CTMUHB Public Board Meeting

Thu 30 May 2024, 09:30 - 13:30

Yr Hwb, Royal Glamorgan Hospital Site, Llantrisant

Agenda

09:30 - 09:35
5 min

1. PRELIMINARY MATTERS / MATERION RHAGARWEINOL

1.1. Welcome & Introductions / Croeso a Chyflwyniadau

Information / Gwybodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd Iechyd*

1.2. Apologies for Absence / Ymddiheiuriadau am Absenoldeb

Information / Gwybodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd Iechyd*

1.3. Declarations of Interest / Datganiadau o Fuddiannau

Information / Gwybodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd Iechyd*

09:35 - 09:40
5 min

2. CONSENT AGENDA BUSINESS / BUSNES YR AGENDA GYDSYNIAD

Information / Gwybodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd Iechyd*

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

Bydd y Cadeirydd yn gofyn a oes unrhyw eitemau o'r Agenda Gydsyniad (Eitem 8) y mae Aelodau'r Bwrdd am eu cyflwyno i'r Prif agenda i'w trafod

09:40 - 10:00
20 min

3. SHARED LISTENING & LEARNING / GWRANDO A DYSGU AR Y CYD

3.1. Dementia in Cwm Taf Morgannwg - Presentation / Dementia yng Nghwm Taf Morgannwg - Cyflwyniad

Discussion / Trafodaeth *Lowri Morgan, Dementia Programme Manager/Rebecca Jones, Community Sister/Ana Llewellyn, Care Group Nurse Director / Lowri Morgan, Rheolwr y Rhaglen Dementia/Rebecca Jones, Prif Nyrs y Gymuned/Ana Llewellyn, Cyfarwyddwr Nyrsio'r Grŵp Gofal*

3.1 Health Public Board presentation (HB format v6).pdf (14 pages)

10:00 - 10:15
15 min

4. SETTING THE SCENE / CYFLWYNO'R CEFNDIR

4.1. Chairs Report / Adroddiad y Cadeirydd

Discussion / Trafodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd Iechyd*

4.1 Chair's Board Report UHB 30 May 2024.pdf (7 pages)

4.1.1. Action Log from the Previous Board Meeting / Cofnodion Gweithredu o Gyfarfod blaenerol yBwrdd

Discussion / Trafodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd Iechyd*

4.1.1 Action Log Health Board UHB 30 May 2024.pdf (3 pages)

4.2. Chief Executives Report / Adroddiad Prif Weithredwr

Discussion / Trafodaeth *Paul Mears, Chief Executive Officer / Prif Weithredwr*

4.2 CEO Board Update Report UHB 30 May 2024.pdf (6 pages)

10:15 - 11:00
45 min

5. GOVERNANCE, RISK AND ASSURANCE / LLYWODRAETHU, RISG ASICRWYDD

5.1. Board Committee and Advisory Group Highlight Reports / Adroddiadau crynhoi Pwyllgorau'r Bwrdd a'r Grŵp Cynghori

Discussion *Committee Chairs / Caderion Pwyllgorau*

5.1.1. Charitable Funds Committee Highlight Report 23 April 2024 / Adroddiad Crynhoi'r Pwyllgor Cronfeydd Elusennol 23 Ebrill 2024

Discussion / Trafodaeth *Lynda Thomas, Independent Member/Committee Chair / Aelod Annibynnol / Cadeirydd Pwyllgor*

5.1.1 CFC Hightlight Report to Board 23 April 2024 UHB 30 May 2024.pdf (4 pages)

5.1.2. Stakeholder Reference Group Highlight Report 11 April 2024 / Adroddiad Crynhoi'r Grŵp Cyfeirio Rhanddeiliaid 11 Ebrill 2024

Discussion / Trafodaeth *Anne Morris, Associate Member/Chair of the Stakeholder Reference Group / Cadeirydd y Grŵp Cyfeirio Rhanddeiliaid*

5.1.2 SRG Chair's Highlight Report - 11 April 2024 UHB 30 May 2024.pdf (5 pages)

5.1.3. Quality & Safety Committee Highlight Report 14 March 2024 /Adroddiad Crynhoi'r Pwyllgor Ansawdd a Diogelwch 14 Mawrth 2024

Discussion / Trafodaeth *Carolyn Donoghue, Independent Member/Committee Chair / Aelod Annibynnol / Cadeirydd Pwyllgor*

5.1.3 QSC Committee Highlight Report UHB 30 May 2024.pdf (5 pages)

5.1.4. Hosted Bodies Audit & Risk Committee Highlight Report 18 April 2024 / Adroddiad Crynhoi'r Pwyllgor Archwilio a Risg Cyrff a Gynhelir 18 Ebrill 2024

Discussion / Trafodaeth *Patsy Roseblade, Independent Member/Committee Chair / Aelod Annibynnol / Cadeirydd Pwyllgor*

5.1.4 Hosted Bodies ARC Highlight Report 18.04.24 UHB 30 May 2024.pdf (4 pages)

5.2. Escalation Status Update / / Diwerddariad Statws Uwchgyfeirio

Information

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

I'w Drafod a'i Nodi - Mae diweddariad mewn perthynas â Statws Uwchgyfeirio wedi'i gynnwys yn Adroddiad y Prif Swyddog Gweithredol yn eitem agenda 4.2

5.3. Board Assurance Framework (Principal/Strategic Risks) / Fframwaith Sicrwydd y Bwrdd(Prif Risgiau/Risgiau Strategol)

Discussion / Trafodaeth *Gareth Watts, Director of Corporate Governance/Board Secretary / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

5.3a Board Assurance Framework - Cover Paper - May 24.pdf (4 pages)

5.3b Appendix 1 BAF Report - May 2024.pdf (60 pages)

5.4. Annual Review of Board Effectiveness Self-Assessment / Adolygiad Blynyddol o Hunanasesiad Effeithiolrwydd y Bwrdd

Decision / Penderfyniad *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd*

5.4a Annual Board Effectiveness Self Assessment - Cover Paper.pdf (3 pages)
5.4b Appendix 1 -CTMUHB - Annual Bd Effectiveness Self-Ass't 23-24.pdf (14 pages)
5.4c Appendix 2 - CTMUHB CG in Central Departments - Code of Good Practice 2017.pdf (12 pages)
5.4d Appendix 3 - CTM IM Scrutiny Toolkitv circulated 10.2.2022.pdf (21 pages)

5.5. Working in Partnerships Item - Development of Maesteg Hospital / Adroddiad Gweithio mewn partneriaeth - Datblygu Ysbyty Maesteg

Discussion / Trafodaeth *Linda Prosser, Executive Director of Strategy & Transformation / Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid*

5.5 Maesteg Hosital Redevelopment Board Briefing UHB 30 May 2024 FINAL(1).pdf (16 pages)

5.5.1. Public Services Board Update / Diweddariad Bwrdd Gwasanaethau Cyhoeddus

Discussion *Linda Prosser, Executive Director of Strategy & Transformation / Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid*

5.5.1 Public Service Board Update UHB 30 May 2024.pdf (7 pages)

5.5.2. Regional Partnerships Board Update / Diwerddiad Bwrdd Partneriaethau Rhanbarthol

Discussion *Linda Prosser, Executive Director of Strategy & Transformation / Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid*

5.5.2 Regional Partnership Board Update UHB 30 May 2024.pdf (8 pages)

11:00 - 12:30
90 min

6. DELIVERING OUR PLAN / CYFLAWNI EIN CYNLLUN

6.1. Integrated Performance Report (Quality, People & Operational Performance) / Adroddiad Perfformiad Integredig (Ansawdd, Pobl a Pherfformiad Gweithredol)

Discussion

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

Trosolwg Rhagarweiniol: Linda Prosser, Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid

Cyflawni Perfformiad Gweithredol : Gethin Hughes, Prif Swyddog Gweithredu

Perfformiad Ansawdd: Greg Dix, Cyfarwyddwr Nyrsio Cyfarwyddwr/Dirprwy Brif Weithredwr, Dom Hurford, Cyfarwyddwr Meddygol, Lauren Edwards, Cyfarwyddwr Gweithredol Therapïau a Gwyddorau

Iechyd Pobl: Hywel Daniel, Cyfarwyddwr Gweithredol Pobl

6.1 HB Integrated Performance Dashboard UHB 30 May 2024.pdf (37 pages)

6.2. Financial Performance Updates / Diweddariad Perfformiad Ariannol

Discussion / Trafodaeth *Sally May, Executive Director of Finance / Cyfarwyddwr Gweithredol Cyllid*

6.2.1. Month 12 Update / Diwerddiad Mis 12

Discussion / Trafodaeth *Sally May, Executive Director of Finance / Cyfarwyddwr Gweithredol Cyllid*

6.2.1 M12 Finance Report UHB 30 May 2024.pdf (20 pages)

6.2.2. Month 1 Update / Diwerddiad Mis 1

Discussion / Trafodaeth *Sally May, Executive Director of Finance / Cyfarwyddwr Gweithredol Cyllid*

6.2.2 M1 Finance Report UHB 30 May 2024.pdf (17 pages)

6.2.3. Capital Update - Quarterly Progress Report / Diweddariad Cyfalaf - Adroddiad Cynnydd Chwarterol

Discussion / Trafodaeth *Sally May, Executive Director of Finance / Cyfarwyddwr Gweithredol Cyllid*

6.2.3 Capital Update UHB 30 May 2024.pdf (17 pages)

6.3. Update on the Getting it Right First Time (GIRFT) Productivity Work - Presentation - To follow / Diweddariad ar y Gwaith Cynhyrchedd Amser Cyntaf Cywir - Cyflwyniad - I ddilyn

Discussion / Trafodaeth *Gethin Hughes, Chief Operating Officer / Prif Swyddog Gweithredu*

6.3 Elective Productivity May 2024 v6.pdf (15 pages)

12:30 - 13:15
45 min

7. STRATEGIC PLANNING / CYNLLUNIO STRATEGOL

7.1. Acute Clinical Services Plan Update / Diweddariad Cynllun Gwasanaethau Clinigol Acíwt

Trafodaeth *Linda Prosser, Executive Director of Strategy & Transformation / Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid*

7.1a CTM Board ACSP update UHB 30 May 2024.pdf (4 pages)
7.1b ACSP for Board May 24 UHB 30 May 2024.pdf (15 pages)

7.2. Tackling Type 2 Diabetes in Cwm Taf Morgannwg / Afael â Diabetes Math 2 yng Nghwm Taf Morgannwg

Discussion / Trafodaeth *Philip Daniels, Executive Director of Public Health / Cyfarwyddwr Iechyd y Cyhoedd*

7.2 Tackling Type 2 Diabetes in CTM UHB 30 May 2024.pdf (10 pages)

13:15 - 13:20
5 min

8. CONSENT AGENDA / AGENDA GYDSYNIAD

8.1. FOR APPROVAL / I'W CYMERADWYO

8.1.1. Unconfirmed Minutes of the meeting held on 28 March 2024 / Cofnodion heb eu Cadarnhauo'r cyfarfod a gynhaliwyd 28 Mawrth 2024

Decision / Penderfyniad *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd*

8.1.1a Unconfirmed Minutes Health Board meeting 28 March 2024 UHB 30 May 2024.pdf (19 pages)
8.1.1b Unconfirmed Minutes Health Board meeting 28 March 2024 (Welsh).pdf (19 pages)

8.1.2. Unconfirmed Minutes of the Extra Ordinary Board meeting held on 9 April 2024 / Cofnodion heb eu cadarnhau o'r cyfarfod o'r Bwrdd Ychwanegol Cyffredin a gynhaliwyd ar 9 Ebrill 2024

Decision / Penderfyniad *Jonathan Morgan, Health Board Chair / Cyfarwyddwr Iechyd y Cyhoedd*

8.1.2a Unconfirmed Minutes Extra Ordinary Board Meeting 09 April 2024 UHB 30 May 2024.pdf (6 pages)
8.1.2b Unconfirmed Minutes Extra Ordinary Board Meeting 09 April 2024 (Welsh).pdf (6 pages)

8.1.3. Committee Annual Reports / Adroddiadau Blynyddol y Pwyllgorau

Decision / Penderfyniad *Gareth Watts, Director of Corporate Governance/Board Secretary / / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

- 8.1.3a Board Committee Annual Reports UHB 30 May 2024.pdf (4 pages)
- 8.1.3b Appendix 1 Quality Safety Committee Annual Report 2023 to 2024 UHB 30 May 2024.pdf (12 pages)
- 8.1.3c Appendix 2 Annual Report 2023-24 PHP Committee UHB 30 May 2024.pdf (7 pages)
- 8.1.3d Appendix 3 - Digital and Data Annual Report 21 UHB 30 May 2024.pdf (7 pages)

8.1.4. Annual Review of Risk Management Framework / Adolygiad Blynyddol o'r Fframwaith Rheoli Risg

Decision / Penderfyniad *Gareth Watts, Director of Corporate Governance/Board Secretary / / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

- 8.1.4a Annual Review of Risk Management Framework HB May 24.pdf (5 pages)
- 8.1.4b Appendix 1 - Risk Management Strategy - Draft v9 30th April 2024.pdf (27 pages)

8.1.5. Infection, Prevention & Control Strategy / Strategaeth Heintiau, Atal a Rheoli

Decision / Penderfyniad *Greg Dix, Executive Nurse Director/Deputy Chief Executive / Cyfarwyddwr Nyrsio /Dirprwy Brif Weithredwr*

- 8.1.5a IPC Strategy 2024-27 QSC UHB 30 May 2024.pdf (6 pages)
- 8.1.5b Cwm Taf Morgannwg IPC Strategy 2024-2027- v7 UHB 30 May 2024.pdf (26 pages)

8.1.6. Amendments to the Standing Orders - Stakeholder Reference Group (Frequency of Meetings) / Diwygiadau i'r Rheolau Sefydlog - Grŵp Cyfeirio Rhanddeiliaid (Amlder Cyfarfodydd)

Decision / Penderfyniad *Gareth Watts, Director of Corporate Governance/Board Secretary / / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

- 8.1.6 Amendments to the Standing Orders SRG TOR UHB 30 May 2024.pdf (4 pages)

8.2. FOR NOTING / I'W NODI

8.2.1. Board Annual Cycle of Business for 2024 / Blaengynllun Gwaith y Bwrdd 2024

Information / Gwybodaeth *Gareth Watts, Director of Corporate Governance/Board Secretary / / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

- 8.2.1a Cover Report Board Annual Cycle of Business UHB 30 May 2024.pdf (3 pages)
- 8.2.1b Appendix 1 Board Cycle of Business 2024 UHB 30 May 2024.pdf (4 pages)

8.2.2. Board Forward Work Programme / Blaengynllun Gwaith y Bwrdd

Discussion / Trafodaeth *Gareth Watts, Director of Corporate Governance/Board Secretary / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

- 8.2.2 Board Forward Work Programme UHB 30 May 2024.pdf (5 pages)

8.2.3. Board Committee and Advisory Group Highlight Reports / Adroddiadau Crynhoi Pwyllgorau'rBwrdd a'r Grŵp Cynghori

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

I'w Nodi (e.e. lle nad oes unrhyw eitemau i'w huwchgyfeirio i'r Bwrdd)

- 8.2.3a Board Committee and Advisory Group Highlight Reports UHB 30 May 2024.pdf (4 pages)
- 8.2.3b Appendix 1 Extra Ordinary PPFC Highlight Report to Board 13.03.24 UHB 30 May 2024.pdf (5 pages)
- 8.2.3c Appendix 2 RTSC Committee Highlight Report 28.3.2024 Final UHB 30 May 2024.pdf (3 pages)
- 8.2.3d Appendix 3 PCC Highlight Report to Board 15.04.2024 UHB 30 May 2024.pdf (5 pages)
- 8.2.3e Appendix 4 CTMUHB ARC Highlight Report 18.04.24 UHB 30 May 2024.pdf (6 pages)
- 8.2.3f Appendix 5 PPFC Highlight Report to Board 30.04.24 UHB 30 May 2024.pdf (7 pages)

8.2.4. Civil Contingencies & Business Continuity Report / Adroddiad ar Fynegiant Sifil a Pharhad Busnes

Information / Gwybodaeth *Linda Prosser, Executive Director of Strategy & Transformation / Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid*

8.2.4 Civil Contingencies and Business Continuity Report 2023-24 UHB 30 May 2024.pdf (13 pages)

8.2.5. Internal Audit Annual Audit Plan 2024-2025 / Archwiliad Mewnol Cynllun Archwilio Blynyddol 2024-2025

Information / Gwybodaeth *Gareth Watts, Director of Corporate Governance/Board Secretary / / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

8.2.5a 2024-25 Internal Audit Plan UHB 30 May 2024.pdf (32 pages)
8.2.5b CTM -2024.25 - Internal Audit - Indicative days UHB 30 May 2024.pdf (5 pages)

8.2.6. Director of Public Health Annual Report / Adroddiad Blynyddol y Cyfarwyddwr Iechyd y Cyhoedd

Information / Gwybodaeth *Philip Daniels, Executive Director of Public Health / Cyfarwyddwr Iechyd y Cyhoedd*

This item will be deferred to the September 2024 Board meeting following presentation to the August 2024 Population Health & Partnerships Committee

Bydd yr eitem hon yn cael ei gohirio i gyfarfod y Bwrdd ym mis Medi 2024 ar ôl ei chyflwyno i Bwyllgor Iechyd y Boblogaeth a Phartneriaethau yn Awst 2024

8.2.7. Nurse Staffing Levels Annual Assurance report 2023-2024 and Three year report 2021-2024 / Adroddiad Sicrwydd Blynyddol Lefelau Staff Nyrsio 2023-2024 ac Adroddiad Tair Blynedd 2021-2024

Information / Gwybodaeth *Greg Dix, Executive Director of Nursing/Deputy Chief Executive / Cyfarwyddwr Nyrsio /Dirprwy Brif Weithredwr*

8.2.7a Annual and 3 year report NSA Final V1.1 UHB 30 May 2024.pdf (8 pages)
8.2.7b Appendix 1 CTM 2021-24 NSL WG 3 Yearly Reporting May 24 UHB 30 May 2024.pdf (16 pages)
8.2.7c 3 yr appendix A NSLWA 2022 annual assurance UHB 30 May 2024.pdf (15 pages)
8.2.7d 3 yr Appendix B NSLWA 2023 annual assurance UHB 30 May 2024.pdf (12 pages)
8.2.7e 3 yr Appendix C NSLWA 2024 annual assurance (002) UHB 30 May 2024.pdf (15 pages)
8.2.7f Appendix D 2023-2024 Annual Assurace Report of the NSLFinal UHB 30 May 2024.pdf (13 pages)

8.2.8. Annual Review of the Standing Orders / Adolygiad Blynyddol o'r Rheolau Sefydlog

Information / Gwybodaeth *Gareth Watts, Director of Corporate Governance/Board Secretary / / Cyfarwyddwr Llywodraethu Corfforaethol & Ysgrifennydd Bwrdd*

The Standing Orders were reviewed in March in light of the Joint Commissioning Committee going live and will be further reviewed ahead of September Board as part of the review of the Board Committee structure.

Adolygwyd y Rheolau Sefydlog ym mis Mawrth yng ngoleuni'r ffaith bod y Cyd-bwyllgor Comisiynu yn mynd yn fyw a chaiff ei adolygu ymhellach cyn i'r Bwrdd gael ei adolygu fel rhan o'r adolygiad o strwythur y Pwyllgor Bwrdd.

13:20 - 13:25
5 min

9. CLOSE OUT BUSINESS / BUSNES I GLOI

9.1. Any Other Business / Unrhyw Fater Arall

Information / Gwybodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd*

9.2. How Did we do in this Meeting / Sut Wnaethon ni yn y Cyfarfod hwn?

Discussion / Trafodaeth *Jonathan Morgan, Health Board Chair / Cadeirydd y Bwrdd*

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?

Mae hyn yn rhoi cyfle i Aelodau'r Bwrdd fyfyrio ar y cyfarfod ac wrth wneud hynny efallai y byddai'n ddefnyddiol ystyried y cwestiynau canlynol:

Oes unrhyw beth y dylem wneud mwy neu lai ohono?

Ydyn ni wedi rheoli ein hamser yn dda ac wedi caniatáu trafodaeth agored a chytbwys?

Ydyn ni wedi ystyried ein gwerthoedd ac wedi gweithredu mewn ffordd sy'n helpu i ymgorffori ein gwerthoedd ar draws CTM?

Ydyn ni wedi cynnal ffocws strategol?

Ydyn ni wedi cael digon o sicrwydd o amrywiaeth o ffynonellau?

Ydy ein trafodaeth wedi ein galluogi i ddeall yn well y risgiau rydym yn eu rheoli a allai effeithio ar gyflawni ein nodau strategol?

13:25 - 13:30
5 min

10. PRIVATE/IN COMMITTEE SESSION / SESIWN PREIFAT/MEWNPWYLLGOR

- Progress Report - Community Diagnostic Hub & Endoscopy Procurement Process and Business Case - Commercially Sensitive
- **Adroddiad Cynnydd - Y Ganolfan Ddiagnostig Gymunedol a'r Broses Gaffael Endosgopi a'r Achos Busnes - sy'n Sensitif yn Fasnachol**

13:30 - 13:30
0 min

11. DATE AND TIME OF NEXT MEETING / DYDDIAD AC AMSER Y CYFARFODNESAF

The next meeting of the Health Board is scheduled to take place on Thursday July 25 2024 at 10:00am

We will also be holding our Annual General Meeting on Thursday 25 July 2024 at 2:00pm

Bwriedir cynnal cyfarfod nesaf y Bwrdd Iechyd ddydd Iau 25 Gorffenaf 2024 am 10:00 y.b.

Byddwn hefyd yn cynnal ein Cyfarfod Cyffredinol Blynyddol ddydd Iau 25 Gorffennaf 2024 2:00 y.p.

Agenda Item 3.1	30 May 2024	Board Meeting	Dementia – A Patient Story

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Lowri Morgan / Rebecca Jones
Presented By:	Lowri Morgan / Rebecca Jones
Approving Executive Sponsor:	Ana Llewellyn / Greg Dix
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	N/A

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	None
Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	No (Explain why) It was not applicable for this particular patient story
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Inspiring People Improving Care

Dementia: a patient story

Angelton : a dementia friendly hospital

How we support in the community

The District Nurse's role in the assessment and management of pain, in patients living with Dementia in the community

- More than 80% of people with dementia live in the community (Lepore et al., 2017).
- In the UK it is estimated that 540,000 family members and friends acting as unpaid carers, saving to the economy of £13.9 billion (Office for Health Improvement and Disparities, 2022).
- Pain is what the patient says it is" McCaffery (1968)
- Community nurses are pivotal – but there is a gap. (May and Scammell, 2020).
- Barriers to pain assessment
- Antipsychotics v analgesia (Regan et al., 2015).
- "Dementia doesn't rob someone of their dignity; it is our reaction to them that does" (Snow, 2022).

Key Points:

- Pain assessment and management in people with dementia can be challenging as they may not be able to verbally communicate their pain
- Community nurses should take a holistic approach to individualised pain assessment, reassessment and monitoring
- Various pain assessment tools are available, but these should not be used in isolation as other aspects, such as the person's medical history, must also be considered
- A stepwise pharmacological approach, alongside the use of non-pharmacological interventions, can be effective in reducing pain in people with dementia

Improvements we've made to make dementia friendly environments

Prince Charles Hospital

Emergency Department

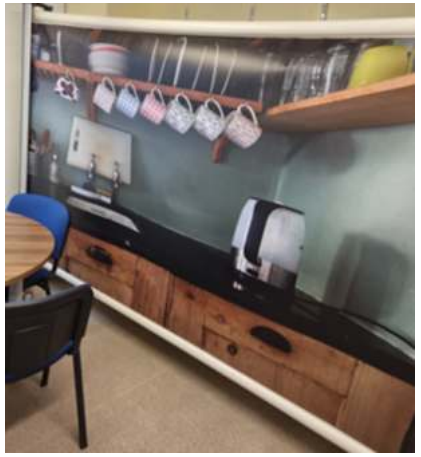
- Better signage
- Screen within cubicle
- Use of RITA Systems to transform the setting

Ward 3

- Therapy dog
- Redeveloped storage room
- Bus stop installed
- Charity connections for crafts and activities
- Activity Trollies created
- Task and finish group established with staff and linked with the front door (ED) to set the scene at the front door to ensure the transition is the best that it can be.

'Such a wonderful team approach and caring attitude'

'Fidget board is fantastic as are all the adaption and decoration in the room.'



'Bus stop is a wonderful concept'

Kings Fund Audit

Coproduction with people with Dementia

- Adapted version of the "Kings Fund" audit tool (is my ward Dementia Friendly).
- Using a collaborative approach, we invited people with lived experience in and asked them their opinion.
- Expanded to KHHP
- Intention to apply the audit across numerous settings and share good practice across CTM as a whole

What we found in YCC

Entrance:
Door way is unfit for purpose, Outside area is unkempt and overgrown.

Well-being:
No sense of wellbeing, no artwork or things of interest, no sense of using plants inside or outside.

Confusing information:
Notice boards were out of date, Little natural light, Flooring is patchy and not consistent, white toilet seats in use.

Signage:
Toilets not easily identifiable, no contrasting colour, no clocks available, no points of interest to aid way finding, does not promote independence.

“Too Hospital looking”, cold, clinical, not homely:
Furniture out dated and clinical looking, Walls painted white, very cold feeling, no artwork or things of interest.

Overall we need to do better

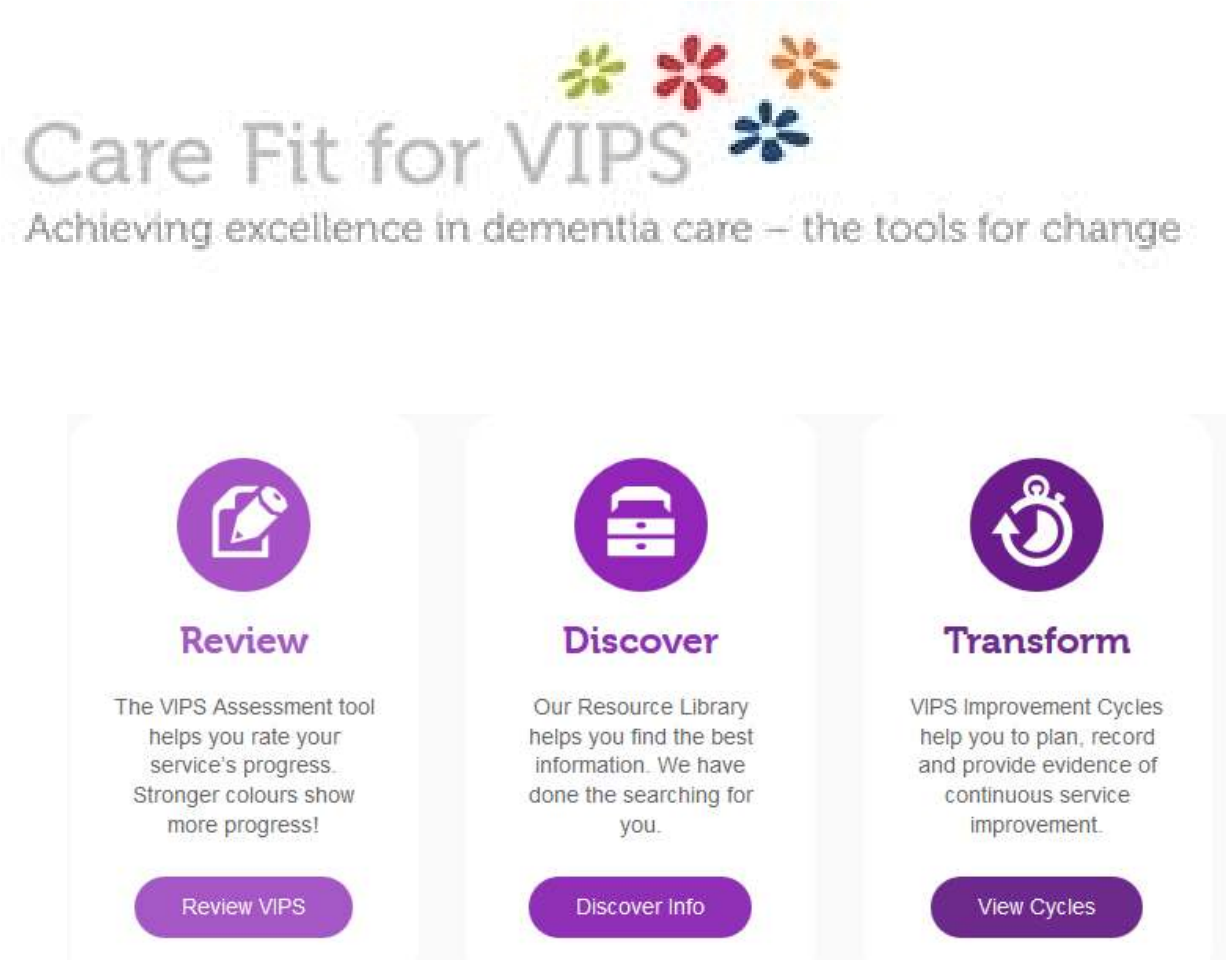
Our plans and challenges

- Keep talking and keep asking
- Well-being
- Independence
- Art work and things of interest
- Outside space
- Funding
- Upkeep and maintenance

'The art work has been well received by the patients attending clinic – the detail, colour and general theme of each painting has provoked positive feeling for our patients' – Dr Smith YCC

Hospital Charter Work moving forward

- Has my care been good enough project
- Robotic pets and HUGS
- Well-being Wednesday to support staff.
- Patients involvement in bedroom door signs on admission, what matters to me conversation.
- This is me monthly audit of assurance.



Any Questions?

'Life is a Journey' written with communities during discussions about living with dementia

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Enhancing lives by raising standards and improving dementia care - CTM (ctmregionalpartnershipboard.co.uk)

Recommendation:	**The Board are asked to Note the presentation**

Agenda Item
4.1

CTM Health Board

CHAIR'S REPORT

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jonathan Morgan, Chair
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Jonathan Morgan, Chair

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
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
WHSSC	Welsh Health Specialised Services Committee
EASC	Emergency Ambulance Services Committee

1. 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

2.1 Chair Update

It is a pleasure to start my report on such a positive note.

Since our last Board meeting the Cabinet Secretary for Health and Social Care has confirmed her agreement with the recommendation that Maternity and Neonatal Services, Quality and Governance, Leadership and Culture,

Trust and Confidence, be de-escalated from enhanced monitoring to routine arrangements. This is a significant milestone for the organisation, for our families and for our staff who have been incredible in working so hard to improve our services. I know the whole Board would want to pay tribute to the dedication of all our staff who have delivered such a step change in our maternity and neonatal services.

Over the past few months I have become increasingly concerned at the system failure across health and community based care that sees too many people needing hospitalisation and too few being able to leave hospital when they are medically fit to do so. The consequences are people not receiving the right care and support at the right time to maximise their wellbeing. Despite efforts of organisations to work across their natural boundaries we have not succeeded in delivering the system wide shift we need in using our collective resources more effectively to improve peoples' health and care outcomes. This means wasting a colossal amount of money not providing what people need.

Recently the CEO and I, together with our CTM Regional Director of Integration, met with the new Minister for Social Care to set out these concerns and to articulate the steps we are taking locally with our partners in local government to address them. Despite the ambition in recent years to address the challenges there has not been enough progress. We will return to this issue as proposals for integration become clearer because the Board together with our three local authorities will need to take action, and quickly if we are to maximise the efforts across health and social care. In the meantime it is important we examine those changes we can make in the way we work to address patient flow.

In our Board discussion today we have a focus on productivity and how to improve the efficiency of what we do in certain areas of activity, maximising how we deliver those high volume low cost procedures. There is a significant opportunity to be better at what we do by working smarter. Today's Board gives colleagues the opportunity to reflect on this across our services and I look forward to us making progress.

2.2 **Independent Member Vacancies**

Nicola Milligan, Independent Member Trade Union, Term of Office is due to end in August 2024. The Cabinet Secretary has approved the Trade Union Independent Member appointment and the recruitment process has commenced. The post has been advertised internally to Cwm Taf Morgannwg University Health Board employees with a closing date of the 31st May 2024. Interviews are planned for July 2024.

2.3 **Extra Ordinary Public Board Meeting – 9 April 2024**

The Board received the following presentation.

- **Emergency Medical Retrieval and Transfer Service – Service Review –** The Chief Executive presented a report that updated the Health Board and the recommended option for the Emergency Medical Retrieval and Transfer Service Review. The Board were asked to **APPROVE** the recommendation in respect of the arrangements for the CTMUHB region.

2.4 **Board Development Session – 25 April 2024**

The Board received the following presentations;

- **Staff Survey Results Feedback** – The Assistant Director of Organisational Development and Wellbeing delivered a presentation to the Board on the staff survey results. The purpose of the session was to brief the Board on the staff survey high level results and what they are telling us, including the links to the wellbeing survey results and how we can compare to the NHS Wales and NHS England results.
- **Cancer in CTM** – The Executive Director of Public Health delivered a presentation on Cancer in Cwm Taf Morgannwg (CTM) UHB. The presentation focussed on the Cancer outcomes and inequalities from a population health perspective and a vision for delivery of cancer services within Cwm Taf Morgannwg UHB.
- **Feedback from the Consultation Institute Session** – The Executive Director of Strategy and Transformation delivered a presentation to update the board on the risk assessment that the Institute have undertaken and best practice information on how we engage and consult and put actions in place to avoid legal challenge moving forward. The Executive Director of Strategy and Transformation also updated the Board on the forthcoming mapping exercise that is scheduled with the ACSP Senior Leaders Group.

2.5 **Diary Commitments**

- Local Authority Leaders/Chair/CEO Meeting
- Independent Members/Chair/CEO Meeting
- 1:1 Chief Executive
- 1:1 Director of Governance
- 1:1 Vice Chair
- Chair Peer Group Meeting
- Meet with NHS Confed Team
- Medical Director / Chair walk round, Princess of Wales Hospital
- Meet with Chair and Chief Executive, NHS Wales Joint Commissioning Committee
- Cwm Taf Morgannwg Regional Partnership Board Meeting
- Arts Factory Event
- Visit to Physiotherapy Department, Prince Charles Hospital

- Visit to Stroke Unit, Prince Charles Hospital
- Women's Health Event
- Visit to Acute Care and Frailty Unit, Princess of Wales Bridgend
- Visit to Occupational Therapy - Inpatient Rehabilitation, Ysbyty Cwm Cynon
- Leadership Group
- Rhondda Cynon Taf Council Meeting
- CTM Community Leaders' Network
- WNHSC Management Committee Meeting
- Meeting with Community Pharmacy Wales
- Staff Q&A
- Audit & Risk Committee, NHS Confed
- VAMT Social Prescribing Meeting
- RCT & Health Board Planning Consultation Meeting
- Cwm Taf Morgannwg UHB and South Wales Police Meeting
- Meeting with Dawn Bowden, Minister for Social Care
- Building a Healthier Wales Coordination Group
- NHS Chairs Meeting with Cabinet Secretary
- CTM Annual Healthy Weight Event
- Meet with Sir Chris Bryant MP
- Board Development Session
- Extraordinary Board Meeting

Meetings / discussions with Local Politicians

- MS/MP monthly meetings with Chair/CEO

3. Key Risks / Matters for Escalation

3.1 COMMON SEAL

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

- **Call Off Contract For Regional Cost Advisor Between Cwm Taf Morgannwg University Health Board and Gleeds Cost Management Limited**, **95 New Cavendish Street, London, W1W 6XF** - The Maesteg Health and Wellbeing Centre Hub Spoke Primary Care Development.

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

3.2 Chairs Urgent Action –UK Covid-19 Inquiry – Core Participant (CP) Status Application for Module 7 – Test, Trace and Isolate

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

- **Approve** the decision that CTMUHB will **NOT** apply for **Individual** Core Participant Status for Module 7.

- **Approve** that should there be an appetite in NHS Wales for **Group** Core Participant Status for Module 7 than 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 with NHS Wales Shared Services Partnership Legal and Risk Team to facilitate such arrangements to support a joint application.

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	The number one focus of the Board and its business is to ensure good quality and safe patient care across all areas of its activity.
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The number one focus of the Board and its business is to ensure good quality and safe patient care across all areas of its activity.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Board endorsement of the Affixing of the Common Seal, is a requirement of the Board's Standing Orders.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 Members of the Board are asked to **NOTE** the report, **ENDORSE** the Affixing of the Common Seal and **APPROVE** the Chairs Urgent Action.

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 6.4	28 September 2023	**Audit Wales and Healthcare Inspectorate Wales Joint Follow Up Review into Quality Governance** Response to be provided to Audit Wales/Healthcare Inspectorate Wales in six months providing an update on progress against the outstanding areas for action contained within the report.	Executive Director of Nursing/Deputy Chief Executive	March 2024 Now April 2024	**In progress** Written response to be drafted on progress in March 2024. Director of Corporate Governance to request an extension for a response to be provided to April 2024.
6.4.1	30 November 2023	**Regional Partnership Board & Public Services Board 6 Monthly Report** Consideration to be given to holding a focussed Board Development session on the Six Goals Programme and Further Faster agenda to provide Board Members with a greater understanding of the work being undertaken.	Director of Strategy & Transformation	To be agreed	**In progress** To be scheduled into the forward work programme for Board Development sessions.
7.2	30 November 2023	**Llantrisant Health Park Project** Further update on progress to be presented to the Board in Summer 2024	Chief Executive	July 2024	**In progress** Forward work programme updated.

5.1	25 January 2024	**Integrated Performance Dashboard** Update to be included in a future report on total demand for Speech and Language Therapy Services and how this compared to other regions	Executive Director of Therapies & Health Sciences	28 March 2024	**In progress**
3.1	28 March 2024	**Listening & Learning Story** Update to be presented to the May Board meeting which identifies the proactive changes that would be undertaken to alleviate some of the issues outlined within the presentation.	Chief Executive	30 May 2024 Now 25 July 2024	**In progress** A report on addressing the challenges of Delayed Transfers of Care will now be presented to the Board meeting being held on 25 July 2024.
7.1	28 March 2024	**Integrated Medium Term Plan and Budget for 2024/2025** G Watts to include the request to consider years two and three finances within a Board Development Session within the next six months to consider the support required for Primary Care, prevention and early intervention.	Director of Corporate Governance/Board Secretary	30 May 2024	**In progress** Topics have been added to the list for further consideration and scheduling

Completed Actions					
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 2024	**Completed and ongoing** Presentation on Cancer in CTM was presented to the Board at the Development Session held on 25 April. Follow up session in the process of being scheduled

Agenda Item
4.2

CTM Health Board

CHIEF EXECUTIVE'S REPORT

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Matthew Butt, Chief of Staff
Cyflwynydd yr Adroddiad / Report Presenter	Paul Mears, Chief Executive
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Paul Mears, Chief Executive / Accountable Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ACSP	Acute Clinical Services Plan
DTOC	Delayed Transfer of Care

1. Situation /Background

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

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

2. Specific Matters for Consideration

2.1 Escalation Status

At the March Board meeting, I updated colleagues on the year end position in relation to the escalation status of the health board. The Health Minister previously confirmed there would be no change to our escalation status following the winter tripartite meeting and would be required to submit our assurance evidence in advance of the summer meeting.

I am pleased to advise the Board that on 26 April, the Health Minister announced the de-escalation of CTM to 'routine arrangements' for maternity and neonatal services, quality governance and trust and confidence.

Our updated escalation status is summarised in the below table:

Area	**Previous Status**	**Updated Status**
Planning and Finance	Enhanced Monitoring	Enhanced Monitoring
Performance – Associated with long wait times	Targeted Intervention	Targeted Intervention

The de-escalation of maternity and quality governance is a significant achievement for our organisation following many years of hard work to deal with significant issues that were previously highlighted by external reviews. I would like to extend my sincere thanks to the many colleagues that have contributed to this successful achievement across maternity and neonatal services and our quality governance processes.

We remained focussed on delivering the improvements in our performance trajectories as agreed with Welsh Government. Monitoring and assurance of this continues to be delivered via monthly oversight meetings between CTM leads and Welsh Government colleagues.

2.2 Integrated Medium Term Plan

We have received initial feedback from Welsh Government on the IMTP submitted at the end of March. Whilst broadly supportive of the plan there was further clarification sought on the investment choices by the Board and any potential quality impact of these.

We have also received updated performance targets which all Health Boards are being required to deliver. These provide further stretch against the targets agreed for the IMTP submission and more detail on these will be shared in the performance update in today's meeting.

2.3 Delayed Transfers of Care Task Group

Following the patient story presented to the Board at the last public meeting which highlighted the challenges for patients waiting for onward care I undertook to update Board members on how we are proposing to have a renewed focus on improvements in our position. I invited a group of frontline clinical, operational and executive colleagues to a focused workshop session to discuss the scale of the challenge CTM is currently facing in relation to delayed transfers and to gather their thoughts on the potential for different solutions to this long-standing problem.

I have now formed a Chief Executive Task Group aimed at scoping and testing new, collaborative and innovative models which we in the Health Board can develop. The first meeting of this group was held on 7 May and there was a real willingness from the staff involved to think differently about how we tackle this problem and improve the care we provide for patients with more people being cared for in their own home after discharge from hospital. We are in the process of establishing workstreams under this task group to develop the potential solutions and I will aim to bring further updates on this work to the July board meeting.

2.4 Executive Priorities 2024/25

As the Board will be aware, our Integrated Medium Term Plan (IMTP) was submitted to Welsh Government in March. Whilst there are internal planning and assurance mechanisms in place to monitor and track our corporate and care group operational plans, the executive team are in the process of compiling a high level set of priorities for this financial year, linked to our corporate goals. This will outline the highest priority actions to be taken, in support of the formal submitted plan. Once compiled, I will share with the Board during a briefing session, to provide an overview of the key executive priorities and timescales across this year.

2.5 Seren Awards

Since the launch in September last year, 1,100 staff have received Seren Awards in recognition of their excellence and dedication to the care and support of patients, public and colleagues.

These peer-to-peer awards are entered into our Seren of Month shortlisting and we are pleased to have now presented seven Seren of the Month Awards, with winners drawn from the breadth of our services.

April '24: Paul Sullivan, Pharmacy Technician, Prince Charles Hospital

March '24: Lisa Jones, Community Mental Health Nurse, Maesteg

February '24: Nicole Overton, Health and Safety coordinator, Bridgend

January '24: Deborah Barron, Therapies Administrative Support Officer, Ysbyty Cwm Cynon

December '23: Joelene Hoskins, Midwife, Tirion Birth Centre

November '23: Yvonne Haggett, Mortuary Services Manager, Royal Glamorgan Hospital

October '23: Louise Quealey, Advanced Nurse Practitioner, HIV services, Dewi Sant Health Park.

2.6 National Nosocomial COVID-19 Programme

The Health Minister wrote recently to thank the Health Board and staff for the valued work undertaken, which contributed to the successful conclusion of the National Nosocomial COVID-19 programme.

18,360 cases were investigated across NHS Wales, with 3233 cases being investigated at CTM, with these investigations helping to provide answers to families and loved ones. Whilst acknowledging the impact of COVID-19 on service users, families, carers, and NHS Wales staff the programme adopted an approach to maximise learning and improvement opportunities. The final learning report will be published and circulated in due course.

3. Key Risks / Matters for Escalation

3.1 Delivering the Q4 performance trajectories to ensure de-escalation with Welsh Government in Q1 2024/25.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

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

Agenda Item
5.1.1

CTM Health Board

CHAIR'S HIGHLIGHT REPORT FROM THE CHARITABLE FUNDS COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Tyler Lewis, Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Lynda Thomas, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance & Procurement

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
CFC	Charitable Funds Committee
NHSCT	NHS Charities Together

1. Situation /Background

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Charitable Funds Committee which took place on 23 April 2024.

1.2 Key highlights from the meeting are contained in section 3.

1.3 The Board are requested to **NOTE** the contents of the report and actions being taken.

2. PURPOSE OF THE CHARITABLE FUNDS COMMITTEE

2.1 The purpose of the Committee is to make and monitor arrangements for the control and management of the CTMUHB's Charitable Funds.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	The CFC held an in-committee session to consider a confidential matter regarding a legacy, and agreed a course of action.
ADVISE	**Ratification of Chair's Action – Stage 3 NHS Charities Together Recovery Grant** • The Committee received the report and ratified the approval under Chair's Action for the Stage 3 NHS Charities Together Recovery Grant funding for the ICU Psychology Service. **General Charitable Funds Update** The Committee **received** the report and noted; • Ongoing process to ensure that all funds have identified fund holders which reflect the updated organisational structure following the Phase 2 reorganisation. • A review of low value funds will be undertaken once the new Head of Charity comes into post.
ASSURE	Nil

INFORM	• The Director of Communications, Engagement, and Fundraising advised that the recruitment process for the **Head of Charity & Income Generation** vacancy was underway, with a Stakeholder session and interviews scheduled for Friday 26 April 2024. • Unconfirmed Minutes of the Meeting Held on 26 October 2023 were **APPROVED.** • Unconfirmed Minutes of the IN-Committee Meeting held on 26 October were **APPROVED.** • The Committee received and **APPROVED** the Annual Cycle of Business for 2024-25.
APPENDICES	**NOT APPLICABLE**

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Not Applicable If more than one applies please list below:

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

4. Recommendation

4.1 Members of the Board are asked to **NOTE** the report.

Agenda Item
5.1.2

CTM Health Board

Highlight Report from the Stakeholder Reference Group

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Anne Morris Chair, Stakeholder Reference Group
Cyflwynydd yr Adroddiad / Report Presenter	As above.
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
IMTP	Integrated Medium Term Plan

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the CTMUHB Stakeholder Reference Group at its meeting on 11th April 2024

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of the CTMUHB Stakeholder Reference Group is to provide independent advice on any aspect of UHB business. This may include: -
- Early engagement and involvement in the determination of the UHB's overall strategic direction;
- Provision of advice on specific service proposals prior to formal consultation; as well as
- Feedback on the impact of the UHB's operations on the communities it serves.

2.2 The CTUHB Stakeholder Reference Group will:-

- Provide a forum to facilitate full engagement and active debate amongst stakeholders from across the communities served by the UHB, with the aim of reaching and presenting a cohesive and balanced stakeholder perspective to inform the UHB's decision making.

3. Highlight Report

Alert / EsAcalate	• **Ratification of Chair for a further 12 months** Members were asked if they would like to consider ratification of the current Chair for a further 12 months, a significant number of positive, supporting emails had been received and members agreed the ratification of the current Chair for a further 12 months, acknowledging that this will require agreement by the Minister.
Advise	• **Stakeholder Reference Group Annual Self Effectiveness Survey Outcome Report with Improvement Plan 2023/2024** The outcomes of the survey and proposed actions within the Improvement Plan were discussed and approved amongst members. In response to the areas of improvement identified the following actions will be undertaken:

	• Chair's Highlight Report to be shared with members prior to being submitted to Board, so that members can ask the Chair for any additions. • SRG Members to email Committee Secretariat their training requirements • Members to note the new process for raising concerns related to SRG. • Members to review meeting culture and passive and active listening slides. • Some SRG meetings to be held face to face throughout the year. • A new process for closing items on the agenda be implemented. • Members to be directed to the Service Change Webpage when it becomes available. • SRG in future to consider if a matter requires referral to another forum and implement new process for that referral. • **Number of Stakeholder Reference Group Meetings Per Annum** As agreement had been made by Board, Stakeholder Reference Group will now meet 4 times per year plus 1 ad hoc meeting as required.
Assure	• There were not items requiring inclusion in this section
Inform	• **"Getting to Know You"** The SRG on 11th April 2024 was a face to face workshop and this provided a useful opportunity for members to get to know each other, share information about themselves, their backgrounds and roles. • **Update on Integrated Medium Term Plan (IMTP) and finance** The Assistant Director of Transformation & Operational Planning gave an update on IMTP. The 3 year plan had been approved by the Health Board on 28th March 2024. The three-year plan sets out to achieve financial balance, however the required savings plans and risks associated with achieving this balance were noted. The plan was formally submitted to Welsh Government on 28th March 2024.

	• **Work Programme and Forward Planning** Discussion was held about future topics for the SRG Work Programme going forward and a number of topics were added to the Work Programme for 2024/2025. Members will forward any addition topics to the Committee Secretariat.
Appendices	•

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	If more than one applies please list below:

5. Recommendation

5.1 The Board is asked to **NOTE** the highlights outlined in section 3 of this report and to consider **RATIFICATION** of the number of meetings per annum as outlined in section 3

Agenda Item
5.1.3

Quality & Safety Committee

Highlight Report from the Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Carolyn Donoghue, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Quality & Safety Committee at its meeting on 14 March 2024.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

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

Alert / Escalate	• The report from the **Clinical Executives** was received. A discussion was held and concerns were raised in relation to the ongoing issues being experienced in relation to boarding of patients. The Committee Chair recognised that the impact on patient dignity and safety was significant and added that she felt concerned that boarding of patients was becoming normal practice and was part of the day to day management of patients which was a risk to both patients and the Health Board. The Committee Chair advised that this practice is below the standard of care and experience the Health Board would wish to afford its patients and staff and that it will continue to be escalated as an area of concern to the Board.
Advise	• The Committee received a **Spotlight Presentation from the Acute Oncology Service**, which included a selection of patient stories. The presentation was welcomed by Committee members who noted that the issues highlighted in relation to resourcing and inequity of service would be discussed further at the Operational Management Board;

	• The **Care Group Quality & Patient Experience and Safety Care Group Highlight Reports** were received and matters contained within the Alert/Escalate sections were discussed and noted; • The **Organisational Risk Register report** was received. Members welcomed the discussions that had taken place in relation to the emerging risks and how they had been mitigated; • The **Healthcare Inspectorate Wales Action Plan Tracker** was received. Members noted that the tracker would be developed further moving forwards, with work being undertaken with System Developers on system content in relation to utilising the Inspection Module in AMaT; • The **Patient Safety, Quality & Experience Dashboard** was received. Members recognised the significant progress being made and it was felt the Care Group system was now starting to embed in regards to how the reports were being generated; • The **Mental Health Adult Inpatient Improvement Programme** was received and noted; • The **Stroke Services Progress report** was received. Committee Members advised that whilst they were pleased to see the progress being made towards regional working, concerns remained that despite the efforts being made, there continued to be reporting of poor results. The following items were received and discussed at the In Committee session: • Listening & Learning story in relation to care provided to a patient with Learning Disability; • Maternity & Neonatal Incident Cluster Review; • Review of Health Visiting Services in Bridgend.
Assure	• The **Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity Annual Report** was received. Assurance was provided that the Team were prioritising packages based on risk and those which were overdue; • The **ICTM Annual Report** was received. Members felt that the innovative work being undertaken by the small team of staff was very impressive and expressed the importance of staff recognising that they have something to offer and encouraging staff to share their ideas and areas of challenge.

Inform	• The following items were received via the consent agenda for approval:
	  ○ Unconfirmed Minutes of the meeting held on 23 January 2024;
	  ○ Unconfirmed Minutes of the In Committee meeting held on 23 January 2024.
	
	• The following items were received via the consent agenda for noting:
	  ○ Action Log;
	  ○ Committee Annual Cycle of Business;
	  ○ Committee Forward Work Programme;
	  ○ Clinical Audit Quarterly Report;
	  ○ Clinical Audit Forward Plan 2024 – 2025;
	  ○ Radiation Safety Committee Highlight Report;
	  ○ Covid 19 Inquiry Preparedness;

Appendices	• Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.1.4

CTM Health Board

Highlight Report from the Hosted Bodies Audit & Risk Committee

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance Gareth Watts, Director of Corporate Governance & Board Business

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Hosted Bodies Audit & Risk Committee at its meeting on 18 April 2024.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

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.

Highlight Report

Alert / Escalate	• The Committee received a verbal update on the new **Wales Joint Commissioning Committee (JCC)** that would be established from the 1st April 2024. The Committee noted that all outstanding recommendations and risks would be collated and passed to the JCC as part of the Welsh Health, Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU) Legacy Statements and would be received at the next meeting of the Committee in June 2024. The Committee were advised that the Accountable Officer Memorandum and Interface Agreement would be finalised shortly and taken forward for Approval.

	Members noted that a Risk Framework was being developed so that the JCC would have an equivalent to the Board Assurance Framework. Members noted the assurance provided with regard to the Organisational Change Policy (OCP) process and that the final Accounts would be submitted in April
Advise	There were no matters to advise.
Assure	There were no matters to raise with regard to assurance.
Inform	• The Unconfirmed Minutes of the meeting held on 22 February 2024 were **APPROVED.**
Appendices	• Nil

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

4. Recommendation

4.1 The Board is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.3

CTM Health Board

BOARD ASSURANCE FRAMEWORK REPORT

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Strategic Risk Owner updates	April 2024	Reviewed and signed Off
Executive Leadership Group	*13th May 2024*	*Pending*

Acronyms / Glossary of Terms	
BAF	Board Assurance Framework

1. Situation /Background

1.1 It is good practice for the Health Board to have a Board Assurance Framework (BAF) that clearly sets out the risks, actions and relevant sources of internal and external assurances to provide a clear picture of the 'health' of the organisation and the high level risks threatening delivery of the Board's strategic goals.

1.2 The Board at this May 2024 meeting are being asked to approve that the BAF remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board. An Internal Audit review of the Board Assurance Framework resulted in an outcome of Substantial Assurance during 2023.

2. Specific Matters for Consideration

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

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

2.2 The Organisational Risk Register is received in its entirety by the Audit & Risk 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

3.1 During April 2024, 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 In addition to updates significant changes have been made as follows:

- Strategic Risk 3 – ***Sufficient workforce to deliver the activity and quality ambitions of the organisation –*** *has had a significant review this period which included changes to how the risk is described.*

- Following the closure of the "Finance Revenue Resources" risk in March 2024, the Finance Directorate have developed a new strategic risk, which is strategic risk 10 – ***"Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government".***

3.4 The Executive Director of Finance is developing a new Strategic Risk for the BAF in relation to ***Capital and Estates*** which is being developed and risk assessed by the Assistant Director of Planning (Capital and Estates), with the support of the Assistant Director of Governance & Risk as required.

3.5 The People Team are undertaking a thorough review of the following risks to ensure they remain reflective of the current risks:

- ***Strategic Risk 6 - Leadership and Management***
- ***Strategic Risk 7 – Culture, Values and Behaviours***

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Dying Well, Growing Well, Living Well, Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Culture and Valuing People, Data to knowledge, Learning, Improving and Research, Whole- system Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Equitable, Person Centred, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to an Impact Assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail captured for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail captured for each risk	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	See detail captured for each risk	

5. Recommendation

5.1 The Health Board is asked to:

APPROVE

- The updates to the BAF Report for May 2024 as captured in Appendix 1.
- The changes outlined in Section 3 of this report.

6. Next Steps

6.1 Routinely review the risks captured in the BAF to it 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.

CTMUHB - BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee	Current score	Scoring Trajectory *(since the last report received by the Board)*
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)	No change as at May 2024 
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 as at May 2024 
3.	**Sufficient workforce to deliver the activity and quality ambitions of the organisation** Click Here for Risk 3	**Sustaining our Future** 	Executive Director of People	People & Culture Committee	**20** (C5xL4)	No change as at May 2024 
4.	**Community and Partner Engagement** Click Here for Risk 4	**Creating Health** 	Director of Communications, Engagement & Fundraising	Population Health & Partnerships	**12** (C4xL3)	No change as at May 2024 
5.	**Delivery of a digital and information infrastructure to support organisational transformation** Click Here for Risk 5	**Improving Care** 	Director of Digital	Digital & Data	**16** (C4xL4)	No change as at May 2024 
6.	**Leadership and Management** Click Here for Risk 6	**Inspiring People** 	Executive Director for People	People and Culture	**12** (C4xL3)	No change as at May 2024 
7.	**Culture, Values and Behaviours** Click Here for Risk 7	**Inspiring People** 	Executive Director for People	People and Culture	**12** (C4xL3)	No change as at May 2024 

8.	**Fulfilling our Environmental and Social Duties and ambitions** [Click Here for Risk 8]	**Sustaining our Future**	Executive Director of Strategy and Transformation	Population Health and Partnerships	**16** (C4xL4)	No change as at May 2024 ⟷
9.	**Healthy Life Expectancy** [Click Here for Risk 9]	**Creating Health**	Executive Director of Public Health	Population Health and Partnerships	**20** (C5xL4)	No change as at May 2024 ⟷
10.	**Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government** [Click Here for Risk 10]	**Sustaining our Future**	Executive Director of Finance	Planning, Performance & Finance Committee	**16** (C4xL4)	New risk escalated May 2024

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		***3***		**3**	
	4		***4,8,7,8***	**4,6,7** ***1,2,5,9,10***	**1,2,5,8,9,10**	
	3					
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

Section 3 –Strategic Risks

Strategic Goal: **Improving Care** • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care	Risk score **16**

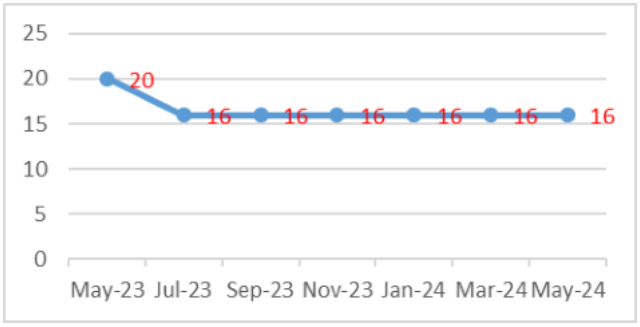
Strategic Risk: **Sufficient capacity to meet emergency and elective demand - (Risk No.1)**		
If the Health Board is unable to meet demands for services at all points in the patient journey.	***Then*** its ability to provide high quality and affordable care and to meet access targets will be reduced	***Resulting in*** avoidable harm to patients, poor patient experience, diminished staff morale, and loss of trust and confidence from the wider community, ongoing overspends.

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

Risk Score Trend this Period:

No change as at May 2024

Risk Score Trajectory



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

Whilst improvement against all Tier 1 trajectories are being sustained, the risk score has been reviewed and remains unchanged on this occasion. The Planned Care Group and Unscheduled Care Group are currently reviewing the 2024-2025 targets and trajectories which is likely to lead to this risk being separated so there will be an Emergence Demand Risk and an Elective Demand Risk.

The potential impact of industrial action on services is also a determinant for the risk score to remain as a 16.

The financial and economic challenges faced by the third sector and local authority partners

	has an impact on the Health Boards ability to mitigate this risk. 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. No change as at May 2024.
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.	• 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

Further Faster – further faster funding has been released from Welsh Government on a recurrent basis which will focus upon:

- Acute Community Team (ACT)expansion
- Virtual Ward development and roll out
- Navigation hub expansion, including expansion of professions within the Multi-Disciplinary Team.

Planned Care Recovery Programme

- Enhanced monitoring process for Cancer Services – twice weekly focussed meetings
- Llantrisant Health Park site plans under development
- Clinical Services Plan Group being established (27th April inaugural meeting)
- Speciality Specific and Cancer Improvement Trajectories Completed.

IMTP – investment agreed by Board in March 2024 for £44m recurrent funding for frontline services.

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.

Development of Acute Clinical Services Plan.

Specific Improvement Groups/Boards

- Stroke Strategy Group, Stroke Programme Board and Stroke Operational Group embedded.
- Pathology Improvement Group
- Ophthalmology Improvement Board
- Dermatology Improvement Board
- Ear Nose Throat Transformation Board
- Theatres Transformation Board

down. Embedding IA process into daily huddle meetings.

- Planning, Performance & Finance monthly report.
- TI meetings
- Planned Care Recovery Operations Board.

- Trauma and Orthopaedic Improvement Board
- Critical Care Unit (CCU) Transformation Board
- Outpatient Improvement Board
- Adult Inpatient Mental Health Improvement Board.

All updates feed into the Planned Care Recovery Operations Board.

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. This plan was refreshed for winter for urgent care.

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/Unscheduled Care Board • Cancer Board to now be led by the Assistant Medical Director (Acute Services) and is being refreshed. • Weekly Cancer Meetings • Planned Care Recovery Board/ Planned Care Recovery Operations Board. • Innovation Board **Operational Processes** • Clear criteria to prioritise based on clinical need • Centralised decision-making around use of spare capacity across the organisation. • Robust Interventions Not Normally Undertaken (INNU) application.	
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.~~ Completed and now at assurance stage as programme of work now being managed by Care Groups, overseen and held to account by the Six Goals Programme Board. • Focussing on the key workstreams integration with the Care Groups now fully embedded ensuring that the Six

	Goals Programme Board has oversight of the current action plan. • 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	• Implementation of online escalation process for all patients outside of agreed component waiting times. • Canisc replacement ongoing. Implementation of Breast, Urology & lower GI datasets • Training undertaken for all cancer trackers to ensure consistency and compliance with new guidance (issued July 23).
• – Improvements being made in elective care trajectories albeit not fully embedded.	• Contract awarded for endoscopy insourcing to increase endoscopy capacity. Commenced in November 2023. Planned Care Group currently updating this in terms of the latest position. • Commenced additional outsourcing of Glaucoma patients. • 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.6-4-2 Theatre Management used across all sites. • Reconfiguration of Trauma ongoing assessment • 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. A further theatre opened in July 2023 at Princess of Wales Hospital (POW) as a hybrid model using POW and ID medical staff. The Health Board has now recruited substantively and will be exiting the external agency medical contract Quarter 4.

	• 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 scheduled and first one to be held in August 2023. Winter plan meetings continue.~~ Winter plan de-brief being worked through in readiness for lessons learnt and forthcoming winter readiness. • In Development – Acute Clinical Services Plan.
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 from point of suspicion (regardless of the referral route). • Patient and delayed ambulance handovers (15min handover)	The following key performance indicators should be considered from the Integrated Performance Dashboard: • Urgent care • planned care, • cancer • and diagnostic indicators

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**
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**
5590	Radiopharmaceutical Business Interruption.	**20**
~~1133~~	~~Long-term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).~~ Risk de-escalated from the Organisational Risk Register in May 2024 as risk score reduced to a 12.	~~**20**~~
5417	Paediatric dentistry – General Anaesthetic theatre list. New risk escalated to the Organisational Risk Register in March 2024.	**16**
3131	Mortuary Capacity	**16**
5404	Post Mortem Backlogs in Mortuary.	**16**
4152	Back log for Imaging in all modalities / areas and reduced capacity	**16**
2808	Waiting Times/Performance: ND Team	**15**

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IMPROVING CARE	Strategic Goal: **Improving Care** • Delivering safe and compassionate care • Developing new models of care • Digital transformation for patients and staff • Ensuring timely access to care	Risk score **16**

Strategic Risk: **Ability to deliver improvements which transform care and enhance outcomes (Risk No.2)**

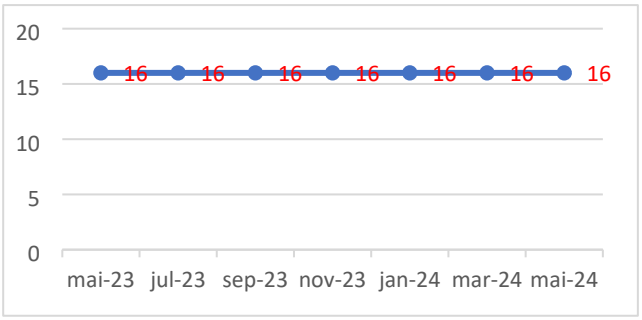
If the Health Board fails to achieve fundamental quality standards or implement improvements in practice and innovations	***Then*** we may not be able to deliver safe, timely, compassionate and effective care in accordance with the Duty of Quality	***Resulting in*** avoidable harm to patients, poor patient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

	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:

No change as at May 2024

Risk Score Trajectory



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

Whilst improvement against trajectories continue to improve the risk score has been reviewed and remains unchanged on this occasion.

Detailed discussion was held in August 2023 to consider reducing the likelihood score to a 3, in response to the positive progress being made e.g. HIW AW Joint Review into Quality Governance arrangements review outcome. However, in triangulating the risk description with incidents and complaints data, and in considering the mitigation activity still underway a decision was made to retain the likelihood score at a 4. Phase 2 of the Organisational Change Process is complete however, as that structure matures and

	develops the risk score will remain unchanged with a review in coming months. 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. It is also recognised that cultural change can only be achieved over time.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however, ongoing risk treatment activity outlined in the mitigating actions section.

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

Controls	Assurances reported to Board and committees
Quality Frameworks and Policies • Strategic review of Infection, Prevention & Control (IP&C) is underway which will result in an IP&C Strategy 2024-2026. Review outcome scheduled to be received at the Quality & Safety Committee in May 2024. • Development of the CTM Safeguarding Strategy 2024-2027. Paused due to national review underway which will inform CTM's approach. • Quality & Safety Framework approved by the Board in January 2023, which is aligned to the Care Group Model, is fully embedded across CTM; • Clinical Guidelines; • Suite of Standard Operating Procedures; • Clinical Education Framework; • The Incident Management Framework, was launched in June 2022 to reflect national changes in national incident reporting; following consultation across CTM, the Incident Management Framework has been updated and was approved in January 2024 at the Quality & Safety Committee. • Incident Investigation training established and being rolled-out across the Health Board on a monthly basis; • Clinical Education Forum (providing overarching Governance) established and	**External Reports** **HIW / AW – Quality Governance Arrangements Joint Review Follow-Up – August 2023:** The follow-up review found the Health Board has made significant progress in addressing the concerns and recommendations of the 2019 report. It has a stronger strategic focus on quality and patient safety, and there is greater clarity on roles and responsibilities in relation to quality and patient safety compared to 2019. The organisation's scrutiny of quality and patient safety has also improved considerably, with greater openness and transparency. There is also greater awareness of risk management across the organisation, and clearer processes in place for identifying, managing, and escalating risks. The Health Board's concerns and complaints processes are much clearer, and new corporate roles have been created to support implementation and ensure consistency. There is also an improved culture of learning, with a series of arrangements now in place to support the sharing of learning and improvement across the organisation. **Annual Reports** • Clinical Audit Annual Report;

continuing through 2024. The Board received the annual report in November 2023.

- Listening & Learning Framework launched and implemented at the Listening and Learning Event in September 2022. A further Listening and Learning Event was held in May 2023 and planning is underway for the next event which is planned for the 26th June 2024. In the meantime, to raise awareness of the new Quality Act responsibilities, the Health Board is undertaking road show events from September and working collaboratively with the Improvement Team. Planning for a spring/early summer event is underway.
- Quality Strategy. A Quality Strategy, Annual Action Plan supports the achievement of the deliverables within the Quality Strategy. Update received at the Quality & Safety Committee in January 2024. Annual Quality Work Plan received in January 2024.
- Accreditation Programme Framework established and will go-live from April 2024.
- Nursing and Midwifery delivery plan to be received at the May 2024 Quality & Safety Committee.
- 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 including the roadshow events mentioned above. The duties within the act are integral to the Quality Strategy and have been built into Board and Committee report templates from November 2023.
- CTM Allied Health Professionals and Health Care Science Delivery Plan. ~~development.~~

Learning from Experience

- New Patient Experience Forum established, with the inaugural meeting taking place in April 2024.
- Executive and Independent Member Patient Safety Walkabouts framework complete and implemented.
- Clinical Education Annual Report;
- Safeguarding Annual Report;
- Putting Things Right Annual Report;
- Infection Prevention and Control Annual Report;
- Medicines Management Expenditure Committee Annual Report;
- Organ Donation Annual Report.
- Health and Care Standards Annual Report; (incorporating patient survey)
- GMC Survey
- Improvement to be reported through Improving Care Board / Change to be reported through Strategic Transformation Board;

Quarterly Reports

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

Internal Assurances

- Executive and Independent Member Patient Safety Walkabouts framework. The revised framework now implemented which includes 'Purpose, Form and Function' of IM Walkaround Visits.
- The Health Board has strengthened the internal governance of all HIW open action plans by developing a central tracker system where any exceptions will be reported to the weekly clinical executive patient safety catch-up. HIW Tracker is now in place;

- Citizen's Voice bodies (Llais) launched in place of CHCs. Unannounced visits by Llais has recommenced and monthly meetings have been set up with Llais and the corporate team for early escalation and assurance of issues.
- Mortality Review programme secondary care established and continues to embed. Medical Examiner reviews fully incorporated. Focus level 2 / 3 reviews across CTM;
  From September 2024, community deaths will need to be included in the Mortality Review Programme with new processes and systems developed to accommodate this requirement.
- Shared Listening and Learning Forum currently paused to consider amalgamating with other forums to avoid duplication. Led by the Deputy Executive Director of Nursing.
- Community Acquired Pressure Ulcer Collaborative. A new collaborative has been created for falls reduction / harm reduction. Forum for shared learning on prevention and improvement with internal and external stakeholders e.g. (Welsh Wound Innovation Centre (WWIC) and Local Authorities). Steering Groups being established for Pressure Ulcers and Falls that will feed into the remit of a new forum being established, Harm Review Forum.
- 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 (current system Civica) being rolled out across the Health Board (PREMS), now rolled out across Emergency Departments. New software procured to replace Civica and to collect PREMS and PROMS - 2024 roll out plan in development with new supplier and CTM teams.
- Launched Nursing & Midwifery Delivery Plan and agreed a set of nursing care related audit standards monitored via the Senior Lead Nurse Forum with onward reporting on annual basis to the Quality & Safety Committee.~~which are being monitored through AMaT platform.~~
- 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.
- Medicines Safety Group, Access to Medicines Group established. Replacing the Medicines Formulary Committee with a broader remit.
- Peer reviews of specific services e.g. critical care;
- Health Inspectorate Wales unannounced visits;
- Medication Prescription and Administration incident update, which reports into the Medication Steering Forum.
- All Safeguarding Hubs working collaborative across CTM population;
- Planned Level 3 Safeguarding training for all Senior Clinical leaders (Execs – Care Group directors); Completed. Plan in place to roll out to all Care Group Clinical Directors and equivalents once in place.
- Multi-agency training days established and being rolled out in terms of Safeguarding training, with the aim of maintaining robust and strong engagement and relationships with agency partners.
- 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 / Falls Reduction Collaborative;
- 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;

- Following discussions in relation to the operating model that will support the new Care Groups it is considered that Quality Assurance has been embedded within the quality reporting structures.
- Patient Safety Clinics, targeting service areas with high or low incident reporting;
- Learning from events coordinator role in place, with lesson of the week via social media and a monthly newsletter is shared across the Health Board sharing learning around incidents and concerns;
- Patient Reported Outcomes Measures system procured and piloted in Heart Failure / Cardiology services and plans in place to roll out across HB (PROMS); PROMS provider selected for CTM wide – procurement complete and roll out plan for 2024 in development. (Linked to PREMS and Civica replacement update above). PREMS now live in Emergency Departments.
- Staff ideas scheme launched across CTM for staff to provide ideas for improvement and collaborate on solutions; Over 1000 individuals registered and using the system.
- 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 concerning advanced practice professionals.

Innovation & Improvement Programmes

- Quality Improvement showcase event held in July 2023 to highlight and share best practice improvement initiatives across CTM. 2024 event taking place July.
- Improvement Community of Practice implemented with over 30 QI champions currently in place.
- Executive Director of Nursing and Executive Director of Therapies and Health Science have undertaken the relevant training on Duty of Quality & Duty of Candour to ensure that there is sufficient knowledge and influence in relation to the legislation at Board level.
- HIW undertake adhoc reviews of medical training within the Health Board.
- Review of Interventions Not Normally Undertaken (INNU) processes to ensure there are robust levels of compliance within clinical practice and appropriate assurances provided.

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~~ Service User 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/deputy executive led patient safety meetings;
- Performance and Assurance Directorate of the NHS Executive—Dashboard reports inform the Health Board in terms of compliance across the Patient, Care and Safety portfolio;
- CTM now have access to the All Wales Beacon Dashboard which allows us to benchmark quality metrics.
- iCTM joint working with academic partners to explore cutting edge quality and safety activity to support the Health Board's continuing improvement journey;
- The Health Board is represented at the Duty of Quality & Duty of Candour all Wales meetings which concluded in March 2024, however, additional meetings will

- Healthcare Pathways Initiative – writing and establishing guidelines from primary to secondary care referrals.
- Theatre Utilisation Group established to pilot the WG initiative to drive efficiency and standardise theatre processes across the Health Board.
- iCTM (Improvement & Innovation) department in place and 2022-2025 iCTM business plan developed aligned to CTM 2030 focusing on Experience, Efficiency and Effectiveness all underpinned by Improved outcomes and Patient Safety;
- Leading for Patient Safety with Improvement Cymru and Institute for Healthcare Improvement (IHI) launched. Work plan established and programme continuing for 2023/2024; Shared learning event held in November 2023. Working with Improvement Cymru to develop the continuation of the collaborative, next meeting scheduled for May 2024 to agree next steps.
- Improvement and Innovation CTM are actively supporting a number of services, a full list is available from iCTM.
    - ~~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.~~
    - ~~Launch of Adult Inpatient Falls Reduction Programme (Adult Mental Health) in early October 2023.~~
- Related escalation Status activity;
- 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;

be held in the future as required to benchmark and share learning;

- 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 & Care Group 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;
  The AmAT Inspection Module is being implemented for HIW Audit Recommendations with the first report being received in May 2024, which will be a hybrid approach as CTM fully transitions to the new automated system.
- Performance and Assurance Directorate of the NHS Executive governance and incident management;
- Performance and Assurance Directorate of the NHS Executive Maternity and Neonatal SI closures;
- Annual Undergraduate Review;
- General Medical Council National Survey Feedback;
- 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;

• Enhanced resources in place for business analysis / data analysis to identify areas of improvement and change through data; • Innovation programme aligned to Value Based Healthcare principles; • Leading and empowering Improvement and Innovation built into the new Ignite, Aspire and Inspire leadership programmes; • Implementation of Care Group Improvement Faculties; • Medical Workforce & Nursing Workforce Productivity Programme established; • Appointment of the Bereavement Clinical Lead to support the implementation of the All Wales Care of the Bereaved Framework and Pathways. • The Improvement Team have aligned resource to care groups and are meeting care group management on a monthly basis to discuss quality improvement activity. • The Deputy Executive Director of Nursing is a steering group member led by WG on the national safeguarding review for health, commissioned by the CNO. This will be due for completion in June 2024. • The Deputy Executive Director of Nursing is a steering group member, working with WG on a program of work following a recent national report on Sexual Safety and associated safeguarding concerns. • Duty of Quality and Duty of Candour Training will be ongoing as required as the Act is embedded within the Health Board. Data on Duty of Candour now routinely reported through weekly Executive Director Led Patient Safety Weekly meetings. Duty of Quality will continue to embed into services. **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. Clinical	• 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; • Following the completion of all tasks and actions set out during the escalation process, it was recommended that Ty Llidiard be de-escalated to Level 0 and out of escalation entirely. This was agreed at a meeting of the WHSSC Corporate Directors held on Monday August 14th. Routine performance monitoring meetings will be set up from September 2023 in line with the WHSSC Performance Framework.

Directors have now been appointed to support this process. • Nursing Productivity Groups operational	
Gaps in Controls and Assurances	**Mitigating Actions**
• Roll out of the Clinical Ward/Department Assurance Programme.	Rolling programme commencing April 2024.
• Strategy & Framework Reviews and Development ○ ~~Incident management framework~~ ○ Safeguarding Strategy ○ IPC Strategy	Timeframes: • ~~Review underway, timeframe end of January 2024.~~ Completed. • Development of a strategy, timeframe end of ~~March~~ July 2024. Paused due to anticipation of the National review expected circa May 2024. • Development of a strategy, timeframe end of March 2024. Revised to May 2024.
• Data and Audit - Real-time performance and quality data accessible via electronic systems across the organisation;	• Mortality Data Improving – should be in place by end of September 2023. Baseline position established by the end of September with dashboard development to follow in the coming months. Implementation delayed due to Digital and Data Team capacity constraints. Progress meetings scheduled with a new timeframe to be agreed. To further support the pace of this activity, the Medical Directorate have engaged the Chief Information Officer to support data intelligence. Data should be available for the purpose of analysis by April 2024. Progress being made, remains on track for April 2024. Proforma agreed – data validation in progress. Availability of the proforma for use is planned for July 2024. The data once the proforma has been implemented will be reviewed initially circa September 2024. • CTMUHB is represented on the work being undertaken with the Performance and Assurance Directorate of the NHS Executive to explore how benchmarking in quality performance can be shared across NHS Wales. The Performance and Assurance Directorate of the NHS Executive are also rolling out a National Quality Safety Framework to support a consistent approach to quality reporting. Timescales dependent on external sources; • Ambition to develop live clinical quality dashboard – live for maternity and

	neonatal services– to be rolled out for other areas by the end of the financial year; Work in progress for other areas. • Improving Care Board has developed a portfolio of improvement programme and projects. Monthly governance meetings established. Move to control next period. • National Safe Care Collaborative Programme Audit recommendations and action plans led by IHI and Improvement Cymru – by the end of 2024; Next steps currently being explored to ensure sustainability.
• Feedback from staff and our communities on the ability to raise ideas, freedom and support to make change and empowerment. Holding engagement sessions for staff;	• Staff ideas scheme implemented (May 22) for raising ideas for improvement – to increase participation in 23/24 – Implemented. Ongoing and numbers increasing through the year. Onsite events planned for Quarter 1/ Quarter 2 2024-2025. • Improvement into practice training taking place every other month. • Permanent funding secured for PREMs and full deployment across the Health Board is planned. Further activity is also scheduled to increase awareness around the mechanism for sharing feedback using the "Have Your Say" process. Recruited and appointed to posts although post holders have not yet commenced.
• Improving flow and efficiencies and productivity	• 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;	Please refer to the following sections of the Integrated Performance Dashboard to triangulate risk, assurance and performance: • Quality Dashboard • Maternity & Neonatal Dashboard • Cancer Standards; • Unscheduled Care; • Six Goals Programme (Emergency & Urgent Care, D2RA); • Waiting List Delays; • Mortality Indicators; • Tier 1 IP&C Indicators;

• NHS Wales National Framework – Management of patient safety incidents following nosocomial transmission of Covid-19. **Children's Charter** To reinforce children's rights and endorse CTM's commitment to upholding these rights within its services. **Safeguarding** • National Improvement Plan; • Further Mental Capacity Act (MCA) awareness being funded by Welsh Government along with measures to strengthen current Deprivation of Liberty Safeguards until MCA becomes the dominant legislation. • Independent Review (by HIW/CIW) being undertaken of CTM Region Safeguarding Boards in relation to Child Protection Practices including the sharing of information. **Chief Nursing Officer's Launch of the Nursing and Midwifery Priorities – 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	• Nurse Sensitive Outcome Measures – Falls, Pressure Ulcers, medication administration; • Sepsis; • Mental Health Measures; • Putting Things Right Compliance; • Patient Safety Solutions compliance
Were there any significant incidents affecting this strategic Risk this period:	
Significant incidents (NRI or LRI) are managed in according with the Incident Framework and reported to the Quality & Safety Committee.	

Associated Risks on the Organisational Risk Register		
Risk no.	Description	Current score
4907	Failure to manage Redress cases efficiently and effectively	**16**
5254	Failure to manage redress cases efficiently and effectively in respect of the Duty of Candour.	**16**
3133	Non-attendance at medical gas safety training and courses being rescheduled	**16**
4906	Failure to provide evidence of learning from events (Incidents and Complaints)	**16**
4417	Management of Security Doors in All Hospital Settings	**16**
4908	Failure to manage Legal cases efficiently and effectively.	**16**
5646	Impact of Right Care Right Person approached. New risk escalated to the organisational risk register in January 2024.	**16**
3993	Fire enforcement notice – POWH Theatres	**15**
4691	New Mental Health Unit	**15**
~~4732~~	~~Lack of orthogeriatrician as NICE guidance and KPI1 NHFD~~ Risk de-escalated from the Organisational Risk Register as new risk score is 12.	~~**15**~~

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Strategic Goals: **Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value based healthcare • Ensuring our estate is fit for the future	Risk score **20**
Strategic Risk: **- Sufficient workforce to deliver the activity and quality ambitions of the organisation (Risk No. 3)**	

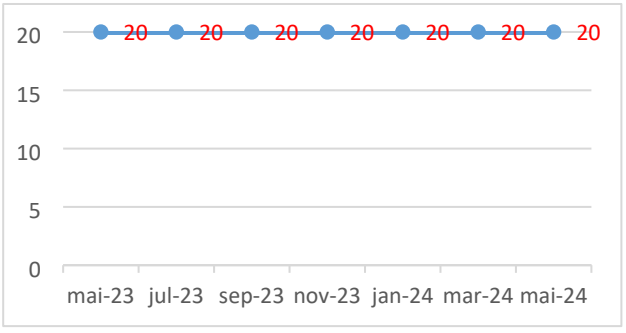
If the Health Board fails to identify and plan for its current and future workforce requirements, and to promote CTMUHB as an attractive place to work	***Then*** we may fail to ensure we have the right people with the right skills and experience, in the right place at the right time and cost to meet service demand. ~~recruit and retain staff with the right skills and experience~~	***Resulting in*** increased gaps in our workforce which adversely affect the quality of care, increased burden on other workforce and the employee experience, with a potential increase in variable pay impacting our ability to deliver high quality and affordable services fit for today and tomorrow. ~~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**	**2**	**10**
Risk Appetite	**Minimal** *(financial stability)* **Cautious** *(quality and safety, (legal and regulatory)*		

Risk Score Trend this Period:

No change as at May 2024.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	This risk is complex and reflects increasing recruitment & retention challenges with skills shortages across health and social care on a local, national and international scale. Therefore, although we are "treating" this risk

	it is recognised that significant progress on this will not be achieved in the short term. Workforce gaps due to lack of available skilled workers either in local or national labour market and we are having to look at alternative options to meet demands and reduce variable pay. International recruitment is being explored but is expensive and not sustainable. Alongside this, innovative solutions such as developing new roles/additional/extended skills take time to grow. The increased burden on existing staff leading to high sickness levels reported as 7.51% in January 2024 reduced in 6.44% in March 2024. Turnover reduced in February 2024 to 11.65% and is 11.55% in April 2024.
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 improved data analytics and strategic workforce planning: workforce transformation, attraction recruitment/ development and retaining our workforce aligned to the current and future workforce requirements.

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

Controls	Assurances reported to Board and committees
Recruitment • Vacancy Scrutiny Panel. • Bank improvement action plan underway • Online recruitment through TRAC. • Review of the CTM 'reducing the time to hire, ownership of the journey' aligned to the NWSSP Recruitment Modernisation Group. • International recruitment of clinical professionals. Development of an International Educated Nursing paper with a recruitment proposal for this year and the next 3 years. • Pathways to Employment programmes (Project Search/Supported Internships, apprenticeships, Network 75, Jobs Growth Wales +, Graduate Activity) alongside NHS graduate training schemes	• Workforce and Organisational Development Metrics report (includes key performance indicators such as staff in post, turnover, sickness) which is regularly reported to the CTM to People & Culture Committee. Data also included in Integrated Performance Report to the Board. Reporting also via Nursing Productivity and Medical Productivity into Values & Effectiveness Board. • Bank improvement plan and International Educated Nurse (IEN) recruitment are standing agenda items at Nurse Productivity. • Medical Productivity meeting includes workstreams on vacancies & recruitment,

- Living Wage employer status
- Medical Recruitment plan in development.
- New Attraction and Resourcing Lead commenced 4 March 2024 currently working on an effective Attraction Strategy initially focussed on nursing and midwifery. Key priorities: increased social media presence, employer branding, student streamlining and attendance at careers fairs to promote CTM as an employer of choice learning to inform future events.
- Actively involved in senior key critical appointments within the People Directorate.
- Reviewing the CTM approach to the selection process.
- Work experience pathway established.

Retention

- Engagement in All Wales Nursing Retention group, alongside launch of local group
- Retaining and Valuing Nurses within the NHS in Wales: A Nurse Retention Plan & HEIW Retention Resources launched 25th September with local plan developed including key areas of focus.
- Career development opportunities, e.g. Apprenticeships, Qualifications & in-house learning and development offer e.g. Leadership & management programmes
- Moving on questionnaires under review with aim of increasing completion rates and providing us with a valuable data source on turnover.
- Lateral Moves Scheme for Band 5 Nurses under development and Midwives launched in February 2024.
- Spring 2024 launch of new All Wales Flexible Working Policy with accompanying promotion and implementation of oversight mechanism.
- Wagestream as a mechanism for regular pay
- Organisational Induction launched
- PDR "Your Conversation" promoting safe and productive environments for managers to interact with and listen to their staff

agency spend, job planning, alternative models and sickness absence.

- Annual Education Commissioning Submission and IMTP Chapter and MDS. This year's IMTP Education and Commissioning submission was approved at ELG on 8 April 2024.
- Quarterly data return submitted to Welsh Government for NHS vacancy statistics
- Suite of BI People dashboards launched, and bespoke Medical dashboard in development with the Nursing dashboard launched through a phased approach with phase 1 delivered during April 24 These have been well received, giving easy access to timely, relevant and accurate People data to inform decision-making. Further reporting automation and dashboards are planned.
- In partnership with Digital and Finance, development of one source of workforce data.
- In partnership with Digital, developing a CTM strategic approach to the use of Robotics.
- In partnership with the National Data Resources (NDR), piloting ONS's data Masterclass within the people directorate to enhance data and analytical capability for leaders to improve data driven decisions.
- Strategic Workforce Planning approach discussed at Inspiring People Board on 10 April 2024 with follow up with Heads of People to align to Care Group Service Plans. ~~identified as a key area of focus for Inspiring People Board.~~
- Positive Review of Workforce Planning Arrangements undertaken by Audit Wales with six recommendations which have been developed into an action plan with agreed deadlines. The audit report and actions were shared at the CTM Audit and Risk Committee on 18 April 2024.
- Retention and Workforce Planning Lead commenced 22 April 2024 to lead the Retention Action plans. The Lead is part

Temporary staffing solutions

- Medical Bank
- Modernised processes for Bank workers 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

- ~~Head of People Analytics commenced in January 2024.~~
- ~~Attraction and Resourcing Lead commencing 4 March 2024 to develop and shape a forward-thinking Attraction and Resourcing Strategy for Cwm Taf Morgannwg (CTM) based on best / evidence-based practice.~~
- Health Education Improvement Wales (HEIW) Workforce Planning Tool and Skills for Health modelling tool.
- Establishment Control ~~being explored~~.
- ~~Development of~~ CTM approach to workforce planning developed and shared at Inspiring People.
- Development of tool for workforce modelling/forecasting,including projecting the impact of interventions. Internal action plan and next steps underway with updates via the Inspiring People Board.
- HEIW all Wales Strategic Workforce Plans across: Dental, Mental Health, Perinatal, Pharmacy and Primary Care with AHPs and Genomics out for consultation. Nursing is in development. Guidance for Radiology is also available.
- The Head of Workforce Planning is aligned to the HEIW Workforce Planning Network.
- 13 Physicians Associates allocated for 2024 intake- building on our commitment to expand into alternative roles.
- SWP Audit by Audit Wales completed and reported in March 2024.
- ~~Attendance at Careers Fairs with learning to inform future attendance.~~
- ~~Work experience pathway established~~ of the Health Education Improvement Wales (HEIW) retention community of practice, which will encourage sharing best practice and utilizing networks across Wales.
- CTM are connected to stakeholder events such as the Physician Associates (14 May 2024) and key stakeholders at the Physician Associate Recruitment Group and Medical Associate Profession (MAPs) groups.
- International Nurse Recruitment (IEN) Paper shared with NWSSP for WG Funding. Outcome expected in the next few months.
- CTM aligned to the all Wales International Medical Recruitment Group and considering opportunities for the autumn 2024 depending on funding arrangements and agreed speciality being recruited from Kerala, India.

• ~~New People data dashboards in place launched across Care Group, giving access to timely, accessible, relevant and accurate People data to inform decision making.~~ • ~~Nursing Data Dashboard in development with the first phase due to be launched on 1 April 2024.~~	
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	~~Appointment to Head of Workforce Planning post, Head of People Analytics post Attraction & Resourcing Lead commencing 4 March 2024 and Retention Lead appointment in process.~~ ~~Designing and developing~~ Designed and developmed an all-encompassing workforce planning approach. This will include establishment control and improved workforce analytics - to ensure we understand whom CTM has and who it needs, to improved attraction and recruitment approaches to employ the best people from the widest possible pool. ~~The appointment of a new People Analytics role will support the~~ Enhancement of our people data (quality & provision), analytics and intelligence. This will support the development of our workforce both for now and the future. The following Workforce Planning activity is also now underway: • Neonatal SWP workshop held on 26 February 2024 with a further workshop to build the plan scheduled for May 2024. • Facilitating the development of workforce plans in Regional Ophthalmology and Orthopaedics, the latter aligned to Llantrisant Health Park. • The Health Board is building a framework for local, operational workforce plans that minimise vacancies and optimise the skills of the existing workforce to ensure opportunities to grow our own are maximised. • 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. • The plans under development will consider all the above, alongside workforce trends and horizon scanning, to inform consideration of future models of care and an understanding of the skills and capabilities needed and education required to deliver the future health needs of the CTM population. Alongside development of our approach to workforce planning we are also developing a framework regarding new roles • Establishment of PA Working Group July 2024. • Development of action plan for HCSW Assistant Practitioner Band 4 nurse role and Registered Nurse Assistant role once agreed. ~~Associate Nurse once announced by the CNO.~~ • Workforce planning alignment to the ACSP to promote opportunities to maximise workforce productivity, integrated working, redesign and new role developments. • Establishment control paper in development. ~~incorporating lessons learnt from other HBs in Wales to inform the options.~~ This should be finalised for consideration in the ~~first~~ second quarter of 2024. • SWP Audit Wales Recommendations Action Plan.
Recruitment & Retention • The Health Board does not currently have a signed off Recruitment & Retention Plan.	• Action plan has been on the 10 HEIW retention themes. We are also represented and actively engaged in the all Wales Retention Group. • Retention updates being provided on an ongoing basis via the People and Culture Committee. • Retention Group established. The next meeting will be arranged for May 2024 now the Retention Leads is in post. ~~and Retention Lead appointment underway.~~
Linked National Priority Measures	**Current Performance - Highlights**
Workforce • 23. Agency spend as a percentage of the total pay bill	The following key metrics are set out within the Workforce and Organisational

• 27. Percentage sickness rate of staff	Development Metrics section of the Integrated Performance Report: • Turnover remains high within the Health Board (11.55% in April 2024). This is an agreed area of focus for the Retention Group now the Retention and Workforce Planning Lead is in post to develop initiatives to reduce turnover and to encourage staff to stay. • Job Planning compliance is now a key agenda item on the V&E; MWPP Performance Escalation Group to improve job planning compliance. • A Framework Group is also in development to address key medical and dental productivity and performance feeding into the V&E MWPP Performance and Escalation Group. • Sickness absence currently high reporting as 6.44% in March 2024; Rolling 12 months' rate for the same period was 6.81%

	Absence FTE %	
Add Prof Scientific and Technic	4.17%	**3.85%**
Additional Clinical Services	8.33%	**9.32%**
Administrative and Clerical	5.56%	**5.62%**
Allied Health Professionals	3.82%	**4.25%**
Estates and Ancillary	10.50%	**10.99%**
Healthcare Scientists	3.15%	**4.28%**
Medical and Dental	1.92%	**2.43%**
Nursing and Midwifery Registered	6.64%	**6.73%**
Students	5.87%	**4.62%**
Grand Total	**6.44%**	**6.81%**

• Staff in post stands at 12,798 headcount and 11,181.41 FTE as at 30th April 2024.

The Health Board's People Dashboard and metrics report sets out further details in respect of workforce related performance metrics, trends and actions that are underway. A workforce metrics report is a standing agenda item at our People & Culture committee and Local Partnership Forum.

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
~~5640~~	~~Potential Junior Doctors Industrial Action~~ Risk score reduced from a 20 to a 12 in May 2024.	~~**20**~~
2713	Backlog of reporting radiology examinations. Risk score reduced in January 2024.	**16**
5658	Lack of Dietetic service provision to Princess of Wales Critical Care.	**16**
4809	Non Compliance with Mandatory Violence and Aggression Training	**15**
4080	Failure to recruit sufficient medical and dental staff	**15**

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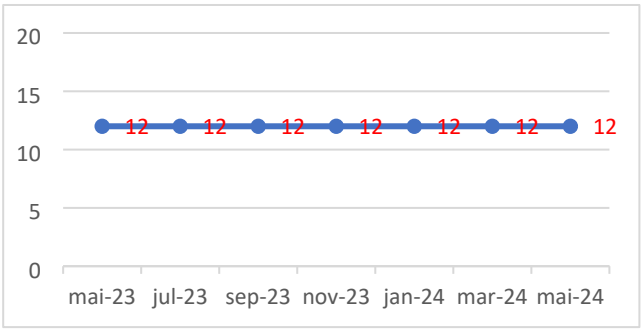
Strategic Goal: **Creating Health** • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation		Risk score **12**
Strategic Risk: **Community & Partner Engagement - (Risk No.4)**		
If the Health Board ***does*** not engage effectively with our population to understand their needs, and with partners in local government social care and the third sector, to understand their viewpoints	***Then*** we will fail to prioritise our efforts and resources appropriately, and to achieve a consensus for change in implementing our Population Health Strategy	***Resulting in*** • Lack of trust between the community and the Health Board. • Loss of opportunity to build relationships and create an inclusive environment where people connect, collaborate, and share ideas. • Challenge to public decisions relating to future service developments due to limited engagement • The inability to affect positive change in terms of improving health inequalities and health outcomes.

	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:

No change as at May 2024

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.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk is being actively managed via the communications team and wider engagement. As above, we will need to **tolerate** the fact that management of the risk will need to be ongoing.

Lead Director	Director of Communications, Engagement & Fundraising.	Assurance committee	Population Health & Partnerships Quality & Safety Committee (Experience element) People & Culture Committee (Values Behaviours)

Controls	Assurances reported to Board and committees
Strategies & Plans • 2030 Strategy – 'Our Health Our Future' • Implementation of key actions in the Population Health Plan approved by Board in May 2021. *Framing and incorporating these actions as part of the Unified Transformation Programme – Creating Health. Completed* • Public Engagement Plan for 'Our Health Our Future' • Becoming an Engaging Organisation • Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021 **Engagement Forums** • Regional Partnership Board • Public Service Board • Area Partnership Board • CTM2030 Leaders Groups • Acute Clinical Services Plan – Senior Leaders Group • **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 Llais including representation on Board • Regular joint executive meetings with the three local authorities • Accelerated Cluster Development Programme Board – engagement across Primary Care • Health and Social Care Integration Board • Forum with local authority Chief Executives to address health inequalities	**Board Development Session –** held on the 14th December 2023 in relation to community engagement and the maturity journey for the Health Board in further developing its approach to being an engaging organisation. Routine discussions with Board undertaken in relation to the engagement strategy for the Acute Clinical Services Plan. **Reports to other committees** • Community Health Council briefing papers to Quality and Safety Committee • People & Culture Committee consider reports in relation to culture and behaviours.

• Community Voluntary Councils (Interlink RCT, BAVO, VAMT) • OPAG (Older Person's Advisory Committee) • CTM 50+ Forums • Maesteg Stakeholder Reference Group • Partnership with CTM WISE (Wellness Improvement Service) • Regional Mental Health Forum • Partnerships with colleges and education providers **Needs Assessment & Consultation Processes** • Population Needs Assessment (Regional Partnership Board) • Formal consultation processes for service reconfiguration, e.g. vascular **Organisational Structures** • Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars	
Gaps in Controls and Assurances	Mitigating Actions
• Review the Becoming and Engaging Organisation Strategy	• Revisit to ensure the principles support the direction of travel, particularly there consistency and alignment with the ACSP engagement strategy, • Board Development Session reviewed the strategy on the 14th December 2023, outputs of which will now be taken forward. • Engaging with the Consultation Institute to develop and embed robust systems and processes within the Health Board for managing consultation. Work has begun with the consultation institute to improve our understanding of our stakeholders and the risks associated with service change. Timeframes: 1st July 2024.
Linked National Priority Measures	Current Performance - Highlights
	Staff Survey Headline Report now received ~~Outcomes still awaited – anticipated for April 2024~~. Indicates a maintained performance for staff engagement vs a national decrease. ~~Feedback from CTM Leaders Forum~~ New Terms of Reference under development with CTM Leaders Forum to embed shared purpose.

	Stakeholder mapping workshop jointly facilitated by CTM with the Consultation Institute taking place on 17 April to improve understanding and identification of stakeholders. ~~Shared Listening and Learning Stories~~

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		
Nil.		

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IMPROVING CARE	Strategic Goal: **Improving Care** • Delivering safe and compassionate care. • Developing new models of care. • Digital transformation for patients and staff • Ensuring timely access to care	Risk score **16**

Strategic Risk: **Delivery of a digital and information infrastructure to support organisational transformation – (Risk No.5)**

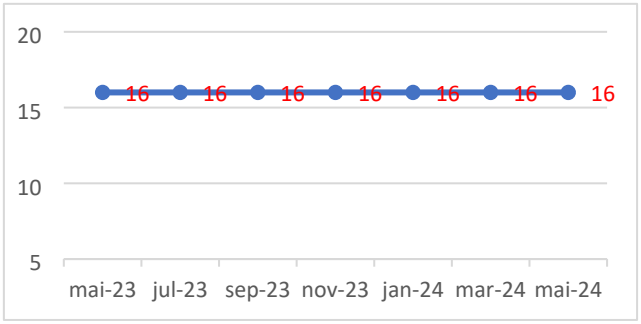
If the Health Board does not accelerate its journey in becoming a digital and data organisation, that demonstrates an embedded culture of working digitally, organisational agility and strategic and functional clarity underpinned by operational sustainability	***Then*** We will be unable to design and execute a Health Board wide strategy to transform services that are tailored to meet the needs of our people and our communities.	***Resulting in*** Continuing health inequalities and poor population health outcomes, an inability to transform our cost base and our service design, which will result in slow progress towards improving our population's and patients experiences, and continue to constrain our ability to work seamlessly across our region.

	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:

No change as at May 2024

Risk Score Trajectory



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

Progress continues to be made in improving the:

- digital & data structure
- security and protection of our data and digital assets.
- digital infrastructure across some sites
- standardisation of digital tools
- Approval of the business case for e-prescribing
- the advancement and availability of our clinical information.
- the advancement our clinical information

	• Consolidation of the clinical systems in the Bridgend disaggregation • Development of a programme of work for patient centred contact • The Health Board continues to manage its information and digital debt on a risk-based basis. The Health Board still has vulnerabilities that need to be managed. A recent cyber-attack on a supplier that delivers critical digital services to the Health Board demonstrates the magnitude and likelihood of the risk that we face in providing secure and resilient digital services and in protecting the sensitive data we hold on behalf of our patients and population. This risk score has been reviewed and the assessment is that it remains unchanged from a score of 16 on this review.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is considered that the Health Board is continuing to 'Treat' this risk as it has a number of actions it is taking forward to mitigate this risk.

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 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.
• Develop a baseline Asset Register and product catalogue	• Development and maintenance of our asset register and product catalogue as part of NIS-D and data protection improvement plans. Cyber Resilience Unit's Assessment of our organisation's maturity has taken place, and we are awaiting the final report.
• 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 the required Capital and Revenue to meet a number of core system deliveries and wider improvement opportunities, 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 Swansea Bay University Health Board 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	• As part of the review of our EPR strategy, we are working with WG, Health Board partners and national services to develop existing commitments for delivery of an open architecture for NHS Wales and exploring alternatives for addressing gaps in functionality. • Consideration of CTMUHB's requirements for clinical and administration management to be undertaken and incorporated into the architectural design and EPR strategy. • Ongoing development of CTMUHB's own clinical data repository to nationally agreed technical and data standards • Increasing representation for National Data Resource programme to accelerate benefits realisation Timeframe: It is not possible to set a specific timeframe as this is dependent upon National Strategic Direction.
• Widespread non-adherence to data standards	• New clinical applications are now required to meet data and technical standards. • A clinical safety assurance process has been described and tested, to support an options appraisal. • Education and Training required for staff to develop their data literacy • Seeking further assurances from DHCW for roadmap that will see their products come into compliance with standards.

	• Improvement and greater multi-disciplinary management of the changes to service models, counting practices and consequent impact on measures which carry significant effect on both the efficiency and reputation of the Health Board (e.g. mortality rates and quality measures, income, bed capacity planning) is required Timeframe: It is not possible to set a specific timeframe as this is dependent upon National Strategic Direction.
• Critical supplier(s) unable to respond to the UHB's requirements and ministerial priorities within defined timescales	• Need to develop a more robust SLA and contract monitoring and management process for critical suppliers. Timeframes – 1 Year. The Health Board is in a planned programme of work with the relevant critical suppliers to ensure delivery against key objectives in year 1)
• Capacity within current team to deliver digital transformation agenda	• Work with other NHS Wales partners, industry, academia and third sector organisations to improve our current digital competencies across the Health Board and our communities • Adoption of self service for basic Business Intelligence • Recruitment to vacant posts. • Resources required for CTMUHB to have the skills and expertise to use data and digital tools effectively- capacity and capability gaps exists when compared to other HBs and DHCW Timeframe: Q2 24/25 - Following ePMA business case approval from Welsh Government we are now actively recruiting Digital Transformation resources as part of the wider ePMA programme.
• Delayed delivery of the digital patient notes programme	• Resourcing required to increase activity and accelerate completion of the programme • Timeframe: 2-3 year programme of work.
~~• Resourcing of Information Governance (IG) function within the Health Board~~	~~• Mitigated, with both teams having successfully recruited to the full and enhanced establishments.~~ IG Resource now in place.
• No function within CTMUHB focussing on benefits realisation	• This function is identified within the Digital Transformation function which will be developed during 2023/2024. Now needs to be resourced as the Health Board moves into 2024-2025.

• Limited progress to reduce/remove paper processes and move to a fully integrated digital patient record	• Scoping of a business case to implement an integrated health record complemented by a digitally enabled patient centred contact programme is now the focus for the Digital and Data team. The March 2024 Board Development session was provided a clear action to develop a strategic outline for the July 2024 Board. • National data resource programme has delivered University Health Board's clinical data resource, which supports capture and transfer of clinical information in line with common language, terminologies and standards. • Proposal being made to the Digital Services for Patients & the Public which will enable the use of the NHS Wales patient portal and secure, authenticated digital communications between patients and clinicians in line with technical, information and clinical safety standards. Timeframe: 2-3 year programme of work.
• 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 Integrated Medium Term Plan (IMTP). Timeframe: Additional resources are being added to the team this year however recurrent funding is still a challenge for some of the National Programmes.
• Information Commissioner Office (ICO) Audit planned to be completed March 2023.	• Mitigated - ICO have signed off their audit engagement with CTMUHB as completed and satisfied sufficient plans are in motion.
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	• Risk relating to the removal of the current video consultation solution has been identified. • Following submission of business case, the Health Board has successfully secured funding to take forward the programme for ePrescribing for Secondary Care. We are actively working with the supplier with a plan to complete the contract signing in Q1 24/25. • Digital and Data team are supporting the successful commission of mobile MRI scanner at the LHP site. MRI scanning is live.

	• Digital and Data team are supporting the procurement of Regional Diagnostic Hub at the LHP site. • Significant end of year capital funding was secured from Welsh Government which will enable a substantial removal of thin client devices and refresh of desktop PCs • The patient contact and medical records transformation business case has been drafted to be submitted and approved by executive team Q1 24/25. • The team are supporting Critical Care services in determining way forward for a single digital system across CTMUHB. • Progress continues to be made with Bridgend disaggregation programme with a further consolidation of clinical systems. WPAS merger is on track to deliver in May 2025. • LIMS2 and RISP national projects are progressing to plan and are expected to deliver to the current project timelines.

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

Critical incidents under NIS-D:

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

Associated Risks 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**
5669	Increased cost of Citrix Subscription.	**16**
4337	Integrated Patient Records across the Health Board	**16**
4671	NHS Computer Network Infrastructure unable to meet demand	**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**

5761	• Cross Health Board Data Sharing - New risk escalated to the Organisational Risk Register in May 2024. Risk score of 16.	

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INSPIRING PEOPLE	Strategic Goal: **Inspiring People** • Viable and inspiring leadership • Promoting diversity and inclusion • Embedding our values and behaviours • Encouraging local employment	Risk score **12**

Strategic Risk: **Leadership and Management – (Risk No.6)**

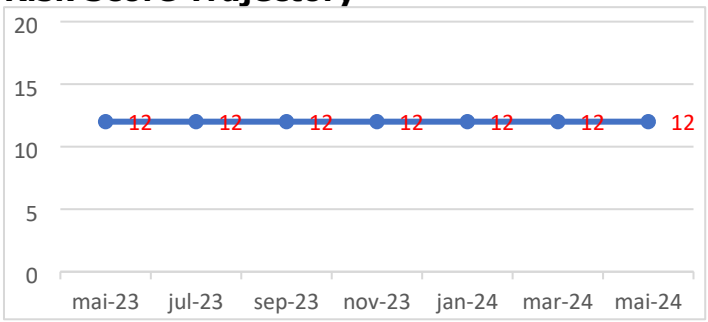
If we fail to provide compassionate and effective leadership at all levels of the organisation and all professions to empower and enable our workforce	***Then*** there will be lack of confidence to enable informed decision-making at the appropriate level and to implement organisational change	***Resulting 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:

No change as at May 2024

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The Health Board is emerging from the Phase 1 and 2 Organisational Change Programmes (OCP) that have seen CTMUHB move from a locality-based model, to one that operates services on a pan-CTM basis. We recognise through the OCP lessons learned, and through workforce metrics and surveys that we still need to work on developing our leadership capability. We need to make clear what good leadership looks like and ensure there is support to enable implementation in order to deliver on our IMTP objectives.
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 • Three in-house programmes creating a fully functioning leadership development pathway for all staff. • Work ongoing to scope and design a wider leadership development offer, using the three existing programmes as a baseline. This will specifically target the upskilling of leaders in response to the Phase 2 organisational restructure. Details of these programmes will be shared via a paper to Executive Leadership Group in Q4 2024. • ~~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.~~ • Board Development Session 24th August 2023 – Compassionate Leadership. • Learning partnerships with University of South Wales, the Institute of Leadership and Management, HEIW, The Kings Fund and Academi Wales • HEIW Compassionate Leadership Programme launching in 2024. • Establishment of Leadership Coaching & Mentoring Network • ~~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. The November session was held and a training schedule is now in place for 2024. • ~~Leading through Change Programme launched in October 2023 to support Leaderships going through OCP – this includes focus on Compassionate Leadership, Restorative, Just & Learning~~	**Internal Assurances** • Inspiring People Board established and scheduled for each quarter • Workforce and Organisational Development metrics report • Employee Relations Update • Medical Workforce and Efficiency Report • Statutory and Mandatory Training Compliance Report • Targeted intervention process incorporated as business as usual. • Annual Wellbeing surveys undertaken, last one launched in May 2023. • Internal Audit took place in January 2024. • PDR – *Your Conversation* 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 achieved in March 2023, awards will be retained for the next three years following which the awards will cease to exist. • National Staff Survey closed December 2023, awaiting results from HEIW • Improved levels of leadership accreditation in staff gaining external qualifications (ILM/CMI).

~~Principles, Leading Inclusively and managing wellbeing.~~ • Leadership Competency Model has now been developed and aligned ~~used during OCP is being reviewed to align~~ to Values & Behaviours, the evidence review and wider Culture work; with input from Subject Matter Experts for each categories. This will then form the basis of ~~be aligned to psychometric methodology to support development and will be aligned to~~ the revised leadership development programmes which includes psychometric testing. • The new Leadership Programme was introduced at the Care Group Launch event on 02/05/2024. **Leadership Engagement with the workforce** • Leaders Headlines Briefing issued by the Director of Communication, Engagement & Fundraising. • Local Partnership Forum • Local Negotiation Committee (medical and dental) • Clinical Advisory Group • Staff Q&A with the Chief Executive via MS Teams • CEO and Senior People Team meetings with Trade Union partners held on a monthly basis. **Employee Wellbeing** • Employee Experience Programme • Emotional Wellbeing Care Pathway • Occupational Health Services • Employee Assistance Programme • Staying Well Plans as part of the PDR Your Conversation meetings • Financial Wellbeing Care Pathway • Wellbeing surveys (Annual)	
Gaps in Controls and Assurances	**Mitigating Actions**
• Full implementation of leadership development programmes and embedding in practice	• Working with Care Group leads to drive accountability and uptake of programmes across the Care Groups, integrating with local development plans in-line with Phase 2 organisational restructure.

• Measuring impact of Organisational Development interventions	• Quantitative data around engagement and completion of the programmes is shared with Care Group/ Directorate Leads via the Heads of People on a monthly basis. • Evaluation of the leadership development offer is continuous, with an evaluation framework embedded into the programmes. This data supports an internal audit being carried out by Shared Services, which commenced in January 2024.
• Improved accessibility to leadership and management toolkits via an online repository, in partnership with HEIW.	• L&D have designed and launched the new CTM Leadership Portal, in collaboration with HEIW and hosted on HEIW's Gwella site. This acts as a virtual central space for all leadership development activity within the Health Board. • This includes facilitating all programmes via the Gwella Learning Management System, bringing an annual cost saving of £40k and further aligning the Health Board's offer to HEIW's resources. • The aim of this is to increase visibility and accessibility of CTM's leadership offer, whilst also providing a space to collaborate with other services to establish a wider range of leadership development pathways (e.g. managing wellbeing at work). • The Health Board also continues to inform the new Compassionate Leadership programme being developed by HEIW.
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	This question is not specifically asked in the Wellbeing Survey. We know that, on average, 64% of referrals to Vivup are from Managers. Please refer to latest performance dashboard information under the people services section.
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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INSPIRING PEOPLE	Strategic Goal: **Inspiring People** • Viable and inspiring leadership. • Promoting diversity and inclusion. • Embedding our values and behaviours. • Encouraging local employment	Risk score **12**

Strategic Risk: **Culture, Values and Behaviours – (Risk No.7)**

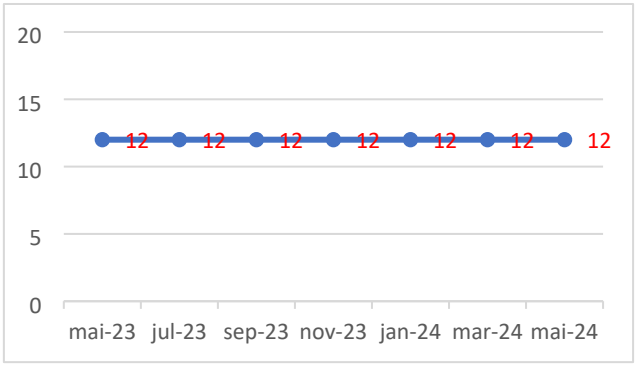
If the Health Board fails to put the values of the organisation into practice	***Then*** we will not have a culture that embraces inclusion, openness, innovation and teamwork	***Resulting in*** poor experience for staff and patients alike, diminishing the trust and confidence of our population

	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:

No change as at May 2024

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The score remains unchanged although progress continues to be made as the Health Board's work on Culture, including values and behaviours ~~become increasingly embedded and work on culture~~ becomes more defined with a focus on how we are working to address inequalities within CTMUHB.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through the expansion of programmes of work that supports culture change – this is following a Culture Current State Analysis which was undertaken during the Summer 23 and a framework for a draft Culture Plan developed. Strategic Equality Plan (SEP) consultation now closed and ~~a draft~~ action plan has been ~~developed~~ signed off by the Board in March 2024 and subsequently published. The SEP underpins the health board's strategic goals and aims to create an inclusive environment

	that welcomes diversity and helps to build a workforce that better represents our communities.

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. • Emerging Culture Plan. • Equality, Diversity and Inclusion Working Group chaired by Linda Prosser (Exec Director for Strategy and Transformation) • Restorative Just and Learning Working Group, Chaired by Lauren Edwards (Exec Director of Therapies). • Strategic Equality Plan including alignment to Welsh Language Plan • Raising Concerns Procedure. • All-Wales work to promote speaking up safely, led by the Director of Corporate Governance / Board Secretary. Currently with WG – expectation is to launch in autumn 2023. **Communication and Engagement re: values & culture** • Stakeholder Analysis was undertaken in Autumn 23 to support the emerging work around the Culture Plan. ~~and this will be supporting the socialisation programme due to be undertaken following sign off at Board.~~ • ~~Communication & Engagement plan for the Culture Plan to be developed following analysis and implemented from Jan April 2024 – this includes Workstreams in:~~ ~~- Restorative Just and Learning~~ ~~- Values & Behaviours~~ ~~- Equality, Diversity & Inclusion~~ ~~- Developing Organisational Capability & Resilience~~ • Soft launch of Restorative, Just and Learning principles with Speak Up Safely Launch in October 2023 undertaken.	• National Staff Survey was conducted in autumn 2023 with results due to be published in spring 2024. • Annual Wellbeing Survey (to be repeated in June 2024). • Values and Behaviours Update. • Equality Annual Report. • Gender Pay Gap Report. • Workforce Race Equality Standards. • Strategic Equality Plan. • Welsh Language Standards Annual Report – scheduled for Board approval in September 2023. • Living Wage Accreditation awarded in February 2023.

- Speaking Up Safely Programme to be more closely embedded with the Restorative Just and Learning work.
- Developed Inclusion Communication Plan with monthly topic focus, which is currently being rolled out.

Putting Values into Practice

- ~~Restorative, Just & Learning Approach Working Group set up with 28 Senior Leaders within CTMUHB who received training by Merseycare. Wider group members invited and x3 task and finish group set up to carry out work on~~
  ~~- Data & Evaluation~~
  ~~- Education (inc Respect & civility)~~
  ~~- Policy~~
- Values Based Recruitment has been picked up by the Attraction and Resourcing Lead. ~~– updated module and intranet pages ; review of strategic recruitment (Band8c+) being undertaken~~
- Suite of values-based resources and activities for managers and staff on SharePoint – further review of behaviours to ensure alignment to new draft culture plan
- Desk based review of behaviours have been undertaken to ensure alignment to new draft culture plan; this will link to the leadership competency model. ~~and be part of the Board Development Session in February 2024 and sign off in March 2024.~~
- Delivered x7 Cultural competency workshops over 5 areas: Executive Team, Strategy & Transformation, People Directorate, Mental Health & Learning Disability, ICTM
- Deliver Cultural Competency Workshops to 3 further areas identified – (Legal & Complaints; Patient Safety; Patient Experience) and an additional 3 areas (yet to be confirmed in discussion with Heads of People and Care Groups) – to be completed by March ’24
- Dedicated support allocated for the completion of the Cultural Competency workbooks for all 11 areas by Dec ‘24
- Developing internal Cultural Competency programme by Q1 24/25and deliver internal programme from Q2 24/25.

• Delivery commenced on the Educational offer to support Culture Plan responding to WG NHS Anti-Racist Wales Action Plan; LGBTQ+ Action Plan, Gender Equality & Disability Action Plans. • Developed framework to support Staff Networks and attended key events to support under-represented groups to raise awareness and deliver education. Developed Joint Chair Network; and supporting infrastructure of network • Developed workshop on Inclusive Thinking and Practice as a Leader to be delivered as well as an Introduction to Restorative, Just & Learning Principles. ~~that is being delivered as part of the as part of Leading through Change Programme to support Phase 2 of Organisational Change Programme~~ • Developed and delivered pre-employment workshops for our minority ethnic community; engaging with community partners to support with recruitment and entry into the Health Board in collaboration with L&D.	
Gaps in Controls and Assurances	**Mitigating Actions**
• Themes from culture current analysis shows further work in role-modelling and embedding values and behaviours is required	• Developed a Values & Behaviours work plan that looks at: review of current behaviours framework; update current resources and tools; update current education and support offer; looking at impact and sharing good practice; linking and aligning to emerging Culture Plan
• Empowering staff to feed back on, or challenge behaviour which is inconsistent with the organisation's values	• Further work ongoing in collaboration with Staff Network Groups. • Speak up Safely Campaign launched in Oct 2023 and further alignment to the Restorative Just and Learning Approach. • Restorative; Just & learning approach launch (soft) in Oct 2023. • Targeted work on Staff survey for 2023 to support developing a baseline for Culture Plan. Awaiting results from survey which are due in ~~March~~ May 2024. • Dedicated education and leadership offering around managing behaviours and conflict; restorative conversations and providing feedback through the emerging Culture programme.
• Cultural Health Check diagnostic tool developed that measures current	• ~~Through our Aspire and Inspire Leadership programmes our approach to leading~~

alignment to values based on participants' contribution to the assessment. The Health Check has been piloted successfully and is being used for subsequent OD interventions.	~~behaviour change through leadership is paramount and a key feature of the programmes.~~ • National Staff Survey is now complete and results will be available from May ~~March~~ 2024 • Developing a Self-service model to support leaders/managers to run values and behaviours health check themselves. This will be following the review of the behaviours and leadership competency model.
• Current Strategic Equality Plan (SEP) has been updated ~~requires review~~ to align with the changing national context.	• ~~Work ongoing to review~~ The Strategic Equality Plan (SEP) has been approved at the Board and now published. Action complete and will be removed. ~~to align with the changing national landscape, in particular the Anti-Racist and LGBTQ+ Wales Plan. SEP currently out for consultation – Ongoing as feedback being reviewed.~~ • ~~SEP Action Plan received at the People and culture on 8 November 2023, will now be submitted to Board for sign off in March 2024 and published.~~
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)	NHS Staff Survey 2023 results demonstrated a 71% engagement score based on an 18.1% return rate. CTMUHB was the only Health Board in Wales to not see a reduction in engagement score. 61.65% of the organisation have had a PDR/Appraisal within the last 12 months.

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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SUSTAINING OUR FUTURE	Strategic Goals: **Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value based healthcare • Ensuring our estate is fit for the future	Risk score **16**

Strategic Risk: **Fulfilling our Environmental and Social Duties and ambitions (Risk No.8)**

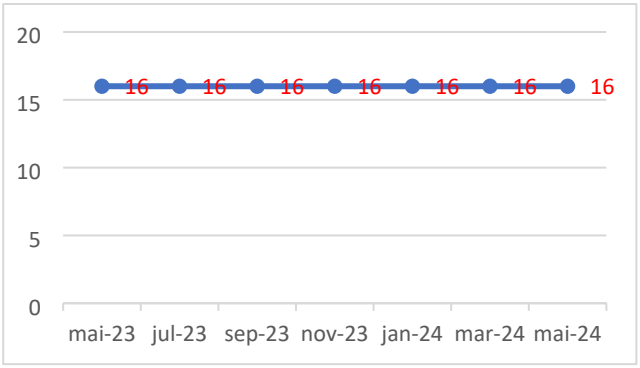
If the Health Board's decisions fail to reflect our values or consider the long-term environmental or social impact	***Then*** we will not fulfil our Socio-economic duty, our Wellbeing of Future Generations objectives and our value-based healthcare principles	***Resulting in*** negative environmental and social impacts, and loss of trust and confidence among stakeholders

	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:

No change as at May 2024

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	It is anticipated that the risk score may remain quite stagnant as the pace of improvement is constrained by workforce and financial capacity constraints, which limits the available investment into the environmental infrastructure.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	It is recognised that there is an element of tolerating this risk in terms of the pace in being able to mitigate it. There are however, ongoing risk treatment activity outlined in the mitigating actions section particularly around the Climate Adaption Plan.

