CTMUHB Health Board Meeting

Thu 27 July 2023, 09:00 - 12:00

Yr Hyb, Unit 2 Gwaun Elai, Ynysmaerdy, Pontyclun CF72 8UX (next to RGH)

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Jonathan Morgan, Chair

1.2. Apologies for Absence

Jonathan Morgan, Chair

1.3. Declarations of Interest

Jonathan Morgan, Chair

09:05 - 09:10
5 min

2. CONSENT AGENDA BUSINESS

Jonathan Morgan, Chair

The Chair will ask if there are any items from the Consent Agenda (Item 8) that Board Members wish to bring forward to the Main agenda for discussion.

09:10 - 09:25
15 min

3. SHARED LISTENING AND LEARNING STORY

"Improving Care, Creating Health, Inspiring People and Sustaining Our Future" *Jonathan Morgan, Chair*

For Discussion and Shared Learning

This Listening & Learning Story will relate to Implementation of Robotics Surgery

09:25 - 09:35
10 min

4. SETTING THE SCENE

4.1. Chairs Report

Jonathan Morgan, Chair

For Noting

4.1 Chairs Report UHB 27 July 2023.pdf (7 pages)

4.1.1. Action Log from the last meeting of the Board

Jonathan Morgan, Chair

For Noting

4.1.1 Action Log Health Board 27 July 2023.pdf (3 pages)

4.2. Chief Executive Report

Paul Mears, Chief Executive

For Noting

To include an update on CAMHS De-escalation

4.2 CEO Board Update Report UHB 27 July 2023.pdf (6 pages)

09:35 - 10:35
60 min

5. DELIVERING OUR PLAN

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

"Improving Care, Creating Health & Sustaining our Future"

For Discussion and Noting

Introductory Overview:
Linda Prosser, Executive Director of Strategy & Transformation

Operational Performance Delivery
Gethin Hughes, Chief Operating Officer

Quality Performance
Greg Dix, Executive Nurse Director / Deputy Chief Executive
Dom Hurford, Medical Director
Lauren Edwards, Executive Director of Therapies & Health Sciences

People
Hywel Daniel, Executive Director for People

5.1 CTM Board Integrated Performance Dashboard UHB 27 July 2023.pdf (27 pages)

5.2. Month 3 Financial Performance

"Improving Care, Creating Health & Sustaining our Future" *Sally May, Executive Director of Finance*

For Discussion and Noting

5.2 M3 Finance Report - FINAL UHB 27 July 2023.pdf (21 pages)

5.3. Annual Plan Update 2023-2026 - Quarter 1 Update

"Improving Care, Creating Health & Sustaining our Future" *Linda Prosser, Executive Director of Strategy & Transformation*

For Noting

5.3a IMTP 2023-26 Q1 update UHB 27 July 2023.pdf (8 pages)
5.3b Appendix 1 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Primary Care Q1 review.pdf (14 pages)
5.3c Appendix 2 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Pathways of care reporting Q1 review.pdf (8 pages)
5.3d Appendix 3 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Urgent Care - Q1 update.pdf (7 pages)
5.3e Appendix 4 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE - USC SDEC IMTP Q1 update.pdf (7 pages)
5.3f Appendix 5 PLANNING FRAMEWORK - MIN UEC Emergency Pressures Escalation Q1.pdf (8 pages)
5.3g Appendix 6 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Outpatients - Q1 update July 23.pdf (13 pages)
5.3h Appendix 7 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Planned Care - Q1 update.pdf (9 pages)
5.3i Appendix 8 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Cancer Q1 update June 23.pdf (8 pages)
5.3j Appendix 9 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE - Planned Care - Reg Diagnostic Q1 update.pdf (8 pages)
5.3k Appendix 10 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE 111#2 Q1 Submission.pdf (6 pages)
5.3l Appendix 11 PLANNING FRAMEWORK - MINISTERIAL TEMPLATE Mental Health Q1 Submission.pdf (9 pages)

10:35 - 11:00
25 min

6. GOVERNANCE, RISK & ASSURANCE

6.1. Escalation Status Update

"Improving Care, Sustaining our Future"

For Discussion and Noting - An update in relation to Escalation Status has been included in the Chief Executive Officers Report at agenda item 4.2

6.2. Board Assurance Framework Report (Principal/Strategic Risks)

"Improving Care" *Hywel Daniel, Executive Director for People*

For Approval

- 6.2a BAF Framework Cover Paper July 2023 - HB.pdf (3 pages)
- 6.2b Appendix 1 - Board Assurance Framwork Report - July 2023 - HB Final.pdf (48 pages)

6.3. Board Committee and Advisory Group Highlight Reports

"Improving Care" *Presented by Independent Member Committee Chairs*

For Discussion and Noting

(where there is escalation for Board)

6.3.1. Clinical Advisory Group Highlight Report

"Improving Care" *Sally Bolt, Associate Member*

Discussion

- 6.3.1 CAG Highlight Report UHB 27 July 2023.pdf (2 pages)

6.3.2. Digital & Data Committee Highlight Report

"Improving Care" *Ian Wells, Independent Member*

Discussion

- 6.3.2 DD Committee Highlight Report 12.6.23 UHB 27 July 2023.pdf (4 pages)

6.3.3. Quality & Safety Committee Highlight Report

"Improving Care" *Jayne Sadgrove, Vice Chair*

Discussion

- 6.3.3 Highlight Report QS Committee 24 May 2023 UHB 27 July 2023.pdf (5 pages)

6.3.4. Planning, Performance & Finance Committee Highlight Report

"Improving Care" *Mel Jehu, Independent Member*

Discussion

- 6.3.4 PPFC Highlight Report UHB 27 July 2023.pdf (3 pages)

6.3.5. Hosted Bodies Audit & Risk Committee Highlight Report

"Improving Care" *Patsy Roseblade, Independent Member*

Discussion

- 6.3.5 Highlight Report Hosted Bodies ARC Committee UHB 27 July 2023.pdf (3 pages)

6.4. ANNUAL REPORT AND ACCOUNTS 2022-2023

"Improving Care, Creating Health, Inspiring People, Sustaining our Future" *Sally May, Director of Finance/Cally Hamblyn, Assistant Director of Governance & Risk*

For Approval

6.4.1. CTMUHB Annual Report & Accounts 2022-23 - Unified Report

6.4.2. Hosted Organisations - Governance Statements and Accounts 2022-23

6.4.3. Audit of the Financial Statements (ISA 260) Report (including the Letter of Representation and Audit Opinion

Audit Wales

11:00 - 11:45
45 min

7. STRATEGIC PLANNING

7.1. CTM 2030 Our Health, Our Future

"Improving Care, Creating Health & Sustaining our Future" *Linda Prosser, Executive Director of Strategy & Performance*

For Noting

- 7.1 CTM 2030 Strategy Development UHB 27 July 2023.pdf (4 pages)

7.2. CTM 2030 Clinical Services Plan

"Improving Care, Creating Health & Sustaining our Future" *Linda Prosser, Executive Director of Strategy & Performance*

For Discussion

- 7.2a Clinical Services Plan Update UHB 27 July 2023.pdf (4 pages)
- 7.2b Appendix A Clinical Services Plan Update UHB 27 July 2023.pdf (12 pages)

7.3. Working in Partnership

"Creating Health, Inspiring People, Sustaining our Future, " *To be determined based on agenda items*

For Noting

e.g. Joint Committees, Statutory Partnerships Update, PSBs Wellbeing Plans, Community Engagement

- 7.3a Joint Committee Reports UHB 27 July 2023.pdf (2 pages)
- 7.3b Appendix 1 JC Briefing (Public) 16 May 2023 UHB 27 July 2023.pdf (7 pages)
- 7.3c Appendix 2 SSPC Assurance Report 18 May 2023 UHB 27 July 2023.pdf (4 pages)

11:45 - 11:50
5 min

8. CONSENT AGENDA

8.1. For Approval

8.1.1. Unconfirmed Minutes of the meetings held on 25 May 2023

Jonathan Morgan, Chair

For Approval

- 8.1.1b Unconfirmed Minutes of In Committee Board 25 May 2023 UHB 27 July 2023.pdf (2 pages)

8.1.2. Amendments to Standing Orders

Cally Hamblyn, Assistant Director of Governance & Risk

For Approval

- Local Partnerships Forum Terms of Reference
- Mental Health Act Monitoring Committee Terms of Reference

8.1.2a Amendment to Standing Orders - Annual Review and Schedules Cover Paper UHB 27 July 2023.pdf (3 pages)
8.1.2b Appendix 1 LPF Advisory Group ToR and Operating Arrangements Final Draft UHB 27 July 2023.pdf (10 pages)
8.1.2c Appendix 2 Schedule 3.4 MHAMC Terms of Reference Reviewed June 2023 UHB 27 July 2023.pdf (8 pages)

8.1.3. Board Committee Annual Reports

Presented by Independent Member Committee Chairs

- Quality & Safety Committee Annual Report
- Stakeholder Reference Group Annual Report
- Remuneration & Terms of Services Committee
- Mental Health Act Monitoring Committee

8.1.3a Board Committee Annual Reports UHB 27 July 2023.pdf (3 pages)
8.1.3b Appendix 1 Quality Safety Committee Annual Report 2022 to 2023 UHB 27 July 2023.pdf (10 pages)
8.1.3c Appendix 2 Remuneration Cmt Annual Report 22-23 UHB 27 July 2023.pdf (5 pages)
8.1.3d Appendix 3 SRG Annual Report UHB 27 July 2023.pdf (20 pages)
8.1.3e Appendix 4 Annual Report 2022-23 MHAM Committee 7 June 2023 UHB 27 July 2023.pdf (6 pages)
8.1.3f Appendix 5 Digital & Data Committee Annual Report 2022-2023 UHB 27 July 2023.pdf (7 pages)
8.1.3g Appendix 6 PPFC Annual Report 2022-23 UHB 27 July 2023.pdf (10 pages)

8.1.4. WHSSC Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service Engagement and Next Steps

Information *Linda Prosser, Director of Strategy & Transformation*

For Noting and Supporting

8.1.4a Cochlear and BCHI HBs v2 UHB 27 July 2023.pdf (13 pages)
8.1.4b Appendix 1 - Presentation of Data Against Questions Asked UHB 27 July 2023.pdf (34 pages)
8.1.4c Appendix 2 - Thematic Analysis UHB 27 July 2023.pdf (38 pages)
8.1.4d Appendix 3 - ASSAG Professional Community Response UHB 27 July 2023.pdf (11 pages)

8.2. For Noting

8.2.1. Board Cycle of Business

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

For Noting

8.2.1a Board Cycle of Business - Cover Paper UHB 27 July 2023.pdf (2 pages)
8.2.1b Appendix 1 Board Cycle of Business UHB 27 July 2023.pdf (4 pages)

8.2.2. Board Forward Work Programme

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

For Noting

8.2.2 Board Forward Work Programme UHB 27 July 2023.pdf (4 pages)

8.2.3. Board Committee and Advisory Group Highlight Reports

Presented by Independent Member Committee Chairs

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

8.2.3a Board Committee Highlight Reports UHB 27 July 2023.pdf (2 pages)
8.2.3b Appendix 1 Highlight Report MHAMC 7.6.23 UHB 27 July 2023.pdf (4 pages)
8.2.3c Appendix 2 SRG Chair's Highlight Report UHB 27 July 2023.pdf (3 pages)
8.2.3d Appendix 3 REMCOM Highlight Board Report JMHD 19.6.23 UHB 27 July 2023.pdf (2 pages)

8.2.3e Appendix 4 LPF Highlight Report LPF UHB 27 July 2023.pdf (4 pages)
8.2.3f Appendix 5 Highlight Report ARC Committee 21 June 2023 UHB 27 July 2023.pdf (4 pages)

8.2.4. Regional Ophthalmology Strategy

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

8.2.4a Ophthalmology Strategy and Cataract Business Case UB 27 July 2023.pdf (7 pages)
8.2.4b Appendix 1 FINAL Regional Cataracts Business Case 12 May 23 UHB 27 July 2023.pdf (152 pages)

8.2.5. JAG Accreditation Position Statement - To follow

Information *Gethin Hughes, Chief Operating Officer*

11:50 - 11:55
5 min

9. CLOSE OUT BUSINESS

9.1. Any Other Business

Jonathan Morgan, Chair

9.2. How did we do in this meeting?

Jonathan Morgan, Chair / Board Members

This provides an opportunity for Board Members to reflect on the meeting and in doing so may find it helpful to consider the following questions:

Is there anything we should do more or less of?

Have we managed our time well and allowed open and balanced discussion?

Have we considered our values and acted in a way that supports embedding our values across CTM?

Have we maintained a strategic focus?

Have we received sufficient assurance from a range of sources?

Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

11:55 - 12:00
5 min

10. PRIVATE / IN COMMITTEE SESSION

Jonathan Morgan, Chair

The following items will be discussed at the In Committee Session of the Board:

- Implementation of Robotics Surgery - Business Case (Commercially Sensitive)
- Laboratory Information Management Contract Extension (Commercially Sensitive)

12:00 - 12:00
0 min

11. DATE & TIME OF NEXT MEETING

Jonathan Morgan, Chair

For Noting

The next meeting of the Health Board is scheduled for the 28 September 2023 at 10:00am and will be held in person at Yr Hwb, Royal Glamorgan Hospital Site, Llantrisant.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
4.1

CTM BOARD

CHAIR'S REPORT

Date of meeting	27 July 2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Jonathan Morgan, Health Board Chair
Presented by	Jonathan Morgan, Health Board Chair
Approving Executive Sponsor	Jonathan Morgan, Health Board Chair

Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
N/A		

ACRONYMS	
AAC	Advisory Appointments Committee
AHP/HCS	Allied Health Professions/ Healthcare Scientists
CEO	Chief Executive Officer
CTMUHB	Cwm Taf Morgannwg University Health Board

HEIW	Health Education and Improvement Wales
HIW	Health Inspectorate Wales
EASC	Emergency Ambulance Services Committee
MS	Members of the Senedd
MP	Member of Parliament
RGH	Royal Glamorgan Hospital
Q&A	Questions & Answers
TI	Targeted Intervention
VAMT	Voluntary Action Merthyr Tydfil
YCR	Ysbyty Cwm Rhondda
WG	Welsh Government

1. SITUATION/BACKGROUND

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

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

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

2.1 Chair Update

In the past few weeks we have celebrated the 75th anniversary of the NHS. An institution that has impacted the lives of millions of people since its creation in 1948, and one that is very different now to what is was. Very few people in the 1940s could have imagined how our health service would develop, the range and complexity of illnesses and treatments, the advances in medical technologies, and the improvements in health and life expectancy.

A significant anniversary is also the right moment to reflect on the challenges and opportunities of sustaining and developing a healthcare system for the future. We face probably the greatest set of risks to the sustainability of our health service due to ill health, poor lifestyle choices, complex demand and service models largely unreformed. If the NHS is to survive it needs to reform, with the opportunity to reimagine the services we deliver, how and where we deliver them, and to grasp with urgency the need to work with others to support an improvement in peoples' health and wellbeing. Our CTM 2030 strategy and the development of our Clinical Services Plan will be crucial in the reform we need to deliver.

As we celebrate what has been done over the past 75 years I am delighted that so many of our nursing staff were nominated and succeeded in winning awards in five of the categories at this year's Royal College of Nursing (RCN) Wales Nurse of the Year Awards. It was amazing to celebrate their success and to recognise what the nursing profession does in Wales. As we continue to identify the opportunities of service transformation I am reminded of the professionalism, commitment and compassion of our staff and their central role in working with us in shaping the services of the future.

2.2 Independent Member Vacancies

I can confirm that Welsh Governement has commenced the public appointment process for the Vice Chair and Independent Member (Legal). Adverts have now gone live on the Welsh Government website with interviews planned for September 2023.

Jayne Sadgrove (Vice Chair) is ending her final term with CTMUHB earlier than planned, on the 31st August 2023, as she has been appointed as an Independent Member to the Health Education Improvement Wales (HEIW) Board. Whilst the Health Board has commenced the public appointment process and interviews are scheduled for early September there will be a period of time where CTMUHB will be without a Vice Chair of the Board. An expression of interest has been sent to Independent Members of the Board to recruit an Interim Vice Chair from 1st September until a substantive position is recruited.

2.3 Board Development Session – 22 June 2023

The Board received the following presentations;

- **Clinical Services Plan (CSP)** delivered by Linda Prosser, Executive Director of Strategy & Transformation and Victoria Wallace, Deputy Director of Strategy and Partnerships.
- **Critical Care Framework –** delivered by Anthony Gibson, Deputy Medical Director for Acute Services.
- **Creating Health through Whole Systems Leadership –** delivered by Philip Daniel, Director of Public Health.

- **Update on Response to HIW report Mental Health Services –** delivered by Ana Llewellyn, Mental Health & Learning Disabilities Care Group Nurse Director with support from Care Group.
- **Audit Wales /HIW - Follow-up Report –** Audit Wales colleagues in attendance to present their key findings.

2.4 **Diary Commitments/Meetings attended as part of Chair's Induction.**

- Local Authority Leaders/Chair/CEO Meeting
- Independent Members/Chair/CEO Meeting
- 1:1s (Chief Executive, Vice Chair, Interim Board Secretary Governance, Executive Directors, Chairs of other HBs)
- 1:1 Vice Chair / Interim Board Secretary
- Maesteg Community Engagement Event
- Introductory Meeting with Chair, Swansea Bay UHB
- Chair Peer Group Meeting
- Meet with Nutrition and Dietetics Team
- Introductory meeting with Leader of Bridgend County Borough Council
- Cwm Taf Morgannwg Regional Partnership Board
- Stakeholder Reference Group
- Tour of Prince Charles Hospital
- Introductory meeting with Chair, WHSSC
- NHS Confed Expo – Manchester
- Introductory meetings with MPs/MSs
- Local Partnership Forum
- WNHSC Management Committee Meeting
- Introductory meeting with the Leader, Rhondda Cynon Taf County Borough Council
- Introductory Meeting with Llais Cymru
- Webinar with the Older People's Commissioner
- Introductory meeting with Sally Lewis, Value in Healthcare
- Introductory meeting with Chair, Aneurin Bevan UHB
- Ty Llidiard Open Day
- Introductory meeting with Clinical Director, Therapies
- NHS 75 Service of Thanksgiving
- Visit New Horizons Mental Health
- Bevan Commission Conference
- Introductory meeting with David Samuel (Consultant hepatologist)
- Introductory meeting Chair, Cardiff & Vale UHB
- Tour of Princess of Wales, Bridgend
- Staff Q&A Session
- Webinar with the Welsh Language Commissioner
- Meet with Health Inspectorate Wales
- Nursing & Midwifery Professional Forum
- CTM2030 Leaders' Meeting
- Independent Member Legal Vacancy SIFT
- Leadership Group Meeting

- Extra-Ordinary Audit & Risk Committee - Approval of the Annual Accounts
- Independent Member Vice Chair SIFT
- NHS Wales Nurse of Year Awards

2.5 **Meetings / discussions with Local Politicians**

- MS/MP monthly meetings with Chair/CEO

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 COMMON SEAL

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

- **Agreement between Cwm Taf Morgannwg University Health Board and Maxime Partnership of C5 Business Centre, North Road, Bridgend Industrial Estate, Bridgend, CF31 3TP** - alterations and refurbishment works within the emergency department Princess of Wales Hospital.
- **Agreement between Cwm Taf Morgannwg University Health Board and TSF Contracts Ltd of Unit 11a Hepworth Business Park, Coedcae Lane, Pontyclun,CF72 9FQ** - works carried out at Royal Glamorgan Hospital Discharge Lounge & DDA WC
- **Agreement between Cwm Taf Morgannwg University Health Board and PJ Saunders Limited, Unit 9 The Beeches Industrial Estate, Talbot Green, CF72 9DY**- Upgrade Works 4 No Digital Radiography Rooms at Royal Glamorgan Hospital and Ysbyty Cwm Rhondda Hospital.
- **Agreement between Cwm Taf Morgannwg University Health Board and Amberwell Engineering Services Ltd of Unit 3, Plot 120, Village Farm Industrial Estate, Pyle, Bridgend,CF35 6BL** - Periodic Electrical Testing of Distribution Board Circuits & Associated Remedial Works (2022/2023) at Prince Charles Hospital and Keir Hardie University Health Park Merthyr Tydfil.
- **Agreement between Cwm Taf Morgannwg University Health Board and Amberwell Engineering Services Ltd of Unit 3, Plot 120, Village Farm Industrial Estate, Pyle, Bridgend,CF35 6BL** - Periodic Electrical Testing of Distribution Board Circuits &Associated Remedial Works (2022/2023) at The Royal Glamorgan Hospital, Llantrisant.
- **Agreement between Cwm Taf Morgannwg University Health Board and Tilbury Douglas Holdings Limited of 1st Floor 30-40 Eastcheap, London, EC3M 1HD and Tilbury Douglas Construction Limited of 30-40 Eastcheap, London, EC3M 1HD** - relating to The Princess of Wales Hospital Theatres Fire Enforcement Notice Works.
- **Agreement between Cwm Taf Morgannwg University Health Board and TSF Contracts Ltd Unit 11a Hepworth Business Park,**

Coedcae Lane, Pontyclun, CF72 9FQ Relating to Royal Glamorgan Hospital - GDAU New Dirty Utility & Decoration.

- **Agreement between Cwm Taf Morgannwg University Health Board and PJ Saunders Limited of Unit 9 the Beeches Industrial Estate, Coedcae Lane, Talbot Green, Rhondda Cynon Taf -** relating to reconfiguration of Unit 2 Gwaun Elai Medi Park.

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

3.2 **Chairs Urgent Action – Covid 19 Inquiry Module 4 – Application for Core Participant Status**

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

- **Endorse** the decision that CTMUHB will **NOT** apply for **Individual** Core Participant Status.
- **Approve** that if there is an appetite in NHS Wales for **Group** Core Participant Status then the Health Board would join this collective, subject to robust governance and legal oversight.
- **Approve** that if a Group Application for Core Participant Status is progressed that the Health Board will Inform its legal team and agree to this information being shared internally within NWSSP Legal & Risk to facilitate such arrangements to support a joint application.
- **Note –** that the default position if no application is put forward or subsequently approved by the Chair of the Inquiry than the Health Board will move forward with no Core Participant Status.
- **Note** – that the Health Board will still retain its own Legal Advisors which includes Senior and Junior Counsel (from Crown Office Row) and designated Legal Advisors from NWSSP Legal & Risk Services.

The Board **APPROVED** the Chair's Urgent Action.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	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.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes but within a Governance Framework.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new,	No
	Not required

changed or withdrawn policies and services.	
Legal implications / impact	Yes (Include further detail below)
	Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 Members of the Board are asked to **NOTE** and **ENDORSE** the Affixing of the Common Seal to the documents listed in section 3.1.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 4.1.1

ACTION LOG HEALTH BOARD MEETING					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at date papers where circulated)
Agenda Item 6.1.2	24 November 2022	**Integrated Performance Dashboard – Operational Delivery Performance** Discussion to be held at a future Board Development Session in relation to Cancer Performance.	Chief Operating Officer	April 2023 To be scheduled into programme for 2023/2024	**In progress** Topic was scheduled for the Board Development session being held in April 2023. Will need to be rescheduled as discussion not held at the April session.
Agenda Item 5.1	26 January 2023	**Chief Executives Report** Ty Llidiard Team to be invited to a future Board meeting to outline the journey they had been through over the last few years.	Director of Therapies & Health Sciences	28 September 2023	**In progress** The Team have been invited to attend the Board meeting in September 2023 to share their Listening & Learning Story
Agenda Item 6.3	30 March 2023	**Integrated Performance Dashboard** Outcome of the review being undertaken by the Medical Director and Deputy Medical Director in relation to Crude Hospital Mortality rates to be presented to either the Planning, Performance & Finance Committee or Quality & Safety Committee for further discussion.	Medical Director	25 July 2023	**In progress** Deputy Medical Director has met with the Head of Concerns and Business Intelligence, who will now meet with Mortuary Staff to discuss what data needs to be recorded. This data will then be included in the Quality Dashboard which is presented to the Quality & Safety Committee on 25 July 2023. A follow up meeting will be held on 20 June 2023 to discuss progress.

Agenda Item 5.4	25 May 2023	**Integrated Performance Dashboard Report** Update to be provided at a future Board Development session in relation to the work being undertaken on workforce planning	Director for People	To be scheduled into programme for 2024	**In progress** This item has been added to the schedule of suggested topics for future Board Development sessions.
Agenda Item 5.4	25 May 2023	**Integrated Performance Dashboard Report** Discussion to be held at a future Board Development Session in relation to Mortality Data and Mortality rates.	Medical Director	25 July 203	**In progress** Report on Crude Mortality Data being presented and discussed at the Quality & Safety Committee being held on 25 July 2023. Discussion to be held as to whether the Board would like to have a follow up discussion at a future Board Development session.
Agenda Item 5.4	25 May 2023	**Integrated Performance Dashboard Report** Review to be undertaken by the Executive Directors in relation to the accuracy of data being presented	Executive Directors	27 July 2023	**In progress**

Completed Actions					
Agenda Item 6.5	30 March 2023	**Audit Wales Review – Structured Assessment** Examples to be provided from other organisations of where performance reporting had been undertaken really well. Further discussion to be held between Audit Wales, Assistant Director of Governance & Risk and the Executive Director of Strategy & Transformation	Audit Wales, Assistant Director of Governance & Risk and the Executive Director of Strategy & Transformation	25 May 2023	**Completed** Discussion held and Audit Wales exploring with other Performance Lead colleagues and will share examples with Health Board colleagues for consideration as appropriate for CTMUHB Performance Dashboard.
Agenda Item 6.3	30 March 2023	**Integrated Performance Dashboard** Letter to be written to the Minister to provide an overview on the steps being undertaken within the Health Board to improve trajectory in relation to Elective Care and Cancer Performance	Chief Operating Officer	25 May 2023	**Completed** The Chief Operating Officer has confirmed that this is closed in line with submission of the Targeted Intervention improvement trajectories

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
4.2

CTM BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	27th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Matthew Butt, Chief of Staff
Presented by	Paul Mears, Chief Executive Officer
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	
AW	Audit Wales
HIW	Healthcare Inspectorate Wales

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to keep the Board up to date with key issues affecting the organisation. A number of issues raised within this report feature more prominently within key reports on the main Board agenda.

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

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

2.1 Escalation Status

The Executive team continue to meet with Welsh Government officials on a quarterly basis to discuss all escalation workstreams within the health board. In addition, a Performance Oversight Group comprising of CTM and Welsh Government colleagues has been established to focus specifically on the TI – Performance elements of escalation. This meeting aligns to the monthly Integrated Performance, Quality and Delivery (IQPD) meeting structure.

As of July 2023, our escalation status currently remains unchanged and is summarised in the table below:

Current escalation status	Area
Enhanced Monitoring	Planning and Finance
Targeted Intervention	Maternity and Neonatal
	Quality and Governance, Leadership and Culture, Trust and Confidence
	Quality issues relating to performance associated with long waiting times

The escalation status of the health board was due to be discussed at the 30 June tripartite meeting. We have subsequently been advised the CTM tripartite discussion will now take place on 14 July to align with the timescales of release of the draft HIW/AW Joint Review follow-up report. I have included a further update in specific relation to this report in section 2.6.

Performance (associated with long waiting times) will continue to be the key focus of escalation over the coming months as we maintain engagement with a series of Welsh Government supported interventions. The Health Board is continuously measuring against the agreed set of performance improvement trajectories and progress against the recovery plan continues to be monitored internally and via fortnightly touchpoints with the Welsh Government Escalation Team, IQPD, performance oversight and quarterly meetings.

2.2 Annual Plan 2023/24

At the May Board meeting, we provided an update on the submission of the annual plan for 2023/24. Our plan had been submitted to Welsh Government on 31 March and the Executive team subsequently attended a scrutiny session with Welsh Government colleagues in April to address key points within our submission. We were advised the plan was not in an approvable position and following the May board we subsequently

submitted an update to the plan at the end of May. At this time, we are still awaiting formal feedback from Welsh Government in relation to our second submission. Meanwhile there are ongoing discussions at CEO level regarding the financial position across Wales.

2.3 Regional Working – Llantrisant Health Park

I am pleased to report positive progress in the development of the Llantrisant Health Park programme. The Health Board has progressed with the formal initiation of the programme and has secured £3.09M of capital funding to commence work against the year one deliverables.

The Health Board maintains its commitment to regional working across a number of programmes within the SE Wales portfolio. The Llantrisant Health Park programme closely aligns to the governance structure of the Regional Portfolio Oversight Board (CEO level) and key work programmes within (Diagnostics and Orthopaedics). The programme is in the process of establishing key working groups to directly link with the regional programmes to agree the scope and requirements for the infrastructure programme.

We are continuing to work with our Health Board partners, Welsh Government, Shared Services Estates to refine the programme structure and baseline the schedule for year one activity. The programme team will bring a full update including the year one+ plan as an agenda item to the September Board.

Whilst the programme continues to be supported by Archus, we are currently running a recruitment process to appoint a Programme Director, with confirmation of an appointment expected at the end of July. The programme team will continue to develop over the coming months, with a combination of new posts, secondments and industry support expected.

2.4 De-escalation of Ty Llidiard

Ty Llidiard is a Tier 4 inpatient Child and Adolescent Mental Health Service (CAMHS) servicing the South Wales region. In June 2021, the service had been placed into Level 4 escalation, with progress appraised and de-escalation to Level 3 effective January of this year. Significant improvement work has been undertaken within the service, resulting in sustained quality improvements for our young people, their families, and our workforce. I am pleased to report the Welsh Health Specialised Services Committee (WHSSC) have formally written to the Health Board to advise that the Ty Llidiard CAMHS service has been further de-escalated to Level 2 as of 27 June.

WHSSC have outlined six key action areas that we will focus on to enable de-escalation to Level 0 - 'routine arrangements'. To support this process, the Health Board will continue to engage in regular (quarterly) meetings with WHSSC and evidence achievement of the outstanding actions. Updates will continue to be received at the Quality and Safety Committee and other appropriate forums.

I would like to extend my thanks to all colleagues and partners that have contributed towards the success of the improvement journey of this service.

2.5 HIW/AW Joint Review – Follow Up Report

A draft copy of the Joint Review follow-up report has been received and shared with the Health Board for clearance, with review comments being compiled at present. It is anticipated the final report will be received at a future meeting of the Board.

The report findings recognises the significant improvement in the quality and governance arrangements since the initial review in 2019. HIW and AW will share their findings with the tripartite meeting this month to support a recommendation made to the Health Minister regarding our escalation status.

2.6 CTM Operating Model Update

The phase two project team have facilitated a process to align the clinical services to our six care groups. The project has supported the care groups to design the operations management, nursing and medical structures required to deliver these services in a pan-CTM operating model.

The implementation of phase two of the operating model will continue to be progressed in two component parts (bands 8a-d and bands 6 and 7). The structures for the implementation of the first part of phase two are now complete and undergoing review and testing to ensure the design requirements are met (quality, safety, functional and financial). The Executive team will undertake a formal review of the proposed structure prior to consultation.

The care group leadership teams are currently compiling inputs to the implementation document and we aim to consult on this with staff from August. The team will continue to keep staff and other stakeholders updated with progress and updated timelines for consultation and implementation of phase two of the operating model.

2.7 Royal College of Nursing 'Nurse of the Year' Awards

I am delighted to report that CTM Nursing colleagues enjoyed a very successful night at the 10th Royal College of Nursing (RCN) 'Nurse of the Year' awards held at City Hall in Cardiff on 29 June. Winning an impressive five awards and securing two runner-up places, our recognised nurses and midwives represented a broad range of roles from across the health board as seen below:

- **Chief Nursing Officer for Wales Award:**
  Sarah Morris, Practice Development Midwife
- **Innovation in Digitalisation in Nursing Award:**
  Mandie Welch, Lead Heart Failure Advanced Nurse Practitioner
- **Primary Care Nursing Award:**
  Andrea Dorrington, Lead Nurse for Urgent Primary Care

- **Supporting Education and Learning in Practice Award:**
  Winners: Hayley Compton, Operational Team Leader, and Carla Evans, Community Nurse
  Runner-up: Laura Little, Fetal Wellbeing and Surveillance Specialist
- **Mental Health & Learning Disabilities Award:**
  Winners: Bethan Williams, Acute Learning Disabilities Liason Nurse and Judith Wall, Acute Learning Disabilities Liason Nurse.
- **Improving Individual and Population Health Award:**
  Winner: Sharon Webber, Public Health Specialist Midwife
  Runner-up: Tracey Evans, Clinical Nurse Specialist

2.8 Leadership Team Update

Director of Communications, Engagement and Fundraising – Following a recent recruitment process, I am pleased to update the Board that Simon Blackburn has been appointed into this position. Simon brings a wealth of knowledge and experience to the organisation and with additional scope factored into this role; he will now begin developing a plan to enhance our fundraising activity.

3 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	It is anticipated that all elements of quality, safety and patient safety will be impacted positively by the implementation of the "Continuous Improvement in response to TI Programme".
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

4 RECOMMENDATION

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

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
5.1

CTMUHB BOARD

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting	27/07/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Jose Roper, Senior Performance Monitoring Officer
Presented by	Linda Prosser, Executive Director of Strategy & Transformation
Approving Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Linda Prosser	14/7/2023	Choose an item.

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

D2RA	Discharge to Recover then Assess model
DHCW	Digital Health and Care Wales
DNA	Did Not Attend
DToC	Delayed Transfers of Care
E.coli	Escherichia coli bacteraemia
ED	Emergency Department
ESD	Early Supported Discharge
FUNB	Follow-up Outpatients Not Booked
HIW	Health Inspectorate Wales
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
Klebsiella sp.	Klebsiella sp. Bacteraemia
LD	Learning Disabilities
LRI's	Locally Reportable Incidents
LPMHSS	Local Primary Mental Health Support Service
MDT	Multidisciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NOUS	Non Obstetric Ultra-Sound
ONS	Office for National Statistics
OoH	Out of Hours
P.aeruginosa	Pseudomonas aeruginosa bacteraemia
PADR/PDR	Personal Appraisal and Development Review
p-CAMHS	Primary Child and Adolescent Mental Health Services
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
POW	Princess of Wales
PSPP	Public Sector Payment Performance
PTR	Putting Things Right
PUs	Pressure Ulcers
QIA	Quality Impact Assessment
QIM	Quality Improvement Measures
RCS	Royal College of Surgeons
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment Times
S.aureus	Staphylococcus aureus bacteraemia
SALT	Speech and Language Therapy
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SCP	Single Cancer Pathway
SIs	Serious Incidents
SOS	See on Symptom
SSNAP	Sentinel Stroke National Audit Programme
WAST	Welsh Ambulance Service NHS Trust
WCP	Welsh Clinical Portal
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Committee
WPAS	Welsh Patient Administration System
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. SITUATION/BACKGROUND

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

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

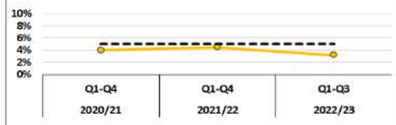
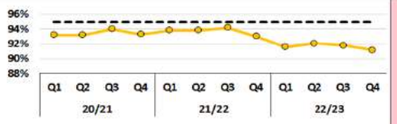
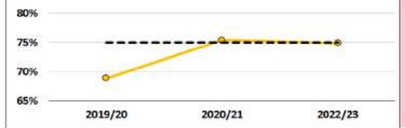
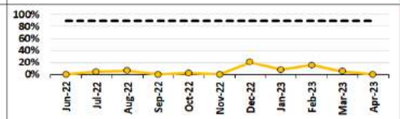
Consequently this report sets out the UHB's performance against a number of areas within the new performance framework, and for which reporting and management arrangements exists.

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

Quadruple Aim 1: Improving Population Health & Wellbeing

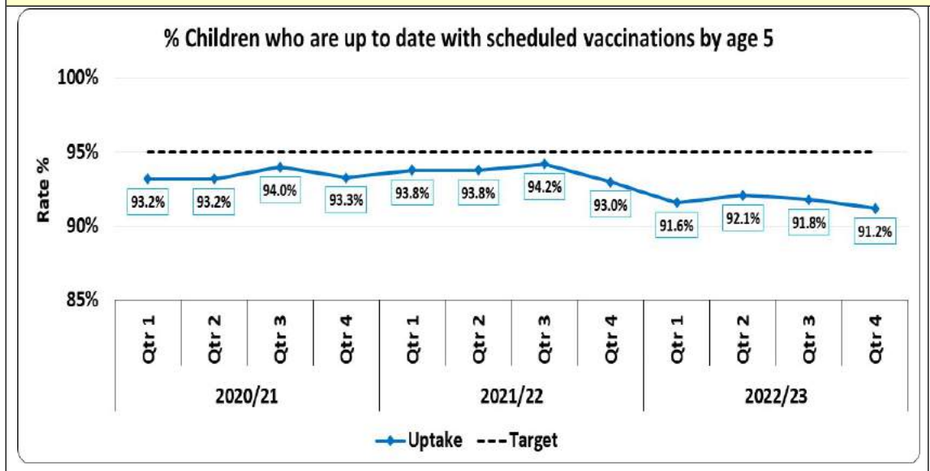
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management

Key: Trend / Target/Trajectory — Key: Target Achieved / Target Failed

	Performance Measure	Target	Latest Position		
Prevention	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% Annual Target		3.18%	Q1-Q3 2022/23
	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 Qtr Improvement Trend	Data not available as yet		
	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' pre-school booster, the Hib/MenC booster and the second MMR dose)	95%		91.2%	Q4 2022/23
	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	Data not available as yet		
	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%		74.9%	2022/23
	Percentage uptake of the COVID-19 vaccination for those eligible - Spring booster 2023: aged 75 yrs and over; residents in care home for older adults and immunosuppressed aged 5 yrs & over. Autumn booster 2023: age range to be confirmed		Data not available as yet		
	Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%		0.00%	Apr-23
	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	Data not available as yet		
	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	95%	Data not available as yet		
	Implementing Help Me Quit in Hospital smoking cessation services and to reduce smoking during pregnancy	Evidence of Improvement	On Track	N/A	Sep 22 - Mar 23
	Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway		Majority on track, but scope to improve		

CTMUHB Improving Population Health & Wellbeing

Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' pre-school booster, the Hib/MenC booster and the second MMR dose) – Target 95%



2022/23 Uptake	
Merthyr Tydfil LA	88.9%
RCT LA	91.0%
Bridgend LA	92.1%
CTMUHB	91.0%

What are the key challenges in delivering vaccination targets & actions to tackle inequalities?

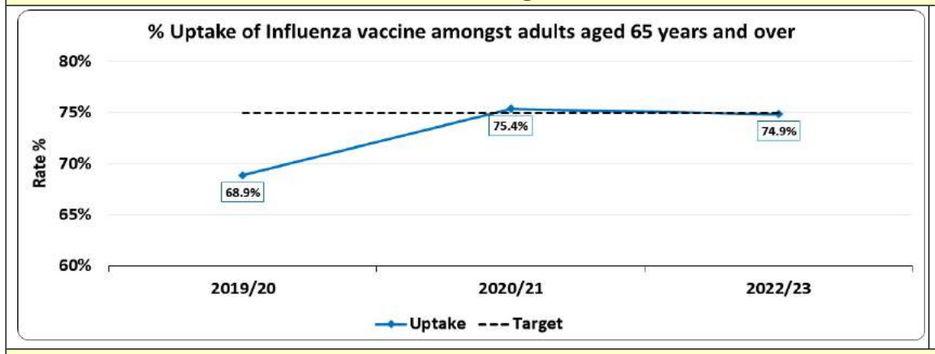
Challenges:

- Uncertainty regarding whether the global sum that comes to the UHB is allocated to the teams delivering the vaccinations
- Distributed leadership model of delivery, and therefore uncertainty regarding the responsible person/team for vaccination programmes. Governance to be reviewed as part of the Strategic Plan.
- Staffing resource within School Nursing
- Unsustainable delivery models, e.g. Fluenz in school based Nursery classes
- Consent forms not being returned to schools
- Reduced capacity within Specialist Immunisation Team
- Staffing levels in Primary Care
- Recall methods no longer mandatory within GMS contract
- No dedicated Communications support – missed opportunities for promotion/sharing of clinics etc.
- National communication resources often received too late
- Limitations with flexing delivery models

Actions

- CTM Vaccine Equity Strategic Plan and toolkit currently under development
- Vaccine equity related targets included in 3-year CTM Vaccination and Immunisation Strategic Plan
- Targeted interventions – during the 2022/23 season, there was a focus on Fluenz uptake in 2 year olds
- Representation on newly formed national Vaccine Equity Network
- Working with Vaccine Preventable Disease Programme (VPDP)

Percentage uptake of the influenza vaccination amongst adults aged 65 years and over Target 75%



2022/23 Uptake	
Merthyr Tydfil LA	70.2%
RCT LA	73.6%
Bridgend LA	78.3%
CTMUHB	74.9%

Challenges posed by the National Immunisation Framework (NIF) & actions being taken?

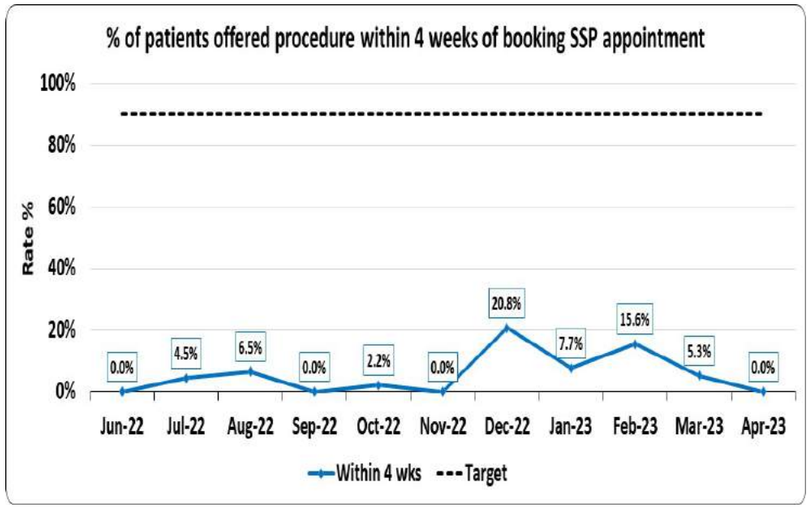
Challenges

- Lack of implementation guidance – NIF launched in October 2022, no timescale for when to expect implementation guidance
- Lack of clarity regarding recurring funding, and the subsequent impact on development of delivery models and recruitment of staff
- Uncertainty regarding how the NIF will impact operationally, making it difficult to change delivery model/introduce interventions

Actions

- Regular communication with Delivery Unit
- CTM representation within national NIF fora

Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment – Target 90%



How are we doing & what actions are we taking?

Improvements have been made at 1st Assessment Stage through the dedicated SSP and Admin team to bring waits down to less than 1 week. Further improvement required to support backlog clearance of our colonoscopy waits.

Challenges

Screening Endoscopist – the Health Board has three approved Endoscopist that perform three BSW list per week, plus one further visiting Endoscopists carrying out one list per week. (42 weeks less ward commitments @ 8 weeks). The list are only performed at PCH & RGH unit.

The operational challenges that impact on activity are:

Not enough core lists to meet current demand – long standing challenge.

Leave/ward cover – list are lost due to consultants covering wards, annual and study leave. With a limited number of approved Screening Endoscopist it is difficult to backfill the screening lists. However our screening colonoscopist will always prioritise screening list and work closely with the ops management teams to reduce lost and fallow lists.

Nursing Staffing – Even though screening lists are always prioritised, the current staffing risks should be raised as we move forward through our recovery stage.

List Utilisation – current utilisation of in session lists

Key Actions to reduce backlog

To increase the 4 to the 6 required screening lists to meet the current demand the service has worked very closely with the clinicians to look at smart ways to increase the weekly core lists.

Additional screening lists at PCH delivered by SD our visiting colonoscopist – going live from July.

The service is currently exploring insourcing to support the backlog clearance. The plan would be to run weekend screening lists for a set period of time to clear the current 230 participants waiting for their screening colonoscopy. It must be noted that this is a short term solution while the service builds and delivers a sustainable model for our screening service.

Quadruple Aim 2: Quality & Better Access to Services

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

Key: Trend --- Target/Trajectory | Key: Target Achieved | Target Failed

	Performance Measure	Target	Trend	Latest Position	
Services Delivered Close to Home	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%		98%	2021/22
	Qualitative report providing assurance on GP access improvement	Evidence of Improvement	Data not available as yet		
	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2023 and 100% by 31 March	Data not available as yet		
	Allied Health Professionals accessible by Health Board and Regional Partnership Board footprint	Annual increase compared to baseline assessment	Data not available as yet		
	Qualitative report detailing progress to embed the National Framework for the Delivery of Bereavement Care in Wales and the National Bereavement Pathway	Evidence of Improvement	Data not available as yet		
	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by 31 March 2024		1559	Jun-23
	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	An increase on the number in the equivalent month in the previous year	Data not available as yet		
	Qualitative report detailing progress to develop a whole schools approach to CAMHS in reach services	Evidence of Improvement	On Track	N/A	Sep 22 - Mar 23
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age under 18 years)	80%		24.6%	May-23
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)			47.1%	
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)			74.1%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)			93.9%	
Access Hospital Services Quickly	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		46.3%	Jun-23
	Median emergency response time to amber calls	12 Month Improvement Trend		70	Jun-23
	Median time from arrival at an emergency department to triage by a clinician	12 month reduction trend		13	Jun-23

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

Key: Trend --- Target/Trajectory | Key: Target Achieved | Target Failed

	Performance Measure	Target	Trend	Latest Position	
Access Hospital Services Quickly	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	12 month reduction trend		64	Jun-23
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Improvement compared to the same month in 2022-23, towards the national target of 95%		69.0% National Target not met but improvement from June 22 (59.9%)	
	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by 31 March 2024		1,517	
	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of 80% by 31 March 2026		49.1%	May-23
	Number of patients waiting more than 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by 31 March 2024		14,368	Jun-23
	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	Improvement trajectory towards a national target of zero by 31 March 2024		52.8%	
	Number of patients waiting more than 14 weeks for a specified therapy (all ages)	Improvement trajectory towards a national target of zero by 31 March 2024		1,455	
	Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero		13,481	
	Number of patients waiting over 36 weeks for a new outpatient appointment			23,065	
	Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	Improvement trajectory towards the national target of zero		34,189	
	Number of patients waiting more than 104 weeks for referral to treatment			4,228	
	Number of patients waiting more than 52 weeks for treatment			27,251	
	% of patients waiting less than 28 days for a first outpatient appointment for Specialist Child and Adolescent Mental Health Services (sCAMHS)	80%		77.3%	May-23
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment			33.8%	
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			46.8%	

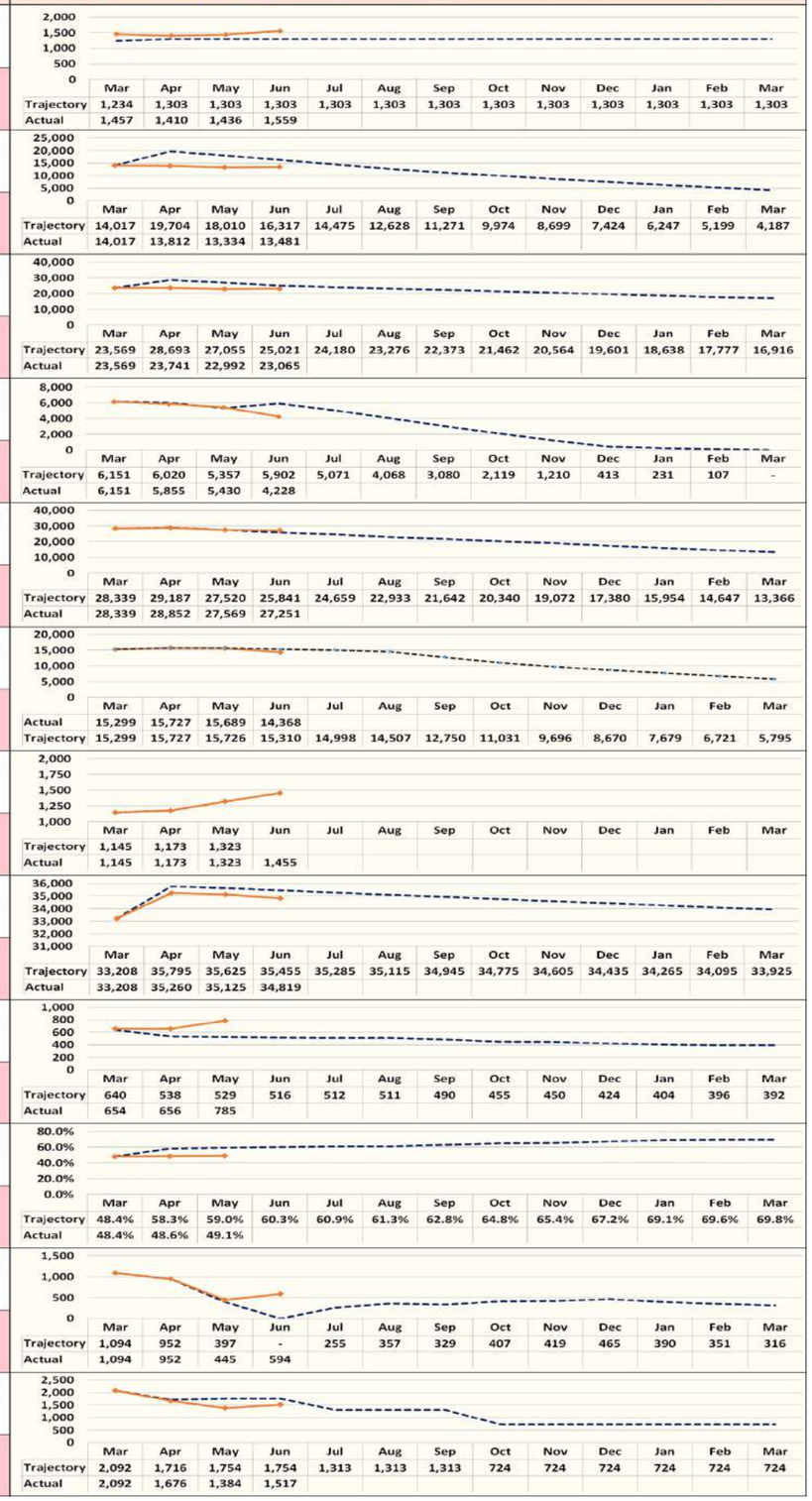
National Performance Trajectory – please note that the following scorecard is in development & trajectory data will be revised in future iterations of this report

2023/24 National Performance Trajectory

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

ACCESS TO TIMELY PLANNED CARE

Measure	Performance Against Target	Current Period
Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by March 2024	1,384
Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023	14,183
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024	23,318
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by June 2023	5,567
Number of patients waiting more than 52 weeks for treatment	Improvement trajectory towards a national target of zero by 2025	23,318
Number of patients waiting over 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by March 2024	15,726
Number of patients waiting over 14 weeks for a specified therapy	Improvement trajectory towards a national target of zero by March 2024	1,349
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Improvement trajectory towards a national target of reduction by March 2024	35,121
Number of patients waiting more than 62 days for their first definitive cancer treatment from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of reduction by March 2024	742
Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of reduction by March 2024	48.6%
Number of ambulance patient handovers over 1 hour	Improvement trajectory towards a national target of zero by March 2024	445
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by March 2024	1,384



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	1,234	1,303	1,303	1,303	1,303	1,303	1,303	1,303	1,303	1,303	1,303	1,303	1,303
Actual	1,457	1,410	1,436	1,559									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	14,017	19,704	18,010	16,317	14,475	12,628	11,271	9,974	8,699	7,424	6,247	5,199	4,187
Actual	14,017	13,812	13,334	13,481									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	23,569	28,693	27,055	25,021	24,180	23,276	22,373	21,462	20,564	19,601	18,638	17,777	16,916
Actual	23,569	23,741	22,992	23,065									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	6,151	6,020	5,357	5,902	5,071	4,068	3,080	2,119	1,210	413	231	107	-
Actual	6,151	5,855	5,430	4,228									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	28,339	29,187	27,520	25,841	24,659	22,933	21,642	20,340	19,072	17,380	15,954	14,647	13,366
Actual	28,339	28,852	27,569	27,251									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	15,299	15,727	15,689	14,368									
Trajectory	15,299	15,727	15,726	15,310	14,998	14,507	12,750	11,031	9,696	8,670	7,679	6,721	5,795

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	1,145	1,173	1,323										
Actual	1,145	1,173	1,323	1,455									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	33,208	35,795	35,625	35,455	35,285	35,115	34,945	34,775	34,605	34,435	34,265	34,095	33,925
Actual	33,208	35,260	35,125	34,819									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	640	538	529	516	512	511	490	455	450	424	404	396	392
Actual	654	656	785										

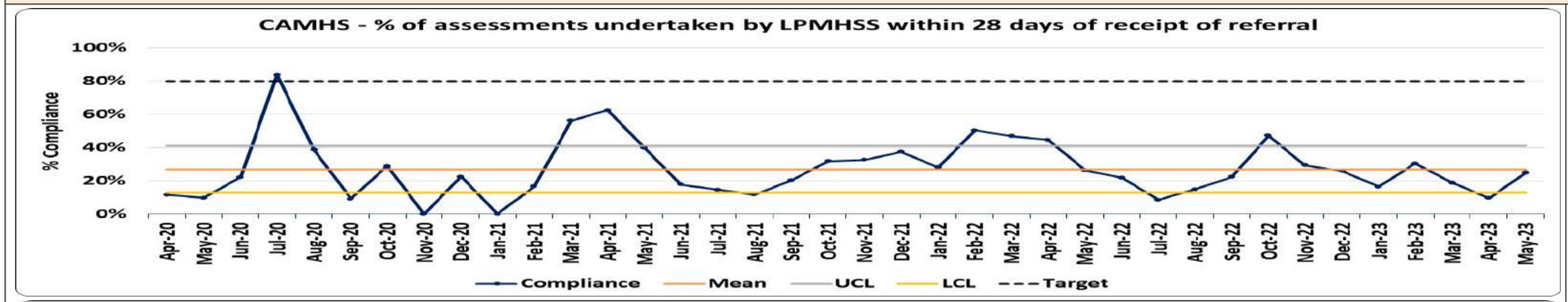
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	48.4%	58.3%	59.0%	60.3%	60.9%	61.3%	62.8%	64.8%	65.4%	67.2%	69.1%	69.6%	69.8%
Actual	48.4%	48.6%	49.1%										

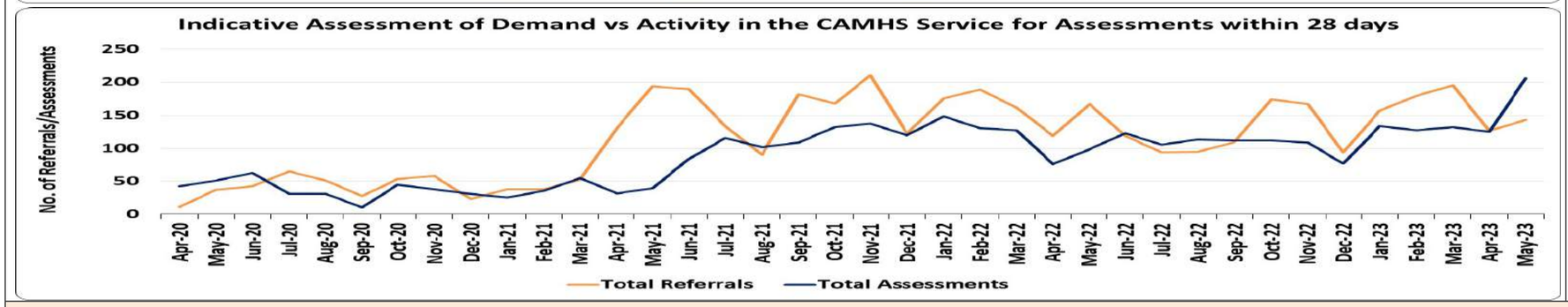
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	1,094	952	397	-	255	357	329	407	419	465	390	351	316
Actual	1,094	952	445	594									

	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	2,092	1,716	1,754	1,754	1,313	1,313	1,313	724	724	724	724	724	724
Actual	2,092	1,676	1,384	1,517									

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

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (24.8%) - Target 80%





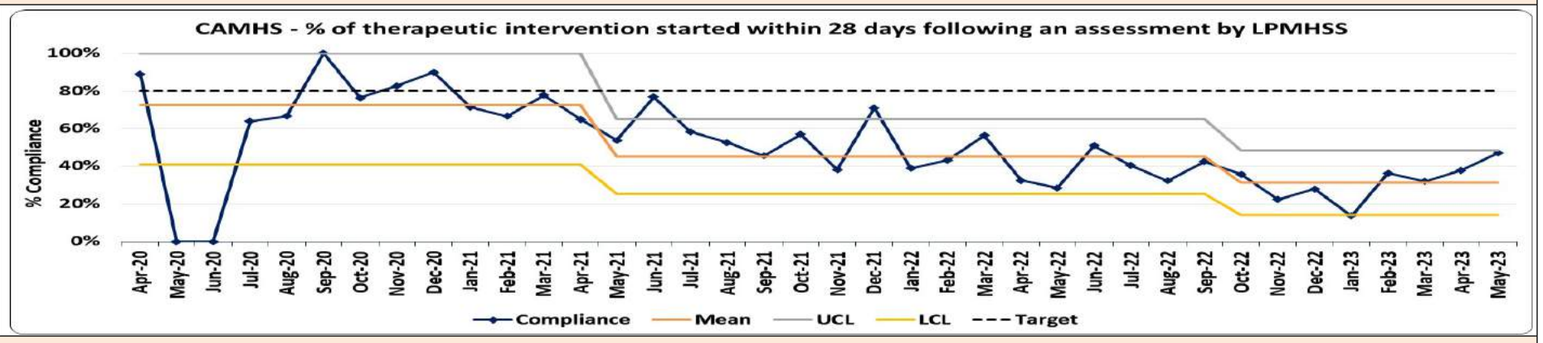
Just under a quarter (24.8%) of assessments were undertaken within 28 days of referral. However, the number of assessments carried out this month was at its highest level, totalling 206 and is 67% higher than the 12 month average (123).

Compliance has remained well below the WG's minimum expected standard of 80% and the last time the target was met was in July 2020, however performance levels will recover going forward as the backlog reduces and average waiting times for assessment improve (please see action section overleaf).

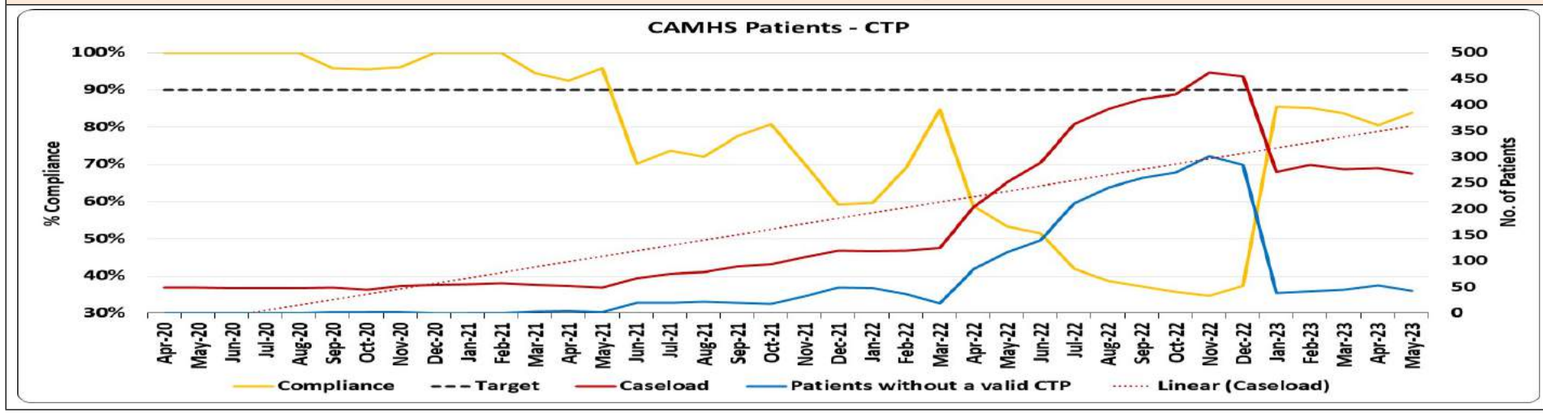
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (47.1%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS, whilst remaining low, improved to 47.1%, with 32 of the 68 interventions during May commencing within 28 days. Compliance is at the highest level seen since June of last year, but continues to lie below the 80% threshold with the last time the target being met December 2020 (90%).

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



Please note that this measure is part of Quadruple Aim 4 - People Centred Care - but has been included in this section for ease of reference with the Mental Health Priorities - % of HB residents who are in receipt of secondary MH services who have a valid CTP (84%) - Target 90%



Part 2 of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each improved to 84.0% during May after a slight dip in the previous month and continuing the improved performance seen from January this year. For context the WG standard is 90%.

As seen in the chart to the left; from the start of the period to May 2021 the caseload volume had been fairly constant and compliance remained above the target threshold. Thereafter, caseload volumes increased incrementally until a sharp rise was seen in April 2022, where caseloads to December had grown, on average by 30 patients each month. From January 2023, we observe that caseloads have fallen, on average by 40% from the peak seen in November 2022 (462). The number of patients without a valid CTP at the end of the month stands at 43.

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

Cont'd…CAMHS

How are we doing and what actions are we taking?

Actions being taken:

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

When is improvement anticipated and what are the main areas of risk?

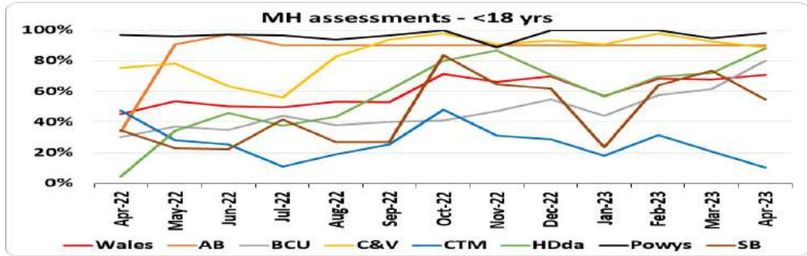
Outputs of improvements

- **Part 1a:** average number of young people waiting continues to reduce, falling from 284 in April down to 182 in May. As the backlog is removed compliance with the 28 day target will grow. Indications are positive that the position will improve strongly in June.
- **Part 1b:** the improvement actions are helping to deliver performance, which for May, is above the improvement trajectory. Current indicators suggest continued improvement going forward. Improvement actions which are helping to raise capacity include, development of group work treatment programs together with Third Sector and digital initiatives.
- **Part 2:** There has been a focus on providing additional capacity and time to support care coordinators to complete CTPs with their patients. As part of the improvement plan, a revised operational policy has been developed. A central register of all care coordinated patients is now in place which helps facilitate ongoing monitoring. At the end of May there were 225 patients that had a valid CTP from a total caseload of 268. There was a rise in compliance from 80.6% in April to 84% in May.

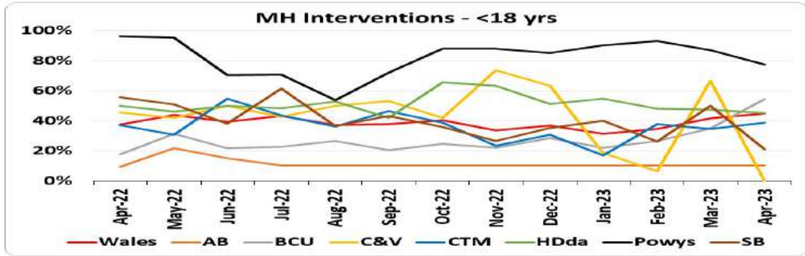
Main areas of risk:

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

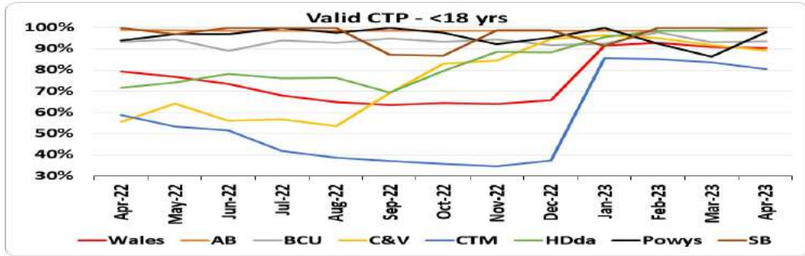
How do we compare with our peers?



Status as at April 2023		
Health Board	**Compliance**	**Rank**
Powys	98.0%	1st
AB	90.1%	2nd
C&V	88.9%	3rd
HDda	88.2%	4th
BCU	80.2%	5th
SB	54.8%	6th
CTM	**10.3%**	**7th**



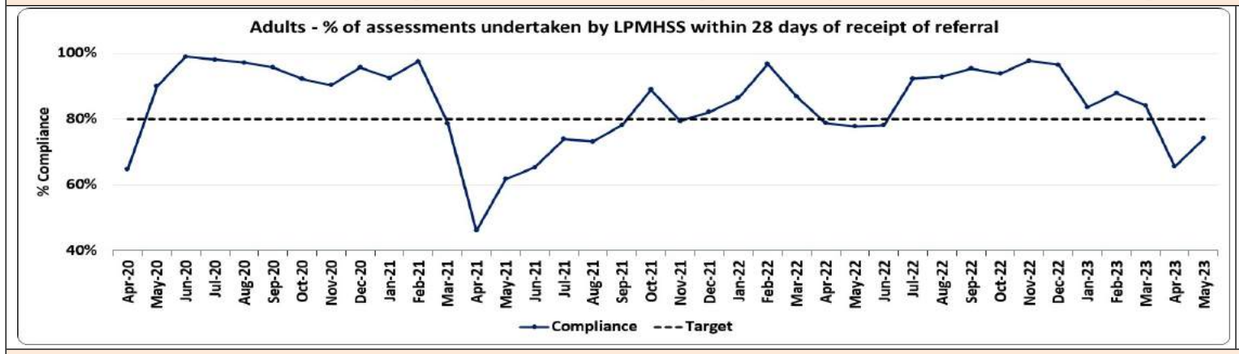
Status as at April 2023		
Health Board	**Compliance**	**Rank**
Powys	77.5%	1st
BCU	54.4%	2nd
HDda	45.2%	3rd
CTM	**39.0%**	**4th**
SB	21.2%	5th
AB	10.3%	6th
C&V	0.0%	7th



Status as at April 2023		
Health Board	**Compliance**	**Rank**
HDda	100.0%	1st
SB	100.0%	2nd
AB	98.6%	3rd
Powys	97.8%	4th
BCU	93.6%	5th
C&V	89.4%	6th
CTM	**80.6%**	**7th**

CTM Mental Health Services (excluding CAMHS) – May 2023

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (74.1%) - Target 80%

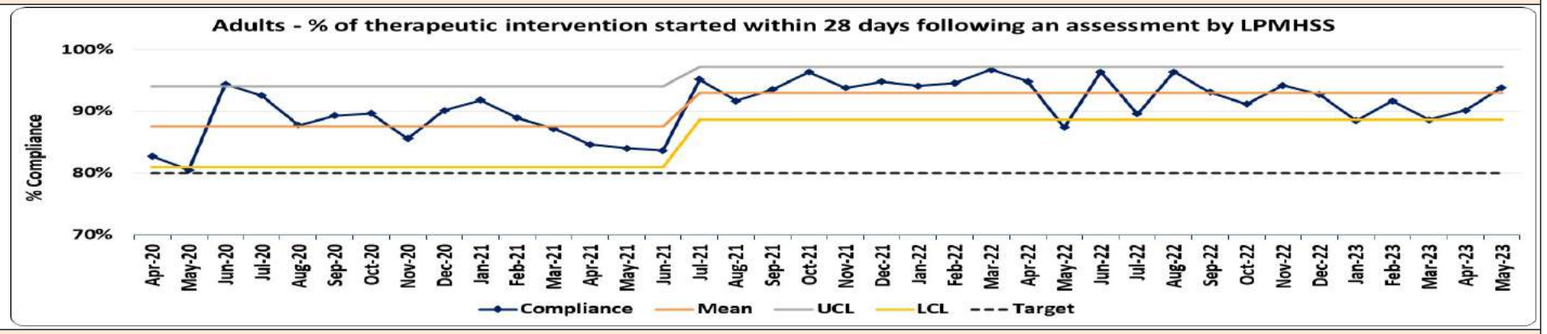


Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target of 80% of referrals to be assessed within 28 days. The compliance for the adult mental health services during May improved to 74.1% after a fall in the previous month, but remaining below the 80% target for the second month after previously maintaining compliance from July last year.

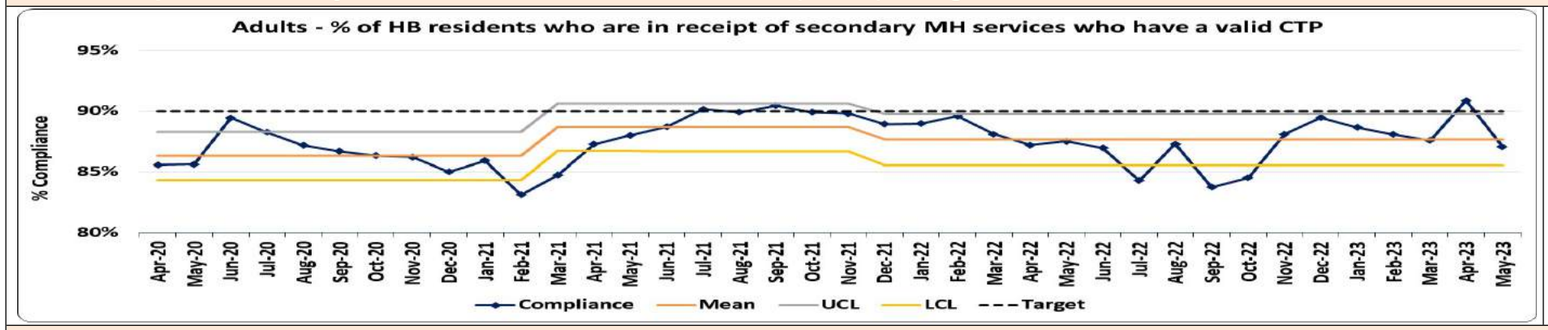
Referrals during May increased by 8.7% from the previous month, bringing the total to 735, with the volume similar to the 12 month average of 732, but continuing to remain lower than pre-Covid levels where referrals were in the region of 1,000 to 1,100.

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (93.9%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS was 93.9% during May with 291 of the 310 interventions commencing within the 28 day timeframe and remaining above the WG target of 80%.



Please note that this measure is part of Quadruple Aim 4 - People Centred Care - but has been included in this section for ease of reference with the Mental Health Priorities - % of HB residents who are in receipt of secondary MH services who have a valid CTP (87.1%) - Target 90%



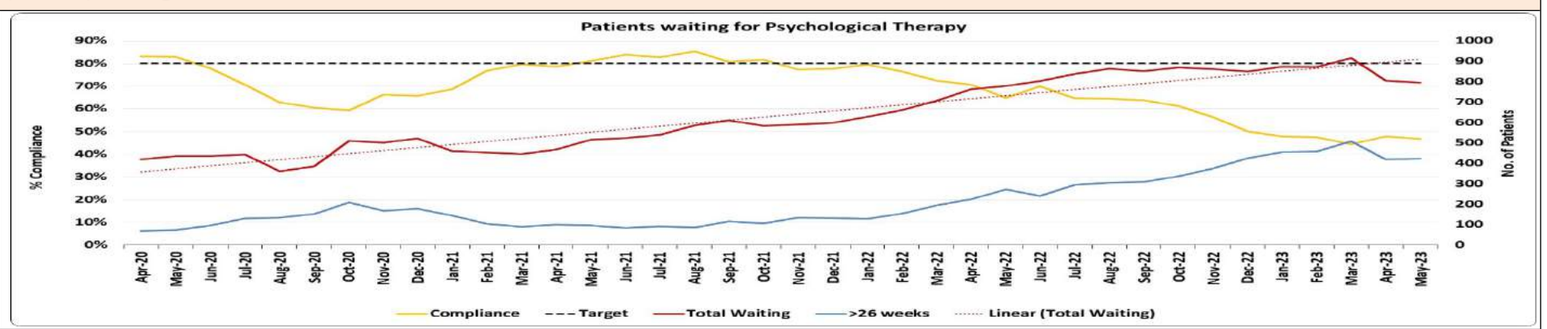
Part Two of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month fell to 87.1% during May and sitting below the 90% WG standard.

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

% of patients waiting less than 26 weeks to start a Psychological Therapy (46.8%) - Target 80%

During May, Psychological Therapies compliance remained almost static at 46.8% (47.8% April) remaining well below the 80% compliance threshold set by WG.

The chart to the right depicts the total waiting list volume (red) with the number of patients waiting more than 26 weeks for a Psychological Therapy (blue) and the proportion waiting less than 26 weeks (the WG target - yellow).



Adult Mental Health Services continued on the next page…

Cont'd…Mental Health Services (excluding CAMHS)

How are we doing?

Part 1a: Adult mental health services performance improved to 74.1% in May.

Both Merthyr Cynon and Rhondda Taf Ely areas are above the threshold of 80%. The Bridgend area is currently at 31.4%, however, this has improved from 17.9% on the previous month.

Part 1b: Performance continues to be above target at 93.9%.

Part 2: Overall compliance for both Adult, Older Adult and Learning Disability Services has decreased to 87.1%, falling below the target threshold of 90%

- Adult Services decreased from 89.4% to 85%
- Older Adult Services decreased from 94.8% to 92%
- Learning Disability Services has remained the same at 95.7%

Psychological Therapies: The overall waiting list has reduced by just 10 which is a combination of the reductions in patients transferred via outsourcing and ongoing waiting list validation. However, this reduction in the overall waiting list was offset by increased demand due to additional assessments and reduction in capacity due to a further vacancy.

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

Part 1a: Actions to improve performance are detailed below:

- Review of IT systems
- Demand and capacity work – review of job plans
- Review data input and reporting

Part 1b: Compliance continues to remain above target.

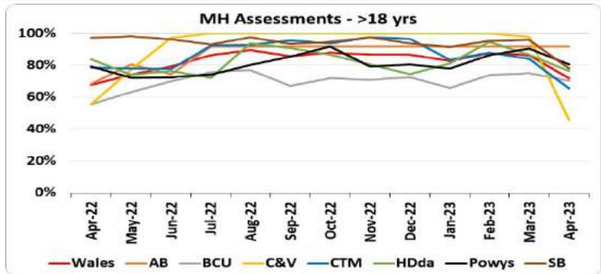
Part 2: Targeted work on non-compliant CTPs is continual. Work will continue with Community Mental Health Team leads and Local Authority partners to ensure any non-compliant CTPs are prioritised based on reducing risk. The primary risk to sustained improvements remains the reduction in staffing capacity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

Senior Nurse action plans to increase compliance are monitored through Mental Health Planned Care Recovery Board. The focus of improvement is around the development of compliance across the multi-disciplinary care co-ordination team. Local teams have been asked to risk assess patients who do not have an up to date CTP in order to provide assurance that care is not adversely affected.

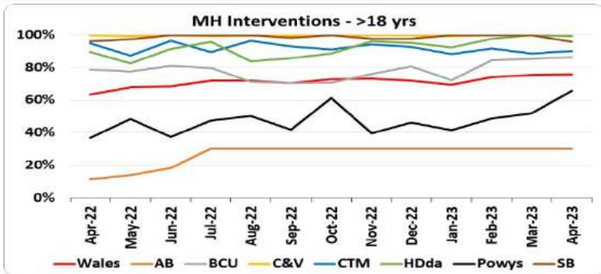
Psychological Therapies: Actions taken to improve position: -

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

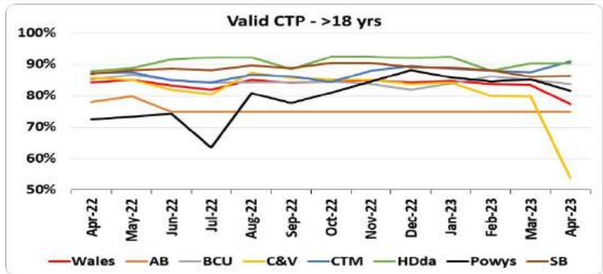
How do we compare with our peers?



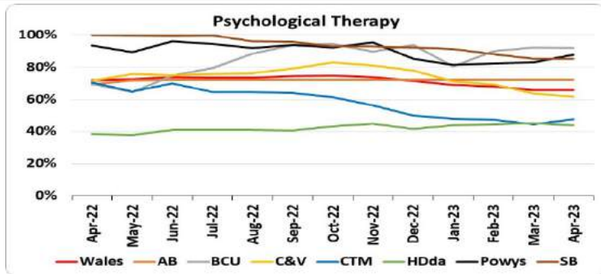
Status as at April 2023		
Health Board	Compliance	Rank
AB	91.9%	1st
Powys	80.4%	2nd
SB	77.9%	3rd
HDda	76.3%	4th
BCU	70.2%	5th
CTM	**65.5%**	**6th**
C&V	45.5%	7th



Status as at April 2023		
Health Board	Compliance	Rank
C&V	100.0%	1st
HDda	99.3%	2nd
SB	95.8%	3rd
CTM	**90.2%**	**4th**
BCU	86.3%	5th
Powys	65.8%	6th
AB	30.2%	7th



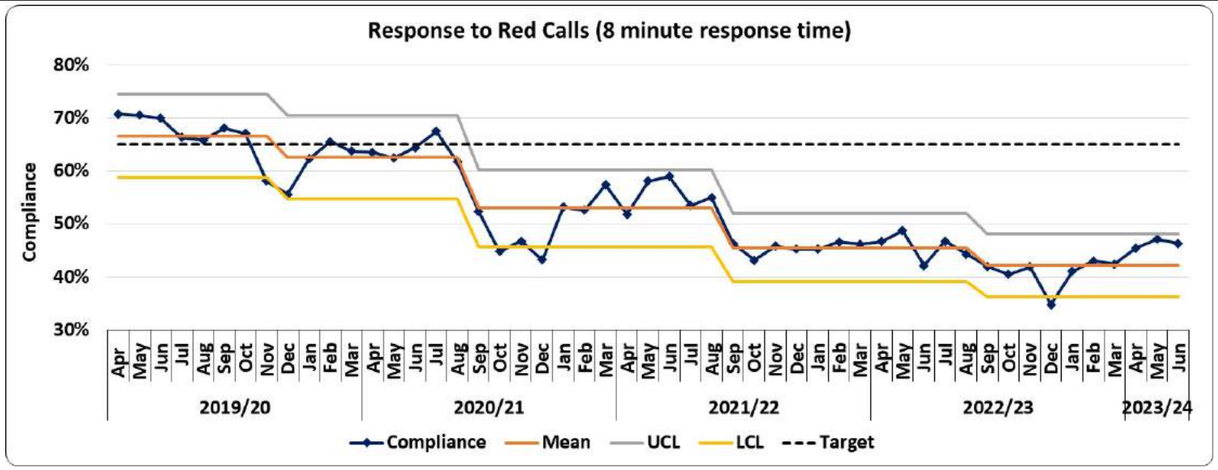
Status as at April 2023		
Health Board	Compliance	Rank
CTM	**90.9%**	**1st**
HDda	90.3%	2nd
SB	86.4%	3rd
BCU	83.8%	4th
Powys	81.6%	5th
AB	75.0%	6th
C&V	53.8%	7th



Status as at April 2023		
Health Board	Compliance	Rank
BCU	91.9%	1st
Powys	87.6%	2nd
SB	85.1%	3rd
AB	72.0%	4th
C&V	61.6%	5th
CTM	**47.8%**	**6th**
HDda	43.9%	7th

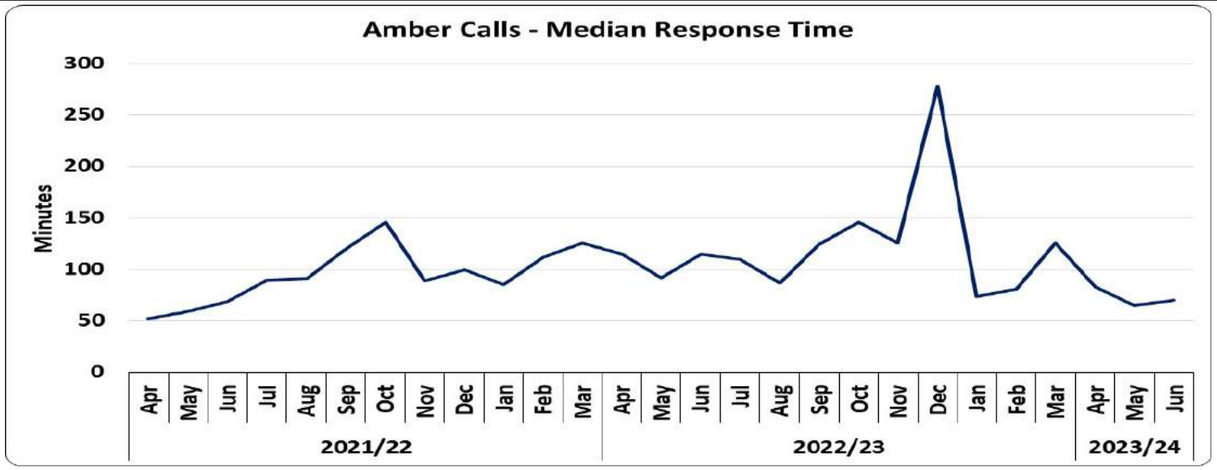
Emergency Ambulance Services – Response to Red Calls & Red Release Requests – June 2023

Response to Red Calls - % of emergency responses to Red Calls arriving within 8 minutes (Target 65%) June 2023 – 46.3%



Median emergency response time to amber calls – Target is 12 month improvement trend

June 2023 - 70 minutes



How are we doing?

Response to Red Calls: Response times to life-threatening calls dipped slightly to 46.3% in June with the National compliance, remaining stable at 54.6%. The minimum expected standard is for 65% of Red Calls to be responded to within 8 minutes.

The volume of Red Calls during June totalled 589 for the CTM area which is just under the 12 month average of 601 per month, but is 7.5% higher than the equivalent period of 2022 (548).

Median Response to Amber Calls: The median response times for serious, but not immediately life threatening calls was 70 minutes during June, which is just over a 36% improvement on the monthly median response times observed over the past 18 months (110 minutes).

What actions are we taking & when is improvement anticipated?

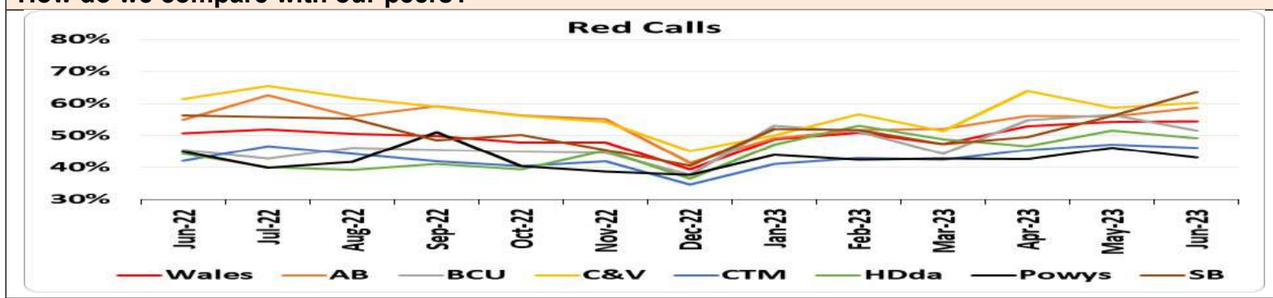
- Weekly data v improvement "deep dive" against trajectories
- Weekly performance/assurance meetings in place
- Navigation Hub increased utilisation
- Pan CTM - Immediate response and Pre-emptive transfer procedures reviewed
- Pan CTM Emergency Pressure Escalation Procedure review complete – plan launch
- Robust out of hours and weekend planning process in place
- Update Safe to Start process pan CTM
- Unscheduled Care Senior leadership team proactively engaged and leading programme for improvement
- Fortnightly Silver operational meetings between CTM and WAST established

What are the main areas of risk?

A number of Winter schemes (funded and unfunded) that were due to cease on 31st March 2023, have been extended. This includes an additional D2RA Ward at the Princess of Wales Hospital Site and the GP assessment area at Prince Charles Hospital.

These schemes are currenty supporting our ability to manage risk. This risk sits across a number of Care Groups.

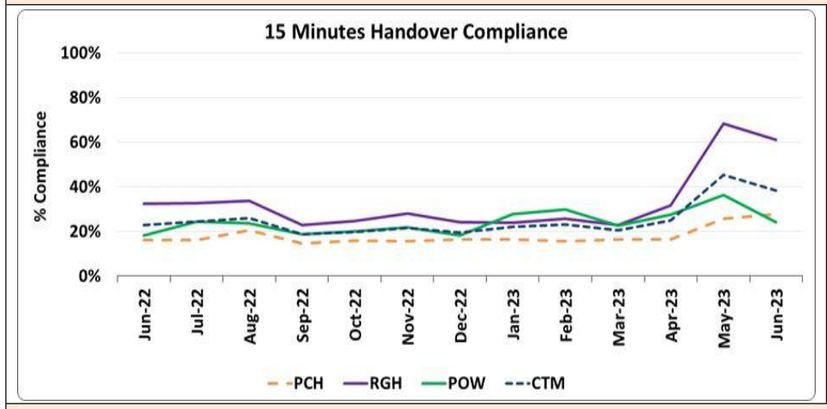
How do we compare with our peers?



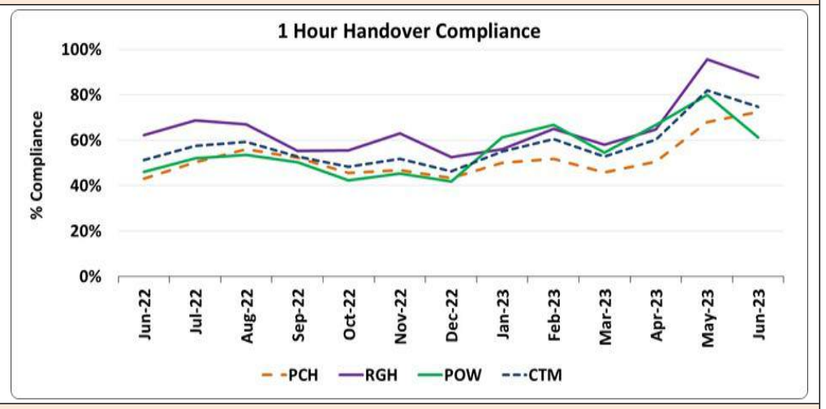
Status as at June 2023		
Health Board	**Compliance**	**Rank**
SB	63.6%	1st
C&V	60.3%	2nd
AB	58.8%	3rd
BCU	51.6%	4th
HDda	49.3%	5th
CTM	**46.3%**	**6th**
Powys	43.2%	7th

Emergency Ambulance Services - Handover Compliance – June 2023

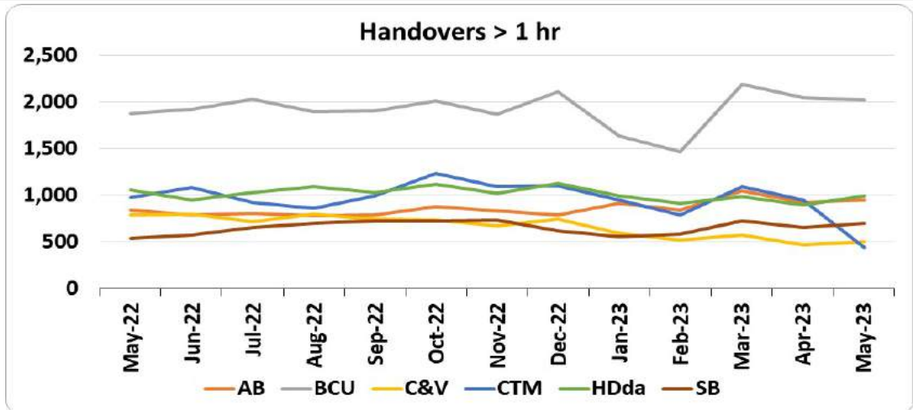
Number of ambulance handovers within 15 minutes – Target Improvement	Number of ambulance handovers over 1 hour – Target Zero - Please note that this measure is Quadruple Aim 4 but has been included in this area for ease of reference
Total handovers 2,346 of which 901 handovers were within 15 minutes (38.4%)	**594 handovers were over 1 hour (74.7% of handovers were within 1 hour)**



	PCH			RGH			POW			CTM		
Period	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %	Handovers	15 Mins %	1 Hour %
Jun-22	777	16.1%	43.1%	845	32.4%	62.4%	596	18.3%	46.0%	2218	22.9%	51.2%
Jul-22	798	16.0%	50.3%	791	32.7%	68.8%	596	24.3%	52.2%	2185	24.3%	57.5%
Aug-22	808	20.4%	56.1%	748	33.7%	67.1%	568	23.6%	53.5%	2124	25.9%	59.3%
Sep-22	761	14.6%	52.4%	759	22.9%	55.2%	591	18.8%	50.4%	2111	18.8%	52.9%
Oct-22	984	15.8%	45.5%	821	24.7%	55.7%	587	19.9%	42.2%	2392	19.9%	48.2%
Nov-22	909	15.6%	46.8%	773	28.1%	63.0%	597	21.8%	45.2%	2279	21.5%	51.9%
Dec-22	775	16.3%	43.2%	745	24.0%	52.5%	527	18.2%	41.7%	2047	19.6%	46.2%
Jan-23	812	16.5%	50.1%	750	23.9%	56.0%	564	27.8%	61.2%	2126	22.1%	55.1%
Feb-23	750	15.7%	51.7%	734	25.7%	65.1%	518	29.7%	66.8%	2002	23.0%	60.5%
Mar-23	849	16.3%	45.9%	873	22.9%	58.1%	593	22.6%	54.6%	2315	20.4%	52.7%
Apr-23	857	16.3%	50.5%	830	31.7%	64.8%	711	27.4%	66.8%	2398	24.9%	60.3%
May-23	831	25.8%	68.0%	962	68.3%	95.5%	678	36.3%	79.9%	2471	45.2%	82.0%
Jun-23	875	27.8%	72.5%	822	60.9%	87.7%	649	24.2%	61.2%	2346	38.4%	74.7%

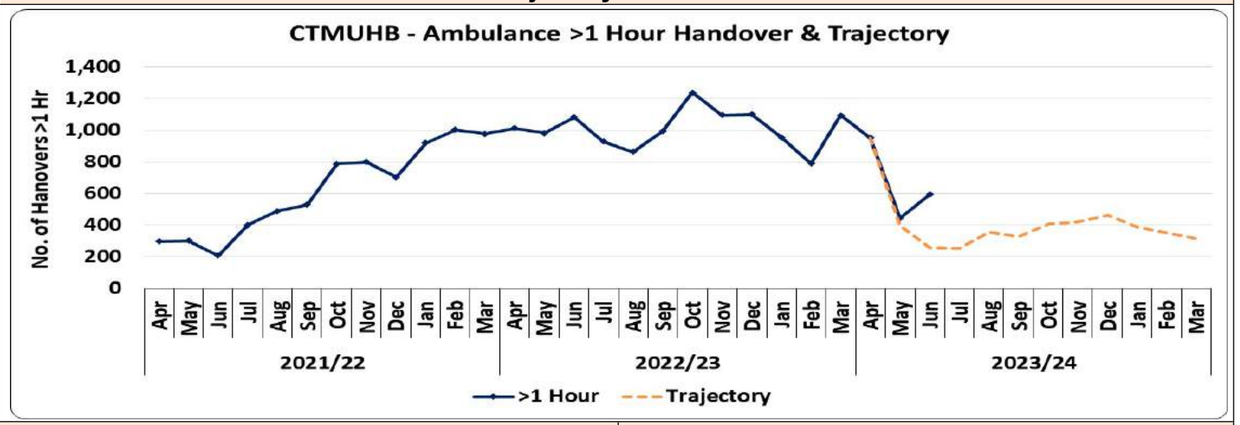


How do we compare with our peers?



Status as at May 2023		
Health Board	Compliance	Rank
CTM	445	1st
C&V	506	2nd
SB	706	3rd
AB	951	4th
HDda	993	5th
BCU	2,025	6th

Reduce >1 Hour Ambulance Handover Trajectory



How are we doing?

Ambulance conveyances to ED are 6% higher in June 23 than they were in June 22, with performance against the 15 minute and 60 minutes handover improving by 15% and 23% respectively.

Performance has however deteriorated in comparison to May, at 38.4% (45.2% in May) and 74.7% (82% in May) respectively. In total there were 594 patients and ambulance crews detained for greater than an hour.

During 2022/23, the number of patients waiting more than 1 hour for their transfer of care averaged 1,012 patients per month. Thus far, the average for this year equates to 664 patients, representing a 34% reduction in the number of patient breaches.

The time lost between notification and handover more than 15 minutes has also improved from 5,127 hrs to 1,911 hrs over the same period of time.

What actions are we taking & when is improvement anticipated?

As per the actions on the previous page with:

- Focused improvement programme to reduce Ambulance Handover delays "go live" at Royal Glamorgan hospital – 28 April 2023 with roll out to Princess of Wales Hospital and Prince Charles Hospital
- Ambulance Handover Escalation Card in place

What are the main areas of risk?

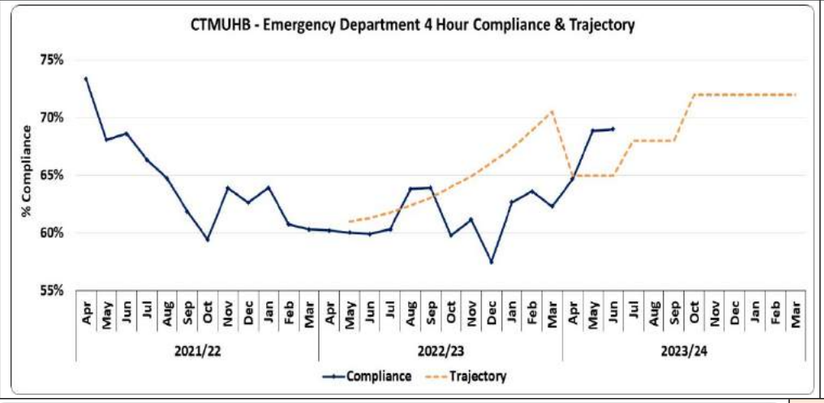
System flow remains highly impacted by capacity within social care.

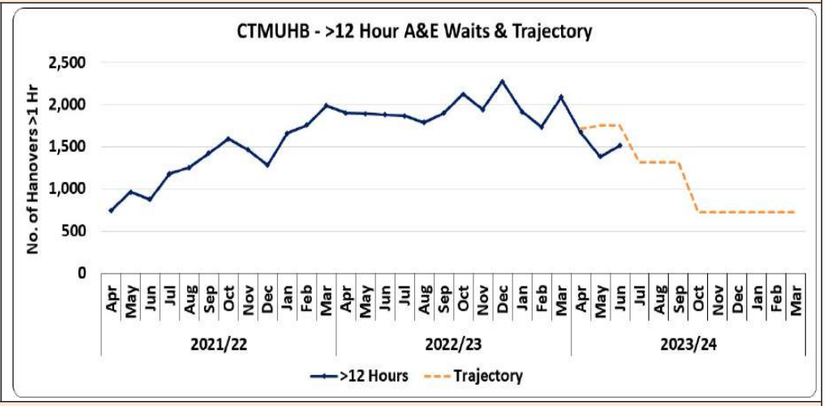
Activity has increased resulting in uncommissioned capacity being utilised to manage demand

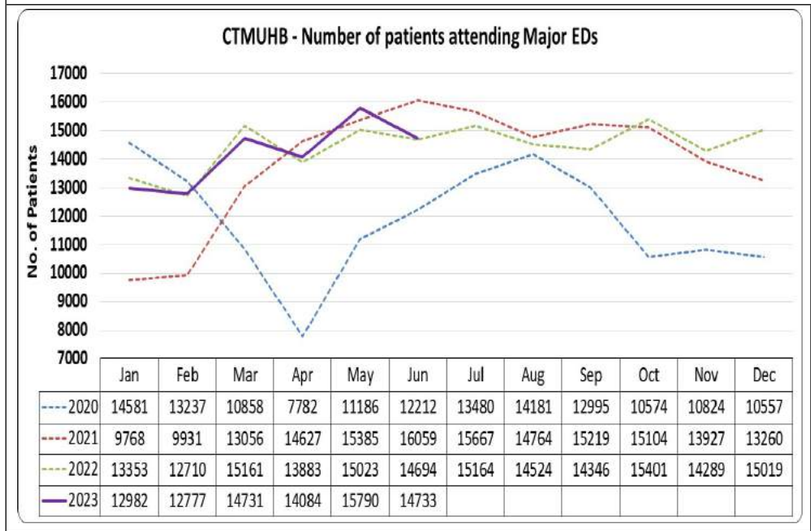
Emergency Unit Waits – June 2023 (Provisional Position) - Total Attendances 16,687

% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge - Target Improvement compared to the same month in 2022/23, towards the national target of 95%	Number of patients who spend 12 hours or more in emergency care facilities from arrival to admission, transfer or discharge - Target Improvement trajectory towards a national target of Zero by 31st March 2024
69.0% were seen within 4 hours (Waiting >4 hrs 5,169)	**9.9% of patients were waiting over 12 hours (1,517)**

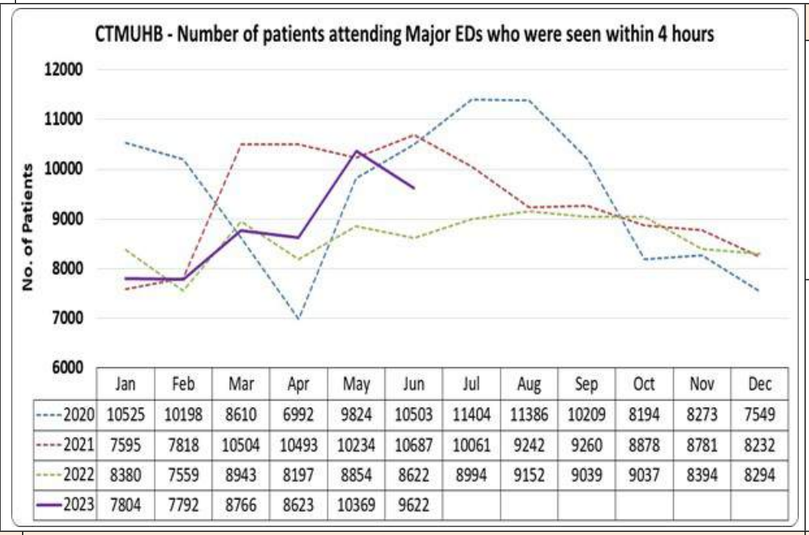
	CTMUHB		
Period	Attendances	4 Hrs %	> 12 Hrs
Jun-22	15149	59.9%	1886
Jul-22	15553	60.3%	1873
Aug-22	14858	63.8%	1794
Sep-22	14715	63.9%	1900
Oct-22	15830	59.8%	2128
Nov-22	15225	61.2%	1946
Dec-22	15829	57.5%	2280
Jan-23	13882	62.7%	1920
Feb-23	13722	63.6%	1740
Mar-23	15844	62.3%	2092
Apr-23	15508	64.7%	1676
May-23	17532	68.9%	1384
Jun-23	16687	69.0%	1517





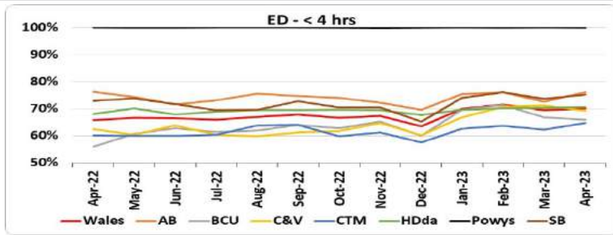


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	14581	13237	10858	7782	11186	12212	13480	14181	12995	10574	10824	10557
2021	9768	9931	13056	14627	15385	16059	15667	14764	15219	15104	13927	13260
2022	13353	12710	15161	13883	15023	14694	15164	14524	14346	15401	14289	15019
2023	12982	12777	14731	14084	15790	14733						

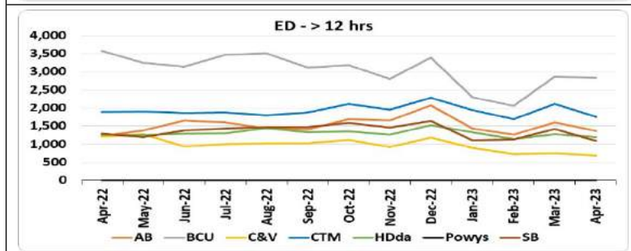


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	10525	10198	8610	6992	9824	10503	11404	11386	10209	8194	8273	7549
2021	7595	7818	10504	10493	10234	10687	10061	9242	9260	8878	8781	8232
2022	8380	7559	8943	8197	8854	8622	8994	9152	9039	9037	8394	8294
2023	7804	7792	8766	8623	10369	9622						

How do we compare with our peers?



Status as at April 2023		
Health Board	Compliance	Rank
Powys	99.8%	1st
AB	76.2%	2nd
SB	75.2%	3rd
HDda	70.7%	4th
C&V	69.3%	5th
BCU	65.9%	6th
CTM	**64.7%**	**7th**



Status as at April 2023		
Health Board	Compliance	Rank
Powys	0	1st
C&V	696	2nd
SB	1,095	3rd
HDda	1,199	4th
AB	1,373	5th
CTM	**1,759**	**6th**
BCU	2,827	7th

How are we doing?

Demand for ED has been almost 11% higher during the first quarter of this year than the equivalent time span of 2022 and attendances during June being 10% higher than the same period of 2022.

The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival at our emergency care facilities remained almost static at 69% in June and continues to remain below the compliance target of 95%.

The improved 12 hours performance observed during May was not sustained during June, with the number of patients who were waiting in excess of 12 hours increasing by around 10% to 1,517.

What actions are we taking & when is improvement anticipated?

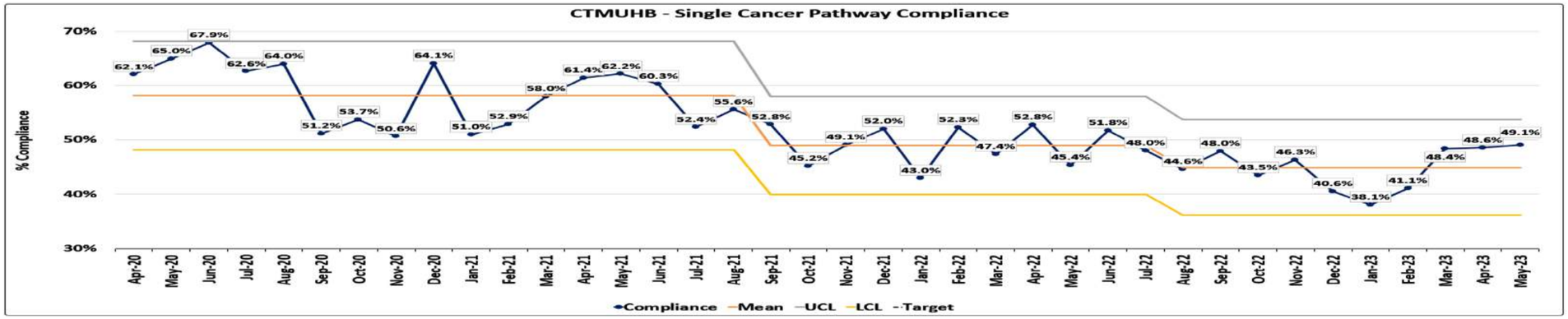
- <4 Hour Trajectories agreed / >12 Hours to be agreed
- Weekly data v improvement "deep dive" against trajectories
- Weekly performance/assurance meetings in place
- Progress development of medical SDEC within PCH and POW incorporating frailty
- Review footprint / activity / workforce
- Audit of reporting measures being undertaken across CTM by CTM internal audit colleagues.
- Ambulance Lost Hours improvement driving flow from ED
- Capital requirements for the SDEC implementation at PCH has been approved and capital design tender process underway. Planned implementation December/January.

What are the main areas of risk?

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

Single Cancer Pathway (SCP) – May 2023

% of patients starting first definitive cancer treatment within 62 days from point of suspicion. Target is Improvement Trajectory towards a national target of 80% by 31st March 2026 **Compliance May 2023 – 49.1%**

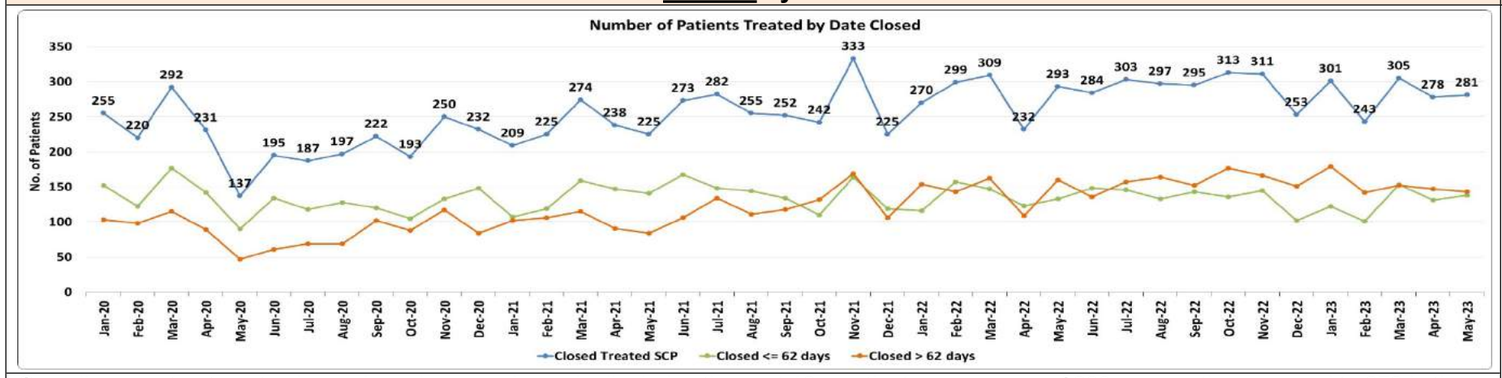


CTMUHB - SCP % Treated Without Suspensions - May 2023				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated in Target Without Suspensions
Head and neck	4	7	11	36.4%
Upper GI	10	15	25	40.0%
Lower GI	12	17	29	41.4%
Lung	23	16	39	59.0%
Skin (exc BCC)	45	12	57	78.9%
Breast	25	22	47	53.2%
Gynaecological	2	11	13	15.4%
Urological	11	36	47	23.4%
Haematological	4	5	9	44.4%
Other	2	2	4	50.0%
Total	138	143	281	49.1%

Performance for May marginally improved to 49.1%, with none of the tumour sites reaching the desired target threshold, as seen in the table above. Predicted compliance for June currently stands at 51.1%.

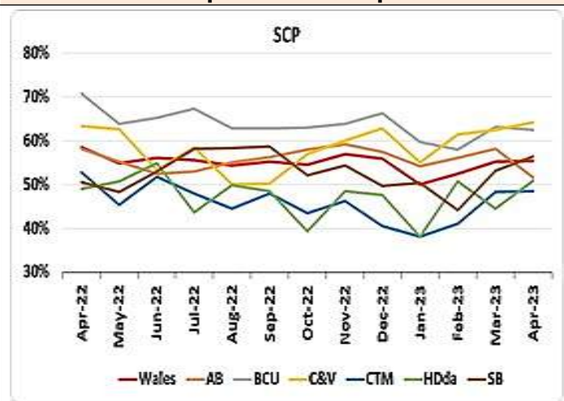
Delays at first outpatient (35%) and diagnostic stage (48%) continue to be the biggest concern and significant factor for not achieving target. Diagnostic delays remain in radiology for CTC's, endoscopy and pathology. Tertiary delays for diagnostics & treatments continue.

Patients Treated by Closed Date



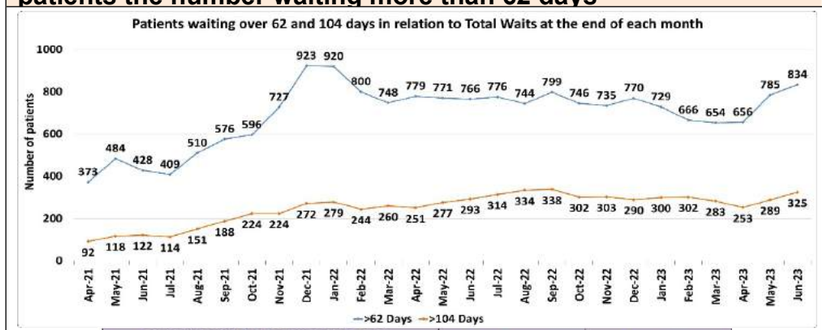
Overall cancer treatment volumes have increased marginally during the past 12 months to an average of 289 per month, compared to 272 in the previous 12 month period. This represents an average monthly increase of 6%.

How do we compare with our peers?



Status as at April 2023		
Health Board	Compliance	Rank
C&V	64.2%	1st
BCU	62.5%	2nd
SB	56.5%	3rd
AB	51.6%	4th
HDda	51.0%	5th
CTM	48.6%	6th

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



SCP "Active" Waits >62 days (data as at 3rd July 2023)	>62 to 124 days	125+ days
Sarcoma	5	
Breast	20	
Brain/CNS		
Gynaecological	168	26
Haematological (exc acute leukaemia)	11	3
Head and neck	16	3
Lower GI	209	83
Lung	28	5
Skin (exc BCC)	19	6
Upper GI	48	30
Urological	94	52
Other	7	1
Total	625	209

What actions are we taking & when is improvement anticipated?

- New Breast surgeon commenced 26th June
- Ongoing discussions with BSW. Awaiting feedback re BSW reporting – concern there is variation throughout Wales
- FIT implemented across all CTM
- T&F group being set up to work through and implement urology action plan
- Shifting of transnasal endoscopies out of endoscopy theatre – room has been identified
- Centralisation of Breast services from all three DGH sites into the Snowdrop Centre, Llantrisant Health Park planned before September
- Merging of Lower GI departments, along with centralisation of operating on one site for major cases & standardisation of all pathways. Proposal currently in development for COO.
- Extension of nurse led triage to RGH site for lower GI
- Transfer of POW Gynae Post Menopausal Bleeding (PMB) patients to gynae hub for scanning. Exploring all options to facilitate hysteroscopy in gynae hub @ RGH
- Outsourcing of pathology

What are the main areas of risk?

- 83% of all patients on the active SCP are at 1st outpatient or diagnostic stage
- Resources required to effectively plan and implement the Wrapper / Canisc replacement Programme.
- Delays in pathology, endoscopy continue with deterioration in SB path for POW patients- currently 6/52
- Delays in tertiary investigations & treatments at SB, Velindre Cancer Centre and C&V.
- Bowel Screening Wales diagnostic colonoscopy – waits up to 6/12 from screening assessment. Now account for 43% of all pre diagnostic active patients within lower GI & 72% of the backlog
- Urology tumour site – nursing establishment
- PMB at NPT
- Implementation of genomic testing for new targeted therapies
- PAC
- Reduced activity due to impending strike action & leave over summer holiday period – plans in place for individual tumour sites to ensure cancer patients not affected

Diagnostics & Therapies – June 2023 (Provisional Position)

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

CTMUHB - Number of Patients waiting more than 8 Weeks for a Diagnostic Test		
Cardiology	Echo Cardiogram	660
Cardiology Services	Cardiac CT	2
	Cardiac MRI	4
	Diagnostic Angiography	88
	Stress Test	34
	DSE	51
	TOE	2
	Heart Rhythm Recording	102
	B.P. Monitoring	1
Bronchoscopy		4
Colonoscopy		595
Gastroscopy		684
Cystoscopy		606
Flexi Sig		706
Radiology	Non-Cardiac CT	701
	Non Cardiac MRI	1290
	NOUS	8027
	Non-Cardiac Nuclear Medicine	53
Imaging	Fluoroscopy	88
Physiological Measurement	Urodynamics	115
Neurophysiology	EMG	302
	NCS	253
Total		14368

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	15,437	15,579	15,363	15,080	15,315	15,570	15,547	15,651	15,886	16,114	15,294	15,299
2023/24	15,727	15,689	14,368									

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

CTMUHB - Number of Patients waiting more than 14 Weeks for a Therapy	
Arts Therapy	1
Audiology	26
Dietetics	1223
Occupational Therapy	33
Physiotherapy	0
Podiatry	0
Speech & Language	172
Total	1455

Therapies	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	1,019	1,370	1,265	1,570	1,795	1,589	1,615	1,452	1,474	1,284	1,175	1,145
2023/24	1,173	1,323	1,455									

Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional – Target is improvement trajectory towards a national target of zero by 31st March 2024

CTMUHB - % of children waiting more than 14 Weeks for AHP	
Arts Therapy	0.0%
Audiology	35.3%
Dietetics	83.0%
Occupational Therapy	90.1%
Physiotherapy	100.0%
Podiatry	100.0%
Speech & Language	71.7%
Total	52.8%

AHP	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	64.4%	68.0%	66.3%	66.1%	56.1%	62.4%	56.7%	49.4%	49.3%	49.4%	49.6%	50.6%
2023/24	50.5%	51.5%	52.8%									

How are we doing?

Diagnostics: At the end of June, 14,368 patients had been waiting in excess of 8 weeks for a diagnostic procedure, which as it currently stands is a reduction of 8.4% (1,321) on the number of patients waiting over 8 weeks that was reported at the end of May.

Endoscopy observed a further improvement of around 6% in the number patients waiting in excess of eight weeks (156 patients), although the number of patients currently breaching the target now stands at 2,595.

The NOUS service continues to have the highest volume of breaching patients with 8,027 currently waiting over 8 weeks for a scan, however a reduction of almost 10% (881) is observed from the May reported position.

Therapies: There are provisionally 1,455 patients breaching the 14 week target for therapies in June, an increase of 10% (132 patients) on the reported position for May.

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

What actions are we taking & when is improvement anticipated?

Endoscopy: Transformation Programme commenced across CTM looking at new ways of working around scheduling, productivity and efficiencies.

Electronic partial booking and text reminder service gone live with good success. The "6-4-2" model agreed and we await a "go live" date.

Weekly Task and Finish Group rolled out with key stakeholders to set priorities, actions and monitor delivery. Standardised templates commenced at PCH to be rolled out across CTM.

Trans Nasal Endoscopy service due to commence 24/07/23 with 2 dedicated clinic rooms within the outpatient setting.

Bowel Screening Wales recovery plan drafted with recovery schemes, planned activity, timeframes and financial risks.

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

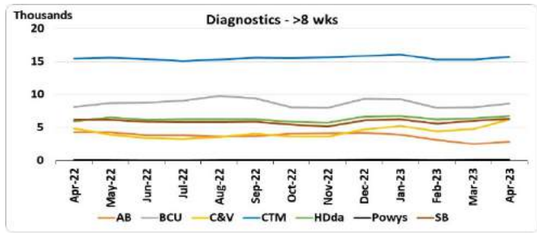
Booking has continued through June with additional weekend and evening slots for Non Obstetric Ultrasound scanning. Now starting to see a steady reduction in the patients waiting over 8 weeks.

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

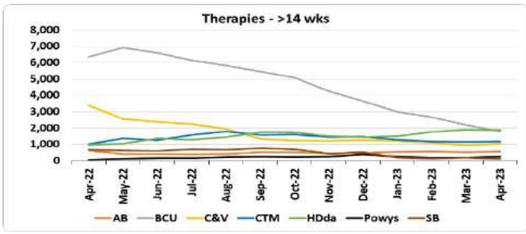
What are the main areas of risk?

- Demand and Capacity imbalance shown in most diagnostic and therapy services as demand has risen. Also CT colon demand likely to rise further with new BSW protocols for earlier screening for younger patients.
- Radiology service continues to hold a number of Consultant vacancies. Looking to re-advertise with good potential to recruit in the next 2 months.
- Endoscopy Competing Priorities – faces challenges with competing priorities with the service trying to deliver and maintain the cancer pathway, accommodate longest waiters for delivery of the RTT targets 156 & 104 weeks, hit the 8 week diagnostic target whilst reducing the backlog of overdue surveillance patients.
- Neurophysiology Services – following a recent reduction in the availability of Neurology services in CTM, capacity for Nerve Conduction Studies has been significantly reduced. This will have a direct impact on delivery for the Orthopaedic targets going forward.
- Cardio Pulmonary Service – Backlogs in CPU will continue to directly impact on the delivery of Cardiology targets.

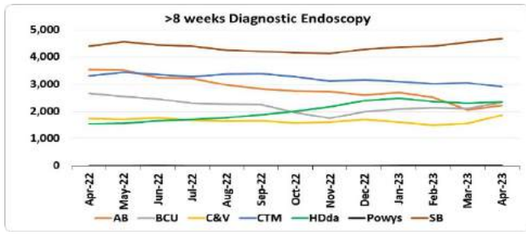
How do we compare with our peers?



