Swansea Bay University Health Board
Unconfirmed
Minutes of the Performance and Finance Committee
held on 26th October 2021 at 9.30am
Microsoft Teams

Present:

Reena Owen	Independent Member
Mark Child	Independent Member
Steve Spill	Vice-Chair
Darren Griffiths	Director of Finance
Siân Harrop-Griffiths	Director of Strategy (until minute 158/21)

In Attendance:

Pam Wenger	Director of Corporate Governance
Inese Robotham	Chief Operating Officer
Liz Stauber	Head of Corporate Governance
Sion Charles	ARCH Head of Strategy and Service Planning (until minute 158/21)
Meghann Protheroe	Head of Performance
Craige Wilson	Deputy Chief Operating Officer (for minutes 158/21 and 159/21)
Tanya Spriggs	Service Group Nurse Director, Primary, Community and Therapies (for minute 160/21)
Neil Thomas	Deputy Head of Risk (for minute 161/21)
Kate Hannam	Service Group Director, Morriston Hospital (for minute 162/21)

Minute	Item	Action
149/521	**WELCOME AND APOLOGIES**	
	Reena Owen welcomed everyone to the meeting, particularly Inese Robotham who had joined the organisation as Chief Operating Officer and Sion Charles and Meghann Protheroe who were observing the Director Strategy and Director of Finance respectively. There were no apologies for absence.	
150/21	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
151/21	**MINUTES OF PREVIOUS MEETING**	

	The minutes of the meeting held on 28th September were **received** and **confirmed** as a true and accurate record.	
152/21	**MATTERS ARISING**	
	There were no matters arising not otherwise on the agenda.	
153/21	**ACTION LOG**	
	The action log was **received** and **noted** with the following updates: (i) <u>Action Point One – CAMHS (Children and Adolescent Mental Health Services</u> Siân Harrop-Griffiths advised that 11 clinicians were undertaking assessments through waiting list initiatives to address the backlog of cases. A full action plan was in place following agreement of funding from Welsh Government for double time allowances. She undertook to circulate a briefing note and bring a more formal update to the next meeting. Steve Spill advised that the board would receive an update at the end of the year on the review of commissioning arrangements and potential to repatriate the service back to the health board. (ii) <u>Action Point Two – Urgent and Emergency Care Update</u> Liz Stauber undertook to circulate the joint response to the Healthcare Inspectorate Wales (HIW) review of ambulance handovers as discussed at the September 2021 meeting. (iii) <u>Action Point Seven – Work Programme (Public Health)</u> Reena Owen agreed to discuss with the Director of Public Health how to progress receiving more public health performance information. (iv) <u>Action Point Eight – Performance Report (Speech and Language)</u> Darren Griffiths advised that there were currently 151 patients waiting for speech and language therapy, the majority of whom were children. A trajectory was in place to reduce the numbers by March 2022 through the establishment of pre-referral clinics. Demand for the service had increased by 20% and capacity was being mapped against this to maximise efficiency. Recent speech and language therapy graduates had now taken up post, which was increasing capacity and the service was developing a business case to create a more sustainable service model. Mark Child stated that the recent lockdowns would have had an impact on	**SHG** **LS** **RO**

