting evidence, as provided to management Board and the Finance, Performance and Workforce Committee.

Engagement – Who has been involved in this work?
The data and information is drawn from the dashboard which originates from a variety of sources each having a number of associated engagement processes. The Integrated Performance Dashboard information has been discussed at both the Finance, Performance & Workforce Committee and Management Board September meetings. Elements are also received at the Quality, Safety and Risk Committee.

Health Board Board Resolution To:							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **DISCUSS** and **NOTE** the summary of the Performance Dashboard, noting that the full dashboard was received by the Management Board on 18 September 2019 and Finance, Performance and Workforce Committee on 19 September.						
Summarise the Impact of the Health Board Report							
Equality and diversity	There are no directly related equality and diversity implications as a result of this report.						
Legal implications	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.						
Population Health	A number of indicators monitor progress in relation to Population Health, such as vaccination and immunisation uptake rates.						
Quality, Safety & Patient Experience	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.						
Resources	There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.						
Risks and Assurance	Within the Integrated Performance Dashboard, actions are listed where performance is not compliant with national or local targets.						
Health and Care Standards	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.						
Workforce	A number of indicators monitor progress in relation to Workforce, such as Sickness and Personal Development Review rates.						
Freedom of information status	Open						

PERFORMANCE DASHBOARD

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide Health Board members with a summary of current performance, by exception, across a range of indicators and key issues arising from the Performance Dashboard as reported to the Management Board and Finance Performance & Workforce Committee at their September meetings.

The report focuses on areas of challenge and progress, together with areas where the Health Board is under formal escalation measures from the Welsh Government and/or where local progress is being monitored.

2. BACKGROUND / INTRODUCTION

This report provides a high level summary of the performance dashboard as received at both Management Board and Finance, Performance and Workforce Committee in September 2019.

Following the request of the Interim Chief Executive, this is a more summarised report than usual, given discussion and scrutiny elsewhere. The Chair of the Finance, Performance and Workforce Committee may also choose to verbally add further perspective from the Committee's recent discussions.

The report brings to the fore any changes to note since the previous month's report and/or where performance is deviating either from expected levels based on recent experience or from agreed trajectories.

It has been agreed to explore how to further develop the dashboard into a more fully integrated dashboard that will potentially negate the need for regular, separate dashboard reports for finance, workforce and quality, but this will require an extensive amount of work to achieve this ambition, which has already been initiated.

Alongside the development of the refreshed reporting, there will be a requirement to establish the reporting mechanism in line with any new structures, governance and performance frameworks currently being developed and/or reviewed. It is anticipated that Board members will have an opportunity to inform this work going forward.

The period of reporting in this report relates to August 2019, with a few exceptions, which are noted as appropriate.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

KEY ISSUES:

- Unreported waiting lists – 29 previously unreported waiting lists are now being reported as part of Referral to Treatment Times (RTT). With 1822 patients in total now added to the RTT position, 420 over 36 weeks and 239 of these over 52 weeks. Validation and treatment plans will start to reduce these numbers. The Health Board's quality team has been kept appraised of progress throughout this process, with any risks identified within these cohorts of patients being reported via the Datix incident reporting system, with appropriate, immediate actions being taken to mitigate any potential harm.

- The RTT position is off trajectory, in part because of the unreported waiting list issue, but also because the core waiting lists are still above planned levels.
  - ✓ There are 512 patients now waiting over 52 weeks, with the majority of 318 relating to Bridgend waiting lists.
  - ✓ There are 2949 patients waiting over 36 weeks, including the 512 waiting over 52 weeks, with the majority relating to the former Cwm Taf waiting lists.

  The main focus of the directorates is to reduce the overall numbers of patients currently waiting over 52 weeks with plans for treating the longest waiting patients in each of their specialties.

- The provisional diagnostic waiting list position is reporting 1,220 patients waiting over the 8 weeks target. This number now includes previous unreported waiting lists for some ECHOs and neurophysiology. There are plans in place for neurophysiology, to provide additional sessions to reduce the waiting list over the next few months to clear the backlog.

- The endoscopy surveillance position continues to improve as a result of additional capacity being created through an insourced service. The number have reduced from 843 patients waiting in June to 597 in August. The insourcing is due to continue until November 2019.

- Reducing the numbers of follow-up outpatients not booked for the former Cwm Taf footprint continues to improve, although patient numbers still remain high at 14,754 in total. Work remains underway to allow the Bridgend footprint to be reported in a similar way.

- Cancellations – there were 17 elective ward cancellations and 27 theatre cancellations. All 27 theatre cancellations were unfortunately due to an anaesthetist being unavailable and the plan is to monitor the position if this is due to the national issue relating to pensions and taxation changes or due to holiday season.

- Unscheduled care targets for the 4 hour and 12 hour indicators were not met, with some patient waits remaining a challenge in August. The 15 minute handover target from ambulance to A&E was also not for the Health Board as a whole.

  The Health Board has been working with the Delivery Unit to review systems, process and governance at Prince Charles Hospital emergency department and this work is planned to progress over the next 4 to 6 weeks, to understand the core contributors to the problem and improvement actions required.

- Ambulance response times were met for red calls

- The delayed transfers of care position has unfortunately significantly deteriorated, especially for rehabilitation patients, between July and August 2019. The operational team are investigating further reasons for the increase with escalated discussions with Local Authority partners, supported also by the Director of Primary, Community and Mental Health.

- Both the 31 and 62 day cancer targets were not met in July 2019, with 1 patient breach in the 31 day Non Urgent Suspected Cancer (NUSC) and 20 patient breaches in the 62 day Urgent Suspected Cancer (USC) category, of which 10 of the 20 related to urology. This is currently being reviewed by the operational team. The single cancer pathway, whilst not having a target set, saw an improvement in performance between the June and July reporting periods.

- Stroke data for August was not available at the time of publishing this report, so the July position is reported, which shows some of the quality improvement measures remain below expected levels. Areas to highlight include the low number of patients being thrombolised within 45 minutes and the low percentage (33.3%) of patients being directly admitted to a stroke unit within 4 hours of the clock start, particularly in the Bridgend locality. This is being further reviewed by the directorates for the underlying causes.

- Mental Health Measures for Part One, as at July 2019, the overall target of 80% was met but whilst the adult target is in excess of the 80%, the CAMHS target was below 80%. The Part Two target of 90% of Care Treatment Plans completed at the end of each month was marginally missed at 89.4% and Part Three measures seeing a drop in performance in July, with just 75% being completed within the target time.

- The neurodevelopmental target of 80% of patients seen in 26 weeks was unfortunately not achieved. Waiting times for Specialist CAMHS also remained below target.

4. RECOMMENDATION

The Health Board is asked to:

- **NOTE and DISCUSS** the summary highlight report of the Performance Dashboard as reported to the Management Board and Finance, Performance and Workforce Committee in September 2019.

Freedom of information status	Open

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Dylanwadu'n Gadarnhaol ar Iechyd a Lles Dinasyddion Cymru

Positively Influencing the Health & Wellbeing of the Citizens of Wales

INTEGRATED PERFORMANCE DASHBOARD

September 2019

Summary

Background

At the end of the calendar year 2017 the Welsh Government issued a consultation proposing that responsibility for healthcare services in the Bridgend County Borough Council (CBC) area should transfer to Cwm Taf University Health Board (Cwm Taf) from Abertawe Bro Morgannwg University Health Board (ABMU); moving the health board boundary accordingly. Following due process, the outcome of the consultation was that the Health Board boundary be changed in accordance with the proposal; the change to take effect from 1 April 2019.

Performance Dashboard

This is the fifth performance dashboard to be produced by the Health Board providing performance reporting for Cwm Taf Morgannwg University Health Board. This dashboard is the September 2019 iteration, the dashboard wherever possible provides august reporting data.

The dashboard has been redesigned with distinct sections that show performance for Cwm Taf University Health Board (as was), Bridgend and Cwm Taf Morgannwg University Health Board.

For ease of reading the following terms have been used:

Cwm Taf University Health Board	has been referred to as "CT"
Bridgend	has been referred to as Bridgend or "B"
Cwm Taf Morgannwg University Health Board	has been referred to as "CTM"

The nomenclature N/A is used to show that data is "not available"

The following colour coding has been used for graphical representation where possible:

CT	Light Blue
CTM	Dark Blue (Corporate Blue)
Wales	Red
Bridgend	Green

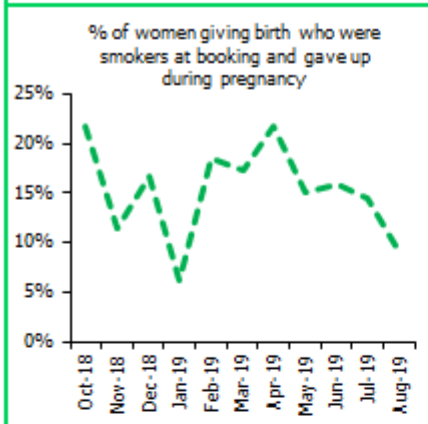
Performance Data

Where performance data is available for CT, B and/or CTM this has been incorporated into this dashboard, where data is not currently available or as yet, not reported, this has been highlighted within the appropriate section. As far as is possible data for Bridgend has been quality assured, however, data should be used with due caution.

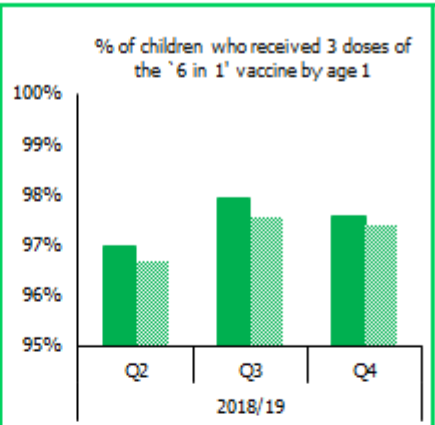
Table of Contents

STAYING HEALTHY – People in Wales are well informed and supported to manage their own physical and mental health

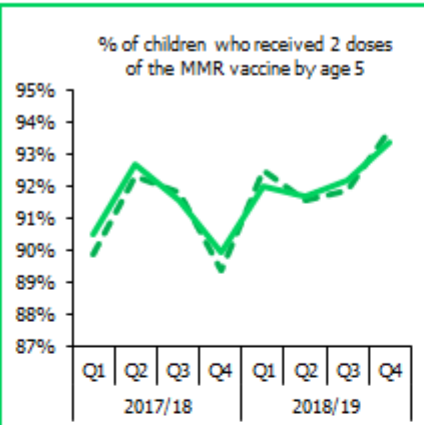
Key: Cwm Taf Morgannwg — **Cwm Taf** - - - **or** **Bridgend**



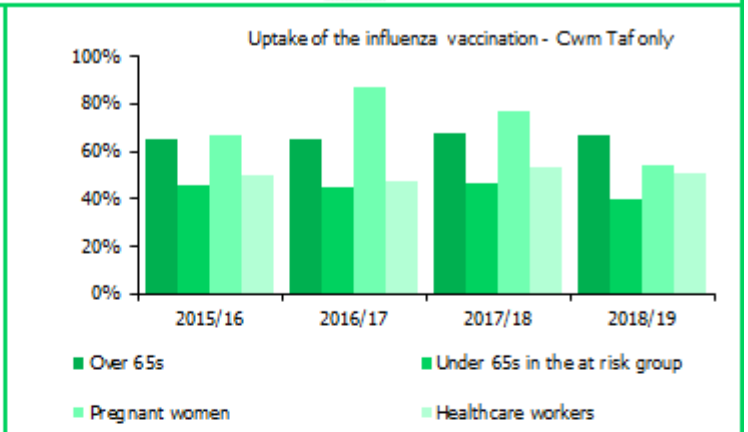
Current Position		
CT	B	CTM
8.93%	N/A	N/A



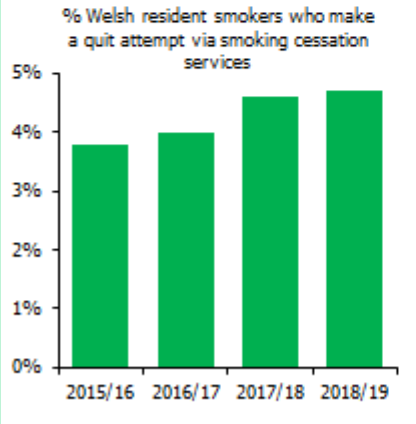
Current Position		
CT	B	CTM
97.6%	97.4%	N/A



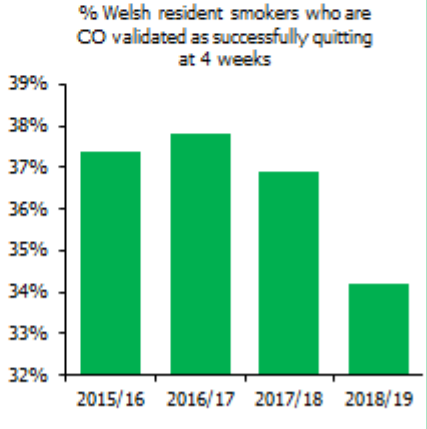
Current Position		
CT	B	CTM
93.8%	92.5%	93.4%



Current Position	CT	B	CTM
Over 65's	67.1%	69.4%	67.9%
Under 65's at risk group	40.0%	41.0%	40.3%
Pregnant women	54.0%	N/A	N/A
Healthcare workers	50.9%	N/A	N/A



Current Position		
CT	B	CTM
4.7%	N/A	N/A



Current Position		
CT	B	CTM
34.2%	N/A	N/A

Indicator 1: Of those women who had their initial assessment and gave birth within the same health board, the percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks of pregnancy)

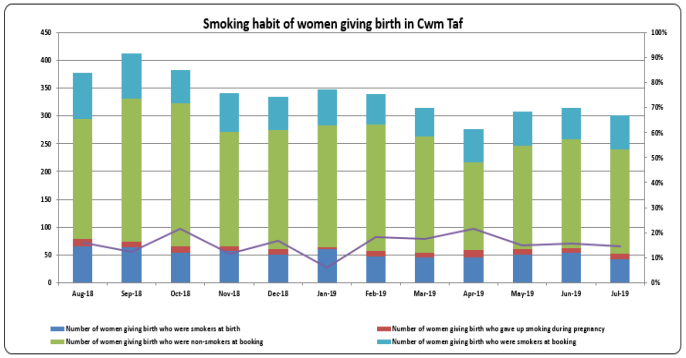
Outcome: My children have a good healthy start in life	Executive Lead: Director of Public Health
Period: Aug 2018 to July 2019	Target: Annual Improvement

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

How are we doing?

- Progress is continuing in relation to the work being undertaken to address the challenges of smoking in pregnancy within CTUHB in line with reducing the low birth weight and the more recent 1000 lives campaign to reduce the stillbirth rate continues to be a priority going forward in particular the universal offer of CO readings at booking.
- MAMSS (Models for Access to Maternal Smoking Cessation Support) MAMSS is now a core service for the whole of Cwm Taf run by two WTE MWSs – MAMSS is not yet in Bridgend – smokers continue to be referred on opt out basis as per NICE PH26 guidance.
- We are currently working 1000 carrying out tests of change to improve the service. this will be ongoing for the next year at least
- Plans are underway to incorporate smoking cessation on mandatory maternity and obstetric updates and also for make every contact count training and brief intervention training mandatory across directorate starting April 2020

What actions are we taking?

- The Families' First project plan was not approved 2018/19 and also funding from Flying start Merthyr was not renewed for 2019-20 however, all areas in Cwm Taf now have access to MAMSS smoking cessation support.
- CO monitoring is now being carried out on all women at each "routine" antenatal appointment and also if a woman attends the Day Assessment Unit (DAU) with a view to readdressing smoking in pregnancy (MECC) and ensuring the safety of our pregnant women with regards to Carbon monoxide that they are being unknowingly exposed to.
- PHW continue to explore other funding streams to assist with expansion of service to the new area of our Health Board.
- Awaiting collaboration of Bridgend smoking cessation data and service information.

What are the areas of risk?

- Cessation of services that have proven improved health outcomes for the women and their unborn/babies.
- Two tiered smoking cessation service in CTMUHB maternity service.

Benchmarking: how do we compare?

	ABMU	AB	BCU	C&V	HDd	Powys
2017/18	4.40%	63.50%	7.40%	18.50%	21.90%	31.30%
2016/17	4.80%	46.00%	10.70%	21.40%	26.80%	10.30%
2015/16	4.70%	32.70%	15.80%	7.10%	69.20%	2.90%

	CT	Morgannwg	CTM			Wales
2017/18	26.50%					27.10%
2016/17	25.10%					23.70%
2015/16	25.00%					22.90%

% of women giving birth who were smokers at booking and gave up during pregnancy

	CT	B	CTM
Aug-18	15.85%		
Sep-18	12.35%		
Oct-18	21.67%		
Nov-18	11.43%		
Dec-18	16.67%		
Jan-19	6.15%		
Feb-19	18.52%		
Mar-19	17.31%		
Apr-19	21.67%		
May-19	15.00%		
Jun-19	15.79%		
Jul-19	14.52%		

Source: Local: MITS Team/Information Team

Indicator 2: Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1
Indicator 3: Percentage of children who received 2 doses of the MMR vaccine by age 5

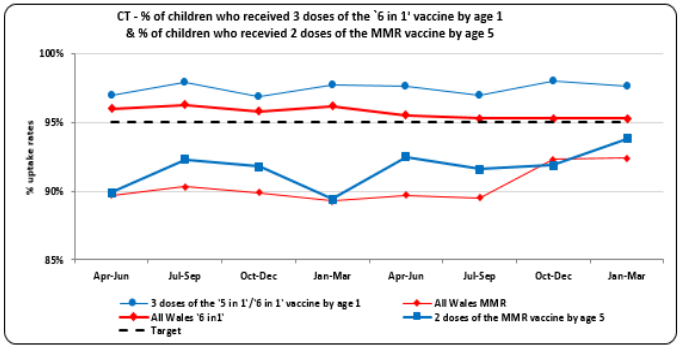
Outcome: My children have a good healthy start in life	Executive Lead: Director of Public Health
Period: Q1 2017/18 – Q4 2018/19	Target: 95%

Current Performance:

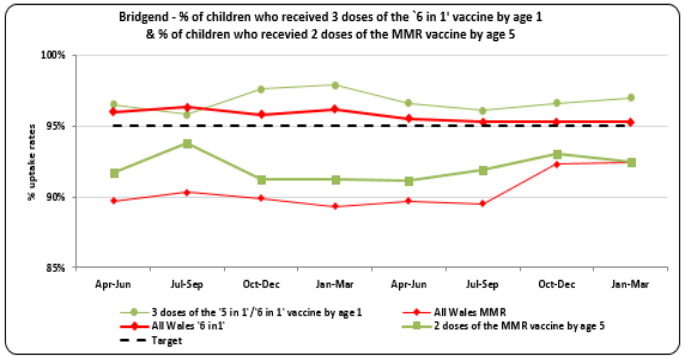
Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend



How are we doing, what actions are we taking?

How are we doing?
Indicator 2: Uptake for CTUHB during Jan-Mar 2019 97.6% remains above target, a 0.40% decrease; was 98.0% during Oct-Dec 2018 (Source: COVER 128 & 129 reports; Note that uptake of pertussis is used as a proxy for the 6 in 1 primary at 1 year).

Indicator 3: Uptake for CTUHB during Jan-Mar 2019 93.8% remains below target despite a 1.9% increase; was 91.9% during Oct-Dec 2018 (Source: COVER 128 & 129 reports).

*Note: WHC (2017) 039 introduced the hexavalent ("6 in 1") vaccine, adding hepatitis B into the routine immunisation schedule, for babies born on or after 1 August 2017.

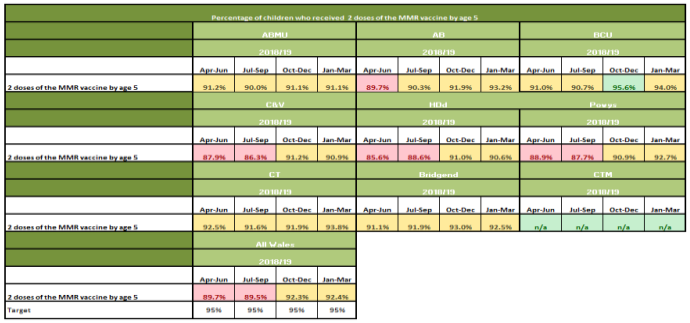
What actions are we taking?
Pilot Sept-March 2019 - Missed 2 immunisation appointments documentation is being highlighted to Health Visiting Service from Child health to improve uptake in children who have incomplete immunisations up to age 5. Plans for a focus group to meet to look at time scales: 1. That health visitors need to respond by, 2. For the pilot's completion/point of evaluation.

The School Nursing service has plans to devise a letter to send to parents at the school entry health review (4 years old rising 5) where immunisations are outstanding, particularly MMR.

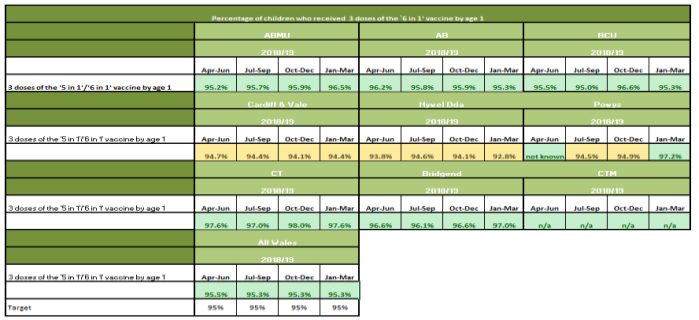
Child Health printing off lists of children with incomplete immunisations status by age 5. Lists are being sent to Health visitors and GPs.

What are the areas of risk?
Potential of outbreaks in local area if stats remain below 95% target
Confirmed outbreak of Mumps in England by PHE (March 2019)
Confirmed outbreak of Mumps in Cardiff by PHW (April 2019 – BBC Wales News)

Benchmarking: how do we compare?



Percentage of children who received 2 doses of the MMR vaccine by age 5												
	ABMU				AB				BCU			
	2018/19				2018/19				2018/19			
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
2 doses of the MMR vaccine by age 5	91.2%	90.0%	91.1%	91.1%	89.7%	90.3%	91.9%	93.2%	91.0%	90.7%	95.6%	94.0%
	CAV				HDd				Powys			
	2018/19				2018/19				2018/19			
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
2 doses of the MMR vaccine by age 5	87.9%	86.3%	91.2%	90.9%	85.6%	88.6%	91.0%	90.6%	88.9%	87.7%	90.9%	92.7%
	CT				Bridgend				CTM			
	2018/19				2018/19				2018/19			
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
2 doses of the MMR vaccine by age 5	92.5%	91.6%	91.9%	93.8%	91.1%	91.9%	93.0%	92.5%	n/a	n/a	n/a	n/a
	All Wales											
	2018/19											
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar								
2 doses of the MMR vaccine by age 5	89.7%	89.5%	92.3%	92.4%								
Target	95%	95%	95%	95%								



Percentage of children who received 3 doses of the '6 in 1' vaccine by age 1												
	ABMU				AB				BCU			
	2018/19				2018/19				2018/19			
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
3 doses of the '5 in 1'/'6 in 1' vaccine by age 1	95.2%	95.7%	95.9%	96.5%	96.2%	95.8%	95.9%	95.3%	95.5%	95.0%	96.6%	95.3%
	Cardiff & Vale				Hywel Dda				Powys			
	2018/19				2018/19				2018/19			
3 doses of the '5 in 1/6 in 1' vaccine by age 1	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
	94.7%	94.4%	94.1%	94.4%	93.8%	94.6%	94.1%	92.8%	not known	94.5%	94.9%	97.2%
	CT				Bridgend				CTM			
	2018/19				2018/19				2018/19			
3 doses of the '5 in 1/6 in 1' vaccine by age 1	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
	97.6%	97.0%	98.0%	97.6%	96.6%	96.1%	96.6%	97.0%	n/a	n/a	n/a	n/a
	All Wales											
	2018/19											
3 doses of the '5 in 1/6 in 1' vaccine by age 1	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar								
	95.5%	95.3%	95.3%	95.3%								
Target	95%	95%	95%	95%								

How do we compare with our peers?

- Indicator 2: Uptake was 95.3% for Wales during Jan-Mar 2019 compared to 97.6% for CTUHB.
- Indicator 3: Uptake was 92.4% for Wales during Jan-Mar 2019 compared to 93.8% for CTUHB.

For both indicators Cwm Taf is above the Welsh Average.

Source: Public Health Wales Health Protection Division: http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=54144

Indicator 5: Uptake of the influenza vaccination among: (a) 65 year olds and over; (b) under 65s in risk group; (c) pregnant women; (d) health care workers

Outcome: I am healthy and active and do the things to keep myself healthy	Executive Lead: Director of Public Health			
Period: Seasons 2015/16 – 2018/19	Target: (a) 75%	(b) 55%	(c) 75%	(d) 60%

Current Performance:

Cwm Taf Morgannwg

See table below

Cwm Taf

Uptake of influenza vaccination a	CT	M	CTM	All Wales
	2019/20			
	as at 24 April 2019			
Over 65s	67.1%	69.4%	67.9%	68.2%
Under 65s in the at risk group	40.0%	41.0%	40.3%	44.0%
Pregnant women*				
Healthcare workers**				
No of pregnant women immunised	1006			

Bridgend

See table above

How are we doing, what actions are we taking?

Cwm Taf Primary Care - as at 24 April 2019
Uptake in those 65 years and older in CTUHB was 67.1% (68.2% Wales average). Uptake in those under 65 years with clinical risk in CTUHB was 40.0% (44.0% Wales average) (*see note 1*)
Cwm Taf Staff Uptake among staff with direct patient contact (*to end of Mar 19*) was 50.9% (55.0% Wales average). Uptake among total staff (*to end of February 2019*) was 48.0% (53.4% Wales average).

What actions are we taking?

- Distinction between strategic and operational immunization groups, and separation of community and staff flu plans should improve oversight and engagement.
- Fluenz pilot from 2016/17 to vaccinate 3 year olds within LA nursery schools instead of by GP's increased uptake; an evaluation of 2017/18 season is underway. Pilot programme has continued for 2018/19 while awaiting evaluation.
- Communication to practices that Fluenz is available to from hospital pharmacy in CTUHB.
- Continue to promote 'It's not too late to be vaccinated',
- Learning from the 2017/18 staff campaign will be incorporated into an updated staff flu plan for 2018/19.
- Staff Flu vaccination workshop planned for May 2019 to evaluate the 2018/19 programme and plan for 2019/20, further engaging with members of the Board and Senior Managers.
- An enhanced service for vaccinating care home staff is now in place.
- GP practices and clusters are now receiving personalised reports to incentivise further uptake efforts.
- Facilitation of vaccine transfer between practices to enable practices who have run out of to continue vaccinating where there is need.
- 36 peer vaccinators have been trained to undertake staff flu vaccinations in the areas of work.
- The Immunisation Team have collaborated with Public Health to ensure Peer Vaccinators and staff flu are incorporated into as many IMTP plans in the health board as possible
- An incentive has been agreed and is in use so that staff received a voucher for a free tea/coffee in the HB, a pen and a lanyard when they have their flu vaccination.
- Occupational Health have extra funding to input staff flu data onto Cohort (50% of forms were not on their system when first figures sent to PHW).
- Communication to staff in a variety of formats that it's not too late to be vaccinated including posters and intranet comms.

Benchmarking: how do we compare?

	ABMU			AB			BCU		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Over 65s	64.6%	65.0%	68.2%	67.7%	68.1%	69.8%	68.7%	68.7%	70.6%
Under 65s in the at risk group	43.4%	43.7%	46.7%	49.4%	49.7%	50.8%	49.3%	49.3%	51.6%
Pregnant women*	44.1%	81.5%	93.3%	43.7%	69.8%	72.5%	50.3%	75.3%	65.2%
Healthcare workers**	54.6%	57.4%	58.5%	41.4%	52.1%	58.0%	43.2%	50.3%	55.1%
No of pregnant women immunised	1980	1851	1911	2476	5422	2621	3673	3579	3878

	C&V			HDda			Powys		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Over 65s	68.9%	69.0%	71.0%	63.9%	63.4%	65.0%	64.3%	63.9%	66.3%
Under 65s in the at risk group	48.3%	48.3%	49.0%	43.2%	42.3%	42.9%	44.2%	46.0%	47.9%
Pregnant women*	51.8%	87.2%	77.2%	42.7%	87.5%	54.8%	53.5%	85.7%	100.0%
Healthcare workers**	46.8%	53.0%	64.7%	52.8%	47.0%	60.6%	60.1%	64.0%	65.4%
No of pregnant women immunised	2602	2659	2614	1278	1208	1265	643	617	647

	CT			Morgannwg			CTM		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Over 65s	65.0%	64.9%	67.7%						
Under 65s in the at risk group	45.9%	45.2%	46.8%						
Pregnant women*	66.7%	57.4%	69.8%						
Healthcare workers**	50.4%	47.2%	53.1%						
No of pregnant women immunised	1003	971	986						

	All Wales		
	2015/16	2016/17	2017/18
Over 65s	66.6%	66.7%	68.8%
Under 65s in the at risk group	46.9%	46.9%	48.5%
Pregnant women*	47.1%	76.8%	72.7%
Healthcare workers**	47.3%	51.5%	57.9%
No of pregnant women immunised	13655	13410	13922

Cwm Taf's position is comparable with peers.

What are the areas of risk?

- Persisting myths around immunisation in the community.
- Delay in Delivery of QIV vaccine and staggered deliveries of aTIV
- Capacity within primary care to increase vaccination uptake.
- Attaining the increased 60% healthcare worker target for 2019/20 represents an additional challenge requiring high levels of directorate support.

Source: Public Health Wales Health Protection Division: http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=34338 http://nww.immunisation.wales.nhs.uk/ct-ivor http://nww.immunisation.wales.nhs.uk/ct-gp-flu)

Indicator 6: The percentage of adult smokers who make a quit attempt via smoking cessation services

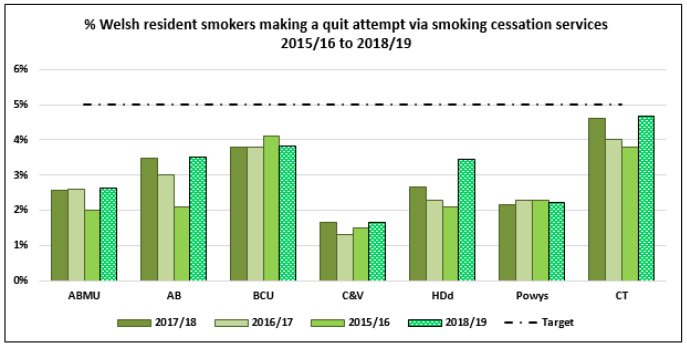
Outcome: I am healthy and active and do the things to keep myself healthy	Executive Lead: Director of Public Health
Period: 2018/19	Target: 5% Annual Target

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

How are we doing?
Data pertaining to Welsh resident smokers making a quit attempt via smoking cessation is available on a quarterly basis.

The number of Welsh resident smokers treated by smoking cessation services during 2017/18 was 14,783 with an estimated number of Welsh resident smokers standing at 476,057 giving an estimated All Wales percentage of 3.11%. The equivalent figures for Cwm Taf were 2,325 of 50,413 i.e. 4.61%. To achieve 5% during 2018/19 we required 2,500 smokers to be treated via the range of available cessation services. Provisional available data to Quarter 1-4 shows a total of 2,376 treated smokers via the following cessation services:

Stop Smoking Wales – 476
Level 3 Community Pharmacy – 1659
MAMSS – 157
Secondary Care Service – 84

(Figures for Q4 are provisional and therefore not included in the table)

Data for Quarter 1 of 2019/20 will be available in October 2019, and will include data for the Bridgend area.

What actions are we taking?
Information on the process of referral into Help Me Quit has been sent to all General Dental Practices in the former Cwm Taf boundary area. This will be extended to the Bridgend area in the near future.

Work is underway with optometry to raise awareness of the options available for clients who smoke, linked to National Eye Health week in September. The optical advisor for the health board is working with the public health team to develop this information.

What are the areas of risk?

Benchmarking: how do we compare?

% Welsh resident smokers who make a quit attempt via smoking cessation services						
	ABMU	AB	BCU	C&V	HDd	Powys
2018/19	2.6%	3.5%	3.8%	1.7%	3.4%	2.2%
2017/18	2.6%	3.5%	3.8%	1.7%	2.7%	2.2%
2016/17	2.6%	3.0%	3.8%	1.3%	2.3%	2.3%
2015/16	2.0%	2.1%	4.1%	1.5%	2.1%	2.3%
Target	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
	CT	Bridgend	CTM			Wales
2018/19	4.7%					3.2%
2017/18	4.6%					3.1%
2016/17	4.0%					
2015/16	3.8%					
Target	5.0%	5.0%	5.0%			

How do we compare with our peers?
To the end of Q3 the number of residents making a quit attempt exceeded all other Health Boards in Wales.

Source: Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 7: The percentage of those smokers who are CO-validated as quit at 4 weeks

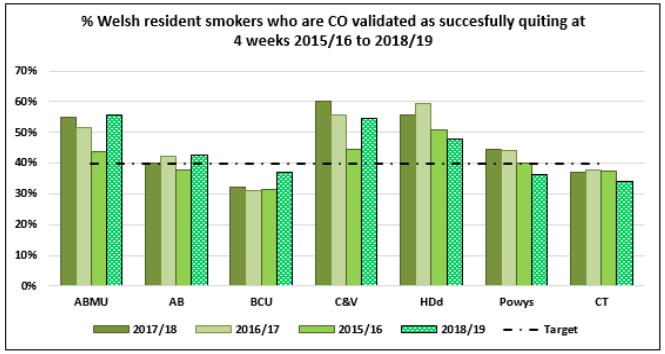
Outcome: I am healthy and active and do the things to keep myself healthy	Executive Lead: Director of Public Health
Period: 2018/19	Target: 40% Annual Target

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

How are we doing?
Data pertaining to Welsh resident smokers CO-validated as quit at 4 weeks is available on a quarterly basis. For quarters 1-4 of 2018/19 average Cwm Taf CO validation rates are 34.2% (provisional).

Data for Quarter 1 of 2019/20 will be available in October 2019, and will include data for the Bridgend area.

What actions are we taking?
Continue to reinforce Russell Standards for the timeline of capturing data, and reporting on four week CO validated quits.

Benchmarking: how do we compare?

% Welsh resident smokers who are CO validated as successfully quitting at 4 weeks (target 40% end of financial year)

	ABMU	AB	BCU	C&V	HDd	Powys
2018/19	55.7%	42.6%	37.0%	54.6%	47.9%	36.4%
2017/18	54.8%	40.1%	32.4%	60.3%	55.6%	44.4%
2016/17	51.6%	42.3%	31.1%	55.8%	59.4%	44.0%
2015/16	43.9%	37.8%	31.3%	44.6%	51.0%	40.1%
Target	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%

	CT	Bridgend	CTM			Wales
2018/19	34.2%					
2017/18	36.9%					
2016/17	37.8%					
2015/16	37.4%					
Target	40.0%	40.0%	40.0%			

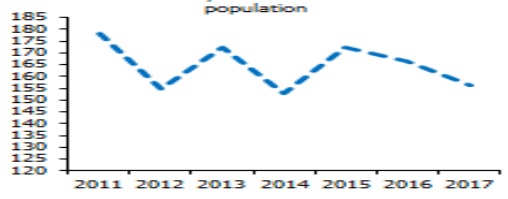
How do we compare with our peers?
Collectively, for all services, the Health Board's performance for 2018/19 is currently below the all Wales Target of 40%, but is near to achieving NICE guidance of 35% (NG92).

Source: Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

SAFE CARE – People in Wales are protected from harm and are supported to protect themselves from known harm

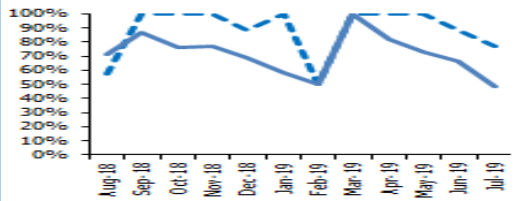
Key: Cwm Taf Morgannwg —— **Cwm Taf** - - - **or** ■ **Bridgend** ■ **N/A - data not currently available**

Amenable mortality per 100,000 of the European standardised population



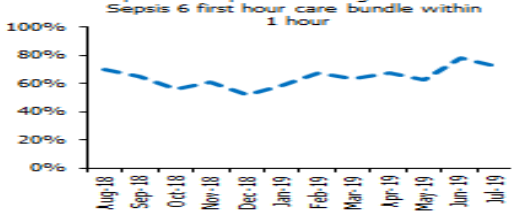
Current Position		
CT	B	CTM
156	N/A	N/A

% in-patients with positive sepsis screening received Sepsis 6 first hour care bundle within 1 hour



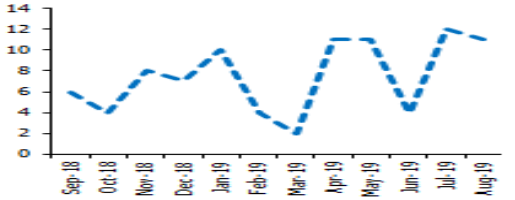
Current Position		
CT	B	CTM
76.9%	N/A	48.8%

% patients presented at ED with positive sepsis screening received Sepsis 6 first hour care bundle within 1 hour



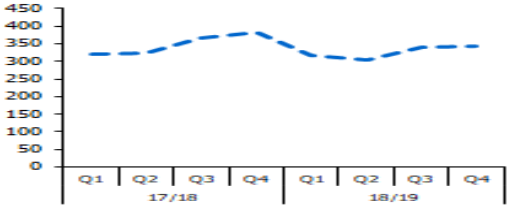
Current Position		
CT	B	CTM
72.9%	N/A	73%

Number of potentially hospital acquired thromboses



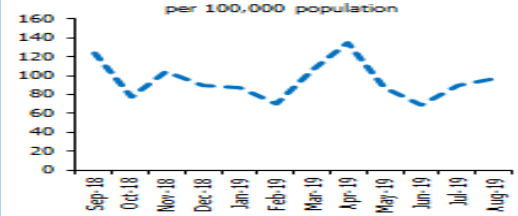
Current Position		
CT	B	CTM
11	N/A	N/A

Total antibacterial items per 1,000 STAR-PUs



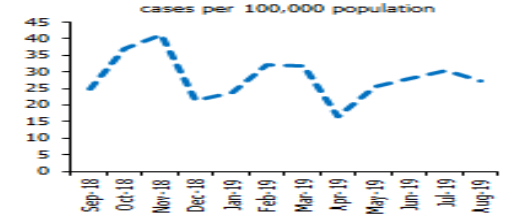
Current Position		
CT	B	CTM
339.3	N/A	N/A

Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population



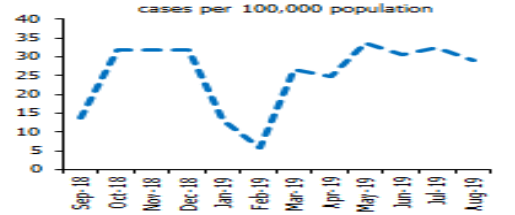
Current Position		
CT	B	CTM
N/A	N/A	96.72

Cumulative rate of laboratory confirmed S.aureus bacteraemia cases per 100,000 population



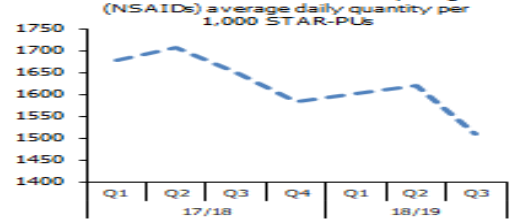
Current Position		
CT	B	CTM
N/A	N/A	27.4

Cumulative rate of laboratory confirmed C.difficile bacteraemia cases per 100,000 population



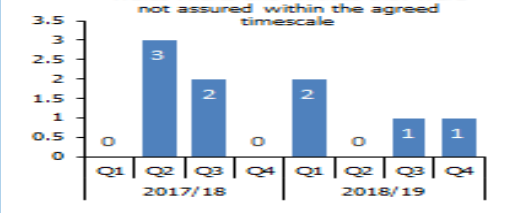
Current Position		
CT	B	CTM
N/A	N/A	29.02

Non steroid anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-PUs



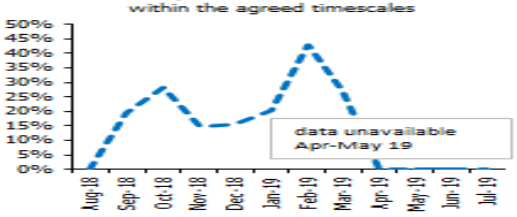
Current Position		
CT	B	CTM
1511	N/A	N/A

Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale



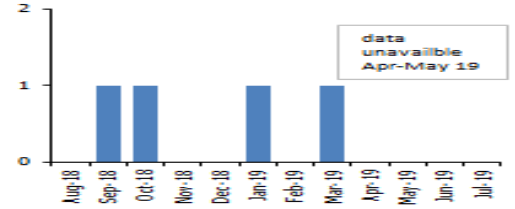
Current Position		
CT	B	CTM
1	N/A	N/A

Of the serious incidents due for assurance, the % which were assured within the agreed timescales



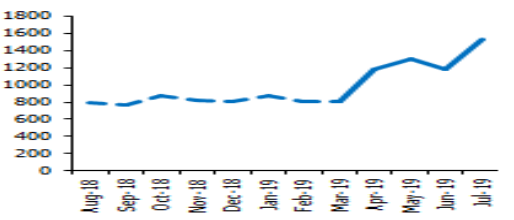
Current Position		
CT	B	CTM
N/A	N/A	2.9%

Number of new never events



Current Position		
CT	B	CTM
N/A	N/A	0

Total Incidents recorded



Current Position		
CT	B	CTM
N/A	N/A	1534

Indicator 12: Amenable mortality per 100,000 of the European standardised population

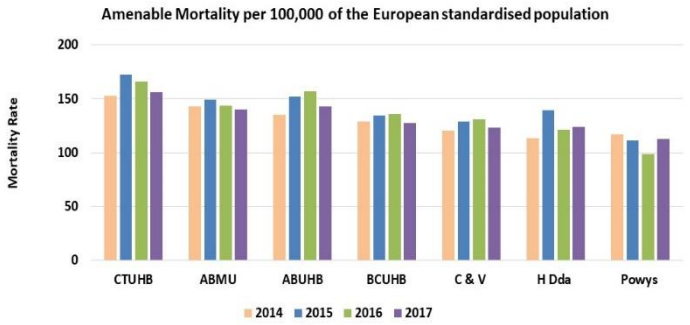
Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Medical Director
Period: 2014 to 2017	Target: Annual Reduction

Current Performance:

Cwm Taf Morgannwg

Not currently available

Cwm Taf



Bridgend

Not currently available

How are we doing, what actions are we taking?

	Amenable Mortality per 100,000 of the European standardised population - Annual Reduction						
	CTUHB	ABMU	ABUHB	BCUHB	C & V	H Dda	Powys
2017	156.0	139.9	142.9	127.2	122.9	124.1	112.7
2016	166.4	143.9	156.6	135.6	130.9	121.3	98.9
2015	172.1	149.0	152.0	134.7	129.0	139.6	111.4
2014	152.9	143	135.5	128.8	120.5	113.3	116.8

The Health Board continues to improve process around mortality to ensure improving performance.

Benchmarking: how do we compare?

Mortality Indicator : Avoidable, Amenable and Preventable Mortality

Causes of death considered avoidable, amenable & preventable, European age-standardised rate (EASR) per 100,000, persons, Wales, 2015-2017

Area of usual residence	Avoidable		Amenable		Preventable	
	Deaths (annual average)	EASR	Deaths (annual average)	EASR	Deaths (annual average)	EASR
WALES	**8,041.3**	**253.5**	**4360.7**	**136.6**	**6729.0**	**212.4**
Isle of Anglesey	187.3	229.2	102.0	122.7	154.3	189.8
Gwynedd	308.3	236.9	160.3	123.9	252.0	193.9
Conwy	355.7	257.4	187.0	135.2	299.3	216.4
Denbighshire	274.3	256.2	150.3	138.5	233.3	218.0
Flintshire	391.7	240.9	210.0	127.0	334.3	206.2
Wrexham	359.7	265.7	193.3	141.1	302.7	223.9
Powys	320.7	200.6	172.0	105.6	272.3	171.4
Ceredigion	177.3	218.8	97.7	119.2	148.7	182.5
Pembrokeshire	327.3	229.7	178.0	121.1	280.3	197.7
Carmarthenshire	510.0	248.3	281.0	133.2	438.0	214.0
Swansea	640.0	272.9	331.0	141.5	548.3	233.8
Neath Port Talbot	431.7	293.7	224.7	150.9	371.7	253.1
Bridgend	376.3	260.1	203.3	138.3	317.3	220.1
The Vale of Glamorgan	276.3	205.4	142.7	105.3	224.7	167.0
Cardiff	691.0	249.8	375.3	138.7	564.0	203.2
Rhondda, Cynon, Taff	677.3	291.1	384.0	163.5	549.7	236.9
Merthyr Tydfil	175.3	304.1	95.3	163.8	142.3	247.6
Caerphilly	501.7	280.8	285.0	157.3	413.3	232.1
Blaenau Gwent	214.0	302.0	127.0	177.2	175.7	248.4
Torfaen	249.3	267.5	133.0	142.0	213.3	228.9
Monmouthshire	219.0	204.4	117.7	108.3	187.0	174.3
Newport	377.0	276.9	210.0	155.0	306.3	225.4

Avoidable, amenable & preventable mortality are classified according to ONS definitions;
amenable (treatable) mortality - deaths that could be avoided through timely and effective healthcare
preventable mortality - deaths that could be avoided by public health interventions
avoidable mortality – deaths that are amenable, preventable or both, where each death is counted only once

Source: Office for National Statistics
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2017

Across the seven Welsh Health Boards, Cwm Taf had the highest rate of amenable mortality during 2017 although a reduction has been seen from 2015, while Powys Teaching Health Board had the lowest.

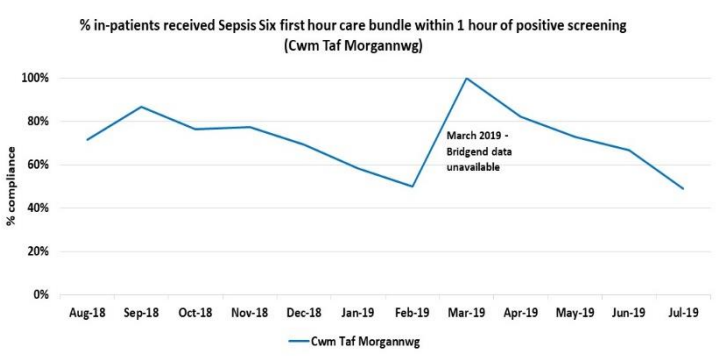
Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/avoidablemortalitybyclinicalcommissioninggroupsinenglandandhealthboardsinwales

Indicator 13: Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening

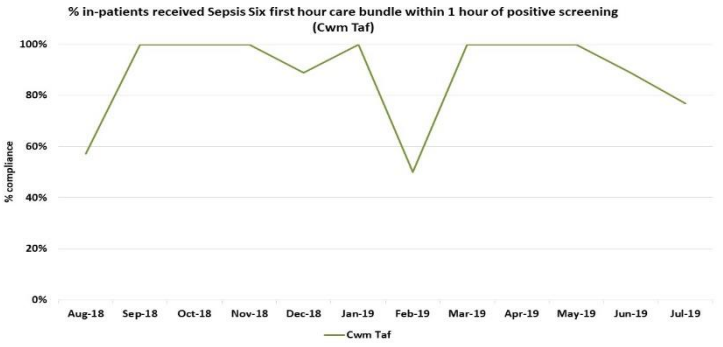
Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Medical Director
Period: Aug 2018 to Jul 2019	Target: 12 month improvement trend

Current Performance:

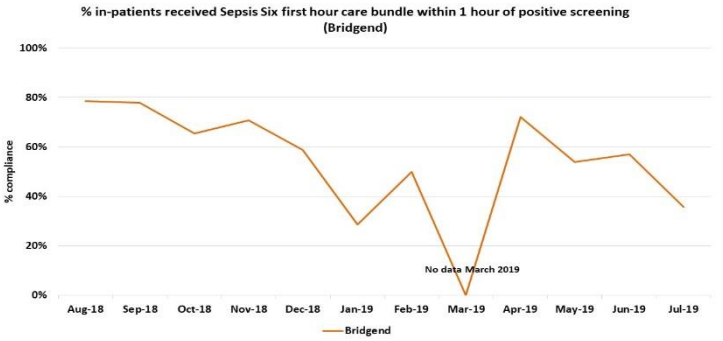
Cwm Taf Morgannwg



Cwm Taf



Bridgend



How are we doing, what actions are we taking?

Sepsis compliance metrics are reported to Welsh Government on a monthly basis. Outreach input is now a formal part of the doctor and nurse orientation programme.

Outreach team continue to promote the work of the RRAILS and AKI groups to improve patient safety and care and there is now 24/7 cover for the whole Health Board. Suspicion of infection leads to sepsis screening and delivery of sepsis 6 of which compliance is measured by the Outreach team.

There is a well-attended multi-disciplinary quarterly group engaged with the national programme.

Working with maternity to produce sepsis guideline and working with District Nursing team to provide NEWS charts and observation equipment.

Education of all frontline HCPs via a mix of induction, rolling programmes and ward based targeted training.

Establishment of DRIPS meetings in both ED's to regularly review response to acute deterioration.

Risks are:

- Engagement of staff who are increasingly finding difficulty in being released from clinical areas for training.
- Outreach team has no capacity to provide teaching when clinical areas take priority.

Benchmarking: how do we compare?

% of inpatients with a positive sepsis screening who have eceived all elements of the Sepsis Six first hour care bundle within one hour of positive screening

	CTUHB	ABUHB	BCUHB	C & V	H Dda	ABMU
May-18	100.0%	50.0%		N/A		27.9%
Jun-18	83.3%	61.3%	100.0%	68.8%	93.9%	16.3%
Jul-18	100.0%	61.1%				36.9%
Aug-18	57.1%	32.3%	100.0%	61.3%	90.3%	18.3%
Sep-18	100.0%			N/A		
Oct-18	100.0%	42.4%	100.0%	77.8%	100.0%	57.1%
Nov-18	100.0%			N/A		
Dec-18	88.9%	52.6%	100.0%	71.4%	84.6%	52.6%
Jan-19	100.0%			N/A		
Feb-19	50.0%	N/A	100.0%	50.0%	93.1%	42.9%
Mar-19	100.0%	66.7%	100.0%	85.7%	86.4%	42.9%
	CTM	AB	BC	C & V	H Dda	SB
Apr-19	82.1%	54.8%	100.0%	68.8%	92.3%	0.0%
May-19	72.7%			not available		
Jun-19	66.7%	61.9%	100.0%	100.0%	94.1%	25.0%

note: not all hospitals/wards may be included in the data supplied by health boards

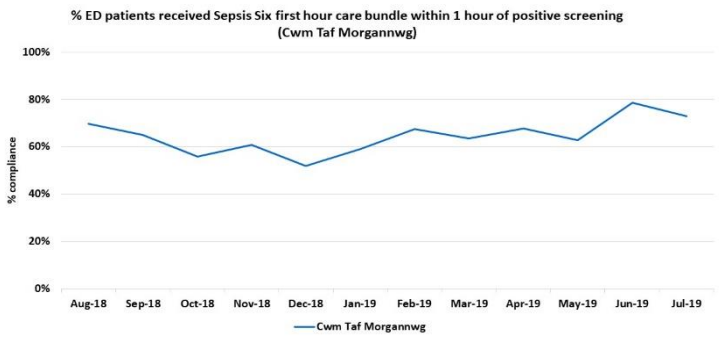
Source: Local Clinical Audit

Indicator 14: Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening

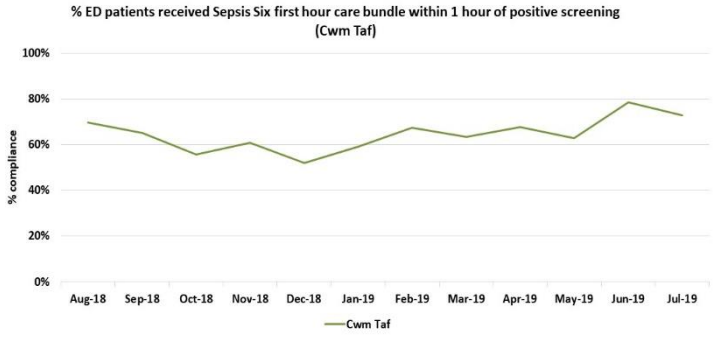
Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Medical Director
Period: Aug 2018 to Jul 2019	Target: 12 month improvement trend

Current Performance:

Cwm Taf Morgannwg:
please note POW do not currently collate data in ED



Cwm Taf



Bridgend

Data not currently collated by Princess of Wales Hospital Emergency Department

How are we doing, what actions are we taking?

Sepsis compliance metrics are reported to Welsh Government on a monthly basis. Outreach input is now a formal part of the doctor and nurse orientation programme.

Outreach team continue to promote the work of the RRAILS and AKI groups to improve patient safety and care and there is now 24/7 cover for the whole Health Board. Suspicion of infection leads to sepsis screening and delivery of sepsis 6 of which compliance is measured by the Outreach team.

There is a well-attended multi-disciplinary quarterly group engaged with the national programme.

Working with maternity to produce sepsis guideline and working with District Nursing team to provide NEWS charts and observation equipment.

Education of all frontline HCPs via a mix of induction, rolling programmes and ward based targeted training.

Establishment of DRIPS meetings in both ED's to regularly review response to acute deterioration.

What are the areas of risk?
Engagement of staff who are increasingly finding difficulty in being released from clinical areas for training.

Outreach team has no capacity to provide teaching when clinical areas take priority.

Benchmarking: how do we compare?

% of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the `Sepsis Six' first hour care bundle within one hour of positive screening

	CTUHB	ABUHB	BCUHB	C & V	H Dda	ABMU
May-18	51.4%	61.7%		N/A		58.0%
Jun-18	61.6%	62.4%	29.7%	61.6%	95.5%	34.2%
Jul-18	64.7%	66.7%	N/A		N/A	43.8%
Aug-18	69.6%	59.8%	39.6%		91.6%	36.4%
Sep-18	65.0%				N/A	N/A
Oct-18	55.8%	69.0%	71.4%		95.0%	75.0%
Nov-18	60.9%	N/A	N/A	N/A	N/A	
Dec-18	52.0%	65.3%	63.8%		94.2%	
Jan-19	59.0%	N/A	N/A			N/A
Feb-19	67.4%		48.6%		87.9%	
Mar-19	63.5%	57.3%	64.9%		88.2%	
	CTM	AB	BC	C & V	H Dda	SB
Apr-19	67.7%	58.7%	66.2%	N/A	90.7%	N/A
May-19	62.7%	not available				
Jun-19	78.6%	58.3%	44.8%	N/A	89.2%	N/A

note: C&V and Swansea Bay no longer supply data. Not all hospitals/wards may be included in the data supplied by health boards

Source: Local Clinical Audit

Indicator 15: The number of potentially preventable hospital acquired thrombosis

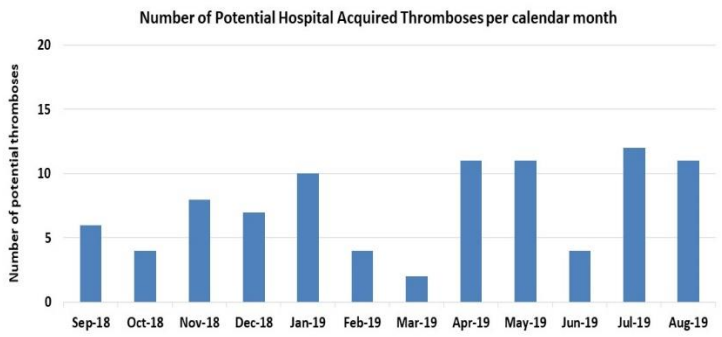
Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Medical Director
Period: 2017/18 to Qtr. 3 2018/19	Target: 4 Quarter Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf – Number of potential hospital acquired thromboses



Bridgend

Data not currently available

How are we doing, what actions are we taking?

The pharmacy team continue to hold awareness and training sessions as well as a continuation of a number of improvement projects.

VTE risk assessment compliance is monitored via monthly Pharmacy audits with immediate feedback provided to the Ward Sister.

The RCAs are informing learning and improvement with regards to prescribing and administration timeliness.

Qlik Sense App developed to allow close monitoring of potential HATs.

Clinical Directors with MDTs to ensure completion of the VTE risk assessments and prophylaxis, prescribing and administration as per local guidelines. To monitor via local Quality and Safety meetings and feedback learning to the VTE Steering group.

The Clinical Audit Facilitator who has taken responsibility for the management of the VTE/HAT process is establishing meetings with the lead clinicians to review all HAT cases.

Benchmarking: how do we compare?

Number of potentially preventable hospital acquired thromboses (HAT) - 4 quarter	2018/19			2017/18			
	Q1	Q2	Q3	Q1	Q2	Q3	Q4
Cwm Taf	0	2	1	5	4	4	1
Abertawe Bro Morgannwg	0	3	2	1	2	2	0
Aneurin Bevan	4	0	2	6	3	3	3
Betsi Cadwaladr	4	2	0	5	0	0	2
Cardiff & Vale	2	0	3	0	6	6	0
Hywel Dda	6	2	8	1	2	2	3
Powys	0	0	0	0	0	0	0

Source: Local Clinical Audit/Local Information Team

Indicator 16: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)

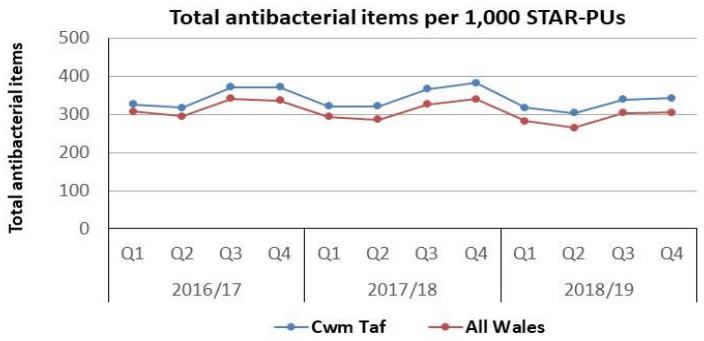
Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Director of Primary, Community and Mental Health
Period: 2016/17 to 2018/19	Target: 4 Quarter Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

CTMUHB have the highest prescribing rates of antimicrobials in primary care in Wales. However CTMUHB have introduced prescribing guidelines to improve the choice of antimicrobials prescribed and this has demonstrated improvement e.g. compliance with the new primary care UTI treatment guidelines is good with current audited practices achieving around 70% compliance.
Recent data in FY 2018 has shown a reduction in the volume of prescribing of both total antibiotics, and specifically broad spectrum antibiotics:

Table MM01: Indicator	2017/18 Quarterly trend	CTUHB Position in Wales (1st = best performing HB)		Cwm Taf change
		March Quarter 2018	March Quarter 2019	June Quarter 2017 v 2018
Antibacterial items per 1,000 PU	▼	7th	7th	-10.8%
4c antimicrobial items per 1,000 patients	▼	7th	7th	-10.9%

CTM have established an Antimicrobial Resistance & Health Care Associated Infection Delivery Group within the HB governance structure. There is an agreed & monitored action plan for both primary and secondary care led and delivered by the antimicrobial pharmacists.

Actions include:
New prescribing guidelines accessible via phone APPs and a quick reference guideline for GPs.
GP practice audits of antimicrobial prescribing with feedback and recommended tailored actions, clinical and public engagement with an outcome of behaviour change via education and training to GPs & community nurses.
Optimise management of urinary tract infection (UTI) in elderly people. Improve hydration of care home residents. Share best practice with carers and health care professionals on appropriate diagnosis of UTI in elderly and catheterised persons. Stop inappropriate antibiotic prophylaxis for UTI.
Develop real time AMR monitoring dashboard with GP practice level data.

Benchmarking: how do we compare?

4 Quarter Reduction Trend		Total antibacterial items per 1,000 STAR-PU's (specific therapeutic group age related prescribing unit)						
		Cwm Taf	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys
2018/19	Q1	**317.1**	307.4	227.8	274.7	263.1	287.9	233.2
	Q2	**303.3**	288.9	263.6	256.9	243.7	266.1	222.3
	Q3	**339.3**	330.7	303.5	289.5	277.3	314	253.1
	Q4	**343.0**	329.6	309.7	292.0	278.5	312.2	260.8
2017/18	Q1	321.1	311.0	294.0	290.0	273.0	297.0	250.0
	Q2	322.0	299.0	287.0	277.0	268.0	293.0	251.0
	Q3	366.0	346.0	331.0	307.0	309.0	335.0	274.0
	Q4	382.9	363.7	339.1	324.7	316.5	353.0	281.7
2016/17	Q1	332.5	340.3	313.2	322.7	290.4	319.3	261.8
	Q2	318.0	310.0	292.0	298.0	273.0	301.0	248.0
	Q3	371.0	356.0	339.0	340.0	315.0	345.0	282.0
	Q4	371.8	348.1	339.0	335.1	311.1	345.3	284.4

For Qtr 4 2018/19, CTUHB are 7th in Wales, however there has been a 14% reduction in the volume of prescribing of antimicrobial items from 2016/17 to 2018/19 in Cwm Taf.

Source: Welsh Government Delivery and Performance Website

Indicator 18: Cumulative rate of laboratory confirmed *E.coli* bacteraemia cases per 100,000 population

Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Director of Nursing
Period: Apr 2019 to Aug 2019	Target: 67 per 100,000 population

Current Performance:

Cwm Taf Morgannwg

Maximum numbers to achieve 2019/20 Financial Year reduction expectation		Current period numbers (Apr to Aug 19)			
Maximum number for FY	<299	432	Actual number for FY		
Maximum average number per month	<25	36	Actual average number per month	Recalculated average monthly number to achieve reduction expectation	<17
Maximum rate/100,000 population	67.00	96.72	Actual rate/100,000 population		
Maximum number for current time period	<125	180	Current period number		

Cwm Taf Morgannwg UHB maximum cumulative monthly numbers of E.coli bacteraemia required to achieve the 2019/20 reduction expectation and provisional cumulative monthly number and rate for Apr-Aug 19

	Maximum cumulative monthly number to achieve reduction expectation	Current cumulative monthly numbers	Difference between maximum and current cumulative monthly numbers	Current cumulative monthly rate/100,000 population
Apr	<25	49	25	134.28
May	<50	82	33	110.51
Jun	<75	107	33	96.67
Jul	<100	141	42	95.02
Aug	<125	180	56	96.72
Sep	<150			
Oct	<175			
Nov	<199			
Dec	<224			
Jan	<249			
Feb	<274			
Mar	<299			

Cwm Taf

Cwm Taf UHB E.coli bacteraemia 2018/19 reduction expectation results

Maximum numbers to achieve 2018/19 FY reduction expectation		Actual 2018/19 FY numbers	
Maximum number for FY	<201	278	Actual number for FY
Maximum average number per month	<17	23	Actual average number per month
Maximum rate/100,000 population	67.00	92.95	Actual rate/100,000 population

Cwm Taf UHB maximum cumulative monthly numbers of E.coli bacteraemia required to achieve the 2018/19 reduction expectation and actual cumulative monthly number and rate

	Maximum cumulative monthly number to achieve reduction expectation	Actual cumulative monthly numbers	Difference between maximum and actual cumulative monthly numbers	Actual cumulative monthly rate/100,000 population
Apr	<17	26	10	105.77
May	<34	48	15	96.03
Jun	<51	72	22	96.56
Jul	<67	93	27	93.03
Aug	<84	121	38	96.52
Sep	<101	147	47	98.03
Oct	<117	165	49	94.10
Nov	<134	189	56	94.53
Dec	<151	211	61	93.64
Jan	<168	236	69	94.12
Feb	<184	253	70	92.44
Mar	<201	278	78	92.95

Bridgend

Data not currently available

How are we doing, what actions are we taking?

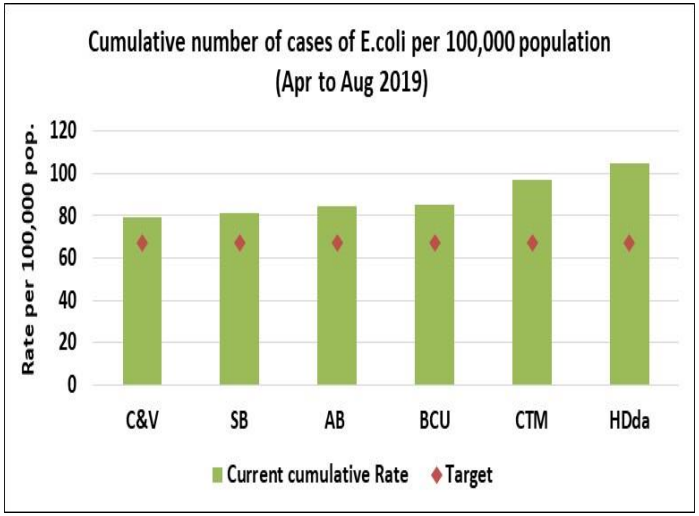
The Cwm Taf Morgannwg UHB 2019/20 reduction expectation for E.coli bacteraemia is to achieve a rate of less than or equal to 67.00 per 100,000 population. This equates to an average of less than 25 E.coli bacteraemia per month and less than 299 for the whole financial year (FY).

5 months into the 2019/20 reduction expectation period, the provisional rate of E.coli bacteraemia in Cwm Taf Morgannwg UHB is 96.72 per 100,000 population. This equates to an average of approximately 36 per month and based on the current trajectory, a total of approximately 432 for the FY. To achieve the 2019/20 reduction expectation the average number of E.coli bacteraemia per month for the remaining 7 months must be less than 17.

The IPC team are discussing all E.coli bacteraemia weekly to identify preventable sources. A collaborative has been formed to identify interventions in primary and secondary care which will support the reduction expectation.

Poor antimicrobial stewardship, poor hand hygiene and poor management of invasive devices.

Benchmarking: how do we compare?



5 months into the 2019/20 reduction expectation period the provisional rate of E. coli bacteraemia in Wales is 84.37 per 100,000 population. This equates to an average of approximately 221 per month. Based on the current trajectory a total of approximately 2657 E.coli bacteraemia cases is projected for the FY. Wales is not currently on target to achieve the 2019/20 reduction expectation. To achieve the 2019/20 reduction expectation the average number of E. coli bacteraemia per month for the remaining 7 months must be less than 143. None of the 6 major health boards are on target to achieve the reduction expectation.

Source: Public Health Wales (WHAIP)

Indicator 19: Cumulative rate of laboratory confirmed *S.aureus* bacteraemia (MRSA & MSSA) cases per 100,000 population

Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Director of Nursing
Period: Apr 2019 to Aug 2019	Target: 20 per 100,000 population

Current Performance:

Cwm Taf Morgannwg

Maximum numbers to achieve 2019/20 Financial Year reduction expectation		Current period numbers (Apr to Aug 19)		
Maximum number for FY	<90	122	Actual number for FY	
Maximum average number per month	<8	10	Actual average number per month	Recalculated average monthly number to achieve reduction expectation: <6
Maximum rate/100,000 population	20.00	27.40	Actual rate/100,000 population	
Maximum number for current time period	<38	51	Current period number	

Cwm Taf Morgannwg UHB maximum cumulative monthly numbers of S. aureus bacteraemia required to achieve the 2019/20 reduction expectation and provisional cumulative monthly number and rate for Apr-Aug 19

	Maximum cumulative monthly number to achieve reduction expectation	Current cumulative monthly numbers	Difference between maximum and current cumulative monthly numbers	Current cumulative monthly rate/100,000 population
Apr	<8	6	-1	16.44
May	<15	19	5	25.61
Jun	<23	31	9	28.01
Jul	<30	45	16	30.32
Aug	<38	51	14	27.40
Sep	<45			
Oct	<52			
Nov	<60			
Dec	<67			
Jan	<75			
Feb	<82			
Mar	<90			

Cwm Taf

Cwm Taf UHB S.aureus bacteraemia 2018/19 reduction expectation results

Maximum numbers to achieve 2018/19 FY reduction expectation		Actual 2018/19 FY numbers	
Maximum number for FY	<60	101	Actual number for FY
Maximum average number per month	<5	8	Actual average number per month
Maximum rate/100,000 population	20.00	33.77	Actual rate/100,000 population

Cwm Taf UHB maximum cumulative monthly numbers of S.aureus bacteraemia required to achieve the 2018/19 reduction expectation and actual cumulative monthly number and rate

	Maximum cumulative monthly number to achieve reduction expectation	Actual monthly numbers	Difference between maximum and actual cumulative monthly numbers	Actual cumulative monthly rate/100,000 population
Apr	<5	14	10	56.95
May	<10	19	10	38.01
Jun	<15	25	11	33.53
Jul	<20	36	17	36.01
Aug	<25	43	19	34.30
Sep	<30	50	21	33.34
Oct	<35	62	28	35.36
Nov	<40	71	32	35.51
Dec	<45	77	33	34.17
Jan	<50	85	36	33.90
Feb	<55	90	36	32.89
Mar	<60	101	42	33.77

Bridgend

Data not currently available

How are we doing, what actions are we taking?

The Cwm Taf Morgannwg UHB 2019/20 reduction expectation for S. aureus bacteraemia is to achieve a rate of less than or equal to 20.00 per 100,000 population. This equates to an average of less than 8 S. aureus bacteraemia per month and less than 90 for the whole financial year (FY).

5 months into the 2019/20 reduction expectation period, the provisional rate of S. aureus bacteraemia in Cwm Taf Morgannwg UHB is 27.40 per 100,000 population. This equates to an average of approximately 10 per month and based on the current trajectory, a total of approximately 122 for the FY. To achieve the 2019/20 reduction expectation the average number of S. aureus bacteraemia per month for the remaining 7 months must be less than 6.

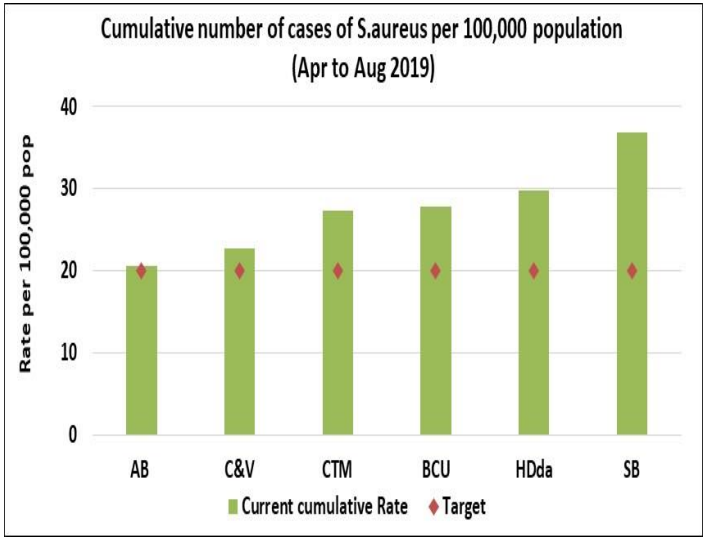
All MRSA bacteremias are investigated by the IPCT and a RCA is performed for all line related bacteremias.

Improvement work is being carried out to improve compliance with MRSA screening in our A&E departments and admission wards.

60% of the MSSA bacteraemia are identified <48 hours post admission.

Poor antimicrobial stewardship. Poor hand hygiene. Poor compliance with MRSA screening and management of invasive devices. Poor hand hygiene.

Benchmarking: how do we compare?



5 months into the 2019/20 reduction expectation period the provisional rate of S. aureus bacteraemia in Wales is 25.76 per 100,000 population. This equates to an average of approximately 68 per month. Based on the current trajectory a total of approximately 811 S. aureus bacteraemia cases is projected for the FY. Wales is not currently on target to achieve the 2019/20 reduction expectation. To achieve the 2019/20 reduction expectation the average number of S.aureus bacteraemia per month for the remaining 7 months must be less than 42. None of the 6 major health boards are on target to achieve the reduction expectation.

Source: Public Health Wales (WHAIP)

Indicator 20: Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population

Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Director of Nursing
Period: Apr 2019 to Aug 2019	Target: TBC

Current Performance:

Cwm Taf Morgannwg

Maximum numbers to achieve 2019/20 Financial Year reduction expectation		Current period numbers (Apr to Aug 19)			
Maximum number for FY	<94	130	Actual number for FY		
Maximum average number per month	<8	11	Actual average number per month	Recalculated average monthly number to achieve reduction	<6
Maximum rate/100,000 population	21.00	29.02	Actual rate/100,000 population		
Maximum number for current time period	<39	54	Current period number		

Cwm Taf Morgannwg UHB maximum cumulative monthly numbers of C. difficile required to achieve the 2019/20 reduction expectation and provisional cumulative monthly number and rate for Apr-Aug 19

	Maximum cumulative monthly number to achieve reduction expectation	Current cumulative monthly numbers	Difference between maximum and current cumulative monthly numbers	Current cumulative monthly rate/100,000 population
Apr	<8	9	2	24.66
May	<16	25	10	33.69
Jun	<24	34	11	30.72
Jul	<32	48	17	32.35
Aug	<39	54	16	29.02
Sep	<47			
Oct	<55			
Nov	<63			
Dec	<71			
Jan	<78			
Feb	<86			
Mar	<94			

Cwm Taf

Cwm Taf UHB C.difficile 2018/19 reduction expectation results

Maximum numbers to achieve 2018/19 FY reduction expectation		Actual 2018/19 FY numbers	
Maximum number for FY	<54	55	Actual number for FY
Maximum average number per month	<5	5	Actual average number per month
Maximum rate/100,000 population	18.00	18.39	Actual rate/100,000 population

Cwm Taf UHB maximum cumulative monthly numbers of C.difficile required to achieve the 2018/19 reduction expectation and actual cumulative monthly number and rate

	Maximum cumulative monthly number to achieve reduction expectation	Actual cumulative monthly numbers	Difference between maximum and actual cumulative monthly numbers	Actual cumulative monthly rate/100,000 population
Apr	<5	8	4	32.54
May	<9	14	6	28.01
Jun	<14	18	5	24.14
Jul	<18	27	10	27.01
Aug	<23	30	8	23.93
Sep	<27	34	8	22.67
Oct	<32	36	5	20.53
Nov	<36	39	4	19.51
Dec	<41	43	3	19.08
Jan	<45	47	3	18.74
Feb	<50	49	0	17.90
Mar	<54	55	2	18.39

Bridgend

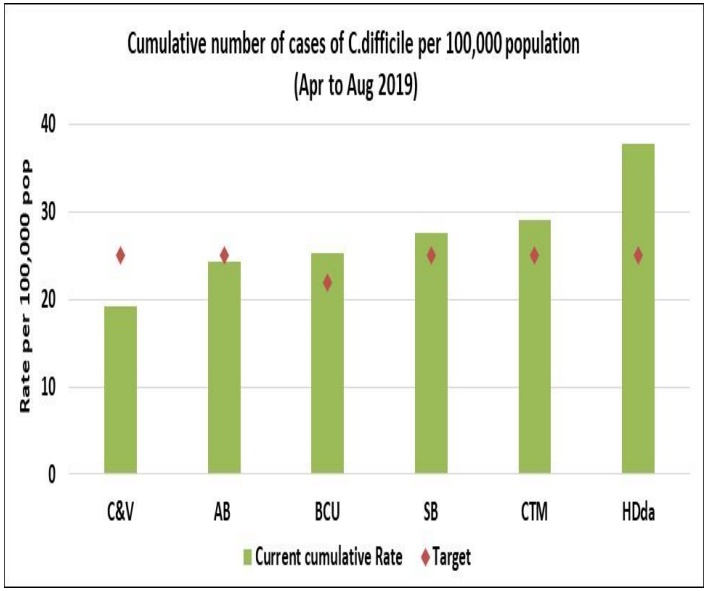
Data not currently available

How are we doing, what actions are we taking?

The Cwm Taf Morgannwg UHB 2019/20 reduction expectation for C. difficile is to achieve a rate of less than or equal to 21.00 per 100,000 population. This equates to an average of less than 8 C. difficile per month and less than 94 for the whole financial year (FY).

5 months into the 2019/20 reduction expectation period, the provisional rate of C. difficile in Cwm Taf Morgannwg UHB is 29.02 per 100,000 population. This equates to an average of approximately 11 per month and based on the current trajectory, a total of approximately 130 for the FY. To achieve the 2019/20 reduction expectation the average number of C. difficile per month for the remaining 7 months must be less than 6.

Benchmarking: how do we compare?



5 months into the 2019/20 reduction expectation period the provisional rate of C. difficile in Wales is 26.14 per 100,000 population. This equates to an average of approximately 69 per month. Based on the current trajectory a total of approximately 823 C. difficile cases is projected for the FY. Wales is not currently on target to achieve the 2019/20 reduction expectation. To achieve the 2019/20 reduction expectation the average number of C. difficile per month for the remaining 7 months must be less than 64. 1 of the 6 major health boards is on target to achieve the reduction expectation (Aneurin Bevan UHB).

Source: Public Health Wales (WHAIP)

Indicator 21: Non steroid anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)

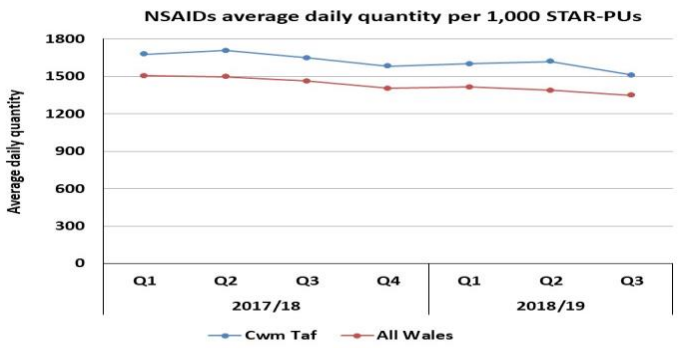
Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Director of Primary, Community and Mental Health
Period: 2017/18 to Q3 2018/19	Target: 4 Quarter Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

CTUHB have the highest prescribing volumes of NSAIDS per STAR PU in Wales. This volume has shown a consistent year on year reduction. However, the choice of NSAID prescribed has a high compliance with current guidance.

The HB have incorporated this into practice work plans over a number of years, including QOF audit. Although this is no longer a prescribing indicator for 2018-19 it will still be incorporated into the prescribing team work plan.

NSAIDS have been shown to be the medicine group most likely to cause an adverse drug reaction requiring hospital admission due to such events as gastrointestinal bleeding and peptic ulceration.

Benchmarking: how do we compare?

4 Quarter Reduction Trend		Non-steriod anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-PU's (specific therapeutic group age related prescribing unit)						
		Cwm Taf	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys
2018/19	Q1	**1601**	1517	1411	1419	1201	1437	1282
	Q2	**1621**	1479	1402	1376	1154	1405	1289
	Q3	**1511**	1447	1347	1368	1094	1385	1258
2017/18	Q1	1679	1571	1508	1495	1309	1577	1376
	Q2	1709	1559	1487	1501	1284	1553	1392
	Q3	1650	1541	1464	1461	1249	1511	1337
	Q4	1584	1496	1407	1405	1195	1430	1278

Cwm Taf have the highest ADQ of NSAID prescribing in Wales. This has reduced consistently (-8.6% from 2016/17 to 2017/18) over the years in line with similar reductions across Wales.

Source: Welsh Government Delivery and Performance Website

Indicator 22: Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale

Outcome: I am safe and protected from harm through high quality care, treatment and support	Executive Lead: Director of Nursing
Period: Qtr. 1 2017/18 to Qtr. 4 2018/19	Target: Zero

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale

Target is Zero		Cwm Taf	Abertawe Bro Morgannw	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys
2018/19	Q1	2	2	1	1	0	1	0
	Q2							
	Q3	1	0	2	1	1	1	1
	Q4	1	1	1	2	1	2	0
2017/18	Q1	0	0	0	0	0	0	0
	Q2	3	2	3	3	2	3	2
	Q3	2	3	3	3	2	2	2
	Q4	0	0	0	0	0	1	0

where a blank appears in the table this means that no alerts or notices were due for assurance in the quarter

Bridgend

Data not currently available

How are we doing, what actions are we taking?

Alerts: A total of 9 Alerts have been received. The Health Board is compliant with 8 of these Alerts.

PSA008 – The PH strips are non CE marked. Work is being undertaken by the suppliers of the PH strips to either CE mark the product, alternatively another supplier will need sourcing for supplying Wales or possible changes to PH testing practice will be required. WG are aware of this ongoing work.

Notices: A total of 50 Notices have been received. The Health Board is non-complaint with 3 of these Notices.

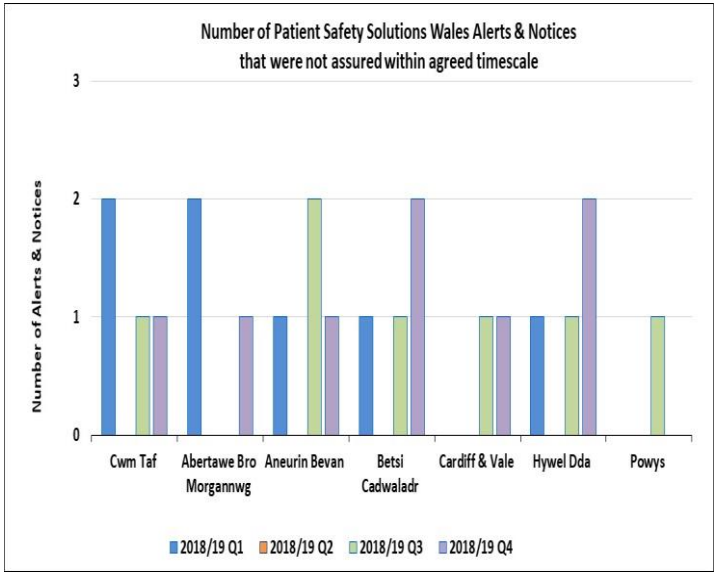
PSN030 –An all Wales self-assessment tool has been completed. All of Wales is non-compliant with this Notice and the Health Board has taken actions to minimise the risk.

PSN046 - The notice has been disseminated to all Clinical Areas. There is currently a Protocol in place which refers to Patients with spinal cord injuries. The Health Board's Bladder and Bowel Health Service deliver a management of bowel dysfunction course approximately 6 times a year throughout the Organisation. Uptake of training in this area requires improvement. Every clinical area, District Nurse base, Residential & Nursing Home has a welcome to the bladder & bowel health service resource file.
The Guideline is being reviewed and a Standard Operating Procedure is being developed which will included more detailed information highlighted in the notice.

PSN049 –multi-professional group established. The following is in place:

- All in-patients with a tracheostomies will be nursed on identified dedicated ward: Prince Charles Hospital, Wards 2 and 10, Royal Glamorgan Hospital, Ward 8 and Medical Wards 19 and 20.
- Cwm Taff Tracheostomy Guidelines (adapted from SEW Critical Care Network Guidelines) available on each dedicated ward and on the intranet.
- Standard documentation for ward based care.
- Tracheostomy weaning plan developed and incorporated into the Cwm Taff Tracheostomy Guidelines.
- Tracheostomy information file on each dedicated ward containing: Tracheostomy Care Regimes, Prescribed Nursing Action Plans, Weaning observation Charts, Weaning Flow Charts, Patient information leaflets.
- Tracheostomy competency document to be completed by all qualified nursing staff and physiotherapist caring for patients with a Tracheostomy.

Benchmarking: how do we compare?



Cwm Taf is comparable with the other Health Boards in Wales.

Source: Welsh Government Delivery and Performance Website *http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data*

Indicator 23: Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales
Indicator 24: Number of new never events

Outcome: I am safe and protected from harm through high quality care, treatment and support

Executive Lead: Director of Nursing

Period: Apr 2018 to Jul 2019

Target - Indicator 23: 90%

Target - Indicator 24: Zero

Current Performance:

Cwm Taf Morgannwg

Period	Serious Incidents	Never Events
Apr-19	N/A	N/A
May-19	N/A	N/A
Jun-19	0.0%	0
Jul-19	2.9%	0

Cwm Taf

Period	Serious Incidents	Never Events
Apr-18	28.6%	0
May-18	27.8%	0
Jun-18	31.4%	0
Jul-18	11.1%	0
Aug-18	0.0%	0
Sep-18	19.4%	1
Oct-18	28.2%	0
Nov-18	14.6%	0
Dec-18	15.4%	0
Jan-19	20.5%	0
Feb-19	42.9%	0
Mar-19	27.0%	0

Bridgend

Period	Serious Incidents	Never Events
Apr-18	93.0%	0
May-18	82.0%	0
Jun-18	82.0%	0
Jul-18	71.0%	0
Aug-18	100.0%	0
Sep-18	100.0%	0
Oct-18	100.0%	0
Nov-18	100.0%	0
Dec-18	100.0%	0
Jan-19	88.0%	0
Feb-19	67.0%	0
Mar-19	N/A	N/A

How are we doing, what actions are we taking?

Reporting
Quarter 2, 2018/19 - 120 serious incidents and one never
Quarter 3, 2018/19 - 109 serious incidents and no never events.
Quarter 4, 2018/19 - 58 serious incidents and no never events.
Quarter 1, 2019/2020 – 66 serious incidents reported and no never events.
Quarter 2, 2019/2020 (July & August) – 48 Serious Incidents reported and no never events.

As at the 5th September 2019 there were 30 closure forms outstanding outside of timescale. The highest numbers are Acute medicine, A&E, Mental health and Obstetrics and Gynaecology.

The Patient Safety Team monitor the number of incidents awaiting review and closure on a monthly basis. The Patient Safety Improvement Managers provide support within the Directorates via regular meetings with responsible Managers.

This information is formally reported to directorates on a monthly and quarterly basis.
This is also reported to the executive team via the weekly patient safety meetings and also to the Quality Safety and Risk committee.

Following the boundary change, opportunity has arisen to review and identify good practice in relation to the Datix incident management system. There is ongoing work which is being supported by the Welsh Risk Pool to ensure consistency of the Datix system across the Health board.

Benchmarking: how do we compare?

Of the Serious Incidents due for assurance, the % which assured in agreed timescale - Target 90%

Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
Aug-18	0.0%	64.0%	17.3%	25.0%	69.0%	33.3%	86.7%
Sep-18	19.4%	35.7%	10.8%	65.5%	48.1%	22.2%	21.4%
Oct-18	28.2%	47.2%	24.8%	69.0%	63.0%	0.0%	0.5%
Nov-18	14.6%	50.0%	25.3%	69.2%	52.0%	20.0%	88.2%
Dec-18	15.4%	29.4%	20.7%	50.0%	35.3%	0.0%	88.9%
Jan-19	20.5%	18.4%	17.0%	60.4%	26.7%	50.0%	48.7%
Feb-19	42.9%	21.7%	33.8%	19.5%	36.0%	0.0%	56.0%
Mar-19	27.0%	39.1%	50.0%	18.6%	33.3%	31.3%	22.2%
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	Not available as yet						
May-19							
Jun-19	0.0%	50.0%	32.3%	14.3%	50.0%	50.0%	22.2%
Jul-19	2.9%	37.5%	41.2%	44.4%	23.8%	33.3%	33.3%

Number of new Never Events - Target Zero

Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
Aug-18	0	0	1	0	0	0	0
Sep-18	1	0	2	1	0	0	0
Oct-18	1	1	1	1	1	0	0
Nov-18	0	0	0	0	0	0	0
Dec-18	0	0	1	0	0	0	0
Jan-19	1	0	0	1	0	0	0
Feb-19	0	0	0	0	0	0	0
Mar-19	1	1	0	0	0	0	0
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	Not available as yet						
May-19							
Jun-19	0	2	0	0	0	0	1
Jul-19	0	0	0	0	0	0	1

The Welsh Government has identified the submission of closure forms as a specific risk for the Health Board which is being closely monitored to ensure improvement.

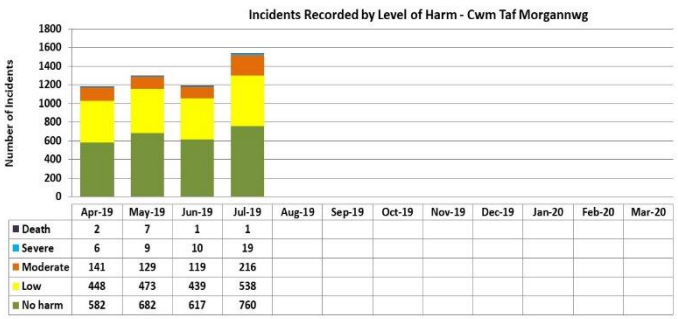
Source: Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649 /Qliksense Datix App/Local Datix

Local Measure: Number of incidents and severity reported

Outcome: I am safe and protected from abuse and neglect	Executive Lead: Director of Nursing
Period: Apr 2018 to Jul 2019	Target: Reduction

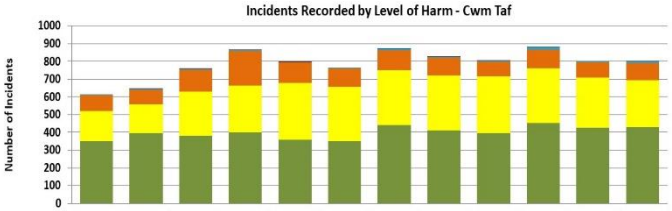
Current Performance:

Cwm Taf Morgannwg



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Death	2	7	1	1								
Severe	6	9	10	19								
Moderate	141	129	119	216								
Low	448	473	439	538								
No harm	582	682	617	760								

Cwm Taf to 31st March 2019



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Death	0	1	1	3	2	0	1	1	4	4	0	3
Severe	2	3	4	3	1	4	5	1	3	9	5	7
Moderate	88	82	125	198	117	107	115	103	83	106	87	101
Low	172	163	247	263	319	305	307	307	319	309	283	262
No harm	350	397	382	399	359	350	442	413	398	453	426	430

Bridgend

Data not currently available

How are we doing, what actions are we taking?

It has been noted there has been low reporting of patient safety incidents on the NRLS. This was an administrative malfunction and has since been resolved.

A high reporting of no and low harm incidents is indicative of a robust safety culture within an Organisation. Moderate incidents reported within the Health Board are currently slightly above the Welsh average – this partly due to an inaccuracy in reporting.

Daily monitoring of moderate and severe incidents is undertaken by the Corporate Team to identify inaccuracies and correct reported incidents.

Training is provided across the Health Board to improve reporting of patient safety incidents, which includes category and severity. Additional training is provided to responsible managers to ensure timely review and investigation of incidents.

A Training Needs Analysis is currently being developed to assess the levels of training in relation to concerns management including patient safety incidents across the whole of the Health Board.

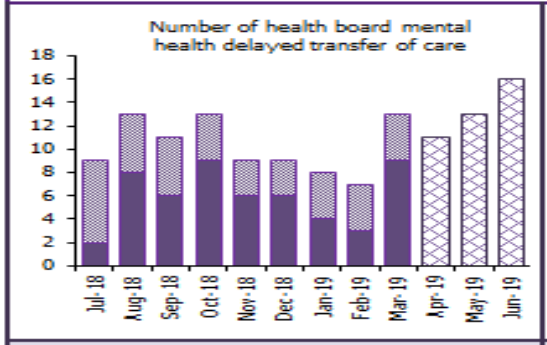
Benchmarking: how do we compare?

Benchmark not available

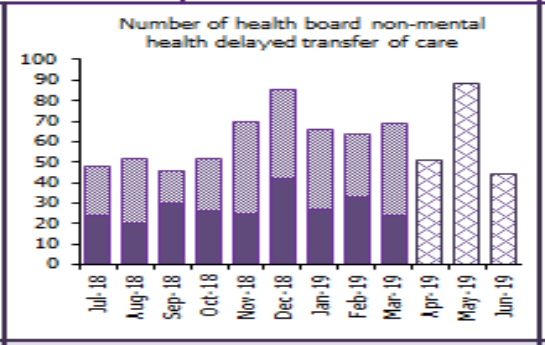
Source: Local Datix

EFFECTIVE CARE – People in Wales receive the right care and support locally as possible and are enabled to contribute to making that care successful

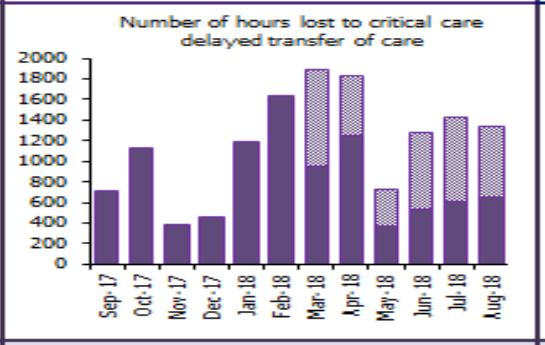
Key: Cwm Taf Morgannwg or **Cwm Taf** or **Bridgend** **N/A - data not currently available**



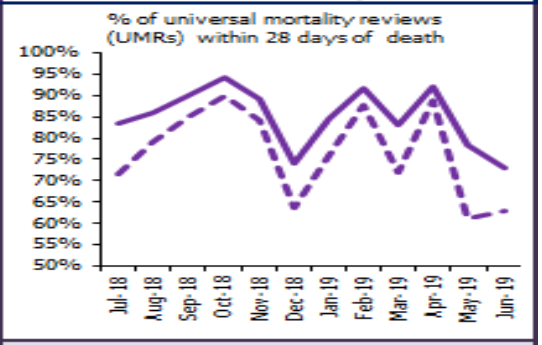
Current Position		
CT	B	CTM
N/A	N/A	16



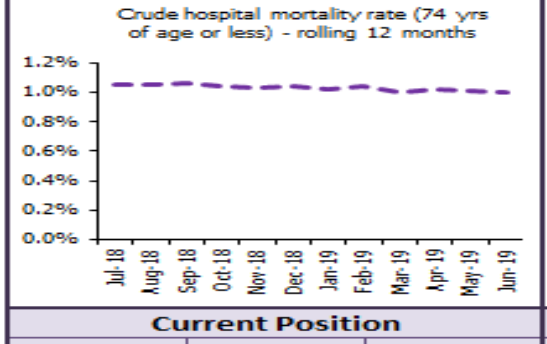
Current Position		
CT	B	CTM
N/A	N/A	44



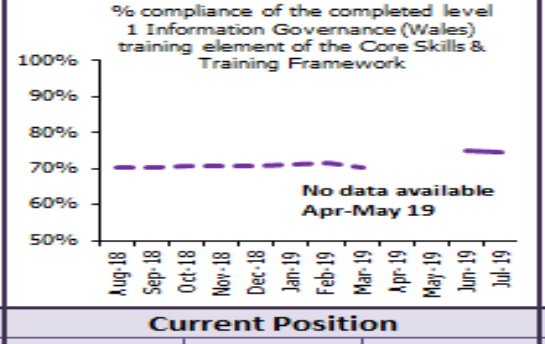
Current Position		
CT	B	CTM
660.1	686	1346.1



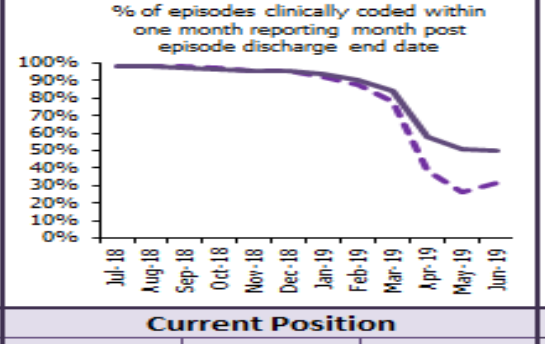
Current Position		
CT	B	CTM
63.1%	88.6%	72.9%



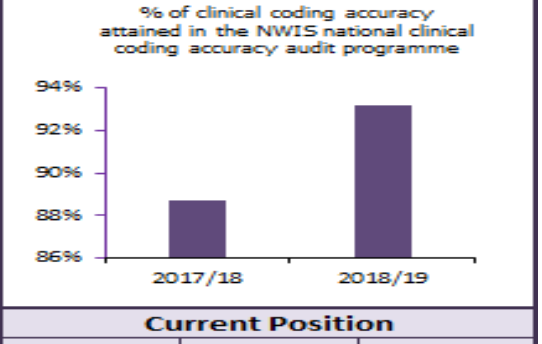
Current Position		
CT	B	CTM
1.01%	N/A	N/A



Current Position		
CT	B	CTM
N/A	N/A	74.31%

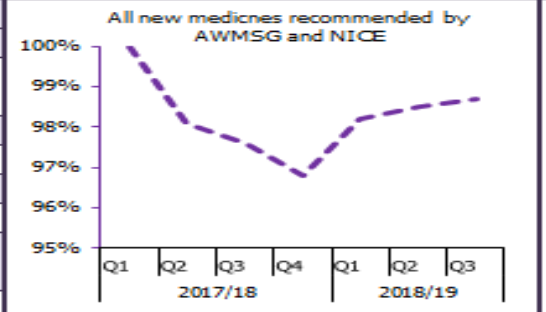


Current Position		
CT	B	CTM
13.3%	33.5%	20.3%



Current Position		
CT	B	CTM
93.2%	N/A	N/A

Health & Care Research Wales		
CT	B	CTM
2018/19		
No. of CRP Studies		
70	N/A	N/A
No. of CS Studies		
9	N/A	N/A
No. of patients recruited CRP Studies		
3616	N/A	N/A
No. of patients recruited CS Studies		
41	N/A	N/A



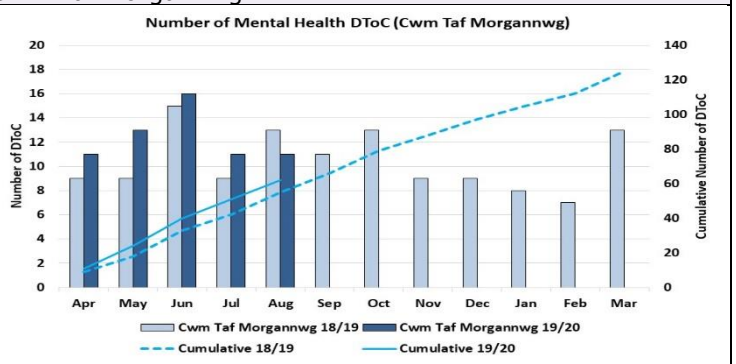
Current Position		
CT	B	CTM
98.7%	N/A	N/A

Indicator 30: Number of health board mental health delayed transfer of care (rolling 12 months)

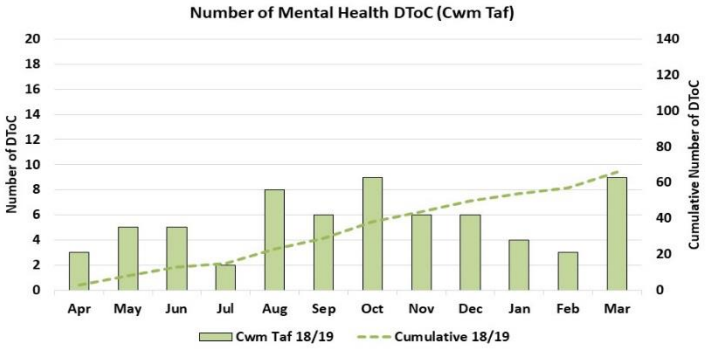
Outcome: Health care and support are delivered at or as close to my home as possible	Executive Lead: Director of Primary, Community and Mental Health
Period: Apr 2018 to Aug 2019	Target: 12 month reduction trend

Current Performance:

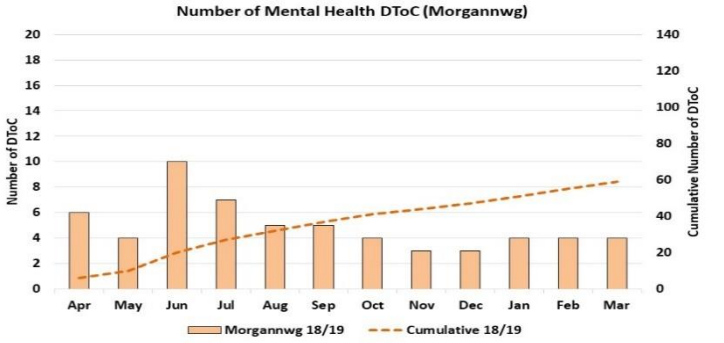
Cwm Taf Morgannwg



Cwm Taf to 31st March 2019



Bridgend to 31st March 2019



How are we doing, what actions are we taking?

The 2019/20 target is a 12 month reduction trend.

This month's position (August) shows 11 delays to transfers of care. This remains the same as in July.

There are 4 people with delays in adult / rehabilitation services, 2 are waiting for mainstream housing, 1 awaiting private provider, 1 awaiting specialist housing. There are 6 delays in older peoples services, 2 are waiting for nursing place availability in care home of choice (EMI), 2 are selecting nursing care placement of choice (EMI) and 2 have mental capacity related issues. There is 1 young person waiting in Ty Llidiard with reason stating other.

All patients with a status of having a delayed transfer of care has progress towards discharge reviewed weekly by Senior Nurses and progress or issues are reported through to the Directorate team. Where necessary lack of progress is escalated to Local Authority Service Managers by ADO when required. A newly developed decision making Matrix for S117 placements in place with RCT is having a positive impact on reducing funding related delays.

Choice related issues continue to cause delays but not for a significant number of people, delays related to capacity assessment processes are starting to emerge more frequently and are being monitored to understand any themes. It is unusual to have so many people awaiting mainstream or adapted housing and this is anticipated to resolve quickly.

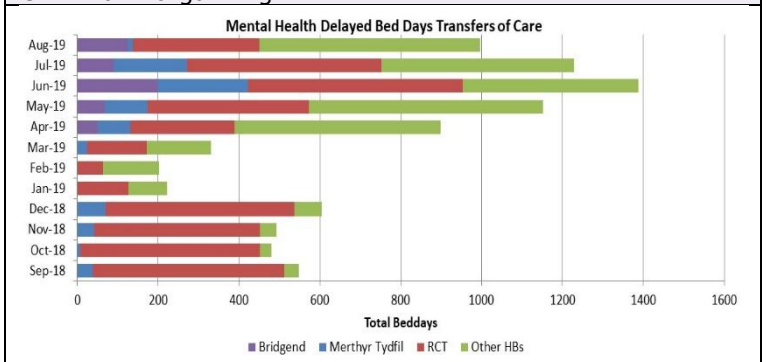
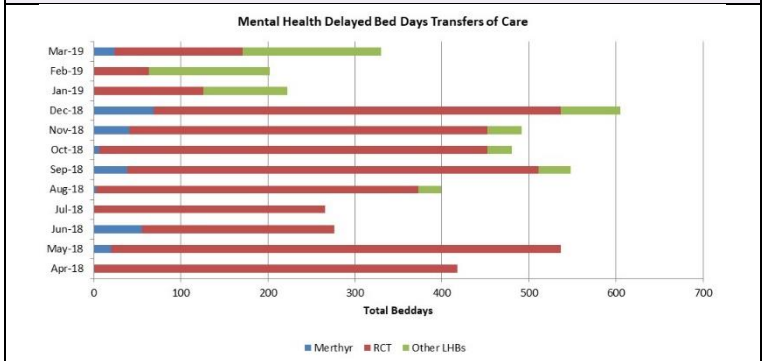
Benchmarking: how do we compare?

Number of health board mental health delayed transfer of care							
Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
Apr-18	3	4	19	9	18	3	28
May-18	5	2	19	8	14	2	22
Jun-18	5	2	17	4	13	2	30
Jul-18	2	5	17	4	8	3	27
Aug-18	8	3	15	4	4	2	30
Sep-18	6	3	14	3	4	2	29
Oct-18	9	7	15	3	12	3	28
Nov-18	6	3	15	3	4	1	26
Dec-18	6	3	13	8	8	4	25
Jan-19	4	3	13	6	5	4	29
Feb-19	3	6	11	5	10	6	26
Mar-19	9	7	10	5	8	7	21
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	11	2	9	3	7	3	18
May-19	13	2	5	7	8	1	23
Jun-19	16	3	12	6	3	2	27
Jul-19	11	5	17	5	2	3	20

Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 30 continued: Number of health board mental health delayed transfer of care

Outcome: Health care and support are delivered at or as close to my home as possible	Executive Lead: Director of Primary, Community and Mental Health
Period: Sep 2018 to Aug 2019	Target: 12 month reduction trend

Current Performance:	How are we doing, what actions are we taking?	Benchmarking: how do we compare?
Cwm Taf Morgannwg  Cwm Taf to 31st March 2019  Bridgend Data not available	Total delayed bed days in August was 996. One patient, a Swansea resident has had a lengthy delay waiting for specialist housing which has contributed to a significant rise in total bed day delays. Senior management oversight is taking place in Swansea Bay to help ensure regular progress is made and agreement has been reached to transfer the person to a Swansea Bay service pending a full discharge plan. All DToC patients' status is reviewed weekly by Senior Nurses and progress or issues report through to the Directorate team as above. Where necessary lack of progress is escalated to LA service managers by ADO when required. A newly developed decision making Matrix for S117 placements in place with RCT is having a positive impact on reducing funding related delays and no delays related to funding of care packages was seen this month. Additional stepped up scrutiny and reporting locally more frequently instigated end May and will remain in place until DToC's are below low 10 in adult mental health.	**Benchmark not available**

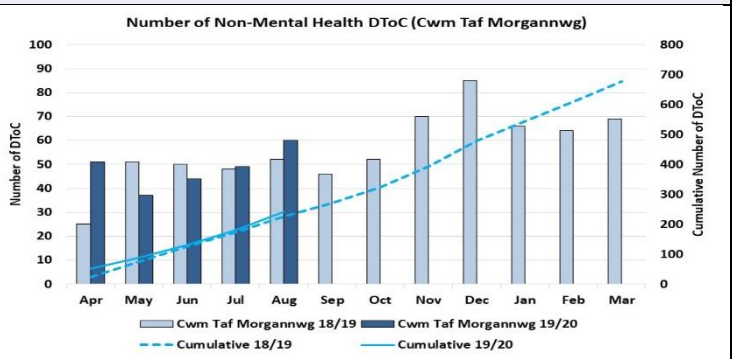
Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 31: Number of health board non-mental health delayed transfer of care (rolling 12 months)

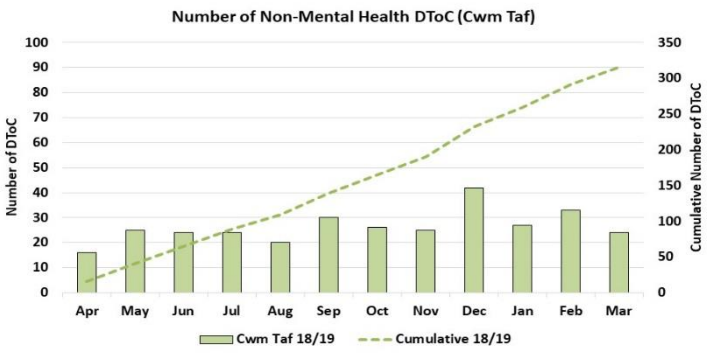
Outcome: Health care and support are delivered at or as close to my home as possible	Executive Lead: Chief Operating Officer
Period: Apr 2018 to Aug 2019	Target: 12 month reduction trend

Current Performance:

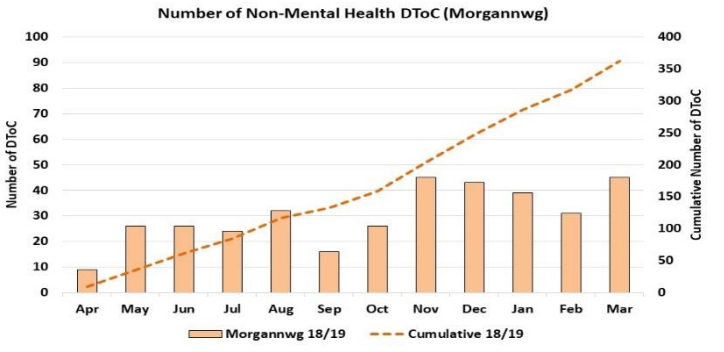
Cwm Taf Morgannwg



Cwm Taf to 31st March 2019



Bridgend to 31st March 2019



How are we doing, what actions are we taking?