Status as at April 2023		
Health Board	Compliance	Rank
Powys	159	1st
AB	2,882	2nd
C&V	6,267	3rd
SB	6,320	4th
HDda	6,767	5th
BCU	8,686	6th
CTM	**15,727**	**7th**



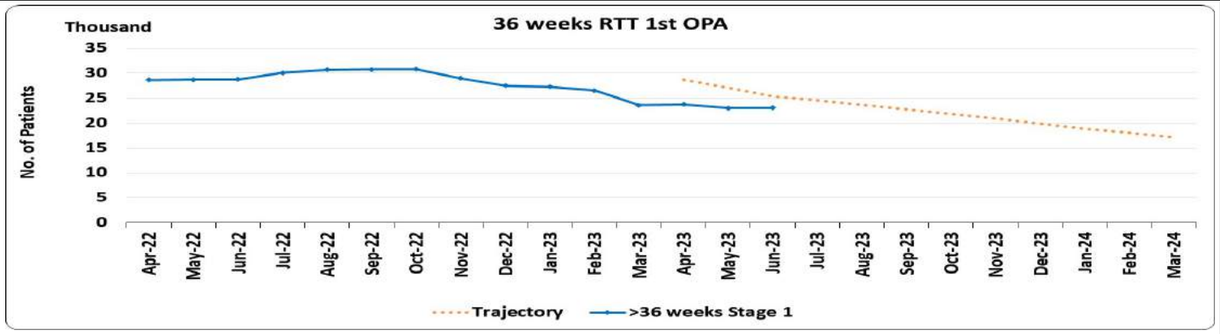
Status as at April 2023		
Health Board	Compliance	Rank
SB	129	1st
Powys	243	2nd
AB	572	3rd
C&V	1,037	4th
CTM	**1,173**	**5th**
BCU	1,791	6th
HDda	1,882	7th



Status as at April 2023		
Health Board	Compliance	Rank
Powys	17	1st
C&V	1,866	2nd
AB	2,219	3rd
BCU	2,324	4th
HDda	2,340	5th
CTM	**2,902**	**6th**
SB	4,677	7th

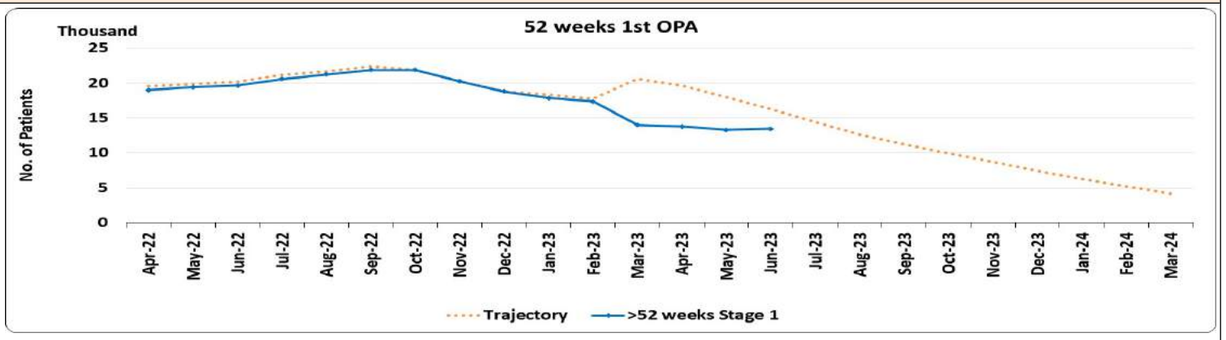
Referral to Treatment Times (RTT) – June 2023 (Provisional Position)

Number of patients waiting **over 36 weeks** for a **new outpatient appointment (23,065)** - Target is Improvement Trajectory towards a national target of Zero



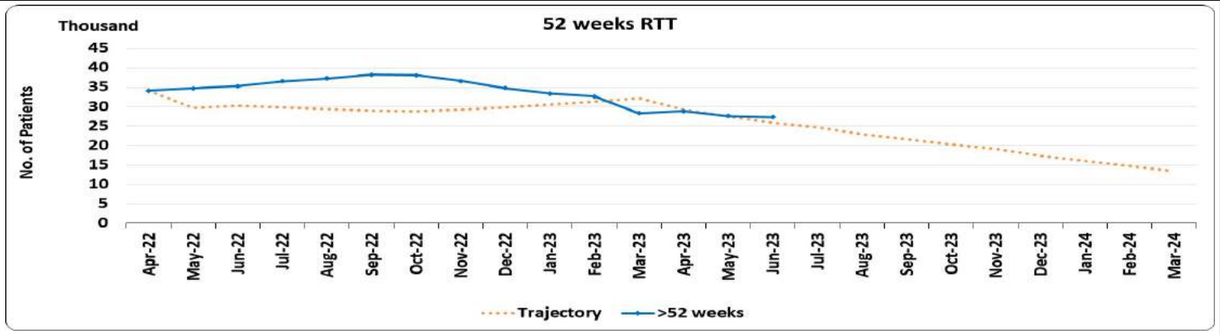
The provisional position across the Health Board for patients waiting over 36 weeks at Stage 1 (1st Outpatient Appointment) at the end of June is 23,065, which as it currently stands is a small increase (73) from the May reported position. (N.B. includes the 13,481 Stage 1 patients waiting over 52 weeks).

Number of patients waiting **over 52 weeks** for a **new outpatient appointment (13,481)** - Target is Improvement Trajectory towards a national target of Zero



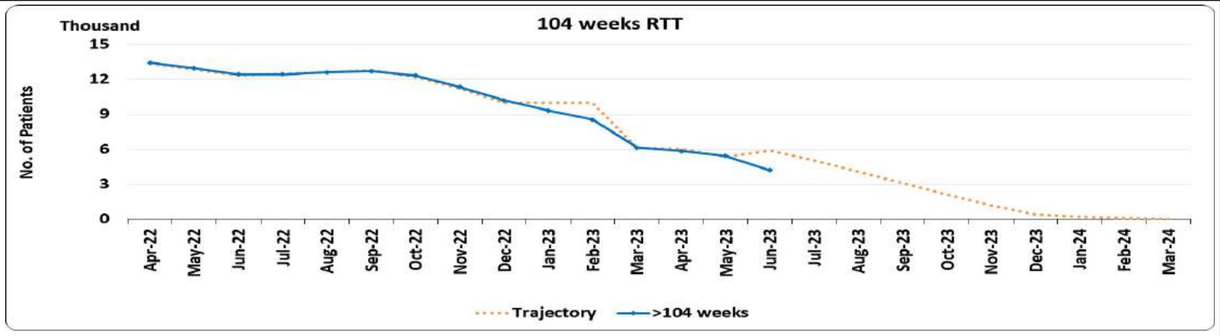
The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of June is 13,481, an increase of 1.1% (147) from the May reported position. The variance from the trajectory is explained by the large number of urgent patients still waiting more than 4 weeks for an appointment.

Number of patients waiting **>52 weeks RTT** (**27,251**) – Target is Improvement Trajectory towards a national target of Zero



The provisional position across the Health Board for patients waiting over 52 weeks for referral to treatment at the end of June is 27,251, a small reduction of 1.1% (318) from the May reported position.

Number of patients waiting **>104 weeks (4,228)** - Target is Improvement Trajectory towards a national target of Zero



The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for referral to treatment at the end of June is 4,228, a reduction of 22% (1,202) from the reported May position.

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

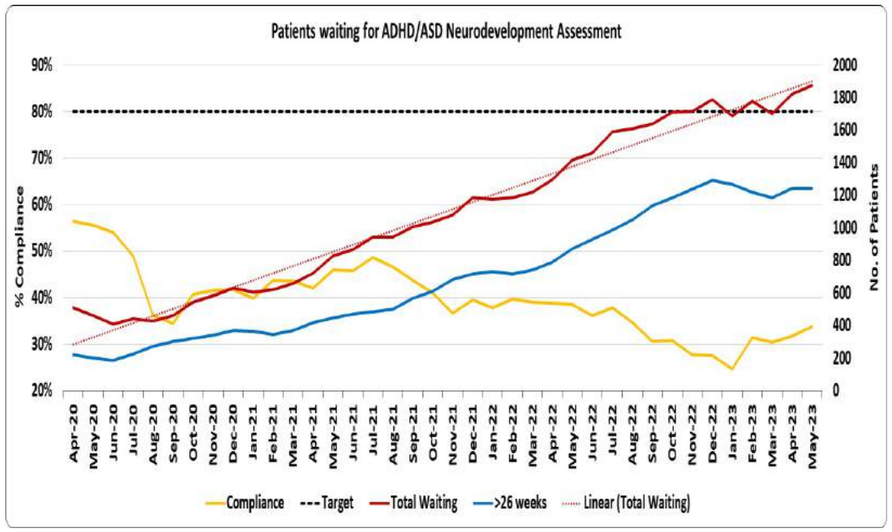
Specialty	Number of Urgent Patients Waiting >12 Weeks	>36 to 52 Weeks	>52 Weeks to 104 Weeks	>104 Weeks	Total Open Pathways
Anaesthetics	138	202	240	36	1027
Cardiology	891	780	229		5126
Care of the Elderly		0	0		56
Dermatology	1585	1251	1634	136	7901
Endocrinology	3	53	4		396
Gastroenterology	1031	567	585	62	3808
General Medicine	496	382	366	101	2842
Nephrology	22	0	0		168
Respiratory Medicine	98	238	211		2114
Rheumatology	334	132	186	60	1538
Sport and Exercise Medicine		0	0		10
Thoracic Medicine	17	40	8		631
Geriatric Medicine	2	0	0		51
Diagnostics		958	2054	172	8797
Therapies		316	45		3099
Ophthalmology	461	2014	4536	390	14352
Oral Surgery	655	507	372	45	3264
Orthodontics	76	28	2		302
Restorative Dentistry	27	19	64		169
Ear, Nose & Throat Service	724	1502	4140	618	12475
Gynaecology	972	1128	1642	480	8461
Paediatrics	197	225	33		2820
Haematology (Clinical)	24	5	0		267
General Surgery	706	1117	2628	390	8596
Orthopaedics	1904	2268	4669	895	13931
Urology	1079	856	2301	595	7397
Breast Surgery	409	210	416	87	1401
Colorectal	619	591	886	122	3501
Rapid Diagnostic Centre		0	0		109
Total	**12470**	**15389**	**27251**	**4189**	**114500**

RTT continued on the next page…

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

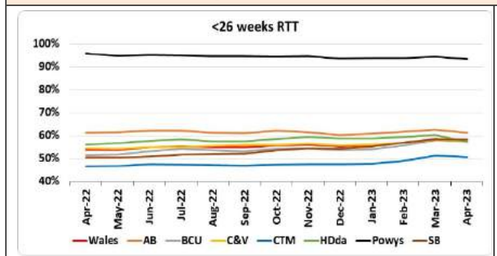
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
Breast Disaggregation- date agreed, clinically there are specific challenges for workforce and infrastructure such as clinic nursing and booking process. Snowdrop Unit: Shortly introducing LA lists Cross site working in General Surgery has begun to clear the >104 week cohort New trauma service model imperative to increase in productivity and activity levels is being developed, however the time line is anticipated to slip beyond August. The 'withdrawal' from the Neath orthopaedic service is close to being finalised, however owing to amendments in the agreement as to which patients will have their care managed by Swansea Bay and the levels of activity already delivered, it is estimated that the associated waiting list reduction will be 150 patients fewer than assessed in the trajectories.	• Posts to be scrutinised in line with prudent health care principles • Vascular – need to pursue network funding arrangements for job plan changes. • New trainees for T&O, ENT and General Surgery • New consultant started in Urology with cross site working • New Corneal surgeon appointed with a September start date; working across sites • New Consultant General surgeon starting in September • Consultant Orthopaedic Surgeon starting in August	• Elective activity with increase of trauma since Covid • Patients requiring increased supervision • Medical staffing rota compliance • HSDU Capacity and Infrastructure risks – ability to manage increased activity • Pre-op Assessment delays in RGH • Delays with Echo's, manometry, NCS • No plans from Diagnostics to clear backlogs • Restrictions on the recruitment of operational staff due to the OCP which is putting excessive strain on operational teams and reducing capacity to manage delivery plans.

% of patients waiting less than 26 weeks to start an ADHD/ASD Neurodevelopment Assessment (33.8%) -Target 80%

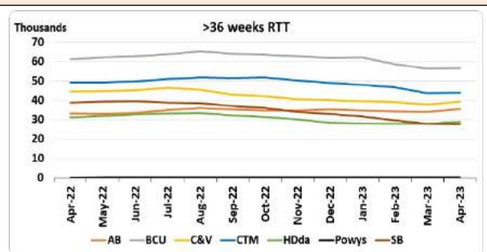


How are we doing?	What actions are we taking & when is improvement anticipated?	What are the risks?
Although a minor improvement in performance is observed from February 2023, the chart to the left highlights that there has been a significant deterioration in the compliance over the last three years against the 26 week target for Neurodevelopment services, with compliance at 33.8% for May and continuing to remain well below the target threshold of 80%. Short term funding has meant that we have been able to deliver WLIs so that no children will be waiting >104 weeks for an assessment. Currently there are 640 patients to be seen before end of March 2024, before reaching 104 weeks. Core capacity will provide 400 and the remainder will need to be seen via WLI to prevent 104 week breach by end of March.	Children & Families are looking to utilise the £100k ND IP resource for waiting list reduction. Further discussions are being convened with planning colleagues to scope options around funds linked to pre & post support. The ND improvement programme is looking at service redesign, spanning early intervention, assessment, education and transition. A workshop took place on 4th July 2023 with the wider multi-disciplinary team to review pathways, devise a single point of access and provide a pan CTM approach. Working group is in place to review the repatriation of the Bridgend element via SLA with SBUHB, with a proposed date of 1st August 2023 being pursued.	Demand outstrips capacity. A better understanding is needed of what is currently offered by the third sector and wider community services and what gaps exist. Resource constraints on multidisciplinary provision that lead to assessment outcomes. Identifying constraints that are impacting on the ability to deliver timely services. Reliance on short term funding does not provide a longer term solution, hence services are being reviewed with partners

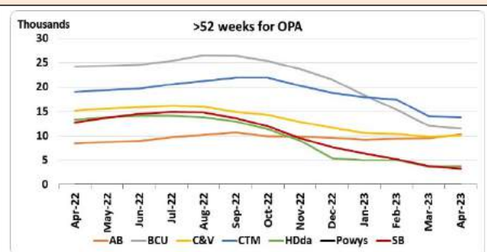
How do we compare with our peers?



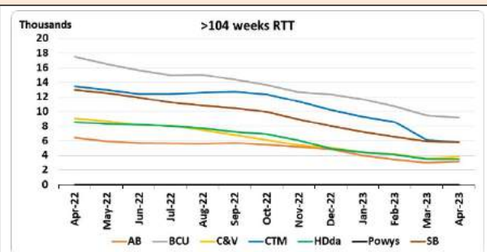
Status as at April 2023		
Health Board	Compliance	Rank
Powys	93.4%	1st
AB	61.3%	2nd
SB	58.3%	3rd
C&V	57.6%	4th
BCU	57.4%	5th
HDda	57.3%	6th
CTM	**50.7%**	**7th**



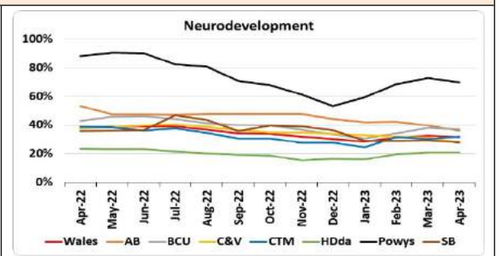
Status as at April 2023		
Health Board	Compliance	Rank
Powys	164	1st
SB	27,714	2nd
HDda	28,851	3rd
AB	35,581	4th
C&V	39,366	5th
CTM	**43,884**	**6th**
BCU	56,699	7th



Status as at April 2023		
Health Board	Compliance	Rank
Powys	1	1st
SB	3,306	2nd
HDda	3,739	3rd
C&V	10,175	4th
AB	10,295	5th
BCU	11,503	6th
CTM	**13,812**	**7th**



Status as at April 2023		
Health Board	Compliance	Rank
Powys	0	1st
AB	3,227	2nd
HDda	3,537	3rd
C&V	3,852	4th
SB	5,822	5th
CTM	**5,855**	**6th**
BCU	9,188	7th



Status as at April 2023		
Health Board	Compliance	Rank
Powys	69.7%	1st
BCU	37.0%	2nd
AB	36.3%	3rd
CTM	**31.9%**	**4th**
SB	28.2%	5th
C&V	27.9%	6th
HDda	21.0%	7th

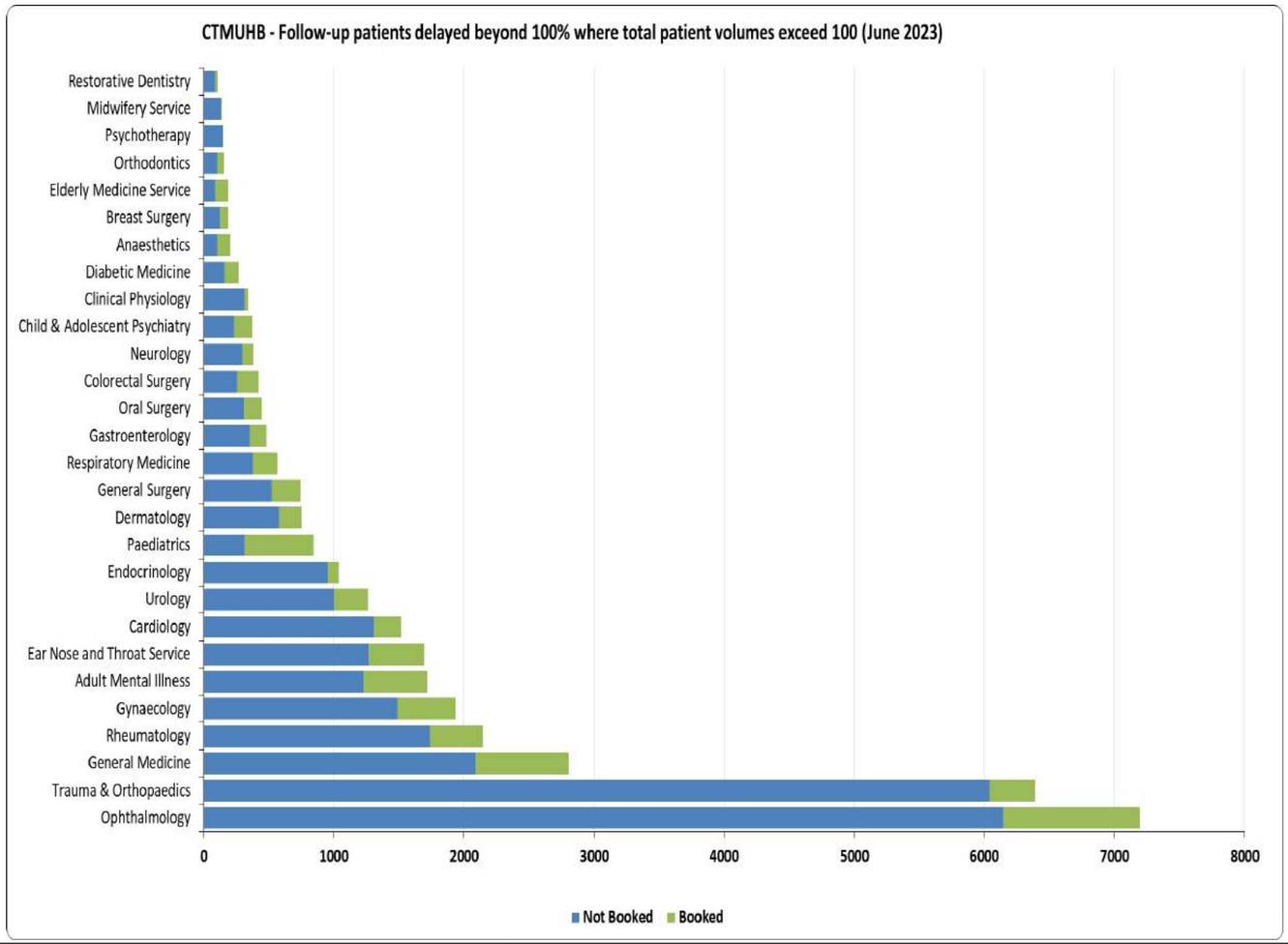
Follow-up Outpatients Not Booked (FUNB) – Provisional Position June 2023

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

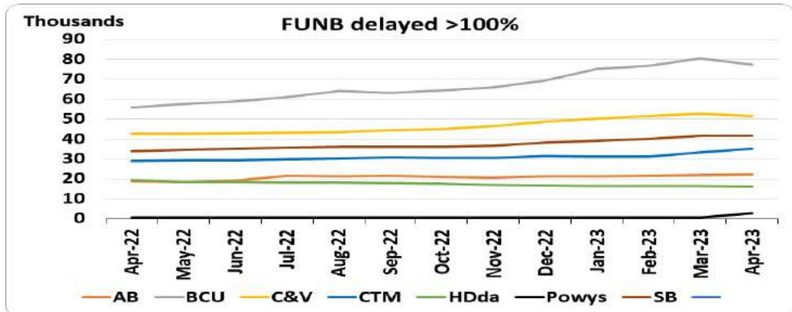
No. of patients waiting for follow-up appointment			
No documented target date	Not Booked	Booked	Total
0	81,619	53,134	134,753

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

No. of patients delayed over 100% past their target date			
Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
27,986	6,833	34,819	25.8%



How do we compare with our peers?



Status as at April 2023		
Health Board	Compliance	Rank
Powys	2,889	1st
HDda	16,181	2nd
AB	22,106	3rd
CTM	**35,260**	**4th**
SB	41,611	5th
C&V	51,630	6th
BCU	77,319	7th

How are we doing?

The number of patients waiting for a follow-up appointment in Cwm Taf Morgannwg UHB, at the end of June 2023, provisionally stands at 134,753 which is an increase of almost 18% on the patients waiting during the equivalent period of 2022. There are currently no patients without a documented target date

Of the patients waiting, 34,189 (around 26%) have been waiting more than 100% longer than their clinician advised, representing an increase of 18.4% on the equivalent period last year.

Combined outpatient activity levels during June 2023 continue to be below pre-Covid levels (around 10% fewer) but 5% higher than the equivalent period of 2022, with the provisional June figures below for new and follow-up patients compared to prior the pandemic:

- Total New Patients seen: 17,114 which is a reduction of around 6% on the 11 month average preceding the Covid pandemic (April 19 to Feb 20) of 18,186.
- Total Follow-up Patients seen: 34,205 which is a 13.4% reduction on the 11 month average preceding the Covid pandemic (April 19 to Feb 20) of 39,506.

What actions are we taking & when is improvement anticipated?

General Surgery: Ongoing validating of the FUNB list with regular consultant input. Return to normal capacity for follow up appointments.

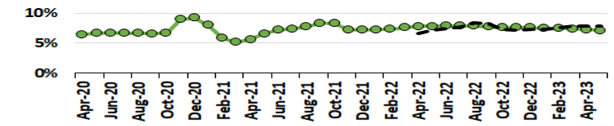
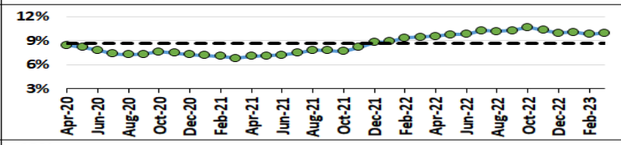
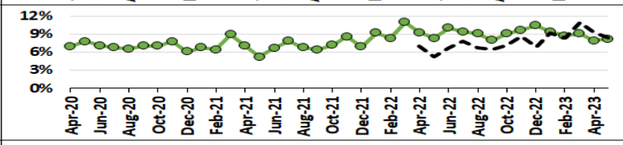
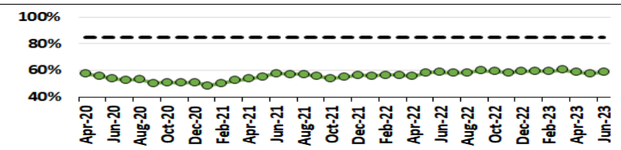
Orthopaedics: Ongoing consultant validating of their FUNB list as significant numbers are not anticipated to require a follow up appointment. Booking of all follow ups into clinics to reduce the FUNB holding list, utilising any spare capacity. Utilise any surplus capacity from the SBU disaggregation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

What are the main areas of risk?

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

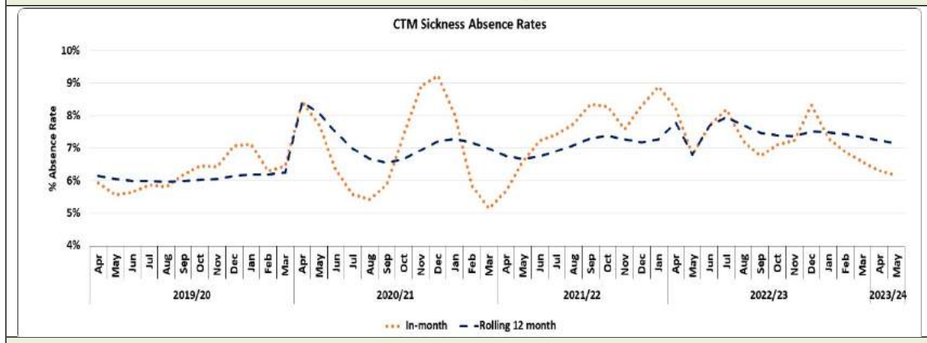
Orthopaedics: Administrative support to remove patients from the FUNB after validating.

Quadruple Aim 3: A Motivated & Sustainable Workforce

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable					
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Motivated & Sustainable Workforce	% of sickness absence rate of staff	12 Month Reduction Trend		7.2%	May-23
	Turnover rate for nurse & midwifery registered staff leaving NHS Wales	Rolling 12 month reduction against a baseline of 2019-20 (8.65%)		9.97%	Mar-23
	Agency spend as a percentage of the total pay bill	12 Month Reduction Trend		8.2%	May-23
	Qualitative report detailing progress made in preparation to embed and report against the Workforce Race Equality Standard (WRES) indicators	Evidence of activity undertaken to prepare to embed reporting against the Workforce Race Equality Standard (WRES) (as described in the reporting template to be released September 2023)	Data not available as yet		
	Qualitative report detailing the progress made against the organisation's prioritised Strategic Equality Plan's equality objectives	Evidence of progress and improvement, along with key risks to delivery, of the identified equality objectives	Data not available as yet		
Training & Development	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training	85%		58.7% *Please note this currently excludes medical appraisals*	Jun-23
	Qualitative report detailing progress to improve dementia care (providing evidence of learning and development in line with the Good Work - Dementia Learning & Development Framework) and increasing access to timely diagnosis	Evidence of Improvement	Majority on track, but scope to improve	N/A	Sep 22 - Mar 23

CTMUHB Workforce Metrics – May/June 2023

% of sickness absence rate of staff – Target is 12 month reduction trend – May 2023 (7.2%)



The overall CTM rolling twelve-month sickness rate to May 2023 is 7.2%, slightly higher than the equivalent rolling period of last year (6.8%).

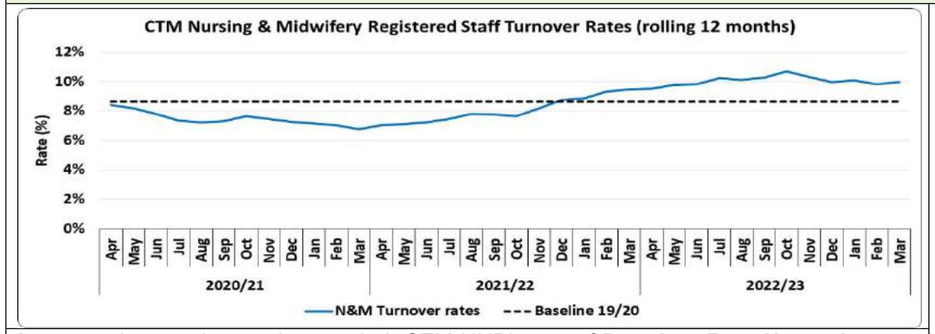
The in-month sickness rate fell slightly from 6.3% in April to 6.2% in May and is slightly lower than the same period of 2022 (6.8%).

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

There has been a slight decrease in sickness absence levels although remaining above pre-COVID levels. Ongoing monitoring is required to see if this decrease continues. Work continues to re-establish effective Managing Attendance practices following COVID and Structural changes to include:

- Managing Attendance training and refresher training provided by People Services
- People Services support to line managers on high priority and complex cases to resolve cases at the earliest opportunity to reduce absence levels.
- Designated People Services contacts have been introduced aligned to Care Groups to enable consistent support and pro-active identification of trends and to support the development of action plans.
- Reduction of sickness rates as an enabler to reduced temporary staffing spend
- Sickness absence rates being monitored through Care Group Performance Reviews and Productivity workstreams

Turnover rate for Nurse & Midwifery registered staff leaving NHS Wales – Target is rolling 12 month reduction against a baseline of 2019/20 (8.65%) – Mar 2023 (10%)



In comparison to the previous period, CTM UHB's use of **Premium Rate Nurse Agency Staff** during June was three times higher than in May, bringing the total to an average of 3.16 Whole Time Equivalents (WTE) per day.

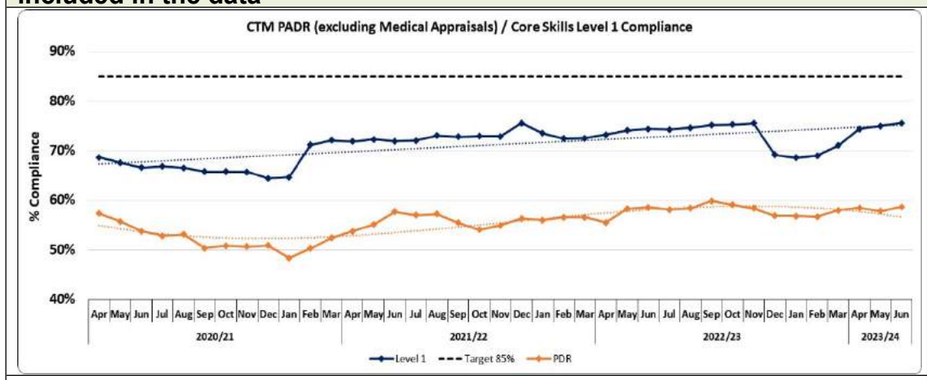
The rolling 12 month turnover rate for registered Nursing and Midwifery Staff as at March 2023 is 10%, 0.5% higher than the equivalent period of 2021/22 and 1.35% higher than the 2019/20 baseline.

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

Since a peak in the Autumn of 2022 there has been a slight decrease in turnover rates for these staff groups. However rates remain high and retention remains an area of focus for both the People and Corporate nursing teams. There is ongoing data analysis of turnover information which has identified nursing as a priority area for the Health Board. As part of our retention plan the UHB is actively involved in the All Wales Nursing Retention work that is underway, and as part of this additional resource will be provided to support the delivery of our internal plans. A Moving On data questionnaire as been launched as part of our revised exit interview process, which enables further insight into reasons for leaving and how we can best support staff to remain in our employment. Worklife balance and promotion remain the top two reasons for leaving.

The risks and challenges within this space are reflective of local, national and international issue in regard to the shortage of registered nursing and midwifery professionals. Improvements in this space will be delivered over the longer term and and are interlinked with other ongoing workstreams including around improved attraction, bolstered recruitment pipelines, attraction and employee experience (including development & flexible working opportunities).

Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training) – Target 85% - June 2023 (58.7%) please note that medical appraisals are not currently included in the data



Overall PADR compliance for June 2023 is 58.7%, with compliance for the past year ranging between 56.7% and 59.8%. However, it is recognised, that this continues to remain well below the target threshold of 85%.

CTM Level 1 Core Manditory Training Compliance June 2023	
Equality, Diversity & Human Rights	84.2%
Health, Safety and Welfare	81.1%
Moving & Handling	80.4%
Safeguarding Adults	80.3%
Safeguarding Children	79.3%
Information Governance	76.9%
Infection Prevention and Control	75.3%
Violence & Aggression	72.7%
Fire Training	71.4%
Resuscitation	54.4%
HB Overall Compliance	**75.6%**

Combined core mandatory training compliance for June stands just below 66.0%, with overall CTM compliance for 'Level 1' disciplines at 75.6% and likewise, remains below the required standard of 85%.

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

PADR:

- Actions are being taken to accelerate improvement trend in order to achieve the 85% target:
  - Detailed PADR Evaluation and Impact Report being compiled to assess engagement levels and highlight key areas for improvement.
  - From this, recommendations will be created and actioned, including the development of additional educational resources.
  - "How to have a PADR" eLearning module being added to ESR to track completion more effectively and target areas of management population where compliance is lowest.
  - Targeted communications being sent to managers with PADR compliance below 85%.
  - Assessment being done to establish how best to capture Medical and Dental appraisals as part of overall figures.

Core Learning:

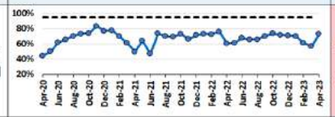
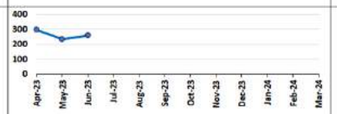
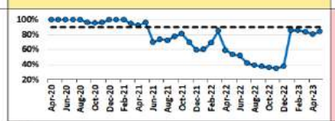
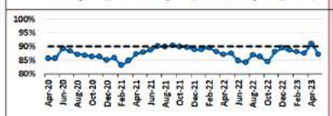
- In order to achieve the 85% target, the L&D team are raising awareness and targeting the areas with poorest compliance figures:
  - Monthly drop-in sessions being advertised, with the Core Learning team attending different sites each month.
  - A wider range of subject guides and educational materials in development to support staff to access their learning.
  - Targeted work happening in Medical and Dental, specifically with regards to Welsh competencies in-line with the ongoing improvement work

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

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

Key: —●— Trend - - - Target/Trajectory

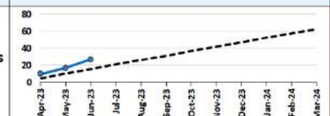
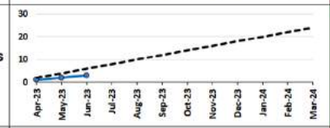
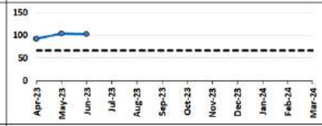
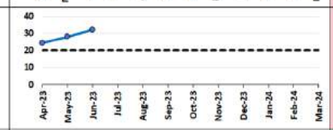
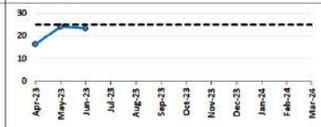
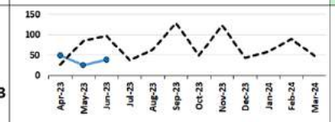
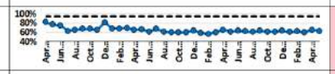
Key: Target Achieved | Target Failed

	Performance Measure	Target	Trend / Latest Position	Latest Position	
Effective Services	% of episodes clinically coded within one reporting month post episode discharge end date	Maintain the 95% target or demonstrate an improvement trend over 12 months		73.3% National target not met but an improvement from Apr 22 (60.8%)	Apr-23
Effective Services	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	Total FCE's: 40460; Total FCE's coded: 29861; Errors outstanding: 256; % errors outstanding: 0.86%	*Please note that this is interim data locally sourced*	1st April to 11th July 2023
Effective Services	Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the Foundational Economy via the delivery of the Foundational Economy in Health and Social Services Programme	Delivery of Foundational Economy initiatives and/or evidence of improvements in decision making process	Majority on track, but scope to improve	N/A	Sep 22 - Mar 23
Effective Services	Report detailing evidence of NHS Wales embedding Value Based Health and Care within organisational strategic plans and decision-making processes	Evidence of activity undertaken to embed a Value Based Health Care approach (as described in the reporting template)	On Track	N/A	
Efficient Services	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	17% or more	Data not available as yet		
Efficient Services	Number of Pathways of Care delayed discharges	12 month reduction trend		258	Jun-23
Efficient Services	Qualitative report detailing progress against the health boards' plans to reduce pathways of care delays	Evidence of Improvement	Data not available as yet		
Efficient Services	Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan		Majority on track, but scope to improve	N/A	Sep 22 - Mar 23
People Centred Care	% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for those age under 18 years	90%		84.0%	May-23
People Centred Care	% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for those age 18 years and over			87.1%	
People Centred Care	Number of patient experience surveys completed and recorded on CIVICA	Month on month improvement	Data not available as yet		
People Centred Care	Qualitative report detailing progress against the priority areas to improve the lives of people with learning disabilities	Evidence of Improvement	Majority on track, but scope to improve	N/A	Sep 22 - Mar 23

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

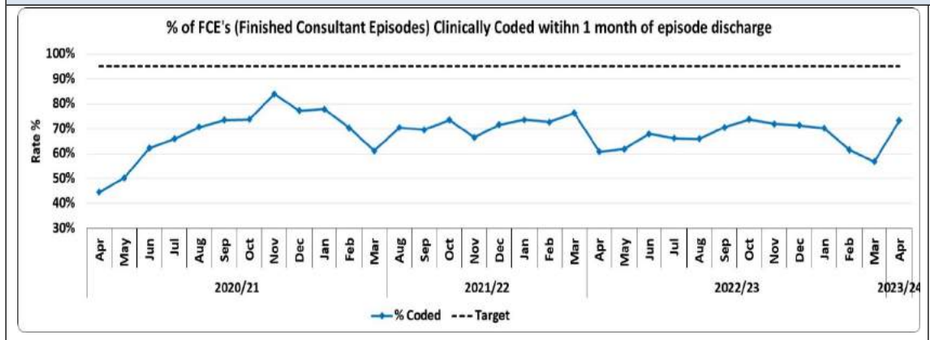
Key: —●— Trend - - - Target/Trajectory

Key: Target Achieved | Target Failed

	Performance Measure	Target	Trend / Latest Position	Latest Position	
Safe Services	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	No more than 60 cases for 2023/24		27	Apr-Jun 2023
Safe Services	Cumulative number of laboratory confirmed bacteraemia cases: Pseudomonas aeruginosa	No more than 24 cases for 2023/24		3	
Safe Services	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli	67.00 per 100,00 population		102.82	
Safe Services	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus (MRSA and MSSA)	20.00 per 100,00 population		32.19	
Safe Services	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	25.00 per 100,00 population		23.25	
Safe Services	% of confirmed COVID cases within hospital which had a definite hospital onset (>14 days after admission)	Reduction against the same month in 2022-23			
Safe Services	% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	95%		63.1%	May-23
Safe Services	Number of ambulance patient handovers over 1 hour	Improvement trajectory towards achievement of zero ambulance patient handover delays >1 hour by March 2024		594	Jun-23
Safe Services	Number of National Reportable incidents that remain open 90 days or more	12 month reduction trend	There are currently 44 NRI's that remain open for 90 days or more	44	Jun-23

Effective Services - Clinical Coding

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



The reported position for April 2023 equates to 73.3% of the FCE's for that month have been coded within the requisite timescale.

As of July 2023 the number of FCE'S for 2023/24 currently stands at 40,460 and of those 73.8% have been clinically coded.

How are we doing?

This is a new target for 23/24. Our Performance against the 22/23 target was by far the best in Wales, with 98.7% of finished consultant episodes coded by the annual deadline of June 21st.

As reported previously the coding profession have transformed themselves, internally developing Cliveseco, as a machine learning, natural language programme, which provides decision support to the coding team by both autocoding our treatment activity from discharge summaries, theatre records and radiology results and validating codes entered by the coders, to flag potential errors against coding standards.

The workforce have reported far higher levels of morale, are keen to develop and take on wider roles and responsibilities in improving the accuracy and completeness of medical record keeping and are now working on the development of clinical e-forms which it is anticipated will enable clinicians to autocode at the time of their entry into the medical record. A process that will greatly improve availability and timeliness of the clinical record to other clinicians and decision makers.

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

Status at 1st April to 10th July 2023			
Total FCE's	Total FCE's coded	Errors outstanding	% errors outstanding
40460	29861	256	0.86%

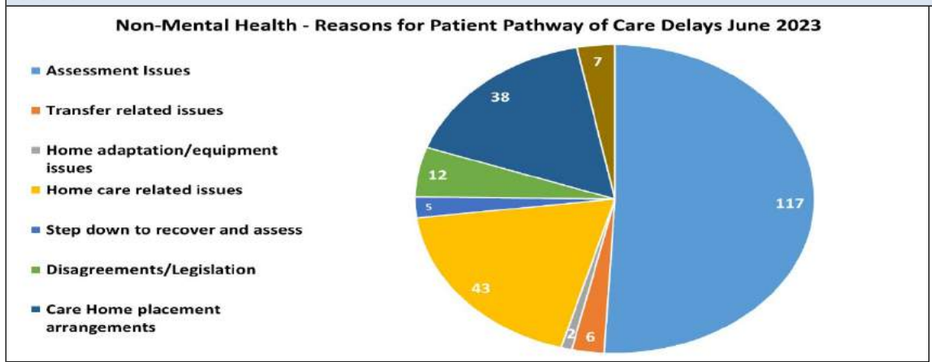
Please note that this is interim data locally sourced

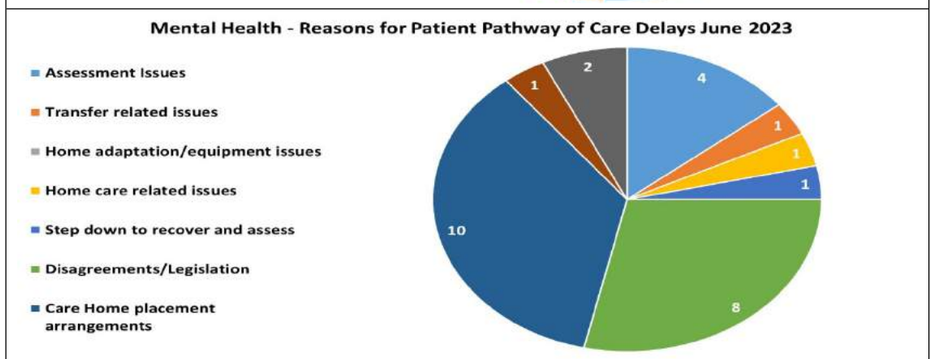
What actions are we taking & when is improvement anticipated? What are the risks?

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

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

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





Healthcare Facility	Blaenau Gwent	Bridgend	Caerphilly	Merthyr Tydfil	Neath Port Talbot	Rhondda Cynon Taff	Vale of Glamorgan	Total
Pinewood House						2		2
Prince Charles Hospital	1		11	5		4		21
Princess of Wales Hospital		82			4		4	90
The Royal Glamorgan Hospital					1	32		33
Ysbyty Cwm Cynon				24		32		56
Ysbyty Cwm Rhondda				1		55		56
Grand Total	**1**	**82**	**11**	**30**	**5**	**125**	**4**	**258**

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

The total number of patients who have been clinically optimised for discharge and are currently awaiting their next stage of care (21st June 2023 census point), equates to 258 patients i.e. 230 non-Mental Health patients and 28 Mental Health patients, as is shown in the pie charts to the left.

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

Actions: The Integrated Discharge Delivery Board has developed a draft action plan that was submitted to Welsh Government in June. This action plan takes a holistic view of improvement across the system and identifies actions that address the main areas for delays in the system.
In summary the action plan focuses on:

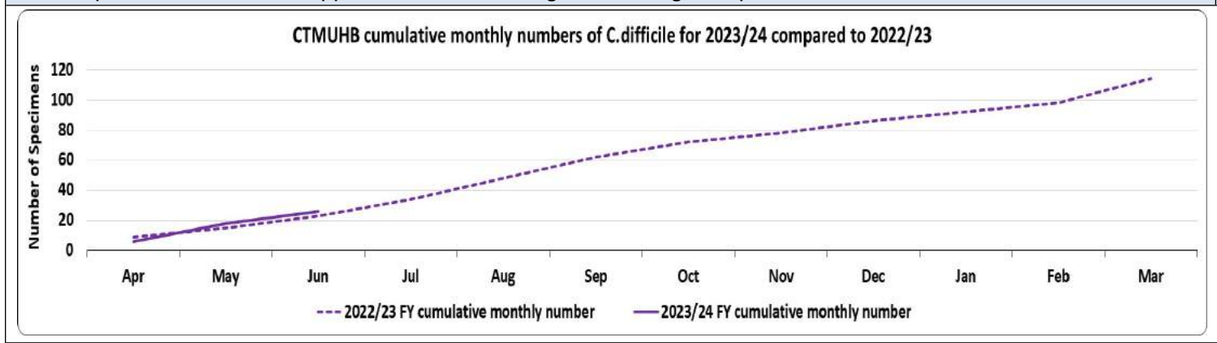
- ***Reducing Assessment delays***: The new process will implement a trusted assessment process across all D2RA pathways through a document that transfers care from a hospital setting into the community. The responsibility for this is an integrated one and so codes with integrated assessment will be used.
- ***Reducing waits for home care***: Local Authorities are working on integrated plans for effective delivery of D2RA pathway 1 (which also includes reablement). All patients waiting for a Pathway of Care will be offered a "bridging" bed either in a residential or community hospital setting; the aim will be to 'right-size' the community package and reduce deconditioning which often increases care needs and further delays discharge.
- ***MCA/CoP Delays***: An integrated Task & Finish group has already issued clarification and support to reduce these delays which has reduced numbers and the work will continue.

- Large scale engagement of optimising flow and discharge was taken across CTM with nearly 100 staff attending on the 3 main sites.
- Review of Electronic White Boards (EWB) codes and data compliance completed in June.
- **Risks:**
- Deconditioning of patients in a hospital setting increases care needs and reduces community capacity.
- Community capacity for D2RA pathways
- Gaps/vacancies in the supported discharge team
- Short-term funding only
- RIF resources to meet the needs of the new discharge process

Safe Services – Healthcare Acquired Infections

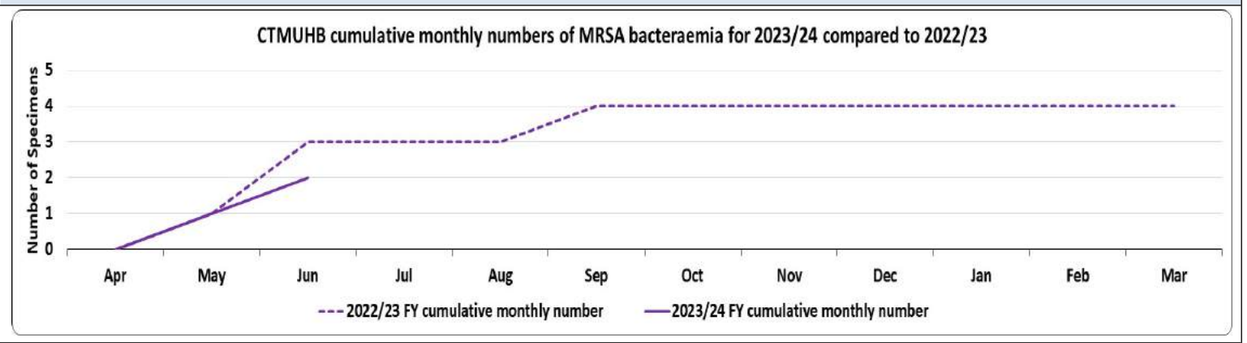
C.difficile

- 26 C.difficile have been reported by CTM between Apr-Jun 2023. This is approximately 13% higher than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 23.25. 56% of the cases are healthcare associated infections (based on sample date compared to admission date) & 22% of the samples were sent from primary care. The IPC team is working with the care groups to improve the RCA process to maximise opportunities for learning and sharing best practice



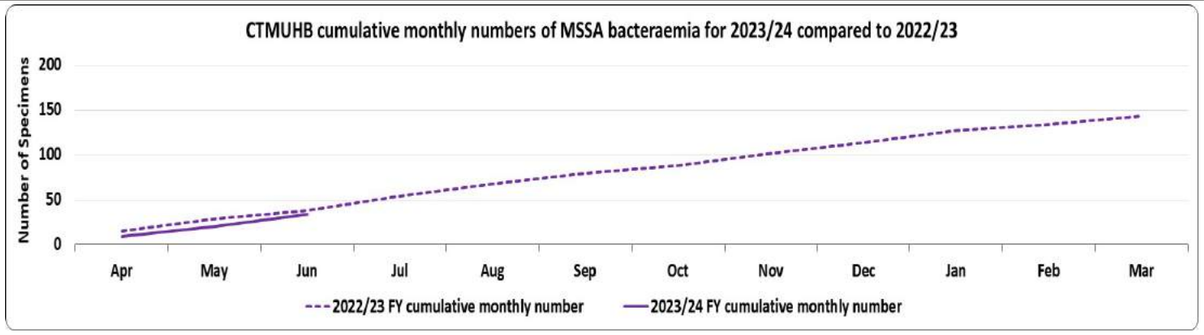
MRSA

- 2 MRSA bacteraemia has been reported by CTM between Apr-Jun 2023. This is 33% lower than the equivalent period of 2022/23. The provisional rate per 100,000 population for 2023/24 is 1.79. The 1 case reported in May 2023 is a community acquired infection, non preventable source.



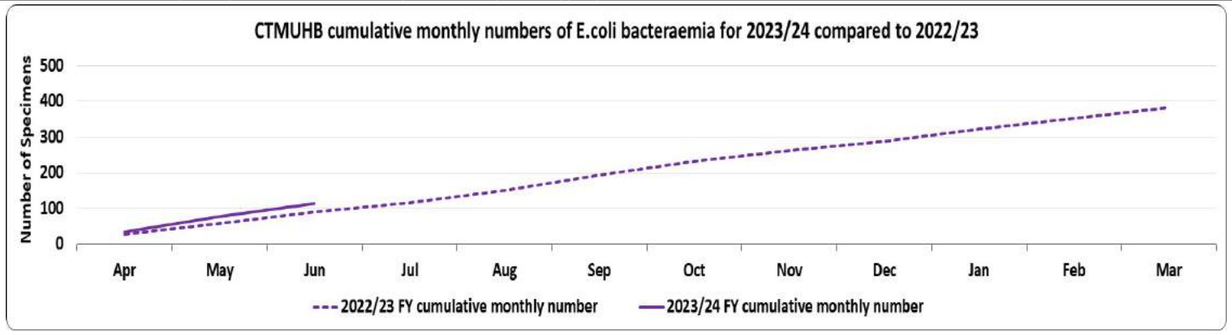
MSSA

- 34 MSSA bacteraemia have been reported by CTM between Apr-Jun 2023. This is approximately 10.5% fewer than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 30.4. 30% of the cases are healthcare associated infections, none had a preventable source.



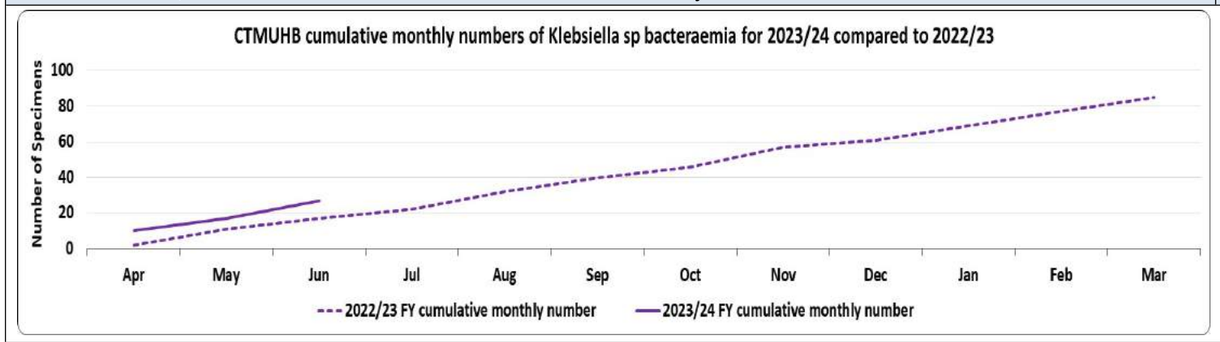
E.coli

- 115 E.coli bacteraemia have been reported by CTM between Apr-Jun 2023. This is approximately 26.4% higher than equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 102.82, which compares to the all Wales rate of 75.53. 36% are healthcare associated infections based on the date the sample was sent compared to the admission date.
- 18% were linked to a urinary catheter and work is ongoing in primary and secondary care to reduce catheter associated urinary tract infections. These include a point prevalence study/ANTT compliance/ introduction of catheter passport in secondary care/improving hydration.



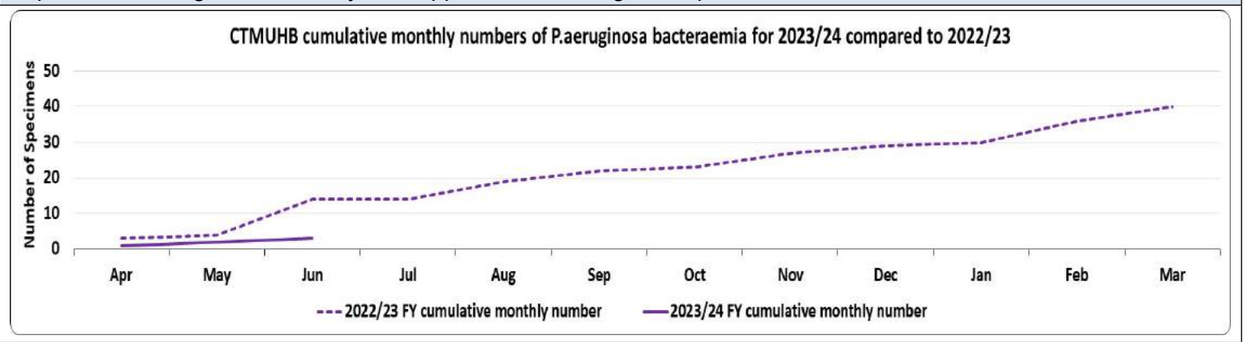
Klebsiella sp

The WG improvement goal requires a 10% reduction compared to 2017/18 figures. This equates to no more than 63 cases. 27 Klebsiella sp bacteraemia have been reported by CTM between Apr-Jun 2023. This is approximately 59% higher than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 24.14 (All Wales rate = 23). 41% are healthcare associated infections based on the sample date compared to the admission date, and 24% of the total cases are linked to a urinary catheter.



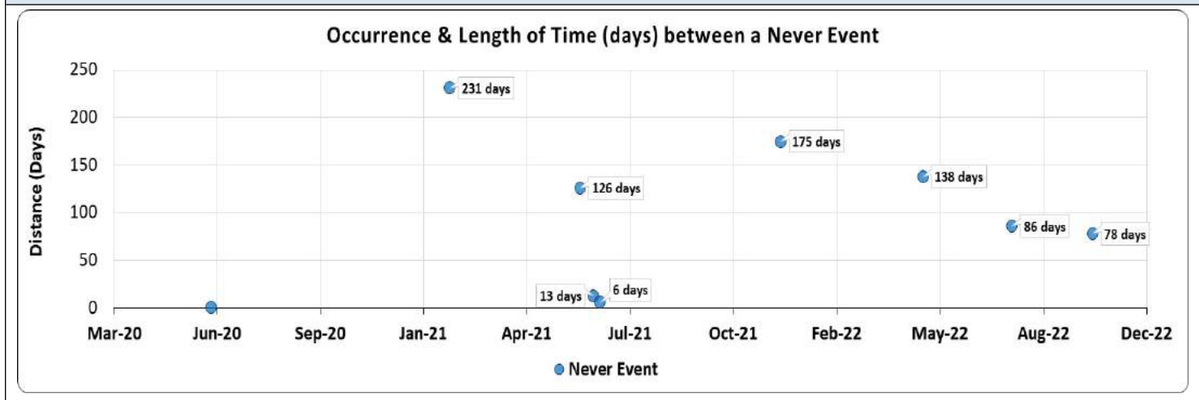
P.aeruginosa

3 P.aeruginosa bacteraemia have been reported by CTM between Apr-Jun 2023. The cases are community acquired infections, no preventable sources. This is approximately 78.6% fewer than in the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 2.68. There is currently no dedicated resource for primary care services. The Executive Director of Nursing has requested a strategic review of the IPC service in order for the team to provide an integrated whole system approach delivering a comprehensive service.



Safe Services – Never Events & Nationally Reportable Incidents

Number of Never Events – June 2023

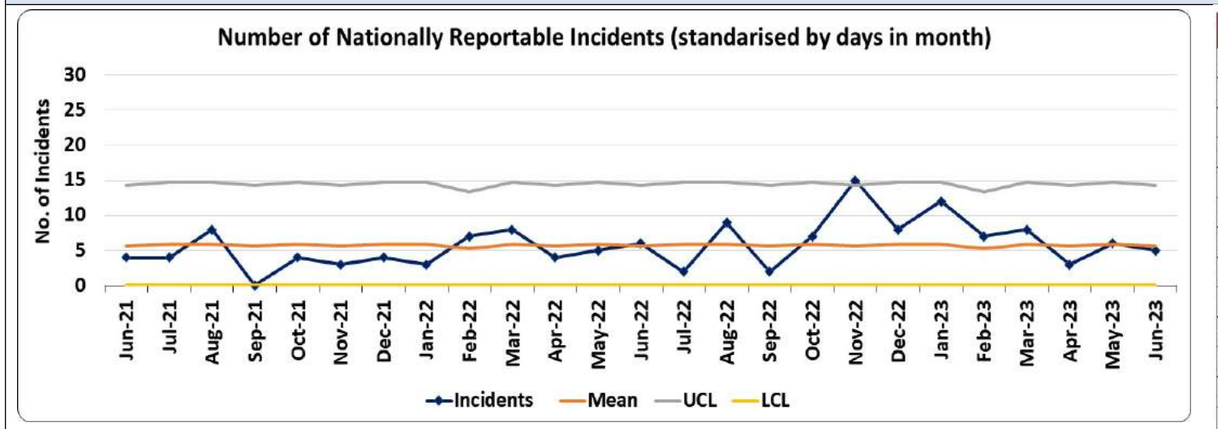


Never events are patient safety incidents that are defined as being wholly preventable. They are considered wholly preventable because guidance or safety recommendations are in place at a national level and should have been implemented by all providers in the healthcare system. This should act as a strong systemic barrier to prevent the serious incident from happening. Learning from what goes wrong in healthcare is crucial to preventing future harm.

There were no Never Events reported in June, with the last occurrence being 13th October 2022 (formal reporting submitted December 2022) relating to a wrong side surgery. The investigation continues and has been allocated to a senior ophthalmology consultant.

In total, 2 reportable events have been observed during the past twelve months, as detailed in the chart to the left.

Number of National Reportable incidents that remain open 90 days or more – Target is 12 month reduction trend



During June, 5 Nationally Reportable Incident notifications were submitted to the NHS Delivery Unit (NRIs are detailed in the table to the right).

In total, there are currently 44 NRI's that remain open for 90 days or more.

Of the National reportable incidents reported this month, 3 have been attributed to pressure damage related incidents, where investigations have been completed and patients or families have been responded to. The 2 other NRI's reported have undergone rapid review meetings, where investigating officers have been appointed and an investigation has been commissioned. Significant work has been undertaken to progress the open Nationally reportable incidents to closure with a working trajectory.

Type of Nationally Reportable Incidents	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Total
Admission / Transfer / Discharge				2	8	1	5		1				17
Pressure Damage		1			1	2	2	2	2	1		3	14
Treatment, Procedure			1	2		1	3		2	1			12
Maternity adverse occurrence				1		1	1	2	1		2		10
Patient/Service user death		2			2			1	1		3	1	10
Clinical Assessment, clinical diagnosis				1	2	1			1		1	1	7
Slip, Trip or Fall	1				2								3
Safeguarding				1		1	1						3
Delays		2											2
Behaviour (including violence and aggression)		2											2
Medication						1				1			2
Monitoring/Observations			1										1
Diagnostic Testing - Radiology		1											1
Records, Information		1											1
Staffing	1												1
Accident, Injury								1					1
Grand Total	2	9	2	7	15	8	12	6	8	3	6	5	87

2.1 Finance update – Month 3

Updates on the financial position become available on the 9th working day of the month. Consequently there is no further update available to that provided in the last financial report.

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

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

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

The following issues/risks have been identified in relation to the **Quality** quadrant:

- Maintenance of robust quality governance arrangements during the transition to a centralised function has remained paramount. The implementation of Organisational Change Policy OCP in relation to Quality and Governance arrangements is nearly complete, with final vacancies in the recruitment process taking place.

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work is underway to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.

- Work is required to ensure data from the range of Health Board systems included in this report are consistently captured and appropriately validated.

- Improving and maintaining compliance with the 30 working days complaint response rate.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.

Related Health and Care standard(s)	Choose an item.
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes. The work reported in this summary and related annexes take into account many of the related quality themes.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not yet assessed
Legal implications / impact	Yes (Include further detail below)
	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

2023-24 Finance Report

Month 3

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

cwmtafmorgannwg.wales

Summary

Situation

Our draft financial plan for 23/24 was submitted to Welsh Government (WG) on 31 March 2023. The draft plan identified a forecast deficit of £79.6m and WG confirmed that the plan was not supportable. The Health Board submitted a supplementary paper to WG at the end of May outlining the further work undertaken and the impact on the plan assumptions. However, the forecast deficit of £79.6m is unchanged. We are awaiting feedback on the 31 May submission.

The draft plan includes a £27.3m savings target which will require a significant step up in savings delivery compared to recent years.

The failure to submit a financially balanced plan is a breach of our statutory duty under the Finance (Wales) Act 2014.

This report outlines our financial performance against the draft plan for Month 3 (i.e. the period to 30th June 2023.

A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at M3 (i.e. the Delegated budget position).This financial performance report is discussed at the Planning, Performance & Finance Committee (PPFC) and the Executive Leadership Group (ELG) meetings.

Background

The financial plan for 23/24 is based on a 'Control Total' approach which requires the Care Groups and Directorates to deliver a maximum allowable overspend of £23.8m.

To meet the Control Total Care Groups and Directorates will need to deliver a £28.3m Savings target from their M11 forecast out-turn positions for 22/23. In addition, since their forecast recurrent positions were greater than the In year positions, the Care Groups and Directorates will also need to deliver £11.7m of savings to cover the Non Recurrent benefits reported in 22/23.

In summary:

	Delegated £m	Non Delegated £m	Total £m
Assessed Underlying Position	63.8	-29.6	34.2
Savings required to cover the NR Benefits from 22/23 assumed to be delivered in 23/24 plan	-11.7	4.8	-6.9
New 23/24 Savings Target	-28.3	1.0	-27.3
Control Total	**23.8**	**-23.8**	**0.0**

Any reported overspends against the Delegated Control Total will therefore be due to.:

- Shortfalls in savings to meet the £28.3m target for 23/24
- Shortfalls in savings to cover the £11.7m of NR benefits reported in 22/23
- Other operating variances

Summary

Assessment

Overall Revenue position:

- The M3 in month position reported a £8.9m deficit (M2: £6.8m).
- The M3 YTD position is reporting a £22.3m deficit against the Revenue Resource Limit. This represents a £2.4m adverse variance compared to 3/12th of the forecast £79.6m deficit in the financial plan (£19.9m).
- The £2.4m adverse variance includes a £2.9m shortfall against the M3 savings target of £6.7m offset by £0.45m of favourable operating variances, This favourable variance is mainly due to Dental contract underspends.
- The year end forecast remains at £79.6m which is consistent with the draft plan. There are significant risks to this forecast of £18.5m offset by opportunities of £4.0m.
- This forecast assumes that we will receive £11m of funding for ongoing Covid programme costs.

Savings position:

- Actual savings to M3 YTD was £3.9m which is £2.9m below the M3 savings target of £6.8m.
- The M3 forecast In year savings is £21.8m. This is £5.5m below the annual savings target of £27.3m.The M3 forecast Recurrent savings of £22.2m is £5.1m below the £27.3m target.
- Forecast savings have increased by £1.9m from M2 but the latest plans are still £5.5m below the target for 23/24.Urgent work is needed to develop robust plans to close the forecast gap of £5.5m In year and £5.1m recurrently.

Cash position:

- The forecast Cash Flow position to year end shows a projected deficit of £79.5m. This reflects the forecast deficit in the draft plan and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

Recommendation

The Board is asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 30th June 2023.

Contents

Slide	Subject Area
5	Executive Summary
6	YTD Performance & Forecast
7-9	Pay Expenditure Trends
10	Non pay Expenditure Trends
11	COVID Expenditure Trends
12	Income Trends
13-14	Income Assumptions
15	Savings
16-17	Risk Management
18	Statement of Financial Position
19	Cash Flow forecast
20	Public Sector Payment Policy Compliance
21	Capital Expenditure

Executive Summary

Overall Revenue Position

- The M3 in month position reported a £8.9m deficit (M2: £6.8m).
- The M3 YTD position is reporting a £22.3m deficit against the Revenue Resource Limit. This represents a £2.4m adverse variance compared to 3/12th of the forecast £79.6m deficit in the financial plan (£19.9m).
- The £2.4m adverse variance includes a £2.9m shortfall against the M3 savings target of £6.7m offset by £0.45m of favourable operating variances. This favourable variance is mainly due to Dental contract underspends.
- The year end forecast remains at £79.6m which is consistent with the draft plan. There remain significant risks totalling £18.5m offset by opportunities of £4.0m (See Risks and Opportunities Page 16 & 17).

Savings

- Actual savings to M3 YTD was £3.9m which is £2.9m below the M3 YTD savings target of £6.8m.
- The M3 forecast In year savings is £21.8m. This is £5.5m below the annual savings target of £27.3m.The M3 forecast Recurrent savings of £22.2m is £5.1m below the £27.3m target.
- Forecast savings have increased by £1.9m from M2 but the latest plans are still £5.5m below the target for 23/24. Urgent work is needed to develop robust plans to close the forecast gap of £5.5m In year and £5.1m recurrently.

Cash

- The closing cash balance at 30th June 2023 was £3.0m.
- The forecast Cash Flow position to year end shows a projected deficit of £79.5m. This reflects the forecast deficit in the draft plan and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

Capital

- The Capital Resource Limit for 2023-24 is currently £67.6m. This is supplemented by £0.2m of donated funds and £0.2m of assets disposed of in this financial year giving an overall programme of £68.0m.
- Expenditure to M3 was £16.3m.
- The forecast outturn capital position is breakeven to the CRL target.

Year to Date Performance and Forecast

	M3 Actual	M3 YTD	M3 Forecast	Financial Plan
	£m	£m	£m	
Core plan deficit	**8.2**	**20.1**	**70.9**	**70.9**
Exceptional Energy costs	0.7	2.2	8.7	8.7
Covid programme costs:				
Health Protection	0.4	1.3	9.1	9.1
PPE	0.0	0.1	0.3	1.0
Adferiad	0.0	0.1	1.0	1.0
Nosocomial	0.0	0.1	0.6	0.6
Anticipated funding	(0.4)	(1.6)	(11.0)	(11.7)
Total	**0.0**	**0.0**	**0.0**	**0.0**
Grand total	**8.9**	**22.3**	**79.6**	**79.6**

Key Points:

- The M3 YTD position is a £22.3m deficit. This represents a £2.4m adverse variance compared to 3/12th of the £79.6m deficit (£19.9m) included in the draft plan submitted to WG on 31 March.
- **The £2.4m adverse variance includes a £2.9m shortfall against the M3 savings target of £6.7m offset by £0.45m of favourable operating variances, This favourable variance is mainly due to Dental contract underspends.**
- The £2m favourable operating variance reported last month has deteriorated by circa £1.6m in M3. The main causes are:
  - Community Pharmacy Contract – Under accrual in 22/23 plus estimated impact for 23/24 - £0.9m
  - Medical Staff Agency and ADH expenditure - £0.4m
  - Increased planned care activity driving additional Non pay expenditure £0.3m
- As at M3 we are maintaining a forecast Core plan deficit of £79.6m for 23/24 which is consistent with the draft financial plan.

Pay Expenditure Trends

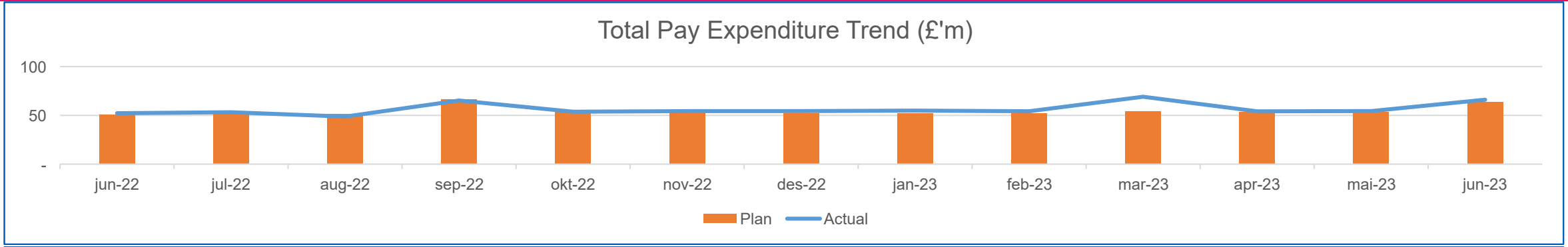
Staff Group	Jan-23 £'m	Feb-23 £'m	Mar-23 £'m	Apr-23 £'m	May-23 £'m	Jun-23 £'m
Administrative & Clerical	7.3	7.1	8.5	7.5	7.3	9.6
Medical And Dental	14.1	13.8	17.7	13.5	14.2	14.4
Nursing And Midwifery Registered	16.3	17.1	22.2	17.1	16.6	21.1
Add Prof Scientific And Technical	1.5	1.5	1.6	1.5	1.5	1.9
Additional Clinical Services	8.1	7.3	9.2	7.2	7.1	9.4
Allied Health Professionals	3.3	3.3	4.4	3.2	3.4	4.2
Healthcare Scientists	1.1	1.1	1.4	1.1	1.1	1.3
Estates And Ancillary	3.1	3.0	4.1	3.0	3.3	4.2
Students	.1	.1	.1	.0	.0	.0
Grand Total	**54.9**	**54.2**	**69.1**	**54.1**	**54.4**	**66.1**

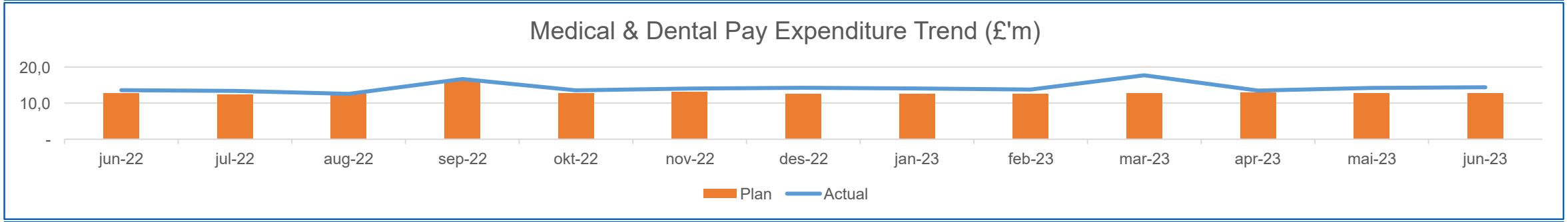
Spend category	Jan-23 £'m	Feb-23 £'m	Mar-23 £'m	Apr-23 £'m	May-23 £'m	Jun-23 £'m
Core	45.0	45.4	58.0	46.2	46.1	58.0
Agency	5.4	4.8	5.5	4.3	4.5	4.0
Overtime	2.0	1.7	2.4	1.3	1.3	1.2
ADH	1.2	1.1	1.5	1.1	1.2	1.4
Bank	1.1	1.0	1.3	1.1	1.0	1.1
WLI	0.1	0.2	0.4	0.1	0.3	0.3
Grand Total	**54.9**	**54.2**	**69.1**	**54.1**	**54.4**	**66.1**

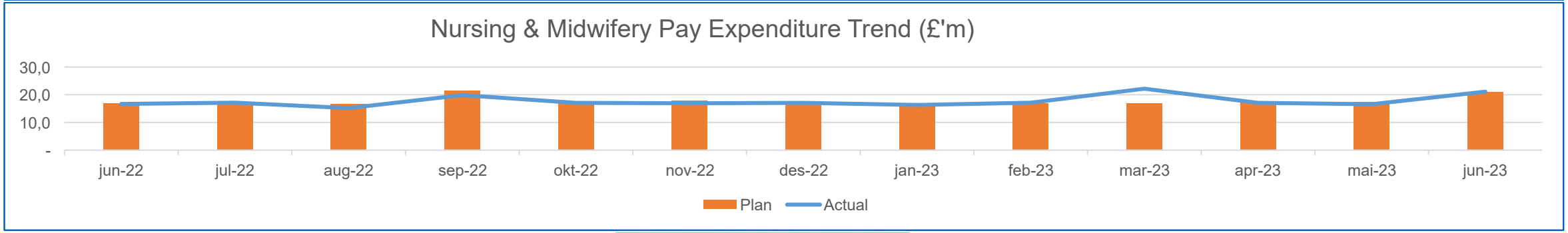
Key Points:

- The M12 expenditure of £69.1m included a number of one off items. The net position after excluding these one off items was £57.5m.
- Total spend in M3 includes £11.5m for the 2022/23 recovery payment. After allowing for this one off payment, the total pay costs increased slightly compared to M2 which reflects the continuation of bank holiday enhancements together with increased ADH payments.
- Core pay expenditure has increased by £11.9m in M3, with £11.5m of this attributed to the one off 2022/23 recovery payment. The remaining £0.4m increase is attributed to enhancements mainly due to bank holidays.
- Agency expenditure is continuing to show reductions. In particular Registered nursing agency costs have fallen for the third consecutive month.
- ADH Expenditure has continued to grow in M3.
- Bank & Overtime remain consistent throughout the quarter.

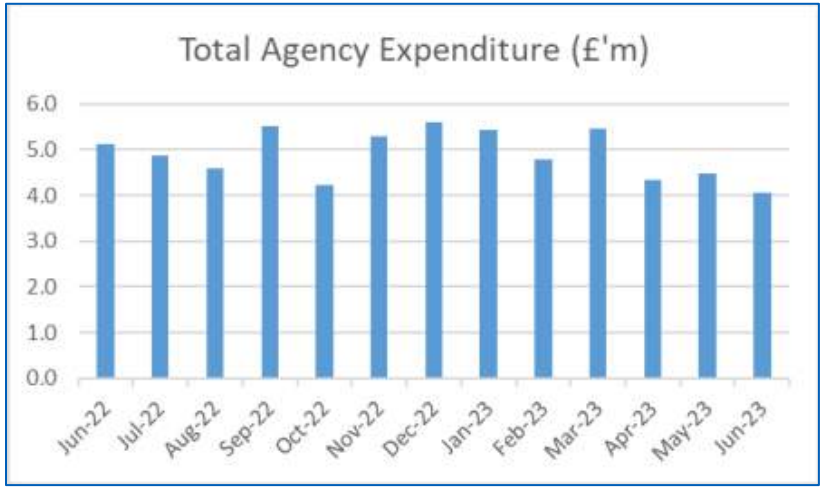
Pay Expenditure Trends

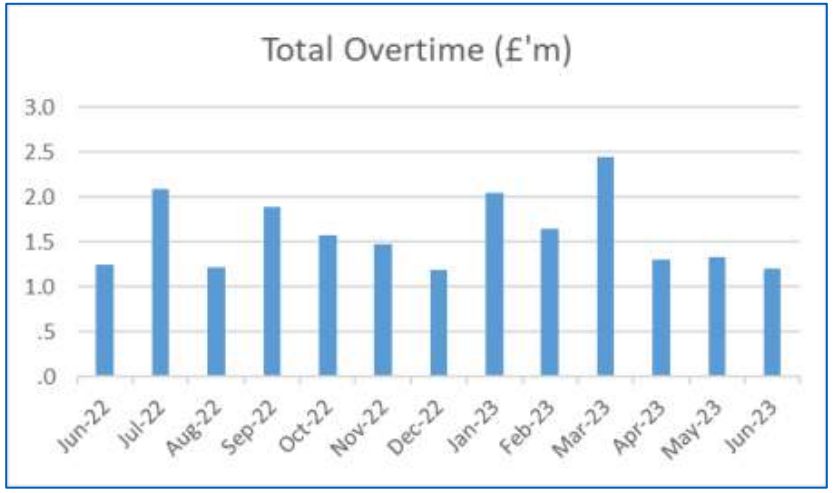


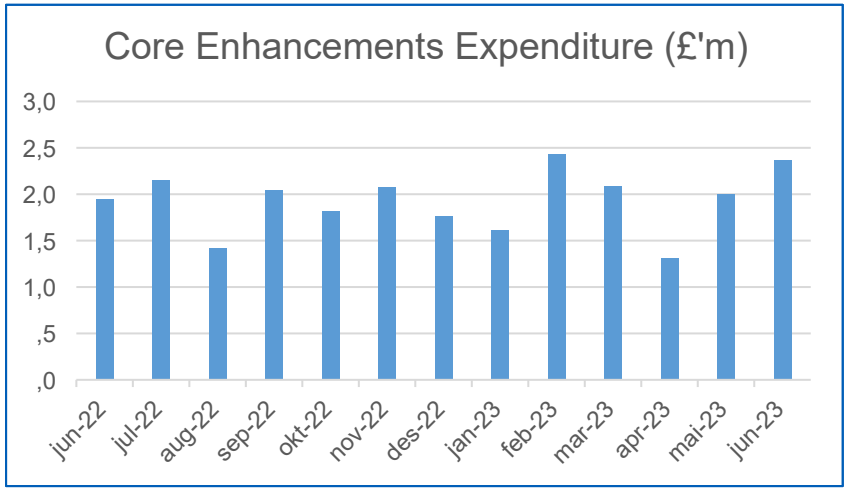


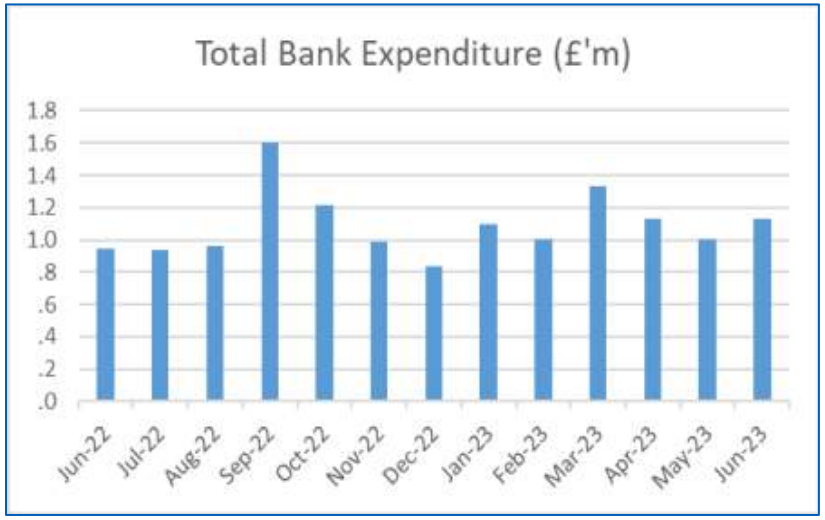


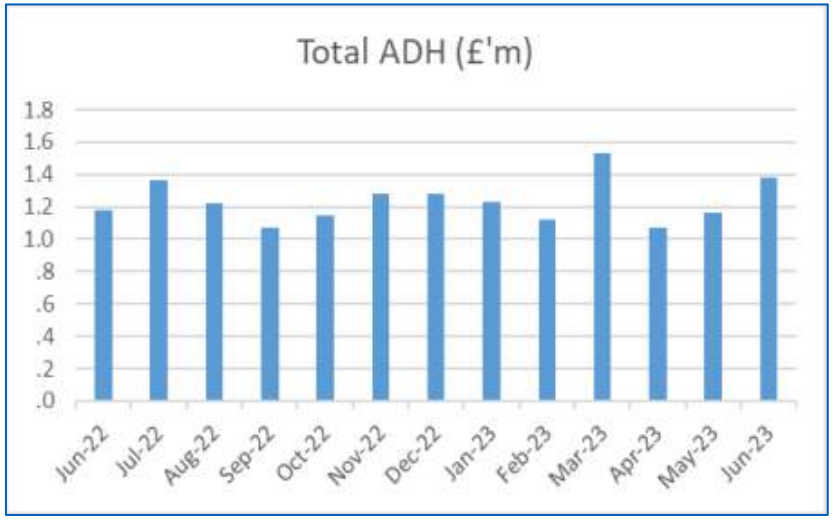
Variable Pay Expenditure Trends









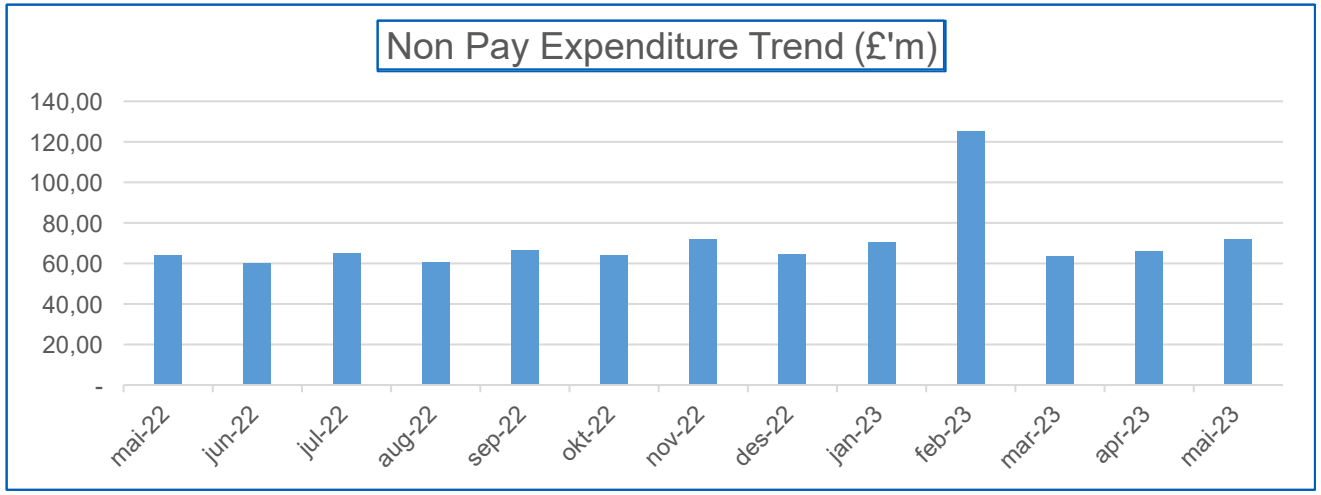


Key Points :

- Agency expenditure is continuing to show reductions. In particular the Registered nursing agency costs have fallen for the third consecutive month.
- Enhancements continue to increase and reflect the delay in payment for bank holidays during April & May
- ADH Expenditure has continued to grow in M3.
- Bank & Overtime remain consistent throughout the quarter.

Non Pay Expenditure Trends

Non Pay Group	Jan-23 £'m	Feb-23 £'m	Mar-23 £'m	Apr-23 £'m	May-23 £'m	Jun-23 £'m
Primary Care Contractors	11.7	11.8	13.8	10.9	11.1	12.3
Primary Care Drugs	8.6	6.6	8.3	9.7	8.4	8.9
Provider Non Pay	12.1	9.9	14.9	8.4	9.3	13.2
Secondary Care Drugs	4.0	4.4	4.6	3.6	5.2	4.6
Healthcare Commissioning	19.4	28.2	23.9	21.2	20.6	22.2
CHC & FNC	5.1	4.7	6.1	5.9	5.9	6.1
Other	3.5	4.7	53.3	3.4	5.4	4.6
Total Expenditure	**64.4**	**70.3**	**124.9**	**63.2**	**65.9**	**71.7**



Key Points:

- The M3 YTD non pay expenditure increased by £5.8m over M2.
- Primary Care contractors expenditure increased by £1.2m. This included a non recurrent £0.7m cost pressure following an under accrual on the Community Pharmacy contract in 22/23.
- Provider non pay expenditure increased by £3.9m. This was mainly due to the recognition of RIF expenditure plans with the Local Authorities for Q1 being reported in full in M3.These costs will be recognised monthly from M4.
- Secondary Care Drugs appears to have settled to similar levels of expenditure to Q4 of 22/23.
- Healthcare commissioning expenditure increased by £1.6m in M3. This was due to M3 being the first period where expenditure has been reported in line with actual activity.
- CHC & FNC expenditure reported a small increase of £0.2m in M3, However, there has been significant increases within Mental Health which are being offset by reductions in non Mental Health cases.
- Included in Other is capital charges. During M2, capital charges increased by £1.4m due to a retrospective adjustment for M1 and the average for M1 & M2 was £4.4m. M3 has the update for the latest capital charges forecast which has slightly increased but this is matched with a corresponding WG allocation adjustment.

COVID Expenditure Trends

COVID Expenditure	Jan-23 £'000	Feb-23 £'000	Mar-23 £'000	Apr-23 £'000	May-23 £'000	Jun-23 £'000
Programme costs						
Health Protection – TTP	293	261	450	113	133	97
Health Protection - Vaccination	336	237	451	372	285	306
PPE	91	69	69	83	(33)	37
Adeferiad	115	80	178	39	47	39
Noscomial	60	64	73	39	27	45
Total Covid costs	**895**	**711**	**1,221**	**646**	**459**	**525**
Anticipated funding	**(895)**	**(711)**	**(1,221)**	**(646)**	**(459)**	**(525)**
Total	**0**	**0**	**0**	**0**	**0**	**0**

Key Points:

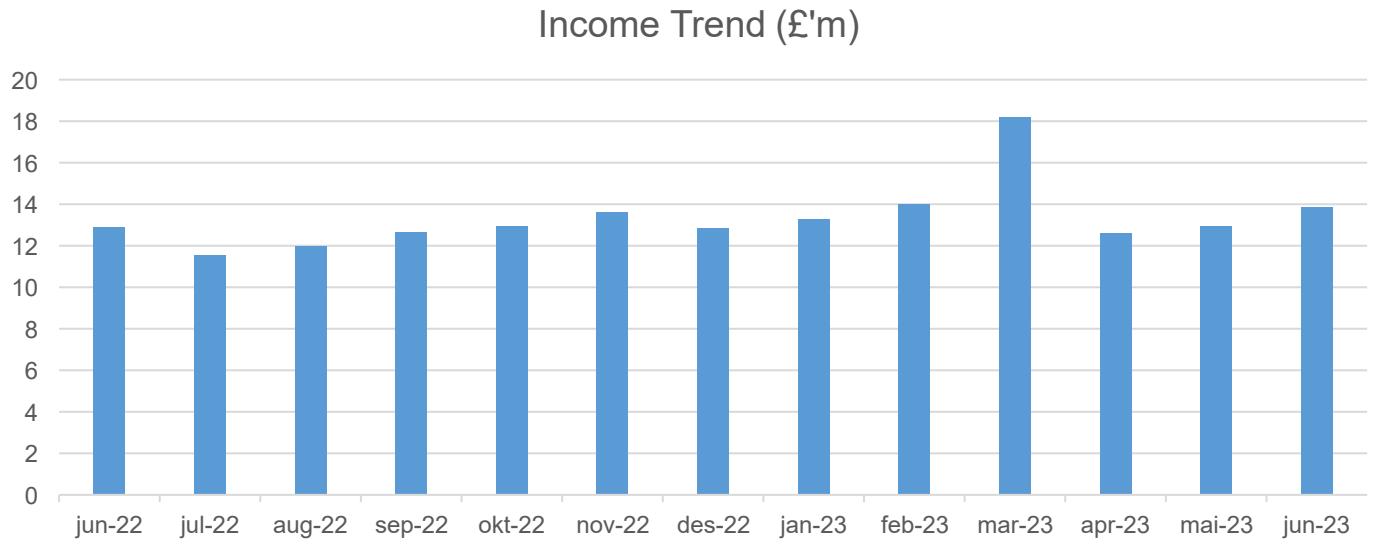
- As at M3 the HB is reporting COVID Programme expenditure for the YTD of £1.6m. In line with the WG guidance, the HB is anticipating that the COVID Programme costs will be fully funded.
- Pending finalisation of the 2023/24 plan for Health Protection, the M3 forecast of £9.1m is based on the indicative allocation noted in Sioned Rees's correspondence dated 22 Dec 2022. There is likely to be slippage on the £9.1m indicative allocation and we note the WG response last month which confirmed that any slippage could not be retained by the HB.
- The Adferiad expenditure in Q1 is significantly lower than Q4 of last year. There is likely to be slippage on the £1m WG allocation, unless there is a significant increase in spend as the year progresses.

Income Trends

Income Group	Jan-23 £'m	Feb-23 £'m	Mar-23 £'m	Apr-23 £'m	May-23 £'m	Jun-23 £'m
Welsh NHS Income	7.4	7.6	8.4	6.8	6.9	7.7
WHSSC Income	1.3	1.1	1.2	1.0	1.0	1.0
Primary Care Contractor Income	1.1	1.1	1.8	0.8	1.2	1.2
CHC Income	0.4	0.4	0.4	0.5	0.4	0.5
Other Income	3.0	3.9	6.4	3.5	3.4	3.5
Total Expenditure	**13.2**	**14.0**	**18.2**	**12.6**	**12.9**	**13.8**

Key Points:

- The M3 income has increased by £0.9m over M2.
- This includes a £0.8m increase in Welsh NHS Income , which is due to M3 being the first month for income to be reported using actual activity information.
- There was no significant changes in other income categories in M3.



Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,062.3	28.5	23.5	83.4	1,197.7
Anticipated Allocations:					
RLW Social Care Workers	4.8				4.8
COVID Programme costs	10.4				10.4
1.5% Consolidate NHS Pay Award 22/23	8.9				8.9
Regional PCR Plans	7.7				7.7
Mental Health Investment Funding	0.4				0.4
Six Goals and Same Day Emergency Care (SDEC)	3.0				3.0
2022/23 recovery payment	11.6				11.6
23/24 Pay award	24.2				24.2
Value in Healthcare NHS Wales Team	2.2				2.2
IFRS Revenue Adjustment	(2.4)				(2.4)
WRP contribution	(3.5)				(3.5)
Other	4.1				4.1
Total Allocations	**1,133.7**	**28.5**	**23.5**	**83.4**	**1,269.2**

Key Points:

- As at M3 the confirmed Revenue Resource allocation was £1,197.7m.
- The forecast position assumes a further £71.5m of Anticipated allocations to give a Total allocation of £1,269.2m.
- Until formally confirmed by WG, there are a number of risks associated with some of the these anticipated allocations. These are included in the Risk table on Page 16.

Income Assumptions - NHS

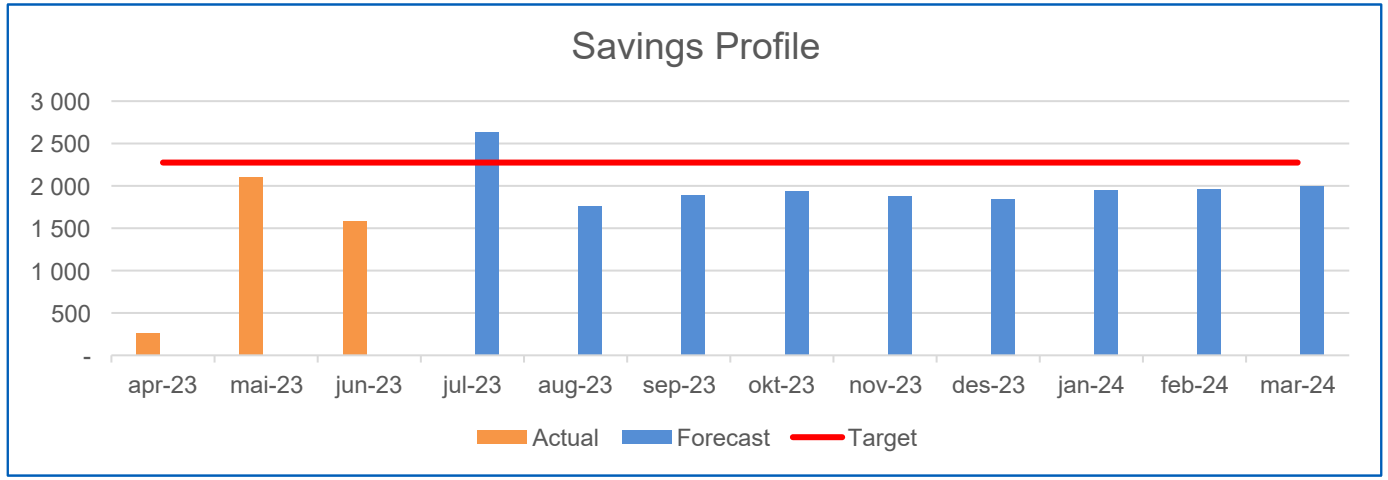
	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	31.7	0.9	32.5
Aneurin Bevan University	21.1	1.3	22.4
Betsi Cadwaladr University	0.0	0.2	0.2
Cardiff & Vale University	16.3	1.5	17.8
Cwm Taf Morgannwg University	0.0	0.0	0.0
Hywel Dda University	0.5	0.3	0.8
Powys	4.8	0.5	5.3
Public Health Wales	3.3	0.8	4.1
Velindre	0.0	10.2	10.2
NWSSP	0.0	0.0	0.0
DHCW	1.3	0.0	1.3
Wales Ambulance Services	0.0	0.1	0.1
WHSSC	12.0	1.1	13.1
EASC	0.0	0.0	0.0
HEIW	0.0	14.7	14.7
NHS Wales Executive	0.0	0.0	0.0
Total	**91.0**	**31.5**	**122.5**

Key Points :

- LTA agreements have been agreed by all Health Boards and Trusts with the exception of ABUHB.
- Despite several efforts to try to resolve the dispute between CTMUHB and ABUHB in respect to our LTA agreement for 2023/24, we were not able to arrive at an agreement by the 30th June. In line with WG guidance an arbitration case was submitted to WG on the 1st July 2023.
- We have received an acknowledgement of the arbitration submission and await the outcome of the WG decision. If WG find in favour of CTMUHB, then the plan remains unchanged, if WG find in favour of ABUHB, then the HB position will deteriorate by £3.1m.This risk is included in the Risk table on Page 16.

Savings

	Month 3			Month 2		
	YTD	23/24	Rec	YTD	23/24	Rec
	£m	£m	£m	£m	£m	£m
Savings target as at M2	6.8	27.3	27.3	4.6	27.3	27.3
Actual and Forecast Savings	(3.9)	(21.8)	(22.2)	(2.2)	(19.9)	(20.7)
Total	2.9	5.5	5.1	2.3	7.4	6.6



Key Points:

- The actual savings to M3 was £3.9m which is £2.9m below the M3 savings target of £6.8m.
- The M3 forecast In year savings is £21.8m. This is £5.5m below the annual savings target of £27.3m.
- The M3 forecast Recurrent savings of £22.2m is £5.1m below the £27.3m target.
- Forecast savings have increased by £1.9m from M2 but the latest plans are still £5.5m below the target for 23/24.
- Urgent work is needed to develop robust plans to close the forecast gap of £5.5m In year and £5.1m recurrently.
- The current month savings in M3 was £1.6m, to reach the forecast position of £21.8m future savings will need to average at £2.0m per month.

Risk Management Risks and Opportunities

	Month 3 £m	May submission £m	Comment
Savings delivery risks:			
Shortfall against planned savings delivery of £27.3m.	5.5	8.6	The latest forecast shortfall at M3 is £5.5m . This assumes that £4.3m of Amber schemes will be fully delivered.
Funding risks:			
Assumed funding for the impact of RLW in 23/24	1.2	1.2	Further clarification needed on funding assumptions for 23/24.
Assumed funding for Regional Planned care Recovery solutions	3.8	3.8	Further clarification needed on funding assumptions for 23/24. In the meantime, the potential risk has been estimated at 50% of the assumed Regional allocation.
Risk of the 23/24 recurrent pay award not being fully funded given the £1.9m recurrent shortfall in 22/23. Estimated costs £24.2m.	1.0	1.0	Further clarification needed on funding assumptions for 23/24.
Risk of pay award payments already made not being fully funded. Actual costs £20.5m	1.0	0.0	
Dental underspends – the latest forecast assumes that any dental underspends can be retained by the Health Board.	1.4	0.0	Further clarification needed on funding assumptions for 23/24.
Cost pressure risks:			
Return to pre Covid Cost & Volume LTA arrangements in 23/24	0.0	1.0	
Contracting risks with other Health Boards	3.1	3.1	See Page 14 re specific risk re ABUHB.
Primary care prescribing – inflation and volume growth different to plan assumptions	Tbc	Tbc	Prescribing data is 2m in arrears and we will not have Q1 data until August 2023.
Significant uncertainty surrounding the expected energy cost pressure	Tbc	Tbc	
NICE costs exceed planned growth of £3.0m	Tbc	Tbc	
Pension changes – Increased pension costs if staff opt back in following changes to the 1995 scheme	0.75	0.75	
Winter plans – All schemes funded non recurrently in 22/23 need to stop by 31 March	0.75	0.75	
Total Risks	**18.5**	**20.2**	

Key Points :

- The draft plan highlighted several significant risks and opportunities.
- As at M3 we are reporting total risks of £18.5m offset by total opportunities of £4m (next page) to give a net position of £14.5m.
- The most significant risk is the savings plan position, where the latest plans are currently £5.5m short of the £27.3m savings target.
- There are also significant risks associated with the WG funding assumptions for 23/24. The risk table includes £8.4m of funding risks where further clarification is needed on the assumptions for 23/24.
- There is also a £3.1m risk with ABUHB which is explained on Page 14.

Risk Management Risks and Opportunities

	Month 3 £m	May submission £m	Comment
Contingencies / Opportunities			
Further balance sheet review within 22/23	(2.5)	(2.5)	
Retrospective vat recoveries – Primary care and Microsoft contract	(0.5)	(0.5)	
Provision for an adverse movement in discount rates in 23/24 (following a positive movement in 22/23) not required	(1.0)	(1.0)	
Potential opportunity if the HB can reduce expenditure for TTP/vaccination below the notified allocation amount – and be allowed to retain any slippage.	0.0	(2.0)	Slippage opportunity removed following confirmation of the WG funding position.
Total Opportunities	**(4.0)**	**(6.0)**	
Total	**14.5**	**14.2**	

Key Points :

- Following confirmation from WG that only actual costs incurred would be funded for COVID Health Protection, the opportunity of retaining Health Protection slippage has been removed from the M3 opportunities.
- No further issues to note at M3.

Statement of Financial Position

Balance Sheet	Opening Balance (01/04/2023) £'m	Closing Balance as at M03 £'000	F/Cast Closing Balance as at M12 £'000
Non Current Assets			
Property, Plant & Equipment	659	667	659
Intangible Assets	3	3	3
Trade and Other Receivables	47	47	47
Total Non-Current Assets	**709**	**717**	**709**
Current Assets			
Inventories	7	7	7
Trade and Other Receivables	75	71	74
Cash and Cash Equivalents	1	3	(79)
Non Current Assets Classified as Held for Sale	0	0	0
Total Current Assets	**83**	**81**	**2**
Current Liabilities			
Trade and Other Payables	(169)	(160)	(169)
Provisions	(27)	(27)	(27)
Total Current Liabilities	**(196)**	**(187)**	**(196)**
Non-Current Liabilities			
Trade and Other Payables	(20)	(20)	(20)
Provisions	(52)	(52)	(52)
Total Non-Current Liabilities	**(72)**	**(72)**	**(72)**
TOTAL ASSETS EMPLOYED	**(524)**	**(539)**	**(443)**
Financed By:			
General Fund	429	444	348
Revaluation Reserve	95	95	95
TOTAL	**524**	**539**	**443**

Key Points within the Cash Flow Forecast :

This is the first update on the 2022/23 balance sheet movements and highlights the main movements since the opening balance at the start of April 2023:

- The main movement since April 2023 has been a reduction in trade and other payables of £9m. This is mainly due to the payment of the 1.5% consolidated pay-award for which there was a creditor on the balance sheet.
- There has also been a reduction in trade and other receivables balance of £4m since April 2023. This is due to a net reduction in debtors across a number of lines.
- The forecast Cash Flow position at year end shows a projected deficit of £79m. This reflects the forecast deficit in the draft plan and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

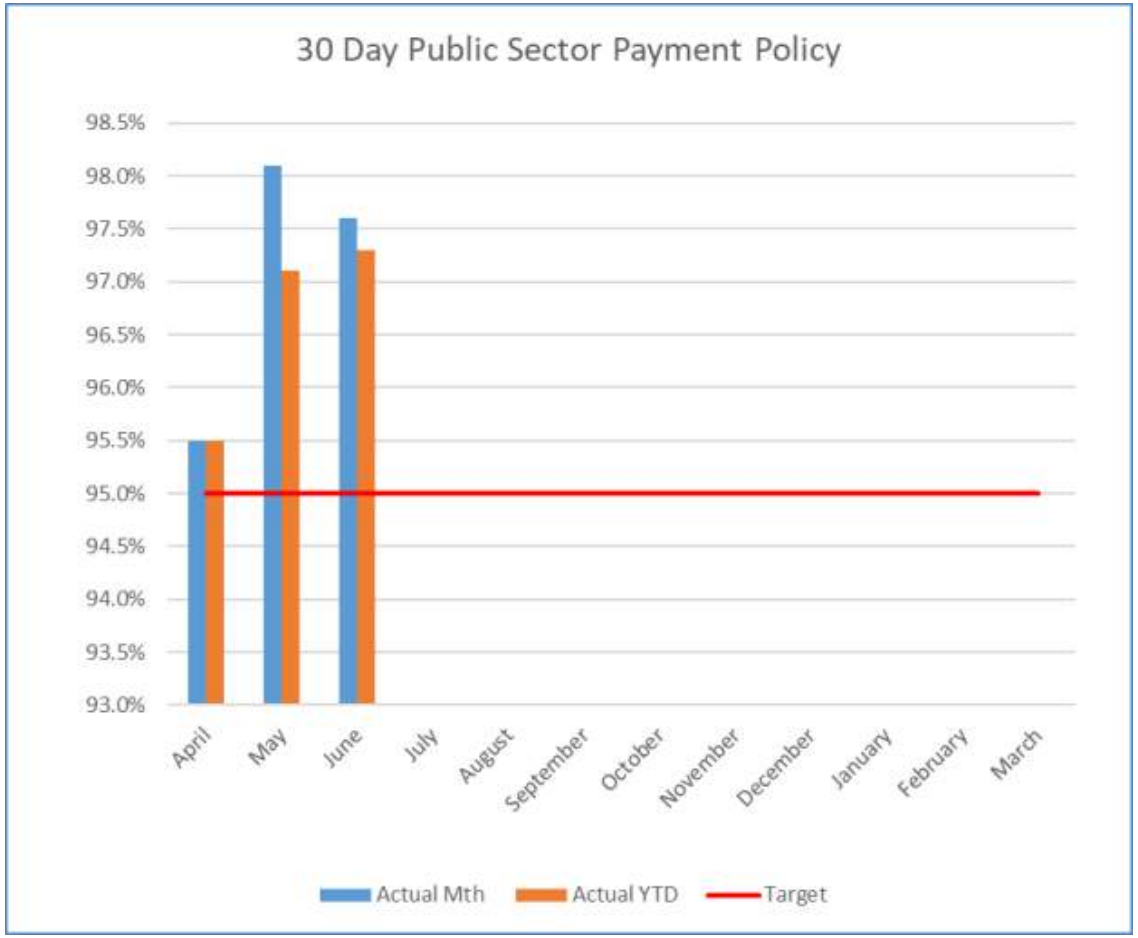
Cash Flow Forecast

Cashflow	Actual/Forecast												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
Receipts													
WG Revenue Funding	113,271	100,294	122,791	111,000	113,200	117,000	94,500	107,500	120,000	97,000	112,000	47,352	1,255,908
WG Capital Funding	0	10,000	5,500	6,500	5,100	4,700	4,100	4,400	4,000	5,600	8,200	11,897	69,997
Sale of Assets	0	249	1	0	0	0	0	0	0	0	0	0	250
Welsh NHS Org'ns	12,193	12,612	9,598	10,600	10,800	10,900	10,900	10,900	10,900	10,900	10,900	10,900	132,103
Other	5,917	7,290	2,069	3,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	50,276
Total Receipts	**131,381**	**130,445**	**139,959**	**131,100**	**133,100**	**136,600**	**113,500**	**126,800**	**138,900**	**117,500**	**135,100**	**74,149**	**1,508,534**
Payments													
Primary Care Services	28,974	7,530	30,657	7,628	17,180	28,530	7,435	19,080	33,335	8,665	19,430	19,015	227,459
Salaries and Wages	50,003	69,212	52,518	61,500	55,200	55,200	53,000	53,300	53,200	53,300	53,000	53,500	662,933
Non Pay Expenditure	43,561	46,456	53,590	51,500	57,600	50,000	49,000	50,000	49,000	50,000	54,000	72,785	627,492
Capital Payments	5,502	6,527	5,649	5,360	5,225	4,640	4,200	4,350	4,050	5,550	8,250	12,171	71,474
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**128,040**	**129,725**	**142,414**	**125,988**	**135,205**	**138,370**	**113,635**	**126,730**	**139,585**	**117,515**	**134,680**	**157,471**	**1,589,358**
Net Cash In/Out	3,341	720	(2,455)	5,112	(2,105)	(1,770)	(135)	70	(685)	(15)	420	(83,322)	
Balance B/F	1,348	4,689	5,409	2,954	8,066	5,961	4,191	4,056	4,126	3,441	3,426	3,846	
Balance C/F	4,689	5,409	2,954	8,066	5,961	4,191	4,056	4,126	3,441	3,426	3,846	(79,476)	

Key Points within the Cash Flow Forecast :

- The closing cash balance at 30th June 2023 was £3.0m.
- The forecast Cash Flow position to year end shows a projected deficit of £79.5m. This reflects the forecast deficit in the draft plan and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

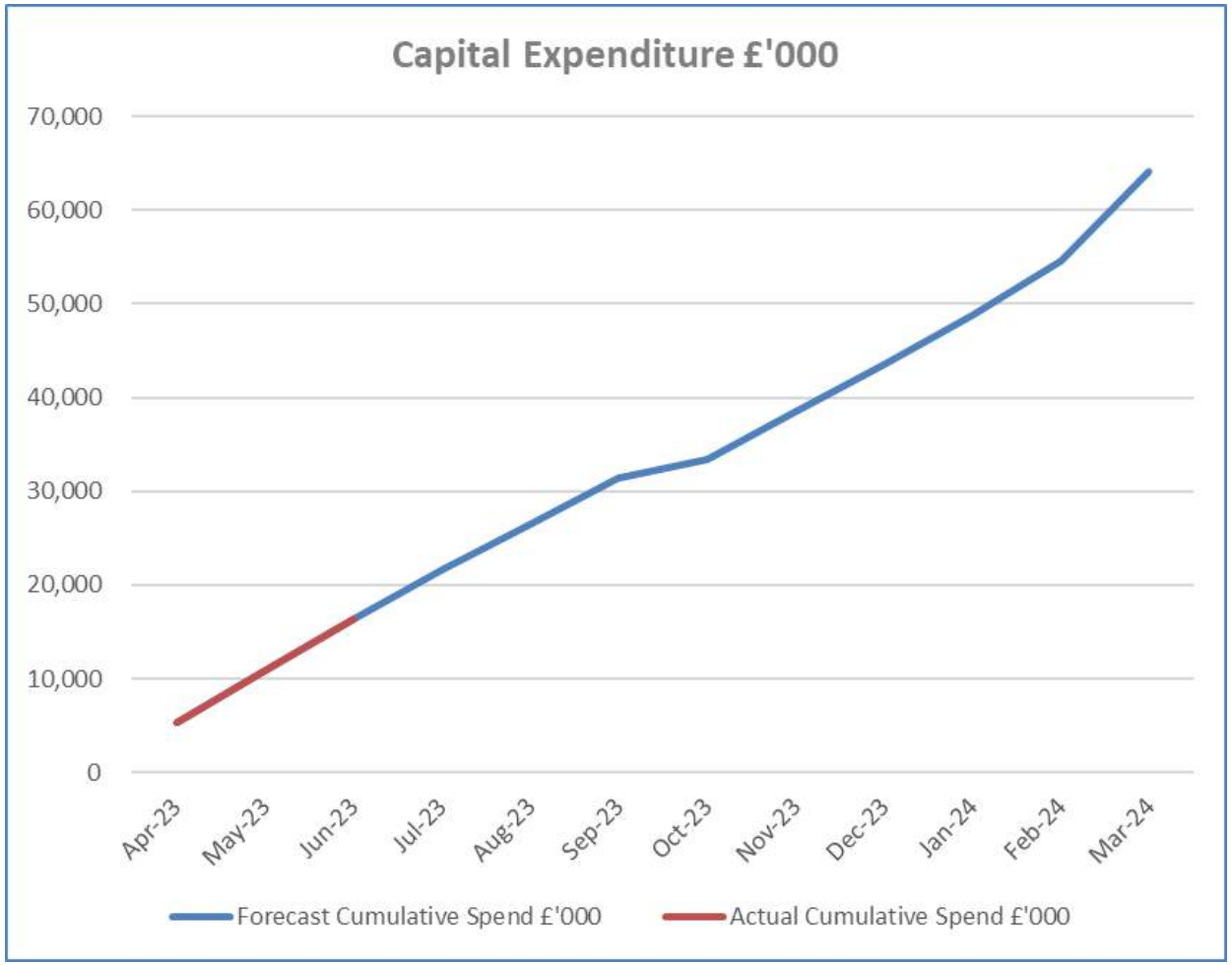
Public Sector Payment Policy



Key Points in the Public Sector Payment Policy :

- The percentage for the number of non-NHS invoices paid within the 30 day target in June was 97.6%.
- The cumulative percentage year to date is 97.3%. The PSPP target is therefore currently being achieved up to M3 of 2023-24.

Capital Expenditure



Key Points in Capital Expenditure:

- The Capital Resource Limit for 2023-24 of £67.6m was issued on the 29th June 2023.
- This is supplemented by £0.2m of donated funds and £0.2m of assets disposed of in this financial year giving an overall programme of £68.0m.
- Expenditure to M3 was £16.3m.
- The forecast outturn capital position is breakeven to the CRL target.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
5.3

CTM BOARD

INTEGRATED MEDIUM TERM PLAN (ANNUAL PLAN) 2023-2026 – QUARTER ONE UPDATE

Date of meeting	27/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elizabeth Beadle, Assistant Director of Transformation
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Board briefing	16/02/2023	NOTED
Planning Performance and Finance Committee	28/02/2023	NOTED
Planning Performance and Finance Committee	22/03/2023	NOTED
Board	30/03/2023	CONFIRMED FOR SUBMISSION

ACRONYMS	
IMTP	Intermediate medium term plan
MDS	Minimum data set

1. SITUATION/BACKGROUND

1.1 Developing an intermediate medium term (three-year) plan (IMTP) is a statutory duty for all Welsh health boards alongside the associated duty to achieve a financial break-even position during the three-year period, in accordance with section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014).

1.2 Since 1st April 2023, the Health Board now has a duty to meet the requirements of the Quality and Engagement Act (2020), which includes a duty of quality and a duty of candour.

1.3 In seeking to meet its statutory requirements, the Health Board's plan was developed with a focus on aligning the delivery of healthcare services to improve health and wellbeing and to tackle ill health of people living in the Health Board area alongside the duty to deliver value and to deliver a balanced financial position.

1.4 During the planning cycle for 2023-2026, the Health Board established that due to the significant current and forecast cost pressures it would not be possible to achieve a financial break-even during the three-year period. Consequently, the planning cycle for 2022 focused on an annual plan. An accountable officer letter was issued to Welsh Government on 28th February 2023 to confirm that the Health Board would be unable to submit a balanced plan.

1.5 The annual plan was submitted to Welsh Government on 31st March 2023. Further discussion was undertaken with Welsh Government on 3rd May and it was requested that the Health Board provide further assurance on the delivery of the ministerial requirements set out in the ministerial templates and to increase assurance of the deliverability of the financial savings plan.

1.6 Updated ministerial requirement plans (the appendices to the IMTP) were submitted in accordance with the requirements of Welsh Government, on 31st May 2023. No further feedback has been received from Welsh Government on the plan.

1.7 The Board approved the use of in-year surplus of £8.5m to invest in in high priority areas. These were:

- Planned care recovery
- Stroke services
- Overseas nurse recruitment
- IM&T infrastructure
- Continued digitisation of medical records

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

Quarter one delivery

2.1 During quarter one, work has progressed on the delivery of key actions in the plan. This is set out in further detail for each of the ministerial priority areas in the attached appendices (Appendices 1-11). A brief summary of progress against each ministerial requirement is set out below.

Primary Care

2.2 General Medical Service access has been reviewed - all 46 practices reported 100% compliance. A sustainability desktop exercise was repeated during quarter one, and identified that four practices previously identified as at risk have been de-escalated to green following intervention by the PC Team.

2.3 Dental services work programme is progressing and key highlights include the achievement of practices having agreed to work with the Health Board to offer additional urgent access appointments. Urgent and Emergency dental appointments are now handled through Navigation Hub to ensure that patients in pain or need are offered an appointment.

2.4 Optometry: preparation is under way for the implementation of the new optometry contract. Whilst funding has been secured to progress WetAMD and Hydroxychloroquine screening.

Pathways of care

2.5 Health Board teams have aligned the new way of reporting pathway of care delays (POCD) with the delivery of discharge to recover then assess pathways (D2RA). Details of progress with delivery of D2RA are set out in appendix 2. There has been a focus on improving data quality through the electronic reporting and a robust process has been put in place to review and scrutinise the data, and agree the improvement plan, through the newly formed Integrated Discharge Board which comprises a range of partners. Large scale engagement of optimizing flow and discharge was taken across CTM with nearly 100 staff attending on the 3 main sites. Improvement is being seen in the following:

- Reduction in length of stay overall with a reduction observed in the last 3 months of 0.9 days (from 8.6 days in April to 7.7 days in June), which cannot be explained by seasonal trends

- Increase in Home First (Pathway 1) from initial baseline data in January of 51% (when the electronic e-whiteboards were introduced) to 66% in June.

2.6 A key enabler to the community services development work is the completion of a business case for Allied Health Professional (AHP) service capacity to create a more resilient urgent care pathway. The proposal has been approved and the implementation phase has been initiated.

Implementation of a 24/7 urgent care service accessible via NHS 111 Wales

2.7 The Navigation Hub continues to embed a range of services 24/7 to support urgent care accessible via 111 but also from health board professionals working in the community. A range of pathways are now operational to avoid unnecessary conveyance into hospitals and to navigate patients to the right service or support. Sitting alongside this is a review of the 'optimum' integrated community model to ensure the delivery of placed based individual care. This work is being overseen by a commissioning group made up of key health and social care representatives. As noted in 2.5, the development of the AHP proposal has been a key step in the work.

Same day emergency care (SDEC)

2.8 Good progress has been made on SDEC plans during quarter one and key milestones for the navigation hub have been met. Capital development work is progressing: lead design consultant appointment was made in early July 2023 and initial scoping meetings with stakeholders have been undertaken and preparation work for contract orders to be placed with NHS Wales Shared Services Partnership (NWSSP) Procurement by CTM by end of July 2023.

Emergency pressures escalation framework/ Ambulance handover

2.9 A review of emergency escalation procedures was undertaken across the Health Board during quarter one and this was consulted upon with teams across all sites during May. Royal Glamorgan Hospital was selected for a focused improvement programme to reduce ambulance handover which commenced on 28th April 2023 and has resulted in a number of changes, including development of a fit to sit area in the emergency department and the wider rebalancing of risk throughout the hospital and wider system through the Safe 2 Start site management meetings.

2.10 Positive impact has been seen in urgent and emergency care indicators as set out in the charts below. The focus is now on maintaining this momentum and expanding to Prince Charles and Princess of Wales Hospitals.