	children's development, so it was important that they received the treatment they needed as early as possible. Darren Griffiths undertook to circulate the brief for completeness as well as provide a regular verbal update on progress with a view to the committee receiving a formal report if an improvement was not evident.	**DG**
154/21	**WORK PROGRAMME 2021-22**	
	The work programme for 2021-22 was **received** and **noted**.	
155/21	**PERFORMANCE REPORT FOR MONTH SIX**	
	A report setting out the performance position for month six was **received.** In introducing the report, Darren Griffiths highlighted the following points: - The recovery trajectories for urgent and emergency care and the single cancer pathway were included within the report; - The four-hour emergency department performance was 72.2% for October 2021, which was just below the recovery trajectory; - The 12-hour emergency department wait was recovering from a peak, with 1,250 cases in September, against the target of 750, and October appeared to be similar; - The national single cancer pathway target was 65% and the figure for September 2021 currently stood at 57%. As more cases were validated, this could increase but it was unlikely to reach the target; - The size of the planned care waiting list continued to be reported but performance trajectories were being developed; - The number of Covid-19 cases for this wave was now the same as the second peak, and this was reflected in the numbers of staff self-isolating, with around 450 currently not in work; - There were currently 72 inpatients with Covid-19 and a further 46 recovering, which equated to four/five wards; - The red ambulance response time had been on a steady decline since June 2021 and was at 44% for October 2021. This highlighted the pressures within the system; - One-hour ambulance handover delays had improved to 642 in September 2021; - There were currently 250 clinically optimised patients awaiting	

	discharge; - The numbers of *clostridium difficile* and *e.coli* infections had improved but a deterioration in *s.aureus bacteraemias* and *klebsiella* had been recorded; - Five serious incidents had been reported in August/September 2021 but the responses to these had not been delivered in the required 60 days; - Inpatient falls had increased since June 2021 which was an indicator of the high occupancy levels and workforce constraints; - Sickness absence had risen from 6% to nearly 8%, which was impacting on the ability to respond to operational pressures; - Good progress was being made to develop primary care measures; - GP referrals to secondary care were relatively low in September 2021 but the demand for access to primary care was still evident; - The numbers waiting more than 26 weeks for an outpatient appointment and 36 weeks for treatment was stable, as some recovery work had started, but there was more to do; - The planned care charts stopped reporting at two years but there were 5,800 people waiting longer than this for treatment; - Improvements had been made in mental health assessments but there was still work to be done in some areas of CAMHS. In discussing the report, the following points were raised: Mark Child commented that it was difficult to take assurance when the single cancer pathway figure reported as part of the introduction was unvalidated and could be subject to change. Darren Griffiths responded that the month six (September) position was recorded within the report but as part of the escalation status of cancer due to performance, he received a weekly update on the current numbers, which meant he was able to provide a more 'real-time' update to the committee. He undertook to share this with the committee on a regular basis. Mark Child referenced the dial outlining relative harms, in particular, 'overwhelmed', which was at a mid-point. He commented that given the pressures, this felt more like a 'red'. Darren Griffiths advised that the dial was based on an algorithm using the number of red, amber and green figures but undertook to review the chart to include a more subjective view to ensure the dial aligned with current performance. Mark Child noted that patients waiting more than two years for treatment were not included in the chart and stated that it was difficult to make comparisons between some of the charts without this information. Darren	**DG** **DG**

	Griffiths stated that he would take this account for the next iteration. Steve Spill commented that it had been pleasing to see CAMHS performance at 100% in August 2021 but this had been the position before and it had then deteriorated, so the health board needed to be mindful of this. He added that anecdotes from GPs had identified challenges in referring patients to the CAMHS services as some had a tendency to be returned. Siân Harrop-Griffiths advised that CAMHS performance had improved in general and the service was more resilient, however, given the low numbers of staff, it was a vulnerable service which felt the impact of any absences, and this caused fluctuations within performance. She added that a robust referral system was in place for GPs but more work was needed to ensure they understood how it worked. Steve Spill stated that while access to GP figures was good, there was some discontent within the communities as to what access constituted, with some wanting a face-to-face appointment rather than virtual. Steve Spill noted the emergency department figures for Neath Port Talbot Hospital and queried if these related to the minor injury unit. Darren Griffiths confirmed that it was the minor injury unit at Neath Port Talbot Hospital and this saw around a third of unscheduled care patients. Performance was consistently around 99% and, as it was open until midnight, the service group had now been challenged to identify ways it could support the emergency department at Morriston Hospital to relieve the pressures.	**DG**
Resolved:	- The report be **noted;** - Weekly cancer update be shared with the committee members; - The next iteration of the report to include a subjective view of the relative harm dials and updated planned care charts to include those waiting more than two years for treatment.	 **DG** **DG**
156/21	**CHANGE IN AGENDA ORDER**	
Resolved:	The agenda order be changed and item 4.1 be taken next.	
157/21	**MONTH SIX FINANCIAL POSITION**	
	A report setting out the month six financial positon was **received.** In introducing the report, Darren Griffiths highlighted the following points: - The financial position up to and including month six was a 12m	