CTMUHB continues to work without LA partners to manage the challenge of DToC's and we recognise there has been an increase this month in a few areas.

Choice related issues: Care Home vacancies fluctuate from time to time, this month has seen an increase in the filling of vacancies for those individuals requiring either permanent or respite provision which has now impacted on choice related issues in our hospitals and increased our DToC position. We are vigorously implementing the choice protocol and asking families to choose vacancies further away from home and even outside the HB's footprint, families find this extremely difficult however we recognise the importance of discharging individuals in a timely way. Our demand for EMI has also increased more recently, it is an area that we have been working with providers to develop services but currently demand is high for this category.

Home care capacity: There continues to be high demand for home care packages as our LA's successfully support people with more complex care packages to live at home rather than in a care home. This continues to put pressure on supply and capacity in some areas of the county at "peak call" times. Providers continue to recruit to their services. Each Of the LA are working with their providers and in house services to minimise impact on delays awaiting commencement of home care packages.

Delays due to housing: There are a number of housing related delays this month. RCT has experienced a sustained increase in demand for housing and housing related support over the past 2 years, with a particular increase in demand for specialist and adapted housing. Work is being done to improve the supply of adapted housing through our Housing Partnerships. Work is required to ensure early identification of complex needs to ensure bespoke adaptations can be prioritised as early as possible to prevent delayed discharge.

Benchmarking: how do we compare?

Cont. - Delays due to housing: In addition, some clients who enter hospital when of no fixed abode are appropriately prioritised in the highest band but have encountered delays in the first quarter of 2019 when bidding via our choice based letting system as they wish to live in very high demand areas. We will work with colleagues to review the process for these clients to improve timely access to housing via the general needs register.

Delays due to Mental Capacity: We have over the past 2 years seen a significant and growing number of cases that require referral to the Court of Protection to confirm ongoing care arrangements (particularly placement into a care home when the person is stating they want to return home). The numbers requiring referral to the court to establish discharge destination in July and August is significant and reflects a more general trend across the service. Whilst there is often a delay between the application and the actual Court date we plan to work with the UHB to consider our procedures to look at ways of identifying cases that are likely to require a Legal process earlier in the discharge planning arrangements

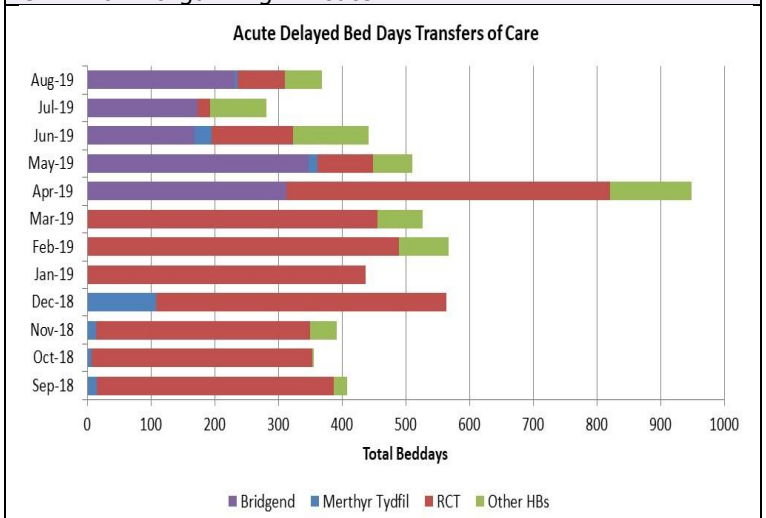
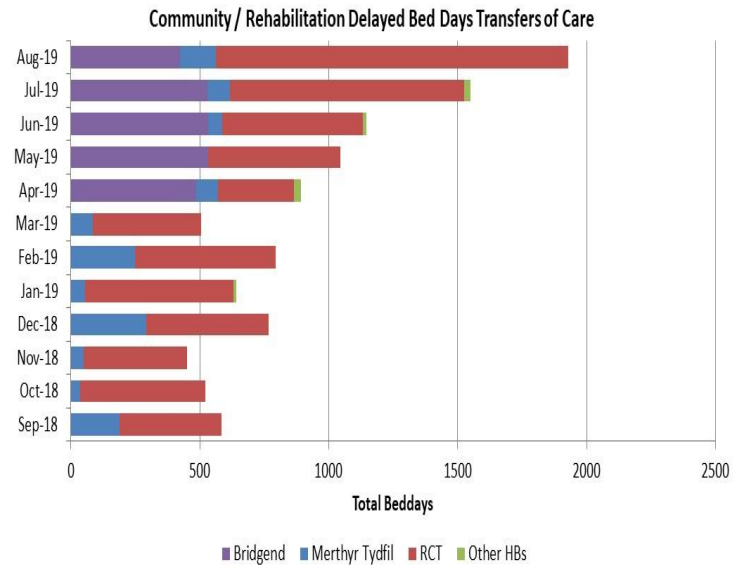
There is an incredible amount of partnership work that occurs on a day to day, HB wide basis in putting patients first in addressing flow and resolving DToC.

Number of health board non-mental health delayed transfer of care

Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
Apr-18	16	89	114	39	54	17	34
May-18	25	73	104	37	49	15	64
Jun-18	24	60	103	47	43	22	75
Jul-18	24	53	111	43	32	17	74
Aug-18	20	61	95	37	29	6	85
Sep-18	30	73	111	26	53	12	69
Oct-18	26	86	105	37	36	20	84
Nov-18	25	97	79	35	44	14	125
Dec-18	42	65	58	43	40	18	117
Jan-19	27	74	52	39	34	18	104
Feb-19	31	69	76	44	44	29	87
Mar-19	24	95	60	32	31	32	112
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	51	61	77	39	46	31	49
May-19	38	63	68	42	43	32	67
Jun-19	44	59	68	40	58	26	70
Jul-19	49	64	67	40	47	67	61

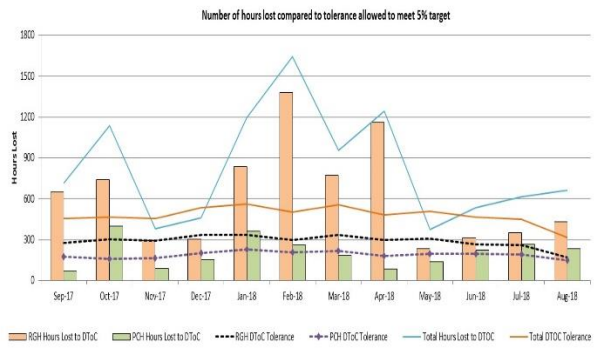
Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 31 continued: Number of health board non-mental health delayed transfer of care (rolling 12 months)	
Outcome: Health care and support are delivered at or as close to my home as possible	Executive Lead: Chief Operating Officer
Period: Sep 2018 to Aug 2019	Target: 12 month reduction trend

Current Performance:	How are we doing, what actions are we taking?	Benchmarking: how do we compare?
Cwm Taf Morgannwg – Acute  Cwm Taf Bridgend – Community / Rehabilitation  	The number of delayed bed days in acute settings had reduced over June and July but for reasons noted on the previous page increased during August. The Health Board continues to work closely with each of the local authorities to ensure any delays are kept to a minimum. Availability of community placements remains a challenge for those with complex and specialist needs. Stimulating and developing the domiciliary care market to reduce delays for vulnerable patients to be discharged with an adequate and sustainable package of care. Additional work with neighbouring LA's and HB's is required as the boundary change and current flow of admissions through POW highlights the need for additional processes to aid discharge and flow.	**Benchmark not available**

Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

Local Measure: Critical Care – Delayed transfer of care	
Outcome: Health care and support are delivered at or as close to my home as possible	Executive Lead: Chief Operating Officer
Period: Sep 2017 to Aug 2018	Target: 5%

Current Performance:	How are we doing, what actions are we taking?	Benchmarking: how do we compare?
Cwm Taf Morgannwg Data not currently available Cwm Taf  Bridgend Data not currently available	From a critical care perspective the delays are calculated on a basis of total number of delayed hours as a percentage of the total number of hours used. The expected level of DToC by the National Critical Care Network is no more than 5%. The main actions to be taken to keep DToC's 5% target is to ensure patient flow is working well. It is proven that when beds are available on the wards to discharge patients DToC reduces. We have now put Critical Care on the Emergency Pressures Escalation Chart so it highlights the visibility of critical care capacity. Ensuring that patient flow is maintained so that we do not have any DToC's in the units.	**Benchmark not available**

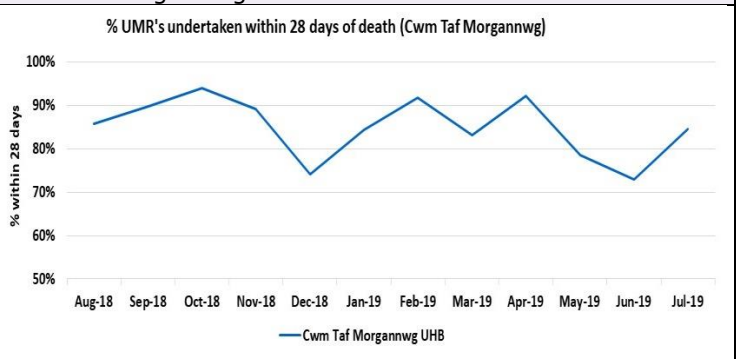
Source: Welsh Government

Indicator 32: Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death

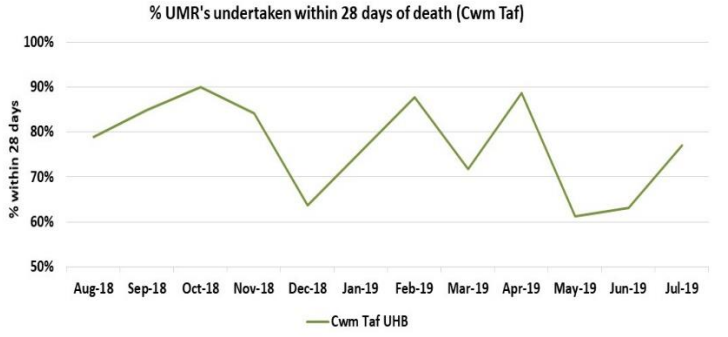
Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Medical Director
Period: Aug 2018 to Jul 2019	Target: 95%

Current Performance:

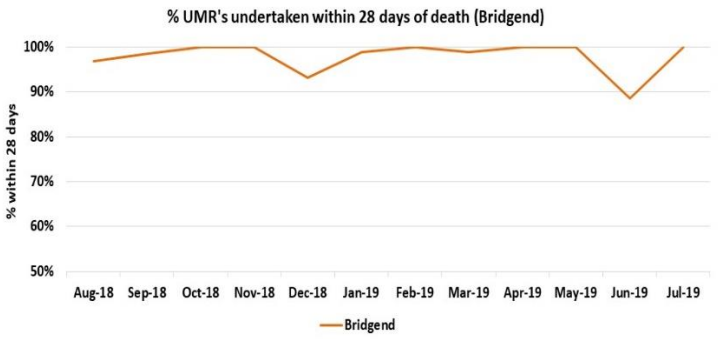
Cwm Taf Morgannwg



Cwm Taf



Bridgend



How are we doing, what actions are we taking?

For PCH & RGH, UMR performance has remained stable since April 2016. However, due to a lack of reviewer availability, performance dropped in PCH for June 2019. Extra sessions have been put in place to address this. Some UMRs continue to be completed as an ongoing pilot of the medical examiner system by two pathologists in accordance with the agreed role of the ME in the Welsh Mortality Review process.

POW have a different system in place with UMR completed by the Clinical team at time of death.

Participation in Stage 2 remains reasonably stable despite there also being 2 different systems for this across CTMUHB.

The Post Stage 2 process has been further refined with a Stage 3 Panel in place, led by the AMD for Quality & Safety, to ensure that lessons learned are translated into effective changes in clinical practice.

Discussions are due to take place to agree one system of undertaking Mortality reviews across CTMUHB. This is also linked to the implementation Medical Examiner system as well as implementation of a Mortality Module on Datix which will link with the Qlik Sense business intelligence tool to add value to our reporting mechanisms to Directorates and other clinical areas.

There are continued risks to the performance particularly the support from primary care at Stage 1. This is too patchy and subject to staff shortages reported in that workforce. Ultimately Stage 1 will become a function of the Medical Examiner.

Risk of running 2 separate systems for Mortality review, which is currently being addressed

Benchmarking: how do we compare?

% Universal Mortality Reviews undertaken within 28 days of death - 95% target							
	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Velindre	Abertawe Bro Morgannwg
Jul-18	72.2%	7.0%	96.2%	65.2%	47.4%	100.0%	94.6%
Aug-18	79.8%	16.7%	86.9%	70.7%	39.5%	100.0%	91.7%
Sep-18	85.0%	43.2%	87.7%	66.2%	81.7%	100.0%	94.6%
Oct-18	86.3%	39.8%	85.8%	71.1%	84.0%	100.0%	98.8%
Nov-18	84.2%	24.9%	90.7%	72.7%	88.0%	100.0%	99.1%
Dec-18	63.8%	16.6%	87.8%	71.3%	78.7%	100.0%	93.5%
Jan-19	75.7%	18.0%	82.7%	82.0%	87.6%	100.0%	97.3%
Feb-19	87.8%	12.1%	94.4%	81.0%	82.5%	75.0%	99.2%
Mar-19	71.8%	20.4%	94.5%	68.9%	87.1%	0.0%	98.1%
	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Velindre	Swansea Bay
Apr-19	92.1%	17.3%	89.7%	68.8%	82.7%	60.0%	98.5%
May-19	78.5%	not available					
Jun-19	72.9%	11.0%	94.7%	74.5%	85.1%	75.0%	99.4%
Powys has been excluded due to HB not having any DGH's							

Source: Local Data Mortality Team

Indicator 33: Crude hospital mortality rate (74 years of age or less)

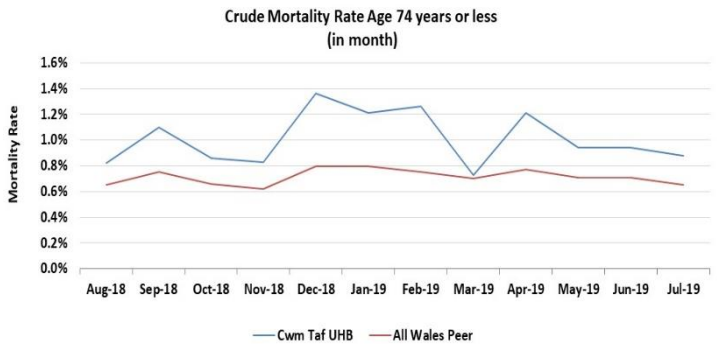
Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Medical Director
Period: Aug 2018 to Jul 2019	Target: 12 Month Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

In order to provide a more up to date position for mortality index, the graphs represent the position from an extrapolation of local data from CHKS. Crude mortality is now the only measure of in-hospital death rates as RAMI has been removed from the Outcomes Framework with effect from April for 2016.

The metric had changed from total crude mortality to crude mortality age 75 years and less 2016/17 and from the 2017/18 Outcomes Framework measures age 74 or less.

There are currently a number of specific quality improvement projects being undertaken:

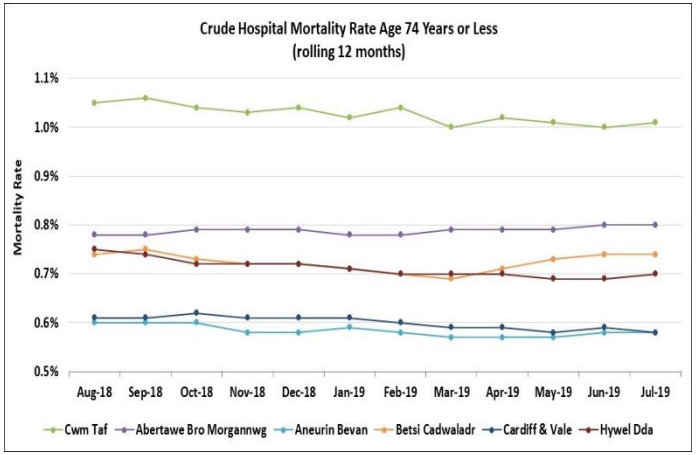
The systematic medical record reviews on the acute sites are continuing on a weekly basis. The process is evolving in readiness for the medical examiner system when introduced.

The systematic reviews of deaths in community hospitals commenced on a fortnightly basis (currently a monthly basis due to small numbers).

Mortality reviews follow a three stage process whereby Stage 1 is to screen out the expected deaths and Stage 2 is for more detailed review of unexpected deaths which could either prove to be unavoidable or proceed to Stage 3 for potential learning and improvement.

The All Wales Mortality Review Group is producing a new set of mortality indicators in line with the recommendations submitted to the Minister by Professor Stephen Palmer in 2015.

Benchmarking: how do we compare?



Cwm Taf does have higher crude mortality rates than Welsh Peers.

Source: CHKS

Indicator 33 continued: Crude hospital mortality rate (74 years of age or less)

Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Medical Director
Period: Aug 2018 to Jul 2019	Target: 12 Month Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Cwm Taf Crude Mortality Rates by Age Profile

Period	0 to 40 years				41 to 74 years				75+ years			
	Deaths	Spells	Cwm Taf	All Wales	Deaths	Spells	Cwm Taf	All Wales	Deaths	Spells	Cwm Taf	All Wales
Aug-18	1	2379	0.04%	0.08%	42	2856	1.47%	1.10%	85	1472	5.77%	4.47%
Sep-18	2	2434	0.08%	0.09%	54	2659	2.03%	1.28%	95	1316	7.22%	4.79%
Oct-18	4	2907	0.14%	0.10%	47	3009	1.56%	1.11%	99	1433	6.91%	4.72%
Nov-18	0	3029	0.00%	0.04%	48	2772	1.73%	1.12%	124	1427	8.69%	5.04%
Dec-18	3	2431	0.12%	0.08%	65	2580	2.52%	1.41%	122	1356	9.00%	6.05%
Jan-19	5	2690	0.19%	0.10%	62	2850	2.18%	1.35%	140	1478	9.47%	5.82%
Feb-19	2	2487	0.08%	0.09%	64	2760	2.32%	1.26%	122	1348	9.05%	5.26%
Mar-19	2	2761	0.07%	0.10%	40	3010	1.33%	1.18%	105	1382	7.60%	5.17%
Apr-19	0	2377	0.00%	0.09%	62	2741	2.26%	1.32%	104	1403	7.41%	5.50%
May-19	1	2565	0.04%	0.09%	50	2833	1.76%	1.20%	100	1485	6.73%	4.88%
Jun-19	1	2276	0.04%	0.09%	45	2614	1.72%	1.19%	83	1175	7.06%	4.74%
Jul-19	1	2452	0.04%	0.06%	46	2879	1.60%	1.09%	112	1495	7.49%	4.05%

Bridgend

Data not currently available

How are we doing, what actions are we taking?

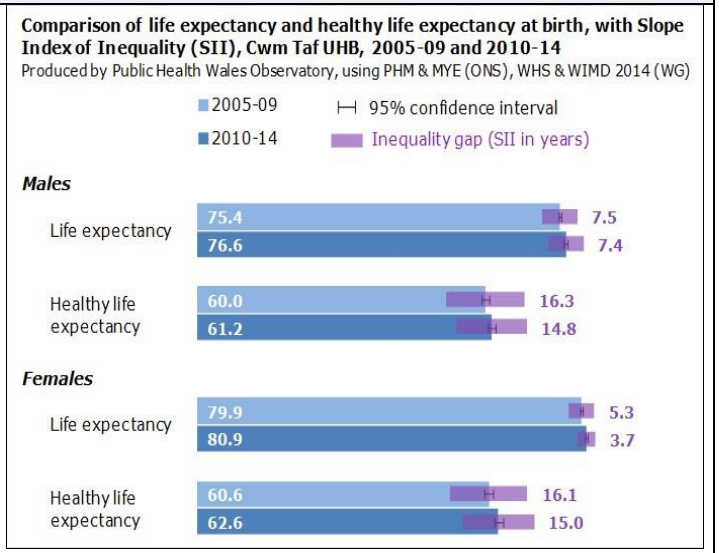
0-40 years: the Health Board is on par with the All Wales mortality with very few deaths.

41-74 years: the Health Board reports higher % mortality than All Wales. Investigation of individual patients indicates this relates to those with a diagnosis of cancer, drug & alcohol related deaths. A high proportion of patients are coded with pneumonia (lung diseases), stroke & palliative care.

75 years and over: Deaths include pneumonias (lung diseases), stroke, heart failure, palliative care, sepsis and other age related diseases are observed. Cwm Taf's population has higher rates of deprivation associated with higher rates of crude mortality as well as having greater rates of co-morbidities.

Contributory factors are lifestyle issues like obesity, smoking, alcohol and drug use which are more prevalent in the Cwm Taf population. The ratio of emergency care to elective care is higher in Cwm Taf and it is known that emergency care has higher risks and mortality. There are also a higher proportion of patients presenting with later stage cancer. 65% of deaths in Cwm Taf take place in hospital compared to an All Wales average of 55.9% therefore further improvement is still required to support patients who wish to die outside of hospital. To address the contributory factors all Cwm Taf UHB local delivery plans have specific areas to address lifestyle issues and support early recognition and speedier management of illness, particularly in cancer.

Benchmarking: how do we compare?

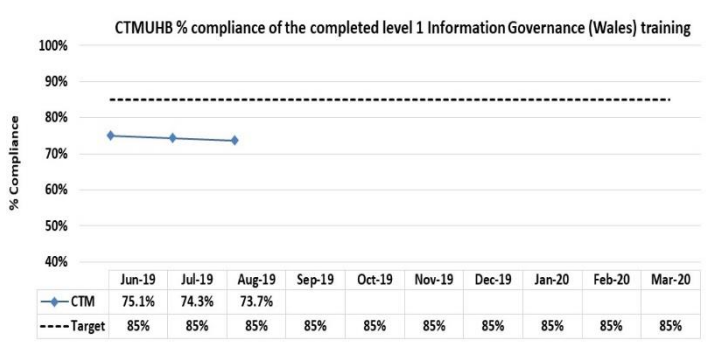
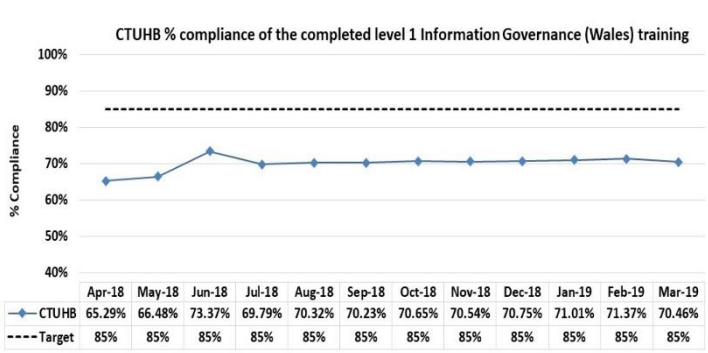


The Measuring Inequalities (2016) report shows that at a population level people are living longer and longer in good health in Wales as a whole. However, the report also indicates at a national level that the difference between life expectancy between the most and least deprived areas of Wales shows no sign of reducing. This is called the Slope Index of Inequalities (SII).

The graph above compares life expectancy and healthy life expectancy for Cwm Taf. It provides a comparison between the time periods 2005/09 and 2010/14 and the variation in the Slope Index of Inequalities (SII). In Cwm Taf, it is a very positive sign that life expectancy and healthy life expectancy (2010-2014) have improved since the previous report (2005-2009). The inequality gap between the most and least deprived has narrowed across all of the parameters and this has not been seen in other parts of Wales. However, we still remain below the Wales averages and for male life expectancy in Rhondda Cynon Taf, the inequality gap has increased since the previous report from 7.4 years to 7.8 years demonstrating the variations within Cwm Taf.

Source: CHKS

Indicator 34: Percentage compliance of the completed Level 1 Information Governance (Wales) training element of the Core Skills and Training Framework	
Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Director of Workforce and Organisational Development
Period: Apr 2018 to Aug 2019	Target: 85%

Current Performance:	How are we doing, what actions are we taking?	Benchmarking: how do we compare?
Cwm Taf Morgannwg: data not available until June 2019  Cwm Taf  Bridgend Data not currently available	Please note: data for CTM was not available for April and May 2019 due to ESR system issues as a result of the boundary change that took place 1st April 2019 Overall the compliance with the IG training has remained static for the last 12 months. Figures are monitored at the Information Governance Group via the standard key performance indicators report. These figures are also submitted to the Quality, Safety & Risk Committee. In addition to this, training compliance is presented at the directorates Clinical Business Meetings to try and increase the uptake of this mandatory training. We continue to hold monthly classroom sessions, promote the E-learning package and the requirement for training is also highlighted at the Corporate Induction session for new starters. Areas of high risk are directorates that have high involvement with medical records, sensitive information and access to clinical systems. We monitor the trends where incidents occur – targeted areas of risk include, CAMHS and Mental Health. Where incidents occur, enforcement action can be considered by the regulatory bodies (which can include a monetary penalty) where these have an effect on an individual. We continue to work towards the 85% target and will routinely monitor progress as set out above.	**Benchmark not available**

	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
CTM	75.1%	74.3%	73.7%							
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
CTUHB	65.29%	66.48%	73.37%	69.79%	70.32%	70.23%	70.65%	70.54%	70.75%	71.01%	71.37%	70.46%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Source: Local/ESR

Indicator 35: Percentage of episodes clinically coded within one reporting month post episode discharge end date

Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Director of Planning and Performance
Period: Apr 2019 to Aug 2019	Target: 95% in month (98% at Year End-Final Submission)

Current Performance:

Cwm Taf Morgannwg

2019/20 Clinical Coding Completeness				
	Reported (frozen) position			Current Postion as at 31/08/2019
Period	Total FCE's	Coded FCE's	% Complete	% Complete
April	12808	6244	51.2%	59.9%
May	13446	6703	49.9%	53.2%
June	12494	6837	54.7%	54.9%
July	0			66.2%
August	0			49.8%
September	0			
October	0			
November	0			
December	0			
January	0			
February	0			
March	0			
Total	38748	19784	51.1%	57.1%

Cwm Taf

2019/20 Clinical Coding Completeness			
Period	Total FCE's	Coded FCE's	% Complete
April	8584	3546	41.3%
May	9009	2781	30.9%
June	8425	3196	37.9%
July	9105	5345	58.7%
August	7540	3186	42.3%
September	0		
October	0		
November	0		
December	0		
January	0		
February	0		
March	0		
Total	42663	18054	42.3%

Bridgend

2019/20 Clinical Coding Completeness			
Period	Total FCE's	Coded FCE's	% Complete
April	4126	4073	98.7%
May	4448	4374	98.3%
June	4047	3645	90.1%
July	4626	3744	80.9%
August	3758	2443	65.0%
September	0		
October	0		
November	0		
December	0		
January	0		
February	0		
March	0		
Total	21005	18279	87.0%

How are we doing, what actions are we taking?

Reaching Clinical Coding Targets continues to be an issue for Cwm Taf due to annual leave, sickness absence, and with the support trainee clinical coders require also contributed to low levels of coding.

Coders from Bridgend Hospital are attempting to support Royal Glamorgan and Prince Charles with the increasing backlog. Casenotes are being sent from Royal Glamorgan to Princess of Wales Coding Department to be coded on a weekly basis.

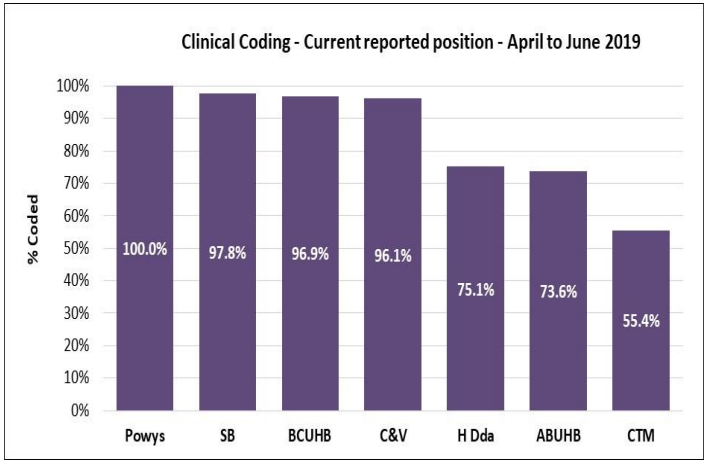
We continue to work towards improving the information that is available to coders particularly in Obstetrics and Gynaecology. Work is being undertaken to identify any anomolies in the clinical coding, and data quality checks are being set up to ensure levels of care are identifed in both diagnostic and procedural fields where appropriate.

We now have a start date for our latest trainee clinical coder who will be joining the department at Royal Glamorgan in September.

Coding managers have been working with NWIS on improving the WPAS reporting system, this will be beneficial to coding staff when needing to manipulate unocoded lists, they are also working with MTED steering group trying to imporve the information on he DAL (Discharge Advice Letter).

Discussions are continuing as to whether Wales will be pro-active with going live with ICD11 and Welsh Government have asked NWIS to identify the effect of going live with ICD-11. As ICD-11 is completely different to ICD-10 the financial cost to the Organisations and external complanies has to be taken into consideration.

Benchmarking: how do we compare?



The uncoded backlog for Cwm Taf continues to be an issue for National Audits due to the reliance of the coded information to identify the patients with particular diagnoses.

However as clinical coding will always be at least 6 weeks in arrears National Audits usually utilise data from completed financial years only.

We are hopeful that the Organisaiton will support the need for contractors to clear the backlog, and that this can be done in a timely manner.

A small amount of overtime is being worked to assist with current backlog, however with sickness and annual leave we strive to improve our coded position at this moment in time

Source: Local WPAS / NWIS

Indicator 36: Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme

Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Director of Planning and Performance
Period: 2018/19	Target: Annual Improvement

Current Performance:

Cwm Taf Morgannwg

Not currently available

Cwm Taf

Code Type	Total Number of Codes Reviewed	Total Number of Correct Codes	% Correct	Target
Primary Diagnosis	320	291	90.94%	90%
Secondary Diagnosis	1379	1307	94.78%	80%
Primary Procedure	152	144	94.74%	90%
Secondary Procedure	423	378	89.36%	80%
Total Accuracy %	2274	2120	93.23%	

Bridgend

Not currently available

How are we doing, what actions are we taking?

This month we continue to carry out some data quality checking of the clinical coding for 1-4th degree Perineal Tears. There will be data quality checks in place to ensure going forward that the diagnostic and procedureal coding reflect what is written in the agreed documentation for coding.

NWIS has also devised a Data Quality Dashboard that produces quality checks looking at any issues in coding assignment indicating that clinical coding standards have not been adhered to. Organisations are given the opportunity to improve on the quality of coding, this is our reasurance that although we occasionally fall short of reaching our in month targets, Cwm Taf coders are producing quality coded data, as demonstrated in the table opposite.

The percentages in the table are from the 2018/19 External Clinical Coding Audit Report carried out by the all Wales Clinical Coding Data Standards Auditors at NWIS. The percentages recorded show that we have met and exceeded the required levels of accuracey. The full report is available via the link below. Whilst there is work to do the conclusion that can be drawn is the organisation can have confidence in coding accuracy.

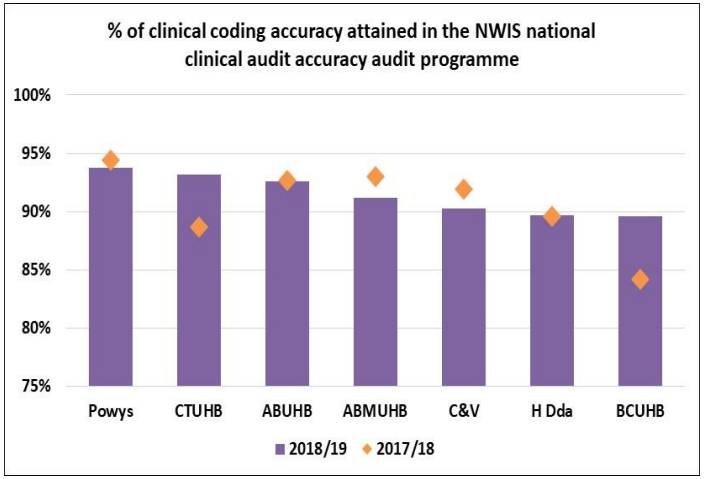
It has been agreed that the Audits undertaken by the Clinical Codign Supervisors will form part of the PDR process for the Clinical Coders.

It is the aim that NWIS will carry out a further audit before the end of the year, this will be usfull to compare the quality of coding.

We will be sending three of our trianees on a Standards course in January.

We are currently in a position to advertise for yet another clinical coder; however we are mindful of the presure this puts on the department, having to train a fuerther member of staff.

Benchmarking: how do we compare?



Cwm Taf Clinical Coding department is pleased to have a 93.23% accuracy level, this is great improvement on last year. With our improved training programme in place for our Annex U and Band 3 trainee clinical coders we are working toward a programme of study for the next two years that will prepare the trainee's and build their knowledge and confidence. Our supervisor who is currently responsible for both PCH and RGH is delivering this training. We are confident that Cwm Taf will go from strength to strength.

Source: NWIS : http://nww.nwisinformationstandards.wales.nhs.uk/sitesplus/documents/299/20190129-REP-Cwm%20Taf%20Clinical%20Coding%20Audit%20Report-2018-19.pdf

Indicator 37: All new medicines recommended by AWMSG and NICE, including interim recommendations for cancer medicines, must be made available where clinically appropriate, no later than two months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation

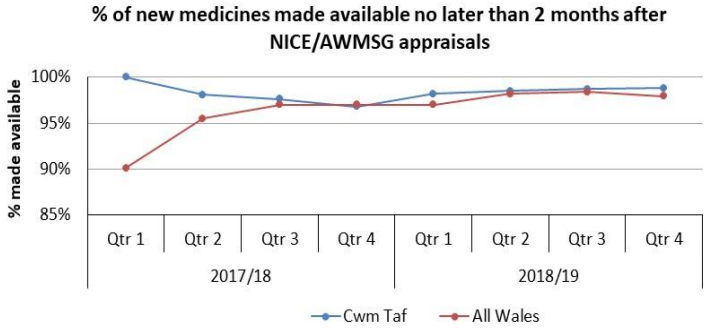
Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Director of Primary, Community and Mental Health
Period: 2017/18 & 2018/19	Target: 100%

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

Cwm Taf have implemented the vast majority of new medicines within the 60 day target set by Welsh Government.

Exceptions to this target have been where there is no clear commissioning pathway, as use within Cwm Taf is not appropriate.

New technologies or medicines which require wider resources to implement their use can take longer to process.

Benchmarking: how do we compare?

% of new medicines recommended by NICE/AWMSG made available, where clinically appropriate, no later than 2 months from the publication of the appraisal

Target is 100%		Cwm Taf	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys
2018/19	Qtr 1	98.2%	100.0%	99.1%	99.1%	95.5%	99.1%	93.6%
	Qtr 2	98.5%	100.0%	99.3%	99.3%	96.3%	99.3%	94.8%
	Qtr 3	98.7%	100.0%	99.3%	99.3%	96.6%	99.3%	95.3%
	Qtr 4	98.8%	96.4%	98.8%	99.4%	97.0%	99.4%	95.8%
2017/18	Qtr 1	100.0%	97.6%	82.9%	95.1%	90.2%	97.6%	100.0%
	Qtr 2	98.1%	98.1%	98.1%	98.1%	90.7%	98.1%	87.0%
	Qtr 3	97.6%	100.0%	98.8%	98.8%	93.9%	98.8%	91.5%
	Qtr 4	96.8%	100.0%	98.9%	98.9%	93.7%	98.9%	91.6%

We compare favourably with our peers, as not all medicines are appropriate to be prescribed or used within Cwm Taf i.e. require commissioning from specialist centres.

Source: Welsh Government Delivery and Performance Website

Indicator 38: Number of Health and Care Research Wales clinical research portfolio studies
Indicator 39: Number of Health and Care Research Wales commercially sponsored studies
Indicator 40: Number of patients recruited in Health and Care Research Wales clinical research portfolio studies
Indicator 41: Number of patients recruited in Health and Care Research Wales commercially sponsored studies

Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Medical Director
Period: 2018/19 **Cwm Taf University Health Board**	Target: AS PER TABLE

Current Performance: How are we doing?

Health and Care Research Wales Indicator	Total 2018/19	2018/19 Q1	Q2	Q3	Q4	% Annual Improvement Target	2017/18	Annual % Change
38 Number of Clinical Research Portfolio Studies	70	38	6	11	15	10%	64	9.38%
2017/18 Data for comparison		*22*	*39*	*52*	*64*			
39 Number of Commercially Sponsored Studies	9	3	0	2	4	5%	7	28.57%
2017/18 Data for comparison		*2*	*3*	*5*	*7*			
40 Number of patients recruited Clinical Research Portfolio Studies	3616	1269	887	727	733	10%	2324	55.59%
2017/18 Data for comparison		*193*	*507*	*1115*	*2324*			
41 Number of patients recruited Commercially Sponsored Studies	41	6	1	6	28	5%	36	13.89%
2017/18 Data for comparison		*9*	*19*	*24*	*36*			

Local Support and Delivery funding is provided to organisations to develop their own research infrastructure to support, deliver, promote and encourage high quality research. Funding is based on research activity for the previous three rolling years (activity based funding) i.e. the number of open Clinical Research portfolio (CRP) studies, number of participants recruited to CRP studies, number of Chief Investigators affiliated to the organisation and the number of clinical research fellows within the organisation. Each NHS Organisation in receipt of the Local Delivery and Support Funding is measured against key performance indicators set by the R&D Division, Welsh Government and these are reported on a quarterly basis. Organisations are expected to increase the number of studies open and adopted onto the clinical research portfolio (CRP) by 10% per annum and commercial studies by 5% and also the number of participants recruited to CRP and commercial studies by 10% and 5% respectively.

There has been excellent performance during the last year reflected in the number of participants being recruited into CRP studies with an increase of 55% in the number of participants recruited from the previous year. The target for non-recruiting CRP studies is set at 0%, which was also met in 2018-19. One of the performance metrics which the department did not meet during 2018-19 included the recruitment to time to target for CRP studies. It is a continuing priority for the R&D team to ensure that the appropriate research nurse and research officer support is allocated to studies in order to meet the recruitment targets, as well as ensuring that early discussions with Principal Investigators establish recruitment targets that are achievable.

During 2018/19, CTUHB exceeded the KPIs for the number of open commercial studies and for the number of participants recruited to CRP and commercial studies, the highest level of annual research activity in CTUHB to date. Undertaking commercial research provides an opportunity to increase R&D related income whereby pharmaceutical and medical device companies pay all necessary costs for the study to be undertaken, to include overheads and capacity building costs. The provision of the overheads and capacity building costs provide flexible funds that can be re-invested, as per appropriate financial practices, into research.

The Assistant Director for R&D, R&D Manager and R&D Finance Analyst attended the annual performance management meeting with the R&D Division, Welsh Government and the Director of Health and Care Research Wales Support Centre on Friday, 12th July. Welsh Government were pleased with the UHB's performance during 2018-19 to include the levels of research activity, the distribution of R&D funding and the Primary Care model of work that has been established across the UHB. The R&D team continue to prioritise the increase in non-commercial and commercial research activity in circulating potential studies and providing support to clinicians in completing feasibility questionnaires, attending site selection visits and the set up and delivery of the study. The R&D team are processing an increasing number of feasibility requests (expressions of interests, feasibility questionnaires) for both commercial and non-commercial companies. Further investment in the R&D infrastructure has resulted additional posts to set up, support and deliver CRP and commercial studies across Cwm Taf.

The strategic objective to increase the number of Chief Investigators aligned to the UHB and to increase the number of "in house" Chief Investigators and research leaders was also met. During 2018-19, there were 16.6 Chief Investigators affiliated to Cwm Taf UHB and 8 of these were in house.
Since April 1st, 2019 all research undertaken within the Bridgend boundary has been the responsibility of Cwm Taf Morgannwg UHB's R&D team. The boundary change has provided an exciting opportunity to develop the R&D infrastructure in Bridgend to provide support to research active professionals (to include secondary / primary / community care and population health) in the set up and delivery of existing CRP and commercial studies. There is also an opportunity to develop and progress their own research ideas with appropriate external funding and support from the CTMUHB R&D team.

Source: Local / https://www.healthandcareresearch.gov.wales/performance-management/

Indicator 38 to 41 continued:	
Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Medical Director
Period: 2018/19 **Cwm Taf University Health Board**	

What are the areas of risk?

Support and investment is required from the Health Board to enable the organisation to continue to develop the infrastructure required to meet the targets and metrics set and performance managed by the Research and Development Division, Welsh Government and the UHB's own R&D strategy, delivery plan and ambition. This includes the further development of its Commercial research portfolio and scope for increasing the UHB's income generation and re-investment into research activities. Increasing this income will serve to complement the income currently provided from the NHS R&D allocation and successful grant applications.

Failure to invest / re-invest in the research infra-structure and maintain or increase the research activity, will result in a decreasing R&D income through grant funding and commercial studies and will be a risk to the success of the UHB's R&D ambitions and evidence based improvements in patient care.

The current Activity Based Funding formula and approach to NHS R&D funding is under review, for possible implementation in April 2020. A Task and Finish group has been set up to be chaired by the Health and Care Research Wales Director for Support and Delivery with representation form Health and Care Research Wales, Academia and the 2 of the NHS R&D Directors. Cwm Taf Morgannwg UHB's Assistant Director for R&D, with the other R&D Directors have raised a concern that there will not be representation from each of the NHS organisations. Cwm Taf UHB's Assistant Director for R&D has sought assurance from the Interim R&D Director at Welsh Government, that discussions will be open and fully transparent and that Cwm Taf Morgannwg will be given the opportunity to have a continual input into the proceedings. A draft engagement plan has been drafted in relation to the consultation process.

The development of a well-equipped, designated Clinical Research Facility that could provide dedicated clinical space for the recruitment and examination of patients consenting to participate in research remains a priority and would be a major step forward in developing Cwm Taf Morgannwg UHB's research portfolio, both commercial and non-commercial. This will optimise the UHB's income generation potential, but most importantly provide additional opportunities for the patients of Cwm Taf Morgannwg to gain access to new and innovative treatments and medical technologies. Development of such a facility would also strengthen the UHB's research infra-structure and reflect its University Health Board status. This programme of work is in setup and support will be sought from UHB Executives.

In addition to the development of the available physical space and accommodation, R&D activity could be increased if the capacity of the workforce could be optimised to ensure that research is central to their roles. This could be facilitated by the inclusion of research sessions in Consultant job plans through SPA. In addition the inclusion of research and the provision of time to undertake research in the job descriptions of the workforce. These alone would increase the research capacity considerably across the UHB, contributing to the improved quality of patient care, but also staff morale, recruitment and retention. With support from the Executives, Human Resources and Line Management this is achievable.

Due to the low volume of clinical trials of investigational medicinal products (cTIMPs) being hosted and sponsored by Cwm Taf Morgannwg a statutory inspection by the Medicines and Healthcare Products Regulatory Agency (MHRA), in relation to the conduct of Clinical Trials has not been required to date. As the clinical trial activity grows in Cwm Taf Morgannwg UHB, the likelihood of an MHRA inspection will increase. An NHS Organisation undergoing MHRA inspection is expected to demonstrate their compliance with Good Clinical Practice and the Clinical Trials Regulations. This includes ensuring training and records are in place for staff, ensuring clarity of roles and responsibilities and ensuring adherence to trial documentation e.g. protocol. "Preparing Teams for Regulatory Inspection – MHRA Inspection Readiness' training took place at Prince Charles Hospital on Thursday 12th July 2018. This training was provided by Wendy Fisher Consulting covering the role of MHRA and inspection planning for clinical trials. 16 members of staff attended.

On completion of a research project, the R&D study file and site file is required to be archived. The length of time is dependent upon the type of study but records must be stored for at least 10 years from project completion. The files should be stored in lockable cabinets that are fire proof and waterproof. R&D files are currently stored in the Plant Room in Royal Glamorgan Hospital but they have been deemed a fire hazard and are required to be moved. It is envisaged that there will be sufficient space for archiving with the development Clinical Research Facility.

Source: Local / https://www.healthandcareresearch.gov.wales/performance-management/

Indicator 38 to 41 continued:

Outcome: Interventions to improve my health are based on good quality and timely research and best practice	Executive Lead: Medical Director

Period: 2018/19 **Cwm Taf University Health Board**

Benchmarking: how do we compare?

	Number of Clinical Research Portfolio Studies	Number of Commercially Sponsored Studies	Number of patients recruited Clinical Research Portfolio Studies	Number of patients recruited Commercially Sponsored Studies
	2018/19			
ABMU	97	37	2276	37
AB	88	12	2134	12
BCU	81	9	1553	9
C&V	205	53	6251	53
C Taf	**70**	**9**	**3616**	**41**
H Dda	58	5	1085	5
Powys	6	0	34	0
	2017/18			
ABMU	96	44	2207	401
AB	80	12	1282	161
BCU	81	10	1834	89
C&V	190	47	5031	305
C Taf	**64**	**7**	**2324**	**36**
H Dda	44	6	984	77
Powys	7	0	108	0
	2016/17			
ABMU	109	36	2784	221
AB	68	9	1932	85
BCU	97	6	1539	553
C&V	176	47	5064	351
C Taf	**54**	**4**	**1468**	**12**
H Dda	50	7	1695	19
Powys	9	0	144	0

Cwm Taf UHB had the largest increase in the number of participants recruited to CRP studies during 2018-19 and recruited the 2nd highest number of participants to CRP studies.

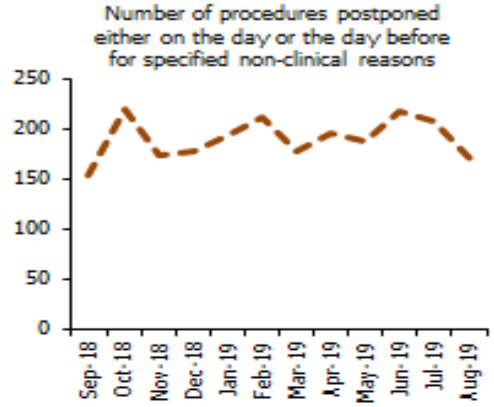
Compared to some NHS Organisations, Cwm Taf UHB appears to have low levels of commercial activity but there has been a significant growth in Cwm Taf UHB's research activity over the last 3 years. Other factors should also be taken into consideration to enable the appropriate comparison against other Health Board's such as the size, infrastructure, patient population and funding received from Welsh Government. All of these factors will affect the Health Board's ability to increase the number of CRP and commercial studies.

The R&D team remain dedicated to exceeding its KPIs to ensure that the opportunity to increase the ABF allocation and other income avenues to invest in the R&D infrastructure are maximised.

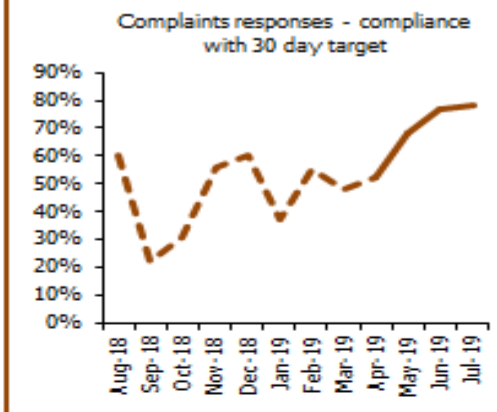
Source: Local / https://www.healthandcareresearch.gov.wales/performance-management/

DIGNIFIED CARE – People in Wales are treated with dignity and respect and treat others the same

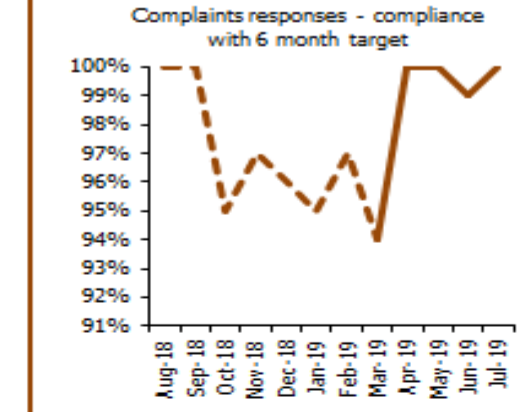
Key: Cwm Taf Morgannwg —— **Cwm Taf** - - - **or** **Bridgend**



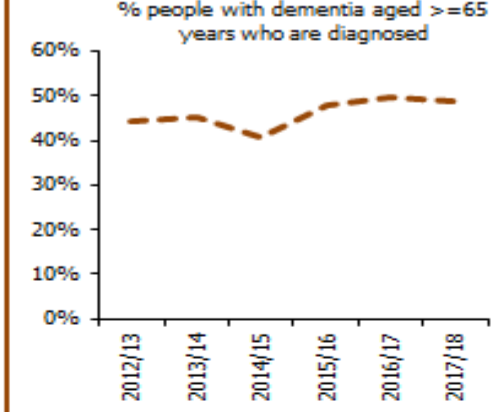
Current Position		
CT	B	CTM
169	N/A	N/A



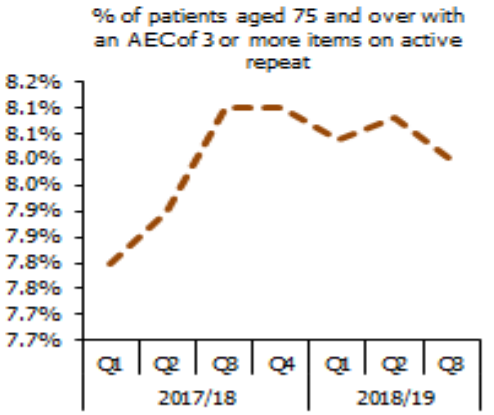
Current Position		
CT	B	CTM
N/A	N/A	78.0%



Current Position		
CT	B	CTM
N/A	N/A	100.0%



Current Position		
CT	B	CTM
48.7%	N/A	N/A



Current Position		
CT	B	CTM
8.0%	N/A	N/A

Indicator 43: Number of procedures postponed either on the day or the day before for specified non-clinical reasons

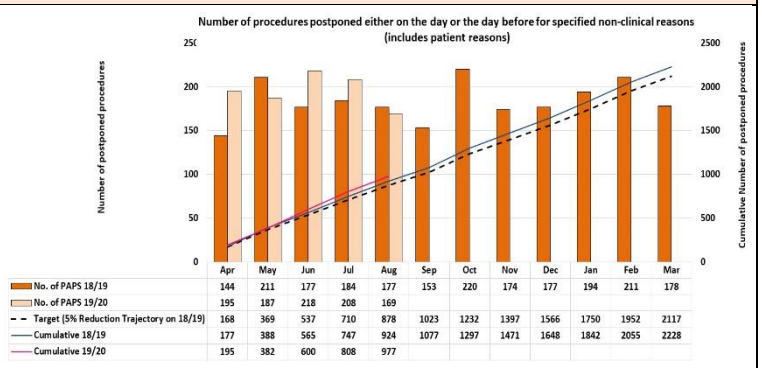
Outcome: I receive a quality service in all care settings	Executive Lead: Chief Operating Officer
Period: Apr 2018 to Aug 2019	Target: >5% reduction from 17/18

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. of PAPS 18/19	144	211	177	184	177	153	220	174	177	194	211	178
No. of PAPS 19/20	195	187	218	208	169							
Target (5% Reduction Trajectory on 18/19)	168	369	537	710	878	1023	1232	1397	1566	1750	1952	2117
Cumulative 18/19	177	388	565	747	924	1077	1297	1471	1648	1842	2055	2228
Cumulative 19/20	195	382	600	808	977							

Bridgend

Data not currently available

How are we doing, what actions are we taking?

The measure for postponed admitted procedures has changed with the 2018/19 Outcomes Framework from "Patients that should their operations be cancelled on more than one occasion, with less than 8 days' notice then they would receive treatment within 14 days of the second cancellation, or at the patient's earliest convenience" to "Number of procedures postponed either on the day or the day before for specified non-clinical reasons".

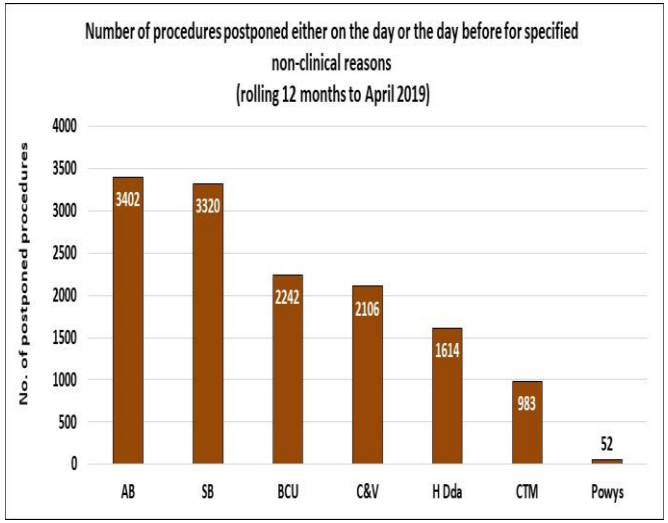
The data for this measure is extrapolated from the Health Board's Welsh PAS application at the end of each month.

The Health Board is raising awareness of this measure amongst patient booking staff and ensuring that data capture accurately reflects the discussions being undertaken with patients. This will ensure increased compliance with this measure.

One of the main issues relates to patients being booked prior to being declared fit by pre-assessment. Booking staff have been instructed to follow Health Board guidance in this area. Pre-assessment delays, which attribute to this issue are being addressed as part of the planned care work-streams.

Periods of patient unavailability need to be accurately recorded for this measure to be calculated precisely. Pre-assessment delays need to be minimised.

Benchmarking: how do we compare?



Cwm Taf is performing better than its peers apart from Powys.

Source: Local Information Team

Indicator 44: Number of patients aged 75 and over with an AEC (Anticholinergic Effect on Condition) of 3 or more for items on active repeat, as a percentage of all patients aged 75 years and over

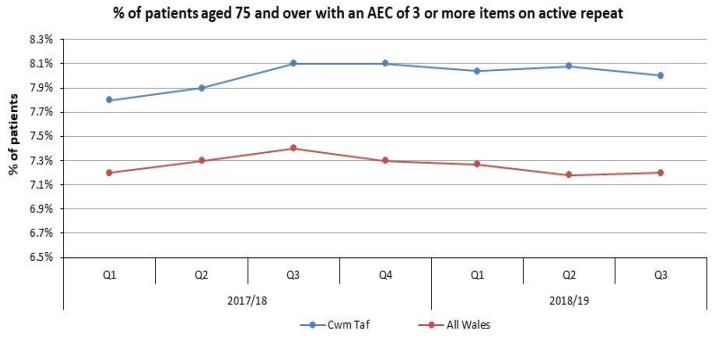
Outcome: I receive a quality service in all care settings	Executive Lead: Director of Primary, Community and Mental Health
Period: 2017/18 to 2018/19 (Qtr 3)	Target: 4 Quarter Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

Cwm Taf have the second highest number of patients aged 75 and over with an AEC of 3 or more. The % has increased slightly over the last few quarters.

The new care home service for community pharmacies in Wales has been designed to identify and review patients who have an ACE burden of 3 or more. This service is being commissioned within the HB from November 2018 onwards.

This work stream is being incorporated into the prescribing team work plan for 2019-20

It is good practice to use medicines with AEC scores of zero and to avoid those scored 1, 2 or 3. The clinician should discuss with the patient and carer the benefits and potential risks of continued use of these medicines with the aim of either stopping them or switching to an alternative drug with a lower AEC score (preferably zero).

There are a large number of medicines that fall into this category and reviewing all patients taking them is a time consuming process. There will be some patients where the risk / benefit ratio may favour the continuation of a higher scoring medicine.

Benchmarking: how do we compare?

Number of patients aged 75 and over with an AEC (Anticholinergic Effect on Condition) of 3 or more for items on active repeat, as a % of all patients aged 75 years and over

		CTUHB	ABMU	AB	BCU	C&V	HDda	Powys
2018/19	Qtr 1	8.0%	8.0%	8.3%	7.3%	6.1%	6.0%	6.3%
	Qtr 2	8.1%	8.0%	8.1%	7.1%	6.2%	5.8%	6.1%
	Qtr 3	8.0%	7.9%	8.2%	7.1%	6.2%	5.9%	5.9%
2017/18	Qtr 1	7.8%	7.9%	8.0%	7.3%	6.5%	5.9%	6.1%
	Qtr 2	7.9%	7.9%	8.0%	7.3%	6.5%	5.9%	6.4%
	Qtr 3	8.1%	8.2%	8.3%	7.5%	6.4%	6.1%	6.4%
	Qtr 4	8.1%	8.0%	8.3%	7.4%	6.2%	6.0%	6.4%

We are currently the 2nd highest prescriber in Wales, there has been an increase in Cwm Taf alongside six other HB's. Only one HB has demonstrated a decrease.

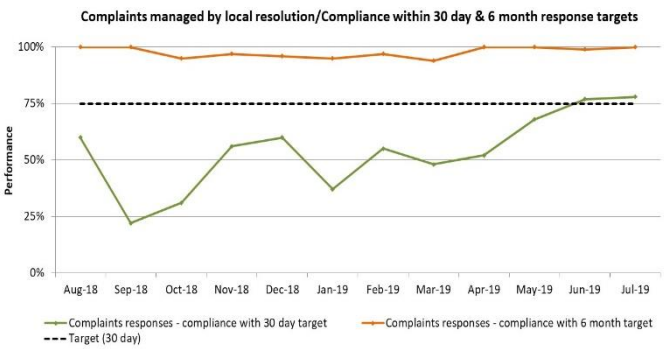
Source: Welsh Government Delivery and Performance Website

Indicator 46: The percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the concern was first received by the organisation

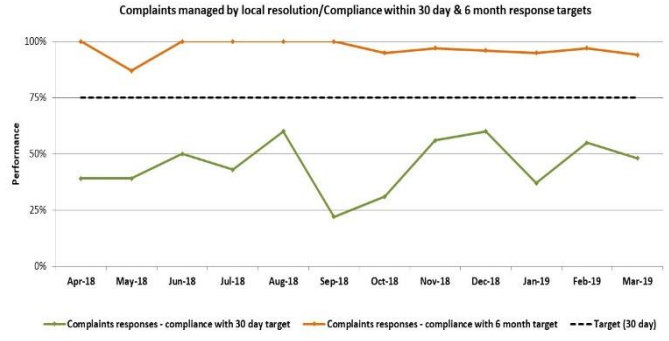
Outcome: My voice is heard and listened to	Executive Lead: Director of Nursing
Period: Jul 2018 to Jun 2019	Target: 75%

Current Performance:

Cwm Taf Morgannwg: from 1st April 2019



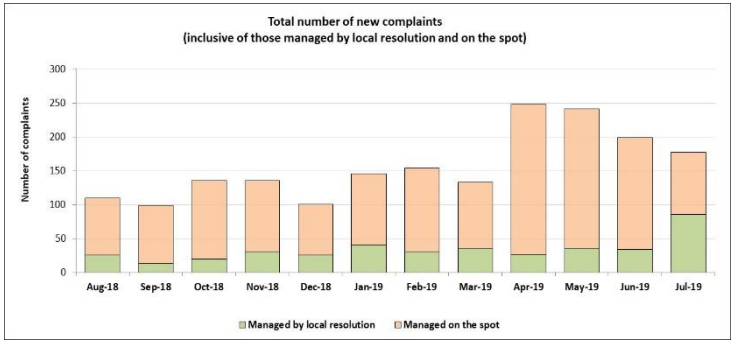
Cwm Taf: to 31st March 2019



Bridgend

Data not available

How are we doing, what actions are we taking?



The Health Board received 704 complaints during Quarter 1 of these **491 (69%)** were managed under early resolution. 278 recorded for Princess of Wales (POW), 111 Royal Glamorgan Hospital (RGH) and 87 Prince Charles Hospital (PCH). This expected increase is in line with the recently implemented changes to the recording of informal complaints and also the transition with POW.
During Quarter 1, 142 formal complaints cases were closed. Details of the complaints closed during the Quarter 1 are provided in appendix 1.

At the end of Quarter 1 there were 239 formal Complaints which were 'ongoing' i.e. in the process of being managed. At the time of writing the report, six complaints were open which were received over 6 months ago. These are complex cases which are still under investigation, 3 for Gynaecology and 3 for general medicine. Clinical pressures within the Directorates has impacted on the ability of staff to complete investigations within the timescales and work is required to enable further improvements in compliance with the 30 working day target.

Compliance with complaint response times during Quarter 1 has increased to 69% this is due to the targeted improvement work undertaken by the team and the changes to logging of cases being managed under early resolution.

Benchmarking: how do we compare?

% of concerns that have received a final reply (Reg 24) or an interim reply (Reg 26) up to & including 30 working days from the date the concern was first received by the organisation - Target 75%							
2018/19	CTUHB	ABMU	AB	BCU	C&V	HDda	Powys
Qtr 1	50.0%	80.7%	51.4%	42.1%	65.6%	62.9%	60.4%
Qtr 2	22.9%	77.2%	47.3%	35.2%	75.2%	66.4%	50.0%
Qtr 3	16.9%	80.7%	42.7%	36.0%	80.8%	68.9%	62.5%
Qtr 4	67.5%	82.0%	34.9%	33.6%	77.3%	66.5%	55.8%

Compliments and positive feedback from patients: The Patient Experience Team collates written compliments that are received at Ward and Department level. For Quarter 1 the wards and departments reported 554 compliments.

The Health Board also regularly receives compliments through the Concerns Team and Chief Executive's office, by email, letter, Social Media Sites and on Patient Opinion websites which are reflected in the figure above.

Source: Local Datix

Indicator 47: Percentage of people in Wales registered at a GP practice (age 65 years or over) who are diagnosed with dementia

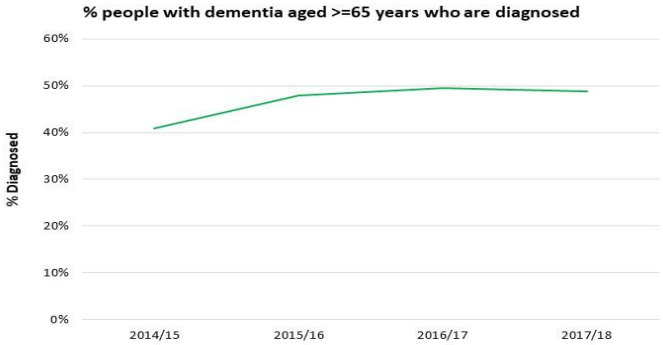
Outcome: My voice is heard and listened to	Executive Lead: Director of Primary, Community and Mental Health
Period: 2014 to 2018	Target: Annual Improvement

Current Performance:

Cwm Taf Morgannwg

Not currently available

Cwm Taf



Bridgend

Not currently available

How are we doing, what actions are we taking?

Health Boards are required to monitor numbers and percentages of patients recorded with Dementia.

Available data for people within dementia in Wales aged 65 years or over who are diagnosed (registered on a GP QOF register) is available up to the period 2017/18.

Discussions to be picked up with Primary Care.

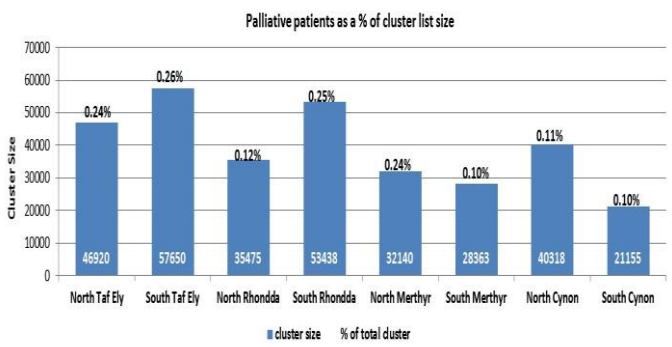
Benchmarking: how do we compare?

	Number of people on QoF dementia register (number with a diagnosis)			
Health Board	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Abertawe Bro Morgannwg	3305	3581	3925	3768
Aneurin Bevan	3608	3685	3873	3883
Betsi Cadwaladr	4614	4705	5191	5092
Cardiff & Vale	2799	2859	3266	3158
Cwm Taf	**1531**	**1622**	**1693**	**1629**
Hywel Dda	2369	2424	2671	2685
Powys	1013	979	1036	1023
Wales	19239	19806	21655	21238
	Estimated number of people with dementia (diagnosed and undiagnosed)			
Health Board	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Abertawe Bro Morgannwg	7359	6412	6480	6545
Aneurin Bevan	7798	6841	6954	7090
Betsi Cadwaladr	10985	9600	9752	9922
Cardiff & Vale	5652	4947	4993	5045
Cwm Taf	**3752**	**3287**	**3321**	**3345**
Hywel Dda	6368	5588	5681	5807
Powys	2448	2160	2204	2239
Wales	44362	43478	39385	39995
	Percent of people with dementia with a diagnosis			
Health Board	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Abertawe Bro Morgannwg	44.9%	55.8%	58.8%	57.6%
Aneurin Bevan	46.3%	53.9%	54.0%	54.8%
Betsi Cadwaladr	42.0%	49.0%	51.6%	51.3%
Cardiff & Vale	49.5%	57.8%	63.4%	62.6%
Cwm Taf	**40.8%**	**47.9%**	**49.5%**	**48.7%**
Hywel Dda	37.2%	43.4%	45.6%	46.2%
Powys	41.4%	45.3%	45.6%	45.7%
Wales	43.4%	51.0%	53.3%	53.1%

Cwm Taf is comparable to its peers

Source:https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister

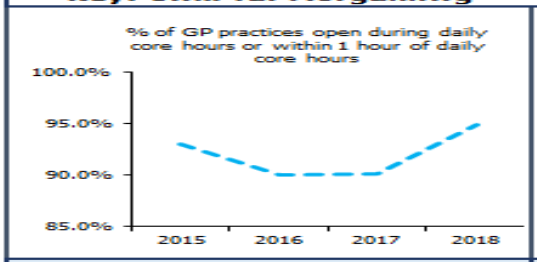
Local Measure: Percentage of Patients registered as receiving palliative care with their GP practice	
Outcome: I am treated with dignity and respect and treat others the same	Executive Lead: Director of Primary, Community and Mental Health
Period:	Target:

Current Performance:	How are we doing, what actions are we taking?	Benchmarking: how do we compare?
Cwm Taf Morgannwg Not currently available Cwm Taf  Bridgend Not currently available	Health Boards are also requested to monitor those patients on a Palliative Care pathway. The graphs shown are for 2016/17 for all patients on the Palliative Register. There is no further update this month. Discussions to be picked up with Primary Care.	**Benchmark not available**

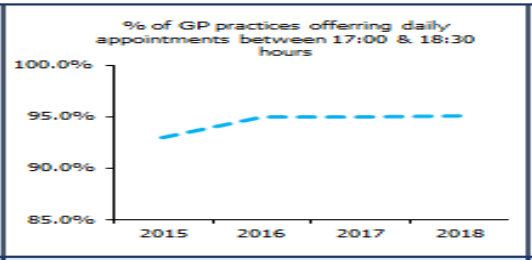
Source: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister

TIMELY CARE - People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care

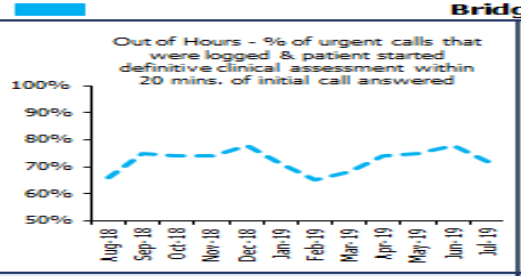
Key: Cwm Taf Morgannwg —— **Cwm Taf** - - - **or** ▬ **Bridgend**



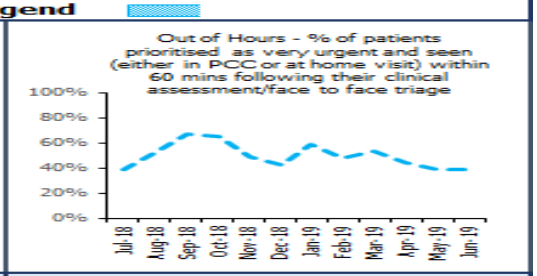
Current Position		
CT	B	CTM
95%	N/A	N/A



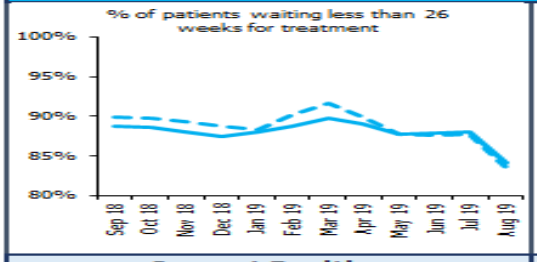
Current Position		
CT	B	CTM
95%	N/A	N/A



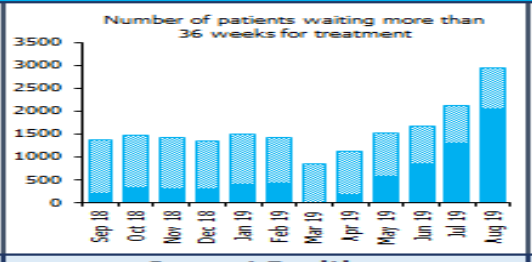
Current Position		
CT	B	CTM
72.0%	N/A	N/A



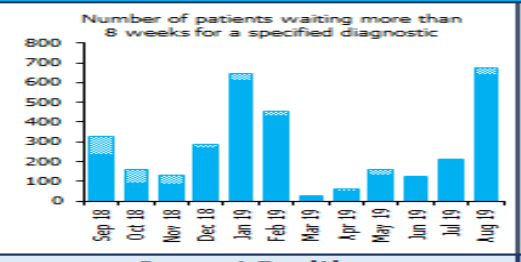
Current Position		
CT	B	CTM
39.0%	N/A	N/A



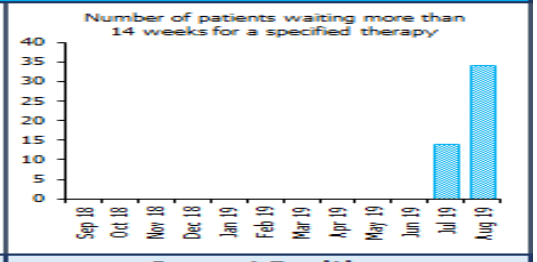
Current Position		
CT	B	CTM
83.6%	85.3%	84.2%



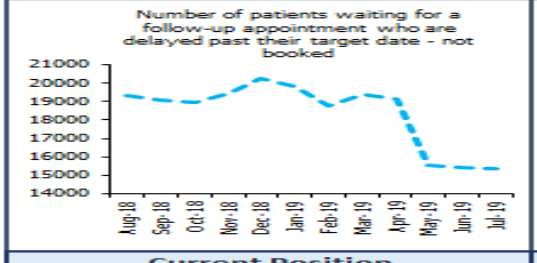
Current Position		
CT	B	CTM
2053	896	2949



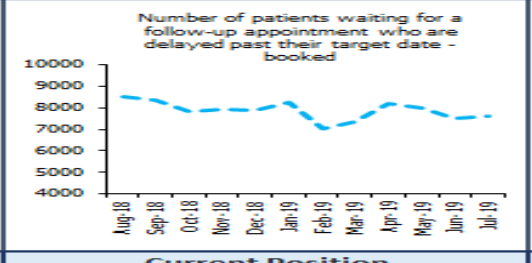
Current Position		
CT	B	CTM
137	19	156



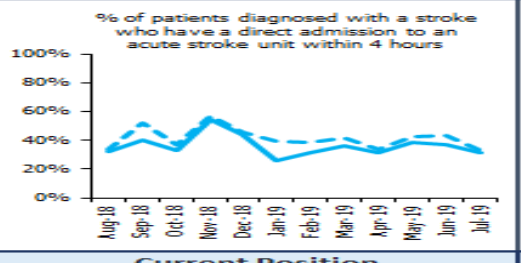
Current Position		
CT	B	CTM
0	34	34



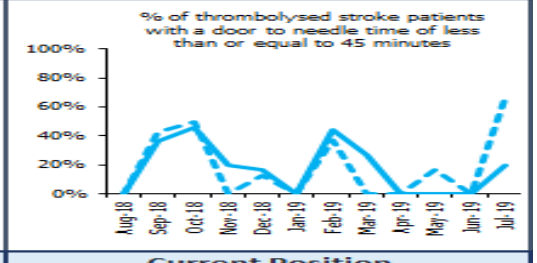
Current Position		
CT	B	CTM
15349	N/A	N/A



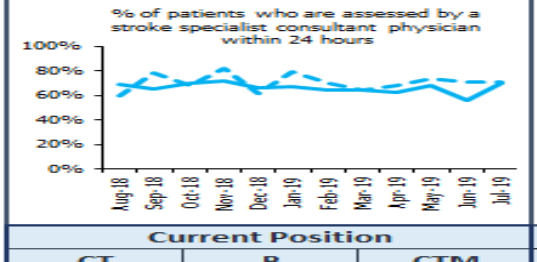
Current Position		
CT	B	CTM
7606	N/A	N/A



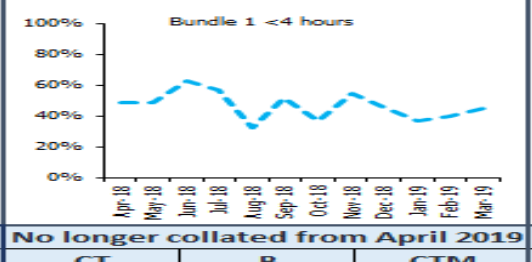
Current Position		
CT	B	CTM
33.3%	28.6%	31.6%



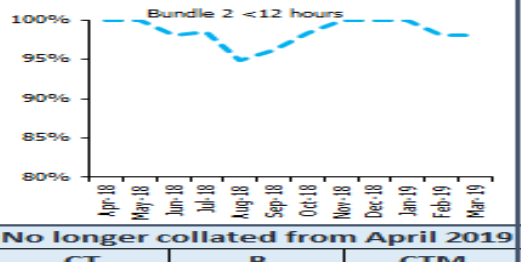
Current Position		
CT	B	CTM
66.7%	N/A	20.0%



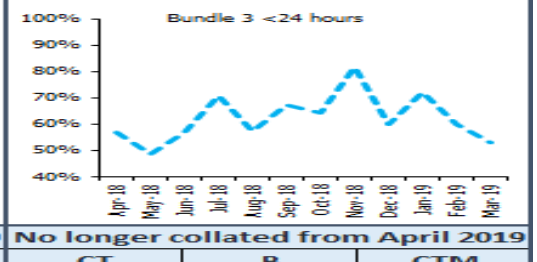
Current Position		
CT	B	CTM
70.5%	69.4%	70.1%



No longer collated from April 2019		
CT	B	CTM
451.0%	N/A	N/A

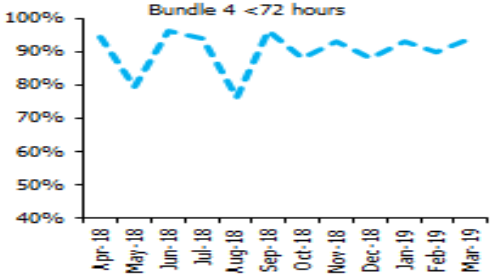


No longer collated from April 2019		
CT	B	CTM
98.0%	N/A	N/A

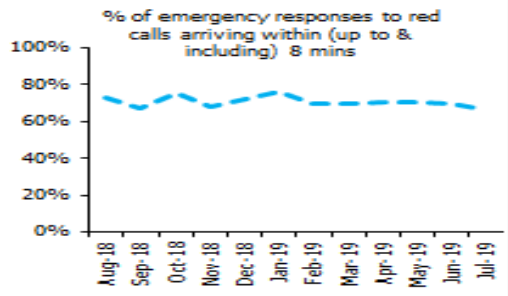


No longer collated from April 2019		
CT	B	CTM
52.9%	N/A	N/A

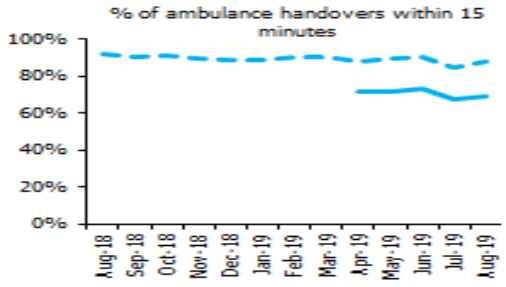
Key: Cwm Taf Morgannwg —— **Cwm Taf** - - - **or** ▬ **Morgannwg**



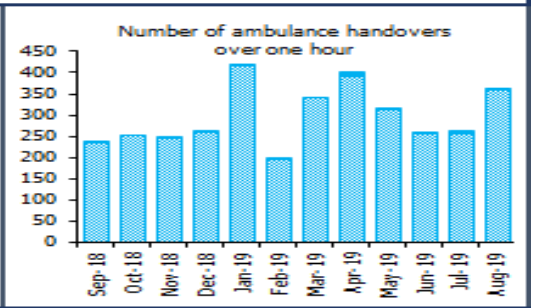
No longer collated from April 2019		
CT	B	CTM
94.1%	N/A	N/A



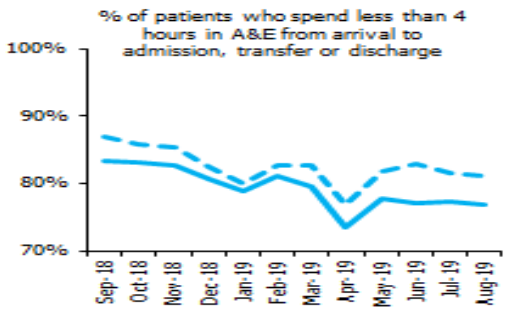
Current Position		
CT	B	CTM
N/A	N/A	66.4%



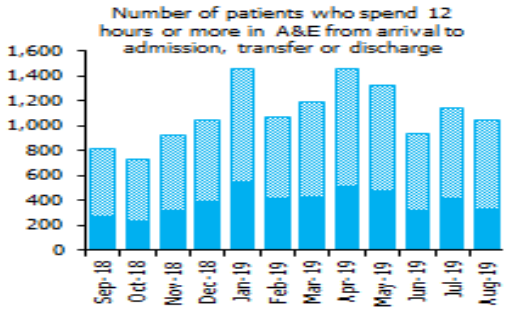
Current Position		
CT	B	CTM
88.4%	18.1%	69.3%



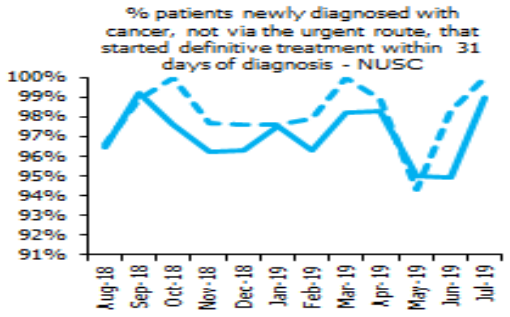
Current Position		
CT	B	CTM
4	354	358



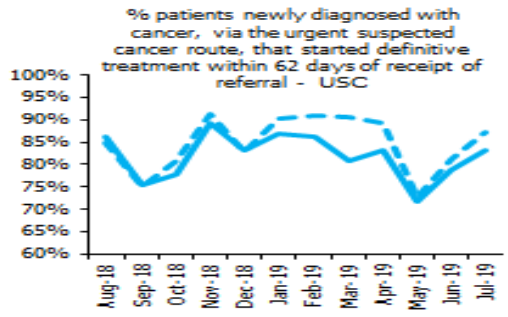
Current Position		
CT	B	CTM
81.2%	67.6%	76.8%



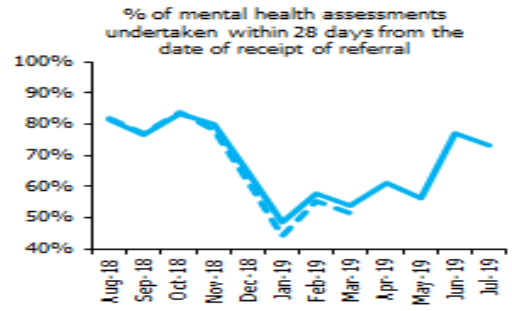
Current Position		
CT	B	CTM
335	381	716



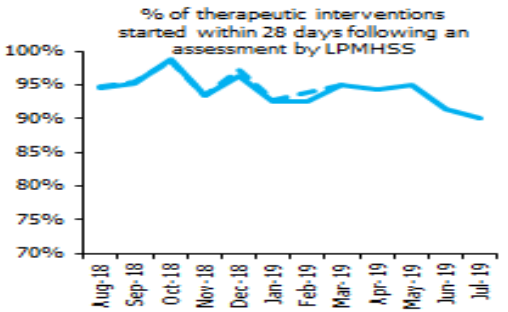
Current Position		
CT	B	CTM
100.0%	95.8%	99.0%



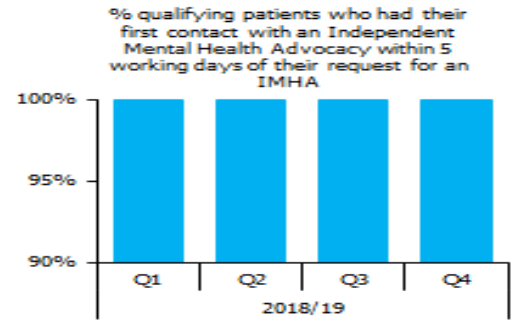
Current Position		
CT	B	CTM
87.3%	75.0%	83.3%



Current Position		
CT	B	CTM
No longer collated		73.1%



Current Position		
CT	B	CTM
No longer collated		90.2%



Current Position		
CT	B	CTM
100%	N/A	N/A

Indicator 53: Percentage of GP practices open during daily core hours or within 1 hour of daily core hours

Outcome: I have easy and timely access to primary care services	Executive Lead: Director of Primary, Community and Mental Health
Period: 2017/18	Target: Annual Improvement

Current Performance:

Cwm Taf Morgannwg

Data is not currently available

Cwm Taf

Data is not currently available

Bridgend

Data is not currently available

How are we doing, what actions are we taking?

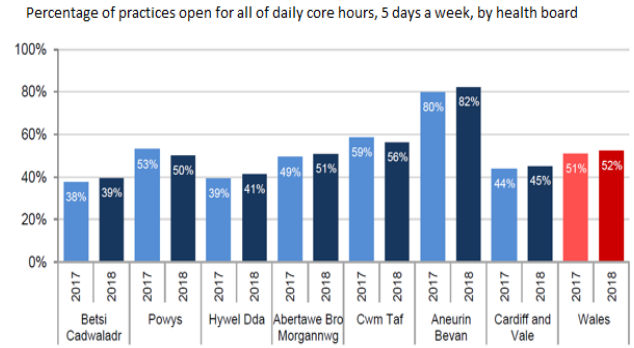
For practices not offering appointments specifically between 18:00 and 18:30 hours, it has been noted that, in the majority of practices, appointments run up to practice closing hours ie 18:30 hours. Depending on need, the last appointment would be scheduled to conclude by closing hours 18:30 hours.

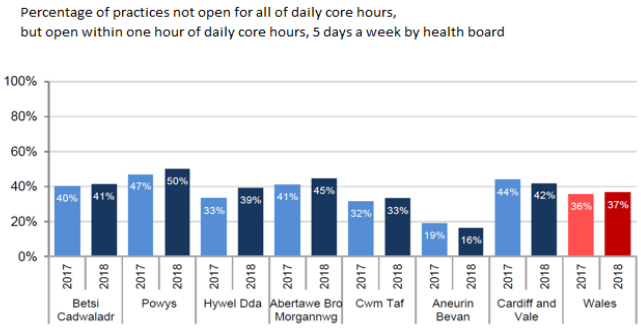
What actions are we taking?

Regular assessing of practices are meeting needs by:

- Practice development visits are completed for all GP practices where discussion on access is an integral part. During the visit the following is reviewed with the practice:
- Practice Opening times and Surgery Sessions: Emphasis is given on the optimum opening times:
- Doors open Phones on 8.00am - 6.30pm
- *Open all day Thursday (unless under special circumstances and agreed with CTUHB)
- Provide access to an appropriate member of the practice primary care team within 24 hours?
- The opportunity to pre book an appointment up to two weeks in advance?
- Giving patients the opportunity to be seen by a GP of the patient's choice, within 4 weeks?
- Allowing patients to book an appointment with one telephone call, with no need to call back or be directed to book online?
- Is telephone access directly to a member of staff (not a recorded message) available from 8.00am - 6.30pm and can patients' book telephone consultations.
- Are the doors open, phones on and reception manned during lunchtimes?
- Practices across all 4 clusters worked with the Primary Care Foundation to analyse their access and capacity to identify areas that they could improve upon or ways to work smarter. They also completed a 'reception quiz' that looked at variation in response to potentially urgent calls across the reception team.
- Cwm Taf DNA policy
- Activity monitoring – winter pressure planning

Benchmarking: how do we compare?





Nearly all (98%) of practices in Wales offer appointments at some point between 17:00 and 18:30, at least one day a week. However, there is much variation between health boards in later appointments offered with nearly half of practices in Cwm Taf offering appointments every week day for the whole half hour period between 18:00 and 18:30, whereas over 90% of practices in Betsi Cadwaladr and Cardiff and Vale do not offer appointments for the whole half hour period on any day.

Cwm Taf Health Board (as was) compared favourably with other Welsh Health Boards.

Source: https://gov.wales/statistics-and-research/?topics=Health+and+social+care&subtopics=GPs&view=Search+results&lang=en
Source: National Survey for Wales

Indicator 54: Percentage of GP practices offering daily appointments between 17:00 and 18:30 hours

Outcome: I have easy and timely access to primary care services

Executive Lead: Director of Primary, Community and Mental Health

Period: 2017/18

Target: Annual Improvement

Current Performance:

Cwm Taf Morgannwg

Data is not currently available

Cwm Taf

Data is not currently available

Bridgend

Data is not currently available

How are we doing, what actions are we taking?

Practices using a variety on innovations to improve patients access to services:

- E-Consult: Online access for medical advice/signposting. Practice GP triage requests which means a patient may not need a trip to the surgery, freeing up appointment slots.
- Patient Partner: Patients are able to book and cancel appointments over the phone. Enabling practices to have an effective and streamlined appointment booking system freeing up telephone lines and appointment slots.
- Increasing use of MHOL: online appointment booking, ordering prescriptions, Sick notes freeing up the telephone lines enabling the practice to free appointment slots for those in need.
- Use of Care Coordinators and social prescribing: Signposting patients to the most appropriate service for their needs, leaving the GP to be available for patients that need to see a GP.
- Use of multi-disciplinary workforce allowing GP appointments available for patients requiring to be seen by a GP

CONTRACT CHANGES 19/20: Access is a domain within the new Quality Assurance and Improvement Framework (QAIF): Practices will be required to meet certain standards coming into place Oct 19 with expected achievements by March 2021:

- Appropriate telephony and call handling systems are in place, which support the needs of callers and avoids the need for people to call back multiple times. These systems will also provide analysis data to the practice.
- Practices have in place a recorded bilingual introductory message, which includes signposting to other local services and emergency services for clearly defined life threatening conditions
- People receive a prompt response to their contact with a practice via telephone
- Practices have in place appropriate and accessible alternative methods of contact including digital solutions, SMS text messaging, email and face to face.
- People are able to use email to request a non-urgent consultation or call back.
- People are able to access information on the different ways of requesting a consultation with a GP and other healthcare professionals and the level of service they can expect from their practice
- People receive a timely, co-ordinated and clinically appropriate response to their needs
- All practices have a clear understanding of patient needs and demands within their practices and how these can be met.

Benchmarking: how do we compare?

Practices offering appointments during the whole half hour between 17:30 and 18:00, by number of weeks days and health board

Percentage

Local health board	no week days			1-4 Days			every week day		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Betsi Cadwaladr	61	61	61	14	12	12	25	27	28
Powys	29	29	31	6	6	0	65	65	69
Hywel Dda	28	29	29	26	22	20	45	49	51
Abertawe Bro Morgannwg	49	42	42	10	11	9	41	47	49
Cwm Taf	0	0	3	10	10	10	90	90	87
Aneurin Bevan	4	4	3	6	5	5	90	91	92
Cardiff and Vale	39	39	40	8	8	8	53	53	52
Wales	**34**	**34**	**33**	**12**	**11**	**10**	**54**	**56**	**57**

Cwm Taf Health Board (as was) compared favourably with other Welsh Health Boards.

What are areas of risk:

- Practice sustainability, particularly the smaller and single handed practices
- Having a number of GPs of similar age coming up to retirement
- Recruitment is still an issue leading to pressure on a practice appointment systems
- High use of locums by some surgeries
- Seasonal pressures on an already stretched workforce

Source: https://gov.wales/statistics-and-research/?topics=Health+and+social+care&subtopics=GPs&view=Search+results&lang=en
Source: National Survey for Wales

Indicator 55: For health boards with Out of Hours (OoH) services, the percentage of urgent calls that were logged and patients started their clinical definitive assessment within 20 minutes of their initial calls being answered; for health boards with 111 services, the percentage of P1 calls that were logged and patients started their definitive assessment within 20 minutes of the initial calls being answered

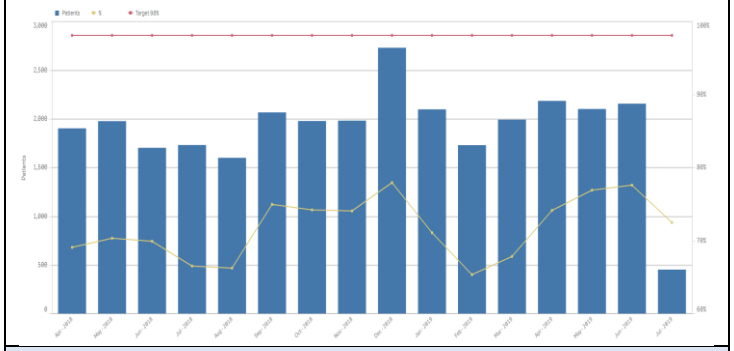
Outcome: I have easy and timely access to primary care services	Executive Lead: Chief Operating Officer
Period: Apr 2018 to Jun 2019	Target: 98%/12 Month Improvement

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Following the boundary change on 1 April 2019 responsibility for Out of Hours for Bridgend remains with Swansea Bay University Hospital

How are we doing, what actions are we taking?

How are we doing?

This chart shows the percentage of patients who received urgent calls and received clinical assessment within 20 minutes.

The current target for this measure is at 98% (with an improvement trend). Our current position is at 78%.
(July data is incomplete: data capture undertaken on 15/7/19).

What actions are we taking?

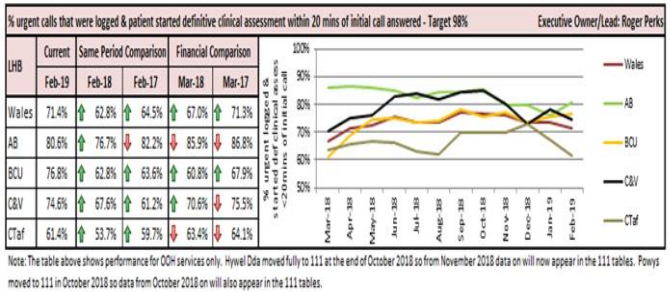
Whilst noting that the targets were set without the benefit of a detailed demand and capacity analysis, it is clear at the moment that there is a gap, with available capacity insufficient to meet the current target.

The main risk would be the availability of medical staff to fill the existing shifts within the core capacity. Thereafter, it may be worth reviewing the nature of the demand to see if there is the potential to reduce the level or avoid certain types of demand altogether.

What are the areas of risk?

Availability of medical staff to fill existing shifts. There is continued commitment within the service to fill as many shifts as possible for every day in order to provide as much resilience as possible to this key unscheduled care service.

Benchmarking: how do we compare?



Cwm Taf's OOH performance compared to peers is poor.

Source: Local OOH/Qlik

Indicator 56: For health boards with Out of Hours (OoH) services, the percentage of patients prioritised as very urgent and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage for health boards with 111 services, the percentage of patients prioritised as P1 and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage

Outcome: I have easy and timely access to primary care services

Executive Lead: Chief Operating Officer

Period: Apr 2018 to Jun 2019

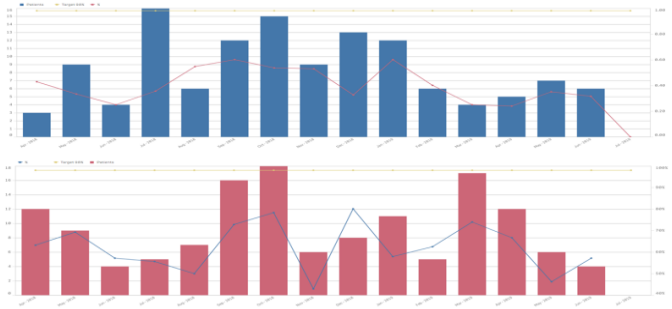
Target: 90%/12 Month Improvement

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Following the boundary change on 1 April 2019 responsibility for Out of Hours for Bridgend remains with Swansea Bay University Hospital

How are we doing, what actions are we taking?

How are we doing?

The charts shown are a combination of urgent face to face consultation either in the home, or at a Primary Care Centre (PCC). The practical ability to be able to meet the very urgent face to face target needs to be reviewed in the context of, for example, the service having to manage overnight with a single GP, working with the team to provide all aspects of the service during that time. This together with the geography of the region and the location of the Primary Care Centres provide significant challenges to be able to provide this type of urgent access, let alone meet very challenging access target times.

(July data is incomplete: data capture undertaken on 15/7/19).

Cwm Taf (from April 2019 onwards)

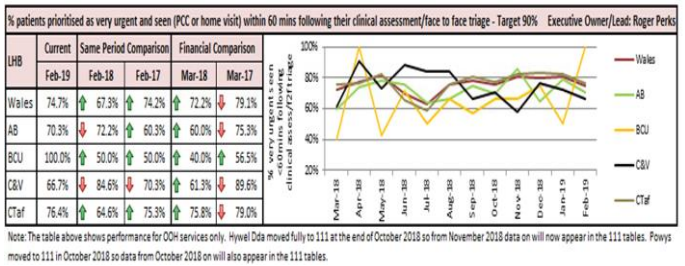
that only have GP Out of Hours (defined as P1 for health boards			
Urgent Face to Face	Apr	May	June
Home Visit	67%	46%	57%
PCC	24%	35%	32%
Total	44%	39%	39%
Number of Patients			
Home Visit	12	6	4
PCC	5	7	6
Total	17	13	10

The relatively small number of patients in these two categories mean that the compliance is highly variable when combined with other variable aspects, such as the available capacity, geography of the patients' home addresses and the distance needing to be travelled by the patients.

What actions are we taking?

The service continues to fill as many shifts as possible for every day in order to provide as much resilience as possible to this key unscheduled care service.

Benchmarking: how do we compare?



Cwm Taf's performance is comparable to other Welsh Health Boards.

Source:

Indicator 58: The percentage of patients waiting less than 26 weeks for treatment

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Sep 2018 to Aug 2019

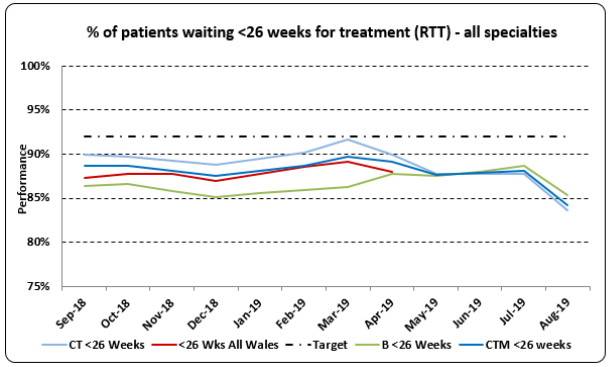
Target: 95%

Current Performance:

Cwm Taf Morgannwg

See graph below

Cwm Taf



Bridgend

See graph above

How are we doing, what actions are we taking?

How are we doing?

In terms of the 26 week position, the provisional position for August is 85.34% for the Bridgend area and 83.61% for the former Cwm Taf area, giving a Cwm Taf Morgannwg compliance of 84.2%.

What actions are we taking?

Activity levels continue to be closely monitored month on month at the weekly RTT meetings with continuing representation from colleagues across the new Health Board.

Weekly deep dive meetings are held with senior members of the Health Board.

What are the areas of risk?

- The number of breaches post 1 April 2019 as a result of the boundary change;
- Additional waiting lists added to RTT reporting as from 1 July 2019;
- The number of open pathways 26 and 36 weeks. The provisional August open pathway position is shown below.

36 Weeks

				2019/20		
				CT	Bridgend	CTM
Month	2016/17	2017/18	2018/19	Total	Total	Total
Apr	1463	249	74	169	959	1128
May	1411	376	157	568	952	1520
Jun	984	474	195	845	831	1676
Jul	1145	507	187	1301	813	2114
Aug	1424	675	229	2053	896	2949

26 Weeks

				2019/20		
				CT	Bridgend	CTM
Month	2016/17	2017/18	2018/19	Total	Total	Total
Apr	5221	3889	2852	3895	2796	6691
May	5355	4398	2998	4831	2835	7666
Jun	4684	4123	2597	4911	2715	7626
Jul	4865	4357	2722	5154	2553	7707
Aug	5295	5238	3325	6541	2998	9539

Benchmarking: how do we compare?

For the period 2018/19 Cwm Taf's performance was comparable with other Welsh Health Boards.

Period	Cwm Taf Compliance	Abertawe Bro Morgannwg	Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales	Bridgend	CT Morgannwg
Apr-18	92.4%	87.8%		90.2%	84.6%	85.7%	86.9%	100.0%	87.5%	85.9%	
May-18	92.0%	88.1%		89.9%	84.6%	85.7%	86.0%	99.8%	87.4%	86.2%	
Jun-18	93.1%	88.7%		90.8%	85.8%	88.7%	86.4%	99.8%	88.7%	86.3%	
Jul-18	92.9%	89.3%		91.1%	85.8%	89.3%	86.7%	99.6%	89.0%	86.6%	
Aug-18	91.4%	89.1%		89.3%	84.5%	87.4%	84.8%	99.4%	87.6%	86.1%	
Sep-18	89.9%	89.1%		89.0%	84.5%	86.7%	85.0%	99.4%	87.3%	86.4%	
Oct-18	89.7%	89.1%		90.0%	84.7%	87.3%	86.1%	99.2%	87.8%	86.6%	
Nov-18	89.3%	88.8%		91.1%	84.1%	87.0%	87.3%	99.0%	87.8%	85.8%	
Dec-18	88.8%	88.0%		90.4%	82.7%	85.5%	87.4%	98.8%	86.9%	85.2%	
Jan-19	89.5%	88.7%		90.7%	83.0%	86.3%	89.5%	99.1%	87.7%	85.6%	
Feb-19	90.2%	89.2%		91.9%	84.0%	87.6%	90.4%	99.3%	88.6%	86.0%	
Mar-19	91.6%	89.3%		92.0%	84.8%	87.9%	90.6%	99.7%	89.1%	86.3%	89.7%
Apr-19	89.9%		88.8%	91.2%	83.2%	87.2%	89.4%	99.0%	88.0%	87.7%	89.1%
May-19	87.7%		88.1%	90.2%	82.3%	86.2%	89.0%	98.6%	87.1%	87.6%	87.7%
Jun-19	87.8%		88.0%	90.6%	82.1%	86.6%	89.8%	98.9%	87.3%	88.0%	87.9%

Source: Local / Welsh Government Delivery & Performance Website: http://howis.wales.nhs.uk/sitesplus/407/page/64649 http://howis.wales.nhs.uk/sitesplus/407/page/55547

Indicator 59: The number of patients waiting more than 36 weeks for treatment

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Sep 2018 to Aug 2019

Target: Zero

Current Performance:

Cwm Taf Morgannwg

The provisional reporting position:
53 weeks – 512 patients 36 week – 2949 patients

CT Morgannwg RTT Open Pathways 36+ Weeks	2018/19												2019/20				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Total	1076	1183	1246	1263	1404	1385	1479	1420	1354	1496	1436	844	1128	1520	1676	2,114	2,949

CT Morgannwg RTT Open Pathways 53 Weeks	2018/19												2019/20				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August
Total			467	470	536	541	536	542	532	489	434	367	318	326	288	439	512

Cwm Taf

The provisional reporting position:
53 weeks – 194 patients
36 weeks – 2053

CT RTT Open Pathways 36+ Weeks	2018/19												2019/20				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Total	74	157	195	187	229	196	321	309	297	399	440	0	169	568	845	1301	2053

CT RTT Open Pathways 53 Weeks	2018/19												2019/20				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	189	194

Bridgend

The provisional reporting position:
53 weeks – 318 patients
36 weeks – 896 patients

Bridgend RTT Open Pathways 36+ Weeks	2018/19												2019/20				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August
Total	1002	1026	1051	1076	1175	1189	1158	1111	1057	1097	996	844	959	952	831	813	896

Bridgend RTT Open Pathways 53 Weeks	2018/19												2019/20				
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Total			467	470	536	541	536	542	532	489	434	367	318	326	288	250	318

How are we doing, what actions are we taking?

How are we doing?
The provisional position for patients waiting over 52 weeks for treatment at the end of August 2019 is 512 patients. Of these 512 patients:

- 318 relate to Bridgend waiting lists.
- 194 relates to Cwm Taf waiting lists.

The provisional position for patients waiting over 36 weeks is 2949 patients across Cwm Taf Morgannwg. Of the 2949 patients:

- 2053 patients relate to the former Cwm Taf waiting lists.
- 896 relate to Bridgend waiting lists.

(NB this figure of 2949 includes the 512 patients waiting over 52 weeks).

What actions are we taking?
Specific focus going into the new financial year will be to remove the volume of patients waiting at, and greater than, 53 week breaches and address waits at stages 1 and 2: the longest waits will be monitored monthly with improvement expected monthly against the agreed trajectory.

Activity levels continue to be closely monitored month on month at the weekly RTT meetings with continuing representation from colleagues across the new Health Board.

What are the areas of risk?
Focus for the Health Boards is to ensure RTT compliance across all specialities.

Benchmarking: how do we compare?

For the period 2018/19 Cwm Taf's performance was the best in Wales.

Period	Cwm Taf	Abertawe Bro Morgannwg	Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales	Bridgend	CT Morgannwg
Apr-18	74	3398		986	6348	2266	1725	0	14797	1002	1076
May-18	157	3349		1090	6381	2569	1798	0	15344	1026	1183
Jun-18	195	3319		848	5767	686	1779	0	12594	1051	1246
Jul-18	187	3383		910	6579	890	1869	0	13818	1076	1263
Aug-18	229	3497		1159	7291	1366	2080	0	15622	1175	1404
Sep-18	196	3381		1067	6291	944	1794	0	13673	1189	1385
Oct-18	321	3370		1214	6574	984	1638	0	14101	1158	1479
Nov-18	309	3193		769	6846	954	1439	0	13510	1111	1420
Dec-18	297	3030		249	7064	948	1394	0	12982	1057	1354
Jan-19	399	3174		336	7939	984	3014	0	14140	1097	1496
Feb-19	440	2967		469	7717	1046	633	0	13272	996	1436
Mar-19	0	2628		112	5918	327	0	0	8985	844	844
Apr-19	169		1973	271	6768	690	213	0	11043	959	1128
May-19	568		2101	478	7396	657	246	0	12398	952	1520
Jun-19	845		2319	653	7886	604	122	0	13260	831	1676

Source: Local / Welsh Government Delivery & Performance Website: http://howis.wales.nhs.uk/sitesplus/407/page/64649 http://howis.wales.nhs.uk/sitesplus/407/page/55547

Indicator 60: The number of patients waiting more than 8 weeks for a specified diagnostic

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Aug 2019

Target: Zero

Current Performance:

Cwm Taf Morgannwg

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	61	159	128	831	1220							

Cwm Taf

As Above

Bridgend

As Above

How are we doing, what actions are we taking?