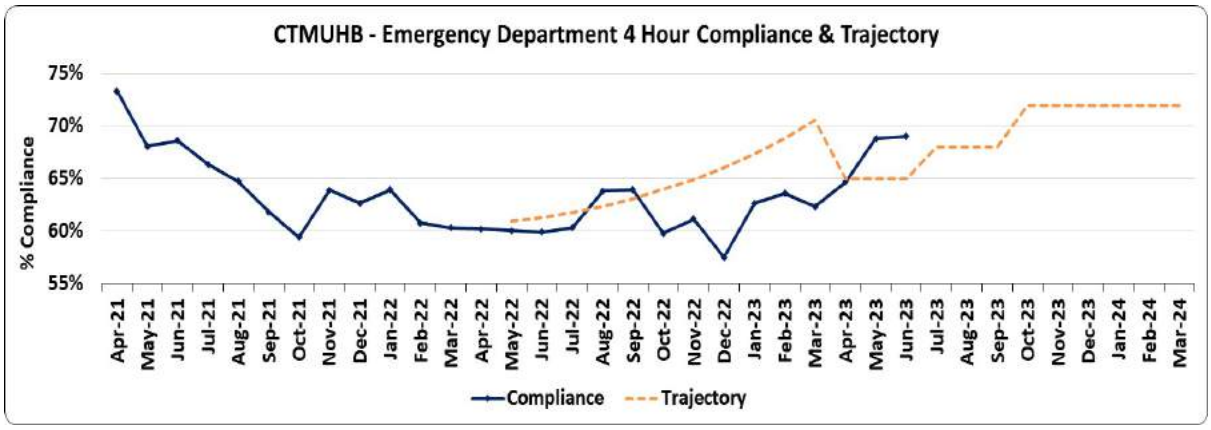


Figure 1 – CTMUHB ED 4 hour compliance and trajectory

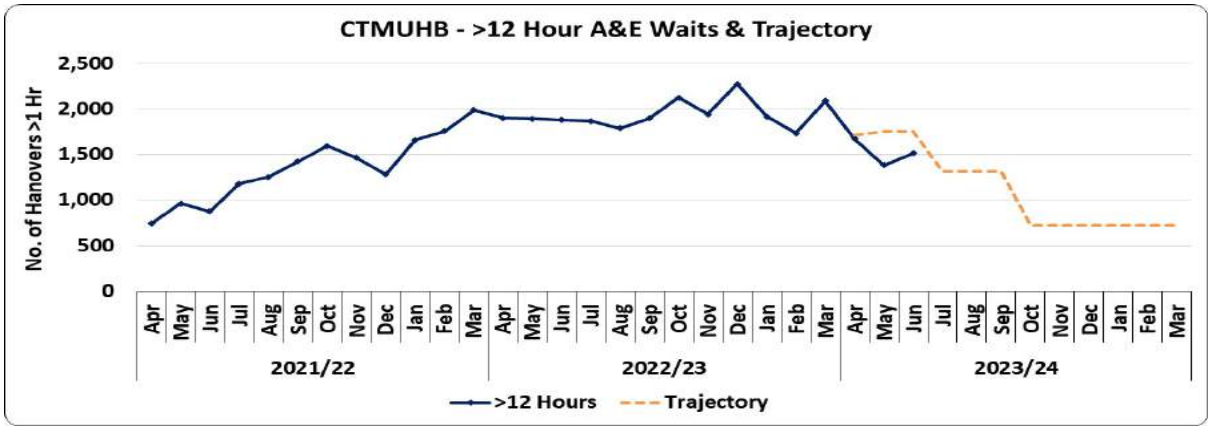


Figure 2 – CTMUHB ED waits exceeding 12 hours performance and trajectory

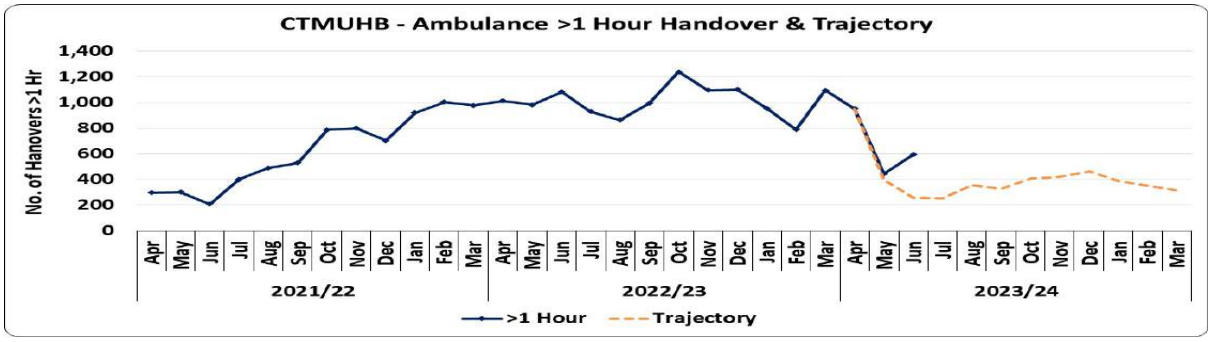


Figure 3 – CTMUHB Ambulance handovers exceeding one hour, performance and trajectory

Outpatients

2.11 Work continues to progress in a number of key areas of outpatients. See on symptom/ patient initiated follow up is being implemented across specialities through the delivery of an eight-stage change process. The quarter one report highlights that this process is taking longer than the intended four-week timescale, but notes improved engagement with the progress.

2.12 Quarter one targets for Attend Anywhere have been achieved with exception of the Attend Anywhere Hub in Maesteg Hospital which is delayed due to a hospital refurbishment project.

2.13 Validation work is on track, however the Welsh Patient Referral System (WPRS) has encountered some delays but continues to progress.

2.14 The outpatient capacity and utilisation project was put on hold in May 2023 due to operational pressures. A workshop is being held in July 2023 to review outpatient transformation.

Planned Care

2.15 Across the breadth of the planned care portfolio there is a range of transformation work being undertaken. All services are expected to deliver efficiency and effectiveness and to seek to manage demand. Of the specific actions identified for quarter one in the appendix to the annual plan, all are on track/ delivered. These include:

- The opening of additional day surgery capacity at Princess of Wales Hospital, supported by ID Medical. One theatre opened in March 2023 and the second in July 2023.
- Delivery of plans to embed a new one-stop Gynaecology Assessment Unit at Royal Glamorgan Hospital with elements of the new service model having commenced.
- Continued work on the regional ophthalmology programme. The business case for regional cataracts developments is pending funding confirmation from Welsh Government.

Planned Care – Cancer

2.16 During quarter one, a number of service developments were progressed, including the implementation of the FIT (bowel screening) pathway, commencement of a new breast surgeon and the opening of the Snowdrop Breast Unit. However, there remain delays to the Bowel Screening Wales (BSW) programme despite progress having been made. There is a health board endoscopy improvement task group which meets weekly and BSW is included in the scope of the endoscopy work being undertaken regionally. This regional work is described below.

Planned Care – Regional Diagnostics Programme

2.17 During quarter one, good progress was made in the regional diagnostic programme. The business case for community diagnostic hubs has been delayed due to challenges in completed an updated

demand and capacity assessment, however remedial action has been agreed.

2.18 An endoscopy operational group has been set up and has held regular meetings since 22nd June 2023. This group is due to complete a review of the clinical specification and pathways documents which were developed by the National Endoscopy Programme, and to assess updated demand and capacity data to inform the requirements for regional development.

2.19 The Pathology programme has made progress in identifying the required model for regional cellular pathology. Feasibility studies have been undertaken and an option appraisal is under way.

Mental Health – 111 #2

2.20 Ministerial expectations included in the NHS Planning Framework for 2023-24 that the Health Board expects to deliver are set out below:

2.21 The plan is on track, with the service having gone live on 4th April 2023 on a 15-hour service basis, including professional Police support line. Further developmental actions were completed within quarter one, which include the recruitment of sixteen staff into the 111 #2 service and the design and approval of the rota by the national programme team. Further details are included in appendix 10.

Mental Health Services - Performance

2.22 Adult mental health performance was consistently positive during 2022-23, so performance trajectories were not set for 2023-24. Key actions for quarter one centred on the Child and Adolescent Mental Health Service (CAMHS).

2.23 Demand and capacity modelling work facilitated realignment of service capacity, which has seen the waiting list drop from 330 in March 2023 to 140 in June 2023. Options to increase capacity are being explored and these include outsourcing.

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

3.1 This report provides the Board with an update on progress with plans during quarter one.

3.2 A key risk to delivery of further plans is the availability of anticipated funds for which the Health Board has submitted proposals/ business cases. If this funding is not able to be accessed a number of actions in our action plans to deliver the ministerial priorities will not be able

to be realised. Efforts will continue to be made to improve internal efficiencies and effectiveness across all services.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The plan necessitates decisions regarding further improvement of the performance position of the Health Board's services. These decisions have been considered with a view to balancing quality, performance and financial risk.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	The IMTP presents the health board's key priorities and plans to address these during a three-year period. Consequently, the IMTP relates to all Health and Care Standards
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Any service changes described within the IMTP would be subject to EIA at the relevant point in the service development and change process.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
	Provision of a board-approved, financially balanced three-year plan is a requirement under section 175(2) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014).
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	This plan sets out the Health Board's financial plan for 2023-24 in the context of the wider three year period
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is requested to **NOTE** the contents of this report including:

- The progress made during quarter one against the delivery plans within the annual plan and associated performance improvements in a number of areas.
- The risk associated with funding for some key actions planned for the remainder of the year.

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

NHS organisations are expected to focus on the following Ministerial priorities. These priorities will feature prominently in the narrative plan and the Ministerial templates below.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

The templates below should provide your planned actions/ milestones etc for 23/24.

Ministerial priorities:

- **Delayed transfers of care**

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination

- **Primary care access to services**

Improved access to GP and Community Services
Increased access to dental services
Improved use of community pharmacy
Improved use of optometry services

- **Urgent & Emergency care**

Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability
Implementation of Same Day Emergency Care services that complies with the following: • Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2 • Is accessible at key times evidenced by the emergency care demand profile in of each hospital site • Is direct access and bypasses Emergency Departments • Delivers a service for at least medical and surgical same day care • Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook. • Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme

Health boards must honour commitments that have been made to reduce handover waits

- **Planned Care, Recovery, Diagnostics and Pathways of Care**

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024
Implement pathway redesign – adopting ‘straight to test model’ and onward referral as necessary

- **Cancer recovery**

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026,

- **Mental health and CAMHS**

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Implement 111 press 2 on a 24/7 basis for urgent mental health issue

MINISTERIAL TEMPLATE BLANK

This blank template shown below needs to be replicated and completed for each of the rows shown as priorities above. E.g., Cancer care: one x template for *Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion* and one template for *Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026*

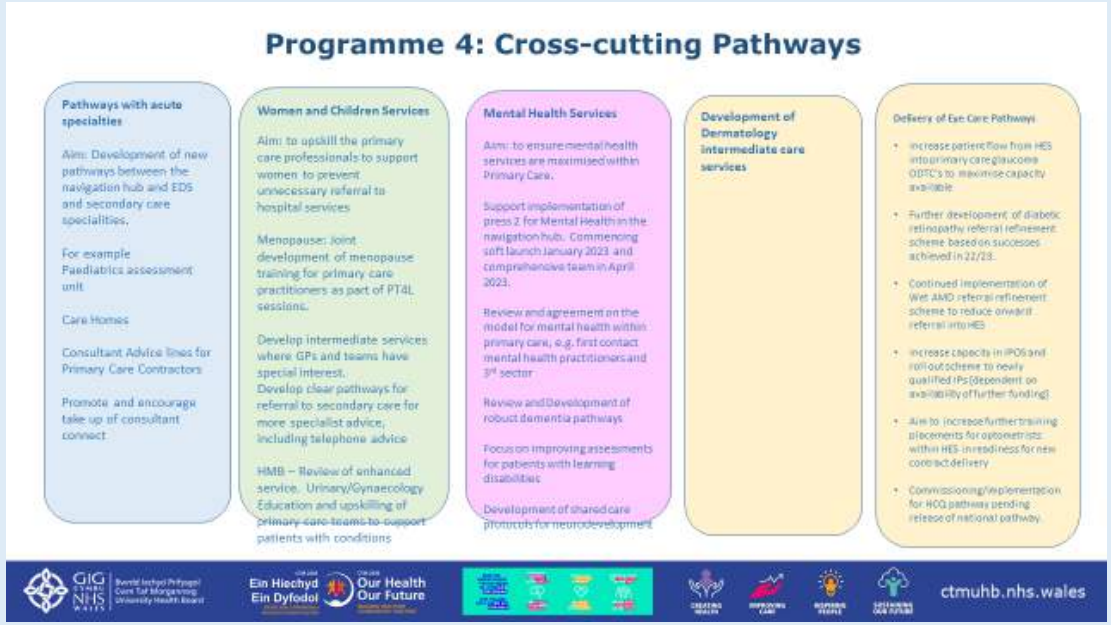
The completed templates must be collated and submitted alongside the organisation's plan and completed Minimum Data Set by 31 March 2023.

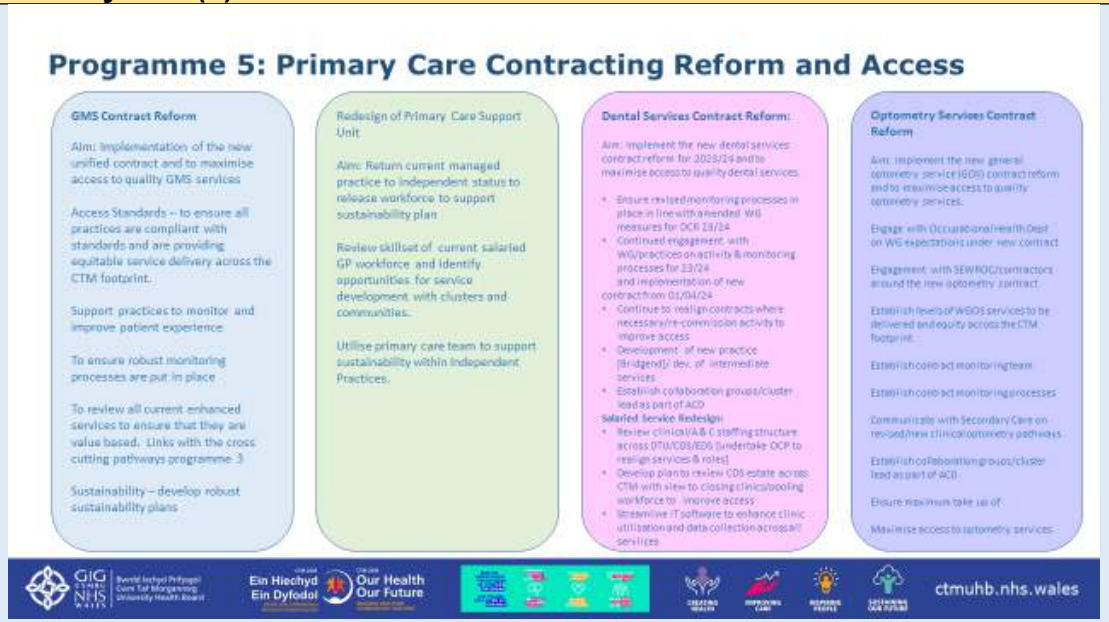
	Priority area(s)
Key focus should be on delivering	Improved access to GP and Community Services
	Increased access to dental services
	Improved use of community pharmacy
	Improved use of optometry services
Baseline	Existing service map:

Community Hospitals	Palliative Care	Primary Care
Inpatient – 10 wards	Inpatient – 3 wards	
Ward A1, Ysbyty Cwm Rhondda	Ward 6, Ysbyty Cwm Cynon	Urgent Primary Care (GP OOH)/Navigation Hub
Ward B2, Ysbyty Cwm Rhondda	Y Bwthyn, Royal Glamorgan Hospital	Primary Care Support Unit (Salaried GPs and Nurses)
Ward C3, Ysbyty Cwm Rhondda	Y Bwthyn Newydd, Prince of Wales Hospital	WISE & Education Programme for Patients (including Education Programme for Patients)
Ward D4, Ysbyty Cwm Rhondda		Inverse Care Health Check Programme (Cardiovascular Risk Disease, AF & Serious Mental Illness)
Ward 1, Ysbyty Cwm Cynon		Immunisation Team, including the COVID immunisation programme and National Immunisation Programme (to transfer 01.04.23)
Ward 2, Ysbyty Cwm Cynon		COVID Testing and Tracing (to transfer 01.04.23)
Ward 3, Ysbyty Cwm Cynon		Health Provision at the HMS Parc Prison
Ward 4, Ysbyty Cwm Cynon		GMS Contracting and Monitoring (46 GP Practices which will reduce to 45 practices with effect from 1st April and further to 44 by October 2023

	Priority area(s)		
	Ward 21 Princess of Wales Hospital		1 Directly Managed GMS Practice
	Ward 16 Princess of Wales Hospital (surge ward)		Dental Contracting and Monitoring
			Dental Teaching Unit (Post Graduate Placements)
			Community Dental Services (including Design to Smile and Gwen am Blyth programmes)
			Optometry Contracting and Monitoring
	Community Services	Inpatient and Community Services	Specialist Eye Care Services (commissioned through planned care, e.g., glaucoma, diabetic retinopathy, WetAMD)
	27 x District Nursing teams across CTM	Specialist Palliative Care CNS team	Accelerated Cluster Development programme and clusters administration
	Wound clinics	Continuing Health Care (CHC) & Funded Nursing Care (FNC) commissioning	Primary Care Estates (strategic planning, development and monitoring)
	@ Home services (MDT team providing assessments for patients requiring care of the elderly assessments)	Tissue Viability Service	
	Acute Care Team (Bridgend Only)	Parkinson Service	Healthcare at HMPS Parc Prison
	Home Oxygen	Lymphoedema Service	
	Nurse assessing team	Bowel and Bladder Services	
	Respiratory Clinical Nurse Specialists		
	Diabetes Clinical Nurse Specialists		
	Aural Care Service (wax management and ear care assessment and treatment)		
May 2023 update	Further services have been transferred into the portfolio includes 1. **Population Health Prevention programmes** (including test and trace, vaccination and immunisation programme for Covid as well as responsibility for the implementation of **National Framework for the Vaccination and Immunisation Famework.** • 1st Q of 2023/24 sees the further development of the **Navigation Hub** and includes the delivery of **nMAB (Antiviral service).** All referrals, including self-referrals are received and triaged and where appropriate medication / transfusion organised and delivered. Also ***PTAS (Physician Telephone and Streaming Service) –*** The 999-dispatch system, known as C3 is reviewed and queried virtually by GPs in the navigation hub. Where appropriate patients are taken off and handled by the navigation hub or signposted to alternative services. In addition to this we have established a **Professional Advice Line** for those working in the community (District Nurses, WAST, LA falls teams, Care Homes) they can call to see if an admission to hospital can be prevented. This takes valuable pressure off GPs and other teams when faced with an ill patient where it is uncertain that admission is necessary.		

	Priority area(s)
	• Rescoping of community resources has progressed and a proposal has been submitted to WG in respect of the additional AHP funding. The proposal includes additional AHPs to form a **falls prevention and rapid response team** which will complement the service development of the Professional Advice Line in the Navigation Hub. This is the beginings of the development of the community redesign in line with the Community Infrastructure Model and ambition of the 6 goals. • **Accelerated Cluster Development (ACD)** – During December to March series of 3 consecutive workshops held for each of the PCPG or newly named 'Locality Planning Groups'. The events were facilitated by the National Association for Primary Care. Purpose was to gain shared understanding and agreement around purpose and role of the LPGs. Excellent multi-professional and multi-agency representation and enthusiasm for the priorities and action which needed to take place. Focus now on next steps to take priorities forward.
Q1 status summary (Key progress and any emerging risks or issues)	Key progress: • Navigation Hub - Continue to embed services. Newest service to be hosted is the Antiviral Service. All GPs working in the hub have now been trained for C3-PTaS to review the WAST stack and identify patients to be handled by the hub. Issue to encourage WAST to mandate to crews that they choose the Navigation Hub as the first point of contact prior to conveyance. To promote the use of the care home pathways to maximise take up. • Redesign of Community Hospitals – Establishment of a Commissioning Group with key health and social care representatives to design the optimum community model. Urgent and Population Health Management pathways are currently being defined. Next steps are to engage with Clusters and other representatives to co-design the model. • Accelerated Cluster Development – Following the workshops feedback has been provided to Regional Partnership Board. Governance reporting process and membership has been reviewed. Further workshops are to be organised in Q2 to refine the optimum integrated community model. • Regular monthly meetings taking place with Children and Families Care Group • Regular monthly meeting taking place with all Care Group Directors • Regular monthly meetings taking place with Mental Health • Eye Care priorities, WetAMD, diabetic retinopathy and HQC funding has been agreed from the planned care programme and joing meetings taking place with the Care Groups • GMS Access: 100% of practices now meeting all phase 1 and phase 2 access standards. Where it is known that practices are facing challenges with access and sustainability active contact is made with the practices to support. Discussions have taken place with a number of practices and action plans agreed. • Dental Access: the urgent and emergency dental access hub is managing calls from patients who are in pain or need of dental treatment. Where appropriate appointments are sources in Dental Practices (through commissioned dental activity in addition to the contracted activity and through the salaried dental services.

	Priority area(s)
Plan narrative	The Primary and Community Services Care Group has developed a transformation portfolio to develop primary and community care services. This comprises the following programmes. Programme 4 – cross cutting work streams: • Pathways with acute services (including a focus on care homes; • Women and children's services • Mental health services • Development dermatology intermediate care services • Delivery of eye care priorities  Programme 5 – Primary Care Contracting Reform and Access • GMS contract reform • Redesign of Primary Care Support Unit • Dental Services Contract reform • Optometry services contract reform

	Priority area(s)
	 There are supporting enabler programmes for: • Workforce • Estates • Digital infrastructure (details in section below).

Delivery plan

Priority	Key actions	Metrics (performance indicator/ outcome/ output)	Timescale Qtr./ Year	Update – May 2023	Q1 update
General Medical Services and Access	1. Continuing to support practices to find ways to improve access to GMS services	1. Ensure 100% compliance of phase 1 & 2 GMS Access Standards	Q1-Q4 2023	• Self-assessments received. All 46 practices report 100% compliance. Evidence is being verified.	1. Final submissions for GMS access standards received and evidence verified. 100% achievement.

	Priority area(s)						
		2. Ensure that each practice establishes a PPG 3. Undertake the sustainability desktop exercise on quarterly basis to identify practices at risk 4. Salaried GP Service re-design	2. Monitor Concerns and complaint for trends, issues and hotspots		Access forum due to meet on the 24th May. • Sustainability desktop exercise repeated. 4 practices identified at risk have been de-escalated to green following intervention by the PC Team. Continue to support those in need with action plan. Review undertaken to ensure changes are embedded. • GMS Practice Development Visit completed and action plan is in the process of being produced for areas of improvement and trends and themes.	2. Where pressures are reported by practices and by stakeholders practices are approached and actions plans are agreed. Currently working with 4 practices. 3. Communications on social media has continued to explain the routes to access and new roles in PC. 4. Liaison with local councillors to share the changes so they can support queries in from constituents 5. HEIW local workforce event took place with good representation form GMS	
	Dental Services	1. Robust commissioning	1. Monitor the urgent and	Q1-Q4 2023	• Activity is being reported into	• Activity continues to be	

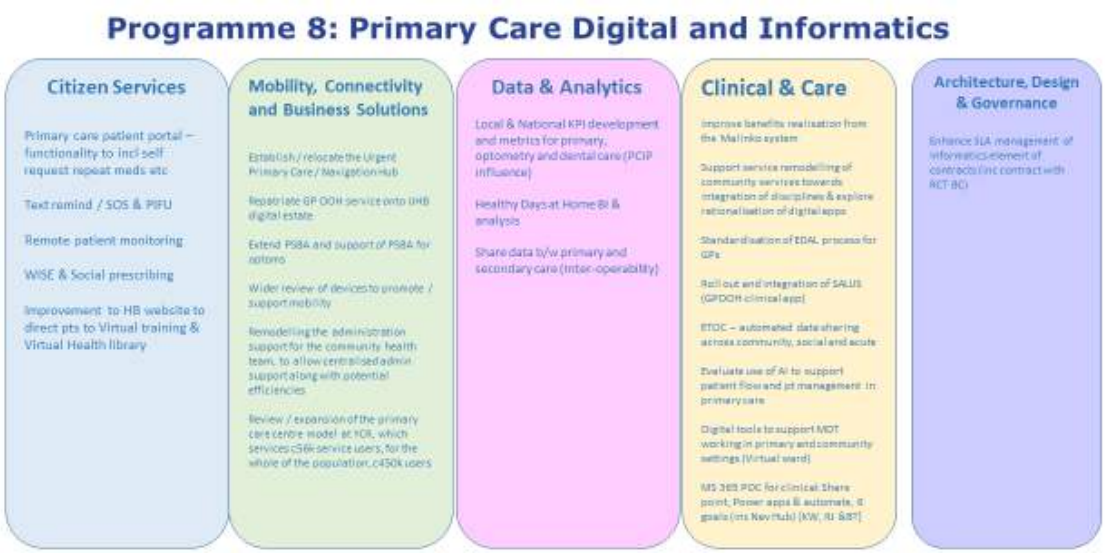
	Priority area(s)						
	Contract Reform and Access	of dental services in areas of need during the re-tender of dental contracts 2. Review of CDS / DTU services 3. Development of model and workforce plan 4. Engagement with teams and stakeholders 5. Encourage participation in the ACD programme	emergency activity 2. Monitor the follow up activity 3. Monitor will be determined by the national dental contract measures 4. MOS activity 5. CDS activity 6. D2S & Gwen a Blyth activity		the Heath Boards Performance and Improvement Board. • 3 handed contracts handed back. 1 tender completed and another tender for large contract in Bridgend due to take place. 3rd was taken on by neighbouring practice. Provides opportunity to redistribute dental contract to meet needs of population. • Practices have agreed to work with the HB to offer additional urgent access appointments. • Urgent and Emergency appointments	shared at performance boards. • Progress of the tender process for the 3 contracts handed back. • Primary Care team continue to direct patients to the additional appointments across reform practices to ensure needs are met. • 310 additional urgent access appointments were available each week in Q1 and allocation managed by dental hub. • Review of CDS continued to take place in Q1 • HEIW local workforce event taken place with	

	Priority area(s)					
					now handled through Navigation Hub • Review of salaried Dental Services taking place to ensure in line with WHC and to maximise efficiencies and activity. Part of wider OCP process • HEIW workforce planning event due to take place 24th May • Regular meetings with LDS to ensure smooth transition for contract reform • Engagement with dentists regarding ACD regularly taking place.	representation from dental.
	Optometry Services Contract	1. Preparation for the phasing of the	1. Monitoring will be determined by	Q1-Q4	• Preparing for the implementation	• Preparation continued.

	Priority area(s)						
	Reform and Access	new optometry contract 2. Engagement with contractors, WG and other contractors on an ongoing basis. 3. Development of team so it is in place to and ready to take on the additional workload 4. Once contract details finalised prepare a plan for the engagement and commissioning of the services from each contractor 5. Further support the shift of activity done traditionally in eye care	the national measures as agreed by the contract 2. Continue to monitor uptake of the specialist services such as glaucoma, cataract, diabetic retinopathy, IPOS and EHEW and low vision services		of the new contract. • A part of wider HB OCP ensuring the resources are in the team to enable them to manage this additional work. • Regular dialogue with SEWROC. • Optometry collaboratives established. • Delivery of specialist eye care services undertaken in conjunction with secondary are and activity/progress reported through to Care Group and Board governance process. • Joint meetings taking place to discuss the implementation of other	• Continued funding agreed this Q for WetAMD, diabetic retinopathy and HCQ.	

	Priority area(s)						
		services from hospital to community optometry, e.g. wet AMD, HCQ, glaucoma and cataract.			specialist services, such as wet AMD and HCQ.		
Risks	Key risks for primary and community care have been identified at the outset of the planning process, in support of developing the programme of work for 2023-2026 and the particular action areas for 2023-24. Identified concerns included: • Unprecedented levels of demand across all elements of primary care. • Impact of commissioning arrangements on delivery of primary care out-of-hours service. • Ability to recruit key staff across all staff groups and to compete with other Health Board areas where deprivation and workload is less and therefore jobs are more attractive. Mitigating actions are in place and the risks have been highlighted within the planning process.						
Outcomes	Through increased collaboration and integration, we will work with partners to deliver improved population health and wellbeing through tackling health inequalities, improving health outcomes and ensuring that our population experience seamless health and care. We will ensure that delivery is achieved and underpinned by common performance data and governance structure. **Population Health** Where ever possible we want to move towards self-managed care encouraging people who have a health condition potentially taking an increasing role in looking after their own health. Services such as care navigators in general practice and the WISE service will support patients to do this and will be guided by coaches and encouraged to make behavioural change and prevention approach. **Tackling Health Inequalities** The impact of health inequalities across CTM remains significant and all stakeholders need to work together, utilising the ACD programme and Locality Planning Groups to identify priorities and apply proportionate universalism. Alongside this will be focused programmes such as that which is taking place in North Bridgend Cluster. **Improving Access** Improving and enabling equitable access to all the Primary Care Contractor Services will facilitate:						

	Priority area(s)
	• improved access to advice and guidance to support wellbeing and manage health • access to preventive services • access to diagnostic and treatment services when required. **Clusters** The cluster will be the platform for • Supporting population health management to reduce inequalities • Enabling personalised care to ensure care needs of our patients are met • Reconfiguration of our community services • Focus on continuous improvement and reducing variation.
Alignment with workforce plans	Key challenges for our primary are and community workforce are: • Increasing sustainability, driven by increasing demand for care, workforce supply and recruitment and retention challenges • Ageing profile of key primary care and community professional groups, such as GPs, practice nurses and district nurses and community hospitals staff. • Changing expectations of the new workforce, for example desire for portfolio careers, part-time working and flexibility which can be obtained via locum or bank working. • Technological advances shaping care • Changes to education training and standards • Contract reform of independent contractor models We aim to focus on key areas which include • Becoming a Care Group that attracts, retains people into our teams • Ensuring everyone has quality health and wellbeing support and we develop a workforce environment which people wish to work in • Developing a positive culture which everyone can contribute to • We will ensure that as part of the plans for transformation we use the full range of people's skills and experience creating opportunities within roles and across services • We will celebrate diversity in every aspect of our workforce • Continue to support and progress the diversity of roles in Primary Care to further develop the primary care model for Wales Key workforce plans included in support of the Primary and Community Care service development plans are: • Continued development of the Primary Care Training Academy and expansion to incorporate wider community disciplines so there is shared learning by multi-professionals

	Priority area(s)
	• Development of the detailed workforce plan to map out current and required skill mix/roles necessary for the key transformation programmes (Integrated community teams, community hospital redesign, palliative care service redesign etc.) • Detailed workforce plan to address difficult to recruit vacancies/succession planning/skill- mix • Identify the gaps in the current team and where non-recurrent funding of essential posts is creating a gap • Promote the role of physicians associates in primary care.
Alignment with financial plans	All service developments are within the existing financial envelope of the Primary and Community Services Care Group or supported by programme funding.
OPTIONAL	
Digital / Technology Opportunities	The transformation change must be underpinned and supported by technology. In order to support primary care and community transformation we will need to deploy digital tools to promote and support self-care, active sign posting, and new types of consultations. This was started during the pandemic with GPs, but now needs to be further embedded and the concept to be further rolled out to the community services. Patients should be able to use online tools to access all primary care services, such as receiving advice, booking appointments etc. The Primary and Community Care Group transformation portfolio incorporates a digital and informatics programme, as set out below. 

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

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All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

The templates below should provide your planned actions/ milestones etc for 23/24.

Ministerial priorities:

- **Delayed transfers of care**

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination

- **Primary care access to services**

Improved access to GP and Community Services
Increased access to dental services
Improved use of community pharmacy
Improved use of optometry services

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Implementation of Same Day Emergency Care services that complies with the following: • Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2 • Is accessible at key times evidenced by the emergency care demand profile in of each hospital site • Is direct access and bypasses Emergency depts • Delivers a service for at least medical and surgical same day care • Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook.

• Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme
Health boards must honour commitments that have been made to reduce handover waits

- **Planned Care, Recovery, Diagnostics and Pathways of Care**

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
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- **Cancer recovery**

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026,

- **Mental health and CAMHS**

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Implement 111 press 2 on a 24/7 basis for urgent mental health issue

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	Priority area(s)
Key focus should be on delivering	Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination
Baseline	There has been work in CTM to align the new way of reporting transfer of care delays with the delivery of D2RA. During COVID formal DTOC reporting was suspended and we were asked to report informally on delays both in and out of D2RA pathways. This was a challenge as the data for CTM was collated manually by discharge liaison nurses and reported mostly non D2RA or 'bypass' pathways. In response to the Delivery Unit recommendations a new process has been introduced to replace DTOC called Pathway of Care Delays. Progress on implementation in CTM includes • Introduction of electronic whiteboards (EWB) that categorise all patients' discharge pathways as simple or complex. • Complex discharges placed on a recommended D2RA pathway within 24hrs of admission to ward with 'bypass' exceptions only being those as stipulated by D2RA guidance (homelessness, complex LD placement, Safeguarding/ Court of Protection and End of Life) • EWB is used to monitor delays to improve flow overall and are categorised as internal or external delays. • Once the patient is optimised for discharge EWB records information on delays to discharge which are aligned to Pathway of Care Delay codes as defined by WG • The delay code records the length of time the patient has been waiting of the action and is reviewed daily. • Delay data is 'live' and can be viewed on the discharge dashboard • Data is validated with LA prior to being submitted to WG.

	Priority area(s)
	This revised process will continue to be embedded through the next year as a priority but it is already providing more qualitative information for teams and the executive to use to monitor continual improvement. **Resilient community services** We wish to wrap a supportive infrastructure around clusters and localities, therefore minimising duplication and removing pressure where we can. We need to make our services more responsive to the needs of our population we service. At the same time, we wish to achieve the 4 pillars of intermediate care which are - Crisis response - Appropriate bed-based services - Home based care - Reablement Our plan sets our ambitious priorities to innovate and redesign community and primary are services, urgent care, including access to the services offered by our independent contractors. At the same time, we want to provide more opportunities for contractors to utilise their specialist skills and to take more planned care out into the community. There is a single vision for the health board footprint and the aim is to develop placed based integrated teams as illustrated below. **Place-based Integrated Teams** The integrated model be built on consistent standards, outcomes, performance monitoring through the Regional Partnership Board and integrated structure. There will also be strong resilient and co-terminus partnership relationships through our Locality Planning Groups (Pan Cluster Planning Groups). The cluster will be the platform for - Supporting population health management to reduce inequalities - Enabling personalised care to meet patients' care needs - Reconfiguration of our community services - Focus on continuous improvement and reducing variation

	Priority area(s)
July 2023 update	Good progress has been made with the implementation and combining of the D2RA and Pathways of Delayed Care processes. Focus has been on improving data quality across all sites for acute and community for the electronic reporting. Learning has been undertaken from the initial launch of D2RA and investment into teams for training has been recognised and further training delivered.

Plan

Priority	Key actions	Metrics (performance indicator/ outcome/ output)	Timescale (Qtr./ Year)	Q1 update
To transform the community services into a single CTM wide model of cluster based integrated teams	1. Establish the work streams 2. Map the current workforce and the funding streams associated 3. Map the current gaps in workforce teams 4. Undertaken engagement sessions with other stakeholders 5. Undertake engagement sessions with teams to share and discuss the vision 6. To align the work programme with the Navigation Hub 7. Implement community nursing principles 8. Implement community nursing specification 9. Implementation of Civica District Nursing scheduling system	1. Implement a whole system approach to integrated care 2. More people to be cared for in their own homes or home of choice 3. Reduction in duplication 4. Reduction in silo working 5. Reduction in various 'hand offs' and referrals 6. Implementation of Seamless Care 7. Reduction in unnecessary admissions 8. Reduction in unnecessary bed days 9. Increase in the response offered to patients in urgent need 10. Supporting D2RA process 11. Improve flow across the whole system 12. Build resilience across the whole system through robust intermediate care services	Q1 Q1 Q1 Q1 Q1 Q1 ongoing Q3-4 Q3-4	1. Integrated Discharge Board (IDB) with health and social care partner representatives implemented and sub workstreams identified. 2. Improvement plan drafted and monitored by the IDB 3. Regularly reporting using the Dashboard for the D2RA and PODC (available on request). 4. Further training for D2RA and e-reporting undertaken on all sites. 5. Increase in Home First (Pathway 1)

	Priority area(s)					
				13. Improvement in maturity of locality cluster teams	By Q4	from initial baseline data January 51% (when EWB were introduced) → 66% June. 6. Reduction of LoS overall with a downward trend with the last 3 months reduction of 0.9 days (8.6 days 04/23 → 7.7 days 06/23) – not explained by seasonal trends 7. Commissioning Group established to review and design the 'optimum' community model for CTM. 2 pathways – urgent and population health management identified. 8. ACD collaboratives continuing to take place and ACD Locality Planning Group memberships been

	Priority area(s)
	reviewed with partners.

Risks

Risk and Performance Measures

The Care Group is a new entity and consequently, over the forthcoming year we will further embed our Risk and Performance Management Frameworks to provide robust mechanism for the identification and mitigation of risk and management of our care group performance. This will facilitate the delivery of safe, high performing, high quality services that meet the needs of our patients, independent contractor practices, stakeholders and staff.

Identified risks include:

Risk	Mitigation
High absence / vacancy rates for RCN nurses in community wards at the same time as a need for increased supervision. If this is not resolved there will continue to be high dependency on bank on the community ward leading to cost pressures but also low morale amongst remaining staffing. It will also prevent the realisation of winter plans to create surge capacity.	Workforce model will be reviewed, ongoing recruitment campaign. Work with People and Wellbeing Team to create a culture and environment where people choose to work within the community.
Increase in demand for District Nursing Services, especially palliative care patients who require longer visits, and if this continues to increase the demand for services will outstrip the capacity within district nursing teams.	A review of District Nursing caseloads, including activity/acuity and administrative support will be undertaken to look for economies of scale and to understand the scale of the problem.
Limited capacity in the provision of care packages and domiciliary care across CTM resulting in long delays in transfers of care. This will lead to a negative impact on flow across the system and patients remaining in hospital or in appropriate place which could lead to delayed	Processes being implemented and embedded within the community as part of the 6 goals programme of care, include: One list, safe to start meetings, D2RA hub and training.

	Priority area(s)	
	recovery or deterioration in condition. Additional capacity in the community is required however.	Collaboration with LA and other stakeholder colleagues to create capacity Review of community hospitals, including bed, medical and workforce model to ensure patients are supported appropriately.
Outcomes	**Please refer to the plan section above.**	
Alignment with workforce plans	**All plans are supported by workforce planning. Please note further detail in appendix 1.**	
Alignment with Financial plans	**All plans are supported by service budgets or programme funding.**	
OPTIONAL		
Digital / Technology Opportunities	**There are opportunities for remote management and monitoring utilising digital opportunities, (telehealth and digital apps).**	

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	Priority area(s)
Key focus should be on delivering	Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability
Baseline	**Urgent Primary Care** We will transform the urgent care system to new integrated care model that will join up urgent, community and primary care services and will utilise the development of the Navigation Hub to do this. We wish to further integrate urgent and emergency care with other contractors such as dental and eye care. Aware that some patients are struggling to access our dental services we aim to integrate General Dental Services, Community Dental Services and other salaried services to improve the range and to development new and exciting roles. Our proposals for integrated community care, incorporating urgent care are set out below (available on request).
May 2023 update	The model for integrated care model is progressing and this is being overseen by a Multi-agency Commissioning Group. The members are from Health, Local Authority and 3rd Sector. Working together the group has developed collaboratively the proposals to secure additional funds for AHP. The objective of the proposal is to further develop the multi-disciplinary team, aligned to the 'Navigation Hub', which can respond to falls and urgent care. It is the first stage of the implementation of the Integrated Community Model as described in the draft proposal in the section above on 'baseline'. For information the AHP proposal is attached below (available on request).

	Priority area(s)					
Plan	**Priority**	**Key actions**	**Metrics (performance indicator/ outcome/ output)**	**Timescale Qtr./ Year**	**May 2023 update**	**Q1 update**
	Develop the Navigation Hub in PC&C to support USC across the whole system and develop capacity and capability	1. Implement and embed pathways with ED to reduce unnecessary conveyance to hospital 2. Implement and embed pathway with Care Homes to ensure that the navigation hub is first point of access not WAST or GP 3. Implement and develop advice line for professionals working in the community 4. Continue to refine the GP OOH dashboard to incorporate the wider navigation hub activity	1. Reduction in unnecessary conveyance by WAST to ED 2. Reduction in admissions into hospital 3. Increased number of patients who have fallen being supported to get up and stay in own home (safely)	Q1 Q1 Q1 Q2	1. PTAS for Cat B now live. 2. Professional line for community teams and Care Homes is operational. This aims to prevent unnecessary admission into hospital and to ensure the individual is directed to the right care. 3. Advice line and provision of emergency medicines for palliative care and end of life 4. District Nursing call handling 5. Urgent and Emergency Dental hub now integral	1. Embedding PTAS process. All GPs in the Nav Hub now trained 2. Embedding the Care Homes pathway. Further promotion between care homes taken place 3. Advice line for emergency medicines already embedded. 4. Antiviral Service has been incorporated and pathway is maturing. 5. Recruitments taken place this quarter for Senior Clinical Editor and Clinical Editors

	Priority area(s)					
					within the Hub. 6. 111#2 live in the hub	for the Healthcare Pathways Latest dashboard below (available on request)
	To transform the community services into a single CTM wide model of cluster based integrated teams	1. Establish the work streams 2. Map the current workforce and the funding streams associated 3. Map the current gaps in workforce teams 4. Undertaken engagement sessions with other stakeholders 5. Undertake engagement sessions with teams to share and discuss the vision 6. To align the work programme with the Navigation Hub 7. Implement community nursing principles 8. Implement community nursing specification 9. Implementation of Civica District Nursing scheduling system	1. Implement a whole system approach to integrated care 2. More people to be cared for in their own homes or home of choice 3. Reduction in duplication 4. Reduction in silo working 5. Reduction in various 'hand offs' and referrals 6. Implementation of Seamless Care 7. Reduction in unnecessary admissions 8. Reduction in unnecessary bed days	Q1 Q1 Q1 Q1	1. Commissioning Group established to progress this work. Model has been agreed and baseline Tor embedded above. Mapping is underway. 2. JD drafted for joint integrated manager post. 3. Self-assessment for District Nursing principles and community nursing infrastructure has been	1. Commissioning Group continued to meet monthly. Mapping of finances and workforce has been undertaken. 2. JD for joint integrated manager post has been advertised and recruitment process in place. 3. Urgent pathway has been defined in this quarter. 4. Work has been shared with RPB and other stakeholders.

	Priority area(s)					
			9. Increase in the response offered to patients in urgent need 10. Supporting D2RA process 11. Improve flow across the whole system 12. Build resilience across the whole system through robust intermediate care services 13. Improvement in maturity of locality cluster teams		completed an submitted. Integral to the redesign of the two pathways for urgent and also anticipatory care. 4. ACD events held across the pan cluster planning groups to start the discussions on priorities. This is now feeding into the redesign of community services	Next steps to take to ACD to refine model. 5. Discussions taken place on the membership of the locality cluster planning groups 6. D2RA and DTOC processes have been combined. Integrated Discharge Board established to review the data and to agree the improvement plan. Data quality and embedding electronic reporting has been a focus for Q1.

	Priority area(s)
Risks	The following risk have been identified 1. The nature of the funding is not recurrent which in the current financial climate for the Health Board creates uncertainty. 2. In order to deliver outcomes the Navigation Hub will require the necessary infrastructure, such as Estates and IT which are both costly and will require investment. 3. The Health Board is going through a wider organisational change process which although can be helpful also adds complexity and uncertainty.
Outcomes	1. Improve access for primary care and community services across the CTM footprint 2. One model for the CTM footprint (at present two models) 3. Improvement in patient experience 4. Improved urgent access for those patients not requiring an admission 5. Reduction in numbers of patients being admitted into hospital 6. Improve satisfaction from our primary care and community colleagues 7. Reduction in duplication across health and social care 8. Timely collaborative care
Alignment with workforce plans	A workforce planning event, driven by HEIW is due to be held on the 24th May for all primary care and community stakeholders. This will explore the national as well as local challenges and priorities going forward. This will help to shape not only the National plan but also the local one. The Health Board is currently in the process of implementing a new operating model and the Care Groups are working through OCP. The re design of primary care and community services will be aligned to delivering the priorities set by the minister and the strategic programme. This in turn ensure there is a strong framework in order to support the necessary planning for independent contractors.
Alignment with Financial plans	As part of the OCP process all financial plans need to align. In view of the significant pressures across all sectors the agreement has been reached that we can achieve redesign through reduction in duplication but more efficient use of existing resources.
OPTIONAL	
Digital / Technology Opportunities	

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	The provision of Medical Same Day Emergency Care in Prince Charles Hospital, Royal Glamorgan Hospital and the Princess of Wales Hospital
Baseline	*As of April 2023, Cwm Taf Morgannwg University Health Board will have established Medical Same Day Emergency Care Provision. We will be building on this during the 2023-24 year by delivering the plan set out below.*
May 2023 update	*Plans progressing with a significant achievement via the identification of capital funding to progress the re-modelling required to create an SDEC area at PCH. Implementation plans are to be developed and timescales to be scoped.* *Plans are monitored via the Six Goals Programme Board.* *The full detail of the SDEC optimal model plan is attached below along with the Six Goals plan (available on request).*
Quarter 1:	**Establishment of a 24 hour Navigation Hub**

	Priority area(s)	
	Expanding and Defining Existing Services **Creation of a Directory of Services**	
- **Milestones**	- **CTM Navigation Hub deployed fully and accessible by GP's, WAST and Nursing Homes to refer patients in to secondary care** - **Current Existing Services Mapped** - **Referral routes identified for Existing Services** - **Gap Analysis completed with opportunity to centralise if possible** - **Directory of Services to support patients on a pathway approach**	**Q1 updates** The following pathways continue to be delivered to support emergency and urgent demand and to avoid hospital conveyance where appropriate. 1. 111Press2 for Mental Health 2. Nursing Home Pathway 3. Physician Triage and Streaming Service (PTaS 1) – inbound calls from paramedics on scene for higher level of clinical advice where conveyance may be appropriately avoided 4. C3 Radius PTAS - Pulling cases directly from ambulance stack 5. Recognition of Life Extinct for Unexpected Death - ROLE Pathway 6. Emergency Department Redirection Pathways 7. Professional Advice Line The National antiviral scheme for those at highest risk of hospitalisation which was started has been embedded over the last two months. No concerns or issue to report to date.
- **Actions**	- **Submission of Capital Estates request to improve environments prioritised by Care Group, agreement to progress to design phase of developing SDEC environment at PCH, first meet reconfiguration meeting – 31 May 2023** - **Continue against current recruitment plans** - **Process Map current pathways against data points with support from Performance and Information** -	**Q1 updates** - Lead design consultant appointment early July 2023 - Initial scoping meetings with stakeholders and sign off of final brief – early July 2023 - Room data sheets completed and signed off/any equipment orders outside the scope of Construction Contract to be agreed for orders to be placed with NWSSP Procurement by CTM by end of July 2023
Quarter 2:	**Exploring options for a suitable model for a 7 day appointment system for Medical SDEC**	

	Priority area(s)
	Begin E-Whiteboard SDEC Development of a data specification (development reliant upon confirmation of funding.)
- Milestones	- Navigation Hub to have ability to book pre-arranged slots for Medical SDEC on acute sites on a Saturday and Sunday - Data to be captured to understand value of running seven day services against cost on all three acute sites - Second Phase E Whiteboard development to begin, incorporating an SDEC viewer to support patients and data collection - Development of capital plans for the SDEC area at PCH.
- Actions	- Booking system to be confirmed through work between Navigation Hub and Secondary Care - Data collection to be cleansed to support validity and accuracy of information - Process mapping to support the design of the second phase E Whiteboard development - Assumption that the Medical SDEC viewer for the E Whiteboard will be in a standalone unit - Build in a marker to support identification of patients who may be on an SDEC pathway but "overnight" – these may remain in Assessment Units - Review current demand data to understand any additional workforce requirements - Capital design to be progressed for the SDEC at PCH.
Quarter 3:	Implement WAST direct access Separation of SDEC and Admission/Assessment Streams
- Milestones	- The Navigation Hub will be able to direct WAST to offload in a defined SDEC area - Medical SDEC environments will be identified - Staffing models will exist against defined environments - Medical SDEC will have defined opening hours, and organisational policy will be to not bed down in SDEC - Medical SDEC will pull from ED/Assessment Units of appropriate patients upon opening
- Actions	- Medical Same Day Emergency Care will be added as a disposition for the Navigation Hub for WAST - WAST will not be allowed to bypass the Navigation Hub, as the Hub will maintain system oversight - Discussion and formalisation around communication strategy for colleagues in WAST/NCCU - Areas defined specifically for Medical Same Day Emergency Care will exist on three acute sites - Direct WAST pathway to be established for existing SDEC services. - A CTM Standard Operating Procedure for Medical SDEC will be defined to demonstrate how the areas will function to support flow

	Priority area(s)
Quarter4:	**Explore Virtual Wards utilising data** **Direct to SDEC ED referrals**
- **Milestones**	- **Consistent data reports in relation to Medical SDEC numbers** - **Clinically led review of data to understand if setting up of virtual wards would add value** - **Discussion to consider value from an individual site basis against having an organisational stance (a virtual ward for CTM)** - **Pilot of direct referrals in to Medical SDEC from ED Nurse Triage**
- **Actions**	- **ICT colleagues to collaborate in design of virtual ward** - **Business case to be designed and submitted to support virtual ward set up and working** - **Data to inform strategy against delivery of virtual ward** - **Acute Medical leads asked to design pilot of direct referrals from ED Nurse triage in to Medical SDEC** - **Data capture and reporting to be set up to monitor outcomes of patients to demonstrate value**
Risks	- **Current constraints within the medical workforce in order to deliver on all three sites.** - **Current data demonstrates poor value where seven day services have been trialled within Cwm Taf Morgannwg, with increased cost for very little patient benefit** - **There is a risk to the traditional 7 day working model as there would be no access to diagnostics over the weekend.** - **Capital works required in order to provide fit for purpose estates to allow the complete segregation of SDEC services on Prince Charles and Princess of Wales Hospital sites**
Outcomes	- **Getting the right patient to the right place on time leading to a reduced admission rate** - **Decreased congestion in Emergency Departments** - **Decreased bed waits within the Emergency Department by offering an agreed, safe alternative stream**
Alignment with workforce plans	- **As part of a standardised offering across Cwm Taf Morgannwg, we aim for a 7.4WTE consultant workforce aligned with Medical SDEC on each acute site** - **A therapy recruitment plan is in place to improve access within Medical SDEC to support early intervention with patients. This equates to the following across the organisation:** ○ **2 x Band 6 OT** ○ **1 x Band 6 Physio** ○ **1 x Band 7 Physio** ○ **1 x Band 7 Falls AHP Lead** ○ **1 x Band 6 Speech and Language Therapist** ○ **1 x Band 6 Dietician**

	Priority area(s)
	○ 4 x Band 4 Health Care Support Workers
Alignment with Financial plans	- There is a capital requirement of £130,000 to support the development of an identified appropriate environment within Prince Charles Hospital footprint. - There is a capital requirement of £30,000 to support the development of an identified appropriate environment within Princess of Wales footprint. - Revenue requirements for staff recruitment are costed and within scope for therapies as described above - Revenue in place to recruit an additional 2 x WTE consultant posts, but would still leave a shortfall against aim of 7.4WTE on each acute site

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

NHS organisations are expected to focus on the following Ministerial priorities. These priorities will feature prominently in the narrative plan and the Ministerial templates below.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

The templates below should provide your planned actions/ milestones etc for 23/24.

Ministerial priorities:

- **Delayed transfers of care**

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination

- **Primary care access to services**

Improved access to GP and Community Services
Increased access to dental services
Improved use of community pharmacy
Improved use of optometry services

- **Urgent & Emergency care**

Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability
Implementation of Same Day Emergency Care services that complies with the following: • Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2 • Is accessible at key times evidenced by the emergency care demand profile in of each hospital site • Is direct access and bypasses Emergency depts • Delivers a service for at least medical and surgical same day care • Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook. • Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme

Health boards must honour commitments that have been made to reduce handover waits

- **Planned Care, Recovery, Diagnostics and Pathways of Care**

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024
Implement pathway redesign – adopting ‘straight to test model’ and onward referral as necessary

- **Cancer recovery**

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026,

- **Mental health and CAMHS**

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Implement 111 press 2 on a 24/7 basis for urgent mental health issue

MINISTERIAL TEMPLATE BLANK

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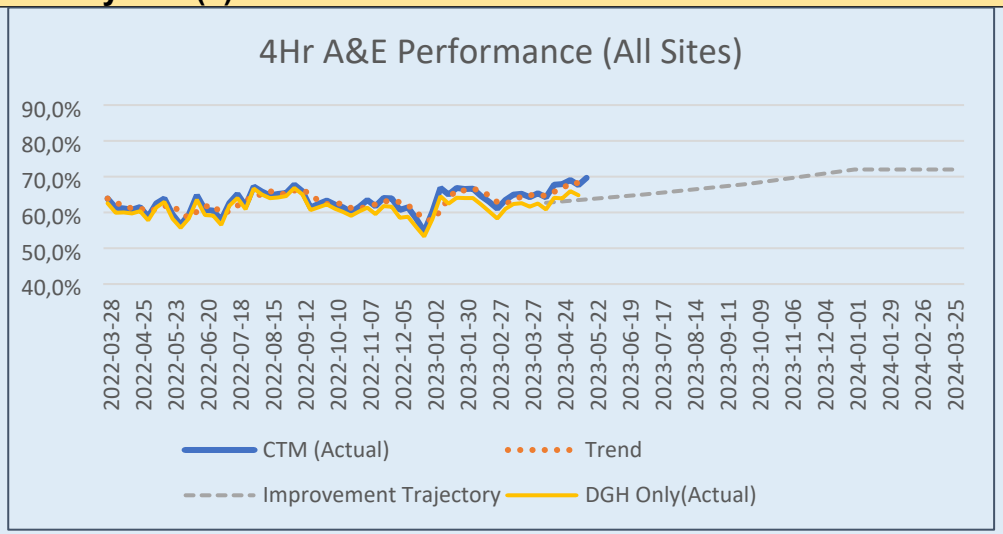
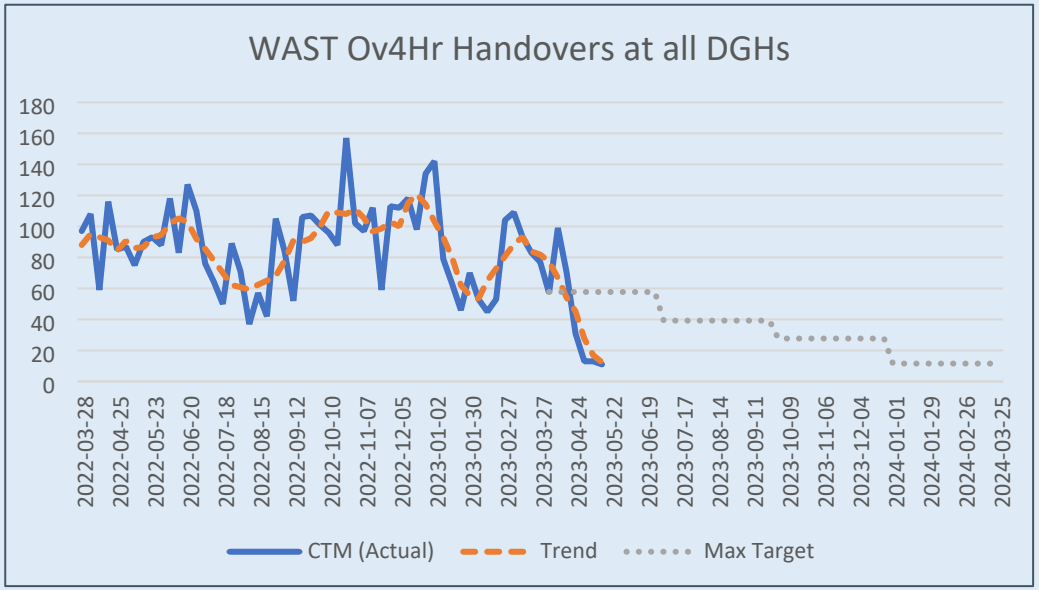
The completed templates must be collated and submitted alongside the organisation's plan and completed Minimum Data Set by 31 March 2023.

	Priority area(s)
Key focus should be on delivering	**Health boards must honour commitments that have been made to reduce handover waits. This will be supported by:** The provision of equitable Emergency Pressure Escalation procedures across the Unscheduled Care Services of Prince Charles Hospital, Royal Glamorgan Hospital and the Princess of Wales Hospital.
Baseline	*As of April 2023, Cwm Taf Morgannwg University Health Board will have established Emergency Pressure Escalation procedures. We will be building on the year by delivering the plan set out below.*

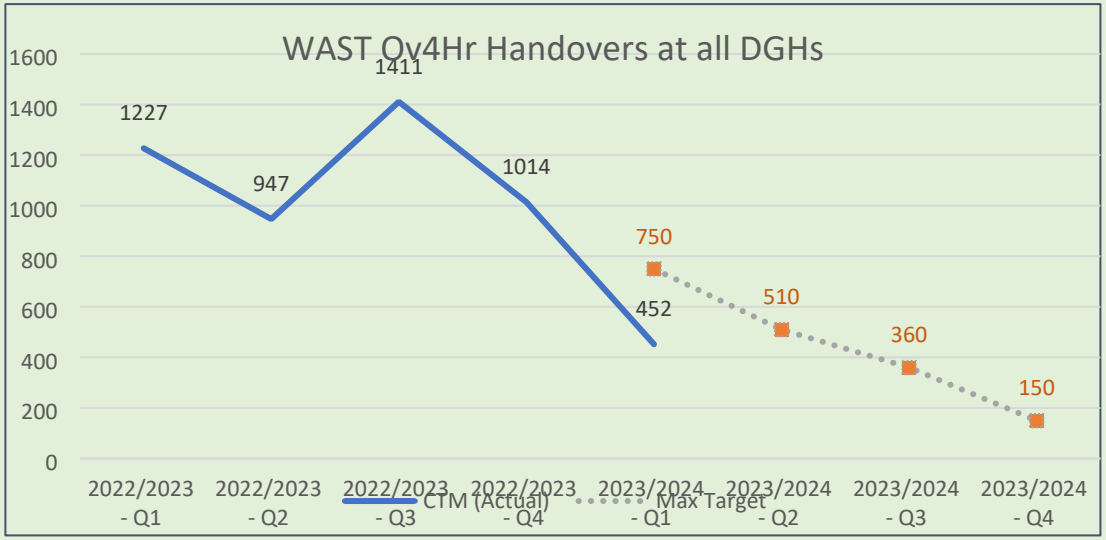
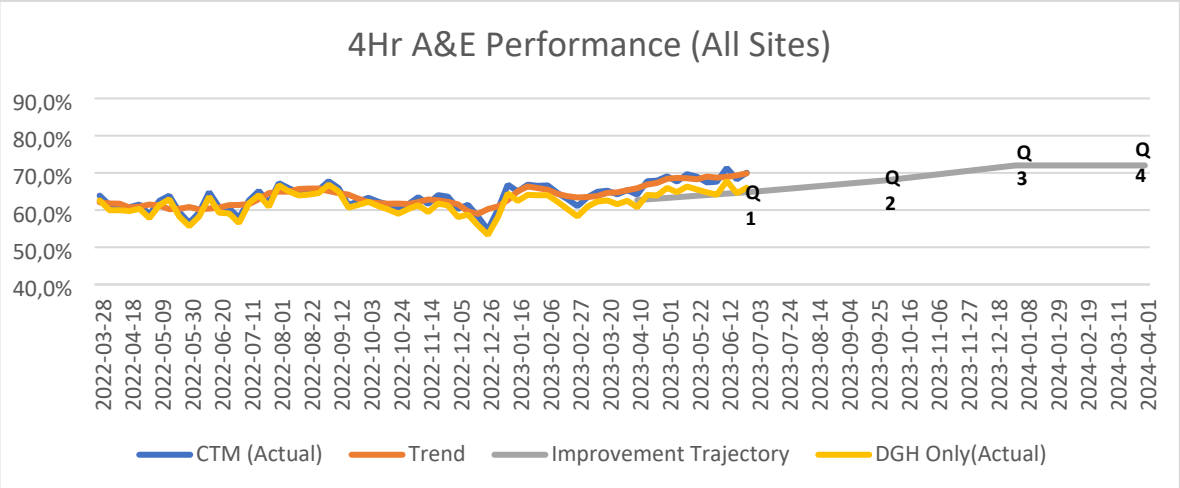
May 2023 update	Our agreed improvement trajectories are set out below.
	
	1) 4 Hour ED Performance by CTM (including MIU) and Acute Site
	• Agreed Targets
	  • Q1 65%
	  • Q2 68%
	  • Q3 72%
	  • Q4 72%
	2) 4 Hour Ambulance Handovers by CTM and Acute Site
	• Agreed Targets
	  • Q1 No more than 750 ambulances over 4 hours
	  • Q2 No more than 510 ambulances over 4 hours
	  • Q3 No more than 360 ambulances over 4 hours
	  • Q4 No more than 150 ambulances over 4 hours

	Priority area(s)





	Priority area(s)	
Quarter 1:	**Implementation of CTM Emergency Pressures Escalation Procedure. Building existing plans to provide a pan CTM approach to the effective management of capacity and escalation across all areas within the Cwm Taff Morgannwg University Health Board.**	
- Milestones	**- Workshop with key stakeholders to review current escalation procedures - Review and recommend on the new Cwm Taf Morgannwg Emergency Pressures Escalation Policy. - Embed a set of standardised triggers alongside associated standardised actions - Risk will be viewed at an organisational level, and the sharing of risk across the system will be done in an agreed way to maintain the safety of patients across the health system - Reduction in lost ambulance hours - Improvement in 4 hour performance**	**Q1 update • Emergency Pressures Escalation Procedure review complete. • Pre-emptive transfer Plan reviewed and incorporated on overarching plan. • Planned launch for the Emergency Pressures Escalation Procedure planned launch date 24 July 2023. • Weekly assurance meetings in place with USC CG and COO/DCOO**
- Actions	**- Trajectories agreed**	**Q1 update • 4 hour ambulance handover > 4 hours Q1 agreed trajectory– 750 • Q1 actual ambulance handover > 4 hours – 452 • ED 4 hour Q1 agreed trajectory target - 65%**

	Priority area(s)	
	- Weekly data v improvement "deep dive" against trajectories - Weekly performance/assurance meetings in place - Navigation Hub increased utilisation - Pan CTM - Immediate response and Pre-emptive transfer procedures reviewed - Robust out of hours and weekend planning process in place - Update Safe to Start process pan CTM - Pan CTM Emergency Pressure Escalation Procedure review complete – out for consultation - 26 May 2023 - Focused improvement programme to reduce Ambulance Handover delays "go live" at Royal Glamorgan hospital – 28 April 2023 - Roll out to Princess of Wales Hospital and Prince Charles Hospital planned 31 July 2023 - Ambulance Handover Escalation Card in place - Unscheduled Care Senior leadership team	• **Q1 actual ED 4 hour performance Q1 - 70%**  

	Priority area(s)
	proactively engaged and leading programme for improvement - Site Based Leadership support – Clinical/Nursing/Ops - Increase activity at YCR MIU -
Quarter 2:	Reduction in Ambulance lost hours
- Milestones	- Reduce lost hours to < 4 hours pan CTM
- Actions	- Review adherence to escalation procedure/action and outcomes - Refine plans on outcomes of review - Ensure equitable response in hours as out of hours - RCA for any delay >4 hours - Monthly USC dashboard review through Directorate performance reviews - Progress patient flow work streams through Six Goals Programme – ewhiteboard/R2G/SAFER/Board Rounds/pre midday discharges
Quarter 3:	Emergency Pressures Escalation Plans ability to respond to seasonal variation
- Milestones	- Prompt response to emergency pressures and timely de-escalation
- Actions	- Review escalation level reporting across CTM by day - Review ability/timeliness in de-escalation - Review action cards and supporting documents - Ensure plans resilient to respond to seasonal variation
Quarter4:	Emergency Pressures Escalation Levels shared pan CTM
- Milestones	- Escalation levels reported “live” on CTM intranet
- Actions	- ICT colleagues to collaborate in reporting escalation levels on the intranet
Risks	- In hour v out of hours response - Inpatient hospital flow - Intelligent diverts - Right patient, right place, right time - De-escalation of winter schemes
Outcomes	- Getting the right patient to the right place on time leading to a reduced admission rate - Decreased congestion in Emergency Departments - Decreased bed waits within the Emergency Department

	Priority area(s)
	- Shared risk across the organisation - Timely de-escalation and return to “Steady State”
Alignment with workforce plans	
Alignment with Financial plans	**Funding is from core budgets or the Six Goals for Urgent and Emergency Care funding.**

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

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The templates below should provide your planned actions/ milestones etc for 23/24.

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The completed templates must be collated and submitted alongside the organisation's plan and completed Minimum Data Set by 31 March 2023.

	Priority area(s)
Key focus should be on delivering	*Outpatient Transformation Programme*
	The aim of the programme is to provide the strategic direct for outpatient transformation across CTM in line with the national recommendations of the recovery plan. The key projects that form this programme are: - See On Symptom/ Patient Initiated Follow Up Project - Attend Anywhere/ VGC Project - WPRS Project - Validation Project - Advice & Guidance Project - Outpatient Utilisation Project The transformation programme together with the overall planned care recovery programme seeks to address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 And to transform outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
	The specific projects listed will be complemented by a number of improvement and efficiency programme across CTMUHB including nursing productivity, medical productivity, estates rationalisation, administrative efficiencies and continued adoption of digital solutions to improve patient experience.
Baseline	To enable the undertaking of this programme and projects a year on year funding allocation is available from Welsh Government for health boards to bid against to enable the transformation of outpatients. This has enabled the programme to be hosted by the Change Hub within iCTM. The funding allocation for 22/24 can be seen below:

HB/Organisation	CTMUHB
Central support	£195,000
Outpatient transformation Projects	£220,000
Eye-care transformation projects	£225,000
TOTAL	£640,000

	Priority area(s)
	The Central Support element of the funding consist of; - 1 WTE 8a Programme Manager that will oversee the programme and direct project management of several projects, - 1 WTE Band 5 Assistant Project Manager to support the WPRS project, - 1 WTE Band 4 Project Support Officer to provide administrative support to the Outpatient Programme as well as the Planned Care Recovery Programme. The Outpatient Transformation element of the funding consist of: - 1 WTE Band 7 Senior Project Manager for the SOS/ PIFU Project (continued from 21/22 and funding secured for 23/24) - 2 WTE Band 6 Project Managers for the Attend Anywhere/Virtual Consultation Project The Eye-Care Transformation element of the funding consists of 4 funded schemes which are directly managed by the operational teams. - Diabetic Retinopathy - Wet AMD - Optometrist Referral Refinement - HCQ Screening Constraints and dependencies The programme team have been constrained by the ability to engage with colleagues due to a lack of capacity to appropriately engage. The programme will with the realisation of the revised operational structure access the subject matter expertise of planning, finance and engagement colleagues form the appropriate care group structures.
May 2023 update	**SOS/PIFU** First two objective milestones listed as amber due to a lack of service group manager engagement and we are unable to identify clinical leads. Objective three: Gastro now red as a result of organisational change but we have identified the correct people to engage and reached out to them. Some areas of concern relating to a lack of clinical engagement raised in the monthly board meetings and subject to separate discussions with the SRO (and others). **Attend Anywhere** Generally on track and delivering well against the milestone objectives set. Delays in some areas (Gynaecology) due to limited capacity within the service to engage. Objective No.3 delayed due to a major refurbishment project underway at Maesteg Hospital. Objective No.9 -Patient survey is on track but limited responses received to date. Some areas of concern relating to a lack of clinical engagement raised in the monthly board meetings and subject to separate discussions with the SRO (and others).

	Priority area(s)
	Validation On track. Delivering against the milestone objectives set. Two more milestones (currently amber) will progress (to green) following the Outpatient Transformation Board meeting this Thursday 18th May. **WPRS** Some delays recently due to sickness leave and operational pressures. Working with colleagues in Medical Records for a coordinated approach to develop process maps. Clear plan in place for the next 4-6 months. **Outpatient Capacity and Utilisation** Initial report produced and approved by board members. Project board members have met, the PID is awaiting approval and workstream teams to be set. Project temporarily paused in order to focus on restarting WPRS (shared Project Manager resource across both projects). **Consultant Connect** On track and delivering well. Review underway to maximise engagement with secondary care, optimise synergy with other programmes and coordinate project resources efficiently.
July 23 Update	**SOS/PIFU** Clinical and care group engagement has improved slightly over the past three weeks and some progress has been made in all identified specialties. The eight stage process identified for the implementation of SOS/PIFU, which should take 4 weeks is taking much longer. Q2 targets focus on engaging services which are using a form of SOS/PIFU and auditing their procedures to ensure they are compliant with the project and consistent with other services within CTM. Some areas of concern raised in the monthly board meetings and subject to separate discussions with the SRO (and others). Usage objective milestones set for operations are still awaiting approval. **Attend Anywhere** Q1 targets have been achieved with exception of the Attend Anywhere Hub in Maesteg Hospital which is delayed due to a Hospital Refurbishment Project. Some of the objectives have been achieved slightly later than anticipated. Some progress has been made since the last update with Gynaecology which had been ragged red due to a lack of clinical engagement, which is very positive. Q2 targets focus on a combination of expanding the Attend Anywhere Hub network availability to new Hospital sites, improved ICT reporting and enabling three new services to have access and use Attend Anywhere. Some areas of concern raised in the monthly board meetings and subject to separate discussions with the SRO (and others). Usage objective milestones set for operations are still awaiting approval. **Validation** On track. Delivering against the milestone objectives set. The team is working autonomously with robust processes in place. Attempted to contact over 1,000 patients already and this is showing a high return rate with around 10% being removed off the lists. This is

	Priority area(s)
	mainly due to duplicate referrals or patients that have been attended to privately and no long require further appointments. The team are also supporting other programmes by signposting patients to Health Management Programmes such as WISE while they wait for their first appointment and this is linked with 3P's policy. **WPRS** Some delays recently due operational pressures. Plan involves receiving comprehensive map of medical records processes, delays in receiving this has resulted in slow progress. BAU work also impacting on ICT Project Manager capacity. **Outpatient Capacity and Utilisation** This project was put on hold in May 23 due to operational pressures on key members of the project team and this was approved by Outpatient Transformation Board on 18th May 2023. **Consultant Connect** Primary care set up complete with 100% of GP Surgeries having access to Consultant Connect. Focus on offering comprehensive local services with secondary care engagement inline with NHS Executive directives for use of Consultant Connect. Meeting scheduled for the 4th July at the request of Sarah James (Deputy COO) for all Care Group Directors to support effective engagement with secondary care. Usage objective milestones set for operations are still awaiting approval.
Quarter 1:	
- **Milestones**	**SOS/PIFU Start 23/24 roll out plan** Identify priority specialty roll out plan based on All Wales priorities identified by WG Based on highest waiting lists the following have been identified as CTM priorities:

Milestone	Description	Date
1	General Medicine	12.05.23
2	Community Medicine	12.05.23
3	Gastroenterology	26.05.23
4	Oral Surgery	26.05.23
5	Rehabilitation	09.06.23
6	Physiotherapy	09.06.23
7	Podiatry	23.06.23
8	Speech and Language Therapy	23.06.23
9	Mental Health (revisit)	30.06.23

Attend Anywhere

Milestone	Description	Date
1	RGH – Attend Anywhere Hub	14.04.23
2	YCC – Attend Anywhere Hub	14.04.23
3	Maesteg Hosp – Attend Anywhere Hub	14.04.23 (Delayed due

	Priority area(s)

		to Hospital Refurb)
4	Joint Event with Tec Cymru	29.04.23 – (Change of date to 05.07.23)
5	Gynaecology	12.05.23
6	Paediatrics	12.05.23
7	Therapies (Revisit)	30.06.23
8	Pain Therapies	30.06.23
9	Patient Survey	30.06.23

Validation

The external validation project vis HBS will end on the 31st March 2023.

Milestone	Description	Date
1	End contract with HBS	03.04.23
2	Handover Meeting	05.04.23
3	Recruitment to band 7 lead x 1wte	07.04.23
4	Recruitment to band 3 x3wte	07.04.23
5	Senior post to undertake development of project management documentation and start monthly reporting.	07.04.23
6	Senior post to develop high level validation processes with key stakeholders and agree sign off at OTP Board.	14.04.23
7	Team to undertake training with 1st appointments teams who currently manage the waiting lists for stage 1 specialities.	21.04.23
8	Agreement for speciality run order of validation for New and FU lists at OTP.	28.04.23
9	Commence validation of waiting lists of specified lists in line with organisation direction.	12.05.23
10	Develop robust benefits tracking for all validation undertaken by the team.	26.05.23

WPRS

Milestone	Description	Date
1	Respiratory	01.05.23
2	Dermatology	01.05.23
3	ENT and Audiology	01.06.23
4	Urology	01.06.23

Priority area(s)		
5	Paediatrics	30.06.23
6	Commence General Surgery	01.06.23

Outpatient Utilisation and Capacity

Milestone	Description	Date
1	Engage stakeholders	01.04.23
2	Commence: review outpatient spaces and rooms work stream.	01.04.23
3	Commence: identification of staff who manage outpatient spaces and rooms.	01.04.23
4	Commence: exploring electronic tools to manage space.	15.06.23

Consultant Connect

Milestone	Description	Date
1	Cwmaman Health Centre	28.04.23
2	Nantymoel Surgery	28.04.23
3	HMP Parc Prison	28.04.23
4	Communication on 100% of CTM GP Practices having access to Consultant Connect.	19.05.23 (Put on hold until resolution with secondary care agreed)
5	Existing CTM Consultants to expand their area of responsibility to cover the whole of CTM area (rather than just a region e.g. Bridgend).	31.05.23 (On hold – due to limited engagement from secondary care. Meeting arranged 4th July 23).
6	Communication update on the number of services covered internally by CTM consultants.	16.06.23 (On hold – due to limited engagement from secondary care. Meeting arranged 4th July 23).
7	Working with Outpatient Recovery Board Members. Increase monthly practice usage from 50% in Jan 23 to 60%.	30.06.23 (Month on month usage just above 50%. Low GP confidence in local service. Engagement with secondary care crucial to improving).

	Priority area(s)
- **Actions**	Programme manage the above milestones including: • Maintain monthly board meetings, • Monitor, review and reporting functions, • Benchmarking progress against other Health Boards, • Reporting on service utilisation (BAU), • Coordination with other services and departments, • Risk management, • Governance structure – effective decision and escalation, • Communications using new Outpatient Transformation Programme Share-point site.
Quarter 2:	
- **Milestones**	**SOS/PIFU implementation in Q2 specialties** Due diligence compliance check on the following services which have been identified as using SOS / PIFU for 10% or more of their Patients not suitable for discharge.

Milestone	Description	Date
1	• Anaesthetics. • Midwifery led care.	11.08.23
2	• Obstetrics inc ante natal • Oncology	25.08.23
3	• Orthoptics • Paediatric neurology	08.09.23
4	• Palliative medicine • Sports and exercise medicine	22.09.23
5	• Clinical Psychology • Therapies community hub	29.09.23

Attend Anywhere

Milestone	Description	Date
1	PCH – Attend Anywhere Hub	28.07.23
2	YCR – Attend Anywhere Hub	28.07.23
3	ICT – Attend Anywhere Query Reporting	11.08.23
4	ENT	25.08.23
5	Oral and Max Fax	15.09.23
6	Urology	29.09.23

Validation

Milestones	Description	Dates
1	Explore automated processes for validation through digital methods.	18.08.23
2	Deal with validation queries/ complaints, internally from stakeholders and externally from patients where applicable.	18.08.23

	Priority area(s)

3	Midway project review, in-depth review of benefits tracking/ realisation to inform business case development in Q3 & Q4.	29.09.23

WPRS

Milestone	Description	Date
1	Gynaecology	01.08.23
2	Pathology and Haematology	31.08.23
3	Commence PMHSS	01.07.23
4	General Surgery	30.09.23

Outpatient Utilisation and Capacity

Milestone	Description	Date
1	Commence: workforce model review	01.07.23
2	Complete: outpatient rooms and spaces work stream	30.09.23
3	Complete: identify staff who manage rooms and space.	30.09.23
4	Progress with: investigating electronic tools for booking space.	30.09.23
5	Complete workforce model	30.09.23

Consultant Connect

Milestone	Description	Date
1	SDEC – new local line	31.07.23
2	General Surgery – new local line	31.07.23
3	Diabetes & Endocrinology – new local line	31.08.23
4	Renal Medicine – new local line	31.08.23
5	Mental Health – Expand current local MH services outside of CAMHS	30.09.23
6	Working with Outpatient Recovery Board Members. Increase monthly practice usage from 60% in Jan 23 to 70%.	31.08.23

- **Actions**	Agree Q3 and Q4 Priorities Programme manage the above milestones including:

	Priority area(s)
	• Maintain monthly board meetings, • Monitor, review and reporting functions, • Benchmarking progress against other Health Boards, • Reporting on service utilisation (BAU), • Coordination with other services and departments, • Risk management, • Governance structure – effective decision and escalation, Communications using new Outpatient Transformation Programme Share-point site.
Quarter 3:	
- **Milestones**	Programme funding beyond 31st March 2024. Extend fixed term contracts for next 12 months (1st April 2024 – 31st March 2025) SOS/PIFU implementation progress in Q3 specialties
- **Actions**	Completion of BAU transition plan.
Quarter4:	
- **Milestones**	Completion of SOS/PIFU implementation and transition plan
- **Actions**	

Risks

Description	Impact Potential	Project Approach
Time to deliver must be achieved within tolerance of completion	High	The trajectory for completion is currently achievable and is supported by a robust onward escalation process via the Outpatients Transformation Programme & Planned Care Recovery Board
Inconsistency and divergence between the specialities' in their engagement with the project.	High	The project team will clearly set out the necessary commitments to achieve the necessary steps to deployment. The project will adopt a principle of deployment by speciality (not site) and escalate concerns appropriately. The programme board membership has been revised for this phase of the project to ensure appropriate senior clinical and operational representation to facilitate appropriate prioritisation.
Resource and capability to develop and deliver the key projects.	Medium	The project teams will regularly review achievement of milestones and where necessary escalate through the appropriate governance routes if additional resource is required to achieve objectives within time tolerance.
Conflicting organisational priorities - impacting adversely on the programme (COVID 2nd wave/winter pressures etc.	Medium	Alignment with the outpatients and elective recovery transformational programmes will provide the necessary steer and prioritisation for its activities.
Changes in the operational model within the HB from ILG to a new structure	Low	The project will identify and engage with the appropriate clinical and operational colleagues for each speciality at the time of deployment for each individual speciality. The programme will benefit from access to core enablement resource such as finance, engagement and workforce expertise within the Planned Care Group.

Interdependencies where milestones require shared input from numerous stakeholders	Medium	The programme will set clear objectives. Risks and issues will be monitored and the monthly board meetings provide a suitable escalation process for effective decision making.

Outcomes	
SOS/ PIFU Project	- Development and implementation of a standardised approach for SOS/ PIFU pathways in CTM. - Review specialities current processes and where required, develop and agree pathways that are suitable for each specialities. - Monitor and report progress to the subgroup, highlighting any areas of improvement needed. - Improve patient outcomes by providing the options for patients to self-manage and initiate appointments when needed, reducing unnecessary follow up appointments.
Attend Anywhere/ VGC Project	- Continue development and implementation of virtual video appointments across CTM. - Review specialities current compliance and work with the teams to understand where and how this can fit with their patient cohorts. - Review booking processes to enable lean booking of patients onto these appointment types. - Monitor and report progress to the subgroup, highlighting any areas of improvement needed. - Develop Video Group Clinics in line with the national recommendation with specific specialities including joint school.
WPRS Project	- Review of current processes and mapping of service pathways to enable the transfer from paper referrals to digital. - Enabling digital triage of all referrals providing where needed a fast return of referral deemed not appropriate with advice & guidance. - Formal roll out of fully digital electronic referrals across the health board. - Monitor and report progress to the subgroup, highlighting any areas of improvement needed.
Validation Project	- To ensure that waiting lists are fully validated with an accurate reflection of patients waiting (*Patients who no longer want or need an appointment removed*). - WPAS updating process to be developed. - Monitor and report progress to the subgroup, highlighting any areas of improvement needed.
Advice & Guidance Project	- Review each speciality offering for advice and guidance, developing this where needed (telephone advice/ messaging through Consultant Connect or where appropriate email/ WPRS messaging) and providing a communication package on each speciality to primary care. - A national procurement exercise is underway to appoint a provider for standardised health pathways system for advice & guidance. This will form part of this project in 23/24.

Outpatient Utilisation	- Project will look to the current outpatient space utilisation across the HB to identify what practice is currently undertaken to ensure maximisation of rooms for F2F appointments and working to develop mechanisms for the reallocation of rooms when needed, including when clinics are cancelled. The aim will be to ensure the maximisation of all clinic space to increase the number of f2f appointments that can take place within the facilities currently available to us. This will include the scoping of external room utilisation systems programmes and any internal solutions, which may be available.
Alignment with workforce plans	
Alignment with Financial plans	
OPTIONAL	
Digital / Technology Opportunities	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

NHS organisations are expected to focus on the following Ministerial priorities. These priorities will feature prominently in the narrative plan and the Ministerial templates below.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

The templates below should provide your planned actions/ milestones etc for 23/24.

Ministerial priorities:

- **Delayed transfers of care**

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination

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Health boards must honour commitments that have been made to reduce handover waits

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52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
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- **Cancer recovery**

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026,

- **Mental health and CAMHS**

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Implement 111 press 2 on a 24/7 basis for urgent mental health issue

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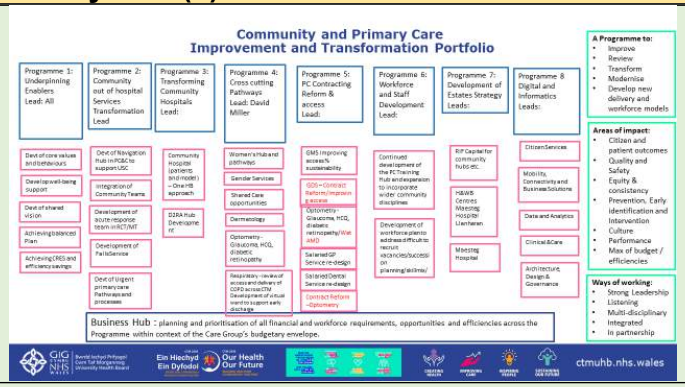
	Priority area(s)
Key focus should be on delivering	52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
	Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
Baseline	A planned care recovery programme is in place and provides leadership and governance for the improvement of planned care delivery. Under the auspices of this programme: • Existing priority investments have been reviewed. • Using an agreed methodology incorporating consideration of areas with quality and safety concerns, high impact improvement potential and feasibility for change aligned to organisational capabilities, priority areas for investment for 2023-24 have been identified. The end of year outturn for 31 March 2023, set out by speciality, is attached to this appendix.
May 2023 update	The revised ministerial requirement as set out below will all be delivered within target date for all specialities. • Ensure all patients who have waited >3 years for an Outpatient Appt. have a booked appointment by August 2023 • 97% of patients will complete their treatment within 104 weeks by the End of Q3 • 99% of patients will complete their treatment within 104 weeks by end of Q4

	Priority area(s)
	D&C modelling and service planning has continued to progress and be refined since the 31.3.23 IMTP submission and the current improvement trajectories are:

Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023 Current Period 14,467	
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024 Current Period 29,187	
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by June 2023 Current Period 6,020	
Number of patients waiting more than 52 weeks for treatment	Improvement trajectory towards a national target of zero by 2025 Current Period 29,187	

2023-24 plans	The table below sets out the delivery timescales for key planned care developments due to take place during 2023-24. Each of these developments is supported by a detailed plan.

Service development	Delivery	May 23 update	Q1 update
Develop an intermediate dermatology service	By Q4	This is being delivered within the primary and community care transformation programme.	This is being delivered within the primary and community care transformation programme.

	Priority area(s)				
					
	Develop community-based ENT services	By Q4	This is being delivered within the primary & community care transformation programme.	This is being delivered within the primary & community care transformation programme.	
	Implementation of our Trauma and Orthopaedic sustainability plan which comprises: • reconfiguring trauma services releasing an additional theatre for inpatient elective operating at the Royal Glamorgan • implementing new pathways providing a minimal stay in hospital. 	Q2 (Anticipated August 2023)	There is a programme in place with a schedule of meetings for the programme board and sub groups. Service demand has been reviewed, by site and by locality (including patients from	Refer to May update. Work has continued to progress. Further work is needed about Urgent and Emergency Care pathways.	

	Priority area(s)				
			out of area. Pathways have been mapped and work streams are progressing the deliverables.		
	Opening additional day surgery capacity at the Princess of Wales Hospital to support improved access for gynaecology, ENT and urology operating.	March 2023 and Q1	ID Medical commenced additional capacity in March 2023. The second theatre is in planning and supplier in place. The delivery of this is dependent on allocated investment as set out in the plan.	Second theatre at PoWH opened in July 2023.	
	Embedding of the new one-stop gynaecology assessment unit at the Royal Glamorgan Hospital. Works due to be finished by April.	Operational by Q1	Capital work completed and the service will commence at the end of May 2023.	Elements of service commenced in May 2023.	

	Priority area(s)				
	Development of the Royal Glamorgan as the Head and Neck inpatient hub for the Health Board.	Q4	A working group is being established this month. Currently on track.	Work is continuing on this project.	
	Consolidation of Ophthalmology services on refined footprint at PoWH.	Q2	Engagement and consultation will be required and this will be mapped into the timeline for this project.	This work is aligned with regional work programmes and there have been GIRFT reviews undertaken.	
	Working in partnership with Cardiff and Vale and Aneurin Bevan Health Board we will provide a regional cataract service. • Business case approved: • Delivery groups have been set up to deliver NHS-provided services (NHH) • Vangaurd extended to deliver into Q1.	Work will progress in Q1	Funding submission undertaken. Awaiting funding approval. Working groups in place to deliver both NHS-based and Vanguard solutions.	As per May update. Awaiting outcome of business case and proposal to WG for funding.	
	Following the opening of the Snowdrop Unit (February 2023), which provides a one-stop-shop to access first assessment and diagnostics, we will complete the implementation of our breast surgery pathway transformation with repatriation of services for Bridgend residents from Swansea Bay UHB.	Q3	Repatriation work is progressing. The service has been fully mapped and the demand	Work is progressing on the repatriation.	

	Priority area(s)			

	Structure to deliver this project includes:
	• CTMUHB project group
	• Joint service-to-service meetings with SBUHB
	• Contracting and commissioning governance structure:
	  ○ C&C meetings
	  ○ Joint Management Group
	  ○ Joint Executive Group
	• Interdependencies with regional pathology developments and the plan for a new Laboratory Information Management System for Wales.
			and capacity assessed. Key dependencies are pathology capacity and wider workforce requirements. Work currently on track.	

	Urology diagnostics – LAPB will move from Princess of Wales Hospital to Royal Glamorgan Hospital.	Q2	Work is progressing with a project structure in place.	The pathway for the LAPB continues to progress. This is currently on track.

Each speciality is supported by a service plan and the expectation for all specialities is to maintain and improve efficiency and to ensure that patients are treated in turn, on the basis of clinical prioritisation.

In addition to internal service development plans and efficiencies, a small number of areas have been identified for insourcing or outsourcing during 2023-2024.

Insourcing

- ID medical – increase to 4 theatres until Q3

Outsourcing

- Dermatology outsourcing being scoped for a tender exercise (now seeking to undertake this work internally via locum – July 2023, Q! update)
- Small levels of outsourcing in key specialities anticipated to support recovery
- Pathology contract to continue in 2023-24 and likely to increase in volume
- Endoscopy to continue in 2023-24

	Priority area(s)
	Diagnostics: Improvements in diagnostics are to be delivered in the medium-term under the auspices of the regional programme. However, for the 2023-2024 year the Health Board is seeking to increase diagnostic capacity through on a short-term basis through a number of mechanisms, including a mobile unit (to be procured in alignment to the regional work on community diagnostic hubs).
Risks	Key risks include capacity to deliver transformational changes, workforce and financial limitations, however all changes are planned within existing or programme budgets and are designed to improve the efficiency of use of our current workforce. There is a risk register for the Planned Care Recovery Programme and each of the projects.
Outcomes	• Reducing inappropriate variation through evidence based approaches, clinically-driven and quality pathway development • Improving access to diagnostics and treatment • Improving patient support while patients await treatment • Delivering care in an accessible way and as close to home as possible • Improving patient outcomes
Alignment with workforce plans	All programmes have workforce plans and are aligned to corporate workforce planning.
Alignment with financial plans	All developments are supported by core service or Planned Care Recovery funds. Funding has been identified as a risk to delivery.
OPTIONAL	
Digital / Technology Opportunities	WPAS systems and clinical systems for Bridgend. Also associated national developments e.g. LIMS

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	Priority area(s)
Key focus should be on delivering	Reduction in backlog of patients waiting over 62 & 104 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion. Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2024.

Baseline

Current trajectories to 31/3/2024 are set out below.

Cancer backlog >62 days	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024
Brain/CNS	1	1	1	1	1	1	1	1	1	1	1	1
Breast	13	13	12	10	10	9	8	8	7	6	6	6
Gynaecological	64	64	64	62	62	59	59	59	58	57	57	57
Haematological	2	2	2	2	2	2	2	2	2	2	2	2
Head and neck	16	16	16	15	15	14	14	13	13	13	13	13
Lower GI	189	189	185	183	183	175	173	173	165	154	152	148
Lung	24	24	23	23	23	22	22	22	22	22	21	21
Other	3	3	3	3	3	3	3	3	2	2	2	2
Sarcoma	0	0	0	0	0	0	0	0	0	0	0	0
Skin (exc BCC)	21	21	20	19	19	19	19	18	18	16	16	16
Upper GI	46	46	45	45	45	45	43	43	42	42	41	41
Urological	176	173	173	173	172	171	169	168	166	164	163	163
Total	**555**	**552**	**544**	**536**	**535**	**520**	**513**	**510**	**496**	**479**	**474**	**470**

Cancer backlog >104 days	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024	Mar-2024
Brain/CNS	0	0	0	0	0	0	0	0	0	0	0	0

Priority area(s)

Breast	0	0	0	0	0	0	0	0	0	0	0	0
Gynaecological	23	23	21	21	21	21	21	21	20	20	20	20
Haematological	1	1	1	1	1	0	0	0	0	0	0	0
Head and neck	3	3	3	3	3	3	3	3	3	3	3	3
Lower GI	56	55	51	51	49	48	46	44	37	34	34	34
Lung	6	5	5	5	5	5	5	5	5	4	4	4
Other	0	0	0	0	0	0	0	0	0	0	0	0
Sarcoma	0	0	0	0	0	0	0	0	0	0	0	0
Skin (exc BCC)	8	8	8	7	7	7	7	7	7	6	6	6
Upper GI	18	18	18	18	17	16	16	15	15	15	15	15
Urological	81	80	77	76	75	74	72	72	70	66	66	66
Total	**196**	**193**	**184**	**182**	**178**	**174**	**170**	**167**	**157**	**148**	**148**	**148**

May 2023 update

Our commitment remains to deliver on ministerial expectations to reduce backlog and deliver a significant improvement on cancer performance.

Our SCP trajectory are set out below.

Cancer compliance <= 62days	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Brain/CNS	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Breast	74%	75%	77%	78%	79%	80%	82%	83%	84%	87%	87%	87%
Gynaecological	37%	37%	37%	38%	38%	40%	43%	43%	44%	46%	46%	47%
Haematological (exc acute leukaemia)	63%	63%	64%	66%	67%	68%	69%	69%	70%	72%	72%	72%
Head and neck	42%	42%	42%	44%	46%	48%	49%	51%	51%	52%	52%	52%
Lower GI	53%	53%	55%	55%	55%	57%	63%	63%	65%	68%	69%	69%
Lung	61%	62%	62%	63%	63%	64%	66%	68%	68%	70%	71%	71%
Other	63%	67%	67%	67%	67%	67%	67%	67%	71%	71%	71%	71%
Sarcoma	67%	67%	67%	67%	67%	67%	67%	67%	67%	67%	83%	83%
Skin (exc BCC)	85%	86%	88%	88%	89%	90%	90%	90%	91%	91%	92%	92%

Priority area(s)

Upper GI	54%	54%	55%	55%	55%	56%	59%	60%	61%	64%	65%	65%
Urological	31%	32%	32%	33%	34%	36%	38%	38%	43%	45%	45%	45%
All Sites	58%	59%	60%	61%	61%	63%	65%	65%	67%	69%	70%	70%

Plans

Aligned with A Cancer Improvement Plan for Wales (2023-26), we continue to develop our local improvement plan. This comprises actions across the breadth of cancer services, including commissioned service provision. We will continue to work towards all national optimum clinical pathways to be fully embedded into local service delivery, and include both pre-habilitation and rehabilitation facilitated through action plans with each tumour site and supported by further development of business intelligence. We will also participate in regional collaborative developments including acute oncology, AOS, prostate self-management, C the Signs and the Transforming Cancer Services Programme.

In addition, the Cancer Business Unit's plans have been set out in support of the delivery of cancer improvement.

Priority	Key actions	Metrics (performance indicator/ outcome/ output)	Timescales (Qtr/Year)	June 23 update	Q1 update
For all National optimum Clinical pathways to be fully embedded into local service delivery, and include both prehabilitation and rehabilitation.	Carry out baseline assessment Develop and implement collaborative action plan with tumour site groups Implementation of digital dictation & voice recognition across all of CTM	Increased STT Increased prehabilitation provision WPES Cancer improvement plan	3 years	Baseline assessment completed and pathways being amended in numerous specialities to assist in compliance with NOCP Actions from cancer improvement plan ongoing	Increased STT in Urology, Gynaecology, lower Gi tumour sites Macmillan AHP appointed. Current prehab & rehab services reviewed. Colloboration with All Wales Cancer Cymru working group to ensure a national and regional approach where possible Development of cancer improvement action plan for HB which is being updated monthly and shared via cancer steering group
Continued development of Business intelligence.	Continued education and training around	Increased number of users	12 months	Ongoing developments	Phase 3 of BI completed as per project.

	Priority area(s)					
		utilisation of relevant cancer apps and application to practice	Improved planning Improved ownership of data		internally with digital team to enhance further.	
	Collaborative working with regional cancer development schemes (current & future)	AOS RDC Prostate self-management Lung health check programme CtheSigns TCS	Successful implementation of development scheme WPES Improved SCP performance	Ongoing	Collaborative working with VCC & network ongoing RDC established& planned to expand to 5 days per week. Lung health check progressing as planned, with pilot due to start June 23	AOS service running across all three acute sites. CtheSigns implemented and being monitored
	Develop and deliver a cancer quality assurance framework and its attributable measures to improve patient safety and outcomes	Digital development of fully functioning dashboard	Implementation of dashboard	12 months	Further enhancements to dashboard are ongoing	Cancer quality assurance Framework developed and dashboard available.
	Full implementation of CANISC replacement programme	Undertake required training UAT as and when required as per rollout	Successful implementation of each phase	Ongoing	Ongoing.	Breast commenced May 2023. Urology commenced June 23
	Oversee the implementation of standardised cancer patient tracking across the HB	Appropriate training for all new and existing staff. Development of SOP and implementation across CTM Support improved pathway management	Improved compliance against KPI at audit (local & national) Assist in improving SCP performance	Ongoing	Workshop scheduled for Aug 2023 to ensure all staff aware of new changes to cancer standards and reporting	All cancer trackers and MDTc centralised to CBU. Training standardised via cancer service supervisors and training booklet developed
	Identify cancer and MDT leads and job plan appropriately	Implementation of JD for both cancer and MDT leads	Number of MDT and cancer leads that have a		MDT and Cancer lead JD's developed and approved. Currently	

Priority area(s)					
	Appropriate time embedded into job planning	JD and defined DTT in job plan Improved patient pathway		working through embedding into respective job plans	

Agreed service improvement actions are set out below.

Service	Actions	Timescales	Update June 23	Q1 update
Lower GI	• FIT pathway approved and started implementation phase. • Challenges with BSW – SSP x2 due to start mid-March which will facilitate additional screening colonoscopy lists being undertaken. • Endoscopy programme board in place to develop regional solutions. • Internal work to develop further endoscopy capacity at PCH ongoing. • Ongoing work to increase productivity and efficiencies.	Q2 Q4 Q2 Q2	Merging of Urology and Lower GI MDTs and streamlining of processes / pathways Endoscopy development work at PCH is on track for delivery in Spring 2024. Workforce model will provide 3 session day working and sustainable endoscopy service to meet demand X1 additional screening colonoscopist sign off July & x1 list conversion to BSW August – Increased capacity for BSW	FIT implemented Significant delays with BSW. Workforce model completed for 3rd theatre. Recruitment commenced
Urology	• Merging of MDT's	Q2	Ongoing. Finalising job plans of core MDT members and MDT lead. Once finalised MDT will merge. Provisional date July 18th	
Breast	• Breast radiologist sought – increase capacity additional clinic alt Thursdays and weekly Friday • Additional Breast surgeon approved • Breast surgery repatriation	Q3-4	Repatriation work with SBUHB is ongoing.	New Breast Surgeon commenced 26.06.23. Breast Unit opened
Upper GI	• TNE plan to increase capacity. • Development of a transformation Programme for Gastro & Endoscopy (aligned to regional endoscopy work)	Q2	Purchased equipment to convert TNE to OP. Awaiting delivery Identified room for TNE to be undertaken	

	Priority area(s)
Risks	• Achievement of SCP target • Sustainable endoscopy service • Sustainable path 7 radiology service and workforce • Sustained reduction in backlog in line with trajectory
Outcomes	• Improved access to diagnostics and treatment • Recruitment of required workforce • Delivery of access targets
Alignment with workforce plans	All development have workforce plans that are aligned to the corporate workforce plan.
Alignment with Financial plans	Developments are funded from core funding or programme funds.
OPTIONAL	
Digital / Technology Opportunities	

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Implement 111 press 2 on a 24/7 basis for urgent mental health issue

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This blank template shown below needs to be replicated and completed for each of the rows shown as priorities above. E.g., Cancer care: one x template for *Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion* and one template for *Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026*

The completed templates must be collated and submitted alongside the organisation's plan and completed Minimum Data Set by 31 March 2023.

	Priority area(s)
Key focus should be on delivering	Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024

Baseline	*Describe the baseline as of April 2023 from which you will be working*
	
	Diagnostic programme:
	During 2022-2023, the SE Wales regional collaborative progressed joint planning to improve services in a number of key pressure and priority areas, including ophthalmic, orthopaedic and diagnostic services.
	
	The Diagnostics Programme has been established with project boards for:
	• Radiology solutions - Community Diagnostics Hubs
	• Endoscopy, and
	• Pathology.
	
	A regional workshop on 28th November 2022 provided a re-set for the portfolio and delivered confirmed aims and objectives for each of the projects within the diagnostics programme.
	
	Milestones for delivery by April 2023 are:
	Community Diagnostic Hubs:
	• Delivery of a position paper and investment rationale for the development of CDHs in SE Wales.
	• Updating the procurement specification to enable procurement to commence in 2023.
	• We have gained clinical consensus that all developments must fulfil the following criteria.
	  ○ *Delivery is more accessible to residents living in areas of deprivation and able to deliver to more than one health board population in the region*
	  ○ *Developments deliver an increase in capacity*
	  ○ *Developments will be founded on seeking sustainable solutions to demand backlogs.*
	
	Endoscopy
	• Agreed revised project structure and governance arrangements with links to the National Endoscopy Programme.
	• Demand and capacity analysis completed with the support of the delivery unit.

	Priority area(s)

	• Confirmation of process to be undertaken to develop an agreed model for regional endoscopy.
	• Cellular Pathology
	  ○ Collection and agreement of Cellular Pathology Demand & Capacity Data
	  ○ Progression of 7 day Cellular Pathology Working Pilot at CVUHB
	  ○ Establish Regional Pathology Scoping Group
	  ○ Develop and agree ToR Regional Pathology Scoping Group
	  ○ Develop and agree Pathology Education Practitioner Roles
	  ○ Scoping work to Identify and agree key interdependencies, constraints and possible options for regional working for short, medium and long term
	  ○ Identify and agree short list of options for regional cellular pathology

Quarter 1:	
- **Milestones**	

Project/Actions	**Q1 Update**
Community diagnostic hubs	
Undertake capacity and demand modelling for the region	Template designed and issued.
Option appraisal for scope, configuration of CDHs across the region, phasing and delivery options (both utilising internal solutions and procurement of external providers)	Formal option appraisal to be completed. Initial option appraisal of models in place.
Preferred model and option selection and approval by Programme Board and Portfolio Oversight Board.	N/A
Completion of procurement specification	Completed
Completion of business case	In progress
Endoscopy	
Confirmed model for endoscopy regional facility and which services lend themselves to regional provision, aligned to the intentions of the National Strategy	Clinical summit held in April and further workshop sessions. Clinical model developed by NEP shared with all HBs for clinical body to comment. Operational group has been meeting since 22nd June 2023 and is due to complete a review of the clinical specification and pathways document and to assess updated demand and capacity data to inform the requirements for regional development.
Feasibility study for potential sites to be undertaken.	Feasibility study previously initiated for one potential site and will be reviewed with other sites.

	Priority area(s)
	Pathology | | Advertise and recruit into newly developed training roles | N/A Implementation of 7 day working at CVUHB for cellular pathology | Completed. Identify preferred option for regional cellular pathology | Site visits undertaken and option appraisal being developed.

- **Actions**	• CDH:
	  ○ Development of regional NHS options
	  ○ Develop procurement strategy for the CDHs
	  ○ Develop RFQs
	  ○ Issue RFQ to potential suppliers
	• Endoscopy
	  ○ ToR reframed to align with National Endoscopy Programme and Regional Diagnostics programme
	  ○ Model task and finish group established
	  ○ D&C assessment to be refreshed with options for development and at a procedure level
	  ○ Assess operational requirements of the regional model including Academy requirements
	  ▪ Workforce requirements
	  • Consider standardisation of job descriptions
	  ▪ Infrastructure
	  ▪ JAG accreditation requirements
	• Pathology
	  ○ Site visit to Cardiff Edge
	  ○ Further develop short listed options for regional pathology solutions
	  ○ Develop operational requirements for identified options
	  ○ Option appraisal of shortlisted options
	  ○ Identification of available capacity due to implementation of seven day working model at CVUHB

Quarter 2:	

- **Milestones**	• CDH:
	  ○ Tender for CDH to be initiated and supplier selection completed.
	  ○ Plan confirmed for staggered delivery of CDHs taking into account opportunities for sites in the region.
	• Endoscopy
	  ○ Development of the business case for the regional model
	  ○ Site option appraisal
	• Pathology
	  ○ Agree preferred option
	  ○ Produce model and service specification for preferred model
	  ○ Movement of work across health board boundaries.

- **Actions**	• CDH
	  ○ Confirmed supplier for procurement option
	  ○ Pathways confirmed
	  ○ Operational issues identified and solutions confirmed.
	• Endoscopy

	Priority area(s)
	○ Develop the business case for the agreed elements of regional endoscopy centre. • Pathology ○ Scope operational pathway of preferred option ○ Identification of operational requirements of preferred option ○ Develop regional training solutions
Quarter 3:	
- **Milestones**	• CDH: ○ Implementation project to commence with NHS and/or preferred procured supplier option • Endoscopy ○ Seek approval of regional model and business case ○ Confirm action plan for JAG accreditation across the region, including the need for additional business cases as required ○ 4 endoscopy theatres (2 additional) at the Royal Gwent Hospital to be operational ○ Completion of 2 x additional endoscopy theatres at UHL • Pathology ○ Seek approval of regional model and agree funding stream ○ Implement regional training solution
- **Actions**	**Regional diagnostics:** • CDH: ○ Delivery actions to be undertaken including site development and equipment • Endoscopy ○ Development of a business case for the regional model for Endoscopy (8 Theatres and 2 Training Centres) ○ Options appraisal and feasibility study • Pathology ○ Development of business case for agreed regional model
Quarter4:	
- **Milestones**	• CDH: ○ Infrastructure installed at 1st CDH ○ First CDH (Site TBC) fully operational ○ Potential Enabling/commissioning work for internal capacity options • Endoscopy ○ Seek partnership ratification for the regional model and approval for business case to build endoscopy centre into 2024-25 planning cycle ○ Development of additional endoscopy theatre at Prince Charles Hospital. • Pathology ○ Approval of business case
- **Actions**	• CDH: ○ Identification of further CDHs • Endoscopy ○ Business case will be progressed through programme and regional portfolio governance structures • Pathology ○ Business case will be progressed through programme and regional portfolio governance structures

	Priority area(s)

Risks	**Regional diagnostics:**
	• General
	  ○ IT systems can't share information across HB boundaries and that patient records get lost through manual processes. ***Mitigation*** is additional IT support into the programme to provide expertise
	  ○ Workforce is a constraint across all three projects. ***Mitigation:*** This will be managed through development of plans to create capacity: e.g. pooling staff where possible, and insourced solutions, where required.
	• CDH:
	  ○ Approval by all 3HBs of the Business Case is not achieved. ***Mitigation*** is a robust Business Case
	  ○ Service provider unable to fulfil staffing requirements. ***Mitigation*** Good contract management and open communication with the Service provider
	  ○ Necessary Funding for the programme is reduced or not available. ***Mitigation*** robust Business Case demonstrating the financial value as well as improved patient care
	• Endoscopy
	  ○ Approval of the model and business cases is not achieved for all 3 HBs. ***Mitigation*** – robust engagement mechanisms and business case.
	• Pathology
	  ○ Delivery of the LINC system

Outcomes	Radiology - CDHs
	The Outcome of this project would be a delivery model consisting of a 3 stage process:
	
	• Diagnose Well -
	  ○ Rapid access to the right diagnostic
	  ○ Increase accessibility
	  ○ Rapid availability of diagnostic outcomes
	
	• Manage Well -
	  ○ Develop pathways where diagnostics before referral are the norm
	  ○ Access for planned and emergency care pathways in the community to ensure that management is always as close to home as possible
	  ○ Virtual links to primary care to aide decision making where a referral is not required
	
	• Live Well -
	  ○ Develop clear plans for patients that do not have a clear diagnostic outcome
	  ○ Support primary care with pathways of management for the "worried Well"
	  ○ Links to therapeutic interventions
	
	In so doing we will ensure:

	Priority area(s)
	• We deliver a high standard of care as defined by the Health Boards and by national and international best practice guidelines. • CDHs are sufficiently resourced to ensure access. • Services are accessible to patients, are appropriate to their needs and responsive to their concerns. • Employ continuous, transparent, quality assurance as the main method of maintaining and improving standards of care. • Demonstrate improvements in process and outcomes, year by year. • Provide a seamless service from the point of referral. • Ensure people with disabilities, additional needs and languages other than English or Welsh are able to use the service. • Identify and implement regional pathology solutions to create a robust, sustainable, future proofed and patient focussed service.
Alignment with workforce plans	**Radiology:** The project will include both development work for NHS based and procured solutions, with a view to the development of the workforce to transition from procured to NHS delivered services in the longer-term. There will be a contractual requirement within the procurement for any provider to work with NHS wales to not destabilise our current workforce and to support in alternative workforce models. This requires alignment of demand and capacity modelling and service development with workforce planning, including commissioning training places. **Endoscopy** Amongst the constraints to the optimisation of current endoscopy services is recruitment and retention of sufficient workforce. The development of the training academy as part of a regional solution would support an enhanced pace of development of endoscopist roles to be able to deliver the required capacity for the region.
Alignment with Financial plans	All funding decisions for the regional portfolio are undertaken at the portfolio oversight board, at which the three Chief Executive Officers are represented. Health Boards have given consideration to the requirements for diagnostics funding within their plans for 2023-24 as part of wider planned care recovery development work. The proposals for CDHs will include both internal and procured solutions, with the intention that the procurement service specification facilitates a flexible approach to accessing CDHs to meet the needs and capabilities of the region. On behalf of the region, Cardiff and Vale UHB has commissioned work from Cardiff University (Cedar) to support the value assessment, health economics review and a social return on investment completed in order to ensure that the outputs drive improved outcomes for patients at a lower cost for overall health care provision.
OPTIONAL	
Digital / Technology Opportunities	**Pathology** Procurement and Implementation of Digital Cellular Pathology enablement is key to the success of any regional pathology solution – Digital Cellular Pathology Business Case

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

NHS organisations are expected to focus on the following Ministerial priorities. These priorities will feature prominently in the narrative plan and the Ministerial templates below.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

The templates below should provide your planned actions/ milestones etc for 23/24.

Ministerial priorities:

- **Delayed transfers of care**

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination

- **Primary care access to services**

Improved access to GP and Community Services
Increased access to dental services
Improved use of community pharmacy
Improved use of optometry services

- **Urgent & Emergency care**

Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability
Implementation of Same Day Emergency Care services that complies with the following: • Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2 • Is accessible at key times evidenced by the emergency care demand profile in of each hospital site • Is direct access and bypasses Emergency depts • Delivers a service for at least medical and surgical same day care • Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook. • Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme

Health boards must honour commitments that have been made to reduce handover waits

- **Planned Care, Recovery, Diagnostics and Pathways of Care**

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024
Implement pathway redesign – adopting ‘straight to test model’ and onward referral as necessary

- **Cancer recovery**

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026,

- **Mental health and CAMHS**

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Implement 111 press 2 on a 24/7 basis for urgent mental health issue

MINISTERIAL TEMPLATE – MENTAL HEALTH

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The completed templates must be collated and submitted alongside the organisation's plan and completed Minimum Data Set by 31 March 2023.

	Priority area(s)	
Key focus should be on delivering	Implement 111 press 2 on a 24/7 basis for urgent mental health issues	
	Ensuring alignment between 111 press 2 and the CTM Navigation Hub	
	Ensuring consistency of pathways following 111#2 calls to support appropriate response.	
Baseline	Completed pilot of 111 press 2 for Mental Health Services as part of the learning, planning and preparedness work for a full implementation. Expected demand = 40 calls per day (based on national programme)	
Quarter 1:		
• **Milestones**	**4rd April 2023** Go Live of 15 hours per day 111 press 2 service for CTM	
• **Actions**	**Q1 actions** • **Recruitment of posts** : To appoint to all posts required to operate 111 press 2 24/7. Actively manage the on-boarding process to reduce delays in delivering the service. • **Rota :** Ensure sufficient qualified staff to cover 15 hour then 24/7 function. Develop Action card to mitigate risk of short staffing. • **Estate / Base :** Align 11 press 2 estate with Navigation Hub, including Out of Hours service.	**Q1 update** 15 Hour Service went live including professional Police support line on 4th April 2023. Action completed within Quarter 1 23/24 include • Recruitment of 16 Staff into 111#2 service • Rota design and sign off by National Programme team • All staff scheduled or trained in readiness for go live

	Priority area(s)	
	• **Training :** Ensure all substantive and bank staff receive full training of the systems, process and pathways prior to commencing in post. • **Telephone system implementation:** Test DDI telephone lines and identify process for resolution of any telephony technical issues. Ensure Professional Line, Welsh and English language lines implemented. • **Triage Tool:** agree triage tool to be used and implement. • **Escalation Process:** Agree escalation process and develop Action Cards and Standard Operating Process. • **Governance:** Agree and sign off the Memorandum of Understanding between WAST and CTMUHB.	• Setup and testing of IT & Telephony Equipment • Development of service SOP which includes escalation action cards • Completed all National check lists for pre- go live including singing the Memorandum of Understanding with WAST
• **Milestones**	**25th April 2023** Go Live of 24 hours per day 111 press 2 service for CTM	24 Hour service went live on 25th April 2023.

• **Actions**	• **Recruitment of posts** : To appoint to and on-board any outstanding vacancies to deliver 24/7 service
	
	• **Monitoring & Reporting :** Implement a reporting process to deliver national standard reporting and any locally identified reporting.
	
	  ○ Calls received / answered
	  ○ Abandoned call rates
		• All actions completed in preparation for go live
		
		• Standard reporting metrics captured via the national dashboard now integrated into local reporting mechanisms for wider awareness on activity and quality of 111#2.

	Priority area(s)	
	○ Activity by time ○ Welsh language call activity ○ Police Support call activity ○ Clinical triage outcome (A-G) ○ Training of staff ○ Patient reported outcomes ○ Significant event recording ○ Sample check quality audits ○ Impact on other services • **Readiness Checklist :** ensure full compliance with readiness checklist ○ **Communication Plan** : to implement plan to share details on the service and to support access by the population	
Quarter 3:		
• **Milestones**	**September 2023** Peer Review of service	
• **Actions**	• **Prepare for the Service Review** : ensuring full access to standards, policies, pathways and data. • **Service Review Visit** : undertake visit to support learning lessons, improvement of the service and providing assurance of quality, safety & performance.	
Quarter 4:		
• **Milestones**	**January 2024** Lessons Learnt & Strategic Future Plan	
• **Actions**	• **Gather Information :** gather evidence from Service Review, internal and external stakeholder reports, concerns, incidents and compliments • **Hold Lessons Learnt Workshop :** share with wide group of stakeholders lessons learnt with a view to identifying opportunities for further development including : ○ Opportunities for improvement ○ Safety assurance ○ Understanding demand and potential new pathways	

	Priority area(s)
	○ Population knowledge & understanding of the service • **Develop Strategic Development Plan**: to maximise the impact of the service and to align with wider CTM services e.g. Navigation Hub, Crisis Teams & SPOA.
Risks	**Recruitment** – Staff either failing recruitment checks or withdrawing from appointed post during the recruitment posts. Mitigated by regular contact with recruits, front load training where applicable. **Demand exceeding capacity** – Potential unmet and un-identified need within communities leading to the service becoming overwhelmed without the resources to deliver effectively. Mitigated by regular demand monitoring and escalation of issues.
Outcomes	**Improved Patient Experience / Patient Centred Approach** • No wrong door – When a person contacts CTMUHB 111#2 MH Service they will receive an inclusive response. • Right Help, Right Time – Working towards a 24/7 approach. • Reducing Duplication – Users of CTMUHB Mental Health Service should not have to repeat their story. The person completing referrals will be a trusted assessor, therefore further assessments should only be additive to the patients care. **Correct care for CTMUHB 111#2 Mental Health users** • The CTMUHB 111#2 MH service will be able to provide information and advice, signpost to other organisations or arrange a 'warm' handover to a specialist mental health team. This would mean the caller would not need to repeat their story.
Alignment with workforce plans	The 111#2 service workforce has been developed through a multi-professional lens, creating a wider opportunity for skill mix and team member development. This aligns with the CTM workforce plan and People Priorities.
Alignment with Financial plans	Funding has been secured through the SIF. Funding, spend and capacity to meet demand will be monitored through the project team and issues will be escalated early, where necessary.
OPTIONAL	
Digital / Technology Opportunities	Implementation of informatics, telephony and data reporting systems have been developed in line with the national team. The utilisation and risks associated with these will be highlighted through the Peer Review and Lessons Learnt process.

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

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The templates below should provide your planned actions/ milestones etc for 23/24.

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- **Mental health and CAMHS**

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Implement 111 press 2 on a 24/7 basis for urgent mental health issue

MINISTERIAL TEMPLATE MENTAL HEALTH PERFORMANCE

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The completed templates must be collated and submitted alongside the organisation's plan and completed Minimum Data Set by 31 March 2023.