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	**Wellbeing and socio-economic duties**

• Integrated Medium Term Planning Process aligned to the seven Welsh wellbeing goals and five ways of working. • 'CTM 2030' delivery focusses on community developments, employment and local procurement where possible. • CTM becoming established as an Anchor Organisation. **Environmental Sustainability – Net Zero** • Decarbonisation Strategy • Established a CTM Environmental Sustainability Group as part of transformation agenda. • 'CTM 2030' seeks to ensure that services take account of the impact on the environment • All-Wales approach to sustainable procurement • Green CTM Staff Forum • Fleet emissions reduction programme and trial of electric vehicles • Tree planting initiatives • Waste management – elimination of landfill for foodstuffs • Use of less environmentally impactful anaesthetic gases • Sustainable Health Care delivered a workshop to Board Members in March 2023. • Decarbonisation Action Plan in place.	• Wellbeing Statement accompanying Annual Plan • Progress reports against the Annual Plan • Case studies of projects contributing to wellbeing and equality, e.g. Connected Communities, Healthy Schools, Social Prescribing, Sustainable Procurement **Environmental Sustainability – Net Zero** • Environmental Sustainability Annual Report • ISO 14001 (Certified Environmental Management System) accreditation Commenced reporting to Board / committees regarding Net Zero. **Independent Assurance** NWSSP Internal Audit Services review of Decarbonisation Action Plan delivery and compliance is underway. All Health Boards are subject to this review. Outcomes will be reported to the appropriate committee and associated actions added to the strategic risk as appropriate.
Gaps in Controls and Assurances	**Mitigating Actions**
• Climate Adaption Plan (moving away from mitigation)	• Climate/Environmental Adaption Plan proposal being considered by the Executive Leadership Group in July 2023. Executive Leadership Group accepted recommendations that the Health Board develop a Climate/Environmental Adaption Plan. This will be scoped at the Environmental Sustainability Group. Timeframes: objective will be to achieve a set of objectives by end of March 2024. Timeframe delayed to align with PSB review to ensure that Health Board considers all learning from their risk assessment against adaption planning. In the meantime, a sub group will be established to support this activity and learn from the PSB outcomes to information Health Board approach. This has been captured within the refreshed Decarbonisation Action Plan. Early stages

	now planned for summer 2024. Inaugural work shop was held Monday 29th April 2024. • Engagement with the Public Services Board on a regional Adaption Plan – Ongoing.
• 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. The Health Board recognises that that there is a risk that the pace of change may slow in light of the current financial environment and challenges faced. Team restructure undertaken to release funding to source a Sustainability Manager as part of the Partnerships Team which is going through the scrutiny / recruitment stage.
• Procurement framework to reduce carbon footprint of goods and services purchased from outside the organisation.	• Procurement team part of Environmental Sustainability Group and wider decarbonisation networks. Ongoing. Pace of progress likely to be slowed as financial considerations become more dominant.
• Mapping against 'More Equal Wales' guidance for Socio-economic Duty which came into effect in April 2021.	• To include as discussion point as part of Building Healthier Communities work moving forward, including public health involvement. Ongoing.
• 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.	• Refreshed Decarbonisation action plan to be reviewed which would consider additional actions. Timeframe – March 2024. On track being received at the Health Board meeting on 28th March 2024. Completed received at March Board action to be removed.
• 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. Ongoing.
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	Quarter 4 reporting against the Decarbonisation Action Plan completed and submitted by the 30th April 2024. Annual Carbon Plan report is due by the 4th September 2023. Completed – submitted to Welsh Government. Next one due September 2025.

• 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**	

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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Strategic Goal: **Creating Health** • Reducing health inequalities • Equal focus on mental and physical health • Supporting our communities • Being a healthy organisation	Risk score **20**
Strategic Risk: There will be a decrease in Healthy Life Expectancy (HLE) and an increase in the gap between the most and least deprived and an unsustainable health service. **(Risk No.9)**	

If the Health Board does not effectively shift its services to prevention and early intervention and engage the population to improve their health	***Then*** we will fail to improve healthy life expectancy and reduce inequalities in healthy life expectancy	***Resulting in*** poorer health outcomes, greater inequalities and an unsustainable health service.

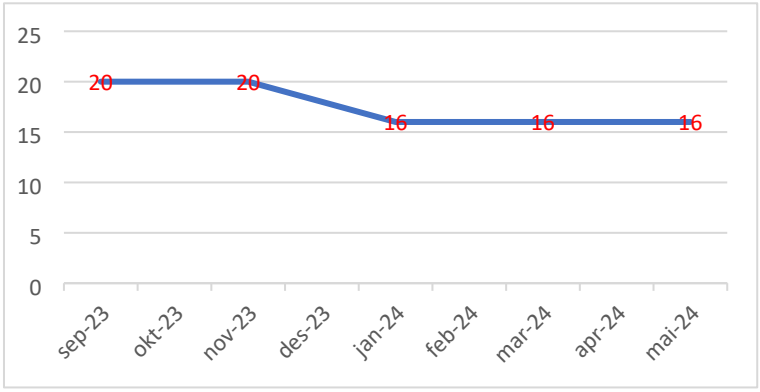
	Consequence	Likelihood	Score
Initial	5	4	20
Current	**5**	**4**	**20**
Target	4*	3	12
Risk Appetite	**Cautious** *(quality and safety; trust and confidence; legal and regulatory)*		

Risk Score Trend this Period:

No change as at May 2024

*The consequence score has reduced for the target score assessment, as there will be an element of both mitigation and adaptation. The Health Board aims to reduce the behaviour and health risks (primary, secondary, tertiary prevention), however, the organisation will still need to adapt as appropriate.

Risk Score Trajectory



Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	Whilst not inevitable, the current trajectory indicates increasing health risks reduced healthy life expectancy and widening inequalities.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	This risk will be treated and managed through programmes of primary, secondary and tertiary prevention across the health board, as well as in partnership with system partners to influence the wider determinants of health.

Risk Lead	Executive Director of Public Health	Assurance committee	Population Health and Partnerships

Controls	Assurances reported to Board and committees
Strategies & Plans • Welsh Government strategies/ plans: "Healthier Wales", "Healthy Weight Healthy Wales", "Smoke Free Wales". • CTM 2030 Strategy – 'Our Health Our Future' • Work programme set out in 'Becoming a Population Health Organisation: a discussion and options paper for Board', May 2021, updated November 2022. • Public Service Board – Well Being Plans Engagement Forums • CTM Creating Health Portfolio Board • Regional Partnership Board • Public Service Board • Area Partnership Board • CTM2030 Leaders Groups • Strategy Groups: Born Well, Growing Well, Living Well, Ageing Well and Dying Well • Engagement with community groups by Lead Independent Members • meetings with the three local authorities • Accelerated Cluster Development Programme Board – engagement across Primary Care • Health and Social Care Integration Board • Forum with local authority Chief Executives to address health inequalities Needs Assessment & Consultation Processes • Population Segmentation & Risk Stratification • Pharmaceutical Needs Assessment • Health Needs Assessments, e.g. Homeless People, Prison Health, staff wellbeing • Wellbeing Assessment (PSB) • Population Needs Assessment (Regional Partnership Board) • Formal consultation processes for service reconfiguration, e.g. vascular Organisational Structures • CTM Leaders Network	Wellbeing and socio-economic duties • Wellbeing Statement accompanying Annual Plan • Progress reports against the Annual Plan Reports to Board • Annual Director of Public Health Annual Report • Creating Health Portfolio Board reports to the transformation board Reports to Population Health & Partnerships Committee • Population Health Management Programme • Health Protection Programme • Vaccination Programme Reports • Regional Partnership Board Annual Report • Transformation Fund and Leadership Board Updates • Mental Health Strategic Update

• Creating Health, Improving Care, Sustaining our Future and Inspiring People Strategic Pillars • Primary Care clusters Services: • Integrated Level 2 and Level 3 Weight Management Services – established in September 2022. • Smoking Cessation Service	
Gaps in Controls and Assurances	**Mitigating Actions**
Delay in developing health protection / immunisation capacity	Recurrent funding for 24/25 onwards now secured. All Hazards Health Protection plan in draft form
~~Limited analytical and health intelligence capacity, particularly in specialist areas such as epidemiology~~	~~Long Term Conditions - CTMUHB AHPs are developing a multidisciplinary model of care for Long Term Conditions termed 'My Health, My Way' – this programme builds on existing services, enhancing a 'needs based' approach, where patients can access help when and where they need it, for complex long term conditions. This builds on the model adopted for Long COVID rehabilitation and is expanding for patients with ME/CFS, fibromyalgia, persistent pain and other physical health conditions. Recruitment has been successful in the most part and referrals routes are open. Q4 2023/24 - Collaborative working with WISE service will enable a comprehensive CTMUHB level 3 rehabilitation offer in the community with coaches and peer support. Q1 2024; the level 4 secondary care rehabilitation service will look to expand to self-referral, and gradually expand the remit of the service driven by clinical evidence based and as training and education of the workforce continues.~~
Strategic Focus on prevention/ inequalities	CTM2030 strategy; Creating Health Portfolio board Creating Health Delivery Plan ~~planned for~~ drafted in Q4 2023/24.
Capacity for population health management	Population health management programme maturing alongside primary care clusters; implementation within health board

Impactful action to address health inequalities	• Whole system approach to Healthy weight • Help me quit/ hospital programme • WISE • Cancer inequalities group • Implementation of Stroke equity Audit recommendations
Coherent prevention (1,2,3) for high burden diseases	Partnership work underway with PHW to address diabetes, with links to CVD, MSK etc.
Ability to influence wider system partners/ determinants of health	Engagement in partnership fora (RPB, PSB, Leaders groups)
Linked National Priority Measures	**Current Performance - Highlights**
Population Health – Ministers Measures Phase One • Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All Wales Weight Management Pathway • Qualitative report detailing progress against the Health Boards' plans to deliver the NHS Wales Weight Management Pathway • Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally. • Percentage of adult smokers who make a quit attempt via smoking cessation services Qualitative report detailing the progress of the delivery of inpatient smoking cessation services and the reduction of maternal smoking rates	Please refer to Integrated Performance Dashboard - Quadruple Aim 1.

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

No

Associated Risks from the Organisational Risk Register

Risk no.	Description	Current score
5462	Adult weight management service - Insufficient capacity to meet demand	**20**
5579	Rising childhood obesity rates resulting in an increase in obesity related conditions and poorer health outcomes.	**16**
5726	Public Health Funding for Microbiology Testing New risk escalated to the Organisational Risk Register in May 2024.	**15**

Click here to go back to the summary Section

Strategic Goals: **Sustaining our Future** • Becoming a green organisation • Ensuring our Services financial sustainability Embedding value based healthcare • Ensuring our estate is fit for the future	Risk score **16**

Strategic Risk 10: **Failure to plan and manage revenue resources within the Revenue Resource limits set by Welsh Government (WG)**		
If the Health Board fails to plan and manage its revenue resources within the Revenue Resource limits set by WG.	***Then*** we may fail to fulfil our two statutory financial duties (i.e. Approved IMTP and break even over 3 year period) and also the planned break-even position for 2024-25.	***Resulting in*** inability to fund planned improvements and new services, and increased regulatory scrutiny and enforcement.

	Consequence	Likelihood	Score
Initial	4	4	16
Current	4	4	16
Target	**4**	**3**	**12**
Risk Appetite	**Minimal** *(financial stability)* **Cautious** *(legal and regulatory)*		

Risk Score Trend this Period:

New risk escalated May 2024

Risk Score Trajectory

New risk escalated May 2024

Rationale for assessment of risk score: *Including where risk score remains unchanged and for any changes*	The Health Board has submitted a balanced financial plan for 24/25 but this plan includes significant risks, including the delivery of £26.3m of efficiency savings.
Risk Treatment Assessment *i.e. Treat, Tolerate, Transfer etc.*	The financial plan highlights a number of significant risks for 24/25. This risk will therefore be ***treated*** until there is confidence that the Health Board can achieve the planned break even position.

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

Controls	Assurances reported to Board and committees
Financial Management • Financial Accountability letters issued by CEO. • Budget setting process and Budgetary control	**Financial Management** • Annual Report and Accounts • Monthly Finance Reports • Monitoring Returns to Welsh Government

• Standing Financial Instructions • Scheme of Reservation & Delegation • Local Counter-Fraud Service • Monthly financial performance reviews for Care Groups and corporate directorates	• Internal Audit Programme • External Audit Programme • Losses and Special Payments Report to Audit & Risk Committee
Gaps in Controls and Assurances	**Mitigating Actions**
1. Understanding of budgetary control and procurement processes in some services	• Deliver budget holder training within Care Groups/Directorates – *Ongoing throughout 2024-2025.* • Deliver procurement training to departments where compliance with procurement processes is low - *Ongoing throughout 2024-2025.*
2. A recognised risk of shortfalls in savings delivery	• Develop a more project and programmatic approach to planning and delivery of efficiency savings schemes, with a focus on pipeline schemes for 25/26 as well as schemes in delivery for 24/25. • Disseminate the learning from the Health Board's Value Based Healthcare projects to drive service planning and improvement going forward. • Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery.
Linked National Priority Measures	**Current Performance - Highlights**
1. YTD position 2. Savings plan position 3. Agency spend as a percentage of the total pay bill 4. Public Sector Prompt Payment (PSPP) Performance.	Information on the M1 position for 24/25 was not available at the time of submitting this report.

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

None

Associated Risks on the Organisational Risk Register

Risk No.		
5764	Failure to achieve the planned break even position in 24/25 (New risk escalated to the Organisational Risk Register in May 2024)	**16**
5765	Failure to reduce the £19.4m recurrent deficit at the start of 24/25 down to the planned £2.1m recurrent surplus at the end of 24/25. (New risk escalated to the Organisational Risk Register in May 2024)	**16**

Agenda Item
5.4

CTM Health Board

Annual Board Effectiveness Self-Assessment

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Consultation with Board Members via email	April 2024	Majority endorsement of Level 4 Maturity Reflections captured.

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Board is required to undertake an annual self-assessment of its effectiveness. The purpose of this report is to bring together the sources of assurance that support this assessment process. During the year the Health Board has undertaken and/or engaged in a number of assessments that would provide internal and external sources of assurances to support the Board in undertaking its annual effectiveness assessment, details of which are included in the appendices to this item.

1.2 The Board has also reflected on the findings of Audit Wales Board Effectiveness Review into Betsi Cadwaladr University Health Board, specifically in the area of 'Building a more cohesive and effective Board and Executive Team'.

2. Specific Matters for Consideration

2.1 Please refer to the supporting documentation appended to this report.

3. Key Risks / Matters for Escalation

3.1 The areas identified for further improvement will be taken forward by the Chair, with the support of the Director of Corporate Governance / Board Secretary, utilising a future Board Development Session.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not considered required for this activity.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate):	If no, please include rationale below: Not considered required for this activity.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board are asked to **APPROVE** the Self-Assessment Maturity Rating of Level 4 as outlined in the appended reports.

6. Next Steps

6.1 The learning identified will be led by the Chair utilising a future Board Development Session.

Cwm Taf Morgannwg University Health Board (CTMUHB)

Annual Assessment of Board Effectiveness 2023-2024

The Board is required to undertake an annual self-assessment of its effectiveness. The purpose of this report is to bring together the sources of assurance that support this assessment process.

1. BACKGROUND

1.1 During the year the Health Board has undertaken and/or engaged in a number of assessments that would provide internal and external sources of assurances to support the Board in undertaking its annual effectiveness assessment, these are outlined below:

2. INTERNAL SOURCES OF ASSURANCE

Effective Management of Board Business Review

2.1 In January 2024, the Board consulted on a proposal to review areas of Board Business. This proposal resulted in a recommendation to March 2024 Board to approve a number of changes which are summarised as below;

- Committee structure review:
- Clarity on the use of Board Development and Board Briefing sessions:
- Formalising the approach to agenda planning sessions.

2.2 The Board tested its rationale for change against the key areas of review that are considered in the annual Structured Assessment (SA) process, undertaken by Audit Wales, as outlined below:

- SA Criteria: There is an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, and meets statutory requirements (in terms of quality, performance, finance, workforce etc.).

  CTMUHB Response: The revised Committee Structure took into account the mandatory and statutory elements outlined in the Model Standing orders and any Welsh Government /legislative requirements such as Mental Health Act as appropriate.

  Each Committee indicates how it aligns to the Strategic Goals and the strategic risks outlined in the Board Assurance Framework.

  The successful integration of the new structure will be measured through self-assessment, such as the annual Board and Committee Self-Assessment effectiveness surveys and externally via the annual Structured Assessment review undertaken by Audit Wales.

- SA Criteria: Board business is distributed equally and fairly across all committees, and there are appropriate arrangements in place to manage cross-cutting matters (e.g., workforce).

  CTMUHB Response: The revised Committee Structure provided an opportunity to review how Board Business is allocated and agendas and cycles of business have been revisited to ensure business is balanced across all Committees.

  The agreed cross-referral process remains for all Committees. This is captured in the Chairs Briefs and Committee Chairs are supported by the Corporate Governance Team if a referral is identified during Committee meetings. Should there be any instances during the meeting where it is felt appropriate to make a Committee Referral, there are three questions that will be considered:

  - What is the issue being referred?
  - Why are we seeking the referral?
  - What is the outcome anticipated as a result of the referral?

- SA Criteria: Committee Terms of Reference are clear and provide adequate coverage of all relevant health board functions.

  CTMUHB Response: In undertaking the review of the Committee Structure, the Corporate Governance Team revisited the following reference points:

  - Public Bodies (Admission to Meetings) Act 1960 (the Act)
  - Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (the Regulations)
  - Model Standing Orders
  - Audit Committee Handbook
  - WG Effective Board Committees (and sample terms of reference and operating arrangements). A Governance Good Practice Guide August 2010.

  The current Terms of Reference are fit for purpose, however, all Committee Terms of Reference are being reviewed in response to the Committee review and will be submitted to the May Board for approval. These will be supported by draft agenda templates and cycles of business.

- SA Criteria: Committees have up-to-date, appropriate, and balanced work programmes (informed by statutory requirements and key strategic priorities and risks).

  CTMUHB Response: In response to any changes in Board Committee structure there will be a review of all Committee Cycles of Business to ensure they remain fit for purpose and balanced. These will be presented

to the May 2024 Board as part of the suite of governance documents that will be going forward for approval.

- SA Criteria: Committee agendas are organised in a way that facilitate adequate discussion, scrutiny, and challenge during meetings.

  CTMUHB Response: The importance of agenda planning has been recognised in this review and there will be a more formal structure adopted for agenda planning which will include:

  - Previous meeting reflections and learning
  - Agenda for next meeting
  - Review of cycle of business and forward work planning
  - Cross reference to the Board Assurance Framework

  Agenda template examples have been developed to ensure there is a standard approach to routine business.

- SA Criteria: Committee meetings are well chaired, and members observe the relevant meeting etiquette.

  CTMUHB Response: Every Board Member has received a copy of the Independent Member Scrutiny toolkit which supports this area of assessment.

  On an annual basis a self-assessment will be undertaken for each Committee which will ask specific questions in this area.

  The "how did we do" question will continue to be asked at the end of every meeting.

  Structured Assessment review will also test the Health Board in this area.

- SA Criteria: Committee papers are clear, timely, and contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

  CTMUHB Response: This will always be a process of continued improvement. In March 2024, the Corporate Governance Team re-established their report writing and presenting education programme which will be rolled out across the Health Board as appropriate. The learning goals for this session is for participants to leave the session feeling more confident and equipped to write a report and/or present at a Board or Committee in accordance with the agreed business standards.

- SA Criteria: There are clear arrangements in place to support the effective cross-referral of matters between committees, and to escalate matters from committees to the Board.

  CTMUHB Response: There is an established Committee Referral process in place that will continue. This is captured in the Chairs Brief for each meeting and Chairs are supported by the Corporate Governance Team.

Matters will be continued to be highlighted to Board via the Committee Highlight Reports.

- SA Criteria: Committees provide effective, reliable, and timely assurance to the Board.
  When new arrangements are established, we would be seeking assurance that the Board has carefully considered whether:

1. New committee is really required to meet business need or whether the function(s) could be overseen by the whole Board or another committee.

The two new Committees replace existing Committees and have been proposed in order to better meet the business needs of the Board by avoiding duplication of discussions in relation to performance and strategy.

The business of the meetings have been mapped to ensure scheduled business matters are met and that the frequency is appropriate.

2. New committee would lead to a lack of clarity over committee roles or create a lack of alignment with other committees and / or the Board.

It is considered that the revised structure creates an improved delegation of Board business. The new committees will hopefully support the avoidance of duplication.

3. The Health Board has the capacity to support a new committee (in terms of IM time and wider corporate governance capacity to administer it).

The proposal reduces the number of Committees within the Board Structure which will provide Independent Members with additional capacity to support them to undertake additional walkarounds, site visits etc. to further triangulate assurance and seek other areas of intelligence.

Board Development Session – Developing High Quality Care Cultures

2.3 In August 2023, Professor Michael West facilitated a Board Development session exploring the role of the Board in embedding inclusive, collective and system leadership in order to sustain compassionate cultures for high quality care. The strategic purpose of this session was to support "Building a Cohesive and Effective Board" and supported Board engagement and relationship building.

Corporate Governance in Central Governance Departments: Code of Practice 2017

2.4 An assessment against the **Corporate Governance in Central Governance Departments: Code of Good Practice 2017**, has been completed using the "Comply" or "Explain" approach. The Self-Assessment against the code of good practice is attached at Appendix 2.

"Good Governance" Activity

2.5 The Health Board continues to adopt the following "Good Governance" activity as business as usual:

- Introduction of **reflective practice** following all Committee and Board meetings to aide continuous improvement of the management of meetings and Board business.
- **Board Committee Effectiveness –** There is a programme in place to ensure Committees of the Board review the following activity on an annual basis.
    - Terms of Reference and Operating Arrangements
    - Committee Effectiveness Annual Surveys
    - Committee Cycle of Business
    - Annual Committee Reports on Activity to the Board

2.5 **Independent Member Scrutiny Toolkit.** This toolkit is designed to support Independent Members (IMs) to provide constructive challenge in their role as Board Members. It may also be of use to Executive Directors to provide constructive challenge to their peers as papers progress through Committees to the Board. This was aligned to the all-Wales Independent Member Scrutiny Toolkit in year. Attached at Appendix 3.

2.6 The **Board Assurance Framework** is now embedded and supports the Board in the triangulation of risks, performance and assurance.

2.7 **Board Development Programme / Board Briefings**
A regular programme of Board Development activity continues, coupled with Board Briefings on topical issues as and when appropriate.

2.8 **"In Committee" Private Meetings and Chairs Urgent Action**
The use of In Committee meetings and/or Chairs Urgent Action is infrequent and only by exception where items have been considered to include Personal Identifiable Information, business or commercially sensitive. This classification is applied in the context of the Freedom of Information Act exemptions. The Health Board is committed to being open and transparent in the conduct of its Board and Committee business.

Annual Review of Risk Management Strategy, Risk Appetite and the Board Assurance Framework

2.9 The annual review of the Risk Management Framework is undertaken routinely involving Board Members in determining whether the approaches remain fit for purpose and a good source of assurance. The latest review commenced in March 2024 and will be presented to the Audit & Risk Committee and Health Board meeting thereafter for approval.

Responding to the 2022-2023 Annual Board Effectiveness Self-Assessment

2.10 The following feedback was captured in the 2022-2023 self-assessment and the action taken in response is outlined below:

What could we be doing better?	Action in Response 2023-2024
Strategic Discussions • Continue to review how the Board allows sufficient time for discussions on strategy	This has been a driver in the Effective Management of Board Business review with greater visibility at Board Development Sessions. The clarity on the role of the Board in determining and setting strategy and also the proposal to establish a Board Committee "Strategic Direction Committee".
Effective Board Business • Reviewing the committee structure to ensure it is still meeting the needs of the Board.	This review commenced in January 2024 with a proposal submitted to Board in March 2024. If supported implementation will follow in the latter part of the year.
Presentation of Performance Information and Data • Continue to review how performance information is presented to the Board to ensure Board members can focus on the key issues. • Improvement in the presentation of data to enable the Board to be better-informed. For example; unless simply setting a baseline for future reference, graphs should normally have at least three data points to identify the direction of travel and assess progress over time. This would support the Board focus on performance.	At the Board Development Session in April 2023 a focussed session was received on the content of the existing Performance Dashboard. This session explored the introduction of identifying local metrics to support and improve reporting. Work continues in this area.
Board Visibility at a Service Level • More could be done in terms of Board engagement with staff at the front line and patients, although it is acknowledged that work is underway in this area.	Executive Director & Independent Member Quality & Patient Safety Walkrounds continued during 2023-2024 with regular reports to the Quality & Safety Committee.
Estate Plan • Positive progress is now being made in relation to workforce strategy; similar progress required in relation to CTM Estate.	Estate Plan linked to CTM 2030. Estates activity now more prominent at the Planning, Performance & Finance Committee to improve visibility at a Board Committee level.

Board Training and Development	Action in Response
• Further Board Development activity on effectively working together	In August 2023, Professor Michael West facilitated a Board Development session exploring the role of the Board in embedding inclusive, collective and system leadership in order to sustain compassionate cultures for high quality care.
• Development and engagement of Board in discussions on elements of strategy e.g. digital, workforce, sustainability, population health • Cyber security to be embedded in the cyclical programme for Board Development and Training.	The Board Development Session in February 2024 had a focussed item on Digital & Data activity including Cyber. A session on Public / Population Health is planned for the Board Development Session in June 2024. The People Services Team are scheduled to lead a session on culture later in the 2024-2025 programme.
• A suggestion would be more sessions focussed on finance and regional partnerships, however, it is appreciated that each Board member will have different needs and views.	These are included on the topic list for Board Development programmes to explore with Board Members in terms of requirements for the session and priority.

External Sources of Assurance & Review

Audit Wales Structured Assessment

2.11 This review was undertaken during 2023 and the full report and management response is available here: Publication | Audit Wales

2.12 Key findings were:

- *"Overall, we found that the Health Board has generally effective arrangements to ensure good governance; however, opportunities exist to improve some of these arrangements further. Addressing the financial challenges currently facing the Health Board and preparing a long-term Clinical Services Plan and an approvable Integrated-Medium Term Plan remain key priorities for the Board".*
- **Board Transparency, Effectiveness and Cohesion** – *"We found that the Board and its committees operate effectively, cohesively, and transparently, but opportunities to further enhance some arrangements remain."*
- **Corporate Systems of Assurance** – *"We found that the Health Board's risk, performance, and quality governance arrangements continue to strengthen, but further work is required to ensure they are fully embedded across the organisation and achieving the desired impact."*
- **Corporate Approach to Planning –** *"We found that the Health Board's corporate planning arrangements have matured, and work is underway to*

develop the Clinical Services Plan. However, as with other Health Boards, it has been unable to produce an approvable IMTP. Furthermore, its arrangements for monitoring the delivery of corporate plans and strategies require further improvement".

- **Corporate approach to managing financial resources – "***We found that despite a clear process for financial planning, and good arrangements for managing and monitoring the financial position, the Health Board's financial position is extremely challenging for 2023-24".*

2.13 Recommendations identified within the report are monitored via the Audit & Risk Committee through to completion via the Audit Tracker report.

Board Assurance Framework

2.14 NHS Wales Shared Services Partnership, Internal Audit Services undertook a review of the BAF. The final report issued in April 2023 provided an assessment outcome of Substantial Assurance.

Joint Escalation and Intervention Arrangements status – Quality & Governance Area

2.15 On 11 September 2023, the Health Board were informed of the Minister's decision regarding the escalation status of CTMUHB following the most recent tripartite meeting. Summarised in the table below is the previous status (agreed September 2022) and the status as at September 2023:

Area	Previous Status	New Status
Quality and Governance, Leadership and Culture, and Trust and Confidence	Targeted Intervention	Enhanced Monitoring

2.16 The Health Board was delighted that following a significant programme of work and sustained improvements that quality and governance, leadership and culture and trust and confidence was de-escalated.

Quality Governance Review (Audit Wales and Health Inspectorate Wales)

2.19 In response to the identification of weaknesses in governance around quality governance arrangements, Health Inspectorate Wales (HIW) and Audit Wales (AW) undertook an urgent review, the findings of which were initially published in November 2019. A subsequent report published in May 2021 set out details of progress made since the original 2019 review. A further follow-up review was undertaken in March 2023 and the key findings from the "CTMUHB – Quality Governance Arrangements Joint Review Follow-Up – August 2023" are captured below:

- *"The Health Board has made significant progress in addressing the substantial concerns and recommendations set out in our 2019 report.*

- *As part of our work, we reviewed the Health Board's arrangements for overseeing the implementation of our 2019 recommendations and the delivery of the required improvements to maternity and neonatal services. We found that the Health Board's arrangements were effective and transparent. Senior Executives and Independent Members have been fully involved, providing a good balance of support, scrutiny, and challenge. The Health Board has also ensured that staff and other stakeholders have appropriately been informed of progress on an ongoing basis.*

- *The Health Board has a stronger strategic focus on quality and patient safety compared to 2019. The Health Board's new three-year Quality Strategy clearly articulates the organisation's quality vision, mission, pledge, ambitions, and goals. It also sets out clearly the Health Board's approach to quality, as well as what success will look like. The strategy, together with the new three-year Quality and Patient Safety Framework, provides a good foundation to support the delivery of the new Duty of Quality and Duty of Candour, which came into effect in April 2023. At the time of our work, the Health Board was developing an Annual Quality Work Plan to set out the quality objectives to support delivery of the strategy. Whilst this is a positive development, finalising the plan at pace must remain a priority for the Health Board to ensure corporate and operational teams fully understand their role in delivering the quality ambitions and goals of the organisation. The Health Board also needs to put robust arrangements in place to monitor the delivery of the plan and strategy to ensure they are improving quality outcomes as intended".*

2.20 The full report is available here: Cwm Taf Morgannwg University Health Board - Quality Governance Arrangements Joint Review Follow-up (audit.wales)

2.21 No further follow-up reviews are planned and progress against any remaining recommendation actions will be monitored through self-assessment and the Audit Tracker received by the Audit & Risk Committee.

2 ASSESSMENT

Following due consideration of section two and the supporting appendices, the Board is asked to confirm what it considers the overall level of maturity to be for the Health Board in respect of governance and board effectiveness for 2023-22024, based on the following criteria:

Assessment Matrix level **Tick the matrix box that most accurately reflects how your service is doing with this standard**	Level 1 In terms of Board effectiveness and Board Governance: We do not yet have a clear, agreed understanding of where we are (or how we are doing) and what / where we need to improve.	Level 2 In terms of Board effectiveness and Board Governance: We are aware of the improvements that need to be made and have prioritised them, but are not yet able to demonstrate meaningful action.	Level 3 In terms of Board effectiveness and Board Governance: We are developing plans and processes and can demonstrate progress with some of our key areas for improvement.	Level 4 In terms of Board effectiveness and Board Governance: We have well developed plans and processes and can demonstrate sustainable improvement throughout the service.	Level 5 In terms of Board effectiveness and Board Governance: We can demonstrate sustained good practice and innovation that is shared throughout the organisation and which others can learn from
			2020-2021 ✓	*2023-2024* ☑ *2022-2023* ✓ 2021-2022 ✓	

3 RECOMENDATIONS

Based on the majority of returns received, the Board has concluded its maturity rating in respect of Board Effectiveness / Governance, Leadership and Accountability to be **Level 4.**

The above assessment will be reported in the Accountability Report.

In concluding this process and in demonstrating continued self-reflection as well as an appetite for continuous improvement, Board Members were asked to identify any areas of activity or improvement which is captured on page 11 onwards.

4 BOARD MEMBER REFLECTIONS

In the Board Member's opinion what are we doing well as a Board?	**A Cohesive and Effective Board** • Able to hold conversations around difficult topics to good effect - professional challenge, respectful, solution-focused. • Relations between the Board members are good and there is a willingness on the part of the Executive members to engage honestly with the Independent Members. • Ensuring that new Board members are properly inducted and supported in their new roles • Developing positive conversations regarding quality and performance improvement. • Ensuring all Board colleagues are able to contribute their views/opinions. • Discussions are inclusive and appropriately challenging. • The relationships across the Board are constructive and respectful. • Collaborating, listening and challenging as a team. • Good at asking the difficult questions and expecting full answers from Executives - this is very evident and also welcome. • When we discuss difficult thorny issues the Board is very receptive and express a wide variety of views but we end the sessions much further forward and clearer on why or what the direction we are taking is. • There is a good working relationship in the Boardroom which allows for constructive and effective challenge and scrutiny • Chair and CEO encourage open and honest conversations and allow time for all Independent Members and others to have their views. • Good representation and discussions led by both members of the Executive teams and others within CTM. I hope that people always feel they are respected and included • The Board is effective in setting strategy, developing insight and response to a multitude of complex issues, and has built a mature and effective working relationship across the membership. • Clear strategy/vision for 2030. • Strong values. • Good partnership working. • Acknowledging where improvements need to be made and highlighting these areas, putting actions in place to mitigate risks. • Working well as a Board with a good range of skills and experience across the IMs and Executive Directors. We are able to ask questions and provide constructive challenge and support and have good discussions when needed. • Relationships and working together are strong. Appropriate levels of challenge and support. • I believe there is sense of shared purpose between Independent Members and Executives, as a result of open, honest discussions and debate about the opportunities and challenges faced by the health board - this includes those issues which are beyond the immediate responsibilities of CTMUHB but which have a profound impact upon our services, staff and patients. • In terms of 'soft' skills, the Board seems able to discharge its function with humour and compassion - the importance of which should not be underestimated. **Effective Scrutiny and Challenge** • Supporting challenge and deep dives into areas of concern. • Providing effective challenge from Independent Members. • Improved questioning from Independent Members and challenging the Executives in a constructive way. • Independent Members provide effective critique. • Good level of constructive scrutiny and debate at Board Committee level. • There is a generally positive atmosphere at Board meetings and Committees, and challenge is constructive and well-tempered. • The culture of challenge and scrutiny feels robust but constructive, with collective ownership of issues and tangible trust and confidence in the ability of the executive to deliver. **Service User and Staff Experience** • Sufficient time for patient story and conversation afterwards at Board meetings. • Patient and staff views are well represented through presentations, surveys, incidents etc. • We listen and learn from patient and staff stories at the start of committees and the Board and these are used to develop future direction of services. • Listening and Learning stories. • Hearing from staff and patients. • Good display of patient stories. **Board Development & Board Briefings** • Board Development Sessions assist in gaining better understanding of the issues facing the Board and the exemplar practices we are already carrying out. • Making increasingly effective use of Board briefing and development sessions. • Excellent Board Development sessions covering a wide range of topics relevant to such a big Health Board. • Board development sessions are extremely helpful and I find the range of topics very conducive to ongoing development. • I love our Board Development days and feel that we cover the right subjects. **Risk Management and Board Assurance Framework** • Through collaboration as a Board and wider teams, our risk register is showing continuous and maintained improvement. • Managing effective governance of the organisation and focussing on key risks facing CTM.

	• The development and implementation of the BAF has been positive. • Keeping a line of sight across a very wide range of issues, getting better at giving time to those that are high priority on the basis of risk and opportunity. **Effective Governance and Management of Board and Committee Business** • The use of the consent agenda has allowed the Board to concentrate on business critical issues however has maintained the ability to move issues to the main agenda so as not to prevent members discussing any matters they feel necessary. • Board meetings are well chaired. • Papers are well-written and board members critically discuss contents. • Building from Targeted Intervention /Special Measures, embedding strong governance across Board and Committees. • Meeting content aligns to the risk register and key strategic issues. • Our Governance processes have been reviewed and improved since I first joined the Board, we have Terms of Reference, Committee Effectiveness Surveys (the results of which are acted upon), an annual cycle of business for all committees together with committee highlight reports to Board and an annual committee report. • Process and structure of the Board and its committees are rigorously overseeing a clear governance process. • Balance between strategy and operational assurance much improved; • Improved quality of reports; • I believe that we are performing better compared to previous years. The running of the Board is now very efficient and professional. As is usual however what we could achieve as an organisation is severely limited by the lack of finance. • Board meetings proceed efficiently and to time. Members have a good opportunity to contribute to discussions. Decisions are clear. • Effective, well-chaired meetings, clear focused agendas with appropriate content, opportunity to contribute, thorough induction process. • There is a good balance of items in Board agendas and we make good use of the time in the meeting by utilising the Consent Agenda where appropriate • The papers are well written and issued on a timely basis with clear objectives, risks and outcomes for example. • The governance team are excellent and support the Board and Committees as well as co coordinating the BAF and risk assurance framework for example. • Clear and well written papers with clear defined outcomes (i.e. For noting or for approval or for discussion)
In Board Members opinion what could we be doing better as a Board?	**A Cohesive and Effective Board** • Building on the skills and experience of all the Board members given many new Independent Members have recently joined the Board. • Continuing the constant review of whether the Board is hearing the voices of staff at all levels, patients and their families. • The Board needs to continue its process of self-development, acknowledging skills gaps and focusing on those pressured areas of demand which require most assurance. **Increased visibility of Board Members** • Greater visibility within the organisation of Board Members not only on the allocated walkabouts, do we visit community groups that support our services and our patients if not we should be exploring the possibility. Increased ability for Board Members to walkabout without a large senior presence which our people report does not encourage them to be open and honest and does not always allow us to triangulate what we are being told by the senior teams with the perspective of all our people. • The Board to be out as a collective holding meetings in other District General Hospital's and our community settings. Greater ability of Board Members to attend face to face meetings which helps to develop improved working relationships and promotes cohesiveness. We need to close the loop on our listening and learning story as not always clear on the learning that has taken place or how services have improved or not as a result. • Visibility - We feel we are very visible as Executives and the Independent Member / Executive walk around are very good however not sure many front line appreciate the role of the Independent Members. • With so many acute sites, community hospitals and community teams being visible is not an easy thing to be for all to see us. • Public engagement is a work in progress but we are moving in the right direction. • I personally feel that I could do more networking with staff and site visits but am aware that others do considerably more of this so the balance is probably right. **Effective Governance and Management of Board and Committee Business** • Planned review of new Board governance structures - impact, effectiveness, benefits, etc. • Usually there are technical issues with video clips at Board - would be good to get this sorted. • Detailed scrutiny of papers happens elsewhere (appropriately so) - brief reference to this is made in the Board meeting but perhaps the headline focus of those discussions would provide reassurance to others. • Increasing the profile of Committees at Board (i.e. being clear where performance has been reviewed at committee and the feedback into Board). • The review of committees is helpful but should remain under scrutiny as they are established. • Papers do not need to be so long.

	• Streamline meeting papers. • To develop the effectiveness of Board meetings further - it's ensuring that the various items on the agenda all have a clear purpose and something which the Board can take forward. Patient/staff stories are an incredibly important aspect of meetings but they need to be relevant to the wider agenda or future meetings. The March 2024 Board meeting was a better example of how we can use these more effectively to further the work of the Board. • The consent agenda is useful however we need to continue to ensure members feel they can bring items onto the main agenda if merited. • The revised committee structure will need bedding in once started and then reviewed in e.g. a year's time. • Sometimes it feels like agendas are too packed and therefore meetings can run over. Is there scope for even more rationalisation about what comes to Board and what can be signed off by Committees? Alternatively, could we make meetings longer so that we have more time for in depth discussions? • The Board could zone in on certain topics to give a greater depth of understanding / assurance. In addition, the level of Board / Committee scrutiny of certain key topics (e.g. Coroner's Inquests) could be stronger and more robust. **Strategic Direction and Discussion** • A greater degree of focus on the strategic issues facing the Health Board and ensuring we have time to discuss/debate how CTM's strategy responds to these. • Ensuring we have a clear set of objectives/plans for the Board which Independent Members can review regularly and hold Executives to account to deliver. • Ensuring that we find the balance of appropriate governance and assurance with relevant and timely discussion on strategic issues. • Remaining strategic in our discussions and not revisiting issues already discussed at committee unless appropriate. • The digital agenda including availability and use of data, however, a recent Board Development session on Digital Strategy, identified areas of weakness and outlined the way forward. • Strengthening the balance between acute/primary care community; • A need to focus on children services - CAMHS, Neuro-diverse patients, reduce waiting lists, delays in Adoption medicals - is there enough resource in this area. • Ensure focus on strategic matters and not deep diving into very operational matters (Executive responsibility) in specific areas of interest of Independent Members. • Emphasis on the importance of diagnostics in patient pathways. • Focus on wider strategy than operational detail. • The scrutiny at Board / Committee level is often operational, and not necessarily strategic. • Patient/service user's stories are a powerful way of focusing minds at Board meetings and reminding members that the currency we are trading in is the lives of those living in and around CTM. I think we could patient stories more strategically, aligning topics to key priorities in order for patient experience - positive or negative -to help inform decision making. **Performance Reporting** • Data analysis in performance reports to ensure the right discussions are happening; A move to time series data - to provide the Board with a longitudinal view and therefore mitigating lengthy discussions on one data point. **Board Development & Board Briefings** • Review is currently underway of what constitutes board "development" and "briefing". • The Board development days have been helpful but I do think that these should be prioritised by everyone so there is maximum attendance when they happen, I am not sure that is the case now. They are a great opportunity for learning and for networking and relationship building. The Board would be less effective without these training opportunities. • Training on specific topics. • We should continue to have more discussion time in board development days and more pre reading as we have started to do.
Is there any further Board Development / Training you would consider helpful as a Board Member	**A Cohesive and Effective Board** • Looking forward to further Boyden session. • A board skills/experience exercise to understand the board members expertise and experience to ensure we are making best use of this. • Further Board development focussed on 'how' we work effectively together and to better understand how the IMs would prefer to receive and process information about topics at the Board. • Use the establishment of the new committee structure as an opportunity to ensure committees focus on items based on the BAF and risk register rather than delving into operational detail - therefore maybe some further development in this area. • Alongside the development of the new committees I think reference to the toolkit to ensure we are appropriately strategic and ensuring agenda setting is effective will be essential. • Continuing in our current vain of bringing the difficult issues to the full Board so discuss the direction proposed but also explain and address the concerns IMs raise. These are always excellent are really useful sessions. • Few smaller group discussions so the Independent Members and Executives really get to know each other and appreciate the skill sets and what we all bring. Would promote even further integration but also challenge I think. • The Board has talked about the development of a structured Board Development programme which would be beneficial for all

- Having missed the Prof Michael West session as I had not started then so a recap on this, especially with a couple of other new IMs recently joining, might be useful at some point this year.
- Expedite the maturing of new Independent Members into the organisation.

Partnership / Joint Working

- Joint board development sessions with Local Authorities (appreciating the differences in structure and mandate), WAST, HEIW, PHW, etc. to better engage on system solutions to share issues.
- Sharing learning from adult and child practice reviews where relevant to health boards.
- Thinking about the role and relationship of the Board to other organisations.
- I would appreciate some focused sessions on adult social care to improve understanding of the challenges faced by Local Authorities, and the barriers that may be preventing a more agile approach to the problem of delayed discharges.

Mandated Training

- Helpful to cover off some mandated training (safeguarding, information governance).

Finance

- A session on NHS Finance might be beneficial.
- Finance Training.
- Finance is the most complicated area. How the numbers stack up and how Board is able to set a budget is one subject matter that members would benefit from.

Strategic Direction and Discussion

- CTM 2030 plans, facilities, workforce constraints, governance processes - all topics that would be good to discuss.
- How to act as a board in relation to novel issues such as AI, workforce of the future, climate change etc.
- A deeper focus on primary care, dentistry and the care sector would be useful.
- As a board member how do we manage risks e.g. long waiting lists?

2023-2024 – CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) SELF ASSESSMENT AGAINST THE CORPORATE GOVERNANCE – CODE OF PRACTICE 2017

REF	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 1	Each organisation should have an effective board, which provides leadership for the business, helping it to operate in a business-like manner. The board should operate collectively, concentrating on advising on strategic and operational issues affecting the department's performance, as well as scrutinising and challenging departmental policies and performance, with a view to the long-term health and success of the Trust. (2.1 and 2.2)	The Effective Management of Board Business proposal aims to further strengthen this area. Proposal will be presented to the Board Meeting in March 2024. The Health Board meets every other month. A Board Cycle of Business is reviewed and approved on an annual basis. The Board routinely receives information on strategic activity, risk and performance matters as set agenda items. The Board has been fully engaged in the development of the CTM: 2030: Our Health Our Future. The Integrated Medium Term plan is scrutinised by the Board. The Board collaborates with partners and key stakeholders as described in the Integrated Medium Term Plan. At the end of each Board and Board Committee meeting the following questions are included on each agenda to support reflective feedback: "How did we do in this meeting?" • Is there anything we should do more or less of? • Have we managed our time well and allowed open and balanced discussion? • Have we considered our values and acted in a way that supports embedding our values across CTM? • Have we maintained a strategic focus? • Have we received sufficient assurance from a range of sources? • Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion. .	Comply	Board and Committee Minutes – demonstrate scrutiny and support. Effective Management of Board Business Proposal. Reference to Board Papers-28th March 2024. Audit Wales Structured Assessment report 2023.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 2	The Board does not decide policy or exercise the powers of the ministers. The department's policy is decided by ministers alone on advice from officials. The board advises on the operational implications and effectiveness of policy proposals. The Board will operate according to recognised precepts of good corporate governance in business: • Leadership – articulating a clear vision for the department and giving clarity about how policy activities contribute to achieving this vision, including setting risk appetite and managing risk • Effectiveness – bringing a wide range of relevant experience to bear, including through offering rigorous challenge and scrutinising performance • Accountability – promoting transparency through clear and fair reporting. • Sustainability – taking a long-term view about what the department is trying to achieve and what it is doing to get there. (2.3)	The completion of a three-year Integrated Medium Term Plan (IMTP) is a statutory requirement for CTMHB. The proposed approach for the 2023-2026 IMTP is to be set in the context of CTM: 2030: Our Health Our Future. CTM 2030 built from service plans for each care group and the corporate portfolios and with relation to partnership planning mechanisms. he intention is to develop a full three-year plan, with the expectation that the plan for the first of the three years will provide more detailed milestones with broader objectives and high-level milestones set for the remaining two years of the plan. It is the Health Board's ambition to seek to achieve a financially sustainable position over the period of the IMTP. However, the financial position moving into 2024-2025 continues to be challenging. The IMTP outlines how the Health Board engages and ensures that it considers the principles of citizen engagement, the Wellbeing of Future Generations Act and also the Health Board's Wellbeing Statement. The Health Board continues to adopt Welsh Government (WG) Model Standing Orders and Standing Financial Instructions (SOs and SFIs), last issued in May 2021, the Health Board's SO's and SFI's are designed to translate the statutory requirements into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of Directors and a Scheme of Decisions to Officers and Others, they provide the regulatory framework for the business conduct of the Health Board. These documents form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Board's Values Framework and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.	**Title:** Audit Wales Structured Assessment **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Standing Orders and Standing Financial Instructions. Audit Wales Structured Assessment report 2023. Integrated Medium Term Plan. CTM: 2030: Our Health Our Future. Board Development Programme.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 4	The Board should meet on at least a quarterly basis; however, best practice is that boards should meet more frequently. The Board advises on five main areas: • Strategic Clarity • Commercial Sense • Talented People • Results focus • Management information (2.4 and 3.10)	The Health Board meets every other month. The Board and Board Committees all have a Cycles of Business that are reviewed annually. The Board routinely receives information on strategic activity, risk and performance, workforce planning matters as set agenda items. The Integrated Medium Term Plan is considered and approved by the Board. The Integrated Performance Dashboard is received at every regular Board meeting. The Board are engaged in the development of the Health Boards Strategy - CTM: 2030: Our Health Our Future. The Board approved the four strategic goals of Creating Health, Improving Care, Sustaining Our Future and Inspiring People and their aligned priorities for action at its Board meeting in January 2022.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion. .	Comply	Standing Orders and Standing Financial Instructions. Audit Wales Structured Assessment report 2023. IMTP. Integrated Performance Dashboard. Board and Committee meeting Agendas and Papers.
CGC 5	The Board also supports the accounting officer in the discharge of obligations set out in *Managing Public Money1* for the proper conduct of business and maintenance of ethical standards**.** (2.7)	The Board approves the Accountability Report on annual basis which includes the Statement by the Accountable Officer assuring the Board on the System of Internal Control. A Governance Statement is also received by the Health Board's hosted organisations (Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC). An Annual Compliance Statement will also be received from the National Imaging Academy, all of which inform and support the Accountable Officer in providing assurance to the Board.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Accountability Report and Hosted Organisations Annual Governance Statements and Compliance Statements. Audit Wales Structured Assessment report 2023. Annual Plan.
CGC 6	Where Board members have concerns, which cannot be resolved, about the running of the department or a proposed action, they should ensure that their concerns are recorded in the minutes. (2.12)	Any concerns raised at Board and Committee meetings are formally recorded in the minutes. The role of the Director of Corporate Governance/Board Secretary is responsible for ensuring these matters are effectively managed, recorded and resolved where possible.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Role of the Board Secretary Audit Wales Structured Assessment report 2023. Board and Committee meeting Agendas and Papers.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 7	The Board should have a balance of skills and experience appropriate to fulfilling its responsibilities. The membership of the board should be balanced, diverse and manageable in size. (3.1, 3.11, 3.12 and 3.13)	Constitution is set out in the Health Board's Establishment Orders and the Health Board abides by this composition. The Health Board's Standing Orders also outlines the composition of the Board. Executive Director Skill mix is considered prior to recruitment to align with Strategic Objectives and required Executive Portfolios, and this is considered prior to new appointments. Workforce Planning is supported by the People and Culture Directorate. The Independent Member roles are appointed in areas of expertise to ensure appropriate Skill Mix. Welsh Government Public Appointments Unit support the process in accordance with the set criteria within an Independent Member Role. Independent Member membership on Board Committees are rotated at appropriate times to ensure there is mix and balance of experience across all meetings. The commitment of Board Members has been reviewed as part of the Effective Management of Board Business review commenced in January 2024.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Health Board's Establishment Orders. Health Board's Standing Orders. Table of Board and Committee Membership. Effective Management of Board Business Proposal. Reference to Board Papers-28th March 2024.
CGC 8	The roles and responsibilities of all board members should be defined clearly in the department's board operating framework. (3.2)	Constitution is set out in the Organisations Establishment Orders and the Trust abides by this composition. Standing Orders also captures the Composition of the Board.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Health Board's Establishment Orders. Health Board's Standing Orders.
CGC 9	The Finance Director should be professionally qualified. (3.3)	The Executive Director of Finance & Procurement is professionally qualified.	N/A	Comply	Recruitment and appointment documentation for the Executive Director of Finance & Procurement.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 10	Independent Members will exercise their role through influence and advice, supporting as well as challenging the executive. (3.5)	Annual Committee Self-Assessment surveys address the effectiveness of how Committees operate and conduct meetings allowing debate and constructive challenge. Meeting principles adopted that support this constructive challenge. Independent Member Scrutiny Toolkit developed and launched in December 2021. Reflective exercise held at the end of each Board and Committee meeting (Introduced in November 2021). The introduction of questions on consent items in advance of Board and Committee meetings has also highlighted the level of scrutiny and challenge members exercise. The compulsory Welsh Government new Independent Member Training captures effective challenge and scrutiny role on the Board. The Health Board's Standing Orders outline the role of the Board Members. Health Board Independent Member induction programme and pack established.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Audit Wales Structured Assessment report 2023. Independent Member Scrutiny Toolkit. Independent Member Induction Pack. Cross – reference to 2.4.
CGC 11	The board should agree and document in its board operating framework a *de minimis* threshold and mechanism for board advice on the operation and delivery of policy proposals.	A Board Cycle of Business is approved on an annual basis. The Terms of Reference Operating Arrangements for the Board Committees articulate the remit information that should be received. The Scheme of Delegation outlines the information that should flow through to Board and its Committees as appropriate. Board Committee Cycles of Business reviewed annually which support the flow of required information through the Board Committees.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Audit Wales Structured Assessment report 2023. Terms of Reference and Operating Arrangements for Board Committees. Board and Committee Cycles of Business. Standing Orders and Scheme of delegation. Board and Committee meeting papers outlining the questions received in advance.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 12	The Board Should ensure that arrangements are in place to enable it to discharge its responsibilities effectively, including: 1. formal procedures for the appointment of new board members, tenure and succession planning for both board members and senior officials 2. allowing sufficient time for the board to discharge its collective responsibilities effectively 3. induction on joining the board, supplemented by regular updates to keep board members' skills and knowledge up-to-date 4. timely provision of information in a form and of a quality that enables the board to discharge its duties effectively 5. a mechanism for learning from past successes and failures within the departmental family and relevant external organisations 6. a formal and rigorous annual evaluation of the board's performance and that of its committees, and of individual board members 7. a dedicated secretariat with appropriate skills and experience (4.1)	The Independent Member Terms of office are monitored by the Director of Corporate Governance/Board Secretary to ensure succession planning is timely and managed in conjunction with the Public Appointments Unit in Welsh Government. Agenda planning is managed by the Director of Corporate Governance/Board Secretary in conjunction with the Chair and CEO to ensure adequate time is spent on the right things at Board meetings. The use of the Consent Agenda and Questions in advance support this process. There is a Board Induction Programme to support the appointment of all Board Members (IM's and Executive Directors). There is a robust induction pack that is shared on appointment. For Independent Members specifically, the induction programme consists of the following areas to ensure that a robust and supportive induction plan is in place for all new Board appointments: • Attendance at the Mandatory Welsh Government Induction Training. • Provision of a detailed induction Pack which includes information about the role of each Board Committee, their role as a Charity Trustee as well an Independent Member • Core Induction Programme – planned within the first month, three months and six months. This includes meeting with the Executive Team and Care Group Directors, and site visits where appropriate. • A buddy and/or shadow arrangement with an existing/experienced Independent Member. • To further support Independent Members ongoing Development the Chair undertakes regular and robust Personal Appraisal and Development reviews in accordance with Welsh Government guidance. • The Health Board has a schedule of Board Development Sessions throughout the year for learning and regular Board Briefings to discuss topical issues. Report templates are continually reviewed to ensure they support effective reports being received at the Board. A training programme has been designed and will be rolled out to support Health Board Officers in preparing for and writing reports for Board and Committees. The Corporate Governance Function support Board and Committee Business overseen by the Head of Corporate Governance & Board Business, Assistant Director of Governance & Risk and the Director of Corporate Governance/Board Secretary. The Director of Corporate Governance/Board Secretary seeks feedback on the effectiveness of the support from the Corporate Governance function to Independent Members in	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Audit Wales Structured Assessment report 2023. Terms of Reference and Operating Arrangements for Board and Committees. Board and Committee Cycles of Business. Standing Orders and Scheme of delegation.

		each of their appraisals to ensure that the function is meeting their requirements. The Director of Corporate Governance/Board Secretary is supported by a Governance Support function with experienced and qualified governance professionals appointed. Board and Board Committee Effectiveness Surveys (Self-Assessment) are undertaken on an annual basis.			
	Corporate Governance Code Principles	**Evidence of Internal Assurance / Supporting Narrative**	**External Assurance**	**Comply or Explain**	**Supporting documentation**
CGC 13	The terms of reference for the nominations committee will include at least the following three central elements: • scrutinising systems for identifying and developing leadership and high potential • scrutinising plans for orderly succession of appointments to the board and of senior management, in order to maintain an appropriate balance of skills and experience • scrutinising incentives and rewards for executive board members and senior officials, and advising on the extent to which these arrangements are effective at improving performance (4.5)	The Terms of Reference and Operating arrangements are based on the model Standing Orders and ensure that roles and responsibilities of Board Committee capture scrutiny and assurance roles.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Audit Wales Structured Assessment report 2023. Terms of Reference and Operating Arrangements for Board and Committees. Board and Committee Cycles of Business. Standing Orders and Scheme of delegation.
CGC 14	The attendance record of individual board members should be disclosed in the governance statement and cover meetings of the board and its committees held in the period to which the resource accounts relate. (4.6)	Board Members attendance records for Health Board and Board Committee meetings are captured in the Accountability Report on an annual basis. Attendance at meetings is also considered at annual appraisal discussions.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Accountability Report section of the Health Boards Annual Report.
CGC 15	Where necessary, board members should seek clarification or amplification on board issues or board papers through the board secretary. The board secretary will consider how officials can best support the work of board members; this may include providing board members with direct access to officials where appropriate. (4.10)	This is the relationship between the Director of Corporate Governance / Board Secretary and the Board Members. The role of the Director of Corporate Governance/Board Secretary is to act as principal advisor to the Board and the organisation as a whole on all aspects of governance, and to ensure that it meets the standards of good governance set for the NHS in Wales.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Board Secretary role description. Standing Orders.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 16	An effective board secretary is essential for an effective board. Under the direction of the permanent secretary, the board secretary's responsibilities should include: • developing and agreeing the agenda for board meetings with the chair and lead non-executive board member, ensuring all relevant items are brought to the board's attention • ensuring good information flows within the board and its committees and between senior management and non-executive board members, including: • challenging and ensuring the quality of board papers and board information • ensuring board papers are received by board members according to a timetable agreed by the board • providing advice and support on governance matters and helping to implement improvements in the governance structure and arrangements • ensuring the board follows due process • providing assurance to the board that the department: • complies with government policy, as set out in the code • adheres to the code's principles and supporting provisions on a comply or explain basis (which should form part of the report accompanying the resource accounts) • acting as the focal point for interaction between non-executive board members and the department, including arranging detailed briefing for non-executive board members and meetings between non-executive board members and officials, as requested or appropriate • recording board decisions accurately and ensuring action points are followed up • arranging induction and professional development of board members (including ministers) 4.11	The Director of Corporate Governance/Board Secretary undertakes these roles as Board Secretary for the Health Board with the support of the Corporate Governance Function.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Board Secretary role description. Standing Orders.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 17	Evaluations of the performance of individual board members should show whether each continues to contribute effectively and corporately and demonstrates commitment to the role (including commitment of time for board and committee meetings and other duties). 4.14	Independent Member appraisal process in place with the Chair and Executive appraisal process in place with the Chief Executive; the latter reported through the Remuneration and Terms of Service Committee. Annual Committee Effectiveness surveys. Attendance record reported in Accountability Report.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Accountability Report Appraisal Documentation and Process.
CGC 18	All potential conflicts of interest for non-executive board members should be considered on a case by case basis. Where necessary, measures should be put in place to manage or resolve potential conflicts. The board should agree and document an appropriate system to record and manage conflicts and potential conflicts of interest of board members. The board should publish, in its governance statement, all relevant interests of individual board members and how any identified conflicts, and potential conflicts, of interest of board members have been managed. 4.15	The Health Board has an agreed process in place for managing Declarations of Interest. All Board Members are asked to formally declare on annual basis and advised of their responsibility to notify of any changes in year. Declarations of interest are captured on a register which is available for public inspection. A report on Declarations of Interest is received by the Audit & Risk Committee and Executive Leadership Group. Declarations of Interest are captured at the start of each Board and Board Committee agenda. The Standards of Behaviour Policy details the responsibility under Declarations of Interest. Standing Orders also outlines the responsibilities for Declarations of Interest. The Declaration of Interest form was further strengthened and approved in January 2023.	**Title:** Audit Wales Structured Assessment Captured in the Internal Audit Programme of Work. **Reference Point:** Structured Assessment - Section 10 – Board transparency, effectiveness and cohesion.	Comply	Standards of Behaviour Framework Policy. Standing Orders. Declarations of Interest Process and Register. Declarations of Interest Form. Audit Wales Structured Assessment report 2023
CGC 19	The board should ensure that there are effective arrangements for governance, risk management and internal control for the whole departmental family. Advice about and scrutiny of key risks is a matter for the board, not a committee. The board should be supported by: • an audit and risk assurance committee, chaired by a suitably experienced non-executive board member • an internal audit service operating to *Public Sector Internal Audit Standards*1 • sponsor teams of the department's key ALBs (5.1 and 5.8)	The Health Board's Audit & Risk Committee is chaired by the Independent Member Finance/Audit Lead. NWSSP Internal Audit Services are appointed as the Trust Internal Auditors. The Health Board's Hosted Organisations report into CTM's Hosted Audit & Risk Committee and inform the Annual Accountability Report though individual Governance / Compliance Statements. The Organisational Risk Register is considered at agenda planning meetings for the Board and Board Committees. The Annual Internal Audit Plan is informed by the Organisational Risk Register, Board Assurance Framework and previous audit work as appropriate.	**Title:** Audit Wales Structured Assessment Internal Audit Report – Review of Risk Management – January 2021 – *Reasonable Assurance Rating.* Internal Audit report – Board Assurance Framework 2022-23 – Substantial Assurance rating. **Reference Point:** Structured Assessment - Section 10 – Board	Comply	Terms of Reference & Operating Arrangements for the Health Board's Audit & Risk Committee. Accountability Report. Audit Wales Structured Assessment report 2023

			transparency, effectiveness and cohesion.		
	Corporate Governance Code Principles	**Evidence of Internal Assurance / Supporting Narrative**	**External Assurance**	**Comply or Explain**	**Supporting documentation**
CGC 20	The board should take the lead on, and oversee the preparation of, the department's governance statement for publication with its resource accounts each year. The annual governance statement (which includes areas formerly covered by the statement on internal control) is published with the resource accounts each year. In preparing it, the board should assess the risks facing the department and ensure that the department's risk management and internal control systems are effective. The audit and risk assurance committee should normally lead this assessment for the board (5.2 and 5.13)	The Governance Statement is included within the Accountability Report which is received by the Audit & Risk Committee to endorse approval formally by the Health Board each year.	**Title:** Audit Wales and Internal Audit receive the Accountability Report for comment and ensuring compliance with the Manual for Accounts. **Reference Point:** Audit Wales Structured Assessment Report Section 10 – Board transparency, effectiveness and cohesion.	Comply	Accountability Report Board and Committee minutes. Annual Report Timetable.
CGC 21	The board's regular agenda should include scrutinising and advising on risk management (5.3 and 5.10)	The Health Board approve the following key documents within the Health Board: - Risk Management Strategy (Including Risk Appetite and the Board Assurance Framework). - Risk Management Policy The Organisational Risk Register is received in its entirety at the Audit & Risk Committee and assigned risks are considered at each Board Committee meeting as appropriate. The Organisational Risk Register is also made available to Board Members at each Board meeting for reference when scrutinising the Board Assurance Report. The Board Assurance Framework Report is received at every regular meeting of the Board.	**Title:** Audit Wales Structured Assessment Internal Audit Report – Review of Risk Management – January 2021 – *Reasonable Assurance Rating.* Internal Audit Review – Board Assurance Framework – *Substantial Assurance rating.* **Reference Point:** Audit Wales Structured Assessment Report Section 10 – Board transparency, effectiveness and cohesion.	Comply	Board and Committee meeting Agendas and Papers. Risk Management Strategy. Risk Management Policy. Internal Audit Review Report on Risk Management – January 2021. Internal Audit Review – Board Assurance Framework – April 2023. Organisational Risk Register. Board Assurance Framework

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 22	The key responsibilities of non-executive board members include forming an audit and risk assurance committee. The board and accounting officer should be supported by an audit and risk assurance committee, comprising at least three members. An audit and risk assurance committee should not have any executive responsibilities or be charged with making or endorsing any decisions. It should take care to maintain its independence. The audit and risk assurance committee should be established and function in accordance with the *Audit and risk assurance committee handbook.* The board should ensure that there is adequate support for the audit and risk assurance committee, including a secretariat function. The terms of reference of the audit and risk assurance committee, including its role and the authority delegated to it by the board, should be made available publicly. The department should report annually on the work of the committee in discharging those responsibilities Boards should ensure the scrutiny of governance arrangements, whether at the board or at one of its subcommittees (such as the audit and risk assurance committee or a nominations committee). This will include advising on, and scrutinising the department's implementation of, corporate governance policy. (5.4 and 5.9, 5.11, 5.12 and 5.14 and 5.15)	The Standing orders are explicit that the Health Board as a minimum must establish Committees that cover certain aspects, one of which is Audit. Audit & Risk Committee established. The Terms of Reference and Operating Arrangements in respect of the Audit & Risk Committee are clear in relation to its authority and delegated responsibilities. Full secretariat function in place supporting the Audit & Risk Committee. The Audit & Risk Committee Terms of Reference are published as a schedule to the Standing Orders on the Health Board's website. The Board Assurance Framework is scrutinised by the Board and Audit & Risk Committee through the consideration of the Risk Management Strategy. Audit Wales and Internal Audit have a routine invite to all Board meetings.	**Title:** Audit Wales Structured Assessment Report **Reference Point:** Section 10 – Board transparency, effectiveness and cohesion.	Comply	Standing Orders. Terms of Reference for the Audit & Risk Committee. Health Board's Internet Site: Key Publications. Board Assurance Framework – contained within the Risk Management Strategy.

	Corporate Governance Code Principles	Evidence of Internal Assurance / Supporting Narrative	External Assurance	Comply or Explain	Supporting documentation
CGC 22	The head of internal audit (HIA) should periodically be invited to attend board meetings, where key issues are discussed relating to governance, risk management processes or controls across the department and its ALBs (5.5)	The role of the Head of Internal Audit (HIA) is clearly set out in the Health Board Standing Orders. The HIA attends all Audit & Risk Committee meetings which report to Board. If there was anything specifically escalated to the Board then the HIA would be invited to attend. The HIA has direct access to the CEO and Chair.	**Title** Head of Internal Audit Opinion Report	Comply	Standing Orders. Terms of Reference for the Audit Committee. Health Board's Internet Site: Key Publications.
CGC 23	The board should assure itself of the effectiveness of the department's risk management system and procedures and its internal controls. The board should give a clear steer on the desired risk appetite for the department2 and ensure that: • there is a proper framework of prudent and effective controls, so that risks can be assessed, managed and taken prudently • there is clear accountability for managing risks • Departmental officials are equipped with the relevant skills and guidance to perform their assigned roles effectively and efficiently. The board should also ensure that the department's ALBs have appropriate and effective risk management processes through the department's sponsor teams Advising on key risks is a role for the board. The audit and risk assurance committee should support the board in this role. (5.6, 5.7 and 5.10)	The Health Board has an agreed Risk Management Strategy – *approved by the Health Board in May 2023.* The Risk Management Strategy outlines the Health Board's Risk Appetite and Board Assurance Framework. The Risk Management Strategy articulates a clear Service to Board Risk Escalation pathway. Regular monthly training dates have been established to cover the Risk Management Strategy, Risk Assessment Process and Datix Risk Entry. The Assistant Director of Governance Risk has risk as dedicated responsibility within their portfolio. The Hosted Organisations are aligned to the Health Board's Risk Management Strategy. The Board Assurance Framework was implemented in March 2022 and the Board Assurance Report is received at all regular meetings of the Board.	**Title:** Audit Wales Structured Assessment Internal Audit Report – Review of Risk Management – January 2021 – *Reasonable Assurance Rating.* Internal Audit Review – Board Assurance Framework – *Substantial Assurance rating.* **Reference Point:** Audit Wales Structured Assessment Report Section 10 – Board transparency, effectiveness and cohesion.	Comply	Risk Management Strategy. Risk Management Policy. Internal Audit Review Report on Risk Management – January 2021. Organisational Risk Register. Internal Audit Review – Board Assurance Framework – January to March 2023. Board Assurance Framework Report.

INDEPENDENT MEMBER (IM) SCRUTINY & ASSURANCE TOOLKIT

BACKGROUND

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

OVERVIEW OF IM SCRUTINY ROLE

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

DIVERSE NATURE OF IM ROLE


Strategy


Support


Stretch


Stakeholder


Scrutiny


Safety

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

INDEPENDENT MEMBER FOCUS

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

AGENDA PLANNING

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

FOCUS OF PAPERS

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

REPORT PRESENTERS

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

EXECUTIVE COLLABORATION

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

ROLE OF THE COMMITTEE CHAIR

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

MEETING CULTURE

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

IM LISTENING

Passive listening (focusing on encouraging speaker to open up)

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

Active listening (to check understanding)

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

IM QUESTIONING

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

EXAMPLES OF ISSUES TO CONSIDER AND QUESTIONS TO ASK;

Does the management response accurately reflect the audit recommendations?

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

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

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

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

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

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

ASSURANCE ‘V’ REASSURANCE

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

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

ORGANISATIONAL INSIGHT

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

ORGANISATIONAL INSIGHT

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

CROSS-COMMITTEE WORKING

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

GOVERNANCE FRAMEWORK

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

ESCALATION TO THE BOARD

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

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Find us on

OUR VALUES HELP US BE AT OUR BEST

WE LISTEN, LEARN AND IMPROVE

WE TREAT EVERYONE WITH RESPECT

WE ALL WORK TOGETHER AS ONE TEAM

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

(Agenda Item) 5.5.	30 May 2024	CTM UHB Board	Working in Partnerships Item - Development of Maesteg Hospital

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Dale Stolzenberg, Assistant Director of Transformation
Presented By:	Linda Prosser, Executive Director Strategy & Transformation, & Dale Stolzenberg, Assistant Director of Transformation
Approving Executive Sponsor:	Linda Prosser, Executive Director Strategy & Transformation
Report Purpose	For Noting
Engagement undertaken to date:	Extensive and ongoing internal and external engagement

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Improvement to patient experience in the Llynfi Valley and surrounding communities
Related Health and Care Standard	Services development
Equality and Welsh Language *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Not at this stage as we're still developing the first two (of three) business cases for the proposed scheme
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes. Change of scope of services that will be delivered in Maesteg, but on a revenue cost-neutral basis
Link to Strategic Goals	Sustaining Our Future Inspiring People Improving Care Creating Health

Creating an Integrated Health, Care & Wellbeing Hub at a redeveloped Maesteg Community Hospital

30 May 2024

A long & locally-treasured history…

- Built in the 1910s for, and funded by, local Miners
- Some of the first patients returned from WWI front
- Strong community attachment to the Hospital
- For example, many residents born before 1984 were born at the Hospital
- Steady degradation of services over decades and community expectation of closure until…

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Significant & ongoing community engagement

Current challenges to improving health in the Llynfi Valley:

- Access to information on services available across all providers
- Access to groups and advice to help avoid social isolation
- Long-waiting lists for health services
- Availability and cost of transport to and from Princess of Wales Hospital, Bridgend
- Parking at Princess of Wales Hospital, Bridgend
- Lack of transport to Maesteg Community Hospital
- Parking at Maesteg Community Hospital
- Difficulties in accessing timely GP appointments
- Lack of community transport in the Llynfi Valley
- Poor housing in the community
- Lack of local employment

Returning beds to Maesteg Community Hospital:

- Opportunity for a new-bed facility on the site for EMI nursing, step up/step down, reablement, respite, rehab and palliative care
- Long-term care for dementia patients

Create a community space:

- Community Café on-site for all to use, including a space for peer groups to meet (dementia café, neurocafe etc.)

Improving use of local assets:

- Improve the use of Maesteg Welfare Park for health and wider services
- Funding junior park run
- Outdoor yoga, Pilates and mindfulness classes

Embedded multi-disciplinary teams at Maesteg Community Hospital:

- Increasing local authority services at the Hospital, including co-location of the Bridgend North Integrated Network
- Drug and Alcohol Services
- Mental Health Teams
- Third Sector involvement, such as Age Connect Morgannwg
- Services to improve healthier eating and nutrition, including cooking classes
- Utilise local Employability Scheme
- Citizens Advice and other advice charities

Redevelopment of Maesteg Community Hospital:

- Modernise but be sensitive to the original features, such as the external façade, tiles in reception and external clock
- Improve wheelchair access
- Create a main entrance and reception
- Change the name of the Hospital, but will always be known locally as the 'Hospital'

Improving wider Llynfi Valley health and care Services:

- Information Hub for local health and wellbeing services with a town centre location
- Better offer to help prevent illnesses
- Improved access to Dementia Groups etc.
- Better coordination of health and care services locally
- Broaden access to men's groups, such as Men's Sheds, to improve men's health and reduce isolation
- More 'Be Happy' activities – dance classes etc.
- Warm Hubs

Future services at Maesteg Community Hospital (building upon current services) to create a Hub and Spoke Model:

- Minor Injury and Illness Unit with improved X-Ray services
- Urgent Primary Care Services
- Children and Families Centre
- Women's Health Hub
- Anti-Natal and Post-Natal Clinics
- Sexual Health Clinic
- Weight Management Services
- Day Centre / Hospital
- Physiotherapy
- Phlebotomy Services
- Increased outpatient clinics
- Remote / Virtual Appointments (preventing need to travel)
- Improved local diagnostic services
- Mobile Testing: CT and MRI Scanning
- Additional Mental Health Services
- Broader range of clinics for diabetes etc.
- Preventative Services, such as frailty / fall clinics
- Better use of technology to support patients in the community
- Better local support for those with Learning Difficulties
- Community Dental Services
- Services addressing chronic diseases

Decarbonising Maesteg Community Hospital:

- Solar panels
- Solar cladding
- Ground Source Heat Pumps
- EV Chargers
- Community garden

- 7 public engagement sessions held in first 6 months of 2023
- Ongoing community, third sector and political representatives engagement
- Identified key health and community services to address significant health inequalities locally
- Identified key building features to be retained

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University Health Board

Health services:

Retention of on-site GP and opportunity for Primary Care expansion

Urgent Treatment Centre

Enhanced radiology and ultrasound services

Increased Outpatient Services and Minor Procedures Treatment Rooms across a wide-range of clinical specialties, inc. Women's and Children's Hub

Enhanced Therapies offer, including podiatry and cancer prehab

Community Mental Health Services and wider mental health support services

Community Dental Services

Sexual Health Clinic

Increased utilisation of digital services

Care services:

Inpatient D2RA intermediate care unit

Meeting the needs of our communities at the planned Maesteg Hub

Wellbeing services:

Co-locating Bridgend Integrated Network Team North

Range of Bridgend County Borough Council (BCBC) Children's Services on-site activity

Range of BCBC front of house activities on a part-time basis

Co-created share community spaces for use by key third sector partners, including (but not limited to): Bridgend College, BAVO, Citizens Advice, The Awen Trust and Mental Health Matters Wales

Community Café

Meeting CTM and National policies:

Integration and Rebalancing Care Fund (IRCF)

CTM 2030

Cwm Taf Morgannwg Regional Partnership Board (created under the Social Services and Wellbeing (Wales) Act 2014)

'A Healthier Wales, the Welsh Government's Long-term Plan for Health and Social Care'

4 of the Welsh NHS 'six goals for urgent and emergency care'

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- Co-locating Bridgend Integrated Network Team North
- Range of BCBC Children's Services on-site activity
- Range of BCBC front of house activities on a part-time basis
- Community Café
- Co-created shared community spaces for use by key third sector partners, including (but not limited to):

Bridgend College Coleg Penybont

BAVO

Bridgend Association of Voluntary Organisations

Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr Bridgend County Borough Council

awen Ymddiriedolaeth Ddiwylliannol Cultural Trust

citizens advice

MENTAL HEALTH MATTERS WALES

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

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Urgent Treatment Centre

Enhanced radiology and ultrasound services

Increased Outpatient Services and Minor Procedures Treatment Rooms across a wide-range of clin

Enhanced Therap

Community Menta

Community Denta

Sexual Health Cli

Increased utilisati

Care services:

Inpatient D2RA intermediate care unit

Meeting CTM & national policies:

- Integration and Rebalancing Care Fund (IRCF)
- CTM 2030
- Cwm Taf Morgannwg Regional Partnership Board (created under the Social Services and Wellbeing (Wales) Act 2014)
- 'A Healthier Wales, the Welsh Government's Long-term Plan for Health and Social Care'
- Relevant Welsh NHS 'six goals for urgent and emergency care'

Wellbeing se

Co-locating Bridg

Range of Bridgen activity

Range of BCBC front of house activities on a part-time basis

Co-created share community spaces for use by key third sector partners, including (but not limited to): Bridgend College, BAVO, Citizens Advice, The Awen Trust and Mental Health Matters Wales

Community Café

Cwm Taf Morgannwg Regional Partnership Board (created under the Social Services and Wellbeing (Wales) Act 2014)

'A Healthier Wales, the Welsh Government's Long-term Plan for Health and Social Care'

4 of the Welsh NHS 'six goals for urgent and emergency care'

Desired outcomes

This project will help improve access to health services in Maesteg and its surrounding communities and tackle significant health inequalities that exist by, amongst others:

- Reducing the number of 'Did Not Attend' and 'Could Not Attend' appointments from within the community across all age ranges
- Decreasing the number of late presentations for a range of health issues
- Decreasing the numbers of Llynfi Valley residents presenting themselves at A&E and Urgent Primary Care services at the Princess of Wales Hospital, Bridgend
- Identified and agreed plan for intermediate care (inc. rehabilitation and reablement) in Bridgend
- Improving awareness, access and utilisation of third party and local authority services

Design principles underpinning redevelopment

- Clinical spaces:
  - will be flexible and multi-purpose and not dedicated to one speciality, wherever possible
  - Where a clinical speciality requires a dedicated room, consideration will be given to how the room can be shared with another relevant speciality / department to maximise usage
  - Outpatient and Treatment Rooms will be bookable / timetabled

- Non-clinical spaces:
  - No individualised desks and smaller desks to maximise number of desks available
  - No single occupancy offices and a focus on open plan, multi-purpose workspaces
  - Shared common Spaces (eg. Reception Desks, Waiting Areas etc.)
  - Bookable meeting rooms

- Building features that must be retained / included based on community engagement:
  - External façade and clock tower
  - Tiles in Outpatients Reception
  - Single entrance with large common space

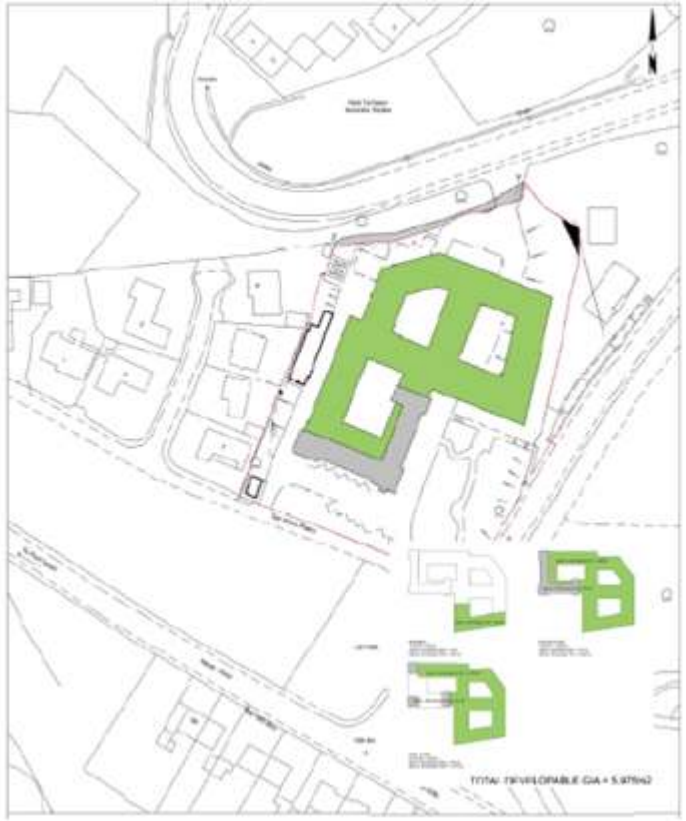
Scope of existing site and redevelopment options

- Current Maesteg Hospital site is 3,100 square metres
- Current planned services scope, including meeting modern healthcare standards, suggests a need for anywhere between 4,200 and 7,500 square metres
  - Likelihood is a requirement for between 4,200 and 6,000 square metres
- Work underway to refine services requirements to determine exact need
- Estimated benchmarking suggests capital costs of £10m per every 1,000 square metres
- Based on these estimates, the Maesteg Health, Care and Wellbeing Hub project could be anywhere between **£42m and £60m capital development cost for Maesteg**
- Current funding of £476k under the Welsh Government (WG) Integration and Rebalancing Care Fund (IRCF) covers development of joint Strategic Outline Case / Outline Business Case (OBC)
  - Additional WG funding requested to cover survey and inflation costs required for SOC / OBC development
  - Further funding for completing a Final Business Case (FBC) to follow pending WG approval of SOC / OBC
  - IRCF currently open to new capital schemes that have completed FBC until March 2027

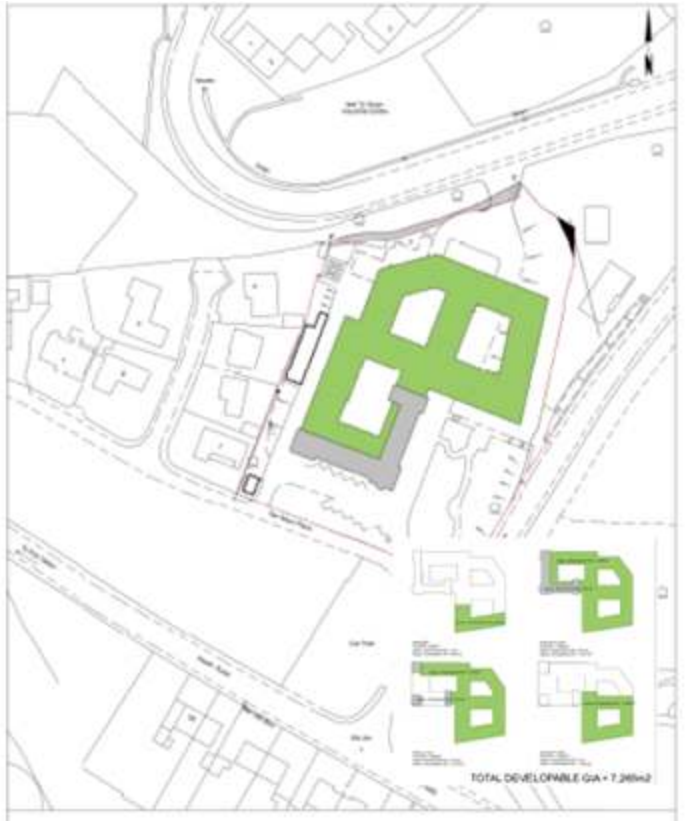
Developable site capacity

At the latest Programme Board, it was agreed to focus on three site capacity options:

4,200 square metres



5,975 square metres



7,295 square metres

Project Risks

Current most significant project risks include:

- Ability to deliver planned healthcare services on a revenue cost-neutral basis
- Availability of capital funding to cover envisaged scheme
- Planning and Highways concerns due to site access, including:
  - parking (current car park held in trust by BCBC on behalf of the Bute Estate)
  - lack of public transport to the current site and need for Active Travel Plan

Extensive internal and external engagement with Welsh Government and BCBC to address these concerns early to avoid any unexpected issues impacting SOC / OBC and FBC submissions

Current Status & Timeline

Jul 2023: Awarded £476k for joint Strategic Outline Case (SOC) / Outline Business Case (OBC) under IRCF

Feb 2024: Key Supply Partners appointed

May / Jun 2024: Services Requirement Workshops

Summer 2024: Initial & design and capital costs completed. Shared with WG to determine final project scope

Sept 2024: Early BCBC planning & highways engagement

Sept-Dec 2024: Ongoing design and development / internal & external engagements to support SOC / OBC

Jan-Mar 2025: Relevant oversight activities

Mar 2025: Submit SOC / OBC to WG

Jun 2025: SOC / OBC approval expected from WG

Early 2026: Submit Final Business Case (FBC) to WG

Mid-2026: FBC approval expected from WG & construction begins thereafter

Appointed External Partners in February 2024:

- **Project Manager:** MACE
- **Cost Advisors:** Gleeds
- **Supply Chain Partner (SCP):** Kier Construction

Recommendation:	The Board are asked to:
	• **Note the ongoing SOC / OBC development (and associated project schedule) for transforming Maesteg Community Hospital into an Integrated Health, Care and Wellbeing Hub**

Agenda Item
5.5.1

CTM Health Board

Public Service Board (PSB) Update- May 2024

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kirsty Smith, Partnership and Community Safety Partnership Manager, Bridgend CBC
Cyflwynydd yr Adroddiad / Report Presenter	Philip Daniels, Exec Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Population Health & Partnerships Committee	20/05/2024	NOTED

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
MT	Merthyr Tydfil
RCT	Rhondda Cynon Taff
CSP	Community Safety Partnership
PSB	Public Services Board
NRW	Natural Resources Wales

1. Situation /Background

1.1 This report provides an overview of the current activities of the Cwm Taf Morgannwg Public Service Board (CTM PSB) and update of the board's activities since the last meeting of the Population Health and Partnerships Committee.

2. Specific Matters for Consideration

Workstream	PSB lead	Update March 2024	Update May 2024
Climate change risk assessment	Executive Director of Strategy & Transformation, CTM UHB	Consultant beginning work 4/4/24 for 9 month contract to produce a climate change risk assessment for the Cwm Taf Morgannwg area. A small task group has been established is using the NRW framework to identify stakeholders, contacts and evidenced of past events and training undertaken.	Consultants have been appointed. A workshop with 65 participants was held on 29th April to set out the risk assessment and explore key issues, what related plans, policies and project are in place that address climate risk, what data is available to help us judge risk, and who else should be involved, specialists and community networks and local contacts across CTM.
Workforce well-being sub board	Valleys To Coast Housing	A standing sub board for the PSB, building on a group from Bridgend PSB, with leads on workforce well-being from partners. Forward work programme includes neurodivergence, menopause and	As small task group on Neuro-divergence has been set up to look at how we support current staff and recruit future staff. Last meeting also looked at support for menstruation from BCBC and fed into the annual report for the PSB. The next session will explore community volunteering for staff and the active travel charter. Work on signing up to be foster friendly is ongoing individually with organisations with support from the Foster Wales team.

		menstruation, bereavement, healthy and well-being and cost of living. Working with Foster Wales on getting PSB partners to sign up to be foster friendly.	
Active Travel Charter	Director of Public Health, CTM UHB	Developing a charter with PSB members to support active travel for health and sustainability benefits. A workshop is being held this week and a larger conference is planned to finalise the charter.	A final draft charter has been prepared for approval by the PSB organisations.
Young Voices	Vice Principal, Bridgend College	A project to bring young voices into the PSB activity. A conference was held with young people from across the area in November. A small number of young people are working with us on a mentoring and work experience project with the PSB members.	A few PSB members have come forward for the reverse mentoring and arrangements are being made.
Collaboration	Chair, Public Service Board	With support from Project Dewi Co-production network for wales a 5 year project with the	The PSB is holding a review of the first 12 months of the regional board at their June meeting that will reflect on how things have gone this last year and where work needs to focus going ahead.

		PSB. Working on the culture and ways of working of the PSB. A workshop held last summer and changes to meetings, 121 meetings with members and support with engagement across the PSB activity. A review of the first year of the PSB will be held shortly.	
Website	PSB Support team	Refreshing the Cwm Taf PSB website to be a focus of information about the CTM PSB. Joining up with the Area Planning Board and Early years programmes to host partnership and related activity. Working with Data Cymru to develop the site and future plans to link to national data and build on the wellbeing assessment.	Work ongoing with Data Cymru. https://www.ctmpublicservicesboard.wales/
Bridgend Food partnership	Bridgend Association of Voluntary Organisations (BAVO)	Development in Bridgend to link with work already in place in RCT and MT in the longer term	The mapping of the food system in Bridgend will be completed this month. The draft charter will also be finalised shortly to become a Sustainable Food Place.

Forward work plan

- Regional CSP – update to next PSB on new structure coming into place in April
- PSB Joint Overview and Scrutiny Panel – update from panel to each meeting on their focus on involvement and collaboration ways of working.
- Budget pressures – an open conversation across PSB members
- PSB support Grant supporting engagement and PSB development
- PSB Annual Report on the well-being plan
- Right care, right person – presentation to last PSB and due to have updates from regional safeguarding board who are leading

3. Key Risks / Matters for Escalation

3.1 As a partnership, progress on these work packages are contingent on ongoing collaboration between partners. Work is planned, supported by Public Health Wales through the Shaping Places for Wellbeing programme, run by Public Health Wales with support from the Health Foundation, to provide a national resource to support Public Services Boards (PSB) in taking a theory and evidence informed systems approach in their work to influence wider determinants of health as they implement their well-being plans, sharing learning between PSB and across the UK.

3.2 A Workshop for the Shaping Places for Wellbeing programme, drawing members from all PSBs across Wales, will be held in June 2024 in Cardiff. A report of this event will be provided at the next committee meeting

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: All
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: All
Dolen i Hwyluswyr Ansawdd	Whole-systems Perspective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Equitable
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the Board **NOTE** the above updates.

6. Next Steps

6.1 Progress will be reported at subsequent Board meetings.

Agenda Item
5.5.2

CTM Health Board

Regional Partnership Board (RPB) Update 2023/24

Dyddiad y Cyfarfod / Date of Meeting	20/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Sarah Mills, Head of Regional Commissioning Unit
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser, Executive Director of Strategy & transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Population Health & Partnerships Committee	20/05/2024	NOTED

Acronyms / Glossary of Terms	
RPB	Regional Partnership Board
RIF	Regional Integration Fund
SSWA	Social services and Well-being Act 2014
HCF	Housing with Care Capital Funding
IRCF	Integration and Re-balancing Care
WG	Welsh Government

1. Situation /Background

1.1 Across Wales Regional Partnership Boards were established under Part 9 of the Social Services and Wellbeing Act (2014) requiring local authorities and health boards to secure a strategic planning partnership to support the integration of services for a range of priorities groups.

1.2 The board brings together partners from health, social care, education, housing, third sector and the private sector as well as carers and citizen representatives.

1.3 These partners work together strategically to develop approaches that will create better health, social care and wellbeing services with a clear focus on co-production and engagement to influence strategic plans and population assessment of need.

1.4 The Social Services and Wellbeing Wales Act require RPBs to report annually on delivery against planned objectives. These reports provide an opportunity to demonstrate to a wide audience the work of the RPB.

1.5 Annual plans are required to be published by 30th June each year. The information noted below provides a summary of the capital and revenue programme delivered under the RPB for 2023/24 and highlights some key priority programmes for 2024/25.

2. Specific Matters for Consideration

2.1 Regional Integration Fund (RIF) end of year financial position is detailed below. The programme achieved a full spend as reported to Welsh Government on 30th April 2024.

2.2 A total of **£22,292,742** was allocated to CTM for financial year 2023/24, which includes funding of **£196,732** for Short Breaks for Unpaid Carers and **£1,703,000** for Dementia Action Plan and Integrated Autism Service.

2.3 RIF is a Match funded programme and the total match funding forecast for the programme for 2023/24 was **£2,530,245** (note this includes match in kind not just cash match).

2.4 RIF supports the development of 6 models of care;

- Community based care – prevention and community coordination.
- Community based care – complex care closer to home.
- Promoting good emotional health and well-being.
- Supporting families to stay together safely, and therapeutic support for care experienced children.
- Home from hospital services.
- Accommodation based solutions

2.5 There is a national reporting framework for RIF. Summary of the key measures is shown below.

Measure	Total
No. of individuals accessing the project	35050
No. of new individuals accessing the project for the first time	4988
No. of referrals received	16684
No. of contacts (count multiple contacts per individual)	52715
No of people received IAA	17552
No of people receiving early help support	21761
No of people receiving Intensive Support	5344
No of People Receiving Specialist Intervention	736
No of individuals feeling less isolated as a result of project support	6945
No of individuals maintaining or improving their emotional health and well-being	6162
No of individuals who feel they have influenced decisions that affect them	13142
No of individuals whose independence has improved or remained the same with the support of the project	3039
No of individuals who feel more confident accessing services following project support	1723
Number of individuals who received support that has prevented them from escalating their level of need	2281

2.6 In addition to the common statistical measures there is a requirement to report 'story of change' templates as part of Welsh Government reporting framework. These reports are available on request.

2.7 To better demonstrate the impact of the programme a series of films have been commissioned. See links below

Complex Care – Community Prevention: BAVO community navigators	**https://youtu.be/KIJsJWEq6_o**
Complex Care Closer to Home: Cwm Taf Care & Repair – health case worker project	**https://youtu.be/NjiNXAD1Mbs**
Complex Care Closer to Home: Bridgend Care & Repair – Dementia First project	**https://youtu.be/FA4kWovXEp8**
Home from hospital: RCT Hospital Discharge Project	**https://youtu.be/M_n2lyyOKs8**

2.8 A summary of capital investment overseen by the RPB is provided below.

2.9 Introduced in April 2022, the new Housing with Care Capital Funding (HCF) and Integration and Re-balancing Care Funding (IRCF), are seen by Welsh Government as enablers to support the development of regional Capital pipeline programmes for investment.

2.10 The Housing with Care (HCF) programme has very specific criteria for large scale Objective 1 and 2 schemes that focus on accommodation where tenancies exist, e.g. for older people and people with learning difficulties (Objective 1), along with residential homes type facilities for children with complex needs, plus other similar schemes (Objective 2).

2.11 In addition to this there is a minor projects Objective 3 programme, that can support small capital works, adaptations and assistive technology that cost up to £100,000 per scheme. The annual budget for this programme to CTM is **£8,729,000**.

2.12 The capital programme enabled the creation of 40 new accommodation beds with a further 97 in trail for 2024/25.

Type of Accommodation Scheme	**Population Group**	**HCF Investment**	**No of Beds**
Extra Care Accommodation Schemes (early stages)	Older People	£2,000,000	60 (at early stages of development
Supported Living Accommodation for People with Learning Disabilities	People with Learning Disabilities	£391,000	22 (at early stages of development)
Prevention & Assessment/ Hospital Discharge Temp Home	Older People/ Various	£208,184*	4 (reconfigure) 2 (new)
Children's Residential Homes	Children Looked After/Complex emotional needs	£2,131,139	29 beds (new completed)
Children's Residential (at early stages)	Children Looked After/ Complex needs	£366,929	15 (early development)
Children Leaving Care Accommodation (16+ years)	Children looked after Leaving Care	£284,362	5 (new completed)
Minor Projects (Objective 3 Programme)	Various (Older people)	£1,410,987	
	HCF BUDGET:	**£8,729,000**	

	PREDICTED END OF YEAR COMMITMENTS:	**£6,792,601**	**40** Total New beds **97** (beds at early stages)
	Predicted Unallocated Funding:	**£1,936,399****	(figures rounded)

*includes Dan yr Allt Scheme, completed in FY 23/24, funding awarded in FY 22/23, agree by WG.

2.13 2023/24 continued to be a difficult year for the construction industry with escalating costs and contractors going into administration impacted on the ability of the programme to achieve full spend.

2.14 Under the Direction of the Capital board, there has been a recognition from Welsh Government for the requirement to overcommit the capital programme for 2024/25 to provide greater options and flexibility at end of year position if scheme timescales slip.

2.15 The Integration and Re-balancing Care (IRCF) programme focusses on Welsh Government's ambitions to develop 50 integrated health and social care hubs across Wales and to support the move towards not-for-profit models of accommodation, re-balancing of the residential care home sector and children's residential homes. This programme requires large scale capital projects to submit business cases to Welsh Government on a bidding process.

2.16 The region has secured two significant investment programmes under IRCF;

- Re-development of Maesteg Community Hospital into an integrated Health and Wellbeing Hub with £476,000 funding awarded to support the development of a Strategic Outline Business Case and joint Outline Business Case. Scheme has been identified as requiring circa £15M to re-develop the former Maesteg Hospital.

- Sunnyside Health and Wellbeing Centre (Bridgend) awarded £17.1M

3. Key Risks / Matters for Escalation

3.1 Community Pathways Implementation is a key programme being taken forward.

3.2 The aim of the programme is to implement a target model of integrated community care services consistently across the region. This will consist of Urgent Community Response and Population Health Management Pathways, and a Clinical Navigation Hub. Pathway development will be underpinned by progress on enablers including streamlined governance, finance and outcomes, digital and engagement.

3.3 Linked to 3.2, the potential role of new organisational forms in an Integrated Community Care System are being explored. Expansion of a Section 33 agreement and the practicalities of a formal public sector Joint Venture are being explored as part of the enablers within the Integrated Pathways implementation Programme.

3.4 Over the past 18 months performance leads from across Wales have been meeting with WG, to discuss the current external reporting process and templates as there has been several issues since the implementation of RIF, including:

- Fitting local projects into models of care restricts ability to demonstrate what's happening on the ground.
- Finance & performance reporting is separate.
- Current reporting regime has significant resource implications.
- Case studies for MOC don't work.
- Report stencils don't allow sufficient narrative.
- Difficult to aggregate national and local data.

3.5 Significant concerns continue, especially in relation to the resource requirements for completing these templates at all levels. Discussions with WG to resolve these are ongoing.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Refine
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No changes to programme delivered.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: No changes to programme delivered.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board are asked to **NOTE** the work under the RPB for 2023/24.

5.2 Note the future direction of travel linked to community pathways.

6. Next Steps

6.1 Formal RPB annual report to be produced by 30th June 2024.

Agenda Item
6.1

CTM Health Board

Integrated Performance Dashboard

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open / Public Not Applicable
Awdur yr Adroddiad / Report Author	Jose Roper, Senior Performance Monitoring Officer
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser, Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Linda Prosser	16/05/2024	Endorsed for Approval

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

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

1. Situation/Background

1.1 During February 2024, Welsh Government released the NHS Performance Framework for 2024/25. The framework supports the delivery of improvements in the Minister's areas of focus and is available to read at the following URL and a summary of the revised measures can be found on page 4:

Cymraeg:https://www.llyw.cymru/fframwaith-perfformiad-gig-cymru-2024-i-2025

English:https://www.gov.wales/nhs-wales-performance-framework-2024-2025-0

2. Specific Matters for Consideration

This report sets out the UHB's performance against the Welsh Government's performance framework and a small number of local priority measures such as stroke care, ambulance red releases, complaints and Level 1 core skills.

A one page summary (page 5) of the UHB's recent performance against the highest profile indicators within the WG framework, which have been the focus of the Executive Directors over the past quarter, is provided overleaf. Over the past month improvements have been noted in 14 out of the 18 areas.

SUMMARY OF REVISIONS TO PERFORMANCE MEASURES

	Performance Measure	Detail of Revision as at February 2024	Detail of Revision by NHS Executive as at May 2024
5	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	Previous Measure: Reported on girls. Reporting Frequency: Dates revised to reflect 2024-25 reporting	
6	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	Reporting Frequency: Dates revised to reflect 2024-25 reporting.	
7	Percentage uptake of the COVID-19 vaccination for those eligible: Spring and Autumn Booster 2024: All eligible people	Previous Measure: Percentage uptake of the COVID-19 vaccination for those eligible: Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over; Autumn Booster 2023: Age range to be confirmed. Reporting Frequency: Dates revised to reflect 2024-25 reporting.	
13	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Reporting Frequency: Dates revised to reflect 2024-25 reporting.	
14	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Previous Target: An increase on the number in the equivalent month in the previous year.	
16	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	N/A	80% by December 2024
18	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years		
20	Median emergency response time to amber calls	Previous Target: 12 month improvement trend.	
21	Median time from arrival at an emergency department to triage by a clinician	Previous Target: 12 month reduction trend.	
22	Median time from arrival at an emergency department to assessment by a clinical decision maker	Previous Measure: Included assessment by a 'senior' clinical decision maker. Previous Target: 12 month reduction trend.	
23	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Previous Target: Improvement compared to the same month in 2022-23, towards the national target of 95%.	
24	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	Previous Target: Improvement trajectory towards a national target of zero by 31 March 2024.	March 2024 baseline 20% reduction by September 2024. Further 20% reduction by March 2025
25	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Previous Target: Improvement trajectory towards a national target of 80% by 31 March 2026.	60% performance by December 2024. 70% performance by March 2025
26	Number of patients waiting more than 8 weeks for a specified diagnostic	Previous Target: Improvement trajectory towards a national target of zero by 31 March 2024.	95% to be zero by December 2024
27	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Previous Target: 12 month improvement trend.	
28	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Previous Measure: Number of patients (all ages) waiting more than 14 weeks for a specified therapy (including audiology). Previous Target: Improvement trajectory towards a national target of zero by 31 March 2024.	Previous Measure: Number of patients (all ages) waiting more than 14 weeks for a specified therapy (including audiology adult hearing aids only). Previous Target: Improvement trajectory towards a national target of zero by 31 March 2024.
30	Number of patients waiting more than 52 weeks for a new outpatient appointment	Previous Target: Improvement trajectory towards a national target of zero.	March 2024 baseline 40% reduction by end of September 2024. Zero by March 2025
31	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Previous Target: Improvement trajectory towards the national target of zero.	
32	Number of patients waiting more than 104 weeks for referral to treatment	Previous Target: Improvement trajectory towards the national target of zero.	Zero by end of December 2024
33	Number of patients waiting more than 52 weeks for referral to treatment	Previous Target: Improvement trajectory towards the national target of zero.	
50	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset (>14 days after admission)	Previous Target: Reduction against the same month in 2022-23.	
51	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Previous Target: 95%.	
52	Number of ambulance patient handovers over one hour	Previous Target: Improvement trajectory towards achievement of zero ambulance patient handover delays >1 hour by March 2024.	March 2024 baseline 30% reduction by December 2024

2.1 Executive Performance Indicators

The direction of the arrow shows whether the quantum of the measure has increased, decreased or statistically no significant change.
The colour is intended to show whether this is positive [green], negative [red] or no significant change/remains within control limits [amber].

Quality

61 NRI's remain open >90 days ➔

This is a slight reduction on the previous period

The % of eligible patients thrombolysed was 27.3% ↑

Compared to last month the rate was 0.0%

85.13 is the rate of E.coli per 100,000 population (2023/24) ➔

Compared to 2022/23 the rate was 86.0

The rolling 12 month mortality rate is 2.53% ↓

Compared to the equivalent period last year the rate was 2.93%

76.2% of complaints received a response within 30 days ↓

Compared to last month the rate was 91.1%

Population Health

72.0% of adults aged 65+ received the influenza vaccine during the last week of Feb 2024 ↑

Compared to the previous period the rate was 71.3%

As at end of Feb 2024 41.4% of frontline healthcare workers received the influenza vaccine ↓

Compared to the 2022/23 season, the uptake was 50%

4.05% of adults who smoke made a quit attempt during Quarters 1 to 3 of 2023/24 ↑

Compared to the previous year 3.18% attempted during the same period

89.2% of children aged 5 were up to date with their vaccinations ➔

Compared to the previous quarter the rate was 89.1%

Operational Performance

66.9% of patients were seen within 4 hours from arrival at an Emergency Department ➔

(there were fewer attendances than the previous month with the number of patients waiting <4 hrs similar)

Compared to last month compliance was 64.5%

100% of GP Practices have achieved in-hours access standards during 2022/23 ↑

Compared to the previous year the rate was 98%

Provisionally there are 2,468 patients waiting longer than 2 years for referral to treatment ➔

Compared to the previous period 2,381 patients had waited this length of time

57.9% of patients started their cancer treatment within 62 days ↑

Compared to the previous month the rate was 49.4%

People

6.81 of staff have been absent due to sickness during the 12 mth period (Apr 23 to Mar 24) ➔

Compared to the previous year the rate was 6.64%

Provisionally the CTMUHB Nursing & Midwifery turnover rate is provisionally 9.45% ↓

Compared to Apr 2023 the rate was 11.43%

64.4% of staff (excluding M&D) have received their PADR ↑

Compared to Apr 2023 the rate was 60.8%

79.9% of staff have completed Level 1 mandatory training ↑

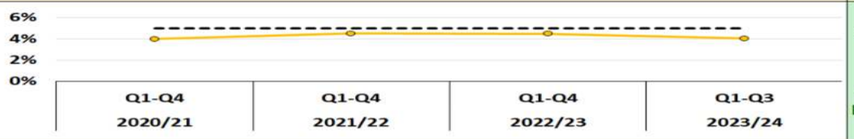
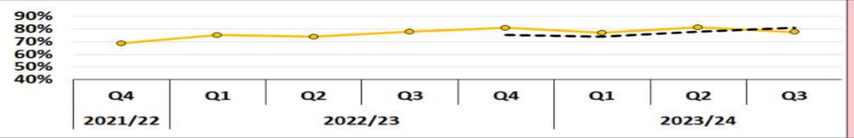
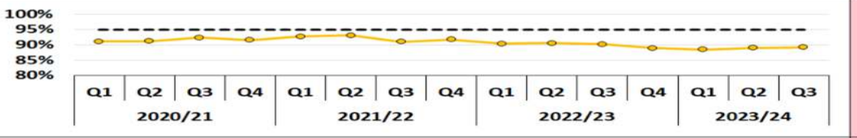
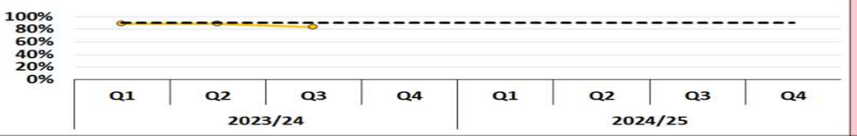
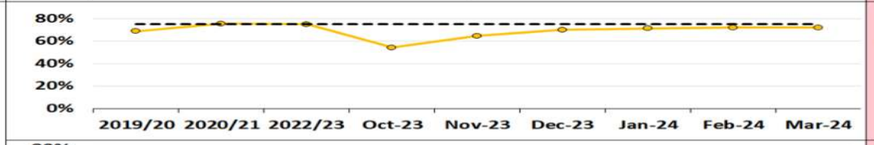
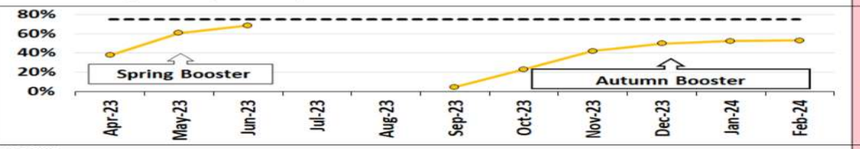
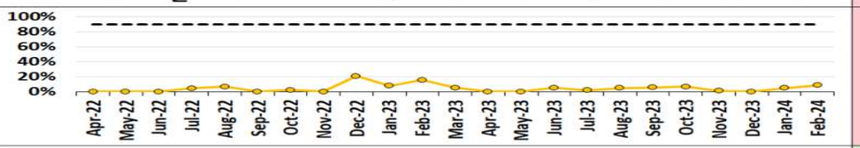
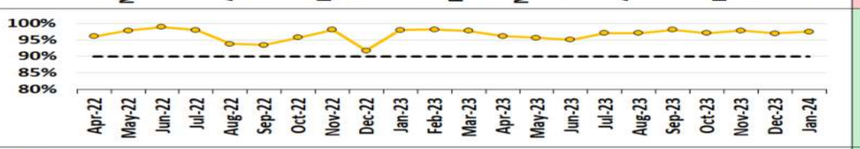
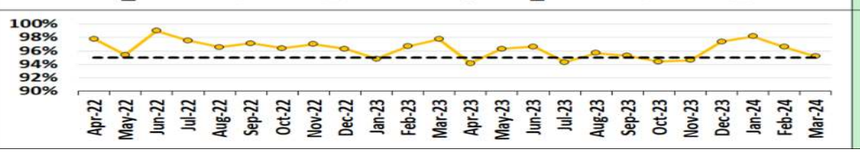
Compared to Apr 2023 the rate was 74.4%

Finance

CTMUHB achieved a break-even position for the year 2023/24, but did not achieve the 3 year break-even duty and forecasts a carry forward of £19.4m core plan deficit

2.2 Welsh Government Performance Indicators: Quadruple Aim 1 - Improving Population Health & Wellbeing

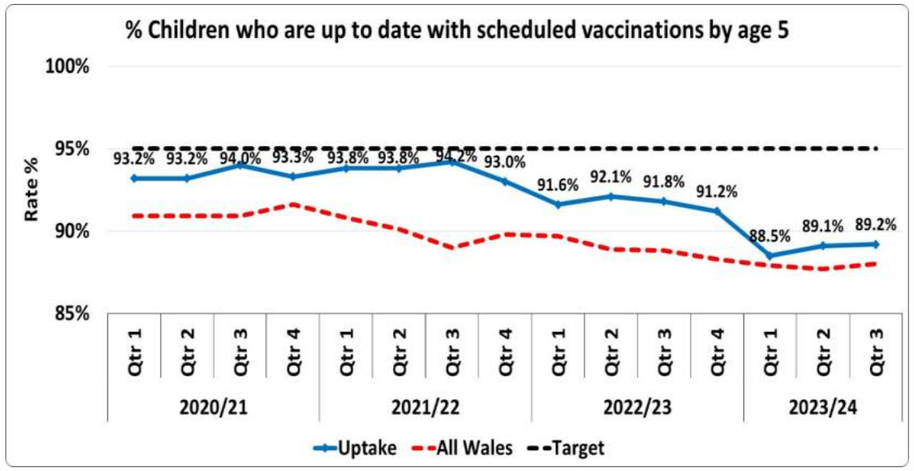
Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management

	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved / Latest Position	Target Failed / Latest Position
Prevention	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% Annual Target		4.05% on the basis of this extrapolation compliance should hit 5.4% at year end	Q1-Q3 2023/24
	Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% Annual Target	Data not available as yet		
	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		77.8%	Q3 2023/24
	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%		89.2%	Q3 2023/24
	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 *(applicable during 01.04.24-30.06.24 & 01.01-31.03.25)*	90%		83.3%	
	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over *(applicable during 01.09.24 - 31.03.25)*	75%		Please note data reflects the last week of March 72.1%	Mar-24
	Percentage uptake of the COVID-19 vaccination for those eligible - Spring & Autumn booster 2024: All eligible people *(applicable 01.04.30.06.24 & 01.09.24 - 31.03.25)*			Please note data reflects the last week of February 53.1%	Feb-24
	Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%		8.4%	Feb-24
	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%		97.5%	Jan-24
	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	95%		95.2%	Mar-24

CTMUHB Improving Population Health & Wellbeing

% 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%

(reporting frequency is quarterly & as expected there is a time lag of approx. 3 months)



Quarter 3 2023/24 Local Authority Uptake	
Merthyr Tydfil LA	**82.7%**
RCT LA	**90.6%**
Bridgend LA	**89.6%**
CTMUHB	**89.2%**

Quarter 3 2023/24 Welsh HB's Uptake	
ABUHB	**87.9%**
BCUHB	**90.0%**
C&VUHB	**85.7%**
CTMUHB	**89.2%**
HDUHB	**87.2%**
PTHB	**92.1%**
SBUHB	**85.8%**
All Wales	**88.0%**

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

Challenges:

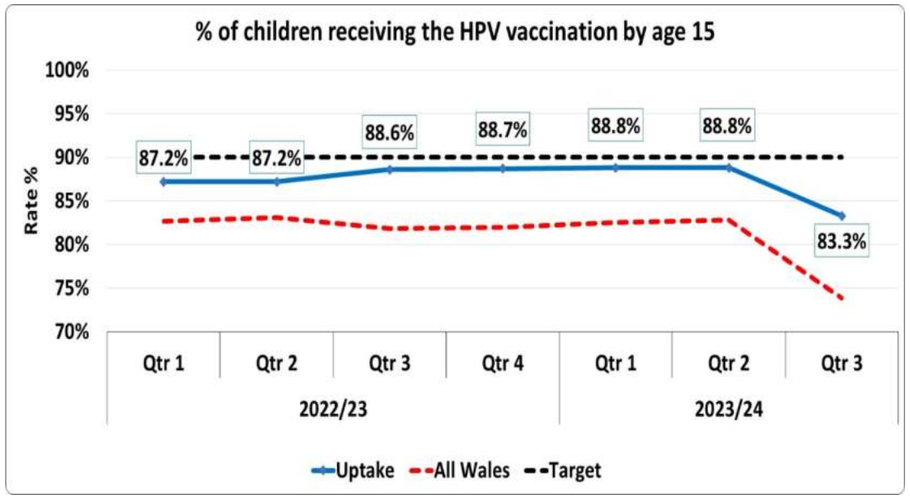
- Changes to the under age 5 routine schedule at the end of 2024; staff may need an out of season training update.
- Increasing diversity within our demographics, thus needing accurate vaccination history for clients and the ability to provide information in required languages.
- Timely and accurate recording on data systems (Child Health and CYPriS).
- Fluenz is not a scheduled vaccine and relies on GP practices to invite children in.
- Transition from Health Visitor to School Nursing – recall into schedule of vaccination changes.

Actions:

- Additional out of season training to reflect changes in scheduling.
- Source literature in all languages and disseminate this source to relevant staff.
- Link practices with Primary Care Nurse Educators to ensure new staff receive timely training.
- Primary Care Nurse Educators to distribute training information to practices on regular basis to ensure practices are aware of training available. Information on training and updates to be provided via Practice Nurse Forum.
- CTM Childhood Vaccination Group established and meets monthly.
- MMR vaccination catch up offered as part of appointed Fluenz catch up clinics.
- Targeted MMR vaccination catch up in Primary Schools – commenced January 2024.

% of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 - Target 90%

(reporting frequency is quarterly, and applicable during 01.04.24 to 30.6.24 & 1.1.25 to 31.03.25)



Quarter 3 2023/24 Local Authority Uptake	
Merthyr Tydfil LA	**71.9%**
RCT LA	**85.2%**
Bridgend LA	**84.9%**
CTMUHB	**83.3%**

Quarter 3 2023/24 Welsh HB's Uptake	
ABUHB	**67.8%**
BCUHB	**75.3%**
C&VUHB	**59.4%**
CTMUHB	**83.3%**
HDUHB	**75.1%**
PTHB	**77.2%**
SBUHB	**88.1%**
All Wales	**73.9%**

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

Challenges:

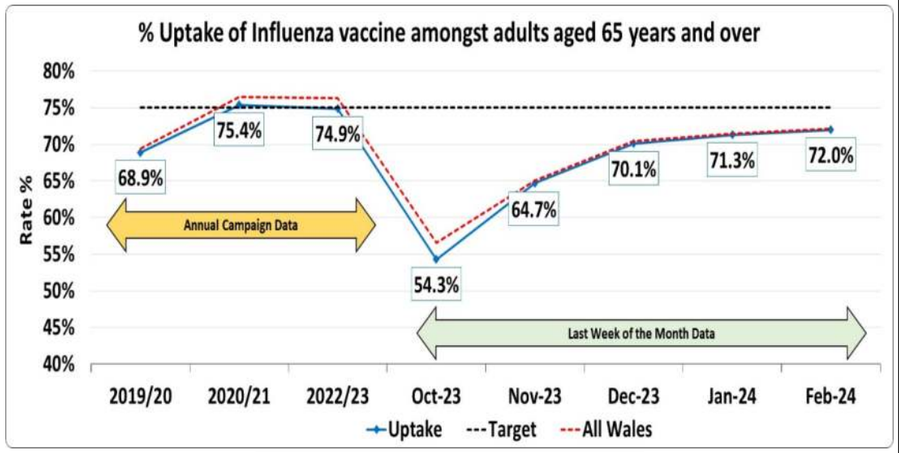
- Lack of positive consent forms not being returned to schools. There is also a lack of capacity within the school nursing service to contact parents directly due to competing service demands within the School Nursing service.
- Lack progress to launch the use of an e-consent system in this academic year, mainly due to Patient portal functionality not being available.
- Lack of engagement from CTM comms to actively raise the profile of HPV and the school based Immunisation Programme as a whole.
- Reliance from PHW on the promotion of school based immunisations via posters, leaflets, videos to send into schools. More innovation needed to utilise social media, radio or television to provide the right information to a wider audience.
- Increasing diversity within our demographics, thus needing accurate vaccination history and the ability to provide information in required languages

Actions:

- Literature sourced from Public Health England, in all languages and disseminate this source to relevant staff involved in vaccination and immunisation
- Pilot and rollout of e-consent aimed for summer term of 2024.
- Engage with comms. in LAs and HB to raise the profile of the school immunisation programme to parents/carers and eligible pupils, signposting to PHW information.
- Partnership working with primary care colleagues to secure support in raising the profile of HPV from GP surgeries.
- Collaboration with Directors of Education and education colleagues to optimise immunisation uptake.
- CTM Childhood Vaccination group established and meets monthly.
- Engage with CYP colleagues to raise the profile of immunisations by acute paediatric wards, paediatrician, Community Children's team and paediatric CNS's.
- School nursing service to adopt a universal, enhanced and intensive approach to target areas known to have low uptake rates with the aim of increasing immunisation rates and reduce inequalities.
- Collaboration by School Nurse Immunisation Coordinator to work with HB colleagues to ensure the smooth and efficient planning and delivery of HPV programme.

CTMUHB Improving Population Health & Wellbeing

% uptake of the influenza vaccination amongst adults aged 65 years & over -Target 75%



Uptake Welsh HB's February 2024	
ABUHB	75.3%
BCUHB	73.2%
C&VUHB	72.8%
CTMUHB	72.0%
PTHB	69.1%
SBUHB	69.3%
HDUHB	69.3%
All Wales	72.1%

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

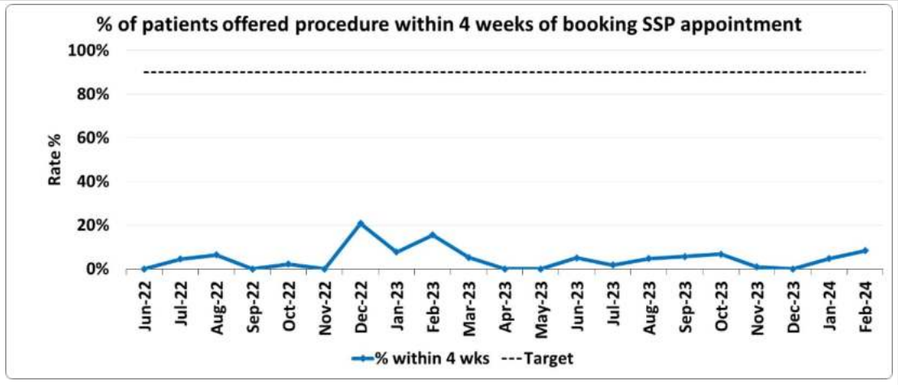
Challenges:

- Ensuring wider implementation of NIF (e.g. vaccine equity and digital platforms) is considered within the planning and delivery of vaccination programmes and the wider health protection system.
- The number of Welsh Health Circulars (WHCs) received requiring immediate action and upcoming new vaccination programmes to be rolled out.
- Changes in Joint Committee on Vaccination and Immunisation (JCVI) guidance and WHC recommendations may impact on the practical aspects related to vaccination clinics and the storage of vaccines.
- Ensuring annual immunisation training updates fit with the immunisation timeline, as guided by WHCs.
- Ensuring that vaccinating services collaborate to raise overall vaccination rates, rather than compete for the same patient groups.
- Establishment of sustainable flu vaccination delivery model for staff and residents in care homes for the elderly
- Ensuring that community pharmacies have sufficient vaccinators and capacity to provide flu vaccination, alongside demand to provide alternative clinical pharmaceutical services.
- Ensuring that community pharmacies have access to sufficient vaccines, at the appropriate time, within their financial constraints.
- Supporting pharmacies to optimise their flu vaccination programme and deliver more vaccinations each year.

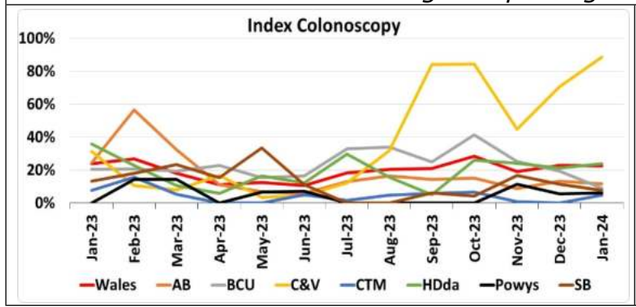
Actions:

- Engage in pilot exploring a model of staff and resident 'in house' vaccination by care home staff (All Wales model with CTM involvement)
- Plan the flu season in collaboration with key leads to ensure the flu programme can commence earlier.
- End of season flu report template disseminated to all GP practices to reflect on previous activity and support future planning
- CTM representation at All Wales Vaccine Equity Network and use of vaccine equity planning toolkit locally.
- Explore the possibility of developing the role of flu champions in GP practices.
- Winter respiratory debrief undertaken February 2024 and insight gathered will be used as part of planning for the 2024/25 campaign.
- Multi-disciplinary approach across all professions to ensure consistent and opportunistic messaging on benefits of flu vaccination.
- CTM to support national work regarding the HEIW vaccinator accreditation framework and:
  - ❖ maintain current position regarding pharmacy opening hours on the weekend.
  - ❖ support pharmacy inclusion in national discussions about centralised procurement of vaccines.
  - ❖ utilise primary care clusters to support a collaborative approach to vaccination.
  - ❖ ensure that public messaging regarding flu vaccination services is timely, accurate and representative of the wider offering.

Percentage patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner (SSP) assessment appointment Target 90% - February 2024 – 8.4%



Please note there is a time lag in reporting of approx. 2 months



Status as at January 2024		
Health Board	Compliance	Rank
C&V	88.7%	1st
HDda	23.9%	2nd
AB	11.8%	3rd
BCU	9.1%	4th
SB	7.7%	5th
Powys	6.3%	6th
CTM	**4.8%**	**7th**

How are we doing & what actions are we taking?

As of the 15th May there are 96 patients waiting for an index colonoscopy of which 89 have a booked appointment, however 61 of these patients will have waited longer than 4 weeks for their procedure. Around 50% of the total patients waiting declined a 1st offer date (patient choice). Internal additional ad hoc lists and flipping of symptomatic lists to overcome lost activity due to sickness has reduced the impact and current waits are around 7 weeks, with further plans over the next 6 weeks to bring the service into '4 week compliance'. Sustainability plans are ongoing to staff unfunded sessions (x 2) at POW; this will continue to support the Optimisation Programme.