How are we doing?
The provisional position for August 2019 is 1220 patients waiting over 8 weeks for diagnostic services. Of the 1220 patients:

- 36 patients relate to Bridgend waiting lists
- 1184 patients related to the old Cwm Taf patients.

What actions are we taking?
There is ongoing work with the Health Board around waiting list reporting.

Provisional August 2019 position

Service	Sub-Heading	>8 weeks			
		CT	Bridgend	CT ADDIN	CTM
Cardiology	Echo Cardiogram	317	2		319
Cardiology Services	Cardiac Computed Tomography (Cardiac CT)	17			17
	Diagnostic Angiography	4	30		34
	Doppler Stress Echocardiogram (DSE)	8			8
	Heart Rhythm Recording	8			8
	Blood pressure monitoring	1			1
Colonoscopy		50	4		54
Gastroscopy		57			57
Cystoscopy		65			65
Flexi		43			43
Radiology - Consultant Referral	Non Cardiac Computed Tomography	3			3
	Non Cardiac MRI	2			2
Radiology - GP Referral	NOUS	53			53
Physiological Measurement	Urodynamics	8			8
Imaging	Fluoroscopy	2			2
Cardio complex Echo					0
Neurophysiology	EMG			264	264
	NCS			282	282
					0
Total		638	36	546	1220

Benchmarking: how do we compare?

Period	Cwm Taf	Abertawe Bro Morgannwg	Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales	Morgannwg	CT Morgannwg
May-18	285	790		279	1147	1379	113	0	3993		
Jun-18	207	915		502	1742	1527	122	3	5018		
Jul-18	175	740		417	2107	1371	84	22	4916		
Aug-18	213	811		663	2462	1186	78	38	5449		
Sep-18	237	762		407	2200	846	48	79	4579		
Oct-18	92	735		283	1504	448	27	83	3172		
Nov-18	86	658		71	1276	431	86	35	3117		
Dec-18	270	693		4	1486	450	82	150	3135		
Jan-19	613	603		60	2116	448	30	122	3992		
Feb-19	431	558		15	2123	270	1	60	3458	23	454
Mar-19	27	437		0	2277	40	0	0	2781	0	27
Apr-19	51		401	31	2548	158	56	16	3271	10	61
May-19	132		401	6	2857	110	185	21	3731	27	159
Jun-19	122		295	35	2737	21	115	9	3337	6	128

(April 18- Sep 18 figures include cardiology pilot figures)

For the period 2018/19 Cwm Taf was one of the better performing Health Boards.

Source: Local/Information Team QL and Welsh Government Delivery & Performance Website https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-

Local Measure: Surveillance Patients

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	Executive Lead: Chief Operating Officer
Period: Census as at 1 September 2019	Target: Zero

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Prince Charles

Cancer

CensusDate 2019-09-01

Values	0 to 2 weeks	3 to 6 weeks	7 to 12 weeks	Grand Total
Patients	63	17	1	81
With an Appointment	36	14	1	51

Urgent Non Cancer

CensusDate 2019-09-01

Values	0 to 3 weeks	4 to 6 weeks	7 to 12 weeks	Grand Total
Patients	155	133	127	415
With an Appointment	16	12	24	52

Routine

CensusDate 2019-09-01

Values	0 to 7 weeks	8 to 17 weeks	Grand Total
Patients	112	41	153
With an Appointment	4	13	17

Surveillance

CensusDate 2019-09-01

Values	0 to 7 weeks	8 to 17 weeks	18 weeks and over	NotPastReviewDate	No Review Date	Grand Total
Patients	101	110	182	1334	44	1771
With an Appointment	8	1	18	0	14	41

Royal Glamorgan

Cancer

CensusDate 2019-09-01

Values	0 to 2 weeks	3 to 6 weeks	Grand Total
Patients	89	15	104
With an Appointment	52	14	66

Urgent Non Cancer

CensusDate 2019-09-01

Values	0 to 3 weeks	4 to 6 weeks	7 to 12 weeks	13 to 16 weeks	Grand Total
Patients	160	124	35	1	340
With an Appointment	24	49	25	0	98

Routine (8 weeks diagnostic RTT)

CensusDate 2019-09-01

Values	0 to 7 weeks	8 to 17 weeks	26 to 51 weeks	Grand Total
Patients	164	21	1	186
With an Appointment	20	7	1	28

Surveillance

CensusDate 2019-09-01

Values	0 to 7 weeks	8 to 17 weeks	18 weeks and over	NotPastReviewDate	No Review Date	Grand Total
Patients	129	131	415	1686	97	2458
With an Appointment	4	0	43	1	18	72

Bridgend

How are we doing, what actions are we taking?

How are we doing?

The tables to the left provide a breakdown of those surveillance patients awaiting treatment within the old Cwm Taf footprint. Patients referred into the service for Endoscopy are manage through four referral pathways each with their own waiting time target.

- USC: target 2 weeks
- Urgent: target 2 weeks
- Routine: target 8 weeks and Surveillance with a target of 18 weeks.

Other than "routine" waits the three remaining cohorts of patients are not managed via an RTT diagnostic pathway. Delays to patients within the USC cohort are discussed at the Cancer management meeting.

What Actions are we taking?

Referral demand into the service continues to increase. The Directorate's D&C plan clearly shows that in order to deal with current demand into PCH and RGH, an additional 10 sessions per week would be required. It is anticipated that this would address the current demand, and also enable booking of all patient categories within the required timescales. That said, the additional 10 sessions will not address the anticipated future increase in demand that is on the horizon with the introduction of FIT.

The Directorate is currently utilising insourcing at Royal Glamorgan, to accommodate the surveillance backlog patients with funding approved to continue the service until the middle of November 2019.

What is the associated risk?

The current backlog of surveillance patients is of the order of 597 (723 in August and 843 the previous month) patients.

Benchmarking: how do we compare?

Benchmarking data is not currently available

Source: Local/Information Team QL and Welsh Government Delivery & Performance Website https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-

Indicator 61: The number of patients waiting more than 14 weeks for a specified therapy

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: August 2019

Target: Zero

Current Performance:

Cwm Taf Morgannwg

Number of patients waiting over 14 weeks for therapies

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
2018/19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2019/20	0	0	0	14*	34*											

*POW

Cwm Taf

Number of patients waiting over 14 weeks for therapies

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Bridgend

Number of patients waiting over 14 weeks for therapies

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
0	0	0	14*	34*											

How are we doing, what actions are we taking?

How are we doing?
There are provisionally 34 therapy breaches for August 2019. All 34 being at POW of which 27 are within physiotherapy (2 paediactric patients and 25 adult). There were also 7 diatetic patients.

What actions are we taking?
Appropriate actions to pull back to, and maintain, a zero position.

Areas of risk?
Currently Cwm Taf Morgannwg is in a sustained period with no immediate risk.

Benchmarking: how do we compare?

Period	Cwm Taf	Abertawe Bro Morgannwg	Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales	Morgannwg	CT Morgannwg
May-18	0	1		15	0	166	164	1	347		
Jun-18	14	0		3	0	163	226	1	407		
Jul-18	0	0		31	0	61	288	0	380		
Aug-18	0	0		9	0	42	307	2	360		
Sep-18	0	0		13	0	20	352	2	387		
Oct-18	0	0		5	0	120	332	8	465		
Nov-18	0	0		0	0	112	265	3	380		
Dec-18	0	0		0	3	12	287	3	305		
Jan-19	0	0		0	0	14	177	14	205		
Feb-19	0	0		5	0	5	51	16	77	0	0
Mar-19	0	0		0	0	0	0	4	4	0	0
Apr-19	0		0	1	0	1	41	2	45	0	0
May-19	0		0	1	4	5	138	9	0	0	0
Jun-19	0			0	0	0	262	0	0	0	0

Cwm Taf Morgannwg is one of three Health Boards continuing to achieve a zero position for therapies.

Source: Local /Information Team QL and Welsh Government Statistics Website
https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month

Indicator 62: The number of patients waiting for an outpatient follow-up (NOT BOOKED) who are delayed past their agreed target date for planned care sub specialties

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Census: September 2019

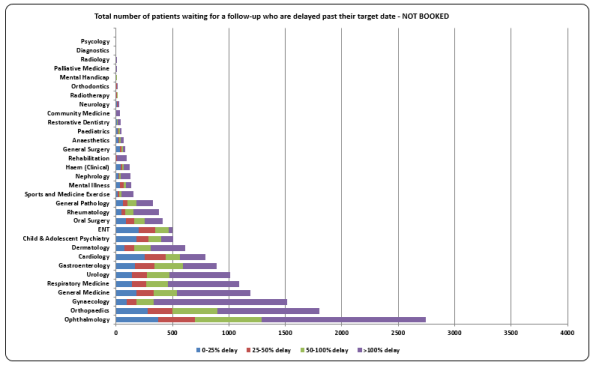
Target: 12 Month Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

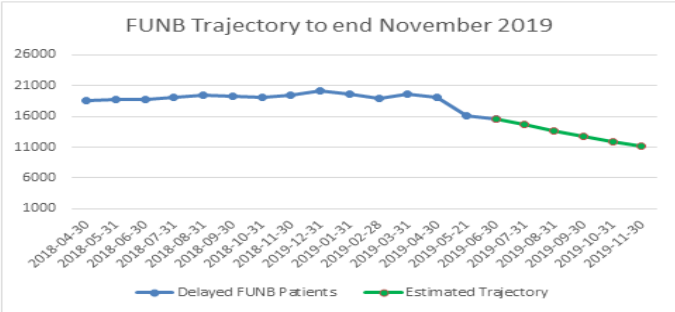
How are we doing?

The number of patients waiting for an outpatient follow-up (not booked) who are currently delayed past their agreed target date as at the beginning of September 2019 is 14,733 (August 15,349).

Census data 4/8/19	0-25% delay	25-50% delay	50-100% delay	>100% delay	Total
Ophthalmology	373	323	594	1453	**2743**
Orthopaedics	281	217	399	905	**1802**
Gynaecology	94	85	153	1185	**1517**
General Medicine	181	149	206	654	**1190**
Respiratory Medicine	143	124	195	627	**1089**
Urology	138	137	195	542	**1012**
Gastroenterology	168	171	250	299	**888**
Cardiology	255	186	125	224	**790**
Dermatology	77	84	146	305	**612**
Child & Adolescent Psychiatry	179	107	112	108	**506**
ENT	198	150	117	32	**497**
Oral Surgery	88	75	90	163	**416**
Rheumatology	46	34	72	229	**381**
General Pathology	61	42	76	147	**326**
Sports and Medicine Exercise	13	17	20	104	**154**
Mental Illness	35	32	19	51	**137**
Nephrology	20	8	10	88	**126**
Haem (Clinical)	40	13	16	49	**118**
Rehabilitation	1	5	3	86	**95**
General Surgery	32	16	11	20	**79**
Anaesthetics	20	10	10	27	**67**
Paediatrics	14	6	16	10	**46**
Restorative Dentistry	5	0	8	28	**41**
Community Medicine	0	1	2	33	**36**
Neurology	6	5	5	14	**30**
Radiotherapy	1	4	9	0	**14**
Orthodontics	4	2	1	2	**9**
Mental Handicap	3	1	3	0	**7**
Palliative Medicine	0	0	0	3	**3**
Radiology	0	0	1	1	**2**
Diagnostics	0	0	0	0	**0**
Psycology	0	0	0	0	**0**
Total					**14733**

What actions are we taking?

A trajectory to November 2019 has been put in place:



Risks and Benchmarking: how do we compare?

What are the areas of risk?

The trajectory is based on the following assumptions:

- That activity in ENT and Urology remains at the same level (ie 80 and 50 cases per specialty per week respectively) and that conversion to discharge rates applied are based on outcomes to date;
- That where clinics have been confirmed for clinical case review, ie additional clinics (Oral and Maxillo Facial Surgery, Gynaecology, Respiratory and Gastroenterology) a conversion to discharge rate has been applied to the number of cases being reviewed which has been based on outcomes to date;
- Outpatient clinics scheduled specifically for FUNB proceed as planned.

An immediate concern is the potential increase in the number of FUNBs as a result of the boundary change. These numbers are not as yet available.

Benchmarking (all FUNB past target date)

Period	Cwm Taf/ CTM	Abertawe Bro Morgannwg/ SB	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales
Apr-18	26548	66526	33823	78232	135810	33599	1691	376229
May-18	13276	24288	9573	40798	77167	15800	325	181227
Jun-18	13181	24469	9361	39664	77468	15800	306	180249
Jul-18	13481	24954	9787	39449	79608	16285	348	183912
Aug-18	Data not available							
Sep-18	14020	24200	11141	45777	80558	16285	320	192301
Oct-18	13797	22553	1089	45946	81014	16887	428	191514
Nov-18								
Dec-18	14091	22931	11532	46836	81727	11680	387	194184
Jan-19	13660	23026	11851	46413	80664	16409	417	192440
Feb-19	Data not available							
Mar-19	13589	23604	10856	49293	38020	16629	359	152350
Apr-19	Data not available		10503	49495	42455	18199	524	
May-19	Data not available							
Jun-19	18359	26545	9040	53733	78195	27793	427	214092

Source: Local Information Team and WPAS Team

Indicator 62 continued: The number of patients waiting for an outpatient follow-up (BOOKED) who are delayed past their agreed target date for planned care sub specialties

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Census: September 2019

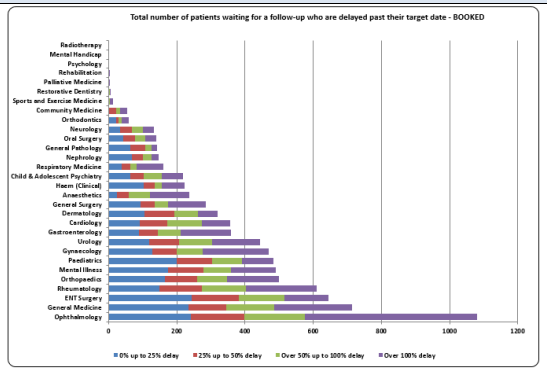
Target: 12 Month Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

How are we doing?

The number of patients waiting for an outpatient follow-up (booked) who are currently delayed past their agreed target date as at the beginning of September 2019 was 8291. This is an increase on previous months.

Census 4/8/19	0% up to 25% delay	25% up to 50% delay	Over 50% up to 100% delay	Over 100% delay	Total
Ophthalmology	242	157	177	505	1,081
General Medicine	233	111	142	227	713
ENT Surgery	243	138	134	129	644
Rheumatology	149	125	129	207	610
Orthopaedics	166	93	87	154	500
Mental Illness	174	105	79	131	489
Paediatrics	199	105	88	91	483
Gynaecology	128	72	76	193	469
Urology	119	88	96	141	444
Gastroenterology	88	56	67	148	359
Cardiology	92	81	100	83	356
Dermatology	106	87	69	58	320
General Surgery	93	41	40	112	286
Anaesthetics	24	34	63	116	237
Haem (Clinical)	103	33	20	66	222
Child & Adolescent Psychiatry	64	38	53	64	219
Respiratory Medicine	38	26	17	80	161
Nephrology	68	32	25	22	147
General Pathology	63	44	19	16	142
Oral Surgery	43	35	30	32	140
Neurology	33	34	34	32	133
Orthodontics	22	7	8	23	60
Community Medicine	2	21	11	20	54
Sports and Exercise Medicine	0	1	3	8	12
Restorative Dentistry	1	1	1	1	4
Palliative Medicine	0	0	2	1	3
Rehabilitation	1	0	0	1	2
Psychology	0	0	0	1	1
Mental Handicap	0	0	0	0	0
Radiotherapy	0	0	0	0	0
Total					8,291

What actions are we taking?

The FUNB Task and Finish group continues to meet on a fortnightly basis to review the FUNB dashboard and to review progress against individual specialty action plans. Work is also ongoing to validate the list of patients recorded as See on Symptom.

Bridgend colleagues now attend meetings and discussions have commenced with regards to the management of FUNB within POW.

What are the areas of risk?

As identified previously.

Benchmarking: how do we compare?

This data is not currently available

Source: Local Information Team and WPAS Team

Indicator 63-66: Percentage compliance with stroke quality improvement measures – QIM's

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Director of Planning and Performance

Period: July 2018 to June 2019

Target: SSNAP UK Quarterly Average

Current Performance:

Cwm Taf Morgannwg

CTM	Measure	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Percentage of patients who are diagnosed with a stroke who have a direct admission to an acute stroke	Total admissions	87	84	90	79	82	73	70	78	90	75	78	95
	No of patients within 4 hours	28	34	30	43	36	19	22	28	28	29	29	30
	% Compliance	32.2%	40.5%	33.3%	54.4%	43.9%	26.0%	31.4%	35.9%	31.1%	38.7%	37.2%	31.6%
Percentage of thrombolysed stroke patients with a door to needle time of <= 45 mins	No of patients within 45 mins eligible	13	11	11	5	12	9	9	11	5	#VALUE!	1	1
	Total thrombolysed	0	4	5	1	2	0	4	3	2	N/A	5	5
	% Compliance	0.0%	36.4%	45.5%	20.0%	16.7%	0.0%	44.4%	27.3%	40.0%	N/A	20.0%	20.0%
Percentage of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Total admissions	88	84	91	81	82	74	71	82	91	76	78	97
	No of patients within 1 hour	48	48	50	51	46	43	38	49	57	46	52	62
	% Compliance	54.5%	57.1%	54.9%	63.0%	56.1%	58.1%	53.5%	59.8%	62.6%	60.5%	66.7%	63.9%
Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	88	84	91	81	82	74	71	82	91	76	78	97
	No of patients within 24 hours	61	55	64	58	54	50	46	53	57	52	44	68
	% Compliance	69.3%	65.5%	70.3%	71.6%	65.9%	67.6%	64.8%	64.6%	62.6%	68.4%	56.4%	70.1%

Cwm Taf

CT	Measure	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Percentage of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit (<4hours)	Total admissions	59	52	59	44	50	43	49	48	62	52	55	60
	No of patients within 4 hours	20	27	22	25	23	17	19	20	21	22	24	20
	% Compliance	33.9%	51.9%	37.3%	56.8%	46.0%	39.5%	38.8%	41.7%	33.9%	42.3%	43.6%	33.3%
Percentage of thrombolysed stroke patients with a door to needle time of <= 45 mins	No of patients within 45 mins eligible	7	7	6	3	8	8	8	6	0	6	6	3
	Total thrombolysed	0	3	3	0	1	0	3	0	1	1	N/A	2
	% Compliance	0.0%	42.9%	50.0%	0.0%	12.5%	0.0%	37.5%	0.0%	N/A	16.7%	n/a	66.7%
Percentage of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Total admissions	59	52	59	44	50	43	50	51	63	53	55	61
	No of patients within 1 hour	34	34	33	32	30	28	28	37	44	37	41	46
	% Compliance	57.6%	65.4%	55.9%	72.7%	60.0%	65.1%	56.0%	72.5%	69.8%	69.8%	74.5%	75.4%
Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	59	52	59	44	50	43	50	51	63	53	55	61
	No of patients within 24 hours	35	41	40	36	31	34	35	33	43	39	39	43
	% Compliance	59.3%	78.8%	67.8%	81.8%	62.0%	79.1%	70.0%	64.7%	68.3%	73.6%	70.9%	70.5%

Bridgend

Bridgend	Measure	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Percentage of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit (<4hours)	Total admissions	28	32	31	35	32	30	21	30	28	23	23	35
	No of patients within 4 hours	8	7	8	18	13	2	3	8	7	7	5	10
	% Compliance	28.6%	21.9%	25.8%	51.4%	40.6%	6.7%	14.3%	26.7%	25.0%	30.4%	21.7%	28.6%
Percentage of thrombolysed stroke patients with a door to needle time of <= 45 mins	No of patients within 45 mins	0	1	2	1	1	0	1	3	2	2	1	4
	Total thrombolysed	6	4	5	2	4	1	1	5	4	N/A	5	N/A
	% Compliance	0.0%	25.0%	40.0%	50.0%	25.0%	0.0%	100.0%	60.0%	50.0%	N/A	20.0%	N/A
Percentage of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Total admissions	29	32	32	37	32	31	21	31	28	23	23	36
	No of patients within 1 hour	14	14	17	19	16	15	10	12	13	9	11	16
	% Compliance	48.3%	43.8%	53.1%	51.4%	50.0%	48.4%	47.6%	38.7%	46.4%	39.1%	47.8%	44.4%
Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	29	32	32	37	32	31	21	31	28	23	23	36
	No of patients within 24 hours	26	14	24	22	23	16	11	20	14	13	5	25
	% Compliance	89.7%	43.8%	75.0%	59.5%	71.9%	51.6%	52.4%	64.5%	50.0%	56.5%	21.7%	69.4%

How are we doing, what actions are we taking?

How are we doing?

During July a total of 97 patients were recorded within the Sentinel Stroke National Audit Programme (SSNAP) database. There were 36 patients presented to the Princess of Wales Hospital, Bridgend and 61 patients that presented to Prince Charles Hospital, Merthyr Tydfil. There were 7 patients thrombolised, four at the Princess of Wales Hospital of which zero patients were thrombolised within 45 minutes. There were three patients thrombolised at Prince Charles Hospital, of which two patients patient were thrombolised within 45 minutes.

Prince Charles

July 2019 Quality Improvement Measures

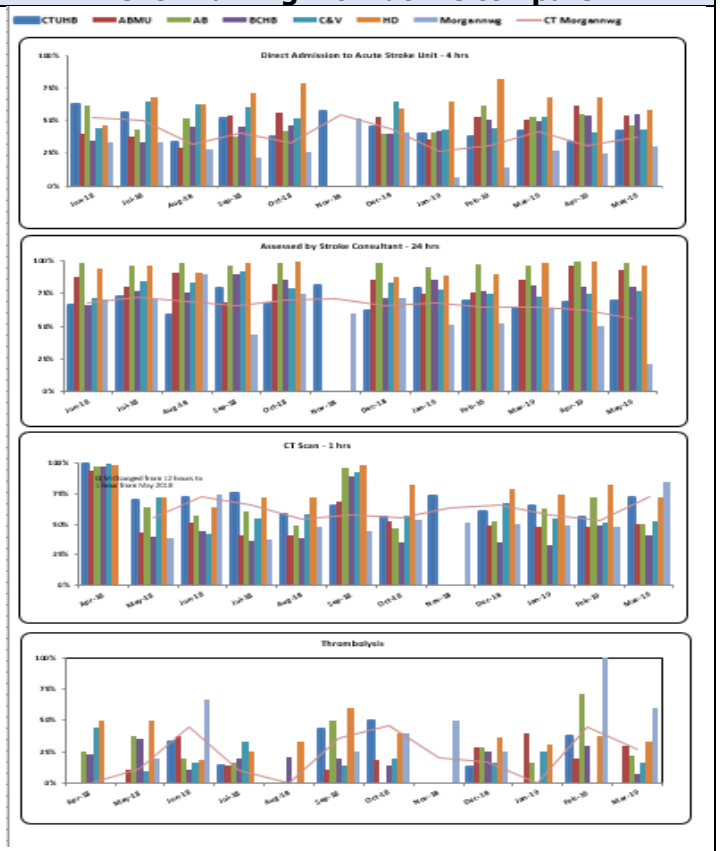
Quality Improvement Measures	Aspiration	Score
Urgent Intervention		
Percentage of all Stroke Patients Thrombolysed	N/A	4.9%
Thrombolysed patients Door To Needle <=45 mins	90%	66.7%
Percentage of patients scanned within 1 hour of clock start	N/A	75.4%
Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	95%	33.3%
Percentage of applicable patients who were given a swallow screen within 4 hours of clock start	95%	83.3%
Urgent Assessment		
Percentage of patients assessed by a stroke specialist consultant physician within 24 hours of clock start	95%	70.5%
Assessed by one of OT, PT, SALT within 24 hours	95%	65.6%
Percentage of applicable patients who were given a formal swallow assessment within 72 hours of clock start	95%	72.4%
Inpatient rehab		
Percentage of applicable patients who spent at least 90 % of their stay on stroke unit	N/A	0.0%
Compliance (%) against the therapy target of an average of 25.7 Minutes of OT across all patients	N/A	89.3%
Compliance (%) against the therapy target of an average of 27.3 Minutes of PT across all patients	N/A	70.4%
Compliance (%) against the therapy target of an average of 16.1 Minutes of SALT across all patients	N/A	37.9%
Discharge Standards		
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge	N/A	100.00%
Percentage of applicable patients discharged with ESD/ Community Therapy Multidisciplinary Team	N/A	41.76%
Percentage of applicable patients discharged with ESD	N/A	34.07%
Percentage of applicable patients discharged with Community Therapy Multidisciplinary Team	N/A	9.89%
Proportion of applicable patients assessed at 6 months	N/A	0.00%

Princess of Wales

July 2019 Quality Improvement Measures

Quality Improvement Measures	Aspiration	Score
Urgent Intervention		
Percentage of all Stroke Patients Thrombolysed	N/A	11.1%
Thrombolysed patients Door To Needle <=45 mins	90%	#N/A
Percentage of patients scanned within 1 hour of clock start	N/A	44.4%
Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	95%	28.6%
Percentage of applicable patients who were given a swallow screen within 4 hours of clock start	95%	87.5%
Urgent Assessment		
Percentage of patients assessed by a stroke specialist consultant physician within 24 hours of clock start	95%	69.4%
Assessed by one of OT, PT, SALT within 24 hours	95%	83.3%
Percentage of applicable patients who were given a formal swallow assessment within 72 hours of clock start	95%	100.0%
Inpatient rehab		
Percentage of applicable patients who spent at least 90 % of their stay on stroke unit	N/A	0.0%
Compliance (%) against the therapy target of an average of 25.7 Minutes of OT across all patients	N/A	130.3%
Compliance (%) against the therapy target of an average of 27.3 Minutes of PT across all patients	N/A	30.9%
Compliance (%) against the therapy target of an average of 16.1 Minutes of SALT across all patients	N/A	32.3%
Discharge Standards		
Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge	N/A	66.67%
Percentage of applicable patients discharged with ESD/ Community Therapy Multidisciplinary Team	N/A	0.00%
Percentage of applicable patients discharged with ESD	N/A	0.00%
Percentage of applicable patients discharged with Community Therapy Multidisciplinary Team	N/A	0.00%
Proportion of applicable patients assessed at 6 months	N/A	0.00%

Benchmarking: how do we compare?



What actions are we taking?

It is anticipated that Cwm Taf Morgannwg compliance will decline in most areas from that of the previous Cwm Taf footprint. The exception to this is percentage compliance for thrombolysis under 45 minutes which has been consistently higher at POW than at PCH over the last year. Prior to the boundary change both POW and PCH were struggling to achieve 4 hours to ASU compliance this continues to be a significant challenge and the Health Board is now working with the Delivery Unit in this regard. The Health Board also continues to work with the Delivery Unit with regards to the follow up action plan from the thrombolysis review at the end of last year.

Source: SSNAP

Indicator 67: The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes

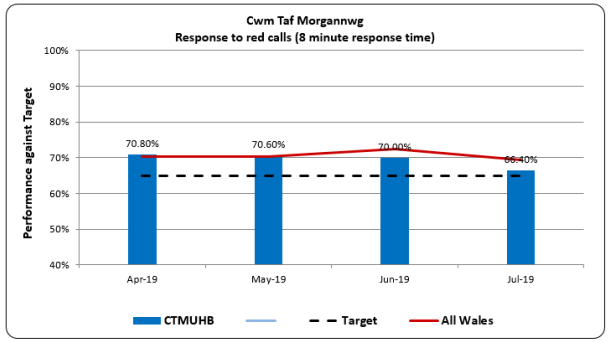
Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	Executive Lead: Chief Operating Officer
Period: May 2019 to Jul 2019	Target: 65%

Current Performance:

Cwm Taf Morgannwg

Data is not currently available

Cwm Taf



Bridgend

Data is not currently available

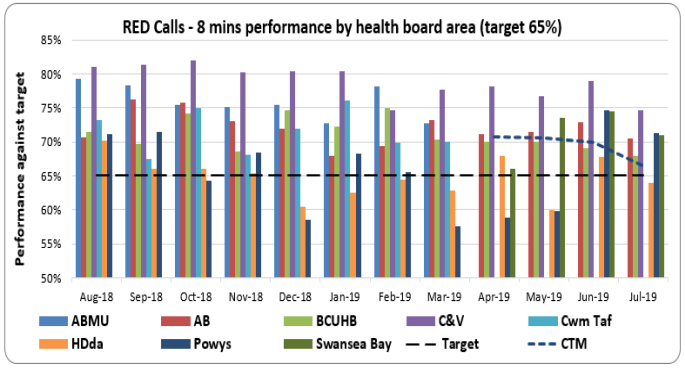
How are we doing, what actions are we taking?

How are we doing?
The Cwm Taf Morgannwg May performance against the Red Ambulance target was 66.4% in July. The All Wales performance being 69.3%.

What actions are we taking?
The Health Board continues to work closely with WAST colleagues to maintain this performance and develop further alternative pathways.

What are the risk areas?
The most significant risk is the boundary change and implications upon the service as a result.

Benchmarking: how do we compare?

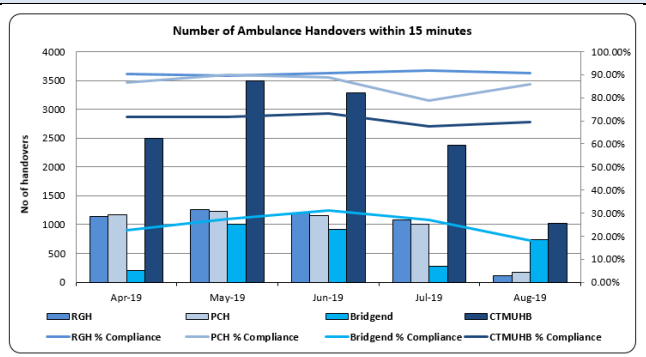


The Health Board remains comparable with peers.

Source: Local/Information Team
https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Performance/Ambulance-Services/emergencyambulancecallsandresponsestoredcalls-by-lhb-month

Local Measure: Number of ambulance handovers within 15 minutes

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	Executive Lead: Chief Operating Officer
Period: Apr 2019 to Aug 2019	Target: Improvement

Current Performance:	How are we doing, what actions are we taking?	Benchmarking: how do we compare?
Cwm Taf Morgannwg  	How are we doing? The A&E departments are committed to ensuring ambulances are released back into the community as soon as clinically possible. Current status for Cwm Taf Morgannwg for August is 69.33%. Compliance for Bridgend fell unfortunately below 20% at 18.05%. Compliance for RGH and PCH was 90.81% and 85.75% respectively. What actions are we taking? Monitoring of the handover performance continues and alerts are sent to senior managers when delays occur so that they can be reviewed. Escalation within the departments is embedded to ensure support during times of high acuity. What are the risk areas? The most significant risk is the boundary change and implications upon the service as a result.	This is a local measure and therefore no benchmarking data is available
Cwm Taf As Above		
Bridgend As Above		

Source: Local/Information Team

Indicator 68: Number of ambulance handovers over one hour

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

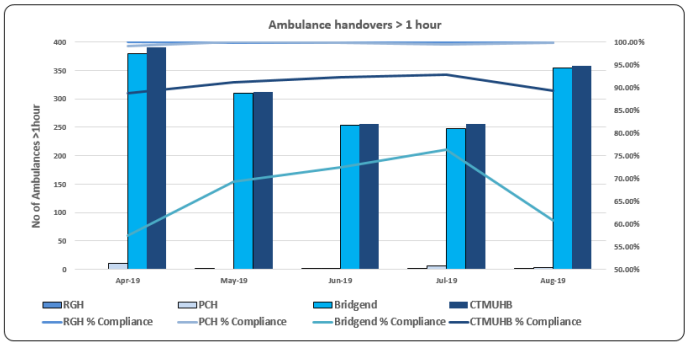
Executive Lead: Chief Operating Officer

Period: Apr 2019 to Aug 2019

Target: Zero

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

As Above

Bridgend

As above

How are we doing, what actions are we taking?

How are we doing?
Monitoring of the handover performance continues on a daily basis. There were 358 ambulance delays over 1 hour in August – 254 in POW and 3 at PCH and 1 at RGH.

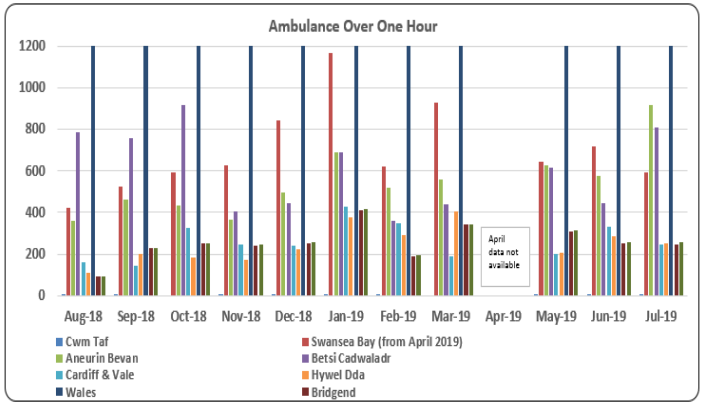
The Cwm Taf Morgannwg performance for emergency ambulance services over one hour was 89.25% with the performance for the Bridgend area being 60.80%. RGH 99.92% and PCH 99.75%.

What are the areas of risk?
This area of performance is reasonably stable at the Royal Glamorgan and Prince Charles and we do not anticipate any problems, notwithstanding the additional delays at Princess of Wales as a result of the impact of the boundary change.

Benchmarking: how do we compare?

Period	Cwm Taf	Swansea Bay (from April 2019)	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Wales	Bridgend	CTM
Jul-18	0	443	293	761	68	209	1790	61	61
Aug-18	2	420	357	785	161	112	1837	90	92
Sep-18	4	526	461	757	145	200	2132	227	231
Oct-18	0	590	432	914	323	183	2486	253	253
Nov-18	3	628	363	403	244	171	1844	241	244
Dec-18	4	842	495	446	241	226	2310	252	256
Jan-19	2	1164	689	690	430	376	3418	412	414
Feb-19	3	619	519	358	351	294	2188	191	194
Mar-19	0	928	558	438	189	407	2544	340	340
Apr-19	Data not available								
May-19	2	646	629	614	200	204	2624	310	312
Jun-19	2	720	578	447	330	284	2634	254	256
Jul-19	7	594	915	811	244	251	3087	248	255

For the period 2018/19 Cwm Taf was the best performing Health Board in this area.



Source: Local/Information Team and Welsh Government Performance and Delivery Site http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 69: The percentage 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

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

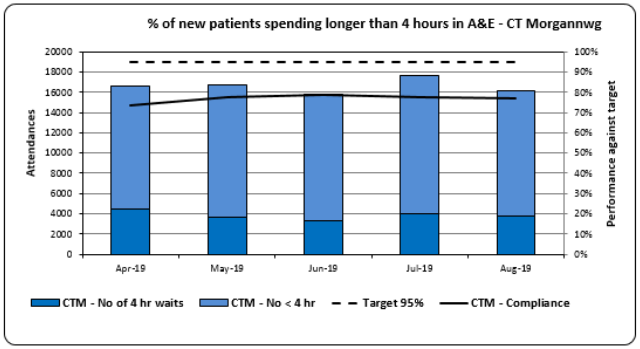
Executive Lead: Chief Operating Officer

Period: Apr 2019 to Aug 2019

Target: 95%

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

As Above

Bridgend

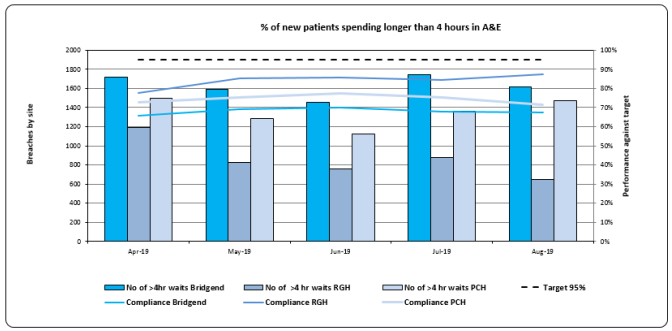
As Above

How are we doing, what actions are we taking?

How are we doing?

The combined performance for Cwm Taf Morgannwg University Health Board for the four hour target for August was 76.8%. Individual departmental performance was 71.4% at Prince Charles Hospital (PCH), 87.28% at Royal Glamorgan Hospital (RGH) and 67.56% at Princess of Wales (PoW). Compliance for Ysbyty Cwm Cynon (YCC) was 99.84% and Ysbyty Cwm Rhondda (YCR) was 100%.

There were a total of 3740 4 hour breaches in August of which there were 645 at RGH, 1475 at PCH, 1619 at POW and 1 at YCC.



What actions are we taking?

- Daily deep dive work on all acute and community wards continues.
- LA staff are fully engaged in all aspects of patient flow and attend weekly multiagency meetings.
- Twice daily bed meetings continue on each site.
- SW@H service is now in place on both DGH sites and early indications suggest that there is a reduction in LoS.

What are the areas of risk?

Staffing issues continue to be closely monitored.

Benchmarking: how do we compare?

Period	Cwm Taf	Abertawe Bro Morgannwg	Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales	Bridgend	CTM
Jun-18	90.1%	81.0%		82.5%	74.8%	91.0%	84.4%	99.6%	83.2%	82.7%	88.1%
Jul-18	88.7%	79.9%		78.8%	71.5%	92.5%	82.9%	99.6%	81.4%	80.1%	86.5%
Aug-18	87.2%	77.9%		78.6%	69.9%	89.7%	82.9%	99.8%	80.0%	76.9%	84.5%
Sep-18	87.1%	77.5%		78.6%	69.7%	90.3%	83.4%	99.8%	80.3%	74.5%	83.6%
Oct-18	86.0%	78.0%		78.4%	70.6%	86.2%	84.0%	99.6%	80.0%	76.2%	83.4%
Nov-18	85.5%	76.7%		78.3%	71.7%	85.7%	85.6%	99.6%	80.1%	75.8%	83.2%
Dec-18	83.0%	76.5%		74.8%	67.6%	83.8%	82.5%	99.7%	77.8%	76.1%	81.0%
Jan-19	80.0%	76.9%		76.2%	66.9%	84.0%	81.9%	99.7%	77.2%	76.3%	79.3%
Feb-19	82.7%	77.2%		76.6%	72.5%	82.0%	84.4%	99.9%	79.0%	77.7%	81.5%
Mar-19	82.8%	75.7%		78.5%	71.1%	84.3%	81.7%	100.0%	78.7%	72.2%	80.0%
Apr-19	76.9%		74.5%	76.8%	69.5%	85.2%	81.3%	100.0%	76.3%	68.7%	73.5%
May-19	81.7%		76.2%	77.6%	71.2%	85.2%	82.8%	99.9%	78.0%	69.1%	77.8%
Jun-19	82.9%		75.4%	76.5%	71.8%	82.2%	84.1%	100.0%	77.9%	69.9%	77.2%

The Health Board's performance remains comparable with peers.

Source: EDDS *http://nww.infoandstats.wales.nhs.uk/page.cfm?orgid=527&pid=53004*
https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst4hourwaitingtimestarget-by-hospital

Indicator 70: The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

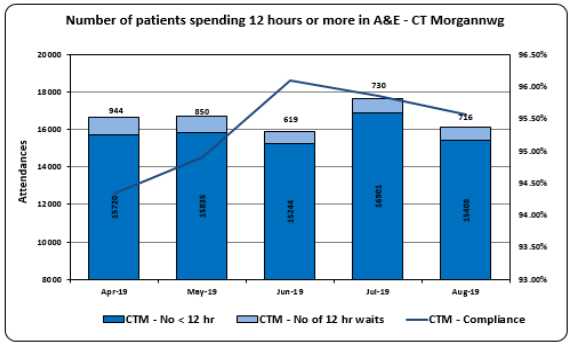
Executive Lead: Chief Operating Officer

Period: Apr 2019 – Aug 2019

Target: Zero

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

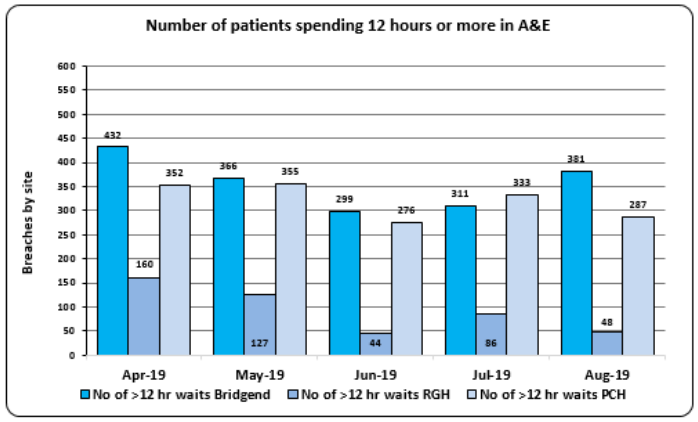
As Above

Bridgend

As Above

How are we doing, what actions are we taking?

How are we doing?
The August 12 hour performance for Cwm Taf Morgannwg was 716 patient breaches. Of the 730 breaches there were 381 breaches at PCH, 48 at RGH and 287 at PoW.



What actions are we taking?

- Daily deep dive work on all acute and community wards continues.
- LA staff are present on both community sites as routine and patients waiting to transfer to community sites have reduced dramatically.
- Concentrated effort is now being made to eradicate 12 hour waits.
- SW@H teams are now in place on both DGH sites and close monitoring of their impact is in place.

What are the risk areas?
Staffing issues continue to be closely monitored.

Benchmarking: how do we compare?

12 hr

Period	Cwm Taf	Abertawe Bro Morgannwg	Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Wales	Bridgend	CTM	YCC
Jun-18	71	476		246	1450	16	650	0	2909	141	212	
Jul-18	148	591		349	1854	17	813	0	3779	141	289	
Aug-18	214	511		389	1898	7	603	0	3622	136	350	
Sep-18	270	588		450	1816	17	663	0	3804	274	544	
Oct-18	230	681		374	1845	94	737	0	3961	275	505	
Nov-18	321	665		437	1404	56	675	0	3558	282	603	
Dec-18	395	758		470	1552	39	690	0	3904	271	666	
Jan-19	550	986		692	1989	137	943	0	5297	365	915	
Feb-19	415	685		615	1429	130	732	0	4006	236	651	
Mar-19	437	861		561	1633	34	948	0	4472	327	764	
Apr-19	512		653	752	1741	51	924	0	5109	432	944	
May-19	482		591	648	1661	65	920	0	4797	366	848	
Jun-19	320		616	555	1403	82	777	0	4057	299	619	

The Health Board's performance, prior to 1 April 2019, was amongst the best in Wales.

Source: http://nww.infoandstats.wales.nhs.uk/page.cfm?orgid=527&pid=53004

Indicator 71: The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days of diagnosis (regardless of referral route)

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

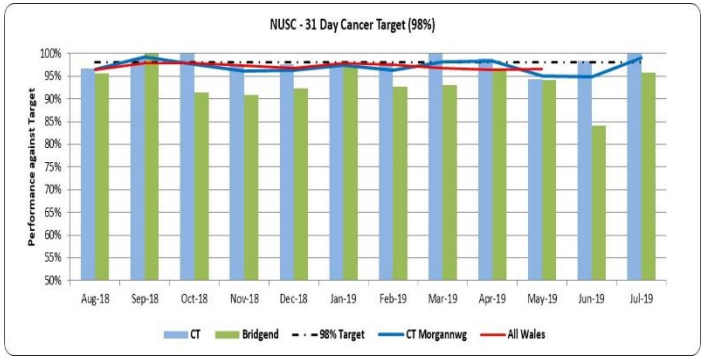
Executive Lead: Chief Operating Officer

Period: Aug 2018 to Jul 2019

Target: 98%

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

	CT	
Month	NUSC Treated <31 days	98% Target
Aug-18	96.64%	98.00%
Sep-18	98.95%	98.00%
Oct-18	100.00%	98.00%
Nov-18	97.66%	98.00%
Dec-18	97.59%	98.00%
Jan-19	97.60%	98.00%
Feb-19	97.87%	98.00%
Mar-19	100.00%	98.00%
Apr-19	98.91%	98.00%
May-19	94.30%	98.00%
Jun-19	98.26%	98.00%
Jul-19	100.00%	98.00%

Bridgend

	Bridgend	
Month	NUSC Treated <31 days	98% Target
Aug-18	95.65%	98.00%
Sep-18	100.00%	98.00%
Oct-18	91.30%	98.00%
Nov-18	90.91%	98.00%
Dec-18	92.31%	98.00%
Jan-19	96.97%	98.00%
Feb-19	92.68%	98.00%
Mar-19	93.10%	98.00%
Apr-19	96.43%	98.00%
May-19	94.14%	98.00%
Jun-19	84.09%	98.00%
Jul-19	95.83%	98.00%

How are we doing, what actions are we taking?

How are we doing?
For the former Cwm Taf area, the 31 day target (NUSC) perfomance of 98% was attained in July standing at 100%.

For Bridgend, the 31 day target (NUSC) perfomance of 98% was not reached in July 2019 at 95.8%.

Overall the 31 day target (NUSC) perfomance compliance for Cwm Taf Morgannwg for July was achieved at 99%.

Benchmarking: how do we compare?

Non-Urgent suspected cancer - Target 98%								
Period	Cwm Taf	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Bridgend	CTM
Jul-18	97.5%	99.3%	96.2%	95.4%	94.4%	99.2%	100.00%	98.14%
Aug-18	96.6%	97.4%	96.8%	98.9%	88.6%	96.0%	95.65%	96.48%
Sep-18	98.9%	95.7%	98.6%	100.0%	95.8%	97.2%	100.00%	98.23%
Oct-18	100.0%	95.9%	96.4%	98.4%	98.8%	99.1%	91.30%	97.55%
Nov-18	97.7%	96.2%	96.4%	99.5%	98.2%	95.5%	90.91%	96.20%
Dec-18	97.6%	85.7%	97.8%	98.1%	93.9%	95.9%	92.31%	96.33%
Jan-19	97.6%	97.7%	99.5%	97.4%	94.8%	98.7%	96.97%	97.47%
Feb-19	97.9%	94.7%	97.5%	98.9%	95.5%	100.0%	92.68%	96.30%
Mar-19	100.0%	93.5%	98.2%	97.2%	96.1%	95.8%	93.1%	98.2%
Apr-19	98.9%	90.8%	96.3%	100.0%	95.1%	94.5%	96.4%	98.3%
May-19	94.3%	91.4%	97.3%	98.3%	98.6%	96.8%	94.1%	95.0%

Cwm Taf's performance in this area is comparable with other Welsh Health Boards.

Source: CANISC/Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 72: The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

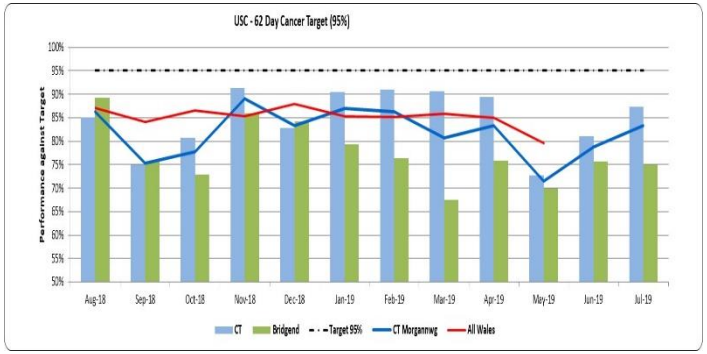
Executive Lead: Chief Operating Officer

Period: Aug 2018 to Jul 2019

Target: 95%

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

Month	CT USC Treated < 62 days	CT Target 95%
Aug-18	85.00%	95.00%
Sep-18	75.00%	95.00%
Oct-18	80.77%	95.00%
Nov-18	91.35%	95.00%
Dec-18	82.76%	95.00%
Jan-19	90.40%	95.00%
Feb-19	91.03%	95.00%
Mar-19	90.57%	95.00%
Apr-19	89.39%	95.00%
May-19	72.70%	95.00%
Jun-19	81.13%	95.00%
Jul-19	87.30%	95.00%

Bridgend

Month	Bridgend USCTreated <62 days	95% Target
Aug-18	89.19%	95.00%
Sep-18	75.61%	95.00%
Oct-18	72.92%	95.00%
Nov-18	85.96%	95.00%
Dec-18	84.21%	95.00%
Jan-19	79.41%	95.00%
Feb-19	76.32%	95.00%
Mar-19	67.50%	95.00%
Apr-19	75.93%	95.00%
May-19	70.00%	95.00%
Jun-19	75.68%	95.00%
Jul-19	75.00%	95.00%

How are we doing, what actions are we taking?

How are we doing?

For the former Cwm Taf area, the 62 day target (USC) performance was again below 90% this month at 87.3%. For Bridgend, the 62 day target (USC) performance was 75%. Overall the 62 day target (USC) performance was 83.3%.

For Cwm Taf Morgannwg there were 9 USC breaches in total, with reasons for non-achievement being delays awaiting diagnostic investigations and delays awaiting surgery, both in local and tertiary centres. The USC breach breakdown is shown in the following tables:

CT

USC	Urology	Lung	LGI	H&N	Gynae	Haem	UGI	Breast	Other	Number of Breaches	Compliance against Target (95%)	Breaches Minus Urology
Apr-19	4	0	0	1	0	0	1	0	1	7	89.4%	3
May-19	7	7	1	0	1	0	0	0	2	18	72.7%	11
Jun-19	3	1	1	0	4	0	0	0	1	10	81.1%	7
Jul-19	3	0	1	1	2	1	0	0	1	9	87.3%	6

Bridgend

USC	Urology	Lung	LGI	H&N	Gynae	Haem	UGI	Breast	Other	Number of Breaches	Compliance against Target (95%)	Breaches Minus Urology
Apr-19	4	1	1	0	1	0	1	4	1	13	75.33%	9
May-19	5	1	1	0	3	1	2	0	2	15	70.00%	10
Jun-19	5	1	2	0	0	0	1	0	0	9	75.68%	4
Jul-19	7	1	1	0	0	1	0	0	0	10	76.74%	3

CTM

USC	Urology	Lung	LGI	H&N	Gynae	Haem	UGI	Breast	Other	Number of Breaches	Compliance against Target (95%)	Breaches Minus Urology
Apr-19	8	1	1	1	1	0	2	2	4	20	83.33%	12
May-19	12	8	2	0	4	1	2	0	4	33	71.55%	21
Jun-19	10	2	2	0	4	1	0	0	1	20	84.44%	10
Jul-19	10	1	2	1	2	2	0	0	1	19	83.33%	9

What actions are we taking?

The new HB has put in place robust processes and actions within POW to address the poor performing areas. These actions include embedding POW into the scrutiny and escalation processes already in place in the former Cwm Taf sites.

A number of the areas above contributing to the breach numbers are outside of CTM. The Directorate escalates these through the respective medical directors, however influencing changes directly is challenging. As well the Directorate is in the process of critically reviewing all pathways as part of the readiness planning for SCP, and this will also contribute to improving USC performance.

Benchmarking: how do we compare?

Urgent suspected cancer - Target 95%								
Period	Cwm Taf	Abertawe Bro Morgannwg/Swansea Bay	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Bridgend	CTM
Jul-18	83.75%	92.20%	84.00%	82.10%	81.80%	88.00%	84.62%	84.03%
Aug-18	85.00%	94.10%	83.60%	85.30%	79.80%	90.90%	89.19%	86.32%
Sep-18	75.00%	82.90%	87.10%	83.00%	83.50%	90.70%	75.61%	75.26%
Oct-18	80.77%	84.30%	89.90%	85.80%	84.50%	93.50%	72.92%	77.78%
Nov-18	91.35%	87.60%	86.10%	80.90%	81.00%	85.50%	85.96%	89.13%
Dec-18	82.80%	88.10%	91.30%	87.20%	85.70%	88.30%	84.21%	83.33%
Jan-19	90.40%	85.40%	88.00%	84.40%	85.90%	78.80%	79.41%	86.92%
Feb-19	91.00%	80.60%	91.40%	80.80%	87.00%	80.70%	76.32%	86.21%
Mar-19	90.60%	84.10%	87.20%	86.80%	84.00%	84.20%	67.50%	80.65%
Apr-19	89.39%	87.00%	85.80%	81.20%	85.20%	87.50%	75.93%	83.30%
May-19	72.70%	80.20%	82.60%	81.50%	80.60%	80.00%	70.00%	71.55%

Single Cancer Pathway

The Minister for Health and Social Services announced in November 2018 his intention to introduce a single cancer pathway (SCP) across Wales, with Health Boards required to publically report performance against the SCP alongside the current cancer waiting times for all patients diagnosed with cancer and treated from June 2019. SCPs will monitored initially for breast, colorectal, Head and Neck/Mucosal, Head and Neck/Neck Lump, Lung, Upper GI/Gastric and Upper GI/Oesophageal.

Source: CANISC/Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 74: The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

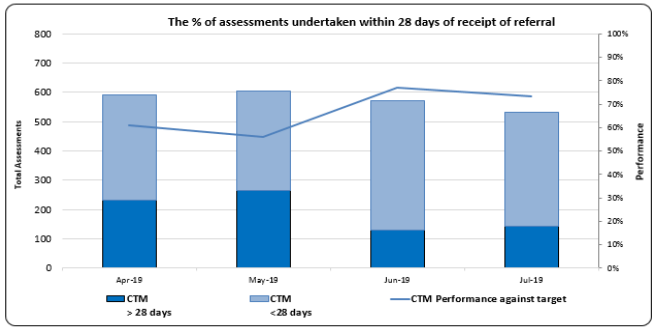
Executive Lead: Director of Primary, Community and Mental Health

Period: Apr 2019 to Jul 2019

Target: 80%

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

As above

Bridgend

As above

How are we doing, what actions are we taking?

How are we doing?
Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target for 80% of referrals to be assessed within 28 days. The July position unfortunately feel again to 73.12% having been 77.10% in June.

What are the areas of risk?
The resilience of a relatively small number of teams to maintain performance when there is annual leave and sick leave.

Benchmarking: how do we compare?

% of assessments by the LPMHSS undertaken within 28 days from the date of referral (target 80%)

Period	Cwm Taf	Swansea Bay (as from April 2019)	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Morgannwg	CT Morgannwg
Jun-18	90.5%	82.5%	86.8%	73.4%	90.5%	96.6%	93.1%	82.35%	89.87%
Jul-18	84.9%	83.8%	87.7%	72.7%	85.2%	96.2%	83.5%	80.56%	84.54%
Aug-18	81.8%	80.5%	83.2%	70.9%	83.1%	93.4%	80.1%	73.08%	81.30%
Sep-18	77.1%	76.4%	82.9%	66.1%	80.1%	93.8%	84.0%	70.21%	76.45%
Oct-18	84.0%	83.8%	91.1%	68.2%	88.6%	96.4%	87.6%	80.52%	83.53%
Nov-18	78.2%	77.7%	84.5%	66.8%	79.7%	93.0%	82.1%	90.14%	80.04%
Dec-18	61.5%	83.8%	84.0%	75.1%	68.7%	93.5%	87.1%	87.80%	64.27%
Jan-19	44.0%	72.6%	88.7%	65.2%	55.5%	92.5%	84.7%	79.10%	48.55%
Feb-19	55.2%	79.8%	86.0%	19.3%	90.4%		90.2%	85.00%	57.71%
Mar-19	51.2%	76.8%	80.6%	75.6%	75.0%	91.9%	88.0%	80.95%	53.65%
Apr-19		86.1%	86.9%	74.6%	56.4%	93.4%	78.6%		61.00%
May-19		84.8%	83.1%	63.3%	49.8%	87.3%	81.8%		56.10%
Jun-19		84.6%	80.9%	63.7%	48.6%	94.3%	81.0%		77.10%

The Health Board remains comparable with peers.

Source: Local Mental Health

Indicator 75: The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

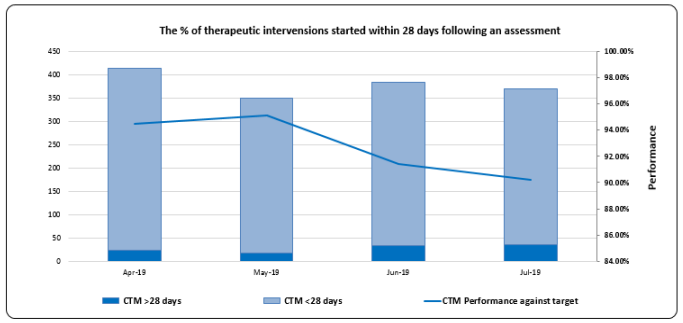
Executive Lead: Director of Primary, Community and Mental Health

Period: Apr 2019 to Aug 2019

Target: 80%

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

As above

Bridgend

As above

How are we doing, what actions are we taking?

How are we doing?
The percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS was 90.24% in July having been 91.41% in June.

What are the areas of risk?
The resilience of a relatively small number of teams to maintain performance when there is annual leave and sick leave.

Benchmarking: how do we compare?

% of therapeutic interventions started within 28 days following assessment by LPMHSS (target 80%)

Period	Cwm Taf	Swansea Bay (as from April 2019)	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Morgannwg	CT Morgannwg
Jun-18	89.4%	79.5%	85.0%	71.5%	71.4%	88.9%	82.1%	70.83%	87.26%
Jul-18	97.1%	79.1%	82.7%	55.4%	82.1%	95.1%	64.8%	78.95%	96.27%
Aug-18	94.9%	90.3%	91.2%	59.9%	74.3%	90.7%	70.7%	88.00%	94.47%
Sep-18	95.5%	88.6%	81.0%	61.1%	59.8%	87.5%	77.1%	91.67%	95.24%
Oct-18	98.7%	91.5%	82.4%	65.9%	64.9%	92.5%	80.3%	100.00%	98.84%
Nov-18	93.5%	87.6%	82.5%	64.0%	67.7%	95.6%	76.1%	92.00%	93.37%
Dec-18	97.3%	85.2%	80.4%	73.8%	73.3%	93.8%	77.8%	80.00%	96.41%
Jan-19	92.7%	86.1%	83.4%	48.8%	89.7%	87.2%	72.3%	88.89%	92.57%
Feb-19	93.9%	87.5%	82.0%	67.1%	85.2%		75.5%	73.08%	92.64%
Mar-19	95.1%	87.7%	83.8%	68.0%	71.2%	81.5%	74.7%	93.75%	95.06%
Apr-19		97.6%	78.3%	70.3%	69.6%	89.8%	71.8%		94.40%
May-19		94.4%	66.8%	62.2%	55.9%	86.3%	61.6%		95.10%
Jun-19		98.5%	60.9%	72.2%	55.4%	88.0%	59.6%		91.40%

The Health Board remains one of the best performing in this area.

Source: Local Mental Health

Indicator 76: The percentage of qualifying patients (compulsory and informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Director of Primary, Community and Mental Health

Period: Q4 2018/19

Target: 80% (5 working days)

Current Performance:

Cwm Taf Morgannwg

Data is not currently available

Cwm Taf

% qualifying patients who had their first contact with an IMHA within 5 working days of their request for an advocate
Target 100%

LHB	2018/19				2017/18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ABM/SB	100%	100%	100%	100%/91%	100%	100%	100%	100%
AB	100%	100%	99.10%	100%	99%	100%	100%	100%
BCU	100%	100%	100%	100%	100%	100%	100%	100%
C&V	100%	100%	100%	100%	100%	100%	100%	100%
CTaf	100%	100%	100%	100%	100%	100%	100%	100%
HDda	100%	100%	99.30%	100%	100%	100%	100%	100%
Powys	100%	100%	100%	100%	100%	100%	100%	100%
Wales	100%	100%	99.70%	91.10%	100%	100%	100%	100%

Bridgend

% qualifying patients who had their first contact with an IMHA within 5 working days of their request for an advocate
Target 100%

LHB	2018/19				2017/18			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ABM/SB	100%	100%	100%	100%/91%	100%	100%	100%	100%
AB	100%	100%	99.10%	100%	99%	100%	100%	100%
BCU	100%	100%	100%	100%	100%	100%	100%	100%
C&V	100%	100%	100%	100%	100%	100%	100%	100%
CTaf	100%	100%	100%	100%	100%	100%	100%	100%
HDda	100%	100%	99.30%	100%	100%	100%	100%	100%
Powys	100%	100%	100%	100%	100%	100%	100%	100%
Wales	100%	100%	99.70%	91.10%	100%	100%	100%	100%

How are we doing, what actions are we taking?

The IMHA performance for Cwm Taf University Health Board for Q4 of 2018/19 was 100%.

Benchmarking: how do we compare?

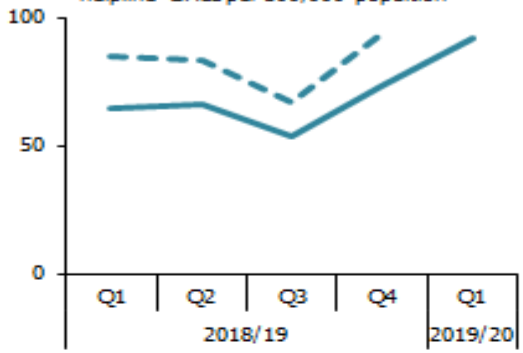
As shown in the graphs to the left.

Source: Local Mental Health

INDIVIDUAL CARE – People in Wales are treated as individuals with their own needs and responsibilities

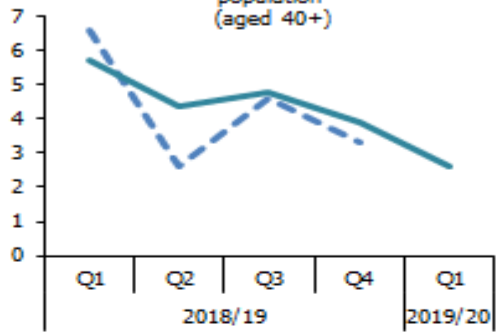
Key: Cwm Taf Morgannwg —— **Cwm Taf** - - - **or** ■ **Bridgend** ▒

Number of calls to the mental health helpline CALL per 100,000 popultion



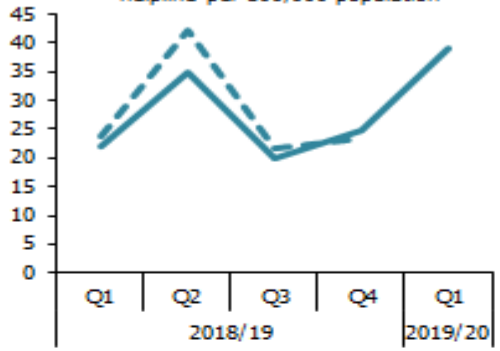
Current Position		
CT	B	CTM
N/A	N/A	92.3

Number of calls to the Wales dementia helpline per 100,000 population (aged 40+)



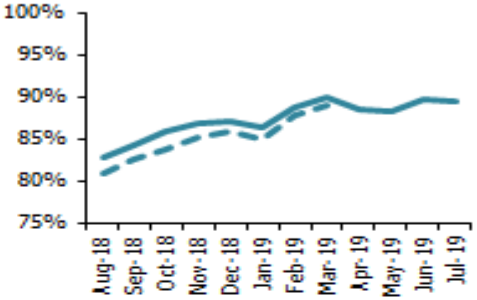
Current Position		
CT	B	CTM
3.3	5.2	3.9

Number of calls to the DAN 24/7 helpline per 100,000 population



Current Position		
CT	B	CTM
N/A	N/A	39.1

The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)



Current Position		
CT	B	CTM
N/A	N/A	89.7%

Residents assessed under part 3 mental health measure to be sent copy of outcome assessment report up to and including 10 working days after assessment

Current Position		
CT	B	CTM
N/A	N/A	100%

Indicator 82: Number of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population

Outcome: My individual circumstances are considered

Executive Lead: Director of Primary, Community and Mental Health

Period: 2018/19 & Qtr. 1 2019/20

Target: 4 Quarter Improvement Trend

Current Performance:

Cwm Taf Morgannwg

Cwm Taf Morgannwg

Number of calls to the mental health helpline CALL per 100,000 population

2018/19				2019/20
Q1	Q2	Q3	Q4	Q1
64.5	65.9	53.9	72.9	92.3

Cwm Taf

Cwm Taf

Number of calls to the mental health helpline CALL per 100,000 population

2018/19			
Q1	Q2	Q3	Q4
84.6	83.6	67.2	93.6

Bridgend

Bridgend

Number of calls to the mental health helpline CALL per 100,000 population

2018/19			
Q1	Q2	Q3	Q4
22.9	29.1	26.3	29.8

How are we doing, what actions are we taking?

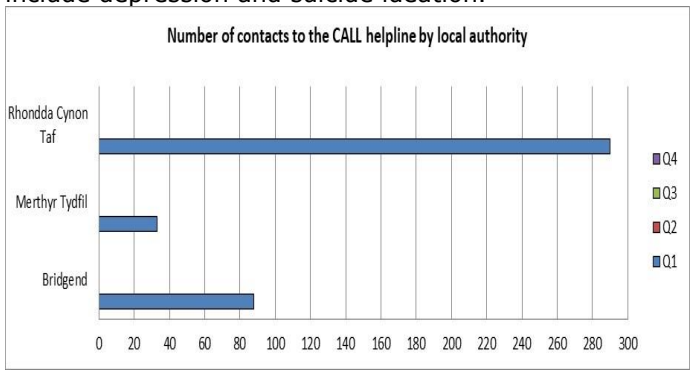
Top subject areas discussed on the CALL helpline by local authority – Quarter 1, 2019-20

	Bridgend		Merthyr Tydfil		Rhondda Cynon Taf	
	No. of enquiries	132	No. of enquiries	55	No. of enquiries	469
1	Mental Health	13.6%	Anxiety	14.5%	Mental Health	10.2%
2	Info. on CALL	7.6%	Depression	7.3%	Suicide Ideation	9.8%
3	Depression	6.1%	Info. on CALL	7.3%	Anxiety	8.1%
4	Anxiety	5.3%	Mental Health	7.3%	Depression	5.5%
5	Suicide Ideation	3.8%	Suicide Ideation	7.3%	Self-Harm	4.7%

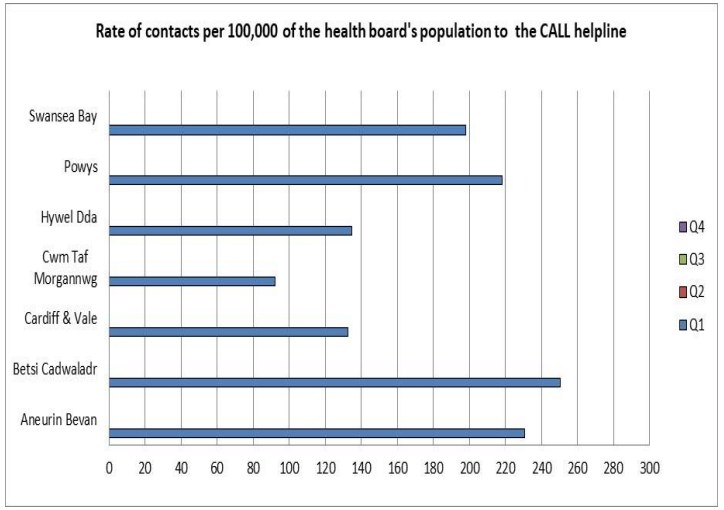
*Number of enquiries is the total number of issues that have been discussed by the local authority's residents. This figure differs to the number of contacts made to the help line.

For quarter 1 2019-20, 411 contacts were made to the CALL helpline from the Cwm Taf Morgannwg University Health Board area (approximately 92 contacts per 100,000 of its population). This accounted 7.1% of the all Wales total. The local authority area with the highest number of callers is Rhondda Cynon Taf (290) – 70.6% of Cwm Taf Morgannwg's total.

Although the data shows that the subjects discussed by individuals contacting the CALL helpline is wide ranging, the top subject for Bridgend and Rhondda Cynon Taf is mental health and for Merthyr Tydfil it is anxiety. The table outlining the top areas of focus for each local authority identifies other reported conditions – these include depression and suicide ideation.



Benchmarking: how do we compare?



For quarter 1 2019-20, 5,881 contacts were made to the CALL helpline, of which 5,760 were made by citizens living in Wales (approximately 184 calls per 100,000 of the population). The health board area with the highest rate is Betsi Cadwaladr University Health Board (with a rate of 250 calls per 100,000 of its population), followed by Aneurin Bevan (a rate of 231 calls per 100,000). The health board with the lowest rate is Cwm Taf Morgannwg (92 calls per 100,000).

Source: Welsh Government

Indicator 83: Number of calls to the Wales dementia helpline by Welsh residents per 100,000 of the population (age 40+)

Outcome: My individual circumstances are considered

Executive Lead: Director of Primary, Community and Mental Health

Period: 2018/19 & Qtr. 1 2019/20

Target: 4 Quarter Improvement Trend

Current Performance:

Cwm Taf Morgannwg

Cwm Taf Morgannwg				
Number of calls to the Wales dementia helpline per 100,000 population (aged 40+)				
2018/19				2019/20
Q1	Q2	Q3	Q4	Q1
5.7	4.4	4.8	3.9	2.6

Cwm Taf

Cwm Taf			
Number of calls to the Wales dementia helpline per 100,000 population (aged 40+)			
2018/19			
Q1	Q2	Q3	Q4
6.6	2.6	4.6	3.3

Bridgend

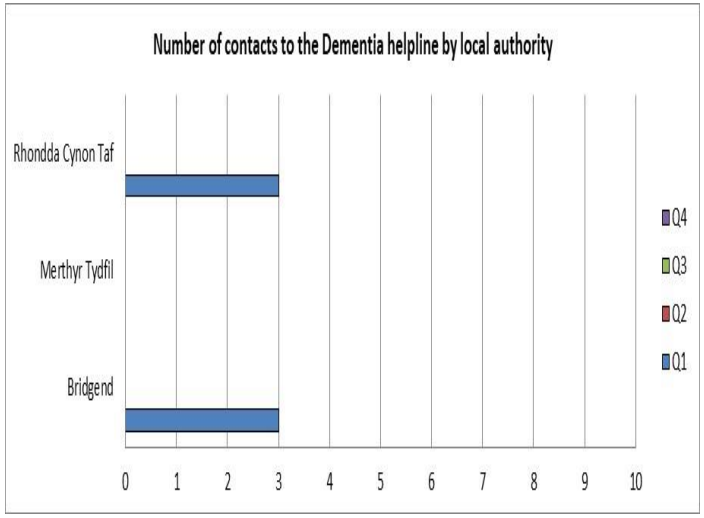
Bridgend			
Number of calls to the Wales dementia helpline per 100,000 population (aged 40+)			
2018/19			
Q1	Q2	Q3	Q4
3.9	7.8	5.2	5.2

How are we doing, what actions are we taking?

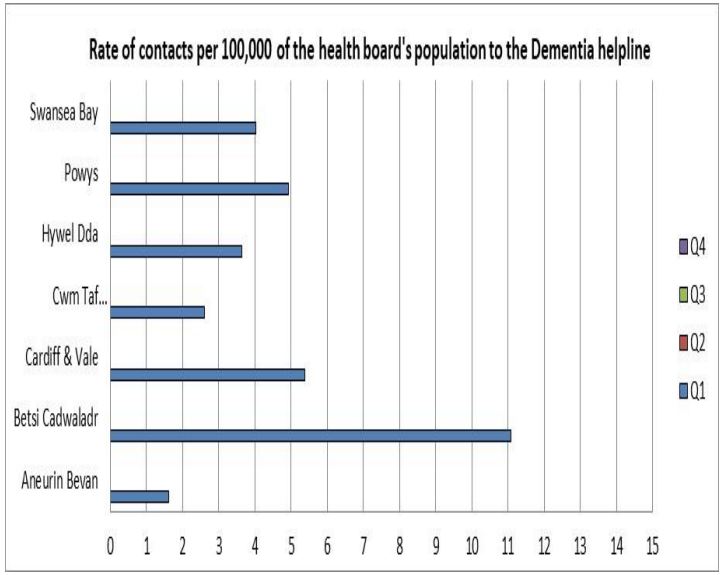
Contacts to the Dementia helpline – Cwm Taf Morgannwg University Health Board					
	2018-19	2019-20			
	Q4	Q1	Q2	Q3	Q4
Rate per 100,000 of health board population*	NA	2.6			
Number of contacts for health board	NA	6			
Percentage of the Wales total	Na	7.0%			

*2018-19 data is based on 2017 mid-year population estimates, whilst 2019-20 data is based on 2018 mid-year population estimates.

During quarter 1 2019-20, 6 contacts to the dementia helpline were made from the Cwm Taf Morgannwg area. This accounted for 7.0% of the all Wales total. Although the number of residents contacting the dementia helpline is low, the local authority areas with the largest number of callers are Bridgend and Rhondda Cynon Taf (with 3 calls each).



Benchmarking: how do we compare?



In comparison with the aforementioned helplines, the number of contacts to the dementia helpline is significantly lower. The total number of contacts to the dementia helpline for quarter 1 was 87, of which 86 were made by citizens living in Wales (approximately 5 calls per 100,000). The health board with the highest rate of contacts is Betsi Cadwaladr (a rate of 11 calls per 100,000 of its population), whilst Aneurin Bevan has the lowest (2 calls per 100,000).

Source: Welsh Government

Indicator 84: Number of calls to the DAN 24/7 helpline (drugs and alcohol) by Welsh residents per 100,000 of the population

Outcome: My individual circumstances are considered

Executive Lead: Director of Primary, Community and Mental Health

Period: 2018/19 & Qtr. 1 2019/20

Target: 4 Quarter Improvement Trend

Current Performance:

Cwm Taf Morgannwg

Cwm Taf Morgannwg

Number of calls to the DAN 24/7 helpline per 100,000 population

2018/19				2019/20
Q1	Q2	Q3	Q4	Q1
21.9	35	19.8	24.8	39.1

Cwm Taf

Cwm Taf

Number of calls to the DAN 24/7 helpline per 100,000 population

2018/19			
Q1	Q2	Q3	Q4
23.7	42.1	21.7	23.4

Bridgend

Bridgend

Number of calls to the DAN 24/7 helpline per 100,000 population

2018/19			
Q1	Q2	Q3	Q4
18	20.1	15.9	27.7

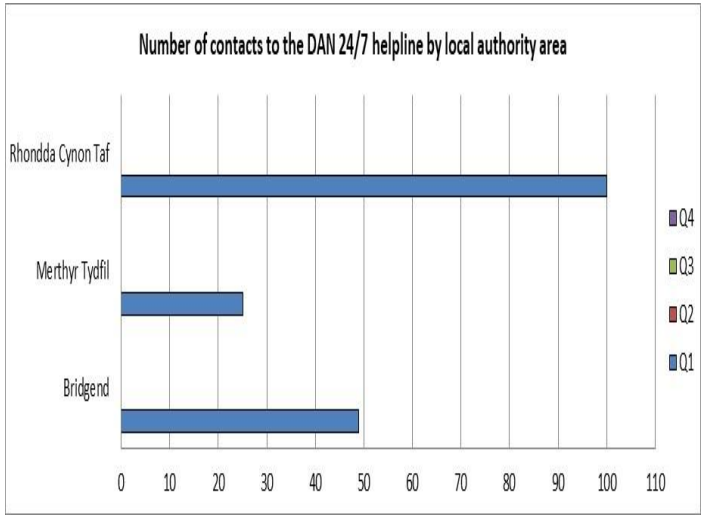
How are we doing, what actions are we taking?

Contacts to the DAN 24/7 helpline – Cwm Taf Morgannwg University Health Board

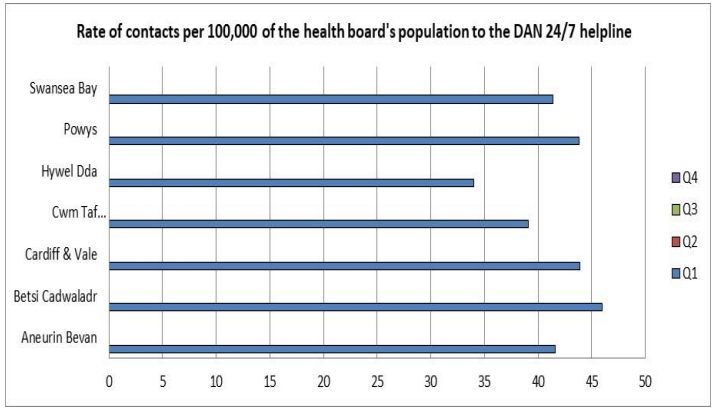
	2018-19	2019-20			
	Q4	Q1	Q2	Q3	Q4
Rate per 100,000 of health board population*	NA	39.1			
Number of contacts for health board	NA	174			
Percentage of the Wales total	NA	13.3%			

*2018-19 data is based on 2017 mid-year population estimates, whilst 2019-20 data is based on 2018 mid-year population estimates.

For quarter 1 2019-20, 174 contacts to the DAN 24/7 helpline came from Cwm Taf Morgannwg's area (approximately 39 calls per 100,000 of its population). This accounted for 13.3% of the all Wales total. The local authority area with the largest number of callers is Rhondda Cynon Taf (100) – 57.5% of Cwm Taf Morgannwg's total.



Benchmarking: how do we compare?



The total number of contacts to the DAN 24/7 helpline for quarter 1 was 1,335. The number of contacts associated with individuals residing in Wales was 1,309 (approximately 42 calls per 100,000 of its population). Betsi Cadwaladr UHB's catchment area had the highest rate of contacts (46 calls per 100,000 of its population), whilst Hywel Dda UHB's catchment area had the lowest rate (34 calls per 100,000).

Source: Welsh Government

Indicator 85: The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)

Outcome: My individual circumstances are considered

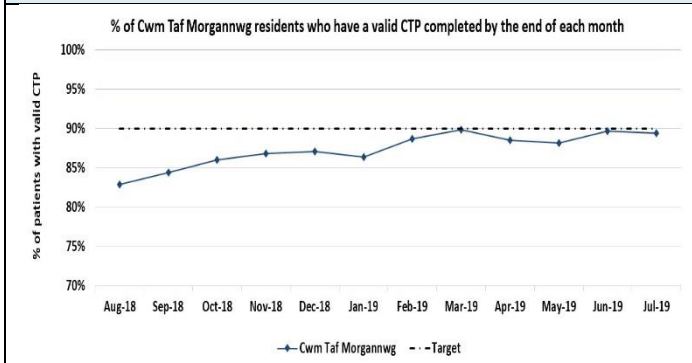
Executive Lead: Director of Primary, Community and Mental Health

Period: Aug 2018 to Jul 2019

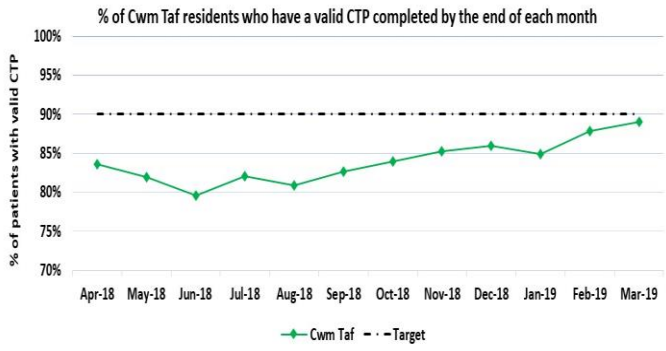
Target: 90%

Current Performance:

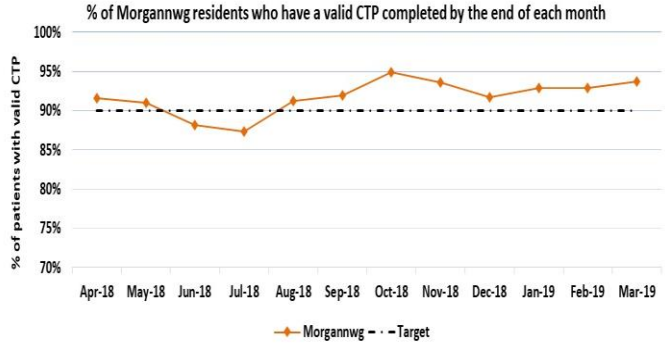
Cwm Taf Morgannwg



Cwm Taf: to 31st March 2019



Bridgend: to 31st March 2019



How are we doing, what actions are we taking?

The Performance Target for Cwm Taf Morgannwg at the end of July was 89.4% which is a decrease from 89.7% at the end of June. This Performance Indicator Target remains at 90%. CAMHS have increased their compliance from 80.3% in June to 84.9% in July and Learning Disabilities have decreased from 95.1% to 92.5%. Both adult and older persons have also decreased compliance with adult services decreasing to 88.5% in July from 88.7% in June and the older persons decreasing from 94.1% in June to 93.4% in July.

- Adult **88.5%**
- Older Persons Mental Health **93.4%**
- Learning Disabilities **92.5%**
- CAMHS **84.9%**

A recent Demand & Capacity exercise in CAMHS shows a gap in current capacity to meet demand. New Welsh Government funding is being directed to help increase capacity, confirmation of this was received in August so the impact should be seen at the end of quarter 3. Engagement on the current model of adult community mental health services reinforcing the challenge in this area and that the volume of CTP's need completion by the medical team is not sustainable, the completion of this process will lead to a number of recommendations and a paper is being finalised and alternative models being explored. Waiting list work will continue until more sustainable approaches are in place.

The graph opposite shows the compliance for Cwm Taf Morgannwg from April 2019 which indicates compliance against the 90% target for Part 2 of the Mental Health Measure.

Benchmarking: how do we compare?

% of HB residents (all ages) to have a valid CTP completed at the end of each month (target 90%)

Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
Jul-18	82.1%	87.4%	88.0%	85.1%	91.1%	95.3%	87.6%
Aug-18	80.9%	90.9%	87.0%	86.1%	93.3%	93.4%	89.7%
Sep-18	82.6%	90.3%	88.0%	85.3%	91.2%	93.9%	91.3%
Oct-18	83.9%	90.6%	89.0%	85.6%	91.8%	92.3%	91.6%
Nov-18	85.2%	90.6%	89.2%	Not available	92.1%	95.4%	90.6%
Dec-18	86.0%	90.2%	89.7%	83.9%	92.5%	96.6%	91.3%
Jan-19	84.9%	91.1%	89.9%	84.2%	91.3%	95.4%	90.9%
Feb-19	87.8%	90.1%	90.7%	84.3%	91.6%	94.5%	91.1%
Mar-19	89.0%	90.3%	90.4%	84.9%	91.1%	96.0%	90.9%
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	88.5%	90.5%	89.9%	83.2%	90.9%	95.1%	88.9%
May-19	88.2%	87.1%	93.7%	82.5%	91.0%	93.2%	89.0%
Jun-19	89.7%	85.6%	91.5%	79.8%	91.6%	93.6%	86.9%

The Cwm Taf Morgannwg University Health Board performance remains below compliance in this area.

Source: Local Mental Health

Indicator 86: All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place

Outcome: My individual circumstances are considered

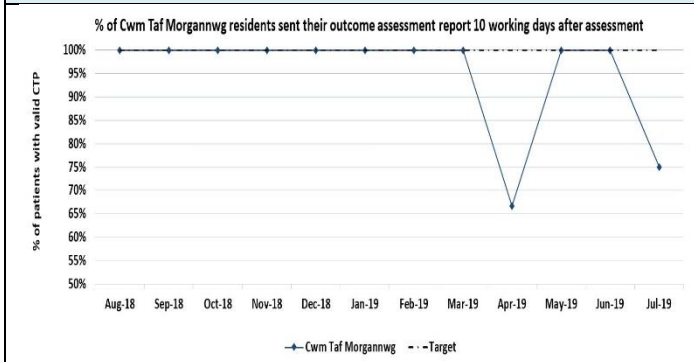
Executive Lead: Director of Primary, Community and Mental Health

Period: Aug 2018 to Jul 2019

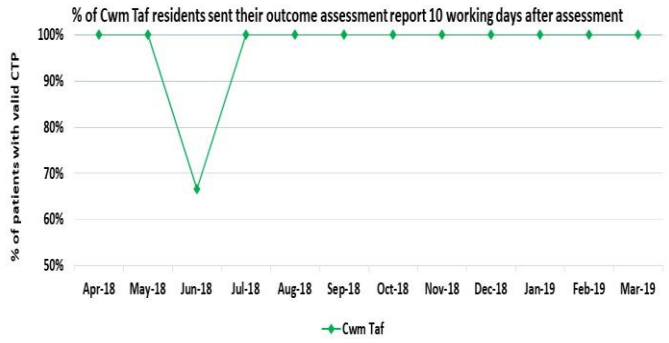
Target: 100%

Current Performance:

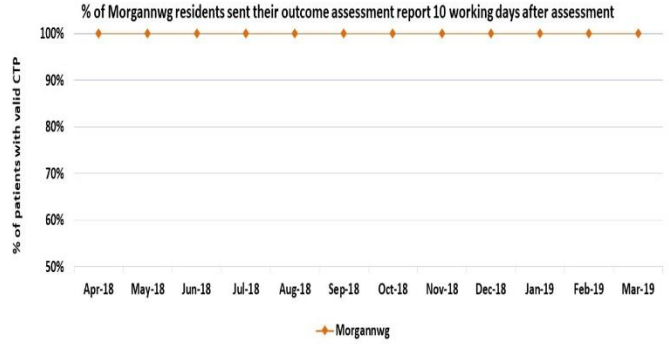
Cwm Taf Morgannwg



Cwm Taf: to 31st March 2019



Bridgend: to 31st March 2019



How are we doing, what actions are we taking?

The current compliance at the end of July has decreased to 75.0% from 100% in June. There has only been two other occasions since June 2018 when compliance has not been at 100%.

The decline is as a result of 1 assessment not having been completed within the required timeframe.

The breach area has been reviewed and the team involved have strengthen their processes and the learning has been shared across the wider service.

Benchmarking: how do we compare?

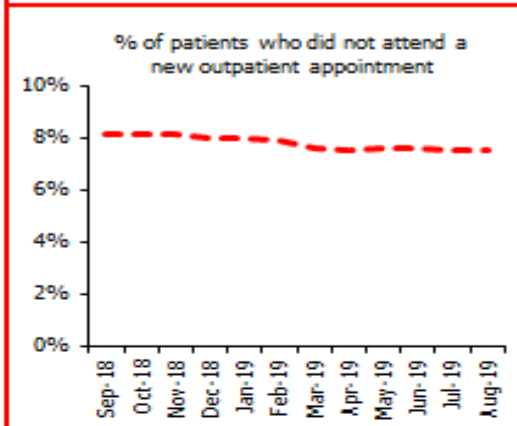
% of HB residents sent their outcome assessment report 10 working days after assessement (target 100%)

Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
Jul-18	100%	100%	100%	100%	62.5%	100%	100%
Aug-18	100%	100%	100%	100%	100%	100%	100%
Sep-18	100%	100%	100%	100%	100%	100%	100%
Oct-18	100%	100%	100%	100%	100%	100%	100%
Nov-18	100%	100%	100%	Not available	100%	100%	100%
Dec-18	100%	100%	100%	100%	Not available	100%	100%
Jan-19	100%	100%	100%	100%	100%	100%	100%
Feb-19	100%	100%	100%	100%	100%	100%	100%
Mar-19	100%	100%	100%	100%	100%	100%	100%
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	67%	100%	100%	75.0%	100%	100%	100%
May-19	100%	100%	100%	50.0%	100%	100%	100%
Jun-19	100%	100%	100%	76.9%	100%	100%	100%

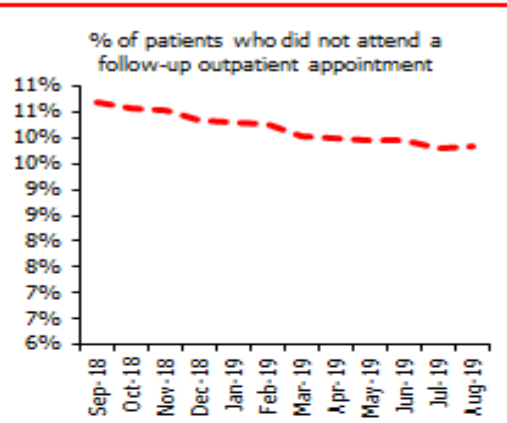
Source: Local Mental Health

OUR STAFF AND RESOURCES – People in Wales can find information about how their NHS is resourced and make careful use of them

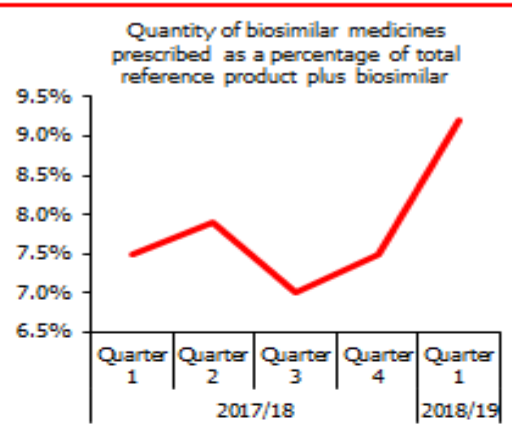
Key: Cwm Taf Morgannwg —— **Cwm Taf** - - - **or** ▬ **Bridgend**



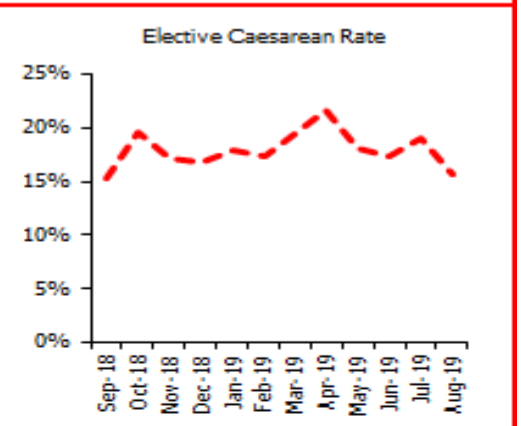
Current Position		
CT	B	CTM
7.5%	N/A	N/A



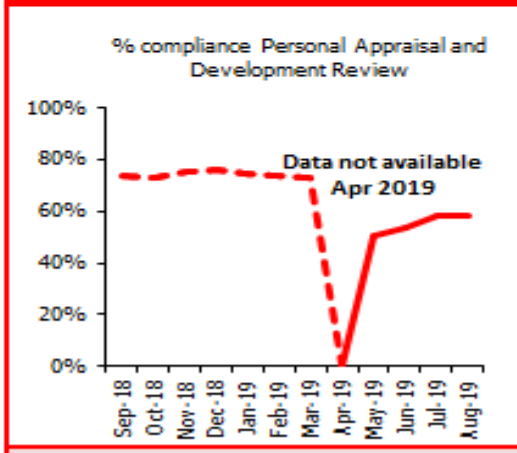
Current Position		
CT	B	CTM
9.9%	N/A	N/A



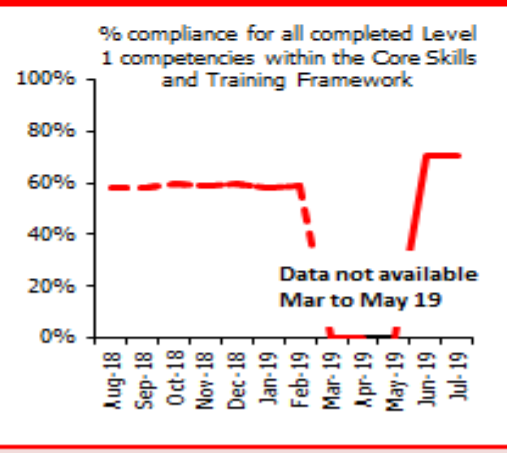
Current Position		
CT	B	CTM
9.2%	N/A	N/A



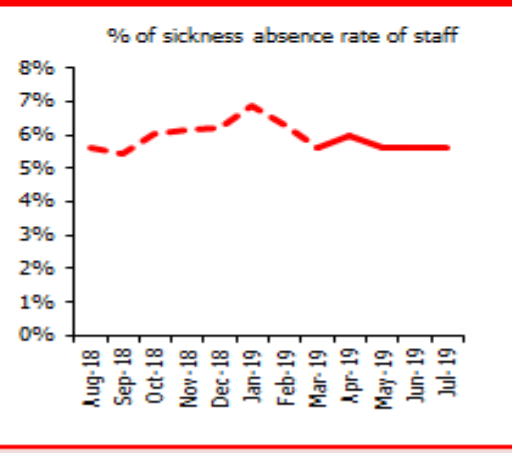
Current Position		
CT	B	CTM
15.8%	N/A	N/A



Current Position		
CT	B	CTM
N/A	N/A	58.04%



Current Position		
CT	B	CTM
N/A	N/A	70.66%



Current Position		
CT	B	CTM
N/A	N/A	5.6%

Indicator 88: The percentage of patients who did not attend a new outpatient appointment (for selected specialties)

Outcome: I work with the NHS to improve the use of resources	Executive Lead: Chief Operating Officer
Period: Sep 2018 to Aug 2019	Target: 12 Month Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

New Outpatient DNA Rates for Specific Specialties (September 2018 to August 2019)

Main Specialty	Number New Outpatients Attendances	Number of DNA's	DNA Rate (%)
Cardiology	5225	276	5.11%
Dermatology	5137	321	5.78%
ENT Surgery	9762	715	6.61%
Gastroenterology	2599	252	8.98%
General Medicine	4136	459	9.92%
General Surgery	10116	755	6.88%
Gynaecology	9777	837	8.07%
Haem (Clinical)	1482	90	5.47%
Nephrology	285	23	7.10%
Neurology	441	68	12.67%
Ophthalmology	8924	924	9.38%
Oral Surgery	5275	383	6.57%
Orthopaedics	13870	1030	7.00%
Paediatrics	3096	512	14.47%
Respiratory Medicine	2581	148	5.43%
Rheumatology	3395	273	7.33%
Urology	5690	388	6.38%
Total	91791	7454	7.51%

Bridgend

Data not currently available

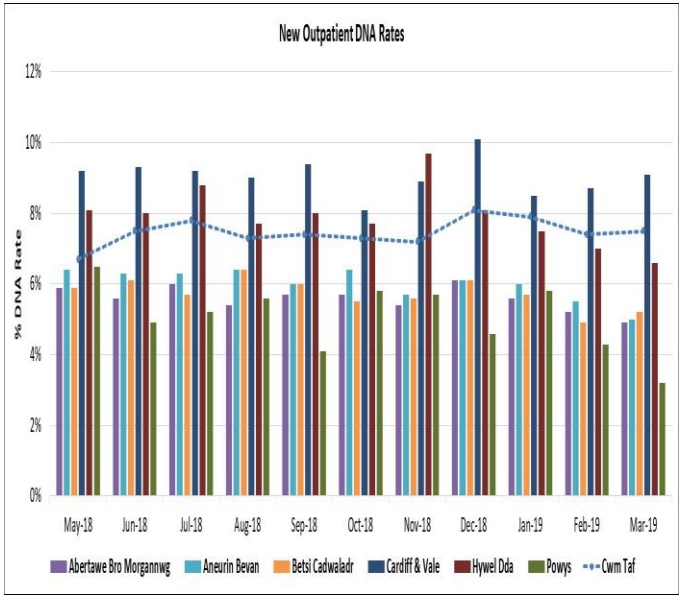
How are we doing, what actions are we taking?

The percentage DNA rate of new outpatient appointments for the specialties identified in the adjacent table for the rolling 12 month period to August 2019 is 7.51%.

Work is in progress as part of the cross cutting themes in this regard within the planned care stream.

Short notice hospital cancellations are the main risk and needs to be reduced to a manageable number.

Benchmarking: how do we compare?



Benchmark data not available from 1st April 2019

Source: Local /Information Team and Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 89: The percentage of patients who did not attend a follow-up outpatient appointment (for selected specialties)

Outcome: I work with the NHS to improve the use of resources	Executive Lead: Chief Operating Officer
Period: Sep 2018 to Aug 2019	Target: 12 Month Reduction Trend

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Follow-up Outpatient DNA Rates for Specific Specialties (September 2018 to August 2019)

Main Specialty	Number of Follow-up Outpatients Attendances	Number of DNA's	DNA Rate (%)
Cardiology	5222	302	5.52%
Dermatology	8991	677	6.94%
ENT Surgery	15163	1679	9.88%
Gastroenterology	3873	482	11.15%
General Medicine	16126	2144	11.69%
General Surgery	12508	1297	9.43%
Gynaecology	10699	1346	11.04%
Haem (Clinical)	26853	1395	4.81%
Nephrology	1961	178	8.67%
Neurology	869	222	19.44%
Ophthalmology	29256	3116	9.58%
Oral Surgery	5328	688	11.19%
Orthopaedics	30349	3303	9.79%
Paediatrics	8839	2388	20.97%
Respiratory Medicine	4637	474	9.42%
Rheumatology	8447	1070	11.36%
Urology	8457	824	8.95%
Total	197578	21585	9.85%

Bridgend

Data not currently available

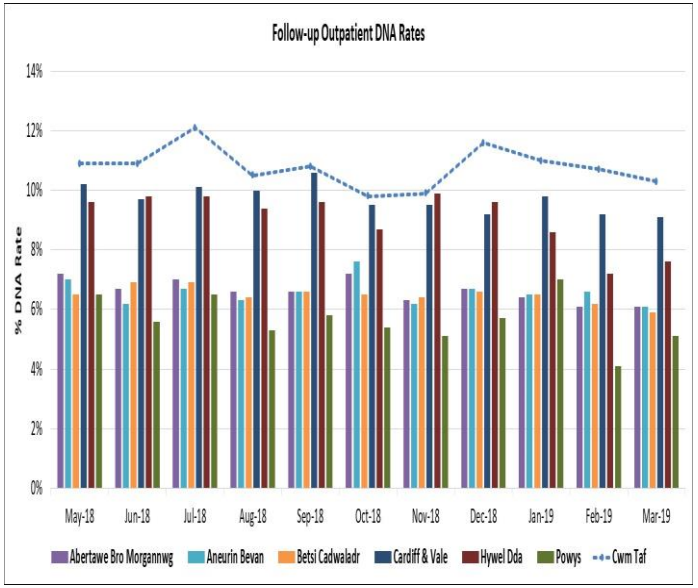
How are we doing, what actions are we taking?

The percentage DNA rate of follow up outpatient appointments for the specialties identified in the adjacent table for the rolling 12 month period to August 2019 is 9.85%.

Work is in progress as part of the cross cutting themes in this regard within the planned care stream, running alongside validation, potentially through case note review via virtual clinics, within specialties.

Short notice hospital cancellations are the main risk and needs to be reduced to a manageable number.

Benchmarking: how do we compare?



Benchmark data not available from 1st April 2019

Source: Local /Information Team and Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

Indicator 90: Quantity of biosimilar medicines prescribed as a percentage of total `reference' product plus biosimilar

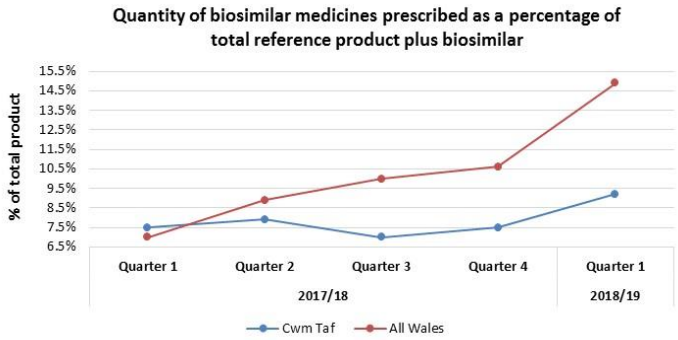
Outcome: Resources are used efficiently and effectively to improve my health outcomes	Executive Lead: Director of Primary, Community and Mental Health
Period: 2017/18 to 2018/19 Qtr. 1	Target: Quarter on Quarter Improvement

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

The table does not reflect the actual status of biosimilar uptake in CTUHB, this could be due to the inclusion of insulin glargine in primary care which is skewing the results of the basket of medicines included. All Wales central data shows that CTUHB has the following percentage use of biosimilar medicines prescribed as a percentage of the reference product:
Etanercept- 86%
Inflximab - 100%
Rituximab - 100%
Filgrastim primary and secondary care - 100%

From up to date local data: All suitable patients have been switched to biosimilar product for these medicines. For insulin glargine there is very little difference in the cost of the biosimilar vs the originator product and so no incentive to switch diabetic patients. In addition CTUHB prescribes proportionately less insulin glargine than other HBs.
Insulin glargine secondary care 4%
Insulin glargine primary care 3%.

CTUHB have agreed a programme of maximising the use of biosimilar products where there is a cost effective benefit. A medicines management nurse is supporting this programme ensuring a safe and effective process for clinical staff and patients. The programme is monitored via the monthly CRES process.

Clinical staff have been engaged and supportive of the changes, although discussions are still ongoing with some clinicians over the use of a new biosimilar – Adalimumab.

Risks are: there are patients who cannot tolerate or do not consent to change to the biosimilar and so there will always be some prescribing of the originator product. Supply of the biosimilar products must be sustainable.

Benchmarking: how do we compare?

Quantity of biosimilar medicines prescribed as a percentage of total reference product plus biosimilar

		CTUHB	ABMU	AB	BCU	C&V	HDda	Powys
2018/19	Quarter 1	9.2%	20.9%	14.0%	14.0%	12.5%	19.7%	5.9%
2017/18	Quarter 1	7.5%	6.4%	6.6%	8.7%	4.7%	9.4%	2.0%
	Quarter 2	7.9%	10.4%	7.4%	10.1%	7.4%	11.3%	3.2%
	Quarter 3	7.0%	12.3%	7.7%	11.7%	9.0%	12.7%	3.4%
	Quarter 4	7.5%	12.2%	8.7%	12.9%	9.0%	13.3%	5.3%

With the medicines we use we are as good as our peers

Source: Welsh Government Delivery and Performance Website

Indicator 92: Elective caesarean rate

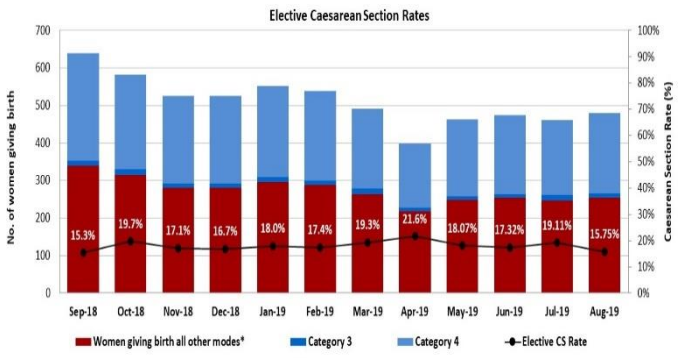
Outcome: Resources are used efficiently and effectively to improve my health outcomes	Executive Lead: Director of Nursing
Period: Sep 2018 to Aug 2019	Target: Annual Reduction

Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf



Bridgend

Data not currently available

How are we doing, what actions are we taking?

Individual clinical practice and women's choice have been identified as the main contributors to high rate of C-Section births. This is being addressed by the multidisciplinary team aiming for a reduction by 1% each year until the combined target rate of 25% is achieved for elective and non-elective c-sections.

Continued drive towards an increase in Midwifery led Care and Normal Birth with all healthy pregnant women having the option of home birth, free standing birth Centre at RGH, Alongside Midwifery Unit at PCH. As the default position in an 'opt out' model rather than 'opt-in' in order to reduce medicalisation of childbirth with increased use of water for labour/birth.

Birth Choices Clinic established 2015 to support and counsel all women who have had a previous CS, traumatic vaginal birth or with a fear of childbirth in support of developing a birth plan in support of normal birth. Women invited to provide 'Patient Stories' to share learning/outcomes and highlight the impact on the Patient Experience
Continuous audit of all Inductions of Labour.

CS rate a standing agenda item on Monthly Audit Meeting, Monthly Labour Ward Forums, Quarterly Directorate Quality & Safety Meeting and Bi-monthly joint (cross sites) Consultant Obstetric.

Meetings with the Directorate Management Team and Senior Midwives.

Education of Community Midwifery Teams ongoing in support of promoting choices for place of birth in line with WAG requirement for 45% of women to be offered birth in a midwifery led environment and to ensure appropriate Lead Professional throughout the pregnancy, with women returning to Midwifery Led care following Obstetric review if appropriate.

Benchmarking: how do we compare?