	Priority area(s)
Key focus should be on delivering	Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Baseline	The baseline data below is based on January & February 2023 : **CAMHS Mental Health Measure** : (see table below) There has been little improvement in 22/23 on the performance but significant work has seen a positive impact on the numbers of people waiting and the duration they wait which needed to take place before the 28 days for both parts would be met. Despite demand rising at the end of February 73 young people were awaiting an assessment for over 28 days. There are a total of 260 young people awaiting an assessment in total. Trajectories have been developed and agreed with the Delivery Unit and will be locally monitored through the MH Planned Care Recovery Board. **Adult Mental Health Measure:** (see table below)

	Target	January 2023	February 2023
Part 1A	80%	16%	30%
Part 1B	80%	14%	36%
Part 2	90%	86%	85%

	Target	January 2023	February 2023
Part 1A	80%	84%	88%

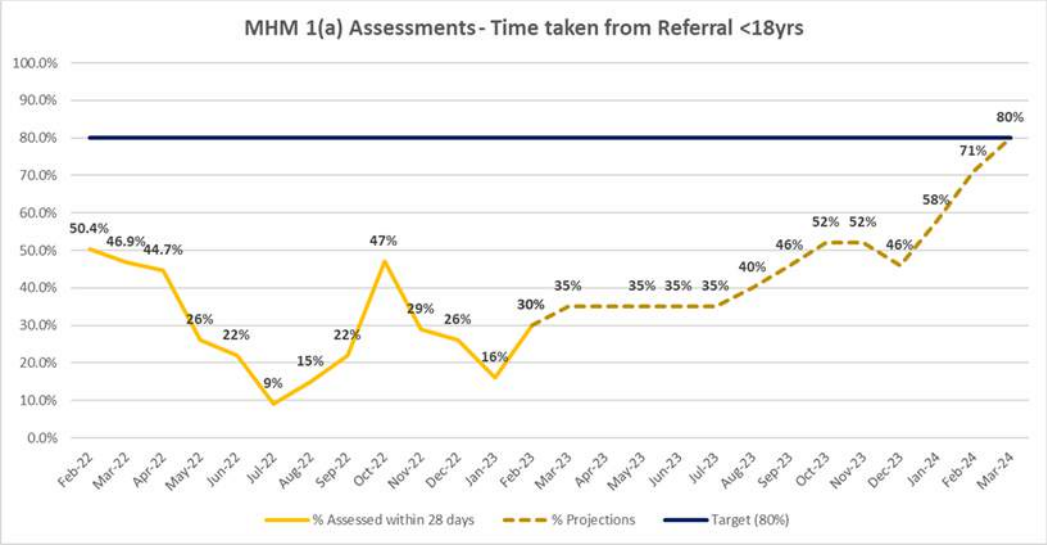
	Priority area(s)			
	Part 1B	80%	89%	92%
	Part 2	90%	88%	88%

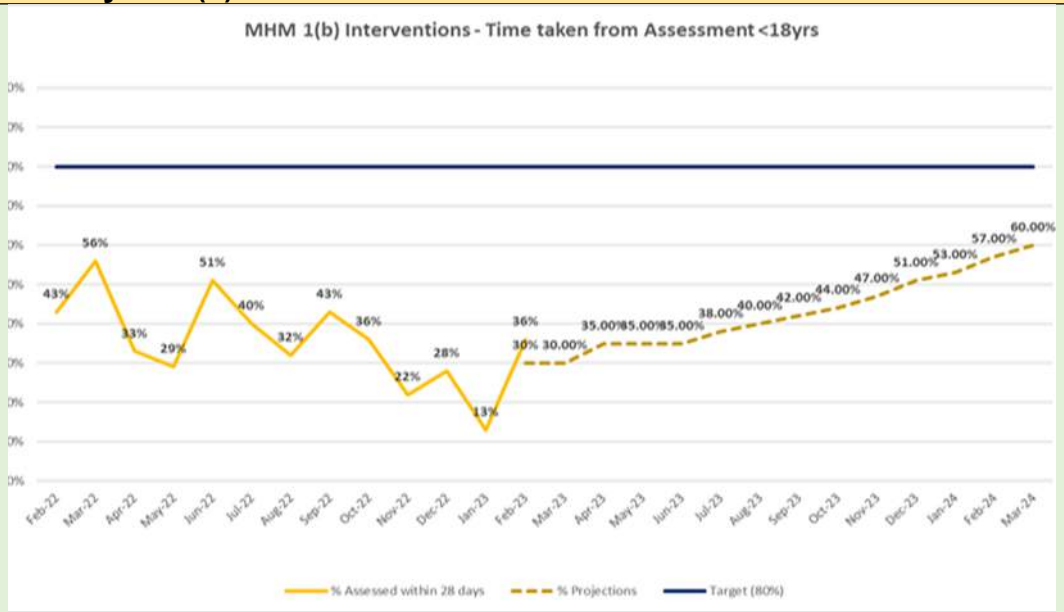
Performance has tracked above the target since June 2022 for Part 1A and consistently throughout the year for Part 1B. Part 2 performance is dependent on reviews by both Health Board and Local Authority Staff.

Trajectories have not been agreed as performance is consistently high however it will be monitored through the Integrated Performance Meetings.

Trajectories

The agreed trajectories for Mental Health Measure CAMHS Part 1A and 1B are below – these have been agreed with the Delivery Unit for the year and have been assessed as reasonable and achievable.



	Priority area(s)	
		
Quarter 1:		
- **Milestones**	By **June 2023** the MHM CAMHS target achievement is : • Part 1a 35% • Part 1b 35%	
- **Actions**	**Q1 actions** • Demand and Capacity Modelling to be revisited and refreshed in order to identify any risks and opportunities for improvement. Invite support from national team to ensure objective review benchmarked against other HBs. • Outsourcing options to be considered to support addressing the backlog of patients waiting	**Q1 action update** • Demand and capacity modelling work was revisited. This resulted in realigning some of the service capacity to support additional assessment alongside the implementation of groups for interventions. This has resulted in an increased number of assessments being undertaken having a significant impact of reducing the waiting list to 330 at the end of March to 140 at the end of June.

	Priority area(s)	
	• Roll out of group work to provide further intervention capacity with third sector organisations • Increase internal capacity through offering Waitlist Initiative clinics where funding is available • Monitor the referral demand to adjust or escalate risks through rising demand alongside implementation of further work to improve liaison with primary care • Monitor delivery through Planned Care Recovery Programme Board and a monthly Performance & Assurance meeting with NHS Wales Executive colleagues to broaden the insights to support improvement and learning.	• The service has reviewed one option around outsourcing and has a further meeting with another provider. The proposal is being considered by the planned care recovery board, although it is noted that the service has cleared a significant portion of the backlog in the last couple of months. • 6 additional groups have been implemented in partnership with a third sector organisation • The service is providing additional capacity through waiting list initiative clinics and this is having a positive impact on performance • Demand has realigned to expected levels following an increase in March 2023. The service is continuing to work with primary care and use of services such as Kooth to manage demand accordingly. • Performance is monitored via the Integrated Performance and Quality meetings with the service and via the Planned Care Recovery Programme Board. The service has started regular monthly performance with the NHS Wales Executive colleagues and is benefiting from this support to sustain improvement and enhance learning from an All Wales perspective.
Quarter 2:		
- **Milestones**	By **September 2023** the MHM CAMHS target achievement is: • Part 1a 46% • Part 1b 42%	
- **Actions**		

	Priority area(s)
	• Recruitment into new posts to provide additional capacity into the Part 1 service • Work with the national team to develop and implement a programme for the CAMHS leadership team on quality performance and leadership, ensuring the best culture and approach. • Monitor seasonal changes in activity, expected to reduce in Q2, and maximise impact of additional capacity • Undertake service review of the referral pathways and processes for assessment and intervention to ensure all capacity is maximised and waiting times limited – seek to reduce any identified duplication within the system.
Quarter 3:	
- **Milestones**	By December 2023 the MHM CAMHS target achievement is : • Part 1a 46% • Part 1b 51%
- **Actions**	• Reflect on the learning from the national meetings and development programmes to ensure maximum impact and implementation. • Review standard operating processes and pathways to ensure CTM-wide consistency and equity of access for children & young people. • Review outstanding vacancies following nursing streamlining and consider wider MDT opportunities and options where recruitment has been challenging. • Continue additional capacity clinics and review ongoing need in line with expected recruitment and service review
Quarter4:	
- **Milestones**	By **March 2024** the MHM CAMHS target achievement is : • Part 1a 80% • Part 1b 60%

	Priority area(s)
- **Actions**	• Identify through service review informed by the capacity and demand analysis any improvements and investment needed to stabilise performance into 24-25. Develop business cases for investment as required. • Review the impact of additionally commissioned activity throughout the year, reflecting on value for money and impact. • Embed and sustain the service model to maintain the required capacity • Evaluation of Schools In reach model following the phased approach and implementation and impact on CAMHS demand • Evaluation of Primary Care liaison work and impact on CAMHS demand
Risks	Resource to continue additional capacity clinics or alternatives to resolve backlog Recruitment into the service vacancies to embed and sustain the service model and core capacity required to meet demand
Outcomes	Reduction in the backlog of patients waiting more than 28 days for both assessment and intervention Improvement in the waiting times for assessment and intervention Reviewed service model to ensure the service is offering a good quality service and options to meet the needs of young people presenting Evaluation of service development to reduce demand on specialist CAMH service
Alignment with workforce plans	Recruitment via streamlining Review of alternative roles within therapies and non-registered workforce Closer working with 3rd sector to explore the use and impact of non-health traditional roles
Alignment with Financial plans	Investment via the Mental Health Service Improvement Funds

	Priority area(s)
OPTIONAL	
Digital / Technology Opportunities	Use of digital service offers via Kooth and Silvercloud to meet young people's needs Implementation of text reminders to maximise the use of service capacity

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.2

CTM BOARD

BOARD ASSURANCE FRAMEWORK REPORT

Date of meeting	27 July 2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable Public Meeting

Prepared by	Philippa Peake-Jones, Interim Head of Corporate Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Assurance
Approving Executive Sponsor	Chief Executive

Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Strategic Risk Owner updates	June / July 2023	Reviewed and signed Off
Executive Leadership Group	9 July 2023	Endorsed for Board Approval

ACRONYMS	
BAF	Board Assurance Framework

1. SITUATION/BACKGROUND

1.1 It is good practice for the Health Board to have a Board Assurance Framework (BAF) that clearly sets out the risks, actions and relevant sources of internal and external assurances to provide a clear picture of

the 'health' of the organisation and the high level risks threatening delivery of the Board's strategic goals.

1.2 In May 2023, the Board approved that the BAF remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board.

1.3 It should be noted that a recent Internal Audit review of the Board Assurance Framework resulted in an outcome of Substantial Assurance.

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

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

- the four strategic goals of the Health Board;
- assurance reporting that supports a streamlined and effective committee and reporting structure;
- a robust mechanism that reaches into each of the Care Groups and central functions to provide assurance on performance, quality and resources across the breadth of the integrated Health Board;
- international best practice; and
- the management of board meetings and agendas to be focussed equally on Oversight, Insight and Foresight i.e. balancing the governance of immediate operational priorities with the need to focus on long-term strategic planning.

2.2 The Organisational Risk Register is received in its entirety by the Audit & Risk Committee and the assigned risks to the other Board Committees as appropriate.

2.3 The latest Organisational Risk Register will be uploaded to the meeting date "document folder" in Admincontrol so although not published it is fully accessible to Board Members should they wish to view the detail behind the linked risks noted in the BAF.

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

3.1 During June and July 2023 the Strategic Risk Owners have reviewed and updated the BAF to ensure it robustly reflects the latest position.

3.2 Please refer to Appendix 1 which outlines the key risks for discussion and review. Amendments have been highlighted in red.

3.3 Following Board feedback in May 2023 the BAF has been updated so that each risk now includes the risk score trajectory, the rational for assessment of the risk score and the risk treatment consideration.

3.4 It is proposed that Strategic Risk 1 *"Sufficient capacity to meet emergency and elective demand"* be reduced from a score of 20 to 16,

following the approval of the Six Goals Framework and the recognition of the Planned Care Recovery activity.

3.5 It should be noted that an additional strategic risk, "Population Health: Prevention and Early Intervention", is being considered for escalation to the Board in September 2023, led by the Interim Director of Public Health.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The BAF will provide a robust mechanism that reaches into each of the localities and central functions to provide assurance on performance, quality and resources across the breadth of the integrated Health Board; international best practice; and
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Health Board is asked to:

APPROVE

- The updates to the BAF Report for July 2023.
- The reduction in risk score for Strategic Risk 1 from a 20 to a 16.

NOTE

- The development of a potential new Strategic Risk in relation to "Population Health: Prevention and Early Intervention".

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CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)	Current score	Scoring Trajectory *(since the last report received by the Board)*
1.	**Sufficient capacity to meet emergency and elective demand** Click Here for Risk 1	**Improving Care**	Chief Operating Officer Executive Director of Strategy and Transformation	Quality and Safety; Planning, Performance and Finance	**16** (C4xL4)	↓ Risk Score proposed for reduction in July 2023, 20 to a 16.
2.	**Ability to deliver improvements which transform care and enhance outcomes** Click Here for Risk 2	**Improving Care**	Executive Dir. Of Nursing, Midwifery Executive Medical Director	Quality and Safety	**16** (C4xL4)	↔ No change to risk score as at July 2023
3.	**Finance Revenue Resources** Click Here for Risk 3	**Sustaining our Future**	Executive Director of Finance;	Planning, Performance and Finance; People and Culture	**20** (C4xL5)	↔ No change to risk score as at July 2023
4.	**Sufficient workforce to deliver the activity and quality ambitions of the organisation** Click Here for Risk 4	**Sustaining our Future**	Executive Director of People	People & Culture Committee	**20** (C5xL4)	↔ No change to risk score as at July 2023
5.	**Community and Partner Engagement** Click Here for Risk 5	**Creating Health**	Executive Director of Public Health	Population Health & Partnerships	**12** (C4xL3)	↔ No change to risk score as at July 2023
6.	**Delivery of a digital and information infrastructure to support organisational transformation** Click Here for Risk 6	**Improving Care**	Director of Digital	Digital & Data	**16** (C4xL4)	↔ No change to risk score as at July 2023

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee(s)	Current score	
7.	**Leadership and Management** **Click Here for Risk 7**	**Inspiring People** INSPIRING PEOPLE	Executive Director for People	People and Culture	**12** (C4xL3)	↔ No change to risk score as at July 2023
8.	**Culture, Values and Behaviours** **Click Here for Risk 8**	**Inspiring People** INSPIRING PEOPLE	Executive Director for People	People and Culture	**12** (C4xL3)	↔ No change to risk score as at July 2023
9.	**Fulfilling our Environmental and Social Duties and ambitions** **Click Here for Risk 9**	**Sustaining our Future** SUSTAINING OUR FUTURE	Executive Director of Strategy and Transformation	Population Health and Partnerships	**16** (C4xL4)	↔ No change to risk score as at July 2023

Click here to view CTMUHB's Risk Appetite Statement

Click here to view CTMUHB's Risk Domain and Scoring Matrix

Section 2 Strategic Risk Heat Map

Current risk scores in **black**
Target risk scores in ***grey italic***

Consequence						
	5				**4**	
	4		*5,7,8*	*1,***5***2,3,4, 6,***8,7	**,6,9,2, 1**	**3**
	3			*9*		
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

Section 3 –Strategic Risks

Strategic Goal: **Improving Care**			Risk score ~~20~~ **16**
Strategic Risk: **Sufficient capacity to meet emergency and elective demand - (Risk No.1)**			
If the Health Board is unable to meet demands for services at all points in the patient journey, exacerbated by the impact of the Covid-19 pandemic	***Then*** its ability to provide high quality care and to meet access targets will be reduced	***Resulting in*** avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community	

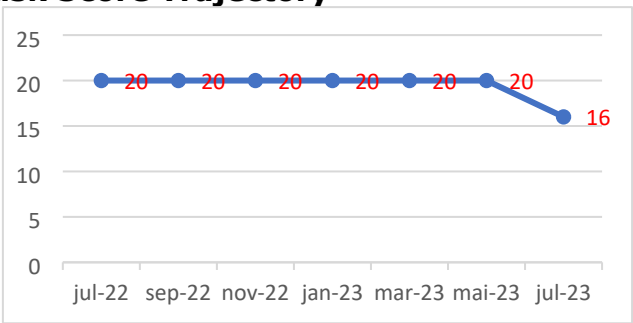
	Consequence	Likelihood	Score
Initial	4	5	20
Current	**4**	~~**5**~~ **4**	~~**20**~~ **16**
Target	4	3	12
Risk Appetite	**Cautious** *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

↓

Risk Score reduced from a 20 to a 16 in July 2023.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	Following the approval of the Six Goals Framework and the Planned Care Recovery activity the risk likelihood has been reduced in recognition of the progress on this activity. It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce, financial and environmental constraints on the service. Demographic change also leads to increasing demand for services particularly non-elective. There are limitations arising from National Policy which limits the Health Boards ability to respond.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however ongoing risk treatment activity outlined in the mitigating actions section.

Risk Lead	• Chief Operating Officer • Executive Director of Strategy & Transformation	Assurance committee	• Quality & Safety Committee *(potential harm)* • Planning, Performance and Finance *(performance targets)*

Controls	Assurances reported to Board and committees
Six Goals for Urgent and Emergency Care Programme (signed off by ELG on 5 June 2023): • Admission Avoidance • Integrated Front Door • Acute Hospital Flow and Discharge • Integrated Discharge This programme expedited the development and mobilisation of the "Front Door" and "Back Door" elements of the Navigation Hub as separate pieces of work for a period of several months, to best enable the launch of Navigation Hub component supporting discharge pathways to be planned and expected on 5th December 2022. Electronic referrals have gone live in to the discharge hub and the navigation hub is operational. Go Live of 111#2 from 4.4.23. **Planned Care Recovery Programme** • Enhanced monitoring process for Cancer Services **– Weekly focussed meetings.** • Llantrisant Health Park site plans under development • Clinical Services Plan Group being established (27th April inaugural meeting) **Specific Improvement Groups/Boards** • Stroke Strategy ~~Improvement~~ Group • Ty Llidiard Improvement Board – deescalated to level 2 from 3 • Plan for a Stroke Programme Board • Pathology Improvement Group • Ophthalmology Improvement Board • Dermatology Improvement Board	• Integrated Performance Report • Nurse Staffing Act twice-yearly compliance reports • Harm Reviews • Assessment Dashboard • Update reports on specific services experiencing pressure, e.g. Ophthalmology • Follow-up reports on outpatients not booked • Urgent Care six goals progress reports • Planned Care Recovery Update report • Escalation processes leading to Chief Operating Officer Report to Quality & Safety Committee including Care Group performance review meetings. • Organisational Risk Register via **Care Group** Risk Registers. • Command Structure initiated to manage periods of Industrial Action (IA) stood down. Embedding IA process into daily huddle meetings.

Established a Mental Health Services Recovery Programme – Which includes CAMHS, Adult Mental Health and Demand and Capacity improvement activity. **Annual Planning Process** **Lessons learnt from Winter Planning** process currently being analysed from a lessons learnt perspective. **Partnership Leadership Team** established with LA and NHS representation to look at planning across the region. **Commissioning Group** established to oversee the delivery of the optimised integrated care model **Annual Capacity Plan established April 2023** to manage demand and making best use of capacity. **NHS run care capacity development** **Escalation Status programme work** **Regional Working** • A Residential and Nursing Care for Older People Report has been completed and approved by the Regional Partnership Board and actions being implemented. • Alternative bed options being worked-up by all CTM local authorities to aid patient flow and 'Discharge to Recover then Assess' (D2RA) out of hospital stabilisation and onward decision-making. • Welsh Government supporting intervention with Bridgend County Borough Council regarding backlog of patients Medically Fit for Discharge. • Regional Pathology Steering Group • South East Regional Programmes of work – Collaborative approach to restoration with a number of targeted work streams. • Integrated Health & Social Care Programme Board. • Regional Integrated Fund (RIF)	

Governance Structures • Operational Services Management Board (Health Board wide) • Improving Care Board (Health Board wide) • Six Goals Board • Cancer Board • Weekly Cancer Meetings • Planned Care Recovery Board • Innovation Board **Operational Processes** • Clear criteria to prioritise based on clinical need • Centralised decision-making around use of spare capacity across the organisation.	
Gaps in Controls and Assurances	Mitigating Actions
• Central digitally-based Capacity Management System	• As part of the Six Goals Framework a range of Task and Finish Group have been established to scope options for a digital alternative e.g. e-whiteboards. Timeline projector available upon request within the six goals information pack which is updated every month. • E-whiteboards in, the next stage is to embed and the next phase is to get them at the front door and SDEC. Timeline projector available upon request within the six goals information pack which is updated every month.
• Robustness of cancer tracking and specialty-specific elective data – Improvements being made in elective care trajectories albeit not fully embedded.	• Speciality Specific and Cancer Improvement Trajectories Completed, will move to control at the next iteration. • Reconfiguration of elective surgery from October 2022 has seen an increase in activity. This will continue to be monitored and developed Completed, will move to control at the next iteration. • Reconfiguration of Trauma still to be completed under phase 2. • In sourced additional staff to open up additional two theatres went live from 9th January 2023 has seen an increase in activity. This will continue to be monitored and developed. A third theatre team will commence on the 1st March 2023 at Princess of Wales Hospital Completed, will move to control at the next iteration.

	• Effective initiation of business continuity plans to respond to increased capacity pressures and challenges in the service (ongoing). • Development (and from November 2022) implementation of Winter Plan. Pressures upon capacity continually being monitored to feed into Winter Plans. Meetings being scheduled imminently to be chaired by the Chief Operating Officer to move this forward. • In Development – Clinical Services Plan ~~Tactical Service Reconfiguration Plan.~~ • IMTP – investment agreed by Board in March 2023 of £5.5m for Planned Care and £0.5m for Stroke services. Completed, will move to control at the next iteration
Linked National Priority Measures	**Current Performance - Highlights**
Ministerial Measures: *Six Goals of Urgent and Emergency Care:* • Percentage total conveyances taken to a service other than a Type One Emergency Department; • Number of people admitted as an emergency who remain in an acute or community hospital over 21 days since admission; and • Percentage of total emergency bed days accrued by people with a length of stay over 21 days. *Access to Timely Planned Care* • Number of patients waiting more than 104 weeks for treatment; • Number of patients waiting more than 36 weeks for treatment; • Percentage of patients waiting less than 26 weeks for treatment; • Number of patients waiting over 104 weeks for a new outpatient appointment; • Number of patients waiting over 52 weeks for a new outpatient appointment; • Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%; • Number of patients waiting over 8 weeks for a diagnostic endoscopy; and • Percentage of patient starting their first definitive cancer treatment within 62 days	The following key performance indicators should be considered from the Integrated Performance Dashboard: • Urgent care • planned care, • cancer • and diagnostic indicators • ~~A review of current risk score to be undertaken once quarter 1 performance analysis available for Cancer, Planned Care, Urgent Care and Mental Health. (Timescale end July 23).~~

from point of suspicion (regardless of the referral route). • Patient and delayed ambulance handovers (15min handover)	

Were there any significant incidents affecting this strategic Risk this period:
None identified for inclusion in the BAF Report.

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4071	Failure to sustain services as currently configured to meet cancer targets	**20**
4103	Sustainability of a safe and effective Ophthalmology service	**20**
4491	Failure to meet the demand for patient care at all points of the patient journey	**20**
4632	Demand and capacity across the stroke pathway	**20**
~~4743~~	~~Failure of appropriate security measures / safety fencing~~ Risk closed July 2023.	~~**20**~~
~~4721~~	~~Shift of the boundary for attendances at the Emergency Department~~ Risk closed July 2023.	~~**20**~~
5462	Adult weight management service - Insufficient capacity to meet demand. New escalation to the Organisational Risk Register in July 2023.	**20**
3826	Emergency Department overcrowding	~~**20**~~ **16**
5036	Pathology services unable to meet current workload demands.	**16**
3131	Mortuary Capacity (New Risk escalated to the Organisational Risk Register in January 2023)	**16**
5404	Post Mortem Backlogs in Mortuary. New escalation to the Organisational Risk Register in July 2023.	**16**
~~4458~~	~~Failure to deliver Emergency Department Metrics (including 15 minute handover and 4 and 12 hour breaches~~ Risk closed in July 2023 as amalgamated with risk 3826.	~~**16**~~
1133	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital	**16**
4152	Back log for Imaging in all modalities / areas and reduced capacity	**16**
2808	Waiting Times/Performance: ND Team	**15**
~~5207~~	~~Care Home Capacity~~ Risk de-escalated from the Organisational Risk Register in July 2023 as score reduced from a 15 to a 10.	~~**15**~~

Click here to go back to the summary Section

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Strategic Goal: **Improving Care**	Risk score **16**
Strategic Risk: **Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)**	

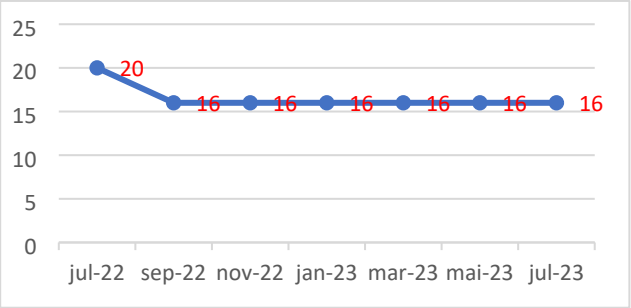
If the Health Board fails to achieve fundamental quality standards or implement improvements in practice and innovations	***Then*** we may not be able to deliver safe, timely, compassionate and effective care in accordance with the Duty of Quality	***Resulting in*** avoidable harm to patients, poor patient experience, diminished staff morale, potential for greater regulatory intervention and loss of trust and confidence

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

Risk Score Trend this Period:

↔

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	Improvements are in train however, it is too early to consider a reduction in risk score at this time.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however ongoing risk treatment activity outlined in the mitigating actions section.

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

Controls	Assurances reported to Board and committees

Quality Frameworks and Policies

- Quality Governance Framework approved by the Board in January 2023 and is aligned to new Care Group Model. Care Group implementation underway as of April 2023;
- Clinical Guidelines;
- Suite of Standard Operating Procedures;
- Clinical Education Framework;
- Incident Management Framework launched June 2022 to reflect national changes in national incident reporting;
- Incident Investigation training established and being rolled-out across the Health Board on a monthly basis;
- Clinical Education Forum (providing overarching Governance) established, with its inaugural meeting in July 2022 and meetings scheduled for 2023;
- Listening & Learning Framework launched and implemented at the Listening and Learning Event in September 2022. Next organisation wide event taking place May 2023 (includes external stakeholder engagement);
- Quality Strategy endorsed at the Quality & Safety Committee in November 2022 and approved by the Board and launched in quarter four.
- Implementation Board for the Duty of Quality and Candour being established – inaugural meeting undertaken. Board Briefing held October 2022. Change Team supporting implementation of Duty of Candour arrangements as of April 2023.

Learning from Experience

- Executive and Independent Member Patient Safety Walkabouts framework currently being finalised for implementation from May 2023.
- Citizen's Voice bodies ~~being~~ launched in place of CHCs;
- Mortality Review programme. Medical Examiner reviews fully incorporated. Focus level 2 / 3 reviews across CTM;
- Shared Listening and Learning Forum
- Community Acquired Pressure Ulcer Collaborative. Forum for shared learning on prevention and improvement with

Annual Reports

- Clinical Audit Annual Report;
- Clinical Education Annual Report;
- Safeguarding Annual Report;
- Putting Things Right Annual Report;
- Infection Prevention and Control Annual Report;
- Medicines Management Expenditure Committee Annual Report;
- Health and Care Standards Annual Report; (incorporating patient survey)
- GMC Survey
- Improvement to be reported through Improving Care Board / Change to be reported through Strategic Transformation Board;

Quarterly Reports

- Quality Dashboard;
- Integrated Performance Dashboard;
- Quality Governance – Regulatory review progress updates;
- IPC Highlight reports;
- Integrated Locality Group reports;
- High level update on mortality indicators;
- Research and Development Update;
- National Clinical Audit and NCEPOD studies;
- Targeted intervention process – continuous improvement self-assessment reports to Board;
- Maternity and Neonatal Improvement Programme Highlight Report;
- Community Health Council briefing papers;
- RADAR Reports;
- Improvement portfolio report;
- Multiple engagement events underway.

Ad hoc Assurances

- PCH spot visits to services – improvement programme. PCH Improvement Board stood-down and Care Groups tracking legacy actions through 'business as usual' processes;
- ~~Purpose, Form and Function of IM Walkaround Visits and the development of a clear framework is crucial to supporting the intelligence that can be gathered;~~
- Peer reviews of specific services e.g. critical care;

internal and external stakeholders e.g. (Welsh Wound Innovation Centre (WWIC) and Local Authorities); • Weekly executive-led patient safety meetings; • Service Level Patient Safety meetings incorporate learning from events; • Joint Executive and Independent Member Walkarounds; • Patient and Staff Stories received at Board Meetings and Quality & Safety Committee; • Active Forums such as "My Maternity My Way" which includes past and present service users; • Real-time patient feedback (Civica System) being rolled out across the Health Board (PREMS); • Following discussions in relation to the operating model that will support the new Care Groups it is considered that Quality Assurance will be will be incorporated within these new structures which plan to be introduced in September 2022; • Patient Safety Clinics, targeting service areas with high or low incident reporting; • Learning from events coordinator role in place, with lesson of the week via social media and a monthly newsletter is shared across the Health Board sharing learning around incidents and concerns; • Patient Reported Outcomes Measures system procured and piloted in Heart Failure / Cardiology services and plans in place to roll out across HB (PROMS); • Staff ideas scheme launched across CTM for staff to provide ideas for improvement and collaborate on solutions; • RADAR (Recognition of Acute Deterioration & Resuscitation) Committee. – Training standards and compliance. This is now a work stream within the Unscheduled Care Group; • It is anticipated that the New Operating Model will support the triangulation and learning across the Health Board as one CTM; • Advanced Clinical Practice Board established to provide governance oversight with regards to advanced practice professionals.	• Health Inspectorate Wales unannounced visits; • Medication Prescription and Administration incident update; • Bridgend Safeguarding Hub; • Planned Level 3 Safeguarding training for all Senior Clinical leaders (Execs – Care Group directors); • Contacted (letter, key message and verbal reminders) all medical teams to emphasise, and expect, need to complete level 2 Safeguarding training and certain areas level 3; • Community Acquired Pressure Damage; • Patient Safety Solutions – safety alerts and notices; • Mental Capacity Act (LPS); • Ad-hoc visits to Ty Llidiard (CAMHS) facility and ad-hoc review of clinical records; • Executive Director of Nursing and Executive Director of Therapies and Health Sciences have undertaken the relevant training on Duty of Quality & Duty of Candour to ensure that there is sufficient knowledge and influence in relation to the legislation at Board level. • HIW undertake adhoc reviews of medical training within the Health Board. **Qualitative Intelligence** • Ongoing weekly safety huddles taking place with Executive Directors and Care Group Directors, and Quality and Safety Team to review concerns and complaints compliance across the Health Board; • Ongoing monthly meetings with Executive Director of Nursing, Directors of Nursing and Ward Managers; • Patient and Staff Stories; • Executive & Independent Member Walkarounds; • Executive Nurse Director weekly clinical focussed site visits; • Improvement case studies; • Social Media feedback and intelligence; • Listening and Learning forum; • Weekly executive-led patient safety meetings; • Performance and Assurance Directorate of the NHS Executive ~~Delivery Unit (DU)~~

Innovation & Improvement Programmes

- iCTM (Improvement & Innovation) department in place and 2022-2025 iCTM business plan developed aligned to CTM 2030 focusing on Experience, Efficiency and Effectiveness all underpinned by Improved outcomes and Patient Safety;
- Leading for Patient Safety with Improvement Cymru and Institute for Healthcare Improvement (IHI) launched. Work plan established and programme continuing for 2023;
- Improvement and Innovation CTM are actively supporting a number of services:
  - Maternity & Neonates
  - Urology
  - General Medicine (RGH)
  - Pressure Ulcer Improvement with WWIC
  - Engaging with external partners to ensure collaboration in relation to multiple stakeholder working to realise benefits for the communities we serve.
- Targeted Intervention / Special Measures programme work;
- Removed as now integrated as business as usual. Immediate make safes complete;
- Monthly Quality Improvement (QI) training commenced from June 2022 and ongoing on a monthly basis;
- Patient Safety Clinics commenced June 2022 and will run bi-monthly or as required by services;
- Investigation and Putting Things Right (PTR) Training commenced during July 2022;
- Value Based Healthcare programme in place aligned to national Value in Health priorities;
- Enhanced resources in place for business analysis / data analysis to identify areas of improvement and change through data;
- Innovation programme aligned to Value Based Healthcare principles;
- Building leading and empowering Improvement and Innovation into the new Ignite, Aspire and Inspire leadership programmes;
- Implementation of Care Group Improvement Faculties;

Dashboard reports inform the Health Board in terms of compliance across the Patient, Care and Safety portfolio;

- iCTM joint working with academic partners to explore cutting edge quality and safety activity to support the Health Board's continuing improvement journey;
- The Health Board is represented at the Duty of Quality & Duty of Candour all Wales meetings;
- Partnership Working with Cardiff & Vale re South Central Regional Stroke Network;
- Board Briefing regarding Regional Stroke Developments held in December 2022 and followed up in January 2023;
- Regular Director of Therapies & Health Sciences Team quality assurance visits to clinical services.

External Assurance

- Ombudsman's Annual Letter;
- Internal Audit Review – CSG & ILG Quality Assurance. August 2022 – outcome of Reasonable Assurance;
- HIW reports e.g. PCH Improvement Programme;
- The Health Board is in the process of strengthening the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up. Local governance of HIW actions will take place through our new Care Group quality and safety committees. The system will allow for the Care Group leads to have a dashboard of all their HIW Inspection activity and continuous monitoring of the improvement plans;
- Audit Wales review of Quality Governance arrangements and follow-up;
- Performance and Assurance Directorate of the NHS Executive ~~Delivery Unit (DU~~ governance and incident management;
- Performance and Assurance Directorate of the NHS Executive ~~Delivery Unit (DU~~ Maternity and Neonatal SI closures;
- Annual Undergraduate Review;

• Medical Workforce & Nursing Workforce Productivity Programme established; • Speciality Teams across CTM are now regularly meeting to enhance shared learning amongst doctors. This will be enhanced further by the care group model currently being rolled-out; • Appointment of the Bereavement Clinical Lead to support the implementation of the All Wales Care of the Bereaved Framework and Pathways. • The Improvement Team have aligned resource to care groups and are meeting care group management on a monthly basis to discuss quality improvement activity. **Research** • Research & Development Programme **Flow Efficiencies and Productivity** • Speciality Teams across CTM are now regularly meeting to enhance shared learning amongst doctors. This will be enhanced further by the care group model currently being rolled-out. ~~Complete and will move to a control;~~ • Nursing Productivity Groups operational	• General Medical Council National Survey Feedback; • MSOP stood-down as of December 2022, oversight and scrutiny now conducted through internal Board mechanisms and to Welsh Government via IQPD and escalation meetings; • Positive IHI and Improvement Cymru visit feedback (autumn 22) as part of Leading for Patient Safety received and feedback to Board received; • National Safe Care Collaborative Programme Audit. Presented findings to the Board in December 22; • WHSSC and NCCU supportive review of Ty Llidiard. Positive report received during December 2022 resulting in de-escalation to level 3. Good progress continues to be made against the Ty Llidiard Improvement Plan, with positive feedback received within regular CTM Ty Llidiard Improvement Board and WHSSC Escalation meetings. Discussions with WHSSC regarding further de-escalation continue.
Gaps in Controls and Assurances	**Mitigating Actions**
• Data and Audit - Real-time performance and quality data accessible via electronic systems across the organisation;	• Central Patient Safety Team are manually reviewing and validating data currently in relation to locally reportable incidents. In progress, pace impacted by the implementation of the new Operating Model - Completed; • Mortality Data Improving – should be in place by end of September 2023. • Following pilot, the Health Board will be implementing an Annual Nursing Ward Assurance Audit, which will report into the Quality & Safety Committee – Completed • Specific Mental Health metrics in development – timeframes end of ~~June 2023 –~~Qtr 3. • CTMUHB is represented on the work being undertaken with the Performance and Assurance Directorate of the NHS Executive ~~Delivery Unit~~ to explore how benchmarking in quality performance can be shared across NHS Wales. The Performance and Assurance Directorate of

	the NHS Executive ~~Delivery Unit~~ are also rolling out a National Quality Safety Framework to support a consistent approach to quality reporting. Timescales dependent on external sources; • Ambition to develop live clinical quality dashboard – live for maternity services – to be rolled out for other areas by the end of the financial year; • Improving Care Group focus will be on four areas and ten metrics to demonstrate improvement. Current position is consideration of metrics. Timeframe: September 2023; • National Safe Care Collaborative Programme Audit recommendations and action plans led by IHI and Improvement Cymru – by the end of 2024; • The Health Board is in the process of strengthening the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up – Completed – HIW Tracker is now in place; • Launched Nursing & Midwifery framework and agreed a set of nursing care related audit standards which are being monitored through AMAT platform - Completed;
• Raising awareness of staff responsibilities under the Duty of Quality and the Duty of Candour linking in with the actions arising out of the All Wales forum for which the Health Board is represented, which will include the development and roll out of training packages;	• The Health Board is represented on the programmes of work supporting the roll out of the Duty of Candour and Duty of Quality. Focus in terms of quality will be on the Code of Practice and the implementation of any training. Timescales: by April 2023; Training will be ongoing as required as the Act is embedded within the Health Board. Roadshows will be live as of September 2023 to engage with clinical leaders from care groups and services on the Duty of Quality and subsequent compliance.
• Feedback from staff and our communities on the ability to raise ideas, freedom and support to make change and empowerment. Holding engagement sessions for staff;	• Executive and Independent Member Patient Safety Walkabouts framework currently under review. The revised framework will include 'Purpose, Form and Function' of IM Walkaround Visits. Timeframe: July 23 – Completed; • Staff ideas scheme implemented (May 22) for raising ideas for improvement – to

	increase participation in 23/24 – Implemented; • Improvement into practice training taking place monthly as of final quarter of 22/23.
• Improving flow and efficiencies and productivity	• Medical Day Surgery expansion expanded to address the backlog in the light of capacity challenges. Plans in place for four specialties with a view to increasing day case surgery throughput. Pace impacted bed pressures; • Increasing amounts of straight to test and one stop clinics across a number of specialities which will improve how people are seen. This will be ongoing and picking up pace. ~~revisit in next review;~~ • Medical & Nursing Workforce Productivity Programmes operating within the transformational programme governance structure and delivering to plan.
Linked National Priority Measures	**Current Performance - Highlights**
Care Closer to Home • 6. Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes; • 7. Percentage of patients (aged 12 years and over) with diabetes achieving all three treatment targets in the preceding 15 months. **Patient Safety Solutions** **Infection Prevention and Control** • Six Tier One IP&C Targets; • National IP&C Guidance – to include implementation of respiratory and non-respiratory pathways; • NHS Wales National Framework – Management of patient safety incidents following nosocomial transmission of Covid-19. **Children's Charter** To reinforce children's rights and endorse CTM's commitment to upholding these rights within its services. **Safeguarding** • National Improvement Plan; • Further Mental Capacity Act (MCA) awareness being funded by Welsh	Please refer to the following sections of the Integrated Performance Dashboard to triangulate risk, assurance and performance: • Cancer Standards; • Unscheduled Care; • Six Goals Programme (Emergency & Urgent Care, D2RA); • Waiting List Delays; • Mortality Indicators; • Tier 1 IP&C Indicators; • Nurse Sensitive Outcome Measures – Falls, Pressure Ulcers, medication administration; • Sepsis; • Mental Health Measures; • Putting Things Right Compliance; • Patient Safety Solutions compliance

Government along with measures to strengthen current Deprivation of Liberty Safeguards until MCA becomes the dominant legislation. • Independent Review (by HIW/CIW) being undertaken of CTM Region Safeguarding Boards in relation to Child Protection Practices including the sharing of information. **Chief Nursing Officer's Launch of the Nursing and Midwifery Priorities – 2022-2024** **New national nurse education standards** **Dementia Standards -** which include standards for inpatient hospital admissions. **NHS Wales Quality and Safety Framework: Learning & Improving**. Published by WG September 2021. **The Health & Social Care** (Quality & Engagement) (Wales) **Act 2020** Improving quality and public engagement in health and social care. **National Value Based Healthcare Strategy –** alignment of CTMs programme of work to meet national priorities	
Were there any significant incidents affecting this strategic Risk this period:	
Significant incidents (NRI or LRI) are managed in according with the Incident Framework and reported to the Quality & Safety Committee.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4479	No centralised decontamination facility in Princess of Wales Hospital	**20**
4907	Failure to manage Redress cases efficiently and effectively	**20**
4922	Covid-19 Inquiry Preparedness – Information Management	**20**
5267	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses.	**20**
5254	Failure to manage redress cases efficiently and effectively in respect of the Duty of Candour. New risk escalated November 2022.	**16**
3133	Non-attendance at medical gas safety training and courses being rescheduled	**16**
~~3585~~	~~Princess of Wales Emergency Department hygiene facilities~~ Risk closed July 2023.	~~**16**~~

4148	Non-compliance with Deprivation of Liberty Safeguards legislation and resulting authorisation breaches	**16**
4906	Failure to provide evidence of learning from events (Incidents and Complaints)	**16**
4417	Management of Security Doors in All Hospital Settings	**16**
3008	Unavailability of opportunities to train and maintain compliance with Manual handling training	**16**
5477	Temporary Suspension of Awen Hub, Community Neurorehabilittion Service. Escalated to the Organisational Risk Register in July 2023.	**16**
5304	The Air Handling Unit (AHU) for the pharmacy aseptic production suite. Escalated to the Organisational Risk Register in July 2023.	**16**
4908	Failure to manage Legal cases efficiently and effectively. Risk re-escalated as risk score increased from a 12 to a 16.	**16**
4928	Special care baby unit infrastructure does not comply with recommendations. Escalated to the Organisational Risk Register in July 2023.	**15**
3993	Fire enforcement notice – POWH Theatres	**15**
4590	Critical care pharmacist resource	**15**
4732	Replacement of press software on the 13 & 10 stage CBW presses	**15**
4691	New Mental Health Unit	**15**
5207	Care Home Capacity	**15**
4217	No infection prevention and control resource for primary care	**15**
~~3638~~	~~Pharmacy & Medicines Management - Training & Development Infrastructure~~ Risk closed July 2023.	~~**15**~~
~~2987~~	~~Fire enforcement order First Floor PCH~~ Risk de-escalated from the Organisational Risk Register in July 2023 as risk score reduced from a 15 to a 12.	~~**15**~~

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Strategic Goals: **Sustaining our Future**			Risk score **20**
Strategic Risk: **Finance Revenue Resource - (Risk No.3)**			
If the Health Board fails to manage its revenue resources that are appropriate and sufficient for now and the future	***Then*** we may fail to fulfil our financial and other statutory duties in 2023-2024.	***Resulting in*** inability to fund planned improvements and new services, and increased regulatory scrutiny and enforcement. Without cash support there will be a cash shortfall in the latter months of the financial year.	

	Consequence	Likelihood	Score
Initial	**4**	5	20
Current	**4**	**5**	**20**
Target	4	3	12
Risk Appetite	**Minimal** *(financial stability)* **Cautious** *(legal and regulatory)*		

Risk Score Trend this Period:

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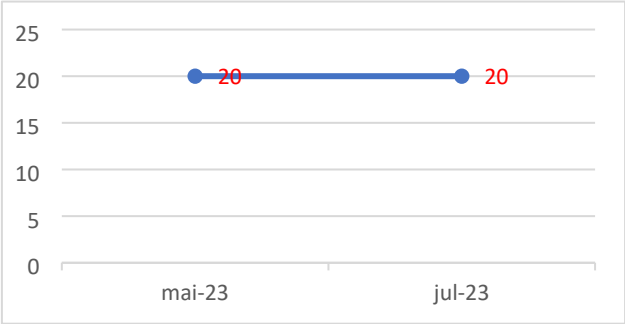
Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	This is new risk, as of April 2023. The latest financial plan includes a forecast deficit of £79.6m which means that the Health Board will not meet its Statutory financial duties in 2023/24. The risk score currently remains unchanged
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	The risk will continue to be treated as the Health Board strives to reduce the deficit position. However, even if the deficit is reduced, it is unlikely that the Health Board will achieve a break even position so the risk score will not change. The proposal is to treat the deficit, however, due to the scale of the deficit it's likely that the Board will need to tolerate this risk in terms of the risk score remaining unchanged.

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

Controls	Assurances reported to Board and committees
Financial Management • Budget setting process • Budgetary control and management accounting • Standing Financial Instructions • Scheme of Reservation & Delegation • Local Counter-Fraud Service • Monthly financial performance reviews for Care Groups and corporate directorates • Recovery plans for financially challenged services accompanied by enhanced monitoring and support • Internal Audit Programme • External Audit Programme	**Financial Management** • Annual Report and Accounts • Monthly Finance Reports • Monitoring Returns to Welsh Government • Internal Audit Programme • External Audit Programme • Losses and Special Payments Report to Audit & Risk Committee
Gaps in Controls and Assurances	**Mitigating Actions**
Finance **1.** Understanding of budgetary control and procurement processes in some services	**Finance** 1. Mitigation Actions for Gap 1: • Deliver training to budget holders within Care Groups/Directorates – *ongoing, for completion by end 2022. Ongoing throughout 2023-2024.* • Deliver procurement training to departments where compliance with procurement processes is low - ongoing, for completion by end 2022. *Ongoing throughout 2023-2024.*
2. A recognised risk of shortfalls in savings delivery	2. Mitigation Actions for Gap 2: • Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. *Ongoing throughout 2023-2024.* • Developing a more a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. *Ongoing throughout 2023-2024.* • Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. *Ongoing throughout 2023-2024.*

Linked National Priority Measures	Current Performance - Highlights
Workforce • 23. Agency spend as a percentage of the total pay bill **Public Sector Prompt Payment (PSPP) Performance**	The M2 YTD position is a £13.4m deficit. This represents a £0.1m adverse variance compared to 2/12ths of the forecast deficit in the draft plan of £79.6m. The M2 YTD savings position is a deficit of £2.3m. The forecast savings in 23/24 is £19.9m, which represents a £7.4m shortfall compared to the annual target of £27.3m. The M2 agency spend was £4.5m (M1: £4.3m). The M2 YTD agency spend is £8.8m which represents 8.1% of the M2 YTD total pay spend of £108.5m. Cumulative PSPP performance at M2 was 97.1%, which is above the 95% target.

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

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
5425	Failure to achieve financial balance in 2023-2024. New risk escalated to the Organisational Risk Register in May 2023.	**20**
5427	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023-2024. New risk escalated to the Organisational Risk Register in May 2023.	**20**

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Strategic Goals: **Sustaining our Future**			Risk score **20**
Strategic Risk: **- Sufficient workforce to deliver the activity and quality ambitions of the organisation (Risk No. 4)**			
If the Health Board fails to identify and plan for its future workforce requirements, and to promote CTMUHB as an attractive place to work	***Then*** we may fail to recruit and retain staff with the right skills and experience	***Resulting in*** Loss of skills and talent, staffing shortages which adversely affect the quality of care and employee experience and prevent us from delivering services fit for today and tomorrow	

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

Risk Score Trend this Period:

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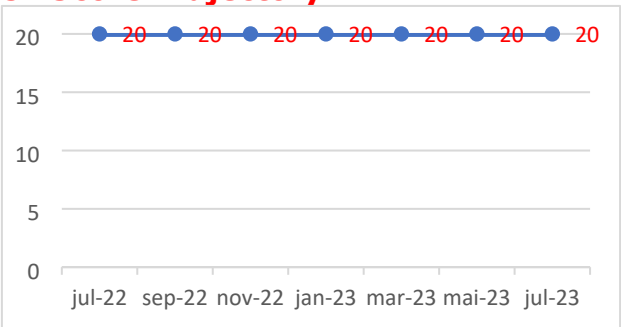
Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	This risk is complex and reflects recruitment & retention challenges across health and social care on a local, national and international scale. Therefore although we are "treating" this risk it is recognised that significant progress on this will not be achieved in the short term.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through the expansion of programmes of work focused on strategic workforce planning, transformation and attracting/ recruiting/ developing/ retaining our workforce

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

Controls	Assurances reported to Board and committees
Recruitment • Online recruitment through TRAC • Overseas recruitment of clinical professionals	• Workforce and Organisational Development Metrics report (includes key performance indicators such as staff in post, turnover, unfilled hours, sickness) which is regularly reported to the CTM to

• Pathways to Employment programmes (~~Kick Start,~~ Project Search/Supported Internships, apprenticeships, Network 75, Jobs Growth Wales +, Graduate Activity) • NHS Wales and Academi Wales public sector graduate trainee programmes • Living Wage employer status • Local Recruitment & Retention Premium Payment Protocol • Medical Recruitment plan in development **Retention** • Career development opportunities, e.g. ~~Pathways into Management programme~~ Apprenticeships, Qualifications & in-house learning and development offer e.g. Leadership & management programmes • Moving on questionnaires ~~to be~~ launched in January 2023 to understand reasons for leaving. • Wagestream as a mechanism for regular pay • Engagement in All Wales Nursing recruitment group and development of local action plan • New Organisational Induction launched • PDR "Your Conversation" promoting safe and productive environments for managers to interact with and listen to their staff **Temporary staffing solutions** • ~~New~~ Medical Bank • Modernised processes for Nurse Bank with service improvement project underway • Locum Managed Service Agreements **Day-to-day management of staffing levels** • Electronic rostering • Medical job planning • Sickness absence management process **Workforce Planning** • Assistant Director role established to lead strategic workforce planning, new Head of Workforce Planning commencing in post in August • Health Education Improvement Wales (HEIW) Workforce Planning Tool and Skills for Health modelling tool • Establishment Control being explored • ~~Procured 'expert'~~ Workforce planning review completed with external "expert" –	People & Culture Committee. Data also included in Integrated Performance Report to the Board. • Bi-annual Medical Workforce and Medical Efficiency Reports • Twice yearly nurse staffing assurance reports to the Board • Benchmarking analysis • Annual Education Commissioning Submission

repot has identified ~~to support CTM to identify immediate~~ tactical priorities ~~that inform our existing plans~~. ~~This will also identify~~ and longer term opportunities for workforce redesign. Tool also developed to all for workforce modelling/forecasting, including projecting the impact of interventions. Report and presentation to Executive Team and engagement now underway across the organisation in regard to the findings and next steps. • ~~As part of an all-Wales piece of work, Nurse Workforce Modelling will provide high level indication of vacancies and routes to fill.~~ • Workforce Strategy development for Health Care Sciences and AHPs is a key priority. • Attendance at National Careers Fairs with learning to inform future attendance. • Engagement with national programme to review Advanced and Consultant level framework. • Work experience pathway established ~~programmes now considered in conjunction with ongoing work in relation to pathways to employment~~. • Launch of All Wales quarterly vacancy reporting • New People data dashboards launched across Care Group, giving access to timely, accessible, relevant and accurate People data to inform decision making	
Gaps in Controls and Assurances	**Mitigating Actions**
Workforce Planning • Workforce Planning process not yet in place – currently at very early stage • Establishment control not in place and ongoing challenges in vacancy reporting	As noted in the controls the People team have recently worked alongside external consultants to undertake a project focused on the following activities: • Developing a framework to build local, operational workforce plans that minimise vacancies and optimise the skills of the existing workforce to ensure opportunities to grow our own are maximised. • Developing the design of an all-encompassing workforce planning approach. This will include establishment control and improved workforce analytics - to ensure we understand who CTM has and who it needs, to improved attraction and recruitment approaches to employ

	the best people from the widest possible pool. • This strategic lens approach will drive consideration of the shape of the workforce, seamless workforce models that are multi professional and multi-agency and consider the roles that are needed in a technology driven workplace where robotics and AI are commonplace. • Plans will now be developed~~ment~~ that that take account all of the above, alongside workforce trends and horizon scanning, to inform consideration of future models of care and an understanding of the skills and capabilities needed and education required to deliver the future health needs of the CTM population. • ~~Work is also nearing completion for our new People data dashboards – which form part of our plan to provide timely, accessible, accurate and relevant People data~~.
Recruitment	
Retention • The Health Board does not currently have a Retention and Recruitment Plan.	• Scoping of work to develop CTM approach to retention building on National Programme of work for nursing workforce being led by People and Nursing leads. • Retention Group to be established to consider all programmes of work in this area of activity. • Collaborative development of a CTM Delivery Plan ~~Strategy~~ for Allied Health Profession~~als~~ & Health Care Sciences. • ~~Retention Group established to consider all programmes of work in this area of activity.~~
Linked National Priority Measures	Current Performance - Highlights
Workforce • 23. Agency spend as a percentage of the total pay bill • 27. Percentage sickness rate of staff	The following key metrics are set out within the Workforce and Organisational Development Metrics section of the Integrated Performance Report: • The number of job plans for consultants and other senior doctors needs to be improved. • Sickness absence currently remains above target

	• Staff in post stands at 12,697~~12,548~~ with staff turnover at ~~13.22%~~(May 2023) The Health Board's integrated dashboard sets out further details in respect of workforce related performance metrics.
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4827	Lack of lead for Face Fit Training along with Face Fit Trainers	**20**
5214	Critical Care Medical Cover	**20**
4780	Patient Handling Training. Risk rated as a 16.	**20**
4106	Increasing dependency on agency staff cover impacting on continuity of care and patient safety	**16**
4157	Difficulty recruiting sufficient numbers of registered nurses and midwives	**16**
4997	Consultant Physician in Ysbyty Cwm Cynon (YCC).	**16**
5364	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage. Escalated to the Organisational Risk Register in July 2023.	**16**
4798	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. Risk reinstated in July 2023.	**16**
4650	Ensuring correct establishment for Special Care Baby Unit (SCBU). Escalated to the Organisational Risk Register in July 2023.	**15**
4500	Difficulty recruiting sufficient numbers of registered therapists and healthcare scientists	**15**
4315	Non Compliance of Fire Training – Provision	**15**
4809	Non Compliance with Mandatory Violence and Aggression Training	**15**
4080	Failure to recruit sufficient medical and dental staff	~~**20**~~ **15**

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Strategic Goal: **Creating Health**			Risk score **12**
Strategic Risk: **Community & Partner Engagement - (Risk No.5)**			
If the Health Board ***does*** not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	***Then*** we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	***Resulting in*** continuing health inequalities and poor population health outcomes, including in relation to Covid-19	

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

Risk Score Trend this Period:

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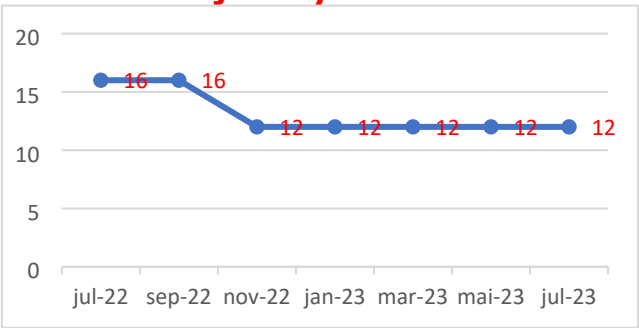
Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	This risk remains unchanged, as engagement with communities and partners is ongoing. Given our ever changing context and population needs, this risk can never be mitigated outright but remains within tolerances.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being actively managed via the comms team and wider engagement. As above, we will need to **tolerate** the fact that management of the risk will need to be ongoing.

Lead Director	Executive Director of Public Health	Assurance committee	Population Health & Partnerships

Controls	Assurances reported to Board and committees
Strategies & Plans • 2030 Strategy – 'Our Health Our Future' ~~(in development)~~ • Implementation of key actions in the Population Health Plan approved by Board in May 2021. *Framing and incorporating*	**Reports to Board** • Director of Public Health Annual Report ~~(estimated January / February 2023)~~ (June 2023) • Population Health Board Report

these actions as part of the Unified Transformation Programme – Creating Health. Completed • Public Engagement Plan for 'Our Health Our Future' • Becoming an Engaging Organisation • Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021 • Public Service Board – Well Being Plans ~~(CT and Bridgend).~~ • Integrated Level 2 and Level 3 Weight Management Services – established in September 2022. **Engagement Forums** • Regional Partnership Board • Public Service Board • Area Partnership Board • CTM2030 Leaders Groups • **Hybrid** Staff Q&A • Stakeholder Reference Group • Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well • Engagement with community groups by Lead Independent Members • Links with Community Health Council including representation on Board • Regular joint executive meetings with the three local authorities • Accelerated Cluster Development Programme Board – engagement across Primary Care • Health and Social Care Integration Board • Forum with local authority Chief Executives to address health inequalities **Needs Assessment & Consultation Processes** • Population Segmentation & Risk Stratification • Pharmaceutical Needs Assessment • Health Needs Assessments, e.g. Homeless People, Prison Health • Wellbeing Assessment (PSB) • Population Needs Assessment (Regional Partnership Board) • Formal consultation processes for service reconfiguration, e.g. vascular **Organisational Structures**	CTM Public Health Team have established baselines for high level indicators in the Population Health Plan to enable system performance accountability and measure the impact of our work which will be reported to Board through update reports. However there are further baseline measures that require engagement with Public Health Wales to develop. **Reports to Population Health & Partnerships Committee** • Covid-19 and Vaccination Programme Reports • Regional Partnership Board Annual Report • Transformation Fund and Leadership Board Updates • Population Health Management Updates • Mental Health Strategic Update **Reports to other committees** • Community Health Council briefing papers to Quality and Safety Committee

• CTM Leaders Network • Public Health Consultants allocated to support Risk Leads for each priority in the Population Health Organisation plan • Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars • ~~Public Health & Primary Care Oversight Group which is an integrated Group established to bring together Public Health and Primary Care to ensure improved coherence across Population Health Programmes / Projects.~~ • Locality Structures enabling more engagement with local communities • ~~Membership of the key partnership forums.~~ **Population Health Assessments** • Completion of the Population Needs Assessments and Wellbeing Assessments undertaken. The community have embraced the themes and CTMUHB along with key partners are taking forward activity as appropriate.	
Strategies & Plans • 2030 Strategy – 'Our Health Our Future' ~~(in development)~~ • Public Engagement Plan for 'Our Health Our Future' • Becoming an Engaging Organisation • Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021 • Public Service Board – Well Being Plans ~~(CT and Bridgend).~~ • Integrated Level 2 and Level 3 Weight Management Services – established in September 2022. **Engagement Forums** • Regional Partnership Board • Public Service Board • Area Partnership Board • CTM2030 Leaders Groups • **Hybrid** Staff Q&A • Stakeholder Reference Group • Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well	**Reports to Board** • Director of Public Health Annual Report ~~(estimated January / February 2023)~~ (June 2023) • Population Health Board Report CTM Public Health Team have established baselines for high level indicators in the Population Health Plan to enable system performance accountability and measure the impact of our work which will be reported to Board through update reports. However there are further baseline measures that require engagement with Public Health Wales to develop. **Reports to Population Health & Partnerships Committee** • Covid-19 and Vaccination Programme Reports • Regional Partnership Board Annual Report • Transformation Fund and Leadership Board Updates • Population Health Management Updates • Mental Health Strategic Update

• Engagement with community groups by Lead Independent Members • Links with Community Health Council including representation on Board • Regular joint executive meetings with the three local authorities • Accelerated Cluster Development Programme Board – engagement across Primary Care • Health and Social Care Integration Board • Forum with local authority Chief Executives to address health inequalities **Needs Assessment & Consultation Processes** • Population Segmentation & Risk Stratification • Pharmaceutical Needs Assessment • Health Needs Assessments, e.g. Homeless People, Prison Health • Wellbeing Assessment (PSB) • Population Needs Assessment (Regional Partnership Board) • Formal consultation processes for service reconfiguration, e.g. vascular **Organisational Structures** • CTM Leaders Network • Public Health Consultants allocated to support Risk Leads for each priority in the Population Health Organisation plan • Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars • ~~Public Health & Primary Care Oversight Group which is an integrated Group established to bring together Public Health and Primary Care to ensure improved coherence across Population Health Programmes / Projects.~~ • Locality Structures enabling more engagement with local communities • ~~Membership of the key partnership forums.~~ **Population Health Assessments** • Completion of the Population Needs Assessments and Wellbeing Assessments undertaken. The community have embraced the themes and CTMUHB along with key partners are taking forward activity as appropriate.	**Reports to other committees** • Community Health Council briefing papers to Quality and Safety Committee

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• Public Health & Primary Care Oversight Group which is an integrated Group established to bring together Public Health and Primary Care to ensure improved coherence across Population Health Programmes / Projects. • Locality Structures enabling more engagement with local communities • Membership of the key partnership forums. **Population Health Assessments** • Completion of the Population Needs Assessments and Wellbeing Assessments undertaken. The community have embraced the themes and CTMUHB along with key partners are taking forward activity as appropriate.	
Gaps in Controls and Assurances	Mitigating Actions
• Work to establish statistical baselines delayed / interrupted by Covid pandemic	• Further baseline work with Public Health Wales in relation to population health outcome measures. *Timeframe April 2023.*
• Limited analytical and health intelligence capacity, particularly in specialist areas such as epidemiology	• Long Term Conditions Programme established which builds on existing work in CTM to provide AHP-led pre-abilitation and rehabilitation services that 'Support People to Live Well both in relation to the effects of Covid-19 infection and other long-term conditions such as cardiac, vascular, diabetes. In progress – target timeframes as follows Q1 ongoing delivery of services & establish workforce plan for level 3 & 4 services; Q2 recruitment, planning and operationalisation of level 3 offer; Q3 training & delivery
• Long-term sustainability of resources to undertake Population Health work	• Refocus preventative early years funding from Welsh Government to tackle gaps in resource – *Completed for 2022-2023. Requires annual review.* • Activity underway to evaluate current deployment of community resources with the aim of rationalising resource to deploy the intelligence from population health management. In Progress – target timeframe 28.2.2023.

Linked National Priority Measures	Current Performance - Highlights
Population Health – Ministers Measures Phase One	Integrated Performance Dashboard: Quadruple aim 1: the percentage of adult

1. Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All Wales Weight Management Pathway 2. Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway 3. Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally. 4. Percentage of adult smokers who make a quit attempt via smoking cessation services 5. Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates	smokers who make a quit attempt via smoking cessation services. Target 5%
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	
Associated Risks on the Organisational Risk Register	

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Strategic Goal: **Improving Care**			Risk score **16**
Strategic Risk: **Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.6)**			
If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	***Then*** We will be unable to design and execute a Health Board wide strategy to transform services that are tailored to meet the needs of our people and our communities.	***Resulting in*** Continuing health inequalities and poor population health outcomes, an inability to transform our cost base and our service design, which will result in slow progress towards improving our population's and patients experiences, and continue to constrain our ability to work seamlessly across our region.	

	Consequence	Likelihood	Score
Initial	4	5	20
Current	**4**	**4**	**16**
Target	4	3	12
Risk Appetite	**Cautious** *(data and information; legal and regulatory)*		

Risk Score Trend this Period:

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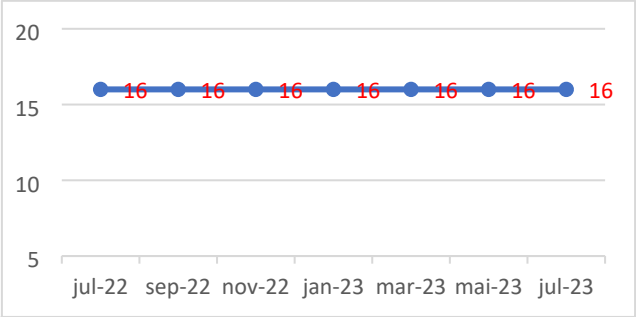
Risk Score Trajectory



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

The Digital & Data function are continuing activity to form their digital Journey, including alignment and standardisation of business practices for business as usual activity and working towards digital transformation.

On the basis of this ongoing activity the risk score has been reviewed and the assessment is that it remains unchanged from a score of 16.

Additional rationale for the risk score not changing is that the Health Board remains insignificant digital debt whereby there is a need to replace in excess of 3,500 devices.

	There is a significant amount of activity underway in relation to digital literacy both for staff and the population.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	As at July 2023, it is considered that the Health Board is continuing to 'Treat' this risk as it has a number of actions it is taking ward to mitigate this risk.

Risk Lead	Director of Digital	Assurance committee	Digital & Data
Controls		**Assurances reported to Board and committees**	
• Digital & Data Strategy • Population Health Strategy • Digital & Data Delivery Programme • IT Infrastructure Review • Digital Delivery Board • Digital Investment Fund • Information Security, Records Management and Information Governance Policies and Improvement Programmes • Project Portfolio Board		**Reports to Digital and Data Committee** • All-Wales Information Governance Toolkit and ICO Audit Review. • NIS-D Cyber Assessment Framework and Improvement Plan (CRU). • Digital Programme Assurance Report • Internal Audit Reports • Coding Improvement Plan • Bridgend Aggregation Programme • Medical Records Assurance Report **Reports to other committees** • Progress updates against Population Health Strategy • Planning, Performance & Finance	
Gaps in Controls and Assurances		**Mitigating Actions**	
• Closing the gap in Digital Helplessness		• Investment required in training resources to embrace and use existing technology, digital tools and basic troubleshooting. Publicise and expand the use of digital material already available. Included within the IMTP Proposal – funding to be determined Timeframe: 2-3 year programme of work.	
• Training and Awareness Programme		• Resources required to prioritise the development of a training and awareness programme. Included within the IMTP and identified as a requirement within the functional proposal for Digital & Data Timeframe: 2-3 year programme of work.	
• Maintaining a healthy cyber posture		• Delivery of the cyber improvement plan (business sensitive) Timeframe: This action will not have a specific timeframe as will be a continuing activity without an endpoint.	

• Tested and integrated cyber incident management plan	• Continued ~~development~~ testing of our cyber incident plan with periodic table-top exercises. Working in conjunction with the Health Board emergency planning lead to ensure greater understanding of risk to service delivery (from a service perspective) and with external service providers most notably SBHB, DHCW and the private sector Timeframe: This action will not have a specific timeframe as this activity will be subject to undergoing periodic testing and iteration of the management plan.
• ~~Incomplete asset register~~ Develop a baseline Asset Register	• Working ongoing to develop our asset register and product catalogue as part of NIS-D and data protection improvement plans. Additional resourcing is required to continue to monitor and deliver this activity Timeframe: 31.3.2024 - Additional resources are being added to the team this year with a view to getting a complete baseline.
• Poor adherence to policies	• Recognised requirement for policies to balance enablement with protection. National discussions ongoing as to whether national policies should be 80:20 based, so that local circumstance can be incorporated within policies, improving adherence. This needs to be undertaken alongside increased training and awareness of policies as part of the OCP process. Timeframe: It is anticipated that this activity will take 24 months to complete recognising the need to ensure it is managed through the new Care Group Structure.
• Insufficient capital and revenue resource allocation and the capacity of the skilled workforce – exacerbated by the short-term nature of funding and seldom meets post implementation requirements.	• Prioritise existing resources and available funding to meet the highest risk areas. We have allocated additional revenue resources this year and a recruitment plan is forming Timeframe: No timeframe set as this action is dependent on external parties. There remains a gap in Capital revenue which is a continuing National challenge that organisations are facing.

• Integration of information systems for services in the Bridgend area transferred from Swansea Bay University Health Board	• Programme agreed with WG, DHCW and SB and year 1 delivery exceeded milestones. Year 2 ongoing however constraints exist most notably with regards to availability of capital funding. • Timeframe: 2-3 year programme of work.
• Lack of an open architecture	• Work with WG, Health Board partners and national services to develop existing commitments for delivery of an open architecture for NHS Wales • Ongoing development of UHB's own clinical data repository to nationally agreed technical and data standards • Increasing representation for National Data Resource programme to accelerate benefits realisation Timeframe: It is not possible to set a specific timeframe as this is dependent upon National Strategic Direction.
• Widespread non-adherence to data standards	• New clinical applications now required to meet data standards • Education and Training required for staff to develop their data literacy • Seeking further assurances from DHCW for roadmap that will see their products come into compliance with standards. Timeframe: It is not possible to set a specific timeframe as this is dependent upon National Strategic Direction.
• Critical supplier(s) unable to respond to the UHB's requirements and ministerial priorities within defined timescales	• Need to develop a more robust SLA and contract monitoring process for critical suppliers Timeframes – 1 Year. The Health Board is in a planned programme of work with the relevant critical suppliers to ensure delivery against key objectives in year 1)
• Capacity within current team to deliver digital transformation agenda	• Work with other NHS Wales partners, industry, academia and third sector organisations to improve our current digital competencies across the Health Board and our communities • Adoption of self service for basic Business Intelligence • Recruitment to vacant posts. • Resources required for UHB to have the skills and expertise to use data and digital tools effectively- capacity and capability

	gaps exists when compared to other HBs and DHCW Timeframe: 31.3.2024 - Additional resources are being added to the team this year with a view to getting a complete baseline.
• Delayed delivery of the digital patient notes programme	• Increased activity by outsourcing day forward scanning • Timeframe: 2-3 year programme of work.
• Resourcing of Information Governance function within the Health Board	• Funding will be allocated to IG for 2023/2024 • Additional resources being added to the IG Team, Head of IG appointment successful.
• No function within the UHB focussing on benefits realisation	• This function is identified within the Digital Transformation function which will be developed during 2023/2024
• Limited progress to reduce/remove paper processes and move to a fully integrated digital patient record	• EPR programme continues to deliver, for e.g., Nursing and inpatient documentation increasingly being digitalised. • Scoping of a business case to implement a digitally enabled patient centred contact and additional funding allocated to resource increased outsource activity for the digital patient notes programme • Timeframe: 2-3 year programme of work.
• Recruitment challenges due to short term funding allocations leading to an increased use of contracting arrangements.	• Work completed to understand substantive baseline. Need to prioritise recruitment of new roles aligned to Health Board Annual Plan Timeframe: Additional resources are being added to the team this year however recurrent funding is still a challenge for some of the National Programmes.
• Information Commissioner Office (ICO) Audit planned to be completed March 2023.	• Challenges in completion of ICO Action Plan due to capacity within the existing IG function. Plans being developed to recruit a Head of IG and new supporting posts Timeframe: Head of IG recruited June 2023 – this will be a priority with completion expected March 2024)

Linked National Priority Measures	Current Performance - Highlights
Digital and Technology National Clinical Framework (WHC 2021/03) Welsh Government, March 2021), Quality and Safety Framework: Learning and Improving (WHC 2021/022 September 2021) Value Based Health and Care Coding standards	• Deployment of Electronic Whiteboards and Electronic Transfer of Care Forms across the whole of CTMUHB with effect from end of March 2023. • Rolled-out Medical Transcription Electronic Discharge and Admissions, Discharges and Transfers in Princess of Wales Hospital as part of the WPAS transition activity and system consolidation. • Majority of agreed digital programmes have delivered (coding, nursing record) or are delivering to timescales however the Emergency Department system implementation is delayed due to funding and capacity constraints. • In terms of 'Open Eyes' CTMUHB is planning to deploy for Glaucoma by 31st March 2023. Further roll-out is subject to funding. • Access to digital funding streams is under review due to proposed decreases in the national digital prioritisation funds • Short term nature of funding constrains the recruitment and ability to implement national projects • IG and Cyber programmes are structured but constrained by resources • Progress continues on infrastructure enhancements across CTM sites • There are continued gaps in analytical capacity to meet the demands of the service which therefore impacts upon service improvement initiatives • Prioritisation of key digital initiatives to be considered as part of the IMTP cycle. • Programme to share data across primary and secondary care on hold due to adverse resource allocation choices. • Delayed implementation of national critical care system

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

During the period there have been 3 critical incidents. The critical incidents are outlined below:

- April 2023 — Major loss of PSBA (Digital Wide area network) across Wales
- March 2023 — Significant data quality issues in the All-Wales Electronic Master Patient Index – which ensures the records are attributed to the correct individual
- February 2023 — External Cyber incident (Other NHS Wales Organisation)

Strategic risk assessment	Holding information securely and confidentially	Effective governance, leadership and accountability	Obtaining information fairly and efficiently	Recording information accurately and reliably	Using information effectively and ethically	Sharing information appropriately and lawfully
Impact	5	4	4	3	3	3
Likelihood	4	2	2	4	4	5
Risk	**20**	**8**	**8**	**12**	**12**	**15**

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
5276	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025.	**20**
4664	Ransomware attack resulting in loss of critical services and possible extortion	**20**
4337	Integrated Patient Records across the Health Board	**16**
4671	NHS Computer Network Infrastructure unable to meet demand	**16**
5431	Dual Deployment at CTM of both RISP and LINC Programmes Systems – New risk escalated to the Organisational Risk Register in May 2023.	**16**
3337	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**15**
4672	Absence of coded structured data & inability to improve our delivery of the national clinical coding targets and standards	**15**
5040	Digital Healthcare Wales (DHCW interdependencies	**15**
4699	Failure to deliver a robust and sustainable Information Governance Function	**15**
4887	Retrieval and filing of case notes in the POW Medical Records Library	**15**
~~4772~~	~~Replacement of press software on the 13 & 10 stage CBW presses~~ Risk de-escalated from the Organisational Risk Register in July 2023 as risk score reduced from a 15 to a 12.	~~**15**~~

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Strategic Goal: **Inspiring People**			Risk score **12**
Strategic Risk: **Leadership and Management – (Risk No.7)**			
If we fail to provide compassionate and effective leadership at all levels of the organisation and all professions to empower and enable our workforce	***Then*** there will be lack of confidence to enable informed decision-making at the appropriate level and to implement organisational change	***Resulting in*** lack of commitment and engagement, poor communication, deterioration of staff wellbeing, and difficulty in recruiting and retaining the staff we need	

	Consequence	Likelihood	Score
Initial	4	4	16
Current	**4**	**3**	**12**
Target	4	2	8
Risk Appetite	**Cautious** *(assets; trust and confidence)*		

Risk Score Trend this Period:

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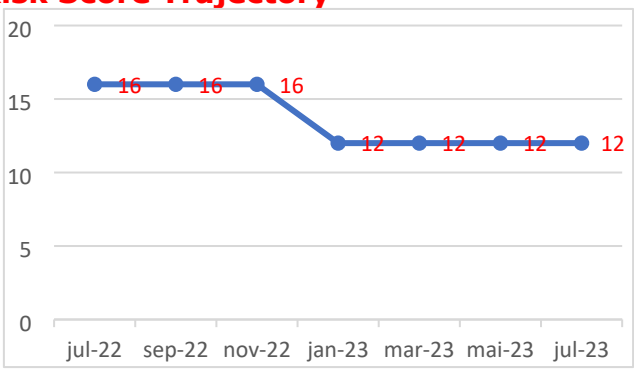
Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	CTM's bespoke leadership and management development programmes were designed in direct response to Targeted Intervention. The risk score was reduced in January 2023 reflecting the leadership development opportunities that are offered across the Health Board. Although the Leadership & Management Programmes provide the foundations, the wider offer within the Health Board is still in development. Further work is now required to embed the offerings and further enhance leadership capacity and capability.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	The risk will continue to be treated, as the Health Board strives to set the underpinning principles, initiatives and frameworks that shape and inform leadership at CTM.

Risk Lead	Executive Director for People	Assurance committee	People and Culture

Controls	Assurances reported to Board and committees
Leadership Development • Board Development Programme – A session has been completed with Board exploring CTM leadership and similar sessions held with Senior Care Group Leads and Assistant & Deputy Directors in February 2023. • Comprehensive leadership development programmes. • In-house Leadership Development Programme (Senior Leaders / Developing Leaders / Management Essentials) • Learning partnerships with HEIW, The Kings Fund and Academi Wales • HEIW Compassionate Leadership Programme • Establishment of Leadership Coaching & Mentoring Network • Re-launch of Leadership 360 Degree Feedback. • Launch of Leadership Community of Practice and associated Leadership Summit (Conference) • Leadership and Culture Workshops for executives and senior leadership teams • Specific & targeted leadership development work within specific services, e.g. Maternity • Launch of Leadership Competency framework. • Training development between DoTHS and University of South Wales to deliver identified leadership priorities for AHP & HCS leads **Leadership Engagement with the workforce** • Leadership Forum • Local Partnership Forum • Clinical Advisory Group • Q&A with the Chief Executive via MS Teams **Employee Wellbeing** • Employee Experience Programme • Occupational Health Services • Employee Assistance Programme • Wellbeing Conversations • Money and Pensions Service •	**Internal Assurances** • Inspiring People Board took place on Monday 17 April 2023. • Workforce and Organisational Development metrics report • Employee Relations Update • Medical Workforce and Efficiency Report • Statutory and Mandatory Training Compliance Report • Targeted intervention process – continuous improvement self-assessment reports (incorporates leadership and culture) • PULSE surveys themed around particular topics (ad hoc) • Post-implementation evaluation report completed and Leadership Programmes relaunched in October 2022 • Performance Development Review (PDR) processes evaluated quarterly. Bilingual. training package launched October 2022 • Living Wage Employer Status – achieved in February 2023. • Disability Competent Leader awarded in February 2023 for a further three years. **External Assurances** • Teaching Hospital status renewal • Corporate Health Standard Gold accreditation received in February 2023. Platinum assessment scheduled for March 2023. • National Staff Survey • Improved levels of leadership accreditation in staff gaining external qualifications (ILM/CMI).
Gaps in Controls and Assurances	**Mitigating Actions**

• Full implementation of leadership development programmes and embedding in practice	• Working with our academic partners at the University of South Wales, participants will be able to accredit their learning with the Institute of Leadership and Management (ILM) from January 2023.
• Measuring impact of Organisational Development interventions	• An initial programme evaluation report was published in September 2022; further evaluation reports will be available every quarter. The report provides quantitative and qualitative data, from registrations and completions to participant's feedback.
• Improved accessibility to leadership and management toolkits via an online repository, in partnership with HEIW.	• Whilst compassionate leadership is interwoven throughout the programme, a dedicated compassionate leadership module and associated resources will be developed which will complement the programme from January 2023. Launched in January and ongoing within programmes of activity.
Linked National Priority Measures	Current Performance - Highlights
Culture, Values and Behaviours • Percentage of staff who report that their manager takes a positive interest in their health and wellbeing • 26. Percentage compliance with all Level 1 competencies of the Core Skills and Training Framework by organisation • 27. Percentage of sickness absence rate by staff	In April 2022 CTM has self-assessed itself as **Level** 4 (maturity early results) for leadership capacity and capability development; and also for employee experience in the targeted intervention framework, having started at Level 1 (principle accepted and commitment to action) in March 2020.
Were there any significant incidents affecting this strategic Risk this period:	
None identified for inclusion in the BAF Report.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score

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Strategic Goal: **Inspiring People**			Risk score **12**
Strategic Risk: **Culture, Values and Behaviours – (Risk No.8)**			
If the Health Board fails to put the values of the organisation into practice	***Then*** we will not have a culture that embraces inclusion, openness, innovation and teamwork	***Resulting in*** poor experience for staff and patients alike, diminishing the trust and confidence of our population	

	Consequence	Likelihood	Score
Initial	4	4	16
Current	**4**	**3**	**12**
Target	4	2	8
Risk Appetite	**Cautious** *(assets; trust and confidence)*		

Risk Score Trend this Period:

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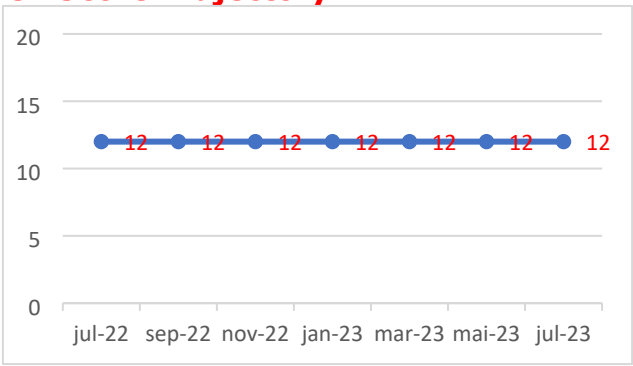
Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The score remains unchanged although progress continues to be made as the Health Board's values and behaviours become increasingly embedded.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through the expansion of programmes of work that supports culture change. This includes the consultation on our Strategic Equality Plan which underpins our strategic goals and aims to create an inclusive environment that welcomes diversity and helps us to build a workforce that better represents our communities.

Risk Lead	Executive Director for People	Assurance committee	People and Culture

Controls	Assurances reported to Board and committees
Policies and Frameworks • Workforce Policies, e.g. Respect and Resolution, Standards of Behaviour • Values and Behaviours Framework – co-produced with staff • Raising Concerns Procedure	• National Staff Survey will be run in ~~Summer~~ Autumn 2023 • PULSE surveys themed around particular topics (ad hoc) • Values and Behaviours Update • Equality Annual Report

• All-Wales work to promote speaking up, led by Executive Director for People **Communication and Engagement re: values & culture** • Values Cafes and Values Workshops • Leadership and Culture Workshops for executives and senior leadership teams • Publicity campaign around values following launch in October 2020 • Back to Behaviour Basics Training Programme • Values based induction run with nurses, healthcare support workers, graduates and junior doctors **Putting Values into Practice** • Listening, Learning and Improvement (Just and Learning) Culture programme – 28 Senior Leaders within CTMUHB received training by Merseycare and Steering Group established to embed approach. • Performance and Development Reviews • Values Based Recruitment • Suite of values-based resources and activities for managers and staff on SharePoint. • Celebrated World Values day on 20th October 2022 supporting the Values in our Community. • Cultural Competence session held on 25th November 2022 for Executive Team and teams reporting directly to them.	• Welsh Language Standards Annual Report • Living Wage Accreditation awarded in February 2023.
Gaps in Controls and Assurances	**Mitigating Actions**
• Embedding values in recruitment after successful launch and communications campaign	• Re-launched values-based recruitment pages in October 2022 to provide advice and guidance including values-based questions to support the process.
• Empowering staff to feed back on, or challenge behaviour which is inconsistent with the organisation's values	• In response to feedback regarding our leaders embodying our values a reverse mentoring programme was launched in October 2022 with senior colleagues and employees from our minority groups. Evaluated the first cohort and this is going to ELG and People and Culture Committee for feedback.
• Cultural Health Check diagnostic tool developed that measures current alignment to values based on participants' contribution to the assessment. The Health Check has been piloted	• Through our Aspire and Inspire Leadership programmes our approach to leading behaviour change through leadership is paramount and a key feature of the programmes.

successfully and is being used for subsequent OD interventions.	• National Staff Survey will be run in Summer 2023 • Award received from CIPD in March 2023 recognising CTM's values work.
• Current Strategic Equality Plan (SEP) requires review to align with the changing national context.	• Work ongoing to review the Strategic Equality Plan (SEP) to align with the changing national landscape, in particular the Anti-Racist and LGBTQ+ Wales Plan. SEP currently out for consultation. • SEP going to People and culture on 10 May 2023
Linked National Priority Measures	**Current Performance - Highlights**
Culture, Values and Behaviours • 24. Overall staff engagement score • 28. Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	In April 2022, CTM has self-assessed itself as **Level 3** (initial achievements realised) for values and behaviours; and also for inspiring shared purpose in the targeted intervention framework, having started at Level 1 (principle accepted and commitment to action) in March 2020.

Were there any significant incidents affecting this strategic Risk this period:
None identified for inclusion in the BAF Report.

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
N/A	No directly linked risks on organisational risk register	**N/A**

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Strategic Goal: **Sustaining our Future**			Risk score **16**
Strategic Risk: **Fulfilling our Environmental and Social Duties and ambitions (Risk No.9)**			
If the Health Board's decisions fail to reflect our values or consider the long-term environmental or social impact	***Then*** we will not fulfil our Socio-economic duty, our Wellbeing of Future Generations objectives and our value-based healthcare principles	***Resulting in*** negative environmental and social impacts, and loss of trust and confidence among stakeholders	

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

Risk Score Trend this Period:

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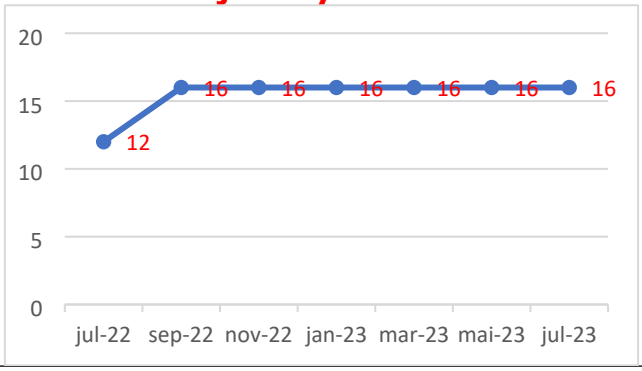
Risk Score Trajectory



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

Risk Lead	Executive Director of Strategy and Transformation	Assurance committee	Population Health and Partnerships

Controls	Assurances reported to Board and committees
Wellbeing and Socio-economic duties • Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible.	**Wellbeing and socio-economic duties** • Wellbeing Statement accompanying Annual Plan • Progress reports against the Annual Plan • Case studies of projects contributing to wellbeing and equality, e.g. Connected

• CTM becoming established as an Anchor Organisation. **Environmental Sustainability – Net Zero** • Decarbonisation Strategy • Established a CTM Environmental Sustainability Group as part of transformation agenda. • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases • Sustainable Health Care delivered a workshop to Board Members in March 2023. • Decarbonisation Action Plan in place.	Communities, Healthy Schools, Social Prescribing, Sustainable Procurement **Environmental Sustainability – Net Zero** • Environmental Sustainability Annual Report • ISO 14001 (Certified Environmental Management System) accreditation Commenced reporting to Board / committees regarding Net Zero – Timeframe: June 2022. Complete - moved to assurance. • Six-monthly reporting of the Decarbonisation Action Plan to the Board (next due in May 2023)
Gaps in Controls and Assurances	**Mitigating Actions**
• Climate Adaption Plan (moving away from mitigation)	• Climate Adaption Plan proposal being considered by the Executive Leadership Group in July 2023. • Engagement with the Public Services Board on a regional Adaption Plan.
• Dedicated resource to manage and deliver Net Zero programme across the whole Health Board.	• Ensure resourcing to manage Net Zero work programme across the Health Board, taking into account potential savings in energy costs. The delivery of the Health Board's decarbonisation plan 2030 is dependent on capital. Timeframe: Ongoing subject to capital availability.
• Enhancing Board reports regarding sustainability issues to address Net Zero 2030 goals.	• Work underway with governance team to include as part of board reporting – Timeframe Qtr 3 – 2023-2024.
• Procurement framework to reduce carbon footprint of goods and services purchased from outside the organisation.	• Procurement team part of Environmental Sustainability Group and wider decarbonisation networks. Ongoing.
• Mapping against 'More Equal Wales' guidance for Socio-economic Duty which came into effect in April 2021.	• To include as discussion point as part of Anchor Institution work moving forward, including public health involvement

• Nationally the formula to establish carbon footprint of our organisation has changed CTMUHB's baseline assessment which has placed the organisation significantly further away from its 2025 goal.	• Decarbonisation action plan to be reviewed which will consider additional actions.
• Global energy crisis will impact on service delivery for our communities and staff, this is being closely monitored as it will impact upon health and wellbeing.	• CTMUHB Financial Care Wellbeing Pathway launched to support the workforce recognising the impact of the cost of living increase impacting our workforce and population.
Linked National Priority Measures	**Current Performance - Highlights**
Economy and Environment • Emissions reported in line with the Welsh Public Sector Net Zero Carbon Reporting Approach • Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan • Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational Economy in Health and Social Services 2021-22 Programme **Wellbeing of Future Generations Act**	The Health Board is developing its approach for an annual report on performance which is anticipated for the latter part of 2022. An integrated approach across the Health Board will be adopted for reporting progress against the Environmental Sustainability Plan. Scheduled for autumn 2023.

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

Nil

Associated Risks from the Organisational Risk Register

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

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.3.1

CTM BOARD	
HIGHLIGHT REPORT FROM THE CLINICAL ADVISORY GROUP	
DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Dr Sally Bolt, Care Group Medical Director Diagnostics, Therapies, Pharmacy and Specialties/Clinical Advisory Group Chair
PRESENTED BY	Dr Sally Bolt, Care Group Medical Director Diagnostics, Therapies, Pharmacy and Specialties/Clinical Advisory Group Chair
EXECUTIVE SPONSOR APPROVED	Dr Dom Hurford, Executive Medical Director

REPORT PURPOSE	FOR NOTING

ACRONYMS	
CAG	Clinical Advisory Group
CNS	Clinical Nurse Specialist

1. PURPOSE

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Clinical Advisory Group (CAG) at its meetings on 8 June 2023 and 7 July 2023.

1.2 Key highlights from the meetings are reported in section 2.

1.3 The Board is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There is significant concern across the organisation about the delay in implementation of phase 2 of the Care Group structure. There is a lack of clarity on escalation pathways, and in which Care Group some specialties will sit.
ADVISE	Many new posts are funded externally on a short term basis. Business cases to have more detail on how posts will be funded following this term. This will be fed back at Operational Management Board. Concern for wellbeing of staff across the organisation due to staff shortages and low morale. There is a keenness to allow staff time to access the wellbeing services, but can be difficult. CNS palliative care service withdrawn for 3-month period from Princess of Wales Hospital due to understaffing in order to concentrate on patients in community. Face to face service reducing to 6 days a week, but telephone advice remains 24/7.
ASSURE	There is an appreciation of the greater emphasis being placed on the review of the risk register. This shows the risks are being regularly revisited and mitigated for, if they cannot be eliminated. The members have been signposted where they can receive additional training on the risk register, and the DATIX system. Similarly, the members have asked for advice on how to formulate a patient story to demonstrate good news and positive feedback to help staff morale. This will be fed back at the next meeting.
INFORM	Good work done in pharmacy around wellness, and Joy at Work sessions. Restructuring of Pharmacy is improving morale and improving governance and parity of service across the Health Board. There will be inclusion of a positive patient story or service development in future Clinical Advisory Group meetings in order to disseminate good news to colleagues.
APPENDICES	**NOT APPLICABLE**

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM 6.3.2

CTM BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE DIGITAL & DATA COMMITTEE

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Ian Wells, Digital & Data Committee Chair / Independent Member
EXECUTIVE SPONSOR APPROVED	Stuart Morris, Director of Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
ICO	Information Commissioners Office
IMTP	Integrated Medium-Term Plan

1. PURPOSE

1.1 This report provides the Board with details of the key issues considered at the meeting of the Digital & Data Committee which took place on the 12 June 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the report.

2. PURPOSE OF THE DIGITAL & DATA COMMITTEE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information & Data, to support health improvement and the provision of high quality healthcare.

2.2 The Committee will seek assurance on behalf of the Board in relation to the Health Board's arrangements for appropriate and effective management and protection of information (including patient and personal information) in line with legislative and regulatory responsibilities.

2.3 The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the Digital and Data Strategies to drive continuous improvement and support digitally enabled health care to achieve the objectives of the Health Board's Integrated Medium Term Plan (IMTP).

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• **Positive Escalation** – The Committee received a presentation and demonstration on the **Digital Services for Patients and the Public Programme, NHS Wales APP.** The Committee felt that this was an innovative initiative for patients that should be highlighted to the Board for consideration of a demonstration at a future Board Development Session. • The Committee expressed concern regarding the recurring risk in relation to **insufficient capacity, skills and resources** within the Digital and Data function to deliver against the Digital and Data Work Programme, which was highlighted in a number of the reports presented. Particular attention was drawn to this risk when the Committee considered the impact of being able to progress the recommendations at the pace required as identified in the Information Commissioners Office Action Plan and the impact that may have on the next ICO review in July 2023.
ADVISE	• The Committee **received** a report on the **Information Commissioners Office (ICO) Audit Action Plan Progress.** The Committee **noted** the limited progress made in delivering the data protection improvement programme and the continuing focus of the Information Governance resource on

	cyber security and new data sharing arrangements. The Committee were advised that the limited resource and capacity within the IG team was likely to result in stronger directives following the next ICO review in July 2023. • **The Information Governance Group Highlight Report** was received by the Committee. The Committee **noted with concern** that there was insufficient resource to comply with data protection legislation and this was duly recorded on the Organisational risk register and was noted to be as a result of key staff departures. The Committee were advised that it was hoped that a new Head of Information Governance would be appointed shortly which should help to alleviate some of the capacity issues and thanks were extended to Members of the team for continuing with 'business as usual' despite challenging circumstances. • A presentation was **received** and **noted** by the Committee on the **Digital Annual Plan.**
ASSURE	• The **Organisational Risk Register** was reviewed. The Committee also received a report on all **Digital Risks** and **noted** the actions being taken to mitigate them. • The **Medical Records Assurance Report** was received by the Committee. The Committee noted the current progress and challenges regarding the Digitisation of the Patient Notes Project. • The Committee **received** an **Internal Audit Follow Up Report** on the **Bridgend Transfer of Informatics Service.** The Committee **noted** that the report was providing a 'reasonable assurance' rating. • The Committee **received** a report on **Digital and Data Assurance.** The Committee **noted** the system and infrastructure projects completed this year and the current position with capital and revenue funding in relation to the digital and data programme and the increase of national systems without local business cases and associated funding.

	• The **"In Committee"** meeting of the Digital and Data Committee received robust updates on the following areas of activity: ○ Cyber Improvement Programme ○ Digital Critical Incidents ○ Organisational Risk Register Risks 4664 & 4671 (Commercially sensitive risks).
INFORM	• The **Committee Annual Report for 2022-23** was approved. • The **All-Wales Independent Member Digital Network Highlight Report** was noted.
APPENDICES	**NOT APPLICABLE**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.3.3

CTM BOARD	
HIGHLIGHT REPORT FROM THE QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Vice Chair and Chair of the Quality & Safety Committee
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on the 24 May 2023.

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

2. PURPOSE OF THE QUALITY & SAFETY COMMITTEE

2.1 The purpose of the Quality and Safety Committee is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	• **Positive escalation** - The Committee Chair extended her congratulations to the Senior Nurse from the Specialist Immunisation Service who had been awarded a Lifetime Achievement award for a range of vaccination related initiatives.
ADVISE	• A **Care Group Spotlight Presentation – Planned Care** which focused on Cancer Services was received by the Committee**.** Members noted that whilst the Health Board did not have any Cancer Wards situated within its Hospitals, patients receiving cancer treatment were being appropriately cared for by the relevant specialty area on general and medical admission wards. Assurance was provided to Committee Members that no cancer patients requiring surgery had been cancelled as a result of unavailability of beds; • A **Care Group Spotlight Presentation – Primary & Community Care** was received. Members noted the work being undertaken in relation to student nurse placements within Community settings, retention of staff and overseas nursing recruitment. • The **Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** was received. Members noted that detailed discussion had been held at the Operational Management Board in relation to risk scoring and moderation and that Care Groups are undertaking a review of their Care Group risks at pace. • The **Maternity Services & Neonates Improvement Programme** report was received. Members noted that there had been an increase in MRSA colonisation of babies within the Special Care Baby Unit at the Princess of Wales Hospital. Members noted that there had been sporadic cases between November 2022 and February 2023, with a further cluster being seen in April 2023 and noted that the last colonisation was on the 20 April, with no further cases since and no babies coming to any harm. Members noted that work was being undertaken by the Estates Team to

ensure surfaces were in line with Infection, Prevention and Control recommendations;

- The **Mental Health In-Patient Improvement Progress Report** was received. Members noted the team were still experiencing issues in relation to compliance with Statutory and Mandatory training. Members noted that trajectories were in place to address the position and noted that balance would be required given the scale of improvement required and the ability to release staff to attend training;
- The **Quality Dashboard** report was received. A number of points of clarification were made by Members in relation to report content which would be responded to outside the meeting. Members noted that in relation to the Duty of Candour, a significant amount of work needed to be undertaken to ensure staff were categorising incidents correctly and noted that future iterations of the Quality Dashboard report would include an update on Duty of Candour triggers;
- The Committee received a **Spotlight Presentation from the Emergency Department – A Review of Falls and Pressure Ulcers.** The Director of Nursing advised he remained concerned in relation to over-crowding within the Emergency Departments and lapses in care;
- The **Care Group Highlight Report for Planned Care** was received. Members noted that the AMaT system was now being used within Care Groups and by Heads of Nursing as part of the triangulation process and noted that there were still some areas that did not have access to the AMaT system and were completing audits on a paper based system, which would need to be addressed moving forwards;
- Care Group Highlight Reports for Mental Health & Learning Disabilities, Children & Families and Diagnostics, Therapies, Pharmacy and Specialties were received and noted;
- The report from the **Chief Operating Officer** was received. Members noted there had been reduced capacity within Sonography as a result of colleagues being unable to scan as a result of Repetitive Strain Injury and noted that this was being addressed by the Diagnostics, Therapies, Pharmacy and Specialties Care Group and was linked to obstetric ultrasound and the volume of scans being undertaken;

At the **In Committee** Quality & Safety Committee held on 31 May 2023, the Committee received reports on the following matters:

- External Review of Practice into Care of a Patient by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf County Borough Council;
- Controlled Drugs Local Intelligence Network (CDLIN) Annual Report: April 2022 – March 2023.

ASSURE	• Members received and welcomed a **Listening & Learning Story** which related to a mum's journey, following the birth of her baby who was very unwell and had to be transferred to the University Hospital of Wales (UHW) and then back to Prince Charles Hospital (PCH) for after care. • The Committee received a report on the **Healthcare Inspectorate Wales Action Plan Tracker – Prototype.** Members noted that AMaT would be used moving forwards to help track overdue recommendations and noted that three monthly updates would be submitted to Healthcare Inspectorate Wales in relation to progress being made against outstanding actions; • The Committee received a report capturing feedback from the **Executive Director and Independent Member Quality Patient Safety Walkrounds January – April 2023;** • The **Learning From Events Backlog – Progress Report** was received. Members noted that there were 17 cases which had been deferred for 10 months and focus was being placed to target these to stop them breaching the 12 month deadline; • Members received the **Ty Llidiard Tier 4 CAMHS Inpatient Unit** report. Members welcomed the improvement work that had been undertaken, the work undertaken on the importance of saying 'thank you' and the work undertaken to improve the environment; • The Committee received an update on **Lessons Learnt – Learning and Actions following a death in Maesteg Hospital.** Members noted the presentation provided some assurance around the outputs from the care issues that had been identified as a result of the incident and the work that had been undertaken to date; • The **Care Group Highlight Report for Unscheduled Care** was received. Members welcomed the news that 72 out of the 74 actions that had been identified following the Healthcare Inspectorate Wales inspection of the Emergency Department at Prince Charles Hospital in October 2021, had now been completed; • Members received the **CTM Allied Health Professionals & Healthcare Science Delivery Plan.** The Committee endorsed the focus of the plan.
INFORM	The following items were received via the consent agenda for approval/noting: • Minutes of the meetings held on 16 March and 27 March 2023; • Quality & Safety Committee Annual Report • Chairs Urgent Action – Policy Approvals • Ratification of Urgent Committee Chairs Action – Policy Approval • All Wales Model Policy for Consent to Examination for Treatment • Policy for the provision of Intraoperative Cell Salvage

	• Committee Action Log • Annual Cycle of Business • Quality & Safety Committee Forward Work Programme • Human Tissues Act Progress Report • WHSSC Quality & Patient Safety Committee Chairs Report • Infection, Prevention & Control Year End Update • Quality Governance – Regulatory Review Recommendations & Progress Updates • Cancer Services Annual Report • RADAR Committee Highlight Report
APPENDICES	**NOT APPLICABLE**

4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 6.3.4

CTM BOARD

HIGHLIGHT REPORT – PLANNING, PERFORMANCE & FINANCE COMMITTEE

DATE OF MEETING	27/07/2023

/

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Mel Jehu, Independent Member (Committee Chair)
EXECUTIVE SPONSOR APPROVED	Executive Director of Strategy and Transformation, Chief Operating Officer, Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
IMTP	Integrated Medium Term Plan
ILG	Integrated Locality Groups
PPF	Planning, Performance & Finance

1. INTRODUCTION

1.1 This paper had been prepared to provide the Board with details of the key issues considered by the Planning, Performance & Finance Committee which took place on 27th June 2023.

1.2 Key highlights from the meeting are contained in section 2.

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

2. PURPOSE OF THE PLANNING, PERFORMANCE & FINANCE COMMITTEE

The Committee will allow appropriate scrutiny and review to a level of depth and detail not possible in Board meetings in respect of planning, performance and finance. The Committee will ensure that evidence based and timely interventions are implemented to drive forward improved performance thereby allowing the Health Board to achieve the requirements and standards determined for the NHS in Wales, and as outlined within the Board's 3 Year Integrated Medium Term Plan.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• **Positive Escalation -** The Committee **received** a report on the **Reinforced Autoclaved Aerated Concrete (RAAC) Survey and Inspection**. The Committee were pleased to **note** that: - Specialist structural engineers had completed appraisals of all properties and/or extensions constructed within the period 1960-1995 for buildings owned by CTMUHB and buildings where CTMUHB hold the head lease - These appraisals have concluded that there is no evidence of RAAC planks in any of the properties inspected. • The **Month 2 Finance report** was **received**. Members **noted** that at M12 the Health Board were reporting the following: - The M2 in month position reported a £6.8m deficit (M1: £6.6m). - The M2 Year-To-Date (YTD) position was reporting a £13.4m deficit against the Revenue Resource Limit. This represented a £0.1m adverse variance compared to 2/12th of the forecast £79.6m deficit in the financial plan (£13.3m). - The M2 YTD Core plan position was a deficit of £11.9m. - The M2 YTD Exceptional energy cost pressure was £1.5m, and remains in line with the plan. - The M2 YTD COVID costs was £1.1m with anticipated Welsh Government funding of £1.1m to match.
ADVISE	• The Committee **received** the **Organisational Risk Register** and reviewed the Planning, Performance & Finance risks, **noting** the updates in terms of the mitigating action identified within the report. • The Committee **received** and **noted** the **Month 2 Financial Performance** of the individual Care Groups and Directorates. • A report was **received** on the **Month 12 Movements from Forecast.** The Committee **noted** the summary of the movements in the Month 12 delegated position.

	• A detailed review of the **Integrated Performance Dashboard** was undertaken with particular focus and scrutiny in the following areas:
	  ○ Stoke Performance
	  ○ Ambulance Response Times and Red Releases
	  ○ Follow Up Patients Not Booked
	  ○ Ophthalmology
	
	• A report was **received** on the **Six Goals for Urgent and Emergency Care**. The Committee **noted** the update on the progress of work and work streams for the Six Goals.
	
	• A report was **received** at the 'private' In Committee meeting on the **Implementation of Robotic Surgery within CTMUHB.** The Committee **noted** and **supported** the approach with regard to the financial aspect and **Endorsed for Board Approval** the Business Case.

ASSURANCE	• **The Ophthalmology Strategy & Cataracts Business Case** was **received** by the Committee. The Committee were advised that although it was originally anticipated that the Health Board would be in a position to finalise the plans associated with commencing this regional service there were still governance and financial considerations ongoing which has altered the position. The Committee **noted** the update and supported the need for any further 'Urgent Chairs Action', subject to allowing sufficient consideration time of any documentation.
INFORM	• The Committee received for information the **Monthly Monitoring Returns to Welsh Government for Months 12, 1 and 2.** • The **Committee Annual Report for 2022-23** was **endorsed** for Board Approval. • A report was received on **Mental Health 2023-24 Service Improvement Funding & Update on 2022-23**. The Committee noted the additional mental health funding allocation and approach by the Mental Health and Learning Disabilities Care Group.
APPENDICES	**NOT APPLICABLE**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
6.3.5

CTM BOARD	
HIGHLIGHT REPORT FROM THE AUDIT AND RISK COMMITTEE	
DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Patsy Roseblade, Independent Member and Chair of the Audit & Risk Committee
EXECUTIVE SPONSOR APPROVED	Sally May, Executive Director of Finance

REPORT PURPOSE	NOTING

ACRONYMS	
IPFR	Individual Patient Fund Request

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Audit & Risk Committee at its meeting on the 21 June 2023.

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

2. PURPOSE OF THE AUDIT & RISK COMMITTEE

2.1 The Committee will function in accordance with the NHS Audit Committee Handbook as appropriate.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services

Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	• Item for Positive Escalation – **In relation to Ambulance Handover Performance**, the effort being made by CTMUHB Health Board to improve the position had been recognized and congratulations were extended to all staff concerned for this achievement. Members noted that whilst improvement had been achieved there was still a further way to go to meet the required turnaround time for all ambulances.
ADVISE	• Members received the **WHSSC Corporate Risk Assurance Framework (CRAF) including the Risk Register**. Members noted that in relation to the risk regarding IPFR, the Terms of Reference for the All Wales IPFR Panel were agreed in March 2023, and reports on the IPFR Policy and Governance Processes would be considered by the Joint Committee in July prior to sharing with Health Board's for approval. It was hoped that the All Wales IPFR panel would be operational in September and Members noted that once approved steps would be taken to recruit a panel Chair. • The **WHSSC Audit Recommendations Tracker** was received. Members noted that two Internal Audit recommendations relating to Risk Management remained open which were due for completion in July; • The **Emergency Ambulance Services Committee (EASC) Update** was received. Members noted that early indications showed that ambulance handover performance had improved during April – June following the decrease in performance seen in March 2023 and noted that the funding received from Welsh Government in relation to resourcing was having a positive impact.
ASSURE	There were no matters raised on this occasion.

INFORM	• The Unconfirmed Minutes of the Meeting held on the 19 April 2023 were received and APPROVED; • The **Audit & Risk Committee Hosted Bodies Action Log** was received and noted.
APPENDICES	**NOT APPLICABLE**

4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
7.1

CTM BOARD

CTM 2030 – OUR HEALTH, OUR FUTURE

Date of meeting	27/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Vicki Wallace, Deputy Director of Strategy and Partnerships
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR DISCUSSION / REVIEW

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

ACRONYMS	
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
RGH	Royal Glamorgan Hospital
WISE	Wellness Improvement Service

1. SITUATION/BACKGROUND

1.1 CTM 2030: Our Health, Our Future was launched in 2021. Since that date, work has been underway to further understand our population health needs and engage with our communities and our staff, to better articulate what this will mean for the population of CTM.

1.2 There are three key strategic themes to CTM2030:
- Developing resilient communities
- Integrated community services
- Clinical services plan

1.3 These strands are underpinned by quality, governance, digital, public health, finance, workforce, communication and engagement and value based healthcare plans.

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

2.1 There are key developments taking place under each of our strategic themes. The developments around our clinical services plan are covered under Agenda item 7.3 in a separate paper to this Board.

2.2 The work around developing resilient communities is being progressed under what was previously the Anchor Institution Steering Group. This group has now been refocused to ensure all elements supporting the development of resilient communities are seen in one place. Key achievements in this space include:

- the appointment of the first Housing, Health and Innovation Programme Manager in Wales. This role will drive forward initiatives to support innovation between the health and housing arena, including the establishment of an employment pathway between residents of social housing and CTMUHB.
- the completion of the work undertaken by the Green Scholars, which highlighted reductions in CO2 and financial savings. Work is underway to understand how the benefit of this work can continue to be realised following the end of the scheme. For example, the cardboard recycling project is being extended to a 6 months project at RGH.
- the development of an Active Travel Charter.
- the continuation of Apprenticeships and Project Search within CTMUHB.

- CTMUHB working in partnership with Food and Drink Wales (Welsh Government) to support local businesses to tender for contracts.

2.3 Work around integrating community services is also continuing at pace. This includes:

- The extension of the WISE service.
- Commencement of the Community Health Pathways project, which will improve the referral process between primary and secondary care.
- The development of the optimum integrated community model which will enact what is set out in Welsh Governments "Further, Faster" initiative.
- Developing a regional approach to neurodevelopmental services to ensure a focus on equity of service, reductions in waiting lists and pre and post diagnosis support.
- Launching a review of dementia services and pathway to ensure our services are fit for purpose, provide an equity of outcome and will meet the changing and growing needs of our population.

2.2 Next steps involve the development of a "brochure" which will set out a high level presentation of CTM 2030 and its intentions.

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

3.1 None identified.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Effective Care
	If more than one Healthcare Standard applies please list below: Staff and Resources Staying Healthy Safe Care Individual Care Timely Care Dignified Care

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	An EIA will be undertaken for each section/element of CTM 2030
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There will be resource implications to the delivery of CTM 2030. Each element of CTM 2030 will have a resource plan to ensure realistic delivery and sustainability.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **note** the update set out within this paper.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
7.2

CTM BOARD

CTM 2030 – CLINICAL SERVICES PLAN

Date of meeting	27/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Vicki Wallace, Deputy Director of Strategy and Partnerships
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Board development session	22/06/2023	SUPPORTED
Executive Leadership Group	10/07/2023	SUPPORTED

ACRONYMS	
CSP	Clinical Services Plan
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group

1. SITUATION/BACKGROUND

1.1 CTM 2030: Our Health, Our Future was launched in 2021. Since that date, work has been underway to further understand our population health needs and engage with our communities and our staff, to better articulate what this will mean for the population of CTM.

1.2 There are three key strategic themes to CTM2030:
- Developing resilient communities
- Integrated community services
- Clinical services plan

1.3 These strands are underpinned by quality, governance, digital, public health, finance, workforce, communication and engagement and value based healthcare plans.

1.4 This report specifically refers to the development of the CSP.

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

2.1 It is acknowledged that the development and delivery of the CSP involves major transformational change and will take several years to complete. It is therefore important to ensure the foundations of this work are sound, as this work will continue to build over the next few years.

2.2 The high level timeline for this work can be seen in the presentation set out in Appendix A. It is important to note that the CSP will be delivered in a phased approach, with short term changes being made to ensure service sustainability, and medium to longer term changes being planned and delivered as the options are scoped and agreed. Immediate service changes may not always be in line with the CSP due to urgent service sustainability issues but will be considered as part of the development of the CSP.

2.3 Engagement at all levels is going to be critical to the development and delivery of the CSP. This includes staff, politicians, the public and our wider partners, including the local authority and third sector partners. CTMUHB will work with the Consultation Institute to ensure appropriate engagement and consultation is taken forward, as we want our population, staff and partners to be confident in our processes, detail and delivery of the CSP.

2.4 As the CSP is a long term strategic plan, it must be underpinned by a clear and defining set of principles. These principles will be referred

to as each decision relating to the CSP is made. It is therefore critical that the CTM Board agree with the principles. Through workshop engagement with leadership teams from the care groups, strategy teams and corporate staff, a draft set of principles has been developed. These were also passed by ELG for comment. These draft principles are set out in Appendix A for discussion and approval.

2.5 At the Board development session in June, it was highlighted that a vision for the CSP was an important element that was currently lacking. Therefore, a draft vision statement is included in Appendix A for discussion and approval.

2.6 Next steps for the development of the CSP include:

- Establishing the governance arrangements;
- Establishing a clear case for change document;
- Producing a live process document, which will detail the short, medium and long term actions. This will include the activity needed to work up the high level options;
- Delivery of an "interoperability project". This will set out which services have to be co-located and will inform the high level options;
- Development of standardised questions for each speciality to work through. This will inform activity, workforce, interoperability and technology plans and will feed into the development of the high level options.

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

3.1 There is a key risk around how the development and delivery of the CSP is articulated to staff, the public and our partners. Experience has highlighted that plans have to be evidence based and clear as otherwise misinformation can circulate and gain traction. The communication and engagement of the CSP moving forward must be transparent and decision making understood.

3.2 There is a key risk that the resources needed to deliver the CSP in full will not be available. This relates to finance (capital and revenue), workforce (frontline and support), estate and digital resources. Realistic resourcing plans will be set out within the CSP, but experience to date has shown that these may not always be delivered due to internal and external influences.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There may be a negative impact on CTMUHBs ability to deliver safe, high quality care if the CSP is not achievable or deliverable. This is then likely to have a negative impact on patient experience.
Related Health and Care standard(s)	Effective Care
	If more than one Healthcare Standard applies please list below: Staff and Resources, Staying Healthy Safe Care, Individual Care, Timely Care Dignified Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	EIAs will be completed as part of the high level options.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There will be resource implications to the delivery of the CSP. The options appraisal process will include resource implications.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **note** the update set out within this paper.

5.2 The Board is asked to discuss and **approve** the draft vision set out in Appendix A.

5.3 The Board is asked to discuss and **approve** the draft CSP principles set out in Appendix A.

CTM 2030
Our Health Our Future
BUILDING HEALTHIER COMMUNITIES TOGETHER

Clinical Services Plan
27.07.23

CYNNAL EIN DYFODOL — SUSTAINING OUR FUTURE
YSBRYDOLI POBL — INSPIRING PEOPLE
GWELLA GOFAL — IMPROVING CARE
CREU IECHYD — CREATING HEALTH

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Datblygu Cymunedau Iachach Gyda'n Gilydd

Building Healthier Communities Together

Timeline & process

Groundwork	May – July 2023	August – Dec 2023	Jan – Feb 2024	March – July 2024	2024/25 onwards
CTM2030 • Launch and Strategic Goals • Internal Staff Meetings and Briefings • Strategy Workshops • Strategy Group Workplans • 26.4.23 Visioning workshop Three 'Chapters' **External** • Engagement on Goals and what it means: • Communities • Services closer to home • Travel further for treatment when needed • What matters to you conversations	Agree process for development of CSP & services in scope Workshops: • Develop principles • Scope outline options Governance: • Exec Leadership Group • Board development session (June) • Board (July) Staff engagement: • Leadership Forum • Workshops OD support • Understand scope and develop the required ask	Engagement on process, principles and high level options. In parallel work up detailed options Briefings: • Politicians • Llais • Staff • Regional partners • Local authorities • Welsh Government Engagement: • Staff • Public • Politicians • Partners Governance: • Exec Leadership Group • Board (July) "What Matters" questions Test of process with Welsh Government, Llais & peers	Digest engagement feedback Options detailed development and modelling (inclu numbers, finance, workforce) Agree preferred option Identify high priority capital requirements; noting constraints	Assume interruption for purdah Consultation on preferred option and potential phasing Board level briefings Agree calendar of events	Delivery plan Capital considerations Outline business case Full business case

Drivers for change

- Short, medium and long term service sustainability
- CTM patients to receive care to Welsh Government standards and prevent deterioration of current performance
- Workforce fragility
- Financial affordability
- Differential access - lack of equity across the Health Board
- Maximise development of Llantrisant Health Park
- Fit for the future estate
- Differential adoption of new technologies
- Over reliance on acute services
- Lack of progress on "left shift"
- Amplifying our exemplar work
- The need to meet Net Zero aspirations

Developing a clear case for change

Vision

Our Clinical Services Plan will change and improve the way we provide NHS services in Cwm Taf Morgannwg, making sure we use our resources and expertise to continue to provide safe, effective care that meets the needs of all those in our communities in the future.

Benefits

Benefits are not just about the pdf

Focusing purpose and direction

Through

- Renewing purpose and values
- Giving direction for decision-making
- Relating to how all staff do their jobs
- Showing partners what you stand for

Accelerating ability to change

Through

- Building capacity and capability
- Innovating new ways of working
- Sharing ownership across groups
- Delivering change from the start

Energising culture and relationships

Through

- Being genuine on what matters most
- Role-modelling your values
- Making hard decisions openly
- Strengthening relationships

Listening to those who matter most

Through

- Empowering staff, citizens, partners
- Finding diverse perspectives
- Understanding past and present
- Knowing impact of external context

* Courtesy of Kaleidoscope Health and Care

Tests for change

Our principles will serve as 'tests' to ensure a consistent and evidenced approach to change. We will challenge ourselves to meet these tests throughout the programme and will expect to be held to account against them.

This will be vital as we enter the external engagement and, latterly, consultation phases during which our rationale for change and the evidence we use to inform our proposals will receive sustained scrutiny.

Principles

Principle	Description	Outputs/Metrics
Patient centred	Patients' needs and experiences will be at the heart of the CSP. Where change is proposed it should improve patient experience and satisfaction. People will be enabled to take greater ownership of their health whilst having access to face-to-face services where appropriate.	TBD
Clinically effective	We will set the highest standards for our services; patients will have better outcomes from their treatment and services will be safer. Guided by the Duty of Quality, we will strive to implement the latest medical advancements and approaches based on robust evidence.	TBD

Principles

Principle	Description	Outputs/Metrics
Access & equality	We will provide the services our population needs and not be restricted by traditional, outdated approaches. We will develop care closer to home and centres of excellence so services are accessible and available to our whole population. When we make changes to the location of services we will always carefully consider the effect of this on local people and will ensure no community is disproportionately impacted	TBD

Principles

Principle	Description	Outputs/Metrics
Population health and prevention focused	The CSP will reduce inequalities and provide every person living in CTM with the same opportunities to live a healthy life. We will use data and information to understand and meet the health needs of our population, ensuring our services add value and incorporate strategies for prevention, early intervention, and health promotion.	TBD
Digital first	Digital solutions and data will underpin all aspects of the CSP, empowering staff to provide excellent, safe care and giving people more control over their health. We will use data to standardise services wherever they are provided.	TBD

Principles

Principle	Description	Outputs/Metrics
Workforce	The CSP will provide our staff with the training, support, and technology they need to provide the care they aspire to. It will create more opportunities for different ways of working and support the development of a workforce that meets the future needs of our organisation and our population.	TBD
Sustainable	The CSP will make CTMUHB more efficient and more effective at what it does. It will improve the way we use our resources – including staff, equipment, finance, technology and facilities – and make it easier for people to make the right decisions for the health of our patients and our population. It will also help us be a greener organisation, following the 5Rs– Refine, Reduce, Reuse, Repurpose & Recycle	TBD

Principles

Principle	Description	Outputs/Metrics
Estate	The CSP will ensure we are making the best use of our estate to provide the right services in the right location. Where we make changes we will employ new technology and make sure buildings are 'future-proofed' so they can meet the changing needs of our communities, enable us to deliver on our Net Zero aspirations, and support integrated, regional working with our partners.	TBD
Integrated	The CSP should aim to improve the co-ordination of care, communication and information to provide seamless and efficient services. It will promote integration and collaboration within the health board, across the south east Wales regional and with other partners.	TBD

Options development

- Site agnostic
- Agreement of scope
- Detailed conversations with clinical teams – red lines and interdependencies
- Working with regional partners
- Testing with Welsh Government, Llais and peer review

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AGENDA ITEM
7.3

CTM BOARD

WORKING IN PARTNERSHIP - JOINT COMMITTEE REPORTS

Date of meeting	27 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 To present the Board with our partners Committee reports for information only.

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

2.1 The following meetings have been held by our partners since the Board last met in May 2023, namely the Welsh Health Specialised Services Joint Committee which met on 16 May 2023 and the Shared Services Partnerships Committee which met on 18 May 2023.