	overspend which put the health board on target to achieve its year-end forecast deficit of £24.4m; - There was a significant underspend within workforce due to vacancies and the application of the recent pay award to these; - The expenditure for operational pressures and increased activity offset the workforce underspend; - Recovery monies had been received from Welsh Government which had been deployed to the service groups but exit plans were now needed for the expenditure as the fund was non-recurrent; - The health board's savings plans (£26m) accounted for a quarter of the national savings which was a good position to be in; - The savings delivery may slip due to the inability to release beds but this would be countered by a reduction in investments. However the non-bed releases would also have an impact on next year; - £109m had been spent as part of the Covid-19 response in comparison with £140m last year, but that included £30m to establish the field hospital and was funded by Welsh Government; - Should the health board deliver its £24.4 forecast deficit target, this would not improve its underlying deficit of £42m and work was needed on its sustainability plan; - There were three significant risks relating to finance: • Continuing Covid-19 cost base (score of 20); • Resources level lower than recovery plan ambition (score of 15). Additional funding had been received from Welsh Government to support in/out-sourcing, diagnostic recovery, cancer, ophthalmology and long-waiting patients; • Availability of capital monies (score of 15); - A further risk was proposed relating to the non-delivery of savings due to the challenges of bed releases. Reconfiguration of the savings plans had been discussed with the health board chair, who was supportive, but also challenged action to address it, as it affected the future sustainability of the financial position; - The Chief Executive had asked the Medical Director and Director of Nursing and Patient Experience to each reduce their establishments by £2m; - The KPMG savings pipeline was also under review for further opportunities. In discussing the report, the following points were raised:	

	Steve Spill noted that £6m of savings were aligned to the bed releases and queried if all was at risk of non-delivery or just a proportion. Darren Griffiths responded that some of the releases were reliant upon service reconfigurations and the initial benefits would be to patient experience by bringing occupancy levels to an acceptable level. It would be the later stages of bed releases which would lead to financial benefits. Steve Spill sought clarity as to whether the underspend in the pay budgets was leading to more bank and agency posts. Darren Griffiths advised that the benefit of the pay award and benefit from vacancies had been £200k in September 2021 due to back-pay. He added that the vacancies within nursing were a result of the staff just not being there to recruit but 130 new graduates were expected imminently, which would help the position. He added that consideration was being given to how therapy staff could be used in lieu of nursing staff, particularly within rehabilitation services. Mark Child commented that part of the savings currently being achieved were as a result of vacancies so should the health board ever achieve a full establishment, it would lose £4.4m of savings. He noted the plans to commission care home beds, which would increase the bed numbers rather than reduce, stating that while the £6m set out for bed releases did need to be achieved, focus needed to be given to these more pressing issues first. Siân Harrop-Griffiths advised the committee that the focus of the current engagement was to provide more services within the community rather than actually removing beds from the system. Providing more services outside of the hospital may then provide more capacity for elective work. Mark Child stated that continuing healthcare costs seemed to be escalating with no real plan to reduce them, and asked if the HB shouldn't accept and budget for a continuing rise. Darren Griffiths responded that the opportunity was being taken to reflect on the growth of learning disability packages and how modernising the service could help reduce the need for ongoing care requirements. He added that a review was being undertaken by mental health services, at the request of the Chief Executive, to ensure service users' packages of care were appropriate for their needs, which would enable the correct budget to be set. Reena Owen queried the percentage of the savings plan that was likely to be achieved and whether there was scope to receive any further Covid-19 funding, noting that £20m from this year would be recurrent into next year. Darren Griffiths advised that the £21.6m additional monies this year would be focused into a number of areas for recovery, particularly the ambition to develop an orthopaedic centre at Neath Port Talbot Hospital. He added that there would be more funds allocated in due course but it was unclear the level of allocation and what criteria would be set around its	