The operational challenges that have an impact on activity are:

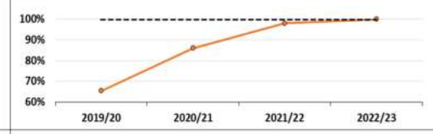
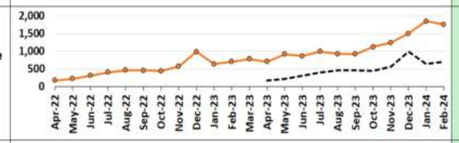
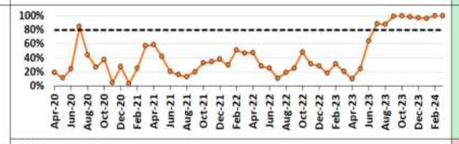
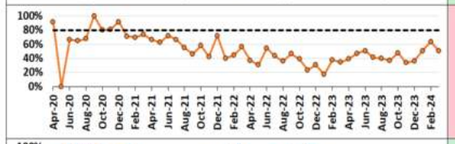
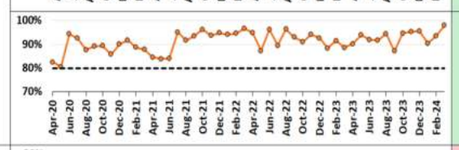
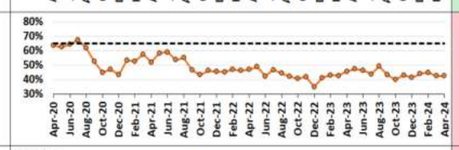
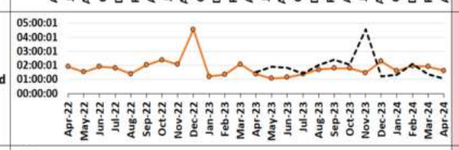
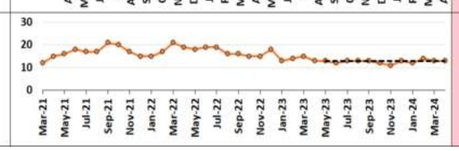
- Participant / Patient choice / refusal remains an issue when booking dates across CTM.
- Current Colonoscopist sickness – internal solutions ongoing
- Providing cover for period of leave and on-call commitments. This continues to be managed through 6/4/2-1 process which has seen an increase of adhoc cover, plus additional lists through backfilling of symptomatic lists and improvement to utilisation through productivity and efficiencies – continues to be monitored.
- Uptake and current conversion to surgery continues to be monitored and escalated.

Actions being taken:

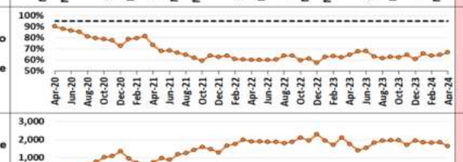
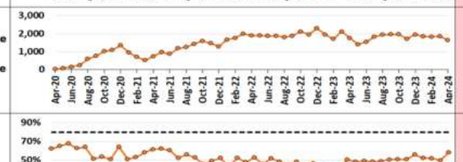
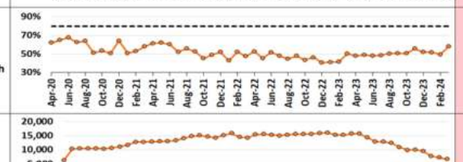
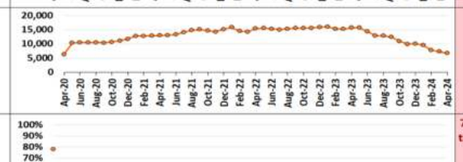
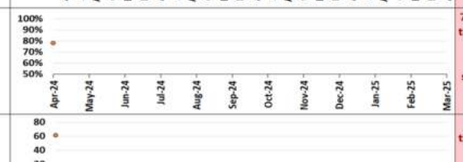
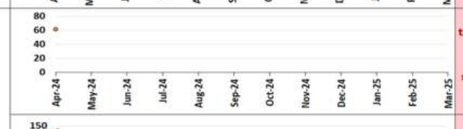
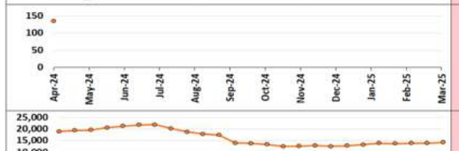
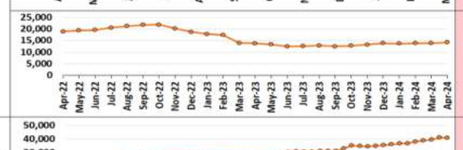
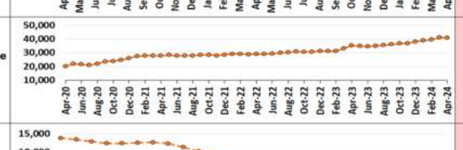
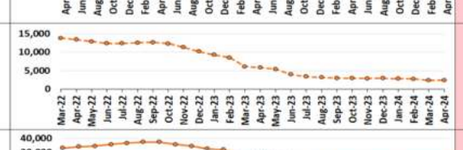
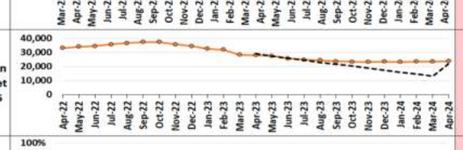
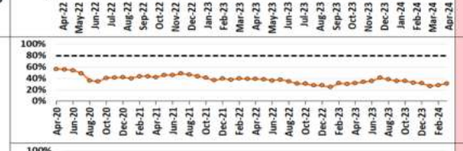
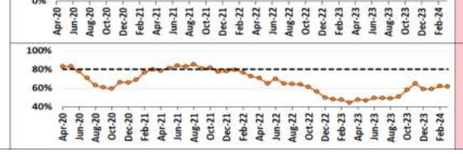
- Insourcing – completed and supported backlog clearance.
- Participants continue to be booked direct to scope at SSP assessment resulting in better patient experience.
- Sustainability plan is ongoing to increase core lists to meet optimisation steps
- Future plans to meet next steps for Optimisation Programme 2024/25 to include new endoscopy unit at PCH with 3rd room – planned move date 17th May 2024. Workforce model and business case completed and approved; funding allocated and recruitment commenced
- Working with theatre services to develop robust general anaesthetic provisions.

2.3 Welsh Government Performance Indicators: Quadruple Aim 2: Quality & Better Access to Services

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

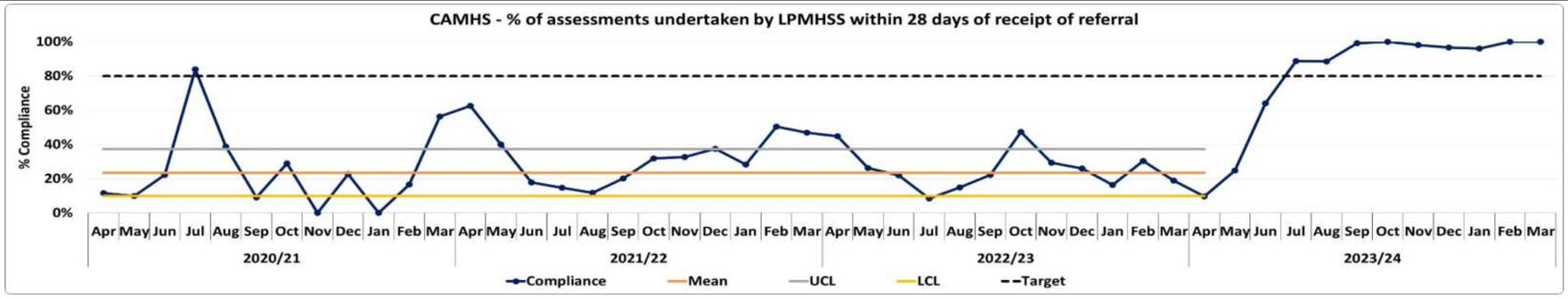
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Services Delivered Close to Home	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%		100.0%	2022/23
	Percentage of patients (aged 12 yrs and over) with diabetes who received all eight NICE recommended care processes	Improvement compared to the same month in the previous year	Data not yet available		
	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 2024 and 100% by 31 March 2025	April 2023 to January 2024	80.6%	as at Jan 2024
	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Increase compared to the same month in the previous year		1,769	Feb-24
	% 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%		100.0%	Mar-24
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)			50.5%	
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)			81.3%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)			98.0%	
Access Hospital Services Quickly	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		42.4%	Apr-24
	Median emergency response time to amber calls	12 Month Reduction Trend		01:38:00	
	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less		13	

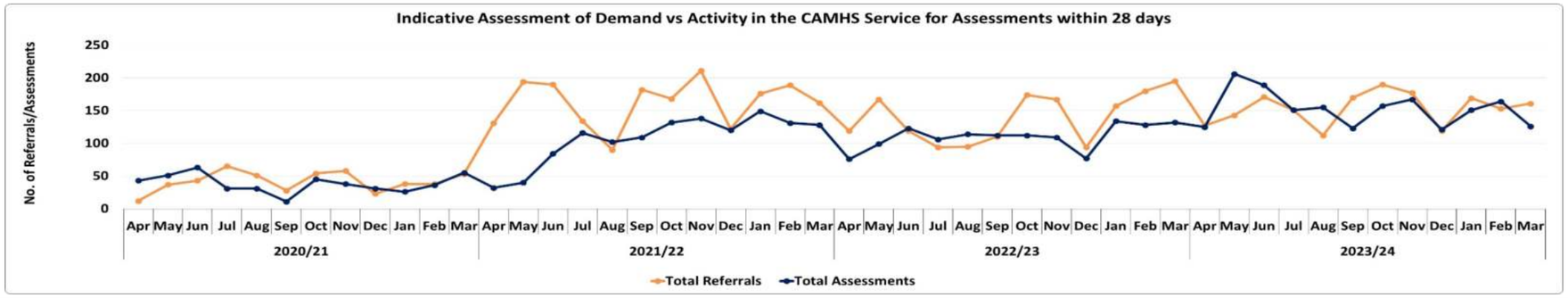
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved	Target Failed
				Latest Position	
Access Hospital Services Quickly	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	60 minutes or less		65	Apr-24
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Improvement compared to the same month in the previous year, towards the national target of 95%		66.9%	
	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	Reduction compared to the same month in the previous year, towards the national target of zero		1,643	
	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	12 month improvement trend towards a national target of 80% by 31 March 2026		57.9%	Mar-24
	Number of patients waiting more than 8 weeks for a specified diagnostic	Zero		6,740	Apr-24
	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	100%		78.3% (please note that due to changes to weight management services data prior to Apr 24 is not comparable)	
	Number of patients waiting more than 14 weeks for a specified therapy (all ages)			61 (please note that due to changes to weight management services data prior to Apr 24 is not comparable)	
	Number of patients (all ages) waiting more than 14 weeks for audiology	Zero		135	
	Number of patients waiting over 52 weeks for a new outpatient appointment			14,264	
	Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	Reduction compared to the same month in the previous year		40,989	
	Number of patients waiting more than 104 weeks for referral to treatment	Zero		2,468	
	Number of patients waiting more than 52 weeks for treatment	Month on month reduction towards the national target of zero by 30th June 2025		23,893	
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%		30.9%	Mar-24
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			61.6%	

CTM Child & Adolescent Mental Health Services (CAMHS) – March 2024

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (100%) - Target 80%





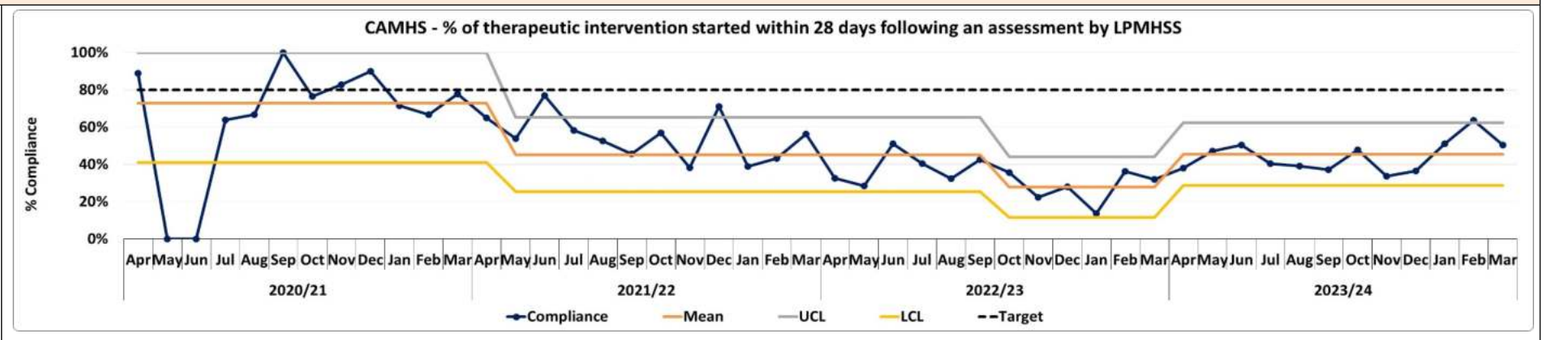
From the summer of 2023, we observe that performance improved markedly in the number of assessments undertaken within 28 days of referral (Part 1a), with compliance during March 2024, once again hitting 100% and continuing to exceed the WG target of 80%.

The number of assessments each month is fairly stationary, given the variability in the number of working days in the month.

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

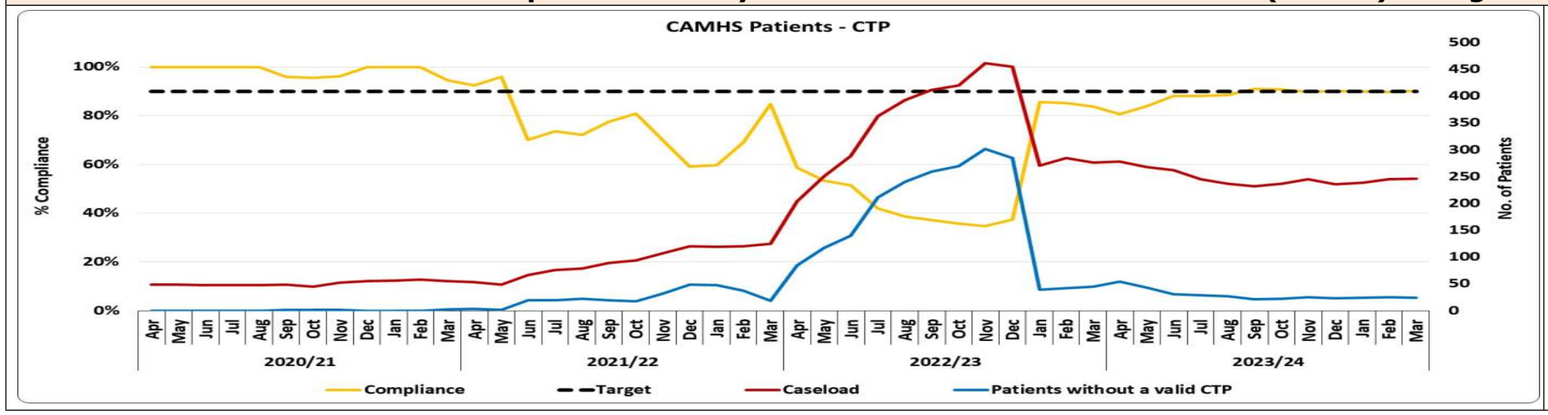
Unfortunately, the improvement seen during February did not continue through to March, with the proportion of therapeutic interventions starting within 28 days following an assessment by LPMHSS falling to 50.5%. This can be explained by an increase in referrals and the volume of clinic time reducing because of the bank holiday break. The number of interventions during the month increased to 95, from 88 in February. Our clinical teams are working through the backlog and the key metric which will help determine our future performance against this target, is the reduction in the number of patients on the waiting list. This reduced from 93 in February to 83 in March. As the clinical teams reduce the volume of the longest waits, the interventions compliance will rise.

Compliance continues to lie below the 80% threshold, with December 2020 being the last time the target was achieved (90%).



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 (90.2%) - Target 90%



Part 2 of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month observed a compliance rate of 90.2% and stands just above the WG standard of 90%.

From the start of 2023, as shown in the chart to the left, we observe that caseloads have seen a reduction of around 50% from the peak seen in November 2022 (462). The number of patients without a valid CTP at the end of the month stands at 24.

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

Cont'd...CAMHS – March 2024

How are we doing and what actions are we taking?

Actions being taken:

- An improvement action plan and trajectory were developed to improve compliance in Parts 1 (a & b) and 2 of the Mental Health Measure. This has delivered improvement in all three areas with additional work required on Part 1b (therapeutic interventions).
- **Part 1a**: Further work is being planned to streamline the processes of the Single Point of Access and the Assessment Team to reduce duplication in the assessment and triage process. Additional work is focusing on balancing capacity with demand. Referral rates fluctuate during the year, but are often predictable with increases coinciding with events such as exams and the start of the new term. Following demand & capacity training, it has helped us to focus on this area.
- **Part 1b:** We are working with the 3rd Sector to increase access to interventions and have agreed a programme of group work interventions with Mental Health Matters across the CTM region. Each course has 6 participants comprising of four sessions and are being delivered in each of the three local authority areas. Referrals to the Silvercloud digital platform are rising and a multi-disciplinary workshop to discuss patient pathways is scheduled for the June.
- **Part 2:** A training programme for care co-ordinators has helped to improve the quality of Care Treatment Plans (CTPs). This includes some joint training between Adult Mental Health services and CAMHS.
- Monthly supportive meetings are in place with the NHS Executive which is helping to improve compliance in all areas and in a sustainable way. The service has completed a self-assessment audit of care and treatment plans which we will present at that meeting shortly.

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

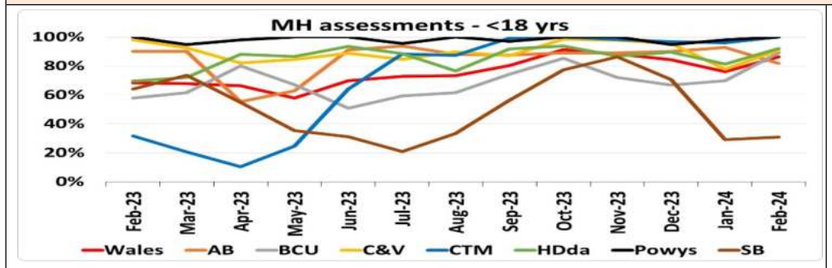
Outputs of improvements:

- **Part 1a:** Our approach to the management of this service includes closely monitoring the waiting times for assessment during the month. As at the end of March we had 119 patients on the waiting list (79 previous month), with no patient waiting beyond 30 days. The average waiting time has decreased to 1.3 weeks from 1.4 weeks.
- **Part 1b:** We carefully monitor the demand for interventions and our capacity to deliver services. The total number of interventions increased to 95 with the average waiting time falling to 3.2 weeks compared to 4.9 in the previous month.
- As clinical teams work through the waiting list backlog our performance against the interventions target will steadily increase.
- Work is also underway to develop the online digital platform Silvercloud to further help with interventions. A memorandum of understanding has been approved with the supplier and a go live date in April was agreed. There remain three Band 5 registrant vacancies in the Intervention Team with the service progressing ongoing recruitment.
- **Part 2:** The focus on quality in relation to CTP's will be supported by the results of the caseload audit that was completed during the end of 2023.

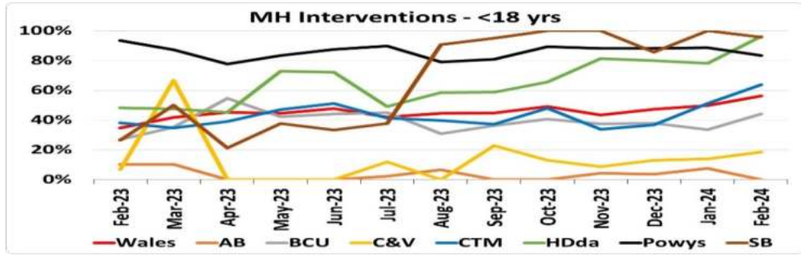
Main areas of risk:

- The CAMHS service experiences regular fluctuations in demand, this can have a negative effect on waiting times for assessment and treatment. The service is planning to temporarily increase capacity to help address this rise in referrals.
- The service is prioritising recruitment to vacant positions. Good progress has been made in filling community team gaps but there remain some registrant vacancies in the Part 1b Interventions Team. Colleagues are continuing discussions with universities to identify possible students nearing qualification.
- Clinical colleagues continue to report rising acuity within their patient population, this may have an impact on delivery going forward.

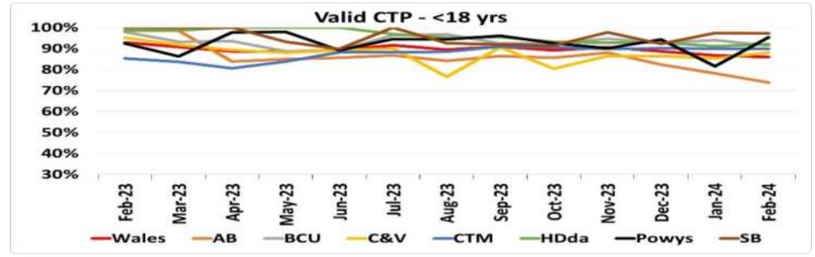
How do we compare with our peers?



Status as at February 2024		
Health Board	**Compliance**	**Rank**
CTM	**100.0%**	**1st**
Powys	100.0%	2nd
HDda	92.0%	3rd
C&V	90.9%	4th
BCU	89.1%	5th
AB	81.8%	6th
SB	31.0%	7th



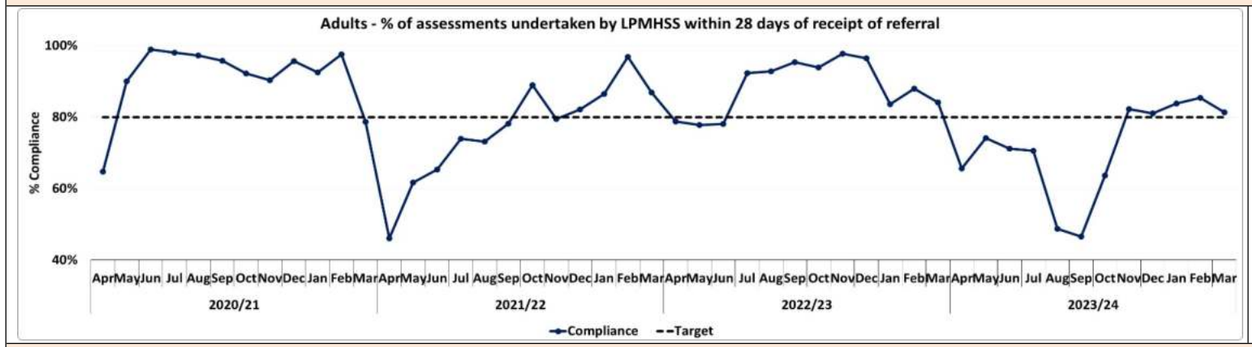
Status as at February 2024		
Health Board	**Compliance**	**Rank**
HDda	96.2%	1st
SB	95.7%	2nd
Powys	83.3%	3rd
CTM	**63.6%**	**4th**
BCU	44.0%	5th
C&V	18.5%	6th
AB	0.0%	7th



Status as at February 2024		
Health Board	**Compliance**	**Rank**
SB	97.2%	1st
Powys	95.4%	2nd
HDda	92.1%	3rd
BCU	91.4%	4th
CTM	**89.8%**	**5th**
C&V	88.0%	6th
AB	73.8%	7th

CTM Mental Health Services (Adult Services) – March 2024

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (81.3%) - Target 80%



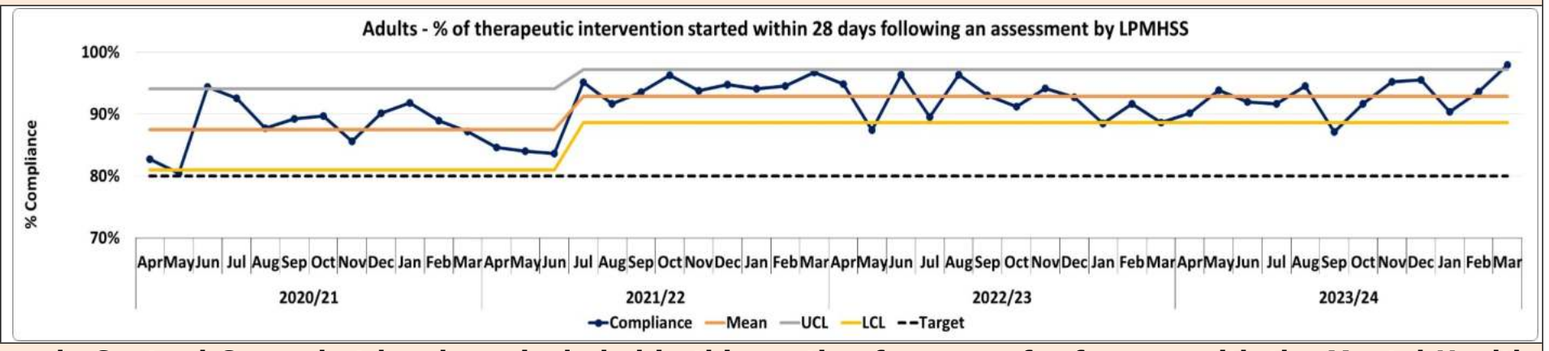
Part One of the Mental Health Measure relates to primary care assessment & treatment and has a target of 80% of referrals to be assessed within 28 days. The performance for the adult mental health services during March dipped to 81.3%, however remaining above the WG target.

Referrals during the month totalled 712; 10% fewer than those received during the equivalent period of 2023. The 12 month average has recorded 709 referrals each month and we continue to observe that volumes remain lower than pre-Covid levels, where referrals were in the region of 1,000 to 1,100.

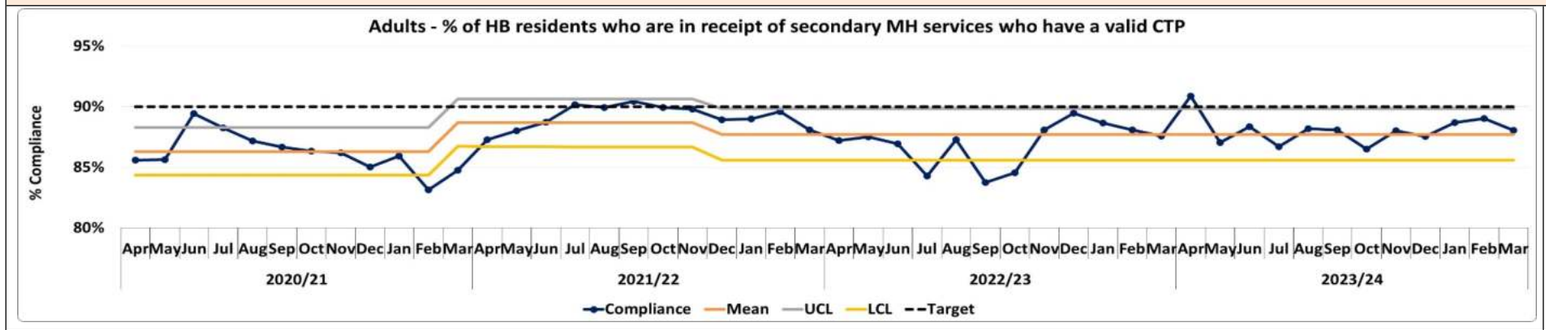
% of therapeutic intervention started within 28 days following an assessment by LPMHSS (98.0%) - Target 80%

Overall, the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS during March reached 98.0% and continues to stand above the WG target of 80%.

During the month, 242 of the 247 interventions commenced within the 28 day timeframe.



Please note that this measure is part of Quadruple Aim 4 - People Centred Care - but has been included in this section for ease of reference with the Mental Health Priorities - % of HB residents who are in receipt of secondary MH services who have a valid CTP (88.0%) - 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 observed 88.0% compliance during March and remains just below the 90% WG standard.

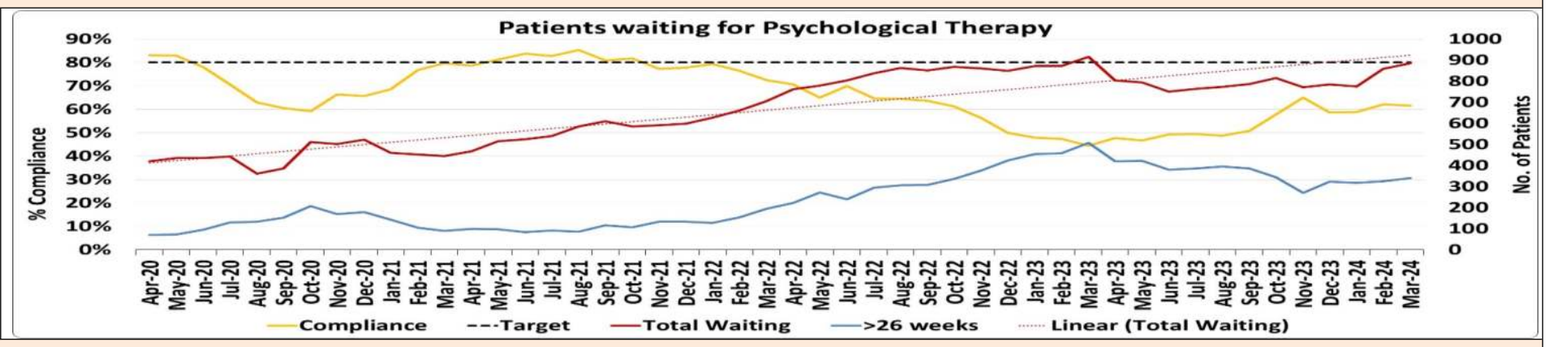
Part 3: There were 8 requests for adult assessments under Part 3 of the Mental Health Measure during March with all reports being sent within the required timescale of 10 working days.

% of patients waiting less than 26 weeks to start a Psychological Therapy (61.6%) - Target 80%

During March, Psychological Therapies compliance remained fairly static at 61.6%, with compliance continuing to remain below the 80% target threshold set by WG. October 2021 was the last time the target was achieved.

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).

At the end of March the waiting list stood at 886 patients; almost double the volume seen pre-Covid and during the past 12 months the list has ranged between 751 and 886 patients.



Adult Mental Health Services continued on the next page...

Cont'd...Mental Health Services (Adult Services) March 2024

How are we doing?

Part 1a: During March, performance remained above target. We continue to closely monitor sickness and absence rates and ensure our activity is balanced across all areas to fully utilise capacity.

The three areas observed the following compliance rates; Merthyr Cynon area has fallen further to 67% with the Rhondda Taff Ely and Bridgend areas improving to 90% & 93% respectively.

Part 1b: Performance continues to be above target at 98%.

Part 2: Overall compliance for both Adult, Older Adult and Learning Disability Services was 89% and compliance for the services is shown below:

- Adult Services - 86.6%
- Older Adult Services - 92%
- Learning Disability Services - 92.4%

Psychological Therapies: The overall position for Psychological Therapies waiting list for March 2024 stands at 886 and those patients waiting over 26 weeks equates to 340 service users. The current performance of 61.6% of people waiting less than 26 weeks is higher than the forecasted trajectory of 57% at March 2024. Overall longest waiter has increased from 161 weeks in February to 166 weeks in March, based in Rhondda LPMHSS.

The overall longest waiting position as not reduced over recent months. The current longest waiting patient had been offered an online therapy as part of the recovery plan, however due to patient choice declined and requested face to face appointment.

Recent validation of the waiting list had identified "legacy" missed opportunities to reset the clock following a declined reasonable offer. The access policy is awaiting approval and will ensure a clear and consistent approach to managing the waiting list.

A total of 78 new referrals were accepted during March, which is a reduction of 101 on those received in February. This was due to extra assessments being undertaken in LPMHSS Bridgend in February which caused an increase in referrals for that month. There are 107 service users waiting >=52 weeks in March, this has reduced by half over the past year, as in April 2023 there were 214 service users waiting in this category. This reduction has been attributed to a mix of validation work, use of third-party providers and locums.

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

Actions to improve performance are:

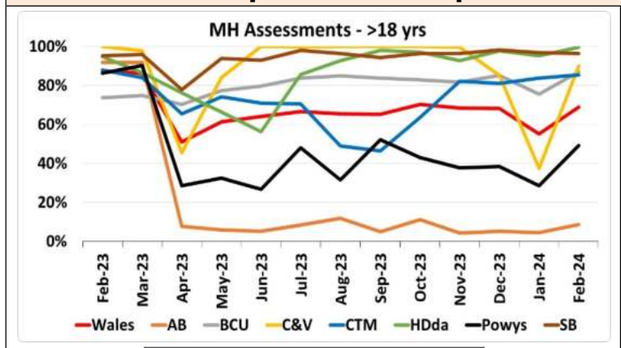
Part 1a:

- Focus on sickness management in teams where they are currently experiencing high levels of absence and strategic review of people with frequent or long absence.
- Posts have been successfully recruited in recent months and the impact of this is expected with improved performance from May onwards.
- Review of IT systems to support proactive performance management of the service through Qlik BI tool.
- Demand and capacity work – review of job plans to identify enough capacity.
- Review data input and reporting and ensure ongoing validation and management with introduction of weekly review meetings
- Where possible appointments are being offered in nearby teams to ensure there is a balance. This is proving effective in reducing the amount of breach appointments in certain areas, thus reducing the time taken to improve compliance as staff return from sickness.

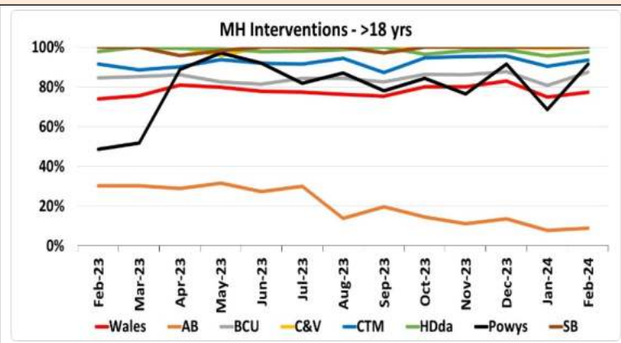
Part 2: Targeted work on non-compliant CTPs is continual with work ongoing to improve reporting and insight to enable managers to target specific areas / personnel of non-compliance. Work continues with Community Mental Health Team leads and Local Authority partners to ensure any non-compliant CTPs are prioritised; based on reducing risk. The primary risk to sustained improvements remains the reduction in staffing capacity caused by sickness and high caseloads in certain areas within CTM. Managers are monitoring compliance weekly, whilst work on Demand & Capacity and resources for large caseloads is reviewed. Increased performance in CTP compliance is expected in May.

Psychological Therapies: Ongoing validation work continues around ensuring that all waiting lists are accurate. There is also ongoing work to clearly identify and record on the waiting lists the types of therapy service users are waiting for to allow efficient allocation of service users to staff resource.

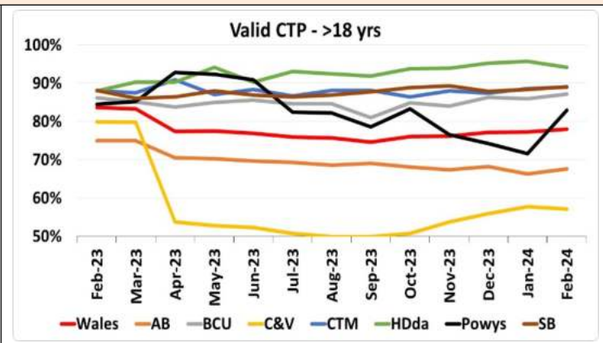
How do we compare with our peers?



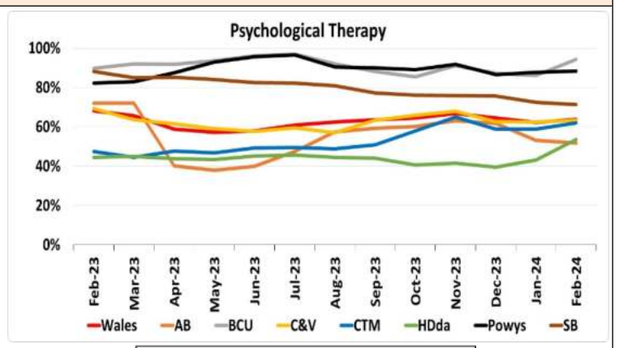
Status as at February 2024		
Health Board	**Compliance**	**Rank**
HDda	99.6%	1st
SB	96.4%	2nd
C&V	90.1%	3rd
BCU	87.0%	4th
CTM	**85.4%**	**5th**
Powys	49.1%	6th
AB	8.6%	7th



Status as at February 2024		
Health Board	**Compliance**	**Rank**
C&V	100.0%	1st
SB	100.0%	2nd
HDda	97.6%	3rd
CTM	**93.7%**	**4th**
Powys	91.4%	5th
BCU	87.4%	6th
AB	9.1%	7th



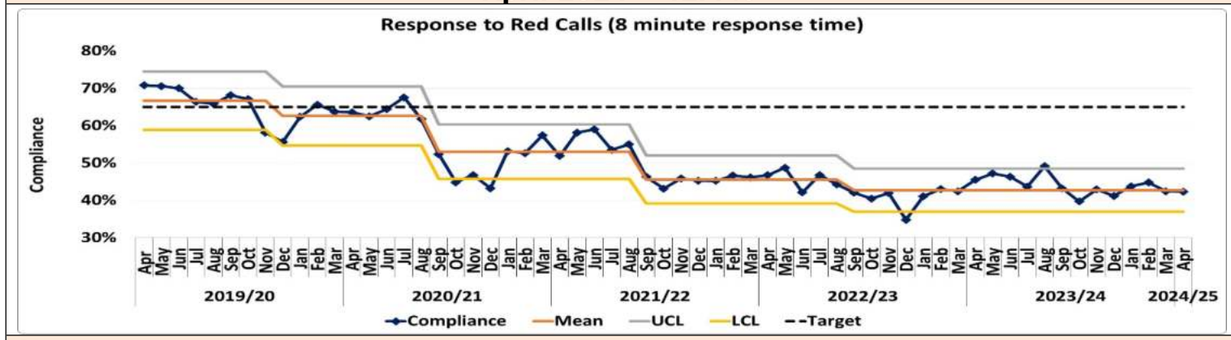
Status as at February 2024		
Health Board	**Compliance**	**Rank**
HDda	94.3%	1st
SB	89.1%	2nd
CTM	**89.0%**	**3rd**
BCU	87.2%	4th
Powys	83.0%	5th
AB	67.7%	6th
C&V	57.2%	7th



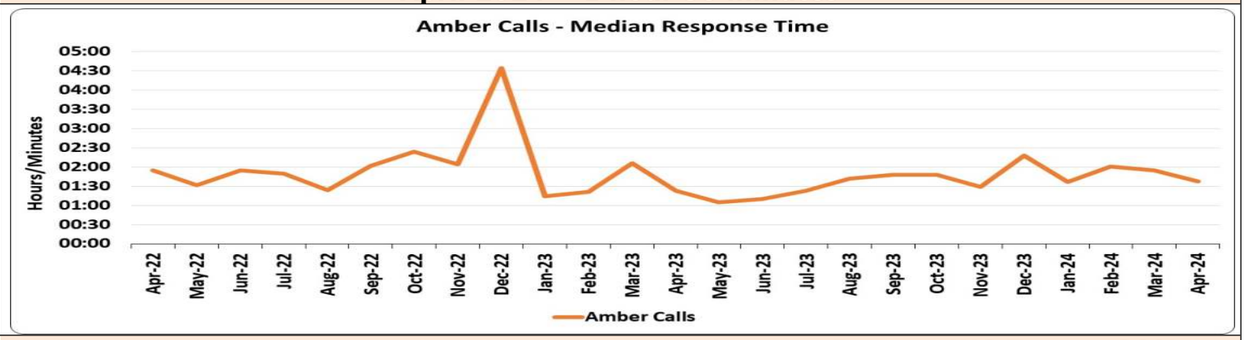
Status as at February 2024		
Health Board	**Compliance**	**Rank**
BCU	94.4%	1st
Powys	88.3%	2nd
SB	71.3%	3rd
C&V	63.3%	4th
CTM	**62.1%**	**5th**
HDda	53.6%	6th
AB	51.8%	7th

Emergency Ambulance Services – April 2024

% of emergency responses to Red Calls arriving within 8 minutes (Target 65%) April 2024 – 42.4%



Median emergency response time to Amber Calls – Target is 12 month reduction trend April 2024 - 1 hour 38 minutes



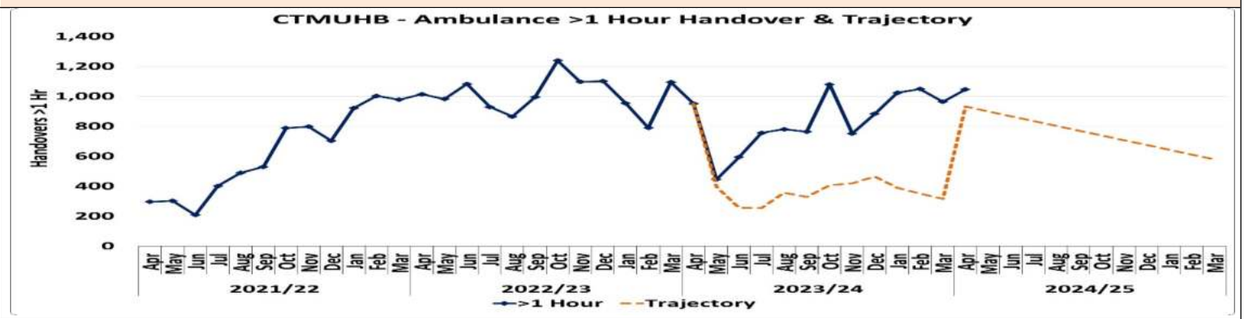
% of ambulance patient handovers within 15 minutes – Target is Improvement compared to the same month in the previous year, towards the national target of 100% within 15 mins.

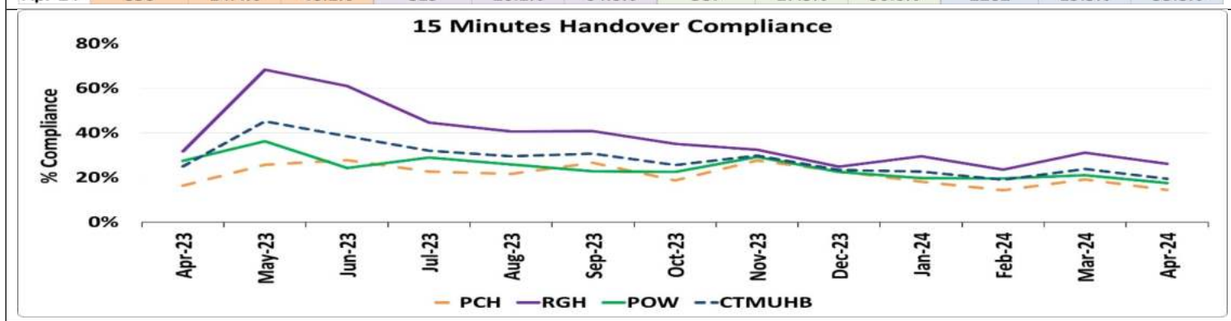
Total handovers 2,262 of which 440 handovers were within 15 minutes (19.5%)

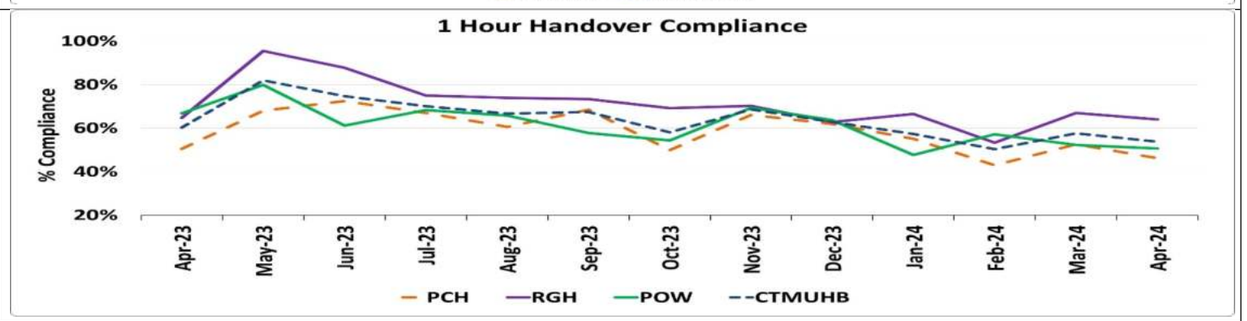
	PCH			RGH			POW			CTMUHB		
Period	Handovers	% <15 mins	% <60 mins	Handovers	% <15 mins	% <60 mins	Handovers	% <15 mins	% <60 mins	Total Handovers	% <15 mins	% <60 mins
Apr-23	857	16.3%	50.5%	830	31.7%	64.8%	711	27.4%	66.8%	2398	24.9%	60.3%
May-23	831	25.8%	68.0%	962	68.3%	95.5%	678	36.3%	79.9%	2471	45.2%	82.0%
Jun-23	875	27.8%	72.5%	822	60.9%	87.7%	649	24.2%	61.2%	2346	38.4%	74.7%
Jul-23	940	22.7%	66.9%	864	44.6%	75.0%	721	28.8%	68.2%	2525	31.9%	70.1%
Aug-23	869	21.6%	60.5%	832	40.6%	73.9%	644	25.8%	65.8%	2345	29.5%	66.7%
Sep-23	876	26.6%	68.5%	837	40.7%	73.4%	628	22.8%	57.8%	2341	30.6%	67.4%
Oct-23	971	18.6%	49.9%	928	35.1%	69.2%	673	22.4%	54.4%	2572	25.6%	58.0%
Nov-23	832	27.6%	66.1%	883	32.5%	70.2%	676	29.1%	69.4%	2391	29.9%	68.5%
Dec-23	863	22.7%	62.0%	833	24.8%	62.8%	676	22.5%	63.8%	2372	23.4%	62.8%
Jan-24	910	18.1%	55.1%	869	29.5%	66.5%	620	19.7%	47.7%	2399	22.6%	57.3%
Feb-24	805	14.3%	43.0%	783	23.5%	53.4%	525	19.6%	57.1%	2113	19.0%	50.4%
Mar-24	870	19.1%	52.6%	807	31.1%	67.0%	600	21.0%	52.3%	2277	23.8%	57.7%
Apr-24	856	14.4%	46.1%	819	26.1%	64.0%	587	17.5%	50.6%	2262	19.5%	53.8%

Number of ambulance patient handovers over 1 hour – Revised WG Target: 30% reduction from March 24 number by December 2024

1,046 handovers were over 1 hour (53.8% of handovers were within 1 hour)





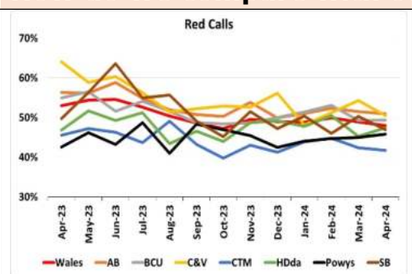


Red Release Requests – March 2024 – 93.1%

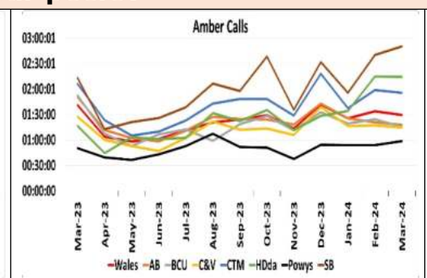
	PCH			RGH			POW			CTMUHB		
Period	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance
Mar-23	14	14	100.0%	12	10	83.3%	11	11	100.0%	37	35	94.6%
Apr-23	15	15	100.0%	7	3	42.9%	3	3	100.0%	25	21	84.0%
May-23	8	8	100.0%	5	5	100.0%	1	1	100.0%	14	14	100.0%
Jun-23	12	12	100.0%	5	4	80.0%	6	6	100.0%	23	22	95.7%
Jul-23	16	16	100.0%	7	7	100.0%	11	10	90.9%	34	33	97.1%
Aug-23	10	10	100.0%	5	5	100.0%	10	10	100.0%	25	25	100.0%
Sep-23	16	16	100.0%	5	3	60.0%	11	11	100.0%	32	30	93.8%
Oct-23	13	13	100.0%	21	19	90.5%	19	19	100.0%	53	51	96.2%
Nov-23	16	16	100.0%	16	16	100.0%	3	3	100.0%	35	35	100.0%
Dec-23	19	19	100.0%	19	16	84.2%	6	6	100.0%	44	41	93.2%
Jan-24	21	21	100.0%	12	11	91.7%	12	11	91.7%	45	43	95.6%
Feb-24	18	17	94.4%	16	16	100.0%	6	6	100.0%	40	39	97.5%
Mar-24	10	10	100.0%	14	12	85.7%	5	5	100.0%	29	27	93.1%

Please note that due to recent changes in verification processes within WAST, the Red Release data now has a time lag and consequently, at the time of writing this report, the most recent data available is to March 2024.

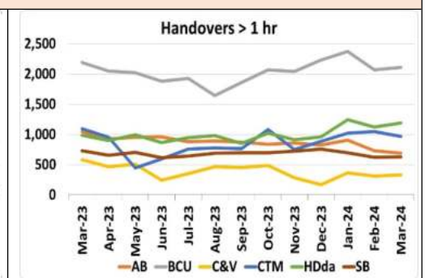
How do we compare with our peers?



Status as at April 2024		
Health Board	Compliance	Rank
AB	50.9%	1st
C&V	50.5%	2nd
BCU	49.4%	3rd
HDda	47.4%	4th
SB	47.0%	5th
Powys	45.8%	6th
CTM	**42.4%**	**7th**



Status as at March 2024		
Health Board	Compliance	Rank
Powys	00:58	1st
C&V	01:14	2nd
BCU	01:15	3rd
AB	01:17	4th
CTM	**01:55**	**5th**
HDda	02:14	6th
SB	02:50	7th



Status as at March 2024		
Health Board	Compliance	Rank
C&V	332	1st
SB	630	2nd
AB	693	3rd
CTM	**964**	**4th**
HDda	1,192	5th
BCU	2,111	6th

Emergency Ambulance Services continued overleaf:

Emergency Ambulance Services continued : April 2024

How are we doing?

Response to Red Calls per WAST Operational Area				
Apr-24	Total Responses	Responses within 8	% within 8 mins	*12 Month Average*
Merthyr	123	66	**53.7%**	*56.5%*
RCT	356	136	**38.2%**	*38.7%*
Bridgend	234	100	**42.7%**	*44.8%*
CTM	713	302	**42.4%**	*43.7%*

Response to Red Calls: Response times to life-threatening calls for the CTM area remained low at 42.4% with the 12 month average recording a rate of 43.7%. Since September 2023 the National compliance has remained below 50%, with the minimum expected standard being 65% of Red Calls to be responded to within 8 minutes.

As can be seen in the table above, there continues to be variance in response times across our region, with RCT borough continuing to experience the poorest response times during April, as has been the case for some considerable time.

The volume of Red Calls during April for CTM totalled 713, in line with the 12 month average.

Median Response to Amber Calls: The median response times for serious, but not immediately life threatening calls was 98 minutes during April; 15% lower (17 mins) than the previous month but 5 minutes (5%) longer than in the equivalent period of last year. The chart (page 13, top right) demonstrates fluctuations in the median response times, although generally during 2023/24, we had observed shorter response times than in 2022/23.

Ambulance Handover Compliance: *Please note that the trajectory shown in the chart on the previous page is in development and will be refined in future reports.*

Ambulance conveyances to ED during April 2024 were slightly lower (5.7% / 136) than the equivalent period of 2023.

Performance against the 15 minute handover was just under 20%, with the number of patients and ambulance crews detained longer than an hour totaling 1,046, which as it currently stands is 24% higher (201) than the 12 month average and 10% higher than the equivalent period of 2023.

Immediate (Red) Release Requests: received when a WAST crew, which is currently with a patient at hospital, needs to be released to respond to an urgent call totalled 29 during March. The ED services were able to support affirmatively 27 (93.1%) of those requests with the expected standard being approval of all requests.

What actions are we taking & when is improvement anticipated?

- Zero tolerance >4 hours wait – improvement plan in place across CTM with regular performance meetings held.
- Out of hours Senior Manager and Executive on call rota under review
- Unscheduled Care Senior leadership team proactively engaged and leading programme for improvement and a Care Group Senior Leadership Team rota has been established to support flow.
- The Unscheduled Care Dashboard went live at the end of March providing real-time information
- The successful collaborative Test of Change that was undertaken at the end of last year, between WAST and RGH Emergency Department, is to be rolled out across POW and PCH ED's. This will ensure clinically safe and dignified pathways for patients into ED following arrival by ambulance by reducing, where possible, handover delays and to deliver early diagnosis and treatment.
- MADE (Multi Agency Discharge Event) took place 10th April – outcomes will be highlighted in the next iteration of this report.
- Bi-weekly team meetings established with WAST
- Discussions ongoing with Informatics and WPAS team to introduce a clinically fit to admit option into the ED dataset to allow for real time recording of 4 hours waits in ED

What are the main areas of risk?

- Additional uncommissioned capacity remains open across all sites.
- System flow remains highly impacted by capacity within social care.
- Activity has increased resulting in uncommissioned capacity being utilised to manage demand.
- Persistent high escalation levels across all sites.

Emergency Unit Waits – April 2024 (Provisional Position) - Total Attendances = 15,568

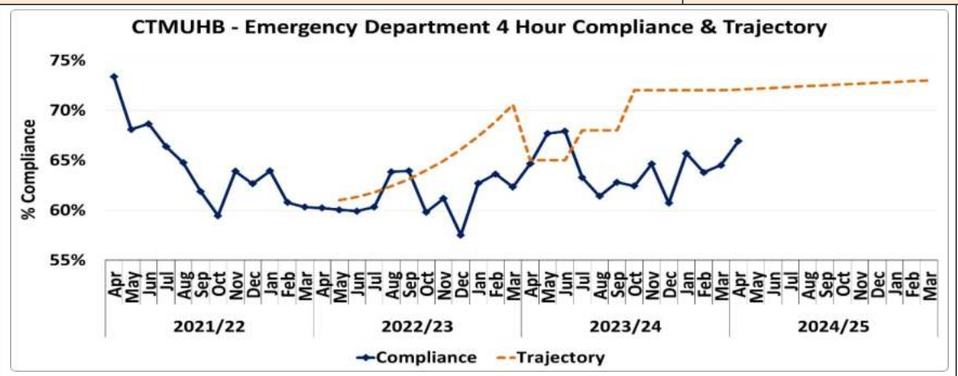
% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge – Target is Improvement compared to the same month in the previous year, towards the national target of 95%

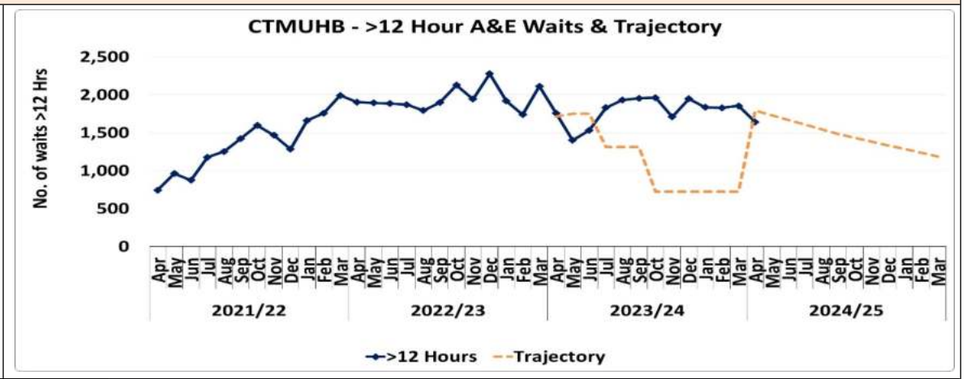
66.9% were seen within 4 hours (Patients Waiting >4 hours 5,149)

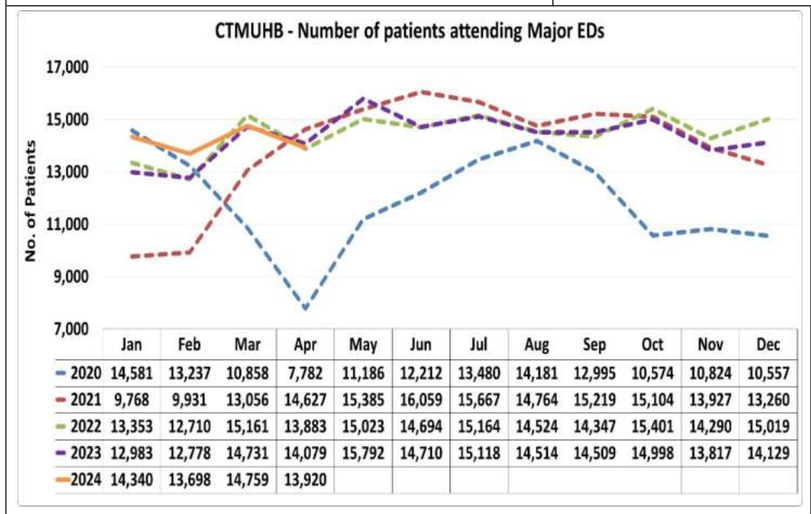
Number of patients who spend 12 hours or more in all hospital major & minor emergency care facilities from arrival until admission, transfer or discharge – Revised Target is a 20% reduction on March 2024 number by September 2024 and a further 20% reduction by March 2025.

10.6% of patients were waiting over 12 hours (1,643)

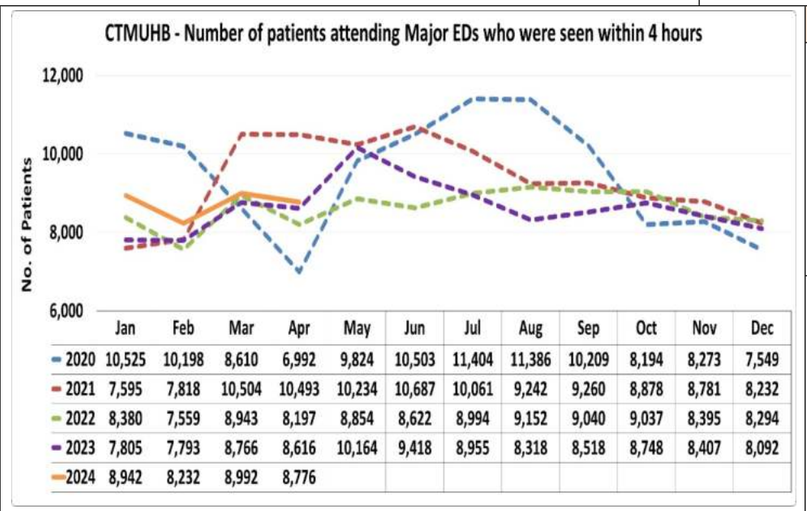
Period	CTMUHB		
	Attendances	4 Hrs %	> 12 Hrs
Apr-23	15,503	64.7%	1,760
May-23	17,531	67.7%	1,402
Jun-23	16,674	67.9%	1,535
Jul-23	16,798	63.3%	1,833
Aug-23	16,066	61.4%	1,932
Sep-23	16,122	62.8%	1,956
Oct-23	16,638	62.4%	1,965
Nov-23	15,298	64.6%	1,712
Dec-23	15,366	60.7%	1,949
Jan-24	15,735	65.7%	1,837
Feb-24	15,099	63.8%	1,830
Mar-24	16,249	64.5%	1,856
Apr-24	15,568	66.9%	1,643





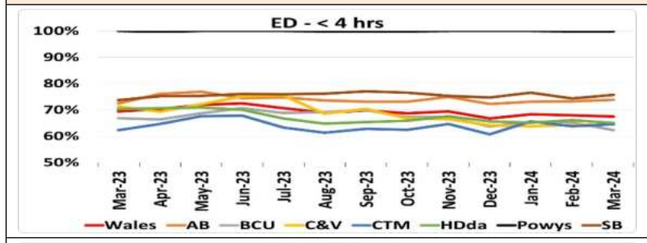


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	14,581	13,237	10,858	7,782	11,186	12,212	13,480	14,181	12,995	10,574	10,824	10,557
2021	9,768	9,931	13,056	14,627	15,385	16,059	15,667	14,764	15,219	15,104	13,927	13,260
2022	13,353	12,710	15,161	13,883	15,023	14,694	15,164	14,524	14,347	15,401	14,290	15,019
2023	12,983	12,778	14,731	14,079	15,792	14,710	15,118	14,514	14,509	14,998	13,817	14,129
2024	14,340	13,698	14,759	13,920								

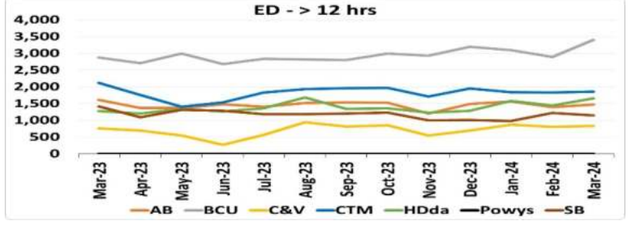


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	10,525	10,198	8,610	6,992	9,824	10,503	11,404	11,386	10,209	8,194	8,273	7,549
2021	7,595	7,818	10,504	10,493	10,234	10,687	10,061	9,242	9,260	8,878	8,781	8,232
2022	8,380	7,559	8,943	8,197	8,854	8,622	8,994	9,152	9,040	9,037	8,395	8,294
2023	7,805	7,793	8,766	8,616	10,164	9,418	8,955	8,318	8,518	8,748	8,407	8,092
2024	8,942	8,232	8,992	8,776								

How do we compare with our peers?



Status as at March 2024		
Health Board	Compliance	Rank
Powys	99.9%	1st
SB	75.7%	2nd
AB	73.9%	3rd
HDda	65.1%	4th
C&V	64.5%	5th
CTM	**64.5%**	**6th**
BCU	62.4%	7th



Status as at March 2024		
Health Board	Compliance	Rank
Powys	0	1st
C&V	831	2nd
SB	1,149	3rd
AB	1,475	4th
HDda	1,655	5th
CTM	**1,856**	**6th**
BCU	3,400	7th

How are we doing?

Please note that the trajectories shown in the charts above are in development and will be refined in future reports.

The chart above shows that throughout April the total number of ED attendances at our three acute hospital sites was slightly lower (1%) than those observed during April 2023, with overall numbers of Minor Injuries and ED attendances being similar to the equivalent period of last year.

The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival at our emergency care facilities during April is provisionally 66.9%, an improvement on April 2023 (64.7%) but remaining well below the WG compliance target of 95%.

The twelve hours performance saw 1,643 patients waiting in excess of 12 hours, down 6.6% (117 patients breaches) on the same period last year.

The average number of twelve hour patient breaches during the past 12 months is 1,788 and is almost 8% lower than equivalent period of 2022/23, where averages were 1,936.

What actions are we taking & when is improvement anticipated?

- Developing proposals to re-model integrated care delivery for patients in hospital beds who are suitable for care outside of hospital
- Exploring requirements to adopt RATZ delivery model in all EDs.
- USC Dashboard launched March 2024.
- Improvement plan in place across CTM with regular performance meetings held.
- 4-hour compliance validation exercise underway in POW which should improve performance figures and clear the backlog.
- Pan CTM review of validation process underway to develop a SOP in line with national guidance to improve data quality and ensure parity of data across the 3 ED departments.
- Development of electronic safety huddle being trialled in RGH ED to provide a real time picture of demand, capacity and risk level.
- Review of MIU clinical criteria and potential available capacity with a view to redirecting a higher proportion of patients from ED.
- Initial discussions with Welsh Clinical Network regarding Continuous Flow Model to improve hospital flow.

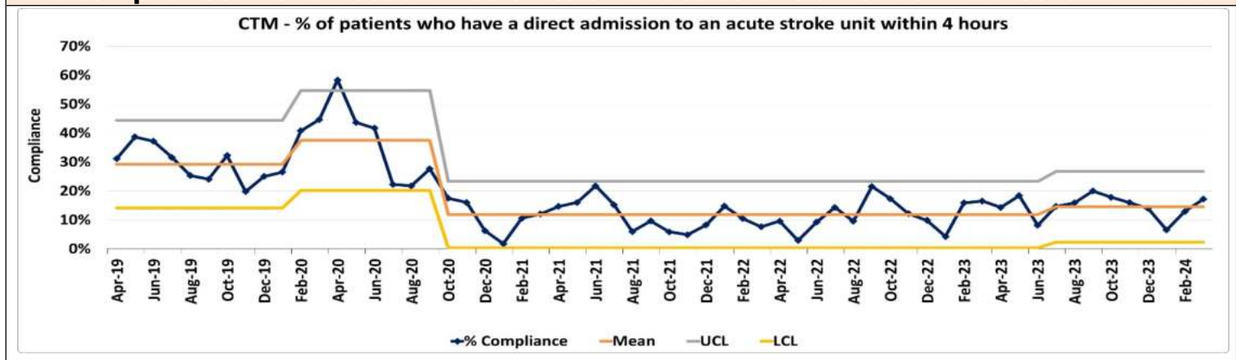
What are the main areas of risk?

- Additional uncommissioned capacity remains open across all sites.
- System flow remains highly impacted by capacity within social care.
- Activity has increased resulting in uncommissioned capacity being utilised to manage demand.
- Persistent high escalation levels across all sites.

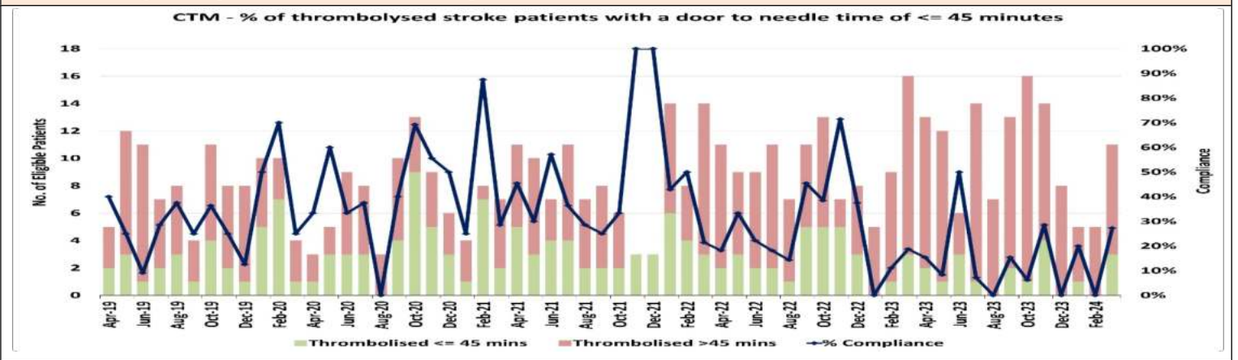
CTMUHB – Focus on Stroke Quality Improvement Measures (QIMs) – March 2024

(please note that Stroke Measures are not included in the 2024/25 WG Performance Framework)

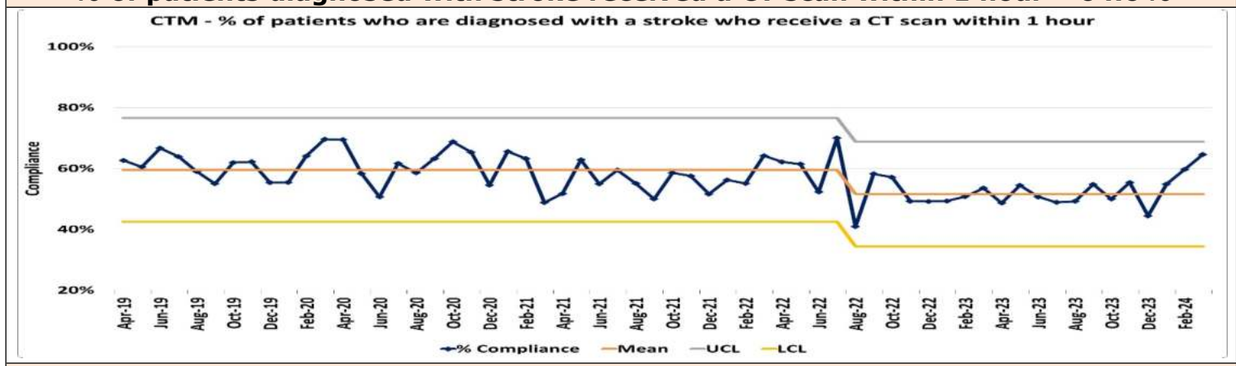
% compliance with direct admission to an acute stroke unit within 4 hours – 17.2%



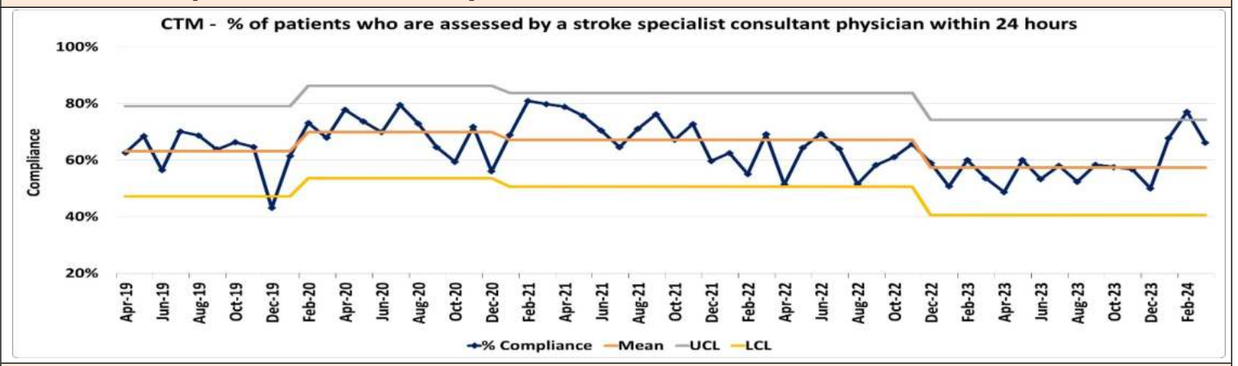
% of eligible patients thrombolysed door to needle time within 45 minutes – 27.3%



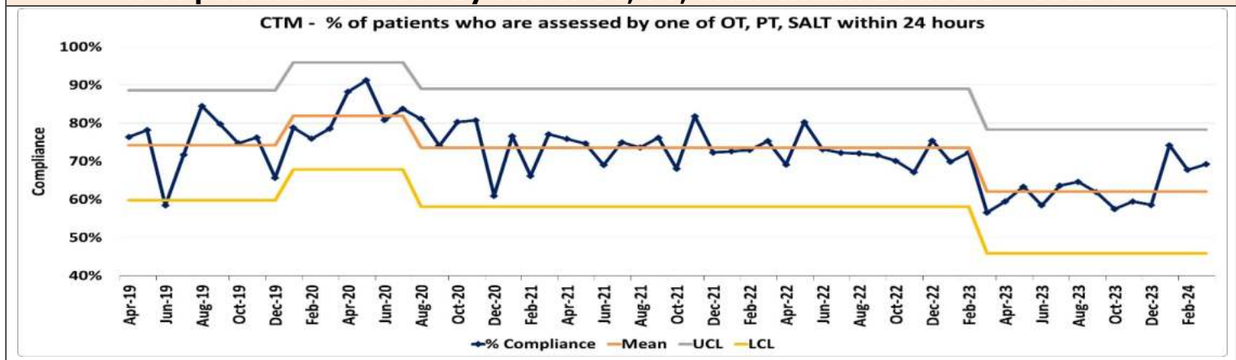
% of patients diagnosed with stroke received a CT scan within 1 hour – 64.6%



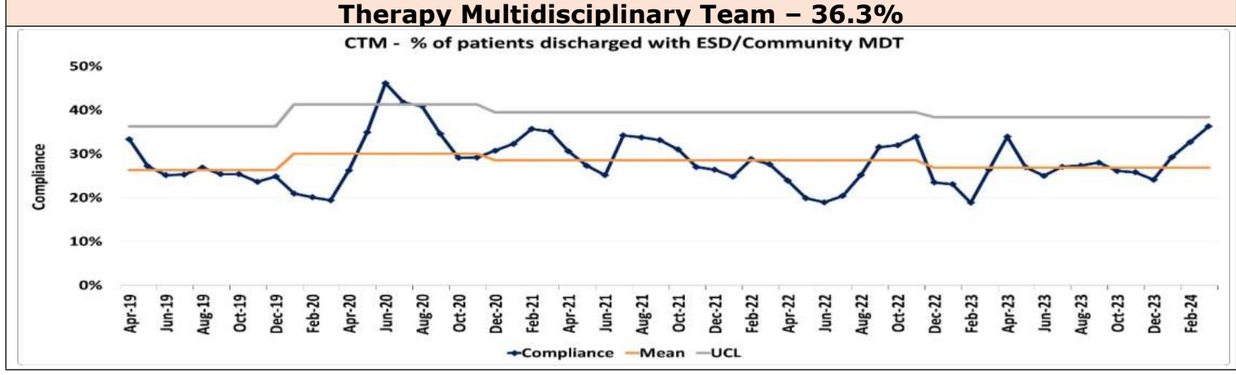
% of patients assessed by a stroke consultant within 24 hours – 66.2%



% of patients assessed by one of OT, PT, SALT within 24 hours – 69.2%



Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team – 36.3%



Current month stats

Stroke QIMs as per current month submitted data - March 2024		PCH	POW	YCR	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	37	27	N/A	64
	No. of patients within 4 hours	11	0		11
	% Compliance	**29.7%**	**0.0%**		**17.2%**
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	6	5	N/A	11
	No of patients within 45 mins	3	0		3
	% Compliance	**50.0%**	**0.0%**		**27.3%**
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	38	27	N/A	65
	No. of patients within 1 hour	25	17		42
	% Compliance	**65.8%**	**63.0%**		**64.6%**
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	38	27	N/A	65
	No. of patients within 24 hours	26	17		43
	% Compliance	**68.4%**	**63.0%**		**66.2%**
% of patients who are assessed by one of OT, PT, SALT within 24 hours	Total admissions	38	27	N/A	65
	No. of patients within 24 hours	22	23		45
	% Compliance	**57.9%**	**85.2%**		**69.2%**
% of applicable patients discharged with ESD/Community Therapy MDT (rolling 3 months)	Applicable Patients	74	68	15	157
	No. of patients with ESD/MDT	31	19	7	57
	% Compliance	**41.9%**	**27.9%**	**46.7%**	**36.3%**

Contd…Stroke Quality Improvement Measures (QIMs) – March 2024

How are we doing?

- During March, 17.2% (11 out of 64) stroke patients were admitted directly to an acute stroke unit within 4 hours. We continue to have significant bed pressures across PCH and POW which is impacting on our ability to transfer patients to a stroke unit within 4 hours. We have recently started a daily audit across all sites to support our understanding of being unable allocate a stroke bed within the required timeframe. We will capture data on how many patients are clinically optimised, how many patients are awaiting a rehab bed, how many medical outlier patients are currently on the stroke unit and how many patients are awaiting transfer from RGH to PCH. We will be completing this for a one-month period to support us with improving patient experience. It is important to note that 10 of the above patients had initial admission to RGH, which will impact on performance outcomes.
- Three (27.3%) of the eleven eligible patients that were thrombolysed received this within 45 minutes. The national average was 17.8% for this KPI.
- 64.6% of patients (42 out of 65 diagnosed patients) had a CT scan within an hour. POW Clinical Nurse Specialists (CNS) are now able to request CT scans, which is supporting continued improvement with this metric. PCH nursing team will have their training completed by the end of May to support further performance improvements.
- 66.2% (43 out of 65) of stroke patients treated in March were seen by a specialist stroke physician within 24 hours of arrival at the hospital. A deterioration with this position due to more patients presenting outside of core hours. The performance for this KPI will continue to fluctuate until we embed a robust 7-day service.
- 69.2% (45 out of 65) of stroke patients were assessed by either an Occupational Therapist, Physiotherapist or Speech and Language Therapist within 24 hours of arrival. We have remained fairly static in performance for this KPI. AHPs run a Monday – Friday core service, which will impact on performance each month, depending on the times patients present to hospital. For March, out of the 20 patients who were not seen within 24 hours, 14 patients either presented initially to RGH, where there is no stroke provision, or presented outside of core hours
- The rolling 3-month discharge standard saw 57 out of 157 (36.3%) of applicable patients being discharged with Early Supported Discharge (ESD) or Community Therapy MDT. However, the numbers will fluctuate each month depending on severity of the patients on the ward as only mild-moderate patients are eligible for the service.

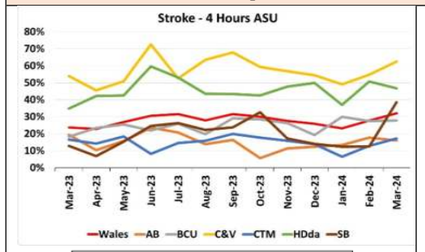
What actions are we taking & when is improvement expected?

- A one-month audit is being undertaken (as detailed above) to support pulling together high-level detail to demonstrate some of the challenges we are facing on a daily basis which is impacting on patient experience and performance for our stroke pathways. We hope by undertaking the audit this will support moving forward conversations around ring-fencing stroke beds to improve patient care and experience.
- The care group has committed to taking through the CNS workforce expansion paper this financial year which, if approved, will support patient experience and outcomes for those patients who are presenting outside of core hours.
- Follow-up meeting with Cardiff & Vale UHB during May to discuss moving forward a regional on-call rota for Stroke.
- Appointment of one of our Consultant Physician's to CTM Clinical Director role for stroke.
- We are continuing to monitor the impact of Brainomix AI software (reporting for CTs and CT angiograms) to ascertain its potential for minimising delays for referrals for thrombectomy
- The CNS team at PCH will complete their E-IR(ME)R (Ionising Radiation Medical Exposure Regulations) training in May, allowing the team to request radiology diagnostics. This will contribute towards increasing the number of patients receiving a scan within one hour
- A contributing factor to some performance measures not being achieved is due to MDT services being run over 5 days opposed to 7 days. In addition, overall numbers for the stroke pathways are small, therefore % for performance will fluctuate each month.
- CT perfusion can now be undertaken at PCH and RGH. POW are waiting for the software to be installed during the next 6 – 8 weeks (this also gives time for training to commence for the radiology team).

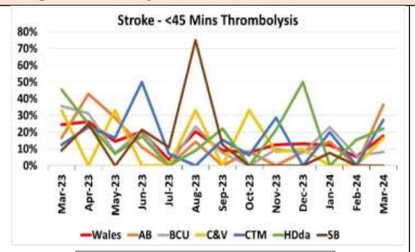
What are the main areas of risk?

1. CNS workforce across POW and PCH: this would require investment to recruit further CNS workforce to extend to 7-day service which would support improved patient care and experience, particularly outside core hours.
2. Inpatient therapies resource does not meet national standards - workforce model under review.
3. Bridgend Early Supported Discharge service has currently closed to new referrals at POW due to workforce constraints/caseload capacity, which is currently under review by the DTPS (Diagnostic, Therapies, Pharmacy & Specialties) Care Group
4. Data quality - additional resource required to support data input / performance reporting across both PCH and POW, which will support with performance monitoring and improvement. This requirement will be included in the CNS workforce expansion paper.
5. Ring-fencing stroke beds continues to be a challenge due to site pressures, as well as high numbers of clinically optimised patients awaiting social care, community hospital and nursing home.
6. Limited stroke rehabilitation capacity.
7. Therapy rooms within ward areas are not fit for purpose in PCH and POW. Space allocation review to be completed on both sites. Many patients are currently receiving therapy input at their bedside, which is not appropriate.
8. Small consultant workforce: currently the service is running a 1 in 6 on-call rota despite only having 4 substantive Consultants. Regional meetings being held around joined up on-call rota with Cardiff as well as an internal review of neurology supporting stroke on-call rota.
9. The amount of delayed clinically optimised patients within CTM creates blockages within ED. This is then having a knock-on effect for all patients, including stroke patients having timely bed allocations.
10. High number of stroke patients still continue to self-present to RGH where there is no longer stroke provision. This also impacts the ability to enact stroke pathway due to no pre-alert for these patients (impacting on timely care).

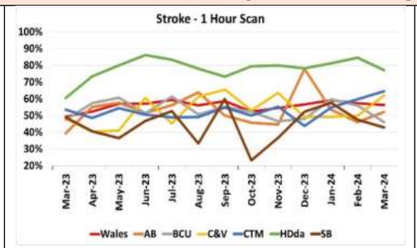
How do we compare with our peers? *(Please note that the data below is subject to change due to data being refreshed monthly – February 2024 not available as yet)*



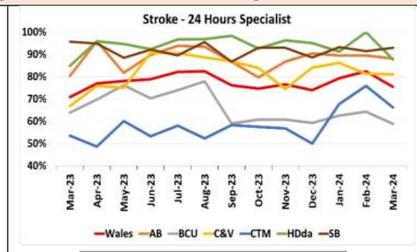
Status as at March 2024		
Health Board	Compliance	Rank
C&V	62.5%	1st
HDda	46.7%	2nd
SB	38.5%	3rd
BCU	27.8%	4th
CTM	**17.2%**	**5th**
AB	16.1%	6th



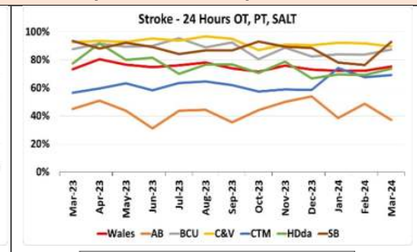
Status as at March 2024		
Health Board	Compliance	Rank
AB	36.4%	1st
CTM	**27.3%**	**2nd**
HDda	22.2%	2nd
C&V	16.7%	4th
BCU	8.3%	5th
SB	0.0%	5th



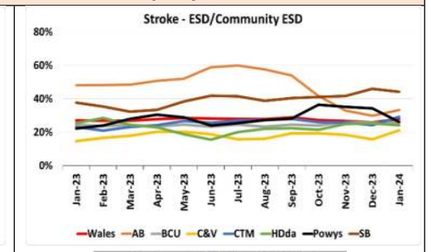
Status as at March 2024		
Health Board	Compliance	Rank
HDda	77.2%	1st
CTM	**64.6%**	**2nd**
C&V	62.1%	3rd
AB	52.2%	4th
BCU	46.2%	5th
SB	42.9%	6th



Status as at March 2024		
Health Board	Compliance	Rank
BCU	58.8%	1st
CTM	**66.2%**	**2nd**
C&V	81.0%	3rd
HDda	87.7%	4th
AB	88.1%	5th
SB	92.9%	6th



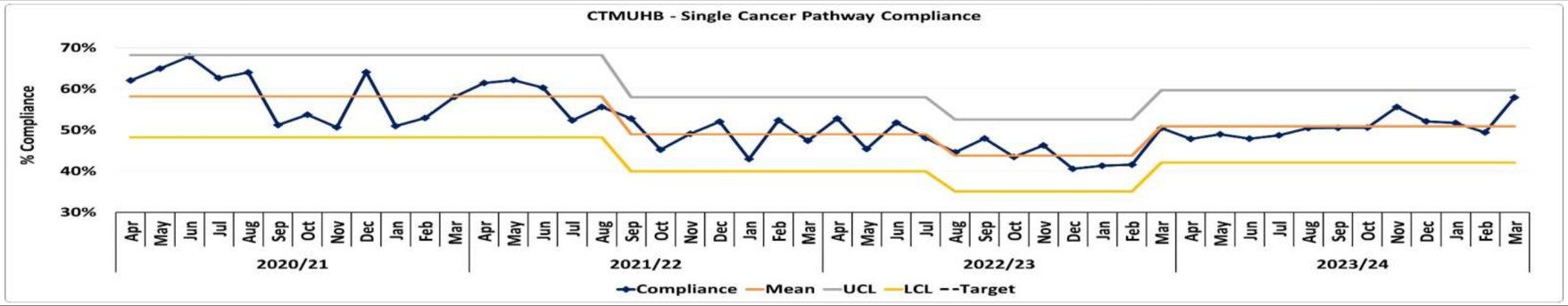
Status as at March 2024		
Health Board	Compliance	Rank
SB	92.9%	1st
C&V	89.7%	2nd
BCU	87.4%	3rd
HDda	73.7%	**4th**
CTM	**69.2%**	**5th**
AB	37.3%	6th



Status as at March 2024		
Health Board	Compliance	Rank
SB	41.8%	1st
AB	35.0%	2nd
C&V	30.5%	3rd
Powys	27.0%	4th
BCU	26.2%	5th
CTM	**25.8%**	**6th**
HDda	25.7%	7th

Single Cancer Pathway (SCP) March 2024 – 57.9%

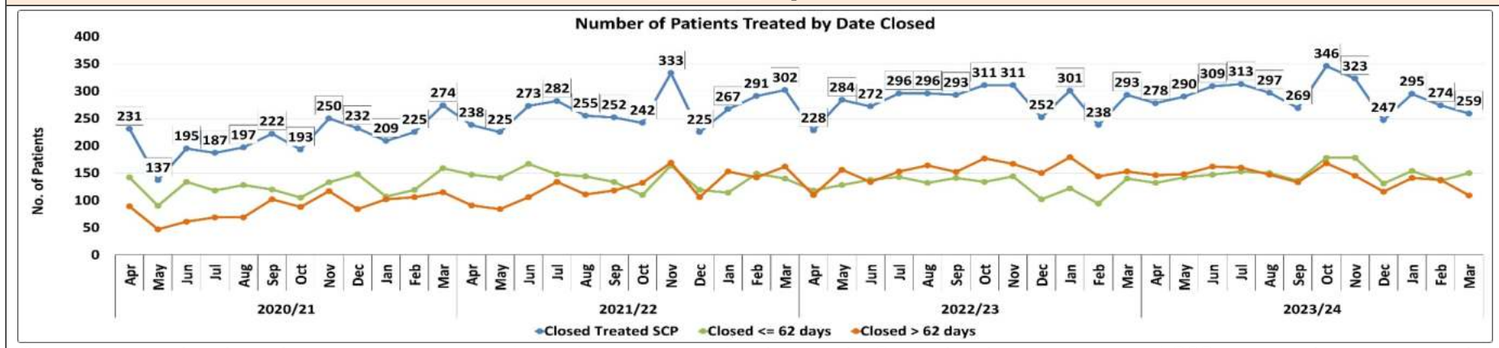
% of patients starting first definitive cancer treatment within 62 days from point of suspicion. Target is 12 month improvement trend towards national target of 80% by 31st March 2026



CTMUHB - SCP % Treated Without Suspensions - March 2024				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated in Target Without Suspensions
Head and neck	3	7	10	30.0%
Upper GI	8	8	16	50.0%
Lower GI	17	16	33	51.5%
Lung	6	8	14	42.9%
Sarcoma	2	1	3	66.7%
Skin (exc BCC)	58	7	65	89.2%
Brain/CNS	3	1	4	75.0%
Breast	19	13	32	59.4%
Gynaecological	2	8	10	20.0%
Urological	19	34	53	35.8%
Haematological	10	5	15	66.7%
Other	3	1	4	75.0%
Total	150	109	259	57.9%

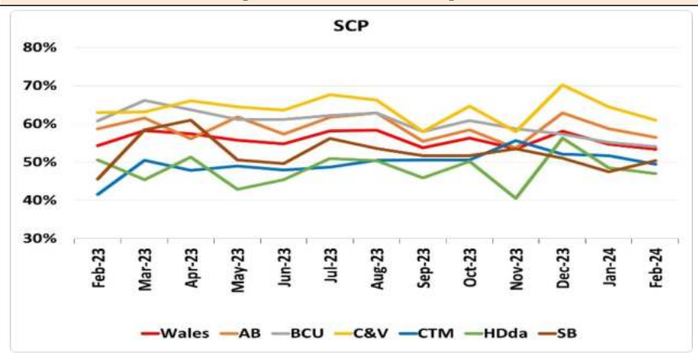
Compliance during March 2024 was 57.9% and stands above the current mean of 50.9%. Just one of the tumour sites reached the desired target threshold this period, as seen in the table above. Predicted compliance for April currently stands at 52.4%. Delays at first outpatient (28%) and diagnostic stage (52%) continue to be the greatest concern and the significant factors in not achieving the target. Diagnostic delays remain in radiology, endoscopy and pathology; although generally improving. Tertiary delays for diagnostics & treatments also continue.

Patients Treated by Closed Date



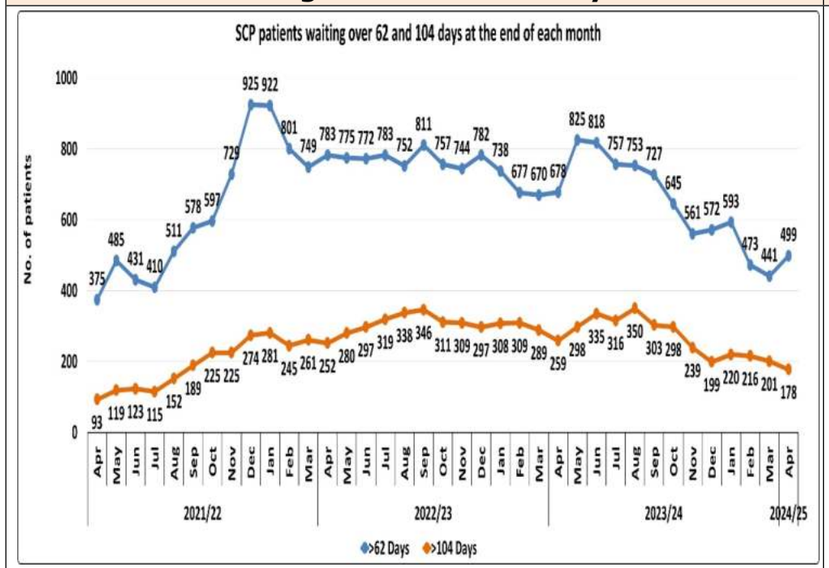
Overall cancer treatment volumes have marginally increased during the past 12 months to an average of 292 per month, compared to 281 the previous 12 month period; representing an average monthly increase of 3.7%.

How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
C&V	60.9%	1st
AB	56.5%	2nd
BCU	54.0%	3rd
SB	50.4%	4th
CTM	**49.4%**	**5th**
HDda	47.0%	6th

Patients currently waiting on a Cancer Pathway waiting in excess of 62 days



What actions are we taking & when is improvement anticipated?

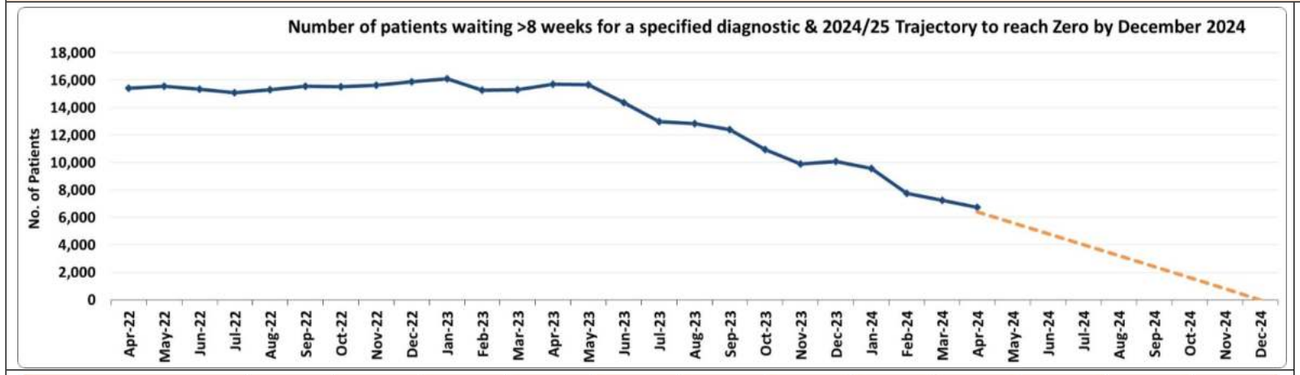
- Centralisation of Breast service – in place from the start of April at Snowdrop Centre next to Royal Glamorgan Hospital.
- Increasing Straight to Test (STT) where possible.
- Merging of Lower GI MDTs. Discussions progressing well, scheduled for early September.
- Rollout of digital vetting.
- Waiting List Initiatives (WLI's).
- Continuing outsourcing of pathology.
- Additional Local Anaesthetic Transperineal Prostate Biopsy machine (LATPB) has been procured – will provide increased flexibility and sustainability of service.
- Modified the urology sustainability meeting to focus on 4 specific areas:
  - 1st OPA
  - Haematuria Pathway
  - LATPB
  - Inpatient Treatments

What are the main areas of risk?

- National shortage of isotope affecting breast and urology cancer pathways.
- Sustainability of CTM Pathology and impact when disaggregating services from SBUHB.
- Delays in tertiary investigations & treatments at SBUHB, Velindre Cancer Centre and C&VUHB.
- Implementation of genomic testing for new targeted therapies.
- Urology diagnostics – specifically prostate pathway consequent to all patients now being offered LATPB over TRUS biopsy. Demand outstripping available capacity.
- Delays in Gynaecology diagnostics and treatments for POW patients via SLA with SBUHB.

Diagnostics – April 2024 (Provisional Position)

Number of patients waiting >8 weeks for a specified diagnostic – All Wales Target is for 95% of modalities to be Zero by March 2025



Diagnostics >8 wks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/24	15,727	15,689	14,361	12,972	12,843	12,390	10,962	9,909	10,079	9,563	7,759	7,236
2024/25	6,740											

Number of Patients waiting >8 Weeks for a Diagnostic Test - April 2024		
Cardiology	Echo Cardiogram	1,461
Cardiology Services	Cardiac CT	3
	Cardiac MRI	7
	Diagnostic Angiography	119
	Stress Test	17
	DSE	41
	TOE	6
	Heart Rhythm Recording	60
	B.P. Monitoring	20
Bronchoscopy		0
Colonoscopy		95
Gastroscopy		120
Cystoscopy		829
Flexi Sig		103
Radiology	Non-Cardiac CT	1,369
	Non-Cardiac MRI	715
	NOUS	764
	Non-Cardiac Nuclear Medicine	43
Imaging	Fluoroscopy	60
Physiological Measurement	Urodynamics	112
Neurophysiology	EMG	356
	NCS	440
Total		6,740

How are we doing?

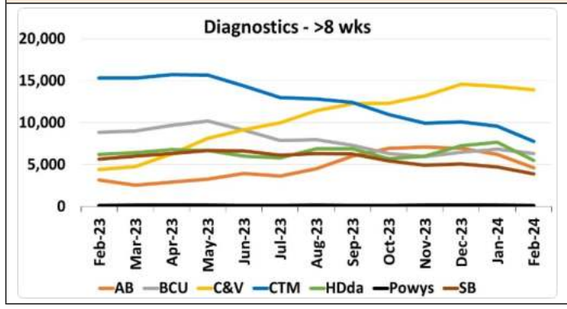
Diagnostics: Provisionally, at the end of April, 6,740 patients had been waiting in excess of 8 weeks for a diagnostic procedure, which as it currently stands is a 7% (496) reduction on the March reported position and rests just above the desired trajectory, as shown above.

The largest contributory factor to the improving diagnostic position has been observed in Non-Obstetric Ultrasound (NOUS), where the number of patients waiting in excess of 8 weeks reduced by 206 patients in month to stand at 764 and non-cardiac MRI where the numbers of breaching patients reduced by 186 to stand at 715 at the end of April.

We also observe that there has been a reduction in the number of patients waiting in excess of 8 weeks for a Echo Cardiogram; falling by 6% (91 patients) from the previous reported position, however there are currently 1,461 patients waiting more than 8 weeks for this diagnostic procedure.

The Endoscopy service continues to incrementally reduce the number of patients breaching the 8 week diagnostic timeframe with the number of patients currently waiting beyond the desired target standing at 1,147. Whilst the volume of breaching patients remains high, we have seen that during the past 12 months there has been a 60% reduction in the number of breaching patients.

How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
Powys	143	1st
SB	3,870	2nd
AB	4,619	3rd
HDda	5,489	4th
BCU	6,292	5th
CTM	**7,759**	**6th**
C&V	13,908	7th

What actions are we taking & when is improvement anticipated?

Radiology:
The NOUS improvement plan delivered a significant reduction in the overall waiting list. The team continues to drive down the number of over 8 week breaching patients. Plans are now in place to sustain a reduction post April.

The service continues to maintain an improved MRI and CT reporting position. The Mobile MRI has been operational since 22/04/24, which has already seen a reduction in over 8 week waits.

Trajectories for CT and MR have been developed and are showing scanning capacity shortfalls with the additional demand trends.

A case is being drawn up on more sustainable solutions to increase the CT scanning capacity in 2024. An updated D&C has demonstrated a maintained increase growth in demand for CT. Meeting arranged to review OOH CT referral criteria and OOH on-call provision to tighten up existing referral pathways.

Endoscopy:
Productivity and efficiencies continue to be monitored weekly through endoscopy 6/4/2-1 process/discussions and Task & Finish Group within the Endoscopy Service. Utilisation maintained over 90%.

Endoscopy mobile unit continues to run from the Royal Glamorgan Hospital to support crossover of the new unit at Prince Charles Hospital going live.

The service has seen an increase in USC demand but has managed to maintain current USC waits. 62 USC's waiting this is average against the number of referrals received weekly. Only 19 patients waiting greater than 14 days (10 due to patient choice and CNA/DNA)

The service has also made significant improvements to our routine waiting list. Total CTM waiting list backlog was over 5,000 (May 2023) and as of April 2024 this has reduced to around 790 (provisionally, patients waiting over 8 weeks = 318).

What are the main areas of risk?

Radiology:
- D&C imbalance shown in most D&T services as demand has risen. CT colon demand likely to rise further as a result of the new BSW criteria and reduction in age limit for testing/screening patients; linked to Endoscopy additional capacity being commissioned. Pathology sampling has already seen this increase which is currently being supported to outsource through the planned care recovery proposals.
- Sustained increase in CT Out of Hours emergency demand, but also increase in elective referrals. Additional outsourcing agreed to help with timely reporting, which has helped reduce the reporting backlog and waiting times. Going forward a plan is being drafted in Radiology to try and reduce any unnecessary demand and look at the opportunities to utilise currently unfunded CT sessions. Current Radiographer staffing model does not align with current OOH demand.
- Radiology service continues to hold 6.0 WTE Consultant vacancies, the ongoing recruitment campaign has proven unsuccessful. Retire and return of substantive consultant will reduce some sessions until we recruit. Prudent use of reliable locums will help bridge the gap temporarily.

Endoscopy:
- Across site working continues to improve but WPAS interface still remains a risk to develop a pooled waiting list – working with our Digital colleagues to overcome.
- GI pathway audit completed and action plan developed. This will allow the pan CTM endoscopy service to operate within a standardised approach.
- With improvements across symptomatic and screening waiting times and lists the service continues to monitor conversions and impacts on stage 4. Ensuring the governance and reporting of impact to quality and patient safety within our long waiting patients.
- Improvements continue within the surveillance cohort, further work ongoing to reduce

Therapies – April 2024 (Provisional Position)

The 2024/25 Performance Framework is measuring three performance indicators for therapy services and from April there has also been a change in the reporting of Weight Management services. As this service is multi-disciplinary involving a number of different therapists all contributing to patient care, Weight Management services was over inflating waiting times for Dietetics. Consequently WG have decided that:

- *All waiting times for Weight Management services should be removed from the Diagnostic and Therapy Services (DATs) formal waiting times national submission from April 2024.*
- *All non-consultant led Weight Management services should be removed from the Referral to Treatment (RTT) waiting times national submission from April.*
- *Any Weight Management service waiting times, which are part of a consultant led RTT pathway, should be reported under the specialty of the consultant responsible for the overall pathway from April.*

Number of patients waiting >14 weeks for a specified therapy (excluding Audiology) - Target is Zero **(April 2024 = 61)**

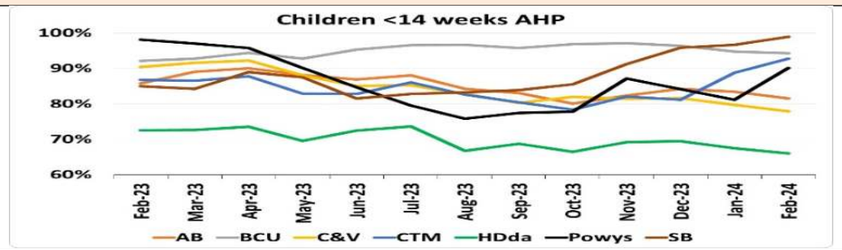
Number of patients waiting >14 weeks for Audiology – Adult Hearing Aids - Target is Zero **(April 2024 = 135)**

% of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional – Target is 100% **(April 2024 = 78.3%)**

Number of Patients waiting >14 Weeks for a Therapy - April 2024	Total Waits	Waits >14 wks	% >14 wks
Arts Therapy	18	0	0.0%
Dietetics	886	44	5.0%
Occupational Therapy	280	4	1.4%
Physiotherapy	1,459	0	0.0%
Podiatry	984	1	0.1%
Speech & Language	536	12	2.2%
Total	***4,163***	***61***	***1.5%***
Audiology *(Adult Hearing Aids)*	1,132	135	11.9%
Grand Total	**5,295**	**196**	**3.7%**

% of children waiting less than 14 Weeks for AHP - April 2024	Total Waits	Waiting < 14 wks	% <14 wks
Art Therapy	16	16	100.0%
Dietetics	295	35	11.9%
Occupational Therapy	118	117	99.2%
Physiotherapy	260	260	100.0%
Podiatry	147	147	100.0%
Speech & Language	366	366	100.0%
Total	1,202	941	78.3%

How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
SB	99.0%	1st
BCU	94.3%	2nd
CTM	**92.8%**	**3rd**
Powys	90.2%	4th
AB	81.5%	5th
C&V	77.9%	6th
HDda	66.0%	7th

Please note that benchmarking data for therapy waits >14 weeks is not yet available

How are we doing?

Therapies: There are provisionally 61 patients waiting in excess of 14 weeks for an initial therapy assessment and 135 adults waiting for a hearing aid fitting during April.

Speech & Language Therapy: those waiting over 14 weeks are a mixture of children and adults who are in the transgender service.

What actions are we taking & when is improvement anticipated?

Dietetics – Level 3 Weight Management Service - Based on the current model, capacity for this service exceeds demand. This is likely to continue without an increase in establishment. Waiting lists are expected to grow and patients are likely to face longer waiting times to access this valuable service falling short of the service we wish to provide.

Actions underway:

- There is a strong focus on whole system working and prevention.
- A newly launched 'Waiting Well for Weight Management' website empowers people to self manage whilst they wait, providing information and signposting.
- Model of service is constantly reviewed with the lens of VBHC to maximise opportunities for efficiencies.
- Business case development for expansion of adult weight management service and creation of Children and Young Persons weight management service.

Speech & Language Therapy: Complex needs service has 1.4 WTE vacancies which are out to advert. A number of mitigations have been explored and put in place, but unless a locum can be found the waiting list will breach.

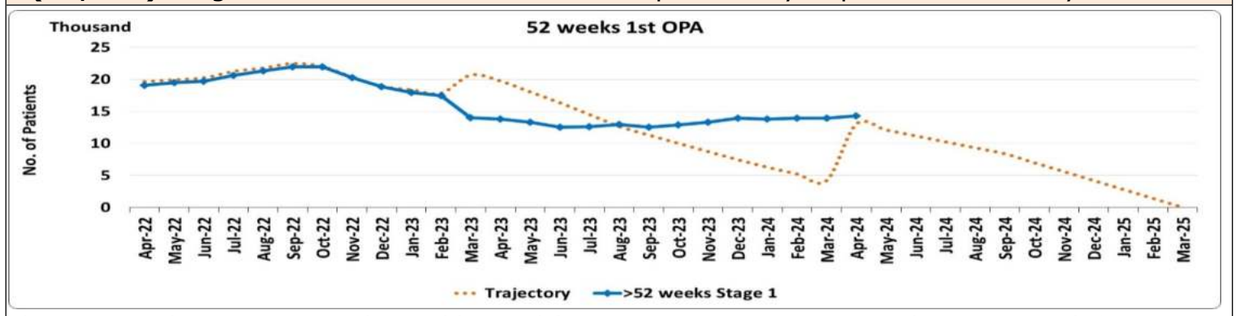
The Transgender waiting time is gradually improving as a result of the HEIW pathfinder funding for extra staff hours.

What are the main areas of risk?

- Inadequate workforce for adult weight management and no workforce for children and young person's weight management.
- High rates of childhood and adult obesity likely to drive increasing demand.
- Time consuming administrative and clinical information processes due to paper based notes and lack of integrated systems.
- Opportunities for digital efficiencies such as self-referral and self-booking not able to be maximised until patient portal and authorisation in place.
- Vacancy freeze on administration staff.
- National shortage of registered staff.

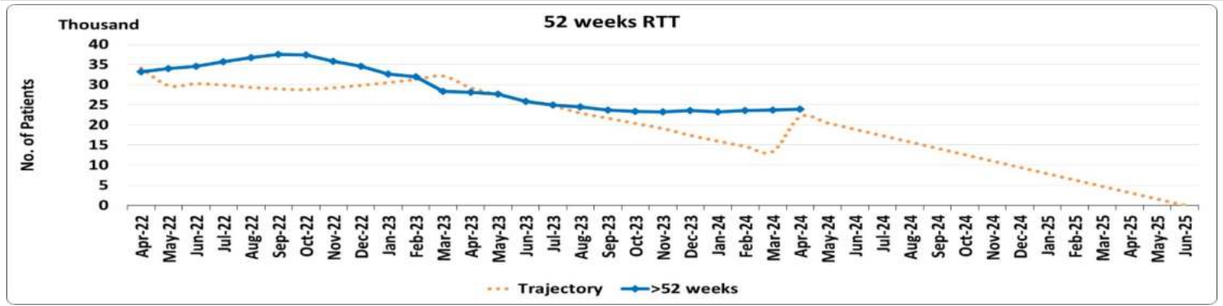
Referral to Treatment Times (RTT) – April 2024 (Provisional Position)

Number of patients waiting **over 52 weeks** for a **new outpatient appointment (14,264)** Target is 40% reduction on March24 position by Sept-24 and Zero by March 25



The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of April is 14,264; an increase of 2.4% (341) on the March reported position and is 10% (1,269) above the desired trajectory, as shown above.

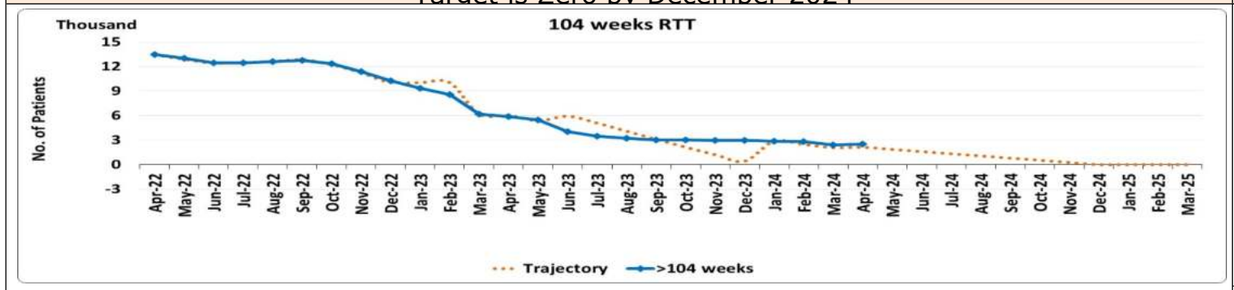
Number of patients waiting **>52 weeks RTT** (**23,893**) – Target is month on month reduction towards the national target of Zero by 30th June 2025



The provisional position across the Health Board for patients waiting over 52 weeks for referral to treatment at the end of April is 23,893, which as it currently stands is a 1% (296) increase on the March reported position and is 8.5% higher than the forecasted level, as shown above.

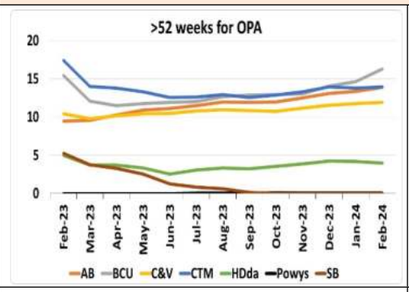
Total number of open pathways per specialty - April 2024 (provisional)					
Specialty	Urgent patients waiting >12 Weeks	All patients waiting >36 to 52 Weeks	All patients waiting >52 Weeks to 104 Weeks	All patients waiting >104 Weeks	Total Open Pathways
Anaesthetics	127	206	234	3	1224
Breast Surgery	114	113	210	19	1433
Cardiology	1361	919	1069	0	6251
Colorectal	699	492	611	21	3098
Dermatology	1168	1187	1610	21	7199
Diagnostics	0	70	55	0	4027
Ear, Nose & Throat Service	1070	1915	3309	509	12175
Endocrinology	2	7	1	0	221
Gastroenterology	1209	681	803	8	4008
General Medicine	747	437	535	1	2955
General Surgery	602	770	900	45	5980
Geriatric Medicine	2	3	0	0	140
Gynaecology	1324	1681	993	157	8832
Haematology (Clinical)	19	64	3	0	312
Nephrology	31	17	0	0	182
Ophthalmology	636	2737	3992	777	15608
Oral Surgery	709	561	488	13	3410
Orthodontics	118	51	12	0	292
Orthopaedics	2179	2294	3475	597	12932
Paediatrics	133	351	118	0	3377
Pain Management	2	0	0	0	47
Rapid Diagnostic Centre	0	2	0	0	131
Respiratory Medicine	163	296	411	3	3092
Restorative Dentistry	41	32	67	23	202
Rheumatology	352	216	106	4	1769
Sport and Exercise Medicine	0	0	0	0	15
Therapies	0	470	238	0	2820
Urology	1504	1200	1867	218	7628
Vascular Surgery	84	245	318	49	1211
Total	**14396**	**17017**	**21425**	**2468**	**110571**

Number of patients waiting **>104 weeks RTT (2,468)**
- Target is Zero by December 2024

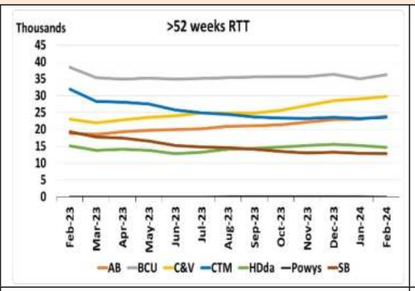


The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for referral to treatment at the end of April is 2,468. As it currently stands this is an improvement of 87 patients (3.7%) from the reported March position but stands 16.6% (352 patients) above the forecasted level, as shown above.

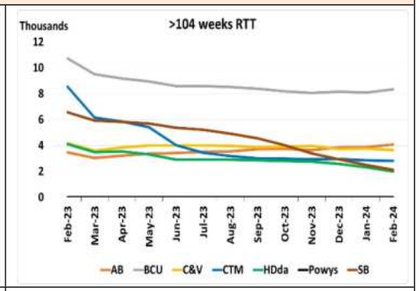
How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
SB	0	1st
Powys	13	2nd
HDda	3,978	3rd
C&V	11,898	4th
AB	13,883	5th
CTM	**13,945**	**6th**
BCU	16,287	7th



Status as at February 2024		
Health Board	Compliance	Rank
Powys	48	1st
SB	12,822	2nd
HDda	14,715	3rd
CTM	**23,539**	**4th**
AB	23,915	5th
C&V	29,786	6th
BCU	36,257	7th



Status as at February 2024		
Health Board	Compliance	Rank
Powys	0	1st
HDda	1,999	2nd
SB	2,116	3rd
CTM	**2,804**	**4th**
C&V	3,645	5th
AB	4,079	6th
BCU	8,340	7th

RTT continued on the next page...

Cont'd...Referral to Treatment Times (RTT) - April 2024

What actions are we taking & when is improvement anticipated?

Ophthalmology: Cataracts - outsourcing restarting July 2024 to Spa Medica (100 patients per month) & regional work commencing September with and improving stage 1 position anticipated.
- Glaucoma – activity for glaucoma tripled in 2023 compared to 2022 but demand outweighs capacity
- Currently receiving 80 referrals per month with capacity for only 30 patients.

Dermatology: WLI clinics were agreed to reduce the length of first appointment for USC patients. However this is not sustainable.
- Maximising available slots across sites so PCH and RGH patients will be offered available slots in POW where most of the capacity is.
- New consultant starting in September who will see paediatric patients across the Health Board.
- Electronic referrals being introduced to the north of the HB with a start date of early June.
- Templates in RGH being looked at for Acne patients with CNS offering additional sessions - waiting for Medical Records to confirm support.

General Surgery: increasing new patient clinic slots in both upper and lower GI with registrars supporting with the aim to reduce the stage 1 and minimise the pathway delays at stages 2 and 3.
- Ongoing validation of stage 3 with the majority of patients now booked for a follow up if required.
- Backfilling sessions across the specialties to increase stage 1 access. Also, where we have experienced middle tier support, we are running clinics to increase capacity.
- Vascular – exploring additional lists on weekends at PCH to treat the long waiting patients and patients who require a theatre setting for their treatment.
- Validation ongoing on all stages and close working with diagnostic teams to support areas requiring expedites.
- Focus has been on the >104 weeks and a reduction has been noted. For areas where improvement has not improved due to conflicts with cancer demand, outsourcing options are being considered via Planned Care Recovery.
- Review of clinic templates ongoing, clinic templates will be adjusted to meet demand in Stage 1 or 3 dependent on numbers waiting appointments

Colorectal: Working closely with Endoscopy and Radiology to ensure all long waiters are booked or partial booked.
- Across site collaboration to support booking first stage patients.

OMFS: Setting up additional New Patient weekend clinics to clear OMFS >104 wks by end of December and improve the >52 wk waits.
- Planned additional weekend clinics from June to October - awaiting clinician confirmation.
- There is interest in running additional MOS (minor oral surgery) evening sessions to reduce the stage 4 >104 wks
- We have a single restorative consultant currently who is managing the patients on clinical need to see as new patient and then treatment plan and carry out treatment, which is completed over many appointments.
- Business case to be escalated to appoint additional restorative consultant

ENT: Stage 4 >156 wks – awaiting outcomes of 5 patients, but have TCIs secured for these before the end of June if they proceed with surgery.
- Stage 2 & 3 >104 wks – weekly validation ongoing.
- Stage 4 >104 wks – 1 consultant has agreed to undertake a telephone validation – awaiting confirmation from remaining ENT consultants as to their availability to do the same.

Urology: Stage 1 – WLIs undertaken.

Stages 2 and 3 – Lists have been validated >104 wks.
- Outcomes / escalated tests are continually followed up
- Stage 4 – regular meetings in place with waiting list teams in RGH and POW to establish plans.
- Patients are actively being transferred from RGH to POW.

T&O: Ongoing validation work to ensure correct RTT pathway is being applied.
- Backfilling capacity for cancelled and vacant lists where possible.
- Working with therapies to ensure efficient validation and booking of patients waiting for a therapy.
- Clinical review of the nerve conduction study pathway to ensure consistent approach across CTM.
- WLI for existing backlog - in discussion with C&V to discuss our longest waiters.

What are the main areas of risk?

Ophthalmology:
- Glaucoma is our biggest risk as approximately 250 patients are waiting over 2 years for 1st appointment.
- HCQ (hydroxychloroquine retinopathy) – is of concern and placed on the risk register as there are no plans in place for these patients to be seen at the moment.

Dermatology:
- Paediatrics – not enough capacity
- USC demand for first appointment
- Acne – currently not enough capacity

General Surgery:
- Significant delays at stage 2 for patients awaiting diagnostics in SBU services. These delays are problematic in achieving WAG targets.
- USC demand is absorbing the majority of colorectal new patient's capacity and this is resulting in a backlog of stage 1 and minimal conversion to stage 4.
- Availability of clinics, theatres and clinician time to meet the demands.

Colorectal:
- Additional clinics may not be sanctioned by Medical Staffing due to staffing levels.
- DSU at PCH is the only source of supporting the initial intake of day cases and inpatients prior to surgery.
- Since the closure of DSU Tuesday 7th May 2024 and temporary relocation of DSU with reduced trolleys, the number of surgical cases going through the system will be less.
- To mitigate the reduction, backfill lists could be offered across sites.

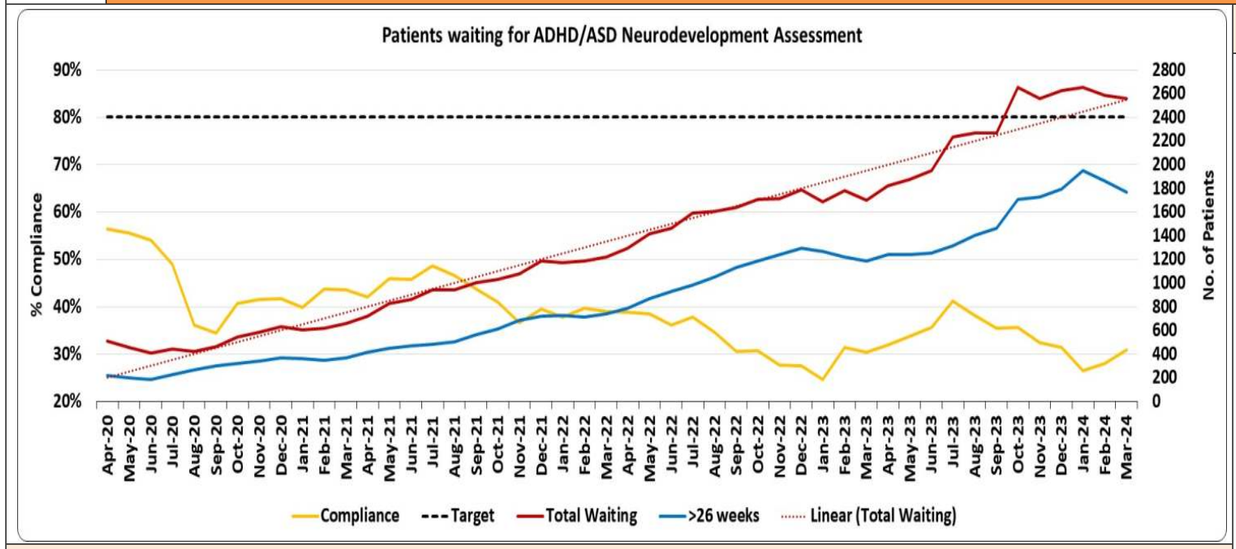
OMFS:
- Clinician availability for additional clinics during evenings and weekends, risk of exhausting workforce and impacting on core activity.

ENT:
- Stage 4 >156 wks – main risk around POW patients – 5 patients in total – no capacity to treat these before the end of June.

Urology:
- Consultants have complex specific cases – 34 patients to be reviewed in clinic and operate - currently looking into outsourcing.

T&O:
- Limitations on procedures undertaken at PCH – only day cases undertaken.
- Availability of staff, theatres and clinics to meet the demand of the service
- Some current issues presenting since the disaggregation, SB are currently refusing to accept SB patients onto their waiting lists if they had not previously been identified as SB patients. Discussions being had between the health boards to resolve.
- A&C staffing constraints following last stage of OCP, this will start to improve following the next stage of the OCP but will cause some issues in relation to validation

% of patients waiting less than 26 weeks to start an ADHD/ASD Neurodevelopment Assessment (Target 80%) March 2024 - 30.9%



How are we doing?

We have observed that the waiting list for assessment has grown incrementally year on year, from 510 patients at April 2020 to currently stand at 2,556 patients; with the greatest growth occurring during 2023/24 with a 50% increase since March 2023.

The yellow line on the chart above shows that correspondingly compliance with the 26 week access target for Neurodevelopmental remains low at 30.9%.

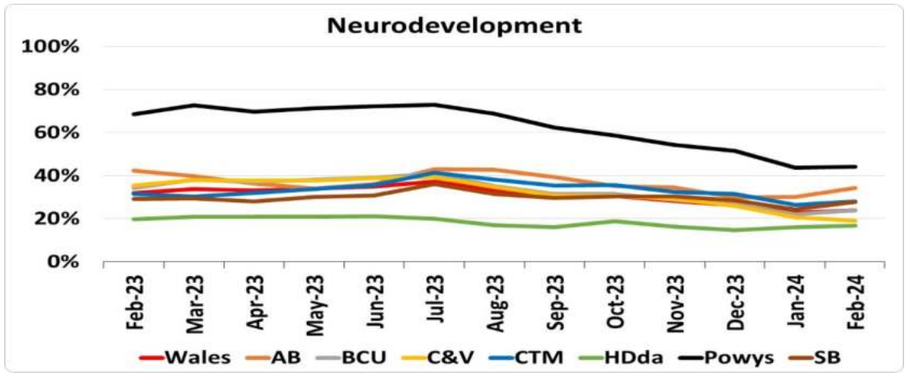
From July 2023 the chart shows that compliance has been fluctuating between 26.5% and 41.3% with access remaining well below the WG target of 80% and will continue to be so until the backlog is addressed.

Waiting list position: 2 patients currently at 104 weeks, appointments booked for May 2024. Average waiting time has decreased to 21 months as a result of NDIP funding.

What actions are we taking & when is improvement anticipated?