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

3.1 Key risks and any matters for escalation are set out in the appended Committee Reports.

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Board are being asked to **NOTE** the following Joint Committee Report:

- Welsh Health Specialised Services Joint Committee 16 May 2023 (Appendix 1);
- Shared Services Partnerships Committee 18 May 2023 (Appendix 2).

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 16 MAY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 16 May 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 14 March 2023 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. WHSSC Specialised Services Strategy
Members received a report and presentation presenting the final draft of the Specialised Services Commissioning Strategy for approval.

Members **noted** that following the Joint Committee workshop to discuss the strategy on 17 April the document had been updated to reflect the feedback received from the Joint Committee and Welsh Government.

Members (1) **Approved** the final draft of the Specialised Services Commissioning Strategy; and (2) **Supported** the decision to undertake further detailed work on the development of a set of meaningful success measures for the strategic objectives, with a timescale of September 2023 for completion.

4. WHSSC & HB Shared Pathway Saving Target – Milestones on Governance System & Process
Members **received** a presentation on the outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target, which had been requested by the Committee following approval of the Integrated Commissioning Plan (ICP) 2023-2024 on 13 February 2023.

Members **noted** that WHSSC had applied a programme management approach to establishing a mechanism to monitor savings and efficiencies and had developed Project Initiation Document (PID) outlining that a Programme Board be established comprising of representatives from each Health Board (HB). The PID had been shared with the Management Group in readiness for detailed discussion on 23 March 2023.

Members **noted** that an update on progress would be provided as a standing item on the agenda of future Joint Committee meetings.

Members **noted** the presentation.

5. Chair's Report

Members received the Chair's Report and **noted**:

- **Chair's Action** - The Chair's Action taken on 9 May 2023 to extend the tenure of Professor Ceri Phillips, Independent Member (IM), WHSSC from 31 May 2023 until 30 June 2023,
- **WHSSC Independent Member (IM) Recruitment** - that a recruitment process for the third WHSSC IM position will open in May 2023,
- **Welsh Government (WG) Review of National Commissioning Functions** - further to the Minister for Health & Social Services's announcement concerning a review of national commissioning functions a facilitated discussion with Joint Committee members took place on 14 March 2023 to coincide with the EASC and WHSSC meetings scheduled for that day; and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Ratified** the Chair's action taken on 9 May 2023 to extend the tenure of Professor Ceri Phillips, Independent Member (IM), WHSSC from 31 May 2023 until 30 June 2023.

6. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Single Commissioner for Mental Health -** Further to the Joint Committee meeting on 10 January 2023, when six of the seven HBs on the Joint Committee supported a recommendation to WG that WHSSC should be the single commissioner for secure Mental Health service in Wales, on 20 March 2023 WHSSC received confirmation from WG that they accepted the recommendation. A letter has been issued to Welsh Government requesting funding for project management support for the associated programme of work,
- **Sacral Nerve Stimulation (SNS) for faecal incontinence in South Wales -** WHSSC has received a request from the Chair of the NHS Wales Health Collaborative Executive Group (CEG) formally requesting that WHSSC take on the commissioning of Sacral Nerve Stimulation (SNS) for faecal incontinence in South Wales. The

WHSSC Team will undertake an evidence review of the procedure and an estimation of demand and budget impact to feed into the WHSSC Integrated Commissioning Plan. A report outlining the process and timeline, will be brought to the July Joint Committee,

- **Spinal Operational Delivery Network (ODN) -** Following highlighting the delay reported in the March 2023 meeting the Implementation Board have confirmed that the plan is for the ODN to go live in September 2023,
- **Thoracic Surgical Centre Update -** Following further detailed capital planning work undertaken by SBUHB as the host provider of the future single Thoracic Surgical Centre a briefing has been received with a more detailed timeline for the delivery of the scheme. At the Project Board meeting in November 2022 an initial indicative timeline was reported that the Centre will be operational during 2026; and
- **All Wales IPFR Policy Review**
  The final draft of the All Wales Individual Patient Funding Panel (IPFR) Policy will be presented to the Joint Committee in July 2023. It has not been possible to complete the work in time for the May committee meeting due to the availability of the KC to consider the draft which has now been agreed by WHSSC and stakeholders.

Members **noted** the report.

7. Review of Specialised Commissioning in Haematology: Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia

Members received a report outlining the main findings and proposals of the report on Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia (HRM) from the review of specialised commissioning in haematology.

Members (1) **Noted** the findings of the specialised haematology review in relation to the opportunities, risks and challenges for the Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia (HRM) service in Wales, (2) **Considered** the options proposed for how specialised commissioning under WHSSC could address the opportunities, risks and challenges in the AML, ALL and HRM service to provide an equitable, high quality and sustainable service for patients in Wales; and (3) **Approved** option 4, the phased implementation of option 1 (all Wales MDT) and option 3 (network service model for Wales), as the preferred option.

8. Review of Specialised Commissioning in Haematology: Allogeneic Haematopoietic Stem Cell Transplantation, Salvage Therapy in Non-Hodgkin's Lymphoma and Secondary Immunodeficiency

Members received a report outlining the main findings and proposals of the review of specialised commissioning in haematology for Allogenic Haematopoietic Stem Cell Transplantation (AHSCT), salvage therapy for high grade Non-Hodgkin's Lymphoma (HG NHL) and Secondary Immunodeficiency in haematology patients.

Members (1) **Noted** the findings of the specialised haematology review in relation to the management of AHSCT, salvage therapy for HG NHL and treatment for secondary immunodeficiency in haematology patients,
(2) **Noted** the options proposed for how specialised commissioning under WHSSC may address the opportunities, risks and challenges in these service; and (3) **Approved** the following specific recommendations:

- Management of AHSCT:
  - Commissioning responsibility for long term follow up (post 100 days) by the specialist AHSCT team is transferred from HBs to WHSSC,
- Salvage therapy for HG NHL:
  - Current commissioning arrangements are retained,
  - The role of central commissioning is re-evaluated once an agreed national pathway for HG NHL is in place,
- Secondary immunodeficiency:
  - Current commissioning arrangements are retained; and
  - Consideration is given to undertaking work at an all Wales level to evaluate the feasibility of a national sub-cutaneous immunoglobulin therapy service for patients with secondary immunodeficiency.

9. Review of Specialised Commissioning in Haematology: Thrombotic Thrombocytopenic Purpura

Members received a report outlining the main findings and proposals of the review of specialised commissioning in haematology for Thrombotic Thrombocytopenic Purpura (TTP).

Members (1) **Noted** the current model of service delivery for TTP across Wales and the risks to equitable access to best treatment, (2) **Approved** the transfer of commissioning responsibility for TTP from Health Boards to WHSSC; and (3) **Approved** the proposed preferred option to commission TTP for the population of south Wales from a designated comprehensive TTP centre in NHS England.

10. Cochlear and Bone Conduction Hearing Implant (BCHI) Engagement & Next Steps

Members received a report outlining the targeted engagement process undertaken regarding Cochlear and BCHI services for people in South East

Wales, South West Wales and South Powys, the findings from that process and the proposed next steps.

Members (1) **Noted** the process that has been followed both in respect of a) the temporary urgent service change for Cochlear services and b) the requirements against the guidance for changes to NHS services in Wales, (2) **Noted** and **Considered** the feedback received from patients, staff and stakeholders with respect commissioning intent, (3) **Approved** the preferred commissioning model of a single implantable device hub for both children and adults with an outreach support model, (4) **Supported** the next steps specifically the undertaking of a designated provider process; followed by a period of formal consultation, (5) **Noted** the process that has been enabled to seek patient and stakeholder views in line with the requirements against the guidance for changes to NHS services in Wales; and (6) **Agreed** to take the outcome and proposed next steps through Health Boards for consideration.

11. Performance Management Framework

Members received a report presenting the draft WHSSC Performance Management Framework approach which subject to approval will be embedded into WHSSC's business as usual processes, and shared with provider organisations, for transparency and awareness.

Members (1) **Noted** the report, (2) **Approved** the proposed approach for an updated WHSSC Performance Management Framework; and
(3) **supported** the proposed implementation arrangements.

12. Development of the Integrated Commissioning Plan 2024-2027

Members received a report outlining the high level process for the development of the WHSSC Integrated Commissioning Plan (ICP) for 2024-2027.

Members (1) **Noted** the report, (2) **Considered** and **Approved** the timeline; and (3) **Received assurance** on the process.

13. Annual Governance Statement 2022-2023

Members received a report presenting the Annual Governance Statement (AGS) 2022-23 for approval.

Members (1) **Noted** the final report, (2) **Noted** that the draft Annual governance Statement was presented to the Integrated Governance Committee on the 18 May 2023 for assurance, (3) **Noted** that the WHSSC Annual governance Statement 2022-2023 will be presented at the CTMUHB Audit & Risk Committee Meeting on 21 June 2023, (4) **Noted** that the WHSSC Annual Governance Statement 2022-2023 will be included in the CTMUHB Annual report submission to Welsh Government and Audit Wales in June 2023, recognising that it has been reviewed and

agreed by the relevant sub committees of the Joint Committee; (5) **Noted** that the final documents will be submitted to the CTMUHB Audit & Risk Committee in July 2023 for recommendation for CTMUHB Board Approval on 27 July 2023; and (6) **Noted** that the final Annual Governance Statement will be included in the Annual Report presented at the CTMUHB Annual General Meeting in September 2023.

14. Sub Committee Annual Reports
Members received a report presenting the Sub-Committee Annual Reports for 2022-2023.

Members **noted** the Sub-Committee Annual Reports for 2022-23.

15. Sub Committee Terms of Reference
Members received a report presenting the updated Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC), and the Welsh Kidney Network (WKN) for approval.

Members (1) **Noted** that the Welsh Kidney Network (WKN) Terms of Reference were discussed and approved at the WKN Board Meeting on 4 April 2023, (2) **Noted** that the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) Terms of Reference were discussed and approved at sub-committee meetings on 18 April 2023,
(3) **Noted** that the MG ToR were discussed at the MG meeting on 27 April 2023 and no changes were proposed; and (4) **Approved** the revised Terms of Reference (ToR) for the IGC, the QPSC and the WKN.

16. Performance & Activity Report Month 11 2022-2023
Members received a report highlighting the scale of the decrease in activity levels during the peak COVID-19 period, and outlining signs of recovery in specialised services activity. The activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements.

Members **noted** the report.

17. Financial Performance Report – Month 12 2022-2023
Members received the financial performance report setting out the financial position for WHSSC for month 12 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The year-end financial position reported at Month 12 for WHSSC was an underspend of (£10.939m). The under spend predominantly relates to releasable reserves of (£18m) arising from 2021/22 as a result of WHSSC

assisting Health Boards to manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts, and to ensure the most effective use of system resources.

Members **noted** the current financial position and forecast year-end position.

18. South Wales Trauma Network Delivery Assurance Group (Quarter 3 Report)

Members received a report providing a summary of the Quarter 3 2022/23 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members **noted** the full South Wales Major Trauma Network (SWTN) Delivery Assurance Group (DAG) report.

19. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

20. Other reports

Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee (QPSC; and
- Welsh Kidney Network (WKN).

21. Any Other Business

- Members noted a Joint Committee development session will be held on 11 September 2023.

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	18 May 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Duty of Quality

Following a formal presentation to the Committee in March, a verbal update was provided demonstrating good progress in identifying the quality measures in each division and mapping the Quality Management Systems already in place within NWSSP. Staff have been briefed on the requirements and implications and discussions have taken place with Welsh Government and Delivery Unit colleagues on how the self-assessment, which is primarily clinically focused, can best be adapted to accurately portray the activities undertaken within NWSSP. A further formal update will be provided in September.

The Committee **NOTED** the update.

Deep Dive – Welsh Risk Pool

The Committee were provided an overview of the many and various activities undertaken by the Risk Pool.

One of the key aims of the Risk Pool is to ensure that NHS Wales organisations learn and share lessons from claims that are received. Learning from Events reports were introduced in 2018 and scrutiny is undertaken by a Learning Advisory Panel. A number of Safety and Learning networks help to share good practice and support is provided to Health Bodies to conduct complex investigations where specialisms and/or independence will add value. Investigations are supported not only by specialists from within NHS Wales, but from across the UK to ensure that advice being provided is of the highest calibre.

The Committee **NOTED** the update.

Chair's Report

The Chair updated the Committee on her attendance at recent meetings, both within NWSSP and externally.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The very positive outcome of the five-yearly External Quality Assessment of the Audit and Assurance Service.
- The recent visit of the NWSSP Senior Leadership Group to North Wales where they visited a number of sites including the Laundry and Stores and presented awards to staff who had been successful in the Staff Awards process that concluded in January of this year.
- The recent visit to India by NWSSP members including the Medical Director and colleagues from Health Boards and Welsh Government which has led to the potential recruitment of 58 nurses and on-going conversations with a further 20 Doctors.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Citizen Voice Body SLA - LLAIS

The Committee were presented with the draft SLA to govern the services provided to LLAIS by NWSSP. Further work is required on the SLA and the accompanying Memorandum of Understanding (MOU) and so while there was **AGREEMENT IN PRINCIPLE** on the documentation provided, the final SLA and MOU will need to be brought back to the Committee for formal approval.

Service Level Agreements

The overarching Service Level Agreement and the supporting schedules for 2023/24, which cover the core services provided to all NHS Wales bodies by NWSSP, were **APPROVED** by the Committee.

Primary Care Workforce Intelligence System

A summary of the Business Case for the Workforce Intelligence System for Primary Care was presented. This pulls together a number of separate systems into one system covering the following:

- Compliant registration of practicing clinicians to meet the NHS regulations via the Performers List & Pharmacy Database;
- The capture and reporting of the primary and community service workforce data and information respectively including the compliance registration for the Scheme of General Medical Practice Indemnity (GMPI) of substantive and Locum workforce; and

- Capture and publication of declarations of interest enabling open and transparent assessment of conflict of interest.

The proposal requires capital funding in Year One but thereafter will deliver savings against current costs.

The Committee **APPROVED** the paper subject to confirmation of Welsh Government funding and sight of the Full Business Case.

Items for Noting

Internal Audit – External Quality Assessment

The 5-year external quality assessment of Internal Audit was undertaken by the Chartered Institute of Public Finance & Accountancy over recent months and resulted in the highest possible rating being awarded to the service that is operated by NWSSP. There were no areas of either partial or non-compliance noted with the standards.

The Committee **NOTED** the paper.

Laundry Services Update

The business case to build two new laundries and to significantly refurbish a third laundry has been put on hold due to a lack of available capital funding. Alternative plans are therefore being developed to ensure that the laundry service meet the appropriate environmental and legal regulations, but within a much-reduced financial envelope. These have been produced but at present Welsh Government are still unable to confirm any capital funding for the laundry service.

The Committee **NOTED** the paper.

Finance, Performance, People, Programme and Governance Updates

Finance –The final (unaudited) position for 2022/23 was a surplus of £12k with £2m re-distributed to Health bodies and Welsh Government. The Welsh Risk Pool position was as forecast in the IMTP, and all allocated capital funding was spent. The value of stock amounted to £24m and reflected several valuation adjustments that had been made in accordance with the relevant Accounting Standards. The adjustments had been approved by and funded by Welsh Government.

People & OD Update – Sickness absence rates remain low, and there has been an increase in Statutory and Mandatory Training compliance to 91%. PADR completion is almost at green. Staff turnover is relatively high, but this is largely due to starters and leavers in the Single Lead Employer Division.

Performance – In-month performance was generally on target with an improvement seen in Recruitment service time to hire. Report turnaround within Audit and Assurance continues to be behind target but is largely outside the direct control of NWSSP. With regards to recruitment the review of, and subsequent

clearance of historic cases, is continuing to adversely affect performance in the short-term but will deliver a longer-term benefit. The Payroll Call Handling Team have achieved their targets for the last three months, which represents a significant turnaround in performance.

IMTP Q4 Progress Report - Progress has been made towards achieving our IMTP objectives that form part of our 3-year rolling plan, with 45% on track for delivery as part of those longer-term programmes of work. 36% of our total objectives were successfully achieved, as planned, in year across our divisions.

Project Management Office Update – The new Case Management System, the Patient Medical Records Accommodation and the TrAMS Projects remain red-rated. All other projects are on track.

Corporate Risk Register – Two of the previously reported seven red-rated risks covering energy costs and industrial action, have been down-graded to amber. A number of COVID-specific risks have also been removed from the Register.

Draft Annual Governance Statement – This was provided for comment at this stage and will come back to the July Committee prior to final approval at the Audit Committee.

The Committee **NOTED** the above Reports.

Papers for Information

The following items were provided for information only:

- Audit Wales Plan
- 2023/24 Internal Audit Plan
- Audit Committee Assurance Report;
- 2022/23 Annual Complaints Report
- Finance Monitoring Returns (Months 12 and 1).
- 2023/24 Forward Plan.

AOB

It was agreed that the planned Committee Development Session scheduled for 9 June would be postponed in recognition of the pressures on NHS Wales colleagues at the current time. The session planned for November will however still go ahead.

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Matters referred to other Committees

N/A

Date of next meeting	20 July 2023

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item Number: 8.1.1b

Minutes of the "In Committee" Meeting of Cwm Taf Morgannwg University Health Board (CTMUHB) held on Thursday 25 May 2023 as an In Person Meeting at Yr Hwb, Royal Glamorgan Hospital Site, Llantrisant (Virtual Meeting held via Microsoft Teams for those unable to attend in person)

Members Present:

Jonathan Morgan	Chair/ Independent Member
Jayne Sadgrove	Vice Chair / Independent Member
Paul Mears	Chief Executive
Ian Wells	Independent Member
James Hehir	Independent Member
Carolyn Donoghue	Independent Member
Dilys Jouvenat	Independent Member
Patsy Roseblade	Independent Member
Mel Jehu	Independent Member
Lynda Thomas	Independent Member
Nicola Milligan	Independent Member
Geraint Hopkins	Independent Member
Greg Dix	Executive Director of Nursing / Deputy Chief Executive
Hywel Daniel	Executive Director for People
Linda Prosser	Executive Director of Strategy & Transformation
Gethin Hughes	Chief Operating Officer
Lauren Edwards	Executive Director of Therapies & Health Sciences
Sally May	Executive Director of Finance
Dom Hurford	Executive Medical Director
Philip Daniels	Interim Director of Public Health (In part)
Sally Bolt	Associate Member

In Attendance:

Stuart Morris	Director of Digital
Matthew Butt	Chief Of Staff (attended virtually)
Simon Blackburn	Assistant Director of Communication & Engagement
Cally Hamblyn	Assistant Director of Governance & Risk
Gareth Cooke	National Programme Lead, Digital Healthcare Wales (attended virtually)
Bronwyn Baldwin	Radiology Service Manager
Sian Phillips	Consultant Radiologist (attended virtually)
Emma Walters	Corporate Governance Manager (Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the meeting.

Unconfirmed

1.2 Apologies for Absence

No apologies for absence were received.

1.3 Declarations of Interest

No additional declarations were made.

2. RADIOLOGY INFORMATICS SYSTEMS PROCUREMENT.

L Edwards presented the report alongside colleagues from Digital Healthcare Wales and the Radiology Senior Management Team.

Following a detailed discussion, Members advised supported the approval of the Business Case and requested that a response was provided to Members outside the meeting in relation to the points of clarification raised.

The Board **RESOLVED** to **APPROVE** the Full Business Case.

Resolution: The Board requested that a response was provided to Board Members outside the meeting in relation to the points of clarification raised.

3. Any Other Urgent Business

The Chair extended his thanks to Board Members for attending the meeting.

4. CLOSE OF MEETING

Unconfirmed

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.1.2

CTM BOARD

AMENDMENT TO STANDING ORDERS ANNUAL REVIEW AND REVIEW OF SCHEDULE 3.4 AND 5.3

Date of meeting	27 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Local Partnerships Forum	20.06.2023	Endorsed for Board Approval
Mental Health Act Monitoring Committee	07.06.2023	Endorsed for Board Approval

ACRONYMS	
SO's	Standing Orders

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the

achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be aware of the SOs and, where appropriate, should be familiar with their detailed content.

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

2.1 **Annual Review**
With the exception of minor/typographical and review of schedules as outlined below, there are no areas of significant change required to the Standing Orders at this time.

2.2 **Standing Orders – Schedule 5.3 – Local Partnerships Forum**
The Terms of Reference were reviewed with changes identified in red as outlined in Appendix 1.

2.3 **Standing Orders – Schedule 3.4 – Mental Health Act Monitoring Committee**
The Terms of Reference were reviewed with changes identified in red as outlined in Appendix 2.

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

3.1 If approved, the Standing Orders will be uploaded to SharePoint and the Health Board's Internet site.

3.2 The Standing Orders will be further strengthened in year as and when required.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Compliance with the SO's support robust quality governance arrangements.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new,	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.

changed or withdrawn policies and services.	
Legal implications / impact	No
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **APPROVE**:

- The amendments to the Health Board's Standing Orders as outlined in section 2 of this report.

Schedule 5.3

Local Partnership Forum Advisory Group
Terms of Reference and Operating Arrangements

This Schedule forms part of, and shall have effect as if incorporated in the Cwm Taff Morgannwg University Health Board Standing Orders

Terms of Reference & Operating Arrangements

Our People
Our Future
Building, thriving, caring together

INTRODUCTION

The Local Partnership Forum (LPF) is a sub group of the Cwm Taf Morgannwg University Health Board (hereafter referred to as the Health Board) and will operate in accordance with the following six Trade Union Congress (TUC) Principles of Partnership Working;

1. A shared commitment to the success of the organisation.
2. A focus on quality of working life.
3. Recognition of the legitimate roles of the employer and trade unions.
4. A commitment by the employer to employment security.
5. Openness by both parties and a willingness by the employer to share information and discuss the organisation's plans.
6. Adding value via a shared understanding that the partnership is delivering measurable improvements for the employer, its employees and the trade unions.

PURPOSE

The purpose of the LPF is to provide regular and formal dialogue between the Executive Directors and trade union / staff organisation colleagues. The meetings will allow all parties to engage with each other to inform, debate and to seek to agree local priorities on workforce and health service issues.

The meeting agenda content (Part A and B) will be structured around the following four strands of the Health Board's 'Inspiring People – People Plan', to inform and test the thinking, review the data to make evidence based decision and determine the priorities:

- Inspiring and inclusive culture and Leadership
- Improving care through change
- Creating health and wellbeing for our people
- Sustaining our future workforce

At the earliest opportunity the Health Board will engage with trade union organisations in key discussions relating to the above strategic goals. These discussions may take place at the Care Group LPFs, Health Board LPF or Board, as appropriate.

OUR VALUES

The LPF members will actively role model the Health Board's values and behaviours:

Value	Behaviours
1. We listen, learn and improve	• We take time to ask and listen carefully to people's worries, views and ideas — then actively do something to make a difference. • We make it safe and easy for people to speak up - as well as being open to giving and receiving feedback as a chance to learn. • We welcome change, bring a positive, 'will do' attitude and find ways to actively improve the way we do things.
2. We treat everyone with respect	• To show that we value other people and see them as equals, we treat everybody with kindness and fairness. • We go out of our way to be supportive, helpful and friendly. • We recognise what people do every day to make a difference, and say 'thank you'.
3. We all work together as one team	• We bring people together and build strong, trusting relationships by including others in decisions and activities. • We look out for people's wellbeing and safety, both physical and psychological and support them if they are at risk. • We are open, clear and honest in the way we communicate, and if we need to change the way we explain something, to help people understand we will. • When we learn something useful and inspiring, we share it with others.

CONSTITUTION

All LPF management and trade union organisation representative members are full and equal members and share responsibility for the decisions.

In consultation with the recognised trade union organisations and professional organisations (hereafter referred to as trade Union organisations) the Health Board shall agree the overall size and composition of the LPF.

The Health Board's Independent Member with responsibility for staff will attend the LPF in an ex-officio capacity.

The Health Board's LPF is the formal mechanism where the Heath Board and trade union organisations work together in partnership, to improve health services for the people of Cwm Taf Morgannwg. It is the forum where key Health Board stakeholders will engage with each other to inform, debate and seek to agree workforce and health service delivery priorities.

SCOPE AND DUTIES

The LPF will provide the formal mechanism for consultation, negotiation and communication between the trade union organisations and Health Board management.

The role of the Health Board LPF is to:

- Establish a regular and formal dialogue between the Executive Directors and trade union organisations, on matters relating to operational and strategic workforce and Health Board service delivery issues.
- Enable the Health Board and trade union organisations to present and discuss issues affecting the workforce.
- Provide opportunities for trade union organisations and Health Board senior managers to input into the organisation's service development plans, at an early stage.
- Consider the workforce implications in respect of service reviews to identify and seek to agree new ways of working.
- Apprise and discuss in partnership the workforce and financial performance of the Health Board, on a regular basis.
- Apprise and discuss in partnership the Health Board's services, activities and the people implications.
- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for the workforce.
- Communicate to their trade union organisations and members the key decisions taken by the Board and senior management.

- Consider national NHS Wales developments, People Strategy and the implications for the Health Board, including matters of service re-profiling, re-organisation etc.
- Negotiate on limited matters that fall outside of national terms and conditions of service that are subject to local determination.
- Ensure trade union organisation representatives are afforded reasonable paid time off to undertake their trade union duties within the Health Board.
- Regularly review trade union organisation facilities arrangements with reference to the minimum standards set out in the National Terms and Conditions of Service Facilities Agreement arrangements.
- Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.

DELEGATED POWERS

The Health Board's LPF will establish seven Care Group LPF sub-groups, to establish ongoing dialogue, communication and consultation on service and operational management issues, specific to their operational areas. The Care Group LPFs will report directly to the Health Board LPF.

AUTHORITY

All LPF management and trade union organisation representatives are full and equal members and collectively share responsibility for the decisions made in partnership.

ACCESS

The Joint Chairs of the LPF shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

The Health Board's Independent Member with responsibility for staff will attend the LPF in an ex-officio capacity.

As a minimum, the membership of the LPF shall comprise:

Management Representatives

As a minimum, the membership of the Health Board LPF shall comprise of the following management representatives:

- Chief Executive or Deputy Chief Executive;
- Executive Medical Director
- Executive Finance Director;
- Executive Director of Nursing, Midwifery and Patient Care ;
- Executive Director for People;
- Senior management representation for each of the Care Groups (identified locally).

Should a management representative be unable to attend a meeting they are required to send an appropriate deputy or assistant director.

Trade Union Representatives

The Health Board recognises those trade union organisations listed below to represent their members employed by the organisation.

As a minimum, the membership of the Health Board LPF shall comprise of the following trade union organisations who must be employees of the health board:

- British Association of Occupational Therapists (BAOT);
- British Dental Association;
- British Dietetic Association;
- British Medical Association (BMA);
- British Orthoptic Society;
- Chartered Society of Physiotherapy (CSP);
- Federation of Clinical Scientists;
- GMB;
- Managers in Partnership (MIP);
- Society of Chiropodists and Podiatrists;
- Society of Radiographers;
- Royal College of Nursing (RCN);
- Royal College of Midwives (RCM);
- UNISON;
- UNITE; and
- A Health and Safety Representative.

Should a trade union representative be unable to attend a meeting they are required to send an appropriate deputy, who is eligible to attend on their

behalf.

Membership

Consistent attendance and commitment of the membership to participate in LPF meetings is essential. Where a member of the LPF does not attend on three consecutive occasions, the joint chairs will write to the member and bring the response to the next meeting for further consideration. This could result in the removal of the member from the LPF.

By Invitation

Other Executive Directors and senior managers may be co-opted to attend the LPF, should they be required to speak to an agenda item.

Full time officers of the recognised trade union organisations may attend LPF meetings, subject to prior notification and agreement by the joint chairs.

Secretariat

The Health Board will provide the LPF secretariat. The secretariat will be responsible for working in partnership with the Joint Chairs to agree and prepare the LPF agenda, take and prepare the meeting minutes and obtaining agreed sign off by the Joint Chair, prior to distribution to the LPF membership.

The People function will provide the LPF secretariat service and will be responsible for the maintenance of the constitution of the LPF membership, the circulation of agenda and minutes as well as the planning and notification of meetings.

Member Appointments

Both management and the local trade union organisations will appoint a Chair who will undertake the role of Joint Chair of the LPF.

Management members of the LPF will be an Executive Director or a nominated deputy or assistant director.

Only trade union organisation representatives employed by the Health Board and accredited representatives, for the purposes of negotiating and bargaining are eligible to attend the LPF. If a trade union representative ceases to be employed by the Health Board or ceases to be an accredited

member of a trade union organisation, they will automatically cease to be a member of the LPF.

Support to LPF Members

The Health Board will provide as appropriate personal and organisational development programmes to ensure that members have the knowledge and skills to enable them to fulfil the breadth of their LPF responsibilities.

LPF MEETINGS

Quorum

Management and trade union representatives will make every effort to maintain a stable LPF membership. There should be minimum of four different trade union representatives and 50% attendance of management representatives for the meeting to be quorate.

No decisions can be made where a LPF meeting is not quorate, but information may be exchanged. In such situations, the joint chairs may agree that an urgent extraordinary LFP meeting is required. Such meetings would be scheduled with seven calendar days' notice.

Frequency of Meetings

LPF meetings will take place on a quarterly basis but will be reviewed regularly. Therefore, meeting frequency may change to reflect trade union and organisational needs.

Circulation of Papers

The appointed LPF Secretary will be responsible for circulating the LPF agenda and minutes of the previous meeting at least 7 calendar days prior to the meeting date. The Secretary will also be responsible for the maintenance of the constitution of the LPF membership, as well as the planning and notification of meetings.

Withdrawal of individuals in attendance

The Joint Chairs of the LPF may ask any member or individual who is normally in attendance, but who is not a member of the LPF to withdraw to facilitate open and frank discussion on any particular matter.

REPORTING AND ASSURANCE ARRANGEMENTS

Then LPF shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Executive Director for People on behalf of the Board shall oversee a process of regular and rigorous self-assessment and evaluation of the LPF's performance and operation.

The LPF will report to the Board via a highlight report following each meeting.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The LPF is a sub group of the Board.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the LPF, except in the area relating to the quorum.

The Health Boards standing orders provide for the establishment of a Local Partnership Forum (LPF). The terms of reference and operating arrangements for the LPF must be formally approved by the Board.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally be circumstances where decisions, which would normally be made by the LPF, need to be taken between scheduled meetings. In these circumstances, the Joint Chairs may deal with the matter on behalf of the LPF, after first consulting with a minimum of two other LPF management and trade union members. The Joint Chairs are responsible for formally recording and reporting such actions to the next meeting of the LPF, for consideration and ratification.

Where a Joint Chair has a personal or business interest in the urgent matter requiring decision, they are not permitted to take chair's action.

REVIEW

The terms of reference and operating arrangements for the Local Partnership Forum will be reviewed and updated, as appropriate, annually by the group.

Reviewed February 2023

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Appendix 2

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

MENTAL HEALTH ACT MONITORING COMMITTEE

TERMS OF REFERENCE & Operating Arrangements

Reviewed 7 June 2023
To be Approved by the Health Board 27.07.2023

INTRODUCTION

The CTMUHB Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and CTMUHB scheme of delegation), the Board shall nominate a committee to be known as the **Mental Health Act Monitoring Committee**- "the Committee**"**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

CONSTITUTION AND PURPOSE

The purpose of the Committee is to advise and assure the Board that the arrangements to monitor and review the way functions under the Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

SCOPE AND DUTIES

The Committee shall consider:

- how the delegated functions under the Mental Health Act are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- a suitable mechanism for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the Mental Health Act 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice
- Develop an annual report for presentation to the Health Board.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Mental Health Act Monitoring Committee has a key role in assisting the Board to fulfil its oversight responsibilities to ensure it is operating effectively and in accordance with legislation.

Hospital Managers may arrange for their functions under the Mental Health Act to be carried out on a day to day basis by particular Officers on their behalf. (COP 11.7) The arrangements for authorising decisions has been set out in a Scheme of Delegation.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:
    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:
A minimum of **(4)** members, comprising

Chair	Vice Chair of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board

The 1983 Act is operated by health and social care practitioners, in collaboration with a range of agencies including police and ambulance services, as well as third sector bodies such as advocacy providers. Membership of the Committee should reflect this, as different agencies and practitioners have differing responsibilities and duties under the Act.

The Vice Chair of the Health Board shall Chair the Committee given their specific responsibility for overseeing the Health Board performance in relation to mental health service.

Attendees

- Chief Operating Officer
- Deputy Chief Operating Officer (Director of Primary, Community & Mental Health) (in their absence nominated Care Group Lead)
- Representative from South Wales Police
- Representative from Rhondda Cynon Taf County Borough Council
- Representative from Merthyr Tydfil County Borough Council
- Representative from Bridgend County Borough Council
- Chair of Mental Health Act Monitoring Operational Group
- Head Administrator - Mental Health Act Administration Team
- Carer Representative from the Together for Mental Health Partnership Board

- Representative from Welsh Ambulance Services Trust (minimum twice per annum)
- Clinical Director for Mental Health
- Head of Nursing for Mental Health Merthyr Cynon Locality Group (minimum twice per annum)
- Mental Health Clinical Service Group Manager Bridgend
- Mental Health Clinical Service Group Manager Rhondda & Taff Ely
- Clinical Director, Child & Adolescent Mental Health Service (CAMHS) (minimum twice per annum)
- Head of Nursing CAMHS

By Invitation:

- Other Directors /Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- Co-ordinate the provision of a programme of training, specific support or organisational development for Committee Members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum
This will comprise of two Independent Members, Deputy Chief Operating Officer (Director of Primary, Community & Mental Health) (in their absence nominated Care Group Lead); a representative from the partner organisations either from the South Wales Police, Local Authorities or the Welsh Ambulance Services NHS Trust and also at least one clinical representative.

Frequency of Meetings
Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the Health Board's annual plan of Board Business.

Withdrawal of individuals in attendance
The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers
The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year

- bring to the Board's specific attention any significant matters under consideration by the Committee

- ensure appropriate escalation arrangements are in place to alert the LHB Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the LHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through the Committee Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and

- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.
The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

Related Sub Groups

- Mental Health Act Monitoring Operational Group
- Together for Mental Health Partnership Board
- Crisis Concordat Meeting Forum.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in relation to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.1.3

CTM BOARD

BOARD COMMITTEE ANNUAL REPORTS

Date of meeting	27 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee	24 May 2023	ENDORSED FOR APPROVAL
Remuneration & Terms of Services Committee	19 June 2023	ENDORSED FOR APPROVAL
Stakeholder Reference Group	8 June 2023	ENDORSED FOR APPROVAL
Mental Health Act Monitoring Committee	7 June 2023	ENDORSED FOR APPROVAL
Digital & Data Committee	12 June 2023	ENDORSED FOR APPROVAL
Planning, Performance & Finance Committee	27 June 2023	ENDORSED FOR APPROVAL

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In line with Standing Order requirements each Board Committee is required to submit to the Board on an annual basis a report setting out its activities together with a review of its performance and any associated improvements being put into place as a result.

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

2.1 The Quality & Safety Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2022 – March 2023 and is attached at Appendix 1 for Board approval.

2.2 The Remuneration & Terms of Services Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2022 – March 2023 and is attached at Appendix 2 for Board approval.

2.3 The Stakeholder Reference Group received its Annual Report during this period. This Annual Report relates to the period April 2022 – March 2023 and is attached at Appendix 3 for Board approval.

2.4 The Mental Health Act Monitoring Committee received its Annual Report during this period. This Committee Annual Report relates to the period April 2022-March 2023 and is attached at Appendix 4 for Board approval.

2.5 The Digital & Data Committee received its Annual Report during this period. This Committee Annual Report relates to the period April 2022-March 2023 and is attached at Appendix 5 for Board approval.

2.6 The Planning, Performance & Finance Committee received its Annual Report during this period. This Committee Annual Report relates to the period April 2022-March 2023 and is attached at Appendix 6 for Board approval.

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

3.1 There are no key risks for escalation to the Board.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below) N/A
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **APPROVE** the following Board Committee Annual Reports for the period 2022/2023:

- Quality & Safety Committee (Appendix 1)
- Remuneration & Terms of Services Committee (Appendix 2)
- Stakeholder Reference Group (Appendix 3)
- Mental Health Act Monitoring Committee (Appendix 4)
- Digital & Data Committee (Appendix 5)
- Planning, Performance & Finance Committee (Appendix 6)

Appendix 1

Quality & Safety Committee

Committee Annual Report 2022-2023

QUALITY & SAFETY COMMITTEE
ANNUAL REPORT 2022-2023

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2022-2023.

During the year, I have been supported by James Hehir, Nicola Milligan, Dilys Jouvenat, Patsy Roseblade and Carolyn Donoghue who have contributed their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my sincere thanks to all the officers of the Committee for their commitment in supporting the Committee in discharging its responsibilities through robust reporting. I would particularly like to extend my thanks to colleagues within the Corporate Governance Team for the support they provided me throughout the year. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales, Healthcare Inspectorate Wales and Delivery Unit colleagues.

Going forward the Committee will continue to pursue a full programme of work covering quality and safety of care for our population together with matters affecting the health and safety of our workplaces with the aims of promoting learning and further strengthening the governance and assurance arrangements of the Health Board.

Jayne Sadgrove
Chair of the Quality & Safety Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Quality & Safety Committee "the Committee" is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

The Committee has embraced the new Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.

The Committee meets every other month, with the key function to provide scrutiny on behalf of the Board on all matters relating to Quality and Safety.

A key area of the Quality Improvement work continues to be focussed on the Health Board's response to the concerns raised in 2019 regarding failings in maternity services. The service and Maternity Improvement Team has continued to deliver improvements during 2022-2023 with a regular report on improvement activity received by the Committee.

During 2022-2023, targeted focus was paid to Ty Llidiard service improvements following concerns raised by the Welsh Health Specialised Services Committee and on Mental Health Services following reviews undertaken by Healthcare Inspectorate Wales. The Committee were also sighted on programmes of improvement in relation to Prince Charles Hospital, Stroke Services and the Minor Injuries Unit at Ysbyty Cwm Cynon.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective Quality & Safety arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Committee's Terms of Reference are reviewed annually and are available via the following link: https://cwmtafmorgannwg.wales/how-we-work/standing-orders/

3.2 MEMBERSHIP

The membership of the Quality & Safety Committee comprises of six Independent members, enabling the Committee to provide robust scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2022-2023 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality & Safety Committee Apr 2022-March 2023

Name	Period
Members	
Jayne Sadgrove (Committee Chair) Independent Member	April 2022 – March 2023
James Hehir Independent Member	Apr 2022 - March 2023
Nicola Milligan Independent Member	Apr 2022 – March 2023
Dilys Jouvenat Independent Member	April 2022 -March 2023
Patsy Roseblade Independent Member	April 2022 – March 2023
Carolyn Donoghue Independent Member	April 2022 – March 2023

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2022-2023

During the year, the Committee met on six occasions. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2022-2023

In Attendance	24 May 2022	19 July 2022	20 Sept 2022	15 Nov 2022	24 Jan 2023	16 Mar 2023	Total
Independent Members							
Jayne Sadgrove (Chair of the Committee)	✓	✓	✓	✓	✓	✓	**6/6**
Dilys Jouvenat – Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
Nicola Milligan – Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
James Hehir – Independent Member	✓	✓	✓	✓	✓	x	**5/6**
Patsy Roseblade Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
Carolyn Donoghue - Independent Member	✓	✓	✓	✓	x	✓	**5/6**

3.4 ATTENDEES

The Committee's work is informed by reports provided by leads within CTMUHB, Cwm Taf Community Health Council, Healthcare Inspectorate Wales, Audit Wales, Internal Audit and the Delivery Unit. Although not members of the Committee, colleagues from these areas are invited to attend each meeting of the Quality & Safety Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. QUALITY & SAFETY COMMITTEE BUSINESS

The Quality & Safety Committee provides an essential element of the Health Board's overall assurance framework. All meetings continued to be held virtually via Microsoft Teams during 2022/2023 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Quality & Safety Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2022/2023 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Quality & Safety Committee are highlighted at full Board by the Committee Chair via the Committee highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

During the course of 2022-2023, the following items were referred to the Quality & Safety Committee from other Committees

- Internal Audit Follow Up Review - Patient Pathway Appointment Management Process – Audit & Risk Committee requested that updates on progress were included in the Chief Operating Officers Report.

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and from the Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference & Operating Arrangements
- Committee Annual Report
- Highlight Reports from the Committee to the Health Board meetings
- Annual Committee Effectiveness Self-Assessment Survey
- Annual Cycle of Committee Business

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

Committee Annual Self-Assessment

The Committee is in the process of completing its Annual Self-Assessment for 2022-2023, any learning and themes identified following the assessment will be presented to the Committee for review and consideration.

7. ASSURANCE TO THE BOARD

The Quality & Safety Committee considers that on the basis of the work completed by the Committee during 2022 - 2023, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2023-2024 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Listening and Learning Stories (Patient and Staff)
- Learning lessons and sharing best practice
- Maternity & Neonate Services oversight and scrutiny
- Quality Governance arrangements
- Compliance with the Nurse Staffing Levels (Wales) Act
- Quality improvement initiatives
- Scrutiny of any Regulatory and Inspectorate Body reports
- Consideration of the Audit Wales Structured Assessment feedback to consider how best to manage and prioritise the volume of the Committees business.
- Monitoring the activity considered by the Health, Safety & Fire Sub Committee established in August 2019

In addition the Committee Chair will meet with the lead officers and the Chair of the Board to discuss progress of the work of the Committee.

The Annual Cycle of Committee Business has continued to be presented to each meeting of the Committee during 2022/2023, alongside the Forward Work Programme. This supports and helps identify the key areas of focus for the Committee and is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.

8. LINKS WITH OTHER COMMITTEES

The Quality & Safety Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Audit & Risk Committee, Planning, Performance & Finance Committee and the People & Culture Committee.

As a Sub Committee of the Quality & Safety Committee, regular highlight reports are received from the Health Safety & Fire Sub Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

APPENDIX 1

1. Consent Agenda

During 2022 – 2023 the following items were received on the Consent Agenda for Approval/Endorsement:

- Quality & Safety Committee Annual Report 2021/2022;
- Quality & Safety Committee Annual Cycle of Business;
- Facilities Policy - Security Policy;
- Estates Policies - PAT Testing Policy;
- Quality & Safety Committee Terms of Reference;
- Children & Young People 16-17 year's Acute Admission Policy;
- Chairs Urgent Action - Policy Approvals;
- Independent Member Walkround Protocols.

During 2022 – 2023 the following items were received on the Consent Agenda for Noting/Information:

- Committee Forward Work Programme;
- Quality & Safety Committee Annual Self-Assessment;
- WHSSC Quality & Patient Safety Chairs Report;
- Audit Wales/Healthcare Inspectorate Wales Joint Review of Quality Governance – Summary of Progress made – April 2022;
- Welsh Ambulance Services NHS Trust - Patient Experience Reports;
- Community Acquired Pressure Ulcer Improvement Plan Update and Measurement Strategy;
- Quality Governance - Regulatory Review Recommendations and Progress Updates;
- Controlled Drug Accountable Officer Annual Report;
- GAP Analysis Children's Community Nursing Service;
- GIRFT Review of Cwm Taf Morgannwg University Health Board February 2022;
- Human Tissue Authority Act Progress Reports;
- WHSSC Quality & Patient Safety Committee Annual Report;
- Putting Things Right Annual Report;
- RADAR Committee Highlight Reports;
- Clinical Audit Quarterly Report and Annual Plan;
- Individual Patient Funding Request Annual Report;
- Learning Disabilities 6 Monthly Progress Report;
- Community Health Council National Surveys and Quality Monitoring Reviews;
- Incident Management Framework - Listening, Learning & Improving Safety;
- Health & Care Standards Annual Report;
- Radiation Safety Committee Highlight Reports;
- Thematic Review of the feedback received from the Community Health Council - Primary Care;
- Transition and Handover from Children to Adults Health Services;
- Health & Care Standards Annual Report;
- National Prescribing Indicator (NPI) Annual Report;

- Clinical Education Annual Report;
- Annual Review 2021/22 – Welsh Risk Pool and Legal & Risk Services;
- Safeguarding & Public Protection Annual Report

2. Main Agenda

During 2022 – 2023 the following items were received:

- Patient Experience/Listening & Learning Stories;
- Sepsis Compliance Improvement Plan;
- Organisational Risk Register - Risks Assigned to the Quality & Safety Committee;
- Concerns, Redress, Claims & Inquests – Actions arising from Internal Audit & Welsh Risk Pool Reviews (also received via the consent agenda on occasion);
- Health, Safety & Fire Sub Committee Highlight Reports (also received via the consent agenda on occasions when no issues to escalate);
- Maternity & Neonates Services Improvement Programme;
- Presentation of PREMS (Patient Reported Experience Measures);
- Maternity Services Self-Assessment Against Ockenden 2022 Recommendations;
- RCOG Recommendations Closure Report;
- Maternity Metrics Report;
- Quality Dashboard Report;
- Spotlight Report on Patient Falls;
- Report from the Chief Operating Officer;
- Planned Care Recovery – Presentations;
- Cancer Services Annual Report;
- Stroke Services Progress Report;
- National Nosocomial Covid-19 Programme - CTM Update (also received on the consent agenda on occasion);
- Response to 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability;
- Infection, Prevention & Control Committee Highlight Reports (routinely received on the consent agenda – added to main agenda when items for escalation had been identified);
- Digitisation of the Nursing Care Record;
- Prince Charles Hospital Neonatal Deep Dive Review Update
- NHS Delivery Unit Findings Report: CTMUHB Maternity and Neonatal Services Serious Incidents Assurance Review & Board Systems and Processes for Reporting, Management and Review of Patient Safety Incidents;
- Ty Llidiard Progress Report;
- Quality & Performance of Service Provision HMP and Young Offenders Institute Parc;
- Dental Contract Reform;
- Development of a Quality Strategy;
- Patient Falls and Absconsions Lessons Learnt Report;
- Covid 19 Inquiry Preparedness;

- Assurance on the Health Board's plan to improve monitoring and reporting in relation to Continuing Healthcare (CHC) and Funded Nursing Care (FNC) activity;
- Annual Letter 2021/2022 – Public Services Ombudsman for Wales;
- NCCU Quality Assessment and Improvement Service - Annual Quality position statement;
- Datix Cymru - Assurance Report;
- Learning from Mortality Reviews/Mortality Indicators Report;
- Civica - People's Experience Feedback System;
- Peer Review of Urgent Primary Care (Out of Hours and UPCC) In CTMUHB;
- Ward Based Nursing Assurance Report;
- Learning From Events Reports - Progress Report;
- CTMUHB Quality and Safety Framework 2022-2025;
- Deep Dive into CAMHS;
- Liberty Protection Safeguards Preparation;
- Child T - Child Practice Review;
- Care Group Spotlight Presentation - Mental Health & Learning Disabilities;
- Care Group Spotlight Presentation - Unscheduled Care;

Integrated Quality & Safety Exception Reports were received up to September 2022 from the following areas:

- Bridgend Integrated Locality Group;
- Merthyr & Cynon Integrated Locality Group
- Rhondda Taff Ely Integrated Locality Group;
- Primary Care Directorate.

The Health Board implemented a new organisational structure during 2022-2023 and reporting changed from Integrated Locality Group reports to a Care Group Structure. Care Group Highlight Reports were received from the following areas:

- Planned Care;
- Unscheduled Care;
- Children & Families;
- Diagnostics, Therapies, Pharmacy & Specialities;
- Primary Care and Community;
- Mental Health & Learning Disabilities.

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Remuneration & Terms of Service Committee

Annual Report (April 2022 – March 2023)

FOREWORD

I am delighted to present the 2022/2023 Annual Report of the CTMUHB Remuneration and Terms of Service Committee and would like to take this opportunity to thank all those involved in the work of the Committee for their contributions over the past year.

Jonathan Morgan, Committee Chair / Chair, CTMUHB.

REMUNERATION & TERMS OF SERVICE COMMITTEE
Annual Report 2022/2023

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between 1st April 2022 and 31st March 2023 and highlights some of the key issues to which the Committee intends to give further consideration going forward.

1.2 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework.

2. Role and Responsibilities

2.1 The primary purpose of the committees is to:

- Provide advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government
- Seek assurance on behalf of the Board in relation to the CTMUHB's arrangements for the remuneration and terms of service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales

The Committee also receives reports relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers (VSMs) of hosted bodies, e.g. Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).

3. Agenda Planning Process

3.1 The Executive Lead for this Committee is the Executive Director for People who works in tandem with the Director of Corporate Governance/Board Secretary with a view to a meeting agenda being produced for each meeting.

3.2 The secretariat for the meeting is provided through the Director of Corporate Governance/Board Secretary mainly via the Head of Corporate Governance & Board Business.

3.4 The agenda and corresponding reports are disseminated to Committee members in advance of each meeting. Where appropriate, reports are accompanied by a coversheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 The Annual Review of the Committee's Terms of Reference and Operating arrangements was most recently undertaken at the meeting held in December 2023 when no changes were made. The Committee Cycle of Business was most recently received and approved with no amendments when the Committee met in March 2023.

4.3 The agendas for each meeting are sufficiently flexible to allow the committee to consider emerging issues.

5. Membership, Frequency and Attendance

5.1 Following a decision approved by the Board in November 2020, all Independent Members now attend meetings of the Committee. During the year the Committee met on nine occasions with member attendance as follows:

Independent Member	Attendance at Remuneration Committee meetings during 2022-2023
Emrys Elias (Until 31st March 2023)	5/6
Jayne Sadgrove	6/6
Dilys Jouvenat	5/6
Mel Jehu	6/6
Ian Wells	5/6
Nicola Milligan	6/6
James Hehir	5/6
Patsy Roseblade	6/6
Carolyn Donoghue	3/6
Lynda Thomas	5/6
Geraint Hopkins	4/6

5.3 The Committee requires the attendance of other CTMUHB Officers (or their representatives) for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

6.1 During 2022-2023 the Committee received and considered reports relating to the recruitment, remuneration and appointment arrangements for substantive as well as interim Executive Team appointments and other senior Welsh NHS appointments relevant to CTMUHB. The Committee also considered and approved a number Voluntary Early Release Scheme applications together with requests to ratify urgent Chair's Action.

7. Committee Effectiveness & Performance

7.1 A committee effectiveness questionnaire was issued in November 2022 prior to the completion of this Annual Report. The feedback from that was received when the Committee met in December 2022. The next survey will be issued during the summer of 2023.

8. Reporting the Committee's Work

8.1 The Committee Chair reports to Board the key issues discussed at each of its meetings by way of a 'Highlight Report'.

9. Conclusion and way forward

9.1 The Committee is grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed.

9.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice. This will provide the assurance that the Committee has the appropriate governance arrangements and resources in place to ensure success in achieving its objectives.

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Appendix 3

Stakeholder Reference Group

Annual Report 2022-2023

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STAKEHOLDER REFERENCE GROUP (SRG)
ANNUAL REPORT 2022-23

1. FOREWORD

I am pleased to present the Annual Report of the Stakeholder Reference Group. The purpose of this report is to formally report on the work of the Group for the year ending 31 March 2023 in accordance with the Terms of Reference.

2022-23 was another challenging year with the effects of the Covid-19 pandemic continuing to impact the health board along with new challenges including the cost of living crisis affecting communities. The Stakeholder Reference Group has continued to foster and promote a culture of working in partnership for the CTM population. 2022-2023 was my first year as the SRG Chair and I would like to extend my thanks to my predecessor Sharon Richards, former SRG Chair. Sharon was key in guiding the Group to its current status and I wish Sharon the best of luck for her future endeavours.

As Chair, I have ensured that the work of the Group progresses in line with its Terms of Reference, which have been amended this year in response to the needs of the Group. The programme of work delivered this financial year has spanned a number of themes and have featured presentations from CTMUHB, Local authorities and third sector across Rhondda Cynon Taf (RCT), Merthyr and Bridgend, highlighting a partnership approach to regional working.

I would like to express my thanks to all the officers of the Health Board, Local Authorities and third sector organisations who have supported and contributed to the work carried out.

Anne Morris –Chair of Stakeholder Reference Group

2. INTRODUCTION

The Stakeholder Reference Group is chaired by the Deputy Chief Executive of Interlink. The work of this Group, including its Terms of Reference, were reviewed and refreshed 30th March 2023. The SRG has continued to evolve with changes to report format and agenda content during the year.

The Committee meets on a bi-monthly basis and, following each meeting, produces a highlight report which is then submitted to the next Board meeting to highlight key issues and risks.

The purpose of the SRG is to provide independent advice on any aspect of UHB business. This may include:

- Early engagement and involvement in the determination of the UHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB's operations on the communities it serves.

The SRG is also responsible for developing an annual report for presentation to the Health Board.

3. MEMBERSHIP The membership of the Stakeholder Reference Group comprises of members from within the health board and includes involvement from a range of bodies and groups operating within the communities serviced.

Independent membership during 2022-23 was as follows:

- Anne Morris – Chair and County Volunteer Councils Representative (RCT)
- Third sector Representative (RCT)
- Third sector Representative (Bridgend)
- Patient Representative (CTUMHB)
- Carer Representative (Merthyr Tydfil)
- Carer Representative (RCT)
- Carer Representative (Bridgend)
- County Volunteer Councils Representative (Merthyr Tydfil)
- County Volunteer Councils Representative (Bridgend)
- Carer Forum Wales Representative
- Local Authority elected Member (Merthyr Tydfil)
- Local Authority elected Member (RCT)
- Local Authority elected Member (Bridgend)
- Local Authority member (Merthyr Tydfil)
- Local Authority member (RCT)
- Local Authority member (Bridgend)
- Over 55's Representative (Merthyr Tydfil)

- Over 55's Representative (RCT)
- WAST Representative

There are several vacancies within the SRG for advisory group members as follows:

- Third sector representative (Merthyr Tydfil)
- Town Council Representative
- Over 55's Representative (Bridgend)

Action is underway to seek replacement nominees and regular meetings will be held between the SRG Secretariat and Chair to monitor updates on this process.

4. MEETINGS

The Stakeholder Reference Group aim to meet bi-monthly and the Group met on six occasions during 2022/23, on the following dates:

- 6th April 2022 (reported to the Board on 26 May 2022)
- 16th June 2022 (reported to the Board on 28 July 2022)
- 15th August 2022 (reported to the Board on 29 September 2022)
- 11th October 2022 (reported to the Board on 24 November 2022)
- 8th December 2022 (reported to the Board on 26 January 2023)
- 9th February 2023 (reported to the Board on 30 March 2023)

The SRG covers a breadth of themes covering the whole remit of the health board, including a sample as below (last few meetings)

- Mental health and learning disabilities
- Cancer
- Winter pressures
- Primary Care
- Volunteering (this is not an exhaustive list)

Stakeholder Reference Group Independent members attendance	6 April 2022	16 June 2022	15 August 2022	11 October 2022	8 December 2022	9 February 2022
Chair / CVCs (RCT)	√	√	√	√	√	√
Patient Representative (Merthyr Tydfil)						

Patient Representative (Bridgend)			√		√	
Third sector representative (RCT)					√	√
Third sector representative (Bridgend)		√				
CVCs Representative (Merthyr Tydfil)		√			√	√
CVCs Representative (Bridgend)	√	√				√
Carer Forum Wales Representative					√	√
Local Authority elected Member (Merthyr Tydfil)						
Local Authority elected Member (RCT)		√	√	√		
Local Authority elected Member (Bridgend)	√		√	√	√	√
Local Authority Member (Merthyr Tydfil)	√	√		√		
Local Authority Member (RCT)	√	√			√	
Local Authority Member (Bridgend)						
Over 55's Representative (Merthyr Tydfil)		√	√	√	√	
Over 55's Representative (RCT)	√	√	√	√	√	√
Over 55's Representative (Bridgend)		√				
WAST Representative						
Town Council Representative	√			√		
CHC Representative	√		√	√	√	
Total Members in attendance	8	10	7	8	10	7

The SRG Terms of Reference were reviewed and approved by the Committee at its February meeting with no amendments however additions were made around quoracy (which will be reviewed going forward) and review and were approved by the Health Board 30th March 2023. For completeness, this Annual Report provides at **Appendix 2,** the current Terms of Reference.

5. MAIN AREAS OF SRG COMMITTEE ACTIVITY

The agenda for each meeting has followed a standard format in four main parts:

- Part 1 - Preliminary Matters
- Part 2 - Items for Discussion
- Part 3 - Items for Information
- Part 4 - Other Matters.

Part 1 - Preliminary Matters
This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB. This includes welcome and apologies, declarations of interest and minutes of the previous meeting which are agreed by members as a true and accurate record.

Part 2 - Items for Discussion
This section has included receiving the updates and presentations from a wide array of speakers, to actively engage with SRG members on health board and wider community issues.

Part 3 - Items for Information
This section has regularly brought the SRG forward work programme to members' attention, to note the contents of the work programme. Members have been encouraged to suggest future topics for consideration and discussion at SRG Meetings (including providing details of engagement and consultations that members can be involved in outside of the meeting).

Part 4 - Other Matters
This section allows members of the SRG to highlight any other business that they wish to discuss.

Links with Other Committees/Boards
Where appropriate a process is in place for any relevant matters to be referred to other Board Committees for scrutiny and or action.

6. ACTION LOG
In order to monitor progress and any necessary follow-up action, the SRG captures actions in the minutes that are produced, that captures all agreed actions and this is reviewed at the beginning of each meeting.

7. GOVERNANCE
The SRG provides an essential element of the overall governance framework for the organisation. The Terms of Reference provide a robust commitment to monitor the application of the SRG

8. ASSURANCE TO THE BOARD

Through the structure of highlight reports and feedback to the board, the SRG provides assurance that stakeholder groups have;

- Been able to undertake early engagement and involvement in the determination of the UHB's overall strategic direction, for example, the SRG received updates on the development of the Integrated Medium Term Plan.
- Provided advice and feedback from the perspective of patients and wider stakeholders on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB's operations on the communities it serves.

The SRG wishes to assure the Board that through the process of the effectiveness survey, the group will continue to develop and scrutinise its' approach.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Appendix 1

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

STAKEHOLDER REFERENCE GROUP COMMITTEE

TERMS OF REFERENCE & Operating Arrangements

(Approved by the Health Board 30th March 2023)

Stakeholder Reference Group

Terms of Reference and Operating Arrangements

THE STAKEHOLDER REFERENCE GROUP (SRG)

1.1 Role

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

- Early engagement and involvement in the determination of the UHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB's operations on the communities it serves.

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

1.1.3 The SRG's role is distinctive from that of Community Health Councils (CHCs), who have a statutory role in representing the interests of patients and the public in their areas. The SRG shall represent those stakeholders who have an interest in, and whose own role and activities may be impacted by the decisions of the UHB. Membership may include community partners, provider organisations, special interest and other groups operating within the UHBs area.

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

1.1.5 In addition to the provisions in 1.1.3 above the Board must set out, the relationships and accountabilities with others, such as the Regional Partnership Board.

1.2 Membership

1.2.1 The membership of the SRG, including the approval of nominations to the Group; the appointment of Chair and Vice Chair; definition of member roles, powers and terms and conditions of appointment (including remuneration and reimbursement) will be determined by the Board, taking account of the views of its stakeholders.

1.2.2 There shall be no minimum or maximum requirement in terms of membership size. In determining the number of members, the Board shall take account of the need to ensure the SRG's size is optimal to ensure focused and inclusive activity.

1.2.3 Membership must be drawn from within the area served by UHB, and shall ensure involvement from a range of bodies and groups operating within the communities serviced by the UHB. Where the Board determines it appropriate, the UHB may extend membership to individuals in order to represent a key stakeholder group where there are not already formal bodies or groups established or operating within the area and who may represent the interests of these stakeholders on the SRG.

1.2.4 In determining the overall size and composition of the SRG, the Board must take account of the:

- Demography of the areas served by the UHB;
- Need to encourage and reflect the diversity of the locality, to incorporate different ages, race, religion and beliefs, sexual orientation, gender, including transgender, disability and socio-economic status. Where appropriate, the UHB shall support positive action to increase representation;
- Balance needed in both the range of difference stakeholders and the geographical areas covered, taking particular care to avoid domination by any particular stakeholder type or geographical area;
- Design and operation of the partnership/stakeholder fora already influencing the work of the UHB at local community levels;
- Need to complement, and not duplicate the work of CHCs; and
- Need to guard against the over involvement of particular stakeholders through their roles across the range of partnership/stakeholder arrangements in place.

1.2.5 The Board shall keep under review the size and composition of the SRG to ensure it continues to reflect an appropriate balance in stakeholder representation.

1.2.6 A minimum of one third of members which includes the SRG Chair or Vice Chair, plus an appropriate senior officer of the UHB must be present to ensure the quorum of the SRG. Meetings shall be held no less than quarterly, and otherwise as the Chair of the SRG deems necessary. The Director of Corporate Governance / Board Secretary, on behalf of the health board's Chair, will ensure that the SRG is properly equipped to carry out its role by arranging the provision of advice and support to members on any aspect related to the conduct of their role.

1.2.7 If a meeting is not quorate, this will be noted in the minutes, however the meeting will continue to ensure members are able to receive relevant updates in a timely manner. If the meeting content requires advice to be provided to the health board, all absent

members will receive details of the discussion and information to provide their comments to ensure a full membership response.

1.0.1

1.3 Member Responsibilities and Accountability:

The Chair

1.3.1 The Chair is responsible for the effective operation of the SRG:

- Chairing Group meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Group business is conducted in accordance with its agreed operating arrangements; and
- Developing positive and professional relationships amongst the Group's membership and between the Group and the UHB's Board and its Chair and Chief Executive.

1.3.2 The Chair shall work in close harmony with the Chairs of the UHB's other advisory groups, and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Group in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.3 As Chair of the SRG, they may as an Associate Member of the UHB Board. The Chair is accountable for the conduct of their role as Associate Member on the UHB Board to the Minister, through the UHB Chair. They are also accountable to the UHB Board for the conduct of business in accordance with the governance and operating framework set by the UHB.

The Vice Chair

1.3.4 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new chair is appointed, and this deputisation includes acting in the role of Associate Member of the UHB Board.

1.3.5 The Vice Chair is accountable, through the SRG Chair to the UHB Board, for their performance as Vice Chair, and to their nominating body or grouping for the way in which they represent their views at the SRG.

Members

1.3.6 The SRG shall function as a coherent Advisory Body, all members being full and equal members and sharing responsibility for the decisions of the SRG.

1.3.7 All members must:

- Be prepared to engage with and contribute fully to the SRG's activities and in a manner that upholds the standards of good governance – including the values and standards of behaviour – set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the SRG within the communities it represents.

1.3.8 SRG members are accountable, through the SRG Chair to the UHB Board for their performance as Group members, and to their nominating body or grouping for the way in which they represent the views of their body or grouping at the SRG.

1.3.9 Members are encourage to provide and invite a deputy to attend in their absence to ensure a wide representation at meetings.

1.3.10 In circumstances where the SRG is providing feedback to the Board on a particular issue and not all members or their representatives were able to attend relevant SRG meeting, the SRG secretariat will (at the request of the SRG Chair/Vice Chair) contact members by email to provide an opportunity for those not present to contribute by a given deadline.

1.0.2

1.4 Appointment and terms of office

1.4.1 Appointments to the SRG shall be made by the Board, based upon nominations received from stakeholder bodies/groupings. The Board may seek independent expressions of interest to represent a key stakeholder group where it has determined that formal bodies or groups are not already established or operating within the area that may represent the interests of these stakeholders on the SRG.

1.4.2 The nomination and appointment process shall be open and transparent, and in accordance with any specific requirements or directions made by the Welsh Ministers. The appointments process shall be designed in a manner that meets the communication and involvement needs of all stakeholders eligible for appointment;

1.4.3 The Board Secretary, on behalf of the Chair of the UHB, will oversee the process of nomination and appointment to the SRG.

1.4.4 Members shall be appointed for a period specified by the Board, but for no longer than 3 years in any one term. Those members can be reappointed but may not serve a total period of more than 5 years consecutively. The Board may, where it considers it appropriate, make interim or short term appointments to the SRG to fulfil a particular purpose or need.

1.4.5 The ***Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration by the UHB Board, who must submit a recommendation on the nomination to the Minister for Health and Social Services. The appointment as Chair shall be made by the Minister, but it shall not be a formal public appointment. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board, and the appointment of the Chair to this role is on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

1.4.7 The ***Vice Chair*** shall be nominated from within the membership of the SRG, by its members, in a manner determined by the Board, subject to any specific requirements or directions made by the Welsh Ministers. The nomination shall be subject to consideration and appointment by the UHB Board. The Constitution Regulations provide that the Welsh Ministers may appoint an Associate Member of the Board. In the SRG Chair's absence, the Vice Chair shall also perform the role of Associate Member on the UHB Board. The appointment of the Vice Chair is therefore also on the basis of the conditions of appointment for Associate Members set out in the Regulations.

1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for an additional one (1) year, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

1.4.9 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform the SRG Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The SRG Chair will advise the Board in writing of any such cases immediately.

1.4.10 The UHB will require SRG members to confirm in writing their continued eligibility on an annual basis.

1.5 Resignation, suspension and removal of members

1.5.1 A member of the SRG may resign office at any time during the period of appointment by giving notice in writing to the SRG Chair and the Board.

1.5.2 If the Board, having consulted with the SRG Chair and the nominating body or group, considers that:

- It is not in the interests of the health service in the area covered by the SRG that a person should continue to hold office as a member; or
- It is not conducive to the effective operation of the SRG

it shall remove that person from office by giving immediate notice in writing to the person and the relevant nominating body or group.

1.5.3 A nominating body or group may request the removal of a member appointed to the SRG to represent their interests by writing to the Board setting out an explanation and full reasons for removal.

1.5.4 If an SRG member fails to attend any meeting of the Group for a period of six months or more, the Board may remove that person from office unless they are satisfied that:

1.0.3

i) The absence was due to a reasonable cause; and
ii) The person will be able to attend such meetings within such period as the Board considers reasonable.

1.5.5 Before making a decision to remove a person from office, the Board may suspend the tenure of office of that person for a limited period (as determined by the Board) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the Board suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

1.6 Relationship with the Board

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

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

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

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

1.0.4

1.7 Relationship between the SRG and others

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

- Ensure effective links and relationships with other advisory groups, local and community partnerships and other key stakeholders who do not form part of the SRG membership;
- Ensure its role, responsibilities and activities are known and understood by others; and
- Take care to avoid unnecessary duplication of activity with other bodies/groups with an interest in the planning and provision of NHS services, e.g., Regional Partnership Boards.

1.8 Working with Community Health Councils

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

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

1.9 **REVIEW**

1.0.5 These Terms of Reference shall be reviewed annually by the Group and submitted to the Board for approval

APPENDIX 1

Cwm Taf Morgannwg University Health Board
Stakeholder Reference Group (SRG) Member
Role Description & Personal Specification

Aim of role

- To represent a defined stakeholder body or grouping, e.g. patient, carer etc, who have an interest in, or whose own role and activities may be impacted by the decisions of Cwm Taf Morgannwg University Health Board (UHB).

Accountability

- You are accountable, through the SRG Chair, to the UHB for your performance as a Group member.
- It is expected that if you resign, that you notify both the Chair and the relevant electing and/or (if applicable) the nominating body, e.g. County Voluntary Council, Local Authority etc.

Responsible to:
The SRG Chair.

Time commitment
A minimum of six meetings per annum, of approximately two hour's duration.

Term of Office
- No longer than three (3) years in any one term. Members can be reappointed but may not serve a total period of more than five (5) years consecutively. Those people who are nominated need to declare if they take on a different role within their nominating organisations (if this applies to the member in question) which affects their ability to represent the views of the organisation/specialist interest group they represent at the SRG.

Key working relationships
- To work closely with the SRG Chair.
- Wherever possible, SRG members should attend the local community groups they represent or other relevant Fora to maintain good working relationships and gather views from stakeholders.
- Where appropriate, SRG members should maintain good working relationships with the UHB, local and community partnerships and other key stakeholders who do not form part of the SRG membership.

Role
You will be expected to:
- Regularly commit to the meetings of the SRG.
- Represent your specialist interest group or organisation at SRG meetings.
- Express opinions clearly and allow others to express theirs.
- Share responsibility for the recommendations of the SRG with other members.
- Promote the work of the SRG in the community it represents.
- Undertake appropriate induction and development training identified by the SRG Chair or UHB.

Key tasks
- Meaningfully engage in the meeting in relation to your special interest group or organisation.
- Suggest ways in which the UHB could better engage with your special interest group or organisation.
- Engage with and contribute fully in SRG activities, accepting responsibility to share workload with other members where identified and completing tasks to set timescales.

Remuneration
SRG members are not paid.

Cwm Taf Morgannwg University Health Board
Stakeholder Reference Group (SRG) Member
Personal Specification

All SRG members will be required to demonstrate the following qualities:

Commitment

- A commitment to the work of the SRG, believing in its purpose and functions.
- Reliable, punctual and professional in attendance and conduct at meetings.
- Willingness to participate in the continuing development of the SRG.
- Compliant with the terms and conditions of the appointment.

Attitude and Approach

- Respectful and appreciative of the contribution that others make.
- Welcoming and encouraging towards people from different backgrounds who may bring with them different opinions and perspectives.
- Sensitive, diplomatic and tactful in dealing with others.
- Flexibility in approaching complex problems and issues.
- Willing to learn new information and contribute to solving problems.

Skills and Experience

- A current connection to the nominating group, body you are representing at the SRG or special interest group, e.g. patient, carer etc.
- Ability to work as part of a team.
- Experience of dealing with confidential issues.
- Ability to consider reports and other documentation and contribute to discussion and decisions.

APPENDIX 2 **SRG CHAIR ROLE DESCRIPTION & PERSON SPECIFICATION**

Cwm Taf Morgannwg University Health Board
Stakeholder Reference Group (SRG) Chair
Role Description

Aim of role

- To ensure the effective operation of the SRG as a coherent Advisory Body, developing positive and professional relationships between the SRG, Cwm Taf Morgannwg University Health Board (UHB) and its Chair and Chief Executive.

Accountability

- As Chair of the SRG, you will be appointed as an Associate Member of the UHB. You will be accountable for the conduct of your role as Associate Member to the Minister, through the UHB Chair.
- You are required to sign the Official Secrets Act as directed by the Minister.
- You are also accountable to the UHB for the conduct of business in accordance with the governance and operating framework set by the UHB.

Responsible to:

- The UHB Chair.

Time Commitment

- A minimum of six SRG meetings, six UHB Board meetings and six Board Development sessions per annum, with other related meetings as required.

Term of Office

- The Chair's Term of Office shall normally be for a period of up to two years, with the ability to stand as Chair for an additional year.
- You may remain as a member of the SRG after your appointment as Chair has ended for the remainder of your term.

Key Working Relationships

- UHB Chair, Chief Executive and Board Secretary.
- Lead Executive for SRG, management support and secretariat.
- SRG members and UHB members
- HB's other Advisory Groups and Committees
- Local and community partnerships and other key stakeholders who do not form part of the SRG membership.

Role
You will be expected to:
- Chair SRG meetings.
- Attend meetings of the UHB, providing advice on behalf of the SRG where appropriate.
- Report regularly to the HB on SRG activities.
- Work with the HB to maintain a strong SRG membership.
- Promote the work of the SRG within the community it represents.
- Undertake appropriate induction and development training identified the UHB.

Key tasks
- Lead the SRG to provide a forum to facilitate full engagement and active debate amongst stakeholders from across the UHB area.
- Provide formal feedback to the SRG from the Health Board meetings.
- Aim to reach and present a cohesive and balanced stakeholder perspective to inform the UHB's decision making, this will include the provision of:
  - Advice on specific service proposals prior to formal consultation.
  - Feedback on the impact of UHB operations within the community.
  - Early stakeholder engagement and involvement for our UHB when it is shaping its overall strategic direction.
  - Casting vote on decisions will remain with the Chair.

Remuneration
The SRG Chair is not a paid role.

Cwm Taf Morgannwg University Health Board
Stakeholder Reference Group (SRG) Chair
Personal Specification

As SRG Chair, you will be required to demonstrate the following qualities:

Commitment

- A commitment to the work of the SRG, believing in its purpose and functions.
- Reliable, punctual and professional in attendance and conduct at meetings.
- Willingness to participate in the continuing development of the SRG and UHB.
- Compliant with the Terms and Conditions of the appointment.

Attitude and Approach

- Ready to develop positive working relationships with others.
- Respectful and appreciative of the contribution that SRG members make.
- Welcoming and encouraging towards people from different backgrounds who may bring with them different opinions and perspectives.
- Sensitive, diplomatic and tactful in dealing with others.
- Flexibility in approaching complex problems and issues.
- Willing to learn new information and contribute to solving problems.

Skills and Experience

- Experience of leading programmes of work and people.
- Ability to analyse complex information, collate views and develop concise reports.
- Ability to influence and be persuasive.
- Ability to work as part of a team.
- Experience of dealing with confidential issues.

Eligibility exemptions

- Statutory nominated members and members in attendance are NOT eligible to run for Chair.

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Appendix 4

Mental Health Act (MHA) Monitoring Committee

Annual Report 2022-2023

MENTAL HEALTH ACT (MHA) MONITORING COMMITTEE ANNUAL REPORT 2022-23

1. FOREWORD

I am pleased to present the Annual Report of the Mental Health Act Monitoring Committee for the period 2022-2023. The purpose of this report is to report formally on the work of the Committee for the year ending 31 March 2023 in accordance with the Committee's Terms of Reference.

I would like to express my thanks to all the officers of the Health Board, Local Authority Partners and South Wales Police who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines.

As members of the Committee will be aware, Philip Lewis, Head of Nursing for Mental Health has recently retired and I would like to extend my thanks to him for the important contribution he had made to the Committee. We now have a new Nurse Director for Primary Care, Community and Mental Health, Ana Llewellyn, who is a member of the Committee.

The Committee has continued to foster and promote a culture of working in partnership with a view to service improvement for the Cwm Taf Morgannwg population. As Chair, I have ensured that the work of the Committee progresses in line with its Terms of Reference and also ensured that crossover work is seamless with the Together for Mental Health Partnership Board which I also chair.

This will be my final Committee Annual Report submission as my time with the Health Board drawing to a close at the end of the summer of 2023. The term of office of two more long standing colleagues who are members of the Committee, James Hehir, and Mel Jehu will also come to an end over the coming months. I would therefore wish to take this opportunity to extend my personal thanks to them for their commitment, contributions and scrutiny of issues.

Jayne Sadgrove
Chair, Mental Health Act (MHA) Monitoring Committee/ Vice Chair, CTMUHB.

2. INTRODUCTION

The MHA Monitoring Committee is chaired by the Vice-Chair of the Health Board and monitors the Health Board's compliance with the statutory requirements of the MHA. The work of this Committee and its Terms of Reference, were reviewed and approved by the Board refreshed in January 2023 and are presented along with this annual report for further review to reflect changes to the membership that now includes the Service Care Groups. The Committee has continued to evolve with changes to report format and agenda content during the year.

As part of CTMUHB's commitment to openness and transparency, the meeting papers for this Board Committee are routinely published on the CTMUHB website.

The Committee meets on a quarterly basis and, following each meeting, produces a highlight report which is then submitted to the next Board meeting to highlight key issues and risks.

The purpose of the MHA Monitoring Committee is to ensure that all the requirements of the MHA 1983 (as amended) are met by the Health Board.

The Committee considers:

- how the delegated functions under the MHA are being exercised (for example using the Annual Audit) and in line with the 'Code of Practice' requirements
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- the operation of the 1983 Act within the Cwm Taf Morgannwg area
- issues arising from the operation of the hospital managers' power of discharge
- suitable mechanisms for reviewing multi agency protocols / policies relating to the 1983 Act
- trends and patterns of use of the MHA 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice.

The Committee is also responsible for developing an annual report for presentation to the Health Board.

3. MEMBERSHIP

The membership of the MHA Monitoring Committee comprises both Independent and an Executive Director Members, enabling the Committee to

provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

Independent membership of the Committee during 2022-23 was as follows:

- Jayne Sadgrove, Vice Chair of the Health Board (Chair of the Committee)
- James Hehir, Independent Member (Vice Chair of the Committee)
- Mel Jehu, Independent Member
- Geraint Hopkins, Independent Member

4. MEETINGS

The MHA Monitoring Committee met on four occasions during 2022/23 and its forward work programme was reviewed to ensure that issues were appropriately prioritised.

The four dates on which it met during 2022-23 were as follows:

- 8 June 2022
- 12 October 2023
- 7 December 2022
- 8 March 2023

Mental Health Act Monitoring Attendance 2021-2022		**8 June 2022**	**12 Oct 2022**	**7 Dec 2022**	**8 Mar 2023**	**Total**
Jayne Sadgrove (Chair)	Vice Chair, Independent Member	√	√	√	√	**4/4**
Mel Jehu	Independent Member	X	√	√	√	**3/4**
James Hehir	Independent Member	√	X	√	√	**3/4**
Geraint Hopkins	Independent Member	√	X	X	√	**2/4**

All of the above meetings were quorate.

The Committee's Terms of Reference were reviewed and approved by the Committee at its December 2022 meeting with minor amendments made and were approved by the Health Board in January 2023. The Terms of Reference are presented to Board for approval as part of the Amendments to Standing Orders report at agenda item 8.1.5 reflecting further amendments in respect of Committee attendees following implementation of Care Group arrangements at operational management level.

5. MAIN AREAS OF MHAM COMMITTEE ACTIVITY

The agenda for each meeting has followed a standard format in five main parts:

- Part 1 - Preliminary Matters
- Part 2 - Items for Approval/Discussion
- Part 3 - Governance, Performance and Assurance
- Part 4 - For Information / Other Matters.

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB. This includes the action log which captures all areas for attention following the meeting.

Part 2 - Items for Approval / Discussion

This section has included receiving the:

- Committee Annual Report 2021-2022 and self-assessment questionnaire
- Results of the Committee Self-Assessment and Self-Assessment Action Plan
- Committee Annual Cycle of Business 2023-2024.

Part 3 - Governance, Performance and Assurance

This section has included reports throughout the year which included:

- Mental Health Act – Quarterly Activity Statistical Report
- Report from Mental Health Operational Group
- Strategic update from South Wales Police (Section 13,15 & 136) - including mental health staff in police control centre
- Strategic update from Local Authority Partners
- Mental Health Act Breaches Relating to the Mental Health Act
- Risks related to the Monitoring of the Mental Health Act
- Crisis Care Concordat
- Processes for Learning Lessons Including Those Related to the Application of the MHA.
- Use of the MHA for Patients with a Learning Disability.
- Update on the South Wales Police Mental Health APP.
- Healthcare Inspectorate Wales Report on Child and Adolescent Mental Health (CAMHS) – Action Plan Progress Report.

Part 4 - For Information / Other Matters

There were no items shared during the meetings held in 2022-2023 under this agenda heading.

The Committee's 'Forward Work Plan' was received at each meeting to ensure appropriate focus of its area of remit.

A Committee Highlight Report is produced following each meeting and subsequently presented to the next available Board meeting.

Links with Other Committees/Boards
Where appropriate a process is in place for any relevant matters to be referred to other Board Committees for scrutiny and or action.

6. ACTION LOG

In order to monitor progress and any necessary follow-up action, the Committee uses an Action Log that captures all agreed actions and this is reviewed at the beginning of each meeting.

7. GOVERNANCE

The Committee provides an essential element of the overall governance framework for the organisation. The Terms of Reference for the Committee provide a robust commitment to monitor the application of the MHA.

8. ASSURANCE TO THE BOARD

Like many service areas, mental health services were impacted by the pandemic and Welsh Government made provision for how the Mental Health Act could be applied and administered should the pandemic have warranted this. The committee was assured that patients' needs were met and full compliance with legislation maintained.

The Committee continued to receive updates regarding ongoing audit work and changes put into place to improve the application of the MHA and work to integrate approaches and policies in relation to the Act have again continued in year.

The MHA Monitoring Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2022-2023, there are effective measures in place to scrutinise and monitor the application of the MHA.

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DIGITAL & DATA COMMITTEE

(Draft) Annual Report 2022-2023

FOREWORD

I am pleased to present the second Annual Report of the CTMUHB Digital & Data Committee which outlines the activity between 1st April 2022 to 31st March 2023.

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information & data with a view to supporting health improvement and enabling high quality healthcare. It is also in being to seek assurance on behalf of the Board around arrangements for appropriate and effective management and protection of information (both patient and personal) as well as to provide advice and assurance to the Board in relation to the direction and delivery of CTMUHB's Digital and Data Strategies.

The Committee has continued to mature since its inception having received numerous reports during this period.

I would like to take this opportunity to thank all my fellow Independent Members who sit on the Committee for their invaluable contributions and scrutiny of the various issues which is essential for the effective operation of the Committee.

I commend the 2022-2023 Digital & Data Committee Annual Report to you.

Ian Wells,
Chair of the Digital & Data Committee/ Independent Member

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Digital & Data Committee
Annual Report 2022 -2023

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between April 2022 - March 2023 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

1.2 The Committee's Annual 'Business Cycle' was reviewed and approved at its March 2023 meeting and is a key component in ensuring that the Committee effectively carried out its role.

1.3 This report reflects the Committee's responsibilities in terms of the development and monitoring of the Governance and Assurance framework with regard to digital and data issues.

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to:

- oversee the development of strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales

- oversee the direction and delivery of the Health Board's Information Communication Technology (ICT), Data and Information Governance Strategies to drive change and transformation in line with the Health Board's Integrated Medium-Term Plan (IMTP) that will support modernisation through the use of information, data and digital technology

- consider implications arising from the development of corporate strategies and plans or those of its stakeholders and partners

- consider the implications of internal and external reviews and reports

- oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation)

- seek assurance through monitoring the Cyber Security Action plan

- review organisational risks assigned to the Committee by the Board and advise on the appropriateness of the scoring and mitigating actions in place.

- complete an annual self-assessment exercise in respect of the effectiveness of the Committee. (The output from this work is due to be considered as a separate agenda item).

- seek assurances that strategies and arrangements are appropriately designed and operating effectively to ensure the safety, security, integrity and effective use of information to support the delivery of high quality, safe healthcare across the whole of CTMUHB's activities.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Committee Vice-Chair, Executive Lead and Meeting Secretariat develop the agenda content in advance by holding an agenda planning meeting.

3.2 The secretariat for the meeting is provided through the Director of Corporate Governance team.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4. The Terms of Reference and Operating arrangements were most recently approved by the Board in September 2022 with minor amendments to the areas of responsibility within management portfolios and are attached as **Appendix 2** for reference.

4.2 Whilst the Committee Cycle of Business (which was most recently approved in March 2023), the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues as necessary.

5. Membership, Frequency and Attendance

5.1 The terms of reference of the Committee state that the Committee should consist of a minimum of **four** members of the Board details of which are set out on the next page.

5.2 During the year the Committee met on four occasions, namely:

- 22 June 2022
- 28 September 2022
- 19 December 2022
- 13 March 2023

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Name	Digital & Data Committee
Ian Wells (Committee Chair)	4 out of 4
Dilys Jouvenat (Committee Vice-Chair)	4 out of 4
Jayne Sadgrove	4 out of 4
Lynda Thomas	2 out of 4

5.3 The Committee have had representation from Digital Health & Care Wales (DHCW) at its 2022/23 meetings.

5.4 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

5.5 Mirroring other Board Committees, the Digital and Data Committee now operates a 'Consent Agenda' system for routine business consideration.

5.6 The vast majority of meeting papers are available publicly via the CTMUHB website. During 2022-23, the Committee held four 'in-Committee' meetings in respect of a very small number of items. In-Committee sessions are only held when the subject matter cannot be legitimately considered in the public domain due to business or commercial sensitivities. However, the subject matter of any one of these Digital and Data Committee 'in-committee' meetings has been routinely reported within the main agenda items of the next meeting of the Committee as well as the respective minutes of the in-committee meeting which are received in public session.

6. Committee Activity 2022/2023

6.1 The following topics were considered at its four meetings of 2022/23:

- **Highlight Reports:**
  - Digital Health Care Wales
  - Information Governance Group
  - Patient Centred Contact

- **Internal Audit Reports:**
  - IT Service Management Follow-Up
  - Digital Strategy
  - Network and Information Systems Directive (NIS-D)
  - Update on progress made in taking forward recommendations made by NHS Wales Internal Audit and Audit Wales

- Committee Referral from Audit & Risk Committee – Internal Audit Reports – Digital Operating Model and Medical Records Management
- Cyber Resilience in the Public Sector – Follow Up Report
- Learning from Cyber Attacks
- Cyber Security

- **Policy Approval**:
  - Live Streaming and Recording Policy
  - Freedom of Information Policy

- **Digital Assurance Report**
- **Digital Risks and Organisational Risk Register**
- **Cyber Security Report**
- **Cyber Improvement Report**
- **Digital Critical Incidents**

- **Other Reports:**
  - Presentation on Digital Whiteboards
  - Clinical Coding Strategy and Auto Coder Demonstration
  - Grant Thornton – Clinical Information Review – Presentation
  - Information Commissioners Office Audit Report Action Plan Progress Report
  - Bridgend Alignment Progress Report
  - Bridgend and Cwm Taf Aggregation Plan
  - Infrastructure Programme
  - Digital Communication
  - New Operating Model and Digital Response
  - Integrated Medium Term Plan 2023-26
  - Infrastructure Review – Management Response
  - Medical Records Assurance Report
  - ICT Major Schemes Update Report
  - Data Protection Improvement Plan
  - Medical Records Peer Review

7. Achievements and Plans

7.1 The Committee is continuing to mature in terms of its role and responsibilities set out within its Terms of Reference.

8. Committee Effectiveness & Performance

8.1 The Committee is committed to reviewing its effectiveness by completing this report on an annual basis, reviewing its cycle of business setting out the basis on which it will monitor its progress during the year, as well as providing clarity for all of those who contribute to the agenda as to the expectations of them. The outcome of the survey that will be undertaken during the summer of 2023 will be considered at the meeting to be held in September 2023 in order that recommendations and aligned actions can once again be developed and implemented in terms of areas identified for improvement.

9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings using a 'Highlight Report' to the Board.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to this important activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 This will provide assurance that the Committee has the appropriate governance arrangements and resources in place to ensure success in achieving its objectives.

11. Further Information

Visit the Health Board's website to access Digital & Data Committee papers.

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Appendix 1

Planning, Performance & Finance (PPF) Committee

Annual Report 2022/23

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

PLANNING, PERFORMANCE & FINANCE (PPF) COMMITTEE ANNUAL REPORT 2022/23

1. FOREWORD

I am pleased to present the Annual Report of the Cwm Taf Morgannwg UHB Planning, Performance & Finance (PPF) Committee for 2022-2023. The purpose of this report is to formally report on the work of the PPF Committee for the year ending 31 March 2023 in accordance with the Committee's Terms of Reference.

During the year my fellow Independent Members – Nicola Milligan, Ian Wells, Patsy Roseblade, Carolyn Donoghue and Geraint Hopkins once again offered their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Independent Members.

In February 2023 the Committee extended a wider invitation to all Members of the Board who joined the meeting to ensure that there was a robust discussion and scrutiny of the Integrated Medium Term Plan and Annual Plan priorities.

The Annual Committee Cycle of Business was approved by the Committee at the meeting held in February 2023, which outlined the forward planning for the work of the Committee for 2023-2024.

I continue to advocate the promotion of a culture of continual improvement, and as usual look forward to the learning that will come from the self-assessment which is undertaken each year to reflect on the Committee's effectiveness.

Mel Jehu
Chair
Planning, Performance and Finance Committee

2. INTRODUCTION

The key function of the Planning, Performance & Finance Committee (PPF) is to provide scrutiny on behalf of the Board on all matters relating to Planning, Performance and Finance. The Committee provides a level of assurance to the Board that all appropriate actions are being taken to reduce risks in these areas.

The Committee meets on a bi-monthly basis following the Strategic Leadership Group where the initial management debate / scrutiny / action is taken. The Committee Chair presents exceptional issues to the Quality & Safety Committee. There is also the opportunity to refer key risks back to the Strategic Leadership Group or through reports from Committee Chair at full Health Board meetings.

All papers relating to the Committee (unless held 'in-committee') are available on the Health Board website. The Committee aims to meet up to six times per annum to scrutinise the Health Board's planning, performance and financial management aligned to its Integrated Medium Term Plan commitments.

Key areas of activity for the Committee during 2022-2023 are outlined below:

- Active involvement in the development and approach to the 2023-2026 Integrated Medium Term Plan and Annual Plan.
- Routinely reviewed and scrutinised the Health Board's integrated performance dashboard.
- Routinely, reviewed and scrutinised financial performance, such as the development of savings plans, budget setting, delivery of agreed savings plans including efficiency savings and the Monthly Monitoring Returns to Welsh Government.
- Routinely, reviewed and scrutinised the delivery of the Planned Care Elective Recovery Programme.
- Routinely, reviewed and scrutinised the organisational risks assigned to the Committee.
- Reviewed and scrutinised a report on the Budget Setting Arrangements.
- Reviewed and scrutinised a report on Child and Adolescent Mental Health Services (CAMHS) Performance Improvement.
- Received a Presentation on the Six Goals for Emergency Care
- Reviewed and scrutinised a report on the Stroke Action Plan.
- Reviewed and scrutinised a report on the Bridgend Transition.
- Reviewed and scrutinised a report on Winter Response Planning.

- Reviewed and scrutinised a report on the South East Wales Regional Collaborative.
- Reviewed and scrutinised a report on Nevill Hall Hospital Satellite Radiotherapy Unit
- Reviewed and noted a report on the Spinal Services Operational Delivery Network.
- Received a Presentation on Enhanced Monitoring Assurance Processes and Governance.
- Received a Presentation on Targeted Intervention and Improving Care.
- Reviewed and scrutinised a report on Sepsis Compliance Progress.
- Reviewed and scrutinised a report on Estates Performance.
- Endorsed for Board Approval the All Wales NHS Energy Procurement Proposal.
- Endorsed for Board Approval the new Velindre Cancer Centre Full Business Case.
- Endorsed for Board approval the following Policies:
    - Business Continuity & Emergency Preparedness Response & Recovery Policy
    - Transport, Travel and Car Parking Policy

3. MEMBERSHIP

Only the Independent Members are formal members of the Committee, however, they are joined at the meeting by Executive Directors and other Senior Officers as appropriate. Other Independent Members from other Health Boards, representatives from Internal Audit, Audit Wales and Welsh Government have also attended the meetings on occasions.

The role of the Independent Member of the Committee is to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes. The tables below outline the membership of the PPF Committee during 2022/23:

Table 1 – Composition of Independent Members

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

3.1 MEETING ATTENDANCE

The Planning, Performance & Finance Committee met on seven occasions during 2022/23. The meeting due to be held on the 20th December 2023 was stood down due to industrial action.

* Two Extra Ordinary meetings were called on the 20th September 2022 and the 22nd March 2023 for the Committee to receive an update on the progress in relation to the Integrated Medium Term Plan for 2023-26 and Endorse for Board Approval the Integrated Radiotherapy Solution and Satellite Radiotherapy Centre Full Business Case.

Name:	26/04/22	28/06/22	23/08/22	20/09/22*	25/10/22	28/02/23	22/03/23*
Core Membership							
Mel Jehu	√	√	√	√	√	√	√
Patsy Roseblade	X	√	√	√	√	X	√
Ian Wells	√	√	√	√	√	√	√
Nicola Milligan	√	√	√	√	√	√	√
Carolyn Donoghue	√	√	√	√	√	√	√
Geraint Hopkins	√	X	X	X	X	√	√

4. MAIN AREAS OF FINANCE PERFORMANCE & WORKFORCE COMMITTEE ACTIVITY

The agenda for each meeting follows a standard format as outlined below:

- Preliminary Matters
- Consent Agenda
- Governance (Including the Organisational Risk Register)
- Improving Care (Performance Activity)
- Sustaining our Future (Finance Update Reports & Estates Update Reports)
- Forward Work Programme, Highlight Report, How did we do today? and items to be referred to other Committees

PART 1
Preliminary Matters
This section provides the apologies for absence, welcome and introduction, declarations of interest, previous meeting minutes, matters arising and the action log.

PART 2 – MAIN AGENDA

Planning
This section of the meeting reviews and monitors the process for the development of the Integrated Medium Term Plan (IMTP), scrutinises strategic or major service plans, monitors and scrutinise the efficient prioritisation of capital schemes, capital plans, capital programmes and business cases.

Performance
This section of the meeting reviews the Integrated Performance Dashboard, which covers all Tier 1 targets set by the Welsh Government as well as critical, local targets.

The dashboard accompanied by a covering report highlights key performance areas which include those:

- under formal escalation with Welsh Government,
- where a cause for concern to the Committee has been raised due to fluctuations in performance levels being attained,
- demonstrating considerable improvements in performance.

The Dashboard is reviewed for changes from the previous month, trends throughout the year and determines the areas that will be discussed in more detail. The report highlights areas that will be brought forward onto the 'Forward Look', which is generally determined by those areas that have shown deterioration over two consecutive months. The Director of Strategy and Transformation or a suitably nominated deputy presents the Integrated Performance Dashboard. Key areas for further detailed discussion are then produced for exception reporting or are requested as part of a 'deep dive' financial presentation or for clinical efficiency review and discussion. Comparative information is also presented and discussed on a quarterly basis.

Finance
This section of the meeting monitors risk to financial delivery including mitigating actions to manage risk. Monitors the delivery of financial plans and savings programmes. Monitors activity and productivity including operational efficiency and effectiveness.

Items for exception reporting, information or update
Throughout the year, various high profile issues have been presented to the Committee by way of exception. These include reports produced by Wales Audit Office on an all-Wales basis.

Forward Work Programme and items to be referred to other Committees

Items for Information/Update
Items that have previously been presented may be placed on a future agenda for a written update or further information. These are received at this point by the Committee. In addition, papers of interest to members may be included in this section.

Forward Look
The 'Forward Look' plan for the Committee is reviewed at each meeting to ensure that it is still targeted at the appropriate risk areas. Issues raised during the Health Board's monthly meetings with Welsh Government's "Quality and Delivery Group" are presented as required.

Links with Other Committees/Boards
The Directors on the Committee provide this linkage to the Operational Management Board, Strategic Leadership Board and Executive Leadership Board. Key risk areas from the Planning, Performance & Finance Committee were highlighted at the Quality & Safety Committee and/or full Board meetings by the Committee Chair.

Key elements, including any patient specific risks, were also taken into account at the Quality and Safety Committee; an important link is made by the Chair of the Quality and Safety Committee and lead directors as appropriate.

The Committee Chair is able to refer items to other Board Committees as felt appropriate. There are three questions that the Committee are required to consider: What is the issue being referred? Why are the Committee seeking the referral? What is the outcome anticipated as a result of the referral.

During this period there were no referrals made.

5. ACTION LOG AND REPORTS TO BOARD

In order to monitor progress and any necessary follow up action, the Committee has developed an action log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and

from the Committee to the Health Board. Following each meeting of the Committee a summary report is submitted to the next Board meeting to update all Board Members as to any decisions made, referrals to other committees or particular concerns the Committee had. These are available via our website.

6. GOVERNANCE

The Committee provides an essential element of the overall governance framework for the organisation and intends to develop its function still further in the forthcoming year. The Committee has an Annual Cycle of Business for each year which is approved at the first meeting of each year.

The Terms of Reference for the Committee were revised with minor amendments at the May 2023 Health Board Meeting (Attached at **Appendix 2**) and provide a robust commitment to monitor Planning, Performance and Finance via the following methodologies:

- a formal escalation protocol, which allows the Committee to deal with concerns in relation to key areas of performance, ultimately bringing a matter to the attention of the UHB Board if necessary;
- the presentation of the most recent data (even where this is an un-validated position) to allow the organisation's performance to be benchmarked where necessary;
- scrutiny of efficiency measures and targets on a quarterly basis.

7. COMMITTEE ANNUAL SELF-ASSESSMENT

The Committee is required to complete an annual self-assessment and the questionnaire is undertaken via Survey Monkey. This year's self-assessment will be completed following the June 2023 meeting and the outcome will be received at the August 2023 meeting.

8. CONCLUSION AND ASSURANCE TO THE BOARD

The Planning, Performance & Finance Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2022/23 there are effective measures in place both to ensure the delivery of the key financial, planning and performance targets and to effectively scrutinise and monitor this important area. There are no outstanding issues that the Committee wishes to bring to the attention of the Board.

In terms of its financial responsibilities, the Health Board has reported a draft deficit of £24.5m for 2022/23 (subject to audit), which is a £2m improvement

from the planned deficit at the start of the year of £26.5m. The £24.5m draft deficit includes:

- A **Core plan** deficit of £24.4m.
- **Exceptional** costs of £17.3m compared with Welsh Government (WG) Allocation of £16.9m.
- **COVID** costs of £29.7m compared to a WG allocation of £30.0m.

The Health Board has therefore not achieved the financial duty to break even against its Revenue Resource Limit over the 3 year period 2020/21 to 2022/23 with a cumulative draft deficit of £24.2m.

The Health Board's recurrent deficit position also deteriorated during 2022/23, with a forecast carried forward financial challenge at the end of 2022/23 of £79.6m. The key movements are summarised below:

C'fwd Challenge at the end of 22/23	**Total £m**
Recurrent deficit at 31 March 2020	17.6
Recurrent savings shortfalls 20/21	16.2
Recurrent savings shortfalls 21/22	11.1
Other recurrent underspends	-0.4
Recurrent Core plan deficit at start of 22/23	**44.5**
Forecast recurrent savings shortfalls 22/23	7.1
Other recurrent overspends	9.3
Ongoing local Covid response costs	10.0
Ongoing Exceptional energy costs	8.7
Forecast c'fwd financial challenge at the end of 22/23	**79.6**

The Health Board submitted its draft financial plan to WG at the end of March 2023 followed by a supplementary report at the end of May. It is important to note that the Health Board does not have a balanced financial plan for 2023/24. The revised Annual Plan, submitted to WG on 31st May 2023, is as follows:

	Recurrent £m	**Non Recurrent £m**	**Total plan £m**
Recurrent Core plan deficit at 31 March 2023	60.9		60.9
Recurrent ongoing COVID costs	10.0		10.0
Non Recurrent ongoing Exceptional energy costs		8.7	8.7
B'Fwd challenge at 31 March 2023	**70.9**	**8.7**	**79.6**
Allocation Adjustments	(17.4)	(12.5)	(29.9)
Cost Pressures & Investments:			
Inflationary Pressures	21.8	0	21.8
Demand Growth	12.3	0	12.3

	Recurrent £m	Non Recurrent £m	Total plan £m
Service Improvement – Local	4.3	2.8	7.0
COVID Programmes	0	11.7	11.7
Other Pressures & Investment	0.8	3.7	4.5
Savings Target	(27.3)	0	(27.3)
Total plan 23/24	**65.3**	**14.4**	**79.6**

Report Title	**Cochlear and Bone Conduction Hearing Implant (BCHI) Engagement & Next Steps**	**Agenda Item**	8.1.4
Meeting Title	**Cwm Taf Morgannwg University Health Board**	**Meeting Date**	27/07/2023
FOI Status	Open		
Purpose of the Report	The purpose of this report is to outline the targeted engagement process undertaken regarding Cochlear and Bone Conduction Hearing Implant (BCHI) services for people in South East Wales, South West Wales and South Powys, to present the findings from that process; and to establish the necessary next steps.		

Specific Action Required	RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
	☐	☐	☒	☐	☒

Recommendations:

Members are asked to:

- **Note** the report,
- **Receive** the outcome of the engagement process
- **Note** the process that has been enabled both in respect of a) the temporary urgent service change for Cochlear services and b) the requirements against the guidance for changes to NHS services in Wales,
- **Note** and **consider** the feedback received from patients, staff and stakeholders with respect of commissioning intent,
- **Support** the next steps specifically the undertaking of a designated provider process; followed by a period of formal consultation,
- **Note** the process that has been enabled to seek patient and stakeholder views in line with the requirements against the guidance for changes to NHS services in Wales; and
- **Note** that the WHSSC Joint Committee meeting on 16 May 2023 agreed the preferred commissioning model of a single implantable device hub for both children and adults with an outreach support model.

COCHLEAR AND BONE CONDUCTION HEARING IMPLANT (BCHI) ENGAGEMENT & NEXT STEPS

1.0 SITUATION

The purpose of this report is to outline the targeted engagement process undertaken regarding Cochlear and Bone Conduction Hearing Implant (BCHI) services for people in South East Wales, South West Wales and South Powys, to present the findings from that process; and to establish the necessary next steps.

2.0 BACKGROUND

There are approximately ***613,000*** people over the age of 16 with severe / profound deafness in England and Wales.[1]

Around ***370*** children in England and ***20*** children in Wales are born with permanent severe/profound deafness each year. Around ***90%*** of these children live with hearing parents. About 1 in every 1,000 children is severely or profoundly deaf at 3 years old. It is 2 in every 1,000 between the ages of 9 and 16.

There are two specialist centres for Cochlear Implant services in South Wales:

- One at the University Hospital of Wales (UHW), Cardiff and Vale University Health Board (CVUHB); and
- One at the Princess of Wales Hospital (PoWH), Cwm Taf Morgannwg, University Health Board (CTMUHB).

Urgent temporary service change arrangements for the Cochlear Implant service located in the PoWH, Bridgend have been in place since September 2019. The patients previously seen at the PoWH are currently seen in the UHW in Cardiff.

There are three centres delivering the BCHI Service. Services from UHW, Cardiff and the other at Neath Port Talbot Hospital (NPTH) are funded by the Welsh Health Specialised Services Committee (WHSSC) on behalf of all Health Boards (HBs).

The service delivered from the Royal Gwent Hospital (RGH) is funded by Aneurin Bevan University Health Board (ABUHB).

[1] Overview | Cochlear Implant implants for children and adults with severe to profound deafness | Guidance | NICE

3.0 ASSESSMENT

3.1 Current Position

Following notification from CTMUHB in 2019, that the HB would no longer be able to provide the Cochlear service from PoWH in Bridgend, due to issues of workforce and sustainability, an urgent temporary service change was enabled that resulted in all patients from South West Wales, South East Wales and South Powys being seen at the UHW within CVUHB.

The Covid19 pandemic delayed the ability to proceed with public engagement / consultation. The process restarted as appropriate within the context of other recovery and commissioning priorities.

When recommenced; a number of processes were enabled to determine a preferred commissioning model onward; and to ensure a solid background to the engagement process. The components of this were:

- A clinical option appraisal,
- An independent assessment of the options by an external assessor (from a comparable service in NHS England); and
- A financial appraisal of the options.

Horizon scanning and reviews of models of specialist auditory provision in other parts of the UK resulted in WHSSC considering the entire / potential services within its remit. This would allow the commissioning ambition for a Centre of Excellence in Wales which would include Cochlear implants, BCHI's, and middle ear implants (should they be approved through a process which is enabled in 2023).

This information was brought together and considered by both the WHSSC Management Group and the Joint Committee, who then supported both the content and process relating to a period of engagement on a 'a single implantable device hub for both children and adults with an outreach support model'.

Agreement was reached through HBs during September 2022, for a period of targeted engagement with regard future provision of both Cochlear and BCHI.

3.2 Aim of the targeted engagement

Early discussions were held with Community Health Councils (CHC's) and a targeted engagement was agreed as the affected patient cohort were small in numbers and it was a highly specialised service.

The scope of the engagement was to seek support or otherwise for a Centre of Excellence for Specialist Auditory Devices (including BCHI, Cochlear and middle ear implants – subject to approval of the latter).

3.3 Process

The process, which was agreed with the CHC, was of a targeted engagement with those accessing the service. Because BCHI services were also included within the scope of the engagement, a broader stakeholder cascade of information was made. A summary of the reach is outlined in ***table 1*** below.

Table 1: Summary of the Reach

GROUP	METHOD
Patients	952 patients cascaded via their local clinical teams
Staff	All documentation made available to clinical teams via the Heads of Service
Stakeholders	National organisations managed by WHSSC Cascade of documentation via: • ABUHB Stakeholder network & website • BCUHB Stakeholder network & website • CTMUHB Stakeholder network & website • CVUHB Stakeholder network & website • HDUHB Stakeholder network & website • PTHB Stakeholder network & website • SBUHB Stakeholder network & website

A number of materials were produced to support the process:

- Core consultation document (English and Welsh),
- Summary document (English and Welsh),
- Easy read document (English and Welsh),
- Video (with British Sign Language (BSL)),
- Questionnaire,
- Equality Impact Assessment (EQIA); and
- Publications on HB websites signposting to the engagement.

3.4 Outcome

There were 201 responses to the questionnaire, of these, 5 were from organisations, and 196 were from individuals. There was also a detailed written response from the clinical community, submitted via the Audiology Standing Specialist Advisory Group (ASSAG). The data from the questionnaire is reported against the engagement questions presented at ***Appendix 1***. The ASSG response is presented at ***Appendix 3***.

A thematic analysis has been undertaken against the data. The key themes that emerged from the analysis are outlined in ***table 2*** below:

Table 2: Key Themes of Analysis

Theme	Summary
• General support for the proposed change	There was good support for a single implantable device hub with 74% of respondents agreeing to the preferred option. The qualitative information presented in ***Appendix 2*** is worthy of further note.
• No support for the proposed change	There were 8% who disagreed with the preferred option and 18% who had no particular view. The qualitative information presented in ***Appendix 2*** is worthy of further note.
• Access, travel, location, parking & costs	The four most consistent themes were of accessibility, i.e. location of services particularly the single hub centre, sustainability, the patient experience and travel and journey times for patients.
• Staff and resources	There were a number of statements related to either staffing levels or service funding.
• Service design	A number of suggestions/comments were made in respect of service design.
• Service feedback/general comments	There was good support and positive comments from respondents about the current provision of services, how they had received excellent quality care and were well looked after by the staff. There were also some areas suggested for improvement.
• Comments on process and options	A number of issues of process were raised, these predominantly related to the length of the process (which delayed through COVID); the separation of Cochlear from BCHI and the separation of children from adults, these responses were predominantly from the clinical community.
• Waiting times	The majority of comments were with regard waiting times.

All responses are reported against the themes outlined in ***Appendix 2***.

(Note - some quotes have been used for illustration in the text, however should not be considered in isolation of the data presented in the appendices).

3.5 Findings and Exploration

The majority of the respondents (74%) were **supportive of the preferred option**. Reasons stated included the benefits of a single Centre of Excellence, all staff in the same place, continuity of personnel and an anticipated benefit regarding waiting times and staff availability. There were examples of respondents being supportive of the preferred option, however they were also aware of a broader impact for example on travel times/distance and associated costs. These have been captured in the thematic report.

I think that this will be a positive move, everything will be easily accessible and all at one place

The most important thing is the experience of the person setting up the hearing aid to give maximum benefit. If you have to travel for this it is worth it.

High volume surgical sites' are key for good outcomes. At the same time follow up services should be 'local to a patient' for better compliance & outcomes

Having one team of skilled experienced specialists in one hub can be a huge benefit to implant surgery. It is however vital that regional outreach support is maintained as access from across Wales to one central hub is not practical for all

A smaller number of respondents (8%) who offered their views as to why they **would not support the preferred option**, with the dominant reason being linked to travel impact for both patients and staff.

Too large, anonymous, patients are not familiar with staff and feel insecure and apprehensive. Harder for relatives to visit.

The view of the professional group was that there is support for the centralisation of Cochlear services, but not for BCHI, due to the reasons outlined in ***Appendix 3***. (Permission to publish the clinical communities' response has been gained).

The highest number of consistent themes from the engagement process were in the areas of: **Access, travel, location, parking & costs.** Cochlear services have all been on a single site since 2019, as such whilst the inconvenience of travel to and parking at a single site, is acknowledged it does not appear to have impacted attendance at clinics to date.

Accessibility is the key problem for me, already having issues with train strikes, limited timetables for all public transport.

People living in far reaches of the area that provides hearing devices have a hard time reaching one hub, especially in inclement weather

With regard **staff and resources**; the main areas of feedback here were with regard adequate staffing numbers; appropriate training; sufficient finances to support the service, and the right level of specialist staff.

The success of delivering the future aims is very much dependable upon consistent funding

For all of the above to be achieved I think will take a long time. It needs much more funding.

Through the responses, a number of observations and suggestions were made with regard ***Service Design***. These included increased access through outreach clinics; weekly hub presence; increased use of technology and new advances in treatment; working to agreed standards, and provision of emotional support to families.

Local outreach and access, including audiology appointments and rehabilitation appointments would enable ease of access

Many respondents took the opportunity through the engagement process to offer general commentary on their experience of the service and some personal patient stories. These collectively offer a rich picture and should be considered in forward planning and delivery of service. (Note the relevant section is outlined in ***Appendix 2***).

A number of comments were also received on the **process** that had been followed. Specifically comments predominantly related to separating Cochlear and BCHI; separating adult and children; the length of time that the process has taken since the urgent temporary change in 2019; and a few respondents suggested they would prefer a different option. There was some suggestion that insufficient regard had been given to the clinical view, and that the incorrect guidance had been used to inform the work, and that there was inconsistency in two of the resources supporting the engagement information.

A theme also emerged with regard to **waiting times**, some regarding aspiration and hope for shortened waiting times as a result of a centralised service, and others with regard actual experience. Some respondents for example, suggested that the proposed single implantable device hub would offer a more timely service with equitable waiting times for all patients, conversely, some respondents commented that it could increase waiting times due to the increase in volume of patients trying to access the service.

The proposed mitigations arising from the engagement are as follows:

I am wondering if this will have a positive impact on waiting times.

Table 3: Proposed Mitigations

Theme	Mitigation
• Access, travel, location, parking & costs	Whilst a single central location is proposed (site to be identified) the service model should a) have a central MDT, b) centralised operations; and c) local follow up, monitoring and modifications. Commitment will remain to local outreach clinics.
• Staff and resources	The financial option appraisal undertaken to inform this work demonstrated that there is sufficient funding within the service, and that finance was not a driver for this work. WHSSC will review further service developments as part of its normal commissioning processes.
• Service design	Issues raised regarding: access through outreach clinics; weekly hub presence; increased use of technology and new advances in treatment; working to agreed standards, and

Theme	Mitigation
	provision of emotional support to families will be included within service modelling and implementation discussions. Further understanding is to be had with regard availability of soundproofed rooms
• Service feedback/general comments	Feedback to be shared with clinical teams delivering services, and suggestions (as appropriate) used to inform future service modelling
• Comments on process and options	Further engagement is required with the Clinical Reference Group regarding the specifics of the issues raised. Also further discussions with the Chair of ASSAG will take place. With regard the specific point raised by the clinical community on the relevance of the guidance - We acknowledge the reference to the latest policy. Both the 2013 and 2016 policies are listed as current published documents on the NHS England website and have therefore been used to inform the review of the services. We acknowledge that BCIG standards are for the Cochlear Implant service only. The BCHI standard" a centre should undertake a minimum of 15 BCHI per year" has been quoted from the Clinical Commissioning Policy: Bone Anchored Hearing Aids, April 2013. Reference NHSCB/D09/P/a.
• Waiting times	Monitoring information on waiting times to continue to be regularly reviewed.

3.6 Conclusion and Next Steps

The engagement process outlined above has tested support or otherwise for the commissioning of a single implantable hub for South East Wales, South West Wales and South Powys. The patient voice appears to give strong support, whilst there is further engagement to be held with the clinical community on the future

service model. A number of mitigations have been highlighted in the response to the patient voice.

The clinical view has been consistent throughout the process, and WHSSC has again considered the issues raised by the clinical community. The feedback obtained through the consultation process does not appear to have identified any information (aside of the need to profile available sound proof rooms), which had not previously been taken into account when the preferred commission model was agreed. Specifically:

- The preferred option will enable the safe and sustainable delivery of services for patients requiring an implantable hearing device which will include:
  - Assessment by a multi-disciplinary team that is able to offer access to all types of (commissioned) hearing implants; and
  - Guidance on standards for BCHI services comes from a consensus statement of experts, which states:

    "That BCHI fitting should take place in a specialist auditory implant device centre performing at least 15 implants per year." *Clinical Commissioning Policy*

In addition, the implementation of the Duty of Quality (Health and Social Care (Quality and Engagement) (Wales) Act 2020) means that WHSSC now risks legal challenge if it derogates from established best practice.

Taking all of the above into account and, in particular, the strong patient support for the single centre, WHSSC continues with the ambition to commission a Centre of Excellence for all Auditory Specialist Implantable Devices (Cochlear, BCHI and middle ear if supported).

To date, no location has been specified for the centre, as such WHSSC will now move forward into a second phase of consultation which includes a preferred location. To do this, a designated provider process will need to be enabled, this means WHSSC will ask providers to submit a proposal outlining if they wish to deliver the centralised service, and if so how they can deliver the service. WHSSC will develop clear criteria against which the service proposals are assessed and will use this information as the basis of consultation on a preferred option.

In the meantime, all Cochlear patients will continue to be seen at CVUHB. There will be no immediate change to the provision of BCHI.

In line with Welsh Government (WG) guidance for engagement and consultation on changes to health services in Wales, guidance is required from CHC colleagues with regard the process that has been enabled, the outcome of the exercise and proposed next steps. Formal discussions to agree next necessary steps are to take place with Llais shortly. The final report to Joint Committee will include their recommendation.

3.7 Llais and Joint Committee consideration

The outcome of the engagement was presented to Llais on the 9 May 2023 where both process and outcome were well received.

The Joint Committee received an update report on 16 May 2023[2] and agreed to the following recommendations:

- **Noted** the process that has been enabled both in respect of a) the temporary urgent service change for Cochlear services and b) the requirements against the guidance for changes to NHS services in Wales,
- **Noted** and **considered** the feedback received from patients, staff and stakeholders with respect commissioning intent,
- **Approved** the preferred commissioning model of a single implantable device hub for both children and adults with an outreach support model,
- **Supported** the next steps specifically the undertaking of a designated provider process; followed by a period of formal consultation,
- **Noted** the process that has been enabled to seek patient and stakeholder views in line with the requirements against the guidance for changes to NHS services in Wales; and
- **Agreed** to take the outcome and proposed next steps through Health Boards for consideration.

Now that the proposal has been formally taken through the Joint Committee to seek support for the change, there is now a requirement for final approval from each of the HBs. Further to the approval to move to a period of engagement through HBs during September 2023, Health Boards are now recommended to consider this report and support the recommendations outlined below.

4.0 RECOMMENDATIONS:

Health Boards are asked to:

- **Note** the report,
- **Receive** the outcome of the engagement process,
- **Note** the process that has been enabled both in respect of a) the temporary urgent service change for Cochlear services and b) the requirements against the guidance for changes to NHS services in Wales,
- **Note** and **consider** the feedback received from patients, staff and stakeholders with respect commissioning intent,
- **Support** the next steps specifically the undertaking of a designated provider process; followed by a period of formal consultation,
- **Note** the process that has been enabled to seek patient and stakeholder views in line with the requirements against the guidance for changes to

[2] *Page 17 of the pdf document bundle*

NHS services in Wales; and

- **Note** that the WHSSC Joint Committee meeting on 16 May 2023 agreed the preferred commissioning model of a single implantable device hub for both children and adults with an outreach support model.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Cochlear Implants and BCHI are deemed a Specialist service, and as such commissioned by WHSSC
Health and Care Standards	Governance, Leadership and Accountability Safe Care Individual Care
Principles of Prudent Healthcare	Reduce inappropriate variation Public & professionals are equal partners through co-production
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement The health and social care workforce is motivated and sustainable
Organisational Implications	
Quality, Safety & Patient Experience	This engagement has been undertaken in order to respond to issues of service sustainability and patient experience.
Finance/Resource Implications	A financial option appraisal has been undertaken to inform this work
Population Health	No adverse implications relating to population health have been identified.
Legal Implications (including equality & diversity, socio economic duty etc.)	An EQIA was undertaken to inform the work. A number of issues have arisen through the process with regard socio economic issues, specifically as related to travel, location and cost. These are detailed within the report, along with any available mitigating actions.
Long Term Implications (incl. WBFG Act 2015)	The framework has been developed cognisant of the relevant long term implications
Report History (Meeting/Date/ Summary of Outcome	WHSSC Management Group (MG) - 27 April 2023 Corporate Directors Group Board (CDGB) – 2 May 2023
Appendices	Appendix 1 - Presentation of data against questions asked Appendix 2 - Thematic analysis Appendix 3 - Professional Community response

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

APPENDIX 1 QUESTIONNAIRE RESPONSES

ENGAGEMENT ON FUTURE PROVISION OF COCHLEAR AND BONE CONDUCTION HEARING IMPLANTS FOR SOUTH EAST WALES, SOUTH WEST WALES, & SOUTH POWYS

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APPENDIX 1

PRESENTATION OF DATA AGAINST QUESTIONNAIRE

1. Presentation of data

There were 201 responses received to the engagement process.

Table: 1 Total Number of respondents.

	Out of **201** responses, received: **191** responded individually and **10** responded as a group.