Elective Caesarean Rate - Annual Reduction Target						
Period	Cwm Taf	Abertawe Bro Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda
2017/18	17.4%	13.2%	11.6%	11.3%	11.9%	13.8%
2016/17	16.7%	14.0%	11.1%	12.8%	11.1%	12.6%
2015/16	14.4%	12.1%	10.6%	9.9%	11.8%	13.3%

Source: Information Team/MITS Team

Local Measure: Theatre efficiency

Outcome: Resources are used efficiently and effectively to improve my health outcomes	Executive Lead: Chief Operating Officer
Period: Sep 2018 to Aug 2019	Target: Annual Reduction

Current Performance:

Cwm Taf Morgannwg

	Sep - 2018	Oct - 2018	Nov - 2018	Dec - 2018	Jan - 2019	Feb - 2019	Mar - 2019	Apr - 2019	May - 2019	Jun - 2019	Jul - 2019	Aug - 2019	Total
Planned Procedures	1912	2230	1994	1751	2024	1829	1999	1823	1865	1818	2068	1730	23043
Total No. of Cancellations	368	452	367	353	392	374	317	387	338	358	406	327	4439
%age total cancellations	19.25%	20.27%	18.41%	20.16%	19.37%	20.45%	15.86%	21.23%	18.12%	19.69%	19.63%	18.90%	19%
Patient - Clinical	19.84%	18.81%	20.71%	18.41%	18.37%	11.23%	18.93%	13.70%	13.61%	14.80%	11.08%	12.84%	16.04%
Patient - Non-Clinical	13.86%	13.94%	13.35%	11.90%	13.01%	16.84%	19.56%	13.95%	12.43%	15.64%	13.79%	12.54%	14.19%
Hospital - Clinical	28.80%	26.77%	37.87%	25.78%	31.12%	26.20%	27.76%	23.77%	33.14%	26.54%	24.38%	24.77%	28.02%
Hospital - Non-Clinical	33.70%	34.51%	25.89%	36.54%	31.63%	40.37%	29.34%	43.15%	32.84%	37.15%	39.41%	42.51%	35.64%
Other	3.80%	5.97%	2.18%	7.37%	5.87%	5.35%	4.42%	5.43%	7.99%	5.87%	11.33%	7.34%	6.10%

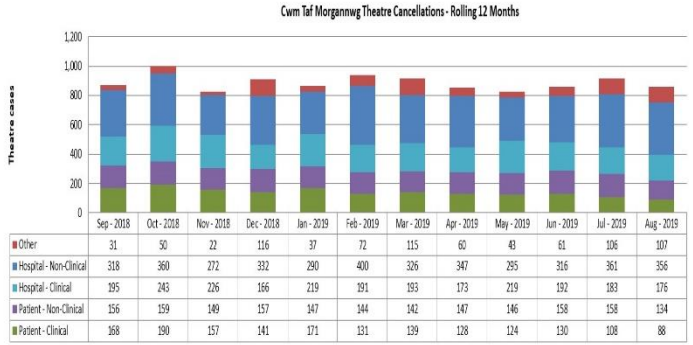
How are we doing, what actions are we taking?

Cwm Taf

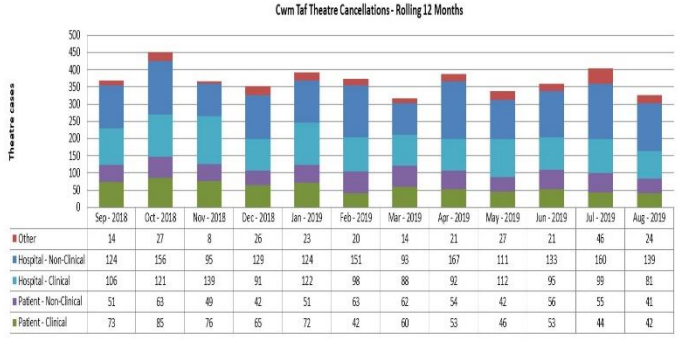
	Sep - 2018	Oct - 2018	Nov - 2018	Dec - 2018	Jan - 2019	Feb - 2019	Mar - 2019	Apr - 2019	May - 2019	Jun - 2019	Jul - 2019	Aug - 2019	Total
Planned Procedures	3657	4267	3781	3337	3985	3591	3844	3440	3800	3635	3928	3397	44662
Total No. of Cancellations	868	1002	826	912	864	939	916	855	827	861	919	861	10650
%age total cancellations	23.74%	23.48%	21.85%	27.33%	21.68%	26.15%	23.83%	24.85%	21.76%	23.69%	23.40%	25.35%	23.85%
Patient - Clinical	19.35%	18.96%	19.01%	15.46%	19.79%	13.95%	15.17%	14.97%	14.99%	15.10%	11.75%	10.22%	15.73%
Patient - Non-Clinical	17.97%	15.87%	18.04%	17.21%	17.01%	15.34%	15.50%	17.19%	17.65%	18.35%	17.19%	15.56%	16.87%
Hospital - Clinical	22.47%	24.25%	27.36%	18.20%	25.35%	20.34%	21.07%	20.23%	26.48%	22.30%	19.91%	20.44%	22.31%
Hospital - Non-Clinical	36.64%	35.93%	32.93%	36.40%	33.56%	42.60%	35.59%	40.58%	35.67%	36.70%	39.28%	41.35%	37.31%
Other	3.57%	4.99%	2.66%	12.72%	4.28%	7.67%	12.55%	7.02%	5.20%	7.08%	11.53%	12.43%	7.70%

Bridgend (Princess of Wales Hospital)

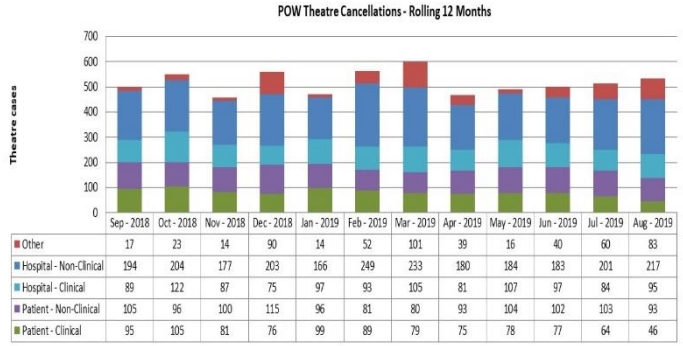
	Sep - 2018	Oct - 2018	Nov - 2018	Dec - 2018	Jan - 2019	Feb - 2019	Mar - 2019	Apr - 2019	May - 2019	Jun - 2019	Jul - 2019	Aug - 2019	Total
Planned Procedures	1745	2037	1787	1586	1961	1762	1845	1617	1935	1817	1860	1667	21619
Total No. of Cancellations	500	550	459	559	472	565	599	468	489	503	513	534	6211
%age total cancellations	28.65%	27.00%	25.69%	35.25%	24.07%	32.07%	32.47%	28.94%	25.27%	27.68%	27.58%	32.03%	29%
Patient - Clinical	19.00%	19.09%	17.65%	13.60%	20.97%	15.75%	13.19%	16.03%	15.95%	15.31%	12.48%	8.61%	15.52%
Patient - Non-Clinical	21.00%	17.45%	21.79%	20.57%	20.34%	14.34%	13.36%	19.87%	21.27%	20.28%	20.08%	17.42%	18.81%
Hospital - Clinical	17.80%	22.18%	18.95%	13.42%	20.55%	16.46%	17.53%	17.31%	21.88%	19.28%	16.37%	17.79%	18.23%
Hospital - Non-Clinical	38.80%	37.09%	38.56%	36.31%	35.17%	44.25%	39.07%	38.46%	37.63%	37.18%	39.38%	40.64%	38.61%
Other	3.40%	4.18%	3.05%	16.10%	2.97%	9.20%	16.86%	8.33%	3.27%	7.95%	11.70%	15.54%	8.84%



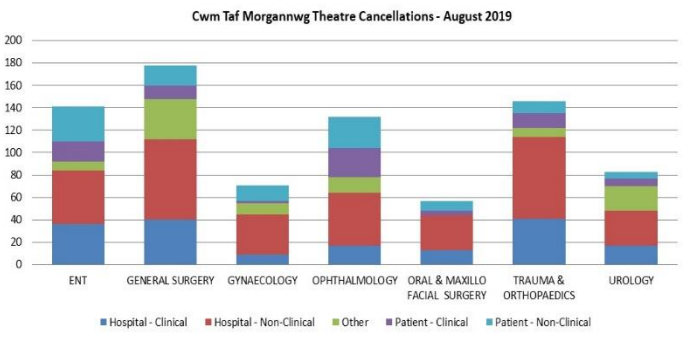
	Sep - 2018	Oct - 2018	Nov - 2018	Dec - 2018	Jan - 2019	Feb - 2019	Mar - 2019	Apr - 2019	May - 2019	Jun - 2019	Jul - 2019	Aug - 2019
Other	31	50	22	116	37	72	115	60	43	61	106	107
Hospital - Non-Clinical	318	360	272	332	290	400	326	347	295	316	361	356
Hospital - Clinical	195	243	226	166	219	191	193	173	219	192	183	176
Patient - Non-Clinical	156	159	149	157	147	144	142	147	146	158	158	134
Patient - Clinical	168	190	157	141	171	131	139	128	124	130	108	88

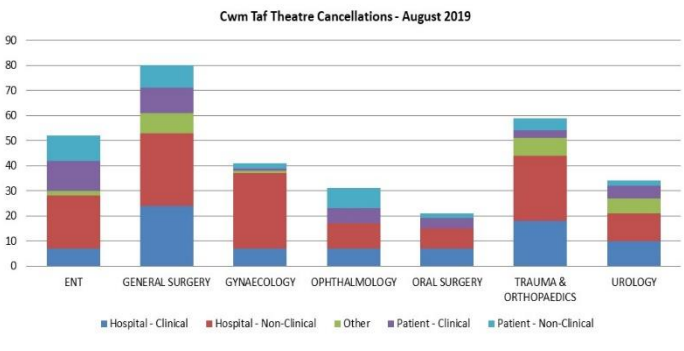


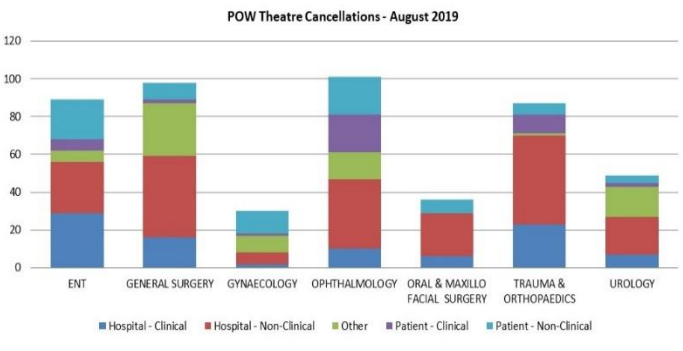
	Sep - 2018	Oct - 2018	Nov - 2018	Dec - 2018	Jan - 2019	Feb - 2019	Mar - 2019	Apr - 2019	May - 2019	Jun - 2019	Jul - 2019	Aug - 2019
Other	14	27	8	26	23	20	14	21	27	21	46	24
Hospital - Non-Clinical	124	156	95	129	124	151	93	167	111	133	160	139
Hospital - Clinical	106	121	139	91	122	98	88	92	112	95	99	81
Patient - Non-Clinical	51	63	49	42	51	63	62	54	42	56	55	41
Patient - Clinical	73	85	76	65	72	42	60	53	46	53	44	42



	Sep - 2018	Oct - 2018	Nov - 2018	Dec - 2018	Jan - 2019	Feb - 2019	Mar - 2019	Apr - 2019	May - 2019	Jun - 2019	Jul - 2019	Aug - 2019
Other	17	23	14	90	14	52	101	39	16	40	60	83
Hospital - Non-Clinical	194	204	177	203	166	249	233	180	184	183	201	217
Hospital - Clinical	89	122	87	75	97	93	105	81	107	97	84	95
Patient - Non-Clinical	105	96	100	115	96	81	80	93	104	102	103	93
Patient - Clinical	95	105	81	76	99	89	79	75	78	77	64	46







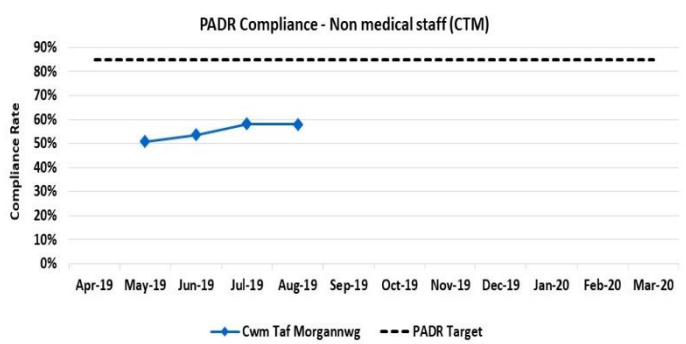
Source: Information Team

Indicator 93: Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)

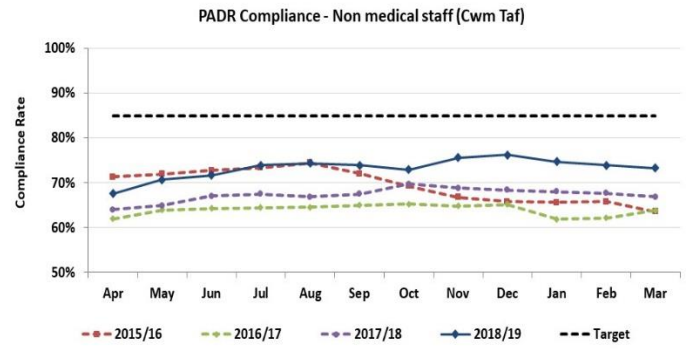
Outcome: Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	Executive Lead: Director of Workforce and Organisational Development
Period: as at 1st September 2019	Target: 85%

Current Performance:

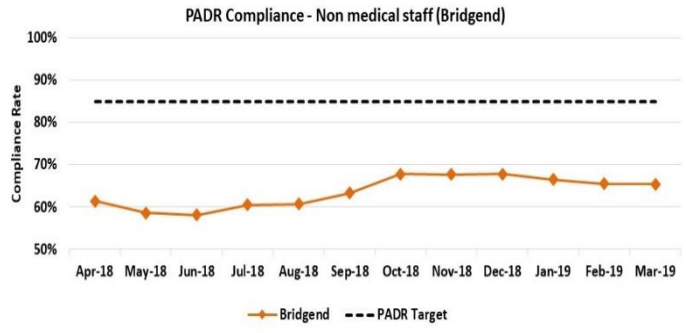
Cwm Taf Morgannwg *(No data available Apr 19)*



Cwm Taf - To 31st March 2019



Bridgend - To 31st March 2019



How are we doing, what actions are we taking?

As at 1st August 2019 PDR compliance is **58.04%**

Using ESR Business Intelligence to report PDR compliance:

- ESR Business Intelligence (BI) continues to be used to report PDR compliance to Directorate Managers & Director of Nursing.
- Managers are continually encouraged to access BI PDR Dashboards through their ESR Self-Serve Accounts allowing them to view a full set of compliance data for their area of responsibility, accessible at any time and always less than 24 hours old.
- Guides on "How to Access/Use BI Dashboards" are available via the ESR Self-Serve SharePoint site

The Learning & Development Department continue to support Directorates in the following ways to improve PDR compliance:-

- Providing a comprehensive suite of reports to DMs on a monthly basis providing the latest PDR compliance data, contextualising each Directorate's performance; what to do to improve compliance; where to seek further help and guidance
- Supporting the PDR agenda at the Clinical & Corporate Business Meetings through preparation of summary reports via the PMO Office.

Benchmarking: how do we compare?

% of headcount who have had a PADR/medical appraisal in the previous 12 months (target 95%)

Period	Cwm Taf	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Abertawe Bro Morgannwg
May-18	70.7%	75.6%	65.7%	61.1%	68.0%	78.7%	58.4%
Jun-18	71.7%	75.4%	65.1%	61.7%	70.2%	77.6%	58.1%
Jul-18	74.0%	73.8%	65.9%	61.5%	71.8%	78.7%	60.4%
Aug-18	74.4%	73.8%	64.5%	61.4%	71.8%	79.2%	60.4%
Sep-18	74.0%	Not available					
Oct-18	72.9%	73.6%	60.3%	60.6%	74.1%	79.2%	64.9%
Nov-18	75.7%	74.0%	61.5%	60.5%	74.3%	80.6%	66.3%
Dec-18	76.3%	Not available					
Jan-19	76.8%	73.4%	61.8%	58.9%	76.7%	80.8%	66.8%
Feb-19	76.0%	79.3%	67.5%	58.9%	78.4%	79.3%	66.7%
Mar-19	74.8%	78.2%	68.7%	58.8%	78.8%	77.6%	66.0%
	Cwm Taf Morgannwg	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Hywel Dda	Powys	Swansea Bay
Apr-19	74.6%	77.3%	70.9%	57.8%	79.6%	72.8%	63.9%

**Please be aware this compliance data now includes staff from the Bridgend area who have transferred across within ESR. Unfortunately the historical PDR data did not come across with the ESR record and has impacted on the overall compliance. L&D are in the process of manually uploading this data into ESR to reflect the actual PDR position. Directorates will be informed when this work is complete.*

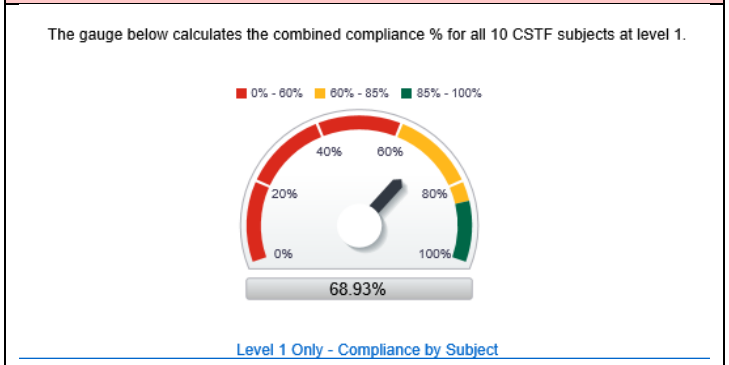
Source: ESR

Indicator 96: Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation

Outcome: Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	Executive Lead: Director of Workforce and Organisational Development
Period: as at 1st September 2019	Target: 85%

Current Performance:

Cwm Taf Morgannwg



Cwm Taf

Data not available

Bridgend

Data not available

Before a detailed training delivery plan can be developed, the new CTM UHB needs a clear picture of its current compliance with Core Mandatory Training requirements. To facilitate this, each individual's historical training record is compared against identified training requirements. The vehicle for managing and monitoring compliance with mandatory training is the ESR.

Training needs and training records exist within ESR for staff from the historical CTUHB but not for staff transferred from the Bridgend area into the new CTMUHB.

Training Completed: The transfer to CTMUHB's ESR of training records and in date ESR competencies for Bridgend staff, for training undertaken prior to 01 April 2019, has been completed.

Training Needs: The actual training requirements for each member of staff from the Bridgend area is currently being determined by the relevant SME and uploaded into ESR.

This work is being undertaken in two phases; the simple, low level training needs have been completed:

- Equality
- Violence Against Women
- Information Governance
- Environmental Waste
- Health, Safety and Welfare Level 1
- Moving and Handling Level 1
- Dementia
- IQT

The table below provides an update on Phase 2, the more complex subjects. The target date for completion of this work is currently November 2019:

Health, Safety and Welfare (Higher Levels)	Complete
Violence and Aggression	Complete
Resuscitation	Underway
Manual Handling (Higher levels)	Underway
Safeguarding Adults	Underway
Safeguarding Children	Underway
Infection, Prevention and Control	Not Started
Fire Training	Not Started

Once this work is complete, reports will provide a true reflection of the UHBs compliance and work can begin on the production of training delivery plans.

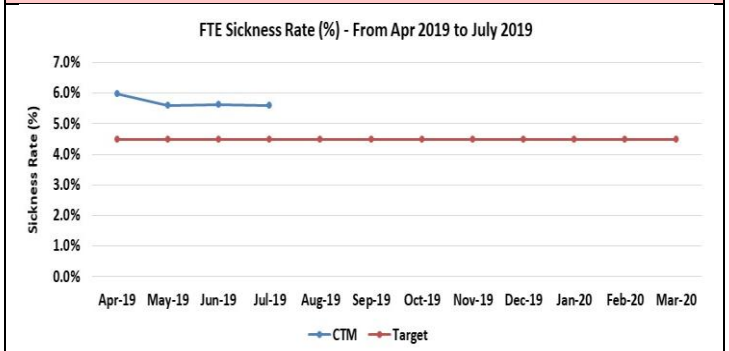
Source: ESR, L&D W&OD

Indicator 97: Percentage of sickness absence rate of staff

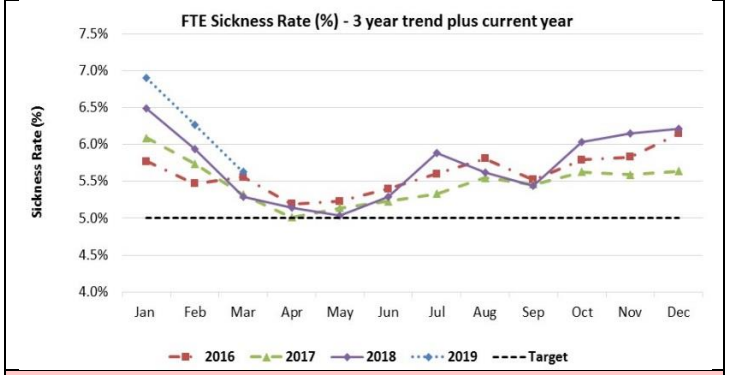
Outcome: Quality trained staff who are fully engaged in delivering excellent care and support to me and my family	Executive Lead: Director of Workforce and Organisational Development
Period: Jan 2016 to Jul 2019	Target: 12 Month Reduction Trend

Current Performance:

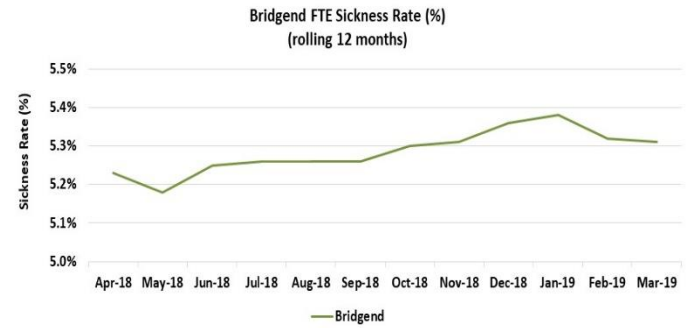
Cwm Taf Morgannwg



Cwm Taf



Bridgend: Rolling 12 months to 31st March 2019



How are we doing, what actions are we taking?

Sickness absence slightly increased to 5.59% in July (5.47% in June) which is above the Health Board's target of 5% (pay review is 4.2%). Short term occurrences have increased since June (789 occurrences in June 2019, compared with 931 occurrences Jul 2019). Anxiety, stress and depression still remains the highest category of sickness absence (around 30%). We continue to monitor hot spot areas are being targeted to attend courses such as mindfulness and managing stress in the workplace.

Attendance of the Managing Attendance at Work package continues to be promoted are we are running two courses per month. Employees from the Princess of Wales Hospital have been attending the courses running at RGH and PCH but from October we will be able to run courses at Princess of Wales Hospital which will increase the attendance. The percentage of all managers attending is now approximately 50%.

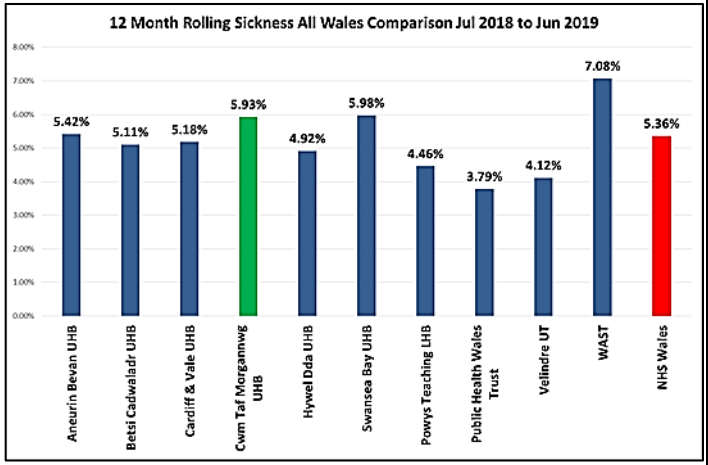
Information around supporting staff with the impact of the menopause is included within the attendance at work training package. The impact of the training will be further analysed by the sickness work stream by the end of the year.

Health and wellbeing initiatives introduced, with a monthly calendar of events. A Health & Wellbeing month with various events will be run on October 2019.

A group of Senior Managers will meet at the end of September to conduct a deep dive on current practices used in managing attendance at work and plan and implement new initiatives.

We are currently reviewing of the stress risk assessment and action plan.

Benchmarking: how do we compare?



For the 12 month period to Jun 2019 (All Wales Dashboard Statistics) we remain in the upper quartile of sickness absence across Wales. We have seen a slight increase in our sickness absence this month and we continue to try and achieve a significant improvement in our position going forward. The Deep Dive organised for the end of September scrutinising Cwm Taf Morgannwg practices when managing attendance at work will hopefully prove fruitful in our drive to improve. As update will be provided next month.

Source: ESR, W&OD/ Welsh Government for Benchmark

Commissioning: Cwm Taf Residents waiting at other health boards for treatment – Referral to Treatment (RTT)

Period: as at 31st July 2019 ***(Commissioning figures remain subject to boundary code changes post 1 April 2019)***

Aneurin Bevan UHB

Cwm Taf Residents at Aneurin Bevan University Local Health Board

Specialty	<=26 Weeks	>26 <=36 Weeks	>36 <=52 Weeks	Grand Total
Allied Health	7			7
Cardiology	5			5
Clinical Haematology	5			5
Dermatology	12			12
Diagnostic	4			4
Endocrinology	5			5
ENT	11			11
Gastroenterology	10	4		14
General Surgery	12	2		14
Geriatric Medicine	1			1
Gynaecology	8	1		9
Interventional Radiology	3			3
Nephrology	2			2
Neurology	3			3
Ophthalmology	18	2	1	21
Oral Surgery	23	3		26
Paediatrics	3			3
Pain Management	1			1
Respiratory Medicine	5			5
Trauma & Orthopaedics	42	6	1	49
Urology	37	7		44
Chemical Pathology	1	1		2
Infectious Diseases	1			1
Grand Total	**219**	**26**	**2**	**247**

There were no patients waiting over 52 weeks.

Betsi Cadwaladr

There were no Cwm Taf Residents waiting at Betsi Cadwaladr University Local Health Board

Cardiff and Vale UHB

Cwm Taf Residents at Cardiff and Vale University Local Health Board

Specialty	<=26 Weeks	>26 <=36 Weeks	>36 <=52 Weeks	>52 Weeks	Grand Total
Allied Health	16				16
Anaesthetics	3				3
Cardiology	141	20			161
Cardiothoracic Surgery	43	5	9		57
Clinical Haematology	36	3			39
Clinical Immunology And Allergy	112	24			136
Clinical Pharmacology	2				2
Dental Medicine Specialties	21	1			22
Dermatology	72	10	1		83
Diagnostic	4				4
ENT	88	10			98
Gastroenterology	20				20
General Medicine	71	4			75
General Surgery	105	13	1	1	120
Geriatric Medicine	2				2
Gynaecology	58	6			64
Nephrology	11				11
Neurology	805	77	1		883
Neurosurgery	142	4			146
Ophthalmology	218	53	6		277
Oral Surgery	60	2			62
Orthodontics	6				6
Paediatric Dentistry	55	5			60
Paediatric Neurology	18	1			19
Paediatric Surgery	106	18			124
Paediatrics	106	6			112
Pain Management	36	1			37
Rehabilitation Service	4				4
Respiratory Medicine	25	2			27
Restorative Dentistry	31				31
Rheumatology	7	1			8
Trauma & Orthopaedics	752	127	41	29	949
Urology	52	5	1		58
Clinical Oncology (previously Radiotherapy)	1				1
Respiratory Physiology	1				1
Grand Total	**3230**	**398**	**60**	**30**	**3718**

Of those waiting over 52 weeks:

Specialty	53 - 56	57 - 60	61 - 64	65 - 68	73 - 76	69 - 72	81 - 84	85 - 88	89 - 92	93 - 96	Grand Total
General Surgery									1		1
Trauma & Orthopaedics	5	4	5	6	2	1	1	4		1	29
Grand Total	**5**	**4**	**5**	**6**	**2**	**1**	**1**	**4**	**1**	**1**	**30**

Source: Information Team/ WG D&P

Commissioning continued: Cwm Taf Residents waiting at other health boards for treatment – Referral to Treatment (RTT)

Period: as at 31st July 2019

Hywel Dda

Cwm Taf Residents at Hywel Dda Local Health Board

Specialty	<=26 Weeks	Grand Total
Cardiology	1	1
Endocrinology	1	1
General Surgery	1	1
Ophthalmology	2	2
Urology	2	2
Breast Surgery	1	1
Grand Total	**8**	**8**

There were no patients waiting over 52 weeks at Hywel Dda Local Health Board

Powys THB

Cwm Taf Residents at Powys Teaching Local Health Board

Specialty	<=26 Weeks	Grand Total
General Surgery	2	2
Pain Management	1	1
Grand Total	**3**	**3**

There were no patients waiting over 52 weeks at Powys Teaching Local Health Board

Swansea Bay UHB

Cwm Taf Residents at Swansea Bay University Local Health Board

Specialty	<=26 Weeks	>26 <=36 Weeks	>36 <=52 Weeks	>52 Weeks	Grand Total
Allied Health	3				3
Cardiology	3	1			4
Cardiothoracic Surgery	5				5
Dermatology	3				3
Diagnostic	1				1
Endocrinology	1				1
ENT	9	2			11
Gastroenterology	1				1
General Medicine	1				1
General Surgery	24			1	25
Gynaecology	3				3
Nephrology	1				1
Neurology	13				13
Ophthalmology	9	1			10
Oral Surgery	15	4	4	5	28
Orthodontics	6				6
Plastic Surgery	170	23	9	6	208
Rheumatology	3				3
Trauma & Orthopaedics	16	4	1	1	22
Urology	8				8
Grand Total	**295**	**35**	**14**	**13**	**357**

Of those waiting over 52 weeks:-

Specialty	53 - 56	57 - 60	61 - 64	105	69 - 72	81 - 84	77 - 80	Grand Total
General Surgery			1					1
Oral Surgery	1		1	3				5
Plastic Surgery	1	2			1	1	1	6
Trauma & Orthopaedics	1							1
Grand Total	**3**	**2**	**2**	**3**	**1**	**1**	**1**	**13**

Source: Information Team/ WG D&P

Acronym	Detail	Explanation
AvLos	Average Length of Stay	A mean calculated by dividing the sum of inpatient days by the number of patients admissions
CALL	Community Advice & Listening Line	Offers emotional support and information/literature on Mental Health and related matters to the people of Wales
C.difficle	Clostridium difficile	A bacterium that can infect the bowel and cause diarrhoea.
CHKS	Part of Capita PLC	Leading provider of healthcare intelligence
CTP	Care and Treatment Planning	New measure within Mental Health Services
DAN 24/7	Wales Drug and Alcohol Helpline	A free and bilingual helpline providing a single point of contact for anyone in Wales wanting further information or help relating to drugs or alcohol.
DNA	Did not attend outpatient clinic	A count of patients that failed to attend an outpatient appointment and did not notify the hospital in advance.
DSU	Delivery and Support Unit	The Welsh Government established the Delivery and Support Unit (DSU) to assist National Health Service (NHS) Wales in delivering the key targets and levels of service expected by both the Welsh Government and the public of Wales.
DTOC	Delayed transfers of care	A patient who continues to occupy a hospital bed after his/her ready-for transfer of care date during the same inpatient episode.
E.Coli	Escherichia coli	A bacteria found in the environment, foods and intestines of people and animals.
EDDS	Emergency Department Data Set	A data set which is made up of both injury data and illness data received from each of the Major Emergency Departments across Wales.
FCE	Finished Consultant Episode	A period of care under one consultant within one hospital
FTE	Full Time Equivalent	Number of employed persons as a whole unit
GP Cluster	GP Practice Cluster	Grouping of GP's & Practices locally determined by individual Local Health Boards
HAI	Hospital Acquired Infection	Any infection that occurs during a patient's stay in hospital
HPV	Human Papilloma Virus vaccination	A vaccination to reduce the incidence of communicable diseases
HONS	Heads of Nursing	
KSF	Knowledge & Skills Framework	KSF defines & describes the knowledge & skills NHS staff need to apply in their work to deliver quality services
LPMHSS	Local Primary Mental Health Support Services	Under provisions of section 2 of the Mental Health (Wales) Measure 2010, all local mental health partners must work jointly to agree a scheme for the provision of mental health services within the area.
MAMSS	Models for Access to Maternal Smoking Cessation Support	Supporting pregnant women to stop smoking
MMR	Mumps, Measles, Rubella vaccination	A vaccination to reduce the incidence of communicable diseases
MRSA	Methicillin Resistant *Staphylococcus aureus*	A type of bacteria resistant to several widely used antibiotics.
MSSA	Methicillin Sensitive *Staphylococcus aureus*	A type of bacteria not resistant to certain antibiotics.
Mortality	Measured as Crude Death Rate	The simplest death rate is the crude death rate & is usually calculated for periods of one year

Acronym	Detail	Explanation
NEWS	National Early Warning Score	Wales became the first country to adopt NEWS, with the life-saving intervention now an integral part of ward care in hospitals across the nation. It is providing frontline clinical teams with a standardised approach to deteriorating patients, meaning life-threatening conditions like sepsis are spotted earlier and stopped more quickly
NIHSS	National Institute of Health Stroke Scale	The NIH Stroke Scale/Score (NIHSS) quantifies stroke severity based on weighted evaluation findings.
NISCHR	National Institute for Social Care & Health Research	Welsh Government body that develops, in consultation with partners, strategy and policy for research in the NHS and social care in Wales.
NUSC	Non Urgent Suspected Cancer	Patients referred as non-urgent patients but subsequently diagnosed with cancer should start definitive treatment within 31 days of diagnosis, regardless of the referral route
NWIS	NHS Wales Informatics Service	Have a national role to support NHS Wales to make better use of IT skills & resources
PDR	Personal Development Review	Process whereby an employee meets at least annually with their manager or nominated deputy to discuss their performance for the last year, appraise objectives set for the previous year and agree a Personal Development Plan (PDP) for the coming year
QOF	Quality Outcomes Framework	The Quality and Outcomes Framework (QOF) is a voluntary system of financial incentives. It is about rewarding GP's for good practice through participation in an annual quality improvement cycle.
RRAILS	Rapid Response to Acute Illness	Patients who become acutely ill whilst on wards benefit from early recognition and intervention with rapid treatment and escalation if needed. The aim is to avoid further deterioration and possibly death.
RTT	Referral to treatment	95% of patients referred to Secondary Care planned care services to receive their treatment within 26 weeks. All patients referred to RTT included services are to receive treatment within 36 weeks of referral.
TOMS	Theatre Operating Management System	Cwm Taf's local electronic system for managing theatre activity
UMR	Universal Mortality Review	Process of reviewing In-Hospital Deaths
USC	Urgent Suspected Cancer	Patients referred as urgent suspected cancer and subsequently diagnosed with malignant cancer to start definitive treatment within 62 days of receipt of referral
WISDM	Welsh Information Solution for Diabetes Management	ICT solution for the management of diabetes patients across Wales. This will provide a clinical, multidisciplinary record, outpatient workflow and it will share and integrate information across primary, secondary and community healthcare settings
YTD	Year to Date	Period commencing 1st April

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.5** **26 September 2019**

University Health Board Report
WORKFORCE & ORGANISATIONAL DEVELOPMENT METRICS

Executive Lead: Anne Phillimore, Interim Executive Director of Workforce & Organisational Development
Author: Hywel Daniel, Deputy Director of Workforce & OD / Donna Hill, Interim Assistant Director of Workforce & Organisational Development
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Purpose of the Health Board Report
To update the Board on the key workforce metrics for July/August, with historic trends shown as appropriate.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined in the 3 Year Integrated Medium Term Plan 2019-2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aim' are being progressed, these in summary are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report aims to support improving quality, safety and patient experience and reducing the per capita cost of care in line with the resources made available to the Health Board.
Supporting evidence	The Workforce and Organisational Development (W&OD) team have supplied the suite of graphs; NHS Shared Services Partnership (NWSSP) provide recruitment data, finance provides the finance data.
Engagement – Who has been involved in this work?	
Director of W&OD, Deputy Director of Finance	

Health Board Resolution To:							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **DISCUSS** the report and associated metrics and report and **NOTE** the detail.						
Summarise the impact of the Health Board Report							
Equality and diversity	There are no equality and diversity implications of the report.						
Legal implications	There are no legal implications of this report.						
Population Health	There are no population health implications of this report.						
Quality, Safety & Patient Experience	The quality, safety, patient experience implications result from the availability of the right staff being available with the right skills, at the right place and time to deliver effective safe patient care.						
Resources	Whilst the efficiency of workforce management and deployment systems directly impacts upon the costs of service delivery, there are no direct resource implications arising from this report.						
Risks and Assurance	The purpose of this report is to ensure that adequate workforce metrics are in place to ensure that workforce risks are minimised and significant trends are identified and understood.						
Health and Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy Safe Care Effective Care Dignified Care Timely Care Individual Care Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this takes into account many of the related quality themes but especially staff and resources.						
Workforce	The report provides an overview of the workforce						
Freedom of Information Status	Open						

WORKFORCE AND ORGANISATIONAL DEVELOPMENT METRICS

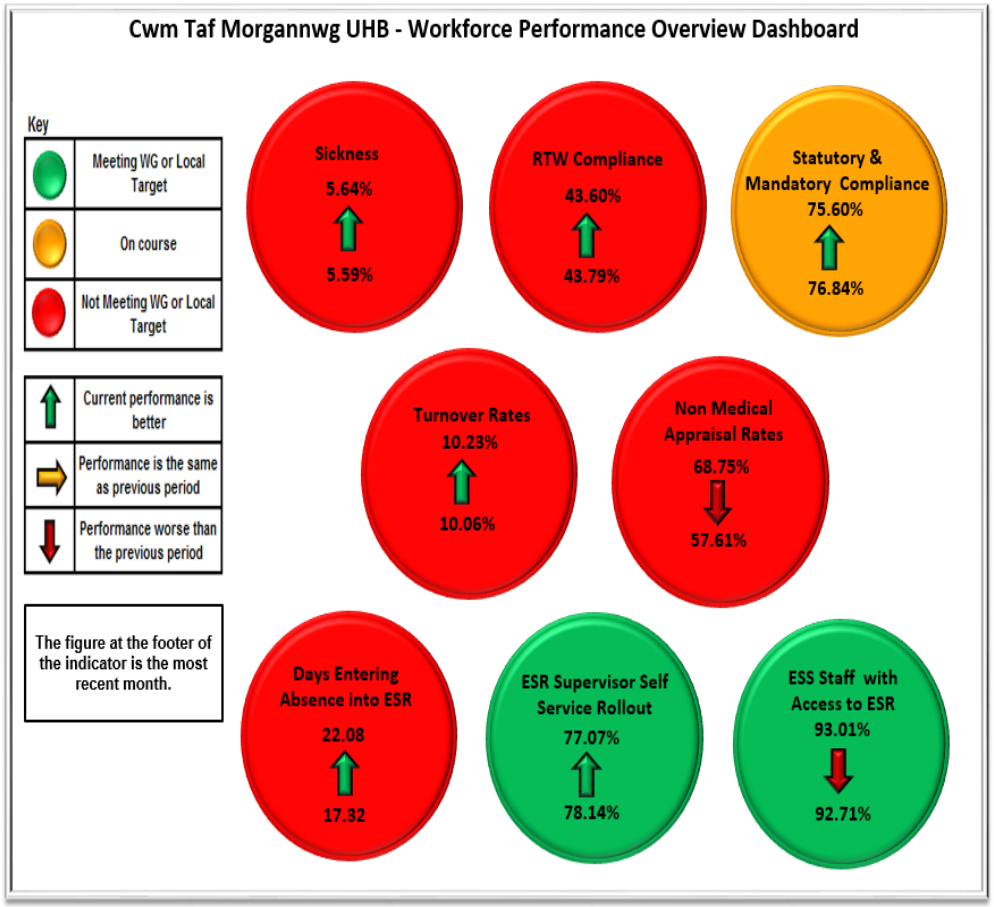
1. SITUATION / PURPOSE OF REPORT

The report provides details on the key workforce metrics contained within the dashboard, and provides a narrative update on any key issues or trends. Where appropriate, benchmarking data comparing Cwm Taf Morgannwg to other Health Boards has been included.

Summary of Key Messages

Key Points	The report details the key workforce-related metrics, including narrative and actions underway as appropriate. Where Bridgend services data impacts on the performance reported below, this is noted in the relevant section accordingly.
Highlights	***Sickness levels*** – Sickness in-month has decreased from 5.64% to 5.59%, and the July sickness rate is slightly lower than 2018/19. The continued roll-out of the new Managing Attendance Policy and associated training is being positively received, and a refreshed Attendance Management Plan is in the process of being produced, including further analysis of our trends, and drivers. ***International recruitment (India)*** – recruitment acitivty is underway, first 7 due to arrive in late September ***Time to Hire*** – the time to hire for non Medical/Dental staff in 2019/20 is currently averaging 70.7 days against a target of 71 days. ***Job Planning*** – the number of signed off job plans has risen to just over 50%, and the number of expired job plans has reduced to 30% (was 36% at the time of the previous report).
Lowlights	***Retention*** – turnover for the year-to-date is relatively static at 10.06%. The staff groups continuing to report the highest turnover are Nursing and Midwifery, and Additional Professional Scientific and Technical, Allied Health Professionals, and Medical and Dental. ***DBS records in ESR*** – number of ESR records with the DBS clearance not recorded is currently higher than would be preferred, an action plan is in place to reduce this and limit the changes of recurrence. ***Nursing Vacancy Levels*** – nursing vacancies on our acute and community adult wards and A&E units remain a concern, with an increase in the deficit on acute wards. ***Temporary Staffing Utilisation*** – demand for and use of temporary nursing resource remains high (trends are available in section 3.5), linked to the vacancy position, with an additional increase from April as a result of the inclusion of the Bridgend area services.
To note	Some figures below, namely regarding statutory training, ESR self service, and Personal Development Reviews (PDRs), are still affected by the transfer of data in to ESR from the boundary change or differences in working practices – work is underway to resolve this.

2. BACKGROUND / INTRODUCTION



Key Points:

- The chart to the left provides a snapshot of performance against the 8 core metrics measured over a one month period - August 2019 (with sickness figures as at July 2019)
- The arrows signify improvement or deterioration since the last report and the colours represent whether we have met the Cwm Taf Morgannwg or Welsh Government targets
- You can see that of the 8 areas of activity:
  - 6 have improved – Time to enter sickness into ESR, Sickness rates, Statutory and mandatory, ESR supervisor self-service rollout, Turnover, Return to work compliance
  - 2 have deteriorated – Non-medical appraisal rates and staff with access to ESR.

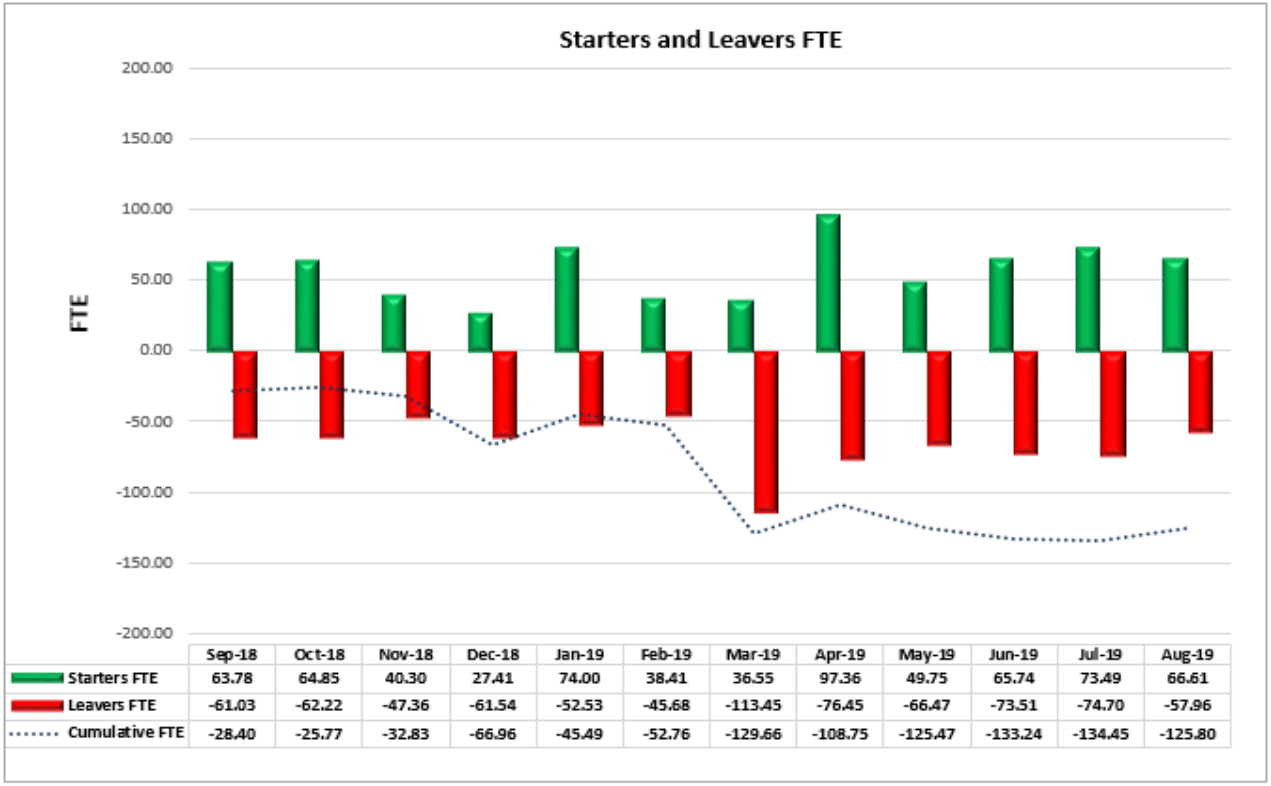
Please note, we are currently exploring alternative means to reflect some of our data beyond in-month changes, as this does not always reflect the position meaningfully (e.g. sickness in-month changes are only partly relevant).

3 ASSESSMENT / GOVERNANCE AND RISK ISSUES

The report provides an update against 6 core activity areas with addition metrics in the appendices.

3.1 Resourcing and recruitment activity
3.2 Sickness absence
3.3 Workforce systems
3.4 Personal Development Review (PDR) and core mandatory training compliance
3.5 Workforce utilisation
3.6 Occupational Health and Wellbeing

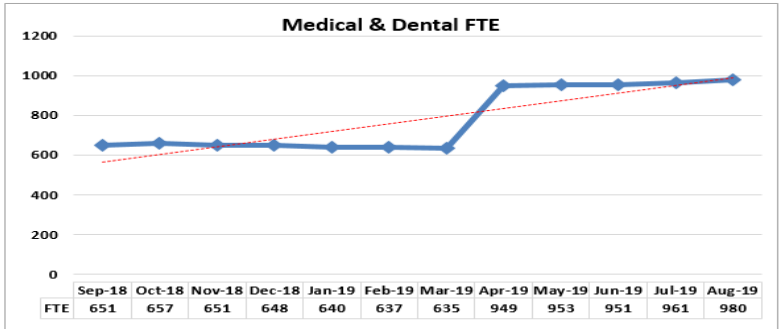
3.1 Resourcing and Recruitment Activity

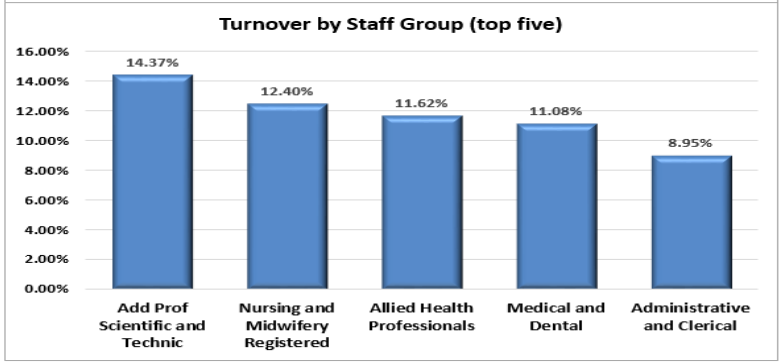


	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Starters FTE	63.78	64.85	40.30	27.41	74.00	38.41	36.55	97.36	49.75	65.74	73.49	66.61
Leavers FTE	-61.03	-62.22	-47.36	-61.54	-52.53	-45.68	-113.45	-76.45	-66.47	-73.51	-74.70	-57.96
Cumulative FTE	-28.40	-25.77	-32.83	-66.96	-45.49	-52.76	-129.66	-108.75	-125.47	-133.24	-134.45	-125.80

Key Points:

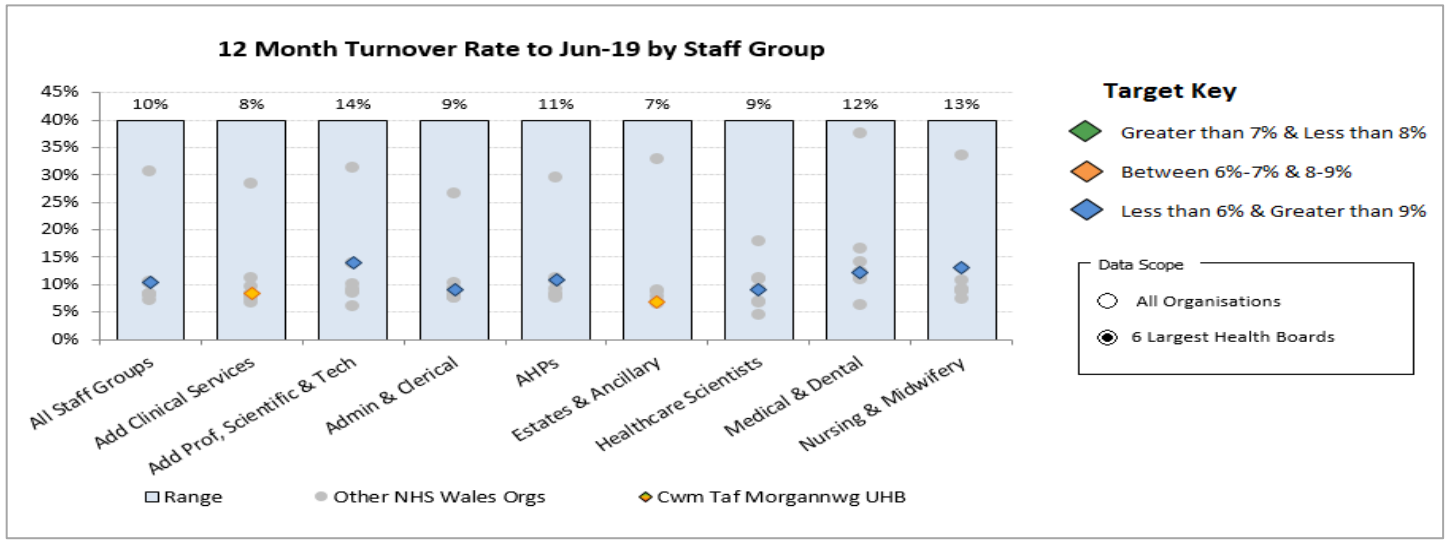
- Headcount at the end of June was 11,809 (10,324.64 WTE) – this reflects the boundary change
- Cumulative change in Whole Time Equivalent (WTE) was -125.80
- Rolling turnover decreased slightly from 10.23% in June to 10.06% in August - Additional Professional Scientific and Technical is our highest group at 14.37%.
- See Appendix 1 for headcount by Directorate



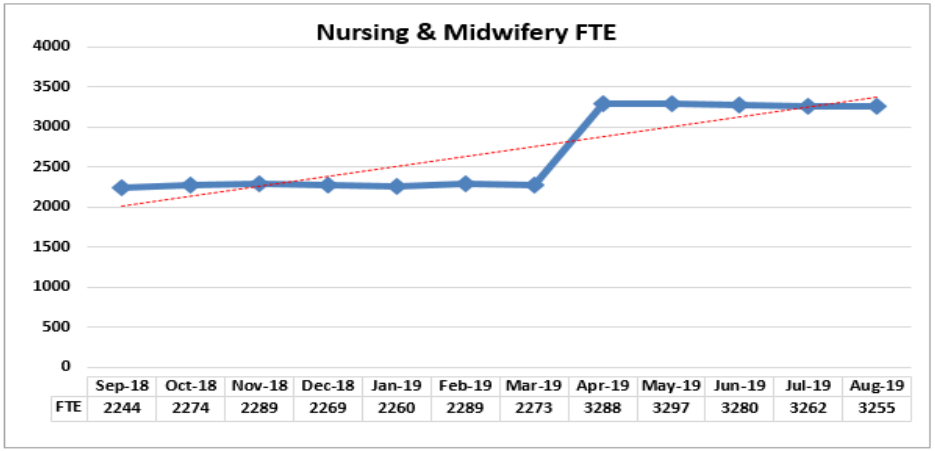


Key Points:

- See Appendix 1 for reasons for leaving for groups over 10%
- Nursing and midwifery remains significant with over 35% of our nurse leavers leaving due to retirement
- Additional Professional/Scientific/Technical, Nursing and Midwifery, and Allied Health Professionals turnover has increased – retirement, promotion, and worklife balance factor highly in the recorded reasons for leaving
- Medical and Dental
  - Turnover does not include trainee rotations
  - Slight increase in Full Time Equivalents (FTE) staffing levels over the last month



Nursing and Midwifery



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
FTE	2244	2274	2289	2269	2260	2289	2273	3288	3297	3280	3262	3255

Key Points:

- International recruitment (currently solely India) has started:
  - Interviews via Skype started in July, more planned through the rest of 2019
  - 7 individuals due to arrive in late September
  - 25 in the pipeline currently onboarding
  - Key challenges are:
    - Suitable accommodation – the on site residences at Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH) are fully occupied
    - Capacity within clinincal education to deliver the training programme to a larger number of students

Key Points:

- Nursing and Midwifery Registered staff vacancies:
  - 245 WTE in acute and community areas, including:
    - 62 WTE at Princess of Wales (PoW)
    - 72 WTE at PCH
    - 93 WTE at RGH
    - 7 WTE at Ysbyty Cwm Cynon (YCC)
    - 11 WTE at Ysbyty Cwm Rhondda (YCR)
- Healthcare Support Worker (HCSW) recruitment continues to fill all current vacancies
- Adverts are running which cover the main acute areas, plus we have specialty-specific adverts running
- YCR is holding an open day/recruitment day in September
- Engaging with January/March 2020 gradute nurses
- Details about maternity vacancies and recruitment are included in the Maternity update.
- Adaptation programme (for nurses trained overseas but resident in the UK)
  - 18 recruited
    - 4 obtained their NMC registration
    - 11 working in RGH – all supported by the Practice Development Nurses and peer group
    - 3 onboarding for PCH

Efficiency of Recruitment Process

Cwm Taf Morgannwg is constantly monitoring its general recruitment performance, with key performance indicators (KPIs) produced on an all Wales basis every month. There are some key stages that can be readily controlled by the appointing managers, namely authorisation, shortlisting and notifying the outcomes of interviews.

Recruitment Volumes	2016-17 totals	2017-18 totals	2018-19 totals	Jul-19	2019-20 YTD
Number of Vacancies Raised	678	1311	1713	265	905
Number of FTE Raised	1064.78	2041.12	2479.97	426.8	1282.9
Number of Conditional Offers Sent	629	1213	1346	244	782
Number of ID Checks Completed	649	1163	1364	232	758
Number of Occupational Health Clearances I	526	1043	1254	156	601
Number of Sponsorships Requested	0	0	0	0	0
Number of References Received	627	1179	1278	204	662
Number of DBS Checks	0	0	812	125	371
Number of Start Dates Requested	605	1118	1222	175	618
Number of Contracts Issued	727	1169	1140	112	431
Number of Ad Hoc DBS Checks	50	67	35	6	10

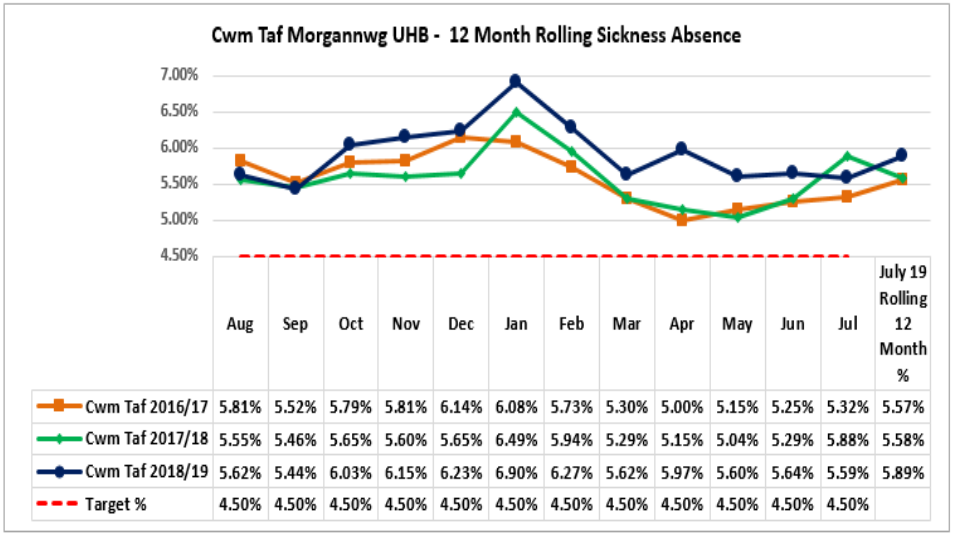
Key Points:

- See Appendix 1 for time to hire comparisons across Wales
- Trajectory is generally improving, and performance has improved through this year compared to last
- Vacancy authorisation and time to shortlist are key areas for improvement

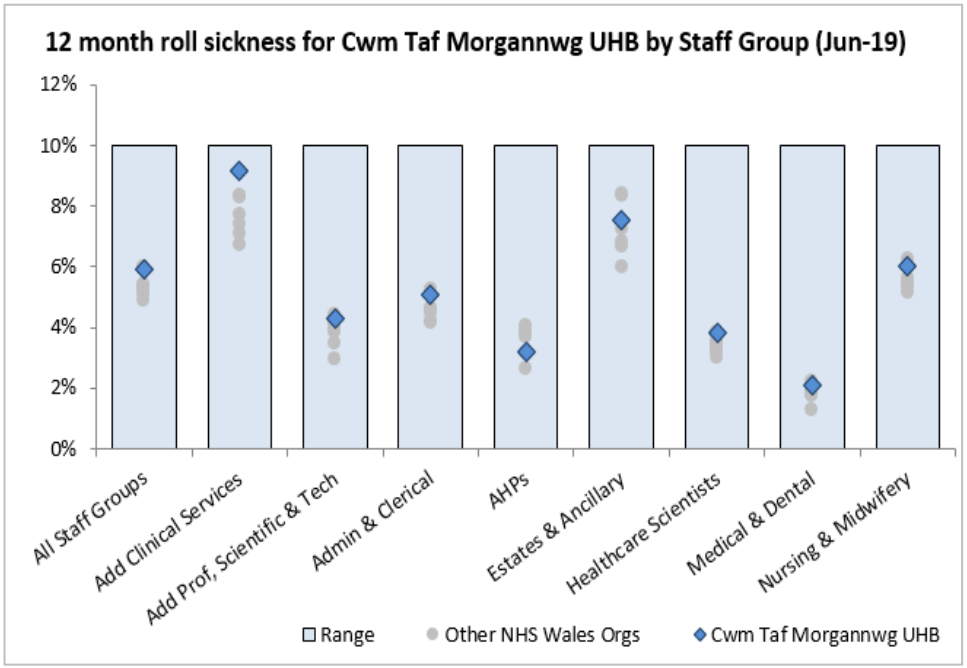
Trac Report Code	Target Times	Responsiblity	Trac Recruitment Health Check Average Times in Working Days	Average 16/17	Average 17/18	Average 18/19	Jul-19	Average YTD
T0a	5	Manager	Notice Date to authorisation start date		36.6	41.0	32.2	49.7
T1a	10	Org	Time to approve vacancy request	14.2	12.9	10.6	12.0	13.5
T1b	2	NWSSP	Time to advertise	2.0	1.7	1.6	1.5	1.7
T3	Variable but target 10	Manager	Duration of advertising	9.2	8.8	8.3	8.4	8.1
T3a	2	NWSSP	Time to move to shortlisting	1.7	1.0	1.0	1.0	1.0
T4	3	Manager	Time to Shortlist (original)	10.1	8.8	6.8	8.3	7.9
T4	3	Manager	Time to Shortlist (cleansed)	-	-	4.7	5.7	5.3
T5	2	NWSSP	Time to send interview invites	1.0	1.3	1.0	0.8	1.0
T5a	Variable between 5 and 10 days	Minimum Requirement	Notification given to applicants for interview	8.9	9.5	8.9	8.7	8.9
T5b	3	Manager	Time to update interview outcomes	4.8	4.7	2.5	2.1	3.7
T6	5 4 from Jan 2018	NWSSP	Time to send conditional offer	3.3	3.6	3.8	3.4	3.5
T7	3	Candidate	Conditonal Offer to ID appointment booked	4.1	6.3	5.9	2.8	4.0
T7a	10	Candidate	Conditional Offer to ID appointment attended	8.1	10.1	8.6	8.2	8.2
T7b	7	Candidate	ID appointment booked to ID appointment attended	5.7	5.8	5.1	6.8	6.0
T7c	1	Candidate	ID appointment attended to DBS form submitted	5.6	3.2	3.7	2.3	2.7
T7d	Variable	DBS Agency	DBS Form sent to DBS to DBS result received			4.7	5.0	4.7
T11a	Variable	All	Checks ok to start date	17.2	14.4	18.9	18.4	17.7
T11b	2	NWSSP	Checks ok to unconditional offer	3.3	1.7	1.6	1.7	1.7
T12	44	All	Vacancy Creation to conditional offer	51.6	51.1	40.8	44.9	43.2
T13	71	All	Vacancy Creation to unconditional offer	88.7	92.3	74.7	75.5	70.7
T15	27	All	From conditional offer to unconditional offer **without outliers**	25.0	27.3	21.6	23.1	22.3
T15	27	All	From conditional offer to unconditional offer **with outliers**	40.8	41.0	32.7	32.3	29.7
T16	Variable	Manager & Candidate	Unconditional Offer to start date	15.7	18.3	19.1	17.2	16.4

* 2016/17 figures only cover October 2016 to March 2017

3.2 Sickness Absence

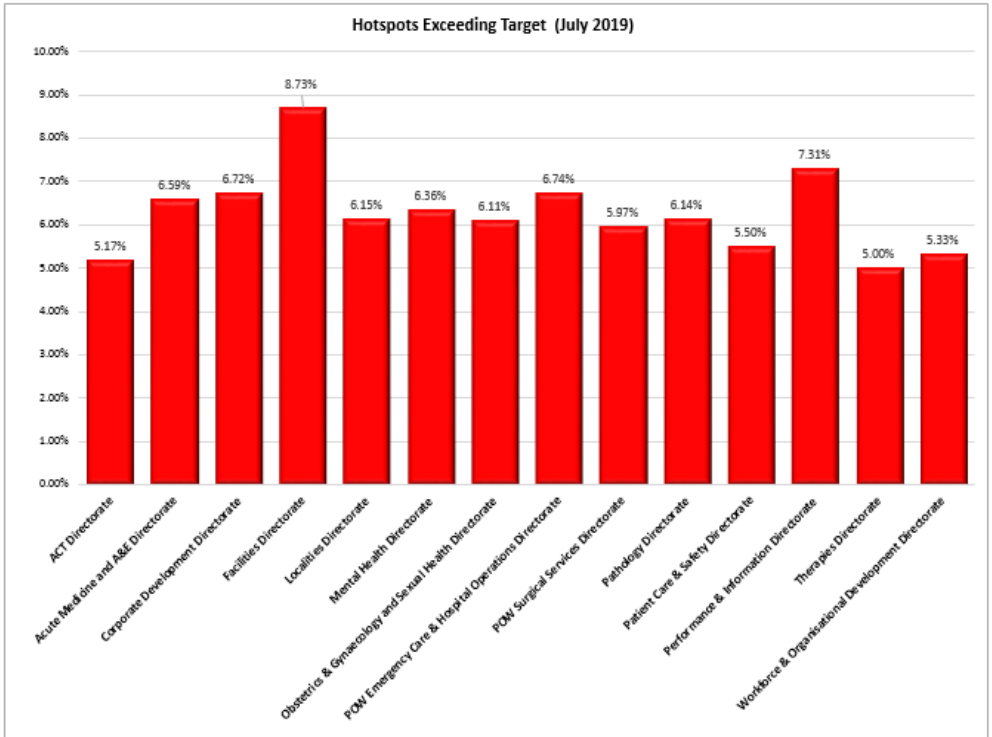


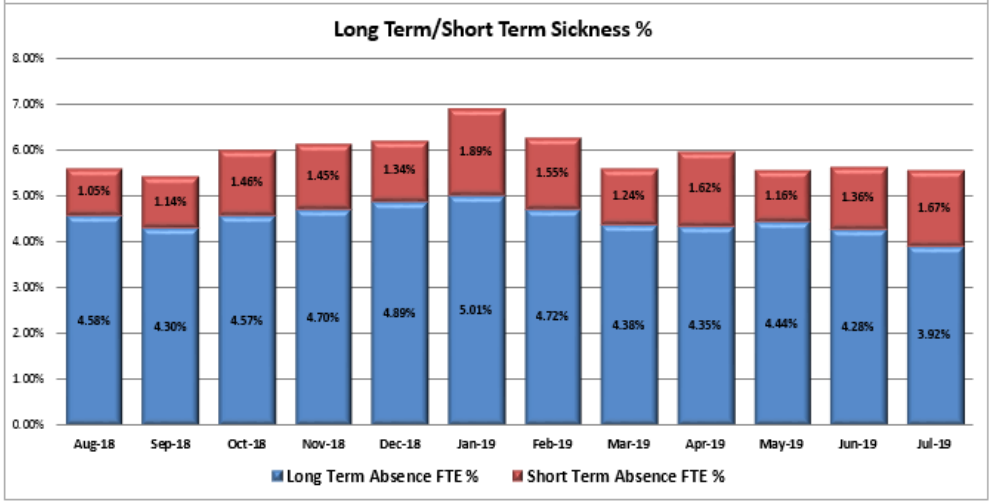
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	July 19 Rolling 12 Month %
Cwm Taf 2016/17	5.81%	5.52%	5.79%	5.81%	6.14%	6.08%	5.73%	5.30%	5.00%	5.15%	5.25%	5.32%	5.57%
Cwm Taf 2017/18	5.55%	5.46%	5.65%	5.60%	5.65%	6.49%	5.94%	5.29%	5.15%	5.04%	5.29%	5.88%	5.58%
Cwm Taf 2018/19	5.62%	5.44%	6.03%	6.15%	6.23%	6.90%	6.27%	5.62%	5.97%	5.60%	5.64%	5.59%	5.89%
Target %	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	



Key Points:

- Sickness has decreased to 5.59% in-month, however the rolling 12 month average remains above the previous two years. This July's sickness is lower than the previous July, hopefully this will continue but this will be monitored.
- Deep dive exercise on 20 September, with HR, staff side and occupational health representatives.
- Anxiety, stress and depression remains the highest category of sickness absence (see the staff survey action plan)
- Training for the new Attendance Management Policy commenced in November, is being delivered in partnership, and is ongoing. Feedback on the training to date is positive, and Cwm Taf Morgannwg are leading the way with training in this area
- Actions being taken to roll out the new policy:
  - Toolkit to support managers when managing attendance has been published
  - Health and wellbeing initiatives introduced, with a monthly calendar of events
  - Sickness workstream meets monthly, including staff side and Occupational Health
  - Currently reviewing the organisation's support process around dealing with stress and anxiety, including a review of the stress risk assessment and action plan
  - Training attendance is highlighted at CBMs with a reminder for all managers to attend, at local establishment meetings for ward areas in RGH and PCH, and within Princess of Wales hospital there are monthly meetings with unit managers



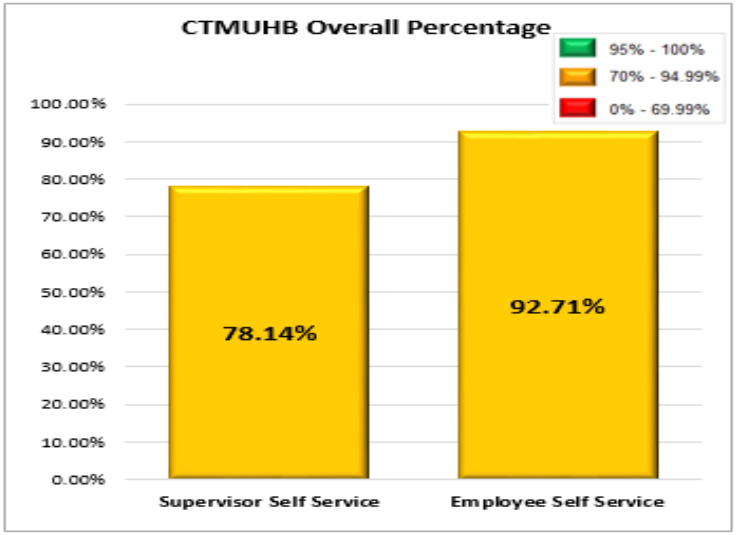


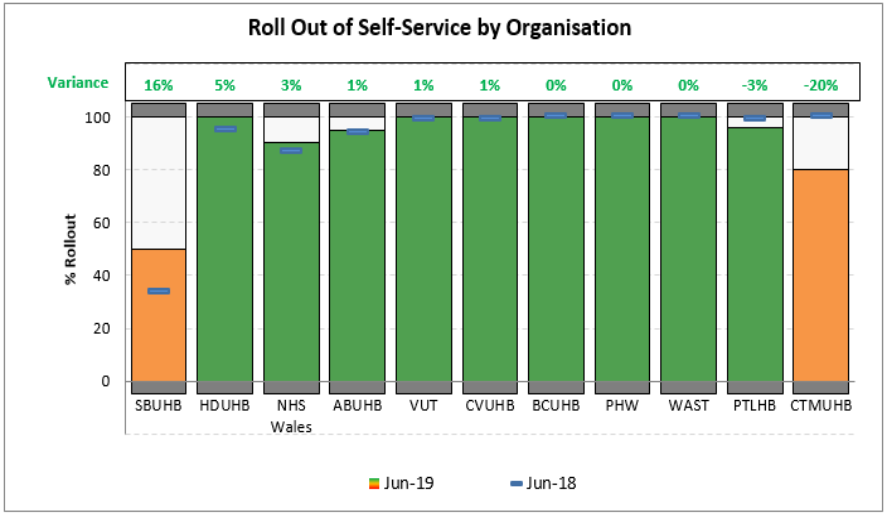
Key Points:

- 14 Directorates are above the 4.5% Cwm Taf Morgannwg target in July (at the last report date (May) there were 11).
- 25 Directorates are below target
- Frequency of short term occurrences has reduced since April 2019 from 1008 (however it has increased slightly from June 2019 from 911 compared to 931 in July 2019)
- Trend on long term occurrences has increased since the start of the 12 month window (565 in July 2019 compared to 485 in Aug 2018)
- For additional details, please see Appendix 2
- Facilities – a deep dive has been carried out, additional managers have been identified for training which is in progress. It also identified that sickness absence had been used when other policies i.e. carers policy or special leave should have been applied – further analysis of this is currently underway before recommendations are made
- Patient Care and Safety – this is a small department so sickness levels have a disproportionate impact on this comparison. Staff have been subject to increased levels of stress as a result of the release of the maternity report.
- Scheduled care wards – piloted the 8 week mindfulness course which saw all the attendees on long term sickness return to work sooner than anticipated

3.3 Workforce systems

ESR rollout and self service





Key Points:

- Self-service access levels have dipped following the boundary change
- Rollout plan underway to improve the position, with robust staff training
- Good progress is being made to increase self-service use with a projection of 95% self service by December
- In the meantime, those without self-service access will be receiving paper payslips via Payroll

Disclosure and Barring Service (DBS) checks

The Workforce Compliance Team have recently re-audited the DBS position of all staff, along with undertaking an assessment of all routes to a role within the organisation. The figures below are the position in ESR in August 2019:

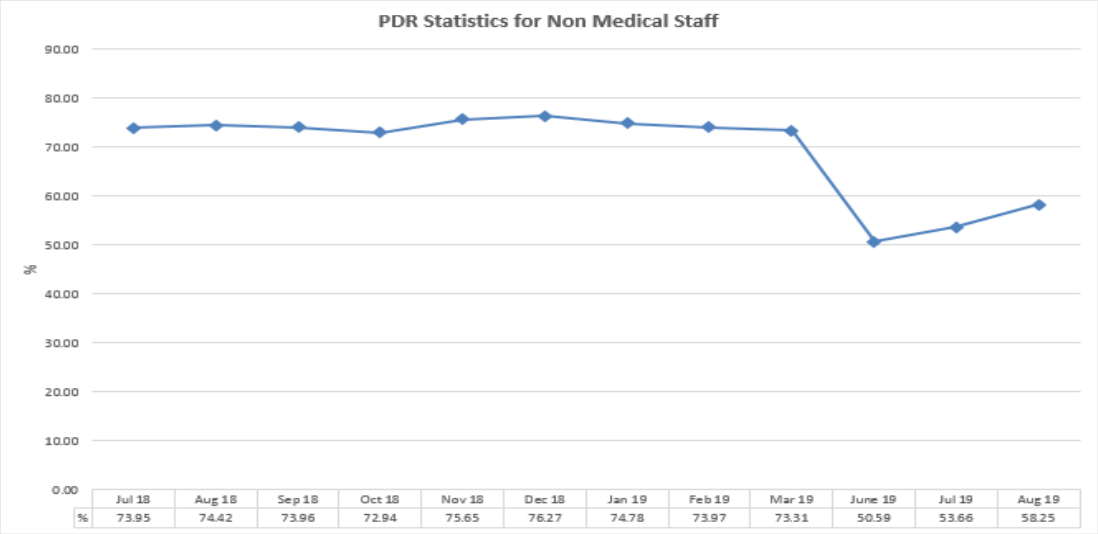
	Match (DBS present)		Mismatch Post v's Employee (DBS level high)		Missing from ESR record		None Required		Pre-DBS required	Retire & Return
	CT	POW	CT	POW	CT	POW	CT	POW	CT	CT
Bank only assignments	695	19	-	-	488	283	135	6	1	-
Medical and dental	466	129	-	-	177	206	-	-	38	6
General	3677	1014	**119**	**25**	**839**	**1559**	2942	489	254	-
Total	**4,838**	**1,162**	**119**	**25**	**1,504**	**2,048**	**3,077**	**495**	**293**	**6**

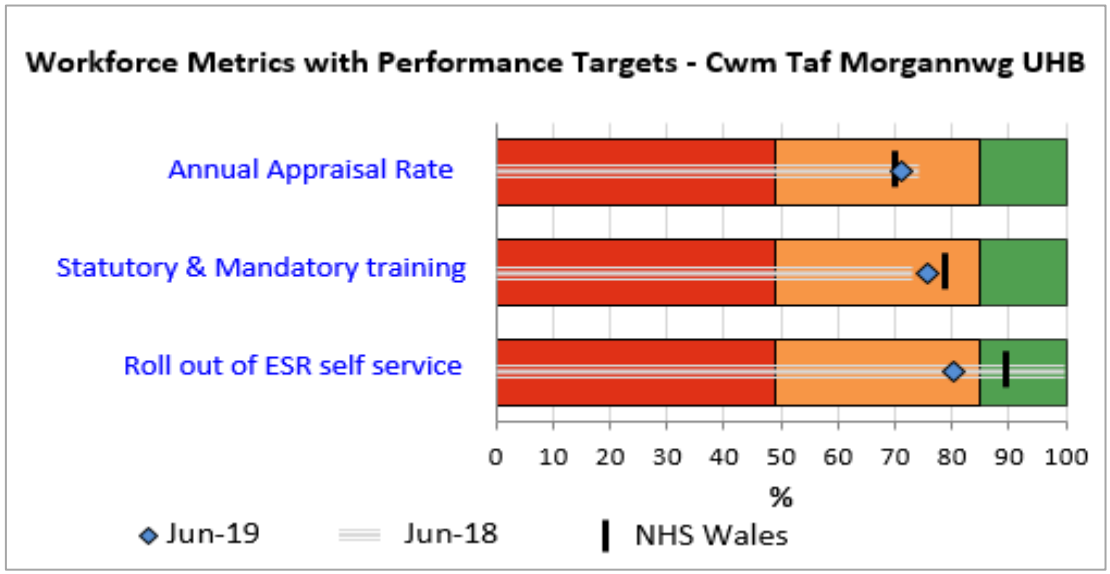
Where evidence is not present, this does not mean that a satisfactory check is not in place; rather that we are unable to evidence it via ESR, it may be recorded on a personal file elsewhere.

Next steps:

- A full action plan has been developed and is being managed by the Compliance team
- Where the DBS is missing from ESR, Workforce will manually interrogate non-ESR records to confirm the position
- Where no DBS can be located, new checks will be carried out
- Work is being undertaken with the Head of Safeguarding to identify and prioritise areas where it is felt there is higher risk
- Review of all routes to a position to identify and mitigate areas of non-compliance, including reviews of any guidance as identified
- A new report will be run quarterly from ESR to monitor and review compliance

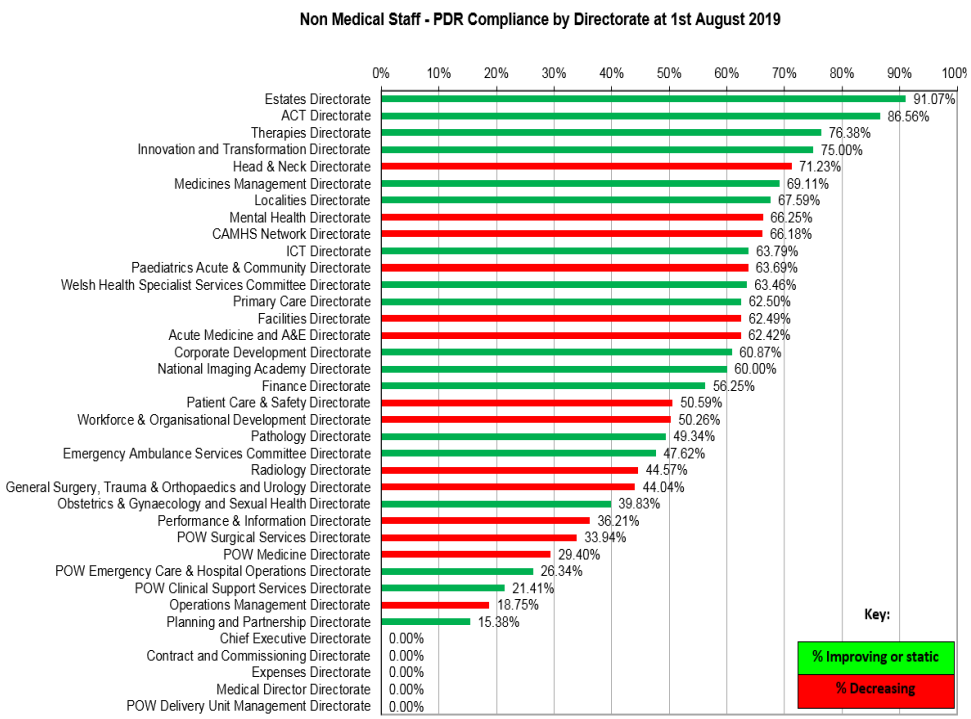
3.4 PDR Compliance





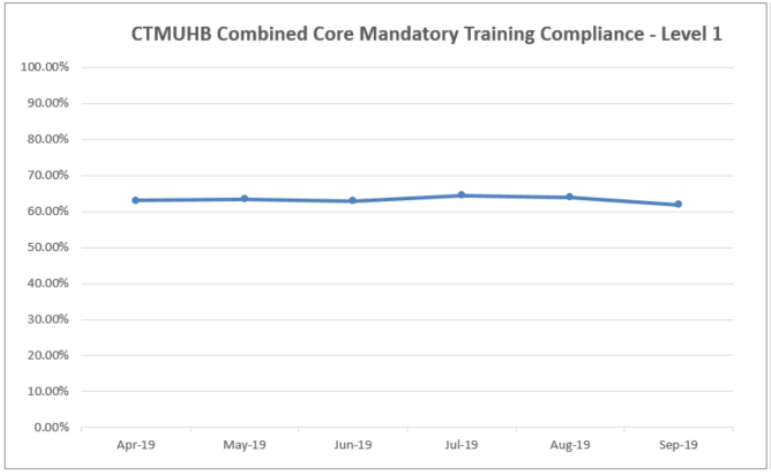
Key Points:

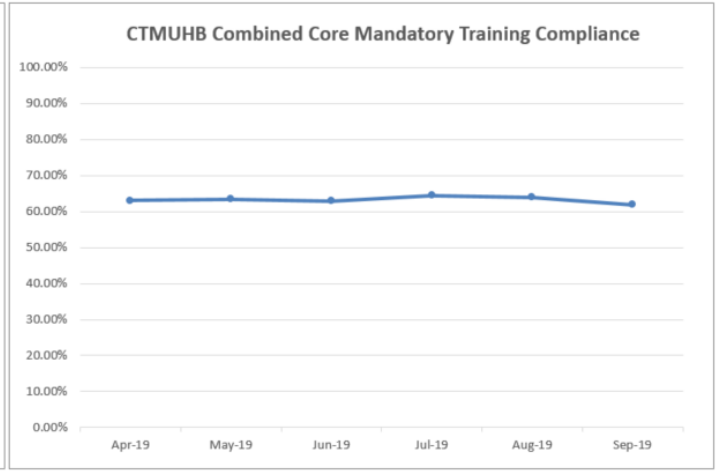
- As at 1 August 2019 compliance is 58.25%, an increase from the July figure of 53.66%.
- This is not necessarily a true representation of the position because the Learning and Development team are manually transferring the records for staff affected by the boundary change. The Personal Development Review (PDR) data did not transfer as part of the Mass Organisational Change Process when the employee records were moved.
- Monthly reports are sent to CBMs and Directors on highlighting the outstanding PDRs. This is being supported by a continued focus from the Directors to ensure the improvement continues.
- The Health Board may wish to consider a targeted campaign around PDR compliance.



Key Points:

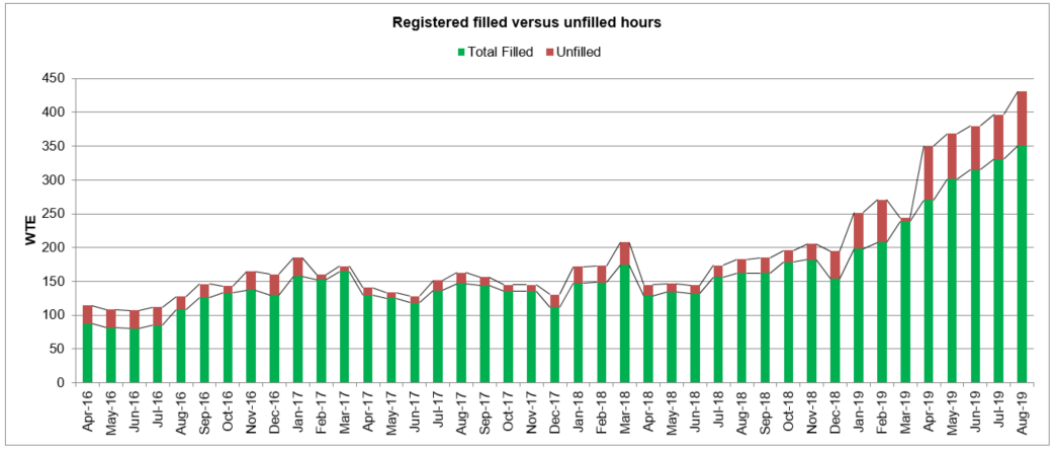
- Managers are continually encouraged to access Business Intelligence (BI) PDR Dashboards through their ESR Self Serve accounts allowing them to view a full set of up to data compliance for their areas
- Appraisal rates by staff group are in Appendix 3
- Learning and Development (L&D) provide a comprehensive suite of reports monthly to Directorate Managers providing the latest PDR compliance data, contextualising performance; what to do to improve compliance; and where to seek further help and guidance
- A shortened, non-accredited PDR Awareness training course for Managers is available.

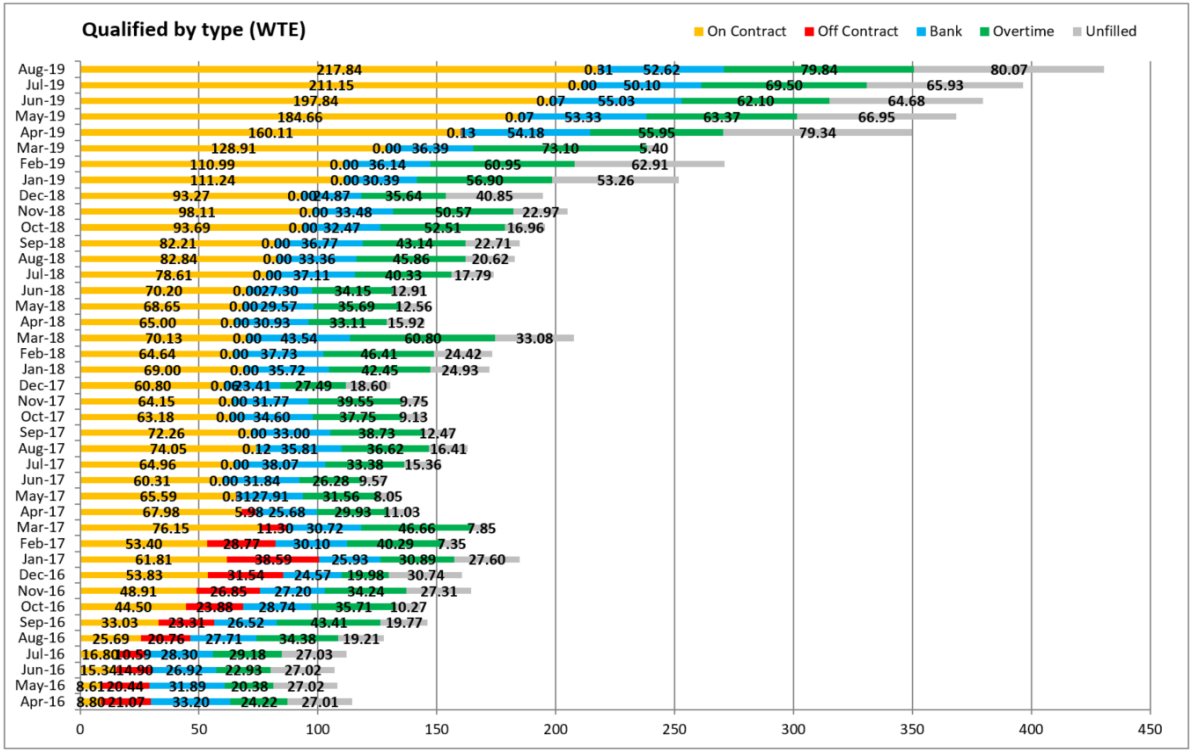




3.5 Workforce Utilisation

Registered Nurse Temporary Staffing Demand and Supply

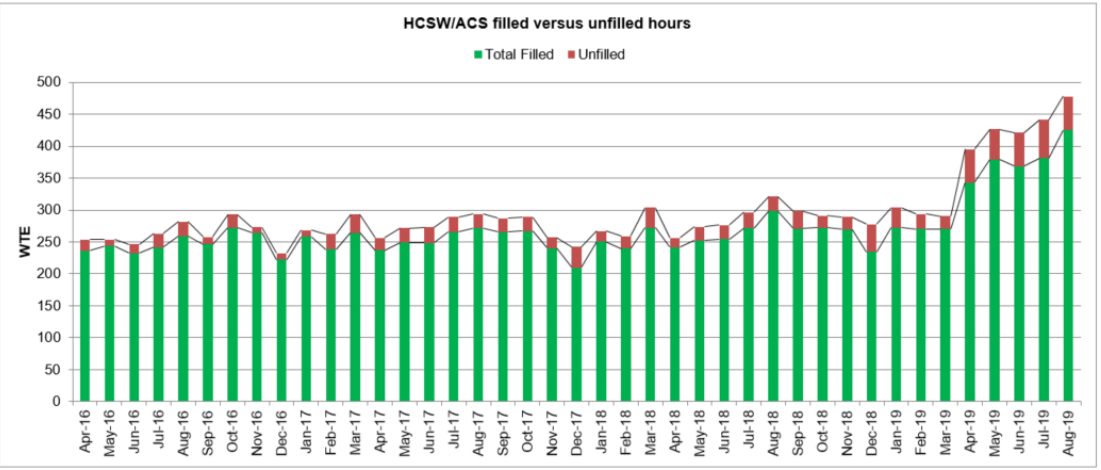


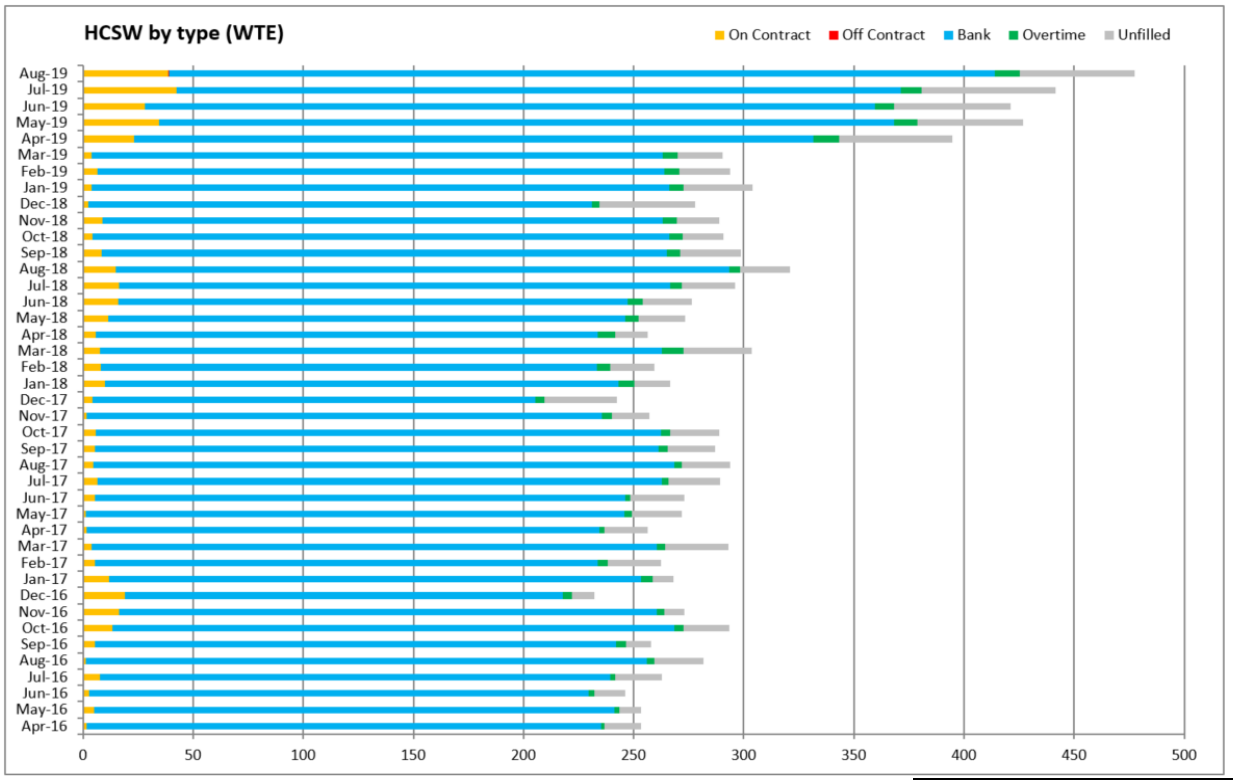


Key Points:

- External (agency) supply continues to exceed internal (bank and overtime) supply
- Data includes the Bridgend County Borough Council (CBC) area services from April 2019 which explains the jump in demand
- March had the lowest unfilled rate to date – this was largely due to rosters being open and released earlier due to the transition down time
- Top 3 areas for demand:
  - RGH A&E (14.97 WTE)
  - RGH AMU (14.67 WTE)
  - PCH A&E (14.46 WTE)
- Primary reasons for demand are: Vacancies, sickness, capacity, and acuity
- Information about the reasons for these 3 areas is in Appendix 4
- In addition to ongoing recruitment activity, work will be undertaken to review rostering arrangements to ensure roster patterns are optimum

Healthcare Support Worker (HCSW) Temporary Staffing Demand and Supply

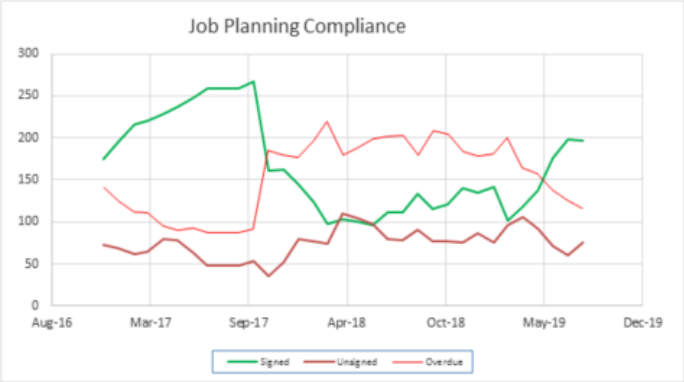




Key Points:

- Demand remains high, trend of use is consistent with previous years
- Top 3 areas for demand:
  - RGH Older Persons Assessment Unit (16.26 WTE)
  - POW Ward 18 (14.42 WTE)
  - POW Ward 20 (13.73 WTE)
- Primary reasons for demand are: Vacancies, 1 to 1s, sickness, and acuity.
- Information about the reasons for these 3 areas is in Appendix 4

Job Planning



Directorate	Head Count	Signed		% Signed	a/w Sign Off	In discussion	Expired	% Expired	Not undertaken	% Not undertaken
110 ACT Directorate	67	61	↔	91%	3		3	4%		0%
110 Acute Medicine and A&E Directorate	88	30	↑	34%	2	2	47	53%	7	8%
110 CAMHS Network Directorate	18	10	↔	56%	2	3	2	11%	1	6%
110 Head & Neck Directorate	36	15	↔	42%	5		14	39%	2	6%
110 General Surgery, Trauma & Orthopaedics and Urology	53	11	↑	21%	1	2	27	51%	12	23%
110 Localities Directorate	17	15	↓	88%	1			0%	1	6%
110 Mental Health Directorate	20	14	↔	70%	1	3	1	5%	1	5%
110 Obstetrics & Gynaecology and Sexual Health	23	7	↓	30%	2	1	10	43%	3	13%
110 Paediatrics Acute & Community Directorate	27	3	↑	11%		16	6	22%	2	7%
110 Pathology Directorate	15	10	↔	67%	1		4	27%		0%
110 Radiology Directorate	24	20	↓	83%	2		2	8%		0%
Total	388	196		51%	20	27	116	30%	29	7%

Key Points:

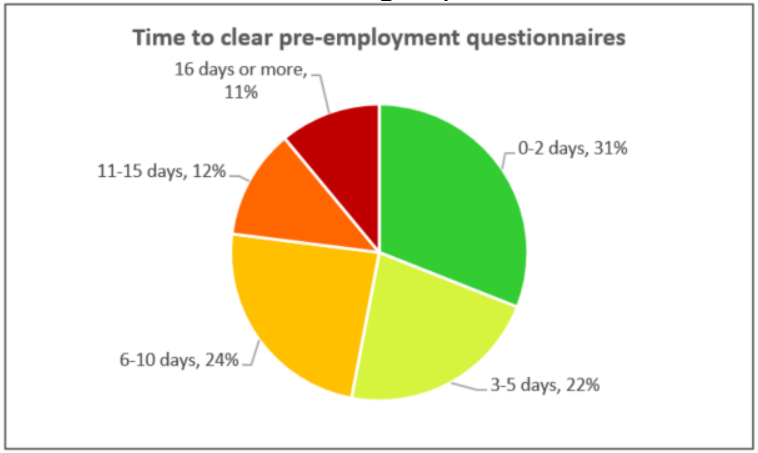
- Job Planning administration continues to work closely with the Directorate Managers (DMs) with regards to tracking their progress. August has been a quiet month due to staff taking annual leave and this is reflected in this month's figures. The overall percentage of signed off Job Plans has dropped by 1%. This is due to several new starters being added to the system, which in turn as increased the percentage of Job plans not yet undertaken to 7%. Expired Job Plans continue to fall and now stands at 30%. An internal audit of Job Planning was undertaken by NHS Wales Shared Services Partnership (NWSSP) in July and we still await the results of this.
- 3 Directorates have shown an increase in their percentage of signed off Job Plans, whilst 5 Directorates have stayed the same and 3 Directorates have shown a slight decrease in their signed off Job Plans showing that the DMs and Job Planning administration continue to work closely together.
- Acute Medicine and A&E –The Directorate has seen a slight increase of 1% of signed off Job Plans. However they still have 47 expired Job Plans and 2 in discussion.

Key Points:

- Localities-The Directorate has seen their Percentage drop from 100% to 88%. This is due to a new Doctor joining the team and another Job plan awaiting sign off.
- Obstetrics and Gynaecology and Sexual Health - The Directorate has seen a decrease from 41% to 30%. A meeting has been arranged with the DM to discuss this and provide any assistance if required.
- Paediatrics - Ongoing issues with rotas have halted the Directorate working on most of their Job Plans. Despite this they have seen a slight increase to 13%.

3.6 Occupational Health and Wellbeing

To increase visibility of the activity levels and performance of the Occupational Health and Wellbeing function, key performance indicators are now being reported – below is the July/August activity for pre-employment clearances:



Key Points:

- July/August is a peak time for pre-employment clearances because of the trainee doctor rotation and student nurse graduations
- July saw the team undertake system testing for the latest version of the Cohort software – this went live at the beginning of August
- Of 687 pre-employment questionnaires received in July/August, 485 have been cleared and around 100 are waiting for individuals to contact the department

4. RECOMMENDATION

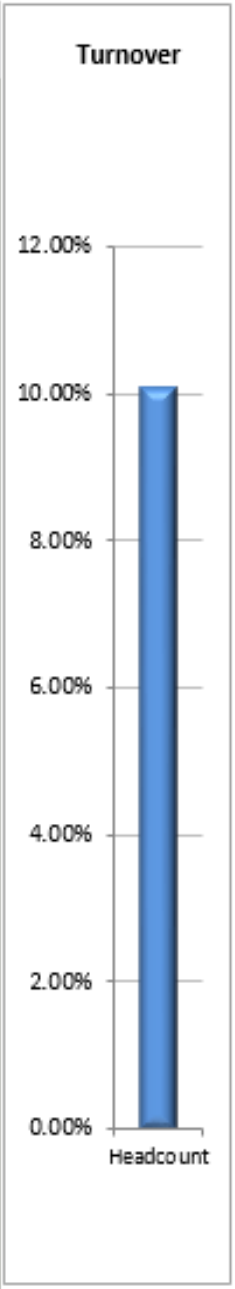
The Health Board is asked to:

- **DISCUSS** the report and associated metrics and report and **NOTE** the detail.