- The Improvement Board is overseeing the impact of the Regional Partnership Board's allocation to Neurodevelopment (ND) services. Ongoing work in progress with local authorities, along with AHP posts to support pre/post diagnosis, with third sector agencies allocated funding to provide support until March 2024. Bids have been submitted for 2024-25 – awaiting outcome.
- Pharmacy input into ND is supporting post-diagnosis follow-up titration & monitoring; releasing medical colleagues to support the waiting list further. Slippage from 2023/24 spend is being utilised by Speech and Language Therapists to take additional patients off the waiting list.
- The service has undertaken a demand and capacity analysis. Re-alignment of the budgets and recruitment of AHP/Nursing colleagues means that when the post holders commence, the available capacity will meet the current demand (if demand remains stable). However, this does not address the backlog of patients. Interviews have taken place and 3.5 wte CNS/AHP staff are due to start by July 2024.
- A report has been prepared highlighting that if we were able to recruit 2 x B7 AHP fixed term for two years, this would address the current backlog and result in no patient waiting over 52 weeks for an initial ND assessment by the end of March 2026.
- Developing a website page in conjunction with our partners in the local authorities and 3rd sector for our service users will increase our self-management and "waiting well" offer, so that families feel supported whilst on the waiting list and informed of what the services provide before families start the assessment journey. Incorporating some of the "myth-busters" that families and referrers often report into our new co-produced referral paperwork will ensure that families and professionals know what to expect from the outset.
- Ongoing validation of waiting list, with transition and signposting to relevant services/agencies as appropriate.

How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
Powys	44.2%	1st
AB	34.3%	2nd
CTM	**28.0%**	**3rd**
SB	27.9%	4th
BCU	23.8%	5th
C&V	19.0%	6th
HDda	16.8%	7th

What are the main areas of risk?

- Demand continues to outstrip core funded capacity. A demand and capacity review was undertaken (January 2024) and templates are being fixed on WPAS to ensure forecast remains accurate. The service has identified what is required to bridge the gap of the deficit in capacity to meet the demand. Without investment of 2 x B7 AHP for 2 years, the backlog of patients will remain an issue.
- Vacancies within the ND team (namely ADHD nurses) is creating additional waits for children/young people on the waiting list for ADHD. However, the team successfully recruited 3.5 wte AHP/CNS posts in March 2024 with anticipated start dates of July 2024.
- Reliance on short term funding does not provide a longer term solution, hence services are being reviewed with partners. The funding requested for 2024/25 included funding for various multidisciplinary posts (which was put on hold) which would have an impact on waiting times. Plans submitted seem positive and an outcome regarding funding allocation is awaited.

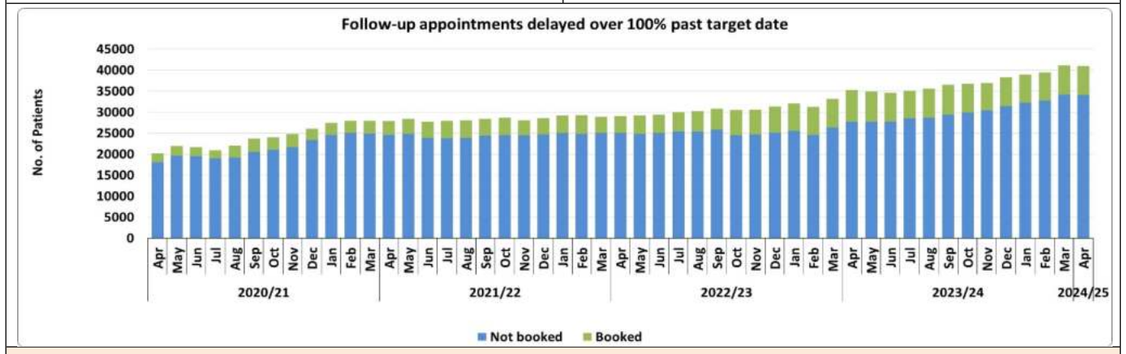
Follow-up Outpatients Not Booked (FUNB) – Provisional Position April 2024

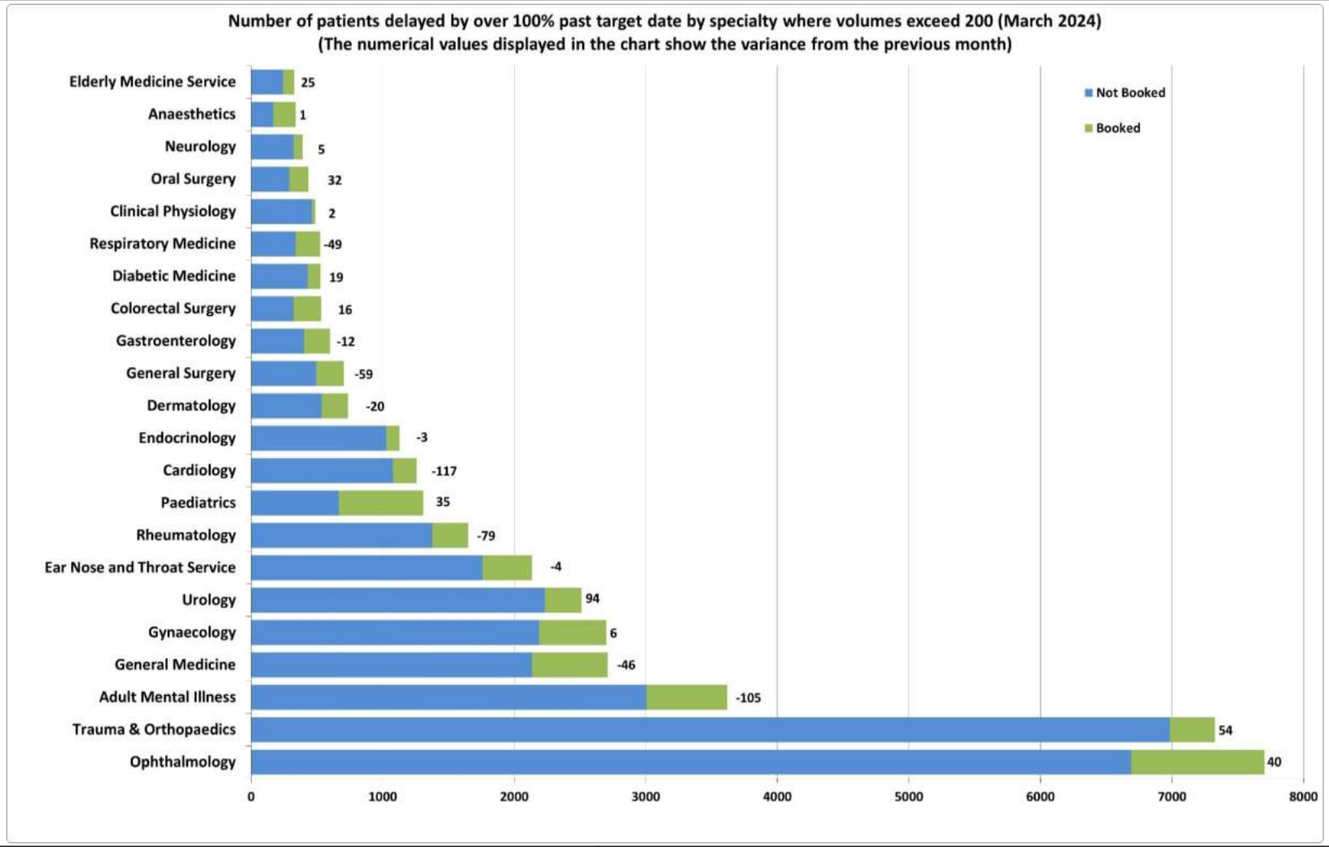
Number of patients waiting for a Follow-up with documented target date

Number of patients waiting for a Follow-up delayed over 100% - Target is Reduction compared to the same month in the previous year

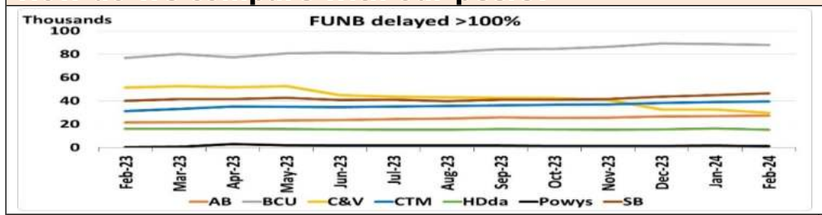
No. of patients waiting for follow-up appointment			
No documented target date	Not Booked	Booked	Total
0	88,893	55,037	143,930

No. of patients delayed over 100% past their target date			
Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
34,090	6,899	40,989	28.5%





How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
Powys	1,256	1st
HDda	15,478	2nd
AB	27,354	3rd
C&V	29,685	4th
CTM	**39,516**	**5th**
SB	46,482	6th
BCU	87,859	7th

How are we doing?

The number of patients waiting for a follow-up appointment in CTM, at the end of April 2024 provisionally stands at 143,930 which is an increase of 2.6% on the patients waiting during the equivalent period of 2023. There are currently no patients without a documented target date.

Of the patients waiting, 40,989 (28.5%) have waited more than 100% longer than their clinician advised, representing an increase of around 16% on the same period last year.

As it currently stands, combined outpatient activity levels during April continue to be below pre-Covid levels (around 11% less), with figures below for new and follow-up patients compared to prior the pandemic:

- Total New Patients seen: 15,832 which is a reduction of 9.5% on the 11 month average preceding the Covid pandemic (April 19 to Feb 20) of 17,493. As it currently stands activity levels for new outpatient appointments during April were 7% higher than the equivalent period of 2023.

- Total Follow-up Patients seen: 34,900 which is a reduction of 12% on the 11 month average preceding the Covid pandemic (April 19 to Feb 20) of 39,506. As it currently stands activity levels for follow-up outpatient appointments during April were 8% greater than the equivalent period of 2023.

What actions are we taking & when is improvement anticipated?

General Surgery: Validation ongoing - clinician review.
- Discussions ongoing regarding increasing virtual FUNB appointments
- SOS/PIFU processes are being circulated again.
- Large proportion of POW Breast FUNB patients were yearly surveillance patients. Following migration to CTM WPAS we have introduced a new system to allow us to track these patients and have therefore removed these patients from FUNB. This has resulted in a significant reduction.

Ophthalmology: Funding required for overtime to validate the FUNB list to reduce the numbers both clinically and clerically.
- Job plans are ongoing with activity being increased in clinics for new and follow up.

Dermatology: Validation - clinical/clerical required

Colorectal: Validation - additional admin hours required.
- Consultants going through their lists in admin time and advise on outcomes.

OMFS: Validation ongoing
- We are awaiting further consultant availability to run additional review clinics, both face to face and virtual. Improvement is anticipated for Dec 24.

Urology: Lists regularly being sent to consultants to validate.

T&O: Ongoing validation work.
- Reviewing clinic templates for balanced review of follow ups to ensure balanced template for new follow ups.

What are the main areas of risk?

Ophthalmology: Glaucoma is again the biggest risk and funding will be needed for overtime both clerically and clinically.

Dermatology: Without validation, the list will grow.
- PIFU and SOS should help going forward.

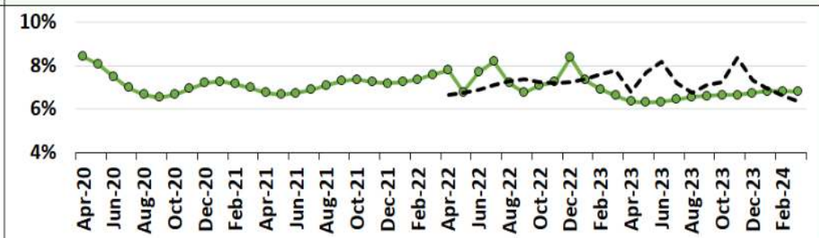
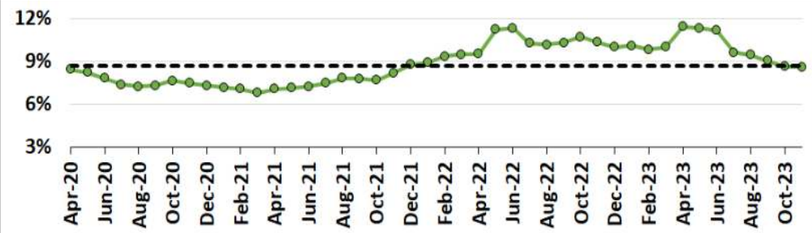
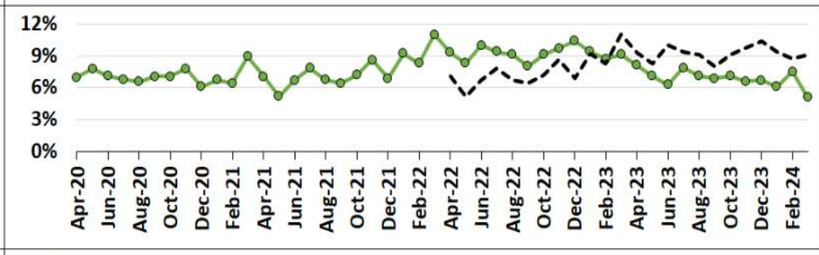
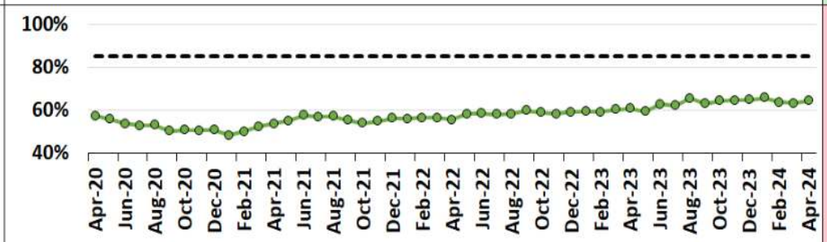
General Surgery: Focus is on new RTT and SCP patients and where possible validation work is underway.
- Minimal clinic capacity for non-urgent follow ups.

Colorectal: Consultants admin session availability dependent on usual workload.

OMFS: Clinician availability for additional evening and weekend clinics.
- There is a risk of exhausting workforce and impacting on core activity.

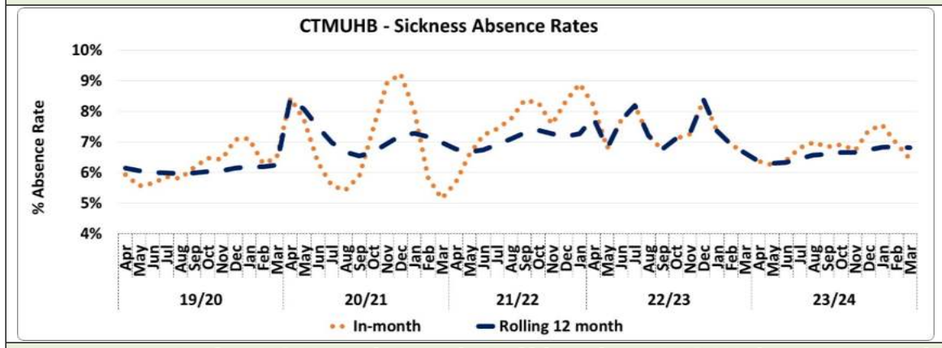
T&O: Lack of capacity for OP clinics.
- A&C staffing challenges due to the OCP

2.4 Welsh Government Performance Indicators: Quadruple Aim 3 - A Motivated & Sustainable Workforce

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable					
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Motivated & Sustainable Workforce	% of sickness absence rate of staff	12 Month Reduction Trend		6.8%	Mar-24
	Turnover rate for nurse & midwifery registered staff leaving NHS Wales	Rolling 12 month reduction against a baseline of 2019-20 (8.65%)		8.58%	Nov-23
	Agency spend as a percentage of the total pay bill	12 Month Reduction Trend		5.1%	Mar-24
Training & Development	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	85%		64.4%	Apr-24

CTMUHB Workforce Metrics

% of sickness absence rate of staff – Target is 12 month reduction trend – Mar 2024 (6.8%)



The rolling twelve-month sickness rate to March 2024 is 6.8% and is slightly higher than the equivalent rolling period of the previous year (6.4%).

The in-month sickness rate is 6.4% and is slightly lower than the equivalent period of 2023 (6.6%).

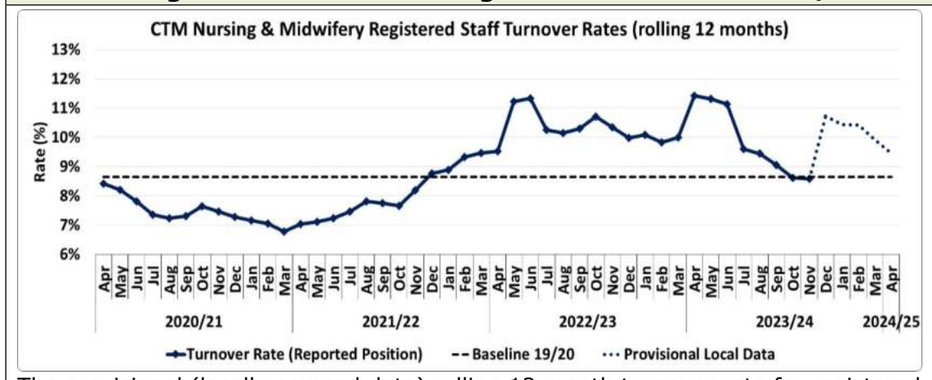
What actions are we taking & when is improvement anticipated? What are the risks?

The People Services Team continue to deliver Managing Attendance at Work Training throughout the Health Board and now have key individuals who support the Care Groups providing consistent advice and establish rapport with managers.

A particular focus has been placed on upskilling managers using the Managing Attendance at Work Policy to understand the prompt process, which includes the managers scope around these prompts and administrative functions that support these actions.

The People Services Team are currently reviewing all absence cases 6 months plus to ensure the correct level of support is being provided by the management teams, as well as ensuring cases are concluded appropriately and in a timely fashion.

Turnover rate for N&M registered staff leaving NHS Wales – Target is rolling 12 month reduction against a baseline of 2019/20



The provisional (locally sourced data) rolling 12 month turnover rate for registered N&M Staff at April 2024 remains higher than the desired level at 9.5%, although reducing incrementally. The equivalent previous rolling 12 month period (May 2022 to Apr 2023) rates were 11.4%. (N.B. rates will be subject to change when HEIW data is received due to the inability to locally monitor staff leaving NHS Wales).

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

Nurse retention is key area of focus for both the 'People' & Corporate Nursing teams. The risks and challenges reflect a complex local, national and international position regarding the shortage of registered nursing and midwives. Without taking action to reduce turnover and retain our workforce this would result in:

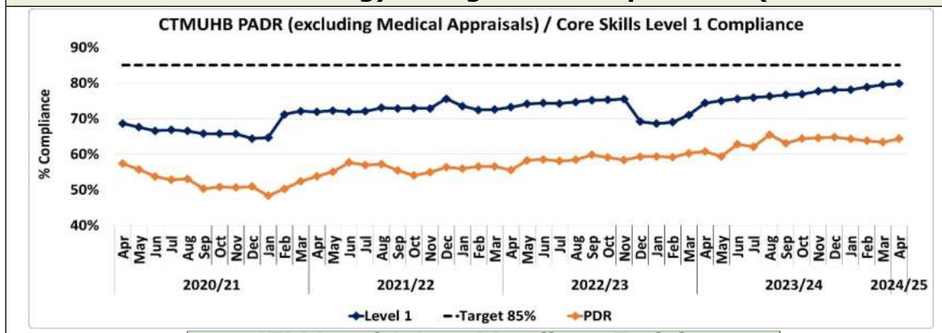
- loss of essential experience and critical skills creating further vacancy gaps
- burden on other workforce and their health and wellbeing resulting in increased sickness absence
- staff costs/variable pay
- further turnover and inability to attract and recruit a wider workforce - potential reputational damage

CTM is actively involved in the national work being led by HEIW. Our Retention Action Plan covers delivery against both internal plans and the actions within the HEIW plan. Our Retention Group gives oversight, direction and engagement on this work. Our Retention and Workforce Planning Lead will encourage sharing best practice and utilising networks across Wales. Key areas of focus will be on 4 key pillars:

1. **Context**: staff survey results, research, think tanks, evidence based practice and different sources of data to influence actions and change.
2. **Planning and Delivery**: the CTM retention action plan and roll out of the HEIW retention self-assessment tool
3. **Retention initiatives**: embedding our newly launched Lateral Moves Scheme, improving flexible working, relaunching our Moving on Questionnaire and promoting areas of good practice / case studies within the health board.
4. **Thinking differently**: developing new initiatives informed by engagement, best practice, research and data.

The specific improvements are being delivered alongside and interlinked with other ongoing work streams around improved attraction, bolstered recruitment pipelines, our culture / wellbeing / employee experience offer.

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% - April 2024 (64.4% - Provisional)



CTM Level 1 Core Manditory Training Compliance April 2024	
Equality, Diversity & Human Rights	85.9%
Safeguarding Children	85.4%
Health, Safety and Welfare	84.8%
Safeguarding Adults	84.4%
Moving & Handling	83.3%
Information Governance	80.5%
Fire Training	78.4%
Violence & Aggression	78.4%
Infection Prevention and Control	74.7%
Resuscitation	63.4%
HB Overall Compliance	79.9%

Overall compliance is improving incrementally; currently standing at 64.4%. Compliance for the past year has ranged between 59.4% and 65.5%, recognising that this remains below the WG target of 85%.

Currently, combined core mandatory training compliance is 71.3% with **Level 1** disciplines at 79.9% and likewise is improving in small increments, but remaining below the required standard of 85%.

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

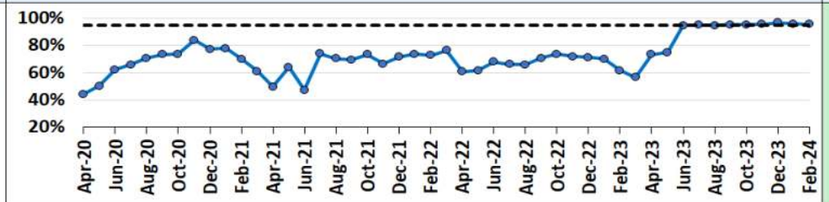
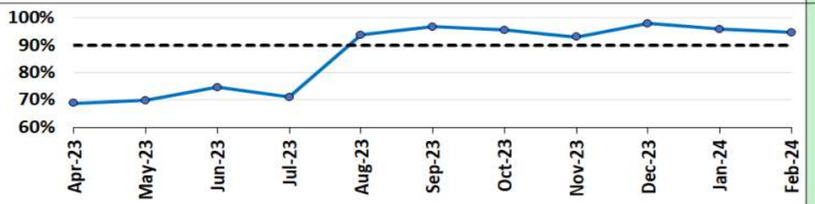
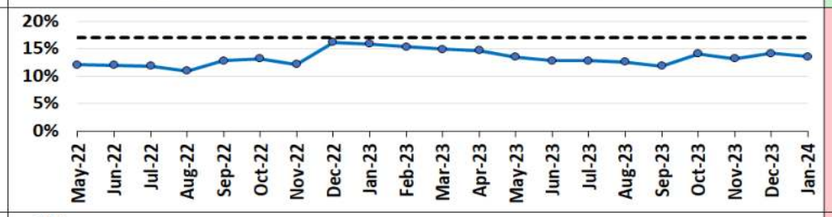
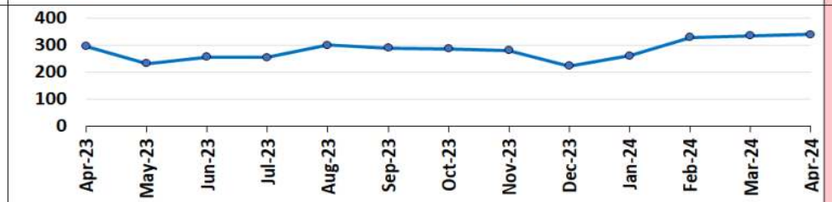
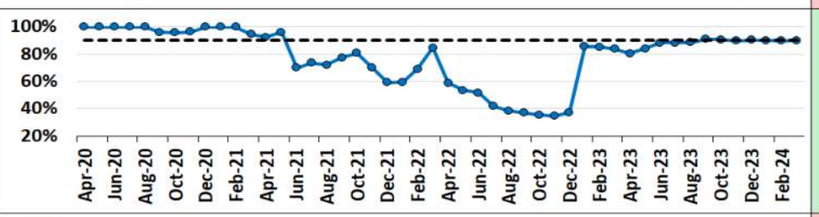
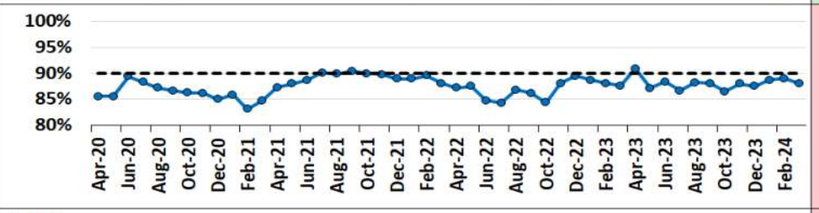
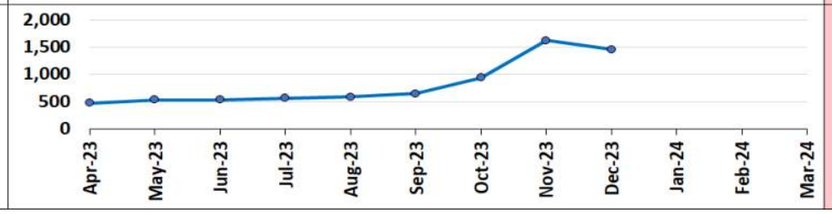
PADR – *Your Conversation*:

- "Making the most of PDR – *Your Conversation*" workshop developed and being delivered with management teams.
- Full day educational offer now available taking staff through PADR process from a systems, individual and manager perspective. This is being embedded into the emerging Leadership Development offer.
- CTM-specific PADR and Pay Progression FAQs developed and shared with affected staff on a monthly basis (i.e. managers with staff who are due to go through a gateway).
- Targeted communications being sent to managers with PADR compliance below 85%.
- Ongoing assessment to establish how best to capture Medical & Dental appraisals as part of overall figures, in collaboration with the ongoing data dashboard work.

Core Learning:

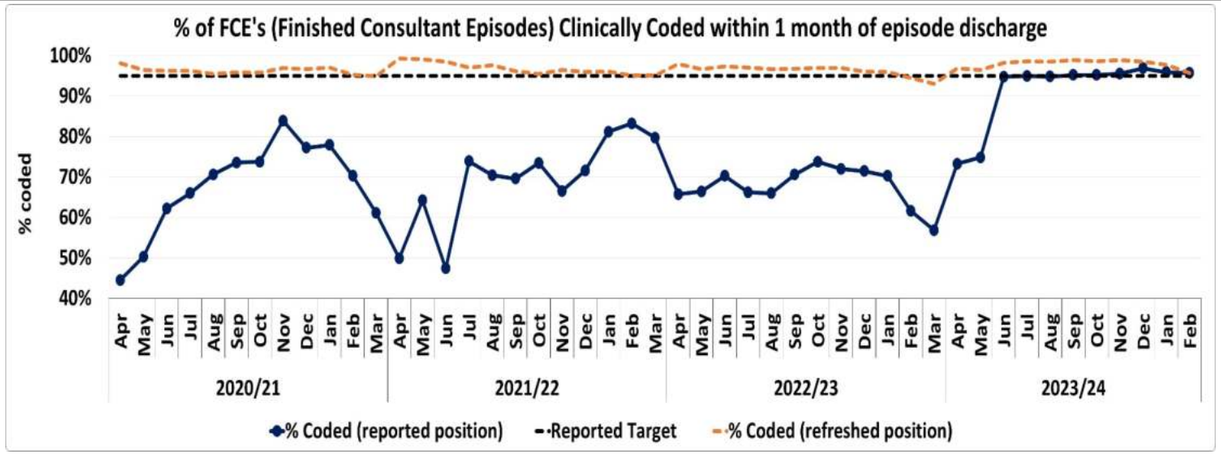
- Core Learning Working Group established to supplement the Core Learning Steering Group with a more focused space to work with Subject Matter Experts to continually drive up compliance.
- All subjects now responsible for the administration of training co-ordination, freeing up Learning and Development resource to undertake organisational activities aimed at creating a culture of compliance.
- Support being given to the Care Group Core Learning Recovery Plans in order to improve compliance across the Health Board.
- Monthly drop-in sessions ongoing, with the Core Learning team attending different sites each month.
- Range of subject guides and educational materials in development to support staff to access their learning.
- Targeted work in Medical & Dental; specifically with regards to Welsh competencies in-line with the ongoing improvement work.

2.5 Welsh Government Performance Indicators: Quadruple Aim 4 - Improvement & Innovation enabled by data & focused outcomes

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes					
	Performance Measure	Target	Key: Trend --- Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Effective Services	% of episodes clinically coded within one reporting month post episode discharge end date	Maintain the 95% target or demonstrate a 12 month improvement trend		95.7%	Feb-24
Effective Services	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%		94.7%	Feb-24
Efficient Services	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	17% or more		14.1%	Feb-24
Efficient Services	Number of Pathways of Care delayed discharges	12 month reduction trend		341	Apr-24
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%		90.2%	Mar-24
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			88.0%	
People Centred Care	Number of service user feedback experience responses completed and recorded on CIVICA	Month on month improvement		1,464	Dec-23

Effective Services - Clinical Coding

% of episodes clinically coded within one reporting month post episode discharge end date. Target - Maintain the 95% target or demonstrate a 12 month improvement trend – February 2024 – 95.7%



Current Coded Position as at 29th April 2024				
2023/24	Total FCE's	Coded FCE's	Uncoded FCE's	% Clinically Coded
Apr-23	9,799	9,628	171	98.3%
May-23	11,350	11,129	221	98.1%
Jun-23	11,507	11,370	137	98.8%
Jul-23	11,444	11,311	133	98.8%
Aug-23	11,320	11,191	129	98.9%
Sep-23	11,936	11,819	117	99.0%
Oct-23	12,715	12,577	138	98.9%
Nov-23	12,926	12,804	122	99.1%
Dec-23	11,511	11,396	115	99.0%
Jan-24	12,418	12,193	225	98.2%
Feb-24	11,715	11519	196	98.3%
Mar-24	11731	10280	1451	87.6%
Total	**140,372**	**137,217**	**3,155**	**97.8%**
2024/25	**Total FCE's**	**Coded FCE's**	**Uncoded FCE's**	**% Clinically Coded**
Apr-24	9517	2278	7239	23.9%
Total	**9,517**	**2,278**	**7,239**	**23.9%**

Uncoded Backlog 2023/24 (Apr 23 to Mar 24)	**1704**	**2.2%**
Uncoded Backlog 2024/25 (Apr 2024)	**7239**	**76.1%**

How are we doing?

The reported position for February 2024 is 95.7% of the FCE's (Finished Consultant Episodes) for that month being coded within the requisite timescale and remaining above the set target of 95%. As of 14th May 2024, the backlog which developed between April 2023 and March 2024 has been largely addressed and coding rates for that period are 98.5% coded.

Compliance for the correction of errors for February once again surpassed the WG target of 90%, with 94.7% (71 of 75) of identified errors corrected within the specified timescale of 35 days.

We continue to demonstrate the value of data science in improving the quality and number of episodes that can be auto coded, with a 40.3% productivity gain having been achieved in the past 12 months.

The flow of information from the Maternity Triage Unit at Prince Charles Hospital continues to improve month on month, which is evident in the amount of additional maternity episodes that have been clinically coded.

Coding team are working with the heart failure nurses to improve the flow of information and in turn improve on the quality of the coding to further support national Heart Failure Audit.

Coding team are also supporting the GIRFT meetings in various specialties.

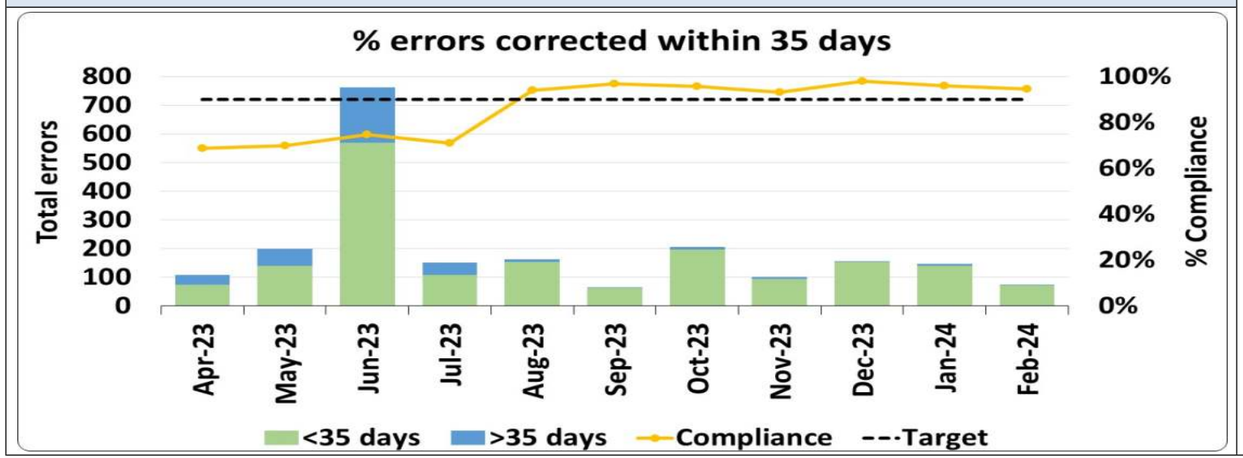
What actions are we taking & when is improvement anticipated? What are the main areas of risk?

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

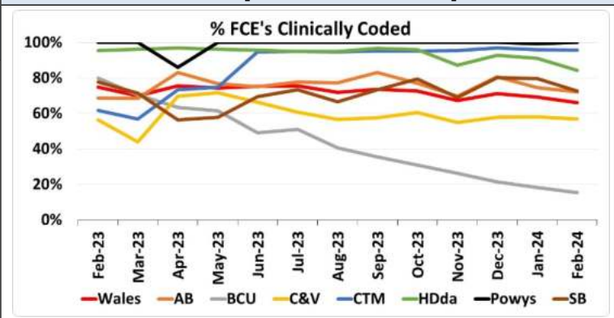
Changes in counting practices, which largely affect the Emergency and Assessment Departments, have led to an increase in admissions and an increasing, but welcome workload for the coding team.

Autocoding and coding at source activities are promulgating, enhancing the richness and availability of our clinical data and our care records.

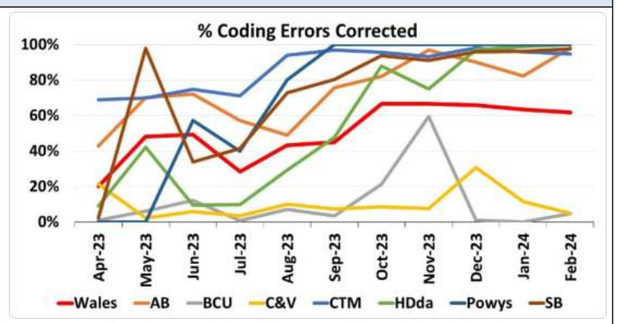
% of all classifications' coding errors corrected by the next monthly reporting submission following identification – Target 90% - February 2024 – 94.7%



How do we compare with our peers?



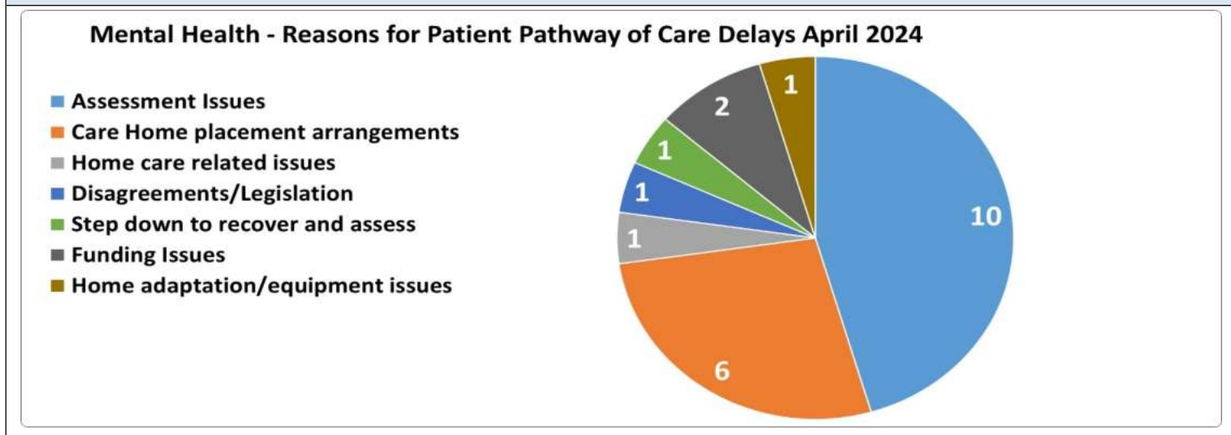
Status as at February 2024		
Health Board	**Compliance**	**Rank**
Powys	100.0%	1st
CTM	**95.7%**	**2nd**
HDda	84.2%	3rd
SB	72.6%	4th
AB	72.1%	5th
C&V	56.9%	6th
BCU	15.3%	7th

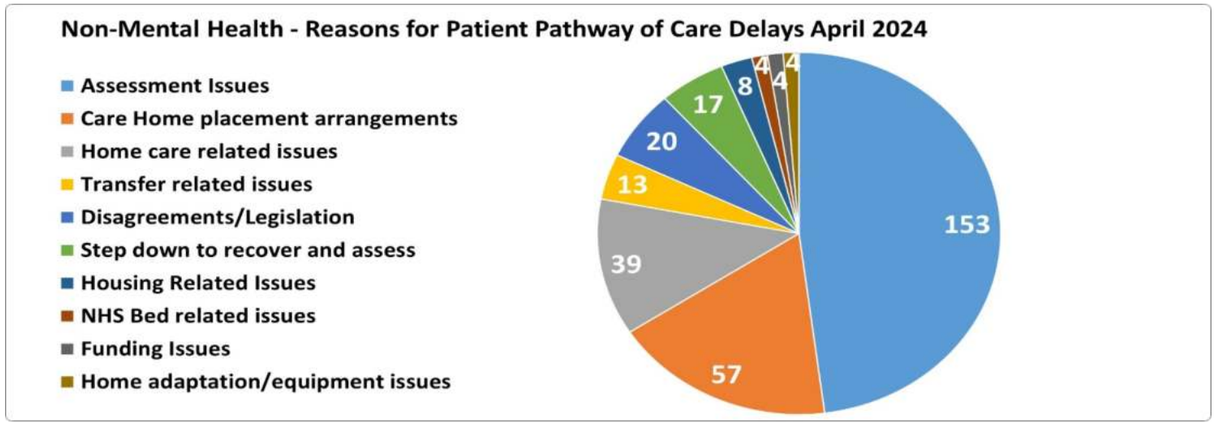


Status as at February 2024		
Health Board	**Compliance**	**Rank**
HDda	100.0%	1st
Powys	100.0%	2nd
AB	98.0%	3rd
SB	97.6%	4th
CTM	**94.7%**	**5th**
C&V	4.8%	6th
BCU	4.7%	7th

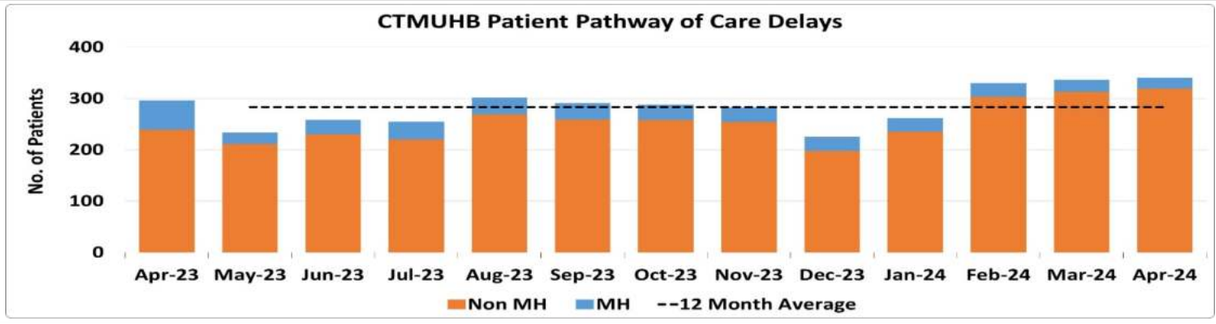
Efficient Services – Pathways of Care Delayed Discharges - April 2024

Number of Pathways of Care delayed discharges
Target is 12 month reduction trend
Mental Health Delays = 22 / Non Mental Health Delays = 319





Delays by Local Authority - April 2024								
Healthcare Facility	Bridgend	Caerphilly	Merthyr Tydfil	Neath Port Talbot	Powys	Rhondda Cynon Taff	Vale of Glamorgan	Total
PCH		2	17		3	17		39
POW	104			8		4	2	118
RGH	1		1			74		76
YCC			27			36		63
YCR						39		39
Ty Llidiard	1							1
Glanrhyd	5							5
Grand Total	111	2	45	8	3	170	2	341



How are we doing?

- Significant improvement in Electronic Whiteboard compliance and accuracy.
- Increase of PoCD delays in line with improved accuracy of reporting.
- Discharge and flow app with live data planned for implementation in May.
- Agreed improvement plan with task and finish group set up to reduce delays for residential homes.

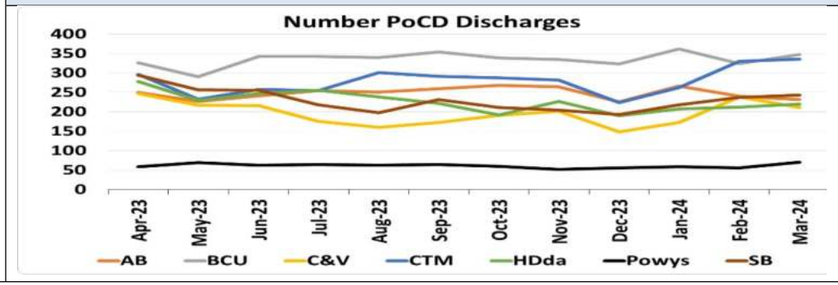
What actions are we taking & when is improvement anticipated?

- Target to reduce assessment delays by 10% over the next 5 months
- CTM represents 19% of the overall population of Wales and PoCD for the region sits at 24% of the national total. The target is to reduce below 19% with a 1% reduction each month for the next 6 months as a minimum.
- MADE (Multi Agency Discharge Event) concluded in POW with a targeted action plan in place.
- Weekly PoCD reporting and validation in place.
- PoCD escalation framework agreed across LA areas coordinated through the discharge hub.
- TA (Trusted Assessor) role starting in May.
- Discharge Policy regionally agreed with implementation plan starting in May

What are the main areas of risk?

- Assessment delays still remain higher than national average
- Increasing length of stay in community beds with longest waits for those undergoing Mental Capacity Act process.
- Significant delays for EMI residential placements.
- Increased third party payments for residential homes restricting choice for patients and families.
- High levels of co-horted and 1 to 1 patients in acute settings are limiting options for discharge destinations.

How do we compare with our peers?

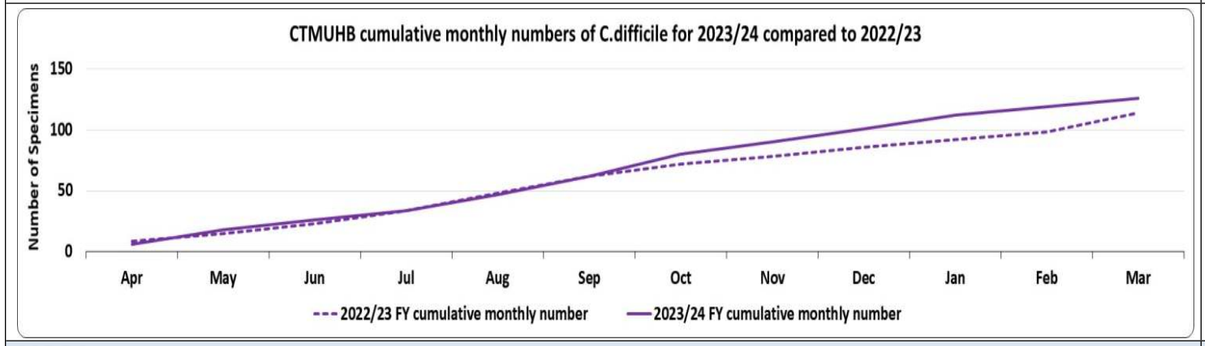


Status as at March 2024		
Health Board	Compliance	Rank
Powys	70	1st
C&V	211	2nd
HDda	220	3rd
AB	232	4th
SB	243	5th
CTM	**336**	**6th**
BCU	347	7th

Safe Services – Healthcare Acquired Infections

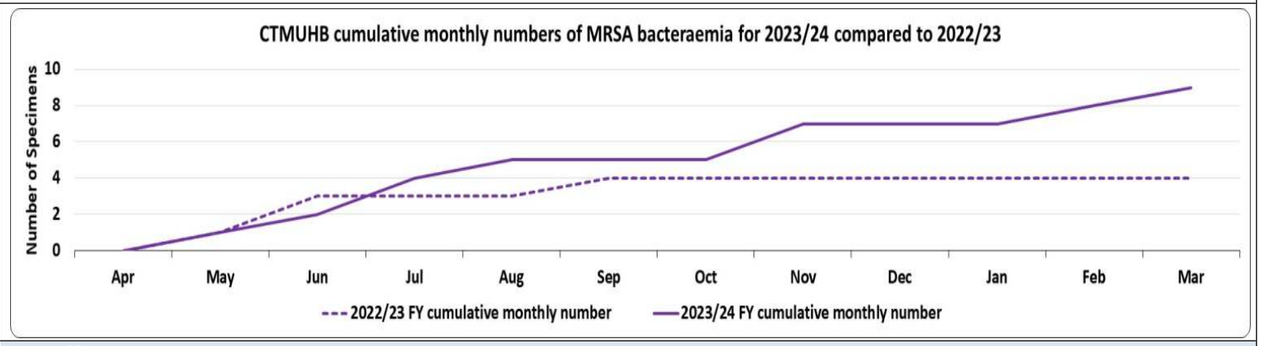
C.difficile

126 C.difficile cases have been reported by CTM between Apr 2023-Mar 2024. This is 12 more cases than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 28.38, which compares to the All Wales rate of 38.89. 36.5% of cases are hospital onset associated infections (based on specimen taken >2 days into an inpatient stay) with the remaining specimens being community onset (specimen taken in a community location or <3 days as hospital inpatient). 7% of the cases were recurrent infection. Opportunities to restructure the IPC team to provide an integrated service continue to be explored.



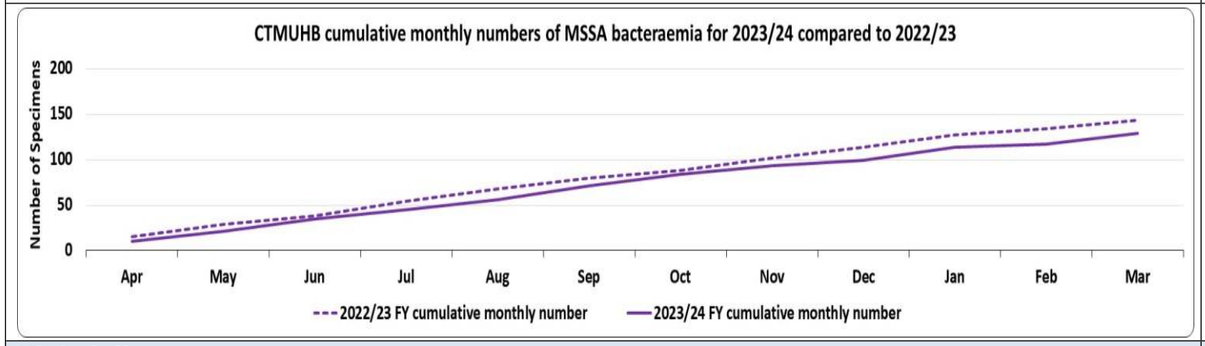
MRSA

9 MRSA bacteraemia have been reported by CTM between Apr 2023-Mar 2024. This is 5 more cases than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 2.03, which compares to the All Wales rate of 1.82. Seven cases are community onset with two cases being hospital onset. There is one preventable source for a community onset case. The bacteraemia is associated with a Peripherally Inserted Central Catheter (PICC) line which is managed by Velindre NHS Trust.



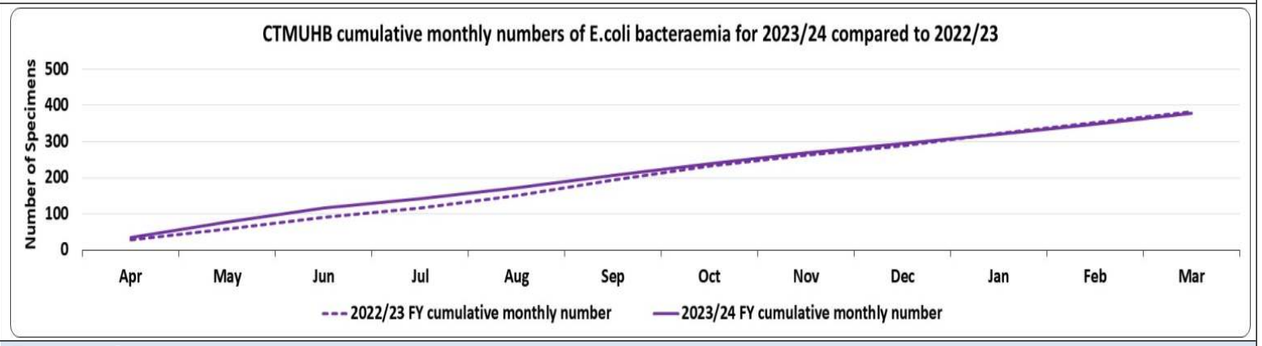
MSSA

129 MSSA bacteraemia have been reported by CTM between Apr 2023-Mar 2024. This is 14 (9.8%) cases fewer than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 29.05, which compares to the All Wales rate of 25.61. 76.0% of the specimens taken are community onset with 12% of the total cases being associated with an IV device. Support is required to restart the IV Steering Group to provide direction for IV device management across CTM.



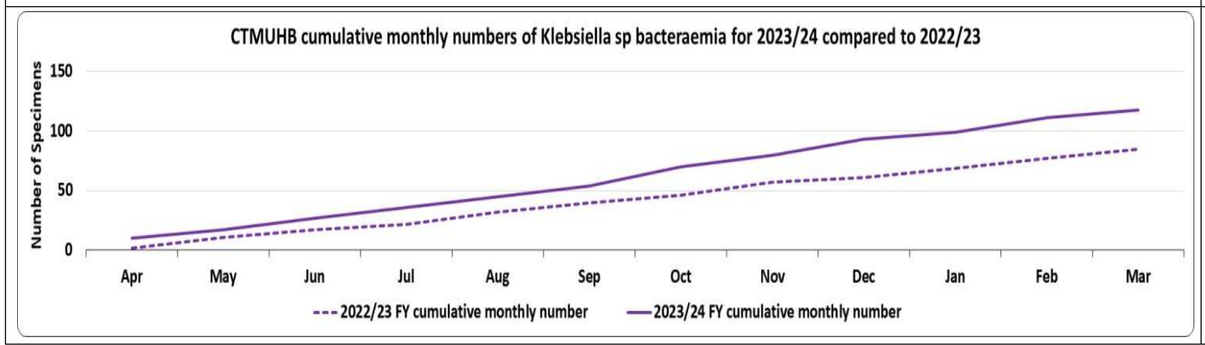
E.coli

378 E.coli bacteraemia have been reported by CTM between Apr 2023-Mar 2024. This is 4 fewer cases than the equivalent period of 2022/23. The provisional rate per 100,000 population for 2023/24 is 85.13, which compares to the all Wales rate of 72.61. 78% of specimens are community onset. Around 10% of cases are linked to a urinary catheter. The IPC team is working with clinical teams to undertake a point prevalence study to identify urinary catheter usage, improve ANTT and IPC training compliance and introduction of the catheter passport in secondary care.



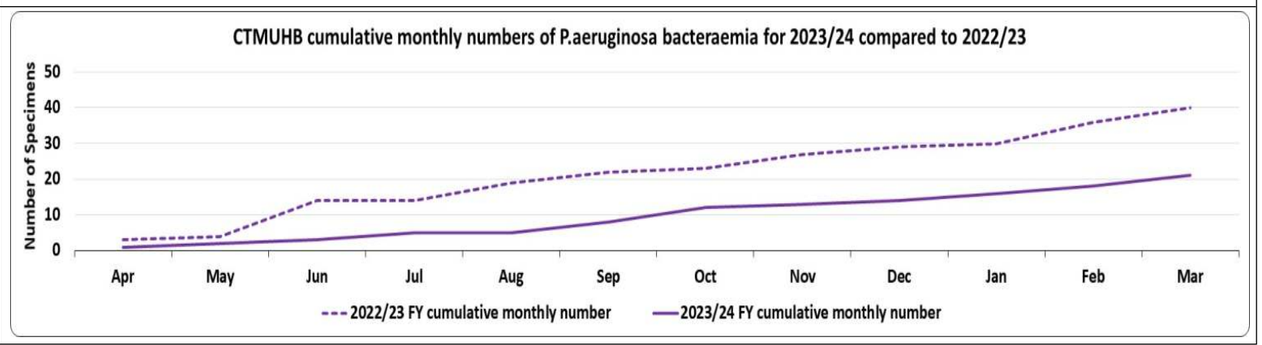
Klebsiella sp

118 Klebsiella sp bacteraemia have been reported by CTM between Apr 2023-Mar 2024. This is 33 (38.8%) more cases than the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 26.57, which compares to the All Wales rate of 23.50. Of the specimens taken, 68% are community acquired infections. 10% of the total cases are associated with a urinary catheter. IPC huddles are held to discuss both community onset and healthcare onset urinary catheter related bacteraemia.



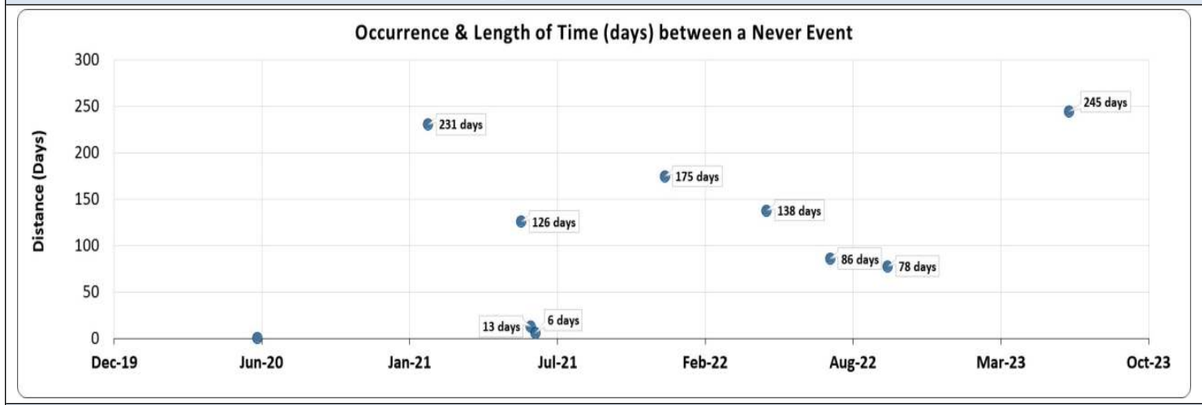
P.aeruginosa

21 P.aeruginosa bacteraemia have been reported by CTM between Apr 2023-Mar 2024. This is 19 (47.5%) fewer cases than in the equivalent period in 2022/23. The provisional rate per 100,000 population for 2023/24 is 4.73, which compares to the All Wales rate of 4.63. Fourteen of the 21 infections are community acquired infections. CTM achieved the healthcare associated improvement goal. 14% of the total cases are linked to a urinary catheter. Learning from IPC huddles are shared widely to influence and inform practice.



Safe Services – Never Events & Nationally Reportable Incidents

Number of Never Events – April 2024 - Zero

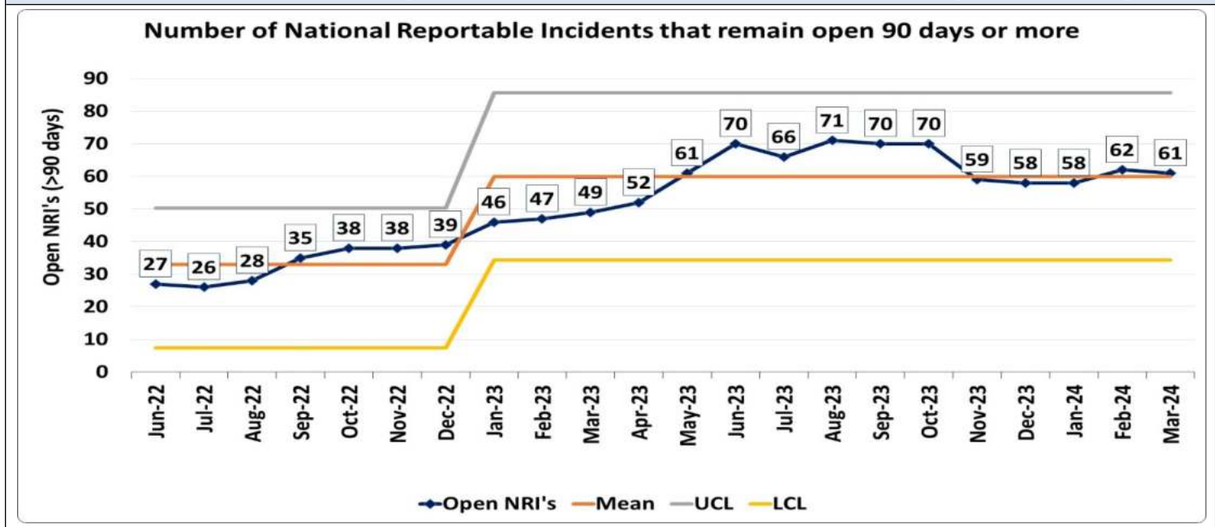


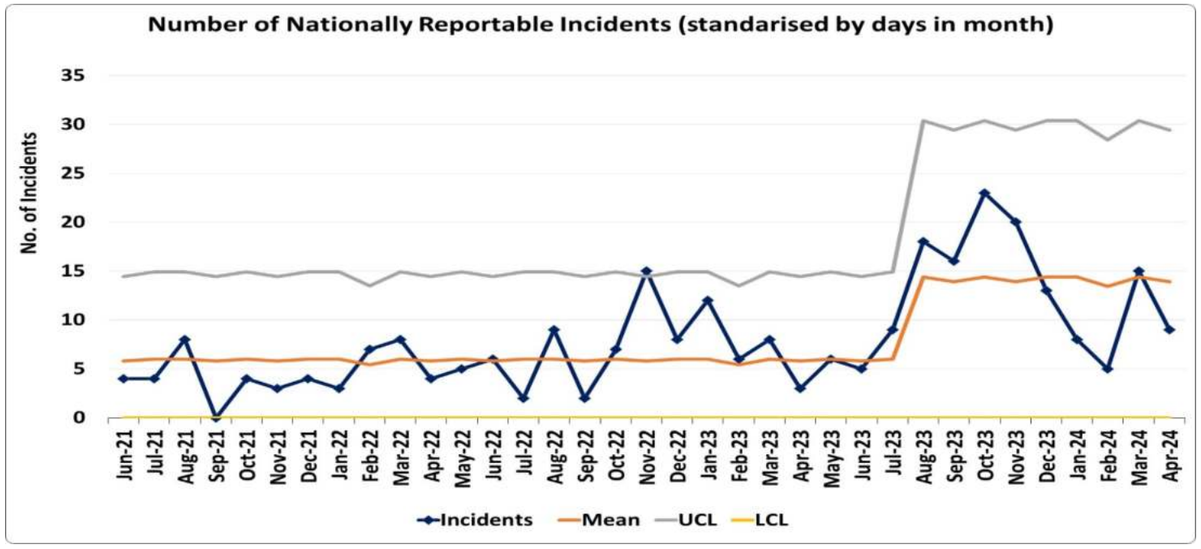
Never events are patient safety incidents that are defined as being wholly preventable. They are considered wholly preventable because guidance or safety recommendations are in place at a national level and should have been implemented by all providers in the healthcare system. This should act as a strong 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 during April 2024, with the last occurrence being June 2023, relating to a wrong side surgery and investigations are continuing.

In total, 1 reportable event has been observed during the past twelve months (May 23 to Apr 24), 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 – March 2024 - 61





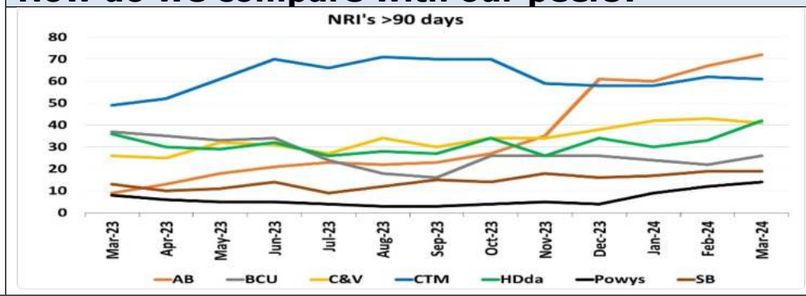
N.B. in order to allow for accurate reporting there is a time lag of approx. one month for the 90 days measure.

During April, 9 NRI notifications were submitted to the NHS Executive (NRI's are detailed in the table below), with a total of 147 incidents submitted during the last 12 months.

Provisionally as at the 30.04.24, the Health Board has 82 open Nationally Reportable Incidents, of which 47 are overdue the timescale (60 days) for completion. A trajectory plan is in place to ensure investigations are concluded and an outcome provided patients and their families.

Type of Nationally Reportable Incidents	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Total
Pressure Damage		3	2	6	2	7	8	5	3	3	5	1	45
Infection Prevention & Control				6	10	13	5	1				1	36
Clinical Assessment, clinical diagnosis	1	1	2	1	3		5	3			2		18
Maternity/Neonatal adverse occurrence	2		1	4				1	1	1	2	4	16
Treatment, Procedure			2		1	1		2			1	1	8
Admission / Transfer / Discharge			1			1	1	1	3		2	1	10
Patient/Service user death	3	1		1					1		2		8
Medication			1			1							2
Slip, Trip or Fall										1			1
Safeguarding											1		1
Infrastructure (Staffing/Facilities/Environment)							1						1
Behaviour (including violence and aggression)												1	1
Grand Total	6	5	9	18	16	23	20	13	8	5	15	9	147

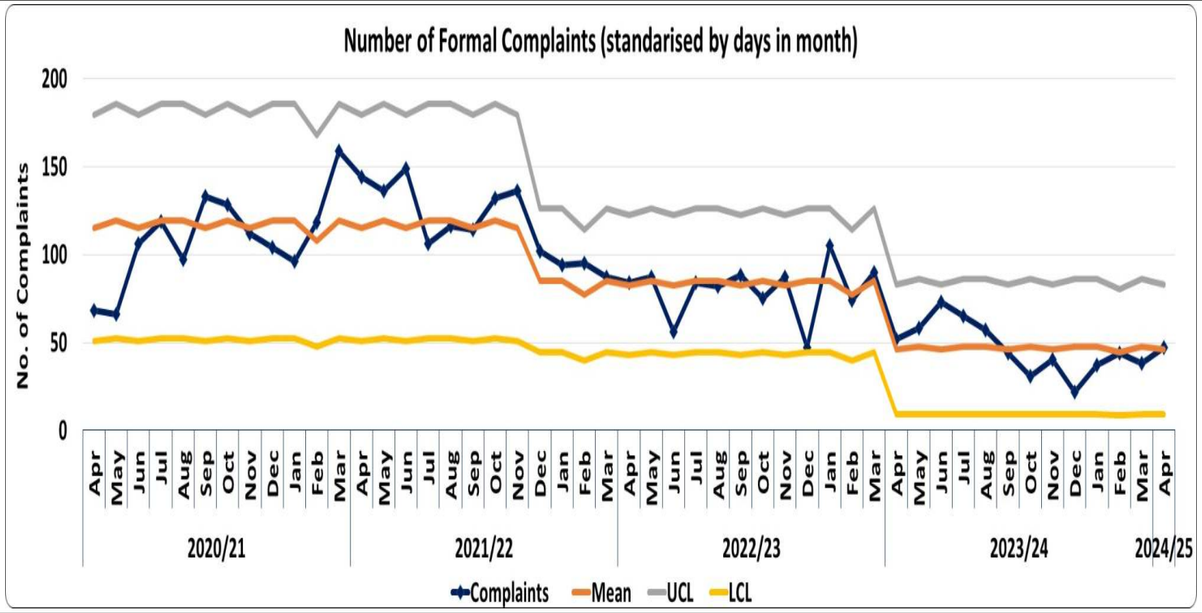
How do we compare with our peers?



Status as at February 2024		
Health Board	Compliance	Rank
Powys	14	1st
SB	19	2nd
BCU	26	3rd
C&V	41	4th
HDda	42	5th
CTM	**61**	**6th**
AB	72	7th

CTMUHB Focus on Putting Things Right

Number of formal complaints managed through Putting Things Right – April 2024 - 47 Formal Complaints

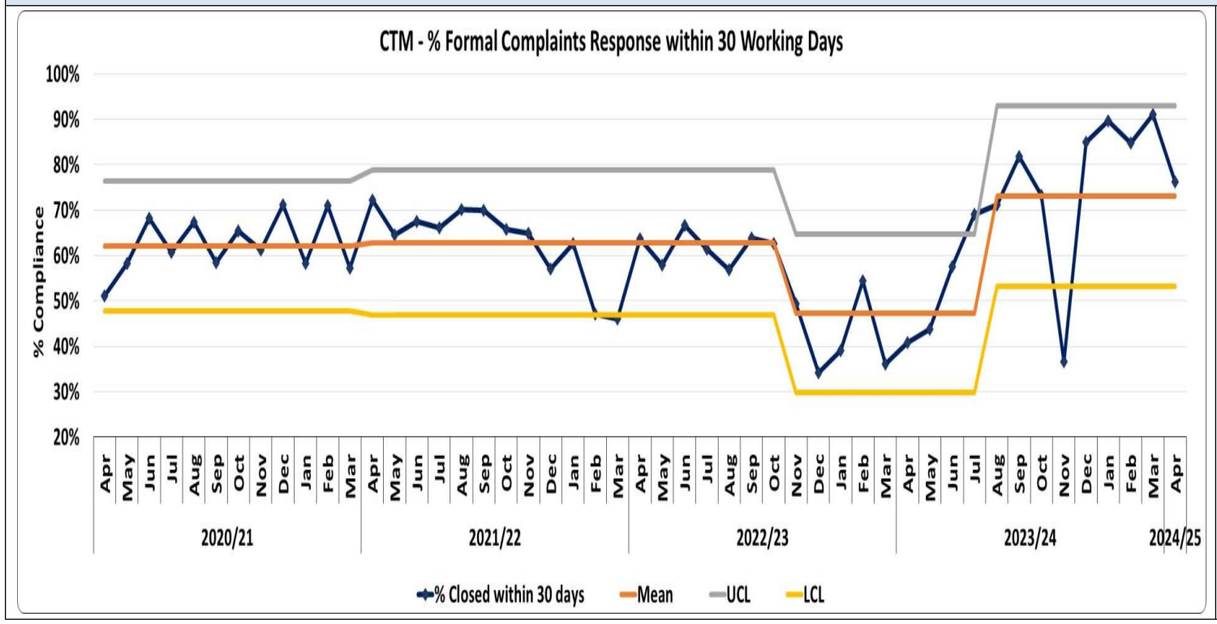


During April, 47 formal complaints were received within the organisation and managed in line with the 'Putting Things Right' regulations with volumes just above the current mean of 46.

For those complaints received during April, the top five themes relate to clinical treatment/assessment (38), discharge issues (3) medication, attitude & behaviour, communication, assault, skin damage and other issues (1 apiece).

Top Ten - Main Themes from Complaints during the last 12 month period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Total
Clincial treatment/Assessment	32	45	36	45	33	23	33	16	31	34	28	38	394
Other	2	2	3	4	5	2	0	2	2	1	1	1	25
Appointments	6	5	6	1	1	1	0	1	1	1	0	0	23
Medication	4	6	2	1	1	1	2	1	2	2	0	1	23
Discharge Issues	2	2	3	2	0	0	0	0	0	3	6	3	21
Attitude and Behaviour	1	3	5	2	1	0	2	1	0	0	1	1	17
Communication Issues (including Language)	6	3	3	0	0	0	0	0	0	0	1	1	14
Patient Care	2	4	2	0	2	0	1	0	1	0	0	0	12
Access (to Services)	0	2	1	2	0	1	0	0	0	2	0	0	8
Referral	1	1	1	0	0	2	1	0	0	0	0	0	6

% formal complaints response within 30 working days – April 2024 – 76.2%

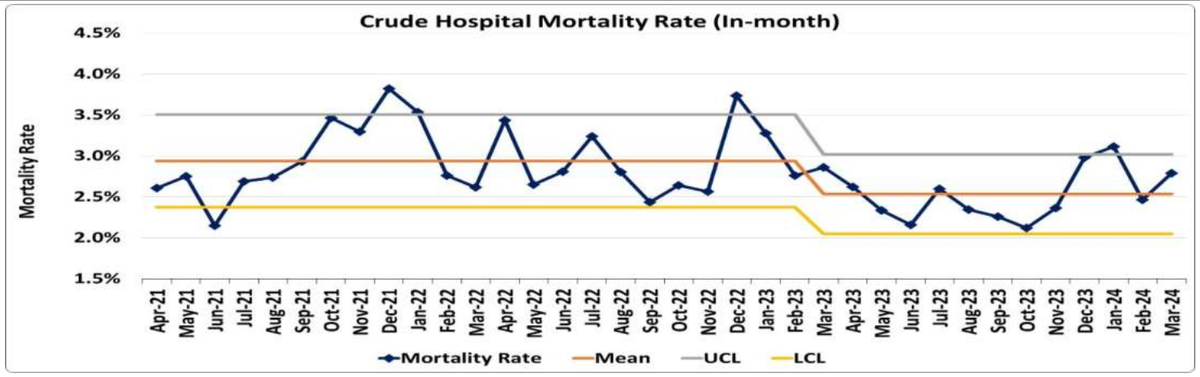


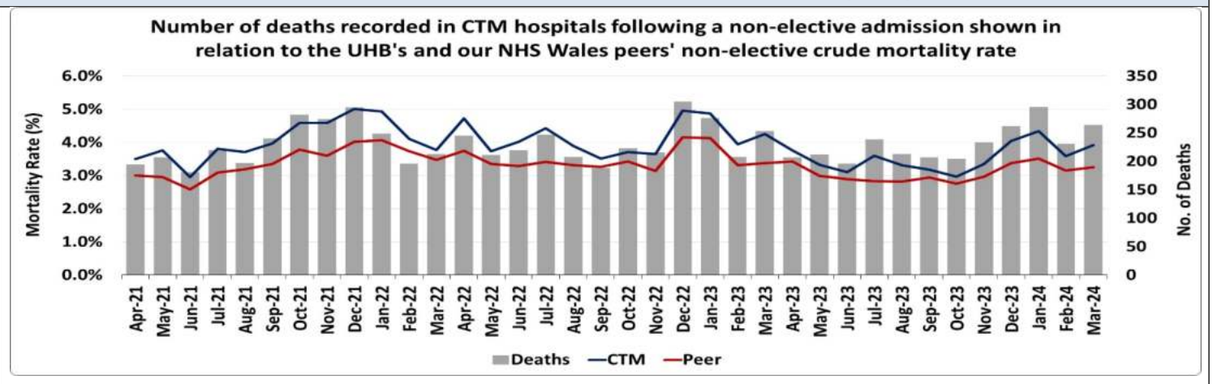
Compliance during April fell to 76.2% from 91.1% in the previous month and stands just above the current mean of 73%.

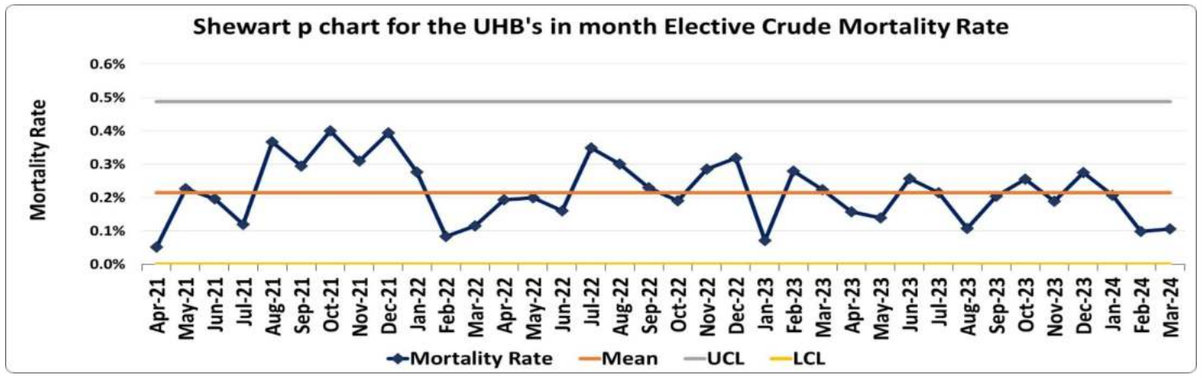
Whilst compliance has remained over the national target of 75% since December 2023, performance fell below the Health Board's internal target of 85% during April 2024. Compliance during April was impacted by the availability of clinicians to provide comments and quality assure responses. A review of processes has been conducted to ensure robust escalation is in place. As at 03.05.24, the Health Board had 62 open formal complaints and of these, 10 complaints were open over 30 working days.

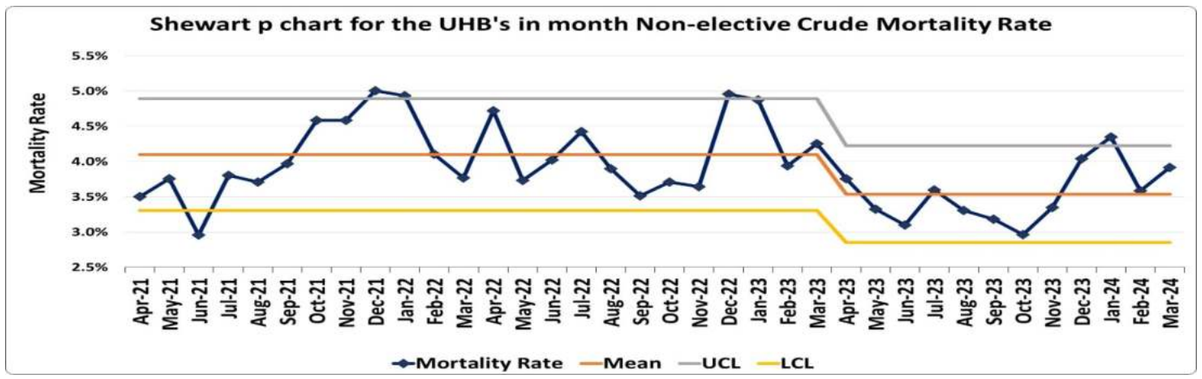
CTMUHB Focus on Mortality Rates

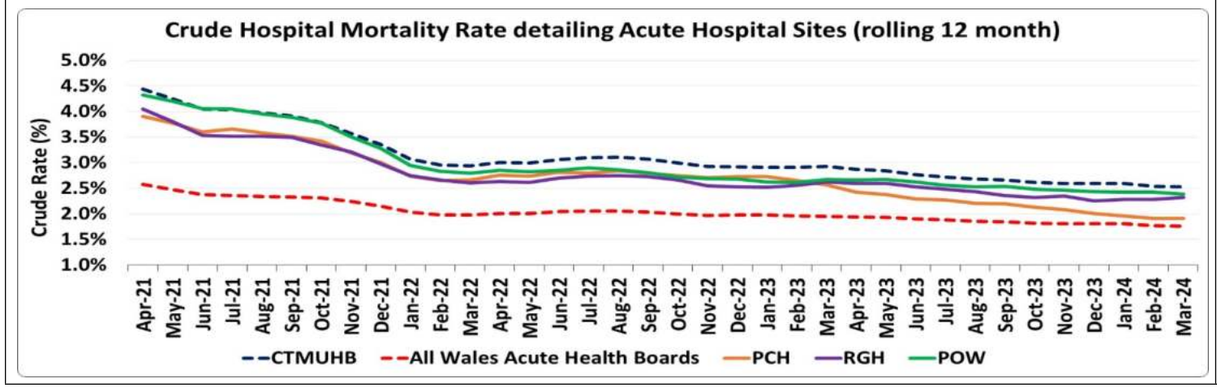
Crude Hospital Mortality Rates - *Please note the mortality data in this report is sourced from CHKS and is derived from the Admitted Patient Care (APC) dataset*











The observed increase in the growth of rate over the winter months is expected and in line with both previous years and our peers as seen in the chart above.

The various mortality indicators used by the Health Board (Crude, Standardised Hospital and Risk Adjusted) are also influenced by the changes in counting practice, with more patients now being admitted following a presentation to the Emergency Department.

As per WG policy the UHB's Multidisciplinary Mortality Review Screening Panel continues to review all deaths in line with the 2014 Palmer Report. Further information is available in previous report to Q&S committee (https://ctmuhb.nhs.wales/about-us/our-board/committees/quality-safety-committee/quality-safety-committee-documents/2022/15-november-2022/66-learning-from-mortality-reviews-update-20102022pdf/).

To aid quantitative approaches to monitoring and analysing trends in mortality, the CHKS dashboards are being revisited and the stage 1 review process is being digitised. Key benefits of which will be: the ability to improve access to the causes of death for patients dying in hospital, the ability to link mortality data to the wider patient record and the ability to digitally include information pertaining to the death within the deceased's health record.

Data linkage between the reason for death stated on the death certificate and Health Board held information has been undertaken, which may re-enforce or inform our actions to reduce avoidable deaths.

Finance Update – Month 1

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

3. Key Risks/Matters for Escalation

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

3.2 The key risks for the **Quality** quadrant are:

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Maintaining compliance with the 30 working days complaints response rate.
- Trajectory plan in place to reduce number of overdue Nationally Reportable Incidents

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality**	Data to Knowledge
	If more than one applies please list below: Data to Knowledge

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	Efficient, Equitable, Person Centred, Timely, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
		This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's performance measures may result in impact to the patient's journey which may result in a risk of harm. Any potential harm could provide legal challenge.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's performance measures may result in impact to the trust and confidence in the Health Boards service provision.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Workforce and financial resources are required to address the Planned Care Recovery plans and improvement trajectories within the Health Board.	

5. Recommendation

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

2023-24 Finance Report

Month 12

Summary

Situation	Background
This Finance report outlines our financial performance for Month 12 (i.e. the period to 31st March 2024. This Finance report is discussed at the Full Board, the Planning, Performance & Finance Committee (PPFC) and the Executive Leadership Group (ELG) meetings. A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at Month 12 (i.e. the Delegated budget position). This report is discussed at the PPFC and ELG meetings. It is important to note that the M12 Position is a draft position and this may change prior to the submission of the draft Annual accounts to WG on 3 May and also the conclusion of the audit process.	Our draft financial plan for 23/24 was submitted to Welsh Government (WG) on 31 March 2024. 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 was not changed. The draft plan included a £27.3m savings target which requires 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. During M7, WG confirmed in year financial support of £62.5m plus up to a further £9.4m for energy pressures (based on actual costs). In recognition of this support, WG have given the Health Board a break even Control Total target for 23/24. This equates to further £8.4m improvement target compared to our original financial plan. The £62.5m additional funding includes £51.1m of recurrent funding which is conditional upon delivering the break even Control Total target in 23/24.

Summary

Assessment	Recommendation

Overall Revenue position- 2023/24:
 	
• The M12 position was a £0.7m surplus and the M12 Draft year end position is now reporting a £0.1m surplus against the Revenue Resource Limit. The Health Board has therefore achieved the break even Control Total Target set by WG for 2023/24.
 	
• The £103k reported surplus in this report was the draft position reported to WG on 9 April 2004. A number of changes were made to the position prior to the submission of the draft accounts to WG on 3 May 2004, which reported a year end surplus of £109k. It is important to note that further changes may arise during the audit process and finalisation of the Annual Accounts for 2023/24.
 	
Recurrent Revenue position:
 	
• As at M12 the HB is forecasting an underlying deficit at the end of 23/24 of £19.4m (M11: £19.4m). Further information is provided on Page 8.The forecast underlying deficit is the starting point for the 2024/25 financial plan.
	The Board, the PPFC and the ELG are asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 31st March 2024.
	
	Financial duties:
	
	• Section 175 of the National Health Service (Wales) Act 2014 places two financial duties on Local Health Boards:
	  • A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years
	  • A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers.
	
	• The Health Board **has not** met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24. The Health Board **has met** its financial duty to break-even against its Capital Resource Limit over the 3 years 2021-22 to 2023-24.
	
	• The Health Board **has not** met its financial duty to have an approved plan for 2023/24.

Contents

Executive Summary

Overall Revenue Position

- The M12 position was a £0.7m Surplus and the M12 YTD position is a £0.1m surplus.
- The Health Board has therefore achieved the break even Control Total set by WG for 2023/24.
- However, the Health Board has not met its statutory duty to achieve a break even revenue position over the 3 year rolling period 2021/22 to 2023/24.
- The forecast underlying deficit at the end of 23/24 is £19.4m (M11: 19.4m). Further information is provided on Page 8. The forecast underlying deficit is the starting point for the 2024/25 financial plan.

Savings

- The actual savings to M12 was £27.4m which is £0.1m above the annual savings target of £27.3m.
- The M12 Recurrent savings of £25.7m is £1.6m below the £27.3m annual target.

Cash

- The closing cash balance at 31st March 2024 was £1.4m.

Capital

- The latest Capital Resource Limit for 23/24 is £75.71m. This was issued on the 27th March 2024.
- The reported outturn position is £33k below the CRL .
- The Health Board has met its statutory duty to achieve a break even capital expenditure position over a 3 year rolling period to 2023/24.

Summary
Income & Expenditure Account

	M12 Actual	M12 YTD	Year End Draft Position
	£k	£k	£k
01. Revenue Resource Limit	113,978	1,364,815	1,364,815
02. Capital Donation / Government Grant Income	146	199	199
03. Welsh NHS Local Health Boards & Trusts Income	7,695	84,984	84,984
04. WHSSC Income	1,113	12,327	12,327
05. Welsh Government Income (Non RRL)	2,082	1,411	1,411
06. Other Income	4,440	46,317	46,317
Total Allocations & Income	**129,454**	**1,510,053**	**1,510,053**
08. Primary Care Contractors	15,297	160,569	160,569
09. Primary Care - Drugs & Appliances	8,454	102,190	102,190
10. Provided Services - Pay	56,947	678,361	678,361
11. Provider Services - Non Pay	9,913	123,899	123,899
12. Secondary Care - Drugs	4,598	56,238	56,238
13. Healthcare Services Provided by Other NHS Bodies	29,777	272,965	272,965
14. Non Healthcare Services Provided by Other NHS Bodies	367	4,345	4,345
15. Continuing Care and Funded Nursing Care	5,213	64,874	64,874
16. Other Private & Voluntary Sector	1,406	16,426	16,426
17. Joint Financing and Other	1,118	3,327	3,327
22. DEL Depreciation\Accelerated Depreciation\Impairments	2,766	33,192	33,192
23. AME Donated Depreciation\Impairments	-7,054	-6,385	-6,385
24. Uncommitted Reserves & Contingencies	0	0	0
25. Profit\Loss Disposal of Assets	1	-51	-51
Total Expenditure	**128,803**	**1,509,950**	**1,509,950**
Grand total	**651**	**103**	**103**

Key Points:

- The Summary I&E account shows the Health Board's Income & Expenditure by the categories used in the Monthly Monitoring Returns submitted to WG.
- The Draft Year end positon is reporting a surplus of £103k.

Year to Date Performance and Forecast

	M12 Actual	M12 YTD	Financial Plan
	£m	£m	
Core plan:			
Core plan deficit	4.6	62.5	70.9
Confirmed WG Funding	(5.2)	(62.5	0
Total	**(0.6)**	**0**	70.9
Energy:			
Exceptional Energy inflation	0.8	8.2	8.7
Anticipated Energy Funding	(0.8)	(8.2)	0
Total	0.0	0.0	8.7
Covid programme costs:			
Health Protection	0.6	6.5	9.1
PPE	0.0	0.4	1.0
Adferiad	0.1	0.8	1.0
Nosocomial	0.0	0.5	0.6
Confirmed funding	(0.7)	(8.3)	(11.7)
Total	**(0.1)**	**(0.1)**	**0**
Grand total	**(0.7)**	**(0.1)**	**79.6**

Key Points:

- The M12 position was a £0.7m surplus, £0.6m Core plan and £0,1m Covid programme costs.
- The reported out-turn position is a £0.1m surplus on the COVID programme costs.

Forecast Underlying Deficit

Recurrent Financial Challenge	M12	M11
	£m	£m
Brought Forward Financial Challenge 1 April 2023	70.9	70.9
Exceptional Energy Costs	0	0
Assumed WG recurrent funding – conditional upon achieving break even in 2023/24	(51.1)	(51.1)
Net Other Movements	(0.4)	(0.4)
Forecast Carry Forward Financial Challenge 31 March 2024	**19.4**	**19.4**

Bridge from 2023/24 Forecast position to Forecast underlying Deficit	M12
	£m
Forecast position 2023/24	0
Non Recurrent 2023/24 WG inflation funding	11.4
Accountancy gains	5.0
Non Recurrent Income – Llantristant Health Park income	1.8
Non Recurrent benefits – VAT & Rates rebates	1.2
Other Non Recurrent items	0
Forecast Carry Forward Financial Challenge 31 March 2024	**19.4**

Key Points:

- As at M12 we are reporting a forecast Underlying deficit at the end of 23/24 of £19.4m (M11: £19.4m).This is the starting point for our 24/25 Financial Plan.
- The movement from the current year (2023/24) forecast break even position to the forecast underlying deficit of £19.4m is summarised in the "Bridge" table.

Pay Expenditure Trends

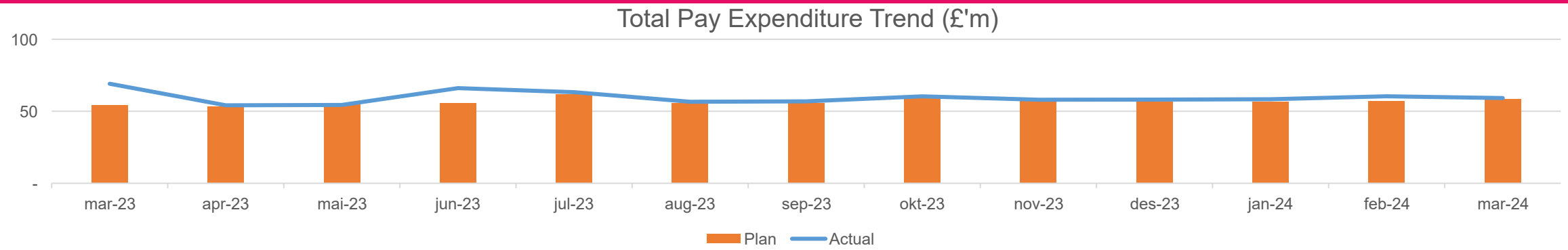
Staff Group	Oct-23 £'m	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m
Administrative & Clerical	7.6	7.6	7.6	7.5	7.7	7.1
Medical And Dental	18.1	15.1	15.4	15.5	15.7	15.1
Nursing And Midwifery Registered	18.0	18.4	18.0	18.2	19.3	19.7
Add Prof Scientific And Technical	1.6	1.6	1.6	1.7	1.7	1.4
Additional Clinical Services	7.1	7.3	7.3	7.3	7.5	7.7
Allied Health Professionals	3.5	3.6	3.6	3.6	3.8	3.6
Healthcare Scientists	1.1	1.1	1.1	1.1	1.2	1.1
Estates And Ancillary	3.3	3.3	3.3	3.4	3.3	3.3
Students	0.0	0.1	0.1	0.1	0.1	0.1
Grand Total	**60.4**	**58.0**	**58.1**	**58.4**	**59.4**	**59.2**

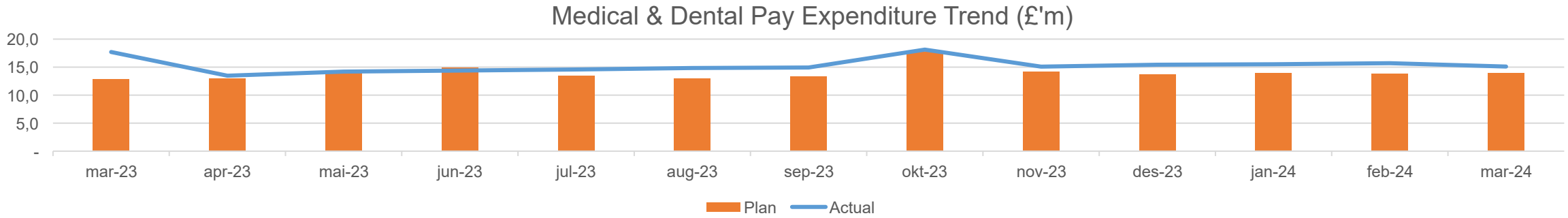
Spend category	Oct-23 £'m	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m
Core	51.6	49.1	50.0	49.6	51.0	49.8
Agency	5.2	3.8	3.8	3.4	4.5	3.7
Overtime	1.6	1.9	1.3	1.7	1.8	2.1
ADH	1.7	1.8	1.7	1.9	1.8	2.1
Bank	0.1	1.3	1.1	1.2	1.2	1.3
WLI	0.2	0.2	0.1	0.1	0.1	0.2
Grand Total	**60.4**	**58.0**	**58.1**	**57.9**	**59.4**	**59.2**

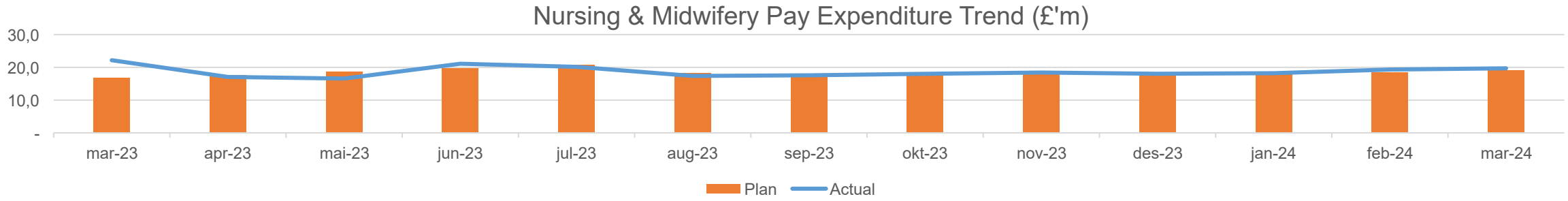
Key Points:

- The M12 (March) expenditure decreased by £0.2m compared to M11.
- This included a £0.8m reduction in Agency spend and a £0.2m reduction in Core spend. These reductions were offset by a £0.3m increase in Overtime and a £0.3m increase in ADHs.

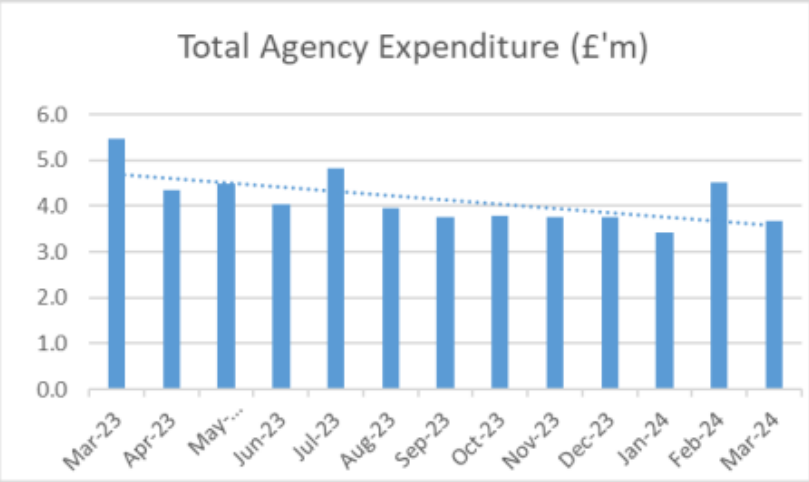
Pay Expenditure Trends

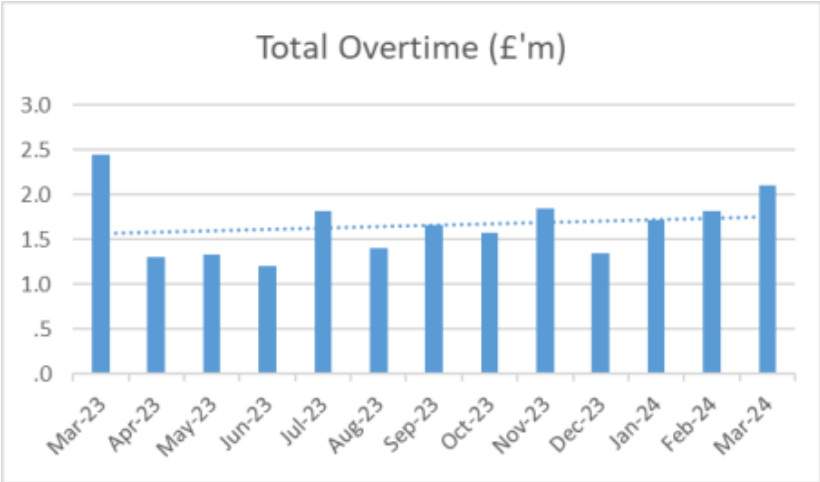


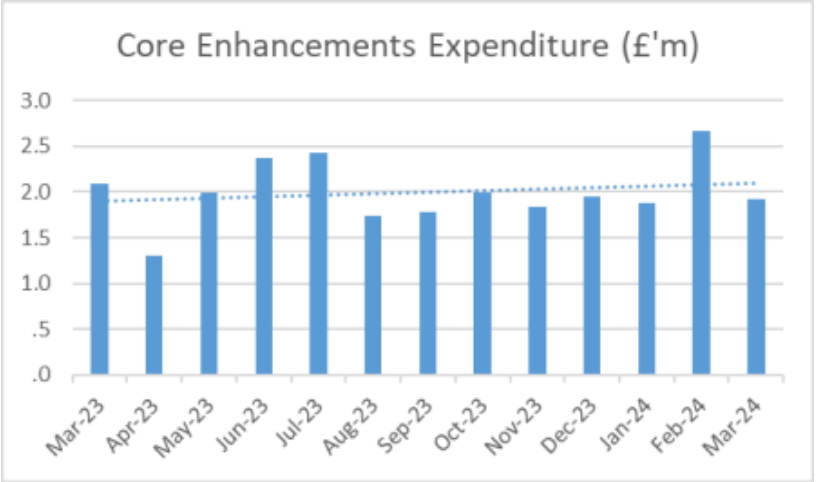


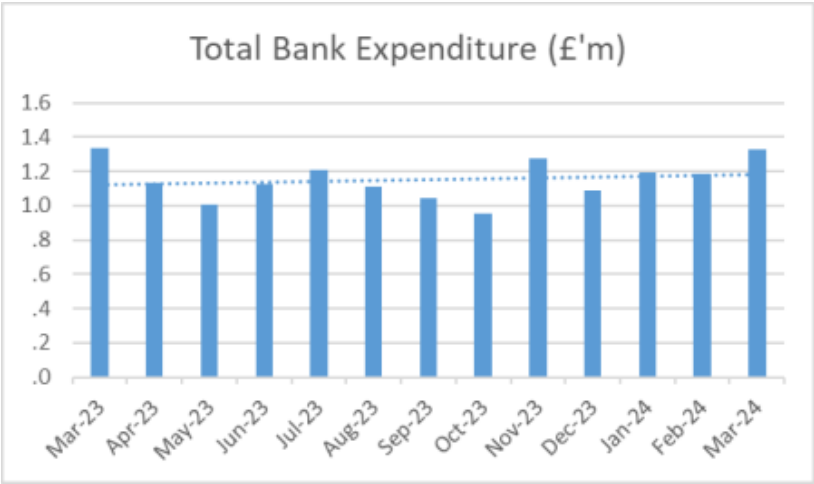


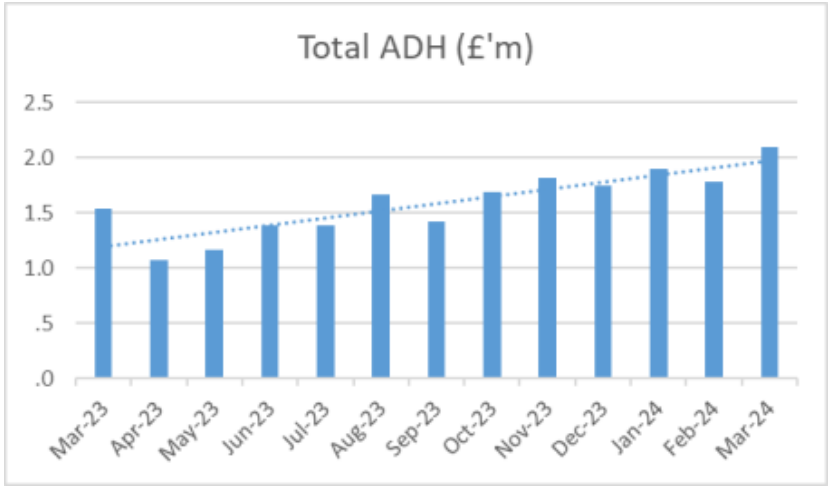
Variable Pay Expenditure Trends











Key Points :

- Total agency expenditure has decreased by £0.8m compared to M11 and Core enhancements by £0.7m.
- Overtime payments and ADHs have both increased by £0.3m over M11.

Non Pay Expenditure Trends

Non Pay Group	Oct-23 £'m	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m
Primary Care Contractors	12.3	11.6	13.0	12.7	16.5	14.5
Primary Care Drugs	7.8	8.5	8.2	8.5	8.4	8.5
Provider Non Pay	9.6	10.5	10.9	12.7	10.6	13.0
Secondary Care Drugs	5.0	5.4	4.4	4.8	4.9	4.6
Healthcare Commissioning	23.0	25.2	22.0	19.9	23.7	29.8
CHC & FNC	6.2	6.0	6.5	6.2	5.7	5.5
Other	5.9	4.9	4.6	4.3	4.7	(1.4)
Total Expenditure	**69.8**	**72.1**	**69.5**	**69.2**	**74.5**	**74.5**

Key Points:

- M12 non pay expenditure is consistent with M11. The main changes were in the following areas:
  - Primary Care Contractors has decreased by £2.0m. This is due to the 2023/24 DDRB inflation uplift for GMS being processed in M11.
  - Provider Non Pay increased by £2.4m.
  - Healthcare Commissioning increased by £6.1m. This is mainly attributed to new allocations received form WHSSC.
  - Included in Other is capital charges which reflects the latest capital charge estimates.

COVID Expenditure Trends

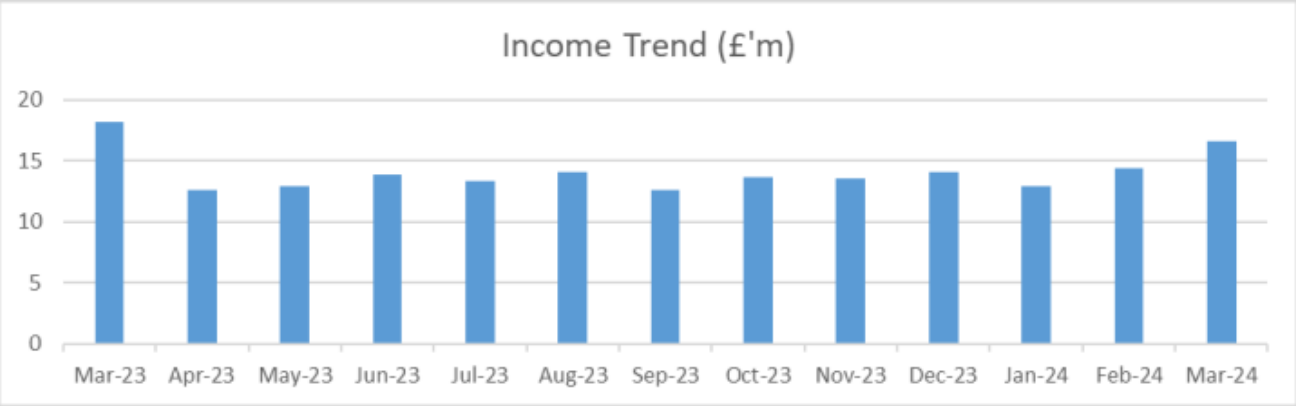
COVID Expenditure	Apr-23 £'000	May-23 £'000	Jun-23 £'000	Jul-23 £'000	Aug-23 £'000	Sept-23 £'000	Oct-23 £'000	Nov-23 £'000	Dec-23 £'000	Jan-24 £'000	Feb-24 £'000	Mar-24 £'000	Total £'000
Programme costs													
Health Protection – TTP	113	133	97	123	70	88	110	78	167	68	161	269	**1,480**
Health Protection - Vaccination	372	285	306	308	475	495	511	662	434	336	395	420	**5,000**
PPE	83	(33)	37	18	58	41	41	41	21	33	35	28	**403**
Adeferiad	39	47	39	50	37	41	53	53	57	87	96	147	**746**
Noscomial	39	27	45	46	55	53	45	44	40	36	43	47	**518**
Total Covid costs	**646**	**459**	**525**	**545**	**695**	**718**	**760**	**878**	**719**	**560**	**730**	**912**	**8,148**
WG funding	**(646)**	**(459)**	**(525)**	**(545)**	**(695)**	**(718)**	**(760)**	**(878)**	**(719)**	**(560)**	**(730)**	**(1,058)**	**(8,294)**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(146)**	**(146)**

Key Points:

- The reported outturn position of £8,148k was £146k lower than the WG funding allocation of £8.294m.

Income Trends

Income Group	Oct-23 £'m	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m
Welsh NHS Income	7.0	7.3	7.4	5.7	7.2	7.7
WHSSC Income	1.0	1.0	1.1	1.1	1.0	1.1
Primary Care Contractor Income	1.4	1.3	1.4	1.6	1.4	1.2
CHC Income	0.5	0.5	0.5	0.5	0.4	0.5
Other Income	3.8	3.5	3.7	4.0	4.3	6.0
Total Income	**13.7**	**13.6**	**14.1**	**12.9**	**14.4**	**16.6**



Key Points:

- The Total Income in M12 was £2.2m higher than M11. The main movements were:
  - Increase in Welsh NHS Income of £0.5m, taking it slightly higher than prior months levels. The reduction in M10 includes a £1.2m reduction due to the Swansea Bay T&O repatriation,
  - Increase in Other income of £1.7m. This includes £1.4m of Capital Grant income received for the Regional Integration Fund (RIF).

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,221.1	29.7	25.0	88.7	1,364.5
Anticipated Allocations:					
Capital charges	0.3				0.3
CHC	0.1				0.1
Total Allocations	**1,221.5**	**29.7**	**25.0**	**88.7**	**1,364.9**

Key Points:

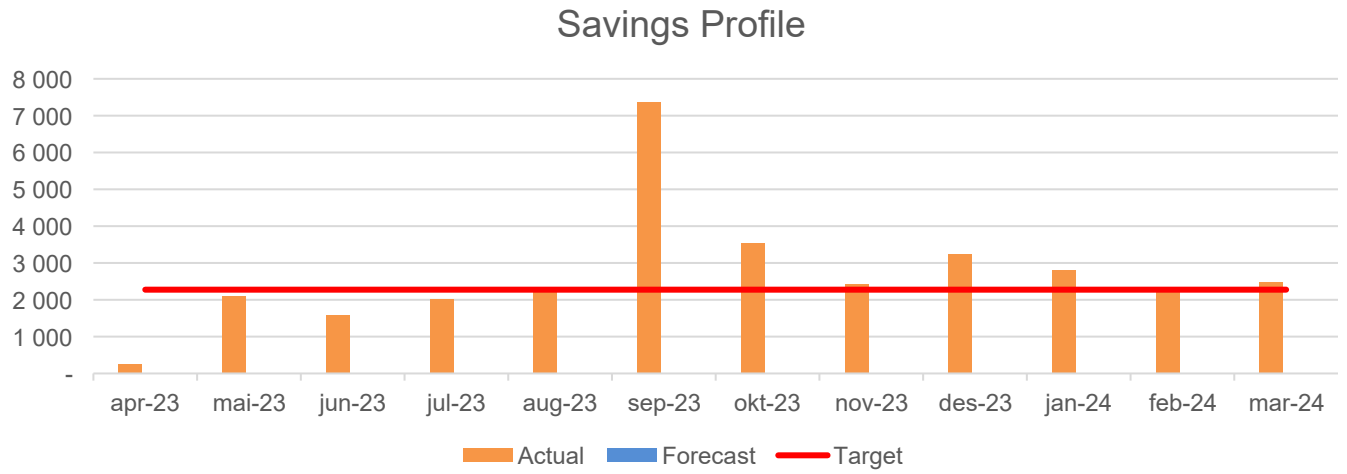
- As at M12 the confirmed Revenue Resource allocation was £1,364.5m.
- The forecast position assumes a further £0.4m of additional allocations to give a Total allocation of £1,364.9m.

Savings

	Month 12			Month 11		
	YTD	23/24	Rec	YTD	23/24	Rec
	£m	£m	£m	£m	£m	£m
Savings target as at M12	27.3	27.3	27.3	25.0	27.3	27.3
Actual and Forecast Savings	(27.4)	(27.4)	(25.7)	(24.9)	(27.6)	(28.3)
Total	(0.1)	(0.1)	1.6	0.1	(0.3)	(1.0)

Key Points:

- Actual savings in M12 was £2.5m compared to £2.3m in M11 and a M11 YTD trend of £2.26m/month.
- The M12 year end savings of £27.4m is £0.1m above the annual savings target of £27.3m.
- The M12 forecast Recurrent savings of £25.7m is £1.6m below the £27.3m annual target.



Statement of Financial Position

Balance Sheet	Opening Balance (01/04/2023) £'000	Closing Balance as at M11 £'000	Closing Balance as at M12 £'000
Non Current Assets			
Property, Plant & Equipment	658,857	689,847	707,904
Intangible Assets	2,833	2,833	2,833
Trade and Other Receivables	47,608	47,608	47,608
Total Non-Current Assets	**709,298**	**740,288**	**758,345**
Current Assets			
Inventories	7,017	6,900	7,367
Trade and Other Receivables	74,622	103,041	97,432
Cash and Cash Equivalents	1,348	7,371	1,485
Non Current Assets Classified as Held for Sale	245	245	245
Total Current Assets	**83,232**	**117,557**	**106,529**
Current Liabilities			
Trade and Other Payables	169,055	177,815	159,206
Provisions	27,320	52,365	50,477
Total Current Liabilities	**196,375**	**230,180**	**209,683**
Non-Current Liabilities			
Trade and Other Payables	20,069	20,069	20,069
Provisions	52,164	52,164	52,164
Total Non-Current Liabilities	**72,233**	**72,233**	**72,233**
TOTAL ASSETS EMPLOYED	**523,922**	**555,432**	**582,958**
Financed By:			
General Fund	428,850	460,360	487,886
Revaluation Reserve	95,072	95,072	95,072
TOTAL	**523,922**	**555,432**	**582,958**

Key Points :

- The balance sheet at M12 is a draft position and there is likely to be a number of changes to Non current assets and other classification changes prior to the submission of the draft Annual accounts to WG on 3 May.

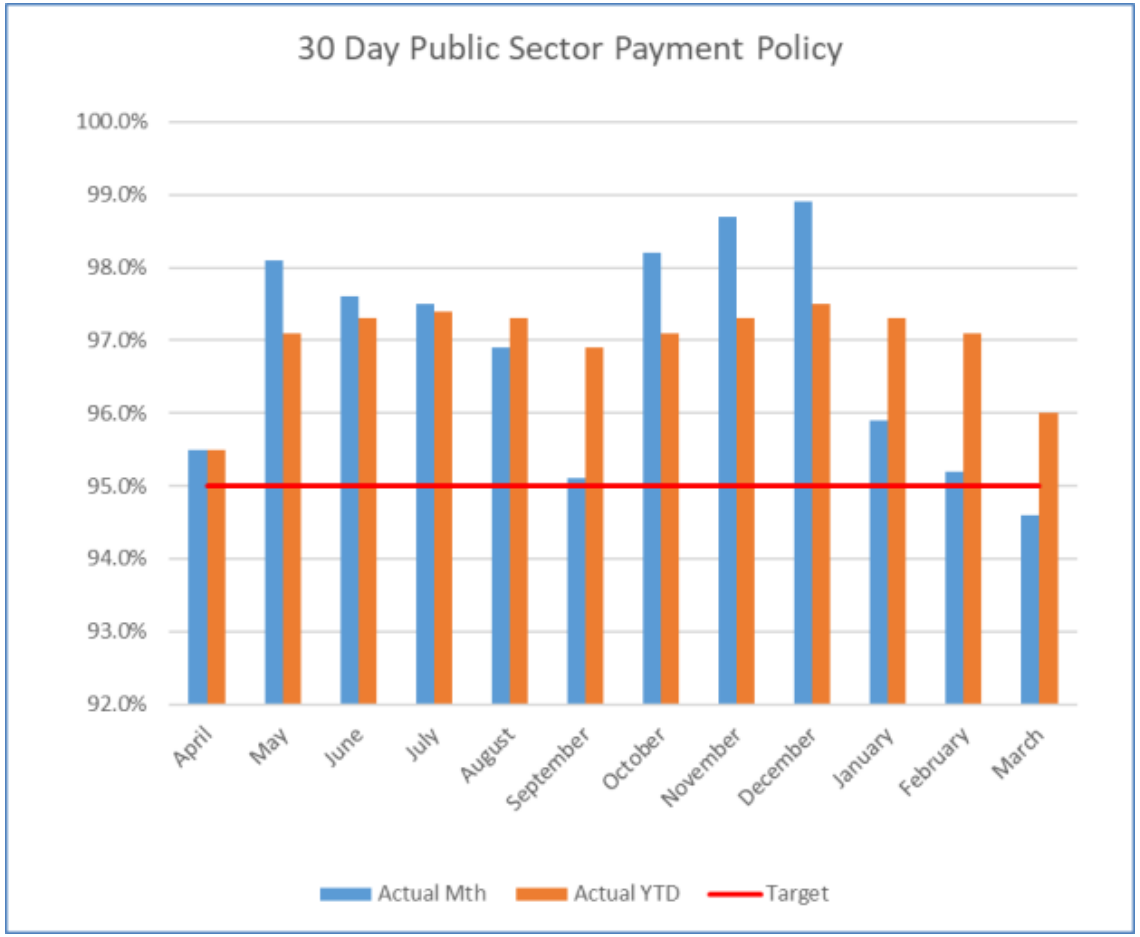
Cash Flow Forecast

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	110,817	99,506	134,790	97,817	110,863	131,686	95,951	106,934	129,010	1,353,730
WG Capital Funding	0	10,000	5,500	6,500	5,100	6,500	4,500	5,400	4,900	5,400	7,700	15,960	77,460
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	11,011	11,091	8,687	15,458	10,081	10,111	10,078	11,545	10,940	133,407
Other	5,917	7,290	2,069	2,737	3,983	4,660	3,001	5,179	6,445	7,666	5,487	6,874	61,308
Total Receipts	**131,381**	**130,446**	**139,959**	**131,065**	**119,680**	**154,637**	**120,776**	**131,523**	**153,142**	**119,095**	**131,667**	**162,784**	**1,626,155**
Payments													
Primary Care Services	28,974	7,530	31,204	7,621	18,675	29,928	8,223	19,076	31,308	9,093	21,869	20,223	233,723
Salaries and Wages	50,003	69,212	(547)	(25)	(189)	(81)	(64)	(66)	120	8	217	106	118,694
Non Pay Expenditure	43,561	46,456	52,518	65,328	52,197	54,532	55,288	58,540	56,266	47,013	65,887	70,253	667,839
Capital Payments	5,502	6,527	0	0	0	0	0	0	0	0	0	0	12,029
Other	0	0	59,241	57,286	46,801	73,680	56,476	53,356	63,105	56,777	48,923	78,134	593,780
Total Payments	**128,040**	**129,725**	**142,416**	**130,210**	**117,483**	**158,059**	**119,923**	**130,906**	**150,799**	**112,892**	**136,896**	**168,716**	**1,626,064**
Net Cash In/Out	3,341	721	(2,457)	856	2,196	(3,422)	853	618	2,343	6,204	(5,229)	(5,931)	
Balance B/F	1,348	4,689	5,410	2,953	3,808	6,004	2,582	3,435	4,053	6,395	12,599	7,370	
Balance C/F	4,689	5,410	2,953	3,808	6,004	2,582	3,435	4,053	6,395	12,599	7,370	1,439	

Key Points within the Cash Flow Forecast :

- The closing cash balance at 31st March 2024 was £1.4m. The balance has reduced by £6.0m during the month as expected for year end.

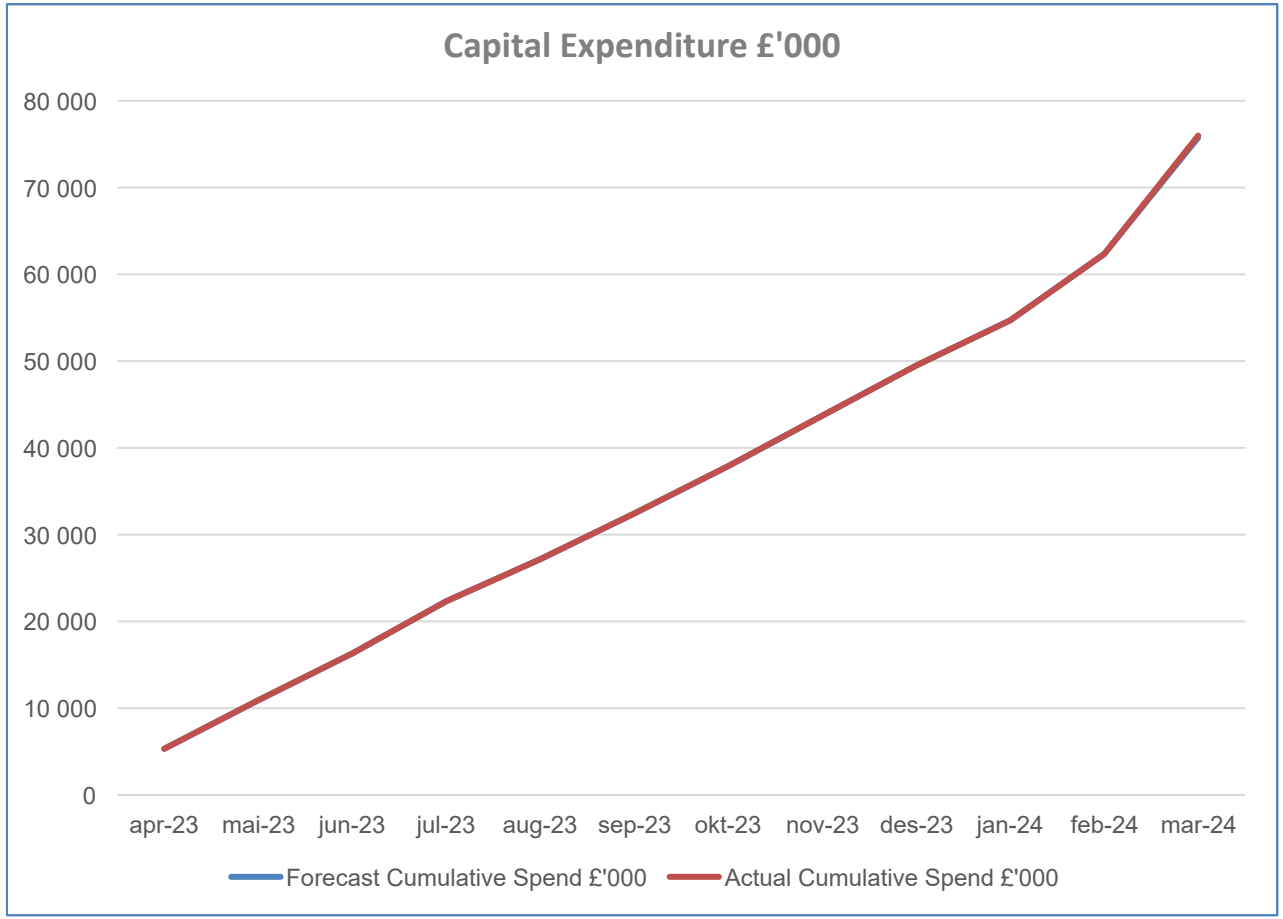
Public Sector Payment Policy



Key Points:

- The percentage for the number of non-NHS invoices paid within the 30 day target in March was 94.6%
- The cumulative percentage to M12 is 96.9%.
- The PSPP target has therefore been achieved for 23/24.

Capital Expenditure



Key Points:

- The Capital Resource Limit for 2023-24 of £75.710m was issued on the 27th March 2024.
- This is supplemented by a forecast of £0.064m for donated funds and £0.252m of assets disposed of in this financial year, giving an overall programme of £76.026m.
- Expenditure to M12 amounted to £75.993m.
- The outturn capital position was £0.033m below the CRL target.
- The Health Board has therefore met its statutory duty to achieve a break even capital expenditure position over a 3 year rolling period to 2023/24.

2024-25 Finance Report

Month 01

Summary

Situation	Background
This Finance report outlines our financial performance for Month 1 (i.e. the period to 30 April 2024). This Finance report is discussed at the Board, the Planning, Performance & Finance Committee (PPFC) and the Executive Leadership Group (ELG) meetings. A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at Month 1 (i.e. the Delegated budget position). This report is discussed at the PPFC and ELG meetings.	Section 175 of the National Health Service (Wales) Act 2014 places two financial duties on Local Health Boards: • A duty under section 175 (1) to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years • A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers. Our draft financial plan for 24/25 was submitted to Welsh Government (WG) at the end of March 2024. This plan showed a break even position with a net risk to the plan of £9.4m. It is important to note that , even if the Health Board delivers a break-even position in 24/25, it will not achieve the 3 year break even duty due to the £24.2m deficit reported in 22/23. However, delivering a break even position in 24/25 will mean that it will be possible to achieve the 3 year break even duty in 25/26.

Summary

Assessment	Recommendation
Overall Revenue position - 2024/25: • The M1 position was a £0.9m deficit. • As at M1 we are continuing to forecast a break even position for 24/25, which is consistent with the break-even plan submitted to WG. • The key risks to the forecast break even position at M1 are estimated at £9.9m and these are summarised on Page 17. **Recurrent Revenue position:** • The b'fwd recurrent deficit at the end of 23/24 was £19.4m. • As at M1 we are reporting a forecast underlying surplus at the end of 24/25 of £2.1m. This is consistent with the IMTP submitted on 31 March 2024 and this position will be reviewed at the end of Q1.	The Board, the PPFC and the ELG are asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 30th April 2024.

Contents

Executive Summary

Overall Revenue Position

- The M1 position was a £0.9m Deficit.
- The Health Board is continuing to forecast a break even position for 24/25, which is consistent with the break-even plan submitted to WG.
- The key risks to the forecast break even position at M1 are estimated at £9.9m and these are summarised on Page 17.

Savings Position

- Actual savings in M1 was £0.5m which was £1.8m below the M1 target of £2.0m.
- The M01 forecast In year savings is £23.0m. The savings increase significantly from M4 onwards, by over £1.5m each month when compared to M1 actuals.
- The M01 forecast Recurrent savings is £22.6m, which is £4.7m below the £27.3m target.

Summary
Income & Expenditure Account

	M1 Actual	M1 YTD	Year End Forecast
	£k	£k	£k
01. Revenue Resource Limit	(112,809)	(112,809)	(1,370,636)
02. Capital Donation / Government Grant Income	(0)	(0)	(0)
03. Welsh NHS Local Health Boards & Trusts Income	(6,612)	(6,612)	(79,344)
04. WHSSC Income	(1,020)	(1,020)	(12,240)
05. Welsh Government Income (Non RRL)	525	525	448
06. Other Income	(3,953)	(3,953)	(47,436)
Total Allocations & Income	**(123,869)**	**(123,869)**	**(1,509,208)**
08. Primary Care Contractor	12,479	12,479	155,600
09. Primary Care - Drugs & Appliances	8,833	8,833	104,772
10. Provided Services - Pay	55,989	55,989	673,517
11. Provider Services - Non Pay	9,644	9,644	115,728
12. Secondary Care - Drugs	4,740	4,740	58,230
13. Healthcare Services Provided by Other NHS Bodies	22,457	22,457	269,484
14. Non Healthcare Services Provided by Other NHS Bodies	0	0	0
15. Continuing Care and Funded Nursing Care	5,775	5,775	73,461
16. Other Private & Voluntary Sector	1,016	1,016	12,192
17. Joint Financing and Other	(392)	(392)	(4,704)
18. Losses Special Payments and Irrecoverable Debts	1,730	1,730	20,591
22. DEL Depreciation\Accelerated Depreciation\Impairments	2,518	2,518	30,215
23. AME Donated Depreciation\Impairments	10	10	122
25. Profit\Loss Disposal of Assets	0	0	0
Total Expenditure	**124,799**	**124,799**	**1,509,208**
Grand total	**(930)**	**(930)**	**0**

Key Points:

- The Summary I&E account shows the Health Board's Income & Expenditure by the categories used in the Monthly Monitoring Returns submitted to WG.
- The year to date position is reporting a deficit of £930k
- The Year end forecast remains a breakeven position.