There were 10 group responses however, from the following organisations:

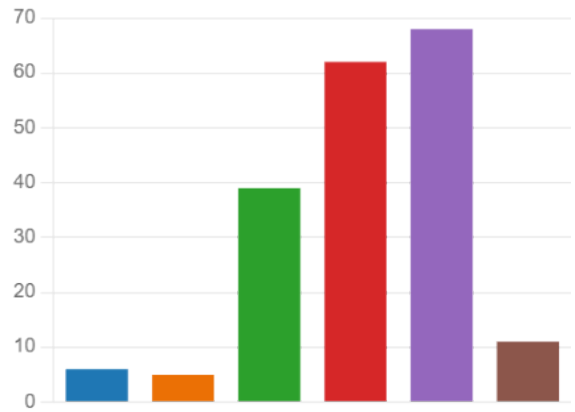
- 6 were from Audiology departments across South East, South West and South Powys
- 1 was from the National Deaf Children's Society
- 1 was from RCT People First
- 1 was from the Audiology Standing Specialist Advisory Group/Audiology Heads of Service Group
- 1 was from the Centre of sign, sight and sound

Demographics and Geographic Profile of Respondents

The age, gender and national identity profile of respondents is shown below:

APPENDIX 1

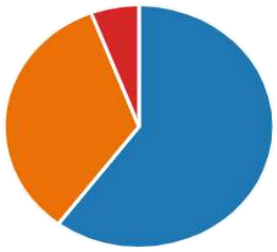
Table 2: Age Profile



Of the **191** individual responses:

- **6** patients were under 16
- **5** patients were between 16-18 years old
- **39** patients were between 19-49 years
- **62** patients were between 50-69 years old
- **68** patients were 70 years old
- **11** preferred not to say

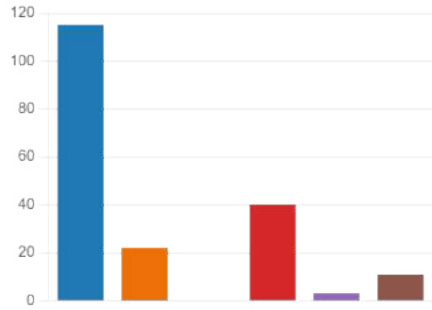
Table 3: Gender Profile



of the **191** individual responses:

- **65** were male,
- **115** were female and
- **11** preferred not to say.

Table 4: National Identity



Out of the **191** individual responses received:

- **115** patients were Welsh,
- **22** were English,
- **40** were British,
- **3** patients advised as other
- **11** preferred not to say.

APPENDIX 1

Table 5: Ethnicity

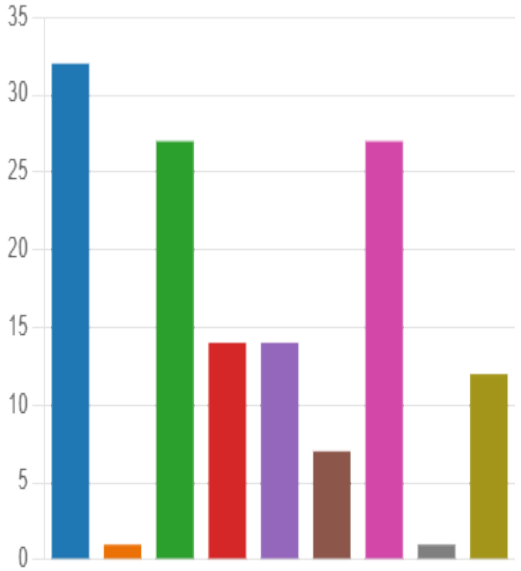
	Out of the **191 individual** responses received:- • **178** patients described themselves as White, • **2** responses described themselves as Asian, Asian Welsh, Asian British and • **11** preferred not to say.

Post Code Reach

Question 6 requested the respondents post code, a more granular method of testing the reach of the response. 191 responses were received.

Table 6: Health Board Area

Not all respondents completed this question, 135 responses were received

	**32** Aneurin Bevan University Health Board **1**Betsi Cadwaladr University Health Board **27** Cardiff & Vale University Health Board **14** Cwm Taf Morgannwg University Health Board **14** Hywel Dda University Health Board **7** Powys Teaching Health Board **27** Swansea Bay University Health Board **1** NHS England **12** Other

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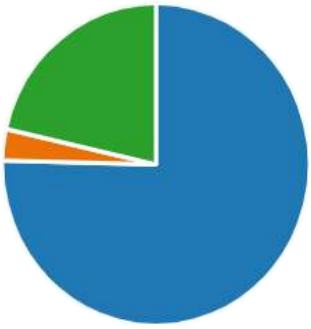
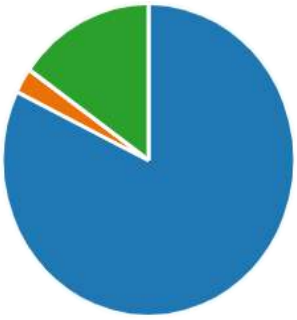
Understanding of how services are organised

8. As a result of reading this information:
 After reading, the information: • **144** patients had a better understanding of how Bone Conduction Hearing Implants and Cochlear services are currently organised. • **6** patients had no understanding of how the Bone Conduction Hearing Implants and Cochlear services are currently organised and • **41** patients understanding of the service remained the same.

9. Understanding of the issues facing the service

	After reading the information: • **157** patients had a better understanding of the issues facing the service • **5** have no understanding of the issues facing the service • **29** patients understanding of the issues is the same

Respondents were also asked to comment on any issues facing the service.

From those that suggested that as a result of reading the document, they had a better understanding of the service, the following comments were made

If possible could we have Baha Bone Anchored Hearing Aid facilities in the Ceredigion area as travelling on a bus to Neath or Cardiff hospital would be too much for a pensioner even myself when during COVID I had to pop into A&E as I developed an infection and not one person seen one of these so thankfully I had a work colleague with me and between us was able to explain what is required but it was a struggle
I have a cochlear implant. The reorganisation of this service is necessary, to create the best service possible to give the service users the best quality of life available. I think it should all come under one central unit with all the surgeons and after care can be carried out.

APPENDIX 1

The only objection I would make is the location of this unit, you have stated that you are using Cardiff as a temporary base but that is where you intend it to be. I will object to this location and I think it should be moved back the Bridgend, it is extremely difficult to travel from any part of West and Mid Wales to Cardiff by road or rail, parking is impossible, taxi fare from the station is £15 to £20, Bridgend is more central to all.
Understandably, patients want local access to services and are reluctant to travel far for those services. Similarly, the health boards also want local services but the specialist nature of the service limits the extent to which each health board can keep the service within its own boundaries.
Yes, the service offered needs to be cost effective (to obtain ongoing funding). Accessible through all stages of delivery and safe. A good robust service not a smattering.
I find the low level of patients described in this document difficult to accept.
Years ago, when my son needed his operations the waiting lists were quite long & funding was difficult. It seems better that these issues are less now.
Yes very much so. Taking away Bridgend causes so many travel problems: 1. a train & then 2. A bus. Parking at Cardiff Hospital is ridiculous and not up to standard for such a large hospital. As I am a pensioner, this means paying high train fares.
Future patients able to be referred to hearing Implant centres by their doctors or consultants for further assessments.
Would travel arrangements/costs for out of area be available?
Some patients will be less likely to opt for BAHA due to travel commitments. I struggle with a small minority of CI candidates who do not want to travel to Cardiff for an assessment. It provides a barrier to some. Otherwise, it is a good idea.
Availability of workforce. Easy access. Parking.
Personal concerns that the issues may affect my own access for any issues, concerns and follow-ups in the future. I have thus far since March 2021 had exemplary care, communication and access to the CI Team at UHW.
There are less patients with BAHAs than I expected
I am wondering if this will have a positive impact on waiting times.
Yes I do. The wait for cochlear implant was long and I had a complication after surgery, which could not be resolved by the operative time. This was very frightening indeed! The Team was not accessible, and they should have been.
Waiting times for appointments
Young persons should have priority.
The arguments are not convincing. There are movements in Wales into having things done centrally. Generally, patients like things done closer to home. The NHS is under pressure at all points. It has coped well, everywhere, with covid

No issues as such but I do think Bridgend Hospital should still be seeing patients that had their operation there with Mr Backhouse. A wonderful service and Cardiff is too far to travel to.
Centralisation - no mention of transportation arrangements.
Only issue I have is I am not seen for 12-18 months.
I was fitted with my BAHA at the QE Hospital 10+years ago in Birmingham. When I moved to South Wales in 2017, I went to Audiology at Gwent Hospital a few times for re-programming as I was experiencing problems. At this time, I had a hearing aid for my other ear. I have recently had a letter from QE Hospital Birmingham to inform me that my device is now obsolete. I have an appointment on the 27/01/2023 at Gwent Hospital to address this problem.
Sustainable hubs for outreach support model for patients needed. Many will be concerned regarding access to local facilities.
If this means that children/adults are able to be assessed and acted on more promptly, it has to be a good change. It has changed my life for the better.
Yes - waiting times are too long.
After being referred to ENT, I was initially told I did not fulfil the requirements for Cochlear Implant, was referred to the Coach Trial - who declined me and said I was eligible for Cochlear Surgery!! What a roundabout!! As soon as I saw a different ENT Surgeon everything went very smoothly.
Having a single centre for CI/BAHA is challenging, surely, for staff intervention. It's a huge catchment area, meaning travel eats into staff hours (for QTOD visiting children).
Not really, but having an implant changed my life and I am eternally grateful. THANK YOU.
ease of access and good communication with clinicians is a key issue
No - just trying to make an appointment with Audiology, messages not passed on.
I am currently waiting for surgery to remove painful and swollen skin around implant - I was placed as Category 2 for surgery in September 2022. I am still waiting and currently on antibiotics for infection - it is vital I have surgery; my fear is when will this happen?
Had my BAHA operation in 1992 with Mr Phillips of The Welsh Hearing Institute. I was the 7th person to have the operation. Before COVID started, I was seen at the hospital once a year for a check-up, which I was always glad of. So I knew there was no infection with the scar in my skull. We no longer get that treatment now.
It would be a good thing if Cochlear were done in more hospitals.
I can understand it but needs some more organisation and regular dates.
To provide a more sustainable and effective service it makes sense to consolidate the main service to one area.
Long term, consistent funding is a concern, especially for training, retaining and replacing specialist staff within a multidisciplinary cochlear/audiological team.

APPENDIX 1

Accessibility for patients
Patients could be asked if they can make a donation towards costs. Whenever greater expenditure would create greater savings this should be looked at.
Still a very poor understanding of Hearing Impairment and Deafness within the community at large.
If this facility is too far away, how are people going to get there?
It is obviously very difficult to maintain a good service with smaller units and lack of staff and expertise.
I could understand that in smaller areas around wales, would also have a smaller amount of patients compared to a big area such as Cardiff. I do understand that in smaller areas may have less qualified specialists/doctors in the area.
I agree that having all the specialist support in one place can benefit surgical procedures and implant recipients.
More of a local service - no further than Cardiff.
Having somewhere local and tidy somewhere service as everywhere else would be a bonus. Many people have recommended this but I have a awaiting a second option in May 2023
I feel those working in this area should have at the very least basic sign language skills.
Funding for these services and location.
The cochlear implant service has been working under 'urgent temporary arrangements' for three and a half years. This could and should have been resolved by now, but putting CI and BCHI has complicated matters. These are different devices for different populations with different needs. The ongoing situation has put enormous strain on the service and staff.
The CI service has been working under temporary arrangements for a long time. This needs to be resolved as it is impacting planning and service development. There is no question that the CI service needs to be in one centralised hub, but the BCHI is not so clear-cut. Putting them both together is just prolonging the difficult situation facing the CI Service. BCHIs require a much simpler surgical procedure and provide a different way of amplifying sound, but the listening experience is essentially the same as with a conventional hearing aid. CI surgery is much more complex and carries more risks. The way sound is delivered by a CI is entirely different to a hearing aid/BCHI and patients need to learn to listen in a different way, which causes physical changes in the brain. This is why additional rehabilitation is needed. The needs of CI and BCHI patients and the services they require are very different. I'm not sure that WHSSC fully understands the differences.
The service needs to be established, as a single centre for cochlear implants in south wales - the talks of mergers has been ongoing for too long. By trying to add in Baha now against clinical judgment it is adding a complexity needlessly.

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I work as a Stakeholder Lead for an NHS organisation undergoing a Transformation Programme to determine a Future Service Model. Totally appreciate all the issues facing the service and they are very relatable.
In table1 Referral's there seems to be enough numbers for cochlear implants and bone conduction hearing implants to meet the criteria for number of patients per surgeons?
Yes, we feel the service was much better previously. The Bridgend Service was fantastic.
The Bridgend Service was significantly better, providing excellent services to me and my family.
I understand more about issues facing the service

From those that stated they had no understanding of the issues facing the service, the following comments were made:

I understand more about issues facing the service Really disappointed that the cochlear implant service was removed from the Princess of Wales Bridgend. The Heath is not easily accessible I feel like the service is being diluted and isn't as comprehensive as it used to be.

From those that felt their understanding was the same, the following comments were made:

Make a weekly hub
The issues described are common to many aspects of life. A centralised service provides more options but inevitably makes it slightly less convenient for customers/clients. This is analogous to the closing of rural primary schools in favour of larger schools with more facilities.
The shortage of fully trained staff and the one hospital closed is awful. We need more staff and more money to enable this much-needed work to be achieved.
If this means that children/adults are able to be assessed and acted on more promptly, it has to be a good change. It has changed my life for the better.
The lack of qualified staff for the demands. The long waiting times involved.
The Government needs to fund services better.
Enough staff is essential.
No privatisation of services should take place.
I can see the problems with staffing. Would the staff from the other hospital be employed by the Heath Hospital?
The treatment I receive is very good. Staff brilliant.
Don't sink to the standards of QA Hospital Portsmouth!

10.Would you agree/disagree with the following aims for a future Cochlear Implant and Bone Conduction Hearing Implant service:
The service: • can deliver a safe and sustainable hearing implant device service for the adult and children in South Wales • has equitable access • meets national standards • has staff in the right place with the right specialist skills • facilitates timely access to surgery **160** patients agreed **12** patients disagreed **19** patients neither agreed or disagreed

Of those that agreed with the service aims, the following comments were made:

I have a dedicated cochlear support nurse
I personally can't fault the care and service I have received
The local service provides timely and effective care. Continuity of patient and specialist relationship is important. I am known to the service by name and not just a NHS number.
My hearing has fallen rapidly in recent years and I would assess my hearing as only being around a 5 - 10 on a scale of 100; whereas with my BAHA I would estimate my hearing to be an 85 - 95. to this end I am scared of losing my BAHA (it can easily be knocked off) and therefore, selfishly, hope that future services will be in my locality should I have some sort of problem. I know that I could not cope without the BAHA.
I have used hearing implant more than five years and I can feel better using hearing implant (Cochlear Implant System).
I am very happy.
If waiting lists and funding are long then the longer it takes for the person to adjust to the implants, causing further issues.
As long as I and others can get the help we need.
Fully aware of the difficult of Cochlear Service in South Wales
I have high confidence
Essential that the service be maintained and available as required.
It has to be accessible to all ages, socioeconomic groups.
It is a very loaded question! No-one will disagree with the premise that you wish to improve the service.
More people in one place will be better.

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The access to timely surgery would be a great outcome here. We also struggle as a small team to dedicate all the admin time to provide figures for the BCIG meetings, if this is managed by one team this would be great.
Right to have one 'Facility' for children and adults. Should make no difference.
I would like to place on record the contribution to cochlear implant hearing service made by Heidi Williams at University Hospital of Wales, Cardiff. She is an immense credit to the service..
I feel the care I've received from the CI Team at Cardiff (UHW) have achieved all the above.
Having everyone (staff) in one place makes more sense to everyone.
From a patient's perspective, all of the above 5 bullet points are vital.
There is NO service for specialist skills to remove implant for MRIC for comer patients in South Wales.
Access may be an issue as some patients and their families will have to travel further but to get excellent standards of care the service needs to be centralised
I think that this will be a positive move, everything will be easily accessible and all at one place.
Multi-disciplinary patient assessment, education, surgery details, skilfully performed implant operation, post-operative follow-ups, early and ongoing support for the implant recipient will work better.
My experience of the team at the Heath hospital has been excellent
I think this will be a positive move, everything will be easily accessible and all at one place.
The issue for those with BCHI/BAHA is how the arrangements for dealing with regular infection flare-ups is CLEARLY stated to BAHA patients, and early entry to deal with infections is paramount!
Centralising a service which serves a small number of the population allows resources to be pooled and staff to gain more experience. This also gives a fairer service and safer.
This would be a brilliant idea.
It's difficult to achieve a cost effective process balancing the needs of a small percentage of the population.
Having the facilities for adults and children under one roof would make more financial sense.
I have access to UHW which is convenient for me but many others will have travel difficulties.
Like all new ideas obviously we need to find out in practice.
By agreeing to the above wording, it suggests that the aims can be met. I would prefer 'aims to' to be added to beginning of each of the above statements rather than 'can, has, meets, has, facilitates'.

This depends on better communication access - I had to fight for live professional captions for a remote consultation. Meeting communication needs must be a priority and not a battle!
Have doubts about equitable service from my personal experience. At my initial appointment, I immediately knew that I was not going to be referred for surgery from the consultant's attitude and apparent lack of interest. Fortunately, it all changed when I saw the ENT Cochlear Surgeon.
From my experience as a deaf person, it was important for me to have familiar staff who I knew well and trusted, therefore a more family type atmosphere, easily accessible.
See above. I am aware that the NHS is under huge pressures. Having one hospital, as a centre for surgery will surely put compromise on availability of beds.
My only problem is getting to the University of Wales due to a walking problem so I have to ask the Ambulance Service for help; they have always obliged.
Local outreach and access, including audiology appointments and rehabilitation appointments would enable ease of access
I agree with what is proposed.
Reassuring that a wider range of specialist skills would be available.
Adults should have better support and more therapy.
I would like to agree because the problem I had before my op. was that I had to wear 2 aids in my ears, the hearing aids caused a lot of infection and irritation, had to go to the hospital every week to have treatment. When I had the chance to have the op., it was great. No more infections and irritations, and a better quality of hearing.
It would be more beneficial to the MDT to be able to maintain their skills/experience and share knowledge by coming together in one location.
Currently I attend the BCHI Unit within the ENT Clinic at Cardiff University Hospital. I live near Pontypool and would NOT wish to travel further than I have to in the future.
I agree with the aims above, but would still prefer to have the services at Bridgend to reduce the need for travelling a long distance for children and the elderly.
A main (one Hub) is the way forward for a seamless approach and understanding.
My National Identity is Scottish (Scottish tick box missing on DB so I couldn't add this! Sarah J)
Having experience of having had my preoperative assessment many years ago i.e. 1996 for a cochlear implant at the old Bridgend Hospital followed by being the 1st to have the implant at the then new in 1997 Princess of Wales Hospital. I agree wholeheartedly with there being one centre with the required service listed.

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It makes sense to rationalise the service and retention of specialists. Post-implementation I would still like to see more D/deaf specialist mental health provision including counselling.
Feel the expertise would be in one place which should be a good thing.
The standard of service keeps improving and I am pleased with the service I have received.
All under one roof would be better and to see consultants quicker would be great (I have no problem with the Royal Gwent Hospital).
It makes sense to provide one central hub for patients and staff.
Whilst Cochlear Implants can benefit from one centre I'm not convinced just having one BCHI Centre is beneficial.
Hope it would give more people with hearing problems access to either implants, As Doctors, Nurses and hearing .specialist available to help.
Please assure people on their own can access appointments in a timely and not costly manner. I have to go to Bristol Eye Hospital - no appointments after 3.00 pm - or transport won't accept. The single from Bristol home is about £200! Not on a pension it isn't - I won't/can't afford it!
If everything was in a central place then standards would improve and the service provided to patients would be better.
No-one is going to argue with these aims, the argument is what services need to look like to deliver these aims.
These are common-sense aims for any service; I can't imagine that anyone is going to disagree with this in principle!
Staffing shortage with Princess of Wales Hospital Cwm Taf Morgannwg being closed
My daughter who is 4 has received outstanding care and support through the process of having her cochlear implants 2 years ago.

Of those that disagreed with the service aims:

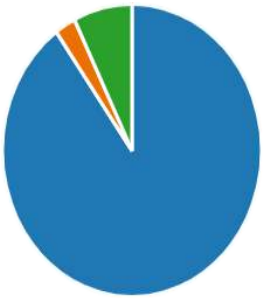
I am concerned about the apparent travelling difficulties created by the proposal.
Centralisation doesn't work. Staff are wonderful but getting to you is not good and there's many much further away than us. If you need to save cash get rid of Managers, etc and get more nurses and doctors.
I could not agree with a proposal for one centre given the difficulties for many of your customers to travel. It is already too far for me to travel to Cardiff as it is.
Timely access to surgery: In my case, this is not happening. Category 2 patient seen by surgeon who implanted the new cochlear implant. Still waiting for surgery.
I cannot fault the service but it’s a shame that I have to travel to Cardiff to be seen as they closed POW.

Cochlear Implant Services do not need to be grouped with BAHAs. They are very different and do not require the same care pre or post operatively. Trying to merge services in this way will be of detriment to patient care. The consultation process sought the views of professionals working within the field and yet you admit in the paperwork that their clinical opinion has been ignored.
Travelling from West Wales to Cardiff is just too far. My family travelled miles to Bridgend but Cardiff is ridiculous. Why if there is to be one centre does it have to be in Cardiff? Why can't it be more central?
Residents from West Wales to Cardiff would have to make a long and often tiring journey. Bridgend is quite far already, but travelling further to Cardiff would take an entire day. A service that is located in a more central region of Wales would be ideal and accessible.

Of those that neither agreed nor disagreed with the service aims

I don't know. I have always thought, highly, of the services.
I have not seen anyone for 12-18 months so cannot agree or disagree.
For all of the above to be achieved I think will take a long time. It needs much more funding.
Like all new ideas, obviously, we need to find out in practice.
the success of delivering the future aims is very much dependable upon consistent funding
It's hard to predict the outcome as this could be overwhelming to move into one location. I do understand that there will be more specialists at hand to do the surgeries/appointments and etc. The concern is the wait time to have these surgeries as there is now going to be a vast amount of people going into one place. I am optimistic that this would work.

11. As a result of reading this information, what was peoples understanding of the process that had been followed to arrive at the preferred option?



172 Patients have an understanding of the process that has been followed to arrive at the preferred option

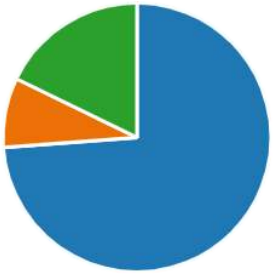
- **5** have no understanding of the process that has been followed to arrive at the preferred option

- **14** patients advised this was not applicable

Of those that commented in this area:

Needs to be robust centralised service, not piecemeal.
I understand the processes but it is always best for everything to be started asap.
No what's the point you won't listen.
Easy on papers. Will it work?
My understanding is that it has been practiced and tried with a positive outcome. That will benefit patients and staff with hopefully the best outcome.
They are used to making very difficult decisions in the NHS. I can't really comment about the process followed.
Financial was a main consideration.
I do not think the needs of the patients have been prioritised, ie the need to go to a near, accessible quiet hospital.
My treatment was 100% professional and caring.
Every children and adult (if deaf) should receive a chance of both operations i.e. whatever they need.
Robust and comprehensively/clearly explained.
I believe a single unit designed to treat all BCHI patients would enable all patients and staff to concentrate on this specialist area of medical treatment.
Many people did not come forward during the pandemic to get advice about their hearing. The number could increase as time goes by, needing more operations.
I can't criticise it and I can't say no.
Have to consider number of CI and BC patients which are very small considering population of Wales.
Perhaps some patients could have been included in this process.
If it means that more operations can be carried out then yes it's definitely needed.
The process followed appears to have been a fair consideration of the views of all parties involved.

12. What do you think about the preferred option of a single implantable device hub for both children and adults with an outreach support model?



- **141** respondents agreed with the preferred option
- **16** respondents disagreed with the preferred option
- **34** respondents had no particular view on the preferred option

From those that agreed with the preferred option, the following comments were made:

It would be great for Adults and children to have one unit
Nice that children and adults can communicate, can help.
I agree with this option because both Cochlear and BCHI, Bone Conduction Hearing Aids, would all be under one umbrella. With the right staff who understand how people with profound hearing loss feel, cope and deal with every day with this very real disability.
I feel centralised services would be more joined up and accountable
This sounds fantastic to have this facility all under one roof. I don't disagree but please consider people who live in rural areas and the valleys where I live, as transport isn't easily available especially if you don't drive. At the moment I go to the Royal Gwent which is easy for me and I could get a bus there. But Cardiff and further afield would be a problem especially if you can't drive (I do drive) so please consider this when deciding where you're going to place it.
It is good. It is better to be in one place so people know where to go. Staff will be with a specialised team. If it is in one place, it may be difficult for some people to get to. One member said she doesn't use hearing aids so she doesn't know much about them. It is a good idea to have a single implant centre. Good thing for children and adults to use the same centre. Keep the same staff as it is good to have the same nurses.
I agree, more service users would benefit
Although I understand the preferred option, I am concerned about the location and travelling further for treatment. I already travel to London for treatment that cannot be met in wales. I am struggling financially because of this, as I am not entitled to travel expenses. However, you dress this up it is a down scaling of services. I had to go to Cardiff for brain surgery as the centre at Morriston hospital was closed. I have also had to attend Cardiff for other services because they cannot be provided locally and the waiting times are longer than local and not acceptable.

I agree that specialist services would be better served where more staff can be accommodated in one or two centres but, as explained above, hope that this is in my areas.
As the number of patients using the CI and BCHI service is relatively small it is reasonable to centralise the Inpatient aspect of the service. However, there are many of the Outpatient aspects that should be provided at a more local site to reduce the impact of travel particularly for patients living in rural areas of West and Mid Wales. For example, initial assessment with Hearing Tests, CT and MRI scans should be available locally. Similarly, post-op assessments could be carried out near to the patients' home.
I have no comment about the preferred option and I agree with the preferred option as a positive option.
All the required skill set in one place.
The professionals doing this work know what they do and know best; they are second to none.
Travelling difficulties and a possible greater inflexibility in the availability of appointments.
We need more hubs; I have no problem with children & adults being together but what next? Will we be going to Bristol next to save cash?
It is biased. While less strain on services, some people find it difficult to travel and a single hub may result in people not getting the help they need. You would not have one optician for the whole country, why should ears be different?
Finance prevents more than two hubs
It is disappointing that this may cause any Implant Centre's to close with further hardship to staff and patients. I feel it is important to maintain the service in the best way possible for everyone involved.
I am not clear how the proposed change will affect me. The change to the service seems aimed at those people yet to receive an implant. So it would be better to ask them - except you can't as you don't know who they are. For myself as a patient with an existing BCHI (BAHA) I have periodic reviews and check. These currently take place in the Royal Gwent. Will this still be the case or will I need to travel further to the new central centre?
You mention a central hub. Where would this be based and at what cost to the Sennydd? Would this be part private funding? Will existing staff be prepared to move to provide same service? If not, what skill base can be retained? In the current climate within the health service, how far down the list for this vital service do you see yourselves?
The only disadvantage is the additional travelling expense where patients reside far from the hub.
I agree however, I think the location in which you choose to put the centre is very important, as it needs to be accessible to all patients.
I am currently happy with the care I receive from UHW/Cardiff but fully understand the issues with the current service. My only concerns are accessibility, communication for my own future CI journey.

Easier for everyone to liaise & patients.
I hope this option will improve the quality of care and I also hope that I can attend a specialist closer to my home.
It is the only option to achieve the aims stated.
It would have to be in the Swansea/Bridgend area as Cardiff is too far East and with older patients and less public transport, the appointment would take a full day.
My only question is WHERE? There was nothing in the report to suggest where the new care centre will be
I have always been pleased with the service for my sister and would be willing to go wherever is convenient for the staff. We are so grateful for all their help.
Centralised services for Cochlear and Bone Conduction Implants will get together highly specialised equipment, resources and specialist expertise in one place. This is a recognised model of delivery highly specialised services to relatively small number of patients, but all of the recipients have got a new lease of life! I would like to benefit from more timely resolution of problems - technical and clinical. A centralised service will have better connections with the industry and more timely upgrades of process and novelties. It is necessary to have accurate information as to who and how to call with any problems and the response service to have a patient advisor present.
Where will the hub be? It must be easily accessible by public transport as well as by car. Will there be dedicated parking spaces for clinic/surgery attendances? Will attendance times take travel distance into account?
Only concern is transportation for non-drivers, low income/elderly
Better to have a central team at one location
Cochlear Implant Clinic needs to be more Central Cardiff - is too far East for most people.
My concern will be accessibility for patients who will have further to travel. Will the additional travel costs be funded? I agree with idea of all services under one roof but will this lead to staff being made redundant?
I have the Cochlear Implant and I became independent since they gave me the implant. I used to be dependent on other people. I know it would be better for every patient to get better services and support for South East and South West Wales and South Powys. I also agree that a single centre would be better and able to provide a high quality service too. At present the hospital service is not able to provide good quality service due to the NHS funding cuts.
As an implanted adult I am happy to continue with the service from Cardiff Heath Hospital.
I think it will make more sense than in the previous options, it will be able to budget and also allow/include the much needed help that will be offered with this new option.
Whilst I agree, the clear arrangements for self-referral for ear infections (BAHA) MUST be made to patients as they will probably be life-long clients.

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I agree and understand why services need to be centralised, for financial reasons and also the usage of services by the clients. I visit Cardiff University Hospital and have been for over 25 years even though I live in Carmarthenshire. I do have a worry of integrating children and adults in the one hub/department unless appointments are staggered.
In an ideal world with money no-object a number of centres is the answer. I can understand that for some people travelling further can be difficult but to access this excellent service we should be prepared to pay additionally towards it. Maybe there could be some funding provided for travelling for patients who would struggle to meet the costs.
The outreach support model in Neath Port Talbot will be accessible to myself.
Preferred Option: I would hope that it will be sustainable to fund the change of staff to implement this preferred option.
I understand the need for a single implantable device hub for children and adults with an outreach support model but am concerned at the level of service that will be provided having experienced a deterioration as a consequence of moving from Bridgend to UHW.
Whilst I agree that a single centre is best, I would want to see NO reduction in staffing resource by centralising. We have seen that centralising other services has worsened service. If the same full time equivalent resource is centralised then it may work. Ideally, I want more time available for CI mapping and enquiries.
Although the preferred option appears to be the most suitable, until I know where the Main Hub will be situated, it is difficult to pass a comment.
One Hub will make travel harder for patients.
I can only say how it changed my life to be able to hear again and to be able to speak to some people on the telephone.
Easier access, locally provision of service, less travel to the centre which can be difficult for some patients, may encourage improved joint working and knowledge of the implants amongst local health board services
I agree that after service of the BAHA in local hospitals or local surgeries are a good thing for transport costs and convenient for patients.
Although it may be useful to have this you would have to think about whether it would have an effect on the surrounding communities.
I agree one place does everything for deaf people.
The most important thing is the experience of the person setting up the hearing aid to give maximum benefit. If you have to travel for this it is worth it.
As long as it provides a first class service to all - and completes necessary operations in expected time scales.
Although I do agree with the preferred option and its supporting arguments, I do find it disappointing that as it is all centred in one place then it will obviously have a significant impact on travelling time for many people.

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Neath Port Talbot ENT has been and still is a very good clinic, and I hope it will continue to be the clinic that I can attend.
Children need both implants in order to develop their speech.
As I have BAHA fitted I know the value. I had my BAHA fitted over 11 years ago when I lived in Barnsley. When in Barnsley I only had to attend 1 hospital for all ENT. But since moving back to Wales I've got to go to the Heath for BAHA, Llwynypia for Audiology and ear cleaning. When I first moved back I had to go to Mountain Ash for ear cleaning which meant I was attending 3 hospitals.
I think it's better to have Option B.
The effectiveness and efficiency delivery of the preferred option is dependent upon the availability of specialist staff
Any future upgrades in technology and or surgical methods can be practised at this hub.
A single hub would streamline the problems faced by all patients with various/different levels of hearing loss. All patients and staff would only be focussing on deafness leading to a superior service than is currently available.
Accountable, joined up, patient focussed.
If there were enough referrals and enough staff, Bridgend would be my choice to continue to have the 2 hospitals giving a service to hard of hearing children and Adults.
As stated above and cost effective service will maximise professionalism. A "Centre of Excellence" in Cardiff.
If I may be so bold as to give my personal view on the location of a central Hospital, then The Princess of Wales Hospital in Bridgend would be my choice. Clients living in Pembrokeshire or even the rural areas of Carmarthenshire find it quite stressful driving so far east to Cardiff.
My BAHA was fitted in Birmingham so I have no experience of the implant service in this region. A single hub for the surgery and implants seems a sensible idea. If the ongoing support remains in the same place as now, then there will be no change for where I access my audiologist. Having most appointments closer to home is better for most people.
I think it’s a good idea to have all the right staff and experience in one location instead of being spread between several sites. This would benefit peoples’ aftercare and when the patient needs advice on any problems that may occur. Cost of one location would be easier and reduce travel costs for staff between sites.
Understand the need of people having to travel to centers. Make it easier for rural patients and for those who find access to one center difficult. It could be done.
A single center at Cardiff would suit me as I live close by.
I think all the proposals and actions are ok.
It would be a good idea to the BCHI and Cochlear Implant Services in one hospital, but I can drive!
Any change for the deaf and hard of hearing would be amazing! The BAHA team do amazing work and to have a unit would be a great help to

the team and patients. The difference the NAHA service has made to my life was that I can still work and enjoy life and not live in the "quiet world" feeling patronized. There is still a long way to go for a better understanding of the effects of loss of hearing and disability. Mr Williams and his team do amazing work, it transforms lives. So anything that can benefit research, funding and a specialist unit would get my support and am available if you need a "voice" to help.
I believe this would make the service more of a nucleus for the S Wales area and consolidate the skills of hearing/audiologists/D/deaf specialists across this part of NHS Wales. By bringing staff and expertise together, better care can be practiced. A trained and responsive Outreach service at local audiologist deaf units would enhance the hub. This is very important especially as someone who was referred by an audiologist with strong knowledge of Cochlear Implants.
I agree with the option if this means more patients can be seen. Would it mean an enlargement of unit at the Heath to accommodate extra staff/patients? Hopefully more cost effective. Would there be more outreach units?
No proper instructions on how to use the kit provided. I am 84 and my wife who has a Cochlear Implant is 83. And so getting to the Heath Hospital would be very testing. It is also hard by telephone to get to the Cochlear Department to order spares to batteries.
I understand the issues the services are facing. I do agree that it should be moved into one location. My main worry is that the wait time to have the appointments and surgeries may be longer. As stated before in the survey, it already took 8 weeks for an adult to be seen for a referral? This fact is based on the hospital in Cardiff, the highest population in Wales. This could take much longer now as more patients are going to one location. Although the Activity rate should now be increased which would be the positive.
I am very sorry that the unit at Bridgend is closed. As a person who has been deaf for many years my confidence levels was very low and I become reluctant to attend medical appointments. However, the small group was friendly and warm I was immediately put at ease and was happy and relaxed throughout the procedure and actually looked forward to the visits. The hospital was easy to get to and parking was not a problem. I have found the opposite to be true of Cardiff, it is extremely busy hospital where you have to wait to be seen for a long time. It’s impossible to park and have to drive out of the hospital grounds and park on the roads outside. I am confined to a wheelchair and makes life very difficult.
I had my CI in March 2021 during the pandemic at UHW. From the first consultation I was received by a great team of highly trained and professionals individuals who helped me make my decision into accepting CI which was done 3 months after my evaluation and clinical decision making appointments. UHW is easily accessible for me although I live 34 miles away, parking is a nightmare. i have had amazing support from all

of the CI team at Cardiff and hope that will continue in the future, wherever you decide to base the unit.
If it means more staff and more people having the op. Yes I'm all for it they are just wonderful at the UHW Cardiff but transport getting to the hospital not everyone has a car but having one place makes sense.
I agree if there is a single center they will provide a high quality service but in my experience they need to have regular dates and appointments. My sons appointments were cancelled several times and one of the reasons was because they were short staffed in a "big hospital"
I do think this is a great idea especially if it helps people get the quality care they need and a shorter waiting time will be helpful for many patients.
Having one team of skilled experienced specialists in one hub can be a huge benefit to implant surgery. It is however vital that regional outreach support is maintained as access from across Wales to one central hub is not practical for all.
Suitably trained staff and facilities at one location.
I think it will make referrals easier and give a more equitable service
On the basis that the central service provides enhanced care then this can only be a positive step.
I agree that it would be beneficial if there was a centre of excellence. My concern would be location as the area covered in these proposals would mean travelling when transport is not the most reliable without a car.
OK but note my comments i.e. Welsh Ambulance times! I'm on my own, as many older people will be; transport in a taxi is beyond my means. No public transport. Even the community transport costs are beyond my means. QA Portsmouth did my surgery & was left in a ward under the care of my aunt for 5 hours! Aftercare didn't exist. Lost my Notes, refused even to remove my stitches. No follow-up. Now they tell Cardiff (excellent treatment) that I never existed! I had different hearing tests by default at QA. I could hear noise though not words properly. Now have a BAHA fitted though no ear chords - bent over.
By having everything in one place ensures that staff are trained to the highest standard and that patients can access everything in one place without the possibility of "falling through the cracks". Patients will know exactly where to go if they have questions or need advice. However, I do believe that follow up is important. After having my BAHA fitted last year I have had one follow up and that's it. I feel like I have been left to my own devices now. It would have been helpful to talk to other people who have an implant for support and real life advice afterwards. I do believe that patients would benefit a lot from being part of a community before and after the surgery and not just left to "get on with things"
Alongside the changes proposed we suggest some families will face additional time and financial costs associated with travel into Cardiff. Whilst some may be entitled to a travel reimbursement, they will still be required to fund the up-front costs associated with the journey. Additionally, for some families, the appointments will require a full day

away from school / work and this may negatively affect patient experience. Any unforeseen problems arising from surgery will not be dealt with locally; therefore, some families may be required to commit to additional journeys to receive the right care and support. Investment to support communication from the host site to local services will likely be required to ensure local service systems can be automatically updated. Families' emotional needs should be considered in these proposals and responded to as appropriate.
I agree that a single hub is appropriate for CI. I do not think it is necessary for BCHI, although it depends what exactly the proposal is. A centralised MDT could be helpful, but it is unnecessary to make patients travel large distances for such a simple surgical procedure.
I do not think it necessary for all BCHI surgeries to be carried out in one hospital. The team who 'independently' assessed the situation and recommended one hub for BCHIs do not even run their own service this way, with surgeries carried out in several hospitals.
From our perspective we already feel that we are part of a single hub set up.
It is better to have all staff in one place instead of having to bounce around hospitals. However it must be central and easily accessible.
I think that by having a single hub you will have access to specialist surgeons and better facilities to better help patients.
As stated the preferred option is not the preferred option of those working in the field with clinical knowledge of the needs of the service. Please reconsider with this pertinent information in mind.
1. Would provide a service with an equitable level of quality and standards across Wales. 2. Would have the same level of governance and accountability. 3. Sustainable - if the financial appraisal has shown Option D to be most cost effective. 4. Opportunities for service development along with technological development. Negative: Socio-economic issues with increased travel times and potential lack of local engagement to CI and BCHI users who may be negatively impacted by loss of local hubs.
'High volume surgical sites' are key for good outcomes. At the same time follow up services should be 'local to a patient' for better compliance & outcomes
Because waiting times would hopefully improve and staff shortages decrease

From those that disagreed with the preferred option, the following comments were made:

Preferred Option: A single device hub ensures and maintains professional input & status, and the outreach support enables access for all service users. It prevents a watering down of the service.
I agree mainly because I think it is very important to employ and keep the highly qualified staff necessary for the service to be provided.

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I think if we could converse/relay our problems to an accessible Audiologist quickly it would take away some of the panic one seems to suffer if we have a problem with our aid. Because it is such a life dependency item. Also a specialised hub would be solely beneficial for us patients. I actually waited 7 years in between my upgrade of my aid.
Too large, anonymous, patients are not familiar with staff and feel insecure and apprehensive. Harder for relatives to visit.
I agree because there are specialists who know their job. So I believe they will make the right decision on a preferred option.
I also agree with Option E as well as Option D. Option D appears to be better than Option E because it has an outreach support model.
I had a cochlear implant at the Heath Hospital in Cardiff (deferred from Bridgend). As I live in South Pembrokeshire it was a long way to travel. However, the benefit of having the Implant far outweighs problems of distance. Help towards travel expenses is available from the NHS if needed.
I would rather have an Adult Hub separate from children.
It is an unnecessary complication to include bone conduction devices. Not all bone conduction hearing aids require surgery yet have similar requirements for follow up and serve a similar population. The follow up required for Cochlear implants is significantly different, requiring users to adapt to an electronic rather than an acoustic signal.
No matter where in Wales the hub is. The travel is a small price for me personally to pay to receive my care.
I consider the change in service to be prudent and the only sensible option
Financially better to have adults and children together to keep the service going. Better qualified staff with the skills that are needed, and more implants can be offered to people who need them.
It would all depend on where the centre is based. At present some of my patients refuse to travel from NHH to RGH so if it's based in the Heath or Bridgend I think a lot of my patients may decline BAHA.
I have been a user of cochlear implants for the last 27 years. I would agree I have had regular appointments with consultants, surgeons and audiology. My only concern going forward is for follow up procedures when things go wrong as a user we heavily rely on them and without them we simply lose confidence, can't join in, have difficulty at work and can be stressful.
Where do you propose to locate the single hub?
No option

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Respondents were asked to comment on the following question 'What do you think the impact of the preferred option would be?'

Again the Heath Hospital has been absolutely amazing ever since I was 4 years old and have always been looked after but now I have moved and would love this facility in the Bronglais Hospital in Aberystwyth as the staff there are amazing and help
As long as it is not in Cardiff a lot of users would benefit, people including myself would be put off with hassle day trips to Cardiff
Impact will be longer travelling, local services will become less patient specific. Waiting times would increase due to everyone treated in one place. Less opportunity for consultants and other medical staff to progress locally and opportunities only available in large centres.
It will leave more travelling for many patients but, ultimately, give a more specialist service and save NHS costs, which can be applied to provision of an even better service.
The quality of the service will be enhanced. Providing outpatient assessments at outreach sites will minimise the impact of inconvenience of travel.
It will be better than before. I am more interested in the Cochlear Implant System than the other old hearing aid.
Hopefully more people would have access to the service or be referred to the service at the appropriate time (I wish I had been referred 30 years earlier). Hopefully the preferred option would provide more awareness medically and within the community, therefore obtaining professional status.
Minimal impact for me. Improved specialism/consistency of service.
Job well done.
Probably not much for me as an individual patient but difficulties for other patients. Thank you for seeking my opinion.
Minor inconvenience for some people, but fairly small number of people affected and most will just be grateful of the opportunity to have cochlear, etc.
I do feel that when patients are separated into children and adults, staff can maybe specialise more easily.
I don't know to be honest and I don't think you do either. Only hope service doesn't suffer as this means we suffer. Employing more nurses on better pay & conditions will improve the service. Less pen pushers. Also bring back Matrons and get rid of Managers.
A lot of people not getting the help they require.
People living in far reaches of the area that provides hearing devices have a hard time reaching one hub, especially in inclement weather
1/ Cause distress and expense for patients who will be required to travel further for all appointments. 2/ Patients referral to be assessed for an implant at a centre living further away may be impacted. 3/ Will training skills for all staff in all areas be maintained at present levels. 4/ Will aftercare following implant and switch-on be affected.

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Accessibility is the key problem for me, already having issues with train strikes, limited timetables for all public transport.
1. Hopefully the service will be better as the surgeons will do more procedures and hence gain more experience. The associated equipment should also be better. 2. In general patients will have to travel further. Nothing much you can do about that although maybe some consultations could be done remotely, although clearly not hearing tests. Maybe some assistance with travel could be provided.
Hope better service and regular check ups
I think it will impact patients in a beneficial way in most senses, however I believe they will want all their care closer to home.
I think it would have positive outcomes
Good if it works. Lot of work ahead though. Continuity of staff. To us they are friends. Easier parking than the Heath Hospital. More help needed to those living along to use new devices, etc. Particularly the older element.
Quicker response, better service, skilled staff. I received my implant 12 years ago. Everything went smoothly and I am very grateful to all the staff involved. However, after my operation, I was put on a general ward, which was very difficult for the staff and myself.
Sincerely hoping that you will be able to maintain and offer the high levels of access, communication and care I currently receive at UHW/Cardiff. Benefits of relocation may be easier access, ie parking or access by Public Transport, though doubt that's achievable or realistic for many of your patients. Hoping you keep your current highly trained staff.
So much better for patients to be in one place, we all have different needs, therefore if all specialists are in one place, it would be so much easier all round. It's just a shame Mid Wales is forgotten and it takes 3 hours to get to my hospital appointments one way.
More centralised services would mean that specialist teams would have a better opportunity to maintain their skills and would mean that finances don't have to be split across a number of services; therefore would be more beneficial from a financial perspective.
I feel the service would become more robust ensuring the correct staff are seeing patients
At present I'm seen in Neath Port Talbot Hospital and this is very difficult for me to get to. I would very much prefer to be seen in Singleton Hospital as I did a few years ago as I can get there much easier. I live in Pontarddulais Swansea and if there is a centre for hearing loss closer to my home and on a bus route, that would be much easier for me.
Although the desired level of service should be assured, the main impact will be on patients who have increased distance to travel for appointments and surgery. For some this may discourage them from attending.

I would need details on the location of the single hub before I could answer. Cardiff would be my preference.
It will impact those who live furthest away, might I suggest having extra facilities available for families to stay overnight?
Better continuity of care provided. I do worry about access as living in Swansea and coming to Cardiff has sometimes proved difficult especially on surgery day as we had to find a hotel, etc. The whole Team were nothing short of amazing and the care I received was second to none. By pulling all the services together, it can only improve.
I think it will make more sense than the previous options. It will be able to keep to budget and also allow included the much needed help that will be offered with this new option.
Faster turnover of patients' appointments, less frequent technical issues during clinical appointments. The personnel is likely to be more involved in patient's care and outcomes in comparison to the service "borrowing" personnel from outpatients' departments of general hospital. I believe such service will be able to arrange timely and expertly dealing with emergencies. It can be the hub for training health professionals. It can develop research unit. It can facilitate patients' support groups, further education and training in using the implants for improved quality of life of the recipients. A Centralised Unit will measure up very favourably with other UK and International Units. I have benefitted tremendously from the skills and professional expertise of UHW Cochlear Implant Service. I cannot praise them highly enough for the years of support I have received. I believe that the Cochlear and Bone Conduction Implant Services in Wales have got a bright future and should be supported throughout. .
More difficult for those living at some distance. But a 'Centre of Excellence' is certainly a preferred way forward. Outreach support must be fully supported and not just pay lip service to the idea. Staff must be fully trained and supervised to a high standard wherever they are based.
Essential to enable all patients to take their places in society with no exclusions for any person’s disabilities.
probably a better service, although the current arrangements are excellent
Potential for a more complete service. Longer and more expensive travel for some people. Will staff have to relocate?
I want a good service for everyone who has hearing issues. At this moment there's not much available and it is very difficult to get help and support.
A personal view: I am 85 next month. I was fitted with a BAHA in 2008 at Singleton Hospital. The hearing loss, in the meantime, has been considerable and it is a chronic disease. The Baha does very little for me now but I can't do without it as it does pick up a level of noise. I appreciate the good work that went into getting one of those. I attend Audiology at Carmarthen Hospital every 3 months, or did pre-covid. A local centre would be nice where the BAHA could be serviced or

replaced. As far as I am concerned, it could be Option A still with as you describe on page 19: "Can be delivered through an outreach model closer to home". At my age, the closer to home things are the better. COVID has made us a lot more hesitant about going to busy places. I think the current system is good. Then, there are your groups claiming it could be improved. Despite best attention, I have lost my hearing. There were problems from a very early age. We were in London for 38 years and had regular appointments at Ilford and Whipps Cross Hospital for treatment. We moved here 20 years ago and the transition to Carmarthen and Singleton Hospitals was seamless. The hearing loss has been dramatic. It is as if the nerve endings have eroded away and there is nothing there to work on. There is an impact on our daily lives, of course. It throws a huge burden on my wife, who has to deal with all those day to day things in our lives. She jots things down for me, rather than try to communicate verbally. I wish I could pull my weight and do a share.
It would be a lot better as you are able to see the same people (surgeons and audiologists) whenever you have an appointment, so that you can build up a patient/Doctor relationship that most people like myself miss.
Centralisation = Centre of Excellence. Retain qualified staff, maintain Dr numbers and allow cover therein. Possibility for innovation. Transport arrangements would prove difficult for more people.
I agree as it gives a fairer and safer service for patients; it will no longer be a 'postcode lottery' as to how quickly and effectively a patient is seen. Largely positive, however, it could mean transport difficulties for some patients. Also, I am assuming the service would require fewer specialists going forward and whilst this may be a cost saving, it will mean there may be losses for the staff involved. Also, would current staff relocate, or would it result in staff shortages as it is a specialist area. I want to know whether the Doctors would still have a working partnership with Paediatric Plastics in Swansea Bay (Morriston) to accommodate BCHI and ear reconstruction to happen at the same time.
Hopefully it will improve services for the clients.
It would be very worthwhile building a specialised hospital where it would enable a high end patient care ad understanding. All Doctors and their Team in a central place would benefit everyone, creating more jobs, more specialised care.
You can never please everyone, but this appears to be the most sustainable option.
A far more accessible and specialised service for both the health providers and the patients
Staff moving to central hub and patients' concerns regarding appointments. Difficult to travel to. I myself had a very good experience with very helpful and professional staff when I had my Cochlear Implant.
I'm sure it should be a big improvement, mostly to relay any problem that us current users face. It can only be a good thing if children/adults

who need help with the hearing problems are sorted quickly. I'm lucky enough to have had a BCHI (BAHA) at Singleton almost 30 years ago. Wish it was available when I was a child/teen. So pleased for children today [to be able to receive this Aid].
A poorer service. Increased costs for families living in West Wales. Increased travelling times. Whilst this is couched as a 'consultation', I believe the decision has already been taken.
I worry it will be an excuse to cut overall staffing - if this happens, no progress will be made. I am now in year 2 since my CI. I believe not enough time is given to mapping - as a result, my confidence has eroded as my CI experience has declined through mapping being done in a rush.
The following problems could arise for many people: 1. Distance they will have to travel; 2. If no car available; 3. What will be the bus service to the location. West Wales patients may have a tremendous distance to travel if the hub is situated in Cardiff for example. The principle in respect of expertise and staff levels is good. But at what price to patients? At present, Swansea, Cardiff and Newport Hubs means patients travelling. Could be more suitable and less distances involved.
I find it hard enough to travel to your centres as they are - one centre would be too much.
There will be an impact for both staff and families, particularly for areas further afield. Putting all your eggs into one basket as it were?
If my experience is that a change would be not needed to improve the service and attention I received when I was attended to. Thank you.
Better service access, knowledge imparted and improved links with local services, especially audiology teams, (if outreach audiology appointments), a possible increase in the number of people being referred/ considering implants, consistent approach
It would not be dire that is for certain but overall unsure. I was unaware that these services were in such a mess and would agree having these services centralised but not affecting people is a good idea.
I currently have BAHA 6 Power. Struggling to get settings correct which can be common from comments on Facebook Group. Would be difficult and I imagine patients would persevere less if they had longer to travel. Would you still be able to have settings adjusted locally? This would be important to me. Do you offer the Osia 2?
1. Would have more in-depth skills in one centre. 2. Would provide more consistent appointment fixtures as there would be more specialists on hand to cover unexpected absences. 3. Unfortunately, would mean significant number of people might have a significant increase in travelling time and therefore additional cost, as well as travel stress.
It would be ideal, if you could provide enough support for Adults, as children get plenty of support and therapy. But I was so struggling on my own. It took time for me to get used to it. Important to ask adults what they do seek from you and give your options of support to adults. Also, staff need to learn basic BSL, just in case. And especially reception

staff are awful. They look down at the system whilst talking to us. How rude.
Better all round. Makes sense to keep both sections in one main centre with Outreach Support.
Whichever the option, some patients are going to travel further.
Think it would impact patients as there have been too many changes already. People want to be seen where they have been seen in the past!
Improved individualised care.
I think the impact would be to go for Option B.
A more timely service with waiting times equal for all areas. Whereas now, it varies greatly between the health boards. I have been fortunate to have been treated at The Royal Gwent Hospital and had a BAHA fitted in 2018. I have received excellent care and any issues I am able to access the Audiologists within their department. Only this week I asked for an appointment as experiencing feedback issues. I have been referred back to my ENT Consultant as the abutment made needed to be replaced by a longer one. I have also been given an appointment for a hearing test as last one was 3 years ago. This is to see if I would benefit from the newer version of the BAHA, funding permitting. I am a Nurse Manager working at the Royal Gwent and am very appreciative of the care and treatment I have received. The BAHA has transformed my hearing problems. I would be more than happy to travel to a central hub with follow ups locally.
Yes for clinical reasons it makes sense but not sure if patients would agree
Distance from hub and travel time for patients will be concerning and could be problematic. May result in an increase of patients not attending.
The impact on some would include, increased travelling cost and time. But having said that as a BAHA wearer, the positive impact of having this aid, far outweighs any negatives of slight upheaval of having to travel a little further or taking a day of work instead of say half a day.
Waiting lists would be reduced. GP's would know exactly where a patient would need to be referred. Staff would not be called away to cover other areas - this does happen in multi-disciplinary hospitals/clinics. Improved communication between patients and staff. Allow for longer consultations. Better understanding of complications following cochlear implants. Patients would know exactly where and who to contact should problems arise. Overall a single centre to deal with BCHI simplified referral, consultation, surgery and all future necessary follow-ups which are essential. Adequate parking.
Improved individual patient care.
Congestion in the Heath Hospital making waiting and travelling a problem. Parking in Cardiff is always a problem. Allowing time for catching buses for people from far away could cause stress. Staff shortages causing congestion of patients waiting for attention. Too many

operations for the surgeons to perform. Too many people waiting to be seen.
I support Option D. If that is the preferred option I think the impact would be best. An outreach support model would then be available for everyone, whenever necessary.
To enhance the lives of people with profound hearing loss. More public awareness by being a centralised approach for Wales. A hub for excellence.
For myself I would simply like a conversation regarding the problems I have with my BAHA. An expert whose input I would value.
A one stop 'SHOP' - all in one place. Great!
For me personally, no impact.
Is there any plan to make more use of digital support for follow up care? I have managed very well with my implants using headsets and Bluetooth. More training will be required for both patients and staff on this.
People might have trouble getting to the hospitals and parking is always a nightmare. Help to set up appointments would be helpful.
If the hospital is long way for some patients to get there without a car it could be a big deal for them. I live in the valleys and buses from our village only run every 2 hours and stop at certain times, so for someone without a car would be a big deal unless a transport service was made available for them.
There needs to be more help and understanding of the deaf community and maybe a complete unit dedicated to this would be an asset
Firstly I wouldn't want there to be an impact on the workforce's work/life balance by having to change work place by excessive commuting, etc. This needs to be managed sensibly. Having previously been a patient at West of England Cochlear Implant Programme, I felt at ease and safe in their care. Larger travelling distances for patients might be an issue, but with good care, long travel shouldn't be consistently necessary post-implant. Good workforce/patient relationships should be maintained if a single hub is the option. Some patients may be too used to the current set-up.
A better and quicker service while some of us have to travel further. I think it will be better for us in the long term, with all the right staff and facilities in the right place.
All things considered, it would benefit everyone who needs assisted hearing aids which are essential, as I for one am very grateful for mine. I think if it makes the process easier I'm all for it.
Benefit for all - staff and patients alike. Increase in referrals. Especially important for children as early diagnosis and help is vital. Having been profoundly deaf I consider my Cochlear Implant to be a "Miracle". Any improvement in the future provision of Cochlear and BCHI is to be welcomed. PS: Many thanks to the Cochlear Team at the Heath Hospital!
To make it easier and more accessible for everyone.

As stated earlier, I think there would be an increased amount of patients heading to one location which in turn will have an increase of wait time is the main concern of mine. I do think the positives is that financially, it could all go into one hospital which would be able to cater for all departments.
Having to travel to a central hub may put some people off having the surgery which would be a great loss to patients of the absolutely massive benefits of an implant (it changed my life for the better by an enormous amount). So the correct support may be required even providing accommodation for the accompanying relative if needed. For the surgical procedure, an overnight stay in hospital.
Would it still be the personal service I have now? I have already moved from Bridgend with no choice or option. Cardiff has been very good to me. A service that I have quick access to if I have a problem with my cochlear implant.
Fewer staff & facilities offering higher level of service to patients. Patients having to travel further for treatment etc.
i think it will result in some patients have if to travel further , but they would be seeing a more experienced team
The centre would have to be child friendly. As a child growing up we had a special Ear, Nose and Throat hospital which catered for children so the environment was welcoming and friendly.
It won't be good for many distance-wise. I can drive to Cardiff; I would NOT drive to Newport. If the new service is as good as Cardiff - fantastic. Met a lady working in Tesco - she is over the moon. Saw a little boy with an implant and showed him mine - he was thrilled. It's a good thing to mix children & adults. Let's hope many more will benefit, especially for surgery not to be in a mixed surgical environment. I heard something about teaching the children to speak with 'normal tones', including regional accents, and not sound flat. Fantastic. I just wish I could hear 'the split' and therefore learn to speak Welsh! (Being old doesn't help). Good luck. When I eventually got mine, I cried when I heard birds sing! My (*name*) said it was selective hearing and bad hygiene - I was 24/7 carer to my Mum. Please teach GP's. From my experience in Wales it's better - but it's so so important. I was also refused access to a hearing dog! Thank you for my treatment this past 9-10 years.
The impact should be better support for those with hearing loss. Support to access doctors who use BSL, access to the Deaf community, and a community of those with implants. A follow up to check on quality of life/ what benefit they have had from the implant would be easy to do. Staff could be trained to higher standards if they are specialising and they would come to know the difficulties facing the patients better.
In response to increased travel, time, and financial costs for some families, it will be imperative to monitor equality of access to the specialist provision once available via a single site, adjusting policy continuously to support families access as appropriate.

Continued investments to ensure effective communications between local systems and the host database systems should be considered. We expect the related services to comply with nationally developed standards. National Deaf Children's Society works with government agencies and professional groups in developing good practice guidance and quality standards that reflect the views of parents and young people. We suggest consideration is given to supporting the emotional needs of families opting for implant assessment, procedure, and follow-on care, which is reflected in policy, pathways and practice.
A positive development for the CI service, formalising the current arrangement and enabling the service to move forward. A centralised MDT could be helpful for BCHI, making things more co-ordinated and potentially leading to more people receiving BCHI. However, it could also be detrimental to patients if care is unnecessarily moved away from their local area.
Positive for the CI service, removing uncertainty and allowing the service to move forward. For BCHIs, it will mean that patients will need to travel further for a simple surgical procedure, for no good reason.
The impact would potentially be minimal for us as currently we only attend appointments annually however we appreciate there could be an impact for others.
More convenience and better quality treatment.
Travelling will be a problem for some people. It was hard to adapt when I used hearing aids. I didn't wait a long time for mine. I think it's a good idea to have in one hospital. It is a good idea for both adults and children to be in one hospital. It will be easier for all the staff to be in one place. My house mate wears a hearing aid; you put it in your ear. 3 hospitals to be put into one is not enough. Travelling too far. It can be a long way to travel. It could be a good idea to ease pressure on emergencies. It's a good idea for adults and children in one place. It may be easier to employ staff.
It is likely that fewer patients will benefit from bone conduction devices if a central referral is required.
Detriment to the service provided to both CI and BAHA patients. The needs of patients is not equitable and trying to lump them together will not be in the best interests of the service.
Personally little impact. Potential however, for other service users to feel that there may be: 1.a lack of local support; 2. financial detriment to attend appointments. 3. Feeling of inequality due to location. 4. It would end in essence 'postcode' lottery - not in terms of treatment or expertise but would ensure consistency. 5. There would be a decrease in staff pool for the services provided. This would mean potential staffing issues

should you have retirement/relocation of staff. It would become an extremely specialised service. It will unfortunately mean some staff would also become de-skilled.
A better, more integrated service for children and adults.
An improved service and a higher skilled workforce
enough patients seen to ensure staff skills are adequate
This would depend on the strength of the outreach support model. Visiting Cardiff from West Wales is a big undertaking - can you imagine doing this with a newly implanted Aid on public transport? If the outreach centre was located in an appropriate location then it may be considered more desirable. Also if you have transport the parking at Cardiff is horrendous. I think that people would miss appointments and feel dread at the thought of going to a big impersonal centre. At Bridgend we were known to staff and made to feel welcome and the service was second to none. The hospital was easy to get to with adequate parking. At the moment with one centre it feels impersonal and rushed. The staff seem rushed and there is little time for the care I feel should be provided for such an important part of my life. I think the impact would be very negative and with the number of adults and children with implants increasing it seems illogical to decrease the service - which I feel is already not as good as it was.
I somewhat agree but there are areas to be considered such as the location of the model. As mentioned previously, the location should be more central, such as Carmarthenshire, thus meaning more people have access to facilities. Parking would need to be of a decent quality. Cardiff has poor parking. In addition, public transport would need to be considered, as not all people with cochlear implants or have an implanted child are able to drive. One singular centre would possibly fail to provide efficient facilities and support and time - especially to newly implanted people and their families. I believe going ahead would be a mistake due to the extensive journey which in my experience is very tiring, as well as the tuning sessions being exhausting - adding hours of travel into the mix amplifies my sheer exhaustion. In addition the system feels very rushed, like patients are tasks to complete instead of people. Growing up, Bridgend was personal to me. I recall being greeted, updating staff on my life and felt more than a list. Taking the next step could discourage people from choosing to be implanted as they will have to take constant tests at the hospital in the immediate aftermath of the surgery and the activation of the implant. Prior to taking the next step, I strongly believe consultation with patients and their families would be ideal as relying solely on data and financial costs would be a severe mistake.
care will improve
A quicker response rate to ongoing needs for children

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

APPENDIX 2 THEMATIC ANALYSIS OF RESPONSES ENGAGEMENT ON FUTURE PROVISION OF COCHLEAR AND BONE CONDUCTION HEARING IMPLANTS FOR SOUTH EAST WALES, SOUTH WEST WALES, & SOUTH POWYS

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Joint Committee 16 May Item 3.6.2
Appendix 2

COMMENTS FROM THE RESPONSES PRESENTED WITHIN THEMES SUPPORT FOR PROPOSED CHANGE

Support for change	I have a cochlear implant. The reorganisation of this service is necessary, to create the best service possible to give the service users the best quality of life available. I think it should all come under one central unit with all the surgeons and after care can be carried out.
Support for change	If this means that children/adults are able to be assessed and acted on more promptly, it has to be a good change. It has changed my life for the better.
Support for change	Yes - waiting times are too long.
Support for change	To provide a more sustainable and effective service it makes sense to consolidate the main service to one area.
Support for change	It is obviously very difficult to maintain a good service with smaller units and lack of staff and expertise.
Support for change	I agree that having all the specialist support in one place can benefit surgical procedures and implant recipients.
Support for change	If this means that children/adults are able to be assessed and acted on more promptly, it has to be a good change. It has changed my life for the better.
Support for change	More people in one place will be better.
Support for change	Right to have one 'Facility' for children and adults. Should make no difference.
Support for change	Having everyone (staff) in one place makes more sense to everyone.
Support for change	I think that this will be a positive move, everything will be easily accessible and all at one place.
Support for change	Multi-disciplinary patient assessment, education, surgery details, skilfully performed implant operation, post-operative follow-ups, early and ongoing support for the implant recipient will work better.
Support for change	I think this will be a positive move, everything will be easily accessible and all at one place.
Support for change	Centralising a service which serves a small number of the population allows resources to be pooled and staff to gain more experience. This also gives a fairer service and safer.
Support for change	This would be a brilliant idea.

Support for change	Having the facilities for adults and children under one roof would make more financial sense.
Support for change	I agree with what is proposed.
Support for change	Reassuring that a wider range of specialist skills would be available.
Support for change	It would be more beneficial to the MDT to be able to maintain their skills/experience and share knowledge by coming together in one location.
Support for change	A main (one Hub) is the way forward for a seamless approach and understanding.
Support for change	Having experience of having had my preoperative assessment many years ago i.e. 1996 for a cochlear implant at the old Bridgend Hospital followed by being the 1st to have the implant at the then new in 1997 Princess of Wales Hospital. I agree wholeheartedly with there being one centre with the required service listed.
Support for change	Feel the expertise would be in one place which should be a good thing.
Support for change	All under one roof would be better and to see consultants quicker would be great (I have no problem with the Royal Gwent Hospital).
Support for change	It makes sense to provide one central hub for patients and staff.
Support for change	Hope it would give more people with hearing problems access to either implants, As Doctors, Nurses and hearing .specialist available to help.
Support for change	Needs to be robust centralised service, not piecemeal.
Support for change	My understanding is that it has been practiced and tried with a positive outcome. That will benefit patients and staff with hopefully the best outcome.
Support for change	I believe a single unit designed to treat all BCHI patients would enable all patients and staff to concentrate on this specialist area of medical treatment.
Support for change	If it means that more operations can be carried out then yes it's definitely needed.
Support for change	It would be great for Adults and children to have one unit
Support for change	I agree with this option because both Cochlear and BCHI, Bone Conduction Hearing Aids, would all be under one umbrella. With the right staff who understand how people with profound hearing loss feel, cope and deal with every day with this very real disability.
Support for change	I feel centralised services would be more joined up and accountable

Support for change	It is good. It is better to be in one place so people know where to go. Staff will be with a specialised team. If it is in one place, it may be difficult for some people to get to. One member said she doesn't use hearing aids so she doesn't know much about them. It is a good idea to have a single implant centre. Good thing for children and adults to use the same centre. Keep the same staff as it is good to have the same nurses.
Support for change	I agree, more service users would benefit
Support for change	I have no comment about the preferred option and I agree with the preferred option as a positive option.
Support for change	All the required skill set in one place.
Support for change	Easier for everyone to liaise & patients.
Support for change	It is the only option to achieve the aims stated.
Support for change	Centralised services for Cochlear and Bone Conduction Implants will get together highly specialised equipment, resources and specialist expertise in one place. This is a recognised model of delivery highly specialised services to relatively small number of patients, but all of the recipients have got a new lease of life! I would like to benefit from more timely resolution of problems - technical and clinical. A centralised service will have better connections with the industry and more timely upgrades of process and novelties. It is necessary to have accurate information as to who and how to call with any problems and the response service to have a patient advisor present.
Support for change	better to have a central team at one location
Support for change	I think it will make more sense than in the previous options, it will be able to budget and also allow/include the much needed help that will be offered with this new option.
Support for change Service design	I agree and understand why services need to be centralised, for financial reasons and also the usage of services by the clients. I visit Cardiff University Hospital and have been for over 25 years even though I live in Carmarthenshire. I do have a worry of integrating children and adults in the one hub/department unless appointments are staggered.
Support for change	In an ideal world with money no-object a number of centres is the answer. I can understand that for some people travelling further can be difficult but to access

Travel and costs	this excellent service we should be prepared to pay additionally towards it. Maybe there could be some funding provided for travelling for patients who would struggle to meet the costs.
Support for change	I agree one place does everything for deaf people.
Support for change	The most important thing is the experience of the person setting up the hearing aid to give maximum benefit. If you have to travel for this it is worth it.
Support for change	As long as it provides a first class service to all - and completes necessary operations in expected time scales.
Support for change	A single hub would streamline the problems faced by all patients with various/different levels of hearing loss. All patients and staff would only be focussing on deafness leading to a superior service than is currently available.
Support for change	Accountable, joined up, patient focussed.
Support for change	I think it's a good idea to have all the right staff and experience in one location instead of being spread between several sites. This would benefit peoples aftercare and when the patient needs advice on any problems that may occur. Cost of one location would be easier and reduce travel costs for staff between sites.
Support for change	A single center at Cardiff would suit me as I live close by.
Support for change	I think all the proposals and actions are ok.
Support for change	It would be a good idea to the BCHI and Cochlear Implant Services in one hospital, but I can drive!
Support for change	I believe this would make the service more of a nucleus for the S Wales area and consolidate the skills of hearing/audiologists/D/deaf specialists across this part of NHS Wales. By bringing staff and expertise together, better care can be practiced. A trained and responsive Outreach service at local audiologist deaf units would enhance the hub. This is very important especially as someone who was referred by an audiologist with strong knowledge of Cochlear Implants.
Support for change	I do think this is a great idea especially if it helps people get the quality care they need and a shorter waiting time will be helpful for many patients.
Support for change	Having one team of skilled experienced specialists in one hub can be a huge benefit to implant surgery. It is however vital that regional outreach support is maintained as access from across Wales to one central hub is not practical for all.

Support for change	I think it will make referrals easier and give a more equitable service
Support for change	It is better to have all staff in one place instead of having to bounce around hospitals. However it must be central and easily accessible.
Support for change	I think that by having a single hub you will have access to specialist surgeons and better facilities to better help patients.
Support for Change However concerns re increased travel times	1. Would provide a service with an equitable level of quality and standards across Wales. 2. Would have the same level of governance and accountability. 3. Sustainable - if the financial appraisal has shown Option D to be most cost effective. 4. Opportunities for service development along with technological development. Negative: Socio-economic issues with increased travel times and potential lack of local engagement to CI and BCHI users who may be negatively impacted by loss of local hubs.
Support for change	'High volume surgical sites' are key for good outcomes. At the same time follow up services should be 'local to a patient' for better compliance & outcomes
Support for change	Because waiting times would hopefully improve and staff shortages decrease
Support for change	Preferred Option: A single device hub ensures and maintains professional input & status, and the outreach support enables access for all service users. It prevents a watering down of the service.
Support for change	I agree because there are specialists who know their job. So I believe they will make the right decision on a preferred option.
Support for change	No matter where in Wales the hub is. The travel is a small price for me personally to pay to receive my care.
Support for change	I consider the change in service to be prudent and the only sensible option
Support for change	Financially better to have adults and children together to keep the service going. Better qualified staff with the skills that are needed, and more implants can be offered to people who need them.
Support for change	It will leave more travelling for many patients but, ultimately, give a more specialist service and save NHS costs, which can be applied to provision of an even better service.
Support for change	The quality of the service will be enhanced. Providing outpatient assessments at outreach sites will minimise the impact of inconvenience of travel.
Support for change	It will be better than before. I am more interested in the Cochlear Implant System than the other old hearing aid.

Support for change	Hopefully more people would have access to the service or be referred to the service at the appropriate time (I wish I had been referred 30 years earlier). Hopefully the preferred option would provide more awareness medically and within the community, therefore obtaining professional status.
Support for change	Minimal impact for me. Improved specialism/consistency of service.
Support for change	Job well done.
Support for change	Minor inconvenience for some people, but fairly small number of people affected and most will just be grateful of the opportunity to have cochlear, etc.
Support for change	1. Hopefully the service will be better as the surgeons will do more procedures and hence gain more experience. The associated equipment should also be better. 2. In general patients will have to travel further. Nothing much you can do about that although maybe some consultations could be done remotely, although clearly not hearing tests. Maybe some assistance with travel could be provided.
Support for change	I think it will impact patients in a beneficial way in most senses, however I believe they will want all their care closer to home.
Support for change	I think it would have positive outcomes
Support for change Service design	Quicker response, better service, skilled staff. I received my implant 12 years ago. Everything went smoothly and I am very grateful to all the staff involved. However, after my operation, I was put on a general ward, which was very difficult for the staff and myself.
Support for change	Sincerely hoping that you will be able to maintain and offer the high levels of access, communication and care I currently receive at UHW/Cardiff. Benefits of relocation may be easier access, ie parking or access by Public Transport, though doubt that's achievable or realistic for many of your patients. Hoping you keep your current highly trained staff.
Support for change Location	So much better for patients to be in one place, we all have different needs, therefore if all specialists are in one place, it would be so much easier all round. It's just a shame Mid Wales is forgotten and it takes 3 hours to get to my hospital appointments one way.
Support for change	More centralised services would mean that specialist teams would have a better opportunity to maintain their skills and would mean that finances don't have to be

	split across a number of services; therefore would be more beneficial from a financial perspective.
Support for change	I feel the service would become more robust ensuring the correct staff are seeing patients
Support for change Location Service feedback	Better continuity of care provided. I do worry about access as living in Swansea and coming to Cardiff has sometimes proved difficult especially on surgery day as we had to find a hotel, etc. The whole Team were nothing short of amazing and the care I received was second to none. By pulling all the services together, it can only improve.
Support for change	I think it will make more sense than the previous options. It will be able to keep to budget and also allow included the much needed help that will be offered with this new option.
Support for change	Faster turnover of patients' appointments, less frequent technical issues during clinical appointments. The personnel is likely to be more involved in patient's care and outcomes in comparison to the service "borrowing" personnel from outpatients' departments of general hospital. I believe such service will be able to arrange timely and expertly dealing with emergencies. It can be the hub for training health professionals. It can develop research unit. It can facilitate patients' support groups, further education and training in using the implants for improved quality of life of the recipients. A Centralised Unit will measure up very favourably with other UK and International Units. I have benefitted tremendously from the skills and professional expertise of UHW Cochlear Implant Service. I cannot praise them highly enough for the years of support I have received. I believe that the Cochlear and Bone Conduction Implant Services in Wales have got a bright future and should be supported throughout. .
Support for change	More difficult for those living at some distance. But a 'Centre of Excellence' is certainly a preferred way forward. Outreach support must be fully supported and not just pay lip service to the idea. Staff must be fully trained and supervised to a high standard wherever they are based.
Support for change	probably a better service, although the current arrangements are excellent
Support for change	It would be a lot better as you are able to see the same people (surgeons and audiologists) whenever you have an appointment, so that you can build up a patient/Doctor relationship that most people like myself miss.

Support for change	Centralisation = Centre of Excellence. Retain qualified staff, maintain Dr numbers and allow cover therein. Possibility for innovation. Transport arrangements would prove difficult for more people.
Support for change	It would be very worthwhile building a specialised hospital where it would enable a high end patient care ad understanding. All Doctors and their Team in a central place would benefit everyone, creating more jobs, more specialised care.
Support for change	You can never please everyone, but this appears to be the most sustainable option.
Support for change	A far more accessible and specialised service for both the health providers and the patients
Support for change	I'm sure it should be a big improvement, mostly to relay any problem that us current users face. It can only be a good thing if children/adults who need help with the hearing problems are sorted quickly. I'm lucky enough to have had a BCHI (BAHA) at Singleton almost 30 years ago. Wish it was available when I was a child/teen. So pleased for children today [to be able to receive this Aid].
Support for change	Better service access, knowledge imparted and improved links with local services, especially audiology teams, (if outreach audiology appointments), a possible increase in the number of people being referred/ considering implants, consistent approach
Support for change Location	1. Would have more in-depth skills in one centre. 2. Would provide more consistent appointment fixtures as there would be more specialists on hand to cover unexpected absences. 3. Unfortunately, would mean significant number of people might have a significant increase in travelling time and therefore additional cost, as well as travel stress.
Support for change	Better all round. Makes sense to keep both sections in one main centre with Outreach Support.
Support for change	Improved individualised care.
Support for change	I agree mainly because I think it is very important to employ and keep the highly qualified staff necessary for the service to be provided.
Support for change	Yes for clinical reasons it makes sense but not sure if patients would agree
Support for change Location	The impact on some would include, increased travelling cost and time. But having said that as a BAHA wearer, the positive impact of having this aid, far outweighs any negatives of slight upheaval of having to travel a little further or taking a day of work instead of say half a day.

Support for change	Waiting lists would be reduced. GP's would know exactly where a patient would need to be referred. Staff would not be called away to cover other areas - this does happen in multi disciplinary hospitals/clinics. Improved communication between patients and staff. Allow for longer consultations. Better understanding of complications following cochlear implants. Patients would know exactly where and who to contact should problems arise. Overall a single centre to deal with BCHI simplified referral, consultation, surgery and all future necessary follow-ups which are essential. Adequate parking.
Support for change	Improved individual patient care.
Support for change	I support Option D. If that is the preferred option I think the impact would be best. An outreach support model would then be available for everyone, whenever necessary.
Support for change	To enhance the lives of people with profound hearing loss. More public awareness by being a centralised approach for Wales. A hub for excellence.
Support for change	A one stop 'SHOP' - all in one place. Great!
Support for change	There needs to be more help and understanding of the deaf community and maybe a complete unit dedicated to this would be an asset
Support for change Workforce balance	Firstly I wouldn't want there to be an impact on the workforce's work/life balance by having to change work place by excessive commuting, etc. This needs to be managed sensibly. Having previously been a patient at West of England Cochlear Implant Programme, I felt at ease and safe in their care. Larger travelling distances for patients might be an issue, but with good care, long travel shouldn't be consistently necessary post-implant. Good workforce/patient relationships should be maintained if a single hub is the option. Some patients may be too used to the current set-up.
Support for change	A better and quicker service while some of us have to travel further. I think it will be better for us in the long term, with all the right staff and facilities in the right place.
Support for change	All things considered, it would benefit everyone who needs assisted hearing aids which are essential, as I for one am very grateful for mine. I think if it makes the process easier I'm all for it.
Support for change	Benefit for all - staff and patients alike. Increase in referrals. Especially important for children as early

	diagnosis and help is vital. Having been profoundly deaf I consider my Cochlear Implant to be a "Miracle". Any improvement in the future provision of Cochlear and BCHI is to be welcomed. PS: Many thanks to the Cochlear Team at the Heath Hospital!
Support for change	On the basis that the central service provides enhanced care then this can only be a positive step.
Support for change Travel	I think it will result in some patients have if to travel further , but they would be seeing a more experienced team
Support for change	A positive development for the CI service, formalising the current arrangement and enabling the service to move forward. A centralised MDT could be helpful for BCHI, making things more co-ordinated and potentially leading to more people receiving BCHI. However, it could also be detrimental to patients if care is unnecessarily moved away from their local area.
Support for change	A better, more integrated service for children and adults.
Support for change	An improved service and a higher skilled workforce
Support for change but concern on travel cost	The only disadvantage is the additional travelling expense where patients reside far from the hub.
Support for change – though no location determined as yet	As stated above and cost effective service will maximise professionalism. A "Centre of Excellence" in Cardiff.
Support for change – though no location determined as yet	My BAHA was fitted in Birmingham so I have no experience of the implant service in this region. A single hub for the surgery and implants seems a sensible idea. If the ongoing support remains in the same place as now, then there will be no change for where I access my audiologist. Having most appointments closer to home is better for most people.
Support for change – though no location determined as yet	I agree with the option if this means more patients can be seen. Would it mean an enlargement of unit at the Heath to accommodate extra staff/patients? Hopefully more cost effective. Would there be more outreach units?
Support for change & location	I agree that it would be beneficial if there was a centre of excellence. My concern would be location as the area

	covered in these proposals would mean travelling when transport is not the most reliable without a car.
Support for change & resources	I agree if there is a single center they will provide a high quality service but in my experience they need to have regular dates and appointments. My sons appointments were cancelled several times and one of the reasons was because they were short staffed in a "big hospital"
Support for change & Resources	Suitably trained staff and facilities at one location.
Support for change and general patient position	I have the Cochlear Implant and I became independent since they gave me the implant. I used to be dependent on other people. I know it would be better for every patient to get better services and support for South East and South West Wales and South Powys. I also agree that a single centre would be better and able to provide a high quality service too. At present the hospital service is not able to provide good quality service due to the NHS funding cuts.
Support for change and location	If it means more staff and more people having the op. Yes I'm all for it they are just wonderful at the UHW Cardiff but transport getting to the hospital not everyone has a car but having one place makes sense.
Support for change but concerns on location	I agree that specialist services would be better served where more staff can be accommodated in one or two centres but, as explained above, hope that this is in my areas.
Support for change	If everything was in a central place then standards would improve and the service provided to patients would be better.
Support for change – access	Access may be an issue as some patients and their families will have to travel further but to get excellent standards of care the service needs to be centralised
Support for change – general patient position	I would like to agree because the problem I had before my op. was that I had to wear 2 aids in my ears, the hearing aids caused a lot of infection and irritation, had to go to the hospital every week to have treatment. When I had the chance to have the op., it was great. No more infections and irritations, and a better quality of hearing.
Support for Cochlear centralised but not for BCHI	Whilst Cochlear Implants can benefit from one centre I'm not convinced just having one BCHI Centre is beneficial.
Support for proposal	Yes, the service offered needs to be cost effective (to obtain ongoing funding). Accessible through all stages of

	delivery and safe. A good robust service not a smattering.
Support for service	I personally can't fault the care and service I have received
Support for service and service feedback	It makes sense to rationalise the service and retention of specialists. Post-implementation I would still like to see more D/deaf specialist mental health provision including counselling.
Support for single team	The access to timely surgery would be a great outcome here. We also struggle as a small team to dedicate all the admin time to provide figures for the BCIG meetings, if this is managed by one team this would be great.

NON SUPPORT FOR CHANGE

More services needed	It would be a good thing if Cochlear were done in more hospitals.
No support for change	Centralisation doesn't work. Staff are wonderful but getting to you is not good and there's many much further away than us. If you need to save cash get rid of Managers, etc. and get more nurses and doctors.
No support for change	I could not agree with a proposal for one centre given the difficulties for many of your customers to travel. It is already too far for me to travel to Cardiff as it is.
No to centralisation	The arguments are not convincing. There are movements in Wales into having things done centrally. Generally, patients like things done closer to home. The NHS is under pressure at all points. It has coped well, everywhere, with covid
Option suggestion	I think it's better to have Option B.
Option suggestion	I think the impact would be to go for Option B.
Single centre challenging	Having a single centre for CI/BAHA is challenging, surely, for staff intervention. It's a huge catchment area, meaning travel eats into staff hours (for QTOD visiting children).

ACCESS, TRAVEL, LOCATION, PARKING & COSTS

Access	Accessibility for patients
Access	It has to be accessible to all ages, socioeconomic groups.
Access and location	Accessibility is the key problem for me, already having issues with train strikes, limited timetables for all public transport.
Cost	Please assure people on their own can access appointments in a timely and not costly manner. I have to go to Bristol Eye Hospital - no appointments after 3.00 pm - or transport won't accept. The single from Bristol home is about £200! Not on a pension it isn't - I won't/can't afford it!
Costs	Patients could be asked if they can make a donation towards costs. Whenever greater expenditure would create greater savings this should be looked at.
Location Positive team feedback	Personal concerns that the issues may affect my own access for any issues, concerns and follow-ups in the future. I have thus far since March 2021 had exemplary care, communication and access to the CI Team at UHW.
Location	No issues as such but I do think Bridgend Hospital should still be seeing patients that had their operation there with Mr Backhouse. A wonderful service and Cardiff is too far to travel to.
Location	More of a local service - no further than Cardiff.
Location	The only objection I would make is the location of this unit, you have stated that you are using Cardiff as a temporary base but that is where you intend it to be. I will object to this location and I think it should be moved back the Bridgend, it is extremely difficult to travel from any part of West and Mid Wales to Cardiff by road or rail, parking is impossible, taxi fare from the station is £15 to £20, Bridgend is more central to all.
Location	I cannot fault the service but it’s a shame that I have to travel to Cardiff to be seen as they closed POW.
Location	Travelling from West Wales to Cardiff is just too far. My family travelled miles to Bridgend but Cardiff is ridiculous. Why if there is to be one centre does it have to be in Cardiff? Why can't it be more central?
Location	Residents from West Wales to Cardiff would have to make a long and often tiring journey. Bridgend is quite far already, but travelling further to Cardiff would take an entire day. A service that is located in a more central region of Wales would be ideal and accessible.

Location	Understandably, patients want local access to services and are reluctant to travel far for those services. Similarly, the health boards also want local services but the specialist nature of the service limits the extent to which each health board can keep the service within its own boundaries.
Location	If I may be so bold as to give my personal view on the location of a central Hospital, then The Princess of Wales Hospital in Bridgend would be my choice. Clients living in Pembrokeshire or even the rural areas of Carmarthenshire find it quite stressful driving so far east to Cardiff.
Location	I do not think the needs of the patients have been prioritised, i.e. the need to go to a near, accessible quiet hospital.
Location	This sounds fantastic to have this facility all under one roof. I don't disagree but please consider people who live in rural areas and the valleys where I live, as transport isn't easily available especially if you don't drive. At the moment I go to the Royal Gwent which is easy for me and I could get a bus there. But Cardiff and further afield would be a problem especially if you can't drive (I do drive) so please consider this when deciding where you're going to place it.
Location	I am not clear how the proposed change will affect me. The change to the service seems aimed at those people yet to receive an implant. So it would be better to ask them - except you can't as you don't know who they are. For myself as a patient with an existing BCHI (BAHA) I have periodic reviews and check. These currently take place in the Royal Gwent. Will this still be the case or will I need to travel further to the new central centre?
Location	I agree however, I think the location in which you choose to put the centre is very important, as it needs to be accessible to all patients.
Location	I hope this option will improve the quality of care and I also hope that I can attend a specialist closer to my home.
Location	It would have to be in the Swansea/Bridgend area as Cardiff is too far East and with older patients and less public transport, the appointment would take a full day.
Location	My only question is WHERE? There was nothing in the report to suggest where the new care centre will be
Location	Cochlear Implant Clinic needs to be more Central Cardiff - is too far East for most people.

Location	Although the preferred option appears to be the most suitable, until I know where the Main Hub will be situated, it is difficult to pass a comment.
Location	Although I do agree with the preferred option and its supporting arguments, I do find it disappointing that as it is all centred in one place then it will obviously have a significant impact on travelling time for many people.
Location	Neath Port Talbot ENT has been and still is a very good clinic, and I hope it will continue to be the clinic that I can attend.
Location	If there were enough referrals and enough staff, Bridgend would be my choice to continue to have the 2 hospitals giving a service to hard of hearing children and Adults.
Location	It would all depend on where the centre is based. At present some of my patients refuse to travel from NHH to RGH so if it's based in the Heath or Bridgend I think a lot of my patients may decline BAHA.
Location	Where do you propose to locate the single hub?
Location	As long as it is not in Cardiff a lot of users would benefit, people including myself would be put off with hassle day trips to Cardiff
Location	People living in far reaches of the area that provides hearing devices have a hard time reaching one hub, especially in inclement weather
Location	I would need details on the location of the single hub before I could answer. Cardiff would be my preference.
Location	At present I'm seen in Neath Port Talbot Hospital and this is very difficult for me to get to. I would very much prefer to be seen in Singleton Hospital as I did a few years ago as I can get there much easier. I live in Pontarddulais Swansea and if there is a centre for hearing loss closer to my home and on a bus route, that would be much easier for me.
Location	Staff moving to central hub and patients' concerns regarding appointments. Difficult to travel to. I myself had a very good experience with very helpful and professional staff when I had my Cochlear Implant.
Location	I find it hard enough to travel to your centres as they are - one centre would be too much.
Location	I had a cochlear implant at the Heath Hospital in Cardiff (deferred from Bridgend). As I live in South Pembrokeshire it was a long way to travel. However, the benefit of having the Implant far outweighs problems of distance. Help towards travel expenses is available from the NHS if needed.

Location	I currently have BAHA 6 Power. Struggling to get settings correct which can be common from comments on Facebook Group. Would be difficult and I imagine patients would persevere less if they had longer to travel. Would you still be able to have settings adjusted locally? This would be important to me. Do you offer the Osia 2?
Location	Think it would impact patients as there have been too many changes already. People want to be seen where they have been seen in the past!
Location	Distance from hub and travel time for patients will be concerning and could be problematic. May result in an increase of patients not attending.
Location	Too large, anonymous, patients are not familiar with staff and feel insecure and apprehensive. Harder for relatives to visit.
Location Service feedback	This would depend on the strength of the outreach support model. Visiting Cardiff from West Wales is a big undertaking - can you imagine doing this with a newly implanted Aid on public transport? If the outreach centre was located in an appropriate location then it may be considered more desirable. Also if you have transport the parking at Cardiff is horrendous. I think that people would miss appointments and feel dread at the thought of going to a big impersonal centre. At Bridgend we were known to staff and made to feel welcome and the service was second to none. The hospital was easy to get to with adequate parking. At the moment with one centre it feels impersonal and rushed. The staff seem rushed and there is little time for the care I feel should be provided for such an important part of my life. I think the impact would be very negative and with the number of adults and children with implants increasing it seems illogical to decrease the service - which I feel is already not as good as it was.
Location & resources	The following problems could arise for many people: 1. Distance they will have to travel; 2. If no car available; 3. What will be the bus service to the location. West Wales patients may have a tremendous distance to travel if the hub is situated in Cardiff for example. The principle in respect of expertise and staff levels is good. But at what price to patients? At present, Swansea, Cardiff and Newport Hubs means patients travelling. Could be more suitable and less distances involved.

Location & travel	If possible could we have Baha Bone Anchored Hearing Aid facilities in the Ceredigion area as travelling on a bus to Neath or Cardiff hospital would be too much for a pensioner even myself when during COVID I had to pop into A&E as I developed an infection and not one person seen one of these so thankfully I had a work colleague with me and between us was able to explain what is required but it was a struggle
Location and accommodation support	Having to travel to a central hub may put some people off having the surgery which would be a great loss to patients of the absolutely massive benefits of an implant (it changed my life for the better by an enormous amount). So the correct support may be required even providing accommodation for the accompanying relative if needed. For the surgical procedure, an overnight stay in hospital.
Location and parking	I am very sorry that the unit at Bridgend is closed. As a person who has been deaf for many years my confidence levels was very low and I become reluctant to attend medical appointments. However, the small group was friendly and warm I was immediately put at ease and was happy and relaxed throughout the procedure and actually looked forward to the visits. The hospital was easy to get to and parking was not a problem. I have found the opposite to be true of Cardiff, it is extremely busy hospital where you have to wait to be seen for a long time. It's impossible to park and have to drive out of the hospital grounds and park on the roads outside. I am confined to a wheelchair and makes life very difficult.
Location and parking	I somewhat agree but there are areas to be considered such as the location of the model. As mentioned previously, the location should be more central, such as Carmarthenshire, thus meaning more people have access to facilities. Parking would need to be of a decent quality. Cardiff has poor parking. In addition, public transport would need to be considered, as not all people with cochlear implants or have an implanted child are able to drive. One singular centre would possibly fail to provide efficient facilities and support and time - especially to newly implanted people and their families. I believe going ahead would be a mistake due to the extensive journey which in my experience is very tiring, as well as the tuning sessions being exhausting - adding hours of travel into the mix amplifies my sheer exhaustion. In addition the system feels very rushed, like patients are tasks to complete

	instead of people. Growing up, Bridgend was personal to me. I recall being greeted, updating staff on my life and felt more than a list. Taking the next step could discourage people from choosing to be implanted as they will have to take constant tests at the hospital in the immediate aftermath of the surgery and the activation of the implant. Prior to taking the next step, I strongly believe consultation with patients and their families would be ideal as relying solely on data and financial costs would be a severe mistake.
Location and Resources	Fewer staff & facilities offering higher level of service to patients. Patients having to travel further for treatment etc.
Location and service design	It is biased. While less strain on services, some people find it difficult to travel and a single hub may result in people not getting the help they need. You would not have one optician for the whole country, why should ears be different?
Location and service feedback	I had my CI in March 2021 during the pandemic at UHW. From the first consultation I was received by a great team of highly trained and professionals individuals who helped me make my decision into accepting CI which was done 3 months after my evaluation and clinical decision making appointments. UHW is easily accessible for me although I live 34 miles away, parking is a nightmare. i have had amazing support from all of the CI team at Cardiff and hope that will continue in the future, wherever you decide to base the unit.
Location and service model	Sustainable hubs for outreach support model for patients needed. Many will be concerned regarding access to local facilities.
Location and travel	If this facility is too far away, how are people going to get there?
Location and travel	I have access to UHW which is convenient for me but many others will have travel difficulties.
Location and travel	My only problem is getting to the University of Wales due to a walking problem so I have to ask the Ambulance Service for help; they have always obliged.
Location and travel	Currently I attend the BCHI Unit within the ENT Clinic at Cardiff University Hospital. I live near Pontypool and would NOT wish to travel further than I have to in the future.
Location and travel	I agree with the aims above, but would still prefer to have the services at Bridgend to reduce the need for travelling a long distance for children and the elderly.

Location and travel	Although the desired level of service should be assured, the main impact will be on patients who have increased distance to travel for appointments and surgery. For some this may discourage them from attending.
Location travel and cost	My concern will be accessibility for patients who will have further to travel. Will the additional travel costs be funded? I agree with idea of all services under one roof but will this lead to staff being made redundant?
Location, transport and cost	Although I understand the preferred option, I am concerned about the location and travelling further for treatment. I already travel to London for treatment that cannot be met in wales. I am struggling financially because of this, as I am not entitled to travel expenses. However, you dress this up it is a down scaling of services. I had to go to Cardiff for brain surgery as the centre at Morriston hospital was closed. I have also had to attend Cardiff for other services because they cannot be provided locally and the waiting times are longer than local and not acceptable.
Location, transport and training	1/ Cause distress and expense for patients who will be required to travel further for all appointments. 2/ Patients referral to be assessed for an implant at a centre living further away may be impacted. 3/ Will training skills for all staff in all areas be maintained at present levels. 4/ Will aftercare following implant and switch-on be affected.
Location, travel and cost	Yes very much so. Taking away Bridgend causes so many travel problems: 1. a train & then 2. A bus. Parking at Cardiff Hospital is ridiculous and not up to standard for such a large hospital. As I am a pensioner, this means paying high train fares.
Location, waiting times, service feedback	I understand the issues the services are facing. I do agree that it should be moved into one location. My main worry is that the wait time to have the appointments and surgeries may be longer. As stated before in the survey, it already took 8 weeks for a adult to be seen for a referral? This fact is based on the hospital in Cardiff, the highest population in Wales. This could take much longer now as more patients are going to one location. Although the Activity rate should now be increased which would be the positive.
Location/Access	I have been a user of cochlear implants for the last 27 years. I would agree I have had regular appointments with consultants, surgeons and audiology. My only concern going forward is for follow up procedures when things go wrong as a user we heavily rely on them and

	without them we simply loose confidence, cant join in, have difficulty at work and can be stressful.
Parking	Easier parking than the Heath Hospital. More help needed to those living along to use new devices, etc. Particularly the older element.
Transport	Centralisation - no mention of transportation arrangements.
Transport and cost	Only concern is transportation for non-drivers, low income/elderly
Transport and cost	I agree that after service of the BAHA in local hospitals or local surgeries are a good thing for transport costs and convenient for patients.
Travel	Some patients will be less likely to opt for BAHA due to travel commitments. I struggle with a small minority of CI candidates who do not want to travel to Cardiff for an assessment. It provides a barrier to some. Otherwise, it is a good idea.
Travel	I am concerned about the apparent travelling difficulties created by the proposal.
Travel	One Hub will make travel harder for patients.
Travel	Whichever the option, some patients are going to travel further.
Travel & service improvement	Easier access, locally provision of service, less travel to the centre which can be difficult for some patients, may encourage improved joint working and knowledge of the implants amongst local health board services
Travel and cost	Potential for a more complete service. Longer and more expensive travel for some people. Will staff have to relocate?
Travel and cost	Would travel arrangements/costs for out of area be available?
Travel and location	Understand the need of people having to travel to centers. Make it easier for rural patients and for those who find access to one center difficult. It could be done.
Travel and location	There will be an impact for both staff and families, particularly for areas further afield. Putting all your eggs into one basket as it were?
Travel and location	If the hospital is long way for some patients to get there without a car it could be a big deal for them. I live in the valleys and buses from our village only run every 2 hours and stop at certain times, so for someone without a car would be a big deal unless a transport service was made available for them.

Travel and parking	People might have trouble getting to the hospitals and parking is always a nightmare. Help to set up appointments would be helpful.
Travel and parking Resources	Congestion in the Heath Hospital making waiting and travelling a problem. Parking in Cardiff is always a problem. Allowing time for catching buses for people from far away could cause stress. Staff shortages causing congestion of patients waiting for attention. Too many operations for the surgeons to perform. Too many people waiting to be seen.
Travel and waiting times	Travelling difficulties and a possible greater inflexibility in the availability of appointments.
Travel, Service design Process	A poorer service. Increased costs for families living in West Wales. Increased travelling times. Whilst this is couched as a 'consultation', I believe the decision has already been taken.
Travel, resources	Personally little impact. Potential however, for other service users to feel that there may be: 1.a lack of local support; 2. financial detriment to attend appointments. 3. Feeling of inequality due to location. 4. It would end in essence 'postcode' lottery - not in terms of treatment or expertise but would ensure consistency. 5. There would be a decrease in staff pool for the services provided. This would mean potential staffing issues should you have retirement/relocation of staff. It would become an extremely specialised service. It will unfortunately mean some staff would also become de-skilled.
Travel, waiting times and staff development	Impact will be longer travelling, local services will become less patient specific. Waiting times would increase due to everyone treated in one place. Less opportunity for consultants and other medical staff to progress locally and opportunities only available in large centres.

STAFF & RESOURCES

Resource	Financial was a main consideration.
Resource	Whilst I agree that a single centre is best, I would want to see NO reduction in staffing resource by centralising. We have seen that centralising other services has worsened service. If the same full time equivalent resource is centralised then it may work. Ideally, I want more time available for CI mapping and enquiries.
Resource	The effectiveness and efficiency delivery of the preferred option is dependent upon the availability of specialist staff
Resources	The shortage of fully trained staff and the one hospital closed is awful. We need more staff and more money to enable this much-needed work to be achieved.
Resources	The Government needs to fund services better.
Resources	Enough staff is essential.
Resources	See above. I am aware that the NHS is under huge pressures. Having one hospital, as a centre for surgery will surely put compromise on availability of beds.
Resources	For all of the above to be achieved I think will take a long time. It needs much more funding.
Resources	the success of delivering the future aims is very much dependable upon consistent funding
Resources	Finance prevents more than two hubs
Resources	You mention a central hub. Where would this be based and at what cost to the Sennydd? Would this be part private funding? Will existing staff be prepared to move to provide same service? If not, what skill base can be retained? In the current climate within the health service, how far down the list for this vital service do you see yourselves?
Resources	Preferred Option: I would hope that it will be sustainable to fund the change of staff to implement this preferred option.
Resources	I worry it will be an excuse to cut overall staffing - if this happens, no progress will be made. I am now in year 2 since my CI. I believe not enough time is given to mapping - as a result, my confidence has eroded as my CI experience has declined through mapping being done in a rush.
Resources	Staffing shortage with Princess of Wales Hospital Cwm Taf Morgannwg being closed
Resources and training	Enough patients seen to ensure staff skills are adequate

Resources travel and cost	Alongside the changes proposed we suggest some families will face additional time and financial costs associated with travel into Cardiff. Whilst some may be entitled to a travel reimbursement, they will still be required to fund the up-front costs associated with the journey. Additionally, for some families, the appointments will require a full day away from school / work and this may negatively affect patient experience. Any unforeseen problems arising from surgery will not be dealt with locally; therefore, some families may be required to commit to additional journeys to receive the right care and support. Investment to support communication from the host site to local services will likely be required to ensure local service systems can be automatically updated. Families' emotional needs should be considered in these proposals and responded to as appropriate.
Staff	Good if it works. Lot of work ahead though. Continuity of staff. To us they are friends.
Staff, training and funding	long term, consistent funding is a concern, especially for training, retaining and replacing specialist staff within a multidisciplinary cochlear/audiological team
Staffing	I can see the problems with staffing. Would the staff from the other hospital be employed by the Heath Hospital?

SERVICE DESIGN

Service design	Make a weekly hub
Service design	The issue for those with BCHI/BAHA is how the arrangements for dealing with regular infection flare-ups is CLEARLY stated to BAHA patients, and early entry to deal with infections is paramount!
Service design	Local outreach and access, including audiology appointments and rehabilitation appointments would enable ease of access
Service design	Is there any plan to make more use of digital support for follow up care? I have managed very well with my implants using headsets and Bluetooth. More training will be required for both patients and staff on this.
Service design	Many people did not come forward during the pandemic to get advice about their hearing. The number could increase as time goes by, needing more operations.
Service design	Have to consider number of CI and BC patients which are very small considering population of Wales.
Service design	As the number of patients using the CI and BCHI service is relatively small it is reasonable to centralise the

	Inpatient aspect of the service. However, there are many of the Outpatient aspects that should be provided at a more local site to reduce the impact of travel particularly for patients living in rural areas of West and Mid Wales. For example, initial assessment with Hearing Tests, CT and MRI scans should be available locally. Similarly, post-op assessments could be carried out near to the patients' home.
Service design	We need more hubs; I have no problem with children & adults being together but what next? Will we be going to Bristol next to save cash?
Service design	Where will the hub be? It must be easily accessible by public transport as well as by car. Will there be dedicated parking spaces for clinic/surgery attendances? Will attendance times take travel distance into account?
Service design	The outreach support model in Neath Port Talbot will be accessible to myself.
Service design	Children need both implants in order to develop their speech.
Service design	Any future upgrades in technology and or surgical methods can be practised at this hub.
Service design	It will impact those who live furthest away, might I suggest having extra facilities available for families to stay overnight?
Service design	I agree as it gives a fairer and safer service for patients; it will no longer be a 'postcode lottery' as to how quickly and effectively a patient is seen. Largely positive, however, it could mean transport difficulties for some patients. Also, I am assuming the service would require fewer specialists going forward and whilst this may be a cost saving, it will mean there may be losses for the staff involved. Also, would current staff relocate, or would it result in staff shortages as it is a specialist area. I want to know whether the Doctors would still have a working partnership with Paediatric Plastics in Swansea Bay (Morriston) to accommodate BCHI and ear reconstruction to happen at the same time.
Service design	The centre would have to be child friendly. As a child growing up we had a special Ear, Nose and Throat hospital which catered for children so the environment was welcoming and friendly.
Service design	The impact should be better support for those with hearing loss. Support to access doctors who use BSL, access to the Deaf community, and a community of those with implants. A follow up to check on quality of life/ what benefit they have had from the implant would be easy to do. Staff could be trained to higher standards

	if they are specialising and they would come to know the difficulties facing the patients better.
Service design	In response to increased travel, time, and financial costs for some families, it will be imperative to monitor equality of access to the specialist provision once available via a single site, adjusting policy continuously to support families access as appropriate. • Continued investments to ensure effective communications between local systems and the host database systems should be considered. •We expect the related services to comply with nationally developed standards. National Deaf Children's Society works with government agencies and professional groups in developing good practice guidance and quality standards that reflect the views of parents and young people. •We suggest consideration is given to supporting the emotional needs of families opting for implant assessment, procedure, and follow-on care, which is reflected in policy, pathways and practice.
Service design	It is likely that fewer patients will benefit from bone conduction devices if a central referral is required.
Service design	No-one is going to argue with these aims, the argument is what services need to look like to deliver these aims.
Service design	Every children and adult (if deaf) should receive a chance of both operations i.e. whatever they need.

SERVICE FEEDBACK/GENERAL COMMENTARY

General comment	Although it may be useful to have this you would have to think about whether it would have an effect on the surrounding communities.
General comment	I don't know. I have always thought, highly, of the services.
General comment	I have not seen anyone for 12-18 months so cannot agree or disagree.
General comment	Like all new ideas, obviously, we need to find out in practice.
General comment	No what's the point you won't listen.
General comment	Easy on papers. Will it work?
General comment	They are used to making very difficult decisions in the NHS. I can't really comment about the process followed.
General comment	Nice that children and adults can communicate, can help.

General comment	It is disappointing that this may cause any Implant Centre's to close with further hardship to staff and patients. I feel it is important to maintain the service in the best way possible for everyone involved.
General comment	Whilst I agree, the clear arrangements for self-referral for ear infections (BAHA) MUST be made to patients as they will probably be life-long clients.
General comment	I can only say how it changed my life to be able to hear again and to be able to speak to some people on the telephone.
General comment	From our perspective we already feel that we are part of a single hub set up.
General comment	Again the Heath Hospital has been absolutely amazing ever since I was 4 years old and have always been looked after but now I have moved and would love this facility in the Bronglais Hospital in Aberystwyth as the staff there are amazing and help
General comment	Probably not much for me as an individual patient but difficulties for other patients. Thank you for seeking my opinion.
General comment	I don't know to be honest and I don't think you do either. Only hope service doesn't suffer as this means we suffer. Employing more nurses on better pay & conditions will improve the service. Less pen pushers. Also bring back Matrons and get rid of Managers.
General comment	A lot of people not getting the help they require.
General comment	Hope better service and regular check ups
General comment	Essential to enable all patients to take their places in society with no exclusions for persons disabilities.
General comment	Hopefully it will improve services for the clients.
General comment	It would not be dire that is for certain but overall unsure. I was unaware that these services were in such a mess and would agree having these services centralised but not affecting people is a good idea.
General comment	For me personally, no impact.
General comment	To make it easier and more accessible for everyone.
General comment	The impact would potentially be minimal for us as currently we only attend appointments annually however we appreciate there could be an impact for others.
General comment	More convenience and better quality treatment.

General comment	care will improve
General comment	A quicker response rate to ongoing needs for children
General comment	By agreeing to the above wording, it suggests that the aims can be met. I would prefer 'aims to' to be added to beginning of each of the above statements rather than 'can, has, meets, has, facilitates'.
General comment	Young persons should have priority.
General patient comment	As I have BAHA fitted I know the value. I had my BAHA fitted over 11 years ago when I lived in Barnsley. When in Barnsley I only had to attend 1 hospital for all ENT. But since moving back to Wales I've got to go to the Heath for BAHA, Llwynypia for Audiology and ear cleaning. When I first moved back I had to go to Mountain Ash for ear cleaning which meant I was attending 3 hospitals.
General Patient comment	OK but note my comments ie Welsh Ambulance times! I'm on my own, as many older people will be; transport in a taxi is beyond my means. No public transport. Even the community transport costs are beyond my means. QA Portsmouth did my surgery & was left in a ward under the care of my aunt for 5 hours! Aftercare didn't exist. Lost my Notes, refused even to remove my stitches. No follow-up. Now they tell Cardiff (excellent treatment) that I never existed! I had different hearing tests by default at QA. I could hear noise though not words properly. Now have a BAHA fitted though no ear chords - bent over.
General patient comment	By having everything in one place ensures that staff are trained to the highest standard and that patients can access everything in one place without the possibility of "falling through the cracks". Patients will know exactly where to go if they have questions or need advice. However, I do believe that follow up is important. After having my BAHA fitted last year I have had one follow up and that's it. I feel like I have been left to my own devices now. It would have been helpful to talk to other people who have an implant for support and real life advice afterwards. I do believe that patients would benefit a lot from being part of a community before and after the surgery and not just left to "get on with things"
General patient position	It won't be good for many distance-wise. I can drive to Cardiff; I would NOT drive to Newport. If the new service is as good as Cardiff - fantastic. Met a lady

	working in Tesco - she is over the moon. Saw a little boy with an implant and showed him mine - he was thrilled. It's a good thing to mix children & adults. Let's hope many more will benefit, especially for surgery not to be in a mixed surgical environment. I heard something about teaching the children to speak with 'normal tones', including regional accents, and not sound flat. Fantastic. I just wish I could hear 'the split' and therefore learn to speak Welsh! (Being old doesn't help). Good luck. When I eventually got mine, I cried when I heard birds sing! My (*name*) said it was selective hearing and bad hygiene - I was 24/7 carer to my Mum. Please teach GP's. From my experience in Wales it's better - but it's so, so important. I was also refused access to a hearing dog! Thank you for my treatment this past 9-10 years.
General patient comment	I am very happy.
General patient comment	Fully aware of the difficult of Cochlear Service in South Wales
General patient comment	Still a very poor understanding of Hearing Impairment and Deafness within the community at large.
General patient comment	The issues described are common to many aspects of life. A centralised service provides more options but inevitably makes it slightly less convenient for customers/clients. This is analogous to the closing of rural primary schools in favour of larger schools with more facilities.
General patient comment	It’s hard to predict the outcome as this could be overwhelming to move into one location. I do understand that there will be more specialists at hand to do the surgeries/appointments and etc. The concern is the wait time to have these surgeries as there is now going to be a vast amount of people going into one place. I am optimistic that this would work.
General comment	The issues described are common to many aspects of life. A centralised service provides more options but inevitably makes it slightly less convenient for customers/clients. This is analogous to the closing of rural primary schools in favour of larger schools with more facilities.
General comment	Fully aware of the difficult of Cochlear Service in South Wales

General comment	Still a very poor understanding of Hearing Impairment and Deafness within the community at large.
General patient position	A personal view: I am 85 next month. I was fitted with a BAHA in 2008 at Singleton Hospital. The hearing loss, in the meantime, has been considerable and it is a chronic disease. The Baha does very little for me now but I can't do without it as it does pick up a level of noise. I appreciate the good work that went into getting one of those. I attend Audiology at Carmarthen Hospital every 3 months, or did pre-covid. A local centre would be nice where the BAHA could be serviced or replaced. As far as I am concerned, it could be Option A still with as you describe on page 19: "Can be delivered through an outreach model closer to home". At my age, the closer to home things are the better. COVID has made us a lot more hesitant about going to busy places. I think the current system is good. Then, there are your groups claiming it could be improved. Despite best attention, I have lost my hearing. There were problems from a very early age. We were in London for 38 years and had regular appointments at Ilford and Whipps Cross Hospital for treatment. We moved here 20 years ago and the transition to Carmarthen and Singleton Hospitals was seamless. The hearing loss has been dramatic. It is as if the nerve endings have eroded away and there is nothing there to work on. There is an impact on our daily lives, of course. It throws a huge burden on my wife, who has to deal with all those day to day things in our lives. She jots things down for me, rather than try to communicate verbally. I wish I could pull my weight and do a share.
General patient comment	I want a good service for everyone who has hearing issues. At this moment there's not much available and it is very difficult to get help and support.
General patient comment Support for change	A more timely service with waiting times equal for all areas. Whereas now, it varies greatly between the health boards. I have been fortunate to have been treated at The Royal Gwent Hospital and had a BAHA fitted in 2018. I have received excellent care and any issues I am able to access the Audiologists within their department. Only this week I asked for an appointment as experiencing feedback issues. I have been referred back to my ENT Consultant as the abutment made needed to be replaced by a longer one. I have also been given an appointment for a hearing test as last one was 3 years ago. This is to see if I would benefit from the newer version of the BAHA, funding permitting. I am a

	Nurse Manager working at (base named) and am very appreciative of the care and treatment I have received. The BAHA has transformed my hearing problems. I would be more than happy to travel to a central hub with follow ups locally.
Question comment	These are common-sense aims for any service; I can't imagine that anyone is going to disagree with this in principle!
Service needed	Essential that the service be maintained and available as required.
General comment	It is a very loaded question! No-one will disagree with the premise that you wish to improve the service.
Comment re Bridgend service	Yes, we feel the service was much better previously. The Bridgend Service was fantastic.
Comment re Bridgend service	The Bridgend Service was significantly better, providing excellent services to me and my family.
Comment re Bridgend service	I understand more about issues facing the service Really disappointed that the cochlear implant service was removed from the Princess of Wales Bridgend. The Heath is not easily accessible I feel like the service is being diluted and isn't as comprehensive as it used to be.
General patient position	I am currently happy with the care I receive from UHW/Cardiff but fully understand the issues with the current service. My only concerns are accessibility, communication for my own future CI journey.
General patient position	I was fitted with my BAHA at the QE Hospital 10+years ago in Birmingham. When I moved to South Wales in 2017, I went to Audiology at Gwent Hospital a few times for re-programming as I was experiencing problems. At this time, I had a hearing aid for my other ear. I have recently had a letter from QE Hospital Birmingham to inform me that my device is now obsolete. I have an appointment on the 27/01/2023 at Gwent Hospital to address this problem.
General patient position	After being referred to ENT, I was initially told I did not fulfil the requirements for Cochlear Implant, was referred to the Coach Trial - who declined me and said I was eligible for Cochlear Surgery!! What a roundabout!! As soon as I saw a different ENT Surgeon everything went very smoothly.
General patient position	Not really, but having an implant changed my life and I am eternally grateful. THANK YOU.

General patient position	I am currently waiting for surgery to remove painful and swollen skin around implant - I was placed as Category 2 for surgery in September 2022. I am still waiting and currently on antibiotics for infection - it is vital I have surgery; my fear is when will this happen?
General patient position	From my experience as a deaf person, it was important for me to have familiar staff who I knew well and trusted, therefore a more family type atmosphere, easily accessible.
Specific patient position	My hearing has fallen rapidly in recent years and I would assess my hearing as only being around a 5 - 10 on a scale of 100; whereas with my BAHA I would estimate my hearing to be an 85 - 95. To this end I am scared of losing my BAHA (it can easily be knocked off) and therefore, selfishly, hope that future services will be in my locality should I have some sort of problem. I know that I could not cope without the BAHA.
General patient position & service feedback	Had my BAHA operation in 1992 with Mr Phillips of The Welsh Hearing Institute. I was the 7th person to have the operation. Before COVID started, I was seen at the hospital once a year for a check-up, which I was always glad of. So I knew there was no infection with the scar in my skull. We no longer get that treatment now.
Service feedback	No - just trying to make an appointment with Audiology, messages not passed on.
Service feedback	I feel those working in this area should have at the very least basic sign language skills.
Service feedback	The treatment I receive is very good. Staff brilliant.
Service feedback	The local service provides timely and effective care. Continuity of patient and specialist relationship is important. I am known to the service by name and not just a NHS number.
Service feedback	I have high confidence
Service feedback	I would like to place on record the contribution to cochlear implant hearing service made by Heidi Williams at University Hospital of Wales, Cardiff. She is an immense credit to the service.
Service feedback	The lack of qualified staff for the demands. The long waiting times involved.
Service feedback	Yes I do. The wait for cochlear implant was long and I had a complication after surgery, which could not be resolved by the operative time. This was very frightening indeed! The Team was not accessible, and they should have been.

Service feedback	I feel the care I've received from the CI Team at Cardiff (UHW) have achieved all the above.
Service feedback	There is NO service for specialist skills to remove implant for MRIC for comer [?coma] patients in South Wales.
Service feedback	My experience of the team at the Heath hospital has been excellent
Service feedback	This depends on better communication access - I had to fight for live professional captions for a remote consultation. Meeting communication needs must be a priority and not a battle!
Service feedback	Have doubts about equitable service from my personal experience. At my initial appointment, I immediately knew that I was not going to be referred for surgery from the consultant's attitude and apparent lack of interest. Fortunately, it all changed when I saw the ENT Cochlear Surgeon.
Service feedback	Adults should have better support and more therapy.
Service feedback	The standard of service keeps improving and I am pleased with the service I have received.
Service feedback	My daughter who is 4 has received outstanding care and support through the process of having her cochlear implants 2 years ago.
Service feedback	It would be ideal, if you could provide enough support for Adults, as children get plenty of support and therapy. But I was so struggling on my own. It took time for me to get used to it. Important to ask adults what they do seek from you and give your options of support to adults. Also, staff need to learn basic BSL, just in case. And especially reception staff are awful. They look down at the system whilst talking to us. How rude.
Service feedback	My treatment was 100% professional and caring.
Service feedback	The professionals doing this work know what they do and know best; they are second to none.
Service feedback	I have always been pleased with the service for my sister and would be willing to go wherever is convenient for the staff. We are so grateful for all their help.
Service feedback	As an implanted adult I am happy to continue with the service from Cardiff Heath Hospital.
Service feedback	I understand the need for a single implantable device hub for children and adults with an outreach support model but am concerned at the level of service that will be provided having experienced a deterioration as a consequence of moving from Bridgend to UHW.

Service feedback	No proper instructions on how to use the kit provided. I am 84 and my wife who has a Cochlear Implant is 83. And so getting to the Heath Hospital would be very testing. It is also hard by telephone to get to the Cochlear Department to order spares to batteries.
Service Feedback	I think if we could converse/relay our problems to an accessible Audiologist quickly it would take away some of the panic one seems to suffer if we have a problem with our aid. Because it is such a life dependency item. Also a specialised hub would be solely beneficial for us patients. I actually waited 7 years in between my upgrade of my aid.
Service feedback	If my experience is that a change would be not needed to improve the service and attention I received when I was attended to. Thank you.
Service feedback	For myself I would simply like a conversation regarding the problems I have with my BAHA. An expert whose input I would value.
Service feedback	Would it still be the personal service I have now? I have already moved from Bridgend with no choice or option. Cardiff has been very good to me. A service that I have quick access to if I have a problem with my cochlear implant.
Service feedback and offer of patient voice	Any change for the deaf and hard of hearing would be amazing! The BAHA team do amazing work and to have a unit would be a great help to the team and patients. The difference the NAHA service has made to my life was that I can still work and enjoy life and not live in the "quiet world" feeling patronized. There is still a long way to go for a better understanding of the effects of loss of hearing and disability. Mr Williams and his team do amazing work, it transforms lives. So anything that can benefit research, funding and a specialist unit would get my support and am available if you need a "voice" to help.
Service feedback	Timely access to surgery: In my case, this is not happening. Category 2 patient seen by surgeon who implanted the new cochlear implant. Still waiting for surgery.
General comment	Availability of workforce. Easy access. Parking.
General comment	There are less patients with BAHAs than I expected
General comment	ease of access and good communication with clinicians is a key issue
General comment	I can understand it but needs some more organisation and regular dates.