Freedom of Information Status	Open

Appendix 1 – Resourcing and Recruitment

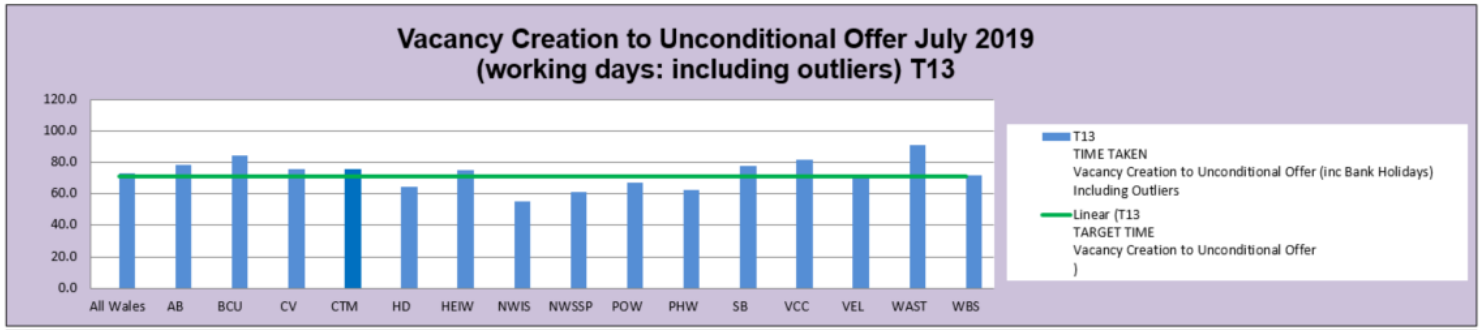
Cwm Taf Head Count and WTE @ 31st Aug 2019		
Directorate	**Headcount**	**FTE**
ACT Directorate	480	451.04
Acute Medicine and A&E Directorate	1,519	1,354.67
CAMHS Network Directorate	231	199.45
Chief Executive Directorate	28	25.63
Contract and Commissioning Directorate	3	3.00
Corporate Development Directorate	47	45.71
Emergency Ambulance Services Committee Directorate	21	20.80
Estates Directorate	169	167.60
Facilities Directorate	1,305	972.30
Finance Directorate	66	63.78
General Surgery, Trauma & Orthopaedics and Urology Directorate	588	541.25
Head & Neck Directorate	206	183.75
ICT Directorate	57	56.60
Innovation and Transformation Directorate	7	7.50
Localities Directorate	923	803.91
Medical Director Directorate	3	2.20
Medicines Management Directorate	322	284.85
Mental Health Directorate	1,034	939.08
National Imaging Academy Directorate	6	5.10
Obstetrics & Gynaecology and Sexual Health Directorate	390	322.90
Operations Management Directorate	47	43.74
POW Clinical Support Services Directorate	395	357.33
POW Delivery Unit Management Directorate	15	13.91
POW Emergency Care & Hospital Operations Directorate	264	240.88
POW Medicine Directorate	485	435.17
POW Surgical Services Directorate	594	516.97
Paediatrics Acute & Community Directorate	720	620.45
Pathology Directorate	248	226.31
Patient Care & Safety Directorate	85	74.50
Performance & Information Directorate	58	52.30
Planning and Partnership Directorate	18	17.81
Primary Care Directorate	383	287.78
Radiology Directorate	217	203.77
Therapies Directorate	603	539.54
Welsh Health Specialist Services Committee Directorate	60	52.77
Workforce & Organisational Development Directorate	209	190.31
Total	**11,809**	**10,324.64**

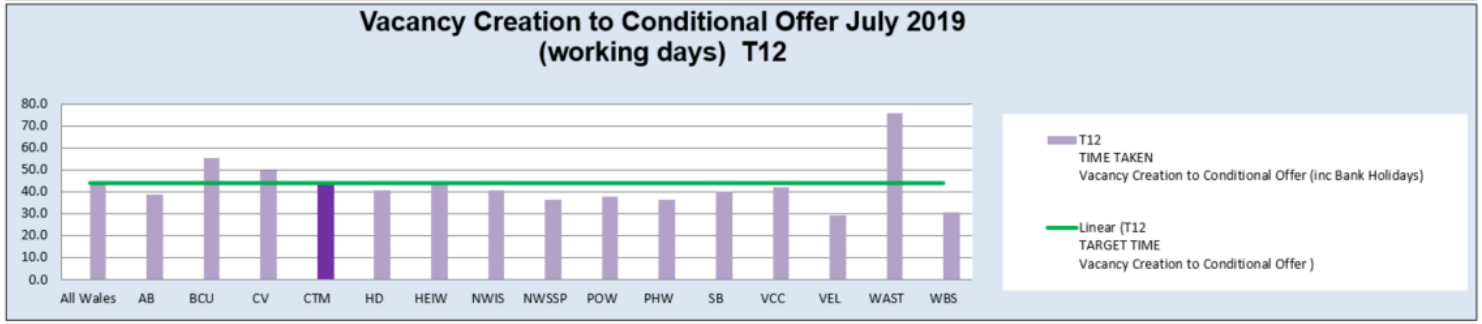


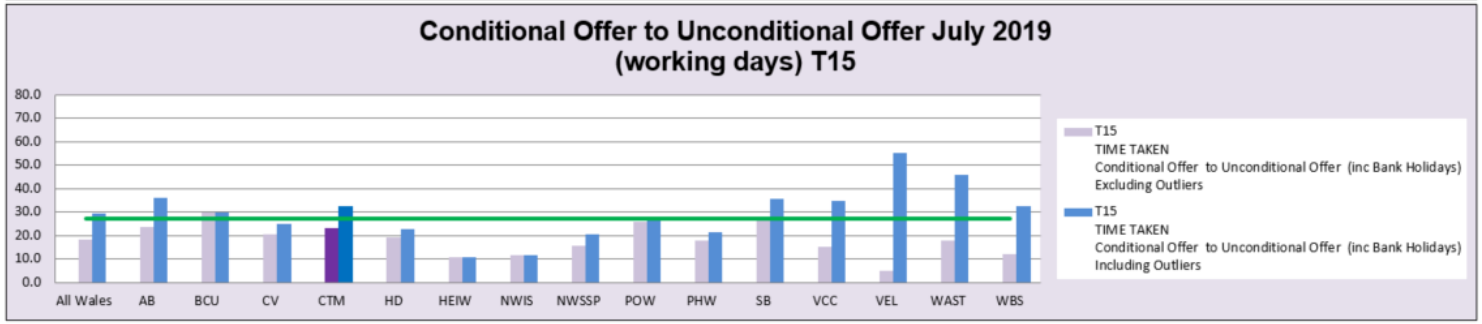
Turnover and Reasons for Leaving (Leaving date between Sept-18 and Aug-19)

	Sum of FTE
Add Prof Scientific and Technic	**35.43**
Voluntary Resignation - Promotion	15.95
Retirement Age	6.00
Employee Transfer	4.90
Voluntary Resignation - Work Life Balance	4.59
Voluntary Resignation - Relocation	4.00
Additional Clinical Services	**77.71**
Retirement Age	37.96
Voluntary Resignation - Work Life Balance	14.10
Voluntary Resignation - Other/Not Known	9.76
Voluntary Resignation - To undertake further education or training	9.55
Voluntary Resignation - Health	6.34
Administrative and Clerical	**94.69**
Retirement Age	31.60
Voluntary Resignation - Promotion	19.55
Voluntary Resignation - Other/Not Known	15.42
Voluntary Resignation - Work Life Balance	14.10
Employee Transfer	14.01
Allied Health Professionals	**45.15**
Voluntary Resignation - Work Life Balance	14.51
Voluntary Resignation - Promotion	12.96
Voluntary Resignation - Relocation	10.68
Voluntary Resignation - Better Reward Package	4.00
Retirement Age	3.01
Estates and Ancillary	**39.96**
Retirement Age	13.55
Retirement - Ill Health	9.09
Voluntary Resignation - Work Life Balance	7.50
Voluntary Resignation - Health	5.43
Voluntary Resignation - Other/Not Known	4.39
Healthcare Scientists	**9.33**
Voluntary Resignation - Work Life Balance	3.00
End of Fixed Term Contract	2.00
Voluntary Resignation - Promotion	2.00
Retirement Age	1.33
Voluntary Resignation - Other/Not Known	1.00
Medical and Dental	**37.90**
Retirement Age	15.90
Voluntary Resignation - Relocation	6.40
Employee Transfer	6.40
Voluntary Resignation - Promotion	5.00
Voluntary Resignation - Other/Not Known	4.20
Nursing and Midwifery Registered	**248.41**
Retirement Age	96.47
Voluntary Resignation - Work Life Balance	52.52
Voluntary Resignation - Relocation	43.61
Voluntary Resignation - Promotion	35.27
Employee Transfer	20.55
Grand Total	**588.59**

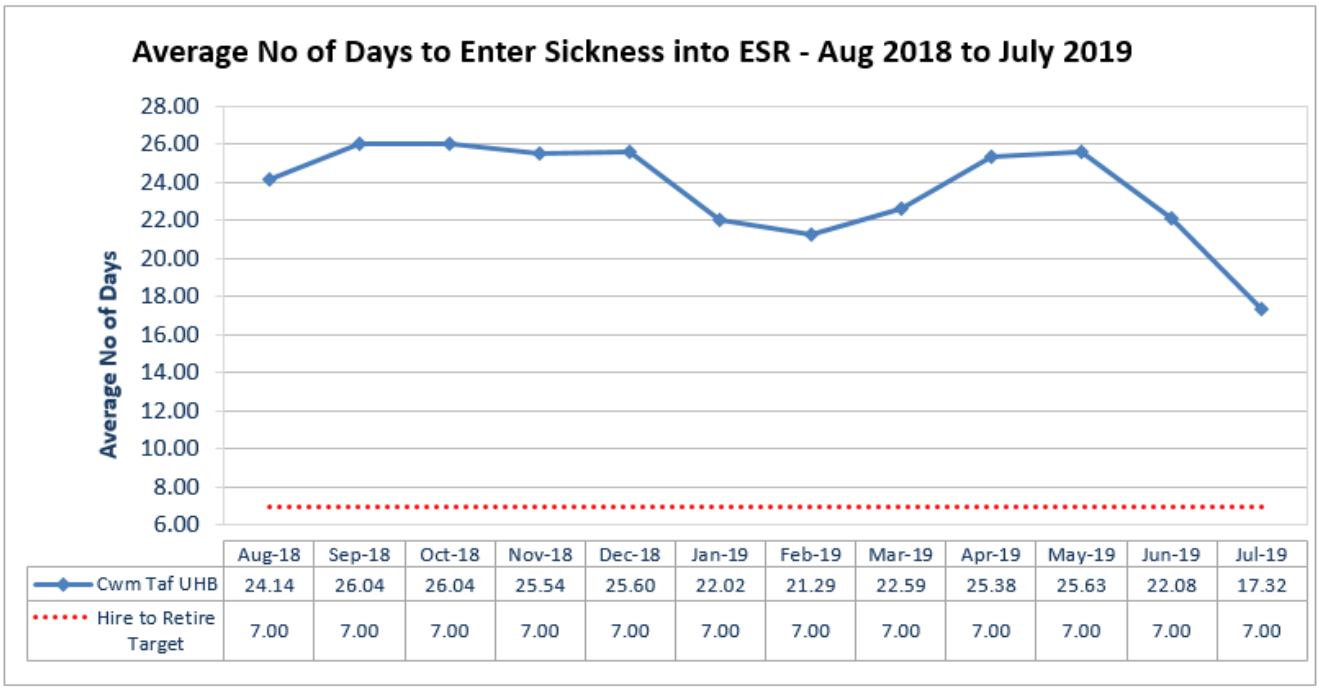
Efficiency of the Recruitment Process – General Recruitment Comparison across Wales



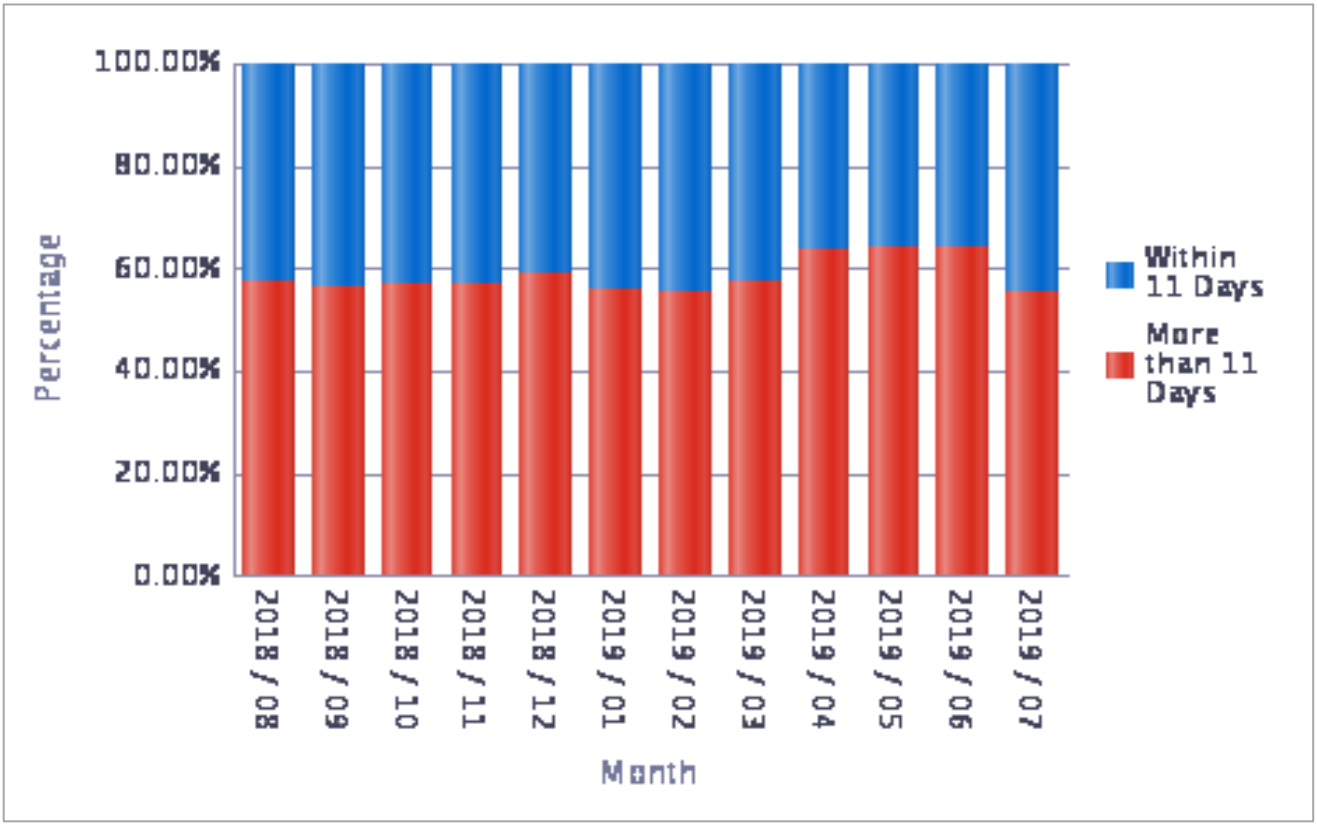


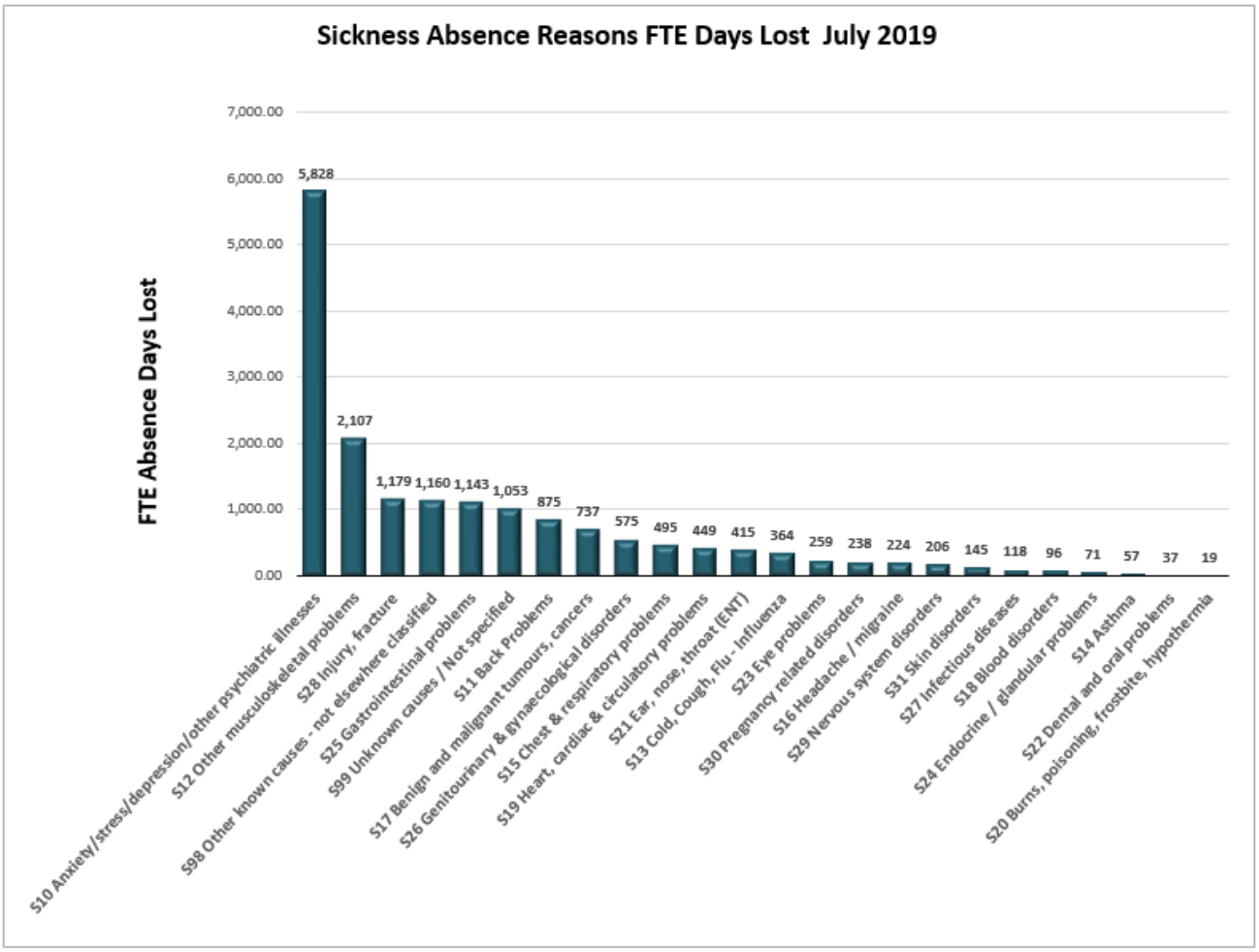


Appendix 2 – Sickness Absence

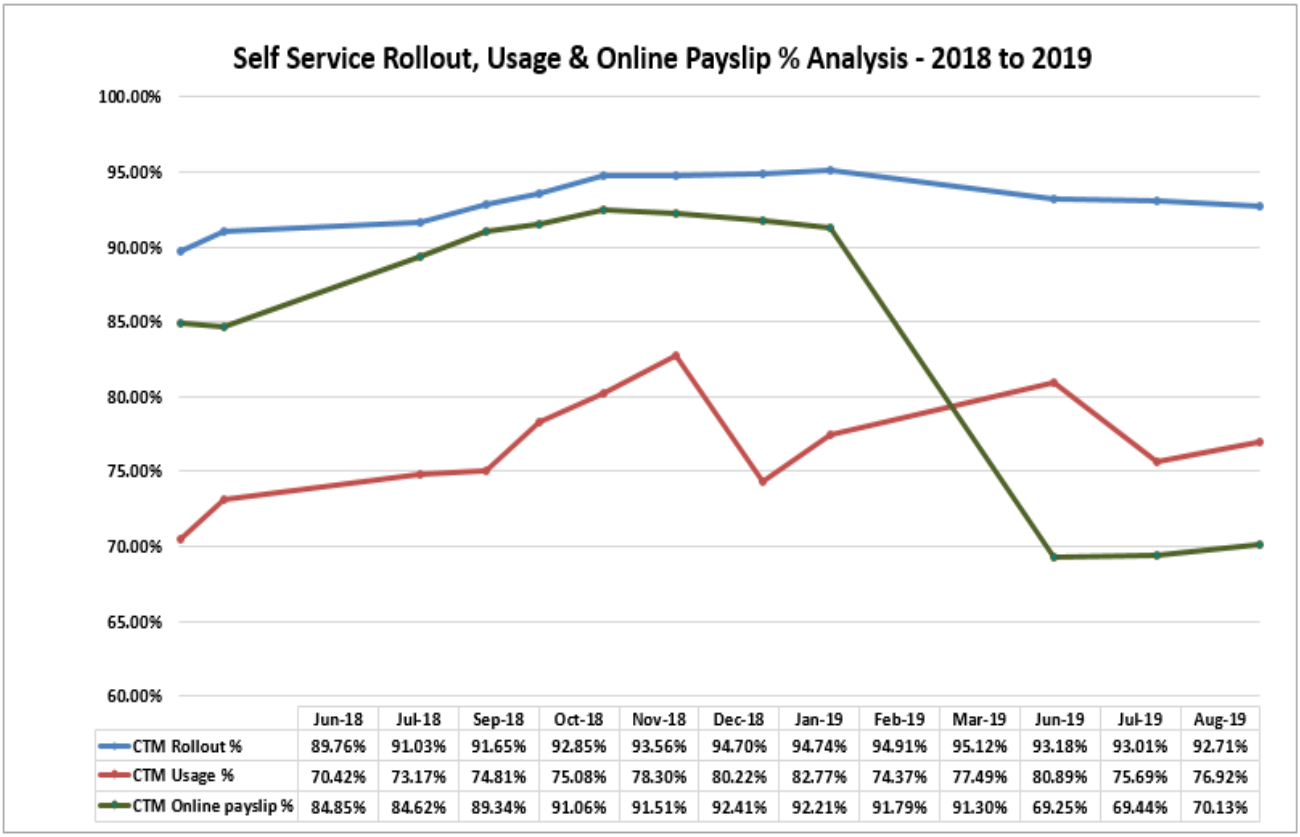


	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19
Cwm Taf UHB	24.14	26.04	26.04	25.54	25.60	22.02	21.29	22.59	25.38	25.63	22.08	17.32
Hire to Retire Target	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00	7.00



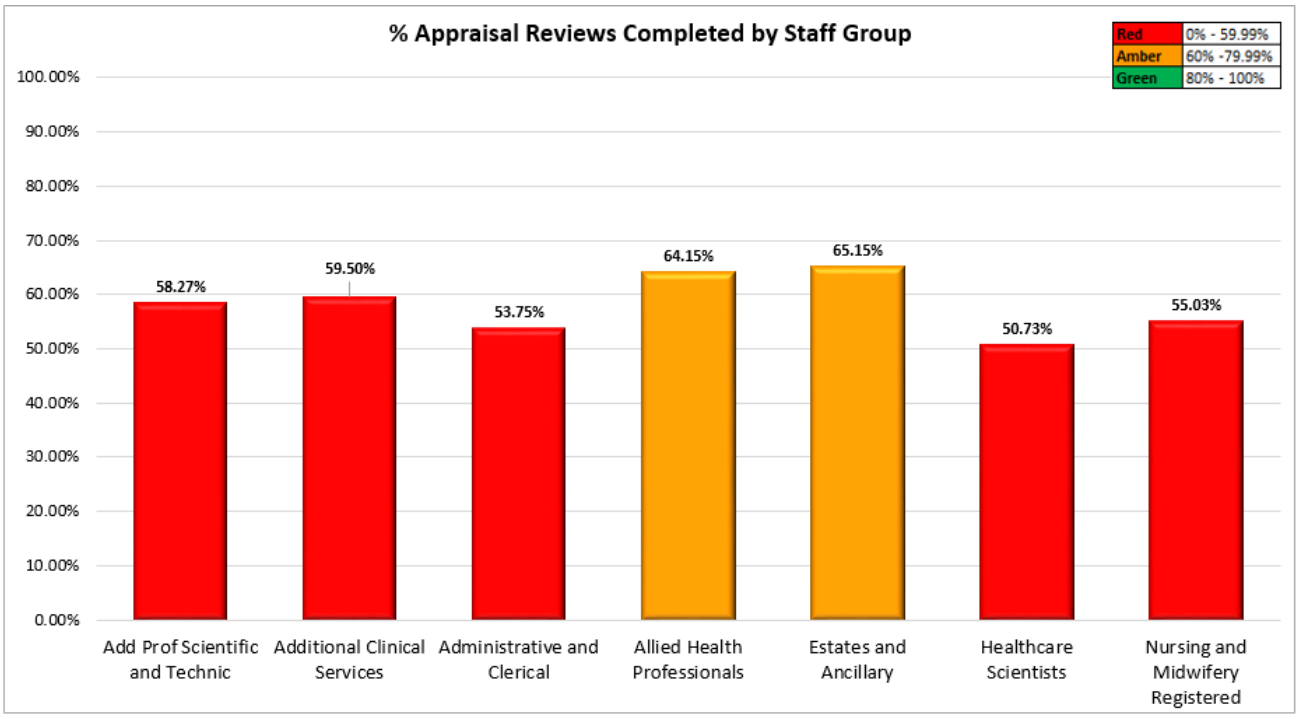

Sickness Absence Reasons FTE Days Lost July 2019
FTE Absence Days Lost
7,000.00
6,000.00
5,000.00
4,000.00
3,000.00
2,000.00
1,000.00
0.00
5,828
2,107
1,179
1,160
1,143
1,053
875
737
575
495
449
415
364
259
238
224
206
145
118
96
71
57
37
19
S10 Anxiety/stress/depression/other psychiatric illnesses
S12 Other musculoskeletal problems
S28 Injury, fracture
S98 Other known causes - not elsewhere classified
S25 Gastrointestinal problems
S99 Unknown causes / Not specified
S11 Back Problems
S17 Benign and malignant tumours, cancers
S26 Genitourinary & gynaecological disorders
S15 Chest & respiratory problems
S19 Heart, cardiac & circulatory problems
S21 Ear, nose, throat (ENT)
S13 Cold, Cough, Flu - Influenza
S23 Eye problems
S30 Pregnancy related disorders
S16 Headache / migraine
S29 Nervous system disorders
S31 Skin disorders
S27 Infectious diseases
S18 Blood disorders
S24 Endocrine / glandular problems
S14 Asthma
S22 Dental and oral problems
S20 Burns, poisoning, frostbite, hypothermia

Appendix 3 – ESR and e-Systems



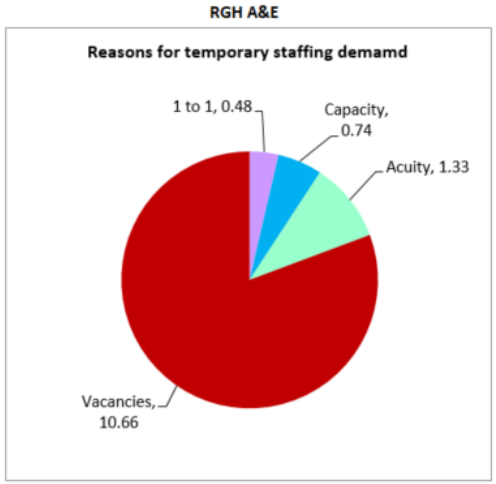
	Jun-18	Jul-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Jun-19	Jul-19	Aug-19
CTM Rollout %	89.76%	91.03%	91.65%	92.85%	93.56%	94.70%	94.74%	94.91%	95.12%	93.18%	93.01%	92.71%
CTM Usage %	70.42%	73.17%	74.81%	75.08%	78.30%	80.22%	82.77%	74.37%	77.49%	80.89%	75.69%	76.92%
CTM Online payslip %	84.85%	84.62%	89.34%	91.06%	91.51%	92.41%	92.21%	91.79%	91.30%	69.25%	69.44%	70.13%

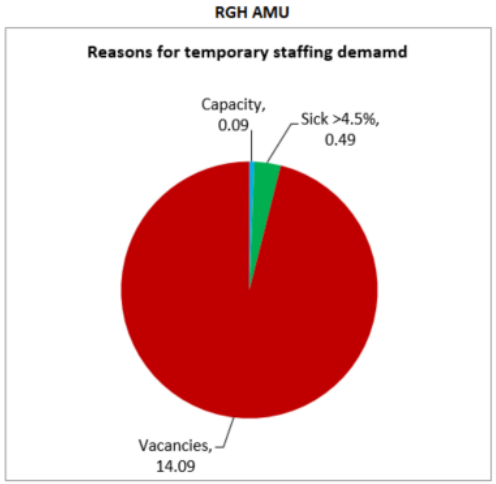
Appraisal Rates by Staff Group

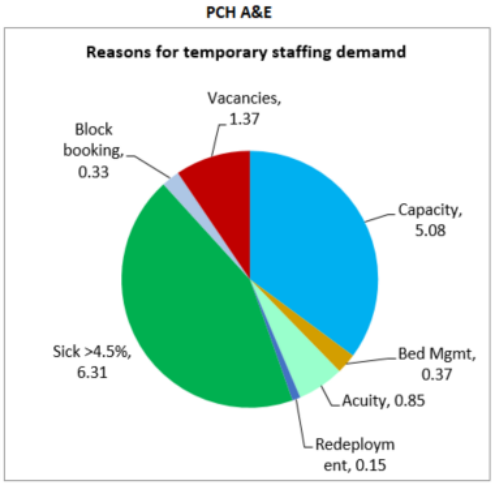


Appendix 4 – Reasons for Temporary Staffing Demand

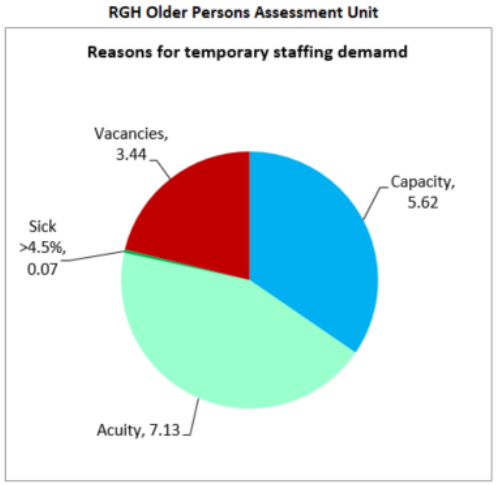
Registered Nurses (top 3 areas)

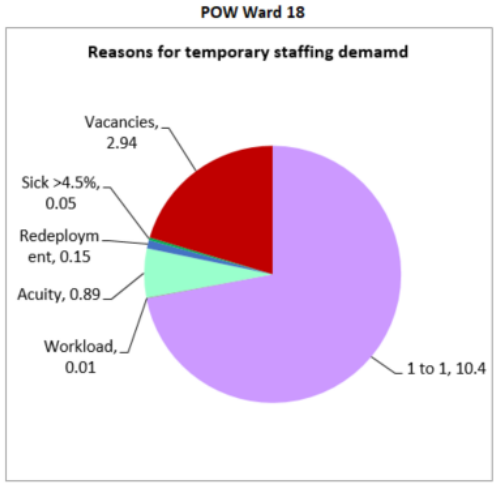


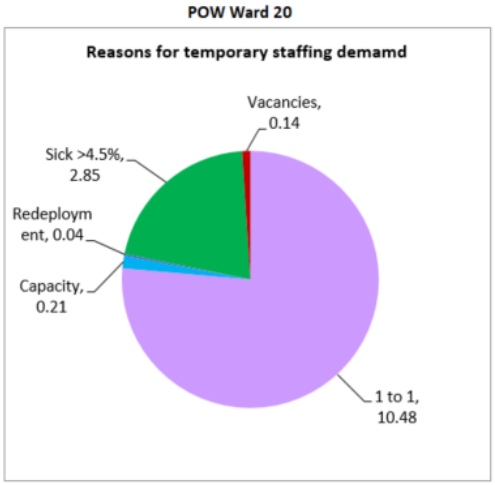




Healthcare Support Workers (top 3 areas)







GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.6** **26 September 2019**

University Health Board Meeting
FINANCE UPDATE – MONTH 5 of 2019/20

Executive Lead: Director of Finance
Author: Deputy Director of Finance
Contact Details for further information: mark.thomas5@wales.nhs.uk

Purpose of the Health Board Report
The purpose of the attached report is to highlight the key messages in relation to the Month 5 financial position.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2019-2022, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses mainly on ensuring good value based care and treatment for our patients in line with the resources made available to the Health Board.
Supporting evidence	N/A
Engagement – Who has been involved in this work?	
The Month 5 position and forecast year end position for the Health Board has been shared with Welsh Government (WG) via our monthly Monitoring return submissions.	

Health Board Resolution To;							
APPROVE		**ENDORSE**		**DISCUSS**	√	**NOTE**	
Recommendation	The Health Board is asked to: • **DISCUSS** the contents of the Month 5 Finance report for 2019/20.						
Summarise the Impact of the Health Board Report							
Equality and diversity	N/A						
Legal implications	No direct legal implications.						
Population Health	N/A.						
Quality, Safety & Patient Experience	N/A						
Resources	The paper is directly relevant to the allocation and utilisation of resources.						
Risks and Assurance	The key risks to the 2019/20 Financial Plan are explained in the forecast section of the report.						
Health & Care Standards	N/A						
Workforce	N/A						
Freedom of information status	Open						

Glossary of Terms

Acronym	Meaning	Acronym	Meaning
A&C	Administration & Clerical	I&E	Income & Expenditure
AWCP	All Wales Capital Programme	LTA	Long Term Agreement
AME	(WG) Annually Managed Expenditure	M1	Month 1 (M2 Month 2 etc)
CHC	Continuing Healthcare	PCMH	Primary Community & Mental Health
COO	Chief Operating Officer	PCH	Prince Charles Hospital
CRES	Cash Releasing Efficiency Savings	POW	Princess of Wales Hospital
CRL	Capital Resource Limit	RGH	Royal Glamorgan Hospital
FNC	Funded Nursing Care	PSPP	Public Sector Payment Policy
HCHS	Healthcare & Hospital Services	WG	Welsh Government
IHI	Institute of Healthcare Improvements	WHSSC	Welsh Health Specialised Services Committee
IMTP	Integrated Medium Term Plan	YTD	Year to Date

FINANCE REPORT – MONTH 5 of 2019/20

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to highlight the key messages in relation to the current month, year to date and forecast year-end financial position of Cwm Taf Morgannwg (CTM)University Health Board as at Month 5 (M5).

2. BACKGROUND / INTRODUCTION

This report should be read in the context of the CTM Integrated Medium Term Plan (IMTP) for 2019/20 to 2021/22 which is available on the website. The annual budget for the new organisation is circa £1,000m.

The IMTP was approved by the Board on 28 February and was approved by the Welsh Government on 26 March 2019. The following key issues are highlighted in relation to the financial plan for 2019/20:

a. Bridgend boundary change

One of the key assumptions within the IMTP was that the Bridgend boundary change should not destabilise the financial balance and performance record of the former Cwm Taf Health Board. The IMTP therefore assumed that the impact of any deficit attributed to Bridgend would be neutral to the new organisation. Our assessment as at April 2019 of the financial impact on CTM was a recurring deficit (after economies of scale) of £7.4m, excluding the performance and demand & capacity issues referred to below. Detailed budgets were set on this basis and the financial plan has been updated to include assumed funding for the £7.4m recurring deficit transferred.

The outcome of the arbitration process was received on 13 August 2019. This confirmed a £7.1m non-recurring allocation for 2019/20 to enable the Board to develop the required financial plan and mitigating actions to be put in place for future years. There is also a potential risk that further adjustments may be made to the £7.1m non-recurring allocation when the due diligence work is completed.

The M5 forecasts have been revised to reflect this position.

b. Performance and RTT targets

Our work on the financial impact assessment of the Bridgend boundary change also highlighted that Bridgend had been running waiting list initiatives (WLI's) throughout 2018/19 at an annualised cost of c £1.8m, which was supplemented with outsourcing towards the end of the financial year. The WLI's had the effect of broadly holding the RTT backlog constant overall and were essentially a non-recurrent measure for meeting a recurrent requirement. Therefore, in reality the recurrent requirement to spend, based on current demand, productivity and core capacity, is around £2m greater than what was reflected in the financial impact assessment noted above of £7.4m. There was also an RTT backlog at the end of 2018/19, which CTM estimated has a non-recurring cost in the region of £4.2m to clear. The Health Board submitted a £8.7m bid to WG to address the performance issues across CTM which is summarised below:

	Former CT	**Bridgend**
	£m	**£m**
Forecast total costs	6.6	6.2
Internal funding sources within the IMTP	(3.1)	(1.0)
Net bid	**3.5**	**5.2**

On 27 June WG confirmed a non recurrent allocation of £7.0m for 2019/20 which is expected to deliver:

- no one waiting over 36 weeks, 8 weeks for diagnostics and 14 weeks for therapy services for the old Cwm Taf footprint; and
- an improvement in the number of people waiting over 36 weeks at the Princess of Wales site, as well as no one waiting over 8 weeks for diagnostics and 14 weeks for therapy services.

c. Savings targets

The financial plan for 2019/20 included a recurring savings target of £12.8m, comprising £9.6m existing Cwm Taf and £3.2m for Bridgend. Following the identification of a number of other opportunities in M1 we have reduced the recurrent savings target by £1.0m and the In year target by £2.8m. The revised savings targets are as follows:

	In year savings target	Recurrent savings target
	£m	**£m**
Former Cwm Taf	7.5	7.8
Bridgend	2.5	3.0
Total	**10.0**	**11.8**

d. Financial Plan update 2019/20

Subsequent to the financial plan being approved by the Board on 28 February, there have been a number of changes in the position of the Health Board which necessitated the plan being reviewed and updated. The key changes were discussed at the Health Board development session on 27 June and agreed at the Health Board meeting on 31 July:

	Former CT			Bridgend			CTM	
	In year	Recurring		In year	Recurring		In Year	Recurring
	£m	£m		£m	£m		£m	£m
Original plan	0	-0.4		0	-0.2		0	-0.6
Total changes	-1.0	2.1		1.0	2.0		0.0	4.1
Bridgend recurrent deficit after econs of scale				7.4	7.4		7.4	7.4
Assumed allocation change				-7.4	-7.4		-7.4	-7.4
Revised Financial plan	**-1.0**	**1.7**		**1.0**	**1.8**		**0.0**	**3.5**

The net impact of these changes does not change the break-even plan for 2019/20. However, it is important to highlight that the recurring position changes from a planned £0.6m surplus to a planned £3.5m deficit. This deterioration is attributed to the following items:

- Recurrent investment in management structures, including clinical leadership, nursing leadership and increased governance and quality improvement capacity £2m.
- Unplanned recurrent deficit associated with the Bridgend boundary change £0.7m.
- Planned care recurrent deficit in Bridgend £1.4m.

Report Sections

The following sections are included in this report:

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

3.1 Headline Messages - Month 5

The overall Income and Expenditure position improved in M5 with a small under-spend of £44k in month giving rise to a year to date (YTD) overspend of £0.5m. This year to date overspend includes a delegated overspend of £9.1m, offset by an under spend on non-delegated budgets of £8.6m. The delegated overspend includes a shortfall in savings delivery of £4.2m plus other overspends on pay, non-pay and income of £4.9m. Further details are provided in Sections 3.3 and 3.9.

The average monthly Delegated overspend in Quarter 1 was £1.5m. This was followed by a M4 Delegated overspend of £3.2m which increased the average monthly overspend for the first 4 months to £1.9m. The Delegated overspend in M5 was still very high at £1.4m but this was a £0.5m improvement compared to the M4 YTD average. Circa £0.2m of this improvement was due to budget changes. Most Divisions reported an improvement against their M4 YTD trends. The only significant deterioration from trend was seen in the Princess of Wales (POW) Delivery Unit which reported a £0.5m deterioration.

We are currently forecasting a breakeven position for 2019/20. The main risk to this position is around a potential reduction to the £7.1m non-recurring allocation for the Bridgend arbitration. Any reduction to this allocation will represent a serious risk to the break-even forecast.

We are currently reporting a £13.2m recurring deficit, which is an increase of £7.4m from the M4 deficit of £5.8m. This increase is attributable to the outcome of the Bridgend arbitration where no recurrent funding has been confirmed against the Bridgend recurrent deficit of £7.4m. Further information on the forecast positions and associated risks is provided in Section 3.3.

In light of the seriousness of the Bridgend position, further detailed work is ongoing to separately report the impact of the Bridgend boundary change which will include validating the forecast cost overspends and the impact of any shortfalls in savings delivery. Our current assessment is as follows:

	19/20	19/20 Recurring
	£m	£m
Former Cwm Taf	(2.6)	1.7
Bridgend	2.6	11.5
Total	**0**	**13.2**

Within this overall positive movement from the very concerning Month 4 report, there are a number of areas of concern. The key issues are summarised below with further information in Sections 3.3 and 3.4 and the more detailed analysis in Sections 3.5 to 3.10.

a. Savings delivery (Section 3.8)

The Delegated savings target of £16.4m represents a M5 target of £6.8m. Only £2.6m of savings have been reported to M5 resulting in an adverse variance against plan of £4.2m. This variance reduces to £1.6m after allowing for the Savings contingency which is being released on a straight line basis. The forecast savings are summarised below.

	Month 5		Month 4	
	19/20	Recurring	19/20	Recurring
	£m	£m	£m	£m
Savings targets	10.0	11.8	10.0	11.8
Forecast savings	9.8	8.8	9.4	9.0
Forecast shortfall	**0.2**	**3.0**	**0.6**	**2.8**

- Forecast In year savings have increased by £0.4m despite removing the Unscheduled care beds scheme (£0.6m).
- Forecast Recurring savings have reduced by only £0.2m after removing the Unscheduled care beds scheme (£1.0m)

The key actions being taken by the Health Board to address this concern are the monthly CRES review meetings with Executive and Assistant Directors, and the continuing oversight of the Efficiency, Productivity and Value Board.

b. M5 YTD Cost overspends- £4.9m

The most significant overspends within the total Pay overspend of £3.0m are as follows:

- Acute Medicine and A&E £624k (Nursing £840k)
- POW Delivery Unit £1,964k (Medical £1,042k, Nursing £1,176k)
- Pathology £313k (Medical £252k, Healthcare Scientists £109k)
- Localities £421k (Nursing £360k)
- CAMHs £225k (Medical & Dental £142k, Admin & clerical £133k)
- ICT £286k (ongoing WCCIS costs plus £150k agency costs)

The £3m overspend includes a £2.2m Nursing overspend and a £1.3m overspend on Medical and dental. A 'deep dive' on the nursing overspends is going to the Finance, Performance & Workforce Committee in October.

There are also significant YTD non pay overspends of £1.4m. The total cost overspends at M5 is now £4.9m which is greater than the Delegated CRES shortfalls of £4.2m. The monthly CRES review meetings have recently been expanded to cover these issues.

3.2 Financial Position and Key Targets – Month 5

The Health Board has a statutory duty to achieve a break even position over a period of three financial years. This applies to both revenue and capital expenditure. Over the last two financial years, the Health Board has achieved a small surplus of £39k and £18k for revenue and capital expenditure respectively. This means that the Health Board can overspend by £39k and £18k for revenue and capital expenditure respectively in 2019/20 and still meet its three year statutory duty. The Health Board's plan for 2019/20 is to break-even on both measures. The Health Board also has an administrative duty to pay a minimum of 95% of all non-NHS invoices within 30 days.

The table below details the Health Board's 2019/20 current and forecast performance against these key financial targets:

Target	Unit	Current Month	Year to Date	Trend	Forecast Year End
Revenue To ensure that the Health Board's revenue expenditure does not exceed the aggregate of it's funding in each financial year. Measured by variance against plan to break even.	£'000 +Adverse ()Favourable	(44)	536		**0**
Capital To ensure net capital spend does not exceed the Welsh Government Capital Resource Limit. Measured by variance against plan to manage to the Resource Limit	£'000 +Adverse ()Favourable	0	0		**(170)**
Public Sector Payment Policy To pay a minimum of 95% of all Non NHS invoices within 30 days. Measured by actual performance	%	97.0%	96.2%		**>95**

3.3 Revenue Performance by Expenditure Category

	Annual Budget	Over/(Under) Spend				Section
		Current Month	Year to Date	Forecast	Recurrent Forecast	
	£'000	£'000	£'000	£'000	£'000	
Delegated Budgets						
Pay	510,716	133	2,994	9,804	12,400	3.5
Non Pay	608,122	170	1,454	5,223	5,238	3.6
Income	(138,613)	257	386	(215)	(494)	3.7
Delegated Savings Plans	(11,863)	817	4,239	7,573	8,434	3.8
Total Delegated Budgets	**968,362**	**1,376**	**9,073**	**22,385**	**25,577**	
Non Delegated Budgets	59,145	(1,421)	(8,538)	(21,193)	(17,405)	3.9
Planned recurrent deficit					3,500	See below
Unplanned Bridgend recurrent deficit				0	7,400	See below
Other items	0	0	0	(1,192)	(5,872)	See below
WG Allocations	(1,027,507)	0	0	0	0	3.10
GRAND TOTAL M5	**0**	**(44)**	**536**	**0**	**13,200**	
GRAND TOTAL M4	**0**	**440**	**580**	**0**	**5,800**	

Further information on the current month, YTD and forecast positions are provided below.

Current Month

- The overall Income and Expenditure position improved in M5 with a small underspend of £44k. This includes a delegated overspend of £1.4m, offset by an under spend on non-delegated budgets of £1.4m. The delegated current month overspend of £1.4m includes a shortfall in savings delivery of £0.8m plus other overspends on pay, non-pay and income of £0.6m.

- The most significant current month overspends within the total Pay overspend of £133k are as follows:
  - POW Delivery Unit £615k (Medical £331k, Additional clinical services £199k & Nursing & Midwifery £126k)
  - Pathology £123k (Medical £96k and Healthcare Scientists £25k)
  - Localities £60k (Additional clinical services 52k)
  - Information, Communication & Technology (ICT) £95k (ongoing WCCIS costs plus £50k agency costs)

- The most significant current month overspends within the total Non Pay overspend of £170k are as follows:
  - POW Delivery Unit £129k (Drugs and Appliances)
  - Pathology £93k (Drugs and Service Level Agreements (SLAs))
  - Children & Young People £142k (Budget transfer between non pay and pay)
  - Mental Health £219k (Continuing Healthcare £208k)
  - Estates £128k (Premises and fixed plant £80k)

- The most significant current month overspends within the total Income overspend of £257k are as follows:
  - POW Delivery Unit £129k – Cardiff & Vale UHB (C&VUHB) Cochlear Implants Income
  - CAMHs £186k- underperformance against Welsh Health Specialised Services Committee (WHSSC) & Swansea Bay Long Term Agreement (LTA) activity
  - Facilities £66k

- Further information on the Savings delivery shortfall is provided in Section 3.8.

Year to Date

- The M5 YTD overspend of £0.5m includes a delegated overspend of £9.1m offset by an under spend on non-delegated budgets of £8.6m. The delegated year to date overspend includes a shortfall in savings delivery of £4.2m plus other overspends on pay, non-pay and income of £4.9m.

- The most significant overspends within the total Pay overspend of £3.0m are as follows:
  - Acute Medicine and A&E £624k (Additional clinical services £577k, Nursing & Midwifery £263k)
  - POW Delivery Unit £1,964k (Medical £1,042k, Additional clinical services £853k)
  - Pathology £313k (Medical £252k, Healthcare Scientists £109k)
  - Localities £421k (Additional clinical services £438k)
  - CAMHs £225k (Medical & Dental £142k, Admin & clerical £133k)
  - ICT £286k (Ongoing WCCIS costs plus £150k agency costs. Urgent work needed to confirm if any of these costs need to be recharged to other budgets)

- The most significant overspends within the total Non Pay underspend of £1,454k are as follows:
  - Acute Medicine and A&E £205k (Drugs £230k)
  - POW Delivery Unit £266k (Medical & Surgical (M&S) supplies £120k and Drugs £80k, Appliances £166k)
  - Pathology £237k (SLAs £180k and M&S supplies £72k)
  - Facilities £401k (Waste & Transport £274k , Trading services £70k)
  - Mental Health £587k (Continuing Healthcare £615k but offset by positive income variance of £479k)

- The most significant overspends within the total Income overspend of £386k are as follows:
  - Contracting & Commissioning £246k - includes £119k injury cost recovery scheme.
  - CAMHs £374k - underperformance against WHSSC & Swansea Bay LTA activity

- Further information on the Savings delivery shortfall is provided in Section 3.8.

- Further information on the Non delegated underspend of £8.6m is provided in Section 3.9.

In Year and Recurring forecasts

	Over/(Under) Spend	Over/(Under) Spend	Over/(Under) Spend
	Bottom up forecast	Straight line forecast	Recurrent Forecast
	£'000	£'000	£'000
Delegated forecasts pre M5	22,385	21,775	25,577
Non Delegated forecasts post M5	(21,193)	(21,193)	(17,405)
Planned recurrent deficit	0	0	3,500
Unplanned Bridgend recurrent deficit	0	0	7,400
Sub total	**1,192**	**582**	**19,072**
Other opportunities and risks:			
Planned new spend – Mgt capacity and clinical leadership	400	400	2,000
Other planned spend	2,600	2,600	0
Assumed full delivery of the £10m In year savings target and the £11.8m Recurring savings target- pre M5	(600)	(3,200)	(2,800)
Anticipated improvement in bottom up directorate forecasts	(3,592)	0	(5,072)
Sub total	**(1,192)**	**(200)**	**(5,872)**
GRAND TOTAL M5	**0**	**382**	**13,200**
GRAND TOTAL M4	**0**	**0**	**5,800**

The key points to highlight are noted below:

In Year forecast

- The break-even forecast for 2019/20 includes a forecast delegated overspend of £22.4m which is based on the bottom up directorate forecasts after M4 and before M5. These forecasts were prepared after the significant deterioration in the M4 delegated overspend, which was £3.1m compared to an average of £1.5m/month for the first 3 months of the year and £1.4m in M5. This overspend is likely to include a degree of 'pessimism bias' and we are anticipating a significant improvement in the M5 delegated forecast. If this does not materialise it will represent a potential risk to the forecast.

- The forecast also includes provision for planned new spend of circa £3m which will need to be managed within the overall position and the anticipated improvement noted above. Key items include overseas nurse recruitment, initial costs of the investment in clinical leadership, quality governance and improvement, costs of reconfiguration projects such as A&E/Paediatrics, and non-capital equipment replacement.

- The M5 straight line forecast indicates that if our spending pattern continued at the rate seen for the first 5 months as a whole, and we increased the delivery on savings to the minimum level in the financial plan of £10m, the planned new spend of circa £3m would be affordable with a further improvement of £382k.

- As noted above, the main risk to the forecast position is around a potential reduction to the £7.1m non-recurring allocation for the Bridgend arbitration. Any reduction to this allocation will represent a serious risk to the break-even forecast.

Recurrent forecast

- We are currently reporting a £13.2m recurring deficit, which is an increase of £7.4m from the M4 deficit of £5.8m. This increase is wholly attributable to the outcome of the Bridgend arbitration where no recurrent funding has been confirmed against the Bridgend recurrent deficit of £7.4m.

- There are two significant risks to the forecast recurring deficit of £13.2m:
  - Assumed full delivery of the £11.8m recurring savings target which requires an improvement of £2.8m based on the M4 forecast recurring savings of £9.0m.
  - Assumed further improvement in the M5 delegated recurring forecasts of £5.1m which will be partly due to the 'pessimism bias' issue noted above in relation to the current year forecast.

3.4 Revenue Performance by Division

		Over/(Under) Spend			
	Annual Budget £'000	Current Month £'000	Year to Date £'000	Forecast £'000	Recurrent Forecast £'000
Chief Operating Officer:					
Unscheduled Care	84,508	161	1,291	3,529	4,269
Planned Care	110,959	(150)	898	3,216	3,850
POW Delivery Unit	98,265	1,112	3,404	6,991	7,976
Clinical Support	58,280	222	766	2,886	2,374
Facilities	36,720	214	1,028	1,021	850
Total COO	**388,732**	**1,559**	**7,387**	**17,643**	**19,319**
PCMH:					
Primary & Community	208,759	108	1,501	2,782	3,205
Mental Health	74,947	(17)	136	152	1,331
Medicines Management	129,557	0	22	485	485
Total PCMH	**413,263**	**91**	**1,659**	**3,418**	**5,021**
Contracting & Commissioning	95,834	(279)	54	599	599
Corporate Functions	70,533	6	(27)	725	637
GRAND TOTAL M5	**968,362**	**1,376**	**9,073**	**22,385**	**25,577**
GRAND TOTAL M4	**963,948**	**3,097**	**7,697**	**19,758**	**21,854**

Current Month and Year To Date

- The above table shows the current month, YTD and forecast positions by Division rather than by Expenditure categories as in Section 3.3 above.

- The main areas of overspends, expressed as a % of budget are as follows:
  - POW Delivery Unit 8.3%, Facilities 6.7%, Unscheduled Care 3.6%, Clinical Support 3.1% & Planned Care 1.9%.

  - The only area of underspend is within Corporate functions which is underspending by 0.1% when expressed as a % of budget.

Year End Forecasts

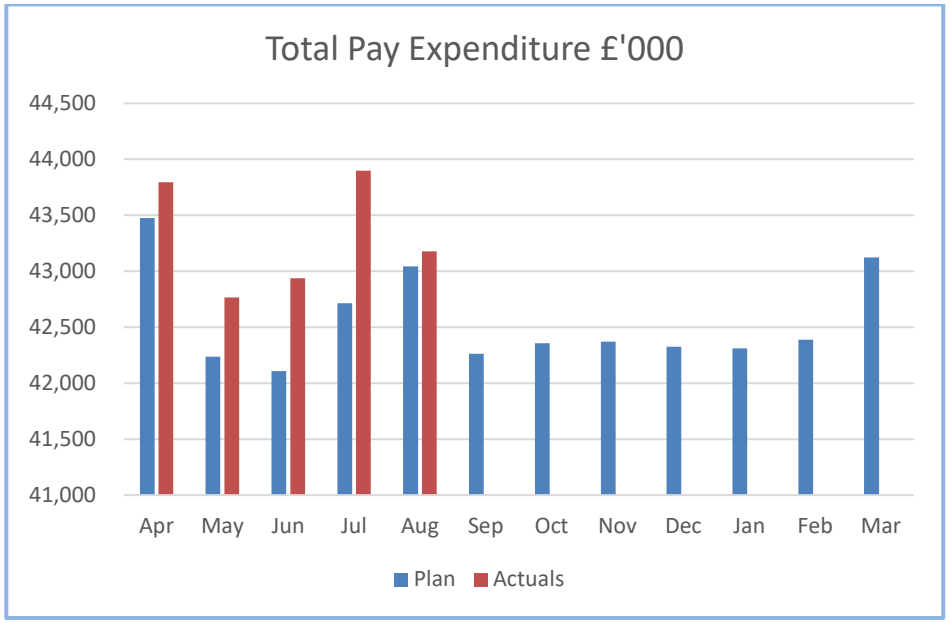
- The divisional forecasts are based upon the M4 financial position and indicate a delegated deficit of £22.4m, this implies a deterioration from straight-line projection of the YTD position at M5 of £0.6m.

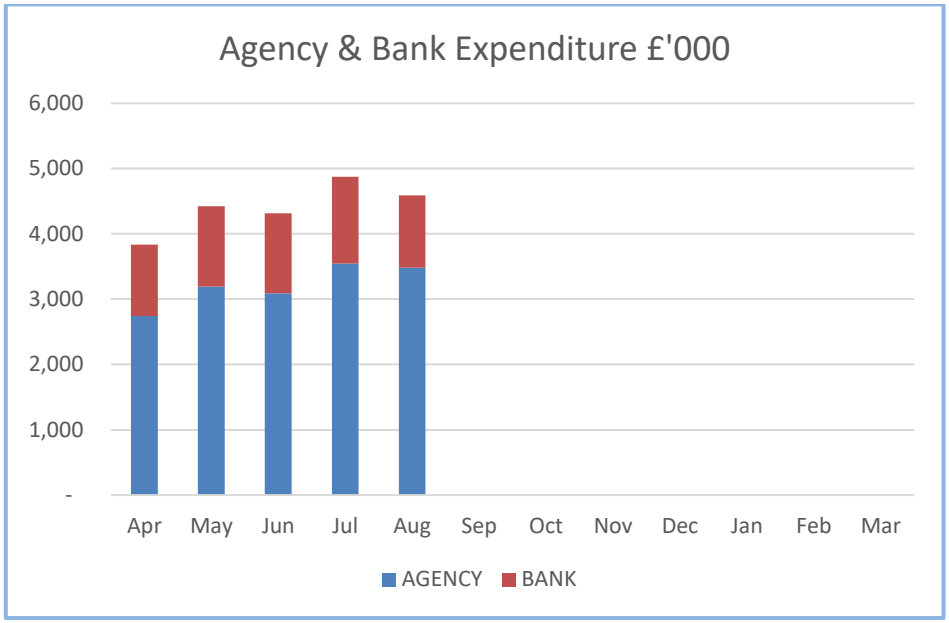
- The most significant areas of forecast deterioration are planned care £1m, Clinical Support £1m, Corporate functions £0.8m, Contracting £0.5m, Unscheduled Care £0.4m and Medicines Management £0.4m.

- The most significant areas of forecast improvement are POW Delivery unit £1m, Facilities £1.5m, Primary & Community £0.8m and Mental Health £0.2m.

3.5 Pay Expenditure

Monthly Trends (Please note scale of Y-axis)





Key Issues

- The budget and spend for April is high because this included £1.6m for the Agenda for Change (A4C) non-consolidated lump sum payment as per the framework agreement.
- The M5 position is reporting Pay expenditure of £43.2m compared to a budget of £43.m giving rise to an over spend of £0.1m. This is an improvement compared to the YTD average overspend of £0.72m per month.
- Agency spend was £3.5m in M5, consistent with M4. This equates to 8.1% of total pay costs in August compared to an average of 7.0% in Q1.
- Bank spend was £1.1m in M5 which is a slight improvement to the £1.3m in M4. This equates to 2.6% of total pay costs.
- The M12 budget profile is showing an increase of circa £0.8m which includes £0.8m for Primary Care Development funding.

Performance by Staff Category

	Annual Budget £'000	Current Month Variance £'000	Year to Date Variance £'000	YTD Variance as % of YTD budget %
Medical And Dental	**129,390**	**76**	**1,297**	**2.40%**
Wards and A&E Nursing:				
Registered Nursing	48,475	142	637	3.14%
Additional Clinical Services	22,209	314	2,013	21.84%
Sub-Total Wards & A&E Nursing	**70,684**	**455**	**2,649**	**8.98%**
Other Nursing:				
Registered Nursing	119,689	(425)	(1,386)	-2.84%
Additional Clinical Services	23,270	64	937	9.45%
Sub-Total Other Nursing	**142,959**	**(360)**	**(449)**	**-0.80%**
Additional Clinical Services	11,775	(44)	(63)	-1.15%
Allied Health Professionals	29,568	(27)	(499)	-4.00%
Add Prof Scientific And Technical	18,604	(66)	(292)	-3.74%
Administrative & Clerical	66,204	(187)	(646)	-2.35%
Estates And Ancillary	31,489	111	266	2.01%
Healthcare Scientists	11,532	41	95	1.97%
Vacancy factors included in budgets for staff turnover	(1,489)	132	634	
Grand Total	**510,716**	**133**	**2,994**	**1.40%**

Key Issues

- Medical Pay deterioration slowed in M5 with a current month variance of £76k. The YTD variance at M5 is £1,297k.
- Wards & A&E have continued to deteriorate in M5, with an in month overspend of £455k and a YTD variance of £2,649k.
- Significant YTD underspends are being reported for :
  - Allied Health Professionals £499k
  - Admin & Clerical £646k
  - Add Prof & Scientific £292k

Performance by Division

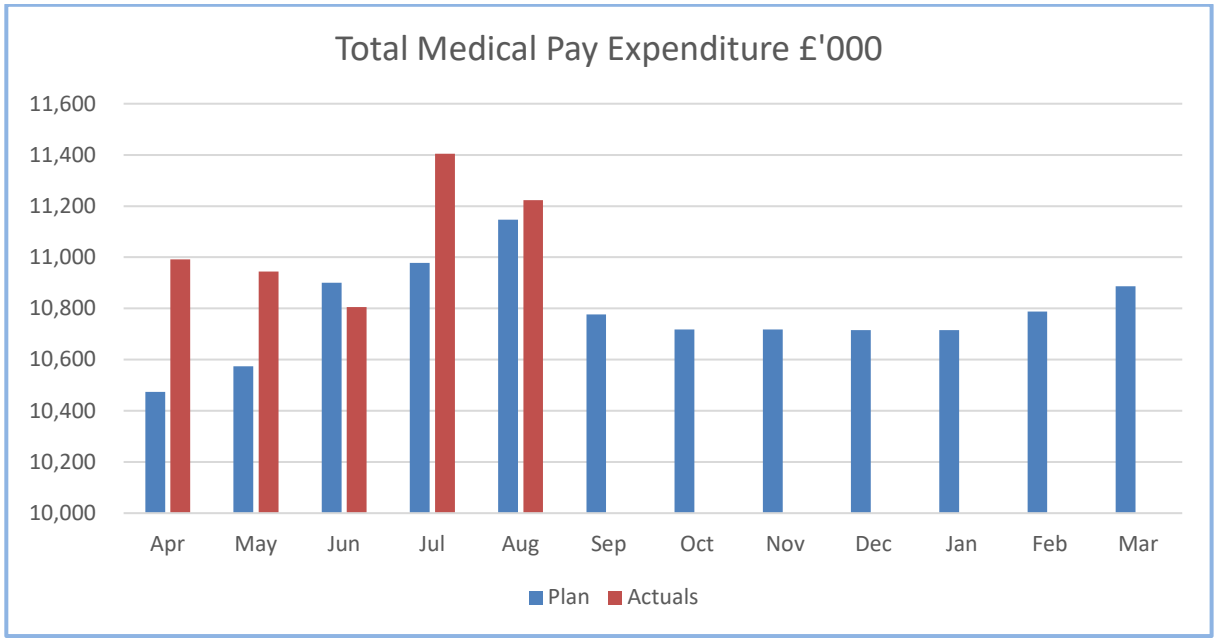
		In Month Variance			Year to Date Variance
		Over/(Under) Spend			Over/(Under) Spend
	Annual Budget £'000	Last Month £'000	Current Month £'000	Change £'000	Current Month £'000
Chief Operating Officer:					
Unscheduled Care	71,709	230	5	(225)	624
Planned Care	91,227	-14	(101)	(87)	86
POW Delivery Unit	88,031	537	616	79	1,964
Clinical Support	43,365	-39	62	101	126
Facilities	28,651	107	12	(95)	48
Total COO	**322,982**	**822**	**593**	**(228)**	**2,847**
PCMH:					
Primary & Community	96,272	261	(273)	(534)	186
Mental Health	44,671	42	(84)	(126)	(256)
Medicines Management	10,877	41	28	(13)	108
Total PCMH	**151,819**	**344**	**(329)**	**(673)**	**38**
Contracting & Commissioning	0	0	0	0	0
Corporate Functions	35,914	18	(130)	(148)	109
GRAND TOTAL	**510,716**	**1,184**	**133**	**(1,049)**	**2,994**

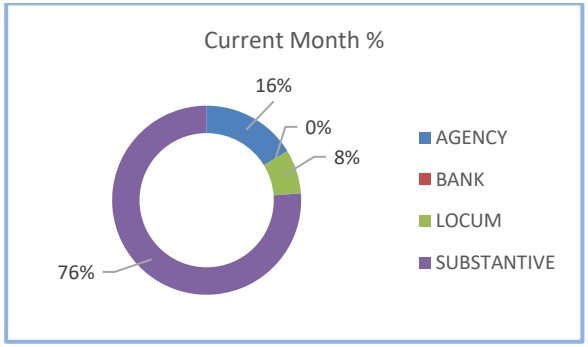
Key Issues

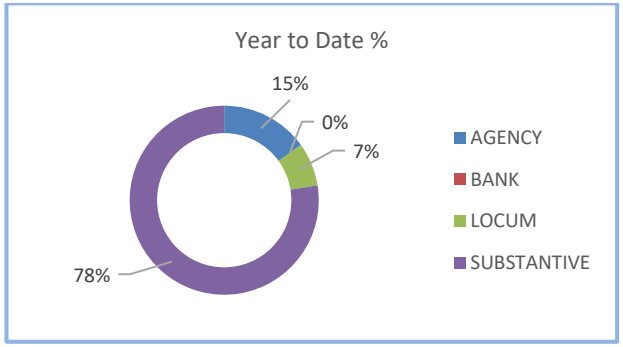
- The M5 YTD Pay overspend is £2,994k. The most significant overspends are in the following areas:
    - Acute Medicine and A&E £624k (Additional clinical services £577k Nursing & Midwifery £263k)
    - POW Delivery Unit £1,964k (Medical £1,042k, Additional clinical services £853k)
    - Pathology £313k (Medical £252k and Healthcare Scientists £109k)
    - Localities £421k (Additional clinical services £438k)
    - CAMHs £225k (Medical & Dental £142k, Admin & clerical £133k)
    - ICT £286k (Ongoing WCCIS costs plus £150k agency costs. Urgent work needed to confirm if any of these costs need to be recharged to other budgets)

Medical and Dental Pay Expenditure

The chart below shows the trends of Medical & Dental pay expenditure and budget. ***(Please note scale of Y-axis)***



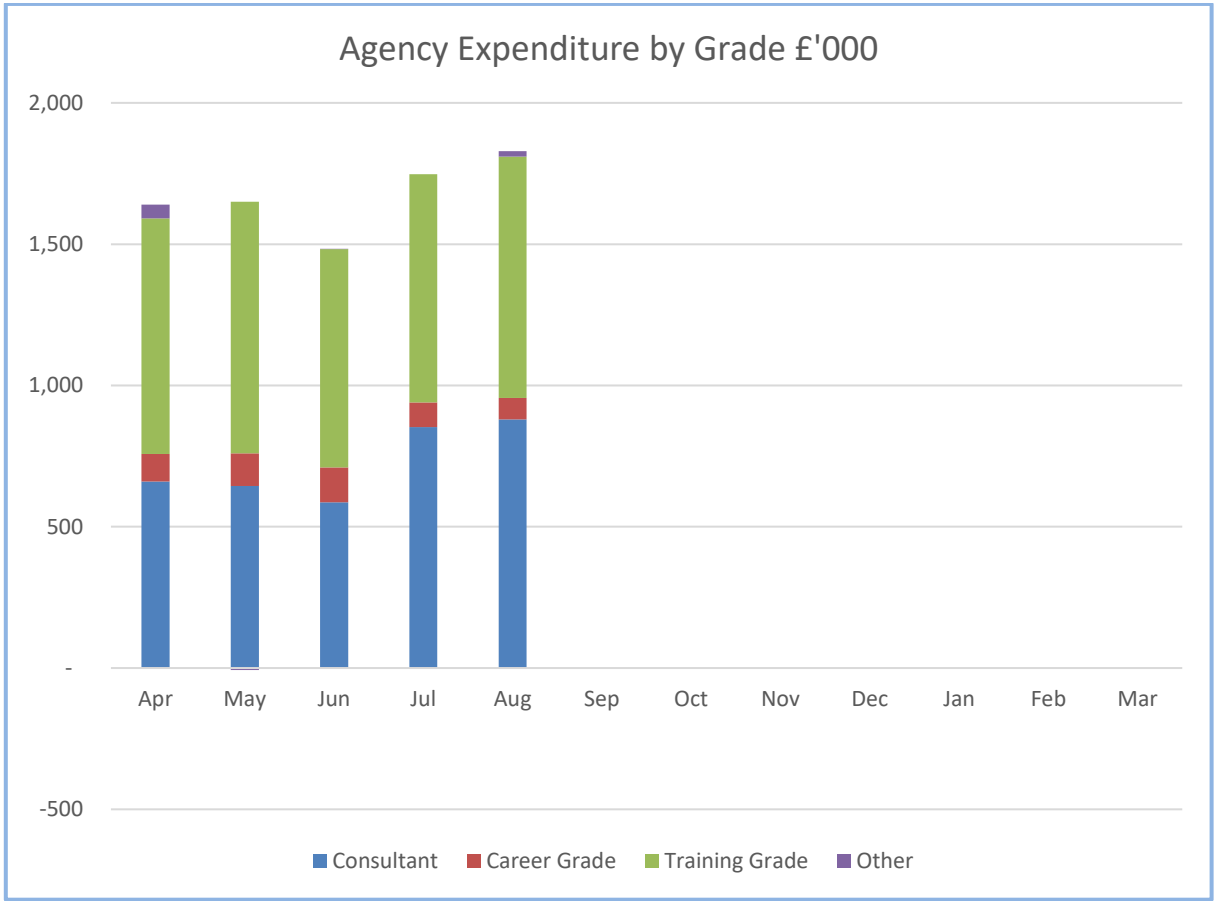




Key Issues

- Expenditure in M5 fell by £182k to £11.2m.
- The increased budget in M5 includes Radiology (£154k), Children & Young People (CYP) (£161).
- The M5 year to date variance is £1,297k adverse.
- M5 Medical agency spend was £1.829m, an increase of £82k from M5.
- M5 agency spend accounted for 16% of total Medical & Dental pay.

The Chart below shows an analysis of the monthly medical agency costs by grade.

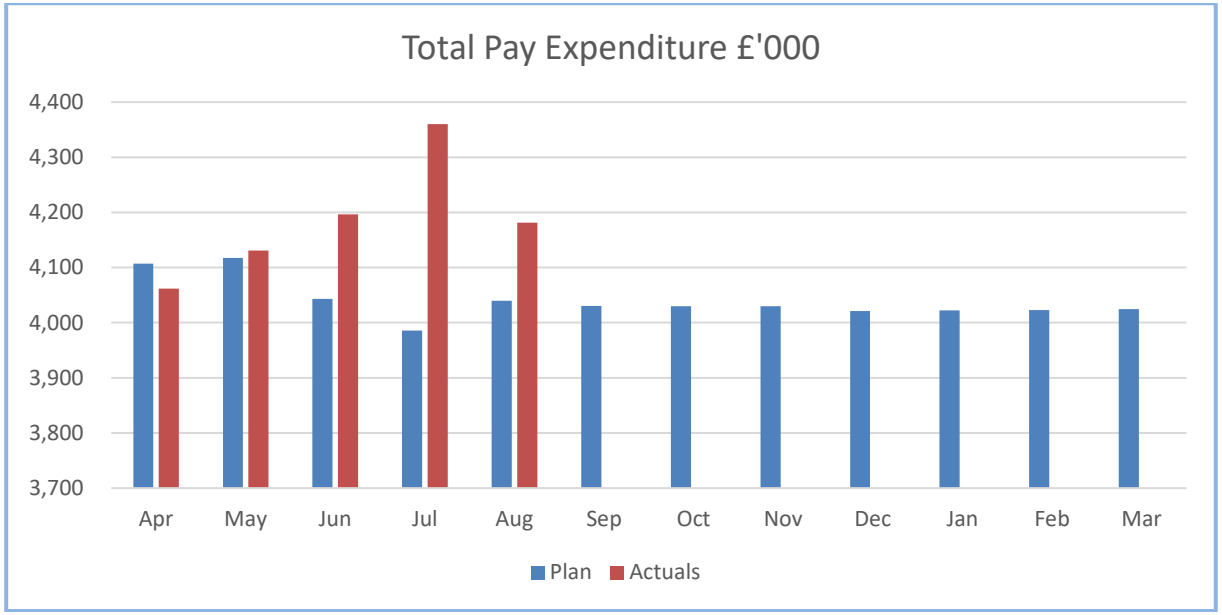


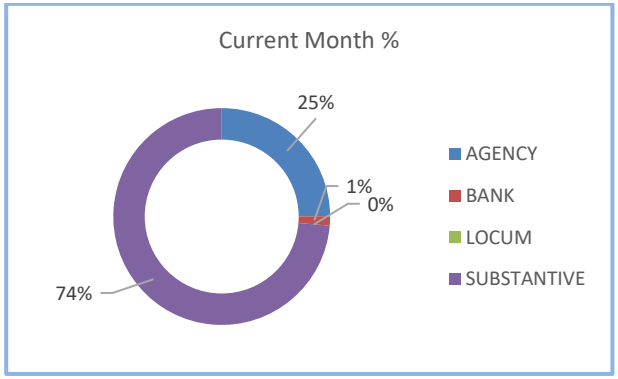
Key Issues

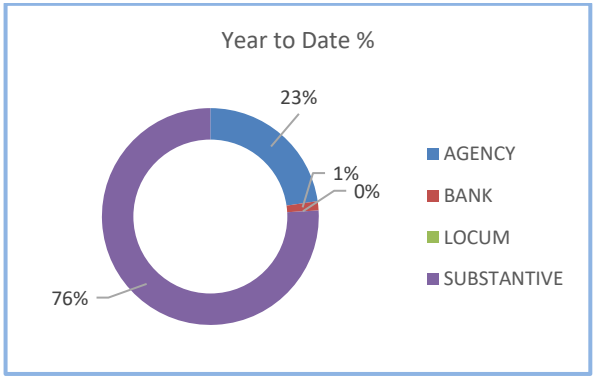
- The level of medical and dental agency expenditure increased in M5 to £1.83m. Medical Agency remains a concern, with agency costs over the last 2 months averaging over £1.79m/month.
- The level of consultant cover increased by £28k to £880k representing 48% of all medical agency costs.
- The most significant increases in agency were reported within:
    - POW Clinical Support £101k
    - POW Medicine £46k

Registered Nursing - Wards and A&E Pay Expenditure

The charts below show the monthly trends for Registered Nursing pay costs in Wards and A&E:
(Please note scale of Y-axis)





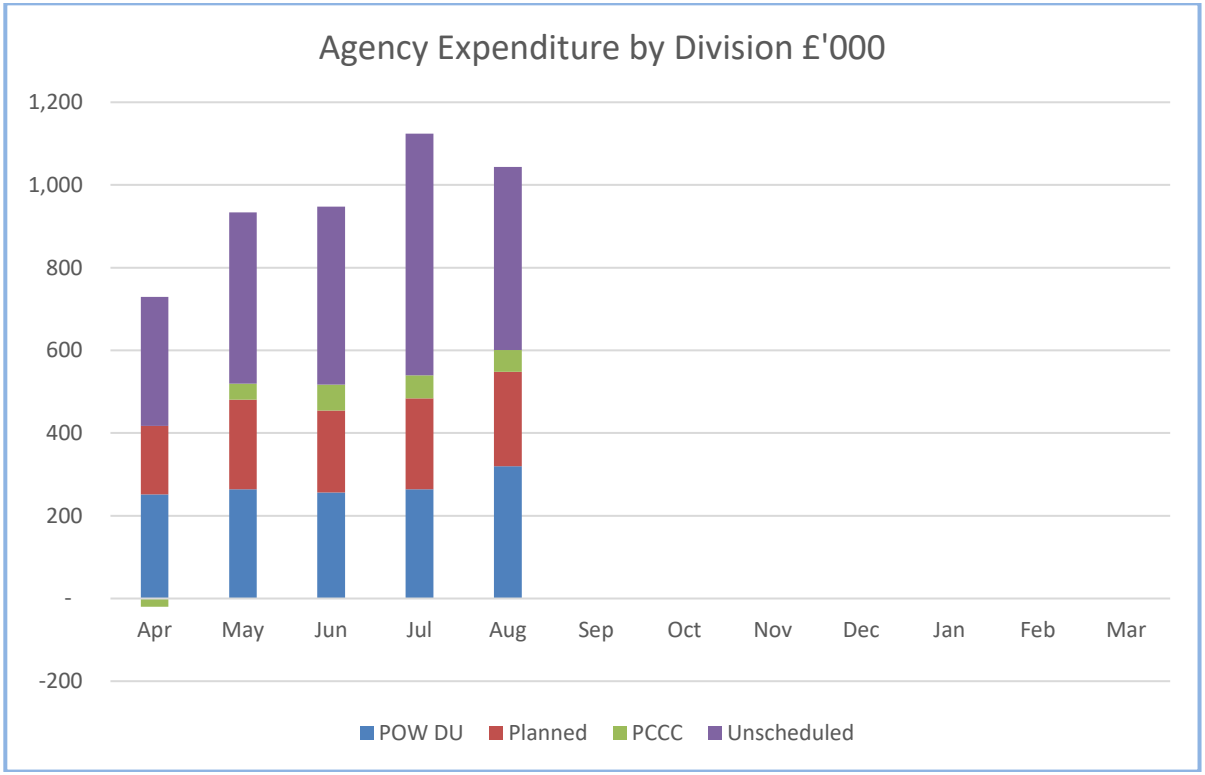


Key Issues

- The budget and spend in M1 & M2 included circa £200k for the non-consolidated lump sum payment and pay awards.
- Expenditure in M5 fell slightly by £146k.
- The M5 YTD Variance was £637k which is a deterioration of £142k from M5.
- M5 agency costs fell by £81k to £1,044k (M5 £1,124k).
- M5 agency spend accounted for 25% of total Ward and A&E registered nursing pay with bank expenditure of 1%.

Registered Nursing - Wards and A&E Agency Expenditure

The chart below shows a split of the monthly agency costs for Registered Nursing in Wards and A&E by Division.

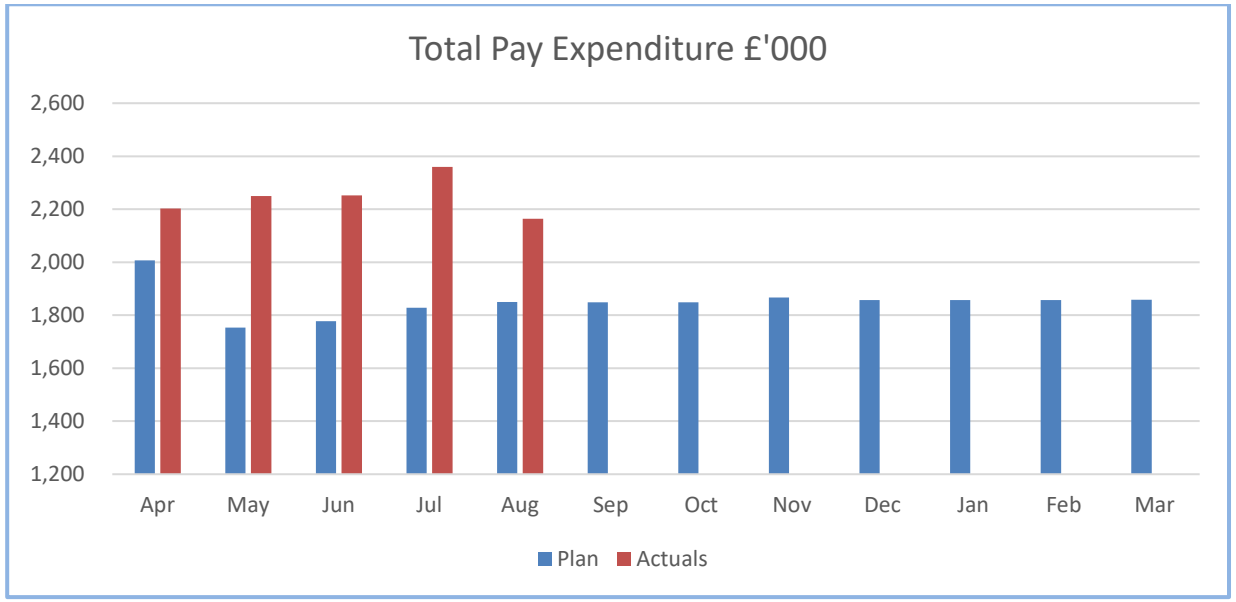


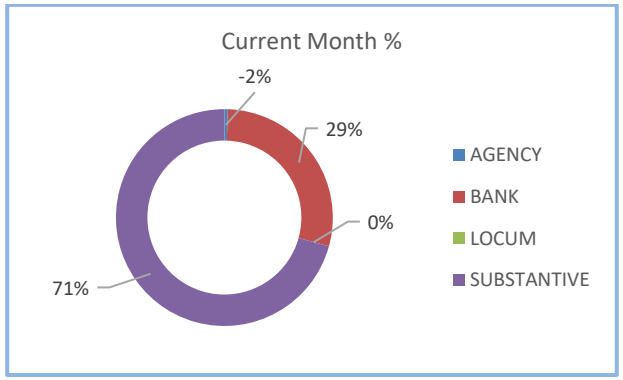
Key Issues

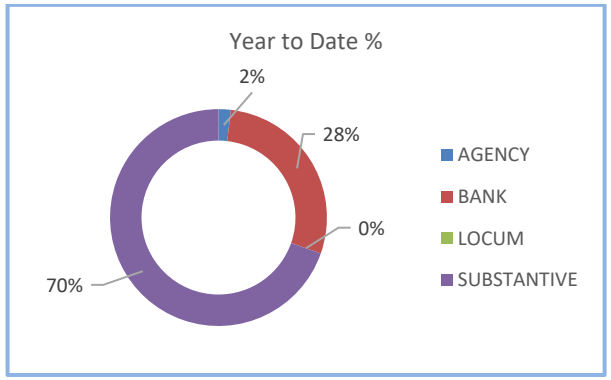
- Total agency spend in M5 was £1,044k, which is a decrease of £81k compared to the M4 expenditure of £1,124k.
- The most significant decrease in agency was reported within unscheduled care within a decrease of £141k
- The most significant increase was reported in the POW delivery unit with an increase of £55k.
- Unscheduled care accounted for 42% of total agency expenditure in M5, with the POW Delivery Unit accounting for 31%.

Additional Clinical Services – Wards and A&E Pay Expenditure

The chart below show the monthly trends for Additional Clinical Services pay costs in Wards and A&E: ***(Please note scale of Y-axis)***







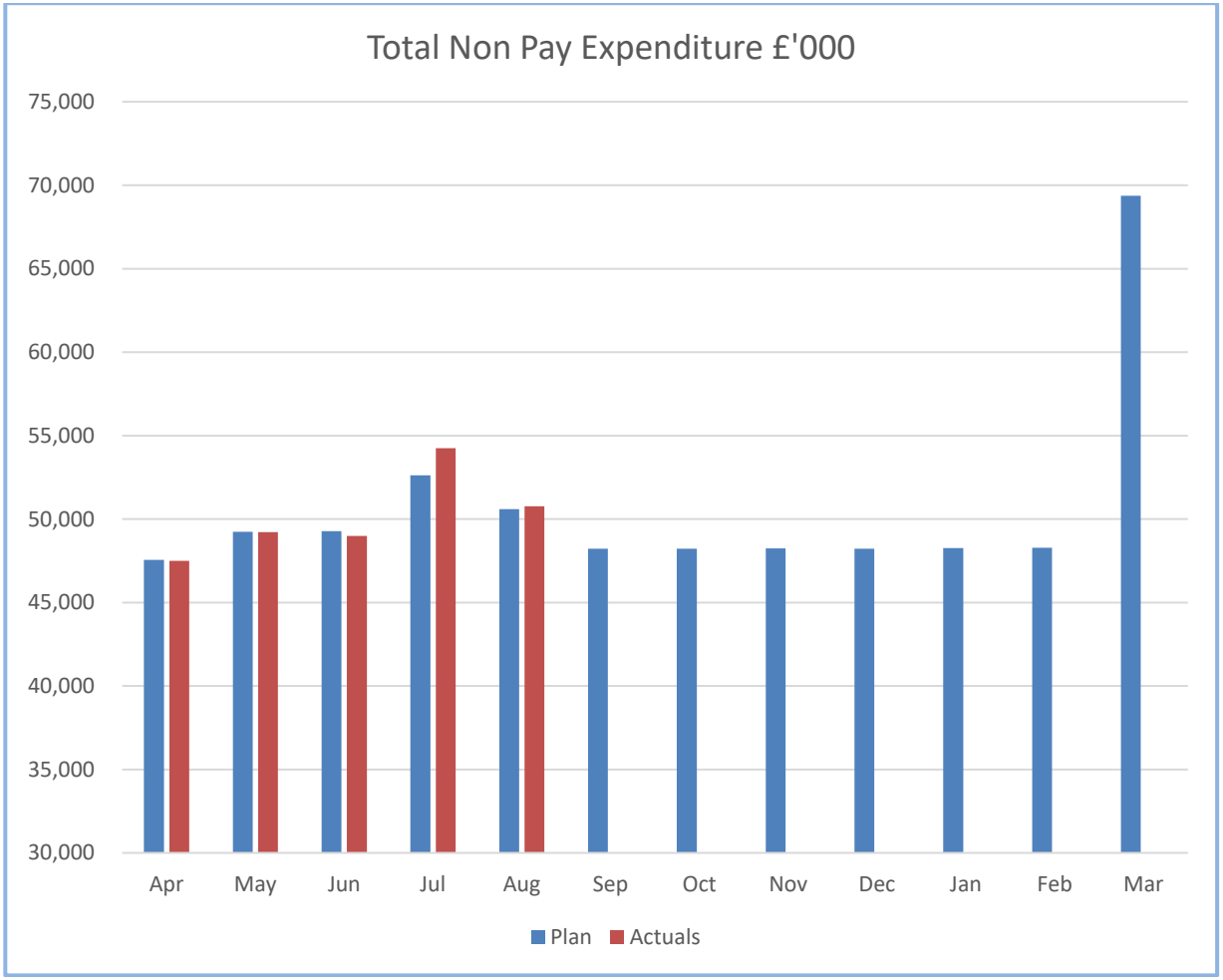
Key Issues

- The budget and spend in M1 included circa £70k for the non-consolidated lump sum payment.
- Expenditure in M5 fell by £197k.
- The M5 YTD overspend increased by £314k to £2.0m.
- M5 agency costs fell by £105k. This decrease was mainly a retrospective adjustment within unscheduled care (£59k), together with a reduction in POW delivery unit (£35k).
- M5 bank costs accounted for 29% of the total pay costs for ACS staff in Wards and A&E.

3.6 Non Pay Expenditure

Monthly Trends

The chart below shows the monthly trends of non pay expenditure and budgets: ***(Please note scale of Y-axis)***



Key Issues

- Non Pay Expenditure in M5 reduced significantly from £54.24m in M4 to £50.77m in M5, a decrease of over £3.47m.

- The M5 YTD overspend was £1,454k an increase of £170k on M5 (M5 £1,284k overspend).

- The increased budget for M12 mainly includes directorate based reserves for:
  - NICE/High cost drugs £5.3m
  - ICF Investment funding £5.2m
  - General Surgery - RTT Performance and investment funding £1.8m
  - POW Unit – RTT and Winter Funding £2.3m
  - Localities - Pooled fund & Growth for CHC £1.0m
  - Acute Medicine – RTT Funding £1.0m
  - R&D £1.0m

Performance by Expenditure Category

The table below shows the current month and year to date variances in respect of non-pay expenditure.

	Annual Budget £'000	Current Month Variance £'000	Year to Date Variance £'000	YTD Variance as % of YTD budget %
Primary Care & Contracts				
Primary Care Contracts	119,539	(210)	(616)	-1.22%
Primary Care Prescribing	86,182	22	33	0.09%
CHC & FNC	50,879	156	546	2.65%
Secondary Healthcare	6,226	14	(28)	-1.03%
Purchases of Healthcare Services	5,464	4	8	0.34%
Services from Other NHS Bodies	205,090	37	939	1.10%
Total Primary Care & Contracts	**473,379**	**23**	**882**	**0.45%**
Traditional Non Pay				
Secondary Care Drugs	30,345	(49)	472	3.03%
Clinical Supplies & Services	38,300	(180)	(73)	-0.46%
General Supplies & Services	6,642	(118)	29	1.04%
Establishment Expenses	11,136	213	378	7.86%
Contract Staffing & Consultancy	120	5	105	131.20%
Misc Services – Other	26,231	98	(801)	-20.87%
Premises & Fixed Plant	21,969	178	462	5.08%
Total Traditional Non Pay	**134,743**	**147**	**572**	**1.10%**
GRAND TOTAL	**608,122**	**170**	**1,454**	**0.58%**

Key Issues:

- The most significant overspends at M5 are in the following areas:
  - CHC/FNC £546k:
    - MH £615k
  - Secondary Care Drugs £472k:
    - Acute Medicine £230k
    - POW Medicine £79k
    - Head & Neck £70k
    - Mental Health £61k
  - Other NHS Bodies £939k
    - GMS OOH £654k
    - Welsh Blood £60k
    - NEPTS SLA £79k
    - Swansea Bay LTA £50k
    - Swansea Bay SLAs £106k
  - Premises & fixed Plant £462k
    - Office Furniture & equipment £253k
    - Furniture & Fittings £105k
  - Establishment Expenses £378k
    - Advertising £185k
    - Transport £142k

- The most significant underspends at M4 are in the following areas:
  - Primary Care £616k:
    - GMS - OOH £622k
  - Misc Services £801k:
    - Directorate based reserves £609k
    - Clinical Negligence £236k

Performance by Division

	Annual Budget	In Month			Year to Date
		Over/(Under) Spend			Over/(Under) Spend
		Last Month	Current Month	Change	Current Month
	£'000	£'000	£'000	£'000	£'000
Chief Operating Officer:					
Unscheduled Care	14,299	25	62	37	205
Planned Care	23,800	113	(266)	(379)	(117)
POW Delivery Unit	20,273	531	120	(411)	266
Clinical Support	18,084	30	89	59	335
Facilities	13,584	314	30	(284)	402
Total COO	**90,040**	**1,013**	**35**	**(978)**	**1,091**
PCMH:					
Primary & Community	130,081	206	(5)	(211)	107
Mental Health	34,074	150	219	69	587
Medicines Management	123,247	(59)	9	68	(58)
Total PCMH	**287,403**	**297**	**223**	**(74)**	**636**
Contracting & Commissioning	190,780	148	(221)	(369)	(156)
Corporate Functions	39,900	164	133	(31)	(117)
GRAND TOTAL	**608,122**	**1,622**	**170**	**(1,452)**	**1,454**

Key Issues:
The most significant overspends within the total Non Pay overspend of £1,454k are in the following areas:

- Facilities £402k:
  - Waste & Transport £274k
  - Trading Services £70k
- Mental Health £587k- Continuing Healthcare £615k but offset by positive income variance of £479k
- Clinical support £335k:
  - Pathology - M&S £72k and SLAs £180k.
  - Radiology- Reporting £95k & X-Ray Equipment Maintenance £69k

The most significant underspends are in the following areas:

- Contracting & Commissioning £156k- Non Contracted Activity £90k, Individual Patient Commissioning £65k

3.7 Income

Performance by Income Category

	Annual Budget £'000	Current Month Variance £'000	Year to Date Variance £'000	YTD Variance as % of YTD budget %
Income From Activities				
Dental Income	(6,043)	0	0	0.00%
Local Health Boards	(75,582)	18	420	1.32%
Other	(30,492)	51	(40)	-0.31%
Total Income from Activities	**(112,117)**	**68**	**379**	**0.80%**
Other Operating Income		0		
Accommodation & Catering	(3,792)	71	87	5.60%
Charitable & Other Contributions	(542)	4	15	5.78%
Education & Training	(15,593)	21	(98)	-1.53%
Laundry, Pathology & Payroll	(338)	(21)	(65)	-44.10%
Mortuary Fees	(299)	1	5	3.84%
Non Patient Care – Income Generation	(697)	(14)	(31)	-10.60%
Other Income	(4,942)	127	96	4.58%
Staff Payments for use of Cars	(284)	(0)	(2)	-1.98%
Total Other Operating Income	**(26,488)**	**190**	**7**	**0.06%**
GRAND TOTAL	**(138,605)**	**257**	**386**	**0.66%**

Key Issues

The most significant M5 YTD adverse variances relate to:

- Local Health Boards £420k:
  - Swansea Bay – CAMHS SLA £90k
  - C&VUHB - POW Surgical Services SLA £162k
  - C&VUHB Other SLAs £74k
  - POWYS SLA £35k
  - C&VUHB LTA £31k
  - Other SLA/LTAs £42k

Performance by Division

	Annual Budget	In Month			Year to Date
		Over/(Under) Spend			Over/(Under) Spend
		Last Month	Current Month	Change	Current Month
	£'000	£'000	£'000	£'000	£'000
Chief Operating Officer:					
Unscheduled Care	(343)	1	(0)	(1)	(20)
Planned Care	(1,596)	24	32	8	84
POW Delivery Unit	(7,316)	35	130	95	187
Clinical Support	(2,464)	32	21	(11)	29
Facilities	(4,227)	(36)	66	102	42
Total COO	**(15,947)**	**58**	**247**	**193**	**322**
PCMH:					
Primary Care, Children & Community	(15,682)	(56)	260	316	498
Mental Health	(2,608)	(83)	(124)	(41)	(445)
Medicines Management	(4,497)	5	(43)	(48)	(57)
Total PCMH	**(22,786)**	**(134)**	**95**	**228**	**(3)**
Contracting & Commissioning	(94,983)	214	(59)	(273)	246
Corporate Functions	(4,898)	(93)	(27)	66	(179)
GRAND TOTAL	**(138,613)**	**44**	**257**	**214**	**386**

Key Issues

The most significant overspends within the M5 YTD overspend of £386k are as follows:

- Primary Care, Children & Community £498k- Swansea Bay CAMHS £90k, C&V CAMHS £110k, WHSSC CAMHS £144k, Local Authority Income £68k, Community Dental Service £74k.
- Contracting & Commissioning £246k – Injury cost recovery scheme £119k and Non Contracted Activity £122k.
- POW Delivery Unit £187k – C&V Surgical Services SLA £162k

The most significant M5 YTD underspends are as follows:

- Mental Health £445k- S117 CHC income from Local Authorities £479k
- Corporate Functions £179k – PC&S Legal £61k, Income generation £45k.

3.8 Savings Plan Performance

	Annual Plan £'000	Variance Against Plan			
		Current Month £'000	Year to Date £'000	Forecast £'000	Recurrent Forecast £'000
Chief Operating Officer:					
Unscheduled Care	1,243	94	483	406	308
Planned Care	3,755	184	844	1,765	1,680
POW Delivery Unit	3,051	248	988	2,237	2,453
Clinical Support	894	51	276	589	591
Facilities	1,294	107	536	931	741
Total COO	**10,237**	**684**	**3,127**	**5,928**	**5,773**
PCMH:					
Primary & Community	2,218	125	709	1,070	1,304
Mental Health	2,477	(28)	250	(0)	879
Medicines Management	225	6	29	(5)	0
Total PCMH	**4,920**	**103**	**988**	**1,065**	**2,182**
Contracting & Commissioning	450	0	(37)	(300)	(300)
Corporate Functions	821	30	161	(31)	(17)
Total Delegated Budgets	**16,428**	**817**	**4,239**	**6,662**	**7,638**
CCT to be allocated to Directorates	600	50	250	600	600
Contingency against recurring savings targets	(7,028)	(585)	(2,928)	(7,028)	(5,228)
Total Non Delegated Budgets	**(6,428)**	**(535)**	**(2,678)**	**(6,428)**	**(4,628)**
GRAND TOTAL M5	**10,000**	**282**	**1,561**	**234**	**3,010**

Key Issues

- The Delegated savings target of £16.4m represents a M5 target of £6.8m. Only £2.6m of savings have been reported to M5 resulting in an adverse variance against plan of £4.2m. This variance reduces to £1.56m after allowing for the Savings contingency which is being released on a straight line basis.

- Forecast In year and recurrent savings as at M5 is £9.8m and £8.8m respectively, leaving a shortfall of £0.2m and £3m respectively.

3.9 Non Delegated Budgets

Non Delegated Budgets and Reserves M5	Current Budget	Year to Date Variance	Forecast In Year Variance	Forecast Recurrent Variance	Note
	£'000	£'000	£'000	£'000	
Non Delegated Budgets:					
Non Recurring Income & Accountancy	(4,500)	0	0	0	**A**
Savings Target to be allocated	(600)	0	600	600	**B**
Capital Charges	23,946	0	0	0	
Other Non Delegated Budgets	(1,961)	701	659	759	
Reserves and Contingencies					
Service Improvement - Transformation	9,594	0	0	0	**C**
Service & Demand Pressures - RTT	1,732	(90)	(216)	(216)	**D**
Savings Contingency	7,027	(2,928)	(7,027)	(5,227)	
Other Reserves & Contingencies	23,905	(6,129)	(15,209)	(13,324)	
TOTAL	**59,145**	**(8,537)**	**(21,193)**	**(17,408)**	

- **Note A – Non Recurring Income Target**
  The revised financial plan, increased the non-recurring income target for 2019/20 from £2.7m to £4.5m.

- **Note B – Savings Target to be allocated**
  The financial plan included a £0.6m savings target for Unscheduled care beds. This scheme is no longer anticipated to be delivered in 2019/20.

- **Note C - Service Improvement – Transformation**
  WG has approved the Regional transformational plan which includes £10.594m of non-recurring funding. The financial plan assumes that any slippage will be returned to WG as per the terms of the funding.

- **Note D - Service & Demand Pressures - RTT**
  The updated financial plan for 2019/20 included a budget of £4.15m to sustain RTT Performance, a further £7m of non-recurring funding has been provided by WG, to give a total plan of £11.15m in 2019/20. As at M5 £9.4m has been allocated to directorates leaving a balance of £1.7m. This includes a Reserve of £1.5m which is expected to be fully committed.

3.10 Welsh Government Allocations

The table below shows the Health Board's current Welsh Government allocation position:

	Annual Budget £'000	Healthcare & Hospital Services £'000	Community Pharmacy £'000	Dental £'000	General Medical Services £'000
Confirmed Allocations	1,005,836	884,778	26,990	19,308	74,760
Unconfirmed Allocations	16,311	13,562	304	1,102	1,343
TOTAL Allocations	**1,022,147**	**898,340**	**27,294**	**20,410**	**76,103**

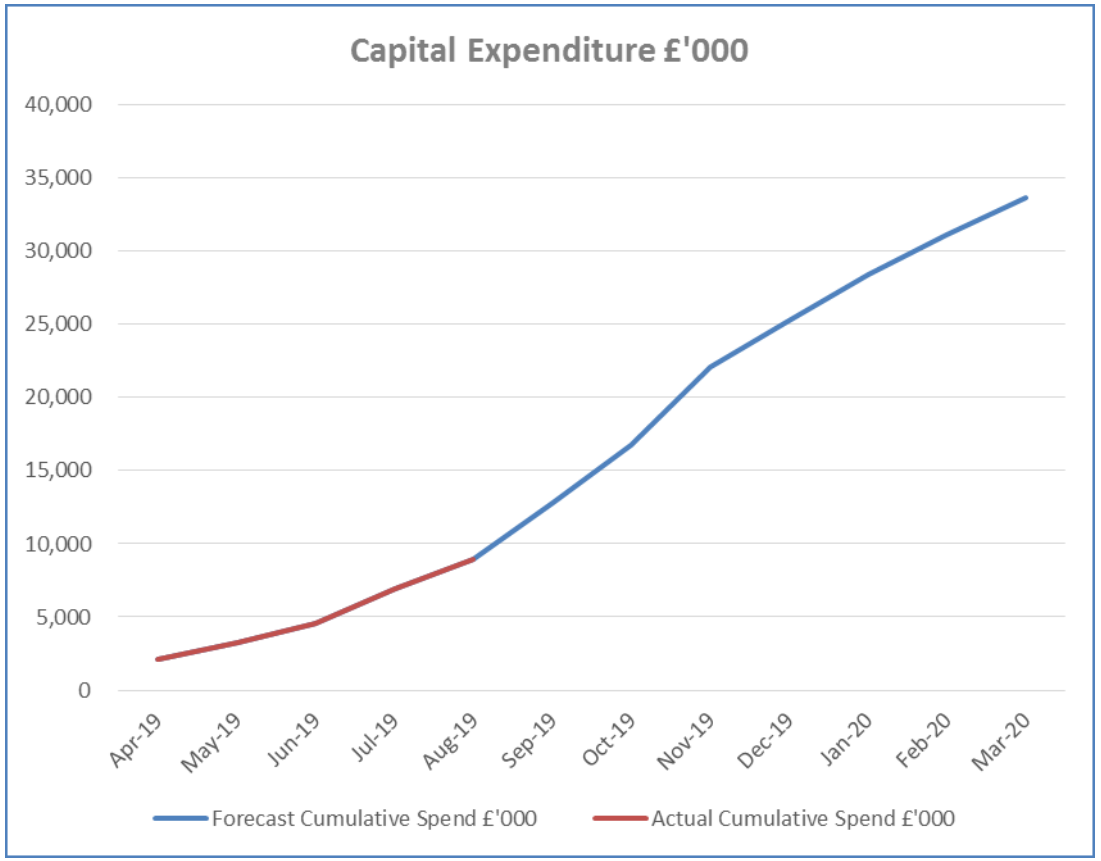
Key Issues

The most significant anticipated allocations include:

- Healthier Wales Transformation Funding - £10.6m
- Substance misuse - £3.4m
- GMS IM&T refresh- £1.3m
- Treatment fund - £1.3m
- ICF Dementia funding - £1.2m
- Dental VTs - £1.1m
- Targeted Intervention Support - £1.1m
- Unsocial Hours Sickness Enhancements - £0.85m
- Depreciation and Impairments – reduction of £5.4m

3.11 Performance against Capital Resource Limit

The actual cumulative capital spend and forecast cumulative capital spend is detailed in the graph below:

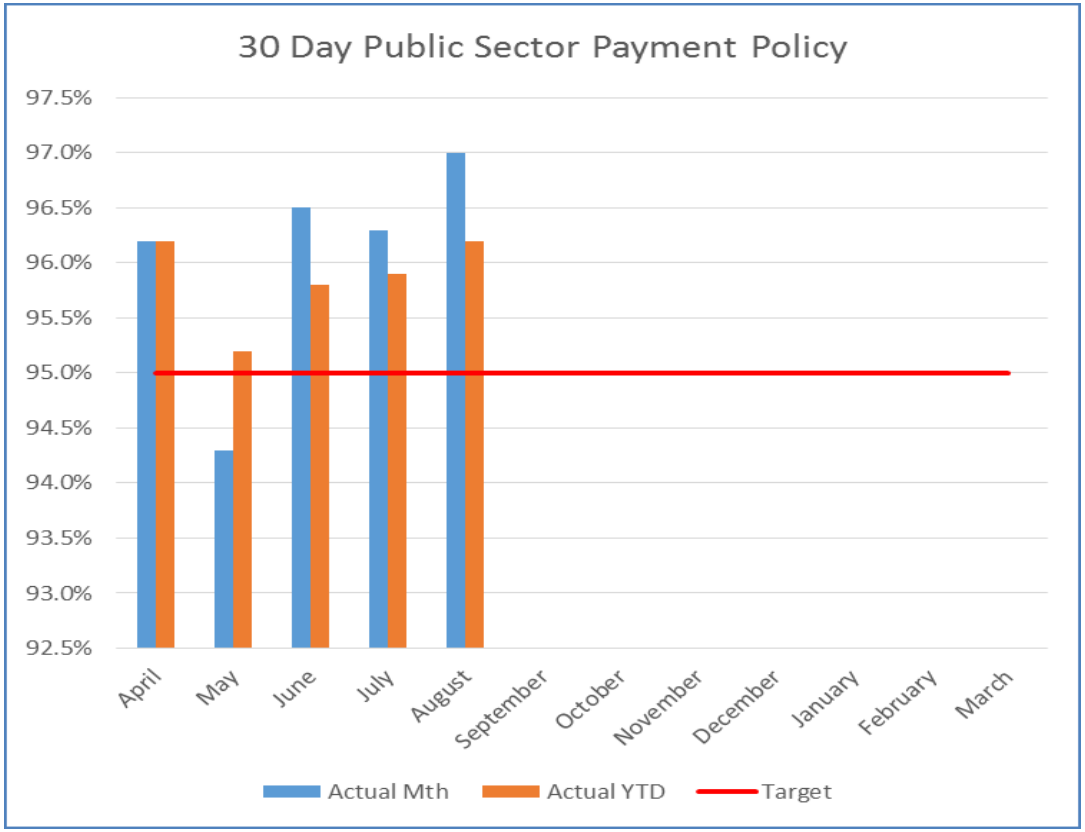


Key Issues

- The current Capital Resource Limit of £31.9m was issued on 30 April 2019, and remains unchanged.
- This is supplemented by £1.8m of donated funds, giving an overall programme of £33.7m.
- Expenditure to date is £8.9m.
- The current forecast capital position is an underspend of £0.170m. This relates to two All Wales Schemes (Tonypandy and PCH MRI Replacement) which have completed.

3.12 Public Sector Payment Performance

The Health Board's monthly performance against the 95% public sector payment target is detailed in the graph below:



Key Issues:

- In M5, 97.0% of the number of non NHS invoices were paid within 30 days.
- The M5 YTD position is 96.2%.
- The forecast position is to achieve the 95% target for the year.

3.13 Balance Sheet

The M5 balance sheet is detailed below.

Balance Sheet	Opening Balance (01/04/2019) £'000	Closing Balance as at M03 £'000	Forecast Closing Balance M12 £'000
Non Current Assets			
Property, Plant & Equipment	363,772	362,053	363,772
Intangible Assets	913	913	913
Trade and Other Receivables	38,734	38,734	38,734
Total Non-Current Assets	**403,419**	**401,700**	**403,419**
Current Assets			
Inventories	4,291	4,286	4,291
Trade and Other Receivables	84,183	113,716	84,183
Cash and Cash Equivalents	316	1,985	355
Total Current Assets	**88,790**	**119,987**	**88,829**
Current Liabilities			
Trade and Other Payables	96,500	119,257	96,539
Provisions	47,797	53,199	47,797
Total Current Liabilities	**144,297**	**172,456**	**144,336**
Non-Current Liabilities			
Trade and Other Payables	1,466	1,466	1,466
Provisions	43,372	43,372	43,372
Total Non-Current Liabilities	**44,838**	**44,838**	**44,838**
TOTAL ASSETS EMPLOYED	**303,074**	**304,393**	**303,074**
Financed By:			
General Fund	277,070	278,389	277,070
Revaluation Reserve	26,004	26,004	26,004
TOTAL	**303,074**	**304,393**	**303,074**

Key Issues

- The forecast closing balance does not reflect any changes relating to the Bridgend Transition, as assets and liabilities have not yet transferred.

3.14 Cash Flow

A cash flow forecast is detailed in the table below:

Cashflow Forecast	Actual/Forecast												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
Receipts													
WG Revenue Funding	67,704	85,194	72,197	83,749	102,291	71,900	82,055	97,785	86,645	86,290	87,245	86,991	1,010,046
WG Capital Funding	2,000	3,000	3,000	2,200	1,500	3,800	2,000	3,700	3,300	2,580	3,200	1,691	31,971
Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Welsh NHS Org'ns	9,272	9,248	9,161	11,509	9,052	10,950	9,000	10,200	9,000	10,200	9,000	10,200	116,792
Other	2,198	5,992	2,258	2,341	2,808	3,360	2,950	3,108	3,273	3,118	3,010	3,000	37,416
Total Receipts	**81,174**	**103,434**	**86,616**	**99,799**	**115,651**	**90,010**	**96,005**	**114,793**	**102,218**	**102,188**	**102,455**	**101,882**	**1,196,225**
Payments													
Primary Care Services	11,546	21,225	9,414	16,236	24,242	8,003	15,532	25,030	18,108	15,976	16,210	8,390	189,912
Salaries and Wages	32,265	40,778	40,809	41,186	41,284	41,880	41,580	42,080	42,550	42,080	42,580	50,550	499,622
Non Pay Expenditure	31,121	38,495	34,687	43,071	46,438	36,399	35,271	43,400	38,150	41,400	40,556	43,401	472,389
Capital Payments	3,724	1,693	78	3,058	1,947	3,800	3,200	3,700	3,300	2,580	3,200	1,691	31,971
Other (Donated asset funding)	302	282	24	760	340	75	108	273	118	10	0	0	2,292
Total Payments	**78,958**	**102,473**	**85,012**	**104,311**	**114,251**	**90,157**	**95,691**	**114,483**	**102,226**	**102,046**	**102,546**	**104,032**	**1,196,186**
Net Cash In/Out	2,216	961	1,604	(4,512)	1,400	(147)	314	310	(8)	142	(91)	(2,150)	
Balance B/F	316	2,532	3,493	5,097	585	1,985	1,838	2,152	2,462	2,454	2,596	2,505	
Balance C/F	2,532	3,493	5,097	585	1,985	1,838	2,152	2,462	2,454	2,596	2,505	355	

Key Issues

- As at the 31 August 2019 the cash balance was £1.985m.
- The forecast cash position is break-even.

4 RECOMMENDATION

The Health Board is asked to:

- **DISCUSS** the contents of the Month 5 Finance report for 2019/20.

Freedom of Information Status	Open

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.7** **26 September 2019**

University Health Board Report
THE PUBLIC SERVICES OMBUDSMAN WALES ANNUAL LETTER 2018/19

Executive Lead: Director of Nursing, Midwifery & Patient Care; Medical Director
Author: Ruth Friel, Head of Patient Experience
Contact Details for further information: Ruth.friel@Wales.nhs.uk . 01443 744819 EXT 24819

Purpose of the Health Board Report
The purpose of this report is to present to Board the Public Services Ombudsman Wales Annual Letter 2018/19, which was received in to the Health Board on the 7 August 2019 and to inform the Board of the two public interest cases referenced in the report as requested by the Chairman.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its Strategy outlined the 3 Year Integrated Medium Term Plan 2019- 2022 and the related organisational objectives aligned with the Institute of Healthcare Improvement's (IHI) 'Quadruple Aims' are being progressed, these in summary are; • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.
Supporting evidence	PSOW Annual Report, 2018-19 https://www.ombudsman.wales/wp-content/uploads/2019/07/Annual-Report-and-Accounts-2018-2019-Final-ENG.pdf Putting Things Right – raising concern about the NHS in Wales (2013). http://www.wales.nhs.uk/governance-emanual/putting-things-right

Engagement – Who has been involved in this work?							
The information within the report has been provided by the Concerns team.							
Health Board Resolution to:							
APPROVE		**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	The Health Board is asked to: • **NOTE** the report						
Summarise the Impact of the Health Board Report							
Equality and diversity	Concerns are managed within the framework of Putting Things Right, ensuring that all issues are dealt with equitably. There are no specific implications relating to equity and diversity within this report.						
Legal implications	Concerns are managed in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2013.						
Population Health	There are no population health implications of this report.						
Quality, Safety & Patient Experience	The experience summarised within this report reflect issues relating to quality of care, patient safety, and patient experience.						
Resources	The resource implications relate to ensuring the right resource is in place to provide a safe and effective service and for our population to have a positive experience of our services.						
Risks and Assurance	The data within this report reflect clinical and reputational risks. The Quality and Patient Safety Governance Framework is established to identify, mitigate and manage risk along with provide assurance.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported relates specifically to Standard 3.1 Safe and Clinically Effective Care, and Standard 6.3 Listening & Learning from Feedback.						
Workforce	There are no workforce implications associated with this report.						
Freedom of Information Status	Open.						

THE PUBLIC SERVICES OMBUDSMAN WALES ANNUAL LETTER 2018/19

1. SITUATION / PURPOSE OF REPORT

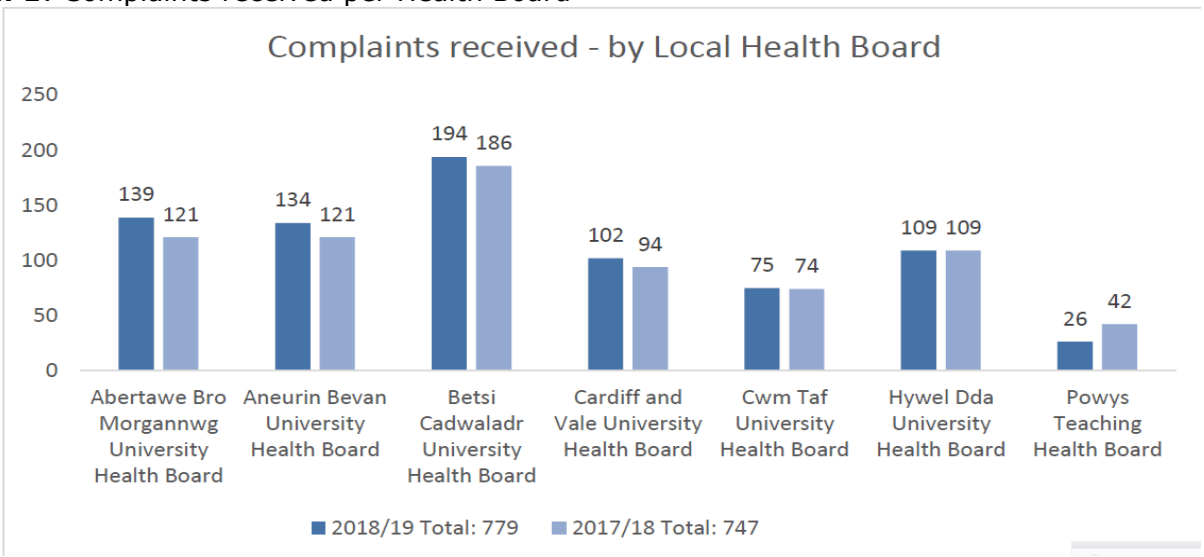
The purpose of this report is to present to Board the Public Services Ombudsman for Wales Annual Letter 2018/19 (**Appendix 1**), which was received in to the Health Board on the 7 August 2019 and to inform the Board of the two public interest cases referenced in the report as requested by the Chair.