Year to Date Performance and Forecast

	Current Month	YTD	Year end Forecast
	£m	£m	£m
Month 1	0.9	0.9	0

Key Points:

The main driver for the overspend in M1 is the £1.7m shortfall in savings delivery compared to the straight-line savings target of £2.2m per month. This has been offset by the following improvements:

- An anticipated reduction in Contracting & Commissioning costs compared to the financial plan. This reduction is subject to agreement of the LTAs for 24/25 and the estimated M1 benefit is £0.4m.
- An anticipated reduction in Agency costs compared to the financial plan. The estimated M1 benefit is £0.2m.
- Other underspends £0.2m

Forecast Underlying Position

Underlying Deficit	Plan £'m	M1 F/Cast £'m
B'Fwd Core Plan Deficit 23/24	19.4	19.4
Allocation & Income Changes	(50.4)	(50.4)
Cost Pressures & Investment	55.2	55.2
Savings Target	(26.3)	(26.3)
Grand Total	**(2.1)**	**(2.1)**

Key Points:

- The b'fwd recurrent deficit at the end of 23/24 was £19.4m.
- As at M1 we are reporting a forecast underlying surplus at the end of 24/25 of £2.1m. This is consistent with the IMTP submitted on 31 March 2024 and will be reviewed at the end of Q1.
- **The indicative financial plan for Year 2 and Year 3 of the IMTP shows that full delivery of the recurrent financial plan in Year 1 (2024/25) should present opportunities for lower savings targets and higher levels of local discretionary investment in Year 2 and Year 3.**

Pay Expenditure Trends

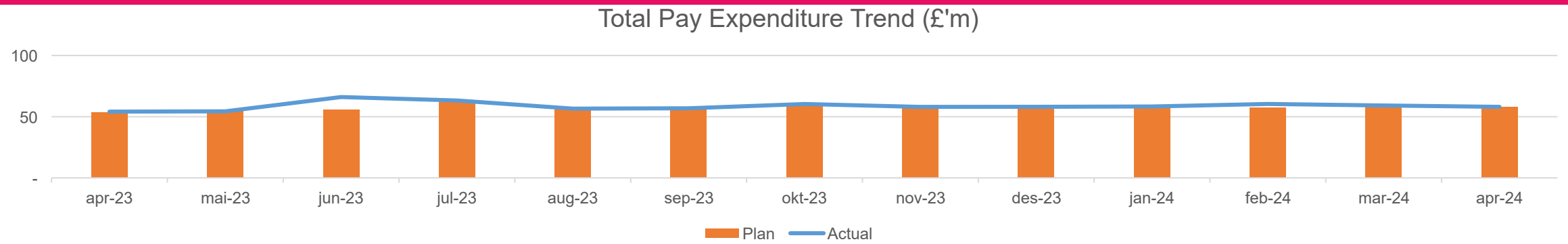
Staff Group	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m	Qtr Ave £'m	Apr-24 £'m
Administrative & Clerical	7.6	7.5	7.7	7.1	7.4	7.5
Medical And Dental	15.4	15.5	15.7	15.1	15.5	15.5
Nursing And Midwifery Registered	18.0	18.2	19.3	19.7	19.0	17.9
Add Prof Scientific And Technical	1.6	1.7	1.7	1.4	1.6	1.7
Additional Clinical Services	7.3	7.3	7.5	7.7	7.5	7.3
Allied Health Professionals	3.6	3.6	3.8	3.6	3.7	3.6
Healthcare Scientists	1.1	1.1	1.2	1.1	1.1	1.2
Estates And Ancillary	3.3	3.4	3.3	3.3	3.3	3.5
Students	.1	.1	.1	.1	.1	.0
Grand Total	**58.1**	**58.4**	**60.4**	**59.2**	**59.3**	**58.1**

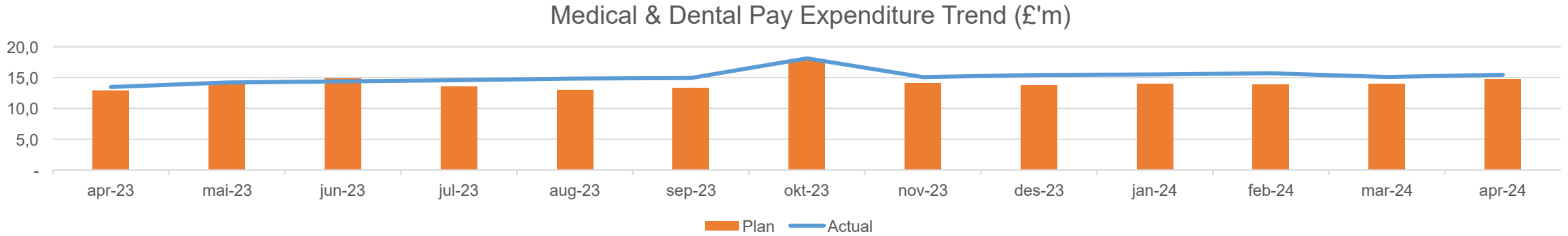
Spend category	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m	Qtr Ave £'m	Apr-24 £'m
Core	50.0	50.1	51.0	49.8	50.3	49.9
Agency	3.8	3.4	4.5	3.7	3.9	3.3
Overtime	1.3	1.7	1.8	2.1	1.9	1.5
ADH	1.7	1.9	1.8	2.1	1.9	2.0
Bank	1.1	1.2	1.2	1.3	1.2	1.1
WLI	.1	.1	.1	.2	.1	.2
Grand Total	**58.1**	**58.4**	**60.4**	**59.2**	**59.3**	**58.1**

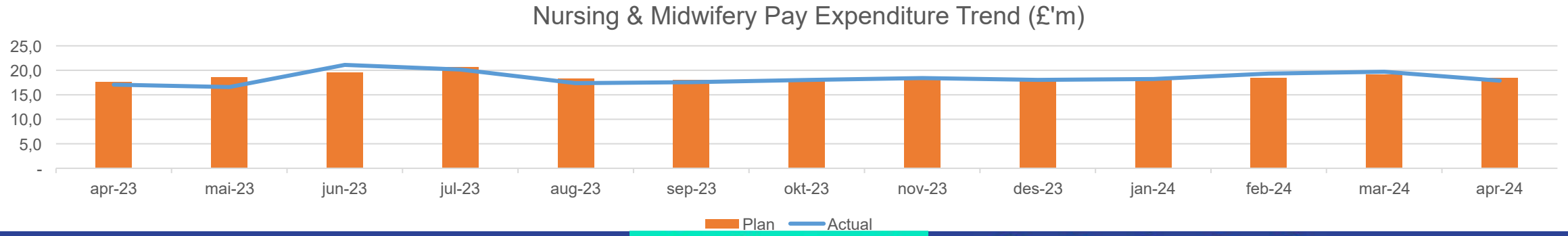
Key Points:

- Nursing is showing a £1.1m improvement compared to the previous quarter average. The high nursing costs experienced during M11 & M12 appear to have eased in M1, with Nursing pay costs returning to previous levels.
- Medical is consistent with the previous quarter average. However, since M1 is the first month since December not to have incurred industrial action (estimated impact of £0.3m per month in Q4), underlying costs have increased by £0.3m.
- Agenda for change staff within bands 1-3 have received an increase in salary to reflect the real living wage from M1. The estimated impact is £0.2m per month. It is assumed this increase will be fully funded by WG.
- The Medical & Nursing agency pressures experienced during M11 & M12 appear to have eased in M1, with agency costs returning to previous levels.
- Overtime costs have reported a decrease compared to the previous quarter average, this mainly relates to Registered Nursing.

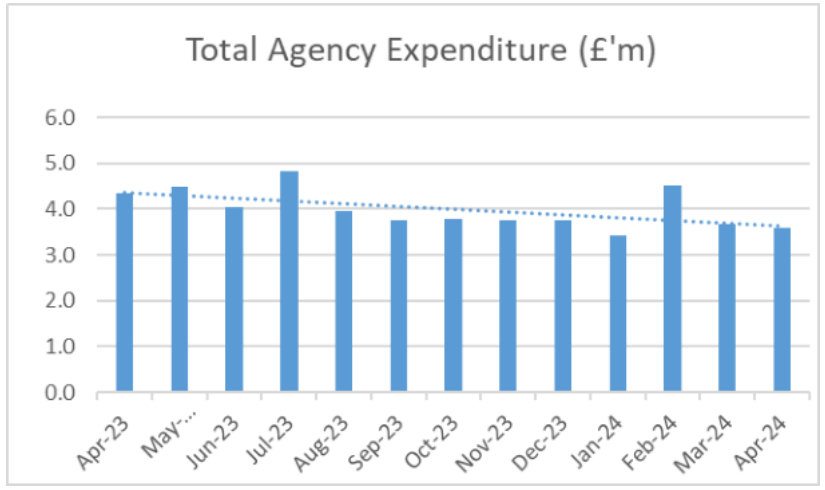
Pay Expenditure Trends

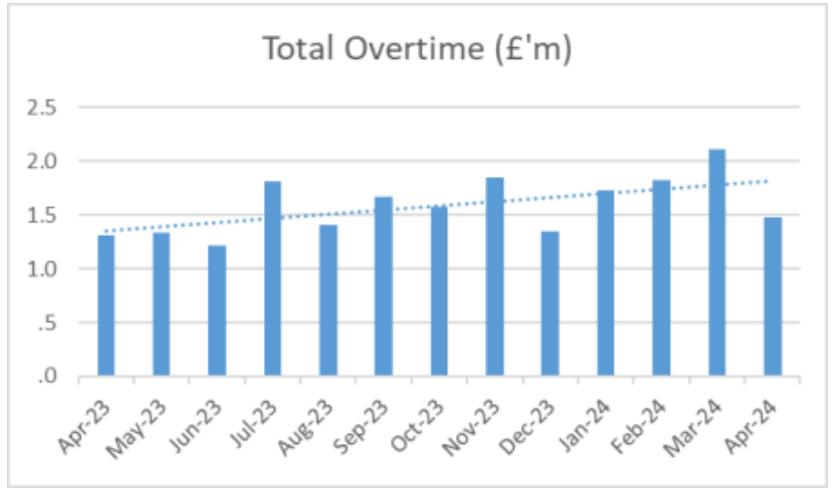


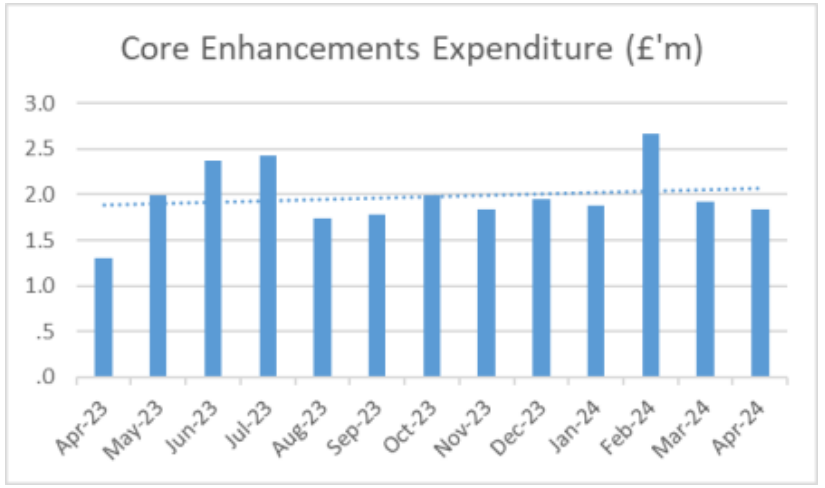


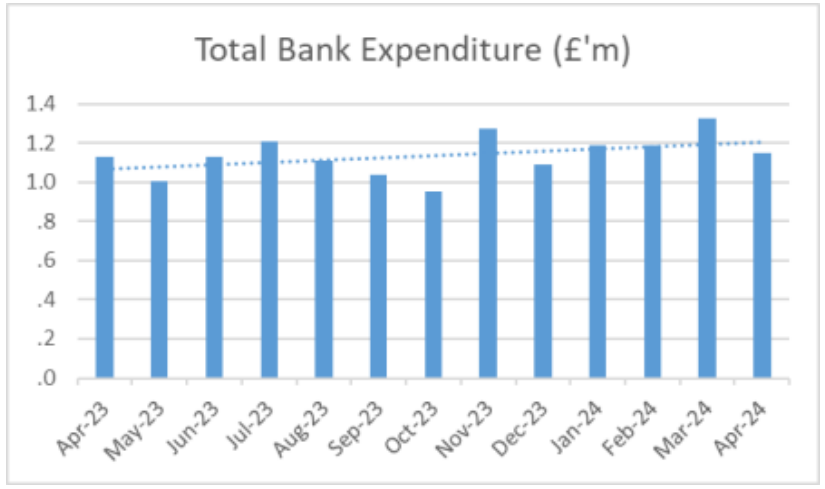


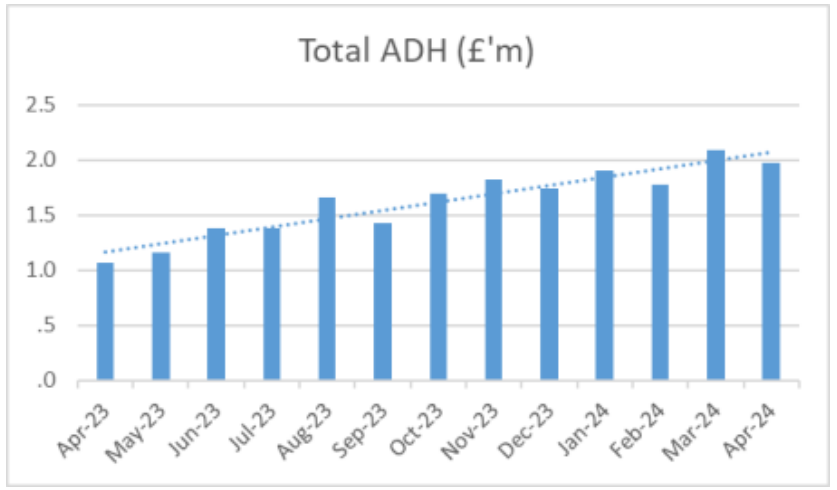
Variable Pay Expenditure Trends









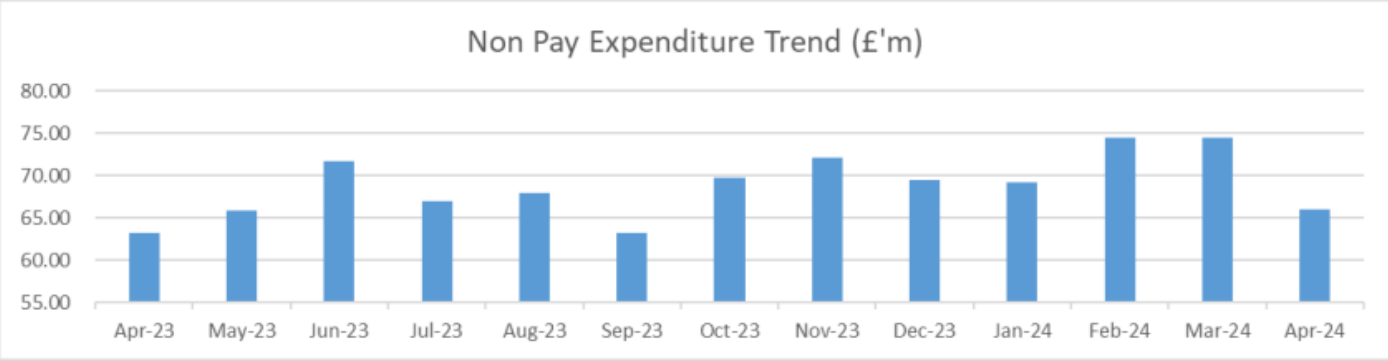


Key Points :

- Total agency expenditure in M1 decreased by £0.4m when compared to M12.
- Overtime payments and core enhancements in M1 decreased by £0.6m & £0.1m respectively when compared to M12.

Non Pay Expenditure Trends

Non Pay Group	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m	Apr-24 £'m
Primary Care Contractors	11.6	13.0	12.7	16.5	14.5	11.6
Primary Care Drugs	8.5	8.2	8.5	8.4	8.5	8.8
Provider Non Pay	9.1	9.6	11.4	9.3	9.5	9.6
Secondary Care Drugs	5.4	4.4	4.8	4.9	4.6	4.7
Healthcare Commissioning	25.6	22.4	20.3	24.0	30.1	22.5
CHC & FNC	6.0	6.5	6.2	5.7	5.5	6.0
Other	5.9	5.6	5.1	5.6	1.8	4.8
Total Expenditure	**72.1**	**69.5**	**69.2**	**74.5**	**74.5**	**68.1**

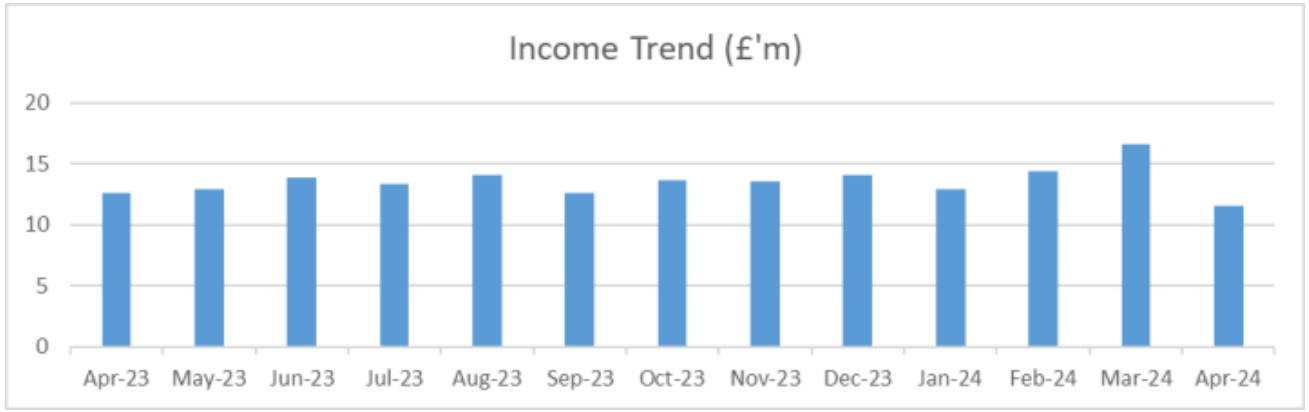


Key Points:

- The level of expenditure in M11 & M12 was higher than normal due to a number of year end adjustments and arrears being processed. The total spend in M1 of £68.1m was £1.1m lower than M10 (Jan-24). The main movements from M10 were:
- Decrease in Primary care contractors £1.1m – This mainly relates to a delay in a technical adjustment for Non Cash Limited..
- Increase in PC Drugs £0.3m – M1 is an estimate and includes growth and inflation assumptions for 24/25.
- Decrease in Provider Non Pay - £1.8m – M10 included a retrospective adjustment for Laundry recharges with NWSSP of £1m and one off costs of recruitment and training of £0.4m, M1 has reported a reduction in clinical supplies & Services of £0.4m.
- Increase in Healthcare commissioning £2.2m – M10 included a retrospective adjustment of £2m. The average spend in Nov, Dec and Jan was £22.8m.
- Decrease in Other £0.3m – relates to capital charge estimates, revised estimates will be provided from M3 onwards.

Income Trends

Income Group	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m	Apr-24 £'m
Welsh NHS Income	7.3	7.4	5.7	7.2	7.7	6.6
WHSSC Income	1.0	1.1	1.1	1.0	1.1	1.0
Primary Care Contractor Income	1.3	1.4	1.6	1.4	1.2	1.0
CHC Income	0.5	0.5	0.5	0.4	0.5	0.4
Other Income	3.5	3.7	4.0	4.3	6.0	4.0
Total Income	**13.6**	**14.1**	**12.9**	**14.4**	**16.6**	**13.0**



Key Points:

- The level of income received in M12 was higher than normal due to a number of year end adjustments .
- The total Income in M1 of £13.0m was £1.4m lower than M11 (Feb-24). The main movements from M11 were:
  - Decrease in Welsh NHS Income of £0.6m- This reflects the removal of COVID protection arrangements for LTAs in 24/25.
  - Decrease in Other income of £0.3m – Various small movements with a reduction in Injury cost recovery income of £0.2m being the most significant.
  - Decrease in Primary Care Contractor income £0.4m – M11 had recognised one off income from ABUHB for OOH.

Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,172.1	29.7	25.0	83.5	1,310.3
Anticipated Allocations:					
2022/23 Pay award	8.9				8.9
2023/24 Pay award	31.9				31.9
2024/25 RLW Pay award	2.6				2.6
Substance Misuse Funding	4.0				4.0
Emergency/Urgent Care	3.0				3.0
RLW Social Care	2.4				2.4
MH Investment	4.1				4.1
IFRS 16 Adjustment	(2.4)				(2.4)
WRP Recovery	(4.6)				(4.6)
GP Pay Uplift 23/24				3.0	3.0
Other Allocations	7.7				7.7
	1,229.6	**29.7**	**25.0**	**86.5**	**1,370.8**

Key Points:

- As at M1 the confirmed Revenue Resource allocation was £1,310.3m.
- The forecast position assumes a further £67.6m of additional allocations offset by a reduction of £7.0m for IFRS and NWSSP Risk Pool to give a Total allocation of £1,370.8m.
- Our M1 year end forecast position assumes that our anticipated allocations for Pay awards (£43.4m) will be fully funded by WG. However, until formally confirmed , there remains a risk that the final allocations will be lower than anticipated. This risk is included in our M1 Risk assessment on Page 17.

Income Assumptions - NHS

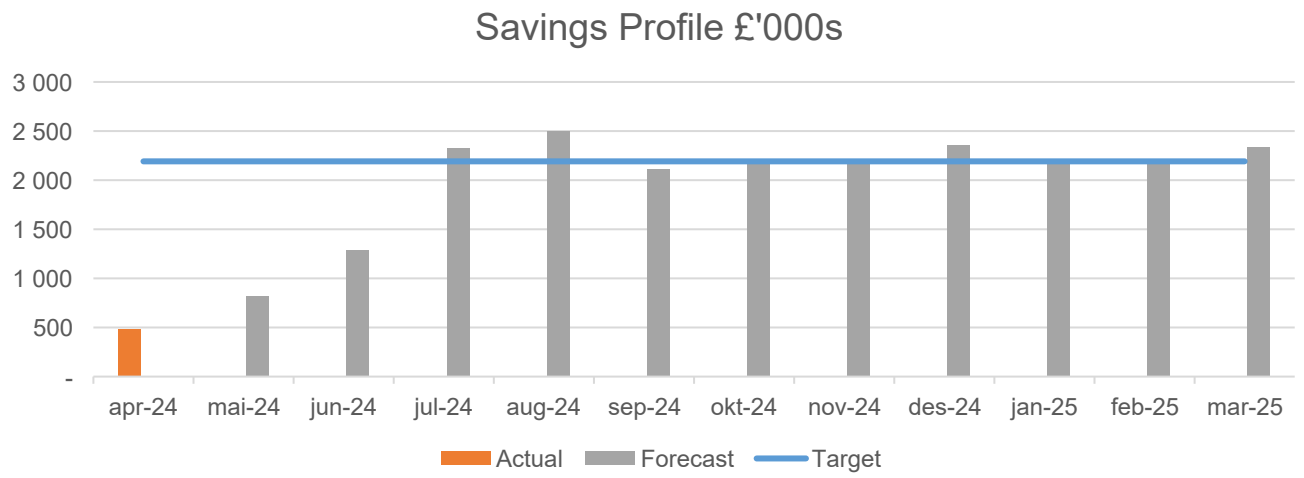
	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	29.8	(2.4)	**27.4**
Aneurin Bevan University	20.0	2.1	**22.1**
Betsi Cadwaladr University	0	0.3	**0.3**
Cardiff & Vale University	17.2	1.1	**18.3**
Cwm Taf Morgannwg University	0.0	0.0	**0.0**
Hywel Dda University	0.5	0.5	**1.0**
Powys	5.1	1.2	**6.3**
Public Health Wales	3.3	1.3	**4.6**
Velindre	0	11.8	**11.8**
NWSSP	0	0.0	**0.0**
DHCW	0.7	0.7	**1.4**
Wales Ambulance Services	0.0	0.1	**0.1**
JCC	11.5	1.0	**12.5**
HEIW	0.0	15.7	**15.7**
NHS Wales Executive	0.0	0.0	**0.0**
Total	**88.3**	**33.3**	**121.5**

Key Points :

- Draft proposals for the 24/25 LTAs have been submitted to all providers and commissioners, apart from SBUHB.
- However, there are a number of disputes in respect to the 24/25 inflation uplift for both LTAs and SLAs which have yet to be agreed with other Health Board's and Trusts.
- The Health Board is working to agree all of the LTAs by the Welsh Government deadline of the 28th June 2024.Failure to agree LTAs by this date will result in organisations having to request arbitration by Welsh Government.

Savings

	Month 1		
	YTD	24/25	Rec
	£m	£m	£m
Savings target as at M1	2.2	26.3	26.3
Actual and Forecast Savings	(0.5)	(23.0)	(22.6)
Total	1.7	3.3	3.7



Key Points:

- Actual savings in M1 was £0.5m which was £1.7m below the M1 target of £2.2m.
- The M1 forecast In year savings is £23.0m, which is £3.3m below the £26.3m target. The M1 savings profiles from Care Groups and directorates are showing low levels of savings in M2 and M3 before increasing significantly from M4 onwards, when savings are forecast to reach £2.0m per month.
- The M1 forecast Recurrent savings is £22.6m, which is £3.7m below the £26.3m target.

Risk Management
Risks and Opportunities

	M1 £m	IMTP £m	Comment
Funding risks:			
Outstanding WG recurrent allocations for 2034/24 pay awards	2.6	2.6	Further clarification needed on funding assumptions for 24/25
Risk of the 24/25 pay award not being fully funded	Tbc	Tbc	Further clarification needed on funding assumptions for 24/25.
Other risks:			
Anticipated improvement of £2.6m in M1 forecast savings plans of £23m to achieve break even position at year end.	2.6	3.3	Risk of not delivering the anticipated improvement.
Delivery risk on latest savings plans for £23m	6.5	2.4	This risk is estimated at 50% of all Amber schemes
Cost pressures	5.0	7.9	
Further industrial action in 24/25.	Tbc	Tbc	
Total Risks	**16.7**	**16.2**	
Opportunities			
Balance sheet opportunities in 24/25	(5.0)	(5.0)	
Retrospective vat recoveries – Microsoft contract	(1.8)	(1.8)	
Potential reduction in Energy costs	Tbc	Tbc	
Total Opportunities	**(6.8)**	**(6.8)**	
Total	**9.9**	**9.4**	

Key Points :

- As at M1 we are reporting an estimated net risk of £9.9m.
- The M1 forecast savings plans of £23m have been risk assessed as £10m Green and £13m Amber. The savings delivery risk at M1 has been estimated at 50% of the Amber schemes.

Agenda Item
6.2.3

CTM Health Board

Capital Programme Update 2023/24 and Plan for 2024/25

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Carolyn Blockley, Head of Capital
Cyflwynydd yr Adroddiad / Report Presenter	Sally May, Executive Director of Finance
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Matters discussed at ECMG	21/03/2024	Noted
Planning, Performance & Finance Committee	30/04/2024	Noted

Acronyms / Glossary of Terms	
ECMG	Executive Capital Management Group
IRCF	Integration and Rebalancing Care Fund
FEN	Fire Enforcement Notice
CRL	Capital Resource Limit
AWCP	All Wales Capital Programme

1. Situation /Background

The purpose of this report is to provide an update on the current capital resource limit and expenditure commitments made to date. The report also covers the actual capital expenditure as at Month 11 and brief update on all current major capital projects as well as plans for the 2024/25 discretionary programme

2. Specific Matters for Consideration

2.1 23/24 Capital Funding Position

The latest capital funding position for 23/24 is shown in **Table 1** below comprising £6.533m discretionary, £68.427m All Wales Capital funding and £0.353m IFRS 16 funding giving a total CRL of £75.313m. This is a £7m increase on the previously reported position, £5.652m of this funding was awarded in February 2024 as additional year end money was secured from Welsh Government. The additional funding in the main covered high-risk equipment replacement and IT investment.

Funding is added to **Table 1** to show the NBV of assets disposed of in year which is £0.002m of equipment and £0.245m for Llwyn Yr Eos. Together with donations of £0.087m this takes the total funding available in year to £75.647m

Table 1 Confirmed CRL funding 2023/24	**Current CRL £'000**
Discretionary allocation 2023/2024	6,533
Prince Charles Hospital Refurbishment - Phase 2	49,294
Prince Charles Hospital Refurbishment - Phase 3 Fees	1,700
Purchase of former BA site, Llantrisant	32
Llantrisant Health Park – PBC Fees	1,691
Efab - Infrastructure	2,598
Efab - Fire	1,249
Efab - Decarbonisation	909
Primary Care - Sunnyside	761
Fire Enforcement Works - Princess of Wales - fees	191
National Imaging Academy Wales	188
Fluoroscopy POW	420
Maesteg Health and Wellbeing Park	100
DPIF - RISP	180
Taith Seculsion Suite, Glanrhyd	378
Fibro Scanner, Community Drug and Alcohol Services	109
Theatre Equipment, Royal Glamorgan Hospital	384
Cyber Security	1,147
Emergency Department and Minor Injury Unit Improvements	580
Diagnostic Equipment	954
Digital Year End Funding - January 2024	200
Year End Funding - January 2024	497
Year End Funding - February 2024	489
DPIF - WNCR Paedatrics	53
DPIF - Digital Medicines Transformation Pre-implementation	1,000
Diagnostic Equipment - February 2024	1,059
Additional Year End Funding - February 2024	389
Digital Radiography Detectors	95
Digital Year End Funding - February 2024	1,780
All Wales Capital Funding	**68,427**
IFRS 16 Funding	**353**
Total WG Funding	**75,313**
Disposal of Assets with NBV	247
Government granted/Donated income	87
Total Capital Funding as at 20.02.2024	**75,647**

2.2 Discretionary Programme Commitments 2023/24

The table above details discretionary capital funding of £6.533m in 2023/24. In addition to this the Executive Capital Management Group (ECMG) agree each year to over commit the programme to assist with managing inevitable year end slippage in capital schemes. A 13.5% overcommitment was made at the start of the financial year based on previous experience however as specific slippage amounts are confirmed this is managed appropriately to ensure a balanced outturn position at the end of the financial year.

Table 2 below shows all approvals and commitments to the end of February against the areas of ICT, Equipment, Backlog Maintenance, Statutory Compliance and Service Redesign.

The position shows that the overcommitment has increased from the original £0.845m to £1.681m. This is a planned position due to known slippage across several schemes and allows for further small amounts of slippage which are likely to materialise over the final few days of the year as schemes come to a close. The forecast is for a balanced outturn against the CRL position

Cwm Taf Morgannwg Discretionary Capital Plan 23/24 M11		
Table 2 - Discretionary Funding and Allocations		**Current Position £'000**
Funding Sources		
Discretionary Capital Funding		9,006
EFAB Top Slice		-1,428
All Wales Capital Scheme Commitments B/F		-1,046
Property Disposals		247
13.5% Over commitment		845
Total Funding (Including over-commitment)		**7,624**
Department Allocations		
IT	Funding	1,838
	Expenditure Allocations	2,038
	Overcommitment against allocation	200
Statutory Compliance	Funding	1,010
	Expenditure Allocations	1,153
	Overcommitment against allocation	143
Backlog Maintenance	Funding	1,114
	Expenditure Allocations	1,213
	Overcommitment against allocation	99
Equipment	Funding	1,765
	Expenditure Allocations	2,306
	Overcommitment against allocation	542
Service Redesign	Funding	1,838
	Expenditure Allocations	1,750
	Overcommitment against allocation	- 88
Sub Total Committed Expenditure		**8,460**
Subtotal Contingency		-
Total anticipated Spend		**8,460**
Position against Funding (including planned overcommitment)		**836**
Position against actual funding		**1,681**

The spend to date on the discretionary programme up to end of February is £5.769m which represents 68% of the required spend in year

2.3 Major Capital schemes

The spend to date on All Wales Capital Programme schemes up to end of February is £56.516m which represents 83% of the approved funding for AWCP

The current status and detail of the major capital projects is provided in **Appendix A.**

2.4 24/25 Capital Programme

WG have confirmed the opening discretionary allocations for 24/25 and this includes a full re-instatement of the funding cut applied in 22/23. This makes the opening discretionary allocation £10.230m. The forecast position for 2024/25 is presented in **Table 3** below based on expected slippage on AWCP and discretionary programmes from 2023/24 that will need to be re-provided in year.

Table 3 - Discretionary Funding and Allocations				
Funding Sources		**24/25**		
Discretionary Capital Funding		10,230		
EFAB Top Slice		- 1,899		
All Wales Capital Scheme Commitments B/F (estimate		- 1,800		
Property Disposals				
10.5% Over commitment				
13.5% Over commitment		882		
17.5% Over commitment				
Total Funding (Including over-commitment)		**7,413**		
Department Allocations			**Disc Proportion 24/25**	**Disc Proportion 23/24**
	ICT	1,638	22%	25%
	Equipment Replacement	1,173	16%	24%
	Statutory	1,167	16%	12%
	Backlog Maintenance	1,301	17%	14%
	Transformation	1,400	19%	25%
	Blast Chillers/Access Controls	787	11%	
Total Expenditure		**7,467**		

As in previous years ECMG approved a 13.5% overcommitment position for the start of the financial year and hence it is anticipated the £7.413m will be available to be allocated across the departments.

Department allocations were discussed at the January, February and March 2024 ECMG and adjusted as necessary throughout those discussions. The limited amount of discretionary capital available compared to the risks across the estate was highlighted. It was noted that a significant amount of additional year end funding had been received, particularly in relation to equipment replacement and IT and so it was suggested the percentage allocations should be reduced in these areas compared to previous years in order to increase the investment in statutory

and backlog. Given the significant backlog maintenance position and the recent internal audit findings re Estates condition this approach was agreed by ECMG. It should be noted that there is also EFAB funding of c£6.3m in 24/25 covering fire, infrastructure and decarbonisation investment.

Whilst there is no contingency in the programme funding has been ringfenced to cover the known unfunded risks of blast chillers in CPU and POWH access controls. Each department allocation will however keep a contingency balance for at least part of the year to allow for urgent unknowns.

Progress is being made on specific allocations within the backlog, statutory and IT headings to allow spend to commence early in 2024/25. Priorities for equipment replacement and transformation schemes will be assessed by the Operational Capital Group in May 2024

2.5 NHS Wales Prioritisation

As reported previously, Welsh Government continue to report that the future years capital programme remains under extreme pressure. As a result WG have launched an all Wales capital prioritisation exercise. The NHS Infrastructure Investment Board (IIB) in Welsh Government have agreed a framework which will provide a common basis for investment decision making. Organisations were asked to complete an investment form for all potential business cases requiring funding from the All Wales Capital Programme, irrelevant of where they are in the business case process. This excludes requests for funding from the Digital Priorities Investment Fund (DPIF) and the Integration and Rebalancing Capital Fund (IRCF).

The investment criteria set out below are the areas that will be scored by IIB, each area has also been given a percentage weighting as indicated.

- **Fit with Priorities and Policy 25%**
- **Clinical Impact 20%**
- **Value for money (VfM) 16%**
- **Statutory Compliance and Risk (SCR) 13%**
- **Equity & Community 13%**
- **Wider Benefits and Climate Change 13%**

Welsh Government made it clear that each of the forms had to be ranked in priority order and no joint priorities would be accepted. The priority list of schemes submitted to WG are detailed below along with an estimated cost profile.

		2024-25	2025-26	2026-27	Further Years	Total
Priority	Scheme	£m	£m	£m	£m	£m
1	Llantrisant Health Park Infrastructure Programme	12.27	67.42	74.05		**153.74**
2	POW Theatres - Fire Safety Requirements	0.50	15.00	0.50		**16.00**
3	PCH - Phase 3		23.20	23.20	11.60	**58.00**
4	POW Programme of infrastructure work	1.00	15.00	45.00	189.00	**250.00**
5	Endoscopy Scope Decontamination POW	3.00	2.00			**5.00**
6	RGH Mechanical Infrastructure	0.50	3.00	2.50	3.00	**9.00**
7	Diagnostic Imaging Replacements	2.00	3.00	2.00		**7.00**
8	Additional ward facilities on 3 major DGH sites	2.00	4.00	3.00	3.00	**12.00**
9	Phased Outpatient Reconfiguration	1.00	2.00	3.00		**6.00**
10	Consolidation of Mental Health Services	1.00	3.00	5.00	41.00	**50.00**
11	ITU - reconfiguration		0.50	1.00	13.50	**15.00**
12	HSDU Single Site Decontamination			0.50	13.50	**14.00**
13	Third Eye Theatre at POW				5.00	**5.00**
14	Regional Pathology		0.50	1.00	48.50	**50.00**
15	Interventional Cardiology Unit				5.00	**5.00**
16	Emergency Dept South			0.50	11.50	**12.00**
17	Reconfiguration of Obs & Gynae South				20.00	**20.00**
18	Mortuary capacity PCH				5.00	**5.00**
19	Diagnostic Imaging Replacements				19.00	**19.00**
20	Centralised haematology day unit				3.00	**3.00**
21	Expand Central Production Unit			0.50	11.00	**11.50**
22	Single CTM Contact Centre				2.00	**2.00**
		23.27	**138.62**	**161.75**	**404.60**	**728.24**

Feedback and queries in relation to the submission are expected over the next few months

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg?* / **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	Legal implication of the capital programme are assessed for each project and advice sought accordingly but 2 programmes are subject to FENs	
Enw da / Reputational	Yes (Include further detail below)	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The paper discusses the use of capital resources	

4. Recommendation

4.1 The Board are asked to

NOTE the additional year end funding received and forecast for 23/24 breakeven position

NOTE the discretionary plan for 2024/25 and how funds are to be split across departments

NOTE the priority schemes submitted to Welsh Government as part of the all Wales NHS prioritisation framework

Appendix A – Major Capital Schemes Update

PCH Ground & First Floor Scheme

Phase	Approved Allocation £000	Previous Years Spend £000	23/ 24 AWCP Allocation £000	Forecast 23/24 spend £000	Forecast Future yr Spend £000	Expected completion date
Phase 2	217,388	90,270	49,294	51,592	76,518	05/08/26
Phase 3	2,887		1,700	1,700	1,187	tbc

Phase 2 of the Ground and First Floor Refurbishment Programme is a £220m scheme addressing the lifting of the Fire Enforcement Notice on Prince Charles Hospital. Construction began in November 2020 and is anticipated to complete in August 2026.

The works are being delivered in 6 Sections of activity. Of the initial 6 Sections, construction work is presently ongoing in Section 3. Three sections have been completed; 1, 2 & 6. Two Sections are yet to commence; 4 & 5.

Section 3 is the ongoing refurbishment of the Out-patient, Therapies and Radiology Department on Ground Floor and Maxillofacial, Endoscopy, Oncology and Theatres areas on the 1st Floor.

The table below details key handover dates within this section.

Section 3 (Prog Rev.38)	
Location	Contractor's Planned Completion Date
Therapies	08/4/24
OPD	08/4/24
Max Facs	19/4/24*1
Endoscopy	23/4/24
Theatres	23/4/24
Transfusion	28/6/24
Pathology	16/9/24
Radiology Ph1	15/8/24
Trauma lift	29/5/24
Pathology Lift (part 1)	18/4/24

*1 Max Facs occupation from 23/4/24

CRL funding for 23/24 for phases 2 and 3 was issued as £50.994M, £1.7M of this being for phase 3. The current forecast spend on both phases in 23/24 is £53.3M which is £2.3M above the agreed CRL for this year. Additional CRL of £0.75M was brokered from WG and AB in March 2024 to cover these overspends which will

need to be returned in 24/25. The remaining overspend will be managed through slippage on other capital schemes.

The remaining contingency balance on the total scheme is currently £2.41m. This balance is £0.107m less than last month due to additional commitments in month. In addition to this there is a forecast gainshare figure of £4.496m. The gainshare forecast includes an estimate for section 1, 2, 3 and 6. It should be noted that the figure is highly likely to change as no final accounts have been agreed. WG will request that this is returned if not required for delivery of the scheme so it **cannot** be assumed that the gainshare will be available to the Health Board. Further discussions will be had with Welsh Government at an appropriate point in the scheme.

The scheme has currently committed 89% of the available contingency. This is being kept under close review with NWSSP-SES and Welsh Government and will be linked to discussions around retention of the gain share and VAT reclaim.

Fluoroscopy POW

Scheme savings from the replacement of the 5 DR rooms last year meant the Health Board was able to carry forward this underspend to deliver the install of the equipment in Fluoroscopy room 3 at POWH (as the actual equipment had already been purchased in 2022/23 and is in storage whilst the works are undertaken).

The contractor commenced works in Room 2 and the ultrasound room in September 2023. Both are now operational and works to Room 3 are well underway with an anticipated completion date of early April 2024.

Bridgend Health and Wellbeing Centre (Sunnyside)

Approved Allocation £000	Previous Years Spend £000	23/24 AWCP Allocation £000	Current Year forecast Spend £000	Completion Date
19,222	1,310	761	139	Autumn 2025

Funding of £10.7M was initially approved by WG in October 2020 for this scheme being delivered in partnership with Linc Cymru. In early July 2021 the contractor (WRW) went into administration. A new contract has now been signed with Wynne Construction Ltd and an uplift of funding up to £19.222m secured to progress with the scheme

The contractor will take possession of the site on 25th March 2024 with Health Centre works commencing on 3rd June. This will allow the contractor adequate time to finalise RIBA Stage 4 design works and mobilise site resources. In the meantime, the HB and contractor have met to discuss and consider additional decarbonisation measures, which could potentially be added to the design

(consideration of these measures was a condition of WG funding approval), and any additional measures agreed can be incorporated into the design before start on site. It is anticipated that the Health Centre element of the development will complete on 20th October 2025 (with the housing element completing slightly later).

POWH – Fire Enforcement Notice and Theatres

Approved Allocation £000	Previous Years Spend £000	23/24 AWCP allocation £000	Forecast 23/24 spend £000
753	562	191	25

The fire enforcement notice was applied to the main theatre at POWH in December 2018, however the former ABMU Health Board was unable to discharge the full requirements prior to the boundary change. Since that time CTM has proactively worked to discharge the "below ceiling" elements of the notice covering storage and training however the above ceiling elements around the theatre infrastructure have proven more complex.

The Fire Enforcement notice has been extended three times since the boundary change. For the most recent extension the HB met with SWFRS on the 27th November 2023 and they were pleased to see a programme with milestones and asked for assurance that no further changes to the plan were anticipated.

They were assured that the preferred way forward for the HB has been agreed and appears acceptable to WG. The Assistant Director of Health, Safety & Fire emailed SWFRS on 13th December formally seeking an extension for 2 years from 1st January 2024. SWFRS agreed to extend the deadline by the maximum they can of one further year, accepting that we will need to apply for a further one year extension in December 2024.

A Project Board meeting on 22nd September 2023 confirmed that the preferred decant option to enable the scheme to progress is:-

- 1 modular decant theatre at POWH for Trauma
- Existing day surgery theatres being used for CEPOD Sessions
- 1 decant theatre at RGH in old obstetrics
- 3 mobile/modular decant theatres at RGH to be sited between OPD and Mental Health

WG have noted the preferred decant option and queried whether the HB needs 3 mobile/modular theatres at RGH or whether 2 would be sufficient, given that the former maternity theatre is being brought back into use. The Director of Planned Care has confirmed the demand and capacity requirements support the need for the four decant theatres

The tender process to appoint a new design team is in process and it expected to conclude by Monday 18th March to allow confirmation of the successful bidder.

WG have been clear that this scheme should focus on the requirements to lifts the FEN. It is understood that the HB may wish to fund plant replacement and electrical safety works to theatres from discretionary capital to be undertaken simultaneously whilst theatres are vacated for the FEN works. To be prudent the electrical works and some of the replacement plant has been included in the scope of the brief for the new design team, although it does not commit to any spend from the 2025/26 discretionary capital at this point.

Given the concern that revenue lease costs for the decant option for 12 months may be circa £4m the Project Board asked that up to date purchase costs be obtained. The approximate £10m cost was discussed with WG on 16th October and an updated paper was tabled. No commitment was given either way regarding funding however it was agreed that both capital and revenue options would be costed and submitted in the business case for WG to consider what funding options are available. It was reiterated that the capacity requirement for decant theatres would form part of the scrutiny. The project manager investigated the procurement route for mobile/modular solutions and confirmed that the national SBS framework allows for a mini competition or direct appointment. The next step will be Capital Planning and Procurement drafting expressions of interest before issuing an Invitation to Tender (ITT).

Centralised Decontamination Unit at POWH

Approved Allocation £000	Previous Years Spend £000	23/24 AWCP allocation £000	Forecast 23/24 spend £000
268	268	0	1

The driver for this scheme was to lift the limited JAG accreditation that was given to the POWH endoscopy unit in 2018 as well as address the infrastructure, capacity and sustainability issues within the current "land locked" HSDU department on the first floor of the main building.

The SOC was approved by WG in March 2020 who provided fees to develop the design and a business justification case for WG submission. An experienced design team was appointed to progress this scheme. User meetings have produced signed-off layouts and the production and completion of room data sheets.

Planning approval for the scheme was granted in February 2023 and tendering was completed in March 2023 with a preferred supplier identified and informed.

However, the Health Board paused the process to assess strategic options given the need to consider decontamination services for the Llantrisant Health Park. The COO is also discussing the possibility of a sub-regional facility with other local Health Boards.
The last JAG accreditation visit occurred on 8th December 2023 and following this the decontamination lead has put several contingency options together to address the situation. The Health Board has subsequently proposed a mobile decontamination facility be brought to the POW site with a decontamination task

& finish group being formed by the COO. The Task & Finish group had a site visit on 13th February to assess potential locations for a mobile unit and an options paper is being drafted by the Group Lead. Whilst the short-term plan for a mobile facility is progressing the longer term plan still needs to be agreed by the service to enable the capital team to continue in developing a business case for submission

Maesteg Health and Wellbeing Centre

The Health Board has successfully secured £476k of fees funding from the Integration and Rebalancing Capital Fund (IRCF) to develop a business case for the re-development of the Maesteg Hospital into a Health Park.

The IRCF preferred approach for this scheme is a joint SOC/OBC followed by an FBC. This is a new approach and means that engagement of a Supply Chain Partner will take place earlier than usual

Project manager, cost advisor and Supply Chain Partner (SCP) were all appointed in February 2024. Contracts were issued on 15th February and are out for signature with the commercial parties to be returned to CTMUHB.

An initial meeting with the project manager and cost advisor indicate that the cost of multiple surveys when added to the fees is likely to exceed the £476k currently allocated. Meetings on 28th February and 13th March 2024 including the SCP looked to firm up the forecast costs so that the HB can discuss with the IRCF, but a few queries still remain, which are expected to be clarified early week commencing 18th March 2024.

From the draft programme issued by the SCP, decisions to firm up the scope of the options for appraisal need to be taken in early April e.g. one or two wards, second GP Practice, pharmacy, etc as the site is constrained.

Estates Infrastructure (EFAB) Schemes

The Welsh Government has approved £11.086M of infrastructure schemes over 2 years as part of its EFAB programme to upgrade and replace significant elements of the Health Board's Estates infrastructure across various sites. The Health Board must contribute 30% of this funding, which is top sliced from the opening discretionary position, the breakdown of approved schemes is detailed below.

			2023/24			2024/25		
Site	Detail	**WG Approved £000**	WG Fund £000	HB Fund £000	**Total £000**	WG Fund £000	HB Fund £000	**Total £000**
POWH	Instal Electrical IPS/UPS (Phase 1)	619	433	186	619	0	0	0
RGH	Instal IPS in ITU	455	32	14	46	286	122	409
		1,074	**465**	**200**	**665**	**286**	**122**	**409**
POWH / RGH	Replace Hotwell Steam Condense Units	593	228	98	326	187	80	267
		593	**228**	**98**	**326**	**187**	**80**	**267**
POWH	Replacement of Failing Electrical Distribution Boards-Phase 1	389	180	77	257	93	40	132
POWH	Phase 1 - HRC Fuse board replacements.	286	100	43	143	100	43	143
POW	Phase 1 - Replacement of Motor Control Panels	389	0	0	0	273	117	389
Maesteg	Replace generator with N+1 configuration, including the main generator tank and oil Supply	623	0	0	0	436	187	623
		1,688	**280**	**120**	**400**	**902**	**386**	**1,288**
ALL Sites	Replacement of highest risk lifts as part of rolling programme	497	129	55	184	219	94	313
		497	**129**	**55**	**184**	**219**	**94**	**313**
Acute Sites	Phase 1 Medical Gas replacement of unsupported and obsolete Medeas medical gas alarm panels	96	34	14	48	33	15	48
		96	**34**	**14**	**48**	**33**	**15**	**48**
POWH	Replacement AHU for AMU	458	321	138	458	0	0	0
POWH	Replacement AHU for Maternity	467	0	0	0	327	140	467
		926	**321**	**138**	**458**	**327**	**140**	**467**
RGH	Replace obsolete Honeywell BMS controllers	642	210	90	300	239	103	342
		642	**210**	**90**	**300**	**239**	**103**	**342**
POWH	Works in the emergency department	918	643	276	918	0	0	0
		918	**643**	**276**	**918**	**0**	**0**	**0**
Maesteg	Remediation works at Bron Y Garn Surgery	200	140	60	200	0	0	0
		200	**140**	**60**	**200**	**0**	**0**	**0**
		6,634	**2,450**	**1,050**	**3,500**	**2,194**	**940**	**3,134**
GRH	Instalation of PV Panels Glan Rhyd Hospital	864	287	123	411	318	136	454
NIAW/W	Instalation of PV Panels NIAW & Williamstown	464	86	37	123	239	102	341
		1,329	**373**	**161**	**534**	**557**	**238**	**795**
HB Wide	Roll out of Voltage Optimisation	65	45	19	64	0	0	0
		65	**45**	**19**	**64**	**0**	**0**	**0**
POWH	Upgrade Drax System to BMS	841	218	93	311	371	159	530
		841	**218**	**93**	**311**	**371**	**159**	**530**
		2,234	**636**	**273**	**909**	**928**	**397**	**1,325**
PCH	Replacement of Detector Heads	232	163	70	232	0	0	0
RGH	Fire Alarm Upgrade	334	234	100	334	0	0	0
GRH	Upgrade Glanrhyd Fire Alarm system	50	0	0	0	35	15	50
		616	**397**	**170**	**567**	**35**	**15**	**50**
HB Wide	Fire Compartmentation Works	1,602	477	205	682	644	276	920
		1,602	**477**	**205**	**682**	**644**	**276**	**920**
		2,218	**874**	**375**	**1,249**	**679**	**291**	**970**
		11,086	**3,960**	**1,698**	**5,657**	**3,801**	**1,628**	**5,429**

Capital and Estates colleagues continue to work together to progress each scheme and in many cases have also appointed consultant experts to assist in scheme design and delivery. By their very nature, each scheme is technically complex and significant external mechanical and electrical engineering expertise is required to ensure appropriately designed schemes are prepared for competitive tender and experienced contractors are appointed to ensure delivery. In some cases however procurement of contractors will be via SQT to ensure compatibility with existing systems and processes (this is particularly the case regarding our fire and BMS systems).

Scheme are monitored on a monthly basis by an EFAB Working Group chaired by the Assistant Director of Estates & Capital. Some additional narrative regarding individual schemes is detailed below:-

It has been agreed with WG that the 4 schemes below will be delivered together to avoid the closure of the POW SCBU unit multiple times.

- POW IPS/UPS
- POW MCPs
- POW AHU for AMU
- POW AHU for Maternity

All four schemes are currently in the design stage and progressing as planned. However, discussions with the service group has noted concerns around the difficulty of securing suitable decant options within the timeframe to allow works to start this summer. The service group, with support from capital planning, produced a high level options paper for Executive Directors to understand the difficulties. The service group are now working with service planning to refine the options and a further paper is being prepared to agree the preferred way forward.

POW Replacement Distribution Boards and POW Replacement HRC Fuse Board schemes have been impacted by the lack of internal operational estates resources necessary to support delivery and have thus been delayed with a resulting reduction in expenditure incurred this year. These issues have now been addressed however and an accelerated programme will be instigated next year.

All Sites Replacement Lift Programme - Due to manufacturing delays this programme is currently behind schedule with a resulting reduction in expenditure incurred this year. Efforts to address this issue are being investigated and it is anticipated that the programme will be back on track next year.

All Sites Roll Out of Voltage Optimisation **-** This scheme has been suspended due to issues surrounding the previous year's installation and a lack of transparency regarding the savings attainable.

Llantrisant Health Park

Ongoing progress is reported through the Programme Board however, key developments are also reported through ECMG around capital spend and progress.

Financial Position

Financial :	
Overall Budget Position	
£3,091,497	CRL Original Funded Position for 23/24
£32,000	Brought Forward funding from 22/23
£1,723,497	Revised CRL Funded Position for 23/24 (31.10.23)
£1,400,000	Funding slipped to 24/25
In Year Position	
£1,723,497	Funded for 23/24
£632,153	Expenditure to 31.01.24
£378,336	Forecast Expenditure to 31.03.24
-£713,009	Current forecast underspend against funding

As can be seen from the table above the programme is now reporting a c £713K underspend against approved funding. This has been agreed and is factored into the financial outturn reporting for 2023/24. The main reasons for the underspend are the delayed delivery date for the mobile MR taking the delivery and expenditure on enabling works and the welfare cabin into April 2024 as well as some delays in design fees caused by the pause whilst the infrastructure review takes place.

Work is ongoing to confirm the level of resource support that will be required on the scheme for 24/25 financial year it is likely that the previously managed £1.4M slippage plus this £0.713M being re-provided will cover the first 5-6 months of cost but further funding will be required and the likely costs are currently being modelled.

The first phase of RIBA 2 works have focussed on detailed surveying of the physical site and buildings. These surveys have identified a number of challenges surrounding floor vibration, building structure strength, plant volume and housing as well as cladding and roof concerns. The result is that the assumptions around refurbishment need urgent review and consideration. An initial meeting with NWSSP-SES has been had which was largely supporting and the Programme team are commencing a detailed options appraisal on the infrastructure options on the site to deliver the maximum amount of clinical space and activity in the shortest timeframe. The preferred way forward is due to be presented at WG IIB update on 28th March 2024.

As mentioned above, there has been a delay to the delivery of the mobile MR and supporting welfare unit largely due to issues associated with planning. The Cardiff MRI is now scheduled to arrive on the 19th April with the modular welfare unit scheduled to arrive earlier that week. The tender package for the enabling works has been let and the site set up has commenced however planning is still outstanding and is being urgently chased. Whilst there are not expected to be

any major issues the wording around some ecology conditions is still being determined. The approval is expected imminently.

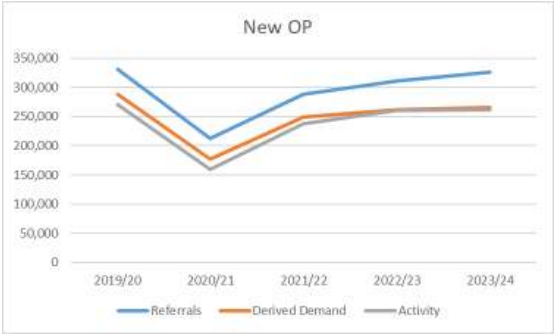
The outcomes of the PAR will be presented to IIB on the 28th March 2024 and an action plan drawn up once the infrastructure plan is confirmed. This is due to the fact that many of the recommendations will be impacted by the determination of the preferred way forward

Elective Productivity

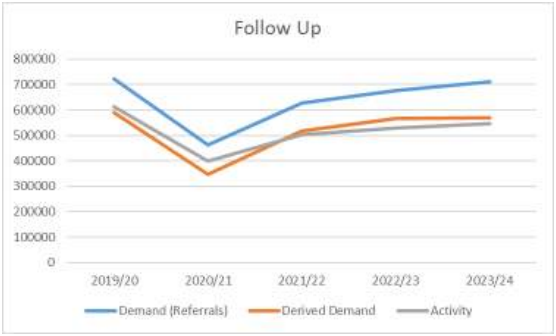
May 2024

Demand and Activity

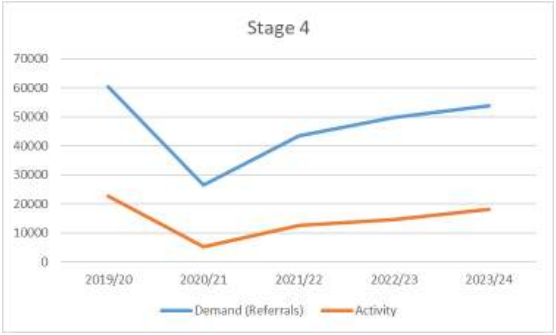
New Outpatients	2019/20	2020/21	2021/22	2022/23	2023/24
Referrals	331,355	212,898	288,676	311,075	326,041
Derived Demand	288,240	176,912	248,698	261,695	265,536
Activity	270,760	159,950	237,490	260,694	261,358



Follow Up	2019/20	2020/21	2021/22	2022/23	2023/24
Referrals	721592	463628	628650	677428	710020
Derived Demand	589635	348323	517182	567714	569160
Activity	614082	398794	503811	530753	547280



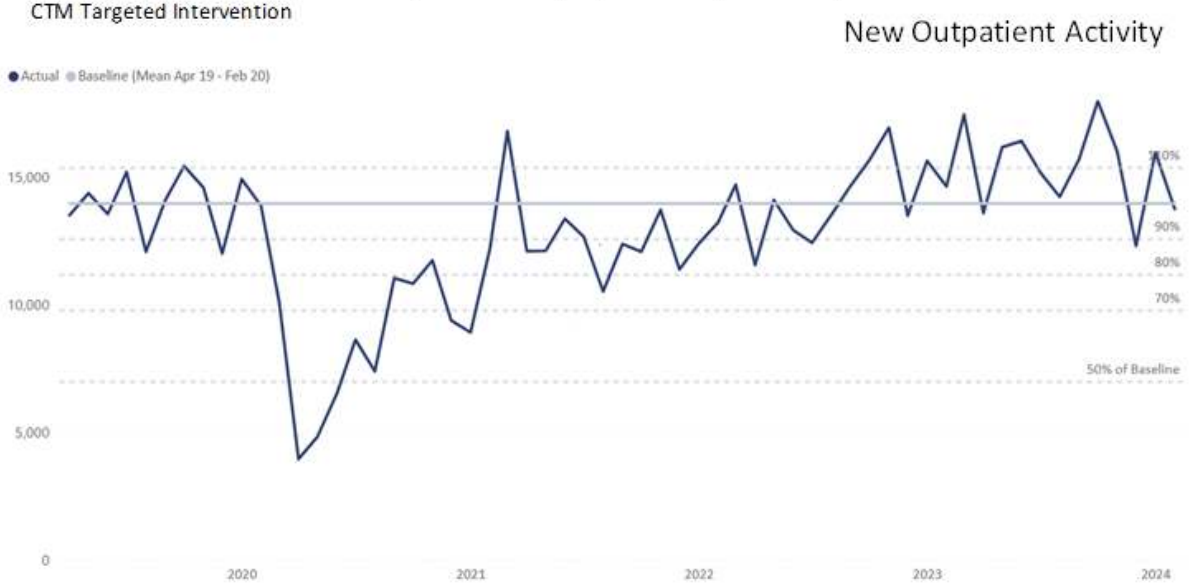
Stage 4	2019/20	2020/21	2021/22	2022/23	2023/24
Referrals	60520	26536	43513	49658	53732
Activity	22733	5182	12551	14583	18115

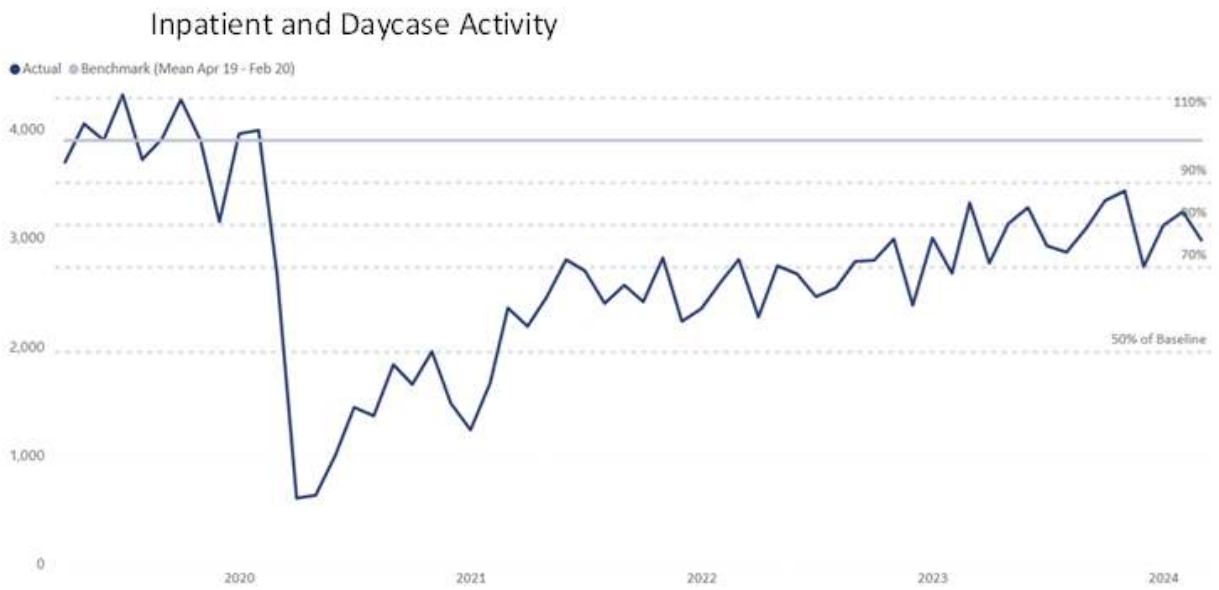


Activity against 2019 Base line

CTM - Activity Levels (against 2019/20)

Last updated on: 10/05/2024 08:50:40
Monthly Outpatient data up to February 2024. Monthly Inpatient & Daycase data up to March 2024
CTM Targeted Intervention





Waiting List Position

Actions taken

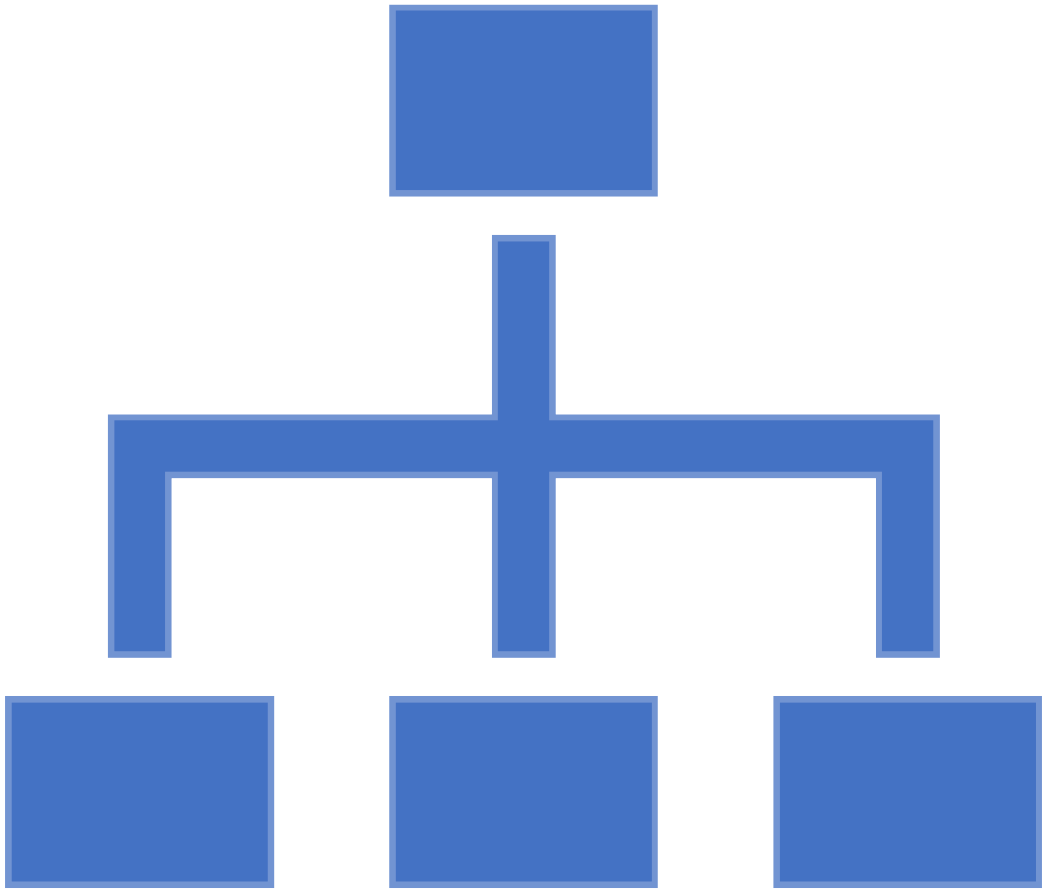
- Re-structure of RTT and Cancer performance meetings
- Establishment of validation team for 'New OP'
- Implementation of 6-4-2 process and Theatre utilisation group
- Move of Orthopaedic arthroplasty from PCH to RGH.
- Ring fenced elective orthopaedic ward at RGH
- Centralisation of the Breast services with the opening of the Snowdrop centre and RGH South Theatre. With the disaggregation of services from SBUHB.

Actions Taken

- GiRFT Reviews
  - Theatres
  - Urology
  - Ophthalmology
  - General Surgery
  - Gynaecology
- All Wales Clinical Implementation Networks established
- CTMUHB ENT service visit to UHW
- Pre-assessment transformation commenced
- Urology improvement group established
- Ophthalmology improvement group established
- Endoscopy weekly performance meeting established
- Regional Ophthalmology activity across SE Wales
- Regional T&O group established across SE Wales

Constraints

- CEPOD and TRAUMA theatre lists maintained on each site post COVID 19
- Strike action
- WPAS across CTMUHB
- Digital enablers
- Demand increase
- Elective bed capacity with emergency pressures



The Productivity Improvement and Transformation (PIT) Programme

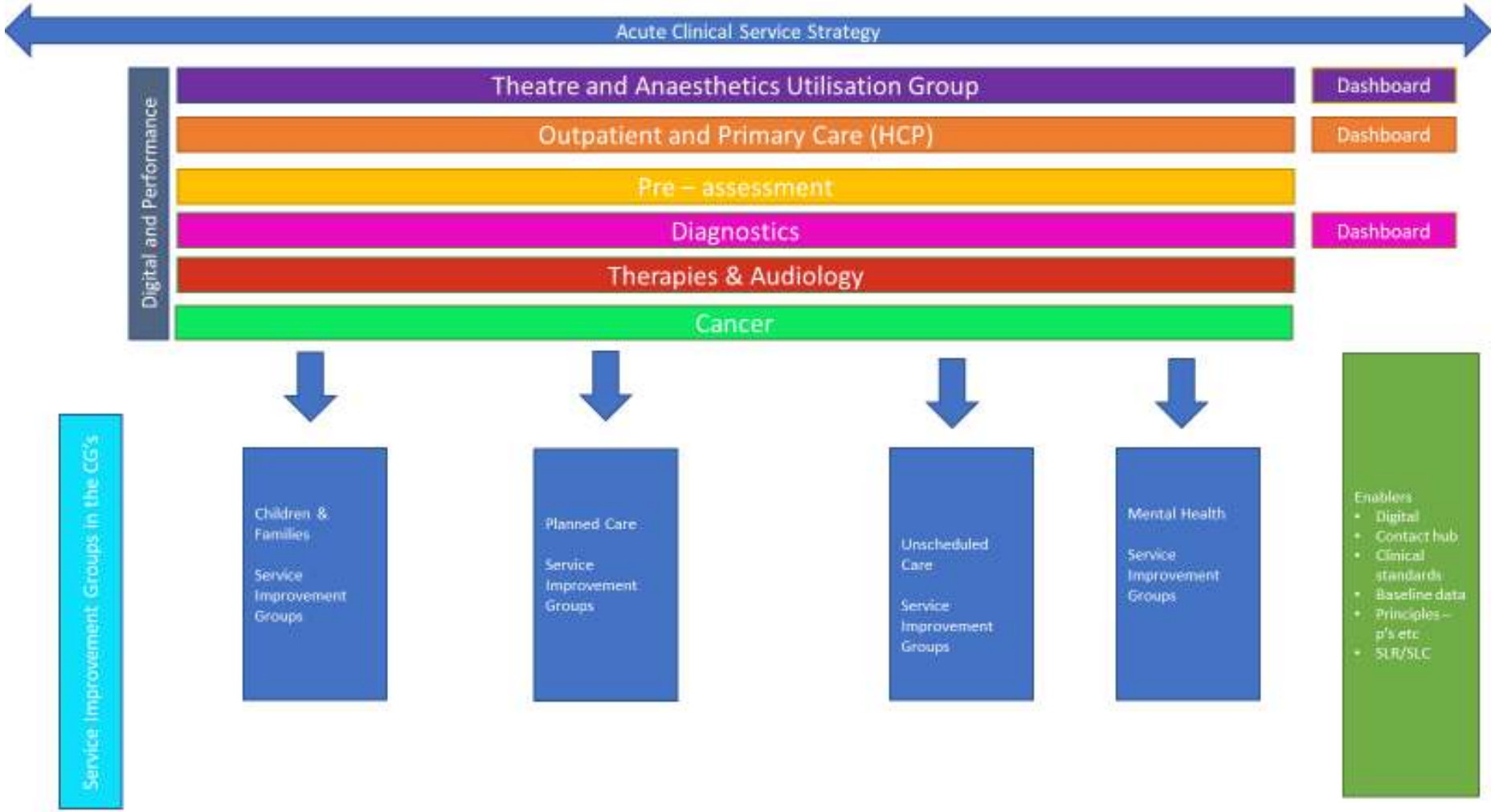
The CTMUHB PIT Programme

Launch of Programme

Programme Objectives

We will establish a Productivity, Improvement and Transformation programme with the primary objective of improving the efficiency and effectiveness of Planned Care and elective services. This will be achieved through optimisation of existing resources, reduction of waste, and working to enhance patient outcomes. All areas of the programme will focus on the following crosscutting themes:

- **Increased efficiency** - streamlining processes to reduce waiting times, eliminate unnecessary delays, and ensure all services are delivered in a cost-effective manner.
- **Enhanced Quality of Care** - ensuring our patients receive the right care at the right time, by sharing best practices, standardising procedures, and improving coordination between services.
- **Optimised resource utilisation** - making better use of the available resource, including staff, equipment, and facilities, to ensure maximum productivity and minimal waste.
- **Improved Patient Outcomes** - focusing on patient-centred care to improve outcomes, satisfaction, and overall experience, whilst ensuring our care is well-co-ordinated and effectively managed.
- **Reduction of Variability** - minimising variations in clinical practices and outcomes by implementing evidence-based guidelines and protocols, delivering consistent and high-quality care.
- **Data utilisation** - using our data and intelligence to pinpoint areas for improvement, regularly monitor key performance metrix and empowering data-driven decision-making to drive continuous improvement
- **Support Workforce Development** - training and supporting our staff to acquire and develop the right skills and knowledge to help implement and sustain necessary changes


Acute Clinical Service Strategy
Digital and Performance
Theatre and Anaesthetics Utilisation Group
Dashboard
Outpatient and Primary Care (HCP)
Dashboard
Pre – assessment
Diagnostics
Dashboard
Therapies & Audiology
Cancer
Service Improvement Groups in the CG's
Children & Families
Service Improvement Groups
Planned Care
Service Improvement Groups
Unscheduled Care
Service Improvement Groups
Mental Health
Service Improvement Groups
Enablers
Digital
Contact hub
Clinical standards
Baseline data
Principles – p's etc
SLR/SLC

3 Key Areas - for 2024/25

Effective Waiting List Management

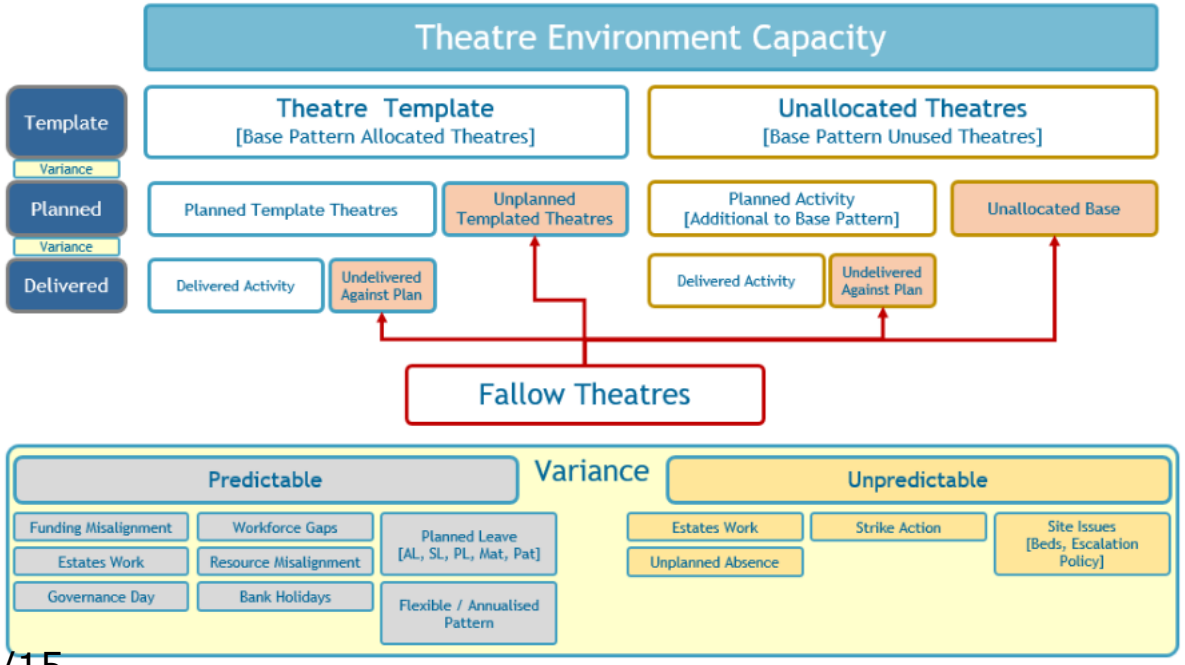
Modernisation of Outpatients and Pre-operative services

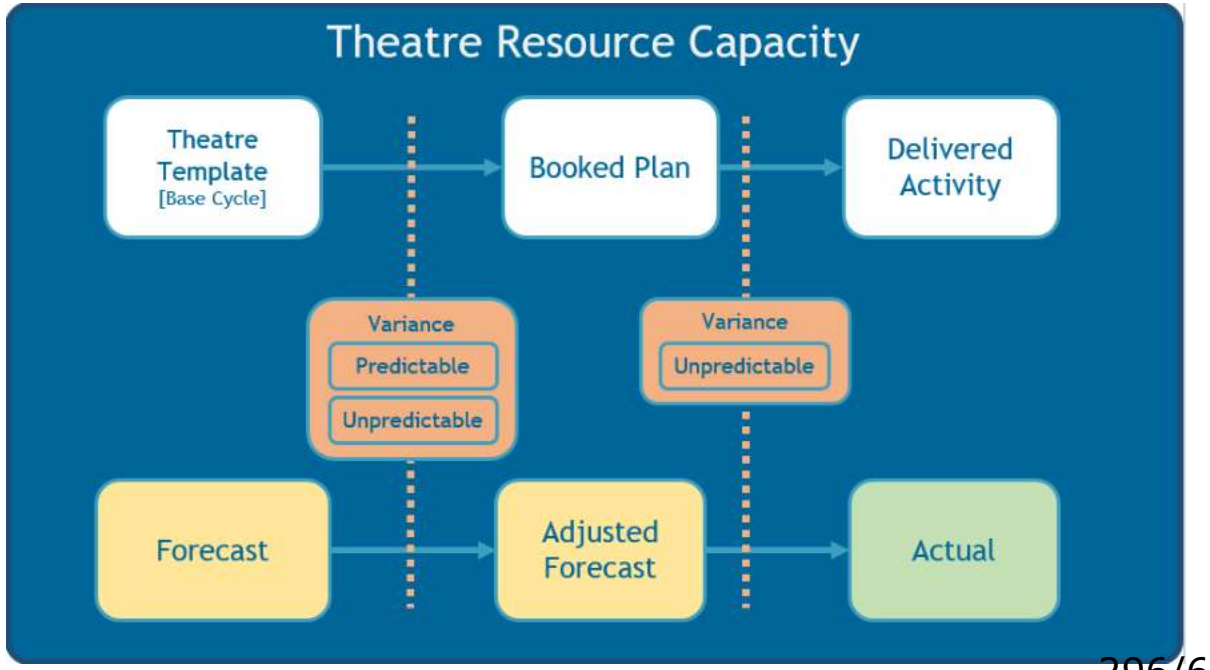
Maximising Theatre Capacity

Increase **Theatre** Productivity by 25%

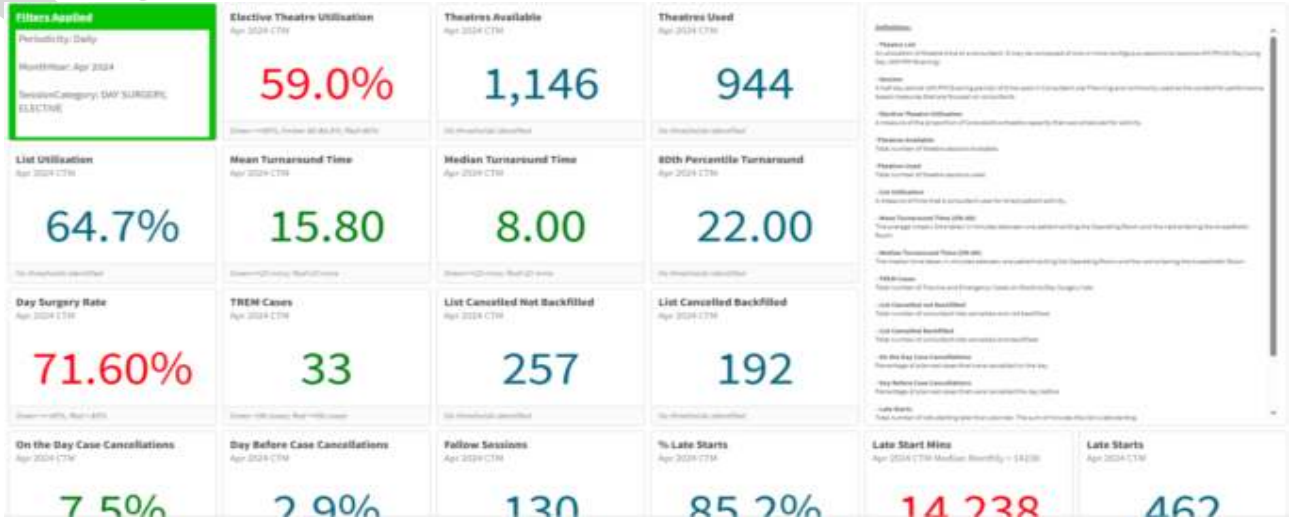
Increase **Outpatient** Productivity by 15%

Next Steps

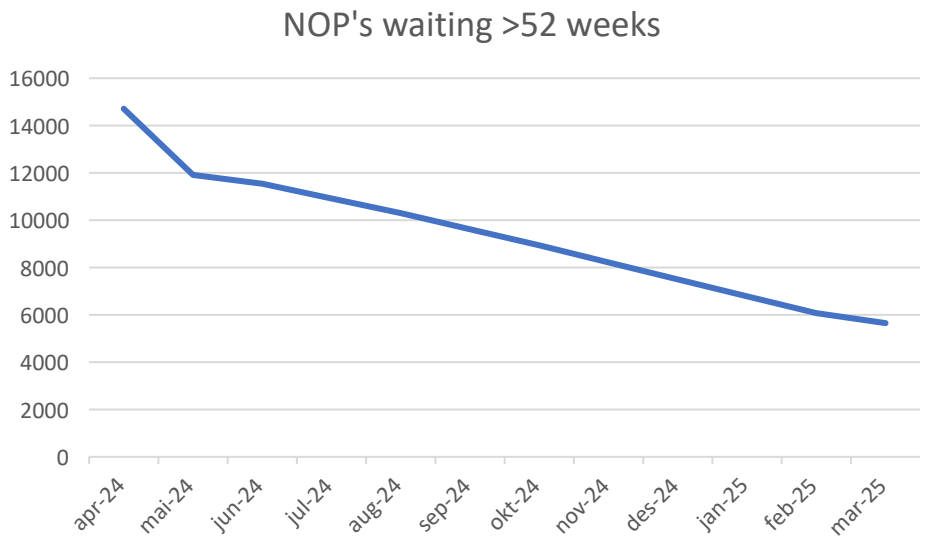

Theatre Environment Capacity
Template
Variance
Planned
Variance
Delivered
Theatre Template
[Base Pattern Allocated Theatres]
Unallocated Theatres
[Base Pattern Unused Theatres]
Planned Template Theatres
Unplanned Templated Theatres
Planned Activity
[Additional to Base Pattern]
Unallocated Base
Delivered Activity
Undelivered Against Plan
Delivered Activity
Undelivered Against Plan
Fallow Theatres
Predictable
Variance
Unpredictable
Funding Misalignment
Workforce Gaps
Planned Leave
[AL, SL, PL, Mat, Pat]
Estates Work
Resource Misalignment
Governance Day
Bank Holidays
Flexible / Annualised Pattern
Estates Work
Strike Action
Site Issues
[Beds, Escalation Policy]
Unplanned Absence


Theatre Resource Capacity
Theatre Template
[Base Cycle]
Booked Plan
Delivered Activity
Variance
Predictable
Unpredictable
Variance
Unpredictable
Forecast
Adjusted Forecast
Actual

Dashboards – Draft with inaccurate non validated data

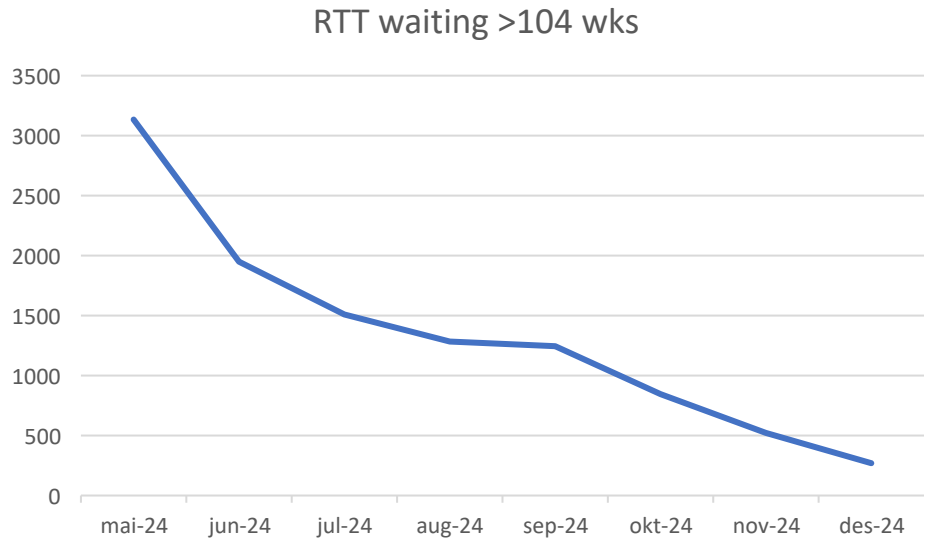


Trajectory (pre productivity gain)



Challenges

- Urology
- Ophthalmology
- Cardiology



Challenges

- T&O

**Neurology C&V reported*

**Neurology C&V reported*

Risks

- Service fragility (workforce) / Clinical Strategy
- Digital enablers Recruitment
- Potential strike action
- Demand management
- Number of areas requiring transformation and reconfiguration
- Regional working
- Pay agreements

Agenda Item
7.1

CTM Health Board

Update on Acute Clinical Services Plan

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Vicki Wallace Deputy Director of Strategy & Partnerships
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser Executive Director of Strategy & Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
CTM Board Development Session	25/04/2024	Discussion

Acronyms / Glossary of Terms	
ACSP	Acute Clinical Services Plan
CTM	Cwm Taf Morgannwg

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:
- Building healthier communities
- Integrated community services
- Acute 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 ACSP.

2. Specific Matters for Consideration

2.1 The Board is asked to consider the presentation attached as appendix 1 to this paper. This presentation provides an update on:
- the approach to engagement and expected consultation processes which will support and enable the delivery of the ACSP;
- the legal context;
- resource needs;
- stakeholder mapping and;
- timeline and next steps

3. Key Risks / Matters for Escalation

3.1 There is a key risk around how the development and delivery of the ACSP 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 ACSP moving forward must be transparent and decision making understood.

3.2 There is a key risk that the resources needed to deliver the ACSP in full will not be available. This relates to finance (capital and revenue), workforce (frontline and support), engagement, estate and digital resources, Realistic resourcing plans will be set out within the ACSP, but experience to date has shown that these may not always be delivered due to internal and external influences.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Sustaining our future Inspiring People
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing Well Living Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below: A Prosperous Wales A Resilient Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Person Centred Efficient Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Will be considered as part of the development of the options

Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Will be considered as part of the development of the options
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	There may be a negative reputational impact on the HB if the delivery of the ACSP is not successful	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	There will be resource implications to the delivery of the ACSP. The options appraisal process will include resource implications.	

5. Recommendation

5.1 The Board is asked to note and discuss the contents of this paper.

6. Next Steps

6.1 The next steps for the development of the ACSP include:
- review of governance processes
- development of leadership team
- understanding of detailed support requirements
- timeline review

CTM 2030
Our Health Our Future
BUILDING HEALTHIER COMMUNITIES TOGETHER

ACSP – delivering next stage
Care Group Launch May 2024

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

Acute Clinical Services Vision

Our Acute 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.

Drivers include demand v future capacity, workforce, quality and financial sustainability (+environment)
Acute driver remains Critical care, for which there isn't even a fully reliable contingency

Work to date

Care group work: Baseline assessment of services and needs

- Comprehensive service line assessment of stability, standards of delivery and risks (Dec 2023)
- Will be updated twice yearly to track impact of mitigations over time (better or need different approach)
- Some feed into IMTP as appropriate

NHS (Wales) Act 2006

S183 Public involvement and consultation

1. Each Local Health Board **must** make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, **involved in** and **consulted on:**
   (a) the **planning** of the provision of those services,
   (b) the **development and consideration of proposals** for changes in the way those services are provided, and
   (c) decisions to be made by the Local Health Board affecting the operation of those services.

Section 242 of the National Health Service Act 2006 extends this requirement to NHS Trusts in Wales

Statute

Health and Social Care (Quality and Engagement) (Wales) Act 2020

- provides the legal framework for the establishment of Llais
- Duty of Quality.

2023 Guidance for NHS organisations on how they can make changes to health services in Wales:

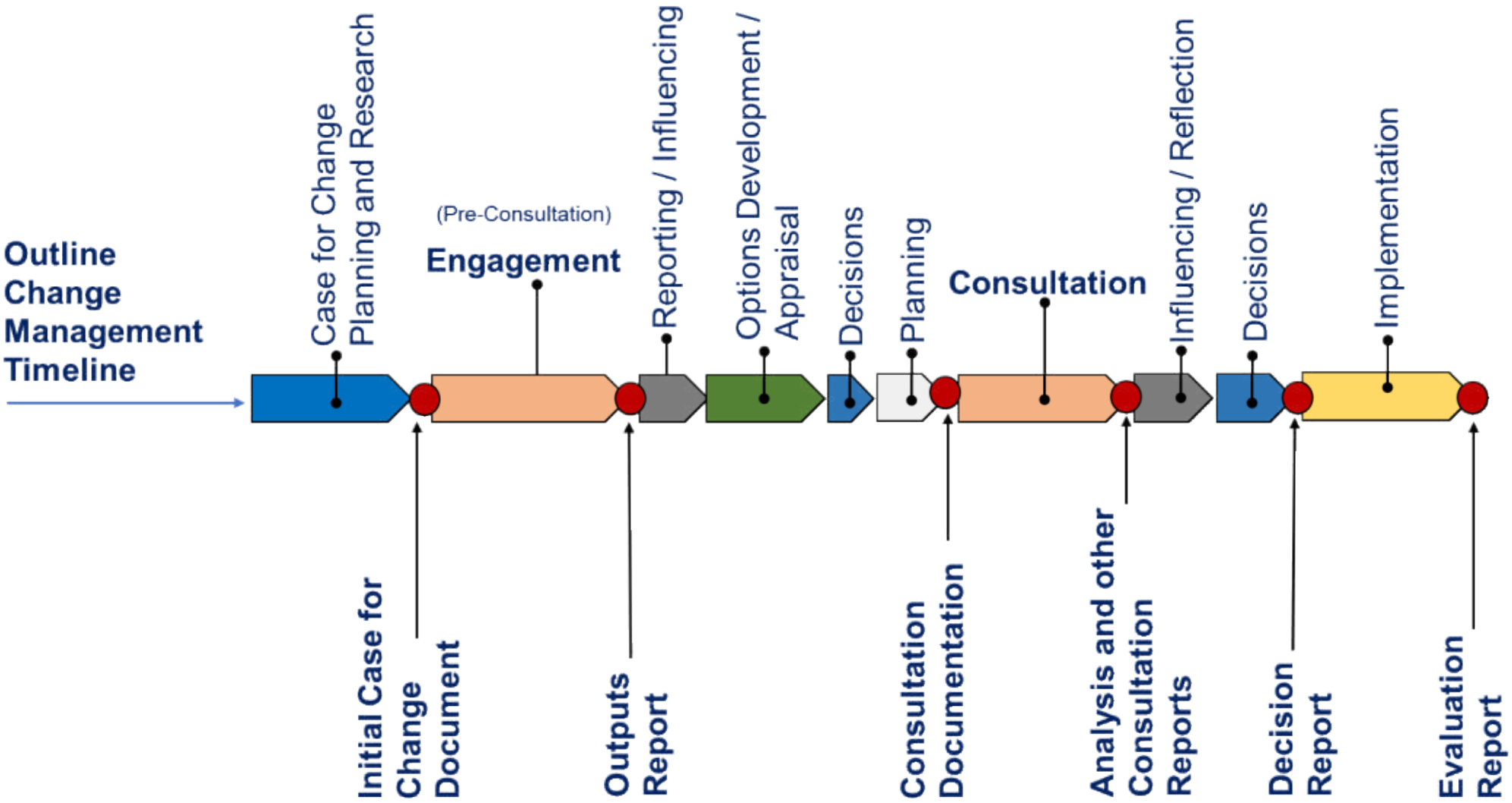
Expectation that NHS service change will be “based on continuous engagement, rather than perfunctory involvement around specific proposals”.

Formal consultation on change proposals will be the exception where proposals for change are ‘substantial’.

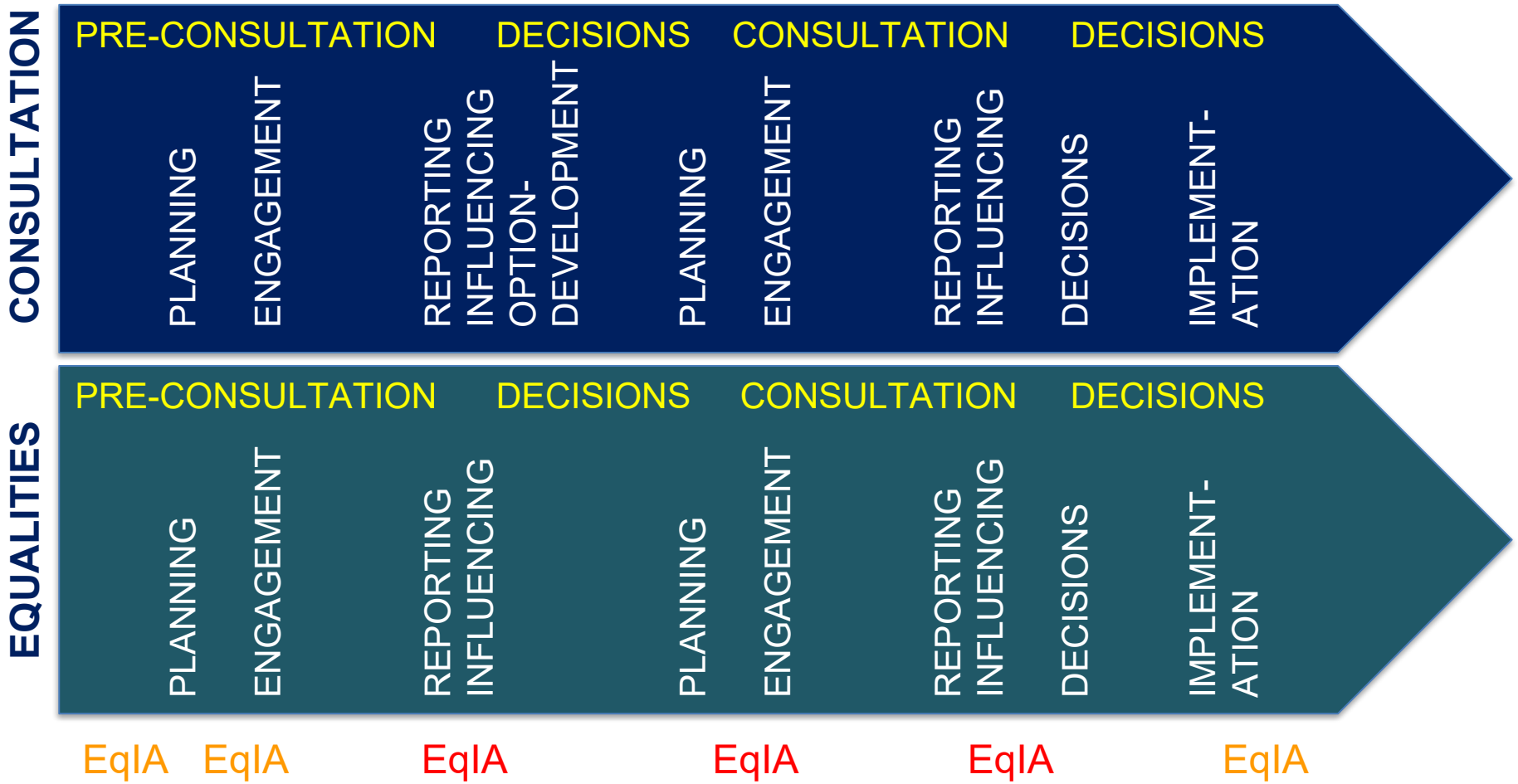
A **two-stage process** for developing and consulting on proposals for substantial change:

1. discussions and explore issues, refine and evaluate proposals, and decide which questions to consult on.
2. a focused formal consultation on fully evaluated proposals lasting a minimum of six weeks.

Engagement Timeline



Statute: Equality Act 2010: PSED Section 149



Common (Public) Law: The Gunning Principles

The Gunning Principles (R ex p Gunning v LB Brent 1985)

1. **Proposals are still at a formative stage**

A final decision has not yet been made, or predetermined, by the decision makers

2. **There is sufficient information to give 'intelligent consideration'**

The information provided must relate to the consultation and must be available, accessible, and easily interpretable for consultees to provide an informed response

3. **There is adequate time for consideration and response**

There must be sufficient opportunity for consultees to participate in the consultation. There is no set timeframe for consultation, despite the widely accepted twelve-week consultation period, as the length of time given for consultee to respond can vary depending on the subject and extent of impact of the consultation

4. **'Conscientious consideration' must be given to the consultation responses before a decision is made**

Decision-makers should be able to provide evidence that they took consultation responses into account

Botched consultation over closure of two schools led Stephen Sedley QC to devise the four **Gunning Principles**

Options Development

Stakeholders contribute to list.

Decisions by experts.
Inclusive communications

Stakeholder contribution to criteria. Internal process.
Open communications

Involve stakeholders.
Inclusive communications

Functional Needs

- Data driven case for change
- International evidence base – setting out of our stall
- Public engagement:
  - public documents – pyramid / accessibility
  - assessment criteria
  - records of all activities and items of feedback
  - EQIAs throughout
  - collate and handle all inputs
  - long list of scenarios
- Integrated activity, finance, estates and workforce model to evaluate long list to short list – ongoing analytics
- Refined future models of care, clinical pathways, population segments / PHM work data integration (demand management to feed into above model):
  - Implement in 1-3 Cluster exemplars
- Agree regional interfaces / impacts / rules of engagement (include WAST)
- Pre-consultation business case – options for potential consultation

Mixture of make and buy

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

Timeline & process - To date

CYNNAL EIN DYFODOL
SUSTAINING OUR FUTURE

YSBRYDOLI POBL
INSPIRING PEOPLE

GWELLA GOFAL
IMPROVING CARE

CREU IECHYD
CREATING HEALTH

Groundwork

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

Internal
- Informal staff group conversations

May – July 2023

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

August – Dec 2023

Continued conversation on process and principles

Undertake baselining work to understand starting point & inform prioritisation

Engagement:
- *CLINCIANS*
- All CTM Staff
- Public
- Politicians
- Partners

Briefings:
- Politicians
- Llais
- Staff
- Regional partners
- Local authorities
- Welsh Government

Governance:
- Exec Leadership Group
- Board

"What Matters" questions

Test of process with Welsh Government, Llais & peers

Jan – March 2024

Digest baseline feedback and pick up outstanding queries with care groups

Develop understanding of key standards and outcomes with care groups

Identify high priority capital requirements; noting constraints

Engage Consultation Institute to develop process for hyper local engagement and risk assessment of engagement process

Engagement:
- *CLINCIANS*
- All CTM Staff
- Public
- Politicians
- Partners

Governance:
- Exec Leadership Group
- Executive Leadership Group Design Authority Meeting
- Board

Suitable input to priority capital programme

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER COMMUNITIES TOGETHER

Timeline & process - Next steps

CYNNAL EIN DYFODOL
SUSTAINING OUR FUTURE

YSBRYDOLI POBL
INSPIRING PEOPLE

GWELLA GOFAL
IMPROVING CARE

CREU IECHYD
CREATING HEALTH

April – June 2024	July – November 2024	December 2024 – March 2025	2025 onwards
Next iteration of baselining, including specific work on priorities, outcomes and standards, influenced by care group workshops Continue work with Consultation Institute to influence approach to engagement Commence and complete work on integrated data model needed for evaluation of future options (patient flow, quality, finance & workforce) Engagement: • *CLINICIANS* • All CTM Staff • Public • Politicians • Partners Briefings: • Politicians • Llais • Staff • Regional partners • Local authorities • Welsh Government Governance: • Exec Leadership Group • Executive Leadership Group Design Authority Meeting • Board	Assume interruption for purdah Agree systematic engagement process ? Engage on Case for Change and success criteria Agree calendar of events Engagement: • *CLINICIANS* • All CTM Staff • Public • Politicians • Partners Briefings: • Politicians • Llais • Staff • Regional partners • Local authorities • Welsh Government Governance: • Exec Leadership Group • Executive Leadership Group Design Authority Meeting • Board	Engagement phase to develop long list of scenarios Establish process for agreement of shortlisted options Engagement: • *CLINICIANS* • All CTM Staff • Public • Politicians • Partners Briefings: • Politicians • Llais • Staff • Regional partners • Local authorities • Welsh Government Governance: • Exec Leadership Group Executive Leadership Group Design Authority Meeting • Board	Undertake process to identify shortlisted options, including phasing of changes ?Identify and consult on shortlisted options Delivery plan Capital considerations Outline business case Full business case

Stakeholder mapping

- Detailing by interest and influence
- Groups and individuals
- Formal and informal
- Ongoing and agile
- Informed by our communities and our staff
- Continuing support from TCI to guide mapping

Next Steps

1. Create suitable leadership team; PD, PMO
2. Detailed specification of support requirement, true cost and option appraisal of split of 'make or buy' + Clearly identify directorate leads with dedicated capacity to work on this / quantify backfill
3. Procurement advice
4. Review governance for CTM 2030 esp ACSP
5. Review timelines again

Agenda Item
7.2

CTM Health Board

Tackling Type 2 Diabetes in CTM

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not applicable
Awdur yr Adroddiad / Report Author	Diane Gibbons -Principal Public Health Practitioner
Cyflwynydd yr Adroddiad / Report Presenter	Philip Daniels – Executive Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Philip Daniels, Executive Director of Public Health

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Diabetes Clinical Planning Group Members	Click or tap to enter a date.	ongoing

Acronyms / Glossary of Terms	
AWDPP	All Wales Diabetes Prevention Programme
NDA	National Diabetic Audit
DESW	Diabetic Eye Screening Wales

1. Situation /Background

1.1 Following on from the September 2023 Board development session, the purpose of this report is to update the board on the current situation and progress made against the potential opportunities for improvement and any challenges met within the areas of type 2 diabetes prevention, identification and management.

1.2 Between 2009/10 and 2021/2022 the number of individuals diagnosed as diabetic, in Wales increased by 40%. Prevalence is predicted to continue rising. Diabetes is associated with the risk of a number of complications, increased healthcare needs and increased likelihood of premature mortality. It is estimated that 10% of the NHS Wales budget is spent on people with diabetes.

1.3 90% of individuals with diabetes are classified as Type 2. A number of the risk factors associated with Type 2 disease are modifiable. It is estimated that around half of type 2 diabetes could be avoided with lifestyle changes to achieve healthy weight, a better diet and increased activity.

1.4 'Pre-diabetes' occurs when blood glucose is above normal but below the threshold for a diagnosis of diabetes. 'Pre-diabetes' is a high-risk state for developing type 2 diabetes. It is difficult to accurately predict the true prevalence of pre diabetes within our community as many individuals within the pre diabetic range are asymptomatic and may go undetected for a long time. Audit plus data available via the Primary Care Information Portal provides an indication of the scale of known cases and their management. During December 2023, 15,593 adults in CTM (3.29% of our adult population) were coded as having a diagnosis of pre diabetes with new patients being identified each week. It is estimated that the true total number of pre diabetics in CTM UHB including all undiagnosed cases, would far exceed this.

1.5 The current position has led to a call for action with Public Health Wales working with partners nationally and at Health Board level to develop and roll out the 'Tackling Diabetes Together Programme'. This programme will complement and support the various improvement workstreams already underway in CTM. The programme enables some aspects such as provision of evidence base, data analysis and campaign development to be done centrally on a once for Wales basis while other aspects such as the recent behavioural systems mapping workshop in CTM, will be piloted in one Health Board with learning shared across all.

1.6 In addition to the national focus on Type 2 diabetes, CTM has identified management of type 1 and gestational diabetes as priority areas for improvement. This is out of scope for this report but funding and resource implications need to be considered as part of the whole diabetes approach. Work includes looking at use of cloud care technology and adoption of NICE guidance on sensor augmented pump therapy to improve outcomes for individuals with Type 1 diabetes. Antenatal approaches include working with community partners to increase pre conceptual awareness and use of GDM software to improve monitoring during pregnancy.

1.7 For type 2 diabetes there are 3 main overarching objectives: -

- Preventing poor outcomes through effective diabetes care
- Preventing onset of type 2 diabetes in those with modifiable risk
- Preventing onset of modifiable risk factors for Type 2 diabetes

Together these support all cohorts across the diabetes pathway, covering primary and secondary through to tertiary prevention approaches. They are underpinned by a further 3 workstreams focusing on workforce development, communication and engagement and monitoring, analysis, research and evaluation. Both use of behavioural approaches and maximising technology to improve outcomes are also key components of this work.

Appendix 1 contains an outline of key action areas across the pathway

1.8 While diabetes is a concern across Wales, the scale of challenge in CTM is considerable
We have the second highest prevalence of diabetics of all Welsh Health Board areas with 8.59% of adults in CTM UHB registered as diabetic. 68% of adults in CTM are overweight or obese with childhood obesity amongst the highest in the UK.
CTM has a higher percentage of more deprived areas than other Health Board areas in Wales which has a clear association with poorer health outcomes.
Changing Health Board boundaries with the inclusion of Bridgend into the Health Board footprint together with ongoing restructuring has left differences and gaps in practice across sites adding to inequities in service provision.

2. Specific Matters for Consideration

The approach for tackling diabetes has a variety of components. Key challenges/opportunities are outlined in table 1 below: -

Table 1

Challenges/ Opportunities	Current Position
Development of systems wide working to help build healthier environments and tackle obesity	The whole Systems Approach (WSA) to healthy weight within CTM is entering its third year. Good engagement has been achieved with those stakeholders holding power over the drivers of obesity within CTM. A full progress report will be presented to the Creating Health Board as agreed. Next steps planned for completion in 2024-25 include further collaboration with stakeholders and the development of a regional joint action plan to design and deliver the healthier communities in CTM where it will be easy for children to grow up to be a healthy weight.
Insufficient weight management support for children and young people	Level 1 provision in the form of the 'Henry' and 'Pipyn' programmes supports healthy lifestyles for ages 0-5 and 3-7 respectively, but there is limited coverage across CTM, short term funding and no provision for older children. CTMUHB does not currently have a level 2 multi-component or level 3 specialist MDT weight management services. (High risk ID: 5579)

	The case for an integrated children's service has been presented at both the Creating Health and Improving Care Boards, where it was positively received. The case has now been submitted to the Children and Families Care Group for consideration.
Insufficient weight management support for adults	The adult weight management pathway continues to be developed. The increasing demand and lack of capacity means there is a considerable waiting list of >1600 people for Level 3 weight management services as of April 2024. Service changes have enabled significant change from the original level 3 model, resulting in a 150% increase in level 3 capacity (100 to 250). This has been achieved without any increase to the establishment budget and through the development of a Level 3 Group programme "HEADSTART" as an initial intervention. Despite this increased capacity, the service does not meet the Welsh Government performance target, to provide a Level 3 service to 0.5% of eligible patients (CTM = 467 patients). (Health Board High Risk Score 20 - ID 5462) New Welsh Government Circular guidance in relation to private bariatric patients is likely to further increase demand for the service. A further issue is the lack of a medication budget to fund Semaglutide, the recommended NICE treatment for obesity alongside a calorie reduced diet and increased physical activity for which the majority of level 3 patients are eligible. An SBAR has been produced and presented to the Access to Medicines Committee. There is a business case in development for the expansion of the level 3 service including additional budget to support medication in line with NICE Technical Appraisal TA875.
Limited symptom and risk awareness amongst population	PHW will develop a number of campaigns as part of the national workplan. Exploration of screening opportunities and corresponding evidence base to be undertaken
Considerable pre diabetic cohort of patients within CTM, at high risk of developing diabetes	CTM has received confirmed funding until March 2025 from AWDPP. The SPPC funding in CTM has committed annual funding of £409k until March 2026 for pre diabetes/obesity. A full situation report and option appraisal has been undertaken with the decision to combine the two existing services to create a single programme, operating to a single AWDPP based service specification. This will provide coverage across all cluster areas with an increased annual patient capacity of 5880, plus some additional weight management capacity to support onward referral. Service development looks promising but challenges of temporary funding remain, particularly regarding recruitment.
No provision of a remission service	The Wales pilot service has shown initially promising results leading to development of a business case for a local service based on an offer to 10% of newly diagnosed annually (144 patients). No funding has been identified to date.

Not all patients receive a structured education programme in first 12 months post diagnosis	All referrals for Type 2 Diabetes structured education are now triaged by nutrition and dietetics via a single point of access. In the last 8 months, significant progress has been made in reducing referral to treat times as part of COVID recovery and all patients are now offered Type 2 education in line with the national pathways and within the 14-week therapy RTT. Uptake is running at 25-40%, although it is hoped this will improve with shorter waiting times and an increased focus on engagement. All people referred for Type 2 Diabetes Structured Education are provided with access to a range of online resources including 'My DESMOND' which has been funded by the National Diabetes Network. However, funding will cease from November 2024 with the expectation that Health Boards will identify local funding routes. Although out of scope for this paper it should be noted that there is insufficient resource to deliver Type 1 education which applies to DAFNE for adults (especially in Bridgend) and SEREN for children and young people.
Considerable % of patients not achieving National Diabetic Audit (NDA) care processes and treatment outcomes	This is a key priority for the national PHW programme in looking at improved data provision and monitoring and the use of behavioural science to improve uptake and compliance. CTM is working with them on this aspect, with an initial workshop held in April. Improving achievement of these targets will feature in the diabetes component of the Community Health pathways national development work. 16 diabetes pathways covering different aspects of care are due for review nationally during 24/25. These will then be localised by the CTM team and made available to clinicians across the Health Board
Improvement of pathways and services for early recognition and management of complications	There are a number of VBHC pilots addressing this aspect particularly for foot and eye care. Greater resource will be required for UHB wide rollout of successful elements. Links have been established with the Programme Lead for DESW to increase referral into and uptake of diabetic eye screening.
Often poor patient engagement/compliance Need for improved patient feedback mechanisms	There are no qualified psychologists funded to work with young adults / adults diagnosed with diabetes and there is a need for posts to be integrated within diabetes teams. A business case has been developed but no funding identified to date. Staff working in weight management and diabetes have received motivational interviewing and Bridges training to support people with health behaviour change, enabling self-management and promoting shared decision making. Learning from pilot work in CTM around behavioural systems mapping can hopefully be applied across a range of service provision to improve wider communication and patient engagement and compliance. Mental health support was raised as a regular need by diabetic specialist nurses during the initial workshop event. Mechanisms for further patient feedback into this work is being explored.

	Issues related to access and uptake are being explored by use of an equity toolkit with patients in Merthyr via Pre diabetes services. Again, learning will be relevant to many aspects of care and shared wider. Similarly, a qualitative patient experience evaluation has been undertaken with Cardiff Met with feedback being incorporated into planning the new single Pre diabetes Service The Therapies PREM is being implemented across services, PROMS are planned to be recorded in line with the Minimum Data Set for Weight Management Services when new PROMs system available. XPERT outcomes are recorded and benchmarked nationally
Technology opportunities not being fully maximised	Considerable potential for digital efficiencies in care processes such as digital self-referral and self-booking. Other changes being explored include: - Adding a specific Diabetes DATIX to all Wales DATIX system Improvement of WISDM use for Type 1 patients

3. Key Risks / Matters for Escalation

Effective diabetes prevention presents the challenge of needing to invest upstream to make a real difference while still having to care for those already in advanced stages of disease. A degree of improvement can be achieved by working differently but unless there is some shifting of resource towards primary and early secondary prevention the challenge of diabetes will continue to escalate.

The key risks to the Health Board failing to meet its objectives are: -

- Potential loss of partner commitment to support system wide working around healthy environments and tackling obesity in current economic climate.
- Insufficient capacity of weight management support across the life course preventing timely care.
- Short term funding of successful approaches such as the All-Wales Diabetes Prevention Programme creating instability and recruitment issues that adversely affect delivery and restrict development of effective pathways.
- Potential limited success in utilising improved access and behavioural approaches to improve engagement and compliance, through lack of operational resource to push through and monitor changes in practice.
- No funding identified to deliver psychological interventions or the offer of remission services despite these being identified in the WG Quality Statement for diabetes as key components of a good service.
- Insufficient and incomplete coverage of services for early recognition and management of complications

4. Assessment

Objectives / Strategy

Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies, please list below: Improving Care Inspiring People
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Choose an item.
	If more than one applies, please list below: Growing Well Living Well Aging Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies, please list below: Whole Systems Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Choose an item.
	If more than one applies, please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Various pathway components will undertake as appropriate
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken an Equality Impact Assessment Screening?		Various pathway components will undertake as appropriate
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Via failure to achieve expected standards of care	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Detailed resource requirements will be developed for future discussion	

5. Recommendation

That Board supports the above package of work.

6. Next Steps

- Identify key areas for more detailed discussion and agreement at Diabetes Board Development Day on 27 June 2024
- Use the Director of Public Health Report this year to highlight the issues around diabetes and raise awareness and support for the changes that need to be put in place to halt the increase in cases and optimally manage those with identified risk/disease.
- Continue to explore potential funding opportunities to allow expansion and piloting of key services as outlined in section 3 for weight management, education and monitoring services, remission and psychology services.
- Ensure collaboration with all stakeholders nationally and central coordination and oversight of activity across the whole pathway at a UHB level to maximise resource, expertise and learning. The mechanism for this to be identified by Diabetes Clinical Planning Group.
- Utilise the learning from the behavioural systems mapping event and behavioural science evidence base to identify areas for action and different approaches to working.
- Prioritise optimal use of data/health intelligence to target action most effectively and monitor progress and return on investment
- Feedback issues of short term funding to Welsh Government and national working groups

Appendix 1 Patient Cohort	Key Action Areas
Population wide - Diabetes risk reduction across lifespan	System wide working to help build healthier environments and tackle obesity Access to good quality food (to include increasing breastfeeding initiation and continuation)/Design of and access to community spaces A strong focus on children and young people
Patients with known risk factors but no diagnosis of pre diabetes/diabetes	Increasing public awareness of diabetes risk Improving 'at risk' patient identification and screening. Provision of a children and young person's service and expansion of adult weight management services
Known Pre diabetics diagnosed by blood testing **HbA1c 42- 47mmols**	Continued development and expansion of Pre-Diabetes Programme offer Improve uptake and target greatest need Adequate provision of weight management support
All newly diagnosed diabetics	Increasing capacity and uptake of structured education programme Adequate provision of weight management support Provision of psychology support as required
Newly diagnosed diabetics with potential for remission (up to 6 years post diagnosis)	Exploring the provision of a remission service in CTM

Patients on Type 2 diabetic registers **Routine Care**	Improving annual uptake of the 8 National Diabetes Audit Care Processes Increase achievement of 3 treatment targets related to BP, HbA1c and cholesterol Implementing diabetic element of Community Heath Pathways Project
Patients on Type 2 diabetic registers **Treatment of complications**	Early recognition and effective referral pathways to further investigation/treatment Adequate best practice service provision
Care for unscheduled admission/surgical intervention	UHB wide protocols in place to ensure appropriate care of diabetic patients irrespective of speciality/service accessed

Agenda Item Number: 8.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University Health Board (CTMUHB) held on Thursday 28 March 2024 as an In Person meeting at Yr Hwb, Royal Glamorgan Hospital Site, Llantrisant (also Broadcast Live via Microsoft Teams)

Members Present:

Jonathan Morgan	Chair
Paul Mears	Chief Executive
Kath Palmer	Vice Chair
Patsy Roseblade	Independent Member (Virtual attendee)
Geraint Hopkins	Independent Member
Carolyn Donoghue	Independent Member
Ian Wells	Independent Member
Dilys Jouvenat	Independent Member
Helen Lentle	Independent Member (in part)
Nicola Milligan	Independent Member
Lynda Thomas	Independent Member (Virtual attendee)
Greg Dix	Executive Director of Nursing/Deputy Chief Executive
Linda Prosser	Executive Director of Strategy & Transformation
Dom Hurford	Executive Medical Director
Sally May	Executive Director of Finance
Gethin Hughes	Chief Operating Officer
Sally Bolt	Associate Member

In Attendance:

Stuart Morris	Director of Digital
Simon Blackburn	Director of Communications, Engagement and Fundraising
Matthew Butt	Chief of Staff
Gareth Watts	Director of Corporate Governance / Board Secretary
Helen Watkins	Deputy Director for People
Ceri Bear	Llais Cymru Representative (Observing)
Elizabeth Stevenson	Llais Cymru (Observing)
Adam Cooke-Young	Clinical Practitioner (In part)
Matt Jenkins	Regional Integration Director
Jonathan Arthur	Consultant Clinical Scientist (Observing)
Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings were also **noted** by the Chair.

1.2 Apologies for Absence

Apologies for absence had been received from:

- Mel Jehu, Independent Member;
- Lauren Edwards, Executive Director of Therapies & Health Science;
- Philip Daniels, Executive Director of Public Health;
- Hywel Daniel, Executive Director for People;
- Lisa Curtis-Jones, Associate Member;
- Anne Morris, Associate Member
- Daniel Price, Regional Director, Llais Cymru

1.3 Declarations of Interest

No Declarations of Interest were noted prior to or during the meeting.

2. CONSENT AGENDA BUSINESS

The Chair asked members if there were any items from the consent agenda that Board Members wished to bring forward to the main agenda for discussion. There were none.

3. SHARED LISTENING AND LEARNING

3.1 Listening & Learning Story

A Cooke-Young presented the listening & learning story which related to Acute Frailty and Care of the Older Person and the Patient Hospital Journey.

The Chair extended his thanks to Adam for sharing the presentation, which he had found to be powerful and added that he found it harrowing to see the impact the entirety of our system had on individuals who are entering the last period of their lives. The Chair advised that a number of these messages would resonate with the work undertaken by Executive colleagues in trying to identify opportunities for improvement and ways to address the significant challenges within the health system, in addition to the services that held the statutory responsibility for delivering social care services.

C Donoghue advised that this story had also been shared at the Quality & Safety Committee, and added that she had found the story to be just as powerful on hearing it for the second time. C Donoghue queried whether this story could be shared in joint meetings with social care to create an opportunity

for raising awareness of the impact discharge delays had on patients and their families in regards to quality of life.

G Dix extended his thanks to A Cooke-Young for sharing the heart-breaking story and advised that there were many patients who were sadly in a similar position. G Dix agreed that the harm being caused to patients who were deconditioning as a result of discharge delays needed to be recognised and added that discussions had been held with Welsh Government and NHS Executive Colleagues as to how the harm event could be properly measured for patients who were deconditioning across the Health Board. G Dix advised that the Board would be happy to commit to trying to resolve the issues identified.

G Hughes welcomed the presentation and advised that whilst there is a perception in place that hospitals are safe places, hospitals are not safe places if a patient is not sick. Indeed, a hospital can be one of the worst places to be if there is no need for a patient to be in hospital, given the risks of infection, deconditioning and mental wellbeing. G Hughes added that it was often safer for an elderly patient to be supported at home and added that there was a need to have conversations with Health Board staff and partners as to how appropriate and respectful care could be provided to frail/elderly patients.

I Wells advised that he found the presentation to be moving and questioned how the Board are learning from some of the issues that have been identified and how the Board will be taking forward the ideas that had been identified to address the position. I Wells added that it would be helpful if the Board could be provided with an update on progress at a future meeting.

P Mears advised that a presentation would be shared later on the agenda in relation to the challenges being experienced regarding flow of patients through the hospitals and added that he had recently raised his concerns with the Chief Executives of the three Local Authorities.

P Mears stated that there were initiatives identified within the presentation that could be taken forward. He added that in the short term, consideration needed to be given as to how to make the experiences of patients as good as possible whilst they are awaiting discharge. He also highlighted the fact that there are some really good examples across sites being put into place to improve patient experience. Members noted that previous discussions had been held in relation to alternative workforce models and upskilling and redesigning the roles of Healthcare Support Workers to support patients as they await discharge.

P Mears suggested that a piece of work would need to be undertaken over the next four to five months to develop a plan which identified how issues could be addressed prior to the next winter period. P Mears suggested that an update was presented to the May Board meeting which identifies the proactive changes that would be undertaken to alleviate some of the issues outlined within the presentation.

L Thomas advised that she felt this situation was unacceptable and added that she felt like action now needed to be taken to address the position. L Thomas advised that she had recently witnessed some good models in place within the Health Board, including a Ward at Ysbyty Cwm Rhondda which was Healthcare Support Worker based, and questioned whether this model could be replicated in other ward areas within the Health Board. L Thomas added that she had witnessed within another NHS organisation two full wards being dedicated to frail elderly patients and questioned whether this was something that could be considered by the Health Board, in addition to some of the virtual ward step up initiatives that had been set up in NHS England.