General comment	I could understand that in smaller areas around wales, would also have a smaller amount of patients compared to a big area such as Cardiff. I do understand that in smaller areas may have less qualified specialists/doctors in the area.
General comment	Having somewhere local and tidy somewhere service as everywhere else would be a bonus. Many people have recommended this but I have a awaiting a second option in May 2023
General comment	I work as a Stakeholder Lead for an NHS organisation undergoing a Transformation Programme to determine a Future Service Model. Totally appreciate all the issues facing the service and they are very relatable.
General comment	I understand more about issues facing the service
General comment	No privatisation of services should take place.
General comment	Don't sink to the standards of QA Hospital Portsmouth!
General comment	I have a dedicated cochlear support nurse
General comment	As long as I and others can get the help we need.
General comment	It's difficult to achieve a cost effective process balancing the needs of a small percentage of the population.
General comment	Like all new ideas obviously we need to find out in practice.
General comment about the service	Years ago, when my son needed his operations the waiting lists were quite long & funding was difficult. It seems better that these issues are less now.
General comment on the service	Future patients able to be referred to hearing Implant centres by their doctors or consultants for further assessments.
General patient comment	I have used hearing implant more than five years and I can feel better using hearing implant (Cochlear Implant System).

COMMENTS ON PROCESS & OPTIONS

Alternate option	I also agree with Option E as well as Option D. Option D appears to be better than Option E because it has an outreach support model.
Alternate option	Option B

Feedback on form – demographic information	My National Identity is Scottish (Scottish tick box missing on DB so I couldn't add this!)
Patient numbers	In table1 Referral's there seems to be enough numbers for cochlear implants and bone conduction hearing implants to meet the criteria for number of patients per surgeons?
Patient numbers	I find the low level of patients described in this document difficult to accept.
Process	I can't criticise it (process) and I can't say no.
Process	The process followed appears to have been a fair consideration of the views of all parties involved.
Process	I understand the processes but it is always best for everything to be started asap.
Process	Robust and comprehensively/clearly explained.
Process	This could and should have been resolved by now, but putting CI and BCHI has complicated matters. These are different devices for different populations with different needs. The ongoing situation has put enormous strain on the service and staff.
Process	The cochlear implant service has been working under 'urgent temporary arrangements' for three and a half years
Process	Perhaps some patients could have been included in this process.
Process	As stated the preferred option is not the preferred option of those working in the field with clinical knowledge of the needs of the service. Please reconsider with this pertinent information in mind.
Process, timescale and suggestion to split Cochlear and BCHI	The service needs to be established, as a single centre for cochlear implants in south wales - the talks of mergers has been ongoing for too long. By trying to add in Baha now against clinical judgment it is adding a complexity needlessly.
Separate children and adults	I would rather have an Adult Hub separate from children.
Separate Cochlear and BCHI	Positive for the CI service, removing uncertainty and allowing the service to move forward. For BCHIs, it will mean that patients will need to travel further for a simple surgical procedure, for no good reason.
Separate Cochlear and BCHI	Detriment to the service provided to both CI and BAHA patients. The needs of patients is not equitable and trying to lump them together will not be in the best interests of the service.

Separation of BCHI and Cochlear	I agree that a single hub is appropriate for CI. I do not think it is necessary for BCHI, although it depends what exactly the proposal is. A centralised MDT could be helpful, but it is unnecessary to make patients travel large distances for such a simple surgical procedure.
Separation of BCHI and Cochlear	I do not think it necessary for all BCHI surgeries to be carried out in one hospital. The team who 'independently' assessed the situation and recommended one hub for BCHIs do not even run their own service this way, with surgeries carried out in several hospitals.
Separation of BCHI and Cochlear	The CI service has been working under temporary arrangements for a long time. This needs to be resolved as it is impacting planning and service development. There is no question that the CI service needs to be in one centralised hub, but the BCHI is not so clear-cut. Putting them both together is just prolonging the difficult situation facing the CI Service. BCHIs require a much simpler surgical procedure and provide a different way of amplifying sound, but the listening experience is essentially the same as with a conventional hearing aid. CI surgery is much more complex and carries more risks. The way sound is delivered by a CI is entirely different to a hearing aid/BCHI and patients need to learn to listen in a different way, which causes physical changes in the brain. This is why additional rehabilitation is needed. The needs of CI and BCHI patients and the services they require are very different. I'm not sure that WHSSC fully understands the differences.
Separation of BCHI and Cochlear	It is an unnecessary complication to include bone conduction devices. Not all bone conduction hearing aids require surgery yet have similar requirements for follow up and serve a similar population. The follow up required for Cochlear implants is significantly different, requiring users to adapt to an electronic rather than an acoustic signal.
Separation of BCHI and Cochlear	1) We support the preferred option for CI services in South Wales. 2) However, it is not possible to form a view on the preferred option for BCHI services, as there is insufficient evidence presented to support the case for change. It should also be noted that there are BCHI services based within Audiology services in NHS England which operate effectively, with clear cross referral pathways to tertiary services where required.

Separation of children and adults	I do feel that when patients are separated into children and adults, staff can maybe specialise more easily.
Suggest split Cochlear and BAHA –	Cochlear Implant Services do not need to be grouped with BAHAs. They are very different and do not require the same care pre or post operatively. Trying to merge services in this way will be of detriment to patient care. The consultation process sought the views of professionals working within the field and yet you admit in the paperwork that their clinical opinion has been ignored.

WAITING TIMES

Waiting lists	If waiting lists and funding are long then the longer it takes for the person to adjust to the implants, causing further issues.
Waiting times	I am wondering if this will have a positive impact on waiting times.
Waiting times	Only issue I have is I am not seen for 12-18 months.
Waiting times – non specific	Waiting times for appointments
Waiting times and resources	As stated earlier, I think there would be an increased amount of patients heading to one location which in turn will have an increase of wait time is the main concern of mine. I do think the positives is that financially, it could all go into one hospital which would be able to cater for all departments.

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) Welsh Health Specialised Services Committee (WHSSC)

The Future of Specialist Hearing Implant Device Services in South Wales Questionnaire

We are seeking the views of patients and other members of the public about how specialist hearing implant device services, such as Cochlear Implants and Bone Conducting Hearing Implant (BCHI) are delivered in South Wales. Your contribution to this is valuable, and helps us shape future discussions. If easier for you, you can complete this questionnaire on-line (at https://forms.office.com/r/s8bSYTaU5K)

Please tick one circle for each question.

Section 1: Please tell us about yourself

1. Are you responding on behalf of a group/organisation or as an individual?

○ **Group/Organisation (please state which group or organisation and move to question 7)**

Audiology Standing Specialist Advisory Group / Audiology Heads of Service Group

○ Individual

2. What is your age?

○ Under 16
○ 16 - 18
○ 19 - 49

- ○ 50 – 69
- ○ 70+
- ○ Prefer not to say

3. What is your gender?

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Prefer not to say

4. How would you describe your national identity?

- ○ Welsh
- ○ English
- ○ Scottish
- ○ Northern Irish
- ○ British
- ○ Other
- ○ Prefer not to say

5. How would you describe your ethnic group?

- ○ White
- ○ Mixed or multiple ethnic groups
- ○ Asian, Asian Welsh, Asian British
- ○ Black, Black Welsh, Black British, Caribbean or African
- ○ Other
- ○ Prefer not to say

6. Please tell us the first four characters of your postcode. (This helps us learn where the answers have come from)

7. Which Health Board area do you come under?

- ○ Aneurin Bevan University Health Board
- ○ Betsi Cadwaladr University Health Board
- ○ Cardiff & Vale University Health Board
- ○ Cwm Taf Morgannwg University Health Board
- ○ Hywel Dda University Health Board
- ○ Powys Teaching Health Board
- ○ Swansea Bay University Health Board
- ○ NHS England
- ○ Other

Section 2: About the Service

8. As a result of reading this information:

- ○ I have a better understanding of how Cochlear Implant and BCHI services are currently organised
- ○ I have no understanding of how Cochlear Implant and BCHI services are currently organised
- ○ **My understanding of how services are currently organised is the same:**

9. As a result of reading this information:

- ○ I have a better understanding of the issues facing the service
- ○ I have no understanding of the issues facing the service
- ○ **My understanding of the issues is the same**

Do you have any comments about the issues facing the service?

The paper does not reflect the significant workforce issues and challenges faced by the Cardiff Cochlear implant service as a result of the Bridgend service being suspended since August, 2019 (due to workforce fragility issues). We understand that funding is still being allocated to CTM for staffing despite only one member of staff from Bridgend working on the CI programme on a part time basis.

The Cardiff and Vale UHB (C&V UHB) Audiology service do not currently have the required estate to see all patients for cochlear implant and BCHI assessments, as

there needs to be a sufficient number of large sound proofed room facilities. This situation has impacted on the current service to patients delivered by C&V UHB. The cochlear implant service issues remain unresolved and the addition of BCHI into the engagement has increased the delay of any decision around funding for the CI service at C&V UHB. As a result of unresolved workforce issues, the service at C&V UHB is now vulnerable due to staff sickness and stress. There now needs to be a clear plan around workforce and accommodation. Failing this, it is highly likely that there will be a subsequent collapse of the C&V implant service.

1) Minimum numbers for BCHI

   a) Section 6 states that 'guidance on standards for bone conduction hearing aids require centres to perform at least 15 procedures per year'. Although the paper then references the commissioning policy from which this minimum number has been quoted with a bookmark, the reference to standards is misleading.

   b) The minimum number quoted in the English commissioning policy has been obtained from professional consensus reached in 1998. It is not clear therefore that this is relevant to services today given the policy, technology and workforce changes that have occurred in the last 24 years.

   c) The commissioning policy referred to in the engagement paper is not the latest version of this policy and appears to have been superseded by NHS England 16041/P (england.nhs.uk) which does not refer to minimum numbers and does reference a more contemporary clinical consensus on standards again with no reference to minimum numbers.

2) The paper does not explain what outcomes are not being met by the current service structure i.e. what requires change and improvement.

3) The paper describes that an implant MDT needs to provide all types of implants. This is not true. CI services need to offer all implants, but the bone conduction commissioning document does not state that BCHI centres have to offer any other devices. This statement in the engagement paper is presumably based on the assumption that the MDT must be a joint CI/BCHI MDT. There are no standards or recommendations for this model, and this is not the model found in most BCHI centres in the UK. The most recent Clinical Commissioning Policy, NHS England 16041/P does not reference a joint MDT but only requires that the MDT must consider which implant is the most suitable for each patient which can be achieved without a single MDT for all implantable devices.

4) In the referenced Clinical Commissioning Policy, section 7 (Epidemiology & Needs assessment) it states that 8-10 BCHI per population of 300,000 is the estimated activity in England and this would translate to in the region of 100 BCHI per year in Wales; of which 75% would be in South Wales. This suggests that there is a large unmet need for this intervention in Wales which may present following removal of 'capped funding' for these devices. Based on meeting the recommended numbers of BCHI fittings there would be sufficient

numbers for multiple centres in South Wales to meet the minimum stated in the NHS England CCP.

ASSAG therefore concludes that the population is underserved, and the recommendation would be to reinforce existing services for BCHI and enable them to meet unmet demand and through agreed National pathways for referral. This would solve the problem of minimum numbers and safety without creating additional barriers for patients.

6) The paper states that a large number of patients would be required to adopt new technologies. Adoption of new technology could be adopted for example middle ear implants could be adopted at a centralised CI service without requiring BCHIs services to be centralised also. Separate BCHI services does not prevent the adoption of new BCHI technologies and so this is not considered to be a case for change.

7) The paper states that a centralised service would deliver an improved service comparable to other regional centres. This would suggest that the services are not currently comparable to those regional centres but does not specify what the differences are. It also makes an assumption that the existing regional services are better than any local services but there is no evidence in the paper for this assumption.

There is no reference related to the statement that procedures carried out at larger centres result in better outcomes.

10. Would you agree/disagree with the following aims for a future Cochlear Implant and Bone Conduction Hearing Implant service:

The service:

- can deliver a safe and sustainable hearing implant device service for the adult and children in South Wales
- has equitable access
- meets national standards
- has staff in the right place with the right specialist skills
- facilitates timely access to surgery

○ **Agree**

○ Disagree

○ Neither agree or disagree

We agree with the aims for the service however wish to make it clear that

equitable access should include distance, travel and cost as well as waiting times.
The paper mentions that some people may not have to travel as far as they do now. As it seems unlikely that any site other than Cardiff would be chosen for the centralised service, we are not aware of any circumstances under which travel to a centralised service would be reduced compared to the current situation

11. As a result of reading this information:

- ○ I have an understanding of the process that has been followed to arrive at the preferred option
- ○ I have no understanding of the process that has been followed to arrive at the preferred option
- ○ Not applicable

Do you have any comments about the process followed?

1) This question does allow for responders to have a partial understanding.

2) It is not clear in the engagement paper which external implantable device centre was chosen to complete the evaluation, what service model is delivered at that centre, why they were chosen or whether stakeholders in that region were also asked to contribute to the evaluation. Evaluation by a single centre could inadvertently have introduced bias into the evaluation. There are two models of bone anchored hearing aid delivery in England. One is single auditory implant centre of which there are 16 in England and the other is a standalone bone anchored hearing aid centre within an audiology centre of which there are over 100. What assurance is there that both models have been consulted?

3) The process does not seem to have considered the Welsh context in which services have run, specifically the current development of All Wales implantable device standards and the close working relationships of all centres in Wales.

4) There is some incorrect information in the engagement documents, which will affect the validity of this engagement process, specifically:

a) In the slide summary (slide 10 of the English version) it states that appointments before the hearing implant and after the hearing implant has been programmed and fitted will take place closer to home. This is factually incorrect for CI and may not be possible for BCIG depending on the outcome of the pathway design.

b) In most versions except the core document, eg slide 7 of the English slide summary, is the statement *British Cochlear Implant Group (BCIG) say that Consultants should undertake a minimum of 10 cochlear implants per surgeon, and that a centre should undertake a minimum of 15 BCHI per year. There are not enough patients to support this across multiple centres.* This is factually incorrect. ASSAG would be concerned that the significance of this statement to the case for change may make the engagement invalid.

12. **Please tell us what you think about the preferred option of a single implantable device hub for both children and adults with an outreach support model.**

- ○ I agree with the preferred option
- ○ **I disagree with the preferred option**
- ○ I have no particular view on the preferred option

Do you have any comments about the preferred option (i.e. why you agree/disagree)?

1) There is no option to partially agree with the preferred option

2) It is not possible to provide a final opinion of the preferred option without more information on the specific models being proposed. It is not clear in the engagement paper what the services will look like and the advantages and disadvantages of each model.

3) Cochlear Implants

   A single site for CI in South Wales would resolve the current and urgent issues facing the cochlear implant service. It would allow for sustainable workforce planning and the development of a full and specialist MDT within the service. Travel for some patients will unfortunately be increased compared to the two-centre model previously provided but this would be balanced by the ability to invest in the best staff, equipment, and facilities at a single centre.

   The other advantage of the CI team would be to assist in the robust and efficient management of the cost of this service. This also fits with the model being provided in England. Our view is that middle ear implants would generally fit within an auditory implant programme as per the English model rather than in a standalone centre.

4) For bone conduction implants the advantages of a single centre are less clear.

There is ample precedence of safe and effective standalone centres working within audiology services for bone anchored hearing aids in England with clear cross referral pathways to a tertiary implant centre where required. There are no standards requiring bone anchored hearing aids to be done in large regional sites or for services to be provided only in those providing other implantable hearing devices.

With regards to the creation of a single MDT the advantages of including bone conduction implant services in a single centre **may** provide additional staff resilience and promote the consideration of potential for middle ear implants however, there is no evidence that this is currently or foreseen to be an issue and it is not required in any recent policies or professional consensus. If bone conduction services remain standalone, then the recommendation would be for mitigations and safeguards such as joint MDTs for patients meeting the criteria for more than one type of device (likely to be very few) to ensure equitable access.

The disadvantages of a single centre are the increased travel and cost for patients which ASSAG do not feel are balanced by any advantages for patients requiring this type of device.

13. If the preferred option was progressed, what do you think the impact would be?

1) The impact of the preferred option for bone conduction hearing aid patients is of decreased access, particularly as the level of service to be provided in centres 'closer to home' is not defined in the paper.

2) The impact of the combined MDT which allows for all options to be offered to patients is not obvious as, patients who are candidates for bone conduction hearing aids are generally not candidates for cochlear implantation and vice versa. Robust cross referral pathways are the norm across multiple disciplines in the Welsh NHS.

3) The impact on quality and outcomes of a centralised service for BCHI's is not clear as the issues and required quality improvements required are not clear in these documents particularly as BCHI surgery is significantly less complex than that of cochlear implantation.

4) A move to one centre would require significant investment in facilities, for example large sound-proof clinical rooms, to avoid an ongoing detrimental impact on the core audiology service. This would require a significant capital investment. The need to provide for both CI and BCHI on a South Wales basis may impact on the site's ability to provide the facilities required for CI.

5) Removing the BCHI service from Swansea Bay UHB may have an impact on the South Wales microtia service, as the advice of surgeons with knowledge of BCHI placement and surgery is important in the management of Microtia.

ANNEX B – GLOSSARY OF TERMS

Audiology	The branch of science and medicine concerned with the sense of hearing.
Specialist Audiologist	A Specialist Audiologist specialises in the diagnosis, analysis and treatment of human auditory disorders such as hearing, tinnitus and audio balance deficiencies.
Bone Conduction Hearing Implant	A Bone Conductor Hearing Implant (BCHI) is a hearing aid which uses bone conduction to help sound get to the inner ear. Note many people also call a BCHI a BAHA.
Clinical Child Psychologist for children	Clinical Child psychologists work with children by assessing, diagnosing and treating children and adolescents with psychological or developmental disorders, and they conduct academic and scientific research
Cochlear Implant System	A Cochlear Implant is an implanted electronic hearing device designed to produce useful hearing sensations to a person with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear.
Hearing Therapist	A Hearing Therapist offers counselling to help with hearing difficulties
Multi-Disciplinary Team (MDT)	A Multi-disciplinary Team is a mixture of team of named healthcare professionals (eg Doctors, audiologists, nurses etc) who are responsible for discussing and arranging facilitating communication and coordinating care for patients.
National Institute for Health and Care Excellence (NICE)	National Institute of Clinical Excellence – sets standards and guidance for services
Paediatric Anaesthetist	Paediatric Anaesthetists are responsible for the general anaesthesia, sedation, and pain management needs of infants and children

Qualified Teacher of the Deaf (QTOD)	Qualified Teachers of the Deaf (also known as QToDs) are qualified teachers who provide support to D/deaf children, their parents and family and other professionals who are involved with a child's education.
Specialist Nurses	Specialist Nurses are dedicated to a particular area of nursing; caring for patients suffering from long-term conditions and diseases.
Specialist Radiologists	Specialise Radiologists are medical doctors that specialise in diagnosing and treating injuries and diseases using medical imaging (radiology) procedures (exams/tests) such as X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET) and ultrasound.
Speech and Language Therapist	A Speech and Language Therapist provides life- changing treatment, support and care for children and adults who have difficulties with communication, eating, drinking and swallowing.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.2.1

CTM BOARD

BOARD ANNUAL CYCLE OF BUSINESS

Date of meeting	27 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Corporate Governance
Approving Executive Sponsor	Chief Executive Officer
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Board should, on annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

1.2 The Cycle of Business covers the period 1 January 2023 to 31 December 2023.

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

2.1 The Cycle of Business has been developed to help plan the management of Board matters and facilitate the management of agendas and Board business.

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

3.1 Please refer to **Appendix 1** – Board Cycle of Business for further detail.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to **NOTE** the Annual Cycle of Business.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 8.2.1

Health Board

Cycle of Business

(1st January 2023 – 31st December 2023)

The Health Board should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Cycle of Business covers the period 1st January 2023 to 31st December 2023.

The Cycle of Business has been developed to help plan the management of Board matters and facilitate the management of agendas and committee business.

The principal role of the Health Board is set out in the Standing Orders 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Health Board's performance across all areas of activity.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 8.2.1

Board Cycle of Business (1st January 2023 – 31st December 2023)

Item of Business	Executive Lead	Reporting period	26 Jan 2023	Feb 2023	30 Mar 2023	April 2023	25 May 2023	12 June 2023	27 July 2023	Aug 2023	28 Sep 2023	Oct 2023	30 Nov 2023	Dec 2023
Consent Agenda														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Action Log	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Chairs Report *(Including affixing of the Common Seal and Chairs Urgent Action Requests)*	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Joint Committee Composite Report (NWSSP, EASC and WHSSC)	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Putting Things Right Annual Report	Director of Corporate Governance	Annually							✓ Defer to Sept		✓			
Safeguarding Annual Report	Executive Director of Nursing	Annually	✓											
Health & Care Standards Annual Report	Executive Director of Nursing	Annually											✓	
Carers Annual Report	Executive Director of Nursing	Annually					✓ Defer to July		✓ Defer to Sept		✓			
Clinical Education Annual Report	Executive Medical Director	Annually											✓	
Infection Prevention & Control Annual Report	Executive Director of Nursing	Annually									✓			
Civil Contingencies & Business Continuity Report	Executive Director of Strategy & Transformation	Annually					✓							
Welsh Language Standards Annual Report	Executive Director for People	Annually									✓			
Director of Public Health Annual Report	Director of Public Health	Annually					✓							
Board Cycle of Business	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Board Forward Work Programme	Director of Corporate Governance	All Regular Meeting	✓		✓		✓		✓		✓		✓	
Committee Highlight Reports	Director of Corporate Governance	All Regular Meetings	✓		✓		✓		✓		✓		✓	

Item of Business	Executive Lead	Reporting period	26 Jan 2023	Feb 2023	30 Mar 2023	April 2023	25 May 2023	12 June 2023	27 July 2023	Aug 2023	28 Sep 2023	Oct 2023	30 Nov 2023	Dec 2023
Committee Annual Reports	Director of Corporate Governance	As and when required	✓		✓		✓		✓		✓		✓	
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually					✓							
Shared Listening & Learning														
Listening & Learning Story	Executive Nurse Director	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Governance														
Chief Executives Report – to include updates on Targeted Intervention – Programme for Continuous Improvement in response to Targeted Intervention	Chief Executive	All regular meetings	✓		✓		✓		✓		✓		✓	
Audit Wales Structured Assessment & Audit Letter	Audit Wales	Annually			✓									
Audit Wales Annual Audit Report	Audit Wales	Annually			✓									
Board Assurance Framework	Director of Corporate Governance	All Regular meetings	✓		✓		✓		✓		✓		✓	
Annual Report (including Performance Report, Accountability Report and Remuneration Report)	Director of Corporate Governance	Annually						✓ Defer to July 2023	✓					
Annual Statutory Accounts	Executive Director of Finance	Annually						✓ Defer to July 2023	✓					
Annual Review of the Standing Orders	Director of Corporate Governance	Annually			✓									
Board Effectiveness Self-Assessment	Director of Corporate Governance	Annually			✓									
Risk Management Strategy	Director of Corporate Governance	Annually					✓							
Nurse Staffing Levels (Wales) Act Report – Annual Assurance Report	Executive Director of Nursing	Annually					✓							
Healthcare Inspectorate Wales Annual Report	Healthcare Inspectorate Wales	Annually									✓			
Delivering Our Purpose & Strategic Direction														

Item of Business	Executive Lead	Reporting period	26 Jan 2023	Feb 2023	30 Mar 2023	April 2023	25 May 2023	12 June 2023	27 July 2023	Aug 2023	28 Sep 2023	Oct 2023	30 Nov 2023	Dec 2023
Integrated Performance Dashboard – to include an update on Improving Urgent Care and Planned Care Recovery	Executive Director of Strategy & Transformation	All Regular Meetings	✓		✓		✓		✓		✓		✓	
Monthly Finance Reports	Executive Director of Finance	All Regular meetings	✓		✓		✓		✓		✓		✓	
Clinical Advisory Group Highlight Report	Executive Director of Strategy & Transformation	Quarterly	✓				✓ Defer to July 2023		✓		✓			
Clinical Advisory Group Annual Report	Executive Director of Strategy & Transformation	Annually					✓ Defer to July 2023		✓ Defer to Sept 2023		✓			
Delivering Our Recovery/Improvement Plan														
Integrated Medium Term Plan – Approval	Executive Director of Strategy & Transformation	Annually			✓									
Annual Plan Quarterly Update	Executive Director of Strategy & Transformation	Quarterly					✓						✓	
Regional Partnerships Board & Public Services Board 6 Monthly Report	Executive Director of Strategy & Transformation	Bi-Annually					✓						✓	
Winter Plan Update	Chief Operating Officer	Annually											✓	
Escalation Status: Special Measures & Targeted Intervention														
Maternity & Neonatal Services Improvement Programme Agreed at the January Board meeting that reports would now be presented to the Board by exception only given the ongoing scrutiny undertaken at the Quality & Safety Committee	Executive Director of Nursing/Executive Medical Director	By exception only	✓											

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 8.2.2

HEALTH BOARD – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Chief Operating Officer referred to this item coming forward to Board at the September 2022 Quality & Safety Committee	Additional Item	JAG Accreditation Business Case	Chief Operating Officer	Was 26 January 2023 – Deferred to 25 May 2023 **– Position Statement On agenda 27th July 2023.**
Email request received on 30 November 2022 from the Assistant Director of Governance & Risk	Additional Item	Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service	Director of Strategy & Transformation	25 May 2023 – Now deferred to 27 July 2023 – **On agenda 27th July 2023.**
Email request received from the Director of Strategy & Transformation	Additional Item	LINC Business Case	Director for Strategy & Transformation	30 March 2023 – Deferred to July 2023. **On agenda for discussion at In Committee Board 27 July 2023**
Email request received from the Service Project Manager, Capital Planning	Additional Item	Business Case for Capital Scheme at the Princess of Wales Hospital	Director of Finance	30 March 2023 – Now 25 May 2023 – **To be deferred – date to be agreed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request received from the Assistant Director of Governance & Risk following discussion at Executive Leadership Group	Additional Item	Major Incident and Critical Business Continuity Plans	Director of Strategy & Transformation	25 May 2023 – **To be deferred – Now 28 September 2023.**
Email request received from the Assistant Director of Governance & Risk following discussion at Executive Leadership Group	Additional Item	Armed Forces Covenant	Director of Strategy & Transformation	25 May 2023 – Now 27 July 2023 – No longer being presented. Director for People to advise on future reporting requirements moving forwards.
Email request from the Head of Corporate Governance and Board Business	Additional Item	All Wales Individual Patient Funding Request Policy	Director of Strategy & Transformation	27 July 2023 – **Now 28 September 2023**
Email request received from the Assistant Director of Governance & Risk	Additional Item	Critical Care – Framework Model of Care Proposal	Medical Director	Planned for 28 September 2023 - Discussed at the Board Development Session held on 22 June 2023. Report being presented to the In Committee Quality & Safety Committee meeting 25 July 2023.
Email request received from the Director of Strategy & Transformation	Additional Item	Clinical Services Plan – Draft Principles	Director of Strategy & Transformation	27 July 2023 – **On agenda** Further report to also be presented to the September 2023 Board
Email request received from the Assistant	Additional Item	Estates, Facilities Performance Management System annual report	Director of Finance	Planned for 28 September 2023

Director of Governance & Risk				
Email request received from the Head of Corporate Governance & Board Business to add this item to the agenda following discussion with Chair	Additional Item	Regional Partnerships Board – Capital Funding Strategy	Director of Strategy & Transformation	Planned for 27 July 2023 – **Deferred to 28 September 2023**
Email request from the Assistant Director of Governance & Risk	Additional Item	WHSSC's and EASCs Model Standing Orders	Director of Corporate Governance	Planned for 28 September 2023
Email request from the Assistant Director of Governance & Risk	Additional Item	CTMUHB Model Standing Orders	Director of Corporate Governance	Planned for 28 September 2023

Completed Requests:				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Email request received from the Assistant Director of Governance & Risk	Additional Item	WHSSC Review of Financial Limits and Reporting – To include the updated Standing Orders and Standing Financial Instructions	WHSSC Director of Finance	**Completed** Received and approved at the Board meeting held on 25 May 2023
Email request received from the Assistant Director of Governance & Risk	Additional Item	Temporary Amendment to the Standing Orders	Assistant Director of Governance & Risk	**Completed** Received and approved at the Board meeting held on 25 May 2023
Email request received from the Assistant Director of Governance & Risk	Additional Item	Policy on Policies - Inclusion of Data Protection Impact Assessment Section	Assistant Director of Governance & Risk	**Completed** Received and approved at the Board meeting held on 25 May 2023

Email request received from the Director of Strategy & Transformation	Additional Item	Decarbonisation Action Plan	Director of Strategy & Transformation	**Completed** Received and noted at the Board meeting held on 25 May 2023
Email request received from the Interim Deputy Director of Public Health	Additional Item	Director of Public Health Report 2020 - 2023	Director of Public Health	**Completed** Received and noted at the Board meeting held on 25 May 2023
Email request received from the Director of Strategy & Transformation	Additional Item	Annual Plan 2023/2024 Resubmission	Director of Strategy & Transformation	**Completed** Received and noted at the Board meeting held on 25 May 2023
Email request received from the Assistant Director of Governance & Risk	Additional Item	Radiology Informatics System Procurement Programme Business Case	Director for Strategy & Transformation	**Completed** Received and approved at the In Committee Board meeting held on 25 May 2023
Email request received from the Assistant Director of Governance & Risk	Additional Item	Update on the Emergency Medical Retrieval Services to be included in the Chief Executives Report	Chief Executive Officer	**Completed** Update included in the Chief Executive Officers Report presented to the meeting held on 25 May 2023
Email request received from the Director of Finance	Additional Item	Phase 2 All Wales RAAC Investigation – CTMUHB	Director of Finance	**Completed** Report presented to the Planning, Performance & Finance Committee held on the 27 June 2023. Updated has been included in the Highlight Report at agenda item 6.3.4

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.2.3

CTM BOARD

BOARD COMMITTEE/ADVISORY GROUP HIGHLIGHT REPORTS

Date of meeting	27/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 In line with the Standing Order requirements each Board Committee and Advisory Group is required to submit a Highlight Report setting out its activities at each meeting. This also provides a mechanism for escalating issues to the Board as required.

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

2.1 A number of Committee/Advisory Groups have been held since the Board last met in May 2023.

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

3.1 Key risks and any matters for escalation to the Board are set out in the appended Highlight Reports.

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Board are being asked to **NOTE** the following Highlight Reports:

- Quality & Safety Committee 24 May 2023 (Included on the main agenda at agenda item 6.3.3);
- Mental Health Act Monitoring Committee 7 June 2023 (Appendix 1);
- Stakeholder Reference Group 8 June 2023 (Appendix 2);
- Digital & Data Committee 12 June 2023 (Included on the main agenda at agenda item 6.3.2);
- Remuneration & Terms of Services Committee 19 June 2023 (Appendix 3);
- Local Partnerships Forum 20 June 2023 (Appendix 4);
- Hosted Bodies Audit & Risk Committee 21 June 2023 (Included on the main agenda at agenda item 6.3.5);
- CTMUHB Audit & Risk Committee 21 June 2023 (Appendix 5);
- Planning, Performance & Finance Committee 27 June 2023 (Included on the main agenda at agenda item 6.3.4).

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Agenda Item 8.2.4

CTM BOARD

HIGHLIGHT REPORT FROM THE MENTAL HEALTH ACT MONITORING COMMITTEE

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kathrine Davies, Corporate Governance Manager
PRESENTED BY	Jayne Sadgrove, Vice Chair & Chair of the Mental Health Act Monitoring Committee
EXECUTIVE SPONSOR APPROVED	Gethin Hughes, Chief Operating Officer

REPORT PURPOSE	FOR NOTING

ACRONYMS	
AMHP	Advanced Mental Health Practitioner
MHA	Mental Health Act
SWP	South Wales Police

1. INTRODUCTION

1.1 This paper had been prepared to provide the Board with details of the key issues considered by the Mental Health Act (MHA) Monitoring Committee at its meeting on 7th June 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. PURPOSE OF THE MENTAL HEALTH ACT MONITORING COMMITTEE

2.1 The purpose of the Committee is to advise and assure the Board that the arrangements to monitor and review the way functions under the Mental Health Act are exercised on its behalf are operating appropriately and effectively and in accordance with legislation.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	Nil to report.
ADVISE	• The Committee **received** a **MHA Operational Group update report**. The Committee **noted** the following key matters: - The Operational Group were continuing to monitor Mental Health Act activity for patients with a learning disability placed in hospitals outside the Health Board. For Q4 there were 3 such patients detained under the Mental Health Act with 0 fundamental breaches reported in the administration of the Act. - Good progress was being made on improving access to the Independent Mental Health Advocacy into Bridgend and Child and Adolescent Mental Health services (CAMHS). Some training events were being scheduled focusing on the relationship between the Mental Health Act and the Mental Capacity Act. - The regional Advanced Mental Health Practitioner (AMHP) and Police Liaison groups were developing electronic systems to improve data collection. This could potentially be used to record delays in the provision of Section 12 Approved Doctor and AMHP services together with the availability of inpatient beds. - The number of Section 135 detentions had increased sharply in Q4. Further work was planned with South Wales Police colleagues to improve data collection and a multi-agency educational event was being planned

to ensure all partners fully understand the circumstances under which these powers should be used.

- The Care Group was prioritising the improvement actions following a number of recent Healthcare Inspectorate Wales (HIW) visits. This included some improvements required in relation to the Mental Health Act. For example, use of Section 17 Leave and communication with patients about their rights.
- The implementation of the 'Right Care – Right Person' Model was being considered for roll out in Wales and the Committee discussed possible implications in relation to changes with the powers of South Wales Police.
- Good progress had been made with regard to the upgrading of the assessment facilities at Prince Charles Hospital.

- **Quarterly Mental Health Act Activity Report for Adult, Older Persons and Children and Adult Mental Health Services (CAMHS)/Breaches and Errors Report** was **received** for Quarter 4. The Committee **noted** that:
  - The reporting period highlighted an increase in detentions in all services between Q3 and Q4 of the current year. Section 4 was applied on six occasions during the reporting period.
  - The nurse's holding power under Section 5(4) was applied on two occasions during the quarter. All within the adult wards.
  - The Committee were pleased to **note** that there were no fundamentally defective errors to report.
  - In Quarter 4, there were 18 minor errors on section papers, all of which were rectified within the fourteen day limit as per Section 15 of the MHA.

- The Committee received a verbal **Strategic Update from South Wales Police.** The Committee **noted** the following key items:
  - **Section 136** – The Committee were pleased to note

	that discharges had decreased and that the majority were applying section 136's correctly and patients were being signposted to the community or primary care which was positive. - **Strategic Re-organisation of Safeguarding Functions** – The Committee were advised of the changes to the strategic leadership of the safeguarding function which would now be centralised with a different officer from South Wales Police attending the Committee. • The Committee received a verbal **Strategic Update from Local Authority Partners.** The Committee **noted** the following key item - Thanks were extended to South Wales Police who had recently supported the Health Board with a matter dealt with under the MHA, it was noted how supportive SWP had been in resolving the matter and taking the required action. • The Committee **noted** the update on the performance of the **111 Service** relating to Mental Health.
ASSURE	• A report on the **Risks relating to the Mental Health Act (MHA) for Quarter 4** January – March 2023 was **received.**
INFORM	• The Committee **received** and **approved** the **Committee Annual Report for 2022-23.** • The Committee **received** an anonymized example of a patient story as a **Case example to highlight the use of the MHA and Outcome.**
APPENDICES	Not Applicable.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.2.4 Appendix 2

CTM BOARD	
HIGHLIGHT REPORT FROM THE STAKEHOLDER REFERENCE GROUP	
DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emily Phillips – Planning Assistant and Elizabeth Beadle, Assistant Director of Transformation
PRESENTED BY	Linda Prosser, Executive Director of Strategy and Transformation
EXECUTIVE SPONSOR APPROVED	Linda Prosser, Executive Director of Strategy and Transformation

REPORT PURPOSE	For noting

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board

1. PURPOSE

1.1 This report has been prepared to provide the Board with details of the key issues considered by the Stakeholder Reference Group at its meeting on the 8th June 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the report.

2. Role of the Stakeholder Reference Group (SRG)

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

- Early engagement and involvement in the determination of the Health Board's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the Health Board's operations on the communities it serves.

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

3. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no issues to escalate.
ADVISE	**EXPRESSIONS OF INTEREST FOR VICE-CHAIR** Following the resignation of the Vice-Chair of the Stakeholder Reference Group in July 2021, expressions of interest/nominations had been requested on several occasions. An agreement has now been made for two SRG members to take up the role of Vice Chair on a rota basis in the absence of the Chair. **MEMBERSHIP** The group currently has gaps in membership, however in the last few weeks, the roles of four vacant members have been filled. Action is still underway to seek replacement nominees and regular meetings will be held between SRG Secretariat and Chair to monitor updates on this process. **THEME OF MEETING – 8th JUNE** The theme of the meeting was centered around Women's health, following a successful event recently hosted by CTMUHB in response to providing a platform for women's health issues in RCT. A presentation was received from the Children and Families Care Group. **CTMUHB DEVELOPMENT OF GYNAECOLOGY AND SEXUAL HEALTH SERVICES**

	The SRG received a presentation around three key areas; cancer, sexual health and early pregnancy services delivered through the Obstetrics, Gynaecology and Integrated Sexual Health service group. An update was provided on significant areas of development and also the current challenges facing the service group. An opportunity for SRG members to ask questions was given and changes in numbers of people accessing services were discussed, for example the number of patients accessing long-acting reversible contraceptives were discussed. The Care Group is still considering the thematic analysis of the changes in trend and there was currently no identification of any specific group amongst the Health Board's resident population that was under-represented, or of any known problems relating to access of awareness for the patients accessing the services. **COMMITTEE ANNUAL REPORT** The draft annual report was circulated prior to the meeting and was presented to members to highlight attendance, membership and themes from the last twelve months. Members were fully supportive of the report being submitted to CTMUHB board in July and discussed the forthcoming committee effectiveness survey and the forward plan for the SRG **Forward work plan** SRG members reflected on their role and discussed the forward work plan. In addition to the group's function to scrutinise and advise on Health Board plans, the group agreed that future agendas would make provision for any emerging issues or concerns from any of the represented stakeholder groups to ensure that the group was able to robustly enact its role to provide feedback on the impact of the Health Board's operations on the communities it serves.
ASSURE	**NOT APPLICABLE**
INFORM	**NOT APPLICABLE**
APPENDICES	**NOT APPLICABLE**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM 8.2.4

CTMUHB

HIGHLIGHT REPORT FROM THE CHAIR OF THE REMUNERATION & TERMS OF SERVICE COMMITTEE

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wendy Penrhyn-Jones, Head of Corporate Governance & Board Business
PRESENTED BY	Jonathan Morgan, Chair/ Independent Member
EXECUTIVE SPONSOR APPROVED	Hywel Daniel, Executive Director for People

REPORT PURPOSE	FOR APPROVAL

ACRONYMS	
	None Identified.

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Remuneration & Terms of Service Committee at its meetings on 19th June 2023.

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

2. PURPOSE OF THE REMUNERATION & TERMS OF SERVICE COMMITTEE

2.1 The purpose of this Committee is to provide:

- ***advice*** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government.
- ***assurance*** to the Board in relation to the UHB's arrangements for the

remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

- ***receive reports*** relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers of hosted bodies.

3. HIGHLIGHT REPORT

ALERT/ ESCALATE	Nil
ASSURE	The Committee: • **RATIFIED** a payment previously approved under Urgent Chair's Action relating to an employment matter; • **APPROVED** the payment in respect of an employment matter; and • The Committee's Annual Report for 2022-2023 was **ENDORSED FOR BOARD APPROVAL**.
INFORM	Nil
APPENDICES	• Draft Annual Report 2022-2023– Remuneration & Terms of Service Committee (included as an Appendix under Agenda Item 8.1.3)

4. RECOMMENDATION

4.1 The Board is asked to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.2.4 Appendix 4

BOARD	
HIGHLIGHT REPORT FROM THE LOCAL PARTNERSHIP FORUM	
DATE OF MEETING	27 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Karen Wright, Assistant Director of Policy, Governance and Compliance
PRESENTED BY	Hywel Daniel, Executive Director of People Policy
EXECUTIVE SPONSOR APPROVED	Hywel Daniel, Executive Director of People Policy

REPORT PURPOSE	FOR INFORMATION

ACRONYMS	
	None Identified.

1. PURPOSE

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Local Partnership Forum at its meeting on 20 June 2023.

1.2 Key highlights from the meeting are reported in Section 2.

1.3 The Board is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Not Applicable.
ADVISE	**Enforcement of the Health Board's Smoking Policy** It was noted the actions being taken by the Health Board and the Local Authority Environmental Health Departments, to enforce the No Smoking Legislation and the Organisation's policy on our premises. Currently fixed penalty notes are not being served by any of our Local Authorities on those found to be smoking on Health Board premises. The current approach is to raise awareness of the legislation and potential to be given a £100 fixed penalty notice. It is hoped this approach will deter individuals from smoking on Health Board premises, which in the longer term will reduce the numbers of smokers in our communities and contribute to the improvement of the health of the people across CTM.
ASSURE	**Terms of Reference** The updated LPF Terms of Reference were endorsed for Board approval. **Care Group LPF Update** The Heads of People for each of the Care Groups attended the meeting to provide an update on the progress being made to establish regular local Care Group LPF meetings. It was noted that some Care Groups are more advanced than others, but assurances were provided that all Care Groups will have held their first local LPF meetings by the end of the Summer. **Wellbeing Survey Findings and Update** An overview of the ongoing Wellbeing Survey work was presented along with an outline of how this information will influence the services provided by the Health Board in the future. **Finance Update** A paper setting out the Health Board's latest financial position was received for month 2. There was no discussion as a Finance Representative was unable to attend.

INFORM	**NHS Pension Scheme Rule Changes and new Flexibilities** A paper was presented setting out the rule changes and the new flexibilities to enable members to access their pension benefits and continue to work in the NHS. It was confirmed that work is well progressed on a new NHS Pension Scheme Benefits Flexibility Policy to reflect the changes. This will be approved and available to managers and staff before the end of July 2023. In the interim, a short communication will be made available to managers and staff to make them aware of the changes and the timescales for the new policy. **Jonathan Morgan – Chair** The new Chair of the Health Board attended the meeting to introduce himself to members. **People Policies Approval** The following People Policies were ratified to be presented to the August 2023 People and Culture Committee for approval • Overtime and Additional Hours Policy • Substance Misuse Policy **Organisational Change** An update was provided in respect of phase two of the Care Group organisational change restructuring. **Strategic Workforce Planning** A presentation was delivered outlining the work and the recommendations of the recent workforce planning review undertaken with KPMG, which will help to support and improve workforce planning and retention across the Health Board. **IMTP Update** An IMTP update was provided, confirming the Health Board has submitted an annual plan using the Welsh Government Delivery Templates. It was confirmed that the Health Board is waiting to receive feedback from the Welsh Government. Once confirmation of the status of the annual plan is received it will be shared with our employees. **Strategic Equality Plan (SEP)** A presentation was delivered setting out the Health Board's SEP strategic goals aligned to the CTM 2030 Plan. The Forum was

	encouraged to share their thoughts on the SEP during the consultation period. **Long Service and Staff Recognition Proposal** A presentation was delivered, setting out the case for the Health Board introducing long service and staff recognition awards. The Forum was asked to consider a number of discussion points and invited to provide their thoughts and comments, to inform the direction of this work. The importance of partnership working on this proposal was emphasised to ensure everyone took ownership and the Health Board's approach met the expectations of our staff.
APPENDICES	**NOT APPLICABLE**

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.2.3 Appendix 5

CTM BOARD	
HIGHLIGHT REPORT FROM THE AUDIT AND RISK COMMITTEE	
DATE OF MEETING	27 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Patsy Roseblade, Independent Member and Chair of the Audit & Risk Committee
EXECUTIVE SPONSOR APPROVED	Sally May, Executive Director of Finance

REPORT PURPOSE	NOTING

ACRONYMS	

1. INTRODUCTION

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Audit & Risk Committee at its meeting on the 21 June 2023.

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

2. PURPOSE OF THE AUDIT & RISK COMMITTEE

2.1 The Committee will function in accordance with the NHS Audit Committee Handbook as appropriate.

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the CTMUHB on behalf of NHS Wales as appropriate. These are the Welsh Health Specialised Services

Committee and the Emergency Ambulance Services Committee. The meeting will be split into two parts with Cwm Taf Morgannwg CTMUHB business and hosted Committee business discussed and recorded separately.

The purpose of the Committee is to advise and assure the Board on whether effective arrangements are in place – through the design and operation of the Health Board system of risk and assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	There were no items the Committee wished to escalate on this occasion.
ADVISE	• The committee reviewed a report in respect of the lapse in **ISO14001 certification** from July 2022, and the lessons learned to avoid a reoccurrence. The committee also received a verbal update on the outcome of the recent assessment by the British Assessment Bureau and were pleased to be advised that, as at 16 June 2023, ISO14001 certification has been confirmed for a period of 12 months; • Members received the **Local Counter Fraud Report.** Members welcomed the report which highlighted the ongoing maturity of the function. Members noted that further work was required in relation to increasing compliance in regards to completion of the Counter Fraud e-learning module and in identifying hot-spot areas in relation to salary overpayments; • The **National Fraud Initiative progress and outcomes** was received and noted; • The **Procurements and Scheme of Delegation Report** was received. Members agreed to **APPROVE** the **Financial Control Procedure for Capital Monitoring** subject to points of clarification requested by Members; • Members received the **Losses & Special Payments Report.** A discussion was held in relation to the current position regarding Learning From Events Reports (LFER). Members noted that considerable focus was being placed on ensuring the number of outstanding LFER reports were completed and submitted to the Welsh Risk Pool in order to avoid further penalties. Members requested an update on progress at the next meeting;

- The **Organisational Risk Register** was received. The Assistant Director of Governance & Risk agreed to respond to the specific risk queries outside the meeting;
- The **Audit Wales Audit & Risk Committee Update** was received and noted;
- The **Audit Wales Forward Work Programme 2023-2026** was received and noted;
- The **Audit Wales National and Local Report Orthopaedic Services** – which included the Local Management Response was received. Members noted the report identified variation across Wales and noted that the Health Board was taking steps to address the position. Members also noted the report identified the areas in which the Health Board was performing well, for example, Physiotherapy;
- The **Audit Wales CTMUHB Detailed Audit Plan 2023** was received and noted;
- The **Internal Audit Progress Report** was received. Members noted the slippage in relation to turnaround times of management responses and requested that a discussion was held with the Executive Team to improve performance;
- The **Internal Audit Review – Welsh Risk Pool** report was received. Members noted that whilst an overall rating of reasonable assurance had been given, there was one area that had been allocated a limited assurance rating;
- The **Internal Audit Follow Up Review – Concerns** was received. Members noted the significant progress that had been made since the last review and noted that reasonable assurance had now been allocated;
- The **Internal Audit Review – SLA Arrangements** was received. Members noted that a Limited Assurance rating had been allocated to this review.

An In Committee Session was also held on 21 June 2023 where the following items were received and discussed:

- CTMUHB – Draft Annual Report including Accountability Report, Remuneration and Staff Report, Performance Report 2022-2023
- WHSSC Draft Annual Governance Statement 2022-2023
- EASC Draft Annual Governance Statement 2022-2023
- National Imaging Academy Governance Compliance Statement
- National Collaborative Commissioning Unit Annual Governance Compliance Statement for 2022-2023
- Draft - Head of Internal Audit Opinion and Annual Report 2022-2023
- CTMUHB Draft Accounts 2022-2023 - **Draft Subject to Final Audit Review**
- CTMUHB Audit Enquiries Letter
- WHSSC and EASC Draft Accounts 2022-2023
- WHSSC Audit Enquiries Letter

	• EASC Audit Enquiries Letter • Audit Wales: Audit of the Financial Statements (ISA 260) Report (Including the Letter of Representation and Audit Opinion) - Verbal Update • Organisational Risk Register - Cyber Security Risks It was noted that the Annual Report related documents were received in private due to their draft status and will be in the published in the July Board Papers that will be available in the public domain.
ASSURE	• The **Audit Recommendations Tracker** was received. Members welcomed the progress that had been made in refining the trackers and cover report which provided Committee members with greater assurance.
INFORM	The following items were received for approval/noting via the Consent agenda: • Unconfirmed Minutes of the meetings held on 19 April 2023; • Committee Annual Cycle of Business and Forward Work Programme
APPENDICES	Choose an item.

4. RECCOMENDATION

4.1 The Board is requested to **NOTE** the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM
8.2.5

CTM BOARD

REGIONAL OPHTHALMOLOGY STRATEGY

Date of meeting	27/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elizabeth Beadle, Assistant Director of Transformation
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
South East Wales Regional Planning Portfolio Board	(14/02/2023)	SUPPORTED
CTMUHB PPFC	27/06/2023	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Chief Executives for the South East Wales region (Cardiff and Vale University Health Board, CAVUHB, Cwm Taf Morgannwg University Health Board, CTMUHB and Aneurin Bevan University Health Board, ABUHB) renewed their commitment to joint working and regional

service provision where clinically appropriate. This is being supported through the Regional Portfolio Board.

1.2 This refreshed approach to the governance of regional working coordinates these efforts and each Health Board is taking the lead for a specific priority area;

1.2.1 ABUHB: Ophthalmology
1.2.2 CTMUHB: Diagnostics
1.2.3 CAVUHB: Orthopaedics

1.3 The purpose of this paper is to provide an update on the regional ophthalmology work, following approval of the regional strategy, with a focus on the associated regional cataracts business case.

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

2.1 The focus of regional partnership arrangements directed by the programme has been on two priority areas of work which, although discrete at present, are intrinsically linked in the medium to long term.

2.2 The first is the development of a South East Wales regional care strategy which describes the wider medium / long term provision for eye care and has been endorsed by Cwm Taf Morgannwg University Health Board's board.

2.3 The second is the progression of regional cataract capacity expansion to support all Health Boards manage immediate waiting list pressures and anticipated demand levels in the coming years.

2.4 The strategy has been developed with clinical and operational input and sets out the intention for the future direction of regional ophthalmic services and is founded on four key principles.

2.5 The table below sets out the pattern of service delivery that is proposed by the strategy. This is founded on more straightforward services being provided locally (within HB regions) and more complex

and fragile services to be provided regionally. Screening, monitoring and (low-risk) follow up activity will be delivered in community settings wherever possible.

Specialty	On a regional level	At a local level	Community
Glaucoma	Surgical / complex Glaucoma	Medical Glaucoma	Stable treated Glaucoma, Ocular Hypotension
Uveitis	Complex Uveitis	Anterior Uveitis	Simple recurrent Uveitis
Emergency Eye Care:	Eye Casualty	Follow up clinics	Follow ups, Minor Ailments
Out of hours Care	Out of hours Care		
Cornea	Cross linking	Routine Cornea	Keratoconus Monitoring
Oculoplastic	Orbit, Complex	Lids, Minor ops	
Medical Retina	Retinal Dystrophies, Genetics, complex Medical Retina	Stable monitoring, injection services, stable diabetic eye disease	Diabetic screening and monitoring
Paediatrics and Orthoptics	Complex Paediatrics	Routine Paediatrics,, Adult Orthoptics, Paediatric Orthoptics	Screening
Neuro Ophthalmology	Neuro Ophthalmology		
Vitreo retinal	Emergency and routine procedures		
Cataracts	Cataracts Expansion	Cataracts	Follow ups

2.6 The cataracts business case and associated reports set out the work undertaken regionally, under the auspices of the regional ophthalmology programme to develop short-term options to deliver additional regional capacity for cataracts to reduce the number of long waiting patients and the length of time that patients wait across the south east Wales region for cataract treatment. The final business case is included as appendix 1.

2.7 A number of proposals to increase regional capacity have been developed and subjected to robust option appraisal process with clinical, operational and planning leads. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working as set out in appendices 3 and 4.

2.8 Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%

- Deliverability: 20%

2.9 The six options identified were:

- **Option 1: Do nothing** - to do nothing and only retain the core capacity of 5,940 per year across the region.

- **Option 2: Maximising the use of Nevill Hall Hospital (NHH) and Princess of Wales Hospital (POWH) -** This option uses one theatre in NHH for 7 weekday sessions and 4 weekend sessions, and the twin theatre in POWH. The option also includes 2,000 outsourced patients. This option would provide total additional capacity of 8,668, which with the core capacity of 5,940 is 14,608 total capacity.

- **Option 3a: Vanguard and NHH -** This option uses one theatre in NHH for 4 weekend sessions and the twin Vanguard theatre, which is currently in situ at University Hospital for Wales and being deployed in quarter four of 2022-23 to provide treatment to patients across the HW. This option would provide total additional capacity of 7,700 plus a core capacity of 6,120 to create 13,820 total capacity.

- **Option 3b: Vanguard and Maximising NHH -** This option uses one theatre in NHH for 7 weekday sessions and 4 weekend sessions, and the twin Vanguard theatre in UHW. This option would provide total additional capacity of 9,310 plus a core capacity of 6,120 creating 15,430 total capacity.

- **Option 4: Weekend Insourcing and Outsourcing only-** This option uses one theatre in NHH for 4 weekend sessions and the twin theatre in POWH. The option also includes 2,000 outsourced patients. Through this option the total additional capacity is 5,000 plus a core capacity of 5,940 is 10,940 total capacity.

- **Option 5: Outsourcing activity to external provider(s) -** This option involves outsourcing 5,000 patients in 12 months. Through this option the total additional capacity is 5,000 plus a core capacity of 5,940 is 10,940 total capacity.

2.10 The outcome of the option appraisal both individually by Health Board and collectively for the region was that option 3b was the most optimal option on the basis of the criteria.

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

3.1 The regional ophthalmology strategy has been approved by the Regional Portfolio Board and was approved by the Cwm Taf Morgannwg University Health Board Strategic Leadership Group on 24th February 2023.

3.2 The PPF Committee approved the strategy on 28th February and also approved the business case in principle on this date, noting that the financial requirements would be presented following completion of the final assessment, for further ratification. This report was considered by the Board on 30th March 2023 and the regional strategy was approved at this time.

3.3 The identification of option 3b as the preferred option for the regional cataracts business case development has been ratified by the Regional Portfolio Delivery Board on 9th February and the Regional Portfolio Oversight Board on 14th February and was endorsed by the PPF Committee on 28th February 2023 and the Board on 30th March 2023.

3.4 The next phase for the regional cataracts business case was the fuller financial appraisal and identification of funding mechanisms has been completed. The business case with the required funding confirmed has been approved at the following fora.

- Regional Ophthalmology Programme Board - 13th February 2023
- Regional Portfolio Delivery Board – 6th April 2023
- Regional Portfolio Oversight Board – 13th April 2023
- Management Executives ABUHB – 13th April 2023
- Investment Group CVUHB – 18th April 2023
- Strategic Leadership Group CVUHB – 4th May 2023
- Management Executives CTMUHB (ELG) – 9th May

3.5 Key points to note for Cwm Taf Morgannwg University Health Board are:

3.5.1 The cost of the regional business case was set out globally in the business case provided to the Planning, Performance and Finance Committee and Board in February and March 2023 and did not set out individual health board shares. The cost to Cwm Taf Morgannwg University Health Board of the proportionate commissioner share is greater than originally anticipated. The costs were originally anticipated to be c£4m but have been confirmed to be £5.1m (£5,125,028). This is in the main related to Cwm Taf Morgannwg University Health Board having 49% of the long waiting cataract patients and consequently requiring the largest share of the activity from the regional solution. There was also a movement in the costs of the business case of an additional £500,000 which is to cover a 5% increase in pay costs for the NHH service.

3.5.2 The proposed mechanism for funding the regional cataract business case collectively is the regional funding held by Welsh Government for planned care recovery and performance improvement. The £5.1m requirement for the Cwm Taf Morgannwg University Health Board commissioner share has been included in the collective South East Wales regional funding proposal that was submitted to Welsh Government in May 2023.

3.5.3 Confirmation of the outcome of the funding proposal has not been received but is expected imminently. Should the full funding be approved this will be used to fund the Health Board's share of the costs of the cataract business case.

3.5.4 Should Welsh Government allocate a lesser amount of funding, the business case will require revision to fit with available resources as agreed by the South East Wales Portfolio Oversight Board. (26th June 2023).

3.5.5 Work is being undertaken on a memorandum of understanding that reflects all parties' (Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Board) requirements. A review of potential contractual mechanisms has been initiated to identify the optimal mechanism for this partnership commissioning arrangement. It is intended that the contractual documentation would include the Cwm Taf Morgannwg University Health Board position that funding would be only to the value of the allocation received from Welsh Government.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Delivery of this strategy is intended to improve access to ophthalmic services and to improve outcomes for patients.

Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: Timely Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Any service change/development proposals arising from the strategy will have equality impact assessments.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board is asked to note the contents of the report and associated appendices and to:

5.1.1 Consider the financial impacts associated with the regional cataracts business case for delivery of option 3b, noting that if the full request to Welsh Government is not authorised, the business case would be revised to reflect the funding envelope available.

5.1.2 Await a further report confirming the funding position and agreed contractual mechanism, once known.

Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg

University Health Boards

Business Case

Title	Regional Cataracts Expansion Business Case		
		Date Last Updated	12/05/2023
Accountable Executive	Chris Dawson Morris, Director of Planning (AB)	**Lead /Project Manager** **Clinical Lead**	Hannah Brayford, Programme Manager Dr Rhianon Reynolds, Dr Siene Ng, Dr Anjana Haridas
Clinical Service		Planned Care, Ophthalmology	

1. Executive Summary

This Business Case seeks to provide a 14 month solution for additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.

This additional capacity will provide a service for health board patients from Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards.

Aims

The aims of the regional solution outlined in this business case are

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets and resources across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

The Regional Ophthalmology Programme Board have also agreed a set of regional working principles on which the approach to expanding cataract capacity will be based.

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all sites
- Adopting shared waiting list (PTL) management arrangements

Each health board is at a different starting point for their waiting list and this is reflected in the trajectories and projections. It is anticipated that as a result of this business case the following trajectories will be met:

- Aneurin Bevan: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cwm Taf Morgannwg: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cardiff and Vale: no patients waiting over 78 weeks for an outpatient appointment by the end of the funding period

Staged Delivery

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 14 months.

- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

Demand and Capacity

The region is presented with a sizable challenge for backlog, demand and capacity. Demand continues to outstrip capacity and is forecast to grow year on year.

- The total number of patients waiting for assessment and treatment for cataracts is forecast to reach over 19,000 by the end of March 2023.

- Demand across the region has returned to pre-pandemic levels and is forecast to be 9,960 per year for 23/24
- The projected combined core capacity across the region for 23/24 with no further intervention is 5,940 treatments and assessments per year, broken down as follows
    - Aneurin Bevan UHB – 2,400
    - Cardiff and Vale UHB – 1,440
    - Cwm Taf Morgannwg UHB – 2,100

Eliminating the waiting list backlog in 23/24 would require a capacity of 28,960 in one year, almost five times the projected combined core capacity. With no further intervention the projected waiting list of 19,000 in March 2023 would therefore be over 23,000 by March 2024.

Delivery Assumptions

Shared PTL

To support a regional approach, the three health boards have agreed to pool their patient treatment lists (PTL) and adopt shared waiting list management arrangements for the allocation of the additional regional capacity. This will be supported by a regional booking team who will also manage the shared patient waiting list ensuring that the patients who have been waiting the longest are treated first, regardless of their 'home' health board.

North and South Hubs

The geography of the region lends itself to distributing the capacity is across a North and South Hub model. This model that will keep service delivery closer to home and reduce patient travel as far as possible.

Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board. A recent survey of 140 patients across the region shows that 71% of patients would be willing to travel.

Allocation by Health Board

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

Options

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum

The options are:

- **Option 1: Do nothing**
  - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 8,668 (plus 5,940 core is 14,608 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 7700 (plus 6,120 core is 13,820 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*
***Costing for this option include 5% increase on all pay costs*

Waiting List Changes
The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal
The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.
Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option
The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing

- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

Preferred Option Financials

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs — **2023/24**

Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient
Provider			Activity	Cost		Cost per case excl capital and pre go live
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151
External	Outsource		1,334	1,861,757	£1,861,757	£1,396
Regional Operational Team		£50,642		£871,566	£922,208	
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**	

2024/25 — **TOTAL ACTIVITY** — **TOTAL COST**

Host Health Board	Delivery	Patients	Patients	Patients	Patients
		Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team			£443,449		£1,365,656
TOTAL		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

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2. Introduction and Background

2.1 Regional Working

The Regional Portfolio is made up of three main programmes, Orthopaedics, Diagnostics and Ophthalmology. The three University Health Boards in South Eat Wales, Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg have agreed to work together regionally and adopt for following regional working principles

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
- To improve resilience.
- To make effective use of capacity and capability in whichever organisation it sits.
- To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that my not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources.
- To enable clinical leaders, and others, to work together, lead together and learn together.
- Distributed leadership (The SRO maybe from organisation A, clinical lead from org B and delivery of service in B and C.)
- Approach collaboration with benign intent, honesty, transparency, and integrity in order to build trusting and effective relationships.
- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind and learn from the past and progress in an open, honest and humble way.

2.2 Regional Ophthalmology Programme and Clinical Summit

The Regional Ophthalmology Programme has been running for 4 years in South East Wales with a pause for the pandemic and restarted with a renewed focus in summer 2021. The Programme aligns strongly with national priorities and is designed around delivering solutions on a regional basis where this would provide the best care to patients. The three Health Boards in the region are committed to working together, sharing resources and solutions across Ophthalmology, where working together would add value for patients and the workforce. The Programme includes active clinical and management representation from Cwm Taf Morgannwg, Cardiff and Vale and Aneurin Bevan University Health Boards.

A Clinical Summit was held in December 2021 where clinical staff were engaged in discussing and agreeing key issues and priorities for Ophthamology services in South East Wales. It was agreed that a new regional strategy should be developed to inform the future direction of the programme, including agreement regarding the ophthalmic specialties that would benefit from a collaborative regional approach

2.3 Regional Ophthalmology Strategy

A Regional Ophthalmology Strategy has been developed with clinical staff to set out the high level direction for the Regional Programme. The principles set out in the strategy are:

The Strategy has a number of delivery themes that reflect the issues and priorities identified in the Clinical Summit and now inform the future direction for the service on a regional footprint, these are set out below

1. Regional Model: Adoption of a regional model would bring together ophthalmic services under the umbrella described as a Regional Centre of Excellence network model. This will provide additional regional cataracts capacity and will use the network model approach to bring experts together to provide the best care for patients and sector-leading teaching and education expertise.
2. Sustainable Services: There are many services that cannot be sustained on a health-board only level and need to be brought together on a regional footprint. These include Vitreo-Retinal (VR) services, Corneal Cross linking and out of hours and emergency cover as requiring the most urgent attention.
3. Workforce: There is a significant skills shortage across the Ophthalmic disciplines and the strategy will also work to address the training and development of key staff to deliver a regional sustainable workforce with strong succession planning, teaching, training and development.
4. Research, Innovation and Development: Key to attracting workforce and achieving the other aspects of the strategy over the longer term is a Regional Clinical Research Facility allowing delivery of high quality clinical research trials which will increase income and quality of care for patients whilst building links with industry partners with strong consultant support.

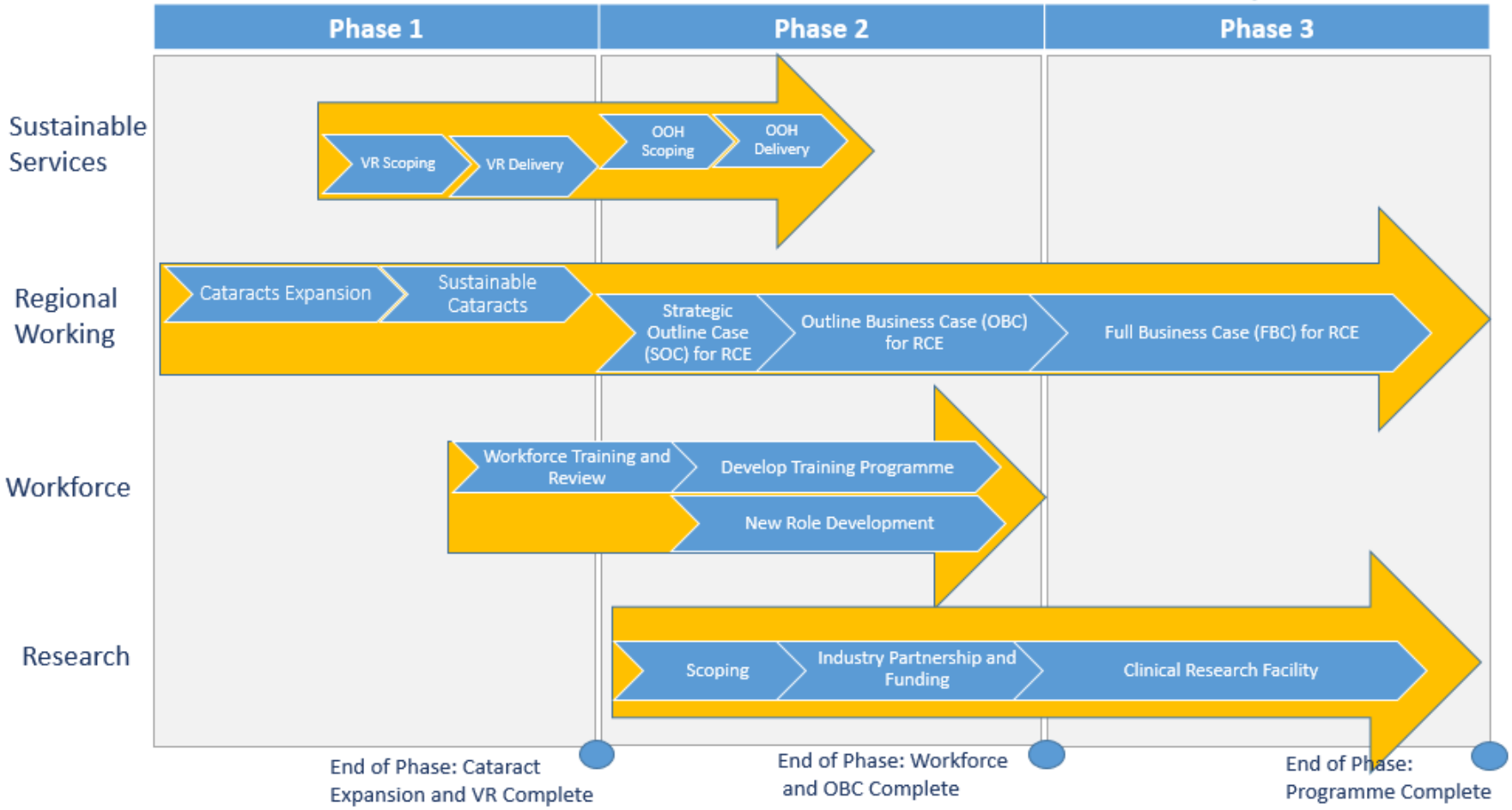
Regionalising Services to ensure their sustainability and offer the best services to patients aligns with *A Healthier Wales*, *The National Clinical Framework* and Royal College

of Ophthalmologists Clinical Guidance and best practice. The long term goal is a South East Wales regional centre of eye care excellence which can co-ordinate and provide the services identified above at a tertiary level. This will enable the region to care for all complex eye care procedures, for specialist clinicians to share and enhance their skills and to reduce the need for patients to travel outside Wales for certain specialist treatment.

2.4 Programme Plans and Phased approach

The diagram below represents the timeframes for the implementation of the strategy through a programme approach. Regional working starts first with the cataracts solution, closely followed by Vitreo Retinal hub and out of hours arrangements. The plans for the Regional Centre of Excellence will be developed through the 3 stage business case process alongside workforce developments and a research and innovation facility.

High Level Programme Plan



2.5 Cataracts Sustainability Staged Approach

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 12 months.
- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

3. The Case for Change

3.1 National Drivers for Change

Throughout the United Kingdom ophthalmic services are under considerable pressure. The Way Forward[1] document produced by the Royal College of Ophthalmologists in 2017 indicate

- Cataract surgery alone represents 6% of all surgery carried out in the UK, with an expected growth within 10 years of 25%.
- 35% of patients over the age of 65 have visually significant cataract.
- 10% of all out-patient appointments within the UK (9 million appointments) are for eye clinics, and the demand on our services is expected to increase by 40% over the next 20 years.
- Overall, the economic burden of sight loss in the country was estimated to be £28 billion.
- In 2019 UK wide there was a shortfall of 230 consultants, and 67% of eye units were using locums to fill 127 vacant posts.
- 85% of units depended on waiting list initiatives in out-of-hours sessions to try and meet their demand.
- 22 patients a month were losing vision from hospital-initiated system delays.

All of these statistics pre-date the Covid pandemic, during which things have grown considerably worse (External Review of Eye Care Services in Wales, 2021[2]).

3.2 Planned Care

The Welsh Government April 2022 document "Our programme for transforming and modernising planned care and reducing waiting lists in Wales" states 5 planned care goals

[1] The Way Forward | The Royal College of Ophthalmologists (rcophth.ac.uk)
[2] External Review of Eye Care Services in Wales (rcophth.ac.uk)

And 7 Planned Care priorities to support and influence recovery planning and investment decisions:

- Transformation of outpatients.
- Prioritisation of diagnostic services.
- Focus on early diagnosis and treatment of suspected cancer patients.
- Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities.
- Eliminating long waiters at all stages of the pathway.
- Build sustainable planned care capacity across the care pathway.
- The provision of appropriate information and support to people.

This business case, and the long term proposals that it supports in stage 2 align closely with the Planned Care priorities, in particular the patient prioritisation and the long waiters.

3.3 Getting It Right First Time (GIRFT)

The Ophthalmology GIRFT Programme National Specialty Report 2019[3] also considers the challenging context for Ophthalmic services in the UK with demand for services across primary and secondary care increasing by over 10% in a 5 year period to 2019 and further increases expected. The report notes that workforce has not grown in line with demand and that Ophthalmology departments are cramped with little room for expansion. This review

[3] Ophthalmology (gettingitrightfirsttime.co.uk)

makes some cataract specific recommendations including making optimum use of theatre time

This business case and the longer-term approach planned for cataract provision across the region addresses the points raised in the report.

3.4 Royal College of Ophthalmologists, External Review of Eye Care Services in Wales

An External Review of Eye Care Services in Wales[4] published in 2021 makes ten recommendations for Wales including Data Management, a reduction in patients transferred to England for treatment and more frequent sharing of best practice. Recommendation 8 is about Cataract Service Redesign and increased use of high-volume surgery. This will reduce waiting times and also - but as the report notes - encourage improvements in the end to end process where surgery is just one part.

This business case aims to address this recommendation for South East Wales and provide an increased number of high volume lists. The longer term approach identified in section 2.5 above will then address other areas for improvements.

3.5 Patient Harm

Cataracts can lead to progressive visual loss and if left untreated can lead to almost total vision loss with the sufferer only being able to perceive light and dark. Prior to Covid-19, vision loss of this nature was an unusual occurrence however, in the current climate this is alarmingly becoming more common.

A significant proportion of patients waiting for this surgery have been rendered severely sight impaired because of the delay to the treatment albeit in a reversible manner. Furthermore, the surgical complexity and time taken to perform cataract surgery increases in such cases. This reduces the number of cases that can be completed on a list, but also increases the risk of a serious complication that could lead to a second or third surgery being needed at a specialist centre.

The disability that cataracts cause has a significant impact on the sufferer. Driving is impossible leading to loss of independence. The ability to work or carry out activities of daily living may also be impaired. Poor mental health in people with vision impairment is an all too familiar problem. Furthermore, it has been identified that falls and the resulting injury and morbidity are significantly increased in this vulnerable population, thereby significantly adding to the trauma load and the hospitalisation that inevitably accompanies it.

Evidence suggests sight impairment in older people is associated with increases in the incidence of falls and hip fractures. Compared to the general older population, this group is

[4] External Review of Eye Care Services in Wales (rcophth.ac.uk)

1.7 times more likely to fall, 1.9 times more likely to have multiple falls and 1.3–1.9 times more likely to experience hip fractures. Often the patients may be a carer for their family, and their preventable visual impairment begins to make this impossible, further increasing the burden on social care.

3.6 Service issues and gaps

There are some significant service issues and gaps that further evidence the need for increased capacity of cataracts procedures across the region. These include:

- Demand across the region being greater than the cataract capacity across the region - with no additional capacity the total number of patients waiting by March 2024 will be over 23,000
- Shortage of trained ophthalmology staff at all levels. All health boards have vacancies they cannot fill
- Burn out amongst staff
- Due to long waits, case mix can be more challenging
- Currently limited ability to share resources across the region for cataract surgery
- Patients waiting longer and are at greater risk of coming to additional harm

4. Current Service Provision

This section sets out the current activity and capacity assumptions for cataract surgery across AB, CAV, and CTM UHB's.

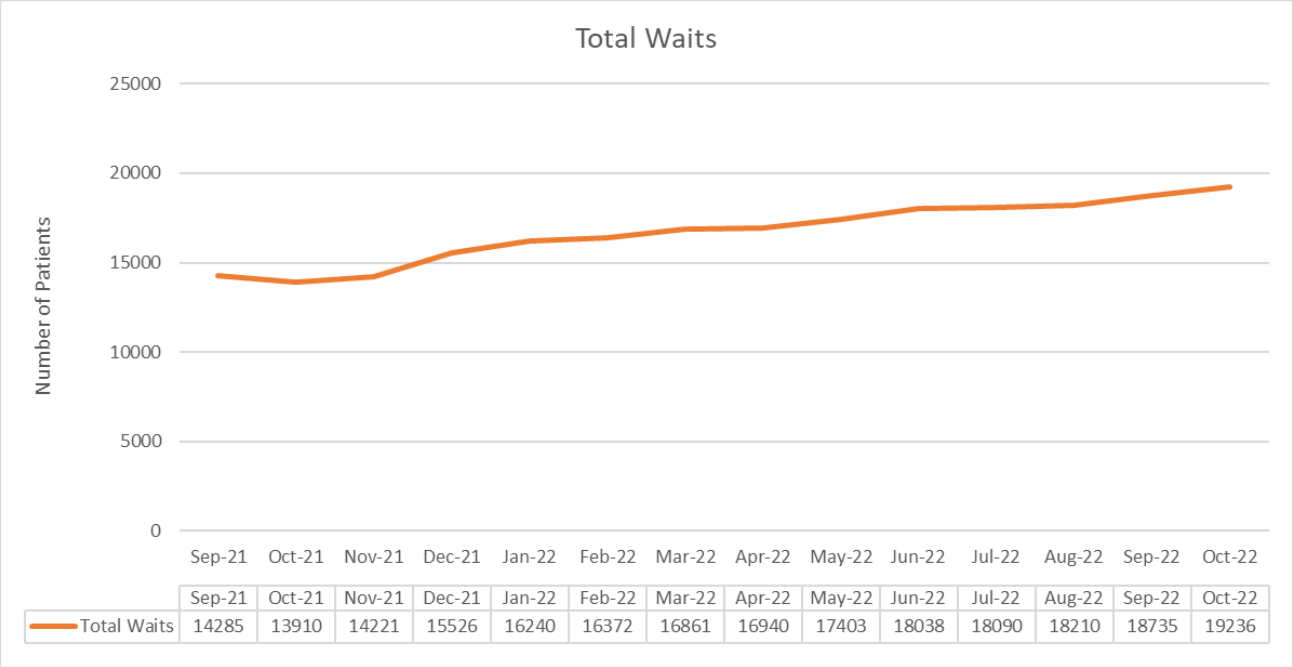
4.1 Current Situation Background

During the covid-19 pandemic, the ability to operate on cataracts patients was reduced significantly. This has resulted in a considerable backlog of patients waiting to be seen for both assessments and surgery. Cataract surgery is the most frequently performed surgery within the NHS. Quality of life gains following successful surgery are amongst the highest of any procedure in Ophthalmology. With an ageing population the demand for the service across the region has steadily grown and demand outstrips the resources available to delivery capacity at current levels.

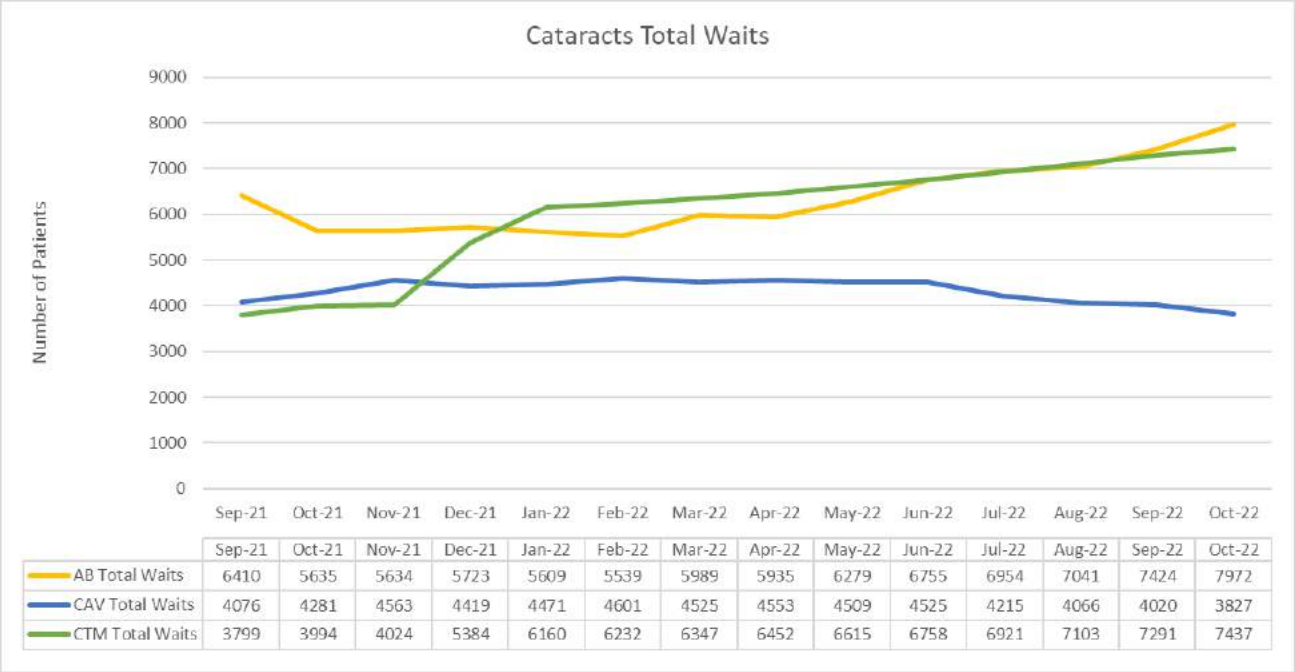
Current demand for cataract surgery is high. Across the region there are over 830 new cataract referrals every month and the current capacity across the region is struggling to cope with this level of demand. Across the region approximately 735 surgical procedures are undertaken per month. This will reduce to 495 per month From April 2023 if there is no further regional investment.

4.2 Current Waiting Lists

Waiting times are high for patients and are increasing across the region as capacity is consistently not able to meet the current demand. The total number of patients waiting across the region as at October 2022 is 19,236 and of these 6,163 (32%) have been waiting longer that 52 weeks



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Total Waits	14285	13910	14221	15526	16240	16372	16861	16940	17403	18038	18090	18210	18735	19236



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB Total Waits	6410	5635	5634	5723	5609	5539	5989	5935	6279	6755	6954	7041	7424	7972
CAV Total Waits	4076	4281	4563	4419	4471	4601	4525	4553	4509	4525	4215	4066	4020	3827
CTM Total Waits	3799	3994	4024	5384	6160	6232	6347	6452	6615	6758	6921	7103	7291	7437

4.3 Pre-pandemic Referral Levels and Demand

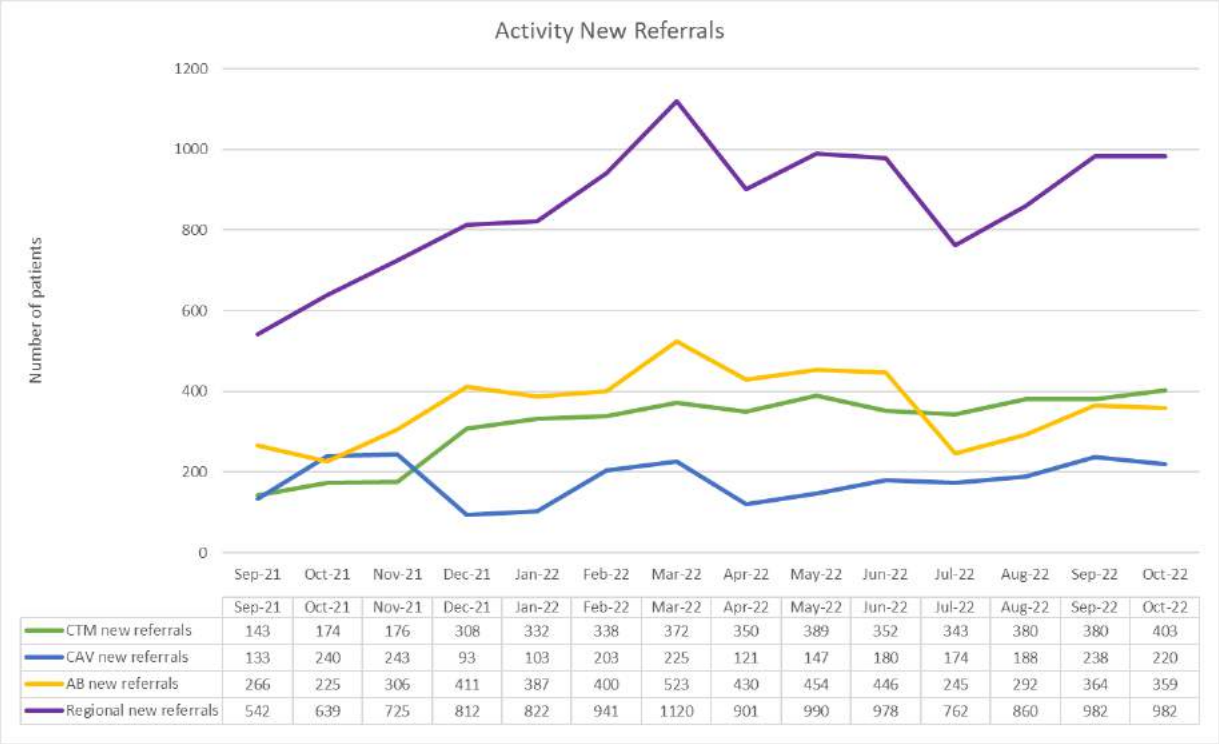
The referrals for cataracts are expected to return to pre pandemic levels once the referrals delayed through covid are received into the system. For planning purposes projections suggest that 830 referrals is the monthly level across the region. This results in approximately 10,000 referrals across the region per year.

Pre pandemic referral levels for cataracts are shown below:

Year	CTM	AB	CAV	Total	Average per Month
2018/19	3705	3571	2205	9481	790
2019/20	4438	3594	2094	10126	844

4.4 Current Referral Levels / Demand

The rate of new referrals in the region is further extending the waiting times for patients, as more patients are added to the list per month than are treated. New referrals have been steadily climbing since September 2021, reaching a peak of over 1,100 in March 2022. From arch 22 onwards referral levels stop climbing and provide a better basis for planning future demand. Between March 2022 and November 2022 inclusive, average demand across the region is Since For the last 5 months the referrals have been returning to pre covid levels or an average of 850 per month across the region.



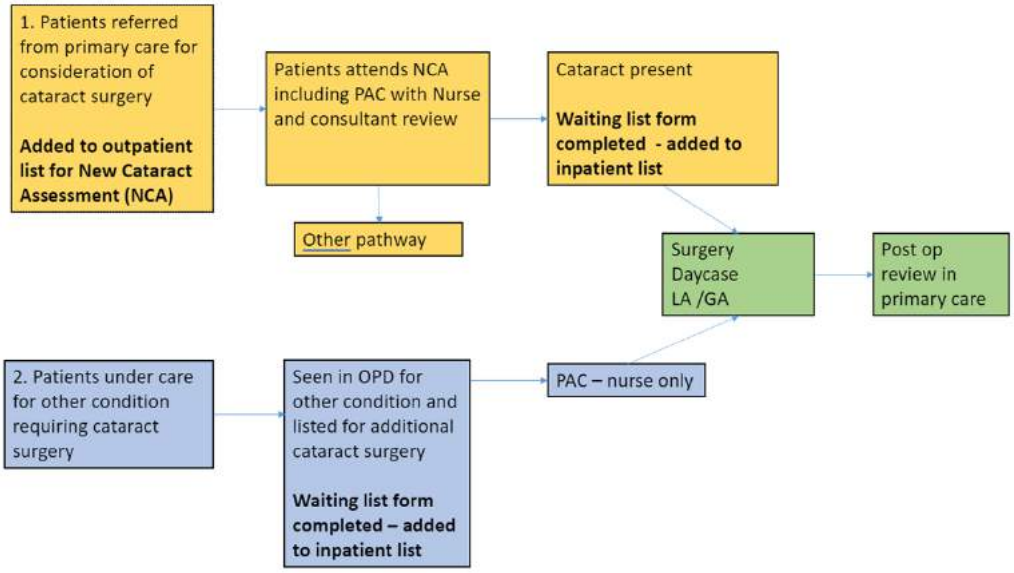
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
CTM new referrals	143	174	176	308	332	338	372	350	389	352	343	380	380	403
CAV new referrals	133	240	243	93	103	203	225	121	147	180	174	188	238	220
AB new referrals	266	225	306	411	387	400	523	430	454	446	245	292	364	359
Regional new referrals	542	639	725	812	822	941	1120	901	990	978	762	860	982	982

For the purposes of this business case the demand is forecast for 2023/24 as shown below:

Health Board	Monthly	Annual
AB	340	4080
CAV	150	1800
CTM	340	4080
Regional Total	**830**	**9,960**

Current referral rates are now slightly higher than pre pandemic levels, indicating that there is still some latent demand coming through the system, however most of the demand that presented by mid-2022 is in line with pre pandemic referral levels for the service.

4.5 Patient Pathway and Case mix



The diagram above demonstrates the patient pathway and the outpatient and inpatient sections of the pathway. Many of the patients are waiting to start this pathway at the outpatient stage and 19% are waiting for the inpatient stage.

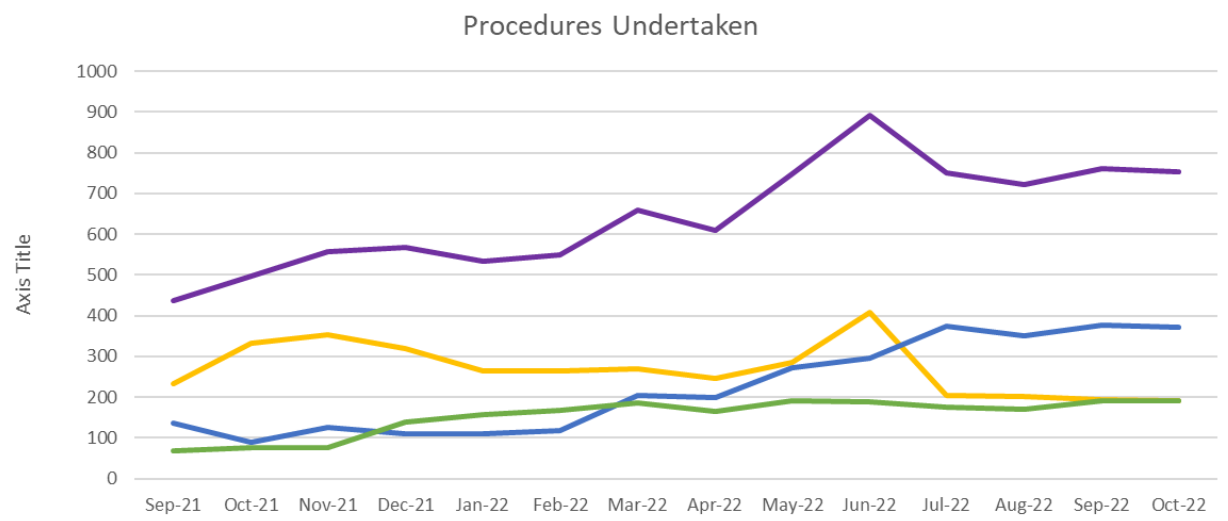
The case mix of the patients at the end of the waiting list has been clinically assessed as:

- 50% complex patients
- 30% non-complex (high flow)
- 20% no further action on cataracts pathway

It is anticipated that the increased capacity that this business case will provide will reduce the percentage of complex patients as backlogs are addressed. The case mix will then move towards a greater proportion of non-complex patients. This will in turn will release core capacity within Health Boards to provide optimal care for the remaining complex cases.

4.6 Current Activity Inpatient and Outpatient

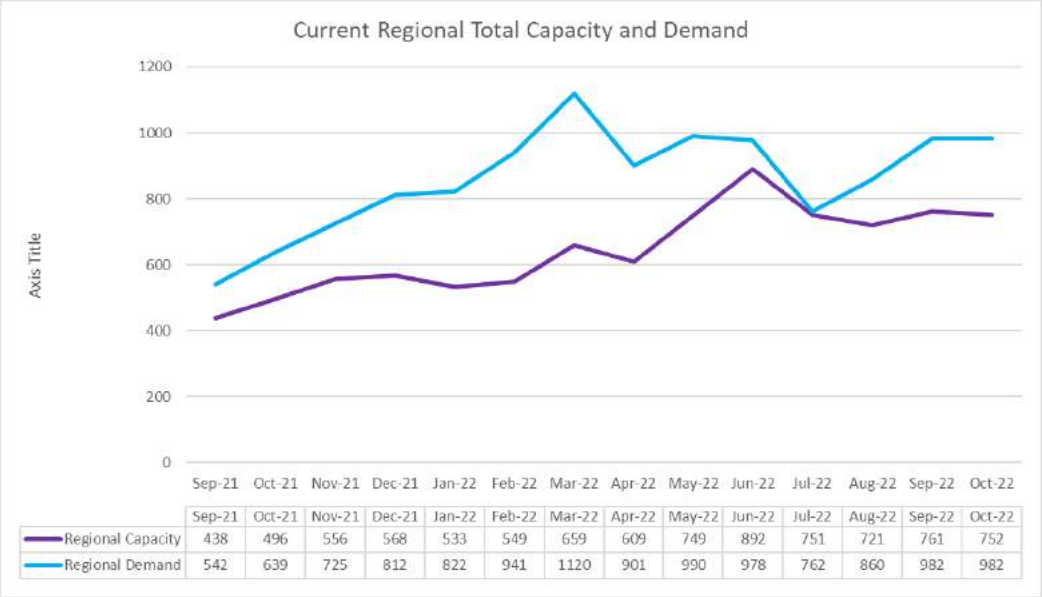
Activity across the region has been increasing, as operational teams and clinical staff work hard to restore sessions and undertake additional sessions to build back capacity post-COVID. The addition of the Vanguard mobile twin theatre theatre unit in Cardiff has also had a big impact towards increasing the activity the teams are able to provide. The Vanguard Unit opened in January 2022 and reached full capacity by March 2022. In September 2021 the regional inpatient activity including outsourcing was 438 procedures per month and in May 2022 including outsourcing, increasing capacity and opening the Vanguard theatres the activity was 749 procedures per month, an increase of 71% capacity in 8 months and demonstrating the work of the operational teams to increase capacity. Outpatient activity to prepare patients for surgery is also a critical step in the pathway. Outpatient activity was 1,038 in September, increasing to 1,564 in May 2022.



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB	234	333	353	319	265	264	269	246	286	408	203	201	194	190
CAV	135	88	126	110	111	118	203	198	272	295	373	351	377	372
CTM	69	75	77	139	157	167	187	165	191	189	175	169	190	190
Regional	438	496	556	568	533	549	659	609	749	892	751	721	761	752

Row Labels	Sum of Sep-21	Sum of Oct-21	Sum of Nov-21	Sum of Dec-21	Sum of Jan-22	Sum of Feb-22	Sum of Mar-22	Sum of Apr-22	Sum of May-22	Sum of Jun-22	Sum of Jul-22	Sum of Aug-22	Sum of Sep-22	Sum of Oct-22
AB	**234**	**333**	**353**	**319**	**265**	**264**	**269**	**246**	**286**	**408**	**203**	**201**	**194**	**190**
procedures outsourced	66	121	130	175	163	115	54	100	100	267	0	0	0	0
Procedures undertaken	168	212	223	144	102	149	215	146	186	141	203	201	194	190
CAV	**135**	**88**	**126**	**110**	**111**	**118**	**203**	**198**	**272**	**295**	**373**	**351**	**377**	**372**
procedures outsourced	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Procedures undertaken	135	88	126	110	111	118	203	198	272	295	373	351	377	372
CTM	**69**	**75**	**77**	**139**	**157**	**167**	**187**	**165**	**191**	**189**	**175**	**169**	**190**	**190**
procedures outsourced	12	18	20	20	15	20	20	20	15	15	15	15	15	15
Procedures undertaken	57	57	57	119	142	147	167	145	176	174	160	154	175	175
Regional	**438**	**496**	**556**	**568**	**533**	**549**	**659**	**609**	**749**	**892**	**751**	**721**	**761**	**752**
procedures outsourced	78	139	150	195	178	135	74	120	115	282	15	15	15	15
Procedures undertaken	360	357	406	373	355	414	585	489	634	610	736	706	746	737

The gap between demand and capacity is growing, as shown in the chart below.



4.7 Workforce

Workforce

The current session planning and job planning arrangements include some sessions that are assigned as cataract only lists and some theatres sessions that run mixed lists where cataracts procedures are on the same surgical list as other ophthalmic procedures. Running mixed lists does enable the service to use any available theatre time to undertake cataract surgery but makes identifying the exact workforce assigned to cataract surgery more difficult.

As an illustration, the workforce typically required to undertake cataract surgery, and the outpatient pre-operative assessment is shown below.

Outpatient Pre-Operative assessment

During 1 session the workforce can see approximately 7 patients on a list, however the numbers may reduce if the patients are more complex. Workforce for 1 session includes a Consultant, 2 pre-assessment Nurses, 2 Health Care Support Workers and a Receptionist. There is also workforce required for booking and for notes retrieval and typing after the session.

Theatre Session

During 1 theatre session there will be up to 6 patients booked on a theatre list, depending upon case complexity. Workforce for 1 session includes a Consultant, Anaesthetist, 2 Scrub Nurses, 1 ODP, 2 Health Care Support Workers and 2 Nurses for the recovery area and a Receptionist. There is also workforce required for booking and for notes retrieval and typing after the session.

Workforce Gaps

The vacancy levels across the region for Ophthalmology services have been identified as shown below. This information helps to demonstrate that in the short term the capacity can only be increased by an insourcing and outsourcing model.

CTMU

- 0.7 WTE Corneal consultant
- 1 WTE Specialty Doctor
- 1 WTE Band 6 nurse
- 1 WTE band 5 qualified nurse

ABUHB

- 1x Band 3 Scheduler & 1 x Band 3 Outpatient booking Clerk- Both Full time posts
- 5.8 WTE Band 5 Nurses

- 3.4 WTE Band 6 Nurse Practitioners,
- 4.7 WTE Band 2 HCSW
- 1 WTE Consultant

CVUHB

- 1 x trainee vacancy
- 2.5 x Band 3 admin vacancies
- 1 x Band 2 nursing vacancy
- 2 x Band 5 Directorate Support Managers

4.8 Service Improvements

All service provision is being reviewed on a continuous basis to identify where small changes can be made to improve the way the service is delivered. These changes will ensure optimal utilisation of existing core capacity in Health Boards, while this business case sets out the further additional capacity required to support cataracts recovery. Actions include:

CTMUHB

- All vacancies within theatres are in the process of being filled, which will ensure all available space can be adequately staffed.
- A Health Board theatre utilisation group has been formed to look at how we can maximise the theatre space we have in both areas, as well as looking at late starts and early finishes.
- IPC regulations are due to change, allowing the department to fill lists at short notice, which will help with utilisation when patients cancel at short notice.
- Eye bay nurse staffing is also being looked at with support from the main nursing hub being sought so that ophthalmic nurses can be utilised elsewhere, such as pre-assessment clinics.
- The concept of a 'golden list' has been developed, involving optimal circumstances of efficiency, flow and patient attendance. This will be rolled out to as many clinicians as possible

ABUHB

- Start and finish times of Theatre sessions are being monitored with reasons being audited for improvements to be identified.
- A patient "Stand by list" is being generated to utilise any very short notice cancellations.
- All patient biometry is being uploaded to Clinical Workstation for Consultants to review patients sooner to prevent delays to treatment and to reduce day of admission cancellations.

CVUHB

- Maximising utilisation by ensuring templates are booked to agreed capacity and backfilled as necessary when cancellations occur.
- Theatre utilisation – both booking and in-session – is monitored with the scheduling team on a weekly basis.

- HVLC lists are run where appropriate cases are identified, with performance and utilisation monitored with the scheduling team on a weekly basis

5. Cataracts and the opportunities for collaboration across the region

5.1 North and South Hubs and Patient Travel

The large geographical area of South East Wales, the road network and the position of the hospitals lends itself to a North / South split that can reduce patient travel across the region by providing hubs in the North and South of the region. These hub have the potential to provide additional capacity.

Geographical options for Cataracts in the North are Prince Charles Hospital (PCH) and Nevill Hall Hospital (NHH). There is no opportunity for expanding provision in PCH due to existing theatre usage and NHH is the remaining North option where 1 theatre is available. In Nevill Hall Hospital in Abergavenny as there is potential theatre space available to the region. The population in the North of the region is approximately 500,000 people and includes North Cwm Taf Morgannwg and North Aneurin Bevan.

In the South the Hub is proposed to be either University Hospital of Wales or Princess of Wales Hospital depending on the option taken forward both site use a twin theatre model. The population of the South of the region is approximately 1,000,000 people and includes South Cwm Taf Morgannwg, Cardiff and Vale and South Aneurin Bevan.

Travel Times By Car (From the centre of the town to the hospital site)

North Hub	South Hub	South Hub
To Abergavenny NHH	To Cardiff Vanguard	To Bridgend POWH
From Cwmbran = 30 minutes / 15 miles	From Newport = 30 minutes / 13 miles	From Pontypridd = 35 minutes / 25 miles
From Merthyr = 30 minutes / 18 miles	From Blackwood = 40 minutes / 23 miles	Treorchy = 35 minutes / 15 miles
From Blackwood = 35 minutes / 20 miles	From Bridgend = 45 minutes / 20 miles	From Newport = 40 minutes / 30 miles
From Aberdare = 45 minutes / 25 miles	From Aberdare = 50 minutes / 23 miles	From Cardiff = 40 minutes / 25 miles
From Newport = 40 minutes / 30 miles	From Treorchy = 55 minutes / 22 miles	From Aberdare = 55 minutes / 40 miles

Through the use of the North and south model no patient would travel further than 40 miles or for longer than 55 minutes by private car in normal traffic conditions.

The North and South hub model enables the additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.

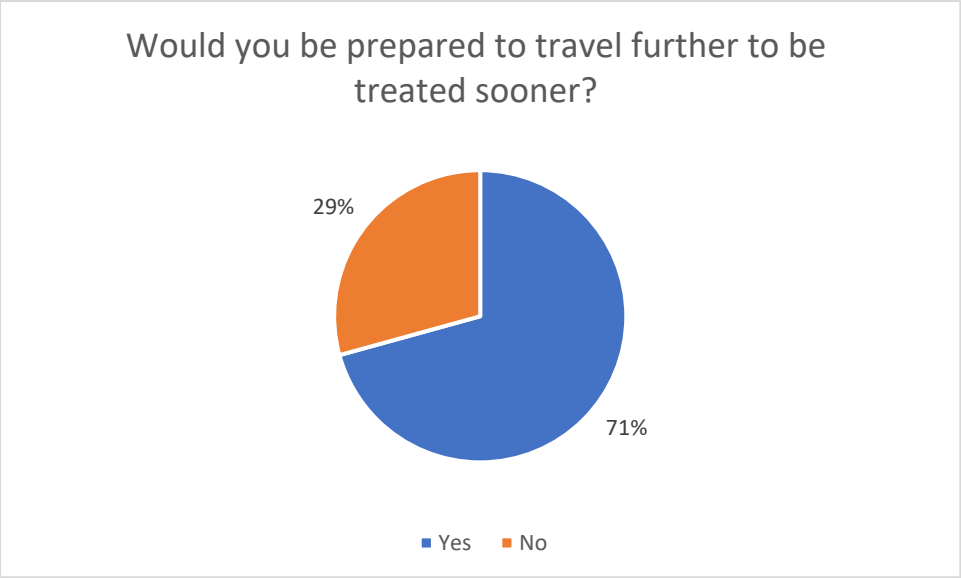
Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board.

Patient travel Survey

A patients travel questionnaire was undertaken in Princess of Wales Hospital on 5th January, Royal Gwent Hospital on 11th January, and University of Wales Hospital on 12th January 2023. A total of 140 patients attending appointments on those day were asked questions about their travel to hospital and their willingness to travel to another hospital for treatment. All respondents were anonymous. An extract of the survey is shown below. Full results are in appendix ten

Would you be prepared to travel further if you could have been treated sooner?



Would you be prepared to travel further to the treated sooner?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Yes	25 (71%)	27 (77%)	47 (67%)	99 (71%)
No	10 (29%)	8 (23%)	23 (33%)	41 (29%)
Grand Total	**35**	**35**	**70**	**140**

Where would you travel to?

- From Princess of Wales Hospital in Bridgend, of the 25 patients willing to travel 25 would go to Cardiff and 19 to Swansea
- From Royal Gwent Hospital in Newport, of the 27 patients willing to travel 19 would be willing to travel to Cardiff and 25 to Abergavenny
- From University Hospital of Wales in Cardiff, of the 47 patients willing to travel 38 would be willing to travel to Bridgend and 41 to Newport

Where would you travel to?	From Princess of Wales Hospital	From Royal Gwent Hospital	From University Hospital of Wales
Bridgend / POWH		7	38
Cardiff / UHW	25	19	
Newport / RGH	11		41
Abergavenny / NHH	5	25	30
Bristol	5	6	10
Swansea	19	3	10
Further in the UK	5	3	4
Grand Total	**70**	**63**	**133**

**patients could provide multiple answers to this question*

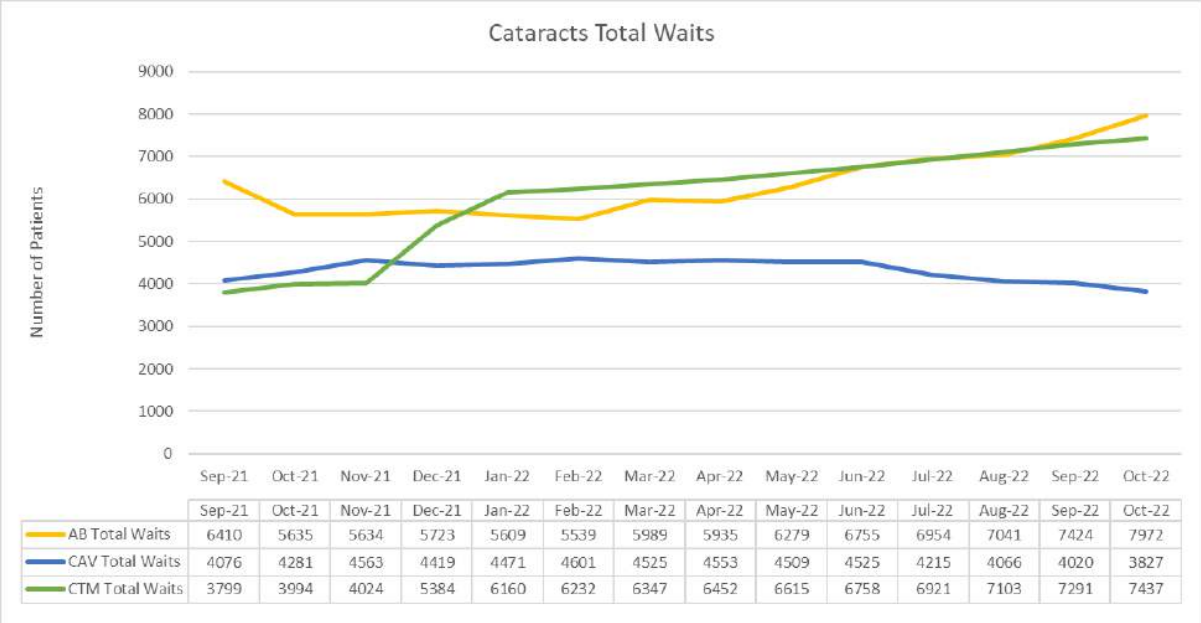
5.2 Regional Working Principles

The Regional Ophthalmology Programme Board have endorsed the following regional working principles

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all centres
- Adopting shared waiting list management arrangements

The three Health Boards have committed to working as a region and understand that this does not necessarily mean sharing the provision requested in this business case equally, but equitably across the region and allocating this provision to the patients of greatest need regardless of their 'home' health board.

The chart below shows the waits for outpatient and inpatient appointments across the region and the variation across Health Boards. Both AB are approaching 8,000 total patients waiting and CTM 7,500. CAV have under 4,000 patients waiting with trajectories moving towards reducing this figure each month.



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB Total Waits	6410	5635	5634	5723	5609	5539	5989	5935	6279	6755	6954	7041	7424	7972
CAV Total Waits	4076	4281	4563	4419	4471	4601	4525	4553	4509	4525	4215	4066	4020	3827
CTM Total Waits	3799	3994	4024	5384	6160	6232	6347	6452	6615	6758	6921	7103	7291	7437

5.3 Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

5.4 Shared Patient Treatment List (PTL)

As an agreed principle of this regional model, the three health boards have agreed to work together to share waiting list management (see section 5.4) and ensure that capacity is distributed across the region to the patients who have been waiting the longest and require this treatment.

The three health boards will share their patient treatment lists through a regional team and those patients at the end of the list that are suitable for this type of treatment will be assessed and treated as part of this regional capacity.

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

5.5 Regional Waiting List Management

Also see section 5.3 (shared PTL)

5.5.1 Shared waiting list management arrangements

All health Boards have agreed to share waiting lists and treat the longest waiters from across the region first.

The waiting lists could be shared via a SharePoint which is supported from an information governance perspective as access is only via NADEX numbers so access can be limited and monitored. To ensure that longest waiters are treated first, the three spreadsheets could be merged.

In terms of how patients are removed from waiting lists once treated, this would be managed in the same way that patients are treated in Spire/Nuffield. The NHH/UHW centres would be added as options for removal on a drop down list a feature which is on the CTM and C&V waiting lists.

The regional team will hold the shared list and the patients waiting the longest will be treated first, any issues will be managed by the regional team and demonstrated with the data.

SLA type arrangements will be in place for sharing data and resolving issues

5.5.2 Regional Booking and Scheduling

There will be a joint Regional Booking and Scheduling Team across the region to book all the additional capacity patients into outpatient appointments and schedule them for surgery. This team will be hosted by a Health Board but work for the region to support this additional service for the patients. Bringing this team together offers resilience in the service and flexibility to book into the North and South hubs via access to all the systems operated by each of the Health Boards.

The manager of this team will also oversee the data integrity for the joint waiting list arrangements with the three regional Ophthalmology Directorate Managers.

5.6 IT and Data Systems

North Hub

Patients booked and scheduled for assessment and treatment in the North Hub will be assigned an AB patient number and recorded on the AB systems as AB patients. Records will be shared with other health boards via Welsh Clinical Portal (WCP). CTM and CAV patients treated in the North hub will be recorded as 'outsourced' on the CTM and CAV systems (see below)

South Hub

Patients booked for outpatient appointments in the South Hub will attend POWH for their appointment and, if required, UHW for surgery. Upon funding approval the specific details for sharing information across the two health boards for patients will be developed and delivered as part of the implementation plan

Outsourcing

There are established practices to follow for recording outsourced patients already as outsourcing is a continuing practice in health boards within the region. Patients are listed as outsourced on the home system and information is shared between the outsourcing provider and the home health board via Welsh Clinical Portal (WCP)

Uploading on to the Welsh Clinical Portal upload records between the Health Boards

IT and data systems will require more full scoping when funding is agreed.

5.7 Additionality

The service model represents additional capacity established in the region when compared to the core base capacity that was provided before the pandemic. In Cardiff and Vale, there were 7.5 cataract sessions per week and the Vanguard Unit has increased this to 20 sessions per week. Through this business case 62.5% (12.5 out of 20 sessions) of the Vanguard Unit would be available for regional use, returning the Cardiff and Vale capacity to pre pandemic levels.

In Aneurin Bevan the way services are delivered has been reconfigured but the total capacity for cataract surgery remains unchanged from pre pandemic levels, demonstrating that this business case represents additional capacity across the region.

6. Benefits, Risks and Governance

6.1 High Level Benefits

The high-level benefits associated with undertaking the additional capacity are demonstrated below. Through the do-nothing option, these benefits will be foregone.

Patient Benefits

- Reduced waiting times for patients
- Improved quality of life (measured through PROMS/PREMS)

Wider Regional and Health Board Benefits

- Increased Capacity across the region
- Reduced waiting list size
- Making the best use of regional resources

Health gain

- Reducing sight loss
- Reducing complications and other relating to sight loss e.g.falls
- Improving outcomes for patients
- Improving timely clinical care and patient experience

Equity

- Equity of service provision and access across the region
- Capacity for the longest waiters

6.2 High Level Risks

The high level risks associate with undertaking the additional capacity are demonstrated below.

High-level Risks to Delivery

Delivery of the business case is dependent on the following risks being managed and mitigated:

Risk	Assessment	Mitigation
Reliability of providers to deliver services: that the service provider cannot fulfil the staffing required to meet the sessions they are contracted for	Prob: 1 Impact: 3 Score: 3 (low)	Contract management and open communication with the provider to manage any changes in the volumes and arrange times to increase capacity in future weeks/months
Availability of additional support service and equipment, trays, HSDU: That the additional capacity on weekends compromises the core capacity and there	Prob: 2 Impact: 3 Score: 6 (Medium)	Early modelling of requirements and ordering of supplies with longer lead in times. Detailed planning of these

Risk	Assessment	Mitigation
is not enough equipment to service the whole capacity required		resources and close monitoring of all usage and risk areas
Booking and scheduling staff appointments: That there is not enough booking and scheduling time to manage the additional patients and that the additional capacity is not fully utilised	Prob: 1 Impact: 4 Score: 4 (Low)	Planning for resource required and bringing them together into a regional team to enable cross cover and resilience to the service.
Ensuring equity of provision across the region: That the regional provision does not go to the patients waiting longest and HB's benefit disproportionately	Prob: 1 Impact: 4 Score: 4 (Low)	Regular and robust waiting lists management processes and pooled lists that adjust and review on a monthly basis to manage the lists as a whole
Reduction in core capacity: That core capacity is reduced or compromised because the regional solution is in place	Prob: 3 Impact: 3 Score: 9 (Medium)	Regular monitoring and early corrective actions towards additional capacity and core capacity alongside waiting list reductions in size and waiting times
IT systems and record keeping: that IT systems can't share information across HB boundaries and that patient records get lost through manual processes	Prob: 3 Impact: 4 Score: 12 (High)	Bring additional IT support into the programme to provide expertise and enable accurate record keeping and sharing through system and maintenance of information governance
Contracting impacting on core capacity: That staff take on contracting shifts and are then not able to provide the core capacity required to maintain Health Board levels of activity	Prob: 3 Impact: 3 Score: 9 (Medium)	Working with the provider to limit impacts on HB staff and planning schedules in advance and communicating this widely. Monitoring sickness levels
Clinical Risk: That staff do not have the appropriate qualifications and experience	Prob: 2 Impact: 5 Score: 10 (Medium)	Clinical Governance processes and working with provider to ensure every member of staff is suitable qualified and experienced.
Clinical Risk: That unsuitable patients are referred for insourcing and outsourcing and are routed back into core capacity making the patient journey longer	Prob: 1 Impact: 4 Score: 4 (Low)	Clear and clinically agreed criteria for referring patients for insourcing and outsourcing treatment routes
Clinical Risk: That patient cancellation rates are high and the insourcing and outsourcing efficiency is compromised	Prob: 1 Impact: 3 Score: 3 (Low)	Communication with patients prior to referral and follow ups of cancelling patients for feedback/reasons

Low Risk 1-5, medium 6-10, High 12-20

6.3 Contracting arrangements

Local Health Boards will utilise the expertise of the All Wales Procurement team to undertake a tender process on behalf of all three Health Boards. Depending on their technical advice the intention would be to undertake one procurement exercise for both insourcing and outsourcing recognising that these will be awarded to separate providers. In

addition, given the scale of the volumes required, the awards may include a multitude of providers to enable flexibility of patients and to promote patient choice.

The procurement timetable will need to include a full 30 days tender advertisement given the volumes and financial value involved. The procurement process will be undertaken by the All Wales team, with the detailed specification around clinical requirements, patient pathways, governance and processes etc led by a small working group comprised of all three Health Boards and involving expertise from all relevant disciplines. This will confirm the contractual arrangements around the awarding and management of the contracts. Tenders will then be evaluated by a team drawn from all Health Boards and awarded to the successful providers.

Contracts are awarded on a cost per case basis with the expectation that the full number of procedures will be delivered by the Provider. The award of any new contracts would be underpinned by an activity plan, with clear timescales for delivery, and any appropriate scaling back of insourced activity in line with the implementation plan for the sustainable regional solution.

6.4 Clinical Governance

The Clinical Governance arrangements will be mainly managed through the contracting arrangements. The contracting will include all the clinical staffing required to undertake outpatient assessments and inpatient procedures.

Specific areas of attention for clinical governance are:

Surgeon Competence

Insourced and Outsourcing contracts need to ensure that surgeons are of an appropriate competence and quality and have comparable complication rates to consultant surgeons on the National Ophthalmic Database. Processes for checking and ageing the competence of surgeons will be in place as part of the contracting and implementation of the business case.

Follow Ups and Complications

As part of core Health Board delivery of this type of surgery, any complications are the responsibility of the operating surgeon and follow up arrangements of this nature will be included in the insourcing contracting details. If follow ups cannot be rectified by the operating surgeon (or insourcing company) then they will be invoiced for the follow up treatments required.

Clinical Processes

Insourcing staff will be expected to follow the clinical processes of the site on which they are working including incident reporting. There may be occasions where clinical policies vary

across sites and the implementation of the business case will aim to address areas of significant variation by aligning guidance across sites as far as practicable, although in the short term this will not be possible in every case.

6.5 Waiting List Modelling

The Regional Ophthalmology Programme have been working with the Delivery Unit to develop a mathematical model to inform the planning of the additional cataracts capacity. Data to feed into the model has been sourced from health boards and operational colleagues have been refining and testing the model with the Delivery unit and have finalised the model for this purpose. The model ensures that there is balance between the outpatient and inpatient capacity based on the following assumptions.

- There is a waiting list of 19,000 patients (forecast position end of March 2023)
- 80% of patients referred as suitable for surgery
- 18% of patients are not suitable for surgery
- 2% of patients DNA
- Patients are reviewed by primary care post-surgery within 3 weeks
- None of the outpatient appointments undertaken on patients expire
- 20% of patients require surgery on a second eye
- One outpatient appointment will cover both eyes
- Second eye surgery is undertaken at least 10 weeks after first eye surgery

In section 4.5 the case mix discusses that 20% of the patients who move through the outpatient stage will not require surgery. However, 20% of the patients who require surgery require it for both eyes and so the demand for surgery/inpatient stage is then in line with the demand for the outpatient stage.

7. Options

The business case considers six options to achieve the following key aims:-

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum
- Deliver value for money

The options are:

- **Option 1: Do nothing**
    - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
    - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
    - Outsourcing (2,000)
    - Total additional 8,668 (plus 5,940 core is 14,608 total)
    - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
    - South Hub: in UHW (1,500 Weekend Insourcing)
    - Outsourcing (2,000)
    - Total additional 7700 (plus 6,120 core is 13,820 total)
    - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
    - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)

  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Theatres Available

- University Hospital of Wales: The Vanguard Unit is a twin theatre set up based in the car park in UHW. This will be used for the weekday and the weekend sessions.
- Princess of Wales Hospital: In Bridgend Eye theatres there is a twin theatre set up. This would be used for the weekend and evening sessions. The 1 NHS session in POWH would be run as a single theatre set up.
- Nevill Hall Hospital: One theatre is available in the main theatres block in NHH. The weekday sessions and the weekend sessions will be run from this theatre.