	expenditure. The overall deficit for NHS Wales was £280m and the health board's was £42m, more than its 12% population share, so there were discussions needed as to potential contributions to improvements. There was also potential additional income once behaviours returned to normal, for example from dental work or private day cases on weekends, as well as from canteens or rented establishments such as Costa.	
Resolved:	- The report be **noted;** - The scores for risks 72, 73 and 79 be **agreed;** - The assessment of a new risk around bed release and savings be **agreed** at a score of 15.	
158/21	**STROKE PERFORMANCE**	
	A report providing an update on stroke performance was **received.** In introducing the report, Craige Wilson highlighted the following points: - The main challenges to the delivery of stroke services was the inability to secure a stroke bed or CT scan within an hour due to the urgent and emergency care pressures; - There had been an improvement in the access to assessment by a therapist or physician; - The health board was below the national average for thrombolysis and admission to stroke wards but was performing well in other areas; - The Chief Executive had made a commitment to establishing a hyper acute stroke unit (HASU), which would require investment into advance nurse practitioners to administer thrombolysis, an increase from three to eight physicians, more ward staffing and additional CT scanning capacity; - Discussions had already commenced with the Chief Executive to determine if additional CT capacity could be arranged while plans for the HASU were further developed; - Work had commenced to create one rehabilitation model rather than the current two to provide better efficiency. In discussing the report, the following points were raised: Reena Owen queried the performance target for admission to a dedicated stroke bed and how the health board's performance compared with others. Craige Wilson responded that the target was 95% and the national	

	average was 20%, with the health board around 19%, so amongst the pack but quite a way from the requirement. Reena Owen asked why a CT scan was needed within an hour and whether there were any consequences of this not being achieved. Craige Wilson advised that the scan was needed to confirm the diagnosis of a stroke and the hour target was the optimal time for thrombolysis. Outside of the window, there was potential for the treatment to be less effective. Reena Owen queried the likelihood of identifying the funds needed for an additional CT scanner. Craige Wilson responded that this was being worked through as part of the HASU case as there would be particular standards that the unit would need to meet. Consideration had been given to having a specialist scanner just for the head but there would be difficulties staffing this, so a better solution would be an additional scanner in the radiology department which could be used by other services when not needed for a stroke patient. Reena Owen asked if there was potential for a regional HASU. Craige Wilson advised that discussions had been undertaken with Hywel Dda University Health Board pre-Covid but ultimately the health board decided it needed to improve its own performance first before it could work with another. He added that there would also be challenges to servicing the full Hywel Dda University Health Board population due to the geographical make-up of the area as not all the areas could reach a HASU at Morriston Hospital within the hour. Reena Owen stated that it appeared to be that there was no immediate plan in place to improve stroke performance. Craige Wilson advised that there were local plans within the service, which were under discussion with the Chief Executive and the first step would be to recruit advance nurse practitioners to support assessments. Agreement had been given to progress the plans for the HASU and to consider what staff could be brought in to support this. The proposal was in development and would be shared with the Management Board in December 2021. Darren Griffiths added that while it was an expensive initiative, it was the right thing to do, and £500k had been allocated to start the work. The requirement for a CT scanner had been noted and consideration given to charitable funds, but it was important that such an investment was value for money and would need to be used by other services when not required for a stroke patient. Reena Owen suggested an update be received in January 2021 setting out the plans and timescales for improving stroke performance, including the establishment of a HASU. This was agreed.	**IR**
Resolved:	- The report be **noted;**	