G Hopkins advised that he found this position to be outrageous and had been an issue for some time and had been discussed on a number of occasions both regionally and nationally. G Hopkins added that this issue could not be addressed by the Health Board or Local Government in isolation. Instead, he advocated a joined up approach is required, alongside significant reinvestment in lower level community provision, which would relieve pressure on hospitals, improve patient flow and would positively impact the residents within the Health Board's communities. G Hopkins advised that he would strongly encourage colleagues at a regional level to revisit some of the initiatives that had been undertaken in the past in regards to preventing admission to hospital and enabling faster discharge. G Hopkins added that the length of time taken to allocate a social worker was unacceptable and advised that it needed to be recognised that every single sector within our society was under significant pressure, which needed to be addressed urgently.

The Chair advised that he and the Chief Executive (P Mears) would be attending a full council meeting with Rhondda Cynon Taf County Borough Council, and he would be happy to share the story, if appropriate, as an example of the system issues that were being experienced, where it was hoped that a commitment would be made to addressing the unacceptable position.

P Mears advised that he accepted and agreed with all the comments that had been made.. P Mears added that there were opportunities to consider the skilling up of more Trusted Assessors within the Health Board who would be able to assess patients who did not require a highly qualified and experienced Social Worker, which would help to address the issues in relation to delayed discharges.

P Mears made reference to some good examples of initiatives that were being undertaken within the Health Board, for example, the Stay Well at Home Team in Rhondda Cynon Taf and Merthyr Tydfil, and advised that steps needed to be taken to create more capacity within these Teams to enable more patients to be discharged more quickly.

L Prosser advised that she welcomed the ideas shared by A Cooke-Young during his presentation in relation to some health related actions that could be undertaken to address the position and advised that she would be happy to link A Cooke-Young into the joint Local Authority and Health Improving Discharge Programme so that his ideas could be shared.

N Milligan advised that she had found this story even more powerful on the second time of hearing it and questioned whether consideration could be given to revisiting the trial that was previously undertaken in relation to rotating Healthcare Support Workers between acute settings and social care which would hopefully help to develop and retain staff and make them feel more valued. N Milligan advised that a high number of applications were received when the Health Board recently advertised for Healthcare Support Worker roles. P Mears advised that this could be explored further with social care partners and added this would help to provide staff with career development in addition to providing additional capacity within community settings.

D Hurford advised that he supported all comments that had been made and added that in addition to physical deconditioning, consideration also needed to be given to the impact of mental deconditioning of patients, which was equally as important to address.

The Chair extended his thanks to A Cooke-Young for sharing the presentation and provided reassurance that work was being undertaken to address the issues identified. P Mears added that there were two presentations which would be received later in the meeting which would identify common themes and suggested that contact was made with A Cooke-Young following the meeting to involve him in some of the work being undertaken. P Mears suggested that a small focus group needed to be established and charged with developing proposals which would identify the actions being taken to mitigate the issues identified, and presented to the Board at its May meeting.

Resolution: The Listening & Learning Story was **NOTED**.

Action: Update to be presented to the May Board meeting which identifies the proactive changes that would be undertaken to alleviate some of the issues outlined within the presentation.

4. SETTING THE SCENE

4.1 Chair's Report

The Chair presented the report and highlighted the key matters for Members attention. The Chair advised that since the report had been drafted, the new First Minister had now formed his new administration, with Eluned Morgan being re-appointed as Cabinet Secretary for Health and Social Care, Dawn Bowden being appointed as Minister for Social Care and Jayne Bryant being appointed as Minister for Mental Health and Early Years. The Chair advised that the continuity of cabinet rank in regards to the Health Minister was helpful and added that a series of meetings would held over the next few months to discuss the areas of work being undertaken by the Health Board and some of the challenges that needed to be addressed, particularly within Social Care.

The Chair advised that Rachel Rowlands would commence her role as the new Independent Member for Community on 1 April 2024 and added that he wished

to extend his thanks to M Jehu for the support he had provided to the Board as an Independent Member over the last eight years

Resolution The Board **NOTED** the report and **ENDORSED** the Affixing of the Common Seal.

4.1.1 Action Log

The Chair presented the action log.

Resolution The Action Log was **NOTED.**

4.2 Chief Executive's Report

P Mears presented the report and highlighted the key matters for Members attention.

The Chair made reference to the Corporate Parenting Charter and advised that he felt it was appropriate that the Board signed up to this as there were areas that the Board could support with, for example the ambition that was already in place to support young people into employment.

In relation to the Emergency Medical Retrieval and Transfer Service, the Chair advised that a Board meeting would be held on Tuesday 9 April to receive an update on the development of the work that was being taken forward over the next couple of weeks. He added that this would be a matter that the new Joint Commissioning Committee (JCC) would need to take a decision on, given it had delegated function from the seven Health Boards in relation to this. The Chair advised that he understood that the Health Board would not be required to take an individual decision on 9 April, and would only need to consider the updates provided and the particular impact any changes would have for the Health Board's population. The Chair added that the Health Board had a statutory duty for the health of its population, with no collective statutory responsibility for other parts of Wales.

Resolution: The report was **NOTED**
The sign up to the Corporate Parenting Charter was **APPROVED**

5. GOVERNANCE, RISK AND ASSURANCE

5.1 Board Committee and Advisory Group Highlight Reports

5.1.1 Quality & Safety Committee Highlight Report 23 January 2024

C Donoghue presented the report and highlighted the matters contained within the alert/escalate section. Members noted that a detailed discussion was held in relation to the presentation that had been shared with the Board at the meeting today, assurance had been provided that work was being undertaken to mitigate any risks relating to the Right Care Right Person initiative and noted that the Committee continued to keep a focus on Sepsis. C Donoghue advised

that the Committee had noted the continued positive development of the Care Group Highlight reports which were more succinct and noted the continued improvements in the development of the Organisational Risk Register reports.

Resolution: The report was **NOTED.**

5.1.2 Digital & Data Committee Highlight Report 21 February 2024

I Wells presented the report and highlighted the matters contained within the alert/escalate section. Members noted that significant progress had been made to address the 35 recommendations that had been made by the Information Commissioners Officer (ICO), with confirmation now received from the ICO that they consider the audit engagement process to be closed. Members noted that an action plan remained in place. I Wells advised that the Committee had also recognised that staffing levels had now improved, with all posts now appointed to within Information Governance, which mitigated the risk that had been included on the Organisational Risk Register.

Resolution: The report was **NOTED.**

5.1.3 Stakeholder Reference Group Highlight Report 8 February 2024

L Prosser presented the report and highlighted the matters contained within the alert/escalate section. Members noted that an update was also provided in relation to the Emergency Medical Retrieval and Transfer Services review.

Resolution: The report was **NOTED.**
The Board **RATIFIED** the proposal to hold 4 meetings per year of the Stakeholder Reference Group with 1 additional ad hoc meeting should this be required

5.1.4 Hosted Bodies Audit & Risk Committee Highlight Report 22 February 2024

P Roseblade presented the report and highlighted the matters contained within the alert/escalate section. Members were provided with assurance that all the outstanding actions and recommendations in relation to previous organisations would be included in a legacy document which would be passed to the JCC to address moving forwards. Members noted that the position would continue to be reviewed by the Audit & Risk Committee for Hosted Bodies.

Resolution: The report was **NOTED.**

5.1.5 CTMUHB Audit & Risk Committee Highlight Report 22 February 2024

P Roseblade presented the report and highlighted the matters contained within the alert/escalate section. Members noted that a detailed discussion was held in relation to the JCC, with a representative from Welsh Government. Members noted that a Committee referral was made to the People & Culture Committee in relation to a proactive piece of work that had been undertaken by the Local

Counter Fraud Team in regards to the employment of agency staff. P Roseblade advised that Committee Members felt this was an issue which required further discussion at the People & Culture Committee in its current form to determine whether a further committee referral is required to other Committees. Members noted that a resolution will be submitted to the Audit & Risk Committee in due course.

Resolution: The report was **NOTED.**

5.2 Escalation Status Update

Members noted that an update in relation to escalation status was included in the Chief Executive's Report.

5.3 Board Assurance Framework

Some questions were raised in advance of the meeting which are outlined below together with the responses provided:

Paper 5.3b – Page 20 – Failure to manage legal cases efficiently and effectively

You will appreciate my interest in this issue given my IM (legal) role and the potential for significant costs in this area if not managed appropriately and pro-actively. I would be interested to know (and happy to have a discussion separately if that would assist) what oversight of all legal cases and spend is undertaken and is that undertaken by the executive, how regularly and what measures are in place so that the Board have a view of the associated costs per annum. Apologies if this is reported en bloc somewhere else but that has not been apparent to me in the short time since I have taken up my IM role. As I say happy to have a separate conversation but I am interested in seeing numbers and costs etc. and details procurement arrangements for legal advice.
Response from Greg Dix - Oversight of claims and redress cases takes place via the weekly Clinical Executive oversight meeting and any high cost/high profile cases are shared with the executive leadership group and individual care groups. An annual Putting Things Right report is shared with the Quality & Safety Committee, although the team would welcome a discussion with Helen Lentle to see how the whole board visibility could be strengthened.

Paper 5.3b Page 32 – Engagement with the community

The risk score was at 20 and has been mitigated to 12 which is clearly a positive move but has been at that level now for 12 months. Are there any plans to mitigate this further given that engagement with the community is key to CTM's plans for the future?

Response from Simon Blackburn - This risk was adapted in December '23 in order to clarify the executive responsibility – previously this sat with Public Health. At that point, and in subsequent reviews, we considered that the

importance of ongoing engagement to build and maintain successful partnerships with communities, and the requirement for a distinct strategy for involvement, engagement and consultation (work that is underway with The Consultation Institute) in relation to the Acute Clinical Services Plan (ACSP) merited the current risk score.

It is our intention to mitigate this further, but we also recognise that a future formal programme of public engagement and consultation may also increase the risk.

Paper 5.6f – Appendix B

In the correspondence from the Minster dated 19/03/24 she says:

"The issuing of Model documents for the NHS Wales Joint Commissioning Committee are in accordance with my powers of direction contained within Section 12(3) of the National Health Services (Wales) Act 2006.
These amendments supersede those issued on 27 July 2023 and as confirmed in Welsh Health Circular WHC2023/032. ***A new WHC will be published to confirm this.****"*

Please can Board members be advised whether the new WHC mentioned by the Minister (I have marked the relevant text in bold above) has been published?

Response from Gareth Watts - The relevant WHC has not yet been published. However, as and when this is published and received I will share this with Board colleagues.

There is a time lag between the issuing of correspondence from the Minister and the subsequent WHC as for the previous amendments issued on 27 July 2023, the subsequent WHC2023/032 was not issued until 24 October 2023.

G Watts presented Members with the Board Assurance Framework and highlighted the key matters for Members attention.

The Chair extended his thanks to H Lentle for submitting three questions in advance of the meeting which had been responded to by email and provided assurance that the questions and responses would be captured within the minutes of the meeting.

K Palmer raised a question in relation to the Financial Risk Score, and advised that whilst she welcomed that the risk score was now reducing, she queried how this would continue to be monitored given that monitoring of finances was going to be essential as a Board. S May advised that a re-set would be undertaken at the start of the next financial year, given that the financial plan showed a balanced plan with an unmitigated risk of 9.5m.

Resolution: The Board Assurance Framework was **APPROVED.**

5.4 Working in Partnerships Report - Implementing a Regional Model of Integrated Community Care Services

M Jenkins shared a presentation and highlighted the key matters for Board Members attention.

K Palmer extended her thanks to M Jenkins for sharing the presentation and welcomed the work that commenced in this important area. K Palmer made reference to the development of the community pathway and added that it would be helpful if this could be mapped from a person centred point of view and advised that it would be helpful if more engagement could be undertaken with people within the Health Board's communities to help them to understand the services in place, with support from Third Sector Partners and others in relation to external engagement.

M Jenkins advised that a discussion would be held as to how patients enter the pathways through referral mechanisms at a workshop that would be taking place and it was hoped that a traditional service specification for the optimal model could be developed following discussions.

P Mears made reference to the well-developed integrated model that was in place in Bridgend, which described the patient experience. This model could be used in future engagement and consultation with the population in order to describe how patients could navigate between different elements of services and the steps that would be taken to improve pathways. P Mears added that the story shared earlier in the meeting could be used to highlight how service models shouldn't be and the steps that would need to be taken to improve service pathways.

G Hughes advised that it was evident that community services within the Health Board were complex to navigate and needed to simplified and welcomed the discussions being held to address this and added that using the story shared earlier in the meeting would help to drive forward the ambition to achieve this. G Hughes also expressed the importance of considering what more could be done for the population and the need to ensure that focus was being placed on performance metrics to ensure this piece of work was having a genuine impact on the population. M Jenkins advised that the quality statement on frailty would be an important entry point and added that work was being undertaken with colleagues to develop that further with both operational measures and outcomes for patients.

L Thomas extended her thanks to M Jenkins for sharing the presentation and highlighted that this issue had not yet been resolved by any health organisation and added that Cwm Taf Morgannwg could lead the way in this area if it takes the right approach.

The Chair advised that this appeared to be a significant piece of work and recognised the strong relationships M Jenkins had in place with Regional Partnerships Board colleagues. The Chair added that the Regional Partnerships Board element was important in providing, supporting and delivering the case

for change and advised that there was ambition in place between the Health Board and the three Local Authority partners to utilise the Section 33 element of the legislation to pull together decision making and resource availability to take forward integrated pieces of work quickly.

Resolution: The presentation was **NOTED.**

5.5 Board Committee Review Proposal

The Chair commenced by thanking all Board Members for engaging in this quite detailed piece of work. The Chair advised that in his almost 12 months as Chair of the Board, he was very keen for a review to be undertaken of the effectiveness of how we operate as a Board.

The Chair extended his thanks to G Watts, C Hamblyn and the Corporate Governance Team for this huge undertaking and advised that detailed consideration had been undertaken on some of the challenges, of the opportunities to reform and improve what the Board does and also a significant period of consultation had been undertaken with all Board Members.

G Watts presented the report and highlighted the key matters for Members attention.

The Chair recognised that the report sets out a new framework where this Board would move to a structure of seven committees as opposed to the nine currently in place. Members noted that in addition to the five statutory Committees, there would be an additional two new committees, one of which would focus on strategic development and the other on operational delivery. Members noted that a recommendation had been made to have three formal sub committees of the Board also. Members noted that discussions would be held over the next few weeks to determine any areas which may require elevation from a committee focus and be discussed at the Board. Such areas include, for example, digital innovation, which was a key strategic enabler, and was of significant value to the Board, and which may require future discussions at Board level.

I Wells advised that he had expressed concerns about this piece of work at the outset of the review, and added that whilst he was not as concerned as he was initially, he still had a few reservations, particularly in relation to 'Digital and Data'. I Wells advised that whilst he was not concerned at the reduction in the number of committees and could see the rationale behind this, he felt concerned as to how some of the areas would be captured to ensure focus remained in place on specific areas, for example Digital and Data and Population Health, in the new Committee structure. Specifically in relation to Digital and Data, I Wells advised that he never saw this as a permanent committee, and the objective of this committee had been to instill a level of digital maturity within the organisation, which the Health Board did not have when the Digital & Data Committee was originally established. I Wells added that whilst significant progress had been made in relation to Digital and Data, he felt the Health Board had not yet reached the desired maturity level and

expressed the importance of the role of the Independent Member for Digital moving forwards.

The Chair agreed with the points raised by I Wells on the importance of the role of the Independent Member for Digital moving forwards. The Chair advised that future agenda planning sessions for the new committees would be driven by the Independent Member Chairs and Executive Leads. This would be critical in ensuring that strategic items and key elements are being captured. D Hurford advised that this provided a new opportunity to consider what specific topics may need to be captured across a number of committees, for example, digital matters.

The Chair advised that whilst a significant amount of work had been undertaken to set out model agenda's and membership of Committees, he would be happy to review the position over the next 12 months to ensure the new system was working effectively.

C Donoghue welcomed and supported the detailed work that had been undertaken and advised that she had some concerns, particularly in relation to Digital and Data being an enabler, that there were a number of other areas that would be considered as enablers for example, Finance, Infection Control and Estates, and added that it would be a challenge to ensure that these issues receive the appropriate scrutiny at the appropriate committee. C Donoghue advised that she accepted that agenda setting was important and added that she would welcome more development in terms of agenda setting, ensuring that discussions being held were strategic, and making decisions on what needs to be escalated to Board. C Donoghue added that she also felt concerned that some committees may become overloaded and accepted that this would be monitored moving forwards.

P Roseblade advised that she supported the piece of work that had been undertaken as a process, and agreed with the comments made by C Donoghue in regards to overloading agendas, and added that the committees needed to be led by risk in the strategic environment, with the Board Assurance Framework being used to help frame the agendas both for Committee's and Board. P Roseblade added that it would be important for meeting dates to be set that would allow for the very latest information to be available for discussion.

S Morris agreed with the comments made by I Wells in relation to the importance of the Independent Member Digital role moving forwards. S Morris advised that he had experience of this change being successfully undertaken in other organisations and added that setting the agenda correctly would be key to the success of this, in addition to focus being placed on the risks. S Morris advised that from an operational perspective there would be areas that would need to be reported on, for example, Information Governance and Cyber Security, and added that consideration would need to be given as to how Board Development sessions were utilised moving forwards to discuss key areas of focus.

K Palmer welcomed the detailed work that had been undertaken and agreed that this would need to be kept under review to ensure the new committee structure was effective, and expressed the importance of Board and Committee members ensuring that discussions being held were not too operational and were at a strategic level. K Palmer also felt that the Executives had a role to play in deciding what needed to be presented to Committee and what shouldn't.

G Watts extended his thanks to the Board for the constructive comments that had been made, and added that if approval is given by the Board, a significant piece of work would be undertaken prior to the new structure going live in regards to transitional arrangements and legacy reports. G Watts agreed that the agenda planning sessions moving forwards would be pivotal, with everyone having a collective role in ensuring appropriate matters are being added to the agenda for discussion, and agreed with the comment made by P Roseblade that the Board Assurance Framework needed to be used as a tool to determine what needs to be discussed at Committee meetings. G Watts agreed that consideration also needed to be given as to how Board Development sessions were utilised in the future, and how skills were being developed for Board Members.

Resolution: The Board **APPROVED:**

- The implementation of new Board Committee and Sub Committee Structure outlined in section 9:
- The responsibilities of all Board Members in terms of the approach to Board Development Sessions, Board Briefings and Agenda Planning.
- The next steps as outlined in section 23.

5.6 Establishment of the NHS Wales Joint Commissioning Committee, as a Joint Committee of Local Health Boards in NHS Wales

G Watts presented the report and highlighted key matters for Members' attention.

The Chair advised that the Board were being presented with quite a comprehensive package of information today, and advised that a dual approach needed to be taken by the Board, the first being the Board were being directed to approve the new arrangements for the Joint Commissioning Committee, and the second matter, which was still being worked through with Welsh Government, was the interface between the individual who would be leading the Joint Commissioning Committee as the Chief Commissioner, but also having accountable officer status which was now being determined by Welsh Government. Members noted that steps were being taken to ensure the appropriate governance was in place to respond to this, as this Health Board have a duty as Host Body, and as a Board, to ensure that our governance arrangements are robust for what is a departure from what has been in place previously. The Chair advised that he would keep the Board updated on progress.

P Roseblade made reference to paragraph 3.12 which made reference to the Memorandum of Agreement between the Health Boards and sought clarity whether a draft version of this was available and whether the Board was assured that it would reflect everything within the report that the Board were being asked to approve. G Watts advised that whilst the Memorandum of Agreement had not been drafted as of yet, this was one of the outputs from the Governance Workstream and added that this would be finalised during April 2024. Members noted that when this was being drafted, steps would be taken to ensure it was fully aligned with the suite of documents being presented to Board for approval.

K Palmer sought assurance as to how this would be reflected in the Board Assurance Framework and risk registers, given that this would be a new body which was in transition. G Watts advised that active consideration would be given to this matter as the Committee goes live, with consideration also given as to how this is reflected in the Hosting arrangements between now and the next Board.

Resolution: The Board **RESOLVED** to:

- **NOTE** the establishment of the NHS Wales Joint Commissioning Committee (JCC) from 1st April 2024, as directed by Welsh Ministers;
- **NOTE** that the JCC will supersede the Board's current joint committees, Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) with effect from 1st April 2024;
- **NOTE** the development of the JCC's governance framework, as a key component of the Health Board's governance framework;
- **ADOPT** the amendments to Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards; and the Standing Orders and Scheme of Delegation and Reservation of Powers for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 18th March 2024;
- **ADOPT** the Standing Financial Instructions for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 19th March 2024; and
- **NOTE** the JCC's Accountability Map for information.

6. DELIVERING OUR PLAN

6.1 Integrated Performance Dashboard

L Prosser presented the report and highlighted key matters for the Board's attention. The Clinical Executives also provided an update on their respective areas.

As part of this item, G Hughes also shared a presentation in relation to Unscheduled Care Flow within the Health Board. Members noted that steps would now be taken to reduce unnecessary conveyance/attendance, increase ambulatory capacity and introduce a new model of integrated discharge.

G Dix advised that he remained concerned about boarding of patients, and provided reassurance that risk assessments were in place when placing patients in these un-commissioned areas, although dignity and experience of care was definitely being compromised, which was clearly identified as an issue in the Listening & Learning story shared earlier in the meeting. Members noted that senior nurses do make contact with these patients every day to ensure the risk assessments are being kept up to date. G Dix advised that he welcomed the data shared by G Hughes during his presentation and welcomed the work that would be undertaken to address issues with flow.

C Donoghue made reference to the issues being experienced with boarding of patients and advised that G Hughes had presented a lot of information of the causes behind this, and suggested the report which will presented to the Board in May needs to include an update on boarding. C Donoghue advised that she had concerns that the boarding of patients would become normal practice and felt that the boarding of patients needed to be resisted at all times. In response to a question raised by C Donoghue, G Dix advised that the Care Group Nurse Directors and Executive Directors held the responsibility of approving the boarding of patients. P Mears advised that the Health Board had been given clear directions by Welsh Government colleagues in relation to the need to ensure ambulances were being offloaded and added that there needed to be ownership in place at a national level of the issues being experienced.

G Hopkins referred to the presentation shared by G Hughes and the reference made to assessments and advised that there appears to be a significant jump very quickly. G Hughes advised that this was as a result of the roll out of e-whiteboards, with one of the issues being not having the ability to capture historical data, with data now being captured on a daily basis as opposed to being captured once a week before the introduction of e-whiteboards. P Mears advised that it would be helpful to annotate on the graph that data wasn't previously being captured electronically which was why there had been a significant increase in reported numbers.

I Wells welcomed the presentation shared by G Hughes and advised that he had recently undertaken a walkabout with L Edwards of the Stroke Unit at the Princess of Wales Hospital to see how things were operating. I Wells added that he was provided with reassurance with what he had witnessed on the unit, with patients regularly being reviewed and monitored by the Stroke Consultants wherever they were situated within the Hospital.

N Milligan also made reference to stroke and advised that she was pleased to see the increase in the percentage of patients who were eligible to be thrombolysed. N Milligan made reference to the Clinical Nurse Specialist model, which was awaiting approval of funding and sought clarity as to when this was likely to be approved. G Hughes advised that this was part of the current planning within the Integrated Medium Term Plan and advised that part of the challenge at present was getting to an agreed position, which would then enable the Health Board to recycle funds from savings within the Unscheduled Care budget into the Clinical Nurse Specialist model.

D Jouvenat made reference to the issues in relation to boarding of patients and sought clarity as to whether a process could be put into place to ensure boarded beds are not being left in inappropriate areas once a patient had been discharged from it. G Dix welcomed this point made and advised that as of today, there were approximately 20 extra patients within a six bedded or four bedded bay to support flow and advised of the challenges being faced and the time it takes to move beds into and out of bed stores, which impacted on the ambulances waiting outside hospitals to offload patients.

G Hughes advised that in terms of boarding, which he recognises iss the wrong thing to be doing for patients, steps were being taken to ensure patients are not being kept in those spaces for prolonged periods of time. G Hughes added that the principle of boarding was around supporting outflow from the emergency departments to keep the department safer and to enable handover of ambulances that were delayed. G Hughes advised that a boarded bed should not be a permanent bed and there should not be a patient in that bed for a prolonged period of time. Members noted that at Prince Charles Hospital, where they have had to board patients for longer periods of time, the Team were very good at ensuring the patients that were going home the following day were placed in a boarded bed, and added that boarded beds are used during the night to maintain an element of flow. The Board noted that there were occasions where it was not possible to take down boarded beds as often as possible given the pressures.

K Palmer extended her thanks to G Hughes for sharing the presentation and requested that the data was kept under review and presented to Board at a later date to ensure monitoring remained in place. K Palmer also requested that Primary Care colleagues were being included in discussions in relation to secondary care and community hospitals, given the feedback she had received from some visits that primary care colleagues would like to be more involved in changes from the outset.

Resolution: The report was **NOTED.**

6.2 Financial Performance Update

S May presented the report and highlighted key updates to Board Members.

K Palmer extended her thanks to the all teams for achieving the position reported and advised that she would find it helpful if future reports could include a break-down of capital spend. S May advised that a six monthly capital spend report is produced to supplement the financial performance report and added that she would be happy to share this at the next meeting.

The Chair advised that he appreciated the robustness and the rigour that was put into place in relation to the financial planning within this Health Board and advised that high levels of confidence were in place in relation to the work being undertaken by S May and her team, alongside the Executive Team and Care Groups, to identify where savings could be delivered and ensuring that attempts were made to adhere to the plan that had been set out a year ago to

Welsh Government. The Chair extended his thanks to the Team for this enormous effort of achieving a balanced position and for the work that had been undertaken on the development of the Integrated Medium Term Plan and budget for 2024/2025. S May advised that this had been a complete organisation wide effort which had not been easy given the amount of pressures in the system, and advised this achievement would provide the Health Board with a better position as plans were being developed to reshape the investment for the future.

Resolution: The report was **NOTED.**

7. STRATEGIC PLANNING

7.1 Integrated Medium Term Plan and Budget for 2024/2025

L Prosser, S May G Hughes and H Watkins presented the report and presentation and highlighted key matters for Members attention.

The Chair extended his thanks to colleagues for providing an update on the key aspects of the Integrated Medium Term Plan (IMTP).

P Roseblade advised that she noted that the Stroke investment had been removed and understood that the risk level needed to be at a certain level, and queried whether it was likely as to whether there would be any national funding available for Stroke following the national review of stroke services. S May advised that she was not aware of any funding being made available and advised that as referred to by G Hughes earlier, the Unscheduled Care Group had been allocated additional funding and had been challenged as a Care Group to carve out sufficient funds to prioritise stroke, which needed to be worked through further.

K Palmer advised that she recognises that the IMTP was a significant amount of work and noted the risk in relation to Mental Health and the risk that was being carried in relation to systems and data. K Palmer also made reference to the embedding of the Care Groups, which were still quite new, with some changes to structures and posts being undertaken through the Organisational Change Process. K Palmer also requested that a session was held with the Board in relation to years two and three finances, within the next six months to consider how we can try to turn things around to support Primary Care, prevention and early intervention.

P Mears made reference to the discussion held earlier in the meeting regarding clinical pathways and pressures, and the significant costs being faced per day to keep patients in beds who could be cared for in a community setting, and advised that these costs be utilised to spend on improving stroke care and primary and community services, for example.

S May reflected on the presentation shared by G Hughes on Unscheduled Care Flow and advised that whilst the numbers of patients presenting had reduced, which had resulted in a funding loss to Prince Charles Hospital alone of over

£6m, despite patients staying for longer in hospital beds. S May advised that a significant amount of work was need to address how the system works.

S Morris advised that in relation to the Mental Health system challenges and data provision that had been referred to by K Palmer, steps were being taken to address the issues and it was hoped that the Health Board would be able to access potential funding that may become available from Welsh Government next year which would help to try and resolve the issues being experienced.

Resolution: The IMTP was **APPROVED** for submission to Welsh Government by 29th March 2024, noting the risks to delivery of a balanced financial plan.

Action: G Watts to include the request to consider years two and three finances within a Board Development Session within the next six months to consider the support required for Primary Care, prevention and early intervention.

7.2 Acute Clinical Services plan Update

L Prosser presented the report and updated Board Members on the progress being made in relation to the development of the Acute Clinical Services Plan.

Resolution: The report was **NOTED**.

8.0 CONSENT AGENDA

8.1 FOR APPROVAL

8.1.1 Unconfirmed Minutes of the meetings held on 25 January 2024

Resolution The minutes were **APPROVED.**

8.1.2 Decarbonisation Action Plan for 2024-2026

Resolution: The Plan was **APPROVED.**

8.1.3 Strategic Equality Plan

Resolution The Strategic Equality Plan was **APPROVED.**

8.2 FOR NOTING

8.2.1 Board Annual Cycle of Business

Resolution: The Annual Cycle of Business was **NOTED.**

8.2.2 Board Forward Work Programme

Resolution The Forward Work Programme was **NOTED**

8.2.3 Board Committee and Advisory Group Highlight Reports

Resolution The report was **NOTED.**

8.2.4 Audit Wales Annual Audit Report

Resolution: The report was **NOTED.**

8.2.5 Annual Plan Quarterly Update

Resolution: The report was **NOTED.**

9. CLOSE OUT BUSINESS

9.1 ANY OTHER BUSINESS

The Chair advised that he had not been notified of any other business.

9.2 HOW DID WE DO IN THIS MEETING?

The Chair invited members/colleagues to put forward any comments for improvement at this point or within two weeks of the meeting to provide feedback in respect of the issues that were covered and in the way in which the meeting had been run and how future meetings could be improved.

10. PRIVATE / IN COMMITTEE SESSION

There were no items requiring discussion at an In Committee session of the Board.

11. DATE & TIME OF NEXT MEETING

Members noted that an Extra Ordinary Public Board meeting would be taking place on Tuesday 9 April at 9:00am and noted that the next scheduled Public Board meeting following that would be taking place on Thursday 30 May at 9:30am.

Cofnodion Cyfarfod Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg (BIPCTM) a gynhaliwyd ddydd Iau 28 Mawrth 2024 fel cyfarfod Personol yn Yr Hwb, Safle Ysbyty Brenhinol Morgannwg, Llantrisant (Darlledwyd yn Fyw hefyd drwy Microsoft Teams)

Aelodau yn Bresennol:

Jonathan Morgan	Cadeirydd
Paul Mears	Prif Weithredwr
Kath Palmer	Is-gadeirydd
Patsy Roseblade	Aelod Annibynnol (Mynychwr rhithwir)
Geraint Hopkins	Aelod Annibynnol
Carolyn Donoghue	Aelod Annibynnol
Ian Wells	Aelod Annibynnol
Dilys Jouvenat	Aelod Annibynnol
Helen Lentle	Aelod Annibynnol (yn rhannol)
Nicola Milligan	Aelod Annibynnol
Lynda Thomas	Aelod Annibynnol (Mynychwr rhithwir)
Greg Dix	Cyfarwyddwr Gweithredol Nyrsio/Dirprwy Brif Weithredwr
Linda Prosser	Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid
Dom Hurford	Cyfarwyddwr Gweithredol Meddygol
Sally May	Cyfarwyddwr Gweithredol Cyllid
Gethin Hughes	Prif Swyddog Gweithredu
Sally Bolt	Aelod Cysylltiol

Eraill oedd yn bresennol:	Cyfarwyddwr Digidol
Stuart Morris	Cyfarwyddwr Cyfathrebu, Ymgysylltu a Chodi Arian
Simon Blackburn	Pennaeth Staff
Matthew Butt	Cyfarwyddwr Llywodraethu Corfforaethol / Ysgrifennydd Bwrdd
Gareth Watts	
Helen Watkins	Dirprwy Gyfarwyddwr Pobl
Ceri Bear	Cynrychiolydd Llais Cymru (Arsylwi)
Elizabeth Stevenson	Llais Cymru (Arsylwi)
Adam Cooke-Young	Ymarferydd Clinigol (yn rhannol)
Matt Jenkins	Cyfarwyddwr Integreiddio Rhanbarthol
Jonathan Arthur	Gwyddonydd Clinigol Ymgynghorol (Arsylwi)
Emma Walters	Pennaeth Llywodraethu Corfforaethol a Busnes y Bwrdd (Ysgrifenyddiaeth)

1 MATERION RHAGARWEINIOL

1.1 Croeso a Chyflwyniadau

Croesawodd y Cadeirydd bawb i'r cyfarfod, yn enwedig y rhai a oedd yn ymuno am y tro cyntaf, y rhai a oedd yn arsylwi a'r cydweithwyr oedd yn ymuno ar gyfer eitemau penodol ar yr agenda. **Nododd** y Cadeirydd fformat y trafodion hefyd.

1.2 Ymddiheuriadau am Absenoldeb

Derbyniwyd ymddiheuriadau am absenoldeb oddi wrth:

- Mel Jehu, Aelod Annibynnol;
- Lauren Edwards, Cyfarwyddwr Gweithredol Therapïau a Gwyddorau Iechyd;
- Philip Daniels, Cyfarwyddwr Gweithredol Iechyd y Cyhoedd;
- Hywel Daniel, Cyfarwyddwr Gweithredol Pobl;
- Lisa Curtis-Jones, Aelod Cyswllt;
- Anne Morris, Aelod Cyswllt;
- Daniel Price, Cyfarwyddwr Rhanbarthol, Llais Cymru

1.3 Datganiadau o Fuddiant

Ni nodwyd datganiadau o fuddiant cyn nac yn ystod y cyfarfod.

2. BUSNES YR AGENDA GYDSYNIAD

Gofynnodd y Cadeirydd i'r aelodau a oedd unrhyw eitemau o'r agenda gydsyniad yr oedd Aelodau'r Bwrdd yn dymuno eu dwyn ymlaen i'r brif agenda i'w trafod. Nid oedd unrhyw eitemau.

3. GWRANDO A DYSGU AR Y CYD

3.1 Stori Gwrando a Dysgu

Cyflwynodd Cooke-Young y stori gwrando a dysgu a oedd yn ymwneud ag Eiddilwch Acíwt a Gofal y Person Hŷn a Thaith Ysbyty'r Claf.

Diolchodd y Cadeirydd i Adam am rannu'r cyflwyniad, a oedd yn bwerus ac ychwanegodd ei fod yn ei chael yn ddirdynnol gweld yr effaith a gafodd ein system gyfan ar unigolion sy'n dechrau ar gyfnod olaf eu bywydau. Cynghorodd y Cadeirydd y byddai nifer o'r negeseuon hyn yn atseinio gyda'r gwaith a wneir gan gydweithwyr Gweithredol wrth geisio nodi cyfleoedd i wella a ffyrdd o fynd i'r afael â'r heriau sylweddol o fewn y system iechyd, yn ogystal â'r gwasanaethau a oedd yn dal y cyfrifoldeb statudol dros ddarparu gwasanaethau gofal cymdeithasol.

Cynghorodd C Donoghue fod y stori hon hefyd wedi cael ei rhannu yn y Pwyllgor Ansawdd a Diogelwch, ac ychwanegodd ei bod wedi canfod bod y stori yr un mor bwerus wrth ei chlywed am yr eildro. Holodd C Donoghue a ellid rhannu'r stori hon mewn cyfarfodydd ar y cyd â gofal cymdeithasol i greu cyfle i godi ymwybyddiaeth o'r effaith a gafodd rhyddhau gohiriedig ar gleifion a'u teuluoedd o ran ansawdd bywyd.

Estynnodd G Dix ei ddiolch i A Cooke-Young am rannu'r stori dorcalonnus a chynghorodd fod llawer o gleifion yn anffodus mewn sefyllfa debyg. Cytunodd G Dix bod angen cydnabod y niwed sy'n cael ei achosi i gleifion a oedd yn datgyflyru o ganlyniad i ohirio eu rhyddhau ac ychwanegodd fod trafodaethau wedi'u cynnal gyda Llywodraeth Cymru a chydweithwyr gweithredol y GIG ynghylch sut y gellid mesur y digwyddiad niwediol yn iawn ar gyfer cleifion a oedd yn datgyflyru ar draws y Bwrdd Iechyd. Cynghorodd G Dix y byddai'r Bwrdd yn hapus i ymrwymo i geisio datrys y materion a nodwyd.

Croesawodd G Hughes y cyflwyniad a dywedodd er bod canfyddiad ar waith bod ysbytai yn llefydd diogel, nid yw ysbytai yn llefydd diogel os nad yw claf yn sâl. Yn wir, gall ysbyty fod yn un o'r lleoedd gwaethaf i fod os nad oes angen i glaf fod yn yr ysbyty, o ystyried y risgiau o haint, datgyflyru a lles meddyliol. Ychwanegodd G Hughes ei bod yn aml yn fwy diogel i glaf oedrannus gael ei gefnogi gartref ac ychwanegodd bod angen cael sgyrsiau gyda staff a phartneriaid y Bwrdd Iechyd ynghylch pa mor briodol a pharchus y gellid darparu gofal i gleifion eiddil/oedrannus.

Cynghorodd I Wells ei fod yn teimlo bod y cyflwyniad yn emosiynol iawn a chwestiynodd sut mae'r Bwrdd yn dysgu o rai o'r materion a nodwyd a sut y bydd y Bwrdd yn bwrw ymlaen â'r syniadau a nodwyd i fynd i'r afael â'r sefyllfa. Ychwanegodd I Wells y byddai'n ddefnyddiol pe gellid rhoi'r wybodaeth ddiweddaraf i'r Bwrdd am gynnydd mewn cyfarfod yn y dyfodol.

Cynghorodd P Mears y byddai cyflwyniad yn cael ei rannu yn ddiweddarach ar yr agenda mewn perthynas â'r heriau sy'n cael eu profi ynghylch llif cleifion drwy'r ysbytai ac ychwanegodd ei fod wedi codi ei bryderon yn ddiweddar gyda Phrif Weithredwyr y tri Awdurdod Lleol.

Dywedodd P Mears fod mentrau wedi'u nodi o fewn y cyflwyniad y gellid eu datblygu. Ychwanegodd bod angen ystyried yn y tymor byr sut i wneud profiadau cleifion cystal â phosibl tra eu bod yn aros i gael eu rhyddhau. Tynnodd sylw hefyd at y ffaith bod rhai enghreifftiau da iawn ar draws safleoedd sy'n cael eu rhoi ar waith i wella profiad y claf. Nododd yr Aelodau fod trafodaethau blaenorol wedi'u cynnal mewn perthynas â modelau gweithlu amgen ac uwchsgilio ac ailgynllunio rolau Gweithwyr Cymorth Gofal Iechyd i gefnogi cleifion wrth iddynt aros i gael eu rhyddhau.

Awgrymodd P Mears y byddai angen gwneud darn o waith dros y pedwar i bum mis nesaf i ddatblygu cynllun a oedd yn nodi sut y gellid mynd i'r afael â materion cyn cyfnod nesaf y gaeaf. Awgrymodd P Mears bod diweddariad yn cael ei gyflwyno i gyfarfod mis Mai y Bwrdd sy'n nodi'r newidiadau

rhagweithiol a fyddai'n cael eu gwneud i liniaru rhai o'r materion a amlinellir yn y cyflwyniad.

Cynghorodd L Thomas ei bod yn teimlo bod y sefyllfa hon yn annerbyniol ac ychwanegodd ei bod yn teimlo bod angen gweithredu nawr i fynd i'r afael â'r sefyllfa. Cynghorodd L Thomas ei bod wedi gweld rhai modelau da yn ddiweddar yn eu lle yn y Bwrdd Iechyd, gan gynnwys Ward yn Ysbyty Cwm Rhondda a oedd yn seiliedig ar Weithiwr Cymorth Gofal Iechyd, a holodd a ellid ailadrodd y model hwn mewn wardiau eraill yn y Bwrdd Iechyd. Ychwanegodd L Thomas ei bod wedi gweld o fewn sefydliad GIG arall dwy ward lawn yn cael eu neilltuo i gleifion oedrannus eiddil a chwestiynodd a oedd hyn yn rhywbeth y gallai'r Bwrdd Iechyd ei ystyried, yn ogystal â rhai o'r mentrau camu i fyny ward rhithwir a sefydlwyd yn NHS England.

Cynghorodd G Hopkins ei fod yn teimlo bod y sefyllfa hon yn warthus a'i fod wedi bod yn broblem ers peth amser a'i fod wedi cael ei drafod ar sawl achlysur yn rhanbarthol ac yn genedlaethol. Ychwanegodd G Hopkins na allai'r Bwrdd Iechyd na Llywodraeth Leol fynd i'r afael â'r mater hwn ar ei ben ei hun. Yn hytrach, roedd yn argymell bod angen dull cydgysylltiedig, ochr yn ochr ag ailfuddsoddi sylweddol mewn darpariaeth gymunedol lefel is, a fyddai'n lleihau'r pwysau ar ysbytai, gwella llif cleifion ac a fyddai'n cael effaith gadarnhaol ar y trigolion yng nghymunedau'r Bwrdd Iechyd. Cynghorodd G Hopkins y byddai'n annog cydweithwyr ar lefel ranbarthol yn gryf i ailedrych ar rai o'r mentrau a gynhaliwyd yn y gorffennol o ran atal mynediad i'r ysbyty a galluogi rhyddhau cyflymach. Ychwanegodd G Hopkins fod yr amser a gymerir i ddyrannu gweithiwr cymdeithasol yn annerbyniol a dywedodd fod angen cydnabod bod pob sector o fewn ein cymdeithas o dan bwysau sylweddol, a bod angen mynd i'r afael ag ef ar frys.

Cynghorodd y Cadeirydd y byddai ef a'r Prif Weithredwr (P Mears) yn mynychu cyfarfod llawn o'r cyngor gyda Chyngor Bwrdeistref Sirol Rhondda Cynon Taf, a byddai'n hapus i rannu'r stori, os yw'n briodol, fel enghraifft o'r materion system a oedd yn cael eu profi, lle y gobeithir y byddai ymrwymiad yn cael ei wneud i fynd i'r afael â'r sefyllfa annerbyniol.

Cynghorodd P Mears ei fod yn derbyn ac yn cytuno â'r holl sylwadau a wnaed. Ychwanegodd P Mears bod cyfleoedd i ystyried uwchsgilio mwy o Aseswyr Dibynadwy yn y Bwrdd Iechyd fyddai'n gallu asesu cleifion nad oedd angen Gweithiwr Cymdeithasol cymwys a phrofiadol iawn, a fyddai'n helpu i fynd i'r afael â'r materion mewn perthynas ag oedi o ran rhyddhau.

Cyfeiriodd P Mears at rai enghreifftiau da o fentrau a oedd yn cael eu cynnal o fewn y Bwrdd Iechyd, er enghraifft, y Tîm Cadw'n Iach yn y Cartref yn Rhondda Cynon Taf a Merthyr Tudful, a chynghorodd fod angen cymryd camau i greu mwy o gapasiti o fewn y Timau hyn er mwyn galluogi rhyddhau mwy o gleifion yn gyflymach.

Cynghorodd L Prosser ei bod yn croesawu'r syniadau a rennir gan A Cooke-Young yn ystod ei gyflwyniad mewn perthynas â rhai camau iechyd y gellid

eu cymryd i fynd i'r afael â'r sefyllfa a dywedodd y byddai'n hapus i gysylltu A Cooke-Young â'r Rhaglen Rhyddhau Awdurdodau Lleol a Gwella Iechyd ar y cyd er mwyn rhannu ei syniadau.

Cynghorodd N Milligan bod y stori hon hyd yn oed yn fwy pwerus iddi ar glywed y stori am yr eildro a holodd a ellid ystyried ailedrych ar y treial a gynhaliwyd yn flaenorol mewn perthynas â chylchdroi Gweithwyr Cymorth Gofal Iechyd rhwng lleoliadau acíwt a gofal cymdeithasol a fyddai, gobeithio, yn helpu i ddatblygu a chadw staff a gwneud iddynt deimlo eu bod yn cael eu gwerthfawrogi'n fwy. Cynghorodd N Milligan fod nifer uchel o geisiadau wedi dod i law pan hysbysebodd y Bwrdd Iechyd yn ddiweddar am rolau Gweithiwr Cymorth Gofal Iechyd. Dywedodd P Mears y gallai hyn gael ei archwilio ymhellach gyda phartneriaid gofal cymdeithasol ac ychwanegodd y byddai hyn yn helpu i ddarparu datblygiad gyrfa i staff yn ogystal â darparu capasiti ychwanegol o fewn lleoliadau cymunedol.

Cynghorodd D Hurford ei fod yn cefnogi'r holl sylwadau a wnaed ac ychwanegodd, yn ogystal â datgyflyru corfforol, bod angen ystyried hefyd effaith datgyflyru meddyliol cleifion, a oedd yr un mor bwysig mynd i'r afael ag ef.

Diolchodd y Cadeirydd i A Cooke-Young am rannu'r cyflwyniad a rhoddodd sicrwydd bod gwaith yn cael ei wneud i fynd i'r afael â'r materion a nodwyd. Ychwanegodd P Mears bod dau gyflwyniad fyddai'n cael eu derbyn yn ddiweddarach yn y cyfarfod fyddai'n nodi themâu cyffredin ac awgrymodd y dylid cysylltu ag A Cooke-Young yn dilyn y cyfarfod i'w gynnwys yn rhywfaint o'r gwaith sy'n cael ei wneud. Awgrymodd P Mears fod angen sefydlu grŵp ffocws bach gyda'r cyfrifoldeb am ddatblygu cynigion a fyddai'n nodi'r camau sy'n cael eu cymryd i liniaru'r materion a nodwyd, a'u cyflwyno i'r Bwrdd yn ei gyfarfod ym mis Mai.

NODWYD y Stori Gwrando a Dysgu.

Penderfyniad:

Cam gweithredu: Diweddariad i'w gyflwyno i gyfarfod mis Mai y Bwrdd sy'n nodi'r newidiadau rhagweithiol a fyddai'n cael eu gwneud i liniaru rhai o'r materion a amlinellir yn y cyflwyniad.

4. CYFLWYNO'R CEFNDIR

4.1 Adroddiad y Cadeirydd

Cyflwynodd y Cadeirydd yr adroddiad a thynnu sylw'r Aelodau at y materion allweddol. Dywedodd y Cadeirydd fod y Prif Weinidog newydd bellach wedi ffurfio ei weinyddiaeth newydd ers i'r adroddiad gael ei drafftio, gydag Eluned Morgan yn cael ei hailbenodi'n Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol, Dawn Bowden yn cael ei phenodi'n Weinidog Gofal Cymdeithasol a Jayne Bryant yn Weinidog Iechyd Meddwl a'r Blynyddoedd Cynnar. Cynghorodd y Cadeirydd fod parhad safle cabinet o ran y Gweinidog Iechyd o gymorth ac ychwanegodd y byddai cyfres o gyfarfodydd yn cael eu cynnal dros y misoedd nesaf i drafod y meysydd gwaith sy'n cael eu gwneud

gan y Bwrdd Iechyd a rhai o'r heriau yr oedd angen mynd i'r afael â nhw, yn enwedig ym maes Gofal Cymdeithasol.

Cynghorodd y Cadeirydd y byddai Rachel Rowlands yn dechrau ei rôl fel yr Aelod Annibynnol newydd dros y Gymuned ar 1 Ebrill 2024 ac ychwanegodd ei fod yn dymuno estyn ei ddiolch i M Jehu am y gefnogaeth a roddodd i'r Bwrdd fel Aelod Annibynnol dros yr wyth mlynedd diwethaf.

Penderfyniad **NODODD** y Bwrdd yr adroddiad a **CHYMERADWYO** Gosod y Sêl Gyffredin.

Log Camau Gweithredu

4.1.1

Cyflwynodd y Cadeirydd y log camau gweithredu.

Penderfyniad **NODWYD** y Log Camau Gweithredu.

4.2 Adroddiad y Prif Weithredwr

Cyflwynodd P Mears yr adroddiad ac amlygodd y materion allweddol i sylw'r Aelodau.

Cyfeiriodd y Cadeirydd at y Siarter Rhianta Corfforaethol a dywedodd ei fod yn teimlo ei bod yn briodol i'r Bwrdd ymrwymo i hyn gan fod meysydd y gallai'r Bwrdd eu cefnogi, er enghraifft yr uchelgais a oedd eisoes ar waith i gefnogi pobl ifanc i gael gwaith.

Mewn perthynas â'r Gwasanaeth Casglu a Throsglwyddo Meddygol Brys, dywedodd y Cadeirydd y byddai cyfarfod Bwrdd yn cael ei gynnal ddydd Mawrth 9 Ebrill i gael y wybodaeth ddiweddaraf am ddatblygiad y gwaith a oedd yn cael ei wneud dros yr wythnosau nesaf. Ychwanegodd y byddai hwn yn fater y byddai angen i'r Cyd-bwyllgor Comisiynu (JCC) newydd wneud penderfyniad arno, o ystyried fod ganddo swyddogaeth dirprwyo gan y saith Bwrdd Iechyd mewn perthynas â hyn. Cynghorodd y Cadeirydd ei fod yn deall na fyddai'n ofynnol i'r Bwrdd Iechyd wneud penderfyniad unigol ar 9 Ebrill, a dim ond ystyried y diweddariadau a ddarperir a'r effaith benodol y byddai unrhyw newidiadau yn ei chael ar boblogaeth y Bwrdd Iechyd y byddai angen iddo wneud. Ychwanegodd y Cadeirydd fod gan y Bwrdd Iechyd ddyletswydd statudol dros iechyd ei boblogaeth, heb unrhyw gyfrifoldeb statudol ar y cyd am rannau eraill o Gymru.

Penderfyniad:

NODWYD yr adroddiad
CYMERADWYWYD y cofrestriad i'r Siarter Rhianta Corfforaethol

5. LLYWODRAETHU, RISG A SICRWYDD

5.1 Adroddiadau Crynhoi Pwyllgorau'r Bwrdd a'r Grŵp Cynghori

5.1.1

Adroddiad Crynhoi'r Pwyllgor Ansawdd a Diogelwch 23 Ionawr 2024

Cyflwynodd C Donoghue yr adroddiad ac amlygodd y materion a gynhwysir yn yr adran rhybudd/uwchgyfeirio. Nododd yr Aelodau fod trafodaeth fanwl wedi'i chynnal mewn perthynas â'r cyflwyniad a rannwyd gyda'r Bwrdd yn y cyfarfod heddiw, darparwyd sicrwydd bod gwaith yn cael ei wneud i liniaru unrhyw risgiau sy'n ymwneud â'r fenter Gofal Cywir Person Cywir, a nodwyd bod y Pwyllgor yn parhau i ganolbwyntio ar Sepsis. Cynghorodd C Donoghue fod y Pwyllgor wedi nodi datblygiad cadarnhaol parhaus Adroddiadau Crynhoi'r Grŵp Gofal a oedd yn fwy cryno a nododd y gwelliannau parhaus yn natblygiad adroddiadau'r Gofrestr Risg Sefydliadol.

Penderfyniad:

NODWYD yr adroddiad.

5.1.2

Adroddiad Crynhoi'r Pwyllgor Digidol a Data 21 Chwefror 2024

Cyflwynodd I Wells yr adroddiad a thynnu sylw at y materion a oedd yn yr adran rhybudd/uwchgyfeirio. Nododd yr Aelodau fod cynnydd sylweddol wedi'i wneud i fynd i'r afael â'r 35 o argymhellion a wnaed gan Swyddog y Comisiynydd Gwybodaeth (ICO), gyda chadarnhad bellach gan yr ICO eu bod yn ystyried cau'r broses ymgysylltu archwilio. Nododd yr Aelodau fod cynllun gweithredu yn parhau i fod ar waith. Dywedodd I Wells fod y Pwyllgor hefyd wedi cydnabod bod lefelau staffio bellach wedi gwella, gyda'r holl swyddi bellach wedi'u llenwi o fewn Llywodraethu Gwybodaeth, a oedd yn lliniaru'r risg a oedd wedi'i chynnwys ar y Gofrestr Risg Sefydliadol.

Penderfyniad:

NODWYD yr adroddiad.

5.1.3

Adroddiad Crynhoi'r Grŵp Cyfeirio Rhanddeiliaid 8 Chwefror 2024

Cyflwynodd L Prosser yr adroddiad ac amlygodd y materion a gynhwysir yn yr adran rhybudd/uwchgyfeirio. Nododd yr Aelodau fod diweddariad hefyd wedi'i ddarparu mewn perthynas â'r adolygiad Gwasanaethau Casglu a
Penderfyniad: Throsglwyddo Meddygol Brys.

NODWYD yr adroddiad.
CADARNHAODD y Bwrdd y cynnig i gynnal 4 cyfarfod y flwyddyn o'r Grŵp Cyfeirio Rhanddeiliaid gydag 1 cyfarfod ad hoc ychwanegol pe bai angen hyn

5.1.4

Adroddiad Crynhoi'r Pwyllgor Archwilio a Risg Cyrff a Letyir 22 Chwefror 2024

Cyflwynodd P Roseblade yr adroddiad a thynnodd sylw at y materion a gynhwyswyd yn yr adran rhybudd/uwchgyfeirio. Rhoddwyd sicrwydd i'r Aelodau y byddai'r holl gamau gweithredu ac argymhellion sy'n weddill mewn perthynas â sefydliadau blaenorol yn cael eu cynnwys mewn dogfen etifeddiaeth a fyddai'n cael ei throsglwyddo i'r Cydbwyllgor Comisiynu i fynd i'r afael â hi wrth symud ymlaen. Nododd yr Aelodau y byddai'r sefyllfa'n
Penderfyniad: parhau i gael ei hadolygu gan y Pwyllgor Archwilio a Risg Cyrff a Letyir.

5.1.5 **NODWYD** yr adroddiad.

Adroddiad Crynhoi Pwyllgor Archwilio a Risg BIPCTM 22 Chwefror 2024

Penderfyniad:

Cyflwynodd P Roseblade yr adroddiad a thynnodd sylw at y materion a gynhwyswyd yn yr adran rhybudd/uwchgyfeirio. Nododd yr aelodau fod trafodaeth fanwl wedi'i chynnal mewn perthynas â'r JCC, gyda chynrychiolydd o Lywodraeth Cymru. Nododd yr Aelodau fod atgyfeiriad Pwyllgor wedi'i wneud i'r Pwyllgor Pobl a Diwylliant mewn perthynas â darn rhagweithiol o waith a wnaed gan y Tîm Gwrth-dwyll Lleol o ran cyflogi staff asiantaeth. Cynghorodd P Roseblade fod Aelodau'r Pwyllgor yn teimlo bod hwn yn fater a oedd yn gofyn am drafodaeth bellach yn y Pwyllgor Pobl a Diwylliant yn ei ffurf bresennol i benderfynu a oes angen atgyfeiriad pwyllgor pellach i Bwyllgorau eraill. Nododd yr Aelodau y bydd penderfyniad yn cael ei gyflwyno i'r Pwyllgor Archwilio a Risg maes o law.

5.2

NODWYD yr adroddiad.

Diweddariad Statws Uwchgyfeirio

5.3 Nododd yr Aelodau fod diweddariad mewn perthynas â statws uwchgyfeirio wedi'i gynnwys yn Adroddiad y Prif Weithredwr.

Fframwaith Sicrwydd y Bwrdd

Codwyd rhai cwestiynau cyn y cyfarfod a amlinellir isod ynghyd â'r ymatebion a ddarparwyd:

Papur 5.3b – Tudalen 20 – Methu â rheoli achosion cyfreithiol yn effeithlon ac effeithiol

Byddwch yn gwerthfawrogi fy niddordeb yn y mater hwn o ystyried fy rôl IM (cyfreithiol) a'r potensial am gostau sylweddol yn y maes hwn os na chaiff ei reoli'n briodol ac yn rhagweithiol. Byddai gen i ddiddordeb gwybod (ac yn hapus i gael trafodaeth ar wahân pe byddai hynny'n helpu) pa oruchwyliaeth o'r holl achosion cyfreithiol a gwariant a wneir ac a wneir hyn gan y weithrediaeth, pa mor rheolaidd a pha fesurau sydd ar waith fel bod gan y Bwrdd olwg o'r costau cysylltiedig y flwyddyn. Ymddiheuriadau os yw hyn yn cael ei adrodd mewn bloc yn rhywle arall, ond nid yw hynny wedi bod yn amlwg i mi yn yr amser byr ers i mi ymgymryd â fy rôl IM. Fel y dywedais, dw i'n hapus i gael sgwrs ar wahân ond mae gen i ddiddordeb mewn gweld niferoedd a chostau ac ati a manylion trefniadau caffael ar gyfer cyngor cyfreithiol.
Ymateb gan Greg Dix - Mae goruchwylio hawliadau ac achosion unioni yn digwydd trwy'r cyfarfod goruchwylio Clinigol Gweithredol wythnosol a chaiff unrhyw achosion cost uchel/proffil uchel eu rhannu gyda'r grŵp arweinyddiaeth gweithredol a grwpiau gofal unigol. Rhennir adroddiad blynyddol Gweithio i Wella gyda'r Pwyllgor Ansawdd a Diogelwch, er y byddai'r tîm yn croesawu trafodaeth gyda Helen Lentle i weld sut y gellid cryfhau gweledded y bwrdd cyfan.

Papur 5.3b Tudalen 32 – Ymgysylltu â'r gymuned

Roedd y sgôr risg yn 20 ac mae wedi'i lliniaru i 12 sy'n amlwg yn gam cadarnhaol ond mae wedi bod ar y lefel honno nawr ers 12 mis. A oes unrhyw gynlluniau i liniaru hyn ymhellach o ystyried bod ymgysylltu â'r gymuned yn allweddol i gynlluniau CTM ar gyfer y dyfodol?

Ymateb gan Simon Blackburn - Addaswyd y risg hon ym mis Rhagfyr '23 er mwyn egluro'r cyfrifoldeb gweithredol - yn flaenorol, roedd hyn yn eistedd gydag Iechyd y Cyhoedd. Ar y pwynt hwnnw, ac mewn adolygiadau dilynol, roeddem o'r farn bod pwysigrwydd ymgysylltu parhaus i adeiladu a chynnal partneriaethau llwyddiannus â chymunedau, a'r gofyniad am strategaeth benodol ar gyfer cynnwys, ymgysylltu ac ymgynghori (gwaith sydd ar y gweill gyda'r Sefydliad Ymgynghori) mewn perthynas â'r Cynllun Gwasanaethau Clinigol Acíwt (ACSP) yn haeddu'r sgôr risg bresennol.

Ein bwriad yw lliniaru hyn ymhellach, ond rydym hefyd yn cydnabod y gallai rhaglen ffurfiol o ymgysylltu ac ymgynghori â'r cyhoedd yn y dyfodol gynyddu'r risg hefyd.

Papur 5.6f – Atodiad B

Yn yr ohebiaeth gan y Gweinidog dyddiedig 19/03/24 mae'n dweud:

"Mae cyhoeddi dogfennau enghreifftiol ar gyfer Cyd-bwyllgor Comisiynu GIG Cymru yn unol â'm pwerau cyfarwyddo sydd wedi'u cynnwys yn Adran 12(3) Deddf Gwasanaethau Iechyd Gwladol (Cymru) 2006.
Mae'r gwelliannau hyn yn disodli'r rhai a gyhoeddwyd ar 27 Gorffennaf 2023 ac fel y cadarnhawyd yng Nghylchlythyr Iechyd Cymru WHC2023/032. ***Bydd Cylchlythyr Iechyd Cymru (CIC) newydd yn cael ei gyhoeddi i gadarnhau hyn.****"*

A ellir cynghori aelodau'r Bwrdd a yw'r CIC newydd a grybwyllir gan y Gweinidog (rwyf wedi oleuliwio'r testun perthnasol uchod) wedi'i gyhoeddi?

Ymateb gan Gareth Watts - Nid yw'r CIC perthnasol wedi'i gyhoeddi eto. Fodd bynnag, pan gaiff hyn ei gyhoeddi a'i dderbyn byddaf yn rhannu hyn â chydweithwyr y Bwrdd.

Mae oedi amser rhwng cyhoeddi gohebiaeth gan y Gweinidog a'r CIC dilynol o ran y diwygiadau blaenorol a gyhoeddwyd ar 27 Gorffennaf 2023, ni chyhoeddwyd y WHC2023/032 dilynol tan 24 Hydref 2023.

Cyflwynodd G Watts Fframwaith Sicrwydd y Bwrdd i'r Aelodau ac amlygodd y materion allweddol i sylw'r Aelodau.

Diolchodd y Cadeirydd i H Lentle am gyflwyno tri chwestiwn cyn y cyfarfod yr ymatebwyd iddo drwy e-bost a rhoddodd sicrwydd y byddai'r cwestiynau a'r ymatebion yn cael eu casglu o fewn cofnodion y cyfarfod.

Penderfyniad:

Cododd K Palmer gwestiwn mewn perthynas â'r Sgôr Risg Ariannol, a chynghorodd er ei bod yn croesawu bod y sgôr risg nawr yn lleihau, gofynnodd sut y byddai hyn yn parhau i gael ei fonitro o ystyried bod monitro cyllid yn mynd i fod yn hanfodol fel Bwrdd. Cynghorodd S May y byddai ail-osod yn cael ei wneud ar ddechrau'r flwyddyn ariannol nesaf, o gofio bod y cynllun ariannol yn dangos cynllun cytbwys gyda risg heb ei lliniaru o 9.5m.

5.4

CYMERADWYWYD Fframwaith Sicrwydd y Bwrdd.

Adroddiad Gweithio mewn Partneriaethau - Gweithredu Model Rhanbarthol o Wasanaethau Gofal Cymunedol Integredig

Rhannodd M Jenkins gyflwyniad a thynnu sylw at y materion allweddol ar gyfer sylw Aelodau'r Bwrdd.

Estynnodd K Palmer ei diolch i M Jenkins am rannu'r cyflwyniad a chroesawodd y gwaith a ddechreuodd yn y maes pwysig hwn. Cyfeiriodd K Palmer at ddatblygiad y llwybr cymunedol ac ychwanegodd y byddai'n ddefnyddiol pe gellid mapio hyn o safbwynt canolbwyntio ar yr unigolyn a dywedodd y byddai'n ddefnyddiol pe gellid gwneud mwy o ymgysylltu â phobl o fewn cymunedau'r Bwrdd Iechyd i'w helpu i ddeall y gwasanaethau sydd ar waith, gyda chefnogaeth gan Bartneriaid Trydydd Sector ac eraill mewn perthynas ag ymgysylltu allanol.

Cynghorodd M Jenkins y byddai trafodaeth yn cael ei chynnal ynghylch sut mae cleifion yn mynd i mewn i'r llwybrau trwy fecanweithiau atgyfeirio mewn gweithdy a fyddai'n cael ei gynnal a'r gobaith oedd y gellid datblygu manyleb gwasanaeth draddodiadol ar gyfer y model gorau posibl yn dilyn trafodaethau.

Cyfeiriodd P Mears at y model integredig datblygedig a oedd ar waith ym Mhen-y-bont ar Ogwr, a ddisgrifiodd brofiad y claf. Gellid defnyddio'r model hwn wrth ymgysylltu â'r boblogaeth yn y dyfodol er mwyn disgrifio sut y gallai cleifion lywio rhwng gwahanol elfennau o wasanaethau a'r camau a fyddai'n cael eu cymryd i wella llwybrau. Ychwanegodd P Mears y gellid defnyddio'r stori a rannwyd yn gynharach yn y cyfarfod i dynnu sylw at sut na ddylai modelau gwasanaeth fod a'r camau y byddai angen eu cymryd i wella llwybrau gwasanaeth.

Cynghorodd G Hughes ei bod yn amlwg bod gwasanaethau cymunedol o fewn y Bwrdd Iechyd yn gymhleth i'w llywio a bod angen symleiddio a chroesawu'r trafodaethau sy'n cael eu cynnal i fynd i'r afael â hyn ac ychwanegodd y byddai defnyddio'r stori a rennir yn gynharach yn y cyfarfod yn helpu i yrru'r uchelgais i gyflawni hyn. Mynegodd G Hughes hefyd bwysigrwydd ystyried beth arall y gellid ei wneud i'r boblogaeth a'r angen i sicrhau bod ffocws yn cael ei roi ar fetrigau perfformiad i sicrhau bod y darn hwn o waith yn cael effaith wirioneddol ar y boblogaeth. Cynghorodd M Jenkins y byddai'r datganiad ansawdd ar eiddilwch yn bwynt mynediad pwysig ac ychwanegodd fod gwaith yn cael ei wneud gyda chydweithwyr i ddatblygu hynny ymhellach gyda mesurau gweithredol a chanlyniadau i gleifion.

Diolchodd L Thomas i M Jenkins am rannu'r cyflwyniad a phwysleisiodd nad oedd y mater hwn wedi'i ddatrys eto gan unrhyw sefydliad iechyd ac ychwanegodd y gallai Cwm Taf Morgannwg arwain y ffordd yn yr ardal hon os yw'n cymryd y dull cywir.

Cynghorodd y Cadeirydd ei bod yn ymddangos bod hwn yn ddarn sylweddol o waith ac yn cydnabod y berthynas gref a oedd gan M Jenkins ar waith gyda chydweithwyr y Bwrdd Partneriaethau Rhanbarthol. Ychwanegodd y Cadeirydd fod elfen y Bwrdd Partneriaethau Rhanbarthol yn bwysig o ran darparu, cefnogi a chyflwyno'r achos dros newid a dywedodd fod uchelgais ar waith rhwng y Bwrdd Iechyd a'r tri phartner Awdurdod Lleol i ddefnyddio elfen Adran 33 o'r ddeddfwriaeth i dynnu ynghyd y broses o wneud penderfyniadau ac argaeledd adnoddau i fwrw ymlaen â darnau integredig o waith yn gyflym.

Penderfyniad:

5.5

NODWYD y cyflwyniad.

Cynnig Adolygiad o Bwyllgor y Bwrdd

Dechreuodd y Cadeirydd drwy ddiolch i holl Aelodau'r Bwrdd am gymryd rhan yn y darn eithaf manwl hwn o waith. Cynghorodd y Cadeirydd ei fod yn awyddus iawn, yn ei 12 mis bron fel Cadeirydd y Bwrdd, i adolygiad gael ei gynnal o effeithiolrwydd y ffordd yr ydym yn gweithredu fel Bwrdd.

Diolchodd y Cadeirydd i G Watts, C Hamblyn a'r Tîm Llywodraethu Corfforaethol am yr ymgymeriad enfawr hwn a dywedodd fod ystyriaeth fanwl wedi'i chynnal ar rai o'r heriau, y cyfleoedd i ddiwygio a gwella'r hyn y mae'r Bwrdd yn ei wneud a hefyd roedd cyfnod sylweddol o ymgynghori wedi'i gynnal gyda holl Aelodau'r Bwrdd.

Cyflwynodd G Watts yr adroddiad ac amlygodd y materion allweddol i sylw'r Aelodau.

Cydnabu'r Cadeirydd fod yr adroddiad yn nodi fframwaith newydd lle byddai'r Bwrdd hwn yn symud i strwythur o saith pwyllgor yn hytrach na'r naw sydd ar waith ar hyn o bryd. Nododd yr Aelodau, yn ogystal â'r pum Pwyllgor statudol, y byddai dau bwyllgor newydd ychwanegol, y byddai un ohonynt yn canolbwyntio ar ddatblygu strategol a'r llall ar gyflawni gweithredol. Nododd yr aelodau fod argymhelliad wedi ei wneud i gael tri is-bwyllgor ffurfiol y Bwrdd hefyd. Nododd yr Aelodau y byddai trafodaethau'n cael eu cynnal dros yr wythnosau nesaf i benderfynu ar unrhyw feysydd a allai fod angen eu huwchgyfeirio o ffocws pwyllgor a'u trafod yn y Bwrdd. Mae meysydd o'r fath yn cynnwys, er enghraifft, arloesi digidol, a oedd yn alluogwr strategol allweddol, ac a oedd o werth sylweddol i'r Bwrdd, ac a allai fod angen trafodaethau yn y dyfodol ar lefel Bwrdd.

Dywedodd I Wells ei fod wedi mynegi pryderon am y darn hwn o waith ar ddechrau'r adolygiad, ac ychwanegodd, er nad oedd mor bryderus ag yr oedd ar y dechrau, bod ganddo ychydig o amheuon o hyd, yn enwedig mewn perthynas â 'Digidol a Data'. Dywedodd I Wells, er nad oedd yn pryderu am y gostyngiad yn nifer y pwyllgorau ac yn gallu gweld y rhesymeg y tu ôl i hyn,

teimlai ei fod yn bryderus ynghylch sut y byddai rhai o'r meysydd yn cael eu dal i sicrhau bod ffocws yn parhau i fod ar waith ar feysydd penodol, er enghraifft Digidol a Data ac Iechyd y Boblogaeth, yn strwythur newydd y Pwyllgor. Yn benodol mewn perthynas â Digidol a Data, cynghorodd I Wells nad oedd erioed wedi gweld hyn fel pwyllgor parhaol, ac amcan y pwyllgor hwn oedd meithrin lefel o aeddfedrwydd digidol o fewn y sefydliad, nad oedd gan y Bwrdd Iechyd pan sefydlwyd y Pwyllgor Digidol a Data yn wreiddiol. Ychwanegodd I Wells, er bod cynnydd sylweddol wedi'i wneud mewn perthynas â Digidol a Data, ei fod yn teimlo nad oedd y Bwrdd Iechyd wedi cyrraedd y lefel aeddfedrwydd a ddymunir eto a mynegodd bwysigrwydd rôl yr Aelod Annibynnol dros Ddigidol wrth symud ymlaen.

Cytunodd y Cadeirydd â'r pwyntiau a godwyd gan I Wells ar bwysigrwydd rôl yr Aelod Annibynnol dros Ddigidol wrth symud ymlaen. Cynghorodd y Cadeirydd y byddai sesiynau cynllunio agenda ar gyfer y pwyllgorau newydd yn y dyfodol yn cael eu gyrru gan yr Aelodau Annibynnol ac Arweinwyr Gweithredol. Byddai hyn yn hanfodol wrth sicrhau bod eitemau strategol ac elfennau allweddol yn cael eu dal. Cynghorodd D Hurford fod hyn yn gyfle newydd i ystyried pa bynciau penodol y gallai fod angen eu casglu ar draws nifer o bwyllgorau, er enghraifft, materion digidol.

Cynghorodd y Cadeirydd, er bod cryn dipyn o waith wedi'i wneud i nodi agenda enghreifftiol ac aelodaeth o Bwyllgorau, y byddai'n hapus i adolygu'r sefyllfa dros y 12 mis nesaf i sicrhau bod y system newydd yn gweithio'n effeithiol.

Croesawodd a chefnogodd C Donoghue y gwaith manwl a wnaed a dywedodd fod ganddi rai pryderon, yn enwedig o ran Digidol a Data fel galluogwr, bod nifer o feysydd eraill a fyddai'n cael eu hystyried yn alluogwyr er enghraifft, Cyllid, Rheoli Heintiau ac Ystadau, ac ychwanegodd y byddai'n her sicrhau bod y materion hyn yn cael y craffu priodol yn y pwyllgor priodol. Dywedodd C Donoghue ei bod yn derbyn bod gosod agenda yn bwysig ac ychwanegodd y byddai'n croesawu mwy o ddatblygiad o ran gosod agenda, gan sicrhau bod trafodaethau sy'n cael eu cynnal yn strategol, a gwneud penderfyniadau ar yr hyn sydd angen ei gyfeirio at y Bwrdd. Ychwanegodd C Donoghue ei bod hefyd yn teimlo ei bod yn bryderus y gallai rhai pwyllgorau gael eu gorlwytho a derbyniodd y byddai hyn yn cael ei fonitro wrth symud ymlaen.

Cynghorodd P Roseblade ei bod yn cefnogi'r darn o waith a wnaed fel proses, ac yn cytuno â'r sylwadau a wnaed gan C Donoghue o ran gorlwytho agendâu, ac ychwanegodd fod angen i'r pwyllgorau gael eu harwain gan risg yn yr amgylchedd strategol, gyda Fframwaith Sicrwydd y Bwrdd yn cael ei ddefnyddio i helpu i fframio'r agendâu ar gyfer y Pwyllgorau a'r Bwrdd. Ychwanegodd P Roseblade y byddai'n bwysig pennu dyddiadau cyfarfodydd a fyddai'n caniatáu i'r wybodaeth ddiweddaraf fod ar gael i'w thrafod.

Cytunodd S Morris gyda'r sylwadau a wnaed gan I Wells mewn perthynas â phwysigrwydd rôl Aelod Annibynnol dros Ddigidol wrth symud ymlaen. Dywedodd S Morris fod ganddo brofiad o'r newid hwn yn cael ei wneud yn llwyddiannus mewn sefydliadau eraill ac ychwanegodd y byddai gosod yr

agenda yn gywir yn allweddol i lwyddiant hyn, yn ogystal â chanolbwyntio ar y risgiau. Cynghorodd S Morris y byddai meysydd y byddai angen adrodd amdanynt, er enghraifft, ar Lywodraethu Gwybodaeth a Seiberddiogelwch, ac ychwanegodd y byddai angen ystyried sut y defnyddiwyd sesiynau Datblygu'r Bwrdd wrth symud ymlaen i drafod meysydd ffocws allweddol.

Croesawodd K Palmer y gwaith manwl a wnaed a chytunodd y byddai angen adolygu hyn i sicrhau bod strwythur newydd y pwyllgor yn effeithiol, a mynegodd bwysigrwydd aelodau'r Bwrdd a'r Pwyllgor gan sicrhau nad oedd trafodaethau a oedd yn cael eu cynnal yn rhy weithredol a'u bod ar lefel strategol. Roedd K Palmer hefyd yn teimlo bod gan y Gweithredwyr rôl i'w chwarae wrth benderfynu beth oedd angen ac na ddylid ei gyflwyno i'r Pwyllgor.

Estynnodd G Watts ei ddiolch i'r Bwrdd am y sylwadau adeiladol a wnaed, ac ychwanegodd, pe bai'r Bwrdd yn cymeradwyo, y byddai darn sylweddol o waith yn cael ei wneud cyn i'r strwythur newydd fynd yn fyw o ran trefniadau trosiannol ac adroddiadau etifeddiaeth. Cytunodd G Watts y byddai sesiynau cynllunio'r agenda wrth symud ymlaen yn allweddol, gyda phawb â rôl gyfunol wrth sicrhau bod materion priodol yn cael eu hychwanegu at yr agenda i'w trafod, a chytunodd gyda'r sylw a wnaed gan P Roseblade bod angen defnyddio Fframwaith Sicrwydd y Bwrdd fel offeryn i benderfynu beth sydd angen ei drafod yng nghyfarfodydd y Pwyllgor. Cytunodd G Watts fod angen ystyried hefyd sut y defnyddiwyd sesiynau Datblygu'r Bwrdd yn y dyfodol, a sut roedd sgiliau'n cael eu datblygu ar gyfer Aelodau'r Bwrdd.

Penderfyniad: **CYMERADWYODD** y Bwrdd:

- Weithredu Strwythur Pwyllgorau ac Is-bwyllgorau newydd y Bwrdd a amlinellir yn adran 9:
- Cyfrifoldebau holl Aelodau'r Bwrdd o ran y dull o ymdrin â Sesiynau Datblygu'r Bwrdd, Briffio'r Bwrdd a Chynllunio Agenda.
- Y camau nesaf fel yr amlinellir yn adran 23.

5.6 Sefydlu Cydbwyllgor Comisiynu GIG Cymru, fel Cyd-bwyllgor Byrddau Iechyd Lleol yn GIG Cymru

Cyflwynodd G Watts yr adroddiad ac amlygodd faterion allweddol i sylw'r Aelodau.

Cynghorodd y Cadeirydd fod y Bwrdd yn derbyn pecyn gwybodaeth eithaf cynhwysfawr heddiw, a dywedodd fod angen i'r Bwrdd fabwysiadu dull deuol, y cyntaf oedd bod y Bwrdd yn cael ei gyfarwyddo i gymeradwyo'r trefniadau newydd ar gyfer y Cydbwyllgor Comisiynu, a'r ail fater, a oedd yn dal i gael ei drafod gyda Llywodraeth Cymru, oedd y rhyngwyneb rhwng yr unigolyn a fyddai'n arwain y Cydbwyllgor Comisiynu fel y Prif Gomisiynydd, ond hefyd bod â statws swyddog atebol a oedd bellach yn cael ei benderfynu gan Lywodraeth Cymru. Nododd yr Aelodau fod camau'n cael eu cymryd i sicrhau bod y llywodraethiant priodol ar waith i ymateb i hyn, gan fod gan y Bwrdd Iechyd ddyletswydd fel Corff sy'n Lletya, ac fel Bwrdd, i sicrhau bod ein trefniadau llywodraethu yn gadarn ar gyfer yr hyn sy'n gwyro oddi wrth yr

hyn sydd wedi bod ar waith o'r blaen. Cynghorodd y Cadeirydd y byddai'n rhoi'r wybodaeth ddiweddaraf i'r Bwrdd am y cynnydd.

Gwnaeth P Roseblade gyfeiriad at baragraff 3.12 a gyfeiriodd at y Memorandwm Cytundeb rhwng y Byrddau Iechyd a gofyn am eglurder a oedd fersiwn ddrafft o hyn ar gael ac a oedd y Bwrdd yn sicr y byddai'n adlewyrchu popeth o fewn yr adroddiad y gofynnwyd i'r Bwrdd ei gymeradwyo. Cynghorodd G Watts, er nad oedd y Memorandwm Cytundeb wedi'i ddrafftio eto, mai dyma un o'r allbynnau o'r ffrwd waith Llywodraethu ac ychwanegodd y byddai hyn yn cael ei gwblhau yn ystod mis Ebrill 2024. Nododd yr Aelodau, pan fydd hyn yn cael ei ddrafftio, y byddai camau'n cael eu cymryd i sicrhau ei fod yn cyd-fynd yn llawn â'r gyfres o ddogfennau sy'n cael eu cyflwyno i'r Bwrdd i'w cymeradwyo.

Ceisiodd K Palmer sicrwydd ynghylch sut y byddai hyn yn cael ei adlewyrchu yn Fframwaith Sicrwydd y Bwrdd a'r cofrestrau risg, o gofio y byddai hwn yn gorff newydd a oedd yn cael ei drawsnewid. Cynghorodd G Watts y byddai ystyriaeth weithredol yn cael ei rhoi i'r mater hwn wrth i'r Pwyllgor fynd yn fyw, gan ystyried hefyd sut mae hyn yn cael ei adlewyrchu yn y trefniadau cynnal rhwng nawr a'r Bwrdd nesaf.

PENDERFYNODD y Bwrdd:

Penderfyniad:

- **NODI** sefydlu Cydbwyllgor Comisiynu (JCC) GIG Cymru o 1 Ebrill 2024, fel y'i cyfarwyddwyd gan Weinidogion Cymru;
- **NODI** y bydd y Cydbwyllgor yn disodli cyd-bwyllgorau presennol y Bwrdd, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (WHSSC) a Phwyllgor Gwasanaethau Ambiwlans Brys (EASC) o 1 Ebrill 2024;
- **NODI** datblygiad fframwaith llywodraethu'r JCC, fel elfen allweddol o fframwaith llywodraethu'r Bwrdd Iechyd;
- **MABWYSIADU'R** diwygiadau i'r Rheolau Sefydlog Enghreifftiol a Chadw a Dirprwyo Pwerau ar gyfer Byrddau Iechyd Lleol; a'r Rheolau Sefydlog a'r Cynllun Dirprwyo a Chadw Pwerau ar gyfer Cyd-bwyllgor Comisiynu GIG Cymru, fel y'i cyhoeddwyd gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ar 18 Mawrth 2024;
- **MABWYSIADU'R** Cyfarwyddiadau Ariannol Sefydlog ar gyfer Cyd-bwyllgor Comisiynu GIG Cymru, fel y'i cyhoeddwyd gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ar 19 Mawrth 2024; a
- **NODI** Map Atebolrwydd JCC am wybodaeth.

CYFLAWNI EIN CYNLLUN

6. Dangosfwrdd Perfformiad Integredig

6.1 Cyflwynodd L Prosser yr adroddiad ac amlygodd faterion allweddol i sylw'r Bwrdd. Rhoddodd y Gweithredwyr Clinigol ddiweddariad ar eu priod feysydd hefyd.

Fel rhan o'r eitem hon, rhannodd G Hughes gyflwyniad hefyd mewn perthynas â Llif Gofal Heb ei Drefnu o fewn y Bwrdd Iechyd. Nododd yr Aelodau y byddai

camau nawr yn cael eu cymryd i leihau cludo/presenoldeb diangen, cynyddu gallu cerdded a chyflwyno model newydd o ryddhau integredig.

Dywedodd G Dix ei fod yn parhau i bryderu am letya cleifion, a rhoddodd sicrwydd bod asesiadau risg ar waith wrth osod cleifion yn yr ardaloedd hyn nas comisiynwyd, er bod urddas a phrofiad o ofal yn bendant yn cael ei beryglu, a nodwyd yn glir fel mater yn y stori Gwrando a Dysgu a rannwyd yn gynharach yn y cyfarfod. Nododd yr aelodau fod uwch nyrsys yn cysylltu â'r cleifion hyn bob dydd i sicrhau bod yr asesiadau risg yn cael eu diweddaru. Cynghorodd G Dix ei fod yn croesawu'r data a rannwyd gan G Hughes yn ystod ei gyflwyniad ac yn croesawu'r gwaith a fyddai'n cael ei wneud i fynd i'r afael â materion yn ymwneud â'r llif.

Gwnaeth C Donoghue gyfeiriad at y materion sy'n cael eu profi gyda chleifion preswyl a chynghorodd fod G Hughes wedi cyflwyno llawer o wybodaeth am yr achosion y tu ôl i hyn, ac awgrymodd fod angen i'r adroddiad a fydd yn cael ei gyflwyno i'r Bwrdd ym mis Mai gynnwys diweddariad ar letya. Cynghorodd C Donoghue fod ganddi bryderon y byddai lletya cleifion yn dod yn arfer arferol a theimlai bod angen gwrthsefyll lletya cleifion bob amser. Mewn ymateb i gwestiwn a godwyd gan C Donoghue, cynghorodd G Dix fod Cyfarwyddwyr Nyrsio a Chyfarwyddwyr Gweithredol y Grŵp Gofal yn gyfrifol am gymeradwyo lletya cleifion. Dywedodd P Mears fod cydweithwyr yn Llywodraeth Cymru wedi rhoi cyfarwyddiadau clir i'r Bwrdd Iechyd mewn perthynas â'r angen i sicrhau bod ambiwlansys yn cael eu dadlwytho ac ychwanegodd bod angen bod perchnogaeth ar waith ar lefel genedlaethol o'r materion a brofir.

Cyfeiriodd G Hopkins at y cyflwyniad a rannwyd gan G Hughes a'r cyfeiriad a wnaed at asesiadau a chynghorodd ei bod yn ymddangos bod naid sylweddol yn gyflym iawn. Cynghorodd G Hughes fod hyn o ganlyniad i gyflwyno e-fyrddau gwyn, ac un o'r materion oedd methu â chipio data hanesyddol, gyda data bellach yn cael ei gipio'n ddyddiol yn hytrach na chael ei gipio unwaith yr wythnos cyn cyflwyno e-fyrddau gwyn. Cynghorodd P Mears y byddai'n ddefnyddiol anodi ar y graff nad oedd data'n cael ei ddal yn electronig o'r blaen a dyna pam y bu cynnydd sylweddol yn y niferoedd a gofnodwyd.

Croesawodd I Wells y cyflwyniad a rannwyd gan G Hughes a chynghorodd ei fod wedi gwneud taith gerdded yn ddiweddar gyda L Edwards o'r Uned Strôc yn Ysbyty Tywysoges Cymru i weld sut roedd pethau'n gweithredu. Ychwanegodd I Wells ei fod wedi cael sicrwydd gyda'r hyn yr oedd wedi'i weld ar yr uned, gyda chleifion yn cael eu hadolygu a'u monitro'n rheolaidd gan yr Ymgynghorwyr Strôc ble bynnag yr oeddent yn yr ysbyty.

Cyfeiriodd N Milligan hefyd at strôc a chynghorodd ei bod yn falch o weld y cynnydd yng nghanran y cleifion a oedd yn gymwys i gael eu thrombolysu. Cyfeiriodd N Milligan at y model Nyrs Glinigol Arbenigol, a oedd yn aros am gymeradwyaeth ariannol a cheisiodd eglurder ynghylch pryd y byddai hyn yn debygol o gael ei gymeradwyo. Cynghorodd G Hughes fod hyn yn rhan o'r cynllunio presennol o fewn y Cynllun Tymor Canolig Integredig a dywedodd mai rhan o'r her ar hyn o bryd oedd cyrraedd sefyllfa y cytunwyd arni, a fyddai

wedyn yn galluogi'r Bwrdd Iechyd i ailgylchu arian o arbedion o fewn y gyllideb Gofal Heb ei Drefnu i'r model Nyrs Glinigol Arbenigol.

Cyfeiriodd D Jouvenat at y materion mewn perthynas â lletya cleifion a cheisiodd eglurder ynghylch a ellid rhoi proses ar waith i sicrhau nad yw gwelyau lletya yn cael eu gadael mewn ardaloedd amhriodol ar ôl i glaf gael ei ryddhau ohono. Croesawodd G Dix y pwynt hwn a wnaed a dywedodd fod tua 20 o gleifion ychwanegol o fewn chwe gwely neu bedwar bae gwely i gefnogi llif a chynghorodd am yr heriau a wynebir a'r amser y mae'n ei gymryd i symud gwelyau i mewn ac allan o siopau gwelyau, a effeithiodd ar yr ambiwlansys yn aros y tu allan i ysbytai i ddadlwytho cleifion.

Cynghorodd G Hughes, o ran lletya, y mae'n cydnabod nad yw'r peth iawn i'w wneud i gleifion, roedd camau'n cael eu cymryd i sicrhau nad yw cleifion yn cael eu cadw yn y mannau hynny am gyfnodau hir. Ychwanegodd G Hughes fod yr egwyddor o letya yn ymwneud â chefnogi all-lif o'r adrannau brys i gadw'r adran yn fwy diogel ac i alluogi trosglwyddo ambiwlansys oedd wedi'u hoedi. Dywedodd G Hughes na ddylai gwely preswyl fod yn wely parhaol ac ni ddylai fod claf yn y gwely hwnnw am gyfnod hir. Nododd yr Aelodau, yn Ysbyty'r Tywysog Siarl, lle maen nhw wedi gorfod lletya cleifion am gyfnodau hirach, bod y Tîm yn dda iawn am sicrhau bod y cleifion oedd yn mynd adref y diwrnod canlynol yn cael eu rhoi mewn gwely lletya, ac ychwanegodd bod gwelyau lletya yn cael eu defnyddio yn ystod y nos i gynnal elfen o lif. Nododd y Bwrdd bod achlysuron lle nad oedd modd tynnu gwelyau lletya i lawr mor aml â phosib oherwydd y pwysau.

Estynnodd K Palmer ei diolch i G Hughes am rannu'r cyflwyniad a gofynnodd am adolygu'r data a'i gyflwyno i'r Bwrdd yn ddiweddarach er mwyn sicrhau bod y monitro yn parhau i fod ar waith. Gofynnodd K Palmer hefyd fod cydweithwyr Gofal Sylfaenol yn cael eu cynnwys mewn trafodaethau mewn perthynas â gofal eilaidd ac ysbytai cymunedol, o ystyried yr adborth a gafodd o rai ymweliadau yr hoffai cydweithwyr gofal sylfaenol gymryd mwy o ran mewn newidiadau o'r cychwyn cyntaf.

NODWYD yr adroddiad.

Penderfyniad:

6.2 Diweddariad Perfformiad Ariannol

Cyflwynodd S May yr adroddiad a thynnodd sylw Aelodau'r Bwrdd at y prif ddiweddariadau.

Estynnodd K Palmer ei diolch i'r holl dimau am gyflawni'r sefyllfa a adroddwyd a dywedodd y byddai'n ddefnyddiol iddi pe gallai adroddiadau yn y dyfodol gynnwys dadansoddiad o wariant cyfalaf. Cynghorodd S May fod adroddiad gwariant cyfalaf chwe mis yn cael ei gynhyrchu i ategu'r adroddiad perfformiad ariannol ac ychwanegodd y byddai'n hapus i rannu hyn yn y cyfarfod nesaf.

Cynghorodd y Cadeirydd ei fod yn gwerthfawrogi'r cadernid a'r trylwyredd a roddwyd ar waith mewn perthynas â'r cynllunio ariannol o fewn y Bwrdd Iechyd hwn a dywedodd fod lefelau uchel o hyder ar waith mewn perthynas â'r gwaith sy'n cael ei wneud gan S May a'i thîm, ochr yn ochr â'r Tîm Gweithredol a'r Grwpiau Gofal, i nodi lle y gellid cyflawni arbedion a sicrhau bod ymdrechion yn cael eu gwneud i gadw at y cynllun a nodwyd flwyddyn yn ôl i Lywodraeth Cymru. Diolchodd y Cadeirydd i'r Tîm am yr ymdrech enfawr hon i gyflawni sefyllfa gytbwys ac am y gwaith a wnaed ar ddatblygu'r Cynllun a'r gyllideb Tymor Canolig Integredig ar gyfer 2024/2025. Cynghorodd S May fod hon wedi bod yn ymdrech ar draws y sefydliad yn gyfan gwbl nad oedd wedi bod yn hawdd o ystyried faint o bwysau sydd yn y system, a dywedodd y byddai'r cyflawniad hwn yn rhoi gwell sefyllfa i'r Bwrdd Iechyd wrth i gynlluniau gael eu datblygu i ail-lunio'r buddsoddiad ar gyfer y dyfodol.

Penderfyniad:

7. **NODWYD** yr adroddiad.

7.1 **CYNLLUNIO STRATEGOL**

Cynllun a Chyllideb Tymor Canolig Integredig ar gyfer 2024/2025

Cyflwynodd L Prosser, S May, G Hughes a H Watkins yr adroddiad a'r cyflwyniad a thynnodd sylw'r Aelodau at y prif faterion.

Diolchodd y Cadeirydd i'w gydweithwyr am roi'r wybodaeth ddiweddaraf am agweddau allweddol y Cynllun Tymor Canolig Integredig (IMTP).

Cynghorodd P Roseblade ei bod wedi nodi bod y buddsoddiad Strôc wedi'i ddileu a'i fod yn deall bod angen i'r lefel risg fod ar lefel benodol, a holodd a oedd yn debygol o fod unrhyw gyllid cenedlaethol ar gael ar gyfer Strôc yn dilyn yr adolygiad cenedlaethol o wasanaethau strôc. Cynghorodd S May nad oedd hi'n ymwybodol o unrhyw gyllid oedd ar gael a dywedodd fod y Grŵp Gofal Heb ei Drefnu, fel y cyfeiriodd G Hughes ato'n gynharach, wedi cael cyllid ychwanegol i'r Grŵp Gofal Heb ei Drefnu a'i fod wedi'i herio fel Grŵp Gofal i gerfio digon o arian i flaenoriaethu strôc, yr oedd angen gweithio drwyddo ymhellach.

Cynghorodd K Palmer ei bod yn cydnabod bod yr IMTP yn waith sylweddol a nododd y risg mewn perthynas ag Iechyd Meddwl a'r risg a oedd yn cael ei chario mewn perthynas â systemau a data. Hefyd, cyfeiriodd K Palmer at wreiddio'r Grwpiau Gofal, a oedd yn dal yn eithaf newydd, gyda rhai newidiadau i strwythurau a swyddi yn cael eu gwneud drwy'r Broses Newid Sefydliadol. Gofynnodd K Palmer hefyd i sesiwn gael ei chynnal gyda'r Bwrdd mewn perthynas â chyllid blwyddyn dau a thri, o fewn y chwe mis nesaf i ystyried sut y gallwn geisio troi pethau o gwmpas i gefnogi Gofal Sylfaenol, atal ac ymyrraeth gynnar.

Cyfeiriodd P Mears at y drafodaeth a gynhaliwyd yn gynharach yn y cyfarfod ynghylch llwybrau a phwysau clinigol, a'r costau sylweddol sy'n cael eu

hwynebu bob dydd i gadw cleifion mewn gwelyau y gellid gofalu amdanynt mewn lleoliad cymunedol, a dywedodd y dylid defnyddio'r costau hyn i wario ar wella gofal strôc a gwasanaethau sylfaenol a chymunedol, er enghraifft.

Myfyriodd S May ar y cyflwyniad a rannwyd gan G Hughes ar Lif Gofal Heb ei Drefnu a dywedodd er bod nifer y cleifion a oedd yn cyflwyno wedi gostwng, a oedd wedi arwain at golled ariannol i Ysbyty'r Tywysog Siarl yn unig o dros £6m, er gwaethaf cleifion yn aros yn hirach mewn gwelyau ysbyty. Cynghorodd S May bod angen cryn dipyn o waith i fynd i'r afael â sut mae'r system yn gweithio.

Cynghorodd S Morris mewn perthynas â heriau a darpariaeth ddata'r system Iechyd Meddwl y cyfeiriwyd atynt gan K Palmer, bod camau'n cael eu cymryd i fynd i'r afael â'r materion a'r gobaith oedd y byddai'r Bwrdd Iechyd yn gallu
Penderfyniad: cael gafael ar gyllid posibl a allai ddod ar gael gan Lywodraeth Cymru y flwyddyn nesaf a fyddai'n helpu i geisio datrys y problemau sy'n cael eu profi.

Cam gweithredu: CYMERADWYWYD yr **IMTP** i'w gyflwyno i Lywodraeth Cymru erbyn 29 Mawrth 2024, gan nodi'r risgiau i gyflawni cynllun ariannol cytbwys.

G Watts i gynnwys y cais i ystyried cyllid blynyddoedd dau a thri o fewn Sesiwn Datblygu'r Bwrdd o fewn y chwe mis nesaf i ystyried y cymorth sydd
7.2 ei angen ar gyfer Gofal Sylfaenol, atal ac ymyrraeth gynnar.

Diweddariad cynllun Gwasanaethau Clinigol Acíwt

Cyflwynodd L Prosser yr adroddiad a diweddaru Aelodau'r Bwrdd ar y cynnydd
Penderfyniad: sy'n cael ei wneud mewn perthynas â datblygu'r Cynllun Gwasanaethau Clinigol Acíwt.

NODWYD yr adroddiad.

8.0 AGENDA CYDSYNIAD

8.1 I'W GYMERADWYO

8.1.1 Cofnodion heb eu Cadarnhau y cyfarfod a gynhaliwyd ar 25 Ionawr 2024

Penderfyniad

CYMERADWYWYD y cofnodion.

8.1.2

Cynllun Gweithredu Datgarboneiddio ar gyfer 2024-2026

Penderfyniad:

CYMERADWYWYD y Cynllun.

8.1.3

Cynllun Cydraddoldeb Strategol

Penderfyniad

CYMERADWYWYD y Cynllun Cydraddoldeb Strategol.

8.2

I'W NODI

8.2.1 **Cylch Busnes Blynyddol y Bwrdd**

Penderfyniad: **NODWYD** y Cylch Busnes Blynyddol.

8.2.2 **Blaenraglen Waith y Bwrdd**

Penderfyniad **NODWYD** y Blaenraglen Waith

8.2.3 **Adroddiadau Crynhoi Pwyllgorau'r Bwrdd a'r Grŵp Cynghori**

Penderfyniad

8.2.4 **NODWYD** yr adroddiad.

Penderfyniad: **Adroddiad Archwilio Blynyddol Archwilio Cymru**

8.2.5 **NODWYD** yr adroddiad.

Penderfyniad: **Diweddariad Chwarterol y Cynllun Blynyddol**

9. **NODWYD** yr adroddiad.

9.1 **BUSNES I GLOI**

UNRHYW FATER ARALL

9.2 Cynghorodd y Cadeirydd nad oedd wedi cael gwybod am unrhyw fusnes arall.

SUT WNAETHON NI YN Y CYFARFOD HWN?

10. Gwahoddodd y Cadeirydd aelodau/cydweithwyr i gyflwyno unrhyw sylwadau i'w gwella ar y pwynt hwn neu o fewn pythefnos i'r cyfarfod i roi adborth mewn perthynas â'r materion a drafodwyd ac yn y ffordd y cynhaliwyd y cyfarfod a sut y gellid gwella cyfarfodydd yn y dyfodol.

SESIWN PREIFAT / MEWN PWYLLGOR

11. Nid oedd unrhyw eitemau yr oedd angen eu trafod mewn sesiwn Mewn Pwyllgor y Bwrdd.

DYDDIAD AC AMSER Y CYFARFOD NESAF

Nododd yr Aelodau y byddai cyfarfod Bwrdd Cyhoeddus Cyffredin Ychwanegol yn cael ei gynnal ddydd Mawrth 9 Ebrill am 9:00am a nodwyd y byddai cyfarfod nesaf y Bwrdd Cyhoeddus yn dilyn y cyfarfod a gynhelir ddydd Iau 30 Mai am 9:30am.

Agenda Item Number: 8.1.2

Minutes of the Extra Ordinary Meeting of Cwm Taf Morgannwg University Health Board (CTMUHB) held on Tuesday 09 April 2024 Broadcast Live via Microsoft Teams)

Members Present:

Jonathan Morgan	Chair
Paul Mears	Chief Executive
Kath Palmer	Vice Chair
Patsy Roseblade	Independent Member
Lynda Thomas	Independent Member
Nicola Milligan	Independent Member
Dilys Jouvenat	Independent Member
Rachel Rowlands	Independent Member
Greg Dix	Executive Director of Nursing/Deputy Chief Executive
Linda Prosser	Executive Director of Strategy & Transformation
Lauren Edwards	Executive Director of Therapies & Health Science
Sally May	Executive Director of Finance
Philip Daniels	Executive Director of Public Health
Hywel Daniel	Executive Director for People
Sally Bolt	Associate Member
Anne Morris	Associate Member (observing via Live Link)

In Attendance:

Stuart Morris	Director of Digital
Simon Blackburn	Director of Communications & Engagement
Anthony Gibson	Deputy Medical Director
Gareth Watts	Director of Corporate Governance / Board Secretary
Cally Hamblyn	Assistant Director of Governance & Risk
Stephen Harrhy	Chief Ambulance Services Commissioner
Daniel Price	Regional Director, Llais Cymru
Emma Walters	Head of Corporate Governance & Board Business (Secretariat)

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the meeting, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings were also **noted** by the Chair.

1.2 Apologies for Absence

Apologies for absence had been received from:

- Carolyn Donoghue, Independent Member;
- Ian Wells, Independent Member;

- Geraint Hopkins, Independent Member;
- Helen Lentle, Independent Member;
- Dom Hurford, Medical Director;
- Gethin Hughes, Chief Operating Officer.

1.3 Declarations of Interest

No Declarations of Interest were noted prior to or during the meeting.

2. MAIN AGENDA

2.1 EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE – SERVICE REVIEW

S Harrhy presented the report that updated the Health Board on the conclusion and the recommended option for the Emergency Medical Retrieval and Transfer Service Review. S Harrhy extended his thanks to the Board for inviting him to present on this important issue.

S Harrhy advised that as Chief Ambulance Services Commissioner, he worked for Health Boards and had a responsibility to ensure that on the Health Boards' behalf, the best Emergency Medical Retrieval and Transfer Service (EMRTS) as possible was being commissioned. Members noted that this service was being delivered in partnership between the NHS and the Wales Air Ambulance Charity, with the Charity funding two thirds of the total running costs and the NHS funding the remaining one third.

Members noted the service was highly specialised and brought critical care services to patients who had a life threatening or limb threatening condition. The Board noted that the numbers of patients who receive this service was quite small, with only seven out of 1200 ambulance incidents on a daily basis resulting in a response from the EMRTS service, which equated to less than 1%. S Harrhy advised that he felt that the service could see more patients than being seen at present.

The Board noted that patients within Cwm Taf Morgannwg were mainly covered by two bases, one being in Cardiff and the other being in Dafen, Llanelli, with resources being available in both bases between 8am and 8pm. Members noted that after 8pm, there was one resource available in Cardiff which covered the whole of Wales. S Harrhy advised that the review that had been undertaken had taken into consideration whether this provision was sufficient or not.

S Harrhy advised that there would be no change to service provision from a Cwm Taf Morgannwg perspective, with services continuing to operate from Dafen and Cardiff and added that a recommendation was being made to introduce an additional night service in north Wales which would be in place until 2am, and would result in two resources being available after 8pm.

S Harrhy advised that there were around three patients per day that would benefit from the EMRTS service who were not currently receiving access to the

service at present, with around 11% of the total unmet demand being within the Cwm Taf Morgannwg region. Members noted that the majority of unmet need was during the hours of darkness, with the one asset available in the Cardiff area being drawn out to other areas resulting in cover not being available for south and south west Wales. Members noted that by introducing an additional asset in north Wales to cover after 8pm, this would result in the reduction in the amount of unmet need within Cwm Taf Morgannwg, which equated to 30-40 patients a year who would have a much better chance of survival and would live better quality lives. S Harrhy advised that independent evaluations had been undertaken of the service and it was evident that expert clinicians working within the service provided an excellent service.

S Harrhy advised that in relation to costs, it was felt that an enhanced service across Wales could be provided within the existing resource envelope, with a need to put in place a bespoke service into rural areas, which could also be delivered within the existing resource envelope.

S Harrhy advised that a comprehensive formal public engagement process had been undertaken and added that whilst there were a small number of responders from within the Cwm Taf Morgannwg area, responses received from CTM residents were positive in relation to the changes being proposed. Members noted that responses from other parts of Wales had been less positive. S Harrhy advised that engagement had been and would continue to be undertaken with Llais Cymru officers and added that it would be important to consider the views being expressed by Llais who had made some important points which had been addressed and would continue to be addressed during the process.

S Harrhy concluded that he had carefully considered all of the recommendations and felt that a better service would be provided, not only for people across Wales, but for patients within the Cwm Taf Morgannwg area.

D Price, Llais Regional Director, advised that in addition to a national position, Llais Cymru had considered the local context also. D Price added that Llais had noted the strength of feeling expressed by rural communities and noted that whilst there were a limited number of responders within Cwm Taf Morgannwg, feedback that had been received had been positive. Members noted that Llais Cwm Taf Morgannwg had not received any direct correspondence from members of the public and communities in relation to EMRTS, with feedback being directly received by the Emergency Ambulance Services Committee via their engagement process.

D Price advised that it had been noted that Task & Finish Groups had been established to refine and develop the approach, which included further public engagement in relation to recommendation four in particular, and it had been noted that further work was required by the Air Ambulance Charity to scope the actual base being proposed for north Wales, which would not impact on Cwm Taf Morgannwg residents.

D Price advised that Llais had noted that no changes were being proposed to base locations until September 2026, and whilst he had no specific concerns relating to Cwm Taf Morgannwg to bring to the attention of the Board, D Price advised that he wished to share the views of Llais Cymru nationally, which mainly related to concerns in relation to the need for urgency in any decision that needed to be taken in this process, whilst matters were still being worked through.

The Chair advised that in relation to the decision making process, it was important to note clarity on the role of individual Health Boards and note that the function of determining the commissioning of EMRTS sits with the new Joint Commissioning Committee, with the role of the Health Board today being to consider the proposed changes for the population of Cwm Taf Morgannwg, which appeared to have a positive impact for the region. Members noted that all seven Health Boards were meeting this week to consider the proposals for their localities ahead of the Joint Commissioning Committee meeting on 23 April 2024.

In response to a question raised by N Milligan as to what impact the risk of decreased donations could have on CTM patients given that two thirds of the service was funded by charity donations, S Harrhy advised that one of the reasons for seeking a prompt decision was to provide the charity with some certainty so that they could redouble their efforts on fundraising and added that a prolonged decision making process would pose as a potential risk to the charity in terms of fundraising, which needed to be mitigated.

P Mears advised that this change would have implications across the whole of Wales and added that it was evident that from a Cwm Taf Morgannwg perspective, its population would see an enhanced services as a result of the changes being proposed. P Mears added that he recognised that concerns had been raised within other Health Board areas which would be discussed further at the Joint Commissioning Committee in regards to what balance needed to be achieved for the whole of the population and the potential implications for different areas within Wales. P Mears advised that he was aware that S Harrhy and his colleagues are working hard to provide assurances on the questions that had been raised, particularly in relation to what alternative provision would be available within rural areas to support the air ambulance service.

P Mears recognised the priority for concluding this agreement swiftly in order to provide the Air Ambulance charity with some certainty and expressed the importance of maintaining positive relationships with the Charity, who would be meeting with the Minister later this month to share their concerns and express the need for rapid resolution.

P Mears concluded that he felt that this proposal would enhance the services available to the population of Cwm Taf Morgannwg and would welcome support from the Board to take this view forward for discussion at the Joint Commissioning Committee on 23 April 2024 where a final decision would be made.

The Chair extended his thanks to P Mears for the helpful summary and advised that it was evident that from reading the report, further work was required in relation to final recommendations, and the further work required in relation to consultation and engagement as the proposal developed. The Chair added that he was certain that all Health Boards would wish to be involved in the consultation process moving forwards to allow for the Joint Commissioning Committee to implement the decision made.

The Chair concluded that whilst the report was requesting that the Board approves and notes the recommendations contained within it, this would be done under a caveat that whilst the Board would be content for the recommendations to be put forward to the Joint Commissioning Committee, it would be the responsibility of the Joint Commissioning Committee to agree the recommendations and to put into place the future of the EMRTS service moving forwards.

Resolution

The Board **RESOLVED** to **APPROVE** and **NOTE** the following recommendations, with caveat that the Board were approving the recommendations to be taken forward to the Joint Commissioning Committee in the context that the recommendations would have a beneficial impact for the population of Cwm Taf Morgannwg and noting that it would be the responsibility for the Joint Commissioning Committee to take the decision for the whole of Wales:

- **APPROVE** the recommendations from the Chief Ambulance Services Commissioner;
- **APPROVE** that all the recommendations be considered collectively;
- **NOTE** the representations raised by Llais and the other representations and the responses updated accordingly Appendices 2 and 3 and NOTE that colleagues and members of the Cwm Taf Morgannwg communities had not raised any responses directly with Llais from a CTM perspective;
- **NOTE and APPROVE** the work undertaken to further develop recommendation 4 and to establish a Task and Finish Group to further refine and develop the approach and to deliver a detailed implementation plan by the end of September 2024;
- **ENDORSE** further work be undertaken by the Wales Air Ambulance Charity to scope an operational base in line with findings to support future decision making;
- **NOTE** the risk to the Charity;
- **NOTE** the national feedback provided by the Picker Institute;
- **NOTE** the risk to patients and under-utilisation levels across Wales;
- **NOTE** the conclusion of Phase 3 and the overall engagement process;
- **NOTE** that the Ambulance and 111 Commissioning Team as part of the new JCC continue to work with the Health Board engagement, communication and service change lead, and Llais throughout the conclusion of the Review.

3. CLOSE OUT BUSINESS

3.1 ANY OTHER BUSINESS

The Chair advised that he had not been notified of any other business.

4. DATE AND TIME OF THE NEXT MEETING

The next scheduled meeting of the Board held in public will take place on Thursday 30 May 2024.

Rhif Eitem Agenda:

Cofnodion Cyfarfod Eithriadol Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg (BIPCTM) a gynhaliwyd ddydd Mawrth 09 Ebrill 2024 wedi'i Ddarlledu'n Fyw drwy Microsoft Teams)

Aelodau yn Bresennol:

Jonathan Morgan	Cadeirydd
Paul Mears	Prif Weithredwr
Kath Palmer	Is-gadeirydd
Patsy Roseblade	Aelod Annibynnol
Lynda Thomas	Aelod Annibynnol
Nicola Milligan	Aelod Annibynnol
Dilys Jouvenat	Aelod Annibynnol
Rachel Rowlands	Aelod Annibynnol
Greg Dix	Cyfarwyddwr Gweithredol Nyrsio/Dirprwy Brif Weithredwr
Linda Prosser	Cyfarwyddwr Gweithredol Strategaeth a Thrawsnewid
Lauren Edwards	Cyfarwyddwr Gweithredol Therapïau a Gwyddorau Iechyd
Sally May	Cyfarwyddwr Gweithredol Cyllid
Philip Daniels	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd
Hywel Daniel	Cyfarwyddwr Gweithredol Pobl
Sally Bolt	Aelod Cyswllt
Anne Morris	Aelod Cyswllt (arsylwi trwy Live Link)

Yn Bresennol:

Stuart Morris	Cyfarwyddwr Digidol
Simon Blackburn	Cyfarwyddwr Cyfathrebu ac Ymgysylltu
Anthony Gibson	Dirprwy Gyfarwyddwr Meddygol
Gareth Watts	Cyfarwyddwr Llywodraethu Corfforaethol / Ysgrifennydd y Bwrdd
Cally Hamblyn	Cyfarwyddwr Cynorthwyol Llywodraethu a Risg
Stephen Harrhy	Prif Gomisiynydd Gwasanaethau Ambiwlans
Daniel Price	Cyfarwyddwr Rhanbarthol, Llais Cymru
Emma Walters	Pennaeth Llywodraethu Corfforaethol a Busnes y Bwrdd (Ysgrifenyddiaeth)

1 MATERION RHAGARWEINIOL

1.1 Croeso a Chyflwyniadau

Croesawodd y Cadeirydd bawb i'r cyfarfod, yn enwedig y rhai a oedd yn ymuno am y tro cyntaf, y rhai a oedd yn arsylwi a'r cydweithwyr oedd yn ymuno ar gyfer eitemau penodol ar yr agenda. **Nododd** y Cadeirydd fformat y trafodion hefyd.

1.2 Ymddiheuriadau am Absenoldeb

Derbyniwyd ymddiheuriadau am absenoldeb oddi wrth:

- Carolyn Donoghue, Aelod Annibynnol;
- Ian Wells, Aelod Annibynnol;
- Geraint Hopkins, Aelod Annibynnol;
- Helen Lentle, Aelod Annibynnol;
- Dom Hurford, Cyfarwyddwr Meddygol
- Gethin Hughes, Prif Swyddog Gweithredu.

1.3 Datganiadau o Fuddiant

Ni nodwyd unrhyw Ddatganiadau o Fuddiant cyn nac yn ystod y cyfarfod.

2. PRIF AGENDA

2.1 Y GWASANAETH CASGLU A THROSGLWYDDO MEDDYGOL BRYS - ADOLYGIAD GWASANAETH

Cyflwynodd S Harrhy yr adroddiad a oedd yn rhoi'r wybodaeth ddiweddaraf i'r Bwrdd Iechyd ar y casgliad a'r opsiwn a argymhellwyd ar gyfer yr Adolygiad o'r Gwasanaeth Casglu a Throsglwyddo Meddygol Brys. Diolchodd S Harrhy i'r Bwrdd am ei wahodd i roi cyflwyniad ar y mater pwysig hwn.

Cynghorodd S Harrhy ei fod, fel Prif Gomisiynydd y Gwasanaethau Ambiwlans, yn gweithio i Fyrddau Iechyd a bod ganddo gyfrifoldeb i sicrhau bod y Gwasanaeth Casglu a Throsglwyddo Meddygol Brys (EMRTS) gorau posibl yn cael ei gomisiynu ar ran y Byrddau Iechyd. Nododd yr aelodau fod y gwasanaeth hwn yn cael ei ddarparu mewn partneriaeth rhwng y GIG ac Elusen Ambiwlans Awyr Cymru, gyda'r Elusen yn ariannu dwy ran o dair o gyfanswm y costau rhedeg a'r GIG yn ariannu'r traean arall.

Nododd yr aelodau fod y gwasanaeth yn hynod arbenigol a'i fod yn dod â gwasanaethau gofal critigol i gleifion â chyflwr sy'n bygwth bywyd neu'n bygwth aelodau o'r corff. Nododd y Bwrdd fod nifer y cleifion sy'n derbyn y gwasanaeth hwn yn eithaf bach, gyda dim ond saith allan o 1200 o ddigwyddiadau ambiwlans yn ddyddiol yn arwain at ymateb gan y gwasanaeth EMRTS, a oedd yn cyfateb i lai nag 1%. Cynghorodd S Harrhy ei fod yn teimlo y gallai'r gwasanaeth weld mwy o gleifion nag sy'n cael eu gweld ar hyn o bryd.

Nododd y Bwrdd fod cleifion Cwm Taf Morgannwg yn cael eu gwasanaethu gan ddau leoliad yn bennaf, un yng Nghaerdydd a'r llall yn Nafen, Llanelli, gydag adnoddau ar gael yn y ddau leoliad rhwng 8am ac 8pm. Nododd yr aelodau, ar ôl 8pm, fod un adnodd ar gael yng Nghaerdydd a oedd yn cwmpasu Cymru gyfan. Cynghorodd S Harrhy fod yr adolygiad a gynhaliwyd wedi ystyried a oedd y ddarpariaeth hon yn ddigonol ai peidio.

Cynghorodd S Harrhy na fyddai unrhyw newid i'r ddarpariaeth gwasanaeth o safbwynt Cwm Taf Morgannwg, gyda gwasanaethau'n parhau i weithredu o Dafen a Chaerdydd ac ychwanegodd fod argymhelliad yn cael ei wneud i gyflwyno gwasanaeth nos ychwanegol yng Ngogledd Cymru a fyddai ar waith tan 2am, a byddai'n arwain at ddau adnodd ar gael ar ôl 8pm.

Cynghorodd S Harrhy fod tua thri chlaf y dydd a fyddai'n elwa o'r gwasanaeth EMRTS nad oeddent yn cael mynediad i'r gwasanaeth ar hyn o bryd, gyda thua 11% o gyfanswm y galw heb ei ddiwallu o fewn rhanbarth Cwm Taf Morgannwg. Nododd yr aelodau fod y rhan fwyaf o'r angen nas diwallwyd yn ystod oriau'r tywyllwch, gyda'r un ased sydd ar gael yn ardal Caerdydd yn cael ei dynnu i ardaloedd eraill gan olygu nad oedd yswiriant ar gael ar gyfer de a de-orllewin Cymru. Nododd yr Aelodau y byddai cyflwyno ased ychwanegol yng Ngogledd Cymru i'w gyflenwi ar ôl 8pm, yn arwain at ostyngiad yn yr angen heb ei ddiwallu yng Nghwm Taf Morgannwg, a oedd yn cyfateb i 30-40 o gleifion y flwyddyn a fyddai â siawns llawer gwell o oroesi ac a fyddai'n byw bywydau o ansawdd gwell. Cynghorodd S Harrhy fod gwerthusiadau annibynnol wedi'u cynnal o'r gwasanaeth a'i bod yn amlwg bod clinigwyr arbenigol sy'n gweithio yn y gwasanaeth yn darparu gwasanaeth rhagorol.

Cynghorodd S Harrhy, mewn perthynas â chostau, y teimlwyd y gellid darparu gwasanaeth gwell ar draws Cymru o fewn yr amlen adnoddau bresennol, a bod angen sefydlu gwasanaeth pwrpasol mewn ardaloedd gwledig, y gellid ei ddarparu hefyd o fewn yr amlen adnoddau presennol.

Cynghorodd S Harrhy fod proses ffurfiol gynhwysfawr o ymgysylltu â'r cyhoedd wedi'i chynnal ac ychwanegodd, er bod nifer fach o ymatebwyr o ardal Cwm Taf Morgannwg, roedd yr ymatebion a dderbyniwyd gan drigolion CTM yn gadarnhaol mewn perthynas â'r newidiadau arfaethedig. Nododd yr aelodau fod ymatebion o rannau eraill o Gymru wedi bod yn llai cadarnhaol. Cynghorodd S Harrhy fod ymgysylltu wedi bod ac y byddai'n parhau i gael ei wneud gyda swyddogion Llais Cymru ac ychwanegodd y byddai'n bwysig ystyried y safbwyntiau a fynegwyd gan Llais a oedd wedi gwneud rhai pwyntiau pwysig yr aethpwyd i'r afael â hwy a byddent yn parhau i gael sylw yn ystod y broses.

Daeth S Harrhy i'r casgliad ei fod wedi ystyried yr holl argymhellion yn ofalus a theimlai y byddai gwell gwasanaeth yn cael ei ddarparu, nid yn unig i bobl ar draws Cymru, ond i gleifion o fewn ardal Cwm Taf Morgannwg.

Cynghorodd D Price, Cyfarwyddwr Rhanbarthol Llais, fod Llais Cymru wedi ystyried y cyd-destun lleol hefyd yn ogystal â'r sefyllfa genedlaethol. Ychwanegodd D Price fod Llais wedi nodi cryfder y teimladau a fynegwyd gan gymunedau gwledig a nododd er bod nifer cyfyngedig o ymatebwyr o fewn Cwm Taf Morgannwg, roedd yr adborth a dderbyniwyd wedi bod yn gadarnhaol. Nododd yr aelodau nad oedd Llais Cwm Taf Morgannwg wedi derbyn unrhyw ohebiaeth uniongyrchol gan aelodau'r cyhoedd a chymunedau mewn perthynas ag EMRTS, gydag adborth yn cael ei dderbyn yn uniongyrchol gan y Pwyllgor Gwasanaethau Ambiwlans Brys trwy eu proses ymgysylltu.

Cynghorodd D Price y nodwyd bod Grwpiau Gorchwyl a Gorffen wedi'u sefydlu i fireinio a datblygu'r dull gweithredu, a oedd yn cynnwys ymgysylltu pellach â'r cyhoedd mewn perthynas ag argymhelliad pedwar yn benodol, a nodwyd bod angen i'r Elusen Ambiwlans Awyr wneud rhagor o waith i gwmpasu'r union

ganolfan sy'n cael ei chynnig ar gyfer Gogledd Cymru, na fyddai'n effeithio ar drigolion Cwm Taf Morgannwg.

Cynghorodd D Price fod Llais wedi nodi nad oedd unrhyw newidiadau yn cael eu cynnig i leoliadau canolfannau tan fis Medi 2026, ac er nad oedd ganddo unrhyw bryderon penodol yn ymwneud â Chwm Taf Morgannwg i'w dwyn i sylw'r Bwrdd, cynghorodd D Price ei fod yn dymuno rhannu safbwyntiau Llais Cymru yn genedlaethol, a oedd yn ymwneud yn bennaf â phryderon mewn perthynas â'r angen am frys mewn unrhyw benderfyniad yr oedd angen ei wneud yn y broses hon, tra bod materion yn dal i gael eu datrys.

Cynghorodd y Cadeirydd, mewn perthynas â'r broses gwneud penderfyniadau, ei bod yn bwysig nodi eglurder ynghylch rôl Byrddau Iechyd unigol a nodi mai'r Cydbwyllgor Comisiynu newydd, gyda rôl y Bwrdd Iechyd, sy'n gyfrifol am benderfynu ar gomisiynu EMRTS. Bydd y Bwrdd heddiw yn ystyried y newidiadau arfaethedig ar gyfer poblogaeth Cwm Taf Morgannwg, a oedd yn ymddangos fel pe baent yn cael effaith gadarnhaol ar y rhanbarth. Nododd yr aelodau fod pob un o'r saith Bwrdd Iechyd yn cyfarfod yr wythnos hon i ystyried y cynigion ar gyfer eu hardaloedd cyn cyfarfod y Cydbwyllgor Comisiynu ar 23 Ebrill 2024.

Mewn ymateb i gwestiwn a godwyd gan N Milligan ynghylch pa effaith y gallai'r risg o lai o roddion ei chael ar gleifion CTM o ystyried bod dwy ran o dair o'r gwasanaeth yn cael ei ariannu gan roddion elusen, cynghorodd S Harrhy mai un o'r rhesymau dros geisio penderfyniad prydlon oedd rhoi rhywfaint o sicrwydd i'r elusen fel y gallent ailddyblu eu hymdrechion ar godi arian ac ychwanegodd y byddai proses benderfynu hirfaith yn peri risg bosibl i'r elusen o ran codi arian, yr oedd angen ei lliniaru.

Cynghorodd P Mears y byddai gan y newid hwn oblygiadau ar draws Cymru gyfan ac ychwanegodd ei bod yn amlwg o safbwynt Cwm Taf Morgannwg, y byddai ei boblogaeth yn gweld gwell gwasanaethau o ganlyniad i'r newidiadau arfaethedig. Ychwanegodd P Mears ei fod yn cydnabod bod pryderon wedi'u codi o fewn ardaloedd Byrddau Iechyd eraill a fyddai'n cael eu trafod ymhellach yn y Cydbwyllgor Comisiynu o ran pa gydbwysedd sydd angen ei gyflawni ar gyfer y boblogaeth gyfan a'r goblygiadau posibl i wahanol ardaloedd yng Nghymru. . Cynghorodd P Mears ei fod yn ymwybodol bod S Harrhy a'i gydweithwyr yn gweithio'n galed i roi sicrwydd ynghylch y cwestiynau a godwyd, yn enwedig o ran pa ddarpariaeth amgen a fyddai ar gael mewn ardaloedd gwledig i gefnogi'r gwasanaeth ambiwlans awyr.

Cydnabu P Mears y flaenoriaeth ar gyfer cwblhau'r cytundeb hwn yn gyflym er mwyn rhoi rhywfaint o sicrwydd i'r elusen Ambiwlans Awyr a mynegodd bwysigrwydd cynnal perthynas gadarnhaol â'r Elusen, a fyddai'n cyfarfod â'r Gweinidog yn ddiweddarach y mis hwn i rannu eu pryderon a mynegi'r angen am ddatrysiad cyflym.