2. BACKGROUND / INTRODUCTION

Concerns are managed in accordance with the All Wales Putting Things Right Guidance (2013), which requires organisations to thoroughly investigate concerns in a timely manner. The Health Board strives to respond in an open, transparent and comprehensive way to the person making the complaint within 30 working days.

All formal response letters provide details of how to make a complaint to the Public Services Ombudsman for Wales office (PSOW), should the response be unsatisfactory to the person making the complaint. Seventy five (75) complaints were made to the PSOW office during the last financial year, by people who were unsatisfied with the response provided to them. The graph below provides information on the number of Health Board complaints across Wales received by the PSOW office between April 2017 – March 2019.

Graph 1: Complaints received per Health Board



3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

The number of complaints received remained consistent with the previous year, with fewer cases requiring investigation by the PSOW office. Also, the number of cases requiring intervention reduced from 37% to 33%. However, of those cases which were investigated, a greater number were upheld (in whole or in part).

3.1 Public Interest Reports- Section 16

Of the 10 public interest healthcare-related reports issued related to NHS Wales, 2 related to care and treatment delivered by this Health Board. One related to delays in providing assessments related to Mental Health and autism spectrum disorder, and the other found serious shortcomings in the treatment of a patient whose bowel was perforated and suffered from sepsis. A summary of both are included in Appendix 2, with the full report available in the PSOW 2018-19 annual report.

3.2 Changes to the Role of the Public Services Ombudsman (Wales) (PSOW)

The Board are advised of the introduction of the Public Services Ombudsman (Wales) Act 2019, this enables increased reach for the PSOW including:

- Improving access to the PSOW office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing the PSOW to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in Welsh public services

4. RECOMMENDATION

The Health Board is requested to:

- **NOTE** the report.

Freedom of Information Status	Open.

Appendix 2

Summary of the Section 16 Reports received into the Health Board between April 2018 and 31 March 2019

Section 16 Response issued on 18 June 2018
SUMMARY Ms X complained about the care and treatment provided to her late brother, Mr Y, during two admissions to Prince Charles Hospital ("the Hospital") in April 2015. Ms X complained about whether it had been clinically appropriate to discharge Mr Y following his first admission. Ms X was also concerned about the care provided to Mr Y during his second hospital admission and whether any action could have been taken to prevent Mr Y's bowel from perforating and sepsis developing, from which Mr Y sadly did not recover. The Ombudsman found that the decision to discharge Mr Y following his first admission was reasonable and did not uphold this element of the complaint. During Mr Y's second hospital admission, the Ombudsman found that there were a number of shortcomings in the care and treatment provided which fell well below reasonable standards. The response to Mr Y's deterioration was highly unsatisfactory and sepsis should have been recognised and treated earlier. A severe complication of colitis (dilation of the colon) was not identified promptly which led to the perforation of Mr Y's colon and critical illness. This was a significant failing and clearly Mr Y should have undergone surgery sooner. The Ombudsman found that the delay significantly increased the likelihood of a poor outcome. The shortcomings in the identification and treatment of sepsis also increased the risk to Mr Y. The Health Board agreed with the Ombudsman's finding that Mr Y should have undergone surgery sooner which would have increased the chance of a more positive outcome for Mr Y. The Ombudsman upheld these complaints. An action plan has been developed and the PSOW confirmed the Health Board's compliance with the report's recommendations on 14 February 2019.

Section 16 Response issued on 18 October 2018
SUMMARY Mrs A complained that the Health Board delayed in providing her son, Mr B, with appropriate and timely mental health and autism spectrum disorder ("ASD") assessments. She also complained about the Health Board's failure to provide her with a robust response to her complaints. In 2015, a Crisis Team assessed Mr B's psychiatric and psychological needs and referred him for both ASD and mental health assessments. The PSOW investigation found that the Health Board's practice of referring patients for ASD assessment prior to a referral for a mental health assessment was contrary to guidance and good clinical practice. In Mr B's case, his ASD assessment was not completed until May 2017. During this time, the Health Board failed to take any action to either consider, or provide for, Mr B's mental ill health. It was therefore two years before his mental health needs were assessed. The Health Board's care fell below expected standards, good clinical practice and guidelines in terms of its lengthy delay in completing Mr B's ASD assessment, its failure to consider Mr B's co-existing mental health needs, and its failure to refer Mr B for a mental health assessment at the same time as his ASD referral. It was not possible to determine whether Mr B's situation would have been different had the Health Board's failings not occurred, but it caused him uncertainty and distress. His human rights under Article 8 were engaged as a consequence of the Health Board's identified failings. When the first Community Mental Health Team ("CMHT") finally assessed Mr B's mental health needs, it concluded that Mr B should be accepted for secondary mental health services. Mr B changed address soon after this assessment and had to be assessed by the second CMHT. This concluded that Mr B was not eligible for secondary mental health services. The investigation was unable to reconcile the differing decisions of the two CMHTs within the same Health Board and only six weeks apart. The Health Board's complaints response failed to address some of Mrs A's specific concerns. The Ombudsman upheld Mrs A's complaints and made recommendations which were accepted by the Health Board. The report and action plan has been shared with the relevant staff and also shared nationally at the all Wales mental health Serious Incident Review committee. An action plan has been developed and the Health Board is currently awaiting the PSOW’s response in relation to its compliance with the report’s recommendations.

Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Our ref: NB

Ask for: Communications

01656 641150

Date: 7 August 2019

communications
@ombudsman-wales.org.uk

Professor Marcus Longley
Chair of the Board
Cwm Taf Morgannwg University Health Board

By Email Only
marcus.longley@wales.nhs.uk

Dear Professor Longley

Annual Letter 2018/19

I am pleased to provide you with the Annual letter (2018/19) for Cwm Taf University Health Board. This year I am publishing my Annual Letters as part of my Annual Report and Accounts. I hope the Board finds this helpful and I trust this will enable it to review its own complaint handling performance in the context of other public bodies performing similar functions across Wales.

The number of complaints received which related to the Health Board remained consistent and fewer cases required investigation by my office. Also, I am pleased that the number of cases requiring intervention by my office reduced from 37% to 33%. However, of those cases which were investigated, a greater number were upheld (in whole or in part). Furthermore, of the ten public interest healthcare-related reports I issued, two related to care and treatment delivered by your Health Board. The two cases raised serious concerns; one related to delays in providing mental health and autism spectrum disorder assessments, and the other case found serious shortcomings in the treatment of a patient whose bowel perforated and who developed sepsis – care which fell well below reasonable standards. I will be following up on the recommendations I made in these reports this year.

The Public Services Ombudsman (Wales) Act 2019 has now been introduced. I am delighted that the Assembly has approved this legislation giving the office new powers aimed at:

- Improving access to my office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing me to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

I am very much looking forward to implementing these new powers over the coming year.

Action for the Health Board to take:

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance
- Reflect upon the findings in the Public Interest reports I have issued and positively act upon my recommendations to improve services
- Continue to reduce the number of cases which require intervention by my office
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **31 October 2019**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely

Nick Bennett
Public Services Ombudsman for Wales

CC: Dr Sharon Hopkins, Interim Chief Executive
Claire Adams, Contact Officer

Factsheet

A. Complaints Received and Investigated with Health Board average adjusted for population distribution

Health Board	Complaints Received	Average	Complaints Investigated	Average
Cwm Taf University Health Board 2018/19	75	74	22	18
Cwm Taf University Health Board 2017/18	74	71	32	25
Abertawe Bro Morgannwg University Health Board	139	132	35	32
Aneurin Bevan University Health Board	134	146	38	36
Betsi Cadwaladr University Health Board	194	173	44	42
Cardiff and Vale University Health Board	102	123	28	30
Hywel Dda University Health Board	109	96	20	23
Powys Teaching Health Board	26	33	3	8

B. Complaints Received by Subject with Health Board average

Cwm Taf University Health Board	Complaints Received	Average
Health - Complaint Handling	3	12
Health - Appointments/admissions/discharge and transfer procedures	1	4
Health - Clinical treatment in hospital	54	70
Health - Clinical treatment outside hospital	5	8
Health - Continuing care	5	4
Health - Medical records/standards of record-keeping	2	1
Health - Other	4	5
Various Other - Rudeness/inconsideration behaviour/staff attitude	1	0

C. Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution / voluntary settlement	Discontinued	Other Reports - Not Upheld	Other Reports - Upheld in whole or in part	Public Interest Reports	Grand Total
2018/19									
Cwm Taf University Health Board	12	10	20	9	2	11	16	2	82
Health Board average (adjusted)	12	9	19	15	1	6	15	1	78
2017/18									
Cwm Taf University Health Board	11	5	16	10	-	9	13	1	65
Health Board average (adjusted)	11	7	17	11	-	5	10	-	62

D. Number of cases with PSOW intervention

Health Board	No. of complaints with PSOW intervention	Total number of closed complaints	% intervention
Cwm Taf University Health Board 2018/19	27	82	33%
Cwm Taf University Health Board 2017/18	24	65	37%
Abertawe Bro Morgannwg University Health Board	54	139	39%
Aneurin Bevan University Health Board	49	128	38%
Betsi Cadwaladr University Health Board	86	210	41%
Cardiff and Vale University Health Board	37	107	35%
Hywel Dda University Health Board	48	115	42%
Powys Teaching Health Board	10	17	59%
Powys Teaching Health Board – All-Wales Continuing Health Care cases	7	16	44%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received and investigated by my office during 2018/19, with the Health Board average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2018/19 with the Health Board average for the same period. The figures are broken down into subject categories.

Section C compares the complaint outcomes for the Health Board during 2018/19, with the average outcome (adjusted for population distribution) during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section D provides the numbers and percentages of cases received by my office in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 4.8** **26 September 2019**

University Health Board Report
ORGANISATIONAL RISK REGISTER

Executive Lead: Director of Governance / Board Secretary
Author: Head of Corporate Services
Contact Details for further information: Gwenan.roberts@wales.nhs.uk

Purpose of the University Health Board Report	
The purpose of this report is for the Health Board Members to review and discuss the organisational risk register and consider whether the assessed and recorded risks are appropriately assigned across the Committees of the Board. The Organisational Risk Register was last considered by the Health Board in July 2019 and by the Quality Safety and Risk Committee and Management Board in June 2019.	
Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2019-2022, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience. • To **protect** and **improve** population health. • To **ensure** that the services provided are accessible and sustainable into the future. • To **provide** strong governance and assurance. • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report aims to provide strong governance and assurance.
Supporting evidence	• There are a number of assessments that help inform the content of the organisational risk register. • The content of this report is informed by the University Health Board's (UHB) Risk Management Strategy.
Engagement – Who has been involved in this work?	
The information contained within this report has been developed following engagement with senior staff and Executive Directors.	

University Health Board Resolution to:							
APPROVE		**ENDORSE**	√	**DISCUSS**	√	**NOTE**	√
Recommendation	The Health Board is asked to: • **DISCUSS** and **NOTE** the update provided within this report and the risks assigned to the Board and its Committees						
Summarise the Impact of the Health Board Report							
Equality and diversity	There are no identified equality & diversity implications.						
Legal implications	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.						
Population Health	No specific impact.						
Quality, Safety & Patient Experience	Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in the UHB.						
Resources	The risks outlined within this report have resource implications which are being addressed by the respective Executive Director leads and taken into consideration as part of the Board's IMTP processes.						
Risks and Assurance	This report and the organisational risk register is an integral element of the Board's risk and assurance arrangements. It should be noted that this work continues to develop.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework. This report focuses mainly on Governance & Accountability but also spans many of the 7 quality themes.						
Workforce	Failure to capture, assess and mitigate risks can impact adversely on the workforce.						
Freedom of Information status	Open						

ORGANISATIONAL RISK REGISTER

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is for the Health Board Members to review and discuss the organisational risk register and consider whether the assessed and recorded risks are appropriately assigned across the Committees of the Board. This version of the Organisational Risk Register was last considered by the Health Board in July 2019 and by the Quality, Safety and Risk Committee and the Executive Board in June 2019.

Members will be aware that a session on risk appetite, risk management and the connection to the Board Assurance Framework took place at the Board Development session on 29 August 2019. At the July meeting Members **NOTED** the changes required to the risk register in terms of the bigger organisational footprint at CTMUHB. Other suggested amendments at the meeting in July have not yet been actioned and will inform the Executive Team in the development of the next iteration of the risk register.

Whilst the cover report summarizes the detail, the supporting appendices provide more detail.

2. BACKGROUND / INTRODUCTION

In light of the decision by the Welsh Government to escalate the organisation into Special Measures for Maternity Services and Targeted Intervention for the wider organisation, made by the Minister, there was an urgent need for a Board Development session on risk appetite and the CTMUHB's risk register development in order to ensure the Board and its Committees are focusing on the right key areas of business. One of the actions from the development session was the agreement that the Board would receive the risk register at every public meeting.

The organisational risk register summarises the key 'live' extreme risks facing the Health Board and the actions being taken to mitigate them. The Health Board manages risk through its Directorate structures and in close alignment with the Board's 'approved' Assurance Framework. The Assurance Framework will also be updated in line with the work on the risk register and will report into the Audit Committee for periodical review, monitoring and scrutiny and also features (at least annually) on the agenda of the Board.

The organisational Risk Register was formerly reported quarterly to the Executive (now Management) Board and routinely to the Quality, Safety & Risk Committee of the Board, for information and where appropriate, scrutiny of any assigned risks.

Members will also be aware that the Chair, in discussion with the Independent Members has agreed that the responsibility for the organisational risk register will move from the Quality, Safety and Risk Committee to the Audit Committee. Work is underway by the team in Corporate Services to amend the respective Committee Terms of Reference to reflect these changes and will be presented to the Board for approval at a future meeting. Members should also **NOTE** that Model Standing Orders have recently been received from the Welsh Government, they will be presented at the November meeting of the Board which will include the changes planned for different Committees of the Board.

It is also important to **NOTE** that the Executives, as risk owners, are appropriately sighted and involved in the development of the organisational risk register, providing updates, including reports on mitigating actions. The organisational risk register will be reviewed and where appropriate updated on a monthly basis by the Executive lead as required. All organisational risks have a lead Executive Director and the risk assigned to either the Board, or as appropriate, a Committee of the Board to ensure appropriate review, scrutiny and where relevant updating.

Each Director is responsible for the ownership of the risk(s) and the reporting of the actions in place to manage/control and/or mitigate the risks.

3. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

Overall analysis

The organisational risk register currently includes 37 Extreme / High risks which are categorised into the following groupings:

Categories / Risk Rating	Extreme (rated 15 -25)	High (rated 8-12)
Setting the direction and performance and operational efficiency	**5**	**3**
To improve quality, safety and patient experience	**10**	**1**
Statutory Compliance	**7**	**3**
Finance (including claims)	**1**	**1**
Workforce / Organisational Development / Innovation	**0**	**1**
Business continuity	**2**	**1**
Total Risks	**25 (-2)**	**10 (+2)**

High / Extreme Risks (Specifically those rated 20 and above)

In considering the robustness of a developing organisational risk register, Board Members need to consider whether the top recorded risks are those that Members of the Board can relate to and indeed evidence that they are informing the work of the Board and its Committees in delivering its related Strategy.

The **highest rated risks** outlined within the Organisation's risk register are:

- **Risk of poor quality unsafe services providing unsatisfactory patient experience and unable to de-escalate to meet the expectations and scrutiny of the Welsh Government and regulators leading to increased levels of escalation. This risk has been reworded as follows "Poor quality unsafe services providing unsatisfactory patient experience which if not adequately addressed will continue to effect escalation status."**
- **Failure to recruit sufficient numbers of medical & dental staff and its related impact on rotas and finance going forward (also aligned with South Wales Programme outcome)**
- **Reduction in medical staff training posts**
- **Failure to recruit sufficient numbers of registered nursing and midwifery staff**
- **Increasing dependency on agency staff to cover registered nursing, midwifery and medical staff gaps**
- **Fire Safety compliance and ongoing issues with Prince Charles Hospital site (Ground & First Floor)**
- **Lack of control and capacity to accommodate all hospital follow up outpatient appointments**
- **Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.**
- **Achieving financial break even on a recurring basis.**
- **Under Reporting of Clinical Incidents in Maternity Services.**
- **Failure to continue to provide GP out of hours services as currently configured.**

Of the categorised risks, these have been broken down as:

Score	How many
25	1
20	10
16	10
15	4
12	10

There are currently 35 Extreme / High risks, contained within the organisational risk register. Members will note, following the Board Development session of the need to consider further risk based issues that have the potential, if not managed and mitigated appropriately, to impact adversely on the quality and safety of the services we provide.

Risk Register Category – Business Objectives / Projects (8 risks)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Setting the Direction and Performance and Operational Efficiency	028	Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.	20 (was 16)	20	⇧	⇨	July 2019	Health Board
	015	Reputational damage & potential legal challenge on the decision making on Funded Nursing Care (FNC).	20	12	⇩	⇨	July 2019	Health Board
	036	Primary Care Workforce - Recruitment and sustainability	20	16	⇨	⇨	July 2019	Primary & Community Care
	030	Failure to continue to provide and sustain GP Out of Hours Services as currently configured.	20	20	⇨	⇨	July 2019	Primary & Community Care
	002	Failure to achieve Referral to Treatment targets.	12	16 (was 12)	⇧	⇧	July 2019	Finance, Performance & Workforce
	003	Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	12	16	⇩	⇧	July 2019	Finance, Performance & Workforce
	013	Implementation of South Wales Programme outcomes.	12	12	⇨	⇨	July 2019	Health Board
	023	Failure to meet the timescale relating to issuing concerns (complaints) responses to patients and/or carers.	20	12	⇩	⇧	July 2019	Quality, Safety & Risk

The Trend column indicates whether the risk overall (from when first assessed), is increasing (↑), reducing (↓) or unchanged (→).

The Controls column indicates whether assessed controls overall are improved (↑), reduced (↓) or unchanged (→) from when first assessed. Regardless of whether the risks rating has changed.

Risk Register Category - Impact on Safety (11 risks)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
To improve quality, safety and patient experience.	007	Failure to recruit sufficient medical & dental staff.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	034	Increasing dependency on Agency Staff cover in Medical and Nursing areas, which has the potential to impact on continuity of care and patient safety and is actually impacting on the UHB financial position.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	035	Failure to recruit sufficient registered nursing and midwifery staff.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	008	Reduction in medical training posts within various specialties & capacity to meet workload demands.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	027	Lack of control and capacity to accommodate all hospital follow up outpatient appointments.	20	20 (was 16)	⇨	⇧	July 2019	Finance, Performance & Workforce
	032	Sustainability of a safe & effective Ophthalmology Service.	20	16	⇩	⇨	July 2019	Quality, Safety & Risk
	005	Failure to sustain services as currently configured to meet cancer targets.	20	16	⇩	⇧	July 2019	Finance, Performance & Workforce
	033	Failure to sustain Child & Adolescent Mental Health Services across the Network	20	16	⇨	⇧	July 2019	Quality, Safety & Risk
	037	Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery	12	12	⇨	⇧	July 2019	Health Board
	(043)	Under Reporting of Clinical Incidents in Maternity Services	20	20	⇨	⇨	July 2019	Quality, Safety & Risk

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
	(46)	Risk of poor quality unsafe services providing unsatisfactory patient experience and unable to de-escalate to meet the expectations and scrutiny of the Welsh Government and regulators leading to increased levels of escalation	25	25	N/A		July 2019	Health Board

Risk Register Category – Statutory Duty / Inspections (10)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Statutory Compliance	017	Failure to meet Fire Safety Standards on ground and first floor PCH.	20	20	⇨	⇨	July 2019	Quality, Safety & Risk
	021	Failure to ensure all Staff obtain competency/ compliance with mandatory training requirements.	20	16	⇨	⇧	July 2019	Quality, Safety & Risk
	025	Failure to meet Fire Safety Standards across CTMUHB.	20	16	⇨	⇨	July 2019	Quality, Safety & Risk
	018	Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	15	15	⇨	⇨	July 2019	Quality, Safety & Risk
	031	Failure to appropriately apply Deprivation of Liberties Safeguards (DoLS) legislation following the West Cheshire court judgement.	16 (was 12)	12	⇩	⇧	July 2019	Quality, Safety & Risk
	016	Failure to comply fully with the arrangements for managing Asbestos	16	12	⇩	⇧	July 2019	Quality, Safety & Risk

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
	039	Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	16	16	⇨	⇧	July 2019	Quality, Safety & Risk
	040	Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	⇨	⇨	July 2019	Quality, Safety & Risk
	041	Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.	16	12	⇩	⇧	July 2019	Quality, Safety & Risk
	042	Failure to ensure successful implementation of the Welsh Government's decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	15	15	⇨	⇧	July 2019	Health Board (Joint Transition Board)

Risk Register Category – Finance / Including Claims (2)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Financial Viability	011	Failure to achieve financial balance on a recurring basis and mitigate reliance on in year non recurring funding slippage.	15	20	⇧	⇨	July 2019	Health Board
	012	Failure to Deliver Major & Discretionary Capital programmes	12	12	⇨	⇨	July 2019	Capital Programme Board

Risk Register Category – Human Resources / Organisational Development / Staff Competency (1)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Workforce Sustainability/ OD and Innovation	019	Failure to achieve the Management of Absence target.	20	12	⇨	⇧	July 2019	Finance, Performance & Workforce

Risk Register Category – Service / Business Interruption (3)

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Business Continuity	006	Failure to appropriately manage Discharge Delays from Hospitals	20	12 (Was 16)	⇩	⇧	July 2019	Finance, Performance & Workforce
Business Continuity Information Technology Systems	044	Risk of information technology failures following national outage during 2018 and cyber security risk which could lead to loss of information or information governance issues	15	15	⇨	⇨	July 2019	Management Board
Business Continuity Brexit	045	Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	16	16	⇨	⇨	July 2019	Management Board

Quality, safety and patient experience
The Health Board's risk management arrangements are in place to ensure risks are assessed and mitigating actions taken to improve the quality, safety and experience of patients and where appropriate escalation arrangements are in place to inform the Board via its key Committees. Further work will be undertaken on the Board Assurance Framework in line with the Structured Assessment Recommendations.

Use of resources
There is a significant risk to the service if robust risk based assessment arrangements are not in place. Good governance arrangements, including effective risk management help to ensure the effective use of resources. It is important to note that routinely as part of the Internal Audit and Assurance Annual Plan, 3 clinical and 1 corporate directorates undergo a governance review each year, which includes a review of its risk management arrangements. This is in addition to the organizational related audit reviews.

Compliance with Legislation
There may be an adverse effect on the organization if arrangements are not in place to manage and mitigate risks.

Performance
Assessment and monitoring of risks within the Health Board is undertaken within Directorates/Localities/Departments. The extreme / high organizational risks will be monitored by the Executive Team / Board and be reviewed and scrutinized by the Board and/or its Committees.

As a general rule the organisational risk register will be routinely reviewed by the Audit Committee and elements discussed at the Integrated Governance Committee, although all Committees of the Board have a role to play in ensuring risks assigned to a Board Committee are considered as part of its work. Risk management arrangements will also be a key element of internal audit work and key risks will help to inform the annual internal audit plan.

4. RECOMMENDATION

The Health Board is asked to:

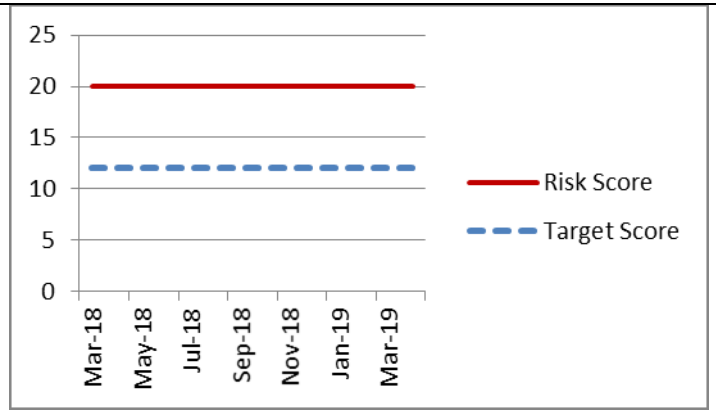
- **DISCUSS** and **NOTE** the update provided within this report and the risks assigned to the Board and its Committees

Freedom of Information	Open

HEALTH BOARD ORGANISATIONAL RISK REGISTER
SUMMARY OF ASSESSED RISKS (OVERALL TREND) – JULY 2019

Impact/Consequence	1	2	3	4	5
5			042 Bridgend Boundary change 044 'New' Loss of IT due to system outages	017 Failure to meet Fire Safety Standards on Ground & First Floor Prince Charles Hospital ↔ 011 Failure to achieve financial balance ↑ 007 Failure to recruit Medical & Dental Staff ↔ 043 Possible under reporting of clinical incidents in maternity services	046 Enhanced monitoring
4			037 Ensuring the development, approval and implementation of a Strategy for Digital Health, that is clinically led and supports staff in care delivery ↔ 016 Management of asbestos ↓ 012 Failure to deliver major and discretionary capital programmes ↔ 006 Discharge delays from acute hospitals ↔ 013 South Wales Plan outcomes ↔ 023 Deterioration in the timescale relating to issuing concerns (complaints) responses to patients and or carers ↔	032 Sustainability of safe & effective Ophthalmology Services ↓ 005 Failure to sustain services as currently configured to meet cancer targets ↓ 033 Sustaining CAMH Services ↔ 036 Primary Care workforce – recruitment & sustainability ↔ 025 Failure to meet Fire Safety standards across the UHB ↔ 015 Reputational damage & potential legal challenge (FNC) ↓ 021 Staff competency – compliance with statutory/mandatory training ↓ 041 Human Tissue Act compliance mortuary / deceased services 045 Brexit 003 Failure to achieve 4 & 12 hour Emergency access targets. ↔ 039 Ensuring Sufficient Health Records Storage 002 Failure to achieve RTT ↑	028 Producing Viable balanced 3 year IMTP ↑ 034 Increasing dependency on agency staffing (medical & nursing) finance impact↔ 035 Failure to recruit registered nursing sand midwifery taff ↔ 008 Reduction in medical training posts within various specialities & capacity to meet workload ↔ 027 Lack of control & capacity to accommodate Follow Up Outpatients↔ 030 Continuing to provide GP Out of Hours Services as currently configured ↔
3				019 Failure to achieve the management of absence target ↑ 031 Failure to appropriately apply DOLS legislation following West Cheshire court judgement ↓	018 Failure to achieve statutory and mandatory planned preventative maintenance programme ↔ 040 Compliance with Welsh Language Standards
2					
1					
C x L	1	2	3	4	5
	Likelihood				

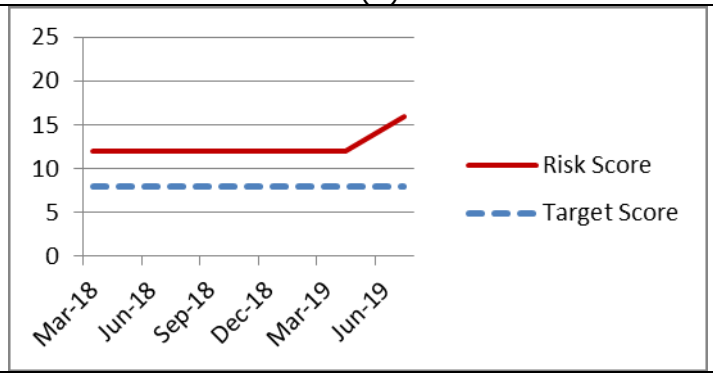
Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Finance **Assuring Committee:** Health Board
Risk: Failure to ensure delivery of a viable balanced/break even 3 year integrated medium term plan.	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** Approved IMTP last 5 years; Monthly monitoring arrangements in place. Breakeven forecast for 19/20 but increased risk due to poor savings performance and Bridgend transfer risks - and underlying recurring financial deficit now planned before taking account of these risks. Internal audit IMTP - reasonable assurance received. **Rationale for target score:** There are a number of uncertainties to support the creation and then delivery of a viable 3 year plan. These include uncertainty around resource allocation; cost pressures over a 3 year period; delivery of recurring savings; innovative solutions to developing and enabling delivery of a plan.
Level of Control =70%		
Date added to the risk register April 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Starting refresh and update of saving delivery and monitoring arrangements • Health Board has sought(with SBUHB) WG arbitration on the Bridgend transfer funding arrangements • Routine monitoring arrangements in place. • Quarterly reports to Board; Monthly reports to Management Board; Finance, Performance & Workforce Committee and routinely to Board. • Separate specific reporting on savings to FP&W going forward • Monitoring returns routinely submitted to Welsh Government and reported to FP&W.	Action	Lead	Deadline
	Strengthened planning process in place that continues to evolve and develop based on experience and learning.	Director of Planning	Ongoing
	Reporting and escalation arrangements for in year planning and delivery is being strengthened	Director of Finance	Ongoing
	WG arbitration on Bridgend transfer financing	Director of Finance	Outcome still awaited from WG

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Efficiency, Productivity and Value Board is in place for executive review and challenge, and its role being re-considered as part of refresh referred to above	Seeking earned autonomy with Welsh Government to use funding allocation more flexibly.

Current Risk Rating	**Additional Comments**	**Ref No. 028**
Current Risk Rating : 5 x 4 = 20	Approved IMTP status for 5 consecutive years up to and including 2018-21. Financial risks could be consolidated / merged - Bridgend position to be clarified	

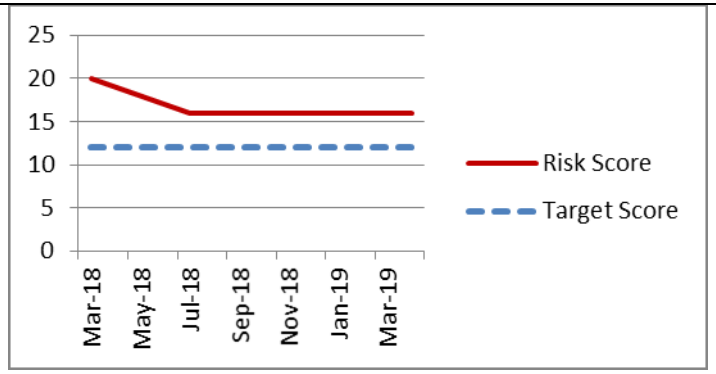
Objective: **Setting the Direction & Performance & Operational Delivery**		**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve Referral to Treatment Times (0)		**Date last reviewed:** July 2019
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 2 = 8 **Level of Control** =50% **Date added to risk register** April 2013		**Rationale for current score:** The current score reflects year end out turn and the significant progress made during 2018-19 to address the large volume of patients awaiting planned treatment. However, working with the Delivery Unit to identify additional patients for lists including neurophysiology, nephrology and specialised paediatrics. **Rationale for target score:** Effective D&C Plans with improved efficiency in flow, length of stay and assessment, and some improvement in theatre performance informs the target score of 8.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Directorate Demand & Capacity Plans in place (and being further developed) with regular RTT meetings in place • Ongoing Flow Programme to address capacity issues • Improved capacity for Day Surgery and 23:59 case load • Monthly and Quarterly monitoring of trajectories, routinely discussed within CBMs • Routine reporting into Finance, Performance & Workforce Committee • Surgical Assessment facilities now available on both District General Hospital sites. • WG has released £7m against a £8.7m resource plan for restoring our trajectory. • Several workshops held to address HNRC tax and pension issues which have significantly eroded consultant sessional availability for ADH and WLI.	Action	Lead	Deadline
	Continue delivery of the controls in place	Ops Directors	Ongoing
	Ensure winter plans to address and respond to surge in demand are effective and support continued delivery of RTT	Ops Directors	Quarter 2
	Develop, implement and monitor Directorate Demand & Capacity Plans	Ops Directors	Ongoing quarterly

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Waiting list reductions; better response times from departments / compliance figures will improve.	F,P&W monitoring progress. Further work required in light of the establishment of CTMUHB. Working with the DU to analyse all waiting times

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	The plan last year (and this), was to sustain RTT position and deliver against the target without (or with limited) external outsourcing. However, this has not been possible and additional outsourcing utilised.	**002**

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve the 4 and 12 hour emergency (A&E) waiting times targets.	**Date last reviewed:** July 2019

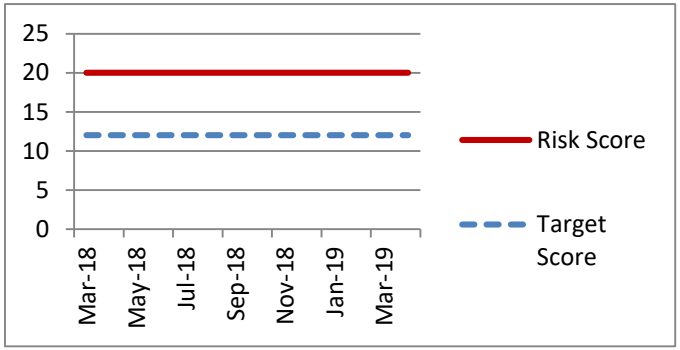
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12		**Rationale for current score:** The 4 hour 90% target is not currently being achieved. RGH performance is almost back to last year's high performance, PoW has 4&12 hour performance and handover challenges and PCH has 4&12 hour performance challenges. However, concerns raised at PCH and working with the Delivery Unit for improvement **Rationale for target score:** To meet the emergency access targets set by Welsh Government is dependent on the patient flow and therefore a target of 12 is challenging for the unscheduled care service (USC).
Level of Control =70%		
Date added to risk register April 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Need to strengthen minors streams at both DGH sites to sustain improved delivery of performance against the 4, 8 and 12 hour targets. Also variable practice across both A&E departments. Additional minors physical capacity at RGH has impacted positively, with variable performance. • Deterioration in PCH performance is being addressed by a DU supportive intervention – full analysis and options appraisal for improvement intiated. • PoW handover performance receiving full review for EASC/CASC team. • PoW/RGH/PCH providing full Safety and Dignity analysis to September QSR committee. • Programme of improvement work with AM&ED, HR and Retinue teams to improve medical booking and staffing to raise shift fill. • Consultant and middle grade gaps in RGH now filled or due to be filled with long term locum or substantive appointments.	Action	Lead	Deadline
	1) Clear discharge planning processes in place.	COO	Ongoing
	2) Improvements in the patient flow and investments to support seasonal planning.	Dep COO	Ongoing
	3) Stay Well At Home (SW@H) Service introduced and evaluated (6 month). Transformation funding not to follow.	Dep COO	Ongoing
	4) SW@H 2 developments being progressed	COO	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Monthly reporting of 4, 8 and 12 hour performance within the Integrated Performance Dashboard.	None identified although reliant on the recruitment and retention of appropriate workforce and general improvement in flow across USC.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Recruitment and retention of staff essential; closure of beds in the operational environment challenging when the numbers of patients continues to rise.	**003**

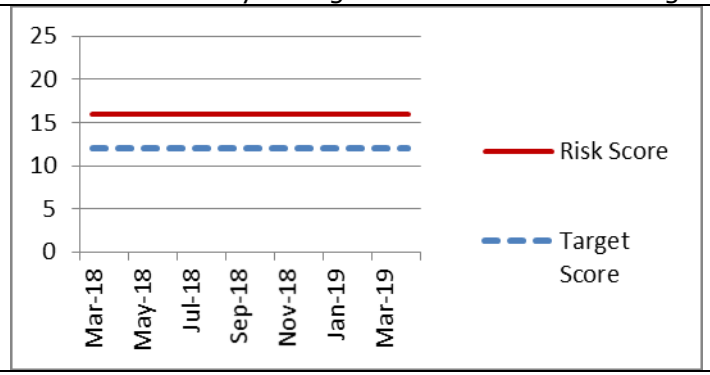
Objective: **To improve quality, safety and patient experience**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Lack of control and capacity to accommodate all hospital follow up outpatient appointments	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current:5 x 4 = 20 Target: 4 x 3 = 12 **Level of Control** =60% **Date added to the risk register** November 2014		**Rationale for current score:** Follow up appointments not booked increasing; concern raised by Board Members, discussed at Audit Committee, Finance Performance & Workforce Committee and Quality, Safety and Risk Committee. Improvement actions not reducing the large numbers of patients awaiting follow up clinic review. **Rationale for target score:** Agreed actions approved by Management Board, being implemented and routine monitoring in place, with regular reports to Committees which is being aligned with the Performance Dashboard.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Continued monitoring of progress at Quality Delivery Meetings with WG. Initial progress with reductions in some specialities but need to change the current operating model, with actions to address the validated position to be progressed at pace across directorates. • Exploring patient safety implications for some categories of follow ups not booked for consideration by the Management Board and at Q,S&R Committee where further audit related action is being undertaken. • Continued improvement against trajectories in specialties. Surgery the first to achieve a 0 FUNB position. • Outsourcing of 6, 500 Ophthalmology cases has now brought us to c.15k patients on the list, reducing to 13.5k. • WG has asked us to put forward a financial bid for balancing the outpatients position to 0 – bid is in the order of £1.5m to deliver 0 position by March 2021.	Action	Lead	Deadline
	1) Scoping exercise undertaken – small investment agreed at Exec Board, will require more	COO / DPC&MH	Ongoing
	2) Actions by speciality agreed, the outcome from which will help D&C planning.	COO / DPC&MH	Ongoing
	3) Service redesign proposals developed by speciality, to be implemented linked to D&C Plans.	COO / DPC&MH	In Progress
	4) Action plans with agreed timescales established, although insufficient capacity. Further resources now released and bid made to WG to achieve balance in outpatients.	COO / DPC&MH	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Good progress made. Still further work needed to address and reduce volume. Further WAO review did not provide assurance of national progress, but CTM the best position in Wales achieved at 7/19.	Need to better understand any safety implications for follow ups not booked and patients waiting past clinic review dates.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 4 = 20	D&C plans not sufficient – not enough capacity; additional resources required; reporting to Committees	**027**

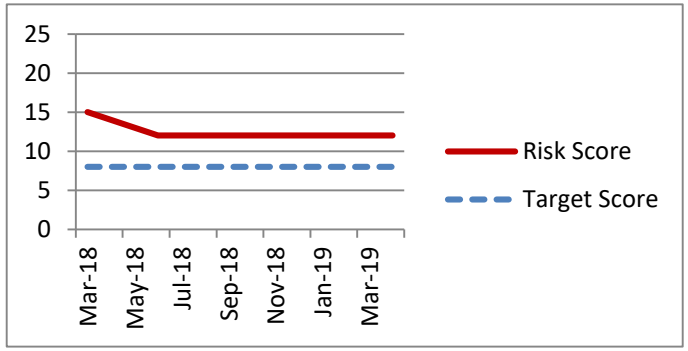
Objective: **To improve quality, safety and patient experience**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to sustain services as currently configured to meet cancer targets	**Date last reviewed:** July 2019
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12 **Level of Control** =70% **Date added to the risk register** April 2014		**Rationale for current score:** An overall reducing trend in current risk assessed score. Whilst target not consistently being met, general improvement trajectory which needs to be sustained. **Rationale for target score:** Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Tight management processes to manage each individual case on the unscheduled care (USC) Pathway. • Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Overall Cancer target performance plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee. • Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target. • Under capacity in radiology led to 4 breaches in current cycle and C&V EBUS also had 4 breaches. Locum maternity cover in radiology now signed off to rectify slip in performance.	Action	Lead	Deadline
	Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced.	COO / DPC&MH Med Dir	ongoing
	Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	COO / DPC&MH Med Dir	Ongoing
	Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	COO / Med Dir	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance (What additional assurances should we seek?)**
General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored. Urology and Radiology remain under constant review.	The need to deliver sustained performance.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Single Cancer Pathway will start to report in September.	**005**

Objective: **Workforce Sustainability/Organisational Development and Innovation**	**Director Lead:** Director of Workforce & OD **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to achieve the Management of Absence target	**Date last reviewed:** July 2019

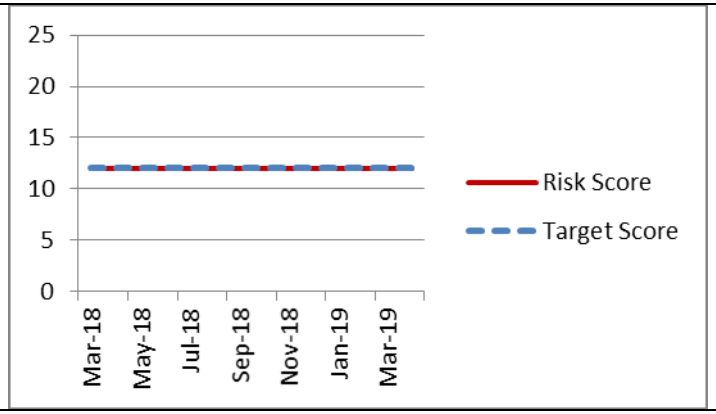
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 2 = 8 **Level of Control** =80% **Date added to risk register** April 2012		**Rationale for current score:** Overall there is a small improvement in trend across the UHB and the overall risk score aligns to the improvement trajectory and strengthened controls in place. **Rationale for target score:** Failure to achieve the Management of Absence target (although greater risk is the impact absence is having on patient safety / care, workforce and associated cover costs) Target is 5%

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
The Workforce Team, through the business partner model are continuing to work proactively with Directorates to manage and reduce sickness absence rates. Regular training is also provided by the Team, including; • Identification of hot spot areas and deep dives undertaken; • Improving the processes around access and timeliness of Occ Health support (Joint consultant appointment with neighbouring Health Board); • Sickness audits in place and routinely discussed at CBMs; • Improving availability via ESR of real time data; • Presentation (including deep dives) on position and actions made to Management Board, WIPF and Finance, Performance & Workforce Committee; • All Wales Sickness Policy adopted and being applied across the UHB.	Action	Lead	Deadline
	Maintain existing controls and ensure consistent application by Line Managers of the All Wales Policy / Procedures.	JD All Directors	Ongoing with monitoring
	Regular review and assessment of sickness management to take place routinely at CBMs.	JD All Directors	Ongoing with monitoring
	Continue the business partner model to support directorates to proactively manage sickness absence.	JD	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Some small reductions in overall sickness levels achieved. Need to continue to monitor improvement and sustain actions.	Need to maintain improvement actions and continue to reinforce the role of line management in consistently applying the Policy / Procedure.

Current Risk Rating	**Additional Comments**	**Ref No. 019**
Current Risk Rating : 4 x 3 = 12		

Objective: **Business Continuity**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Finance, Performance & Workforce
Risk: Failure to appropriately manage Discharge Delays from Hospitals	**Date last reviewed:** July 2019

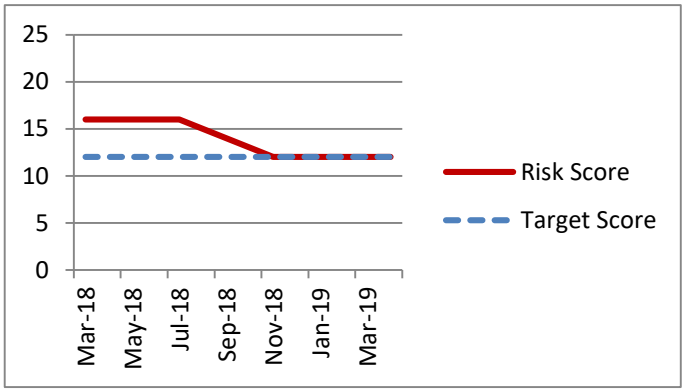
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 3 =12		**Rationale for current score:** The current score reflects the overall improvement in reductions in DTOCs with a number of related initiatives established to reduce, in partnership with Local Authority colleagues. **Rationale for target score:** The target score reflects the requirement to reduce the numbers of patients delayed, whilst the impact can be significant for patients whose discharge is delayed, for them individually and for those awaiting admission.
Level of Control =70%		
Date added to the risk register April 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Grouping of complex discharges; Implementation of Anticipated Date of Discharge (ADD), significant improvements following focus on flow work. • Working with Local Authority partners within the consortium to develop a partnership response. • General staff awareness being raised with regards the court ruling and its related impact. • Deprivation of Liberties Safeguarding (DoLS) strengthened to support assessment and discharge. Prioritisation process in place for DoLs applications and training for all disciplines.	Action	Lead	Deadline
	Ensure robust monitoring arrangements are maintained and actions in place to mitigate flow barriers and escalate impact on flow	COO / DPC&MH	Ongoing
	Maintain Flow improvement work and ensure all enablers (including planned benefits) to reduce dependency on hospital and appropriately support patients in their own communities are realised.	COO / DPC&MH	Ongoing
	Winter planning work also monitoring DToC position	COO / DPC&MH	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
The overall reduced trend in numbers, provides assurance that the improvement actions are having a positive effect.	As there is seasonal volatility in DTOCs, important still to monitor our position routinely.

Current Risk Rating	**Additional Comments**	**Ref No. 006**
Current Risk Rating : 4 x 3 = 12	Maintain monitoring and joint working with Partners	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Health Board
Risk: Reputational damage and potential legal challenge on the decision making on funded nursing care (FNC).	**Date last reviewed:** July 2019

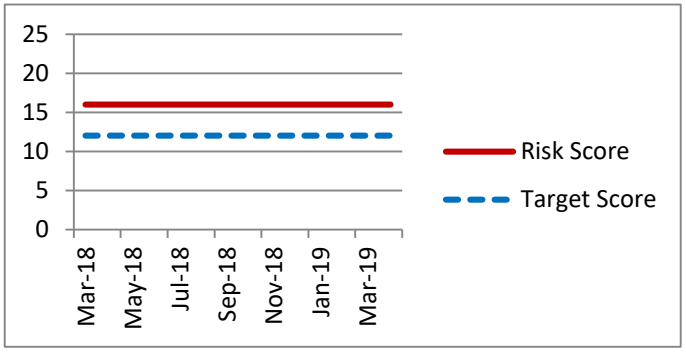
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 3 =12 **Level of Control** =70% **Date added to the risk register** November 2014		**Rationale for current score:** The risk rating has been maintained as although the Supreme Court of Appeal has made the ruling, the impact of this is still being worked through and potential for further challenge not fully mitigated. **Rationale for target score:** The score identifies the potential reputational damage to the NHS as a consequence of a successful legal challenge on the decision making on Funded Nursing Care and the potential financial impact specifically on Cwm Taf.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Contribute to the national outcomes framework. • National Procurement system to be established for continence pads. • Ongoing updates as required being provided to Board. • Note Legal advice procured across all Welsh HBs, to support NHS Wales in JR Process. It should be noted that the JR had initially been considered in February 2015 and the judge had ruled against the NHS. • A subsequent appeal was won by Health which resulted in Supreme Court Appeal which ruled that all parties need to renegotiate arrangements.	Action	Lead	Deadline
	Board approved rates last 2 years	-	Complete
	Further update to be considered by Boards following outcome of legal process.	DofN	Complete
	Outcome of Supreme Court Appeal ruling considered and acted upon.	DofN	Complete

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Continue to work in partnership with the sector, local authorities and WG to apply the outcome of the legal rulings.	

Current Risk Rating	**Additional Comments**	**Ref No. 015**
Current Risk Rating : 4 x 3 = 12	Risk requires further review for removal from the Register.	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Primary, Community and Mental Health (DPCMH) **Assuring Committee:** Primary and Community Care Committee
Risk: Primary Care Workforce – recruitment and sustainability	**Date last reviewed:** July 2019

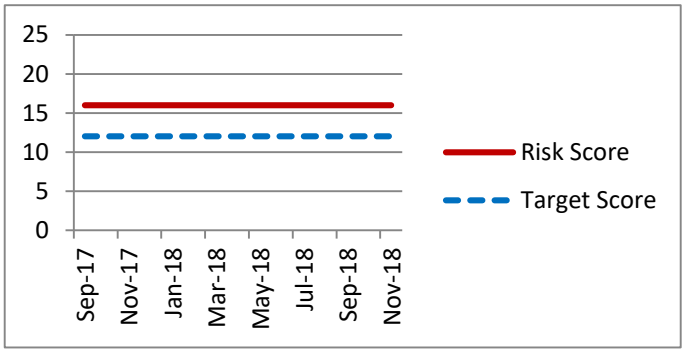
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 =12		**Rationale for current score:** An increasing number of practices across the UHB are advertising for GP sessions currently due to (and other staff groups) vacancies. **Rationale for target score:** Recruitment to Primary Care for GPs and some other professional groups across Cwm Taf UHB remains challenging (reflecting a National problem).
Level of Control =60%		
Date added to the risk register August 2016		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Where possible the Primary Care Team is working with the practices to find solutions, which include practice mergers; considering where possible directly managing solutions and/or working to recruit on behalf of the practices. • Primary and Community Care Committee in place to scrutinise delivery of the IMTP. • Local and National recruitment campaigns progressed, with some reported success.	Action	Lead	Deadline
	Development of the Cluster arrangements maturing, working with Primary Care and localities to develop solutions;	DPCMH	Ongoing
	The UHB has been successful following submission of bids against non recurring Primary Care monies;	DPCMH	Complete
	The Board has developed its Strategy for Primary Care aligned with its Integrated 3 Year Plan and National guidance. This includes milestones for addressing some of the related reported risks.	DPCMH	Ongoing milestones being monitored

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Recruitment and retention data.	

Current Risk Rating	**Additional Comments**	**Ref No. 036**
Current Risk Rating : 4 x 4 = 16	We are working closely with the Welsh Government on the recruitment of staff – Train, Work, Live campaign	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Primary, Community and Mental Health (DPCMH) **Assuring Committee:** Primary and Community Care Committee
Risk: Failure to continue to provide GP out of hours services as currently configured	**Date last reviewed:** July 2019

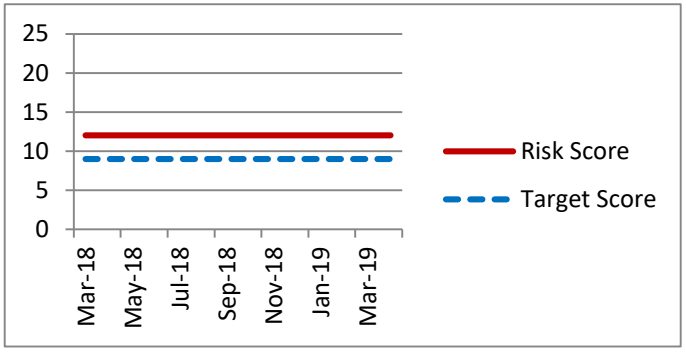
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** The Out of Hours team is encouraging GPs to fill shifts. However, many sessions are filled via Locum Agency Doctors, which is expensive and flexible sessions are offered. However, the fill rate remains variable and is challenging to maintain services. The effect of the HMRC tax implications is now having an impact. **Rationale for target score:** There are ongoing and developing Primary Care recruitment problems (reflecting a National problem). It is becoming increasingly difficult to secure GP sessions for the GP Out of Hours Service and many sessions especially on the weekend remain unfilled putting additional demand on both existing A&E departments.
Level of Control =60%		
Date added to the risk register November 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• OOHs services reconfigured and number of centres reduced from 4 to 2 in order to sustain services. An evaluation update considered by the Board in July 2016, agreed to continue with the current service which is scrutinized and monitored by the Primary and community Care Committee. • There continues to be ongoing engagement and discussions with those practitioners currently supporting the revised model. • There continues to be engagement with key stakeholders including the Community Health Council, GPs and patients. • Further options are being considered in order to address ongoing sustainability issues with the current service configuration	Action	Lead	Deadline
	The out of hours team continuing to work with GPs and other primary care staff, in a flexible way for the best shift fill rates.	DPCMH	Ongoing
	All Wales approach being progressed to mitigate variability of approaches across NHS Wales Health Boards	Directors of W&OD/ Directors of PC&MH	Ongoing (2017/18)
	Regular dialogue with OOHs service and Primary Care Clusters to ensure OOHs cover is strengthened and supported.	DPCMH	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Shift fill rates; patient experience surveys	The current service model is not sustainable and alternative solutions are required.

Current Risk Rating	**Additional Comments**	**Ref No. 030**
Current Risk Rating : 5 x 4 = 20	Lack of an All Wales Approach results in HBs competing with each other on GP sessional pay rates.	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Health Board
Risk: Failure to implement South Wales Plan outcomes.	**Date last reviewed:** July 2019

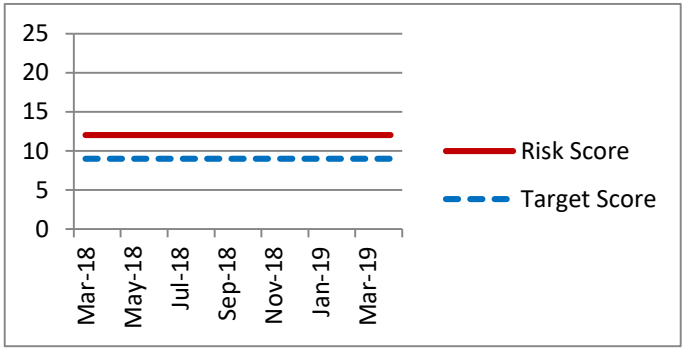
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 =12 Target: 3 x 3 =9		**Rationale for current score:** The issues around reciprocity and working with other health boards continues **Rationale for target score:** The Implications of implementing the South Wales Plan outcomes was a considerable challenge and posed risks to the organisation in terms of reputation and the changes required for service provision including location.
Level of Control =60%		
Date added to the risk register February 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Collaborative working arrangements in place, across Regions • Health Board involved and being kept updated. • Issues related to shared risks and interdependencies on others to deliver. • Diagnostic hub completed and opened. • Regional Planning & Delivery Forum established to oversee related work. • Obstetric service moved from RGH to PCH in March 2019. • Move of inpatient paediatric service from RGH to PCH– awaiting confirmation of date from the PON Board.	Action	Lead	Deadline
	Capital Scheme to be completed and implementation plan enacted	COO	Qtr 3 & 4 2018/19
	Awaiting confirmation date for the move of the inpatients paediatric date from RGH to PCH	COO	Qtr 2/3

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Planned capital work to support the change of service provision completed	

Current Risk Rating	**Additional Comments**	**Ref No. 013**
Current Risk Rating : 4 x 3 = 12	The Cabinet Secretary is seeking more pace in terms of working across boundaries with reciprocity at the centre	

Objective: **Setting the Direction & Performance & Operational Delivery**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Management Board
Risk: Failure to meet the timescale relating to issuing concerns (complaints) responses to patients and or carers	**Date last reviewed:** July 2019

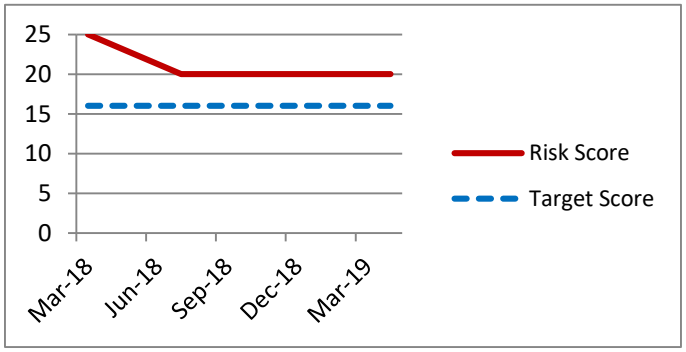
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 3 x 3 =9		**Rationale for current score:** Whilst position is slowly improving, there remains an ongoing capacity issue to meet the demand and expectations being placed. **Rationale for target score:** Putting Things Right provides the Welsh Government's guidance to the time that the NHS should respond to any concerns raised and following the publication of the Evans Report internal actions have been identified within Cwm Taf to meet the requirements.
Level of Control =60%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Actions have been taken to ensure a reduction in the backlog of outstanding concerns in delivering the action plan (internal response to the Evans report). • Actions are being taken, coordinated by the Director of Nursing, supported by other Executive Director colleagues, to ensure concerns responses for the less complex complaints are not unnecessarily delayed. • Whilst responses to complex complaints are known at the outset that these will be delayed, this is also communicated to those raising concerns; • Variable performance improvement to above 60% compliance, although sustaining this remains challenging.	Action	Lead	Deadline
	Progress continues to be monitored via the Concerns Scrutiny Panel and onwards to the Quality Safety and Risk Committee.	Nurse Director	Ongoing
	Improvement plans, developed with Directorates, following Internal Audit Limited Assurance review is making progress in some areas and whilst performance overall has improved slightly, more needs to be done for sustained improvement delivery.	Director of Nursing Lead Officers	Ongoing Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Improved performance in answering concerns within the timescales	Improved progression of responding to concerns within the timescale

Current Risk Rating	**Additional Comments**	**Ref No. 023**
Current Risk Rating : 4 x 3 = 12	Will require further review in light of establishment of CTMUHB.	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Medical Director **Assuring Committee:** Management Board
Risk: Failure to recruit sufficient medical and dental staff	**Date last reviewed:** July 2019

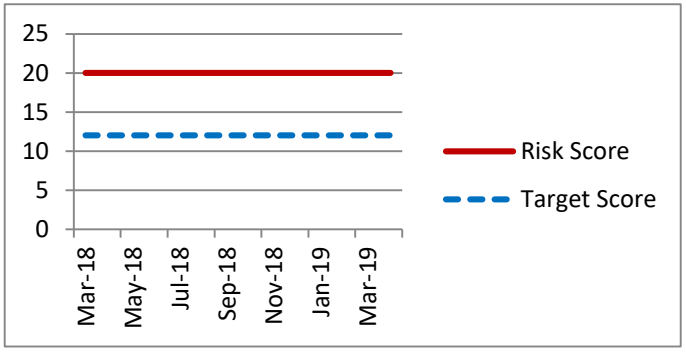
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 4 =16		**Rationale for current score:** The agency costs for medical staff has risen annually and the lead in time to develop our own staff or provide different support by alternate practitioners etc takes time to implement. **Rationale for target score:** There are ongoing recruitment problems (reflecting a National problem). Changes led by the Wales Deanery have also featured in discussions around the South Wales Plan and the ability for Cwm Taf to continue services as configured on all sites.
Level of Control =50%		
Date added to the risk register August 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Linked with IMTP, modernise the workforce to support clinical service redesign and align the development of the clinical services strategy. • Continue to review and develop workforce plans, including role redesign to mitigate the requirements of the SWP implementation and reduce dependency on the reducing medical workforce. • Continue to develop and implement new roles to support clinical practice. • Recruit known clinicians to the UHB who have previously undertaken locum work. • Resort to Agency cover, with strict vetting of CVs by the Directorates, with any concerns fed back to the Agency. Implement all Wales Agency Cap. • Exploring joint appointments within Regional footprints (where appropriate). • Consultants are supported by Nurse Practitioners/ Surgical Care Practitioner and Associate Specialists. • Developing other supporting roles in the therapy and health science staff groups.	Action	Lead	Deadline
	Continue to Work with WG to maximise Train Work Live	Medical Director	Ongoing
	Maximise the lessons from the Rhondda Docs website and use of social media including the development of short videos of current medical staff aiming to recruit new colleagues – highlighting that Cwm Taf is a great place to work and live	Medical Director	Ongoing
	There are ongoing discussions between all HBs and the Deanery regarding the trainee rota. This is subject to ongoing review and separate risk assessments - Contingency plans in place for Paeds, developing plans for other key specialities.	Medical Director	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reduction of medical agency costs	Impact of locum workforce on safe standards for patient care

Current Risk Rating	**Additional Comments**	**Ref No. 007**
Current Risk Rating : 5 x 4 = 20	National problem being discussed at the highest level. Cwm Taf supported WG to launch Train, Work, Live.	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Medical and Nurse Directors **Assuring Committee:** Quality, Safety & Risk Committee
Risk: Increasing dependency on Agency Staff cover in Medical and Nursing areas, which has the potential to impact on continuity of care and patient safety and is actually impacting on the UHB financial position.	**Date last reviewed:** July 2019

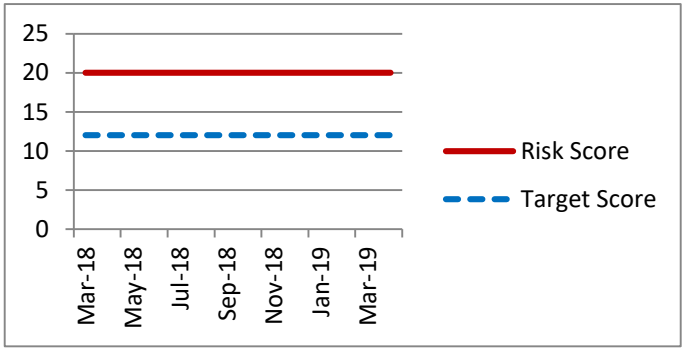
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** The agency costs for medical and nursing staff has risen annually and the lead in time to develop our own staff or provide different support by alternate practitioners etc takes time to implement. Agency and bank costs are at their highest now. **Rationale for target score:** Increasing dependency on Agency Staff cover in Medical and Nursing areas, has the potential to impact on continuity of care and patient safety and will impact on the UHB financial position.
Level of Control =60%		
Date added to the risk register June 2015		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Ongoing advertisements of posts in medical and nursing. • Proactive recruitment programme in place in areas where dependency on agency locum cover is increasing. • Maintain strict vetting of CVs (Agency medical staff) by the Directorates, with any concerns fed back to the Agency. • Wherever possible, use long term locum staff. • For nursing, maximise opportunities to recruit graduate nurse students for each of the twice annual cohorts. • Review all arrangements for payments to existing staff to make the best use of the resources available, maintain strong controls on the use of bank and agency staff, including stopping any off contract high agency shifts • Adjust bed complement/configuration and skill mix to ensure safe staffing levels are maintained.	Action	Lead	Deadline
	Continue with the campaigns to recruit medical and nursing staff – including using social media to have the widest impact across the UK and internationally.	Medical and Nurse Directors	Ongoing
	Continue to work with other HBs nationally to avoid increases in agency costs and influence the reduction of off contract spend	Medical and Nurse Directors	Ongoing
	Continue with strong controls in place to monitor all demand and approval for agency requests.	Medical and Nurse Directors	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reduction in bank, locum and agency costs	

Current Risk Rating	**Additional Comments**	**Ref No. 034**
Current Risk Rating : 4 x 5 = 20	Launched Nurse and Medical recruitment campaigns in Cwm Taf with Welsh Government	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Nursing, Midwifery and Patient Services **Assuring Committee:** Management Board, Quality Safety and Risk Committee
Risk: Failure to recruit sufficient registered nursing and midwifery staff.	**Date last reviewed:** July 2019

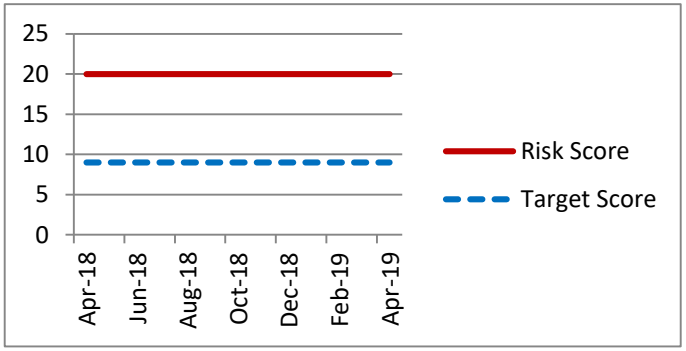
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** The ability to recruit registered nursing and midwifery staff remains a considerable challenge (reflecting the national problem). Unable to achieve the Nurse Staffing Act (Wales) – identified areas non-compliant **Rationale for target score:** There are ongoing recruitment problems (reflecting a National problem) for nursing and midwifery which will impact on the patient experience and patient safety.
Level of Control =60%		
Date added to risk register January 2016		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Continuous advertisements for nursing and midwifery posts in Cwm Taf • Proactive recruitment programme in place in areas where dependency on agency locum cover is increasing. • Maximise opportunities to recruit graduate nurse students for each of the twice annual cohorts. • Review arrangements for nursing and midwifery enhanced hours payments, including the targeting of A4C overtime payments in areas where Agency staff usage is excessive or increasing. In addition, validation by Heads of Nursing of need for use of agency nurses, including not using off contract. • Adjust bed complement/configuration and skill mix to ensure Nurse staffing levels are recorded and reviewed. • Develop the health care support workers role to support registered nurses and ensure safe and effective care for patients in Cwm taf	Action	Lead	Deadline
	Continue with the nursing recruitment campaign making particular use of the social media aspect to influence potential staff across the UK and beyond	Director of Nursing	Ongoing
	Work nationally with other HBs and Trusts to agree strengthened Agency contract.	Director of Nursing	Ongoing
	Work nationally with other HBs and Trusts to address workforce plans and reduce dependency on agency staff.	Director of Nursing	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Increasing numbers of registered nursing and midwifery staff; retention levels improve	Actively monitor patient experience

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 5 = 20	Management Board Report developed outlining resources required to fulfil compliance and impact of Nurse Staffing Act	**035**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Medical Director **Assuring Committee:** Management Board, Quality Safety and Risk Committee
Risk: Reduction in training posts within various specialties & capacity to meet workload demands.	**Date last reviewed:** July 2019

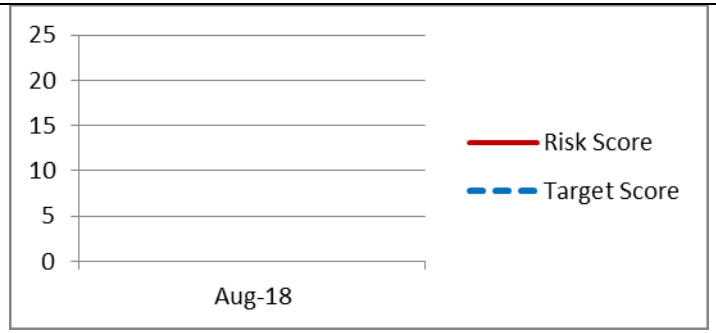
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 3 x 3 =9		**Rationale for current score:** Impact of insufficient trainees on the organisations ability to provide safe services remains challenging and problematic. **Rationale for target score:** A number of specialties rely on the training posts to ensure safe and effective services across the sites within Cwm Taf, reductions in trainee posts can significantly affect the organisations ability to provide services safely.
Level of Control =60%		
Date added to the risk register August 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Workforce Plan agreed by the Board as part of the 3 year IMTP • The Postgraduate Dean has written to all Health Boards seeking plans to mitigate against predictable rota gaps. • Continue to work with the Wales Deanery to ensure that the specific requirements for Cwm Taf to maintain safe services are understood and the impact assessed • Ongoing meetings in place within the Region involving the Deanery. • Exploration of joint appointments across the Region continue. • Some appointment success e.g. Paediatrics that mitigated the risks associated with sustaining rotas.	Action	Lead	Deadline
	Continue to develop alternative supporting roles by other professional staff	Medical director	Ongoing
	Undertake service change in line with agreed models within the South Wales Plan such as maternity services	Chief operating officer	Qtr 4. 2018/19
	Continue to work in partnership with other health boards to work across boundaries and develop safe and efficient services for the local populations	Chief Executive	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Able to provide safe and effective services	Regional solutions delivered at pace. Contingency plans in place.

Current Risk Rating	**Additional Comments**	**Ref No. 008**
Current Risk Rating : 5 x 4 = 20	Will require further review in light of establishment of the CTMUHB.	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Quality Safety and Risk Committee
Risk: Sustainability of a safe & effective Ophthalmology Service.	**Date last reviewed:** July 2019

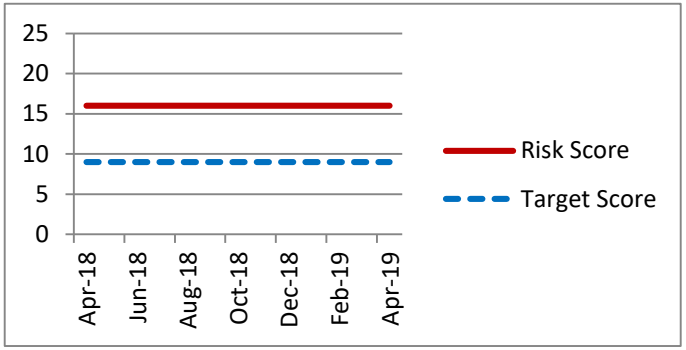
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 =12		**Rationale for current score:** Monitoring of the service continued, referral to treatment times remain challenging and the numbers of patients requiring a follow up appointment but have not yet been booked remains high
Level of Control =60%		**Rationale for target score:** An action plan was developed for ophthalmology services to address service improvement requirements but included revising the staffing profile to ensure service sustainability.
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Action plan developed and ongoing monitoring • Staffing structure stabilised and absence reduced. • Ongoing monitoring is in place with regards RTT impact of Ophthalmology, this risk relates to quality and safety of patients affected. • In line with other services, to meet the RTT requirement services are being outsourced- maintaining this level of performance will be challenging going forward. • Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases). • Additional services provided in Community settings through ODTC (imminent start date).	Action	Lead	Deadline
	Follow up appointments not booked being closely monitored	COO	Ongoing
	Regular updates re follow up appointments not booked being monitored by Management Board / QS&R (patient safety issues) and Finance, Performance and Workforce Committee (performance issues)	COO	Ongoing
	Reviewing UHB Action Plan in light of more recent WAO follow up review of progress.	COO	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Numbers of patients waiting for follow up appointments are reducing	Still excess amount of FUNB patients and efficiency issues remain

Current Risk Rating	**Additional Comments**	**Ref No. 032**
Current Risk Rating : 4 x 4 = 16	Ongoing review work is taking place in targeted specialities, to examine the safety of patients waiting for follow up appointments.	

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Primary, Community and Mental Health **Assuring Committee:** Management Board / Finance, Performance and Workforce Committee
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** July 2019

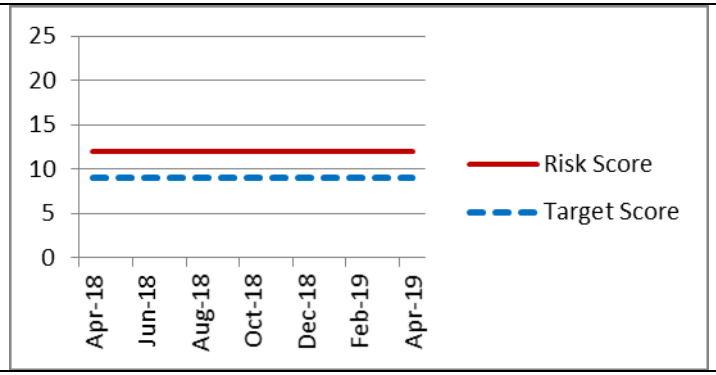
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9		**Rationale for current score:** Difficulties remain in recruiting key staff and new model of care being implemented; waiting times for specialist CAMHS and the new neurodevelopmental service remains challenging. **Rationale for target score:** Increasing demands being placed on the Core CAHMS Services resulted in long waiting times and the service was experiencing difficulties in recruiting staff
Level of Control =70%		
Date added to the risk register January 2015		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Reported local and Network pressures across the CAHMS Network with variable problems dependant on the area of the network. • Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. • Service Model developed around Core CAHMS in Cwm Taf which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. • New investment impact being routinely monitored	Action	Lead	Deadline
	Performance scrutiny takes place at Finance, Performance and Workforce Committee quarterly. Included within Integrated Performance Dashboard monthly	DPCMH	Ongoing
	Commissioning discussions taking place across the Network in relation to service pressures and funding.	DPCMH	Ongoing
	Implementation of the Choice and Partnership Approach (CAPA) started on 1st April 2017 and being closely monitored.	DPCMH	Ongoing
	A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee.	DPCMH	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reduction in waiting times; increased user satisfaction.	User satisfaction information – variability across network.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Network service; varying levels of funding by commissioners; different waiting times in localities. Cardiff and Vale – reproviding services being worked through	**033**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director lead for ICT / Chief Operating Officer **Assuring Committee:** Health Board
Risk: Ensuring the development, approval and implementation of a Strategy for IM&T, that is clinically led and supports staff in care delivery.	**Date last reviewed:** July 2019

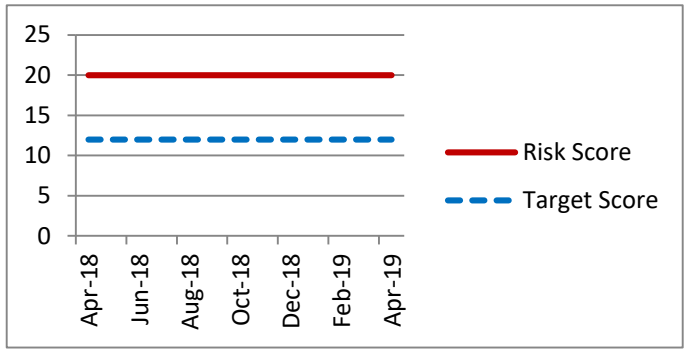
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 3 x 3 =9 **Level of Control** =50% **Date added to the risk register** December 2016		**Rationale for current score:** Although work has continued behind the scenes, having an executive lead, supported by an Assistant Director is potentiating the actions identified and move forward on the action plans and strategic outline programme. **Rationale for target score:** Developing an ICT Strategy that is clinically led and supports staff in care delivery is challenging in view of the current financial constraints although IM&T underpin all aspects of the patient pathway.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• ICT Strategy developed with support from ATOS Consulting – being updated by Assistant Director and Digital Strategy Steering Group • Governance arrangements to oversee delivery of the Strategy agreed and will require review. • Align key elements of the Strategy and related SOP to the Board's IMTP. • Realignment of Executive lead and management structure and portfolio for ICT • Digital Strategy Steering Group well established and work programme linking national and local improvements well underway. • New Independent Member for ICT appointed and work on going to hold first ICT Committee meeting as soon as possible. • Work on Transformation programme initiating following successful funding bid.	Action	Lead	Deadline
	A major constraint/required action to delivery the strategy is additional capital and revenue investment supported by a business case which is clear on the non-financial and financial returns	COO	ongong
	Implement the action plan developed with the Strategy; set up the group which will lead the work	COO	Complete through DSSG
	Review and consider, the effectiveness of the related governance arrangements – new governance initiating Sept 2019	COO / Board Sec	Complete

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Monitor the timescales and milestones identified in the action plan. Strategy approved by the Health Board in May 2017	Group now established to take forward the actions agreed. Need to consider effectiveness of related governance / scrutiny arrangements

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 3 = 12	New ICT Committee to be established, following comments and recommendations of WAO Structured Assessment. New IM now in post	**037**

Objective: **Statutory Compliance**	**Director Lead:** Director of Governance / Board Secretary **Assuring Committee:** Quality, Safety & Risk Committee / Capital Programme Board
Risk: Failure to meet Fire Safety Standards on ground and first floor PCH.	**Date last reviewed:** July 2019

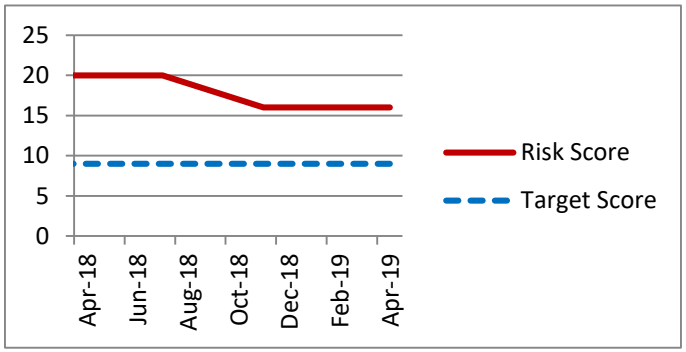
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** Fire enforcement notice will remain until works are completed. Note there remains a 6 year programme of capital works in place. **Rationale for target score:** Fire enforcement notice related to the ground and first floor at Prince Charles hospital
Level of Control =60%		
Date added to the risk register October 2009		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Progress and extension of existing Fire Enforcement Notice from June 2014. • Discretionary capital scheme completed to address minimum requirements. OBC approved and FBC to deal with asbestos & fire issues to WG Dec 2014. Implementation of Action Plan. • Meetings held annually between CEO and SWF&R Chief Officer, agreed annual review of progress against requirements of the Enforcement Action. • Joint meeting has also taken place with Cwm Taf, WG & SWF&R to discuss related risks. • Both Cwm Taf and SWF&R Service have attended the Welsh Government June 2015 Capital Investment Board to discuss the FBC and related business case approach.	Action	Lead	Deadline
	Regular meetings being held with Fire Authority.	Board Secretary	Ongoing
	Ongoing discussions and engagement with WG Capital and the UHB to agree the plans to phase the related work.	Dir of Planning	Ongoing
	Revised options submitted to WG Capital Board late in 2015 / 16 and agreed, amended programme for delivery being progressed. Programme director appointed to ensure work progresses.	Dir of Planning	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Enforcement notice will only be lifted when work completed	Deliver the agreed business cases to complete the scheme.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 4 = 20	(Current notice extended on an annual basis subject to confirmation and evidence of ongoing improvement towards full compliance - recent positive review meeting)	**017**

Objective: **Statutory compliance**	**Director Lead:** Director of Workforce and Organisational Development **Assuring Committee:** Quality Safety and Risk Committee
Risk: Staff Competency/ Compliance with mandatory training requirements.	**Date last reviewed:** July 2019

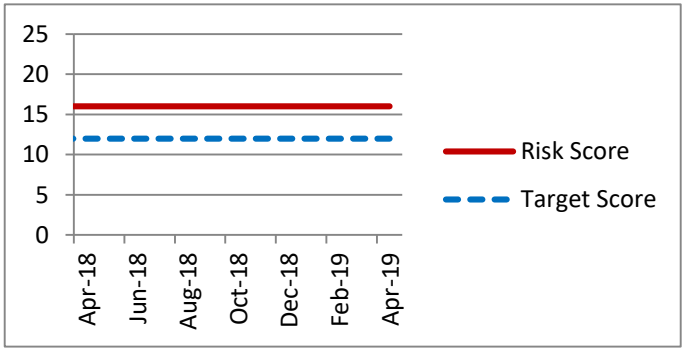
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9 **Level of Control** =70% **Date added to the risk register** June 2014		**Rationale for current score:** Although additional opportunities for staff to undertake moving and handling training uptake continues to fluctuate; increasing numbers of compliance with mandatory training but needs to be constantly attended, remains challenging. **Rationale for target score:** Backlog of training for bank health care support worker staff identified in July 2014; fixed term resource to resolve training backlog agreed but delayed due to recruitment.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Risk assess requirements and review delivery options; move to competency based assessment rather than mandatory updates where appropriate • Implementation of UK Core Skills Training Framework (CSTF), general improvement in compliance levels overall (against 10 Core Skills) • CSTF Task & Finish Group established Chaired by DW&OD and includes Director of Nursing and Board Secretary; • Significant investment in Moving and Handling equipment from year end discretionary capital progressed. • Ongoing monitoring of actions through Management Board and Committee • HSE re-visits and audits resulted in enforcement notice on Moving & Handling being lifted but significant work still needed to maintain progress made.	Action	Lead	Deadline
	Compliance generally with Core Skills Training Framework improving; discussed routinely at Clinical/Corporate meetings	Workforce Director	Ongoing
	Specific action plans in place to address moving and handling training, particularly for bank staff – although ceased and fixed term support ended – prioritised to address in IMTP.	Board secretary	Ongoing
	Making best use of the Electronic Staff Record – ensuring staff maintain mandatory requirements	Workforce director	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Improved training compliance percentages – note overall improvement trajectory	Continue to maintain profile of performance and general improvement of the levels of compliance. Must address solution for M&H.

Current Risk Rating	**Additional Comments**	**Ref No. 021**
Current Risk Rating : 4 x 4 = 16	Additional impact of Bridgend Boundary change being identified	

Objective: **Statutory compliance**	**Director Lead:** Director of Governance / Board Secretary **Assuring Committee:** Management Board
Risk: Failure to meet Fire Safety Standards across the UHB.	**Date last reviewed:** July 2019

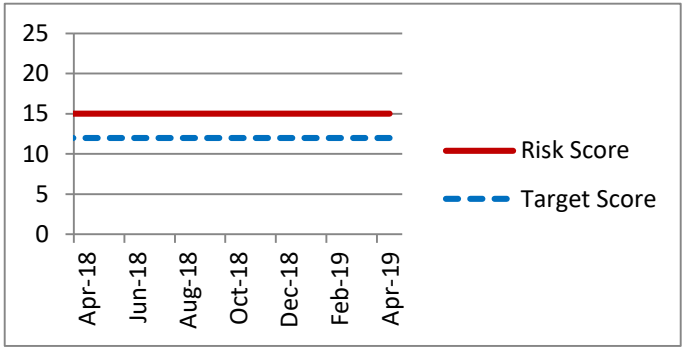
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 =12		**Rationale for current score:** Ongoing and close working with South Wales Fire and Rescue Service (SWF&RS) and the UHB to maintain high awareness. Continuing to monitor the requirement for staff to undertake mandatory training which remains challenging Fire enforcement notice and issues within systems and controls identified at Princess of Wales **Rationale for target score:** Actions relating to Fire Safety across the UHB as a key element of patient, staff and public safety management; this is a mandatory requirement for staff
Level of Control =70%		
Date added to the risk register October 2009		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Robust risk assessment processes in place to ensure the Board manages and mitigates identified risks; • Implementation of Action Plans in response to pro active risk assessments. • Alignment (where appropriate) of UHB risk assessment processes with those of Fire Service • Constructive and positive working relationship in place with SWF&R Service and regular meetings between senior staff with at least Annual review meetings being led by CEO and Chief Fire Safety & Rescue Officer. • Other enforcement actions taken for example ICU at Royal Glamorgan Hospital, but plan in place to address and agreed with SWF&R service. • Ongoing work at the POW site – identification of key issues and mitigation	Action	Lead	Deadline
	Pro active management via Clinical / Corporate Business Meetings (CBMs) to ensure profile for fire safety remains high.	Board Secretary	Ongoing
	Regular inspections and dialogue with South Wales Fire & Rescue Service.	Board Secretary	Ongoing
	Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.	Head of Fire Safety	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reducing numbers of enforcement notices received.	Fire enforcement actions being progressed and routinely monitored.

Current Risk Rating	**Additional Comments**	**Ref No. 025**
Current Risk Rating : 4 x 4 = 16	Continuous progress needs to be demonstrated on improvement actions and related capital scheme (s)	

Objective: **Statutory compliance**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Management Board
Risk: Failure to achieve statutory and mandatory planned preventative maintenance (PPM) programme.	**Date last reviewed:** July 2019

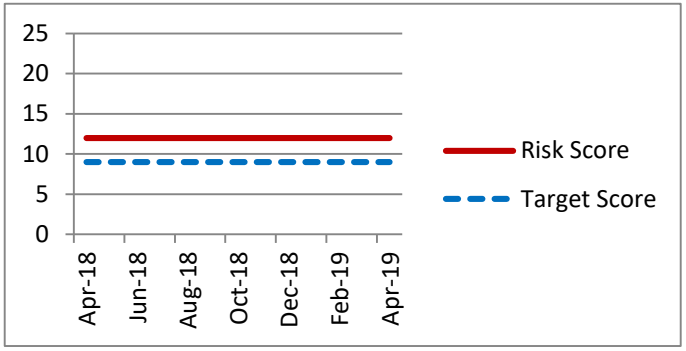
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 15 Current: 5 x 3 = 15 Target: 5 x 2 =10		**Rationale for current score:** Additional staff have been appointed to the Estates team; however, although improvements have been made additional work is required to ensure full compliance. **Rationale for target score:** Reassurance was required in order that the statutory and mandatory planned preventative maintenance programme was well managed during time of increased vacancies in the estates department.
Level of Control =70%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• All vacancies now filled; workforce plan developed. • Estates Officers responsible for ensuring external contractors complete PPM on time. • TABS (Computer-Aided Facilities Management) is being used to plan, monitor and record work undertaken by external contractors. • Development and implementation of staffing strategy for estates. • PPM prioritised work of the estates department. • Annual Estates Report considered by the Management Board and Health Board – next report due shortly for 2018/2019. • Whilst significant improvements noted, recognised that further work needed to ensure full compliance with Statutory PPM.	Action	Lead	Deadline
	Capital and estates governance group oversees the overall compliance	Assistant Director of Estates	Ongoing
	Routine monitoring of progress, with use of CBM process to support also.	Director of Plan & Perf.	Ongoing quarterly
	Presentation of Annual Report to Board & Management Board	Director of Plan & Perf.	July 2019
	Review of Estates performance at least annually at Finance, Performance and Workforce Sub-Committee.	Director of Plan & Perf.	Annually

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Overall levels of compliance improving	

Current Risk Rating	**Additional Comments**	**Ref No. 018**
Current Risk Rating : 5 x 3 = 15	Will require further review in light of new CTMUHB estate responsibilities.	

Objective: **Statutory Compliance**	**Director Lead:** Director of Nursing, Midwifery and Patient Care **Assuring Committee:** Management Board
Risk: Failure to appropriately apply Deprivation of Liberties Safeguards (DoLS) legislation following the West Cheshire court judgement.	**Date last reviewed:** July 2019

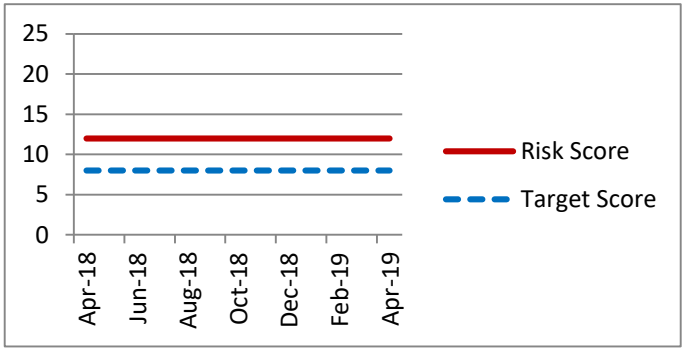
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 3 x 3 =9		**Rationale for current score:** Whilst Best Interests Assessors (BIA) are in place, these are insufficient to address the increased demand, resulting in a back log accumulating. Internal Audit Report gave a limited assurance rating on the management of Deprivation of Liberties Safeguards in March 2017. **Rationale for target score:** UHB requirements increased (along with other Public Bodies) as a consequence of the recent court judgement.
Level of Control =60%		
Date added to the risk register October 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• January 2015 Management Board approved to develop a DoLS team. The new UHB DoLs team set up, to include co-ordinator post and dedicated Best Interest Assessor time. • Internal Audit report on DoLS to Audit Committee (April 2016) provided limited assurance in relation to the backlog in assessment required. Action Plan in place to address and recent additional investment to help address some of the actions and mitigate the risks provided. • DoLS processes established and in place.	Action	Lead	Deadline
	Internal Audit Report recommendations progressed.	Nurse Director	Complete
	Prioritisation process in place for DoLs applications and training for all disciplines in the Mental Capacity Act ongoing.	Nurse Director	Complete
	General staff awareness being raised with regards the requirements of the legislation.	Nurse Director	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Time taken to respond to requests reducing. Full delivery of Action Plan required.	Are staff generally understanding the requirements of the legislation

Current Risk Rating	**Additional Comments**	**Ref No. 031**
Current Risk Rating : 4 x 3 = 12	Internal Audit review of two previous Limited Assurance reports provided Substantial assurance (Sept 17). Review for consideration of removal of the Risk Register.	

Objective: **Statutory Compliance**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Management Board
Risk: Failure to comply fully with the arrangements for managing Asbestos	**Date last reviewed:** July 2019

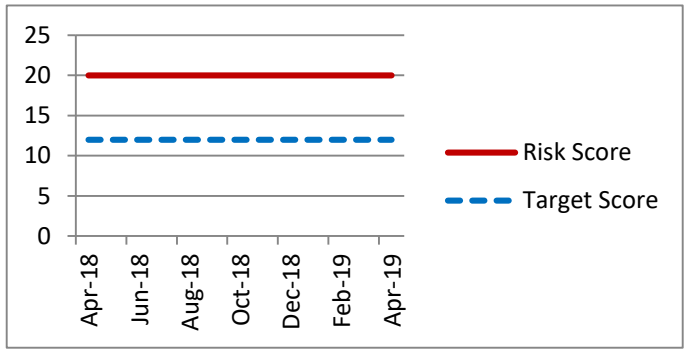
Risk Rating (consequence x likelihood): Initial: 4 x 4 =16 Current: 4 x 3 = 12 Target: 4 x 2 = 8		**Rationale for current score:** The Asbestos Register was being transferred to an in-house system and was available in hard copy only; reasonable assurance on IA report but some actions to be completed. **Rationale for target score:** There was an All Wales focus on asbestos management with audit to be undertaken. Potential risks could include Enforcement Action; Serious Ill Health/mortality; Personal Injury/Fatality Claim.
Level of Control =80%		
Date added to the risk register April 2012		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Approved updated Asbestos Management Plan which sets out clear guidance on the roles and responsibilities and operational procedures, in line with the asbestos regulations (CAR2012) and best practice. • Competent Person and Asbestos Advisory Group in place reporting to the Estates Governance Board and onwards through exception reports to the Quality Safety and Risk Committee • Training Needs Analysis completed. • Training programme has been developed to provide participants with an awareness of their responsibilities as defined by the plan. • Internal Audit report noted that a programme of annual asbestos awareness training for UHB employees was evident, in line with the Regulations.	Action	Lead	Deadline
	Implement Internal Audit report recommendations and action plan	Assistant Director of Estates	Complete
	We have recommended central monitoring of attendance at the annual asbestos awareness training to ensure full compliance	Assistant Director of Estates	Ongoing
	UHB staff do not undertake any direct work with asbestos (i.e. they are not involved in the removal, repair or disturbance of asbestos); all asbestos-related jobs are contracted to licensed contractors.	Assistant Director of Estates	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Periodical review of Asbestos Plan along with periodical internal audit review of its application.	

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 3 = 12	Will require further review in light of CTMUHB asbestos management plan and review of properties transferred.	**016**

Objective: **Financial Viability**	**Director Lead:** Director of Finance **Assuring Committee:** Health Board
Risk: Failure to achieve financial balance on a recurring basis.	**Date last reviewed:** July 2019

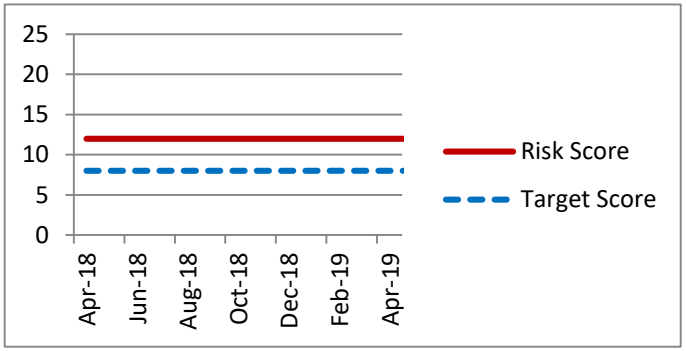
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 4 = 20 Target: 4 x 3 =12		**Rationale for current score:** Recurring underlying deficit – Health Board breaks even through non recurrent slippage (meeting 3 year financial duty) **Rationale for target score:** Target risk is based on sustained delivery of underlying recurring savings target
Level of Control =60%		
Date added to risk register April 2013		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Monthly monitoring and review by Welsh Government; • Clinical Business Meetings established • Three Year Integrated Medium Term Plan approved by the Board and approved by Welsh Government for third successive year. Three year planning process introduced by Welsh Government supports more medium term planning and service re-design approach; • Risks are managed by Directorate Action Plans and monitored through the Executive Programme Board and onto the Management Board; • Integrated service planning which includes and requires significant service re-design • Additional non recurring resource allocated, is not addressing the underlying recurring deficit.	Action	Lead	Deadline
	Efficiency Productivity and Value Board established and first meeting held; Terms of Reference now finalised.	Chief Exec	Ongoing
	Two weekly information required by each directorate and preparation of quarterly position against their specific actions	DOF	Ongoing
	Significant internal risks being managed and external risks have been raised with WG Routine monitoring arrangements in place to track the financial delivery and impact of the IMTP.	DOF	Each month's finance report

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Strong scrutiny process within FP&W Committee	Focus required on recurring savings plans and their delivery.

Current Risk Rating	**Additional Comments**	**Ref No. 011**
Current Risk Rating : 5 x 4 = 20	Over reliance on in year non-recurring slippage to deliver savings plans. Needs further review across CTMUHB. Potential opportunity to merge risks or identify Bridgend financial position separately	

Objective: **Financial Viability**	**Director Lead:** Director of Planning and Performance **Assuring Committee:** Capital Programme Board
Risk: Failure to Deliver Major & Discretionary Capital programmes	**Date last reviewed:** July 2019

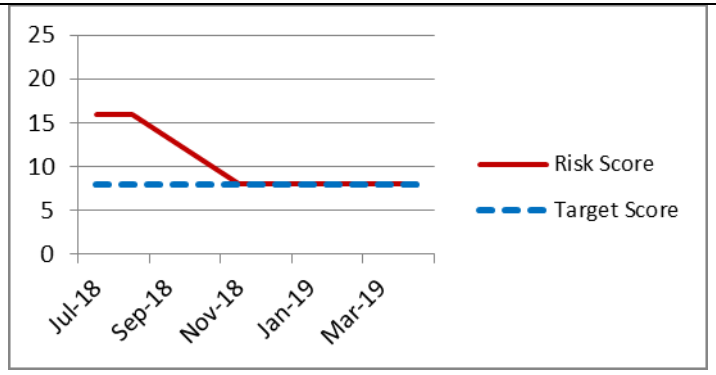
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 =8		**Rationale for current score:** Risks remain due to the size, value and complexity of the capital programme although discretionary capital managed (including slippage) **Rationale for target score:** Major capital programme will be in place for the foreseeable future and very large capital schemes underway – potential risks to the organisation in terms of finance and cost as well as reputational
Level of Control =50%		
Date added to the risk register April 2014		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Prepare, review and submit regular monitoring returns to Welsh Government. • Executive Capital Management Group to monitor the compliance with the actions agreed. • Capital Board in place to monitor development and delivery of the Board's Capital schemes. • Quarterly update reports are presented to Management Board and the health Board meetings. • Whilst increased pressure as a consequence of capital slippage, plans in place to address.	Action	Lead	Deadline
	Capital Programme Board and Executive Capital Management Group in place	RT	Ongoing
	Work programme and review of bids on an ongoing basis.	RT	Ongoing
	Discretionary capital processes in place for allocation and slippage funding	RT	Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Continue to work closely with Welsh Government. Elements of the Capital Programme feature routinely in the UHB's Internal Audit Plan	

Current Risk Rating	**Additional Comments**	**Ref No. 012**
Current Risk Rating : 4 x 3 = 12	PCH GFF Project - internal audit report received a limited assurance, although good progress with improvement actions is being reported through to Audit Committee.	

Objective: **Statutory Compliance**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Quality, Safety & Risk Committee / Management Board
Risk: Failure to ensure sufficient storage capacity (or alternative solutions) are in place to safely store and secure patient records.	**Date last reviewed:** July 2019

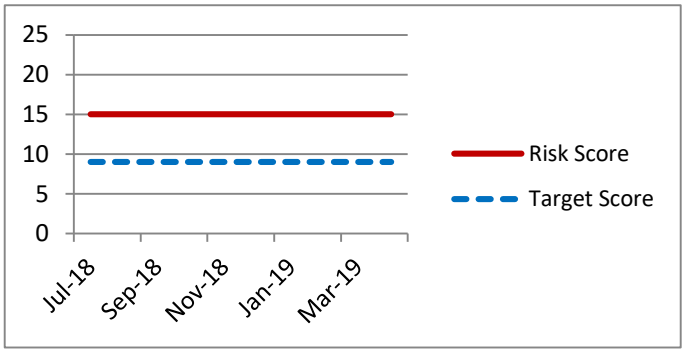
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** =60% **Date added to the risk register** July 2018		**Rationale for current score:** The effectiveness of the Williamstown Records Storages Hub is reliant on digitisation of health records. In the absence of an agreed business case and investment, it's likely that records storage will once again start to be undertaken across multiple sites, increasing risks to staff and patient safety. **Rationale for target score:** Delivering the Digitisation of health records, alongside the records hub will ensure a sustainable, safe & secure storage solution.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Williamstown Hub is yet to reach full capacity • Digitisation of Records Business Case signed off (December 2018) and Civica will initiate contract in November 2019 covering old CT and PoW footprints. • WG Invest to Save bid signed off June 2019. • Requirement to stop disposing of records in line with the Infected Blood Inquiry; impact being closely monitored potentially to use a building leased by the Welsh Government to assist.	Action	Lead	Deadline
	BJC for Digitisation to be considered and approved via Management Board / Board as appropriate	COO	Approved
	Ensure Records management processes fully applied in Williamstown to maximise use of available physical capacity	COO	Ongoing
	Ensure no temporary storage solutions are agreed, without full consideration of the Executive.	COO	Ongoing

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Compliance with regulations including H&S @ Work.	That the capacity at Williamstown is fully utilised and that records management processes are being applied in full, including culling etc.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	Impact of Infected Blood Inquiry to be further considered; Management Board considered and supported phase 1 of work	**039**

Objective: **Statutory Compliance**	**Director Lead:** Director of Workforce & OD **Assuring Committee:** Quality, Safety & Risk Committee / Equality & Welsh Language Forum
Risk: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	**Date last reviewed:** July 2019

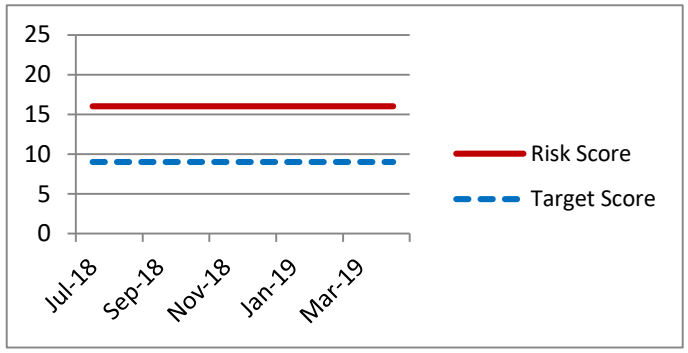
Risk Rating (consequence x likelihood): Initial: 3 x 5 = 15 Current: 3 x 5 = 15 Target: 3 x 3 = 9		**Rationale for current score:** As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. **Rationale for target score:** Working through its related improvement plan the likelihood of non-compliance will reduce as awareness and staff training in response to the Standards, is raised.
Level of Control =60%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• The Welsh Language Unit has undertaken a self-assessment of the requirements of the Standards and how they apply to Cwm Taf • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. • Regular reports to the Board to raise awareness • Support group set up to assist managers	Action	Lead	Deadline
	Continue to review and act on the UHBs Self-Assessment findings and related improvement actions.	DW&OD	Ongoing
	Ensure the Board is fully sighted on the UHB's position	DW&OD	Quarter 3
	Continue to work with Directorates to develop action plans in response to the requirements of the Standards	DW&OD COO DPC&MH	Quarters 3 & 4

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Compliance with Statutory requirements outlined in Welsh Language Act and related Standards.	

Current Risk Rating	**Additional Comments**	**Ref No. 040**
Current Risk Rating : 3 x 5 = 15	The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards and this will inform its response to the Commissioner in seeking further time to implement those Standards considered more challenging.	

Objective: **Statutory Compliance**	**Director Lead:** Chief Operating Officer **Assuring Committee:** Quality, Safety & Risk Committee
Risk: Failure to fully meet all the licensing requirements of the Human Tissue Authority in relation to Mortuary & Services for the Deceased.	**Date last reviewed:** July 2019

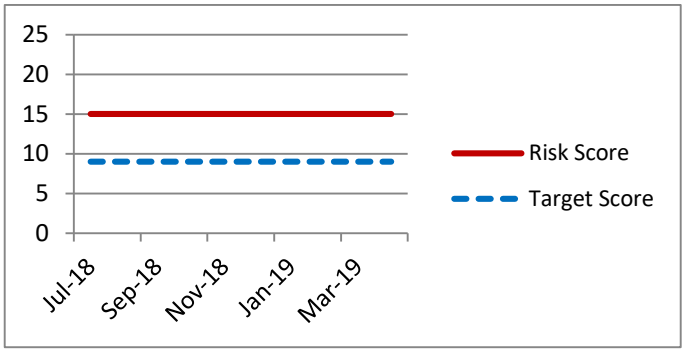
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Reflect the Directorate led baseline assessment and the findings of the HTA inspection in April 2018. **Rationale for target score:** Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.
Level of Control =70%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• The Pathology Directorate has undertaken a baseline review which identified a number of areas for action in advance of the HTA inspection • The Pathology Directorate has developed a comprehensive action plan in response to the HTA findings with Board agreed scrutiny & Monitoring arrangements in place via the Q,S&R Committee. • Related controls are considered strong with regards knowing what the related issues are and what actions need to be taken to achieve full compliance. • HTA signed off on all 32 CAPA plans on 10/7/2019 and 0 HTARIs achieved by 13/7/19. • The first line of defence (the Board's internal assurance) was not sufficiently strong enough to ensure related matters were raised and addressed in advance of the Licence Regulators informing the UHB when the statutory environment had changed and raised the standards required for compliance.	Action	Lead	Deadline
	Ensure the Directorate Corrective Action Plans are fully implemented	COO	Completed
	Establish more robust monitoring arrangements, to ensure the Board's first line of assurance (defence) detects and informs corrective action plans.	COO	Ongoing through HTA Project Board and Care of the Deceased Project Board

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Compliance with Statutory requirements outlined in the Human Tissue Act and related Standards.	

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 4 x 4 = 16	All 32 CAPA plans completed and submitted to the HTA. Will also need to consider Bridgend site.	**041**

Objective: **Statutory Compliance**	**Director Lead:** Chief Executive Officer **Assuring Committee:** The Health Board
Risk: Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	**Date last reviewed:** July 2019

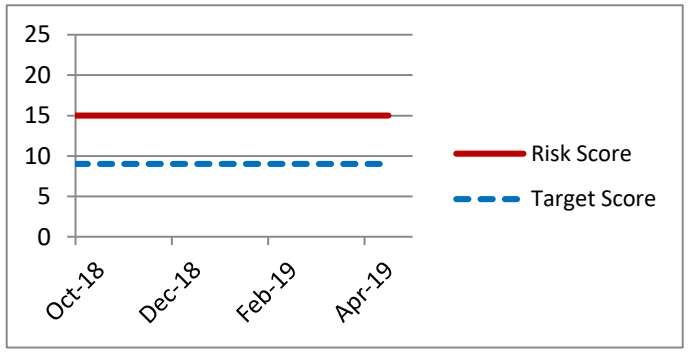
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**Rationale for current score:** Reflect the Directorate led baseline assessment and the findings of the HTA inspection in April 2018. **Rationale for target score:** Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.
Level of Control =70%		
Date added to the risk register July 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Joint Transition Board in place across CTUHB and ABMU HB • Programme Management Arrangements in place • Programme Director / Team appointed • Agreed work streams established along with related reported arrangements • Internal Audit involvement being agreed • External Audit (critical Friend observer status) on Transition Board • Strong Partnership arrangements already established, which are a strong platform to deliver the revised legislative programme / change.	Action	Lead	Deadline
	Ensure delivery of the Programme's agreed milestones	CEO Prog Dir	April 2019
	That established work streams deliver on their key products and routinely provide exception reports into Programme Structure	CEO Prog Dir Dep CEO	Ongoing
	Ensure partners remain involved and updated on related progress and play their part where appropriate to deliver the requirements of the change.	CEO Prog Dir	April 2019

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Compliance with the revised legislative changes proposed as a consequence of the Bridgend Boundary change.	Delivery of the Programme within the proposed timescales, which all recognise is extremely tight / challenging.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 3 = 15	Joint Transition Board Programme formally closed at May 2019 Board.	**042**

Objective: **To improve quality, safety and patient experience**	**Director Lead:** Director of Nursing, Midwifery and Patient Care **Assuring Committee:** Health Board
Risk: Under reporting of clinical incidents in maternity services	**Date last reviewed:** July 2019

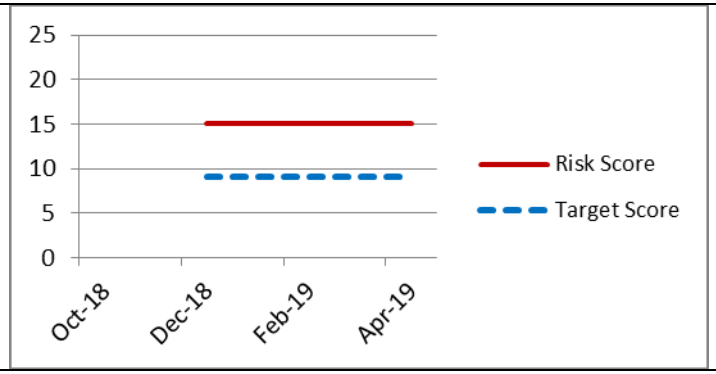
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 =20 Target: 3 x 3 = 9 **Level of Control** 50% **Date added to the risk register** September 2018		**Rationale for current score:** Reflect the findings of the directorate review on incident reporting **Rationale for target score:** Likely rating once the issues identified are addressed and the corrective action & improvement plan is fully implemented.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Significant piece of work being undertaken to review the possible under reporting of clinical incidents, • Processes have been developed within maternity to flag whether an incident should have been reported and that consideration would need to be given as to how to ensure that all clinical incidents were being reported, • Guidance being issued for staff as to what is needed to be reported as an incident • Working with the Welsh Government's RCOG and RCM review of Cwm Taf maternity services. • Ensuring the actions in response to the publication of the RCOG & RCM Report is fully implemented.	Action	Lead	Deadline
	Work is progressing to get MDT's to review data. External review planned for early October, weekly rhythm to drive action plan. This will provide assurance to Management Board. CMO/CNO discussion on assurance,	Director of Nursing, Midwifery and Patient Services	Jan 2019
	The Director of Nursing, Midwifery and Patient Services will chair 3 weekly meetings and additional monthly meetings will be chaired by Denise Llewelyn until January 2019		Jan 2019
	Take immediate action on initial findings of the RCOG / RCM review		Feb 2019

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Greater awareness on incident reporting, increase in incidents reported and increased patient satisfaction.	Greater monitoring of incidents reported through monthly meetings with key staff and analysis of incident reports.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating : 5 x 4= 20	Health Board now in Special Measures for its Maternity Services. Regular reports to the Health Board and to Quality Safety and Risk Committee (Standard agenda item)	**043**

Objective: **Service / Business Interruption**	**Director Lead:** Chief Operating Officer / Director of Governance **Assuring Committee:** Management Board
Risk: Risk of information technology failures following national outages during 2018 and cyber security risk which could lead to loss of information or information governance issues	**Date last reviewed:** July 2019

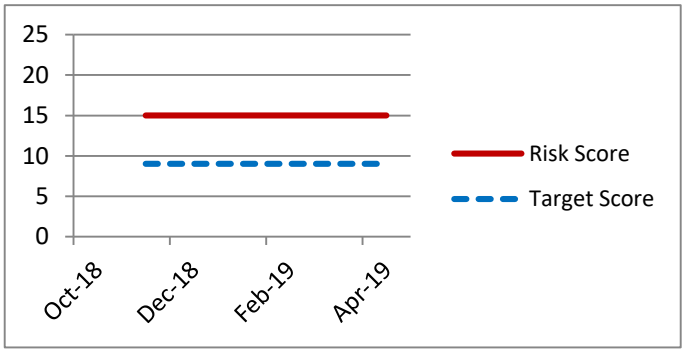
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**Rationale for current score:** System failures during 2019 but service continuity plans in place and services were maintained **Rationale for target score:** New risk identified and at best impact could be severe and likelihood appears moderate. Much is outside of the control of the UHB although all systems have business continuity plans
Level of Control = 50%		
Date added to the risk register December 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Carry out gap analysis/risk assessment on IT systems. • Business continuity plans updated. • Working with NWIS to gain assurance on the major national systems. • Representations made to National Informatics Management Board on recent data centre outage. • Ongoing improvements of local system resilience through DSSG.	Action	Lead	Deadline
	Work nationally with NWIS and other HBs and Trusts to share business continuity plans.	Board Sec COO	March 2019
	Continue with strong controls in place to ensure "business as usual" through robust business continuity plans	Board Sec COO	Ongoing
	Working with other HBs and Welsh NHS Confederation learn lessons from other organisations	Board Sec COO	April 2019

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
The Health Board is providing services "business as usual" with no interruption to service sustainability and provision of patient care.	Undertake a business continuity exercise to test existing business continuity plans to identify any gaps in resilience.