	- An update be received in January 2022 setting out the plans and timescales for improving stroke performance, including the establishment of a HASU	**IR**
159/21	**PLANNED CARE UPDATE**	
	A report providing an update in relation to planned care was **received.** In introducing the report, Craige Wilson highlighted the following points: - A significant amount of work had been undertaken around advice and guidance to reduce the numbers of people requiring a referral to secondary care – it started with the top 10 specialties in June and rolled-out more widely in September 2021; - The work had resulted in 30% of referrals being redirected to planned care; - 40% of outpatient appointments had been undertaken virtually in 2020-21 and a recommendation given by Welsh Government that a minimum of 35% of appointments should be virtual going forward; - Current waiting lists were being reviewed to ensure patients needed to remain on them; - 66 cardiology patients had been redirected to a pilot within a primary care cluster and through this to alternative pathways; - Work was being undertaken within ENT (ear, nose and throat) to ensure patients were put on the correct pathway; - Surgical capacity was to be re-balanced between Singleton and Morriston hospitals and additional day surgery lists to be established for ophthalmology; - In/out-sourcing had been procured for a number of services and theatre capacity was being increased for weekend working; - Elective capacity was now back to pre-Covid levels and was working more effectively within post-Covid requirements; - A further 36 theatre sessions were to be added across the three acute sites which would provide additional capacity, not just for those clinically prioritised, but also ones with the longest waits and those as part of the WHSSC (Welsh Health Specialised Services Committee) contract lists; - It was unclear what impact this work would have on the total waiting lists but a performance framework was in development to monitor recovery within the service;	

	- Emergency pressures within the system were causing some challenges to elective services as well as staffing constraints. In discussing the report, the following points were raised: Steve Spill noted that as a result of the GP cluster work, 23% of cardiology patients had been taken off a waiting list and 27% redirected to other services. He queried if there were more opportunities in other specialities, as it would be of significant benefit. Craige Wilson responded that an approach had been made from the primary care clusters as to how they could support the operational pressures. Diabetes, respiratory services and cardiology were initially identified as potential areas but only cardiology was appropriate to progress. After a discussion with a GP, 23% did not need to speak with a consultant and 27% could be put onto a different pathway within cardiology rather than having to be assessed by a consultant and then redirected into the service. As 80% of ENT patients did not go on to need further appointments following an initial outpatient appointment with a consultant, a proposal was now being developed to move more ENT access into the primary care clusters as well as widen the cardiology service. A GP was a member of the outpatient recovery group which was providing a different perspective on pathways. It was important to deal with the backlogs as well as find new ways of working to treat the new referrals. Steve Spill calculated that around a quarter of the population was awaiting an appointment with a consultant and queried if it was possible that some were on a list more than once. Craige Wilson responded that the validation exercise would identify these and remove the duplicate entries. Mark Child noted the constraints around outsourcing for complex orthopaedic cases and queried the reasons. Craige Wilson responded that the complexity of some cases meant they could only be operated on at Morriston Hospital, as the only independent provider in the health board area could only accommodate day cases, and those outside of the boundaries could not care for those with co-morbidities. There was a plan to create an orthopaedic centre at Neath Port Talbot Hospital from summer 2022 but this would take some time due to the infrastructure and workforce needed. Reena Owen noted that there was insufficient accommodation for outpatient services and queried what had happened to the previous facilities. Craige Wilson advised that 40 consulting rooms had been lost at Morriston Hospital as a result of needing to create two temporary intensive care units within the outpatient building. Virtual appointments were helping to mitigate some of the lost capacity along with alternative accommodation within primary and community services and optimising the use of outpatient areas on other sites.	