Daeth P Mears i'r casgliad ei fod yn teimlo y byddai'r cynnig hwn yn gwella'r gwasanaethau sydd ar gael i boblogaeth Cwm Taf Morgannwg ac y byddai'n croesawu cefnogaeth gan y Bwrdd i fwrw ymlaen â'r safbwynt hwn i'w drafod

yn y Cydbwyllgor Comisiynu ar 23 Ebrill 2024 lle byddai penderfyniad terfynol yn cael ei wneud.

Diolchodd y Cadeirydd i P Mears am y crynodeb defnyddiol a dywedodd ei bod yn amlwg o ddarllen yr adroddiad bod angen gwneud rhagor o waith mewn perthynas â'r argymhellion terfynol, a'r gwaith pellach sydd ei angen mewn perthynas ag ymgynghori ac ymgysylltu wrth i'r cynnig ddatblygu. Ychwanegodd y Cadeirydd ei fod yn sicr y byddai pob Bwrdd Iechyd yn dymuno bod yn rhan o'r broses ymgynghori wrth symud ymlaen er mwyn caniatáu i'r Cydbwyllgor Comisiynu weithredu'r penderfyniad a wnaed.

Daeth y Cadeirydd i'r casgliad tra bod yr adroddiad yn gofyn i'r Bwrdd gymeradwyo a nodi'r argymhellion ynddo, byddai hyn yn cael ei wneud dan gafeat, er y byddai'r Bwrdd yn fodlon i'r argymhellion gael eu cyflwyno i'r Cydbwyllgor Comisiynu, cyfrifoldeb y Cydbwyllgor Comisiynu fyddai cytuno ar yr argymhellion a rhoi dyfodol y gwasanaeth EMRTS ar waith wrth symud ymlaen.

Penderfyniad **PENDERFYNODD** y Bwrdd **GYMERADWYO** a **NODI'R** argymhellion a ganlyn, gyda chafeat bod y Bwrdd yn cymeradwyo'r argymhellion i'w dwyn ymlaen i'r Cydbwyllgor Comisiynu yn y cyd-destun y byddai'r argymhellion yn cael effaith fuddiol ar boblogaeth Cwm Taf Morgannwg a nodi mai cyfrifoldeb y Cydbwyllgor Comisiynu fyddai gwneud y penderfyniad ar gyfer Cymru gyfan:

- **CYMERADWYO'R** argymhellion gan y Prif Gomisiynydd Gwasanaethau Ambiwlans;
- **CYMERADWYO** bod yr holl argymhellion yn cael eu hystyried ar y cyd;
- **NODI'R** cynrychiolaethau a godwyd gan Llais a'r cynrychiolaethau eraill a diweddaru'r ymatebion yn unol â hynny, Atodiadau 2 a 3 a NODI nad oedd cydweithwyr ac aelodau o gymunedau Cwm Taf Morgannwg wedi codi unrhyw ymatebion yn uniongyrchol gyda Llais o safbwynt CTM;
- **NODI A CHYMERADWYO'R** gwaith a wnaed i ddatblygu argymhelliad 4 ymhellach ac i sefydlu Grŵp Gorchwyl a Gorffen i fireinio a datblygu'r ymagwedd ymhellach ac i gyflwyno cynllun gweithredu manwl erbyn diwedd Medi 2024;
- **CYMERADWYO** gwaith pellach i'w wneud gan Elusen Ambiwlans Awyr Cymru i gwmpasu sylfaen weithredol yn unol â chanfyddiadau i gefnogi gwneud penderfyniadau yn y dyfodol;
- **NODI'R** risg i'r Elusen;
- **NODI'R** adborth cenedlaethol a ddarparwyd gan Picker Institute;
- **NODI'R** risg i gleifion a lefelau tanddefnyddio ar draws Cymru;
- **NODI** diwedd Cyfnod 3 a'r broses ymgysylltu gyffredinol;
- **NODI** fod y Tîm Comisiynu Ambiwlans ac 111 fel rhan o'r JCC newydd yn parhau i weithio gydag arweinydd ymgysylltu, cyfathrebu a newid gwasanaeth y Bwrdd Iechyd, a Llais trwy gydol diwedd yr Adolygiad.

3. BUSNES I GLOI

3.1 UNRHYW FATER ARALL

Cynghorodd y Cadeirydd nad oedd wedi cael gwybod am unrhyw fusnes arall.

4. DYDDIAD AC AMSER Y CYFARFOD NESAF

Cynhelir cyfarfod nesaf y Bwrdd a gynhelir yn gyhoeddus ddydd Iau 30 Mai 2024.

Agenda Item
8.1.3

CTM Health Board

Board Committee Annual Reports

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Quality & Safety Committee	16/05/2024	Endorsed for Board Approval
Population Health & Partnerships Committee	20/05/2024	Endorsed for Board Approval
Digital & Data Committee	21/05/2024	Endorsed for Board Approval

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 In line with Standing Order requirements each Board Committee is required to submit to the Board on an annual basis a report setting out its activities together with a review of its performance and any associated improvements being put into place as a result.

2. Specific Matters for Consideration

2.1 The Quality & Safety Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2023 – March 2024 and is attached at Appendix 1 for Board approval.

2.2 The Population Health & Partnerships Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2023 – March 2024 and is attached at Appendix 2 for Board approval.

2.3 The Digital & Data Committee received its Committee Annual Report during this period. This Committee Annual Report relates to the period April 2023 – March 2024 and is attached at Appendix 3 for Board approval.

3. Key Risks / Matters for Escalation

3.1 There are no key risks for escalation to the Board.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	A Healthier Wales
	If more than one applies please list below:

Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 The Board is asked to **APPROVE** the following Board Committee Annual Reports for the period 2023/2024:

- Quality & Safety Committee;
- Population Health & Partnerships Committee;
- Digital & Data Committee.

Appendix 1

Quality & Safety Committee

Committee Annual Report 2023-2024

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 2023-2024.

During the year, I have been supported by Jayne Sadgrove (previous Chair of the Committee), James Hehir, Nicola Milligan, Dilys Jouvenat, Patsy Roseblade. Kath Palmer and Helen Lentle 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.

Carolyn Donoghue
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 2023-2024 with a regular report on improvement activity received by the Committee. It was agreed at the September 2023 meeting that progress in relation to Maternity & Neonates would be reported via the Children's & Families Care Group Highlight Report from November 2023 given the de-escalation of the service.

During 2023-2024, continued focus was paid to Ty Llidiard service improvements following concerns raised by the Welsh Health Specialised Services Committee on Mental Health Services following reviews undertaken by Healthcare Inspectorate Wales. In relation to Ty Llidiard, it was agreed that following de-escalation, progress updates would be reported via the Mental

Health & Learning Disabilities Care Group Highlight Report from November 2023 onwards.

The Committee were also sighted on programmes of improvement in relation to Stroke Services.

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 2023-2024 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality & Safety Committee Apr 2023-March 2024

Name	Period
Members	
Jayne Sadgrove (Committee Chair until June 2023) (Committee Member until July 2023) Independent Member	April 2023 – July 2023
Carolyn Donoghue (Committee Chair from July 2023) Independent Member	April 2023 – March 2024
James Hehir Independent Member	Apr 2023 - September 2023
Nicola Milligan Independent Member	Apr 2023 – March 2024
Dilys Jouvenat	April 2023 - March 2024

Independent Member	
Patsy Roseblade Independent Member	April 2023 – March 2024
Helen Lentle Independent Member	January 2024 – March 2024
Kath Palmer Vice Chair	November 2023 – March 2024

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2023-2024

During the year, the Committee met on six occasions in public. Five In Committee sessions were also held. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2023-2024

Public Meeting - In Attendance	24 May 2023	25 July 2023	21 Sept 2023	21 Nov 2023	23 Jan 2024	14 Mar 2024	Total
Independent Members							
Jayne Sadgrove (Chair of the Committee until June 2023)	✓	✓					**2/2**
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓	✓	✓	✓	✓	✓	**6/6**
Kath Palmer Vice Chair/Independent Member (from November 2023)				✓	✓	✓	**3/3**
Dilys Jouvenat – Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
Nicola Milligan – Independent Member	✓	x	✓	✓	✓	✓	**5/6**
James Hehir – Independent Member (until September 2023)	✓	✓	✓				**3/3**
Patsy Roseblade Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
Helen Lentle – Independent Member (from January 2024)					x	✓	**1/2**

In Committee Meeting - In Attendance	31 May 2023	25 July 2023	21 Sept 2023	23 Jan 2024	14 Mar 2024	Total
Independent Members						
Jayne Sadgrove (Chair of the Committee)	✓	✓				**2/2**
Carolyn Donoghue - Independent Member (Chair of the Committee from July 2023)	✓	✓	✓	✓	✓	**5/5**
Dilys Jouvenat – Independent Member	✓	✓	✓	✓	✓	**5/5**
Nicola Milligan – Independent Member	x	✓	x	✓	✓	**3/5**
James Hehir – Independent Member (until September 2023)	✓	✓	x			**2/3**
Patsy Roseblade Independent Member	x	x	✓	✓	✓	**3/5**
Helen Lentle - Independent Member (from January 2024)				x	✓	**1/2**

3.4 ATTENDEES

The Committee's work is informed by reports provided by leads within CTMUHB, Llais Cymru (formerly Cwm Taf Community Health Council), Healthcare Inspectorate Wales, Audit Wales, 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 2023/2024 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 2023/2024 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 2023-2024, there were no items referred to the Quality & Safety Committee from other Committees

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 2023-2024, 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 2023 - 2024, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2024-2025 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Listening and Learning Stories (Patient and Staff)
- Learning lessons and sharing best practice
- Maternity & Neonate Services oversight and scrutiny (via the Childrens and Families Care Group Highlight Report)
- 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 2023/2024, 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 2023 – 2024 the following items were received on the Consent Agenda for Approval/Endorsement:

- Quality & Safety Committee Annual Report 2022-2023;
- 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;
- Volunteer Service Policy;
- Concerns Policy;
- Rapid Tranquilisation Policy;
- Cwm Taf Morgannwg Carers End of Year Progress Report 2022/23;
- Medicines Policy;
- Safeguarding Policy;
- Clinical Policies Approval Process;
- Violence Against Women, Domestic Abuse and Sexual Violence Policy;
- Measles Policy;
- Meningitis Policy;
- Safeguarding Annual Report;
- Quality & Safety Committee Terms of Reference.

During 2023 – 2024 the following items were received on the Consent Agenda for Noting/Information:

- Action Log;
- Committee Annual Cycle of Business;
- Committee Forward Work Programme;
- Human Tissue Act Compliance and Progress Reports;
- Welsh Health Specialised Services Committee Quality & Patient Safety Chairs Reports;
- Infection, Prevention & Control Mid Year Update, End of Year Update and Annual Reports;
- Quality Governance – Regulatory Review Recommendations and Progress Updates;
- Cancer Services Annual Report;
- RADAR Committee Highlight Reports and Annual Report;
- Putting Things Right Annual Report;
- Clinical Audit Quarterly Updates and Forward Plan 2024-2025;
- Radiation Safety Committee Mid Year and Annual Updates;
- Nosocomial Investigation Update Report;
- Recovery Plan Hep B and Hep C;
- Welsh Risk Pool Claims Final Internal Audit Report and Action Plan;
- Concerns Final Internal Audit Report and Action Plan;
- Cwm Taf Morgannwg Individual Patient Funding Requests (IPFR) Annual Report 2022/23;
- Public Services Ombudsman For Wales A Year of Change – A year of Challenge Annual Report and Accounts 2022/2023;
- Incident Management Internal Audit Report;

- A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report;
- Public Services Ombudsman for Wales Groundhog Day 2: An opportunity for Cultural Change in Complaints Handling?;
- Prescribing Annual Report;
- Clinical Education Annual Report;
- Organ Donation Committee Annual Report;
- Cwm Taf Morgannwg Maternity Metrics - An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022;

2. Main Agenda

During 2023 – 2024 the following items were received:

- Patient Experience/Listening & Learning Stories;
- Spotlight Presentations on:
    - Planned Care – Focus on Cancer Services;
    - Primary & Community Care;
    - Emergency Department – A Review of Falls and Pressure Ulcers;
    - Diagnostic, Therapies, Pharmacies and Specialties;
    - Planned Care - Focus on Ophthalmology Backlog;
    - Frailty;
    - Sepsis;
    - Acute Oncology Service;
- Organisational Risk Register – Risks Assigned to the Quality & Safety Committee;
- Healthcare Inspectorate Wales Action Plan Tracker reports;
- Maternity & Neonates Services Improvement Programme reports – including final closure report;
- Maternity & Neonatal Metrics;
- Maternity Quality Improvement Annual Update 2022-2023;
- Ty Llidiard Progress Reports;
- Mental Health In-Patient Improvement Progress Reports;
- Patient Safety & Quality Dashboard Reports;
- Lessons Learnt – Learning and Actions following a death in Maesteg Hospital;
- Report from the Chief Operating Officer;
- Learning from Events Backlog – Progress Reports;
- Development of a CTM Allied Health Professionals & Healthcare Science Strategy;
- Stroke Services Progress Reports;
- Datix Cymru – Assurance Report;
- Mortality Indicators and Mortality Reviews Assurance Reports;
- Liberty Protection Safeguards Progress Reports;
- Covid 19 Inquiry Preparedness (also received via the consent agenda on occasion);
- CTMUHB Staff Process for Raising Concerns;
- CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unit Interim Learning Report;
- Quality & Safety Committee Annual Self Effectiveness Survey;

- Summary of Irradiated Blood Alerts incorrectly added to Digital Patient Records;
- National Collaborative Commissioning Unit (NCCU) Quality Improvement and Assurance Service Annual Position Statement;
- Report from the Clinical Executives;
- Update on Mental Capacity Work;
- Health, Safety & Fire Sub Committee Highlight Reports (also received via the consent agenda when no items requiring escalation);
- Incident Management Framework;
- Emergency Ambulance Services Committee (EASC) Quality & Safety Highlight Report;
- Quality Strategy Annual Plan;
- Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity Annual Report;
- ICTM Annual Report.

Care Group Highlight Reports continued to be received from the following areas:

- Planned Care;
- Unscheduled Care;
- Children & Families;
- Diagnostics, Therapies, Pharmacy & Sciences;
- Primary Care and Community;
- Mental Health & Learning Disabilities.

The following reports were received at the In Committee Sessions:

- External Review of Practice into Care of Ms. R by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf County Borough Council – Verbal Update;
- Controlled Drugs Local Intelligence Network (CDLIN) Annual Report: April 2022 – March 2023;
- Critical Care Reconfiguration;
- MBRRACE-UK Perinatal Mortality Report: 2021 Births;
- Stillbirth Thematic Review 2022;
- Internal Data 'Deep Dive' in to Neonatal Morbidity and Mortality At Cwm Taf University Health Board;
- Nationally Reportable Incidents (NRI)/Maternity Incident Cluster Reports;
- Review of Health Visiting Services (Bridgend);

Appendix 2

Population Health & Partnerships Committee

Draft Annual Report 2023-2024

POPULATION HEALTH & PARTNERSHIPS COMMITTEE
DRAFT ANNUAL REPORT 2023-24

1. FOREWORD

As Chair of the Population Health & Partnerships Committee, I am pleased to commend this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year ending 2023-2024.

Following a revisit of the Committee structures and membership, I took over as Chair of the Committee during July 2023 following the departure of Jayne Sadgrove, Health Board Vice Chair. Jayne has been succeeded by Kath Palmer, Vice Chair as a Member of the Committee as of November 2023 and Lynda Thomas replaced myself as Vice Chair of the Committee from August 2023.

During this year we also welcomed Mel Jehu, Independent Member as a new Member of the Committee whose knowledge and expertise helped to strengthen the membership of the Committee. Mel's term of office as an Independent Member came to an end in March 2024 and he has been succeeded by Rachel Rowlands, Independent Member.

During the year all my fellow Independent Members – Ian Wells, Lynda Thomas, Geraint Hopkins, Mel Jehu and Kath Palmer have once again offered their considerable knowledge and wide-ranging experience to the Committee and for this, I extend my thanks.

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 my fellow Independent Members in undertaking scrutiny of the information being reported in order to provide the Board with assurances.

In accordance with our Committee Business, I can confirm that at the meeting held in March 2024 the Committee received and approved the Annual Committee Cycle of Business, which outlined the forward planning for the work of the Committee for 2024-2025.

Carolyn Donoghue
Chair, Population Health & Partnerships Committee

2. INTRODUCTION

The key function of the Committee is to provide advice and assurance to the Board to assist it in discharging its functions and responsibilities as they relate to population health across primary and secondary care. This will have been achieved through various initiatives including partnership arrangements. The Committee will also consider cross-cutting themes and how the organisation is delivering effective service integration and transformation agendas.

All papers relating to the Committee (unless held 'In-Committee') are available on the Health Board website. The Committee aims to meet up to four times per annum to scrutinise the Health Board's performance in relation to population health across primary and secondary care and partnership working.

Following each meeting of the Committee, a Board Highlight report is prepared setting out the key matters considered, issues for assurance as well as any risks or topics that need to be escalated for Board consideration. There is also the opportunity to refer key risks back to the Executive Leadership Group or through reports from Committee Chair at full Health Board meetings.

Key areas of activity for the Committee during 2023-2024 are outlined below:

- Primary Care Strategic Update
- Mental Health Strategic Update
- Learning Disabilities Strategic Update
- Strategy Groups Update
- Strategy Groups Update – Living Well Adulthood
- Partnership Updates:
  - Partnership Boards Remit & Responsibilities
  - Regional Integrated Fund Update
  - Public Service Board Update
  - Area Public Service and Public Service Board
  - Resilient Communities & Anchor Institution Update
  - Regional Partnership Board Further Faster Pathway
- Building Healthier Communities Group Update
- Population Health Management and Population Health Profiles for Accelerated GP Clusters and Local Authority Area
- Green Scholar Programme
- Post Payment Verification – Mid Year Update
- CHOICE Year 3 Service Report
- Health Protection System

- Creating Health Strategic Pillar
- University Health Board Status Progress Report
- Intermediate Care with Allied Health Professionals (AHP) Funding
- Platinum Corporate Health Standard
- Breast Feeding in Cwm Taf Morgannwg
- 111#2 Service
- Closure Report HM Prison Parc and Youth Offenders Institute
- Listening & Learning Stories:
  - CHOICE Project
  - Homelessness Service
  - Cardboard Recycling Project
  - Veterans Health

MEMBERSHIP

The attendance at the Committee comprises both Independent Members and Executive Directors, enabling the Committee to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes.

Independent membership during 2023-24 was as follows:

- Jayne Sadgrove, Health Board Vice Chair (Chair of the Committee)(Until August 2023)
- Carolyn Donoghue, Independent Member (Chair of the Committee) (From July 2023)
- Ian Wells, Independent Member
- Lynda Thomas, Independent Member (Vice Chair of the Committee) (From July 2023)
- Geraint Hopkins, Independent Member
- Kath Palmer, Health Board Vice Chair
- Mel Jehu, Independent Member

3. MEETINGS

During the period 2023-24 the Committee met on four occasions, namely:

- 3 May 2023
- 2 August 2023
- 7 November 2023
- 7 March 2024

Independent Member attendance at these four meetings was follows:

Name	Population Health & Partnerships Committee
Jayne Sadgrove (Committee Chair) (Until August 2023)	1 out of 2
Carolyn Donoghue (Committee Chair) (From July 2023)	4 out of 4
Ian Wells	4 out of 4
Lynda Thomas	3 out of 4
Geraint Hopkins (Until July 2023)	1 out of 1
Mel Jehu (From July 2023)	3 out of 3
Kath Palmer (From November 2023)	1 out of 1

The above meetings were quorate.

4. MAIN AREAS OF PHP 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/Endorsement
- Part 3 - Governance, Performance and Assurance
- Part 4 - Items for exception reporting, information or update
- Part 5 - Forward Work Programme and Items to be referred to other Committees

Part 1 - Preliminary Matters

This section of the meeting provides the introductory elements to the meeting including apologies for absence, declarations of interest, minutes of the previous meeting, matters arising and details of the action log.

Part 2 - Items for Approval / Endorsement

This section has included receiving the:

- Committee Annual Report 2022/2023 and self-assessment questionnaire
- Committee Terms of Reference
- Committee Annual Cycle of Business 2023-2024
- Director of Public Health Annual Report 2020-2023
- Decarbonisation Action Plan
- Active Travel Charter

Following the presentation of the results of the annual Committee Self Assessment questionnaire at the meeting of the Committee in August 2024 a corresponding action plan will be developed to seek to continually improve the role played by this meeting.

Part 3 - Governance, Performance and Assurance
This section has included reports throughout the year which included:

- Organisational Risk Register
- Regional Partnership Board Annual Report
- Decarbonisation Audit

Part 4 - For Information / Other Matters
There were no items shared with the Committee for information purposes. The 'Forward Look' plan for the Committee was reviewed at each meeting to ensure its content remained appropriately focused.

The Committee Highlight Report is produced following each meeting and subsequently presented by the Committee Chair to the next available Board meeting.

Links with Other Committees/Boards
Where appropriate a process is in place enabling any relevant matters to be referred to other Board Committees for scrutiny and or action as appropriate.

5. 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 each meeting.

6. GOVERNANCE

The Committee has four scheduled meetings each year with additional meetings being held as required. The role of the Committee secretariat is crucial to the ongoing development and maintenance of a strong governance framework for CTMUHB, and is a key source of advice and support for the Chair and Committee members.

The purpose of the Committee effectiveness survey is to comply with the Health Board's Standing Orders and evaluate the performance and effectiveness of:

- the Committee Members and the Chair of the Committee
- the quality of the reports presented to Committee
- the effectiveness of the Committee secretariat

7. COMMITTEE ANNUAL SELF-ASSESSMENT

The Committee needs to complete an annual self-assessment. In line with arrangements put in place for all Board Committees during 2023-24, following which an action plan will be developed arising from this for the purposes of Committee improvement.

8. TERMS OF REFERENCE

The existing Terms of Reference were approved most recently by the Board in May 2023 and are available on the Health Boards website via the following link: Standing Orders - Cwm Taf Morgannwg University Health Board (nhs.wales).

DIGITAL & DATA COMMITTEE

(Draft) Committee Annual Report 2023-2024

FOREWORD

I am pleased to present the second Annual Report of the CTMUHB Digital & Data Committee which outlines the activity between the periods 1st April 2023 to 31st March 2024.

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 2023-2024 Digital & Data Committee Annual Report to you.

Ian Wells,
Chair of the Digital & Data Committee/ Independent Member

Digital & Data Committee
Annual Report 2023 -2024

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between the periods April 2023 - March 2024 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 2024 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 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 February 2024 and are available via the following link: Standing Orders & Standing Financial Instructions - Cwm Taf Morgannwg University Health Board (nhs.wales)

4.2 Whilst the Committee Cycle of Business (which was most recently approved in March 2024), 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:
- 12 June 2023
- 12 September 2023
- 14 November 2023
- 21 February 2024

5.3 The Board Member attendance for these meetings is captured in the following table:

Digital and Data Committee Attendance 2023-2024		**12 June 2023**	**12 Sep 2023**	**14 Nov 2023**	**21 Feb 2024**	**Total**
Ian Wells (Chair)	Independent Member	✓	✓	✓	✓	**4/4**
Lynda Thomas	Independent Member	×	×	✓	✓	**2/4**
Carolyn Donoghue	Independent Member	—	✓	✓	✓	**3/3**
Kath Palmer	Independent Member	—	—	×	✓	**1/2**

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 2023-24, 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 2023/2024

The agenda for each meeting has followed a standard format in six main parts:

- Part 1 - Preliminary Matters
- Part 2 - Consent Agenda
- Part 3 - Main Agenda
- Part 4 - Governance
- Part 5 - Improving Care
- Part 6 - Sustaining Our Future

Part 1 - Preliminary Matters

This section of the meeting provides the standard governance approach within all Board Committees within CTMUHB

Part 2 - Consent Agenda

This section has included receiving the:

FOR APPROVAL

- Unconfirmed Minutes of previous Meetings and In-Committee Meetings
- Committee Annual Report

FOR NOTING

- Committee Annual Self-Assessment
- All Wales Independent Member Network Highlight Report
- Annual Cycle of Business
- Terms of Reference
- Action Log

Part 3 - Main Agenda

This section has included reports throughout the year which included:

- Matters Arising not Contained within the Action Log
- Spotlight Topic

Part 4 - Governance

This section has included reports throughout the year which included:

- Organisational Risk Register
- Information Governance
- ICO Audit Action Plan

Part 5 – Improving Care

This section has included reports throughout the year which included:

- Digital and Data Assurance
- Medical records Assurance

Part 6 – Sustaining Our Future

This section has included reports throughout the year which included:

- Digital Annual Plan
- Digital and Data Overview
- Integrated Medium Term Plan

Internal Audit Reports:

- Follow up Bridgend Transfer of Informatics Service
- Performance Management
- Infrastructure Management

Other Reports:

- Breach Analysis for Subject Access Requests on Mental Health
- ICT Business Continuity

In- Committee Reports:

- Cyber Improvement Programme
- Digital Critical Incidents
- Organisational Risk Register
- Service Critical National Implementation
- Spotlight : Digital Medicines – e-Prescribing
- Spotlight : Cyber Assessment

7. Committee Effectiveness & Performance

7.1 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 winter 2023 will be considered at the meeting to be held in May 2024 in order that recommendations and aligned actions can once again be developed and implemented in terms of areas identified for improvement.

8. Reporting the Committee's Work

8.1 The Committee Chair reports the key issues discussed at each of its meetings using a 'Highlight Report' to the Board.

8.2 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.

9. Conclusion and way forward

9.1 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.

9.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

9.3 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.

Agenda Item
8.1.5

CTM Health Board

Annual Review: Risk Management Framework

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Board Members Via Email	26.3.2024-8.4.2024	Endorsed
Executive Leadership Group	15.4.2024	Reviewed and Management Sign Off received
Audit & Risk Committee	18.4.2024	Endorsed for Board Approval
Health Board Meeting	30.5.2024	Pending

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 As good governance on an annual basis the Health Board reviews its risk management framework which is made up of the following suite of documents:

1. Risk Management Strategy
2. Board Assurance Framework
3. Risk Appetite Statement
4. Risk Domain & Scoring Matrix
5. Risk Management Policy
6. Risk Assessment Procedure

1.2 This annual review focusses on items one to four and during April 2023, Board Members considered these areas of the risk management framework in terms of its continued adoption for a further 12 months.

1.3 The Risk Management Policy and Risk Assessment Procedure were reviewed and approved in 2022 with the next review date set for 2025. They remain extant.

2. Specific Matters for Consideration

2.1 This section is broken down into the review of the relevant component parts of the framework.

2.2 ***Risk Management Strategy*** *(Appendix 1)*
The purpose of the strategy is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

The Strategy has been subject to amendments to Appendix 2 and 5.

1.3 ***Risk Appetite Statement*** *(Appendix 2 of the Risk Management Strategy)*
An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's risk appetite.

During the recent review of the Risk Appetite Statement, an additional "Innovation" domain was proposed. Following consultation on the review it has been suggested that in order to avoid potential duplication with the "Technical Advances" domain further work is needed before inclusion, also incorporating research and development definitions. Therefore it is

recommended that for this review the status quo remains and work will be undertaken during the year on these future developments.

1.4 ***Risk Domain Scoring Matrix*** *(Appendix 2 of the Risk Management Strategy)*
No changes proposed in this year's review.

1.5 ***Board Assurance Framework (BAF)*** *(Appendix 5 of the Risk Management Strategy)*
The BAF is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation.

There were no changes to the concept of the BAF. There have been changes in year to Strategic risks that have been approved by the Board.

It should be noted that in April 2023 an Internal Audit review of the Board Assurance Framework resulted in an outcome of Substantial Assurance.

The BAF and its current principal/strategic risks are captured in Appendix 5 of the Risk Management Strategy. Which includes a new risk seeking approval at the Board in May 2024.

3. Key Risks / Matters for Escalation

3.1 The principal risks are outlined in the BAF, which is reviewed at all routine meetings of the Health Board.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Learning, Improvement & Research

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome for Equality (delete as appropriate): Completed – No potential negative impact identified	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to:

- **APPROVE** the Risk Management Strategy.
- **APPROVE** the Risk Appetite Statement and agree that it is implemented for the next 12 months with assurance that it is set to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.

- **APPROVE** the Risk Domain & Scoring Matrix and its continued application.
- **APPROVE** that the Board Assurance Framework remains fit for purpose and appropriately reflects the strategic risk profile of the Health Board.

RISK MANAGEMENT STRATEGY & BOARD ASSURANCE FRAMEWORK

Ref:	RM 01
Document Author:	Assistant Director of Governance & Risk
Executive Sponsor:	Director of Corporate Governance / Board Secretary
Approval / Effective Date:	*30th May 2024*
Review Date:	*30th May 2024*
Version:	Version 8 Draft

Target Audience:

People who need to review this document in detail	All Staff with the responsibility for undertaking risk assessments. All staff who approve risks as a risk owner or manager.
People who need to have a broad understanding of this document	All staff.
People who need to know that this document exists	All staff.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** 20.11.2020
	Outcome: No potential negative impact identified.
Welsh Language Standard	Yes - If Standard 82 applies you must ensure a Welsh version of this policy is maintained.
Date of approval by Equality Team:	23.11.2020
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

Approval Route:

Where	When	Why
Audit & Risk Committee	*18th April 2024*	Endorse for Board Approval
Health Board	*30th May 2024*	Approved

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

1. Introduction and Aims

1.1 Cwm Taf Morgannwg University Health Board (CTMUHB) is committed to developing and implementing a Risk Management Strategy (and Board Assurance Framework) that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Medium Term Plan (IMTP). The Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon strategic objectives. It will be considered alongside other key management tools, such as workforce, performance, quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

1.2 The purpose of this document is to provide guidance to all staff on the management of strategic and operational risks and the Board Assurance Framework within the organisation.

1.3 It aims to:

- set out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation;
- set out responsibility for Board committees, in particular, the Audit and Risk Committee;and
- describe the procedures to be used in identifying, analysing, evaluating and controlling risks to the delivery of strategic objectives;

1.4 The objectives of CTMUHB's Risk Management Strategy (and Board Assurance Framework) are to:

- minimise impact of risks, adverse incidents, and complaints by effective risk identification, prioritisation, treatment and management;
- ensure that risk management is an integral part of CTMUHB's culture;
- maintain a risk management framework, which provides assurance to the Board that strategic and operational risks are being managed effectively;

- maintain a cohesive approach to corporate governance and effectively manage risk management resources;
- minimise avoidable financial loss;
- ensure that CTMUHB meets its obligations in respect of Health and Safety and Quality and Safety;
- Manage all potential risks CTMUHB are exposed to;
- supports the calibration of risk scoring so the Health Board can achieve a consistent and moderated approach to risk assessment;
- supports an informed understanding of risk in order for the Health Board to be able to appropriately scrutinise risk treatment options; and
- compliment the Risk Management Policy and Risk Assessment Procedure.

2. Scope

2.1 The Risk Management Strategy (and Board Assurance Framework) covers the management of Strategic/Principal and Organisational risks and the process for the escalation of risks for inclusion on the Organisational Risk Register and Board Assurance Framework.

2.2 A risk can be defined as: "the chance of suffering harm caused by a hazard, loss or damage or the possibility that the CTMUHB will not achieve an objective".
Risk is the uncertainty surrounding events and their outcomes that may have a significant effect, either enhancing or inhibiting:

- Achievement of aims and objectives
- Operational performance
- The meeting of stakeholder expectations

Types of Risk

2.3 ***Strategic/Principal Risks****:* are significant risks that have the potential to impact upon the delivery of Strategic Objectives and are reviewed and monitored by the Strategic Leadership Group (SLG), Board Committees and the Board.

2.4 ***Organisational Risks:*** are risks that are mainly operational in nature and arise from the CTMUHB's day-to-day activities.

2.5 The Board Assurance Framework (BAF) is an integral part of the system of internal control and defines the strategic/principal risks, which impact upon the delivery of Strategic Objectives/Goals of the organisation. It also summarises the controls and assurances that are in place or plans to mitigate them. The BAF aligns strategic/principal risks, key controls and assurances on controls alongside each of the Health Boards strategic objectives.

2.6 The BAF identifies the assurances reported to Board and Committees in relation to the strategic/principal risk identified. It also highlights the gaps in controls and assurances. This enables the development of an action plan for closing the gaps and mitigating the risks, which is subsequently monitored by the Board for implementation.

2.7 This Strategy applies to all Staff directly employed by CTMUHB and/or those that hold any form of contract (including agency, honorary, locum etc).The culture of risk management and discussion of risk with partners and stakeholders, where appropriate should be encouraged.

2.8 The Risk Management Strategy is intended to cover all the potential risks that the organisation could be exposed to.

3. Risk Management Organisational Structure

The Board

3.1 Executive Directors and Independent Members share responsibility for the effective management of risk and compliance with relevant legislation. In relation to risk management, the Board is responsible for:

- articulating the Strategic Objectives/Goals of CTMUHB;
- articulating the Strategic/Principal Risks of CTMUHB;
- protecting the reputation of CTMUHB;

- providing leadership on the management of risk;
- approving the risk appetite for CTMUHB;
- ensuring the approach to risk management is consistently applied;
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it effectively and appropriately;
- reviewing and approving risks on the Board Assurance Framework;
- endorsing risk related disclosure documents;
- approving the Risk Management Strategy and Board Assurance Framework on an annual basis.

Audit & Risk Committee

3.2 The Audit and Risk Committee has a specific role in relation to undertaking an annual review of the effectiveness of the Risk Management Strategy and the Board Assurance Framework.

3.3 In relation to risk management, the Audit and Risk Committee shall review the establishment and maintenance of an effective system of internal control and risk management. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion and/or other appropriate independent assurance, prior to endorsement by the Board.

- the structures, processes and responsibilities for identifying and managing clinical and non-clinical risks facing the organisation. This will be addressed by ensuring there is a periodical review that risk registers are in place and updated for corporate and clinical areas.

- the Health Board's organisational risk register and the adequacy of the scrutiny of risks by assigned Committees. This will be addressed by ensuring all significant risks (i.e. those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) are assigned to a Board Committee for scrutiny, and ensuring that updates on actions to mitigate the risks are provided at each committee meeting.

- the Board Assurance Framework.
- the policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct and accountability requirements. By identifying and assessing regulatory, legal and code of conduct issues that could have been prevented by more effective management of risk and assurance of controls in place.
- the operational effectiveness of policies and procedures, through regular review of policies and procedures.
- the effectiveness of risk identification, management, escalation and monitoring. This will be addressed by reviewing the number of risk registers in place, the frequency of updates to the risk register and the escalation of high risks to the Care Group /Central Function and Organisational Risk Registers.

All Board Committees

3.4 All Board Committees have a role to play in ensuring effective risk management in particular they will:

- Receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny.
- will receive updates in terms of actions taken to mitigate the risks, and provide feedback and challenge to risk owners on the actions taken and any further action required.

Executive Leadership Group (ELG)

3.5 The ELG undertake the following duties:

- Promote a culture within the Health Board, which encourages open and honest reporting of risk with local responsibility and accountability.
- Provide a forum for the discussion of key risk management issues within the Health Board.
- Ensure appropriate actions are applied to organisational risks.
- Enable risks which cannot be dealt with locally to be escalated, discussed and prioritised.
- Ensure Care Groups and Central Corporate Functions Risk Registers are appropriately rated and action plans agreed to control them.

- Review the risks on the Organisational Risk Register (those escalated to the organisational risk register scoring 15 or above or those not able to be managed locally) to determine whether they will impact on the Health Boards Strategic Objectives/Goals, and if so, the risk will be added to the Board Assurance Framework (BAF) aligned to the appropriate Strategic/Principal Risk.
- Review the Organisational Risk Register and Board Assurance Framework prior to its presentation to the Board and Committees as appropriate.
- Review and monitor the implementation of the Risk Management Strategy and Board Assurance Framework.
- Ensure that all appropriate and relevant requirements are met to enable the Chief Executive to sign the Governance Statement, outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.
- Approve documentation relevant to the implementation of the Risk Management Strategy and Board Assurance Framework.
- Provide assurance to the Board that there is an effective system of risk management across the Organisation.

Care Groups /Local Services Groups / Corporate Central Functions Leads

3.6 Care Groups, Local Service Groups / Corporate Central Functions are responsible for risks within their areas of operation and providing assurance to the SLG on the operational management and any support required in relation to the management of risk.

3.7 These functions are responsible for the implementation of the Risk Management Strategy and relevant policies, which support the Health Board's risk management approach.

3.8 Specifically they will:

- promote a risk culture which encourages open and honest reporting of risk with local responsibility and accountability;
- use the Datix Risk Management system for recording and reviewing risk.
- ensure a forum for discussing risk, risk management and organisational learning is maintained within their system

group area of responsibility;

- co-ordinate the risk management processes which includes risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- update ELG on the management and mitigation of risk for their area;
- provide reports to the Management Board and appropriate Committee of the Board that will contribute to the organisational monitoring and auditing of risk;
- escalate service risks graded 15 and above all those not able to be managed to the Strategic Risk Owner for consideration and review at the ELG for escalation to the Organisational Risk Register and Board Assurance Framework;
- contribute to the organisational monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the moderation and calibration of risks across the Health Board to avoid duplication, ensure compliance and alignment with the Risk Management Strategy and ensure shared learning across the Health Board;
- review and updating of existing risks, consider new risks for inclusion and escalate/de-escalate risks as appropriate to the Executive Team Member assigned as the Strategic Risk Owner for the risk being escalated.

3.9 CTMUHB's 'Risk Management Process – Service to Board' is included at Appendix 3.

4. Duties

4.1 The following paragraphs set out the respective risk management duties and responsibilities for individual staff members.

All Staff

4.2 All members of staff are accountable for maintaining risk awareness, and identifying and reporting risks as appropriate to their line manager.

4.3 In addition, they will ensure that they familiarise themselves and comply with all the relevant risk management strategies and procedures for CTMUHB and attend/complete risk management training as appropriate.

4.4 They will:

- accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that may be affected by the Health Board's business;
- report all incidents/accidents and near misses;
- comply with the Health Board's incident and 'near miss' reporting procedures;
- be responsible for attending mandatory and relevant education and training events;
- participate in the risk management system, including the risk assessments within their area of work and the notification to their line manager of any perceived risk which may not have been assessed; and
- be aware of the Health Board's Risk Management Strategy and Policy documents, ~~and~~ Board Assurance Framework and processes and the local strategy and procedures and comply with them.

All Managers (Leaders of Teams, Service Managers, Area Leads etc)

4.5 The identification and management of risk requires the active engagement and involvement of staff at all levels, as staff are best placed to understand the risks relevant to their areas of responsibility and must be supported and enabled to manage these risks, within a structured risk management framework.

4.6 Managers at all levels of the Organisation are therefore expected to take an active lead to ensure that risk management is embedded into the way their service/team/area operates. Managers must ensure that their staff understand and implement this Strategy and supporting processes, ensuring that staff attend relevant mandatory and local training programmes.

4.7 Managers must be fully conversant with the Health Board's approach to risk management and governance. They will support the application of this Strategy and its related processes and participate in the monitoring and auditing process.

Director of Corporate Governance

4.8 The Director of Corporate Governance will, with the support of the Assistant Director of Corporate Governance & Risk:

- work closely with the Chair, Chief Executive, Chair of the Audit and Risk Committee and Executive Directors to implement and maintain the Risk Management Strategy and Board Assurance Framework and related processes, ensuring that effective governance systems are in place;
- work with the Board of CTMUHB to develop a shared understanding of the risks to the CTMUHB's strategic objectives/goals;
- develop and communicate the Board's risk awareness, appetite and tolerance;
- develop and oversee the effective execution of the BAF and ensure effective processes are embedded to rigorously manage the risks therein;
- monitor the action plans and reporting to the Health Board and relevant Committees.

Executive Directors

4.9 Executive Directors are accountable and responsible for ensuring that their areas of responsibility are implementing this Strategy and related policies. Each Director is accountable for the delivery of their particular area of responsibility and will therefore ensure that the systems, policies and people are in place to manage, eliminate or transfer the key risks related to the Health Board's strategic objectives.

4.10 Specifically they will:

- act as strategic risk owner for risks within their remit escalated to the Organisational Risk Register;
- use the Datix Risk Management system for recording and reviewing risk;
- communicate to their staff the Health Board's strategic objectives and ensure that Care Group, Clinical Service Group and Corporate Departments and individual objectives and risk reporting are aligned to these;
- ensure that a forum for discussing risk and risk management is maintained within their area which will encourage the proactive management of risk;
- co-ordinate the risk management processes which include: risk assessments, incident reporting, the investigation of incidents/near misses and the management of the risk register;
- ensure there is a system for monitoring the application of risk management within their area and that risks are treated in accordance with the risk grading action guidance contained in this document;
- provide reports to the appropriate committee of the Board that will contribute to the monitoring and auditing of risk;
- ensure staff attend relevant mandatory and local training programmes;
- ensure a system is maintained to facilitate feedback to staff on risk management issues and the outcome of incident reporting;
- ensure the specific responsibilities of managers and staff in relation to risk management are identified within the job description for the post and those key objectives are reflected in the individual performance review/staff appraisal process;

and

- ensure that the BAF and the risk management reporting timetable are delivered to the Health Board.

Chief Executive

4.11 The Chief Executive as Accountable Officer of the Health Board has overall accountability and responsibility for ensuring it meets its statutory and legal requirements and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management, health and safety, finance, and organisational control and governance.

4.12 The Chief Executive has overall accountability and responsibility for:

- ensuring the Health Board maintains an up-to-date Risk Management Strategy and Board Assurance Framework endorsed by the Board;
- promoting a risk management culture throughout the Health Board;
- ensuring that there is a framework in place which provides assurance to the Health Board in relation to the management of risk and internal control;
- putting in place and maintaining an effective system of risk management and internal control.

4.13 The Welsh Government requires the Chief Executive to sign a Governance Statement on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

Internal Audit

4.14 Internal Audit Services, provided by NHS Wales Shared Services Partnership will, through a risk based programme of work, provide the Health Board with independent assurance in respect of the adequacy of the systems of internal control across a range of financial and business areas in accordance with the standards

and good practice. They will also review the effectiveness of risk management arrangements as part of their programme of audits and reviews, reporting findings to the Audit and Risk Committee as appropriate.

5. Risk Management Process

5.1 CTMUHB is committed to developing a pro-active and systematic approach to risk management.

5.2 Appendices 2 and 3 outline the risk management and risk quantification process.

Risk Assessment

5.3 Each service within the Health Board needs to identify risks through the completion of risk assessments and ensure that risk assessments are completed and regularly reviewed on an ongoing basis.

Organisational Risk Register (Risks Rated 15 or above and/or those that cannot be managed locally)

5.4 The Organisational Risk Register is a record of all the risks identified across the Health Board through the Risk Management process, their controls, score and risk treatment/mitigation.

Management of Local Risks (Risk Rated below 15)

5.5 Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area. These risks can typically be resolved quickly and relatively easily if the correct actions are identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each service area / department.

5.6 Any risks identified and evaluated as having a medium rating, i.e. a score between 9 and 12 are managed as follows:

- If a risk is scored below 12 and can be managed at Service Group Level it will not require escalation, however, it is felt that the risk can no longer be managed at Service Group level and requires more Senior input and support then it will be first escalated through the relevant structure e.g. Care Group.

- If a risk is scored at 12 or above it should be escalated to the Care Group. or relevant escalation point within the function.

5.7 All local risks should be reviewed and updated regularly in accordance with the risk grading. This may need to be more frequent if circumstances require. Risks have been reviewed more frequently (i.e. Monthly) as a consequence of alignment to the new operating model and the new revised Organisational Risk Register.

5.8 If a risk is scored 15 and above it should be escalated as outlined in Appendix 3.

Board Assurance Framework (BAF)

5.9 The Health Board's Board Assurance Framework was last approved by the Board on the 25th May 2023. The BAF is reviewed on annual basis by the Audit & Risk Committee for onward approval by the Board.

5.10 The BAF will be articulated via a Board Assurance Report (BAR) presented to Board that brings together the Health Board's strategic goals and the principal/strategic risks, which may prevent them from being achieved.

5.11 The BAR identifies the controls in place to manage these risks and the assurances, which show whether they are working.

5.12 The BAR will:

- Incorporate action plans for the strategic risks within the "Mitigating Actions" section of the BAR which are closely aligned to the gaps in controls and/or assurances;
- link to key measures of performance and National Priority Measures;
- align strategic risks to operational risks on the Organisational Risk Register.

5.13 The benefits of the BAF include:

- that it is designed specifically for Board-level oversight
- it is a structured and evidence-based assessment of the key risks facing the CTMUHB.

- can be used to shape cycles of business and the work of the Board & committees
- enables Independent Members to focus their scrutiny and constructive challenge
- supports strategic decision-making

5.14 The table below articulates how the BAF differs from the Organisational Risk Register:

Board Assurance Framework	**Organisational Risk Register**
• Strategic/Principal risks aligned to the Health Board's four strategic priorities • Includes only nine principal risks • Risks identified advised by the Executive Team and agreed by Board ('top down') • Decisions to add, remove or re-score risks are taken by the Board • Risks are organisation-wide in scope	• Mostly operational risks arising from the CTMUHB's day-to-day activities • Includes over 50 of the highest level (currently scored over 15) risks • Risks usually identified by individual services or departments ('bottom up') • Agreed by Executive Leadership Group following triage by Care Group / relevant leads • Some are organisation-wide, others are specific to services or directorates, but require involvement by the Executive Team or other services

5.15 The Health Board will monitor and ensure the BAF remains up to date by the following activity:

- Each strategic/principal risk has a Lead Executive(s);
- The Assistant Director of Governance and Risk will review the risk score, action plan and current performance with the Lead Executive(s) in readiness for reporting to the Board;
- Each principal risk has a lead Board Assurance Committee;
- More than one Board Committee will monitor some principal risks. These committees will scrutinise and seek assurances on the principal risks which they own;

- The Board should consider annually whether the principal risks are comprehensive, or if risks need to be added / removed / changed.

5.16 The Audit and Risk Committee, as a Committee of the Board, has oversight of the processes through which the Board gains assurance in relation to the management of the BAF.

Risk Quantification and Escalation & De-escalation

5.17 The approach to quantifying risk is described in Appendix 2. Each risk is assessed and scored on the likelihood of occurrence and the severity/impact in the initial (without controls), current (with controls) and target risk score (after completion of actions). A risk-scoring matrix to describe the quantification of risk is also included in the Procedure.

5.18 The process of risk escalation and de-escalation will be monitored by the Audit and Risk Committee, through monitoring new risks hitting threshold scores and being escalated as appropriate and/or current risks having their risk grading reduced so that the risks are appropriately de-escalated from the Organisational Risk Register.

5.19 The score of a particular risk will determine at what level decisions on acceptability of the risk should be made and where it should be reported. The Board defines as "High" any risk that has the potential to damage the Organisation's objectives. General guidelines are:

High Risk	Score 15 - 25 and above or a risk which can no longer be monitored locally	Report immediately to relevant Executive Director and escalate to the Organisational Risk Register. Where a risk is considered appropriate, the Executive Director will escalate to the SLG. In the event this causes delay, the Care Group Director can report directly to the Chief Executive. Formally record on Datix.
Medium Risk	Score 9-12	9-11 – reports to Clinical Service Group

		12-14 – reports to Care Groups /Corporate Functions Formally record on Datix.
Low Risk	Score 1-8	Report to Service Lead / Team Lead with proposed treatment/action plans, for particular monitoring. Formally record on Datix.

Risk Appetite

5.20 At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.

5.21 Decisions on accepting risks may be influenced by the following:

- the likely consequences are insignificant;
- a higher risk consequence is outweighed by the chance of a much larger benefit;
- occurrence is rare;
- the potential financial costs of minimising the risk outweighs the cost consequences of the risk itself;
- reducing the risk may lead to further unacceptable risks in other ways.

5.22 Therefore, a risk with a high numerical value may be acceptable to the organisation, but that decision would be taken at an appropriate level.

5.23 The Board will review its risk appetite on an annual basis to ensure that progress is being made to the 'risk appetite' the Health Board wishes to achieve.

5.24 The matrix has the following risk levels:

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key

	deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

5.25 The Health Board's Risk Appetite Statement is included at Appendix 4.

6. Information / Support

6.1 Support and guidance is available from the Assistant Director of Governance & Risk via cally.hamblyn2@wales.nhs.uk.

6.2 Risk Assessment templates and training information is available via the following site on SharePoint: http://ctuhb-intranet/dir/HealthandSafety/default.aspx

7. Appendix 1 - Definitions

Assurance	Confidence gained, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved. Sources of assurance include; reviews, audits, inspections both internal & external.
Assurance rating	This is the rating which has been given regarding the level of assurance: (1)= Management Reviewed Assurance (2)= Board Reviewed Assurance (3)= External Reviewed Assurance
Control Measures	A control is any measure or action that modifies risk. Controls include any policy, procedure, practice, process, technology, technique, method, or device that modifies or manages risk. Risk treatments become controls, or modify existing controls, once they have been implemented.
Current Risk Rating	The risk rating whilst risk responses are in the process of being implemented. Some controls are probably in place but others required are still being actioned & will be shown as gaps in control & actions until implemented.
Initial Risk Rating	The risk rating before any controls have been put in place.
Risk Actions	Actions required to mitigate the risk. Actions should be SMART & have clear owners assigned. This will allow action progress to be tracked & monitored & issues with action completion to be visible & dealt with.
Risk Appetite	At its simplest, risk appetite can be defined as the amount of risk that an organisation is prepared to accept in the pursuit of its strategic objectives.
Risk Assessment	Risk assessment is a process that is made up of three separate processes: risk identification, risk analysis, and risk evaluation. Risk identification is a process that is used to find, recognize, and describe the risks that could affect the achievement of objectives. Risk analysis is a process that is used to understand the nature, sources, and causes of the risks that you have identified and to estimate the level of risk. It is also used to study impacts and consequences and to examine the controls that exist. Risk evaluation is a process that is used to compare risk analysis results with risk criteria in order to determine whether or not a specified level of risk is acceptable or tolerable.
Risk Description	A structured statement describing the risk usually containing the following elements: sources, events, causes and consequences / impact. A well-written risk statement captures three main parts; If, Then, Resulting In.

Risk Management	Risk management refers to a coordinated set of activities and methods that is used to direct an organization and to control the many risks that can affect its ability to achieve objectives. The term risk management also refers to the programme that is used to manage risk. This programme includes risk management principles, a risk management framework, and a risk management process.
Risk Owner	Senior person best placed to keep an eye on the risk with decision making authority. This person is accountable for the Risk & should be aware of its current status.
Risk Rating	This is calculated by multiplying consequence x likelihood (impact x probability). Consequence: is the outcome of an event and has an effect on objectives. Likelihood: is the chance that something might happen. Likelihood can be defined, determined, or measured objectively or subjectively.
Risk Treatment	This is a risk modification process. It involves selecting & implementing one or more treatment options. Once a treatment has been implemented, it becomes a control or it modifies existing controls. Treatment options include; Avoidance / Remove the source of the risk Reduction Transference Retain / Accept the risk Also known as the four T's – Treat, Transfer, Tolerate & Terminate
Strategic Risk Owner	Usually the Executive Director in relation to the risk area.
Target Risk Rating	When action is taken to treat risks, it may eradicate the possibility of the risk occurring. However, actions are often more likely to reduce the probability of the risk occurring, leaving the residual risk. The remaining level of risk after all treatment plans have been implemented is the residual risk. Generally the target level is the level at which the organisation is saying it's happy to live with. All agreed controls are in place & assurance is being provided that controls are working as planned. At this point the risk should be closed unless further actions are deemed required.

8. Appendix 2 - Risk Domain and Scoring Matrix

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low-level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event, which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of severa key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low-level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets.10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised, other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate/ Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.
Fraud/Bribery	Unlikely to result in material loss or reputational damage. (Little or no loss to the organisation, material loss less than £500)	Material loss or reputational damage likely to be minimal. (Some risk to the organisation, which may result in minor reduction in service capacity or material loss of up to £5000. Reputational damage likely to be within the organisation which may lead to complaint)	Could result in material loss or reputational damage. (Moderate risk to the organisation, which may result in reduction of service. Material loss of up to £10000. Reputational damage across the NHS with a high potential for complain or a low risk of litigation)	Could result in high material loss or reputational damage (may result in temporary loss of service or material loss of up to £50,000. Reputational damage widespread and outside of NHS with a likelihood of litigation.	Could result in significant material loss or reputational damage. (High risk, which may result in, prolonged loss o service or material loss of over £50,000. Nationwide media coverage causes reputational damage, which is likely to lead to criminal prosecution or external investigation.

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

RISK REVIEW

It is essential to continue to reduce risks to their lowest level practicable through ongoing monitoring and review. It is best conducted through normal day-to-day management. A review must be undertaken whenever there are any changes to the existing risk assessment. Risk assessments should also be reviewed on a regular basis as determined below:

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

9. Appendix 3 – Risk Management Process – Service to Board Escalation

	TASK / ACTIVITY	RISK RATING	RESPONSIBILITY	RISK REGISTER	ESCALATION
1.	**Risk Assessment** • Identify Operational and Strategic risks through the completion of risk assessment and for ensuring that risk assessments are completed on an ongoing basis. **Training is available for Risk Assessments and for the Datix System** **Please contact:** **Cally.Hamblyn2@wales.nhs.uk or visit:** Risk Assessment - Risk		Each: It is everyone's responsibility to identify risks however, escalation would be through the • Care Group • Central Leads • Corporate Function Lead • Executive Lead	N/A	No
2.	**Risk Register** • Use the Datix Risk Management System to record **all risks** identified through the Risk Management Process, their Controls, and score and risk treatment/mitigation and generate risk registers.		Each: • Care Group • Central Corporate Function • Executive Lead	N/A	No
3.	**Management of Local Risks** • Any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area. • These risks can typically be resolved quickly and relatively easily if the correct actions identified, completed and become controls under business as usual. These risks are recorded locally in the local risk register within each service area/department. • All local risks should be reviewed and updated as per the frequency captured in Section 9 of the Risk Assessment Procedure.	Scored Between 1-8	Each: • Care Group • Central Corporate Function Executive Lead **Held and Managed Locally**	Local Risk Register	**NO** If it can be managed locally. **YES** If it is felt that the risk can **no longer be managed locally** and requires more Senior input and support then it will be first escalated by the risk owner up through the using the notification / escalation via the Datix system **Care Group Director Triumvirate or Central Corporate Functions as appropriate**
4.	**Clinical Service Group Risks** • Risks Identified at a Service Level should be recorded by a relevant Manager on a Service Group Risk Register. • Reviewed **at least** bi-monthly at the relevant Service Group / Directors meeting.	Scored Between 8-12	Central / Clinical Service Group **Held and Managed at Service Group Level**	Central / Clinical Service Group Risk Register	**NO** If it is scored below 12 and can be managed at Service Group Level **YES** 1) If it is felt that the risk can no **longer be managed at Service Group level** and requires more Senior input and support then it will be first escalated up through the **Care Group Director Triumvirate as appropriate** through the using the notification / escalation via the Datix system And 2) If the risk is scored at **12 or above** it should be escalated to the **Care Group Director Triumvirate**
5.	**Central and Care Group Risks** • The Central Function Director Lead and Care Group Director Triumvirate should have sight of the Service Group Risk Registers and ensure that risks scored at 12 or above are recorded. • Care Group Risk Registers should be monitored at Care Group QSPE Meetings and considered for escalation to the Organisational Risk Register at the Operational Management Service Board. • Central Function Risk Registers should be received at Senior Management Team meetings and considered for escalation to the Organisational Risk Register at the Operational Management Service Board.	All Risks	Central Functions Care Group Director Triumvirate **Held and Managed at Care Group Level**	Care Group Risk Register Central Corporate Functions Risk Register	**NO** If scored below 15. **YES** 1) If it is felt that the risk can no **longer be managed at Central and Care Group Level** and requires Executive Level input and support then it will be first escalated up through the **Operational Management Board (OMB) or the Executive Leadership Group (ELG) as appropriate** to consider escalation to the Organisational Risk Register 2) If the risk is scored at **15 or above** and/or novel or contentious it should be considered for escalation by the Operational Management Board (OMB) or Executive Leadership Group (ELG) as appropriate to the **Organisational Risk Register**

Appendix 4 – Risk Appetite Statement

Cwm Taf Morgannwg University Health Board

Risk Appetite Statement

1. Introduction:

Public sector organisations cannot be culturally risk averse and be successful. Effective and meaningful risk management in government remains more important than ever in taking a balanced of risk and opportunity in delivering public services. Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to take opportunities and to take managed risks not simply to avoid them, and systematically anticipates and prepares successful responses. A key consideration in balancing risks and opportunities, supporting informed decision-making and preparing tailored responses is the conscious and dynamic determination of the organisation's **risk appetite**.[1]

The Health Board should make a strategic choice about the style, shape and quality of risk management and should lead the assessment and management of opportunity and risk. The Board should determine and continuously assess the nature and extent of the principal risks that the organisation is exposed to and is willing to take to achieve its objectives - **its risk appetite** – and ensure that planning and decision-making reflects this assessment. Effective risk management should support informed decision-making in line with this risk appetite, ensure confidence in the response to risks and ensure transparency over the principal risks faced and how these are managed.[2]

The challenge for the Board in managing risk whilst balancing **quality & safety**, **people**, **performance activity** and **financial duties** is not underestimated, and the intention of the Risk Appetite Statement is to support an informed risk based decision.

2. Cwm Taf Morgannwg University Health has adopted the following **Risk Appetite Matrix:**

Risk Appetite	Description
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is key objective. Activities undertaken will only be those considered to carry virtually no inherent risk.
Minimalist	Preference for very safe business delivery options that have a low degree of inherent risk with the potential for benefit/return not a key driver. Activities will only be undertaken where they have a low degree of inherent risk.
Cautious	Preference for safe options that have low degree of inherent risk and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity. Activities undertaken may carry a high degree of inherent risk that is deemed controllable to a large extent.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.

3. Cwm Taf Morgannwg University Health Boards **Risk Appetite Statement:**

The Health Boards risk appetite has been defined following consideration of organisational risks, issues and consequences. Appetite levels will vary, in some areas our risk tolerance may be cautious in others we may be eager for risk and are willing to carry risk in the pursuit of important strategic objectives.

The Health Board will always aim to operate organisational activities at the levels defined below. Where activities are projected to exceed the defined levels, this will be escalated through the appropriate governance mechanisms to the Board for ratification.

- **Quality and Safety risks -** *(including physical and/or psychological harm) of its patients, people and the population)* – the Health Board has adopted a **Cautious** stance for quality and safety risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.

- **People risks -** *(including physical and/or psychological harm) to people directly engaged by the Health Board as staff or volunteers* – the Health Board has adopted a **Cautious** stance for people risks, with a preference for consideration of the impact on the well-being of staff, including insufficient staffing numbers, unmanageable workload, burnout, or any safety risks, tolerating a cautious degree of residual risk and choosing the option most likely to result in a positive, healthy experience of work for our people, while also balancing service provision to our population.

[1] Government Finance Function – Risk Appetite Guidance Note – August 2021 – V2.0
[2] The Orange Book – Section A

- **Operational Performance risks –** the Health Board has adopted an **Open** stance for Operational Performance risks, with a preference for innovating service delivery, adoption of new technologies and models of service reconfiguration for the benefit of its patients, people and the population.

- **Reputation / Adverse Publicity (Trust in Confidence) risks** - the Health Board has adopted a **Cautious** stance for reputational risks, with a preference for safer delivery options, tolerating a cautious degree of residual risk and choosing the option most likely to result in successful delivery, high quality care and value for money services to its population.

- **Business Continuity risks -** the Health Board has adopted a **Cautious** stance for Business Continuity Risks. The Board will receive ongoing assurance from the testing of business continuity plans.

- **Legal / Regulatory Compliance risks –** the Health Board has adopted a **Cautious** stance for Legal, Regulatory and Compliance risks, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. The Board will receive assurance that compliance regimes are in place.

- **Data and Information Management risks –** the Health Board has adopted a **Cautious** stance for data and information management risks seeking a preference for adhering to responsibilities and safe delivery options with little residual risk. There is acceptance for the need for operational effectiveness with risk mitigated through careful management of information sharing and limiting distribution.

- **Financial stability risks –** the Health Boards stance for financial risk is varied as follows:
  - **Averse** for financial propriety, statutory and regularity risks with a determined focus to maintain effective financial control framework accountability structures.
  - **Averse** – in terms of risks related to the Health Boards qualification of accounts, associated process and deviation from reporting timescales.
  - **Cautious -** in terms of risks related to the Health Board's financial breakeven duties set out in the NHS Wales Finance Act (Wales) 2014, recognising the need to ensure appropriate balance with the Duty of Quality.
  - **Cautious** – In relation to the Health Boards budget, spend with the intention that it should maximise the use of resource each year. The Health Board will seek safe delivery options with little residual risk that only yield some upside opportunities. The Board would receive ongoing assurance through reporting structures that policies and procedures are in place to comply with HMT guidance.

- **Assets and Estates risks –** the Health Board has adopted **Cautious** and **Open** stances for assets and estates respectively, seeking value for money but with a preference for proven delivery options have that a cautious residual risk. this means that the Health Board will us solutions for purchase, rental, disposal, construction, and refurbishment that ensures it protects the public purse from as much risk as possible, producing good value for money whilst fully meeting organisational objectives.

- **Technological advances -** the Health Board has adopted an **Open** stance for risks associated with technological advances accepting that system and technology developments can enable improved delivery. Responsibility for non-critical decisions may be devolved in accordance with the Scheme of Delegation. Plans aligned with functional standards and organisational governance.

10. Appendix 5 – Board Assurance Framework (Strategic / Principal Risks)

As at the 30th April 2024, the current Strategic/Principal Risks are:

Risk no	Strategic / Principal Risk	Strategic Goal	Lead(s) for this risk	Assurance committee
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
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
3.	**Sufficient workforce to deliver the activity and quality ambitions of the organisation** Click Here for Risk 3	**Sustaining our Future**	Executive Director of People	People & Culture Committee
4.	**Community and Partner Engagement** Click Here for Risk 4	**Creating Health**	Director of Communications, Engagement & Fundraising	Population Health & Partnerships
5.	**Delivery of a digital and information infrastructure to support organisational transformation** Click Here for Risk 5	**Improving Care**	Director of Digital	Digital & Data
6.	**Leadership and Management** Click Here for Risk 6	**Inspiring People**	Executive Director for People	People and Culture
7.	**Culture, Values and Behaviours** Click Here for Risk 7	**Inspiring People**	Executive Director for People	People and Culture
8.	**Fulfilling our Environmental and Social Duties and ambitions** Click Here for Risk 8	**Sustaining our Future**	Executive Director of Strategy and Transformation	Population Health and Partnerships
9.	**Healthy Life Expectancy** Click Here for Risk 9	**Creating Health**	Executive Director of Public Health	Population Health and Partnerships
10.	**Failure to plan and manage revenue resources within the Revenue Resource limits set by WG** **Click Here for Risk 10** **Approval being sought at 30.5.24 Health Board Meeting.**	**Sustaining our Future**	Executive Director of Finance	Planning, Performance & Finance Committee

Agenda Item
8.1.5

CTM Health Board

CTM INFECTION, PREVENTION AND CONTROL STRATEGY 2024/27

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Richard Hughes, Deputy Executive Director of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Richard Hughes, Deputy Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Structured interviews with colleagues and stakeholders.	June 2023-Feburary 2024	Information to inform the strategy development.
Presentation to CTM IPC Committee	16/04/2024	Approved with agreed adjustments.
Quality & Safety Committee	16/05/2024	Endorsed for Board Approval

Acronyms / Glossary of Terms	
	(Referred to in the body of the paper)

1. Situation /Background

The quality of care and the safety of our patients and staff is paramount to the Health Board and integral to our CTM2030; 'Our Health, Our Future' strategic vision. The provision of a robust infection prevention strategy is an essential element in contributing to and achieving this vision, whilst in ensuring compliance to the Duty of Quality Statutory Guidance and to national, regional and local targets. With specific targeted interventions to reduce microbial related infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, surgical site infections and Clostridioids difficile (C. difficile) infection. In support of our teams providing clinical care directly in our hospitals and the community, our Infection Prevention and Control team in partnership with our Public Health team and other key stakeholders, will build on the work underpinned by the aforementioned quality and safety drivers and continue to actively promote a culture of zero tolerance to avoidable healthcare associated infections (HCAIs).

2. Specific Matters for Consideration /

The development of the CTM IPC Strategy 2024/27 has been a collaborative endeavour, undertaken in consultation with key stakeholders since June 2023. From the outset, inclusivity and transparency were paramount. We engaged a diverse range of stakeholders, including internal departments, external partners, experts, and material provided by regulatory bodies. Through interviews and group discussions, we gathered valuable insights, ensuring a holistic perspective and enriching the strategy with varied expertise.

Needs assessments and goal-setting exercises formed the foundation of our process. We analysed data and evaluated trends to understand stakeholder concerns and aspirations regarding the future of the service and organisational focus. Interviews provided avenues for stakeholders to express their expectations, aligning the strategy with organisational and key clinical objectives.

Central to our approach were collaborative sessions, where stakeholders shared their expertise and contributed ideas. These interactive forums, facilitated by the Deputy Executive Director of Nursing, sought to enable creativity, consensus-building, and synergy among contributors. Through structured interviews and scenario planning, we explored strategic options, evaluating their feasibility, impact, and alignment with organisational values.

The drafting phase saw the synthesis of insights gathered from stakeholder engagement activities. We crafted an initial draft of the CTM IPC Strategy 2024/27, which served as a starting point for refinement. Circulating the draft among stakeholders for feedback, we encouraged candid input and suggestions for improvement. Iterative revisions and collaborative dialogue honed the strategy to address emerging challenges and reflect the collective vision of stakeholders.

Throughout the process, alignment with organisational goals and national policy remained paramount. Regular check-ins with senior leadership and a presentation to the IPC Executive Group ensured ongoing alignment, providing opportunities for feedback and course correction. This iterative process culminated in the

finalisation of the CTM IPC Strategy 2024/27, ready for presentation to the board for approval.

In conclusion, the development of the CTM IPC Strategy 2024/27 exemplifies our commitment to inclusive, collaborative decision-making. Through interviews, group discussions, and iterative refinement, we have crafted a strategic roadmap that reflects the collective wisdom of our diverse stakeholder community. As we embark on implementation, we remain dedicated to collaboration, agility, and continuous improvement, ensuring the successful execution of our strategic objectives in the dynamic landscape of intellectual property and commercialization.

3. Key Risks / Matters for Escalation

3.1 **Patient Safety and Quality of Care:** Any changes or initiatives introduced through the CTM IPC Strategy must prioritise patient safety and the delivery of high-quality care. Risks related to medical errors, adverse events, or compromised patient outcomes must be carefully assessed and mitigated.

3.2 **Regulatory Compliance:** Compliance with regulatory requirements and healthcare standards is paramount within the NHS in Wales. Risks associated with non-compliance, regulatory changes, or audits could result in penalties, legal consequences, or reputational damage to the organisation.

3.3 **Clinical Governance:** Ensuring effective clinical governance processes is essential to maintain accountability, transparency, and quality improvement in healthcare delivery. Risks related to clinical effectiveness, risk management, and patient experience will be carefully monitored and addressed.

3.4 **Workforce Challenges:** The NHS workforce faces various challenges, including staffing shortages, workload pressures, and retention issues. Risks associated with workforce capacity, skill mix, and staff morale could impact the successful implementation of the strategy and the delivery of patient care. The implementation phase will seek to work with workforce experts to ensure we continually seek to attract professionals into the field of infection prevention. Furthermore, working with care groups and public health colleagues, we will ensure that the strategic output for workforce arrangements reflect the the new structure and works to provide the opportunity to realign roles and responsibilities.

3.5 **Health Inequalities and Access to Care:** Addressing health inequalities and ensuring equitable access to healthcare services are core principles of the strategy. Risks associated with disparities in healthcare access, service provision, or patient outcomes will be carefully considered to avoid exacerbating existing inequalities.

3.6 **Financial Sustainability:** Amidst budget constraints and increasing demand for healthcare services, financial sustainability is a key concern for CTM and the team overseeing the implementation of the strategy. Risks related to funding cuts, budget overspends, or inefficiencies in resource allocation could impact the delivery of services and the achievement of strategic objectives. The senior leadership team will work within the current financial envelope in implementing the elements of the strategy, working

with care groups and other stakeholders in seeking new initiatives in resource, service design and allocation.

3.7 Mitigating these risks requires a comprehensive approach that integrates clinical, operational, and governance perspectives. Collaboration across multidisciplinary teams, robust risk management frameworks, and continuous monitoring of key performance indicators are essential to safeguard patient safety, uphold regulatory compliance, and ensure the effective delivery of healthcare services within the CTM.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Creating health
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies, please list below: A globally responsible Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies, please list below: Learning, improvement and research, whole-system perspective and data to knowledge.
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Efficient, effective, equitable, person centred and timely.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below: Refine and recycle.

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Highest score in QIA 6 (impact 2, likelihood 3) where assessing for staff wellbeing. Low impact, will be reviewed at least 6 monthly.	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome for Equality: POSITIVE Outcome for Welsh Language: NEUTRAL	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	A workforce evaluation plan will be incorporated into the implementation and service design phase of the strategy.	

5. Recommendation

It is recommended that the Board members **Approve** the implementation of the CTM IPC Strategy 2024/27, emphasising continuous monitoring, stakeholder engagement, and agile adaptation to mitigate potential challenges and ensure the successful execution of the IPC Strategy within CTM.

6. Next Steps

6.1 In conclusion, the development of the CTM IPC Strategy 2024/27 exemplifies our commitment to inclusive, collaborative decision-making. Through interviews, group discussions, and iterative refinement, we have crafted a strategic roadmap that reflects the collective understanding of our diverse stakeholder community.

6.2 As we embark on implementation, we remain dedicated to collaboration, agility, and continuous improvement, ensuring the successful execution of our strategic objectives in the dynamic landscape of infection prevention and control throughout the region, Wales and the UK as a whole.

6.3 The senior leadership team will work with care group and corporate colleagues to ensure the IPC service is aligned to and harmonises with the needs and existing skillsets across the organisation.

6.4 The Deputy Executive Director of Nursing will work with colleagues across CTM to ensure alignment and where required, revision of the governance processes for infection prevention and control to ensure streamlined and achievable processes with the availability of data to inform and assure.

#WeAreHereForYou

Cwm Taf Morgannwg University Health Board

Infection Prevention and Control Strategy2024/27

OUR BIG IDEA

The aim of this strategic plan is to support the Health Board's values in providing the safest, most effective care possible whilst attending to All Wales national drivers. The strategic plan seeks to provide the Board and Cwm Taf Morgannwg (CTM) community with sufficient assurance that appropriate structures and processes are in place to minimise the risks of health care acquired infections (HCAI) to patients, staff and our community.

Glossary

•AMR	Antimicrobial Resistance
•C.diff	Clostridioids difficile
•DTPS	Diagnostic, Therapies, Pharmacy and Sciences
•E.Coli	Escherichia coli
•HCAI	Health Care Associated Infection
•HIW	Healthcare Inspectorate Wales
•iCTM	Improvement Cwm Taf Morgannwg
•IPC	Infection Prevention and Control
•IPCC	Infection Prevention and Control Committee
•IQPD	Integrated Quality, Planning and Delivery
•MRSA	Methicillin Resistant Staphylococcus Aureus
•MSSA	Methicillin Sensitive Staphylococcus Aureus
•NRI	Nationally Reportable Incident
•Q(1-4)	Period of time (quarters) in the financial years
•PIR	Post infection review
•PC&C	Primary Care and Community

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INTRODUCTION

Health Care Acquired Infections (HCAIs) remain high on the Welsh Government's agenda with Wales committed to achieving the goals of the UK AMR Strategy and the 5-year ambitions outlined in the UK National Action Plan 2019-2024 and addendum published in May 2022 (Welsh Government 2023). Furthermore, maintaining safe care environments is reinforced by the Healthcare Inspectorate Wales (HIW) ensuring we meet the Quality Standards (2023), actively promoting safety and welfare. All risks will be/must be identified and monitored in order to prevent or reduce them.

The quality of care and the safety of our patients and staff is paramount to the Health Board and integral to our CTM2030; 'Our Health, Our Future' strategic vision. The provision of a robust infection prevention strategy is an essential element in contributing to and achieving this vision, whilst ensuring compliance to the Duty of Quality Statutory Guidance and to national, regional and local targets, with specific targeted interventions to reduce microbial related infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia, surgical site infections and Clostridioids difficile (C.difficile) infection. In support of our teams providing clinical care directly within our hospitals and community setting, our Infection Prevention and Control team in partnership with our care group and our public health team will build on the work underpinned by the aforementioned quality and safety drivers and continue to actively promote a culture of zero tolerance to avoidable HCAIs.

The prevalence of HCAIs is not associated with any single factor, but to several recognised interdependencies.

Known interdependencies

- The use of invasive devices such as urinary, peripheral and central devices which compromise the body's natural defence mechanisms.
- The reliance on antibiotics which increases the resistance to infections over time.
- Organisational factors such as staff to patient ratios and the increase in bed occupancy levels.
- Physical infrastructure e.g. building works and lack of isolation facilities.
- Poor compliance with best practice e.g. failure to decontaminate hands before/following key activities.
- The cleanliness of the clinical environment is critical when dealing with certain micro-organisms such as C.diff.
- The demographics of patient population suggesting an older, increasingly clinically complex and vulnerable population.
- Global factors and travel contribute to the rapid nature of spread of infectious agents as seen in COVID-19 and novel influenza strains.

Roles & responsibilities

Staff

Are responsible to ensure they maintain and support a coordinated approach to infection prevention within their areas of responsibility. All staff must comply with Health Board policies and attend to their mandatory education requirements.

Clinical care groups

Have a responsibility to ensure staff have the tools and resources to implement best practice to facilitate a safe working environment and formulate action plans and take corrective action where shortfalls exist. Any corrective actions will be monitored at Care Group Quality, Safety, Risk and Experience (QSRE) groups, Infection Prevention and Control Committee and local governance forums.

IPC Team

Have the mandate to deliver the strategic plan using expert knowledge and to facilitate operational and strategic support for clinical leaders across CTM. This will maximise their influence in ensuring infection prevention principles are embedded into the Care Groups and Directorates daily professional practice.

Delivery of the Strategy

Leadership

- Board leadership; the strategic plan is approved by the Quality and Safety Committee with the delivery supported and overseen by the Infection Prevention and Control Committee (IPCC).
- The care group leadership teams are responsible for local performance against the prevention and control of HCAI.
- Health Board business planning processes; IPC issues must be considered in business plans and advice sought from the IPC where required.

Governance and monitoring

- IPC policies; based on national best practice guidance with performance against the policies being monitored through extensive clinical audit.
- Local and Health Board performance management; performance against HCAI trajectories and ward/unit accreditation are reported through key performance indicators, clinical governance and the IPCC.

Clinical practice and responsibilities

- Training and education; the IPC Team to ensure provision of training for all new and existing staff.
- All Health Board staff have a responsibility to adhere to infection prevention and control policies in order to reduce the occurrence of HCAI.
- The IPC Team; delivering an Infection Prevention and Control Annual Programme.

Strategic objectives

Surveillance & reporting

Working with the Patient Safety and digital teams, explore and update surveillance mechanisms and reporting to facilitate embedding of best practice.

Partnership

In partnership with stakeholders such as Llais, Local Authorities, Public Health Wales and CTM Public Health, enhance patient and public involvement in infection prevention in order to improve patient experience.

Learn and develop

Working with the CTM Learning Academy and local educational providers to Develop innovative methods of educating staff in the delivery of high quality infection prevention and control.

IPC fit for the future

Complete and implement strategic review of operational IPC service delivery by Q3 of 2024 to ensure relevance to the Health Board's requirements.

Minimise harm

Minimise the risk of HCAIs to patients with the goal of reducing all avoidable infections by ^50%.

Compliance

Continue to comply with statutory requirements related to the Duty of Quality, Welsh Government goals (2023/23), HIW, Public Health Wales and related bodies to maintain a safe environment.

Antimicrobial stewardship

Review antimicrobial stewardship arrangements across acute, primary care, community and mental health settings within the Health Board. Formulate and adopt national tools to enhance processes with the aim of achieving:

a. *25% reduction in antimicrobial usage in the community from 2013 baseline.
b. *10% reduction in the use of "reserve" & "watch" antibiotics in hospitals from 2017 baseline.

Improvement, innovation & sustainability

Working with iCTM, Research and Development and other key stakeholders to explore opportunities to participate in research and quality improvement in underpinning future practice attending to sustainability as well as improving both patient experience and outcomes.

^using 2023/23 CTM HCAI data as the baseline for improvement
[1]Welsh Government (2023) Welsh Health Circular: AMR & HCAI Improvement Goals for 2023-24. https://www.gov.wales/sites/default/files/publications/2023-08/amr-hcai-improvement-goals-for-2023-24.pdf

Surveillance & reporting

The ambition

The Health Board has a process for reviewing learning from infection events using national reporting and local mechanisms. The surveillance of 'alert microorganisms' such as mandatory reporting e.g. C.difficile, MRSA, E.Coli and MSSA is already well established using a PIR process.

It is anticipated through multidisciplinary collaboration with Planned care and Children & Families care groups, surveillance of surgical site infection will be further expanded to strengthen reporting and learning opportunities.

Working with the care groups, the IPC team will review and align other processes for identifying, sharing, collaborating and responding to incidences of alert microorganisms including associated common sources of infection e.g. urinary catheters and intravascular devices.

The commitment

- Review current surveillance approaches and refine to best meet the needs of the service and take into account national priorities and regulatory compliance.
- Identify new digital and business intelligence opportunities in data capture and visibility.
- Focus on embedding a robust surgical site monitoring scheme focusing on elective joint replacements with timely feedback to clinicians on key performance indicators (to ensure futureproofing in support of elective delivery plans).
- Develop surveillance schemes to minimise infections from invasive devices and feedback mechanisms to maintain practice within best published results.
- Continue to carry out and enhance Post Infection Review processes to help refine current approach, governance and the IPCC both in the acute and community settings.

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Surveillance & reporting (cont.)

The ambition

- The Health Board will also work with NHS Wales Executive colleagues in achieving a standardised approach to the reporting of HCAIs across Wales.

The commitment

- Work with Patient Care and Safety team as well as NHS Wales Executive team in reviewing and implementing internal and external reporting pathways.

Partnership

The ambition

In partnership with stakeholders such as Llais, Local Authorities, Public Health Wales and CTM Public Health, enhance patient and public involvement in infection prevention in order to improve patient experience.

The IPC team and the Health Board are committed to improving on the involvement of our community and patient population to provide a service that meets the needs of those using the service.

The commitment

- A wholescale review and update of the communication media whilst exploring new ways of disseminating information.
- Working with the Corporate Nursing Team, Patient Experience colleagues, Llais and our Communications Team, we will set out to review signage, posters and information sources ensuring maximum community and stakeholder involvement.
- The introduction of the CTM Infection Prevention Charter in 2024 aligned with CTM2030 will set out the Health Board's commitment to strengthening partnership arrangements and expand on the opportunities for infection prevention across all of our community and acute services.

Learn & develop

The ambition

The Health Board is committed to ensuring our workforce have the knowledge, skills and tools to enable them to provide high quality care. In partnership with the CTM Learning Academy the IPC team will create a suite of educational activities such as hand hygiene, high impact interventions (Aseptic Non Touch Technique) which will be monitored annually by the academy's faculty and IPC senior leadership team.

Staff training compliance data will be monitored by the respective care group leadership teams through local governance monitoring arrangements and will be reported to the Infection Prevention and Control Committee.

Working with the Corporate Nursing and Patient Safety Team, ward practice will be monitored by structured quarterly visits from the IPC team, as well as participation in the structured accreditation .

The commitment

- In partnership with care groups and educationalists, the IPC Team will review and update the available learning resources for staff to ensure it meets the needs of staff, volunteers and students.
- Inform the Board of staff training compliance using existing reporting methods.
- Participate in the annual review of the ward accreditation program to ensure infection prevention and control principles are fully updated as part of the accreditation framework.
- Provide a suite of learning tools for use in targeted support and intervention.
- Work with the Learning Academy and South Wales University to develop a curriculum for our emerging and existing IPC practitioners and leaders.

IPC fit for the future

The ambition

Within the new organisational structure of CTM, our IPC service is reviewing the model of care and leadership to ensure the service will meet the needs of the service.

In 2024, through widespread stakeholder engagement the IPC service is committed to modifying its techniques and procedures of service delivery to ensure it meets the needs of the care groups, wider Health Board and the CTM community. Through the application of evidence, digital solutions and policy, the IPC team will review and adapt the service to ensure optimal productivity and efficiency.

The commitment

- Complete and implement strategic review of operational IPC service delivery by Q3 of 2024 to ensure relevance to the Health Board's requirements.
- Working with the Digital Clinical Leads and Corporate Nursing team, the IPC service will set out to optimise and advance current digital and data sharing opportunities, ensuring a reduced administrative burden and maximised clinical presence.
- In collaboration with iCTM, the IPC service will review current service regimes to ensure optimal productivity and efficiency.
- The IPC senior leadership team will carry out an annual review of current best practice, evidence national policy developments to ensure the Health Board is working to the most up to date policies and procedures.

Minimise harm

The ambition

The Health Board is committed to the implementation of a zero avoidable infection culture. To see this embedded, standards of practice will be monitored with measures to support and intervene where practice falls below expected levels.

With support from national and local agencies, the Health Board will set out to minimise the risk of HCAIs to patients with the goal of reducing all avoidable infections by 50%.

All wards and large departments will be expected to participate in the ward accreditation programme which aims to embed and sustain safe levels of practice.

The commitment

- Complete and implement strategic review of operational IPC service delivery by Q3 of 2024 to ensure relevance to the Health Board's requirements.
- Working with the Digital Clinical Leads and Corporate Nursing team, the IPC service will set out to optimise and advance current digital and data sharing opportunities, ensuring a reduced administrative burden and maximised clinical presence.
- In collaboration with iCTM, the IPC service will review current service regimes to ensure optimal productivity and efficiency.
- The IPC senior leadership team will carry out an annual review of current best practice, evidence, national policy developments to ensure the Health Board is working to the most up to date policies and procedures.

Compliance

The ambition

The Health Board is committed to ensuring it retains full compliance aligned to the Duty of Quality (2023) and Duty of Candour (2023) Statutory Guidance.

The Health Board will monitor gaps in compliance through the care groups QSRE, IPC Operational Huddle (two weekly), reporting on exceptions to the IPCC, Quality and Safety Committee and Board.

Through triangulation of IPC audit data, ward accreditation outputs, incident reporting and reports from area visits, care groups and the IPC team will report by exception to the IPCC.

The IPC team will provide monthly analysis for the Executive and Deputy Executive Directors of Nursing for monitoring and discussion with NHS Wales executive colleagues.

The commitment

- We will continue to monitor gaps in assurance through exception reporting, with the aim of achieving full compliance.
- Continue to provide ward, directorate and care group level data, identifying any gaps in compliance.
- Directorates and care groups will continue to monitor compliance and address non-compliance through their governance processes.
- Review and improve cohort and other IPC operational guidance for ward managers and clinical leaders.
- Work closely with Facilities leadership teams to review current operational procedures for general and enhanced cleaning programmes with the aim of designing and publishing a revised and updated approach by Q3 2024

Antimicrobial stewardship

The ambition

The IPC team with stakeholder colleagues will review antimicrobial stewardship arrangements across acute, primary care, community and mental health settings within the Health Board. Formulate and adopt national tools to enhance processes with the aim of achieving:

a. 25% reduction in antimicrobial usage in the community from 2013 baseline.

b. 10% reduction in the use of “reserve” & “watch” antibiotics in hospitals from 2017 baseline.

The IPC team, antimicrobial pharmacist and wider pharmacy team will ensure there are systems in place to monitor prescribing is in accordance with policy and implement measures to address any deviation.

The commitment

- Establish and implement an AMS/HCAI steering group to maximise processes on the antibiotic point prevalence to ensure frequency and provision of timely feedback to clinicians/prescribers.
- Establish and review a platform for information to Health Board colleagues across CTM (antimicrobial SharePoint page).
- Review and implement current antibiotic policies to maintain relevance.
- Develop and provide innovative resources and education materials to staff groups.
- Work with public health, pharmacy, primary care and community colleagues to ensure greater impact and support for clinicians and clinical leaders working across the CTM communities on antimicrobial prescribing.

Antimicrobial stewardship (cont.)

Initiatives & priorities

Using a multiple stakeholder approach, CTM will seek to continue and develop on the work already established in the field of antimicrobial stewardship in areas such as:

a. Influencing antimicrobial prescribing on surgical wards
b. Implementation of a fluoroquinolone prescribing aid project and assessment of sustainability/usability/impact on prescribing.
c. Influencing antimicrobial prescribing for Community Acquired Pneumonia across both primary and secondary care
d. Lymphoedema/cellulitis in primary care
e. Evaluating the association of antibiotic prescribing volume in General Practice with hospital admissions related to infection through linking Cwm Taf Morgannwg University Health Board data sets from the financial year 2023/24.

Deliverables & enablers

CTM will seek to deliver on the ambition through a number of commitment principles or goals, some of which are featured below.

- Visual summaries for the management of seasonal infections ahead of the linked season, e.g. respiratory tract infections in winter, urinary tract infections or insect bites summer. Top 12 most common infections
- To determine patient specific characteristics from the infection related hospital admissions, e.g. gender, age, indication for admission, co-morbidities, General Practice origin.
- Primary care: measure current prescribing for community acquired pneumonia, educational intervention around course length reduction, reaudit to assess improvement in compliance to guidelines.

Improvement, innovation & sustainability

The ambition

Working with iCTM, NHS Wales Executive, Research and Development, the Health Board will seek to explore opportunities to participate in research and quality improvement in underpinning future practice to improve patient experience and outcomes.

The IPC team are committed to leading the implementation of research and quality improvement to facilitate implementation of high quality care and to enhance the patient experience

CTM will seek to deliver a modern IPC service for patients and staff aligned to addressing the issues of sustainability in the modern healthcare environment.

The commitment

- Explore opportunities to work with commercial partners to evaluate new product lines.
- Develop and build on research portfolios and promote the Health Board as a leader using publication outputs and conference opportunities.
- Working with CTM communication experts, maintain and improve communication mechanisms e.g. QR code information, leaflets, SharePoint, social media e.g. X feeds.
- Working directly with iCTM and NHS Wales Executive colleagues, the IPC team will identify, review and promote quality improvement programmes that minimise harm from infection.
- Working with experts and key stakeholders, IPC in CTM will ensure services and policies are aligned to and consider the sustainability agenda in Wales.

Implementation

The strategy will be implemented by the Infection Prevention Committee, led by the Executive Director of Nursing. The Infection Prevention Committee will co-ordinate delivery plans in order to implement the strategy.

Members of the Infection Prevention Committee link to other groups and committees (Quality and Safety Committee, Improving Care Board, Medication Safety Group, Care Group QSRE) to ensure that actions to achieve this strategy are fully embedded within the Care Groups delivery plans.

Infection Prevention and Control Committee members will act as a conduit for information, so that care area plans can be linked via the Infection Prevention Committee to the annual Health Board infection prevention programme. The Executive Director of Nursing will continue to have direct access to the Medical Director and / or Executive Lead if matters require immediate escalation and attention.

The following key teams and committees will also support implementation:

- Decontamination Group
- Antimicrobial leadership colleagues
- Laboratory (DTPS and Deputy Director of Therapies and Health Sciences)
- Hospital Management Teams, Out of hours / Clinical Sites Management Team
- Nursing and Midwifery Directors Group
- Care Group Quality, Safety, Risk and Experience Groups
- Directorate Governance Forums
- Estates and Facilities
- CTM Public Health team
- Public Health Wales
- Patient safety Groups
- Local Partnership Forum
- Improving Care Board
- Quality and Safety Committee
- Board

Implementation (continued)

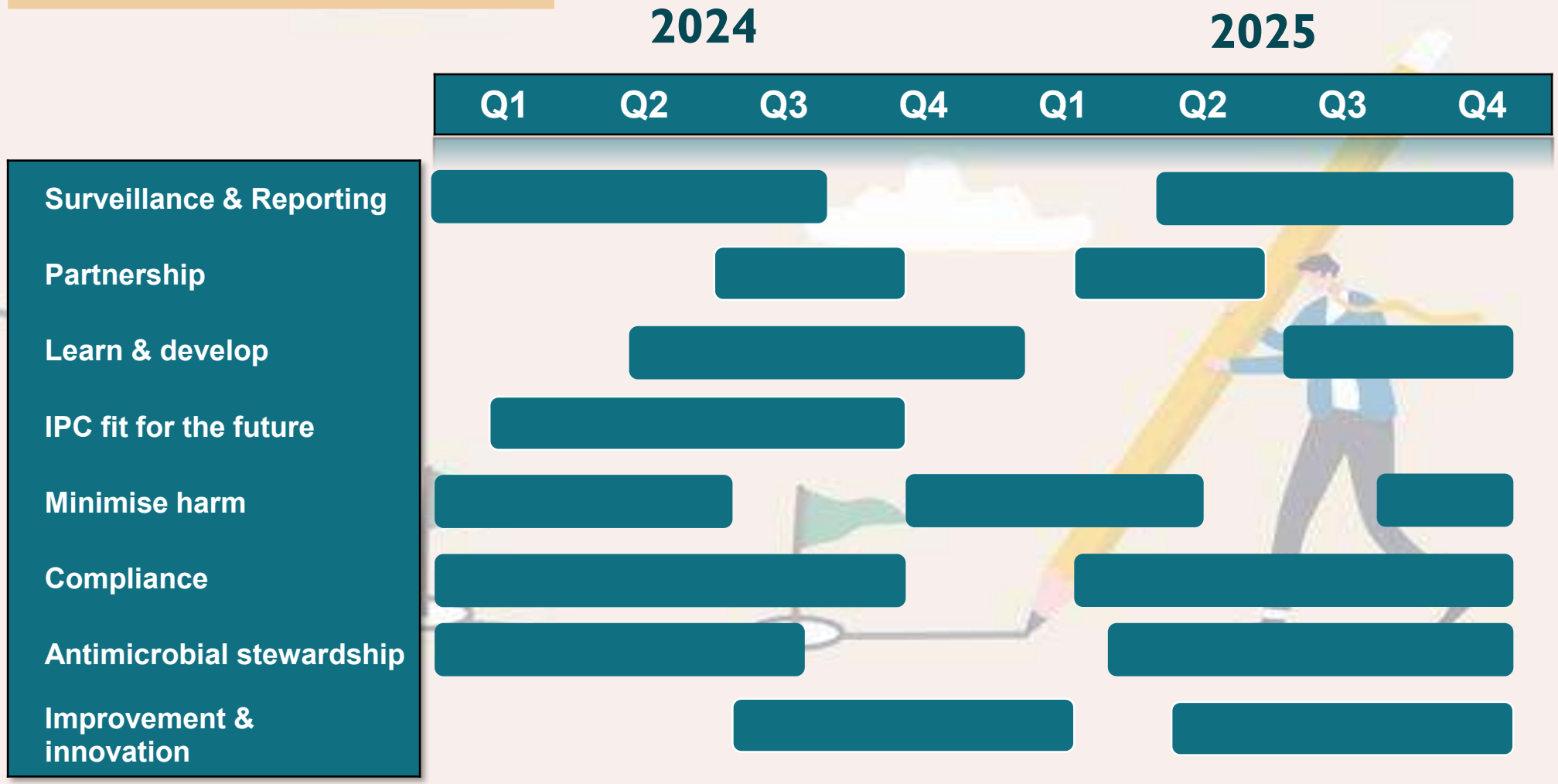
Teams within the Health Board will contribute to the implementation of this strategy and reducing HCAIs through:

- The investigation into and learning of significant infections.
- Working with Clinical Site Manager teams, Heads of Nursing, Lead Nurses, Senior Nurses, Consultants and other clinical leaders to ensure patients with infections are placed appropriately to meet their care needs and in order to protect other patients.
- Seeking specialist Infection Prevention and Microbiology advice where required.
- Ensuring that staff are trained in basic infection prevention and control.
- Working with estates and facilities teams to ensure the clinical environment is clean and safe for patients.
- Ensuring availability of accurate and purposeful data and information for IPC and clinical leaders to make clinical judgements in managing actual and emerging infection control incidents.

Dissemination of strategic plan

Once approved by the IPCC (April 2024) and Quality and Safety Committee (May 2024), the strategic plan will be available on the Health Board SharePoint pages and will be shared for discussion and dissemination with Care Group Directors, Corporate Directors and wider stakeholder agencies.

Milestones


2024
2025
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Surveillance & Reporting
Partnership
Learn & develop
IPC fit for the future
Minimise harm
Compliance
Antimicrobial stewardship
Improvement & innovation

The Board is responsible for ensuring that the Health Board has appropriate Infection Prevention and Control systems and resources in place to enable the organisation to deliver its objectives and statutory requirements.

Activities to validate that infection prevention and control is an essential part of clinical and corporate governance including:

- The Board receiving and formally approving (Quality and Safety Committee)
- Health Board Infection Prevention and Control Strategic Plan
- The Annual Infection Prevention and Control Report
- Quality and Safety Committee reports.

Assurance framework

The Strategic plan aims to outline objectives and responsibilities and is a requirement of the organisation. The IPCC sets objectives for the year, identifies priorities for action, evidence that policies have been implemented and reports progress against the objectives.

The IPC Annual Report provides performance information from the preceding year and highlights any outstanding issues that need to be addressed by the IPCC and associated stakeholders (e.g. care groups).

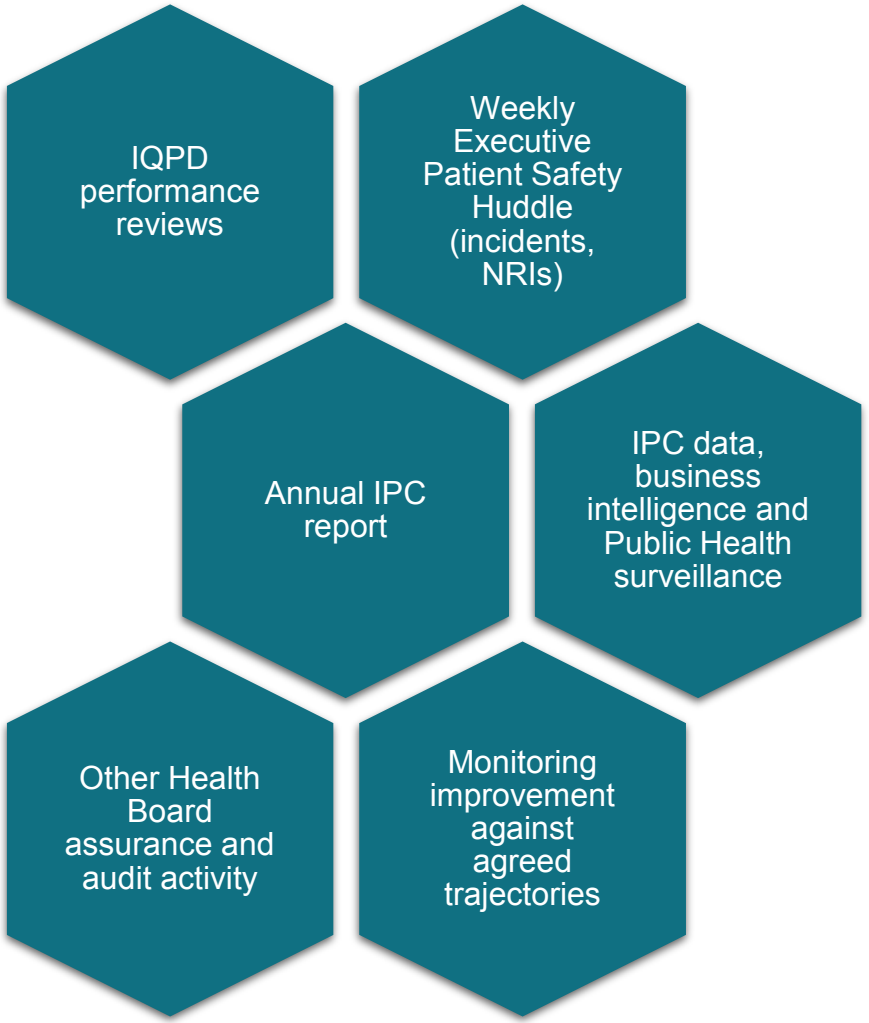
Reporting monthly Health Board infection prevention and control key performance indicators reports through the Board, Quality and safety Committee, the care groups governance forums and to NHS Wales Executive colleagues (IQPD) to the board.

Exception reports are prepared by the Executive Director of Nursing or delegated individual as required. The Infection Prevention and Control Committee's purpose is to seek assurance that the Health Board has a robust framework for infection prevention and control as part of a whole CTM health community. The Committee meets six times a year and is represented by key organisation stakeholders such as hospital leaders and care group leadership teams who will update on IPC performance related concerns.

Assurance framework

Component of plan to be monitored	Lead	Methodology	Frequency	Senior Responsible Officer(s)	Reported to where
Objectives from strategic plan	IPC Head of Nursing (HoN)	IPC Operational Meetings	Two weekly	Executive Director of Nursing	IPCC
Training & Education	Assistant Director (AD) of Education, AD of Nursing, Care Group Nurse Directors	Training needs analysis, compliance ESR data	Training needs analysis (annually), compliance data (monthly)	Deputy Executive Director of Nursing	IPCC
Antimicrobial stewardship	Chief Pharmacist, IPC HoN, Care Group Medical Directors	Point prevalence audits and compliance audits, AMS/HCAI steering group	Monthly	Chief Pharmacist, Medical Director for PC&C Care Group	IPCC
Ward/unit environment and cleanliness	Director of Facilities, Heads of Nursing, IPC HoN	AMaT audits, cleaning schedules, accreditation, visits	Audits and cleaning schedules (monthly), accreditation (annually), visits (quarterly)	Care Group Nurse Directors, AD of Nursing	IPCC, Care Group QSRE
Regulatory and statutory compliance	AD Quality and Safety, AD Risk and Compliance, IPC HoN, Care Group Directors	Risk register management, HIW inspection reports, Welsh Health Circulars	Risk register (monthly), HIW and Welsh Health Circulars (when required)	Executive Director of Nursing, Executive Medical Director, Chief Operating Officer, Director of Corporate Governance	IPCC, Quality and Safety Committee exception reports

Surveillance of the key strategic objectives will also be facilitated through:



Key challenges

- The use of invasive devices such as urinary, peripheral and central devices which compromise the body's natural defence mechanisms.
- Level of hospital activity and capacity
- Community prevalence outside of healthcare settings
- Associated chronic conditions and interdependencies
- Isolation / cohort / ensuite facilities
- Emerging infections and new strains/variants i.e. pandemics
- Ensuring public confidence
- Educating workforce, patients and the public
- Non-substantive and transient workforce
- Ensuring a clean and appropriate environment
- Motivating staff and the engagement of staff
- Meeting national and local targets

Strategic plan for review

The CTM IPC Strategic Plan will be subject to a prescribed review in 2026, however an informal review will be undertaken on a quarterly basis and reported by exception to the IPCC.

Strategic Plan Author: Richard Hughes, Deputy Executive Director of Nursing (2024)

Our stakeholders and partners in Cwm Taf Morgannwg University Health Board:

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr
BRIDGEND
County Borough Council

LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

University of South Wales
Prifysgol De Cymru

GIG CYMRU NHS WALES
Y Weithrediaeth Executive

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Cysylltu Trawsffurfio Cymru
ICTM
Connect Transform Motivate
Innovation

Cyngor Bwrdeistref Sirol
MERTHYR TUDFUL
MERTHYR TYDFIL
County Borough Council

agic hiw
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

UK Health Security Agency

RHONDDA CYNON TAF

Powys

Agenda Item
8.1.6

CTM Health Board

AMENDMENT TO STANDING ORDERS – STAKEHOLDER REFERENCE GROUP – FREQUENCY OF MEETINGS

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Stakeholder Reference Group	08/02/2024	Endorsed for Board Approval

Acronyms / Glossary of Terms	

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

2.1 In response to feedback identified through the completion of the annual self-assessment of effectiveness process, members of the Stakeholder Reference Group suggested that the number of meetings per annum is reduced from a minimum of six to a minimum of four meetings with one additional Adhoc meeting if required. This was endorsed by the Stakeholder Reference Group and the Board are asked to consider formal ratification of this decision.

3. Key Risks / Matters for Escalation

3.1 Board approval is required as this will be a variation to the Model Standing orders.

3.2 If approved, the Standing Orders will be updated and a revised version published and uploaded to SharePoint and the Health Board's Internet site.

3.3 The Standing Orders will be further strengthened in year as and when required.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
	A Resilient Wales

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate):	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the

	POSITIVE/NEUTRAL NEGATIVE	appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is being asked to **APPROVE** the variation to the Standing Orders in the reduction of Stakeholder Reference Group meetings to four meetings per year, with one additional Adhoc meeting should this be required.

6. Next Steps

6.1 Once approved the Terms of Reference will be uploaded to the Health Board's website.

Agenda Item
8.2.1

CTM Health Board

BOARD ANNUAL CYCLE OF BUSINESS

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Nil	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
None identified.	

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 2024 to 31 December 2024.

2. Specific Matters for Consideration

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

3.1 Please refer to **Appendix 1** – Board Cycle of Business for further detail.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is asked to NOTE the Annual Cycle of Business for 2024.

6. Next Steps

6.1 There are no next steps required.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Agenda Item 8.2.1

Health Board

Cycle of Business

(1st January 2024 – 31st December 2024)

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 2024 to 31st December 2024.

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.

Board Cycle of Business (1st January 2024 – 31st December 2024)

Item of Business	Executive Lead	Reporting period	25 Jan 2024	Feb 2024	28 Mar 2024	April 2024	30 May 2024	11 July 2024	24 July 2024	Aug 2024	26 Sep 2024	Oct 2024	28 Nov 2024	Dec 2024
Shared Listening & Learning														
Listening & Learning Story	Executive Director of Nursing	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Setting the Scene														
Chairs Report *(Including affixing of the Common Seal and Chairs Urgent Action Requests)*	Health Board Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Action Log	Health Board Chair	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Chief Executives Report (to include updates on Targeted Intervention – Programme for Continuous Improvement in response to Targeted Intervention)	Chief Executive	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Delivering our Plan														
Integrated Performance Report (Quality, People & Operational Performance)	Executive Director of Strategy & Transformation	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Financial Performance Report	Executive Director of Finance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Governance, Risk and Assurance														
Board Assurance Framework	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Board Committee & Advisory Group Highlight Report (where there are matters identified for escalation)	Director of Corporate Governance	All Regular Meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Working in Partnership Reports (to include Joint Committee Highlight Reports)	Executive Director of Strategy & Transformation	As and when required	⚑		⚑		⚑		⚑		⚑		⚑	
Joint Committee Annual Update	Director of Corporate Governance	Annually											⚑	
Nurse Staffing Levels (Wales) Act Reports	Executive Director of Nursing	Bi-Annually					⚑						⚑	
Audit Wales Structured Assessment & Audit Letter	Audit Wales	Annually	⚑											
Audit Wales Annual Audit Report	Audit Wales	Annually			⚑									
Annual Review of the Standing Orders	Director of Corporate Governance	Annually			⚑ Defer to May 2024		⚑ Defer to Sept 2024				⚑			

Item of Business	Executive Lead	Reporting period	25 Jan 2024	Feb 2024	28 Mar 2024	April 2024	30 May 2024	11 July 2024	24 July 2024	Aug 2024	26 Sep 2024	Oct 2024	28 Nov 2024	Dec 2024
Board Effectiveness Self-Assessment	Director of Corporate Governance	Annually			Defer to May 2024									
Risk Management Strategy	Director of Corporate Governance	Annually												
Annual Report (including Performance Report, Accountability Report and Remuneration Report)	Director of Corporate Governance	Annually												
Annual Statutory Accounts	Executive Director of Finance	Annually												
Charitable Funds Annual Report and Accounts	Executive Director of Finance	Annually												
Strategic Planning														
Integrated Medium Term Plan – Approval	Executive Director of Strategy & Transformation	Annually												
Clinical Services Plan Progress Updates	Executive Director of Strategy & Transformation	All Regular Meetings												
Regional Partnerships Board & Public Services Board 6 Monthly Report	Executive Director of Strategy & Transformation	Bi-Annually												
Winter Plan Update	Chief Operating Officer	Annually												
Consent Agenda – For Approval														
Minutes of the previous Board Meeting	Director of Corporate Governance	All Regular Meetings												
Amendments to the Standing Orders (Terms of Reference)	Director of Corporate Governance	As and When required												
Committee Annual Reports	Director of Corporate Governance	As and When Required												
Consent Agenda – For Noting														
Board Cycle of Business	Director of Corporate Governance	All Regular Meetings												
Board Forward Work Programme	Director of Corporate Governance	All Regular Meetings												
Committee Highlight Reports	Director of Corporate Governance	All Regular Meetings												
Putting Things Right Annual Report	Executive Director of Nursing	Annually												

Item of Business	Executive Lead	Reporting period	25 Jan 2024	Feb 2024	28 Mar 2024	April 2024	30 May 2024	11 July 2024	24 July 2024	Aug 2024	26 Sep 2024	Oct 2024	28 Nov 2024	Dec 2024
Safeguarding Annual Report	Executive Director of Nursing	Annually	⚑											
Carers Annual Report	Executive Director of Nursing	Annually									⚑			
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	Executive Director of Public Health	Annually					⚑ Defer to Sept 2024				⚑			
Internal Audit Annual Audit Plan	Head of Internal Audit	Annually					⚑							
Capital Update – to be taken as an In Committee item given commercial sensitivities	Executive Director of Finance	Quarterly			⚑ Defer to May 2024		⚑		⚑				⚑	
Annual Plan Quarterly Update	Executive Director of Strategy & Transformation	Quarterly			⚑				⚑				⚑	

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**
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 – 28 September 2023. To be Deferred – Was January 2024. Was March 2024 – Was May 2024 – **Now July 2024**
Email request received from the Assistant Director of Governance & Risk	Additional Item	Estates, Facilities Performance Management System annual report	Director of Finance	Planned for 28 September 2023 – Now 30 November 2023 – To be deferred from November – date to be confirmed
Suggested as an item for discussion at a future Board meeting at an agenda planning session for the January 2024 meeting	Additional Item	CTM 2030 Strategic Public Health Promotion (Diabetes)	Executive Director of Public Health	Planned for January 2024 – Deferred to 28 March 2024 – Now 30 May 2024 – **On agenda**
Identified as a report coming forward within the Chief Executive Report presented to the July Board	Additional Item	Llantrisant Health Park Update – To include the year one+ Plan	Chief Executive	**In progress** Received and noted at the meeting held on 30 November 2023. Further update to be presented to the Board in **July 2024.**

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 Deputy Director for People	Additional Item	Development of the CTM People Plan	Executive Director for People	Planned for 28 March 2024 – Was 30 May 2024 – **Now 25 July 2024**
Email request from the Executive Director for People	Additional Item	Agency Reduction Plan and Decision Making Framework for CTM	Executive Director for People	Date to be confirmed
Email request from the Assistant Director of Organisational Development and Wellbeing	Additional Item	Update on Culture	Executive Director for People	Planned for 28 March 2024 – Item deferred
Email request from the Assistant Director of Governance & Risk	Additional Item	Community Diagnostic Hub & Endoscopy Procurement Process and Business Case	Executive Director of Strategy & Transformation	Was planned for 28 March 2024 – Now 30 May 2024 – **Progress report to be discussed at the In Committee Board meeting**
Email request from the Assistant Director of Governance & Risk	Additional Item	Maesteg Community Hospital Development – Outline Business Case	Executive Director of Strategy & Transformation	Planned for 28 November 2024
Email request received from the Strategic Planning & Commissioning Manager	Additional Item	CTM Baby & Toddler Voice	Executive Director of Strategy & Transformation	Planned for 30 May 2024 – **It has now been proposed that a briefing on this matter will be given at a future Board Development Session**
CEO requested an update to come	Additional Item	Development of Plan to address Delayed Discharge Issues	Chief Operating Officer	Planned for 30 May 2024 – **As stated within the CEO report**

forward at the March Board				**to May Board, this will now be presented to the Board on 25 July 2024**
COO advised that this report would be coming forward to May Board at the March 2024 meeting	Additional Item	Outcome of the Productivity work undertaken with GIRFT	Chief Operating Officer	Planned for 30 May 2024 – **On agenda**
Agreement given by the Chair for this item to be added to the agenda for approval	Additional Item	Infection, Prevention & Control Strategy	Executive Director of Nursing	Planned for 30 May 2024 – **On agenda**
Advised by Director of Digital that this item would be coming forward for July Board	Additional Item	Electronic Patient Records	Director of Digital	Planned for 25 July 2024
Suggestion made at agenda planning session that it would be helpful if this item could be received at the July Board	Additional Item	Workforce Planning	Executive Director for People	Planned for 25 July 2024

Completed Requests:				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request received from the Assistant Director of Governance & Risk for this to be added to the agenda for March Board	Additional Item	Board Committee Review Proposal	Health Board Chair	**Completed** Received and approved at the meeting held on 28 March 2024
Email request received from the Deputy Director of Strategy & Partnerships	Additional Item	Decarbonisation Action Plan for 2024-2026 (consent agenda for approval)	Executive Director of Strategy & Transformation	**Completed** Received and approved at the meeting held on 28 March 2024
Verbal request received from the Assistant Director of Organisational Development and Wellbeing	Additional Item	Strategic Equality Plan	Executive Director for People	**Completed** Received and approved at the meeting held on 28 March 2024
Email request received from the Director of Corporate Governance & Board Business	Additional Item	Establishment of the NHS Wales Joint Commissioning Committee, as a Joint Committee of Local Health Boards in NHS Wales	Director of Corporate Governance/Board Secretary	**Completed** Received and approved at the meeting held on 28 March 2024
Email request received from the Director of Corporate Governance & Board Business	Additional Item	EMRTS Service Review Phase 3 Engagement	Chief Ambulance Services Commissioner	**Completed** Received and approved at Extra Ordinary Public Board meeting held on 9 April 2024
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	**Completed** As reported in the CEO report to March Board, the Armed Forces Covenant was signed by the CEO on behalf of the Health Board on 25 March 2024

Verbal request received from the Assistant Director of Organisational Development and Wellbeing	Additional Item	Annual Equality Plan	Executive Director for People	**Completed** Confirmed that there is no requirement for this report to be presented to Board given that has been presented to People & Culture Committee
Verbal request received from the Assistant Director of Organisational Development and Wellbeing	Additional Item	Gender Pay Gap Report	Executive Director for People	**Completed** Confirmed that there is no requirement for this report to be presented to Board given that has been presented to People & Culture Committee

Agenda Item
8.2.3

CTM Health Board

Board Committee and Advisory Group Highlight Reports

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance/Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 In line with the Standing Order requirements each Board Committee and Advisory Group is required to submit a Highlight Report setting out its activities at each meeting. This also provides a mechanism for escalating issues to the Board as required.

2. Specific Matters for Consideration

2.1 A number of Committee/Advisory Groups have been held since the Board last met in March 2024.

3. Key Risks / Matters for Escalation

3.1 Key risks and any matters for escalation to the Board are set out in the appended Highlight Reports.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /*	Safe
	If more than one applies please list below:

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒ This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
	Outcome:	If no, please include rationale below:
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Board is being asked to NOTE the following Highlight Reports:

- Extra Ordinary Planning, Performance & Finance Committee 13 March 2024 (Appendix 1);
- Quality & Safety Committee 14 March 2024 (On main agenda at agenda item 5.1.3);
- Remuneration & Terms of Services Committee 28 March 2024 (Appendix 2);
- Stakeholder Reference Group 11 April 2024 (On main agenda at agenda item 5.1.2);
- People & Culture Committee 15 April 2024 (Appendix 3);
- Hosted Bodies Audit & Risk Committee 18 April 2024 (On main agenda at agenda item 5.1.4);
- CTMUHB Audit & Risk Committee 18 April 2024 (Appendix 4);
- Charitable Funds Committee 23 April 2024 (On main agenda at agenda item 5.1.1);
- Planning, Performance & Finance Committee 30 April 2024 (Appendix 5)

Agenda Item
8.2.3 Appendix 1

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE EXTRA ORDINARY PLANNING, PERFORMANCE & FINANCE COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Choose an item. Linda Prosser, Executive Director of Strategy & Transformation Gethin Hughes, Chief Operating Officer Sally May, Executive Director of Finance & Procurement

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
IMTP	Integrated Medium Term Plan

1. Situation /Background

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Extra Ordinary Planning, Performance & Finance Committee which took place on 13th March 2024.

1.2 Key highlights from the meeting are contained in section 3.

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

2.1 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	There were no matters requiring escalation on this occasion.
ADVISE	• The Committee received the **Draft Integrated Medium Term Three Year Plan 2024-2027.** The Committee discussed and **noted** the following key matters: - **Draft 3 Year plan:** The plan aims to balance quality, performance and finance, with a focus on stabilising frontline services and investing in digital and infrastructure. There were still some risks and gaps to address, especially around planned care targets and urgent care demand. The plan would be finalised and submitted to the board by the end of March 2024. - **Finance summary:** The plan assumed break even, but it was highlighted that there was an unmitigated risk of up to £20 million, based on current submissions from care groups and directorates. Further work with Care Groups was required to improve the savings position and reduce the unmitigated risk to less than £10m. The plan assumed that central Welsh Government funding would be secured for the patient centred contact model and for Internationally Educated Nurse recruitment.

	- **Care group plans:** Each care group plan on a page, highlighted key actions, priorities, and challenges for the next year. Some of the areas discussed included planned care recovery, same day emergency care, diagnostics and therapies, primary and community care, mental health, and children and families. Some questions and comments were raised by the committee members, such as the impact of vacancies, the weight management service and the Local Development Plans consultation. - **People plan:** The people plan covered the main workforce priorities, such as recruitment, retention, workforce planning, training, and equality, diversity and inclusion. Some of the changes and challenges for the next year include the introduction of Workforce Race Equality Standard (WRES) data, the flat cash regime for training numbers Health Education & Improvement Wales (HEIW), and the alignment with the Board Assurance Framework risks. - **Digital and data plan:** The digital and data plan covered the main IT and infrastructure priorities, such as electronic prescribing, intensive care units, inpatient, mental health, and community care systems, and the Citrix replacement. Some of the investments are still subject to business case approval and affordability. There is also a need to produce a summary of the plan for wider communication.
ASSURANCE	• There were no matters requiring assurance on this occasion
INFORM	• There were no matters relating to information on this occasion
APPENDICES	**NOT APPLICABLE**

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies please list below:
	Not Applicable

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4. Recommendation

4.1 Members of the Board are asked to **NOTE** the report.

Agenda Item
8.2.3 Appendix 2

CTM Health Board

Highlight Report from the Remuneration & Terms of Service Committee

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	C Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Jonathan Morgan, Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Not applicable.	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
JCC	Joint Commissioning Committee

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the Remuneration & Terms of Service Committee at its meetings on 28th March 2024.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

2.1 The purpose of this Committee is to provide:

- ***advice*** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government.

1. ***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.
2. ***receive reports*** relating to the remuneration and terms of service, including contractual arrangements, for Directors and Very Senior Managers of hosted bodies.

3. Highlight Report

Alert / Escalate	Nil
Advise	**Appointment to the NHS Wales JCC Interim Chief Commissioner** The Committee approved the appointment and remuneration to the post of JCC Interim Chief Commissioner on a temporary secondment basis, for a period of up to 6 months, from 4 April 2024. **Extension of Fixed Term Contract – Director of Commissioning, Ambulance Services and 111** The Committee approved the remuneration and extension to a three month fixed term contract extension for the current post holder from the 1st April 2024, on a part-time basis, to provide stability and business continuity across this portfolio. This will be for a period of three-months, with the option to extend for a further three-months, upon review, and if required, without the need to return to the Committee.
Assure	Nil
Inform	Nil
Appendices	Nil

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /	Sustaining Our Future
	If more than one applies please list below:

Link to CTMUHB Strategic Goal(s)	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: All domains of quality apply.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

5. Recommendation

5.1 The Board is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
8.2.3 Appendix 3

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE PEOPLE & CULTURE COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dilys Jouvenat, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
EDI	Equality, Diversity and Inclusion
SUS	Speaking Up Safely
WHC	Welsh Health Circular
WG	Welsh Government

1. Situation /Background

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the People & Culture Committee which took place on the 15th April 2024.

1.2 Key highlights from the meeting are contained in section 3.

1.3 The Board are requested to **NOTE** the contents of the report and actions being taken.

2. PURPOSE OF THE PEOPLE & CULTURE COMMITTEE

2.1 The role of the People and Culture Committee is to advise the Board on all matters relating to staff and workforce planning of the Health Board, and enhance the environment that supports and values staff in to engage the talent, nurture the leadership capability of individuals and teams, working together to drive the desired culture throughout the health service to deliver safer better healthcare.

2.2 The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of the organisational development and other related strategies to drive continuous improvement and to achieve the objectives of the Health Board's Integrated Medium Term Plan (IMTP).

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• There are no matters to escalate to the Board on this occasion.
ADVISE	• The Committee received and noted the **Outcome of the NHS Wales Staff Survey.** The Committee noted the breakdown of survey information for Cwm Taf Morgannwg (CTM) and for Wales. • A report was received and noted on the **Strategic Equality Plan.** The Committee noted progress to date on the development of the Plan for 2024-2028 as part of the CTM 2030 'Our Health, Our Future Strategy'. • The Committee received a Presentation on the **Development of the CTM People Plan Progress Report,** noting the progress made with the development of the CTM People Plan to date. • A report was received on the **Revalidating Quality Review.** The Committee noted that the review had been

	largely positive and described a functioning appraisal system. • A report was received and noted on the **Development of a Strategy for Implementation of Basic Life Support Training and other Resuscitation Training to be provided across CTM.** The Committee noted the progress to date with regard to the development of the new Strategy to be implemented across the Health Board. • The Committee discussed the application process for the **Seren Awards** under **Any Other Business** where it was noted that there had only been three winners in the previous six months. The Director of Engagement, Communications and Fundraising advised that he would address the concerns raised and provide an update to the next meeting of the Committee.
ASSURE	• The Committee **received** the **Workforce Metrics Report** for the period January - February 2024, which included historic trends. • The Committee **received** a report on the **Employee Relations (ER) Update,** noting the ongoing ER cases and trends within the Health Board. • The Committee received a report on the **Organisational Risk Register** for those matters where risks had a score of **15 or more** assigned to the Committee, noting actions taken to manage or mitigate those high-level risks. • A **Committee Referral** was received from the Audit & Risk Committee in relation to the Local Counter Fraud report and the request from Audit & Risk Committee for the People & Culture Committee to seek assurance that the checks and electronic booking processes were robust to prevent staff being able to work back-to-back shifts. The Committee noted the assurance provided that bank staff checks and the automated booking system had the necessary safeguards in place.
INFORM	• The **Minutes** from the meeting held on 7th February 2024 were **APPROVED.**
APPENDICES	Not applicable.

Objectives / Strategy		
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable If more than one applies please list below:	
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable If more than one applies please list below:	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐ Outcome:	No: ☒ If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐ Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	No: ☒ If no, please include rationale below: Not applicable

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4. Recommendation

4.1 Members of the Board are asked to **NOTE** the report.

Agenda Item
8.2.3 Appendix 4

CTM Health Board

Highlight Report from the CTMUHB Audit & Risk Committee

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Sally May, Executive Director of Finance Gareth Watts, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Board with details of the key issues considered by the CTMUHB Audit & Risk Committee at its meeting on 18 April 2024.

1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

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.