Current Risk Rating **Current Risk Rating: 5x3 =15**	**Additional Comments** Recent issues with national outages – working with staff at CTM to respond to the impact on services to report to NWIS	**Ref No. 044**

Objective: **Service / Business Interruption**	**Director Lead:** Director of Public Health **Assuring Committee:** Management Board
Risk: Risk of interruption to service sustainability, provision and destabilising the Board's financial position as a result of Brexit.	**Date last reviewed:** July 2019

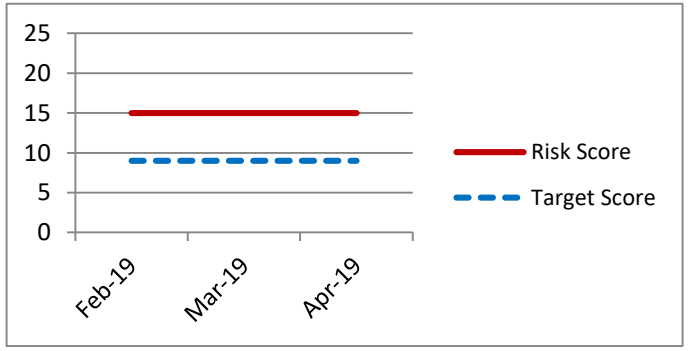
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Whilst Brexit negotiations continue the Health Board must prepare for every eventuality based on a thorough risk assessment on the impact of Brexit on the Health Board. **Rationale for target score:** Whilst Brexit negotiations continue the Health Board must prepare for every eventuality based on a thorough risk assessment on the impact of Brexit on the Health Board.
Level of Control = 50%		
Date added to the risk register November 2018		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Carry out gap analysis/risk assessment on Brexit • Complete the Wales Audit Office (WAO) call for evidence self-assessment • Respond to WG as requested to inform of plans • Directorate Business Continuity plans being updated – particularly in Medicines Management; Facilities (food); ICT; Workforce; Estates; R&D • Regular dialogue with Welsh Government and working with the Welsh NHS Confederation • Emergency Planning, Preparedness & Response (EPPR) for the sites transferring to CTUHB from ABMU managed by the Governance work stream of the project. • Small number of staff within CTUHB potentially need to apply for settled status through the EU Settlement Scheme. • Establish internal Brexit group • Assessment of potential risks to the flow of personal data following Brexit	Action	Lead	Deadline
	Work nationally with Welsh Government, Local Resilience Forums and other HBs and Trusts to share business continuity plans.	Board Sec CCM	March 2019
	Continue with strong controls in place to ensure "business as usual" through robust business continuity plans	Board Sec CCM	Ongoing
	Working with other HBs and Welsh NHS Confederation learn lessons from other organisations and provide information on SharePoint to allow opportunities for staff across the HB to identify and areas of concern	Board Sec CCM	April 2019

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
The Health Board is providing services "business as usual" with no interruption to service sustainability and provision of patient care.	Undertake a business continuity exercise to test existing business continuity plans to identify any gaps in resilience.

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating: 4x4 =16	Whilst Brexit negotiations continue the Health Board will work with other organisations to identify risk	**045**

Objective: T**o improve the quality, safety and patient experience**	**Director Lead:** Director of Nursing, Midwifery and Patient Care **Assuring Committee:** Health Board
Risk: Poor quality unsafe services providing unsatisfactory patient experience which if not adequately addressed will continue to effect escalation status.	**Date last reviewed:** July 2019

Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 3 x 3 = 9		**Rationale for current score:** Enhanced monitoring by Welsh Government (WG) and regulators - Plan developed to comply with the 7 areas for improvement including requirements of: SI reporting; Healthcare Inspectorate Wales reporting; Nurse Staffing (Wales) Act; Radiation protection (IR(ME)R); Human Tissue Authority; Structured Assessment (WAO); Maternity Services and RCOG/RCM Review **Rationale for target score:** Return to routine monitoring and able to maintain WG and regulators confidence in the systems, processes, actions and behaviours within the Health Board where the consequences and likelihood is mitigated and managed
Level of Control = 25%		
Date added to the risk register February 2019		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Board discussion with the Director General • Chair, CEO and Vice Chair to meet with regulators to discuss assurance requirements • Working with the WG officials and regulators to fully comply with requirements • Developing more inclusive relationships with external bodies • Identifying lead directors and actions for completion with timescales • Clarifying key actions to be taken and increase the pace • Clarifying the governance route for actions and sign off	Action	Lead	Deadline
	Develop plans in response to areas of concern.	CEO	Ongoing
	Monitor key actions and progress at Exec Catch up meetings weekly and onwards to Board and Committees	CEO	Ongoing
	Seek assistance from the WG and Regulators and work with other external bodies to learn lessons and improve services in Cwm Taf	CEO	ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Regular liaison with WG and Regulators for feedback; key improvements made to actions required at pace – leading to improved quality safety and patient experience and staff satisfactionf	Work with the OD team to develop Cwm Taf as an open and transparent organisation where learning is at the centre; develop a better understanding of the culture and behaviours required to develop more robust processes and receive and disseminate lessons learned

Current Risk Rating	**Additional Comments**	**Ref No.**
Current Risk Rating: 5 x 5 = 25	Aim to return to Level 1 – Routine Monitoring as soon as practicably possible	**046**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**AGENDA ITEM 5.1** **26 September 2019**

University Health Board Report
COMMITTEE CHAIRS REPORT

Executive Lead: Board Secretary
Author: Kathrine Davies, Interim Corporate Governance Support
Contact Details for further information: Kathrine.davies2@wales.nhs.uk

Purpose of the University Health Board Report
The purpose of this report is to provide an update on the discussions in the meetings of the Board Committees. The Board is asked to approve a number of reports from Chairs of Committees as set out below.

Governance	
Link to Health Board Strategic Objective(s)	The Board's overarching role is to ensure its strategic objectives, and the related organisational objectives outlined within the 3 Year Integrated Medium Term Plan 2019-2022, are being progressed. Aligned with the 'Quadruple Aim' described within 'A Healthier Wales' (Welsh Government, June 2018) these objectives are: • To **improve** quality, safety and patient experience • To **protect** and **improve** population health • To **ensure** that the services provided are accessible and sustainable into the future • To **provide** strong governance and assurance • To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board. This report focuses on all the above objectives, but specifically on **providing** strong governance and assurance.
Supporting evidence	• Summaries and or confirmed minutes from reporting Committees.
Engagement – Who has been involved in this work?	
The attached reports and minutes demonstrate the extent of engagement in the work of the Committees of the Board.	

University Health Board Resolution To:							
APPROVE	√	**ENDORSE**		**DISCUSS**		**NOTE**	√
Recommendation	Members of the University Health Board are asked to: • **NOTE** the contents of this report. • **APPROVE** the minutes of the Committee meetings. • **APPROVE** the Annual Report for the Finance, Performance & Workforce Committee and the revised terms of reference. • **APPROVE** the revised terms of reference for the Stakeholder Reference Group. • **APPROVE** the revised Terms of Reference for the Quality, Safety & Risk Committee.						
Summarise the Impact of the University Health Board Report							
Equality and diversity	No impact						
Legal implications	It is essential that the Board enacts its Standing Orders which include receiving updates and approving minutes received from its Committees.						
Population Health	No impact						
Quality, Safety & Patient Experience	Ensuring the Board discharges its business appropriately through its Committees and aligned with its Standing Orders, is a key requisite to ensuring the quality, safety & experience of patients receiving care.						
Resources	No impact.						
Risks and Assurance	Any governance and risk issues are managed via the Committee meetings and exception reports will be provided to the Board by the respective Chairs.						
Health & Care Standards	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy; Safe Care; Effective Care; Dignified Care; Timely Care; Individual Care; Staff & Resources. http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work reported in this summary takes into account many of the related quality themes (as applicable)						
Workforce	No impact						
Freedom of information status	Open						

COMMITTEE CHAIRS REPORT

1. SITUATION / PURPOSE OF REPORT

The purpose of this report is to provide an update, including the minutes and Chair summaries, where appropriate on matters considered by the Board's Committees. The Board is asked to approve a number of summary reports from Chairs of Committees and / or endorse approved minutes as set out below.

2. BACKGROUND / INTRODUCTION

The Board will be aware that a number of Committees have been established under the Health Board Standing Orders and a number of Board level Champions have been designated for specific areas of work. Each Committee and Champion will present reports to the Board during the course of a year and this report sets out a number of reports that require endorsement and / or approval.

3. ASSESSMENT / GOVERNANCE AND RISK ISSUES

Any governance and risk issues are managed via the Committee meetings and exception reports will be provided to the Board by the respective Chairs.

REPORTS FROM COMMITTEE CHAIRS

Finance, Performance & Workforce Committee

The Board is asked to **receive** and **approve** the confirmed minutes of the meeting held on 25 July 2019, which are included as **Appendix 1**. A meeting of the Committee took place on 19 September 2019, a brief summary of the key issues discussed is attached as **Appendix 2** and a verbal update will be provided at the meeting.

Audit Committee

A special meeting of the Committee took place on 3 September 2019, a verbal update will be provided at the meeting.

Primary and Community Care Committee

A meeting of the Committee took place on 24 July 2019, a summary of the key issues discussed is attached as **Appendix 3.**

Stakeholder Reference Group

The Board is asked to **receive** and **note** the confirmed minutes of the 13 June 2019, which are included as **Appendix 4.** A meeting of the Group was held on 15 August 2019, a summary of the key issues discussed is attached as **Appendix 5.**

Quality, Safety & Risk Committee
The Board is asked to **receive** and **note** the confirmed minutes of the meetings held on 9 July 2019 and 5 August 2019, which are included as **Appendix 6** & **7.** A meeting of the Committee was held on 5 September 2019, a summary of the key issues discussed is attached as **Appendix 8.**

Healthcare Professionals Forum
A meeting of the forum was held on 12 July 2019, a summary of the key issues discussed is attached as **Appendix 9.**

Mental Health Act Monitoring Committee
The Board is asked to **receive** and **note** the confirmed minutes of the meeting held on 2 April 2019, which are included as **Appendix 10.** A meeting of the Committee was held on 6 August 2019, a summary of the key issues discussed is attached as **Appendix 11.**

Welsh Health Specialised Services Committee
The Board is asked to **receive** and **note** the confirmed minutes of the meeting held on 28 June 2019, which are included as **Appendix 12.** A meeting of the Committee was held on 23 July 2019, a summary of the key issues discussed is attached as **Appendix 13.**

Emergency Ambulance Services Committee
The Board is asked to **receive** and **note** the confirmed minutes of the meeting held on 23 July 2019, which are included as **Appendix 14.**

Shared Services Partnership Committee
The Board is asked to **receive** and **note** the Assurance Report from the meeting held on 18 July 2019, which is attached as **Appendix 15.**

NHS Wales Collaborative Leadership Forum
The Board is asked to **receive** and **note** the confirmed minutes of the meeting held on 13 May 2019, which are included as **Appendix 16.**

4. RECOMMENDATION

Members of the University Health Board are asked to:

- **NOTE** the contents of this report;
- **APPROVE** the minutes of the Board committee meetings;
- **APROVE** the revised Terms of Reference for the Healthcare Professional Forum.

Freedom of information status	Open

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Finance, Performance & Workforce Committee Meeting

'Confirmed' Minutes of the meeting held on
25 July 2019
Ynysmeurig House, Abercynon

Present

Mel Jehu	Independent Member (Chair)
Paul Griffiths	Independent Member
Dilys Jouvenant	Independent Member

In attendance

Ruth Treharne	Director of Planning & Performance
Steve Webster	Director of Finance
Anne Phillimore	Interim Director of Workforce & OD (in part)
David Jenkins	Independent Advisor
Emma Walters	Committee Secretariat
Wendy Penrhyn-Jones	Head of Corporate Admin
Rita James	Head of Benchmarking (in part)
Kath McGrath	Deputy Chief Operating Officer/Assistant Director Medicine
Melanie Harries	Delivery Unit (Observing)

FPW/19/91 **WELCOME AND INTRODUCTIONS**

Mel Jehu **WELCOMED** everyone to the meeting, particularly Melanie Harries, Performance Improvement Manager at the Delivery Unit who was attending as an observer and Rita James who was attending part of the meeting to present the Clinical Coding update report.

FPW/19/92 **APOLOGIES FOR ABSENCE**

Apologies for absence were **RECEIVED** from Keiron Montague, Alan Lawrie, John Palmer, Paul Dalton, and Elaine Williams.

FPW/19/93 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interest declared.

FPW/19/94 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the meeting held on 20 June 2019, were **RECEIVED** and **APPROVED** as a true and accurate record, subject to minor typographical amendments which would be discussed outside of the meeting and re-presented to the September meeting for completeness

FPW/19/95 **UPDATE ON ACTION LOG**

Member **RECEIVED** and **NOTED** an update on the Finance, Performance & Workforce Committee Action Log.

Ruth Treharne advised Members that on Page 2, endoscopy figures were now being included in the dashboard and therefore this action could be marked as 'completed' and that the second action on page 2 which related to recently reported waiting lists for neurophysiology could now also be marked 'completed'

FPW/19/96 **MATTERS ARISING**

Page 6, second paragraph, Ruth Treharne confirmed that she had shared with Members some examples of comparative data from the dashboards, and would be happy to continue to share this information with the Committee 2-3 times per year (**added to the action log**).

FPW/19/97 **FORWARD LOOK**

Members **RECEIVED** and **NOTED** the Forward Look. The Chair extended his thanks to Ruth Treharne and the Corporate Team for the continued development of the Forward Look. Members were reminded that at the previous meeting they had agreed to share their views with Mel Jehu in relation to prioritisation of issues (**added to the action log**).

Members **RESOLVED** to:-

- **NOTE** the Forward Look.
- **AGREE** that Independent Members would forward thoughts to the Chair.

FPW/19/98 **CHANGE TO AGENDA ORDER**

It was proposed that agenda item 2.5 be taken next and this was **AGREED**.

NWIS CLINICAL CODING REPORT

Rita James presented the report which provided Members with an update on the Clinical Audit Report for 2018/19 and the Admitted Patient Care (APC) costing resubmission 2018/19.

Members **NOTED** that Clinical Coding was the translation of medical terms in case-notes into alpha numeric codes and that codes were assigned to each episode of patient care by a team of clinical coders. Rita James advised that the organisation aspired to ensuring that the whole team were fully qualified.

Members **NOTED** that the report demonstrated the improvements made in quality which was important and that capturing the main diagnosis was critical. Members **NOTED** that the Team had achieved the measures for each of the four categories and had increased the target in some areas. Members **NOTED** that this was a significant achievement particularly as the team had not previously met targets. Members **NOTED** that completion within the target was critical and needed to be 98% complete.

Rita James advised that the Team had been delighted to have attained the standard and were keen to retain it acknowledging that there were further improvements that could be made. Members **NOTED** that the Health Board's clinical coders now included an experienced team based at the Princess of Wales Hospital (POWH) all of whom were accredited.

Members **NOTED** that there were challenges, particularly in relation to the content of the casenotes. If a diagnosis or procedure had not been recorded it could not be coded, with some casenotes containing no primary diagnosis. Members **NOTED** the need to raise the profile of the content of the clinical case note with no clear route in place to take this forward.

Ruth Treharne advised that Clinical Coding performance was an area that the Committee had routinely monitored and that an internal audit review of Clinical Coding had also been undertaken, and suggested that this may also be of interest to the Audit Committee and the Quality, Safety and Risk Committee.

Paul Griffiths welcomed the NWIS Clinical Coding Report which he felt was encouraging.

Paul Griffiths made reference to the conclusion of the main report which stated that there was a lack of a planned programme of internal audit and suggested that more internal audits should be undertaken. Rita James advised that the need to employ a qualified auditor and qualified trainer had been included in the Integrated Medium Term Plan (IMTP) and it was possible that existing team members would want to undertake the necessary training. Members **NOTED** that funding would be required to enable this which would need to be considered alongside the various other completing priorities that existed within the organisation.

Paul Griffiths suggested it may be helpful for the report to be referred to the Information, Communication & Technology Committee which was being established.

Dilys Jouvenat congratulated staff in terms of the positive points drawn out in the report noting that there were a couple of issues where there was failure to comply with the recommendations or where compliance remained problematic. Rita James advised that the 40 Finished Consultant Episodes per day was an aspirational target initially but that the Team had subsequently achieved and even surpassed the target on occasion.

Steve Webster advised that a benchmarking exercise had been undertaken of clinical coding staffing which showed that the organisation had had average staffing levels for its workload.

Mel Jehu extended his thanks to Rita James for presenting the report, and advised that it was rare to read a report which contained such positive statements and commended the work being undertaken.

Members **RESOLVED** to:

- **NOTE** the improvements in quality of Clinical Coding and the achievement of the Clinical Coding completeness targets for 2018/2019
- **AGREED** to refer a copy of the report to both the ICT Committee and Quality Safety & Risk Committee.

FPW/19/99 **FINANCE UPDATE – MONTH 3**

Steve Webster presented the report which highlighted the key messages in relation to the Month 3 financial position. Members **NOTED** that the Health Board were forecasting a break-even position, £140k over accumulatively. Members **NOTED** that there was delegated overspend of £4.6m on operational budgets and a £4.5m underspend on non-delegated budgets.

Members **NOTED** that savings remained a concern, with the year to date position being 0.5% and the forecast position being 1% (£8m) against the 2% target (£16m). Members **NOTED** the minimum savings target of £10.5m. Steve Webster advised that a high level focus would be required and this was being raised at meetings with Service Groups so that there was clarity that a minimum expectation of 2% savings needed to be included within their plans.

Members **NOTED** that other areas of concern included Medical and Nursing pay, with spend against Nursing pay being £1.3m year to date. Members **NOTED** that this related to a combination of operational issues, with requests being made for more nursing staff to be rostered which largely related to Acute Medicine and A&E Following discussion it was **AGREED** that it would be beneficial to undertake a financial deep-dive into Nursing pay spending. (**added to the action log**).

In relation to Medical pay spending, it was **NOTED** that there was an overspend of £0.8m year to date, £500k of which related to Princess of Wales Hospital and mostly related to Ear, Nose & Throat services rota changes which had been introduced by Abertawe Bro Morgannwg Health Board prior to transfer. Steve Webster suggested that the Committee may also benefit from a deep-dive into Princess of Wales Hospital as a Service Group.

Kath McGrath stated that she would welcome a deep-dive into Nursing spending in order to further understand the opportunities for managing this differently.

Mel Jehu sought clarification as to who would lead the deep-dive and how long this would take to complete. Members **NOTED** that the Executive Lead would be Greg Dix, supported by John Palmer and Kath McGrath. Steve Webster advised that it could be possible to complete the deep dive for the either the September or October 2019 meeting of the Committee.

Members **NOTED** that the Health Board had been awarded £7m by Welsh Government for Referral to Treatment Targets (RTT) to ensure the waiting times for the former Cwm Taf were maintained and those that required improvement within Bridgend were addressed. Members **NOTED** that this would not assist in addressing the risks which the Health Board were currently experiencing, for example those had had arisen from changes in taxation rules in relation to pensions for those earning above £150k..

Members **NOTED** that there were a number of proposed changes that would require resources which were not currently included in the plan and **NOTED** that the forecasted break-even position for year-to-date did not include the investments that would be required to address these. .

Members **NOTED** that the Health Board was still awaiting the outcome of the Financial Arbitration (regarding the Bridgend Boundary Service Changes) via Welsh Government although this was anticipated within the next few weeks. Members **NOTED** that in the overall financial plan there was some headroom provided in terms of slippage monies however, this was being used to address overspends in areas such as nursing.

Paul Griffiths questioned the value for money of A&E services. Steve Webster advised that the Health Board currently had below average staffing levels and that opportunities to improve value did not equate with reducing costs.

Members **RESOLVED** to:

- **NOTE** the report;
- **AGREE** to receive the deep-dive into Nursing pay spending at the September 2019 meeting.

FPW/19/100 **INTEGRATED PERFORMANCE DASHBOARD**

Ruth Treharne presented the report the purpose of which was to provide the Committee with a summary of current performance across a range of indicators and key issues, in particular where there were current organisational challenges and achievement and/or the organisation is under formal escalation with the Welsh Government. The following key points were **NOTED**:

Referral to Treatment Targets (RTT)

- Correspondence had been received from Welsh Government confirming the funding allocation of £7m and the agreed trajectories
- Further understanding was now being gained in relation to the Bridgend performance element
- The Cwm Taf Morgannwg trajectory would be included in next month's dashboard report
- Members **NOTED** that a Delivery Unit review was being undertaken which highlighted that there were potentially unreported waiting lists which could have an impact on the Health Board's RTT reporting. A final report would be presented to the Committee once the review had been completed (**added to the action log**)
- The June performance for CTM was 288 patients breaching the 52 week target, mainly in the Bridgend area, and 1676 patients breaching the 36 week target in both Bridgend and former Cwm Taf areas. Members **NOTED** that this was a concern and excluded unreported numbers at present. The 26 week performance was 86.9%
- Members were reminded that Welsh Government expected the Health Board to be at 0 patients waiting 36 weeks from April 2020, particularly in former Cwm Taf

Kath McGrath advised that changes to pension taxation for those earning above £150k were having an impact on the RTT position as clinical staff, anaesthetists in particular, did not want to undertake additional sessions which was having an impact on delivering services. Members **NOTED** that this would likely result in 52 week breaches.

Members **NOTED** that outsourcing had been undertaken in Ophthalmology and new pathways were being put into place.

Members **NOTED** that internal cancellations had been having an impact on plans within General Surgery with Directorates working hard to produce final plans in the next fortnight.

Mel Jehu questioned whether the taxation rule changes would result in an adverse impact upon service quality. Members **NOTED** that operational decisions were being made on a weekly basis in this regard and that attempts were being made to procure an appropriate outsourcing provider in particular to undertake Pain Clinics.

Paul Griffiths questioned whether the RTT funding from Welsh Government would result in different waiting times for Cwm Taf Morgannwg patients. Ruth Treharne offered assurances that efforts were being made to equalise performance across sites

Diagnostic Waits

- The Health Board was currently meeting the end of year trajectory with no patients waiting over 8 weeks for Diagnostics and no patients waiting over 14 weeks for Therapies
- The reported position for June was 128 patients waiting over 8 weeks for Diagnostic services, 6 patients within the Bridgend area and 122 within the former Cwm Taf area.

Clinical Neurophysiology

- Members **NOTED** that figures for Neurophysiology were not currently included but would be incorporated into future dashboard performance reports from September 2019 onwards. Members **NOTED** that there were currently 290 patients waiting over 36 weeks and the improvement work required was under consideration with a plan to address the position within 6-7 months. Members **NOTED** that further investment would be required to achieve this.

Discussion ensued regarding the non-reporting of these particular performance figures Members **NOTED** that there were lessons that needed to be learned with a possibility of national guidance being issued as a result as this matter affected all Health Boards.

Members **NOTED** that a review of Follow Ups Not Booked (FUNB) was also underway. Members **NOTED** that this was a significant piece of work which would commence in July 2019.

Members **NOTED** that the Delivery Unit were assisting the Health Board in undertaking a review of the position and that the respective Terms of Reference attached to the report for information.

Surveillance Monitoring

- Members **NOTED** that whilst not part of the national outcomes framework, visibility had been provided on the endoscopy surveillance performance and the figures included in the report showed that the Health Board had a backlog in surveillance numbers, which was not unusual. Members **NOTED** that this needed to be made more visible as there were some quality, safety and risk issues associated for patients. Members **NOTED** that the backlog of 843 patients would continue to be reported in the dashboard until an improvement in the position was being seen
- Members **NOTED** that some patients would have been kept on the list for clinical reasons and that insourcing of the list was being undertaken to reduce numbers

Urgent Suspected Cancer (USC) Performance

- Members **NOTED** that the Delivery Unit (DU) had expressed concern in relation to performance at Prince Charles Hospital (PCH) A&E and were undertaking a review, the Terms of Reference for which were attached.

Elective Bed Cancellations

- Elective Bed cancellations in June 2019 were **NOTED** to have been low with the majority (23) being at PCH.

Delayed Transfers of Care (DTOC)

- Figures for Cwm Taf Morgannwg remained static with 60 reported in June 2019. Discussions were due to be held with local authority colleagues to revisit the position.

Kath McGrath advised that the PCH site were continuing to have issues with bed cancellations following the transfer of gynaecology services. Members **NOTED** that overall there did not appear to have been an increase, with patients regularly being diverted to Royal Glamorgan Hospital (RGH). Members **NOTED** that the RGH position had improved following an extremely challenging April and May 2019.

Cancer Performance

- The Health Board had not met either the 31 or 62 day target in respect of the former Cwm Taf area, with a performance of 94.3% against the 31 day target and 72.7% against the 62 day target, which was a significant drop

- Despite previously showing improved performance for urology, there had been an increase in the number of breaches (7) and a rise in lung cancer breaches also (7). A 'worse case' forecast indicated 80% compliance over the next 3 months.

Members **NOTED** that a deep-dive had been undertaken which indicated that the deterioration in Urology related to a combination of radiological delays and limited capacity in Urology consultant time. Members **NOTED** that the issues with Lung were mainly related to Endobronchial Ultrasound Bronchoscopy (EBUS) procedure delays in Cardiff and Vale University Health Board and consideration was now being given to undertaking EBUS within Cwm Taf Morgannwg. Members **NOTED** that a request had been made by John Palmer for weekly cancer performance meetings to be put in place in the interim. Members **NOTED** that the position would be closely monitored over the next few months.

Stroke Performance

- The SSNAP score had been added into the report which was felt to provide more depth of reporting. Members **NOTED** that the Minister was keen for Health Board's to be focused on this data
- Member **NOTED** that there had been a deterioration in performance at PCH with the issues being well known to the Health Board with investment now required into a 24/7 service
- Admissions to the Stroke Unit remained challenging, with current challenges with the recruitment and retention of Speech and Language therapists (SALT)
- With regard to the discharge process, further understanding was required as to why the Health Board reduced to 'D'.

Discussion ensued regarding the range of services requiring investment which were not deemed priority areas. Members **NOTED** that there may be a need review the position.

Mel Jehu praised the resilience of staff and advised that the service was being run by a small group of nurses and depended on 1 or 2 individuals attending work. Kath McGrath agreed that the service heavily relied on specialist individuals.

Ruth Treharne advised that there would be a need to further understand the stroke services in Bridgend which could be reviewed at the Stroke Implementation Group.

Paul Griffiths made reference to the absence of a simplistic summary at the start of the report which made the report not always easy to read due to the significant amount of information and diagrams contained within the report. Ruth Treharne advised that she would welcome the opportunity to meet with Independent Members to discuss the future report content.

This was welcomed by Paul Griffiths who reiterated that Independent Members needed to be satisfied that they were focussing scrutiny on matters of most importance.

Steve Webster suggested that consideration could be given to standardising some of the graphs in the report akin to the Finance dashboard.

Members **RESOLVED** to:

- **NOTE** the report.

FPW/19/101 **WORKFORCE DASHBOARD**

Anne Phillimore presented the report which provided an update on the key workforce metrics for May-June 2019, with historic trends shown as appropriate. Anne Phillimore stated that the issue of sickness/absence would be covered as a separate matter later in the agenda.

Members **NOTED** the following key points:

- International recruitment had commenced, however logistical issues were being experienced particularly in relation to availability of housing accommodation for international nurses
- Issues had been experienced in relation to the provision of counselling services, with increased demand being seen as a result of issues within maternity services
- There had been some difficulties experienced with an information system following a system update. Members **NOTED** the excellent response received from the Information Technology Team
- Investment was being made into Occupational Health Services with a view to reducing the length of time staff needed to wait to be seen which was as long as 16 weeks in some cases.
- Retention was shown to be relatively static, however, further analysis showed that the position was variable. Members **NOTED** the high turnover in nursing and midwifery areas, and that a number of new groups were being established, with revised Terms of Reference, who would be focussing on recruitment and retention
- There had been an increase in agency spend, medical and non-medical, with an increase in nurse agency spend also being seen, particularly in the Bridgend area which was now being addressed.

With reference to page 4 of the report, Mel Jehu stated that he felt the dashboard content required further review to aid interpretation. Anne Phillimore advised that she would be happy to consider the format of the report further to determine whether there was a more meaningful way or presenting the information (**added to the action log**).

Anne Phillimore advised that nurse retention remained an issue, and support packages were being wrapped around new starters from overseas.

Members **RESOLVED** to:

- **NOTE** the content of the report.

FPW/19/102 **OPPORTUNITIES FROM SUMMARY OF NHS BENCHMARKING NETWORK REPORTS ON CWM TAF UHB**

Steve Webster presented the report which provided the Committee with a summary report from the NHS Benchmarking Network (NHSBN).

Members **NOTED** that in order to stand still the Health Board would need savings of 2%, but if the Health Board could achieve above this then investment could be made into areas of need. Members **NOTED** that a piece of work had commenced to identify these potential areas.

Members **NOTED** that the report sets out a summary of the NHS Benchmarking Network reports which was the largest benchmarking network in the NHS. Members **NOTED** the very high level of participation in the network across the UK, with greater focus on organising and coordinating the content of reports. Members **NOTED** that Welsh Government were utilising the data as part of its system of performance management and that the Health Board needed to be aware of the potential opportunities in this regard

Steve Webster advised that the Network produced around 15-20 reports a year, with the Health Board participating in approximately 75% of them, with 10-12 reports a year being shared with different parts of the organisation. Members **NOTED** that the report identified the headline opportunities following the 2017/18 review, with key messages highlighted below:

A&E

The report stated that the Health Board had below average levels of medical and nursing staff relative to the number of patients being seen. As a result of agency usage and staff sickness the costs of the service were average but with relatively low levels of staff it did not provide good value, but also did not have a high cost per attendance. The main issue for A&E remained the sustainability of staffing.

Paul Griffiths advised that the report also indicated that there may be a significant level of inappropriate and avoidable attendances.

Planned Care

The report suggested a relatively low day case rate compared with other Health Boards with very high outpatient referral rates.

Follow-Up rates & DNA

Members **NOTED** that these rates were really high, subsequently taking up a large element of outpatient resources.

Urgent Care

The report looked at services relative to population which were high for the Health Board. Members **NOTED** that A&E attendances per head of population was high with significant resource involved with urgent responses. Members **NOTED** that the work being undertaken by Kelechi Nnoaham on Population Health would be key to this piece of work in order to establish whether the high number of A&E attendances related to population health.

Steve Webster advised that there were a number of opportunities which would enable the Health Board to get better value out of the spend and that work would need to be undertaken with the Executive Team as to how this information could be used more rigorously. Steve Webster asked what role the Finance, Performance and Workforce Committee would wish to take in relation to this piece of work.

Paul Griffiths stated that this was a very useful indicator as to where time and effort needed to be spent and questioned whether there was enough internal resource and capability in place to undertake this piece of work and whether external resource would need to be sourced, for example, from Internal and External Audit. Steve Webster advised that provision had been made for improving change management capacity and added that clinical leadership and engagement would be essential in order to affect change.

Ruth Treharne concurred with Steve Webster making reference to the previous Organisational Strategy and Performance Management Framework. Members **NOTED** that the Health Board had previously received support from external experts to review theatre efficiency. .

Ruth Treharne said it was disappointing to note there were areas where performance required improvement Anne Phillimore observed that where external support had been provided, reports had been produced but recommendations had not been embedded. Anne Phillimore stated it was crucial to empower the managers with appropriate investment to instigate and embed change.

Paul Griffiths expressed the importance of acting on this report and ensuring it makes a difference. Kath McGrath advised that she would echo the comments made by Members and advised that a number of the Teams were fully aware of the issues and just needed the time and resources to address and consider the best way forward.

David Jenkins made the Committee aware of the continuous improvement programme pursued in Aneurin Bevan Health Board which had strong clinical support as a result of change being led as a

quality improvement rather than a clinical efficiency exercise.

Dilys Jouvenat stated that it would be important that staff were given the opportunity to share any good ideas of their own whilst managing expectations, rather than change being imposed.

Steve Webster indicated that perhaps the Independent Members were in the best position to question why there was disparity between services and best practices, and how the Health Board were intending to address this.

Mel Jehu stated that he had found this report very helpful and would wish to have this embedded into the organisation. Mel Jehu also added that he would like to see how the Executives would ensure that Independent Members were being provided with the right information to enable them to ask the most appropriate questions.

Ruth Treharne informed Members that during Health Board wide discussions, it had been made clear that there would be a need to focus on quality, which was a key piece of work. Members **NOTED** that Executive Directors and Independent Members would need to ask questions as to how the new structures were being implemented with strong focus being placed on culture.

Steve Webster suggested that it would be helpful if this report could be shared at Board for further discussion in 2-3 months so that further consideration could be given to the cycle for monitoring. Steve Webster **AGREED** to discuss further with Sharon Hopkins and the Executive Team as to the correct process to follow (**added to the action log**).

Members **RESOLVED** to:-

- **NOTE** the content of the report.
- **AGREE** to forward the report to the Board, following further discussion with Sharon Hopkins and the Executive Team.

FPW/19/103 **DEEP-DIVE REVIEW INTO SICKNESS ABSENCE**

Mel Jehu advised Members that this was an important area which would require a detailed discussion and stated that Hywel Daniel would today being providing a presentation on the key issues ahead of a detailed report being scrutinised at the next meeting in in September 2019. .

Anne Phillimore presented a brief summary report to the Committee. Members **NOTED** that the Health Board was above average in terms of sickness absence in Wales and that Cwm Taf had historically been an outlier in relation to sickness absence. Anne Phillimore stated that consideration was being given to commissioning a piece of work to

understand how population demographics impacted upon staff sickness absence levels.

Members **NOTED** that on average, the figures showed that 19 days per year per employee were lost to sickness, which was quite high. The reasons for absence varied, with 31% of recorded sickness absence being related to anxiety/stress or depression, which was a worrying figure.

Members **NOTED** that the majority of absence was short term, with the highest levels of sickness being experienced in Additional Clinical Services staff, particularly amongst Bands 2-4 working in clinical areas. High levels of sickness were also being seen amongst Healthcare Support Workers, Nursing & Midwifery Staff and Estates & Ancillary staff.

Members **NOTED** that following the introduction of a revised Sickness/Absence Policy there would be need for training with managers to determine the circumstances of discretion exercised and that there would be a need to review and revise the management toolkit for new managers. Members **NOTED** the need for rapid access to occupational health, and the introduction of a menopause policy.

Members **NOTED** that there were variations in how enhancements were being paid, and feedback had been received from staff side that managers had advised that they felt able to exercise their discretion.

Members **NOTED** that Cwm Taf had earned the Platinum Corporate Health Standard and that this achievement needed to be made more visible across the Health Board.

Members **NOTED** that an Occupational Psychologist was about to be appointed, and consideration was being given to the benefits of introducing an Employee Assistance Programme.

Mel Jehu thanked Anne Phillimore for her presentation which had set the tone for more detailed discussion at the September 2019 meeting.

Dilys Jouvenat welcomed the more flexible approach for the management of staff sickness/absence

Members **RESOLVED** to:-

- **NOTE** the update received.

ITEMS FOR INFORMATION

FPW/19/104 Members **RECEIVED** and **NOTED** the Month 3 Monitoring Returns

which had been submitted to Welsh Government.

FPW/19/105 Members **RECEIVED** and **NOTED** the Delivery Unit (DU) - Terms of Reference – Performance Intervention Prince Charles Hospital Emergency Department and Acute Unscheduled Care System.

FPW/19/106 Members **RECEIVED** and **NOTED** the Delivery Unit (DU) - Terms of Reference Intervention into Cwm Taf Morgannwg UHB Systems and Processes

FPW/19/107 **International Health Coordination Centre – A Charter for International Health Partnerships in Wales**

Mel Jehu advised that he had discussed this document with Anne Phillimore..

Anne Phillimore informed Members that the Charter would be launched in September 2019, and that she would present an update report to a future meeting on progress being made. Members **NOTED** that Dilys Jouvenat had agreed to be the nominated lead for the Charter.

Members **NOTED** the Charter.

FPW/19/108 **Correspondence Relating to the NHS Performance Fund 2019/20**

Members **NOTED** the correspondence.

FPW/19/109 **Update on Follow Up Patients Not Booked**

Members **RECEIVED** and **NOTED** the update.

ANY OTHER BUSINESS

<u>Items referred to other Committees</u>

FPW/19/110 The members **RESOLVED** to forward the Clinical Coding report to the

- Audit Committee
- Information. Communication & Technology Committee
- Quality, Safety and Risk Committee

FPW/19/111 Ruth Treharne suggested that the Forward Look for September 2019 be updated to include a Nursing Spend deep-dive also with a deep-dive into Sickness Absence.

Mel Jehu thanked everyone for their attendance and contributions and closed this section of the meeting.

FPW/19/112 **DATE OF THE NEXT MEETING**

The next meeting of the Finance, Performance & Workforce Committee was scheduled for Thursday, 19 September 2019 at 1 pm, in Ynysmeurig House, Navigation Park, Abercynon.

Signed …….

Mel Jehu, Independent Member

Date ……..

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Reporting Committee	**Finance, Performance & Workforce Committee**
Chaired by	Mel Jehu, Independent Member
Lead Executive Director	Director of Planning and Performance
Author and contact details	Kathrine.davies2@wales.nhs.uk
Date of last meeting	19 September 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The Finance, Performance & Workforce Committee last met on 19 September 2019. The Agenda and papers for this meeting are available on the UHB's Internet site via the following link:
http://cwmtaf.wales/how-we-work/finance-performance-workforce-committee/

Welsh Government Quarterly Report on Agency & Locums – Medical and Dental
The Committee **received** and **noted** the report which was presented by Anne Phillimore. Members **noted** the issues raised and the report and **agreed** to retrospectively approve the Quarter 1 2019/2020 report which had been submitted to Welsh Government.

Update on Commissioning
Members received the report which was presented by Julie Keegan.

Members **noted** the updated provided on the performance of commissioned activity for the former Cwm Taf UHB for 2018/2019 which included waiting list performance. Members **noted** the plan for commissioning arrangements for 2019/2020, including the Bridgend population which set out the commissioning and contracting arrangements between Swansea Bay and Cwm Taf Morgannwg UHBs.

Finance Dashboard
The Committee **received** and **noted** the Month 5 finance Dashboard which was presented by Steve Webster.

Efficiency Savings Programme Update – Month 5
Members **received** and **noted** the report which was presented by Steve Webster.

Members **noted** that the report set out the latest position and current Cash Release Efficiency Saving Schemes to close the financial gap for 2019/2020. Members **noted** that the report also set out potential cross-cutting and enabling schemes to form part of the forward schemes.

Workforce Dashboard
The Committee **received** and **noted** the report which was presented by Anne Phillimore.

Performance Dashboard
The Committee **received** and **noted** the report which was presented by Ruth Treharne.

Committee Referral from Primary & Community Care committee – Ophthalmic Diagnostic & Treatment Centres
Members, **received, discussed** and **noted** the Committee Referral from the Primary and Community Care Committee at its meeting held on the 24 July 2019. Ruth Treharne advised members in regard to the decision of the Committee to refer the item.

Committee Referral from Quality, Safety & Risk Committee – Issues in Relation to Coding of Quality Data
Members, **received, discussed** and **noted** the Committee Referral from the Quality, Safety & Risk Committee at its meeting held on the 5 August 2019. Members **noted** that discussions had been held between the Chair and the Chair of Quality, Safety & Risk Committee in regard to this matter.

Months 4 & 5 Monitoring Returns to Welsh Government
Members **received** and **noted** for information the Months 4 & 5 Monitoring Returns that had been submitted to Welsh Government.

Referral to Treatment 2019/2020
Members **received** and **noted** for information the letter from Welsh Government to health boards in relation to the RTT Delivery for 2019/2020.

Key risks and issues/matters of concern and any mitigating actions	
- Unscheduled Care Performance – To receive a further update report at the June Meeting;	
Matters requiring Board level consideration and/or approval	
- There were none	
Matters referred to other Committees	
- There were non	
Date of next meeting	24 October 2019

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Reporting Committee	**Primary and Community Care Committee**
Chaired by	Maria Thomas
Lead Executive Director	Director of Primary, Community and Mental Health
Author and contact details	Kathrine.davies2@wales.nhs.uk
Date of last meeting	24 July 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The Primary and Community Care Committee last met on 24 July 2019 the agenda and papers are available at the following link:

http://cwmtaf.wales/how-we-work/decision-making-2/primary-care-committee/

Chair's Update

Mrs Maria Thomas, Committee Chair, updated Members on the Vice Chairs meeting with the Minister. Discussions were held on:

- Primary Care Milestones – Report in relation to delivery for the first quarter for 2019/20 due in September 2019. Minister was keen to ensure that progress was being driven with pace.
- Update on Primary Care National Work from Sue Morgan, National Lead and Service Director. The work would bring greater consistency to services across health boards in Wales.
- Discussion was held on the recent publication by the Health & Social Care Committee where it had been noted that GP sessional rates varied amongst health boards
- Assurance that Primary and community Care issues were visible at Board level was discussed.

Primary Care Estates Strategy 2018/2028

Members **received** a presentation from Sarah Bradley. Members **noted** the update on progress during the past two years, current schemes within Cwm Taf Morgannwg UHB, third party funded improvements and the challenges and opportunities that existed.

Members **noted** that the Health Board wide Estates Strategy was currently being refreshed and this would need to align with the Primary Care Estates Strategy.

Members were of the opinion that the Primary Care Estates Strategy was ambitious and that appropriate consideration was required in regards to the links to the Integrated Medium Term Plan and the organisation's financial strategy.

Members **agreed** that for assurance purposes, updates on the Primary Care Estates Strategy should become a standing item on the agenda.

Primary and Community Care Committee 'Draft' Annual Report 2018/2019 including Committee Self-Assessment & Terms of Reference

Members **received** the draft Annual Report which was presented by Wendy Penrhyn-Jones. Members **noted** that the Annual Report, Terms of Reference and findings of the Self-Assessment, once approved, would need to be presented to the Board.

Members **agreed** that the Terms of Reference be subject to further discussion between the Health Board Chair and the Director of Primary, Community & Mental Health outside of the meeting and that the Self-Assessment be relayed to those required to complete this for subsequent consideration by the Chair and further discussion at the next meeting as necessary.

Organisational Risk Register

The Risk Register was **received** by the Committee and **noted.** Members **Noted** that the Primary and Community Care Committee were allocated two high rated risk for scrutiny on the Organisational Risk Register, namely:

- **Risk 030**: Continued Provision of GP Our-of-Hours Services, and
- **Risk 036**: Primary Care Workforce - Recruitment and sustainability.

Members **agreed** to retain Risk 030 on the Organisational Register and **noted** that Risk 036 would be recalculated to determine if this warranted retention.

Population Health Programme Update – Population health Management

Members **received** a presentation which was delivered by Kimberley Cann setting out the progress of Population Health Management for Cwm Taf Morgannwg UHB.

Members **noted** that there were four elements to the work and each individual health board would determine how they would take the work forward.

Members discussed Phase 2 Rhondda Primary Care Pilot and sought clarity in terms of timescales when the outcomes feedback would be available.

Members **agreed** to **endorse** the Phase 2 Primary Care Pilot and **agreed** to receive a position statement on Population Segmentation for future meetings.

Report of the Director of Primary, Community and Mental Health

Members **received** and **noted** the report. Alan Lawrie gave an overview of key areas including:

- Neighbourhood Nursing
- Update on the Business Case for Dewi Sant Hospital
- Update on Mountain Ash Primary Care Development
- Progress update on Y Bwythyn
- GP Sustainability – **agreed** that an update would be received at the next meeting.

Members had assurance on all key areas.

Cluster Update – Bridgend Cluster
Members **received** and **noted** the update report from Sarah Bradley. Members were provided with a brief overview of the current work of the Bridgend Primary Care Cluster.

Members **noted** that in regard to repeat prescribing in Bridgend, this was due for evaluation and a decision as to whether it would continue from April 2020 would be determined by the Executive Board in due course.

Delivery Agreements for 2019/2020
Members **received** and **noted** the verbal update from Sarah Bradley. Members **noted** that different models were in use within the Bridgend locality and the former Cwm Taf localities. Members were advised that a report on Delivery Agreements and associated spending was due to be considered at the forthcoming Clinical Business Meeting and an update would be received at the next meeting of the Committee in October 2019 to gain assurance on delivery and timescales.

Actions Arising from Improvement Plans for Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda
Members **received** the report which was presented by Paul Crank. Members discussed whether the report was more appropriate for consideration by the Quality, Safety & Risk Committee, and **agreed** that matters should be reported by exception to the Quality, Safety & Risk Committee. Members **agreed** to receive an update report in six months' time.

Transformation Fund Implementation Plan
Members **received** the report which was presented by Alan Lawrie. Members **agreed** to receive assurance reports for future meetings and that the Transformation Fund should be considered for inclusion on the Organisational Risk Register.

Review of Ophthalmic Diagnostic & Treatment Centres
Members **received** the report which was presented by Craige Wilson. Members **noted** that there were six recommendations arising from the visit undertaken by the Delivery Unit in November 2018 and that an Action Plan had been developed. Members **noted** that the matter had not yet been considered by the Executive Board in terms of any actions required and **agreed** that Craige Wilson and Alan Lawrie would discuss outside of the meeting so that there was clarity of understanding the routes for reporting issues to the Executive Board.

Members **agreed** that a copy of the report be referred to the Finance, Performance & Workforce Committee for consideration.

Review of HIW Reports and Update on Progress with Implementation
Members **received** the report providing an update in relation to actions arising from visits to New Tynewydd Surgery and Ferndale/Maerdy Medical Centre in 2017 which had previously been discussed at the Quality, Safety and Risk Committee. Members were advised that the actions were largely complete but given that the two practices were managed by the health board an update had been brought to the Committee for completeness. Members **agreed** that any reports and action plans relating to Healthcare Inspectorate Wales should be received by the Committee in a timely manner.

Primary Care Out-of-Hours Implementation Plan National Out-of-Hours Report
Members **received** an update on work being undertaken by the GP Out of Hours Service in terms of its redesign to improve sustainability following the Cwm Taf Peer Review in 2018 and progress towards 111 roll-out.

Members **noted** that not all of the actions had yet been achieved and 11 roll-out was part of the next phase.

Members **noted** there were risks with rolling-out 111 during the winter period and therefore a review had been requested. Members **noted** that the outcome of the work would be reported to a future meeting of the Committee and **agreed** that an update would be reported at the next meeting particularly in regard to the issues with the Out of Hours Centre and leasing arrangements at Prince Charles Hospital.

Items received for information included:

- Update on a "Healthier Wales" Primary Care Strategic Plan – January 2019
- IMTP Quarter 1 Review

Key risks and issues/matters of concern and any mitigating actions
None identified
Matters requiring Board level consideration and/or approval
None
Matters referred to other Committees
Review of Ophthalmic Diagnostic & Treatment Centres – to be referred to Finance, Performance and Workforce Committee.

Date of next meeting	30 October 2019

STAKEHOLDER REFERENCE GROUP
13 JUNE 2019
YNYSMEURIG HOUSE, NAVIGATION PARK, ABERCYNON

PRESENT

Bill Smith	Merthyr Tydfil CBC
Clare Williams	Cwm Taf Morgannwg UHB
Eleanor Johnson	Carer Representative (RCT)
Jason Roome	WAST
Lynda Corre	Older Persons Representative (RCT)
Margaret Goodwin	Patient Representative (MT)
Paula Martyn	Care Forum Wales
Roy Bailey	Carer Representative (MT)
Sharon Jeynes	Cwm Taf Morgannwg UHB
Sharon Richards	VAMT (Vice-Chair)

IN ATTENDANCE

Amy Lewis	Cwm Taf Morgannwg UHB
Angela Hopkins	Cwm Taf Morgannwg UHB
Carmel Donovan	Bridgend CBC
Chris Moss	Cwm Taf Morgannwg UHB
Kay Harries	BAVO
Lynn Hudson	Cwm Taf Morgannwg UHB
Rhian Webber	Cwm Taf Morgannwg UHB

NO	AGENDA ITEM	ACTION
1.1	**WELCOME & INTRODUCTIONS** Sharon Richards (Chair) **welcomed** everyone to the Stakeholder Reference Group (SRG) and introductions were made. Sharon Richards advised that as the last meeting had not been quorate, the speakers due to present at that meeting would attend later in the year.	
1.2	**APOLOGIES FOR ABSENCE**	

DISCLOSURE BARRING SERVICE (DBS)

NO	AGENDA ITEM	ACTION
	Apologies were **received** from Anne Morris, Leanda Wynn, Paul Beckerton, Robert Williams and Ruth Treharne.	
1.3	**DECLARATIONS OF INTEREST** There were no interests declared.	
1.4	**MINUTES FROM THE LAST MEETING** Members **agreed** to **approve** the minutes of the meeting held on 20 February 2019.	
1.5	**MATTERS ARISING** **Dutch 'Neighbourhood' Nursing' Pilot** Sharon Jeynes **confirmed** that the Dutch 'Neighbourhood Nursing' Pilot would be brought to the December meeting. **Cancer Services** Sharon Jeynes **confirmed** that the Cancer Services update had been scheduled for the February 2020 meeting. **Additional Learning Needs (ALN)** Bill Smith queried whether the Health Board had linked in with local authorities and schools in relation to the Additional Learning Needs. Sharon Jeynes **agreed** to seek an update on the Health Board's position and report back. **Car Parking – Prince Charles Hospital** Bill Smith raised the issue of the car parking situation at Prince Charles Hospital which was causing difficulties for local residents. Sharon Jeynes **agreed** to seek an update on the Health Board's position and report back.	**SJ** **SJ**
2.1	**CWM TAF MORGANNWG (CTM) STAKEHOLDER REFERENCE GROUP (SRG) TERMS OF REFERENCE** Sharon Jeynes presented the revised Cwm Taf Morgannwg SRG Terms of Reference for approval. It was **noted** that the revised terms of reference had first been circulated with papers for April's meeting and subsequently recirculated in May at which point, members had been invited to comment by 5 June 2019. It was	

DISCLOSURE BARRING SERVICE (DBS)

NO	AGENDA ITEM	ACTION
	further **noted** that no comments had been received from members by this deadline. Sharon Jeynes explained that the rationale for revising the terms of reference related to the Bridgend boundary change and that the function and purpose of the SRG fundamentally remained unchanged. Amendments however were highlighted under the following sections: • Membership The membership would continue to be rooted in the community, however to simply mirror the current configuration to reflect the wider geographical area would make the size of the group significantly high. Members **agreed** to the proposal to reconfigure the membership to one representative per stakeholder groupings for each geographical area, i.e. Rhondda Cynon Taff, Merthyr Tydfil and Bridgend. The exception to this configuration related to national organisations such as WAST and Care Forum Wales patient, who would have one representative for the whole of Cwm Taf Morgannwg. • Quorum Members **agreed** to the proposal that quorum should be set at no less than 30% of the membership. • Term of office for members Members **agreed** to the proposal to introduce a term of office for membership. Under the new arrangement, members can serve in office for no longer than three years in any one term. Members can be reappointed, but may not serve a total period of more than five years consecutively. • Role description and person specification Members agreed to the introduction of role descriptions and person specifications thus ensuring representatives appointed understand what is expected of them and the commitment they must make to the group.	

DISCLOSURE BARRING SERVICE (DBS)

DISCLOSURE BARRING SERVICE (DBS)

NO	AGENDA ITEM	ACTION
	Members **agreed** to **approve** the revised Terms of Reference. Members were advised that the Terms of Reference would be submitted to the Health Board in July for approval. In the meantime, nominations would now be pursued via the nominating bodies. Sharon Jeynes **advised** that the election of a SRG Chair and Vice-Chair would take place in August's meeting. Sharon Richards thanked Mrs Jeynes for the update.	
2.2	**CREATIVE ARTS AND WELL BEING STRATEGY** Amy Lewis and Rhian Webber provided an overview of the work being undertaken in relation to the Board approved Creative Arts, Health & Wellbeing Strategy 2019-22. Amy Lewis **advised** that the successful implementation of the strategy required the co-operation of staff, statutory and third sector partners and more importantly patients, carers and members of the public. In December 2018, an action plan had been developed and launched to progress the strategic themes, which would be closely monitored by the Creative Arts, Health and Wellbeing Steering Group. Carmel Donovan commented that she was pleased that Princess of Wales Hospital and Glanrhyd Hospital had been included in the review, but noted that the document was still in the former Cwm Taf format. In response, Members were **advised** that the team were reviewing and refreshing documentation to reflect to the new organisation. Roy Bailey queried what engagement was there in relation to schools and asked what would be regarded as a successful outcome of the strategy. In response, members were **advised** that the artist in residence had links with universities, secondary and primary schools and that once the Creative Arts Co-ordinator had been appointed, they would also connect with communities.	

DISCLOSURE BARRING SERVICE (DBS)

NO	AGENDA ITEM	ACTION
	Amy Lewis added that implementing the action plan would be seen as a huge success. Paula Martyn asked what links were in place with nursing and residential homes. In response, members were **advised** that links would be forged within these settings at the earliest opportunity. Sharon Richards asked what mechanisms were in place to involve people in implementing the strategy. In response, members were **advised** that this would be something the new Creative Arts Coordinator would focus on once appointed. Sharon Richards thanked Amy Lewis and Rhian Webber for the information provided and asked members to share details of the strategy within their own communities and networks.	
2.3	**REGIONAL SERVICE MODELS** Chris Moss provided an overview of service redesign models across the region. Members **noted** the regional service update for:- • Vascular Services in South East Wales • Ophthalmology • ENT Service Redesign • Head and Neck Cancer Roy Bailey asked how capacity was considered in relation to vascular services and what the timescale for implementation was. In response, Mr Moss **advised** that work was currently being revisited and that there was a workshop being held tomorrow. Work had been done on capacity and patient flows going to Cardiff and the clinical model and revisit. Discussions had been held with clinicians across the three Health Boards and feasibility of timescale being September 2019. Members raised concern with cancelled glaucoma clinics which was a huge issue with cataracts and retinopathy	

NO	AGENDA ITEM	ACTION
	appointments with waits up to two years from appointment. In response, members were advised that in terms of workshare cover, they were looking at solving on a regional basis. The Health Board was exploring options and how to address cataracts going forward as a region. Roy Bailey queried the position in terms of costing for the ENT Service redesign and shortage of staff. Chris Moss advised that the ENT Project Board had identified an additional resource requirement which equated to one Paediatric ENT bed (and associated staffing) in the Princess of Wales Hospital. This was built into the wider Paediatric inpatient service change within the Health Board. Members were **advised** that the key drivers for this change was a shortage of staff, particularly Princess of Wales middle grade doctors and that we looked at how we could use the staff we had in a more effective way. The work was looking at how we best use the resources we have for a sustainable safe and wider service going forward as there were challenges as we were not able to have permanent doctors in place. Lynda Corre raised the issue of access to transport for patients travelling to Princess of Wales and Prince Charles Hospital. Clare Williams advised that it was difficult to put on additional transport services and would make sure there was the right transport service in place. Jason Roome added that the ambulance service was working closely with the service change and that they are developing pathways to take patients directly to where they need to be with regard to high quality treatment. Non-emergency transport provide services for vulnerable people who meet the criteria and would be taken to the centre for out-patient admissions.	**CM**

DISCLOSURE BARRING SERVICE (DBS)

NO	AGENDA ITEM	ACTION
	Sharon Richards thanked Chris Moss for the presentation and invited him back to the group to update on transport services.	
2.4	**MATERNITY SERVICES** Building on previous discussions, Angela Hopkins provided an update on Maternity Services following the publication by Welsh Government in April 2019 of the external review undertaken by the Royal College of Obstetrics and Gynaecologists (RCOG) and Royal College of Midwives (RCM). Members noted that as a consequence of the recent publications and related serious findings, the Minister for Health & Social Services had announced that for Maternity Services, Cwm Taf Health Board had been escalated to 'Special Measures', the highest level of escalation. In addition Cwm Taf Morgannwg Health Board's escalation level of 'enhanced monitoring' had been increased to 'targeted intervention'. The Welsh Government appointed an external Oversight Panel for maternity services going forward. The Health Board fully accept all recommendations within the reports and are already working hard to making improvements within the service. Members noted that the Executive Team was working with Welsh Government and the Oversight Panel and that two weeks ago some members were called to account before the Health, Social Care and Sports Committee of the Welsh Government to provide evidence on the background and actions taken and improvements. Work was already underway to make improvements in maternity care through the actions taken and overseen by the Maternity Improvement Board. Roy Bailey asked how the Health Board was managing staff morale and whether sufficient resources had transferred	

DISCLOSURE BARRING SERVICE (DBS)

NO	AGENDA ITEM	ACTION
	following the Bridgend boundary change. In response, members were **advised** that staff morale had been included within the report and that the Health Board needed to change the culture. However, this would not happen overnight and supporting staff was important. Members were also **advised** that Bridgend had transferred with all the associated resources. Members **noted** that Greg Dix, Director of Nursing, Midwifery and Patient Care would provide further updates at future meetings. Sharon Richards thanked Angela Hopkins for the update.	
3.1	**UHB BOARD UPDATE** Members **noted** that the Board update was not available at this time but would be circulated as soon as they became available.	
3.2	**SRG FORWARD WORK PROGRAMME** Members **noted** the forward work programme for June 2019 to June 2021. Members were **reminded** to contact the Health Board should they wish to add any items in the work programme going forward.	
4.1	**ANY OTHER BUSINESS** Sharon Richards advised members that Sharon Jeynes would be retiring at the end of June and wished to thank her for all the hard work, dedication and investment given, not only with this group, but for the organisation and that she would be sorely missed. All the members wished her a happy retirement and best wishes for the future.	
4.2	**DATE & TIME OF NEXT MEETING** Thursday, 15 August 2019 at 2:00 pm, UHB Headquarters, Ynysmeurig House, Abercynon.	

DISCLOSURE BARRING SERVICE (DBS)

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Reporting Committee	**Stakeholder Reference Group (SRG)**
Chaired by	Ms Sharon Richards, SRG Vice Chair
Lead Executive Director	Director of Planning & Performance
Author and contact details	Heather Smith, Business Support Manager – Planning & Partnerships
Date of last meeting	15 August 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The following provides a brief summary of the topics discussed at the Stakeholder Reference Group (SRG) meeting held on 15 August 2019.

INTEGRATED AUTISM SERVICES (IAS)

Catherine Edevane, Specialist Nurse provided an overview and update on the Integrated Autism Service in the former Cwm Taf footprint (the service in Bridgend was provided by Western Bay).

Members were advised that a one-day awareness sessions had been provided for Local Authority and Health Board staff which had been commissioned and funded by Welsh Government. Members **NOTED** that work was ongoing to provide information and advice sessions and future sessions would need to include a wider audience. Moving forward the IAS team would also be providing Train the Trainer courses.

Members **NOTED** a number of challenges including a number of vacant posts within the team which was an issue reflected in other Health Boards across Wales. Proposals were in place regarding staffing with a view to advertising shortly.

It was **AGREED** that a further update would be provided at a future meeting in early 2020.

DRINK A DROP AND PROTECTED MEAL TIMES INITIATIVES

Rebecca Thomas, Senior Nurse Professional Standards and Quality provided and update on the outcome of the recent Drink A Drop audit and the current progress with implementation of the droplet hydration aid. Members **NOTED** that the former Cwm Taf was the first Health Board to test the use of Droplet

and would be working with the Bevan Commission to consider how this could be replicated in other Health Boards across Wales.

Members were advised that the Droplet was being piloted in Ty Gurnos Nursing Home for one month. The amount of fluid intake would be monitored and it was **AGREED** that feedback would be provided at a future meeting.

Members were also advised of the work and review undertaken by the Drink a Drop team. The audit found that the initiative was well embedded in Prince Charles Hospital but further work was required in other areas and this would include those in the Bridgend area moving forward.

ANY OTHER BUSINESS

It was **AGREED** that Maternity and Paediatric Services would be included as a standing agenda item for future meetings.

Key risks and issues/matters of concern and any mitigating actions
Risks associated with items on the agenda were raised and discussed in the summary outlined above.
Matters requiring Board level consideration and/or approval
• The confirmed minutes of the SRG meeting held on 13 June 2019 have been submitted to Board.
Matters referred to other Committees
None

Date of next meeting	10 October 2019

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'CONFIRMED' MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND RISK COMMITTEE, HELD ON 9 JULY 2019 AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT:

Maria Thomas (Chair)	-	UHB Vice Chair
James Hehir	-	Independent Member
Nicola Milligan	-	Independent Member
Dilys Jouvenat	-	Independent Member
Keiron Montague	-	Independent Member

IN ATTENDANCE

Alison Davies	-	Assistant Director, Quality & Patient Experience
Greg Dix	-	Director of Nursing, Midwifery and Patient Services
Erica Emes	-	Healthcare Inspectorate Wales
Anne Phillimore	-	Interim Director of Workforce & Organisational Development
Rowena Myles	-	Cwm Taf Morgannwg Community Health Council (CHC)
John Palmer	-	Chief Operating Officer (In part)
Kamal Asaad	-	Medical Director
Martin Gill	-	Staff Side Health & Safety Representative
Paul Dalton	-	Head of Internal Audit
Gwenan Roberts	-	Head of Corporate Services
Gaynor Jones	-	Royal College of Nursing Convenor
Craige Wilson	-	Assistant Director, Primary Care, Children & Community Services
Tim Burns	-	Assistant Director, Capital & Estates (In part)
Eiri Jones	-	Programme Director (Observing)
Julie McCabe	-	Assistant Director, Quality & Safety, Delivery Unit
Melanie Harries	-	Quality & Safety Manager, Delivery Unit
Emma Walters	-	Corporate Governance/Committee Secretariat

PART 1. PRELIMINARY MATTERS

QSR/19/053 **WELCOME AND INTRODUCTIONS**

Maria Thomas (Chair) **welcomed** everyone to the meeting, particularly Erica Emes, Healthcare Inspectorate Wales (HIW), Craige Wilson, attending on behalf of Alan Lawrie, Eiri Jones, Programme Director who was attending the meeting as an observer; Julie McCabe and Melanie Harries from the Delivery Unit.

Members **NOTED** that Tim Burns, Assistant Director Capital and Estates would be attending part of the meeting to present an update report on Legionella.

QSR/19/054 **APOLOGIES FOR ABSENCE**

Apologies for absence were **RECEIVED** from Alan Lawrie, Kevin Smith, Robert Williams, Chris Beadle, Martin Gill, Kelechi Nnoaham, Sara Utley and David Jenkins

QSR/19/055 **DECLARATIONS OF INTERESTS**

There were no additional interests declared.

QSR/19/056 **The Patient Story**

Members **RECEIVED** the Patient Story video which related to a positive experience received by a patient within the Mental Health service. The patient advised that the Expert Patient Programme course he attended had been of great benefit and helped improve his health and wellbeing and advised that they were considering offering their support to the programme in order to help others. Greg Dix extended his thanks to the patient for sharing the story which he found to be very powerful and welcomed the news that the patient was now considering support others.

Keiron Montague also welcomed the story and advised that there were a number of community based Therapy services in place and it would be helpful if a report could be developed and presented to a future meeting to outline the service they provide and the impact they were having (**action**).

John Palmer advised that Valley Steps had been a positive intervention and was a service which had been well utilised. Members **NOTED** that the impact of the service had been tracked very carefully by Welsh Government and advised that he would be happy to circulate the impact of the service over the last 24 months to Members (**action**).

Nicola Milligan advised that the patient seemed to have been able to have rapid access to occupational health services which the majority of staff within the UHB would not have access to. Gaynor Jones advised that the Health Board do advise staff who are off sick to access the occupational health service.

QSR/19/057 **TO RECEIVE THE UNCONFIRMED MINUTES OF THE MEETING HELD ON 6 JUNE 2019**

The minutes of the Quality, Safety and Risk Committee held on 6 June 2019 were **received** and **confirmed** as accurate record of meeting, subject to the following amendment:

Page 13: Maternity Services Update Report, fourth sentence of the second paragraph to read 'Royal College of Obstetricians and Gynaecologists and Consultant *Midwives*'.

Page 21: fourth sentence of the first paragraph to read 'Members **NOTED** that and *update* would be presented'.

Members **RESOLVED** to:

- **APPROVE** the Minutes of the Quality, Safety and Risk Committee held on 6 June 2019.

QSR/19/058 **TO RECEIVE THE COMMITTEE ACTION LOG**

Members **RECEIVED** and **NOTED** the Committee Action Log.

QSR/17/39 & 19/44 – John Palmer advised that a report on Follow Up Outpatients Not Booked (FUNB) had not been developed for the meeting as a full update report had been presented at the June meeting. Members **NOTED** that focus was being placed on the Ophthalmology cohort of patients as a result of the risks associated with these patients whilst they were awaiting an appointment. Members **NOTED** that following feedback received from the Community Health Council and the National Body for Diabetes, an Independent Oversight Panel had been established to review cases and determine whether there were any areas of concern. John Palmer **AGREED** to present an update report on Ophthalmology FUNB patients to the August meeting.

QSR18/50 – Gwenan Roberts advised that the Board were still keen to undertake a discussion at Board Development in relation to Risk Appetite, Risk Register and the Board Assurance Framework. Members **NOTED** that the Chair was keen for this to be resolved and a discussion would hopefully be held at the August Board Development Session.

QSR/18/81 – Members **NOTED** that the Corporate Policy Sub Group had not yet been set up and it was hoped that this would be set up in August. In relation to the Clinical Policy Sub Group, Members **NOTED** the plans to establish this within the next six months. Gwenan Roberts advised that the Corporate Services and Patient Care & Safety Teams were working closely together to ensure processes aligned.

QSR/18/88 – Kamal Asaad advised that he had attended the Rapid Response to Acute Illness Learning Set (**RRAILS**) Peer Review and advised that he would provide an update report as soon as available.

QSR/19/08 – Alison Davies confirmed that she had met with Community Health Council colleagues following the last meeting to discuss the Quality & Safety Governance Framework where it was agreed that an easy read version of the framework would be developed. Members **NOTED** that this would be taken forward by Eiri Jones over the next six months.

QSR/19/35 – Anne Phillimore **AGREED** to provide a verbal update at the August meeting to advise whether the monitoring of Disclosure and Baring Service checks was being led by the Finance, Performance & Workforce Committee.

QSR/19/46 – Members **NOTED** that a referral had been received from the Finance, Performance & Workforce Committee which outlined concerns they had in relation to the nature of the Royal Glamorgan Hospital A&E department staffing model, which mainly consisted of locums. Members **NOTED** that a review was being undertaken of A&E staffing models across all three sites and a full update report would be developed for discussion at the September meeting of the Quality, Safety & Risk Committee. Keiron Montague advised that the concerns had been referred to the Committee as it was felt that performance issues identified may have an impact on quality and safety for patients.

QSR/19/48 – Members **NOTED** that in the absence of Alan Lawrie, and update in relation to the Lymphoedema service would be provided at the next meeting.

Keiron Montague advised that since becoming Cwm Taf Morgannwg UHB, a number of performance issues had been identified and questioned whether the Committee could be updated in terms of quality, safety and risk issues which had been identified following the Bridgend boundary change and clear analysis for the areas which the Committee would need to focus on.

Greg Dix advised that he had asked for a further review to be undertaken and would present a report to the September meeting outlining the outcome of the review (**added to the action log**).

QSR/19/059 **TO REVIEW MATTERS ARISING NOT CONTAINED WITHIN THE ACTION LOG**

The following matters arising were discussed:

Page 3 – 19/034 – Gaynor Jones questioned why nursing and facilities staff and not other staff had been singled out in relation to needle-stick injuries and use of safety devices and advised that she was unhappy with the statement made. John Palmer apologised and advised that it was because nursing staff had been referred to in the report and recognised that it was likely that it related to all staff; Members **NOTED** that it was not as large an issue as first thought.

Page 4 – 19/022 – James Hehir confirmed that he had discussed issues relating to WIFI connectivity with John Palmer and this matter was now closed.

Page 6 – 19/036 – Rowena Myles questioned what progress had been made in relation to the establishment of a Quality & Patient Experience Group. Greg Dix advised that he had discussed his initial thoughts in relation to developing a forum with Cathy Moss and it was noted that Eiri Jones would expedite this work with a commitment made to hold the first meeting in September. Greg Dix advised that he would welcome support from Rowena Myles in developing the forum. Members **NOTED** that all four proposed sub groups would require development moving forward.

Page 19 – 19/048 – Rowena Myles questioned whether the absence of a Quality Governance Manager within Radiology had now been resolved. John Palmer advised that this had not been resolved and added that strong quality governance support had been requested for all Directorates which was being considered as part of the structures consultation. Members **NOTED** that a supernumerary post had been in place in Radiology to undertake quality governance and **NOTED** that this person was no longer working in the role. John Palmer advised that the Team had been advised that this post would be considered as part of the structures consultation and it had also been identified as an issue in the Directorate Review undertaken by Internal Audit.

Page 14 – 19/042 – James Hehir questioned whether a discussion had been held with the Human Tissue Authority (HTA) in relation to extending the deadline from June to August. John Palmer confirmed that a discussion had not been held as the deadlines had been met. Members **NOTED** that the HTA had confirmed that they would be happy for the audit to be completed by the June deadline with completion of the action plan taking place after the deadline. Members **NOTED** that there were now four CAPA plans and HTARI's awaiting sign off.

Page 20 – 19/048 – Maria Thomas questioned whether the switchboard issues had now been resolved. John Palmer advised that all work had been undertaken in relation to the current approach and added that the Deep Dive had not yet been completed. John Palmer **AGREED** to provide an update at a future meeting (**added to the action log**).

QSR/19/060 **CHAIRS REPORT**

Maria Thomas presented her report and drew the Committee's attention to the joint review being undertaken by the Wales Audit Office and Healthcare Inspectorate Wales of the Quality Governance and advised that a draft report would be received by the Health Board in September. Members **NOTED** that the Terms of Reference for the review had been shared and Members requested that if any urgent matters were identified during the review they be escalated to Members immediately.

Members **NOTED** that Eiri Jones had joined the Health Board as a Programme Director and would be supporting Greg Dix in delivering the Quality Governance Framework and implementation plan. Eiri Jones advised that she had met with a number of staff and had planned to undertake some site visits and would also be holding 1-1 meetings with Executive Directors. Eiri added that priority work had been identified and added that she expected to meet the timeline given. Greg Dix advised that Eiri was a very experienced Chief Nurse and Nurse Director and had previously undertaken significant governance reviews in other health establishments and advised that the Health Board was very fortunate to have her support.

Maria Thomas advised that it was her intention to suggest and discuss with the Chair that Independent Members be connected to Director's portfolios. Members **NOTED** Maria's expectation that this would provide Independent Members a better understanding of the service in more detail which will assist in the scrutiny, particularly of directorate exception reports.

Maria Thomas advised that work had been undertaken by the Patient Care & Safety Team in relation to Executive Director and Independent Member walkabouts. Alison Davies advised that a draft programme was being developed and communications on the programme would be shared soon. Members agreed that it would be helpful if the buddy system could be changed after 6 months.

Members **NOTED** that the Quality, Safety & Risk Committee meetings would now be held monthly to enable more time for scrutiny, with focus being placed on 2-3 exception reports per meeting, and focus being placed on high risk areas.

Maria Thomas advised that Members had met with the Independent Maternity Services Oversight Panel and robust discussions had been held with Directors at the Board Development Session. Members **NOTED** that the Oversight Panel would be working closely with the Maternity Improvement Board.

PART 2. ITEMS FOR APPROVAL/ENDORSEMENT

QSR/19/061 **QUALITY SAFETY AND RISK COMMITTEE ANNUAL REPORT**

Gwenan Roberts presented Members with the draft Quality, Safety & Risk Committee Annual Report which related to the last financial year. Gwenan Roberts advised that finding the right balance of the approach had been difficult and the Annual Report contained factual information in relation to the reports that had been received by the Committee.

Gwenan Roberts advised that she would welcome Members comments as to how to frame some of the wording contained on page 9 of the Annual Report, particularly in relation to the Committee providing assurance to the Board that effective measures were in place. James Hehir advised that it was helpful to pull the Committee's attention to this because if the Health Board had effective measures in place potentially the organisation would not be in in escalation at the Targeted Intervention level. James Hehir added that there would be a need to identify the specific areas of challenge. Keiron Montague also agreed with the comments made.

Following discussion, Members **AGREED** to send comments to Gwenan Roberts within one week to enable Maria Thomas to take Chairs action prior to the submission of the report to Board (**added to the action log**).

In relation to the Terms of Reference, Members **NOTED** that there had been no significant amount of change. In relation to quorum, Members were reminded that Independent Members were the Members of the Committee, with all other persons being in attendance. Members **NOTED** and **AGREED** that for effective governance, two Executive Directors should be in attendance, one of which should be a Clinical Director.

Members **NOTED** that there had also been an amendment made to the frequency of meetings, with the Committee now meeting not less than ten times per year. Detailed discussion was held in relation to the Self-Assessment questionnaire which Members completed as a group. The following key comments were made:

- Question 5 – Keiron Montague advised that he felt that the Committee did not have the time to undertake a thorough review of the reports or had been provided with the correct data. Members **AGREED** to answer no to this question
- Question 8 – Members **AGREED** that there had not been effective scrutiny previously, and felt this would improve moving forward. Members suggested that a discussion was held as to whether representatives from Performance and Finance should be invited to join the Committee and agreed that Independent Members required further development. Members **AGREED** to answer no to questions 8 and 9
- Question 14 – Members **AGREED** to answer no to this question with a statement added that said this would improve moving forward following the establishment of the sub groups
- Members **AGREED** to answer no to questions 16 and 17 with a note to be added referencing the two improvement steps being taken, the establishment of sub groups and the increase in frequency of committee meetings. Members **NOTED** the importance of ensuring actions were being completed
- Question 18 – Members agreed to answer no this question. James Hehir advised that it would be helpful moving forward if Independent Members could have more training
- Members **AGREED** to answer yes to question 19 and no to questions 20 and 21. Members **NOTED** that in addition to the four new sub groups, the existing sub groups would still report into the Committee
- Question 26 – Members **NOTED** that the Committee would be receiving a report on External Regulators at every meeting moving forward
- Question 35 – Members requested that the response was changed from yes to no
- Question 36 – Members **AGREED** to answer no to this question. Keiron Montague suggested the Corporate Team did not have sufficient capacity which needed to be addressed

- Question 37 – Members **AGREED** to answer no to this question
- Question 38 – Members **AGREED** to answer no to this question. Gwenan Roberts **AGREED** to request that Finance undertake a review of the costs associated with running a Committee
- Question 39 – Members **AGREED** to answer no to this question. Members **NOTED** that work would need to be undertaken by Directors moving forward in relation to reports to the Committee which needed to be more succinct, with less narrative and needed to provide a good level of assurance
- Question 40 – Members **AGREED** to answer yes to this question and advised that a discussion would need to be held with the Communications team as to how key messages from the Board could be cascaded to staff. Gaynor Jones advised that it was important to not only use social media as not all staff used social media platforms and added that it may be helpful to re-introduce the staff briefing system used previously
- Question 42 – Members **AGREED** to answer no to this question.

Gwenan Roberts thanked Members for the discussion and suggested that given some of the comments made, it may be helpful to develop a separate report for Board outlining the discussion held.

Members **RESOLVED** to:

- Receive a further iteration of the Annual Report before submission to Board
- **ENDORSE** the Terms of Reference for submission to Board for approval.

PART 3. GOVERNANCE, PERFORMANCE & ASSURANCE

QSR/19/062 **UPDATE REPORT ON LEGIONELLA**

Tim Burns was in attendance for this item.

Greg Dix presented the report which provided an update of the recent detection of Legionella pneumophilia in water samples taken from the Princess of Wales Hospital. Members **NOTED** that a strain of legionella had been detected in 8 outlets within the hospital. Tim Burns advised that the outbreak occurred at the start of May and added that on the day of the outbreak key members of the Water Safety Group were brought together to address the issue. An external water specialist had been brought into the Health Board to assist.

Members **NOTED** that key tasks were carried out which included:

- Completely draining the whole site overnight
- Disinfecting the system overnight
- Number of retests had been carried out with negative results now being seen
- A request had been made for a water risk assessment to be undertaken.

Members **NOTED** that the Estates Team had early indication of some of the issues at Princess of Wales Hospital which suggested that the Health Board had not been provided with the correct information as part of the handover statement. Members **NOTED** that constant temperature checks were being undertaken with samples constantly being sent to Llandough Hospital for testing. Tim Burns added that risk assessments were being awaited for the whole site before assurance could be provided that the matter was fully resolved.

Members **NOTED** that all legionella tests had come back negative. Keiron Montague thanked the Team for ensuring this had been escalated to the Committee and advised that it seemed like this had been happening for some time. Greg Dix provided assurance that no legionella had been detected in samples taken from patients over the last few months. Maria Thomas also extended her thanks to the Team for the significant amount of work undertaken to address the issues.

Members suggested that it would be helpful if concerns could be escalated to Swansea Bay UHB as there may be issues in place at other sites as a result of processes followed and it was also suggested that it would be helpful if lessons learnt could be documented to minimise the risk of issues reoccurring (**added to the action log**).

Following discussion, Members **RESOLVED** to:

- **NOTE** the report
- Advise that the Committee had been **ASSURED** that regular monitoring was being undertaken and that as of today samples were negative
- Request that Swansea Bay UHB were informed of the issues experienced

Tim Burns left the meeting at 15.35pm.

QSR/19/063 **UPDATE REPORT ON MATERNITY SERVICES**

Maria Thomas extended her apologies for the late submission of the report and advised that Greg Dix had some concerns regarding the content which meant the report had to be altered.

Greg Dix presented the report and advised that over the last month there had been a great deal of activity within Maternity Services. Members **NOTED** that the Independent Maternity Services Oversight Panel (IMSOP) had now been established led by Mick Giannasi and the first meeting was about to be held.

In relation to Midwifery staffing, Members **NOTED** that an empirical evidence based review had not been undertaken in relation to staffing at Prince Charles Hospital prior to the move and **NOTED** that the current establishment had been based on assumptions and professional judgement. Greg Dix advised that Birth Rate Plus would now undertake a review of the establishment and would report back in September.

Members **NOTED** that based on assumptions, there were 14 Whole Time Equivalent (WTE) vacancies across the Cwm Taf Morgannwg footprint, which did not include Princess of Wales Hospital. Members **NOTED** that sickness remained high with stress being the main reason for sickness absence. Greg Dix advised that occupational health were continuing to provide support to staff.

Members **NOTED** that the Health Board had taken part in a recruitment event in which only 8 midwives opted to work for Cwm Taf Morgannwg as their first choice.

In relation to Medical staffing, there were 4 consultant vacancies, 3 of which had been recruited to. Members **NOTED** that the Clinical Director for Maternity had stepped down from the role and that there had been some Clinicians at Princess of Wales Hospital who had expressed an interest in taking on this role; although Members **NOTED** that there may be a need for a national advert.

Keiron Montague expressed his concern in relation to the nurse staffing position and advised that he had not been totally assured in relation to what steps would be taken if the Health Board could not recruit to vacant posts. Greg Dix provided assurance that the assumptions had been made by professional judgement by very senior midwifes. Members **NOTED** that staff from the Princess of Wales (POW) had also been providing support to the unit at Royal Glamorgan Hospital (RGH).

Members **NOTED** the SITREPs were in place each day and escalation processes were being put into place if SITREPs became Amber or Red.

Members **NOTED** that a decrease in capacity was now being seen at Princes Charles Hospital (PCH) with patients now flowing from PCH/RGH to POW. Greg Dix advised that there were women who were choosing to give birth elsewhere and risk assessments were being undertaken on a daily basis. Members **NOTED** that student midwives continued to work on the unit with positive feedback being received from the University regarding the support being provided. Members **NOTED** and agreed that cultural issues needed to be addressed moving forward.

Members **NOTED** that the Quality & Safety Governance Framework was now in place and had been shared with the IMSOP, Healthcare Inspectorate Wales and Welsh Government. Greg Dix advised that a significant increase in incidents being reported had been seen since the introduction of the framework.

Members **NOTED** that the Maternity Improvement Plan had been revised over the last four weeks, themes had been identified within the plan along with Executive Leads for each area. Members **NOTED** that there were 140 actions within the plan with progress made outlined within the report. Members **NOTED** that the full risk register would be included within the report at the next meeting.

In relation to assurance for maternity services, Members **NOTED** that the IMSOP had been supporting the work to date and had recently reviewed the 43 cases and had contacted the women who had been in touch with the Health Board since the publication of the Royal College report. Members **NOTED** that a member of the IMSOP would be developing a database to ensure all information was being captured.

Members **NOTED** that in relation to the directorate structure, an increase in resourcing and capacity had been agreed and there would be a dedicated team in place to support the programme. Members **NOTED** that a full time Programme Director and Programme Manager had been appointed.

Anne Phillimore advised that a significant amount of work was being undertaken to address the cultures in maternity services and one of the key tasks would be to have a senior directorate team in place in order to move the work forward. Members **NOTED** that work had taken place with the Team and Affina Team Performance for compassionate leadership.

Anne Phillimore advised that this process was difficult and would take time as a number of staff had already indicated that they had no trust or confidence in the management at all levels within the organisation.

Members **NOTED** that the information received from staff was being acted upon and Greg Dix advised that there were a number of midwifery staff who were undertaking good practice and a number of areas where focussed work was required. Members also **NOTED** that a meeting was being held with the Kings Fund to find out what type of support they could offer the Health Board.

Greg Dix presented Members with an update on user experience and advised that since April a member of the patient experience team had been undertaking surveys of 25 women each week at PCH. Members **NOTED** that although women were generally having a good experience, there were some women who were not having a positive experience. Some women's experience was poor, especially at night on the maternity unit. Greg Dix advised that he had given considerable thought as to how this could be addressed and advised that he had written to all midwives outlining what he, as the Director of Nursing Midwifery and Patient care, felt was acceptable and not acceptable behaviour strongly advising that he would not accept that women on the unit were being exposed to unprofessional behaviour of midwives. Members **NOTED** that the letter had been shared with staff side, the Independent Maternity Services Oversight Panel, Healthcare Inspectorate Wales and the Community Health Council.

To provide balance, Greg Dix advised that the Health Board had incredible skills and compassionate midwives working in the service and had apologised to those who provided expert care to women.

Maria Thomas welcomed the report which she found very helpful but also concerning. Maria Thomas advised that Greg Dix had the full support of the Committee to address the issues experienced.

John Palmer arrived at 16.10pm.

Keiron Montague advised that he found the report upsetting to read, particularly in relation to people's behaviours and attitudes and added that he was extremely disappointed that this had not been addressed previously. Dilys Jouvenat also expressed her disappointment at the negative comments and advised that the health board should not forget those staff that were consistently performing well.

Erica Emes, HIW, expressed her thanks to Greg Dix for sharing the report and letter which she felt was really open and honest with the tone being entirely appropriate.

Greg Dix advised that in relation to challenges and concerns raised by external partners, Members **NOTED** that he had attended the Rhondda Cynon Taf full council meeting, the Community Health Council full council meeting and the CHC special council meeting to respond to questions raised relating to Maternity.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/064 **DIRECTORATE EXCEPTION REPORTS**

Members **NOTED** that a new style of Directorate Exception Report had been developed and it was hoped that this would improve reporting moving forward. The Committee received 4 Directorate exception reports. The following key updates were received:

Obstetrics & Gynaecology

Members **NOTED** that:

- A number of Board level exceptions had been generated
- Monthly governance days were being put into place (including risk management within the multidisciplinary team)
- None of the ward contingency had needed to be used
- An agreement had been reached with Cardiff & Vale UHB who were prepared to take on the flow of 500 women annually from Nevill Hall
- A proposal for the future model of the Gynaecology Day Assessment Unit (GDAU) was being developed alongside a proposal for Obstetrics Theatres
- Recruitment to medical posts continued to remain challenging
- Issues had been experienced in relation to ultrasound scanning and Demand & Capacity planning was now being undertaken as a result

Rowena Myles advised that in relation to the GDAU, issues had been raised during one CHC visit to RGH, in which it was advised that women in danger of pregnancy loss were potentially being asked to wait in a corridor. John Palmer advised that a single incident had occurred on the first day of the change and that steps had been taken to ensure this did not re-occur. Gaynor Jones advised that if a patient presented at RGH with complications they would be transferred quickly to PCH.

Maria Thomas advised that it would be helpful if future reports could identify outcomes as well as mitigations and trend analysis.

Pathology
Members **NOTED** that:

- A review had been commissioned on Clinical Haematology as a result of issues and concerns relating to staffing and capacity and accommodation
- A Serious Incident review had been undertaken in relation to a misdiagnosis made by a Consultant Histopathologist in mid-2018. A full report would be presented to the Committee in August
- A demand & capacity exercise was being undertaken within Microbiology following historical issues relating to staffing
- Significant progress had been made against recommendations of the Human Tissue Authority
- A positive follow up report had been received following the UKAS inspection and it had been identified that there would be a requirement for ongoing resource
- A full time Transfusion Practitioner had now been appointed
- The service in the Mortuary had now resumed.

A discussion was held in relation to the Haematology Day Unit and Keiron Montague advised that he was not assured that the service was being provided as it needed to be and questioned whether to be concerned about the quality and safety for patients. John Palmer advised that the issues had been raised within the last 10 days following a walkabout of the unit undertaken by Kath McGrath, although no concerns had been raised by clinicians or patients. Members requested an update report at the August meeting regarding the red escalation issues (**added to the action log**).

Acute Medical Directorate
Members **NOTED** that:

- A Deep Dive was being undertaken of all three A&E sites to determine the fragility and sustainability of the service. Members **NOTED** that Greg Dix had also asked Sharon O'Brien to conduct an analysis of dignity within the A&E departments
- A review would need to be undertaken of the service being provided by Retinue in relation to issues experienced regarding filling of shifts
- There had been an increased demand of 1,100 extra attendances at PCH.

Dilys Jouvenat expressed concern in relation to the issues raised regarding Retinue, particularly as previous reports had indicated that experiences had been positive. John Palmer advised that the position had become more challenging over the last couple of months.

Keiron Montague advised that as part of the deep dive report being developed on fragility of A&E services, he would also like to see what system changes would be required in order to make the service more sustainable. Members **NOTED** that this would also form part of the Clinical Services Strategy.

General Surgery
Members **NOTED** that:

- Nurse staffing levels were challenging and the importance of recruitment days
- Investments were being made into the middle grade doctor rota
- HMRC changes were impacting on anaesthetics and surgery which had resulted in a loss of sessional time
- Challenges remained in relation to flow
- A recommendation had been made by HIW in relation to the Monday morning trauma multidisciplinary team (MDT) – the work to implement 'Getting it right first time' (GiRFT) would take longer than first anticipated and an executive decision would be required regarding the changes proposed
- Internal Audit had undertaken a review into Surgery and a reasonable assurance rating had been allocated
- The Directorate were preparing for the Joint Review being undertaken by the Wales Audit Office and HIW regarding Governance.

Alison Davies extended her thanks to Directorates for embracing the new way of reporting and it was felt that generally this was helpful and the work to date had been positive.

Members **RESOLVED** to:

- **NOTE** the reports

QSR/19/065 **EXTERNAL REVIEWS**

Alison Davies presented the report and gave an overview of the ongoing external reviews. Members **NOTED** that there were 3 reviews ongoing, one of which related to a review of DATIX which was being supported by the Welsh Risk Pool. Members **NOTED** that the review was focussing on legacy log issues.

Erica Emes, Healthcare Inspectorate Wales, confirmed that openness and transparency was now being seen in the reviews being undertaken.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/066 **MENTAL HEALTH STATUS REPORT ON VALLEY LIFE – WARD 35**

Craige Wilson presented the report which provided an update on the delivery of phase 4 of Valley LIFE, as well as outlining the progress made over the past 4 years on such. This included the remaining timescales and the community investments to support this work.

Members **NOTED** that phase 4 was in relation to the closure of Ward 35 as part of the overall programme of Older Persons Mental Health Services. Members **NOTED** that there were 5 patients still on the ward, one of which was awaiting placement at a local care home, with the remaining 4 waiting placement at Ysbyty Cwm Cynon (YCC).

Members **NOTED** that there would be a need to transfer some staff over to Ward 7, YCC which would result in an over establishment at some point in time. Members **NOTED** the intention to close the ward by end of July 2019.

Gaynor Jones advised that there were a number of staff who were very unhappy with the changes relating to this and added that the concerns raised were being addressed.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/067 **DEEP DIVE INTO THE INCREASE IN NEEDLESTICK INJURIES**

John Palmer provided an oral update an advised that a report would be developed for the August Committee. Members **NOTED** that during the last quarter, only 4 needlestick injuries had been sustained in PCH and 1 in RGH. Gaynor Jones expressed the importance of cascading messages to staff regarding the safe disposal of sharps.

QSR/19/068 **SUB GROUP DEVELOPMENT GOVERNANCE FRAMEWORK**

Alison Davies presented the report which provided assurance related to the development and establishment of the sub groups of the Quality, Safety and Risk Committee. Members **NOTED** that Executive Leads had been identified for each group and **NOTED** that the suggested way forward may evolve and change. Members **NOTED** that the work would be led by Eiri Jones and a significant amount of work would be required to establish the groups.

Members **RESOLVED** to: **NOTE** the report.

QSR/19/069 **UPDATE ON LATEST 'NO SURPRISES REPORTING TO WELSH GOVERNMENT**

Greg Dix presented an oral update and advised that the Health Board had reported 15 'no surprises' to Welsh Government last month which was an increase compared to previous months. Members felt that this provided assurance that the Health Board was reporting as openly and honestly as possible.

Members **NOTED** that the 'no surprises' related to issues of safeguarding, medical staffing and the Emergency Department at RGH.

In relation to the reporting of information to the Committee moving forward, Maria Thomas advised that a discussion would be held outside of the meeting to agree reporting mechanisms. Gwenan Roberts advised that any future written reports potentially would need to be discussed 'In Committee'.

John Palmer advised that an issue had been highlighted at the Finance, Performance & Workforce Committee regarding some under-reporting of waiting lists relating to services being provided in Cardiff. Members **NOTED** that work was being undertaken with the Delivery Unit to review the position and if any harm has been identified this would be presented to the Quality, Safety & Risk Committee.

Members **RESOLVED** to:

- **NOTE** the update provided.

QSR/19/070 **MINUTES OF SUB GROUPS**

Members **RECEIVED** and **NOTED** the minutes of the Infection, Prevention and Control Committee meeting held on 18 February 2019.

Gwenan Roberts advised that the Quality, Safety & Risk Committee Annual Report had highlighted how many of the sub groups did not report into the Committee last year and it was **NOTED** that a discussion would need to be held outside of the meeting.

PART 4. ITEMS FOR INFORMATION

QSR/19/071 **ITEMS RECEIVED FOR INFORMATION**

Members **RECEIVED** and **NOTED** the following items for information:

- Update on Capital Issues at the Maternity Unit, Prince Charles Hospital
- Committee Referral from Finance, Performance & Workforce Committee – Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales – Welsh Health Circular WHC/2017/042

Members **RESOLVED** to:

- **NOTE** the reports

QSR/19/072 **PART 5. OTHER MATTERS**

Any Other Business

Kamal Asaad advised that he had three matters to raise under any other business, which included:

- CTMUHB professional issues between surgeons and anaesthetists. The Royal College of Surgeons had raised concerns in relation to professional behaviour and team working and a recommendation had been made to undertake a wider service review of clinical care aspects of the intensive therapy unit (ITU). A discussion had been held with clinicians at Swansea Bay (SBUHB) who had agreed to be part of the review. Members **NOTED** that the Welsh Government and HIW had been made aware of the issues, along with the Chair, Vice Chair and Interim Chief Executive. Terms of Reference were in the process of being finalised and meetings had been held with clinical leaders on all sites
- A National Maternity Audit was due to be published at the end of the summer this year and a letter had been received advising that the Health Board was a potential outlier against one of the obstetrics outcomes (3rd and 4th degree perineal tears). A telephone call had been arranged with the National Audit Team to discuss data discrepancies
- A National Audit on survival outcomes for patients admitted to PCH following Trauma was being undertaken. A letter received related to a specific group of patients assessed as having 85% of survival and the number reported seemed to be an outlier. This related to a group of 40 patients, 27 of which had a survival over 85%, 13 of which had a survival chance of less than 80%.

Maria Thomas thanked Kamal Asaad for the update and requested a written update report be provided to the next meeting.

Forward Look

Members **NOTED** that the Forward Look would be discussed outside of the meeting.

QSR/19/073 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place at 2pm on 5 August 2019.

…….
Maria K Thomas, Chair

Date……

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'CONFIRMED' MINUTES OF THE MEETING OF THE QUALITY, SAFETY AND RISK COMMITTEE, HELD ON 5 AUGUST 2019 AT YNYSMEURIG HOUSE, ABERCYNON

PRESENT:

Maria Thomas (Chair)	-	Health Board Vice Chair
James Hehir	-	Independent Member
Nicola Milligan	-	Independent Member
Dilys Jouvenat	-	Independent Member
Keiron Montague	-	Independent Member

IN ATTENDANCE

Alan Lawrie	-	Director of Primary, Community & Mental Health Services
Alison Davies	-	Assistant Director of Quality & Patient Experience
Carol Moseley	-	Wales Audit Office
David Jenkins	-	Independent Advisor
Gwenan Roberts	-	Head of Corporate Services
John Palmer	-	Chief Operating Officer
Julie McCabe	-	Assistant Director, Quality & Safety, Delivery Unit
Kamal Asaad	-	Medical Director
Kelechi Nnoaham	-	Director of Public Health
Mark Simons	-	Staff Side Health & Safety (Vice Chair) Representative
Martin Gill	-	Staff Side Health & Safety Representative
Melanie Harries	-	Quality & Safety Manager, Delivery Unit
Michelle Hurley-Tyers	-	Senior Workforce & OD Project Manager
Rowena Myles	-	Cwm Taf Morgannwg Community Health Council (CHC)
Emma Walters	-	Corporate Governance/Committee Secretariat
Eiri Jones	-	Programme Director (Observing)

PART 1. PRELIMINARY MATTERS

QSR/19/074 **WELCOME AND INTRODUCTIONS**

Maria Thomas (Chair) **welcomed** everyone to the meeting, particularly Carol Moseley, Wales Audit Office, Julie McCabe and Melanie Harris from the Delivery Unit and Michelle Hurley-Tyers, who was attending the meeting on behalf of Anne Phillimore.

QSR/19/075 **APOLOGIES FOR ABSENCE**

Apologies for absence were **RECEIVED** from Greg Dix, Kevin Smith, Chris Beadle, Erica Emes, Anne Phillimore, Cathy Moss, Paul Dalton, Sara Utley, Robert Williams and Gaynor Jones.

QSR/19/076 **DECLARATIONS OF INTERESTS**

There were no additional interests declared.

QSR/19/077 **TO RECEIVE THE UNCONFIRMED MINUTES OF THE MEETING HELD ON 9 JULY 2019**

The minutes of the Quality, Safety and Risk Committee held on 9 July 2019 were **received** and **confirmed** as an accurate record of meeting, subject to the following amendments:

Page 4: Action Log reference QSR/19/48, second sentence to read *an* update not *and* update.

Page 6: Chairs Report, last paragraph, start of fifth sentence to read '*services* in more detail'.

Page 7: Quality, Safety & Risk Committee Annual Report, second paragraph, eighth sentence to read 'not be *in* escalation at the Targeted Intervention level'.

Members **RESOLVED** to:

- **APPROVE** the Minutes of the Quality, Safety and Risk Committee held on 9 July 2019.

QSR/19/078 **TO RECEIVE THE COMMITTEE ACTION LOG**

Members **RECEIVED** and **NOTED** the Committee Action Log.

QSR/17/39 & 19/44 – John Palmer advised an update on Follow Up Outpatients Not Booked (FUNB) related to Head & Neck had been included in the Directorate Exception report and added that a full update report on FUNB would be presented to the September meeting **(on Forward Look)**. Members **NOTED** that each time there had been an episode of harm identified a detailed review had been undertaken.

QSR18/11 – Members **NOTED** that an update report on Skin Surveillance would now be presented at the October meeting **(on Forward Look).**

QSR/18/50 – Members **NOTED** that in relation to the Corporate Risk Register, a discussion would be taking place at the August Board Development Session. Members **NOTED** that the Wales Audit Office and Healthcare Inspectorate Wales had also planned to undertake a review of the risk register.

QSR/18/81 – Members **NOTED** that a meeting was being held this week to discuss the arrangements for the Clinical Policy Sub Group.

QSR/18/88 – Kamal Asaad advised that the Health Board had not yet received the Rapid Response to Acute Illness Learning Set (RRAILS) report and added that this would be added to the agenda for the September meeting if the information had been received **(on Forward Look)**.

QSR/19/08 – Eiri Jones confirmed that she would be attending the Community Health Council Board next week to discuss the Quality & Safety Governance Framework and the development of the easy read version.

QSR/19/20 & QSR/19/34 – John Palmer confirmed that this action had now been completed with a full update provided at the July meeting.

QSR/19/35 – Michelle Hurley-Tyers provided Members with an update in relation to the Disclosure and Barring Service (DBS). Members **NOTED** that information recorded in January 2018 identified that out of 4,700 posts, 134 post holders had been recorded as not having a DBS check. Members **NOTED** that as of July 2019, there were 120 employees who had been recorded as not having a DBS check and that work was being undertaken to address this.

Maria Thomas recognised that there had been a significant reduction from the information previously reported to the Finance, Performance & Workforce Committee and asked when the 120 outstanding DBS checks were likely to be completed. Members **NOTED** the plan to complete by the end of August.

Keiron Montague welcomed the good progress made and added that he was still unhappy that there remained outstanding checks. Keiron Montague added that he would wish to be advised as to what areas the staff were working, what the associated risks were and the future programme of work to ensure future checks were undertaken.

Michelle Hurley-Tyers **AGREED** to circulate information to Members outside of the meeting and **AGREED** to discuss further with Keiron Montague. A further update would be provided at the October meeting **(on Forward Look)**.

QSR/19/40 – Members **NOTED** that the Delivery Unit review into Child and Adolescent Mental Health Services (CAMHS) would be presented at the September meeting.

QSR/19/42 – John Palmer confirmed that on the 19 July 2019 the Health Board had received the licences from the Human Tissue Authority (HTA) restoring the Health Board's compliance with HTA guidance and legislation.

QSR/19/46 – John Palmer advised that there continued to be a significant amount of work undertaken in this area with a site analysis being undertaken of all 3 Emergency Departments. Members **NOTED** that a report would be presented to the September meeting and would include mitigations that had been put into place **(on Forward Look)**.

QSR/19/47 – Members **NOTED** that an oral update had been provided to the last meeting and **NOTED** that future updates on the Quality and Governance in Healthcare Bill would be added provided **(on Forward Look).**

QSR/19/48 – John Palmer advised that in relation to the two issues identified in the Pathology Directorate Exception Report at the last meeting, a report on Clinical Haematology would be presented at this meeting and a report on Histopathology would be presented to the September meeting **(on Forward Look).**

QSR/19/56 – Alan Lawrie advised that information had previously been circulated to Members regarding Valley LIFE and advised that he would re-circulate the information. Keiron Montague advised that it would be helpful if a discussion could be held as to the role of patient stories and future stories having a brief summary of the specific service. Eiri Jones advised that it would be the role of the Patient Experience Group to develop patient stories and added that Greg Dix had some thoughts as to how to make future stories more meaningful for the Committee.

QSR/19/58 – Members **NOTED** that a report on Bridgend Related Risks would be presented to the September meeting **(on Forward Look).**

QSR/19/59 – Members **NOTED** that the issues related to Switchboard had been responded to and that this action was now complete.

QSR/19/61 – Maria Thomas advised that a meeting was in the process of being arranged with Independent Members to discuss the feedback given in relation to the self-assessment questionnaire.

QSR/19/62 – Alison Davies **AGREED** to confirm whether a discussion had been held with Swansea Bay University Health Board regarding processes previously followed in detecting legionella.

QSR/19/079 **TO REVIEW MATTERS ARISING NOT CONTAINED WITHIN THE ACTION LOG**

There were no matters arising.

QSR/19/080 **CHAIRS REPORT**

Maria Thomas presented her report and advised that the change to monthly meetings was helping to assist re-focus the Committee on its agenda and extended her thanks to Gwenan Roberts and the Corporate Team for helping the Committee to achieve this.

Members **NOTED** that Maria Thomas had met with Greg Dix and the Team to discuss the roll out of the Quality & Governance Framework and stressed the importance of the framework being embedded into the organisation, with quality being identified as everyone's business. Members **NOTED** that the roll out of the plan would take time and would need to be embedded into the Directorate Structures.

Maria Thomas advised that she had recently attended the Maternity Improvement Board meeting and also planned to attend the Independent Maternity Services Oversight Panel meetings for monthly updates. Members **NOTED** that the action plan in place included 125 actions and Welsh Government had acknowledged that some of the actions would take time to address.

Members **NOTED** that the work that was being led by Cath Broderick, Independent Maternity Services Oversight Panel Member, would be critical. Maria Thomas expressed the importance of letting staff know that there were still some excellent services being provided in order to lift their morale.

Maria Thomas advised that over the last month she had undertaken a number of Patient Dignity Visits at Princess of Wales Hospital and had also undertaken walkabouts within Primary Care facilities, including the Treharris Health Centre. Members **NOTED** that visits would also be undertaken at Prince Charles Hospital and Ysbyty Cwm Cynon this week and to the freestanding Midwifery Unit at Royal Glamorgan Hospital next week.

Maria Thomas made reference to the message expressed from Sharon Hopkins, Chief Executive (Interim) at the last Board meeting, asking Members to re-focus their values and advising that there would be a Board Development session held on Values & Behaviours.

PART 2. ITEMS FOR APPROVAL/ENDORSEMENT

QSR/19/081 **IMPLEMENTATION OF THE QUALITY & PATIENT SAFETY GOVERNANCE FRAMEWORK**

Eiri Jones, Programme Director presented the report which provided an update on progress made on the implementation of the newly approved Quality and Patient Safety Governance Framework. Eiri Jones advised that part of her role would be to ensure the framework becomes embedded into the organisation over the next few months.

Eiri Jones advised that she had now undertaken visits to every acute site and advised that she had started engaging with Primary Care and Mental Health Services and had arranged 1-1 meetings with key staff and stakeholders.

Members **NOTED** that there were a number of actions being progressed and that a full update on progress against the actions would be presented to the September meeting, as well as an update on engagement undertaken and feedback received from staff.

Members **NOTED** that progress was being made in relation to the establishment of four sub groups of the Committee, with a planning meeting held last week of the Quality Assurance Group. Members **NOTED** that a quarterly update report would be presented to the October meeting and a 6 month update report would be presented to the December meeting containing recommendations from the review undertaken **(on Forward Look)**.

Eiri Jones advised of the need to ensure the right resources were in place to support Directorates and added that there would be a need to ensure the Board had sufficient time to make the framework successful. Members **NOTED** that feedback from front line staff on what is good governance would be key alongside feedback on suggested improvements. Kamal Asaad advised that this was beginning to take shape at the Corporate level and that further work would be required to finalise Directorate structures.