	Reena Owen queried what work/investment was being undertaken to support those on waiting lists with their emotional wellbeing. Craige Wilson responded that a bid had been submitted to Welsh Government to create a planned care optimisation clinic to provide support for anyone on a specialised cancer pathway. Darren Griffiths advised that a report was to be submitted to the special board meeting later that week setting out further proposals for in/out-sourcing to provide more elective care. Reena Owen suggested a further update on planned care performance be received in three months' time. This was agreed.	**IR**
Resolved:	- The report be **noted**; - A further update on planned care performance be received in three months' time.	**IR**
160/21	**CONTINUING HEALTHCARE QUARTER ONE REPORT**	
	A report setting out the quarter one continuing healthcare performance report was **received.** In introducing the report, Tanya Spriggs highlighted the following points: - There were still some issues around the national framework which was preventing its implementation; - The number of retrospective cases remained low but it was anticipated the number would rise once face-to-face multidisciplinary teams restarted; - A number of care homes had escalated concerns and the health board was working with the local authorities and care home inspectorate to manage the situation; - There were a number of patients in hospitals who needed to be in care homes; - The Welsh Government hardship fund for care homes started to wind down in September 2021 and a collective piece of work was taking place as to how to manage the fragility, as there were around 30 homes in the 'red' category, either due to occupancy levels or standards; - Potential uplifts for funded nursing care were under discussion nationally, with the current proposal at 3%, which would be in-line with all-Wales partners;	

	- There was a lower case load in quarter two but this had not led to a reduction in costs as a number were of high complexities; - Joint key priorities and partnership working would be critical to better supporting the sector. In discussing the report, the following points were raised: Mark Child queried if the health board was in a position to influence the number of registrants given the challenges within workforce. Tanya Spriggs responded that good quality of care could not be delivered without the right staff and this was a key priority of the commissioning care group, including a focus on overseas recruitment. Mark Child sought clarity as to whether any further information had been received from Welsh Government in relation to judicial reviews as families were currently waiting in hiatus. Tanya Spriggs advised that services across Wales were working with Welsh Government to agree timescales. Mark Child noted that continuing healthcare costs appeared to be on an upward trajectory in mental health and learning disabilities and queried what work was being undertaken to contain costs. Tanya Spriggs advised that colleagues within that service were developing a value for money approach to commission care packages.	
Resolved:	- The report be **noted**.	
161/21	**PEFORMANCE AND FINANCE RISK REGISTER**	
	A report setting out the risk register for performance and finance was **received.** In introducing the report, Neil Thomas highlighted the following points: - The board last received the risk register in July 2021 after which the executive directors reviewed the entries assigned to them; - The updated health board risk register had been endorsed by the Management Board the previous week; - There were nine risks assigned to the committee with a score of 20 or higher; - Urgent and emergency care had been rescored from 16 to 25 but the risk for access to cancer services had reduced; - Two Covid-19 risks had been escalated in relation to workforce. In discussing the report, the following points were raised:	

	Steve Spill noted that the risk score assigned to CAMHS was 16 and queried if this was sufficient given how vulnerable the service was. He added that a review of the service was to be shared with the board later in the year. Neil Thomas responded that this could be looked at as part of the next refresh of the register. Steve Spill asked whether the review of internal controls had taken place in quarter one as set out. Darren Griffiths advised that budgets had been rebased in quarter one as part of the system for internal control and recovery measures had been introduced, such as a recruitment freeze in the workforce function. Covid-19 funding was also being monitored in order to set the budgets for next year. Reena Owen commented that urgent and emergency care and planned care both had the maximum possible risk score (25). She stated that consideration was needed as to how to prioritise in such situations, especially given the pressures around urgent and emergency care. Reena Owen queried the focus given to risks below a score of 20. Neil Thomas responded that the board had agreed its risk appetite at 20 so any with such a score or higher were subsequently reported.	
Resolved:	- The report be **noted.**	
162/21	**URGENT AND EMERGENCY CARE UPDATE**	
	A report providing an update on urgent and emergency care was **received.** In introducing the report, Kate Hannam highlighted the following points: - Attendance levels were now at pre-Covid levels but improvements had been seen in terms of ambulance handovers and hours lost, but there were still challenges to address; - A joint plan with the Welsh Ambulance Service NHS Trust (WAST) was in development to address ambulance handover delays, with 'zero tolerance' set at five hours; - The delays within the department were a sign of the operational pressures throughout the system; - Focus was being given to the use of other services now co-located with the emergency department, including the acute GP unit; - The number of specialists working within the emergency department was to be increased to support patients waiting for a	