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m

Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*
***Costing for this option include 5% increase on all pay costs*

Waiting List Changes
The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal
The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.
Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing

Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option
The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

8. Option 1 - Do Nothing

This option involves providing no further funding and resources to cataract surgery across the region at this stage. Each health board will continue with only their planned core capacity and there will be no sharing of patient treatment lists (PTL's). The Vanguard rental will end on 30th June 2023 following the short term regional extension arrangement.

8.1.1 Core capacity

The annual core capacity of each Health Board is shown below

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	**Regional Total Core**	Regional Demand	Difference
Annual capacity	2400	1920	180	1440	5940	9,960	-4,020

8.1.2 Option Assumptions

This option is based on the following assumptions

- Use of Vanguard ends by 30th June 2023
- Capacity in CTM and AB for 23/24 remains at 2022 activity levels
- CAV have 7.5 sessions in main theatres to undertake core cataracts activity, reverting to pre-Vanguard capacity.

8.2 Option 1 – Option Appraisal

8.2.1 Option 1 Benefits

The high level benefits identified above (section 6.1) are foregone in this option. The benefits identified for this option are listed below

- No changes to the way that services are currently run
- No management capacity required to organise additional services
- No direct costs

8.2.2 Option 1 Risks

The specific risks associated with option 1 are:

- Demand continues to outstrip supply (high risk as business case is mitigation action)
- Backlogs will continue to grow (high risk as business case is mitigation action)
- Planned Care target will be missed (high risk as business case is mitigation action)
- Increased proportions of higher complexity patients as waiting times are increased (medium risk as business case is mitigation action)
- Loss of experienced and well trained staff at the Vanguard Unit (medium risk as business case is mitigation action)

- Reduction in training capacity across the region (medium risk as business case is mitigation action)
- Increases the backlog by 4,046 patients (high risk as business case is mitigation action)

8.2.3 Option 1 Patient Considerations

Through this option all patients will continue to be treated by their home health board. They will be treated within their own health board boundary but are likely to have to wait more than 1 year for assessment and treatment. As patient waits lengthen, the risk increases of patients coming to harm while waiting.

8.2.4 Option 1 costs

There are no direct costs associated with this option

Indirect costs include:

- Increased reliance on WLI's / agency staff
- Increased patient complaints
- Multiple patient referrals as primary care escalate patients due to deterioration
- Additional waiting list validation required
- Increased costs of complications as patient complexity increases

8.2.5 Option 1 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 5,940 cataracts procedures per year (114 per week, 495 per month)
- 5,940 outpatients per year (114 per week, 495 per month)
- 9,960 referrals per year (192 per week, 830 per month)

After 52 weeks of the total capacity of 5,940 per year the waiting list is increased from 19,000 across the region to 23,046

9. Option 2 – Maximising the use of NHH and POWH

Option 2 is an NHS recruitment, insourcing and outsourcing option involving a two-hub model of NHH in the North and POWH in the South. At both sites the weekday and weekend capacity is utilised, along with outsourcing in the following volumes over a 12 month period:

- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 3,558 (2,058 weekdays plus 1,500 weekends) outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 8,668 additional**
- **Total capacity 14,608 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs: £12.4m
- Cost per patient: £1,436

9.1. Option 2 - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

9.1.1 Clinical Service Model North Hub (NHH)

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used for 7 sessions in the week by NHS staff and both days on the weekend by an insourcing team.

Delivery Plan for NHH Sessions

Delivery Plan Outpatients

	Month 1	Month 2	Month 3	Month 4	Months 5-11	Month 12		Total

Patients per list	6	7	8	8	8	8		
Sessions per week	5	5	5	5	5	5		
weeks	4	4	4	4	25	1		42
total patients	120	140	160	160	1000	40		1620

Delivery Plan Inpatients

	Month 1	Month 2	Month 3	Month 4	Months 5-11	Month 12		Total
Patients per list	4	5	6	6	6	6		
Sessions per week	4	5	5	7	7	5		
weeks	1	4	4	4	28	1		42
total patients	16	100	120	168	1176	30		1610

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

9.1.2 Clinical Service Model South Hub (POWH)

Through Option 2 the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital site on weekdays and weekends via an insourcing company with one weekday session per week provided by NHS staff.

Delivery Plan

weekdays
Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
1 day session	Insourcing	8	1	8	38	304
Evenings	Insourcing	8	6	48	38	1824
Total				**56**		**2128**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
1 day session	NHS Staff	7	1	7	42	294

Evenings	Insourcing	7	6	42	42	1764
Total				**49**		**2058**

weekends

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	8	4	32	32	1024
Sunday	Insourcing	8	2	16	31	496
Total				**48**		**1520**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	7	4	28	36	1008
Sunday	Insourcing	7	2	14	36	504
Total				**42**		**1512**

9.1.3 Outsourcing Arrangements

Option 2 Outsourcing @ 2,000 cases per year

9.1.4 Booking and scheduling For Option 2 (Maximising the use of NHH and POWH):

In one year the team will need to book 6,700 outpatient appointments across both the North and South Hubs and schedule 6,700 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 15,400 patient bookings per year. A Regional booking and scheduling team are required for these patient volumes, along with a POWH Eye Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

9.1.5 Option 2 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed

- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

9.2 Option 2 – Option Appraisal

9.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Regional	**Total**	Average Demand	Difference
AB	2400	36%	3121	**5521**	4080	1441
CAV	1440	15%	1300	**2740**	1800	940
CTM	2100	49%	4247	**6347**	4080	2267
Regional Total	5940		8668	**14608**	9960	4648

9.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
Capacity	2400	3121	5521

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
Capacity	1920	180	4247	6347

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
Capacity	1440	1300	2740

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	5521	2740	6347	14608

9.2.3 Option 2 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Recruiting additional NHS workforce for NHH
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the POWH Eye Unit 7 days per week
- Enables a greater reduction in the backlog
- No additional capital required
- Reduces the backlog by 4,648 patients waiting

9.2.4 Option 2 Risks

The specific risks associated with option 2 are:

- High volumes of surgery through POWH Eye Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

9.2.5 Option 2 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

9.2.6 Option 2 costs

Option 2: POWH and NHH

Revenue Costs **2023/24**

Provider Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Aneurin Bevan	Weekday Capacity	1,610	£184,342	1,610	£1,659,078	£1,843,420
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
Cwm Taf	Insource Weekday	2,058		2,058	£2,671,284	£2,671,284
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£934,145
TOTAL		**8,668**	**£758,374**	**8,668**	**£10,754,006**	**£12,446,525**

Indicative Cost per Patient £1,436

9.2.7 Option 2 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 14,608 cataracts procedures per year (281 per week, 1217 per month)
- 14,608 outpatients per year (282 per week, 1224 per month)

After 52 weeks of the total capacity of 14,608 per year the waiting list is reduced from 19,000 across the region to 14,352

Further details on Option 2 can be found in Appendix Four

10. Option 3a –Vanguard and NHH

Option 3a is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 12 month period:

- South Hub: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 6,120
- **Plus 7,700 additional**
- **Total capacity 13,820 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24: £12.9m
- Cost per patient: £1,672

10.1 Option 3a - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

10.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 31st March 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

10.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used on both days on the weekend by an insourcing team.

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

10.1.3 Clinical Service Model South Hub

Through this option The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The Vanguard Unit would be used 7 days per week.

On weekdays the twin theatre unit will be staff by NHS staff in a continuation of current practice. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Weekdays

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekdays	NHS Staff	8	7.5	60	46	2760

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients (less CNA's)
Weekdays	NHS Staff	5	12.5	62.5	48	2700

Weekends

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	8	6	48	32	1536

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	7	6	42	36	1500

10.1.4 Outsourcing Arrangements

Outsourcing @ 2,000 cases per year

10.1.5 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 5,900 outpatient appointments across both the North and South Hubs and schedule 5,900 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 13,800 patient bookings per year. A Regional booking and scheduling tam are required for these patient volumes, along with a Vanguard Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

10.1.6 Option 3a Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

10.2 Option 3a – Option Appraisal

10.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	2772	**5172**	4080	1092
CAV	1620	15%	1155	**2775**	1800	975
CTM	2100	49%	3773	**5873**	4080	1793
Regional Total	6120		7700	13820	9960	3860

10.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
Capacity	2400	2772	5172

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
Capacity	1920	180	3773	5873

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
Capacity	1620	1155	2775

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	5172	2775	5873	13820

10.2.3 Option 3a Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[5]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[6]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 3,814 patients waiting

10.2.4 Option 3a Risks

The specific risks associated with option 3a are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

10.2.5 Option 3a Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

[5] Insourcing and Outsourcing will take the less complex patients

[6] Vanguard offers the opportunity for more training lists that are shorter in size

10.2.6 Option 3a Costs

Option 3a: Use of NHH weekends and Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource Weekend	1,500		1,500	£2,831,000	£2,831,000
Cardiff and Vale	NHS Weekday	2,700		2,700	£1,944,000	£1,944,000
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£899,438
TOTAL		**7,700**	**£574,032**	**7,700**	**£8,998,144**	**£10,471,614**

Revenue: Indicative Cost per Patient £1,360

Capital Costs

Temporary Theatre @UHW	**£2,400,000**

Indicative Cost per Patient £1,672

10.2.7 Option 3a Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 13,820 cataracts procedures per year (266 per week, 1152 per month)
- 13,820 outpatients per year (266 per week, 1152 per month)

After 52 weeks of the total capacity of 13,820 per year the waiting list is reduced from 19,000 across the region to 15,186

Further details on Option 3a can be found in Appendix Five

11. Option 3b –Vanguard and maximising NHH

This is the preferred option

As the preferred option this option has been developed in more detail than the other options.

Realistic assumptions have been made about the feasibility of delivery and the model has been designed to be distributed over 14 months split across 23/24 and 24/25.

Option 3b

As option 3a but with the addition of 7 weekday NHS sessions in NHH

Option 3b is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 14 month period:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

11.1 Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

11.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 30th June 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

11.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits using an additional theatre in NHH on weekdays, staffed by NHS staff and on both days on the weekend by an insourcing team

Delivery Plan for NHH Sessions Weekdays NHS Staff

Delivery Plan Outpatients

Delivery from months 3-14 of the plan

	Month 3	Month 4	Month 5	Month 6	Months 7-13	Month 14		Total
Patients per list	6	7	8	8	8	8		
Sessions per week	5	5	5	5	5	5		
weeks	4	4	4	4	25	1		42
total patients	120	140	160	160	1000	40		1620

Delivery Plan Inpatients

Delivery from months 3-14 of the plan

	Month 3	Month 4	Month 5	Month 6	Months 7-13	Month 14		Total
Patients per list	4	5	6	6	6	6		
Sessions per week	4	5	5	7	7	5		
weeks	1	4	4	4	28	1		42
total patients	16	100	120	168	1176	30		1610

Delivery Plan for Insourcing Sessions in NHH Weekends

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

11.1.3 Clinical Service Model South Hub

Through this option The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The Vanguard Unit would be used 7 days per week.

On weekdays the twin theatre unit will be staff by NHS staff in a continuation of current practice. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Weekdays

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekdays	NHS Staff	8	7.5	60	46	2760

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients (less CNA's)
Weekdays	NHS Staff	5	12.5	62.5	48	2700

Weekends

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients

Weekends	Insourcing	8	6	48	32	1536

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	7	6	42	36	1500

11.1.4 Outsourcing Arrangements

Outsourcing @ 2,000 cases per year

11.1.5 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 7,310 outpatient appointments across both the North and South Hubs and schedule 7,310 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 16,620 patient bookings per year. A Regional booking and scheduling team are required for these patient volumes, along with a Vanguard Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

11.1.6 Delivery Plan

The delivery will run for 14 months and individual streams of activity will start and finish as follows:

- Month 1 to month 12
  - Vanguard Weekdays
- Month 2 to month 12
  - Vanguard Insourcing
- Month 2 to month 13
  - NHH Insourcing
  - Outsourcing
- Month 3 to month 14
  - NHH Weekdays

11.1.7 Option 3b Assumptions

- NHH Workforce can be fully recruited
- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement

- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- CTM continue with their current levels of outsourcing (15 per month)
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

11.2 Option 3b – Option Appraisal

11.2.1 Additional Regional Capacity

Capacity	Core 14 months	Additional Capacity %	Additional Regional	**Total**	14 months demand	Difference
AB	2800	36%	3352	**6152**	4760	1392
CAV	1890	15%	1397	**3287**	2100	1187
CTM	2440	49%	4562	**7002**	4760	2242
Regional Total	7140		9310	**16450**	11620	4830

11.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages.

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 39%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179

1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

11.2.3 Option 3b Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[7]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[8]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Greater proportion of cataracts surgery undertaken by NHS staff
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 4,832 patients waiting

11.2.4 Option 3b Risks

The specific risks associated with this option are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing

[7] Insourcing and Outsourcing will take the less complex patients

[8] Vanguard offers the opportunity for more training lists that are shorter in size

capacity (low risk following mitigation actions)

11.2.5 Option 3b Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

11.2.6 Option 3b Costs

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient
Provider			Activity	Cost		Cost per case excl capital and pre go live
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151
External	Outsource		1,334	1,861,757	£1,861,757	£1,396
Regional Operational Team		£50,642		£871,566	£922,208	
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**	

2023/24

Host Health Board	Delivery	Patients	Patients
		Activity	Cost
Cardiff and Vale	Insource Weekend	410	£651,344
Cardiff and Vale	Weekday	675	£547,907
Aneurin Bevan	Insource Weekend	500	£664,206
Aneurin Bevan	Weekday Capacity	670	£771,366
External	Outsource	666	£929,483
Regional Operational Team			£443,449
TOTAL		**2,921**	**£4,007,754**

2024/25

TOTAL ACTIVITY	TOTAL COST
Patients	Patients
Activity	Cost
1,500	£2,382,967
2,700	£2,191,628
1,500	£2,118,401
1,610	£2,017,103
2,000	£2,791,240
	£1,365,656
9,310	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

11.2.7 Option 3b Activity Modelling

This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year

After 14 months the total capacity of 16,450 per year the waiting list is reduced from 19,000 across the region to 14,168

Further details on Option 3b can be found in Appendix Six

12. Option 4 – Weekend Insourcing and Outsourcing Only

The Insourcing and outsourcing option involves a two hub model of NHH in the North and the use of POWH in the south for outpatients and Inpatients, along with outsourcing in the following volumes over a 12 month period:

- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7.5m
- Cost per patient: £1,504

12.1 Option 4 – Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

12.1.1 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used on both days on the weekend by an insourcing team.

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50

total patients	1504	1500

12.1.2 South Hub

Through this Option the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital in Bridgend on weekends via an insourcing company

weekends

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	8	4	32	32	1024
Sunday	Insourcing	8	2	16	31	496
Total				**48**		**1520**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	7	4	28	36	1000
Sunday	Insourcing	7	2	14	36	500
Total				**42**		**1500**

12.1.3 Outsourcing Arrangements

This Option will deliver an additional 2,000 cases per year. Outsourcing arrangements and costs include patient travel.

12.1.4 Booking and scheduling for Option 4 (Weekend Insourcing and Outsourcing)

In one year the team will need to book 3,000 outpatient appointments across both the North and South Hubs and schedule 3,000 inpatient procedures in addition to facilitating 2,000 outsourced patients totalling 8,000 patient contacts per year. A Regional booking and scheduling tam are required for these patient volumes.

12.1.5 Option 4 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements

- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

12.2 Option 4 – Option Appraisal

12.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

12.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list, 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
Capacity	2400	1800	4200

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
Capacity	1920	180	2450	4550

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
Capacity	1440	750	2190

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	4200	2190	4550	10940

12.2.4 Option 4 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Reduces the backlog by 517 patients waiting

12.2.5 Option 4 Risks

The specific risks associated with this option are:

- Loss of experienced and well trained staff at the Vanguard Unit (low risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)

12.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

12.2.7 Option 4 Costs

Option 4 costs are shown here

Option 4: POW and NHH weekends without Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
External	Outsource	2,000	316,000	2,000	2,379,333	2,695,333
Regional Operational Team						£524,453
TOTAL		**5,000**	**£574,032**	**5,000**	**£6,423,644**	**£7,522,129**

Indicative Cost per Patient £1,504

Costing assumptions-

- Cost assumptions are based on locally provided figures
- Insource cost estimates are based on Framework expectation of PbR plus 10% but will depend on casemix and provider
- Outsourcing estimates are based on PbR with an element for transport but dependent on casemix and provider

12.2.8 Option 4 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 10,940 cataracts procedures per year (202 per week, 874 per month)
- 10,940 outpatients per year (202 per week, 874 per month)

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Further details on Option 4 can be found in Appendix Seven

13. Option 5 – Outsourcing

The option involves outsourcing the whole additional capacity. By using outsourcing only, the demands on the regional booking and scheduling team also reduce. It is unlikely that one supplier would be able to fulfil the whole 5,000 procedures per year and so it would be split across different providers with the following volumes over a 12 month period:

- An additional 5,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7m
- Cost per patient: £1,410

13.1 Option 5 – Clinical and Service Model

13.1.1 Outsourcing Arrangements

Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Through this option 5,000 cases are outsourced. Outsourcing arrangements and costs include patient travel.

Patients are reviewed by a non-clinical administrator for their suitability for outsourcing and then referred on to the outsourcing company for assessment and treatment. Communication with the patient about booking and scheduling and locations are conducted by the outsourcing company. Follow ups post-surgery are conducted in primary care. Hospital patient records are updated.

13.1.2 Booking and scheduling For Option 5 (Outsourcing)

In one year the team would need to facilitate 5,000 outsourced patients and ensure records are kept up to date and that these patients are suitable for the outsourcing route.

13.1.3 Option 5 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Outsourcing contracting will be done at a National level
- Outsourcing may be through a number of providers

- That outsourcing capacity will be available in the market through contracting arrangements
- Outsourcing company(ies) to carry out enough outpatient assessments to treat 5,000 patients
- Effective clinical governance arrangements

13.2 Option 5 – Option Appraisal

13.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity (outsourced)	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

13.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
Capacity	2400	1800	4200

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
Capacity	1920	180	2450	4550

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
Capacity	1440	750	2190

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	4200	2190	4550	10940

13.2.4 Option 5 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Additional capacity delivered at reduced costs from insourcing
- Reduces the backlog by 517 patients waiting

13.2.5 Option 5 Risks

The specific risks associated with option 2 are:

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)
- Increased number of patients required to travel further for treatment

13.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels.

This option is for outsourcing activity where patients who meet the criteria for this additional capacity would be directed to outsourcing for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and outsourcing capacity provision. This option also includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity does not include patient travel contributions.

13.2.7 Option 5 Costs

Option 5: Outsourcing Only

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£312,427
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£7,050,760**

Indicative Cost per Patient £1,410

13.2.8 Option 5 Activity Modelling

The assumptions used in this option are the same as in option 4, as the capacity stays the same but the mode of delivery changes.

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Further details on Option 5 can be found in Appendix Eight

14.Preferred Option

14.1 Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

14.2 Options Appraisal

The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.

Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard	Option 4 Weekends	Option 5 Outsourcing

				and Max NHH		
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

14.3 Option Costs

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs — **2023/24**

Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient
Provider			Activity	Cost		Cost per case excl capital and pre go live
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151
External	Outsource		1,334	1,861,757	£1,861,757	£1,396
Regional Operational Team		£50,642		£871,566	£922,208	
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**	

2024/25 — **TOTAL ACTIVITY** — **TOTAL COST**

Host Health Board	Delivery	Patients	Patients	Patients	Patients
		Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
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Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team			£443,449		£1,365,656
TOTAL		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

15.Summary

The business case demonstrates a clear need for additional capacity for cataracts assessment and surgery in the South East Wales Region. By working together the three health boards can provide this capacity for patients and deliver the benefits described in the case.

This business case has strong strategic links with the National Planned Care goals, the Ophthalmology GIRFT Programme report and the Royal College of Ophthalmologists External Review of Eye Care Services in Wales and contributes towards the delivery of reducing waiting times for patients.

The additional capacity addresses the significant backlog in this area and provides the headroom necessary to plan and implement longer term sustainable solution and to demonstrate the successes of regional working. This business case enables the region to maximise the existing capacity available on our hospital sites and more provide timely care to patients regardless of where they live within the region.

The table below summarises the options

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*
***Costing for this option include 5% increase on all pay costs*

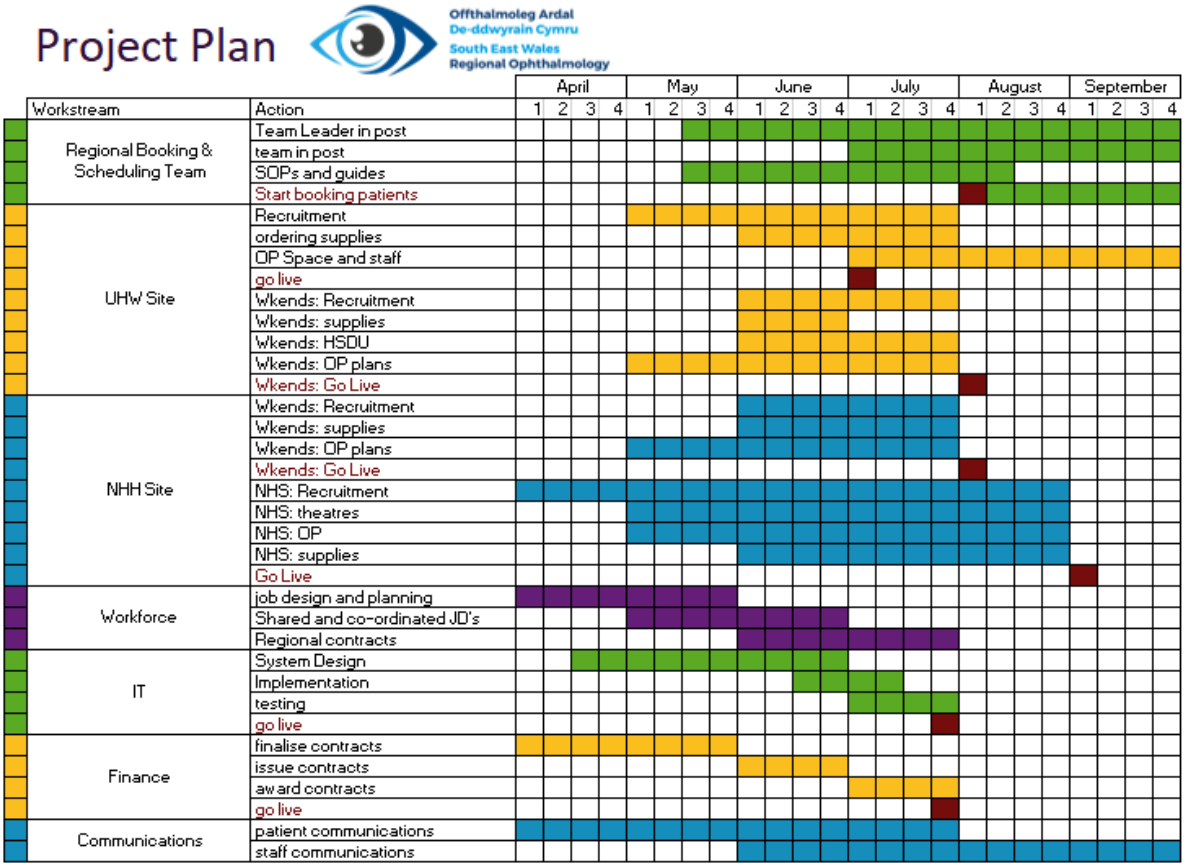
16.Interdependencies

The interdependencies identified through this work are:

- Stabilising and protecting core capacity in CAV
- Stabilising and protecting core capacity in CTM
- Stabilising and protecting core capacity in AB
- Commissioners –appropriate commissioning frameworks to be developed
- Capital funding required for Vanguard.

17.Implementation Plans

The implementation plan for the business case is shown below.



Implementation

The Implementation of this business case is a priority across Health Boards and the outline plan above is for the implementation phase. This will be an intensive phase of activity across the health boards and will require an additional project manager to work full time on this work as part of the programme. There will likely be a soft launch of the additional capacity and time will be required to embed the new models and make improvements to processes. As part of the wider Regional Programme proposals for a regional Vitreo-Retinal hub service need to be planned and implemented early in the calendar year to support the complications arising from the cataract service and so additional project support and a dedicated clinical lead is required for the programme.

18.Approvals

Milestone	Date	Decision
Completion by the working group	Wednesday 16th November	Agreement to go forward to Ophthalmology Programme Board
Ophthalmology Programme Board	12th December	Approved to go forward to next stage
Regional Portfolio Delivery Board	6th April 2023	Approved to go forward to next stage
Regional Portfolio Oversight Board	13th April 2023	Approved to go forward to next stage
Management Execs AB	13th April 2023	Approved to go forward to next stage
Investment Group CAV	18th April 2023	Approved to go forward to next stage
Management Execs (SLB) CAV	4th May 2023	Approved to go forward to next stage
Management Execs CTM	9th May 2023	Approved to go forward to next stage
Welsh Gov Submission	12th May	
Board Meeting AB	24th May 2023	
Board Meeting CAV	25th May 2023	
Board Meeting CTM	25th May 2023	

Appendix One: Financials

Option 3b - Preferred Option

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
					2023/24					2024/25	TOTAL ACTIVITY	TOTAL COST
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

Option 1 – Do nothing

Do nothing – no additional costs

Option 2 – Maximising NHH and POWH

Option 2: POWH and NHH

Revenue Costs **2023/24**

Provider Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Aneurin Bevan	Weekday Capacity	1,610	£184,342	1,610	£1,659,078	£1,843,420
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
Cwm Taf	Insource Weekday	2,058		2,058	£2,671,284	£2,671,284
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£934,145
TOTAL		**8,668**	**£758,374**	**8,668**	**£10,754,006**	**£12,446,525**

Indicative Cost per Patient £1,436

Option 3a Costs vanguard and NHH Weekends

Option 3a: Use of NHH weekends and Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource Weekend	1,500		1,500	£2,831,000	£2,831,000
Cardiff and Vale	NHS Weekday	2,700		2,700	£1,944,000	£1,944,000
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£899,438
TOTAL		**7,700**	**£574,032**	**7,700**	**£8,998,144**	**£10,471,614**

Revenue: Indicative Cost per Patient £1,360

Capital Costs

Temporary Theatre @UHW	**£2,400,000**

Indicative Cost per Patient £1,672

Option 4 - Weekend Insourcing and Outsourcing Only

Option 4: POW and NHH weekends without Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
External	Outsource	2,000	316,000	2,000	2,379,333	2,695,333
Regional Operational Team						£524,453
TOTAL		**5,000**	**£574,032**	**5,000**	**£6,423,644**	**£7,522,129**

Indicative Cost per Patient £1,504

Option 5 - Outsourcing

Option 5: Outsourcing Only

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£312,427
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£7,050,760**

Indicative Cost per Patient £1,410

Appendix Two: Options Appraisal details

The following six options were considered as part of the options appraisal.

Business Case
Options Appraisal Criteria

Offthalmoleg Ardal
De-ddwyrain Cymru
South East Wales
Regional Ophthalmology

The options developed in the business case will be assessed through separate financial and non-financial appraisals. The proposed criteria for assessing non-financial options in the business case is set out below

Domain	Weight	Principles	Business Case Aims
Quality & safety	35%	Evidences a reduction in unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level. Evidences patient safety, quality and/or compliance issues Evidences any poor benchmarking indicators across the region are being addressed.	to address current waiting list backlogs to reduce clinical risk on an equitable basis across the region
Effective use of resources	10%	Makes effective use of capacity and capability across the region Evidences a direct link to one or more operational 'targets' for HBs and/or region	to provide additional regional capacity for cataract outpatient and inpatient stages to demonstrate optimal utilisation of our assets across the region Deliver value for money
Strategic Fit	10%	Evidence of fit with national clinical strategies and professional reviews Evidences a direct link to improving population health Evidences a direct link to key national policy / frameworks / legislation	to enact a collaborative regional approach to recovery
Sustainability	15%	Evidences improved sustainable service resilience. Evidences a link to the NHS Wales decarbonization agenda	Protect the viability of the core capacity
Access	10%	To agree approaches to engagement and communications together.	Keep patient travel to a minimum
Deliverability	20%	Evidence that benefits, measures and a critical path for delivery is understood and achievable.	Be mobilised quickly Be deliverable with the resources available

Method: There are six options in the business case, each Health board will assess each option against each domain and award a score between 1-5 (5 fully meets, 1 does not meet). The scores will be combined to determine the preferred option.

Results of the Options appraisal are shown below

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Total	5.05	10.75	11.00	12.15	6.30	5.80

Appendix Three: Option 1 Details

This option involves providing no further funding and resources to cataract surgery across the region at this stage. Each health board will continue with only their planned core capacity and there will be no sharing of patient treatment lists (PTL's). The Vanguard rental will end on 31st March 2023 following the two month short term regional arrangement.

8.1.1 Core capacity

The annual core capacity of each Health Board is shown below

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	**Regional Total Core**	Regional Demand	Difference
2023/24	2400	1920	180	1440	5940	9,960	-4,020

8.1.2 Option Assumptions

This option is based on the following assumptions

- Use of Vanguard ends by March 31st 2023
- Capacity in CTM and AB for 23/24 remains at 2022 activity levels
- CAV have 7.5 sessions in main theatres to undertake core cataracts activity, reverting to pre-Vanguard capacity.

8.2 Option 1 – Option Appraisal

8.2.1 Option 1 Benefits

The high level benefits identified above (section 6.1) are foregone in this option. The benefits identified for this option are listed below

- No changes to the way that services are currently run
- No management capacity required to organise additional services
- No direct costs

8.2.2 Option 1 Risks

The specific risks associated with option 1 are:

- Demand continues to outstrip supply (high risk as business case is mitigation action)
- Backlogs will continue to grow (high risk as business case is mitigation action)
- Planned Care target will be missed (high risk as business case is mitigation action)
- Increased proportions of higher complexity patients as waiting times are increased (medium risk as business case is mitigation action)

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk as business case is mitigation action)
- Reduction in training capacity across the region (medium risk as business case is mitigation action)
- Increases the backlog by 4,046 patients (high risk as business case is mitigation action)

8.2.3 Option 1 Patient Considerations

Through this option all patients will continue to be treated by their home health board. They will be treated within their own health board boundary but are likely to have to wait more than 1 year for assessment and treatment. As patient waits lengthen, the risk increases of patients coming to harm while waiting.

8.2.4 Option 1 costs

There are no direct costs associated with this option

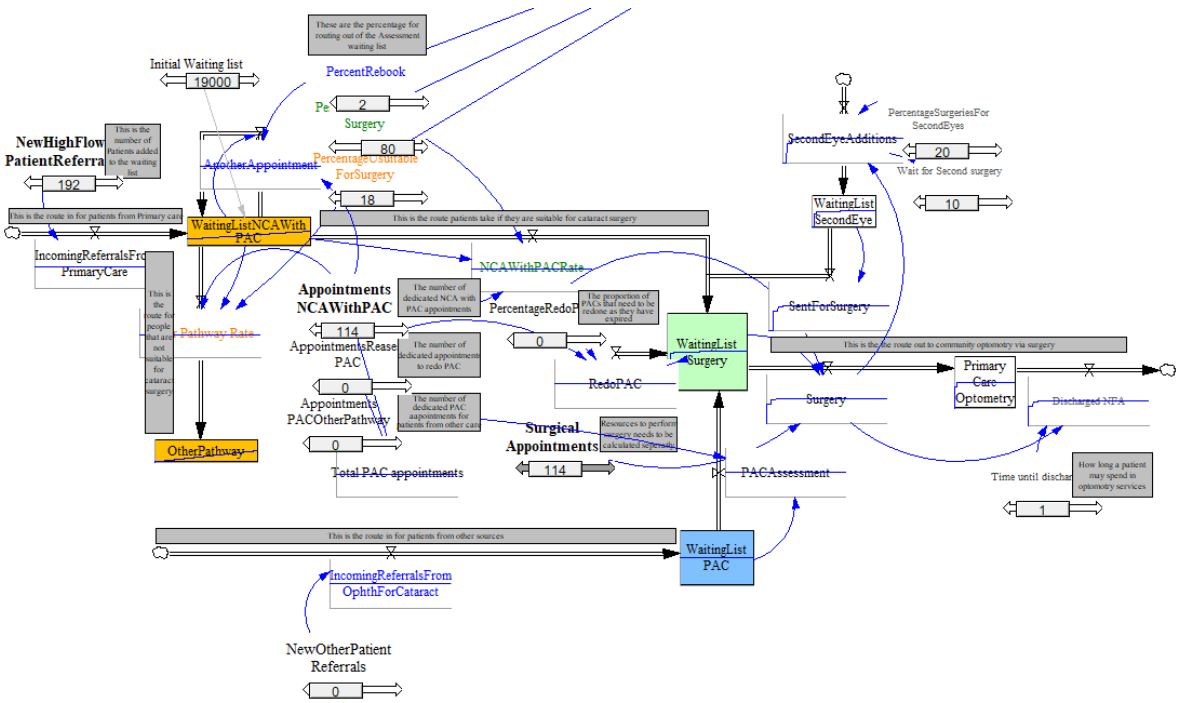
Indirect costs include:

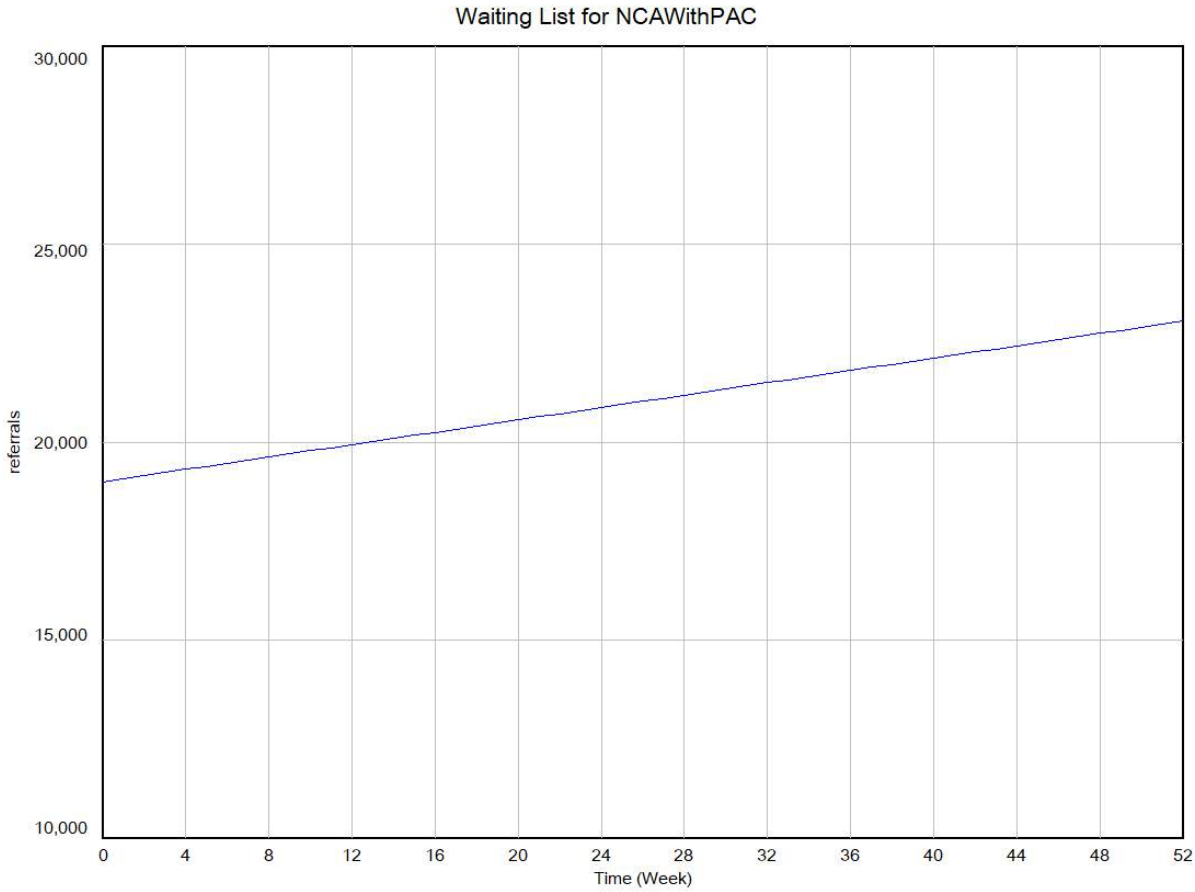
- Increased reliance on WLI's / agency staff
- Increased patient complaints
- Multiple patient referrals as primary care escalate patients due to deterioration
- Additional waiting list validation required
- Increased costs of complications as patient complexity increases

8.2.5 Option 1 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 5,940 cataracts procedures per year (114 per week, 495 per month)
- 5,940 outpatients per year (114 per week, 495 per month)
- 9,960 referrals per year (192 per week, 830 per month)





After 52 weeks of the total capacity of 5,940 per year the waiting list is increased from 19,000 across the region to 23,046

Appendix Four: Option 2 Details

Option 2 is an NHS recruitment, insourcing and outsourcing option involving a two-hub model of NHH in the North and POWH in the South. At both sites the weekday and weekend capacity is utilised, along with outsourcing in the following volumes over a 12 month period:

- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 3,558 (2,058 weekdays plus 1,500 weekends) outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 8,668 additional**
- **Total capacity 14,608 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24: £12.4m
- Cost per patient: £1,436

9.1. Option 2 - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

9.1.1 Clinical Service Model North Hub (NHH)

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits.

Weekdays: Outpatients Stage (NHS Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 135 outpatient appointments per month (38 per week, 1,620 per year) the sessions will be a ‘one stop shop’ model, held on weekdays in the OP dept in NHH.

4 consulting rooms will be required plus a waiting area. This weekday activity will be staffed through recruitment of NHS staff for all of the clinical and not clinical staff required.

Weekends: Outpatient Stage (Insourcing Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a 'one stop shop' model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area. This will be staffed thought an insourcing company

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Outpatients Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays; Inpatient Stage (NHS Staff)

Patients attending the weekday regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekday arrangements in NHH with NHS staff.

In order to undertake 38 procedures per week (135 per month, 1,610 per year) the procedures will be undertaken in Main Theatres at NHH on weekdays, Mondays and Wednesday to Friday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity.

Weekends: Inpatient Stage (Insourcing Staff)

Patients attending the weekend regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekend arrangements in NHH with insourcing staff.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH on Saturdays and Sundays.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity.

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Non-Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
Cleaning / Waste / Facilities - £47,883

HSDU costs (Including transport) - £30,000 Purchase of additional surgical trays and equipment - £38,284 Stellaris Handpieces- £87,500 Pharmacy costs, Lens and consumables - £224,310 Additional lens costs £7,716

9.1.2 Clinical Service Model South Hub (POWH)

Through Option 2 the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital site on weekdays and weekends via an insourcing company with one weekday session per week provided by NHS staff.

Weekdays: Outpatient Stage

During Weekdays the outpatient stage will be undertaken through insourcing with all clinical staff provided by the insourcing company. Outpatient assessments will be carried out during evenings on the POWH site. Two pre assessment rooms are available.

Weekends: Outpatient Stage

The POWH site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

Staff Recruitment

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

Weekends
• 0.5 WTE B2 Receptionist • 0.5 WTE B3 Booking • 0.5 WTE B6 Governance Nurse

Non- staffing costs

- Cleaning for evenings and weekends

Outpatient Clinical Model

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays: Inpatient Stage (Insourcing, plus 1 NHS staffed session)

Patients accessing the additional capacity for weekday insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub weekday arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a morning. Weekday capacity in POWH will be achieved through 1 weekday 'in hours' session to be staffed by NHS staff and 3 evenings per week to be staffing through insourcing.

By running the two theatres on three evenings per week on weekdays, 42 patients can be seen in the evenings (total 6 sessions) plus the additional day session with 7 patients on a list totalling 49 patients per week on evenings and the 1 day session.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Weekends: Inpatient Stage (Insourcing)

Patients accessing the additional capacity for weekend insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub weekend arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen

in a morning. By running the two theatres on Saturdays all day and Sunday mornings, 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Staff Recruitment

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

Weekends
• 0.6 WTE Receptionist Band 2 £18,936 • 0.6 WTE Health Records Clinical Notes Band 2 £18,936 • 0.6WTE Governance Nurse band 6 £35,246

Non Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
• Cleaning / Waste / Facilities - £47,883 • HSDU costs (Including transport) - £30,000 • Purchase of 45 additional surgical trays and handpieces - £239,682 • Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

9.1.3 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through

the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Outsourcing arrangements and costs include patient travel.

- Option 2 Outsourcing @ 2,000 cases per year

9.1.4 Booking and scheduling For Option 2 (Maximising the use of NHH and POWH):
In one year the team will need to book 6,700 outpatient appointments across both the North and South Hubs and schedule 6,700 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 15,400 patient bookings per year

A team of 16 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A POWH Eye Unit Manager and NHH Eye Unit Manager is also required to manage the unit on evenings and weekends as much of the activity is happening outside of usually office hours and to ensure capacity levels are maximised.

Staff Required:

- 8 WTE Patient Schedulers Band 3
- 8 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE POWH Eye Unit Manager Band 7
- 1 WTE NHH Unit Manager Band 7

Non Staff Costs

- Facilities costs for 22 members of staff, IT costs and office space have been estimated at £90,000

9.1.5 Option 2 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through

- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

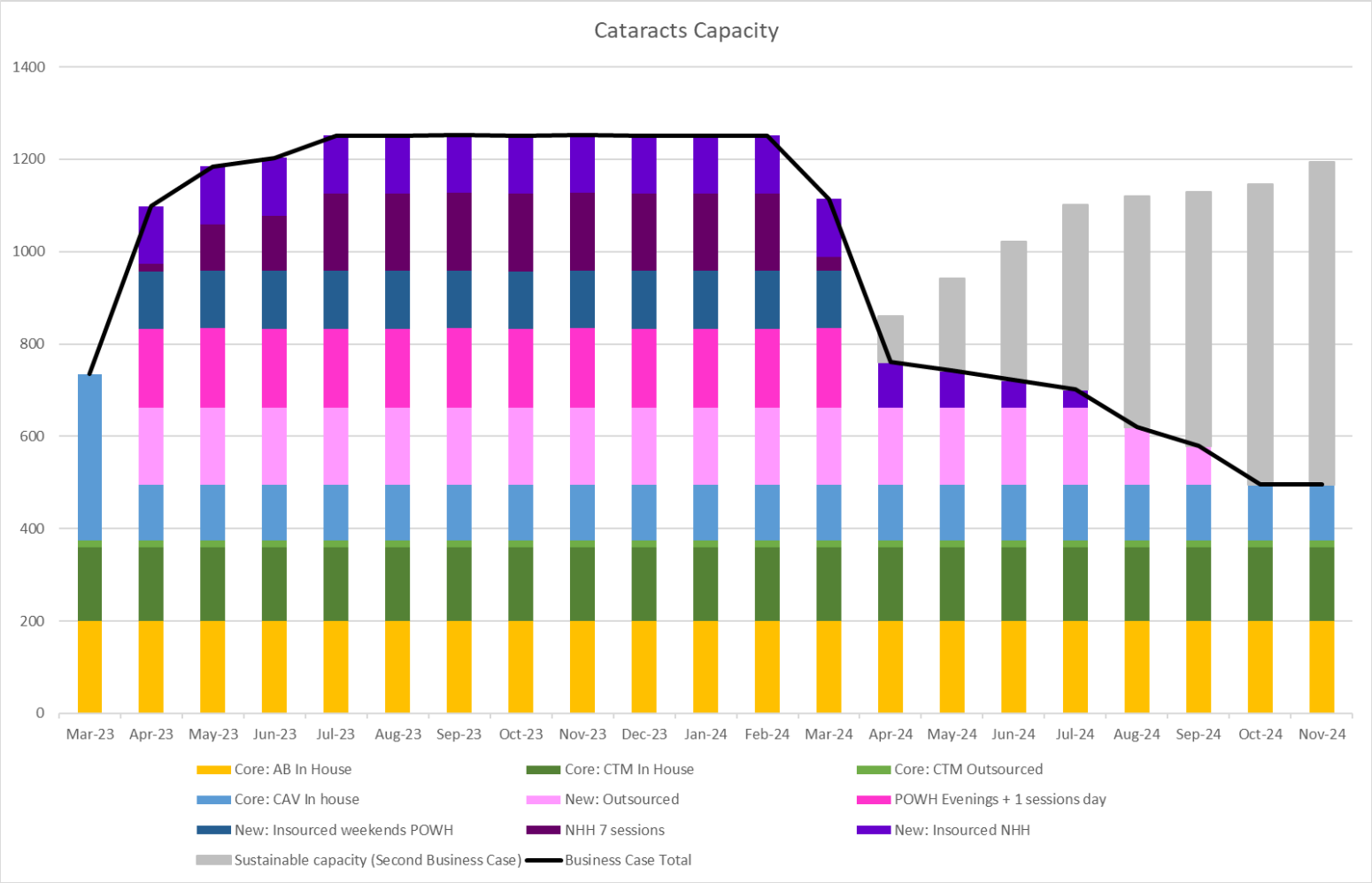
9.2 Option 2 – Option Appraisal

9.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Regional	**Total**	Average Demand	Difference
AB	2400	36%	3121	**5521**	4080	1441
CAV	1440	15%	1300	**2740**	1800	940
CTM	2100	49%	4247	**6347**	4080	2267
Regional Total	5940		8668	**14608**	9960	4648

9.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	3558	3110	**14608**
2024/25	1200	960	90	720	875	0	280	**4125**

9.2.3 Regional Delivery by Site

This chart indicates the volumes that will be delivered on each site, for outpatients and for day case/inpatients

For Outpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	Business Case Total
23/24	2400	1920	180	1440	2000	3628	3120	14688
24/25	1200	960	90	720	875	0	280	4125

For Inpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	Business Case Total
23/24	2400	1920	180	1440	2000	3558	3110	14608
24/25	1200	960	90	720	875	0	280	4125

9.2.4 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
2023/24	2400	3121	5521
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
2023/24	1920	180	4247	6347
2024/25	960	90	566	1616

CAV Patients (estimated)

	Core: CAV In house	CAV 15%	CAV Total from this business case
2023/24	1440	1300	2740
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	5521	2740	6347	14608
2024/25	1616	893	1616	4125

9.2.5 Option 2 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Recruiting additional NHS workforce for NHH
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the POWH Eye Unit 7 days per week
- Enables a greater reduction in the backlog
- No additional capital required
- Reduces the backlog by 4,648 patients waiting

9.2.6 Option 2 Risks

The specific risks associated with option 2 are:

- High volumes of surgery through POWH Eye Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

9.2.7 Option 2 Patient Considerations

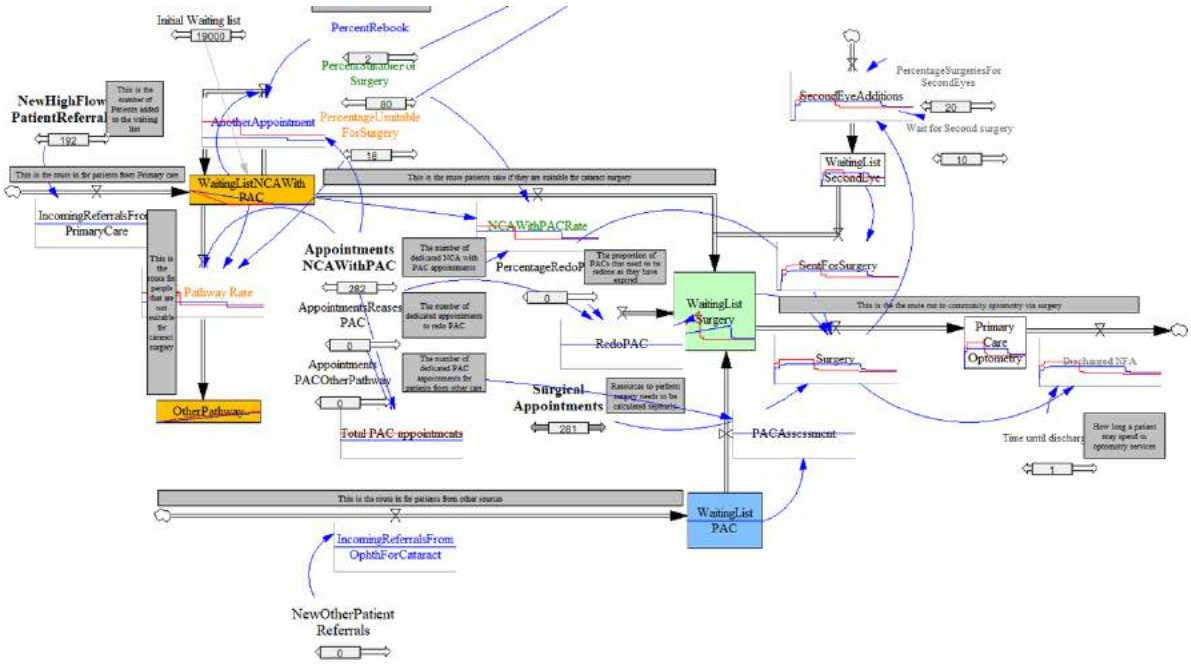
Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

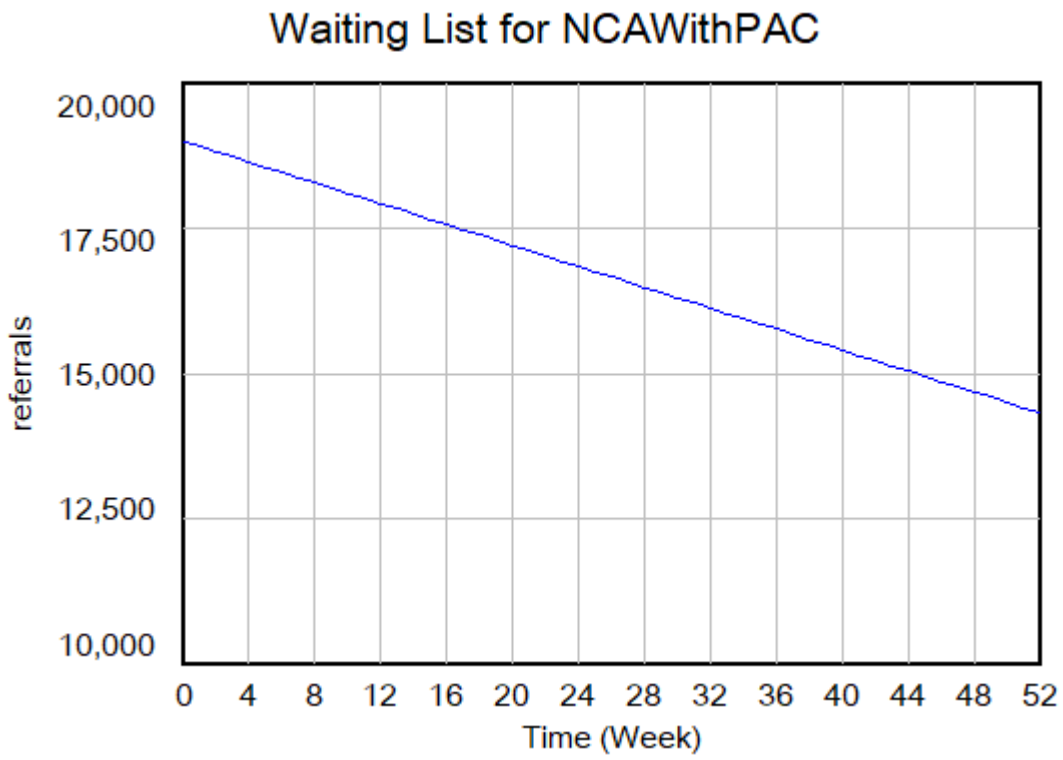
This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

9.2.9 Option 2 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 14,608 cataracts procedures per year (281 per week, 1217 per month)
- 14,608 outpatients per year (282 per week, 1224 per month)





After 52 weeks of the total capacity of 14,608 per year the waiting list is reduced from 19,000 across the region to 14,352

Appendix Five: Option 3a Details

Option 3a –Vanguard and NHH

Option 3a is an insourcing and outsourcing option involving a two-hub model of NHH in the North and a combination of POWH for outpatients and Vanguard for Inpatients in the South, along with outsourcing in the following volumes over a 12 month period:

- South Hub: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 6,120
- **Plus 7,700 additional**
- **Total capacity 13,820 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24:
- Cost per patient:

10.1 Option 3a - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

10.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 31st March 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

10.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny.

Outpatient Stage

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a 'one stop shop' model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area.

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies

- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage

Patients accessing the additional capacity for insourcing in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub arrangements in NHH.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH every Saturday and Sunday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of additional surgical trays and equipment - £38,284
- Stellaris Handpieces- £87,500
- Pharmacy costs, Lens and consumables - £224,310
- Additional lens costs £7,716.

10.1.3 Clinical Service Model South Hub Weekends (Option 1 UHW)

Through Option 1 The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from University Hospital of Wales on weekends via an insourcing company

Outpatients Stage (Weekend Insourcing in UHW)

The UHW site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

- 0.5 WTE B2 Receptionist
- 0.5 WTE B3 Booking
- 0.5 WTE B6 Governance Nurse

Non- staffing costs are

- Cleaning

Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage (Weekend Insourcing in Vanguard Unit UHW)

Patients accessing the additional capacity for insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their Outpatient assessment through the South hub insourcing arrangements in UHW.

In the Vanguard theatres the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a

morning. By running the two theatres for AM and PM on Saturdays and AM on Sundays 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.33WTE Receptionist Band 2 £TBC
- 0.33WTE Health Records Clinical Notes Band 2 £TBC
- 0.33WTE Governance Nurse band 6 £TBC
- 1 wte Manager 8b (included in section 8.1.5)

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities
- HSDU costs - £TBC
- Purchase of 45 additional surgical trays and handpieces - £239,682
- Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

10.1.4 Additional Vanguard Capacity for the Region

This option includes the additional Vanguard capacity for the region. The Vanguard Unit surgical capacity and the associated outpatient capacity required to run the service would continue to operate as it has since January 2022, retaining the same staff, maintaining the same list size, training opportunities and job plans as are currently in place and operational Monday to Friday for 20 sessions per week across the twin theatre arrangement. Through this option this existing service model would be retained until March 2024.

7.5 sessions out of 20 per week (37.5%) of the capacity would be for Cardiff and Vale core capacity funded by Cardiff and Vale and the other 12.5 sesions ourt of 20 (62.5%) would be available to the regional patients and funded by this regional business case.

As it is currently set up, the Vanguard Unit treats more complex patients that the outsourcing and insourcing capacity can. The unit will continue to treat the same complexity

of patient and clinical criteria will need to be developed to determine the referral criteria for the regional proportion of the Unit.

Under this model, patients treated in the Vanguard unit will have their outpatient assessment on the UHW site on a weekday and this will continue to run as it currently is with the Cardiff and Vale staff and estates.

10.1.5 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Outsourcing arrangements and costs include patient travel.

- Outsourcing @ 2,000 cases per year

10.1.6 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 5,900 outpatient appointments across both the North and South Hubs and schedule 5,900 inpatient procedures and facilitate 2,000 outsourced patients.

A team of 14 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A Vanguard Unit Manager and NHH Eye Unit Manager are also required to manage the unit and to ensure capacity levels are maximised.

Staff Required:

- 7 WTE Patient Schedulers Band 3
- 7 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE Vanguard Unit Manager Band 8b
- 1 WTE NHH Eye Unit Manager Band 7

Non Staff Costs

- Facilities costs for 20 members of staff, IT costs and office space have been estimated at £90,000

10.1.7 Option 3a Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

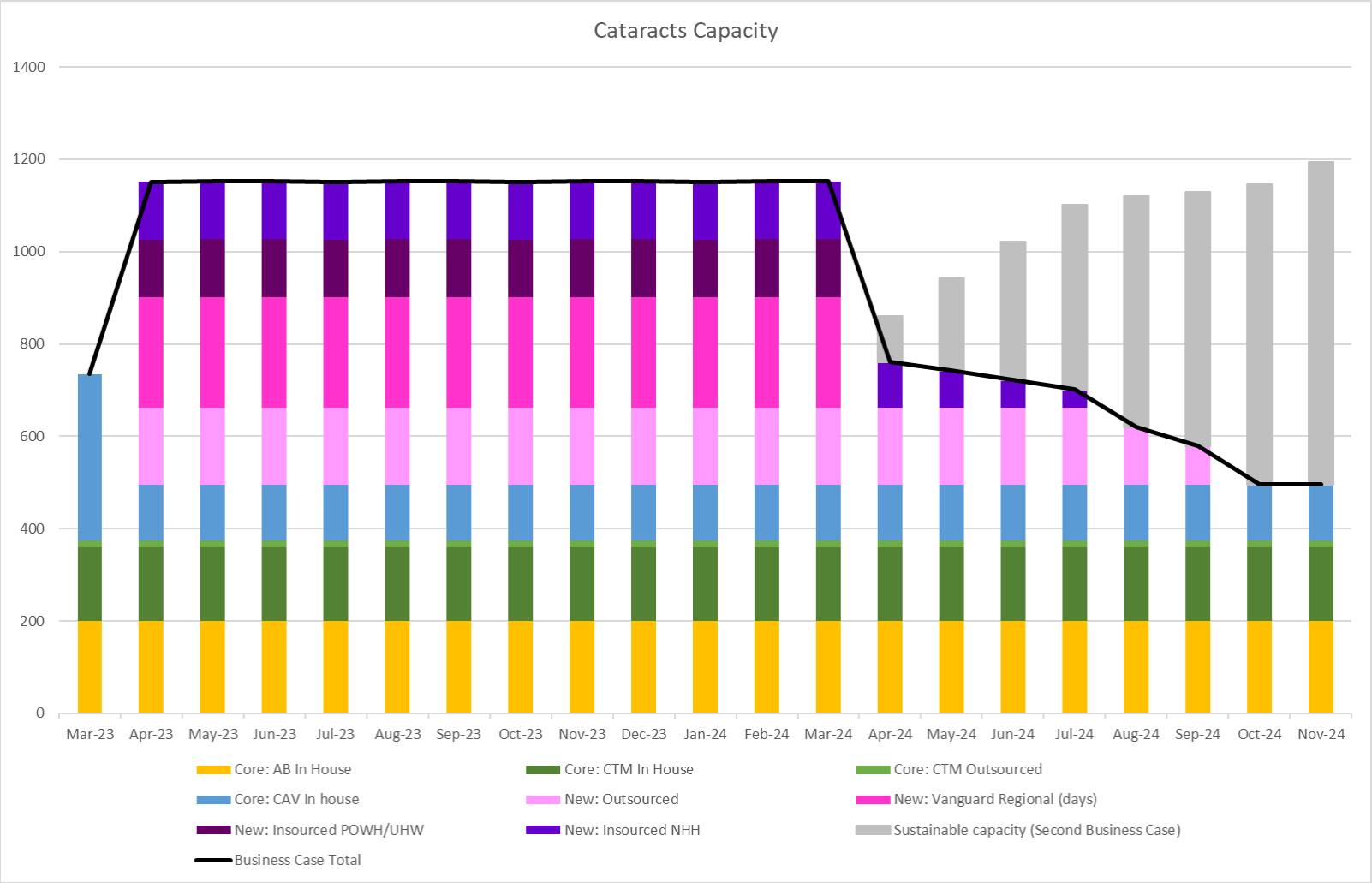
10.2 Option 3a – Option Appraisal

10.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Vanguard	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1037	1800	**5237**	4080	1157
CAV	1440	15%	432	750	**2622**	1800	822
CTM	2100	49%	1411	2450	**5961**	4080	1881
Regional Total	5940		2880	5000	**13820**	9960	3860

10.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)	New: Insourced POWH/UHW	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	2880	1500	1500	**13820**
2024/25	1200	960	90	720	875	0	0	280	**4125**

10.2.3 Regional Delivery by Site

This chart indicates the volumes that will be delivered on each site, for outpatients and for day case/inpatients

For Outpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)	New: Insourced POWH	New: Insourced NHH	Business Case Total
23/24	2400	1920	180	1440	2000	2880	1500	1500	13820
24/25	1200	960	90	720	875	0	0	280	4125

For Inpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)CAV Surgery	New: Insourced UHW	New: Insourced NHH	Business Case Total
23/24	2400	1920	180	1440	2000	2880	1500	1500	13820
24/25	1200	960	90	720	875	0	0	280	4125

10.2.4 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
2023/24	2400	2837	5237
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
2023/24	1920	180	3861	5961
2024/25	960	90	566	1616

CAV Patients (estimated)

	Core: CAV In house	CAV 15%	CAV Total from this business case
2023/24	1440	1182	2622
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	5237	2622	5961	13820
2024/25	1616	893	1616	4125

10.2.5 Option 3a Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[9]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[10]
- Provides a solid base to develop the sustainable regional solution

[9] Insourcing and Outsourcing will take the less complex patients
[10] Vanguard offers the opportunity for more training lists that are shorter in size

- Fully utilised the Vanguard unit 7 days per week
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 3,814 patients waiting

10.2.6 Option 3a Risks

The specific risks associated with option 1 are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

10.2.7 Option 3a Patient Considerations

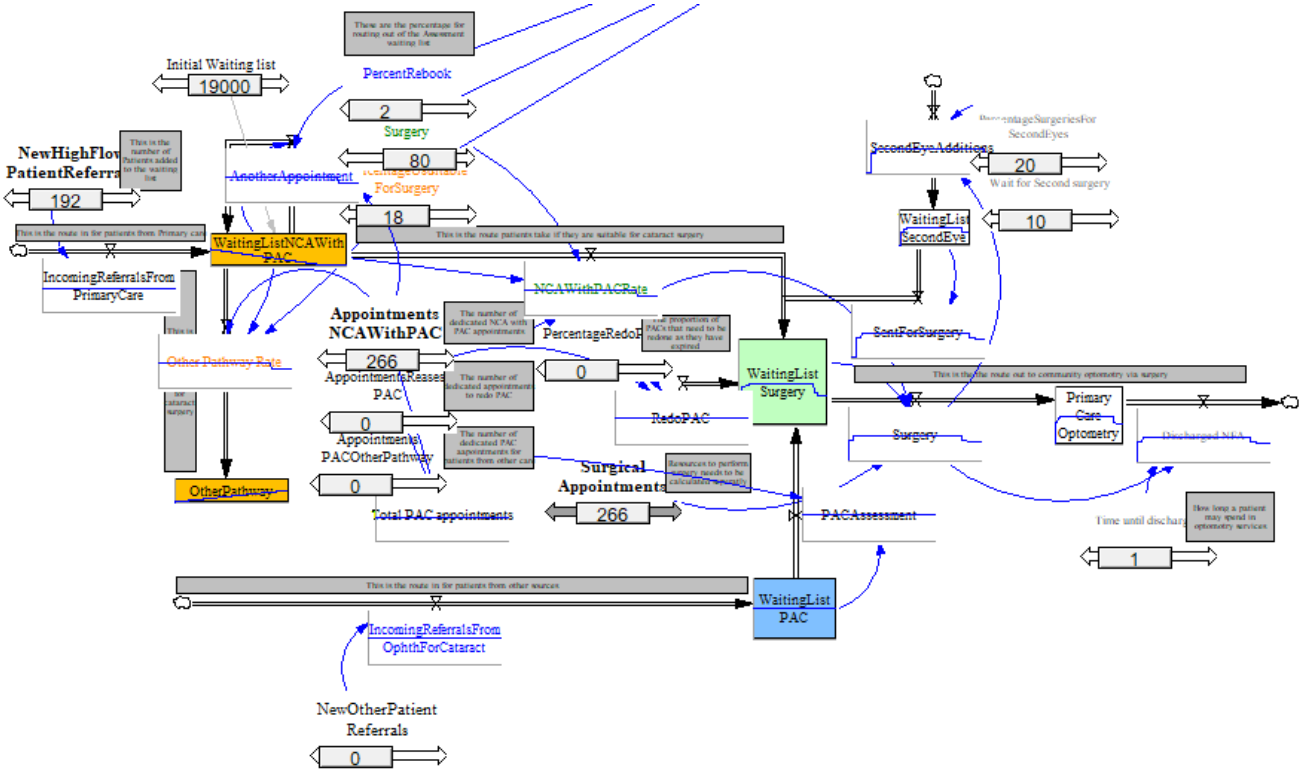
Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

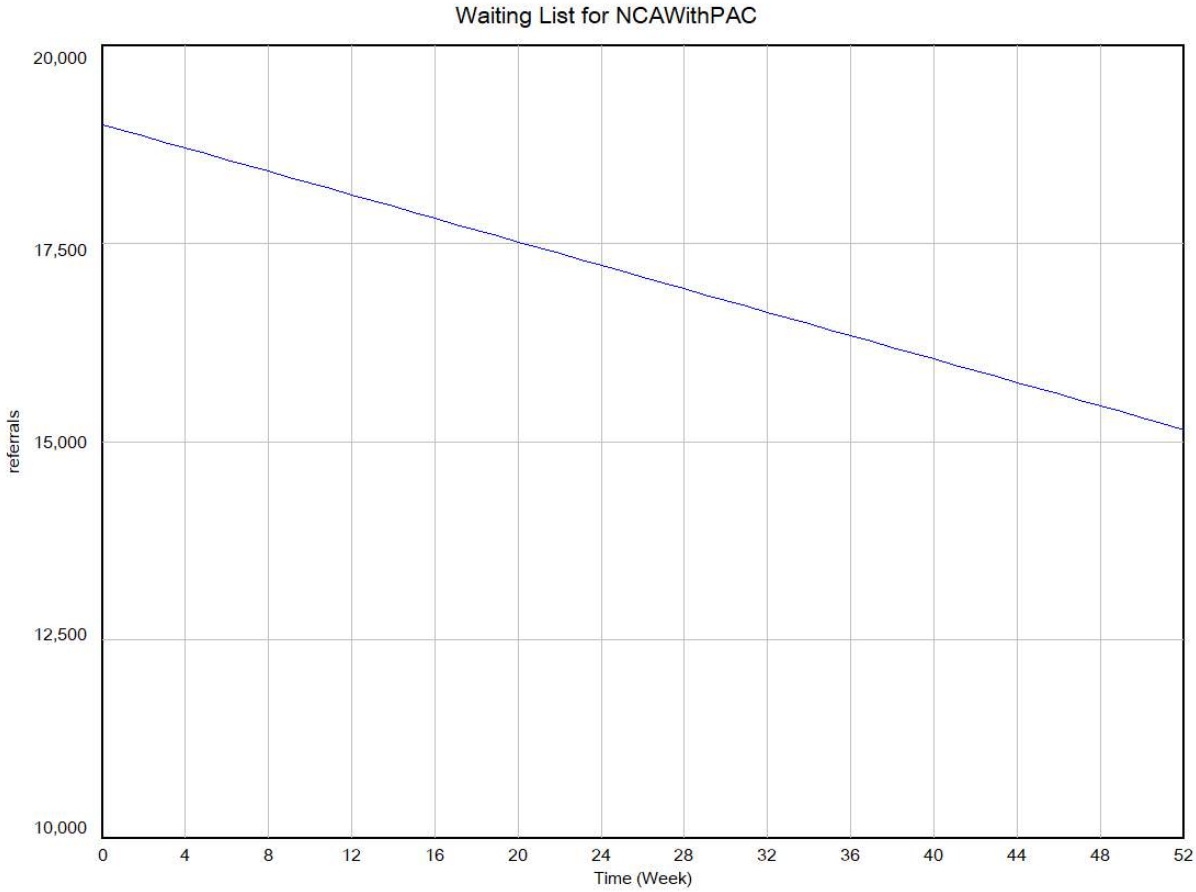
This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

10.2.9 Option 3a Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 13,820 cataracts procedures per year (266 per week, 1152 per month)
- 13,820 outpatients per year (266 per week, 1152 per month)


Initial Waiting list
19000
PercentRebook
2
Surgery
80
ForSurgery
18
NewHighFlow
PatientReferra
192
AnotherAppointment
WaitingListNCAWith
PAC
IncomingReferralsFrom
PrimaryCare
Appointments
NCAWithPAC
266
AppointmentsReased
PAC
0
Appointments
PACOtherPathway
0
OtherPathway
Total PAC appointments
NCAWithPACRate
PercentageRedoP
0
RedoPAC
WaitingList
Surgery
Surgical
Appointments
266
PACAssessment
SecondEyeAdditions
20
Wait for Second surgery
WaitingList
SecondEye
10
SentForSurgery
Surgery
Primary
Care
Optometry
Time until discharg
1
WaitingList
PAC
IncomingReferralsFrom
OphthForCataract
NewOtherPatient
Referrals
0


Waiting List for NCAWithPAC
20,000
17,500
15,000
12,500
10,000
referrals
0
4
8
12
16
20
24
28
32
36
40
44
48
52
Time (Week)

After 52 weeks of the total capacity of 13,820 per year the waiting list is reduced from 19,000 across the region to 15,186

Appendix Six: Option 3b Details

Option 3b –Vanguard and maximising NHH

This is the preferred option

As the preferred option this option has been developed in more detail than the other options.

Realistic assumptions have been made about the feasibility of delivery and the model has been designed to be distributed over 14 months split across 23/24 and 24/25.

Option 3b

As option 3a but with the addition of 7 weekday NHS sessions in NHH

Option 3b is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 14 month period:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

11.1 Clinical and Service Model

11.1.1 Clinical Service Model North Hub (NHH) Additional for Option 3b

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits.

Weekdays: Outpatients Stage (NHS Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 135 outpatient appointments per month (38 per week, 1,620 per year) the sessions will be a 'one stop shop' model, held on weekdays in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area. This weekday activity will be staffed through recruitment of NHS staff for all of the clinical and not clinical staff required.

Outpatients Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays; Inpatient Stage (NHS Staff)

Patients attending the weekday regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekday arrangements in NHH with NHS staff.

In order to undertake 38 procedures per week (135 per month, 1,610 per year) the procedures will be undertaken in Main Theatres at NHH on weekdays, Mondays and Wednesday to Friday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional

Non-Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
Cleaning / Waste / Facilities - £47,883 HSDU costs (Including transport) - £30,000 Purchase of additional surgical trays and equipment - £38,284 Stellaris Handpieces- £87,500 Pharmacy costs, Lens and consumables - £224,310 Additional lens costs £7,716

11.1.2 Booking and scheduling For Option 3b (Vanguard and Maximising NHH):
In one year the team will need to book 7,500 outpatient appointments across both the North and South Hubs and schedule 7,500 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 17,000 patient bookings per year

A team of 18 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A Vanguard Unit Manager and NHH Eye Unit Manager are also required to manage the unit and to ensure capacity levels are maximised.

Staff Required:

- 9 WTE Patient Schedulers Band 3
- 9 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE Vanguard Unit Manager Band 8b
- 1 WTE Eye Unit Manager NHH band 7

Non Staff Costs

- Facilities costs for 24 members of staff, IT costs and office space have been estimated at £100,000

11.1.3 Option 3b Assumptions

- NHH Workforce can be fully recruited
- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters

- 52 weeks waiters numbers under monthly review
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- CTM continue with their current levels of outsourcing (15 per month)
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes
- NHH Workforce can be fully recruited

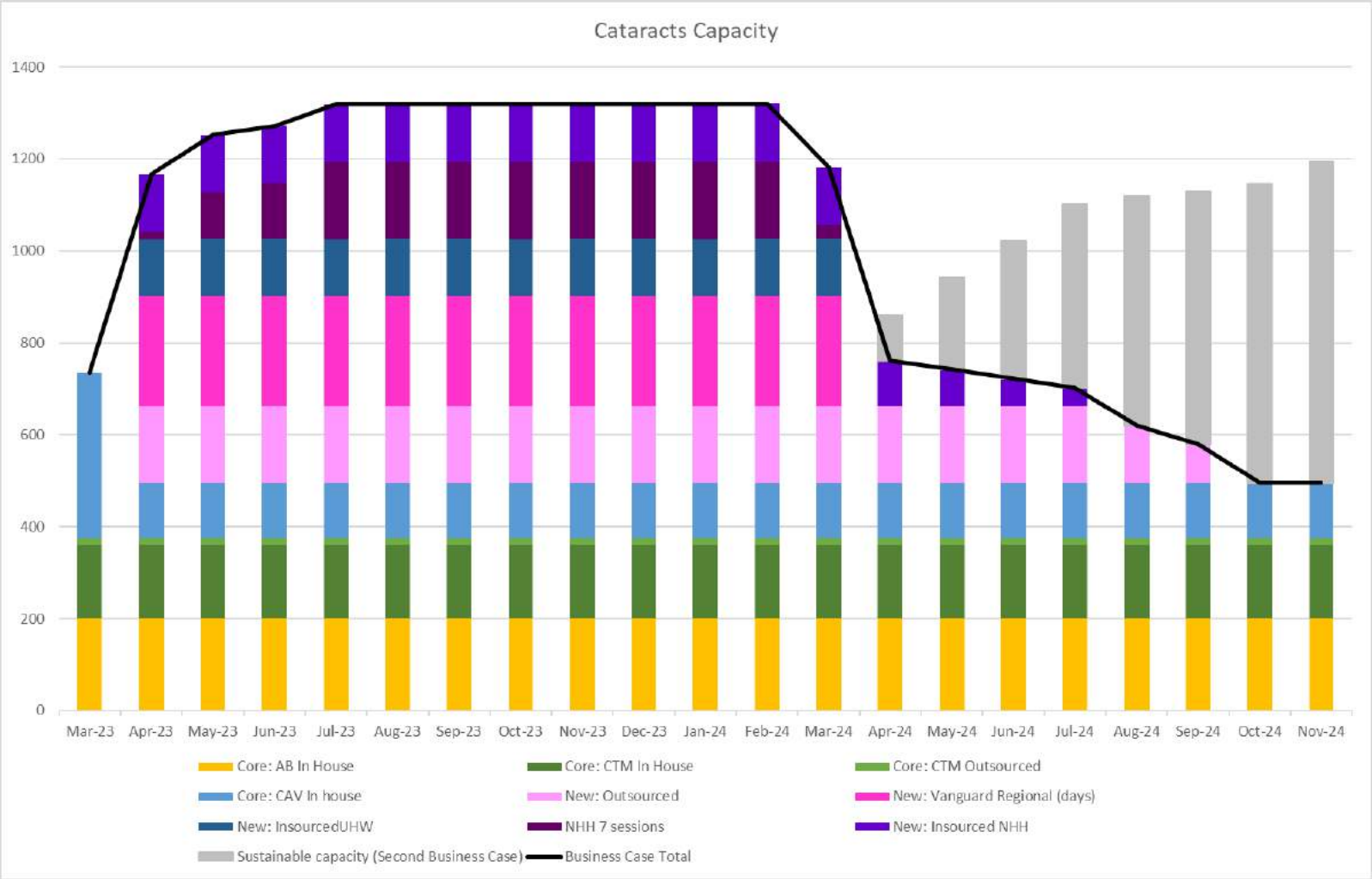
11.2 Option 3b – Option Appraisal

11.2.1 Additional Regional Capacity

Capacity	Core 14 months	Additional Capacity %	Additional Regional	**Total**	14 months demand	Difference
AB	2800	36%	3352	**6152**	4760	1392
CAV	1890	15%	1397	**3287**	2100	1187
CTM	2440	49%	4562	**7002**	4760	2242
Regional Total	7140		9310	**16450**	11620	4830

11.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.


Cataracts Capacity
1400
1200
1000
800
600
400
200
0
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Core: AB In House
Core: CTM In House
Core: CTM Outsourced
Core: CAV In house
New: Outsourced
New: Vanguard Regional (days)
New: InsourcedUHW
NHH 7 sessions
New: Insourced NHH
Sustainable capacity (Second Business Case)
Business Case Total

11.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages.

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 39%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179
1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

11.2.4 Option 3b Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[11]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[12]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Greater proportion of cataracts surgery undertaken by NHS staff
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 4,832 patients waiting

11.2.5 Option 3b Risks

The specific risks associated with this option are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

11.2.6 Option 3b Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

[11] Insourcing and Outsourcing will take the less complex patients

[12] Vanguard offers the opportunity for more training lists that are shorter in size

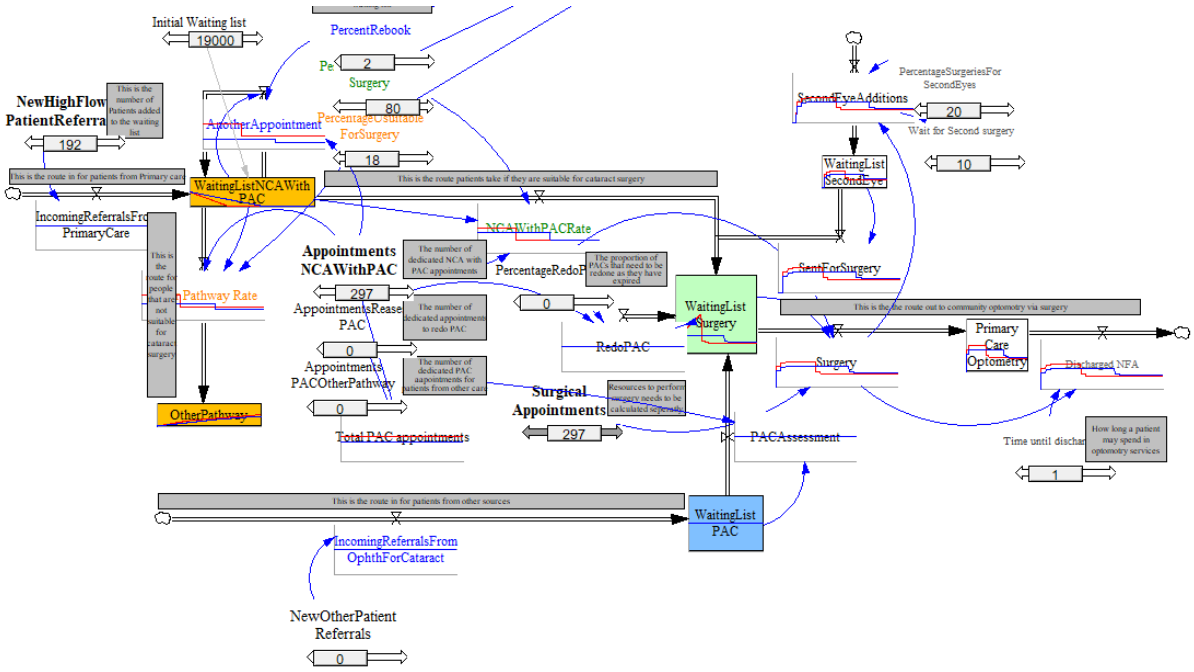
11.2.8 Option 3b Activity Modelling

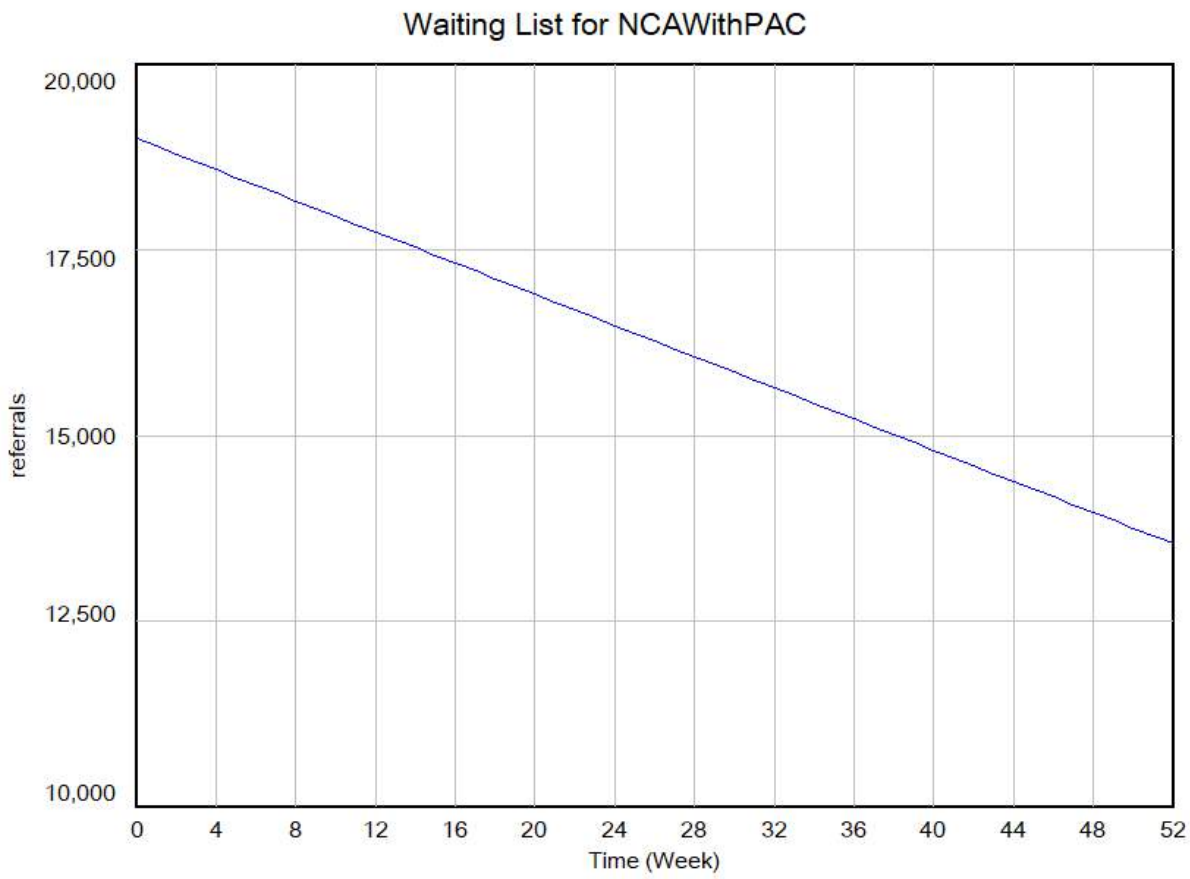
This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year





This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year

After 14 months the total capacity of 16,450 per year the waiting list is reduced from 19,000 across the region to 14,168

Appendix Seven: Option 4 Details

Option 4 – Weekend Insourcing and Outsourcing Only

The Insourcing and outsourcing option involves a two hub model of NHH in the North and the use of POWH in the south for outpatients and Inpatients, along with outsourcing in the following volumes over a 12 month period:

- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7,193,028
- Cost per patient: £1,439

12.1 Option 4 – Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

12.1.1 North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny.

Outpatient Stage

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a ‘one stop shop’ model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area.

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage

Patients accessing the additional capacity for insourcing in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub arrangements in NHH.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH every Saturday and Sunday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of additional surgical trays and equipment - £38,284
- Stellaris Handpieces- £87,500
- Pharmacy costs, Lens and consumables - £224,310
- Additional lens costs £7,716.

12.1.2 South Hub

Through Option 2 The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital in Bridgend on weekends via an insourcing company

Outpatients Stage (Weekend Insourcing in POWH)

The POWH site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

- 0.5 WTE B2 Receptionist
- 0.5 WTE B3 Booking
- 0.5 WTE B6 Governance Nurse

Non- staffing costs are

- Cleaning

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage *(Weekend insourcing at POWH)*

Patients accessing the additional capacity for insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a morning. By running the two theatres on Saturdays all day and Sunday mornings, 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of 45 additional surgical trays and handpieces - £239,682
- Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

12.1.3 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Option 4 will deliver an additional 2,000 cases per year. Outsourcing arrangements and costs include patient travel.

12.1.4 Booking and scheduling for Option 4 (Weekend Insourcing and Outsourcing)

In one year the team will need to book 3,000 outpatient appointments across both the North and South Hubs and schedule 3,000 inpatient procedures in addition to facilitating 2,000 outsourced patients. There is also a requirement to confirm which patients are suitable for the additional capacity and which need to be treated as part of core capacity as they are more complex cases.

A team of 8 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5.

Staff Required:

- 4 WTE Patient Schedulers Band 3
- 4 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7

Non Staff Costs

- Facilities costs for 14 members of staff, IT costs and office space have been estimated at £30,000

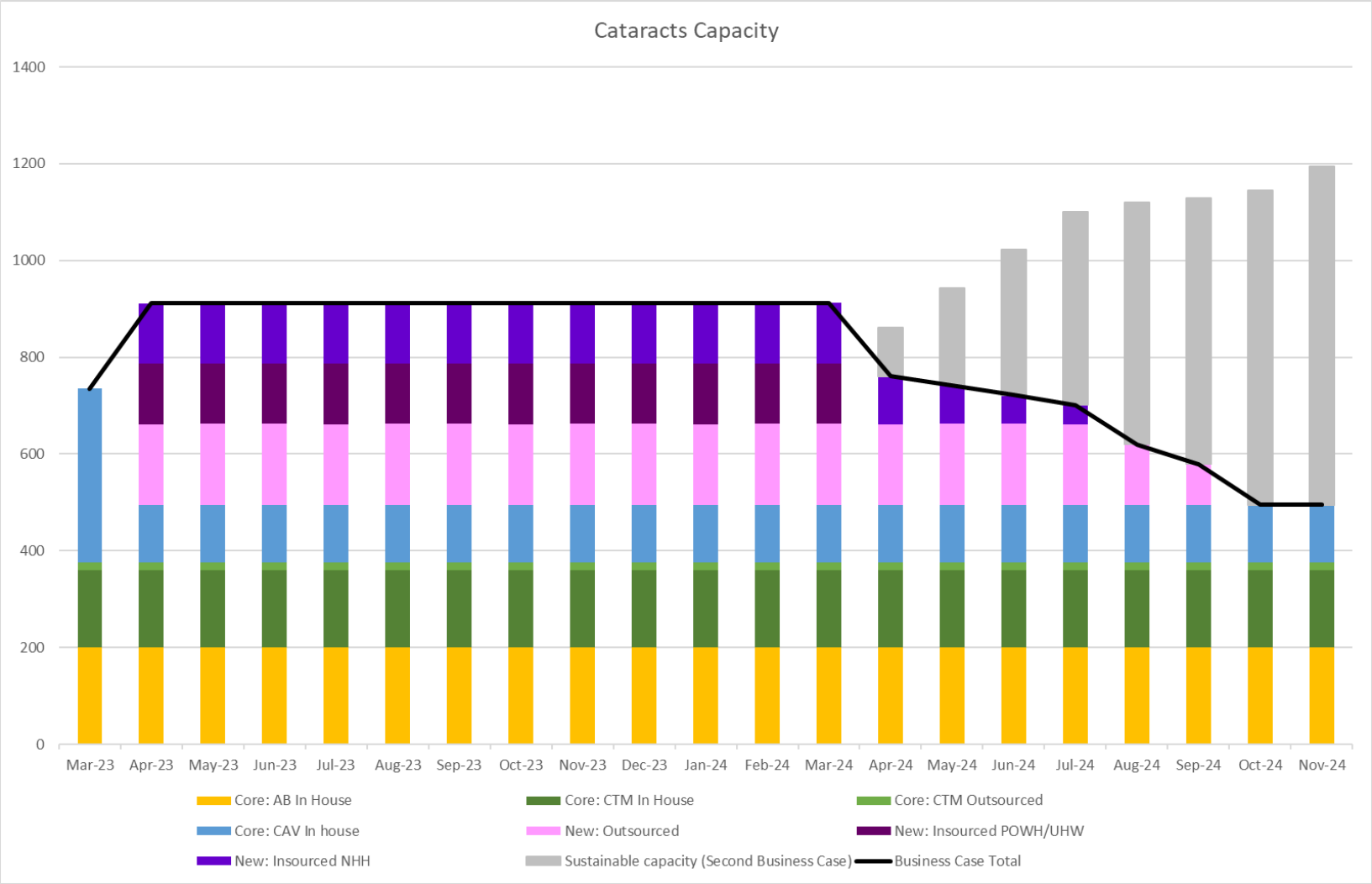
12.2 Option 4 – Option Appraisal

12.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

12.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Insourced POWH	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	1500	1500	**10940**
2024/25	1200	960	90	720	875	0	280	**4125**

12.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list, 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
2023/24	2400	1800	4200
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
2023/24	1920	180	2450	4550
2024/25	960	90	566	1616

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
2023/24	1440	750	2190
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	4200	2190	4550	10940

2024/25	1616	893	1616	4125

12.2.4 Option 4 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Reduces the backlog by 517 patients waiting

If the Vanguard theatres are not taken forward after March 2023 there will be additional staff from UHW that could be utilised at one of the other hub areas.

12.2.5 Option 4 Risks

The specific risks associated with this option are:

- Loss of experienced and well trained staff at the Vanguard Unit (low risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)

12.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

12.2.7 Option 4 Costs

Option 4 costs are shown here

Option 2: Use of NHH and POWH and not retaining Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale						
Aneurin Bevan	Insource	1,500	£246,182	1,500	£1,711,811	£1,957,993
Cwm Taf	Insource	1,500	£246,182	1,500	£1,711,811	£1,957,993
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£581,709
TOTAL		**5,000**	**£808,364**	**5,000**	**£5,802,955**	**£7,193,028**

Indicative Cost per Patient £1,439

2024/25

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource					
Aneurin Bevan	Insource	280	£45,954	280	£319,538	£365,492
Cwm Taf	Insource	280	£45,954	280	£319,538	£365,492
External	Outsource	875	£138,250	875	£1,040,958	£1,179,208
Regional Operational Team						£229,441
TOTAL		**1,435**	**£230,158**	**1,435**	**£1,680,034**	**£2,139,633**

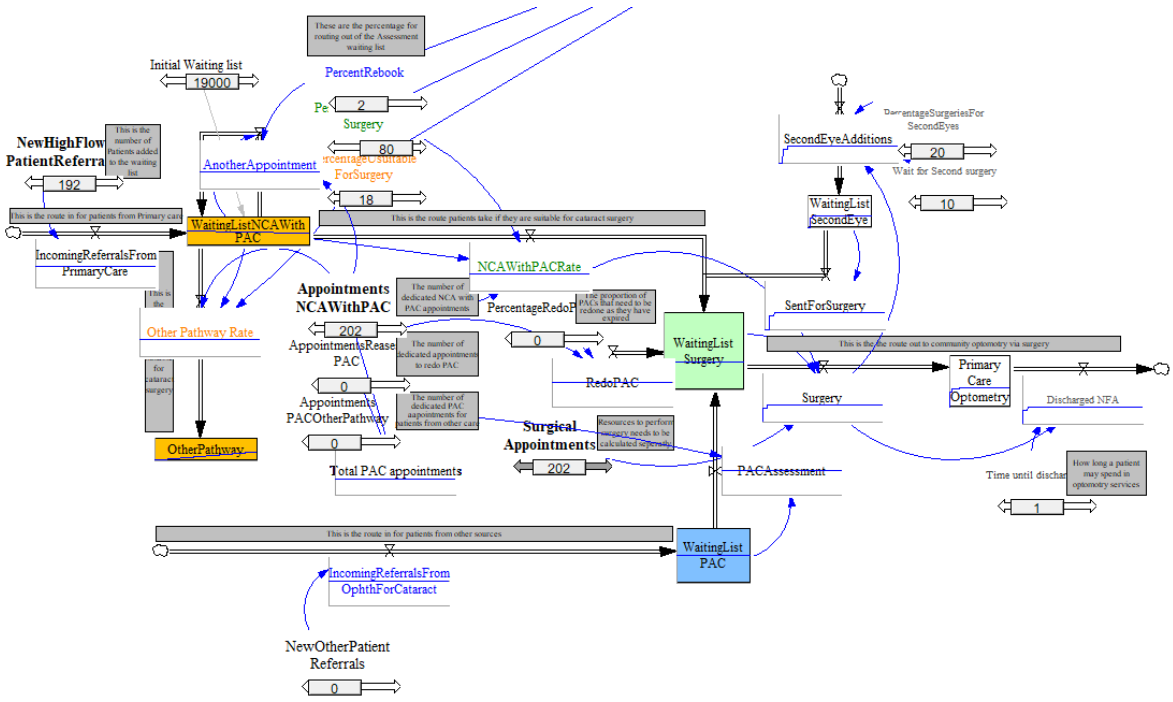
Assumptions-

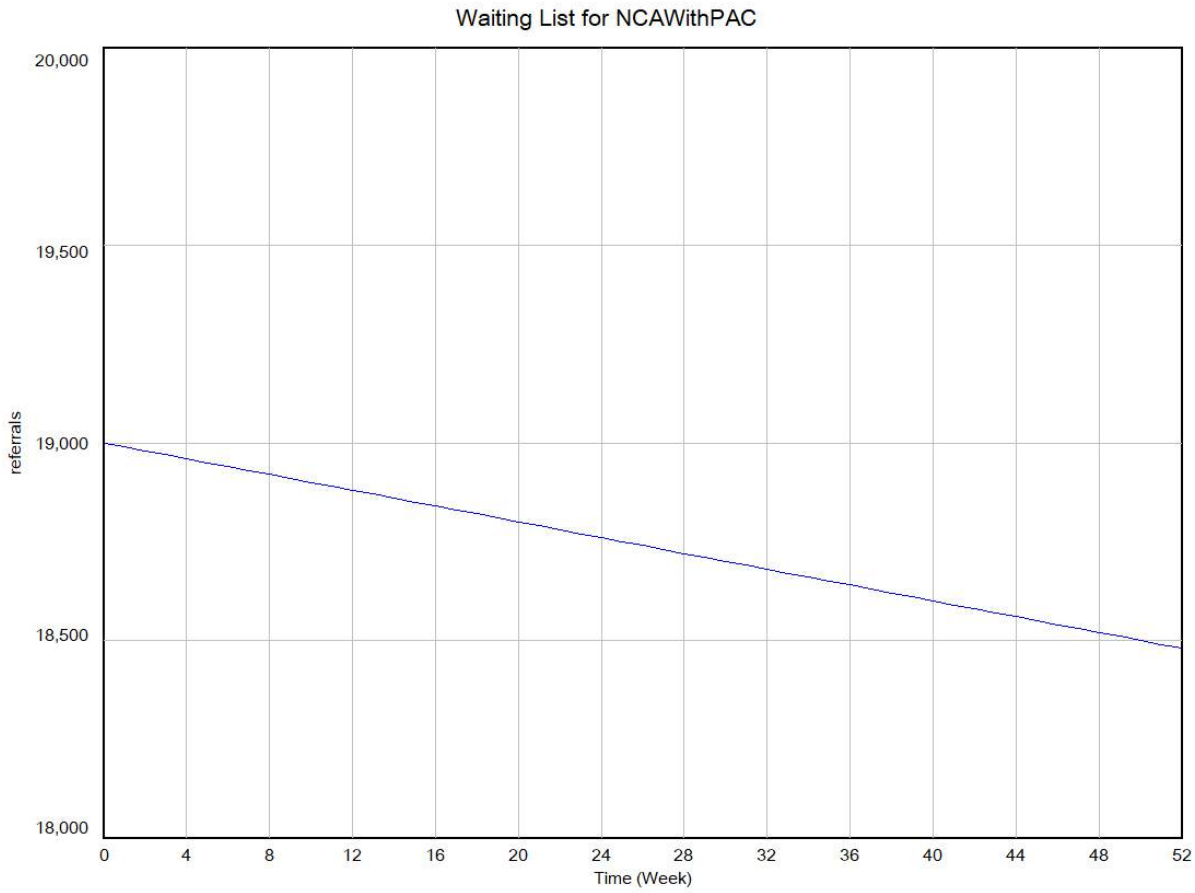
- Cost assumptions are based on locally provided figures
- Insource cost estimates are based on Framework expectation of PbR plus 10% but will depend on casemix and provider
- Outsourcing estimates are based on PbR with an element for transport but dependent on casemix and provider

12.2.8 Option 4 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 10,940 cataracts procedures per year (202 per week, 874 per month)
- 10,940 outpatients per year (202 per week, 874 per month)





After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Appendix Eight: Option 5 Details

Option 5 – Outsourcing

The option involves outsourcing the whole additional capacity and not insourcing or using the Vanguard Unit for capacity. By using outsourcing only, the demands on the regional booking and scheduling team also reduce. It is likely that one supplier would not be able to fulfil the whole 5,000 procedures per year and so it would be split across different providers with the following volumes over a 12 month period:

- An additional 5,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**

- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £6,978,436
- Cost per patient: £1,396

13.1 Option 5 – Clinical and Service Model

13.1.1 Outsourcing Arrangements

Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Through this option 5,000 cases are outsourced. Outsourcing arrangements and costs include patient travel.

Patients are reviewed by a non-clinical administrator for their suitability for outsourcing and then referred on to the outsourcing company for assessment and treatment. Communication with the patient about booking and scheduling and locations are conducted by the outsourcing company. Follow ups post-surgery are conducted in primary care. Hospital patient records are updated.

13.1.2 Booking and scheduling For Option 5 (Outsourcing)

In one year the team would need to facilitate 5,000 outsourced patients and ensure records are kept up to date and that these patients are suitable for the outsourcing route.

A team of 4 patient liaison, 1 waiting list manager and a team leader are required to support the outsourcing

Staff Required:

- 4 WTE Patient Liaison Band 3
- 1 WTE Waiting List Manager Band 5
- 1 WTE Team Leader Band 7

Non Staff Costs

- Facilities costs for 6 members of staff, IT costs and office space have been estimated at £15,000

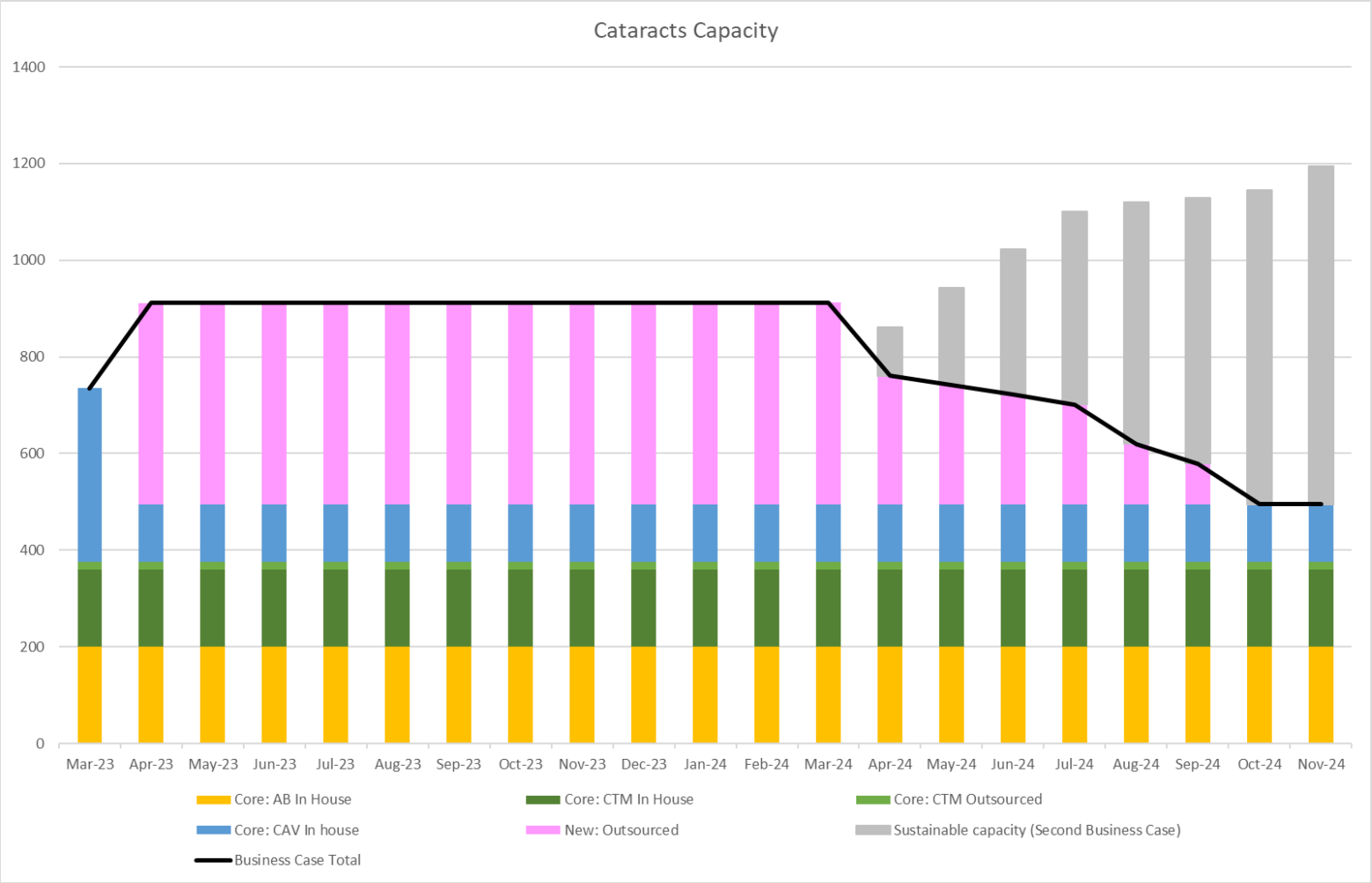
13.2 Option 5 – Option Appraisal

13.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity (outsourced)	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

13.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Insourced POWH	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	5000	0	0	**10940**
2024/25	1200	960	90	720	1155	0	0	**4125**

13.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
2023/24	2400	1800	4200
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
2023/24	1920	180	2450	4550
2024/25	960	90	566	1616

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
2023/24	1440	750	2190
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	4200	2190	4550	10940

2024/25	1616	893	1616	4125

13.2.4 Option 5 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Additional capacity delivered at reduced costs from insourcing
- Reduces the backlog by 517 patients waiting

13.2.5 Option 5 Risks

The specific risks associated with option 2 are:

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)
- Increased number of patients required to travel further for treatment

13.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels.

This option is for outsourcing activity where patients who meet the criteria for this additional capacity would be directed to outsourcing for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and outsourcing capacity provision. This option also includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity does not include patient travel contributions.

13.2.7 Option 5 Costs

Option 3: Outsourcing

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£240,103
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£6,978,436**

Indicative Cost per Patient £1,396

2024/25

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	875	£138,250	875	£1,040,958	£1,179,208
Regional Operational Team						£120,052
TOTAL		**875**	**£138,250**	**875**	**£1,040,958**	**£1,299,260**

13.2.8 Option 5 Activity Modelling

The assumptions used in this option are the same as in option 4, as the capacity stays the same but the mode of delivery changes.

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Appendix Nine: Split of Preferred Option By Health Board

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179
1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

Appendix Ten: Full Patient Travel Survey

Patient Travel Survey

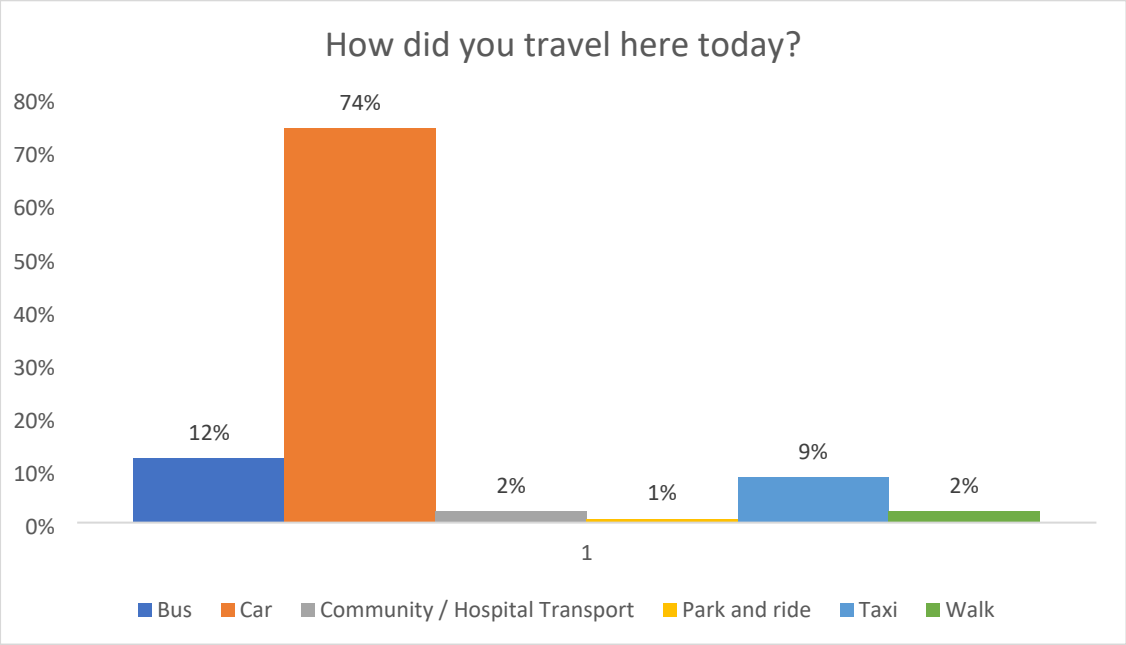
January 2023

A patients travel questionnaire was undertaken in Princess of Wales Hospital on 5th January, Royal Gwent Hospital on 11th January, and University of Wales Hospital on 12th January. 140 patients attending appointments on those day were asked questions about their travel to hospital and their willingness to travel to another hospital for treatment. All respondents were anonymous. This report show the total responses from each location and will form part of the supporting information for the Regional Cataracts business case.

Question 1. Which Hospital are you attending today?

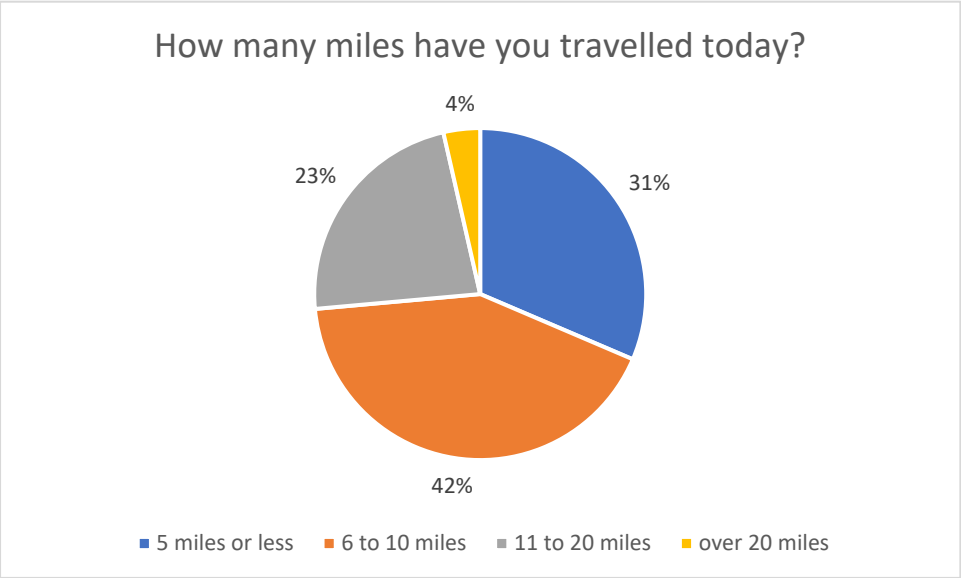
Princess of Wales	35 patients	25%
Royal Gwent	35 patients	25%
University Hospital of Wales	70 patients	50%
Total	140 patients	100%

Question 2. How did you travel here today?



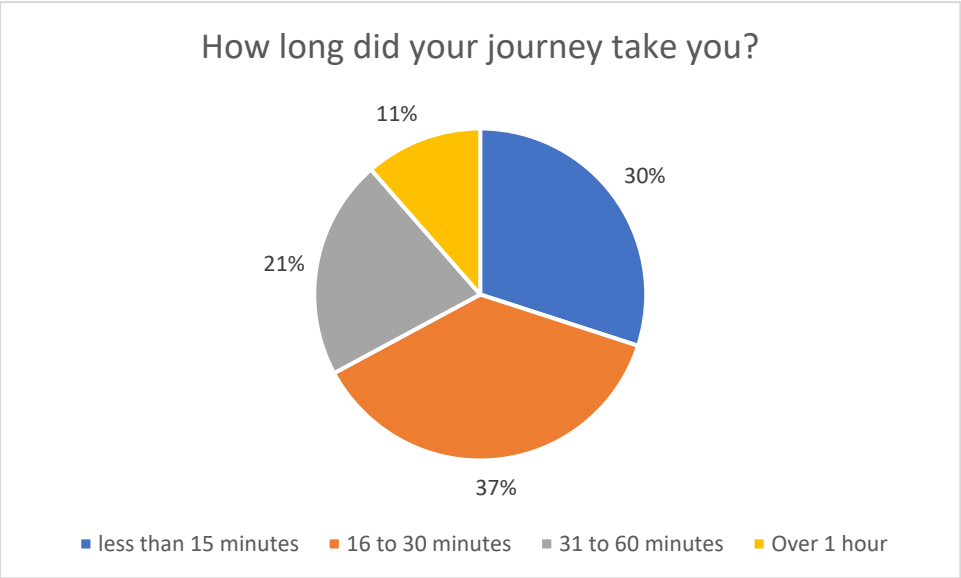
How did you travel here today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Bus	6	1	10	17
Car	28	29	47	104
Community / Hospital Transport			3	3
Park and ride			1	1
Taxi		4	8	12
Walk	1	1	1	3
Grand Total	**35**	**35**	**70**	**140**

Question 3. How many miles Have you travelled today?



How many miles have you travelled today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
5 miles or less	17	7	20	44
6 to 10 miles	16	15	28	59
11 to 20 miles	2	13	17	32
over 20 miles			5	5
Grand Total	**35**	**35**	**70**	**140**

Question 4. How long did your journey take you?

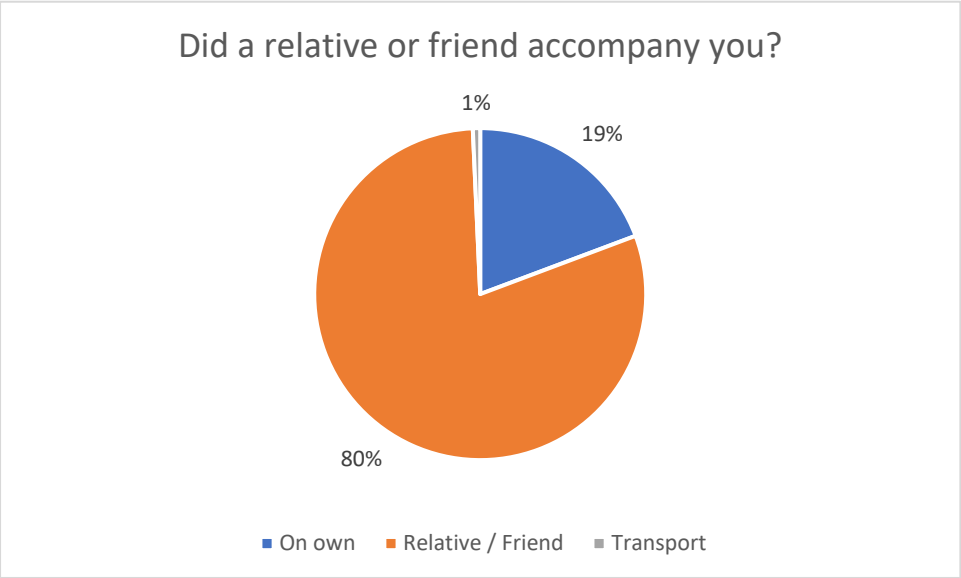


How long did your journey take you?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
less than 15 minutes	16	6	20	42
16 to 30 minutes	16	18	18	52
31 to 60 minutes	3	10	17	30
Over 1 hour		1	15	16
Grand Total	**35**	**35**	**70**	**140**

*on the day of the survey in UHW there was sever weather, flooding and an accident on the A470 resulting in journeys that were longer than the patients were expecting.

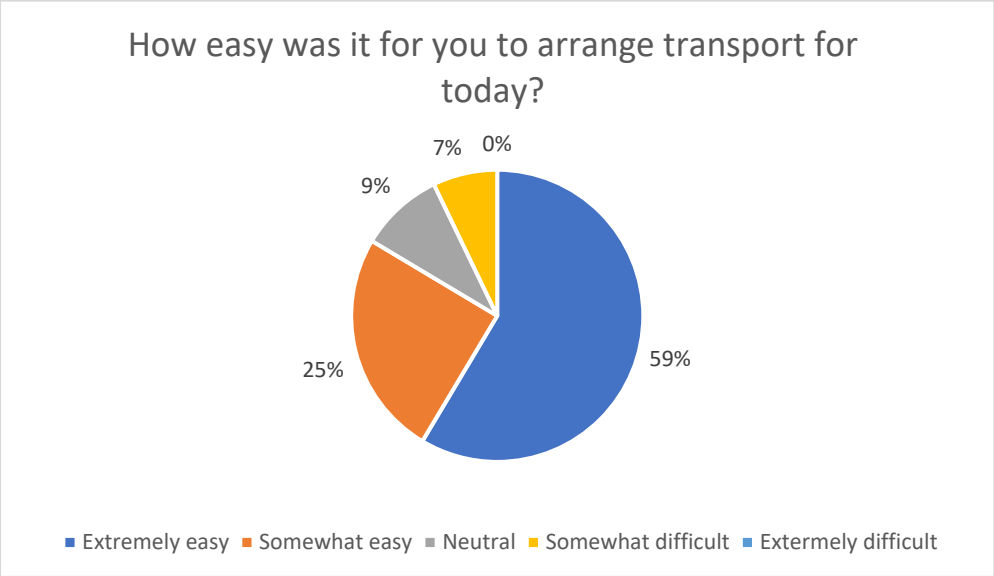
Question 5 asked patients where they travelled from

Question 6. Did a Relative or friend accompany you?



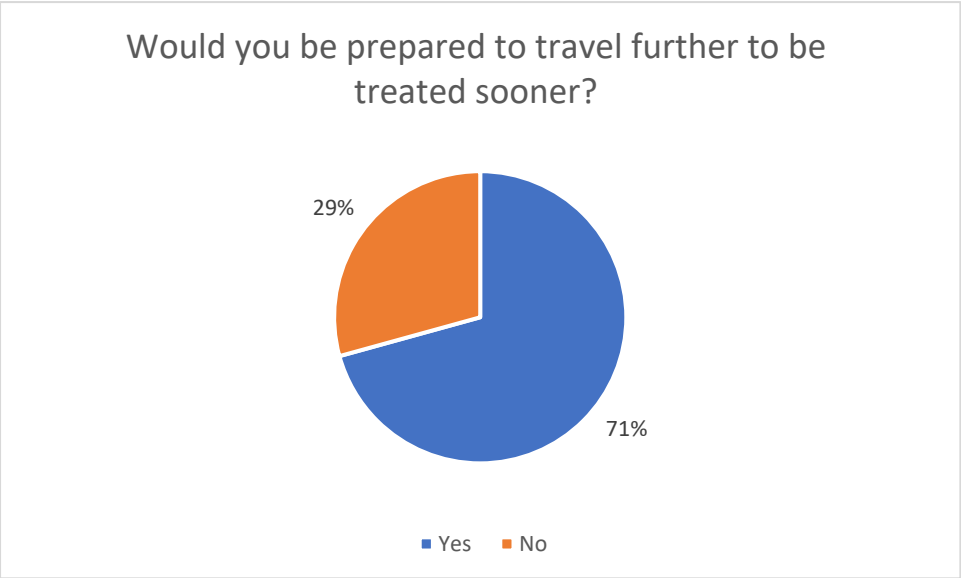
Did a relative or friend accompany you?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
On own	5	3	19	27
Relative / Friend	30	32	50	112
Transport			1	1
Grand Total	**35**	**35**	**70**	**140**

Question 7. How easy has it been for you to arrange transport today?



How easy was it for you to arrange transport for today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Extremely easy	24	23	35	82
Somewhat easy	6	9	20	35
Neutral	4	1	8	13
Somewhat difficult	1	2	7	10
Extremely difficult				0
Grand Total	**35**	**35**	**70**	**140**

Question 8. Would you be prepared to travel further if you could have been treated sooner?



Would you be prepared to travel further to the treated sooner?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Yes	25 (71%)	27 (77%)	47 (67%)	99 (71%)
No	10 (29%)	8 (23%)	23 (33%)	41 (29%)
Grand Total	**35**	**35**	**70**	**140**

Question 9. Where would you travel to?

- From Princess of Wales Hospital in Bridgend, of the 25 patients willing to travel 25 would go to Cardiff and 19 to Swansea
- From Royal Gwent Hospital in Newport, of the 27 patients willing to travel 19 would be willing to travel to Cardiff and 25 to Abergavenny
- From University Hospital of Wales in Cardiff, of the 47 patients willing to travel 38 would be willing to travel to Bridgend and 41 to Newport

Where would you travel to?	From Princess of Wales Hospital	From Royal Gwent Hospital	From University Hospital of Wales
Bridgend / POWH		7	38
Cardiff / UHW	25	19	
Newport / RGH	11		41
Abergavenny / NHH	5	25	30
Bristol	5	6	10
Swansea	19	3	10
Further in the UK	5	3	4
Grand Total	**70**	**63**	**133**

**patients could provide multiple answers to this question*