Highlight Report

Alert / Escalate	• There were no matters requiring escalation on this occasion

Advise	• The **Internal Audit Progress Report** was received. Members noted that the Health Board was achieving a target of 38% against an 80% target rate for the time taken for management response to draft report within 15 days as per the Internal Audit Charter and noted that it had decreased from 55% since the last meeting. Members noted that five reports had been finalised, one report was in draft, and there was ongoing fieldwork in relation to 11 reviews, of which a number were concluding. • The **Internal Audit Annual Audit Plan 2024-25** and the **Internal Audit Charter** was **APPROVED** by the Committee. The Committee noted the associated internal Audit resource requirements and Key Performance Indicators. • The **Audit Recommendations Tracker report** was received and discussed. Members noted the progress they were making in transitioning to an automated system. • The **Audit Wales Audit & Risk Committee Update** was received and noted. • Committee Members received an update on **Cyber Security Risks** and the **Audit Recommendations Tracker** during the In Committee session of the Committee.
Assure	• The **Local Counter Fraud** report was received. Members noted the detail on the tasks and actions undertaken with the four strategic counter fraud work areas. • The **Organisational Risk Register** Report was received and noted. Members discussed the risk and mitigation included on the 'LIMS Software', 'Community Dental' and the 'Ophthalmology Business Case' and agreed that these would be reviewed for the next iteration of the Risk Register. • The **Procurement and Scheme of Delegation** report was received. • The Committee received a report on **Medical Rostering**, noting the progress achieved to date • The Audit Wales **Workforce Planning Audit** was received. The Committee noted that the overall findings of the audit outlined that the Health Board were facing significant workforce challenges. • The Internal Audit Review – **PCH Financial Management and Change Control Progress Report** was received. Members noted that the review had been allocated a Reasonable Assurance rating. • The Internal Audit Review – **Management of Controlled Drugs** was received. Members noted that the review had been allocated a Reasonable Assurance rating. • The Internal Audit Review – **Gastro Intestinal (GI) Pathways** was received. Members noted that the review had been allocated a Reasonable Assurance rating.

	• The Internal Audit Review – **Decarbonisation** was received. Members noted that the review had been allocated a Reasonable Assurance rating; Members agreed that the management response on recommendations 4.1 and 4.2 would be reviewed and brought back to a future meeting. • The Internal Audit Review – **Digital Operating Model Follow Up** was received. Members noted that the review had been allocated a Reasonable Assurance rating and that good progress had been made to date • The **Annual Risk Management Framework** was **endorsed for Board approval.**
Inform	• The **Unconfirmed Minutes of the meeting held on 19 22 February 2024** were **APPROVED**; • The **Unconfirmed In Committee Minutes of the meeting held on 22 February 2024** were **APPROVED**; • The **Annual Cycle of Business for 2024-25** was received and noted; • The Committee **Annual Report Timetable 2023-24** was received and noted; • The **Local Counter Fraud Annual Report** was received and noted; • The Committee **Annual Self Effectiveness Survey Outcome** was received and noted. • The **Forward Work Programme** was received and noted.
Appendices	

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)		
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research	
	If more than one applies please list below:	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

4. Recommendation

4.1 The Board is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
8.2.3 Appendix 5

CTM Health Board

CHAIRS HIGHLIGHT REPORT FROM THE PLANNING, PERFORMANCE & FINANCE COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kathrine Davies, Corporate Governance Manager
Cyflwynydd yr Adroddiad / Report Presenter	Patsy Roseblade, Independent Member/Committee Chair
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Choose an item. Linda Prosser, Executive Director of Strategy & Transformation Gethin Hughes, Chief Operating Officer Sally May, Executive Director of Finance & Procurement

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
YTD	Year to Date

CAMHS	Child & Adolescent Mental Health Services
PDR	Personal Development Review

1. Situation /Background

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Planning, Performance & Finance Committee which took place on 30th April 2024.

1.2 Key highlights from the meeting are contained in section 3.

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

2.1 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	There were no matters requiring escalation on this occasion.

ADVISE	• The **Month 11 & Month 12 Finance report** was received. Members **noted** that at M10 the Health Board were reporting the following:
	
	Overall Revenue Position 2023-24:
	• The M12 position was reporting a £0.7m surplus and the M12 Draft year end position was now reporting a £0.1m surplus against the Revenue Resource Limit. The Health Board had therefore achieved the break-even Control Total Target set by Welsh Government (WG) for 2023/24.
	• Section 175 of the National Health Service (Wales) Act 2014 placed two financial duties on Local Health Boards:
	  • A duty under section 175 (1) to secure that its expenditure did not exceed the aggregate of the funding allotted to it over a period of 3 financial years
	  • A duty under section 175 (2A) to prepare a plan in accordance with planning directions issued by the Welsh Ministers, and for that plan to be submitted to and approved by the Welsh Ministers.

- The Health Board **had not** met its financial duty to break-even against its Revenue Resource Limit over the 3 years 2021-22 to 2023-24. The Health Board **had met** its financial duty to break-even against its Capital Resource Limit over the 3 years 2021-22 to 2023-24.
- The Health Board **had not** met its financial duty to have an approved plan for 2023/24.

Recurrent Revenue position:

- As at M12 the Health Board was forecasting an underlying deficit at the end of 2023/24 of £19.4m (M11: £19.4m). The forecast underlying deficit was the starting point for the 2024/25 financial plan.

Savings:

- The actual savings to M12 was £27.4m which was £0.1m above the annual savings target of £27.3m.
- The M12 Recurrent savings of £25.7m was £1.6m below the £27.3m annual target.

Cash:

- The closing cash balance at 31st March 2024 was £1.4m.

Capital:

- The latest Capital Resource Limit for 2023/24 was £75.71m. This was issued on the 27th March 2024.
- The reported outturn position was £33k below the Capital Resource Limit.
- The Health Board had met its statutory duty to achieve a break even capital expenditure position over a 3 year rolling period to 2023/24.

- A detailed review of the **Integrated Performance Dashboard** was undertaken with particular focus and scrutiny in the following areas:
  - Stroke
  - Child & Adolescent Mental Health Services (CAMHS) Performance
  - Therapy Waits
  - Red Ambulance Response Times
  - Vaccinations
  - Follow Up Patients Not Booked (FUNB)
  - Neurodevelopment Services

- The Committee **received** a report on the **Capital Quarterly Update.** The Committee **noted** the current capital resource limit and expenditure commitments made to date, the actual capital expenditure as at Month 11 and the update on all current major

	capital projects as well as plans for the 2024/25 discretionary programme. • A report was received at the 'CLOSED' In Committee Session on the **Regional Diagnostics Programme**. The Committee **noted** the update on progress for regional developments of community diagnostic hubs and a regional endoscopy centre, including associated risks.
ASSURANCE	• A Presentation was **received** and **noted** on the **Planned Care Trajectories for 2024-25** and an **Update on Cancer Performance.** • The Committee **received** the **Organisational Risk Register** and reviewed the Planning, Performance & Finance assigned risks, **noting** the updates in terms of the mitigating action identified within the report.
INFORM	• The Committee received for **information the Monthly Monitoring Returns to Welsh Government** for Month 11. • The **Committee Annual Cycle of Business 2024-25** was received and noted. • The **Forward Work Plan** was received and noted. • The **Minutes of the Meeting held on 27th February 2024** were **APPROVED.** • The **Minutes of the Extra Ordinary Meeting held on the 13th March 2024** were **APPROVED.**
APPENDICES	**NOT APPLICABLE**

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Not Applicable
	If more than one applies please list below:
	Not Applicable

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below:	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable	
	If more than one applies please list below:	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable	
	If more than one applies please list below:	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable	
	If more than one applies please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies please list below:	
Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: Not applicable

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

4. Recommendation

4.1 Members of the Board are asked to **NOTE** the report.

Agenda Item
8.2.4

CTM Health Board

CIVIL CONTINGENCIES AND BUSINESS CONTINUITY REPORT 2023-24

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jason Evans, Emergency Preparedness, Response and Recovery Manager
Cyflwynydd yr Adroddiad / Report Presenter	Linda Prosser, Executive Director of Strategy and Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
EPRR	Emergency Preparedness, Resilience and Response
EPRRM	Emergency Preparedness, Resilience and Response Manager
CCA	Civil Contingencies Act 2004
PPE	Personal, Protective Equipment

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

1. Situation /Background

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

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

1.2 This report covers the work and actions of CTMUHB in relation to Emergency Preparedness, Resilience and Response (EPRR) during 2023, aligning with the Annual Return that the Health Board is mandated to submit to Welsh Government.

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

2. Specific Matters for Consideration

The Annual report provides an oversight and assurance of how CTMUHB is performing against its duties under the Civil Contingencies Act 2004.

Specific areas of compliance to note are:

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

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

a. Extensive internal health board planning fully aligned to WG Emergency Preparedness structures has been actioned along with extensive operational response to instances of industrial action. Utilising data and cross organisational/sector and external partner collaboration to ensure effective pre-plans are in place along with robust strategic, tactical and operational incident response structures to maintain patient, staff and organisational safety through challenging industrial action periods.

b. Responding to the publication of findings from the Manchester Arena Inquiry and the implementation of Martyn's Law. This includes training and awareness for Emergency Department staff in changes to triage protocols implemented following the Manchester Arena Inquiry. Work is ongoing to enhance security vulnerable assessments across all CTMUHB sites and refresh lockdown procedures to enhance patient/staff and visitor safety. CTMUHB EPRRM provides the external link with Local Resilience Forum colleagues and is in consultation with Facilities/Estates leads to ensure organisational compliance.

c. Working collaboratively via the SWLRF multi agency structures to develop plans to ensure that adequate mortuary provision is in place across the region to maintain dignity. Ensuring the collaborative service provision is maintained.

d. Response to the notification of adverse weather events, and the subsequent risk assessed activation of HB severe Weather plans.

e. Continuing to contribute to the update of the SWLRF Community Risk Register through continually engaging in the evaluation and analysis of developing and emerging risk that has the potential to impact on our services. Work is ongoing with partners to align existing plans and develop additional plans where needed.

f. Ongoing work for the completion and testing/exercising of a pan Wales Mass Casualties Dashboard.

g. Testing and exercising major incident/mass casualty plans/arrangements by participation within Exercise 'Pen Y Darren' (Mass Casualty Exercise) in partnership with WG and all NHS Wales organisations to ensure readiness.

h. Exercising to test and validate the recently updated Communicable Disease Outbreak Plan for Wales in partnership with PHW and CTM Public Health colleagues.

2.2 Putting in place emergency plans:

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

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

2.2.2 Work continues to review plans and address structural changes in relation to revised Care Group Structures as they embed across CTMUHB.

2.2.3 An extensive 'Scheme of Work' continues to ensure readiness of the organisation's 'Major Incident and Critical Business Continuity Procedural Guidance'. Cross Care-Group working groups are in place across all acute sites and the significant work of revising and developing site specific MI guidance plans to enhance MI response within CTMUHB reaches the final stages.

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

2.3 Put in place Business Continuity Management arrangements:

2.3.1 Amongst the range of BCM plans that exist within CTMUHB the following are examples of plans that have been activated in 2023-24:

- Provision of assurance through adverse weather occurrences that has included instances of excess heat/flooding and ice/snow.
- Provision of assurance through periods of Industrial Action
- Suspected Viral Haemorrhagic Fever Incidents – Princess of Wales/Royal Glamorgan Hospital
- Ward Fire – Princess of Wales
- Provision of assurance through activation of the Measles Policy
- Provision of assurance through the activation of Major Incident/Mass Casualty Plan to respond to fatal explosion/mass casualty incident at Treforest Industrial Estate – Full incident management structure activated within CTMUHB and full support provided for SWLRF multi-agency incident management structures.

2.4 Collaborative Working

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

2.4.2 Participation in such groups has resulted in the ability of CTMUHB to adopt and take assurance from national plans, such as the Communicable Disease Outbreak Plan for Wales that has recently been updated by PHW following extensive consultation and exercising. It also ensures that CTMUHB are linked into the development and amendment of Strategic and Tactical regional and national planning, and are updated on emerging risks utilizing shared

situational awareness to ensure the best planning and response is in place.

2.4.3 CTMUHB has an internal Strategic Emergency Preparedness, Response and Recovery Group, chaired by the Executive Director of Strategy and Transformation. This group brings together Care Group leads with the aim of providing Strategic focus on emergency preparedness response and recovery. The group has a developed work plan and de-brief action plan.

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

3. Key Risks / Matters for Escalation

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

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

3.3 The Health Board and its nominated responsible person for EPRR must maintain adequate resourcing for EPRR. Awareness of EPRR continues to increase positively across CTMUHB. In addition it is planned to enhance the resourcing of EPRR within current budgets via increased awareness of planning team members to provide ongoing support across care group and in embedding pan CTMUHB.

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below: Cross – cutting organisational legislative requirements
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Board information and assurance only
Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below: Board information and assurance only
Cyfreithiol / Legal	Yes (Include further detail below)	
	The Civil Contingencies Act 2004 places legal requirements on Organisations. These powers have been conferred on WG who now have the power to inspect and examine and Organisation's emergency preparedness.	
Enw da / Reputational	Yes (Include further detail below)	
	As a Cat 1 responding organisation under the CCA 2004 – CTMUHB has specific duties to address and response requirements to varying incident types	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 To **note** the Civil Contingencies and Business Continuity annual report.

Appendix A: Civil Contingencies and Business Continuity activities

Major incident and business continuity plans

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

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

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

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

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

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

Operational Support

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

The EPRRM chairs the SWLRF Health and Infectious Disease Group and sits on a number of SWLRF sub groups such as the:

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

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

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

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

The Asst. Director and EPRRM form part of the recently introduced CTM Health Protection Board and the EPPRM is a member of the IP&C Strategic Committee and Tactical Cell and has liaised with Infection, Prevention Control Leads on the PPE issues and guidance from WG and PH. The EPRRM is currently liaising with PHW to review the PPE and procedures for dealing

with Highly Infectious diseases including Viral Haemorrhagic Fever type diseases, Ebola and SARs.

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

Training and Development:

The EPRRM is a member of the Wales Gold development and delivery group and continues to deliver training and development in the following areas:

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

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

Exercises/Conferences:

The EPRRM has recently had direct involvement through the SWLRF Training and Exercising Group with the development and delivery of Exercise 'Pen Y Darren', a national exercise to test the mass casualty dispersal arrangements in the event of a national major incident.

CTMUHB provided Strategic and Tactical Leads along with medical/nursing/operational and planning colleagues from across all sites who fully participated in the exercise. Identified national and organisational learning from the exercise is currently being utilised to amend and strengthen organisational BCM planning.

The EPRRM has also had direct involvement with the development and delivery of exercising to test and validate the recently updated Communicable Disease Outbreak Plan for Wales in partnership with PHW and CTM Public Health colleagues the updated plan is currently being utilized to update the CTMUHB Pandemic Operational Framework in partnership with Public Health colleagues.

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

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

The EPRRM has continued to provide no-notice abduction exercises in partnership with the maternity department and facilities colleagues. This exercise has been successfully implemented to provide assurance across all CTMUHB maternity sites during 2023-24.

Annual Internal Audit Plan

Internal Audit Charter

April 2024

Cwm Taf Morgannwg University Health Board

Contents

1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Health Board Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit and Risk Committee (the 'Audit Committee'), with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Health Board management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by DHCW, NWSSP, and the NHS Wales Joint Commissioning Committee (JCC) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for Digital Health and Care Wales (DHCW), NWSSP and the Health Board (for the JCC) but the results, as in previous years, are reported to the Health Board and relevant trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

1.2 NHS Wales Joint Commissioning Committee (JCC)

The proposed Plan includes time to undertake work within the newly formed JCC. In previous years we completed audits within the hosted bodies that preceded the JCC: Welsh Health Specialised Services Committee (WHSSC); and the Emergency Ambulance Services Committee (EASC). These audits are included as an additional section in Appendix A. Similarly to previous years, the results of these audits are reported to the relevant health boards and trusts and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and

- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities, such as the duties of Quality and Candour, and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP), and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Directors of Corporate Governance and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at health boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance and the Board Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key strategic risks and priorities from the Organisational Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Directors of Corporate Governance, Directors of

Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Health Board, namely NWSSP, DHCW, and the JCC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Health Board's systems of assurance

The risk based internal audit planning approach integrates with the Health Board's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the three year Integrated Medium Term Plan (IMTP);
- an assessment of the Health Board's governance and assurance arrangements and the contents of the organisational risk register;
- risks identified in papers to the Board and its committees (in particular the Audit and Risk Committee, the Quality and Safety Committee, and the Planning, Performance and Finance Committee);
- strategic risks identified within the Board Assurance Framework and significant risks identified within the organisational risk register and assurance processes;
- discussions with directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW, and the JCC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;

- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Health Board executives and independent members to discuss current areas of risk and related assurance needs. Meetings have been held, and planning information shared, with the Health Board's executive team, the Chair of the Audit and Risk Committee and the Chair of the Board.

The draft Plan has been provided to the Health Board's executive management team to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our, and the organisation's, assessment of risk and assurance requirements as defined in the Health Board's risk management policy, Board Assurance Framework and organisational risk register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic risks identified within the organisational risk register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of

the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our Digital and IT team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that a fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Health Board, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, as in previous years, capital audit work in relation to the Prince Charles Hospital refurbishment project will be charged for separately on the basis of a separately agreed Integrated Audit & Assurance Plan. A provision for this work was included by the Health Board in its business case submission.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Paul Dalton

Head of Internal Audit
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
New care group model	1	SRR2	To consider scheme of delegation, clinical governance arrangements, and governance and risk management arrangements.	Chief Operating Officer	Q2
Cancer tracking process	2	SRR1	Focus on effective implementation and adherence to optimal clinical pathways and how the MDTs are functioning. Focus on two areas (potential gynae and urology).	Chief Operating Officer	Q3
Elective care criteria - Access to diagnostics	3	SRR1	Consideration of new criteria for access to diagnostics. Compliance review - booking patients in line with policy. Ensuring that patients that are listed meet the threshold.	Chief Operating Officer	Q3
End of life care management	4	SRR2	To consider the application of the strategy and arrangements in place. Focus on advanced care planning and DNRCP.	Chief Operating Officer / Director of Nursing/ Medical Director	Q3

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Discharge planning	5	SRR2/SRR5	Consideration of how well new policy and procedures are embedding to ensure the timely and safe discharge of patients.	Chief Operating Officer	Q4
Primary Care	6	SRR5	Focus on either accelerated cluster development, or dentistry development of community services.	Chief Operating Officer / Director of Therapies	Q4
Information provision / Use of Data	7	SRR6	To review the capabilities in place, from a people, process and technology perspective, for the Health Board to manage and transform its data to deliver the appropriate and accurate intelligence to inform better decisions. Work to be undertaken by our Digital team.	Director of Digital	Q1
Digital benefits realisation	8	SRR2/ SRR6	Is the Health Board gaining the anticipated value from investment in digital solutions. Consideration of digital transformation team function, who have benefits realisation as part of their remit. To be undertaken by our digital team.	Director of Digital	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Clinical coding	9	SRR6	To consider the structure, process and plan in place for timely and accurate clinical coding. Focus on waiting list patients. Work to be undertaken by our digital team.	Director of Digital	Q3
Duty of Candour	10	SRR2	To consider the process and procedure implemented by CTM to ensure compliance with the Duty of Candour.	Director of Nursing	Q1
Continuing Health Care	11	-	To provide assurance over the arrangements the Health Board has in place for managing Continuing Health Care.	Director of Nursing	Q3
Ensuring quality when commissioning care services	12	SRR2/ SRR5	To consider ensuring quality has visibility in services commissioned by CTM from external care providers.	Director of Nursing	Q3
Service user experience	13	SRR2	To consider how patient feedback process is operating across CTM. Note - PALS officers in all sites and Civica feedback system across Health Board.	Director of Nursing	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Welsh risk pool	14	-	Work required by WRP guidance. Will include element relating to learning from events (LFER).	Director of Nursing	Q4
New PDR process	15	SRR8/ SRR4	Consideration of the implementation of the new PDR process. Ensuring the new process is being followed across CTM.	Director of People	Q1
Pay rates/ Additional duty hours	16	SRR1	Implementation of new system to manage ADHs. To consider compliance and monitoring. Pay rate cards - the need for uniformity and consistency of application across CTM, with consideration of out of hours periods. To consider including Waiting List Initiatives payments.	Medical Director/ Director of People	Q1
Medical job planning	17	SRR4	Consideration of procedures for job planning. Link of job planning to pay and to demand and capacity planning within service groups. Deferred from 2023/24.	Medical Director	Q2
Capital systems	18	-	To review the control framework, systems and processes in place to manage discretionary, EFAB or other capital/ estates funded schemes (not	Director of Finance	Q1

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			progressed through integrated audit plans (IAP) – ensuring compliance with minimum requirements. The focus of the audit for 2024/25 will include: •initial governance arrangements, •tendering and/or selection, and •approval to award and contract completion. Work to be undertaken by our capital team		
Energy management	19	SRR9	To gain assurance that appropriate arrangements are in place to manage energy consumption within the Health Board. Whilst the specific scope is to be agreed with management, the proposed coverage may include: • Roles and responsibilities clearly assigned. • An assessment will be undertaken to ensure appropriate energy contract arrangements are in place and compliance with any resulting requirements/ clauses.	Director of Finance	Q2

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			• Appropriate systems are in place to gather data on energy consumption. • Adequate checks are undertaken to verify the quality/ reliability of the data. • The audit will also look at resulting monitoring and reporting arrangements to ensure that anomalies are understood, benchmarking is undertaken where appropriate, and any resulting management action is appropriately tracked. Work to be undertaken by our capital team		
Charitable funds	20	-	To consider controls and governance arrangements.	Director of Finance	Q2
Core financial systems	21	SRR3	To consider the controls in place to manage key risk areas across the main financial systems. Detailed focus to be agreed.	Director of Finance	Q3

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Vaccination policy implementation	22	SRR10	Review of the strategy implementation process and plans for ensuring equity for vaccine uptake (MMR, flu Covid).	Director of Public Health	Q2
Regional integration fund	23	SRR5	Consideration of the delivery of project work identified in the pillars of the model of care.	Director of Strategy	Q2
Stroke management process	24	SRR1	Focus on process and outcomes. Possible consideration of deployment of action plans to improve stroke performance and risk mitigations.	Director of Therapies	Q3
Llantrisant Health Park	25	-	The focus on the timely action taken by management to address the recommendations raised at the recent Project Assessment Review (PAR) undertaken by the Welsh Government's Integrated Assurance Hub. Work to be undertaken by our capital team.	Chief Executive Officer	Q3
Risk management	26	All		Director of Corporate Governance	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
			Wide approach to risk is settled. Proposal to focus on more granulated risk arrangements.		
Follow up work					
Follow up – Facilities governance arrangements	27	-	Previous year limited assurance report.	Chief Operating Officer	Q1
Follow up – Performance management 4 hour target	28	-	Previous year limited assurance report.	Chief Operating Officer	Q2
Follow up – Interventions not normally used (INNU)	29	-	Previous year limited assurance report.	Chief Operating Officer	Q2
Follow up – GI pathways management	30	-	Previous year limited assurance report.	Chief Operating Officer	TBC
Follow up – Financial savings in care groups	31	-	Previous year limited assurance report.	Director of Finance/ Chief Operating Officer	Q1

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Follow up - Decarbonisation	32	-	Previous year limited assurance report.	Director of Strategy	TBC
Annual Governance Statement	N/A	N/A	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Director of Corporate Governance	Q4
Follow Up Action Tracker	-	-	To review the systems in place to monitor progress with the implementation of actions in response to internal audit reports.	-	-
Other activity					
NHS Wales - Joint Commissioning Committee (JCC)	-	-	We plan to meet with the JCC to identify a programme of work for 2024/25.	-	-
NHS Wales national audit work	N/A	N/A	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales NHS Trust, NWSSP, and DHCW.	Director of Corporate Governance	Q4

Planned output	Audit Ref	Risk Reference	Outline Scope	Executive Lead	Outline Timing
Integrated Audit & Assurance Plans					
Management of Prince Charles Hospital capital project	-	-	See Separate Integrated Audit & Assurance Plan (IAAP).	Director of Finance	Q1-Q4

Please note: National audits undertaken at DHCW and NWSSP will be added later.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	100%
Audit opinion 2023/24 delivered by 31 May	✓	100%
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 days]	✓	95%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Cwm Taf Morgannwg University Health Board with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Cwm Taf Morgannwg University Health Board. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Cwm Taf Morgannwg University Health Board. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;
- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity’s performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular

private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as the Digital Health and Care Wales, NHS Wales Shared Services Partnership, WHSSC and EASC.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation’s objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the organisational or corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external

auditors; and

- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW and NWSSP on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the

assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Board Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the

relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational

managers to confirm understanding and shape the reporting stage through issue of a discussion draft report;

- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the closure of fieldwork. Operational management will be required to respond to the discussion draft report within 5 working days of issue.
- The discussion draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The discussion draft report will also indicate priority ratings for individual report findings and recommendations;
- Following the receipt of comments on the discussion draft (for factual accuracy etc), operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- Reminder correspondence will be issued to the Executive Director and the Board Secretary 5 working days prior to the set response date.
- Where management responses are still awaited after the 20 working days deadline, or are of poor quality, the matter will be immediately escalated to the Executive Director and copied to the Board Secretary and Chair of the Audit Committee.
- If non-compliance continues, the Board Secretary and the Chair of the Audit Committee will decide on the course of action to take. This may involve the draft report being submitted to the Audit Committee, with the Executive Director being called to the meeting to explain the situation and why no responses/poor responses have been received;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary, return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.

- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
April 2024

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Cwm Taf Morgannwg University Health Board

Internal Audit 2024-25 – Indicative days

April 2024

NWSSP Audit and Assurance Services

1 Overview

1.1 This document sets out the indicative days for the Internal Audit Plan for 2024/25, as requested by the management of the Health Board.

1.2 We use indicative day information to help us plan our resourcing across the year. As we note in our plan, as part of our planning process we undertake a resource needs assessment to confirm that we have the necessary resources to deliver the plan.

1.3 The days used to complete an individual audit may vary from the indicative days identified during the annual planning process for a number of reasons. For example, at the start of each individual audit we undertake detailed scoping work which may identify that more time needs to be allocated to an audit due to complexities within the area under review or different systems operating across sites. Similarly, delays during an individual audit due to a lack of engagement and the provision of information will often mean that more time is taken during our fieldwork stage.

1.4 The information set out in Table 1 below identifies the total budgeted days for the programme of work for the Health Board granulated to reflect the indicative days allocated to each planned review. The table also shows the time we have allocated to our follow up work, management time, and a contingent amount of time.

Table 1 - Internal Audit Plan 2024/2025 – Indicative days

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
New care group model	1	SRR2	Chief Operating Officer	Q2	25
Cancer tracking process	2	SRR1	Chief Operating Officer	Q3	30
Elective care criteria - Access to diagnostics	3	SRR1	Chief Operating Officer	Q3	25
End of life care management	4	SRR2	Chief Operating Officer / Director of Nursing/	Q3	25

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
			Medical Director		
Discharge planning	5	SRR2/ SRR5	Chief Operating Officer	Q4	25
Primary Care	6	SRR5	Chief Operating Officer / Director of Therapies	Q4	25
Information provision / Use of Data	7	SRR6	Director of Digital	Q1	20
Digital benefits realisation	8	SRR2/ SRR6	Director of Digital	Q4	20
Clinical coding	9	SRR6	Director of Digital	Q3	20
Duty of Candour	10	SRR2	Director of Nursing	Q1	20
Continuing Health Care	11	-	Director of Nursing	Q3	25
Ensuring quality when commissioning care services	12	SRR2/ SRR5	Director of Nursing	Q3	25
Service user experience	13	SRR2	Director of Nursing	Q4	20
Welsh risk pool	14	-	Director of Nursing	Q4	20
New PDR process	15	SRR8/ SRR4	Director of People	Q1	20

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
Pay rates/ Additional duty hours	16	SRR1	Medical Director/ Director of People	Q1	25
Medical job planning	17	SRR4	Medical Director	Q2	20
Capital systems	18	-	Director of Finance	Q1	25
Energy management	19	SRR9	Director of Finance	Q2	20
Charitable funds	20	-	Director of Finance	Q2	20
Core financial systems	21	SRR3	Director of Finance	Q3	25
Vaccination policy implementation	22	SRR10	Director of Public Health	Q2	20
Regional integration fund	23	SRR5	Director of Strategy	Q2	20
Stroke management process	24	SRR1	Director of Therapies	Q3	25
Llantrisant Health Park	25	-	Chief Executive Officer	Q3	10
Risk management	26	All	Director of Corporate Governance	Q4	20
Follow up – Facilities governance arrangements	27	-	Chief Operating Officer	Q1	10

Planned output	Audit Ref	Risk Ref.	Executive Lead	Outline Timing	Indicative days
Follow up – Performance management 4 hour target	28	-	Chief Operating Officer	Q2	10
Follow up – Interventions not normally used (INNU)	29	-	Chief Operating Officer	Q2	10
Follow up – GI pathways management	30	-	Chief Operating Officer	TBC	10
Follow up – Financial savings in care groups	31	-	Director of Finance/ Chief Operating Officer	Q1	10
Follow up - Decarbonisation	32	-	Director of Strategy	TBC	10
Annual Governance Statement	N/A	N/A	Director of Corporate Governance	Q4	5
Follow Up Action Tracker	-	-	-	-	10
NHS Wales national audit work	N/A	N/A	-	Q4	10
Management time – Includes planning, annual reporting, committee, liaison meetings, review time.					75
Contingency					55
Total					**790**

Agenda Item
8.2.8

CTM Health Board

NURSE STAFFING LEVELS ANNUAL ASSURANCE REPORT 2023-2024 AND THREE YEAR REPORT 2021-2024

Dyddiad y Cyfarfod / Date of Meeting	30/05/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Tanya Tye, Nurse Staffing Act Lead
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore- Dix, Executive Director of Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
NSLWA	Nurse Staffing Levels Wales Act
CGND	Care Group Nurse Directors
CNO	Chief Nursing Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
WBC	Ward Based Caterer

1. Situation /Background

1.1 The Nurse Staffing Levels (Wales) Act (NSLWA) 2016 (hereafter referred to in this document as the Act) was introduced into law in March 2016, coming into effect in April 2018 for all acute adult medical and surgical ward areas. From the 1st October 2021, the second duty of the Nurse Staffing Levels (Wales) Act was extended to paediatric inpatient wards.

1.2 Section 25E of the Act requires Health Boards/Trusts to report compliance in maintaining the nurse staffing level for all wards to which Section 25B pertain. Furthermore, The Health Board (HB) must submit a three-yearly report to the Welsh Government, this is the second three year period which covers from 6th April 2021 to 5th April 2024. To facilitate this, a process of submitting an annual assurance report, using a nationally agreed template, to each Health Board has been agreed through the All-Wales Nurse Staffing programme.

1.3 The Board is asked to formally receive and note the following:-

- The information contained within the 2023/2024 Nurse Staffing Levels (Wales) Annual Assurance Report (Appendix C). The triangulated methodology prescribed in section 25C of the Act sets out the principles for calculating the nurse staffing levels. As the Health Board continues to adjust, resetting back to business as usual, work has been undertaken to ensure wards are realigned and returned to their pre-pandemic status. There is a repository of data available for reference to reflect all changes (Appendix D).
- The 2021-2024 caveated three-year report (Appendix 1) which has been produced using the agreed NHS Wales reporting template. This report is caveated due to the timeframe for closing serious incident reports and the statutory timeframe set out by the Act. A final, updated version of the report will be presented to the Board in September 2024 and then Welsh Government in October 2024.

2 Specific Matters for Consideration

2.1 2023-2024 annual assurance report

The Annual assurance report 2023-2024 (Appendix A) sets out the progress Cwm Taf Morgannwg University Health Board has made

in meeting the statutory requirements of the Nurse Staffing Levels Wales Act specifically covering 6th April 2023 - 5th April 2024.

2.1.1 Following the acuity audits in January and June 2023 staffing changes were made on the following wards:

Prince Charles Hospital (PCH)
Ward 9 medical ward (Gastroenterology) - HCSW numbers decreased by 5.69 Whole time equivalent (wte) back to 14.21 wte after a temporary increase in May 2021 to 19.9wte. This decision was made following the January 2023 acuity audit as there were no distinctive changes in the quality indicator metric.

Royal Glamorgan Hospital (RGH)
Ward 19 medical ward (Respiratory) – there was an increase of 5.68 wte Registered nurses, bringing the total to 26.59. This adjustment was agreed to meet the staffing requirements for a new Non-Invasive Ventilation (NIV) bay within the ward. This has since reverted to the original Registered Nurse staffing levels of 20.90 wte as there is no increased activity or acuity to justify an increase in staffing at present.

Ward 20 medical ward (Acute) was repurposed into a rehabilitation ward. Following the June 2023 acuity and a change of speciality, the ward has decreased their registered nurses by 2.03wte from 20.90wte to 18.06wte. The ward is no longer classified as a S25B ward, this has been reported in the November 2023 board paper.

Princess of Wales Hospital (PoWH)
Ward 18 (Surgical ward to Medical ward) was aligned to Unscheduled Care from Planned Care in June 2023 and remains a medical ward.

Details of individual wards and their calculated nurse staffing levels is provided in Appendix D.

To note: - Two work streams are being undertaken at Princess of Wales Hospital which could affect nurse staffing required levels:

- The Facilities Department is conducting a service review across their inpatient ward areas to ensure consistency in the provision of the ward-based caterer across the Health Board, this review and any subsequent changes that effect the nursing staffing levels will be reported in subsequently papers.

- A review of controlled access is being conducted which will assist with maintaining the safety of staff and patients in addition to the potential reduction in acuity levels with cognitively impaired patients at risk of independently exiting the ward environment. This will be reported in the next report.

2.1.2 Caveated three-year report 2021-2024

To provide assurance that Cwm Taf Morgannwg University Health Board is compliant with Section 25E of the NSLWA. Due to the requirements of the Act and the availability of data relating to the quality indicators and complaints about nursing care, a full report will be presented to the Board in September 2024 with submission to the Welsh Government in October 2024.

3 Key Risks / Matters for Escalation

3.1 Financial Impact

3.2 During 2021-2022 & 2022-2023 wards in PCH & RGH, temporarily increased staffing using non-recurring monies that had been provided to support the pandemic response to aid with reducing the overall increased staffing costs to the health board.

3.3 Following January 2023 biannual acuity audit staffing reverted back to pre-pandemic funded establishment levels. The table below shows the overspend in each year for these uplifts.

3.4 The only ward with no cost implications was at PoWH Ward 18, as the only change made was a speciality change from surgical to medicine.

Ward	21/22 spend	22/23	23/24
PCH Ward 9	£189k	£189k	£15k
RGH Ward 19	£481k	£481k	£0k
RGH Ward 20	£288k	£288k	£55k
PoWH Ward 18	No cost implications - Speciality change only		

There is a requirement to formally report any impact on issues relating to safety or quality of care, which are attributed to non-compliance with the NSA staffing levels. Specifically, these incidents cover:

- Hospital-acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).

- Medication-related never events.

There are adjusted definitions cited for paediatric inpatient areas, which include:

- Hospital-acquired pressure damage (grade 3, 4, and unstageable).
- Infiltration/extravasation injuries
- Medication-related never events.

In addition for all Section 25B wards complaints wholly or partially related to nursing care are also reported.
All incidents and concerns referenced to in this report have been reviewed and assessed by Heads of Nursing and Care group Nurse Directors via relevant internal assurance panel meetings.

4 Conclusion

4.1 In summary, the reporting year 2023-2024 demonstrated a significant number of developments and initiated projects, affecting the wider workforce thus providing the oversight and assurance of quality of care and staffing level compliance. One such example would be the implementation of Safe Care across 33 wards within CTM.

4.2 SafeCare is a system which is part of the Allocate Health Roster system which provides information relating to patient acuity, dependency and staffing, supporting triangulation of data that assists with risk assessments and support decision-making in real time.

4.3 A significant focus on workforce recruitment and retention has been undertaken, the highlights are as follows:

- Between April 2023 & April 2024, the international recruitment programme, Supported 40 internationally nurses to gain their Nursing Midwifery Council registration and obtain a substantive post in CTM.
- A further 11 internationally educated nurses already working in CTM in a Healthcare Support Worker capacity achieved their registration through a local adaptation program.
- A total of 103.55 wte nurses were recruited via the student streamlining process during the September 2023 and March 2024 streamlining process.
- The launch of the Lateral Move policy in February 2024 to support the opportunity in expanding clinical expertise and career development.
- Employment of a lead for recruitment and attraction in CTM.

- Continuing to actively influence future works through the All-Wales Nurse Staffing Programme and HEIW strategic workforce program.

5 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Resilient Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Cydraddoldeb a'r Gymraeg *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /* **Equality and Welsh Language** *Have you undertaken an Equality and Welsh Language Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	The nurse staffing act is a legal requirement for compliance	
Enw da / Reputational	Yes (Include further detail below)	
	The Nurse Staffing Act is reportable to Welsh Government	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	There may be requirements for financial input if staffing is required	

6 Recommendation

6.1 The Board is asked to Note:

The 2023-2024 annual report:

- Assurance that the statutory requirements relating to section 25B wards have been completed.
- Further work is ongoing at the Princess of Wales to scrutinise wider workforce and workload demands.
- Following both the January and June 2023 biannual acuity audits, the Care Group Nurse Directors have improved over-sight of the changing patient requirements and services essential to meet these requirements whilst continuing to refine and adjust services as required.
- A separate review of the dedicated ward-based caterer service will be presented following completion of the review.

Three yearly report 2021-2024:

- The three yearly report outlines the Health Board's position in line with the responsibilities defined by the NSLWA, acknowledging that the full report is to be presented to Board in September 2024 prior to submission to Welsh Government in October 2024

7 Next Steps

7.1 Assurance period 2024-2025

- To strengthen the utilisation of Safe Care in the daily operations of the ward management, providing oversight in the acuity and dependency of patients in the acute ward setting.
- Work alongside recruitment and attraction Health Board leads to refine nurse recruitment processes maximising all streams (streamlining, IEN's, internal development of staff OU/ flexi-route nursing).
- Realignment of services within both planned and unscheduled care across the Health Board.

	Caveated Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Cwm Taf Morgannwg University Health Board (CTM UHB)		
Reporting period	The reporting period is 6th April 2021- 5th April 2024. However, due to the time needed to thoroughly investigate and close any new serious incident reports, the three-yearly report presented to Board in May 2024 will only include data relating to serious incidents closed by 28th February 2024. The final version of the report reflecting all serious incident reports that occurred between 8th February and April 5th 2024 will be presented to the health Board in September 2024, final submission for presentation to Welsh Government October 2024. Note: where the number remains as a single digit, this reflects the area that have never deviated and remains the same every year.		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Health Board	**26th May 2022** Appendix A	**25th May 2023** Appendix B	**30th May 2024** Appendix C
Number of adult acute medical inpatient wards where section 25B applies	Number of wards at lowest and highest point during this period. **15-19**	Number of wards at lowest and highest point during this period. **16-17**	Number of wards at lowest and highest point during the reporting period. **16-17**
Number of adult acute surgical inpatient wards where section 25B applies	Number of wards at lowest and highest point during the reporting period. **12-16**	Number of wards at lowest and highest point during the reporting period. **15-18**	Number of wards at lowest and highest point during the reporting period. **15-16**

Number of paediatric inpatient wards where section 25B applies	Number of wards at lowest and highest point during the reporting period. 3	Number of wards at lowest and highest point during the reporting period. 3	Number of wards at lowest and highest point during the reporting period. 3
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards** 1	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute <u>medical</u> inpatient wards** 0
	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute surgical inpatient wards** 1	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute surgical inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute surgical inpatient wards** 0
	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **<u>paediatric</u> inpatient wards** 0
Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	**Reporting Period 2021-2022 Highlights** The annual assurance report from April 6th 2021- April 5th 2022 explains how the Health Board (HB) has maintained compliance with the Nurse Staffing Levels (Wales) Act 2016, (this will be referred to as 'the Act'). The impact of COVID-19 has resulted in legacy nurse staffing levels in some areas with temporary staffing increases in the wards' staffing to accommodate some service delivery changes. The narrative below explains how the nursing establishment has been adapted to ensure safe delivery of care. Following the directive set out by the Chief Nursing Officer (CNO) in March 2020 clarifying the status of Section 25B wards, an additional three wards were included with them being repurposed to either an adult acute medical or surgical inpatient ward, requiring reporting compliance under Section 25A (S25A) of the Act. • 3 wards increased staffing temporarily due to a change in speciality to a high-care area (PCH ward 3, RGH ward 7, PoWH ward10) • 5 ward decreased staffing due to the relocation of the ward area (RGH wards 2 & 9, PoWH Wards 7, 8 & 11)		

	• 6 wards received increases in nurse staffing due to Covid-19 temporarily for 6 months (PCH ward 9, RGH ward 1, PoWH wards 5, 6, 9, 11) The Covid-19 virus predominantly affected patients with respiratory complications resulting in a high demand for acute medical care, requiring a number of surgical wards to be converted to acute medical inpatient wards. During this period, fluctuating numbers of admissions and infection prevention constraints resulted in wards continually assessed and changed accordingly to minimising risk and ensure admitting capacity. To maintain oversight of staffing numbers daily staffing meetings held on a daily basis, allowing patient acuity and staffing numbers to be reviewed and where necessary redeployment of staff to mitigate risks while maintaining compliance with the Act, Further details are outlined in the annual assurance reports. Highlighted in the previous three-year report the Health Board (HB) during the pandemic, the Health Board commissioned a field hospital to support patients as step down facility and support rehabilitation. At the peak of the pandemic, this facility reached 98 beds and continued during this reporting period. Staff were redeployed from alternative areas that had been temporarily been stood down and a community ward that had temporarily decommissioned for rebuilding. This remained open until 2022 when the “field hospital” was decommissioned. **Reporting period 2022- 2023 Highlights** A detailed outline of the HB's compliance with the Nurse Staffing Levels (Wales) Act 2016 is in the annual assurance report 6th April 2022- 5th April 2023. During this period, while Covid-19 remained in circulation, some surgical services were restarted which led to repurposing of wards from medical speciality to surgical to accommodate. The three wards (PCH ward 3, RGH ward 7, PoWH ward10) used as temporarily high-care Covid-19 area returned to acute medical or surgical wards bringing them back under Section 25B (S25B) of the Act. Across the District General Hospital (DGH) sites, several ward moves were undertaken to ensure services demands were attained. These temporary changes resulted in two bi-annual re-calculations of the Nursing staffing Levels Temporary funding for COVID-19 ‘uplifts’ to the establishment were removed during this period following the biannual acuity audits, this ensured wards increased or decreased staffing accordingly. **Reporting period 2023-2024 Highlights** During the third year of the reporting period, the Health Board undertook a service remodelling and transitioned from an Integrated Locality Group model to the creation of Care Groups. Changes in ward allocation as a result of the service realignment, resulted in staffing level adjustments, reflecting patient acuity, pathways, and flow over the three-year reporting period. With the number of changes taking place during this period, as well as to maintain oversight and assurance, a report of acuity, staffing levels and untoward incidents was provided to the Heads of Nursing on a weekly basis. They were required to review, update and maintain a log for decisions made with associated rationales. As a result of clinical areas demonstrating maintained stability, an adjustment to the monitoring process was made to monthly reporting.

Informing patients	Following each biannual acuity audit presentation to the Board, Heads of Nursing are provided with updated bilingual ward templates to be updated and displayed outside their ward areas. However, the RCN Progress and Challenge Report (2023) highlighted that the wards in CTMUHB were not always updating them. To address this, the templates have been recirculated to all ward areas that care covered by the act and reminders of the need to update and display. The senior nursing team are responsible for completing regular audits to provide assurance of compliance to be collated digitally via the Audit Management and Tracking (AMaT) system. Further improvements to ensure compliance with the Act have been implemented across CTM which includes: • Introduction of ward boards at every ward entrance. There is a dedicated area to display the up-to-date template allowing this information to be visible for all patients and relatives. • The All-Wales Nurse Staffing Act (NSA) Leads in partnership with Health Education Improvement Wales (HEIW) are exploring the production of QR codes for the patient leaflets which will be displayed at ward level in addition hard copies.

Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	**Number of wards: 29**		
		RN: 600.77		
		HCSW: 452.34		
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards CALCULATED during first cycle (May)	**Number of wards: 31**	**Number of wards: 32**	**Number of wards:33**
		RN: 632.89	**RN: 644.94**	**RN: 654.24**
		HCSW: 464.21	**HCSW: 496.96**	**HCSW: 494.99**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards FUNDED during first cycle (May)	**Number of wards: 31**	**Number of wards: 32**	**Number of wards: 33**
		RN: 632.89	**RN: 644.94**	**RN: 654.24**

		HCSW: 464.21	**HCSW: 496.96**	**HCSW:654.24**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards CALCULATED during second cycle (Nov)	**Number of wards: 34**	**Number of wards: 33**	**Number of wards: 33**
		RN: 648.01	**RN: 672.97**	**RN: 647.23**
		HCSW: 531.80	**HCSW: 514.90**	**HCSW: 504.7**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards FUNDED during second cycle (Nov)	**Number of wards: 34**	**Number of wards: 33**	**Number of wards: 33**
		RN: 684.01	**RN:672.97**	**RN: 647.23**
		HCSW: 531.80	**HCSW: 514.90**	**HCSW: 504.7**
		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster) (Two surgical wards in PoWH have the same Band 7 across 2 wards This explains the deficit of 1 Band 7 in the 2023/2024 figures compared to wards above)	**WTE: 30**	**WTE: 33**	**WTE:32**
	Accompanying narrative: Over the last 3 years, Covid 19 affected the clinical presentation of patients requiring a high demand on acute medical services which has resulted in a number of wards under section 25B being repurposed. This is due to Covid 19 predominantly affecting individual's respiratory systems which is classified as an acute medical speciality. Further details can be found in the annual assurance reports attached as appendices (A, B, C). During the same reporting period, some areas required temporary funding, which have now been reviewed and adjusted as necessary following the outcomes of the biannual acuity audits. There continues to be an ongoing focused piece of work to address the partial absence of ward-based caterers at the Princess of Wales site to bring into alignment across the health Board. Band 7 Ward Managers remain supernumerary to the agreed establishments in line with the statutory guidance. CTMUHB remains committed to staff recruitment and retention, organising biannual student streamlining events and participating in the All-Wales recruitment of internationally educated nurses (IENs). Over these three years the Health board has recruited 358 internationally			

	educated nurses, 11 completing an adaptation program specifically designed for CTM as an internal pathway, with a further, 429.72 whole-time equivalent student nurses employed through the streaming process into CTM. In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included in the data for this report. Further information is provided within the annual assurance report (Appendix D) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.			
	Required establishment (WTE) of paediatric inpatient wards prior to extension of the 2nd duty of the Act (October 2021)	**Number of wards: 3** **RN: 93.97** **HCSW: 19.1**		
Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u>		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of paediatric inpatient wards CALCULATED during first cycle (May)		**Number of wards: 3**	**Number of wards: 3**
			RN: 93.97	**RN: 93.81**
			HCSW: 19.1	**HCSW: 19.1**
	Required establishment (WTE) of paediatric inpatient wards FUNDED during first cycle (May)		**Number of wards:3**	**Number of wards: 3**
			RN: 93.97	**RN:93.81**
			HCSW: 19.1	**HCSW: 19.1**
	Required establishment (WTE) of paediatric inpatient wards <u>CALCULATED</u> during second cycle (Nov) NB (*) The 1st calculation was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act on 1st October 2021.	**Number of wards: (*) 3**	**Number of wards: 3**	**Number of wards: 3**
		RN: (*) 93.97	**RN: 93.97**	**RN:93.20**
		HCSW: (*) 19.1	**HCSW: 19.1**	**HCSW:20.31**
	Required establishment (WTE) of paediatric inpatient wards FUNDED during second cycle (Nov) NB (*) The 1st calculation was presented to the Board in September 2021 prior to extension of the 2nd duty to the Act **on** 1st October 2021.	**Number of wards: (*) 3**	**Number of wards: 3**	**Number of wards: 3**
		RN: (*) 93.97	**RN: 93.97**	**RN:93.20**
		HCSW: (*) 19.1	**HCSW: 19.1**	**HCSW:20.31**

		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 3**	**WTE: 3**	**WTE: 3**
	Accompanying narrative: The extension of the Act incorporating paediatrics came into effect in October 2021 and was reported to Board in November 2021. Biannual reviews have taken place on the three-paediatric wards with amendments made to two of the wards in the third year of the reporting period with all establishments funded. Recalculations have taken place using the triangulated methodology set out in Section 25C of the Act. It is noted, that due to vacancies in PCH, this has resulted in the use of a temporary workforce via the staff bank to cover any deficits to ensure the planned roster is met. Recruitment and retention remains a focus for the Health board with the appointment of an attraction and retention lead for CTM now in post and ongoing focus to fill registered nursing vacancies. For more details of individual wards and their required establishments, refer to the annual assurance reports. Band 7 Ward Managers remain supernumerary to the agreed establishments in line with the statutory guidance. In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals contributing to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information provided within the annual assurance report (Appendix D) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.			
Extent to which the planned roster has been maintained within <u>adult acute medical and surgical</u> inpatients <u>wards</u>	NHS Wales is committed to utilising a national informatics system as a central repository for collating data to evidence the extent to which the nurse staffing levels maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels. Extensive work has been undertaken across NHS Wales to implement a national system to enable health boards to meet the reporting requirements of the Act on a Once for Wales approach to ensure consistency. The Allocate Safe Care system has been rolled out across Wales over the previous 3-year reporting period progressing at varying speed in each HB. This has resulted in reliance of the existing Healthcare Monitoring System (HCMS), which has been adapted to ensure consistency in the data collection, and analysis to support reporting until this is fully embedded across all Wales. In CTMUHB, the Allocate Safe Care system has been implemented since July 2023 with ongoing training to ensure competency for use. Since January 2024, this has replaced HCMS and will be the only system to be used to collect the data going forward. This system will have the functionality to capture professional judgments and red flags following assessment that all reasonable steps and mitigation that has been taken.			

Extent to which the planned roster has been maintained within <u>paediatric inpatient wards</u>	The process and systems used within paediatrics inpatients wards align to those used within the adult medical and surgical wards with the use of Safe Care and the narrative outlined above is the same.
Process for maintaining the nurse staffing level for Section 25B wards	The Health Board is required, as detailed within the statutory guidance, to ensure that "All Reasonable Steps" are taken to maintain the nurse staffing levels in 25B wards. Through the All-Wales Nurse Staffing programme, Executive Nurse Directors across Wales have agreed and issued further clarification on what constitutes the 'All Reasonable Steps' which should be taken in order to maintain the nurse staffing levels at the calculated levels. It is the responsibility of the Ward sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards. This is escalated and approved by the senior nurse confirming that the decision-making, risk assessments and deployment of nurses is authorised. To provide analysis and oversight, workforce meetings are attended by Nursing, Finance, Workforce and Roster teams, held on a monthly basis. These metrics and presented to the Nursing and Midwifery workforce steering group. There are well-established processes on each of the acute sites to review nurse-staffing levels on a daily basis via the safe to start meetings. This supports decision making when considering staff deployment to other clinical areas based on risk assessments that review the hospital as whole to balance the risk and take actions to mitigate the risk, which may be deployment of staff to maintain safe staffing levels. During 2022 /2023, Safe Care was implemented for use on the S25B Wards as well as some of the section 25A wards across the acute sites. Nursing teams report at their Safe to start meetings any Level 4 & 5 patients, whilst further analysis of details such as patient acuity and dependency can be viewed on the Safe Care system daily. This is intended to inform staffing and to record operational decisions relating to staff deployment. The Health Board is also reliant upon temporary staffing for both registered nurses and HCSWs to maintain the required nurse staffing levels. The use of 'Allocate' rostering has provided a standardised approach to rostering and booking temporary staffing via the Nurse Bank Office. The Nurse Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for CTM UHB was published in March 2020. The purpose of this operating framework is to support the calculation and maintenance of the nurse staffing levels in adult acute medical and surgical wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. Within the acute hospitals, nurse staffing levels are reviewed three times a day and where required, staff are deployed accordingly using all reasonable steps together with professional judgement to inform decision making as to the appropriate nurse staffing levels required. There are embedded processes within the nursing structures on each of the acute sites for reviewing nurse staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meeting.

To ensure compliance with the 2016 Act, a Once for Wales approach is being developed with the use of a national system to record and review the nurse staffing levels and collate the data required to inform the reporting requirements. This includes an agreement to implement the rostering software 'Allocate' nationally. CTM already utilises this system however, further discussions are ongoing with 'Allocate' with regard to adaptations to the Safe Care system and the implementation of a national system to aid reporting of incidents & concerns.
Following a January 2023 acuity audit, HEIW and DHCW were unable to produce the visuals, therefore an internal solution was realised by CTM through using Qliksense.

CTM have a number of key initiatives to support Nurse staffing levels as outlined below:-

- Safe Care to provide overview of staffing on a daily basis
- Use of Temporary staffing via Nurse bank/ agency/ overtime
- Establishment meetings held monthly by Heads of Nursing, workforce, finance and roster team

Recruitment and Retention

- The Health Board continues to recruitment internationally educated nurses and is part of the All-Wales initiative, which has brought 358 WTE nurses across three acute hospital sites across this reporting period and more recently into the acute.
- Through Student streamlining CTM has recruited 429.72 wte newly registered nurses.
- Of a total of 82 wte nurses who successfully applied for Flexi student programme, 77 of these have subsequently taken up a registered nurse role within CTMUHB in the last 3 years
- The creation of a "Lateral movement" policy for band 5 nurses to seamlessly move into vacancies was implemented in February 2024 has been positively received. This policy will support easy transition for individuals to move into new roles to gain wider clinical expertise, supporting career progression, and remain in the health board.
- Establishing a Band 5, 6 & 7 development programmes alongside the CTMUHB Leadership programmes

Exploration of innovative training opportunities in partnership with the University South Wales.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e., 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	Year 1	48	2	0	40
	Year 2	10 (14)	2 (2)	0	25 (11)
	Year 3	55	0	0	6
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	9	6 (initial level of harm reported as severe)	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	Year 1	3	2	0	0
	Year 2	4	1	0	0
	Year 3	1	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	Year 1	3	1	0	0
	Year 2	1	1	0	0
	Year 3	0	0	0	0

Inpatient Acute adult medical and surgical wards

The Once for Wales incident reporting system was updated in April 2022 to include a mandatory field ensuring that ward staffing levels are considered when a fall, hospital acquired pressure ulcer or medication error is reported. All incidents have been reviewed by the Heads of Nursing on the three acute hospital sites via internal weekly scrutiny panel meetings. Following these panels, any incidents where inappropriate nurse-staffing levels are deemed to have been a contributing factor are shared wider for learning.

Hospital acquired pressure ulcers

There has been a decrease in reportable incidents relating to skin damage compared to the previous three-year reporting period. Of 104 incidents reported, 8 were deemed unavoidable, notwithstanding an indication that the nurse staffing levels were not consistently maintained. It was concluded that all appropriate risk assessments and mitigation were in place at the time the incidents occurred. All incidents and subsequent learning has been shared for wider learning across the health board.

9 incidents remain open and under investigation, these will be reported in the next reporting period 2024-2025 in the annual assurance report.

Falls

Overall, there has been a decrease in reportable falls incidents compared to the previous three year reporting period a total of 6 falls where serious harm or Death occurred were recorded (To note this figure was taken from initial reporting of the incident and a subsequent number were downgraded). Following scrutiny 3 of these were deemed to have occurred when the nurse staffing levels were not maintained and were unavoidable as all measures were in place. 2 of these were considered to have happened when there was a failure to maintain the nurse staffing levels. All incidents and subsequent learning has shared for wider learning across the health board

6 incidents remain open and under investigation, these will be reported in the next reporting period 2024-2025 annual assurance report.

Medication Errors

The reporting criteria for these “never events” are set by Welsh Government. There has been no medication errors reported in this period, which is a decrease by 1 since the last three year reporting period, 2018-2021

Complaints about nursing care

There has been a total of 130 incidents reported in this period specifically relating to nursing care. Following investigation, it was determined that none of these related to noncompliance of nurse staffing levels. All learning from these complaints have been shared across the HB.

All Wales Update

Based on a review of the Health Boards first 3 yearly reports as well as in feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, that included a series of recommendations to improve and refine the reporting process. This led to a sub-group of the All-Wales Nurse Staffing Group set up, with the key objective to improve and refine the reporting process. This will standardise reporting in line with the Duty of Candour set out in the Quality & Engagement Act (2020), and broaden the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication error incidents.

The work of the reporting sub-group included the measures for the adult medical and surgical inpatient wards presented to Executive Nurse Directors in August 2023. The changes to the adult ward measures were agreed, with the amendments coming into effect at the beginning of the next reporting period i.e., April 2024.

The quality indicators for the adult inpatient wards were agreed as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right, PTR))

The data to be reported for each of the above was agreed as follows:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level were identified as a contributing factor, even when planned roster had been maintained.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards

incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Infiltration and extravasation injuries	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)

		TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current reporting period.	**Year 1 (*)**	0	0	0	5	1
	Year 2	0	0	0	7	1
	Year 3	0	0	22	7	5
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	**TOTAL**	0	0	2	3	2
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained	**Year 1 (*)**	0	0	0	0	1
	Year 2	0	0	4	0	1
	Year 3	0	0	1	0	0
Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had been maintained	**Year 1 (*)**	0	0	0	0	0
	Year 2	0	0	0	0	0
	Year 3	0	0	0	1	0

NB (*) for year 1 paediatrics inpatients only reported incidences and complaints from the 1st October 2021 when the 2nd duty of the Act was extended

Paediatric Inpatient wards

The work of the reporting sub-group, as mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e., April 2024.

The quality indicators for the paediatric inpatient wards were agreed as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries

- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above was agreed as follows:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

CTM Reporting 2021- 2023

During this reporting period there were10 complaints recorded and 9 untoward incidents where planned roster numbers were not met. Following investigation by the Head of Nursing for Children & Young People through stablished governance routes, there was partial evidence to suggest decreased nurse staffing levels were a contributory factor in some incidents. Any Lessons identified, have been disseminated across the HB through high-level quality and safety meetings as well as ward areas.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	The Health Board is committed to reviewing and learning from all incidences that occur and has a robust process through which incidents are reviewed and investigated to ensure lessons are learnt, corrective action is taken, risks are minimised and wider sharing is carried out. Through this reporting period the actions taken by the Health Board in order to maintain the nurse staffing levels in section 25B wards have been challenging and has required a multifaceted approach to address when nurse staffing levels are not maintained. All of the incidents included in this report have been examined both by the Care group operational and corporate leads to review whether the nurse staffing levels were maintained at the time of the incident, and if not, whether failure to maintain the nurse staffing level contributed to any harm experienced by the patient. To assist in maintaining nurse staffing levels on hospital wards, Safety Huddles were implemented in 2017, these continue to be led by the Heads of Nursing to ensure that all reasonable steps and mitigating actions are taken, these include: • Access and availability of temporary staff, bank and agency

	• Block booking of temporary staffing through agencies • Moving staff from other areas – this is risk assessed on a shift-by-shift basis and a new tool to monitor this practice is in development • Ensuring the e-roster has been examined and signed off by the Senior Nurse • The Ward Sister or Senior Nurse working within the ward numbers • Balancing staffing and safety through periods of surge, where the option to consider repurposing of in patients beds considering risk to patient care and safety while maintaining patient flow Since the establishment of the Care groups, there has been consistency in the use of assurance panels, reviewing and investigating untoward incidents relating to falls, skin damage and medication errors. This consistent approach provides assurance of analysis into contributing factors, including adequate nurse staffing levels and wider learning opportunities. Some of the challenges as a result of the COVID-19 pandemic for 25B wards reported included difficulties in updating reporting systems due to operational pressures and the lack of a robust national IT system. Over the last 3 year reporting period, there have been 4 incidents attributed to deficits in the planned nurse staffing levels as a contributory factor; 2 hospital acquired pressure damage and 2 inpatient falls. It should be noted that neither of the incidents met the harm threshold for National Reported Incident reporting criteria set by Welsh Government. All 4 incidents were reviewed via the Care Group quality and safety, safeguarding processes staffing was deemed a contributing factor. In respect to these incidents, feedback has been provided to the wards sisters/charge nurses and steps taken to address the issues raised. It should be noted that it is not yet possible to draw any conclusions or trends as to cause and effect with the small numbers of serious incidents provided in this report. The required level of analysis will be enabled through the ongoing collection of data in conjunction with the Once for Wales incident reporting system introduced in September 2021.
Conclusion & Recommendations	This is the second three-yearly assurance report providing details as to the compliance of the Nurse Staffing Levels (Wales) Act. It remains clear that year 1 of the COVID-19 pandemic continued to pose significant challenges for the HB resulting in the need to repurpose clinical areas in response to the service demands at the time. Following a return to 'business as usual', wards have now been realigned to meet post-Covid requirements with work ongoing across the Care groups led by Nurse Directors to ensure efficacy and accuracy in the alignment. At the ongoing work also extends to ensuring areas have appropriate nurse staffing levels to provide the delivery of high-quality nursing care and positive outcomes and experiences for patients. In summary, during the reporting period the Health Board has: • Set out to achieve progress in meeting the requirements of the Nurse Staffing Levels (Wales) Act 2016.

	• Continued to progress nurse recruitment in order to fill vacancies with the short to medium term investment into recruitment of registered nurses within the Health Board including 358 overseas registered nurses (year 1-211, year 2-96, year 3-51), 429.72wte Student Nurses from the Streamlining process. • Committed to increasing maturity in the availability of information to nurse leaders to support and inform clinical decision making, including the creating of The Nursing Nurse staffing levels (Wales) Act (2016) Operating Framework and Escalation Policy and All Reasonable Steps. • Continued to make improvements to the information provision for patients and the public in relation to Nurse staffing levels in our hospitals • Refined governance systems and processes in line with the 2016 Act and revised organisational structure. • Has incorporated the extension of the Act into Paediatric inpatient areas (October 2021). • Implemented the rollout of Safe Care as well as updates to the incident reporting system to provide information and augmented intelligence enabling operational and management teams to utilise systems effectively to inform local decision making and inform the reporting requirements of the Act. Recommendations and work programmes associated with the 2016 Act in 2024-2027, to ensure that the Health Board continue to meet its statutory duty under the 2016 Act includes the following priorities: • To review and update the current sign off process for the templates, placing ownership to and empowering the operational teams to complete the relevant processes ready for final approval. • Work with the senior nursing team and ward managers on the Section 25B wards within the Health Board to ensure nurse staffing levels are appropriate with the undertaking of recalculations and updating of templates as required by the Act when needed. • Review recruitment and retention initiatives within the HB both ‘grow your own’, local and international recruitment • Understand how the incident reporting system can align the data and dashboard to illustrate the required reporting metrics for the NSA templates and reports ensuring accuracy and accessibility.

Appendix A

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee

Health board	Cwm Taf Morgannwg University Health Board (CTMUHB)		
Date annual assurance report is presented to Board	26th May 2022 The reporting period is from April 6th 2021- April 5th 2022		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest 15 and highest 19	Lowest 12 and highest 16	3
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0	1 Ward 8 at POWH – surgical ward	0
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing levels (Wales) Act 2016 (hereafter referred to in this document as the Act) came into effect in April 2018. When referring to section 25B wards in this report, these are the adult acute medical and surgical inpatient wards within the Health Board (HB). From the 1st October 2021 the second duty of the Nurse staffing Levels (Wales) Act was extended to paediatric inpatient wards. Therefore, from the 1st October when discussing section 25B wards it will also include paediatric inpatient wards as well as adult acute medical and surgical inpatient wards. Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical and paediatric inpatient wards. The calculation is undertaken bi-annually in January and June as per agreement within the once for Wales approach. The triangulated methodology prescribed in section 25C of the Act sets out the principles to calculating		

	the nurse staffing levels. Due to the continuing Covid-19 pandemic during this reporting period and the pressure this placed in the acute settings in hospitals, the Welsh Government informed Health Boards that they were not mandating for the bi-annual audit in January 2021 to be undertaken. In response with the 'Once for Wales' approach Executive Nurse Directors agreed that their Organisations would defer this bi-annual audit and subsequent calculations of nurse staffing levels until June 2021. **January 2021 staffing calculation** In order to maintain oversight with compliance of the 2016 Act, the Health Board did not undertake the formal bi-annual acuity audit but it did conduct a review of the Section 25B wards in February/March 2021, where calculations were solely reliant on the professional judgement of the Ward Sisters/Senior/Lead and Heads of Nursing to complete the nurse staffing establishment templates. A Board report was presented on the 27th May 2021 regarding compliance in maintaining the nurse staffing level for their Section 25B wards. **June 2021 Staffing Calculation** For each inpatient ward identified under Section 25B for the June 2021 bi-annual acuity audit, data capture from various systems was collated and analysed to assess compliance with the nurse staffing recommendations. The following areas were considered and explored with the Ward Sister, Senior Nurse and Lead Nurse responsible for the ward and the Heads of Nursing from each acute hospital to generate the report: • Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager and ward administrators (in Princess of Wales (PoW) only). • Patient acuity data for the month of June 2021. • Care quality indicators data from the previous 24 months (falls, medication errors, pressure damage and serious incidents). • Workforce related metric data, mandatory training compliance, vacancy, recruitment and sickness. • Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system 'Qlik Sense', a system which allows live information to be available to the Ward Managers, Heads of Nursing and ILG Nurse Directors for review.

	• Assurance of compliance that all workforce models included in the Nurse Staffing Levels Act have an uplift of 26.9% and supernumerary Band 7 Ward Sister/Charge nurse calculated within the overall workforce plan for that ward. The planning templates were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and by the ILG Directors of Nursing. The final templates were endorsed by the Executive Nurse Director. **Paediatric inpatient wards** As outlined above, a similar methodology and approach was used for the paediatric inpatient wards in calculating their staffing levels and subsequent calculations. Following this initial triangulation in September 2021, these wards will now align to the 6 monthly cycle used for the adult acute medical and surgical inpatient wards. A Board report was presented on the 25th November 2021 regarding compliance in maintaining the nurse staffing levels for their Section 25B wards.
Informing patients	The statutory guidance states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). The statutory requirements to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed. Bilingual poster templates are displayed either outside or inside the ward entrance for both inpatient acute adult medical and surgical wards and paediatric inpatient wards. The poster template identifies the information of the nurse staffing numbers calculated for the identified period and also the date that the calculation was undertaken and signed off by the designated person. To ensure transparency and consistency across Wales, the All Wales Adult Acute Medical & Surgical Inpatient Work Stream Group redesigned the informing patient's templates, which were issued to section 25B wards within the Health Board following the June 2021 bi-annual acuity audit and calculation. All Section 25B informing patient templates within CTMUHB have been updated accordingly.

	Paediatric inpatient wards have paediatric specific informing patient templates which were issued following the initial calculation and are being used within CTMUHB. All Section 25B wards have patient information leaflets available for informing patients of the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy read versions) can be provided to answer any more detailed questions a patient or a visitor may have about the Act, a children and young person's poster is visible on all paediatric inpatient wards.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

Extent to which the required establishment has been maintained within adult acute medical and surgical wards.		**Period Covered 6/4/21= 5/4/22**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	31	632.89	464.21
	WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	31	632.89	464.21
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	34	684.01	531.80
	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	34	684.01	531.80
	Accompanying narrative: During the last reporting period there has been a number of wards under section 25B that have changed (for more details of individual wards and their calculated nurse staffing levels, refer to Appendix B). Prior to the Covid-19 Pandemic the 25B wards within CTMUHB were relatively stable regarding their required staffing establishment, however in response to the pandemic there have been a number of wards repurposed frequently across CTMUHB to meet demand. At the time of this			

	report there are still 5 ward areas across CTMUHB which continue to be repurposed into high care respiratory or ITU and therefore remain outside of the Section 25B wards. These are currently: • Ward 9 in PoWH has been repurposed from an acute surgical ward into a Covid-19 high care admissions area. • Ward 3 in PCH has been repurposed from an acute orthopaedic surgical ward into a Covid-19 high care area and Ward 4 has been converted temporarily from an acute trauma surgical ward into ITU due to building works. • Ward 3 in RGH has been repurposed from an acute Trauma & Orthopaedics surgical ward into a Covid-19 admission ward. Ward 7 has been repurposed from an acute surgical ward into ITU surge capacity **Wards added to section 25B within CTMUHB:** • Ward 10 in RGH, is currently an elective surgical green pathway ward area. • Ward 20 in RGH has been repurposed from a rehabilitation ward to an acute medical ward. • Ward 21 PoWH is currently an adult acute short stay surgical unit. • Protected Elective Surgical Unit (PESU) in PCH, is currently a green elective surgical ward. **Wards no longer within Section 25B** • Ward 8 in PoWH is currently relocated to Ward A in Ysbyty'r Seren and has been repurposed into a rehabilitation ward therefor no longer sits within the Act. • Ward 11 in PoWH was a respiratory ward during Covid-19 but has now been decommissioned and is closed. • Ward 15 in PoWH was an Acute elderly ward during Covid-19 but has now been repurposed into a rehabilitation ward therefor no longer sits within the Act Whilst at the second bi-annual calculation in November 2021 there appears to be an additional staffing establishment requirement, this is primarily due to wards either being repurposed and/or reopened and then being included into the section 25B of the 2016 Act. These actions were taken to support capacity within the CTMUHB hospitals in relation to the on-going COVID-19 pandemic. When required, the ILGs Nurse Directors have realigned their budgets to meet the ongoing staffing requirements for section 25B wards.

Extent to which the required establishment has been maintained within paediatric inpatient wards					**Period Covered 1/10/21 – 5/4/22**		
					Number of Wards:	**Number of Wards:**	**Number of Wards:**
	Funded establishment (WTE) of paediatrics inpatient wards prior to 1st October 2021				3	3	3
	Required establishment (WTE) of paediatrics inpatient wards calculated during second calculation cycle (Nov)				3	3	3
	WTE of required establishment of paediatrics inpatient wards funded following second (Nov) calculation cycle				3	3	3
	Accompanying narrative: During the initial calculation, the nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps. There have been ongoing challenges in relation to filling registered nurse vacancies following the first calculation which has meant that some posts identified are still to be recruited into. The new calculation has been completed using the same processes and is unchanged from the initial calculation. A focus on the recruitment processes continues to enable timely appointment of new staff, and a new recruitment and retention plan has been developed. As the longer-term effects of the pandemic on nurses is not fully understood, the nursing retention plan has been revised to reflect the new challenges posed in terms of staff wellbeing.						
Extent to which the planned roster has been maintained within both adult medical and surgical wards and paediatric inpatient wards		**Total number of shifts**	**Shifts where planned roster met and appropriate**	**Shifts where planned roster met but not appropriate**	**Shifts where planned roster not met but appropriate**	**Shifts where planned roster not met and not appropriate**	**Data completeness**
	TOTAL	20 698	12 287	724	1812	5875	79.9(%)
Extent to which the planned roster has been maintained within adult acute medical and surgical wards		**Total number of shifts**	**Shifts where planned roster met and appropriate**	**Shifts where planned roster met but not appropriate**	**Shifts where planned roster not met but appropriate**	**Shifts where planned roster not met and not appropriate**	**Data completeness**
	TOTAL	19 661	11 989 61 %	714 3.6%	1197 6.1 %	5761 29.3%	79.2%

	Accompanying narrative: When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and Health boards/Trusts were using a variety of e-rostering and reporting systems. During the first reporting period Health boards/Trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system ((HCMS) in lieu of a single ICT solution) to enable each Organisation to demonstrate the extent to which the nurse staffing levels across the Health board/Trust. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Over the last 3 years extensive work has been undertaken to inform the development of the Safecare system that continues to be implemented within Health Boards and Trusts within Wales through a phased approach. Each Health Board/Trust is at different stages of implementation, CTMUHB will begin the process to implement the use of Safecare shortly, this process will take approximately 18 months from start to finish to embed the system. The implementation of this national IT system will ensure consistency in recording and reporting data across organisations and support the 'Once for Wales' approach'. For the first reporting period (April 2018-April 2021) this Health Board, together with all other Health board/Trusts in Wales, provided a narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. During the latter part of the second reporting period (April 2021-April 2024) because of a robust national IT system being implemented, it is anticipated that Health Boards/Trusts can collate, review and report more information relating to the extent that nurse staffing levels have been maintained. In addition, Health Boards/Trusts will be able to demonstrate the extent to which the planned roster has been maintained and whether the deployment of nurse staffing was appropriate to meet the needs of patients sensitively. During year 1 of the current reporting period (April 2021-April 2024) Heath boards/Trusts have utilised 2 systems to enable the capture and analysis of data, the HCMS and Safecare. Due to the COVID-19

	pandemic Health boards/Trusts have experienced extreme operational pressures which has impacted on the Organisations ability to implement Safecare within the desired timeframe. The Health Board will continue to utilise the HCMS to demonstrate the extent to which the nurse staffing levels across their Section 25B wards are being met. The use of the HCMS system will be used until Safecare is introduced within the Health Board over the next 18 months. When using HCMS, the nurse in charge of the ward assesses on a shift by shift basis the deployed workforce against the planned rostered workforce, they will then make a professional judgement as to whether the ward is adequately staffed or inadequately staffed for that shift. This data is extracted from HCMS into the Power BI app. The completeness of the data is higher in the paediatric inpatient wards compared to the inpatient acute adult wards (95% vs 79.2%) this equates to approximately 5163 missing shifts without data entered. Mitigating factors and caveats for this could be: 1. That the figures were obtained during COVID-19 pandemic and the hospital wards were extremely busy and therefore the data was not captured daily as per protocol. 2. Due to the amount of internal ward moves within each HB site, the tracking of data for each of the wards within section 25B is not 100% accurate as the system has not allowed for in inputting of key variables including if a ward closed or opened midway through the year the data reported will be for the entire time period and not for when the ward open or closed. It is the responsibility of the Sister/Charge Nurse to ensure effective roster management and deployment of the nursing staff within the required establishment of their wards. It is the responsibility of the Senior Nurse to sign off the planned roster to authorise and confirm that it reflects an appropriate deployment of the nurse staffing resource that sits within the establishment for each ward. The monthly Nursing Establishment Meetings undertaken on each of the acute hospital sites focus on workforce management, effective rostering, efficiency of temporary staffing and staff well-being. The Health Board's Nursing and Midwifery Workforce group continues to be the forum where all the above key performance metrics are scrutinised. Utilisation of the Adult Nursing staffing Levels Wales Act (2016) Operating Framework & Escalation

Policy has enabled the nurse in charge of the ward to assess, on a shift by shift basis the deployed workforce against the planned rostered workforce, they will then make a professional judgement as to whether the ward is adequately staffed for that shift and escalate and action accordingly.

In addition, one hospital in the Health Board has embedded 'Safe 2 Start' daily meetings Attendance includes, Head of Patient Flow, Head of Nursing, Ward Managers, Lead and Senior Nurses. The aim of the meeting is to provide a staffing position for the day within the hospital, it focuses on key quality and safety metrics relating to patient care and Emergency Department demand. At the meeting the Ward Managers and Senior Nurses work together to problem solve staffing challenges to support any areas of the greatest need and move staff accordingly to ensure that wards and departments are in a safe to start position. The aim is to replicate these Safe 2 Start meetings on the other two acute hospital sites.

Extent to which the planned roster has been maintained within paediatric inpatient wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	1 037	298 28.7 %	10 1%	615 59.3%	114 11%	95(%)

Accompanying narrative:

On the 1st October 2021 the second duty of the 2016 Act was extended to paediatric inpatient wards therefore this report contains information from the 1st October 2021 until 5th April 2022.

Prior to the extension date the ward managers and senior nurses calculated their nurse staffing levels for each paediatric inpatient ward and this was presented to the Board in September 2021. The process and systems used within paediatric inpatient wards align to those that are used within the adult medical and surgical inpatient wards, including the HCMS and Safecare modules.

Daily acuity scoring has meant that nursing teams have been able to assess their patient's acuity on a daily basis to ensure that the correct nursing numbers and skill mix can be deployed. Utilisation of the Paediatric Operating Framework & Escalation Policy has enabled the nurse in charge of the ward to assess, on a shift by shift basis the deployed workforce against the planned rostered workforce. They will then make a professional judgement as to whether the ward is adequately staffed or inadequately staffed for that shift and escalate and action accordingly.

Process for maintaining the Nurse staffing level	The NSLWA statutory guidance requires that the Health Board takes 'all reasonable steps' to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. Any actions taken to maintain the staffing levels support the premise that all reasonable steps have been taken. The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health Board supports the calculation and maintenance of nursing staffing levels in Adult Acute Medical and Surgical and paediatric inpatient wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. **Strategic/corporate steps taken to maintain staffing levels** The Heads of Nursing within the Health Board chair monthly workforce meetings to discuss their wards current vacancies and recruitment plans. As part of this meeting, the Allocate/Rostering department provide feedback and scrutiny of the ward rosters for efficiencies and compliance against key metrics to ensure that all rosters are completed as per policy. All nurse rosters are subject to an approval process monitored by the senior nurse team to ensure maintenance of a safe and effective roster. **Operational steps taken to maintain staffing level** Within the Acute Hospitals staffing levels are reviewed three times a day and if required staff are deployed accordingly using All Reasonable Steps together with professional judgement to draw on information at a local and national level to inform their decision as to the appropriate staffing levels required. The All Wales Executive Nurse Directors have agreed, and through the All Wales Nurse Staffing programme group have issued, further clarification on what constitutes the 'All Reasonable Steps' which are statutorily required to be taken in order to maintain the nurse staffing levels at the calculated levels. This document has been in place within health Board since November 2019. There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings. The COVID-19 pandemic has had a profound effect within the three DGHs and how the hospitals have responded to maintain patient safety and their staff that work within the wards. To assist in process of maintaining the extent to which staffing levels are maintained since November 2020 the Heads of

	Nursing for the 3 principal hospital sites have provided monthly staffing profiles for all their section 25B wards. Over the past year recruitment has been challenging for the Health Board. Within the last year and going into next reporting period the Health Board has devised a series of interactive meetings for student nurses who are entering the streamlining process to promote 'working for Health Board'. During this reporting period we have successfully recruited through streamlining 188 student nurses. The Health Board has been an active member in the newly established All Wales International Registered Nurse Programme and will be recruiting 100 nurses into CTM UHB, starting in the 1st quarter of 2022/2023. There is also representation at the All Wales forums exploring the creation of career frameworks for registered nurses, advanced clinical practitioners and Band 4 nursing roles. **Strategic/corporate steps taken to maintain staffing levels** • Planned recruitment of identified posts across the Health Board. • Roster completion – ensuring that all rosters are completed as per policy and that all rosters are developed to ensure that the correct number of staff are able to be provided, underpinned by a suite of rostering metrics. • Roster approval process – all nurse rosters are subject to an approval process monitored by the senior nurses to ensure safe and effective roster. **Operational steps taken to maintain staffing level** • Robust systems of daily staff planning, and patient flow and acuity held on each acute site to inform plans for ensuring appropriate staffing levels are in place, risk assessed and managed where required, for the forthcoming 24 hours. Within Paediatrics, staff are also deployed across sites where risks are identified to ensure appropriate clinical skills met. • Escalation process to manage staffing deficits clearly articulated in an operating framework and nurse staffing escalation policy. • Signposting for staff to wellbeing support mechanisms and facilities. • Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required. • Enhanced overtime payment rates to substantive staff for a defined period to secure additional workforce capacity.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	62	48	14	26 increase (22 closed last year)	3	3
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	4	2	2	0	2	1
Medication errors never events	0	0	0	0	-	-
Any complaints about nursing care	51	40	11	1233% Increase compared to last year (3 cases closed last year)	-	-

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and	0	0	0	N/A	0	0

unstageable)						
Medication errors never events	0	0	0	N/A	0	0
Infiltration/ extravasation injuries	5	5	0	N/A	4	Unable to comment as not documented as part of the Datix
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0	0	0	N/A	0	0
Any complaints about nursing care	1	0	1	N/A	1	1
NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)						

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
	Inpatient Acute Adult Medical and Surgical Wards During the last year (6/4/21-5/4/22) there has been 5 incidents where not maintaining the planned nurse staffing level was deemed to have contributed to these incidents, 3 hospital acquired pressure damage and 2 falls. There has been an increase in the amount of complaints received relating to nursing care, however, of the closed complaints, failure to maintain the nurse staffing level has not be a contributing factor. The total analysis for the impact of not maintaining the staffing level for this reporting period cannot be made due to 27 open incidents still being investigated. From 1st April 2022, the updated Once for Wales datix reporting system includes a mandatory field ensuring that ward staffing levels are always considered when a fall, medication error or pressure damage is reported. All the incidents and complaints included in this report have been reviewed by the Heads of Nursing in the three Acute Hospitals via their internal weekly, scrutiny panel meetings. The incidents which

	identified that the nurse staffing levels were a contributing factor and subsequent learning from these has been shared more widely. **Paediatrics Inpatient wards** Between 1st October 2021 to 5th April 2022, there has been 1 complaint where not maintaining the planned roster could have been a contributing factor and 4 extravasation injuries that occurred when the planned roster had not been maintained. All the incidents and complaints included in this report have been reviewed by the Head of Nursing for Children & Young People via their governance meetings, who identified that the nurse staffing levels were a contributing factor and lessons learnt from the incidents have been shared more widely.
Conclusion & Recommendations	In summary, 2021-2022 has been a challenging year due to the continued impact of COVID-19 pandemic within the Health Board and its communities. Meeting the staffing levels for the 25B wards has been difficult due to higher levels of sickness and staff requiring to shield at home. The repurposing of wards including retraining of staff to meet the clinical demands during the COVID-19 pandemic and the temporary re-deployment of staff to support the additional demands including high care respiratory wards, ITU and the temporary Field Hospital has placed additional pressure on the Health Board. However, despite these challenges there continues to be successes and achievements within this reporting period: • Paediatric inpatient wards have successfully been incorporated into section 25B wards via the extending the 2nd duty of Act on 1st October 2021. • The majority of the wards that were repurposed to meet the clinical demands during the COVID-19 pandemic are returning to either there originally specialty/designation, or be utilised to support a new clinical model. • 211 of the 216 overseas Registered Nurses who were recruited into the Health Board during 2020/2021, remain working within CTMUHB. • 188 nurses have been recruited via the student streamlining process. Next steps for 2022-2023 • The first bi-annual acuity audit and report for inpatient paediatric wards will be undertaken. • Plans to implement 'Safecare' within the Health Boards Section 25B wards. • The CNO has provided 18 months funding for the recruitment of a designated AWNSA Lead. It is anticipated that this individual will be in post by July/August 2022.

	• As part of the All Wales overseas RN recruitment programme, there will be 100 nurses recruited into CTM UHB between April 2022- November 2022.

Appendix A

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee

Health board	Cwm Taf Morgannwg University Health Board (CTMUHB)		
Date annual assurance report is presented to Board	25th May 2023 The reporting period is from April 6th 2022- April 5th 2023		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest 16 and highest 17	Lowest 15 and highest 18	3
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	1 - PoWH ward 18 changed from surgery to medicine July 22		0
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to in this document as the Act) came into effect in April 2018 for Adult Acute Medical and Surgical inpatient wards. From the 1st October 2021 the second duty of the Nurse staffing Levels (Wales) Act was extended to paediatric inpatient wards. When referring to Section 25B wards in this report, these are the adult acute medical and surgical inpatient and Paediatric inpatient wards within the Health Board (HB). Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all of these wards. The calculation is undertaken bi-annually in January and June as per agreement within the once-for-Wales approach.		

The triangulated methodology set in section 25C of the Act, sets out the principles to calculate the nurse staffing levels. This is a summary of the findings at each acuity audit period.

January and June 2022 staffing calculation

For the January 2022 bi-annual acuity audit each Section 25B ward was analysed using the data captured from various digital systems. The data was collated and analysed to assess compliance with the nurse staffing recommendations.

The data from the following areas were reviewed and examined with the Ward Sister, Senior Nurse, and Lead Nurse responsible for the ward and the Heads of Nursing from each acute hospital to generate the report:

Key Areas of Data capture:

- Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager.
- Patient acuity data for the month of January and June 2022.
- Care quality indicators data from the previous 6 months (falls, medication errors, pressure damage and serious incidents).
- Workforce-related metric data, mandatory training compliance, vacancy, recruitment and sickness.
- Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system Datix reporting, a system that allows live information to be available to the Ward Managers, Heads of Nursing and ILG Nurse Directors (now known as care group Nurse Directors) for review.
- Assurance of compliance that all workforce models included in the Nurse Staffing Levels Act have an uplift of 26.9% and supernumerary Band 7 Ward Sister/Charge nurse calculated within the overall workforce plan for that ward.

The planning templates were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and the ILG Directors of Nursing. The final templates were endorsed by the Executive Nurse Director.

	A report from each audit was presented separately to the Board giving an overview of the findings and assurance regarding compliance in maintaining the nurse staffing levels for their Section 25B wards. January 2022 audit was presented on the 25th May 2022 and June audit was presented on the 24th November 2022.
Informing patients	The statutory guidance states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level" (paragraph 20). The statutory requirements are to inform patients of the nurse staffing levels by ensuring that the most up-to-date information is displayed on wards in relation to the staffing levels agreed. To ensure transparency and consistency across Wales, the All Wales Adult Acute Medical & Surgical Inpatient Work Stream Group redesigned the templates to ensure compliance with this guidance for CTMUHB, bilingual poster templates are displayed either outside or inside the ward entrance for all 25B wards that are included in the Act including Paediatrics. The poster template identifies the information of the nurse staffing numbers calculated for the identified period and also the date that the calculation was undertaken and signed off by the designated person. following the June 2022 bi-annual acuity audit and calculation all eligible wards were issued the new template to be completed and displayed with the responsibility to ensure they are completed correctly with oversite given to Ward manager and Senior nurses to ensure compliance. Paediatric inpatient wards have paediatric specific templates which were issued following the initial calculation and are being used within CTMUHB. All Section 25B wards have patient information leaflets available for informing patients about the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy-read versions) can be provided to answer any more detailed questions a patient or a visitor may have about the Act, children and young person's poster is visible on all paediatric inpatient wards.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

		Period Covered 06/04/22- 05/04/23		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
Extent to which the required establishment has been maintained within adult acute medical and surgical wards.	**Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)**	32	644.94	496.96
	WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	32	644.94	496.96
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	33	672.97	514.90
	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	33	672.97	514.90

Accompanying narrative:

Following the Covid-19 Pandemic S25B, across CTMUHB, there has been a period of resetting and wards have been realigned. This has led to some wards changing specialty and service delivery. This has also been influenced by the surgical recovery programme (for more details of individual wards and their calculated nurse staffing levels, refer to Appendix B).

Wards that have been added to S25B

- Ward 7 PCH reverted from Covid-19 to a general surgical and orthopaedic ward

Wards no longer within Section 25B

- Protected Elective Surgical Unit (PESU) in PCH, closed in December 2022 now used as a surge area.
- Ward 21 PWH is currently a community ward housing Llynfi Ward

- Ward 19 PWH, which had previously been located on Ward 8 (moved to its current location in June 2022) has been repurposed to a medical rehabilitation ward, therefore now sits outside of S25B and will be subjected to the audit going forward.
- Ward 15 PWH, has been repurposed to Care of the Elderly Rehabilitation ward and is deemed to sit outside of S25B.

In November 2022 calculations is evidence to suggest additional staffing establishment requirement, this is primarily due to wards either being repurposed from Covid wards and/or reopened and then being included into the section 25B of the 2016 Act.

When required, the Care Groups (Formally ILGs) Nurse Directors will review and realign their budgets accordingly to meet the ongoing staffing requirements for section 25B wards.

Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u>

	Period Covered 06/04/22- 05/04/2023		
	Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
Required establishment (WTE) of <u>paediatric inpatient wards</u> calculated during first cycle (May)	3	93.97	19.1
WTE of required establishment of <u>paediatric inpatient wards</u> funded following first (May) calculation cycle	3	93.97	19.1
Required establishment (WTE) of <u>paediatric inpatient wards</u> calculated during second calculation cycle (Nov)	3	93.97	19.1
WTE of required establishment of <u>paediatric inpatient wards</u> funded following second (Nov) calculation cycle	3	93.97	19.1

Accompanying narrative:

During the initial calculation, the nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps. There have been ongoing challenges in relation to filling registered nurse vacancies following the first calculation which has meant that some posts identified are still to be recruited into.

The new calculation has been completed using the same processes and is unchanged from the initial calculation. A focus on the recruitment processes continues to enable timely appointment of new staff,

	and a new recruitment and retention plan has been developed. As the longer-term effects of the pandemic on nurses is not fully understood, the nursing retention plan has been revised to reflect the new challenges posed in terms of staff wellbeing.						
Extent to which the planned roster has been maintained within <u>both adult medical and surgical wards and paediatric inpatient wards</u>		**Total number of shifts**	**Shifts where planned roster met and appropriate**	**Shifts where planned roster met but not appropriate**	**Shifts where planned roster not met but appropriate**	**Shifts where planned roster not met and not appropriate**	**Data completeness**
	TOTAL						
Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>		**Total number of shifts**	**Shifts where planned roster met and appropriate**	**Shifts where planned roster met but not appropriate**	**Shifts where planned roster not met but appropriate**	**Shifts where planned roster not met and not appropriate**	**Data completeness**
	TOTAL						
	Accompanying narrative: When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and Health boards/Trusts were using a variety of e-rostering and reporting digital systems. During the first reporting period, Health boards/Trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system (HCMS) (in lieu of a single ICT solution) to enable each organisations to demonstrate the extent to which the nurse staffing levels across the Health Board/Trust. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse						

<table>
<tr><td></td><td>staffing levels required.

Following the January bi-annual audit it was found that Health Education Improvement Wales (HEIW) was unable to extract the data required to inform the creation of the visualisers via the Business intelligence system due to the national changes made to the Health Care Monitoring System (HCMS). Despite liaison between HEIW and Digital Health Care Wales (DHCW), a solution was not found and as a result, Health Boards/Trusts sought local solutions. Work within the Health Board Informatics team, is looking into a solution to provide this information, therefore for this Board paper this data is currently unavailable, however, it is anticipated that the data will be available for subsequent reports as well the 3 yearly compliance report due in May 2024.</td></tr>
<tr><td>Extent to which the planned roster has been maintained within <u>paediatric inpatient wards</u></td><td>
<table>
<tr><th></th><th>Total number of shifts</th><th>Shifts where planned roster met and appropriate</th><th>Shifts where planned roster met but not appropriate</th><th>Shifts where planned roster not met but appropriate</th><th>Shifts where planned roster not met and not appropriate</th><th>Data completeness</th></tr>
<tr><td>TOTAL</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
Accompanying narrative:
Due to the challenges encountered with IT (Information Technology) platform change for HCMS, CTMUHB has been unable to access the information when using the Power BI digital application this is not unique to CTM and is an issue raised across the whole of Wales, CTMUHB ICT alongside Clinical Audit are working on a solution to provide this information for the HB, therefore for this Board paper, this data is currently unavailable. Safecare digital platform, will be implemented and operational across CTMUHB in all 25B wards by November 2023, which will allow reports to be generated to capture data through one system, therefore data will be used using a blended source for the 3 yearly compliance report and the Annual Assurance report due in May 2024.</td></tr>
<tr><td>Process for maintaining the Nurse staffing level</td><td>Strategic/corporate steps taken to maintain staffing levels
• Planned recruitment of identified posts across the Health Board.
• Roster completion – ensuring that all rosters are completed as per policy and that all rosters are developed to ensure that the correct number of staff are able to be provided, underpinned by a suite of rostering metrics.</td></tr>
</table>

- Roster approval process – all nurse rosters are subject to an approval process monitored by the senior nurses to ensure a safe and effective roster.

- As part of the Health board recruitment program, over the last year and going into the next reporting period (April 2023- April 2024) the Health Board have implemented a series of interactive meetings for student nurses who are entering the streamlining process to promote 'working for the Health Board'. During this reporting period, we have successfully recruited through streamlining 131.71wte student nurses.

- The Health Board has been an active member in the newly established All Wales International Registered Nurse Programme and has recruited 96 nurses into CTM UHB, during 2022/ 2023. There is also representation at the All Wales forums exploring the creation of career frameworks for registered nurses, advanced clinical practitioners and Band 4 nursing roles.

Operational steps taken to maintain staffing level

- Robust systems of daily staff planning, and patient flow and acuity held on each acute site (Safe to Start) to inform plans for ensuring appropriate staffing levels are in place, risk assessed and managed where required, for the forthcoming 24 hours. Within Paediatrics, staff are also deployed across sites where risks are identified to ensure appropriate clinical skills met.

- Escalation process to manage staffing deficits clearly articulated in an operating framework and nurse staffing escalation policy.

- Signposting for staff to well-being support mechanisms and facilities.

- Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required.

- Enhanced overtime payment rates to substantive staff for a defined period to secure additional workforce capacity.

The NSLWA statutory guidance requires that the Health Board takes 'all reasonable steps' to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. The Nursing

	Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health Board supports the process of calculation and maintenance of nursing staffing levels in all S25B wards and paediatric inpatient wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained. **Strategic/corporate/ heads of nursing responsibilities to maintain staffing levels** The Heads of Nursing within the Health Board chair monthly workforce meetings to discuss their wards' current vacancies and recruitment plans. To support these meetings, the Allocate/Rostering team provides feedback and scrutiny of the ward rosters to review efficiencies and compliance against key metrics and in line with the rostering policy. All nurse rosters are subject to an approval process monitored by the senior nurse team to ensure the maintenance of a safe and effective roster. **Ward level responsibilities to maintain staffing level** Since November 2019 , the All Wales Executive Nurse Director, through the All Wales Nurse Staffing programme forum implemented a guidance document to support what constitutes 'All Reasonable Steps' to support decision-making in relation to ensure maintaining safe staffing levels. This is a statutory requirement to be taken in order to maintain the nurse staffing levels at the calculated levels. Within the Acute Hospitals, staffing levels are reviewed three times a day and where required staff are deployed accordingly to risk and using All reasonable steps and professional judgement to aid decision making. . Across CTUHB, there are well- established processes for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	16	10	6	Decrease	4	1
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	2	2	0	Same	1	1
Medication errors never events	0	0	0		0	0
Any complaints about nursing care	35	25	10	Decrease	0	0

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints during last year	Number of closed incidents/ complaints during current year	Total number of incidents/ complaints not closed and to be reported on/during the next year	Increase (decrease) in number of closed incidents/ complaints between previous year and current year	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents /complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	0	1		0	0
Medication errors never events	0	0	0		0	0
Infiltration/ extravasation injuries	7	7	0	Increase of 2	5	3
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0	0	0		0	0
Any complaints about nursing care	1	1	0		0	0

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
	Inpatient Acute Adult Medical and Surgical Wards During the last year (6/4/22-5/4/23) there has been 2 incidents where not maintaining the planned nurse staffing level was deemed to have contributed to these incidents, 1 hospital acquired pressure damage and 1 falls. There has been an reduction in the amount of complaints received relating to nursing care, however, of the closed complaints, failure to maintain the nurse staffing level has not be a contributing factor. The total analysis for the impact of not maintaining the staffing level for this reporting period cannot be made due to 16 open incidents still being investigated. From 1st April 2022, the updated Once for Wales datix reporting system includes a mandatory field ensuring that ward staffing levels are always considered when a fall, medication error or pressure damage is reported. All the incidents and complaints included in this report have been reviewed by the Heads of Nursing in the three Acute Hospitals via their internal weekly, scrutiny panel meetings. The incidents which identified that the nurse staffing levels were a contributing factor and subsequent learning from these has been shared more widely. **Paediatrics Inpatient wards** During the last year (6th April 2022- 5th April 2023) there has been 3 complaints where not maintaining the planned roster could have been a contributing factor and 5 extravasation injuries that occurred when the planned roster had not been maintained. All the incidents and complaints included in this report have been reviewed by the Head of Nursing for Children & Young People via their governance meetings, who identified that the nurse staffing levels were a contributing factor and lessons learnt from the incidents have been shared more widely.
Conclusion & Recommendations	In summary, 2022-2023 has been a year of resetting following the COVID-19 pandemic within the Health Board and its communities and getting back to business as usual. There continue to be ongoing temporary staffing uplifts within PCH and RGH until March 2023 at a cost pressure.

	• The majority of the wards that were repurposed to meet the clinical demands during the COVID-19 pandemic have returned to either there original specialty/designation, or been utilised to support a new clinical model. • The start of the implementation programme of 'SafeCare' to Section 25B wards within the HB (15 live wards using safe care, with a further 20 wards to implement) • The recruitment of AWNSA Lead (when) • As part of the All Wales overseas RN recruitment Programme, the HB recruited, trained and register (NMC Registration) 96 internationally educated nurses • 138.17wte. nurses have been recruited via the student streamlining process. Next steps for 2023-2024 • To continue to embed SafeCare into the daily routine of ward staff. • Phase two of International Educated Nurse recruitment. • Further resetting and development within planned care that will predominately affect the surgical S25B wards within the Health Board.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Cwm Taf Morgannwg University Health Board (CTM UHB)		
Date annual assurance report is presented to Board	May 2024 Reporting period is from April 6th 2023- April 5th 2024		
	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest 16- Highest 17	Lowest 15- Highest 16	3
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	PoWH- Ward 18 changed speciality from Surgery to Medical	Nil	Nil
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (hereafter referred to in this document as the Act) came into effect in April 2018 for Adult Acute Medical and Surgical inpatient wards. From the 1st October 2021 the second duty of the Nurse staffing Levels (Wales) Act was extended to paediatric inpatient wards. When referring to Section 25B wards in this report, these are the adult acute medical and surgical inpatient and Paediatric inpatient wards within the Health Board (HB). Section 25B requires Health Boards/ Trusts to calculate and take reasonable steps to maintain the nurse staffing level in all of these wards. The calculation is undertaken bi-annually in January and June with an annual paper being presented in November combining both audit results into one paper as per agreement within the once-for-Wales approach. The triangulated methodology set in section 25C of the Act, sets out the principles to calculate the nurse staffing levels. This is a summary of the findings at each acuity audit period.		

	January and June 2023 Staffing calculations For both Biannual acuity audits in 2023 each Section 25B ward was analysed using the data captured from various digital systems. The data collated and analysed to assess compliance with the nurse staffing recommendations. The data from the following areas were reviewed and examined with the Ward Sister, Senior Nurse, and Lead Nurse responsible for the ward and the Heads of Nursing from each acute hospital to generate the report: Key areas of data capture: • Current nurse staff availability, including staff not included in the core roster such as supervisory ward manager. • Patient acuity data for the month of January and June 2023. • Care quality indicators data from the previous 6 months (falls, medication errors, pressure damage and serious incidents, Paediatric specific infiltration and extravasation). • Workforce-related metric data, mandatory training compliance, vacancy, recruitment and sickness. • Information relating to patient flow, patient acuity and care quality metrics via the IT performance reporting system Datix (that allows information to be available to the Ward Managers, Heads of Nursing and Care Group Nurse Directors) for review. • Finance data which gives assurance that all workforce models included in the Nurse Staffing Act has an uplift of 26.9% and supernumerary Band 7 Ward Sister/Charge nurse calculated within the overall workforce plan for that ward. The planning templates were discussed and ratified by the Ward Sister/Charge Nurse, senior nurses, Heads of Nursing and the Care Group Nurse Directors with the final templates endorsed by the Executive Director of Nursing. A report from each audit was presented separately to the Board giving an overview of the findings and assurance regarding compliance in maintaining the nurse staffing levels for their Section 25B wards. January 2023 audit was presented on the 25th May 2023 and June 2023 audit was presented on the 30th November 2023.
Informing patients	The statutory guidance states that “Local Health Boards (LHBs) and Trusts “must make arrangements to inform patients of the nurse staffing level” (paragraph 20). The statutory requirements are to inform patients of the nurse staffing levels by ensuring that the most up-to-date information is displayed on wards in relation to the staffing levels agreed. To ensure transparency and consistency across Wales, the All Wales Adult Acute Medical & Surgical Inpatient Work Stream Group redesigned the templates to ensure compliance with this guidance. In CTMUHB, bilingual poster templates are displayed either outside or inside the ward entrance for all 25B wards that are included in the Act including

	Paediatrics. These are audited for compliance and shared with the senior nursing teams The template identifies the information of the nurse staffing numbers calculated for the identified period and the date the calculation was undertaken and signed off by the designated person. Following the June 2023 bi-annual acuity audit and calculation all eligible wards were issued the new template to be completed and displayed with the responsibility to ensure they are completed correctly with oversight given to Ward manager and Senior nurses to ensure compliance. Paediatric inpatient wards have Paediatric specific templates which were issued following the June 2023 bi-annual acuity audit and are being used within CTMUHB. All Section 25B wards have patient information leaflets available which informs patients and relatives with the information relating to the Nurse Staffing Levels (Wales) Act 2016. Information posters explaining the purpose of the Act and a Frequently Asked Questions leaflet (available in standard and easy-read versions) can be provided to answer any more detailed questions. , A child and young person friendly poster is visible on all paediatric inpatient wards. To ensure all the information is readily at hand, there is a shared drive for nurse staffing act resources which is available for staff across CTMUHB to access through the SharePoint system.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

34Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2023 following January audit Second cycle: autumn 2023: following June audit		**Period Covered 06/04/2023-05/04/2024**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	**33**	654.24 (including Band 7)	494.99
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	**33**	654.24 (including Band 7)	494.99
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	**33**	647.23 (including Band 7)	504.7

	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	**33**	647.23 (including Band 7)	504.7
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 32 (1 B7 covers 2 areas in PoWH)**		

Accompanying narrative:

CTMUHB undertakes any re-calculations using the triangulated methodology and compare to the current funded establishments to determine any workforce gaps with joint decisions from both the designated person, Service Group representatives, finance and workforce colleagues. Band 7 managers are supernumerary to the funded establishment and these are reflected in the table in Appendix B.

Changes to the staffing from the May 2023 cycle to November 2023 cycle is due to the following:-

Prince Charles Hospital (PCH)
Ward 9 medical ward- Gastrology HCSW decrease by 5.69wte this has been a temporary increase since May 2021 however following review, a decision has been made to reduce back to original level as no distinctive changes to quality indicator metric.
Royal Glamorgan Hospital (RGH)
Ward 19 medical ward- Respiratory initially increased to support a Non-Invasive Ventilation (NIV) bay RN decreased by 5.68wte as there is not the anticipated activity on the ward area to support the increase in staffing at present.
Princess of Wales Hospital (PoWH)
Ward 18 has changed speciality from Surgery to Medicine in June 2023 and remains as a medical ward.

There are two pieces of work being undertaken at Princess of Wales hospital which will affect nursing numbers required. Firstly, the Facilities department is undertaking a service review across the inpatient ward areas to ensure there are ward based caterers available on all wards to ensure consistency across site. Secondly a review of controlled access wards, this will reduce the number of Health care support workers allocated to provide enhanced care for patients who are high risk of wandering off the ward. For more details of individual wards and their calculated nurse staffing levels please refer to appendix B

The Care Group Nurse Directors and service leads are currently undertaking some remodelling of services across CTMUHB and alignment of wards accordingly to meet the ongoing staffing requirements for Section 25B wards.

There are specific key programs of work that are being undertaken to address recruitment and retention challenges such as student streamlining events, recruitment events across the HB and universities as well as participating in the All wales internationally educated nurse recruitment program. More recently CTUHB has launched a Lateral Move policy to support a streamline process for nurses to move across the HB to gain experiences across the Health Board rather than move to another Health Board.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the required establishment has been maintained within paediatric inpatient wards

NB: First cycle: spring 2022 following January audit
Second cycle: autumn 2022: following June audit

	Period Covered 06/04/2023-05/04/24		
	Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
Required establishment (WTE) of paediatric inpatient wards calculated during first cycle (May)	**3**	**93.81**	**19.1**
WTE of required establishment of paediatric inpatient wards funded following first (May) calculation cycle	**3**	**93.81**	**19.1**
Required establishment (WTE) of paediatric inpatient wards calculated during second calculation cycle (Nov)	**3**	**93.20**	**20.31**
WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle	**3**	**93.20**	**20.31**
WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 3**		

Accompanying narrative:

The nurse staffing levels were calculated using the triangulated methodology and compared to the current funded establishments to determine any workforce gaps.

	The new calculation has been completed using the same processes and has changed from the initial calculation for PoWH to support a Band 4 Nursery Nurse being added to the calculation, and the deduction of 0.61 WTE RN to support the workforce between the spring/summer months of March- September due to the anticipated reduction in activity and acuity, which has been evidenced through previous years. The staffing will increase back during the winter months to accommodate the increased acuity as predicated during this period. This will be managed operationally by careful planning of annual leave etc. In Prince Charles Hospital there has been ongoing challenges filling registered nurse vacancies following the previous calculation meaning that the validity of the calculation remains untested on that site. Paediatric services support the Health Boards student streamlining and recruitment events both internally and externally throughout the year. *In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.*
Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>	CTMUHB can confirm that all requirements of 'the Act' have been met during this reporting period. 'All reasonable steps' described in the statutory guidance have been utilised. CTMUHB, hold daily safe to start huddles as well as monthly assurance meetings to review nursing workforce establishments attended by Workforce, Rostering, Nursing teams and finance colleagues. CTMUHB continue to embed SafeCare into the daily routine on an almost 'live' basis and encourage the use of raising of red flags and professional judgements which provides understanding of ward activity, this support staffing decisions and reporting requirements Recording of patient acuity using the Welsh Levels of Care is embedded in practice with scrutiny undertaken During the introduction of SafeCare staff were given an update on the Welsh Levels of Care, sessions are provided as requested.
Extent to which the planned roster has been maintained within <u>paediatric inpatient wards</u>	The process and systems used in paediatric inpatient wards align to those used in the adult medical and surgical inpatient wards and use of Safecare, as per the adult wards, has enabled HBs to capture the data required to inform the reporting requirements under section 25E of 'the Act' from this date. Within CTMUHB, paediatric in-patient wards commenced use of Safecare in January 2023.
Process & systems for capturing data on the extent to which the planned roster has been	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and Health boards/Trusts were using a variety of e-rostering and reporting digital systems. Each health board/trust is committed to implementing Allocates 'Safecare' system with each organisation at different stages of implementing this system within their areas, prioritising section 25B wards. Whilst the SafeCare system has been implemented, Health boards/Trusts

maintained on wards where section 25B applies.	have also been using the Health Care Monitoring system (HCMS) which has been adapted to ensure consistency in the data collection and analysis to aid reporting. CTMUHB implemented SafeCare into Section 25B wards by July 2023 and have commenced rollout to additional areas, due to the infancy of the system and difficulty with generating reports, the decision was taken to use HCMS for both acuity audits in 2023. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.
Process for maintaining the Nurse staffing level	**Strategic/corporate steps taken to maintain staffing levels** • Planned recruitment of identified posts across the Health Board. • Roster management – ensuring that all rosters are completed as per policy and that all rosters are developed to ensure that the correct number of staff are able to be provided, underpinned by a suite of rostering metrics. • Roster approval process – all nurse rosters are subject to an approval process monitored by the senior nurses to ensure a safe and effective roster. • Ward managers / off ward staff deployed 'into numbers' to meet planned roster where all other options have been explored • Staff numbers enhanced via temporary staffing (redeployment of staff from other areas within the organisation, overtime, bank or agency) • Reflecting on the last reporting period (April 2023- April 2024) the Health Board have implemented a series of interactive meetings for student nurses who are entering the streamlining process to promote 'working for the Health Board'. CTMUHB, have successfully recruited through streamlining 103.55wte nurses. • The Health Board has been an active member in the All Wales International Registered Nurse Programme and has recruited 40 internationally educated nurses into CTM UHB, during 2023/ 2024, the HB has had an 11 addition internal nurse who have successful passed the OSCE (Objective structured Clinical Exam) exam to enable to register as registered nurses.

- There is also representation at the All-Wales forums exploring the creation of career frameworks for registered nurses, Advanced Clinical Practitioners and Band 4 nursing roles.

- Launch of the lateral move policy to support staff to move across the Health board to gain experience

Operational steps taken to maintain staffing level

- Robust systems of daily staff planning, and patient flow and acuity held on each acute site (Safe to Start) to inform plans for ensuring appropriate staffing levels are in place, risk assessed and managed where required, for the forthcoming 24 hours. Within Paediatrics, staff are also deployed across sites where risks are identified to ensure appropriate clinical skills met.

- Escalation process to manage staffing deficits clearly articulated in an operating framework and nurse staffing escalation policy.

- Signposting for staff to well-being support mechanisms and facilities.

- Deployment of supernumerary Ward Sister/Charge Nurse to undertake direct care delivery when required.

- Enhanced overtime payment rates to substantive staff for a defined period to secure additional workforce capacity.

The NSLWA statutory guidance requires that the Health Board takes 'all reasonable steps' to maintain its staffing levels and this includes strategic/ corporate as well as operational steps. The Nursing Staffing Levels (Wales) Act (2016) Operating Framework and Escalation Policy for the Health Board supports the process of calculation and maintenance of nursing staffing levels in all S25B wards and Paediatric inpatient wards and the actions that are taken to review, record and escalate where nurse staffing levels are not maintained.

Strategic/corporate/ heads of nursing responsibilities to maintain staffing levels

The Heads of Nursing within the Health Board chair monthly workforce meetings to discuss their wards' current vacancies and recruitment plans. To support these meetings, the Allocate/Rostering team provides feedback and scrutiny of the ward rosters to review efficiencies and compliance against key metrics and in line with the rostering policy. All nurse rosters are subject to an approval process monitored by the senior nurse team to ensure the maintenance of a safe and effective roster.

Ward-level responsibilities to maintain staffing level

Since November 2019 , the All Wales Executive Nurse Directors, implemented a guidance document to support what constitutes 'All Reasonable Steps' to support decision-making in relation to ensure maintaining safe staffing levels. T his is a statutory requirement in order to maintain the nurse staffing levels at the calculated levels.

Across CTMUHB, there are well- established processes for reviewing staffing levels operationally on a daily basis and for making operational, risk-based decisions about the deployment of staff via the bed/staffing meetings. Every Acute Hospital holds "safe to Start" meetings where staffing levels are reviewed three times a day. Following a risk assessment, using All reasonable steps and professional judgement to aid decision-making, staff are deployed where possible.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	55	0	0	6
Total number of incidents/ complaints not closed and to be reported on/during the next year	9	6 (Initial level of harm reported as severe)	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	1 (2)	0	0	0
Number of closed incidents/ complaints where failure to maintain the	0 (2)	0	0	0

nurse staffing level (planned roster)was considered to have been a contributing factor				

For the annual period 2023-2024 the following information supports the below:-

Reportable Pressure Damage (Grade 3, 4 and ungradable)

There has been a total of 55 reportable Hospital acquired pressure ulcers during the period 2023-2024, with 2 incidents identified where planned nurse staffing level were deemed as a contributory factor . Following a scrutiny panel review by the Head of Nursing - one of the pressure areas was downgraded from a Grade 3 to a Grade 2 and therefore not reportable and deemed unavoidable as all measures in Place. The second although there was a staffing shortfall it was deemed by the scrutiny panel as unavoidable as all measures were in place for this patient.

Reportable Falls (Resulting in severe harm or death)

There are 6 reported falls with an initial level of harm recorded as severe, as the investigation is still ongoing it is not possible to assess if staffing levels were a contributory factor. The outcomes will be reported in the next annual assurance report.

Reportable Medication Errors (Never events)

No medication never events have been reported in the reporting period 2023-2024

Reportable complaints about nursing Care

There has been 6 complaints received in this reporting year in relation to nursing care, following investigation there are no contributory factors reported relating to nurse staffing levels.

All the incidents and complaints included in this report have been reviewed by the Heads of Nursing in the three Acute Hospitals via their internal weekly, scrutiny panel meetings. Any incidents which identified that the nurse staffing levels were a contributing factor and subsequent learning from these has been shared widely.

Based on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process.

Following this a sub-group of the All Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), and broaden the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication error incidents.

The reporting sub group presented the recommendations for the amended measures to the Executive Nurse Directors in August 2023 who agreed to the changes being proposed with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the adult medical and surgical wards will be as follows:

- *Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/ complaints not closed and to be reported on/during the next year*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Hospital acquired pressure damage (grade 3, 4 and unstageable)**	**Falls resulting in serious harm or death (i.e. 4 and 5 incidents).**	**Complaints**	**Infiltration and extravasation injuries (specifically**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints**

				reportable for Paediatrics)	regulations (Putting Things Right (PTR)
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	0	0	22	7	5
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period			2	3	2
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained			1		
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor				1	

Additional narrative

One of the incident under extravasation injury, nurse staffing compliance was considered to be a contributory factor which resulted in a formal complaint. On investigation it was determined that the incident was attributed to the agency nurse caring for the patient , hence the incident being attributed to Staffing levels.

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained

Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)
Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	As discussed, all reasonable steps are implemented to mitigate/ reduce risk where the nurse staffing level has not been maintained, due to the demand for services it is not always possible to close beds as a way to mitigate the risk. The teams on the Acute District General Hospital (DGH) sites undertake safe to start meetings thrice daily to discuss staffing, mitigate risk and put in place any plans to help maintain rosters and patient safety. The SafeCare system enables the team to have a birds eye view across the site. Senior nurse leadership is available across 24 hours 7 days a week to enable professional decisions to take place at any time.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A	Due regard has been given to review and ensuring sufficient nurses are within Section 25A areas in the HB:-

(NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	• Ward managers in the Community hospitals undertake regular meetings with the lead nurses and Heads of nursing. to Care group Nurse Director to escalate risks/identify gaps and review staffing levels.. • Mental Health services in CTMUHB are currently undertaking an establishment review across the directorate, where staffing is identified as below agreed level this is escalated in line with the agreed process • Section 25A adult ward areas undergo monthly establishment reviews and staffing levels discussed and escalated with senior nurses and Heads of Nursing
	Conclusion & Recommendations
	In summary, there has been continued support for the Nurse Staffing Levels (Wales) Act 2016 during the period 2023-2024. The Heads of Nursing conduct the biannual triangulated reviews and review staffing on a monthly basis during establishment Meetings. Temporary funding for some areas have continued at a cost pressure whilst further work is undertaken to remodel wards to ensure patients and clinical areas are able to provide the correct level of care. **Highlights of reporting period** • SafeCare system has been rolled out to Section 25B areas with the system being rolled out to Community hospital wards, Maternity, and Mental Health commencing March 2024. • An All Wales review of the specific question relating to the Nurse staffing Act on Datix. This has resulted in a set of amended questions which will go live April 2024. It is hoped that these improvements will provide more robust complete data surrounding the reportable incidents and complaints. Further work is planned to develop an All Wales Nurse Staffing Report from Datix to ensure consistent reporting across Wales. • As part of the All Wales overseas RN recruitment Programme, the HB recruited, trained 40 internationally educated nurses, with a further 11 health board staff who met the International adaptation program who went on to gain their NMC registration register (NMC Registration) • 138.17wte. nurses have been recruited via the student streamlining process. **Next steps for 2024-2025** • To explore how Safe Care can be utilise to enhance daily staffing meetings on the acute sites. • In partnership with Workforce and Organisational development colleagues gain an insight and understanding for the themes that underpin the obstacles to staff retention. This will entail examining data from Exit interviews and through staff feedback and staff surveys. • To develop a coherent recruitment strategy for the short and medium term in line with the HB IMTP and CTM 2030 strategy. • Further resetting and development within planned care that will predominately affect the surgical S25B wards within the Health Board.

	• Work alongside our Business Intelligence team to ensure CTM have a robust process to provide a consistent and standardised review of incidents of patient harm, ensuring lessons are learnt for the benefit of all patients and to support any agreed changes to the reporting parameters of the quality indicators and the enhancements within Datix. • Roll out of the Lateral Move policy to support staff retention **The Board is asked to:** • Receive the report as assurance that the statutory requirements relating to section 25B wards under the Act 2016 • Note the ongoing reasonable steps taken to monitor & as far as possible maintain the Act 2016. • Note that the most recent bi-annual calculation (January 2024) of Section 25B wards will be reported through the internal governance process and included in the November 2024 Annual Assurance Report in a “Once for Wales” approach.

Appendix: Annual Assurance Report

Health board/trust:
Period of the report
adult acute medical wards

Adult Acute Medical Inpatient wards

	Required Establi this report (Spri includin
Name of Ward	TOTAL WTE RN (band 5,6)
2	19,9
3	19,9
9	19,9
10	19,9
11	19,9
12	22,74
5	19,9
12	19,9
14	19,9
19	19,9
20	19,9
4	27,24
5	19,07
6	19,9
10	22,79
18	19,07
20	19,07
	348,88

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 an
required to deliver the planned roster. It is acknowledged that there is a range of addit
can be found within the main body of the annual assurance report

ishment at the start of ing calculation cycle) g uplift 26.9%	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establis period of this rep including
TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)
14,21	1	19,9
14,21	1	19,9
19,9	1	19,9
19,9	1	19,9
14,21	1	19,9
17,06	1	22,74
19,9	1	19,9
19,9	1	19,9
19,9	1	19,9
19,9	1	19,9
19,9	1	17,06
16,34	1	27,24
13,62	1	19,07
13,62	1	19,9
13,62	1	22,79
13,62	1	19,7
13,62	1	19,9
283,43	17	347,5

nd its associated Statutory Guidance, the 'nurse staffing level' is the e
tional healthcare professionals that contribute to the delivery and coo

shment at the end of the port (autumn calculation cycle) ng uplift 26.9%	Biannual calcul	
TOTAL WTE HCSW (bands 2,3,4)	**Completed (Yes/No)**	**Changed**
14,21	Y	N
14,21	Y	N
14,21	Y	N
19,9	Y	N
14,21	Y	N
17,06	Y	N
19,9	Y	N
19,9	Y	N
19,9	Y	N
19,9	Y	N
19,9	Y	N
16,34	Y	N
13,62	Y	N
13,62	Y	N
13,62	Y	N
13,62	Y	N
13,62	Y	N
277,74		

establishment of registered nurses - and other staff to whom nursing duties have been de
ordination of patient care and treatment. However, these staff are not included within this

lation cycle reviews, and rationale for any changes made
Rationale
HCSW tempoary funded uplift reduced back to funded establishment
*2.84 Band 3 OT tech in establishment
Change of speciality from acute medical to rehabilitation (S25A)
*0.67 Band 6 covers GDU (S25A)

elegated by a registered nurse - appendix but further information

Any reviews outside of biannual calculation, if any changes made		
Completed (Yes/No)	**Date**	**Changed**
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		
N		

yes provide rationale for
Rationale

Appendix: Annual Assurance Report

Health board/trust:	
Period of the report	
adult acute surgical wards	

Adult Acute Surgical Inpatient wards

Name of Ward	
5	PCH
6	PCH
7	PCH
8	PCH
PESU	PCH
2	RGH
3	RGH
8	RGH
9	RGH
10 11	RGH
15	RGH
7	PWH
8	PWH
9	PWH
11	PWH
Bridgend clinic	PWH

Name
start & end date
Number

TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establi this report (Spri includin
	TOTAL WTE RN (band 5,6)
1	19,9
1	19,9
1	19,9
1	19,9
0	11,37
1	19,9
1	19,9
1	19,9
1	17,06
1	23,74
1	13,21
1	20,07
1	19,07
1	19,07
1	13,62
	11,9
14	288,41

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 an required to deliver the planned roster. It is acknowledged that there is a range of addit be found within the main body of the annual assurance report

ishment at the start of ing calculation cycle) g uplift 26.9%	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establis period of this rep includin
TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)
14,21	1	19,9
14,21	1	26,86
14,21	1	19,9
19,9	1	19,9
8,53		
14,21	1	19,9
17,06	1	20,9
19,9	1	19,9
14,21	1	17,06
17,05	1	23,74
10,56	1	13,21
13,62	1	20,07
13,62	1	19,07
13,62	1	19,07
13,62	1	13,62
10,9		11,9
229,43	14	285

nd its associated Statutory Guidance, the 'nurse staffing level' is the e
tional healthcare professionals that contribute to the delivery and coo

shment at the end of the port (autumn calculation cycle) ng uplift 26.9%	Biannual calc	
TOTAL WTE HCSW (bands 2,3,4)	**Completed (Yes/No)**	**Changed**
19,89		
21,09		
14,21		
19,9		
14,21		
17,06		
19,9		
14,21		
17,05		
8,52		
13,62		
13,62		
13,62		
13,62		
10,9		
231,42		

establishment of registered nurses - and other staff to whom nursing duties have been delega
ordination of patient care and treatment. However, these staff are not included within this appe

culation cycle reviews, and rationale for any changes made

Rationale
increase in HCSW to support GAU activity (S25A area)- redesign of surgery
increase in staffing to support SAU activity (S25A area)- redesign of Surgery
* Band 7 shared with Day surgery- Ward closed April 2023
ward 11 is a Day surgery unit but staffing shared by ward 10
Bed numbers remained at 15 staffing readjusted

ıted by a registered nurse -
endix but further information can

Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Completed (Yes/No)	**Date**	**Changed**	**Rationale**

Appendix: Annual Assurance Report

Health board/trust:	CTMUHB
Period of the report	start & end date
paediatric inpatient wards	3

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Paediatric Inpatient wards

	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the start of this report (Spring calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the end of the period of this report (autumn calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
PCH- 32	1	34,11	7,72	1	34,11	7,72							
RGH 17	1	31,27	5,69	1	32,69	5,69							
PWH- Childrens ward	1	28,43	5,69	1	27,21	6,9							