Keiron Montague questioned how the Committee could be assured that the framework was being successful and that connectivity was in place between ward to Board. Kamal Asaad advised that this could be achieved through a variety of mechanisms, for example, Independent Member walk rounds, drop in sessions and Community Health Council (CHC) visits which should all provide the Board with additional intelligence.

Rowena Myles agreed that quality should be seen as the business of everyone and was keen to understand how this would be made possible. Eiri Jones advised that the Executive Team were fully engaged and that steps were now being taken to engage with Clinical Directors. Members **NOTED** that meetings would also be held with support staff to discuss their roles in relation to quality. Eiri Jones explained the importance of the sub groups of the Quality, Safety & Risk Committee, particularly the Quality Governance & Learning Group, where questions could be asked in relation to surgical site infection rates for example.

Kelechi Nnoaham highlighted that the report made reference to the development of a quality scorecard which should provide the Board with a sense of the outcomes of quality arrangements. Members **NOTED** the importance of having a Ward to Board scorecard in place in addition to Quality Business Partners who would take part in discussions at Clinical Business meetings.

Maria Thomas recognised the engagement being undertaken and noted that the plan was on target to be achieved. Maria Thomas requested that the detailed programme be presented to the September meeting, alongside progress being made with the development of a quality scorecard and quality resource requirements **(on Forward Look)**.

Members **RESOLVED** to:

- **NOTE** the progress made to date
- **NOTE** future plans in terms of assurance of implementation
- **APPROVE** future reporting plans
- **AGREE** to receive an update report to the September meeting

QSR/19/082 **HEALTH AND CARE STANDARDS ANNUAL AUDIT REPORT 2018**

Alison Davies presented the Health and Care Standards Annual Audit Report 2018, the parameters of which had been set by Welsh Government. Members **NOTED** the benefits of engaging in the Annual Audit which had been outlined on page 4 of the report. Members **NOTED** that there were a number of questions where 100% had been reported and that questions had been asked in relation to the subjectivity of some of the questions.

Members **NOTED** the main messages which included that care and standards were being audited, localised improvement plans had been developed and monitored by Senior Nurses and an All Wales discussion would be required on the robustness of the questions asked.

Kelechi Nnoaham welcomed the report and advised that the report gave a good indication of the progress made year on year. Members **NOTED** that in relation to the 'Staying Healthy' elements, an assessment was still being undertaken on whether information was being given in relation to use of language and whether staff were utilising the 'Making Every Contact Count' information.

Members **NOTED** the improvement in relation to smoking in 2017 outlined on page 12 of the report and that the Health Board had been provided with funding of £160,000 by the Respiratory Health Information Group which enabled the Health Board to put in place a secondary care smoking cessation programme. Members **NOTED** that funding for this service would cease in December 2019 and that a proposal was being developed for further funding.

Kelechi Nnoaham advised that the Cardio Vascular Reduction Programme served populations and not patients and added that Cwm Taf Morgannwg was the only one out of the 7 Health Boards that did not provide a weight management service. Members **NOTED** that the Business Case was in the process of being developed for the Executive Team to consider.

James Hehir welcomed the report and advised that the report would need to be put into context considering the increase in the Health Board's escalation status.

Following concern raised by Nicola Milligan in relation to some of the data presented in the report which appeared confusing, Alison Davies agreed to feed the comments back to the All Wales Group.

Maria Thomas advised that it had been made clear from the report and the discussion that the Health & Care Standards were not fit for purpose and added that some discussion would be needed on this, possibly with support from Wales Audit Office colleagues at the national level. Alison Davies advised that feedback on the report would now be provided to each clinical area, a localised plan would be developed and fed back through the Directorate Clinical Governance meetings.

Members **RESOLVED** to:

- **APPROVE** the Health & Care Standards (2018) annual audit findings which were presented in this report as an assurance that the care delivered within the Health Board continued to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.

QSR/19/083 **HEALTHCARE INSPECTORATE WALES REVIEW OF MENTAL HEALTH SERVICES**

Alan Lawrie presented the report which provided rapid information and assurance with regards to the Healthcare Inspectorate Wales (HIW) unannounced inspection into Mental Health services at the Royal Glamorgan Hospital on the 8 July 2019 - 11 July 2019.

Members were reminded that HIW issued a critical report to the Health Board in September 2018 which highlighted that the Health Board had not learned lessons following the visit undertaken in June 2018 and that actions had not been addressed in a timely manner. Members **NOTED** that a piece of work was undertaken to address the issues and the Committee had been provided with regular updates on progress made.

Members **NOTED** the report identified that some care plans were not compliant and there were audit processes that had not been embedded in enough detail. Members **NOTED** that the vast majority of the issues identified had been resolved on the day of the visit.

Alan Lawrie advised that a number of positive actions had been taken forward, particularly in relation to the environment and HIW advised that the Mental Health Team had made significant progress in a number of areas. Members **NOTED** that the final report would be presented to the Committee once available alongside the action plan and QAIT plan. Keiron Montague advised that he was disappointed to see that in relation to training, some wards fell below the base standard. Alan Lawrie advised that some of the data provided was not complete and provided assurance that the training position was much better than initially reported.

Keiron Montague questioned how learning was being shared across the organisation following the review and stressed the importance of not treating this in isolation. Alan Lawrie advised that not sharing lessons across wards in Mental Health had been identified as an issue during the review and had now been addressed. Maria Thomas advised that internal visits to Wards were being undertaken under the arrangement of Multi-Disciplinary Team partnership working and Independent Members could start to ask questions regarding sharing of lessons learnt during their Walkabouts.

Keiron Montague questioned whether Independent Members could be provided with a summary of key themes during walkabouts and it was advised by Alison Davies that the Executive Team had designed the internal assurance programme with discussion held at Executive Catch Up regarding the importance of placing focus on certain areas during visits.

Alan Lawrie advised that he hoped there was safe and effective care was being provided and was disappointed that the report highlighted that basic issues had not been addressed. Members **NOTED** that Head of Nursing support was in place who focussed on Quality, Safety & Governance and was supported by two Deputy Heads of Nursing. Members **NOTED** that a temporary Clinical Director would be in place to be supported by 3 Directorate Managers.

In response to a comment made by Rowena Myles regarding ownership of the issues, Members **NOTED** that Julie Denley had obtained support from external partners for support in addressing the issues. Dilys Jouvenat supported this and advised that Julie had fully involved third sector partners when making key appointments to her team.

Maria Thomas advised that it had been made clear that an improvement journey had been made and assurance had been provided that there was clear sighting from Directorate Ward level to Board although there were issues to resolve.

Members **RESOLVED** to:

- **NOTE** the process in place to ensure good governance regarding inspection visits with clear lines of communication between Board and the Directorate
- **ENDORSE** the process as described.

PART 3. GOVERNANCE, PERFORMANCE & ASSURANCE

QSR/19/084 **UPDATE REPORT ON MATERNITY SERVICES**

Maria Thomas advised Members that the report had been discussed in detail at the Board meeting held on 31 July 2019.

Alison Davies confirmed that interviews for the Obstetrics & Gynaecology Clinical Director post were taking place today and that the Head of Midwifery post was currently on hold following the first advert not yielding enough candidates.

Maria Thomas advised that she was heavily involved in the work of the Maternity Improvement Board and the Independent Maternity Services Oversight Panel and would be closely monitoring the position moving forward.

Maria Thomas advised that a discussion was held at the Board meeting regarding timescales within the improvement plan with some actions being implemented immediately. Members **NOTED** that a discussion had also been held in relation to the need to identify top 10 priorities within the plan.

Following discussion, Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/085 **DIRECTORATE EXCEPTION REPORTS**

The Committee received 5 Directorate exception reports. The following key updates were received:

CAMHS & Children & Young People

Members **NOTED** that:

- The risk scores within the report did not take into account the measures that had been put into place and this would be resolved for the next report
- In relation to patient mix, there were a significant number of dysregulated children on the unit (children whose behaviours often mimicked mental health issues) which was a real of concern. Members **NOTED** that these children often needed secure Local Authority accommodation
- Ligature risk reduction works commenced in July
- A Delivery Unit report on Primary CAMHS would be presented to the September meeting

- At present the Nurse Staffing Level (Wales) Act did not apply to Paediatrics but would soon. Risk mitigations were in place and additional staff were being moved to Royal Glamorgan Hospital to ensure there was safe staffing.

Mental Health
Members **NOTED** that:

- Performance against Part 1 of the measure was now improving
- All risks were being reviewed monthly, with ligature risks now reducing
- The biggest area of risk remained to be multiple IT systems.

Primary Care
Members **NOTED** that:

- The most significant risk related to Lymphoedema which would be discussed later on the agenda
- There were a number of vacancies within Ysbyty Cwm Rhondda (YCR) and a Deep Dive was being undertaken to determine why it was difficult to fill vacancies at this site. The Senior Nurse from Maesteg Hospital had now been moved to YCR to manage the risk.

Facilities
Members **NOTED** that:

- Following the adverse finding allocated to Medical Devices & Equipment following a review undertaken by Internal Audit, a resource request had been made which was in the process of being discussed with the Director of Finance

Following a question raised by Dilys Jouvenat regarding issues relating to staff attending training courses, John Palmer **AGREED** to confirm whether this was as a result of staff not wanting to attend or as a result of competing priorities **(added to Action Log).**

Maria Thomas advised that in relation to Quality Key Performance Indicators, cleanliness seemed to be declining and sought assurance as to why this was occurring and requested an update to be provided in the next Facilities Exception report **(on Forward Look)**.

Maria Thomas made reference to the high risk areas of tagging of babies on the Maternity ward and questioned when the service would be fully compliant. John Palmer advised that this was a complicated sequence of magnetic doors and additional security had been put into place.

Gwenan Roberts advised that a successful test of the system had been undertaken by the Civil Contingencies Manager and the whole team at Prince Charles Hospital.

Head & Neck
Members **NOTED** that:

- The main area of concern remained to be Ophthalmology, particularly in relation to Consultant availability, with a fair degree of turnover being seen with the service. Members **NOTED** that the Team regularly reviewed skill mix
- There were a number of issues which were being clinically prioritised by the new Clinical Director
- Ophthalmology was a very high risk area although no red risks had been highlighted.

Maria Thomas **NOTED** the mitigations that had been put into place and advised that because of the potential harm to patients this may need to be escalated to the Board.

Nicola Milligan advised that as a result of the volume of Follow Up Outpatients Not Booked (FUNB) patients outlined on page 4 of the report, she could not see a clear picture of the risk. John Palmer provided assurance that each time harm was being identified this was being presented in full to the Committee and advised that a detailed report would be presented to the September meeting, with focus being placed on Ophthalmology FUNB patients. John Palmer advised that the Health Board had received further funding of £300k towards improving the position and the Team were well supported by the Board to make these improvements.

Members **RESOLVED** to:

- **NOTE** the reports

QSR/19/086 **CANCER SERVICES UPDATE REPORT**

Kamal Asaad presented the report which provided an update on the activity relating to cancer in the Cwm Taf Health Board during 2018 / 19 specifically focussing on Urgent Suspected Cancer (USC) / Non Urgent Suspected Cancer (NUSC) / Single Cancer Pathway (SCP) Performance, Peer Reviews of Breast Cancer and Acute Oncology, Rapid Diagnostic Service, Macmillan funded posts and Patient Experience.

Members **NOTED** that Cancer Services within the Health Board was being run by a Team of dedicated staff and there had been three areas of achievement:

- An Early Cancer Diagnosis Project Board had been set up and 600 cases had been reviewed to date
- A Cancer Welfare service had been set up to assist with making patients aware of the support they are entitled to. Funding had been maintained from Macmillan with 700 patients benefiting from the advice given
- A number of clinically led peer reviews had been undertaken with Welsh Government now considering whether to extend into non cancer areas.

Members **NOTED** that the Health Board recently had success in the recruitment of a very experienced Consultant to Breast Services.

Maria Thomas thanked Kamal Asaad for presenting the report and advised that she felt unclear as to whether there were any serious risks in this service area which the Committee needed to be made aware of. Members **NOTED** that Cancer breaches were regularly being reported to and scrutinised by the Finance, Performance & Workforce Committee and Keiron Montague confirmed that the Committee understood the risks and the areas of concern.

A discussion was held in relation to the Single Cancer Pathway and Maria Thomas requested an update report on this matter in three months time. Kelechi Nnoaham advised a robust screening pathway needed to be put into place in order to have earlier cancer diagnosis and added that the uptake of Breast screening had declined. John Palmer advised that the Health Board would soon be receiving the evaluation of the Rapid Diagnostic Clinic from Bath University and consideration may need to be given as to how pathways for cancer could be changed over the next 20 years and rethinking the approach taken.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/087 **COMPLAINTS DATA SUBMISSION TO WELSH GOVERNMENT**

Alison Davies presented the report which provided the Quality, Safety and Risk Committee with information on the changes in the reporting of complaints data to Welsh Government.

Members **NOTED** that there had been variance across Wales as to how reporting and categorisation of complaints had been undertaken.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/088 **PATIENT DIGNITY VISITS UPDATE**

Alison Davies presented the report which provided the detail to the Quality Safety & Risk Committee of the findings from the Cwm Taf Morgannwg University Health Board (CTMUHB) Partnership Dignity Visit undertaken on 28 May 2019 to Ward 12, Royal Glamorgan Hospital.

Members **NOTED** that these visits were part of an internal assurance activity programme which would be reviewed as part of the Quality & Governance Framework. Members **NOTED** that some of the challenges highlighted from the visit included low staff morale and **NOTED** that a number of immediate actions had been undertaken by the Head of Nursing and Alison Davies.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/089 **DEMAND AND CAPACITY WITHIN THE LYMPHOEDEMA SERVICE**

Alan Lawrie presented the report which highlighted the current demand and capacity challenges and inherent risk issues presenting within the Lymphoedema service across Rhondda Cynon Taf and Merthyr Tydfil (RCT & MT) areas. Members **NOTED** that the report did not take account of the Lymphoedema service within Bridgend as this was currently being delivered via a Service Level Agreement (SLA) with Swansea Bay University Health Board (SBUHB) and was appropriately resourced.

Members **NOTED** that a National Audit report had been received at the end of April which identified that Cwm Taf was a significant outlier which resulted in the Health Board undertaking a review of the services to see if they agreed with the results of the audit.

Members **NOTED** that there were significant breaches in relation to achieving Welsh Government targets and a national business case was in place which identified that investment was required into the service to strengthen resources. Alan Lawrie advised that a discussion had been held with the Director of Finance who had confirmed he would support the investment required.

Keiron Montague questioned when the Health Board were likely to see an improvement. Alan Lawrie advised that it was hoped that an improvement would be seen in September with a rapid change not being seen until key staff were in post which was likely to be at the end of quarter 3. Maria Thomas requested an update report to be presented to the Committee in early 2020 showing progress made **(on Forward Look)**.

Members **RESOLVED** to:

- **NOTE** the demand/capacity challenges presenting within the service and **SUPPORTED** the resource requirements as outlined in the report based on the All Wales value based business case
- **AGREE** to receive an update report in early 2020.

QSR/19/090 **EXTERNAL REVIEWS AND INTERNAL ASSURANCE MATTERS**

Alison Davies provided Members with an oral update and advised that a written report was not provided this time as reviews were currently in the process of being undertaken and would be reported into the September/October Committee meetings.

Members **RESOLVED** to:

- **NOTE** the update

QSR/19/091 **UPDATE ON LATEST 'NO SURPRISES REPORTING TO WELSH GOVERNMENT'**

Alison Davies presented an oral update and reminded Members that a discussion was held at the last meeting regarding the individualised nature of 'no surprises' and the challenges in relation to providing the data.

Members **NOTED** that the highest number of no surprises reported specifically related to staff and individual patients, with a number being service related. Alison Davies advised that each incident would be highly specific with a bespoke set of circumstances.

Keiron Montague questioned how this report would be brought forward in a meaningful way which respected the anonymity of the individuals involved. Alison Davies advised that she would give some consideration to this prior to the next meeting and suggested that the report could be taken as an In Committee item in future.

Members **RESOLVED** to:

- **NOTE** the update provided.

QSR/19/092 **UPDATE ON CLINICAL HAEMATOLOGY**

John Palmer presented the report which provided an update on the current risks and mitigations in relation to the staffing and accommodation issues in the Clinical Haematology departments in the Royal Glamorgan Hospital (RGH) and at Prince Charles Hospital (PCH).

Members **NOTED** that these issues had been raised within the Pathology Directorate exception report at the last meeting. John Palmer advised that a recent inspection undertaken by the Infection, Prevention and Control (IPC) Team indicated that the Clinical Haematology units were not fit for purpose. As a result of this alternative accommodation options were explored with a decision made to move the unit to Ward 33 in PCH and Ward 11 in RGH.

Members **NOTED** that issues had also been raised in relation to staffing, with some delays being experienced in relation to the appointment of 2 Band 6 posts. Members **NOTED** that these issues were now being resolved with further discussions taking place at Clinical Business meetings regarding a further middle grade appointment and an additional Band 6.

Members **NOTED** the issues raised previously regarding a Clinical Haematologist who had inconsistencies in addressing the backlog of GP referrals. Members **NOTED** that a review was being overseen by Vijay Singh, Assistant Medical Director with no harm identified to the cohort of patients concerned. Members **NOTED** that further follow up discussions were being undertaken with the individual concerned.

Maria Thomas extended her thanks to the Team for addressing the accommodation issues and welcomed the assurance provided that no harm had been identified against the cohort of patients under the care of the Haematologist.

In response to a question raised by Keiron Montague regarding the length of time taken to resolve the issues, John Palmer advised that the Directorate had been working very hard to resolve a number of issues, which included the intensive work required to address the issues raised by the Human Tissue Authority. Members **NOTED** that when the IPC team had undertaken the inspection the reaction had been immediate.

Members **RESOLVED** to:

- **NOTE** the report.

QSR/19/093 **MINUTES OF SUB GROUPS**

Members **RECEIVED** and **NOTED** the Annual Report from the Medicines Management Expenditure Committee.

PART 4. ITEMS FOR INFORMATION

QSR/19/094 **ITEMS RECEIVED FOR INFORMATION**

Members **RECEIVED** and **NOTED** the following items for information:

- Clinical Audit Forward Plan for 2019 - 2020
- The Baby Friendly Initiative Accreditation Report. Maria Thomas advised that this highlighted good evidence of the work that had been undertaken in Maternity and advised that staff needed to be congratulated for this piece of work.

Members **RESOLVED** to:

- **NOTE** the reports

QSR/19/095 **PART 5. OTHER MATTERS**

Any Other Business

There was none.

Forward Look

Members **NOTED** that the Forward Look would be discussed outside of the meeting.

Exception Reports

Maria Thomas extended her thanks to the Executive Directors for the way in which the exception reports had been presented.

QSR/19/096 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place at 9am on 5 September 2019.

…….

Maria K Thomas, Chair

Date……

Reporting Committee	**Quality, Safety & Risk Committee**
Chaired by	Maria K Thomas
Lead Executive Directors	Greg Dix Director of Nursing, Midwifery and Patient Services. Georgina Galletly, Interim Board Secretary
Author and contact details	Kathrine.davies2@wales.nhs.uk
Date of last meeting	5 September 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The Quality Safety & Risk Committee last met on the 5 September 2019, the agenda and papers are available on the following link: https://cwmtafmorgannwg.wales/how-we-work/quality-safety-risk-committee/

Emergency Department Review and Assurance

Members **received** the report and presentation which outlined the review of the key risks associated with the three Emergency Departments (ED) within Cwm Taf Morgannwg. The report provided assurance to the Committee that the key risks were understood and appropriately managed to ensure that the quality and safety of the patient experience within the departments was maintained. Members **noted** the following key issues contained within the report:

- Key risks within each Emergency Department
- Assurance processes and ongoing reviews
- Analysis against the Kings Fund evidence on Emergency Department reconfiguration
- Patient safety dashboards.

Members **noted** the assurance that escalation issues were in place and were of the opinion that the Clinical Services Strategy was key to improvements within the Emergency Department and needed to be implemented as soon as possible.

Members **noted** the work that was being undertaken with the Delivery Unit and Healthcare Inspectorate Wales and **agreed** to receive a further update in two months' time.

Follow Up Outpatients Not Booked (FUNB) Review of Harm/Focus on Ophthalmology Patients

Members **received** the report which was presented by John Palmer.

Members **noted** the actions being taken to address the follow up appointments not booked (FUNB) position across all specialties and were provided with reassurance that there were programme arrangements in place to see the work through effectively.

Members were advised that Directorates had requested to highlight any early potential clinical risks and **noted** that concerns had been raised in the following areas:

- Urology
- Ophthalmology
- Oral Surgery
- Dermatology
- Respiratory Medicine

Members **noted** that the FUNB trajectory sets out an ambitious plan to achieve a reduction of 12,000 FUNB by March 2020 to 10,000 patients. The plans were providing a positive movement on the journey to achieve this position with patient numbers standing at their lowest since the project began at 14,556.

Members **noted** that funding of £210,290 from Welsh Government had been secured for 2019/20 which was to support the health board in delivering its outpatient commitments as part of the national outpatient targets.

Members **noted** that the Chief Operating Officer continued to lead the work to address the FUNB position within Cwm Taf Morgannwg and that progress was being monitored via the Planned Care Board. Members were advised that whilst there had been steady improvement, the programme of work was expected to take two to three years to complete under current arrangements. Quality Safety & risk Committee will continue to monitor the position in regard to clinical reviews of long waiters to assure no harm is caused.

Update on the Quality & Patient Safety Governance Framework

Members **received** the report which was presented by Eiri Jones.

Members **noted** the update on actions and progress for the past month (month 2 of 6) of the implementation of the newly approved Quality and Patient Safety Governance Framework.

Members **noted** the 4 key main areas of update and progress:

- Implementation of Quality, Safety and Risk Committee Sub Groups - Members **noted** that planning meetings had been held for two of the four sub groups, Quality Assurance and Patient Experience. Dates were in place for planning meetings for the two other groups and these would be held before the next Quality Safety and Risk Committee. Members **noted** that dates for the four sub groups had been planned for the period to December 2020 which were outlined in the forward plan.

- Quality resource required moving forward – Members **noted** that discussions had commenced with the relevant Executive Directors. Members were advised that the work needed to be aligned with and informed by the future values and behaviours work-stream and organisational strategy planning. Members **noted** that the two activities would, in turn, inform the structures required to deliver the Health Board strategy.
  Clinical Policies Sub Group – Members **noted** that an initial planning discussion had taken place in relation to establishing the group. Work has also been completed on a directory of all clinical policies and their current status. A request had been made through the Medical Director for a senior doctor to Chair the group. It was intended that the group would meet monthly.
  Development of the Quality Dashboard – Members **noted** and discussed the attached Dashboard and were advised that the work had progressed over the past month. Discussions with the Director of Nursing, Medical Director and Director of Public Health had taken place to confirm key metrics for the dashboard. It was anticipated that the Dashboard would be presented monthly from October 2019.

Members **agreed** to endorse the proposed approach and that a further update would be received at the November 2019 meeting.

Update on the Legacy Statement from the Bridgend Boundary Quality and Patient Safety Work Stream

Members **received** and discussed the report that was presented by Greg Dix and Debbie Bennion.

Members were advised that prior to the Bridgend Boundary transition both Abertawe Bro Morgannwg University Health Board (ABMUHB) and Cwm Taf University Health Board (CTUHB) had worked collaboratively to create a series of work streams with the aim to produce clear, agreed and jointly approved legacy logs. The respective Executive Directors of Nursing of each Health Board jointly chaired the Quality and Patient Safety Work stream.

Members **noted** that following the formation of Cwm Taf Morgannwg University Health Board (CTUHB) there was a requirement to review the progress of the actions contained within the legacy log. The aim of which was to ensure that risk assessments for each of the sub-groups within the Quality & Patient Safety Work stream were updated with a plan implemented for any areas that required further work beyond April 2019.

Members **noted** the key items contained within the report:

- Safeguarding – All risks were being monitored by the Safeguarding Board.
- Clinical Effectiveness and Audit - the Head of Clinical Audit and Quality Informatics had reviewed all outstanding risks and these along with associated work plans would be reported and monitored

via the Audit Committee and Finance, Performance and workforce Committee.

- Complaints and Concerns - the predicted workforce redesign required would be in line with the CTMUHB implementation of the revised Organisational Structures.
- Datix - remains a risk that following the Bridgend Boundary merge of the current CTMUHB Datix system may result in inconsistent management of incidents. The risk was currently managed via the CTMUHB Datix Management Group. The Welsh Risk Pool had undertaken a review of the current Datix management system and a formal report was expected in September 2019.
- Infection Prevention and Control - The Head of Infection Prevention and Control had reviewed all outstanding risks and these along with associated work plans will be reported and monitored via the Infection, Prevention and Control Committee.
- Quality Improvement – the Assistant Director for Quality and Patient safety had reviewed the planned action and any outstanding risks. Updated work plans to the Quality Improvement agenda would be reported via the Quality Improvement and Clinical Effectiveness sub group of the Quality, Safety and Risk Committee.
- Clinical Policies – the new formed Clinical Policies sub group will report into the newly formed Quality Improvement and Clinical Effectiveness sub group.
- Healthcare Inspectorate Wales Reports and Action plans
- Inquests - CTMUHB governance team had received the requested schedule of inquests from former ABMUHB.

Members **agreed** to **approve** the closure of the Legacy Statement with all outstanding actions monitored via the relevant CTMUHB Board Committees.

Rapid Response to Acute Illness Learning Set (RRAILS) Peer Review

Members **received** and **noted** the verbal update report from Kamal Asaad. Members were advised that the peer review refers to the former Cwm Taf UHB. Members were advised that the peer review had been well received by clinicians and **noted** that the report review was looking at quality improvement. Members were advised that a formal report once finalised would be received at the October or November 2019 meeting.

Update on Maternity Services

Members **received** and **noted** the update report on maternity services from Greg Dix.

Members **noted** that the Maternity Improvement Board were meeting on a monthly basis and was being monitored via the Quality, Safety and risk Committee.

Members **noted** that the Independent Oversight Panel (IMSOP) had held two meeting on 22 July 2019 and had received a presentation on progress to date. Members were advised that a Workshop had been held on 12 August 2019 with IMSOP and Welsh Government to consider the performance and assurance framework and this had been endorsed at the IMSOP meeting on the 19 August 2019.
Members **noted** that there were 9 key actions to be delivered by next meeting on the 23 September 2019.

Members **noted** that the work in regard to the development of the Quality & Safety Performance Assurance Framework was almost complete.

Members were advised that the newly appointed Clinical Director would take up post on the 9 September 2019. Members were advised that a substantive Directorate Manage had also been appointed and the Director of Midwifery post was currently out to advert.

Members **noted** that sickness levels in maternity had reduced from 12 to 11%. All members of staff were being supported as per usual via health board processes.

Members **noted** that in regard to leadership and culture an organisational development plan had been developed with a number of actions required at different stages.

Members **resolved** to **note** the report.

Directorate Exception Reports

The Committee **received, discussed** and **noted** four Directorate exception reports:

- Anaesthetics, Critical Care & Theatres
- Radiology
- Therapies
- Workforce

The reports informed members of the common themes raised and risk and mitigating actions taken within/across the exception reports. Members were assured that actions were being taken where necessary to mitigate those risks.

Members **resolved** to **note** the reports.

Workforce Health, Safety & fire Report
Members **received** the report which was presented by Chris Beadle.

Members **noted** the key areas highlighted in the report:

- Health and Safety Executive Involvement
- General Health and Safety Update

- Manual Handling
- Violence and Aggression/Clinically Challenging Behaviour
- Fire Safety
- Safer Needles.

Members **noted** that there were currently two active Fire Enforcement Notices for the ground and first floor, Prince Charles Hospital and Theatres in Princess of Wales Hospital.

Members **resolved** to **note** the reports.

Mental Health and Learning Disabilities Commissioning

Members **received** the report which was presented by Alan Lawrie. The report updated the Committee on the current arrangements for the commissioning of individual patient placements for people with Mental Health and Learning Disabilities (MH&LD) and provided assurance on the arrangements for reviewing the quality and safety of care provided at these establishments.

Members **noted** that there were currently 280 people supported in individually commissioned placements full or partially funded by the Health Board. The cost of all these placements and care packages was £32,427m.

Members were advised that for those people in commissioned placements who are subject to part 2 of the Mental Health (Wales) Measure 2010 (MHM) there was a legal requirement to be allocated a care co-ordinator. The care coordinator was essential to the assessment and review of the person in commissioned care and is required under the MHM to remain actively involved and in regular contact with the Relevant Patient regardless of setting, for example, care homes, hospitals and prisons, (MHA Code Practice 2010)

Members **noted** that under part 2 of the MHM the care coordinator was responsible for facilitating an annual review of the patient care and treatment plan and that compliance with part 2 of the MHM as of month 3 was 89.7%.

Members **noted** that the National Framework provided an alert mechanism set up to inform nominated CTMUHB and Local Authority employees of alleged safeguarding incidents in any of the hospital or care homes on the framework. Members were advised that in 2018-19 there were 54 and in 2019-20 to date there had been 25. The majority were reported from hospital settings with only 11 alerts being received from Care Homes.

Members **resolved** to **note** the report.

Child and Adult Mental Health Services (CAMHS)
Update on Healthcare Inspectorate Wales Review into Ty Llidiard
Members **received** the report which was presented by Alan Lawrie.

Members **noted** that Ty Llidiard, the Tier 4 Child and Adolescent Mental Health Service (CAMHS) inpatient unit, serving Mid, South and West Wales, had been inspected by Healthcare Inspectorate Wales (HIW) in May 2015, March 2017, April 2018 and most recently May 2019. An action plan had been developed following the most recent inspection and had been updated.

Members were provided with an overview of the inspection feedback and the associated action plan. Members **noted** that the action plan demonstrated the significant progress that had been made against the actions identified. Members were advised that there were several key areas that would continue to require focus going forward.

Update on the Delivery Unit Action Plan
Members **received**, **discussed** and **noted** the Delivery Unit Review of Primary Care CAMHS for Cwm Taf Morgannwg UHB that had been undertaken in April 2019.

Members **noted** the Improvement Plan that had been developed in light of the review and the progress made to date.

Members **resolved** to **note** the report and the Improvement Plan and **agreed** to receive a further update at the next meeting.

Organisational Risk Register
Members **received** a verbal report on the Organisational Risk Register. Members **noted** that the Board would be holding a Development Session in August in relation to Risk and **agreed** that following this the Risk Register would be updated and brought back to the next meeting.

Serious Incidents and No Surprises
Members **received** an oral update and were advised by the Chair that this item had been discussed in the 'In Committee' closed session of the Committee.

Histopathology Incident Update
Members **received** an oral update and were advised by the Chair that this item had been discussed in the 'In Committee' closed session of the Committee.

Community Health Council Quarterly Monitoring Reviews
Members **received** and **noted** the report which provided a summary of the findings of the Community Health Council (CHC) during quality monitoring visits undertaken during December 2018, March 2019 and April 2019.

Members **noted** that during this period the CHC had undertaken 10 visits which included Ward 8 Royal Glamorgan Hospital, Ward 3 Royal Glamorgan Hospital and the Accident and Emergency Departments Royal Glamorgan Hospital and Prince Charles Hospital.

Risk Register – Welsh Health Specialised Services Committee and Emergency Ambulance Services Committee.
Members **received** and **noted** the oral report given by Kevin Smith on the risk registers of both hosted bodies.

Forward Work Plan
Members **noted** that the Forward Work Plan would be discussed outside of the meeting.

Key risks and issues/matters of concern and any mitigating actions	
There were none	
Matters requiring Board level consideration and/or approval	
There were none	
Matters referred to or from other Committees	
There were none	
Date of next meeting	3 October 2019

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf
University Health Board

Reporting Committee	**Healthcare Professionals Forum**
Chaired by	Mrs Suzanne Scott Thomas
Lead Executive Directors	Clinical Executives
Author and contact details	lucy.timlin@wales.nhs.uk
Date of last meeting	12 July 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The Healthcare Professionals met on 12 July 2019 – the agenda and papers are available at the following link:

Members **NOTED** that this was the first meeting of the Healthcare Professionals Forum for over a year and agreed they were pleased that the meetings were happening again. They were also pleased that Suzanne Scott Thomas had agreed to be the Chair: Jonathan Arthur agreed to undertake the role of Vice Chair.

Issues Discussed:

1. Terms of Reference

The terms of reference were broadly agreed, with some additions to the attendance. Lucy Timlin agreed to rewrite the document and circulate ahead of the next meeting where it was anticipated that they could be endorsed for approval by the Board.

2. Programme for the Coming Year

There was discussion about the programme for the coming year, and the following was agreed, which reflected the issues that were significant for the organisation. Colleagues felt that the HPF needed to be very relevant in the UHB:

October 2019 – Greg Dix and Alison Davies: Governance and Safety Issues
January 2020 – Q&A with the CEO and the Chair
April 2020 – Transformation
July 2020 – Mental Health including Health Psychology with Julie Denley and Juan Delport

3. Key Objectives

Colleagues were keen to ensure that the HPF "voice" was heard at all levels and provided the leadership for this important group of staff. It was anticipated that this would develop as the Forum continued.

4. Presentation

Colleagues enjoyed a presentation from Mark Briggs, Head of Gene and Cell Therapy at the Welsh Blood Service, "The Adoption of Advanced (Cell & Gene) Therapies in Wales".

Items received for information:

There was brief discussion for information on Winter Planning.

Next meeting Members requested the following items:
Nil this quarter.

Future agenda items:

- Described above – the meetings are set now until July 2020
- Structures

Key risks and issues/matters of concern and any mitigating actions	
None identified	
Matters requiring Board level consideration and/or approval	
Nothing this quarter.	
Matters referred to other Committees	
None.	
Date of next meeting	15 October 2019

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Mental Health Act Monitoring Committee Meeting

Minutes of the meeting held on 2nd April 2019
Held at Ynysmeurig House, Cwm Taf Morgannwg Health Board HQ, Abercynon.

Present	
Maria K. Thomas (Chair)	Vice Chair of the University Health Board
Mel Jehu	Independent Member of the Board
James Hehir	Independent Member of the Board
Alan Lawrie	Director of Primary, Community & Mental Health
Colin Hatherley	South Wales Police Mental Health Officer
Jeremy Burgwyn	Head Administrator, Mental Health Team
Julie Cude	Head of Nursing, CAMHS
Julie Denley	Asst. Director of Operations Mental Health & Learning Disabilities
Karen Thomas	Superintendent, South Wales Police
Samantha Shore	Chair of MHAM Operational Group
Jeane Smith	Directorate Support Manager
Jackie Davies	Bridgend County Borough Council
Dave Semmens	Delivery Unit (Observing)
In Attendance	
Wendy Penrhyn-Jones	Head of Corporate Administration
Kathrine Davies	Corporate Governance Support (Secretariat)

MHA/19/021 **WELCOME AND INTRODUCTIONS**

Maria Thomas **welcomed** everyone to the meeting and gave a special welcome to Dave Semmens from the Delivery Unit.

MHA/19/022 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Greg Lloyd, Kishore Kale, Frances Hall, Phil Lewis, Peter Watkins and Robert Williams.

Maria Thomas emphasised that it was important to have good attendance of at the Committee.

MHA/19/023 **DECLARATIONS OF INTEREST**

There were none.

MHA/19/024 **MINUTES OF THE PREVIOUS MEETING**

The minutes of the meeting held on the 2 April 2019 were **CONFIRMED** as a **true** and **accurate** record.

MHA/19/05 **ACTION LOG**

Members **RECEIVED** a copy of the action log and discussed the following:

- **MHAM/17/45** – CAMHS MHA Breaches – Whilst an update had been due this was not available. It was **AGREED** the matter be placed on the agenda for the next meeting noting that the matter had first been raised in September 2017.
- **MHAM/18/39 –** Business Case for Section 136 – Joint Venture. Colin Hatherley stated that a meeting had been held on this matter earlier that day on this issue which was largely an internal police issue which was largely resolved. It was **AGREED** that the issue would be removed from the action log.
- **MHAC/18/40 –** Memorandum of Understanding – This had been included within the "on-call" communications pack and it was **AGREED** the issue could be removed from the action log.
- **MHAC/18/47 (part 1) –** The audit of patients discharges prior to a hearing had been completed and it was **AGREED** the matter be removed from the action log.
- **MHAC/18/47 (part 2) –** Alan Lawrie related to concerns previously raised around the rising number of sections and would be discussed later in the agenda.
- **MHAC/18/65** – Consultant attendance at Operational Group meetings – whilst the issue had been brought to the attention of Kishore Kale, Clinical Director for Mental Health and a consultant psychiatrist having been designated to attend, they had not attended the two most recent meetings. Alan Lawrie recommended that he had drafted a joint letter from himself and the Committee Chair to Kishore Kale mandating the attendance of a consultant to all future meetings of the Operational Group. This was **AGREED.**

MHA/19/06

MATTERS ARISING

- **Page 2 –** The Chair requested that if Kishore Kale as the Clinical Director was unable to attend Mental Health Act Monitoring Committee that an alternative representative may need to be designated. It was **AGREED** this requirement would be included in the joint letter that Alan Lawrie was drafting regarding attendance at the Operational Group meetings.
- **Page 3 –** The Chair reminded Julie Denley that this related to a query as to whether breaches were reportable matters via the DATIX incident reporting system and if so whether such instances were being reported. Julie Denley confirmed that breaches were indeed reportable and she was also provided assurances that this requirement was also being being met.

MHA/19/07 **CHAIR'S REPORT**

With reference to the meeting of the Vice-Chairs and the Minister held on 14th February 2019 at which the Deputy Minister and the Director General/Chief Executive NHS Wales, Dr Andrew Goodhall had also been present. Members **NOTED** there the issue of compliance of the Mental Health Act around CAMHS and access to mental health services in general had been raised. Maria Thomas said that the Deputy Minister had remarked that there were varying levels of engagement in terms of the plans for such services from each health board and that a request was made to encourage greater engagement and partnership working.

The Chair said there had also been discussions around service performance and that the Minister was keen to understand from Vice-Chairs as to how they gained assurance on the performance and quality of such services and that there was appropriate visibility of the issues at Board level.

Maria Thomas stated that the Health Board achieved this through her report as Chair of the Mental Health Monitoring Act Committee to the Board. Maria Thomas stated that there had been discussions at the Vice-Chair's meeting regarding a forthcoming report regarding Community Mental Health Service performance which would be critical of performance across Wales. The Chair asked Alan Lawrie to discuss the issues of engagement and partnership working with his team along with performance including milestones for service improvement aligned to target dates. In addition she said that the Vice-Chairs meeting had highlighted the need for significant improvements to be made in CAMHS and primary care which included sustainability solutions.

It was **NOTED** that performance & workforce issues were considered by the Finance, Performance & Workforce Committee and quality, safety and risk related issues via the Quality, Safety and Risk Committee which enabled information to be triangulated. Alan Lawre **AGREED** to discuss the point raised via the Vice-Chair's meeting with his management team.

The Chair said that the issue of the Crisis Care Concordat has also been discussed. Maria Thomas reported that Chief Constables had raised concerns regarding numbers of people with mental health issues that police were becoming involved in which increasingly related to social behavioural issues. The Chair said that the Deputy Minister had asked Vice-Chairs to foster stronger engagement with the Police on mental health issues particularly in the South Wales area. Maria Thomas stated that Alan Lawrie had given an undertaking to discuss this matter with the Chief Executive to ensure these issues were considered at a senior level as there was a level of

concern as to future funding arrangements.

Alan Lawrie stated that mental health issues were currently discussed at various Board Committees each of which reported to the Board via the respective Committee Chair reports. It was suggested that further discussions were held between Alan Lawie and the three board committee Chairs with a view to agenda planning of strategic mental health & learning disability service topics going forward whether this was in respect of the meeting of the Board held in public and or via a Board Development session. This was **AGREED.** Alan Lawrie also referenced the work regarding the Police Control Centre which he said had been positive and discussions were needed around how this was taken forward and reported. Gwen Roberts stated that there had been regular discussions around this at the Emergency Ambulance Services Committee and that discussions were planned with the Chief Constable to understand the requirements of the various stakeholders involved.

Gwen Roberts referenced the excellent representation from South Wales Police and local authority colleagues at the Mental Health Act Monitoring Committee meetings acknowledging that the WAST representative was not required to attend every meeting. Mel Jehu stated that as Vice-chair of the South Wales Police and Crime Panel he ensured mental health issues were discussed at every meeting.

Colin Hatherley referenced the need to consider extending committee representation given that the Health Board's area of responsibility had been extended to included the County Borough of Bridgend. The Chair suggested that relevant colleagues discussed this further and communicated the outcome to Interim Board Secretary.

Members **RESOLVED:**

- To **NOTE** the verbal responses and Chair's report;
- To **NOTE** discussions around performance, future service delivery plans, sustainability and levels of engagement with regard to mental health, learning disabilities and CAMHS services were being led by the Director of Community & Mental Health;
- To **NOTE** plans for future discussion of mental health related issues at Board level were being co-ordinated through the Director of Primary, Community & Mental Health Services;
- To **NOTE** following discussion of Police representation for the Bridgend locality would be confirmed.

PART 2 – GOVERNANCE, PERFORMANCE AND ASSURANCE

MHA/19/08 **MENTAL HEALTH ACT – QUARTERLY ACTIVITY STATISTICAL REPORT**

Members **RECEIVED** the Mental Health Act – Quarterly Activity Statistical Report in respect of quarter 3 (October – December 2018) for discussion and scrutiny and **NOTED** that Appendix 1 provided a useful glossary of terms.

Julie Denley presented the report and Members **NOTED** section 2 and 3 performance showed significant improvement on the number of lapses around the third quarter of 2018/19. Members **NOTED** performance in Section 5.2 lapses were a matter of concern and recommendations had been made for training and the use of guidance sheets. Members **NOTED** all Section 136 assessments had been reached showing the commitment towards the concordat.

Julie Denley asked Members to consider the report content and to offer feedback regarding content.

Maria Thomas stated that at the previous meeting she had asked that all breaches be reported in full as well as any corrective actions and learning. Whilst acknowledging that some some learning had been included the report Members **NOTED** it did not yet provide sufficient assurance to allow independent members to be satisfied regarding performance, particularly 5a breaches which were increasing.

Mel Jehu **NOTED** that whilst there were a number of learning points contained within the report he did not yet have assurance that this was being enacted and therefore suggested that future reports included learning outcomes. Alan Lawrie stated that the current report contained significant new data which was positive but that the current content needed to be reformatted so that it formed supporting appendix. Alan Lawie suggested he met with Julie Denley and Jeremy Burgwyn to discuss the key messages that needed to be set out in future reports - the positives and negatives and where to find them which would help independent members to focus their scrutiny. This was **AGREED.** Mel Jehu and Jim Hehir offered to participate in the meeting to feedback independent member views.

Julie Denley stated that she had reviewed the past 12 month's reports and agreed that whilst there was significant learning set out in reports (which was subject to discussion at the operational group), this needed to be more closely monitored in terms of this being followed through to become embedded into daily practice on a sustained basis with monitoring feeding the position into future reports to the Committee.

James Hehir stated that the suggestions would demonstrate joint working to achieve the required outcomes. In referencing page 7 of the report, section 5 which related to an assessment by a junior doctor rather than a responsible clinician which illustrated the organiation did not always have the right people at the right level which inevitably had an impact on learning lessons. Julie Denley concurred saying that the attendance of the Clinical Director at future meetings was key.

The Chair thanked Julie Denley for the report and for the contributions made regarding improving the content of future reports.

RESOLVED:

- To **NOTE** the format and content of future reports be revised to provide a dashboard which included outcomes and lessons learned with a view to enabling robust scrutiny.

MHA/19/09 **REPORT FROM MENTAL HEALTH ACT (MHA) OPERATIONAL GROUP**

Members **RECEIVED** the report presented by Julie Denley (on behalf of Samantha Shore who had been unable to attend the meeting). Julie Denley stated that as with the previous report, the content of this report item also needed review. Members **NOTED** that whilst the Operational Group was well established representation over the past twelve month varied which inevitably resulted in a lack of continuity.

The audit had looked at service users who had been removed from a detention prior to a hearing or a mental health act tribunal. Julie Denley suggested that performance in this area needed to be routinely reviewed with any readmissions being tracked in terms of aftercare and reported back to the Committee. This was **AGREED.**

Whilst finding the report helpful, James Hehir commented that the presentation of the position had been clearly presented at the meeting but this understanding could not have been gained from reading the report alone. He suggested that this be considered in the drafting of future reports.

Mel Jehu referenced the issues listed in the report which were discussed by the Operational Group and suggested that in future these be prioritised and detail captured around any issues which impacted upon Mental Health Act compliance. He referenced an issue contained within the report regarding the involvement of the Ambulance Service which he felt to be significant. He said that the list currently did not provide the relevant context in terms of what the outcome of discussions

around this issue had been and importantly that the issue had been resolved. Julie Denley **AGREED** and undertook to ensure this was considered as part of the review of report content.

Mel Jehu sought clarity around services received by armed services or military personnel. Julie Denley responded that there was good work ongoing within the Operational Group but currently the links to enable this to be concisely reported to the Committee had not been made. With regard to services provided to the armed services or military personnel she stated that data was not currently collected specficially in terms of the Mental Health Act and therefore such service users would be priorised for the services they required.

Alan Lawrie stated that a previous steer had been provided in terms of the content of this particular report and whilst the current content did not provide the required assurance that issues were being followed through and escalated as and where necessary. Mel Jehu stated that in future the report needed to provide information on any issues impacting on the Health Board's ability to comply with the Mental Health Act.

Jackie Davies advised that the invite for a Bridgend representative to attend future meeting was currently being worked though.

The Chair asked if the designated consultant representative was now attending meetings of the Operational Group. Julie Denley said that the representative had not attended the previous two meetings of the Operational Group. The Chair said that she would ensure this was referenced in joint letter that was being drafted to Kishore Kale, Clinical Director as detailed in her Chair's report earlier in the agenda.

RESOLVED:

- To **NOTE** further work was required around the format and content of future reports from the Operational Group and that appropriate links be made in terms of the changes being made to the quarterly performance report.
- To **NOTE** the requirement for appropriate and consistent attendance of the designated consultant representative at meetings of the Operational Group would be addressed via the joint letter being drafted to Kishore Kale, Clinical Director from the Director of Primary, Community & Mental Health Services and the Vice Chair/ Chair of the Mental Health Act Monitoring Committee.

MHA/19/10 **STRATEGIC UPDATE FROM SOUTH WALES POLICE - Policing and Crime Act 2017 (S13 5 & 136 of the Mental Health Act 1983) and including Place of Safety Report**

Members **RECEIVED** the a strategic update report from South Wales Police presented by Peter Thomas. Members **NOTED** an update on Section 136 data for quarter three of 2018/19, the Crisis Care Condordat and the Community Psychiatirc Nurses (CPN) in the Public Service Centre Scheme.

Members **NOTED** that from an England and Wales perspective Section 136 detentions were increasing which was a concern. This was possibly linked to substance misuse although ultimately it was unclear.

Members **NOTED** the Crisis Care Concordat had been rolled-out in five areas and training had also been delivered. They also **NOTED** that training had also been delivered around the pilot and had started discussions with the former Aertawe Bro Morgannwg University Health Board (now known as Swansea Bay University Health Board) and Hafal regarding provision of an 'alternative place of safety' facility and a task & finish group had been established to consider funding issues. Members **NOTED** that to date two of the five objectives had now been delivered. In May 2019, the first 'alternative place of safety' facility was due to open in Llanelli. It was **NOTED** the scheme was going well with incidents referrals reducing the impact upon police time.

The Chair thanked Peter Thomas for the report.

Julie Denley reflected upon the statistics in the report, how Cwm Taf Morgannwg compared with other health boards in terms of performance and any lessons that could be learned from this via the Operational Group particularly in terms of repeat attendees. Mel Jehu stated that he was pleased with the report and suggested that the positives from partnership working should be promoted as it was benefiting the local community. It was **NOTED** that the work would be independently evaluated at the end of the trial period. South Wales Police representatives were thanked for their support.

Gwen Roberts sought clarity around the details from the report which were marked as "restricted" and confirmed that this would not be included in the papers available on the Cwm Taf Morgannwg website.

Alan Lawrie stated that whilst the report confirmed the successes that had come out of the joint Police/Health working in relation to the Public Service Centre, this would inevitably start to have an impact upon operational services on a day-to-day basis and therefore a strategic discussions were required at Chief Constable / Chief Executive level in order that decisions could be taken as regards the future commitment of

resources.

Members **RESOLVED:**

- To **NOTE** the matter of future strategic direction of joint working with the Police regarding the Public Service Centre be discussed at Executive level;
- To **NOTE** restricted police data would not be included in published Committee meeting papers.

MHA/19/11 **MENTAL HEALTH ACT BREACHES**

Members **RECEIVED** the Mental Health Act Breaches report.

Members **NOTED** the report set out activity data regarding the application of the Mental Health Act and breaches in procedures for both adult and Child & Adolescent Mental Health Services.

The report raised concerns around breaches for category 4 matter but failed to provide the required context behind what had occurred and the actions taken as a result.

Alan Lawrie suggested that given the next meeting was not imminent he recommended that the necessary information was gathered and sent to Committee members within four weeks of the meeting. This was **AGREED.** Julie Denley stated that whilst the issues had been raised with the relevant senior clinician their non-attendance at the Operational Group had impacted on follow through actions.

The Chair expressed her personal disappointment that the report failed to provide the necessary information given that this was requested at the previous meeting by the Committee and that a robust report was required at each future meeting.

Members **RESOLVED**:

- To **NOTE** the report;
- To **AGREE** the Director of Primary, Community & Mental Health Services would contact the Clinical Director to seek context as to the breach report and actions taken as a result and that this be shared with Committee Members within four weeks of the meeting; and
- To **NOTE** future Mental Health Act Breach reports would need to contain the above detail as a matter of course.

MHA/19/12 **UPDATE ON THE INTERFACE BETWEEN THE EMERGENCY DUTY TEAM AND THE COMMUNITY MENTAL HEALTH TEAM**

Members **RECEIVED** the above report.

Julie Denley presented the report reminding members that they had asked for further information regarding the relationship between the Emergency Duty Team and the core Community Mental Health team. Members **NOTED** the Emergency Duty Team already provided a service to the Bridgend area which was a longstanding arrangement which worked well and that mental health issues represented only a small part of the remit of the Emergency Duty Team. Julie Denley stated that it was the remit of the Community Mental Health Team to intervene so as to avoid service users needing to access the Emergency Duty Team. Members **NOTED** that the Emergency Duty Team were not currently part of the membership of the Operational Group and this would be addressed. Julie Denley stated that this would allow any learning and monitoring around service group service usage.

The Chair thanked Julie Denley for the helpful report and it was **AGREED** that it would be shared with on-call managers following the correction of two typographical errors.

Members **RESOLVED**:

- To **NOTE** the report;
- To **NOTE** the Emergency Duty Team would be invited to nominate a representative on the Operational Group;
- To **NOTE** the report would be added to the sharepoint to be shared with on-call managers.

MHA/19/13 **NATIONAL CONFIDENTIAL INQUIRY INTO SUICIDE AND HOMICIDE BY PEOPLE WITH MENTAL ILLNESS 2018 – SUMMARY AND OBSERVATIONS FOR CWM TAF**

Members **RECEIVED** the above report presented by Julie Denley. In order to validate information and complete inquests Members **NOTED** there was a necessary time-lag in the data becoming available.

Members **NOTED** the number of suicides in the Health Board area had declined since 2006 when the Health Board had the largest numbers of suicides. It was **NOTED** the most common methods being strangulation and self-harm.

With regard to suicides of in-patients, Members **NOTED** there had been 56 deaths over a ten-year period up to 2016 with the most common methods being hanging and strangulation. In terms of the proportion of these deaths which were in-patients, Members **NOTED** these amounted to 14 with the remainder taking place whilst a patient was on leave or following a period when the service user had left the ward without permission.

Julie Denley referenced page 11 of the report in relation to the work that had taken place to reduce levels of suicides in respect of making patient areas safer, early discharge and follow-up. The number of out-of-area admissions was **NOTED** to be a positive, as was the operation of Crisis Teams which were on course to operating on a 24/7 basis across the patch. It was **NOTED** that a group was looking at the Suicide Strategy and they were seeking to involve relatives affected by a suicide as well as being involoved in the clinical review process. This was **NOTED** to be having a positive contribution as regards the grief process.

With regard to the management of depression it was **NOTED** that a pathway existed which had been created following joint work with Primary Care. Members **NOTED** there were well established personalised risk management processes were in place which had been acknowledged following reviews by Health Inspectorate Wales and the Welsh Government's Delivery Unit. Members **NOTED** there was futher work to do in respect of Outreach and Recovery Teams.

Julie Denley stated that whilst staff turnover was low in general, in-patient services tended to suffere depletion as new money became available for community based services. Members **NOTED** this was particularly the case for CAMHS.

Members **NOTED** that all admissions were processed via a central admission unit in the former Cwm Taf area which was struggling in staffing terms however an advert for a dual diagnosis Advanced Nurse Practitioner post would complement existing team of staff.

A 'Walk-Out' procedure had been agreed with colleagues in the Emergency Department and the Police to address instances where people with a mental health issue left before being seen. James Hehir stated this the existence of this process was important as once registered the organisation had a duty of care to the service user.

Julie Denley referred to strategic work that was underway with the Mental Health Partnership Board which had made significant progress over the past year with regard to a strategic plan for suicide reduction – Project 34.

Julie Denley referenced a recommendation arising from the National Assembly report: 'Everyone's Business' regarding urgent referral routes for GPs. Members **NOTED** that this was in place within the former Cwm Taf area and checks would need to be made to confirm the same for the Bridgend locality.

The Chair thanked Julie Denley for the report noting that

further work to improve performance would be brought back to the Committee in due course.

Alan Lawrie stated that the intention was to use the report as the basis of a report to the Board in May 2019.

Members **RESOLVED**:

- To **NOTE** the report and the intention use the report to form the basis of an update to the Board Meeting in May 2019.

MHA/19/14

IMPLICATIONS OF THE BRIDGEND BOUNDARY CHANGE IN RELATION TO THE MENTAL HEALTH ACT MONITORING COMMITTEE

A report was **RECEIVED** regarding work undertaken in readiness for the service transition.

Members **NOTED** that a review of existing sections had been undertaken following the service transfer taking effect as of 1st April 2019. Thanks were extended to the Mental Health Act team for all their hard work.

Members **RESOLVED**:

- To **NOTE** the report.

MHA/19/15

MENTAL HEALTH ACT MONITORING COMMITTEE TERMS OF REFERENCE

A report was **RECEIVED** around the Committee's Terms of Reference (TOR) which had been updated to reflect the changes resulting from boundary change.

A suggestion was made that consideration should be given to representation from South Wales Police following the inclusion of Bridgend locality in the Health Board's portfolio. With regard to a carer representative it was noted that the representative had only attended one meeting todate. It was suggested that the representative be given an open invitation.

Members **AGREED** that Julie Denley be included as a member of the Committee who would also represent the interests of service vetrans. Members **AGREED** that the WAST representative be asked to attend twice a year and that there be a similar attendance requirement for the Clinical Director and Head of Nursing.

Members **RESOLVED**:

- To **AGREE** the TOR be amended and submitted to the Board on 30th May 2019 for approval.

MHA/19/16

RISKS RELATED TO THE MONITORING OF THE MENTAL HEALTH ACT

Members **RESOLVED:**

- To **DEFER** this item to the next meeting.

PART 3 - FOR INFORMATION

MHA/19/17

INVESTMENTS FOLLOWING DISCUSSIONS WITH AGENCIES

Members **RESOLVED:**

- **AGREED** to defer this item to the next meeting.

PART 4 - OTHER MATTERS

MHA/19/18

TO REVIEW THE FORWARD LOOK FOR 2018/19

It was suggested that this issue be subject to discussion between the Interim Board Secretary and the Committee Chair outside the meeting and included on the agenda for the next meeting.

Members **RESOLVED**:

- To **NOTE** the intention to include a revised forward look on the next agenda.

MHA/19/19

ANY OTHER URGENT BUSINESS

It was suggested that consideration be given to venues for future meetings.

MHA/19/20

DATE OF NEXT MEETING

It was suggest that the meeting scheduled for 9th May 2019 be cancelled and therefore the next meeting would be 8th August at 2.00pm at Ynysmeurig House, Abercynon. ***(Subsequent to the meeting, it was necessary to bring the meeting forward to 6th August 2018).***

Signed …….

Maria Thomas (Chair)

Dated: …….

Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Reporting Committee	**Mental Health Act Monitoring Committee**
Chaired by	Mrs Maria Thomas
Lead Executive Director	Director of Primary, Community & Mental Health
Author and contact details	Kathrine Davies – Interim Corporate Governance Support – Kathrine.davies2@wales.nhs.uk 01443 744808
Date of last meeting	6 August 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The Mental Health Act Monitoring Committee last met on Tuesday 6 August 2019. The Agenda and papers for this meeting are available on the UHB's Internet site via the following link:
http://cwmtaf.wales/mental-health-act-monitoring-committee/

Chairs Report

Members **received** the oral update report from Maria Thomas, Chair of the Committee. Members were updated on the Vice Chairs meeting with the Minister where they discussed the following:

- The need to foster relationships between health boards and South Wales Police and to ensure that the Crisis Concordat was fully established.
- The importance of the Welsh Ambulance Services Trust (WAST) being represented at Mental Health Act Monitoring Committees had been raised.
- The Minister had a particular interest in mental health services and any learning and best practice that could be shared in the provision of such services locally in conjunction with primary care.
- In relation to specialist Child and Mental Health Services (s-CAMHS) at Ty Llidiard, Princess of Wales Hospital, the Minister had sought an update on current commissioning and de-escalation. Members **noted** that the Finance & Performance Committee were actively monitoring performance and the actions being taken to improve this. A letter had also been sent to Welsh Health Specialised Services (WHSSC) in regard to commissioning. Members **noted** that discussions had been held with the Delivery Unit in terms of plans for the future including additional support over the next few weeks.
- The Chair advised that the use of Welsh Language within services had been raised. Members **noted** that there was an operational Welsh Language Group in Cwm Taf Morgannwg which had recently discussed an action plan relating to reception and dementia services. Members **noted** the Electronic Staff Register system was being updated to reflect the number of staff that speak Welsh.

Mental Health Act Monitoring Committee Draft Annual Report 2018/19
Members **received** the report which included the revised terms of reference which was presented by Wendy Penrhyn-Jones.

Members **agreed** to endorse the Annual Report for submission to the Health Board, subject to any further comments received. Members **agreed** to review the membership, the Terms of Reference and the Committee Self-Assessment outside of the meeting.

Members **agreed** that discussions would be held with the Chair of the health Board in regard to Induction Training for new Members and succession planning for the future Committee.

Mental Health Act – Quarterly Activity Statistical Report
Members **received** the report on the Mental Health Activity for Quarter 1 in relation to Adult Mental Health and Children and Adolescent Mental Health Services (CAMHS). Members **noted** that Quarter 1 had seen an anticipated rise in Mental Health Activity following the integration of Bridgend services and were advised that the mean number of detentions had risen to 123 in Quarter 1.

Members discussed the Use of Section 135/136 Police Powers and noted that the number of Section 136 assessments for quarter 1 was 73% which was higher than in 2018. It was **agreed** that if the pattern continued for Quarter 2 the Operational Group would be asked to review activity across the health board area in greater detail.

Report from Mental Health Act (MHA) Operational Group
Members **received** the report providing an update from the Mental Health Act (MHA) Operational Group.

Members **noted** that the group had met twice since the last meeting and considered operational and practical issues relating to mental health matters.

Members **noted** the work undertaken on policies in relation to the Bridgend boundary change. Members were advised of the training that had been undertaken between March and June 2019 with further sessions planned for September to November 2019.

Members **noted** the key risks outlined in the report as:
- Effective medical input and attendance at Operational Group;
- Increase in MHA detentions for older person services;
- Transportation of detained patients between hospital sites.

Members discussed Section 136 and **agreed** to receive analysis of the findings of the Section 136 audit once completed.

Mental Health Act Breaches
Members **received** the Mental Health Act Breaches report and **noted** the actions taken to reduce the breaches.

Risks Related to the Monitoring of the Mental Health Act
Members **received** a verbal report from Julie Denley. Members **noted** the current risks in relation to transportation and were advised that a broader conversation would be required with WAST. Members **noted** that arrangements were in place with St John's Ambulance for transportation. Members **noted** that work was underway to enable transfer of patients into Princess of Wales Hospital. Members **noted** that consideration was being given to recruiting additional hospital managers to support panel hearings in the Merthyr & Cynon areas.

Policing and Crime Act 2017 (S135 & 136 of the Mental Health Act 1983)
Members **received** a report from South Wales Police providing an update on the work being undertaken to comply with the Policing and Crime Act 2017 and S135 & 136 of the Mental Health Act 1983.

Members **noted** that there had been a 14.2% increase in s135 detentions between 2017/18 and 2018/19. In terms of England and Wales Section 136 detentions were increasing.

Members **noted** that the Crisis Care Concordat National Action Plan had been launched. The delivery plan was being locally implemented and the National Concordat Assurance Group would provide assurance to Welsh Government on a six monthly basis.

Members **noted** the update in regard to the Mental Health APP that had been developed by South Wales Police and were advised that they would be working with health boards to trial the APP. Members **agreed** to receive a presentation at the next meeting.

Matters requiring Board level consideration and/or approval
• None
Matters referred to other Committees
• None

Date of next meeting	Thursday 25 November 2019

Minutes of the Meeting of the Welsh Health Specialised Services Committee

at held on 28 June 2019 at 14:00hrs
at Health and Care Research Wales, Castlebridge 4, 19-15 Cowbridge Road East
Cardiff, CF11 9AB

Members Present:

Vivienne Harpwood	(VH)	Chair
Carole Bell	(CB)	Director of Nursing and Quality Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB (by VC)
Paul Griffiths	(PG)	Independent Member/Audit Committee Representative
Sharon Hopkins	(SH)	Interim Chief Executive, Cwm Taf Morgannwg UHB
Charles Janczewski	(CJ)	Independent Member/Chair of the WHSSC Quality and Patient Safety Committee
Sian Lewis	(SL)	Managing Director, WHSSC
Tracy Myhill	(TM)	Chief Executive, Swansea Bay UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (by VC)
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Ian Phillips	(IP)	Independent Member
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Jennifer Thomas	(JT)	Medical Director, WHSSC

Apologies:

Kieron Donovan	(KD)	Affiliate Member/ Chair of the Welsh Clinical Renal Network

In Attendance:

Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC

Minutes:

Michaella Henderson	(MH)	Corporate Governance Officer, WHSSC

The meeting opened at 14:05hrs

JC19/017	**Welcome, Introductions and Apologies** The Chair formally opened the meeting and welcomed members. The Chair welcomed IP to his first meeting. Apologies were noted as above.
JC19/018	**Declarations of Interest** The Joint Committee noted the standing declarations. There were no additional declarations to note. The Chair reminded the Independent Members of their obligation under the Standing Order 1.3.2 to act in a balanced manner, ensuring any opinion expressed is impartial and based on the best interests of the health service across Wales. The Chair reminded all Members of their obligation under Standing Order 7.3.1 that individual board members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services. The Chair also reminded Members of Standing Order 7.3.3 whereby any Health Board Chief Executive who feels conflicted about the matter under discussion, in the event of a vote, may need to abstain from voting. The Chair noted Members responsibilities to consider all relevant matters in an open, balanced, objective and unbiased manner, and to determine the relative weighting to be given to the evidence of the independent experts and the health board Medical Directors, to avoid potential legal challenge. The Chair explained that the whole adult thoracic surgery review process had been transparent, had involved engagement and formal consultation, and the latest paper reflected the output from actions agreed at the previous meeting of the Joint Committee.
JC19/019	**Thoracic Surgery Workforce Planning** The Joint Committee received the paper the purpose of which was to: 1. To re-confirm the advice from the provider Medical Directors and to provide the Joint Committee with further information regarding the thoracic surgery consultant workforce arrangements required for a single service located at Morriston Hospital, Swansea and the cover arrangements for the Major Trauma Centre (MTC). This included:

- Detail regarding the anticipated demand for thoracic surgery in south Wales, this included out-patient and surgical activity and allowed for the planned 20% increase in activity;
- Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills;
- Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants;
- Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants;
- Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (e.g. telephone advice or on site input); and
- Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons).

2. To make recommendations regarding the future consultant workforce model and emergency cover of the MTC.

The Chair directed members to the Recommendations section (section 4.0) of the paper and identified what was being asked of members.

SL summarised the key points set out in the paper.

Members noted there was currently no increasing trend in thoracic surgery activity but accepted the service would need to be able to react if such a trend developed.

Members noted that the experts' opinions indicated that, in order to maintain their surgical skills, each consultant thoracic surgeon would need to perform at least 50 primary lung resections per annum and have at least one full day of operating in theatre per week, also, in their view, eight surgeons would mean this target may be difficult to meet, thus compromising patient safety. Furthermore they felt that it was neither desirable nor necessary to operate a two rota system. On this basis they felt that, based on current activity and a planned 20% increase, the right number was six consultant thoracic surgeons.

SL confirmed that, when making their own recommendations, the independent experts were aware of the recommendations of the provider health board Medical Directors and that the Thoracic Surgery Centre and the MTC would be 45 miles apart.

	SL confirmed thoracic surgeons on site at University Hospital Wales would be used to maintain local thoracic clinics, support the MTC and provide ongoing support for thoracic patients on trauma wards. Members noted it was anticipated 3–12 patients per annum would require an immediate thoracic surgery intervention at the MTC but that other patients might simply need stabilising immediately and could then be dealt with by a thoracic surgeon during their next scheduled daytime shift. Members noted that it was expected that thoracic out-patient clinics would be run in CVUHB so patients wouldn't have to travel to SBUHB for these clinics. Members discussed the differences in the advice given by the health board medical directors and independent experts, as set out in the paper. Members agreed the engagement of the service's clinicians would be the key to a successful service change. Members were generally supportive of a review during the 12 months prior to opening the new Thoracic Surgery Centre to determine the appropriate number of consultant thoracic surgeons engaged in the service but had differences of opinion as to whether the starting number of eight proposed by the provider Medical Directors was necessary. Members discussed the potential risks in the seventh consultant post being a locum appointment and suggested it should be a substantive appointment instead. LR reported that CVUHB was supportive of the recommendation for an extra consultant thoracic surgeon being appointed at UHW from April 2020 to support the MTC, subject to subsequent review. Members agreed quality of service and patient safety should be paramount in any decisions taken. TM reported that she did not have the support of the SBUHB Medical Director for the recommendations set out in the paper. Members carefully considered the information provided in the paper and, after protracted discussion, SL, with the approval of the Chair, withdrew the motions set out in the paper. Members then proposed and seconded two alternative motions that were voted on, being: **Motion A:** To acknowledge and support the views of the Medical Directors and clinical body across CVUHB and SBUHB, balanced with the independent experts' opinions; at this stage committing to the appointment of an additional consultant thoracic surgeon to support

	implementation of the MTC from April 2020 and thereafter to act on the real world experience from the MTC and updated activity figures to ensure that we have the appropriate number of consultant thoracic surgeons in place by the time of opening the new Thoracic Surgery Centre at Morriston Hospital, Swansea. **Motion B:** To accept and support the recommendations of the Medical Directors and clinical body across CVUHB and SBUHB, balanced with the independent experts' opinions; at this stage committing to 7 consultant thoracic surgeon posts with effect from April 2020 with phasing to 8 (or the appropriate final number required) as demonstrated by the real world experience from the MTC and updated activity figures, based on needs and succession planning, to ensure that we have the appropriate number of consultant thoracic surgeons in place by the time of opening the new Thoracic Surgery Centre at Morriston Hospital, Swansea. Members voted as follows on the alternative motions: Motion A For – PG, IP, CS, JP, VH, SL, SD, CB = 8 Motion A Against – TM, LR, SH, SM, GD, JT, CJ = 7 Motion B For - TM, LR, SH, SM, GD, JT, CJ = 7 Motion B Against - PG, CS, JP, VH, SL, SD, CB = 7 Motion B Abstention – IP Neither motion achieved the required two-thirds majority to succeed. **ACTION: It was agreed the Managing Director of WHSSC would seek advice from Welsh Government on next steps.**
JC19/020	**Date and Time of Next Meeting** The Joint Committee noted the next scheduled meeting would take place at 13:30hrs on 23 July 2019 at Education Centre, University Hospital Llandough, Penlan Road, Penarth, CF64 2XX.

The meeting closed at 16:15hrs

Chair's Signature: .....

Date: .....

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – JULY 2019

The Welsh Health Specialised Services Committee held its latest public meeting on 23 July 2019. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

http://www.whssc.wales.nhs.uk/2019-20-whssc-joint-committee

Action log & matters arising

Members noted the action log.

Chair's Report

The Joint Committee received an oral report from the Chair. The Chair's annual appraisal with the Minister the previous week had gone well and the Minister had confirmed that the Chair's appointment was extended by a further year.

Managing Director's Report

The Joint Committee noted the content of the Managing Director's report and, in particular, an update on Radiofrequency Ablation for Barrett's Oesophagus in south and mid Wales, where expressions of interest for provision of a south Wales based service had been received from CVUHB and SBUHB. The service development is anticipated to be cost neutral or cost saving. The WHSS Team is progressing the CVUHB proposal but the original timeline for a service model recommendation by July 2019 has slipped.

Adult Thoracic Surgery for South Wales

The Joint Committee received a paper that (1) summarised the outstanding issues from the November 2018 Joint Committee meeting regarding the single site model for thoracic surgery based at Morriston Hospital, Swansea and the progress in addressing those issues; and (2) made recommendations regarding the future thoracic surgery consultant workforce model and emergency thoracic surgery cover for the Major Trauma Centre (MTC).

The latest proposals built on the consensus previously achieved regarding the additional (fourth) thoracic consultant post at UHW, to support the opening of the MTC, the funding for which would be included within the MTC business case and approved for 12 months. This appointment would need to be subject to an ongoing evaluation and extended if necessary. Also during this time the two thoracic centres would develop plans to work together developing a single emergency rota.

Members acknowledged that because of the uncertainty regarding the future consultant workforce requirements for the single thoracic surgery unit at Moriston Hospital, it is proposed that additional funding for two posts is allocated with the MTC business case when it is considered in September 2019. This would be in addition to the existing establishment of six posts. However funding release is dependent on an ongoing review of the real world experience from the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres. This will ensure that a fully informed recommendation can be brought back to the Joint Committee well in advance of the move to a single site and that the new centre opens with the right number of consultant thoracic surgeons to ensure a safe and sustainable service.

Members:

- Noted the work that had been undertaken by the medical directors of CVUHB and SBUHB as well as the WHSS Team to develop workforce proposals for the consultant thoracic surgical service;
- Supported the appointment of an additional consultant thoracic surgeon, funded through the MTC work stream, to support implementation of the MTC from April 2020 initially on an interim basis, pending clarity of the level of need;
- Supported the allocation of funding for an additional two consultant surgeons (in addition to the existing establishment of six) from the MTC business case when the new single centre at Morriston Hospital is opened – the funding release for which will be dependent on consideration by the Joint Committee of the real world experience of the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres;
- Noted the information set out in the May Joint Committee paper which provided assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises; and
- Supported the recommendations going forward to the six affected health boards and agreed that they be asked to confirm their

unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea.

Major Trauma Network for South Wales (MTN)
The Joint Committee received an oral update on the latest developments regarding the MTN. This included an overview of the recently completed Gateway Review and its eleven recommendations, and assurance that the WHSS Team was still working to the original timeline (April 2020 'go live'), which included Management Group scrutiny and a presentation to Joint Committee for consideration in September 2019. It was noted that the Trauma Network Board was addressing the recommendations from the Gateway Review and the SRO would need to take a view on whether the original timeline could still be achieved in light of the outcome of this work; it was anticipated that this view would be taken in around three weeks' time.

Cystic Fibrosis 2019-20 ICP Strategic Priority
The Joint Committee received a paper that (1) provided an update on the implementation of Phase 1 investment for the All Wales Adult Cystic Fibrosis Centre; and (2) requested approval for the release of funding for the Adult Cystic Fibrosis Service 2019-20.

Members:
- Noted the information presented in the report;
- Approved the release of funding from 2019-20 ICP slippage to recruit to the remaining posts in Phase 2 Part A to support the current cohort and the continued development of the satellite clinics; and
- Supported taking forward the case for a recurrent Home IV service and satellite clinic staff to the 2020-21 ICP, in the event that Welsh Government declined separate 'Healthier Wales' funding.

Other reports
The Joint Committee received the Integrated Performance Report and the Financial Performance Report. The Joint Committee also noted the update reports from the following joint sub committees and advisory groups:
- Management Group;
- All Wales (WHSSC) Individual Patient Funding Request Panel;
- Integrated Governance Committee; and
- Quality & Patient Safety Committee.

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 23 JULY 2019 AT THE EDUCATION CENTRE LLANDOUGH HOSPITAL CARDIFF

PRESENT

Members	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Gary Doherty	Chief Executive, Betsi Cadwaladr UHB
Len Richards	Chief Executive, Cardiff & Vale UHB
Sian Harrop-Griffiths	Swansea Bay UHB
Karen Miles	Hywel Dda UHB (Via VC)
Carol Shillabeer	Chief Executive, Powys THB
Glyn Jones	Director of Finance/Deputy CEO, Aneurin Bevan UHB
In Attendance:	
Jason Killens	Chief Executive Welsh Ambulance Services NHS Trust
Anthony Hayward	Corporate Director, National Collaborative Commissioning Unit
James Rodaway	Head of Commissioning, EASC
Jamie Kaijaks	Finance Graduate Trainee, Swansea Bay UHB
Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Shane Mills	Director Quality and Patient Experience, National Collaborative Commissioning Unit
Stuart Davies	Director of Finance, WHSSC and EASC Joint Committees
Chris Polden	Managing Director ORH (for one item)
Gwenan Roberts	Head of Corporate Services, Cwm Taf Morgannwg UHB (Secretariat)

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 19/48	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. The Chair advised that the main business would be followed by a development session involving a presentation from James Rodaway on Risk Management.	

EASC 19/49	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Judith Paget, Len Richards, Steve Moore, Tracy Myhill, Sharon Hopkins, Julian Baker, Steve Webster and Robert Williams.	
EASC 19/50	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	
EASC 19/51	**MINUTES OF THE MEETING HELD ON 14 MAY 2019** The minutes were **confirmed** as an accurate record of the meeting held on 14 May 2019.	
EASC 19/52	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** progress as follows: **EASC17/44 & 17/73 & 19/21** **Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway review** Members **NOTED** that a further update would be provided at the next meeting. **EASC 18/06 & 18/65 & 19/21** **Integrated Performance Dashboard** Members **NOTED** that work was continuing on the development of the Dashboard which was linking data across the system. A further update would be provided at the next meeting. **EASC 18/107 & 19/21** **Expansion of EMRTS (Emergency Medical Retrieval and Transfer Service)** Members **NOTED** that an update would be provided in the Chief Ambulance Service Commissioner's report. **EASC 19/08 & 19/21** **Mental Health Staff Clinical Desk** Members **NOTED** that work was continuing with the Welsh Government in terms of developing a national approach. A further update would be provided to the Committee in November (**Added to the Forward Look**).	CASC CASC CASC Director of Quality and Experience

	EASC 19/08 & EASC 19/21 & EASC 19/23 **Emergency Medical Retrieval and Transfer Service (EMRTS)** Members **NOTED** that information was awaited in relation to the Gateway Review, a meeting was scheduled to take place in early August and an update would be provided at the November meeting. **Ambulance Quality Indicators (AQI)** Members **NOTED** the work to link the AQIs with the performance dashboard. Members **RESOLVED** to: • **NOTE** the action log.	CASC
EASC 19/53	**MATTERS ARISING** There was none.	CASC
EASC 19/54	**CHAIR'S REPORT** The Chairs report was **received** by Members. In presenting the report Chris Turner highlighted his key meetings which had taken place since the last meeting of the Committee. Members **NOTED** that during the appraisal with the Minister, the emphasis had been on driving change across the system and ensuring that the EAS Committee was operating corporately. Other issues discussed included Amber implementation and the Red performance. Members also **NOTED** that a request has been received from the Deputy Chief Executive at NHS Wales for a discussion to take place at EASC on the regional escalation processes. Members **RESOLVED** to: • **NOTE** the Chair's Report.	Chair
EASC 19/55	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioners (CASC) report was **received** by the Committee. • **Update on Emergency Medical Retrieval and Transfer Service (EMRTS) Gateway Review** Members **NOTED** that the CASC was due to meet with colleagues from Swansea University at the beginning of August to receive the first draft of the Gateway Review.	CASC

	The document would be shared with Committee Members when received and discussion would take place at the next available Management Group meeting and a summary of the discussions would be provided to the Committee.	CASC
	• **Update on Management Group** Members **NOTED** that the first meeting of the Management Group took place on 12 July was well attended. The meeting concentrated on the use of the 1% 'A Healthier Wales' allocation which allowed time to discuss in detail. The CASC explained that a good and positive start had been made at the first Management Group meeting. Sian Harrop-Griffiths asked about the Terms of Reference and membership for the Management Group; Stephen Harrhy explained that it was similar to the approach to the Welsh Health Specialised Services Committee (WHSSC) management group and the terms of reference would be shared with the Committee at the next meeting. The aim was to ensure that the right representatives attend management group. Stephen Harrhy agreed to ensure that the meetings were scheduled and planned in advance to ensure the right staff were available to represent the health boards (**Added to the Action Log**).	CASC
	• **RED performance** Members **NOTED** that the performance in June was over 65% and was an improvement on the previous 2 months. Red performance across Wales was in excess of 70% and although was 61.9% in Hywel Dda this was slowly increasing. Members **NOTED** that the Powys and Hywel Dda areas were regularly reporting lower than 65%.	
	• **Mental Health** Members **NOTED** that South Wales Police requested continuation of the funding for Mental Health clinicians in the control room. Shane Mills explained that discussions were taking place with the Police Federation lead which included Carol Shillabeer as the lead Chief Executive. Although the report is yet to be published, the South Wales Police have shared that early findings from a review are that there has been a reduction in persons with 'MH issues' requiring a Police response. Members **NOTED** that further discussion and analysis would need to take place in order that Members understood how this all fits together with 111 and the WAST clinical desk.	

	Members **NOTED** that the Mental Health Access review was due to report in the new year which would give a better understanding of demand from people with mental health distress for urgent care services. Carol Shillabeer explained that the term 'mental health' was being used in its widest form. Jason Killens also supported that there was a need for a better service but suggested a 'Once for Wales' approach was needed. Shane Mills and Carol Shillabeer agreed to develop further information for Committee Members to capture all of the work to date (**Added to the Action Log**). Members **RESOLVED** to: • **NOTE** the update and the actions agreed.	Carol Shillabeer /Shane Mills
EASC 19/56	**DEMAND AND CAPACITY REVIEW** Jason Killens provided an overview of the work on the Demand and Capacity Review at the Welsh Ambulance Services NHS Trust (WAST) to date and invited Chris Polden from ORH to give a short presentation. Members **NOTED** the intention to provide a final report to the Committee at the November meeting. Chris Polden gave an overview of the work of the ORH Management Consultancy set up in 1986 who were working globally with emergency services. Members **NOTED** the work across the UK with ambulance services who were identifying similar themes to those identified by WAST. Other issues such as the ageing population, long waits for patients in Amber category and seasonal variation were also considered as part of the review. The Review aims were clarified as: • Forecast incident demand over the next 5 years • Agree the required level of quality and time performance for each type of patient • Model the resources needed to achieve these levels of time and quality assuming current operations • Identify WAST efficiencies and the impact these will have on the staffing required • Identify unscheduled care system efficiencies and the impact these will have on the staffing required • Model the impact of planned service changes and their impact on patient flows • Model the resources required for call handling clinical staff and dispatch in the clinical contact centres.	Jason Killens

	The Review would ensure comprehensive data collection to identify issues across Wales and would also model the incident life cycle. Members discussed the impact of the work and the potential to widen across the pathway. Chris Polden confirmed that work was underway to also benchmark both within and outside of Wales and the UK. Members **NOTED** that a steering group would be developed to oversee the work. It was felt that clinical service plan leads could provide the right links to get the best information for the Review and although the review would not include aspirational ideas although they would be captured as issues. Directors of Planning had also been involved in the work which included the changes planned for the major trauma service although the steering group would clarify what could be included in the work. Members discussed the information shared and suggested that the work on population segmentation may also be helpful for the Review team. Members **NOTED** that schemes which have been evaluated were included, such as the clinical desk and advanced paramedic practitioners. Members felt that the role of the steering group would be important to test the model and analyse the choices to be made about the future provision. Steve Moore would provide the leadership for the group and the reports and minutes of meetings would be shared with Members (**Added to Action Log**). The Chair thanked Chris Polden for the helpful presentation on the overview of the work and it was agreed to receive further information on the work, if available, at the next meeting (**Added to the Action Log).** Members **RESOLVED** to • **NOTE** the presentation.	Steve Moore Steve Moore
EASC 19/57	**PROVIDER ISSUES BY EXCEPTION** The Welsh Ambulance Services NHS Trust Provider Update was received by the Committee. In presenting the report, Jason Killens highlighted some key issues: • **Serious Adverse Incidents (SAIs)** Members **NOTED** the increasing trends for SAIs in the Aneurin Bevan and Swansea Bay University Health Board areas. The Directors of Nursing were discussing the Joint Investigation Framework in July to identify the best practice on investigating incidents going forward.	Jason Killens

	• **RED Performance** Members **NOTED** that in the main Hywel Dda and Powys health board areas were dipping below the 65% target; recovery plans were in place and further actions had been added although it was recognised that there was more work to do to improve response times. Members **NOTED** the current improvement focus areas had been identified and were being actioned including: • Continuing to develop and utilise information on demand, capacity and efficiency to inform action planning. This includes the use of sophisticated performance analysis and modelling software (Qliksense and Optima Predict) to support Operations • Overproducing on RRV unit hours at times when red performance is poor (twilight shifts) • Increasing the number of Community First Responders • Working with Trade Union Partners to understand post production hours lost and to identify actions to reduce them • Continuing work to reduce abstraction rates, with sickness levels now on a downward trend • Reviewing deployment points, moving them where possible to reduce response times. The expansion of the Advanced Paramedic Practitioner (APP) was discussed and Members **NOTED** the plans for the condensed APP MSc programme. Members **NOTED** that WAST had also been working to reduce hours lost from handover to clear. As part of this work to cleanse and refine the data, a dual pin system for handover was being rolled out in each Emergency Department and the work would be completed by the end of August. Jason Killens explained that the service changes and the Major Trauma Network work would have an impact and WAST felt that a co-ordinating desk would be required for 16 hours. Members **NOTED** that the WAST bid covered training and how much in the current allocation or getting the ambulance teams for the major trauma centre, call handling requirements would also need to be considered. Members **RESOLVED** to • **NOTE** the report.	

EASC 19/58	**UPDATE ON AMBER REVIEW** Members **received** the report on the Amber Review which was presented by Shane Mills. Members **NOTED** that additional work was required and an action plan had been developed; a group was in place to oversee the work working with the team at WAST to ensure progress was being made. The aim was to have a comprehensive action plan which included all health board to reduce the numbers of ambulances waiting. Members **NOTED** that patients are being informed when the service is at escalation and a script has been developed for the staff. Shane Mills explained that the aim was to link the data across the whole system and to use the NHS Wales Informatics Service (NWIS) data set. The work to complete the Amber Review should be completed by the end of the year and Members may need to consider the commissioning intentions for the service. A further update would be provided at the next meeting (Added to the Action Log). Members **RESOLVED** to: • **NOTE** the report	Shane Mills Shane Mills
EASC 19/59	**INTEGRATED MEDIUM TERM PLAN (IMTP) UPDATE** Members received the IMTP Update Report which was presented by Anthony Hayward. Members **NOTED** the clarity of information relating to the accountability conditions as part of the reporting proforma for 2019-2020. The EASC IMTP Quarter 4 for 2018/19 and the Quarter 1 for 2019/20 progress was discussed and **NOTED**. Areas identified which had slipped from the target timescale included: • Quality assurance and improvement findings reporting for EMRTS • Quality assurance and improvement findings reporting for NEPT • EMS commissioning Intentions • NEPTS commissioning Intentions Members were assured that plans were in place to recover the position. Members **RESOLVED** to: • **NOTE** the report.	Anthony Hayward

EASC 19/60	**REGIONAL ESCALATION** Members **AGREED** to discuss further in the development session.	Chair
EASC 19/61	**FINANCE REPORT** Members r**eceived** the Finance Report which was presented by Stuart Davies. Members **NOTED** that the identified risks were being managed. Members **RESOLVED** to: • **NOTE** the report.	Stuart Davies
EASC 19/62	**1% 'A HEALTHIER WALES' ALLOCATION** Members received the report on the allocation of the 1% 'A Healthier Wales' funding. The Chief Ambulance Services Commissioner gave a short overview of the work to date and James Rodaway presented the report which highlighted the important principles being adopted. Members **NOTED** that a long list would be developed for further discussion and no information would be sifted before the meeting of the Management Group to finalise the allocation, this would take place on 26 July 2019. Following discussion, Members requested that the Management Group undertake an evaluation of all the Schemes which should be shared with the Committee (**Added to Action Log**). Members **NOTED** that all of the information was being captured to ensure the principles were upheld. The evaluation panel would take place on Friday and the recommendations would be sent to Members. Stephen Harrhy explained that if there were any specific issues to be resolved a special meeting of the Committee would be convened. Following discussion Members **RESOLVED** to: • **NOTE** the report • **APPROVE** that the Management Board evaluate the bids and report back to the Committee.	James Rodaway CASC
EASC 19/63	**EASC GOVERNANCE UPDATE** The governance update report was **received** by the Committee and presented by Gwenan Roberts.	Gwenan Roberts

	Members **NOTED** that the Annual Governance Statement had been finalised and received at the Audit Committee on 30 May 2019. Members **RECEIVED** and **NOTED** the Internal Audit Report on Handover of Care at Emergency Departments Follow-up Health Board Related Recommendations which was received by the Host Body's Audit Committee on 9 July 2019. Members **NOTED** that the report received a 'Reasonable' assurance rating and four medium priority recommendations had been made. The actions required would be factored into the forward work plan for the Committee with the majority to be delivered by the next meeting. Members **RESOLVED** to: • **ENDORSE** the Annual Governance Statement • **NOTE** the report.	
EASC 19/64	**CLINICAL RISK REVIEW – CLOSURE REPORT** The closure report for the Clinical Risk Review was **received**. In presenting the report, Ross Whitehead confirmed that 24 actions had been identified and most had now been completed or now informed the work of the Management Group. Member **NOTED** the importance of the clinical records within the Ambulance service; additional clinical audits would also be carried out and access to policies and guidelines would take place. Members **RESOLVED** to: • **NOTE** the report • **ENDORSE** the closure report.	Ross Whitehead
EASC 19/65	**FORWARD PLAN OF BUSINESS** Members **received** the forward plan of business. Members **RESOLVED** to: • **NOTE** the Forward Plan • **AGREE** that the Chair and the Chief Ambulance Services Commissioner review the Forward Plan for future	*ALL*

ANY OTHER BUSINESS		
EASC 19/66	There was none.	
DATE AND TIME OF NEXT MEETING		
EASC 19/67	A meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 10 September 2019 at the National Collaborative Commissioning Unit, Treforest Industrial Estate.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date:……

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	18 July 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

The full agenda and accompanying reports can be accessed on our website.

1. Health Courier Services (HCS) Deep Dive

Tony Chatfield, Head of Operations, provided an introduction to the services that HCS provide. Many of these are viewed as best practice across the UK and has earned HCS a place on the Department for Transport Emergency Driving Group. Examples were provided of the developments and initiatives being undertaken with various Health Boards and customer surveys highlighted a high level of satisfaction with the service provided. The presentation was well received by the Committee.

2. Laundry Business Case

A paper was tabled by the NWSSP Director of Workforce and OD on the proposals for consulting staff directly affected by the preferred option to reduce the number of laundries from five to three. The paper set out the basic principles on which NHS Wales Shared Services Partnership propose to engage with and manage the relationship with HBs and their staff affected by the proposals. There are three core principles as follows, supported by detailed actions:

- Effective staff communication;
- Collaborating throughout; and
- Caring for and looking after our staff during re-organisational change.

It was agreed that this process should commence with staff roadshows hosted by the relevant HBs, with local WOD, Staff side & Laundry representatives in attendance; facilitated by NWSSP WOD & Project staff.
The Committee fully endorsed the principles.

A separate paper was presented by the Director of Specialist Estates Services, on the actions required following the initial submission of the OBC to Welsh

Government. In order to ensure that those areas identified in the feedback were addressed in a timely manner the Committee agreed to the establishment of a new Programme Board, which would include representation from across NHS Wales. SSPC members were asked to consider identifying appropriate individuals from within their own organisations to participate in taking the project forward.

3. Managing Director's Report

The Managing Director updated the Committee on:

Medical Examiner Service - Andrew Evans, Deputy Director of Primary Care at Powys THB has now started in post as Project Manager, and Dr Jason Shannon has been appointed as the Lead Medical Examiner for Wales. The Lead Medical Examiner Officer role is current being advertised and the recruitment process will commence shortly for the Medical Examiners and Medical Examiner Officers that will be based out at Health Board sites. To progress this, NWSSP will need to work with Health Boards to secure appropriate office space, preferably close to Bereavement Services at main hospital sites.

Brexit/IP5 - Brexit preparations continue although some further work is still required on identifying current key non-stock requirements in the event of a no-deal Brexit. This will primarily involve working with the NHS Collaborative, various clinical networks and Medical in terms of finalising the lists of required items. Further testing on links to the national systems are currently being arranged to assess readiness should there be a no-deal Brexit. To ensure additional resilience the current smaller store in Cwmbran will also relocate to IP5, which will enable a seamless rotation of Brexit stock with normal operations to avoid any issues of out of date stock. Further work continues on developing options for the remaining space in IP5 with the intention of holding mini-workshops with relevant stakeholders over the next few weeks.

NHAIS Replacement – Following discussions with the Chief Executive of the Business Services Organisation in Northern Ireland, NWSSP have written to the Permanent Secretary covering the NI Health Department for permission to further explore the opportunities of using their GP Payments System to pay Primary Care Contractors in Wales. They are due to visit in late August to progress this issue.

Primary Care Sustainability - Working with Welsh Government, NWSSP Employment Services has established a number of key systems and processes advancing delivery of 'A Healthier Wales' and the Strategic Programme for Primary Care. These developments include the introduction of a single point website to advertise multi-disciplinary vacancies, Wales National Workforce and Reporting System capturing for the first time primary care workforce information and the All Wales Locum Register for Primary Care providing confirmation of Locum GPs registered on the Wales Scheme for General Medical Practice Indemnity. Maximising opportunities, these changes will remove current advertising costs for GP Practices, visibility of GP vacancies enabling GP Trainee Streamlining, improved quality and understanding of primary care multi-disciplinary workforce demographics to achieve greater workforce and cross-

cluster planning.

4. Items for Approval

The Committee reviewed and approved the following contract extensions for national support systems:

- Selenity (e-expenses)
- Trac (recruitment)
- Finance Procurement Enterprise Systems Contract (Oracle

In addition, the Committee discussed the recommendations of the Concerns Management System report. It was noted that the proposed new system had improved functionality over the current system however, it was more expensive. The Committee approved the awarding of the contract for the new system but proposed that the mechanism to recharge the costs should be reviewed and agreed by the Deputy Directors of Finance Group.

The Committee also noted and approved the progress and implementation of three primary care initiatives relating to:

- GP Wales Website;
- Wales National Workforce Reporting System; and
- All-Wales Locum Register.

The Committee also noted the Velindre Board agreement for NWSSP to proceed by the publication of a Voluntary Ex-ante Notice (VEAT) for the GP Wales website.

5. Items for Noting

- **Construction Industry Update -** The Director of Specialist Estates Services provided an update on the current position within the construction industry. The industry has not fully recovered since the financial crash of 2008, and while there are challenges in Wales, the use of framework arrangements has protected NHS Wales from some of the significant issues experienced by NHS organisations in England.
- **PMO Highlight Report -** The Committee noted the updates on projects and that there were no major concerns with any at the current time.
- **Finance & Workforce Report -** The Committee noted that NWSSP is currently reporting a small underspend but that a number of financial challenges remain. KPIs were generally noted as also being on track.
- **IMTP Quarterly Report** – The Committee reviewed and noted the report.
- **Blaenavon Data Centre Outage** – The Committee were provided with a summary of the reasons for, and the implication of, the recent outage. A report from NWIS on root cause analysis and required next steps was also reviewed.
- **Corporate Risk Register** – The Committee noted that two red risks remain and that updates on both had been provided as part of the MD's report. One risk relating to the Bridgend boundary change has now been

removed from the Register.

- **Gifts & Hospitality Report 2018/19** – The Committee noted the declarations and queried whether all of the entries required disclosure.
- **Complaints Annual Report 2018/19** – The Committee noted the increase in the number of complaints from the previous year, particularly relating to payroll and salary sacrifice, but that action was being taken to learn from these issues and address the root cause.
- **Audit Committee Annual Report 2018/19 and Terms of Reference** – The Committee noted the positive tone of the Annual Report and the minor changes to the Terms of Reference which have already been signed off at Audit Committee. The Committee noted that the report gave assurance that NWSSP were operating robust systems on behalf of NHS Wales. It was agreed that an Audit Committee Assurance Report would be developed and produced for Health Boards, Trusts and HEIW. It was agreed that the Director of Internal Audit services would also discuss with Audit Committee Chairs.
- **Audit Committee Highlight Report** – the report relating to the meeting held on 9 July was reviewed and the Committee noted that the reports taken to the meeting were positive in their assessment of controls and systems within NWSSP.

6. Items for Information

The following papers were provided for information:

- Months 2 & 3 Monitoring Return;
- Wales Audit Office Management Letter 2018/19;
- Wales Audit Office Report into Nationally Hosted Systems 2018/19;
- Counter Fraud Lessons Learned Report; and
- NHS Wales Fighting Fraud Strategy.

Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.	
Matters referred to other Committees	
N/A	
Date of next meeting	18 September 2019

NHS Wales Collaborative Leadership Forum

Minutes of Meeting held on 13 May 2019

Author: Mark Dickinson	**Version:** 1 (Approved)

Members present	Ann Lloyd (Chair), Chair, Aneurin Bevan UHB (AL) Maria Battle, Chair, Cardiff & Vale UHB (MB) Tracey Cooper, Chief Executive, Public Health Wales (TC) Andrew Davies, Chair, Swansea Bay UHB (AD) Vivienne Harpwood, Chair, Powys tHB (VH) Alex Howells, Chief Executive, Health Education & Improvement Wales (AH) Chris Jones, Chair, Health Education and Improvement Wales (CJ) Brendan Lloyd, Medical Director, Welsh Ambulance Service NHS Trust (BL) (for Jason Killens) Marcus Longley, Chair, Cwm Taf UHB (ML) Donna Mead, Chair, Velindre NHS Trust (DM) Tracy Myhill, Chief Executive, Swansea Bay UHB (TM) Judith Paget, Chief Executive, Aneurin Bevan UHB (JP) Mark Polin, Chair, Betsi Cadwaladr UHB (MP) Judith Hardisty, Vice Chair, Hywel Dda UHB (JH) (for Bernadine Rees) Carol Shillabeer, Chief Executive, Powys tHB (CS)
In attendance	Mark Dickinson, NHS Wales Health Collaborative (MD) Rosemary Fletcher, Director, NHS Wales Health Collaborative (RF)
Apologies	Gary Doherty, Chief Executive, Betsi Cadwaladr UHB Steve Ham, Chief Executive, Velindre NSH Trust Jason Killens, Chief Executive, Welsh Ambulance Service NHS Trust Steve Moore, Chief Executive, Hywel Dda UHB

	Bernadine Rees, Chair, Hywel Dda UHB Len Richards, Chief Executive, Cardiff & Vale UHB Allison Williams, Chief Executive, Cwm Taf Morgannwg UHB Jan Williams, Chair, Public Health Wales Martin Woodford, Chair, Welsh Ambulance Service NHS Trust

Welcome and introduction	**Action**
AL welcomed colleagues to the meeting and noted apologies for absence.	

Minutes of previous meeting	**Action**
The minutes of the meeting held on 6 December 2018 were **approved** as a correct record. The minutes will be forwarded to board secretaries for noting at health board and trust board meetings.	**MD**

Action log and matters arising	**Action**
The action log was reviewed. It was noted that the majority of actions had been closed as completed. Those actions that remain open all relate to the development of an NHS Wales National Executive function. It was noted that RF and MD are meeting Jo Jordan and Samia Saeed-Edmunds in Welsh Government on 14 May to discuss this. It is anticipated that this will be primarily focused on WG gathering information about the Collaborative. It was noted that detail was awaited in respect of progress with plans for the NHS Executive. *(DM joined the meeting at this point)*	

Year End Report against 2018/19 Collaborative Work Plan	**Action**
RF introduced the report against last year's work plan, noting that it had already been received by the Collaborative Executive Group. Some outstanding actions have been carried forward into the plan for 2019/20. Concerns were noted around delays to the critical care clinical information system and MD provided an update, reporting that it was hoped that procurement documentation would be signed off during May.	

The heightened emphasis on maternity services was noted in the context of the need to establish the new Wales Maternity and Neonatal Network. It was noted that the planned appointment of a National Mental Health Director had been delayed pending progress with the NHS Executive. CS reported that it was approximately a year since the previous director had retired, but was optimistic that progress could soon be made. *(AD joined the meeting at this point)* AL queried why the Eating Disorders dashboard was being delayed until 2022. CS responded that this was due to the timing of the implementation of the WCCIS system, but that some aspects of the dashboard would be operational before full WCCIS roll out. AL thanked RF for the report and noted that, given the context, the Collaborative team has done very well to get through so much work and to complete many important actions.	
Collaborative Annual Report 2018/19	**Action**
RF introduced the Annual Report, noting that this is the first time a narrative annual report has been produced by the Collaborative team. The report is intended to respond to the need for more information for key stakeholders and also the desire of team members to promote the work done. The target audience is primarily stakeholders in NHS Wales, Welsh Government and CHCs and the content has been shaped to reflect this. The report covers both core business for NHS Wales and additional work in support of WG. Content had been provided by staff in individual teams and programmes. RF drew attention to the new areas of work covered in the report, including support to the Women's Health Implementation Group and to the nationally directed programme for endoscopy. RF also noted Collaborative-wide activities, including peer review. RF referred to the fact that the Collaborative team has grown in size and emphasised the efforts being made to engage with staff and to act on their feedback, including via a newly established staff forum.	

(TC joined the meeting at this point) AL noted that the report was very clear and helpful. JP referred to the section on the lymphoedema network, suggesting that, as staff are involved in direct care delivery, there was a need to review the governance and respective roles and responsibilities of the Collaborative and health boards. **RF undertook to review the governance arrangements for the lymphoedema network.**	**RF**
AD suggested that lessons need to be learned about how work is led and about lines of accountability, particularly for work undertaken for WG. DM referred to the reference in the report to Save a Life Cymru, noting that WG had not agreed for CPR training to go into schools, although this was the case in other parts of the UK. BL added that it had been suggested that CPR could have been added to the content of the Welsh Baccalaureate qualification. AD noted the potential role of further education. ML noted that approximately half of resource of the Collaborative is invested in the Wales Cancer Network and queried the rationale for this. RF responded that this is purely a legacy issue reflecting the history of investment decisions over many years. RF added that the Collaborative is increasingly taking opportunities to work across networks and programmes, citing work to develop a Collaborative-wide analytical function as an example. AL stated that there is a need to move towards a more balanced deployment of resources. TC noted the context for the year ahead, anticipating plans for the NHS Executive. There is a need to ensure that resources are aligned behind strategic priorities, including those specified in whatever national delivery plans exist post 2020. **RF undertook to consider the issues raised in the further development of the report.**	**RF**
AL thanked RF and the Collaborative team for producing a helpful and informative report.	

Collaborative Work Plan 2019/20	**Action**
RF introduced the high level work plan, noting that the individual sections will be the subject of 'deep dives' at forthcoming meetings of the Collaborative Executive Group, with the first one being on the work of the Wales Cardiac Network in May. AL asked about the work of the new Maternity and Neonatal Network and how its work will interface with the recently announced action by a number of agencies. RF responded that discussions are ongoing to clarify this. AL queried whether the key deliverables are clearly enough articulated and are both measurable and achievable. TC suggested that the 'big ticket' items should be more clearly identified in the introduction. CJ suggested the need for greater clarity as to where is assurance held and the mechanisms for assurance. MP raised a specific issue of accountability in relation to the LINC programme, which had recently been subject to formal reporting to boards. RF responded to these issues, noting that the Collaborative team had produced a paper last year to clarify the governance and accountability of each of networks back through network boards to the Collaborative Executive Group and the Collaborative Leadership Forum (and, in some contexts to WG). RF added that this was the first she had heard about the concerns in relation to LINC and noted that update reports on LINC had been brought to the last three meetings of the Forum. JP added that the last update had included specific consideration of the process for taking the LINC business case to boards. CJ reported that he still has outstanding concerns about the governance arrangements for work commissioned directly from the Collaborative team by WG. AL responded that these concerns have previously been raised with WG, including directly with Andrew Goodall and it is known that these problems are recognised. AD stressed the need for the work of the Perinatal Mental Health Network (and other parts of the Collaborative) to align with the wider work on health improvement and the early years being led by Public Health Wales. DM referred to the work of the Wales Cancer Network on the single cancer pathway and also the wider work on	

diagnostics, stressing the importance of analytical work to gain a greater understanding of the growth in demand for cancer diagnosis and treatment services. TC noted that, in their respective lead roles for cancer, pathology and imaging, she, Steve Moore and Len Richards are working increasingly closely on these issues. It is planned to submit a three year plan for cancer diagnostics to WG for investment. AH noted that the wider context is shifting with the development of a national NHS Wales clinical plan. AL responded that chairs are not currently sighted on this work. CJ noted the references in the plan to peer review, stressing the need for a more holistic approach. MD reported that peer review was being introduced across the Collaborative's networks, in line with the NHS Wales Peer Review Framework (previously agreed by the Forum) and that learning and experience was being shared across networks. **It was agreed that an updated three year peer review programme will be brought to the next meeting in September**. **RF undertook to consider the issues raised in the implementation of the work plan.**	**MD/RF** **RF**
Collaborative update	**Action**
RF introduced a written update report, containing briefings on a number of areas of work and other issues. *Major trauma network* RF referred to the report and provided additional information. A very productive workshop had been held, which had benefited from patient input. The aspiration remains for the network to be operational from April 2020, but this remains challenging. Engagement is taking place in Hywel Dda in relation to interim trauma unit designation, which may raise issues for other health boards. It was noted that consideration of workforce requirements for thoracics will be taken forward through the WHSSC Joint Committee. TM emphasised both the importance and benefits of having patients 'in the room' participating in the planning and development of services. The precedent set through the workshop needs to be maintained through the ongoing work of the network board. TM also noted the new appointment in	

Cardiff and Vale UHB to the role of Programme Director for the Major Trauma Centre.

CJ emphasised the need for clarity about the OD requirements for the new network, and networks more generally, because they traverse normal boundaries. Participants need support to transition into the required new ways of working.

Single cancer pathway (SCP)
RF introduced the report, referring to £3m WG investment and the fact that the Wales Cancer Network was running a process that had sought, and would be evaluating, applications from health boards and trusts. RF noted the increasing alignment across the SCP work, diagnostics networks and the new endoscopy programme, each of which has associated funding streams.

The processes for allocating the various funding streams were discussed. It was noted that £1m would be deployed under the auspices of the Endoscopy Programme Board, but there was not yet clarity over how the £1.4m for diagnostics and healthcare sciences would be allocated. It was noted that multi-organisation bids had been encouraged in the SCP process and that these should be treated positively, without detriment to Betsi Cadwaladr as, effectively, a 'region' in its own right.

JH expressed concern that there were too many individual funding streams, being allocated separately. This was noted as a recurring theme.

Major conditions implementation groups
The transfer to the Collaborative of responsibility for supporting major conditions implementation groups, together with the TUPE transfer of relevant staff was noted.

AL noted that funding directed via such groups was time limited, but had, in many cases been allocated to ongoing services. Evaluation of the effectiveness of such investment is variable. AL had written to the Deputy Chief Medical Officer on this issue in January and had received a holding response.

RF reported that the Collaborative has worked on mapping the spend of the £1m allocations and will be working with

implementation groups to develop appropriate exit strategies for when the funding ends or is altered. *Wales Maternity and Neonatal Network* The content of the report was noted, as was the need to be clear about purpose of network. The need for close working between the new network and the Perinatal Mental Health Network was stressed. *National endoscopy programme* The content of the report was noted, as was the challenging timescale. *LINC* It was noted that, notwithstanding the issues referred to above, the outline business case has now been approved by health boards and trusts and that the WG scrutiny process had recommended approval. A gateway review has also been undertaken. A substantive paper is to be reported to the May meeting of the Collaborative Executive Group. *Accommodation* The content of the report was noted. *Hosting agreement* The recently agreed extension to the hosting agreement, under which Public Health Wales hosts the Collaborative team on behalf of NHS Wales was noted.	**RF/MD**
Other Business	**Action**
It was noted that it was AD's last meeting of the Collaborative Leadership Forum. AL thanked AD for his contribution, noting specifically his wisdom. CJ, as the previous chair of the Forum, added his thanks and noted that he expected that AD would continue to find ways of collaborating. CJ added that AD demonstrated the value of public service friendship and support and wished him well for the future.	
Date of next meeting	
Post meeting note: the next meeting will be held at 9am on 17 September 2019 at the NHS Wales Confederation, Phoenix House, Cathedral Road, Cardiff.	