	bed to release emergency department staff to see other patients; - Staff sickness was high; - The redesign of acute medical services to centralise services in Morriston Hospital would be an opportunity to review the use of the bed base; - Initiatives to support more timely discharges were being implemented, including early board rounds and inclusion of nurses in the discharge process; - Additional community capacity was being sought for those who were clinically optimised and ready to leave; - A digital dashboard which highlighted all clinically optimised patients was in use and this highlighted those who were ready to leave hospital and those who needed further assessment first; - A performance dashboard was in development to hold service managers to account. In discussing the report, the following points were raised: Inese Robotham stated that there were a number of work programmes in progress to resolve the issues within urgent and emergency care, including 'plan, do, study, act' (PDSA) cycles for simple discharges. The Chief Executive was also in discussions with WAST to identify members of staff who could triage those dialling '999' to see if there were alternative services to which they could be conveyed, rather than the emergency department, as well as reviewing clinical pathways. Steve Spill noted that a post had been published on social media over the weekend inviting families to take home their loved ones with appropriate medications. He added that the reach of social media would be thousands and queried if any communication was being undertaken more directly with the relevant families. Kate Hannam responded that at the start of Covid-19, there had been an influx of families taking home their relatives and this was also the same at Christmas. The types of patients currently waiting for care packages could be managed by loved ones on a short-term basis and these type pf discussions were taking place with the families. Mark Child queried whether any lessons had been learned in terms of patient flow. Kate Hannam responded that an improvement plan had been developed by the emergency department team and developments were ongoing, finding different ways to support patients while they waited, which included the use of volunteers to ensure that they had enough to eat/drink. The team had also been asked to develop a workforce plan to determine what was needed in times of high demand.	

	Mark Child sought clarity as to how the success of the improvement plans would be measured. Kate Hannam advised that a detailed spreadsheet was in place with key performance indictors to measure the impact. A dashboard was also in development with the business intelligence team. Reena Owen advised that as part of the last update to the committee, members asked for a list of the pathways for clinically optimised patients to understand what was in the health board's control and what was not. Kate Hannam responded that this information was held in a dashboard and could be shared as part of the next update. Reena Owen referenced the plan to commission additional care home beds to create more capacity and queried the patient choice element. Kate Hannam responded that patient choice had been suspended during Covid-19 and patients were offered the next available bed, which meant that difficult discussions were required upon admission. Patients would not be transferred until they were well enough not to be in an acute setting. Reena Owen suggested a further update on urgent and emergency care be received at the December 2021 meeting. This was agreed.	
Resolved:	- The report be **noted.** - A further update be received on urgent and emergency care in December 2021.	
163/21	**FINANCIAL MONITORING RETURN**	
	The financial monitoring return was **received** and **noted.**	
164/21	**ITEMS FOR REFERRAL TO OTHER COMMITTEES**	
	There were no items to refer to other committees.	
165/21	**ANY OTHER BUSINESS**	
	(i) <u>Maturity Matrix</u> Darren Griffiths reminded members of the board maturity assessment which was undertaken earlier in the year in which the section on 'money/value for money' had been scored as being 'early progress (two on a scale of five). He undertook to re-circulate the narrative and invited	

	members to put forward outcomes which could be worked towards in the next few months to improve the position for the next assessment.	**DG**
	There was no further business and the meeting was closed.	
166/21	**DATE OF NEXT MEETING**	
	The next scheduled meeting is **Tuesday, 24th November 2021.**	